`

CASE STUDY ON CARDIAC DYSRHYTHMIA

In partial fulfillment of the requirements in Related Learning Experience (RLE)

Ilocos Training Regional and Medical Center - GERIATRICS WARD

Presented by:

Dela Cruz, Rhenzel Jet Balancio
Duculan, Kurt Rusty Tacadena
Fangon, Aeron Joe Mercado
Dacanay, Jocelle Irish Tacas
Del Rosario, Maureen Sibolboro
Delos Santos, Kate Angeline A.
Directo, Leah Mae D.
Laroco, Jeozell G.
Ledda, Hannah Grace
Lianko, Sunshine
Student Nurses

Presented to:

Samantha Amiel Gracias, Rn
Clinical Instructor

College of Nursing, Lorma Colleges
City of San Fernando, La Union

Bachelor of Science in Nursing (BSN)

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CHAPTER I

INTRODUCTION

Cardiac dysrhythmia, also known as cardiac arrhythmia, is a significant cardiovascular condition characterized by an abnormality in the rate, rhythm, or electrical conduction of the heart. It occurs when the heart's electrical impulses malfunction, causing it to beat too fast (tachycardia), too slowly (bradycardia), or irregularly. The condition is commonly triggered by structural heart changes, endocrine disorders such as thyroid disease, chronic smoking, electrolyte imbalances, and aging. Older adults are particularly vulnerable to cardiac dysrhythmias due to age-related degeneration of the cardiac conduction system and the presence of underlying comorbidities. If not properly monitored and managed, persistent cardiac dysrhythmia can impair cardiac output and progress to severe, life-threatening complications such as stroke, heart failure, myocardial infarction, or sudden cardiac arrest (European Heart Rhythm Association , 2025; Mayo Clinic, 2026).

Globally, cardiovascular diseases remain the leading cause of mortality, accounting for an estimated 17.9 million deaths annually (World Health Organization [WHO], 2025). According to the European Heart Rhythm Association (2025), approximately 1 in 3 people worldwide are at risk of developing a serious heart rhythm disorder during their lifetime, with atrial fibrillation alone affecting nearly 59 million individuals globally and contributing to roughly 340,000 deaths each year (Global Burden of Disease, 2025). In the Philippines, heart disease continues to be the number one cause of mortality, accounting for 19.4% of all recorded deaths nationwide (Philippine Statistics Authority [PSA], 2025). Cardiac dysrhythmias frequently contribute to adult hospitalizations, particularly among elderly individuals in rural communities where limited financial resources, lack of maintenance medications, and delayed medical checkups hinder early detection and preventive cardiovascular care.

The patient in this case study is Mr. D.G.T. (Danilo Gorosin Tumabcao), a 66-year-old married Filipino male from Barangay Carisquis, Luna, La Union, admitted on November 10, 2026, with a chief complaint of cardiac dysrhythmia (admitting impression noted as "Checkup sana, mahina ang heart"). Based on the patient's health history and clinical profile, several predisposing and precipitating factors contributed to the development of his condition. Predisposing factors include his advanced age (66 years old), male sex, a family history of thyroid disease on both maternal and paternal sides, and a personal history of a thyroid disorder (with a past biopsy) and asthma. Precipitating factors include his 50-year history of cigarette smoking, the absence of regular maintenance medications, a high-exertion livelihood involving manual labor and harvesting (gapas), inadequate sleep averaging only 5 hours per night, and socioeconomic stress stemming from limited income while supporting six children.

Following prolonged exposure to nicotine and metabolic strain from underlying thyroid dysfunction (evidenced by an enlarged neck/goiter on physical examination), abnormal electrical automaticity and conduction disturbances develop within the myocardium. Thyroid hormone imbalances sensitize myocardial tissue to catecholamines, accelerating heart rate and increasing cardiac workload, while decades of smoking promote vascular endothelial damage and myocardial ischemia. These alterations disrupt normal sinoatrial and atrioventricular node signaling, leading to irregular cardiac rhythms, decreased ventricular filling time, and diminished cardiac output omanifesting clinically as perceived heart weakness ("mahina ang heart"), fatigue, and generalized body strain. Studies emphasize that uncorrected thyroid abnormalities and a history of chronic tobacco use significantly elevate the risk of sustained arrhythmias in older adults.

Evidence-based management of cardiac dysrhythmia involves thorough cardiac monitoring, electrocardiogram (ECG) evaluation, identification and correction of underlying triggers such as thyroid dysfunction, pharmacological rate or rhythm control, and lifestyle modification (Mayo Clinic, 2026).

Based on the patient's clinical presentation, supportive care and medical evaluation were initiated upon admission to stabilize his cardiac status, complemented by his current intake of multivitamins and ascorbic acid, smoking cessation, and a low-fat diet consisting mainly of rice and vegetables. Early medical consultation, adherence to prescribed maintenance therapy, and consistent follow-up at local health facilities such as the Luna Rural Health Unit and Balaoan District Hospital are essential to prevent hemodynamic instability and thromboembolic complications.

This case study aims to provide a comprehensive understanding of cardiac dysrhythmia, specifically its etiology, pathophysiology, clinical manifestations, medical management, and nursing interventions in an older adult patient. Through holistic nursing assessment, continuous cardiovascular monitoring, health education, and supportive care, life-threatening complications may be prevented and long-term cardiovascular wellness may be promoted effectively.

Patient-Centered Objectives

Throughout the duration of the study, the patient and his relatives are expected to:

- Demonstrate stable cardiac rate and rhythm within normal limits, free from signs of decreased cardiac output such as chest pain, severe dizziness, or dyspnea.
- Verbalize understanding of the nature of cardiac dysrhythmia, its relationship to thyroid health, and potential warning signs requiring immediate medical attention before discharge.
- Identify modifiable risk factors and commit to maintaining smoking cessation, adequate rest/sleep hygiene (7–8 hours per night), and stress-reduction practices.

- Comply with prescribed maintenance medications, diagnostic follow-ups (such as ECG and thyroid function monitoring), and heart-healthy dietary habits.
- Participate actively in monitoring pulse rate, blood pressure, and daily symptom changes at home and during follow-up visits at the Rural Health Unit.

Student-Centered Objectives

At the end of the case study, the student nurses will be able to:

- Perform a comprehensive, systematic health history and head-to-toe physical assessment of an older adult patient presenting with cardiac dysrhythmia.
- Trace and explain the pathophysiology, predisposing factors, and precipitating factors contributing to the patient's cardiac condition.
- Formulate accurate, prioritized nursing diagnoses based on the patient's subjective and objective clinical findings.
- Develop and implement an evidence-based nursing care plan focused on maintaining optimal cardiac output, activity tolerance, rest, and health education.
- Demonstrate accurate monitoring and interpretation of vital signs, apical-radial pulse rates, and signs of hemodynamic compromise.
- Provide culturally appropriate, accessible health teachings tailored to the patient's educational background and socioeconomic status regarding medication adherence, nutrition, and regular checkups.
- Evaluate the effectiveness of implemented nursing interventions through measurable stabilization of the patient's cardiovascular status and readiness for discharge.

CHAPTER II

NURSING HEALTH HISTORY

A. BIOGRAPHIC DATA

Patient M.A.M. is a 6-year-old Filipino female currently residing in Ambalite, Pugo, La Union. She is the youngest among the five children in the family and was born on May 31, 2019. She will be a Grade 2 pupil for the school year 2026–2027 at the elementary level. Her nationality is Filipino, and her religion is Roman Catholic. She speaks Iloco and Filipino.

B. REASON(S) FOR SEEKING HEALTH CARE

Due to symptoms of a stomachache, patient M.A.M. was taken to Rosario District Hospital on May 3, 2026. The patient was weak and had diarrhea and vomiting, according to her mother. "Uray na la iriyaw/isangit ta nasakit tiyan na," the mother said during the interview, indicating that the child's crying was caused by a stomach ache.

The patient's mother claims that on May 2, 2026, in the afternoon, the patient began to have stomachaches after eating a ripe Indian mango. This could have caused indigestion, which could have caused the following stomach pain.

C. HISTORY OF PRESENT HEALTH CONDITION

The patient was admitted on May 3, 2026, at 10:00 AM with a diagnosis of Acute Gastroenteritis with signs of moderate dehydration related to urinary tract infection. One day prior to admission, the patient experienced loose bowel movements four times, vomiting four times, and decreased appetite. No fever was noted. Due to the persistence of these symptoms, consultation and admission to the hospital were done, 1 day history of LBM 4x, Vomiting 4x, ⬇️ Appetite (-) fever ➡️ consult.

D. PAST HEALTH HISTORY

The patient has no history of previous surgeries or injuries. This is the first time the patient has been admitted to the hospital since birth.

E. FAMILY HEALTH HISTORY

There is no known history of serious illnesses in the patient's family. However, the mother stated that the patient's older brother ("kuya") also has a history of experiencing stomachaches.

F. LIFESTYLE & HEALTH PRACTICES

a. Description of a Typical Day

Patient M.A.M. usually eats breakfast at 7:30 AM, which is when her day typically starts. Because her playmates live close by, she walks outside to play with them after breakfast. They typically play with dolls for a while. She sometimes consumes rice as a snack during recess or break. She often eats dinner between 5:00 and 6:00 PM and lunch at around 11:30 AM. She usually goes to bed between 6:00 and 7:00 p.m. Patient M.A.M. is a loving daughter who loves playing with her mother and spending time with her family.

b. Nutrition & Weight Management

Patient M.A.M.'s dietary habits consist of rice, vegetables, meat, fruits, and seafood, which she particularly enjoys, as stated by her mother. In addition, she consumes approximately six cups of water per day. However, the mother verbalized that "mahilig siya sa mga junk foods at soft drinks." Recently, the patient weighed 22.5 kg. The mother ensures that her child consumes healthy foods and carefully monitors the food intake of

patient M.A.M. Kung nanay nagpapakain, strict. Pero dahil may tita and tito nagkakaroon ng unhealthy.

c. Activity Level & Exercise

Patient M.A.M. engages in social activities, such as playing outside their home. "Mahilig siyang makipaglaro, takbuhan, ganyan" are activities that are part of the patient's daily routine and are considered as light exercise, as stated to her mother.

d. Sleep & Rest

Patient M.A.M. usually goes to bed between 6:00 and 7:00 PM and wakes up between 7:00 and 7:30 AM to begin her day. This indicates that she gets more than eight hours of sleep per day, which is appropriate for her age and supports healthy growth and development as a six-year-old. Recognizing the need of sleep in maintaining general health and wellbeing, the mother also makes sure her child receives adequate sleep and rest.

e. Medication & Substance Use

The medications administered for her condition include omeprazole, diphenhydramine, racecadotril, paracetamol, and Erceflora. These medications were given during her hospital stay to help manage and treat her current illness.

f. Self-Concept & Self-Care Responsibilities

Patient M.A.M. is a happy, loving child who likes to play outside and hang out with her friends. She typically washes her hands properly after playing outside to get rid of dirt to prevent getting sick, showing that she is conscious of her personal hygiene and takes

responsibility for her own health. This demonstrates her growing independence in applying age-appropriate self-care responsibilities and her positive self-concept.

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g. Social Activities

Patient M.A.M. maintains her social life by interacting, playing, and spending time with her neighborhood friends. Her engagement in social activities helps in the development of essential social abilities including empathy, cooperation, communication, and sharing. As she grows up, these encounters may help her gain confidence in establishing connections, adapting to social situations, and developing a positive sense of community.

h. Relationships

Patient M.A.M. enjoys spending time with her family, especially with her mother, as well as with her friends.

i. Values & Belief System

Patient M.A.M. is a six-year-old Roman Catholic who has learned from her family to always pray to God. Her faith is strengthened and she is inspired to form a practice of prayer and faith in God by this early spiritual guidance

j. Education and work

Patient M.A.M. will be a Grade 2 pupil in the coming school year 2026–2027 at the elementary level.

k. Stress Levels & Coping Styles

The patient felt empty and sad during her almost five days in the hospital because she missed playing with her friends. Throughout her hospital stay, the mother reassured her by remaining positive and by her side.

l. Environment

Patient M.A.M. resides with her family in a mountainous or "kabanbantayan" area of Ambalite, Pugo, La Union. Their home is surrounded by fruit-bearing trees such as rambutan and mango trees. Their drinking water supply consists of deep well purified mineral water, while their water for daily use, such as cooking and bathing, is sourced from a "bubon" or well water source. In addition, their house is a bungalow-type structure. She has one pet dog. The mother also stated that their home is located close to their neighbors' houses.

G. DEVELOPMENTAL LEVEL

Patient M.A.M., a 6-year-old child, is currently in Erik Erikson's Psychosocial Stage 3: Initiative vs. Guilt (Preschool Age: 3–6 years) and is transitioning toward Stage 4: Industry vs. Inferiority (School Age: 6–12 years).

At this stage of development, M.A.M. is starting to demonstrate signs of initiative by actively playing, exploring her surroundings, and interacting with other kids. Her love of playing with people in the neighborhood and engaging in outside activities is clear evidence of this. She gains ability to make choices, initiative in social situations, creative ability, and independence as a result of these experiences.

She is gradually shifting into the Industry vs. Inferiority stage, when the emphasis is on building intellectual and social abilities, as she preparing to take Grade 2. Children start to value achievement, productivity, and responsibility at this age. M.A.M.'s development toward a sense of industry and confidence is supported by her positive school engagement and the development of self-care habits, such as participation in daily routines and good hygiene practices.

CHAPTER III

PHYSICAL ASSESSMENT

The physical assessment was conducted on May 7, 2026, at 10:03 am. By this time, the patient is already 4 days admitted. The patient was cooperative and participated in some parts of the assessment, answering questions appropriately. She appeared engaged and responsive throughout the process.

A. GENERAL SURVEY

The patient was lying on the bed, awake, conscious, and alert. She appeared tidy and well-groomed with normal posture. Vital signs at the time of assessment were: Temperature = 36.4°C, PR = 72 bpm, RR = 17, BP = 100/70 mmHg, O_2 saturation = 98%.

B. SKIN, HAIR, AND NAILS

The patient's skin is intact and smooth, and evenly pigmented with no notes of dryness, discoloration, or lesions. Skin temperature is warm and equal bilaterally. Nails are smooth, firm, and clean, and no clubbing or cyanosis observed. Hair is smooth, firm, shiny and black. Capillary refill time is within 2 seconds.

C. HEAD AND NECK

The patient's head appears symmetrical, with no observed lesions or deformities, and no involuntary head movements are noted. The patient is able to move his neck freely in all directions, with symmetry observed in the neck and no palpable lymph nodes.

D. EYES AND EARS

The patient's cornea and lens are clear. Pupils are round, equal, and normal in size, and are equally reactive to light. No yellowish discoloration of the sclera. No signs of impaired vision or presence of cataracts. The eyelids are intact, symmetrical, and close completely, with no discharge, discoloration, or swelling. The conjunctiva is pink, with no redness, swelling, or lesions. Eyeballs are properly aligned in the sockets, with no protrusion or sinking noted. The ears are symmetrical, smooth, and equal in color to the facial skin. No lesions, or nodules are noted upon palpation of the auricles or mastoid areas. Hearing is intact and equal bilaterally. No abnormalities are noted.

E. MOUTH, THROAT, NOSE, AND SINUSES

The patient has intact teeth without any decay. The gums are healthy, and the lips are dry and the tongue is symmetrical, but white in color. The patient experiences no difficulty or discomfort when talking or swallowing. There is no unusual odor to the breath, and the patient did not report any facial pain or pressure. The external nose is symmetrical with no discoloration, swelling, or malformations. Nasal mucosa is pinkish red with no discharge, swelling, malformations, or foreign bodies.

F. HEART AND NECK VESSELS

The patient's heart rate is in normal range, with a regular rhythm. The jugular vein is not distended. Pulse is strong and regular with no abnormal sounds.

G. THORAX AND LUNGS

No abnormalities were noted. Breathing is regular, sounds are clear bilaterally, and chest expansion is symmetrical. Breath sounds are soft, low-pitched, and clear bilaterally. No adventitious sounds are noted.

H. ABDOMINAL ASSESSMENT

The abdominal skin is intact. Skin color is consistent with the surrounding areas, with no jaundice noted. The umbilicus is midline and clean. The abdomen is soft and not distended. No guarding behaviour and rebound tenderness is not present. Bowel sounds are hyperactive in all quadrants. The patient reports pain in the left lower abdomen. No ascites or abnormal masses are noted. Ilan ang bilang ng borborygmi

I. EXTREMITIES

The skin was warm to touch, and symmetrical bilaterally. Limb circumferences were equal bilaterally, with no noted asymmetry. The patient demonstrated a full range of motion in all joints. Capillary refill time was within less than two seconds. Radial and brachial pulses were palpable, and graded at 2+ bilaterally.

J. NEUROLOGIC

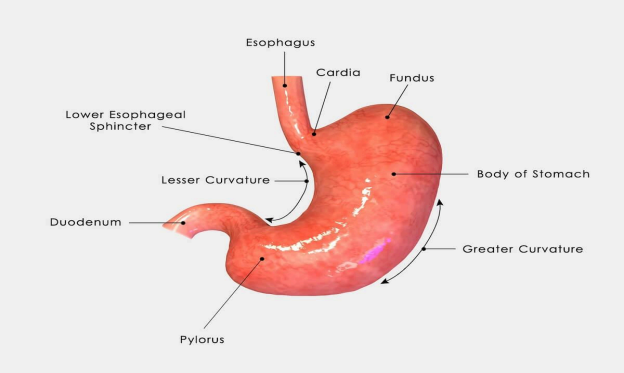
The patient is attentive, alert and oriented to person, place, and time with speech in a moderate rate and volume with clear articulation. No motor deficits are noted. Speech is clear and fluent.

K. CONGENITAL DEVELOPMENT:

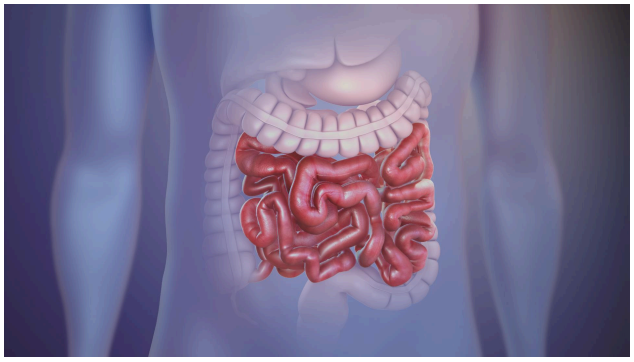
The patient shows no visible signs of congenital deformities or developmental abnormalities. Physical growth and body proportions appear appropriate for age. No musculoskeletal deformities, abnormal posture, or structural abnormalities were observed during the assessment. Developmental milestones are presumed to be achieved appropriately based on the patient's current functional status and ability to communicate and perform activities as expected for age.

CHAPTER IV

ANATOMY AND PHYSIOLOGY

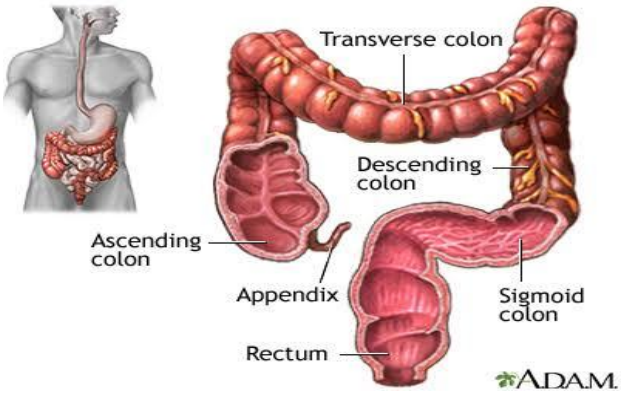


Stomach. The stomach is a J-shaped, muscular organ that weighs about 150 grams when empty. It is located in the upper left part of the abdominal cavity, between the esophagus and the small intestine, protected by the lower ribs. The stomach is responsible for storing food and breaking it down through the action of gastric acids and digestive enzymes. Through muscular contractions and chemical digestion, food is converted into a semi-liquid substance called chyme before moving into the small intestine. The stomach also helps destroy harmful microorganisms that enter through food. In Acute Gastroenteritis, the stomach becomes inflamed, causing nausea, vomiting, abdominal cramps, and stomach pain.

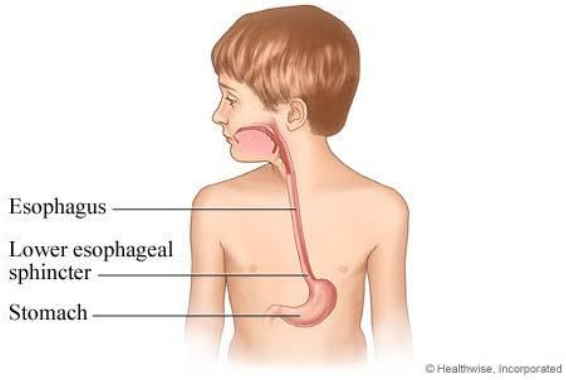


Small intestine. The small intestine is a long, coiled digestive organ that weighs about 1.5 kilograms and measures approximately 6 meters long in adults. It is located between the stomach and the large intestine in the abdominal cavity. The small intestine is responsible for completing digestion and absorbing nutrients, vitamins, minerals, and water into the bloodstream. Through the action of digestive enzymes and tiny finger-like projections called villi, nutrients are

efficiently absorbed and distributed throughout the body.



Large Intestine. The large intestine, also called the colon, is a wider and shorter tube-like organ that weighs about 1.5 kilograms. It surrounds the small intestine within the abdominal cavity and connects to the rectum. The large intestine is responsible for absorbing remaining water and electrolytes from undigested food while forming and storing feces before elimination. It also contains beneficial bacteria that support digestion and vitamin production. In acute gastroenteritis, the colon may become irritated, causing frequent bowel movements, abdominal discomfort, and watery stools.



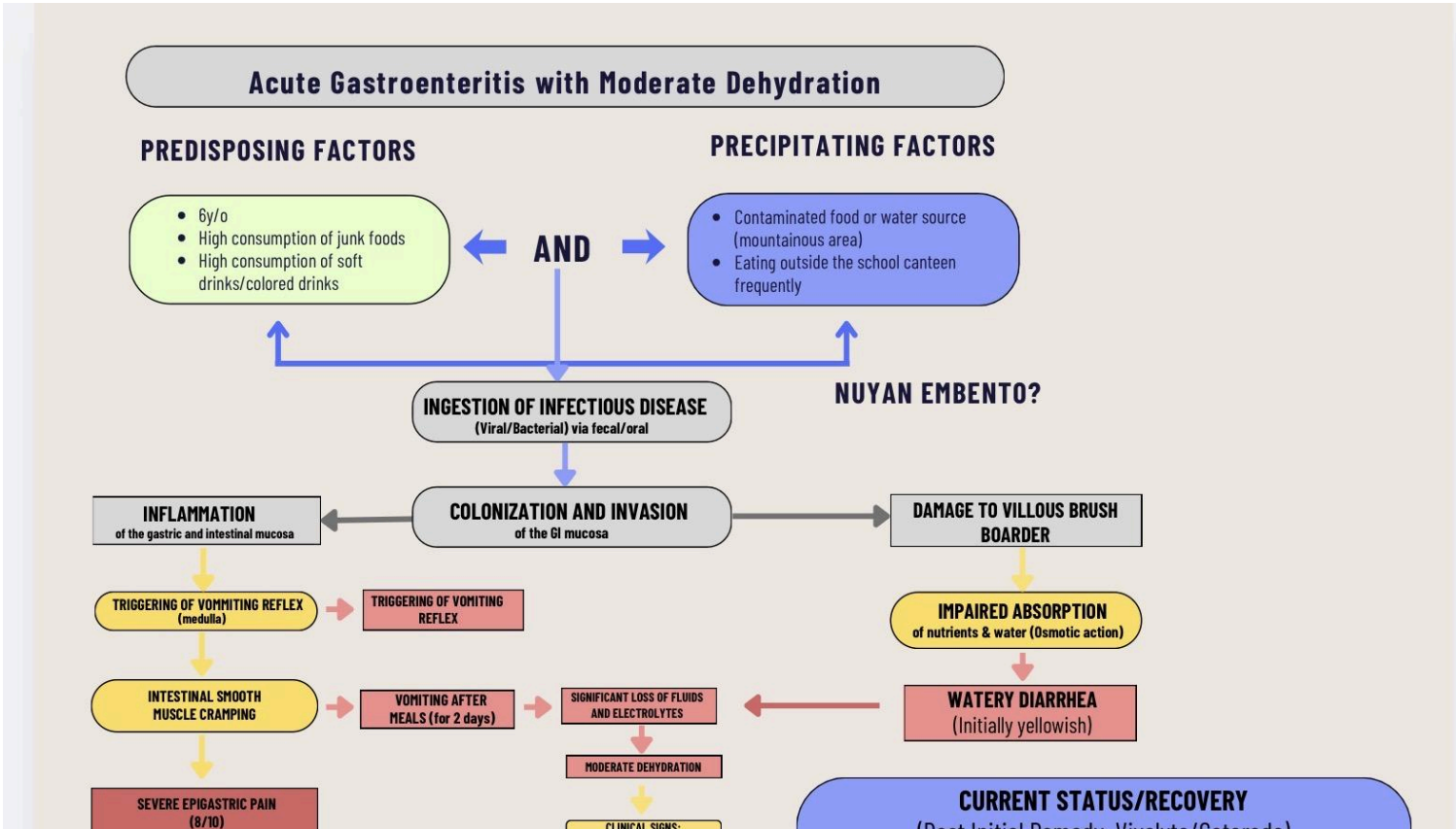
Esophagus. The esophagus is a muscular tube that weighs around 35–50 grams and measures about 25 centimeters long. It is located between the throat and the stomach, passing through the chest cavity behind the trachea. The esophagus is responsible for transporting food

and liquids from the mouth to the stomach through rhythmic muscular movements called peristalsis. A lower esophageal sphincter helps prevent stomach contents from flowing backward. During acute gastroenteritis, repeated vomiting may irritate and inflame the esophagus, causing throat pain, burning sensation, and discomfort while swallowing.

Intestinal and stomach infected=infection

CHAPTER V

PATHOPHYSIOLOGY



CHAPTER VI

LABORATORY RESULTS AND DIAGNOSTIC PROCEDURES

URINALYSIS AND URINE PREGNANCY TEST

May 03, 2026

EXAMINATION	RESULT	UNIT	SIGNIFICANCE
PHYSICAL EXAMINATION			
Color	YELLOW		NORMAL
Transparency	HAZY		This is due to mucus threads and concentrated urine, which is common in dehydration.
CHEMICAL			

EXAMINATION			
Glucose:	NEGATIVE		NORMAL
Protein:	TRACE		Mild proteinuria can occur due to dehydration.
PH:	6.0		Slightly acidic urine
Specific Gravity	1.025		Slightly concentrated urine suggesting dehydration.
SPECIAL EXAMINATION			
Leukocytes:	NEGATIVE		NORMAL
Nitrite:	NEGATIVE		NORMAL
Blood:	NEGATIVE		NORMAL
Urobilinogen	NORMAL		NORMAL
Ketone:	3+		This indicates high concentration of ketone, which indicates fat breakdown due poor oral intake, diarrhea, or dehydration.
MICROSCOPIC EXAMINATION			
Pus/White blood cells:	0-2	/hpf	NORMAL
Red blood cells:	0-2	/hpf	NORMAL
Epithelial cells:	RARE	/hpf	NORMAL
Bacteria:	RARE	/hpf	NORMAL
Cast:		/hpf	
		/hpf	
Crystal:		/hpf	
		/hpf	
Amorphous Urates	FEW	/hpf	Few amounts of amorphous urates are usually caused by dehydration and the slightly concentrated urine.

Amorphous phosphates:		/hpf	
Mucus Thread	MANY	/hpf	Maybe associated with concentrated urine/dehydration.
Others:		/hpf	

HEMATOLOGY
MAY 03, 2026

TEST	RESULT	REFERENCE RANGE	SIGNIFICANCE
HEMOGLOBIN	146	Male: 130-170 g/L Female: 120 - 150 g/L Child: 115- 135 g/L	NORMAL
HEMATOCRIT	0.43	Male: 0.40-0.54 Female: 0.32 -0.46 Child: 0.33 -0.40 Newborn: 0.50 - 0.62	NORMAL
White Blood Cell Count	15.43	Adult: 4-10 X 10%/L Newborn: 9-30 X 10°/L	The patient,s elevated WBC count indicates an ongoing inflammatory response associated with the acute gastroenteritis and dehydration
Differential Count:			
Neutrophils	0.91	Adult: 0.50 - 0.70; Child: 0.30 -0.60	NORMAL
Lymphocytes	0.06	Adult: 0.20 - 0.40; Child: 0.25 - 0.050	NORMAL
Eosinophils		0.02-0.05	
Monocytes	0.03	0.03-0.08	NORMAL
Basophils		0.00-0.01	
Platelet Count	446	150-400 X 10^9 /L	NORMAL

Red Blood Cell Count		Male: 4.5-6.0 X102/L Female: 4.0-5.5 X102/L Child: 4.6-4.8 X10/L	
Blood Indices:			
MCV		80-100 fL	
MCH		27-33 pg	
MCHC		310-370 g/L	
Clotting Time		2-5 minutes	
Bleeding Time		2-5 minutes	
Erythrocyte Sedimentation Rate		Male: 0-15 mm/hr Female: 0-20 mm/hr Child: 0 - 10 mm/hr	

STOOL ANALYSIS

May 5, 2026

EXAMINATION	RESULT	UNIT	SIGNIFICANCE
PHYSICAL EXAMINATION			
Color	Yellow Brown		NORMAL
Consistency	Loose		This suggest diarrhea associated with acute gastroenteritis
CHEMICAL EXAMINATION			
Occult Blood:			
MICROSCOPIC EXAMINATION			

Pus/White blood cells	2-4	/hpf	The patient's high WBC count suggests that the acute gastroenteritis and dehydration are causing a continuing inflammatory response.
Red blood cells		/hpf	
Fat Globules		/hpf	
Yeast Globules		/hpf	
PARASITE	No helmetic ova or protozoan parasite seen		NEGATIVE FOR PARASITIC INFECTION
Entamoeba histolytica/ E. dispar cyat			
Erstamoeba histolytica/ E. dispar trophozoite:			
Giardia lamblia cyst**:**			
Entamoeba lamblia trophozoite:			
Entamoeba coli cyst:			
Entamoeba coli trophozoite**:**			
Trichomonas hominis:			
Blastocystis spp:			
Ascaris lumbricoides ova:			
Trichuris trichiura ova:			
Hookworm spp. ova:			
Hookworm spp. larva:			
Enterobius vermicularis ova:			
Strongyloides stercoralis larva:			
Heterophyid ova:			

Taenia spp ova:			

May 08, 2026

EXAMINATION	RESULT	UNIT	SIGNIFICANCE
PHYSICAL EXAMINATION			
Color	Yellow Brown		NORMAL
Consistency	Soft		Soft stool may indicate mild gastrointestinal irritation.
CHEMICAL EXAMINATION			
Occult Blood:			
MICROSCOPIC EXAMINATION			
Pus/White blood cells	1-2	/hpf	The patient's minimal WBCs suggest mild inflammatory response associated with acute gastroenteritis.
Red blood cells		/hpf	
Fat Globules		/hpf	
Yeast Globules		/hpf	
PARASITE	No helmetic ova or protozoan parasite seen		NEGATIVE FOR PARASITIC INFECTION
Entamoeba histolytica/ E. dispar cyat			
Erstamoeba histolytica/ E. dispar trophozoite:			
Giardia lamblia cyst**:**			
Entamoeba lamblia			

trophozoite:			
Entamoeba coli cyst:			
Entamoeba coli trophozoite**:**			
Trichomonas hominis:			
Blastocystis spp:			
Ascaris lumbricoides ova:			
Trichuris trichiura ova:			
Hookworm spp. ova:			
Hookworm spp. larva:			
Enterobius vermicularis ova:			
Strongyloides stercoralis larva:			
Heterophyid ova:			
Taenia spp ova:			

kidney does not allow protein

Hindi maganda filtration

Is it consistent with the patient

CHAPTER VII

DRUG NAME	CLASSIFICATION	MECHANISM OF ACTION	INDICATION	CONTRAINDICATION	SIDE EFFECTS	NURSING RESPONSIBILITIES
Generic Name: Diphenhydramine **Brand Name:** Children's Benadryl Allergy **Dosage:** Children ages 6 to 1I: 12.5 to 25 mg PO every 4 to 6 hours. Maximum dose, 150 mg daily. **Route:** PO **Frequency:**	**Therapeutic class:** Antihistamines **Pharmacologic class:** Ethanolamines	Competes with histamine for H1-receptor sites. prevents, but doesn't reverse, histamine-mediated responses, particularly those of the bronchial tubes, GI tract, uterus, and blood vessels.	Allergy Symptoms	Don't use parenteral form as a local anesthetic due to risk of local necrosis **Precaution** Do not give Children's Benadryl (diphenhydramine) to children under 2 (some guidelines say under 6) without consulting a doctor, as misuse can cause serious side effects, including sedation, hallucinations, or death. Never use it	Possible side effects: Headache, diarrhea, abdominal pain, nausea, vomiting **Adverse Reactions** Epigastric distress, vomiting, and diarrhea Side effects: Dry mouth	• Advise mother to consult prescriber before using OTC sleep and cold products (drug is in any of these products). • Warn mother not to take drug with any other products that contain diphenhydramine (in-cluding topical therapy) because of increased risk of adverse reactions. • Teach about proper drug administration and handling. • Tell mother to notify prescriber if tolerance develops because a different antihistamine may need to be prescribed.

After meal **Timing:** q8 **Form:** Tablet				to make a child sleepy. Use the lowest effective dose based on weight, never exceed six doses in 24 hours, and use only the provided measuring tool		• Warn mother of possible photosensitivity reactions. Advise use of sunblock. -

CHAPTER VIII
NURSING CARE PLAN

LORMA COLLEGES - CON

NURSING CARE PLAN

RELATED LEARNING EXPERIENCE

PROBLEM: Fluid volume deficit **DATE & TIME:** May 09, 2026

ASSESSMENT	NSG DIAGNOSIS	PLANNING	IMPLEMENTATION	RATIONALE	EVALUATION
Subjective: Mother verbalized "Nu uminom danom ket isarwa na" The mother of the patient also verbalized "pag uminom siya ng tubig nag-aalburoto tyan niya" The patient verbalized " kanayon nak maka ininom danom" **Objective:** Dry lips observed upon assessment Weak in appearance	**Fluid volume deficit related to frequent vomiting evidenced by dry lips and skin turgor**	**SHORT TERM GOAL:** The patient will receive prescribed IV fluid boluses as ordered to stabilized frequency of vomiting within the next 4 hours **LONG TERM GOAL:** The patient will demonstrate improved hydration status after the shift as evidenced by normal skin turgor, moist lips, increased oral intake, and absence of vomiting.	INDEPENDENT: ● Monitor vital signs BP,pulse rate,respiratory rate, spO2 and temperature. ● Assess and record intake and output (I&O) ● Observe frequently,amount and characteristics of vomiting. DEPENDENT: ● Administer IV fluids as the doctor's ordered. ● Give electrolyte replacement as doctor's ordered. ● Administer oral rehydration solution as the doctor's order.	INDEPENDENT: ● To detect early signs of dehydration and possible complications. ● To evaluate fluid balance and determine the extent fluid loss. ● To monitor severity of condition and effectiveness of interventions. ● To rapidly replace lost fluids and restore circulating volume. ● To assess electrolyte levels and guide further treatment. ● Replaces lost fluids and electrolytes (like sodium and potassium) due to diarrhea and vomiting. Prevents dehydration,	**SHORT TERM Partially Met.** After 4 hours of nursing interventions, the patient received the prescribed IV fluid boluses and demonstrated decreased frequency of vomiting. **LONG TERM Goal Met.** After the shift, the patient demonstrated improved hydration status, as evidenced by normal skin turgor, moist lips, increased oral intake, and absence of vomiting.

			COLLABORATIVE: ● Collaborate with the physician for laboratory monitoring (e.g., serum electrolytes, BUN, creatinine) ● Coordinate with dietitian for appropriate diet (e.g., oral rehydration solution, soft diet)	which is the most common complication. ● Helps evaluate the severity of dehydration and guides treatment. ● Ensures proper nutrition and fluid intake to support recovery.	

PROBLEM: Imbalanced Nutrition **DATE & TIME:** May 09, 2026

ASSESSMENT	NSG DIAGNOSIS	PLANNING	IMPLEMENTATION	RATIONALE	EVALUATION
Subjective:	**Imbalanced**	**SHORT TERM GOAL:**	INDEPENDENT: -Assess and monitor	INDEPENDENT: -Determines adequacy of nutritional	**SHORT TERM** **Partially Met.**

"Hindi niya nauubos yung pagkain niya, kahit kalahati lang," as verbalized by the mother. "Laging umiinom ng tubig," as verbalized by the mother. **Objective:** -Moderate food intake noted -Dry lips observed -Increased thirst noted -hyperactive bowel sounds	**Nutrition: Less Than Body Requirements related to decrease appetite as evidenced by moderate food intake and inability to consume half of meals**	After 4 hours of nursing interventions, the patient will: -demonstrate improved appetite and tolerate small frequent feedings without vomiting. **LONG TERM GOAL:** After 24 hours of nursing interventions, the patient will: -consume at least 75% of meals served, -maintain adequate hydration as evidenced by moist lips -demonstrate improved nutritional status without recurrence of vomiting or	food and fluid intake. -Encourage small frequent feedings and oral fluid intake as tolerated. -Monitor signs of dehydration such as dry lips, poor skin turgor, delayed capillary refill, and decreased urine output. -Provide comfort measures and allow adequate rest periods. DEPENDENT: -Administer prescribed medications as ordered -IV fluid therapy as prescribed COLLABORATIVE: -Collaborate with the dietitian regarding appropriate diet progression.	and hydration status. -Small meals are easier to digest and may improve appetite. -Early detection prevents recurrence of dehydration. -Conserves energy and promotes recovery. -Helps reduce gastric irritation, relieve pain, and maintain hydration. -Helps improve nutritional intake while minimizing gastrointestinal discomfort.	After 4 hours of nursing interventions, the patient was able to tolerate small frequent feedings without vomiting. However, the patient still demonstrated moderate appetite and consumed less than half of the meals served. **LONG TERM Goal Met.** After 24 hours of nursing interventions, the patient was able to: -consistently tolerate small frequent feedings without vomiting, -Consume improved and adequate portions of meals,and maintain adequate hydration as evidenced by moist oral mucosa, good skin turgor, and stable

		diarrhea. .			vital signs.

PROBLEM: **DATE & TIME:** May 09, 2026

ASSESSMENT	NSG DIAGNOSIS	PLANNING	IMPLEMENTATION	RATIONALE	EVALUATION
Subjective:		**SHORT TERM GOAL:** **LONG TERM GOAL:**	INDEPENDENT: DEPENDENT:	INDEPENDENT: •	**SHORT TERM** **Partially Met.**

Objective:		.	. COLLABORATIVE:		**LONG TERM** **Goal Met.**

CHAPTER IX

EVALUATION

Patient M.A.M., a 6-year-old female pediatric patient, was admitted due to abdominal pain, vomiting, watery diarrhea, and weakness. Prior to admission, the patient experienced repeated vomiting after eating or drinking accompanied by watery yellowish stools and severe abdominal pain rated 8/10. Initial management at home included oral hydration using Vivalyte, Gatorade, and Pocari Sweat; however, persistence of symptoms necessitated hospitalization for further medical evaluation and management.

Upon assessment, the patient manifested signs and symptoms consistent with acute gastroenteritis with moderate dehydration, including dry lips, thirstiness, weakness, watery stools, abdominal tenderness, and hypoactive bowel sounds. The patient also exhibited decreased comfort due to abdominal pain. Additional findings included pink conjunctiva, pink buccal mucosa, white tongue, soft low-pitched breath sounds, and an episode of epistaxis during confinement. Despite her condition, the patient remained active and playful and was able to interact appropriately with others.

During hospitalization, nursing and medical interventions focused on maintaining hydration, relieving abdominal discomfort, monitoring bowel movements, promoting adequate nutrition, and preventing complications associated with dehydration. Continuous monitoring of intake and output, hydration status, bowel patterns, and vital signs was performed throughout

confinement. Health teachings regarding proper hygiene, hydration, food safety, and nutritional practices were also provided to the caregiver.

The patient-centered objectives stated in Chapter I were partially achieved. The patient demonstrated improved hydration status as evidenced by decreased dryness of the lips, reduced thirst, and improved activity tolerance. Episodes of vomiting were resolved, while diarrhea episodes lessened and stool consistency gradually improved from watery to partially formed stools. The patient and caregiver verbalized understanding regarding proper hydration, handwashing, food safety, and nutritional practices. The caregiver also actively participated in monitoring symptoms such as stool frequency, abdominal pain, and fluid intake during hospitalization. Compliance with prescribed medications, oral rehydration therapy, and dietary modifications was likewise observed throughout confinement.

The student-centered objectives were also achieved through comprehensive assessment of the patient, identification and explanation of the pathophysiology and contributing factors related to acute gastroenteritis with moderate dehydration, and formulation of appropriate nursing diagnoses based on the patient's condition. Evidence-based nursing interventions focusing on hydration, comfort, nutrition, and infection prevention were properly implemented. Student nurses also demonstrated proper monitoring of hydration status, intake and output, bowel movements, and vital signs. Furthermore, health teachings regarding hygiene, hydration, food safety, and prevention of recurrence were successfully provided to the caregiver. The effectiveness of nursing interventions was evidenced by measurable improvement in the patient's condition during hospitalization.

As of the present, the patient remains admitted in stable condition while awaiting laboratory results and continuous medical evaluation to further monitor progress and ensure complete recovery.

Final Diagnosis: Acute Gastroenteritis with Moderate Dehydration.

Describe patient when she was discharged

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