

N431 Care Plan

Lakeview College of Nursing

Tyler Yager

N431 Care Plan

Demographics (5 points)

Date of Admission 09/13/2019	Patient Initials BH	Age 72	Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies Penicillin G
CodeStatus Full Code	Height 5' 8" (172.7 cm)	Weight 140 lb (63.5 kg)	

Medical History (5 Points)**Past Medical History:**

History of hypertension and diverticulitis.

Past Surgical History:

In the past, the patient has had a tonsillectomy (no date noted), hysterectomy (no date noted), and coronary artery bypass graft (no date noted).

Social History (tobacco/alcohol/drugs, pertinent social factors):

The patient is married and living with her husband in Gifford, Illinois. The patient has two sons that live in Gifford, and grandchildren who live in Rantoul. The patient is a retired home health aide and her husband is a retired farmer who leases his land to local farmers. Patient's highest education is an associate degree from Parkland. She denies any alcohol, tobacco, or drug use. The patient has her husband with her at the bedside, he is her main support. She has a good social support group with her local church and her family is very supportive.

Family History:

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Father and mother had hypertension; mother died of breast cancer. No other pertinent medical history.

Admission Assessment

Chief Complaint (2 points):

Severe abdominal pain.

History of present Illness (10 points):

BH is a 72 y.o. female who presented to the Gibson community hospital on 09/09/19 with complaints of severe abdominal pain (8/10) and intermittent fever/chills for the past 2 weeks. Patient stated that her pain gets worse upon exertion and is relieved by rest. The patient presented alert and oriented x3. The patient had a CT scan performed on 09/10/19 which showed acute diverticulitis with an abscess which perforated. She presented here with continued abdominal pain for consult with a gastroenterologist to consult for surgery. The abscess can not be drained percutaneously so she will have to undergo surgery with the possibility of a colostomy. She is scheduled to have her surgery on Friday. She currently has 0/10 abdominal pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):

Acute diverticulitis with abscess and perforation.

Secondary Diagnosis (if applicable):

Not applicable.

Pathophysiology of the Disease, APA format (15 points):

Two disease processes can occur within the diverticulum, diverticulosis and diverticulitis. Diverticulosis occurs in the bowel wall due to weakened areas that form small pouches within the diverticula which can collect small amounts of feces. Diverticulitis is the inflammation of

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diverticula that produces more symptoms and can cause complications. Weakened bowel musculature occurs where branches of the blood vessels enter the colonic wall which creates protrusions when there is an increased intraabdominal pressure. Common complications of this disease process include small bowel obstructions, perforations, or abscesses (Capriotti & Frizzell, 2016).

Signs and symptoms for diverticulitis can vary widely from patient to patient. Common symptoms include dull or acute abdominal, fever, tachycardia, constipation or diarrhea, increased flatulence, and anorexia. BH presented with acute abdominal pain, tachycardia, and a fever. Diverticulitis exacerbations can be diagnosed using abdominal x-ray, lower GI series, CT scan, MRI, or can be visualized with a colonoscopy (Capriotti & Frizzell, 2016). Upon examination using CT scan with contrast of BH's abdomen, it was found that she had an exacerbation of diverticulitis with an abscess perforation.

Treatment for diverticulitis and its complications may vary depending on the situation. For mild exacerbations, dietary modifications are the first line of treatment to prevent constipation and reduce symptoms. If the patient presents with constipation, an NG tube will be inserted and TPN will be initiated until bowel movements return. During acute episodes, IV broad spectrum antibiotics will be initiated. Surgery may be necessary to remove infected tissues, or a temporary colostomy may be used to allow the bowel to rest and promote healing (Capriotti & Frizzell, 2016).

Reference:

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

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Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (6th ed.). Philadelphia, PA: F.A. Davis Company.

Laboratory Data (15 points)

CBC: Highlight All Abnormal Labs, Explanations must contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC (10⁶/mcL)	3.80 - 5.30	4.32	3.96	
Hgb (g/dL)	12.0 - 16.5	13.4	12.2	
Hct (%)	36.0 - 47.0	39.9	36.1	
Platelets (10³/mcL)	140 - 440	369	370	
WBC (10³/mcL)	4.00 - 12.00	10.7	6.1	
Neutrophils (%)	47.0 - 73.0	70.5	57.0	
Lymphocytes (%)	18.0 - 49.0	18.2	28.3	
Monocytes (%)	3.0 - 13.0	1.10	11.5	
Eosinophils (%)	0.0 - 8.0	0.10	2.6	
Bands (%)	0.0 - 1.0	0.10	0.6	

Chemistry: Highlight Abnormal

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na⁺ (mmol/L)	133 - 144	135	140	
K⁺ (mmol/L)	3.5 - 5.1	4.1	4.1	
Cl⁻ (mmol/L)	98 - 107	102	106	
CO₂ (mmol/L)	21 - 31	27	26	

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Glucose (mg/dL)	70 - 99	98	84	
BUN (mg/dL)	7 - 25	4	13	Low BUN may be caused from a low protein diet or overhydration. BH has been either NPO or on a full liquid diet, so this likely contributed to her low BUN (Van Leeuwen & Bladh, 2015)
Creatinine (mg/dL)	0.50 - 1.20	0.92	0.98	
Albumin (g/dL)	3.5 - 5.7	N/A	N/A	
Calcium (mg/dL)	8.6 - 10.3	8.8	8.6	
Mag (mg/dL)	1.6 - 2.6	N/A	N/A	
Phosphate (mg/dL)	2.5 - 4.5	N/A	N/A	
Bilirubin (mg/dL)	0.2 - 0.8	N/A	N/A	
Alk Phos (U/L)	34 - 104	N/A	N/A	
AST (U/L)	13 - 39	N/A	N/A	
ALT (U/L)	7 - 52	N/A	N/A	
Amylase	N/A	N/A	N/A	
Lipase	N/A	N/A	N/A	
Cholesterol	N/A	N/A	N/A	
Triglycerides (mg/dL)	<150	N/A	N/A	
Lactic Acid (mmol/L)	0.5 - 2.0	N/A	N/A	

Other Tests **Highlight Abnormal**

Lab Test	Normal	Value on	Today's	Reason For Abnormal
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	Range	Admission	Value	
INR	<1.1	1.5	N/A	INR is increased in people with thrombocytopenia, or if they are on anticoagulation therapy. HK is currently taking aspirin which may cause a slightly increased INR (Van Leeuwen & Bladh, 2015).
PT	10 - 30 seconds	17.8	N/A	
PTT	N/A	N/A	N/A	
D-Dimer	N/A	N/A	N/A	
BNP	N/A	N/A	N/A	

Urinalysis **Highlight Abnormal**

Lab Test	Normal Range	Value on Admission	Today's Value	Reason For Abnormal
Color & Clarity	Clear/ yellow	N/A	N/A	
pH	5.0 -9.0	N/A	N/A	
Specific Gravity	1.003 - 1.035	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative	N/A	N/A	
RBC	Negative	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings

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Urine Culture	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (6th ed.). Philadelphia, PA: F.A. Davis Company.

Other Diagnostic Tests (EKG, Echocardiogram, Xrays, CT scan, etc) (5 points):**CT scan (abdomen and pelvis with contrast)**

Computed tomography scanning can be used to visualize pelvic structures and vascularities to assist in diagnosing infection, breaks, bleeds, masses, or cysts (Van Leeuwen & Bladh, 2015, p. 569). Multiple axial CT sections of the abdomen and pelvis obtained with coronal and sagittal views. Diverticulosis in the descending and sigmoid colon with pericolonic fat stranding in the proximal to mid sigmoid colon was noted on the GI tract. A small contained perforation was noted on the mid sigmoid colon. No drainable abscess fluid collection is initiated. The doctor noted that these findings are consistent with acute diverticulitis in the sigmoid colon with perforation.

Diagnostic Test Correlation, APA Format & References (5 points):

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (6th ed.). Philadelphia, PA: F.A. Davis Company.

Current Medications (10 points, 1 per completed med))

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Home Medications (5 required)

*Patient's MAR listed four home medications.

Brand/Generic	acetylsalicylic acid (ASPIRIN) (Nurse's Drug Handbook, 2019)	HYDROcodone-acetaminophen (NORCO) (Nurse's Drug Handbook, 2019)	metoprolol tartrate (LOPRESSOR) (Nurse's Drug Handbook, 2019)	metronIDAZOLE (FLAGYL) (Nurse's Drug Handbook, 2019)	Only taking 4 home medications
Dose	81 mg	5-325 milligram	25 milligrams	25 mg	
Route	Oral (chewable)	Oral	Oral	Oral	
Classification	Platelet Aggregation Inhibitor	Opioid Analgesic	Beta-Adrenergic Blocker	Antibiotic	
Action	Inactivates cyclooxygenase via acetylation which inhibits platelet aggregation	Promotes analgesia by binding selectively with the mu receptor	Acts on beta-1 adrenoreceptors in the cardiac muscles to reduce cardiac output	Anaerobic bacterial DNA synthesis inhibitor	
Reason Client Taking	Prophylactically to prevent MI after coronary artery bypass graft	To treat pain related to diverticulitis abscess	To treat hypertension	Anaerobic abscess (diverticulitis perforation)	
Contraindications (2)	Hypersensitivity, asthma	Respiratory depression, alcohol consumption	Bradycardia, history of heart block	Alcohol consumption, pregnancy	
Side Effects/Adverse Reactions (2)	Hemorrhage, tinnitus	Constipation, respiratory depression	Dizziness, heart failure	Ototoxicity, hepatotoxicity	
Nursing Considerations (2)	Monitor PT/INR, monitor for signs and symptoms of gastric ulcers	Monitor respirations after administration, continually monitor pain before and after administration	Do not administer if heart rate is below 60, monitor blood pressure before and after administration	Monitor for signs and symptoms of liver toxicity, check culture and sensitivity before treatment	
Client Teaching needs (2)	Report any signs of excessive bleeding; report any epigastric comfort which may indicate an ulcer	Tell patient to report symptoms of respiratory depression; avoid activities that require mental alertness	This drug may cause diarrhea, depression, or fatigue; report signs and symptoms of cardiac failure	Tell patient to avoid alcohol while using this drug; report symptoms of aseptic meningitis, encephalopathy, or peripheral neuropathy	

Hospital Medications (5 required)

Brand/Generic	cefepime (MAXIPIME) (Nurse's Drug Handbook, 2019)	metronIDAZOLE (FLAGYL) (Nurse's Drug Handbook, 2019)	morphine (INFUMORPH) (Nurse's Drug Handbook, 2019)	Patient is only taking 3 medications currently	
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Dose	1 gram	500 milligrams	1 milligram		
Route	Intravenous	Intravenous	Intravenous		
Classification	Antibiotic	Antibiotic	Opioid analgesic		
Action	Bactericidal drug that inhibits cell wall synthesis	Anaerobic bacterial DNA synthesis inhibitor	Promotes analgesia by binding selectively with the mu receptor		
Reason Client Taking	Infectious disease of the abdomen (diverticulitis perforation)	Anaerobic abscess (diverticulitis perforation)	To treat pain related to diverticulitis abscess		
Contraindications (2)	Hypersensitivity, pregnancy	Alcohol consumption, pregnancy	Respiratory depression, alcohol consumption		
Side Effects/Adverse Reactions (2)	Stevens-Johnson syndrome, diarrhea	Ototoxicity, hepatotoxicity	Constipation, respiratory depression		
Nursing Considerations (2)	Monitor WBC count to monitor efficacy, monitor renal function in elderly patients	Monitor for signs and symptoms of liver toxicity, check culture and sensitivity before treatment	Monitor respirations after administration, continually monitor pain before and after administration		
Client Teaching needs (2)	Report and signs or symptoms of hypersensitivity, such as rash or difficulty breathing; stress the importance of finishing entire antibiotic course	Tell patient to avoid alcohol while using this drug; report symptoms of aseptic meningitis, encephalopathy, or peripheral neuropathy	Tell patient to report symptoms of respiratory depression, avoid activities that require mental alertness		

Lab Reference (APA Format):

2019 Nurse's Drug Handbook. (2019). Burlington, MA: Jones & Bartlett Learning.

Assessment**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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0730	82	154/76	16	97.9 F (oral)	97% room air
1132	77	133/68	16	98.1 F (oral)	99% room air

Physical Exam (18 points)

<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERRLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation, Mental Status, Speech, Sensory, LOC:</p>	<p>Patient is alert and oriented x 3. Patient moves upper extremities well with equal strength. BH can move all extremities equally and can ambulate on her own. Eyes are PERRLA and she uses glasses for both distance and near. Patient uses hearing aids and is able to articulate clearly.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status, ROM, Supportive devices/strength</p> <p>ADL Assistance Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Morse Fall Scale: 20</p> <p>Patient shows an active range of motion bilaterally in upper and lower extremities. Patient does not show signs of neurovascular issues. Patient is not a fall risk. Patient is able to get up with no assistance and does not use any equipment.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable) Peripheral Pulses: Radial & pedal Capillary refill: <3 seconds Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema _____.</p>	<p>Patient is not being monitored by telemetry. Heart sounds auscultated x5; S1, S2 heart sounds noted with normal sinus rhythm. No S3, S4 noted. Pulses graded 2+ bilaterally throughout. Capillary refill <3 seconds. Patient has no pitting edema noted and is negative for neck vein distention. Patient has one I.V. on the right median cubital vein.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Accessory muscles used when breathing. Patient has 16 breaths per minute that are deep and regular. Normal vesicular breath sounds heard over all lung fields. No crackles, wheezing, or rhonchi auscultated. Pulse oximetry was 97% on room air.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Patient eats a “normal” diet at home, three meals per day. Current Diet: Currently on a liquid diet with Ensure and soups. Tolerated one bottle of Ensure for breakfast. Height: 172 cm</p>	<p>Patient currently on full liquid diet of ensure and soup only. Patient tries to eat a well-rounded diet with plenty of fruits and vegetables to reduce diverticulosis flare ups. Patient denies alcohol consumption. No rashes or ascites noted on abdomen. Bowel sounds present in all four quadrants. Patient denies pain on palpation. No</p>

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<p>Weight: 63.5 kg Auscultation Bowel sounds: Last BM: This morning before 0900 Palpation: Pain, Mass etc Inspection: distention, incisions, scars, drains, wounds Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: _____</p>	<p>masses present. No ostomy, nasogastric tube, or PEG tubes. No drains present. Patient had two BMs this morning before 0900. Patient denies any rapid weight loss currently.</p>
<p>INTEGUMENTARY (2 points): Skin color caucasian character, turgor, rashes, bruises: wounds: Braden scale : 23 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type NONE</p>	<p>Patient is Caucasian and presents with a fair skin tone. Skin has normal elasticity and is warm to the touch. No abnormal texture or cellulitis noted upon inspection. Normal skin turgor with no tenting. No rashes or bruises.</p> <p>Braden scale: 23</p>
<p>HEENT (2 points): Head: Ears: Eyes: Nose: Teeth</p>	<p>Head is midline, hair is all white in color. Ears show no abnormal drainage with some hearing deficits - she uses a hearing aid in her left ear. PERRLA is noted. Nose is midline and oral mucosa is pink with no abnormalities. Patient has good dentition with some dental fillings.</p>
<p>GENITOURINARY (2 Points): Color, character, quantity of urine, pain, Dialysis Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patient has no incontinence issues. No dialysis, or catheter. Urine is clear and yellow. Patient denies any pain, hesitancy, or urgency in urination. No abnormal odor. Patient is not on I&Os.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping methods, Educational level Developmental level, Ethnicity, Religion & what it means to pt. Occupation (previous if retired) Personal/Family Data (Think about home environment, family structure, and available family support)</p>	<p>Patient is AAO x3. Patient did take some naps throughout the day and she stated she does have trouble sleeping in the hospital. Husband is present at bedside. Patient denies current tobacco or alcohol use. Patient has completed high school and college, and she is retired from working as a home health aid. She currently lives in Gifford at her house with her husband. The patient is able to perform all ADLs by herself with no limitations. She attends church weekly with her family in Rantoul, her church is a major support group for her.</p>

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Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0715	Numeric Scale 0/10	N/A	N/A	N/A	No interventions
1132	Numeric Scale 0/10	N/A	N/A	N/A	No interventions

IV Assessment (2 Points)

Site Location, Patency/Condition & Date	Fluid Type/Rate or Saline Lock
Peripheral IV - median vein (underside of arm) 18 gauge Date established: 09/13/19 @ 2220 Right peripheral IV is stable, patent with no infiltrations. Patient denies any pain at the site. No evidence of erythema, drainage, or swelling. Flushes easily.	Continuous infusion 0.9% normal saline 50mL/hr continuously

Intake and Output during Your Shift (2 points)

Intake	Output
Not measuring I/O	Not measuring I/O

Nursing Care

Summary of care- Narrative of Nursing care provided, patient status throughout the day, any major concerns, etc (2 points):

Patient remained in her bed throughout the day and moved to her chair at 1000. Patient tolerated her breakfast well and drank her entire bottle of Ensure. Vital signs were gathered at 0715 and 1132 and were stable throughout the day. The patient bathed herself at 0930 with no issues. The patient's husband and son came to visit around 1015 which decreased her anxiety. BH tolerated 100% of her Ensure at 1305. BH's lab values are consistent with her past medical

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history and his suspected diagnosis. Patient was compliant with dietary restrictions and treatment.

Discharge Planning- Identify discharge needs, education, home health services/equipment, family involved, etc (2 points):

BH is being discharged later today back to her home in Gilford with her husband. She will be returning on Friday to have surgery with her gastroenterologist. The provider stated she may need a colostomy temporarily which will require extra teaching. She does not need the assistive services of case management or home health. Her family is very supportive and will ensure she is cared for.

***The following must be listed in order of priority and must be NANDA approved Diagnosis (18 points Total, 3 points for each complete diagnosis with 2 interventions & Rational, 3 points for correct prioritization)**

Nursing Diagnosis	Rational	Intervention (2 per dx)
Risk for infection (Swearingen, 2016).	This is related to diverticulitis as evidenced by perforation on CT scan	<ol style="list-style-type: none"> 1. Note changes in mental status such as confusion or altered LOC. 2. Assess vital signs every 4 hours for hypotension, fever, or tachycardia.
Deficient fluid volume (Swearingen, 2016).	This is related to liquid stool as evidenced by decreased BUN.	<ol style="list-style-type: none"> 1. Monitor vital signs every 4 hours and note any hypotension. 2. Maintain accurate I&O as well as daily weights.
Acute pain (Swearingen, 2016).	This is related to perforated diverticulitis as evidenced by verbalization of pain as 8/10 on admittance.	<ol style="list-style-type: none"> 1. Provide comfort measures such as back rubs or deep breathing. 2. Administer analgesics as indicated.
Risk for imbalanced	This is related to altered diet	<ol style="list-style-type: none"> 1. Auscultate bowel sounds

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nutrition: less than body requirements (Swearingen, 2016).	as evidenced by decreased BUN.	and note any hyperactivity. 2. Monitor BUN, protein, albumin, and glucose as indicated.
Anxiety (Swearingen, 2016).	This is related to a change in health status as evidenced by verbalization of anxiety.	1. Evaluate anxiety level and encourage the free expression of emotions. 2. Ensure adequate rest with uninterrupted sleep.

Reference:

Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER.

Overall APA Format/Neatness/Grammar (5 point):**Concept Map Attached (20 points):**