N311 Care Plan #1

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission 03/11/2020	**Patient Initials** Z.S.	**Age** 55	**Gender** Male
Race/Ethnicity White/Caucasian	**Occupation** Plumber	**Marital Status** Single	**Allergies** Penicillin-Whole Body Hives
Code Status Full Code	**Height** 6'0"	**Weight** 80 kg	

Medical History (5 Points)

Past Medical History: N/A

Past Surgical History: Tonsillectomy at age 6.

Family History: Mother: no known problems; Father: Colon Cancer.

Social History (tobacco/alcohol/drugs): Pt reports use of tobacco (smoking) for 30 years, and smokes 2 packs a day. Pt also reports use of alcohol, and drinks 1 case (24) of beer a week.

Admission Assessment

Chief Complaint (2 points): Colon resection on 3/11, compression, nausea, and pain on sacral area.

History of present Illness (10 points): Onset: On March 11, a 55 y/o white, single, male was admitted to the Medical Surgical unit for a colon resection, and later that night, complained of compression, nausea, and pain in the abdomen and sacrum. Location: Stomach/abdomen and sacrum. Duration: Pt had colon resection yesterday, and started complaining of pain, nausea, and sacral pain last night. Characteristics: The pt is experiencing burning pain in his stomach and his nausea comes in waves. Pt states his pain is 5/10 on the numeric scale. Aggravating: Turning over makes his pain worse. Relieving: Sleep, and pain medication (only works for 10 minutes). Treatment: Use of incentive spirometer, PCA pump, nausea medication, turned pt, and provided TED hose and SCDs.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Colorectal cancer

Secondary Diagnosis (if applicable): Pneumonia

Pathophysiology of the Disease, APA format (20 points): Colorectal cancer is the second leading cause of death by cancer. It is preventative if patient's keep up with their screenings (Capriotti & Frizzell, 2016). This includes colonoscopies and fecal occult blood tests (Capriotti & Frizzell, 2016). If a patient is diagnosed with colorectal cancer, it usually requires surgery. Also, new advances in chemotherapy drugs are lowering chances of the disease (Capriotti & Frizzell, 2016). Experts suggest that after an individual turns 50, they have a screening every 10 years. Colorectal cancer usually occurs between the ages of 60-69 years of age (Capriotti & Frizzell, 2016).

While colorectal cancer can be preventable, it can also be genetic. It can start as a polyp, and in the later stages, the cells can break off and spread to other major organs, like the liver, via the blood stream (Capriotti & Frizzell, 2016). Other risk factors include tobacco use, poor diet, obesity, being physically inactive, and insulin resistance (Capriotti & Frizzell, 2016). Also, people who have Crohn's disease or IBD also have a higher risk of colorectal cancer (Capriotti & Frizzell, 2016). Signs and symptoms may include anemia, rectal bleeding, changes in bowel movements, bowel obstruction, or abdominal pain (Dragovich, 2020).

As mentioned previously, colorectal will usually start as a polyp that eventually becomes cancerous. These polyps are called adenomatous (Capriotti & Frizzell, 2016). About 90% of these are malignant and small, but the other 10% have a 10% chance of causing cancer, and are larger than the 90%, usually over 1 cm (Capriotti & Frizzell, 2016). "On a molecular level, colon cancer is caused by genetic changes that result in defective tumor suppressor genes, activated

oncogenes, or mismatched gene repair." (Capriotti & Frizzell, pg. 964). A build-up of mutations can lead to the development of normal colonic mucosal cells, to benign adenoma, to adenomatous polyps, to adenocarcinoma (Capriotti & Frizzell, 2016). There are three types of adenomatous polyps: tubular adenomas, villous adenomas, and tubulovillous adenomas (Capriotti & Frizzell, 2016). Tubular adenomas have a clump of cells and are attached to the intestinal wall through a stalk. Villous adenomas penetrate the intestinal wall with their fingerlike projections. These can be harder to remove, and they have the highest risk of mutating into cancer. Tubulovillous adenomas are a mixture of tubular and villous (Capriotti & Frizzell, 2016). An individual can also have a flat lesion instead of a polyp, and that can also lead to cancer. They are superficial, but then can go deep into the intestinal wall and then it would be considered adenocarcinoma (Capriotti & Frizzell, 2016).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P. (2016). *Pathophysiology: Introductory concepts and clinical perspectives.* (1st ed.). Philadelphia, PA; F.A. Davis Company.

Dragovich, T. (2020). *Colon cancer: Practice essentials, background, pathophysiology.* Retrieved March 18, 2020, from https://emedicine.medscape.com/article/277496-overview

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	4.5 – 6.3	3.9		Anemia caused by colorectal cancer
Hgb	14 – 18	11.4		Anemia; Decreased number of RBC's
Hct	41 – 15	36%		Anemia; Decreased number of RBC's
Platelets	140 – 440	140		

WBC	4 – 10	15.6		Fighting infection – Colorectal cancer
Neutrophils	2 – 6.9	81.4%		Primary WBC – Will respond to infection, like colorectal cancer
Lymphocytes	0.6 – 3.4	1.0		
Monocytes	0 – 8	6		
Eosinophils	0 - .5	0.1		
Bands	UNK	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-	136 – 145	142		
K+	3.5 – 5.1	4.2		
Cl-	98 – 107	99		
CO2	21 – 31	28		
Glucose	74 – 109	91		
BUN	7-25	15		
Creatinine	0.7 – 1.2	0.8		
Albumin	3.5 – 5.2	2.0		Colonoscopy – Intestines aren't absorbing and digesting proteins (Sarah Bush Lincoln Health Center, 2020).
Calcium	8.6 – 10.3	9.0		
Mag	UNK	n/a		
Phosphate	UNK	n/a		
Bilirubin	0.3 – 1.0	0.5		

Alk Phos	40 - 130	60		

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	N/A	N/A		
pH	N/A	N/A		
Specific Gravity	N/A	N/A		
Glucose	N/A	N/A		
Protein	N/A	N/A		
Ketones	N/A	N/A		
WBC	N/A	N/A		
RBC	N/A	N/A		
Leukoesterase	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	N/A	N/A		
Blood Culture	N/A	N/A		
Sputum Culture	N/A	N/A		
Stool Culture	N/A	N/A		

Lab Correlations Reference (APA):

Sarah Bush Lincoln Health Center (2020). *Reference range (lab values).* Mattoon, IL.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Chest X-Ray (CXR) – LLL consolidation

CT of Pelvis – Mass in sigmoid colon

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

Medications (5 required)

Brand/Generic	Cefazonlin/ Ancef, Kefzol	Metronidazole / Flagyl	Famotidine/ Pepcid	Enoxaparin/ Lovenox	Promethazine / Anergan
Dose	1000 mg	500 mg	20 mg	40 mg	50 mg
Frequency	Every 8 hrs	Every 6 hrs	Every 12 hrs	Every Day	Every 6 hrs prn
Route	IVPB	IVPB	IVPB	SQ	IV/IM
Classification	Antibiotic	Antiprotozoal	Antiulcer Agent	Anticoagulant	Antiemetic
Mechanism of Action	Impedes bacterial cell wall synthesis by blocking the final step in the cross-linking of peptidoglycan strands	Undergoes intracellular chemical reduction during anaerobic metabolism. After metronidazole in reduced, it damages DNA's helical structure and breaks its strands, which inhibits bacterial nucleic acid synthesis and causes cell death	In normal digestion, parietal cells in the gastric epithelium secrete H+ ions, which combine with Cl- ions to form HCl. HCl can inflame, ulcerate, and perforate gastric and intestinal mucosa normally protected by mucus. Famotidine reduces HCl formation by preventing histamine from	Potentiates the action of antithrombin III, a coagulation inhibitor, By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. Without thrombin, fibrinogen can't convert to fibrin and clots can't form.	Competes with histamine for H1- receptor sites, therefore antagonizing many histamine effects and reducing allergy signs and symptoms. It also prevents motion sickness, nausea, and vertigo by acting centrally on medullary chemoreceptive trigger zone and by decreasing vestibular stimulation and labyrinthine

			binding with H2 receptors on the surface of parietal cells.		function in the inner ear.
Reason Client Taking	Pneumonia	Prevent perioperative bowel infection	Prevent or treat GI bleeding in hospitalized patients who cannot take oral drug	Prevent DVT after abdominal surgery for patients with thromboembolic risk factors (cancer, general anesthesia lasting longer than 30 minutes, a history of DVT or pulmonary embolism, obesity, or over age 40).	Prevent or treat nausea and vomiting in certain types of anesthesia and surgery
Contraindications (2)	Hypersensitivity to cefazolin, other cephalosporins or their components	Disulfiram use within past 2 weeks, hypersensitivity to metronidazole or its components	Hypersensitivity to famotidine, other H2-receptor antagonists, or their components	Active major bleeding; history of heparin-induced thrombocytopenia (HIT) or immune-mediated HIT within past 100 days or in the presence of circulating antibodies	Benign prostatic hyperplasia, Stenosing peptic ulcer
Side Effects/Adverse Reactions (2)	Abdominal cramps, Nausea	Abdominal cramps or pain, Nausea	Abdominal pain, Nausea	Nausea, Thrombocytosis	Nausea, Vomiting (2020 Nurse's Drug Handbook, 2020).

Medications Reference (APA):

2020 Nurse's drug handbook. (2020). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and oriented to time, place and person x3 No distress Well-groomed and appropriately dressed
INTEGUMENTARY: **Skin color:**	 Normal for race

Character: **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	Dry/normal 98.6 F Good (no tenting/under 3 seconds) None None Clean, dry, and dressing intact 19 – mild risk Jackson Pratt Drain
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Normal pigment, symmetric, lymph nodes not palpable Pearly gray Tympanic Membranes PERRLA No turbinates or polyps, no septum deviation No decay, good condition
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:**	 Normal S1, S2 Regular Strong and equal Under 3 seconds
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 Left Lower – coarse crackles Right Middle - Wheezes
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 ☐**	 Normal/regular NPO 6’0” 80 kg Hypoactive in all 4 quadrants Laxatives the morning of the 11th Pain with palpation No Yes No J.P. – serosanguineous No

Size: **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	14
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	 Amber Clear but dark 350 mL Normal, no discharge Foley 12
MUSCULOSKELETAL: **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☒**	 Good ROM; moved extremities well Walker Weak bilaterally (arms and legs) Heavy assist with bath 60 – high risk 2 assist No Walker or wheelchair
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☒ Arms ☒ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Weak bilaterally (arms and legs) Alert and oriented x3 Alert and awake Clear None
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):**	 Supportive Fiancé Appropriate for age None Fiancé – “We are a team;” Good support at home

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0915	90 bpm	144/82 mmHg	24 rr	37.7 C	92% 2 mL nasal canula

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0915	Numeric	Abdomen; Buttocks	5	Burning, pressure, nauseous	Turn pt to right, cleared NG tube of clog, gave PCA pump, taught deep breathing, taught incentive spirometer (10x hr), sat pt up to get more O2

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
IV (125 lM/hr for 8hr shift) – 1 L 500 mL Cefazolin Piggyback 250 mL Metronidazole Piggyback Total = 1750 mL	350 mL – Urinary 600 mL – Emesis 10 mL – stoma bag (blood) 90 mL – JP drain Total = 1050 mL

Nursing Diagnosis (15 points)
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. Nausea	Related to clog in NG tube, as evidenced by: "I feel nauseous and	**1.** Administer Antiemetic every 6 hours prn for nausea relief.	Goal met. Meds are given by nurse every 6 hours as needed.

	no one has checked my NG tube all night."	**2.** Check NG often for clogs	Goal met. Kept NG tube clear of obstruction to function properly and reduce nausea.
2. Pain, Acute	Related to pain from stitches and not being repositioned, as evidenced by: "I have abdominal compression and no one has turned me all night."	**1.** Reposition client every 2 hours and use pillows for side lying position **2.** Teach pt to deep breath with pillow, and to use incentive spirometer 10x per hour.	Goal met. Repositioned pt every two hours, and used pillows for side lying position. Goal met. Pt now deep breathes with a pillow, and uses the incentive spirometer 10x an hour, and tries to reach 1000 each time.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Pt states: "My abdomen and bottom hurts from my stitches. It hurts to deep breath or cough. I have nausea that comes in waves. I have a burning pain in my stomach. It hurts to turn over."

Nursing Diagnosis/Outcomes

Nausea related to clog in NG tube, as evidenced by: "I feel nauseous and no one has checked my NG tube all night."
Goal met: Antiemetics are given every 6 hours as needed for nausea relief.
Goal met: Kept NG tube clear of obstruction to function properly and reduce nausea
Acute Pain related to pain from stitches and not being repositioned, as evidenced by: "I have abdominal compression and no one has turned me all night."
Goal met: Repositioned patient every 2 hours, and used pillows for side lying position.
Goal met: Patient now deep breathes with a pillow, and uses the incentive spirometer 10x an hour, and tries to reach 1000 each time.

Objective Data

Client's chief complain is compression and nausea, after a colon resection yesterday. He is diagnosed with colorectal cancer.
Vitals:
BP: 144/82
RR: 24
Temp: 37.7 C
Sp02%: 92%
Pulse: 90

Patient Information

Chest X-Ray shows LLL consolidation. CT of pelvis shows a mass in the sigmoid colon.

Nursing Interventions

Administer Antiemetic every 6 hours prn for nausea relief.
Check NG often for clogs.
Reposition client every 2 hours and use pillows for side lying position.
Teach patient to deep breath with a pillow, and to use incentive spirometer 10 times per hour.

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