N311 Care Plan #4

Lakeview College of Nursing

Cidney Hinchman

Demographics (5 points)

Date of Admission 01/18/2020	**Patient Initials** J.L.	**Age** 36	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Realtor	**Marital Status** Single	**Allergies** Sulfa
Code Status Full code	**Height** 5'6"	**Weight** 130 lb.	

Medical History (5 Points)

Past Medical History: Pt was diagnosed with Crohn's disease with intermittent gastritis at the age of 20, also has a history of depression and anxiety

Past Surgical History: Pt had surgery and an ileostomy six months ago

Family History: Sister has a history of Crohn's disease and was diagnosed when she was 14. Father has a history of anxiety and depression and was diagnosed as a kid. Mother has "no known medical history" per pt.

Social History (tobacco/alcohol/drugs): Pt reports drinking alcohol every now and then. Pt states "maybe two or three times a month" and she denies any past or current drug and tobacco use.

Admission Assessment

Chief Complaint (2 points): Weakness, dizziness, abdominal pain,

History of present Illness (10 points):Onset: On January 18th, 2020, a 36 y/o white, single, female, brought herself to the emergency department because she was experiencing weakness, dizziness, and abdominal pain beginning around 0800. **Location**: Pt is experiencing pain in her lower right quadrant. **Duration:** This morning around 0700, on January 18th, the pt woke up and started noticing she was weaker than usual and became very dizzy. Pt stated, "after I got out of bed and started moving around my lower right side of my stomach started hurting and has been

persistent ever since". **Characteristics:** The pt described her pain as "crampy and sharp". Pt rated her pain a 6 on a scale of one to ten. Pt also stated, "When I get stressed, I don't eat healthy foods and then I get headaches and take Ibuprofen". **Associated Manifestations:** Walking around and moving seems to make the abdominal pain worse. **Relieving factors:** Ibuprofen helps her headaches and pt states, "when I lay down in a dark room it seems to help, and I don't feel as dizzy". **Treatment:** Pt has not had previous treatment.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Gastrointestinal (GI) Bleed

Secondary Diagnosis (if applicable):

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

Gastrointestinal (GI) bleeding is not a disease but a symptom of a disease that happens inside of your digestive tract (Mayo Clinic, 2018). Your digestive tract includes your esophagus, stomach, small intestine, large intestine or colon, rectum, and anus (MedlinePlus, 2019). GI bleeding can happen in the upper or lower GI tract and can be from a number of different reasons (Mayo Clinic, 2018). Upper GI bleeding can cause peptic ulcers, tears in the lining of the tube that connects your throat to your stomach, abnormal enlarged veins in the esophagus, and esophagitis (Mayo Clinic, 2018). Peptic ulcers are the most common cause of an upper GI bleed (Mayo Clinic, 2018). Lower GI bleeding can cause diverticular disease, inflammatory bowel disease, tumors, colon polyps, hemorrhoids, anal fissures, and proctitis (Mayo Clinic, 2018). Signs of bleeding in the upper digestive tract could include bright red blood in vomit, vomit that looks like coffee grounds, black or tarry stool, and dark blood mixed with stool (MedlinePlus, 2019). Signs of bleeding in the lower digestive tract could include black or tarry stools, dark blood mixed with stool, and stool mixed or coated with bright red blood (MedlinePlus, 2019).

Signs and symptoms of gastrointestinal bleeding can be either overt or occult (Mayo Clinic, 2018). Signs and symptoms will depend on where the bleeding is happening and that can be anywhere from the mouth to the anus and the rate at which you are bleeding (Mayo Clinic, 2018). Overt bleeding could show up as vomiting blood, black tarry stools, and rectal bleeding (Mayo Clinic, 2018). Occult bleeding could have you feeling lightheadedness, you could have trouble breathing, you could faint, you could experience chest pain, and you could also experience abdominal pain (Mayo Clinic, 2018). If you happen to start bleeding abruptly and it progresses very quickly you are likely to go into shock (Mayo Clinic, 2018). Signs and symptoms of shock include your blood pressure dropping, urinating infrequently and in very small amounts, a rapid pulse, and unconsciousness (Mayo Clinic, 2018). As for Ms. Liberman her occult stool came back positive for the presence of blood, she was also experiencing weakness, dizziness, and had mentioned she felt like she was going to faint. Her lab values could also indicate the presence of a GI bleed. Ms. Liberman had a low RBC count, low hemoglobin, low hematocrit, low albumin, elevated BUN, and elevated bilirubin.

A gastrointestinal bleed can be very dangerous and lead to many complications. A few of those complications include shock, anemia, and death (Mayo Clinic, 2018). You can help prevent a GI bleed by limiting your use of nonsteroidal anti-inflammatory drugs, limiting your use of alcohol, quitting smoking if you are a smoker, and if you have GERD follow your physicians orders for treating it (Mayo Clinic, 2018). NSAIDs like ibuprofen can cause ulcers, bleeding, or holes in the stomach or intestine. NSAIDS can irritate and gradually wear away the gastric lining causing peptic ulcers disease which is the most common cause of an upper GI bleed. Ms. Liberman had a history of chronic ibuprofen to help treat her migraines that were

brought on by stress. Therefore, her chronic use of ibuprofen is probably what caused her to have a gastrointestinal bleed.

Diagnosing a gastrointestinal bleed will include your doctor looking at your medical history and seeing if you have a previous history for bleeding (Mayo Clinic, 2018). Your doctor will then conduct a physical exam and possibly order some tests (Mayo Clinic, 2018). A blood test, a stool test, a nasogastric lavage, upper endoscopy, a colonoscopy, a capsule endoscopy, a flexible sigmoidoscopy, a balloon-assisted enteroscopy, a angiography, and an imaging tests are all tests that your doctor could order to check for a GI bleed (Mayo Clinic, 2018). Although it is rare there are times a GI bleed can be so severe that a noninvasive tests can't find the source and you will need surgery so that the doctors can view the entire small intestine (Mayo Clinic, 2018).

Treatment for a GI bleed depends on where the bleeding is taking place, but GI bleeding often stops on its own (Mayo Clinic, 2018). In some cases, while they are doing a test if they see bleeding, they can give you medication or perform a procedure to help control the bleeding (Mayo Clinic, 2018). If you have an upper GI bleed you could be given an IV drug known as a proton pump inhibitor to help suppress stomach acid production and once the source of the bleeding is identified the doctor will determine whether or not you need to continue taking the medication (Mayo Clinic, 2018). Also depending on how much bleeding has occurred a doctor may require you to have some fluids through an IV and possibly a blood transfusion (Mayo Clinic, 2018). Ms. Liberman typed and cross-matched for two units of packed red blood cells and had them administered to her. She got almost through the second unit when the transfusions were stopped due to a transfusion reaction. My patient was also taking a 20mg of omeprazole everyday which is a proton pump inhibitor to help her suppress her stomach acid production while she is experiencing a GI bleed.

Pathophysiology References (2) (APA):

Mayo Clinic. (2018, September 21). *Gastrointestinal bleeding - Symptoms and causes.* https://www.mayoclinic.org/diseases-conditions/gastrointestinal-bleeding/symptoms-causes/syc-20372729

MedlinePlus. (2019, May 7). *Gastrointestinal Bleeding.* https://medlineplus.gov/gastrointestinalbleeding.html

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 *10^6/uL*	2.7		RBCs are decreased due to a loss of blood in the GI tract (Capriotti & Frizzell, 2016)
Hgb	12.0-16.0 *g/dL*	7		Hgb is low due to experiencing blood loss in the GI tract (Capriotti & Frizzell, 2016).
Hct	37.0-48.0%	21%		These values are consistent with a low number of red blood cells due to blood loss (Capriotti & Frizzell, 2016).
Platelets	135,000-317,000 per uL	162,000mm^3		
WBC	5,000-10,000 per uL	6,000mm^3		
Neutrophils		N/A		
Lymphocytes		N/A		
Monocytes		N/A		
Eosinophils		N/A		
Bands		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 *mmol/L*	150		Sodium levels are slightly increased due to the loss of fluid (Capriotti & Frizzell, 2016)
K+	3.5-5.1 *mmol/L*	4.4		
Cl-	98-107 *mmol/L*	100		
CO2	21.0-32.0 *mmol/L*	N/A		
Glucose	60-99 *mg/dL*	102mg/dL		Blood sugar slightly elevated due to trauma (Capriotti & Frizzell, 2016).
BUN	5-20 *mg/dL*	24		BUN levels are increased due to decreased fluid volume and GI bleed (Capriotti & Frizzell, 2016).
Creatinine	0.5-1.5 *mg/dL*	1.0mg/dL		
Albumin	*3.4-5.4 g/dL*	2.5		The values are consistent with Crohn's disease because your body cannot properly absorb and digest protein (Capriotti and Frizzell, 2016).
Calcium	8.5-10.1 *mg/dL*	N/A		
Mag	1.6-2.6mg-dL	N/A		
Phosphate	2.5-4.5 mg/dL	N/A		
Bilirubin	0.0-0.4mg/ dL	0.5		Bilirubin levels are slightly elevated due to stress and anemia from the loss of blood (Capriotti & Frizzell, 2016).
Alk Phos	20-140 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	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
Color & Clarity	Colorless-Yellow, Clear	Colorless, yellow, clear, no odor present		
pH	5.0-7.0	5.6		
Specific Gravity	1.003-1.005	1.030		Specific gravity elevated due to decreased fluid volume (Capriotti & Frizzell, 2016)
Glucose	Negative	Negative		
Protein	Negative	3 mg/dL		This value can be due to high albumin levels (Capriotti & Frizzell, 2016)
Ketones	Negative	Negative		
WBC	0-25/*uL*	0		
RBC	0-20/*uL*	0		
Leukoesterase	Negative	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	Today's Value	Explanation of Findings
Urine Culture		No culture in file		
Blood Culture		No culture in file.		
Sputum Culture		No culture in file.		
Stool Culture	Negative for blood	Positive for blood in stool		Positive blood in stool is due to GI bleed (Capriotti & Frizzell, 2016).

Lab Correlations Reference (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (10 points)

- Pt was typed and crossed-matched including an antibody screening: Blood Type A, RH Negative
- Pt Partial Thromboplastin Time (PTT) was 21 seconds and the normal range is 10-14, but therapeutic is 20-42 seconds.
- Pt Prothrombin Time (PT) was 12.2 seconds and the normal range is 25-40, but therapeutic is 50-120 seconds. PT is low due to the GI bleed and the proportion of red blood cells to fluid is unequal and is low making the pt's PT lower than normal (Capriotti & Frizzell, 2016)
- Pt International Normalized Ratio (INR) is 0.7 and the normal range is 1.0, but therapeutic is 2-3. INR is low due to the GI bleed and the proportion of red blood cells to fluid is unequal and is low making the pt's INR lower than normal (Capriotti & Frizzell, 2016).

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)	Infliximab (Remicade)	Omeprazole (Prilosec)	Citalopram (Celexa)
Dose	4mg	650mg	5mg/kg	20mg	20mg
Frequency	q.2.h. PRN	q.4.h. PRN	Every 8 weeks	q.d.	q.d.

Route	IV bolus	Oral	IV	Oral	Oral
Classification	Opioid analgesic	Nonsalicylate, para-aminophenol derivative, antipyretic, nonopioid analgesic	Monoclonal antibody, Anti-inflammatory	Proton pump inhibitor, antiulcer	Antidepressant
Mechanism of Action	Binds with and activates opioid 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. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.	Binds with cytokine tumor necrosis factor-alpha, preventing it from binding with its receptors. As a result, TNF-alpha can't produce proinflammatory cytokines and endothelial permeability. Infiltration of inflammatory cells into inflamed intestine and joints declines.	Omeprazole interferes with gastric acid secretion by inhibiting the hydrogen potassium adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells. Normally, the proton pump uses energy from hydrolysis of adenosine triphosphate to drive hydrogen and chloride out of parietal cells and into the stomach lumen in exchange for potassium, which leaves the stomach lumen and enters parietal cells. After this exchange, H+ and Cl-	Blocks serotonin reuptake by adrenergic nerves, which normally release this neurotransmitter from their storage sites when activated by a nerve impulse. This blocked reuptake increases serotonin levels at nerve synapses, which may elevate mood and reduce depression.

				combine in the stomach to for hydrochloric acid. Omeprazole irreversibly blocks the exchange of intracellular K+. By preventing H+ from entering the stomach lumen, omeprazole keeps additional HCI from forming.	
Reason Client Taking	This medication is being taken to keep the pt's pain level under control.	This medication is being taken to decrease the pt's fever and keep the pt's pain level under control.	This medication is being taken to help control the pt's long term Crohn's disease.	This medication is being taken to suppress the pt's sstomach acid production while she is having a GI bleed.	This medication is being taken to treat depression.
Contraindications (2)	Respiratory depression, upper airway obstruction	Severe hepatic impairment, severe active liver disease	Breastfeeding; doses greater than 5mg/kg in patients with moderate to severe heart failure; hypersensitivity to infliximab	Concurrent therapy with rilpivirine-containing products; hypersensitivity to omeprazole, other proton pump inhibitors, substituted benzimidazoles, or their	Hypersensitivity to citalopram or its components, pimozide therapy, use within 14 days of MAO inhibitor therapy.

				components	
Side Effects/Adverse Reactions (2)	Agitation, drowsiness	Agitation, fatigue	Chills, dizziness	Agitation, headache	Agitation, anxiety

Medications Reference (APA):

Jones & Bartless Learning. (2019). *2019 Nurse's drug handbook* (18th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Pt appears uncomfortable and in pain A&O x3 Oriented to person, time, place, and current events. Pt appears uncomfortable and pale. Looks like she is in a lot of pain
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 White/ looks a little pale for her race Appears slightly dehydrated, clean. Warm Normal turgor 2+ None noted None noted None noted 20

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head and neck symmetrical, no bumps or lesions noted. Trachea is midline. Lymph nodes are nonpalpable Ears are free of discharge, no bumps or lesions noted, healthy cerumen, and tympanic membrane is a pearly grey Client uses glasses to help with nearsighted vision. Upon inspection sclera was white, cornea was clear, conjunctiva was wink with no lesions or discharge noted. Normal EOM Septum midline. No drainage or bleeding noted. No deviation or abnormalities and sinuses are not tender Patient has natural teeth on top and bottom. Good dentition overall. No lesions or bumps noted. Mouth is pink and moist.
CARDIOVASCULAR: **Heart sounds:** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	S1 and S2 heart sounds normal with no murmurs, gallops, or rubs present. Pulse is 62bpm radial Capillary refill is between 5-6 seconds.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds:**	 Patient has normal lung sounds. Respirations are nonlabored.
GASTROINTESTINAL: **Diet at home:** **Current diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation:** **Inspection:** **Distention:** **Incisions:**	Normal eating at home, pt stated if she was stressed, she does not eat healthy at home Clear liquid diet 5’6” 130 lbs Bowel sounds are normoactive in each quadrant Two days ago No pain or masses noted on palpation No abnormalities found upon inspection for distention, incision, scars, drains, or wounds.

Scars: **Drains:** **Wounds:** **Ostomy: Y ☒ N ☐** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type: N/A**	Patient has an ileostomy. Stoma appears red and beefy.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Clear, yellow, and no odor present Pt voided three times and the output total was 875mL.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) X** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Pt has no neurovascular deficits noted. ROM is good. No supportive devices are needed Good, equal bilaterally. Fall risk is 15. Pt is a high risk for falls. Pt walks with one assist and gait belt. Pt tends to get dizzy.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ i Legs ☐ (Left) Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Moves both arms and legs well bilaterally. Oriented to person, time, place, and current events. Good Good Glasses are present for nearsighted vision Alert and oriented x3
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	While in the hospital, sister keeps pt occupied No deficits noted Pt identifies as Christian and typically goes to church every Sunday morning with her sister.

Personal/Family Data (Think about home environment, family structure, and available family support):	Pt does lives alone but her and her sister are close and check in on each other at least a couple of times a week. Pt states, “I like living alone. I work a lot and it’s nice to be able to just come home and relax in peace and quiet. ”.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	62 radial	94/56 RA	16	97.6 °F orally	96% without O2

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numerical 1-10 6/10	Pain in the LRQ of the abdomen	Pt described her pain as “crampy and sharp”. Pt also said her pain was persistent and rated her pain a 6 on a scale of one to ten.	Pt described her pain as “crampy and sharp”. Pt also stated, “when I get stressed, I don’t eat healthy foods and then I get headaches and take Ibuprofen”.	Pt is taking 4mg of morphine sulfate every two hours as needed through an IV bolus to help keep her pain level under control. Pt is also taking 650mg of Tylenol orally every four hours as needed to help decrease her fever and keep her pain level under control.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Clear liquid diet 475mL of H2O @ 0800	 Pt voided 500mL of urine @ 0745

280mL of H2O @ 1200 Intake total = 755mL	Pt voided 375mL of urine @ 1200 Output Total = 875mL

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. Fluid volume deficit related to GI bleed as evidenced by weakness and delayed capillary refill	The pt has a decreased amount of fluid volume running through her body which is why her blood pressure is low. Her b/p was documented at 0800 and was 94/56. The pt came in with a chief complaint of feeling weak and her capillary refill was between 5-6 seconds during her assessment.	1. Encourage pt to drink 2 to 3 L of water a day as tolerated to maintain and restore lost fluids. 2. Pt has been prescribed an IV of 0.9% sodium chloride 1000mL infusing at 150mL/ hr to help maintain and restore lost fluid. 3. Watch for fluid overload	Pt had an oral input of 755mL and was not drinking nearly enough water. Pt's sister was there to help encourage the pt to drink more fluids. She was unable to meet the goal of 2 to 3 L of water a day but is continuing to try to increase fluids. Pt was given the medication continuously and her skin turgor and capillary refill began to improve indicating she was becoming hydrated again.
1. Acute pain related to GI bleed as evidenced by blood in stool and pain in LRQ	Pt's biggest complaint was her acute pain in her lower right abdomen area. Pt's stool culture came back positive for blood in the stool due to the GI bleed. Pt rated her pain a 6/10 when she arrived at the ED and a few hours	1. Pt will get 4mg of morphine every 2 hours as needed to help control her pain level. 2. Assess pt's pain characteristics and assess for signs and symptoms relating to pain 30 minutes	Pt was given morphine every 2 hours and was assessed 30 minutes after each given dose. Before my shift ended pt was assessed and the pt's pain level went from an 8/10 to in between a 2 and a 3 out of 10. Pt said the medication helped a lot and her cramps weren't nearly as sharp or persistent. Overall goals

	later rated her pain an 8/10.	after giving the prescribed pain meds.	were met.

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*. St. Louis, MO: Elsevier.

Concept Map (20 Points):

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Subjective Data

Abdominal pain in LRQ
Weakness
Dizziness
Stomach feels crampy and sharp

Nursing Diagnosis/Outcomes

1. Fluid volume deficit related to GI bleed as evidenced by weakness and delayed capillary refill.
   - Pt had an oral input of 755mL and was not drinking nearly enough water. Pt's sister was there to help encourage the pt to drink more fluids. She was unable to meet the goal of 2 to 3 L of water a day but is continuing to try to increase fluids.
   - Pt was given the medication continuously and her skin turgor and capillary refill began to improve indicating she was becoming hydrated again.
2. Acute pain related to GI bleed as evidenced by blood in stool and pain in LRQ.
   - Pt was given morphine every 2 hours and was assessed 30 minutes after each given dose. Before my shift ended pt was assessed and the pt's pain level went from an 8/10 to in between a 2 and a 3 out of 10. Pt said the medication helped a lot and her cramps weren't nearly as sharp or persistent. Overall goals were met.

Objective Data

Chief complaint: Weakness, dizziness, and abdominal pain
Diagnosed with GI bleed
Vital signs: B/P- 94/56 RA
P – 62 radial
RR – 16
T – 97.6°F oral
O2 – 96%
without O2
Pain – 6/10
RBC, Hgb, Hct, and albumin, are all decreased.
Na-, glucose, BUN, bilirubin, specific gravity, and protein are slightly elevated.
Urine was yellow, clear, and had no odor present.

Patient Information

A 36-old female with a prior medical history of Crohn's disease with intermittent gastritis, depression, and anxiety brought herself into the ED because she as experiencing weakness, dizziness, and abdominal pain in her LRQ. The pt was admitted and diagnosed with a GI bleed. Six months ago she had surgery and had an ileostomy put in. She is currently taking ibuprofen for stress and headaches.

Nursing Interventions

- Encourage pt to drink 2 to 3 L of water a day as tolerated to maintain and restore lost fluids.
- Pt has been prescribed an IV of 0.9% sodium chloride 1000mL infusing at 150mL/hr to help maintain and restore lost fluid.
- Watch for fluid overload.
- Pt will get 4mg of morphine every 2 hours as needed to help control her pain level.
- Assess pt's pain characteristics and assess for signs and symptoms relating to pain 30 minutes after giving the prescribed pain meds.

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