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Constipation with immobility Response monitoring

Nursing Foundation | Response monitoring

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

65-year-old man recovering from a fracture. Care stage: During review after prescribed initial care.

Medical history: The bowel pattern was regular before the fracture. Activity and oral intake have fallen during recovery, and the medicine list requires review for constipating agents. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

Clinical assessment

Subjective: Hard stools, straining and no comfortable bowel movement for several days.

Objective findings and required checks: Reduced activity and low intake; abdominal examination has no acute red flags in this scenario.

Physical examination and investigations: Review bowel chart, abdominal findings, medication list and investigations if obstruction or secondary causes are suspected.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Constipation with immobility: Reduced mobility, altered intake and some medicines slow stool transit.

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Medical / surgical management

Exclude red flags; support privacy, safe activity, appropriate fluids and the prescribed bowel regimen.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed osmotic laxative	Soften stool and support bowel movement	Monitor response, diarrhea and hydration
prescribed stool softener	Support comfort when indicated	Review ongoing need and bowel pattern.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Hard stools, straining and no comfortable bowel movement for several days. Reduced activity and low intake; abdominal examination has no acute red flags in this scenario. The team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

Nursing diagnosis

Prioritize bowel pattern disrupted by illness or reduced activity; pain interfering with rest or activity; movement limited by weakness, discomfort or restriction; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

At the next scheduled reassessment, with its interval chosen for acuity: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Exclude red flags; support privacy, safe activity, appropriate fluids and the prescribed bowel regimen. Compare the current assessment with the documented baseline and identify benefit, harm or lack of response. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Compare the current assessment with the documented baseline and identify benefit, harm or lack of response.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about stool frequency, consistency, pain and usual bowel pattern. Assess: Assess abdominal findings, bowel records and signs of obstruction or dehydration.	Bowel pattern disrupted by illness or reduced activity. Possible factors: altered intake, motility or medicine effects. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Bowel-related discomfort decreases without new red-flag findings. Longer-term: Before the clinically approved transition or agreed follow-up: Describes an appropriate bowel routine and when to seek review.	1. Assess abdominal red flags before routine bowel measures. Rationale: Severe pain, distension or vomiting may indicate urgent pathology. 2. Support privacy, mobility and the prescribed food and fluid plan. Rationale: An individualized routine supports comfortable elimination. 3. Administer prescribed treatment and document stool response. Rationale: Response monitoring helps prevent undertreatment and adverse effects. 4. Exclude red flags; support privacy, safe activity, appropriate fluids and the prescribed bowel regimen. Rationale: Reduced mobility, altered intake and some medicines slow stool transit. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about pain site, onset, severity, quality and the	Pain interfering with rest or activity. Possible	Short-term: At the next scheduled reassessment, with its interval chosen	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	for acuity: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Explains the most important immediate action in their own	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale:	Record the baseline and reassessed finding, the time and whether this goal is met,

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
identify specific gaps.	prior teaching. Validate against the patient's assessment.	words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Discuss a regular bowel routine, food and fluid advice suited to the condition and avoiding unsupervised laxative escalation. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Discuss a regular bowel routine, food and fluid advice suited to the condition and avoiding unsupervised laxative escalation.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Severe abdominal pain, vomiting, marked distension or inability to pass flatus needs urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Reduced mobility, altered intake and some medicines slow stool transit.

- Priority concerns: Bowel pattern disrupted by illness or reduced activity; Pain interfering with rest or activity; Movement limited by weakness, discomfort or restriction; Learning needs about the condition and care plan.

- Severe abdominal pain, vomiting, marked distension or inability to pass flatus needs urgent review.

- Discuss a regular bowel routine, food and fluid advice suited to the condition and avoiding unsupervised laxative escalation.

Exam / viva: Which observations demonstrate response, and which findings would require revising or stopping the current intervention?

References

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