N431 Care Plan 2

Lakeview College of Nursing

Name: Bryton Bui

Demographics (3 points)

Date of Admission 10/19/19	Patient Initials JW	Age 63	Gender Male
Race/Ethnicity Caucasian	Occupation server	Marital Status single	Allergies Erythromycin
Code Status Full	Height 5'11	Weight 118.7kg	

Medical History (5 Points)

Past Medical History: asthma, hypertension

Past Surgical History: hernia repair

Family History: Cancer, heart disease

Social History (tobacco/alcohol/drugs): social drinker and smoker

Assistive Devices: none

Living Situation: lives alone

Education Level: high school diploma

Admission Assessment

Chief Complaint (2 points): severe umbilical pain

History of present Illness (10 points): The patient is a 63-year-old male with a past medical history of an incarcerated umbilical hernia. He was seen in the OSF ER on 2017 with complaints of recurrent umbilical pain. After reduction of an umbilical hernia and provision of a large abdominal binder through the ER on 2017 with plans for elective repair after he had time to get his affairs in order. He was wearing his binder and on October 18, 2019 attended a concert at Krannert where he did some singing. Prior to that he ate chili around 1500 and had a bowel movement around 1600. He started having gas like pains around 2230 and ultimately had severe recurrent abdominal pain in the

umbilical area with protrusion of the umbilical skin again. He returned the ER at 0200 and the ED physician indicated that he had an incarcerated umbilical hernia again and could not reduce it. Pain was managed with a topical ice pack and IV pain medication and an Elastoplast role was placed in the umbilical depression and over this the binder was placed.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Incarcerated umbilical hernia

Secondary Diagnosis (if applicable): none

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

An umbilical hernia is when part of the small intestine breaks through the abdominal cavity near the umbilicus. Risk factors of umbilical hernia are: obesity, increased abdominal wall distention like in pregnancy, stretching of the abdominal wall fibers, liver cirrhosis, ascites, or peritoneal dialysis (Coste, 2019). The umbilical hernia may contain preperitoneal fat tissue, omentum, and part of the small intestine. The hernia can become incarcerated or strangulated which is when its neck narrows and blood flow to the hernia lessons. If this happens surgery is needed to repair it.

Typical signs and symptoms of an umbilical hernia are a bulge or a protrusion near the umbilicus, abdominal pain, GI discomfort, tenderness around the umbilicus, gas-like pain, and some skin color changes. Umbilical hernias are diagnosed through physical exams, abdominal ultrasound, CT, and in some cases X-ray. Umbilical hernias can be managed with a reduction and abdominal binder and if they are not able to be managed they should be surgically repaired.

In my patient's case, his obesity was most likely the primary risk factor to him developing an umbilical hernia. When the umbilical hernia first appeared in 2017 the ED physician confirmed it with a CT, was able to reduce it, and manage it with an abdominal binder. However, when it reappeared he had sudden abdominal pain, gas-like pain, and he noticed the return of the bulge near his umbilicus. This time surgery was required to fix the hernia, which my patient received and from what I saw two days post-op, the hernia showed no signs of reappearing. The patient was instructed to keep wearing his abdominal binder just in case to lower the chances of the hernia reappearing and to help with healing.

Pathophysiology References (2) (APA):

Coste, H. Anouchka (2019). *Umbilical Hernia*. StatsPearls retrieved October 26, 2019 from
https://www.ncbi.nlm.nih.gov/books/NBK459312/

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health 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	4.2-6.0	3.61	3.54	Incarcerated hernia's can decrease blood flow to that section and since it is an open wound in the body there could be some bleeding (Hinkle, 2018).
Hgb	12-18	11.4	11.0	Incarcerated hernia's can decrease blood flow to that section and since it is an open wound in the body

				there could be some bleeding (Hinkle, 2018).
Hct	**37-52**	**32.4**	**32.1**	**Incarcerated hernia's can decrease blood flow to that section and since it is an open wound in the body there could be some bleeding (Hinkle, 2018).**
Platelets	**140-440**	**254**	**249**	
WBC	**5.0-10.0**	**10.0**	**6.9**	
Neutrophils	**55.0-75.0%**	**65.9%**	**56.1%**	
Lymphocytes	**26.0-46.0%**	**26.4%**	**45.4%**	
Monocytes	**2.0-12.0%**	**6.9%**	**7.3%**	
Eosinophils	**0.0-6.0%**	**1.8%**	**4.7%**	
Bands	**0.0-0.1%**	**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**	**137**	**139**	
K+	**3.5-5.0**	**4.0**	**4.9**	
Cl-	**98-106**	**104**	**105**	
CO2	**21-31**	**23**	**29**	
Glucose	**70-100**	**108**	**109**	
BUN	**7-20**	**21**	**14**	
Creatinine	**0.6-1.2**	**1.09**	**1.08**	
Albumin	**3.4-5.0**	**4.2**	**3.6**	

Calcium	**8.5-10.5**	**9.5**	**9.3**	
Mag	**1.5-2.5**	**n/a**	**n/a**	
Phosphate	**2.5-4.5**	**n/a**	**n/a**	
Bilirubin	**0.2-0.8**	**0.3**	**0.3**	
Alk Phos	**44-147**	**65**	**57**	
AST	**10-40**	**16**	**15**	
ALT	**7-56**	**19**	**16**	
Amylase	**23-85**	**n/a**	**n/a**	
Lipase	**0-160**	**n/a**	**n/a**	
Lactic Acid	**0.5-1**	**n/a**	**n/a**	
Troponin	**0.0-0.04**	**n/a**	**n/a**	
CK-MB	**5-25**	**n/a**	**n/a**	
Total CK	**22-198**	**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**	**n/a**	**n/a**	
PT	**11-13.5**	**n/a**	**n/a**	
PTT	**30-40**	**n/a**	**n/a**	
D-Dimer	**< 500**	**n/a**	**n/a**	
BNP	**<125**	**n/a**	**n/a**	

HDL	**40-59**	**n/a**	**n/a**	
LDL	**100-129**	**n/a**	**n/a**	
Cholesterol	**<100**	**n/a**	**n/a**	
Triglycerides	**<150**	**n/a**	**n/a**	
Hgb A1c	**4-6.4%**	**n/a**	**n/a**	
TSH	**0.4-4.0**	**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	**Yellow, clear**	**n/a**	**n/a**	
pH	**5.0-9.0**	**n/a**	**n/a**	
Specific Gravity	**1.003-1.030**	**n/a**	**n/a**	
Glucose	**Negative**	**n/a**	**n/a**	
Protein	**Negative**	**n/a**	**n/a**	
Ketones	**Negative**	**n/a**	**n/a**	
WBC	**Negative**	**n/a**	**n/a**	
RBC	**0-2**	**n/a**	**n/a**	
Leukoesterase	**Negative**	**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	**7.35-7.45**	**n/a**	**n/a**	

PaO2	**70-100**	**n/a**	**n/a**	
PaCO2	**35-45**	**n/a**	**n/a**	
HCO3	**22-26**	**n/a**	**n/a**	
SaO2	**93-97**	**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	**Negative**	**n/a**	**n/a**	
Blood Culture	**negative**	**n/a**	**n/a**	
Sputum Culture	**negative**	**n/a**	**n/a**	
Stool Culture	**negative**	**n/a**	**n/a**	

Lab Correlations Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray, 12 Lead EKG

Diagnostic Test Correlation (5 points): Pre-operation precautions to make sure heart function is good and an X-ray to assess lung structure and rule out pneumonia.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins

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

Brand/Generic	Zesteril/ Lisinopril	Melatonin	Qvar/ Beclomethasone	Ventolin/ Albuterol	Micr HCT
Dose	20 mg	5 mg	2 puffs	2 puffs	25 m
Frequency	BID	Daily	BID	PRN	BID
Route	oral	oral	Inhalation	Inhalation	Oral
Classification	Ace Inhibitor	Pineal hormone	corticosteroid	Bronchodilator	diure
Mechanism of Action	Inhibits the angiotensin-converting enzyme in the body	Inhibits cAMP signal transduction pathway	Inhibits inflammatory response	Relaxes smooth muscles of airways	Bloc reabs sodiu chlor
Reason Client Taking	History of hypertension	Sleep aid	Asthma	asthma	hype
Contraindications (2)	History of angioedema, hypersensitivity	Concurrent immunosuppressive treatment, impaired liver function	Status asthmaticus, Hypersensitivity	Hypersensitivity and hypersensitivity to milk proteins	Anur sulfo aller
Side Effects/Adverse Reactions (2)	Headache, cough	Abdominal pain, dizziness	Headache, back pain	Tremors, tachycardia	Weal hypo
Nursing Considerations (2)	Monitor BP, assess LOC	Monitor LOC, put patient on telemetry	Monitor respirations and heart rate	Monitor respirations and heart rate	Moni fall r
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Potassium levels and kidney function	Assess for benzodiazepine use	Assess glucose and bone density labs	Assess lung sounds and O2 sat	Obta level
Client Teaching needs (2)	Avoid alcohol and measure BP before taking	Avoid alcohol, do not take in the morning	Avoid caffeine and increase calcium	Avoid caffeine and take first before anything else	Do n bed t chan slowl

Home Medications (5 required)

Hospital Medications (5 required)

Brand/Generic	**Cefotetan/ Cefotan**	**Decadron/ dexamethasone**	**Dilaudid/ hydromorphone**	**Ambien/ Zolpidem**	**Asmanex/ Mometasone**
Dose	**2 g**	**4 mg**	**0.5 mg**	**5 mg**	**200 mcg (2 puffs)**
Frequency	**Q 12, BID**	**PRN**	**Q2**	**Once**	**BID**
Route	**IV**	**IV**	**IV**	**Oral**	**Inhalation**
Classification	**antibiotic**	**Anti-nausea Corticosteroid**	**Opioid, analgesic**	**Nonbarbiturate hypnotic**	**Corticosteroid**
Mechanism of Action	**Inhibits bacterial cell wall synthesis**	**Inhibits inflammatory process**	**Suppresses CNS**	**Inhibits neuronal excitations**	**Inhibits inflammatory effect**
Reason Client Taking	**Post-op infection precaution**	**For nausea**	**Pain management**	**Sleep aid**	**History of respiratory problems**
Contraindications (2)	**Colitis, hemolytic anemia**	**Fungal infection Ocular infection**	**GI obstruction Respiratory depression**	**Hepatic failure Medicine induced insomnia**	**Hypersensitivity to milk proteins, status asthmaticus**
Side Effects/Adverse Reactions (2)	**Diarrhea, rash**	**Fluid retention Rash**	**Skin flushing Hypotension**	**Nausea Dizziness**	**Cough Headache**
Nursing Considerations (2)	**Monitor vitals and temperature**	**Assess vision Monitor vitals**	**Monitor RR Assess for opioid addiction**	**Monitor mental status and RR**	**Monitor O2 and RR**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Obtain WBC**	**WBC and electrolytes**	**RR and mental status**	**Liver labs**	**Assess lung sounds**
Client Teaching needs (2)	**Finish prescription, do not stop abruptly**	**Monitor changes in vision Increase activity**	**Avoid alcohol and avoid benzodiazapines**	**Avoid alcohol, do not take with other sleep aids**	**Take in the morning and afternoon, avoid caffiene**

Medications Reference (APA): Lawler, Kristent. (2016).RN Pharmacologoy for Nursing (7 th Edition). Assessment Technologies Institute.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient was A&O x 4, with no signs of distress and a well kept appearance**
INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry** **Temperature: warm** **Turgor: good** **Rashes: none** **Bruises: none** **Wounds: none** **Braden Score: 18** **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): **Head/Neck: symmetrical, no neck distention** **Ears: no drainage, with equal hearing** **Eyes: PERRLA, no redness or swelling noted** **Nose: no drainage and moist** **Teeth: clear, no bleeding from the gums**	.
CARDIOVASCULAR (2 points): **Heart sounds: S1 and S2 normal rate** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): normal**	.

Peripheral Pulses: 3 +, in all limbs **Capillary refill: < 3** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Present, clear, and in all lobes bilaterally**
GASTROINTESTINAL (2 points): **Diet at home: normal** **Current Diet: normla** **Height: 5'11** **Weight: 118.7 kg** **Auscultation Bowel sounds: present in all quadrants** **Last BM: prior to surgery** **Palpation: Pain, Mass etc.: no pain with palpation and no masses noted** **Inspection:** **Distention: none** **Incisions: from surgery, no signs of dehiscence** **Scars: none** **Drains: none** **Wounds: none** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	.
GENITOURINARY (2 Points): **Color: yellow** **Character: clear** **Quantity of urine: 200 ml** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: not able to assess, patient uncomfortable** **Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL (2 points): **Neurovascular status: sensation present**	.

in all extremities **ROM: full ROMs** **Supportive devices: none** **Strength: equal in all limbs** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:0** **Activity/Mobility Status:** **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: to time, space, and self** **Mental Status: normal** **Speech: clear** **Sensory: no deficits** **LOC: normal**	.
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):**	**The patient is Methodist and is active in his church and community. He is very independent and helps out in the community and goes on mission trips. He has five adopted sons who are all coming back to help him recover. He understands the need for rest and will do so until he is fully healed and can return to his normal life.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0735	68	129/65	18	97.4	98
.1125	74	116/62	16	97.9	99

Vital Sign Trends: stable

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0715	**1-10**	**umbilicus**	**5**	**constant**	**Dilaudid**
1113	**1-10**	**umbilicus**	**4**	**constant**	**dilaudid**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV: left hand** **Date on IV: 10/19/19** **Patency of IV: patent** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: intact**	50 ml potassium chloride

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1181	**1225**

Nursing Care

Summary of Care (2 points)

Overview of care: post-op care, prepare for discharge

Procedures/testing done: hernia repair, CBC, CMP, EKG, Chest X-ray

Complaints/Issues: umbilical pain and wanting to go home

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: tolerating normal diet and was able to walk with steady gait, required little assistance

Physician notifications: one

Discharge Planning (2 points)

Discharge location: home

Home health needs (if applicable): none

Equipment needs (if applicable): none

Follow up plan: See PCP for wound care

Education needs: wound care and how to monitor for dehiscence and proper healing

Future plans for patient: discharge home

Nursing Diagnosis (15 points)

	The patient is at risk for falls because he normally very independent and used to taking care of others rather than being taken care of	**1. remind patient he can still be independent but within their limitations** **2. provide positive reinforcement when the patient meets or advances toward goals**	**The patient understood the need to rest. He stated one of his sons was coming back to help take care of him.** **He promised to rest according to the plan and would resume activity slowly and carefully.**

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• 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 injury as evidenced by umbilical hernia**	**The patient reported a sudden intense pain at is umbilicus which could only be managed by IV medication**	**1. assess patient's pain with appropriate scale** **2. administer NSAIDs and monitor effectiveness**	**The patient was able to describe is pain based off the numerical scale and when he was given the medication his pain was brought down to a more acceptable level.**
2. **Infection related to incision as evidenced by hernia repair surgery**	**Like any post op patient he is at risk for infection because he has a new wound on his stomach and his older age slows his healing process**	**1. monitor WBC levels** **2. monitor vitals and temperature for sepsis**	**Educated the patient on signs and symptoms of infection and how to monitor the wound for infection. The patient received the education well and understood it, the patient's WBC count was WDL**
3. **impaired tissue integrity related to incision as evidenced by hernia repair surgery**	**The patient had just had surgery and due to his older age and higher BMI he is at risk for lower tissue perfusion to the incision**	**1. monitor wound for absence of healing ridge, drainage, or extra inflammation** **2.encourage movement to promote circulation of blood to help with the healing process**	**The patient understood the education on how to monitor the wound for dehiscence and had already begun to move on his own. The wound appeared to be healing properly upon inspection**
4. **risk for bleeding related to surgery as evidenced by low RBC count**	**The patient is at risk for bleeding because he just had an invasive surgery and his body is still in the process of healing**	**1.Monitor BP especially for decrease in systolic** **2.Monitor LOC and assess for any changes such as confusion**	**Educated the patient on when to report feelings of lethargy, headache, lightheadedness. He received it well and remained vigilant during my time with him. He also said he would keep a log of his BPs at home**

1. **risk for ineffective role performance related order for bed rest as evidenced by patient being restless in hospital room**			

Must be NANDA approved nursing diagnosis and listed in order of priority

Other References (APA):

Swearingen, Pamela. (2016). *All-in-One Nursing Care Planning Resource*. Elsevier

Concept Map (20 Points):

N431 Care Plan

Subjective Data

The patient states the pain is 4-5/10 and is constant but is managed with dilaudid. His only other complaint is not being able to return to his normal life immediately

Nursing Diagnosis/Outcomes

Risk for acute pain > the patient has little to no pain and can manage it without medication
Risk for infection > the patient does not run a fever and his WBC levels stay in range
Risk for bleeding > the patient's vitals remain stable and is Hgb, Hct, and RBC levels are within range
Risk for impaired tissue integrity > the patient's wounds heal properly and do not show signs of infection
Risk for ineffective role performance > the patient understands this is temporary and they will be able to return to their normal life

Objective Data

The patient's wound was healing appropriately with no signs of dehiscence. His vitals were stable, the patient was able to stand and walk without assistance and reported no dizziness or weakness. Full ROMs and equal strength in all extremeties.risk

Patient Information

The patient is a 63 year old male who has a history of an umbilical hernia. It became incarcerated and when the patient came into the ER it was unable to be reduced with an abdominal binder. He had a hernia repair surgery and was fit for discharge when seen.

Nursing Interventions

Monitor vitals, analgesics for pain, fall risk, maintaining diet, therapeutic communication for concerns

N431 Care Plan

N431 Care Plan