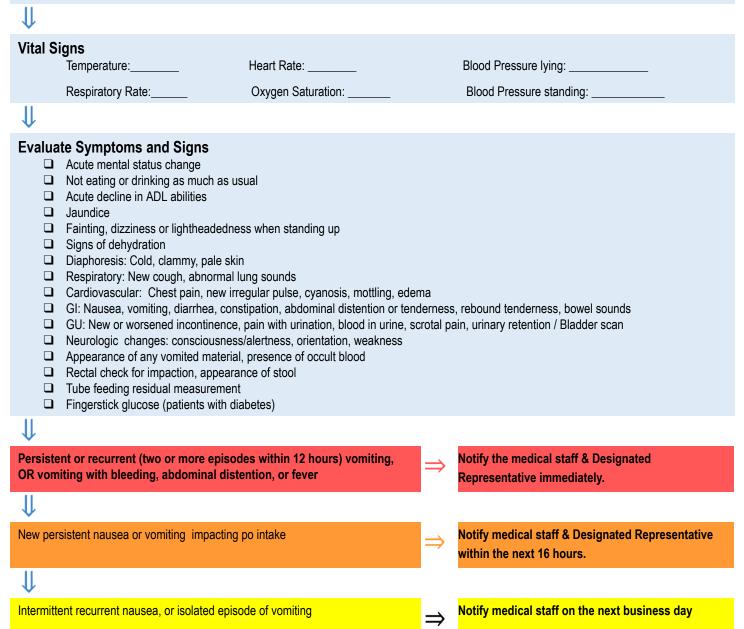
Nausea / Vomiting

Causes

- Common: Constipation, fecal impaction, gastroenteritis, gastroparesis, medications
- Less common: Obstruction, diverticulitis, cholecystitis, pancreatitis, ulcers, food poisoning, kidney stones, UTI, kidney failure, metabolic derangement, liver failure, cancer, increased intracranial pressure, pneumonia

Goal is to identify and treat the underlying cause of the nausea / vomiting.



Continued on Next Page

Nausea / Vomiting Continued

SBAR Report	
Situation: "(Nausea) (Vomiting), associated with:" (fever) (other acute symptoms)	
Background: Report	Have Available
Reason the patient is in the nursing home (rehab for, long term care for	☐ Chart / logged in to Electronic Medical Record☐ MAR
 When the symptoms started, vomiting frequency and amount, getting worse or staying the same, alleviating or aggravating factors, what treatments have been used. 	 □ Recent medical problems & order changes □ Major diagnoses □ Allergies
 □ Abnormal Vital Signs based on patient's previous values □ MOLST / Advance Directives □ Percent illness surrory antibiotics medication changes falls 	☐ Recent lab results & previous results if abnormal☐ Intake record
 Recent illness, surgery, antibiotics, medication changes, falls General observation of patient condition Appearance of vomited material, presence of blood 	Bowel recordList of emergency medications available in the facility
■ Bowel record for the last week, including prn medication use	
 Diet restrictions, Fluid restriction, thickened liquids Similar symptoms in other patient(s) on unit or in facility 	
☐ Tube feeding rate, water flush orders, residual measurements, recent	
changes Availability of IV or clysis hydration (i.e., PICC line)	
Assessment: I think the problem is:	
I am concerned about:	
Recommendations/Requests: ☐ Labs: CBC with manual diff, Lactic Acid, ☐ Straight catheterization for urine sample ☐ Nausea Medication	
CMP/Chem14, Amylase, Lipase, Drug for urinalysis and culture (unle levels is able to collect clean-catch, r	
☐ X-ray abdomen or free air series urine)	blood pressure
☐ Ultrasound abdomen☐ Stool for occult blood testing☐ Diet change	
□ IV or SC (clysis) fluids □ Other:	
Clarify expectations for care, interventions, and illness course/prognosis. Repeat any telephone orders back to the provider to ensure that they are correct and complete	
\Downarrow	
Management ☐ Monitor vital signs, fluid intake/urine output every 4-8 hrs for 2-3 days ☐ Offer fluids frequently if nausea/vomiting allow	
☐ Place on Intake & Output monitoring	
□ Place on 24-hour report for 2-3 days□ Record all episodes of vomiting or diarrhea	
 Obtain lab results (if ordered), and notify medical as needed of: Significantly abnormal values in lab tests (refer to appropriate Situation) 	
☐ WBC > 12,000 or neutrophils > 90%	
Abnormal X-ray resultsUrine results suggest infection and symptoms or signs present (Refer to "UTI" Situation)	
☐ Monitor meal acceptance	
☐ Assure bowel regularity☐ Clear liquid diet	
☐ Resume normal diet and discontinue prn nausea medications when symptoms are resolved	
 Implement infection control measures if indicated Update care plan regarding fall risk, pressure ulcer prevention, assistance needed with ADLs, supervision for safety, restorative needs 	
Review status and plan of care with designated representative daily	

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