N321 Care Plan 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/19/19	**D.Z.**	**40**	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Mexican	**Teacher**	**Single**	**none**
Code Status	**Height**	**Weight**	
Full code	**5’3” (160cm)**	**341 lbs (155kg)**	

Medical History (5 Points)

Past Medical History: The patient has a history of papillary thyroid carcinoma, status post resection, with a history of Hashimoto’s thyroiditis, morbid obesity, depression, and hypertension.

Past Surgical History: The patient has recently under gone a thyroidectomy, esophageal ablation, exploratory laparotomy for a small bowel obstruction. Patient has also had a cholecystectomy, thyroidectomy, and a ventral hernia repair.

Family History: Mother has arthritis and heart disease. Father had allergies.

Social History (tobacco/alcohol/drugs): No tobacco or alcohol use.

Assistive Devices: none

Living Situation: Patient lives at home with her daughter and her mother.

Education Level: Patient did not state.

Admission Assessment

Chief Complaint (2 points): Vomiting, and Abdominal Pain

History of present Illness (10 points):.

The patient is a 40-year-old female with a history of asthma, depression, OSA, thyroid cancer, post thyroidectomy. Who presented to the ED October 19th, 2019, complaining of nausea and vomiting for five hours. She denies any fevers. No diarrhea. The patient has a history of

incarcerated ventral hernia. The ED doctor ordered IV fluids, Zofran, and Fentanyl. Imaging studies were taken and showed a multiple of loops of the small bowel, which caused worry for small bowel obstruction. The ED Doctor on call ordered an exploratory laparotomy and lysis of adhesions and released of bowel obstruction for her incarcerated ventral hernia. The procedure was tolerated well by the patient.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): Morbidly Obesity

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

Obstruction of the bowel is when a blockage prevents the normal flow of intestinal contents through the GI tract (Hinkle & Cheever, 2018). Essentially it means that the bowel is tied up in knots or loops. Obstruction frequently causes abdominal pain, nausea, vomiting, constipation, and distention. The patient could pass blood or mucus, but no stool. The blockage prevents the normal movement of digested products. Small bowel obstructions (SBOs) are more common than large bowel obstructions (LBOs) and are the most frequent indication for surgery repairs or removals (Smith & Nehring, 2018). Laparoscopy surgery is the name of the operation taken place to remove or unloop the bowel. Before Surgery, there are diagnostic tests such as an abdominal X-ray and CT scan, have to be taken to find the exact location of the obstruction. Nursing considerations for SBO are to monitor NG tube, assess and measure the output of the NG tube, assess fluids and electrolytes, decrease pain or distention and help pass flatus (Hinkle & Cheever, 2018).

Obesity is a growing epidemic. Individuals are consuming more unhealthy foods and a decrease in activities to compensate for the lack of healthy foods. Morbidly Obesity is having a BMI 35 and over. Obesity defined as a complex disease involving an excessive amount of body fat, which can lead to other health problems like diabetes, High blood pressure, and some cancers (Hinkle & Cheever, 2018). Some signs and symptoms of the disease are excessive fat build up around the abdominal area, quickly out of breathing, difficulty walking, and trouble breathing. The diagnostic tests used to diagnose this disease are CBC, CMP, BMI, and Body fat percentage (Capriotti, 2016). Treatment options are diet, exercise, medications, and surgery. The surgery can be gastric banding or gastric bypass. Both are used to decrease the amount of food intake. Typically for an individual to receive the operation, they have to lose a certain amount of weight first. So the primary treatment for these individuals is diet and exercise.

Pathophysiology References (2) (APA):

Capriotti, Theresa, (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives* Philadelphia, Pa: F.A. Davis Company.

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer

Smith DA, Nehring SM. (2018). Bowel Obstruction. StatPearls Treasure Island. StatPearls Publishing. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK441975/

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	3.8-5.1	4.54	4.24	
Hgb	12.0-16.0	13.2	10.3	Patient has a decrease in Hgb which could be caused by previous medical history of thyroid cancer and post-surgical exploratory laparotomy (Mayo, 2018).
Hct	35-45%	40	35.0	Patient has a decrease in Hct due to post exploratory laparotomy. Based on an article, it states that Hct can be low due to trauma, wounds, or cancer (Davis &Shiel, 2019).
Platelets	50-150 x10^9	143	304	Patient has an increase in platelets possibly due to infection in her bowel. Typically and increase in platelet counts are unknown cause (Hinkle & Cheever, 2018).
WBC	4.5-11.0		12.00	
Neutrophils	57-67%	33	16.9	Patient has a decrease due history of cancer. Patient had thyroid cancer and cancer drugs typically cause destruction to neutrophils, which hare the body's natural fighting cells (Capriotti, 2016).
Lymphocytes	20-40%	22	9.2	Patient has a decrease due to the infection in the abdominal cavity. The infection is related to SBO (Capriotti, 2016).
Monocytes	2-8%	6	1.3	Patient has a decrease in due to infection in the abdominal cavity. The patient complains of nausea and vomiting which can be related to history of incarcerated ventral hernia (Capriotti, 2016).
Eosinophils	<3%	2.5	0.5	Patient has a low level of eosinophil related to history of asthma. One article states that eosinophil play an important role in the inflammation related to allergies, eczema, and asthma (Marcin, 2017).
Bands	3-5%	------	-----	

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	139	140	
K+	3.5-5.0	4.2	3.0	Patient has a decrease in potassium due "vomiting, diarrhea, adrenal gland disorders, or diuretics." (Lewis, 2018). The patient has hypokalemia due to the fact that they came into the ED on 10/19/19 complaining of nausea and abdominal pain. An NG tube was placed to compensate for the last nutrients, due to the SBO.
Cl-	97-107	99	101	
CO2	20-29	28	31.5	Patient has an increase in CO2 due to an imbalance in electrolytes from last the NG tube that was inserted to decompress the stomach (D'Souza, 2019).
Glucose	<100	63	31.5	
BUN	7-20	10	8	
Creatinine	0.6-1.5	1.0	0.50	A decrease in creatinine indicates a poor diet, or liver diseases (Hinkle &Cheever, 2018).
Albumin	3.5-5.0	3.6	2.5	Patient has a decrease in albumin due to inflammation in the patient's abdominal cavity (AACC, 2019). This is because of the SBO.
Calcium	8.6-10.2	9.2	7.5	Patient has a decrease due to fluid and imbalance of electrolytes because of the NG tube insertion (Hinkle and Cheever, 2018).
Mag	1.8-2.5	1.9	1.7	Patient has a decrease due to low dietary consumption. This is because the patient has a NG tube inserted to rest the bowel because of their SBO (Hinkle and Cheever, 2018).

Phosphate	2.5-4.5	3.0	3.3	
Bilirubin	0.3-1.9	1.0	0.6	
Alk Phos	33-131	69	89	
AST	<35	22	24	
ALT	<35	43	40	An increase in ALT indicates a liver disease, or damage to another organ like the heart or lungs (Hinkle & Cheever, 2018). In this case the patient has high levels due to a history of HTN, and obesity.
Amylase	23-85	56	46	
Lipase	0-160	82	67	
Lactic Acid	----------	-----	-----	

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	1-2	-----	-----	
PT	9-12	-----	-----	
PTT	24-45	-----	-----	
D-Dimer	0-0.5	-----	-----	
BNP	0-100	----------	-----	
HDL	>50	----------	-----	
LDL	<130	----------	-----	
Cholesterol	<200	----------	-----	

Triglycerides	<150	----------	-----	
Hgb A1c	5.6-7.5	----------	-----	
TSH	--------	----------	-----	

****Theses labs were not taken for the patient. ****

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	Yellow/clear	Amber/ clear	Patient has amber/ clear color because the patient's NG tube was just taken out. Captiotti states that it will take 1-3 days for urine to change back to natural clear yellow color after the NG tube has been taken out (Capriotti, 2016).
pH	4.5-8.0	5.5	4.6	Patient's pH is low because their NG tube was just removed and she has a SBO (small bowel obstruction) which is why the pH of the patient's urine is so acidic (Sills, 2015).
Specific Gravity	1.01-1.025	1.025	1.025	
Glucose	Negative	Negative	Negative	
Protein	0-20	Trace	Negative	
Ketones	Negative	Negative	Negative	
WBC	0-5%	3-5	4	
RBC	0-4%	0-2	1	
Leukoesterase	Negative	Negative	Negative	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal	Value on	Today's	Explanation of Findings

	Range	Admission	Value	
Urine Culture	-------	-------	--------	
Blood Culture	-------	-------	--------	
Sputum Culture	-------	-------	--------	
Stool Culture	-------	-------	--------	

**** Cultures were not taken for the patient, because of the SBO (reference).****

Lab Correlations Reference (APA):

AACC. (2019). Albumin. Retrieved from https://labtestsonline.org/tests/albumin.

Capriotti, Theresa, (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives* Philadelphia, Pa: F.A. Davis Company.

Davis, C. P. (2019, September 3). Hematocrit Blood Test: Normal, High, Low Ranges & Results. eMedicineHealth. Retrieved from https://www.emedicinehealth.com/hematocrit_blood_test/article_em.htm.

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer

Holman, H.C., et al. (2019). *RN Adult Medical-Surgical Nursing* (11th ed.). Assessment

Lewis, J. L. (2018). Hypokalemia (Low Level of Potassium in the Blood) - Hormonal and Metabolic Disorders. Retrieved from https://www.merckmanuals.com/home/hormonal-and-metabolic-disorders/electrolyte-balance/hypokalemia-low-level-of-potassium-in-the-blood.

Marcin , J. (2017). Eosinophil Count: What It Is and What It Means. Healthline. Retrieved from https://www.healthline.com/health/eosinophil-count-absolute.

Mayo Clinic Staff. (2018). Low hemoglobin count Causes. Retrieved from https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/causes/sym-20050760.

Sills, J. (2015). *The Comprehensive Respiratory Therapy Exam Review*. 6th ed. St. Louis, Missouri: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray and CT of abdomen/ pelvis with contrast were taken.

Diagnostic Test Correlation (5 points):

A CT scan is an X-ray image made using a form of tomography in which a computer controls the movements of the scan and processes the data (Oxford, 2019). Typically a CT for abdomen/ pelvis was taken because the patient came in and complained of nausea and abdominal pain. The patient was given a CT with contrast to see what was going on in the abdomen better (Hinkle & Cheever). This test correlates to the primary medical diagnoses of a small bowel obstruction. On the CT scan, there was a multitude of loops intersecting the small and large intestine. Those loops are the cause of nausea and abdominal pain.

A chest x-ray is an image of the chest done by a portable x-ray machine. The x-ray is taken for this patient because the patient had an NG tube done. NG tubes or nasal gastric tubes are inserted through the nose and descended into the patient's stomach (Hinkle & Cheever, 2018). To check that the tube ended up in the stomach and not the lungs. A Chest X-ray is done to confirm the placement. When inserting an NG tube, one has to measure it for accuracy.

Diagnostic Test Reference (APA):

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer

Ct Scan. (2019). Merriam-Webster. Retrieved from https://www.merriam-webster.com/dictionary/CT scan.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed
Home Medications (5 required)

Brand/Generic	**Lisinopril**	**ondansetron**	**Levothyroxine**	**Diclofenae**	**Famotidine**
Dose	**10mg**	**40mg**	**112mcq**	**75mg**	**20mg**
Frequency	**Daily**	**Once**	**Daily**	**2x Daily**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Ace inhibitor**	**Chemotherapy**	**Thyroid hormone**	**NSAID**	**Histamine-2 blocker**
Mechanism of Action	**Prevents clots**	**Blocks serotonin**	**Binding to thyroid receptor proteins contained in the cell nucleus**	**Treats mild to moderate pain**	**Blocks the action of histamine**
Reason Client Taking	**High Blood pressure**	**Thyroid cancer**	**Thyroid cancer**	**SBO, inflammation**	**GERD, ulcers**
Contraindications (2)	**GI Bleeding, Pregnant**	**Low amount of Mag, low amount of K+**	**Overactive thyroid gland, diabetes**	**Hypersensitivity, asthma**	**Gastric cancer, GI bleeding**
Side Effects/Adverse Reactions (2)	**Bleeding, irregular heartbeat**	**Headache, fatigue**	**Increased appetite, weight loss**	**Gas, headache**	**Constipation, diarrhea**
Nursing Considerations (2)	**Prevent bleeding, monitor**	**Fast Acting**	**Take 30mins to 1 hour before meals**	**Weight gain, swelling of arms and legs**	**Take with 8 oz of water, shake the**

	EKG				**bottle well**

Hospital Medications (5 required)

Brand/Generic	**Lisinopril**	**Hydrochlorothiazide**	**Citalopram**	**Amlodipine**	**Enoxaparin (lovenox)**
Dose	**10mg**	**25mg**	**40mg**	**10mg**	**40mg**
Frequency	**Daily**	**q 4**	**Daily**	**Daily**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Ace inhibitor**	**Microzide- diuretic**	**Anti-depression**	**Calcium channel blocker**	**anticoagulant**
Mechanism of Action	**Prevents clots**	**Reduces blood volume by acting on kidneys**	**Inhibitors serotonin**	**Blocks calcium causing a reduction in electrical conductive**	**Bind and accelerates the activity of anti-thrombin**
Reason Client Taking	**High Blood pressure**	**To treat edema**	**Depression**	**high blood pressure**	**High blood pressure**
Contraindications (2)	**Bleeding, pregnancy**	**Do not take if Diabetes and penicillin sensitivity**	**Don't take it if on a low sodium diet, creates a drop in potassium levels**	**Shock, hypersensitivity**	**Brain operation, eye surgery**
Side Effects/Adverse Reactions (2)	**Bleeding, irregular heartbeat**	**Headaches, dizziness, rash**	**Ejaculatory disorder, nausea**	**Swelling of legs and ankles, insomnia**	**Nausea, fever**
Nursing Considerations (2)	**Prevent bleeding, monitor EKG**	**May cause dizziness hypokalemia, watch BP**	**Taken at night, do not breastfeed on**	**Catch BP and pulse before giving medication, monitor I/O's**	**Do not take aspirin, or naproxen will increase bleeding**

			medication		**affects; watch for fall risk**

Medications Reference (APA):

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer

Jones & Bartlett Learning (2019). Nurse's Drug Handbook (18th ed.). Jones & Bartlett Learning, LLC an Ascend learning company Boston, MA.

Vallerand, A. H., Sanoski, C.A., & Deglin J. H., (2015). Davis's Drug Guide for Nurses (14th ed.). F.A. Davis Company Philadelphia, PA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert, orientated, with no distress. Patient is a female middle- aged Caucasian, morbidly obese.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient's skin is clear, pink, and dry; temperature is warm. Patient has an abdominal wound Medline, with 36 straps and two gauge pads all four sides are covered and adhesion to the skin. Wound is clean, and dry. Barden score 18. Patient has a NG tube connected to a suction.

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	PERRLA, sclerae nonicteric, conjunctivae were pink. Nose: clear. Throat: mucous membranes are moist. Neck: supple, obese no nodes appreciated. Patient has own teeth, appears yellow stain. .
CARDIOVASCULAR (2 points): **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: normal sinus, clear S1 & S2 sounds, no murmurs. All Peripheral pulses are strong and 2+. Capillary refill is less than equal sequential compression is on. No neck vein distention. Edema 2+ located bilateral legs. No CVA tenderness. No rash. No ecchymosis, evidence of trauma on the abdomen. No deformities appearance.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Breath sounds were auscultated and clear at all points anterior and posterior. Accessory muscles are in use.
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 ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Patient is morbidly obese. At home diet was not stated by patient. Current diet is NPO with ice chips. Ht 5’3”, Wt 341 lbs. Patient has active/hypoactive bowel sounds, last BM yesterday, Palpation of abdomen was tender and patient states some discomfort. Inspection there is an incision on the midline of the abdomen, there is a NG tube in place hooked up to a suction canister. Wounds appear on abdomen, 36 staples, covered with a dry dressing, tape is adhesive to skin. Nasogastric- yes, size was not given. No feeding tubes.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Flush pink, Quantity of urine was 50ml output. intake was 50ml. some discomfort when urination. Urine was amber orange and clear. No Dialysis. No catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **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☐**	Fall risk- yes; Fall score 75. due to recent surgery. no supportive devices. Patient appears reliable source for information. ROM is weak due to recent trauma. Strength is good in all limbs. Patient is independent; mobility status is impaired due to weight.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	PERRLA, sclerae nonicteric, conjunctive were pink. Grip strength is equal in both legs and arms. Patient is oriented, reliable source of history. Mental status is good. Patient recalls accident and childhood memories. Speech is clear. No confusion. Sensory factors indicted and functional. LOC- none, patient is alert and orientated, consciously aware of their surroundings.
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):**	Coping methods are watching TV, talking to family members, playing on phone; patient did not respond and looked away, patient lives at home with her daughter and her mother. Education was not mentioned by patient.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0832	99	112/57	18	98.6 F degree	93
1138	98	120/68	16	98.7 F degree	94

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0832	**1**-10; 10 being the worst	abdomen	6-7/10	Tolerable until they start to move then sharp pain	Given pain medication
1138	**1**-10; 10 being the worst	abdomen	3/10	Dull, tolerable	Relaxation techniques- couldn't get another one until 1300.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 gauge **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	LR 125/ 1000ml/hr. IV Zosyn; IV is located in the Right AC arm. Date on IV was 10/19/19. No sign of erythema, drainage. IV dressing was intact and dry.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
None—NPO, with ICE chips PRN	**50mL**

Nursing Care

Summary of Care (2 points)

Overview of care:

Night nurse gave shift report at 0700 in SBAR format. Patient was good throughout the night. No major complications. Patient was monitored for less than 400mL output in order to take out NG

tube. Patient's canister was measured at 0832 being 50ml output. Charged Nurse called provider at 0840 about taking out NG tube. Assessment and vitals were completed at 0850. Round 0930 provider called and informed the Charged Nurse that NG tube was taken out. Abdomen wound dressing was changed at 1130. Patient was put on a clear diet. Shift ended at 1200.

Procedures/testing done:

Patient under went produce to remove the NG tube. Labs were completed CBC, CMP, and a UA were completed.

Complaints/Issues:

Patient complained of abdomen pain and discomfort.

Vital signs (stable/unstable):

Vital signs are stable and were completed during shift. First round take at 0832, SPO2: 93, PR: 99, BP: 112/57, RR 18, Temp.: 98.6, Pain located in abdomen, patient described it as 6-7/10, and states pain is sharp when moving but dull when still. Second round a vital signs were at 1130, SPO2: 94, PR 98, BP: 120/68, RR: 16, Temp. 98.7, Pain is rated 3/10 and patient states it's dull, and tolerable.

Tolerating diet, activity, etc.: Patient tolerated NPO diet. Activity level is non-existing. Patient lays in bed all day. Ambulation is planned for evening shift.

Physician notifications: Physician notes that patient is alert, aware, and orientated. Physician has done assessment, checked vitals, and removed NG tube. Physician plans to release the patient later this evening.

Future plans for patient: Patient will continue meditations as needed. She will continue IV Zosyn. The patient is NPO. Hold blood pressure medications, hold thyroid medications, and hold depression medications until patient is on a diet.

Discharge Planning (2 points)

Discharge location: Patient will be discharged home later this evening if patient is able to ambulate and pass a stool.

Home health needs (if applicable): Patient will need assistance moving around home for next couple of days. So that the patient can focus on healing.

Equipment needs (if applicable): N/A

Follow up plan: Patient will follow up with Dr. Chase's surgical consult.

Education needs: Patient will need education on depression, nutrition, and mobility.

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	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1.	Patient is nutrition, imbalanced related to morbidly obesity as evidenced a BMI of 36, and distended abdominal.	The diagnosis was chosen because patient claims to be morbidly obese du to history of high blood pressure, difficulty walking, standing, and	**1.**Patient will go walk the halls 3 times with a nurse by her side in order promote healthy activity. **2.**Patient will check blood pressure before meals.	The Patient responded to goals set for them by stating " whatever gets me to go home I will do it." Modifications have been made to the plan. A nurse will walk behind the patient with a wheelchair in case of falls.

		over eating.		
2	Patient is activity intolerance related to Post-op exploratory laparotomy as evidence by limited range of motion, hypoactive bowel sounds, and pain upon movement.	The diagnosis was chosen because patient claims to be in moderate pain after post surgery to unloop the SBO.	1. Patient will get up and walk to bathroom by themselves 3 times a day before discharged. 2.Patient will decease pain and stress by relaxation techniques in order to be discharged.	The Patient responded to goals set for them by stating " I have most discomfort when getting up and walking to bathroom". And "I play on my phone or talk to my daughter to relax". Modifications have been made to the plan. A nurse will monitor patient getting up and going to the bathroom in order to observe the contains of the urine.
3	Patient is at risk for wound care impairment related to post- op surgery as evidence by midline insertion site on abdomen.	The diagnosis was chosen because patient claims to have a wound from surgery on her abdomen.	1. Patient will have dressing changes twice a day. 2. Patient will clean surgical site wound before applying new dressing.	The Patient responded to goals set for them by stating " I will change the dressing twice a day once in the morning and once at night". Modifications have been made to the plan, a nurse or health tech will watch the patient clean her own dressing with equipment that they would use at home.
4	Patient is risk for ineffective peripheral tissue perfusion related to recent trauma as evidence by compression	The diagnosis was chosen because patient claims to have poor circulation to extremities legs due to the compressions the patient has on her legs.	1. The patient will raise feet every 2 hour. To improve circulation. 2. Patient will apply own compressions and wear them when sleeping at night.	The Patient responded to goals set for them well and did not take off the compressions during the night. Modifications have been made to the plan, a nurse is to check on the compressions every hour with vitals.
5	Absorption impartment of	The diagnosis was chosen	1. Since the NG tube was	The Patient responded to goals set for them

	electrolytes related to NG tube placement as evidence by low Mag levels, dehydration, and low calcium levels.	because patient claims to have impaired electrolyte imbalance because she has an NG tube and and that NG tube is draining her of all her fluids and electrolyte from cells.	taken out, the patient is put on a clear liquid diet and the patient will drink 24 fl oz. before discharged. **2.** Patient will include sports drinks to increase electrolytes.	well and increased fluids, but they still complained and wanted normal food. Modifications have been made to the plan, patient is allowed regular food, with increased fluids on tray.

Other References (APA):

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer

NANDA. (2017). NANDA- Approved Nursing Diagnoses 2015-2017. Retrieved from https://www.deanza.edu/faculty/hrycykcatherine/NANDA_2015-2017_list__November_2014.pdf

Concept Map (20 Points):

****See Map Below****

Subjective Data

Patient complains of pain as being sharp when moving and dull when laying down. Patient states that they are feeling well and want to go home soon.

Patient complains of pain 6/10 around 0832, then of pain 3/10 at 1100.

Nursing Diagnosis/Outcomes

Patient is risk for ineffective peripheral tissue perfusion related to recent trauma as evidence by compression.
Absorption impartment of electrolytes related to NG tube placement as evidence by low Mag levels, dehydration, and low calcium levels.
Patient is at risk for wound care impairment related to post- op surgery as evidence by midline insertion site on abdomen.
Patient is activity intolerance related to Post-op exploratory laparotomy as evidence by limited range of motion, hypoactive bowel sounds, and pain upon movement.
Patient is nutrition, imbalanced related to morbidly obesity as evidenced a BMI of 36, and distended abdominal.

Objective Data

-Patient came to ED with complaint of nausea and abdomen pain
-Patient was given a CT of abdomen and Pelvic and it showed Small bowel obstruction
-exploratory laparotomy
- Vital signs are stable and were completed during shift. First round take at 0832, SPO2: 93, PR: 99, BP: 112/57, RR 18, Temp.: 98.6, Pain located in abdomen, patient described it as 6-7/10, and states pain is sharp when moving but dull when still. Second round a vital signs were at 1130, SPO2: 94, PR 98, BP: 120/68, RR: 16, Temp. 98.7, Pain is rated 3/10 and patient states it's dull, and tolerable.
-NG tube, and CT, X-Ray
- Labs: urine pH 4.6, amber/clear; ALT 40, mag 1.7, Albumin 2.5, Ca+ 7.5, cratinine 0.50, CO2 31.5, K+ 3.0, Eosinophil 0.5, Monophils 1.3, lmyphocteyes 9.2, Neutrophils 16.9, Hct 35.0, Hgb 10.3
- Wounds appear on abdomen, 36 staples, covered with a dry dressing, tape is adhesive to skin

Patient Information

Patient admitted 10/19/19
.Z. 40 years, mexican, Lives with mother and Daughter, no allergies, full code, Ht 5'3", Wt 341 lbs; History of The patient has a history of papillary thyroid carcinoma, status post resection, with a history of Hashimoto's thyroiditis, morbid obesity, depression, and hypertension. Mother has arthritis and heart disease. Father had allergies.

Nursing Interventions

The patient will go walk halls with a nurse or tech 3 times before discharged. Patient will check blood pressure before meals, Take patient's NG tube out and put them on clear clears with added sport drinks to restore electrolytes. Patient will elevated legs every 2 hours and put compressions on every night. Patient will decrease pain and stress by relation techniques.