N321 Care Plan # 1

Lakeview College of Nursing

Taylor Hamilton

Demographics (3 points)

Date of Admission 2/12/20	**Patient Initials** L.M	**Age** 68	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Single	**Allergies** Codeine, penicillins
Code Status Full	**Height** 5’5”	**Weight** 100.4lbs	

Medical History (5 Points)

Past Medical History: Arthritis, asthma, atypical chest pain, cataracts, chest pain, demand ischemia, depression, diabetes mellitus, GERD, heme positive stool, hyperlipidemia, ileus neuropathy, NSTEMI, sepsis

Past Surgical History: Tubal ligation, cholecystectomy, joint replacement, cardiac catherization, colonoscopy, abdomen surgery, breast lumpectomy, colon surgery, and colostomy.

Family History: Two of her brothers, her mother, and her sister had cancer, her father died of a myocardial infarction.

Social History (tobacco/alcohol/drugs): Never a smoker, does not drink, does not do drugs

Assistive Devices: N/A

Living Situation: Lives at Gardenview Manor

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): In the past week, she has been feeling nauseous and been vomiting gastric content. Patient reports abdominal pain near her colostomy site. Patient reported she has not had a fever or chills, she has not had stool in her ostomy output. Patient reported she had bilateral leg weakness. Patient is pending stool results C. Diff results. Patient was placed on contact isolation.

History of present Illness (10 points): Patient is a 60-year-old female with a PMH of bowel perforation status post colectomy and ileostomy in August of 2019. Patient was admitted to SHMC on February 12, 2020. Patient has a history of Patient had an anastomosis reversal complicated by ileus and anastomotic leak with pneumoperitoneum, complicated with E. Coli., bacterium, and acute respiratory failure requiring intubation. Patient has a history of arthritis, asthma, atypical chest pain, cataracts, chest pain, demand ischemia, depression, diabetes mellitus, GERD, heme positive stool, hyperlipidemia, ileus neuropathy, NSTEMI, and sepsis. Patient reported leg weakness when she was admitted into the hospital but expressed she was feeling much better. Patient also reported her abdominal pain was not as bad as it was when she was admitted.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Patient was admitted for possible C. diff and abdominal pain

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Clostridioides difficile, C. diff, is a bacterium that can cause symptoms that range from mild diarrhea to life-threatening inflammation of the colon. C.diff bacteria is found throughout the environment in the air, water, feces, food products, and soil which it can be contracted from. Spores from C. diff can be passed from feces to food, surfaces, and objects and can be transmitted to humans if they are touching objects or eating food that has been infected with the bacterium. C. diff can also be acquired from overuse of antibiotics. This is because the antibiotics can kill off not only the bad germs, but also the good germs, normal flora, that help protect our bodies from infection. It can be

transferred easily if a person is not using proper hand hygiene. Once C. diff has made its way into the body, it produced toxins that can attack the lining of the intestines which destroys cells, produces inflammatory cells and decaying cellular debris inside the colon, and causes watery diarrhea. It can also be found in some humans naturally – these patients would not have ill effects from the infection. Women are more likely than men to have C. diff, and ages older than 65 are more at risk to acquire C. diff compared to younger individuals. C. diff can increase the risk for future other infections.

Pathophysiology References (2) (APA): CDC. (2020, January 4). C. difficile infection. Retrieved from https://www.mayoclinic.org/diseases-conditions/c-difficile/symptoms-causes/syc-20351691

Clostridium Difficile Infection | C. difficile. (2019, September 13). Retrieved from https://medlineplus.gov/clostridiumdifficileinfections.html

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	3.8-5.3		2.99	Medications that treat diabetes can cause low RBC
Hgb	12.0-15.8		8.4	Associated with more rapid decline in glomerular filtration rate
Hct	36.0%-47.0%		26.2%	Patient could be dehydrated
Platelets	140-40		554	
WBC	4.0-12.0		16.80	Could be high due to infection
Neutrophils				
Lymphocytes				

Monocytes				
Eosinophils				
Bands				

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-				
K+				
Cl-				
CO2				
Glucose	70-99		100	Patient has diabetes
BUN	7-25		27	Could be elevated due to dehydration
Creatinine				
Albumin	3.5-5.7		3.2	Could be low due to inflammation or malnutrition
Calcium				
Mag				
Phosphate				
Bilirubin				
Alk Phos	34-104		180	Could indicate liver is not properly working
AST	13-39		44	Could indicate liver is not properly working

ALT				
Amylase				
Lipase				
Lactic Acid				

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				
PT				
PTT				
D-Dimer				
BNP				
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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				
pH				
Specific Gravity				
Glucose				
Protein	Negative		1+	Could indicate kidney issues
Ketones				
WBC	Negative 0-5		11-20	Could indicate inflammation in urinary tract or kidneys
RBC	Negative 0-2		6-10	Could indicate kidney issues or kidney stones
Leukoesterase				

Blood – normal range is negative – pt had 3+

Many budding yeast present in urine

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	**N/A**			
Blood Culture	**N/A**			
Sputum Culture	**N/A**			
Stool Culture	**Negative**			**Was pending a stool culture to rule out C. Diff**

Lab Correlations Reference (APA):

Fareed, K. (2019, September 11). Urinalysis (Urine) Test: Types, Drugs, Alcohol, Results and Interpretation. Retrieved from https://www.medicinenet.com/urinalysis/article.htm

Blood Urea Nitrogen. (n.d.). Retrieved from https://www.uofmhealth.org/health-library/aa36271.

Stöppler, M. C. (n.d.). 14 Low Blood Sugar Symptoms, Signs, Treatment, Dangers. Retrieved from https://www.medicinenet.com/hypoglycemia/article.htm.

Kwon, E., & Ahn, C. (2012, September). Low hemoglobin concentration is associated with several diabetic profiles. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3443718/.

Cinar, Y., Demir, G., Paç, M., & Cinar, A. B. (1999, July). Effect of hematocrit on blood pressure via hyperviscosity. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10411372/.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of abdomen / pelvis without contrast

Diagnostic Test Correlation (5 points): "CT normal except gastric wall was mildly thickened but not well distended" was reported in the patients charts following the CT scan. Mayo clinic stated "a positive CT for c. Diff would show complication such as thickening of the colon wall, expansion of the bowel, or a hole (perforation) in the lining of the colon.

Diagnostic Test Reference (APA): C. difficile infection. (2020, January 4). Retrieved from https://www.mayoclinic.org/diseases-conditions/c-difficile/diagnosis-treatment/drc-20351697

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

Home Medications (5 required)

Brand/Generic	Tylenol (Acetaminophen)	Pepcid (famotidine)	Duragesic (fentanyl transdermal system)	Vitamin B9 (Folvite)	Fluoxetine hydrochloride (Prozac)
Dose	650mg	40mg	25mcg/hr	1mg	20mg
Frequency	Every 4 hours/ PRN	Daily	Every 72 hours	Daily	Daily
Route	Oral	Oral	Transdermal	Oral	Oral
Classification	Non-opioid analgesic	Gastric acid secretion inhibitor	Opioid	Vitamin	antidepressant
Mechanism of Action	Inhibits cyclooxygenase blocking prostaglandin production and interfering with pain impulse	Reduces HCl formation in the gastric juices	Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain	Binds to intrinsic factors during transit through the stomach and intestines and enters the mucosal cell for absorption.	Selectively inhibits reuptake of the neurotransmitters serotonin by CNS neurons and increases the amount of serotonin available in nerve synapse.
Reason Client Taking	Pain PRN	GERD	Pain	Vitamin B deficiency	depression

Contraindications (2)	Hypersensitivity to acetaminophen or it components, severe hepatic impairment, sever active liver disease	Hypersensitivity to famotidine, other H2-receptor antagonists, or their components	Acute or severe bronchial asthma, patients who are not opioid tolerant	Hereditary optic nerve atrophy, anemia, respiratory infection	Hypersensitivity to fluoxetine, use within 14 days of a MAOI inhibitor
Side Effects/Adverse Reactions (2)	Hypotension, constipation	Abdominal pain, bronchospasm	Lack of coordination, anaphylaxis	Headache, itching, swelling, anxiety	Arrhythmia, dyspnea
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment or active hepatic disease. Monitor renal function before and during long term use	Shake oral suspension vigorously for 5-10 seconds before administering, dilute injection form (2ml) with normal saline to 5 or 10 ml	Should not be given to women who are pregnant or breastfeeding, Never apply a transdermal patch if seal has been broken or patch has been cut, damaged, or changed	Women who are planning a pregnancy should be advised to take folic acid daily before conception to prevent occurrence of neural tube defects,	Use cautiously in patients with history of seizures, screen for bipolar disorder before starting this medication for depression

Hospital Medications (5 required)

Brand/Generic	Merrem	Diflucan	Insulin	Lovenox	DUO-NEB
Dose	1g in 0.9NS	200mg	10 units	40mg	3ml
Frequency	Every 8 hours	Nightly	Nightly	Every 24 hours	4/day
Route	IV	Oral	SQ	SQ	Nebulizer
Classification	Antibiotic	Antifungal	Anti-diabetic hormone	Antithrombotic	bronchodilator

Mechanism of Action	Penetrate cell walls of most gram-negative and gram-positive bacteria, causes cell death	Damages fungal cells by interfering with a cytochrome p-450 enzyme needed to convert essential parts of the fungal cell membranes	Lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat. Inhibiting hepatic glucose production	Potentiates the action of antithrombin III, a coagulation inhibitor. Binds with and inactivates clotting factors.	Relaxes the muscles in the airway and increases air flow into the lungs
Reason Client Taking	Broad-spectrum antibiotic	Antifungal medication	Diabetes	Following surgery to avoid DVT.	Asthma
Contraindications (2)	Hypersensitivity to meropenem, other carbapenem drugs	Coadministration of drugs known to prolong QT interval, hypersensitivity to fluconazole or its component.	Hypoglycemia, allergy to insulin	Active major bleeding, history of heparin induced thrombocytopenia or immune HIT within past 100 days or in the presence of circulating antibodies.	Use cautiously on patients using diuretics, hypersensitivity to atropine
Side Effects/Adverse Reactions (2)	Headache, elevated liver enzymes	Prolonged QT interval, leukopenia	Hypoglycemia, swelling	Bloody stool, epidural or spinal hematoma.	Tachycardia, hypokalemia
Nursing Considerations (2)	Monitor patient for diarrhea (which could be c. Diff), add 10 ml of	Expect to obtain BUN and creatine levels, liver enzymes before	Monitor food intake and output, educate on healthy diet	Monitor for signs of bleeding, do not eject air bubble prior to injection	Educate patient to call if patient experiences cough, headache,

	sterile water for injection to 20 ml vial	starting medication, monitor hepatic and renal function			dizziness, nausea, or GI distress occurs, monitor lung sounds, blood pressure, and heart rate prior to and during use

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and orientated x3, does not appear to be in any acute stress, overall looks stated age.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	Skin pink, warm, dry and intact. Turgor within 3 seconds, no rashes or bruises. Braden score 11
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:**	. Head and neck symmetrical, all teeth present. No visual drainage from eyes or ears. Nose symmetric. Teeth intact.

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:**	. Heart sounds S1 and S2 present and strong. No rubs, murmurs or gallops present. All peripheral pulses present and strong. Capillary refill within 3 seconds No neck vein distension or edema
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	When breathing, patient did not use accessory muscles. Breath sounds were clear bilaterally with no rubs or crackles.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **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:**	. Patient is on a normal diet but urged to stay away from spicy foods and dairy due to GERD. Patient is 5'5" and weighs 100.4lbs Bowel sounds were strong and present. Last bowel movement was on 2/13 During inspection observed ostomy bag, and a drain for an abscess in the abdomen. No other scars or incisions were viewed by this nurse. Drain was freshly covered and not physically viewed.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	 Urine was cloudy, yellow and had small traces of pus. Patient reported no pain with foley catheter size 16.

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**☐	. Strength was strong and equal bilaterally in hands and legs. Patient was a fall risk with a score of 16. Patient needs assistance to stand up and walk. Neurovascular status was intact, and patient had full range of motion. Patient is to remain in bed.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient was alert and orientated x3, mental status and sensory appeared to be intact. Patient reported she had no LOC Strength was equal and strong bilaterally in both arms and legs.
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):**	Patient had her daughter with her since she was admitted the night before and said her daughter was supportive and very helpful with her care.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1530	80	119/62	16	97.0 F	95
N/A – left early	N/A	N/A	N/A	N/A	N/A

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

1530	0	N/A	N/A	N/A	NA
N/A – left early	N/A	N/A	N/A	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:**	20 gauge IV in left hand. 2/12/20 IV patent No signs of erythema, drainage IV dressing was dry, clean and intact

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
600 mL	250 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was admitted and had a stool diagnostic test to rule out C. Diff. Patient was placed on contact isolation pending the results of her stool test. Patient has a drain in her abdomen draining an abscess. Patient is working on pain management control and working to figure where her abdominal pain is coming from.

Procedures/testing done: C. diff

Complaints/Issues: Abdominal pain

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: Yes

Physician notifications: N/A

Future plans for patient: Continue IV therapy, PT, OT, pain management

Discharge Planning (2 points)

Discharge location: Nursing home Gardenview Manor – met with social worker to try to get moved to a different nursing home.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Follow up with primary care provider in 2 weeks following discharge

Education needs: Diet modifications

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

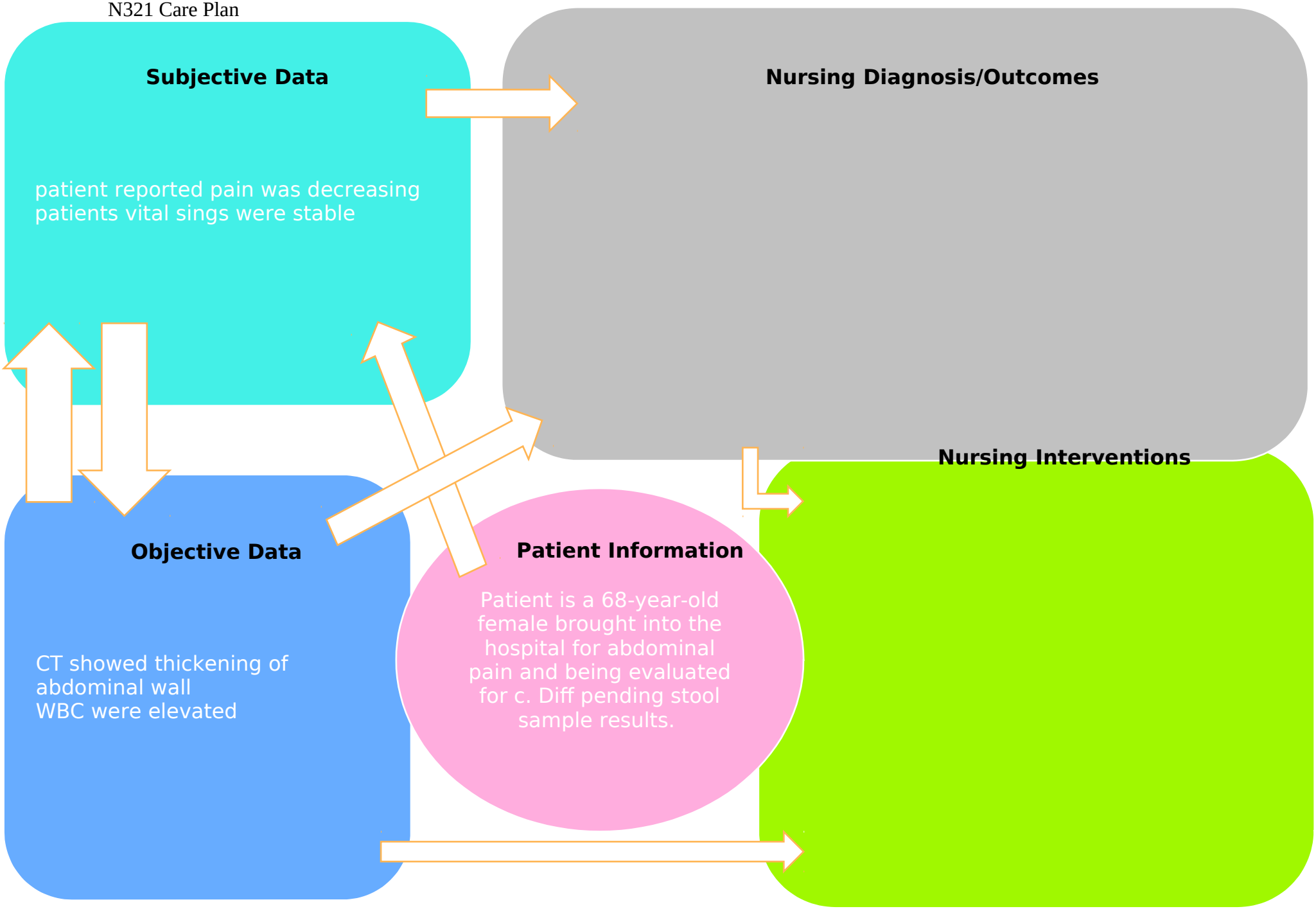
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for infection related to foley catheter.	Foley catheters make for a greater risk for a patient to acquire an infection.	1.Ensure when administering / removing foley to have sterile field 2.Have proper hand hygiene and ensure perineal care is done using soap and water.	Short day, wasn't able to discuss interventions with patient
2. Risk for impaired skin integrity related to ostomy.	Patient is at a higher risk of impaired skin integrity due to the opening in the abdomen for the ostomy bag.	1. Ensure ostomy bag is being properly taken care of to maintain skin integrity. 2.Report any signs to physician as soon as	Short day, wasn't able to discuss interventions with patient

		any changes in skin integrity are noticed.	
3. Risk for anxiety related to continuous abdominal pain.	Patient is at risk for anxiety due to continuous abdominal pain. Could also have anxiety due to her own medical history and her families past medical history.	1. Educate patient on signs and symptoms of medical problems to be aware and proactive of. 2. Educate patient on relaxation techniques and pain-relieving alternatives like massage, meditation, massage, etc.	Short day, wasn't able to discuss interventions with patient

Other References (APA):

Concept Map (20 Points):

N321 Care Plan



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