N311 Care Plan #

Lakeview College of Nursing

Name

N311 Care Plan

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
01/18/20	JAL	36	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Waitress	Married	Sulfa
Code Status	**Height**	**Weight**	
Full Code	5' 6"	130 lb	

Medical History (5 Points)

Past Medical History: Crohn's disease with intermittent gastritis.

Past Surgical History: Abdominal surgery and ileostomy six months ago.

Family History: Father has a history of hypertension and diabetes. Mother has a history of gastric ulcers and ulcerative colitis. Brother suffers from heart disease.

Social History (tobacco/alcohol/drugs): The patient describes herself as a "social drinker", and reports having two to three drinks once a week. She denies the use of tobacco or recreational drugs.

Admission Assessment

Chief Complaint (2 points): Abdominal pain, weakness, dizziness

History of present Illness (10 points):. Onset: A 36-year-old woman presented to the Emergency Department with a complaint of abdominal pain, weakness, and dizziness. She reports her symptoms began upon waking up this morning on 1/18/20. Location: She states the pain is located at the top of her stomach. Duration: The patient reports her symptoms have been constant since waking up this morning. Characteristics: Ms. Lieberman describes her pain as sore and crampy, and would rank her current pain as a 6/10 on a scale of 0 to 10. Associated Manifestations/Aggravating Factors: There were traces of

serosanguineous effluent present in the ostomy bag upon arrival. She states that her abdominal pain is worsened with stress. She explains that when she is stressed, she also suffers from associated headaches. Relieving Factors: She states she takes Ibuprofen for her associated headaches, and attempts to relieve stress with unhealthy eating. Treatment: Patient started Infliximab IV six months ago, with her last received dose given seven months ago.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):. Risk for bleeding.

Secondary Diagnosis (if applicable):. Fluid volume deficit related to diarrhea as evidenced by hypotension.

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

GI bleeds can be caused by a lesion, erosion, ulceration, varicose vein, or tear in the GI lining. Disorders, such as PUD, esophageal varices, Mallory-Weiss syndrome, Boerhaave syndrome, esophageal cancer, and hemorrhagic gastritis and many additional conditions, can cause a GI bleed (National Institute of Diabetes and Digestive and Kidney Disease, 2016). The morbidity rate of GI bleeding is directly relative to the amount of blood lost during the bleed (Capriotti & Frizzell, 2016).

A GI bleed to be classified as chronic or acute. An acute bleed is due to a rupture, tear or perforation in the esophageal, gastric, or colon lining. A chronic bleed results from a small tear or opening in the GI tract that causes gradual blood loss. An acute GI bleed with a large loss of blood may result in sudden hypotension and hypovolemic shock. Meanwhile, a chronic bleed may cause fatigue, low hemoglobin, and low iron levels and resulting anemia (Capriotti and Frizzell, 2016). GI bleeds may also lead to tachycardia, tachypnea, anxiety, weakness and dizziness (National Institute of Diabetes and Digestive and Kidney Disease, 2016). Hematemesis (bright blood or coffee ground vomit) and melena (black tarry stool) indicate an upper GI bleed, while bright red stool may indicate a lower GI bleed (Capriotti and Frizzell, 2016).

A stool guaiac test or fecal occult blood test (FOBT) confirm the presence of blood in stool. Decreased fluid volume and decreased absorption of blood proteins into the intestines may result in elevated BUN levels. Other diagnostic tests for GI bleeds include CBC, endoscopy, video capsule endoscopy to visualize the entire GI tract (Capriotti & Frizzell, 2016).

For an acute GI bleed, treatment includes rapid fluid replacement, insertion of a nasogastric tube to prevent abdominal distention from accumulation of blood, and blood transfusion to replace lost blood. Laparoscopic and open surgical repair of the injured site is also used for acute bleeds with significant blood loss. Chronic GI bleeds are typically treated with proton pump inhibitors (PPIs), such as omeprazole for 4 to 8 weeks. Adhesive medications, such as sucralfate, may also be used to protect the gastric lining if ulceration is the cause of bleeding (Capriotti & Frizzell, 2016).

Pathophysiology References (2) (APA):

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

National Institute of Diabetes and Digestive and Kidney Disease. (2016). ***Symptoms & causes of GI bleeding.*** **https://www.niddk.nih.gov/health-information/digestive-diseases/gastrointestinal-bleeding/symptoms-causes**

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.0 - 4.9 million mm^3	2.7 million/mm^3	N/A	RBCs are decreased due to overall blood loss through the GI tract.
Hgb	12.0 - 16.0 g/dL	7 g/dL	N/A	Decreased Hgb has occured due to a decrease in RBCs.

Hct	**37.0 - 48.0%**	**21%**	**N/A**	**Hct is also decreased due to fewer RBCs present from blood loss.**
Platelets	**150 - 400 10^3**	**162,000/mm^3**	**N/A**	
WBC	**4.1 - 10.9 10^3/uL**	**6,000/mm^3**	**N/A**	
Neutrophils	**1.50 7.70 10^3/uL**	**2.0 10^3/uL**	**N/A**	
Lymphocytes	**1.00 - 4.90 10^3/uL**	**1.15 10^3/uL**	**N/A**	
Monocytes	**0.00 - 0.80 10^3/uL**	**0.20 10^3/uL**	**N/A**	
Eosinophils	**0.00 - 0.50 10^3/uL**	**0.10 10^3/uL**	**N/A**	
Bands	**N/A**	**N/A**	**N/A**	

Coagulation- I have included these values due to their pertinence to the patient's care plan.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Partial Thromboplastin Time (PTT)	**10 - 12 seconds**	**21 seconds**	**N/A**	
Prothrombin Time (PT)	**30 - 45 seconds**	**12.2 seconds**	**N/A**	
International Normalized Ratio (INR)	**1 - 2**	**0.7**	**N/A**	

Type and Cross Match- I have included these values due to their pertinence to the patient's care plan.

✓ Type and Cross Match including antibody screen	**✓ Type (ABO, RH)**
Blood Type: Type A	**RH factor: Negative**

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-	136 - 145 mEq/L	140 mEq/L	N/A	
K+	3.5 - 5.1 mEg/L	3.6 mEg/L	N/A	
Cl-	98 - 107 Eg/L	101 Eg/L	N/A	
CO2	21.0 - 32.0 mmHg	23 mmHg	N/A	
Glucose	60 - 99 mm/dL	65 mm/dL	N/A	
BUN	5 - 20 mg/dL	5 - 20 mg/dL	N/A	
Creatinine	0.5 - 1.5 mg/dL	1.0 mg/dL	N/A	
Albumin	3.4 - 5.4 g/dL	5.0 g/dL	N/A	
Calcium	8.5 - 10.1 mg/dL	9.1 mg/dL	N/A	
Mag	1.6 - 2.6 mg/dL	1.0 mg/dL	N/A	
Phosphate	2.5 - 4.5 mg/dL	3.1 mg/dL	N/A	
Bilirubin	0 - 0.4 mg/dL	0.2 mg/dL	N/A	
Alk Phos	20 - 140 IU/L	30 IU/L	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	Colorless	Light yellow/clear	N/A	
pH	5.0 - 7.0	6.2	N/A	
Specific Gravity	1.003 - 1.005	1.004	N/A	
Glucose	Negative	Negative	N/A	
Protein	Negative	Negative	N/A	
Ketones	Negative	Negative	N/A	
WBC	0 - 25/uL	11/uL	N/A	
RBC	0 - 20/uL	13/uL	N/A	
Leukoesterase	Negative	Negative	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	N/A	N/A	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	

Stool Culture	**Negative for blood**	**Positive for blood**	**N/A**	**Positive blood occult in stool may be evidence of blood lost during a GI bleed.**

Lab Correlations Reference (APA):

Peace Health (2020). ***Stool analysis.***

https://www.peacehealth.org/medical-topics/id/aa80714#tp16704

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

No other tests available at this time.

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	**Morphine sulfate**	**0.9% sodium chloride**	**Infliximab IV**
Dose	**4 mg**	**1000 mL**	**5 mg/kg**
Frequency	**Q2hr prn for pain**	**150 mL/hr**	**Every 8 weeks (for maintenance)**
Route	**IV**	**IV**	**IV**
Classification	**Pain medication**	**Crystalloid**	**Tumor Necrosis Factor (TNF)-Alpha Inhibitors (Other classifications also available)**
Mechanism of Action	**Morphine is a potent mu-opiate agonist. Medication binds to opiate receptors to modulate pain.**	**Saline allows for the regulation of fluid levels by working with osmotic forces.**	**Medication inhibits the effects of tumor necrosis factor and therefore inhibiting inflammatory reactions.**

Reason Client Taking	**Pain management**	**Regulation of fluids and corresponding blood pressure.**	**This pain medication reduces the inflammatory reactions of Crohn's disease through action of tumor necrosis factor.**
Contraindications (2)	**Those with hypotension**	**N/A**	**Those with suppressed immune system.**
Side Effects/Adverse Reactions (2)	**Episode of severe hypotension and possible addiction.**	**N/A**	**Risk for developing infection.**

Medications Reference (APA):

Prescriber's Digital Reference (2020). ***Drug information.***

https://www.pdr.net/browse-by-drug-name

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is A & O x 3. She appears in mild distress.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score: 20**	**Skin is pale, warm, and dry to the touch. No presence of rashes, bruises or wounds. Patient has an ileostomy. The external apparatus appears clean and dry.**

Drains present: Y ☐ N ✓ **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is symmetrical. No adenopathy. Carotids are 2+. Thyroid is nonpalpable. Trachea is midline. Tympanic membrane is pearly gray, bilaterally. Auricles are pink and dry. For the eyes, sclera is white, cornea is clear, conjunctiva is moist and pink. No drainage from eye. EOMs intact. PERRLA. Nose is symmetrical. Turbinates are pink and moist, with no polyps present. Dentition is good.**
CARDIOVASCULAR: **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:**	**Clear S1 and S2 is present and regular without the presents of gallops or murmurs. Pulses are 2+, bilaterally. Capillary refill is less than 3 seconds.**
RESPIRATORY: **Accessory muscle use: Y☐ N ✓** **Breath Sounds: Location, character**	**Patient is slightly tachypneic. Clear lung sounds found throughout without crackles, wheezes or rhonchi.**
GASTROINTESTINAL: **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 ✓**	**Patient is on a regular diet with clear liquids. She is 5' 6" and 130 lb. Bowel sounds are active. Patient has serosanguinous stool present in her ostomy bag. Upon inspection, patient has no obvious abdominal distention or wounds. Stoma appears to be a red meaty color. Patient is tender upon palpation.**

Type:	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ✓** **Dialysis: Y ☐ N ✓** **Inspection of genitals:** **Catheter: Y ☐ N ✓** **Type:** **Size:**	**Patient is voiding light yellow urine with normal odor regularly. Genitals appear moist and pink upon inspection.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ✓** **Fall Risk: Y ☐ N ✓** **Fall Score:** **Activity/Mobility Status: Independent** **Independent (up ad lib) ✓** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**.Patient has good strength and full ROM in all extremities. She uses no supportive devices and receives no assistance with ADLs.**
NEUROLOGICAL: **MAEW: Y ✓ N☐** **PERLA: Y ✓ N☐** **Strength Equal: Y ✓ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**.Patient is orientated to person, place and time. She is of expected mental status. Speech is clear. Patient is alert and has no obvious sensory deficits.**
PSYCHOSOCIAL/CULTURAL: **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 method includes eating unhealthy food and practicing her faith, subjective. She is mature and at a sufficient developmental level for her age. Patient is a Christian, and reports her faith also "helps her during stressful times. Patient has a husband, and states she has a very close relationship with her mother and other friends and family members.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500	110	94/56	26	37.0 C (98.6 F)	95% on 2L
1530	114	100/60	22	37.1 C (98.8 F)	95% on 2L

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1530	0-10	Top of the stomach	6/10	Sore and crampy. Pain worsened with stress and with unhealthy food.	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
PO- 100 mL at 1530 IV- 300 mL at 1530 Total input - 400 mL	500 mL at 1500 Total output- 500 mL

Nursing Diagnosis (15 points)

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Must be NANDA approved nursing diagnosis

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 bleeding.	**This patient may be at risk for a GI bleed. This is evidenced by abnormal decreases in the RBC, Hgb and Hct values, which are characteristics of GI bleeding (Hulland, 2018).**	**1. Teach about unintended or adverse effects of medication, such as ibuprofen, that increase the risk for bleeding or prolong clotting** **2. Teach patient about promotion of a healthy lifestyle and stress management.**	**Goal met- Patient is able to teach back the undesired effects of ibuprofen that she takes in excess for headache relief.** **Goal met- Patient has discussed positive lifestyle changes that may help reduce stress.**
2. Fluid volume deficit related to diarrhea as evidenced by hypotension.	**The patient may suffer from fluid volume deficit due to the blood lost through the GI tract. The patient had serosanguinous stool draining from her ileostomy, which is an indicator of bleeding. The volume deficit may be further confirmed by her hypotensive state (Capriotti and Frizzell, 2016).**	**1. Administer parenteral fluids to prevent further fluid loss.** **2. Measure urine output at regular intervals of at least once an hour.**	**Goal partially met- Patient is receiving parenteral fluids, but we will continue to monitor vital signs for a more stabilized blood pressure.** **Goal met- Staff has measured urine output at regular intervals, ensuring accurate recordings.**

Other References (APA):

Hulland, O. (2018). ***Gastrointestinal bleed*****.** ***Acute Care Casebook*****, p. 155.**

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Concept Map (20 Points