N321 Care Plan # 1

Lakeview College of Nursing

Ana Punsalan

Demographics (3 points)

Date of Admission 2/12/2020	**Patient Initials** C.N.	**Age** 78	**Gender** Female
Race/Ethnicity African American	**Occupation** No occupation	**Marital Status** Single	**Allergies** Chocolate, Clonidine, Lisinopril, Metformin
Code Status DNR	**Height** 5'8	**Weight** 159 lbs.	

Medical History (5 Points)

Past Medical History: Acute on chronic combined systolic and diastolic congestive heart failure, Arteriosclerotic heart disease, Diabetes mellitus, End-stage renal disease on dialysis, GERD, Hypertension, Hyperlipidemia, Hypothyroidism, Stage 3 chronic kidney disease, Pulmonary embolism, Coronary artery disease, Stroke

Past Surgical History: Cesarean section, Appendectomy, Hernia repair, Cholecystectomy, Hysterectomy, Cardia catheterization, Insertion dialysis catheter, Colonoscopy

Family History: Renal failure in her brother, paternal uncle, and sister

Social History (tobacco/alcohol/drugs): No tobacco, alcohol, or drugs

Assistive Devices: Walker, Wheelchair, and a shower seat

Living Situation: Patient lives alone in a single-story home.

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Left-sided abdominal pain and intermittent nausea

History of present Illness (10 points): Patient complains of left-sided abdominal pain and intermittent nausea. Patient has also been having tremors of the bilateral hands. Patient recently had an EGD done as an outpatient. It was thought that her pain maybe related to constipation. She was given a does of magnesium citrate and had a bowel movement.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Constipation

Secondary Diagnosis (if applicable): N/A

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

Pathophysiology References (2) (APA):

Mayo Clinic. (2019, June 29). Constipation. Retrieved from https://www.mayoclinic.org/diseases-conditions/constipation/symptoms-causes/syc-20354253

Sethi, S. (2019, August 23). What you should know about constipation. Retrieved from https://www.healthline.com/health/constipation

Constipation

Chronic constipation is infrequent bowel movements or difficult passage of stools that persists for several weeks or longer. Constipation is generally described as having fewer than three bowel movements a week. Though occasional constipation is very common, some people experience chronic constipation that can interfere with their ability to go about their daily tasks. Chronic constipation may also cause people to strain excessively in order to have a bowel movement (Mayo Clinic, 2019).

Signs and symptoms of chronic constipation include: passing fewer than three stools a week, having lumpy or hard stools, straining to have bowel movements, feeling as though there's a blockage in your rectum that prevents bowel movements, and feeling as though you can't completely empty the stool from your rectum, which patient has experienced (Mayo Clinic, 2019).

Diagnostic tests and procedures include blood tests, x-ray, sigmoidoscopy, colonoscopy, anorectal manometry, balloon expulsion test, colon transit study, defecography, and an MRI defecography.

Treatment include adding fiber-rich foods to diet, exercising most days of the week, don’t ignore the urge to have a bowel movement, adding fiber supplements to diet, using laxatives sparingly, and drink plenty of fluids (Seth, 2019).

Patient complains of left-sided abdominal pain and intermittent nausea. It was thought that her pain maybe related to constipation. She was given a does of magnesium citrate and had a bowel movement. Patient also had a CT abdomen & pelvis without contrast test done.

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	4.40-5.80			
Hgb	13.0-16.5	11.9	N/A	Having stage 3 chronic kidney disease decreased Hgb value.
Hct	38.0-50.0	35.3	N/A	Having stage 3 chronic kidney disease decreased Hct value.
Platelets	140-440	121	N/A	Hemodialysis decreased platelet count.
WBC	4.00-12.00			
Neutrophils	40.0-68.0%			
Lymphocytes	19.0-49%			
Monocytes	3.0-13.0%			
Eosinophils	0.0-8.0%			
Bands	0.0-4.0			

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 mmol/L			
K+	3.5-5.0 mmol/L			
Cl-	98-108			
CO2	23-29			
Glucose	70-100 mg/dL	107	N/A	Having diabetes increased glucose value.
BUN	8-25 mg/dL	34	N/A	Having stage 3 chronic kidney disease increased BUN value.

Creatinine	0.6-1.3 mg/dL	5.61	N/A	Having stage 3 chronic kidney disease increased creatinine value.
Albumin	3.5-5.2 gm/dL			
Calcium	8.6-10 mg/dL			
Mag	1.5-2.6			
Phosphate	2.5-4.5			
Bilirubin	<1.5 mg/dL			
Alk Phos	34-104			
AST	10-30 units/ L			
ALT	10-40 units/ L			
Amylase	23-470			
Lipase	20-86			
Lactic Acid	0.5-1.0			

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	2-3			
PT	F: 9.5-11.3 s M: 9.6-11.8 s			
PTT	30-40 s			
D-Dimer	≤250 ng/mL			
BNP	<125			
HDL	40-59			

LDL	100-129			
Cholesterol	<200			
Triglycerides	<150			
Hgb A1c	4-5.6%			
TSH	0.4-4.0			

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	Ambery yellow clear			
pH	5.0-9.0			
Specific Gravity	1.003-1.030			
Glucose	Negative			
Protein	-0.8 mg/dL			
Ketones	Negative			
WBC	0.4			
RBC	≤2			
Leukoesterase	Negative			

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	(-) < 10,000mL (+)> 100,000mL			
Blood Culture	Negative			
Sputum Culture	Normal upper respiratory tract			
Stool Culture	Normal intestinal flora			

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T.J., & Pagana, T.N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed). MO; Elsevier.

All Other Diagnostic Tests (5 points):

CT abdomen & pelvis without contrast:

Lung bases/thorax: small bilateral pleural effusions

Stomach: post-op changes from gastric surgery

Liver: multiple simple hepatic cyst

Gallbladder: post-op changes from cholecystectomy

Kidneys/ureters: left-sided renal cyst that measures up to 4.5cm size

Diagnostic Test Correlation (5 points): Patient complains of left-sided abdominal pain. CT is to help detect diseases of the small bowel, colon and other internal organs and is often used to determine the cause of unexplained pain.

Diagnostic Test Reference (APA):

Rogers, G. (2017, July 5). *What is an abdominal CT scan?*. Retrieved from https://www.healthline.com/health/abdominal-ct-scan

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	aspirin (acetylsalicylic acid)	allopurinol (Zyloprim)	amiodarone (Cordarone)	amlodipine (Norvasc)	atorvastatin (Lipitor)
Dose	81 mg	100mg	200mg	5mg	10mg
Frequency	Daily	Daily	BID	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Nonopioid analgesic	Antigout	Class III antiarrhythmic	Anti-hypertensive	Anti-hyperlipidemic
Mechanism of Action	Subside inflammatory symptoms and pain	Inhibits uric acid production	Improves myocardial blood flow	Decreases myocardial workload	Inhibit cholesterol synthesis
Reason Client Taking	To relieve mild pain	To treat hyperuricemia	To treat recurrent V.fibs and V.tachs	To control hypertension	To control lipid levels
Contraindications (2)	-low levels of vit K -anemia	-dehydration -chronic heart failure	-overactive thyroid gland -liver problems	-severe narrowing of the aortic valve -significantly low BP	-alcoholism -brain hemorrhage
Side Effects/Adverse Reactions (2)	-Excess stomach acid secretion -Heartburn	-Skin rash -Hives	-Trouble with walking -Weakness of arms or legs	-Swelling of ankles or feet -Feeling of warmth	-Unusual tiredness or weakness -fever
Nursing Considerations (2)	-Don’t crush tablets. -Advise pt not to drink with ibuprofen.	-Obtain CBC & uric acid level. -Maintain a fluid intake to produce urinary output of 2L daily.	-Assess thyroid hormone levels. -Monitor liver enzymes, as ordered.	-Monitor BP while adjusting dosage. -Assess pt for chest pain.	-Expect liver function tests to be performed. -Monitor diabetic pt’s blood glucose.

Hospital Medications (5 required)

Brand/Generic	acetaminophen (Tylenol)	apixaban (Eliquis)	losartan (Cozaar)	calcitriol (Rocaltrol)	metoclopramide (Reglan)
Dose	650mg	5mg	25mg	0.5mcg	5mg
Frequency	Q4H	BID	Daily	Daily	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Nonopioid analgesic	To reduce risk of stroke	Anti-hypertensive	Anti-hypoparathyroid	Upper GI stimulant
Mechanism of Action	Interfere with pain impulse	Inhibit platelet aggregation	Reduce BP	Increase calcium absorption	Promotes gastric emptying and peristalsis
Reason Client Taking	To relieve mild to moderate pain	To reduce risk of stroke and systemic embolism	To manage hypertension	To treat hypoparathyroidism	To treat gastroesophageal reflux disease
Contraindications (2)	-caloric undernutrition -severe renal impairment	-increased risk of bleeding -kidney disease	-diabetes -high cholesterol	-kidney stones -high amount of calcium in the blood	-depression -high BP
Side Effects/Adverse Reactions (2)	-Rash -Nausea & headache	-Excessive bleeding -diarrhea or constipation	-Backache -Muscle weakness	-Dehydration -High or low calcium levels	-Diarrhea -Drowsiness
Nursing Considerations (2)	-Monitor renal function. -Ensure daily dose does not exceed maximum daily limits.	-Not be given to pts with severe hepatic dysfunction. -Monitor pt closely for bleeding.	-Monitor BP & renal function. -Monitor potassium level for hyperkalemia.	-Check pt receives enough calcium. -Monitor pt closely.	-Assess pt for signs of intestinal obstruction. -May increase catecholamine levels.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (18th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Appears alert & oriented; No apparent distress; looks her age; Clean; Appears frail & fatigued
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Skin is within patient's norm Fair skin; warm & dry; She is not diaphoretic; Temperature is within average range; Turgor shows hydration; No rashes, bruises, wounds; Braden Score:16
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head & neck are symmetrical; trachea is midline without deviation; Auricle is moist and pink without lesions; sclera is white; conjunctiva is clear; lids are moist & pink; septum is midline; sinuses are nontender; dentition is good
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:**	Normal rate; S1 & S2 without murmurs, gallops, or rubs; pulses are 2+ throughout; capillary refill less than 2 seconds
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular even & nonlabored, symmetrical, no wheezes or crackles noted;
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:**	 Eats a regular balanced diet at home; Currently consumed 100% of lunch; Height: 5'8 Weight: 159 lbs.

Auscultation Bowel sounds: **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Bowel sounds are normoactive. Last BM: One day ago; Soft, tenderness (left flank), no mass; No distention, incisions, scars, drains, or wounds
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient was in dialysis; did not urinate Genitals appear pink & moist
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 ☒**	CV II-XII are intact; Reflexes are 1-2+ throughout; Coordination: Normal finger to nose bilaterally; No pain, paralysis; No paresthesia; Not pallor; Warm temperature; No swelling or increased pressure; Needs supportive devices: walker, wheelchair, and a shower seat; She is independent with her ADLs; Fall Score: 15
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	Alert & oriented to person & place; Speech is articulate; Decreased sensation to pinprick in a stocking and glove fashion; No LOC; Judgement & thought content normal

Sensory: **LOC:**	
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):**	Watches TV and naps; Ego integrity, wisdom & the ability to participate in life with a sense of satisfaction; Protestant; has a son and a daughter for support

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	73	121/78	18	97 °F	100
1545	72	118/78	18	97.2°F	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	Numeric	N/A	0/10	N/A	N/A
1545	Numeric	N/A	0/10	N/A	N/A

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:**	 N/A N/A N/A N/A	N/A – Patient did NOT have an IV

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

360mL	0mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient didn't complain of any abdominal pain. Patient was cooperative and didn't complain during dialysis.

Procedures/testing done: CT abdomen & pelvis without contrast

Complaints/Issues: Left-sided abdominal pain & intermittent nausea

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Tolerates diet and activities

Physician notifications: Keep day-by-day list to track the number, hardness, and pattern of stools.

Future plans for patient: Relieve constipation

Discharge Planning (2 points)

Discharge location: To home

Home health needs (if applicable): Has caregivers that come 3hrs/day 5days/week.

Equipment needs (if applicable): Walker and wheelchair

Follow up plan: Abdominal & constipation – continue to give magnesium citrate and monitoring.

Education needs: Prevent constipation. Instruct patient to eat a diet that is high in fiber including fresh fruits, vegetables, and whole grains. Drink plenty of water and fruit juices.

Exercise regularly or increase activity level. Establish healthy bowel diets. Go to the bathroom when you feel the need to void.

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

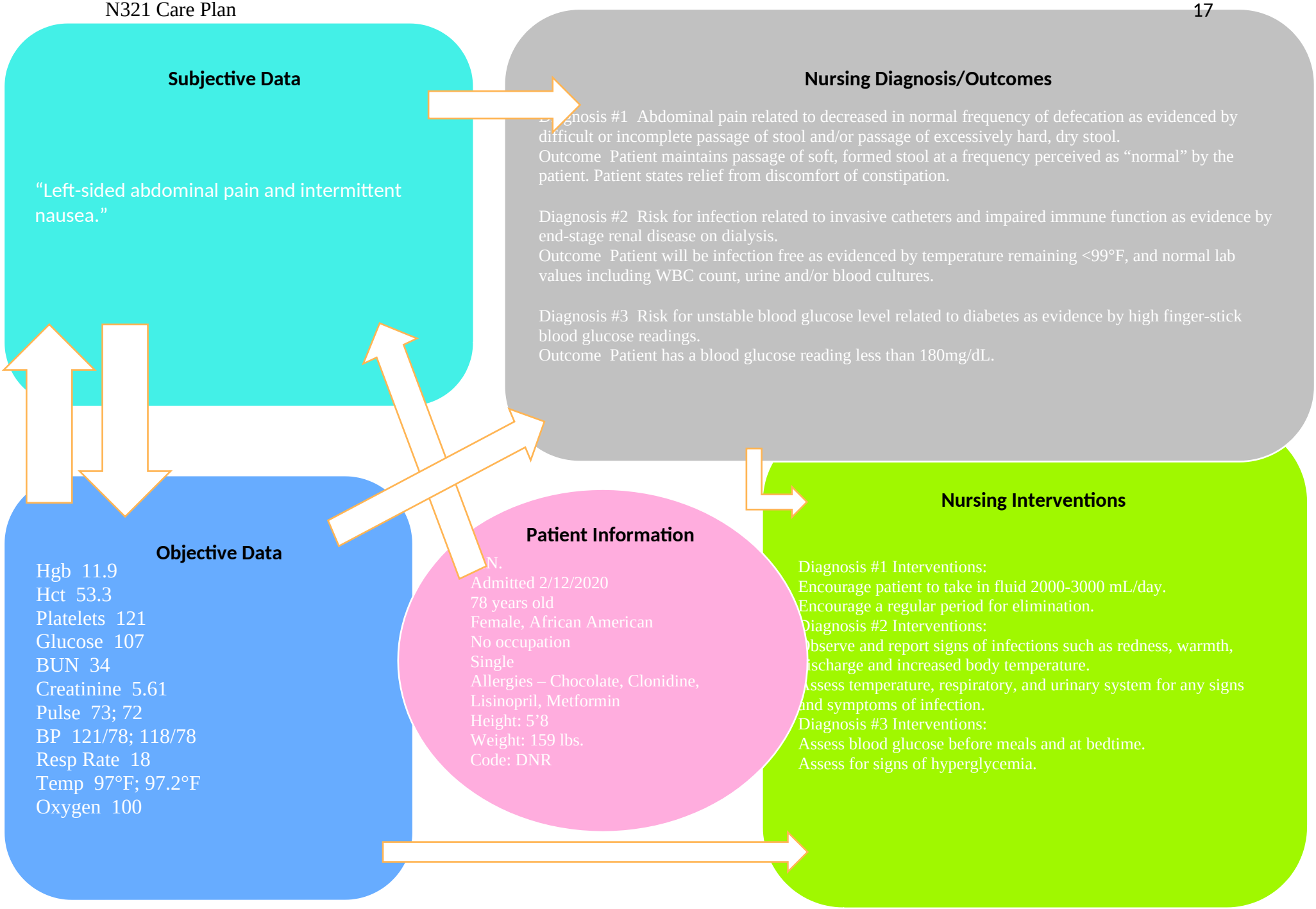
Nursing Diagnosis	Rational	Intervention (2 per	Evaluation

• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen	**dx)**	• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Abdominal pain related to decreased in normal frequency of defecation as evidenced by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool.	Patient's complain was thought to be related to constipation. She was given a dose of magnesium citrate and have a bowel movement.	1. Encourage patient to take in fluid 2000-3000 mL/day. 2. Encourage a regular period for elimination.	Patient maintains passage of soft, formed stool at a frequency perceived as "normal" by the patient. Patient states relief from discomfort of constipation.
2. Risk for infection related to invasive catheters and impaired immune function as evidenced by end-stage renal disease on dialysis.	Patient has stage 3 chronic kidney disease.	1. Observe and report signs of infections such as redness, warmth, discharge and increased body temperature. 2. Assess temperature, respiratory, and urinary system for any signs and symptoms of infection.	Patient is infection free as evidenced by temperature remaining <99° F, and normal lab values including WBC count, urine and/or blood cultures.
3. Risk for unstable blood glucose level related to diabetes as evidence by high finger-stick blood glucose readings.	Patient has high glucose levels due to diabetes.	1. Assess blood glucose before meals and at bedtime. 2. Assess for signs of hyperglycemia.	Patient has a blood glucose reading less than 180mg/dL.

Other References (APA):

Swearingen, P. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (4th ed.). Elsevier.

Concept Map (20 Points):


Subjective Data
"Left-sided abdominal pain and intermittent nausea."
Nursing Diagnosis/Outcomes
Diagnosis #1 Abdominal pain related to decreased in normal frequency of defecation as evidenced by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool.
Outcome Patient maintains passage of soft, formed stool at a frequency perceived as "normal" by the patient. Patient states relief from discomfort of constipation.
Diagnosis #2 Risk for infection related to invasive catheters and impaired immune function as evidence by end-stage renal disease on dialysis.
Outcome Patient will be infection free as evidenced by temperature remaining <99°F, and normal lab values including WBC count, urine and/or blood cultures.
Diagnosis #3 Risk for unstable blood glucose level related to diabetes as evidence by high finger-stick blood glucose readings.
Outcome Patient has a blood glucose reading less than 180mg/dL.
Objective Data
Hgb 11.9
Hct 53.3
Platelets 121
Glucose 107
BUN 34
Creatinine 5.61
Pulse 73; 72
BP 121/78; 118/78
Resp Rate 18
Temp 97°F; 97.2°F
Oxygen 100
Patient Information
N.
Admitted 2/12/2020
78 years old
Female, African American
No occupation
Single
Allergies – Chocolate, Clonidine, Lisinopril, Metformin
Height: 5'8
Weight: 159 lbs.
Code: DNR
Nursing Interventions
Diagnosis #1 Interventions:
Encourage patient to take in fluid 2000-3000 mL/day.
Encourage a regular period for elimination.
Diagnosis #2 Interventions:
Observe and report signs of infections such as redness, warmth, discharge and increased body temperature.
Assess temperature, respiratory, and urinary system for any signs and symptoms of infection.
Diagnosis #3 Interventions:
Assess blood glucose before meals and at bedtime.
Assess for signs of hyperglycemia.