N321 CARE PLAN #1

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N321: Adult Health I

Kristal Henry

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Demographics

Date of Admission 09/14/25	Client Initials KN	Age 64	Biological Gender Female
Race/Ethnicity white	Occupation Retired	Marital Status divorced	Allergies Doxycycline and Tetracyclines and related
Code Status Full code	Height 4’ 11”	Weight 121 LBS	

Medical History

Past Medical History: Nonobstructive CAD, HLD, and HTN

Past Surgical History: Tonsillectomy, tubal ligation, hysterectomy, colon surgery, and heart catheterization

Family History: Patient stated there was no family history to be noted

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Quit smoking, use to smoke cigarettes, no smokeless, no drugs or alcohol use

Education: Completed high school, 2 years of college

Living Situation: Lives at home with her stepson, in the home she owns

Assistive devices: No assistive devices

Admission History

Chief Complaint: Back pain that radiated to left hip and thigh

History of Present Illness (HPI)– OLD CARTS

Patient presented to the ED at 1 am on Sunday September 14th with severe lower back pain that radiated through to her left hip and thing area. Pain had been going on for roughly 12 hours when she came to the ED. She describes her pain as sharp and radiating. She says she tried Tylenol, heat pad, and ice but nothing was helping subside the pain. The ambulance ride made it

a lot worse from being bounced around. She currently rates her pain as 0-10 but when she came into the ED it was at an 8-10.

Admission Diagnosis

Primary Diagnosis: Ileus

Secondary Diagnosis (if applicable): N/A

Pathophysiology

An ileus of the bowel is where the intestine freezes. It stops working the way it should and can cause blockages in the intestine and a lot of pain for the patient. There are a few different kinds of ileus that are determined by the cause of the ileus.

Signs of an ileus usually consist of abdominal pain, bloating, nausea and vomiting, fatigue, loss of appetite, and constipation with the inability to pass gas. My patient had severe pain in her back that radiated her thighs. She was also nauseated for hours. She had not passed a bowel movement is serval days.

To diagnosis an ileus you can do a physical head to toe assessment, have an abdominal xray or CT scan performed and run blood test. My patient has done all this to conclude that she had an ileus of the bowel.

Treatment to reserve and resolve an ileus can be a few different things. You can have a NG tube placed to suction out the contents of the stomach. You can give IV fluids to keep your hydrated and electrolytes balanced. Medications can be given to help stimulate bowel movement and help you pass a stool. Medications can also be given to help with the pain caused by the ileus. In severe cases a surgery may be needed to get the blockage out.

Pathophysiology References (2) (APA):

Beach EC, De Jesus O. Ileus. [Updated 2023 Aug 23]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK558937/

capriotti, theresa. (2020). 22. In *davis advantage for pathophysiology* (2nd ed., pp. 538–540). essay, fa davis company.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Chloride	108 mmol/L	108 mmol/L	98-107 mmol/L	Patient has a decrease in electrolyte absorption
Co2, Venous	20 mmol/L	24 mmol/L	22-30 mmol/L	Patient was breathing quicker due to pain
MPV	7.9 fL	8.7 fL	9.7- 12.4 fL	Patient has an ileus and bowel mobility is low
Neutrophils	74.3 %	69.9 %	47.0-73.0 %	My patient is in a lot of pain and her body is

				under a lot of stress
Lymphocytes	**17.3%**	**19.6%**	**18.0-42.0 %**	**Patient is not absorbing nutrients the way they should be**
Urine RBC's	**3-5/ hpf**	**N/A**	**Negative, 0-2 hph**	**Patient may have the start to an UTI**
WBC Esterase	**1+**	**N/A**	**Negative**	**Patient may have the start to an UTI**

Current Diagnostic Test & Purpose	Clients Signs and Symptoms	Results and correlate to client diagnosis and condition
CT ab pelvis w/ contrast to see what was happening in her abdomen	**Left sided abdominal pain**	**No acute abnormal in the ab/pelvis**
Xray/chest for a ng tube placement	**Patient had an Ng tube put in the xray to make sure it's in the correct place.**	**Ng tube tip near the GE junction and repositioning is suggested**
Xray ab KUB flat plate to check for a bowel obstruction	**Patient was having extreme pain in her**	**No bowel dilation/ interval reposting of Ng tube**

	abdomen and lower back	

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023a). ***Mosby's Diagnostic and Laboratory Test Reference*****. Elsevier.**

Active Orders

Active Orders	Rationale
All clear liquid diet	**Give the digestive tract time to relax and rest**
IP consult to general surgery	**Facilitate communication and documentation**
IP consult to neurology	**Facilitate communication and documentation**
CMP daily (AM)	**Keeping track of the patient's lab values with her being NPO**
CBC daily (AM)	**Keeping track of the patient's lab values with her being NPO**
Magnesium(mg) daily (AM)	**Keeping track of the patient's lab values with her being NPO**
MRI L spine w/wo contrast	**To check for subtle or small changes in the**

	spine that could be causing her pain
MRI T spine w/wo contrast	**To check for subtle or small changes in the spine that could be causing her pain**
Pulse oximetry, spot	**To monitor any changes in heart rate and breathing**
Admission weight	**To properly dose certain medications**
Ambulate patient 3X daily w/ assistance	**Get the patient up and moving to get her digestive track moving again**
Bleeding risk	**Checking for a VTE prophylaxis**
Clamp NG tube	**To slowly take her off her NPO status**
Insert/maintain peripheral IV	**To give patient medicine and fluids that she needs or may need**
Intake/output every 8 hours	**To monitor patient's fluid replacement**
Notify physician (specify)	**To let the physician know of any major changes in vital signs or input and output.**
Patient may shower	**To prevent infection in case of surgery**
Perform tap water enema	**To clear any blockage that may be in the bowel**
Up as tolerated	**Keep patient moving to help mobility of the digestive tract**
Vital signs per unit routine	**Monitor the vitals to make sure the patient is not having any other complications like fluid overload**

Hospital Medications (Must List ALL)

Brand/ Generic	**0.9 % sodium chloride solution**	**Acetaminophen (Orirmev)**	**Methocrarbamol (Robaxin)**	**Acetaminophen (Tylenol)**	**Calcium carbonate (TUMS)**
Dose, frequency, route	**125 mL/hr, IV, continuous**	**1,000 mg(once) over 15 minutes- 400 mL/hr**	**750 mg, orally, every 4 hours**	**650 mg 3 times, daily, orally**	**1,000 mg, orally, PRN every 18 hrs**
Classification (Pharmacological and therapeutic and action of the drug	**Electrolyte replenisher and fluid replacer**	**Analgesic and antipyretics** **Pain reducer and fever reducer**	**SMR and muscle relaxant**	**Analgesic and antipyretics** **Pain reducer and fever reducer**	**Chemical compound reduces acid**
Reason Client Taking	**Client is NPO and is taking this to keep from being dehydrated**	**Client is taking for pain**	**Client is taking for muscle spams**	**Client is taking for pain**	**Client is taking for heartburn**
Two contraindications (pertinent to the client)	**Congestive heart failure And Hepatic impairment**	**Active liver disease and severe hepatic impairment**	**Seizures and do not take if pregnant or trying to get pregnant**	**Active liver disease and severe hepatic impairment**	**High urine calcium levels and achlorhydria**
Two side effects or adverse effects (Pertinent to the client)	**1. Swelling** **2. Increased heart rate**	**Difficulty breathing** **Rash**	**Memory problems and insomnia**	**Difficulty breathing** **Rash**	**Increased urine output and loss of appetite**
Key nursing assessment(s)	**1. Assess for fluid**	**Assess for prior pain-**	**Assess for pregnancy**	**Assess for prior pain-**	**Assess calcium**

prior to administration	**overload** **2. Assess for hypertension**	**relieving meds** **Assess for trouble breathing**	**Assess pain and range of motion**	**relieving meds** **Assess for trouble breathing**	**levels and assess phosphate levels**

Brand/ Generic	**Diazepam (Valium)**	**Hydromorphone (Dilaudid)**	**Lorazepam (Ativan)**	**Melatonin**	**Nicotine (Nicoderm CQ)**
Dose, frequency, route	**5 mg, orally or injection, 2 times daily PRN**	**1mg, injections, every 13 hours**	**0.5 mg, once, injection**	**6 mg, orally, PRN nightly**	**21mg/ 24hrs, patch, daily**
Classification (Pharmacological and therapeutic and action of the drug	**Benzodiazepine Muscle relaxant**	**Schedule II controlled opioid agonist and blocking pain signals**	**Benzodiazepine** To sedate patient	**Biogenic amine and regulates the sleep wake cycle**	**Stimulant of autonomic ganglia and induces stimulation and pleasure**
Reason Client Taking	**Client is taking for muscle spasms**	**Client is taking for moderate pain.**	**Client was given before MRI to help keep them calm.**	**Client is taking help aid in sleep**	**Client is taking for nicotine dependency**
Two contraindications (pertinent to the client)	**1. respiratory insufficiency** **2. sleep apnea syndrome**	**1. respiratory depressions** **2. status of asthmaticus**	**Acute narrow angle glaucoma and respiratory depression**	**Messes with high blood pressure medications and medications broken down in the liver**	**Uncontrolled blood pressure and arrhythmias**
Two side effects or adverse effects	**1. muscle weakness** **2. trouble**	**Sedation and flushing**	**Dizziness and weakness**	**Dry itchy skin and feeling irritable**	**Increased blood pressure and**

(Pertinent to the client)	**with balance**				**narrows the arteries**
Key nursing assessment(s) prior to administration	**1. make sure their respiratory system is working properly** **2. Make sure they are not having trouble sleeping or falling asleep**	**Assess respiratory status** **Assess for nausea and vomiting**	**Assess respiratory status** **Assess cardiovascular status**	**Assess for low blood pressure and make sure they aren't taking hypotension medications**	**Assess for high blood pressure and any blockages in the heart**
Brand/ Generic	**Ondansetron(Zofran)**				
Dose, frequency, route	**Orally or injection, 4 mg every 6 hours**				
Classification (Pharmacological and therapeutic and action of the drug	**5-HT3 antagonist and antiemetics blocks serotonin**				
Reason Client Taking	**Client is taking for nausea**				
Two contraindications (pertinent to the client)	**1. Hypotension** **2. Loss of consciousness**				
Two side effects or adverse effects	**1. Headache** **2. Constipa**				

(Pertinent to the client)	**tion**				
Key nursing assessment(s) prior to administration	**1. Assess vital signs** **2. Assess bBowel sounds**				
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.Diazepam (Valium)	**My client was there for severe pain so getting her pain under control was our main priority**	**1. constipation 2. tiredness**
2.Hydromorphone (Dilaudid)	**My client was there for severe pain so getting her pain under control was our main priority**	**1. Sedation 2. Constipation**
3.0.9 Sodium Chloride Solution	**To keep my client hydrated and electrolytes balanced while she was NPO**	**1. muscle cramping 2. stomach cramps**

Medications Reference (1) (APA)

Drugs.com. (n.d.-a). *Prescription drug information*. Drugs.com. https://www.drugs.com/

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: Alert Alertness: alert and responsive Orientation: person, time, place, and situation Distress: N/A Overall appearance: appropriate, well	

groomed, and clothed **Infection Control precautions: N/A** **Client Complaints or Concerns: pain in lower back and thighs and none at the time of assessment**	
VITAL SIGNS: **Temp:96.4 degrees** **Resp rate: 18** **Pulse: 61** **B/P:138/71** **Oxygen:96%** **Delivery Method: room air**	
PAIN ASSESSMENT: **Time: 1500** **Scale:0-10** **Location: N/A** **Severity:N/A** **Characteristics: N/A** **Interventions: N/A**	
IV ASSESSMENT: **Size of IV:20 gauge** **Location of IV: right forearm** **Date on IV: 9/14/25** **Patency of IV: flows freely with no resistance** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: dry, clean, and intact** **Fluid Type/Rate or Saline Lock: 0.9 sodium chloride solution at 125 mL/hr**	
INTEGUMENTARY: **Skin color: tan, usual for ethnicity** **Character: dry, soft** **Temperature: warm to touch** **Turgor: normal, returns immediately** **Rashes: N/A** **Bruises: N/A** **Wounds: N/A** **Braden Score: 22** **Drains present: Y☐ N ☒** **Type:**	
HEENT: **Head/Neck: symmetrical, trachea midline, no bumps or lesions** **Ears: hearing was good, no unusual findings**	.

Eyes: normal findings, vision good **Nose: no discharge, septum midline** **Teeth: no bleeding gums, white and no chips in teeth**	
CARDIOVASCULAR: **Heart sounds: normal rhythm and rate heard S1, And S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): N/A** **Peripheral Pulses: bounding +3** **Capillary refill: less than 3 second refill time** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character- clear, unlabored, no noted rales, crackles, or wheezing**	.
GASTROINTESTINAL: **Diet at home: normal diet** **Current Diet: all clear liquid** **Is Client Tolerating Diet? yes** **Height: 4' 11"** **Weight: 121 lbs** **Auscultation Bowel sounds: heard in all 4 quadrants** **Last BM: 3 days prior to being admitted, roughly September 11th** **Palpation: Pain, Mass etc.: upper left quadrant was tender upon palpations** **Inspection: clean, no bloating, scars or lesions** **Distention: N/A** **Incisions: N/A** **Scars: N/A** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size: 16 gauge** **Feeding tubes/PEG tube Y ☐ N ☒**	.

Type: N/A	
GENITOURINARY: **Color: yellow** **Character: clear** **Quantity of urine: 2, unmeasurable** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: normal findings** **Catheter: Y ☐ N ☒** **Type: N/A** **Size: N/A**	
Intake (in mLs) 480 mL **Output (in mLs) 150 mL NG output**	
MUSCULOSKELETAL: **Neurovascular status: nail beds blanch, no edema, warm and dry** **ROM: active** **Supportive devices: N/A** **Strength: 5** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 14, low** **Activity/Mobility Status: up as tolerated** **Activity Tolerance: yes** **Independent (up ad lib) yes** **Needs assistance with equipment N/A** **Needs support to stand and walk N/A**	.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: person, place, time, situation** **Mental Status: Normal** **Speech: Clear and soft** **Sensory: all senses intact** **LOC: Alert**	.
PSYCHOSOCIAL/CULTURAL: **Coping method(s): music, god, and the**	.

bible **Developmental level: wisdom and formal operational** **Religion & what it means to pt.: Christian and it is very important to her** **Personal/Family Data (Think about home environment, family structure, and available family support): she has family support**	

Discharge Planning

Discharge location: home

Home health needs: she does not need any home help

Equipment needs: no equipment needed

Follow up plan: follow up with primary care giver

Education needs: how to use stool softeners if needed, get your water intake up it helps keep intestines active, and be active, being active keeps, everything moving.

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" components • Listed in order by	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**

priority – highest priority to lowest priority pertinent to this client				
1. Acute pain related to bowel distention and cramping.	**Patient was admitted through the ED because she was having severe pain**	**Get patients pain under control**	**1.apply heat or cold, as ordered** **2.help patient into a comfortable position and use pillows to support painful area**	**Patient and family agree with this outcome**
2. Dysfunctional gastrointestinal motility related to impaired peristalsis	**Patient had not had a bowel movement in multiple days**	**Get bowels moving and get her using the restroom**	**1. Monitor intake and output to identify need for restoration of fluids** **2.encourage walking as tolerated by patient**	**Patient and family agree with this outcome**
3. Imbalanced nutrition related to the inability to absorb nutrition correctly	**Patient could not absorb nutrition due to no mobility in the intestines, and she was NPO**	**Get bowels moving and get her off of NPO status**	**1. Monitor electrolyte levels and report any abnormal values** **2. Monitor bowel sounds at least once per shift**	**Patient and family agree with this outcome**

Nursing Process Prioritization	**Rationale**
1. Acute pain related to bowel distention and cramping.	**Getting her pain under control is the first**

	thing that needs to be done so she can do what needs to be done to get better
2. Dysfunctional gastrointestinal motility related to impaired peristalsis	**Getting the motility of her intestines going will resolve her other problems**
3. Imbalanced nutrition related to the inability to absorb nutrition correctly	**Getting her nutrition back on track so she can completely recover and not get sick again.**

Other References (APA):

Phelps, L. L. (2023). ***Nursing diagnosis reference manual*****. Wolters Kluwer.**