N311 Care Plan 2

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Merriweather

02/22/2026

Demographics

Date of Admission	**Client Initials**	**Age**	**Biological Gender**
2/18/2026	V.L.	30	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Hispanic	N/A	Single	None
Code Status	**Height**	**Weight**	
Full	5’3	145	

Medical History

Past Medical History: Bowel obstruction due to a gunshot wound to the abdomen (2022).

Past Surgical History: N/A.

Family History: N/A.

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

N/A.

Education: N/A.

Living Situation: Prison inmate.

Assistive devices: None.

Admission Assessment

Chief Complaint: Flank, back, and abdominal pain. Painful urination.

History of Present Illness (HPI) – OLD CARTS:

Patient presented to the emergency department on 2/18/2026 with complaints of flank, back, and abdominal pain, and painful urination. The patient reported that the pain began two days prior to admission and progressively worsened over a 24-hour period. The pain was described as persistent and increasing in intensity. The patient denied relief with rest or position changes. The patient had a previous trauma to the abdomen in 2022 from a gunshot wound.

Primary Diagnosis

Primary Diagnosis on Admission: Small bowel obstruction.

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Pathophysiology of the Disease, APA format:

Small bowel obstruction (SBO) is an interruption in the normal flow of intestinal contents caused by a blockage in the small intestine, preventing the passage of food, fluids, or gas. An obstruction can be acute or chronic, partial or complete, and can affect the bowel wall, vascular supply, and systemic physiology (Schick, 2025). The most common cause of a small bowel obstruction is due to post-surgical adhesions, contributing to 60% of the reasons for SBO, as well as Crohn's disease, malignancy, and hernias (Capriotti, 2024). Small bowel obstruction can often be diagnosed with a triad of abdominal pain, vomiting, and abdominal distention (Schick, 2025). Adhesions are bands of connective tissue that form between tissues and organs, typically resulting from a previous injury sustained during surgery. The risk of SBO increases with the number of abdominal surgical procedures a patient is exposed to. Adhesions cause the intestines to bond to one another, interfering with movement throughout the gastrointestinal tract. This can later result in peritonsillar and muscular accumulation, worsening the blockage further (Capriotti, 2024). When experiencing a small bowel obstruction, the patient will usually complain of pain, nausea, vomiting, and hyperactive bowel sounds (Capriotti, 2024). The characteristics of the patient's pain can usually guide what type of obstruction the patient is experiencing. Pain that is constant and increasing over time can mean that the bowel is at risk for strangulation, while pain

described as sharp and cramping can lead to the occurrence of contractions of hyperactive peristalsis (Capriotti, 2024). Patients may also experience diarrhea, which is common with partial obstruction; liquid contents can bypass the obstruction and travel through the tract. Early management of SBO includes fluid and electrolyte replacement, nasogastric tube decompression, and early identification of any bowel strangulation (Schick, 2025).

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Schick, M. A. (2025, January 19). *Small bowel obstruction*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK448079/

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	83	109/63	16	97.2	98

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
10:54	1-10	Abdominal diffuse pain	8	Radiating	Toradol, Reglan, Zofran

Intake and Output

Intake (in mL)	Output (in mL)
0mL (NPO)/(nasogastric tube)	950mL

Nursing Diagnosis
Must be NANDA-approved nursing diagnosis

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. Fluid volume deficit related to vomiting and decreased oral intake as evidence by an output of 950mL.	Small bowel obstructions cause vomiting and fluid shifts within small bowel this can result in an imbalance of electrolytes and fluid loss can lead to hypovolemic shock if untreated.	**1.** Monitor intake and output every 4 hours. **2.** Administer fluids as prescribed and monitor electrolyte levels.	**1.** Patient will be properly hydrated and maintain balance of electrolyte levels.	No signs of worsening dehydration. Stable vital signs maintained.
2. Acute pain related to intestinal distention as evidence by patient report of 8/10 abdominal	Obstruction can cause increased peristalsis and bowel distention, leading to abdominal pain described as	**1.** Assess pain every 2-4 hours using the 0-10 pain scale. **2.** Administer prescribed medications and determine	**1.** Patient's pain will decrease within 1 hour of medication being administered.	Decreased pain report after medication has been given, continue to monitor patient.

pain and radiating discomfort.	cramping.	effectiveness.		

Other References (APA):