Surgical Case 2: Stan Checketts

Documentation Assignments

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

T:98.6 P: 130 RR: 28 O2: 90% BP: 110/79 4/10 cramping stomach pain
Patient stated that he started vomiting 1-2 days ago, he feels dizzy and weak, and stomach feel bloated.
Upon inspection, Abdomen bloated and tender, sweaty and cool skin. Hyperactive bowel sounds from the abdomen when auscultated.

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

- Restore and redistribute intravascular volume with fluid, blood replacement
- treat underlying cause and provide supplemental oxygen

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.

Closely monitor all vital signs, especially on the blood pressure. Decrease in blood pressure may indicate fluid loss which can cause the hypovolemic shock. Also pay attention to patient's pale and diaphoretic skin and the urine out put
Administer 500 ml of normal saline through a large bore IV, and provide supplemental oxygen. May need to place the patient on modified Trendelenburg position in order to increase venous return and blood flow to the brain. Notify HCP about the patient's condition
Re-evaluate patient's vital signs, level of consciousness, urine output, and skin color and temperature

4. Document the two sets of vital signs (before and after nursing interventions) in the Stan Checketts scenario.
T: 98.6 P: 130 RR: 28 O2: 90% BP: 106/77 4/10 cramping stomach pain
T: 98.6 P: 126 RR: 29 O2: 93% BP: 106/76 pain 3/10

5. Identify and document key nursing diagnoses for Stan Checketts.
Risk for Deficient fluid volume, acute pain, and Diarrhea

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.

The patient is AAO x 4. Small bowel obstruction is diagnosed with CT scan. Patient had nausea and received ondansetron. Ondansetron was affective. 02 Saturations are 98% on oxygen 15 L per non-rebreather mask. Heart rate is 117. Patient shas pain level 4/10.

Continue to monitor vital signs and respiratory assessment every 15 minute. Assess if we can decrease FiO2 to target SpO2 of 92 %. Follow up with HCP regarding the plan and provide patient education.