

N311 Care Plan #3

Lakeview College of Nursing

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Demographics (/5 points)

Date of Admission	Patient Initials	Age	Gender
01/18/20	J.A.L	36	Female
Race/Ethnicity	Occupation	Marital Status	Allergies
Caucasian	N/A	Married	Sulfa
Code Status	Height	Weight	
Full Code	167.6 cm (66 in)	59 kg (130 lbs)	

Medical History (/5 Points)

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

Past Surgical History: Ileostomy

Family History: Hypertension (maternal and paternal), Irritable bowel syndrome (maternal)

Social History (tobacco/alcohol/drugs): Up to five alcoholic drinks/night,

Admission Assessment

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

History of present Illness (/10 points): 36 y/o female admitted to emergency department on January 18th reporting abdominal pain caused by gastrointestinal bleeding. Client states sharp and intense pain throughout her abdominal area. Client reports symptoms began early this morning and have lasted without relief since. Client describes pain level 6/10. Client states that abdominal pain occurs when under stress. Client also suffers from headaches caused by the stress. She uses ibuprofen to relieve the headaches. Client is prescribed infliximab IV, last given six months ago.

Primary Diagnosis

Primary Diagnosis on Admission (/3 points): Gastrointestinal bleed

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (/20 points): Gastrointestinal bleeding is a symptom of a disorder of the gastrointestinal tract (Capriotti & Frizzell, 2016). Depending on the amount of blood present, it's severity can be anywhere from mild to like threatening. Signs and symptoms of a GI bleed include bright red, or dark and tarry stools, scant blood found in stools, lightheadedness, dizziness, abdominal pain, and fainting (Mayo Clinic, 2018). A GI bleed can also lead to shock if blood loss is extreme. Causes of a GI bleed include colitis, colon polyps, angiodysplasia, gastritis, and peptic ulcers (NIDDK, 2016). In this client's case, the GI bleed was more than likely caused by her frequent use of NSAID's. Frequent use of NSAID's can cause peptic ulcers in the lining of the digestive tract, and those peptic ulcers can bleed. Typically, peptic ulcers create an upper GI bleed. In a client with no ostomy, this would show as a dark tarry stool due to how far it takes the feces to travel after it has picked up the blood. It is dark because the blood has dried within the feces. Because this client has an ileostomy, it shows up as a bright red fluid in her ostomy bag. It is bright red due to the fact that her feces does not travel as far as it would with no ostomy, therefore it does not have time to dry up within the stool. This issue can be diagnosed through blood tests, stool tests, endoscopy (Mayo Clinic, 2018)

Treatment of GI bleeds include proton pump inhibitors, or other ways to treat the reason that the GI bleed has started. Treatment also includes blood transfusions and supplemental fluid through an IV, like saline. In this client's case, the peptic ulcers need to be treated. To treat peptic ulcers, the client may be prescribed antibiotics, or proton pump inhibitors. For our client, no longer taking the NSAID's to treat her headaches would stop the occurrence of peptic ulcers and would resolve the issue of having a GI bleed in the future.

Pathophysiology References (/2) (APA):

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

Gastrointestinal bleeding. (2018, September 21). Retrieved from <https://www.mayoclinic.org/diseases-conditions/gastrointestinal-bleeding/symptoms-causes/syc-20372729>

Symptoms & Causes of GI Bleeding. (2016, July 1). Retrieved from <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	4.00-6.10	2.7	NA	RBCs are low due to blood loss in GI tract.
Hgb	14.0-18.0 g/dL	7 g/dL	NA	Hgb is low due to decrease in RBCs.
Hct	37.0-51.0%	21%	NA	Hematocrit is low due to decrease in RBCs.
Platelets	150-400	162	NA	
WBC	5.00-12.00	6.0	NA	
Neutrophils	2.0-8.0 x 10 ⁹ /L	3.0 x 10 ⁹ /L	NA	
Lymphocytes	1.0-4.0 x 10 ⁹ /L	3.0 x 10 ⁹ /L	NA	
Monocytes	0.2-0.8 x 10 ⁹ /L	0.3 x 10 ⁹ /L	NA	
Eosinophils	< 0.5 x 10 ⁹ /L	0.3 x 10 ⁹ /L	NA	

	L	10⁹/L		
Bands	< 1.0 x 10⁹/L	0.4 x 10⁹/L	NA	

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	NA	
K+	3.5-5.0 mEq/L	4.4 mEq/L	NA	
Cl-	98-106 mEq/L	100 mEq/L	NA	
CO2	35-45 mm Hg	40 mm Hg	NA	
Glucose	70-100 mg/dL	90 mg/dL	NA	
BUN	8-20 mg/dL	12 mg/dL	NA	
Creatinine	0.7-1.3 mg/dL	1.0 mg/dL	NA	
Albumin	3.5-5.5 g/dL	4.2 g/dL	NA	
Calcium	9.0-10.5 mg/dL	9.0 mg/dL	NA	
Mag	1.5-2.4 mg	1.8 mg	NA	
Phosphate	3.0-4.5 mg/dL	3.6 mEq/L	NA	
Bilirubin	0.3-1.2 mg/dL	0.7 mg/dL	NA	
Alk Phos	36-92 U/L	NA	NA	

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	Pale yellow- Yellow; Clear	Clear; Yellow	NA	
pH	5-7	6.2	NA	
Specific Gravity	1.005-1.025	1.01	NA	
Glucose	Negative	Negative	NA	
Protein	Negative	Negative	NA	
Ketones	Negative	Negative	NA	
WBC	<5	Negative	NA	
RBC	<3	Negative	NA	
Leukoesterase	Negative	Negative	NA	

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*	N/A*
Blood Culture	Negative	*	*	*
Sputum Culture	Negative	*	*	*
Stool Culture	Negative	Positive for blood	*	Blood in stool caused by GI bleed.

Lab Correlations Reference (APA): ATI. (2016). *RN Adult Medical Surgical Nursing* (10.0 ed., Content Mastery Series)

Diagnostic Imaging

All Other Diagnostic Tests (/10 points): Patient received hemocult test which showed positive results for blood within the stool, indicating the patient was experiencing a gastrointestinal bleed.

Current Medications (/10 points, 2 points per completed med)

Brand/Generic	Morphine Sulfate (Arymo ER)	0.9% sodium chloride (saline solution)	Infliximab (Remicade)	Acetaminophen (Tylenol)	
Dose	4 mg	1000 mL	5 mg/kg	650 mg	
Frequency	Every 2 hours PRN	150 mL/hr	Every 8 weeks	Every 4 hours, or PRN	
Route	IV	IV	IV	PO	
Classification	Opioid Analgesic	Crystalloid	Anti-inflammatory	Antipyretic and nonopioid analgesic	
Mechanism of Action	Binds with and activates opioid receptors in brain and spinal cord to produce analgesia and euphoria.	Allows regulation of fluid through osmosis.	Binds with cytokine tumor necrosis factor alpha (TNF-alpha), preventing it from binding with its receptors.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the PNS.	
Reason Client Taking	Pain management	Regulation of fluid	To control moderate to severe Crohn's disease long-term	Pain control	
Contraindications (2)	Heart failure, seizure disorders	N/A	Breastfeeding; hypersensitivity to infliximab.	Hypersensitivity to acetaminophen;	

				liver disease	
Side Effects/Adverse Reactions (2)	Bradycardia; hypotension	N/A	Arrhythmias, hepatotoxicity	Hypertension; hepatotoxicity	

5 different medications must be completed

Medications (5 required)

Medications Reference (APA): Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18/18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	-Client was alert and oriented. -Client showed signs of distress due to abdominal pain. -Client was well groomed.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: 23 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	-Clients skin was dry -Clients skin temperature was warm to the touch -Clients skin turgor was normal -No rashes, bruises, or wounds present.

<p>Type:</p> <p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>-Head/Neck: Normal; no deviations, symmetrical. -Ears: TM pearly grey; without drainage -Eyes: Sclera's are slightly yellow, positive RLR, Rosenbaum 14/14 -Nose: Moist, pink; no septal deviation -Teeth: Dentition good, client does not use dentures.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>-S1 and S2 sounds audible, no murmurs or gallops present. - Clear heart sounds throughout. -Capillary refill < 3 seconds. -Pulses present bilaterally on upper and lower extremities, 2+ throughout. -No edema present</p>
<p>RESPIRATORY: Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>-Respirations are slightly elevated. -Lung sounds clear throughout without crackles or wheezes. -Breathing is unlabored</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet: Regular Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>-Bowel sounds present; hyperactive -Patient has ostomy bag. -Ostomy bag has serosanguinous fluid present. -Stoma is normal, presents as red and meaty. -Abdomen is tender upon palpation.</p>
<p>GENITOURINARY: Color:</p>	<p>-Urine is yellow; clear. -No odor present.</p>

<p>Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size: N/A</p>	<p>-Genitals moist and pink.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Full, without deficit. Supportive devices: None Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>-Client is independent. -Full ROM -Moves without any assistive devices.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>-Client was alert and oriented. -Pupils were equal and reactive to light. -Speech was normal. -No mental impairments present.</p>
<p>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):</p>	<p>-Client is Caucasian -Client does not identify with any religion. -Uses alcohol to cope, as well as unhealthy eating. -Patient lives with husband -Client has 1 daughter.</p>

Vital Signs, 1 set (/5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500	110/radial	94/56	26	98.6	95%

		Left arm		Fahrenheit	2L/min/NC
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Pain Assessment, 1 set (/5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1530	6/10	Abdomen	Intense, sharp pain radiating throughout abdominal region.	“Crampy, sore”	Client received 4 mg of morphine sulfate to manage pain.

Intake and Output (/2 points)

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

Nursing Diagnosis (/15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 		<ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes,

			modifications to plan.
1. Fluid volume deficit related to blood loss as evidenced by hypotension	Because the client lost blood within her GI tract, they will lose essential fluids from their circulatory system as well.	<ol style="list-style-type: none"> 1. Administer saline fluid to prevent further loss of essential fluids from the blood. 2. Measure urine input and output to ensure no fluids are being lost within bodily functions. 	<p>Goal met: Client received saline fluids and showed improvements with blood pressure. Blood pressure raised to normal levels.</p> <p>Goal met: Fluid input is equal to fluid output regularly, showing signs of appropriate fluid retention.</p>
2 Acute pain related to gastrointestinal trauma as evidenced by patient complaint and increased respirations and pulse.	Due to the trauma within the upper GI tract, the patient was experiencing extreme pain within the abdomen.	<ol style="list-style-type: none"> 1. Administer 4 mg of morphine sulfate as needed to halt and prevent pain. 2. Assess pain scale, respirations, and pulse regularly to identify how client is reacting to pain medications. 	<p>Goal met: Client reported pain as 6/10 upon arrival. After pain medicine was administered, client's pain rating reduced down to no pain present.</p> <p>Goal met: Respirations and pulse returned to normal range once pain medicine was administered.</p>

Other References (APA):

Concept Map (/20 Points)

Subjective Data

- Tachypneic
- Tachycardic
- Hypotensive
- Weakness
- Dizziness
- Pain in abdominal are

Nursing Diagnosis/Outcomes

- Fluid volume deficit related to blood loss as evidenced by hypotension.
Goal met: Client given 1000 mL of 0.9% sodium chloride, showed improvements in blood pressure.
Goal met: Fluid input equivalent to fluid output.
- Acute pain related to gastrointestinal trauma as evidenced by patient complaint and increased respirations and pulse.
 - Goal met: Client was given morphine sulfate, reducing pain.
 - Goal met: Respirations and pulse returned to normal range upon administration of pain medication.

Objective Data

Ostomy bad contains serosanguineous fluid.
Patient has blood present in stool
Temp: 98.6
Pulse: 110
Resp: 26
BP: 94/56

Patient Information

Janet Lieberman
36 y/o
DOB: 06/29/1983
Hemocult shows blood in stool

Nursing Interventions

- Administer 0.9% sodium chloride
- Assess fluid I/O on regular basis.
- Pain medication given PRN
- Assess vitals on regular basis.

