N321 Care Plan #1

Lakeview College of Nursing

Kelly Lonergan

Demographics (3 points)

Date of Admission 09/17/2019	**Patient Initials** GC	**Age** 46	**Gender** M
Race/Ethnicity Caucasian	**Occupation** Unemployed-previous truck driver	**Marital Status** Divorced	**Allergies** Ellipta, Spiriva, Advair, Meloxicam, Budesonide, Flovent
Code Status Full	**Height** 68in	**Weight** 216lbs	

Medical History (5 Points)

Past Medical History: Significant for anxiety and asthma exacerbation, status post cardiac arrest in July, 2018.

Past Surgical History: None.

Family History: Diabetes and arrhythmias on maternal side.

Social History (tobacco/alcohol/drugs): Smoked for 30 years, five ppd. Quit smoking 5 years ago. Uses smokeless tobacco. Does not drink.

Assistive Devices: None

Living Situation: Lives alone in country.

Education Level: High school.

Admission Assessment

Chief Complaint (2 points): Increasing abdominal pain and heartburn

History of present Illness (10 points): Patient is a 45-year-old man, presenting to the ER with increasing abdominal pain and heartburn. The abdominal pain started yesterday afternoon. He has been unable to pass gas the past couple days, making him feel “uncomfortable and bloated.” The abdominal pain starts around his umbilicus and works its way up, causing heart burn. He

reports the discomfort is worse when moving around. He is afebrile, has no nausea/vomiting. He has not taken any medication to help relieve symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute diverticulitis

Secondary Diagnosis (if applicable): None.

Pathophysiology of the Disease, APA format (20 points):

Diverticulitis is a disease in which diverticula, small outpouchings of the mucosa through the muscle layers of the colon, become inflamed (Sorenson, Quinn, & Klein, 2019). Complicated diverticulitis is inflammation associated with obstruction, bleeding, or a perforation. Diverticulitis is commonly found in the descending colon however, it can occur in any portion on the GI tract (Mayo Clinic Staff, 2019). When the diverticula become inflamed, it can cause severe abdominal pain (especially in the left lower quadrant), abdominal distention, fever, nausea, decreased appetite, and changes in bowel habits Vital signs include an increased heart rate and decreased blood pressure (Sorenson, Quinn, & Klein, 2019).

For acute diverticulitis, CT scans, ultrasounds, and MRIs can be useful in diagnosing the disease. CBC and BMP should be collected to assess leukocyte, electrolyte, and renal levels (Sorenson, Quinn, & Klein, 2019). UTI, pregnancy, and GI bleeds should be ruled out with urine and stool specimens. Treatment includes a clear liquid diet and broad-spectrum antibiotics. This condition is common, especially after forty. Other risk factors include obesity, smoking, lack of exercise, high animal fat and low fiber diet, and certain medications (Mayo Clinic Staff, 2019). “Approximately 25% of patients who are admitted with acute diverticulitis will require a surgical

or procedural intervention" (Sorenson, Quinn, & Klein, 2019). 94% can be treated in an outpatient setting.

Pathophysiology References (2) (APA):

Mayo Clinic Staff (2019). Diverticulitis. Retrieved from https://www.mayoclinic.org/diseases-conditions/diverticulitis/symptoms-causes/syc-20371758

Sorenson, M., Quinn, L, & Klein, D. (2019). *Pathophysiology: Concepts of human disease* (1st ed.). Hoboken, NJ: Pearson Education, Inc.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4-5.5 mil	5.15 mil	4.85 mil	
Hgb	12-16 g/dL	14.9 g/dL	13.9 g/dL	
Hct	37-51%	43.9%	41.7%	
Platelets	140,00—400,000	312,000	298,000	
WBC	4,000-11,000	12.44	8.15	An elevated WBC indicates an infection, a reaction to a drug, abnormal bone marrow function, or immune system disorder (Mayo Clinic Staff, 2018). This level is elevated on this patient due to the inflammation in his colon. Also, the patient experiences environmental allergies, which can cause an increase in WBC levels.

Neutrophils	1.5-8.0	7.18	4.48	
Lymphocytes	20-40%	17.8%	35%	
Monocytes	0-10	8.0	8.3	
Eosinophils	0-6	0.2	1.0	
Bands	0-2	0.1	0.1	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145 mmol/L	136 mmol/L	139 mmol/L	
K+	3.5-5.0 mmol/L	3.6 mmol/L	3.8 mmol/L	
Cl-	98-108 mmol/L	99 mmol/L	104 mmol/L	
CO2	21-32 mEq/L	26.8 mEq/L	26.5 mEq/L	
Glucose	60-99 mg/dL	91 mg/dL	96 mg/dL	
BUN	7-18 mg/dL	15 mg/dL	12 mg/dL	
Creatinine	0.6-1.3 mg/dL	1.09 mg/dL	1.1 mg/dL	
Albumin	3.4-5.0 gm/dL	4.1 gm/dL	3.5 gm/dL	
Calcium	8.5-10.1mg/dL	9.1 mg/dL	8.6 mg/dL	
Mag	1.8-2.4 mg/dL	2.0 mg/dL	Lab was not drawn	
Phosphate	2.5-4.5 mg/dL	No lab result		
Bilirubin	0.2-1.0 mg/dL	0.6 mg/dL	0.7 mg/dL	
Alk Phos	45-117 U/L	74 U/L	63 U/L	

AST	15-37 U/L	12 U/L		
ALT	12-78 U/L	17 U/L	15 U/L	
Amylase	0-137 U/L	No lab result		
Lipase	12-70 U/L	No lab result		
Lactic Acid	0.5-1 mmol/L	Lab was not drawn		

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	2-3	No lab results		
PT	9.5-11.3sec	No lab results		
PTT	30-40 sec.	No lab results		
D-Dimer	<0.5	<0.27		
BNP	<125 pg/mL	No lab results		
HDL	>60 mg/dL	No lab results		
LDL	<130 mg/dL	No lab results		
Cholesterol	<200 mg/dL	No lab results		
Triglycerides	<150mg/dL	No lab results		
Hgb A1c	<7%	No lab results		
TSH	0.4-4.0 ml/L	No lab results		

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Colorless-yellow	Yellow	No results	
pH	5.0-8.5	7.0	No results	
Specific Gravity	1.000-1.030	1.010	No results	
Glucose	Negative	Negative	No results	
Protein	Negative	Negative	No results	
Ketones	Negative	Negative	No results	
WBC	None or Rare	No results		
RBC	None or Rare	No results		
Leukoesterase	Negative	No results		

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	<100,000/ml	Not available		
Blood Culture	Negative	Not available		
Sputum Culture	negative	Not available		
Stool Culture	Negative	Not available		

Lab Correlations Reference (APA):

Mayo Clinic Staff (2018). High white blood cell count. Retrieved from https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/causes/sym-20050611

Sorenson, M., Quinn, L, & Klein, D. (2019). *Pathophysiology: Concepts of human disease* (1st ed.). Hoboken, NJ: Pearson Education, Inc.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Patient was monitored on a continuous EKG. Monitored in normal sinus rhythm. CT scan and Ultrasound performed earlier in the morning. No results given at the time.

Diagnostic Test Correlation (5 points): CT scans allow physicians to view the diverticula of the colon. This scan is able to show any inflammation or infection that may be present within the diverticula. Contrast may be given via IV or orally. This contrast allows for better images of the intestines. An Ultrasound of the pelvis allows the physician to view the abdominal organs, without exposing the patient to radiation. Images of Ultrasounds are not as clear as CT scans (radiologyinfor.org, 2019)

Diagnostic Test Reference (APA):

Radiologyinfo.org (2019). Diverticulitis. Retrieved from https://www.radiologyinfo.org/en/info.cfm?pg=diverticulitis

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Ventolin/ Albuterol	Xanax/ Alprazolam	Tums/ Calcium carbonate	Flagyl/ Metronidazole	Singulair/ Montelukast

Dose	90mcg	0.0125 mg	500 mg	500mg	10 mg
Frequency	Every 4 hours, PRN	2x daily, PRN	PRN	3x daily for 10 days	1/evening
Route	Inhaler	P.O.	P.O.	P.O.	P.O.
Classification	Broncho-dilator	sedative	Antacid	Antibiotic	Anti-inflammatory
Mechanism of Action	Relaxes muscles of airways to lung, making breathing easier	Increases effects of neurotransmitters that control emotional behavior (GABA)	Increases intra/extra cellular calcium levels to maintain homeostasis	Damages DNS strands, inhibiting bacterial cell replication	Inhibits allergen receptors in airways
Reason Client Taking	Asthma	Anxiety	Abdominal pain	Inflammatory response	Inflammatory response/ allergies
Contraindications (2)	Hypersensitivity Tachycardia	Glaucoma, hypersensitivity	Hypercalcemia Renal calculi	Breastfeeding Hypersensitivity	Acute asthma attacks Depression
Side Effects/Adverse Reactions (2)	Anxiety Arrhythmias	Agitation Blurred vision Chest pain	Hypotension hypercalcemia	Aseptic meningitis Dark urine	Abdominal pain, cough
Nursing Considerations (2)	Administer during second half of inspiration Monitor potassium levels	Warn against withdrawal symptoms Instruct to never increase dosage	Monitor vitals-BP Monitor calcium levels	Don’t give direct IV injection Monitor CBC and cultures	Monitor vitals Watch for suicidal tendencies

Hospital Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol	Alprazolam/ Xanax	Fluticasone/ Breo Ellipta	Hydrocodone-acetaminophen/ Norco	Hydromorphone/ dilaudid
Dose	650mg	0.5mg	100mcg	5-325mg	1mg

Frequency	Every 4 hours/ PRN	2x/day PRN	1 puff daily	Every 4 hours/ PRN	Every 6 hours/ PRN
Route	P. O.	P.O.	inhalation	P.O	IV
Classification	Analgesic	Anti-anxiety	Glucocorticoid	Opioid analgesic	Opioid analgesic
Mechanism of Action	Interferes with pain impulses. Directly targets hypothalamus for temperature control	Increases effects of neurotransmitters that control emotional behavior (GABA)	Inhibits cellular response to inflammation	Produces pain relief by activating sites in brain and spinal cord	Alters the perception and emotional response to pain
Reason Client Taking	Pain relief	Anxiety	Asthma therapy	Pain relief	Relieve pain
Contraindications (2)	Hypersensitivity Severe liver disease	Glaucoma Hypersensitivity	Hypersensitivity Acute asthma	Acute asthma hypersensitivity	Acute asthma GI obstruction
Side Effects/Adverse Reactions (2)	Hepatotoxicity nausea	Blurred vision Chest pain	Allergic rhinitis bronchospasm	Hypotension constipation	HTN Blurred vision
Nursing Considerations (2)	Monitor renal function Monitor Liver function	Warn against withdrawal symptoms Instruct to never increase dosage	Monitor respirations Have fast-acting bronchodilator available	Monitor BP Monitor BM	Use during pregnancy can result in neonatal withdrawal Monitor vitals

Medications Reference (APA):

N.A. (2018). Nurse's Drug Handbook (17th ed). Burlington, MA: Jones & Bartlett learning, LLC.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented x4 Well-groomed and dressed. Ambulating on own. No dyspnea or obvious distress. Appears comfortable. Anxious at times
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Skin is warm and pink. No bruises, rashes, or open wounds. Multiple tattoos on arms/back. Normal/rapid turgor Braden Score: 23 No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	PERRLA Normocephalic Moist mucous membranes Clean ears/nose Clean, white teeth .
CARDIOVASCULAR (2 points): **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:**	Clear S1, S2 Normal sinus rhythm 2+ pulse throughout Rapid capillary refill No neck vein distention No edema present
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No crackles/wheezes or rubs No accessory muscle use

GASTROINTESTINAL (2 points): **Diet at home:** **Current 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:**	No at home diet Height: 68in Weight: 216lbs Hypoactive bowel sounds Last BM: yesterday Hard distention of abdomen, mild pain with light palpation No incisions, scars, drains, or wounds No ostomy No nasogastric No feeding tubes
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Pale-yellow urine No pain or trouble with urination No dialysis No catheter
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Active/full ROM all extremities No supportive devices Equal/strong grips No ADL assistance Fall Risk: medications, IV infusion= 4points= not a fall risk Independent ambulation Does not need assistance with grooming, standing, walking
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐**	MAE PERRLA Strength equal- all extremities

Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Alert and oriented x 4 Anxious-intermittently Clear speech No LOC
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Difficulty coping with anxiety. Experiences mild asthma/anxiety attacks- treated with neb. High School diploma Patient mentions God as having a role on his health, even though he sees it as unfair. Lives alone, son lives hour away attending college. 1 dog at home

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	70	100/57	20	98 F	97% on room air
1400	81	132/84	22	98 F	98% on room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1330	6	Abdomen	“Miserable”	Discomfort, bloated, SOB	Received Neb Tx, Xanax, Tylenol
1430	3	Abdomen	More comfortable after Tx	Bloated/constipated	Tums given

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20G **Location of IV: R. Hand** **Date on IV: 09/09/2019** **Patency of IV: Clean/clear** **Signs of erythema, drainage, etc.: None.** **IV dressing assessment: intact, clean**	.9% NaCl Flagyl 300ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600ml	**1400ml**

Nursing Care

Summary of Care (2 points)

Overview of care: Pt received 1000 ml .9% NaCl and 300ml of Flagyl via IV. Tolerated well. Reported nausea and SOB with Flagyl administration. Treated with nebulizer, Tylenol, and tums.

Procedures/testing done: None.

Complaints/Issues: Mild anxiety attack with medication administration. 6/10 abdominal pain/discomfort relieved to 3/10 after nebulizer and Tylenol. No other complaints/issues

Vital signs (stable/unstable): All vital signs stable

Tolerating diet, activity, etc.: Tolerating clear liquid diet well. Tolerating activity with no complaints

Physician notifications: None.

Future plans for patient: Monitor diet. Avoid diverticulitis aggravation.

Discharge Planning (2 points)

Discharge location: Plan for patient to discharge home tomorrow provided no changes over night.

Home health needs (if applicable): None.

Equipment needs (if applicable): None.

Follow up plan: Primary care follow up scheduled for 2 weeks out

Education needs: Medication use/administration guidelines. Importance of managing stress and ways to prevent asthma attacks. Education of proper diet for new diagnosis of diverticulitis.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

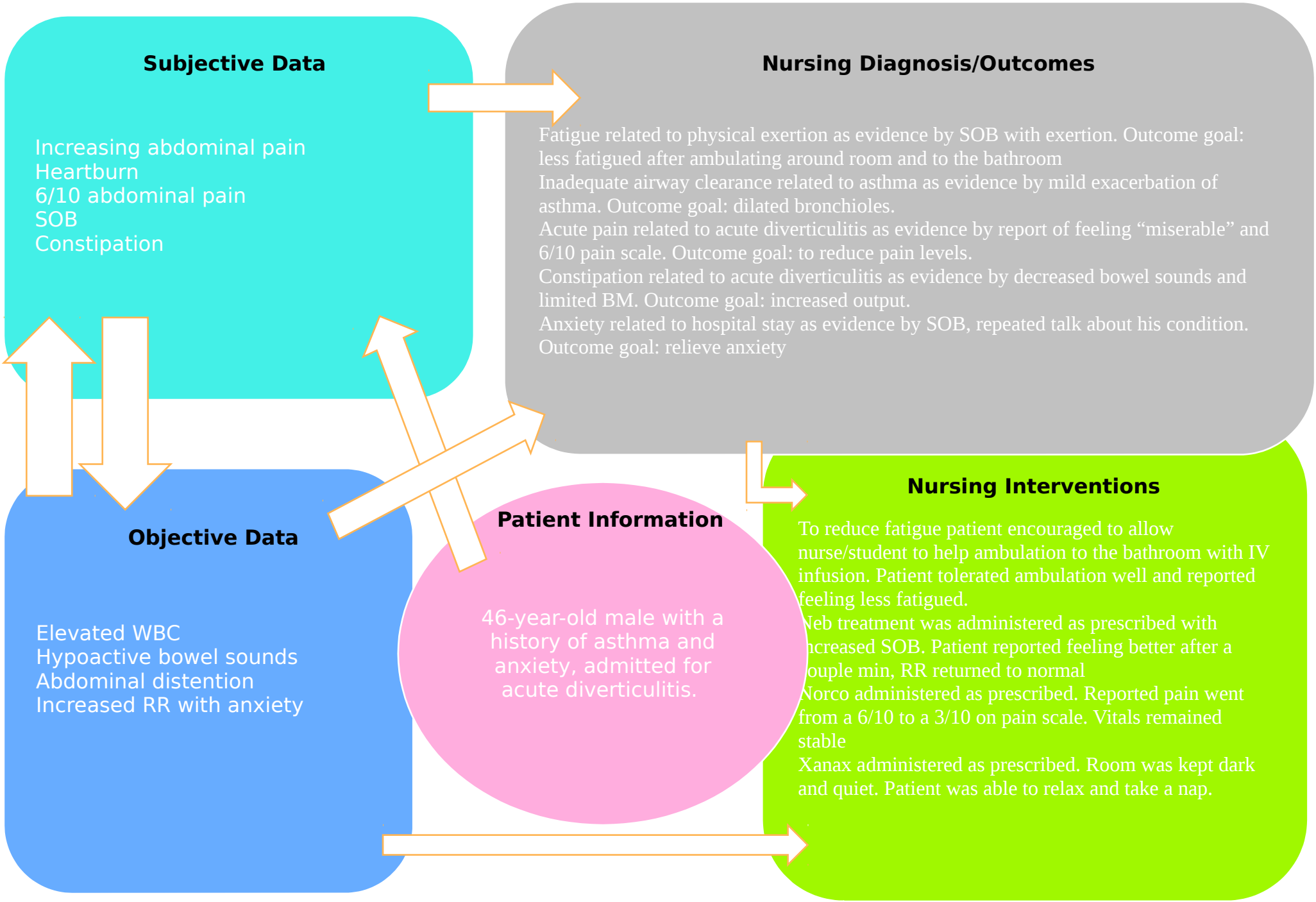
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Constipation related to acute diverticulitis as evidence by decreased bowel sounds and limited BM	This diagnosis was chosen because of the patient' new diagnosis of diverticulitis.	**1.**Placed on clear liquid diet **2.**Monitored I/O	• Tolerated clear liquid diet well. Ate adequate amount of food throughout the day • Adequate I/O levels.
2. Anxiety related to hospital stay as evidence by SOB, repeated talk about his condition.	This diagnosis was chosen is response to actions observed by the patient. He requested neb treatment suddenly, SOB quickly came on.	**1.**Prescribed Xanax PRN **2.**Kept room quiet and dark so patient could relax, limited disturbances	• Tolerated treatment well • Anxiety reduced within a few min of medication administration
3. Acute pain related to acute diverticulitis as evidence by report of feeling "miserable" and 6/10 pain scale	Diverticulitis commonly causes acute pain in abdomen. Controlling pain is a primary nursing responsibility	**1.** Administer Norco PRN **2**Monitor vitals and pain levels one hour after administration of medications	• Tolerated medication well. No reports of AE such as nausea or dizziness. • Vitals remained stable; pain level decreased from a 6 to a 3/10 scale

4. Inadequate airway clearance related to asthma by evidence by mild exacerbated asthma	This nursing diagnosis was chosen because of the patient's discomfort expressed during asthma/anxiety attacks.	1.Administer nebulizer treatment 2.Elevate head of bed.	• Treatment tolerated well. Breathing returned to normal after a couple minutes into treatment • Patient breathing easier when sitting up or in chair than when laying down and trying to nap.
5. Fatigue related to physical exertion as evidence by increased respiration rate after exertion	Patient expressed feeling tired after ambulating to bathroom.	1.Gradually increase activity levels by recommending walking around the room a couple times per day. 2. Provide assistance as needed when needing to go to bathroom	• Feels better if he moves every couple of hours vs. only when needing to. • Tolerated moving to bathroom better when he allowed us to assist with the IV infusion. Less fatigued when getting back to bed.

Other References (APA):

Nursing Diagnosis List (2018). Retrieved from www.nandanursingdiagnosislist.org

Concept Map (20 Points):


Subjective Data
Increasing abdominal pain
Heartburn
6/10 abdominal pain
SOB
Constipation
Nursing Diagnosis/Outcomes
Fatigue related to physical exertion as evidence by SOB with exertion. Outcome goal: less fatigued after ambulating around room and to the bathroom
Inadequate airway clearance related to asthma as evidence by mild exacerbation of asthma. Outcome goal: dilated bronchioles.
Acute pain related to acute diverticulitis as evidence by report of feeling “miserable” and 6/10 pain scale. Outcome goal: to reduce pain levels.
Constipation related to acute diverticulitis as evidence by decreased bowel sounds and limited BM. Outcome goal: increased output.
Anxiety related to hospital stay as evidence by SOB, repeated talk about his condition. Outcome goal: relieve anxiety
Objective Data
Elevated WBC
Hypoactive bowel sounds
Abdominal distention
Increased RR with anxiety
Patient Information
46-year-old male with a history of asthma and anxiety, admitted for acute diverticulitis.
Nursing Interventions
To reduce fatigue patient encouraged to allow nurse/student to help ambulation to the bathroom with IV infusion. Patient tolerated ambulation well and reported feeling less fatigued.
Neb treatment was administered as prescribed with increased SOB. Patient reported feeling better after a couple min, RR returned to normal
Norco administered as prescribed. Reported pain went from a 6/10 to a 3/10 on pain scale. Vitals remained stable
Xanax administered as prescribed. Room was kept dark and quiet. Patient was able to relax and take a nap.