N431 Care Plan 1

Lakeview College of Nursing

Taniya Varghese

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
09/13/2019	NH	23 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Currently does not work	Single	Vancomycin
Code Status	**Height**	**Weight**	
Full Code	5’2	48.2 kg	

Medical History (5 Points)

Past Medical History: Crohn’s disease diagnosed six years ago.

Past Surgical History: Patient does not have any surgical history.

Family History: Patient lives at home with her mother and father, and her siblings.

Social History (tobacco/alcohol/drugs): Patient denied smoking, alcohol drinking, recreational drug use

Assistive Devices: Patient does not use any assistive devices.

Living Situation: Patient lives in Champaign with her family.

Education Level: Patient does have a high school diploma.

Marital Status/ Relationship Status : Single

Education level: Patient has a degree but not college degree.

Occupation: Patient currently does not work

Admission Assessment

Chief Complaint (2 points): Abdominal Pain, fatigue

History of present Illness (10 points):.

NT is a twenty-three-year-old female with a past medical history of Crohn’s disease. Patient reported that she did not have Crohn's disease flare up for the past five years. Patient reported

that her flare up started in August and came to the hospital with the symptoms of a flare up since she started taking steroids. Patient is taking 60mg daily of steroids. Patient started having symptoms of abdominal pain, cramping, fatigue after starting a steroid with a dose of 45 mg daily. Next day patient was complaining chills, feeling hot but patient did not measure her temperature. Patient continued to have abdominal pain, fatigue, lightheadedness, numbness, generalized weakness. Patient got an extra dose of 20 mg steroids at night. On next day patient reported having chills, fever of 103. Patient contacted her physician who told her to present to the ED. In the ED patient was complaining of fatigue, generalized weakness. Patient denied having any diarrhea. Patient reported having some episodes of constipation which she uses for MiraLax for. Patient reported having intermittent chills, sweating for the past 2 days. Patient denied having any chest pain, shortness of breath, runny nose, cough, headaches, burning sensation during urination.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Crohn's disease

Secondary Diagnosis (if applicable): N/A

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

Crohn's disease also known as an inflammatory bowel disease. It is mainly known as the inflammatory disease of the digestive tract that will spread into the deep layer of the intestines. Most people the are diagnosed with Crohn's disease are only affected with its symptoms in the last segment of the small intestine. This portion of the small intestine is also known as the ileum. Signs and symptoms of the Crohn's disease can range from mild to severe. Some symptoms of Crohn's are diarrhea, fever, fatigue, abdominal pain, blood in the stool, mouth sores, rapid weight loss. It is vital to see a primary care provider with the pain in the abdomen intensifies,

blood in the stool, unexpected fever and unexpected weight loss. There is no specific cause for Crohn's disease. Factors such as diet and stress can worsen and even bring on the symptoms of Crohn's disease. Other factors like hereditary and immune system can trigger Crohn's disease. Crohn's disease can be diagnosed through blood tests and special procedures like a colonoscopy, a CT scan, MRI, endoscopy (Bladh, 2017). Other treatments like medications can be used like anti-inflammatory, immunosuppressive medications, and lastly antibiotics. Lifestyle changes can also factor into gaining control and not exacerbating the inflammation.

Pathophysiology References (2) (APA):

Crohn's disease. (2019, September 13). Retrieved from https://www.mayoclinic.org/diseases-conditions/crohns-disease/symptoms-causes/syc-20353304

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company.

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	**3.8-5.3 x10^6**	**5.09 x10^6**	**4.34 x10^6**	
Hgb	**12.0-15.8**	**12.9**	**11.0**	Patient has low hemoglobin count because the patient is having renal failure. (Van Leeuwen & Bladh, 2017, p. 481)
Hct	**36.0-47.0%**	**39.1%**	**33.5**	Patient has low hematocrit levels because the patient is experiencing renal failure is incapable of producing components of red blood cells.

				(Van Leeuwen & Bladh, 2017, p. 474)
Platelets	**140-440 x10^3**	**189 x10^3**	**214 x10^3**	
WBC	**4.00-12.00 x10^3**	**12.80 x10^3**	**6.90 x10^3**	Patient has an elevated white blood cell count due to the inflamed bowel and possible infection in the bowel. (Van Leeuwen & Bladh, 2017, p. 482)
Neutrophils	**47.0-73.0%**	**76.5%**	**83.8%**	Patient has an elevated white blood cell count due to the inflamed bowel and possible infection in the bowel. (Van Leeuwen & Bladh, 2017, p. 482)
Lymphocytes	**18.0-42.0%**	**10.7%**	**12.0%**	Patient has an elevated white blood cell count due to the inflamed bowel and possible infection in the bowel. (Van Leeuwen & Bladh, 2017, p. 482)
Monocytes	**4.0-12.0%**	**12.7%**	**3.3%**	Patient has an elevated white blood cell count due to the inflamed bowel and possible infection in the bowel. (Van Leeuwen & Bladh, 2017, p. 482)
Eosinophils	**0.0-5.0%**	**0.0%**	**0.0%**	
Bands	**na**	**na**	**na**	

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-	**133-144**	**126**	**N/A**	
K+	**3.5-5.1**	**3.6**	**N/A**	
Cl-	**98-107**	**88**	**N/A**	
CO2	**21-31**	**30**	**N/A**	
Glucose	**70-99**	**114**	**N/A**	
BUN	**7-25**	**12**	**N/A**	

Creatinine	**0.5-1.20**	**0.89**	**N/A**	
Albumin	**3.5-5.7**	**3.4**	**N/A**	
Calcium	**8.6-10.3**	**8.3**	**N/A**	
Mag	**1.6-2.6**	**2.0**	**N/A**	
Phosphate			**N/A**	
Bilirubin	**0.2-0.8**	**0.5**	**N/A**	
Alk Phos	**34-104**	**58**	**N/A**	
AST	**13-39**	**14**	**N/A**	
ALT	**7-52**	**20**	**N/A**	
Amylase			**N/A**	
Lipase	**11-82**	**8.2**	**N/A**	
Lactic Acid	**0.5-2.0**	**1.0**	**N/A**	
Troponin	**N/A**	**N/A**	**N/A**	
CK-MB	**N/A**	**N/A**	**N/A**	
Total CK	**N/A**	**N/A**	**N/A**	

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	**N/A**	**N/A**		
PT	**N/A**	**N/A**		
PTT	**N/A**	**N/A**		

D-Dimer	**N/A**	**N/A**		
BNP	**N/A**	**N/A**		
HDL	**N/A**	**N/A**		
LDL	**N/A**	**N/A**		
Cholesterol	**N/A**	**N/A**		
Triglycerides	**N/A**	**N/A**		
Hgb A1c	**N/A**	**N/A**		
TSH	**N/A**	**N/A**		

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	**N/A**	**N/A**		
pH	**N/A**	**N/A**		
Specific Gravity	**N/A**	**N/A**		
Glucose	**N/A**	**N/A**		
Protein	**N/A**	**N/A**		
Ketones	**N/A**	**N/A**		
WBC	**N/A**	**N/A**		
RBC	**N/A**	**N/A**		
Leukoesterase	**N/A**	**N/A**		

Arterial Blood Gas 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

pH	**N/A**	**N/A**		
PaO2	**N/A**	**N/A**		
PaCO2	**N/A**	**N/A**		
HCO3	**N/A**	**N/A**		
SaO2	**N/A**	**N/A**		

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	**N/A**	**N/A**		
Blood Culture	**N/A**	**N/A**		
Sputum Culture	**N/A**	**N/A**		
Stool Culture	**N/A**	**N/A**		

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT Abdomen pelvis without contrast

Diagnostic Test Correlation (5 points): This test looks at the entire bowel as well as at tissues outside the bowel. CT is a scan that provides better images of the small bowel and will allow the care provider to see the obstruction of problems that can further affect the primary diagnosis.

Diagnostic Test Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Azathioprine Imuran	Ciprofloxacin Cipro	Methotrexate Trexall	N/A	N/A
Dose	250mg	400 mg	30mg	N/A	N/A
Frequency	Daily	Daily	Weekly	N/A	N/A
Route	PO	PO	PO	N/A	N/A
Classification	Immunomodulators	Antibiotic	Immunomodulators	N/A	N/A
Mechanism of Action	Prevent proliferation and differentiation of activated B and T cells	Inhibits DNA enzyme from unwinding and causes bacterial cells to die	Immunosuppressive effects by inhibiting replication and function of T and B lymphocytes.	N/A	N/A
Reason Client Taking	To inhibit inflammatory response	To treat any cause of inflammation	To inhibit inflammatory response	N/A	N/A

Contraindications (2)	Hypersensitivity to azathioprine	Myasthenia gravis Concurrent therapy with tizanidine	Breastfeeding Hypersensitivity to methotrexate	N/A	N/A
Side Effects/Adverse Reactions (2)	Fever Leukopenia	Abnormal gait Angina	Hematuria Dry cough	N/A	N/A
Nursing Considerations (2)	Monitor patient for thrombocytopenia Monitor patient for abnormal signs of lymphomas	Allow patient to be well hydrated when taking this medication. Monitor for rashes, hypersensitivity and diarrhea.	Increase patient's fluid intake Assess for bleeding and infection	N/A	N/A
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Obtain baseline laboratory tests Monitor liver enzymes	Obtain culture and sensitivity tests before giving medication	Monitor CBC, liver and renal function tests	N/A	N/A
Client Teaching needs (2)	Take oral medication with wood. Teach patient how to reduce risk of bleeding.	Urge patient to finish prescribed dose. Urge patient to report watery and bloody stool.	Prepare calendar of treatment days Urge women of childbearing age to use reliable contraception.	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	Loperamide	Metoclopramide	Ferrous Sulfate Slow-Fe	N/A	N/A
Dose	2mg	5 mg	300mg	N/A	N/A
Frequency	Daily	Daily	Daily	N/A	N/A
Route	PO	PO	PO	N/A	N/A
Classification	Antiemetic	Antiemetic	Antianemic	N/A	N/A
Mechanism of Action	prevention of chemotherapy-induced nausea and vomiting	promotes motility in the upper gastrointestinal tract	To treat iron deficiency	N/A	N/A
Reason Client Taking	Patient has had chemotherapy	Improve with nausea and vomiting	To normalize RBC production	N/A	N/A
Contraindications (2)	Concomitant use of apomorphine Hypersensitivity to ondansetron or any component of the product	Epilepsy Tardive Dyskinesia	Hemochromatosis Hemolytic anemia	N/A	N/A
Side Effects/Adverse Reactions (2)	Constipation Hypoxia	Headache Fatigue	Dyspnea Fever	N/A	N/A
Nursing Considerations (2)	Monitor ECG because of electrolyte imbalance Monitor bowel for patients	Monitor blood pressure Monitor hydration level	Take with a full glass of water or orange juice Monitor Patients	N/A	N/A

	with bowel obstruction		blood pressure		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**CBC**	**CBC**	CBC	N/A	N/A
Client Teaching needs (2)	Instruct patient to report signs or symptoms of serious cardiac arrhythmias Patient should not to chew or swallow the oral film but should wash their hands after taking it	avoid activities requiring mental alertness until drug effects are realized Take oral tablets 30 min before meals and at bedtime	Do not take with milk Do not chew any solid forms of iron	N/A	N/A

Medications Reference (APA):

Jones & Bartlett Learning., & Jones & Bartlett Publishers. (2019). *Nurse's drug handbook*.

Sudbury, MA: Jones and Bartlett Publishers

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is awake in bed , patient exhibits no signs of drowsiness. Patient does not seem annoyed or agitated. Patient speaks English fluently and at a normal pace. Patient has equal strength is equal bilaterally on upper extremities.. There are no signs of neurological damage.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient is Caucasian and has a light skin tone. Skin is normal and warm to touch, there are no signs of infection or drainage from anywhere on the skin. There are no lesions present and no signs of skin breakdown. Patient's hair is white. There are no rashes or bruises present. There is no notable skin turgor.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient has brown hair and shows no sign or hair loss. Head is midline and no signs of deviation. Patient has a midline trachea, there is no sign of deviation. Turbinates are equal bilaterally. There is no sign of drainage from her ears and tympanic membrane is pearly grey. There are no lesions on the patient's ears. PEERLA is noted and positive. Patient does not wear glasses. Patient's oral mucosa is pink and moist with no lesions and no notable abnormalities. Patient's dentition is good, teeth are white in color.
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 and S2 heard in patient, and has a normal sinus rhythm. Patient is not monitored by a telemetry. Radial and pedal pulses are assessed. They are strong bilaterally, graded at 2+. Capillary refill is assessed and noted at less than 2 seconds on fingers and toes. Patient does not have neck vein distention. Patient does not have a central line put in.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐**	Clear lung sounds heard bilaterally. Both anterior and posterior lungs are auscultated. No crackles

Breath Sounds: Location, character	or wheezing noted. Patient does not use accessory muscles during respirations. Patients trachea is midline with not deviations. Patient does show signs of shortness of breath. Patient does not use both oxygen therapy or nebulizer treatment.
GASTROINTESTINAL (2 points): **Diet at home: Regular 3 meals a day** **Current Diet:** Patient states that she eats "whatever she wants" **Height: 5'2** **Weight:48.2 kg** **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:**	Patient does not follow any specific type of diet at home. Patient does consume alcohol at home. Bowel sounds present in all quadrants. Patient denies pain during light palpation and deep palpation. No masses present, no drains are present. Patient does not have an ostomy bag, an NG tube, or PEG tube. Ostomy bag is present. Soma is pink.
GENITOURINARY (2 Points): **Color: clear slightly yellow** **Character:** **Quantity of urine: N/A** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient is not capable of standing and ambulating to the bathroom and back. Patient does have a foley catheter. Urine is yellow and normal and patient denies pain when urinating. Patient is not monitored for I&O's
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:**	Patient is capable of walking and standing on his own. Patient does not use a walker. Patient was seen by the physical therapist and occupational therapist. Patient was able to mobilize themselves and but on his own clothes. Patient shows no sign neurovascular deficit. patient is not a fall risk. Patient has equal strength bilaterally.

Activity/Mobility Status: Active **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient does not seem annoyed or agitated. Patient speaks English fluently and at a normal pace. Patient has equal strength is equal bilaterally on upper extremities. There are no signs of neurological damage. PEERLA is noted and positive.
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):**	Patient shows no sign of fatigue or lethargic behavior. Patient was able to sleep well throughout the night. Patient did not have his family visit him. Patient states that she is currently not working. She lives in Champaign, IL. Patient has no known religious preference. Patient is not employed. Patient enjoys spending time with family.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
14:15	**84**	**112/78**	**18**	**97.7**	**98** ***Room air***
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
14:15	**Numeric Scale** **0/10**	**No generalized or specific pain**	**No severity when touching abdomen**	**No pain radiating or persistent**	**Monitor for another bowel inflammation symptoms**

N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: Right peripheral IV 20g **Location of IV:** **Date on IV: 09/13/2019** **Patency of IV: positive not occluded** **Signs of erythema, drainage, etc.: no drainage nor erythema** **IV dressing assessment:**	Continuous Infusion Lactated Ringers 1,000mL 100mL/hr.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL) -NOT RECOREDED**
N/A	**N/A**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient shows no signs of discomfort and realizes the triggers that she should avoid to not have another flare up.

Procedures/testing done: CT scan

Complaints/Issues: Abdominal Pain

Vital signs (stable/unstable):Stable

Tolerating diet, activity, etc.: Diet is back to normal and is able to eat what the patient themselves decides to.

Physician notifications: No specific physician notifications

Future plans for patient: Identify triggers and avoid them

Discharge Planning (2 points)

Discharge location: Patient's home in Champaign, IL

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: Modify diet with low trigger foods

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

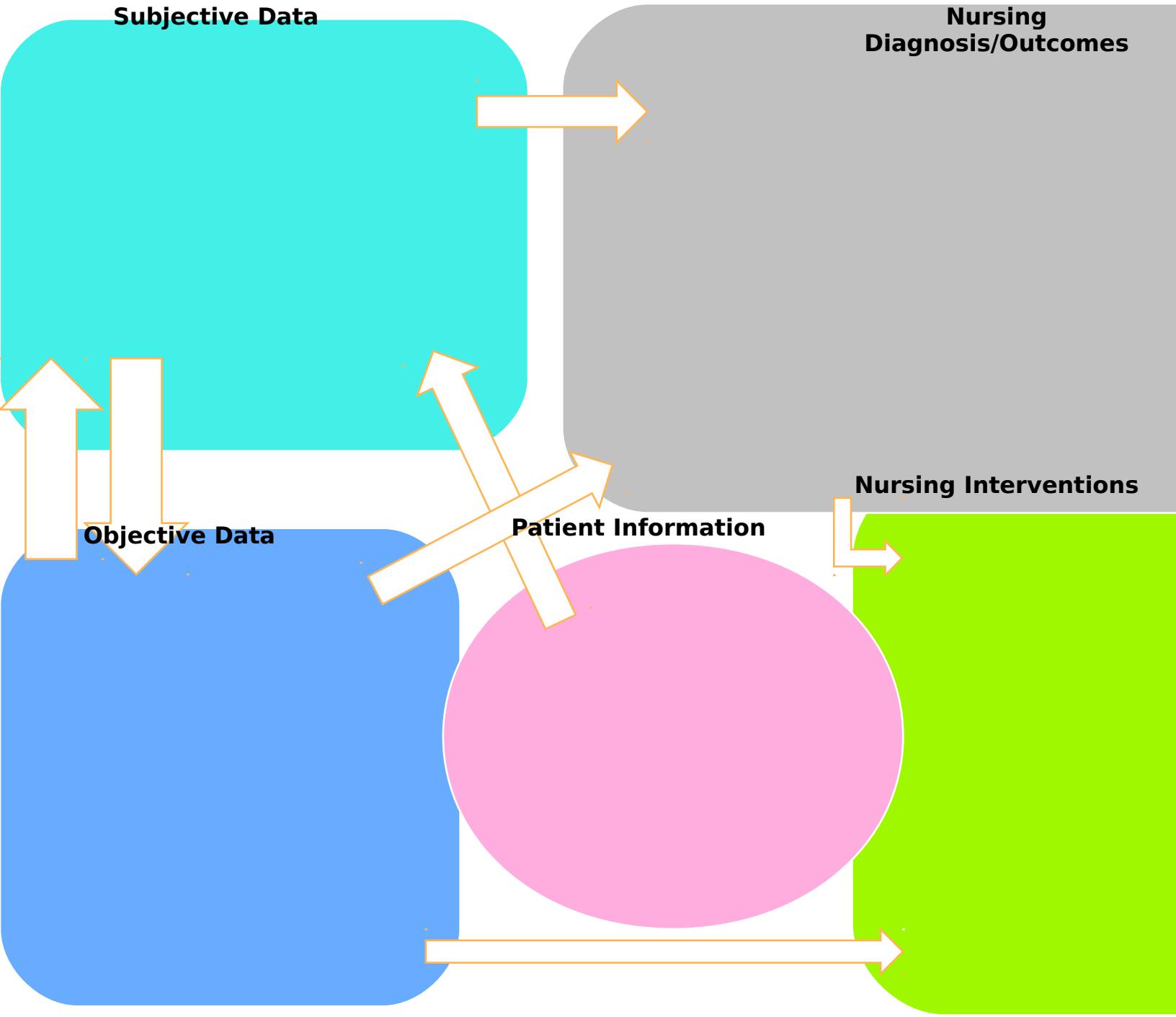
Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	Rational ● Explain why the nursing diagnosis was chosen	Intervention (2 per dx)	Evaluation ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to inflamed bowel as evidence by pain scale.	Patient is no longer able to continue her bowel movements due to the inflamed bowel which leads to pain	1. Maintain pain medications 2. Assess pain and note intensity and location	Patient's family and the patient herself was compliant with pain management. Patient's goal is to monitor pain.
2. Activity intolerance related to pain as evidence by maintaining minimal activity	Due to pain that is localized to the abdomen, the patient will not be able to move easily	1. Monitor patient's gait, assess for fall risk 2. Tolerate activity with stand by assistance	Patient and patient's family agreed to limited activity due to the patient pain. Patient agrees to continuing to try to move as best as she can.
3. Risk for infection related to bowel inflammation as evidence by high WBC.	Patient can have an infection occur due to the lack of bowel movements.	1. Maintain medications and monitor for signs and symptoms of sepsis 2. Maritain medication compliance	Patient and patient's family agreed on reducing the chance of infection and possible sepsis.

4. Risk for deficient fluid volume related inflamed bowel and evidence by low output as told by patient.	Due to the inflamed bowel, patient is not retaining or excreting as much fluid as needed.	1. Monitor BP and Pulse 2. Monitor I & O	Patient and patient's family agreed on maintaining a proper fluid balance.

Other Reference

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

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Patient Information