MARGARET H. ROLLINS SCHOOL OF NURSING

N101 Care Plan Form

Student Name_____Suzette_____

General Information

Patient Initials: E.S **Date(s) of Care:** **Clinical Instructor:** **Attending physician: DR. Raulo**

Reason for admission/Medical Diagnosis: Dehydration

Allergies: Nuts, latex, penicillin **Date of Birth: 01/01/1962** **Age: 63** **Admission Date: 9/23/25**

Primary Nursing Diagnosis & Clinical Reasoning	Additional Pertinent Nursing Diagnoses
- **Insuffienient fluid volume**	- Impaired Gas exchange as evidence by crackles in all lung fields bilaterally
- Clinical Reasoning: due to hypotension BP: 104/68 and sluggish skin turgor	
- **Fall Risk**	
- Clinical Reasoning: morse fall score 45, out of bedside with assist, weak, dizzy, drowsy	
Expected Outcome (s)	**Assigned Medications & IVF** *(dose, frequency, route)*
- E.S BP will improve to > 100 with increase fluid intake	- Prochlorperazine 10mg 1 tab PO Q 6 hrs. PRN for nausea and vomiting
- E.S will stop vomiting by end of my care	- 0.9% NSS w/ 20 mEq KCL 1000mL: Run 100 mL/hr (10 hours)
- E.S will not fall during my time of care	
- E.S will demonstrate the proper use of a call bell and not get up without assistance during my care	
Patient care orders *(treatment, diagnostic studies, labs, etc.).*	
- CBC w/ auto diff daily x 3 days	Dietary Consult (pt appears emaciated 73kg before chemo now 70kg due to inability to eat/drink due states no appetite)
- Basic Metabolic Panel	Chest x-ray (no evidence of infiltrates right lower lobe 4 cm mass consistent with lung cancer) 9/23/25
- CT (to rule of evidence of obstruction) 9/23/25	

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Data Collection (Mandatory Satisfaction Completion) *(for each day of care)*	
Day 1 *(can include pertinent data prior to your day of care)*	***Day 2***
Subjective: E.S Staes "I'm weak and don't want to fall", I don't have to use the bathroom right now" **Objective: Complains of intractable Nausea/Vomiting and weight loss after recent round of chemotherapy, skin intact but reports dryness, oral mucosa is dry** **Own assessment:** sluggish skin turgor in all extremities, Hypotensive 104/68 HR: 98, O2 99% on RA, RR:20, Temp:37.7 abdominal pain 2/10 , + 1 pedal pulse weak/thready, complains of generalized weakness, up with assistance **Labs & Diagnostics *(include interpretation)*:** CBC **WBC: 4.0, HgB:11, Plt's :95, HCt: 37.2** **BMP: Na 132 ↓, Cl 85 ↓, K 3.3 ↓, CO_2 27, BUN 87 ↑, Cr 1.8 ↑, GFR 27 ↓** **Albumin 3.2 ↓, Total protein 6.0 low-normal**	**Subjective: "Pt states I have to use the bathroom"** **Objective: Still C/O of weakness and antiemetics are not effective, decreased appetite and 4 episodes of emesis since admit (clear -light brown not projectile but associated with eating or drinking), urine darker than normal, skin tenting and pallor** **Own assessment**: Void 50ml dark yellow urine, + 2 bilaterally (carotid), crackles in all lung fields, skin slow to recoil, voided 50 mL of dark yellow urine, BP: 94/62, HR:90, Oz 97% on RA., RR:20 **Labs & Diagnostics *(include interpretation)*: WBC: 3.0, HgB:12, Plt's :90, HCt: 38** Decrease in WBC due to bone marrow suppression from chemo and drop in HGB/HCT due to anemia causing weakness and fatigue also from chemo killing good and bad cells **Na 130 ↓, Cl 83 ↓, K 3.2 ↓, CO_2 29 ↑, BUN 90 ↑, Cr 1.9 ↑, GFR 27 ↓** Sodium and chloride dropped signs of further electrolyte imbalance. BUN/Cr rising indication decrease renal function consistent with dehydration **Albumin 3.3 ↓, Total protein 5.8 ↓:** decrease albumin reflects poor nutrition and decreased intake
Nursing Assessments *(Include Timeframes)*	**Rationale**
1. Assess nausea at start of shift then Q2 2. Assess BP and vitals for fluid deficit Q4 3. Measure and record intake and output Q2 4. Monitor weight daily	1. Helps to evaluate the effectiveness of antiemetic and prevents the worsening of symptoms 2. Vitals are important indicators of dehydration fever can increase fluid loss 3.To monitor fluid loss due to decrease oral intake 4. Weight loss or gain can indicate dehydration
Nursing Interventions *(include timeframes)*	**Rationale** *(relate how NIs will help correct ND)*
1. Ask preferred beverages and assess swallow ability at begin of shift 2. 0/9% NS w 20 meq KCL 1000mL Run at 100mL/hr for 10 hrs 3. Physical therapy/ occupational therapy 4. Clear Liquid Diet including clear liquid supplement to meal try and encourage small sips 5.Place fall risk band on patient and educate	1. 1. To encourage fluid intake and time to assess swallow and gag reflex 2. IV fluids replace electrolytes loss from vomiting and poor oral intake, increase BP and restore potassium levels 3. Improves strength, mobility and independence while reducing fall risk 4. Helps build tolerance to oral intake and assess emesis is any 5.Increase awareness about weakness, hypotension and fatigue which promotes cooperation

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<table>
<tr><th colspan="2">Evaluation Summary</th></tr>
<tr><td>1. For each expected outcome, answer the following:
(a) Are expected outcomes realistic and met?
(b) Will they remain the same or change?
(c) Why?</td><td rowspan="4">2. Did NIs change or remain the same? If changed, state why.

Fall precautions, nausea/vomiting and hydration interventions remain the same while on Day 2 while auscultating the lungs crackles were heard bilaterally in all fields. E.S was education on use of Incentive spirometer, HOB elevated, continuous pulse ox attached, lung assessment q4 and E.S on reported SOB and dyspnea

3. Does the ND still exist and why?

Yes, ND remains the same because E.S still has signs of dehydration and it a risk for falls due to generalized weakness and fatigue. Education and intervention effective but still high fall risk. Although antiemetics seem to decrease vomiting E.S still reports nausea and has episodes of emesis.</td></tr>
<tr><td>a. 1.outcme not met
2. No E.S is stilling vomiting but not as frequent as it was upon admission
3.Yes E.S has not fallen during my time of care
4. Yes met E.S appropriately used the call bell</td></tr>
<tr><td>b. 1. Change BP dropped below intend target
2. Improved but not completely resolved
3. E.S still high risk but no falls
4.Remained the same use call bell throughout shift</td></tr>
<tr><td>c. 1. This decline may indicate worsening of fluid volume due to decreased appetite and poor oral intake
2. Antiemetic and IV fluids helped reduce vomiting but nausea still persistent and poor oral intake resulting in effectiveness of intervention
3. Fall Precautions implemented, fall band on, call bell within reach
4. Education has effective E.S no has increased awareness of safety and demonstrates proper use of the call bell.</td></tr>
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Nursing Care Plan Grading Rubric

Topic	Criteria	Satisfactory = 1 point	Unsatisfactory = 0 points	Category Total
General Information	• All general information filled out correctly and completely. • All assigned medication orders included and complete. • All current doctor's orders included. *(dates of care and standing orders)* • 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	• 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	• 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)***	• 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	• 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	• 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	• 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		**6-7 = Satisfactory**	**0-5 = Unsatisfactory**	**Total Score** _____