

Assessment Information	Analysis of Information	Nursing Diagnosis
<p>Includes relevant information from history and exam, also include a completed Functional Health Pattern Assessment (use the form).</p>	<p>Include your conclusions of <u>diagnostic reasoning</u>. Construct patterns, eg., shortness of breath at night along with fatigue could be a pattern of decreased cardiac output because low output compromises tissue perfusion, venous output to lungs and overall cellular metabolism.</p>	<p>Define each nursing diagnosis and related factors, eg., Pain R/T decreased circulation to lower extremities AEB duskiness of both lower extremities and c/o “spasm”.</p>
<p><u>History from Record, Diagnostic Studies, Other Sources</u> 31 year old, male, Hispanic, primarily Spanish-speaking, admitted through ER on 10/2 with c/o intermittent epigastric pain, bilious vomiting, bowel sounds absent in upper two quadrants, sluggish in lower two quadrants, distended abdomen, no BM or flatus within 24°. Difficult, painful urination, NGT placed draining large amounts of dark brown liquid, abdominal KUB/xray showed SBO, fluid present, but no free air. Foley catheter placed. NPO with IVF (lactated ringers with 20 mEq KCL, 150 cc/hr/ATC), Pepcid, 20 mg, IVP, bid, Heparin 5000u SC, bid to prevent DVT, Demerol, 50 mg (IM/SC), Q4, prn, for pain. All lines, catheter and IV's dc'd on 10/5 at 7 a.m., started on clear liquids.</p> <p><u>Labs:</u> LFTs/lytes WNL</p> <p><u>Pmhx:</u> partial pancreatectomy for ETOH pancreatitis (April 1997), repair of incision hernia (October 1997), ETOH abuse, syphilis.</p> <p><u>Meds:</u> Ultram (non-opoid analgesic), Buspar (anxiolytic) and Remeron (antidepressant).</p> <p><u>DX education:</u> unable to describe his medical condition and need for current therapies.</p> <p><u>Subjective Information</u> Pt states he voided and moved his bowels. He denies abdominal pain, but c/o intermittent nausea following clear liquid breakfast.</p> <p><u>Objective Information</u> Pt voided approximately 200cc clear yellow urine and BM x 1 (loose). Breakfast po fluid intake 400 cc. No vomitus. Pt's abdomen soft, non-tender, slightly distended. + bowel sounds all 4 quadrants, + flatus. Pt ambulating in hall without difficulty. VSS, no fever. Ten pound weight loss since admission.</p>	<p>Pt has small bowel obstruction (ileus) mechanical in origin, probably secondary to adhesions from previous partial pancreatectomy that entrap a portion of the small intestine. Signs and symptoms of an upper intestinal obstruction are abdominal pain, distention, nausea and vomiting, either hypo- or hyper- bowel sounds, and constipation. The obstruction prevents feces from passing.</p> <p>Signs and Symptoms often cause the patient intermittent epigastric, crampy pain that is relieved by vomiting. The crampy pain is due to lessening motility. As the obstruction worsens, the pain generally becomes worse and constant D/T strangulation of the involved section of the intestine.</p> <p>Bowel sounds will be abnormal. Proximal to the obstruction, bowel sounds are often high-pitched or hyperactive, often in “rushes”. Distal to the obstruction, bowel sounds will often be absent since there is no motility.</p> <p>With a complete obstruction, the patient will be constipated and unable to pass flatus.</p> <p>Signs that a patient's obstruction is resolving without a resort to surgery are the passage of flatus, present bowel sounds in all four quadrants, BM, and tolerance of po intake without nausea or vomiting. Abdominal distention should dissipate as the obstruction clears. The abdomen should be soft, non-tender</p>	<ol style="list-style-type: none"> <u>Altered elimination</u> R/T decreases or absent intestinal motility AEB decreased/absent bowel sound absence of stool abd. distention and nausea/vomiting. <u>Fluid volume deficit, risk for</u> R/T small bowel obstruction AEB excessive fluid losses from vomiting, NGT drainage, and inadequate po fluid intake. <u>Knowledge deficit</u> R/T nature of condition, nutritional and fluid needs and reason of hospitalization AEB inability to discuss clinical information and care. <u>Pain</u> R/T an increase in peristalsis and abdominal distention AEB intermittent to persistent colicky abdominal discomfort constipation and abd distention. <u>Altered nutrition. Less than body requirements</u> R/T decreased desire/ability to eat and nausea AEB ten pound weight loss since admission. <p>**Prioritize Nursing diagnoses and choose one (1) to process for the NCP.</p>

<p><u>Number ALL outcomes/goals consecutively</u> <u>** Be specific/measurable</u></p>	<p><u>Plan/Interventions</u> Number ALL interventions as related to outcomes/goals. If more than one intervention/goal, add a letter to the number. Example, goal 1 corresponds with intervention 1a, 1b, 1c.</p>	<p><u>On-going Evaluation</u> Number all evaluations as related to outcomes/goals. Example evaluation 1 relates to outcome 1.</p>
<p>1a. Patient will report whether he is passing flatus, moves his bowels or voids by October 5, 1999.</p> <p>1b. Patient will not report any abdominal cramping, nausea and vomiting by October 5, 1999.</p> <p>1c. Patient will gradually increase his po fluid intake to avoid dehydration and electrolyte imbalance by October 5, 1999.</p> <p>1d. Patient will maintain balanced intake and output by October 5, 1999.</p> <p>1e. Patient will increase his physical activity and ambulate around the unit at least three times qshift during waking hours by October 5, 1999.</p>	<p>1a. Assess patient's abdomen for tenderness, auscultate for bowel sounds in all 4 quadrants, palpate for distention and inquire whether patient is passing flatus or has had bowel movements qshift.</p> <p>1b. Instruct patient to report any instances of abdominal cramping, nausea or vomiting.</p> <p>1c. (i) Instruct patient, and if necessary d/t language barrier his girlfriend, as to the importance of increasing his po fluid intake in order to prevent dehydration and electrolyte imbalance.</p> <p>1c. (ii) Encourage patient to increase his po fluid intake to at least 8 eight-oz glasses/day and ensure that juices are left at this bedside for him to drink.</p> <p>1d. Monitor and record patient's intake and output, noting the color and consistency of any stools.</p> <p>1e. Encourage patient to ambulate around the unit at least 3 times per shift during waking hours.</p>	<p>1a. Patient's abdomen will be assessed, auscultated and palpated for the presence of bowel sounds and distention and the patient will be asked about whether he is passing flatus or had a bowel movement by October 5, 1999.</p> <p>1b. Patient will report all instances of abdominal cramping, nausea and/or vomiting by October 5, 1999.</p> <p>1c. (i) Patient and/or his girlfriend will verbalize an understanding of the need for him to increase his po fluid intake by October 5, 1999.</p> <p>1c. (ii) Patient will be monitored for increased po fluid intake and juices will be left at this bedside by October 5, 1999.</p> <p>1d. Patient's intake and output will be balanced and strictly monitored and recorded by October 5, 1999.</p> <p>1e. Patient will be observed ambulating around the unit at least three times per shift by October 5, 1999.</p>

Scientific Rational and Principles for ALL interventions (list according to intervention number and letter, as indicated) Include References

1a. To assess whether there is GI motility, the abdomen needs to be fully assessed. First, it should be physically inspected. Then it should be assessed for the presence of bowel sounds. This is done through auscultation. All four quadrants should be listened to with the nurse making note of the existence and character of any bowel sounds. Next, the abdomen should be percussed. The presence of trapped gas will have a resonant sound. To test for distention, which reflects a full bowel and/or gas, the abdomen can be visually inspected and percussed. The abdomen should also be palpated, after the patient is asked whether he has any tender areas, to determine hernias, distention, bulges, liver or spleen enlargement, etc. The absence of, or sudden disappearance of, bowel sounds is indicative of an obstruction, Peritoneal irritation may be reflected by muscle guarding. McConnell, E., RN. (1994) Loosening the grip of intestinal obstructions. *Nursing 94*, 3, 34-41. Porth, C. (1994). *Pathophysiology: Concepts of altered health states*. Philadelphia: J.B. Lippincott Co. See also Jarvis, C. (1996). *Physical examination and health assessment*. Philadelphia: W. B. Saunders Company.

1b. A return of abdominal cramping, nausea or vomiting would indicate that the obstruction is not completely resolved. Since these complaints are somewhat subjective, it is imperative that the nurse ask the patient whether he has such also complaints and also instruct the patient to report the existence of such symptoms. McConnell, E., RN. (1994). Loosening the grip of intestinal obstructions. *Nursing 94*, 3, 34-41. See also Lewis, S. Heitkemper, M., Dirksen S. (1999) (Fifth Edition) *Medical-surgical nursing*, New York, NY: Mosby, 1164-67.

1c. Since the patient has been NPO, but has been vomiting and starting to have loose stools, he is at risk of becoming dehydrated. The negative fluid balance also carries the risk that he will have electrolyte imbalances because vomit from a small intestinal blockage is high in hydrochloric acid and potassium. To restore the proper fluid balance, the patient, who is no longer receiving isotonic IV fluids (lactated ringers with KCL), must orally replace lost fluids. In order to ensure that the patient is meeting his metabolic needs, the nurse needs to strictly monitor and record all fluids that he takes in and all fluids that he excreted, i.e. urine, stool, and vomit. Since there is a language barrier, it may be difficult for the patient to ask for juices. Therefore, it will encourage him to drink more if juices are conveniently left for him at his bedside. McConnell, E., RN. (1994) Loosening the grip of intestinal obstructions. *Nursing 94*, 3, 34-41.

1e. Encouraging the patient to ambulate will help him expel flatus, ease his abdominal distention and promote the urge to defecate once the obstruction has begun to resolve. This is because physical activity promotes peristalsis. Ambulating, therefore, helps to promote normal elimination. Potter, C. & Perry, A. (1996). *Fundamentals of nursing: Concepts: Process and practice*. St. Louis, MO: Mosby, 1345.

Revised 4/3/03