N433 Care Plan #2

Lakeview College of Nursing

Matthew Catlett

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
4/8/21	C.F.	3 years & 1 month	Male
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full Code	14.4 kg	15.8 m^2	No Known Allergies

Medical History (5 Points)

Past Medical History: No significant past medical history.

Illnesses: This client has had no previous illnesses.

Hospitalizations: Previous hospitalizations relate to past surgical history.

Past Surgical History: Adenoidectomy (2020), Myringotomy (2020), and Tonsillectomy (2021).

Immunizations: This client has received all necessary vaccines in congruence with the immunization schedule for a child this age.

Birth History: No birth history is recorded in the client's chart.

Complications (if any): No complications were documented for this client's birth.

Assistive Devices: This client uses no assistive devices.

Living Situation: This client lives with both parents in a single-story home.

Admission Assessment

Chief Complaint (2 points): The client's chief complaint is excessive bleeding in the throat.

Other Co-Existing Conditions (if any): No other co-existing conditions are present for this client.

Pertinent Events during this admission/hospitalization (1 points): This client's hemoglobin level was 8 at admission and has decreased to 7. The client's bleeding has not returned during their stay.

History of present Illness (10 points):

The 3-year-old client reported to the Danville emergency department with his parents with complaints of excessive bleeding following a tonsillectomy that was performed on 4/6/21. The parents stated that the bleeding continued throughout the day and did not subside until after 1900. The client was then transported to the Carle emergency department and admitted to the pediatric unit. The client is experiencing no pain with bleeding.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Anemia caused by acute blood loss.

Secondary Diagnosis (if applicable): Post-op bleeding.

Pathophysiology of the Disease, APA format (20 points):

Anemia occurs when there is a decrease in red blood cells circulating within the cardiovascular system. When a client loses a large amount of blood, this blood loss can cause anemia. This decrease in red blood cells causes the client's hemoglobin and hematocrit to decrease as well. The typical hemoglobin for someone that has suffered from acute blood loss is 7-8 g/dL (Alder & Tambe, 2020). Blood loss is the most common cause of acute anemias.

Signs and symptoms of anemia from acute blood loss include pallor, clammy skin, and anxiety. For severe instances of acute blood loss, the client may suffer from loss of

consciousness as well. The client may have increased heart rate, respirations, and decreased blood pressure.

When diagnosing anemia, providers look at the client's complete blood count as well as vital signs, arterial blood gases, and blood chemistry if the bleeding is not easily identified. For this child's diagnosis, arterial blood gases and chemistry are not necessary to identify if the child is actively bleeding because the child recently received a tonsillectomy, and the location of bleeding is easily visible upon inspection. The client did receive a complete blood count to determine the extent of the child's anemia.

Treatment for anemia caused by acute blood loss includes treating potential shock and increasing blood volume. Providers will treat the client's decreased blood volume by administering 0.9% normal saline. If the client experiences extensive hemorrhaging, a blood transfusion may be necessary. C.F. did not receive a blood transfusion but did receive 0.9% normal saline. Oxygen may need to be provided to the patient to increase oxygen saturation (Capriotti & Frizzell, 2016).

Complications of anemia from acute blood loss include hypovolemic shock and tissue hypoxia. Both complications can be life-threatening if they are not treated immediately. Tissue hypoxia can cause the client to suffer from a myocardial infarction, heart failure, and respiratory failure (Alder & Tambe, 2020). When a client is experiencing tissue hypoxia, they may have confusion, rapid breathing, and blue-tinged skin.

Pathophysiology References (2) (APA):

Alder, L., & Tambe, A. (2020, July 19). *Acute anemia*. https://www.ncbi.nlm.nih.gov/books/NBK537232/.

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: The client should increase activity as tolerated.	**The client is up independently and playing without issue.**
Diet/Nutrition: The client should remain on a liquid-only diet.	**The client has no issues with the liquid-only diet.**
Frequent Assessments: Vital signs should be performed every 4 hours.	**The client's vital signs have remained within normal limits.**
Labs/Diagnostic Tests: The client's blood was drawn for a complete blood count with differential twice.	**The client's hemoglobin lowered from 8 to 7 throughout his stay at the hospital.**
Treatments: No treatments are needed at this time.	**N/A**
Other: The nurse should notify the physician if the client is actively bleeding.	**The client's bleeding has not returned since admission.**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
The client should be discharged	**The client's discharge occurred at 1330.**

immediately.	

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	**3.89-4.97**	**2.65**	**2.89**	**The client's decreased RBC count is caused by the client's blood loss (Capriotti & Frizzell, 2016).**
Hgb	**10.2-12.7**	**8.0**	**7.0**	**The client's decreased Hgb count is caused by the client's blood loss (Capriotti & Frizzell, 2016).**
Hct	**31-37.7%**	**21.8%**	**22.4%**	**The client's decreased Hct is caused by the client's blood loss (Capriotti & Frizzell, 2016).**
Platelets	**202-403**	**281**	**297**	
WBC	**5.14-13.38**	**7.52**	**7.81**	
Neutrophils	**1.6-8.29**	**1.6**	**1.33**	**The client's mild neutropenia may be caused by a deficiency of vitamins or minerals (Giorgi, 2021).**
Lymphocytes	**1.13-5.52**	**5.42**	**5.62**	**Bacterial or viral infections can cause increased lymphocytes. These levels can also be increased in a client who has leukemia (Morris, 2018).**
Monocytes	**0.19-0.94**	**0.41**	**0.39**	
Eosinophils	**0.03-0.53**	**0.07**	**0.23**	

Basophils	**0.01-0.06**	**0.06**	**0.02**	
Bands	**0.01-0.06**	**0.01**	**0.00**	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission or Prior Value	Today's Value	Reason For Abnormal
Na-	**133-144**	**N/A**	**N/A**	**Chemistry blood work is not documented for this client.**
K+	**3.5-5.1**	**N/A**	**N/A**	
Cl-	**98-107**	**N/A**	**N/A**	
Glucose	**70-99**	**N/A**	**N/A**	
BUN	**5-18**	**N/A**	**N/A**	
Creatinine	**0.3-0.5**	**N/A**	**N/A**	
Albumin	**3.4-5.0**	**N/A**	**N/A**	
Total Protein	**6.4-8.2**	**N/A**	**N/A**	
Calcium	**8.8-10.8**	**N/A**	**N/A**	
Bilirubin	**0.2-1.0**	**N/A**	**N/A**	
Alk Phos	**54-369**	**N/A**	**N/A**	
AST	**15-37**	**N/A**	**N/A**	
ALT	**12-78**	**N/A**	**N/A**	
Amylase	**25-115**	**N/A**	**N/A**	
Lipase	**73-393**	**N/A**	**N/A**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	3-13 mm/hr	N/A	N/A	
CRP	<10 mg/L	N/A	N/A	
Hgb A1c	<7.5%	N/A	N/A	
TSH	0.55-5.31 mU/L	N/A	N/A	
PTT	22.4-35.9	24.6	N/A	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	Colorless or yellow	Yellow; clear	Yellow; clear	
pH	5.0-7.0	N/A	N/A	A urinalysis is not documented for this client.
Specific Gravity	1.003-1.035	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0-25	N/A	N/A	
RBC	0-20	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**N/A**	**N/A**	**Cultures were not tested for this client.**
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	
Respiratory ID Panel	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*.

Giorgi, A. (2021, February 12). *Neutropenia*. https://www.healthline.com/health/neutropenia.

Morris, S. Y. (2018, September 28). *Everything You Should Know About Lymphocytes*. Healthline. https://www.healthline.com/health/lymphocytes.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): No other diagnostic tests were performed on this client.

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA): N/A

Current Medications (8 points)
****Complete *ALL* of your patient's medications****

Brand/Generic	**Tylenol/ acetaminophen**	**Zyrtec/ cetirizine**	**Ferrous sulfate**			
Dose	**217.6 mg**	**5 mg**	**44 mg**			
Frequency	**Q4h, PRN**	**Daily**	**Daily**			
Route	**PO**	**PO**	**PO**			
Classification	**Antipyretic**	**Antihistamine**	**Anti-anemic**			

Mechanism of Action	**Inhibits cyclooxygenase which blocks prostaglandin production that causes inflammatory response.**	**This medication inhibits peripheral H1 receptors.**	**Binds with hemoglobin and normalized RBC production.**			
Reason Client Taking	**This client is receiving this medication to treat any pain or inflammation they may be experiencing.**	**The client is receiving this medication for seasonal allergic rhinitis.**	**The client is receiving this medication because of the client's blood loss.**			
Concentration Available	**160 mg/ 5 ml**	**1 mg/ml**	**8.8 mg/ 1 mL**			
Safe Dose Range Calculation	**229-343 mg (10-15 mg/kg/dose)**	**In children ages 2-5, 2.5-5 mg is the appropriate range.**	**43.2-86.4 mg (3-6 mg/kg/day)**			
Maximum 24-hour Dose	**650 mg**	**5 mg**	**6 mg**			
Contraindications (2)	**This medication should not be given to clients with hypersensitivity to acetaminophen.** **This medication should not be given to clients with severe hepatic impairment.**	**This medication should not be given to clients who have a hypersensitivity to cetirizine.** **This medication should not be given to children who suffer from hepatic or renal failure.**	**This medication should not be given to clients who suffer from hemolytic anemia or hemochromatosis.**			
Side Effects/Adverse Reactions (2)	**Hypotension; hepatotoxicity**	**Side effects include drowsiness and dry mouth.**	**Side effects include hypotension and angioedema.**			

Nursing Considerations (3)	**Use cautiously in clients with hepatic impairment.** **Liver function tests should be performed before and during long-term therapy.** **Use cautiously in patients who have severe renal impairment.**	**Assess respiratory status before administering this medication.** **Medication should be stopped 48 hours before an allergy test is administered.** **Assess symptoms before and after administration to identify the therapeutic effect.**	**Administer oral ferrous sulfate with a straw to avoid staining the client's teeth.** **Ferrous sulfate should be given 1 hour before or 2 hours after a meal to maximize absorption.** **Do not give dairy products within one hour of administration of this medication.**			
Client Teaching needs (2)	**Do not exceed prescribed or recommended dosage.** **Teach the client to recognize signs of hepatotoxicity.**	**This medication can be taken with or without food.** **Use a calibrated device when administering liquid form to children to ensure correct dosage.**	**Educate client on eating foods that contain high amounts of Vitamin C as this can increase absorption.** **Educate the patient on the change in color of feces. The feces will become dark green or black when the client is receiving this medication.**			

Medications Reference (APA): Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Client is alert and oriented x4.** **Client shows no signs of distress.** **Client is well groomed.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score: 23** **Drains present: Y☐ N ☒** **Type:** **IV Assessment (If applicable to child):** **Size of IV: 22 gauge** **Location of IV: Left forearm** **Date on IV: 4/7/21** **Patency of IV: Intact, flushes as expected without leaking or infiltration.** **Signs of erythema, drainage, etc.: No signs of erythema or drainage present.** **IV dressing assessment: Dressing is clean and shows no signs of bleeding.** **IV Fluid Rate or Saline Lock: 0.9% normal saline @ 55 mL/ hr. This IV fluid was discontinued on 4/9/21.**	**The client's skin is dry and warm to the touch.** **The client's skin is mildly pale.** **Skin turgor < 2 seconds.** **The client has no rashes, bruises, or wounds.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:**	**The head, neck, and trachea are symmetrical.** **The client's ears are clear from dirt and drainage.** **The client's tympanic membrane is pearly gray. No inflammation is present.**

Teeth: **Thyroid:**	**Sclerae are white with no hemorrhaging.** **The nose shows no drainage, and the septum is midline.** **Dentition is present and appropriate for the client's age.** **The client has mild swelling and redness in the pharynx from their tonsillectomy.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**S1 and S2 heart sounds are present.** **The client's cardiac rhythm is regular without deviation.** **Peripheral pulses are 2+.** **Capillary refill <3 seconds.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Client's lung sounds are clear in all lobes.** **No wheezes, crackles, or rhonchi present.**
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current diet: N/A** **Height (in cm): 121.9 cm** **Auscultation Bowel sounds:** **Last B.M.: 04/08/21 @ 1900** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**The client's bowel sounds are normoactive and present in all four quadrants.** **The client has no nausea, vomiting, or diarrhea.** **The client has no abdominal pain.** **The client's abdomen is soft and non-distended.** **The client has no incisions, scars, drains, or wounds present.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:**	**The client's urine is yellow but clear.** **The client is not experiencing any urgency, frequency, or pain with urination.**

Catheter: Y ☐ N ☒ **Type:** **Size:**	
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 20** **Activity/Mobility Status: N/A** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**The client has full range of motion in all extremities.** **No muscle weakness present.** **The client's reflexes are 1+.** **The client does not use any supportive devices.** **The client is independent.** **The client has equal strength in all extremities.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The client's strength is equal in all extremities.** **The client's speech is appropriate for his age.** **The client is not experiencing any changes to orientation, mental status, or level of consciousness.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s) of caregiver(s):** **Social needs (transportation, food, medication assistance, home equipment/care):** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Caregivers are Christian and attend church regularly.** **The parents use religion as a means of coping.** **The family requires no assistance.** **The family lives in a single-level house.**

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0821	**99 bpm**	**119/69**	**20**	**36.3 C**	**99% RA**
1201	**124 bpm**	**114/62**	**24**	**36.9 C**	**100% RA**

Vital Sign Trends: The client's pulse, respirations, and temperature have increased. The client's blood pressure and oxygen saturation have stayed baseline.

Normal Vital Sign Ranges (2.5 points)
****Need to be specific to the age of the child****

Pulse Rate	**70-120**
Blood Pressure	**89/46-112/72**
Respiratory Rate	**20-30**
Temperature	**35.5-37.8**
Oxygen Saturation	**>98%**

Normal Vital Sign Range Reference (1) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. (4th ed.). Wolters Kluwer.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1507	**rFLACC**	**Pharynx**	**4**	**Moans, whimpers, occasional facial grimacing.**	**The client is provided with PRN acetaminophen.**
Evaluation of pain status *after* intervention	**rFLACC**	**Pharynx**	**0**	**N/A**	**N/A**
Precipitating factors: N/A **Physiological/behavioral signs: Facial grimacing.**					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
240 mL from liquid diet on the day of clinical	**248 mL in the previous 24 hours.**

Developmental Assessment (6 points)
Be sure to highlight the achievements of any milestone if noted in y our child. Be sure to highlight any use of diversional activity if utilized during clinical. There should be a minimum of 3 descriptors under each heading

Age Appropriate Growth & Development Milestones

1. **The child should grow 6.5-9 cm per year.**
2. **The child's head should be proportional to chest circumference.**
3. **The client should gain 2-3 kg per year.**

Age Appropriate Diversional Activities

1. **Drawing, coloring, or painting pictures are appropriate diversional activities at this age.**
2. **Children at this age enjoy pretending or role-playing as their favorite characters.**
3. **This client specifically enjoyed playing with his action figures and stuffed animals.**

Psychosocial Development:

Which of Erikson's stages does this child fit?

This child fits into the "Autonomy vs Shame and Doubt" stage.

What behaviors would you expect?

At this stage, the child would show behaviors of a need for independence and negative feelings towards others when they are not given this independence.

What did you observe?

Evaluation of this child's behavior could not be assessed as this child was discharged shortly after arriving to the floor.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference?

This child fits into the "preoperational" stage.

What behaviors would you expect?

At this stage, children will struggle with understanding other people's perspectives. The child will begin to learn words and what these words represent.

What did you observe?

The child's behavior could not be assessed as this child was discharged shortly after arriving to the floor.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

A child at this age will be able to use sentences that contain several words but may not be able to build sentences quickly.

Any concerns regarding growth and development?

There are no concerns for this child's growth and development.

Developmental Assessment Reference (1) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. (4th ed.). Wolters Kluwer.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk of aspiration related to hemorrhage as evidenced by bleeding in the throat.	**The client is at risk for aspirating on the blood from the wound caused by the tonsillectomy.**	**1. Maintaining a patent airway by the client on his side.** **2. Frequent**	**The client's bleeding did not continue, and the client did not aspirate.**

		assessment of the mouth and pharynx to identify active bleeding.	
2. Decreased tissue perfusion related to impaired gas exchange as evidenced by decreased RBC and hemoglobin count.	**The client may have decreased tissue perfusion from the lack of red blood cells and hemoglobin in the blood. These parts of the blood help oxygen transport.**	**1. Administering a blood transfusion to the client if bleeding continues.** **2. Frequent vital signs to identify the client's oxygen saturation.**	**The client's oxygen saturation remained >94% so these interventions were not necessary. The client's skin became less pale, and color returned by the time of discharge.**
3. Risk of infection related to open wound as evidenced by bleeding in the pharynx.	**The client's open wound leaves him at risk for infection.**	**1. Perform frequent vital signs to identify if the client's temperature, respirations, or heart rate change as these can be used to identify if a client may have an infection.** **2. Administer antibiotics if the client shows signs of infection.**	**The client did not show signs of infection during his stay in the hospital, so no interventions were necessary.**
4. Fluid volume deficit related to hemorrhage as evidenced by decreased hematocrit.	**The client's blood loss places him in a fluid volume deficit.**	**1. Provide the client with 0.9% normal saline.** **2. Strict input and output to identify the retention of loss of fluids.**	**The client's I&O's were equal within the last 24 hours before discharge.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Client is suffering from anemia caused by post-operational bleeding.
Tonsillectomy occurred on 4/6/21
Client's skin is pale.
Client is up and moving independently.
Client expected discharge is 4/9/21

Objective Data

Pulse: 124 bpm
Blood pressure: 114/62
RR: 24
Temperature: 36.9 C
Pain: 4 via rFLACC
O2 Saturation: 100% on room air
BMI: 15.8 m^2
Hgb: 7.0
Hct: 22.4%

Patient Information

Initials: C.F.
Age: 3 years & 1 month
Anemia caused by acute blood loss
No Known Allergies
Full Code

Nursing Diagnosis/Outcomes

Diagnosis: Risk of aspiration related to hemorrhage as evidenced by bleeding in the throat.

Outcome: The client's bleeding did not continue, and the client did not aspirate.

Diagnosis: Decreased tissue perfusion related to impaired gas exchange as evidenced by decreased RBC and hemoglobin count.

Outcome: The client's oxygen saturation remained >94% so these interventions were not necessary. The client's skin became less pale, and color returned by the time of discharge.

Diagnosis: Risk of infection related to open wound as evidenced by bleeding in the pharynx.

Outcome: The client did not show signs of infection during his stay in the hospital, so no interventions were necessary.

Diagnosis: Fluid volume deficit related to hemorrhage as evidenced by decreased hematocrit.

Outcome: The client's I&O's were equal within the last 24 hours before discharge.

Nursing Interventions

Maintaining a patent airway by the client on his side.

Frequent assessment of the mouth and pharynx to identify active bleeding.

Administering a blood transfusion to the client if bleeding continues.

Frequent vital signs to identify the client's oxygen saturation.

Perform frequent vital signs to identify if the client's temperature, respirations, or heart rate change as these can be used to identify if a client may have an infection.

Administer antibiotics if the client shows signs of infection.

Provide the client with 0.9% normal saline.

Strict input and output to identify the retention of loss of fluids.