N321 Care Plan # 1

Lakeview College of Nursing

Caitlyn Blakeney

Demographics (3 points)

Date of Admission 9/22/2021	Patient Initials DG	Age 77	Gender F
Race/Ethnicity White	Occupation Unemployed	Marital Status Widowed	Allergies Penicillin Clindamycin
Code Status Full	Height 5'5	Weight 163	

Medical History (5 Points)

Past Medical History: A Fib, Anemia, Anxiety, Fatter Liver

Past Surgical History: Breast reconstruction, cataract removal R, Cataract removal L, colon resection, colonoscopy, Ear surgery, mastectomy R, PR ligate fallopian tube, sigmoid flex with sedations CFH.

Family History: Cancer lung father, Cancer Breast Mother, stroke mother, hypertension sister, lipids, psychiatry anxiety son.

Social History (tobacco/alcohol/drugs): No drug use, No alcohol use, former smoker quit in 1966.

Assistive Devices: Stand by assist.

Living Situation: Lives alone

Education Level: Highschool Education

Admission Assessment

Chief Complaint (2 points): Nausea and vomiting.

History of present Illness (10 points): Pt is a 77 y/o female with a PMH of Afib on warfarin, R kidney cancer and stroke and a s surgical history of mastectomy with TRAM flap reconstructions and subsequent mesh infection and removal in 2002 and partial colectomy for tubulovillous adenomas in 2005 who presented to the er with a 1 day history of nausea, vomiting, bloating and abdominal pain. She states she has been constipated recently and her last bowel movement yesterday was smaller and darker than normal. She stated her emesis has been dark but that she has been drinking chocolate protein shakes in preparation for knee surgery at the end of the month. Her last episode of emesis was this morning . She has not had any bloody emesis. She states the last time she remembers passing gas was earlier this morning. She has has no oral intake since last night. She states she had constipation and nausea toward the beginning of this year for which she was treated at Sarah Bush with an enema.

Primary Diagnosis

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

Secondary Diagnosis (if applicable):.

Pathophysiology of the Disease, APA format (20 points): A small bowel obstruction can be acute or chronic and partial or complete (Capriotti, 2020). An acute obstruction has a sudden onset that can occur with adhesions or a herniation of the bowel, whereas a chronic obstruction is often seen with inflammatory disease or tumors. A partial obstruction decreases the flow of intestinal contents through the bowel, whereas a complete obstruction prevents passage of all contents and fluid through the bowel and is considered a surgical emergency.

Etiology: The major cause of SBO is postsurgical adhesions (60%), followed by malignancy, Crohn's disease, and hernias. Postoperatively, surgeries that most often cause adhesions are appendectomy, colorectal surgery, and gynecological and upper GI procedures (Capriotti, 2020).

Pathophysiology: Adhesions are bands of connective tissue that form between tissues and organs, often as a result of injury during surgery (Capriotti, 2020). In the abdomen, adhesions commonly bond sections of intestine together. The adhesions cause obstruction and interfere with the intestine's normal function. Intestinal contents cannot move forward through the bowel. At the point of obstruction, there is increased peristalsis and mucus accumulation that worsen the blockage.

Clinical Presentation: The presentation of intestinal symptoms is directly related to the severity of the obstruction. The larger the obstruction, the more dramatic the symptoms. Abdominal distention, pain, nausea, vomiting, and hyperactive bowel sounds occur. Abdominal distention occurs proximal to the site of obstruction from the accumulation of chyme and intestinal gases (Capriotti, 2020). Pain is sharp, cramping, and intermittent, occurring with the contractions of hyperactive peristalsis. Pain that is continuous and steadily increases in severity is associated with a strangulation of the intestine. This indicates ischemia or necrosis of the intestinal lumen and requires emergency surgery. Nausea and vomiting can cause fluid and electrolyte depletion, which could potentially lead

to dehydration, hypotension, or hypovolemic shock. Diarrhea is present with a partial obstruction because liquid intestinal contents can leak around an obstruction in the lumen.

Diagnosis and Treatment: Abdominal x-ray provides visualization of the area of obstruction and severity of the blockage (Capriotti, 2020). X-ray will show excessive gas in the area of intestine proximal to the obstruction. CT and ultrasound can also be used to identify the obstruction. A nasogastric tube is inserted to decompress the bowel and remove the accumulation of fluid within the bowel. IV fluids are given to assure adequate fluid and electrolyte balance. The majority of partial SBOs can resolve with medical treatment. Pain management, antiemetic medications, and antibiotics are frequently necessary. Complete obstructions usually require surgical intervention.

Pathophysiology References (2) (APA):

Capriotti, Theresa M. "Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives" 2nd ed. (2020). *F.A Davis Company.*

All-in-One Nursing Care Planning Resource 5th Edition by Pamela Swearingen,

Jacqueline Wright and Publisher Elsevier (HS-US)

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	4.0-4.9 10^6/uL	5.45	4.91	Increased RBC due to small bowel obstruction. (Capriotti & Frizzell, 2016)
Hgb	12.0-16.0 g/ dL	16.0	14.5	
Hct	37.0-48.0%	48.0	43.5	
Platelets	150-400 10^3/uL	298	244	
WBC	4.1-10.9 10^3u/L	10.39	10.02	
Neutrophils	1.50-7.70 10^3/uL	N/A	N/A	
Lymphocytes	1.00-4.90 10^3/uL	N/A	N/A	
Monocytes	0.00-.0.80 10^3/uL	N/A	N/A	
Eosinophils	0.00-0.50 10^3/uL	N/A	N/A	
Bands	N/A	N/A	N/A	

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 mmol/L	139	139	
K+	3.5-5.1 mmol/L	3.9	3.4	Increased potassium due to vomiting. (Capriotti & Frizzell, 2016)
Cl-	98-107 mmol/L	98	100	
CO2	21.0-32.0	29.0	30.0	
Glucose	60-99 mg/ dL	114	96	Increased glucose due to the intestines not absorbing the nutrients as it should from vomiting (Capriotti & Frizzell, 2016)
BUN	5-20 mg/ dL	35	31	Increased BUN levels due to dehydration from vomiting and diarrhea (Capriotti & Frizzell, 2016).
Creatinine	0.5-1.5 mg/ dL	1.32	1.23	
Albumin		N/A	N/A	
Calcium	8.5-10.1 mg/dL	11.1	10.1	Increased calcium in the body due to the disease/infection in the blood stream caused by the small bowl obstructions (Capriotti & Frizzell, 2016).
Mag	1.6-2.6	2.2	2.2	

	mg/ dL			
Phosphate	**3-4.5 mg/dL**	**N/A**	**N/A**	
Bilirubin	**0.3-1 mg/dL**	**N/A**	**N/A**	
Alk Phos	**30-120 U/L**	**102**	**N/A**	
AST	**0-35 U/L**	**28**	**N/A**	
ALT	**4-36 U/L**	**24**	**N/A**	
Amylase	**60-120 U/L**	**N/A**	**N/A**	
Lipase	**0-160 U/L**	**55**	**N/A**	
Lactic Acid	**0.5-2.2 mmol/L**	**N/A**	**N/A**	

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**	**1.7**	**N/A**	**Slightly elevated INR due to the patient taking heparin (Capriotti & Frizzell, 2016).**
PT	**11-12.5 seconds**	**34.3**	**N/A**	**Increased PT due to the patient taking heparin (Capriotti & Frizzell, 2016).**
PTT	**60-70 seconds**	**N/A**	**N/A**	
D-Dimer	**Greater then 0.4 mcg/mL or greater than 250 ng/mL**	**N/A**	**N/A**	
BNP	**Less than 100 pg/mL**	**N/A**	**N/A**	
HDL	**Male:**	**N/A**	**N/A**	

	greater than 45 mg/dL Female: greater than 55 mg/dL			
LDL	**Adult: less than 130 mg/dL Children: less than 110 mg/dL**	**N/A**	**N/A**	
Cholesterol	**Less than 200 mg/dL**	**N/A**	**N/A**	
Triglycerides	**40-180 mg/dL**	**N/A**	**N/A**	
Hgb A1c	**Below 5.7%**	**N/A**	**N/A**	
TSH	**2-10 mU/L**	**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		**N/A**	**N/A**	
pH		**N/A**	**N/A**	
Specific Gravity		**N/A**	**N/A**	
Glucose		**N/A**	**N/A**	
Protein		**N/A**	**N/A**	
Ketones		**N/A**	**N/A**	
WBC		**N/A**	**N/A**	
RBC		**N/A**	**N/A**	
Leukoesterase		**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**	
Blood Culture		**N/A**	**N/A**	
Sputum Culture		**N/A**	**N/A**	
Stool Culture		**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT SCAN of abdomen and pelvis with contrast.

Diagnostic Test Correlation (5 points): CT Scan: Impression: There appears to be small bowl obstruction in the anterior mid abdomen involving the mid small bowl with maybe be secondary to adhesions. Computed tomography (CT) of the chest uses special x-ray equipment to examine abnormalities found in other imaging tests and to help diagnose the cause of unexplained cough, shortness of breath, chest pain, fever, and other chest symptoms (Capriotti, 2020). CT scanning is fast, painless, noninvasive, and accurate. Because it is able to detect exceedingly small nodules in the lung, chest CT is especially effective for diagnosing lung cancer at its earliest, most curable stage. The purpose of a non-contrast CT is to not give the patient any contrast media in situations, where it is not really needed (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). ***Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives*** **(2nd ed.). F. A. Davis Company.**

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

Hospital Medications (5 required)

Brand/	Famotidine	Fentanyl	Heparin	Hydrola	Potassium

Generic	**(Pepcid)**		**Injection**	**zine**	**chloride in water**
Dose	**20mg**	**25mcg**	**5000 units**	**5mg**	**200mEq/ 100ml 20Eq IVPB**
Frequency	**Daily**	**Every 2 hrs**	**Every 8 hrs**	**Every 8 hrs**	**Every 2 hrs**
Route	**IV**	**IV**	**IV**	**IV**	**IV**
Classification	**Histamine - 2 blocker**	**Opioid**	**Anticoagulant**		**Electrolyte cation. Electrolyte replacement.**
Mechanism of Action	**In normal digestion, parietal cells in the gastic epithelium secrete hydrogen ions, which combine with chloride ions to form hydrochloric acid.**	**Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathways. Fentanyl may alter neurotransmitter release from afferent nerves responsive to painful stimuli.**	**Binds with antithrombin III, enhancing antithrombin IIIs inactivation of the coagulation enzymes thrombin and factors Xa and Xia. At low doses, heparin inhibits factor Za and prevents conversion of prothrombin to thrombin.**		**Acts as the major cation in intracellular fluid, activating many enzymatic reactions essention for physiologic processes, including nerve impulse transmission and cardiac and skeletal muscle contrations.**
Reason Client Taking	**To provide short term treatment for active, benign gastric**	**To provide surgical premedication. As adjunct to regional anesthesia.**	**To prevent and treat peripheral arterial embolism, pulmonary**		**To prevent hypokalemia in patients who cant ingest**

	ulcer. To treat gastroesophageal refluz disease.	**To manage postoperative pain in postanesthetic care unit.**	**embolism, thromboembolic complications associated with atrial fibrillation.**		**sufficient dietary potassium or who are losing potassium because of a condition.**
Contraindications (2)	**Hypersensitivity to famotidine, other H2 receptor antagonists, or their components.**	**Hypersensitivity to fentanyl, alfentanil, sufentanil or their components;intermittent pain;opioid nontolerance, significant respiratory depression.**	**Breastfeeding, infants, neonates, or pregnant woman; history of heparin induced thrombocytopenia or heparin inducked thrombocytopenia.**		**Acute dehydration, Addisons disease, concurrent use with amiloride or triamterene or sparing diuretics, crushing syndrome, disorders that delay drugs passing through the GI Tract.**
Side Effects/ Adverse Reactions (2)	**Agitation, anxiety asthenia, confusion, depression, dizziness, fatigue, fever, hallucinations, headache, insomnia, mental or mood changes.**	**Agitation, amnesia, anxiety, asthenia atazia, confusion, delusions, depression, dizziness, drowsiness, euphoria, fever, hallucinations, headache, lack of coordination.**	**Chills, dizziness, fever, headache, peripheral neuropathy, chest pain, rebond hyperlipemia, thrombosis. Asthma, dyspnea, wheezing.**		**Chills, confusion, fever, paralyisis, paresthesia, weakness, Arrhythmias, asystole, bradycardia, cardiac arrest, chest pain, ECG**

					changes, Throat pain when swallowing .
Nursing Considerations (2)	**Shake famotidine oral suspension vigorously for 5 to 10 seconds vefore administration. Dilute injection form with normal saline solution or other solution to 5 to 10ml.**	**Know that fentanyl transdermal system should be used only in paitents already receiving opioid therapy and with demonstrated opioid tolerance and require at least a fentanyl dosage of 25mcg/ hr to manage their pain.**	**Know that hepalrin sodium injection, USP, preserved with benzyl, alcohol, should not be given to infants, neonates, pregnant women or women who are breastfeeding the can result in death.**		**Review patients medical history before administering potassium chloride, because there are many conditons that may predispose patient to develop hyperkalemia and increased sensitivity to potassium.**

Home Medications (5 required)

Brand/ Generic	**Lisinopril**	**Metoprolol injection**	**Ondansetron HCL PF injection**	**Prochlorperazine (Compazine)**	**Clopidogrel Plavix**

Dose	**10mg**	**5mg**	**4mg**	**10mg**	**75mg**
Frequency	**1 x a day**	**Every 6 hrs**	**Daily as needed may repeat 1x**	**Every 6 hrs.**	**Daily**
Route	**Oral**	**IV push**	**IV push**	**Oral**	**oral**
Classification	**Angiotensin-converting enzyme.**	**Beta 1 adrenergic blocker**	**Selective serotonin receptor antagonist.**	**Piperaze phenothiazine**	**P2Y12 platelet inhibitor**
Mechanism of Action	**May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin. II. Angiotensin II is a potent vasoconstrictor that also stimulates adrenal cortex to secrete aldosterone. Lisinopril may also inhibit renal and vascular production of angiotensin II.**	**Inhibits stimulation of beta 1 receptor sites, located mainly in the heart, resulting decreased cardiac excitability, cardiac output, and myocardial oxygen demand. These effects help relieve angina, minimize cardiac tissue damage from myocardial infarction, and help relieve symptoms of heart failure.**	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in chemotherapy.**	**Alleviates psychotic symptoms by clocking dopamine receptors, depressing release of selected hormones, and producing alpha-adrenergic blocking effect in the brain.**	**Binds to adenosine diphosphate receptor on the surface of activated platelets. This action blocks ADP, which deactivated nearby glycoprotein IIb/IIIa receptor and prevents fibrinogen from attaching to receptor.**
Reason Client Taking	**To treat hypertension. As adjunct with digitalis and diuretics to treat**	**To manage hypertension, alone or with another antihypertensives.**	**To prevent nausea and vomiting associated with highly**	**To control nausea and vomiting related to surgery. To manage**	**To reduce thrombotic events**

	heart failure.		**emetogenic cancer chemotherapy.**	**psychotic disorders and schizophrenia.**	**such as MI and stroke in patients with acute coronary syndrome.**
Contraindications (2)	**Concurrent aliskiren use in patients with diabetes or patients with renal impairment; hereditary or idiopathic angioedema or history of angioedema related to previous treatment with ACE inhibitor.**	**Acute heart failure, cardiogenic shock; hypersensitivity to metoprolol, its components, or other beta blockers; pheochromocytoma; pulse less than 45 beats/min.**	**Concomitant use of apomorphine, congenital long QT syndrome, hypersensitivity to ondansetron or its components.**	**Age less than 2 years, blood dyscrasias, bone marrow depression, cerebral arteriosclerosis, coma, coronary artery disease, hepatic dysfunction hypersensitivity.**	**Active pathological bleeding, including peptic ulcer and intracranial hemorrhage; hypersensitive to clopidogrel or its components.**
Side Effects/ Adverse Reactions (2)	**Ataxia, confusion, CVA, depression, dizziness, fatigue, hallucinations, headache, insomnia, irritability, memory impairment, mood alterations, nervousness.**	**Anxiety, confusion, CVA, depression, dizziness, drowsiness, fatigue, hallucinations, headache, insomnia, nightmares, paresthesia, short term memory loss, Angina, heart failure.**	**Agitation, akathisia, anxiety, ataxia, dizziness, drowsiness, dystonia, fever, headache, hypotension, restlessness.**	**Akathisia, altered temperature regulation, dizziness, drowsiness, extrapyramidal reactions, pseudoparkinsonism, hypotension, blurred vision.**	**Confusion, depression, dizziness, fatigue, fever, hallucinations, headache, diarrhea.**
Nursing Considerations (2)	**Be aware that lisinopril should not be given to a patient who is hemodynamically unstable after an**	**Know that patients undergoing noncardiac major surgery should not begin a high dose regiment using**	**Be aware that oral disintegrating tablets may contain aspartame,**	**Avoid contact between skin and solution forms of prochlorperazine because contact dermatitis could**	**Avoid clopidogrel in patients who have a**

	acute MI. Use lisinopril cautiously in patients with FVD, heart failure, impaired renal function or sodium depleation.	**extended-release metoprolol. Because such use in patients with cardiovascular risk factors has been associated with bradycardia, hypotension, stroke and death.**	**which is metabolized to phenylalanine and must be avoided in patients with phenylketonuria**	**result. Rotate IM injections sites to prevent irritation and sterile abscesses. Protect prochlorperazine from light.**	**genetic variation in CYP2C19 or are receiving CYP2C19 inhibitors.**

Medications Reference (1) (APA): (Jones & Bartlett Learning, 2020)

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.). Jones & & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: A&O x 4** **Orientation: Oriented to person, place, time, and current events.** **Distress: No acute Distress** **Overall appearance: Well groomed**	
INTEGUMENTARY (2 points):	

Skin color: pale pink **Character: Appears hydrated, clean. Temperature: Warm.** **Turgor: Rapid recoil.** **Rashes: None noted.** **Bruises: From IV. L arm AC** **Wounds: None** **Braden Score: 19** **Drains present: None** **Drains present: Y☒ N ☐** **Type: NG Tube**	**Branden score:19**
HEENT: **Head/Neck: Symmetrical** **Ears: Auricle was pink, moist, with no rashes or lesions.** **Eyes: Sclera white, cornea clear, con- junctiva pink with no lesions** **Nose: Septum midline. No drainage Teeth: Appear normal. No cavities.**	.
CARDIOVASCULAR (2 points): **Heart sounds: s1,s2 clear with no mur- murs or gallops.** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 78bpm** **Radial Capillary refill: less than 3 seconds on fingers and toes bilaterally** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	.
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character:** **Lung sounds are normal bilaterally.**	**Nasal canula 2L O2**
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: NPO** **Height: 5'5** **Weight:191**	.

Auscultation Bowel sounds: present in all 4 quadrants. Normoactive **Last BM: 9/23/21** **Palpation: Pain, Mass etc.: no pain or masses noted** **Inspection:** **Distention: slight distention in abdomen.** **Incisions:None** **Scars:None** **Drains: None** **Wounds:None** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size: 58cm** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color:clear light, yellow** **Character:no cloudiness or sediment in urine.** **Quantity of urine: spontaneous** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: n/a** **Catheter: Y ☐ N ☒** **Type: n/a** **Size: n/a**	
MUSCULOSKELETAL (2 points): **Neurovascular status: no deficits noted** **ROM: Pt performed flexion/extension, doris/planter independently without pain.** **Supportive devices: Pt needs standby assistance.** **Strength: overall good.** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status: ambulate as tolerated**	.

Independent (up ad lib) ☐ **Needs assistance with equipment ☐** **Needs support to stand and walk☐ yes**	
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: oriented to person, time, place and current events x 4.** **Mental Status: normal** **Speech:normal without slurring** **Sensory:good** **LOC: Alert, difficulty breathing.**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): Self support** **Developmental level: None noted** **Religion & what it means to pt.: none noted.** **Personal/Family Data (Think about home environment, family structure, and available family support): her boss helps her.**	.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:03	**103**	**147/88**	**20**	**98.1**	**88**
11:09	**78**	**149/91**	**21**	**98.6**	**94**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
7:03	**0**	**N/A**	**N/A**	**N/A**	**N/A**
11:09	**0**	**N/A**	**N/A**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV: L AC** **Date on IV:9/22/21** **Patency of IV: yes** **Signs of erythema, drainage, etc.: No** **IV dressing assessment: Transparent. Clean, dry and intact.**	**Lactated Ringer infusion 120ml/hr IV continuous.**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Lactated Ringer 120/hr	**300mL**

Nursing Care

Summary of Care (2 points)

Overview of care: I helped pass medications to the patient with the oversee of the nurse.

Procedures/testing done: CT Scan

Complaints/Issues: Patient had no complaints at the time of care when I was there.

Vital signs (stable/unstable): Patients vital signs were stable at the time of my care. She was placed on 2L of oxygen.

Tolerating diet, activity, etc.: Pt is tolerating diet, as she is NPO.

Physician notifications: None.

Future plans for patient: Patient should continue NPO until her follow up with her doctor. Patient could also have education on how to stay hydrated.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Patient has not yet been discharged and is still being monitored by the physician.

Education needs: Patients education needs are to how to keep herself from being dehydrated.

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. Risk for Deficient Fluid Volume as evidence by the patient vomiting.	**Indicates excessive fluid loss or resultant dehydration.**	**1.Observe for excessively dry skin and mucous membranes, decreased skin turgor, slowed capillary refill.** **2.Assess vital signs (BP, pulse, temperature)**	**Patients skin turgor was normal. Patient also had a +3 capillary refill. Goals met. Patients vitals were all normal, patient is stable. Patient was put on 2 L of oxygen and is stable. Goals met.**
2. Risk for infection related to development of inflammator	**Certain abnormal laboratory results could be an indicator of infection.**	**1. Report and note any abnormal laboratory values to healthcare provider.** **2.Assess mental**	**1.) No other labs were tested at the time I was there.** **2.) Patient seemed alert and**

y process or worsening bowl obstruction.		**status and level of consciousnesses every 4-6 hours.**	**oriented x4 while I was there. Goals met.**
3. Risk for acute pain related to intestinal obstruction distention as evidence by the patient's pain level when she was admitted.	**Patient stated upon arrival her pain level was a 9/10.**	**1.Assess level of pain using appropriate pain scale. Assess pain 30 minutes before and after pain medications is given** **2Administer pain medication as prescribed and indicated.**	**The patients pain is resolved or controlled at the time of my care. Goals met** **Patient revealed a decrease discomfort. Her pain level was 0 at the time of my care. Goals met.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Pt states "I was brought in for nausea and vomiting."
Patient stated upon arrival her pain level was a 9/10.
Paitent stated "I have been constipated recently but my last bowel movement was today (9/23/21)

Nursing Diagnosis/Outcomes

Risk for Deficient Fluid Volume as evidence by the patient vomiting.
Risk for acute pain related to intestinal obstruction distention as evidence by the patient's pain level when she was admitted.
Risk for acute pain related to intestinal obstruction distention as evidence by the patient's pain level when she was admitted.

Objective Data

Patients pain level is 0/10.
A & O x 4
IV: L. AC
Vitals:

Patient Information

Pt is a 77 y/o female with a PMH of Afib on warfarin, R kidney cancer and stroke and a s surgical history of mastectomy with TRAM flap reconstructions and subsequent mesh infection and removal in 200a2 and partial colectomy for tubulovillous adenomas in 2005 who presented to the er with a 1 day history of nausea, vomiting, bloating and abdominal pain.

Nursing Interventions

Observe for excessively dry skin and mucous membranes, decreased skin turgor, slowed capillary refill. Assess vital signs (BP, pulse, temperature)

1. Report and note any abnormal laboratory values to healthcare provider.

.Assess mental status and level of consciousnesses very 4-6 hours.
1.Assess level of pain using appropriate pain scale. Assess pain 30 minutes before and after pain medications is given

2Administer pain medication as prescribed and indicated.