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| **Assessment: Client Data** *(What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)* | Nursing Diagnosis Statement(NANDA Approved) | | |
| ***Subjective Data:*** *(What did the client say about the issue?)* | ***NANDA Label:***  Deficient Fluid Volume  *Definition: Decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration, water loss alone without change in sodium level* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.} do you have about the issue?)* | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * repeated vomiting * repeated diarrhea * decreased fluid intake * blood loss * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are* ***the signs and/or symptoms*** *that prove the NANDA Label is a problem.)* | | |
| **Planning: Client Outcome** |  | | |
| ***Outcome*** *(Only one behavior/response. Needs to be specific, observable, measurable, achievable, realistic and timed for THIS client.)* | | ***Time*** *(When you expect the response to occur. If there is an agency policy for reassessment, such as with pain, utilize that time frame in your outcome to add it to your workflow.)* | |
| **The client will:**   * Will drink 2000mL of fluids * Have no loss of fluids; emesis, diarrhea, blood; * Identify 2 measures that prevent or treat fluid deficit * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * By the end of hospital day \_\_\_\_\_ *(1, 2, 3?)* * within \_\_\_\_\_ minutes of administration of \_\_\_\_\_\_ (medication) * by discharge / transfer *(circle one)* * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **PLANNING:** **Interventions** *(Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)* | **IMPLEMENTATION:** *(****Document how you implemented the intervention and the client’s response*** *If you were unable to implement the intervention, state that, and why.)* |
| * Monitor total fluid intake and output every 4 hours (or every hour for the unstable client or the client who has urine output equal to or less than 0.5 mL/kg/hr). *To modify interventions early if output is decreasing (Potter, Perry, Stockert, & Hall, 2020).* |  |
| * Provide fresh water and oral fluids preferred by the client. *Client will increase intake if fluids are provided to them increasing fluid volume (Ackely, Ladwig, & Makic, 2020).* |  |
| * Provide oral replacement therapy as ordered and tolerated with a hypotonic glucose-electrolyte solution when the client has acute diarrhea or nausea/vomiting*. Hypotonic solutions increase water absorption and replenish electrolytes lost, increasing client fluid volume (Ackely, et al, 2020).* |  |
| * Administer antidiarrheals and antiemetics as ordered and appropriate. *To stop fluid loss, increasing the amount the fluid retained (Ackely, et al, 2020).* |  |
| * Encourage fluid intake by offering fluids regularly and with daily routines. *To remind the client to keep taking in fluids and increase the times the fluids are available to the client to increase fluid volume (Ackely, et al, 2020).* |  |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
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