

# Nursing npr essay



PRIMARY NURSING CARE PLAN 15. Client Information Sheet Student name: \_Scott Watson\_ Clinical Date: \_02/20/07\_ \* Reminder: Do not remove the patient care summary or other documents from the hospital! Room/Bed Age: Gender: Marital Status: 632A 60 F Married Admit Date: 2/17/07 Reason for Admit: Pt presented to the ED with complaints of abdominal distention and pain along with bilateral lower extremity swelling and erythema for several weeks. Pt also has jaundice.

Pt came into the ED for increasing jaundice and abdominal pain secondary to increasing distention of the abdomen. This has not been acute but has been an accumulative process. Significant Medical History: Significant for liver cirrhosis, diabetes mellitus type 2, alcohol abuse, and chronic pancreatitis. Pt states she has not been on medications for one year. Primary Diagnosis: Tense ascites due to cirrhosis Surgical Procedure and Date (if any at this admission): Diet Ordered: Rationale: Diab-sodium control 1800cal, 2 gm NA Low NA to reduce fluid retention (ascites) Activity Level: Rationale: Bed rest To get rid of the fluid from lower extremities Lab Procedures ordered: (Results on back) Xtra pink-draw & hold; LDH, peritoneal; Albumin, peritoneal; Protein total, peritoneal; Hemoglobin A1C; Culture bacterial, U midstream; Sodium, random UR Other Tests: (Results on back)DUS: Paracentesis (Dx ascites) DUS: leg-useven, bilateral, eval for DVT Allergies: (Include reaction) Code Status: No known allergies Full code LAB VALUES ON ADMIT, MOST RECENT AND NORMAL VALUES FOR THE INSTITUTION.

INCLUDE INTERPRETATIONS FOR ALL ABNORMAL VALUES. Admit 2/18/07 Recent 2/19/07 High/Low Normal Range Rationale RBC 2.25 2.5 L3. 90-5. 20 k/ul Platelets 107 110 L 150-450 k/ul cirrhosis Hematocrit 25.

926. 0L35. 0-47. 0 % Hemoglobin9.

39. 3L11. 5-15. 0 gm/dl WBC9.

99. 54. 3-10. 0 k/ul Glucose122126H65-99 mg/dl Calcium7.

88. 0L8. 4-10. 5 mg/dl Potassium3. 82. 7L3.

5-5. 5 mmol/lchronic hypokalemic acidosis common in pts w/ chronic alcoholic liver disease Sodium117124L135-147 mmol/lsecondary to fluid overload BUN15148-23 mg/dl Creatinine0. 700. 790.

4-1. 1 mg/dl Phosphorus3. 82. 7-4. 5 mg/dlMagnesium1.

61. 6-2. 6 mg/dl Ammonia78H11-40 umol/l inability of failing liver to convert ammonia to urea and shunting of intestinal blood via collateral vessels.

PATHOPHYSIOLOGY Describe, in your own words, the pathophysiology as it relates to this client. Include etiology, signs and symptoms and medical plan of care.

Be sure to include a brief description of all comorbid diseases. Be sure to include all references for this section and corresponding full APA format reference on the Reference Page. Do not limit yourself to the space allotted here—use as much room as you need! Cirrhosis is a chronic, serious disease in which normal configuration of the liver is changed, resulting in cell death. When new cells are formed, the resulting scarring causes disruption of blood and lymph flow.

Although pathologic changes do not occur for many years, structural changes gradually lead to total liver dysfunction. Manifestations of cirrhosis

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are related to hepatocellular necrosis and portal hypertension.

Complications caused by cellular failure are similar to those of acute hepatitis and include inability to metabolize bilirubin and resultant jaundice (which fits my pt and she has jaundice); difficulty producing serum proteins, including albumin and certain clotting factors (my pt is being tested for albumin levels in her paracentesis); hyperdynamic circulation and decreased vasomotor tone; pulmonary changes (ventilation-perfusion mismatch) and sometimes cyanosis; changes in nitrogen metabolism (e. g. inability to convert ammonia to urea (my pt has an elevated ammonia level); and difficulty metabolizing some hormones (especially the sex hormones).

Complications related to portal hypertension include development of ascites (my pt's admitting diagnosis is ascites), bleeding esophageal and gastric varices, portal-systemic collaterals, encephalopathy, and splenomegaly.

Alcoholic cirrhosis (which my pt appears to have as she is a long-time drinker/alcoholic) is associated with long-term alcohol abuse; accounts for 50% of all cirrhosis cases. Changes in liver structure caused by cirrhosis are irreversible, but compensation of liver function can be achieved if the liver is protected from further damage by alcohol cessation and proper nutrition.

The histologic definition of this form of cirrhosis is microconodular cirrhosis.

Fatigue and malaise are common but nonspecific symptoms of the illness.

Anorexia My pt claims to have diminished appetite), early satiety, dyspepsia, altered bowel habits (my pt has diarrhea), and easy bruising (my pt reports being easily bruised) and bleeding also are reported often. Alterations in mental status, personality, or behavior (“ hepatic encephalopathy”) are

common but vary in severity and may not be noticed initially (my pt appeared to be disoriented upon admission).

Pruritus is reported when significant jaundice is present. Signs of the illness may include ascites (my pt has significant ascites); asterixis; bleeding from gums, nose, or gastroesophageal varices; “mousy” breath odor; edema (my pt has pitting 3-4+ edema to bilateral lower extremities); jaundice (my pt is jaundice); and an irregular liver edge with hepatic enlargement (the liver may shrink when complete loss of function is present). Multiple skin findings may include abnormal pigmentation, palmar erythema, spider angiomas (my pt has spider angiomas especially around the chest area), ecchymoses, and dilated abdominal veins. Limited thoracic expansion due to hepatomegaly or ascites and endocrine changes such as menstrual irregularities, testicular atrophy, gynecomastia, and loss of chest and axillary hair may also be present (some of these signs are specific to the male and obviously do not apply to my pt).

Urine may be dark (brownish) because of the presence of urobilinogen, and stools may be pale and clay colored because of the absence of bilirubin. A urinalysis on my pt shows a trace amount of protein, positive for bilirubin, blood (1+), and a leukocyte estimate-large. Liver transplantation may be curative, but its use is limited by the number of donor organs available. Posttransplantation survival rates at 1 and 5 years are 70 and 60%, respectively. Shunting procedures to divert blood flow from the hepatic to the systemic circulation may improve portal hypertension and its consequences (Swearingen, 2007). The plan for my pt is as follows: continue on lasix and aldactone for diuresis (to get rid of water that is being retained-

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edema and ascites); hyponatremia will be addressed via diuresis with the lasix and aldactone as well; pt's urine osmolality and sodium level will be checked to rule out SIADH; pt will take lactulose to address increased ammonia level (possible hepatic encephalopathy), as well as softening the stool to guard against straining and rupture of varices; alcohol cessation will be encouraged and a social work evaluation will be ordered.

A paracentesis is being performed on my pt to drain the fluid from the abdominal area (ascites), and to diagnose the ascites as well. My patient's comorbidities are diabetes mellitus type 2 and chronic pancreatitis. Type 2 diabetes is a life-long disease marked by high levels of sugar in the blood. It occurs when the body does not respond correctly to insulin, a hormone released by the pancreas.

Type 2 diabetes is the most common form of diabetes. Type 2 diabetes is a group of forms of diabetes mellitus that occur predominantly in adults. The insulin produced is sufficient to prevent ketoacidosis but insufficient to meet the total needs of the body. This form of diabetes in nonobese patients can usually be controlled by diet and oral hypoglycemic agents, such as sulfonylurea drugs or metformin, a nonsulfonylurea drug. Occasionally insulin therapy is required. In some patients the condition can be controlled by careful diet and regular exercise.

My patient's diabetes appears to be managed without medication. Chronic pancreatitis is a form of pancreatitis that results from repeated or massive pancreatic injury, marked by the formation of scar tissue, which leads to malfunction of the pancreas. The pain may be mild or severe, tending to

radiate to the back. Jaundice, weakness, emaciation, malabsorption of proteins and fats, and diarrhea are present (Black & Hawks, 2005). NURSING DIAGNOSIS #1 DERIVED FROM THE ASSESSMENT INFORMATION. FEEL FREE TO USE MORE THAN ONE DIAGNOSIS FOR YOUR PT! Fluid volume excess r/t cirrhosis (compromised regulatory mechanism with sequestration of fluids secondary to portal hypertension and hepatocellular failure) aeb ascites, hyponatremia, and jaundice.

Primary Goal: Short term goal that is patient centered, ie. , the patient will identify, demonstrate, list, verbalize, etc. What do you want the patient to achieve? Patient will be normovolemic aeb stable or decreasing abdominal girth, RR 12-20 breaths/min with normal depth and pattern, HR 100 bpm or less, edema 1+ or less on a 0-4+ scale, and absence of crackles (rales) by at least 24 hours before hospital discharge. Nursing Interventions: What actions you, as a nurse, can do to help the patient achieve their goal-rationales are the supportive reasons for selection of specific action.

Why are you doing it? Customize for your patients! Actions: Rationale: Do not limit yourself to the space allotted here—use as much room as you need! 1) Obtain baseline abdominal girth measurement (Place pt in supine position and mark abdomen with indelible ink to ensure serial measurements from same circumferential site. This will allow for monitoring of reduction of abdominal distention. ) 2) Monitor weight and I&O (Output should be equal to or exceed intake. Weight loss should not exceed 0.23 kg/day.

Assess degree of edema and document accordingly. This allows for the monitoring of progress of fluid volume/ascites/edema. 3) Administer diuretics

as prescribed (Diuretics help to rid body of excess water. ) 4) Have pt state the name, purpose, dosage, route, scheduling, potential food/herb/drug interactions, major side effects, importance of taking medications and impact of missing medications (this will help pt to know how to safely and effectively take the meds prescribed to her.

) 5) Remind pt to avoid foods and nonfood items that contain Na<sup>+</sup> such as antacids, baking soda, and some mouthwashes (Na<sup>+</sup> causes fluid to be retained in the body. )Evaluation: (May write on the back) Don't forget this component!! Nursing Diagnosis #2 (Psychosocial Dx) Refer to your text or care plan textbook; this is different than a physical domain nursing diagnosis Ineffective denial r/t refusal to acknowledge alcoholism aeb delay of seeking health care attention to the detriment of health. Primary Goal: Pt will vocalize her feelings about her alcohol use and state her intention as to whether she will continue to drink or not by the end of my shift (1400). Nursing Interventions: Actions: Rationale: ) Spend time with the pt and allow time for responses (nursing presence, one-on-one interaction, connecting with the client's experience, going beyond the scientific data, and knowing what will work and when to act all support the nurse-client relationship and affirm their respective selves) 2) Assess for subtle signs of denial (minimization and denial are part of the alcoholism pathophysiology) 3) Avoid confrontation (rather than direct confrontation, informing of the reality of consequences of a specific behavior may be more therapeutically assimilated into the client's appraisal framework) 4) Sit at eye level (honest caring behaviors on the part of the nurse facilitate acceptance of reality on the part of the client) 5) Use touch if appropriate and with permission. Touch the client's hand or arm



(appropriate expression of caring on the part of the nurse facilitates therapeutic client response) 6) Have the client make choices regarding treatment and actively involve her in the decision-making process (interventions that increase the self-efficacy of clients support maintenance of abstinence) Evaluation: (On Back) MEDICATIONS BE SURE TO INCLUDE ALL IV FLUIDS, HOURLY RATE OF ADMINISTRATION AND DROPS PER MINUTE.

Name Trade/generic Dosage Class Rationale Precautions Saline flush INJ 1.

5ml Q8h 09 For maintenance of heparin lock IV flush Furosemide (Lasix) INJ 40mg IV Q12h 09 loop diuretic inhibits reabsorption of sodium and chloride from proximal and distal renal tubule; increases renal excretion of water, sodium, chloride, magnesium, hydrogen, calcium; may have renal and peripheral vasodilatory effects; diuresis and subsequent mobilization of excess fluid, decreases blood pressure contraindicated in pre-existing electrolyte imbalance, hepatic coma, anuria caution in severe liver disease, electrolyte depletion Spironolactone (Aldactone) 1 tab 25mg PO 09 potassium sparing diuretic causes loss of sodium bicarbonate and Ca while saving potassium and H ions weak diuretic caution in hepatic dysfunction Lactulose (Cephulac) 20gm (30ml) Q4h PO 09 13 laxative osmotic adjunct in mgt of portal-systemic encephalopathy; increases water content and softens stool, lowers pH of colon which inhibits diffusion of ammonia from colon into blood reducing blood ammonia levels (improved mental status) caution in severe hepatic impairment (not to exceed 30mg/day); may cause dizziness, headache, diarrhea, abdominal pain, nausea Cefepime (Maxipime) INJ 1gm IVPB/IVSS Q12h (dilute in 50ml D5W or NS and infuse over 30min) 09 anti-infective fourth generation cephalosporins Binds to the bacterial cell wall

membrane, causing cell death bactericidal action against susceptible bacteria caution in pts with hepatic dysfunction or poor nutritional status (increased risk of bleeding), renal impairment poss s/e: rashes, pain at IM site, phlebitis at IV site Morphine sulfate INJ 4-6mg IV Q2-4h PRN for pain opioid analgesic opioid agonist controls severe acute or chronic pain; also for pulmonary edema; binds to opiate receptors in the CNS; alters the perception of and response to painful stimuli while producing generalized CNS depression may cause sedation, respiratory depression, constipation, tolerance, and dependence; controlled substance with a high potential for abuse; dosage reduction for geriatric pts; caution in Clonidine (Catapres) 1tab 100mcg Q6h PO PRN for systolic > 170 diastolic > 100 antihypertensive adrenergic centrally acting decreases blood pressure and decreases pain stimulates alpha-adrenergic receptors in the CNS; which results in decreased sympathetic outflow inhibiting cardioacceleration and vasoconstriction centers; also, prevents pain signal transmission to the CNS by stimulating alpha-adrenergic receptors in the spinal cord increased risk of orthostatic hypotension and adverse CNS effects in geriatric patients (decreased dose recommended); may cause drowsiness, dry mouth, and withdrawal phenomenon Granisetron (Kytril) INJ 0. 1mg IV Q12h PRN for N/V antiemetic 5-HT<sub>3</sub> antagonist prevention and treatment of nausea and vomiting; blocks the effects of serotonin at receptor sites (selective antagonist) located in vagal nerve terminals and in chemoreceptor trigger zone in the CNS may cause hypertension, headache, anxiety, constipation, diarrhea

Primary Care Plan 21. Educational Needs Part 2: Identify one educational need of your client and list your teaching plan with rationales. Evaluate your teaching outcome.

Educational need of the client (using NANDA nursing diagnosis): Deficient knowledge r/t disease process/severity of cirrhosis and other comorbidities and inability or refusal to manage her disease.. Goal (client centered and measurable and address specifically the educational need of the client) Client will explain disease state, recognize need for medications, and understand treatments. Teaching plan with rationales: 1) Assess client's level of knowledge of her disease (Need to know what she knows so can know where to begin to give instruction) 2) Observe the client's ability and readiness to learn (Learning best occurs when learners are motivated and attend to the important aspects of what is to be learned) 3) Assess barriers to learning (The client brings to the learning situation a unique personality, established social interaction patterns, cultural norms and values, and environmental influences) 4) Explain course of disease, signs and symptoms, risk factors, treatment options, and possible outcomes in layman's terms (Teach client about her disease in a manner that allows her to understand it) 5) Ask her if she has any questions (Allows for assessment as to what client is understanding or not) Evaluation (include if the goal was achieved or not): References Ackley, B. , & Ladwig, G.

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