

(FLUID VOLUME DEFICIT) NURSING CARE PLAN

Medical Diagnosis: Fluid Volume Deficit

Subjective Data:	Nursing Intervention (ADPIE)	Rationale
<ul style="list-style-type: none"> • Weakness • Extreme thirst • Dizziness 	Monitor and document VS (BP & HR, orthostatic BP) 20 mm drop in systolic and 10 mm drop in diastolic)	Decrease in blood volume can cause hypotension and tachycardia
	Assess skin turgor and mucous membranes	Dehydration can be detected through the skin.(Dry membranes and decreased skin turgor)
	Monitor I&O's (encourage fluid intake and monitor urine output) Noting urine color, amount, clear/cloudy, etc)	Make sure patient is taking in an adequate amount of fluids. Concentrated or decreased urine can indicate dehydration
Objective Data: <ul style="list-style-type: none"> • Alterations in mental state • Weight loss • Concentrated urine/ decreased urine output • Dry mucous membranes • Weak pulse/tachycardia • Decreased skin turgor • Hypotension • Postural hypotension • Sunken eyes/cheeks 	Monitor lab values	Dysrhythmias can reflect hypovolemia or electrolyte imbalances such as K, Mg. Elevated BUN, Creatinine, and urine specific gravity can reflect dehydration. Also, elevated hematocrit with no change in hemoglobin also reflects fluid volume deficit
	Give IV fluids (isotonic solutions) such as normal saline, lactated ringers, 5% dextrose in water)	Giving isotonic solutions will help aid in rehydrating the patient
	Daily weights (usually same time each day)	Best way of showing any fluid volume imbalance.
	Get proper health history from patient	Such factors as GI losses, uncontrolled DM II, or diuretic therapy can cause fluid volume deficit)
	Educate the patient/family on prevention/ treatment/S&S/when to call physician	Patient should know how to prevent dehydration and know when they should be concerned and contact physician if needed