N433 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
06/03/2020	**EM**	**5 years and 4 months**	**Female**
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full Code	**20.5 kg**	**14.2**	**NKA**

Medical History (5 Points)

Past Medical History: None

Illnesses: None

Hospitalizations: None

Past Surgical History: None

Immunizations: Up to date

Birth History: No complications

Complications (if any): None

Assistive Devices: None

Living Situation: Lives with mom and dad

Admission Assessment

Chief Complaint (2 points): Vomiting and Diarrhea

Other Coexisting Conditions (if any): N/A

Pertinent Events during this admission/hospitalization (1 points): Her weight is down 0.7 kg from last weight.

History of present Illness (10 points):.

Eva is a five year old female who presented to the emergency department on 6/2 at 0700 with complaints of vomiting and diarrhea, inability to keep fluids down, and no urine output since yesterday at 2000. She states, "I feel dizzy." Her latest health appointment was a few months ago. Her weight at that time was 21.2 kg. Her weight today is 20.5 kg. Her mucous membranes are dry along with appearing pale and listless. Since she is weak, she does not want to move much. Her mom has tried to give her apple juice to no avail. She has finished an IV bolus of 400 mL that was given in the emergency department. She just arrived on the pediatric floor. Maintenance fluids will also be given.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Dehydration

Secondary Diagnosis (if applicable):. N/A

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

Pathophysiology of Dehydration: Dehydration occurs when you lose more fluid than you take in, and your body does not have sufficient water and other fluids to carry out its normal functions. If one does not restore lost fluids, one's body will get dehydrated (Mayo Clinic, 2019). Dehydration reduces overall body fluid in both intracellular and extracellular fluid volumes. Volume reduction closely correlates with the signs and symptoms of dehydration. The total fluid volume in humans is spread between two general compartments. "Two-thirds of the total body weight is in the intracellular compartment, and the other one-third is distributed between interstitial space (75%) and plasma (25%)" (Vega et al., 2019, para.5). The ratio of fluid volume to body size is higher in children as compared to adults. As indicated earlier, dehydration is an overall volume reduction of circulation volume. Dehydration is caused by diarrhea, vomiting, sweating excessively, urinating too much, fever, and not drinking adequate amounts of fluid (MedlinePlus, 2019).

Signs/Symptoms: The signs and symptoms include: dry mouth and tongue, crying without tears, no wet diapers for 3 hours or more, high fever, being unusually sleepy or drowsy, feeling dizzy, irritability, dry skin, eyes that look sunken.

The expected findings of dehydration include: dry mucous membrane, dizziness, thirst, fatigue, muscle cramps, and headache.

Diagnostic testing: Blood test: blood samples may be used to check for several factors, such as the levels of sodium and potassium electrolytes and kidney function.

Urinalysis: Urine test can stratify fluid levels from well hydrated to severely dehydrated. They also can check for signs of a bladder infection.

Labs or test performed on the child: The urine sample collected for this patient was concentrated and had a strong smell. The urine dipstick was negative for nitrite, hemoglobin, leukocytes, glucose, protein.

The sample has been sent to the lab for analysis. A stool culture was also collected and sent to the lab for further investigation.

Treatment: The only helpful treatment for dehydration is to restore lost fluids and electrolytes. Best methods for treating dehydration depend on its severity, cause and age of the patient. For infants and children who have become dehydrated from diarrhea, vomiting or fever, use an over-the-counter oral rehydration solution. These solutions contain water and salts in specific concentrations to replace both fluids and electrolytes. Start with about one teaspoon and then increase as tolerated. It may be easier to use a plunger for very young children. Older children can be given diluted sports drinks. Use a 1 to 1 sport drink to water dilution. (Mayo Clinic, 2019)

Treatment used with this child: This patient is on continuous cardiorespiratory monitoring. She is also on continuous pulse ox. When she arrived at the ED she was given a normal saline bolus of 400 mL to infuse over 15 minutes. After the IV bolus, she was given D5 ½ NS IV at maintenance rate 62 mL/hour. She is on strict intake and output since she is dehydrated and it's important to keep track of her fluid shifts. She is also to be weighed daily. A urinalysis and stool culture was obtained to check for any abnormalities. She has a repeat Chem 7 tomorrow in the morning.

Potential complications (2): The potential complications of dehydration are: shock from hypovolemia and seizures due to imbalanced electrolytes of potassium and sodium.

Urinary and kidney problems: Frequent occurrences of dehydration can cause urinary tract infections, kidney stones and even kidney failure.

Low blood volume shock (hypovolemic shock): This is one of the most severe, and sometimes life-threatening, complications of dehydration. It happens when low blood volume causes a drop in blood pressure and a decline in the amount of oxygen in your body.

Include s/s and preventative nursing actions with each potential complication:

Shock from hypovolemia: signs and symptoms: loss of fluid through vomiting and diarrhea, inability to keep fluids down, no urination since the night before, weight down 0.7 kg. Preventative nursing actions include making sure the patient is drinking adequately, monitor diarrhea episodes, monitor patient's weight.

Seizures due to imbalanced electrolytes: signs and symptoms: tachycardia, fatigue, lethargy, nausea, vomiting, diarrhea, hyperactive bowel sounds, changes in blood pressure. Preventative nursing actions include administering appropriate fluids, monitoring cardiac and respiratory systems of patient, make sure patient is comfortable,

Clinical data which correlates to this child: Urine specimen appears very concentrated and has a strong smell, indicative of dehydration. Patient's mucous membranes are dry and she has a loss in body weight. Her blood pressure is 80/64 which is fairly low for a child her age. She is also tachycardic which is another symptom of dehydration. The body is trying to compensate for loss of fluid volume so the heart will beat faster.

Pathophysiology References (2) (APA):

Mayo Clinic. (2019, September 19). ***Dehydration.***
https://www.mayoclinic.org/diseases-conditions/dehydration/symptoms-causes/syc-20354086

MedlinePlus. (2019, May 29). ***Dehydration*****. https://medlineplus.gov/dehydration.html**

Vega, R. M., Avva, U. (2019, February 03). ***Pediatric Dehydration*****.**
https://www.ncbi.nlm.nih.gov/books/NBK436022/

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	**Up ad lib**
Diet/Nutrition:	**Diet as tolerated**
Frequent Assessments:	**Cardiorespiratory monitoring, Continuous pulse ox, daily weight**
Labs/Diagnostic Tests:	**Urinalysis and stool ova and parasites**
Treatments:	**Normal saline bolus 400 mL to infuse over 15 minutes (started in ED)**
Other:	**Repeat Chem 7 tomorrow AM**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
(*The only orders are the orders listed above*)	(* The only orders are the orders listed above*)

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	4.40-5.80	n/a	n/a	
Hgb	12-17.5	n/a	20	Hgb increases due to decreased plasma volume (Pagana, 2019).
Hct	37.0-51.0%	n/a	60	Hct decreases due to decreased plasma volume (Pagana, 2019).
Platelets	140-440	n/a	345	
WBC	4.00-12.00	n/a	6.6	

Neutrophils	**40-68**	**n/a**	**n/a**	
Lymphocytes	**18-49**	**n/a**	**n/a**	
Monocytes	**3.0-13.0**	**n/a**	**n/a**	
Eosinophils	**0.0-8.0**	**n/a**	**n/a**	
Basophils	**<1**	**n/a**	**n/a**	
Bands	**<1**	**n/a**	**n/a**	

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-	**133-143**	**145**	**180**	**Sodium level in the blood becomes abnormally high when**

				fluid loss exceeds sodium loss (Pagana, 2019).
K+	3.6 - 4.6	4.7	4.9	Potassium levels in the blood rise due to fluid loss exceeding potassium loss (Pagana, 2019).
Cl-	101-111	110	143	Increased blood chloride may occur when too much base is loss from the body. Hyperventilation can create respiratory alkalosis, causing this to occur (Pagana, 2019).
Glucose	65-100	65	85	
BUN	8-25	20	56	Dehydrated patients present with elevated BUN due to low urine flow rate and increased renal reabsorption of urea (Pagana, 2019).
Creatinine	0.6-1.3	0.9	0.9	
Albumin	3.5-5.7	n/a	n/a	
Total Protein	6.0-8.3	n/a	n/a	
Calcium	8.6-10	n/a	9.9	
Bilirubin	0.2-0.8	n/a	n/a	
Alk Phos	34-104	n/a	n/a	

AST	**10-30**	**n/a**	**n/a**	
ALT	**10-40**	**n/a**	**n/a**	
Amylase	**23-85**	**n/a**	**n/a**	
Lipase	**0-160**	**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	**0-10**	**n/a**	**n/a**	
CRP	**<3.0**	**n/a**	**n/a**	
Hgb A1c	**4-5.6**	**n/a**	**n/a**	
TSH	**0.4-4.0**	**n/a**	**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	Yellow Clear	n/a	Concentrated and strong smell	Eva is dehydrated, thus her urine is concentrated and has a smell (Pagana, 2019).
pH	5.0-8.0	n/a	n/a	
Specific Gravity	1.005-1.034	n/a	n/a	
Glucose	Negative	n/a	Negative	
Protein	Negative	n/a	Negative	
Ketones	Negative	n/a	Negative	
WBC	Negative N	n/a	Negative	
RBC	Negative	n/a	Negative	
Leukoesterase	Negative	n/a	Negative	

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**	
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 (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mo: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (APA): N/A

Current Medications (8 points)

****Complete *ALL* of your patient's medications****

Brand/Generic	**Normal saline bolus/sodium chloride injection**	**D5 ½ NS IV/5% dextrose in water**	**n/a**	**n/a**	**n/a**
Dose	**400 mL**	**400 mL**	**n/a**	**n/a**	**n/a**
Frequency	**Infuse over 15 minutes**	**Infuse 62 mL/hour**	**n/a**	**n/a**	**n/a**
Route	**IV**	**IV**	**n/a**	**n/a**	**n/a**
Classification	**Fluid and electrolyte**	**Fluid and electrolyte**	**n/a**	**n/a**	**n/a**

	replenishment-isotonic	**replenishment- both isotonic and hypotonic**			
Mechanism of Action	**Used to provide hydration and help electrolyte disturbances**	**Used to provide hydration and help electrolyte disturbances**	**n/a**	**n/a**	**n/a**
Reason Client Taking	**For dehydration**	**For dehydration**	**n/a**	**n/a**	**n/a**
Concentration Available	**0.9% and 0.45%**	**5%**	**n/a**	**n/a**	**n/a**
Safe Dose Range Calculation	**0.9% and 0.45%**	**5%**	**n/a**	**n/a**	**n/a**
Maximum 24-hour Dose	**Dose is dependent on weight and severity of dehydration**	**Dose is dependent on weight and severity of dehydration**	**n/a**	**n/a**	**n/a**
Contraindications (2)	**None**	**Should not**	**n/a**	**n/a**	**n/a**

		take if allergic to dextrose, **Stop using dextrose 5% in water if fever, cough, wheezing develop**			
Side Effects/Adverse Reactions (2)	**None known**	**Severe burning,** **fever**	**n/a**	**n/a**	**n/a**
Nursing Considerations (3)	**Monitor changes in: -fluid balance, -electrolyte concentrations, and** **--acid balance during prolonged parenteral therapy**	**Keep medicine out of reach of children,** **Never share medication with others**	**n/a**	**n/a**	**n/a**
Client Teaching needs (2)	**Side effects include injection site swelling,**	**Tell the doctor if you are developing cough or**	**n/a**	**n/a**	**n/a**

	Contact your doctor if you experience serious side effects such as fast heartbeat, fever, or rash	**wheezing** **Tell the doctor if you receive regular blood transfusion**			

Medication Reference (APA):

Jones & Bartlett Learning. (2019). ***2019 Nurse's Drug Handbook*** **(18th ed.). Burlington, MA**

Assessment

Physical Exam (18 points)

GENERAL (1 point):	
Alertness:	Alert and oriented to time, place, and person
Orientation:	A & O x3
Distress:	Pt is in some distress
Overall appearance:	Pt is pale, weak, listless
INTEGUMENTARY (2 points):	
Skin color:	Pale
Character:	Dry
Temperature:	Cold

Turgor:	Tenting observed
Rashes:	None
Bruises:	None
Wounds: .	None
Braden Score:	23
Drains present: Y☐ N ☐	None
Type:	N/a
HEENT (1 point):	
Head/Neck:	Head and neck symmetrical, normal cephalic
Ears:	Patient's ears are free of discharge, negative hearing loss, eyes symmetrical EOM, nose symmetry, no deviation, teeth well-groomed.
Eyes:	
Nose:	
Teeth:	Thyroid aligned
Thyroid:	
CARDIOVASCULAR (2 points):	.
Heart sounds:	Heart sounds normal S1 and S2, no murmurs, gallops, or rubs detected in S3 and S4.
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:**	 Peripheral pulses 2+ symmetric. Capillary refill is more than 8 seconds. No neck vein distention No edema
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The chest is moving equally Breath sounds are clear and equal bilaterally

GASTROINTESTINAL (2 points):	.
Diet at home:	Normal diet
Current diet:	Normal diet as tolerated
Height (in cm):	120 cm
Auscultation Bowel sounds:	Hyperactive bowel sounds heard in all four quadrants
Last BM:	0900
Palpation: Pain, Mass etc.:	Pt states “my tummy hurts”
Inspection:	No CVA tenderness
Distention:	
Incisions:	
Scars:	
Drains:	No abnormalities found upon inspection for distention, incision, or drains.
Wounds:	
Ostomy: **Y** ☐ **N** ☐	
Nasogastric: **Y** ☐ **N** ☐	
Size:	
Feeding tubes/PEG tube **Y** ☐ **N** ☐	
Type:	

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Concentrated** **Strong odor**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	. **Pt alert and responsive** **Normal ROM** **None** **Strength in upper and lower extremities bilaterally** **None** **Pt is active and mobile** **Yes** **No** **No**

NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. **Yes** **Yes** **Cognitive of space, time, and location,** **Articulative speech** **Mature and cognitive** **Alert** **No gross focal neurological deficits**
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):**	. mother and father none Mother and father are her main caregivers.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0930	183	82/66	32	99 F	94%

Normal Vital Sign Ranges (2.5 points)

****Need to be specific to the age of the child****

Pulse Rate	**80-120**
Blood Pressure	**89-112/46-72**
Respiratory Rate	**20-28**
Temperature	**98.6 F**
Oxygen Saturation	**92-100 %**

Normal Vital Sign Range Reference (APA):

Nall, R. (2017, March 20). ***A Mom's Guide to Pediatric Vital Signs.***

https://www.healthline.com/health/pediatric-vital-signs

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1050	**Faces scale 0-5**	**Stomach**	**2**	**Stomach hurts**	**Given fluids and pain medication**
Evaluation of pain status *after* intervention	**Faces scale 0-5**	**Stomach**	**0**	**n/a**	**n/a**
Precipitating factors: vomiting and diarrhea **Physiological/behavioral signs:** pt wincing and face grimace					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
400 mL	**250 mL**

Developmental Assessment (6 points)

Be sure to highlight the achievements of any milestone if noted in your 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. Speaks very clearly

2. Tells a simple story using full sentences

3. States name and the pain level she is in

Age Appropriate Diversional Activities

1. Giving child favorite juice

2. Giving child stuffed animal

3. Comforting child by adjusting bed height

Psychosocial Development:

Which of Erikson's stages does this child fit? -- Initiative vs Guilt

What behaviors would you expect? -- Preschoolers learn to initiate tasks and carry out plans, or they feel guilty about efforts to be independent.

What did you observe? -- Patient was feeling dizzy and unwell. She was able to talk about her pain level and where her pain was at.

Cognitive Development:

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

What behaviors would you expect? -- Symbolic thinking, use of proper syntax and grammar to express concepts. Imagination and intuition are strong, but complex abstract thoughts are still difficult. Conservation is developed.

What did you observe? -- I observed patient stating, "my tummy hurts." She was able to answer simple questions. Her mom answered most questions about what happened.

Vocalization/Vocabulary: -- Patient was able to vocalize that she had pain and where the pain was. She could answer simple questions. Her vocabulary was normal for her age.

Development expected for child's age and any concerns? – Yes, child's development is appropriate for age. No concerns noted.

Any concerns regarding growth and development? – No concerns regarding growth and development. Child's development is appropriate for her age.

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. Fluid volume deficit related to excess vomiting and diarrhea as evidenced by dry mucous membranes	**Patient was having vomiting and diarrhea since last 3 days**	**1. Monitor weight daily. Assess intake and output every shift. Assess heart rate, postural blood pressure, skin turgor, small-vein filling time, capillary refill time, fontanel (infant), and urine specific gravity every 4 hours or more frequently as indicated.** **2. Administer intravenous fluids as ordered. Monitor for crackles in dependent portions of the lungs.**	**Pt responded well. Her pain level was decreased from level 9 to 0.** **Mother seemed to appear more content after daughter is feeling well.** **Goal met, no modifications to plan.**
2. Acute pain related to vomiting as	**Patient states, “my tummy**	**1. The nurse will assess the patient's**	**Patient rated pain 0 after treatment. Mother**

evidence by patient rating pain 9 on face scale	**hurts”**	**pain rating every 4 hours.** **2. The nurse will assess the patient's energy level every shift.**	**seems relieved that her child is doing better.** **Goal met, no modifications to plan.**
3. Risk for ineffective tissue perfusion related to decreased blood flow as evidenced by hypotension	**Patient’s blood pressure was 74/65**	**1. The nurse will monitor vital signs and continuous cardiopulmonary functioning.** **2. Monitor laboratory tests such as complete blood count, sodium level, and serum creatinine.**	**Patient’s blood pressure increased after treatment. Her blood pressure increased.** **Goal met, no modifications to plan.**
4. Risk for impaired skin integrity related to decreased skin turgor as evidenced by patient’s skin tenting	**Patient’s skin was tenting**	**1. Observation of skin (i.e. whether pale or red)** **2. Discuss importance of hydration with patient and mother**	**Patient’s skin was intact and had good skin turgor after fluid treatments. She had no further skin issues and her skin integrity went back to normal.** **Goal met, no modifications to plan.**

Other References (APA):

Swearingen, P. (2016). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*** **(4th ed.). St.Louis, MO: Elsevier**

Concept Map (20 Points):

Pt states, “my tummy hurts. It hurts really bad. ”

1. **Fluid volume deficit related to excess vomiting and diarrhea as evidenced by dry mucous membranes. Goal met: no modifications to plan. Pt responded well. Her pain level was decreased from level 9 to 0. Mother seemed to appear more content after daughter is feeling well.**

2. **Acute pain related to vomiting as evidence by patient rating pain 9 on face scale. Patient states, “my tummy hurts”. Goal met. Patient rated pain 0 after treatment. Mother seems relieved that her child is doing better.**

3. **Risk for ineffective tissue perfusion related to decreased blood flow as evidenced by hypotension. Patient’s blood pressure was 74/65. Goal met. Patient’s blood pressure increased after treatment. Her blood pressure increased.**

4. **Risk for impaired skin integrity related to decreased skin turgor as evidenced by patient’s skin tenting. Patient’s skin was intact and had good skin turgor after fluid treatments. She had no further skin issues and her skin integrity went back to normal.**

Patient’s cc is vomiting and diarrhea. The patient received a urinalysis and stool sample. Her stool sample was negative but she had concentrated urine. Her BUN, Cl-, potassium, and sodium were elevated, indicating dehydration.

Eva is a five year old female who presented to the emergency department on 6/2 at 0700 with complaints of vomiting and diarrhea, inability to keep fluids down, and no urine output since yesterday at 2000. She states, “I feel dizzy.” Her latest health appointment was a few months ago. Her weight at that time was 21.2 kg. Her weight today is 20.5 kg. Her mucous membranes are dry along with appearing pale and listless. Since she is weak, she does not want to move much. Her mom has tried to give her apple juice to no avail. She has finished an IV bolus of 400 mL that was given in the emergency department. She just arrived on the pediatric floor. Maintenance fluids will also be given.

1. Monitor weight daily. Assess intake and output every shift. Assess heart rate, postural blood pressure, and skin turgor, every 4 hours

2. Administer intravenous fluids as ordered. Monitor for crackles in dependent portions of the lungs.

1. The nurse will assess the patient's pain rating every 4 hours.

2. The nurse will assess the patient's energy level every shift.

1. The nurse will monitor vital signs and continuous cardiopulmonary functioning.

2. Monitor laboratory tests such as complete blood count, sodium level, and serum creatinine.

1. Observation of skin (i.e. whether pale or red)

2. Discuss importance of hydration with patient and mother