

Ileus

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	<p><b>Acute pain</b>  <b>Related factors:</b>                      Bowel obstruction  <b>Symptoms / Risk factors:</b>                      Changes in appetite and eating                      Facial mask                      Abnormal Bowel sounds                      Constipated and unable to pass flatus                      Crampy pain                      Abdominal distention  <b>Outcome / Goal:</b>                      Patient appears relaxed and comfortable                      Patient verbalizes relief of pain</p>		<p><b>Pain Management</b>                      Asses cause of pain                      Instruct patient to relax and rest                      Optimize the patient's comfort in bed  <b>Analgesic Administration</b>                      Administer medication as prescribet                      Obs. pain (effectivnes of medication)</p>	
	<p><b>Risk for deficient fluid volume</b>  <b>Related factors:</b>                      Fasting                      Vomiting                      Diarrhea  <b>Symptoms / Risk factors:</b>                      Excessive losses through normal routes (e.g., diarrhea)                      Deviations affecting access, intake, or absorption of fluids                      Lowered blodpressure and tachycardia                      Oliguria                      Electrolyte imbalance  <b>Outcome / Goal:</b>                      Patient will maintain balanced fluid intake and output                      Normal vital signs</p>		<p><b>Fluid Management</b>                      Restrict oral intake until vomiting stops                      Maintain intravenous infusion as prescribed                      Monitor and record patient's intake (IV) and output (urin)                      Provide fluid po if prescribet  <b>Vital Signs Monitoring</b>                      Monitor patient's vital signs every ___hours                      Monitor urine output  <b>Urinary Catheter care</b>                      Check the drainage tube frequently to make sure it is not kinked.                      Keep the urinary drainage bag below the level of the bladder                      Remove catheter as soon as possible  <b>Intravenous (IV) Therapy</b>                      Change IV tubing every __ hours to prevent contamination                      Obs dressing and change if necessary (as prescribet)                      Observe for potential complications</p>	
	<p><b>Imbalanced nutrition: Insufficient</b>  <b>Related factors:</b>                      Bowel obstruction  <b>Symptoms / Risk factors:</b>                      Aversion to eating                      Weight loss                      Nausa and Vomiting  <b>Outcome / Goal:</b>                      Patient will maintain balanced intake and output</p>		<p><b>Nutrition Management</b>                      Assess overall nutritional status                      Consult a dietitian                      Assess current timing and content of meals.                      Suggest the patient take small bites of food                      Monitor weight ____.                      Offer antiemetics as prescribed</p>	
	<p><b>Activity intolerance</b>  <b>Related factors:</b>                      Bed rest or immobility                      Weakness                      Fear and pain  <b>Symptoms / Risk factors:</b>                      Verbal report of fatigue or weakness                      Inability to perform ADLs  <b>Outcome / Goal:</b>                      Patient maintains activity level within capabilites</p>		<p><b>Teaching: Prescribed Activity/Exercise</b>                      Encourage activity as tolerated, rest as needed                      Obs. symptoms(comfort,vital sign and skin color) of patients activity</p>	