N431 Care Plan #2

Lakeview College of Nursing

Sydney Morgan

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/6/2019	DS	56	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	mechanic	Married	Simvastatin
Code Status	**Height**	**Weight**	
Full	175.3 cm	78.2 kg	

Medical History (5 Points)

Past Medical History: HTN, sigmoid colon cancer stage IIIc

Past Surgical History: Sigmoid colectomy and colostomy (2016); surgical resection with sigmoid colectomy and exploratory laparotomy (2018)

Family History: None

Social History (tobacco/alcohol/drugs): Patient denies use of tobacco, drugs, or alcohol

Assistive Devices: None

Living Situation: at home with wife

Education Level: no anticipated learning barriers; high school diploma/trade educated

Admission Assessment

Chief Complaint (2 points): bleeding from stoma

History of present Illness (10 points):. Patient is a 56-year-old male with history of sigmoid colon cancer. Patient presented to the ED with reports of bleeding from his stoma. DS reported noting some minor bleeding around the stoma in the morning around 8 AM after feeling a sharp pain in the LLQ while getting out of bed. By 11 AM DS reported his ostomy bag was half full with blood, and by 4 PM DS noted the ostomy bag was completely full of bright red blood. After noting the amount of blood DS reported the finding to his oncologist who advised he seek emergency medical attention, DS arrived to the ED with his ostomy bag full of bright red blood.

Patient presented tachycardic and tachypneic and baseball size blood clots were removed from the stoma area and colostomy bag. Patient had last chemotherapy treatment Tuesday (10/01/2019) prior to admission.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Gastrointestinal Bleeding

Secondary Diagnosis (if applicable): Sigmoid colon cancer stage IIIc

Pathophysiology of the Disease, APA format (20 points): Gastrointestinal bleeding, or gastrointestinal hemorrhage, is a result of a perforation somewhere in the gastrointestinal tract. The signs and symptoms of gastrointestinal hemorrhage can often help identify the source of bleeding. Hematemesis, vomiting bright red blood, often indicates the bleed is proximal to the ligament of Treitz. Melena, dark or tarry stools, can indicate the hemorrhage originates in the upper gastrointestinal tract. Hematochezia, bright red blood found in the rectum or stools can indicate hemorrhoids or a lower gastrointestinal bleed. In DS's case, a large amount of bright red blood was seen from his stoma at the sigmoid colon, indicating the bleed is in the proximal large intestine. Gastrointestinal hemorrhage is not a disease process itself, but is often the result of an underlying disease process or abdominal trauma (Swearingen, 2016). In DS's case the underlying disease process is sigmoid colon cancer stage IIIc. Colon cancer often begins in the mucosa of the intestine with generalized abnormalities of cell replication, often developing from adenomatous polyps. A polyp is considered malignant when the neoplastic cells move into the submucosa of the intestine. In DS's case a portion of his colon was removed due to these malignancies and an ostomy was created. Symptoms of colon cancer include: changes in bowel habits, rectal bleeding, blood in stool, persistent abdominal discomfort, a feeling of incomplete bowel evacuation, weakness/fatigue, and unexplained weight loss (Porth, 2011).. DS has had

reports of all these symptoms, with weakness/fatigue and weight loss being the most prominent. Colon cancer's peak incidence is between 60 and 70 years of age, and is increased in patients with a family history of colon cancer. DS was diagnosed prior to peak incidence at 52 with no pertinent family history. Other risk factors for colon cancer include: older age, African-American race, history of polyps or colorectal cancer, inflammatory bowel disease, family history of colon cancer, low-fiber, high-fat diet, sedentary lifestyle, obesity, diabetes, smoking, and alcohol use (Porth, 2011). Risk factors that pertain to DS include: older age (56), history of polyps/colorectal cancer, low-fiber, high-fat diet, and sedentary lifestyle. Screening for colorectal cancer is recommended every 10 years starting at age 50, if polyps are found diagnosis of malignancies is done via biopsy. DS had been doing screenings more frequently, annually, due to a history of colorectal cancer and was diagnosed with recurrent sigmoid colon cancer. Treatment for colon cancer can involve surgery; to remove the diseased bowel, radiation and/or chemotherapy. Initial treatment for DS was a bowel resection with colostomy placement. DS is now receiving chemotherapy as a treatment for recurrent colon cancer.

Pathophysiology References (2) (APA): Swearingen, P. L. (2016). *All-in-One Nursing Care Planning 4th Edition.* St. Louis, Missouri: Elsevier

Porth, C. M. (2011). *Essentials of Pathophysiology 3rd Edition.* Lippincott Williams & Wilkins.

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	**4.2-6.1**	**3.09**	**4.3**	**Patient had active bleed at time of admission resulting in a decrease in RBCs.**
Hgb	**12-18**	**8.9**	**12.4**	**Patient had active bleed at time of admission resulting in a decrease in Hgb.**

Hct	**37-52**	**27.5**	**37.2**	**Patient had active bleed at time of admission resulting in a decrease in Hct**
Platelets	**150-400**	**137**	**149**	**Patient had active bleed at time of admission resulting in a decrease in platelets, platelets had risen from admission but not returned to baseline during my shift**
WBC	**4-11.7**	**5.7**	**6.0**	
Neutrophils	**45-75%**	**93.8**	**73.9**	
Lymphocytes	**20-40%**	**4.2**	**13.3**	
Monocytes	**4-6%**	**0.9**	**8.1**	
Eosinophils	**10%**	**0.8**	**4.2**	
Bands	**0**	**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**	**139**	**141**	
K+	**3.5-5.0**	**3.6**	**3.8**	
Cl-	**96-106**	**106**	**105**	
CO2	**20-29**	**23**	**25**	
Glucose	**70-110**	**88**	**91**	
BUN	**7-25**	**12**	**7**	
Creatinine	**0.8-1.2**	**0.86**	**0.77**	
Albumin	**35-55**	**35**	**N/A**	
Calcium	**8.5-10.2**	**8.6**	**8.8**	

Mag	**1.3-2.1**	**N/A**	**N/A**	
Phosphate	**3.0-4.5**	**N/A**	**N/A**	
Bilirubin	**0.3-1**	**0.4**	**N/A**	
Alk Phos	**30-120**	**N/A**	**N/A**	
AST	**10-40**	**21**	**N/A**	
ALT	**44-147**	**15**	**N/A**	
Amylase	**30-220**	**N/A**	**N/A**	
Lipase	**0-160**	**N/A**	**N/A**	
Lactic Acid	**0.5-1**	**N/A**	**N/A**	
Troponin	**less than 0.04**	**N/A**	**N/A**	
CK-MB	**3-5%**	**N/A**	**N/A**	
Total CK	**5-25**	**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	**0.8-1.1 (2-3 on warfarin)**	**1.17**	**N/A**	**Patient had active bleed at the time of admission, clotting factors were likely decreased causing an increased INR**
PT	**11-12.5**	**15.1**	**N/A**	**Patient had active bleed at the time of admission, clotting factors were likely decreased causing an increased PT**
PTT	**30-40**	**N/A**	**N/A**	
D-Dimer	**less than 0.4**	**N/A**	**N/A**	

BNP	**less than 100**	**N/A**	**N/A**	
HDL	**greater than 40**	**N/A**	**N/A**	
LDL	**less than 100**	**N/A**	**N/A**	
Cholesterol	**less than 200**	**N/A**	**N/A**	
Triglycerides	**less than 150**	**N/A**	**N/A**	
Hgb A1c	**4-5.6% (if diabetic less than 7%)**	**N/A**	**N/A**	
TSH	**0.4-4**	**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	**clear and yellow**	**N/A**	**N/A**	
pH	**6.0**	**N/A**	**N/A**	
Specific Gravity	**1.005-1.035**	**N/A**	**N/A**	
Glucose	**0**	**N/A**	**N/A**	
Protein	**0**	**N/A**	**N/A**	
Ketones	**0**	**N/A**	**N/A**	
WBC	**less than 5**	**N/A**	**N/A**	
RBC	**0-3**	**N/A**	**N/A**	
Leukoesterase	**0**	**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	Value on	Today's	Explanation of Findings

	Range	Admission	Value	
pH	**7.35-7.45**	**N/A**	**N/A**	
PaO2	**75-100**	**N/A**	**N/A**	
PaCO2	**35-45**	**N/A**	**N/A**	
HCO3	**22-28**	**N/A**	**N/A**	
SaO2	**95-100%**	**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	**0**	**N/A**	**N/A**	
Blood Culture	**0**	**N/A**	**N/A**	
Sputum Culture	**0**	**N/A**	**N/A**	
Stool Culture	**0**	**N/A**	**N/A**	

Lab Correlations Reference (APA): ATI Nursing Education. (2016). *Content Mastery Series: RN Adult Medical Surgical Nursing Edition 10.0.* Assessment Technologies Institute, LLC.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT abdomen and pelvis with contrast

Diagnostic Test Correlation (5 points): A CT of the abdomen and pelvis was done to determine the possible site of bleeding and to assess the extent of DS's cancer. CT abdomen and pelvis with contrast showed splenomegaly; mucosal thickening in the descending colon and hepatic flexure of the colon; colostomy is unobstructed; large volume of abdominal and pelvic ascites; some stranding in the omentum which is concerning for metastatic disease

Diagnostic Test Reference (APA): ATI Nursing Education. (2016). *Content Mastery Series: RN Adult Medical Surgical Nursing 10.0.* Assessment Technologies Institute, LLC.

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

Home Medications (5 required)

Brand/Generic	**Imodium (loperamide)**	**TUMS (magnesium carbonate-calcium carbonate)**	**Toprol (metoprolol succinate)**	**Tylenol (acetaminophen)**	**Centrum One-a-Day (multivitamin)**
Dose	**2 mg**	**300-250 mg (x2)**	**25 mg**	**1000 mg**	**1 tab**
Frequency	**q4h PRN**	**Daily**	**Daily**	**q6h PRN**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**antidiarrheal**	**antacid**	**beta adrenergic antagonist (beta blocker)**	**analgesic**	**vitamin supplement**
Mechanism of Action	**acts by slowing intestinal motility and by affecting water and electrolyte movement through the bowel**	**acts by neutralizing hydrochloric acid in gastric secretions. Subsequent increases in pH may inhibit the action of pepsin**	**inhibits stimulation of beta1 receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand**	**blocks prostaglandin production and interferes with pain impulse generation in the peripheral nervous system**	**acts to prevent deficiencies by providing necessary vitamins/ minerals as a dietary supplement**
Reason Client Taking	**Reduce and thicken**	**heartburn managemen**	**hypertension**	**as needed for**	**deficiency preventio**

	ostomy output	**t**	**management**	**headaches/joint pain**	**n due to possible imbalanced nutrition caused by colon cancer**
Contraindications (2)	**hypersensitivity concurrent broad spectrum antibiotic use**	**impaired kidney function hypercalcemia**	**heart rate less than 45 bpm acute heart failure**	**hepatic impairment hypersensitivity**	**diverticular disease hemolytic anemia**
Side Effects/Adverse Reactions (2)	**dry mouth urinary retention**	**anorexia nausea/vomiting**	**orthostatic hypotension arrhythmias (including AV block and bradycardia)**	**nausea/vomiting hepatotoxicity**	**abdominal discomfort (n/v) fat-soluble vitamin toxicity**
Nursing Considerations (2)	**Assess frequency and consistency of stools and bowel sounds prior to and during therapy** **Assess balance and skin turgor for dehydration**	**Observe patient closely for symptoms of hypocalcemia (paresthesia, muscle twitching, laryngospasm, colic, cardiac arrhythmias, Chvostek's or Trousseau's signs)** **Assess patient for nausea, vomiting,**	**monitor patient for symptomatic bradycardia** **Monitor intake and output ratios and daily weights.** **Assess routinely for signs and symptoms of HF**	**do not exceed more than 4000 mg per day monitor for signs of hepatotoxicity - bleeding, easy bruising, and malaise**	**Assess patient for signs of nutritional deficiency before and throughout therapy** **monitor for symptoms of vitamin toxicity**

		anorexia, thirst, severe constipation, paralytic ileus, and bradycardia as these could be signs of toxicity			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor fluid and electrolytes prior to and during therapy to assess hydration status**	**Monitor serum calcium or ionized calcium, chloride, sodium, potassium, magnesium, albumin, and parathyroid hormone (PTH)concentrations before and periodically during therapy for treatment of hypocalcemia**	**Monitor HR and BP prior to administration to prevent hypotension /bradycardia**	**monitor liver and renal function (ALT, AST, BUN, creatinine, bilirubin) prior to and during therapy**	**Monitor patient vitamin levels prior to and during therapy to avoid toxicity**
Client Teaching needs (2)	**May cause drowsiness. Advise patient to avoid driving or other activities requiring alertness until response to**	**Instruct patients on a regular schedule to take missed doses as soon as possible, then go back to regular schedule**	**instruct patient to take with food at the same time daily notify PCP if HR falls below 60 bpm or is significantly less than**	**tablets may be crushed or swallowed whole educate patient on s/s of hepatotoxicity**	**take tablet with a full glass of water each morning advise patient to not take more than is directed**

	drug is known. Advise patient that frequent mouth rinses, good oral hygiene, and sugarless gum or candy may relieve dry mouth	**Advise patient to avoid excessive use of tobacco or beverages containing alcohol or caffeine**	**normal**		**and not to combine multiple multivitamins unless directed by PCP**

Hospital Medications (5 required)

Brand/Generic	**Narcan (naloxone)**	**Zofran (ondansetron)**	**Eliquis (apixaban)**	**Depakote (valproic acid)**	**Norvasc (amlodipine)**
Dose	**1 mL**	**2 mL**	**5 mg - common dosage**	**initial - 10-15 mg/kg/day maximum - 60 mg/kg/day**	**5-10 mg**
Frequency	**PRN**	**q6h PRN**	**BID**	**BID**	**Daily**
Route	**IV push**	**IV push**	**PO**	**PO**	**PO**
Classification	**opioid antagonist**	**antiemetic**	**antithrombotic lytic**	**anticonvulsant**	**antihypertensive; antiaginal**

Mechanism of Action	**antagonizes mu, kappa, and sigma receptors in the CNS thus reversing analgesia**	**blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine**	**inhibits free and clot-bound factor Xa and prothrombinase activity**	**may decrease seizure activity by blocking reuptake of GABA neurotransmitter**	**binds to dihydropyridine and dihydropyridine cell membrane receptor sites on myocardial and vascular smooth muscle cells and inhibits influx of calcium ions across slow calcium channels - relaxing cardiac muscles**
Reason Client Taking	**as needed for analgesic side effects**	**nausea management**	**Drug assigned by instructor Hurt because patient was lacking 10 medications**	**Drug assigned by instructor Hurt because patient was lacking 10 medications**	**Drug assigned by instructor Hurt because patient was lacking 10 medications**
Contraindications (2)	**hypersensitivity use cautiously in known patients physically dependent on opioids; can cause**	**congenital long QT syndrome hypersensitivity**	**active pathological bleeding hypersensitivity**	**hepatic impairment urea cycle disorders**	**concurrent aliskiren therapy in patients with diabetes or renal impairment hypersens**

	acute abstinence syndrome				**itivity**
Side Effects/Adverse Reactions (2)	**severe hypertension ventricular tachycardia**	**arrhythmias accommodation disturbances**	**hemorrhagic stroke syncope**	**bradycardia hepatotoxicity**	**arrhythmias peripheral edema**
Nursing Considerations (2)	**keep resuscitation equipment readily available during administration be prepared to administer repeat doses as prescribed**	**monitor patient closely for serotonin syndrome - agitation, chills, confusion, diaphoresis, fever and hyperactive reflexes monitor patient for decreased bowel activity**	**do not give to patients with severe hepatic impairment monitor patient closely for bleeding - there is no antidote for apixaban**	**give with food to decrease GI irritation; delayed-release capsules can be sprinkled on semi-solid food for administration monitor patient for hyperammonemia**	**use cautiously in patients with hepatic or renal impairment assess patient frequently for chest pain when beginning or changing dosages**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**monitor patient vitals prior to and throughout administration; particularly BP, HR, RR**	**ensure potassium and magnesium levels are within normal limits prior to administration as abnormalities may increase risk for arrhythmias**	**monitor INR prior to and regularly throughout administration**	**monitor liver enzymes as ordered to assess for hepatic impairment prior to and throughout administration**	**monitor BP prior to and frequently during administration**
Client Teaching needs (2)	**caution patient that**	**advise patient to**	**emphasize importance**	**instruct patient to**	**advise patient to**

	drug may cause nausea on first dose; repeat doses typically do not cause nausea tell patient to report any adverse effects - coughing, abdominal pain, dyspnea	**seek immediate medical attention if patient experiences persistent, severe, or worsening symptoms advise patient to immediately report signs of hypersensitivity, such as rash**	**of taking apixaban only as prescribed educate patient on s/s of bleeding and to report any signs immediately to PCP**	**swallow capsules who to prevent irritation to mouth and throat; delayed-release sprinkle capsules should also not be chewed encourage patient to avoid alcohol during therapy**	**take any missed doses as soon as remembered and next dose in 24 hours advise patient to immediately report dizziness, swelling, dyspnea, hives or rash**

Medications Reference (APA): Jones & Bartlett Learning. (2018). *Nurse's Drug Handbook 17th Edition.* Burlington, MA: Jones & Bartlett Learning.

Janice L. Hinkle PhD, R.C. (2017). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing.* New York, New York: Wolters Kluwer.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alertx4** **Orientation: Orientedx4** **Distress: no apparent distress** **Overall appearance: no abnormalities**	**Patient appeared within normal limits. No apparent distress. AOx4.**
INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry** **Temperature: warm** **Turgor: good** **Rashes: none** **Bruises: none** **Wounds: none** **Braden Score: 22** **Drains present: N** **Type: none**	**Skin appeared pink, warm, and dry. No noted lesions, rashes, or abrasions. Good skin turgor, within normal limits.**
HEENT (1 point): **Head/Neck: normocephalic, no noted lumps or abnormalities.** **Ears: Tympanic membranes pearly gray bilaterally** **Eyes: PERRLA** **Nose: no noted abnormalities, turbinates appeared pink and dry** **Teeth: all teeth present, no abnormalities**	**No reported ear pain, no reported nasal congestion, no reported sore throat. Normal hearing to voice, no noted deficits. Oral mucosa appeared moist and intact. No noted sinus tenderness.**

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2** **Cardiac rhythm (if applicable): normal sinus** **Peripheral Pulses: 3+** **Capillary refill: less than 3 sec.** **Neck Vein Distention: N** **Edema N** **Location of Edema: none**	**No reported chest pain, palpitations. Normal heart rate and rhythm. No noted clicks, gallops, or rubs. No murmur. No noted edema.**
RESPIRATORY (2 points): **Accessory muscle use: N** **Breath Sounds: clear bilaterally**	**No reported SOB or cough. Non-labored breathing. Clear to auscultation bilaterally in all lobes.**

GASTROINTESTINAL (2 points): **Diet at home: regular** **Current Diet: regular** **Height: 175.3 cm** **Weight: 78.2 kg** **Auscultation Bowel sounds: active bowel sounds in all 4 quadrants** **Last BM: 10/9/2019** **Palpation: Pain, Mass etc.: none** **Inspection:** **Distention: none** **Incisions: none** **Scars: none** **Drains: none** **Wounds: none** **Ostomy: Y** **Nasogastric: N** **Size:** **Feeding tubes/PEG tube N** **Type:**	**Abdomen was soft, non-tender, and slightly distended. Some ascites was noted, likely due to sigmoid colon cancer. Normal, active bowel sounds auscultated in all 4 quadrants. No noted lesions, lumps, or masses. Patient denied nausea, vomiting, or abnormalities to stool. Ostomy appeared within normal limits. No redness, swelling, or tenderness to stoma. Bag had been changed immediately prior to my assessment, very little output noted.**

GENITOURINARY (2 Points): **Color: light yellow** **Character: clear** **Quantity of urine: unable to measure** **Pain with urination: N** **Dialysis: N** **Inspection of genitals: no noted abnormalities** **Catheter: N** **Type:** **Size:**	**Patient denies any abnormalities.**
MUSCULOSKELETAL (2 points): **Neurovascular status: no noted deficits** **ROM: no noted limitations** **Supportive devices: none** **Strength: equal bilaterally** **ADL Assistance: N** **Fall Risk: N** **Fall Score: 20** **Activity/Mobility Status: up ad lib**	**No limitation in ROM. No tenderness or swelling. Patient up ad lib with no assistance.**

NEUROLOGICAL (2 points): **MAEW: Y** **PERLA: Y** **Strength Equal: Y** **Orientation: AOx4** **Mental Status: no noted deficits** **Speech: no noted deficits** **Sensory: no noted deficits** **LOC: alert and oriented**	**No noted neurologic deficits. Patient was AOx4. Cranial nerves intact. Sensation to light and touch intact.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): religion, family support** **Developmental level: developmentally appropriate for age** **Religion & what it means to pt.: Christian, important to patient** **Personal/Family Data (Think about home environment, family structure, and available family support): wife is patient's main family support**	**Patient remained very calm and at ease during my shift. Patient was calm and cooperative. Appropriate mood and affect.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1301	89	141/92	18	36.7	97%
1445	88	127/82	18	36.7	99%

Vital Sign Trends: DS's vitals were stable for my shift. The decrease in blood pressure is a result of his dose of metoprolol.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1301	**Numeric**	**LLQ**	**2**	**dull**	**none; patient denied Tylenol**
1445	**Numeric**	**LLQ**	**0**	**none**	**none**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 g **Location of IV: centrally tunneled catheter; left chest** **Date on IV: 10/7/2019** **Patency of IV: patent; fluids running** **Signs of erythema, drainage, etc.: no redness, drainage or swelling** **IV dressing assessment: clean, dry, and intact**	normal saline 100 mL/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
750 mL (IV NS) **PO intake was unmeasured**	**unmeasurable; patient was up ad lib to the bathroom, colostomy bag was emptied prior to my shift and output was not measured before discharge**

Nursing Care

Summary of Care (2 points)

Overview of care: Preformed head to toe assessment and vitals at the beginning of my clinical shift upon meeting DS. Did not administer any medications to DS, scheduled medications had been given prior to the start of my shift and DS denied any need for his

PRN medications. DS was able to be discharged during my shift, prior to his discharge central line was flushed with heparin to prevent clotting and removed. Vitals were obtained prior to discharge and DS was accompanied to 2 south to his wife's inpatient room.

Procedures/testing done: No procedures or testing done for DS during my shift

Complaints/Issues: DS had no complaints or issues, he was calm and cooperative for all aspects of care

Vital signs (stable/unstable): DS's vitals were stable during my shift, there was a significant decline in BP due to the metoprolol given prior to my shift but BP remained within normal limits.

Tolerating diet, activity, etc.: DS was up ad lib with no issues, no issues reported with diet or activity

Physician notifications: Hospitalist saw DS once during my shift and approved him for discharge with recommendation to follow up with oncologist and regular ostomy care nurse at the VA in Mattoon.

Future plans for patient: A follow up appointment at the VA was made for DS regarding his ostomy to ensure no further bleeding and proper management.

Discharge Planning (2 points)

Discharge location: DS was discharged to go home; his wife is currently admitted to 2 south so DS remained at SBL after discharge in his wife's patient room.

Home health needs (if applicable): no home health required

Equipment needs (if applicable): DS was provided some scissors and measuring tools to assist with changing his ostomy bag prior to discharge.

Follow up plan: A follow up appointment at the VA was made for DS regarding his ostomy to ensure no further bleeding and proper management.

Education needs: DS was given instructions on proper care of his ostomy and signs and symptoms of bleeding in case this were to occur again. Education is anticipated to continue with regular ostomy nurse at upcoming VA follow up appointments.

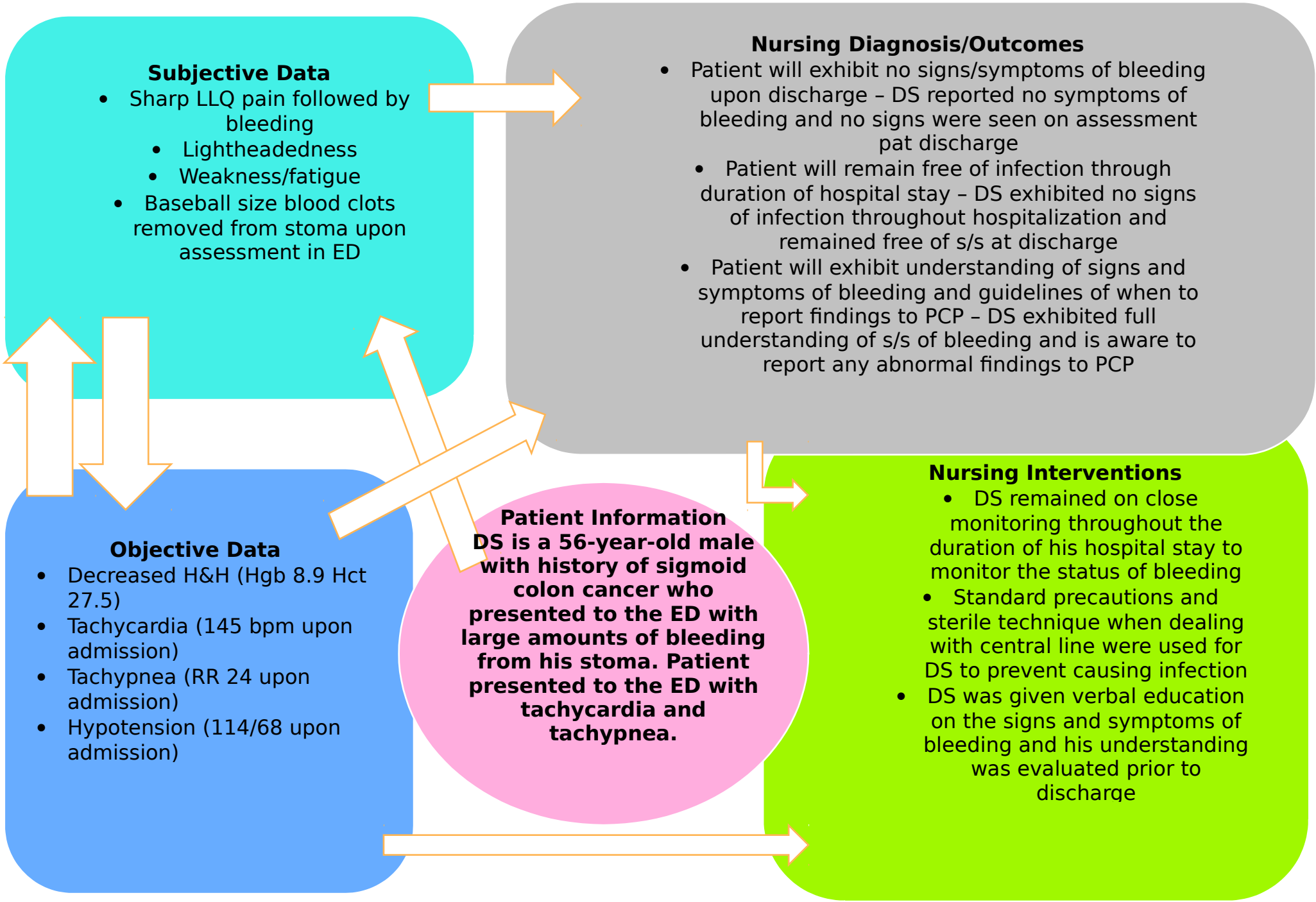
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Deficient fluid volume related to active GI bleed as evidenced patient reported large amounts of blood loss through stoma upon admission.	**I chose this nursing diagnosis because DS is at risk for hypovolemia due to the active bleed in his GI tract.**	**1. DS was given continuous NS through his central line to maintain adequate fluid level.** **2. DS's H&H was regularly monitored during his hospitalization to ensure there were no serious deficits.**	**DS responded well to nursing actions, he was cooperative regarding all treatment, DS's H&H returned to baseline at discharge.**
2. Ineffective tissue perfusion related to active GI bleed as evidenced by patient reports of lightheadedness upon admission.	**I chose this nursing diagnosis because DS is at risk for decreased tissue perfusion due to his bleed, his H&H was decreased upon admission**	**1. DS was regularly assessed for signs of decreased tissue perfusion - peripheral pulses, skin assessment.**	**DS responded well to interventions and demonstrated understanding when s/s of decreased tissue perfusion were explained to him. DS was advised to notify staff of any of these symptoms. DS denied at symptoms upon discharge and no**

	leading to decreased perfusion.	**2. DS's vital signs were regularly monitor to assess for signs of decreased tissue perfusion - BP, O2Sat.**	**signs were seen upon assessment.**
3. Risk for infection related to central line port as evidenced by port placement for chemotherapy.	**I chose this nursing diagnosis because DS has a central line and port placed for chemotherapy treatment, central lines can be access for bacterial infections and chemotherapy can increase the risk of opportunistic infections.**	**1. DS's central line was cleaned and the dressing was changed according to protocol during his hospital stay.** **2. DS was explained the s/s of infection and advised to report any changes to the dressing and line to staff.**	**DS was cooperative with interventions. He demonstrated understanding of s/s of infection. He denied any symptoms upon discharge and no signs were seen on assessment.**
4. Nausea related to sigmoid colon cancer as evidenced by patient reports of feeling nauseous.	**I chose this nursing diagnosis for DS because he had reported feelings of mild nausea during the first part of my clinical shift and had said that it was a frequent occurrence.**	**1. DS was offered Zofran as an antiemetic.** **2. DS was advised to rest as much as possible to avoid increasing feelings of nausea.**	**DS denied Zofran, stating the nausea "wasn't that bad". DS remained in bed for the majority of my shift, and following a nap he denied any feelings of nausea.**

Other References (APA):

Concept Map (20 Points):


Subjective Data
• Sharp LLQ pain followed by bleeding
• Lightheadedness
• Weakness/fatigue
• Baseball size blood clots removed from stoma upon assessment in ED
Nursing Diagnosis/Outcomes
• Patient will exhibit no signs/symptoms of bleeding upon discharge – DS reported no symptoms of bleeding and no signs were seen on assessment pat discharge
• Patient will remain free of infection through duration of hospital stay – DS exhibited no signs of infection throughout hospitalization and remained free of s/s at discharge
• Patient will exhibit understanding of signs and symptoms of bleeding and guidelines of when to report findings to PCP – DS exhibited full understanding of s/s of bleeding and is aware to report any abnormal findings to PCP
Objective Data
• Decreased H&H (Hgb 8.9 Hct 27.5)
• Tachycardia (145 bpm upon admission)
• Tachypnea (RR 24 upon admission)
• Hypotension (114/68 upon admission)
Patient Information
DS is a 56-year-old male with history of sigmoid colon cancer who presented to the ED with large amounts of bleeding from his stoma. Patient presented to the ED with tachycardia and tachypnea.
Nursing Interventions
• DS remained on close monitoring throughout the duration of his hospital stay to monitor the status of bleeding
• Standard precautions and sterile technique when dealing with central line were used for DS to prevent causing infection
• DS was given verbal education on the signs and symptoms of bleeding and his understanding was evaluated prior to discharge