

N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 6/22/2020	Patient Initials MB	Age 83	Gender Female
Race/Ethnicity White	Occupation Works at a church	Marital Status Married	Allergies Alendronate, Bee venom, Cephalexin, Nitrofurantoin, Penicillin's, Sulfa antibiotics
Code Status Full Code	Height 5'4"	Weight 152lb	

Medical History (5 Points)

Past Medical History: Diverticulitis, GERD, Syncope & TIA, Hypotension

Past Surgical History: Skin graft, Laparoscopic colon resection, Rotator cuff repair (L),
Cataract removal

Family History: Mother – Heart disease & Pacemaker; Father – Macular degeneration

Social History (tobacco/alcohol/drugs): Client has never smoked cigarettes or used smokeless tobacco. Client does not use drugs or drink alcohol.

Assistive Devices: Client uses a cane.

Living Situation: Client lives at home with her husband.

Education Level: High school diploma and some college.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

History of present Illness (10 points): Client is a 83 year old female who was admitted on 6/22/2020. Client has a past medical history of diverticulitis, GERD, TIA, and hypotension. The client presents to the ER with complaints of left lower quadrant pain and nausea when she tries to eat. She states the pain has been worsening since the night before. She states nothing helps the pain and she has not taken any medications for the pain. Patient also reports history of diverticulitis and colon resection.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Diverticulitis

Secondary Diagnosis (if applicable): N/A

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

Diverticulitis is when diverticula form in the at the weak areas throughout the bowel and bulge through the muscle. Once cause is decreased dietary fiber in the diet which can contribute to occurrences of diverticulitis (Matrana & Margolin, 2009). The client has a past medical history of diverticulitis as well as colon resection.

For diverticulitis, important lab tests include a CBC or complete blood count, BMP or basic metabolic panel, and urinalysis (Wilkins et al., 2013). The CBC showed increased white blood cells and neutrophils which is consistent with an infection. The urinalysis showed no abnormalities and showed no signs of the client having a urinary tract infection. The BMP was ran; however, all levels appear to be normal. With diverticulitis they can also do diagnostic imaging including a CT scan. The CT scan showed distal descending and sigmoid colon segment of acute diverticulitis with wall thickening and adjacent infiltration of the fat. This confirms the presence of acute diverticulitis.

Signs and symptoms of diverticulitis include left lower quadrant pain, nausea, vomiting, fever (Mayo Clinic, 2020). Upon arrival at the ER, the client had complaints of left lower quadrant abdominal pain and nausea. Also, upon assessment the client had described her last bowel movement as loose and watery, and upon light palpitation her abdomen was tender. At 0730 on 6/22/20 the client reported her pain a 3/10 in the left abdomen that was tender and constant. She was given pain medications to help with the pain.

For medical management, the client was given pain medications to help with the pain. The client was also given antibiotics, Levaquin and Flagyl, to help resolve the infection (Pagana et al., 2019). The client will need education as well before discharge. Educational topics to include would be regular exercise daily, high-fiber diet, and drinking adequate amounts of fluids. Some high-fiber foods include fresh fruits, fresh vegetables, and whole grains (Mayo Clinic, 2020).

Pathophysiology References (2) (APA):

Matrana, M. R., & Margolin, D. A. (2009). Epidemiology and pathophysiology of diverticular disease. *Clinics in colon and rectal surgery*, 22(3), 141–146. <https://doi.org/10.1055/s-0029-1236157>

Mayo Clinic. (2020, May 7). *Diverticulitis*.

<https://www.mayoclinic.org/diseases-conditions/diverticulitis/symptoms-causes/syc-20371758>.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosbys diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Wilkins, T., Embry, K., & George, R. (2013). Diagnosis and Management of Acute Diverticulitis. *American Family Physician*, 87(9), 612–620. <https://www.aafp.org/afp/2013/0501/p612.pdf>

Laboratory Data (15 points)

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	4.40 – 5.80	4.50	N/A	

Hgb	13.0 – 16.5	13.1	N/A	
Hct	38.0 – 50.0%	39.6	N/A	
Platelets	140 – 440	325	N/A	
WBC	4.00 – 12.00	15.1	N/A	Increased WBC indicate infection and inflammation which is consistent with the patients diagnosis of acute diverticulitis (Pagana et al., 2019).
Neutrophils	40 – 68%	73.3	N/A	Increased neutrophils indicate infection or stress (Pagana et al., 2019).
Lymphocytes	19 - 49%	19.4	N/A	
Monocytes	3.0 – 13.0%	12.1	N/A	
Eosinophils	0 – 8.0%	0.5	N/A	
Bands	3 - 5%	N/A	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-	133 – 144	137	139	
K+	3.5 – 5.1	4.2	4.2	
Cl-	98 – 107	104	107	
CO2	21 – 31	26	25	
Glucose	70 – 99	96	89	
BUN	7 – 25	14	14	
Creatinine	0.50 – 1.20	0.73	0.64	
Albumin	3.5 – 5.7	3.7	N/A	
Calcium	8.6 – 10.3	10.1	9.2	
Mag	1.6 – 2.6	N/A	N/A	

Phosphate	2.5 – 4.5	N/A	N/A	
Bilirubin	< 1.2	N/A	N/A	
Alk Phos	34 – 104	81	N/A	
AST	13 – 39	35	N/A	
ALT	7 – 52	32	N/A	
Amylase	30 - 110	46	N/A	
Lipase	0 - 160	20.2	N/A	
Lactic Acid	0.5 - 2	N/A	N/A	
Troponin	0 - 0.04	N/A	N/A	
CK-MB	30 - 135	N/A	N/A	
Total CK	0%	N/A	N/A	

Other Tests **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
INR	0.9 – 1.1	N/A	N/A	
PT	10.1 – 13.1	N/A	N/A	
PTT	25 - 36	N/A	N/A	
D-Dimer	< 250	N/A	N/A	
BNP	< 100	N/A	N/A	
HDL	35 - 80	N/A	N/A	
LDL	< 100	N/A	N/A	
Cholesterol	< 200	N/A	N/A	

Triglycerides	< 150	N/A	N/A	
Hgb A1c	4 – 5.6	N/A	N/A	
TSH	0.270 – 4.200	N/A	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	Yellow / clear	Yellow	N/A	
pH	5.0 – 9.0	6.0	N/A	
Specific Gravity	1.003 – 1.030	1.006	N/A	
Glucose	Negative	Negative	N/A	
Protein	Negative	Negative	N/A	
Ketones	Negative	Negative	N/A	
WBC	0 - 5	0-5; Negative	N/A	
RBC	0 - 4	Negative	N/A	
Leukoesterase	Negative	N/A	N/A	

Arterial Blood Gas **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
pH	7.35 – 7.45	N/A	N/A	
PaO2	75 - 100	N/A	N/A	
PaCO2	35 - 45	N/A	N/A	

HCO3	22 - 26	N/A	N/A	
SaO2	94 - 100	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	Negative	-	-	*Results are Pending
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostic Test Correlation (5 points):

6/22/20: CT abdomen/pelvis with contrast

Impression: Distal descending and sigmoid colon segment of acute diverticulitis with wall thickening and adjacent infiltration of the fat described. Previous right hemicolectomy and appendectomy performed. No bowel obstruction or free fluid. Bilateral para-pelvic renal cysts, cortical cysts as described and measured below. 2 cm posterior left lobe liver cyst. Multifocal subs-segmental atelectasis and scarring at the lung bases along the diaphragms and also note posteriorly as described.

Correlation: This test was performed to confirm suspicion of acute diverticulitis. CT scans can show infected or inflamed patches and their severity to confirm diverticulitis (Mayo Clinic, 2020).

Diagnostic Test Reference (APA):

Mayo Clinic. (2020, May 7). *Diverticulitis*.

<https://www.mayoclinic.org/diseases-conditions/diverticulitis/symptoms-causes/syc-20371758>.

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

Brand/Generic	Biotin (Appearax)	Acetaminophen (Tylenol)	Aspirin EC	Meclizine (Antivert)	Metoprolol Succinate (TOPROL-XL)
Dose	1000 mcg	500 mg	81 mg	12.5 mg	12.5 mg
Frequency	Daily	PRN	Daily	TID	Daily
Route	PO	PO	PO	PO	PO
Classification	Vitamins	Antipyretic, non-opioid analgesic	Anti-inflammatory, antiplatelet, antipyretic, non-opioid analgesic	Antiemetic, antiverigo	Antianginal, antihypertensive, MI prophylaxis and treatment
Mechanism of Action	It is a form of vitamin B found in foods. Biotin helps the body break down fats, carbohydrates, and proteins.	May reduce the production of prostaglandins in the brain. Prostaglandins are chemicals that cause inflammation and swelling.	Aspirin relieves pain by inhibiting production of chemicals called prostaglandins, aspirin works to diminish the body's response to a chain of chemical processes that eventually leads to pain. This mechanism of action works on a cellular level.	May inhibit nausea and vomiting by blocking cholinergic synapses in the brain's vomiting center and reducing sensitivity of labyrinthine apparatus.	Beta-blocker that affects the heart and circulation.

Reason Client Taking	To supports the health of the skin, nerves, digestive tract, metabolism, and cells.	To relieve mild to moderate pain.	To relieve mild pain or fever.	To treat motion sickness or to prevent vertigo.	To manage hypertension, alone of with other antihypertensive
Contraindications (2)	Kidney disease Hypersensitivity to biotin or its components.	Severe hepatic impairment. Severe active liver disease.	Asthma Bleeding problems	Hypersensitivity to meclizine or its components. (Only 1 listed in the book)	Acute heart failure Pulse less than 45 beats/min
Side Effects/Adverse Reactions (2)	Upset stomach Diarrhea	Agitation Peripheral Edema	Confusion Ecchymosis	Hypotension Jaundice	arrhythmias constipation
Nursing Considerations (2)	A significant reaction like wheezing; chest tightness; fever; itching; bad cough; blue skin color; seizures; or swelling of face, lips, tongue, or throat. Ask client's about taking other herbal supplements and check for drug interactions.	Tell patients that tablets may be crushed or swallowed whole. Teach patient to recognize signs of hepatotoxicity , such as bleeding, easy bruising, and malaise.	Don't crush timed-release aspirin tablets unless directed. Ask about tinnitus. This reaction usually occurs when blood aspirin level reaches or exceeds maximum dosage for therapeutic effect.	Use meclizine cautiously in patients with asthma, glaucoma, or prostate gland enlargement. Be aware that drug may mask signs of brain tumor, intestinal obstruction, or ototoxicity.	Expect to taper dosage over 1 – 2 weeks when drug is discontinued Assess ECG of patients who take metoprolol because they may be at risk for AV block
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Biotin can cause false results with certain medical tests. Tell any doctor who treats you that you are using biotin.	Liver function test results, including AST, ALT, bilirubin, and creatinine levels, as ordered must be monitored to check for hepatotoxicity.	Monitor patient for signs and symptoms of chickenpox or flu symptoms because of risk of Reye syndrome.	Monitor for hepatic or renal impairment.	Monitor patient for hyperthyroidism. Also check blood pressure and pulse before giving.
Client Teaching needs (2)	Do not use extra biotin to make up the missed dose. Biotin can cause false results with certain medical tests. Tell any doctor who treats you that you are using biotin.	Tell patient that tablets may be crushed or swallowed whole. Instruct the patient to read manufacturer's label and follow dosage guidelines precisely.	Advise adult patient taking low-dose aspirin not to also take ibuprofen because it may reduce the cardio protective and stroke preventive effects of aspirin. Instruct patient to take with food or after meals because it may cause GI upset if taken on an empty stomach.	Instruct the client to report blurred vision or other adverse effects that are prolonged or severe. Caution patient to avoid hazardous activities until drug's CNS effects are known.	Take at bedtime. Advise patient to notify prescriber if pulse rate falls below 60 beats/minute or is significantly lower than usual.

Hospital Medications (5 required)

Brand/Generic	Levofloxacin (Levaquin)	Metronidazole (Flagyl)	Miconazole 2% Powder	Latanoprost (Xalatan)	Ondansetron (Zofran)
Dose	750 mg	500 mg	Thin layer (QS)	1 drop	4 mg
Frequency	100 mL/hour	200 mL/hour	BID	Daily	Q12 PRN
Route	IV	IV	Topical	Eyes	PO
Classification	Antibiotic	Antibiotic, antiprotozoal	Topical antifungal	Ophthalmic glaucoma agents	Antilucer
Mechanism of Action	Interferes with bacterial cell replication by inhibiting the bacterial enzyme DNA gyrase, which is essential for repair and replication of bacterial DNA.	Undergoes intracellular chemical reduction during anaerobic metabolism. After metronidazole is reduced, it damages DNA's helical structure and breaks its strands, which inhibits bacterial nucleic acid synthesis and causes cell death.	They inhibit biosynthesis of ergosterol or other sterols, damaging the fungal cell membrane and altering its permeability.		Irreversibly blocks the enzyme system on parietal cells that is needed for secretion of gastric acid.
Reason Client Taking	Acute Diverticulitis	Acute Diverticulitis	Skin infections	Used to treat glaucoma or lower high eye pressure.	To treat symptomatic gastroesophageal reflux disease (GERD)
Contraindications (2)	Hypersensitivity to levofloxacin or its components. Myasthenia Gravis	Breastfeeding Hypersensitivity to metronidazole or its components.	Hypersensitivity to the components (Only 1 listed)	Hypersensitivity to latanoprost Swelling in the eye	Concurrent therapy with rilpivirine containing products. Hypersensitivity to omeprazole or its components.
Side Effects/Adverse Reactions (2)	Increased ICP Seizures	Chills Chest pain	For ringworm: Use daily for 4 weeks. If condition persists, consult a healthcare professional. For jock itch: Use daily for 2 weeks. If condition persists longer, consult a healthcare professional.	Eye irritation Eye discharge	Chest pain Diarrhea
Nursing Considerations (2)	Use medication cautiously in patients with renal insufficiency. Avoid giving drug within 2 hours of	Use cautiously in patients with CNS diseases. Discontinue primary IV infusion during	Do not use if the safety-sealed tube is punctured or damaged. Do not use on children under 2	Have your eye pressure and eyesight checked as you have been told by the doctor. Wash hands before	Give omeprazole before meals preferably in the morning. Advise patient to

	antacids.	metronidazole infusion.	years of age unless directed by a healthcare professional.	administering medication.	notify provider immediately about abdominal pain or diarrhea.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor renal function. Expect to obtain culture and sensitivity tests before treatment,	Monitor patients with severe liver disease. Monitor CBC and culture and sensitivity tests.	None specified on website	Check to make sure they aren't using another drug like this. Ask about other medications taking including herbal supplements.	Monitor for hypokalemia and hyperkalemia.
Client Teaching needs (2)	Advise patient to increase fluid intake during therapy to prevent crystalluria. Tell patient to complete the drug as prescribed, even if symptoms subside.	Urge the patient to take metronidazole at evenly spaced intervals during the day and with food to minimize adverse GI reactions. If patient reports dry mouth, suggest ice chips or sugarless hard candy or gum; suggest a dental visit if dryness lasts longer than 2 weeks.	Stop use and ask a healthcare professional if irritation occurs or if there is no improvement within 4 weeks. Clean the affected area and dry thoroughly before using.	Store unopened bottles in the refrigerator. Do not freeze. Throw away unused or expired drugs. Do not flush down a toilet or pour down a drain unless you are told to do so.	Advise patient to immediately report signs of hypersensitivity, such as rash. Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA.

Latanoprost Eye Drops (Solution) Information. (2020). <https://www.drugs.com/cdi/latanoprost-eye-drops-solution.html>.

MICONAZOLE Nitrate 2% Cream ANTIFUNGAL (cream) RTMH Enterprises DBA Research Technology Medical Home. Drugs.com. (2019). <https://www.drugs.com/otc/1137434/miconazole-nitrate-2-cream-antifungal.html>.

Multum, C. (2019). *Biotin Uses, Side Effects & Warnings*. Drugs.com. <https://www.drugs.com/mtm/biotin.html>.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient is A&x4. Patient is responsive. No distress noted. Patient is compliant and her speech is clear. Overall appearance is appropriate.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Patient’s skin is pink, warm, and dry. Turgor is elastic with quick recoil to normal state. No rashes, bruises, or wounds noted. Client’s Braden score is 22. No drains present.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head, neck, nose, and eyes are symmetrical. Client uses visual aid. Mouth is pink and moist. Teeth indicate good dentition no cracks or yellowing.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable):</p>	<p>S1, S2 noted. No murmurs or gallops. Regular rhythm. Peripheral pulses +3 bilaterally. Cap refill is less than 3 seconds. No neck vein distention. Mild edema on right forearm or +1</p>

<p>Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>related to infiltration.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>No accessory muscle use, pattern is even. Breath sounds are clear, equal, bilaterally. Respiratory pattern is regular.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" 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>Diet at home is regular. Current diet in the hospital is clear liquid. Clients is 5' 4" and weighs 152 lbs. Bowel sounds are hyperactive in all quadrants. Patient stated last bowel movement was earlier in the morning (6/22), she described it as loose and watery. On palpation, abdomen was soft and tender, no masses noted. On inspection there is no distention, scars, drains, or wounds. No ostomy, nasogastric tube, or feeding tubes.</p>
<p>GENITOURINARY (2 Points): Color: 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:</p>	<p>Urine was clear and yellow. Client urinated 250 mL while we were there. No pain with urination noted. Genitals appear clean and moist. No dialysis or catheter.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Client is alert, oriented and compliant. Client has full range of motion in all extremities. Strength is a 5 in all extremities. Client uses a cane to walk. She is a not fall risk with a score of 4. Client is independent (up ad lib).</p>

<p>Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input checked="" type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	
<p>NEUROLOGICAL (2 points):</p> <p>MAEW: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no -</p> <p>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</p>	<p>Client moves all extremities well. Pupils are equal, round, and react to light and accommodation. Strength is equal in both arms and legs. Client is oriented. Mental status is normal cognition. Speech is clear. Level of consciousness is alert, awake and answers all questions.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points):</p> <p>Coping method(s):</p> <p>Developmental level:</p> <p>Religion & what it means to pt.:</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Client is coping well and hopes to leave the hospital when her pain is under control. Client is religious, the priest came in and said a prayer with her. The client’s family was very supportive and have been keeping up with her via phone calls, they are accepting of her care. She has also requested more information about her condition and preventable measures.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0701	83	106/40	16	98 F (Temporal)	97 (room air)
0338	70	99/44	14	97.7 F (Temporal)	95 (room air)

Vital Sign Trends:

Vital signs appear stable and consistent. Diastolic blood pressure does appear low but when looking in the chart, that appears to be normal for the client (I also asked the nurse and she said this was normal for the client).

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0701	0 - 10	Left abdomen	5	Tender & constant	Pain medications
0338	0 - 10	Left abdomen	1	Dull	Position change

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	Client has a 22 gauge, single lumen in the left lower arm. Inserted 6/23/20. Dressing is dry and intact. No phlebitis, infiltration, erythema, or drainage. The line is patent and flushes easily. Continuous LR is running at 75 mL/hour.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
300 mL (IV fluids)	250 mL (urine)

Nursing Care**Summary of Care (2 points)**

Overview of care: Client presented to the ER with complaints of lower left quadrant abdominal pain. After performing a CBC, urinalysis, and CT scan, the client was diagnosed with acute diverticulitis. The client was put on antibiotics to help resolve the infection.

Procedures/testing done: A CT scan was performed and confirmed diagnosis of diverticulitis.

Complaints/Issues: Client has complaints of constant pain and tenderness in her abdomen.

Vital signs (stable/unstable): Vital signs are stable and consistent.

Tolerating diet, activity, etc.: Client tolerates her diet and activity well.

Physician notifications: Notify physician if pain continues to get worse.

Future plans for patient: Introduce soft diet, continue with fluids and antibiotics.

Discharge Planning (2 points)

Discharge location: Client will be discharged home with her husband.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Client uses a cane.

Follow up plan: Client will have a follow up with her primary care provider.

Education needs: Client will need education on when to call her physician if the pain persists and other signs and symptoms to be aware of. Client will need education on any antibiotics she is sent home on including to not stop the therapy abruptly. She will also need education on exercising regularly, introducing a high-fiber diet, and increasing daily fluids.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <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.
<p>1. Third Risk for imbalanced nutrition: less than body requirements related to acute diverticulitis as evidenced by the</p>	<p>Since the client is experiencing nausea when she eats, she is not eat adequate amounts during the day.</p>	<p>1.Advance from clear liquids to soft food as tolerated.</p> <p>2.Assess abdomen frequently for return to softness,</p>	<p>The client responded well to the nurse’s actions. After introducing soft foods into the client’s diet she reported no feelings of nausea and less stomach pain.</p>

<p>patient stating feelings of nausea when she eats.</p>		<p>reappearance of normal bowel sounds, and passage of flatus.</p>	
<p>2. Second Acute pain related to inflammation of the diverticula as evidenced by patient rating abdominal pain a 5/10.</p>	<p>Because of the inflammation in the bowel, the client is experiencing pain that needs managed.</p>	<p>1. Investigate pain reports regularly, noting location, duration, intensity, and characteristics. 2.Administer pain medications as prescribed.</p>	<p>The patient responded well to the nurse’s actions. After administration of pain medications the patient reported a decrease in pain to a 1/5.</p>
<p>3. FourthDeficient knowledge related to lack of information regarding condition as evidenced by client verbalization of problems.</p>	<p>Client asks the nurse about more information about the disease to help prevent complications in the future.</p>	<p>1. Provide patient with printed information about preventative measures that can be taken to reduce the risk of complications in the future. 2.Include teaching about daily regular exercise, implementation of high-fiber foods into the diet, and how to increase daily fluids.</p>	<p>Client responded well and understood the information provided to her. She verbalized how she was going to get more exercise and fluids into her daily routine as well as foods she was going to introduce into her diet.</p>
<p>4. First Risk for infection related to left lower quadrant abdominal pain as evidenced by an increased white blood cell count of 15.1.</p>	<p>Client complains of abdominal pain which indicates there is a problem and increased white blood cells indicate an infection.</p>	<p>1. Administer antibiotics or antimicrobials as prescribed. 2. Assess vital signs frequently and note any changes.</p>	<p>The patient responded well to the nurse’s actions. After antibiotic therapy the white blood cells decreased to a normal level and patients abdominal pain lessened.</p>

Other References (APA):

Vera, M. (2020). *Nursing Care Plans (NCP): Ultimate Guide and Database*. Nurses Lab. <https://nurseslabs.com/nursing-care-plans/>.

Concept Map (20 Points):

Subjective Data

Patient came into the ER complaining of left lower quadrant abdominal pain and nausea. Patient explained the pain was worsening since the night before. She has a past medical history of diverticulitis, colon resection, and GERD. She was diagnosed with acute diverticulitis which was confirmed by CT scan.

Nursing Diagnosis/Outcomes

- Risk for imbalanced nutrition: less than body requirements related to acute diverticulitis as evidenced by the patient stating feelings of nausea when she eats.
Outcome: Client will begin introducing soft foods and won't experience nausea.
- Acute pain related to inflammation of the diverticula as evidenced by patient rating abdominal pain a 5/10.
Outcome: After pain medications, pain will decrease and the client will be more comfortable.
- Deficient knowledge related to lack of information regarding condition as evidenced by client verbalization of problems.
Outcome: After providing teaching to the client, the client will understand and implement changes into her daily life.
- Risk for infection related to left lower quadrant abdominal pain as evidenced by an increased white blood cell count of 15.1.
Outcome: After antibiotic treatment, client will experience less abdominal pain and infection will subside.

Objective Data

0701:

Pulse	B/P	Resp Rate	Temp	Oxygen
83	106/40	16	98 F	97 (room

0338:

70	99/44	14	97.7 F	95 (room air)
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Patient Information

The patient is an 83-year-old female. She is married and works at a church. She is 5' 4" and weighs 152 lbs. She doesn't smoke or use smokeless tobacco. She occasionally drinks alcohol and no drugs.

Nursing Interventions

- Advance from clear liquids to soft food as tolerated.
- Assess abdomen frequently for return to softness, reappearance of normal bowel sounds, and passage of flatus.
- Investigate pain reports regularly, noting location, duration, intensity, and characteristics.
- Administer pain medications as prescribed.
- Provide patient with printed information about preventative measures that can be taken to reduce the risk of complications in the future.
- Include teaching about daily regular exercise, implementation of high-fiber foods into the diet, and how to increase daily fluids.
- Administer antibiotics or antimicrobials as prescribed.
- Assess vital signs frequently and note any changes.

