

**MARGARET H. ROLLINS SCHOOL OF NURSING
N101 Care Plan Form**

Student Name: Janiyah McGriff

General Information

Patient Initials: ES
Dr.Rualo

Date(s) of Care: 9/23/25- 9/24/25

Clinical Instructor: Mrs. Lagano

Attending physician:

Reason for admission/Medical Diagnosis: Dehydration

Allergies: Nuts, Latex, Penicillin
Age: 63

Admission Date: 10/2/25

Date of Birth:

Primary Nursing Diagnosis & Clinical Reasoning	Additional Pertinent Nursing Diagnoses
Dehydration- Related to nausea and vomiting secondary to chemotherapy as evidenced by dry mucous membranes, sluggish skin turgor, dark concentrated urine, and 7lb weight loss.	Impaired Skin Integrity- Related to immobility and poor nutritional status as evidenced by stage 1 sacral pressure injury.
	High Fall Risk- Related to weakness and dizziness from dehydration and drowsiness from prochlorperazine.
Expected Outcome (s)	Assigned Medications & IVF (dose, frequency, route)
Mrs. ES will maintain urine output > 30mL/hr. during my time of care.	Prochlorperazine 10mg 1 tab PO every 6 Hours PRN for nausea/ vomiting.
Mrs. Es will report moist mucous membranes and improved skin turgor by the end of my care.	0.9% NSS with 20 MEQ KCL- IV at 100mL/hr. continuously
Mrs. Es will tolerate at least 100mL of oral fluids without vomiting during my care.	
Mrs. ES will remain free from falls and further skin breakdown during my care.	
Patient care orders (treatment, diagnostic studies, labs, etc.).	
CT scan- To rule out abdominal obstruction.	Telemetry Monitor- Continuous Cardiac Monitoring, change electrodes daily.
Chest X-Ray-Evaluate for possible spread of cancer in the lungs.	Vital Signs- Every 4 hours
Oncologist- Management of chemotherapy regimen.	Intake & Output- Every 8 Hours
Nutritionist- Address weight loss and poor nutritional intake.	Assess Braden and Morse Scores- Each shift
Case Manger- Routine assessment and discharge planning.	Diet- Clear liquid diet, high-protein clear supplement with each meal.

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Physical Therapy/ Occupational Therapy- Evaluate weakness, promote safe mobility.	
CBC w/ auto differential daily x3 day	
Basic Metabolic Panel daily x3 day	

Data Collection (Mandatory Satisfaction Completion)
(for each day of care)

Day 1 *(can include pertinent data prior to your day of care)*

<p>Day 2</p> <p>Subjective: “I feel so weak; I don’t want to fall.” “I’m thirsty but I don’t know what to drink.” Reports nausea and dry mouth.</p> <p>Objective: Dry oral mucosa, sluggish skin turgor, dark concentrated urine (30mL output at 1710), BP 90/60, HR 110, clear liquid diet, IV fluids running at 100mL/hr., Stage 1 sacral pressure injury, Braden 19, Morse 45.</p> <p>Own assessment: Labs & Diagnostics (include interpretation): Na+: 133mEq/L Consistent with dehydration and fluid loss from vomiting, K+: 3.3mEq/L Mild hypokalemia losses likely from vomiting, Cl-: 98mEq/L Within Normal Range, BUN: 38mg/dL Elevated, indicating decreased renal perfusion from dehydration, Creatinine: 1.9mg/dL Elevated suggest acute kidney stress from fluid deficit, CO2: 27mEq/L Normal, Glucose: 92mg/dL Normal, WBC: Slightly elevated might reflect mild inflammatory response from chemotherapy, Hgb: 9.4g/dL Low consistent with chemotherapy related anemia, Hct: 27% Low, aligns with Hgb, Platelets: Normal, Calcium: 8.4mg.dL slightly low related to poor intake.</p>	<p>Subjective: Patient reports, “My mouth feels better,” after oral care and “ I feel less dizzy.”</p> <p>Objective: Oral mucosa moist, tolerated 230mL oral fluids without emesis, skin turgor improved, urine output adequate >30mL/hr. No progression of pressure injury, no falls observed.</p> <p>Own assessment: Labs & Diagnostics (include interpretation): Na+: 136mEq/L, K+: 3.8mEq/L, Cl-: 101mEq/L, BUN: 24mg/dL, Creatinine: 1.3mg/dL, CO2: 26mEq/L, glucose 94mg/dL, Hgb 9.2g/dL, Hct 28%, calcium 8.6mg/dL. Day 2 labs show improvement in hydration normalized electrolytes and decreased BUN/Creatinine, indicating the IV therapy and oral fluids were effective. Chemotherapy related anemia persists but remains stable.</p>
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Nursing Assessments <i>(Include Timeframes)</i>	Rationale
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<ol style="list-style-type: none"> 1. Measure and record intake and output each shift or every 8 hours. 2. Assess mucous membranes and skin turgor each shift. 3. Monitor daily weight. 4. Assess nausea level using 1-10 scale before and after administering antiemetic. 	<ol style="list-style-type: none"> 1. Provides accurate data on hydration status and kidney function; low output < 30mL/hr. may indicate worsening dehydration or renal impairment. 2. Identifies signs of dehydration (dryness, poor elasticity) and evaluates improvement as fluids are replaced. 3. Indicator of fluid balance; sudden changes reflect fluid loss or retention. 4. Evaluates medication effectiveness and helps determine readiness for oral intake.
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Nursing Interventions <i>(include timeframes)</i>	Rationale <i>(relate how NIs will help correct ND)</i>
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<ol style="list-style-type: none"> 1. Encourage small, frequent sips of clear fluids as tolerated. 2. Administer prescribed IV fluids to maintain hydration (0.9% NSS+KCL) at 100mL/hr.) 3. Offer cool mouth care and ice chips every 2 hours. 4. Educate patient on pacing oral intake after nausea subsides; and provide antiemetic before meals as needed. 5. Collaborate with provider, dietitian, and physical therapy if vomiting and weakness persist. 5. Collaborate with provider and nutritionist if persistent vomiting occurs despite antiemetic. 	<ol style="list-style-type: none"> 1. Gradual rehydration minimizes nausea and promotes fluid balance. 2. Restores circulating volume and correct electrolyte imbalances. 3. Moistens mucous membranes, relieves discomfort, and encourages oral intake. 4. Prevents vomiting and supports gradual return to normal intake. 5. Interdisciplinary care ensures comprehensive management of dehydration, nutrition, and mobility.
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Evaluation Summary

<p>1. For each expected outcome, answer the following:</p> <p>(a) Are expected outcomes realistic and met?</p> <p>(b) Will they remain the same or change?</p> <p>(c) Why?</p>	<p>2. Did NIs change or remain the same? If changed, state why. The Nis mostly remained the same; ongoing monitoring of intake/output, skin turgor, and mucous membranes continued to be effective. Oral fluid encouragement was increased as the patient's nausea improved. Interventions were adjusted to promote gradual oral hydration as patient tolerated fluids better.</p>
<p>a.</p> <p>1.</p>	<p>3. Does the ND still exist and why?</p> <p>Yes, the ND of dehydration does still exist but it is improving. Skin turgor is still slightly sluggish, and the</p>
<p>b.</p>	

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	patient remains at risk for fluid deficit due to ongoing chemotherapy-related nausea and decreased oral intake. Continued monitoring and fluid management are needed to fully resolve the problem.
c.	

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Nursing Care Plan Grading Rubric

Topic	Criteria	Satisfactory = 1 point	Unsatisfactory = 0 points	Category Total
General Information	<ul style="list-style-type: none"> All general information filled out correctly and completely. All assigned medication orders included and complete. All current doctor's orders included. <i>(dates of care and standing orders)</i> All IV fluids must be included. 	Meets 3 or more of the elements described in criteria.	Meets 2 or less of the elements described in criteria.	
Nursing Diagnosis/Problem List	<ul style="list-style-type: none"> Highest priority nursing diagnosis is correct. Clinical reasoning is listed & correlates to priority problem. Other pertinent nursing diagnoses are listed. Priority order is correct >50% of the time. 	Meets 3 or more of the elements described in criteria.	Meets 2 or less of the elements described in criteria.	
Expected Outcomes	<ul style="list-style-type: none"> EO's are included for top priority problem. EO's are specific, realistic, measurable, written in terms of patient behavior, and include a time frame >50% of the time. EO's are relevant to patient problem >50% of the time. 	Meets 2 or more of the elements described in criteria.	Meets 1 or less of the elements described in criteria.	
Data Collection (Mandatory Section)	<ul style="list-style-type: none"> Subjective and objective data included for each day. Own assessment included for each day. Relevant diagnostic studies and labs included and interpreted correctly >50% of the time. Relevant data included to support patient problem >50% of the time (i.e.: VS, I&O, ht. wt., etc.). Data concise, summarized, organized in chronological order. 	Meets 4 or more of the elements described in criteria.	Meets 3 or less of the elements described in criteria.	
Nursing Interventions	<ul style="list-style-type: none"> Nursing assessments with rationale included >50% of the time. Five NI's with time frames & rationales are included. NI's are individualized, realistic & include a time frame >50% of the time. Rationale correct, complete & specifically written to help correct patient problem >50% of the time. 	Meets 3 or more of the elements described in criteria.	Meets 2 or less of the elements described in criteria.	
Evaluation Summary	<ul style="list-style-type: none"> All three evaluation questions are addressed. Conclusions for each question are correct >50% of the time. 	Meets 1 or more of the elements described in criteria.	Does not meet either element described in criteria.	
Format	<ul style="list-style-type: none"> No more than 3 misspellings or grammatical errors. No more than 3 errors in medical terminology. Printed single-sided for submission to instructor. Grading Rubric printed and attached as separate page. 	Meets 3 or more of the elements described in criteria.	Meets 2 or less elements described in criteria.	
Grading Scale		<u>6-7 = Satisfactory</u>	<u>0-5 = Unsatisfactory</u>	Total Score <hr style="width: 100px; margin: 0 auto;"/>