**NURSING CARE PLAN**

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>DIAGNOSIS</th>
<th>INFERENCE</th>
<th>PLANNING</th>
<th>INTERVENTION</th>
<th>RATIONALE</th>
<th>EVALUATION</th>
</tr>
</thead>
</table>
| **Subjective:**  
“Nagsusuka ako” as verbalized by patient.  
**Objective:**  
- Hyperactive bowel sounds.  
- Pale conjunctiva and mucus membrane.  
- V/S taken as follows:  
  T: 36.6  
P: 98  
R: 18  
Bp: 110/90 | **Nutrition imbalanced less than body requirements related to nausea and vomiting.**  
**Nausea and vomiting are not diseases, but rather are symptoms of many different conditions, such as infection (“stomach flu”), food poisoning, motion sickness, overeating, blocked intestine, illness, concussion or brain injury, appendicitis, and migraines. Nausea and vomiting can sometimes be symptoms of more serious diseases such as heart attacks, kidney or liver disorders, central nervous system disorders, brain tumors, and some forms of cancer.** | **After 3 days. Of nursing interventions, the client will be able to maintain usual weight.**  
**Independent:**  
- Auscultate bowel sounds, noting absence or hyperactive sounds.  
- Eliminate smells from the environment.  
- Avoid foods that might cause or exacerbate abdominal cramping like caffeinated beverages, chocolate, orange juice.  
- Measure abdominal girth.  
- Observe skin or mucous membrane dryness, and turgor. Note peripheral edema  
- Inflammation or irritation of the intestine may be accompanied by intestinal hyperactivity, diminished water absorption and diarrhea.  
- Reduces gastric stimulation and vomiting response.  
- Might increase abdominal cramping. |  
- Inflammation or irritation of the intestine may be accompanied by intestinal hyperactivity, diminished water absorption and diarrhea.  
- Reduces gastric stimulation and vomiting response.  
- Might increase abdominal cramping.  
- Provides quantitative evidence of changes in gastric or intestinal distention.  
- Hypovolemia, fluid shifts and nutritional deficits contribute to poor skin | After 3 days. Of nursing interventions, the client will be able to maintain usual weight. |
and sacral edema.
- Assess abdomen frequently for return to softness, appearance of normal bowel sounds, and passage of flatus.
- Weigh daily.

**Collaborative:**
- Monitor BUN, protein, prealbumin or albumin, glucose, nitrogen balance as indicated.
- Advance diet as tolerated.

**Indicates return of normal bowel function and ability to resume oral intake.**
- Initial losses or gains reflect changes in hydration.
- Reflects organ function and nutritional status and needs.
- Careful progression of diet when intake is resumed reduces risk of gastric irritation.
Collaborative:
  - Refer to physical therapy.