N433 Care Plan # 2

Lakeview College of Nursing

Joey Runde

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
10/22/2020	K.C	3 years & 2 months	Male
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full Code	17.9	Not able to be measured	No Allergies

Medical History (5 Points)

Past Medical History: Dehydration, Fever

Illnesses: Fever and URI (1-30-2018)

Hospitalizations: Fever & URI (1-30-2018)

Past Surgical History: No past surgeries

Immunizations: All immunizations are up to date

Birth History: Full term birth

Complications (if any): No complications with birth

Assistive Devices: No assistive devices used

Living Situation: Patient lives with his mother and maternal grandmother at home.

Admission Assessment

Chief Complaint (2 points): Fever

Other Co-Existing Conditions (if any): Dehydration

Pertinent Events during this admission/hospitalization (1 points): Dehydration

History of present Illness (10 points):

K.C started feeling sick on 10-19 and went to the emergency department on 10-22. K.C was feeling very tired, lethargic, no appetite, diarrhea, and has a fever. The patient's mom complains

that his symptoms are continually happening and that he has trouble bearing weight on his legs. The patient's mom denies any aggravating factors. The relieving factors consist of ibuprofen and acetaminophen. The patient is currently taking cephalosporin to help treat his sickness, and his pain is a four on the Flacc scale.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): Fever

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

K.C came into the emergency department due to having a fever and some shortness of breath. Later, to find out that K.C's sickness had to do with pneumonia. Pneumonia is commonly caused by breathing in droplets containing bacteria or other pathogens (Capriotti & Frizzell, 2016). The droplets will then enter the upper airways and go into the lung tissue (Capriotti & Frizzell, 2016). The pathogens enter into the epithelium and stimulate an inflammatory reaction (Capriotti & Frizzell, 2016). The inflammatory response will then spread into the low respiratory tract and alveoli (Capriotti & Frizzell, 2016). At the site of inflammation, vasodilation occurs, and neutrophils enter into the air spaces (Capriotti & Frizzell, 2016). Goblet cells will then secrete mucous and exudative edema build up between the alveoli and the capillaries (Capriotti & Frizzell, 2016). The alveoli then tend to open against the purulent exudate, but some do not have the ability to (Capriotti & Frizzell, 2016). Pneumonia will ultimately affect multiple body systems. Pneumonia will cause the heart to work hard, increasing the pulse (Capriotti & Frizzell, 2016). Along with that, pneumonia will decrease the oxygen to other body parts in the body, causing hypoxemia (Capriotti & Frizzell, 2016). Pneumonia will mostly affect the respiratory tract, causing severe shortness of breath and coughing (Capriotti & Frizzell, 2016).

With pneumonia, a patient can exhibit a lot of symptoms. Some of the symptoms consist of chills, fever, chest pain, dyspnea, sore throat, and nasal congestion (Hinkle & Cheever, 2018). Along with that, the patient can exhibit a headache, myalgia, rash, orthopnea, fatigue, and a decrease in appetite (Hinkle & Cheever, 2018). Pneumonia will cause the patient pulse to elevate to an abnormal level, increase temperature, and increase respirations (Hinkle & Cheever, 2018). When looking at a patient's labs, there will be an elevated white blood cell count, inflammatory markers, and a decrease in red blood cells (Hinkle & Cheever, 2018). It is essential to have a chest x-ray, a blood culture, and a sputum culture to diagnose pneumonia (Hinkle & Cheever, 2018).

The labs that were performed on this patient to help diagnose pneumonia is a chest x-ray. Along with that, the patient had a decrease in red blood cells and an increase in inflammatory markers. The patient is receiving ceftriaxone to help treat pneumonia.

One complication that with pneumonia is shock and respiratory failure (Hinkle & Cheever, 2018). The symptoms with shock are hypotension and a significant drop in pulse oximetry readings (Hinkle & Cheever, 2018). Ensure the patient has an adequate amount of fluid intake and make sure they are therapeutic with their medications to prevent shock (Hinkle & Cheever, 2018). Another complication that with pneumonia is a pleural effusion (Hinkle & Cheever, 2018). The symptoms with a pleural effusion consist of dyspnea and cough (Hinkle & Cheever, 2018). To prevent this from happening is to ambulate the patient and perform deep breathing exercises (Hinkle & Cheever, 2018).

This patient is experiencing a bunch of symptoms that correlate with pneumonia patients. The patient is experiencing symptoms such as using accessory muscles to breathe, an elevated

pulse, an infrequent cough, and increased respirations. Along with that, she has increased decreased red blood cells and an increase in inflammatory markers.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis Company.

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Limited Activity	The patient is a fall risk and needs to be assisted when he gets up from bed and when he is ambulating.
Diet/Nutrition: Regular diet	The patient is on a regular diet until discontinued. He is also on strict I & O's.
Frequent Assessments: Vital Signs & Pulse Oximetry	The patients vital sign is assessed every eight hours. K.C has a continuous pulse oximetry running.
Labs/Diagnostic Tests: CMP, CRP, Chest X-ray	The patient had a chest x-ray to help diagnose his pneumonia. The chest x-ray was positive. Along with that, his labs helped with diagnosing pneumonia.
Treatments: Medications	The patient is taking ceftriaxone to help treat his pneumonia. Along with that, he is taking ibuprofen and acetaminophen to help treat his fever.
Other: Emergency Order	Have the code 99 sheet calculated for pediatrics and placed at the bedside for emergency situations.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
CMP	The patient had a CMP done to make sure his lab results are turning to normal ranges.
CRP	The patient received an order for CRP to

	make sure his inflammatory marker is dropping.
N/A	N/A

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	4.03-5.29	4.21	3.58	The patient has low a red blood cell count due the inflammatory response taking place in the body (Mayo Clinic, 2019).
Hgb	11-14.5	11.3	9.7	The patient has low hemoglobin levels due to having pneumonia (Mayo Clinic, 2020).
Hct	33.9-43.5	33.8	29.2	The patient has a low hematocrit levels due to having a nutritional deficiency (Medline Plus, 2020).
Platelets	175-332	100	140	The patient has thrombocytopenia due to the infection in his body (Hinkle & Cheever, 2018).
WBC	3.84-9.84	7.98	8.0	Lab was normal
Neutrophils	1.54-7.04	5.47	4.96	Lab was normal
Lymphocytes	1.0-4.8	1.64	2.3	Lab was normal
Monocytes	2-8	9.6	3.9	The patient has elevated monocytes due to having an infection (Hinkle & Cheever, 2018).
Eosinophils	0-6	0.1	3.9	Lab was normal
Basophils	0-1	0.01	0	Lab was normal
Bands	0-10%	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	127.1	138	The patient had low sodium levels due to being dehydrated (Capriotti & Frizzell, 2016).
K+	3.5-5.1	4.1	4.5	Lab was normal
Cl-	98-107	95	112	The patient has hypochloremia due to excessive sweating from having a high fever (Hinkle & Cheever, 2018). The patient had hyperchloremia levels due to being dehydrated (Hinkle & Cheever, 2018).
Glucose	60-99	101	109	The patient has elevated blood glucose levels due to having an infection (Hinkle & Cheever, 2018).
BUN	7-18	21	13	The patient has elevated BUN levels due to taking ibuprofen (Jones & Bartlett Learning, 2019).
Creatinine	0.5-1.0	0.42	0.29	The patient has low creatinine levels due to not consuming an adequate diet (Stephens, 2017).
Albumin	3.4-5	3.0	1.8	The patient is experiencing hypoalbuminemia due to not eating a well-balanced diet (Stephens, 2018).
Total Protein	6.4-8.2	6.9	4.9	The patient has low protein levels due to not having a well-balanced diet (Martinez, 2019). The patient has not been eating that much food ever since he has been sick.
Calcium	8.5-10.1	9.0	8.3	The patient has low calcium levels due to not consuming enough vitamin D in his diet (Capriotti & Frizzell, 2016). The patient has had a poor diet in the past few days.
Bilirubin	0.2-1.0	0.5	0.2	Lab was normal
Alk Phos	45-117	168	115	The patient has elevated alkaline

				phosphatase levels due to taking acetaminophen (Jones & Bartlett Learning, 2019).
AST	15-37	40	24	The patient has elevated aspartate transaminase due to taking acetaminophen (Jones & Bartlett Learning, 2019).
ALT	12-78	46	23	Lab was normal
Amylase	30-300	N/A	N/A	N/A
Lipase	3-216	N/A	N/A	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	3-15	N/A	N/A	N/A
CRP	<0.8	N/A	N/A	N/A
Hgb A1c	4-6%	N/A	N/A	N/A
TSH	0.36-5.80	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	N/A	N/A	N/A
pH	5.0-8.0	N/A	N/A	N/A
Specific Gravity	1.005-1.034	N/A	N/A	N/A
Glucose	Normal	N/A	N/A	N/A
Protein	Negative-Normal	N/A	N/A	N/A

Ketones	Negative	N/A	N/A	N/A
WBC	<5	N/A	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	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	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A
Respiratory ID Panel	Negative	Negative	N/A	Lab was normal

Lab Correlations Reference (APA):

ATI (2019). *Content mastery series review module: RN nursing care of children* (11th ed.). Assessment Technologies Institute, LLC.

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

Jones & Bartlett Learning. (2019). *Nurses drug handbook.*

Martinez, K. (2019, December 10). What to know about hypoproteinemia? *Medical News Today.* https://www.medicalnewstoday.com/articles/320050

Mayo Clinic. (2019, August 16). *Anemia.* https://www.mayoclinic.org/diseases-conditions/anemia/symptoms-causes/syc-20351360

Mayo Clinic. (2020, September 22). *Low hemoglobin count causes.* https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/causes/sym-20050760

Medline Plus (2020, July 31). *Hematocrit test.* https://medlineplus.gov/lab-tests/hematocrit-test/

Normal values per epic charting system

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing (3rd ed.).* Philadelphia, PA: Wolters Kluwer.

Stephens, C. (2018, September 2). What is hypoalbuminemia and how is it treated? *Healthline.* https://www.healthline.com/health/hypoalbuminemia

Stephens, C. (2017, November 2). All you need to know about low creatinine levels. *Medical News Today.* https://www.medicalnewstoday.com/articles/319892#what-is-creatinine

University of Rochester Medical Center (2020). Creatinine (blood). https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=167

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's comprehensive handbook of laboratory and diagnostic tests with nursing implications* (7 ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. The patient had a CT of his brain without contrast due to having a headache and an infection.
2. The patient received a CT of the neck without contrast due to having neck pain.
3. The patient received a chest x-ray due to being short of breath.

Diagnostic Test Correlation (5 points):

1. A CT scan helps show cross-sectional images of the brain (Hinkle & Cheever, 2018). The CT scan can help diagnose tumors, injury to the brain, and trauma (Hinkle & Cheever, 2018). The patient's brain CT scan showed no abnormalities, no intracranial hemorrhage, or fluid collections.
2. A CT scan of the neck will ultimately show a more detailed image than an x-ray (Hinkle & Cheever, 2018). The neck CT scan helps establish if the patient has any fractures, trauma, or injury to soft tissue (Hinkle & Cheever, 2018). The patient's CT scan of his neck showed no mass in the neck. The CT scan was positive for inflammatory lymph nodes and pleural effusions in the bilateral lungs.
3. A chest x-ray is essential to help diagnose pneumonia (Hinkle & Cheever, 2018). Normal pulmonary tissue consists mostly of air and gases (Hinkle & Cheever, 2018). A patient with pneumonia will have densities produced by fluid, tumors, foreign bodies, and other pathologic conditions (Hinkle & Cheever, 2018). The patient's chest x-ray revealed right pleural collection and worsening bilateral central parabronchial wall thickening.

Diagnostic Test Reference (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins

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

Brand/Generic	Tylenol/ acetaminophen	Motrin/ ibuprofen	Klor-Con /0.5-0.9% NaCl with KCl	Rocephin/ ceftriaxone	N-acetyl-5-methoxytryptamine /melatonin
Dose	262.4 mg/ 8.2 mL	176 mg/ 8.8 mL	20 meq	700 mg/ 50 mL	3 mg
Frequency	Every 4 hours PRN	Every 6 hours PRN	60 mL/hour continuously	Every 12 hours	Once tablet daily at bedtime
Route	PO	PO	Intravenously	IV piggy back	PO
Classification	Analgesic & Antipyretic	NSAID	Potassium Replacement	Cephalosporin 3rd generation	Herb and Supplement
Mechanism of Action	Acts directly on the hypothalamus to increase vasodilation and sweating.	Ibuprofen block prostaglandin synthesis, modulates T-Cell production, and blocks COX-1 and COX-2.	Acts as a major cation in intracellular fluid, activating many enzymatic reactions. Potassium also helps maintain electroneutrality in cells by controlling exchange of intracellular and extracellular ions.	Inhibits the third and last step of bacterial wall synthesis by binding to one or more penicillin-binding proteins.	Melatonin helps regulate the circadian rhythms of several biological functions, including the sleep wake cycle.
Reason Client Taking	Pain/ Fever	Pain/ Fever	Potassium Replacement	Pneumonia	Sleep Aid
Concentration Available	160 mg/ 5 mL	100 mg/ 5 mL	20 meq	700 mg	3 mg
Safe Dose Range Calculation	125-275 mg	704 mg	10-20 meq	447.5- 895 mg	0.5-3 mg
Maximum 24-hour Dose	1572 mg	125-200 mg	480 meq	1790 mg	3 mg
Contraindications (2)	1.Impaired renal function 2.Hepatic Impairment	1.Asthma 2. Bronchospasm	1.Acute dehydration 2.hyperkalemia	1.Calcium-containing IV solutions 2.Hypersensitivity	1. Hepatic Insufficiency 2.Renal Impairment

				to penicillin	
Side Effects/Adverse Reactions (2)	1.Constipation 2.Hypotension	1.Dyspnea 2.hemorrhage	1.Arrhythmias 2.Bloody Stools	1.Fever 2.leukopenia	1.Confusion 2.Headache
Nursing Considerations (3)	1.Make sure all dosages of acetaminophen are weight based. 2.Assess the patient for hepatotoxicity. 3.Acetylcysteine is the antidote used for acetaminophen.	1.Have the patient take the drug with food. 2.Be aware that GI bleeding can occur while taking this drug. 3.Monitor BUN and serum creatinine levels.	1.High concentrations of potassium chloride should be only given through a central port. 2.Monitor serum potassium level before administering medication. 3.Monitor serum creatinine level and urine output during administration.	1.Obtain culture and sensitivity results, if possible before giving the drug. 2. Ask the patient if an allergic reaction was ever experienced when given other antibiotics. 3. Assess CBC for abnormal labs.	1.Watch for signs that exhibit renal impairment. 2. Monitor patient for adverse effects. 3.Monitor the patient for signs of central nervous system depression.
Client Teaching needs (2)	1.Tell the caregiver that tablets can be crushed. 2.Tell the caregiver not to exceed the recommended dosage of acetaminophen.	1.Advise the caregiver to not give the drug in higher doses for a long period of time. 2.Advise the caregiver to not take another NSAID at the same time.	1.Advise the caregiver to watch for stools for changes in color and consistency. 2.Teach the caregiver to keep the follow up appointment with laboratory to determine serum potassium levels.	1.Educate the caregiver to watch for stool changes such as diarrhea in the patient. 2.Advise the caregiver to report a hypersensitivity reaction such as rash to the provider.	1. Educate the caregiver to give the medication at night. 2. Do not exceed the daily dosage range.

Medication Reference (APA):

Frandsen, Geralyn. (2020). *Abrams clinical drug therapy: Rationales for nursing practice*. S.l.:

Wolters Kluwer Medical.

Jones & Bartlett Learning. (2019). *Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is A & O x 4. The patient is slightly agitated and afraid to be in the hospital. Overall, his appearance is well kept for his age.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patients skin color is normal for his ethnicity. The skin is very hot to touch, dry, intact, and elastic. K.C skin returned when it was pulled on. There were no apparent bruises or wounds. He did have a rash on his left cheek, right anterior thigh, and left thigh. His Braden score was a 4 and he didn't have any drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	The patients head, neck, face, ears, eyes, and nose are all symmetrical. The neck did not contain any edema or trachea deviation. Along with that, the patient had slight cerumen and his tympanic membrane is intact. The patient did not have any nasal drainage and no deviations. K. C's mucosa was pink and moist except for white patches on tongue. All of his teeth were intact. The patient's thyroid was palpated and with no swelling. Also, the patients PERRLA was noted.
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:**	The patients had normal heart sounds with S1 & S2 auscultated. There were no murmurs noted. Along with that the rhythm was normal and the capillary refill was under 2 seconds. The patient was tachycardic and the pedal pulses and radial pulses were palpated at +4. The patient did not have neck vein distention or edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient had clear breath sounds equally in all lobes. Also, the rhythm and rate were equal. He did have rapid breathing and an infrequent cough. K.C did have to use accessory muscle such as his abdomen to help with breathing. There were no rhonchi, wheezes, or crackles noted.
GASTROINTESTINAL (2 points): **Diet at home:**	The patient is on a regular diet in the hospital and a regular diet at home. The patient's height was

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:**	unmeasurable. His bowel sounds were active in all four quadrants and his last bowel movement was on 10/21. The patient did not have any pain or mass upon palpation of the abdomen. Along with that, there were no distention, incisions, scars, drains, or wounds on the abdomen. The patient does not use an ostomy bag, a nasogastric tube, or a feeding tube.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient had yellow, clear, and no odor with his urine. The patient is able to urinate at an adequate rate and does not have any pain with urination. Also, he does not do dialysis and does not use a catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	The patient does not have any discoloration and has feeling in his whole body. The patient has a full range of motion in all limbs and does not use supportive devices. The patient is slightly weak and does need some assistance with walking and standing. His activity is slightly limited due to being weak. He does not need assistance with his activities of daily living. K.C is a fall risk and his fall score is a 2. Also, he does not need assistance with equipment due to not having any equipment.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:**	The patient is able to move all extremities well and PERLA was noted. He did have equal strength in all four of his limbs. The patient is A & O x 4 and his mental status is normal for his age. Along with that his speech is normal and not slurred. He also has sensory in his whole body

Mental Status: **Speech:** **Sensory:** **LOC:**	and is 100% conscious.
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):**	The patient is slightly agitated and he is helping cope with his agitation through the comfort of his mom. All of the patient's social needs are provided through his mother and he does not need any additional equipment. K. C's lives at his home with his mother and his grandmother.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0750	143 BPM	89/42 mmHg	68 BPM	37.2 ℃	93 %

Vital Signs Trend:

The patient vital signs are all in the normal ranges except his temperature. His pulse, blood pressure, respiration rate, and oxygen are out of range due to the infection in his body.

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

Pulse Rate	60-110 BPM
Blood Pressure	Systolic 86-120 Diastolic 44-75
Respiratory Rate	21-25 BPM
Temperature	37.2℃
Oxygen Saturation	95%-100%

Normal Vital Sign Range Reference (APA):

Holman, H.C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0750	Flacc	No specific location	4	Crying & slightly agitated	ibuprofen
Evaluation of pain status *after* intervention	Flacc	No specific location	2	Crying & slightly agitated	ibuprofen
Precipitating factors: The patient is having a lot of agitation due to the infection and elevated temperature. **Physiological/behavioral signs:** K.C is showing some slight agitation and crying because of his pain.					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
1608.4 mL	771.4 mL

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. Toddlers develop gender identity by three years of age.
2. They should be able to speak in sentences of three to four words at the ages of three and four.
3. They should enjoy talking, and languages becomes their primary method of communication**.**

Age Appropriate Diversional Activities

1. Playing ball
2. Putting puzzles together
3. Painting

Psychosocial Development:

Which of Erikson's stages does this child fit?

Initiative vs. Guilt

What behaviors would you expect?

1. Energetic learners
2. Have guilt when they are in trouble and misbehaved
3. Attempt activities within their capabilities

What did you observe?

The patient ultimately did not show any of the initiative vs. guilt stage. The patient just laid in bed and slept due to not feeling very well. Overall, I was not able to distinguish if this patient met the stage or not.

Cognitive Development:

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

Sensorimotor stage

What behaviors would you expect?

1. The concept of object permanence becomes fully developed
2. Toddlers have and demonstrated memories of events that relate to them
3. Domestic mimicry is evident
4. Symbolizes objects and people to imitate previously seen activities

What did you observe?

The patient revealed that the object prominence is fully developed, and he was able to symbolize people to imitate previously seen activities. The patient always cried when the nurse and I went in there due to medical professionals' experience causing pain. Overall, the patient did fit in the sensorimotor stage.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

The patient should be able to combine several words to create simple sentences using grammar rules. Along with that his age group uses language as their primary communication.

Any concerns regarding growth and development?

There are no concerns regarding the patient's vocabulary and vocalization. He was able to provide simple and effective sentences. Along with that, he used his vocab to communicate with his mom.

Developmental Assessment (APA)

Holman, H.C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC.

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. Decreased gas related to altered oxygen supply and as evidence by the client pulse oximetry readings being below normal ranges.	Dyspnea	1.Monitor and promptly report signs and symptoms of respiratory distress. 2.Administer oxygen as prescribed.	1.The patient was monitored frequently and showed no signs of respiratory distress. 2.The patient was administered oxygen when her levels fell really low.
2. Dehydration related to increased sensible loss occurring with tachypnea and fever and as evidenced by the client's respiration being elevated.	Fever and tachypnea	1. Assess intake and output frequently. 2.Encourage fluid intake and maintain intravenous therapy as prescribed.	1.The patient intake and output were strictly assessed. 2. The patient was encouraged to drink fluid and the intravenous fluids were going continuously.
3. Potential for falls related to weakness and as evidenced by client being imbalanced when walking.	Weakness	1.Maitain the bed in the lowest position when leaving the patient's room. 2 Identify if the patient is at risk for falling and compensate for the risk factors.	1.The patient's bed was always in the lowest position when we stepped out of the room. 2.The patient did not have a fall during my shift.

4. Fatigue with decrease intolerance related to an imbalance in oxygen supply and as evidenced by client using accessory muscles to help facilitate breathing.	Fatigue	1.Stress the importance of good nutrition to the family. 2. Assess for fatigue and activity intolerance related to decrease in oxygen.	1.The mom was agreeable to encourage him to eat as much as possible. 2.The patient activity and fatigue were assessed and managed on a routine basis.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.

Concept Map (20 Points):

Subjective Data

The patient cried when he given food
The patient cried when they got him up to walk

Nursing Diagnosis/Outcomes

Potential for decreased gas exchange due to altered oxygen supply
The patient did not show signs of respiratory distress
Dehydration related to tachypnea and having a fever
The patient intravenous fluids are being ran continuously
Potential for fall related to weakness
The patient did not have a fall during my shift
Fatigue related to an imbalance in oxygen supply
The patients mother was encouraged to get the toddler to eat

Objective Data

K.C pulse was 143 BPM
K.C respirations was 68 BPM
K.C oxygen saturation was 93%
Her red blood cells were 3.58
The patient used accessory muscles when breathing
The patient's pain was a 4

Patient Information

The 3-year-old male is admitted due to having shortness of breath and a fever.

Nursing Interventions

Nursing Diagnosis #1
Monitor and promptly report signs of respiratory distress
Administer oxygen as prescribed
Nursing Diagnosis #2
Assess I & O's frequently
Encourage fluid intake and maintain IV fluids
Nursing Diagnosis #3
Maintain the bed in the lowest position when not in the room
Identify the patients risk factors for falls
Nursing Diagnosis #4
Stress the importance of good nutrition to the mom
Assess for signs of fatigue due to a decrease an oxygen supply