NURSING B23
MEDICAL SURGICAL NURSING 2

NURSING PROCESS

Student name:
Date of Care: ---- 2010
Instructor: Gabi Martin

PART I: DEMOGRAPHICS & CURRENT PHYSICIAN ORDERS

Room # / Initials	Height	Weight (kgs)	Age / Gender	Immunization / Date	Advanced Directive	Code Status	Admit Date	Date(s) of Care
220-2 B.W.	**67”**	**116 Kg**	**39 y/o male**	☐ **Influenza –** refused ☐ **Pneumovax -** refused **X Tetanus –** date UNK	☐ **Yes** **X No**	**X Full** **☐Directed** ☐ **CPR** ☐ **Drugs** ☐ **Ventilator** ☐ **Defibrillate** **☐DNR**	**--/--/10**	**--/--/10**

Presenting Signs / Symptoms

Nausea, vomiting, and diffuse lower abdominal pain for 24 hours.

Admitting Diagnosis

Right Lower Quadrant abdominal pain; nausea and vomiting

Secondary Diagnoses (Acquired during hospital stay, subsequent to admitting diagnosis)

Acute Appendicitis

History of present Illness (Sequence of events beginning from admission expanding to day of care)

S: --/--/10 – CC: Nausea and vomiting; diffuse abdominal pain that began to localize to RLQ. Went to the ER in Tehachapi and was diagnosed with Acute Appendicitis there. Sent to Mercy Truxton due to no general surgeon in Tehachapi. Open appendectomy on --/--/10 with no complications.

B: NKA/NKDA PSH: Left knee surgery for minor meniscus tear. PMH: none

A: C/O of 5/10 pain in lower abdomen from surgical procedure. Dressing on surgical incision- dry, clean, and intact. VS stable. Abdomen is distended with absent BSx4, wheezing in upper lung fields bilaterally. Productive cough with thin yellow sputum. SpO2 – 95% RA. IV in left AC – no redness, swelling, or tenderness

R: Incentive Spirometer every hour, increase fluid intake, splint abdomen when coughing to help with pain, increase fluid intake, ambulate at least 3-4 times a day as tolerated

Recent Surgical Procedure(s) / Date(s) (Within in the past five years, or relevant to current diagnoses)

Left Knee surgery in 2009

Past Medical History

None

Substance Use (include type, frequency, and duration)

Tobacco **X Yes – one pack a day for “several years” Last smoked on --/--/10**

Alcohol	**X Yes – occasional - last time UNK**
Elicit drugs	**□ Yes X No**
OTC	**X Yes - occasionally; Tylenol or Motrin for minor pain**

Allergies / Reactions

NKA/NKDA

Ethnicity	Religious Preference	Marital Status / Family Structure	Occupation
Caucasion	None	Married / No children	Miner

ALL CURRENT (ACTIVE) PHYSICIAN ORDERS

--/--/10	Admit to Med/Surg per Dr. Micheal
	Dx: Acute Appendicitis
	IVF: D5 ½ NS @ 125mL/hr
	DC plan as per Dr. Guerrera
	Clear liquid diet when awake
	Do not remove tegaderm until F/U on --/--/10
	Home Meds for discharge: Keflex 500mg PO q6h; Vicodin tab #40 PO q4h PRN for pain
	CBC w/ diff, BMP, Mag, Phos qAM
	Morphine 2mg IV q2h PRN for pain
	Reglan 10mg IV q6h PRN for nausea/vomiting
	Protonix 40mg IV daily
	K+ protocol
	Zosyn 3.375g IVPB q6h
	Zofran 4mg IV q6h PRN for nausea/vomiting
--/--/10	DC IV
	DC home

TIME: 0935 **VS - BP:** 139/83 **P:** 86 **R:** 26 **T:** 99.0

PHYSCIAL ASSESSMENT **DATE/TIME:** --/--/10 @ 0900

General: 39 y/o male sitting up in bed eating breakfast. Body type overweight. Good oral and body hygiene. IV left AC, no swelling, redness, tenderness; IVF D 5 ½ NS @ 125mL/hr.

Neuro: PERRLA; A&Ox3; Speech clear, answers questions appropriately. Grips strong and equal bilaterally. Sensation present to all extremities. Pain 5/10 on pain scale. States does not want pain meds at this time.

Cardiac: Apical pulse 87 bpm, strong and regular. Nail beds pink cap refill <3 sec in all extremities. Pulses present in all extremities. No edema in all extremities or sacral area.

Resp: Wheezing in upper lung fields bilaterally upon auscultation. Denies SOB or difficulty breathing. Cough noted, producing thin yellowish sputum. SpO2 95% RA. Equal expansion bilaterally. States his abdomen hurts and the pain interferes with effective coughing.

GI: Absent BS x4. Abdomen distended and slightly firm. No guarding. No masses palpated. 2-3" surgical incision RLQ covered with dressing – dry, clean, intact. Last BM on 10/12/10 in AM before going to hospital. Denies nausea or vomiting. Tolerates PO intake well.

GU: BRP as tolerated. Denies pain or burning with urination. Urine yellow and clear. No bladder distention palpated.

MS: Moves all extremities freely. Ambulatory with no assistance. Gait strong and steady. States he has "some soreness in his lower abdomen and shoulders"

Integumentary: Skin warm, dry to touch. No scars, tattoos, rashes, lesions, or other breakdown observed. 2-3" surgical incision on RLQ S/P open appendectomy. Dressing clean, dry, intact.

Pysch/Soc: States he feels "better today". Affect is pleasant and friendly. Visiting with wife through out the day.

What cultural influence will affect your care? States he does not have any special cultural beliefs. Wife wishes to be involved with his care. Will educate both patient and his wife about hospital care and on discharge planning.

Nursing Notes

Date/time	
--/--/10 @ 0720	Report received and care assumed. Sleeping quietly in bed. IV left AC. No swelling, redness, or tenderness.
0930	Educated on how to use the Incentive Spirometer and how often to use it. Provided extra pillow to use as a splint to help with pain when coughing. Encouraged ambulation as tolerated. Encouraged to increase PO fluid intake.
1045	States pillow is helping him when he coughs and is able to cough up "the junk in his chest." Ambulated around unit with no assistance. Denies any pain, dizziness, or difficulty with ambulation.
1230	Wheezing in all lung fields. SpO2 96% RA. Reported findings to Kim, staff RN.
1400	Hypoactive BS x 4. States he "feels something moving around down there." Attempted to have a BM with no result.
1445	Report given to Toya RN. Pain 5/10 – states he does not want any pain meds at this time. VS stable. Resting in bed and visiting with wife.

TIME: 1000 **VS: BP:** 126.78 **P:** 81 **R:** 20 **T:** 98.9 F

PART II: PATHOPHYSIOLOGY CONCEPT MAP

Risk factors

Signs and Symptoms

Potential complications

Disease Process _____

Pathophysiology (Definition / etiology chronicity and prognosis)

Medical interventions, labs and diagnostic studies

Nursing interventions

PART II: PATHOPHYSIOLOGY CONCEPT MAP

Risk factors

Signs and symptoms

Potential complications

Disease Process _____

Pathophysiology (Definition / etiology chronicity and prognosis)

Medical interventions, labs and diagnostic studies

Nursing interventions

PART III: *T A C T I S* FACESHEET

Complete a medication list for all drugs, routine and PRN, which includes drug, dose and frequency.

Routine Medication (PO, IM, IV, etc)

Zosyn 3.375g in 50mL IVPB q6h

Protonix 40mg IV daily

Parental fluids: Intravenous Infusions

Intravenous fluid: composition of fluid: Dextrose 5% in 0.45% Normal Saline

Additives:

Why is your client getting this solution? Maintain fluid volume due. Client is on a full liquid diet S/P appendectomy and needs adequate fluid to help with the body's healing process.

Site: Left AC

Tubing: Change --/--/10

PRN Medications

PO: none

IV: Reglan 10mg IV q6h PRN for nausea/vomiting

Zofran 4mg IV q6h PRN for nausea/vomiting

Morphine 2mg IV q2h PRN for pain

Other: none

PART III: PRESCRIBED MEDICATIONS: *T A C T I S*

Medications – Trade/Generic: Protonix (pantoprazole)

Dose / Route / Frequency: 40mg IV daily

Pharmacological Classification: benzimidazole

Why is this client receiving this drug? Client is S/P appendectomy and is on a full liquid diet; and to help with stress induced acid production from being admitted to the hospital.

T **Therapeutic Effect**	**A** **Action**	**C** **Contraindications** (*list only if contraindicated for this client*)	**T** **Toxic /Side Effects** (*Most serious & frequent*)	**I** **Interventions** (*Include nsg intervention, labs, parameters for this med*)	**S** **Safety** (*Include MSI *& MSD*for all IV Meds*)
Increases gastric pH and reduces gastric acid production.	Irreversibly binds to and inhibits hydrogen potassium adenosine triphosphate, an enzyme surface of gastric parietal cells. Inhibits hydrogen ion transport into gastric lumen	No known contraindications for this drug	*Toxic effects:* Rarely- hyperglycemia *Frequent SE:* **Diarrhea**, **HA**, **dizziness**, pruritus, **rash**	- Obtain baseline labs including serum creatinine and cholesterol - Evaluate for therapeutic response - Be aware of GI discomfort or nausea	Safe dose: **X** Yes □ No Usual dose: 40mg /day IV for 7-10 days Reconstitute 40 mg vial with 10mL of 0.9% NaCl Infuse 10mL dilution over 2 min

*All meds being titrated (i.e., heparin) state appropriate lab results related to medication administration. ** MSI – minimum safe infusion; MSD – minimum safe dilution

Reference: Hodgson, B. (2010) Nursing Drug Handbook. (pp. 879-880). Saunders Elsevier. St. Louis, MO.

PART III: PRESCRIBED MEDICATIONS: *T A C T I S*

Medications – Trade/Generic: Zosyn (piperacillin sodium and tazobactam sodium)

Dose / Route / Frequency: 3.375g every 6 hours IVPB

Pharmacological Classification: Extended spectrum penicillin and beta-lactamase inhibitor

Why is this client receiving this drug? Client has a diagnosis of appendicitis and is S/P appendectomy; and to prevent further infection in the peritoneal cavity.

T **Therapeutic Effect**	**A** **Action**	**C** **Contraindications** (*list only if contraindicated for this client*)	**T** **Toxic /Side Effects** (*Most serious & frequent*)	**I** **Interventions** (*Include nsg intervention, labs, parameters for this med*)	**S** **Safety** (*Include MSI *& MSD*for all IV Meds*)
piperacillin- Bactericidal tazobactam – Inactivates bacterial beta-lactamase Protects piperacillin from enzymatic degradation, extends the spectrum of activity, and prevents bacterial overgrowth	Inhibits cell wall synthesis by binding to bacterial cell membranes	N/A for this client	*Toxic effects:* Antibiotic-associated colitis may result from altered bacterial balance. Rarely – severe hypersensitivity including anaphylaxis. *Frequent SE:* **Diarrhea**, **HA**, **constipation**, **nausea**, insomnia, **rash**, hypokalemia	- Monitor for sensitivity - Monitor daily pattern of bowel activity and consistency - Monitor I&O - Monitor serum electrolytes; esp. potassium - Monitor renal function - IV infusion may cause thrombophlebitis, observe IV site frequently	Safe dose: **X** Yes □ No (3g x 4 doses = 12g daily) (0.375g x4 doses = 1.5g daily) Usual dose: 3.375g q6h Max dose: 18g/2.25g daily 3.375g is 3g of piperacillin with 0.375g of tazobactam is given every six hours (for every 1g of piperacillin there is 0.125g of tazobactam) Dilute with each 1g with at least 5mL of SW or NS. Give over 30min

*All meds being titrated (i.e., heparin) state appropriate lab results related to medication administration. ** MSI – minimum safe infusion; MSD – minimum safe dilution

Reference: Gahart. B, A. Nazareno (2010) Intravenous Medications 26th ed. (pp. 1091-1094). Mosby Elsevier. St. Louis, MO.;

Hodgson, B. (2010) Nursing Drug Handbook. (pp. 914-915). Saunders Elsevier. St. Louis, MO.

PART III: PRESCRIBED MEDICATIONS: *T A C T I S*

Medications – Trade/Generic: Morphine

Dose / Route / Frequency: 2mg IV every 2 hours PRN for pain

Pharmacological Classification: Narcotic agonist

Why is this client receiving this drug? To control pain S/P appendectomy

T **Therapeutic Effect**	**A** **Action**	**C** **Contraindications** (*list only if contraindicated for this client*)	**T** **Toxic /Side Effects** (*Most serious & frequent*)	**I** **Interventions** (*Include nsg intervention, labs, parameters for this med*)	**S** **Safety** (*Include MSI *& MSD*for all IV Meds*)
Alters pain perception and emotional response to pain	Binds with opioid receptors in the CNS	None for this client	*Toxic effects:* **Respiratory depression**, Skeletal muscle flaccidity, cold/clammy skin, cyanosis, extreme somnolence leading to SZ, stupor, coma *Frequent SE:* sedation, decreased B/P, orthostatic hypotension, diaphoresis, facial flushing, **constipation**, **dizziness**, **drowsiness**, **nausea**, vomiting	- Assess pain location, quality, and level before administration - Assess VS before administration and 5-10 min after administration, esp. Resp. and B/P - Assess B/P 30 min after administration - Monitor daily bowel activity - Take measures to avoid constipation - Initiate TCDB - Consult with physician if pain relief is not adequate	Safe dose: **X** Yes □ No Usual dose: 2.5-5mg q3-4h PRN. Repeated doses may be given more frequently. May be given undiluted. IV injection may be diluted 2.5-15mg morphine in 4-5mL of sterile water. Administer very slowly – over 4-5min (rapid IV admin increases the risk of severe adverse reactions)

*All meds being titrated (i.e., heparin) state appropriate lab results related to medication administration. ** MSI – minimum safe infusion; MSD – minimum safe dilution

Reference: Hodgson, B. (2010) Nursing Drug Handbook. (pp. 773-776). Saunders Elsevier. St. Louis, MO.

PART III: PRESCRIBED MEDICATIONS: *T A C T I S*

Medications – Trade/Generic: Zofran (ondansetron)

Dose / Route / Frequency: 4mg IV every 6 hours PRN for nausea/vomiting

Pharmacological Classification: Selective receptor antagonist

Why is this client receiving this drug? Client may experience nausea and vomiting from the analgesia used during surgery, and from Zosyn and morphine.

T **Therapeutic Effect**	**A** **Action**	**C** **Contraindications** (*list only if contraindicated for this client*)	**T** **Toxic /Side Effects** (*Most serious & frequent*)	**I** **Interventions** (*Include nsg intervention, labs, parameters for this med*)	**S** **Safety** (*Include MSI *& MSD*for all IV Meds*)
Prevents nausea and vomiting	Blocks serotonin both peripherally and on vagal nerve terminals in chemo-receptor trigger zone	N/A for this client	*Toxic effects:* HTN, acute renal failure, GI bleeding, **respiratory depression**, coma occurs rarely *Frequent SE:* Anxiety, **dizziness**, **HA**, **drowsiness**, fatigue, **constipation**, **diarrhea**, hypoxia, urinary retention	- Assess for dehydration if excessive vomiting occurs - Assess for bowel sounds - Assess mental status, monitor daily pattern of bowel activity and consistency	Safe dose: **X** Yes □ No Usual dose: 4mg IV as a single dose IV injection may be given undiluted. Give over 2-5 min

*All meds being titrated (i.e., heparin) state appropriate lab results related to medication administration. ** MSI – minimum safe infusion; MSD – minimum safe dilution

Reference: Hodgson, B. (2010) Nursing Drug Handbook. (pp. 850-852). Saunders Elsevier. St. Louis, MO.

PART III: PRESCRIBED MEDICATIONS: *T A C T I S*

Medications – Trade/Generic: Reglan (metoclopramide)

Dose / Route / Frequency: 10mg IV every 6 hours PRN for nausea/vomiting

Pharmacological Classification: Dopamine receptor antagonist

Why is this client receiving this drug? Client may experience nausea and vomiting from the analgesia used during surgery and from Zosyn and morphine. Also, peristalsis and gastric empting may be slowed due to surgical manipulation of the intestines.

T **Therapeutic Effect**	**A** **Action**	**C** **Contraindications** (*list only if contraindicated for this client*)	**T** **Toxic /Side Effects** (*Most serious & frequent*)	**I** **Interventions** (*Include nsg intervention, labs, parameters for this med*)	**S** **Safety** (*Include MSI *& MSD*for all IV Meds*)
Accelerates intestinal, transit, gastric emptying and relieves nausea and vomiting	Stimulates motility of upper GI tract. Decreases reflux into esophagus. Raises threshold activity in chemo-receptor trigger zone.	N/A for this client	*Toxic effects:* Concurrent use of medications likely to produce extrapyramidal reactions (mostly in children) *Frequent SE:* **Drowsiness**, restlessness, fatigue, lethargy	- Assess for dehydration - Monitor for anxiety, restlessness, extrapyramidal reactions ESP w/IV administration. - Monitor for therapeutic effect of gastroparesis - Monitor daily pattern of bowel activity and consistency - Monitor renal function - Monitor B/P and HR	Safe dose: **X** Yes □ No Usual Dose: 10-20mg IV q4-6h PRN May be given undiluted; Dilute doses greater than 10mg in 50mL of D5W, NS, NaCl, or LR and infuse over 15min IV push at rate of 10mg over 1-2 min IV rate that is too fast may produce intense feelings of restlessness and/or anxiety followed by drowsiness

*All meds being titrated (i.e., heparin) state appropriate lab results related to medication administration. ** MSI – minimum safe infusion; MSD – minimum safe dilution

Reference: Hodgson, B. (2010) Nursing Drug Handbook. (pp. 741-742). Saunders Elsevier. St. Louis, MO.

PART IV: ADULT LABORATORY / DIAGNOSTIC TOOL

Test	Reference Range	Date Baseline- --/--/10	Date --/--/10	Date --/--/10	Identify ↑ ↓/ Significance / Analysis / Nursing Interventions
WBC	4.5 - 11	15.5 H	12.9 H	11.4 H	WBC with differential provides specific information related infection and disease processes. WBC is elevated, but is decreasing over time. This indicates that the client is fighting an infection from his diagnosis of appendicitis; with antibiotic treatment the WBC count is decreasing. Nursing Interventions include: Check WBC w/ differential daily to determine if the WBC counts are decreasing or increasing; Assess client for S/S of continuing or worsening infection (elevated temp, increased pulse rate; redness, swelling, edema, drainage from wound site); assess for S/S of healing [LeFever-Kee, 2010]
RBCs	4.6 - 6.2	4.81	4.45 L	4.91	Mostly WNL; however on the day after surgery there is a slight decrease. This may be due to the minor blood loss during surgery and the effects of the body fighting an infection. Also, the client has been receiving IV fluids and the RBC count may be diluted to the fluids. Nursing interventions include: Determine if the client is over hydrated; check for blood loss post-op by assessing abdominal girth and firmness, Decrease in B/P and increase in HR, and check surgical dressing for excessive blood or fluid. [LeFever-Kee, 2010]
Hgb	14 - 16.5	15.7	14.5	16.0	WNL
Hct	42 - 52	44.7	41.1 L	45.6	WNL; however, on the day after surgery the client's level is slightly decreased. This may be due to some blood loss during surgery, the surgical removal of the appendix, and from receiving IV fluids. Nursing interventions: Monitor for S/S of blood loss. [LeFever-Kee, 2010]
MCV	80 - 90	93.0	92.5	92.9	WNL
MCH	25 - 32	32.7 H	32.5 H	32.5 H	Indicates the weight of the hemoglobin in the RBC regardless of the RBC size. It is a marker determining if an adequate amount of oxygen is being picked up by the RBC's in the lungs and distributed throughout the body. This client's slightly elevated count may be due to his history of smoking a pack of cigarettes a day. Nursing Interventions: Educate on the importance of quitting smoking, provide information on smoking cessation.
MCHC	32 - 36	35.2	35.2	35	WNL
RDW	9.5 - 15	12.8	12.5	12.7	WNL

Retic.	N/A	N/A	N/A	N/A	N/A
Platelet	150 - 400	176	162	179	WNL; however there was a slight decrease on the day after surgery. This may be due to the client receiving antibiotic therapy for acute appendicitis and form the surgical procedure itself. Nursing Interventions: assess platelet lab daily to monitor for decreasing platelet count and report any abnormal counts. [LeFever-Kee, 2010]
Neutrophils	2.25 - 7.7	13.3 H	10.8 H	9.4 H	Neutrophils respond rapidly to inflammatory and tissue injury. They are the first line of defense in acute infections. This client's neutrophil count is high due to a diagnosis of appendicitis and from his recent appendectomy surgery. The fact they are decreasing indicates that his infection and inflammation of surgery are healing. Nursing Interventions: Monitor WBC labs daily; asses for worsening infection, assess for adequate healing of surgical site. [LeFever-Kee, 2010]
Lymphocytes	0.9 – 4.4	1.0	0.9	0.9	WNL
Monocytes	0.11 – 0.99	1.2 H	1.0 H	1.0 H	Monocytes are the second line of defense against bacterial infection and inflammation. They respond late in the acute phase of infection and inflammation. This client's monocyte count is high due to acute appendicitis and from the inflammation associated with appendicitis. The count remains high from the body's natural inflammatory response due to surgery. Nursing Interventions: Monitor WBC labs daily; continue to asses for worsening infection, assess for adequate healing of surgical site. [LeFever-Kee, 2010]
Eosinophils	0.01 – 0.55	0.1	0.1	0.1	WNL
Basophils	0 – 0.33	0.0	0.1	0.0	WNL

PART IV: ADULT LABORATORY / DIAGNOSTIC TOOL

BLOOD CHEMISTRY

Test	Reference Range	Date Baseline --/--/10	Date --/--/10	Date --/--/10	Identify ↑ ↓/ Significance / Analysis / Nursing Interventions
Sodium	132 - 150	138	134	135	WNL
Chloride	96 - 110	101	101	98	WNL
Potassium	3.5 – 5.5	3.5	3.5	3.5	Potassium is important for cardiac and muscle function. The serum range is narrow so it is important to monitor serum potassium levels often when indicated. The client's serum levels are on the low end of normal which may be due to the client being on antibiotic therapy with a potential SE of hypokalemia and from the client receiving IV fluids as well as PO fluids. Over hydration can give a false low result. Nursing interventions: Monitor potassium levels daily; administer PO or IV potassium as per hospital protocol and re-test serum levels 1 after IV administration and 4 hours after PO administration; determine if client is over hydrated; observe for S/S of hypokalemia such as confusion, irritability, mental depression, hypotension, cardiac dysrhythmias, N/V, diarrhea, and muscle. weakness and leg cramps. [LeFever-Kee, 2010]
CO2	23 - 31	25.0	28.0	29.1	WNL
BUN	5 - 23	12	8	7	WNL; however, on the day of surgery the level was slightly more elevated than the following days. This may be due to the client's possible dehydration from vomiting and NPO status. Nursing interventions: monitor BUN labs daily, hydrate the client as ordered, monitor creatinine levels with BUN to determine of kidney issues are present. [LeFever-Kee, 2010]
Creatinine	0.61 – 1.27	0.95	1.00	0.98	WNL
Glucose	65 - 105	126 H	121 H	130 H	The client's glucose levels are elevated possibly due to the infection from the diagnosis of acute appendicitis and from receiving D 5% in NS IV fluid on a continuous basis while in the hospital. Anesthesia drugs may also increase glucose levels as can stress from the trauma of surgery. Nursing Interventions: continue to monitor serum blood levels daily or more frequently if levels are excessively high; administer insulin as ordered if levels are excessively high; be aware of S/S associated with hyperglycemia (polydipsia, polyuria, ploy phagia) . [LeFever-Kee, 2010]
Magnesium	1.8 – 2.6	N/A	2.1	2.3	WNL

	Calcium	8.7 – 10.2	8.5 L	8.3 L	8.6 L	Calcium is necessary in blood clotting and in nerve impulse transmission. Slightly decreased levels may be due to antibiotic therapy, and from the client not ingesting calcium due to him being on a full liquid diet. Nursing Interventions: Check serum calcium labs daily and report any abnormal results; observes for S/S of hypocalcemia; administer PO calcium before or 1-1 ½ hours after meals. If giving IV infusion administer slowly with 5% dextrose and monitor EKG. [LeFever-Kee, 2010]
	Phosphorus	2.0 – 5	N/A	1.7 L	3.0	Phosphorus helps with the metabolism of fats and carbohydrates and with the metabolism of calcium. Usually there is a relationship between phosphorus and calcium (when phos increases Ca decreases and vise versa) The client has a low phos level on the day after surgery possibly due to him receiving continuous IV fluids with dextrose, full liquid diet status, and NPO status before surgery. Nursing Interventions: monitor labs daily and report any abnormal findings; observe for S/S of hypophosphsatemia and hypercalcemia; do not administer antacids that contain aluminum hydroxide. [LeFever-Kee, 2010]
C	INR	2.0 – 3.0	2.1	N/A	N/A	WNL
O	PT	11.2 – 15	16.9 H	N/A	N/A	Client has an increased level on the day of surgery. This may be due to the administration of penicillin antibiotics. The client does not meet any other criteria for an increased PT level. Nursing Interventions: monitor labs daily and report findings as required, observes for S/S of bleeding, administer vitamin K via IM injection as required. [LeFever-Kee, 2010]
A	PTT	22.4 – 41.2	30.8	N/A	N/A	WNL
G	Why on anticoag?	N/A	N/A	N/A	N/A	N/A

PART IV: ADULT LABORATORY / DIAGNOSTIC TOOL

	Test	Reference Range	Date	Date	Date	Identify ↑ ↓/ Significance / Analysis / Nursing Interventions
L	AST	N/A	N/A	N/A	N/A	N/A
I	ALT	N/A	N/A	N/A	N/A	N/A
V	Acid Phosphatase	N/A	N/A	N/A	N/A	N/A
E	Ammonia	N/A	N/A	N/A	N/A	N/A
R	LDH	N/A	N/A	N/A	N/A	N/A
	Alk. Phos.	N/A	N/A	N/A	N/A	N/A
F	Total Bilirubin	N/A	N/A	N/A	N/A	N/A
U	Cholesterol	N/A	N/A	N/A	N/A	N/A
N	Uric acid	N/A	N/A	N/A	N/A	N/A
C	Total protein	N/A	N/A	N/A	N/A	N/A
T	Albumin	N/A	N/A	N/A	N/A	N/A
I	Globulin	N/A	N/A	N/A	N/A	N/A
O	Amylase	N/A	N/A	N/A	N/A	N/A
N	Lipase	N/A	N/A	N/A	N/A	N/A

PART IV: ADULT LABORATORY / DIAGNOSTIC TOOL

	Test	Range	Date	Date	Date	Identify ↑ ↓/ Significance / Analysis / Nursing Interventions
A B G' S	**pH**	N/A	N/A	N/A	N/A	N/A
	pCO_2	N/A	N/A	N/A	N/A	N/A
	pO_2	N/A	N/A	N/A	N/A	N/A
	BE	N/A	N/A	N/A	N/A	N/A
	O_2 Sat	N/A	N/A	N/A	N/A	N/A
	HCO_3	N/A	N/A	N/A	N/A	N/A
	Interpretation	N/A	N/A	N/A	N/A	N/A
	***Oxygen**	Device % FiO_2	Device % FiO_2	Device % FiO_2	Device % FiO_2	N/A
	Action taken to correct balance?	N/A	N/A	N/A	N/A	N/A

PART IV: ADULT LABORATORY / DIAGNOSTIC TOOL

D R U G

Test	**Range**	**Date** ***Baseline***	**Date**	**Date**	Identify ↑ ↓/ Significance / Analysis / Nursing Interventions
Digoxin	N/A	N/A	N/A	N/A	N/A
Theophylline	N/A	N/A	N/A	N/A	N/A
Dilantin	N/A	N/A	N/A	N/A	N/A
Antibiotics	N/A	N/A	N/A	N/A	Zosyn does not require peak and trough labs.

U A

Source:	**Range**	**Date**	**Date**	**Identify ↑ ↓/ Significance / Analysis / Nursing Interventions**
Color	N/A	N/A	N/A	N/A
Appearance	N/A	N/A	N/A	N/A
Spec.gravity	N/A	N/A	N/A	N/A
Protein	N/A	N/A	N/A	N/A
Glucose	N/A	N/A	N/A	N/A
Ketones	N/A	N/A	N/A	N/A
Nitrites	N/A	N/A	N/A	N/A
Leukoesterase	N/A	N/A	N/A	N/A
Bacteria	N/A	N/A	N/A	N/A
Blood	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A

PART IV: ADULT LABORATORY / DIAGNOSTIC TOOL

Test	Body Part Involved	Reason this test performed on client	Date Result	Date Result	Identify ↑ ↓/ Significance / Analysis / Nursing Interventions
X rays	N/A	N/A	N/A	N/A	N/A
X rays	N/A	N/A	N/A	N/A	N/A
X rays	N/A	N/A	N/A	N/A	N/A
MRI / CT	CT of the abdomen and pelvis	Client CO abdominal pain in RLQ and nausea and vomiting. Done to diagnose or rule out appendicitis	--/--/10	N/A	CT scans of the abdomen and pelvis are useful in finding abnormalities of the GI tract. The client's CT resluts shows that the appendix is enlarged (13mm) with surrounding inflammatory changes. Indicates a diagnosis of Appendicitis with no free air or any fluid collection. Nursing intervention: make sure that consent has been signed and understood by client; if IV/PO contrast is used monitor client's BUN and creatinine labs for kidney issues. observe for delayed allergic reaction to contrast after the scan, if contrast has been used encourage the client to increase PO intake if able to do so. [LeFever-Kee, 2010]
Nuclear Scan	N/A	N/A	N/A	N/A	N/A

PART V: NURSING DIAGNOSES: PRIORITIES AND RATIONALES

NANDA Statement in Order of Priority	Rationale for Priority
1. Risk for ineffective respiratory function r/t immobility secondary to surgery. PC: Pneumonia	Client has wheezing in upper lung fields in the morning and in all lung fields later in the day. He is a smoker of one pack a day and has increased pulmonary secretions from smoking. He is immobile after surgery and states that the pain from the surgical incision interferes with effective coughing. If the client is unable to cough and if he remains immobile the secretions in his lungs may possibly turn into pneumonia extending his stay in the hospital.
2. Dysfunctional gastrointestinal motility r/t open appendectomy and immobility after surgery e/b absent BS x 4, distended abdomen, and client states that he has not been able to pass any flatus since before surgery on --/--/10.	Client has a distended abdomen that is slightly firm with absent bowel sounds x 4. Peristalsis is already decreased from the abdominal surgery and he is immobile with very little PO intake from an all liquid diet. He states he does not like the diet and is not drinking very much water. He is also immobile after surgery stating that he has a hard time getting out ob bed because of the pain in his abdomen from the surgery.
3. Acute pain r/t mechanical trauma secondary to surgery e/b client states that pain level is 5/10 on pain scale.	The client states that his pain after surgery has been consistently 5-6 / 10 on the pain scale. His surgical incision is on the RLQ of his abdomen and makes it hard for him to get out of bed and move around. Client states “I didn’t realize how much you use your abdominal muscles until they cut through mine.” He has been experiencing pain for less than six weeks making the pain acute and not chronic.
4. Decisional conflict r/t risks versus benefits of smoking cessation e/b client states that he wishes he “could quit but it is hard and I don’t know if I could stick to it.”	Client states that he wishes to quit smoking as he just found out that his wife is pregnant with their first child. He states that he has tried to quit in the past but is was very difficult for him. When asked if he ever attended any smoking cessation classes had any knowledge of smoking cessation recourses he admitted that he did know a little but wasn’t really committed to not smoking at the time.

PART V: PLAN OF CARE

Priority #	NANDA Diagnostic Statement	Goals	Nursing Interventions	Rationale	Evaluation
1	NDx: Risk for ineffective respiratory function R/T: immobility secondary to surgery PC: pneumonia Assessment: - client has wheezing in upper lung fields in my initial physical assessment - in my reassessment after lunch the client had wheezing in all lung fields - client demonstrated ineffective cough secondary to surgical pain - client states that he has not been drinking very much water or other PO fluids - client denies SOB; however, he had increased respiratory rate of 26	STG: Client will: demonstrate effective coughing by the end of the day on --/--/10. LTG: Client will: maintain clear lung sounds for length of stay in hospital.	1. Assess respiratory rate, ability to cough, color and consistency of sputum and lung sounds every 2-4 hours. 2. Assess I&O and assess skin turgor and mucous membranes every shift or as needed 3. Encourage and educate on the importance PO fluid intake and maintain IVF as ordered. 4. Encourage educate on the importance of ambulation and have client ambulate 3-4 times a day as tolerated. 5. Provide a pillow or blanket for the client to use as a splint over the surgical site to help with pain when coughing. 6. Educate and provide information on the importance of smoking cessation.	1. Frequent assessment is essential in monitoring if respiratory status is improving or worsening [Lemone & Burke, 2008] 2. Inadequate fluid intake and decreased urine output, dry mucus membranes, and poor skin turgor indicate dehydration. Dehydration can make lung secretions thick and difficult to expectorate. [Lemone & Burke, 2008] 3. Increasing fluid intake and maintaining IVF will thin secretions making them easier to expectorate. [Lemone & Burke, 2008] 4. Ambulation will keep secretions from pooling in the lungs which would increase the risk of pneumonia [Lemone & Burke, 2008] 5. Providing a splint to hold the abdomen will allow the client to cough effectively and expectorate secretions. [Lemone & Burke, 2008] 6. Education and providing information and/or referrals can help the client make an informed decision regarding smoking cessation. [Lemone & Burke, 2008]	Goals accomplished? STG ? **X** Yes □ No By the end of my shift the client was observed to be coughing and expectorating thin yellowish sputum. LTG ? □ Yes **X** No During reassessment is was found that there was some wheezing in the lower right lobe; however, there was a great improvement as all other lung sounds were clear upon auscultation on --/--/10 Assessing respiratory status often thought out the day enabled me to determine if the client's resp. status was worsening. By assessing PO intake and I&O I was able to determine if dehydration was a contributing factor. By educating the client on the importance of PO intake I decreased any knowledge deficit about the relationship between dehydration and lung secretions. By decreasing his knowledge deficit he was more compliant about increasing his PO intake as tolerated. Encouraging ambulation and educating about ambulation helped the client to understand that immobility after surgery increased his risk of pneumonia and possibly having a longer stay in the hospital. I observed the client ambulating often throughout the day. Providing a pillow to use as a splint allowed the client to cough and

					expectorate thin yellowish sputum. After coughing he stated that he felt a little better. I observed him using the splint several times throughout the day. By providing information on where to find resources for smoking cessation the client stated that he “may me able to quit with proper support.”

PART V: PLAN OF CARE

Priority #	NANDA Diagnostic Statement	Goals	Nursing Interventions	Rationale	Evaluation
2	NDx: Dysfunctional gastrointestinal motility R/T: abdominal surgery and immobility after surgery AEB: absent BS x 4, distended abdomen, and client states that he has not been able to pass any flatus since before surgery on --/--/10 Assessment: Client had absent BS x4 during my initial physical assessment Abdomen was distended and slightly firm upon palpation Client states that he has attempted to pass flatus or have a BM with no success Client was immobile after surgery stating he had a hard time getting out of bed due to pin form surgical procedure Client has not been drinking PO fluids or eating much of his full liquid diet	STG: Client will: demonstrate BS x 4 by the day on --/--/10 LTG: Client will: have at least one BM a day for the remainder of his stay at the hospital.	1. Assess for abdominal distention and for BS x4 and monitor for flatus or BM to start within 24-48 hours post-op. 2. Keep client on NPO status until bowel sounds return. When indicated begin the client on small amounts of clear fluids such as water and fruit juice. 3. Educate and encourage the importance ambulation as tolerable 3-4 times every day as tolerated. 4. Monitor for S/S of paralytic ileus every four hours as indicatged: localized, sharp and intermittent pain, hiccups, N/V, constipation, distended abdomen, and rebound tenderness.	1. Surgery and anesthesia decrease innervation of the bowels which reduces peristalsis and possibly leading to dysfunctional motility. [Carpenito-Moyet, 2010] 2. Client will be unable to tolerate fluids until peristalsis and bowel sounds return. Small amounts of PO fluids will decrease the risk of constipation and increase peristalsis. [Carpenito-Moyet, 2010] 3. Activity stimulates peristalsis decreasing the risk for paralytic ileus and constipation associated with dysfunctional GI motility. [Carpenito-Moyet, 2010] 4. Intra-operative manipulation of the bowels and abdominal organs and the depressive effects of narcotics on peristalsis can cause paralytic ileus, typically between the third and fifth day post-op. [Carpenito-Moyet, 2010]	Goals accomplished? STG ? **X** Yes □ No Upon reassessment in the afternoon of --/--/10 there were hypoactive BSx4. BS were almost absent but this was an improvement from absent BS during my initial assessment on --/--/10 in the morning. LTG ? **X** Yes □ No On --/--/10 the client had two small BM. Evaluation: Assessing the abdomen for increasing distention, for returning BSx4, any N/V, or other S/S of paralytic ileus helped me to prevent complications due to paralytic ileus and for increased discomfort and distress. Encouraging the increase of fluids helped the return of BS and helped the client to have a BM on --/--/10. By encouraging ambulation educating on the importance of ambulation the client was more compliant on activity after surgery. With ambulation on --/--/10 the client's BS began to return by the end of my shift.

Part VI: Summary Statement

Once your process is complete, review each section in terms of specific Level Outcomes including the RN's role as a Provider of Care, Manager of Care, and Member of the Nursing Profession. Write a short summary statement on how you have met these three RN roles.

Provider of Care:

During the care of my client I demonstrated that I am a Provider of Care by educating my client on the importance of smoking cessation. I also administered IV medications as ordered to two clients in a safe manner. I assessed my client's condition to see if his respiratory status and GI status was improving or worsening. I educated on the importance of ambulation and on the intake of adequate PO fluids to decrease the risk for respiratory dysfunction and to increase GI peristalsis after surgery. By providing ways to help the client achieve effective coughing his status was improving by the time of discharge. By using my critical thinking skills I was able to use safe and effective nursing intervention to help my client heal and untimely be discharged home. During my care I maintained hand hygiene and aseptic techniques at all times as appropriate.

Manager of Care:

During my care I demonstrated that I am manager of care by prioritizing and organizing care for two clients. I took VS and gave bed baths to the client that had physical therapy before the client that had no therapy or procedures scheduled. I gave report to other co-students when left the floor for lunch and received report on their client's in return. I also gave report to the staff RN for both of my client's at the end of my shift. I recorded VS, linen changes, and bed baths in the client's bed side chart as required. I reviewed labs and noted any abnormal values. I asked for guidance and clarification from my instructor as needed. I used only the supplies I needed so as to not waste any supplies.

Member of the Nursing Profession:

During my care I demonstrated that I am a Member of the Profession by adhering to the dress code and being punctual on clinic days. I came to clinic prepared to take care of two clients and write daily care plans/processes on both. I maintained professionalism in the care of my clients, with my instructor, regular staff, and with my fellow students. I did not give any care to my clients that were out of the scope of practice as a RN or as a student.

REFERENCES

Carpenito-Moyet, L. (2010) Handbook of Nursing Diagnosis 13th ed. (pp. 613-614)

Wolters Kluwer/Lippincott Williams & Wilkins. Philadelphia.

Gahart. B, A. Nazareno (2010) Intravenous Medications 26th ed. (pp. 1091-1094)

Mosby Elsevier. St. Louis, MO.

Hodgson, B. (2010) Nursing Drug Handbook. (pp. 879-880; 914-915; 773-776; 741-743; 850-852)

Saunders Elsevier. St. Louis, MO.

LeFever-Kee, J. (2010) Laboratory and Diagnostic Tests with Nursing Implications 8th ed.

(pp. 84-86; 96-100; 204-212; 220-222; 358; 325-327; 365-368; 437-439)

Pearson Prentice Hall. New Jersey.

LeMone, P. & K. Burke. (2008) Medical Surgical Nursing 4th ed. (pp. 766 – 769; 1336 -1337; 1340)

Pearson Prentice Hall. New Jersey.

Mayo Foundation for Medical Education and Research (1995-2010). Torn Meniscus. Retrieved from

http://www.mayoclinic.com/health/torn-meniscus/DS00932/

Wood, D. (2010). Appendicitis. Beth Israel Deaconess Medical Center. Retrieved from

http://www.bidmc.org/YourHealth/ConditionsAZ/Appendicitis.aspx

NURSING PROCESS GRADE SHEET
Nursing B23 Medical Surgical 2

Name: _____

Part	Grading Criteria	Possible Points	Points Earned	Comments
I	**Demographics** PMH HP Current (active) MD Orders	**5**		
II	**Patho Concept Map** (2 needed) Definition, etiology, chronicity, prognosis, risk factors, signs and symptoms, lab and diagnostic studies, medical and nursing interventions, and potential complications.	**20**		
III	**Medications** Tactis Facesheet – list of ALL current meds 5 TACTIS – (discuss with instructor) Client specific	**10**		
IV	**Labs / Diagnostics** Client specific Analysis including nursing intervention	**10**		
V	**Physical Assessment** Validates diagnosis Narrative nurses notes for day of care	**10**		
VI	**Plan of Care** Top 4 Nursing Diagnosis Prioritized with rationales Write up of 2 of top 4 nursing Diagnoses **Goals** Patient specific Realistic and measurable time frame **Interventions and Rationales** Appropriate Realistic Minimum of 4 per diagnosis Prioritized **Evaluation** Where the STG and/or LTG met?	**40**		
VII	**Summary Statement** Insightful statement reflecting on care (Use syllabus as guide) Presentation and format	**5**		
	FINAL SCORE	100		**Note: Please see comments thru out paper**.