N321 CARE PLAN

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Lakeview College of Nursing

N321: Adult Health I

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09/19/2025

Demographics

Date of Admission	**Client Initials**	**Age**	**Biological Gender**
September 13, 2025	PAW	51	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Disability	Married	Bupropion Hcl, Cephalexin, Gabapentin
Code Status	**Height**	**Weight**	
FULL CODE	5ft’10in” (177.8 cm)	135.2kg (298 lb)	

Medical History

Past Medical History: Cardiac Arrest (2011), Orthostatic Hypertension, Non-alcoholic fatty liver disease, Myocardial infarct (HCC), Kidney disease, Hypertension, Hyperlipemia, Diabetes mellitus (HCC), coronary artery disease. Congestive heart failure (CHF) (HCC), Arthritis.

Past Surgical History: Pacemaker insertion (ad dfib), Laminectomy lumbar, Laminectomy cervical, Coronary angioplasty with stent placement, cholecystectomy, cardiac catheterization (03/24/2021), CABG, Arterial, single (2015)

Family History: Maternal grandmother, Heart attack (Deceased), client did state that both parents died of heart failure but never had any heart conditions. Father had Diabetes mellitus.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Former smoker, quit smoking 12/16/2018. Never drank alcohol, no drug use.

Education: Associate degree

Living Situation: Has a house with his wife.

Assistive devices: C-PAP

Admission History

Chief Complaint: Abdominal pain

History of Present Illness (HPI)– OLD CARTS: Mr. PAW arrived at the ED on 09/13/2025 with complaints of lower abdominal pain. MR. PAW stated that his pain characteristics are consistent and sharp, and said he "doesn't have to be moving to have this pain". Mr. Paw stated that it worsened overnight about a few days ago. Client stated that he hasn't had any nausea, vomiting, or diarrhea. Mr. PAW has no alleviating factors; he says nothing seems to help with the pain. Mr. PAW did have a recent CT scan of his pelvis, which was negative for kidney stones.

Admission Diagnosis

Primary Diagnosis: Appendicitis

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Acute Appendicitis is the most common cause of emergency in general surgery practice worldwide and is also a frequent reason for emergency department admission due to abdominal pain (Tüzün, 2025). There are two significant events can initiate Appendicitis, one of which is the narrowing of the appendix lumen due to an obstruction that results in ischemia and can also compromise the blood supply to the region (Capriotti, 2024). Lymphoid hyperplasia resulting from obstruction of the appendix lumen plays a key role in the etiology (Tüzün, 2025). The second way is due to the narrowing of the lumen, which develops a medium bacterial growth as normal mucus secretions, which remain trapped in the lumen and add to the increasing intraluminal pressure and distention (Capriotti, 2024). As a result of these two events, luminal bacteria will multiply and attack the appendix wall, causing inflammation, which compromises the protective mucosa layer of the appendix (Capriotti, 2024). If Appendicitis is left untreated it can become life-threatening, and the appendix can rupture, which causes peritonitis (Capriotti, 2024). Peritonitis happens when the contents of the appendix include bacteria, WBCs, and mucus and spill into the peritoneal cavity (Capriotti, 2024).

Someone who is experiencing Appendicitis usually complains of vague pain in the abdomen, which usually starts in the umbilical or epigastric area, and the severity of the pain increases over time and localizes to the right lower quadrant of the abdomen (Capriotti, 2024). Nausea and vomiting have been the main symptoms of Appendicitis (Tüzün, 2025). Patient pain can increase with any jarring movements, coughing, or taking deep breaths, and a patient can report vomiting, nausea, anorexia, fever, constipation or diarrhea, abdominal bloating, and chills (Capriotti, 2024). A patient who has Appendicitis typically experiences ~~something called~~ McBurney's point, which is abdominal pain that originates in the umbilical region radiating to the right lower quadrant (Capriotti, 2024). When the nurse is performing the physical examination, the nurse

should palpate the client's right lower quadrant; signs that occur during this are rebound tenderness, Psoas sign, Rovsing's sign, and Obturator sign, all of which are indicators of Appendicitis (Capriotti, 2024). Appendicitis can be diagnosed based on a combination of physical examinations, abdominal x-ray, CT scan, abdominal ultrasound, elevated C-reactive protein, and elevated WBC count (Capriotti,2024). Patients who receive early treatment for Appendicitis should take antibiotics that are effective against gram-negative, the patient will need to take the antibiotics pre-operatively and up to at least 48 hours postoperatively (Capriotti,2024). Laxatives and pain medications should be avoided before the diagnosis of Appendicitis because they can mask diagnostic signs (Capriotti,2024). It is important for the nurse to continuously monitor for peritonitis and IN therapy to restore or maintain fluid and electrolyte balance (Capriotti,2024). The primary treatment after surgical removal of the appendix through laparoscopic surgery is effective pain management (Capriotti,2024). The goal of the surgeon is to selectively operate on patients, knowing that they have Appendicitis, and to minimize having to perform surgery on patients whose appendix isn’t inflamed (Capriotti,2024). Even though the surgeon does not want to perform unnecessary surgery on patients, waiting to perform surgery can allow the occurrence of perforation (Capriotti,2024). With increased morbidity, the rate of negative appendectomy is 10% to 15% and has been accepted to minimize the incidence of perforated Appendicitis (Capriotti,2024). There are some patients that has non-perforated appendicitis, which can be treated with only antibiotics, (Capriotti,2024). They have lower and similar pain scores and only require a few doses of narcotics, (Capriotti,2024). These patients usually return to work sooner and have a lower perforation rate, (Capriotti,2024). During the first year, about 70% of patients treated with antibiotics during the initial admission

can avoid surgery, (Capriotti,2024). Due to recurrent appendicitis or symptoms of abdominal pain, the other 30% will require appendectomy, (Capriotti,2024).

My patient arrived at the emergency room with left lower abdominal pain. He stated, "The pain is consistent and sharp and has been going on for a few days now". Upon my assessment of the abdomen, when palpating the lower left of the abdomen, the client's reaction and facial expression showed he was in pain. My patient's vital signs were good, but his lab work showed that he had some inflammation going on. Mr. PAW's monocytes were low, and his C-reactive protein was also low, which means there is inflammation in the body. A CT scan on 9/13/2025 showed some mild stranding and thickening around the appendiceal base. Mr. PAW did have surgery, and his appendix was removed. Mr. Paw's care now focuses on recovering from the surgery, which consists of monitoring pain and incision site, ensuring he resumes his oral intake, and encouraging mobility.

Pathophysiology References (2) (APA)

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Tüzün, A., Durgun, C., & Dalbaşı, E. (2025). A rare cause of appendicitis in adults: Parasitic appendicitis. *Turkish Journal of Trauma and Emergency Surgery*, *31*(5), 445-449.

Laboratory/Diagnostic Data

Lab Name	Amission Value	Today's Value	Normal Range	Reasons for Abnormal
Potassium	3.1	3.5	3.5-5.1 mmol/L	Insulin administration/ poor intake (Pagana et al., 2023)
Creatinine, Blood	1.60	1.51	0.7-1.30 mg/dL	Dehydration (Pagana et al., 2023)
GFR, Estimated	52	56	>=60	Reduced kidney function (Pagana et al., 2023).
Bun/Creatinine Ratio	11	10	12-20 ratio	Low protein intake, (Pagana et al., 2023)
Alkaline Phosphatase	172	n/a	40-150 U/L	Stress, (Pagana et al., 2023)
GFR, EST NONAFRICAN	46	49	>=60	Reduced kidney function, (Pagana et al., 2023)
GFR, EST, AFRICAN	56	59	>=60	Reduced kidney function, (Pagana et al., 2023)
WBC	2.80	3.90	4.00-12.00 10(3)/mcL	Post-surgical stress, (Pagana et al., 2023)
RBC	3.95	4.36	4.40-5.80 10(6)/mcL	Nutritional deficiency, (Pagana et al., 2023)
HEMOGLOBIN (HGB)	10.8	11.9	13.0-16.5 g/dL	Blood loss, anemia (Pagana et al., 2023)
Hematocrit	32.2	35.8	38.0-50.0 %	Blood loss, anemia (Pagana et al., 2023)
MCV	81.7	82.1	82.0-96.0 fL	Iron deficiency, (Pagana et al., 2023)
Platelet Count	69	81	140-440 10(3)/mcL	Post surgical effect, Medications, (Pagana et al., 2023)
RDW	16.9	17.2	11.8-15.5%	Mixed anemia, recent blood loss,(Pagana et al., 2023)
MPV	7.9	8.0	11.8-15.5%	Low platelet production, (Pagana et al., 2023)
Monocytes	13.3	11.3	3.0-13 %	Chronic inflammation, (Pagana et al., 2023)

Calcium	8.7	8.6	8.7-10.5 mg/dL	Vitamin D deficiency, (Pagana et al., 2023)
Absolute Neutrophils	0.50	1.30	0.90-3.30 10(3)/mcL	Infection, (Pagana et al., 2023)
Glucose	195	99	70-99 mg/dL	Stress hyperglycemia, (Pagana et al., 2023)
C-reactive Protein	4.01	n/a	<0.50 mg/dL	Acute inflammation or infection, (Pagana et al., 2023)

Previous diagnostic prior to admission (ER, clinic etc.) if pertinent to admission diagnosis	**Previous diagnostic results and correlation to client admission**	**Current Diagnostic Test & Purpose**	**Clients Signs and Symptoms**	**Results and correlate to client diagnosis and condition**
N/A	**N/A**	CT Abdomen Pelvis with Contrast • ***Purpose***: noninvasive diagnostic imaging test/scan that generates	Patient had consistent sharp pain in his lower abdomen.	**Small Bowel: Obstruction is not displayed. There were some mild stranding and wall thickening around the appendiceal**

		images in multiple planes to help diagnosis the cause of abdominal or pelvic pain (RadiologyInfo.org, 2024) ● ***Date***: September 14, 2025		**base, it's difficult to say if that appendicitis is developing.** **Gallbladder/Billary Tree: The gallbladder is missing and biliary tree is in normal limits.**
N/A	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**

Diagnostic Test Reference (1) (APA):

Pagana, K., Pagana, T., Pagana, T. (2023). Mosby's Diagnostic & Laboratory Test Reference Sixteenth Edition. Elsevier.

RadiologyInfo.org. (2024). *Abdominal and Pelvic CT*. Radiologic Society of North America. https://www.radiologyinfo.org/en/info/abdominct#:~:text=Doctors%20typically%20use%20this%20procedure,collections%2C%20also%20known%20as%20abscesses

Active Orders

Active Orders	Rationale
DIET NPO Effective Now	This is an order due to the patient having surgery, which keeps the patient from aspiration during surgery.
IP Consult to General Surgery	To ensure the information about the surgery is getting done. This provides the assessment and potential operative planning.
Admission Weight	To monitor weight changes in the client and to be able to dose the patient correctly.
For blood sugar of 70 mg/dL or less	To prevent hypoglycemia or and perioperative complications.
Insert/Maintain Peripheral IV	To provide fluids and medication for surgery.
Intake and Output	This is to monitor the hydration of the client.
Maintain IV while on Telemetry	This is to monitor for arrhythmias.
Notify Physician	Symptomatic Bradycardia Ventricular Arrhythmias - These indicate if the condition is getting worse.
Notify the physician when the Prior To Admission (PTA) medication review has been completed.	This is for safe surgical planning.
Nursing Night Calls	This is for if the patient has any changes, such as worsening in the abdominal pain, fever or hypotension.
Perform POC Blood Glucose - AC & HS	This helps with the prevention of perioperative
Place Seq Comp Device (HUC orders equip)	Reduces the risk of venous thromboembolism.
Post-hypoglycemia treatment and blood sugar greater than or equal to 80 mg/dL	This is so that the surgery and recovery will go well.
Up With Assistance	Prevents falls.
Verify Informed Consent	Ensure the patients understand the procedure and potential risk.
Vital Signs per unit routine	These should be down 15 mins after surgery to monitor for fever, sepsis, and or hypotension.

Hospital Medications (Must List ALL)

Brand/Generic	clonazePAM (KlonoPIN)	HYDROmorphone (DILAUDID)	influenza virus vacc split PF (Flulaval,Fluarix)	insulin lispro (HumaLOG)	levoFLOXacin in D5W (LEVAQUIN)	LORazepam (ATIVAN)
Dose, frequency, route	0.5, by mouth (PO) , per order	0.5mg IV per order	0.5 mL IM, single dose	100 UNIT/ML injection 2-12 Units, SQ sliding scale with means and HS	750mg IV, daily	0.5 mg IV, per order
Classification (Pharmacological and therapeutic and action of the drug	Pharmacological: benzodiazepine (Jones &Bartlett,	*Pharmacologic:* Opioid agonist (Jones &Bartlett, 2024).	*Pharmacologic:* Vaccine, inactivated virus (Jones	*Pharmacologic:* Rapid-acting insulin (Jones	*Pharmacologic:* Fluoroquinolone antibiotic (Jones	*Pharmacologic:* Benzodiazepine (Jones &Bartlett,

	2024) *Therapeutic:* Anticonvulsant, anxiolytic, sedative. (Jones &Bartlett, 2024) *Action:* Enhances the effect of GABA in the CNS and sedation, reduces anxiety, seizure control (Jones &Bartlett, 2024).	*Therapeutic:* Analgesic (Jones &Bartlett, 2024). *Action:* Binds to mu-opioid receptors in CNS which alters pain perception and response (Jones &Bartlett, 2024).	&Bartlett, 2024). *Therapeutic:* Immunization (Jones &Bartlett, 2024). *Action:* Stimulates active immunity against influenza virus strains (Jones &Bartlett, 2024).	&Bartlett, 2024). *Therapeutic:* Antidiabetic (Jones &Bartlett, 2024). *Action:* Lowers blood glucose by facilitating uptake into muscle/fat and inhibiting hepatic glucose production (Jones &Bartlett, 2024).	&Bartlett, 2024) *Therapeutic:* Anti-infective (Jones &Bartlett, 2024) *Action:* Inhibits bacterial DNA synthesis to bactericidal (Jones &Bartlett, 2024)	2024) *Therapeutic:* Anxiolytic, sedative (Jones &Bartlett, 2024) *Action:* Potentiates GABA neurotransmission and CNS depression, sedation, reduced anxiety (Jones &Bartlett, 2024)
Reason Client Taking	To manage anxiety. (Jones &Bartlett, 2024)	For moderate to severe abdominal pain related to	Routine seasonal influenza prevention during hospitalizati	To manage hyperglycemia during acute	To treat/prevent infection related to appendicitis or	To manage anxiety, agitation, or as pre-procedure sedation,

		appendicitis. (Jones &Bartlett, 2024)	on (Jones &Bartlett, 2024)	illness (Jones &Bartlett, 2024)	suspected perforation (Jones &Bartlett, 2024)	(Jones &Bartlett, 2024) .
Two contraindications (pertinent to the client)	1.Severe respiratory depression (especially with opioids), (Jones &Bartlett, 2024). 2.History of substance dependence (Jones &Bartlett, 2024)	1. Severe respiratory depression (Jones &Bartlett, 2024) 2. Hypersensitivity to opioids (Jones &Bartlett, 2024)	1. Severe allergic reaction to vaccine or egg protein 2.Acute febrile illness (Jones &Bartlett, 2024)	1.Hypoglycemia (<70 mg/dL) 2. Hypersensitivity to insulin (Jones &Bartlett, 2024)	1.Hypersensitivity to fluoroquinolones 2.History of tendon disorders with quinolone use. (Jones &Bartlett, 2024)	1.Severe respiratory insufficiency (especially with opioids) 2.Acute narrow-angle glaucoma, (Jones &Bartlett, 2024)
Two side effects or adverse effects (Pertinent to the client)	1.Drowsiness, confusion (Jones &Bartlett, 2024)	1. Respiratory depression (Jones &Bartlett, 2024)	1.Injection site soreness, redness (Jones &Bartlett, 2024)	1.Hypoglycemia (Jones &Bartlett, 2024)	1.Tendon rupture, muscle pain (Jones &Bartlett, 2024).	1.Drowsiness, sedation, confusion (Jones &Bartlett,

	2.Can cause respiratory depression if taken with opioids. (Jones &Bartlett, 2024)	2.Constipation, nausea, sedation (Jones &Bartlett, 2024)	2.Mild fever, malaise (Jones &Bartlett, 2024)	2.Injection site reaction (Jones &Bartlett, 2024)	2.GI upset, diarrhea, possible C. diff. (Jones &Bartlett, 2024)	2024) 2.Respiratory depression (Jones &Bartlett, 2024)
Key nursing assessment(s) prior to administration	~~1. Monitor respiratory rate and LOC prior to administration, (Jones &Bartlett, 2024).~~ 2Assess for fall risk and level of sedation, (Jones &Bartlett, 2024).	1. Assess pain level and response to therapy, (Jones &Bartlett, 2024). ~~2. Monitor respiratory rate, O_2 sat, and LOC, (Jones &Bartlett, 2024).~~	1.Assess for history of allergy to vaccine components, (Jones &Bartlett, 2024). ~~2.Monitor for 15 minutes post-injection for adverse reaction (Jones &Bartlett, 2024).~~	1.Check blood glucose prior to administration, (Jones &Bartlett, 2024). 2.Assess for signs/symptoms of hypoglycemia, (Jones &Bartlett, 2024).	1~~. Monitor for infection improvement (fever, WBC, pain), (Jones~~ &Bartlett, 2024). 2. Assess for tendon pain/swelling, monitor renal function, (Jones &Bartlett, 2024).	~~1.Monitor respiratory status and LOC, (Jones &Bartlett, 2024).~~ 2.Assess need for anxiolysis or sedation level, (Jones &Bartlett, 2024).

Brand/ Generic	metroNIDAZOLE (FLAGYL)	ondansetron (ZOFRAN)	pantoprazole (PROTONIX) injection 40 mg	sodium chloride 0.9 %	glucose (GLUTOSE) 40 % gel	dextrose 50 % solution
Dose, frequency, route	500 mg IV, per order	4 mg IV, per order	40 mg IV daily	1,000 mL IV bolus	15 g oral gel PRN	12.5 g IV PRN
Classification (Pharmacological and therapeutic and action of the drug	*Pharmacologic:* Nitroimidazole antimicrobial (Jones &Bartlett, 2024). *Therapeutic:* Anti-infective (Jones &Bartlett, 2024).	*Pharmacologic:* 5-HT3 receptor antagonist (Jones &Bartlett, 2024) *Therapeutic:* Antiemetic (Jones	*Pharmacologic:* Proton pump inhibitor (Jones &Bartlett, 2024) *Therapeutic:* Antiulcer agent	*Pharmacologic:* Electrolyte/Isotonic crystalloid (Jones &Bartlett, 2024) *Therapeutic:* Fluid/ele	*Pharmacologic:* Carbohydrate (Jones &Bartlett, 2024) *Therapeutic:* Antihypoglyce	*Pharmacologic:* Carbohydrate (Jones &Bartlett, 2024) *Therapeutic:* Antihyp

	Action: Disrupts DNA synthesis in anaerobic bacteria, causing cell death (Jones &Bartlett, 2024).	&Bartlett, 2024) *Action:* Blocks serotonin receptors in GI tract and CNS then reduces nausea/vomiting (Jones &Bartlett, 2024).	(Jones &Bartlett, 2024) *Action:* Suppresses gastric acid secretion by inhibiting H+,K+-ATPase enzyme (Jones &Bartlett, 2024)	ctrolyte replacement (Jones &Bartlett, 2024) *Action:* Expands intravascular volume (Jones &Bartlett, 2024)	mic (Jones &Bartlett, 2024) *Action:* Rapidly increases blood glucose (Jones &Bartlett, 2024)	oglycemic (Jones &Bartlett, 2024) *Action:* Rapidly raises blood glucose (Jones &Bartlett, 2024)
Reason Client Taking	Given with other antibiotics (e.g., levofloxacin) to cover anaerobic bacteria in suspected or confirmed appendiceal infection or perforation (Jones &Bartlett, 2024).	o control nausea/vomiting related to appendicitis, pain, or opioids; prevents aspiration risk pre-op (Jones &Bartlett, 2024).	Stress ulcer prophylaxis post-op (Jones &Bartlett, 2024).	Fluid replacement and hydration post-op (Jones &Bartlett, 2024).	For mild hypoglycemia if able to swallow (Jones &Bartlett, 2024).	For severe hypoglycemia when NPO or unresponsive (Jones &Bartlett, 2024).

Two contraindications (pertinent to the client)	1.Severe hepatic impairment, (Jones &Bartlett, 2024). 2.Alcohol use (disulfiram-like reaction), (Jones &Bartlett, 2024).	1Hypersensitivity to ondansetron, (Jones &Bartlett, 2024). . Caution with prolonged QT syndrome, (Jones &Bartlett, 2024).	1. Hypersensitivity (Jones &Bartlett, 2024). 2. Caution in hepatic impairment (Jones &Bartlett, 2024).	1. Hypernatremia (Jones &Bartlett, 2024). 2. Fluid overload /CHF (Jones &Bartlett, 2024).	1. Inability to swallow (Jones &Bartlett, 2024). 2. Unconsciousness (Jones &Bartlett, 2024).	1. Intracranial/intraspinal hemorrhage (Jones &Bartlett, 2024). 2. Caution in uncontrolled diabetes (Jones &Bartlett, 2024).
Two side effects or adverse effects (Pertinent to the client)	1.Nausea, metallic taste, GI upset 2.Peripheral neuropathy, seizures (rare)	1. Nausea, metallic taste, GI upset (Jones &Bartlett, 2024).	1. Headache, diarrhea (Jones &Bartlett, 2024).	1. Edema (Jones &Bartlett, 2024). 2.	1. Hyperglycemia (Jones &Bartlett, 2024).	1. Hyperglycemia (Jones &Bartlett, 2024).

		2. Peripheral neuropathy, seizures (Jones &Bartlett, 2024).	2. Hypomagnesemia (long term) (Jones &Bartlett, 2024).	Electrolyte imbalance (Jones &Bartlett, 2024).	2. GI upset (Jones &Bartlett, 2024).	2. Phlebitis at IV site (Jones &Bartlett, 2024).
Key nursing assessment(s) prior to administration	1.~~Monitor infection improvement (fever, WBC, pain), (Jones &Bartlett, 2024).~~ 2.Assess for neuro symptoms (numbness, seizures), (Jones &Bartlett, 2024).	1.Asses for nausea and vomiting. (Jones &Bartlett, 2024). ~~2.Monitor patient CBC and platelets, (Jones &Bartlett, 2024).~~	~~1.Monitor GI bleeding, (Jones &Bartlett, 2024).~~ 2. check electrolytes if prolonged use (Jones &Bartlett, 2024).	~~1. Monitor lungs sounds, (Jones &Bartlett, 2024).~~ 2. ~~Monitor I/O and electrolytes, (Jones &Bartlett, 2024).~~	1. Check blood glucose, (Jones &Bartlett, 2024). 2.Ensure that the patient can swallow, (Jones &Bartlett, 2024).	~~1.Monitor blood glucose, (Jones &Bartlett, 2024).~~ 2. Check IV site for irritation, (Jones &Bartlett, 2024).

Brand/ Generic	Glucagon Emergency injection KIT	HYDROcodone-acetaminophen (NORCO)	nicotine (NICODERM CQ)	ondansetron (ZOFRAN-ODT)		
Dose, frequency, route	1 mg IM/SC/IV PRN	10-325 mg per tablet, 1 tab PO PRN	21 mg/24 hr transdermal patch	4 mg PO disintegrating tab, PRN		
Classification (Pharmacological and therapeutic and action of the drug	*Pharmacologic:* Pancreatic hormone, (Jones &Bartlett, 2024) *Therapeutic:* Antihypoglycemic (Jones &Bartlett, 2024) *Action:* Stimulates hepatic glycogenolysis to raise blood glucose (Jones &Bartlett, 2024)	*Pharmacologic:* Opioid agonist + non-opioid analgesic (Jones &Bartlett, 2024) *Therapeutic:* Opioid analgesic (Jones &Bartlett, 2024) *Action:* Alters pain	*Pharmacologic:* Nicotine agonist (Jones &Bartlett, 2024) *Therapeutic:* Smoking deterrent (Jones &Bartlett, 2024) *Action:* Provides controlle	*Pharmacologic:* Selective serotonin (5-HT3, receptor antagonist, (Jones &Bartlett, 2024) *Therapeutic:* Antiemetic (Jones &Bartlett, 2024) *Action:*		

		perception; acetaminophen inhibits prostaglandins (Jones &Bartlett, 2024)	d nicotine to reduce withdrawal symptoms (Jones &Bartlett, 2024)	To prevent postoperative nausea and vomiting, (Jones &Bartlett, 2024)		
Reason Client Taking	Backup for severe hypoglycemia without IV access, (Jones &Bartlett, 2024).	For moderate postoperative pain after appendectomy (Jones &Bartlett, 2024).	Smoking cessation during hospitalization, (Jones &Bartlett, 2024).	For nausea/vomiting management postoperative, (Jones &Bartlett, 2024).		
Two contraindications (pertinent to the client)	1. Mitral valvular rheumatic heart disease, (Jones &Bartlett, 2024). 2. Coronary artery disease,	1. Severe respiratory depression (Jones &Bartlett, 2024). 2. Severe hepatic	1. Hypersensitivity to nictone (Jones &Bartlett, 2024).	1.Concomitant use of apomorphine, (Jones &Bartlett, 2024).		

	(Jones &Bartlett, 2024).	impairment (Jones &Bartlett, 2024).	2. Severe arrhythmias (Jones &Bartlett, 2024).	2. Hypersensitivity to ondansetron or its components, (Jones &Bartlett, 2024).		
Two side effects or adverse effects (Pertinent to the client)	1. Angina (Jones &Bartlett, 2024). 2. Constipation (Jones &Bartlett, 2024).	1. Constipation (Jones &Bartlett, 2024). 2. Respiratory depression (Jones &Bartlett, 2024).	1. Skin irritation (Jones &Bartlett, 2024). 2. Insomnia, vivid dreams , (Jones &Bartlett, 2024).	1. GI: Abdominal pain, diarrhea, (Jones &Bartlett, 2024). 2. CV: Chest pain, hypotension, (Jones &Bartlett, 2024).		
Key nursing assessment(s)	1.Check blood glucose. (Jones	1.Asses pain,	1.Asses smoking	1.Assess bowel		

prior to administration	&Bartlett, 2024). 2.Place on side to prevent aspiration, (Jones &Bartlett, 2024).	(Jones &Bartlett, 2024). 2.Monitor respiratory rate, O2 saturation, (Jones &Bartlett, 2024).	history, (Jones &Bartlett, 2024). 2.Inspect skin at site, (Jones &Bartlett, 2024).	sounds and abdominal distention, (Jones &Bartlett, 2024). 2. Assess fluid intake/output, mucous membranes, and skin turgor, (Jones &Bartlett, 2024).		

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. HYDROmorphone (DILAUDID) injection 0.5 mg	This medication was chosen for the patient, sharp pain he was having in his lower left abdominal.	1. Constipation (Jones & Bartlett, 2024) 2. Drowsiness (Jones & Bartlett, 2024)
2. ondansetron (ZOFRAN) injection 4 mg	This medication was chosen because it helps with the nausea when taking Dilaudid.	1. Headache (Jones &Bartlett, 2024) 2. Constipation (Jones & Bartlett, 2024)
3. metroNIDAZOLE (FLAGYL)	This medication was chosen because client was going to surgery.	1. Nausea (Jones &Bartlett, 2024) 2. Metallic taste in mouth (Jones &Bartlett, 2024)

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2024). *NDH: Nurse's Drug Handbook: Twenty-Four Edition*. World headquarters.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	**Pt was alert and oriented x4, to person place time and situation. Pt wasn't under any distress. The pt was well-groomed. Pt has a full head of hair thats spread thinly, facial hair, eye lashes, eye brows. Pt looked clean. Pt respond to verbal stimuli.** ● **Isolation**: n/a ● **Precautions**: n/a **Chief Complaint**: Left lower abdominal pain
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	**Client vitals were taken at 0805,** ● **Temp**: 97.6F orally ● **Respiration**: 22 ● **Pulse**: 86 ● **b/p**: 127/74, sitting in bed, L arm ● **O2**: 99%, room air
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:**	**At 0805 pt was asked his pain level pt stated it was a 9 out of a 10. The scale I used was preferred pain scale 0-10. The pain was in his lower left abdomen. He said it was a constant and sharp pain. To help with the pain I gave my pt Dildiudo**

Characteristics: **Interventions:**	
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	**Location**: o Right arm, cephalic vein ● **Size**: 20G ● **Date**: 09/13/2025 ● **Patency**: able to be flushed, blood return noted ● **Signs**: dry, clean and intact, no signs of redness, pain or infiltration ● **Dressing**: clean, dry, intact **Fluid Type**: saline lock
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	● **Color**: Usual for ethnicity ● **Character**: clean, dry, intact with normal quantity, distribution and texture of hair throughout his body. ● **Temp**: warm and dry upon palpation ● **Turgor**: normal mobility ● No rashes or drains ● No bruises ● Wound: Client has surgical scar down the middle of his chest. Also, he has an incision left shoulder not too far from his chest one. ● **Braden Score**: 22

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	● **Head/Neck**: symmetrical head and face, trachea is midline without deviation, thyroid is not palpable, no nodules noted ● **Ears**: no visible or palpable deformities, lumps, or lesions, bilateral canals clear, no swelling, redness, drainage, or tinnitus. ● **Eyes**: sclera white and cornea clear bilaterally, no drainage or discoloration, PERRLA intact, no lumps or lesions ● **Nose**: septum is midline, nares moist and pink bilaterally, no bleeding, frontal sinuses are nontender upon palpation, no tenderness, smell intact, nares patent ● **Mouth**: oral mucous membrane not quiet moist but not too dry and pink without sores or lesions, tonsils and pharynx moist, size 2+ tonsil size, uvula midline, swallowing without difficulty, tongue pink, no teeth present**.**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	● **Heart sounds**: Heart sounds are clear S1 and S2 sounds without murmuring ● **Rhythm**: normal rate and rhythm ● **Peripheral pulses**: 2+ bilaterally ● **Capillary refills**: less than 3 seconds on fingers and toes bilaterally ● No neck distention ● No pitting edema.
RESPIRATORY:	● There were no accessory muscles used

Accessory muscle use: **Y☐ N ☐** **Breath Sounds: Location, character**	• Breath sounds: regular unlabored breathing, equal lung aeration bilaterally
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating Diet?** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	• **Home Diet**: Regular • **Current diet**: NPO Yes, the client is tolerating the diet. • **Height**: 5ft'10in'' (177.8cm) • **Weight**: 298lbs (135.2 kg) • **Bowel sounds**: Pt has hypoactive bowel sounds in the lower left of the abdomen. Couldn't really hear patient upper abdomen. • **Last BM**: 9/10/2025 • Upon palpation, firm tender abdomen lower left bowel sounds were hypoactive in lower left abdominal. Client did report pain when palpating the lower left abdominal. No ostomy, or feeding/PEG tube • There was a Nasogastric size 16ft in the right naris during surgery. Inspection • Distention: No • Scars/Wound/Incisions: Client also has 3 incisions scars from his surgery, one near umbilical scar, one in the lower left abdomen, and one in the suprapubic area which is above the pubic bone: Band-Aid on the smaller incisions and a 2x2 gauze with Tegaderm on the on under the suprapubic area. • NO drains

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	• **Color**: Dark yellow Pt npo • **Character**: clear • **Quantity of urine:** 2 occurence • **Pain**: no pain upon urination • No dialysis • No foley
Intake (in mLs) **Output (in mLs)**	**Intake (in mLs)-** **Client was npo by mouth due to surgery.** **Output (in mLs) - 2 occurence+300 mL at surgery.**

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	● **Neurovascular**: Pt nails show no clubbing or cyanosis, all extremities warm, dry and symmetrical. ● **ROM**: Pt has extremities full ROM and symmetrical movement ● **Devices**: no devices ● **Strength**: 3+, bilateral normal and equal hand grip strength, pedal pushes and pull strength equal and normal bilateral, dorsiflexion and plantar flexion performed with normal equal strength on bilateral ● **Fall Risk**: **18** ● **Mobility**: Independent. Pt doesn't need help with ADLs.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	● MAEW: intact ● PERLA: intact ● Strength o Arms – equal 3+ o Legs – equal 3+ ● Orientation: Pt is alert and orient x4 to person, place, time, and situation ● Mental status: normal cognition ● Speech: clear, logical, monotone. LOC: PT answer questions appropriately.

Sensory: **LOC:**	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	● Developmental level: Generativity vs. Stagnation ● Religion: Christian, didn't state what it meant to him. He said he grew up as a Christian. ● PT stated that they feel safe at home.

Discharge Planning

Discharge location: Mr. PAW will be discharged from the hospital to his home with his wife.

Home health needs: The patient will be sent home with oral pain medication.

Equipment needs: Clients don't need any equipment.

Follow up plan: Mr. PAW is to follow up with surgeon in two weeks.

Education needs: No lifting of greater than 10lb, or any exercise. Signs and symptoms of infection. Notify doctor if you have a fever goes 100.3 or above, of any redness or oozing, drainage of the wound and foul smelling. To keep pain under control, take ibuprofen or Tylenol.

Nursing Process

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis · Include full nursing diagnosis with “related to” and “as evidenced by” components · Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** · Explain why the nursing diagnosis was chosen	**Outcome Goal** **(1 per dx)**	**Interventions** **(2 per goal)**	**Evaluation of interventions**
1. Acute pain related surgical incisions and tissue trauma as evidenced by patients who reports having serve abdominal pain 7/10 and holding his incision site, (Phelps 2023.	After surgery, pain is the number one priority because it interferes with breathing, mobility, and recovery. Client with effective pain management helps promote comfort, prevention of complications such as pneumonia or DVT (Phelps 2023.	The patient will report his pain decrease to be a three or less using the number scale at 30-minute intervals (Phelps 2023.	1. As the nurse, I use a number scale 0-10 and assess the client's pain every two hours before and after administering analgesics (Phelps 2023. 2. As the nurse, I will prescribe analgesics as ordered and I will encourage the client to use a nonpharmacol	After I administered the patient's analgesic through his IV, the patient reported that his pain decreased to a 2 out of 10 within the 30-minute interval. Pt did meet their goal.

			ogical pain relief method, such as placing an extra pillow underneath him for when he moves or coughs (Phelps 2023.	
2. Risk for infection related to surgical incision as evidenced by disruption of skin integrity and postoperative status (Phelps 2023.	A patient with a surgical incision increases the chances of getting an infection. For a good recovery, the key points are to prevent disease and recognize the early signs of complications (Phelps 2023.	The patient will remain free of infection while during my shift at the hospital with evidence by the vital signs, normal WBC, and the dressing of the incision site (Phelps 2023).	1. I will monitor vital signs every 30 minutes and assess the incision site for abnormal results such as redness, swelling, purulent drainage, or foul-smelling discharge (Phelps 2023. 2. I will perform hand hygiene before and after wound care and administer prescribed antibiotics as ordered	The patient remained free from fever, and the incision site was clean, dry, and intact, with no drainage noted. Pt WBC count was good. The patient met their goal.

			(Phelps 2023.	
3. Impaired physical mobility related to abdominal incision and postoperative discomfort as evident by decreased in activity tolerance and slow guarded movements (Phelps 2023).	A patient who indicates pain and fear after surgery may restrict mobility due to wound disruption. The patient should be encouraged to have mobility to promote circulation, lung expansion, and recovery. If limited to movement, this can increase the risk of pneumonia, DVT, and constipation (Phelps 2023.	The patient will ambulate to the bathroom by himself, about 30ft in total, and back to the bed by the end of the shift (Phelps 2023).	1. Teach the patient splinting techniques, holding the pillow over the incision. (Phelps 2023 2. Encourage early ambulation by assisting with mobility, having the patient sit at the edge of the bed, slowly get up, take short walks, and increase distance. (Phelps 2023	Patient ambulated to the bathroom by himself with standby assistance and demonstrated splinting technique correctly. The patient did meet their goal.

Nursing Process Prioritization	**Rationale**
1. Acute Pain	According to Maslow's hierarchy of needs,

	when caring for a patient in pain, nurses must prioritize ensuring the patient has a higher need and a safe recovery. (CareRev, 2024).
2. Risk for infection	If not prevented, early infections can become sepsis, which is life-threatening (Picmonic, 2024).
3. Impaired physical mobility	To ensure patient safety during movement, infection prevention, and safe ambulation, these things must be prioritized after pain and infection because pain control is necessary (Nurseslabs, 2024).

Other References

CareRev. (2024, February 20). *Maslow's hierarchy of needs in nursing*. Retrieved September 16, 2025, from https://www.carerev.com/blog/maslows-heirarchy-nursing-education

Nurseslabs. (2024, November 20). *Impaired physical mobility & immobility nursing diagnosis & care plans*. Retrieved September 16, 2025, from https://nurseslabs.com/impaired-physical-mobility/

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer.

Picmonic. (2024, November 20). *Levels of nursing prioritization - NCLEX review*. Retrieved September 16, 2025, from https://www.picmonic.com/pathways/nursing/courses/standard/professional-standards-of-nursing-8246/prioritizing-care-32342/guidelines-for-prioritizing_8454

StatPearls. (2025, March 15). *Nursing process*. In *StatPearls*. Retrieved September 16, 2025, from https://www.ncbi.nlm.nih.gov/books/NBK499937/