Surgical Case 2: Stan Checketts

Documentation Assignments

1. Document your focused assessment of Stan Checketts' abdomen.
Patient was alert and oriented on assessment. His bowel sounds were hyperactive. His abdomen was also distended and he was complaining of nausea and vomiting as well as abdominal pain rated a 4/10. He says he has been having vomiting and pain for a few days, the pain is worse with movement.

2. Document immediate priority actions related to the treatment of hypovolemic shock.
The patient was treated with normal saline at a bolus of 500 ml over 30 minutes. He was also on 2 liters of oxygen on nasal cannula because his SpO2 was 90%.

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.
Patient is alert and oriented x4. He has acute pain rated a 4/10 and vomiting for the past several days. Medications were given based on nausea and pain. Patients abdomen is distended and he was assessed to have hyperactive bowel sounds. Patient was placed on 2L nasal cannula. NG tube was placed on intermittent suction. Patient was started on 500 ml bolus of normal saline over 30 minutes. Labs were drawn, patient was sent for abdominal x-ray as well as CT scan. PCP was notified.

4. Document the two sets of vital signs (before and after nursing interventions) in the Stan Checketts scenario.
Initial vital signs included Spo2 90%, HR 130, BP 110/75, RR 26, and pain 4/10.

Vital signs after intervention were SpO2 93%, HR was around 120, RR 24, BP 104/93, and pain 3/10.

5. Identify and document key nursing diagnoses for Stan Checketts.
Risk for imbalanced fluid volume
Risk for hypovolemic shock
Acute pain
Risk for electrolyte imbalance

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.
Upon entering I greeted the patient, washed my hands, and identified the patient.

I communicated with the patient about his current pain level, past medical history, and education on current illness. I took vital signs before and after intervention. I placed an emesis basin at the bedside. Patient was placed on oxygen, IV access with a bolus of normal saline, morphine, and ondasetron IV were both given as well. Patient was attached to a 3 lead ECG and assessed abdomen. Patient obtained an abdominal x-ray, CT scan, and laboratory studies.
Situation: Patient was admitted with severe abdominal pain. The radiology showed that there was a small bowel obstruction. PCP was called and he is coming to further evaluate the patient.
Background: Patient is a 52 year old male who was admitted yesterday. He is having increasing pain and nausea and vomiting. He has a past surgical history of multiple surgeries in the past five years. He has an allergy to the medication Demerol with a side effect of rashes. He is a widower.
Assessment: He is A&Ox4. O2 is 90%, Temperature 98.6F, HR 130, BP 110/90, and pain 4/10. Bolus infusion of normal saline 500 ml started at a rate of 30 minutes. Morphine and Ondansetron were given to control pain and nausea. Small bowel obstruction was diagnosed after the CT.
Recommendation: Continue to monitor vital signs and pain level. Follow up with provider regarding plan of care.