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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, measureable, 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.)/* ***Make sure to cite the source (Ackley book) and add the page number at the end of each rationale in the box(es) below.*** | **IMPLEMENTATION:** *(Document how you implemented the intervention and the client’s response If you were unable to implement the intervention, state that, and why.)* |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
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