N321 Care Plan 1

Lakeview College of Nursing

Angel Roby

Demographics (3 points)

Date of Admission 03/18/2020	**Client Initials** D.J.	**Age** 45 years old	**Gender** Male
Race/Ethnicity African American	**Occupation** Paramedic	**Marital Status** Single	**Allergies** PCN
Code Status Full code	**Height** 5’10”	**Weight** 180 lbs	

Medical History (5 Points)

Past Medical History: IBS, GERD

Past Surgical History: N/A

Family History: Mother – IBS, Father – GERD, Hypertension**,** Sister – Obesity, Diabetes Mellitus Type 2

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

1 pack/day smoker for 20 years, states he drinks, “a few beers on the weekends.”

Assistive Devices: N/A

Living Situation: Lives at home with significant other

Education Level: High school diploma, formal paramedic training 1995

Admission Assessment

Chief Complaint (2 points):

Abdominal pain for 2 days with nausea/vomiting

History of Present Illness – OLD CARTS (10 points): The patient is a 45-year-old male who presented to the Emergency Department for chronic abdominal pain, nausea, and vomiting for 2 days. Famotidine, lidocaine oral suspension, and ondansetron was provided with little relief. A

KUB was performed to reveal a small bowel obstruction. A NG was placed to decompress the abdomen. He will be admitted to the medical-surgical unit for further evaluation.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

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

A small bowel obstruction (SBO) can be acute or chronic and partial or complete. An acute obstruction has a sudden onset that can occur with adhesions or a herniation of the, whereas a chronic obstruction is often seen with inflammatory disease or tumors (Capriotti, 2020). A partial obstruction decreases the flow of intestinal contents through the, whereas a complete obstruction prevents passage of all contents and fluid through the bowel and is considered a surgical emergency (Capriotti, 2020). Adhesions are bands of connective tissue that form between tissues and organs, often because 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 (Capriotti, 2020). The presentation of intestinal symptoms is directly related to the severity of the obstruction. The larger the obstruction, the more dramatic the symptoms (Capriotti, 2020). The initial symptom is usually crampy pain that is wavelike and colicky due to persistent peristalsis both above and below the blockage (Hinkle et al., 2022). The patient may pass blood and mucus but no fecal matter and no flatus. Vomiting occurs. If the obstruction is complete, the peristaltic waves initially become extremely vigorous and eventually assume a

reverse direction, with the intestinal contents propelled toward the mouth instead of toward the rectum (Hinkle et al., 2022). Diagnosis is based on the symptoms, physical assessment findings, and the results of imaging studies. Early in the process, bowel sounds are high-pitched and hyperactive to pass the obstruction; later, bowel sounds will be hypoactive (Hinkle et al., 2022). Laboratory studies (i.e., electrolyte studies and a CBC) reveal a picture of dehydration, loss of plasma volume, and possible infection (Hinkle et al., 2022). Decompression of the bowel through insertion of an NG tube is necessary for all patients with small bowel obstruction; this may be tried for up to 3 days for patients with partial obstructions, as resting the bowel in this manner can result in resolution of the obstruction (Hinkle et al., 2022). The patient showed signs of abdominal pain for this patient, and the KUB identified a small bowel obstruction. The NG tube insertion is in hopes of decompression of the bowels to relieve any pain and any other symptoms.

Pathophysiology References (2) (APA):

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

Hinkle, J.L., Cheever, K.H., & Overbaugh, K. (2022). *Brunner & suddarth's textbook of medical-surgical nursing* (15th 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	3.9 – 4.98	N/A	N/A	N/A
Hgb	13 – 17 g/dL	13.1	13.1	N/A

Hct	38.1 – 48.9 (%)	42.1	42.1	N/A
Platelets	149 – 393 K/ mcL	N/A	N/A	N/A
WBC	4.0 – 11.7 K/ mcL	12.4	12.4	The WBC may be high because of infection. Intestinal obstruction can cut off the blood supply to part of your intestine. Lack of blood causes the intestinal wall to die. Tissue death can result in a tear (perforation) in the intestinal wall, which can lead to infection. This could lead onto another condition called Peritonitis which is an infection in the abdominal cavity (Van Leeuwen & Bladh, 2019).
Neutrophils	40 – 60 (%)	N/A	N/A	N/A
Lymphocytes	12 – 44 (%)	N/A	N/A	N/A
Monocytes	2 – 8 (%)	N/A	N/A	N/A
Eosinophils	0 – 0.5 (%)	N/A	N/A	N/A
Bands	10 – 16 (%)	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-	135 – 145 mmol/L	130	130	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 (Capriotti, 2020). Since the patient has been vomiting for the past 2 days, the loss of GI fluids is high which explains why his sodium levels are low. The patient is also on an NG tube which increases the likelihood that the patient will have an electrolyte imbalance.

K+	3.5 – 5.1 mmol/L	4.2	4.2	N/A
Cl-	98 – 107 mmol/L	N/A	N/A	N/A
CO2	21 – 31 mmol/L	N/A	N/A	N/A
Glucose	74 – 109 mg/dL	97	97	N/A
BUN	7 – 25 mg/dL	9	9	N/A
Creatinine	0.7 – 1.30 mg/dL	1.01	1.01	N/A
Albumin	3.5 – 5.2 g/dL	N/A	N/A	N/A
Calcium	8.6 – 10.3 mg/dL	N/A	N/A	N/A
Mag	1.6 – 2.2 mg/dL	N/A	N/A	N/A
Phosphate	2.5 – 4.5 mg/dL	N/A	N/A	N/A
Bilirubin	0.3 – 1.0 mg/dL	0.4	0.4	N/A
Alk Phos	34 – 104 units/L	N/A	N/A	N/A
AST	13 – 39 units/L	15	15	N/A
ALT	7 – 52 units/ L	52	52	N/A
Amylase	100 – 300 units/L	N/A	N/A	N/A
Lipase	0 – 60 units/ L	N/A	N/A	N/A
Lactic Acid	3 – 23 mg/dL	N/A	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	< or = 1.1	N/A	N/A	N/A
PT	11 – 13.5 seconds	N/A	N/A	N/A
PTT	60 – 70 seconds	N/A	N/A	N/A
D-Dimer	< 250 ng/mL	N/A	N/A	N/A
BNP	< 100 pg/mL	N/A	N/A	N/A
HDL	23 – 92 mg/dL	N/A	N/A	N/A
LDL	< 100 mg/dL	N/A	N/A	N/A
Cholesterol	< 199 mg/dL	N/A	N/A	N/A
Triglycerides	0 – 149 mg/dL	N/A	N/A	N/A
Hgb A1c	< or = 6.4 %	N/A	N/A	N/A
TSH	0.45 – 5.33 mlU/mL	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	Yellow, clear	N/A	N/A	N/A
pH	5.0 – 9.0	N/A	N/A	N/A
Specific Gravity	1.005 – 1.025	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	0 – 0.5	N/A	N/A	N/A
RBC	0 – 3.0	N/A	N/A	N/A
Leukoesterase	Negative	N/A	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	10,000 colonies/mL	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Van Leeuwen, A. M., & Bladh, M.L. (2019). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication* (8th ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): KUB - a small bowel obstruction can be identified in the lower left quadrant of the abdomen. Gas can be seen throughout the abdomen. No sign of perforation or free air within the abdominal cavity. EKG – NSR without ectopy

Diagnostic Test Correlation (5 points): Abdominal x-ray provides visualization of the area of obstruction and severity of the blockage. X-ray will show excessive gas in the area of intestine proximal to the obstruction (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	Famotidine	Loperamide	Calcium Carbonate	N/A	N/A
Dose	20 mg	4 mg	750 mg	N/A	N/A
Frequency	Daily	Q6H, PRN for diarrhea	Q4H, PRN for heartburn	N/A	N/A
Route	Oral	Oral	Oral	N/A	N/A
Classification	Pharmacological: Histamine-2 blocker Therapeutic: Antiulcer agent	Antidiarrheal	Pharmacological: Calcium salts Therapeutic: Antacid	N/A	N/A
Mechanism of Action	Reduces HCl formation by preventing histamine from binding with H2. The drug helps prevent peptic ulcers from forming and helps heal existing ones.	Loperamide is an opioid-receptor agonist and acts on the μ-opioid receptors in the myenteric plexus of the large intestine. It works like morphine, decreasing the activity of the myenteric plexus, which decreases the tone of the longitudinal and circular smooth muscles of	Increases level of intracellular and extracellular calcium. Oral forms neutralize or buffer stomach acid to relieve discomfort caused by hyperacidity.	N/A	N/A

		the intestinal wall.			
Reason Client Taking	GERD	Diarrhea	GERD	N/A	N/A
Contraindications (2)	Hypersensitivity, Other H2 receptor antagonists.	Bloody diarrhea, liver problems	Cardiac resuscitation with risk of existing digitalis toxicity or presence of ventricular fibrillation. Use of calcium supplements.	N/A	N/A
Side Effects/Adverse Reactions (2)	Seizures, arrhythmias	Constipation, fatigue	Hypotension, hypercalcemia	N/A	N/A
Nursing Considerations (2)	Shake vigorously for 5 to 10 seconds before administration. Know that adult patients who have a suboptimal response or an early symptomatic relapse after completing therapy should be evaluated for gastric malignancy.	Keep this medication in the container it came in, tightly closed, and out of reach of children. Store it at room temperature and away from excess heat and moisture	Store at room temperature and protect from heat, moisture, and direct light. Don't freeze. Monitor serum calcium level as ordered and evaluate Chvostek's and Trousseau's signs.	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	Ondansetron	Promethazine	Morphine	Acetaminophen	Pantoprazole
Dose	4 mg	12.5 mg	2 mg	1,000 mg	40 mg

Frequency	Q6H, PRN for nausea	Q8H, PRN for nausea	Q4H, PRN for pain	Q8H, PRN for fever > 38.0 C.	Daily, PRN for indigestion
Route	IVP	IVP	IVP	IV	IV
Classification	Pharmacological: Selective serotonin Therapeutic: Antiemetic	Pharmacological: phenothiazine Therapeutic: antiemetic, antihistamine, antivertigo, sedative	Pharmacological: opioid Therapeutic: opioid analgesic-controlled substance II	Pharmacological: Para aminophenol derivative Therapeutic: Antipyretic, nonopioid analgesic	Pharmacological: Proton pump inhibitor Therapeutic: Antiulcer
Mechanism of Action	Reduces nausea and vomiting by preventing serotonin release in the small intestine and by blocking signals to the CNS.	Prevents motion sickness, nausea, and vertigo by acting centrally on medullary chemoreceptive trigger zone and by decreasing vestibular stimulation and labyrinthine function in the inner ear.	Binds with and activates opioid receptors in brain and spinal cord to produce analgesia and euphoria.	Acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.	Interferes with gastric acid secretion by inhibiting hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells.
Reason Client Taking	Nausea	Nausea	Abdominal pain	Fever	Small bowel obstruction/ GERD
Contraindications (2)	Concomitant use of morphine, hypersensitivity	Comatose state, intra-arterial or subcutaneous injections	Acute or severe bronchial asthma, gastrointestinal obstruction	Hypersensitivity, severe hepatic impairment, severe active liver disease	Concurrent therapy with rilpivirine containing products, hypersensitivity
Side Effects/Adverse Reactions (2)	Hypotension, arrhythmias	Bradycardia, angioedema	Coma, Increased intracranial pressure	Stridor, hypoglycemic coma	Hepatic failure, pancreatitis
Nursing Considerations (2)	If hypokalemia or hypomagnesemia is present it needs to be corrected before administration, monitor patient	Use cautiously in children and older adults because they may be more sensitive to its effects. Inject IM form deep into	Be aware that morphine can lead to abuse, addiction and misuse. Use extreme caution administering morphine to	Use cautiously in patients with hepatic impairment, alcoholism, malnutrition, and hypovolemia. Monitor renal	Flush IV line with normal saline solution before and after giving drug. When giving IV over 2 minutes, reconstitute with

	closely for signs and symptoms of anaphylaxis and bronchospasm	large muscle mass and rotate sites.	patients with conditions accompanied by hypercapnia, hypoxia, or decreased respiratory reserve.	function in patient in long term therapy.	10 ml of normal saline injection.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is A/O x4, and is oriented to time, place, and person. The patient is not in any distress, besides the pain in his abdomen. Patient's overall appearance is within expected range under the circumstances.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is pink, warm, and dry. Patient's skin turgor is elastic and shows no signs of abnormality. The patient does not have any rashes, bruises, and wounds. The patient's Braden score is mild and does not show any signs of pressure ulcers. The patient does not have any drains present at this moment.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The ears, eyes, nose, and teeth are all within expected range.
CARDIOVASCULAR:	Radial pulses are 2+. The S1 and S2 are present

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:**	with no signs of S3, S4, or murmurs. The peripheral pulses are all within expected range. The capillary refill is also within expected range and the patient isn't showing any signs of neck vein distention and edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Airway is patent with no signs of change in clinical course. Breathing is clear and equal bilaterally.
GASTROINTESTINAL: **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:**	Diet at home is unknown. Current diet is NPO. Blood glucose needs to be checked Q6H. Patient's height is 5'10" Patient's weight is 180 lbs. Upon auscultation, bowel sounds are absent in the RLQ. Hypoactive bowel sounds in all other quadrants. Patient's last bowel movement is unknown. Upon palpation, abdomen is soft, but tender. No signs of distention, incision, wounds, or scars. The patient does not have any drains present at this moment. The patient's NF tube remains in place measuring 65 cm at the nares. It is connected to low-intermittent suction with bile-green colored return. The patient does not have an ostomy bag or feeding tubes at this moment.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient's urine is within expected range. The patient does not have any pain urinating, and the patient is currently not on dialysis. Patient also does not have a catheter in place.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:**	The patient's neurovascular status is within expected range. The patient can move all extremities equally.

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☐**	The patient does not have any supportive devices and his strength is within expected range. The patient is not a fall risk and is able to ambulate independently.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient can move all extremities equally. The patient shows signs of PERLA. The patient has strength in all his extremities. The patient is A/O x4, denies any numbness or tingling. The patient's speech is not affected and is within expected range. The patient has his sensory motor skills and consciousness intact.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient does not state any coping methods. The patient has acquired a high school diploma and a former paramedic training certificate. The patient lives with significant other.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

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

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	8/10	Abdomen	Severe	Generalized	Morphine administered

1100	4/10	Abdomen	Moderate	Generalized	Morphine administered

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18G **Location of IV:** Left antecubital, right wrist **Date on IV:** 03/18/2020 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** N/A **IV dressing assessment:** Infusing without difficulty, no complications, dressing clean/dry/intact	D5NS at 100 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
D5NS at 100 mL/hr x 4 hours	Urine 450 mL total voided in 4 hours Stool x0

Nursing Care

Summary of Care (2 points)

Overview of care:

No noted discharge needs or case management concerns – Adhere to strict NPO status until bowel sounds return or the patient is passing gas. At that time, please call MD for further orders. Continue morphine for pain. Alert MD for fever >38.0 despite Acetaminophen administration. Begin patient education regarding the following: need for bowel rest/NPO, blood glucose monitoring, and IV fluids. Oral swabs are permitted sparingly. Discharge preparation will be initiated upon relief of small bowel obstruction.

Procedures/testing done: KUB, EKG, Hgb, Hct, WBC, Na, K, Glucose, BUN, Creatinine, AST, ALT, Total Bilirubin

Complaints/Issues: Abdominal pain

Vital signs (stable/unstable): The only unstable vital sign was the blood pressure which showed mild hypertension at 0700. Afterwards the vital signs were stable

Tolerating diet, activity, etc.: The patient is tolerating the diet and activity well

Physician notifications: Please call MD for further orders, also alert if the fever is > 38.0 despite Acetaminophen administration.

Future plans for client: Continue morphine for pain, adhere to strict NPO status until bowel sounds return or the patient is passing gas. Discharge plans will be initiated upon relief of small bowel obstruction.

Discharge Planning (2 points)

Discharge location: No noted discharge needs or case management concerns

Home health needs (if applicable): N/A

Equipment needs (if applicable): Oral swabs are permitted sparingly

Follow up plan: If the patient shows signs of pain, administer morphine PRN. After the patient shows signs of relief of the bowel obstruction, the patient will be free to be discharged.

Education needs: Need for bowel rest/NPO, blood glucose monitoring, and IV fluids.

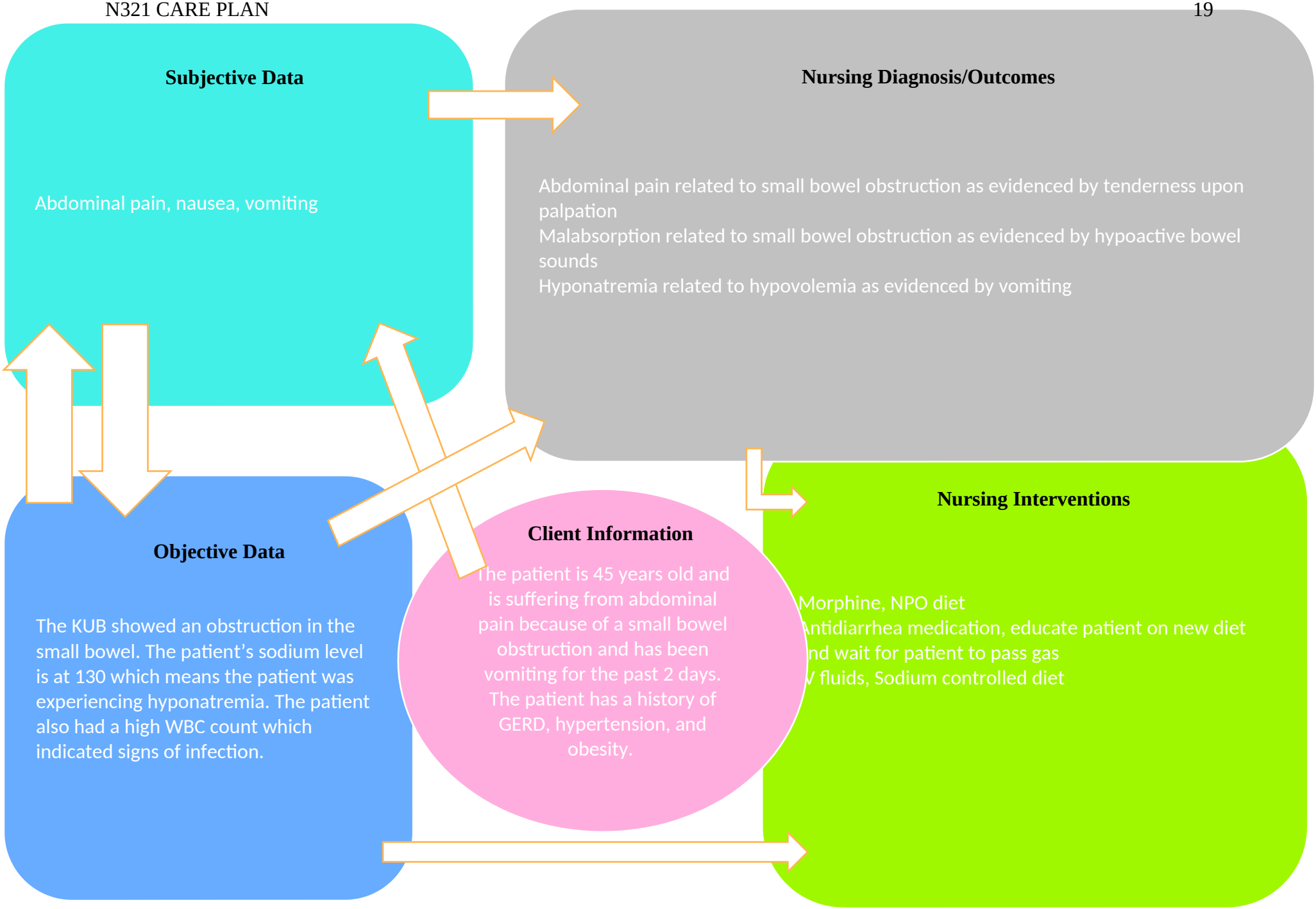
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Abdominal pain related to small bowel obstruction as evidenced by tenderness upon palpation	The patient's chief complaint is abdominal pain and upon assessment discovered a small bowel obstruction.	1. Morphine 2. NPO diet	1. Relief of abdominal pain	The patient's family were grateful that the medication gave some relief to his abdominal pain. The client was glad that his pain went down from an 8/10 to a 4/10.
2. Malabsorption related to small bowel obstruction as evidenced by hypoactive bowel sounds	The patient is experiencing tenderness and hypoactive bowel sounds which is the signs and symptoms for an	1. Antidiarrhea medication 2. Educate patient on new diet and wait for patient to pass gas	1. Hyperactive bowel sounds and passing of gas to relieve the bowel obstruction	The patient's family was grateful that his symptoms are slowly minimizing. The patient is glad that he isn't experiencing as much diarrhea as he did when he was first

	obstruction in the bowel and is affecting the patient.			admitted.
3. Hyponatremia related to hypovolemia as evidenced by vomiting	The patient has been vomiting for the past two days which is causing the patient to experience hypovolemia because of the small bowel obstruction.	1. IV fluids 2. Sodium controlled diet	1. Increase in sodium levels	The patient's family is glad that his nausea is going down. The patient is glad that his vomiting has minimized and that he is getting treatment for the loss of fluid.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Abdominal pain, nausea, vomiting
Nursing Diagnosis/Outcomes
Abdominal pain related to small bowel obstruction as evidenced by tenderness upon palpation
Malabsorption related to small bowel obstruction as evidenced by hypoactive bowel sounds
Hyponatremia related to hypovolemia as evidenced by vomiting
Objective Data
The KUB showed an obstruction in the small bowel. The patient's sodium level is at 130 which means the patient was experiencing hyponatremia. The patient also had a high WBC count which indicated signs of infection.
Client Information
The patient is 45 years old and is suffering from abdominal pain because of a small bowel obstruction and has been vomiting for the past 2 days. The patient has a history of GERD, hypertension, and obesity.
Nursing Interventions
Morphine, NPO diet
Antidiarrhea medication, educate patient on new diet
nd wait for patient to pass gas
V fluids, Sodium controlled diet