N433 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 6/19/2020	**Patient Initials** E.M.	**Age (in years & months)** 5 years & 5 months	**Gender** Female
Code Status Full Code	**Weight (in kg)** 20.5 kg	**BMI** 14.2	**Allergies/Sensitivities (include reactions)** No Known Allergies

Medical History (5 Points)

Past Medical History:

Illnesses: The patient has no illness history.

Hospitalizations: The patient does not have hospitalization history.

Past Surgical History: The patient does not have any previous surgical history.

Immunizations: The patient's vaccinations are up to date.

Birth History:

Complications (if any): The patient did not have any problems.

Assistive Devices: The patient does not need assistive devices.

Living Situation: The patient lives with her mom and dad.

Admission Assessment

Chief Complaint (2 points): Vomiting and diarrhea for three days.

Other Co-Existing Conditions (if any): N/A

Pertinent Events during this admission/hospitalization (1 point): The patient lost 0.7 kg since her last check-up. She is pale, lethargic, and has dry mucous membranes. An intravenous saline bolus of 400 mL started in the emergency department.

History of present Illness (10 points):

Eva is a 5-year-old female who presented to the emergency department on 6/19/2020. Her mom complained that Eva has had a three-day history of vomiting and diarrhea, can't keep fluids down, and hasn't had urination since yesterday. Eva says she has a crampy pain in her tummy and rates it a 2/5 on a FACES pain scale and worsens whenever she moves. She states, "nothing makes me better." Eva also feels dizzy, appears pale, lethargic, and her mucous membranes are dry. She has finished an intravenous saline bolus of 400 mL in the emergency department and is now on the pediatric floor.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Dehydration

Secondary Diagnosis (if applicable): Gastroenteritis

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

Dehydration

Dehydration is a condition of decreased water volume in the body. In dehydration, there is a deficit of intracellular fluid, which causes the body cells to deflate. There is also a reduced amount of water in the extracellular fluid (Capriotti & Frizzell, 2016).

Signs and symptoms include thirst, dry mucous membranes, and weakness (Capriotti & Frizzell, 2016). E.M. is not able to keep fluids down; her mucosa is dry; she appears pale and listless.

Expected findings include low urine output, dark urine, poor skin turgor, dry mucous membranes, hypotension, and a rapid heart rate (Kahn, 2019). E.M. had not been able to urinate since 2000 yesterday, her urine is concentrated and has a strong smell, has a capillary refill more than eight seconds, has dry mucosa, and has a B.P. of 81/65 and a pulse rate of 185 bpm.

Diagnostic testing includes high blood urea nitrogen (BUN), oliguria, and a sodium blood test (Capriotti & Frizzell, 2016). E.M.'s BUN level is 20 and is within the normal range. Her sodium level is at 145, higher than the normal range due to dehydration (Pagana et al., 2019).

Particular tests performed are urinalysis and stool ova and parasites + culture for E.M.'s secondary diagnosis of Gastroenteritis (Capriotti & Frizzell, 2016). E.M.'s urinalysis is mostly in the normal range, except for being concentrated.

Treatment includes oral fluids and I.V. 0.45% NaCl (Capriotti & Frizzell, 2016). E.M. received normal saline bolus 400 mL I.V. over 15 minutes while in the emergency department and is now on dextrose 5% in 0.45% standard saline IV at 62 mL/hr on the pediatric floor.

One potential complication associated with dehydration is urinary and kidney problems. Extended or recurrent periods of dehydration can cause UTI, kidney stones, and kidney failure (Mayo Clinic, 2019). Ways to prevent this complication include reducing salt intake, drinking enough water, and exercising regularly (Biggers, 2019).

A second potential complication is seizures, where the electrolytes in the body are imbalanced, which causes involuntary muscle contractions and sometimes leads to a loss of consciousness (Mayo Clinic, 2019). Drinking plenty of fluids can help reduce the chances of electrolyte imbalance (Olsen, 2019).

Pathophysiology References (2) (APA):

Biggers, A. (2019). *How to prevent kidney failure*. https://www.healthline.com/health/kidney-health/how-to-prevent-kidney-failure

Capriotti, T., & Frizzell, J.P. (2016). *Pathophysiology: introductory concepts and clinical perspective* (1st ed.). F. A. Davis Company.

Kahn, A. (2019). *What to know about dehydration*. https://www.healthline.com/health/dehydration

Olsen, N. (2019). How to prevent an electrolyte imbalance. https://www.healthline.com/health/food-nutrition/how-to-prevent-an-electrolyte-imbalance

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference (14th ed.). Elsevier.

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. Strict I&O. Weigh daily.
Labs/Diagnostic Tests:	Urinalysis, stool ova and parasites + culture.
Treatments:	Normal saline bolus 400 mL to infuse over 15 min (started in ED). After bolus, begin D5 ½ NS at maintenance rate 62 mL/hr.
Other:	Repeat Chem 7 tomorrow a.m.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
There are no new orders.	There are no new orders.

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	Lab not ordered.	Lab not ordered.	
Hgb	13.5-17.5 g/dL	Lab not ordered.	Lab not ordered.	
Hct	40-50%	Lab not ordered.	Lab not ordered.	
Platelets	150-400*10^9	Lab not ordered.	Lab not ordered.	
WBC	4-11*10^9	Lab not ordered.	Lab not ordered.	
Neutrophils	40-60%	Lab not ordered.	Lab not ordered.	
Lymphocytes	20-40%	Lab not ordered.	Lab not ordered.	
Monocytes	2-8%	Lab not ordered.	Lab not ordered.	
Eosinophils	1-4%	Lab not ordered.	Lab not ordered.	
Basophils	0.5-1%	Lab not ordered.	Lab not ordered.	
Bands	0-3%	Lab not ordered.	Lab not ordered.	

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	Lab not ordered.	Sodium is elevated due to patient being dehydrated (Pagana et al., 2019).
K+	3.6-4.6 mEq/L	4.7	Lab not ordered.	Potassium is elevated dur to patient being dehydrated (Pagana et al., 2019).
Cl-	101-111 mEq/L	110	Lab not ordered.	

Glucose	65-140 mg/dL	65	Lab not ordered.	
BUN	8-23 mg/dL	20	Lab not ordered.	
Creatinine	0.8-1.4 mg/dL	0.9	Lab not ordered.	
Albumin	3.4-5.4 g/dL	Lab not ordered.	Lab not ordered.	
Total Protein	6.0-8.3 gm/dL	Lab not ordered.	Lab not ordered.	
Calcium	8.8-10 mg/dL	Lab not ordered.	Lab not ordered.	
Bilirubin	<0.3 mg/dL	Lab not ordered.	Lab not ordered.	
Alk Phos	100-320 U/L	Lab not ordered.	Lab not ordered.	
AST	13-35 U/L	Lab not ordered.	Lab not ordered.	
ALT	10-25 U/L	Lab not ordered.	Lab not ordered.	
Amylase	23-85 U/L	Lab not ordered.	Lab not ordered.	
Lipase	0-160 U/L	Lab not ordered.	Lab not ordered.	

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	Lab not ordered.	Lab not ordered.	Lab not ordered.	
CRP	Lab not ordered.	Lab not ordered.	Lab not ordered.	
Hgb A1c	Lab not ordered.	Lab not ordered.	Lab not ordered.	
TSH	Lab not ordered.	Lab not ordered.	Lab not ordered.	

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	Amber yellow clear	Lab not ordered.	Dark yellow	The patient's urine is dark due to dehydration (Pagana et al., 2019).
pH	5.0-9.0	Lab not ordered.	Lab not ordered.	
Specific Gravity	1.005-1.030	Lab not ordered.	Lab not ordered.	
Glucose	Negative	Lab not ordered.	Negative	
Protein	Negative	Lab not ordered.	Negative	
Ketones	Negative	Lab not ordered.	Lab not ordered.	
WBC	Negative	Lab not ordered.	Lab not ordered.	
RBC	Negative	Lab not ordered.	Negative	
Leukoesterase	Negative	Lab not ordered.	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	(+)<10,000mL (-)>100,000 mL	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.	
Blood Culture	Negative	Lab not ordered.	Lab not ordered.	
Sputum Culture	Normal upper respiratory tract	Lab not ordered.	Lab not ordered.	
Stool Culture	Normal intestinal	Information	Information	

	flora	unavailable due to limitations in the vSim.	unavailable due to limitations in the vSim.	
Respiratory ID Panel	Negative	Lab not ordered.	Lab not ordered.	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference (14th ed.). Elsevier.

Diagnostic Imaging

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

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

Diagnostic Test Reference (APA): N/A due to information unavailable due to limitations in the vSim.

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

Brand/Generic	Normal Saline (sodium chloride injection)	Dextrose 5% in 0.45% Sodium Chloride (dextrose and sodium chloride inj)	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.
Dose	400 mL	62mL	N/A	N/A	N/A
Frequency	Infuse over 15 minutes	Continuous	N/A	N/A	N/A
Route	IV	IV	N/A	N/A	N/A
Classification	Mineral and electrolyte replacements (*2019 Nurse's Drug Handbook*,	Nutritional supplement (*2019 Nurse's Drug Handbook,* 2019).	N/A	N/A	N/A

	2019).				
Mechanism of Action	Maintain water distribution, fluid, and electrolyte balance (*2019 Nurse's Drug Handbook*, 2019).	Acts as an osmotic diuretic (*2019 Nurse's Drug Handbook*, 2019).	N/A	N/A	N/A
Reason Client Taking	For hydration (*2019 Nurse's Drug Handbook*, 2019).	To replace calories (*2019 Nurse's Drug Handbook*, 2019).	N/A	N/A	N/A
Concentration Available	0.9% and 0.45%	5%	N/A	N/A	N/A
Safe Dose Range Calculation	410 mL/hr	41-82 mL/dose	N/A	N/A	N/A
Maximum 24-hour Dose	17mL	3mL	N/A	N/A	N/A
Contraindications (2)	1. Contraindicated in pt.'s with renal impairment. 2. Contraindicated in pt.'s with sodium retention (*2019 Nurse's Drug Handbook*, 2019).	1. Diabetic coma & elevated glucose. 2.Overhydration (*2019 Nurse's Drug Handbook*, 2019).	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	1. Edema 2.Hypervolemia (*2019 Nurse's Drug Handbook*, 2019).	1. Fluid overload. 2. Local pain/irritation at IV site (*2019 Nurse's Drug Handbook*, 2019).	N/A	N/A	N/A
Nursing Considerations (3)	1. Assess fluid balance throughout therapy. 2. Assess for	1. Assess infusion site regularly for infiltration. 2. Monitor for	N/A	N/A	N/A

	hyponatremia. 3. Monitor sodium, potassium, bicarbonate, and chloride concentrations (*2019 Nurse's Drug Handbook*, 2019).	hypovolemia. 3. Assess for glucosuria (*2019 Nurse's Drug Handbook*, 2019).			
Client Teaching needs (2)	1. Report signs of pain at I.V. site. 2. Report signs of infection at I.V. site (*2019 Nurse's Drug Handbook*, 2019).	1. Report signs of discomfort at I.V. site. 2. Instruct pt. to monitor blood glucose (*2019 Nurse's Drug Handbook*, 2019).	N/A	N/A	N/A

Medication Reference (APA):

2019 Nurse's Drug Handbook (2019). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented. Patient is in distress due to her tummy ache. Patient is pale and lethargic. Patient looks her age.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Skin is within patient's norm. Fair skin; does not seem to be diaphoretic. Temperature is colder than the average range. There is tenting sign of the skin. No rashes, bruises, wounds, or scars; No peripheral edema is noted. There are no drains present. **Braden Score**: Information unavailable due to limitations in the vSim.
HEENT (1 point):	

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Head and neck are symmetrical. Face appears flushed, dry mucosa. No abnormalities are noted. Ears have no lesions. Extraocular movement is intact. The pupils are 7mm and react to light bilaterally. Septum is midline. Dentition is good. Thyroid: Information unavailable due to limitations in 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:**	Heart sounds normal. S1 and S2 without murmurs, gallops, or rubs. The heart rate and rhythm are regular. Heart rate is fast. Peripheral pulses 2+ symmetric. The capillary refill time is more than 8 seconds. No neck vein distention or edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Breath sounds are present and equal bilaterally. Patient is breathing 31 breaths per minute.
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:**	Has not been eating or drinking much at home. Current – diet as tolerated. Height: 120cm Bowel sounds are hyperactive. Last BM: Information unavailable due to limitations in the vSim. Patient has tummy ache and hurts when she moves. No mass. No distention, incisions, scars, drains, or wounds.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒**	The urine looks concentrated and has a strong smell. Quantity & Inspection of genitals: Information unavailable due to limitations in the vSim.

Dialysis: Y ☐ N ☒ **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	
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 ☐**	The muscle strength, sensation, and deep tendon reflexes are normal. There are no signs of clonus. Coordination: Normal finger to nose bilaterally. No pain, paralysis. No paresthesia. Cold temperature. No swelling or increased pressure. Do not need supportive devices and is active and mobile. **Fall Score**: Information unavailable due to limitations in 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:**	Alert and oriented to person and place. Speech is articulate. Normal sensation. No LOC. Judgement and thought content normal.
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):**	She has a stuffed toy with her. She lives with both of her parents and they are also her support. Her family is Baptist.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0948	185	81/65	31	99°F	94%

Normal Vital Sign Ranges (2.5 points)

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

Pulse Rate	80-120 (Novak, 2018).
Blood Pressure	89-112/46-72 (Novak, 2018).
Respiratory Rate	20-28 (Novak, 2018).
Temperature	98.6°F (Novak, 2018).
Oxygen Saturation	92-100% (Novak, 2018).

Normal Vital Sign Range Reference (APA):

Novak, C. (2018). *Pediatric vital signs reference chart*. https://www.pedscases.com/pediatric-vital-signs-reference-chart

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0948	FACES 0-5	Tummy	2	Crampy	Information unavailable due to limitations in the vSim.
Evaluation of pain status *after* interventio n	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the vSim.
Precipitating factors: Vomiting and diarrhea. **Physiological/behavioral signs:** E.M.'s facial expressions include frowning and wincing. She slightly moans while talking.					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
Information unavailable due to limitations in the vSim.	Information unavailable due to limitations in the 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. Child can speak four to five sentences.
2. Child does not show stranger anxiety.
3. Better understanding of the concept of time and the order of daily activities.

Age Appropriate Diversional Activities

1. Having stuffed toys.
2. Playing pretend.
3. A simple jigsaw puzzles.

Psychosocial Development:

Which of Erikson's stages does this child fit? E.M. fits in Erikson's initiative vs. guilt.

What behaviors would you expect? During this stage, children start to have control over their surroundings through social interaction and play. Children can face challenges, accomplish tasks, and experience fear and guilt when mistakes occur (Ricci et al., 2017).

What did you observe? E.M. answered all the questions during the pain assessment well, such as locating the pain, its onset, and asked for something to relieve her pain.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? E.M. fits in Piaget's preoperational phase.

What behaviors would you expect? During this phase, preschoolers use symbolic thinking; language becomes more developed and develops imagination and memory (Ricci et al., 2017).

What did you observe? E.M. is aware of her environment and can verbalize and use the FACES pain scale to express her pain intensity. She also has a stuffed dog for comfort.

Vocalization/Vocabulary: E.M. communicates well for her age. She can speak in sentences of four to five words and can describe her pain.

Development expected for a child's age and any concerns? The expectation of E.M.'s growth is standard, and there are no concerns.

Any concerns regarding growth and development? There are no concerns regarding E.M.'s growth and development.

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.Weight loss due to inadequate intake of fluid as evidenced by vomiting, diarrhea, and 0.7kg reduction in weight.	The patient has been having diarrhea and vomiting for the last three days and a loss of 0.7kg.	1. Assess weight on admission and daily. 2. Assess dietary intake through 24hr recall or questions regarding usual intake of food groups.	Within 24-48hrs after intervention/treatment, the patient maintains or gains weight and exhibits no further vomiting or diarrhea.

2. Fluid volume deficit related to inability to ingest fluids as evidenced by vomiting, diarrhea, oliguria, and dry mucous membranes.	The patient has not been drinking much at home due to diarrhea and vomiting. She also has dry mucous membranes and oliguria.	1. Assess and document skin turgor. Check hydration status by pinching skin over the sternum of forehead. 2. If the patient is receiving IV therapy, assess cardiac and respiratory systems for signs of overload. Assess the apical pulse and listen to lung fields during every VS assessment.	Within 24hr after interventions, the patient's vital sighs, urine color, consistency, and concentration are within normal limits for this patient. The patient's mucous membranes are moist, and there is no tenting of skin. The patient's intake equals output.
3. Ineffective breathing pattern related to pain as evidenced by use of accessory muscles.	The patient says she has trouble breathing and is breathing at 31 bpm.	1. Place patient with proper body alignment for maximum breathing pattern. 2. Encourage frequent rest periods and teach patient to pace activities.	The patient maintains an effective breathing pattern, as evidenced by relaxed breathing at normal rate and depth and absence of dyspnea.
4. Acute pain related to gastroenteritis as evidenced by pain rating of 2/5 on a FACES pain scale and wincing.	The patient says she has pain in her tummy and rated it a 2/5 on a FACES pain scale while wincing.	1. Assess for behavioral and physiologic indicators of pain at frequent intervals. Document responses. 2. Use a formal patient-specific method of assessing self-reported pain when possible, including description, location, intensity, and aggravating/alleviating factors.	The patient's subjective report of pain using a pain scale, the mother's report, and behavioral and/or physiologic indicators reflect that pain is either reduced or at an acceptable level within 1-2hr.

Other References (APA):

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

Swearingen, P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):

N422 Care Plan

Subjective Data

Three-day history of vomiting and diarrhea, inability to keep fluids down, and no urination since 2000 yesterday. Patient states, “I feel dizzy.” She also states, “I have some pain in my tummy.”

Nursing Diagnosis/Outcomes

Nursing Diagnosis #1 1. Weight loss due to inadequate intake of fluid as evidenced by vomiting, diarrhea, and a 0.7kg reduction in weight.
Outcome Within 24-48hrs after intervention/treatment, the patient maintains or gains weight and exhibits no further ...ing or diarrhea.
Nursing Diagnosis #2 Fluid volume deficit related to inability to ingest fluids as evidenced by vomiting, diarrhea, oliguria, and dry mucous membranes.
Outcome Within 24hr after interventions, the patient’s vital sighs, urine color, consistency, and concentration are within normal limits for this patient. The patient’s mucous membranes are moist, and there is no tenting of skin. The patient’s intake equals output.
Nursing Diagnosis #3 Ineffective breathing pattern related to pain as evidenced by use of accessory muscles.
Outcome The patient maintains an effective breathing pattern, as evidenced by relaxed breathing at normal rate and depth and absence of dyspnea.
Nursing Diagnosis #4 Acute pain related to gastroenteritis as evidenced by pain rating of 2/5 on a FACES pain scale and wincing.
Outcome The patient’s subjective report of pain using a pain scale, the mother’s report, and behavioral and/or physiologic indicators reflect that pain is either reduced or at an acceptable level within 1-2hr.

Objective Data

Sodium 145
Potassium 4.7
Urine concentrated and has foul odor
Pulse 185
BP 81/65
Resp Rate 31
Abnormal results indicating that the patient is dehydrated.

Patient Information

E.M.
Admitted 6/19/2020 for a three-day history of vomiting and diarrhea.
5 years old & 5 months
Female, Caucasian
Weight: 20.5 kg
BMI: 14.2
Allergies: No known allergies
Code: FULL

Nursing Interventions

Intervention 1:
Assess weight on admission and daily.
Avoid BRAT diet
Intervention 2:
Assess and document skin turgor.
Assess cardiac and respiratory systems for overload when receiving IV.
Intervention 3:
Place pt. with proper body alignment for maximum breathing pattern.
Encourage rest periods and to pace activities.
Intervention 4:
Assess for behavioral & psychological sings of pain/
Use formal patient specific methods of assessing self-reported pain when possible, using OLDCART.