N321 CARE PLAN #1

Ngoc Trinh

Lakeview College of Nursing

N321: Adult Health I

Kristal Henry

September 15th, 2025

Demographics

Date of Admission	Client Initials	Age	Biological Gender
09/14/25	GH	64	Male
Race/Ethnicity Caucasian, non-Hispanic	**Occupation** Ceader's Collision Repair	**Marital Status** Married	**Allergies** N/A
Code Status Full code	**Height** 5'8 (175.3 cm)	**Weight** 127lb (57 kg)	

Medical History

Past Medical History: The patient states that he has never been sick

Past Surgical History: The patient stated he has never been in surgery

Family History: The patient states he was adopted

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

The patient denies smoking, alcohol, and drug use.

Education: 12th grade

Living Situation: Living with his wife

Assistive devices: No lift equipment needed, independent.

Admission History

Chief Complaint: Abdominal pain, nausea, vomiting, and weakness.

History of Present Illness (HPI)– OLD CARTS

The 64-year-old Caucasian male presented as a transfer from OSF on September 14, 2025, with abdominal pain, weakness, and nausea at 1440. The patient suffered from abdominal pain that came and went; the location of the pain was on the right lower abdomen. He also states that the symptoms are worse when he stands straight. The patient describes the pain as aching and throbbing and rates the pain a 6/10 on a numerical scale. The patient states that he used Tylenol to relieve the pain at home.

Admission Diagnosis

Primary Diagnosis: Small Bowel Instruction

Secondary Diagnosis (if applicable): Acute Kidney Injury

Pathophysiology

Small bowel obstruction (SBO) is a mechanical or functional blockage of the intestinal lumen that is partial or complete and acute or chronic (Capriotti & Frizzell, 2020). At the cellular level, obstruction results in enhanced peristaltic activity proximal to the blockage in an attempt to push intestinal contents distally (Capriotti & Frizzell, 2020). This creates heightened pressure that results in increased accumulation of gas and fluid, leading to bowel wall edema, venous congestion, and impairment of arterial blood flow to the intestine (Capriotti & Frizzell, 2020). With time, the obstruction impairs mucosal integrity and function, leading to ischemia and necrosis and eventually perforation and sepsis in severe cases (Hinkle, Cheever, & Overbaugh, 2022). Fluid and electrolytes are also shifted into the intestinal lumen, resulting in systemic dehydration and electrolyte imbalances (Hinkle, Cheever, & Overbaugh, 2022). This is also how the client came to have low sodium, low chloride, high BUN/creatinine, and low GFR; all of which are consistent with dehydration and acute kidney injury.

The most common cause of SBO is postsurgical adhesions, and then malignancy, Crohn's disease, and hernias (Capriotti & Frizzell, 2020). Adhesions are fibrous bands that tether the intestines to nearby tissues, and thereby, prevent normal peristaltic action (Capriotti & Frizzell, 2020). Peristaltic contractions are heightened at the site of obstruction and cause sharp, cramping pain, while excess mucus and intestinal contents accumulate and lead to worsened distension (Capriotti & Frizzell, 2020). If blood flow is cut off to a patient, he or she will be in terrible pain all the time. The patient is either strangulated or they have ischemia, both of which need medical attention.

Clients with SBO classically present with abdominal pain, abdominal distension, nausea, vomiting, and hyperactive bowel sounds. Vomiting further depletes the client of fluid and electrolytes, which can result in hypotension, tachycardia, and evidence of hypovolemic shock without treatment (Capriotti & Frizzell, 2020). In this patient, the nausea, vomiting, and abdominal pain in the right lower quadrant rated as 6/10, along with the abnormal laboratory values, is a classic finding in SBO.

Diagnostic testing for SBO can include abdominal x-ray, computed tomography (CT) scan, and ultrasound. X-ray can show dilated bowel loops with air-fluid levels in the presence of bowel obstruction. CT abdomen/pelvis with intravenous contrast is the most reliable diagnostic modality as it can visualize the obstruction and the degree of bowel perfusion. In this case, the patient underwent a CT abdomen/pelvis with contrast and found to have thickening and swelling of the small bowel at the transition point.

Treatment of SBO is dependent on severity. Partial obstructions may be managed conservatively with nasogastric (NG) tube decompression, NPO status, IV fluid resuscitation, electrolyte replacement, and management of symptoms with analgesics and antiemetics (Hinkle et al., 2022). Obstructions that are complete or are complicated by ischemia or perforation often require surgical intervention. The client in this case received NG tube decompression, 0.9% sodium chloride IV fluids at 125 mL/hr, hydromorphone for pain, and ondansetron for nausea, which are all in line with evidence-based recommendations for management of this condition.

In conclusion, pathophysiology of SBO begins with mechanical blockage of the intestines leading to fluid and gas accumulation in the lumen, and the resultant increased pressure that impairs bowel perfusion. Fluid and electrolyte shifts then lead to imbalances in laboratory values and systemic dehydration. The client's chief complaint, abnormal laboratory values, and CT results are all expected with this disease process. Early interventions such as NG decompression and IV hydration are important to avoid bowel ischemia and sepsis.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. J. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

Laboratory/Diagnostic Data

Lab Name	**Admission Value**	**Today's Value**	**Normal Range**	**Reasons for Abnormal**
Sodium	109 mmol/L	116 mmol/L	135-145 mmol/L	The sodium lab is abnormally low due to hyponatremia from fluid imbalance (Taylor et al., 2023).
Chloride	71 mmol/L	78 mmol/L	98-107 mmol/L	The chloride lab is abnormally low due to fluid loss or metabolic alkalosis (Taylor et al., 2023).
Co2, Venous	16 mmol/L	20 mmol/L	22-30 mmol/L	The CO_2, Venous lab is abnormally low due

				to metabolic acidosis (Taylor et al., 2023).
Anion Gap	22 mmol/L	18 mmol/L	<18.0 mmol/L	The anion gap lab is abnormally elevated due to dehydration (Taylor et al., 2023).
BUN	173 mg/dL	157 mg/dL	10-20 mg/dL	The BUN lab is abnormally elevated due to renal impairment or dehydration (Taylor et al., 2023).
Creatinine, Blood	3.38 mg/dL	2.55 mg/dL	70-99 mg/mL	The BUN/creatinine ratio lab is abnormally elevated due to dehydration (Taylor et al., 2023).
GFR, Estimated	14	27	>=60	The GFR lab is abnormally low due to impaired kidney filtration (Taylor et al., 2023).
BUN/Creatine Ratio	51 ratio	62 ratio	12-20 ratio	The BUN/creatinine ratio lab is abnormally elevated due to dehydration (Taylor et al., 2023).
Glucose	108 mg/dL	124 mg/dL	70-99 mg/dL	The glucose lab is abnormally elevated due to inflammation of cells and tissue (Taylor et al., 2023).
Total Protein	83 g/dL	N/A	60-80 g/dL	The total protein is abnormally elevated due to dehydration (Taylor et al., 2023).
GFR, EST. Nonafrican	18	26	>=60	The GFR lab levels is low due to reduced kidney filtration (Taylor et al., 2023).
GFR, EST African	22	31	>=60	The GFR Non-African lab is abnormally low due to reduced kidney filtration (Taylor et al., 2023).
MCH	32.5 pg	33 pg	26.0-32.0 pg	The MCH lab is

				abnormally elevated due to macrocytic red blood cells (Taylor et al., 2023).
MPV	7.4 fl	7.4 fl	8.0-12.6 fl	The MPV lab is abnormally low due to inflammation (Taylor et al., 2023).
Neutrophils	84.1 10^3/uL	83.3 10^3/uL	1.60-7.70 10^3/uL	The neutrophil lab is abnormally elevated due to infection or inflammation (Taylor et al., 2023).
Monocytes	11.9 %	13.1 %	3.6-13.0%	The monocyte lab is abnormally elevated due to chronic inflammation or infection (Taylor et al., 2023).
Absolute Neutrophils	8.00 10(3) mcL	7.40 10(3) mcL	1.40-5.30 10(3) mcL	The absolute neutrophil lab is abnormally elevated due to infection or inflammation (Taylor et al., 2023).
Absolute Lymphocytes	0.40 10(3) mcL	0.30 10(3) mcL	1.40-5.30 10(3) mcL	The absolute lymphocyte lab is abnormally low due to infection (Taylor et al., 2023).
Absolute Monocytes	1.10 10(3) mcL	1.20 10(3) mcL	1.40-5.30 10(3) mcL	The absolute monocyte lab is abnormally low due to inflammation (Taylor et al., 2023).
Protein, random urine	Trace	N/A	Negative	The urine protein lab is abnormally positive due to kidney damage (Taylor et al., 2023).
WBC Esterase	Trace	N/A	Negative	The WBC esterase lab is abnormally positive due to infection (Taylor et al., 2023).
Bacteria, Urine	Trace	N/A	Negative	The urine bacteria lab is abnormally positive due to infection

				(Taylor et al., 2023).
Urine Ketones	Trace	N/A	Negative	The urine ketones lab is abnormally positive due to impaired glucose metabolism or ketoacidosis (Taylor et al., 2023).
Lymphocytes	3.7 %	3.1 %	19.0-49.0 %	The lymphocyte lab is within normal limits (Taylor et al., 2023).

Current Diagnostic Test & Purpose	Clients Signs and Symptoms	Results and correlate to client diagnosis and condition
XR Chest Single **Purpose:** NG placement (Pagana et al., 2025). **Date:** September 14th, 2025	The patient has the presence of a NG tube requiring confirmation of correct placement.	- The interior tube located correctly. -This order was done to verify the correct placement of the nasogastric tube, ensuring it is in the stomach not in the lungs.
CT abdomen pelvis **Purpose:** Evaluate abdominal pain (Pagana et al., 2025). **Date:** September 14th, 2025	Abdominal pain	- Stomach is slightly swollen from IV fluid. At the transition point, there was some thickening around the edge from the small bowel being swollen. - This order was done to identify the location and cause of the small bowel obstruction, assess for bowel wall thickening.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's diagnostic and laboratory test reference* (17th ed.). Mosby. ISBN 9780323828666

Active Orders

Active Orders	Rationale
Diet: NPO	To prevent worsening obstruction, nausea, vomiting, or risk of aspiration.
IP Consult to general surgery	To evaluate the severity of the small bowel obstruction and determine if surgical intervention is required.
IP Consult to Nephology	To assess and manage electrolyte imbalances, dehydration.
Sodium	To monitor for hyponatremia or electrolyte disturbances caused by vomiting, nasogastric suctioning.
Pulse oximetry	To continuously monitor oxygen saturation and detect hypoxemia.
Admission weight	To provide a baseline for monitoring fluid balance.
Elevated HOB 30 degree	To enhance comfort in the presence of abdominal distension.
Insert NG tube	To decompress the stomach, relieve pressure, aspiration risk.
Maintain IV while on telemetry	To ensure continuous access for IV fluids, electrolytes.
NG tube maintenance	To prevent complications such as obstruction or aspiration.
Neuro check baseline & every 1 hours	To monitor neurological status for changes.
Notify physician	Pulse less than 50 and greater than 120 Respiration less than 10 and greater than 30 Temp greater than 101.5F Urinary output is less than 240mL/8hr Or new onset or worsening pain Pulse ox less than 90 or now onset symptoms

	Systolic less than 85 and greater than 180 Diastolic less than 50 and greater than 105 Symptomate bradycardia &Ventricular Arrhythmia discontinued. When prior to admission medication review has been completed – routine.
Place SCD (sep comp device)	To prevent venous thromboembolism.
Saline lock IV	To provide intermittent IV access for medications or fluids.
Strict I&O	To monitor fluid imbalance closely since SBO.
Vital sign per routine	To detect early signs worsening obstruction.

Hospital Medications (Must List ALL)

Brand/ generic	Pantoprazole / PROTONIX	Sodium chloride 0.9%/ 1000 ml	Hydromorphone / DILAUDID	Ondansetron / ZOFRAN	Ondansetron / ZOFRAN
Dose, frequency, route	40mg/daily/ IV injection	1 dose/ Once/ IV	0.5 mg/E4hr/ IV	4 mg/E6hr PRN/ Oral	4 mg/E6hr PRN/ IV
Classification (Pharmacological and therapeutic and action of the drug	**Pharmacologic**: Proton pump inhibitor (Jones & Bartlett, 2024). **Therapeutic**: Antiulcer agent (Jones & Bartlett, 2024).	**Pharmacologic:** Electrolyte, isotonic solution (Jones & Bartlett, 2024). **Therapeutic:** Fluid and electrolyte replacement	**Pharmacologic:** Opioid agonist (Jones & Bartlett, 2024). **Therapeutic:** Analgesic (Jones & Bartlett, 2024).	**Pharmacologic:** 5-HT3 receptor antagonist (Jones & Bartlett, 2024) **Therapeutic:** Antiemetic (Jones & Bartlett, 2024)	**Pharmacologic:** 5-HT3 receptor antagonist (Jones & Bartlett, 2024) **Therapeutic:** Antiemetic (Jones & Bartlett, 2024)

		(Jones & Bartlett, 2024).			
Reason Client Taking	To reduce gastric acid secretion (Jones & Bartlett, 2024).	To restore fluid balance and treat dehydration (Jones & Bartlett, 2024).	To severe pain relief (Jones & Bartlett, 2024).	To treat nausea and vomiting (Jones & Bartlett, 2024)	To treat nausea and vomiting (Jones & Bartlett, 2024)
Two contraindications (pertinent to the client)	**1.** Known hypersensitivity to proton pump inhibitor (Jones & Bartlett, 2024). **2.** Caution in severe hepatic impairment (Jones & Bartlett, 2024).	**1.**Severe hypernatremia (Jones & Bartlett, 2024). 2.Severe fluid overload or pulmonary edema (Jones & Bartlett, 2024).	**1.** Severe respiratory depression (Jones & Bartlett, 2024). 2. Acute or severe bronchial asthma (Jones & Bartlett, 2024).	**1 .**Hypersensitivity to ondansetron (Jones & Bartlett, 2024). 2. Concurrent use with apomorphine (Jones & Bartlett, 2024).	**1 .**Hypersensitivity to ondansetron (Jones & Bartlett, 2024). 2. Concurrent use with apomorphine (Jones & Bartlett, 2024).
Two side effects or adverse effects (Pertinent to the client)	**1.** Headache (Jones & Bartlett, 2024). **2.** Diarrhea (Jones & Bartlett, 2024).	**1.** Fluid overload (Jones & Bartlett, 2024). **2 .**Hypernatremia (Jones & Bartlett, 2024).	**1.**Respiratory depression (Jones & Bartlett, 2024). 2.Constipation (Jones & Bartlett, 2024).	**1.** Headache (Jones & Bartlett, 2024). 2. Constipation (Jones & Bartlett, 2024).	**1.** Headache (Jones & Bartlett, 2024). 2. Constipation (Jones & Bartlett, 2024).
Key nursing assessment(s) prior to administration	**1.** Monitor for abdominal pain or bleeding (Jones & Bartlett, 2024).	1.Monitor intake/output and daily weight (Jones & Bartlett, 2024).	**1.** Assess the effectiveness of analgesia (Jones & Bartlett, 2024).	**1.** Assess for nausea, vomiting, bowel sounds, and abdominal distension (Jones &	**1.** Assess for nausea, vomiting, bowel sounds, and abdominal distension (Jones &

	2. Monitor liver function (Jones & Bartlett, 2024).	2.Assess lung sounds for signs of fluid overload (Jones & Bartlett, 2024).	2. Monitor respiratory rate (Jones & Bartlett, 2024).	Bartlett, 2024). 2. Monitor ECG in patients at risk for QT prolongation (Jones & Bartlett, 2024).	Bartlett, 2024). 2. Monitor ECG in patients at risk for QT prolongation (Jones & Bartlett, 2024).

Brand/Generic						
Dose, frequency, route						
Classification (Pharmacological and therapeutic and action of the drug						
Reason Client Taking						
Two contraindications (pertinent to the client)	**1.** **2.**					
Two side effects or adverse effects (Pertinent to the client)	**1.** **2.**					
Key nursing assessment(s) prior to administration	**1.** **2.**					
Brand/Generic						
Dose, frequency, route						
Classification (Pharmacological and therapeutic and						

action of the drug						
Reason Client Taking						
Two contraindications (pertinent to the client)	**1.** **2.**					
Two side effects or adverse effects (Pertinent to the client)	**1.** **2.**					
Key nursing assessment(s) prior to administration	**1.** **2.**					
Brand/Generic						
Dose, frequency, route						
Classification (Pharmacological and therapeutic and action of the drug						
Reason Client Taking						
Two contraindications (pertinent to the client)	**1.** **2.**					
Two side effects or adverse effects (Pertinent to the client)	**1.** **2.**					
Key nursing assessment(s) prior to administration	**1.** **2.**					

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1.Pantoprazole/ PROTONIX	This medication was chosen because it helps the patient reduce gastric acid secretion.	**1.** Headache (Jones & Bartlett, 2024). **2.** Diarrhea (Jones & Bartlett, 2024).
2. Sodium chloride 0.9%/ 1000 ml	This medication was chosen because it helps the patient correct fluid imbalances.	**1.**Fluid overload (Jones & Bartlett, 2024). **2.** Hypernatremia (Jones & Bartlett, 2024).
3. Hydromorphone/ DILAUDID	This medication was chosen because it helps the patient manage abdominal pain.	**1.** Respiratory depression (Jones & Bartlett, 2024). **2.** Constipation (Jones & Bartlett, 2024).

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2024). *NDH: Nurse's Drug Handbook: Twenty-Four Edition*. World headquarters.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	**Alertness:** Patient was alert. **Orientation:** Oriented x person, place, and time. **Distress:** The patient showed no signs of distress. **Overall appearance:** The patient was not well-groomed and did not have a clean look. **Infection Control precautions:** Standard precaution **Client Complaints or Concerns:** Abdomen pain-aching and throbbing

VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	 **Temp:** 95.9 F Temporal **Resp rate:** 19 respiration per minute. **Pulse:** 93 bpm **B/P:** 119/79 mmHg **Oxygen:** 98% Room air **Delivery Method:** N/a
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	 **Time:** 1417 **Scale:** Numeric Scale **Location:** Right lower abdomen **Severity:** 6/10 **Characteristics:** Aching, throbbing. **Interventions:** Hydromorphone.
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	 **Size of IV:** 20 G **Location of IV:** Left Antecubital. **Date on IV:** 9/14/2025. **Patency of IV:** Able flushing a vein with saline. **Signs of erythema, drainage, etc.:** Dry, no sign of redness, pain or infiltration. **IV dressing assessment:** Clean, dry, intact. **Fluid Type/Rate or Saline Lock:** Normal saline 0.9%/ 125 mL/hr.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	 **Skin color**: Usual for ethnicity **Character**: Dry, intact, normal quantity, distribution, and texture of hair. Nails without clubbing or cyanosis. Capillary refill less than 3 seconds fingers and toes bilaterally. **Temperature**: Skin warm and dry upon palpation. **Turgor**: Skin turgor normal mobility. **Rashes**: None reported. **Bruises**: None reported. **Wounds**: None reported. **Braden Score**: 20 **Drains present:** Y☐ N ☒ **Type**:
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head/Neck: Head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy in the head or neck is noted. **Ears:** Bilateral auricles no visible or palpable

	deformities, lumps, or lesions. Bilateral canals clear with pearly grey tympanic membranes. **Eyes:** Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally, red light reflex present bilaterally, Snellen 20/20, EOMs intact bilaterally. **Nose:** Septum is midline, turbinates are moist and pink bilaterally and no visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation. **Teeth:** Missing teeth, use denture.
CARDIOVASCULAR: **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:**	**Heart sounds:** Clear S1 and S2 without murmurs gallops or rubs. PMI palpable at 5th intercostal space at MCL. Normal rate and rhythm. **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Normal sinus rhythm. **Peripheral Pulses:** All extremities pink, warm, dry and symmetrical. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. No edema inspected or palpated in all extremities. Epitrochlear lymph nodes nonpalpable bilaterally. Homan's sign negative bilaterally. **Capillary refill:** Capillary refill less than 3 seconds fingers and toes bilaterally. **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Accessory muscle use: Y☐ N ☒** **Breath Sounds:** Normal rate and pattern of respirations, respirations symmetrical and non-labored, lung sounds clear throughout anterior/posterior bilaterally, no wheezes, crackles, or rhonchi noted. **Location**: Lung sounds were normal for age; high-pitched breath sounds in all lobes bilaterally anteriorly and posteriorly. **Character**: Loud, high-pitched bronchial breath

	sounds.
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating 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:** Regular **Current Diet:** NPO **Is Client Tolerating Diet?** No **Height:** 5'8 (175.3 cm) **Weight:** 127lb (57 kg) **Auscultation Bowel sounds:** Bowel sounds are normoactive in all four quadrants. No CVA tenderness noted bilaterally. **Last BM:** 9/9/25 **Palpation: Pain, Mass etc.:** Abdomen is soft, nontender, no organomegaly or masses notes upon palpation of all four quadrants. **Inspection:** No CVA tenderness noted bilaterally, hair distubution. **Distention:** None reported. **Incisions:** None reported. **Scars:** None reported. **Drains:** None reported. **Wounds:** None reported. **Ostomy:** Y ☐ N ☒ **Nasogastric:** Y ☒ N ☐ **Size:** 16 Fr, Left nostril, Catheter length: 56 cm **Feeding tubes/PEG tube** Y ☐ N ☒ **Type:**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	 **Color:** Yellow **Character:** Dilute **Quantity of urine:** 1000 ml, no urgency or frequency. **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** No rashes, lumps or discharge, hair distribution. **Catheter: Y ☐ N ☒** **Type:** **Size:**

Intake (in mLs) **Output (in mLs)**	**Intake (in mLs): NS:** 1000 ml **Output (in mLs):** 25 ml
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	**Neurovascular status:** Alertness Ox4. Patient was able to verify his name, DOB, location (hospital), time, and event. **ROM:** All extremities have full range of motion (ROM). **Supportive devices:** No equipment need **Strength:** Active motion against full resistance, hand grips and pedal pushers and pulls demonstrate normal and equal strength. Balanced and smooth gait. **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 11 **Activity/Mobility Status:** Independence. **Independent (up ad lib)**
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**MAEW:** Upper extremities are equal in strength bilaterally; lower extremities are equal in strength bilaterally. **PERLA:** Pupils constrict normally. **Strength Equal: Y ☒ N ☐** **if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** A/Ox4 to person, place, situation and time. **Mental Status:** Cranial nerves intact, normal Cognition. **Speech:** Hoarse. **Sensory:** Respond to commands and stimuli. **LOC:** Alert, awake & answers questions appropriately.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and**	**Coping method(s):** The patient uses techniques like deep breathing to cope with the pain and discomfort. **Developmental level:** Generativity vs. Stagnation (Cherry, 2024).

available family support):	**Religion & what it means to pt.:** The patient identifies as Christian and expresses that his faith is a source of strength, providing his with emotional support during difficult times. **Personal/Family Data (Think about home environment, family structure, and available family support):** The patient has his wife to support.

Discharge Planning

Discharge location: Go home with wife, no expected discharge yet.

Home health needs: Focus on safety, nutrition, monitor fluid, and support cover.

Equipment needs: No equipment needed.

Follow-up plan: Schedule follow-up appointments with the primary care provider and gastroenterologist to monitor recovery.

Education needs: The patient should follow a gradual diet progression, more fluid intake, and take medication as prescribed.

Nursing Process

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"	**Rationale** • Explain why the nursing diagnosis was	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**

components • Listed in order by priority – highest priority to lowest priority pertinent to this client	chosen			
1.Dehydration related to fluid imbalance as evidenced by low sodium, low chloride, elevated BUN/ creatinine, and low GFR (Phelps, 2020).	This diagnosis was chosen because the patient had decrease urine output 25 ml.	The patient will maintain the fluid balance as evidenced by urine output more than 30 ml/hr, and improvement of sodium, chloride, BUN/ creatinine, and GFR level toward the normal range within 48 hrs of IV therapy (Phelps, 2020).	**1.** Replace electrolytes (Phelps, 2020). 2.Monitor sodium, chloride, BUN/ creatinine, and GFR level daily (Phelps, 2020).	The patient responded well to the nurse's actions and urine output remained more than 30 mL/hr and sodium, chloride, BUN/Creatinine levels were within normal range within 36 hrs.
2.Ineffective tissue perfusion related to obstruction as evidenced by abdominal pain, nausea and vomiting (Phelps, 2020).	This diagnosis was chosen because the patient has taken ondansetron due to nausea and vomiting.	The patient will report nausea within 30 minutes of prescribed interventions as a evidence by decreased vomiting with 24 hrs (Phelps, 2020).	1.Monitor abdominal pain nausea, vomiting every 2 hours (Phelps, 2020). 2.Maintain NPO status (Phelps, 2020).	The patient will report nausea improved after ondansetron administration and vomiting reduced within 24hrs.
3.Acute pain related to inflammation as evidenced by neutrophils lab elevated, monocytes lab elevated, Absolute Neutrophils lab elevated, Absolute Lymphocytes lab	This diagnosis was chosen because the patient has reported pain of 6/10.	The patient will report the pain relief from 6/10 to 3/10 within 20 minutes after starting the IV hydromorphone, as evidence by use the numeric pain scale	**1.**Administer pain medications as ordered such as Hydromorphone as order, ensuring safe administration and side effects (Phelps, 2020).	The patient reports a pain level of 2/10 after receive pain management intervention, showing improving, continued

abnormal low (Phelps, 2020).		(Phelps, 2020).	**2.**Provide comfort measures such as dim light, deep breathing, CAM, playing music and game (Phelps, 2020).	monitoring are recommended.

Nursing Process Prioritization	Rationale
1. Fluid imbalance	This diagnosis was chosen because the patient had decrease urine output 25 ml.
2. Ineffective tissue perfusion	This diagnosis was chosen because the obstruction can reduce blood flow to the bowel, which may lead to necrosis of intestinal tissue.
3. Acute pain	This diagnosis was chosen because the patient has reported pain of 6/10.

Other References (APA):

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