

N433 Care Plan # 1

Lakeview College of Nursing

Name Kayley Sollers

Demographics (3 points)

Date of Admission 6/8/2020	Patient Initials E.M.	Age (in years & months) 5 years 5 months	Gender Female
Code Status Full	Weight (in kg) 20.5 kg	BMI 14.2	Allergies/Sensitivities (include reactions) NKA

Medical History (5 Points)

Past Medical History:

Illnesses: No recent illnesses. Her mother states there are no hereditary illnesses in the family.

Hospitalizations: Information unavailable due to limitations in the vSim.

Past Surgical History: Information unavailable due to limitations in the vSim.

Immunizations: The patient is up to date on her immunizations.

Birth History: Information unavailable due to limitations in the vSim. Her mother states that her growth and development have been normal.

Complications (if any): Information unavailable due to limitations in the vSim.

Assistive Devices: Information unavailable due to limitations in the vSim.

Living Situation: Due to the scope of the simulation the mother is the next of kin Heather Madison, there are no smokers in the household, and no pets at home.

Admission Assessment

Chief Complaint (2 points): The patient presents with a three-day history of vomiting and diarrhea, inability to keep fluids down, and no urination since 2000 yesterday.

Other Co-Existing Conditions (if any): Information unavailable due to limitations in the vSim.

Pertinent Events during this admission/hospitalization (1 points): There are no pertinent events due to the limitations within the simulation.

History of present Illness (10 points): The patient is a 5-year-old Caucasian female; she arrived at the emergency department on 6/8/2020 at 0700. The patient has a three-day history of vomiting and diarrhea, inability to keep fluids down, and no urination since 2000 yesterday. The patient's mother said she experienced dark and smelly urine the day previous of admission. The patient had lab values drawn, and everything came back normal except an elevation in her Hemoglobin, Hematocrit, Sodium, Potassium, Chloride, and BUN. The patient states the location of her pain is "in my tummy" and began "a few days ago." The mother states the patient has had "stomach pain, vomiting, and diarrhea for three days. The patient has described the pain characteristics as a two on the Faces pain scale with a range of zero to five. A two on the Faces pain scale is described in the text as, "it hurts a little more" (Ricci et al., 2017, p. 1173). The patient describes the aggravating factors as "any movement really" makes the pain worse, and that "nothing really makes me better." The treatment the patient has tried is unavailable due to the scope of the simulation. She will be admitted to the pediatric unit for monitoring and rehydration due to her diagnosis of dehydration. She has been started on a Normal Saline bolus of 400ml/ 15 min. and a continuous infusion of Dextrose 5% in 0.45% NS.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Dehydration

Secondary Diagnosis (if applicable): Information unavailable due to limitations in the vSim.

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

Dehydration occurs when the body is depleted of fluids. Dehydration is a decrease in the water accumulated within the body. It causes a reduction in the intracellular and extracellular fluid volume—dehydration results in not replacing the fluids that the body needs to function correctly. The body systems that may be affected by dehydration are the skin, muscles, brain, kidneys, and cardiovascular system. Dehydration can affect the many-body systems such as the kidneys because there is a decrease in blood flow to the vital organs, due to depletion of fluid in the body. A significant indication of dehydration can be by observing the color and concentration of urine.

Dehydration signs and symptoms are dry mucous membranes, sunken eyes, extreme thirst, less frequent urination, dark-colored urine, fatigue, dizziness, and confusion (Dehydration, 2019). The patient in the simulation experiences symptoms of dry mucous membranes, dark and foul urine the day previously admitted, less frequent urination, and complaints of feeling dizzy.

Expected findings related to dehydration such as vital signs are, the patient may be tachycardic, have a fever, decreased blood pressure, and present with tachypnea. The patient in the simulation presents with tachycardia. Expected findings related to dehydration, such as laboratory findings are an imbalance in electrolytes such as sodium, potassium, and chloride. The patient experienced electrolyte imbalances in her laboratory values, which resulted in elevated sodium, potassium, and chloride.

Diagnostic testing used to identify dehydration are physical assessment, blood tests, and urinalysis. A physical assessment was performed for the patient, blood tests were drawn, and a urinalysis was ordered, but the results were not back due to the simulation. Treatment for dehydration includes the involvement of replenishing fluids and electrolytes. Eva has had a 0.9% Normal Saline bolus in this clinical simulation and has a continuous infusion of Dextrose 5% in 0.45% Normal Saline.

Two potential complications of dehydration include kidney failure and seizures. Kidney failure can occur because the kidneys can stop working in regards to moving the extra fluid and waste from the blood. There are many signs and symptoms of kidney failure, including decreased urine output, fluid retention, and shortness of breath. Preventative nursing actions for kidney failure are staying hydrated and monitoring the patient closely. Seizures can occur due to electrolyte imbalances. Signs and symptoms of seizures may include confusion and jerking movements from the extremities. Preventative nursing actions for seizures include electrolyte monitoring, staying hydrated, and providing safety measures (Ricci et al., 2017).

Pathophysiology References (2) (APA):

Dehydration. (2019, September 19). Retrieved June 12, 2020, from

<https://www.mayoclinic.org/diseases-conditions/dehydration/symptoms-causes/syc-20354086>

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Philadelphia: Wolters Kluwer.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Up ad lib.	Patient stayed in bed during my clinical simulation.
Diet/Nutrition: As tolerated.	The patient took a drink when I offered her favorite drink.
Frequent Assessments: Daily weight, continuous pulse ox, and cardiorespiratory monitoring. Strict I & O.	The patient's pulse ox and cardiorespiratory monitoring remained within the baseline range. I was able to monitor the patient's intake due to IV fluids. I was unable to monitor the output due to simulation.
Labs/Diagnostic Tests: Urinalysis, Stool ova and parasites + culture, and repeat Chem 0700 tomorrow,	Information unavailable due to the limitations in the vSim.
Treatments: Normal saline bolus, D5 ½ NS.	Unable to determine due to simulation.
Other: Information unavailable due to the limitations in the vSim.	
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
Information unavailable due to the limitations in the vSim. No new orders were addressed for the clinical day.	

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	(4.2-5.4*10 ⁹ /L)	N/A	5.1	
Hgb	(13.5-17.5 g/dL)	N/A	20	The patient has increased Hemoglobin due to dehydration from diarrhea and lack of fluids (Capriotti & Frizzell, 2016).
Hct	(40-45%)	N/A	60	The patient has increased Hematocrit due to dehydration as a result of loss of fluids (Capriotti & Frizzell, 2016).
Platelets	(150-400 * 10 ⁹ /L)	N/A	380	
WBC	(4-11 * 10 ⁹ /L)	N/A	7.7	
Neutrophils	55-70%	N/A	N/A	
Lymphocytes	20-40%	N/A	N/A	
Monocytes	2-8%	N/A	N/A	
Eosinophils	1-4%	N/A	N/A	
Basophils	0.5-1%	N/A	N/A	
Bands	1-5%	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 mEq/L)	145	180	The patient has elevated sodium due to dehydration causing electrolyte imbalances (Capriotti & Frizzell, 2016).

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K+	(3.6-4.6 mEq/L)	4.7	4.8	The patient has increased Potassium due to dehydration causing an electrolyte imbalance (Capriotti & Frizzell, 2016).
Cl-	(101-111 mEq/L)	110	134	The patient has increased Chloride due to dehydration causing an electrolyte imbalance (Capriotti & Frizzell, 2016).
Glucose	(65-140 mg/dL)	65	84	
BUN	(8-23 mg/dL)	20	55.2	The BUN is elevated due to the patient having moderate dehydration (Capriotti & Frizzell, 2016).
Creatinine	(0.8-1.4 mg/dL)	0.9	0.9	
Albumin	3.5-4.8 gm/dl	N/A	N/A	
Total Protein	6.4-8.3 g/dL	N/A	N/A	
Calcium	8.5-10.1 mg/dL	N/A	N/A	
Bilirubin	0.2-0.8	N/A	N/A	
Alk Phos	38-126 U/L	N/A	N/A	
AST	15-37 U/L	N/A	N/A	
ALT	12-78 U/L	N/A	N/A	
Amylase	23-85 U/L	N/A	N/A	
Lipase	11-82	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 mm/hr	N/A	N/A	

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CRP	<1.0 mg/L	N/A	N/A	
Hgb A1c	<6%	N/A	N/A	
TSH	0.45-4.5 mU/L	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	Clear/ yellow	N/A	N/A	
pH	4.6-8.0	N/A	N/A	
Specific Gravity	1.003-1.040	N/A	N/A	
Glucose	0-0.8 mmol/ L	N/A	N/A	
Protein	1-15 mg/dL	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative	N/A	N/A	
RBC	Negative	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	<10,000 colonies/mL	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	Negative	N/A	N/A	

Panel				
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Lab Correlations Reference (APA):

Capriotti, T. & Frizzell, J.P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. 1st ed. F.A. Davis Company: Philadelphia, PA.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Information unavailable due to the limitations in the vSim.

Diagnostic Test Correlation (5 points): Information unavailable due to the limitations in the vSim.

Diagnostic Test Reference (APA): Information unavailable due to the limitations in the vSim.

Current Medications (8 points)

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

Brand/Generic	Normal Saline 0.9% Bolus	Dextrose 5% in 0.45% Normal Saline
Dose	400 mL over 15 min.	62 mL/hr
Frequency	ONCE	CONTINUOUS
Route	IV	IV
Classification	Electrolyte replenishment	Electrolyte replenishment
Mechanism of Action	Isotonic solution given to correct volume depletion, increasing fluid volume in blood	Electrolyte replenishment solution, and balances the electrolyte disturbances in the body. The

	vessels.	solution provides the body with sugars when unable to drink fluids.
Reason Client Taking	Dehydration	Dehydration
Concentration Available	0.9% Normal Saline	5% Dextrose in 0.45% Normal Saline
Safe Dose Range Calculation	400 mL/15 min.	62 mL/hr.
Maximum 24-hour Dose	1510 mL/day	1510 mL/day
Contraindications (2)	Overhydration. Pulmonary edema.	Allergies to sugars. Allergies to dextrose.
Side Effects/Adverse Reactions (2)	Hypernatremia . Fluid retention.	Redness or pain at injection site. Trouble breathing.
Nursing Considerations (3)	Monitoring of basic metabolic laboratory values. Monitoring urinary output. Assessment of physical examination findings.	Monitor laboratory values. Monitor IV site for any redness or inflammation. Monitor respiratory status.
Client Teaching needs (2)	Explain the purpose of the medication. Reiterate to not touch the IV site.	Monitor the insertion sight for any signs of inflammation. Explain the purpose of the medication.

Medication Reference (APA):

Jones & Bartlett Learning. (2018). 2018 Nurses Drug Handbook. Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>A&O X3. The patient is awake, orient to place, and the names of her parents. The patient reports feeling dizzy. The patient appears to be in some distress due to being pale and listless.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>The patient is pale has tenting sign of the skin, and the skin is cold. No note of rashes, bruises, wounds, Braden score, or drains mentioned due to the scope of the simulation. Braden score: cannot determine due to simulation</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>No obvious airway obstruction. Mucous membranes are dry. No abnormalities with the patient's head, neck, ears, eyes, nose, or teeth noted from observation. Due to limitations in the simulation the patient's thyroid was not palpated.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>Rate and rhythm regular without murmurs. Heart rate is tachycardic at 189 bpm. No noted peripheral pulses, capillary refill, neck vein distention, or edema due to limitations in the vSim.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breath sounds clear and equal bilaterally, breathing at 30 breaths per minute. No use of accessory muscle noted.</p>
<p>GASTROINTESTINAL (2 points): Diet at home:</p>	<p>Diet at home unable to be verified, current diet is as tolerated. Height: 120 cm.</p>

<p>Current diet: Height (in cm): Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Hyperactive bowel sounds. Liver is not enlarged. Last BM unable to be verified. Palpation unable to perform due to limitations in vSim. No noted inspection of distention, incision, scars, drains, or wounds due to simulation. No use ostomy, nasogastric, or feeding/PEG tube noted.</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>The patient's uranalysis results were not returned due to the simulation. The color, character, quantity of urine, and pain with urination is unable to be determined due to the simulation. No dialysis noted. Inspection of genitals information unavailable due to limitations in the vSim. No use of catheter noted.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>The patient is conscious. The muscle strength, sensation, and deep tendon reflexes are normal. No signs of clonus. The ROM, supportive devices, ADL assistance, fall risk, and fall score is unable to be determined due to limitations in the vSim. The patient's activity is up ad lib.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation:</p>	<p>Extraocular movement is intact. The pupils are 7 mm. and react to light bilaterally. The patient's MAEW is unable to be identified due to vSim. The patient is awake and responsive. The patient is conscious, and orient. The patient's mental status, speech, and sensory</p>

Mental Status: Speech: Sensory: LOC:	are within baseline range for growth and development. The patient does not experience a LOC.
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):	The patient's religion is Baptist. The coping methods of the caregiver are not able to be determined due to the scope of the simulation. The patient's social needs and personal/family data are unable to be determined due to limitations in the simulation.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0010	189 bpm	80/64	29	99 F (37.3 C)	97% Room
			breaths/min	Axillary	Air

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

Pulse Rate	60 to 100 bpm
Blood Pressure	Systolic 89 to 112
	Diastolic 46 to 72
Respiratory Rate	22 to 34 breaths/min
Temperature	Axillary (least invasive) 36.5 to 37.5 C
Oxygen Saturation	>94%

Normal Vital Sign Range Reference (APA):

Novak, C., & Gill, P. (2018, July 10). Pediatric Vital Signs Reference Chart. Retrieved June 12, 2020, from <https://www.pedscales.com/pediatric-vital-signs-reference-chart>

PALS Digital Reference Card. (2020). Retrieved June 12, 2020, from

<https://shopcpr.heart.org/pals-digital-reference-card>

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0949	Faces scale 0/5	Abdomen	2	A 2 on the faces scale is described in the text as “it hurts a little more” (Ricci et al., 2017, p. 1173).	Information unavailable due to the limitations in the vSim.
Evaluation of pain status <i>after</i> intervention	Information unavailable due to the limitations in the vSim.	Information unavailable due to the limitations in the vSim.	Information unavailable due to the limitations in the vSim.	Information unavailable due to the limitations in the vSim.	Information unavailable due to the limitations in the vSim.
<p>Precipitating factors: The child is having stomach pain due to previously being nauseous and having diarrhea. Physiological/behavioral signs: The patient groans and is in distress due to being pale and listless.</p>					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
462 mL IV fluid intake	Output information unavailable due to limitations in the vSim.
Intake offering of favorite drink unable to calculate.	

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. Begin playing cooperatively with one another**
- 2. Speaks in sentences of four to five words**

3. The average height and weight of a 5-year-old is 110 cm (43.5 in) and weighs 18.5 kg (41 lb). **The patient met this goal as she is 120 cm tall and weighs 20.5 kg.**

Age Appropriate Diversional Activities

1. Riding tricycles
2. Playing pretend dress-up activities
3. Putting puzzles together

Psychosocial Development:

Which of Erikson's stages does this child fit? The child fits the initiative vs guilt stage of Erikson.

What behaviors would you expect? In initiative vs guilt stage, the behaviors I would expect within the child are being energetic learners and guilt when misbehaved.

What did you observe? During the clinical with this child the observation was limited due to the simulation, I observed the child lying in bed and reporting pain in the abdomen are of a two on the faces scale.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? The child is in the preoperational phase of Piaget.

What behaviors would you expect? I would expect the child to experience magical thinking, animism, centration, and time. The child should have developed social awareness, consider others' viewpoints, and making judgements on visual appearance.

What did you observe? During the clinical with this child I observed the child being socially aware, and she was able to make judgements based on visual appearance when describing her pain.

Vocalization/Vocabulary:

Development expected for child’s age and any concerns? At the age of five a child should be able to speak in four to five-word sentences, and the vocabulary should increase to more than two thousand one hundred words (Ricci et al., 2017).

Any concerns regarding growth and development? There are no concerns regarding growth and development for the child.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? <ul style="list-style-type: none"> • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain r/t physical agents a.e.b. reported stomach pain of a 2 on the faces scale.	The patient reports pain of a two on the faces scale.	1. Provide comfort measures by offering dog stuffed animal. 2. Help the child obtain uninterrupted rest.	Adequate rest promotes the child’s well-being and enhances healing.
2. Imbalanced nutrition r/t insufficient intake a.e.b. reported dark	The patient’s mother reported the child having dark and smelly urine yesterday.	1. Monitor electrolyte values and report abnormalities.	Ensures adequate fluid and electrolyte levels.

<p>and smelly urine yesterday.</p>		<p>2. Provide parenteral fluids as ordered.</p>	
<p>3. Diarrhea r/t malabsorption a.e.b. reported loose stools for the past three days.</p>	<p>The patient has had diarrhea for the past three days.</p>	<p>1.Record intake and output, skin turgor, and condition of mucous membranes.</p> <p>2.Record daily weight before the first feeding each morning.</p>	<p>Child is tolerating IV fluids well and taking sips of favorite drink when offered.</p>
<p>4. Risk for deficient fluid volume r/t vomiting a.e.b. reported vomiting for the past three days.</p>	<p>The patient has been vomiting for the past three days.</p>	<p>1. Monitor IV fluid infusion every hour.</p> <p>2.Secure the IV site by wrapping it in a soft bandage.</p>	<p>No signs of irritation to the IV site. The child is able to move her arm freely.</p>

Other References (APA):

Lippincott Williams & Wilkins. (2013). *Spark & Taylors: Nursing diagnosis reference manual (9th ed.)*. London.

Concept Map (20 Points):

Subjective Data

Vomiting, diarrhea, and tummy pain for three days
Describes pain on faces pain scale as a 2
Dark and smelly urine

Diarrhea r/t malabsorption a.e.b. reported loose stools for the past three days. / Child is tolerating IV fluids well and taking sips of favorite drink when offered.
Risk for deficient fluid volume r/t vomiting a.e.b. reported vomiting for the past three days. / No signs of irritation to the IV site. The child is able to move her arm freely.
Acute pain r/t physical agents a.e.b. reported stomach pain of a 2 on the faces scale. / Adequate rest promotes the child's well-being and enhances healing.
Imbalanced nutrition r/t insufficient intake a.e.b. reported dark and smelly urine yesterday. / Ensures adequate fluid and electrolyte levels.

Nursing Interventions

Record intake and output, skin turgor, and condition of mucous membranes.
Record daily weight before the first feeding each morning.
Monitor IV fluid infusion every hour.
Secure the IV site by wrapping it in a soft bandage.
Provide comfort measures by offering dog stuffed animal.
Help the child obtain uninterrupted rest.
Monitor electrolyte values and report abnormalities.
Provide parenteral fluids as ordered.

Objective Data

Pulse 189 bpm (tachycardic)
Pale
Listless
Dizzy
Cool skin
Dry mucous membranes
Elevated labs: Sodium, Potassium, Chloride, BUN, Hgb, Hct

Patient Information

E.M. 5 years and 5-month year-old female is admitted for dehydration.

