N321 Care Plan 1

Lakeview College of Nursing

Sarah Evans

Demographics (3/3 points)

Date of Admission 06/04/21	**Patient Initials** DH	**Age** 04/07/51 70 yrs	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Retired Financial Aid Advisor	**Marital Status** Married to Kim 40 years	**Allergies** No known Allergies
Code Status Full Code	**Height** 6'2"	**Weight** 89 kg (196 lbs)	

Medical History (5/5 Points)

Past Medical History: Atrial flutter, History of small bowel obstruction (12/05/17), HTN, Cancer of skin.

Past Surgical History: Splenectomy, Exploratory Laparotomy (12/05/17).

Family History: Mother (Deceased) – Dementia, MI, Heart Disease. Father (Deceased)- COPD.

Social History (tobacco/alcohol/drugs): Patient denies ever smoking. Patient reports drinking beer 1-2 times per month, usually 3-6 beers. Patient denies drug use.

Assistive Devices: Patient wears contacts.

Living Situation: Patient lives with his wife in a home that they own in Mattoon.

Education Level: Patient graduated from collage with a degree in business, he then worked at Eastern Illinois University as a financial aid advisor. Patient stated he has been retired for over ten years. He enjoys retirement by playing tennis and traveling with his wife to visit their 23 year old son.

Admission Assessment

Chief Complaint (2/2 points): Severe abdominal pain, nausea, and vomiting.

History of present Illness (10/10 points): On June 4th at 1700 (beginning of encounter), a distressed 70 yo man presented to Sarah Bush Lincoln Health Center Emergency Department in Mattoon, IL. Patient complained of sever pain in the peri umbilical area of his abdomen (location). Patient stated: “The pain was constant (duration). It felt like a knife was stabbing me” (characteristics). Patient stated that his pain was a 10/10 using the numeric pain scale while in the Emergency Department. Patient denied associated factors and said nothing made it feel better (associated, relieving). Patient stated that he played tennis for most of the day on 06/03/21 and was fine when he went to bed. On the morning of 06/04/21 (onset) he noted a significant amount of pain. He tried to wait to see if the pain would get better but it got worse so he decided to come to the hospital. Patient reported seeking treatment a few years ago for a small bowel obstruction that was successfully treated with decompression and rest. A CT scan was performed on 06/04/21 which showed a small bowel obstruction with distention of the stomach and small intestine up to 4.5 centimeters diameter. The CT notes the probable cause is an adhesion. The physician suggested NG Tube placement. My patient’s admitting diagnosis was Small Bowel Obstruction. He was admitted on 06/04/21 for further management.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

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

A small bowel obstruction (SBO) is a complete or partial blockage of the small intestine. Acute obstruction is either caused by herniation of the intestinal wall or by adhesions. Chronic SBOs are caused by inflammatory disorders or tumors (Capriotti, 2020). Roughly 60% of SBOs that are caused by adhesions are due to adhesions that happen after appendectomy, upper GI surgery, gynecological procedures, or colorectal surgery (Capriotti, 2020). Often after a surgery takes place, scar tissue develops in the form of adhesions that bind sections of the intestines together. Unfortunately, the adhesions sometimes become too tight or too large and begin to obstruct the passage of gastric contents in the small intestine (Capriotti, 2020). When gastric contents become blocked this causes the production of excess gastric mucus which causes distention of the intestine which then backs up into the stomach and causes pain, nausea, and vomiting.

The signs and symptoms of SBO include severe pain that is cramping, sharp, and intermittent or constant. There is often distention of the abdomen at the side of blockage. Bowel sounds are hyperactive. The patient experiences nausea and vomiting and electrolyte depletion as a result (Capriotti, 2020).

Risk factors Previous surgery in the abdominal area is a risk factor for adhesions that can cause SBO. Inflammatory disorders of the bowel like Crohn's disease, infection of the lining of the small intestine, hernias, and tumors (Capriotti,2020).

SBO is diagnosed by x-ray of the abdomen or by CT scan. The x-ray can show the obstruction and the distention of the intestine and stomach. The CT scan can confirm the presence of an adhesion. Sometimes ultrasounds are also used.

SBO can sometimes be treated by NG tube and low intermittent suction (LIS) to take the excessive contents out of the stomach to prevent nausea and vomiting. When using LSI it is very important to replace the patient's electrolytes in order to prevent imbalances (Capriotti). When blockages are not resolved by decompression and resting the gut surgical intervention becomes necessary. Sometimes the intestine's blood supply can be cut off, making it a medical emergency.

My patient's SOB was caused by an adhesion in the small intestine. My patient was at higher risk for adhesions because of his previous laparotomy in 2017. My patient's CT scan showed an adhesion that blocked the passage of gastric contents in his small intestine. The blockage caused excessive production of gastric mucus which caused the distention of his small intestine to 4.5 centimeters in diameter. The health care team at Sarah Bush placed an NG Tube to decompress the stomach of my patient. This relieved his nausea and vomiting well, but not entirely. During my shift we removed 1500 ml of fluid via the NG tube and were able to control his pain well. My client is at risk for future small bowel obstructions.

Therefore, he should be educated on the signs and symptoms of small bowel obstructions and guidelines that will help him understand when to seek medical care. My client is having surgery so he will also need education regarding surgical site infection signs and symptoms. He will likely be sent home on new medications including pain medication and antibiotics. These will be new drugs and will require some education.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Davis advantage for pathophysiology: Introductory concepts and clinical perspectives (2nd ed.). F.A. Davis.

Hinkle, J. L., & Cheever, K. H. (2018). Brunner & Suddarth's textbook of medical-surgical nursing (14th ed.). Wolters Kluwer.

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	4.4-5.8	4.39	4.20	Slight decreases in RBCs can be

				decreased by dietary deficiency (Pagana et al, 2019).
Hgb	12.0-15.8	14.8	14.1	n/a
Hct	36.0-47.0	43.1	42.4	n/a
Platelets	140-440	277	281	n/a
WBC	4.0-12.0	12	6.5	n/a
Neutrophils	40-60	70.6	70.6	Physical and emotional stress can cause an elevation in Neutrophil counts (Pagana et al, 2019).
Lymphocytes	19-49	14.5	9.3	Splenectomy can cause a reduction in lymphocyte production (Eibl, 1985).
Monocytes	3.0-13.0	9.7	19.9	A study from Japan shows a correlation between increasing monocyte counts and small bowel obstructions. (Shiomi, 2007)
Eosinophils	0-8.0	4.1	0.2	n/a
Bands	n/a	n/a	n/a	n/a

Lab	**Normal Range**	**Admission Value**	**Today's Value**	**Reason for Abnormal**
Na-	**134-144**	**142**	**144**	n/a
K+	**3.5-5.1**	**3.8**	**4.2**	n/a
Cl-	**98-107**	**105**	**108**	n/a
CO2	**21-31**	**19.9**	**27**	n/a
Glucose	**70-99**	**93**	**102**	Stress can cause elevated blood glucose levels. (Pagana et al, 2019).

BUN	**7-25**	**13**	**30**	BUN can be increased by GI bleeding. It is possible my patient might be bleeding due to his bowel obstruction. Another possibility is that starvation causes increased BUN. My patient has been on NPO status for 3 days at this point. (Pagana et al, 2019).
Creatinine	**0.50-1.20**	**1.04**	**0.87**	n/a
Albumin	**3.5-5.7**	**4.3**	**4.0**	n/a
Calcium	**8.6-10.3**	**9.5**	**8.7**	n/a
Mag	**1.6-2.6**	**n/a**	**n/a**	n/a
Phosphate	**n/a**	**n/a**	**n/a**	n/a
Bilirubin	**0.3-1.0**	**1**	**0.9**	n/a
Alk Phos	**30-120**	**92**	**72**	n/a
AST	**0-35**	**22**	**16**	n/a
ALT	**4-36**	**25**	**15**	
Amylase	**60-120**	**n/a**	**n/a**	
Lipase	**0-160**	**19**	**n/a**	
Lactic Acid	**0.5-2.2**	**n/a**	**n/a**	

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

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	0.9-1.1	n/a	n/a	n/a
PT	10.1-13.1	n/a	n/a	n/a

PTT	25-36 seconds	n/a	n/a	n/a
D-Dimer	n/a	n/a	n/a	n/a
BNP	>400	n/a	n/a	n/a
HDL	n/a	n/a	n/a	n/a
LDL	n/a	n/a	n/a	n/a
Cholesterol	n/a	n/a	n/a	n/a
Triglycerides	n/a	n/a	n/a	n/a
Hgb A1c	n/a	n/a	n/a	n/a
TSH	n/a	n/a	n/a	n/a

Urinalysis 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
Color & Clarity	Clear, yellow	Clear, light yellow	n/a	n/a
pH	5.0-9.0	8.0	n/a	n/a
Specific Gravity	1.003-1.013	1.01	n/a	n/a
Glucose	Negative	Negative	n/a	n/a
Protein	Negative	Negative	n/a	n/a
Ketones	Negative	Negative	n/a	n/a
WBC	Negative	Negative	n/a	n/a
RBC	Negative	Negative	n/a	n/a
Leukoesterase	Negative	Negative	n/a	n/a

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	n/a	n/a	n/a	n/a
Blood Culture	n/a	n/a	n/a	n/a
Sputum Culture	n/a	n/a	n/a	n/a
Stool Culture	n/a	n/a	n/a	n/a

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). Davis advantage for pathophysiology: Introductory concepts and clinical perspectives (2nd ed.). F.A. Davis.

Eibl, M. (1985). Immunological Consequences of Splenectomy. Gastro-Esophageal Reflux in Childhood Problems of Splenic Surgery in Childhood, 139–145. https://doi.org/10.1007/978-3-642-70276-1_18

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference (Fourteenth edition. ed.). Elsevier.

Shiomi, H., et al (2007). Relations Among Circulating Monocytes, Dendritic Cells, and Bacterial Translocation in Patients With Intestinal Obstruction. World Journal of Surgery, 31(9), 1806–1812. https://doi.org/10.1007/s00268-007-9110-7

Diagnostic Imaging

All Other Diagnostic Tests (5/5 points):

X-Ray abdomen Kidney Urinary Bladdar (6/5/21, repeated on 6/6/21, and 6/7/21)- This patient needed these diagnostic tests to check the progression of his small bowel obstruction. The findings were consistent with ongoing small bowel obstruction because no contrast had progressed into the large bowel after four hours for each test.

X-Ray NG Tube Placement (06/05/2021) This diagnostic test was necessary to check the placement of the clients NG Tube so that it could be used for gastric decompression. The position was verified.

CT Scan with contrast (06/04/21) This diagnostic test was necessary to confirm that this patient has a small bowel obstruction. The findings showed a small bowel obstruction with stomach and small intestine distention up to 4.5 cm in diameter. The physician noted the likely cause of the small bowel obstruction is an adhesion. The physician suggested NG Tube placement.

Diagnostic Test Correlation (5/5 points):

This patient needed two different types of X-rays. One was to check for the correct positioning of the NG Tube. An X-ray is the best way to check for accurate NG Tube placement (Capriotti, 2020). The other X-Ray was an X-Ray with contrast that was used to check the ongoing progression of this patient's diagnosis. Sometimes decompression via NG tube and rest can resolve small bowel obstructions. That was not the case in this instance. This was confirmed because after four hours no contrast had moved into the large intestine. The X-ray Abdomen KUB is used when the doctor needs a visualization of the abdomen, but does not need

precise detail (Kidney, 2021). The progression of the small bowel obstruction can be observed with an x-ray and it is a less expensive diagnostic procedure. The CT scan of the abdomen was the diagnostic test used to confirm the presence of the small bowel obstruction. A CT scan was used in this instance because the physician can observe the organs of the body in greater detail (Capriotti, 2020)

Diagnostic Test Reference (1)(APA):

Capriotti, T. (2020). Davis advantage for pathophysiology: Introductory concepts and clinical perspectives (2nd ed.). F.A. Davis.

Kidney, Ureter, and Bladder X-ray. (2021). Johns Hopkins Medicine. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/kidney-ureter-and-bladder-xray#:~:text=A%20kidney%2C%20ureter%2C%20and%20bladder%20(KUB)%20X%2D,to%20assess%20the%20urinary%20system.

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

Brand/ Generic	acetylsalicylic acid (Aspirin)	atorvastatin (Lipitor)	diltiazem (Cardizem)	sildenafil (Viagra)	B12 cyanocobalamin
Dose	81 mg	8 mg	120 mg	50 mg	1000 mcg
Frequency	Once daily	Once Daily	Once daily	daily as needed	Once daily
Route	PO	PO	PO	PO	PO
Classification	Salicylate NSAID, antiplatelet, antipyretic, nonopioid analgesic	HMG-CoA reductase inhibitor Antihyperlipidemic	Calcium channel blocker Antianginal, antiarrhythmic, antihypertensive	Phosphodiesterase 5 inhibitor Antihypertensive, erectile dysfunction agent	Water soluble B Vitamins

Mechanism of Action	Blocks platelet aggregation by stopping the production of thromboxane A2 which stimulates platelet aggregation. (Jones, 2021)	Reduces plasma cholesterol and lipoprotein levels by reducing HMG-coA and liver synthesis of cholesterol. This increases LDL uptake and breakdown. (Jones, 2021)	Inhibits smooth muscle cell contraction by blocking the movement of calcium into the smooth muscle cells of the arteries. (Jones, 2021)	Enhances nitric oxide released by the penis during arousal. Nitric oxidee increases cGMP levels which will relax the smooth muscle and allow for increased blood flow into the penis. (Jones, 2021)	B12 aids in DNA synthesis and energy production. (Vasavada,2020)
Reason Client Taking	To prevent MI	Combined with diet to treat dyslipidemia	History of atrial flutter.	To treat probable erectile dysfunction.	To treat B12 deficiency.
Contraindications (2)	Active bleeding, Ulcers (Jones, 2021)	Active hepatic disease, hypersensitivity to atorvastatin or its components (Jones, 2021)	Acute MI, Cardiogenic Shock. (Jones, 2021)	hypersensitivity to sildenafil, nitrate therapy (Jones, 2021)	Hypersensitivity to B12, taking other folic acids (Vasavada,2020)
Side Effects/Adverse Reactions (2)	GI bleeding, prolonged bleeding time (Jones, 2021)	Hypoglycemia, hepatic failure (Jones, 2021)	AV block, bradycardia (Jones, 2021)	CVA, HF (Jones, 2021)	Diarrhea, feeling body is swollen (Vasavada,2020)

Nursing Considerations (2)	Instruct patient to take it with food because it may cause GI upset. Tell patient to notify provider if they pass dark tarry stools or are coughing up blood that looks like coffee grounds. (Jones, 2021)	Monitor diabetic patient's blood glucose levels because atorvastatin can affect blood glucose control. Monitor patient for signs of liver failure such as jaundice and notify provider. (Jones, 2021)	Use cautiously in patients with renal or liver function impairment. Monitor patient's blood pressure, heart rhythm, and heart rate by telemetry while using this medication. (Jones, 2021)	Use cautiously in older adult patients who have renal or liver impairment. Use cautiously in patients who have heart dysrhythmias or who have had an MI. (Jones, 2021)	Use cautiously for those with heart failure. Also use carefully for those with pulmonary function impairment. (Vasavada,2020)

Home Medications (5 required)

Brand/ Generic	Diltiazem	pantoprazole/ Protonix	Hydromorphone Dilaudid	ondansetron/ Zofran	promethazine/phenergan
Dose	100 mg/hr	40 mg	0.5 mg	4 mg	12.5 g
Frequency	Daily	Daily	PRN Q2H	PRN nausea and vomiting Q6H	PRN Q4H
Route	IV	IV Push	IV Push	IV Push	IM

Classification	Calcium channel blocker Antianginal, antiarrhythmic, antihypertensive	Proton Pump Inhibitor Anti ulcer	Opioid Opioid analgesic, controlled substance schedule II	selective serotonin receptor antagonist Antiemetic	Phenothiazine Antiemetic
Mechanism of Action	Inhibits smooth muscle cell contraction by blocking the movement of calcium into the smooth muscle cells of the arteries. (Jones, 2021)	PPIs block the last setp of gastric acid production which prevents more stomach acid from forming. (Jones, 2021)	Binds with opioid receptors in the spinal cord which is believed to alter the perception of the emotional response to pain. (Jones, 2021)	Blocks serotonin receptors at the vagal nerve terminals in the intestine which reduces nausea and vomiting. (Jones, 2021)	Inhibits back-diffusion of hydrogen ions and adsorbs bile acids and pepsin to prevent reoccurring ulcer formation. (Jones, 2021)
Reason Client Taking	HTN	Prophylaxis for GI ulcer that could be cause by NG Tube.	To treat severe pain caused by small bowel obstruction.	To treat nausea/ vomiting.	To treat nausea/vomiting.
Contraindications (2)	Uncontrolled active bleeding, Acute MI, Cardiogenic Shock. (Jones, 2021)	Concurrent therapy with rilpivirine containing products, or hypersensitivity to pantoprazole. (Jones, 2021)	Acute asthma, GI obstruction (Jones, 2021)	Use of apomorphine, or hypersensitivity to ondansetron. (Jones, 2021)	Children under the age of 2, comatose state. (Jones, 2021)
Side Effects/ Adverse Reactions (2)	AV block, bradycardia (Jones, 2021)	C-diff, hepatic failure (Jones, 2021)	CNS depression, confusion (Jones, 2021)	hypotension, arrhythmias (Jones, 2021)	seizures, bradycardia (Jones, 2021)

Nursing Considerations (2)	Use cautiously in patients with renal or liver function impairment. Monitor patient's blood pressure, heart rhythm, and heart rate by telemetry while using this medication. (Jones, 2021)	When giving IV over 2 minutes, reconstitute with 10ml of normal saline injection. Solution may be stored for up to two hours at room temperature. (Jones, 2021)	Risk for abuse and addiction. Give IV form over at least 2 minutes. Can be mixed with normal saline, D5W, or LR. (Jones, 2021)	Warning this medication may contain aspartame and should be avoided in patients with phenylketonuria. Correct hypokalemia or hypomagnesemia before administration of ondansetron. (Jones, 2021)	Drug may suppress cough reflex which could be dangerous in COPD or asthmatic patients. Children and the elderly should be monitored closely while using this medication. (Jones, 2021)

Hospital Medications (5 required)

Medications Reference (1) (APA):

2020 Nurse's drug handbook (Nineteenth edition. ed.). (2020). Jones & Bartlett Learning.

Vasavada, A. (2020). Cyanocobalamin. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK555964/#:~:text=Mechanism%20of%20Action,-Oral%20cyanocobalamin%20absorption&text=Vitamin%20B12%20is%20essential%20for,particularly%20in%20erythroid%20progenitor%20cells.&text=The%20reported%20but%20unconfirmed%20mechanism,and%20inhibition%20of%20guanylate%20cyclase.

Assessment

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented x 4 to person, place, situation, and time. No acute distress noted. Patient appears younger than his age and appears to have good hygiene practices.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Lightly tanned but appropriate for ethnicity. Patient stated he regularly plays tennis outdoors. Skin warm and dry upon palpation. Skin turgor did not show any signs of tenting. Patient claims to have no rashes. Patient claims to have no bruises. Patient claims to have no wounds. Braden score 20, because he lost points for his NPO status. My patient is currently up at liberty to move around his room. He requested to be unhooked from his IVs and suctioning at least once that I know of during this shift. He did not want to ambulate in the hall. Nails show no clubbing or cyanosis. Hair appeared to have normal quantity, distribution, and texture. No drains are present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical. Trachea is without deviation and midline. No lymphadenopathy inspected or palpated. Thyroid is non palpable. Ears without drainage and non tender. Patient denies hearing deficit. Patient denies recent changes in visual acuity Symmetrical EOMs. Eyes PERRLA bilaterally. Sclera white. Conjunctiva pink. Patient denies nasal tenderness and drainage. Dentition is good, patient stated that one tooth is missing.

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Clear S1 and S2 heart sounds. No audible murmur, gallops, or rubs noted. Pulses 2+ palpated at carotid, radial, posterior popliteal, and doornails pedis bilaterally. Capillary refill normal, less than 3 seconds. No JVD noted. No edema noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Breath sounds even, vesicular and nonlabored bilaterally. No crackles, wheezes, or rhonchi noted.
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:**	Patient stated he and his wife eat healthy at home. Patient said his diets consists of proteins, fresh fruit and vegetables, and whole grains. Patient is currently NPO d/t small bowel obstruction. Is allowed small cup of ice chips Q4H. 6’2” 196 lb. Hypooactive, Patient is NPO and had bowel obstruction for 3 days at the time of auscultation. 06/07/21,. Last bowel movement was on 06/04/21. Student nurse observed the surgeon palpate the patient's abdomen and he denied any pain with light palpation. No abdominal distention noted at time of assessment. Scar in LLQ from previous laparotomy. No incisions, drains, ostomy, or peg tubes. Patient has a low intermittent suction NG Tube placed in his left nostril.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☒ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	This patient was up at liberty so I was not always aware when he was using the restroom. I know he urinated at least twice during the shift. He denied pain with urination. Color, character, and quantity of urine were not noted. No catheter or dialysis.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **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**	All expected findings noted. Student nurse did not observe ROM for this patient, but he plays tennis several times per week, so one could assume pt likely has full ROM in all extremities and is not limited by anything except his abdominal pain. Patient is up at liberty and requires no assistance with ambulation or ADLs. Fall score 35. Patient is only limited in activity by pain. Patient needs assistance with disconnecting from IV and NG tube suction in order to get up. Patient does not need assistance with ambulation.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Oriented to person, place, time, and situation. Cognitive with normal speech. Normal sensory response in fingers and toes. Patient is alert.

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):**	Patient stated that he gets through difficult situations by "hanging in there until things get better". Normal, collage graduate. Patient is Baptist but stated that he is "slightly Christian" and that religion doesn't really help him with coping much. Patient lives with his wife Kim of 40 years. They have one adult son who does not live locally. Patient stated that his wife had major back surgery in February 2020 and is not able to get out to come to the hospital currently. They spoke via phone several times during the shift, Kim also called the nurse to check in.

Physical Exam (18/18 points)

Vital Signs, 2 sets (5/5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	60	138/82 RA	14	98.7 tympanic	95 % RA
1130	72	122/80 RA	16	98.9 tympanic	98% RA

Pain Assessment, 2 sets (2/2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	Numerical	N/A	0/10	N/A	N/A

1120	Numerical	Peri umbilical area	2/10	achy and annoying	Patient had two PRN pain medications available. Ofirmev (acetaminophen) and hydromorphone (Dilaudid). Patient did not want to take Dilaudid so he decided to wait one hour for the next dose of Ofirmev. By the time the dose was scheduled he no longer needed it.

IV Assessment (2/2 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:**	20 L H, 18 L FA Left hand, and left forearm Left hand (06/06/21), Left forearm (06/05/21) Patent None Checked at 0830 and 1130. No signs of infiltration, erythema, or drainage. Dry and intact.

Intake and Output (2/2 points)

Intake (in mL)	**Output (in mL)**
Patient is NPO except for 1/2 cup of ice chips Q4H. Estimated oral intake 240 of water. Patient also had two lozenges to help with throat discomfort during this shift.	Patient voided at least twice, but clarity was not observed by student nurse. No BM since 06/04/21.

Nursing Care

Summary of Care (2/2 points)

Overview of care: The goals for this patient today included continued monitoring of the status of his small bowel obstruction, pain management, and preparation for exploratory laparoscopy with possible bowel resection.

Procedures/testing done: Patient did not leave the floor for any procedures during this shift, but he was preparing for surgery as the student nurse was leaving.

Complaints/Issues: Patient complained of annoying pain in his peri umbilical area that eventually went away without medication. Patient also asked for throat lozenges for milk throat discomfort due to NG tube.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Patient did not need assistance with any activities except for being unhooked from the IV and NG tube suctioning so that he could get up. Patient is

tolerating moving well and was able to reposition himself and sit up at the side of the bed with ease.

Physician notifications: The only communication we had with the physician during this shift was doing the consent for surgery.

Future for patient: Patient will have surgery as soon as possible.

Discharge Planning (2/2 points)

Discharge location: Patient is going to be discharged to home post surgery. His wife is at home and able to help him if necessary.

Home health needs (if applicable): A nurse follow up visit either in the home or via telephone would be helpful.

Equipment needs (if applicable): Patient does not require any equipment prior to surgery and is not expected to need any equipment post surgery.

Follow up plan: Follow up with surgeon and PCP as outlined by surgeon.

Education needs: Patient will be educated on how to identify signs and symptoms of infection of surgical site. Additional education about signs and symptoms of bowel obstructions and when to seek medical care is also necessary since he has now had two bowel obstructions. Education regarding post operative medications like pain medication and antibiotics is also necessary.

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

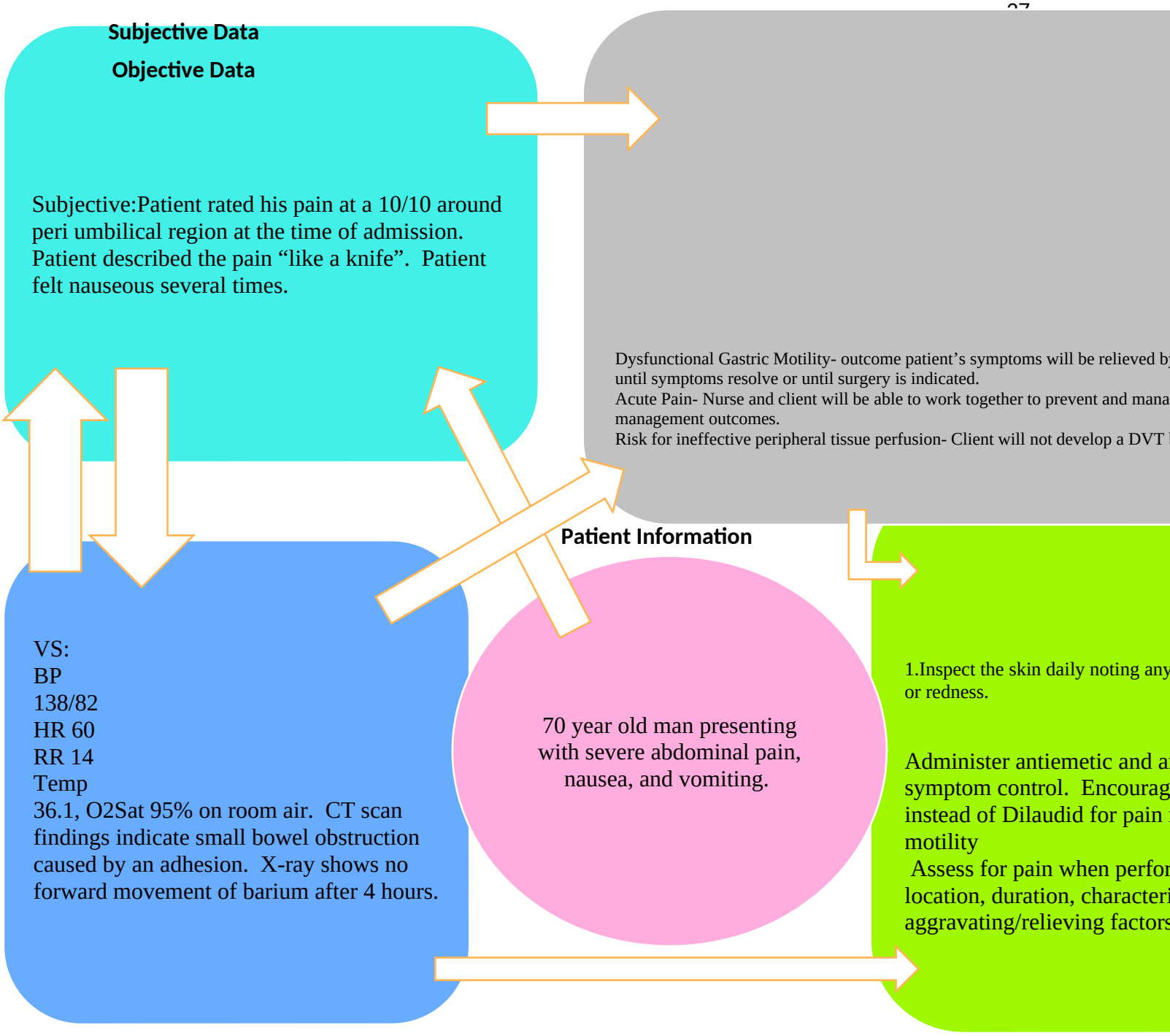
N321 CARE PLAN

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. Dysfunctional gastric motility r/t bowel obstruction AEB pain around peri umbilical area with numerical rating of 10/10 at time of admission, continued output of gastric secretions via NG tube suction, nausea and vomiting, and no flatus or BM since 06/04/21.	Patient's gastric motility has been impaired by the bowel obstruction. Nursing care can elevated discomfort caused by the obstruction until it resolves or until surgical intervention.	1.Continue gastric decompression via NG tube suction to relieve nausea and vomiting. 2.Administer antiemetic and analgesic as necessary for symptom control. Encourage client to choose Ofirmev instead of Dilaudid for pain relief to promote gastric motility.	Goal met- Patient's NG tube was connected to low intermittent suction during this shift. We removed 1500ml of gastric contents. Goal met- The patient complained of nausea around 1300 and we administered 4 mg of ondansetron (Zofran) via IV push. The patient's pain was well controlled. At 0830 he rated his pain at 0/10. At 1120 he rated it at 2/10 but did not need medication.

2. Acute pain related to small bowel obstruction AEB pain rated on numeric pain scale at 10/10 upon admission.	Pain interferes with daily activities and sleep. It also affects the patient's mood. This patient is experiencing intense pain because of his small bowel obstruction.	1. Assess for pain when performing vital signs. Assess location, duration, characteristics, intensity, and aggravating/relieving factors. 2.Use at least two identifiers before administering pain medications. Administer opioid analgesic for severe pain as prescribed.	Goal met- Pain assessment was completed at 0830 during head to toe assessment. Pain assessment was also completed at 1120 and was rated at 2/10 but the client decided not to take pain medication at that time. I also assessed it at 1300 to find out if the client wanted to take his pain medication. He stated that he no longer needed the medication. Goal met- Patient's identification was verified using name and date of birth before administering ondansetron.
3. Risk for peripheral tissue perfusion r/t immobility AEB patient remaining in bed for most of 9 hour shift.	Impaired mobility increases risk of DVT. Patient's immobility is caused somewhat by his pain and somewhat by his indifference to ambulating long distances.	1. The use of sequential compression device was part of the patient's care plan. 2Assess for DVT by checking lower extremities for warm, redness, and swelling.	Goal not met- The patient did not wish to use SCDs. The re were no SCDs in his room and the nurse said he refused to use them. Goal met- I assessed the patient's lower extremities during my physical assessment at 0830.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning



Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning

Concept Map (20/20 Points):

Nursing Diagnosis/Outcomes