N311 Care Plan #4

Lakeview College of Nursing

Ashley Holm

N311 Care Plan

Demographics (5 points)

Date of Admission 1/18/xx	**Patient Initials** J.L.	**Age:** 36 **DOB:** 06/29/xx	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Stockbroker	**Marital Status** Single	**Allergies** Sulfa
Code Status Full Code	**Height** 5'6"	**Weight** 130 lbs.	

Medical History (5 Points)

Past Medical History:

- Crohn's disease
- Intermittent gastritis
- Colectomy w/ Ileostomy due to Crohn's → **7/2009**

Past Surgical History:

- Colectomy (6 months ago)

Family History:

- No family Hx mentioned in scenario

Social History (tobacco/alcohol/drugs):

- **Tobacco:** Never
- **Drugs:** Never
- **Alcohol:** Sometimes up to 5 glasses per night

Admission Assessment

Chief Complaint (2 points):

- General weakness, Dizziness, Abdominal pain (RLQ w/ soreness and cramping), Serosanguineous effluent in ostomy bag.

History of present Illness (10 points):

- 36 y/o Caucasian female presents to the ED 01/18/xx, c/o generalized weakness, dizziness, and abdominal pain in RLQ. Has a history of intermittent gastritis and six months ago she had surgery and an ileostomy. She has serosanguineous effluent present in her ostomy bag upon arrival. She is c/o of abdominal pain at the RLQ that is sore and crampy with a pain level of 6 which started this morning. Vital signs on admission are: Blood Pressure 94/56, Pulse 110 bpm, O2 nasal cannula at 95% 2 L, Respiration 26,

Pain worsens during times of elevated stress due to poor eating habits and is accompanied by a headache that she ingests ibuprofen for treatment. On admission primary diagnosis is GI Bleed.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):

- GI Bleed

Secondary Diagnosis (if applicable):

- None

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

Crohn disease (CD), also know as chronic inflammatory disease that can involve any part of the gastrointestinal (GI) tract from the mouth to the anus. Usually the disease occurs segmentally, demonstrating discontinuous areas of disease with segments of healthy bowel in between. In 45%-50% of cases, the end of the ileum and cecum/ascending colon are involved (ileocolitis); in 35% of cases, the terminal ileum is affected (ileitis); and in 20% of cases, the colon alone is affected (Crohn colitis). A small number of patients have involvement of the jejunum, duodenum, stomach, esophagus, and mouth; in these cases, the ileum, colon, or both are also involved. Approximately 30%-35% of patients have perianal fistulas, fissures, or abscesses. A family history of this disease or ulcerative colitis occurs in 15%-20% of affected patients (Swearingen,2019).

The cause of Crohn Disease in unknown, but theories include infection, immunologic factors, environmental factors, and genetic predisposition. In a genetically susceptible subject, an outside agent of substance, such as a bacterium, virus, or other antigen, interacts with the body's immune system to trigger the disease or may cause damage to the intestinal wall, initiating or accelerating the disease process. The resulting inflammatory response continues unregulated by the immune system. As a result, inflammation continues to damage the intestinal wall, causing the symptoms of CD. It is a chronic disease that has no cure. However, there are effective treatments to aid in controlling the disease. Initial treatment is nonoperative, individualized, and based on symptomatic relief. Surgery is reserved for complications rather than used as a primary form of therapy (Swearingen,2019).

CD is generally diagnosed between the ages of 15 and 35 years, but it also can occur in young children and in people 70 years of age or older. Clinical presentation varies as a direct reflection of the location of the inflammatory process and its extent, severity, and relationship to contiguous structures. Sometimes onset is abrupt, and patients can appear to have appendicitis, UC, Intestinal obstruction, or a fever of obscure origin. Acute symptoms include RLQ pain, tenderness, spasm, flatulence, nausea, fever, and diarrhea. More typical is insidious onset with more persistent but less severe symptoms, such as vague abdominal pain, unexplained anemia, and fever. Diagnostic test includes: Stool examination, Sigmoidoscopy, Colonoscopy, Endoscopic ultrasonography, Small bowel enteroscopy, Wireless capsule, Barium enema and upper GI series with small bowel follow through, CT, CT enterography, MRI and MR enterography, Serum antibody testing, Radionuclide imaging, Blood tests, Urinalysis and urine culture, and test for malabsorption (Swearingen,2019).

The disorder will characteristically affect the entire thickness of the bowel mucosa and submucosa throughout the affected portion. This chronic inflammation response causes tissue damage, deep fissures, fistulas, abscesses, and ulcerations of the perianal area. (Capriotti, 2016) Other adverse effects occur with the progression of this disorder as well and include: a cobble stoning effect of the bowel mucosa, secondary infection occurrence development, scarring and fibrosis leads to thickened bowel walls with stenosis of the bowel lumen which shortens the colon. In rare cases, a portion of the colon can suffer from a condition of hyperdilation of the colon that causes malabsorption of fluids and electrolytes and total obstruction of the bowel. This is called toxic megacolon that can result in perforation and peritonitis and is a life-threatening condition. (Capriotti, 2016)

My patient has a history of Crohn’s Disease and c/o RLQ abdominal pain, tenderness, and dizziness. At the age of 36 y/o, she falls into the age range of when CD is generally diagnosed. She had a colectomy w/ ileostomy six months ago. The disease affects all layers of the bowel; the mucosa, submucosa, circular and longitudinal muscles, and serosa, predisposing to intestinal strictures and fistulas. The resulting inflammatory response continues unregulated by the immune system. As a result, inflammation continues to damage the intestinal wall, causing CD symptoms (Swearingen,2019). My patient has a history of intermittent gastritis. An endoscopy was performed to find and heal the bleeding.

N311 Care Plan

Pathophysiology References (2) (APA):

- Capriotti, T., & Frizzell, J. P. (2016). Pathophysiology: Introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.
- Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier.

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

Lab	Normal Range	Admission Value 1/18/xx @1507	Today's Value 01/21/xx @ 0600	Reason for Abnormal Value
RBC	3.90-4.98	**2.7**	**3.0**	A low RBC count is an indication of anemia
Hgb	12.0-15.5	**7 g/dL**	**12 g/dL**	A low Hgb level suggests anemia.
Hct	35-45	**21%**	**37%**	A low Hct level are an indication of hemorrhage or anemia.
Platelets	140-400	162,000/mm^3	162,000/mm^3	------
WBC	4.0-9.0	6,000/mm^3	6,000/mm^3	------
Neutrophils	40-70%	------	------	------
Lymphocytes	10-20%	------	------	------
Monocytes	------	------	------	------
Eosinophils	------	------	------	------
Bands	------	------	------	------

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

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

Lab	Normal Range	Admission Value 01/18/xx @1507	Today's Value 01/21/xx @ 0600	Reason for Abnormal
Na-	135-145	------	------	**NO CHEMISTRY LABS**
K+	3.5-5.1	------	------	
Cl-	98-107	------	------	
CO2	22-29	------	------	
Glucose	70-99	------	------	
BUN	6-20	------	------	
Creatinine	0.50-1.00	------	------	
Albumin	3.5-5.2	------	------	
Calcium	8.4-10.5	------	------	

Mag	------	------	------	
Phosphate	------	------	------	
Bilirubin	0.0-1.2	------	------	
Alk Phos	35-105	------	------	

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 01/18/xx @1507	Today's Value 01/21/xx @0600	Reason for Abnormal
Color & Clarity	Yellow/Clear	------	------	**NO URINSALYSIS LABS**
pH	5.0-9.0	------	------	
Specific Gravity	1.001-1.029	------	------	
Glucose	Negative	------	------	
Protein	Negative	------	------	
Ketones	Negative	------	------	
WBC	Negative	------	------	
RBC	Negative	------	------	
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 01/18/xx @1507	Today's Value 01/21/xx @0600	Explanation of Findings
Urine Culture	Negative	------	------	
Blood Culture	Negative	------	------	
Sputum Culture	Negative	------	------	
Stool Culture	Negative	**Positive**	------	Can indicate a GI bleed either upper or lower.

Coagulation Study

- Partial Thromboplastin Time (PTT) → 21 seconds
- Prothrombin Time (PT) → 12.2 seconds
- International Normalized Ratio (INR) → 0.7

Type and Cross Match including anibody screen: Type (ABO, RH)

Blood Type: A

Lab Correlations Reference (APA):

Nursing diagnosis list on Taylor's book 9th edition, page 369, Chapter 15 Diagnosing.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

- **Endoscopy**-Active bleeding found and resolved with the use of endo-clips
- **Transfusion of PRBC**- 2 units of PRBC ordered; 1 unit administered and the 2nd unit was partially administered with approximately. 225 mL remaining in bag when pt. presented with symptoms of a transfusion reaction complaining of restlessness, headache, chills, and muscle stiffness. The transfusion was discontinued immediately. IV tubing was replaced with new tubing and a new bag of 0.9% sodium chloride was administered and the provider was notified.

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

Medications (5 required)

Brand/Generic	**Morphine Sulfate**	**Acetaminophen** (Tylenol)	***NO OTHER***	***MEDs MENTIONED***	***IN SCENARIO***
Dose	4mg	650mg			
Frequency	Q4 hour PRN	Q4 hour PRN			
Route	IV bolus	PO			
Classification	Opioid analgesic	Antipyretic, Nonopioid analgesic			
Mechanism of Action	Binds with and activates opioid receptors (mainly mu receptors) in brain and spinal cord to produce analgesia and euphoria.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and **interfering with pain impulse generation in the peripheral nervous system. Also acts directly on temperature-regulating** center in the hypothalamus by inhibiting			

		synthesis of prostaglandin E_2			
Reason Client Taking	To relieve moderate to severe pain	To relieve moderate to severe pain and fever			
Contraindications (2)	*For I.M., I.V., or subcutaneous Injection:* Acute alcoholism, Alcohol withdrawal syndrome, arrhythmias, brain tumor, heart failure caused by chronic lung disease, seizure disorders.	*Severe hepatic impairment *Severe active liver disease			
Side Effects/Adverse Reactions (2)	*Intestinal Obstruction *Bronchospasm	*Pulmonary edema *Hypotension			

Medications Reference (APA):

Jones and Bartlett Learning. 2020 Nurse's Drug Handbook. 19th ed., Jones & Bartlett Learning, 2020.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	• A/O x3 • Distressed due to epigastric pain/cramping • Hygiene good
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	• Fair/Pale • Dry/smooth to the touch • Warm • Skin Turgor- 1 • Surgical scars on abdomen w/ ostomy present on RLQ • 22 • 24 g IV Left forearm
HEENT:	

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:**	• Head/Neck- Normocephalic • Auricle-moist and pink. Canal-clear • Sclera is white, conjunctiva is pink • Symmetrical, no septal deviation, no drainage • Mouth/Throat- pink, dry mucosa, no lesions. Uvula rises on phonation
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 heart sounds w/ HR elevated • S1/S2 normal • Rhythm strong and regular. Slight tachycardia. • Peripheral pulses- strong w/ regular rhythm • Cap refill- Good. Nail beds pink
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	• Respirations are even and nonlabored • Symmetrical bilateral, Clear-No wheezes/crackles
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Inspection:** **Palpation: Pain, Mass etc.:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☒ N ☐**	• Somewhat healthy diet containing some vegetables but high in simple carbs, processed foods, and caffeine intake. • Balanced diet high in protein and fiber that is divided into small frequent meals throughout the day. • 5'6" • 130 lbs • Hyperactive bowel sounds present. Tympany to percussion in all 4 quadrants • BM today • Soft, flat, w/ no apparent masses. • Tympany to percussion x4 quadrants. Liver/ Spleen palpated- no masses • Moderate abdominal tenderness, No rebound tenderness or guarding • Surgical scars RLQ from previous ileostomy • 24 g IV Left forearm • No wounds present on the abdomen. • Ileostomy present RLQ draining semi-liquid stool w/ red streaks.

Nasogastric: Y ☐ N ☒ **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	• Stoma is beefy read and functional, Tissue is intact and dry, Serosanguineous effluent was present in ostomy on arrival.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	• Yellow • Clear • 500 mL • Clean and Dry
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 ☐**	• Pink w/ a capillary refill of <2 sec 3+ pulses palpated at each pulse point, in all extremities • Normal ROM in all extremities • Strength in all extremities • 3 • Independent • No assistance w/ equipment or support to stand/walk
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	• Bilateral strength in all extremities • Alert and Oriented x3 • Mature • Clear speech • No major focal neurological deficits • Alert to time, location, and self
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):**	• To relieve stress relief, to relax, and to promote sleep the pt. sometimes has about 5 non/alcoholic drinks per night. • Appropriate developmental level • Pt. has no religious affiliation • Lives alone and doesn't have a good support system. She has a stressful job as a stockbroker and her daily commute is lengthy. She doesn't exercise regularly

	because she “doesn’t have time”. She drinks alcohol nightly and eats unhealthy foods as a coping mechanism for stress management.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500 **(On admission)**	110 bpm	94/56	26	98.6 F oral	95% 2L Nasal Cannula

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500 **(On Admission)**	0-10 **Pain Scored @ 6**	Top of stomach	Moderate	Stress makes pain worse. Sore/crampy	Morphine administered for pain as prescribed

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
100 mL **(PO)**	500 mL+ 400mL + 350mL @ 1500 **(Voided)**
300 mL+ 150mL+ 50mL+ 50mL **(IV)**	200mL **(BM)**
350mL + 125 mL **(Blood)**	375mL + 250mL + 175mL **(Voided)**
150mL + 150mL **(PO)**	300mL+200mL+300mL **(BM)**
180mL + 90mL **(IV)**	500mL+475mL+350mL **(Voided)**
475mL+610mL+350mL **(PO)**	225mL+250mL+300mL **(BM)**
Total: 3,130 mL	**Total: 5,150 mL**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

N311 Care Plan

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 related to gastrointestinal condition as evidenced by positive hemoccult and lab results.	Assessment of vital signs can detect compensatory changes associated with bleeding, including increased heart rate and respiratory rate. At first blood pressure maybe stable, before beginning to decrease. Medication monitoring can help prevent recurrent of GI irritation and bleeding.	**1.** Monitor heart rate and Blood pressure for signs of Hypovolemia **2.** Prepare for transfusion per Physician/Physician Assistant/ Advanced Practice Nurse Orders and Protocol. Goal is to increase blood volume and treat or prevent hypovolemic shock.	**Intervention #1** Goal met, vitals monitored frequently and remained stable thought the nurse's shift with no orthostatic changes in BP. **Intervention #2** Goal partially met, 2 units of blood transfusions given. 1 unit given but 2nd unit stopped due to transfusion reactions. Goal met, with identifying reactions found with frequently monitoring pt.
1. Stress overload related to excessive stress and insufficient support system as evidenced by negative physical and psychosocial impacts from stress.	Educating pt. about removing or minimizing some stressors, changing responses to stressors, and modifying the long term effects of stress are all actions that can assist those with chronic illness and stress.	1. Assist to set realistic goals to achieve a more balanced health-promoting lifestyle. Setting realistic goals will increase confidence and success. **2.** Encourage how to break the stress cycle and how to decrease heart rate, respirations, and strong feelings of anger.	**Intervention #1** Goal met, using therapeutic communication skills the nurse encouraged the client to communicate current stressors and coping methods that were currently being used for stress. After making a list together, they discussed what modifications could be made to promote the goal of relaxation and well-being. She was given referral information and informative pamphlets about these resources and expressed her readiness to change her lifestyle. **Intervention #2** Goal met, By giving pt different coping methods to try and information on healthy habits on how to lower stress.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). St. Louis, MO: Elsevier.

Carpenito, L. J. (2017). *Handbook of nursing diagnosis*. Philadelphia: Wolters Kluwer.

Concept Map (20 Points)

N311 Care Plan

Subjective Data

- **Abdominal pain w/ cramping in RLQ region**
- **Pt states, "I'm feeling more lightheaded and dizzier", "I feel like I am going to faint"**
- **After endoscopy- pt rated pain as an 8 that started about an hour ago and after eating a bowl of soup.**

Nursing

1. **Risk for bleeding related to gastrointestinal condition as evidenced by positive hemoccult and lab results.**
2. **The nurse explained to the patient why frequent vital sign monitoring was important in relation to blood loss. The patient's vital signs remained stable throughout the nurse's shift with no signs of orthostatic change in blood pressure. The nurse educated and provided written material to the patient about the increased risk for bleeding when taking certain NSAIDs. The patient was eager to learn and agreed to only take the approved medications listed in the written material that the nurse provided unless otherwise instructed by her provider. She understands that by not doing so she is at an elevated risk for gastrointestinal irritation that could lead to GI bleeding.**
3. **Stress overload related to excessive stress and insufficient social resources as evidenced by negative physical and psychosocial impacts from stress.**
4. **The nurse used good communication skills to encourage the client to vocalize any stressors present and coping mechanisms used to manage stress. After making a list together, they discussed what modifications could be made to promote the goal of relaxation and well-being. The nurse suggested various alternative and complimentary therapies that could be beneficial to the patient as well as the importance of establishing social relationships that provide support. The nurse stressed the significance of a**

Objective Data

- History of Crohn's Disease and intermittent gastritis
- Colectomy w/ ileostomy 6 years ago
- Vital Signs:
  - BP→ 94/56
  - Pulse→ 110 bpm
  - O2 → 95% 2 L nasal cannula
  - Resp.→ 26
  - Pain level → 6
- Braden Score- 22
- Serosanguineous effluent

Patient Information

The patient arrives at the emergency department with complains of weakness and dizziness. She has a history of intermittent gastritis and Chron's disease with recent a colectomy and ileostomy 6 months ago. She had serosanguineous effluent present in her ostomy bag upon arrival to the emergency department. She is also complaining of abdominal pain at the epigastric level that is sore and crampy with a pain rating of 6 which started this morning. Her primary diagnosis upon admittance is GI Bleed.

Nursing Interventions

1. The nurse will help the client categorize stressors as modifiable or nonmodifiable and help client modify or reduce stressors that are modifiable.
2. The nurse will discuss with the client possible therapeutic approaches to manage stress and establish positive coping mechanisms.
1. The nurse will assess vital signs at frequent intervals to assess for physiological evidence of bleeding, such as tachycardia, tachypnea, and hypotension and orthostatic blood pressure changes.
2. The nurse will monitor all medications for potential to increase bleeding including aspirin, NSAIDs, SSRIs, and complementary and alternative therapies

N311 Care Plan

N311 Care Plan