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Intestinal obstruction Initial assessment

Adult Health Nursing | Initial assessment

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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

62-year-old woman with suspected bowel obstruction. Care stage: At the first supervised assessment.

Medical history: Abdominal pain, vomiting and failure to pass stool or flatus developed during the current episode. The fictional history includes a remote abdominal operation, making adhesions one possible cause for surgical assessment. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: A remote abdominal operation is reported; the surgical team is evaluating the cause of obstruction. 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 patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Colicky abdominal pain, vomiting and inability to pass stool or flatus.

Objective findings and required checks: Distension and reduced intake; dehydration and aspiration risk require assessment.

Physical examination and investigations: Review abdominal imaging, electrolytes, renal function, observations and surgical evaluation.

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

Clinical focus and pathophysiology

Intestinal obstruction: Mechanical blockage or loss of motility prevents normal intestinal transit.

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Medical / surgical management

Follow prescribed fasting, decompression and fluid plans; monitor losses and signs of ischemia or perforation.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed IV fluid/electrolytes	Replace assessed losses	Monitor fluid status and laboratory trends
prescribed antiemetic	Manage nausea when indicated	Monitor effect without delaying assessment of deterioration.

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

Nursing process - ADPIE

Assessment

Colicky abdominal pain, vomiting and inability to pass stool or flatus. Distension and reduced intake; dehydration and aspiration risk require assessment. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize insufficient fluid replacement for current losses; pain interfering with rest or activity; bowel pattern disrupted by illness or reduced activity; 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

After the first indicated intervention, at the documented review time: 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

Follow prescribed fasting, decompression and fluid plans; monitor losses and signs of ischemia or perforation. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. 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 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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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 thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition. 4. Follow prescribed fasting, decompression and fluid plans; monitor losses and signs of ischemia or perforation. Rationale: Mechanical blockage or loss of motility prevents normal intestinal 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.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: 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.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication 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.	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 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: After the first indicated intervention, at the documented review time: 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.	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	Learning needs about the condition and care plan. Possible	Short-term: After the first indicated intervention, at the	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	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
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: 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. Explain decompression and treatment, then individualized diet and recurrence advice after resolution. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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.

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Health education and continuing care

Explain decompression and treatment, then individualized diet and recurrence advice after resolution.

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

Continuous severe pain, peritonism, fever with shock or reduced consciousness is urgent.

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

- Mechanical blockage or loss of motility prevents normal intestinal transit.

- Priority concerns: Insufficient fluid replacement for current losses; Pain interfering with rest or activity; Bowel pattern disrupted by illness or reduced activity; Learning needs about the condition and care plan.

- Continuous severe pain, peritonism, fever with shock or reduced consciousness is urgent.

- Explain decompression and treatment, then individualized diet and recurrence advice after resolution.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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