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Insufficient fluid replacement for current losses Intestinal obstruction

Adult Health Nursing | Focused diagnosis-based template

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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.

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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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: At the next patient-specific reassessment: 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Health Alterations - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/healthalts/

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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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