N433 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 6/15/2020	**Patient Initials** E.M.	**Age (in years & months)** 5 years, 4 months	**Gender** Female
Code Status Full	**Weight (in kg)** 20.5	**BMI** 14.2	**Allergies/Sensitivities (include reactions)** No known allergies or sensitivities

Medical History (5 Points)

Past Medical History: Patient's mother expresses that she has no significant medical history to report, upon being questioned. No access to past electronic medical records is available within the vSim.

Illnesses: Information unavailable due to limitations in the vSim.

Hospitalizations: Information unavailable due to limitations in the vSim.

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

Immunizations: Patient's mother reports that they follow the recommended schedule of immunizations and the EMR states that the patient is up to date on immunizations.

Birth History: Information unavailable due to limitations in the vSim.

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

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

Living Situation: The patient lives in a home with no smokers and no pets. Patient's mother reports no travel in the last year. Any other information is unavailable due to limitations in the vSim.

Admission Assessment

Chief Complaint (2 points): The patient complains of "feeling dizzy" and that her "tummy hurts". The primary complaint is dehydration and diffuse abdominal pain, likely related to gastroenteritis, as evidenced by vomiting, diarrhea, and anorexia.

Other Co-Existing Conditions (if any): Patient's mother reports no known conditions or other recent illnesses. At the patient's last well-child visit, mother states that the primary care provider stated she seemed healthy with normal growth and development.

Pertinent Events during this admission/hospitalization (1 points):

History of present Illness (10 points): The patient's mother reports that starting approximately 3 days ago, the patient began producing emesis and diarrhea. She has also lost her appetite and is unable to hold down anything taken in orally. She has not voided in approximately 12 hours, which correlates with her other symptoms and suggests dehydration. The patient has lost weight since last recorded measurement at annual well-child visit (21.2 to 20.5 kg, or a total loss of ~1.5 lbs) which may be related solely to symptoms experienced the past several days or to other causes. The patient reports being "dizzy" and that her "tummy" hurts. Patient's mother reports no changes in diet, recent travel, or any other events of note related to potential exposures to pathogens.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Dehydration

Secondary Diagnosis (if applicable): Gastroenteritis

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

Gastroenteritis is one of the most common illnesses of childhood and is a non-specific inflammation of the gastrointestinal tract related to exposure to bacterial, viral, or parasitic agents. It is unusual for a child to not have had at least one bout of gastroenteritis from infancy to school-age, especially if they are part of a community setting such as daycare. Even with appropriate oral vaccination with the live virus at 2 and 4 months of age per the CDC guidelines most children will still suffer from the symptoms of infection with exposure. Transmission of the pathogen is usually via the fecal-oral route as well as through ingestion of contaminated food or water. Foods often associated with this illness include leafy vegetables, fresh fruits, and shellfish. It is important that children receive produce that has been washed or peeled and avoid all raw seafood to decrease their risk of contracting this infection. Viral gastroenteritis is related to either rotavirus or norovirus. Bacterial gastroenteritis is most commonly associated with infection by *E. coli* or with species of *Salmonella*, *Shigella*, or *Campylobacter*; the culprits of parasitic infections are usually *Giardia* or *Cryptosporidium*.

Children will present with nausea, vomiting, and diarrhea primarily, sometimes complaining of abdominal pain. They may also have a low-grade fever. A more unusual finding is tenesmus, defined as a painful and urgent need to void or have a bowel movement, but without results. Dehydration quickly follows bouts of vomiting and diarrhea as infants and young children have a greater

percentage of weight comprised of fluid and insensible water loss is higher given the ratio of body surface area to body mass. Areas of highest concern with acute gastroenteritis are fluid balance, nutritional intake, and maintenance of normal electrolyte values. Our patient displays the classic signs and symptoms of gastroenteritis, especially with the persistence of the vomiting and diarrhea over several days and anorexia. She is also purportedly a healthy child with no current medications, illnesses, or history that could otherwise explain these symptoms. The lab work performed also shows that the only deviations from expected values are in the levels of potassium and sodium, which is a classic trait of dehydration, in this case secondary to gastroenteritis. The patient's BUN levels are also at the higher end of normal with a low level of creatinine, supporting dehydration versus kidney disease as a primary diagnosis and explanation for the observed anuria.

Pathophysiology References (2) (APA):

Hinkle, J.L., Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of medical-surgical nursing* (14th ed.). Philadelphia, PA: Wolters Kluwer

Swearingen, P.L. (2016). *All-in-One nursing care planning resource (4th ed.)*. St. Louis, MO: Elsevier.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Up ad lib	The patient was not observed to be up independently but was not prevented from ambulating.
Diet/Nutrition: Fluids and regular diet as tolerated.	Oral rehydration solution and water were not options provided in the vSim, only juice. Juice was identified in the vSim to exacerbate

	the gastroenteritis symptoms due to its high osmolality, so only maintenance I.V. fluids were provided. Providing food is not an option in the vSim.
Frequent Assessments: Cardiorespiratory monitoring with continuous pulse oximetery Strict monitoring of intake and output. Daily weight.	Auscultation of the heart and lungs were performed frequently. The patient continued to be tachypneic and tachycardic despite completion of recommended interventions. SpO_2 fluctuated between 94-97% without provision of supplemental oxygen. The I.V. fluids were the only observed input, at a rate of 62 mL/hr. No output was indicated within the parameters of the vSim. Weight was determined in the ED prior to the patient's arrival on the unit.
Labs/Diagnostic Tests: Urinalysis Stool culture (ova and parasties) Repeat of basic metabolic panel and electrolyte chemistry 6/16/20 at 0700.	Urinalysis indicated dehydration due to the urine being highly concentrated with a strong odor. Culture is pending to rule out UTI. The stool culture was collected and results are pending. The basic metabolic panel will be repeated as requested.
Treatments: Normal saline bolus (400 mL/15 min or 1600 mL/hr) D5 0.45% NS IV (62 mL/hr)	The bolus was completed in the ED. After identifying the patient and collecting vitals the I.V. was assessed, with patency good and the dressing clean, dry, and intact. The maintenance fluids were initiated at a rate of 62 mL/hr per physician's orders.
Other: N/A	N/A
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
No changes after contacting the provider.	Per provider, continue with interventions and orders as given 6/15/20.

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	4.2-5.4x10^9/L	N/A	N/A	N/A
Hgb	13.5-17.5 g/dL	N/A	N/A	N/A
Hct	40-45%	N/A	N/A	N/A
Platelets	150-400x10^9/L	N/A	N/A	N/A
WBC	4-11x10^9/L	N/A	N/A	N/A
Neutrophils	3000-5800 cells/mcL	N/A	N/A	N/A
Lymphocytes	1500-3000 cells/mcL	N/A	N/A	N/A
Monocytes	285-500 cells/mcL	N/A	N/A	N/A
Eosinophils	50-250x10^6/L	N/A	N/A	N/A
Basophils	15-50 cells/mcL	N/A	N/A	N/A
Bands	150-400 cells/mcL	N/A	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	N/A	A decrease in extracellular fluid volume related to dehydration will cause an increase in serum concentrations of electrolytes.
K+	3.6-4.6 mEq/L	4.7	N/A	A decrease in extracellular fluid volume related to dehydration will cause an increase in serum concentrations of electrolytes.
Cl-	101-111 mEq/L	110	N/A	N/A
Glucose	65-140 mg/dL	65	N/A	N/A
BUN	8-23 mg/dL	20	N/A	N/A
Creatinine	0.8-1.4 mg/dL	0.9	N/A	N/A
Albumin	3.7-5.5 g/dL	N/A	N/A	N/A
Total Protein	6-8 g/dL	N/A	N/A	N/A
Calcium	8.5-10.9 mg/dL	N/A	N/A	N/A
Bilirubin, Total	<10 mg/dL	N/A	N/A	N/A

Alk Phos	150-380 U/L	N/A	N/A	N/A
AST	15-50 U/L	N/A	N/A	N/A
ALT	10-25 U/L	N/A	N/A	N/A
Amylase	30-100 U/L	N/A	N/A	N/A
Lipase	25-120 U/L	N/A	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	<5 mg/dL	N/A	N/A	N/A
CRP	67-1800 ng/mL	N/A	N/A	N/A
Hgb A1c	3-6.2% of total Hgb	N/A	N/A	N/A
TSH	1.0-2.5 mIU/mL	N/A	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	Today's Value	Reason for Abnormal

		Value		
Color & Clarity	Pale to light yellow	N/A	Dark	Dehydration will cause urine to be concentrated.
pH	4.5-8.0	N/A	Unknown	N/A
Specific Gravity	1.005-1.030	N/A	Unknown	N/A
Glucose	Negative	N/A	Negative	Absence of glucose assessed with dipstick
Protein	Negative	N/A	Negative	Absence of nitrites assessed with dipstick
Ketones	Negative	N/A	Negative	Absence of ketones assessed with dipstick
WBC	Negative	N/A	Unknown	N/A
RBC	Negative	N/A	Negative	Absence of hematuria assessed with dipstick
Leukoesterase	Negative	N/A	Negative	Absence of leukocytes assessed with dipstick

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	Pending	As the urine seems to have an odor there is the potential for a UTI, especially given recurrent bouts of diarrhea. More likely that the strong odor is related to the urine being highly concentrated.

Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	Pending	If the infection is related to a virus or bacteria the result is likely to be negative.
Respiratory ID Panel	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

Andropoulos, D.B. (2011 August). *Appendix B: Pediatric normal laboratory values*. Texas Children's Hospital Clinical Laboratory. Retrieved from https://onlinelibrary.wiley.com/doi/pdf/10.1002/9781444345186.app2

Peirson, E. (2017 April 3). *Pediatric thyroid reference ranges* [Blog]. Peirson Center for Children. Retrieved from https://www.peirsoncenter.com/articles/pediatric-thyroid-reference-ranges

Swearingen, P.L. (2016). *All-in-One nursing care planning resource (4th ed.)*. St. Louis, 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	5% dextrose 0.45% normal saline
Dose	Based on available guidelines for weight-based maintenance fluid administration: <10 kg = 100 mL per kg 11-20 kg = 1000 mL + 50 mL/kg for the next 10 kg >20 kg = 1500 mL + 20 mL/kg for each kg over 20 kg
Frequency	PRN
Route	I.V.
Classification	Dextrose solution
Mechanism of Action	Replaces extracellular fluid volume lost due to vomiting, diarrhea, fever, and insensible losses.
Reason Client Taking	Dehydration related to acute gastroenteritis
Concentration Available	5% dextrose in a solution of ½ (0.45%) normal saline.
Safe Dose Range Calculation	For a patient of 20.5 kg, no more than 1510 mL per day to avoid hypervolemia.
Maximum 24-hour Dose	I.V. fluids administered at a rate of 62 mL/hr x 24 hours = 1488 mL/day
Contraindications (2)	None.
Side Effects/Adverse Reactions (2)	Hypervolemia and electrolyte imbalances

Nursing Considerations (3)	Monitor the patient closely for signs and symptoms of hypervolemia and electrolyte imbalances (crackles, polyuria, dysrhythmias, abnormal musculoskeletal reactivity). Strict monitoring of inputs and outputs should be performed with rate of fluid administration adjusted accordingly. Monitor the I.V. site closely for signs of infiltration (cool skin, edema) and phlebitis (erythema, warmth, tenderness).
Client Teaching needs (2)	Recommend oral rehydration solutions with symptoms of vomiting and diarrhea and to avoid carbonated beverages and sugary drinks. As the patient recovers, they should advance slowly back to their regular diet as tolerated. Appropriate hand hygiene and personal hygiene are important for preventing gastrointestinal infections, along with proper food preparation (wash all produce and avoid contact with raw meat and juices).

Medication Reference (APA):

Ricci, S.S., Kyle, T., Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Swearingen, P.L. (2016). *All-in-One nursing care planning resource (4th ed.)*. St. Louis, MO: Elsevier.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is well-groomed and appears to be in good overall health. Nonverbal and verbal indicators of pain are present as assessed using the FACES scale (rated 2/5). Patient is awake, alert and oriented x3. No other information is available due to

	limitations of the vSim.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin is pale and cool but intact with no rashes, bruises, or wounds. Skin turgor is poor with tenting upon assessment. Braden Score not applicable given limitations of vSim. No other information is available due to limitations of the vSim.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Mucous membranes are dry. No other findings of note per vSim assessment. No other information is available due to limitations of the vSim.
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:**	The heart rate and rhythm are normal with no evidence of murmurs. Patient is tachycardic, but with a normal sinus rhythm per ECG. Peripheral pulses are strong and regular. Capillary refill is >8 seconds. No other information is available due to limitations of the vSim.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Labored breathing is audible with tachypnea as evidenced by a respiratory rate of 30-32 breaths/ minute. No evidence of airway obstruction. Lung

	sounds are clear and equal bilaterally. Chest movement is equal bilaterally. No other information is available due to limitations of the vSim.
GASTROINTESTINAL (2 points): **Diet at home:** **Current diet:** **Height (in cm):** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient's mother reports that the patient has not eaten anything unusual. Vomiting and diarrhea reported over last 3 days. Anorexia reported by patient's mother. Bowel sounds are hyperactive. No other information is available given the limitations of the vSim.
GENITOURINARY (2 Points): **Color:** Dark yellow **Character:** Odor **Quantity of urine:** 20 mL **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** N/A **Catheter: Y ☐ N ☒** **Type:**	The urine is concentrated with a strong odor. Dipstick is negative for nitrite, hemoglobin, leukocytes, glucose, and protein. No other information is available due to limitations of the vSim.

Size:	
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices: N/A** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: N/A** **Activity/Mobility Status:** **Independent (up ad lib) x** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Muscle strength, sensations, and deep tendon reflexes are normal and intact, with no signs of clonus. The patient is ambulatory and up ad lib. No other information is available due to limitations of the vSim.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	EOM are intact. Pupils are approximately 7 mm in size and reactive to light bilaterally. Patient's mother reports no LOC and patient is alert and oriented. Growth and development are appropriate for age-related developmental milestones. No other information is available due to limitations of the vSim.
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**	No pets are in the home. No smokers live in the home. The patient has not traveled within the last year.

available family support):	

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0947	190 beats/min	83/65	30 breaths/min	99°F (tympanic)	97% (room air)

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

Pulse Rate	65-110 bpm
Blood Pressure	Patient's is > 97th percentile for height. SBP: 96-120 DBP: 56-81
Respiratory Rate	20-25 breaths/min
Temperature	97-100.4°F
Oxygen Saturation	94-100% on room air

Normal Vital Sign Range Reference (APA):

Ricci, S.S., Kyle, T., Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Wyckoff, A.S. (2009 November 1). Thermometer use 101. American Academy of Pediatrics (AAP) News, 30(11), p. 29. https://doi.org/10.1542/aapnews.20093011-29a

Pain Assessment, 2 sets (2 points)

Time	**Scale**	**Location**	**Severity**	**Characteristics**	**Interventions**
0947	FACES (0-5)	Abdomen	2/5	N/A	No orders provided for analgesics and nonpharmacological interventions not available in vSim.
Evaluation of pain status *after* intervention	N/A	N/A	N/A	N/A	N/A
Precipitating factors: Vomiting, diarrhea, and anorexia related to gastroenteritis and dehydration. **Physiological/behavioral signs:** Nonverbal cues include trembling voice and facial grimace.					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
Bolus in ED: 400 mL Over 30-minute duration of vSim: 31 mL 24-hour total: 1888 mL	Not provided related to limitations of vSim**.**

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. Can count 10 or more objects and identify at least 4 colors.
2. Use 4-5 word sentences in conversation or to pose questions and make observations.
3. Develops sexual identity; recognizes themselves as male or female.

Age Appropriate Diversional Activities

1. Provide a simple jigsaw puzzle.
2. Provide crayons and a coloring book.
3. Simple board games, such as Candy Land or Chutes & Ladders.

Psychosocial Development:

Which of Erikson's stages does this child fit?

A five-year-old is characterized as a preschooler according to models of growth and development. This would place the patient in Erikson's stage of developing a sense of initiative vs. guilt. Initiative is developed as the child is able to successfully complete simple tasks, such as household chores, and is not expected to perform any activity in which they are overextended or expected to provide results that are inconsistent with their current growth and development, which could lead to feelings of guilt. Moral development is also ongoing across the years of 3-6 years of age, so children are developing a simple understanding of right and wrong but with a view that is very black and white.

What behaviors would you expect? The child is likely to seek out opportunities to help the adults in their life with housekeeping tasks. Likely to express frustration and sadness if they feel as though the task is too hard or can't be completed as directed. Expressions of judgement regarding whether their actions and those of others are "good" or "bad", perhaps judgements on whether that makes someone a "nice" or "mean" person.

What did you observe? The patient was calm and cooperative. Based on the patient's understanding explanations of assessments and procedures, the ability to provide samples of urine and stool with assistance, and appropriate communication she seems developmentally normal. Any further conclusions are limited by the nature of the vSim.

Cognitive Development:

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

Preschool age children remain in the preoperational stage of cognitive development, meaning they have an egocentric view of the world. They understand issues or conflict from only one point of view and are unable to understand that others may have a different perspective. Magical thinking, an expanding imagination, and imaginary play are another characteristic of this age group. These are important components for how the child interprets and understands the world around them and their experiences.

What behaviors would you expect?

An imaginary friend and observation of a patient conversing with this friend are expected findings. Magical thinking may lead the child to believe their thoughts manifested in events in reality. Children at this age enjoying feeling purposeful and helping with simple

tasks. Modeling procedures on a stuffed animal or related toy to help explain a procedure will be useful in this age group and they may mimic your actions.

What did you observe? Cognitive development is difficult to assess given the limitations of the vSim. The patient was able to answer questions appropriately and expressed feeling dizzy and that her tummy hurt, which is consistent with expected symptoms given her diagnosis and suggests she understands these concepts and feelings.

Vocalization/Vocabulary: A child of this age should be able to speak in four to five word sentences and can have a vocabulary of ~2000 words. The child should be able to enunciate well and is usually understood by family and unfamiliar adults. Conversations become more involved and longer and the curiosity of this group prompts them to ask "Why?" frequently in attempts to increase their understanding. They should know their name and may be able to state their address and identify their parents or other family members.

Development expected for child's age and any concerns? Growth and development seem appropriate, which was confirmed at the child's last well-child appointment with the primary care provider per mother.

Any concerns regarding growth and development? No concerns at this time, especially within the limitations of the vSim.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing	• Explain why		• How did the

diagnosis with "related to" and "as evidenced by" components	the nursing diagnosis was chosen		patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Deficient fluid volume related to vomiting, diarrhea, and limited oral intake as evidenced by dry mucous membranes, tenting of the skin, and laboratory values.	Gastroenteritis puts pediatric patients at high risk for dehydration, abnormal electrolyte values, and imbalanced nutrition due to poor oral intake of fluids and food matched with losses from vomiting and diarrhea.	**1.** Provide oral rehydration solution and encourage oral fluid intake 2. Strict monitoring of I&Os.	Patient drinks at least 50 mL of oral rehydration solution per day, with at least 20 mL urine output per hour.
2. Risk for electrolyte imbalance related to dehydration as evidenced by elevated serum K+ and Na+	Gastroenteritis puts pediatric patients at high risk for dehydration, abnormal electrolyte values, and imbalanced nutrition due to poor oral intake of fluids and food matched with losses from	**1**. Encourage fluid intake equivalent to needs based on weight **2.** Provide maintenance fluids intravenously	Skin turgor improves, mucous membranes appear moist, capillary refill is <2 sec. Maintenance fluids will be adjusted down as oral intake improves, and eventually eliminated. Signs and symptoms of infiltration and phlebitis are absent.

	vomiting and diarrhea.		
3. Imbalanced nutrition, less than body requirements related to anorexia as evidenced by guardian's report of limited food and fluid intake and anuria.	Gastroenteritis puts pediatric patients at high risk for dehydration, abnormal electrolyte values, and imbalanced nutrition due to poor oral intake of fluids and food matched with losses from vomiting and diarrhea.	1. Assess weight at the same time each day. 2. Avoid the BRAT(bananas , rice, applesauce, and toast) diet and foods that are fried and high in saturated or trans fats. No sugary or carbonated beverages.	Patient meets caloric needs based on age and BMI with appropriate percentages of health fats, carbohydrates, and proteins (~1400 cal/day). Absence of vitamin and mineral deficiencies and electrolyte imbalances. Patient tolerates oral intake of regular diet without gastrointestinal distress (absence of nausea, vomiting, diarrhea, and constipation).
4. Risk for infection related to deficient hygiene practices as evidenced by acute gastroenteritis signs and symptoms and lack of experience with infectious	Gastroenteritis is transmitted via the fecal oral route through poor hygiene practice or contaminated food and water.	1. Teach patient appropriate techniques for hand hygiene 2. Educate about potential dietary sources of pathogens (produce, raw meat and seafood).	Patient can express that washing hands for as long as it takes to sing "Happy Birthday" is an appropriate amount of time for this practice. Patient expresses an understanding of the importance of keeping hands away from the eyes, mouth, and face and not sharing food or beverages with anyone.

process			

Other References (APA):

Ackley, B.J., Ladwig, G.B., Flynn Makic, M.B., Martinez-Kratz, M., Zanotti, M. (2020). *Nursing diagnosis handbook: An evidence-based guide to planning care* (12th ed.). Elsevier.

Ricci, S.S., Kyle, T., Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Swearingen, P.L. (2016). *All-in-One nursing care planning resource (4th ed.)*. St. Louis, MO: Elsevier.

Concept Map (20 points):

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Subjective Data

Anorexia
Lethargy (“listless”)
Patient reports feeling “dizzy”
Patient reports “tummy hurts”

Nursing Diagnosis/Outcomes

Primary Diagnosis of Dehydration r/t Acute Gastroenteritis

Return of normal capillary refill (<2 sec), elastic skin turgor, and moist mucous membranes

Return of baseline vital signs within expected reference ranges (resolution of tachypnea and tachycardia)

Absence of viral, bacterial, and parasitic pathogens in the gastrointestinal tract with a pain rating of 0/5 using FACES scale

Regular diet is resumed with return to previous weight

Objective Data

Tachycardia
Tachypnea
Hypotension
Poor capillary refill
Poor skin turgor
Low grade fever
Anuria
Electrolyte imbalances (elevated potassium and sodium)

Patient Information

E.M.
5 year, 4 month female
120 cm, 20.5 kg
No Known Allergies
No Past Medical or Surgical History
Full Code

Nursing Interventions

Strict I&O
Delivery of I.V. maintenance fluids
Frequent assessment of vital signs and cardiopulmonary status
Provide oral rehydration solution
Resume regular diet as tolerated
Request analgesics for reported abdominal pain
Education regarding treatment and transmission of gastroenteritis and hygiene

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Concept Map (20 Points):