Pt Initials: KD Age:59 Sex: Female Race: White Code Status: Full Allergies/Reactions: Sulfanilamide

Admit Date: 3/17/2026 Day #: 2 Adv. Directives: Not received Marriage Status/Support System: Married Spouse/Significant other

Providers/Consults: Sivagowri Tharmendira, MD Living arrangements/Social Status: Not employed

Possible Discharge Date/Needs:3/20/2026 Scheduled Home Health/SNF/NH: Private Residence

Admitting Diagnosis: small bowel obstruction

Patho for primary medical diagnosis – be complete in explanation to include what is the standard treatment: (meds/labs/ radiology), and the clinical manifestations of the admitting diagnosis as well as you need to identify the symptoms your patient was having).

Small bowel obstruction occurs when there is a mechanical or functional blockage in the small intestine. The most common cause of SBO is intra-abdominal adhesions followed by hernias, Crohn disease, malignancy and volvulus. The obstruction leads to accumulation of gas, fluid and intestinal secretions proximal to the blockage causing distention. Identifying patients with small bowel obstruction who need operative intervention and those fail nonoperative intervention is challenging. Most non bowel obstructive are manageable by nonoperative. Malnutrition need to be monitored if patient went with operative management.

References in APA format:

Bower, K. L., Lollar, D. I., Williams, S. L., Adkins, F. C., Luyimbazi, D. T., & Bower, C. E. (2018). Small Bowel Obstruction. *The Surgical clinics of North America*, *98*(5), 945–971. https://doi.org/10.1016/j.suc.2018.05.007

PMH:

Essential hypertension, morbid obesity, seasonal allergic rhinitis, primary osteoarthritis of ankle, lumbar radiculopathy

PSH:

Back surgery, cholecystectomy, hysterectomy

Vitals: (X2 SETS) HT: 5’ 2” WT: 138 kg BMI: 55.8

	BP	HR	RR	T	O2 Sats/ Device Flowrate	Pain Scale/Ratings
Time: 0800	138/81	71	18	98.4	96%	5
Time: 1030	132/78	67	16	97.8	97%	5

Diet Ordered NPO Diet Status

Meal Intake %: B: 0 L: 0 D: 0

Oral Intake: 0

IV Intake: 0 Output: 0

Course of Present Illness: (brief synopsis of what brough pt in and what has gone on during hospitalization thus far).

Patient was admitted to hospital of small bowel obstruction due to hernia. Patient had constipation and presence of gases and no bowel movement in last 3 days and urine was last done one day ago. Abdominal edema was present and the patient was having CT of abdominal pelvis and tube placement of X-Ray tube feeding. Patient is in NPO diet status.

Anticipated Teaching Needs:

Patients need to educate small bowel obstruction of hernia and report if abdominal pain, lack of bowel movements, nausea, vomiting. Patient should know the purpose of tube feeding and progression from NPO diet to clear liquids and then advancing as bowel function returns. Patient should receive post operative care so that recurrence of hernia can be avoided in future.

Medications orders: (Medication*Dose*Frequency*Route*Classification*Indication *Nursing Actions*Patient Education).
. iopamidol (ISOVUE-370) 370 mg iodine/ml Dose: 149mL intravenous once in imaging: contrast
Class: nonionic, low-osmolar iodinated contrast media
Indication: enhances contrast to improve visualization of structures
Nursing Actions: assess for iodine or contrast allergy, evaluate renal function
Patient Education: encourage fluid intake
. piperacillin-tazobactam (ZOSYN) 4.5 g in sodium chloride 0.5% 100 mL IUPB (with adaptor)
Class: broad -spectrum penicillin antibiotic
Indication: serious bacterial infections (esp. Pseudomonas infections)
Patient education: report rash, diarrhea, or difficulty breathing immediately
: acetaminophen (OFIRMEV) injection 1000 mg: 400 mL/hr. intravenous: once
Class: non-opioid analgesic/antipyretic
Indication: mild moderate pain and fever
Nursing action: Monitor total daily dose and liver function
Patient education: do not exceed 4000 mg/day and avoid alcohol
: enoxaparin (LOVENOX) syringe 40 mg: subcutaneous every 12 hours
Class: anticoagulant
Indication: prevention/treatment of DVT/PE (deep vein thrombosis)
Nursing action: monitor for bleeding and platelet counts (risk of HIT)
Patient education: avoid injury and report unusual bleeding or bruising immediately
Pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9% (PF) 10 mL syringe 40 mg intravenous every 24 hrs. needed
Class: proton pump inhibitor
Indication: GERD and ulcers (gastroesophageal reflux disease)
Nursing action: monitor for symptom relief and long-term risks (low magnesium, fractures)
Patient education: take before meals and do not crush/chew tablets
: levothyroxine Synthroid tablet 25 mcg: oral: daily
Class: thyroid hormone replacement
Indication: Hypothyroidism
Nursing action: monitor TSH levels and for signs of hyperthyroidism
Patient education: take on empty stomach in morning and avoid taking with calcium and iron
: labetalol (Normodyne) injection 5mg intravenous every 4 hours PRN: high BP
Class: alpha-and -beta adrenergic blocker
Indication: hypertension
Nursing action: monitor BP/HR and hold if bradycardic
Patient education: change positions slowly and do not stop abruptly
: morphine injection 2 mg intravenous every 4 hours PRN severe pain (7-10)
Class: opioid analgesic
Indication; severe pain
Nursing action: monitor respiratory rate and level of consciousness
Patient education: avoid alcohol and report excessive sedation or breathing difficulty
Hydralazine (APRESOLINE) injection 10 mg intravenous every 6 hours PRN
Class: direct vasodilator
Indication: hypertension Nursing Action: monitor BP and heart rate Patient education: report palpitations, swelling, or joint pain

Pertinent Labs: Compare side by side the admit and most current Metabolic Panel and CBC. Write down **all** the values. Mark highs and lows with a **H** or **L**. Include any other relevant labs (UA, coags, etc) for your patient.

CBC	Admitting Date:	Recent Date:	CMP	Admitting Date:	Recent Date:	Other Relevant Labs:
WBC:	**8.8**	**12H**	Glucose:	**105**	105	
RBC:	5.32	**5.32**	BUN:	13	13	
Hgb:	14.1	**14.2**	Creatinine:	0.9	0.9	
HCT:	43.2	**44**	Sodium:	140	141	
MCV:	81.1	81	Potassium:	3.6	4.3	
MCH:	26.6	26.2	Chloride:	106	104	
MCHC:	32.8	32.4	Bicarb:			
RDW:	**16.9 H**	**16.9H**	Anion Gap:	8	**8**	
Platelet:	238	242	BUN/Cr ratio:			
MPV:	8.3	8.3	Osmolality Calc:			
Segs:			Calcium:	**8.8**	8.4	
Lymphocyte:	**1.5**	**1.5**	Total Protein:	7	7	
Monocytes:	**7.4**	7.4	Albumin:	4.2	4.2	
Eosinophils:	1.9	1.6	AST:	19	19	
Basophils:	0.9	**0.9**	ALT:	16	16	
			GFR:	>60	>60	

Abnormal Labs and Explanations:
The patient has high Red Cell Distribution Width which means significant variation in red blood cells a condition known as anisocytosis. It signals early-stage anemia, nutritional deficiencies or chronic conditions. High white blood cells mean immune system is reacting to inflammation, stress, or a bone marrow disorder.

Diagnostics (relevant imaging, diagnostic tests, etc.):
The patient underwent CT abdomen Pelvis with contrast which is to produce detailed images of organs, blood vessels and tissues. It is commonly used to diagnose appendicitis, diverticulitis, cancer, infections, and unexplained abdominal pain.

Any other labs/diagnostics you think would be relevant/helpful?
The blood culture can be helpful to rule out sepsis if obstruction is complicated by ischemia or perforation.

Assessment Key (Required to do Head-to-toe)

HEENT: Head-shape, tender, visible or palpable masses, hair texture and distribution; Eyes-visual impairment, wears glasses, contacts, conjunctiva clear, Ears-non-tender without discharge, hard of hearing, wears hearing aids; Nose-nares patent, nasal mucosa pink/moist, nasal septum midline; Throat/Mouth-oral mucosa is pink and moist, tongue description/movement, any lesions, redness, swelling

Neurological: Orientation x? (person, place, time, situation), level of consciousness (awake, alert, drowsy, sedated), Mental status (pleasant, angry, calm, cooperative, uncooperative, confused, withdrawn, restless, anxious) speech patterns/clarity, pupil size/PERRLA), limb movement (symmetrical/asymmetrical), gag reflex (if indicated), Glasgow coma scale

Cardiovascular: Auscultation of aortic, pulmonic, tricuspid, mitral area. Identify S_1, S_2. Assess for presence of S_3 and S_4 in mitral and tricuspid area. Assess for murmurs, rub, and sounds of prosthetic heart valves. Assess for regularity, quality, and characteristics of abnormal sounds, pulses (3-point scale), cardiac rate/rhythm; skin color, clubbing, capillary refill, skin temperature and texture, hair distribution, edema location RUE/LUE/RLE/LLE (grade), including sacral edema, pacemaker/implanted defibrillator.

Respiratory: Shape of thorax, symmetry of movement of the chest wall, use of accessory muscles of respiration, respiratory rate, pattern, depth, symmetry, position, cough (productive/nonproductive), presence and characteristics of sputum, expansion of chest, tracheal position, breath sounds, adventitious sounds (include phase heard, location, if clears with coughing. Oxygen modality (N/C, venturi, ect.), liter, SPO2%. Trach present, mechanical ventilation settings (mode, TV, FIO_2, rate, PEEP.)

Integumentary/Wounds: Braden scale, color, temp, moisture, turgor, rashes, scars, pressure ulcers, lesions/incisions-drainage, sutures, drains; IV/access: location, gauge/type, date inserted, appearance, patent, saline lock (SL) or continuous fluids-type and rate.

Gastrointestinal: mouth, mucous membranes, dentition (missing teeth, partial or full dentures); abdominal pain, bowel sounds (normoactive, hypo or hyperactive quadrants), date/describe last bowel movement, ostomy (type, assessment of stoma and effluent) If present: enteral feeding device & type/rate of feeding. Do they need help with feedings.

Genitourinary: External genitalia, presence of tubes/drains (catheters, ostomies), discharge, urine characteristics (color, clarity, amount), female LMP, breasts tender

Musculoskeletal: Morse fall risk, posture, gait and mobility (cane, walker, wheelchair, 1 or 2-person assist); range of motion, muscle strength (grade on 0-5 scale), deformities, amputation, activity tolerance.

Endocrine: If endocrine disorders are present such as Diabetes, etc. BS? Insulin orders? Other charting pertinent to specified endocrine disorder as needed

Psychosocial/spiritual/family: Mood, manner, speech, facial expression, family support/role in family, assistance at home, financial concerns, crisis of hospitalization, cultural/spiritual considerations

HEENT: Head is round, symmetrical and non-tender. No masses or lesions noted. Does not wear hearing aid. Pupils are PERRLA and size of pupil 4mm. Mucosa is pink and moist.

Neuro: Client is alert and orient *4. Patient is cooperative and supportive, calm.

Glascow Coma scale:15

CV: S1 and S2 are present at aortic, pulmonic, Erb's point, tricuspid, and mitral locations. No murmur or extra beats noted. Bilateral pulses are equal to 2+. Capillary refill is less than 2 seconds.

Resp: Breathing sounds are equal bilaterally and no adventitious sounds noted. SPO2 is 97% on room air. No use of accessory muscles noted.

Skin: Skin is warm and dry, no masses or lesions noted. IV site noted. Skin turgor is elastic without tenting. Skin color is according to ethnicity.

Braden score: 18

GI: Edema present in abdomen. Abdomen is hard with presence of gases because of bowel obstruction. Bowel movement 3 days ago. Stool was brown color kind of diarrhea.

GU: Reports patients urinate yesterday without any pain and normal color of urine.

MSK: Grip strength is slightly weak. Strength is equal bilaterally 4/5 in both upper extremities and lower extremities.

Morse Fall Risk score: 22 (Low Fall Risk)

END: None

Psychological: Patient is alert and consciousness. Speech is clear and normal.

What assessment findings are the most concerning? Provide rationale.

The most concerning is edema of abdomen or swollen abdomen because of presence of gases and bowel obstruction. This can increase the risk for compromised organ function, impaired ventilation and decreased perfusion.

What additional assessments might be needed?

Close monitoring and further diagnostic evaluation are strongly indicated. Assess for associated symptoms such as nausea, vomiting, constipation, and inability to pass gas, can worsen the condition.

Identify the patient's priority problem. (Use PES format)

Constipation related to small bowel obstruction as evidence by patient report no bowel movement for last 2 days and gases formation on abdomen.

Priority Nursing Interventions (2 interventions for each SMART goal)-include rationales for each.

SMART Goal #1. Patient will have at least one bowel movement within 8 hours.

Evaluation: Goal not met, patient did not have any bowel movement at the end of the shift.

Interventions for Goal #1.

1a. Nurse will help patient to ambulate slowly in the room or hallway.

Rationale: Walking will promote peristalsis.

1b. Nurse will assist the patient to reposition side to side in bed every 2 hours

Rationale: Frequent repositioning helps promote the movement of intestine gas and contents which can reduce abdominal distention.

SMART Goal #2. Patient will report pain reduced from 5 to 1 or none within next 8 hours.

Evaluation: Goal met, patient report pain level of 1 or none within 8 hours of the shift.

Interventions for Goal #2. Nurse will position patient in Semi-Fowler's position

2a. Nurse will position patient in Semi-Fowler's position

Rationale: It helps to decrease abdominal pressure and discomfort.

2b. Nurse will assess pain regularly using scale

Rationale: It helps to track pain progression and response.

Identify the patient's priority problem. (Use PES format)

Abdominal distention related to accumulation of gas and intestinal contents secondary to bowel obstruction as evidenced by firm and swollen abdomen.

Priority Nursing Interventions (2 interventions for each SMART goal)-include rationales for each.

SMART Goal #1. Patient will demonstrate a decrease in abdominal grith by at least 1- 2 cm from baseline measurement within 8 hours

Evaluation: Goal met as patient abdominal grith decreased by 1 inch within 8 hours.

Interventions for Goal #1.

1a. Nurse will measure abdominal grith using a tape measure every 2 to 4 hours at the same location

Rationale: consistent techniques help in mearing accurate and reliable data to detect any changes in distention.

1b. Nurse will assess abdomen for firmness, tenderness and distention and help to perform kind of light exercises.

Rationale: Light exercises help the patient in bowel movement.

SMART Goal #2. Patient will demonstrate the importance of NPO status and IV fluid infusion during the shift.

Evaluation: Goal met as the patient demonstrate the importance of NPO status and infusion in abdominal distention

Interventions for Goal #2.

2a. Nurse will keep patient NPO as prescribed and reinforce education.

Rationale: Patient education is important for further prevention of accumulation of intestinal contents.

2b. Nurse will monitor IV fluid rate and ensure proper infusion

Rationale: It helps for bowel function and maintain hydration despite NPO status.

Identify any additional complications/concerns you would anticipate for this patient. What are some interventions that can prevent these complications?

The patient would have many complications with NPO status because of bowel obstruction. One major concern is dehydration and fluid volume deficit due to lack of oral intake. The nurses should monitor intake and output, assess vital signs, and administer IV fluids as prescribed. The patient is also risk at electrolyte imbalance such as low potassium and low sodium which require close monitoring of laboratory value and cardiac status. The nurse should also monitor for worsening abdominal pain, distention, fever, or changes in bowel sound. Prolonged NPO status can lead to malnutrition so nutritional status should be monitored and alternative nutrition such as Total Parental Nutrition should be considered if needed.

Reflection-What items require further monitoring or intervention? What would you do differently in the future? What skills can you improve on to better care for future patients?

Patient education and emotional support is also needed for patient to recover faster. Patient also need to be monitored to prevent further secondary complications such as skin breakdown, venous thromboembolism and decreased mobility. I would also ensure skin assessments and repositioning of client every 2 hours.

Student Name: Clinical Instructor:

NURS 3605 Nursing Concept Map Grading Rubric

Page 1 & 2	Points Possible
Patient Info	5
Demographic Data: (Admit Date, Age, Sex, Race)	1
Allgeries, Code Status	1
Support and Discharge Planning/ Needs	1
Advanced Directives	1
Admitting Diagnosis	1
Patho	6
PMH/PSH	2
Vitals/Measurements	7
Ht/Wt/BMI	1
Vitals (2 sets)	2
Pain/Scale used	1
Intake/Output	2
Diet	1
Course of Present Illness/Pt teaching	3
Meds	6
Name and Classfiication	1
Intended Use	1
Side Effects	1
Nursing Interventions	3
Labs/Diagnostics	6
2 sets minimum, Explain Abnormals	4
Relevant Diagnostics (imaging, xrays)	1
Other labs / diagnostics you think would be relevar	1

Page 3	Points Possible
Patient Charting	17
HEENT	1
Neuro	1
Glasgow Coma Scale	1
CV	1
Respiratory	1
Skin	1
Braden Scale	1
GI	1
GU	1
MSK	1
Morse Fall Scale	1
END	1
Psychosocial	1
Focused Assessment	1
Concerning Findings/Priority	2
Rationale	1

Instructor notes on charting:

Care Plan: Page 4/5

Nursing Diagnosis 1	5
Priority Problem	1
Appropriate for patient	1
Written in correct format	3
SMART goal 1	5
Follows SMART criteria; Appropriate for ND	3
Evaluation (Met/Unmet)	1
Student Observation of outcome	1
Interventions (2 per goal)	4
Appropriate for patient/goal	2
Rationale	2
SMART goal 2	5
Follows SMART criteria; Appropriate for ND	3
Evaluation (Met/Unmet)	1
Student Observation of outcome	1
Interventions (2 per goal)	4
Appropriate for patient/goal	2
Rationale	2
Anticipated Complications	1
Reflection	1
Days Late (-10 points per day)	

Nursing Diagnosis 2	5
Priority Problem	1
Appropriate for patient	1
Written in correct format	3
SMART goal 1	5
Follows SMART criteria; Appropriate for ND	3
Evaluation (Met/Unmet)	1
Student Observation of outcome	1
Interventions (2 per goal)	4
Appropriate for patient/goal	2
Rationale	2
SMART goal 2	5
Follows SMART criteria; Appropriate for ND	3
Evaluation (Met/Unmet)	1
Student Observation of outcome	1
Interventions (2 per goal)	4
Appropriate for patient/goal	2
Rationale	2
Student Grade	

***Up to 5 points may be deducted for lack of cohesiveness throughout; missing informatic**