Dx: Deficient fluid volume related to active fluid volume loss as evidenced by diarrhea and lack of appetite
Expected outcome: The client will intake 2000 ml of oral fluids daily for the next week

Interventions

1: Assess weight on admission and daily on the same scale at the same time
2: Replace fluid orally or via IV as ordered by physician
3: Encourage patient to drink prescribed fluid amounts
4: Measure vital signs every 4 hours
5: Document baseline mental status and record during each nursing shift.
6: Assess skin turgor and mucous membranes for signs of dehydration.

Rationales

1: Gives more accurate results. Weight is a beneficial factor in assessing fluid balance
2: patient is staying hydrated and will also help the body maintain homeostasis
3:Oral fluid replacement is indicated for mild fluid deficit
4: HR is usually elevated in loss of fluid from the body
5: Dehydration can alter mental status
6: skin turgor should be assessed over the sternum or on the inner thighs
Evaluation: The patient drank 2000 mL of water 7 days in a row

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Dx: Risk for ineffective tissue perfusion related to decreased intravascular volume due to diarrhea as evidenced No S/S with "Risk for dx"
Expected Outcome: The patient will maintain adequate tissue perfusion throughout the hospital stay not measureable

Interventions "Tissue perfusion may not be appropriate dx"

1: Measure stool output-Assess
2: Assess skin turgor
3: Monitor vital signs every 2 hours
4: Monitor for changes in urine output
5: Monitor for changes in mental status such as restlessness & dysrhythmias
6: Use standard precautions and contact isolation

Rationales

1: Amount should be decreasing as treatment measures are successful
2: Poor skin turgor is a sign of dehydration
3: Decreased blood pressure and increased heart rate are signs of dehydration
4: Decreased urine output indicates
5: May indicate dehydration
6: Prevents spread to other patients or staff
Evaluation: The patient maintained adequate perfusion for the length of the hospital stay

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Dx: Risk for impaired skin integrity related to moisture as evidenced by frequent loose liquid stools
Expected Outcome: The patient will not show any signs of dehydration for the next 2 weeks not appropriate EO

Interventions

1: Assess patient's ability to move
2: Monitor site of skin impairment at least once a day for color changes, redness, swelling, warmth, pain
3: Change the patient's position every two hours when in bed
4: Minimize exposure of skin impairment and other areas to moisture from incontinence
5: Use pressure-relieving beds, mattress overlays, and chair cushions
6: Assess for edemahow is this related to pt situation?

Rationales

1: Immobility is the greatest risk factor in skin breakdown.
2: Inspection can identify impending problems early
3: Position changes relieve pressure, restore blood flow, and promote skin integrity
4: Moisture can accelerate the skin break down process
5: These devices redistribute pressure when frequent position changes are not possible
6: Skin stretched tightly over edematous tissue is at risk for impairment
Evaluation: The patient's skin remained hydrated and intact for 2 weeks

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Dx: Anxiety related to health status change as evidenced by social isolation "How is he isolating himself?
Expected Outcome: The client will remain free of anxiety for the duration of the hospital stay

Interventions

1: Decrease anxiety by using therapeutic touch
2: Encourage use of successful coping skills
3: Assess clients level of anxiety and physiologic reactions
4: Determine if patient feels socially isolated you indicated this already
5: Teach the client interventions that will reduce anxiety
6: Assess for depression or sadness

Rationales

1: Helps the client feel more relaxed
2: Previously used coping skills may help
3: Anxiety can cause negative effects on clients recovery
4: Contact isolation can make pt feel this way
5: Remove sources of anxiety when possible
6: Helps determine severity

anxiety during the hospital stay.

Can't visualize Eval statement for each dx

During the assessment there was bilateral lower quadrant pain with abdominal distention. Rectal bleeding is also present. This client complained of fatigue, congestion, post nasal drip, abdominal pain and constipation. No blood present in the stools. Positive for C. Difficile. The ct scan displayed severe thickening of the colon, specifically the rectosigmoid. The patient is now on a clear liquid diet. Labs show a low hemoglobin of 11.8 and hematocrit 35.9. Alert and orientated times 4, and ambulated without help. Calm and sitting without distress. Heart sounds heart were normal S1 and S2, no murmurs gallops, or clicks. Lungs were clear to auscultation equal bilaterally. Clients output of stool was mostly weary and blood tinged, with small particles. Voiding is regular, producing a clear amber urine. Abdomen is round, hyperactive bowel sounds heard in left lower and upper quadrants, and normoactive bowel sounds heard in right upper and right lower quadrant. Full range of motion in all extremities with 2+ strength in upper and lower extremities. Skin was warm and dry to touch, without any lesions or rashes. Capillary refill was less than 3 seconds, normal skin turgor. Dorsalis pedis pulses were strong at 2+. Medications include metronidazole infusion of 500mg/5ml and tramadol.

Required to list all medications ordered

Lab results

Past med hx