Surgical Case 2: Stan Checketts

Documentation Assignments

1. Document your focused assessment of Stan Checketts' abdomen.

The abdomen was bloated and tender to touch. His skin was cold and there was decreased skin turgor. There were hyperactive bowel sounds.

- The abdomen was bloated and tender to touch; his skin was cold, and there was decreased skin turgor; there were hyperactive bowel sounds. Small bowel obstruction is diagnosed with CT enterography.

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decreased skin turgor. There were hyperactive bowel sounds.

2. Document immediate priority actions related to the treatment of hypovolemic shock.
   - I started a bolus of 500 mL of normal saline IV, running wide open. This was indicated by order.

3. Create a nursing note reflecting priority assessments, interventions, and method of evaluation as they relate to the care of a patient experiencing signs of hypovolemic shock.

My first assessment of vital signs showed: HR 131, BP 108.77, RR 29, SpO2 90%
and temperature 99 F. My last assessment of vital signs showed: HR 116, BP

106/76, RR 28, SpO2 93% and temperature 99 F

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and temperature 99 F.
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- Assess the client's HR and BP, including peripheral pulses. Use direct intra-arterial monitoring as ordered; Assess the client's ECG for dysrhythmias; Assess the central and peripheral pulses; Assess the central and peripheral pulses; Assess the respiratory rate,

rhythm, and auscultate breath sounds; Assess for any changes in the level of consciousness; urine output, skin color, temperature, and moisture.
- Monitor oxygen saturation and arterial blood gases; Monitor the client's central venous pressure (CVP), pulmonary artery diastolic pressure (PADP), pulmonary capillary wedge pressure, and cardiac output/cardiac index.
- Provide electrolyte replacement as prescribed.
- If possible, use a fluid warmer or rapid fluid infuser.
- Administer fluid and blood replacement therapy as prescribed.
- If the client's condition progressively deteriorates, initiate cardiopulmonary resuscitation or other lifesaving measures according to Advanced Cardiac Life Support guidelines, as indicated.

4. Document the two sets of vital signs (before and after nursing interventions) in the Stan Checketts' scenario.
   - My first assessment of vital signs: ECG – Sinus tachycardia, HR 130, BP 108/70, RR 28, SpO2 90%, Temp 98.6 °F.
   - My last assessment of vital signs: ECG – Sinus tachycardia, HR 112, BP 113/80, RR 28, SpO2 98%, Temp 98.6 °F.

5. Identify and document key nursing diagnoses for Stan Checketts.
   - Deficient fluid volume related to inadequate fluid volume intake.
   - Decreased Cardiac Output related to heart rate and rhythm alterations, decreased ventricular filling, and late uncompensated hypovolemic shock.

6. Referring to your feedback log, document the nursing care you provided to Stan Checketts. Include an SBAR note with recommendations reflecting the key assessments the oncoming nurse should be alert to when monitoring Stan Checketts.

After introducing myself and washing my hands, I got vitals on Mr. Checketts and

then performed an abdominal assessment by auscultating the abdomen first and
then palpating it. I then started an IV and gave fluids after assessing the patency
of the IV. I placed an NG and checked placement by X-ray. I got a venous blood
sample for a CBC and metabolic panel. I got an

abdominal X-ray for diagnostic purposes. I then gave buprenorphine IV for pain and ondansetron IV for nausea. I placed a NC on Mr. Checkettes to increase his SpO2 from 90-93% and I put it on 2L. I re-examined his abdomen and re-assessed his pain. I updated the physical

and educated the patient appropriately.
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then performed an abdominal assessment by auscultating the abdomen first and
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- After introducing myself and washing my hands, I got vitals on Mr. Checketts. And I then performed an abdominal assessment by auscultating the abdomen first and then palpating it. I asked him about his pain rate, location, and symptoms. And then, I gave him an emesis basin at the bedside since he felt nauseated. Then I started an IV and gave him 500 mL of normal saline IV boluses, running wide open. I placed an NG tube as ordered and checked placement by an abdominal X-ray to confirm the nasogastric tube placement. And then, I administered 4 mg of ondansetron IV for nausea and a morphine dose of 2 mg for pain (I verified this with another nurse). After that, I placed an NC on him to increase his SpO2 from 90 – 94% on 2 L. I reassessed his abdomen and his pain. I educated the patient, and then a patient handoff was performed.