Caring for the Surgical Client

Emily Johnson 10/15/2025 20:57

Caring for the Surgical Client

If you want to view this feedback later, use the Print button to download a copy.

Summary

Daphne Nieto had a colon resection for diverticulitis. You cared for her on the med-surg unit following her surgery.

Thanks to your help, her nursing care team was able to put together a solid plan of care. Let's look into more details below.

Recognize Cues

You correctly recognized the following cues as relevant to Daphne's immediate health needs:

- (1430) Breath sounds clear bilaterally, diminished in bases
• Airway always takes priority when changes are present. Diminished bases are unexpected.

- (1430) Drowsy & oriented x4
• The nurse needs to investigate the drowsiness to ensure it is improving.

- (1430) Absent bowel sounds x4 quads
• Although these are expected findings, they need to be assessed because of the surgery the client had.

- (1430) Nasogastric tube right nare secured in place to low wall suction, noted scant blood-tinged drainage
• The NG drainage needs to be assessed regularly.

- (1430) Burning at IV site
• Burning at the IV site could be of concern and needs to be assessed.

You missed the following relevant cues:

- (1430) Large abdominal dressing dry and intact with binder in place
• The abdominal dressing needs to be assessed for drainage and intactness regularly.

- (1430) Vital signs
• Vital signs need to be assessed per policy.

You incorrectly selected the following cues. These *were not* relevant to Daphne's immediate health needs:

- Abdomen round and firm

- Pain 2 out of 10

Reflection Questions

Considering how this scenario played out, what are your biggest lessons learned?

If you were to encounter this scenario in real life, what would you focus on? What distractions would you avoid?

Analyze Cues

You correctly selected the following cues as needing immediate follow-up:

- (1430) Breath sounds clear bilaterally, diminished in bases
• This may be atelectasis, which requires action.

- (1430) Burning at IV site
• The client needs a functioning IV so this needs to be assessed for patency.

You missed the following cues that required immediate follow-up:

- (1430) Vital signs
• The nurse needs to follow up on any vital signs that are unexpected.

You incorrectly selected the following cues. These *did not* require immediate follow-up:

- (1430) Drowsy & oriented x4

- (1430) Absent bowel sounds x4 quads

Reflection Questions

How does providing holistic care affect your analysis of assessment findings and cues?

Prioritize Hypotheses

You selected (1430) Absent bowel sounds x4 quads as your top priority. This was incorrect; your top priority should have been (1430) Breath sounds clear bilaterally, diminished in bases. After surgery on the intestines, peristalsis stops so this would be expected.

You selected (1430) Breath sounds clear bilaterally, diminished in bases as your second priority. This was incorrect; your second priority should have been (1430) Burning at IV catheter site. Assessing breath sounds is the top priority based on the ABC priority framework.

Reflection Questions

When using the ABC priority-setting framework, how can you still address the client's psychosocial needs while focusing on airway, breathing, and circulation?

Generate Solutions

(1430) Breath sounds clear bilaterally, diminished in bases

You correctly identified the following nursing actions to address this priority:

- Encourage coughing and deep breathing
• Coughing and deep breathing is essential to maintain clear lungs and open the lung fields, particularly in the bases.
- Encourage client to use incentive spirometer 10 times an hour
• The incentive spirometer will assist with maintaining clear lung fields.
- Reassess breath sounds
• Reassessment is essential to determine if the interventions improved the condition.

You missed the following nursing actions to address this priority:

- Raise head of bed to 60 degrees
• This will help the client to breathe easier with the large abdominal dressing and binder.
- Splint abdomen with pillow
• Splinting the abdomen will decrease abdominal pain with coughing and moving.

You incorrectly planned the following nursing actions. These *would not* help address this concern:

- Anticipate decreasing oxygen

You incorrectly planned the following nursing actions. These would be *contraindicated* and may have caused harm:

- Increase oxygen percentage

(1430) Burning at IV site

This should have been a top priority. If you had generated solutions for this concern, the correct solutions would have been:

- Assess insertion site for patency, redness, inflammation, and temperature
• The nurse will then know if the IV needs to be replaced.

- Apply warm compress to arm
• A warm compress can decrease the burning at the IV site.

(1430) Absent bowel sounds x4 quads

This was an incorrect priority. (1430) Breath sounds clear bilaterally, diminished in bases and (1430) Burning at IV site were higher priorities to address.

But you correctly identified nursing actions to address this concern:

- Get client out of bed

Take Actions

See how you did addressing Daphne's main concerns:

Urinary Catheter

You removed the client's urinary catheter at 0900. This was correct. There was an order to remove the urinary catheter after 24 hours and it had been 24 hours.

Pain

You assessed the client's pain. Upon finding her pain to be a 7 out of 10, you administered pain medication as ordered.

Reflection Question

Consider the actions you took. What would you do differently next time?

Evaluate Outcomes

You correctly selected the following findings that indicate an effective outcome:

- Client ambulated to room door and back
• Increased activity helps with post-operative recovery.
- Hypoactive bowel sounds noted
• Increasing bowel activity is a sign that recovery is progressing well.
- Pain score decreased to 3 out of 10
• Pain interventions are successful.
- IV remains patent
• Interventions are successful.
- Client passing flatus
• Client is recovering well and bowel is now functioning.

You incorrectly selected the following findings. These *do not* indicate an effective outcome:

- Urinated 30 mL in commode

The client urinating is not an outcome.

Reflection Questions

If you were to continue caring for this client, what findings might indicate she was continuing to improve?
