Children with urinary disorders should be assessed for intake and output. Urine should be monitored for amount, color, clarity, odor, and specific gravity. (Normal specific gravity of urine is 1.010 to 1.025.) Assess the abdomen using light palpation to prevent damage to internal organs. Assess the child for signs of dehydration or fluid excess, including the presence of edema and monitoring daily weights.

Numerous nursing diagnoses could apply to the child with urinary disorders and their families. Nursing diagnoses might include:
- Risk for Infection, related to urinary stasis
- Excess Fluid Volume, related to impaired kidney function
- Risk for Deficient Fluid Volume, related to impaired kidney function
- Impaired Urinary Elimination, related to structural or functional impairment of the urinary system.

Nursing interventions follow the general health guidelines presented in previous chapters of this book. Adaptation of interventions with the child is addressed as follows:
- Encourage children to drink water and a variety of juices daily. Frozen pops and frozen juice can be used to increase fluid intake. Adequate fluid intake is essential to proper kidney function. Additional fluids may be needed during times of illness, infection, and fever.
- Follow doctor’s orders for fluid restriction in children with urinary disorders. See Procedure 15-3 for more information on managing fluid restrictions. When sodium and water retention are present, fluids should be limited.
- Administer medications as ordered, such as analgesics and steroids. Dysuria may make the child reluctant to void. If surgery is needed, the child must be medicated for comfort. Steroids reduce the immune response.
- Provide instruction to the child and parents about care. Be aware of family strain, and refer to RN and social worker as necessary. The life-threatening nature of urinary disorders contributes to family strain. The long-term effects and treatment contribute to caregiver strain.
- Provide client teaching concerning signs of infection after surgery (Box 23-5).

The child’s condition is evaluated by blood and urine analysis, weight loss, and a return of general health. Monitor closely for side effects of medications. The function of the kidneys (or a remaining kidney) must be evaluated frequently. Report any signs of urinary infection or renal failure to the physician immediately. Repeat urine samples may be done after treatment with antibiotics to determine complete eradication of the causative organism.

Due to the strain of acute life-threatening illness on the child and family, frequent evaluation of family functioning is important. Referral to support groups and agencies may be necessary.

### NURSING PROCESS CARE PLAN

#### Child With Nephrotic Syndrome

James, a 22-month-old child, has been admitted to the pediatric unit with a diagnosis of possible nephrotic syndrome. James has gained 2 lb in the last week and a half. His mother states, “His face is so swollen, I can hardly recognize my own child.” Laboratory reports indicate a low blood albumin and high proteinuria. James is irritable and whines most of the time.

#### Assessment
- 2+ edema
- Crackling lung sounds
- Vital signs: P 150, R 48

#### Nursing Diagnosis. The following important nursing diagnosis (among others) is established for this client:
- Excess Fluid Volume, related to altered urinary function.

#### Expected Outcomes. Intake and output will be within 100 mL by third hospital day.

#### Planning and Implementation
- Measure and record intake and output every 8 hours.
- Check output hourly. If no urinary catheter, weigh diapers.
- Monitor specific gravity.
- Take daily weights.
- Reposition every half-hour.

#### BOX 23-5 CLIENT TEACHING

**Signs of Infection After Surgery**

Teach parents to understand the following signs and symptoms of infection and to report them promptly to the primary care provider. Signs of infection include:
- Increased temperature
- Cloudy urine
- Foul odor from the surgical site
- Purulent drainage
- Decreased feeding
- Increased fussiness.