N321 Care Plan #2

Lakeview College of Nursing

Lindsey Platt

Demographics (3 points)

Date of Admission 10/13/2019	Patient Initials JB	Age 71	Gender Female
Race/Ethnicity white	Occupation Retired	Marital Status Married	Allergies
Code Status DNR	Height 160 cm	Weight 81.9 kg	

Medical History (5 Points)

Past Medical History: HTN, GERD, morbid obesity, stage IV ovarian cancer, DM, SOB

Past Surgical History: hysterectomy and an esophagogastroduodenoscopy biopsy (08/19)

Family History: Mother has hypertension. Father has diabetes.

Social History (tobacco/alcohol/drugs): drinks 1 or 2 times a year

Assistive Devices: glasses, walker

Living Situation: lives at home with her spouse

Education Level: some college

Admission Assessment

Chief Complaint (2 points): Chest pain radiating down neck and left arm

History of present Illness (10 points): Patient is a 71 year old female who came to the emergency department yesterday with complaints of nausea, vomiting, abdominal cramping, and shortness of breath. She was diagnosed with colitis and a UTI. She has stage IV ovarian cancer and recently stopped her chemotherapy treatments.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Colitis, UTI

Secondary Diagnosis (if applicable): sepsis, hyponatremia, abdominal ascites, metabolic acidosis

Pathophysiology of the Disease, APA format (20 points): Colitis is an inflammatory bowel disease (IBD) that causes long-lasting inflammation and ulcers (sores) in your digestive tract. Ulcerative colitis affects the innermost lining of your large intestine (colon) and rectum. Symptoms usually develop over time, rather than suddenly. Signs and symptoms may include: diarrhea, abdominal pain and cramping, rectal pain, rectal bleeding, urgency to defecate, inability to defecate despite urgency, weight loss, fatigue, fever, and a reduced appetite. One possible cause is an immune system malfunction. When your immune system tries to fight off an invading virus or bacterium, an abnormal immune response causes the immune system to attack the cells in the digestive tract, too. Risk factors may include age younger than 30, race (white), and a family history. To help confirm a diagnosis of ulcerative colitis, you may have one or more of the following tests and procedures: blood tests, stool sample, colonoscopy, x-ray, CT scan. Ulcerative colitis treatment usually involves either drug therapy or surgery. Medications usually include 5-aminosalicylic acid (5-ASA), corticosteroid, immunomodulator drugs, biologics. You will need more-frequent screening for colon cancer because of your increased risk. The recommended schedule will depend on the location of your disease and how long you have had it.

My patient's signs and symptoms include loss of appetite, abdominal cramping, and fatigue. She had a FOBT done which showed positive for blood in her stool. Her risk factors include that she is white. A cause she has gotten colitis is because her immune system is already compromised by her having stage IV ovarian cancer. She however does not have a family history of bowel diseases nor had a fever today. She does get parenthesis done at an outpatient clinic every two weeks.

Pathophysiology References (2) (APA):

"Ulcerative Colitis." *Mayo Clinic*, Mayo Foundation for Medical Education and Research, 4 Oct. 2019, https://www.mayoclinic.org/diseases-conditions/ulcerative-colitis/symptoms-causes/syc-20353326.

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	**4.0-5.2**	**3.95**	**3.43**	**Cancer**
Hgb	**F:12-15 M: 14-16**	**10.9**	**9.6**	**Cancer**
Hct	**F:42-52**	**35.3**	**30.0**	**cancer**

	M:35-47			
Platelets	**140-440**	**229**	**N/A**	
WBC	**4.0-11.0**	**23.5**	**22.7**	**She has infections: UTI, Colitis**
Neutrophils	**45-75%**	**N/A**	**N/A**	
Lymphocytes	**20-40%**	**2.0**	**1.0**	**infection**
Monocytes	**4-6%**	**4.0**	**3.0**	**She has infections**
Eosinophils	**<7%**	**N/A**	**N/A**	
Bands	**<3%**	**2.0**	**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**	**130**	**133**	**She is on a diuretic**
K+	**3.5-5.0**	**5.2**	**4.6**	**chemotherapy**
Cl-	**98-107**	**101**	**104**	
CO2	**35-45**	**8**	**14**	**Metabolic acidosis**
Glucose	**70-100**	**147**	**171**	**She has DM and has not had any medications to treat it today**
BUN	**6-20**	**51**	**52**	**Sepsis**
Creatinine	**0.6-1.3**	**3.16**	**2.94**	**Dehydration**
Albumin	**3.4-5.4**	**2.8**	**2.3**	**infection**
Calcium	**8.5-10.5**	**8.5**	**7.1**	**Low protein level**
Mag	**1.7-3.4**	**2.2**	**1.9**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	
Bilirubin	**<1.5**	**1.1**	**0.7**	

Alk Phos	**20-140**	**139**	**106**	
AST	**10-30**	**39**	**36**	**Ovarian cancer**
ALT	**10-40**	**17**	**16**	
Amylase	**23-85**	**N/A**	**N/A**	
Lipase	**60-160**	**N/A**	**N/A**	
Lactic Acid	**0.5-1**	**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	**0.86-1.16**	**1.28**	**N/A**	**She is on an anticoagulant**
PT	**11.9-14.9**	**16.2**	**N/A**	**Anticoagulant**
PTT	**60-70 secs**	**40.2**	**N/A**	**anticoagulant**
D-Dimer	**<250**	**N/A**	**N/A**	
BNP	**<450 if under the age of 75 <125 if under the age of 74**	**N/A**	**N/A**	
HDL	**>60**	**N/A**	**N/A**	
LDL	**<130**	**N/A**	**N/A**	
Cholesterol	**<200**	**N/A**	**N/A**	
Triglycerides	**<150**	**N/A**	**N/A**	
Hgb A1c	**<7-8%**	**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 and clear	Amber and hazy	N/A	UTI
pH	6.0	5.0	N/A	
Specific Gravity	1.010-1.025	1.014	N/A	She has an infection
Glucose	0-0.8	normal	N/A	
Protein	0-20	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	4.5-11	13	N/A	UTI
RBC	4	1	N/A	UTI
Leukoesterase	2-5	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		Labs not drawn	Labs not drawn	
Blood Culture		Labs not drawn	Labs not drawn	
Sputum Culture		Labs not drawn	Labs not drawn	
Stool Culture	-	+ FOBT	Labs not drawn	cancer

Lab Correlations Reference (APA):

Fareed, K. (n.d.). Urinalysis (Urine) Test: Types, Drugs, Alcohol, Results and Interpretation.

Retrieved from https://www.medicinenet.com/urinalysis/article.htm

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of the abdomen and pelvis for abdominal pain without contrast showed the gallbladder is distended. Chest XR for SOB showed enlarged heart and streaky bibasilar opacities suggest scarring or atelectasis.

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	**oxyCODONE**	**Ondanstron (Zofran)**	**metoprolol**	**pantoprazole**	**Clonazepam**
Dose	**5 mg**	**4 mg**	**50 mg**	**40 mg**	**10 mg**
Frequency	**Q6H PRN**	**Q6H PRN**	**daily**	**BID**	**daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Analgesic**	**Antiemetic**	**Antianginal**	**Antiulcer**	**Anticonvulsant**
Mechanism of Action	**Blocking release of inhibitory neurotransmitters**	**Blocks serotonin receptors**	**Inhibits beta1-receptor sites**	**Inhibits proton pump in gastric cells**	**Potentiates GABA**
Reason Client Taking	**Pain relief**	**Nausea**	**High BP**	**GERD**	**anxiety**
Contraindications (2)	**Asthma, GI obstruction**	**Long QT syndrome, hypersensitivity**	**Heart failure, hypersensitivity**	**hypersensitivity**	**Hepatic disease, glaucoma**
Side Effects/Adverse Reactions (2)	**N/V, constipation**	**Headache, diarrhea**	**Dizziness, depression**	**Headache, diarrhea**	**Drowsiness, depression**
Nursing Considerations (2)	**Should be used with benzodiazepines, monitor for decrease in consciousness**	**Monitor for serotonin syndrome**	**If dosage exceeds 400 mg, monitor for bronchospasm**	**Give before meals**	**Should only be used with opioids, monitor for decrease in consciousness**

Hospital Medications (5 required)

Brand/Generic	**Enoxaprin (Lovenox)**	**D5 in water with sodium bicarbonate 1016**	**Zosyn**	**Acetaminophen (Ofirmev)**	**Spironolactone**
Dose	**30 mg**	**75 mg**	**3.375 mg = 50 mL**	**100 mL**	**25 mg**
Frequency	**daily**	**Twice**	**Once**	**Once**	**daily**
Route	**SQ**	**IV drip**	**IV piggyback**	**IV piggyback**	**PO**
Classification	**Antithrombotic**	**antacid**	**Antibiotic**	**Analgesic**	**antihypertensive**
Mechanism of Action	**Potentiates antithrombin III (coagulation inhibitor)**	**Raises blood pH**	**Binds with proteins to destroy microorganism**	**Pain reliever**	**Prevents sodium and water reabsorption**
Reason Client Taking	**Prevent DVT**	**metabolic acidosis**	**UTI and Colitis**	**pain**	**HTN**
Contraindications (2)	**Don't mix with other IV fluids, hypersensitivity**	**Hypocalcemia, NG suction**	**Allergic reaction**	**Alcohol, oral contraceptives**	**Renal failure, Addison's disease**
Side Effects/Adverse Reactions (2)	**Fever, diarrhea**	**Frequent urge to urinate, loss of appetite**	**Diarrhea, rash**	**Dizziness, nausea**	**N/V, dry mouth**
Nursing Considerations (2)	**Use cautiously in hepatic or renal impairment**	**Monitor sodium intake, assess IV site often**	**Common allergy with sulfa**	**Long term use can lead to liver disease**	**Watch for hyperkalemia**

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:**	**A+Ox4** **Patient does not show emotional or**

Orientation: **Distress:** **Overall appearance:**	**respiratory distress** **Appears well-nourished**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin appeared pink, warm and dry** **Varicose veins on lower extremities** **Temperature was** **No rashes, bruises, or wounds** **Skin turgor was normal, capillary refill less than 3 seconds** **Braden score of**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head appeared normocephalic** **Normal hearing to voice** **TMs are clear bilaterally** **Patient wears glasses** **Nasal passages are clear and moist** **Stated she has some false teeth** .
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:**	**No murmurs. Peripheral pulses were normal 3+. Capillary refill less than 3 seconds. Lower extremities showed edema.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Lungs clear but diminished to auscultation bilaterally**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:**	**Regular diet at home, she is now on** **160 cm tall, 81.9 kg** **Bowel sounds active in all four quadrants** **pain upon palpation** **No distention, incisions, scars, drains, or wounds** **Last BM was this morning with diarrhea**

Scars: **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Color of urine was dark amber** **No output**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	**Active ROM** **Fall risk of 85** **She can get up and ambulate with one assist with use of her walker**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**A+Ox4** **Slow to answer, seemed confused at first** **No headache, lightheadedness, or focal weakness** **No slurred speech or sensory deficits**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:**	**Has support from husband. Christian and goes to church. Highest level of education completed is some college.**

Religion & what it means to pt.: **Personal/Family Data (Think about home environment, family structure, and available family support):**	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	**102**	**108/53**	**18**	**36.7**	**100**
1040	**96**	**112/76**	**18**	**36.5**	**97**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**0**				
1015	**0**				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	No signs of erythema or infection. Port in right chest dated Oct. 13

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
43.33	**0**

Nursing Care

Summary of Care (2 points)

Overview of care: This is her second day in the hospital. I administered ____

Procedures/testing done: stool culture

Complaints/Issues: nausea/vomiting

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: patient is compliant and can walk with assist

Physician notifications: palliative care consult

Future plans for patient: treat her infections

Discharge Planning (2 points)

Discharge location: home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: try to schedule her paracentesis every Friday instead of every other week

Education needs: importance of daily weights

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. Electrolyte imbalance	**She had acidic pH and HCO3**	**1. administer sodium bicarb as prescribed**	**The labs from after the sodium bicarb was**

r/t metabolic acidosis AEB acidic pH and HCO3 levels	**levels**	**2.assess lab values**	**started were more normal than before**
2. Risk for deficient fluid volume r/t fluid loss AEB diarrhea and vomiting	**She was having diarrhea and vomiting and hadn't eaten anything**	**1. monitor I+O** **2.assess for thirst and poor skin turgor**	**Skin turgor was normal, she was drinking her water however she had not voided all morning**
3. Risk for infection r/t inflamed colonic mucosa AEB UTI	**She was diagnosed with a UTI**	**1. c.diff ordered** **2. assess pt for fever, hypotension, or tachycardia**	**Vital signs were within normal limits, she did have a UTI, stool specimen was ordered to rule out c.diff**

Other References (APA):

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Place of publication not identified: MOSBY.

Concept Map (20 Points

Subjective Data

Abdominal pain upon arrival
Nausea
Loss of appetite
She wanted a palliative care consult

Nursing Diagnosis/Outcomes

Electrolyte imbalance
Outcome: The labs from after the sodium bicarb was started were more normal than before
Risk for deficient fluid volume
Outcome: Skin turgor was normal, she was drinking her water however she had not voided all morning
Risk for infection
Outcome: Vital signs were within normal limits, she did have a UTI, stool specimen was ordered to rule out c.diff

Objective Data

Labs show metabolic acidosis
Patient can ambulate independently
EKG showed normal sinus rhythm
+ FOBT
She didn't eat breakfast
Stomach had some ascites
Swelling in lower extremities
Vomiting

Patient Information

J.B. is a 71-year-old female with a history of DM, GERD, HTN, stage 4 ovarian cancer presented to the ED with nausea and vomiting and was diagnosed with a UTI and colitis.

Monitor vital signs: Pulse oximetry, blood pressure, heart rate, and respiration rate. Report significant findings
Auscultate breath sounds frequently.
Assess patient's pain.
Monitor for signs of bleeding
Administer PRN pain medication, if prescribed.
Provide frequent breaks and rest periods in between activities
Speak in a calm, therapeutic manner
Establish honest, therapeutic communication in an empathetic manner
Explain all interventions, diagnostics and medications
Try to get paracentesis ordered for more often than every other week
Get her medication history so she can take the medicine she usually takes at home

Nursing Interventions