N431 Care Plan # 3

Lakeview College of Nursing

Lindsey Davis

Demographics (3 points)

Date of Admission 3-18-20	**Patient Initials** D.J.	**Age** 45 yrs	**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: None

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

Social History (tobacco/alcohol/drugs): 1 pack/day smoker for 20 years, states he drinks “a few beers on the weekends” And denies all drug use.

Assistive Devices: None need.

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 two days with nausea/vomiting

History of present Illness (10 points):

The patient is a 45-year-old male who was brought to Sarah Bush Hospital emergency department via significant other on 3/18/20 for abdominal pain, nausea, and vomiting for two days. The patient states that he was home on the couch when the pain started in his abdominal region. He rates his pain as a 9/10, reporting it is a constant sharp pain. The pain is worse when bending over or too much activity. The patient tried heat and Tylenol at home, which helps for a while but has just gotten progressively worse, so his significant other brought him in. The patient

was given Famotidine, lidocaine oral suspension, and ondansetron shortly after arrival with little relief. A KUB was performed to reveal a small bowel obstruction. An 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 (SOB) 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 bowel. In contrast, a chronic obstruction is often seen with inflammatory disease or tumors" (Capriotti & Frizzell, 2016, p. 661). Common contributing factors can be postsurgical adhesions. Surgeries that most often caused adhesions are appendectomy, colorectal surgery, gynecological, and upper GI procedures. "Adhesions are bands of connective tissue that form between tissue and organs as a result of injury during surgery and can bond sections of intestines together (Brunner & Suddarth, 2018).

Characteristics of small bowel obstructions are related to the severity of the obstruction. The larger the obstruction, the worse the symptoms will be. Symptoms include abdominal distention, pain, nausea, vomiting, and hyperactive bowel sounds (Capriotti & Frizzell, 2016). Abdominal distention can be found proximal to the site of obstruction. "Pain is characterized as sharp, cramping and intermittent, occurring with the contractions of hyperactive peristalsis" (Capriotti & Frizzell, 2016, p. 661). The severity of the strangulation of the intestines can cause pain to be continuous and steadily increase. Left untreated can cause ischemia or necrosis of the intestines and does require emergency surgery. Due to the common symptoms of nausea and

vomiting, the patient should be monitored for fluid and electrolyte imbalance leading to dehydration, hypotension, or hypovolemic shock.

The diagnostic test would include an abdominal x-ray for visualization of the obstruction and severity. CT and ultrasound can also identify an obstruction. Treatments of small bowel obstruction patient are NPO, and the nasal gastric tube is placed to decompress the stomach removing any accumulation of fluids from the bowl. IV fluids are given to maintain proper hydration. Some obstructions do require surgical intervention. “Then pain management, antiemetic medications, and antibiotics are frequently necessary” (Henry, 2016, p610).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Ball, B. S., Holman, H. C., … Lemon, T. (2016). *Rn adult medical surgical nursing: review module*. Assessment Technologies Institute.

Hinkle, J. L., Cheever, K. H., & Hinkle, J. L. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing*. 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	4.2-5.4	n/a	n/a	
Hgb	12-16	13.1	n/a	
Hct	37-47	42.1	n/a	
Platelets	150,000-	n/a	n/a	

	400,000			
WBC	4.5-11.1	12.4	n/a	"Assist in identification of abscess, infection, and inflammation of the bowel" (Bladh, 2019, pg 1248).
Neutrophils	2.0-7.0	n/a	n/a	
Lymphocytes	1.0-3.0	n/a	n/a	
Monocytes	4-6%	n/a	n/a	
Eosinophils	7% or less	n/a	n/a	
Bands	45-75%	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	130	n/a	"Hypertonic glucose draws water into extracellular fluid, and sodium is diluted" (Bladh, 2019, pg 1079).
K+	3.5-5.0	4.2	n/a	
Cl-	98-107	n/a	n/a	
CO2	22-29	n/a	n/a	
Glucose	70-100	97	n/a	
BUN	6-20	9	n/a	
Creatinine	0.6-1.3	1.01	n/a	
Albumin	3.5-5.2	n/a	n/a	
Calcium	8.6-10	n/a	n/a	
Mag	1.7-2.2	n/a	n/a	
Phosphate	2.5-4.5	n/a	n/a	

Bilirubin	0.1-1.2	0.4	n/a	
Alk Phos	20-140	n/a	n/a	
AST	10-30	15	n/a	
ALT	10-40	52	n/a	"Related to release of ALT from damaged liver, kidney, heart, pancreas, red blood cells, or skeletal muscle cells" (Bladh, 2019, p 17).
Amylase	56-90	n/a	n/a	
Lipase	0-110	n/a	n/a	
Lactic Acid	0.5-1	n/a	n/a	
Troponin	>0.03	n/a	n/a	
CK-MB	>90	n/a	n/a	
Total CK	30-170	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	0.9-1.2	n/a	n/a	
PT	11-14	n/a	n/a	
PTT	0-250	n/a	n/a	
D-Dimer	0-250	n/a	n/a	
BNP	<100	n/a	n/a	
HDL	<40	n/a	n/a	
LDL	>100	n/a	n/a	
Cholesterol	<200	n/a	n/a	

Triglycerides	<150	n/a	n/a	
Hgb A1c	<7%	n/a	n/a	
TSH	0.4-4.0	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	
pH	5.0-8.0	n/a	n/a	
Specific Gravity	1.005-1.035	n/a	n/a	
Glucose	Normal	n/a	n/a	
Protein	negative	n/a	n/a	
Ketones	Negative	n/a	n/a	
WBC	<5	n/a	n/a	
RBC	0-3	n/a	n/a	
Leukoesterase	Negative	n/a	n/a	

Arterial Blood Gas 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
pH	7.35-7.45	n/a	n/a	
PaO2	80-100	n/a	n/a	
PaCO2	35-45	n/a	n/a	
HCO3	21-28	n/a	n/a	

SaO2	95-100	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	negative	n/a	n/a	
Blood Culture	negative	n/a	n/a	
Sputum Culture	negative	n/a	n/a	
Stool Culture	negative	n/a	n/a	

Lab Correlations Reference (APA):

M., V. L. A., & Bladh, M. L. (2019). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications*. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

A KUB and EKG were performed.

Diagnostic Test Correlation (5 points):

The patient received two KUBs on 3/18/20. This is used to "visualize and assess the abdominal organs for obstruction or abnormality related to mass, trauma, bleeding, stones, or congenital anomaly" (Bladh, 2019, pg301). Due to the patient's chief complaint of chronic abdominal pain, nausea, and vomiting, this test can be used to identify a bowel obstruction. This KUB results came back with a small bowel obstruction that 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. The second KUB was obtained to check the placement of the nasal gastric tube before use. The KUB results came back to the tip of the NG/OG is coiled with the stomach. All other findings are unchanged from previous films and interpretations. The next test ordered was an electrocardiogram (EKG), “to evaluate the electrical impulses generated by the heart during the cardiac cycle to assist with the diagnosis of cardiac blocks, damage or infection.” (Bladh, 2019, pg522). This EKG showed normal sinus rhythm and no noted abnormalities. Letting the provider know there was no heart damage done due to infection.

Diagnostic Test Reference (APA):

M., V. L. A., & Bladh, M. L. (2019). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications*. 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 / Pepcid	Loperamide/ Imodium	Calcium Carbonate/ Tums	Morphine/	Acetaminophen/ Tylenol
Dose	20 mg	4 mg	750 mg	2 mg	1,000 mg
Frequency	Daily	Q6h/PRN	Q4h/PRN	Q4h/PRN	Q8h/PRN
Route	Oral	Oral	Oral	IV Push	IV
Classification	Histamine	Anticholinergic	antacid	opioids	analgesics
Mechanism of Action	Selectively antagonizes histamine H2 receptors	Monitor for diarrhea and constipation	Essential component and participant in physiologic systems and reactions	Binds to various opioid receptors, producing analgesia and	Antipyretic

				sedation.	
Reason Client Taking	Reduce stomach acid	Treat diarrhea	heartburn indigestion	Pain management	Pain/Fever
Contraindications (2)	Caution if renal impairment, hypertensive	Abdominal pain, bloody or infectious diarrhea	Hypercalcemia, and dehydration	Respiratory depression, cardiac arrest	Hepatic impairment, hypovolemia
Side Effects/Adverse Reactions (2)	AV block, angioedema	Toxic megacolon, paralytic ileus	Hypercalcemia nephrolithiasis	Cardiac arrest, shock	renal tubular necrosis, headache
Nursing Considerations (2)	Monitor for anaphylaxis and side effects.	Caution if hepatic impairment, bradycardia	caution if renal impairment or hyperparathyroidism	Warning if GU and obstruction.	caution if malnutrition or renal impairment
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor to Cr.	Monitor vitals and bowel habits	Monitor kidney function tests.	Monitor BP and assess respiratory status before administering it.	Monitor liver function
Client Teaching needs (2)	Monitor for diarrhea and constipation	Teach patient to check heart rate for bradycardia	Take by mouth with water.	No alcohol use and take with food.	Don't take with alcohol

Hospital Medications (5 required)

Brand/Generic	Hydromorphone/ Dilaudid	Pantoprazole/ protonix	Ondansetron/ Zofran	Promethazine/	Dextrose 10% in

				Phenergan	water
Dose	1 mg	40 mg	4 mg	12.5 mg	250mL
Frequency	Q2h/PRN	BID	PRN (q6hr)	IV push	PRN
Route	IV	IV	IV push	Q4h	IV
Classification	Opiate analgesic	Antiulcer	anti nausea/ vomiting	antihistamines	Fluid
Mechanism of Action	Inhibits ascending pain pathways in CNS	Inhibits gastric parietal cell	selectively antagonizes serotonin 5-HT3 receptors	Non-selectively antagonizes central and peripheral histamine H1 receptors.	Needed for adequate utilization of amino acids
Reason Client Taking	Severe pain	IBS	Pt take for nausea	Nausea	Hypoglycemic
Contraindications (2)	If hypersensitivity to addiction. caution in renal/hepatic disease	Hypomagnesemia	QT prolongation, bradycardia	Reye syndrome Respiratory depression.	Do not use during hyperglycemia episodes. Hemorrhage
Side Effects/Adverse Reactions (2)	Sedation Seizure Respiratory depression	anaphylaxis	ECG if electrolyte abnormalities, CHF	Apnea, hallucinations	Hyperglycemia or fluid volume overload.
Nursing Considerations (2)	Assess for respiratory dysfunction. Assess pain control	Interstitial nephritis, caution if hypomagnesemia	CK levels and LFTs	Check for a patent IV site. Check for respiratory depression before admin.	Inspect site for a patent IV site. Check for edema or necrosis.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess Bowel function, Assess for CNS changes.	Check Mg level for long term use. Assess IV site.	Continue monitoring nausea. Monitor for constipation in long term use.	Monitor CBC with diff, ophthalmic exam if prolonged. LOC	Check electrolytes (K, Na, Ca, Cl, Mg)

Client Teaching needs (2)	That physical dependency may result when used for an extended time. Avoid driving, other hazardous activities, drowsiness may occur.	To patient to watch for symptoms of diarrhea or headaches and contact provider.	Teach them that long term use causes constipation. Teach route of administration PO, sublingual, and IV.	To notify the nurse if they feel short of breath or feel like their heart is beating fast.	The reason for the dextrose infusion. Review the symptoms of hypoglycemia and hyperglycemia.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient had facial grimacing during the interview. Patient knew where he was, who he was, the year, and the president. A&O x4. Besides the pain, the patient had no complaints.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The Patient's skin is pink, dry, and warm. Patients' stomach and back appear well moisturized, and no rashes detected. Skin integrity was intact, localized abnormalities. Lower extremities have no pitting edema, and no varicose veins present. Nails normal for ethnicity. Cap normal less than 3 seconds. Skin turgor was normal, 1 second of tenting. No bruises or wounds noted. The Patient's Braden score was 22.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Pupils are symmetrical, with no sclera. Head and Neck appear in normal limits. No jugular vein distention, no carotid bruit, no lymphadenopathy. Trachea midline, no thyroid tenderness. The ear is within normal limits and hearing intact, pearly grey tympanic membrane. Patient denies the use of glasses. The nose appears normal, with no deviation, turbinate's inspected. Patient has no dentures, and no cavities noted at this time.

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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:**	Regular rate and rhythm, S1 and S2 are normal, no murmurs/rubs/or gallops, point of maximal intensity nondisplaced. The capillary refill was normal within 3 seconds. Nail beds normal for ethnicity. No edema on the ankle, pedal bilaterally. Pulses normal 2+ radial and dorsal bilaterally. Pulses intact and symmetrical in all extremities.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lungs sound clear in upper and lower lungs bilaterally both anterior and posterior upon auscultation. No rales/rhonchi/wheezes. Patient has regular unlabored breathing—patient on room air. No cough noted.
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:** 65 cm **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient has a regular diet at home. And is NPO in hospital. Weight is 81.8 kg, and height is 177.8 cm, making the BMI 25.9, placing this patient in the overweight category for his height and weight. Bowel sounds absent in RLQ and hypoactive in all other quadrants. resonant to percussion, soft, non-distended and tender on the right side both upper and lower quadrants., no rebound or patient was guarding on the right side, no hepatomegaly. No palpable masses. No eating difficulties, fair appetite, no nausea. No voiding difficulties, no bladder distention. NG-connected to low-intermittent suction with bile-green colored. Last bowel movement was 3/18/2020
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:**	Patient's urine is light yellow to clear. No visible sediment, no foul smell. No problems voiding.

Size:	
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** ☐	Patient reports pain in the upper and lower left quadrants. No signs of pallor, paresthesia, or paralysis, a pulse is within the normal range. Patient is about to complete ROM exercises on her own on the left side with no pain. Patient does not need supportive devices, and the patient is up with one assist and walker. Patient's strength is 5/5 bilaterally on upper and lower extremities. Patients fall score is 35.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patients' pupils were equal, round, and reactive to light when assessing with a penlight. Patient was orientated to person, place, time, and situation. The Patient's level of consciousness was within normal limits. The patient was easily arousable. The Patient's speech was clear and easy to understand. Judgment is intact. No LOC
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):**	Patients coping methods are playing guitar. Patient completed high school and paramedic training in 1995. Patient is a Christian and believes in God. Patient lives at home independently with significant other.

Vital Signs, 2 sets (5 points)

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

Vital Sign Trends:

The patient's blood pressure is slightly elevated, and this could be due to the pain that the patient was experiencing at this time.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	abdominal	8/10	Constant sharp pain	Morphine administer
1100	Numeric	Abdominal	4/10	cramping pain	Morphine administer

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	18G left antecubital & right wrist 3/18/20 IV left attached and infusing D5NS at 100 mL/hr with no problems. IV right saline locked. Sites dry, clean, and intact. Dressing allusive with no phlebitis or infiltration present, catheter present, and patent.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
D5NS- 100 mL/hr x 4 hours Total- 400	Urine- 450 mL in 4 hrs. Total- 450

Nursing Care

Summary of Care (2 points)

Overview of care:

During this shift, we worked to provide comfort to the patient. By delivering heat packs and pain medications.

Procedures/testing done:

No procedures were done on this shift, but a blood draw was performed. KUB and EKG were performed. Blood sugar checks q6h

Complaints/Issues:

The chief complaint was abdominal pain for two days with nausea and vomiting.

Vital signs (stable/unstable):

Patients vitals were stable for current condition.

Tolerating diet, activity, etc.:

Patient is currently NPO and tolerating it.

Physician notifications:

The provider was notified at 0830 of a fever >38.0 despite acetaminophen administration.

Future plans for patient:

Patient should adhere to strict NPO status until bowel sounds return or the patient is passing gas. When this occurs, please notify the provider for further orders. Continue scheduled morphine for pain management. Oral swabs are permitted sparingly. The discharge will be initiated upon the relief of small bowel obstruction.

Discharge Planning (2 points)

Discharge location:

Home with significant other.

Home health needs (if applicable):

None currently.

Equipment needs (if applicable):

None.

Follow up plan:

Follow up with PCP one week after discharge.

Education needs:

Patient needs education on 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	**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. Risk for sepsis related to small bowel obstruction as evidence by KUB image and high WBC.	Sepsis would be a considerable risk if the bowl were to perforate the intestines.	**1.** Assess vital signs for elevated temperature, increased pulse rate, hypotension, and shallow/rapid respiration. **2.** Assess the abdomen for worsening pain.	The family responds well to education on nonverbal indicators of pain, such as elevated heart rate or grimacing.
2. Risk for electrolyte imbalance related to NPO order.	Patient has had nausea, vomiting, and now has a prescription for NPO.	**1.** Assess vitals for signs of dehydration, such as tachycardia and hypotension. **2.** Assess lab values such as CBC.	Patient was educated on the benefits of the IV fluid he would be received to prevent dehydration.
3. Acute pain related to	Patients with obstructions are in	**1.** Assess the level of pain, location,	Provided patients with a schedule for medications,

abdominal distension and increased peristalsis.	severe pain.	intensity, duration. 2 Provide a comfortable position and promote a restful environment.	so the patient had an idea of what to expect, and pain could be reduced.
4. Imbalanced nutrition less than body requirements related to intestinal obstruction and vomiting.	Patient is unable to absorb nutrition due to NPO and vomiting.	**1.** When able to eat again. NG can be used for feedings. **2.** Provide a liquid diet rich in protein and high caloric diet.	Patient would be educated on the importance of a balanced diet and high protein to promote healing.

Other References (APA):

Ladwig, G. B., & Ackley, B. J. (2016). *Mosbys Guide to Nursing Diagnosis.* Elsevier Health Sciences.

Concept Map (20 Points):

Subjective Data

Pain 8/10
Sharp constant pain
Denies drug use
Drinks alcohol on weekends
Smoker 1 pack/day
Home diet regular
No difficulties voiding
Last bowel movement 3/18/2020

Nursing Diagnosis/Outcomes

k for sepsis related to small bowel obstruction as evidence by KUB image and high WBC.
Family respond well to education on nonverbal indicators of pain such as elevated heart rate or grimacing.
Risk for electrolyte imbalance related to NPO order.
Patient was educated on the benefits of the IV fluid he would be receive to prevent dehydration.
Acute pain related to abdominal distension and increased peristalsis.
Provided patient with a schedule for medications so patient had an idea of what to expect and pain could be reduced.
Imbalanced nutrition less than body requirements related to intestinal obstruction and vomiting.
Patient would be educated on the importance of a balanced diet and high protein to promote healing.

Objective Data

Grimacing when abdomen was assessed.
Branden score: 22
Fall risk: 35
A&O x4
Regular heart rate and rhythm
Judgement intact
Appetite: none NPO
Active bowel sounds in all 3 quadrants RUQ absent.
No rashes
Skin pink, dry and warm

Patient Information

.J.
45 years old
Male
African American
Allergies – PCN
Full code
5’ 10”
180 lbs.

Nursing Interventions

Assess vital signs for elevated temperature, increased pulse rate, hypotension and shallow/rapid respiration.
Assess of abdomen for worsening pain.
Assess vitals for signs of dehydration such as tachy cardia and ypotension.
ssess lab values such as CBC.
Assess the level of pain, location, intensity, duration.
Provide comfortable position and promote restful environment.
When able to eat again. NG can be used for feedings.
Provide liquid diet rich in protein and high caloric diet.