N321 Care Plan #1

Lakeview College of Nursing

Kristine Johnson

Demographics (3 points)

Date of Admission 9/16/19	**Patient Initials** CDH	**Age** 75	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Unemployed/retired	**Marital Status** Married	**Allergies** No known
Code Status Full (no ACP docs)	**Height** 6’0”	**Weight** 220 lbs. (99.8 kg)	

Medical History (5 Points)

Past Medical History: Hypertension, Hyperglycemia, Hyperlipidemia, Vitamin D deficiency

Past Surgical History: Knee arthroscopy, Humerus surgery, Appendectomy, Colonoscopy, Total Hip arthroplasty, PR Appendectomy

Family History: Married, Father = Stroke, Brother = Heart disease

Social History (tobacco/alcohol/drugs): Former smoker, 1-2 beers a day

Assistive Devices: Gait belt when out of bed, 2-3 caregiver when lifting

Living Situation: Home with wife

Education Level: Highschool degree

Admission Assessment

Chief Complaint (2 points): Nausea, vomiting, and abdominal pain

History of present Illness (10 points): The patient was seen 9/15/19 and was evaluated after previously being in the hospital for acute pancreatitis. The patient states that the “abdominal pain isn’t as severe as it was but still experiencing pain”. He says he is not experiencing a “temperature, vomiting, or chills”. The patient’s lipase elevated from 200 to 3000, 4 days after being discharged. The patient also states he is “not drinking” and “no smoking” and that he is “following instructions for his diet”.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Pancreatitis

Secondary Diagnosis (if applicable): Not Applicable

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

Pathophysiology References (2) (APA):

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	4.10-5.70	3.31	2.97	
Hgb	12.0-16.0	9.9	8.8	
Hct	37.0-51.0%	29.6%	26.8	
Platelets	140-400	255	233	
WBC	4.00-11.00	15.44	14.18	
Neutrophils	1.60-7.70	11.30	10.31	
Lymphocytes	1.00-4.90	1.97	1.81	
Monocytes	0.00-1.10	1.69	1.51	
Eosinophils	0.00-0.50	0.18	0.31	
Bands	N/A	N/A	N/A	

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	135	135	
K+	3.5-5.0	3.5	3.8	
Cl-	98-107	100	102	
CO2	21.0-32.0	24.1	22.8	
Glucose	60-99	104	101	
BUN	7-18	13	17	
Creatinine	0.60-1.30	1.14	1.01	
Albumin	3.4-5.0	2.3	1.9	
Calcium	8.5-10.1	8.3	7.7	
Mag	1.8-2.4	Not preformed	1.7	
Phosphate	N/A	N/A	N/A	
Bilirubin	N/A	N/A	N/A	
Alk Phos	45-117	76	63	
AST	15-37	33	26	
ALT	12-78	56	49	
Amylase	N/A	N/A	N/A	
Lipase	73-393	3051	3360	
Lactic Acid	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	N/A	
PT	N/A	N/A	N/A	
PTT	N/A	N/A	N/A	
D-Dimer	N/A	N/A	N/A	
BNP	N/A	N/A	N/A	
HDL	N/A	N/A	N/A	
LDL	N/A	N/A	N/A	
Cholesterol	N/A	N/A	N/A	
Triglycerides	N/A	N/A	N/A	
Hgb A1c	N/A	N/A	N/A	
TSH	N/A	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	N/A	
pH	N/A	N/A	N/A	
Specific Gravity	N/A	N/A	N/A	
Glucose	N/A	N/A	N/A	
Protein	N/A	N/A	N/A	
Ketones	N/A	N/A	N/A	
WBC	N/A	N/A	N/A	
RBC	N/A	N/A	N/A	

Leukoesterase	N/A	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	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): MRSA screening

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (APA):

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

Home Medications (5 required)

Brand/Generic	Lisinopril	Melatonin	Tamsulosin (Flomax)	Carvedilol (Coreg)	Atorvastatin (Lipitor)
Dose	40 mg	3 mg	0.4 mg	12.5 mg	10 mg
Frequency	Daily	At bed time	At bed time	Twice daily	Daily
Route	P.O.	P.O.	P.O.	P.O.	P.O.
Classification	Antihypertensive ACE inhibitor	Pineal Hormone Agents	Micturition Agent	Alpha/Beta Adrenergic blocking agent	Antihyperlipidemic
Mechanism of Action	Inhibits angiotensin converting enzyme	Attaches to receptors in hypothalamus	Selectively antagonizes prostate alpha-1a adrenergic receptors	Blocks Alpha-1 adrenergic receptors	Inhibits 3-hydroxy-3-methylglutaryl-coemzyme A (HMG-CoA) reductase
Reason Client Taking	Lower high blood pressure	Help with sleep	Enlarged Prostate	Treat high blood pressure	Lower high cholesterol levels
Contraindications (2)	Pregnancy Angioedema	Immunosuppressant drugs Hypersensitivity	Hypersensitivity Caution with cataract surgery	Bradycardia Heart failure	Pregnancy Myopathy
Side Effects/Adverse Reactions (2)	Dizziness Hypotension	Abdomen cramps Alertness decreased	Rhinitis Dizziness	Fatigue Dizziness	Headache Diarrhea
Nursing Considerations (2)	Monitor Blood pressure Notify provider of a persistent cough	Administer at client's bed time Monitor blood glucose	Give 30 mins after same meal daily Monitor blood pressure	Monitor blood glucose as ordered Cautious with patients	Monitor blood glucose in diabetics Expect liver function tests before therapy is started

				with peripheral vascular disease	

Hospital Medications (5 required)

Brand/Generic	Ondansetron HCL (PF) (Zofran)	Heparin injection	Fentanyl (PF)	0.9% NaCl with KCL 20 mEq	Magnesium sulfate 2g in sterile water 50 mL IVBP Premix
Dose	4 mg	5,000 units	25 mcg	100 mL/hr	0.5-1 g/hr > 12.5-25 mL/hr
Frequency	Every 8 hrs	Every 8 hrs	Every 6 hrs	Continuous	One time
Route	IV push	SubQ	IV push	IV	IVPB
Classification	Antiemetic/ Antivertigo agent	Heparin & related preparations	Opioid Analgesic	Potassium replacement	Magnesium salt replacement
Mechanism of Action	Selectively antagonizes serotonin 5-HT3 receptors	Binds to antithrombin III to prevent further thrombin activity	Binds to various opioid receptors to reduce pain	Replace potassium with fluids	Physiologic process to replace magnesium
Reason Client Taking	Prevent vertigo	Prevent clots while in bed	Pain management	Raise low potassium levels	Raise low magnesium levels
Contraindications (2)	Hypersensitivity Congenital long QT syndrome	Thrombocytopenia hemorrhage	Hypersensitivity Caution with elderly	Hyperkalemia Hyperglycemia	Myocardial damage Heart block
Side Effects/Adverse Reactions (2)	Headache constipation	Bleeding Thrombocytopenia	Respiratory depression Respiratory arrest	Nausea Vomiting	Depressed reflexes Hypotension
Nursing Considerations (2)	Monitor for bradyarrhythmia's IV push should be	Monitor aPTT for therapeutic affect Monitor for bleeding	Monitor respiratory statue Be aware	Monitor creatinine and urine output Review history	Monitor toxicity levels Monitor

	done slowly over 1-2 minutes		100mcg fentanyl = 10mg morphine	for increased sensitivity to potassium	Blood pressure

Medications Reference (APA): Jones & Bartlett Learning. (2019) *2019 Nurse's Drug Handbook, eighth edition.* Burlington, MA, Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to surrounding Appears alert and calm Well groomed
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Braden scale: 18 Moist skin Low skin turgor No visible rashes or bruises No wounds No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	PERRLA with vision aid= glasses Dentin good Nose clear palps Ears moist and pink .
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, No murmurs, Cap refill with in few seconds, Pulses +2 bilaterally, no neck vein distention, no edema

RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Sounds were clear bilaterally Breathing room air Some use of upper accessory muscles
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:**	Normoactive bowel sounds Current diet: Ice chips Home diet: High in carbohydrates Weight: 99.8 kg Last BM was yesterday Pain in abdomen Abdomen appeared distended No incisions Scars from appendectomy No drains or wounds No ostomy No NG tube or feeding tube
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Dark yellow Hesitancy Voids about 2 times a day No pain during urination No dialysis No catheter Patient is using a urinal
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:**	. Assistance transferring with caregiver present and a gait belt Equal strength bilaterally Full ROM Nerves intact Fall Scale: 5 Mildly impaired

Independent (up ad lib) ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Needs little ADL assistance
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW PERRLA Strength equal bilaterally Speaks clearly Full sensory status Mental status: Alert and no cognitive impairment
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):**	Coping: pout/ read newspaper and watch stocks and the history channel Christian Highschool education Lives at home with wife Older Adult Married

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
2:40 pm	67	179/77	30	98.7 Temporal	95 Room air
4:56pm	71	187/85	28	98.2 Temporal	95 Room air

Pain Assessment, 2 sets (2 points)

Time	Scale 0-10	Location	Severity	Characteristics	Interventions
4:12pm	5	Abdomen	Worst pain ever	Stabbing	repositioning
4:56pm	6	Abdomen	Constant	Dull	Pain Medicine

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18G
Location of IV:	Left arm/ antecubital
Date on IV:	9/16/19 @ 1532
Patency of IV:	IV is patent/Flushable
Signs of erythema, drainage, etc.:	No erythema, or drainage
IV dressing assessment:	Clean/Dry/Intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A	**N/A**

Nursing Care

Summary of Care (2 points)

Overview of care: Keep patient comfortable and NPO while labs are being completed and the doctor comes to see him.

Procedures/testing done: No procedures done, CBC, CMP, Lipase, and magnesium labs have been done.

Complaints/Issues: Patient had complained of discomfort in the upper abdomen and scored it as a 5-6 and said it was the worst pain he ever felt.

Vital signs (stable/unstable): Vital signs for the blood pressure and respirations were slightly elevated but were stable.

Tolerating diet, activity, etc.: NPO since admitted and is only eating ice chips.

Physician notifications: Notified the nurse on duty the change in pain levels of the patient so he could receive pain medication.

Future plans for patient: Focused Diagnostic imaging of pancreas

Discharge Planning (2 points)

Discharge location: The patient will go home with his wife upon discharge**.**

Home health needs (if applicable): Patient might need assistance at home if he is still a fall risk at discharge.

Equipment needs (if applicable): Patient may need to continue use of assistance with gait belt or use a walker when getting around.

Follow up plan: Patient will return to do the focused diagnostic imaging of the pancreas so the physician can possibly see if the ducts are blocked and causing pain.

Education needs: The patient needs watch his diet because he said he eats a high carbohydrate diet. He should include foods with potassium and magnesium since those labs were low. He should use a walker and be taught how to use it with physical therapy if possible. Until he is seen again the nurse can teach him pain management strategies and that is the pain becomes severe again to come back.

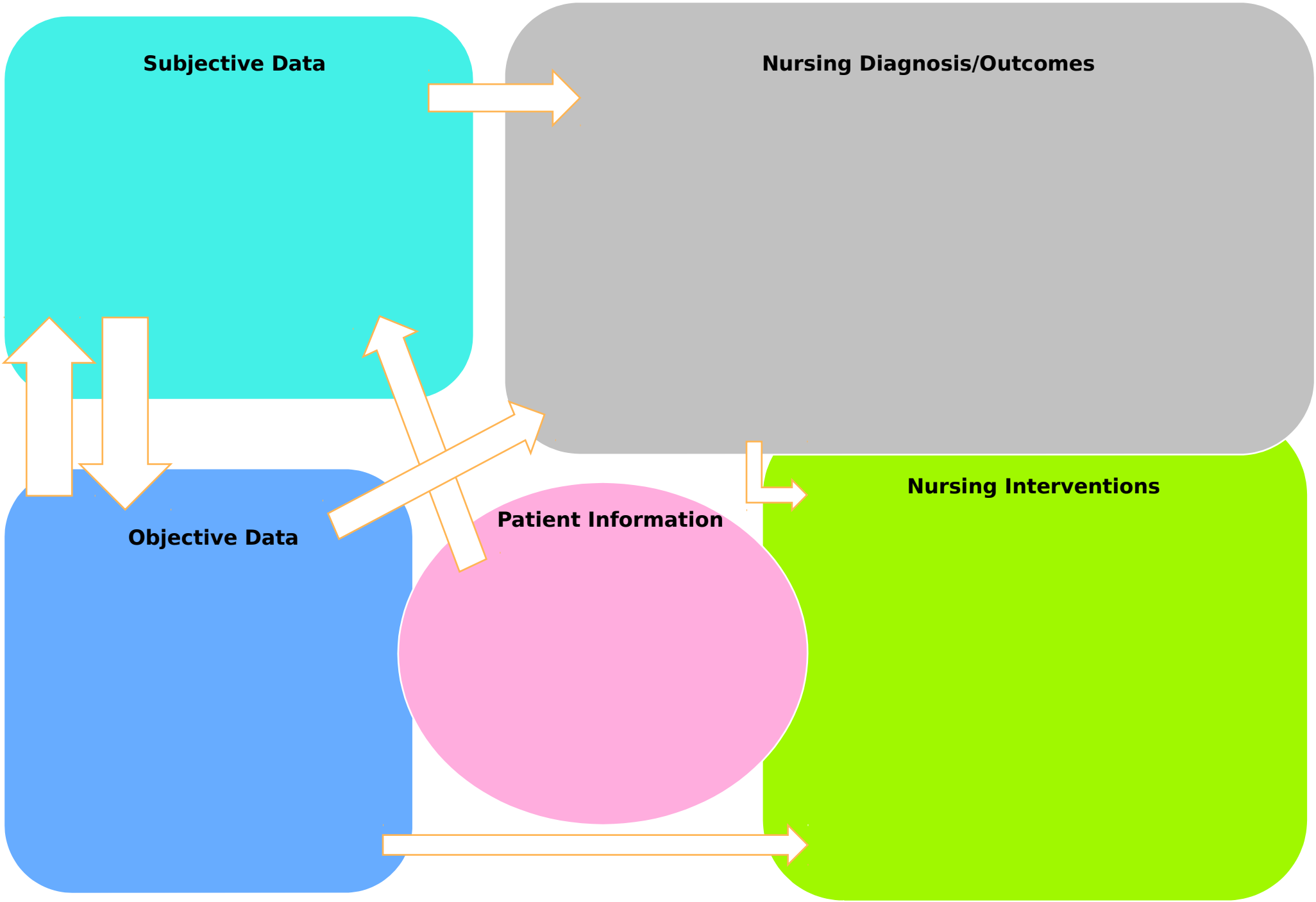
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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 abdominal pain as evidence by acute pancreatitis	Patient is experiencing recent abdominal pain due to the inflammation of the pancreas	1.Ask patient to rate pain on a scale of 0-10 2.Ask patient to request analgesic before pain is severe	The client complied and get the rating as a 5 and asked for an analgesic when he was returned to the bed.
2. Fluid volume excess related to low	Patient's abdomen seemed distended and potassium and magnesium levels were low	1. Obtain a base line abdominal girth measure 2.Monitor weight and	

electrolytes as evidence by distended abdomin		I/O's	
3. Risk for Bleeding related to heparin as evidence by thinning the blood	Patient is on heparin which is a blood thinner = excess bleeding	1. 2.	
4. Risk for impaired tissue integrity related to being in bed as evidence by lack of mobility	Patient is laying in bed or sitting for long periods of time	1. 2.	
5. Impaired walking related to fall risk score of 5 as evidence by use of gait belt	Patient needs a gait belt and a 2-3 aid assist when walking	1. 2.	

Other References (APA):

Concept Map (20 Points):


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