N441 Care Plan

Lakeview College of Nursing

Sydney Morgan

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/8/2020	MM	90	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	Atorvastatin, Calcium channel blockers, codeine, diltiazem, morphine, penicillin, trandolapril, adhesive bandages, yellow food dye
Code Status	**Height**	**Weight**	
DNR/DNI	159 cm	67.4 kg	

Medical History (5 Points)

Past Medical History: Anemia, blind left eye, CAD, Depression, Chronic diastolic HF (grade 3), chronic respiratory failure with hypoxia, CKD (stage III), COPD, Fibromyalgia, GERD, HTN, Hypothyroidism, Lumbar stenosis, Mitral stenosis with moderate to severe regurgitation, Mixed hyperlipidemia, Obstructive sleep apnea, OA, PAD, Cardiomyopathy, Pulmonary HTN, RA, history of TIA

Past Surgical History: EGD (2019), Excision -- head/neck and upper extremity (2019), abdominal hysterectomy, appendectomy, basal cell carcinoma, CABG x 2 (1992), Cardiac stents x2 (1992), cardiac catheterization, carotid endarterectomy, cataract, history of lumbar spine surgery

Family History: Father - CHF, dementia, MI, HTN, TIA; Mother - GI ulcer, HTN, ovarian cancer; Sister - RA; Child - RA

Social History (tobacco/alcohol/drugs): Patient denies use of alcohol or illicit drugs. Patient reports she was a previous smoker, quit over 10 years ago.

Assistive Devices: Dentures (not present in room)

Living Situation: Patient comes from Brookstone Estates, assisted living facility. Lives alone.

Education Level: No noted educational barriers. High school equivalent education.

Admission Assessment

Chief Complaint (2 points): Unrelieved nausea and headache

History of present Illness (10 points):. Patient arrived to the ED, 2/8/2020, via EMS from the assisted facility due to complaints of headache, fatigue, upper abdominal pain, nausea and vomiting that has been unrelieved by any OTC medications or home remedies for two days. Patient has a significant medical history. Patient stated she “thought her blood pressure was high” due to persistent headache and feeling fatigued. Blood pressure obtained in the ED was 200/68. Hydralazine was given in the ED with little improvement. Lipase level upon admission was over 2000. CT of abdomen was then ordered, which suggested positive pancreatitis. GI was consulted regarding the pancreatitis, and the patient was admitted to CCU with orders for hydralazine and labetalol to reduce blood pressure.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. Acute pancreatitis

Secondary Diagnosis (if applicable):. Hypertensive urgency

Pathophysiology of the Disease, APA format (20 points): Acute pancreatitis is defined as a "reversible inflammatory process of the pancreas acini brought about by premature activation of pancreatic enzymes" (Porth, 2011, p.755). With pancreatitis, pancreatic tissue is digested by its own enzymes that have been inappropriately activated. This process begins with the inappropriate activation of trypsin. Activated trypsin can in turn activate other digestive enzymes which attribute to pancreatic injury. Pancreatic injury induces an intense inflammatory response. The inflammatory response itself can cause severe tissue damage, and in some cases can progress to multi-organ damage. There are various possible causes of pancreatitis including gallstones, hyperlipidemia, hypercalcemia, infections, abdominal/surgical trauma, and thiazide diuretics (Porth, 2011, p.755). In MM's case the cause was likely due to her history of hyperlipidemia, although this cause was not confirmed because a lipid panel was not drawn on MM. Signs and symptoms of pancreatitis can range from mild to severe to even fatal. The hallmark symptom of pancreatitis is described as band-like epigastric pain. Other symptoms include nausea, vomiting, and anorexia. Signs upon physical assessment include; fever, tachycardia, hypotension, severe abdominal tenderness, respiratory distress, and abdominal distention (Porth, 2011, p.755). Symptoms exhibited by MM remained fairly mild. Her vital signs were within normal limits, outside of her blood pressure. MM's second diagnosis of hypertensive urgency attributes to her abnormal blood pressure. MM reported epigastric pain and nausea, and experienced diarrhea. Laboratory tests relative to pancreatitis include elevated pancreatic enzymes, amylase and lipase, and elevated CRP due to inflammation. WBC count and bilirubin may also be elevated. (Porth, 2011, p.755). MM's amylase and CRP were not drawn, but her lipase level was significantly increased indicating pancreatic injury. Other diagnostics of pancreatitis include abdominal ultrasound to detect for the presence of gallstones as the underlying cause and abdominal CT can be used to visualize necrosis and accumulation of fluid. MRCP and ERCP studies can be used to visualize the pancreatic and bile ducts. (Swearingen, 2016, p.443). MM's abdominal CT showed dilation of the pancreatic and bile duct, as well as gallbladder distention, which pointed to acute pancreatitis. It was recommended MM follow up with an ERCP, which had not yet been completed. An ERCP may not be performed until the acute episode has subsided (Swearingen, 2016, p.443).

MM's secondary diagnosis was deemed hypertensive urgency. Hypertensive urgency is known as hypertensive state which shows no obvious signs of organ damage. In urgent hypertensive situations, blood pressure should be lowered quickly to prevent progression to hypertensive crisis; which is likely to cause organ damage. Untreated hypertension and increased arterial pressure can lead to the damage of the arterial walls and possible rupture. Hypertension is believed to involve both environmental and innate factors involving kidney function and its ability to maintain adequate extracellular fluid balance, as well as diet and activity level (Swearingen, 2016, 179). MM exhibits risk factors for hypertension including family history, advanced age, post-menopausal, immobility, and hyperlipidemia.

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**	**4.69**	**4.67**	
Hgb	**12-18**	**11.4**	**12.2**	
Hct	**33-52**	**34.9**	**35.6**	
Platelets	**150-400**	**266**	**216**	

WBC	**5-10**	**7.8**	**6.0**	
Neutrophils	**45-79%**	**N/A**	**80.9%**	**Acute pancreatitis is likely the cause of increased neutrophil count.**
Lymphocytes	**12-46%**	**N/A**	**7.9%**	**Acute pancreatitis is likely the cause of increased lymphocyte count.**
Monocytes	**4.4-12%**	**N/A**	**9.8**	
Eosinophils	**Less than 10%**	**N/A**	**N/A**	
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**	**142**	**143**	
K+	**3.5-5.0**	**3.6**	**3.6**	
Cl-	**96-106**	**98**	**106**	
CO2	**20-29**	**28**	**26**	
Glucose	**70-110**	**110**	**111**	**Blood glucose was slightly elevated likely attributed to acute pancreatitis.**
BUN	**7-25**	**29**	**24**	**Elevated BUN on admission is related to dehydration. MM reported nausea and decreased fluid intake.**
Creatinine	**0.8-1.2**	**1.65**	**1.05**	**Elevated creatinine on admission**

				is related to dehydration. MM reported nausea and decreased fluid intake.
Albumin	**3.5-5.5**	**4.5**	**3.6**	
Calcium	**8.5-10.2**	**9.6**	**8.5**	
Mag	**1.3-2.1**	**N/A**	**N/A**	
Phosphate	**3.0-4.5**	**N/A**	**N/A**	
Bilirubin	**0.3-1**	**0.6**	**0.4**	
Alk Phos	**30-120**	**49**	**53**	
AST	**10-40**	**20**	**26**	
ALT	**7-52**	**11**	**10**	
Amylase	**30-220**	**N/A**	**N/A**	
Lipase	**0-160**	**2682**	**1505**	**Increased lipase levels are indicative of pancreatitis.**
Lactic Acid	**0.5-1**	**N/A**	**N/A**	
Troponin	**Less than 0.04**	**0.031**	**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)	0.92	N/A	
PT	11-12.5	12.4	N/A	
PTT	30-40	27.6	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	Clear and yellow	Clear and yellow	
pH	6.0	6.0	N/A	
Specific Gravity	1.005-1.035	1.008	N/A	
Glucose	0	0	N/A	
Protein	0	0	N/A	
Ketones	0	0	N/A	
WBC	Less than 5	0	N/A	
RBC	0	0	N/A	
Leukoesterase	0	0	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	75-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	

HCO3	**22-26**	**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): Head CT, Abdominal CT

Diagnostic Test Correlation (5 points): CT of the head and neck showed CSF spaces are normal for the patient's age, regarding size and configuration. Normal parenchymal attenuation. No noted fluid collection or masses. No noted thickening of sinus mucosa. Extensive loss of cerebral volume is present. Overall results of head CT are reported negative for abnormalities.

CT of the pelvis and abdomen showed dilation of the pancreatic duct and common bile duct. The gallbladder is seen to be moderately distended. No other abnormalities were noted. The final findings

were consistent with acute mild pancreatitis. Recommendations were made to follow with MRCP or ERCP.

Both scans were completed without contrast dye.

Diagnostic Test Reference (APA): ATI Nursing Education. (2016). *Content Mastery Series: RN Adult Medical Surgical Nursing Edition 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	**Synthroid (**Levothyroxine)	**ProAir (albuterol)**	**Lasix (furosemide)**	**Xanax (alprazolam)**	**Pepcid (famotidine)**
Dose	75 mcg	2.5mg/3mL (1 vial)	40 mg	0.25 mg	20 mg
Frequency	Daily	PRN for wheezing/SOB	BID	Daily/PRN for anxiety	BID
Route	PO	Nebulizer inhalation	PO	PO	PO
Classification	Synthetic thyroxine	Adrenergic bronchodilator	Sulfonamide diuretic	Benzodiazepine	H2 antagonist
Mechanism of Action	Replaced endogenous thyroid hormone	Attaches to Beta2 receptors on bronchial cells leading to bronchodilati	Inhibits sodium and water reabsorption in the loop of Henle and increases	Increase GABA effects by binding to benzodiazepine receptors which	Blocks H2 receptors; decreases gastric acid

		on	urine formation	inhibits excitatory stimulation controlling emotional behavior	
Reason Client Taking	Hypothyroidism management	COPD	CHF	Depression/ anxiety	GERD
Contraindications (2)	Acute MI Hypersensitivity	Glaucoma Hypersensitivity	Anuria unresponsive to furosemide Hypersensitivity to sulfonamides	Concurrent ketoconazole therapy Glaucoma	Hepatic insufficiency Hypersensitivity
Side Effects/Adverse Reactions (2)	Insomnia Weight gain	Anxiety Hypokalemia	Dizziness/orthostatic hypotension Hyperglycemia	Palpitations/ tachycardia Hepatic dysfunction	Arrhythmias Dry mouth
Nursing Considerations (2)	Administer 30-60 minutes before breakfast Give 4 hours before/after any aluminum or magnesium containing antacids	Monitor respiratory status - pulse oximetry, respiratory rate and effort, auscultate lung sounds Monitor potassium level	Use cautiously in patients with history of hepatic impairment or electrolyte imbalances Monitor daily weights and fluid status	Monitor neurologic function and level of consciousness Taper medication dosage down to discontinue	Monitor renal function Monitor for signs of hypersensitivity
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess thyroid hormone levels	Monitor pulse oximetry prior to and after	Monitor blood pressure, hepatic and renal	Assess neurologic function, level of consciousnes	Assess GI function and monitor for signs of

		administration	function, BUN, creatinine, and electrolyte levels prior to and throughout therapy	s, and orientation before administration to establish a baseline then continue to monitor throughout therapy	upset
Client Teaching needs (2)	Drug will most likely be life-long Inform patient they will need periodic blood work to check hormone levels	Instruct patient on how to correctly use and clean nebulizer equipment Advise patient to notify PCP immediately if symptoms do not improve after treatment	Advise patient to take furosemide at the same time each day, typically in morning/early afternoon to avoid nocturia Advise patient to change positions slowly to avoid the effects of orthostatic hypotension	Explain to client that dependency may occur and to not stop the drug abruptly to avoid withdrawal Advise client to avoid alcohol	Caution patient to avoid alcohol Instruct patient not to take famotidine with other acid-reducing agents

Hospital Medications (5 required)

Brand/Generic	**Catapres (clonidine)**	**Lovenox (enoxaparin)**	**Ativan (lorazepam)**	**Protonix (pantoprazole)**	**Zofran (ondansetron)**

Dose	0.2 mg	30 mg	0.5 mg	40 mg	4 mg
Frequency	Daily (24 hr. wear)	Daily	Q6 hr	BID	Q6 hr
Route	Transdermal patch	SubQ	IV Push	IV push	IV push
Classification	Alpha-2-adrenergic receptor agonist	Anticoagulant	Benzodiazepine	Proton pump inhibitor	Antiemetic
Mechanism of Action	Inhibits sympathetic neurotransmission resulting in a reduction in vasomotor tone	Inhibits clotting factors	Increase GABA effects by binding to benzodiazepine receptors which inhibits excitatory stimulation controlling emotional behavior	Inhibits proton pump; decreasing gastric acid secretion	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine
Reason Client Taking	HTN	DVT prophylaxis	Depression/ anxiety	GERD	Nausea management
Contraindications (2)	Severe bradyarrhythmia Hypotension	Bleeding disorders Thrombocytopenia	Glaucoma Hypersensitivity	Hypersensitivity Concurrent therapy with rilpivirine containing products	Congenital long QT syndrome Hypersensitivity

Side Effects/Adverse Reactions (2)	Sedation Dry eyes	Bleeding/hemorrhage Injection site irritation	Thrombocytopenia Euphoria/ delusions	Dizziness Hypoglycemia	Arrhythmias Accommodation disturbances
Nursing Considerations (2)	Rotate patch application sites Use gloves when removing/administering patches	Monitor coagulation studies Monitor for signs of bleeding	Monitor neurologic function, level of consciousness, and for suicidal ideations Use extreme caution when given to elderly patients as lorazepam can cause respiratory depression	Monitor patient for macrocytic anemia Monitor for hypomagnesemia	Monitor patient closely for serotonin syndrome - agitation, chills, confusion, diaphoresis, fever and hyperactive reflexes Monitor patient for decreased bowel activity
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor HR and BP prior to administering	Continually monitor blood counts - platelets, Hgb, Hct; throughout therapy	Assess neurologic function, level of consciousness, and orientation before administration to establish a baseline then continue to monitor throughout therapy	Perform assessment to establish data	Ensure potassium and magnesium levels are within normal limits prior to administration as abnormalities may increase risk for arrhythmias
Client Teaching needs	Encourage	Educate	Advise	Take drug	Advise

(2)	adequate fluid intake Advise patients to avoid concurrent sedative medications if possible (antidepressants)	patient on signs of bleeding and bleeding precautions Advise client to notify provider of neurological side effects	patient to report excessive drowsiness and nausea Advise patient to avoid alcohol	before eating breakfast Notify PCP of abdominal pain or diarrhea	patient to seek immediate medical attention if symptoms are persistent, severe, or worsen Advise patient to immediately report signs of hypersensitivity, such as 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: Alert x3** **Orientation: Oriented x1-2** **Distress: No apparent distress** **Overall appearance: no abnormalities**	Patient was drowsy but responded to stimuli and commands. Patient's orientation status fluctuated during care. At times, she was aware of herself and her location while others she was only oriented to herself.

INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry** **Temperature: warm** **Turgor: good** **Rashes: none** **Bruises: none** **Wounds:** none **Braden Score: 14** **Drains present: N** **Type: none**	Skin appeared pink, warm, and dry. No noted lesions, rashes, or abrasions. Good skin turgor, within normal limits in regards to patient age.
HEENT (1 point): **Head/Neck: normacephalic, no noted lumps or abnormalities** **Ears: tympanic membranes pearly gray bilaterally** **Eyes: PERRLA on the right, blind left eye** **Nose: no noted abnormalities, turbinates appeared pink and dry** **Teeth: no teeth present; patient typically wears dentures at home**	No reported ear pain, nasal congestion, or sore throat. Dry lips and oral mucosa were noted. Age-related hearing deficits were noted. .

CARDIOVASCULAR (2 points): **Heart sounds: S1, S2** **Cardiac rhythm (if applicable): sinus rhythm/ sinus bradycardia** **Peripheral Pulses: 2+** **Capillary refill: 3 sec.** **Neck Vein Distention: N Edema Y** **Location of Edema: trace edema in lower extremities**	No reported chest pain or palpitations. Patient reported some lightheadedness. Normal to slightly bradycardic heart rate. No noted clicks, gallops, or rubs. No murmur. Trace edema was noted to be present in lower legs and feet.
RESPIRATORY (2 points): **Accessory muscle use: N** **Breath Sounds: Location, character: Crackles present in lower lobes, bilaterally** **ET Tube: N/A** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	No reported SOB or cough. Non-labored breathing. Lung sounds auscultated in all lobes. Noted crackles in lower lobes bilaterally.

GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: NPO** **Height: 159 cm** **Weight: 67.4 kg** **Auscultation Bowel sounds: active bowel sound in all 4 quadrants** **Last BM: 2/11/2020** **Palpation: Pain, Mass etc.: none** **Inspection:** **Distention: none** **Incisions: none** **Scars: none** **Drains: none** **Wounds: none** **Ostomy: N** **Nasogastric: N** **Size:** **Feeding tubes/PEG tube N** **Type:**	Abdomen was soft and nondistended. Mild epigastric pain noted. Normal, active bowel sounds auscultated in all 4 quadrants. No noted lesions, lumps, or masses. Patient reported mild nausea and was experiencing loose stools.

GENITOURINARY (2 Points): **Color: 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:** **CAUTI prevention measures:**	Patient denies any pain with urination. Patient was incontinent, urine output was unable to be measured.
MUSCULOSKELETAL (2 points): **Neurovascular status: no noted deficits** **ROM: no noted limitations** **Supportive devices: none** **Strength: equal bilaterally** **ADL Assistance: Y** **Fall Risk: Y** **Fall Score: 60** **Activity/Mobility Status: Bed rest** **Independent (up ad lib) N** **Needs assistance with equipment Y** **Needs support to stand and walk Y**	No reported pain or weakness. No noted limitations in ROM. No tenderness or swelling. Patient on bed rest with scheduled position changes.

NEUROLOGICAL (2 points): **MAEW: Y** **PERLA: Y** **Strength Equal: Y** **Orientation: x2** **Mental Status: occasional confusion** **Speech: no noted deficits** **Sensory: no noted deficits** **LOC: mildly drowsy, but arousable**	Patient was AOx2. Patient did remain oriented to self at all times, but occasionally became disoriented to her location. Patient was not oriented to situation or time. No noted sensory deficits.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): family support** **Developmental level: developmentally appropriate for age; mildly disoriented** **Religion & what it means to pt.: none documented** **Personal/Family Data (Think about home environment, family structure, and available family support): daughters and grandchildren are main source of support**	Patient was agitated and mildly disoriented during my care. Patient's daughters remained at the bedside during the majority of my care.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	55	178/88	16	36.7	99
1130	52	166/74	16	36.6	98

Vital Sign Trends/Correlation: Patient's blood pressure remained elevated and heart rate was slightly bradycardic during my shift. Medications were given at the 0800 vital signs reading, which can account for the slight decrease in blood pressure and heart rate, as a new clonidine patch was administered.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	Epigastric region	3/10	Patient unable to discern	No interventions taken
1130	Numeric	Epigastric region	5/10	Patient unable to discern	Tylenol given

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV: L AC** **Date on IV: 2/9/2020** **Patency of IV: Fluids running** **Signs of erythema, drainage, etc.: no noted erythema or drainage** **IV dressing assessment: clean, dry, and intact**	Normal saline at 125 mL/hr
Other Lines (PICC, Port, central line, etc.)	None

Type: N/A **Size: N/A** **Location: N/A** **Date of insertion: N/A** **Patency: N/A** **Signs of erythema, drainage, etc.: N/A** **Dressing assessment: N/A** **Date on dressing: N/A** **CUROS caps in place: N/A** **CLABSI prevention measures: N/A**	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1200 mL	Patient was incontinent of stool and urine; output was unable to measured

Nursing Care

Summary of Care (2 points)

Overview of care: Preformed assessments and took vital signs on MM as needed. Gave morning medications; Lovenox, Protonix, and hung a bag of Ertapenem. Assisted care partner and nurse with daily bathing. Tylenol was given mid-shift due to reports of moderate epigastric pain. No other medications or procedures were done during my shift.

Procedures/testing done: No procedures or testing done during my shift.

Complaints/Issues: No specific complaints noted. Patient was agitated and preferred not to be bothered.

Vital signs (stable/unstable): Vital signs were cycled during my shift. Appeared stable, but remained hypertensive.

Tolerating diet, activity, etc.: Patient was NPO and remained on bed rest during my shift. Patient will remain NPO until lipase levels decrease back to normal levels.

Physician notifications: Hospitalist saw MM once during my shift, recommendation was made to continue monitoring lipase levels and continue clonidine for hypertension**.**

Future plans for patient: MM is to continue being closely monitored. She will remain NPO until lipase levels return to a more normal level. HR and BP will continue to be monitored closely, clonidine will continue to be administered for hypertension management. Labatelol is ordered, if necessary, for hypertensive emergencies.

Discharge Planning (2 points)

Discharge location: MM will return to Brookstone Estates.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: MM will continue to be monitored by staff at Brookstone Estates, and follow up with PCP after discharge.

Education needs: Because MM is occasionally disoriented, education was primarily given to the family regarding health status and medications**.**

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. Nausea related to acute pancreatitis as evidenced by patient's continued reports of nausea.	I chose this nursing diagnosis for MM because she had reported feelings of nausea since admission that were frequently recurring despite medications and being NPO.	1. MM was ordered Zofran as an antiemetic. 2. MM was advised to rest as much as possible to avoid increasing feelings of nausea.	MM reported Zofran decreased nausea for short periods, but it continued to recur. She remained in bed and rested for the majority of my shift.
2. Acute pain related to acute pancreatitis as evidenced by patient reports of epigastric pain.	I chose this nursing diagnosis for MM because she had complained of mild to moderate epigastric pain during my shift.	1. MM was encouraged to rest and her room was kept dark and quiet to decrease outside stimuli.	MM remained in bed and rested for the majority of my shift. She responded well to Tylenol, reporting it decreased pain shortly after administration.

		2. MM was ordered Tylenol as a pain reliever.	
3. Imbalanced nutrition related to insufficient intake as evidenced by NPO status.	I chose this nursing diagnosis because MM had been NPO since admission on 2/8, and did not appear that her diet would advance very quickly.	1. MM's electrolytes and nutrition status are continually monitored. 2. MM's weight was checked daily to monitor for significant loss.	MM's electrolytes and weight remained within normal limits with no significant changes or deficits. She will continue to be monitored throughout her hospital stay.
4. Risk for impaired tissue integrity related to incontinence as evidenced by multiple loose stools per day.	I chose this diagnosis for MM because of her advanced age, incontinence, and immobility. This combination places MM at higher risk for impaired tissue integrity and possible pressure injuries.	1. Frequent skin care was provided for MM, that was both scheduled and after incontinence episodes. 2. MM had frequent scheduled position changes and skin assessments.	MM was agitated when perianal care was done, but responded well to position changes. She cooperated appropriately for skin assessments. No apparent skin issues at the end of my shift.
5. Impaired physical mobility related to	I chose this diagnosis for MM	1. Frequent position	MM responded well to position changes, and

advanced age as evidenced by Morse score of 60.	because she remained in bed for all of my shift, she is able to reposition herself in bed but unable to leave the bed on her own.	changes were scheduled regularly for MM. 2. MM was encouraged to spend time in the bedside chair each day.	actively changed positions on her own. MM did not want to sit in the chair during my shift.

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

Concept Map (20 Points):