N431 Care Plan # 3

Lakeview College of Nursing

Marranda Steffen

Demographics (3 points)

Date of Admission 3/18/20	**Patient Initials** D.J.	**Age** 45 years old	**Gender** Male
Race/Ethnicity African American	**Occupation** Paramedic	**Marital Status** Single	**Allergies** Penicillin
Code Status Full Code	**Height** 177.8 cm	**Weight** 81.8 kg	

Medical History (5 Points)

Past Medical History: IBS, GERD

Past Surgical History: None

Family History: Mother – IBS; Father – GERD, HTN; Sister – Obesity, DM Type 2

Social History (tobacco/alcohol/drugs): Tobacco – 1 pack/day smoker for 20 years; Alcohol – patient stats he drinks “a few beers on the weekends”; Drugs - None

Assistive Devices: None

Living Situation: Patient lives at home with his significant other.

Education Level: Patient has a high school diploma and completed the Formal Paramedic Training in 1995.

Admission Assessment

Chief Complaint (2 points): Abdominal pain for 2 days with nausea and vomiting**.**

History of present Illness (10 points): The patient is a 45-year-old male who presented to the Emergency Department for chronic abdominal pain, nausea, and vomiting for the past 2 days. Famotidine, lidocaine oral suspension, and ondansetron was provided with little relief. A kidney, ureter, and bladder X-Ray was performed to reveal a small bowel obstruction. A nasogastric tube was placed to decompress the abdomen. He will be admitted to the medical-surgical unit for further evaluation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Small Bowel Obstruction

Secondary Diagnosis (if applicable): None

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

Small Bowel Obstruction

According to Mayo Clinic (2018), a small bowel obstruction can be defined as food or liquid that is unable to pass through the small intestines due to a blockage. The obstruction can be described as a partial obstruction, which is when there is an obstruction and some food and liquid can get through, or as a complete obstruction, which is when nothing is able to pass through (Mayo Clinic, 2020). If the obstruction goes untreated, it can lead serious problems and might result in part of the intestine dying (Mayo Clinic, 2018). On the other hand, the obstruction can be treated if it is brought to medical attention (Mayo Clinic, 2018).

A patient can present with multiple signs and symptoms that point toward an obstruction, both partial and complete (Mayo Clinic, 2018). Those consist of crampy abdominal pain, loss of appetite, constipation, vomiting, and inability to pass gas or a bowel movement (Mayo Clinic, 2018). Other signs could be a nausea, vomiting, and a swollen, tender, or bloated abdomen (Harvard Health, 2020). Another sign might be diarrhea due to liquid stool leaking around the partial obstruction (Harvard Health, 2020) Patients who have severe abdominal pain along with other symptoms that might point to a small bowel obstruction should seek medical attention immediately (Mayo Clinic, 2018). Patient with an obstruction could have low potassium and sodium levels with an elevated WBC level (Harvard Health, 2020).

When diagnosing an obstructed bowel, the physician can order an X-Ray, CT Scan, Ultrasounds, or Air/Barium Enema (Mayo Clinic, 2018). All of these diagnostic tests can be used to help support the diagnosis a small bowel obstruction (Mayo Clinic, 2018). The physician could perform a physical exam on the patient to assess if the abdomen is swollen or tender (Mayo Clinic, 2018). The physician may even be able to palpate a mass on the abdomen (Mayo Clinic, 2018). Physical assessment can help support the diagnosis of a small bowel obstruction (Mayo Clinic, 2018).

A small bowel obstruction treatment can be treated differently depending on whether it is a complete or partial obstruction (Mayo Clinic, 2018). The treatment can also vary depending on the cause of the condition (Mayo Clinic, 2018). The first step to the treatment, which is for all causes, is stabilizing the patient (Mayo Clinic, 2018). The patient will receive an IV with a continuous flow of fluids (Mayo Clinic, 2018). Then, the patient will have a nasogastric tube put in place to help suction out the air and fluids in the stomach to relieve the abdominal swelling (Mayo Clinic, 2018). The patient will have a straight catheter put into place to drain the bladder and collect a sample of the urine (Mayo Clinic, 2018). Generally, patients will be hospitalized to stabilize the condition and to complete diagnostic tests to observe the type of obstruction it is (Mayo Clinic, 2018). For a partial obstruction, the patient will get symptomatic treatment then discharged home with orders to follow a special low-fiber diet in hopes that the blockage will clear itself (Mayo Clinic, 2018). If the blockage is not cleared then surgery is the next option for this patient (Mayo Clinic, 2018). For a complete obstruction, the patient will get symptomatic treatment then have surgery to remove the obstruction along with any section of the intestine that has been damaged or died (Mayo Clinic, 2018).

The patient's clinical manifestations, such as abdominal pain, nausea, vomiting, and distended abdomen, correlates with the signs and symptoms of a small bowel obstruction. His blood test results showed a decrease in sodium and an increase in WBC which are also indicators of a small bowel obstruction. The X-Ray that was completed confirmed the diagnosis due to the findings of a small bowel obstruction in the left lower quadrant of the abdomen.

Pathophysiology References (2) (APA):

Harvard Health. (2020, February). Bowel Obstruction. Retrieved November 17, 2020, from https://www.health.harvard.edu/diseases-and-conditions/bowel-obstruction-a-to-z

Mayo Clinic. (2018, November 06). Intestinal obstruction. Retrieved November 17, 2020, from https://www.mayoclinic.org/diseases-conditions/intestinal-obstruction/symptoms-causes/syc-20351460

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	4.28-5.56	----	----	
Hgb	13-17	13.1	----	
Hct	38.1-48.9	42.1	----	
Platelets	149-393	----	----	
WBC	4-11.7	12.4	----	The WBC are elevated due to intestinal bacterial translocating into the bloodstream, causing a systemic inflammatory response (Jackson & Raiji, 2011).
Neutrophils	45.3-79	----	----	
Lymphocytes	11.8-45.9	----	----	

Monocytes	4.4-12.9	----	----	
Eosinophils	0-6.3	----	----	
Bands	0-6	----	----	

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-	136-145	130	----	Low sodium level due to vomiting (Harvard Health, 2020).
K+	3.5-5.1	4.2	----	
Cl-	98-107	----	----	
CO2	21-31	----	----	
Glucose	74-109	97	----	
BUN	7-25	9	----	
Creatinine	0.7-1.3	1.01	----	
Albumin	3.5-5.2	----	----	
Calcium	8.6-10.3	----	----	
Mag	1.6-2.4	----	----	
Phosphate	2.5-4.5	----	----	
Bilirubin	0.3-1	0.4	----	
Alk Phos	34-104	----	----	
AST	13-39	15	----	
ALT	7-52	52	----	

Amylase	23-85	----	----	
Lipase	0-160	----	----	
Lactic Acid	0.5-1	----	----	
Troponin	0-0.4	----	----	
CK-MB	5-25	----	----	
Total CK	22-198	----	----	

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	0.8-1.1	----	----	
PT	11-13.5	----	----	
PTT	25-35	----	----	
D-Dimer	< 0.5	----	----	
BNP	<100	----	----	
HDL	> 40	----	----	
LDL	< 100	----	----	
Cholesterol	125-200	----	----	
Triglycerides	< 150	----	----	
Hgb A1c	< 5.7	----	----	
TSH	0.4-4.0	----	----	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
Color & Clarity	Clear	----	----	
pH	4.5-8.0	----	----	
Specific Gravity	1.002-1.030	----	----	
Glucose	Negative	----	----	
Protein	Negative	----	----	
Ketones	Negative	----	----	
WBC	Negative	----	----	
RBC	Negative	----	----	
Leukoesterase	Negative	----	----	

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	----	----	
PaO2	75-100	----	----	
PaCO2	35-45	----	----	
HCO3	22-26	----	----	
SaO2	94-100	----	----	

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	----	----	
Blood Culture	Negative	----	----	

Sputum Culture	Negative	----	----	
Stool Culture	Negative	----	----	

Lab Correlations Reference (APA):

Harvard Health. (2020, February). Bowel Obstruction. Retrieved November 17, 2020, from https://www.health.harvard.edu/diseases-and-conditions/bowel-obstruction-a-to-z

Jackson, P., & Raiji, M. (2011, January 15). Evaluation and Management of Intestinal Obstruction. Retrieved November 17, 2020, from https://www.aafp.org/afp/2011/0115/p159.html

Diagnostic Imaging

All Other Diagnostic Tests (5 points): KUB X-Ray, KUB X-Ray (NG insertion), EKG

Diagnostic Test Correlation (5 points):

X-Rays of the abdomen was a diagnostic test that was used for this patient (Harvard Health, 2020). The results from the X-Ray showed a small bowel obstruction was identified in the lower left quadrant of the abdomen and gas can be seen throughout the abdomen. The X-Rays showed no sign of perforation or free air within the abdominal cavity. At admission to the emergency department an EKG was performed to rule out any cardiac issues that could possibly be the cause of the pain.

Diagnostic Test Reference (APA):

Harvard Health. (2020, February). Bowel Obstruction. Retrieved November 17, 2020, from https://www.health.harvard.edu/diseases-and-conditions/bowel-obstruction-a-to-z

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Pepcid famotidine	Imodium loperamide	Tums calcium carbonate	5% Dextrose NS glucose	Zofran ondansetron
Dose	20 mg	4 mg	750 mg	100 ml/hr	4 mg
Frequency	Daily	PRN	Q4h, PRN	Continuously	Q8h, PRN
Route	PO	PO	PO	IV	IV
Classification	Antiulcer Agent	Antidiarrheal	Antacid	Nutritional Supplement	Antiemetic
Mechanism of Action	Inhibits the action of histamine at the H2 receptor site located primarily in gastric parietal cells, resulting in inhibition of gastric acid secretion. Therapeutic Effects: Healing and prevention of ulcers. Decreased symptoms of gastroesophageal reflux. Decreased secretion of gastric acid.	Inhibits GI peristaltic activity by direct action on circular and longitudinal intestinal muscles. Prolongs transit time of intestinal contents, increases consistency of stools, and reduces fluid and electrolyte loss.	Rapid acting antacid with high neutralizing capacity and relatively prolonged duration of action. Decreases gastric acidity, thereby inhibiting proteolytic action of pepsin on gastric mucosa. Also increases lower esophageal sphincter tone. Although classified as a non-systemic and acid, a slight to moderate alkalosis usually develops with prolong therapy.	Prevents protein and nitrogen loss, promotes glycogen deposition, prevents or decreases ketosis, and, in large amounts, acts as an osmotic diuretic. Dextrose is readily metabolized and undergoes oxidation to carbon dioxide and water.	Selective serotonin (5-HT3) receptor antagonist. Serotonin receptors are located centrally in the chemoreceptor trigger sone (CTZ) and peripherally on the vagal nerve terminals. Serotonin is released from the wall of the small intestine and stimulates the vagal efferent through the serotonin receptors and initiates the vomiting reflex.
Reason Client Taking	GERD	Diarrhea	Heartburn	Loss of nutrients by vomiting	Vomiting
Contraindications (2)	Hypersensi-tivity to famotidine,	Severe colitis & Acute diarrhea	Hypercalcemia &	Alcohol withdrawal syndrome in	Hypersensitivity to ondansetron

	other H2-receptor antagonists, or their components	caused by broad-spectrum antibiotics	Hypercalciuria	dehydrated patients & Hepatic Coma	& Orally disintegrating tablets contain aspartame and should not be used in patients with phenylketonuria
Side Effects/Adverse Reactions (2)	Confusion & Arrhythmias	Toxic Megacolon & Dry mouth	Constipation & Vomiting	Glycosuria & Confusion	Dizziness & Headache
Nursing Considerations (2)	Shake famotidine oral suspension vigorously for 5 to 10 seconds before administration. If using one dose a day, administer drug at bedtime.	Discontinue if there is no improvement after 48hr hours of therapy for acute diarrhea. Notify physician promptly if the patient with ulcerative colitis develops abdominal distention or other G.I. symptoms.	Observe for signs and symptoms of hypercalcemia in patients receiving frequent or high doses, who have impaired renal function. Note the number inconsistency of stores.	Give highly concentrated dextrose solution by central catheter – not by subcutaneous or I.M. route. Assess infusion site for signs of infiltration.	Assess motor function and report any extrapyramidal reactions. Monitor improvements in GI symptoms to evaluate effectiveness.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor CBC and gastric pH levels.	Monitor therapeutic effectiveness. Chronic diarrhea usually responds within 10 days. If Improvement does not occur within this time, it is unlikely that symptoms will be controlled by further administration. Monitor fluid and electrolyte balance.	Monitor serum and urine calcium weekly in patients receiving prolonged therapy and in patients with renal dysfunction.	Monitor for signs of hypervolemia. Monitor glucose levels.	Assess gait, balance, other functional activities before walking patient. Monitor fluid and electrolyte levels is vomiting persists.
Client Teaching needs (2)	Have a regular medical follow-up while on this drug to evaluate your response. Report sore throat fever,	Record number and consistency the stools. Learn measures to relieve dry mouth; rinse mouth	Do not continue this medication beyond 1 to 2 weeks, since it may cause acid rebound,	Instruct patient to monitor blood glucose levels as directed. Emphasize importance of reporting	Instruct patient to report bothersome side effects such as sever or prolonged headache,

	usually bruising or bleeding, severe headache, muscle or joint pain.	frequently with water, suck hard candy.	which generally occurs after repeated use for 1 or 2 weeks and leads to chronic use. Do not use calcium carbonate repeatedly with foods high in vitamin D or sodium bicarbonate, as it causes milk-alkali syndrome.	discomfort, pain, or signs of infection at I.V. site.	weakness, fatigue, or GI problems. Be aware that headaches requiring a analgesic for relief is a common adverse effect.

Hospital Medications (5 required)

Brand/Generic	Phencen promethazine	Avinza morphine	Tylenol acetaminophen	D10W Dextrose 10% in Water	Protonix pantoprazole
Dose	12.5 mg	2 mg	1,000 mg	250 mL	40 mg
Frequency	Q8h, PRN	Q4h, PRN	Q8h, PRN	PRN	Daily, PRN
Route	IV	IV	IV	IV	IV
Classification	Antiemetic	Narcotic (Opiate) agonist	Nonnarcotic analgesia	Carbohydrate substrate	Proton pump inhibitor; Gastrointestinal agent

Mechanism of Action	Long-acting derivative of phenothiazine with marked antihistamine activity and prominent sedative, amnesic, antiemetic, and anti-motion-sickness actions. Unlike other phenothiazine derivatives, relatively free of extrapyramidal adverse effects; however, in high doses it carries same potential for toxicity.	Natural opium alkaloid with agonist activity by binding with the same receptors as endogenous opioid peptides. Narcotic agonist effects are identified with 3 types of receptors: Analgesia at supraspinal level, euphoria, respiratory depression and physical dependence; analgesia at spinal level, sedation and miosis; and dysphoric, hallucinogenic and cardiac stimulant effects.	Produces analgesia by unknown mechanism, perhaps by action on peripheral nervous system. Reduces fever by direct action on hypothalamus heat-regulating center with consequent peripheral vasodilation, sweating, and dissipation of heat. Unlike aspirin, acetaminophen has little effect on platelet aggregation, does not affect bleeding time, and generally produces no gastric bleeding.	Immediate source of glucose and H2O for nutrient deprived cells. Transient osmotic diuretic	Gastric acid pump inhibitor; belongs to a class of antisecretory compounds. Gastric acid secretion is decreased by inhibiting the H+, K+-ATPase enzyme system responsible for acid production.
Reason Client Taking	Nausea refractory to Ondansetron	Pain	Fever >38.0C	Loss of nutrients by vomiting	Indigestion
Contraindications (2)	Narrow-angle glaucoma & Stenosing Peptic Ulcer	Hypersensitivity to opiates & Acute Alcoholism	Hypersensitivity to acetaminophen or phenacetin & Use with alcohol	None	Hypersensitivity to pantoprazole or other proton pump inhibitors (PPI); & Severe hepatic insufficiency
Side Effects/Adverse Reactions (2)	Respiratory Depression & Apnea	Cardiac arrest & Severe respiratory depression	Hepatic coma & Acute renal failure	Cough & Dizziness	Abdominal Pain & Diarrhea
Nursing Considerations (2)	Supervise ambulation & Monitor	Encourage changes in position, deep breathing,	Use cautiously in patients with hepatic impairment or	Monitor for level of effectiveness. Monitor signs	Be aware that symptomatic response to the drug does not

	respiration function in patient with respiratory problems.	and coughing at regular intervals. Be alert for nausea and orthostatic hypotension in ambulatory patients.	active hepatic disease, alcoholism. Monitor for signs and symptoms of hepatoxicity.	and symptoms of infiltration around the IV site.	rule out the presence of a gastric tumor. Monitor for and immediately report S&S of angioedema or a severe skin reaction.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess gait, balance, other functional activities before walking patient. Monitor fluid and electrolyte levels is vomiting persists.	Monitor vital signs at regular intervals for respiratory or cardiac depression. Monitor I&O ration and patterns.	Assess liver function tests including AST, ALT, bilirubin, and creatinine.	Monitor for signs of hypervolemia. Monitor glucose levels.	Urea breath test 4 to 6 weeks after completion of therapy. Monitor urine output because it may cause acute intestinal nephritis.
Client Teaching needs (2)	Do not drive or engage in other potentially hazardous activities requiring mental alertness and normal reaction time until response to drug is known. Do not take OTC medications without physician's approval.	Avoid alcohol and other CNS depressants while receiving morphine. Do not use any OTC drug unless approved by physician.	Do not take other medications containing acetaminophen without medical advice. Do not self-medicate adults for paint more than 10 days without consulting a physician.	Instruct patient to monitor blood glucose levels as directed. Emphasize importance of reporting discomfort, pain, or signs of infection at I.V. site.	Contact physician promptly if any of the following occur: peeling, blistering, or loosening of skin; skin rash, hives, or itching; swelling of the face, tongue, or lips; difficulty breathing or swallowing. Instruct patient to swallow tablets whole and do not chew or crush.

Medications Reference (APA):

BC Emergency Health Services. (2020). Confirmation. Retrieved November 16, 2020, from https://handbook.bcehs.ca/treatment-guidelines/drug-monographs/d10w-dextrose-10-in-water/

Drugs.com. (2020, May 30). Famotidine (Professional Patient Advice). Retrieved November 16, 2020, from https://www.drugs.com/ppa/famotidine.html

F. A. Davis. (2020). Davis's Drug Guide for Rehabilitation Professionals. Retrieved November 16, 2020, from https://fadavispt.mhmedical.com/content.aspx?bookid=1873

Mayo Clinic. (2020, October 01). Dextrose (Intravenous Route) Side Effects. Retrieved November 16, 2020, from https://www.mayoclinic.org/drugs-supplements/dextrose-intravenous-route/side-effects/drg-20073387

RNpedia. (2019, February 12). Famotidine Nursing Considerations & Management. Retrieved November 16, 2020, from https://www.rnpedia.com/nursing-notes/pharmacology-drug-study-notes/famotidine/

Wilson, Shannon, & Stang. (2007). Pearson Drug Guide. Retrieved November 16, 2020, from http://www.robholland.com/Nursing/Drug_Guide/

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented times four. He showed no signs of being in distress. His appearance is appropriate for the circumstances.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	The patients skin color is was appropriate for his ethnicity. It is dry and warm to the touch. His skin is elastic and non-tenting with no rashes, bruises, wounds, or drains present. He has a Braden score of 22 which put him at no risk for skin breakdown.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient was normocephalic with his ears and eyes level. His nose was midline. His extraocular muscles are intact, and eyes follow PERRLA. Patient does not have dentures; his teeth are intact. .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.**	His heart rate and rhythm is normal with S1 and S2 sounds present. There is no murmur present. His pedal pulses were equal bilaterally and felt at

Cardiac rhythm (if applicable): **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	a 2+. Patient's capillary refill is less than 3 seconds. There is no neck vein distention or edema present.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	He is on room air with an oxygen saturation of 98%. His breaths are unlabored at a regular rate and rhythm. He is not using accessory muscles to breathe. His breath sounds are clearly heard anteriorly and posteriorly in all lobes of both the left and right lungs. His nail beds are normal for his ethnicity.
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 ☐ N ☐** **Nasogastric: Y ☒ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	He is on a regular diet at home with no restrictions. He is currently NPO. He is 177.8 cm tall and weighs 81.8 kg. Bowel sounds are absent is the RLQ and hypoactive in all other quadrants. His last BM was 3/12/20. The abdomen is soft but distended and tender on palpation. There is no incisions, scars, drains, wounds, feeding tube, or ostomy present. There is a NG tube in place measuring 65 cm at the nare. It is connected to low-intermittent suction to decompress the abdomen and has a return of bile-green colored substance.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	His urine is a clear and yellow. He had a quantity of 450 mL urine output today. The patient stated there was no pain with urination at this time. He is not on dialysis. His genitals were appropriate for his age and gender. There is no catheter present.
MUSCULOSKELETAL (2 points): **Neurovascular status:**	His neurovascular status was normal, and he is able to complete active range of motion on all

ROM: **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	four extremities. He has no supportive devices. There is equal strength bilaterally in both arms and legs. He does not need assistance with ADLs. He has a fall score of 20, which means that he is not a risk for falling. He can move well independently with no limitations. He is up ad lib.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	He moves all extremities well and his eyes follows PERRLA. He has equal strength bilaterally in both arms and legs. He is alert and oriented time four. His speech is clear and appropriate for his developmental age. His sensory abilities are intact. He responds to conversations and commands.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient's ability to cope with stress and religious preferences are unknown. His developmental metal level is appropriate for his age. The patient lives at home with his significant other.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	76	133/76	16	37.5 C	98%
1100	69	124/63	18	36.9 C	97%

Vital Sign Trends:

The patient's vital signs are stable. He does have an elevated blood pressure due being in pain (Medscape, 2003). His pulse rate at 1100 is slightly decreased which could mean be from laying down in bed relaxing before it was taken.

Medscape. (2003, December 04). Pain and Blood Pressure. Retrieved November 17, 2020, from https://www.medscape.com/viewarticle/465355

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Abdomen	8/10	Crampy Abdominal Pain	Morphine administer
1100	Numeric	Abdomen	4/10	Crampy Abdominal Pain	Morphine administer

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:**	Patient has 18-guage IV in the left antecubital that was placed on 3/18/20. D5NS is infusing at the rate of 100 mL/hr without difficulty. There is no signs of erythema or drainage at the IV site. The dressing is clean, dry, and intact. The patient also has an 18-guage IV saline lock in the wrist that was placed on 3/18/20. It flushes without difficulty and has good blood return. There is no signs or erythema or drainage at the IV site. The dressing is clean, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
400 mL	450 mL

Nursing Care

Summary of Care (2 points)

Overview of care:

The 45-year-old male presented to the emergency department with abdominal pain, nausea, and vomiting for the past 2 days. An EKG was done to rule out any cardiac causes of the pain. The patient was prescribed fluids, pain medication, and nausea medication to help treat the symptoms that he was experiencing. The patient has a series of tests ran on him to help diagnose the cause of the discomfort and pain he was feeling. An KUB X-ray was performed to find out that he had a small bowel obstruction. An NG tube was then put in place to decompress the stomach and he was placed on an NPO diet. The patient was then admitted to receive inpatient care for the small bowel obstruction. From there, the patient would be seen by one of the hospitalists to discuss the plan of care from this point forward.

Procedures/testing done:

The patient had two KUB X-Rays and an EKG performed.

KUB X-Ray: IMPRESSION – A small bowel obstruction can be identified in the lower left quadrant of the abdomen. Gas can be seen throughout the abdomen. No sign of perforation or free air within the abdominal cavity.

KUB s/p NG Insertion: The tip of the NG/OG is coiled within the stomach. All other findings are unchanged from the previous films and interpretations.

EKG: NRS without ectopy.

Complaints/Issues:

The patient has no complains or issues at this time.

Vital signs (stable/unstable):

The patient's vital signs are stable. He does have an elevated blood pressure due being in pain (Medscape, 2003). His pulse rate at 1100 is slightly decreased which could mean be from laying down in bed relaxing before it was taken.

Medscape. (2003, December 04). Pain and Blood Pressure. Retrieved November 17, 2020, from https://www.medscape.com/viewarticle/465355

Tolerating diet, activity, etc.:

Patient is tolerating his diet of being NPO and he is adhering to it. He is tolerating normal activity and ADLs.

Physician notifications:

Notify physician for further orders, if bowel sounds return or the patient is passing gas. Alert the physician if the patient has a fever of greater than 38.0C regardless of receiving acetaminophen or not.

Future plans for patient:

Further plans for the patient will be dependent on if the patient passes gas or has a return of bowel sounds after adhering to the NPO diet.

Discharge Planning (2 points)

Discharge location:

Patient will be discharged home with his significant other.

Home health needs (if applicable):

None

Equipment needs (if applicable):

None

Follow up plan:

The follow up plan will be determined upon discharge after the relief of the small bowel obstruction.

Education needs:

The patient is in need of teaching about bowel rest and NPO status. The patient completing the bowel rest by being NPO can give his small intestines the chance to move the obstruction out. He also needs teaching about how to monitor his own glucose levels and the IV fluids that he is being given. The glucose levels are important because the IV fluids that he is receiving.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to irritation to gastrointestinal lining as evidenced by pain stating he was in pain.	Patient stated that his pain was 8 out of 10 on the numeric pain scale.	1.Assess for the presence of and location of the pain. 2.Administer analgesic medication before the pain becomes severe.	The patient responded well to the interventions. He was having pain relief from the interventions that was provided. The goal was to decrease his pain at least in half, which would be from an 8/10 to 4/10 or under on the numeric pain scale by the end of clinical. Outcome was met and the patient's pain was down to a 4/10 when reassessing his pain.
2. Risk for infection related to disruption of fecal evacuation as evidenced by the patient not having a bowel	The patient expressed that his last bowel movement was 6 days ago. The patient's WBC are slightly elevated as well, which could	1. Assess vital signs for temperature increases and associated increases in heart and respiratory rates. Notify the health care provider of sudden temperature and	The patient responded well to the interventions. He was compliant with the NPO status and understood the importance of assessing his vital signs often. The goal was to maintain vital signs within

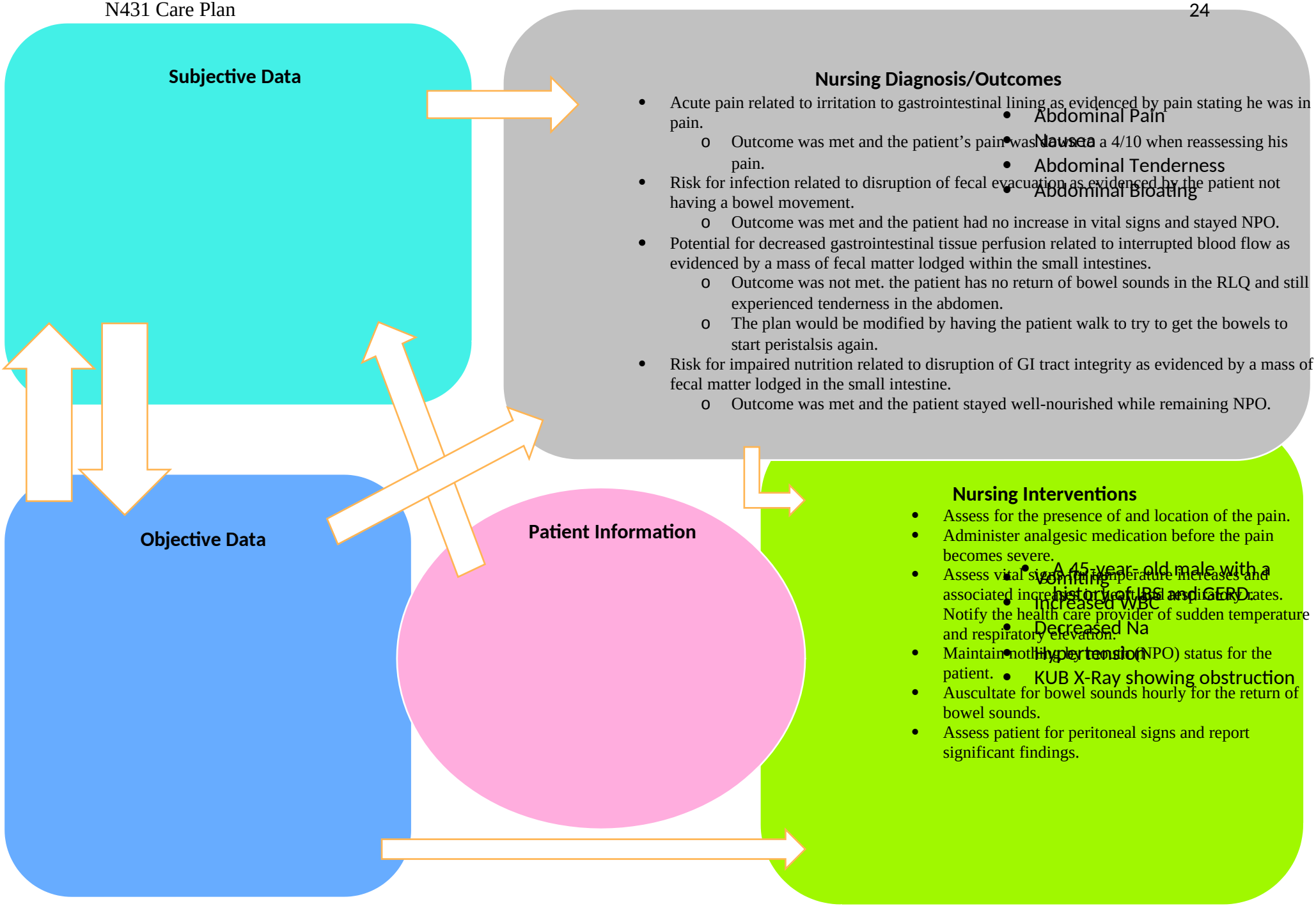
movement.	mean that there is bacteria getting into the blood stream and might be starting to cause an infection (Jackson & Raiji, 2011).	respiratory elevation. 2. Maintain nothing by mouth (NPO) status for the patient.	normal limits along with maintaining NPO status by the end of clinical. Outcome was met and the patient had no increase in vital signs and stayed NPO.
3. Potential for decreased gastrointestinal tissue perfusion related to interrupted blood flow as evidenced by a mass of fecal matter lodged within the small intestines.	X-Ray of the KUB shows there is fecal matter lodged within the small intestines.	1.Auscultatefor bowel sounds hourly for the return of bowel sounds. 2Assess patient for peritoneal signs and report significant findings.	The patient responded well to the interventions. He was in compliance with the assessments the nurse had to perform. The goal was for the bowel sounds to return and have no abdominal tenderness/ cramping by the end of the clinical. Outcome was not met. the patient has no return of bowel sounds in the RLQ and still experienced tenderness in the abdomen. The plan would be modified by having the patient walk to try to get the bowels to start peristalsis again.
4. Risk for impaired nutrition related to disruption of GI tract integrity as evidenced by a mass of fecal matter lodged in the small intestine.	X-Ray of the KUB confirms a mass of fecal matter lodged in the small intestines which is resulting in the patient vomiting.	1.Monitor laboratory values, including prealbumin, albumin, total protein, and blood glucose. 2. Collaborate with the health care provider, nutritionist, and pharmacists to assess the patient's metabolic needs based on type of injury, activity level, and baseline nutritional status.	The patient responded well to the interventions. He was in compliance with the plan of health care provider to remain NPO and get nutritional supplements through IV fluids. The goal was for the patient to maintain a good nutritional status while NPO and just receive the IV fluids ordered by the end of clinical. Outcome was met and the patient stayed well-nourished while remaining NPO.

Other References (APA):

Jackson, P., & Raiji, M. (2011, January 15). Evaluation and Management of Intestinal Obstruction. Retrieved November 17, 2020, from https://www.aafp.org/afp/2011/0115/p159.html

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):


Subjective Data
Abdominal Pain
Nausea
Abdominal Tenderness
Abdominal Bloating
Nursing Diagnosis/Outcomes
Acute pain related to irritation to gastrointestinal lining as evidenced by pain stating he was in pain.
Outcome was met and the patient's pain was down a 4/10 when reassessing his pain.
Risk for infection related to disruption of fecal evacuation as evidenced by the patient not having a bowel movement.
Outcome was met and the patient had no increase in vital signs and stayed NPO.
Potential for decreased gastrointestinal tissue perfusion related to interrupted blood flow as evidenced by a mass of fecal matter lodged within the small intestines.
Outcome was not met. the patient has no return of bowel sounds in the RLQ and still experienced tenderness in the abdomen.
The plan would be modified by having the patient walk to try to get the bowels to start peristalsis again.
Risk for impaired nutrition related to disruption of GI tract integrity as evidenced by a mass of fecal matter lodged in the small intestine.
Outcome was met and the patient stayed well-nourished while remaining NPO.
Objective Data
Vomiting
Increased WBC
Decreased Na
Hypertension
KUB X-Ray showing obstruction
Patient Information
A 45-year- old male with a history of IBS and GERD.
Nursing Interventions
Assess for the presence of and location of the pain.
Administer analgesic medication before the pain becomes severe.
Assess vital signs for temperature increases and associated increases in heart rate and respiratory rates. Notify the health care provider of sudden temperature and respiratory elevation.
Maintain nothing by mouth (NPO) status for the patient.
Auscultate for bowel sounds hourly for the return of bowel sounds.
Assess patient for peritoneal signs and report significant findings.