N433 Care Plan #1

Lakeview College of Nursing

Morgan Drennan

Demographics (3 points)

Date of Admission 7/6/20	Patient Initials EC	Age (in years & months) 17 years & 2 months	Gender Female
Code Status Full	Weight (in kg) 46.4 kg	BMI 17.5	Allergies/Sensitivities (include reactions) NKA

Medical History (5 Points)

Past Medical History: none reported

Illnesses: none reported

Hospitalizations: none reported

Past Surgical History: wisdom teeth removal

Immunizations: n/a

Birth History: none reported

Complications (if any): n/a

Assistive Devices: none prior to admission

Living Situation: Patient lives with parents

Admission Assessment

Chief Complaint (2 points): Motor Vehicle Accident

Other Co-Existing Conditions (if any): Traumatic Brain injury

Pertinent Events during this admission/hospitalization (1 points): Patient was in the passenger seat of the car and the car was found wrapped around a tree.

History of present Illness (10 points): The patient was in a motor vehicle accident on July 6th of 2020, with one other passenger in the vehicle. The car was wrapped around a tree

when found. The patient's injuries were mostly sustained on the head, chest, and abdomen. She has had these pain and medical conditions since the crash on 7/6/20. The patient endured a mandible fracture, right frontal subcortical hemorrhage, right putamen contusion, and a left frontal lobe contusion. The patient presents with nonverbal cues for pain upon being moved. The family reports that the patient is most at ease when she is laying on her back and listening to music. She is being treated with medication to prevent muscle spasms that would increase pain. She is also NPO and being administered medications and feeding through a PEG tube.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Traumatic Brain Injury

Secondary Diagnosis (if applicable): Shock Bowel

Pathophysiology of the Disease, APA format (20 points):

A traumatic brain injury is an injury that results from a violent jolt to the head that can cause bruising, torn tissues, bleeding and other forms of damage to the brain and the brain cells. Traumatic brain injuries can range from temporary to long-term damage to possibly even death. Patients that have a mild injury can experience headache, vomiting, fatigue, loss of consciousness, difficulty sleeping, and sensitivity to light or sound. The more severe cases of traumatic brain injury experience symptoms such as seizures, agitation, dilation of pupils of the eyes, persistent headache, and inability to wake from sleep or coma. When determining the degree of injury, a Glasgow Coma Scale is used, along with the history and information related to the injury, such as how the injury occurred, and

which part of the body was impacted the most. A CT and MRI are used to visualize the injury and see if there is bleeding or swelling of the brain. Lab tests that can be ran include the basic CBC and CMP, but the provider will mostly likely want a PT, PTT, and INR done on the patient to check clotting time. The WBC should be increased because the body is in distress. The Hgb, Hct, and RBC are most likely going to be low if there is a brain bleed occurring and if the patient was in an MVA like this specific patient being discussed, she lost blood during the crash. Respirations may be low if the chest was impacted during the crash. The pulse and blood pressure could be high because the body is under stress, but they could also be low depending on how much blood was lost on the scene of the crash. Treatment that is used for this condition include surgery, diuretics, anti-seizure medications, come-inducing drugs, rehab from OT, PT, psychiatry, speech and language pathology, social work, and other rehabilitation professionals (Mayo Clinic Staff, 2019). The treatment this specific patient is receiving are multiple anti-seizure and muscle relaxant medications to manage pain from muscle spasms. She is also receiving enoxaparin to prevent blood clots, since she is not moving a large amount. The patient is receiving treatment from the occupational therapist to try to create a communication mechanism between the patient and others with yes and no buttons. Complication that can be associated with this diagnosis can include possibility of infection and risk for DVT. The patient could experience risk for infection if there are any open lacerations from the MVA and in the case of this specific patient she has a PEG tube which could get infected. The patient is being assessed daily and her PEG tube is being flushed and assessed at every medication administration and any note of infection or irritation is being addressed as needed. The patient is not mobile independently so her risk for developing a DVT is high.

She is on enoxaparin to prevent blood clots and PT is working with her regularly (Nurse's Drug Book, 2019).

Pathophysiology References (2) (APA):

(2019). *Nurse's Drug Handbook*. (18th ed.). Jones and Bartlett Learning.

Mayo Clinic Staff. (2019). *Traumatic Brain Injury*. https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/diagnosis-treatment/drc-20378561.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: none	**PT/OT will continue working with her as they see fit.**
Diet/Nutrition: continuous feeds	**85mL/hr of Osmolite; flush Q4H with 35mL of sterile water.**
Frequent Assessments: vitals; extremity temperature	**Vitals Q4H; vascular boots PRN for extremity coolness**
Labs/Diagnostic Tests: none	**n/a**
Treatments: control pain	**Pains seems to be manageable**
Other:	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Assess patients' skin	**Rash is presenting on arms and chest with unknown cause**

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	**3.93-4.90**	**3.05**	**3.84**	**Hemorrhage occurring within the brain upon admission. Patient could possibly be anemic currently or she has not recovered from original trauma and blood loss (Mosby, 2010).**
Hgb	**10.8-13.3**	**8.9**	**11.7**	**Hemorrhage occurring within the brain upon admission (Mosby, 2010).**
Hct	**33.4-40.4**	**27.2**	**35.9**	**Hemorrhage occurring within the brain upon admission (Mosby, 2010).**
Platelets	**194-345**	**174**	**400**	**Hemorrhage occurring within the brain upon admission. Patient could currently be anemic which explains high platelet count currently (Mosby, 2010).**
WBC	**4.19-9.43**	**15.79**	**8.91**	**The body was under stress from the MVA upon admission (Mosby, 2010).**
Neutrophils	**n/a**	**n/a**	**n/a**	
Lymphocytes	**n/a**	**n/a**	**n/a**	
Monocytes	**n/a**	**n/a**	**n/a**	
Eosinophils	**n/a**	**n/a**	**n/a**	
Basophils	**n/a**	**n/a**	**n/a**	

Bands	**n/a**	**n/a**	**n/a**	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission or Prior Value	Today's Value	Reason For Abnormal
Na-	**136-145**	**n/a**	**134**	**Most likely related to dietary intake (Mosby, 2010).**
K+	**3.5-5.1**	**n/a**	**3.9**	
Cl-	**98-107**	**n/a**	**102**	
Glucose	**60-99**	**n/a**	**87**	
BUN	**7-18**	**n/a**	**22**	**The cause of the increase BUN could be shock to the body and excessive protein ingestion because of the use of the PEG tube (Mosby, 2010).**
Creatinine	**0.55-1.02**	**n/a**	**0.41**	**Decreased muscle mass due to immobility is the most likely cause of this abnormality (Mosby, 2010).**
Albumin	**3.4-5.0**	**3.4**	**n/a**	
Total Protein	**6.4-8.2**	**7.5**	**n/a**	
Calcium	**8.5-10.1**	**n/a**	**9.6**	
Bilirubin	**0.2-1.0**	**0.3**	**n/a**	
Alk Phos	**45-117**	**186**	**n/a**	**The patient was taking a benzodiazepine prior to admission which could cause the increase in ALP levels (Mosby, 2010).**
AST	**15-37**	**43**	**n/a**	**The increased level is due to trauma related to the MVA (Mosby, 2010).**
ALT	**12-78**	**82**	**n/a**	**Shock and trauma led to this abnormal lab value upon admission (Mosby, 2010).**

Amylase	**n/a**	**n/a**	**n/a**	
Lipase	**73-393**	**381**	**n/a**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	**10-20**	**29**	**n/a**	**Blood loss related to the MVA (Mosby, 2010).**
CRP	**0-0.29**	**0.87**	**n/a**	**Tissue damage related to the MVA (Mosby, 2010).**
Hgb A1c	**n/a**	**n/a**	**n/a**	
TSH	**n/a**	**n/a**	**n/a**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow & clear**	**Yellow & Cloudy**	**n/a**	**Cloudy urine could be caused by the increase in WBCs related to the shock sustained in the MVA (Mosby, 2010).**
pH	**5-7**	**9.0**	**n/a**	**Most likely related to the increased WBCs related to shock (Mosby, 2010).**
Specific Gravity	**1.003-1.035**	**1.020**	**n/a**	
Glucose	**Negative**	**Negative**	**n/a**	
Protein	**negative**	**Negative**	**n/a**	
Ketones	**negative**	**Negative**	**n/a**	
WBC	**0-25**	**0**	**n/a**	
RBC	**0-25**	**0**	**n/a**	

Leukoesterase	**negative**	**negative**	**n/a**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
Urine Culture	**No growth**	**No growth**	**n/a**	
Blood Culture	**No growth**	**No growth**	**n/a**	
Sputum Culture	**No growth**	**n/a**	**n/a**	
Stool Culture	**N/a**	**n/a**	**n/a**	
Respiratory ID Panel	**n/a**	**n/a**	**n/a**	

Lab Correlations Reference (APA):

Pagana & Pagana. (2010). ***Mosby's: Manual of Diagnostic and Laboratory Tests*** **(4th ed.) Elsevier.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): XR KUB and CT of the brain without contrast

Diagnostic Test Correlation (5 points): XR KUB shows thickening of the right colonic bowel, this suggests that there is gas within the bowel wall. This test was completed to determine why the patients digestive system is not functioning properly and to see if there is any damage related to the MVA present. The CT of the brain without contrast shows compression of the brain with fluid collection. The brain has also been shifted from the midline. These injuries are related to the impact of the MVA. This test was completed

determine the severity of the brain bleed related to the previous MVA and to see if there was any improvement since the last CT scan.

Diagnostic Test Reference (APA):

Pagana & Pagana. (2010). ***Mosby's: Manual of Diagnostic and Laboratory Tests*** **(4th ed.) Elsevier.**

Current Medications (8 points)
****Complete *ALL* of your patient's medications****

Brand/Generic	**Dantrolene/ Dantrium**	**Enoxaparin/ Lovenox**	**Gabapentin/ neurontin**	**Pantoprazole/ Protonix**	**Bromocriptine/ Parlodel**
Dose	**50mg**	**50mg**	**400 mg**	**40 mg**	**2 mg**
Frequency	**TID**	**BID**	**TID**	**daily**	**BID**
Route	**IGAS**	**SQ**	**IGAS**	**IGAS**	**IGAS**
Classification	**antispastic**	**Antithrombotic**	**Anticonvulsant**	**Antiulcer**	**antidyskinetic**
Mechanism of Action	**Reduces the force of reflex muscle contraction**	**Inactivates clotting factors**	**Prevents firing of neurons associated with seizures and painful stimuli**	**Interferes with gastric secretions**	**Decreases dopamine turnover in the CNS**
Reason Client Taking	**Treat muscle spasms**	**To prevent clots**	**Painful stimuli and muscle spasms**	**Prevent GERD**	**Prevent muscle spasms**
Concentration Available	**100 mg capsules**	**0.8 mL syringe**	**200mg capsules**	**20mg tablets**	**0.8mg tablets**
Safe Dose Range Calculation	**23.2mg-400mg**	**46.4mg-92.8mg**	**300mg-600mg**	**20mg-40mg**	**1.25mg-2.5mg**
Maximum 24-hour Dose	**400 mg**	**92.8mg**	**1800mg**	**40mg**	**15 mg**
Contraindications (2)	**Skeletal muscle spasms caused by rheumatic disorders; active hepatic disease**	**Hx of heparin-induced thrombocytopenia; active major bleeding**	**Hypersensitivity to gabapentin**	**Hypersensitivity to pantoprazole; concurrent therapy with rilpivirine-containing products**	**Peripheral vascular disease; ketoacidosis**
Side	**Backache;**	**A-fib; dyspnea**	**Muscle**	**Elevated**	**Indigestion;**

Effects/Adverse Reactions (2)	**abdominal cramps**		**twitching; rash**	**triglycerides; elevated liver enzymes**	**hypertension**
Nursing Considerations (3)	**Monitor BP and HR; reconstitute drug with 60mL sterile water; infuse into central vein if possible**	**Don't give drug by IM injection; use caution in patients with increased risk for hemorrhage; keep protamine sulfate in MAR in case of accidental overdose**	**Monitor renal function tests; various brands of gabapentin are not interchangeable ; give gabapentin at least two hours after antacid is given**	**Administer delayed release oral suspension 30 minutes before a meal; monitor PT or INR if anticoagulant is being taken; monitor patients' urine output**	**Monitor BP; assess patient for GI bleed; monitor patient for mental disturbances and confusion**
Client Teaching needs (2)	**Advise patient to take medication with food to prevent gastric upset; explain the drugs' sedating effects**	**Teach patient or family how to give enoxaparin at home; Teach patient and family about the proper disposal of sharps**	**Encourage good oral hygiene; explain to the patient that adverse effects decline in severity over time.**	**Educate patient that they will not have relief of symptoms for at least two weeks; advise patient to follow bleeding precautions if on anticoagulant**	**Advise patient to take medication with a snack or meal; advise against sudden position changes**

Medication Reference (APA):

(2019). *Nurse's Drug Handbook*. (18th ed.). Jones and Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Unable to assess AO** **Patient does not seem to be showing any nonverbal signs of distress** **The patient's overall appearance is appropriate, considering her circumstance.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** .	**Skin color is appropriate for ethnicity and intact. Turgor is as expected for patient's age** **The skin is cool to the touch.** **Red circular rashes are present across the entire chest and arms from unknown origin.** **Patient has bruising on stomach and chest from impact of MVA.** **There is a healed wound on the left orbit that**

Braden Score: **Drains present: Y☐ N ☒** **Type:**	**has resulted in a scar.** **Braden score is 12**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	**Head, ears, eyes, and nose are symmetrical. The thyroid is midline. Patient has good dentition. There is scarring on the left orbit due to MVA. Patient's PERRLA is not intact.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**S1 and S2 are present. Capillary refill is < 3 seconds. Pulses are present and strong. Cardiac monitor was not being used so the cardiac rhythm was not assessed. There is no edema present or neck vein distention.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Lung sounds are bilaterally clear. There are no accessory muscles being used.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current diet:** **Height (in cm):** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☒ N ☐** **Type: PEG**	**Diet prior to MVA was regular. Current diet is continuous feeds at 85mL/hr. The patients height is 162.6 cm. Bowel sounds are present in all four quadrants and are active. Last BM was around 0805 of 9/25/20. There were nonverbal signs of pain upon palpation. There are no masses present upon palpation. There is no distention, incisions or drains present. There is scarring from other injuries related to the MVA. There are no open wounds present. The patient does have a PEG tube on the left side of the abdomen that is used for continuous feeding and medication administration.**
GENITOURINARY (2 Points): **Color:**	**Color of urine is pale yellow and clear. The patient had two unmeasurable urinary voids**

Character: **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**during shift. The patient does not show any nonverbal signs of pain with urination. The patient is not on dialysis. The patient's genitals are pale and intact, appearance as expected for female genitalia of this developmental age. The patient does not have a catheter in place.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 30** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☒**	**The patient does not have active ROM, the right side is more active than the left. The patient does have passive range of motion when assisted by personnel. The patient's neurovascular status was not fully assessed because of limitations. The patient uses a wheelchair when she is moved to it, she also has braces for her hands that are used as needed, although she does not like them. Strength is not equal. Her right side is stronger than her left as evidenced by movement and hand squeezes. The patient is not a fall risk because she is on bed rest and cannot move on her own. The patient is fully dependent on staff and family.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☒** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patient moves her right side better than her left side and more frequently. The pupils are not reactive to light, so PERRLA is not intact. The strength is not equal in the legs and arms; she is stronger on her left side than her right. AO was unable to be adequately assessed due to condition. Mental status was unable to be assessed. Speech is not present. Patient is responsive to verbal cues, so hearing is intact to an unknown degree. Patient cannot see. Olfactory was unable to be assessed. Patient's taste is intact as evidenced by disgust on face after oral swab. LOC is unable to be assessed.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s) of caregiver(s):** **Social needs (transportation, food, medication assistance, home equipment/care):** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Unable to assess coping methods, but patient's family believes laying on her back and listening to music soothe the patient. The family seems to be coping by holding onto hope that the patient will improve and become her old self prior to the MVA. The patient is completely dependent on family for transportation. Nutrition and medication assistance will have to be provided to the**

	family. Depending on the state that the patient is in when she is discharged will determine the home equipment needs. The family is very supportive. Grandmother was at bedside for the assessment. Father and mother are also present in the patient's life.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0805	**74 bpm**	**111/73 mmHg**	**16 breaths/min**	**98.8°F (37.1°C)**	**100% on room air**

Normal Vital Sign Ranges (2.5 points)
****Need to be specific to the age of the child****

Pulse Rate	**50-90 bpm**
Blood Pressure	**102/64 mmHg-121/79 mmHg**
Respiratory Rate	**12-20 breaths per minute**
Temperature	**97.6°F-99.4°F**
Oxygen Saturation	**95%-100%**

Normal Vital Sign Range Reference (APA):

University of Iowa Heath Care. (2020). *Pediatric Vital Signs Normal Ranges*.

https://medicine.uiowa.edu/iowaprotocols/pediatric-vital-signs-normal-ranges.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0805	**rFLACC**	**Unable to assess**	**4**	**Unable to assess**	**Turn in bed**
Evaluation of pain status *after* intervention	**rFLACC**	**Unable to assess**	**6**	**Unable to assess**	**Turn in bed**
Precipitating factors: movement of patient caused pain **Physiological/behavioral signs: patient was moaning**					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
Continuous tube feeding; 510ml during shift	**2 urinary voids** **1 stool void**

Developmental Assessment (6 points)
Be sure to highlight the achievements of any milestone if noted in y our child. Be sure to highlight any use of diversional activity if utilized during clinical. There should be a minimum of 3 descriptors under each heading

Age Appropriate Growth & Development Milestones

1. **Have more interest in romantic relationships**
2. **Show more independence from parents**
3. **Learn more defined work habits**

Age Appropriate Diversional Activities

1. **Grandmother talked to patient to calm her**
2. **Stuffed animals to squeeze onto**
3. **Peaceful music playing in the background**

Psychosocial Development:

Which of Erikson's stages does this child fit?

Identity vs. Role Confusion

What behaviors would you expect?

Patient should be developing their own personality and ego. The patient should also be becoming more independent from their parents.

What did you observe?

The patient is unable to be independent. She is also unable to speak so her ego and personality could not be assessed.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference?

Formal operational

What behaviors would you expect?

It is expected that the patient at this stage in their life be able to grasp abstract concepts and think outside the box

What did you observe?

The patient's thought process was unable to be assessed because of her medical state

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

The developmental stage of vocabulary was unable to be assessed because the patient is unable to speak.

Any concerns regarding growth and development?

Concerns related to the patient's growth and development are present because in her current state she is not able to develop. It is uncertain how well she will recover from the MVA or if she will recover.

Cherry, K. (2019). ***Identity vs. Role Confusion in Psychosocial Stage 5*****.** **https://www.verywellmind.com/identity-versus-confusion-2795735.**

Marcin, A. (2018). ***What are Piaget's Staged of Development and How Are They Used?*****.** **https://www.healthline.com/health/piaget-stages-of-development.**

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute Pain related to pain from MVA as evidenced by nonverbal cues of pain upon movement.	**The patient showed facial grimace and moaning upon movement and palpation.**	**1.Assess for muscle spasticity every 4-6 hours.** **2.Assess the patient with the rFLACC pain scale.**	**The patient is given medication to prevent muscle spasms and to help with comfort. When the patient is repositioned is the only time she presents pain with the assessment of the rFLACC pain scale, so her pain seems manageable.**
2. Injury to the tissue related to MVA as	**The patients' CT scans show abnormalities of**	**1. Assess patients neuro status with PERRLA daily.**	**The patient is assessed daily to see if there are any changes in the**

evidenced by abnormal CT scans.	**the brain. It is shifted midline and had a previous hemorrhage.**	**2.Perform ROM to assess neuro.**	**neuro status of the patient. To this date there are no improvements.**
3. Decreased ability to cope related to major change in life as evidenced by nonverbal stress signs	**The patient is very tense and confused. She likes to have someone hold her hand and comfort her.**	**1. Assess the patients family's understanding of the patients coping mechanisms** **2 Encourage the family to share their concerns**	**The patient is showing nonverbal signs of fear and stress. Allowing the patient to comfort herself with stuffed animals improves her mood. The family seems to have high hopes that the patient will improve, however it is likely that she will not. The family seems to need counseling and assistance with coping mechanisms.**
4. Potential for skin breakdown related to immobility as evidence by patient's complete dependence on family and staff.	**The patient is unable to move and is at a very high risk for skin breakdown. Her mobility is completely dependent on the staff and family.**	**1. turn the patient Q2** **2. check the patient to see if her diaper needs changed Q2**	**The patient was turned Q2 and there were no signs of erythema or breakdown. Checking the patients diaper after turning her was effective she had a urinary void about Q2, so the objective to check the patients diaper is effective.**

Other References (APA):

Swearingen, P. & Wright, J. (2019). ***All in One: Nursing Care Planning Resource*****. Elsevier**

Concept Map (20 Points):

Subjective Data

The patient was in a MVA on July 6th and was in the passenger seat of the vehicle. There was one other passenger in the vehicle. The patient presents with nonverbal cues of pain such as facial grimacing and moaning. The rFLACC pain scale was utilized during assessment.

Nursing Diagnosis/Outcomes

Acute Pain related to pain from MVA as evidenced by nonverbal cues of pain upon movement. Patient is given medication to prevent muscle spasms and to help with comfort. When the patient is repositioned is the only time she presents pain with the assessment of the rFLACC pain scale, so her pain seems manageable.
Injury to the tissue related to MVA as evidenced by abnormal CT scans.
The patient is assessed daily to see if there are any changes in the neuro status of the patient. To this date there are no improvements.
Decreased ability to cope related to major change in life as evidenced by nonverbal stress signs
The patient is showing nonverbal signs of fear and stress. Allowing the patient to comfort herself with stuffed animals improves her mood. The family seems to have high hopes that the patient will improve, however it is likely that she will not. The family seems to need counseling and assistance with coping mechanisms.
Potential for skin breakdown related to immobility as evidence by patients' complete dependence on family and staff.
The patient was turned Q2 and there were no signs of erythema or breakdown. Checking the patients diaper after turning her was effective she had a urinary void about Q2, so the objective to check the patients diaper is effective.

Objective Data

The patient has multiple brain contusions and a mandibular fracture. Multiple labs are abnormal. All vital signs are within normal limits. The patients PERRLA is not intact. She has bruising on the chest and abdomen. She also has red circular rashes on the arms and chest from unknown origin.

Patient Information

17 year old female with prior MVA. She has suffered a TBI and shock bowel. She is compliant and nonverbal.

Nursing Interventions

Assess for muscle spasticity every 4-6 hours.

2.Assess the patient with the rFLACC pain scale.
Assess patients neuro status with PERRLA daily.

2.Perform ROM to assess neuro.
Assess the patients family's understanding of the patients coping mechanisms

2 Encourage the family to share their concerns
1. turn the patient Q2

2. check the patient to see if her diaper needs changed Q2