Nursing care plan and basic conditioning

Literature

COMMUNITY COLLEGE DEPARTMENT OFNURSINGCLINICAL ASSESSMENT TOOL Subjective Data (Basic Conditioning Factors) Student: Date of Care: 10/03/09 Patient’s Initials: P. V. Age: 37 Room #: 3114 Bed 1Allergies: Food: NKA Gender: FMedications: NKA Environmental: NKA Admitting Diagnosis: Pancreatitis Developmental Stage (Erickson and Havinghurst): (List Developmental stage and tasks, assess each task) 1. Selecting a mate: Although patient is single, she has many friends. Patient was happy to introduce her friends that came to visit.

Introductions were all made as friends, no boyfriend or husband mentioned. 2. Starting afamilyand raising children: Patient is not interested in these aspects of life. Patient is more concerned over her friends and their activities that they do together. 3. Managing home: While the patient lives alone, she would prefer to have a roommate to share housekeeping tasks and rent. 4. Taking civicresponsibility: Patient is not interest in helping out community. 5. Starting occupation: Patient has been a Title Researcher for two years, she claims that it is just a job to pay the bills. 6.

Finding congenial social group: Patient claims that she has a tight group of friends that she enjoys going out with. While the patient was agreeable, she wanted to be left alone. The Erickson stage that the patient is in is adulthood; Intimacy vs. Isolation. I find that Miss F. V. to be in isolation, developmentally. She wanted no socialization from myself, lives alone, and works alone. She is not actively looking for a mate and was demanding to have her door shut my entire shift, which was the norm since she was admitted 20 days ago. History of present illness: On 9/13/09 patient presented with severe ABD pain in ED.

A computed tomography Scan (CT-Scan) of the abdomen and pelvis with contrast was performed; showing severe pancreatitis with prominent pancreas demonstrating significant edema. Moderate to large amounts of ABD ascites demonstrating simple fluid attenuation was noted. Peritoneal enhancement was predominantly noted within the left ABD, reflecting significant peritonitis. No bowel obstruction was noted and pancreatic necrosis was not excluded. Moderate bilateral pleural effusions were also noted. Past medical history : Irritable Bowel SyndromeAnxietyDepression

Cocaine use (1998) Smoker Past surgical history: none Medications: Drug NameDoseRoute FrequencyClassification Metoprolol Tartrate50mgPO q12hAntihypertensive Enoxaparin Sodium40mgSQ dailyAnticoagulant Esomeprazole Mag Trihy40gmPO dailyAnti-ulcer Hydromorphone hydr2mgPO PRN Opioid Analgesic Ergocalciferol800int unitsPO daily Vitamin Complementary/Alternative Medical Practices Herbal Remedies: None Vitamins/Minerals: Daily multivitamins Meditation/Yoga: None Massage: None Acupuncture/Acupressure: None Aromatherapy: None

Other: NoneHealthCare Systems (Current orders and role of health care members): Low fat diet IV/hr q24h Double Lumen PICC line Left AC CBC OOB Sociocultural / spiritual orientation: none Family system: Patient has family support, however lives alone in a walk up apartment. Patterns of Living: A. Employment: Title Researcher B. Education: Some college C. Hobbies / interest: None D. ETOH / drug use: Social onlyEnvironment(Conditions of living and working): Client lives alone, although the answer changed from 9/13/09 to 9/14/09 to lives with a friend.

Family is supportive. Friends are supportive. Available Resources (Economic, personal, agencies): Primary Insurance: Primary Insurance is a HMO with BlueCross BlueShield. Objective Assessment of the USCR's Pt: F. V. Room 13314 Bed 1 Jennifer Hughes Please use Y, N, NA to indicate Yes, No or Not Applicable Day 1Day 2Additional Data Psychosocial Solitude v. Social Interaction or Normalcy Well groomed/Good hygieneY Appropriate/Full range affect Y Maintains eye contactN Calm moodN Cooperative attitudeY

Able to concentrateY Clear speech (volume/tone) Y Psychomotor retardation N Tics/Tremors N Hyperactivity/Restlessness/Agitation N Hallucinations/Illusions N Suicidal/Homicidal Ideations N Activity/Rest Well-rested N FatiguedN Slept through night N Neuromuscular (prevention of hazards) Alert and oriented Y Times 3 Gait steady Y Hygiene independentN Refused AM care Primary notified Pain free NDilaudid 2mg given @ 6am by primary Hand grasp, strong and equal bilat Y Foot push, strong and equal bilat Y Smile symmetrical Y Tongue to midline Y PERL Y

Meets developmental task Y Cardiovascular (air or water) Palpable pedal pulses bilaterally Y Oral mucosa pink Y Conjunctiva pink Y Capillary refill within 2 seconds Y Absence of edema Y Apical/radial regular rhythm YRate= 94 Blood pressure YBP= 86/60 primary notified Telemetry Y Integument (prevention of hazards) Temperature YTemp= 98. 0 Skin turgor WNL Y No tenting noted Skin warm to palpation Y Cool to touch Skin intact Y Incisions N Wounds N Day 1Day 2Additional Data Respiratory (air) Resps easy and even Y Lungs clear Y Secretions N Oxygen in use N Oxygen saturationY 98

Cough and deep breathe N Chest tubesN Gastrointestinal (Food or Elimination) Abdomen softY Tender to the touch Abdomen non-distended Y Bowel sounds presentYAll 4 quads Abdominal drainsN Stomach tubesN Bowel movementN Nausea/vomiting N Feeds selfY Breakfast (% consumed) 50% Lunch (% consumed) 75% Dinner (% consumed) Tube feedingN IV solution (type and rate) YTPN @83cc/hr bag @ 1200cc @ 07: 40 IV site (location)YLeft AC PICC Double Lumen IV site without redness or swelling Y IV dressing dry and intact Y Chemstick n/a Gastrointestinal (food or Elimination)

Voids in bedpan or bathroom Y Pt. using bathroom Foley catheterN Suprapubic tube N Urine clearY Color yellow-amber Y Yellow Amount (cc's)n/a Continuous bladder irrigation N Lab Data (explain abnormal values) RANGE WBC: 4. 5 - 11. 0 HGB: Men 14. 7 - 16. 1 Women 9. 3 L12. 0 16. 0May indicate anemia. HCT: Men 42. 0 - 52. 0 Women 27. 1 L37. 0 47. 0May indicate anemia, bone marrow dysfunction, malnutrition, over hydration Platelet 490 H150. 0 - 450. 0 Could indicate hemorrhage or inflammatory disorder.

Glucose 8370. 0 - 110. 0WNR Sodium 140135. 0 - 145. 0 WNR Chloride 10395. 0 - 110. 0 WNR Potassium 4. 3 3. 5 - 5. 1 WNR Calcium 8. 1 L8. 4 - 10. 2May indicate protein & vitamin D deficiency, malnutrition, cushing syndrome, acute pancreatitis Albumin 2. 6 L 3. 4 - 5. 0Could indicate malnutrition, ulcerative colitis, use of penicillin, sulfonamides, aspirin or ascorbic acid. BUN: 127. 0 - 20. 0 WNR CR: . 40. 3 - 1. 5 WNR PT: Not in labs 10 - 12 sec PTT: Not in labs 3045 sec INR: Not in labs 2 - 3