

N431 Care Plan # 2

Lakeview College of Nursing

Jillian Kurtz

Demographics (3 points)

| | | | |
|---|---------------------------------|---------------------------------|--------------------------------|
| Date of Admission 10/18/2021 | Patient Initials D.J. | Age 45 years old | Gender Male |
| Race/Ethnicity African American | Occupation Paramedic | Marital Status Single | Allergies Penicillin |
| Code Status Full | Height 5' 10" | Weight 180 lbs. | |

Medical History (5 Points)

Past Medical History: Irritable bowel syndrome, Gastroesophageal reflux disease

Past Surgical History: Patient has no past surgical history.

Family History: Patient's mother has IBS. Patient's father has GERD. Patient's sister has obesity and diabetes mellitus type 2.

Social History (tobacco/alcohol/drugs): The patient has been smoking 1 pack/day for the last 20 years, and states he drinks "a few beers on the weekends." Patient denies use of any drugs.

Assistive Devices: None

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

Education Level: Patient has a high school diploma and Formal Paramedic Training since 1995.

Admission Assessment

Chief Complaint (2 points): Abdominal pain for 2 days with nausea/vomiting

History of present Illness (10 points): A 45-year-old African American male presented to the emergency room on 10/18/2021 with abdominal pain, nausea, and vomiting. The patient stated that it started two days ago. The patient was provided famotidine, lidocaine oral suspension, and ondansetron with little relief. A KUB was performed and showed a small bowel obstruction. A NG tube was placed to decompress his abdomen. The patient 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): N/A

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

A small bowel obstruction can be acute or chronic and partial or complete (Capriotti, 2020). The major causes of small bowel obstructions are postsurgical adhesions, malignancy, Crohn's disease, and hernias. Surgeries that most often cause adhesions are appendectomy, colorectal surgery, gynecological and upper GI procedures (Capriotti, 2020). These adhesions cause obstruction and interfere with the intestine's normal function. The obstruction will cause increased peristalsis and mucus accumulation which then worsens the block.

The signs and symptoms depend on the severity of the obstruction. If the block is larger, the symptoms will present as abdominal distention, pain, nausea, vomiting, and hyperactive bowel sounds (Capriotti, 2020). My patient presented to the emergency room with abdominal pain, nausea, and vomiting. Upon assessment, my patient had a soft but tender abdomen and hypoactive bowel sounds. Pain can persist as sharp, cramping, and intermittent. Continuous pain is usually associated with strangulation of the intestine (Capriotti, 2020). When this happens, it is considered an emergency surgery because it can lead to necrosis or ischemia. Persistent nausea and vomiting can cause fluid and electrolyte depletion, which could manifest in dehydration, hypotension, and hypovolemic shock (Capriotti, 2020).

As mentioned earlier, there are three main risk factors of a small bowel obstruction. A patient who had an abdominal or pelvis surgery is at an increased risk because these surgeries cause adhesions, which can cause intestinal obstruction (Mayo Clinic 2021). Another risk factor

is someone diagnosed with Crohn's disease, which causes the intestine walls to thicken and narrow the passageway (Mayo Clinic, 2021). Lastly, having cancer in your abdomen increases your risk of developing a small bowel obstruction. Cancer in the abdominal area such as ovarian, bowel or stomach cancer presses on the bowel. Cancer can grow into the nerve supply of the bowel and damages it, which then interrupts the muscles from working (Mayo Clinic, 2021).

Complications can occur with small bowel obstructions that can be life-threatening if left untreated, including tissue death and infection. Tissue death causes an intestinal obstruction that can cut blood supply to a part of the intestine (Mayo Clinic, 2021). Lack of blood will then cause the intestinal wall to die off, leading to infection if a tear in the intestinal wall occurs. Infection or peritonitis is an infection in the abdominal cavity which is a medical emergency and requires surgical attention (Mayo Clinic, 2021).

A small bowel obstruction is commonly diagnosed using an abdominal x-ray, CT scan, and ultrasound. An x-ray provides a visualization of the area of obstruction and the severity. X-rays will normally show how much gas is in the area of the intestine proximal to the block (Capriotti, 2020). Typically, an NG tube will be inserted to decompress the bowel and remove fluid accumulation within the bowel (Capriotti, 2020). My patient was diagnosed using a kidney, ureter, and bladder x-ray, which showed a small bowel obstruction in the lower left quadrant of the abdomen. Gas was seen throughout the abdomen, with no sign of free air within the abdominal cavity. My patient also had an NG tube inserted to help decompress the stomach and relieve pain. Commonly IV fluids are given to help manage fluid and electrolyte balance.

A majority of small bowel obstructions can be treated with medical treatment. Most common treatment options for small bowel obstructions include pain management, antiemetic medications, and antibiotics. My patient was receiving Morphine for pain management and

Ondansetron for nausea. My patient received an IV infusion of potassium chloride in 5% dextrose and sodium chloride to maintain electrolyte and fluid balance. If the obstruction becomes complete, surgical intervention is usually required.

Pathophysiology References (2) (APA):

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

Mato Clinic (2021, January 20). *Intestinal obstruction - Symptoms and causes*. Retrieved October 19, 2021, 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 | 3.8-5.41 | N/A | N/A | |
| Hgb | 11.3-15.2 | 13.1 | N/A | |
| Hct | 35.2-45.3 | 42.1 | N/A | |
| Platelets | 149-393 | N/A | N/A | |
| WBC | 4.0-11.7 | 12.4 | N/A | The patient's white blood cell are elevated because small bowel obstructions are commonly caused by an infection, which could be the case in the patient (Capriotti, 2020). |
| Neutrophils | 45.3-79 | N/A | N/A | |
| Lymphocytes | 11.8-45.9 | N/A | N/A | |
| Monocytes | 4.4-12.0 | N/A | N/A | |

| | | | | |
|--------------------|---------|-----|-----|--|
| Eosinophils | 0.0-6.3 | N/A | N/A | |
| Bands | 3-5 | 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 | 130 | N/A | The patient has low sodium due to the patient stating he has had nausea and vomiting for the past 2 days which leads to fluid and electrolyte imbalance (Capriotti, 2020). |
| K+ | 3.5-5.1 | 4.2 | N/A | |
| Cl- | 98-107 | N/A | N/A | |
| CO2 | 21-31 | N/A | N/A | |
| Glucose | 74-100 | 97 | N/A | |
| BUN | 7-25 | 9 | N/A | |
| Creatinine | 0.7-1.3 | 1.01 | N/A | |
| Albumin | 3.5-5.2 | N/A | N/A | |
| Calcium | 8.6-10.3 | N/A | N/A | |
| Mag | 1.6-2.4 | N/A | N/A | |
| Phosphate | 3.0-4.5 | N/A | N/A | |
| Bilirubin | 0.3-1.0 | 0.4 | N/A | |
| Alk Phos | 34-104 | N/A | N/A | |
| AST | 13-39 | 15 | N/A | |
| ALT | 7-52 | 52 | N/A | |

| | | | | |
|--------------------|----------|-----|-----|--|
| Amylase | 30-220 | N/A | N/A | |
| Lipase | 11-82 | N/A | N/A | |
| Lactic Acid | 0.5-2.0 | N/A | N/A | |
| Troponin | 0.0-0.03 | N/A | N/A | |
| CK-MB | 0.6-6.3 | N/A | N/A | |
| Total CK | 30-223 | 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 | 0.86-1.14 | N/A | N/A | |
| PT | 11.0-15.0 | N/A | N/A | |
| PTT | 22.6-35.3 | N/A | N/A | |
| D-Dimer | 0.0-0.62 | N/A | N/A | |
| BNP | 0-100 | N/A | N/A | |
| HDL | >55 | N/A | N/A | |
| LDL | <120 | N/A | N/A | |
| Cholesterol | <200 | N/A | N/A | |
| Triglycerides | 35-135 | N/A | N/A | |
| Hgb A1c | 4.5-9 | N/A | N/A | |
| TSH | 0.45-5.33 | 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 | Value on | Today's | Reason for Abnormal |
|----------|--------|----------|---------|---------------------|
|----------|--------|----------|---------|---------------------|

| | Range | Admission | Value | |
|----------------------------|-------------------------|------------------|--------------|--|
| Color & Clarity | Yellow & clear | N/A | N/A | |
| pH | 5.0-8.0 | N/A | N/A | |
| Specific Gravity | 1.005-1.034 | N/A | N/A | |
| Glucose | Normal | N/A | N/A | |
| Protein | Negative | N/A | N/A | |
| Ketones | Negative | N/A | N/A | |
| WBC | Less than or equal to 5 | N/A | N/A | |
| RBC | 0-3 | N/A | N/A | |
| Leukoesterase | Negative | N/A | N/A | |

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 | N/A | N/A | |
| PaO2 | 80-100 | N/A | N/A | |
| PaCO2 | 35-45 | N/A | N/A | |
| HCO3 | 21-28 | N/A | N/A | |
| SaO2 | 95-100 | 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 | No growth/ Negative | N/A | N/A | |
| Blood Culture | No growth/ Negative | N/A | N/A | |

| | | | | |
|-----------------------|------------------------|-----|-----|--|
| Sputum Culture | No growth/ Negative | N/A | N/A | |
| Stool Culture | No growth/ Negative | 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 Company.

Sarah Bush Lincoln Health Center (2021). *Cerner*. <https://www.sarahbush.org/>

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

KUB x-ray: The results showed a small bowel obstruction in the lower left quadrant of the abdomen. Gas can be seen throughout the abdomen. There is no sign of perforation or free air within the abdominal cavity.

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

12-lead EKG: The results showed normal sinus rhythm without ectopy.

Diagnostic Test Correlation (5 points):

The KUB x-ray was performed because the patient came into the emergency room with abdominal pain, nausea, and vomiting. A KUB is performed to assess the abdominal area for causes of abdominal pain, or to assess the organs and structure of the urinary or GI system (Capriotti, 2020). This test will confirm the cause of the abdominal pain.

The KUB s/p NG insertion was performed on the patient to confirm the placement of the patient's NG tube. A KUB is performed to assess the abdominal area and to confirm that the NG

tube is placed in the patient’s stomach to allow for effectiveness in decompressing the abdomen (Capriotti, 2020). This test will confirm proper NG tube placement.

The 12-lead EKG was performed as protocol when coming into the emergency room to ensure the patient does not have any abnormal heart rhythm or rate. The purpose of an EKG is to record the electrical signals from your heart to check for any abnormal heart conditions (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***

Home Medications (5 required)

| | | | | | |
|-----------------------|---|---|---|---|--|
| Brand/Generic | Famotidine/ Pepcid | Loperamide/ Imodium | Calcium Carbonate/ Apo-Cal | Atorvastatin (Lipitor) *Assigned | Diphenhydra mine (Benadryl) *Assigned |
| Dose | 20 mg | 4 mg | 750 mg | 40 mg | 50 mg |
| Frequency | Daily | Q6H PRN | Q4H PRN | Daily at bedtime | Q6H PRN |
| Route | Oral | Oral | Oral | Oral | Oral |
| Classification | Pharmacolog ical: Histamine -2 blockers Therapeutic: Antiulcer agent | Pharmacologica l: Opiate receptor agonist Therapeutic: Antidiarrheal | Pharmacolog ical: Calcium salts Therapeutic: Antacid | Pharmacologi c: HMG-CoA reductase inhibitor Therapeutic: Antihyperlipid emic | Pharmacolog ic: Antihistamine Therapeutic: Antianaphyla xis adjunct, antidyskinetic , antiemetic, antihistamine, antitussive, antivertigo, sedative- hypnotic |
| Mechanism of | Reduces HCl | Inhibits | Increases | Reduces | Binds to |

| | | | | | |
|---|--|---|--|--|---|
| Action | formation by preventing histamine binding with H2 receptors on the surface of parietal cells which helps prevent peptic ulcers from forming and helps heal existing ones | peristalsis and reduces the volume of feces while increasing the bulk and viscosity | levels of intracellular and extracellular calcium, which is needed to maintain homeostasis; oral forms also neutralize or buffer stomach acid to relieve discomfort caused by hyperacidity | cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and increasing the number of LDL receptors in enhance uptake and breakdown | central and peripheral H1 receptor, competing with histamine for these sites and preventing it from reaching its site of action |
| Reason Client Taking | The patient is taking this for treatment of GERD. | The patient is taking this for diarrhea. | The patient is taking this for heartburn. | The patient is taking this for a history of CAD. | The patient is taking this for an allergic reaction to penicillin. |
| Contraindications (2) | Hypersensitivity to its components Individuals who have chronic kidney disease | Hypersensitivity to its components Individuals who have bloody or tarry stools | Hypersensitivity to its components Kidney calculi | Active hepatic disease Hypersensitivity to atorvastatin or its components | Hypersensitivity to its components High blood pressure |
| Side Effects/Adverse Reactions (2) | Arrhythmias Seizures | Constipation Dizziness/ Drowsiness | Hypotension Hypercalcemia | Arrhythmias Hypoglycemia | Agranulocytosis Hemolytic anemia |
| Nursing Considerations (2) | Shake oral suspension for 5-10 seconds before administration Give IV injection over 2 minutes with normal saline | May lead to constipation Assess bowel function and fluid/electrolyte levels | Instruct patient on foods that contain vitamin D and encourage fluid intake May cause hypotension, bradycardia, and arrhythmias | Monitor diabetes glucose with administration It may be used with colestipol and cholestyramine for additive antihyperlipidemic effects | Expect to parental form when oral isn't available Expect to discontinue 72 hours before skin or allergies test |
| Key Nursing | It is important to monitor | It is important to monitor all | It is important to monitor HR | It is important | It is important |

| | | | | | |
|---|--|--|---|---|--|
| Assessment(s)/Lab(s) Prior to Administration | kidney function and labs. | electrolytes levels because the body can lose fluids quickly. | and BP before administration and following. | to assess liver enzymes and blood glucose is diabetes patients. | to monitor blood pressure and respiratory rate, it could cause CNS depression. |
| Client Teaching needs (2) | Instruct patients to thoroughly chew tablets before swallowing Caution patient to avoid alcohol and smoking | Take loperamide with a full glass of water Chewable tablets should be chewed thoroughly before swallowing | Urge patient to chew tablets thoroughly before swallowing and to drink a glass of water afterwards Take tablets 1-2 hours after meals and other forms with meals | No do substitute for a low cholesterol diet Tell patient to take the drug at the same each day to minimize effects | Take drug with food to minimize GI upset. Advise patient to avoid taking OTC drugs that contain diphenhydramine to prevent additive effects |

Hospital Medications (5 required)

| | | | | | |
|----------------------------|---|---|---|--|--|
| Brand/Generic | Ondansetron/ Zofran | Promethazine/ Phenazine | Morphine/ MS Contin | Acetaminophen Injection/ Tylenol | Pantoprazole/ Pantoloc |
| Dose | 4 mg | 12.5 mg | 2 mg | 1,000 mg | 40 mg |
| Frequency | Q6H PRN | Q8H PRN | Q4H PRN | Q8H PRN | Daily PRN |
| Route | IV push | IV push | IV push | IV | IV |
| Classification | Pharmacologic al: Selective serotonin (5-HT ₃) receptor antagonist Therapeutic: Antiemetic | Pharmacologic al: Phenothiazine Therapeutic: Antiemetic, antihistamine, Antivertigo, Sedative-hypnotic | Pharmacologic al: Opioid Therapeutic: Opioid analgesic | Pharmacologic al: Non salicylate, Para-aminophenol derivative Therapeutic: Antipyretic, nonopioid analgesic | Pharmacologic al: Proton pump inhibitor Therapeutic: Antilulcer |
| Mechanism of Action | Blocks serotonin receptors centrally in the chemoreceptor | Decreasing vestibular stimulation and labyrinthine function in the | Binds with and activates opioid receptors in brain and spinal cord to produce | Inhibits the enzyme cyclooxygenase, blocking prostaglandin | Interferes with gastric acid secretion by inhibiting the hydrogen- |

| | | | | | |
|---|---|--|---|--|---|
| | trigger zone and peripherally at vagal nerve terminals in the intestine | inner ear; promoted sedation and relieves anxiety by blocking sites in the CNS, directly reducing stimuli to the brain | analgesia and euphoria | production and interfering with pain impulse generation in the PNS; acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2 | potassium-adenosine triphosphate enzyme system, or proton pump, in gastric parietal cells |
| Reason Client Taking | The patient is taking this for nausea. | The patient is taking this for nausea refractory to Ondansetron. | The patient is taking this for pain. | The patient is taking this for a fever > 38.0 C. | The patient is taking this for indigestion. |
| Contraindications (2) | Concomitant use of apomorphine Hypersensitivity to its components | Hypersensitivity Stenosing peptic ulcer | Respiratory depression Upper airway obstruction | Hypersensitivity to its components Severe hepatic impairment | Concurrent therapy with rilpivirine-containing products Hypersensitivity to pantoprazole |
| Side Effects/Adverse Reactions (2) | Hypotension Prolonged QT interval | Bradycardia Hypotension | Cardiac arrest Seizures | Pulmonary edema Hypotension | Hepatic failure Stevens-Johnson syndrome |
| Nursing Considerations (2) | Correct any electrolyte imbalance before administration Monitor for signs and symptoms of hypersensitivity | Monitor hematologic status as it may cause bone marrow suppression Patients shouldn't have intradermal allergen tests within 72 hours | Be aware morphine can lead to abuse, addiction, and misuse Assess patient's drug use including OTC and prescription drugs before administration. | Monitor patients on long term therapy Monitor the end of a parental infusion to prevent possibility of air embolism | Ensure the continuity of gastric acid suppression from oral to IV (vice versa) Flush I.V line with D5W normal saline, or lactated ringers injection before and after giving drug |
| Key Nursing Assessment(s)/Lab(s) Prior to Administration | It is important to monitor HR and electrolyte levels. | It is important to monitor liver enzymes and assess for signs of bleeding. | It is important to monitor heart rate and respiratory rate. | It is important to monitor hepatic and renal function. | It is important to monitor blood and electrolyte levels. |
| Client Teaching needs (2) | Advise patient to report signs | Advise client to allow OTC | Warn patients not to stop | Caution patient not to exceed | Instruct patients to take tablets |

| | | | | | |
|--|---|--|--|--|--|
| | and symptoms of hypersensitivity Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours | drugs unless approved by prescriber Urge patient to avoid alcohol and other CNS depressants | taking the drug abruptly Advise patients to avoid potentially hazardous activities during therapy | recommended dosage or take other drugs containing acetaminophen Teach patient to recognize signs and symptoms of hepatotoxicity | whole and not to chew or crush them Advise patient to notify prescriber if there is a decrease in the amount of urine or blood in the urine |
|--|---|--|--|--|--|

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse’s drug handbook* (19th ed.). Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

| | |
|--|--|
| GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance: | The patient was A&O x4. The patient was oriented to self, time, and space. The patient does not appear to be in distress. He was calm and cooperative. The patient appears to be normal for ethnicity and age. The patient was well groomed. |
| INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: | The patient’s skin color was pink and usual for ethnicity. The patient’s skin was intact and dry. The patient’s temperature is warm to touch. The patient’s kin turgor was elastic. The patient had no rashes. The patient had no bruises. The patient has no wounds. 22 N/A |
| HEENT (1 point): Head/Neck: Ears: Eyes: Nose: | The trachea was midline; oral mucosa was moist and intact. The uvula was midline. The tongue was pink with no lesions. The ears are symmetrical, and the tympanic |

| | |
|--|--|
| <p>Teeth:</p> | <p>membrane appears pearly grey bilaterally. The eyes are symmetrical, sclera appeared white, PERLA. There was no conjunctivitis present or drainage. The septum is midline with no deviation noted. There was no drainage present. The patient had no dental carries present.</p> |
| <p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p> | <p>S1 and S2 heart sounds auscultated, S1 and S2 present. The cardiac rhythm was sinus rhythm without ectopy. Radial pulses 2+ bilaterally The capillary refill was normal, upper, and lower extremities blanched white in less than three seconds. N/A</p> |
| <p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p> | <p>Clear bronchial vascular lung sounds when auscultated anteriorly and posteriorly, upper and lower lobes, on the left and right side Respirations were non-labored and equal Patient is on room air, no oxygen needed at this time.</p> |
| <p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p> | <p>The patient's diet at home is regular. The patient's current diet is NPO. 177.8 cm 81.8 kg Bowel sounds are hypoactive in RUQ, LUQ, LLQ; bowel sounds absent in RLQ Patient has not had a bowel movement. The abdomen is soft but tender to palpation. The patient has no distention. The patient has no incisions. The patient has no scars present. The patient has no drains present. The patient has no wounds present. NG remains in place measuring 65 cm at the nare. It is connected to low-intermittent suction with bile-green colored return.</p> |
| <p>GENITOURINARY (2 Points): Color: Character:</p> | <p>Light yellow Clear</p> |

| | |
|---|--|
| <p>Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p> | <p>450 mL</p> <p>No abnormalities were noted. The genitals were clean and intact with no lesions present.</p> <p>N/A N/A</p> |
| <p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p> | <p>The skin was warm in the upper and lower extremities. Radial pulses 2+ bilaterally. The patient demonstrates functional active range of motion in both upper and lower extremities bilaterally. The patient does not use any supportive devices. The upper extremities were equal in strength bilaterally. The lower extremities were equal in strength bilaterally. 25 The patient is independent.</p> |
| <p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p> | <p>The patient was oriented to self, time, and space. The patient's mental status was normal for age. The patient's speech was clear and easy to understand. The patient's sensation was intact with no numbness or tingling present. The patient was alert and oriented.</p> |
| <p>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):</p> | <p>The patient copes by spending time with his significant other and resting. The patient has an appropriate developmental level for his age. The patient does not identify with any religion. The patient will be going home with his significant other upon discharge.</p> |

Vital Signs, 2 sets (5 points)

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|------|-------|--------|-----------|--------|--------------|
| 0700 | 76 | 133/76 | 16 | 37.5 C | 98 % on room |

| | | | | | |
|------|----|--------|----|--------|--------------------|
| | | | | | air |
| 1100 | 69 | 124/63 | 18 | 36.9 C | 97% on room air |

Vital Sign Trends: D.J. 's vitals remained stable and within normal limits between 0700 and 1100. There were no remarkable changes in the patient’s vitals that needs to be noted.

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|------|---------|----------|-------------|--|--|
| 0700 | Numeric | Abdomen | 8 out of 10 | The patient states it is generalized abdominal pain. | The patient received morphine to help with the pain. |
| 1100 | Numeric | Abdomen | 4 out of 10 | The patient states it is generalized abdominal pain. | The patient received morphine to help with the pain. |

IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
|--|--------------------------------|
| <p>Size of IV: 18G Location of IV: Left antecubital/Right wrist Date on IV: 10/18/2021 Patency of IV: The IV is patent and infusing without difficulty. Signs of erythema, drainage, etc.: No signs of erythema, complications, or drainage. IV dressing assessment: IV dressing is clean, dry, and intact.</p> | <p>D5NS- 100 mL/hr</p> |

Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
|---------------------------|-----------------------|
| D5NS: 100 mL/hr x 4 hours | Urine: 450 mL |
| Total: 400 mL | Stool x0 |
| | Total: 450 mL |

Nursing Care**Summary of Care (2 points)**

Today, I performed a head-to-toe assessment, obtained two sets of vitals, and two pain assessments. My patient had a kidney, ureter, and bladder x-ray because of abdominal pain which assisted in the diagnosis of a small bowel obstruction. The patient also had a KUB to help confirm the placement of his NG tube. Lastly, the patient had an EKG which showed normal sinus rhythm without ectopy. The patient complained of generalized abdominal pain and rated his pain an 8 out of 10 at 0700. The patient still complained of generalized abdominal pain and rated his pain a 4 out of 10 at 1100. The patient will continue to receive morphine 2 mg IV push every four hours as needed for pain. D.J.'s vitals showed stability during my clinical shift and were all within normal limits at both vital assessments. The patient is on a NPO diet until bowel sounds return or he starts passing gas. The doctor should be notified once bowel sounds return for future orders. The doctor should also be alerted if the patient develops a fever >38.0 C despite Acetaminophen administration. Future plans for patient include discontinuing his NG tube once bowel sounds return or he begins to pass gas. Patient will then be started on a clear liquid diet that will be advanced as tolerated. Discharge preparation will be initiated upon relief of small bowel obstruction. The patient he will go home with his significant other. There will be no home health or equipment needs. The follow up plan is to have a follow up appointment in 7-

10 days with his primary care provider. The patient will receive education on the need for bowel rest/NPO status, blood glucose monitoring, and IV fluids. No noted discharge needs or case management concerns.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

| <p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components | <p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen | <p>Intervention (2 per dx)</p> | <p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan. |
|---|--|--|---|
| <p>1. Risk for electrolyte imbalance related to a small bowel obstruction as evidenced by hyponatremia</p> | <p>This nursing diagnosis was chosen because the patient has a small bowel obstruction which cause the vomiting leading to an electrolyte imbalance and possibly others.</p> | <p>1. Monitor respiratory rate and depth 2. Monitor level of consciousness and neuromuscular response</p> | <p>Goal met. Patient’s respiratory rate remained within the preferred ranges of 12-20 bpm and patient remained A&O x4. Goal: The nursing diagnosis goal would be for the patient to increase his sodium intake levels so his levels are in the appropriate range of 135-145.</p> |
| <p>2. Acute pain related to a small bowel obstruction as evidenced by the pain states my pain is a 8 out of 10</p> | <p>This nursing diagnosis was chosen because the patient has a small bowel obstruction which is very discomfort and having the patient to have abdominal pain.</p> | <p>1. Provide morphine every 4 hours as need for pain as prescribed. 2. Assess pain every 2 hours and have the patient rank their pain on a numeric scale</p> | <p>Goal met. Patient was administered Morphine for pain as prescribed. Patient was also assessed every 2 hours for pain and he ranked it on the numeric scale. Pain decreased after Morphine administration. Goal: The nursing diagnosis goal would be for the patient to be pain</p> |

| | | | |
|--|---|---|---|
| | | | free and achieve the most comfort before getting discharged. |
| 3. Risk for aspiration related to a small bowel obstruction as evidenced by an NG tube. | This nursing diagnosis was chosen because the patient has a small bowel obstruction and had an NG tube placed to help decompress the stomach. | 1.Auscultate bowel sounds to assess for GI mobility 2Assess pulmonary status for evidence of aspiration noting crackles and rhonchi. | Goal met. Patient has bowel sounds auscultated which showed hypoactive bowel sounds. Pulmonary status was auscultated, and no adventitious breath sounds were noted. Goal: The nursing diagnosis goal would be for the patient to have active bowel sounds once Ng is removed and continue to have no adventitious lung sounds. |
| 4. Impaired comfort related to a small bowel obstruction as evidenced by nausea and vomiting | This nursing diagnosis was chosen because the pain has a small bowel obstruction and has had constant pain with nausea and vomiting. | 1.Provide non-pharmacological techniques 2. Assess the patient’s coping strategies for discomfort | Goal met. Patient received non-pharmacological techniques such as meditation and guided imagery. Patient discussed his coping methods and how he deals with discomfort. Goal: The nursing diagnosis goal would in increase the comfort for the patient until his small bowel obstruction is resolved. |

Other References (APA):

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

- Patient states, "I have had abdominal pain with nausea and vomiting for 2 days."
 - That patient states that he has 8 out of 10 and 4 out of 10 abdominal pain.
1. Risk for electrolyte imbalance related to a small bowel obstruction as evidenced by hyponatremia
 - a. **Goal:** The goal for this diagnosis is to have the patient increase their sodium levels from 130 into normal range which is 135-145 by the time of discharge.
 2. Acute pain related to a small bowel obstruction as evidenced by the patient states my pain is an 8 out of 10
 - a. **Goal:** Patient will tolerate pain a 4 out of 10 or less by the time of discharge.
 3. Risk for aspiration related to a small bowel obstruction as evidenced by an NG tube.
 - a. **Goal:** The patient's respiratory status will remain clear from adventitious sounds until the time of discharge.
 4. Impaired comfort related to a small bowel obstruction as evidenced by nausea and vomiting
 - a. **Goal:** The patient will have increased comfort and proper coping mechanism until the time of discharge.

Objective Data

Patient Information

Nursing Interventions

- Nursing diagnosis 1:
- Monitor respiratory rate and depth.
 - Monitor level of consciousness and neuromuscular response.
- Nursing diagnosis 3:
- Provide suction every 4 hours as needed for mucus as prescribed for the past 20 years and states, "I have had a cough for 20 years and have the patient rank their pain on a scale of 1-10. The patient presented to the ER with abdominal pain for 2 days with nausea and vomiting. He was diagnosed with small bowel obstruction and had an NG tube placed with suction at the bedside in the RLQ and hypoactive bowel sounds in all other quadrants.
- Nursing diagnosis 4:
- Provide non-pharmacological techniques.
 - Assess the patient's coping strategies for discomfort.



