

Surgical Case 2: Stan Checketts

Documentation Assignments

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

The assessment is to gather information regarding the client's initial complaint. My focused assessment regarding Mr. Checketts was to inspect, auscultate, percuss and palpate. Assessment presented decreased turgor, cool, sweaty skin, hyperactive bowel sounds, tender upon palpation.

2. Document immediate priority actions related to the treatment of hypovolemic shock.

The immediate priority actions related to the treatment of hypovolemic shock is to administer bolus of normal saline of 500mL over 5 minutes, running wide open to help replacement of fluid and electrolyte loss.

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

Assessment:

Head-to-toe: Abdomen is distended, Auscultation of abdomen yields hyperactive sounds.

Patient has poor skin turgor and dry mucous membranes, cold, sweaty skin, and tachycardia

V/S: Temp: 98.6 F (37 C), HR: 131, RR: 28, BP: 110/79, SpO2: 90%, continuous 3 ECG with Sinus tachycardia, Conscious state: Appropriate. Abdomen is distended. Pt complained of pain 4 on a scale of 0-10 in the abdomen and N/V. Patient has not voided since the prior day.

Nursing Diagnosis - Deficient fluid volume related to vomiting as evidenced by decreased skin turgor, capillary refill greater than 3 seconds; cold, sweaty skin, and tachycardia. And acute pain related to abdominal distention as evidenced by clients stating pain of 5 on a pain scale of 0-10 in abdomen and swelling on abdomen.

Planning: Restore fluid, oxygenation and control of pain.

Intervention: Administered IV bolus of N.S. 500mL over 5 minutes, morphine 2 mg slowly pushed and Applied 2 liters via N.C to maintain saturation >92%. Nasogastric tube inserted and applied to intermittent suction. Abdominal x-ray confirmed. Labs (CBC, BMP) completed and added to the chart.

Method of Evaluation : Inspection, Auscultation, Percussion and Palpation. Continuous pulse Sat, NIBP, 3 lead ECG, abdominal x-rays, I/O, skin assessment, daily weight, pain scale of 0-10 after 2hrs of intervention.

4. Document the two sets of vital signs (before and after nursing interventions) in the Stan Checketts scenario.

Before nursing interventions V/S was Temp: 98.6 °F (37.0 °C), HR: 131, RR: 28, BP: 110/79 mm Hg, Conscious state: Appropriate. SpO2: 90%, Pain of 4 on the scale of 0-10.

After nursing interventions V/S was Temp: 98.6 °F (37.0 °C), HR: 118, RR: 28, BP: 113/80 mm Hg, Conscious state: Appropriate, SpO2: 94% and a pain of 3 on scale of 0-10.

5. Identify and document key nursing diagnoses for Stan Checketts.

The key nursing diagnosis for Stan Checketts is deficient fluid volume related to vomiting as evidenced by decreased skin turgor, cold, sweaty skin, and tachycardia. And acute pain related to abdominal distention as evidenced by clients stating pain of 5 on a pain scale of 0-10 in abdomen and swelling on abdomen.

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.

When I entered the room I identified the patient to maintain patient safety and performed hand washing to prevent infection to keep patient safe. Position the Pt from supine to semi-fowler. I asked if the patient was allergic to anything , to which he replied: “Yes. I'm allergic to Demerol. I got a skin rash the last time.” Assessed vital signs, abdomen, skin turgor. Applied oxygen via nasal cannula at 2L to maintain oxygen saturation of 92% as ordered. Applied continuous pulse Sat, NIBP and 3 lead ECG as ordered. Auscultate Heart, Lungs, Abdomen and Neck. Head-to-toe assessment, Did V/S. Assess the IV and administered normal saline bolus of 500mL over 5 minutes as ordered. I administered pain medications to reduce the client's pain level. Inserted NG tube on low intermittent suction as ordered. Obtained abdominal X-Ray for placement. Obtained labs for CBC and BMP as ordered And lastly reassess Pt after intervention and gave hand-off report.