N431 Care Plan #1

Lakeview College of Nursing

Lindsey Davis

Demographics (3 points)

Date of Admission 2/20/2020	**Patient Initials** AT	**Age** 39yrs.	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Disabled	**Marital Status** Married	**Allergies** Adhesive bandage Contrast media
Code Status Full	**Height** 182.88cm	**Weight** 114.0kg	

Medical History (5 Points)

Past Medical History: Acute on chronic, necrotizing pancreatitis, Attention deficit disorder, arthritis, asthma, bronchitis, acute and chronic pancreatitis, colitis, depression, diabetes mellitus, GERD, hiatal hernia, hypercholesterolemia, hypertension, sleep apnea

Past Surgical History: liver biopsy, appendectomy, ERCP, hand implantable venous access port, nephrectomy, a pancreatic stent.

Family History: Father- hypertension, and stroke. Mother- breast cancer

Social History (tobacco/alcohol/drugs): Denies alcohol and drugs. Former smokers quit more than 30 days ago (4 or fewer cigarettes a day). The patient admitted to still chewing tobacco but slowly trying to cut back (about one can per week).

Assistive Devices: No assistive devices needed.

Living Situation: Patient lives at home independently with spouse and daughter.

Education Level: High school graduate

Admission Assessment

Chief Complaint (2 points): Severe epigastric pain, ongoing problem.

History of present Illness (10 points): The patient was brought to Sarah Bush Hospital emergency department via EMS on 2/20/2020, for severe epigastric pain. Patient was at home playing on the floor with his daughter when the abdominal pain became unbearable. Patient

points to is upper and lower left quadrant areas as the main source of pain. He denies pain radiating to any other locations of the body. He states he had not been feeling well before this admission also acknowledges that he was not taking his insulin as prescribed due to low food intake and not feeling well. Patient states that his normal pain level daily is a 7, but his pain was an 11 when he came into the emergency room. He said the pain was constant, sharp pain making him feel nauseous but denies ever vomiting. Patient states just moving made the pain worse, and due to his history with pancreatitis, he knew his only option was to go to the hospital and did not attempt any relieving factors at home. The Patient's pain started in the evening, and he was not doing anything specific to cause the pain. Patient was admitted for pain management.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute pancreatitis

Secondary Diagnosis (if applicable): Acute abdominal pain

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

Acute pancreatitis is an “inflammatory disease of the pancreas that can result from episodes of untreated cholecystitis caused by gallstones.” (Capriotti and Frizzell, 2016, p. 733). The common contributing factor is the obstruction of the pancreatic duct by gallstones, and these block the free flow of enzymes. Once enzymes are backed up, which allows for autodigestion of the gland parenchyma and destroys cells of the pancreatic. This leads to severe damage to the pancreas leading to edema, vascular insufficiency, and ischemia. People are more at risk for pancreatitis if they have “abdominal trauma, hypercalcemia, hyperparathyroidism, hypercalcemia, hypertriglyceridemia, and alcohol abuse” (Hinkle et al., 2018).

Characteristics associated with acute pancreatitis are severe abdominal pain that can radiate into the back and left shoulder. Symptoms include “nausea, vomiting, diarrhea with anorexia. Fever, tachycardia, and hypotension, dyspnea, and tachypnea may also occur” (Capriotti and Frizzell, 2016). During the assessment, abdominal tenderness, muscular guarding, and distention are commonly observed. Patients may appear jaundice, pale, diaphoretic, and lethargic.

Diagnostic testing related to pancreatitis is abdominal and endoscopic ultrasound, CT scan, chest x-ray, and magnetic resonance cholangiopancreatography (MRCP). Laboratory blood work includes complete blood count (CBC), blood glucose level, blood urea nitrogen, serum calcium, lactic dehydrogenase, amylase, and lipase. Elevated lipase level is a true indicator of acute pancreatitis.

This patient's flare-up is unknown to why but does follow many of the expected findings. Patient presented with severe abdominal pain, with symptoms of nausea, tachycardia, and abdominal guarding. Patient received many blood tests: CBC, blood glucose level, calcium, lactic acid, and lipase. The patient's lipase was consistently elevated, pointing to acute pancreatitis as a cause. Patient also received a chest x-ray to rule out other issues; chest x-ray came back normal. Patient also received a CT scan of the abdomen a week before admission at an outside hospital concerning his pancreatitis.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Ball, B. S., Holman, H. C., … Lemon, T. (2016). *Rn adult medical surgical nursing: review module*. Assessment Technologies Institute.

Hinkle, J. L., Cheever, K. H., & Hinkle, J. L. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing*. Wolters Kluwer.

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	4.2-5.4	5.16	n/a	
Hgb	12-16	13.7	n/a	
Hct	37-47	39.8	n/a	
Platelets	150,000-400,000	391,000	n/a	
WBC	5,000-10,000	9,200	n/a	
Neutrophils	2.0-7.0	6.3	n/a	
Lymphocytes	1.0-3.0	2.8	n/a	
Monocytes	4-6%	6.0	n/a	
Eosinophils	7% or less	1.9	n/a	
Bands	45-75%	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	138	136	
K+	3.5-5.0	4.2	4.0	
Cl-	98-107	94	100	"Decreased in acute pancreatitis complication of pancreatitis related to hypoalbuminemia and calcium-binding by excessive fats" (Bladh, 2019, pg 256).
CO2	22-29	24	29	
Glucose	70-100	531	115	"Increased pancreatitis related to decreased pancreatic function" (Bladh, 2019, pg 626).
BUN	6-20	11	4	"Decreased in inadequate dietary protein urea nitrogen is a by-product of protein metabolism; less available protein is reflected in decreased BUN levels" (Bladh, 2019, pg 1182).
Creatinine	0.6-1.3	0.69	0.71	
Albumin	3.5-5.2	4.3	n/a	
Calcium	8.6-10	8.9	8.3	
Mag	1.7-2.2	n/a	n/a	
Phosphate	2.5-4.5	n/a	n/a	
Bilirubin	0.1-1.2	0.2	n/a	
Alk Phos	20-140	123	n/a	
AST	10-30	16	n/a	
ALT	10-40	13	n/a	

Amylase	56-90	n/a	n/a	
Lipase	0-110	148	n/a	"Increased chronic diseases of the pancreas that cause permanent damage to acinar cells. Lipase is contained in pancreatic tissue and is released into the serum when cell damaged, or necrosis occurs" (Bladh, 2019, pg 780)
Lactic Acid	0.5-1	1.4	n/a	"increase in diabetes inefficient aerobic glycolysis and decreased blood flow caused by diabetes result in accumulation of lactic acid from anaerobic glycolysis" (Bladh, 2019, pg 763)
Troponin	>0.03	n/a	n/a	
CK-MB	>90	n/a	n/a	
Total CK	30-170	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	0.9-1.2	n/a	n/a	
PT	11-14	n/a	n/a	
PTT	0-250	n/a	n/a	
D-Dimer	0-250	n/a	n/a	
BNP	<100	n/a	n/a	
HDL	<40	n/a	n/a	
LDL	>100	n/a	n/a	
Cholesterol	<200	n/a	n/a	
Triglycerides	<150	n/a	n/a	

Hgb A1c	<7%	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	5.0-8.0	n/a	n/a	
Specific Gravity	1.005-1.035	n/a	n/a	
Glucose	Normal	n/a	n/a	
Protein	negative	n/a	n/a	
Ketones	Negative	n/a	n/a	
WBC	<5	n/a	n/a	
RBC	0-3	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	7.42	n/a	
PaO2	80-100	80.5	n/a	
PaCO2	35-45	35.0	n/a	
HCO3	21-28	23.4	n/a	
SaO2	95-100	96.0	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):

M., V. L. A., & Bladh, M. L. (2019). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications*. Davis Company.

Diagnostic Imaging

Other Diagnostic Tests (5 points):

A chest x-ray was performed on 2/20/2020.

Diagnostic Test Correlation (5 points):

The patient received a chest x-ray on 3/20/20. This test is used to "evaluate the cardiac, respiratory, and skeletal structure within the lunch cavity and diagnose multiple diseases" (Bladh, 2019, pg301). Due to this patient coming in with severe epigastric pain, the doctors wanted to rule out any kind of infection and check the lung cavity for abnormalities. His chest x-ray came back with normal heart size, clear lungs, osseous structures are intact, and no visualized pneumothorax or pulmonary embolism. Due to this test coming back negative for any

abnormalities, this helps diagnose him with acute on chronic pancreatitis with pain relating to his flare-up.

Diagnostic Test Reference (APA):

M., V. L. A., & Bladh, M. L. (2019). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications*. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Venlafaxine/ effexor	FentaNYL/ Abstral	Atenolol/ Tenormin	insulin lispro/ admelog	Albuterol/ Proari HFA
Dose	25 mg	25mcg	50 mg	100 units	90 mcg
Frequency	daily	One patch every 72 hours	daily	daily AM	inhalation
Route	oral	IV	Oral	SQ	PRN
Classification	non-steroidal aromatase inhibitor	Opioids	Beta-blocker	Antidiabetic	Beta-2 agonists
Mechanism of Action	inhibits enzymatic	Binds to various	Selectively antagonizes beta-1	Stimulates peripheral glucose	Selectively stimulates beta-2

	androgen conversion to estrogen	opioid receptors, producing analgesia and sedation	adrenergic receptors	uptake	adrenergic receptors, relaxing airway smooth muscle
Reason Client Taking	antidepressant	Given during EC TEE	Hypertension	Type 1 diabetic	Asthma
Contraindications (2)	avoid abrupt withdrawal, no alcohol use	Caution if renal impairment hepatic impairment	Sinus bradycardia and heart failure patients	Caution if hypokalemia or renal impairment.	Severe hypersensitivity to milk protein. Caution if ischemic heart disease.
Side Effects/Adverse Reactions (2)	suicidality, seizures	Respiratory depression apnea	angina exacerbation if abrupt d/c. Raynaud phenomenon	Injection site lipodystrophy, Hypoglycemia	Bronchospasm, anaphylaxis
Nursing Considerations (2)	Cr at baseline, lipid panel	ECG monitor vital signs	Monitor Heart rate and blood pressure	Monitor for visual impairment, caution if hepatic impairment.	Monitor for allergic reactions. Monitor heart rate.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess the nursing mental status. Check electrolytes	Assess vital signs for respiratory depression. Monitor for CNS changes.	Monitor I&O and daily weight.	Check blood glucose as prescribed. Monitor site of the administration site, route	Monitor for tachycardia; listen to lung sounds.
Client Teaching needs (2)	Notify prescriber of rash, hives, or allergic	Notify prescriber is hives, rash —caution	Not discontinue product abruptly.	Teach how to monitor blood sugar. Teach the	How to give an inhaled medication

	reaction—caution when driving could cause drowsiness.	when driving could cause drowsiness.	Report bradycardia, dizziness.	signs of hypoglycemia and hyperglycemia	. Teach normal side effects, elevated heart rate, nervous

Hospital Medications (5 required)

Brand/Generic	enoxaparin/ lovenox	Zofran/ onansetron	acetaminophen-hydrocodone/ Norco	Dextrose 10% in water/	hydromppphone/ Dilaudid
Dose	40 mg	4 mg	325 mg	250mL	2mg
Frequency	daily	PRN (q6hr)	PRN (q6hr)	1x bolus	PRN (q2hr)
Route	Sq	IV push	Oral	IV	IV push
Classification	anticoagulant	anti nausea/ vomiting	Opioid	Fluid	Opiate analgesic
Mechanism of Action	binds to antithrombin and accelerates activity	selectively antagonizes serotonin 5-HT3 receptors	Binds to opiate receptors in CNS to reduce pain	Needed for adequate utilization of amino acids	Inhibits ascending pain pathways in CNS

Reason Client Taking	patient is at risk for PE or DVT due to inactivity	Pt take for nausea	Epigastric pain	Hypoglycemic	Epigastric pain
Contraindications (2)	hepatic impairment, coagulation disorder	QT prolongation, bradycardia	Do not abruptly d/c. Cushing's	Do not use during hyperglycemia episodes. Hemorrhage	If hypersensitivity to addiction**.** caution in renal/hepatic disease
Side Effects/Adverse Reactions (2)	hemorrhage, thrombocytopenia	ECG if electrolyte abnormalities, CHF	Drowsiness Dizziness	Hyperglycemia or fluid volume overload.	Sedation Seizure Respiratory depression
Nursing Considerations (2)	monitor CBC, and platelet	CK levels and LFTs	Monitor for CNS changes such as dizziness, hallucinations.	Inspect site for a patent IV site. Check for edema or necrosis.	Assess for respiratory dysfunction. Assess pain control
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess for bruising, scaring. Monitoring for site irritation.	Continue monitoring nausea. Monitor for constipation in long term use.	Continue pain assessments. Monitor for nausea/vomiting, gastrointestinal upset.	Check electrolytes (K, Na, Ca, Cl, Mg)	Assess Bowel function, Assess for CNS changes.
Client Teaching needs (2)	Teach that patient is at a higher risk for bleeding. No razor use, soft bristle toothbrush.	Teach them that long term use causes constipation. Teach route of administration PO, sublingual, and IV.	Report CNS changes. That withdrawal symptoms may occur nausea, vomiting, cramps, fever, faintness, anorexia.	The reason for the dextrose infusion. Review the symptoms of hypoglycemia and hyperglycemia.	That physical dependency may result when used for an extended time. Avoid driving,

					other hazardous activities, drowsiness may occur.

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient appeared tired and in pain due to lack of an IV. No pain medications could be given at this time. Patient had facial grimacing during the interview. Patient knew where he was, who he was, the year, and the president. A&O x4. Besides the pain, the patient had no complaints, and the only request was for coffee.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ■** **Type:**	The Patient's skin is pink, dry, and warm. Patients' stomach and back appear well moisturized, and no rashes detected. Skin integrity was intact, localized abnormalities. Patient did appear to have small scabs on his body, upper extremities mainly. Lower extremities have no pitting edema, and no varicose veins present. Nails normal for ethnicity. Cap normal less than 3 seconds. Skin turgor was normal, 1 second of tenting. No wounds or bruises were noted on the assessment. The Patient's Braden score was 22.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Pupils are symmetrical, with no sclera. Head and Neck appear in normal limits. No jugular vein distention, no carotid bruit, no lymphadenopathy. Trachea midline, no thyroid tenderness. The ear is within normal limits and hearing intact, pearly grey tympanic membrane. Patient denies the use of glasses. The nose appears normal, with no deviation, turbinates inspected. Patient has no dentures, and no cavities noted at this time.

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:**	Regular rate and rhythm, S1 and S2 are normal, no murmurs/rubs/or gallops, point of maximal intensity non displaced. The capillary refill was normal within 3 seconds. Nail beds normal for ethnicity. +2 edema on the ankle, pedal bilaterally. Pulses normal 3+ radial and dorsal bilaterally. Pulses intact and symmetrical in all extremities.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ■** **Breath Sounds: Location, character**	Patient does sound clear in upper and lower lungs bilaterally both anterior and posterior upon auscultation. No rales/rhonchi/wheezes. Patient has regular unlabored breathing—patient on room air. No cough noted.
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 does not follow any special diets at home. But is on a restricted fat diet during this admission due to his chronic pancreatitis. Weight is 140.0 kg, and height is 182.88cm, making the BMI 41.9, placing this patient in the obese category for his height and weight. Normal bowel sounds normal in all four quadrants (sounds heard within 1 minute). resonant to percussion, soft, non-distended and tender on the right side both upper and lower quadrants., no rebound or patient was guarding on the right side, no hepatomegaly. No palpable masses. No eating difficulties, fair appetite, no nausea. No voiding difficulties, no bladder distention. Last bowel movement was 2/19/2020
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's urine is light yellow to clear. No visible sediment, no foul smell.
MUSCULOSKELETAL (2 points):	Patient reports pain in the upper and lower left

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☐**	quadrants. No signs of pallor, paresthesia, or paralysis, a pulse is within the normal range. Patient is about to complete ROM exercises on his own. Patient does not need supportive devices, and the patient is up ad-lib. Patients strength is 5/5 bilaterally on upper and lower extremities. Patients fall score is 35.
NEUROLOGICAL (2 points): **MAEW: Y** ■ **N☐** **PERLA: Y** ■ **N☐** **Strength Equal: Y** ■ **N ☐ if no -** **Legs ☐ Arms ☐ Both** ■ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patients' pupils were equal, round, and reactive to light when assessing with a penlight. Patient was orientated to person, place, time, and situation. The Patient's level of consciousness was within normal limits. The patient was easily arousable. The Patient's speech was clear and easy to understand. Judgment is intact. No 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):**	Patients coping methods are watching TV and chewing tobacco. Patient completed the 12th grade. Patient is a Christian and believes in God. Patient lives at home independently with his wife and daughter.

Vital Signs, two sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:39	76	153/95	18	36.1	94
15:10	94	153/90	18	36.8	96

Vital Sign Trends:

The patient's blood pressure is elevated consistently, and this could be due to his chronic pain or hypertension. Patients Oxygen saturation was low at 7:39, and it's possible that the patient could have been sleeping at this time, and this number would be reflective of his sleep apnea diagnosis.

Pain Assessment, two sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
12:55	numeric scale	abdomen	10	dull/constant	pain meds given
15:13	numeric scale	upper and lower abdomen	8	dull/constant	notified nurses, pain meds can not be given. Offered to dim lights and shut the door.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **The date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 gauge-Midline Right upper arm 2/24/20 @ 12:55pm Right midline was clamped, and no line attached. Site was dry, clean, and intact. Dressing was allusive with stat lock in place, no phlebitis or infiltration present, catheter present, and patent.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
3360	1400

Nursing Care

N431 Care Plan

Summary of Care (2 points)

Overview of care:

During this shift, we worked on getting the patient's pain level down to a comfortable level. By administering IV pain medications, offering dim lights, a shut door for quiet, and tv for distraction.

Procedures/testing done:

Patient did not have to leave the floor for any procedures. Patient had morning lab work done. Patient lost his IV due to infiltration, and IV start was unsuccessful, so a midline was placed in the patient's right upper arm. Patient tolerated the procedure well.

Complaints/Issues:

The only complaint was pain control. Due to the loss of IV, IV pain medications were unable to be given promptly. This was resolved with the placement of midline.

Vital signs (stable/unstable):

Patients vitals were stable for condition and past medical history.

Tolerating diet, activity, etc.:

Patient ambulated on his own to the bathroom and bed. And tolerated an omelet and potatoes during my shift.

Physician notifications:

Physician was not notified on my shift.

Future plans for patient:

The plan is to get the patient's pain to a manageable level for oral pain medications. Patient lives at a seven pain level daily. And then follow up at Northwestern Hospital concerning getting pancreatectomy.

N431 Care Plan

Discharge Planning (2 points)

Discharge location:

Patient will be discharged home with his wife and daughter.

Home health needs (if applicable):

No needs.

Equipment needs (if applicable):

No needs.

Follow up plan:

Patient will follow up with doctors at Northwestern Hospital in regards to pancreatectomy.

Education needs:

Patient could use education on managing Diabetes while sick if efforts to better control their diabetes.

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, the status of goals and outcomes, modifications to plan.
1. At risk for falls related to multiple pain medications prescribed.	Patient is only multiple pain medication ordered.	**1.** Bed alarm **2.** hourly rounding	Verbalized understanding of importance.
2. Acute pain related to irritation and edema of the inflamed pancreas.	Related to pancreatitis	**1.** Alternating pain schedule for medications. **2.** Providing nonpharmacological	Patient was receptive to nonpharmacological interventions such as dim lights and door closed.

		interventions for pain.	
3. Risk for unstable blood glucose level as evidence by high blood sugar on admission.	Related to his type 1 diabetes	1. ACHS glucose checks. 2. Monitor for signs and symptoms of hyperglycemia	Patient actively participated in glucose checks with no complaints. Patients' blood sugar is still high but better controlled.
4. Risk for infection related to hyperglycemia.	Because of his type 1 diabetes, he is more at risk for infection.	1. The monitoring lab works for elevated WBC count. **2.** Monitor temperature change or elevated heart rate.	Patient participation is regular vital checks. And verbalized understanding of the reason for blood work.

Other References (APA):

Ladwig, G. B., & Ackley, B. J. (2016). *Mosbys Guide to Nursing Diagnosis.* Elsevier Health Sciences.

Concept Map (20 Points):


Subjective Data
Severe abdominal pain (dull constant pain)
Nausea
Pain scale is 9
Denies alcohol and drug use
Former tobacco smoker
Currently chews tobacco
Home diet: regular
No difficulties voiding
Last bowel movement 2/19/20
Nursing Diagnosis/Outcomes
sk for falls related to multiple pain medications prescribed
Verbalized understanding of importance.
Acute pain related to irritation and edema of the inflamed pancreas.
Patient was receptive to non-pharmacological interventions such as dim lights and do
closed.
Risk for unstable blood glucose level as evidence by high blood sugar on admission.
Patient actively participated in glucose checks with no complaints. Patients' blood su
still high but better controlled.
Risk for infection related to hyperglycemia.
Patient participation is regular vital checks. And verbalized understanding for the rea
for blood work.
Nursing Interventions
Objective Data
Abdominal guarding
Braden score:22
Fall risk: 35
A&O x4
Regular heart rate and rhythm
Judgement intact
Appetite: fair
Active bowel sounds in all 4 quadrants
Hearing intact
No rashes
Skin pink, dry and warm
Patient Information
39yr old male
Caucasian
Full code
Height: 182.88 cm
Weight: 114.0 kg
Allergies: Adhesive bandage and contrast media
Married
Bed alarm
Hourly rounding
lternating pain schedule for medications.
roviding non pharmacological interventions for pain
CHS glucose checks.
Monitor for signs and symptoms of hyperglycemia
Monitoring lab work for elevated WBC count.
Monitor for temperature change or elevated heart rate