# N431 Care Plan 1

Lakeview College of Nursing

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## Demographics (5 points)

| **Date of Admission** 10/8/2019 | **Patient Initial** B.J. | **Age** 73 | **Gender** Female |
|---|---|---|---|
| **Race / Ethnicity** Caucasian | **Occupation** Retired | **Marital Status** Married | **Allergies** NKA |
| **Code Status** **DNR** | **Height** 165.1 cm | **Wight** 93.2kg | |

## Medical History (5 points)

**Past Medical History:**

- Ch. A fib
- Myasthenia gravis
- Breast Cancer
- Hypertension
- Hyperlipidemia
- Type II diabetes mellitus
- Diverticula
- Ch. Depression
- Sleep apnea

**Past Surgical History:**

- Sigmoid colon ostomy
- Mastectomy

**Family History:** Father side with hx of heart disease, mother side has diabetes.

**Social History (Tobacco / Alcohol / Drugs, Patient Social Factors):**

Patient living in a single home with her husband in Mattoon. She diagnosed with Myasthenia gravis for years along with multiple other chronic health conditions. She denied tobacco and alcohol or any other illicit drug use. Her husband is the one taking care of her for

many years, and he refused to send her to the nursing home because financial reason. They stay home most of the time.

## Admission Assessment

**Chief Complaint (2 points):**

- Pt present to ER in severe abdominal pain, nausea and vomiting.

**History of Present Illness (10 Points):**

Patient present in ER via EMS in Oct, 8th complain of severe 9/10 abdominal pain, with nausea and vomiting. VS: Temp 38.7C, BP 155/75, HR 98, RR 22, O2 Sats 92%. Pt with multiple complicated health history, Ch A fib, Myasthenia gravis, diabetes mellitus, breast cancer, HTN, chronic respiratory insufficiency, diverticula, chronic use of anticoagulant and steroids, etc. Pt has regular diet @ home, decreased appetite since last month. Patient was given IV hydromorphone (Dilaudid) to control the pain. Abd. X-ray and Cystoscopy was done the same day and she was diagnosed with intraabdominal abscess with colovesical fistula, as well as bilateral renal calculus. An open abdominal surgery done to remove abscess and renal stones, as well as repaired the colovesical fistula. Pt was transferred to CCU due to uncontrolled A fib following the surgery day, and transferred back to med-surg floor on Oct. 20th.

### Primary Diagnosis

**Primary Diagnosis on Admission (2 points):**

- Intrabdominal Abscess

**Secondary Diagnosis (if applicable):**

- Colovesical Fistula
- Renal calculi

- AKI

**Pathophysiology of the Disease, APA Format (15 Points):**

Colovesical Fistula refers to an opening connects between colon and the bladder, which allows fecal material from colon to enter the bladder causing infection and other compilation such as abscess. Surgery or other trauma to this part of the body can cause a fistula to form. When an opening develops, the result is colovesical fistula, also known as vesicocolic fistula (Colovesical Fistula, 2019). The most case of colovesical fistula caused from diverticular disease, the other causes are including colorectal cancer, Inflammatory bowel disease, Crohn's disease, surgery, radiotherapy, etc. The signs and symptoms including pneumaturia, fecaluria, dysuria, hematuria. Pt present with dysuria, nausea and vomiting, she had diverticula disease, and diagnosed upon cystoscopy.

The urolithiasis refer to calculi (stone) formation in the urinary track and kidney. The stones are formed in a condition also rereferred to as supersaturation, when urinary concentration increases in substances such as calcium oxalate, calcium phosphate, struvite (magnesium and ureic acid. The level of saturation depends on the amount of the substance, ionic strength, and pH of the urine. The location of the stone formation may find anywhere from the kidney to the bladder, and may vary in size from sand and gravel (granular deposit) to as large as an orange (Hinkle & Cheever, 2018, P1632).

There are few major factors including infection, urinary stasis, immobility, all of which slow kidney drainage and altered calcium metabolism are contribute to formation of renal calculi. In addition, increased calcium concentration in blood and urine promote precipitation of calcium and formation of stone. That will include hyperparathyroidism, renal tubular acidosis, cancer, dehydration, granulomatous disease (sarcoidosis, TB), excessive intake of vitamin D, milk and alkali, myeloproliferative disease (polycythemia) (Hinkle & Cheever, 2018, P1632).

The clinical manifestation of renal calculi includes mild to severe abdominal or flank pain, hematuria, and renal colic due to blockage of renal blood flow. Patient presented with 9/10 abdominal pain, nausea, and vomiting, along with dysuria. She diagnosed with cystoscopy along with Colovesical Fistula in Oct. 8th.

**Reference:**

Colovesical Fistula: Symptoms, Surgery, and Recovery. (n.d.). Retrieved October 26, 2019, from https://www.healthline.com/health/colovesical-fistula.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

Lewis, S. M. (2011). *Medical-surgical nursing: assessment and management of clinical problems*. St. Louis, MO: Elsevier/Mosby.

**Laboratory Data (15 points)**

**CBC: Highlight all abnormal labs, explanation must contain in-text citation in APA format.**

| Lab Test | Nomal Range | Adm Value1 0/8 | Today Value 10/23 | Reason for Abnormality |
|---|---|---|---|---|
| **RBC** | 3.8-5.41 | 3.95 | 2.48 | Decreased RBC, Hgb, and Hct indicate anemia due to excessive blood loss throughout surgery, and bleeding disorder from chronic coumadin use for chronic A fib (Corbett, 2008). |
| **Hgb** | 11.3-15.2 | 12.9 | 8.5 | |
| **Hct** | 33.2-45.3% | 38.7 | 24 | |
| **Pletlet** | 149-493K | 155 | 167 | |
| **WBC** | 4-11.7K | 11.5 | 10.2 | |
| **Neutrophil** | 45.3-79% | | | |
| **Lymphocyte** | 11.8-45.9 | | | |
| **Monocyte** | 4.4-12 | | | |
| **Eosinophil** | 0-6.3 | | | |
| **Bands** | | | | |
| **Chemistry: Highlight the Abnormal** | | | | |

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|---|---|---|---|---|
| **Na** | 135-145 | 140 | 140 | |
| **K** | 3.5-5 | 4.8 | 3.3 | Decreased K level due to use of Lasix, a K wasting diuretic use (Corbett, 2008). |
| **Cl** | 98-107 | 102 | 99 | |
| **CO2** | 22-26 | 32 | 35 | Blood CO2 level is to determine blood pH, Increased CO2 level indicates the low pH in blood, Acidosis (Corbett, 2008). |
| **Glucose** | 70-99 | 180 | 283 | Elevated glucose level can be seen in Pt with liver disease, but in this case indicates Pt has type II Diabetes Mellitus. However, it also can be seen with Pt after meal unless it was taken for fasting (Corbett, 2008). |
| **BUN** | 6-20 | 30 | 45 | BUN measures kidney function, increased BUN indicates dehydration, poor renal perfusion and kidney dysfunction. Pt diagnosed with AKI due to kidney stones (Corbett, 2008). |
| **Creatine** | 0.5-0.9 | 1.22 | 1.35 | Creatine is kidney muscle waste, it measures kidney function, increased Creatine indicates destruction of nephrons, thus, indicates kidney dysfunction. Pt diagnosed with AKI due to kidney stones (Corbett, 2008). |
| **Albumin** | 3.5-5.2 | 3.3 | 2.2 | Decreased albumin level indicates malnutrition, malabsorption, and muscle wasting (Corbett, 2008). |
| **Ca** | 8.6-10.4 | 6.1 | 8 | Decreased Ca level indicates hypocalcemia, due to Lasix, electrolyte wasting diuretic use (Corbett, 2008). |
| **Mg** | 1.6-2.4 | | | |
| **Phosphate** | | 62 | 58 | |
| **Bilirubin** | 0-1.2 | 0.6 | | |
| **Alk Phos** | 35-105 | 74 | | |
| **TSH** | 0.4-4.5 | | | |
| **AST** | 0-32 | 21 | 34 | AST, ALT are both liver enzymes and measure liver function. Elevated AST and ALT indicate lever damage (Corbett, 2008). |
| **ALT** | 0-33 | 38 | 31 | |
| **Amylase** | | | | |
| **Lipase** | | | | |
| **Lactic Acid** | | | | |
| **Cholesterol** | 200> | | | |
| **HDL** | 45< | | | |
| **LDL** | 130> | | | |
| **Triglycerol** | 35-160 | | | |
| **Lactic Acid** | 0.5-2.4 | | | |
| **Other Test: Highlight Abnormals** | | | | |
| **INR** | 1 | 2.94 | 1.84 | Elevated PT and INR indicate increase risk for bleeding due to chronic Coumadin use for Ch A fib (Corbett, 2008). |
| **PT** | 9.5-11.8 | 30.5 | 21.3 | |
| **PTT** | 25-40 | 35.8 | | |
| **D-Dimer** | 250> | | | |
| **BNP** | 500> | | | |
| **A1C** | 5.7> | | | |
| **Urinalysis:** | | | | |

| | | | | |
|---|---|---|---|---|
| **C & C** | Clear/Yellow | Amber Cloudy | | |
| **pH** | 4.5-8 | 7.0 | | |
| **S. Gravity** | 1.005-1.035 | 1.020 | | |
| **Glucose** | 0 | Norma | | |
| **Protein** | 0 | 1+ | | |
| **Ketones** | 0 | Neg | | |
| **WBC** | 5> | Neg | | |
| **RBC** | 0-3 | 3+ | | |
| **Leukoesterase** | Negative | | | |
| **Arterial Blood Gas:** | | | | |
| **pH** | 7.35-7.45 | | | |
| **PaO2** | 80-100 | | | |
| **PaCO2** | 35-45 | | | |
| **HCO3** | 22-26 | | | |
| **SaO2** | 95%< | | | |
| **Culture:** | | | | |
| **Urine** | Negative | | | |
| **Blood** | Negative | Neg | | |
| **Sputum** | Negative | | | |
| **Stool** | Negative | | | |
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| | | | | |

**Lab Correlations Reference (APA):**

Corbett, J. V. (2008). *Laboratory tests and diagnostic procedures: with nursing diagnoses*. Harlow: Prentice Hall.

**Other Diagnostic Tests (EKG, Echocardiogram, Xrays, CT scan, etc) (5 points)**

- **ECG**

  The electrocardiography is a graphic image of electrical currents of the heart. The 12-lead ECG is used to diagnose dysrhythmia, conduction abnormalities, and chamber enlargement, as well as myocardial ischemia, injury, or infarction (Hinkle & Cheever, 2018). Patient's ECG indicates normal sinus rhythm.

- **Abdominal X-Ray**

Abdominal X-Ray is obtained to determine the size, contour, and position of the digestive organs. It visualize abnormalities organs such as liver, stomach, small or large intestines, as well as kidney (Hinkle & Cheever, 2018). The patient's abdominal X-Ray indicates bilateral renal calculi and abscess.

- **Cystoscopy**

  Cystoscopy is an endoscopy to visualize interior of the bladder with a tubular lighted scope, it can be used to remove calculi obtain biopsy, and treat bleeding lesion (Hinkle & Cheever, 2018). The patient's result indicates bilateral renal calculi and abscess.

**Diagnostic Test Correation, APA format Reference (5 points):**

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

**Current Medication (10 points, 1 per completed med)**

| **Home Medication** | | | | | |
|---|---|---|---|---|---|
| **Brand/Generic** | ASA<br>-Aspirin | atorvastatin<br>-Lipitor | metformin<br>-Glucophage | docusate sodium<br>-Colace | lisinopril<br>-Zestril |
| **Dose** | 81mg | 10mg | 1000mg | 100mg | 2.5mg |
| **Route** | PO | PO | PO | PO | PO |
| **Classification** | Non-opioid Analgesic | Antilipidemic | Antidiabetic | Stool softener | Antihypertensive<br>ACE Inhibitor |
| **Action** | Block prostaglandin synthesis | Inhibits HMG-CoA Reductase production | Increase storage of glucose in liver and reduce glucose production | Decreasinng surface tention between oil and water in feces. | Block RAAS |
| **Reason** | Low dose used for blood thinner. Prevention of blood clots. | Pt has hyperlipidemia, to reduce cholesterol level. | Manage and control blood glucose level for diabetic Pt | To prevent constipation that may cause excessive cardiac work load | Lower blood pressure |

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|---|---|---|---|---|---|
| **Contra-indication** | Pregnancy<br>No children use<br>Hemophilia<br>Bleeding d/o | Liver d/o<br>Antibiotics use<br>Pregnancy/ Lactation<br>Grapefruits | Hypersensitivity<br>RF | Pregnancy<br>Hypersensitivity | No w/ NSAID<br>Lithium |
| **S/E, A/R** | GI bleeding<br>Ulceration | Hepatotoxic<br>Myopathy | Hypoglycemia<br>Abd distention<br>N/V/D | Syncope<br>Palpitation<br>Abd cramp distention | Hpotension<br>Dry cough<br>Angioedema<br>Hyperkalemia |
| **Nursing Intervention** | Monitor s/s of bleeding tendency | Monitor:<br>AST / ALT<br>CK level | Monitor: s/s of Renal function<br>CBC, CMP<br>Take w/ food | Monitor: abuse F/E imbalance | Monitor: s/s of VS, BMP, CBC, I&O, ECG, Facial edema |
| **Patient Teaching** | Not w/ alcohol<br>Take w/ food<br>(Nurse's, P1287) | Take w/ meal @ night time<br>(Nurse's, P629) | Follow schedule<br>Scheduled Acu check<br>Limit carbohydrate intake<br>(Nurse's, P793) | Increasing fiber fluid intake, encourage exercise<br>(Nurse's, P442) | d/c NSAID<br>Avoid K rich foods<br>d/c/slowly<br>(Nurse's, P170) |
| **Hospital Medications** | | | | | |
| **Brand/Generic** | Digoxin -Diltiazem | Gabapentin - Neurontin | KCl | Furosemide - Lasix | Insulin aspart - Novolog |
| **Dose** | 240mg BID | 300mg BID | 40 mEp BID | 40mg/4ml | Low Dose |
| **Route** | PO | PO | PO | IV push | SubQ |
| **Classification** | Digitalis Glycoside Antiarrhythmi | Analgesic adjunct, Anticonvulsant | Electrolyte supplement | Diuretics | Antidiabetic |
| **Action** | Increase force of myocardial contraction. Increase cardiac output and slow HR. | Unknown, may affect transport of amino acid across neuronal membranes. | Maintain acid base balance, isotonicity, and electrophysiologic balance. Maintain normal muscle function. | Inhibits reabsorption Na and water from loop of henle | Stimulate glucose uptake in muscle, fat, inhibit glucose production |
| **Reason** | Pt take this for ch. A fib. | Pt chronic back and neck pain due to Myasthenia gravis. | Treatment for hypokalemia, Pt's level 3.3 | Management of rid of excess fluid in lungs | Manage and control blood glucose level for diabetic Pt |
| **Contra-indication** | Bradycardia, Hypersensitivity, uncontrolled V arrythmia, AV block. | Hypersensitivity, renal impairment, geriatrics. | Hyperkalemia, severe renal impairment, alcohol, hypersensitivity | Hypersensitivity of thiazide or sulfonamide | Hypersensitivity<br>Hypoglycemia |
| **S/E, A/R** | Bradycardia, arrythmia, anorexia, N/V | Confusion, depression, drowsiness | Dysrhythmia<br>Confusion<br>Palpitation, N/V/D | Dehydration, aplastic anemia, agrauerocytosis | Hypoglycemia<br>N/V/D, Anaphylaxis |
| **Nursing Intervention** | Monitor: S/S of toxicity, monitor | Monitor: seizure activity, seizure precaution, pain | Monitor: K level, cardiac status, ECG, | Monitor: K, Na, Cl, Mg, daily weight, | Monitor: s/s of hypoglycemia |

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|---|---|---|---|---|---|
| | digoxin level: 0.5-2, Apical pulse for full min, monitor ECG, take as schedule, no double dose. | level, VS, BUN, Creatine, U output, | VS, S/S of toxicity and overdose: bradycardia, fatigue, muscle weakness, dyspnea, confusion. | Creatine, skin turgor, BP, hypotension | CBC, take before food |
| **Patient Teaching** | Instruct Pt to report: N/V, decrease LOC. (Nurse's, P415) | Take as directed, do not take with antacid, avoid driving or activities, avoid alcohol and CNS depressant (Nurse's, P591) | Avoid salt, and its substitutes, Report: S/S hyperkalemia (Nurse's, P996) | Change position slowly, diet high in K, (Nurse's, P587) | Report: Shaky, dizziness, confusion, diaphoresis occurs (Nurse's, P671) |
| | | | | | |

**Lab Refenrence (APA Format):**

*2018 Nurses drug handbook*. (2018). Burlington, MA: Jones & Bartlett Learning.

## Assessment

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

| Time | Pulse | BP | RR | Temp | O2 |
|---|---|---|---|---|---|
| 0300 | 60 | 132/54 | 16 | 36.7 C | 97% |
| 0800 | 62 | 131/68 | 18 | 37.5 C | 100% |

**Physical Assessment (18 Points)**

| | |
|---|---|
| **GENERAL(1 points):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | Patient is present lying on the bed. She is A&O x4, cooperative but with distress. Pt appear to be fatigued and hardly stay awake. |
| **INTEGUMENTARY (2 points):**<br>**Skin color:**<br>**character, turgor, rashes, bruises:**<br>**wounds:**<br>**Braden scale :**<br>**Drains present: Y N**<br>**Type** | Pt is Caucasian female and present with fair skin tone. Skin has normal elasticity and texture, warm to touch. No rashes, lesions, or scars present. Pt has normal skin turgor, no s/s of dehydration. Pt has bruises on left and right arms due to unsuccessful IV insertion. No S/S of infection. PICC line @ right upper arm, medium amount of bleeding noted, dressing reapplied @ 0900. |
| **HEENT (2 points):**<br>**Head/Neck:** | Head is midline with no deviation. Hair is short, grey in color. Ears shows no drainage. |

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|---|---|
| **Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth** | PERRLA is noted, Pt use glasses regularly. Nose shows no deviated septum, turbinate equal bilaterally. Pt wears nasal canula with 2L of O2, no S/S of skin break down. Oral mucosa is pale and dry with no other abnormalities. Pt wears full denture. |
| **CARDIOVASCULAR (2 points): Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable)**<br>**Peripheral Pulses: Radial, pedal**<br>**Capillary refill:** 3><br>**Neck Vein Distention: Y N**<br>**Edema: Y N**<br>**Location of Edema:** +2 pitting edema in both lower extremities. | Pt monitored by ECG, Pt was noted to be normal sinus rhythm. Heart sound auscultated x5, no abnormality noted. Pt denies chest pain. Pedal pulse was equal bilaterally, +2of pitting edema noted. Pt states she had the edema for years, not a new finding for her. Negative for neck vein distension. |
| **RESPIRATORY (2 points):**<br>**Accessory muscle use: Y N**<br>**Breath Sounds: Location, character** | No accessory muscles use when breathing. Trachea in midline, no deviation. Pt denies SOB and denies sputum production. Lung sound auscultated, clear throughout bilaterally, no crackle, rhonchi, wheezes noted. Pt breathing with nasal canula, 2L of O2. |
| **GASTROINTESTINAL (2 points):**<br>**Diet at home:** Regular diet<br>**Current Diet:** Soft<br>**Height:** 165.1 cm<br>**Weight:** 93.2 kg<br>**Auscultation Bowel sounds:** x4 quadrants<br>**Last BM:**<br>**Palpation:**<br>**Inspection:**<br>**Ostomy: Y N**<br>**Nasogastric: Y N**<br>**Feeding tubes/PEG tube Y N**<br>**Type:** | Pt eat regular diet at home, although Pt is obese as evidenced by her BMI 34.<br>Pt's abdominal inspection is completed. BS auscultated x 4 quadrants, soft to touch. The surgical site @ center of Abd, covered with PICO dressing, JP drainage of 24ml @ 0830. Pt has new ostomy @ LLQ, stoma appear to be beefy red and no S/S of infection. Skin is intact and warm to touch, with no lesion or rash, No mass or tenderness, distension upon palpation. |
| **GENITOURINARY (2 Points):**<br>**Color, character, quantity of urine, pain,**<br>**Dialysis Y N**<br>**Inspection of genitals**<br>**Catheter: Y N**<br>**Type: Foley** | Pt is unable to ambulate to the bathroom by herself. No dialysis but currently has Foley catheter. Urine appears yellow and cloudy. There are stage two pressure ulcer developed @ perineal area where catheter came out, no abnormal odor noted. |
| **MUSCULOSKELETAL (2 points):**<br>**Neurovascular status:**<br>**ROM:**<br>**Supportive devices/strength:** | Pt's currently unable to mobilize herself, she has difficulty to turn herself. |

| | |
|---|---|
| **ADL Assistance: Y N**<br>**Fall Risk: Y N**<br>**Fall score: 22**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib)**<br>**Needs assistance with equipment Y N**<br>**Needs support to stand and walk** | |
| **NEUROLOGICAL (2 points):**<br>**MAEW: Y N**<br>**PERLA: Y N**<br>**Strength Equal: Y N**<br>**if no - Legs Arms Both**<br>**Orientation, Mental Status, Speech, Sensory,**<br>**LOC:** | Pt can only lying on the bed. She is A&O x4, cooperative but with s/s of distress. Pt appears very fatigued and slow to response. Pt's strength are very weak in all extremities. |
| **PSYCHOSOCIAL/CULTURAL (2 points):**<br>**Coping methods,**<br>**Educational level**<br>**Developmental level,**<br>**Ethnicity,**<br>**Religion & what it means to pt.**<br>**Occupation (previous if retired)**<br>**Personal/Family Data (Think about home environment, family structure, and available family support)** | Pt is 73 years old Caucasian female, married and retired, living in Mattoon with her husband. They are both Mormons, and go to church as much as they can. Her husband is the one being taking care of her for more than a decade. He refused to send her to the nursing home. They have a daughter who come visits a lot. |

**Pain Assessment, 2 sets (2 Points)**

| Time | Scale | Location | Severity | Characteristic | Intervention |
|---|---|---|---|---|---|
| 0800 | 0/10 | | | | |
| 1030 | 0/10 | | | | |

**IV Assessment**

| Site location, Patency / Condition & Date | Fluid Type / Rate or Saline Lock |
|---|---|
| Right Upper PICC Line<br>Date established: 10/22/2019<br>IV site is stable, however, bleeding noted upon assessment. The site was re-dressed @ | TPN 10ml/hr |

| | |
|---|---|
| 0800, 10/24/2019. No s/s of infiltration, phlebitis, or other complications.<br>Pt denies pain or numbness, tingling. No evidence of erythema or swelling noted. | |

**Input & Output**

| Input | Output |
|---|---|
| 2207 ml | 2260 ml |

## Nursing Care

**Summary of care (2 points):**

**Overview of care:**

Pt appears to be depressed and fatigued. Pt would refuse to voice out if she didn't have to. Pt currently still in monitor and observe for the response of the open abdominal surgery. There are many lab values are still out of wrack and need to be corrected. Pt still in the process of adaptation.

**Procedure / testing done:**

Open abdominal surgery was done to remove abscess and renal calculus, as well as repaired colovecical fistula, the incision site covered with PICO dressing, JP drain attached. Colonostomy was done, a sigmoid colon resected; an ostomy stoma established in LLQ.

**Complain / issues:** Pt does not states any complains

**Vital signs (stable/ unstable):** Pt's VS was stable upon assessment

**Tolerating diet, activities, etc.:** Pt tolerate small amount of soft diet, and have TPN to supplement nutrition need.

**Physician notification:** N/A

**Future plans for patient:** Pt needs to

**Discharge Planning (2 points)**

**Discharge location:** Pt currently not in the condition to discharge any time soon

**Home health needs (if applicable):** N/A

**Equipment needs (if applicable):** O2 tank,

**Follow up plan:** Pt needs to contact his primary doctor for further evaluation.

**Education needs:**

Upon discharge, patient will be going back to her home with her husband. Patient would benefit from a diet high in protein and fiber, low in carbohydrate, sodium, and fat. Patient need to be educated in ostomy care, such as how to clean the stoma site and how to re-apply ostomy bag, the bag should be emptied when 1/3 full to avoid pulling away from the stoma and cause skin tear, and note and report S/S of infection (redness, swelling, pain, warmth). Pt should be measuring blood pressure and blood glucose level every day, so she would able to self-aware and monitoring of her health condition. She needs to follow the schedule medication every day and stick with it. Patient would follow the scheduled check-up for long-term management of her medical condition. Her home environment needs to be assessed as well to minimized the risk of fall.

***The following must be listed in order for priority and must be NANDA approved Diagnosis (18 Points total, 3 Points for each complete diagnosis with 2 interventions & rationales, 3 Points for correct priortization.)**

| Nursing Diagnosis | Rationale | Intervention (2 per dx) | Evaluation |
|---|---|---|---|
| 1. Impaired skin integrity RT immobility AEB Pt developed stage II pressure ulcer | This is related to Pt's immobility, and Pt has diabetes mellitus, put her increased risk for infection and | 1. Monitor Pt's fluid and nutrition balance, and maintain skin integrity to promote wound healing. | Pt shows no S/S of new redness or blister by end of shift. |

| | | | |
|---|---|---|---|
| in lower back and perineal area.<br><br>(Lewis, 2011) | difficulty of wound healing. | 2. Turn the Pt every two hours to prevent new pressure ulcer to develop. | |
| 2. Risk for bleeding RT Pt's chronic Warfarin use.<br><br>(Lewis, 2011) | This is related to Pt's diagnosis of chronic A fib, Pt uses warfarin for many years. Her PTT & INR were elevated, that put her increased risk for bleeding. | 1. Monitor for the therapeutic range for PTT & INR.<br><br>2. Avoid needle stick as much as possible. | Pt had excess bleeding @ PICC line insertion site upon morning assessment. The dressing was reapplied @ 0900. |
| 3. Risk for infection RT chronic use of Corticosteroid due to Myasthenia gravis.<br><br>(Lewis, 2011) | Pt is using prednisone to manage Myasthenia gravis for many years. | 1. Monitor VS especially for temperature, which the first sign of infection.<br><br>2. Teaching the Pt note and report the S/S of infection, such as local redness, swelling, pain, and warmth. | Pt did not present S/S of infection during the shift. |
| 3. Depression RT multiple diagnosis AEB Pt present with manifestation of depression such as lack of motivation and slow response.<br><br>(Lewis, 2011) | Pt was diagnosed with chronic depression related to Myasthenia gravis. | 1. Administration of analgesic Neurontin to eliminate pain related to post-op and chronic low back pain.<br><br>2. Encourage use of relaxation techniques | Pt present S/S of depression throughout shift. |
| 3. Activity intolerance RT post-op weakness AEB Pt present with lack of | This is related to Pt's diagnosis of Myasthenia gravis, put her increased risk for activity intolerance. | 1. Administration of passive ROM.<br><br>2. Monitor Pt's O2 response to nursing activity to determine level of | Pt did not perform any activity throughout shift. |

| | | | |
|---|---|---|---|
| motivation, and slow to response.<br><br>(Lewis, 2011) | | activity can be performed. | |

**Reference:**

Lewis, S. M. (2011). *Medical-surgical nursing. assessment and management of clinical problems*. St. Louis, MO: Elsevier/Mosby.