

N433 Care Plan #1

Lakeview College of Nursing

Jessica Kavajecz

**Demographics (3 points)**

<b>Date of Admission</b> 2-3-2021	<b>Patient Initials</b> I.B.	<b>Age (in years &amp; months)</b> 17 years and 11 months.	<b>Gender</b> Female
<b>Code Status</b> Full code	<b>Weight (in kg)</b> 63.8 kg	<b>BMI</b> 24.92 kg/m <sup>2</sup>	<b>Allergies/Sensitivities (include reactions)</b> Amoxicillin- breaks out in hives.

**Medical History (5 Points)**

**Past Medical History:** This patient has no major past medical history. The patient does have Raynaud's phenomenon.

**Illnesses:** Raynaud phenomenon

**Hospitalizations:** No previous hospitalizations.

**Past Surgical History:** Surgery in October 2006 (age 3 years): removal of ganglion cyst on the left thumb. This surgery was outpatient and there was no complications.

**Immunizations:** All immunizations up to date. Dtap, Hep B, Hep A, Gardasil (HPV series), influenza, MMR, meningococcal, pneumonia, polio, T-dap, varivax.

**Birth History:** No abnormal birth history.

**Complications (if any):** None.

**Assistive Devices:** The patient does not have any assistive devices.

**Living Situation:** The patient lives at home with her mom, dad, and 2 siblings.

**Admission Assessment**

**Chief Complaint (2 points):** Diarrhea

**Other Co-Existing Conditions (if any):** Raynaud's phenomenon.

**Pertinent Events during this admission/hospitalization (1 points):** The patient came into the Emergency department in 2-3-21 with complaints of nausea, diarrhea, stomach pain, and a fever. She was admitted and is being treated.

**History of present Illness (10 points):** Onset: 2-1-2021 (2 days before coming into the emergency department). Location: stomach pain is located in the lower left and right quadrant and occasionally in the upper right. Duration: pain is constant. Characteristics: pain is dull, aching, and constant. Associated factors: stomach pain is associated with a low grade fever, nausea, and weakness. Relieving factors: Patient is having a hard time finding relief. Pain medications help reduce the pain and antiemetic's help reduce nausea.

**Treatment:** The patient sought out treatment on 2-3-2021.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Clostridium difficile (C.Diff).

**Secondary Diagnosis (if applicable):** Dehydration.

**Pathophysiology of the Disease, APA format (20 points):** Clostridium difficile is a bacterium that is spore forming and grows in the small and large intestine (Capriotti and Frizzell, 2016). When these organisms end up in the GI tract, they send toxins that disrupt the intestinal mucosa (Capriotti and Frizzell, 2016). When the intestinal mucosa is disrupted, this causes the patient to become sick. The causes of C. Diff can be found anywhere in the environment. This could be included in soil, air, human and animal feces, processed meats, food products, water, and can even be carried in normal healthy individuals (Mayo Clinic, 2020). C.Diff can be spread easily because it can be passed

through feces. If someone goes to the bathroom and doesn't wash their hands well enough and they touch a surface or food, then it could be passed that way (Mayo clinic, 2020). The patient could have gotten C. Diff anywhere. She goes to high school and is surrounded by other kids her age. Prevention of C. Diff is basic and includes hand washing and cleaning surfaces (Mayo clinic, 2020). If someone is infected with C. Diff, then following the proper precautions would be necessary for prevention. Risk factors for C. Diff include taking antibiotics, living in a long-term care facility, having a serious illness, being a female (higher risk factor than males), or previously having C. Diff (Mayo clinic, 2020). The patient does not have any of these risk factors other than being female. Some signs and symptoms of C. Diff; watery diarrhea, abdominal cramping and pain, rapid heart rate, fever, blood or pus in the stool, nausea, dehydration, loss of appetite, and increased white blood cell count (Mayo Clinic, 2020). The patient came into the emergency department on 2-3-21 with nausea, vomiting, loose stool, a fever, abdominal pain and cramping, dehydration, loss of appetite, tachycardia, and an increased white blood cell count (so all the symptoms of a C. Diff infection). A patient's labs would show an increased white blood cell count and low electrolyte counts because of dehydration. The patient's labs correlate this this expected finding. She had an elevated white blood cell count and some low electrolyte levels. To diagnose C. Diff stool tests have to be ran. Imaging tests can also be done (CT or X-ray) to make sure that the bowel is not perforated to that it is not another condition (Mayo Clinic, 2020). The patient had stool tests ran and a CT of her abdomen which confirmed the diagnosis of C. Diff. Treatment of C. Diff include antibiotics, rest, and fluids. Common antibiotics that are prescribed are Vancomycin and Metronidazole (Mayo Clinic, 2020). The patient is on both antibiotics, is resting, and is receiving fluids. Potential

complications of C. Diff include dehydration and kidney failure. Signs of dehydration include low blood pressure, fatigue, lightheadedness, dark urine, and dry mouth. To prevent dehydration fluids, food, and rest is necessary (Mayo Clinic, 2020). Signs of kidney failure include decreased urinary output, fatigue, nausea, and shortness of breath. To prevent kidney failure, encourage the patient to drink fluids and take antibiotics. (Mayo Clinic, 2020). The patient is presenting signs of dehydration. She is dehydrated because she can barely keep any food/fluids down and has diarrhea. She has a low blood pressure and fatigue. Fluids are being administered and she has agreed to try and eat solid food. Since admission, the patient no longer has blood in her stool and is having less frequent bowel movements. She is currently on metronidazole and vancomycin. The patient is still complaining of abdominal pain/cramping, slight nausea, and loss of appetite. However, she has agreed to drink more fluids and eat solid foods. She plans on walking down the hall later to increase her strength so she can be discharged.

**Pathophysiology References (2) (APA):**

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

Mayo Clinic. (2020, January 4). *C. difficile infection* <https://www.mayoclinic.org/diseases-conditions/c-difficile/symptoms-causes/syc-20351691>.

**Active Orders (2 points)**

Order(s)	Comments/Results/Completion
Activity: Regular activity (Try to increase	The patient is under regular activity and is

<p><b>as she eats more)- Up ad lib. Independent.</b></p>	<p><b>independent to the bathroom. Activity should be increased as she gains some strength back.</b></p>
<p><b>Diet/Nutrition: Regular diet.</b></p>	<p><b>The patient has not eaten much since admission. Some slushies here and there. Food tolerance is hoping to increase.</b></p>
<p><b>Frequent Assessments: Continuous pulse Ox. Vital signs every 4 hours with a blood pressure.</b></p>	<p><b>The patient's vitals have been within normal range for the most part. Blood pressure has been low due to dehydration.</b></p>
<p><b>Labs/Diagnostic Tests: Urine culture and CBC.</b></p>	<p><b>CBC and urine culture were off balance (due to infection) so those labs have been ran daily to monitor for any changes.</b></p>
<p><b>Treatments: Vancomycin and Metronidazole.</b></p>	
<p><b>Other: No other orders in place.</b></p>	
<p><b>New Order(s) for Clinical Day</b></p>	
<p><b>Order(s)</b></p>	<p><b>Comments/Results/Completion</b></p>

Laboratory Data (15 points)

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

\*Normal range levels per epic at Carle\*

Lab	Normal Range (specific to the age of the child) Per epic at carle	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	3.93- 4.90	4.51	3.70	The patients RBC was slightly low on today's value. This could be caused from dehydration or the blood that was lost from the stool (Capriotti and Frizzell, 2016).
Hgb	10.8-13.3	12.8	10.3	The patient's hemoglobin was slightly low on today's value. This could be from dehydration or the blood that was lost from the stool (Capriotti and Frizzell, 2016).
Hct	33.4-40.4%	39.1%	32.3%	The patient's hemoglobin was slightly low on today's value. This could be from dehydration or the blood that was lost from the stool (Capriotti and Frizzell, 2016).
Platelets	194-345	346	250	
WBC	4.19-9.43	27.23	15.71	An elevated WBC would indicate infection or inflammation (Capriotti and Frizzell, 2016).
Neutrophils	1.82-7.47	22.33	12.17	Neutrophils are the "first responders" to infection or inflammation so an elevated count could indicate infection/inflammation (Capriotti and Frizzell, 2016).
Lymphocytes	1.16-3.33	1.36	5.0	High lymphocytes could indicate infection/inflammation (Capriotti and Frizzell, 2016).
Monocytes	0.19-0.72	3.54	2.30	High monocytes can indicate the

				<b>body is fighting infection (Capriotti and Frizzell, 2016).</b>
<b>Eosinophils</b>	<b>0.02-0.32</b>	<b>0</b>	<b>0.03</b>	
<b>Basophils</b>	<b>0.02-0.32</b>	<b>0</b>	<b>0.02</b>	
<b>Bands</b>	<b>0.0-1.0%</b>	<b>NA</b>	<b>NA</b>	

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

**\*Normal range levels per epic at Carle\***

<b>Lab</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason For Abnormal</b>
<b>Na-</b>	<b>136-145</b>	<b>135</b>	<b>NA</b>	
<b>K+</b>	<b>3.5-5.1</b>	<b>3.3</b>	<b>NA</b>	<b>Potassium levels can be low because of dehydration (Capriotti and Frizzell, 2016).</b>
<b>Cl-</b>	<b>98-107</b>	<b>105</b>	<b>NA</b>	
<b>Glucose</b>	<b>60-99</b>	<b>94</b>	<b>NA</b>	
<b>BUN</b>	<b>7-18</b>	<b>7</b>	<b>NA</b>	
<b>Creatinine</b>	<b>0.55-1.02</b>	<b>0.95</b>	<b>NA</b>	
<b>Albumin</b>	<b>3.4-5.0</b>	<b>3.5</b>	<b>NA</b>	
<b>Total Protein</b>	<b>6.4-8.2</b>	<b>7.6</b>	<b>NA</b>	
<b>Calcium</b>	<b>8.5-10.1</b>	<b>8.8</b>	<b>NA</b>	
<b>Bilirubin</b>	<b>0.2-1.0</b>	<b>0.4</b>	<b>NA</b>	
<b>Alk Phos</b>	<b>45-117</b>	<b>99</b>	<b>NA</b>	
<b>AST</b>	<b>15-37</b>	<b>14</b>	<b>na</b>	<b>AST could be slightly low due to dehydration (Capriotti and</b>

				Frizzell, 2016).
ALT	12-78	19	NA	
Amylase	23-85 u/L	NA	NA	
Lipase	12-70 u/L	Na	NA	

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	1–20 mm/hr	NA	NA	
CRP	0.00-0.29	22	19	A high CRP level can indicate inflammation (Capriotti and Frizzell, 2016).
Hgb A1c	4% and 5.6%	NA	NA	
TSH	0.4 and 4.0 milliunits per liter	NA	NA	

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

\*Normal range levels per epic at Carle\*

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	Clear & yellow.	Clear, dark yellow.	NA	Urine can be a darker color if the patient is dehydrated (Capriotti and Frizzell, 2016).
pH	4.2-8.0	6.5	NA	
Specific Gravity	1.005-1.030	1.025	NA	
Glucose	Negative	Negative	NA	
Protein	Negative	100	NA	Protein in urine can indicate

				<b>infection (Capriotti and Frizzell, 2016).</b>
<b>Ketones</b>	<b>Negative</b>	<b>15</b>	<b>NA</b>	<b>Ketones in urine can indicate infection (Capriotti and Frizzell, 2016).</b>
<b>WBC</b>	<b>0-25</b>	<b>25</b>	<b>NA</b>	
<b>RBC</b>	<b>0-20</b>	<b>9</b>	<b>NA</b>	
<b>Leukoesterase</b>	<b>Negative</b>	<b>Negative</b>	<b>NA</b>	

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

**\*Normal range levels per epic at Carle\***

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
<b>Urine Culture</b>	<b>Negative- no growth</b>	<b>NA</b>	<b>NA</b>	
<b>Blood Culture</b>	<b>No growth-negative</b>	<b>NA</b>	<b>NA</b>	
<b>Sputum Culture</b>	<b>No growth-negative</b>	<b>NA</b>	<b>NA</b>	
<b>Stool Culture</b>	<b>Negative</b>	<b>Positive</b>	<b>NA</b>	<b>There was blood in the patients stool—indicating infection. C-diff tests were ran and they came out positive (Capriotti and Frizzell, 2016).</b>
<b>Respiratory ID Panel</b>	<b>Not detected</b>	<b>Not detected</b>	<b>NA</b>	

Lab Correlations Reference **(1)** (APA):

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

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points): D-dimer: results; 0.67. This could be elevated due to infection (Capriotti and Frizzell, 2016). PTT- 33.4. Normal range: 22.4-35.9. Within normal limits according to the Epic system at Carle. Covid test came back negative.**

**Diagnostic Test Correlation (5 points): D-dimer: results; 0.67. This could be elevated due to infection (Capriotti and Frizzell, 2016). PTT- 33.4. Normal range: 22.4-35.9. Within normal limits according to the Epic system at Carle. Covid test came back negative. CT of abdomen came back clear. C-diff detection came back positive.**

**Diagnostic Test Reference (1) (APA):**

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

**Current Medications (8 points)**

**\*\*Complete ALL of your patient’s medications\*\***

<b>Brand/ Generic</b>	<b>Acetaminophen/ Tylenol</b>	<b>D5 0.9% NaCl with KCL.</b>	<b>Ketorolac/ Toradol</b>	<b>Metronidazole / Flagyl</b>	<b>Vancomycin / Vancocin</b>
<b>Dose</b>	<b>650 mg</b>	<b>20 mEq 125 ml/hr</b>	<b>30mg</b>	<b>500mg</b>	<b>125mg</b>
<b>Frequency</b>	<b>Every 4 hours PRN</b>	<b>Continuous</b>	<b>Every 6 hours PRN</b>	<b>Every 6 hours</b>	<b>4X daily</b>
<b>Route</b>	<b>Orally</b>	<b>IV fluids.</b>	<b>IV push.</b>	<b>IV drip</b>	<b>orally</b>
<b>Classification</b>	<b>Antipyretic, nonopioid analgesic</b>	<b>IV fluid replacement.</b>	<b>NSAID, analgesic.</b>	<b>Antiprotozoal.</b>	<b>Antibiotic.</b>
<b>Mechanism of Action</b>	<b>Inhibits the enzyme cyclooxygenase,</b>	<b>Extracellular fluid volume</b>	<b>Blocks cyclooxygenase, an enzyme</b>	<b>Undergoes intracellular chemical</b>	<b>Inhibits bacterial RNA and</b>

	<b>blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.</b>	<b>and pressure is controlled.</b>	<b>needed to synthesize prostaglandins.</b>	<b>reduction during anaerobic metabolism.</b>	<b>cell wall synthesis; alters permeability of bacterial membranes, causing cell wall lysis and cell death.</b>
<b>Reason Client Taking</b>	<b>The client is taking for pain.</b>	<b>The client is taking for hydration.</b>	<b>The client is taking for pain.</b>	<b>The client is taking for treatment of C. Diff.</b>	<b>The client is taking for treatment of C.Diff.</b>
<b>Concentration Available</b>	<b>650mg tablets available.</b>	<b>1,000 ml bags.</b>	<b>Available in 30 &amp; 60 mg.</b>	<b>Available in a 500 mg bag.</b>	<b>125 mg</b>
<b>Safe Dose Range Calculation</b>	<b>Children 12 years and older can have 3,250 mg (5 doses) in 24 hours.</b>		<b>Adults 17-64 30 mg every 6 hours as needed.</b>	<b>Safe dosage is 15mg/kg infused over 1 hour and then 7.5 mg/kg up to 1,000mg infused over 1 hour every 6 hours for 7 days or longer. Patient is 63.8 kg(15)= 957 mg.</b>	<b>500 mg to 2 grams daily in 3-4 divided doses for 7-10 days.</b>
<b>Maximum 24-hour Dose</b>	<b>3250 mg max dosage in 24 hours.</b>		<b>Maximum dose in 24 hours: 120 mg.</b>	<b>Maximum dosage in 24 hours is 4,000 mg daily. The patient is receiving 2,000 mg/day.</b>	<b>Maximum dosage is 2,000 mg daily. The patient is taking 500mg daily.</b>

<b>Contraindications (2)</b>	<b>Hypersensitivity to acetaminophen or its components, severe hepatic impairment.</b>	<b>Fluid overload, Can increase potassium levels.</b>	<b>GI perforation, hemophilia or other bleeding problems.</b>	<b>Breastfeeding, hypersensitivity to metronidazole or its components.</b>	
<b>Side Effects/ Adverse Reactions (2)</b>	<b>Hypotension, Hepatotoxicity.</b>	<b>Nausea, Vomiting, Diarrhea.</b>	<b>GI bleeding, renal failure.</b>	<b>Pancreatitis, seizures.</b>	<b>Hypotension, C.diff associated diarrhea.</b>
<b>Nursing Considerations (3)</b>	<b>Use acetaminophen cautiously in patients who have hepatic impairment, know that before and during long-term therapy including parenteral therapy, liver function test results, including AST, ALT, bilirubin, and creatinine levels must be monitored.</b>	<b>Do not administer fluid that is cloudy (make sure it is clear), Check patients labs to make sure there is no fluid overload.</b>	<b>Assess patient's skin routinely for rash or other evidence of hypersensitivity, monitor CBC for decreased hemoglobin and hematocrit because the drug may worsen anemia.</b>	<b>Use cautiously in patients with CNS disease, Don't give IV administration by direct IV injection.</b>	<b>Expect to monitor blood vancomycin concentrations frequently, assess hearing during therapy.</b>
<b>Client Teaching needs (2)</b>	<b>Tell the patient that the tablets may be crushed or swallowed whole, Teach patient to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise.</b>	<b>Teach the client how to recognize symptoms of fluid overload (crackles, edema), teach the client how to recognize that the IV site is</b>	<b>Instruct patient to take with a meal to prevent stomach upset, caution patient not to take for more than 5 days because reactions can occur.</b>	<b>Urge patient to complete the entire course of therapy, instruct patient to notify prescriber if no improvement occurs within a few days of</b>	<b>Advise patient to notify prescriber if no improvement occurs after a few days, instruct patient to take full course of vancomycin as</b>

		infiltrate d.		taking.	prescribed .
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**Medication references:**

Drugs.com (2021). *Potassium Chloride in Dextrose and Sodium Chloride*. [Potassium Chloride in Dextrose and Sodium Chloride - FDA prescribing information, side effects and uses \(drugs.com\)](#)

Jones & Bartless Learning. (2020). *2020 Nurse’s drug handbook (19th ed.)*. Burlington, MA.

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (1 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p><b>Alert and oriented times 4.</b>  <b>Patient is in mild distress due to discomfort.</b>  <b>Patients overall appearance is normal. (well groomed). Patient seemed weak and in pain.</b></p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b>  <b>Braden Score:</b>  <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Type:</b></p> <p><b>IV Assessment (If applicable to child):</b>  <b>Size of IV:</b>  <b>Location of IV:</b>  <b>Date on IV:</b>  <b>Patency of IV:</b></p>	<p><b>Skin is dry and intact.</b>  <b>Skin is white (slightly pale).</b>  <b>Skin is warm.</b>  <b>Normal turgor: 2+</b>  <b>No rashes.</b>  <b>No bruises.</b>  <b>No wounds.</b>  <b>Braden score: 5.</b>  <b>No drains present.</b></p> <p><b>Patient had a 20 gauge IV in the left hand.</b>  <b>Date on the IV 2-3-21.</b>  <b>IV is patent, no signs of erythema or drainage.</b>  <b>Dressing is intact.</b>  <b>IV fluid rate: 125 ml/hr.</b></p>

<p><b>Signs of erythema, drainage, etc.:</b>  <b>IV dressing assessment:</b>  <b>IV Fluid Rate or Saline Lock:</b></p>	
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b>  <b>Thyroid:</b></p>	<p>The clients head is symmetrical (midline with no deviations).  Hair is brown with no patches or balding.  Ears are clear and pink with no drainage.  Tympanic membrane is visible, pearly grey.  PEERLA is present.  No nasal deviation (turbinate’s equal bilaterally).  Oral mucosa is pink and moist (no abnormalities).  Teeth present and in good condition.</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Location of Edema:</b></p>	<p>. Normal sinus rhythm noted.  S1 &amp; S2 are present.  Radial and pedal pulses palpable.  No peripheral edema.  Normal capillary refill: less than 3 seconds.  The patient has slight tachycardia.</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Breath Sounds: Location, character</b></p>	<p>Breath sounds are normal and unlabored.  Clear breath sounds bilaterally.  100% oxygen on room air.  The patient has a dry cough.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current diet:</b>  <b>Height (in cm):</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>      <b>Distention:</b>      <b>Incisions:</b>      <b>Scars:</b>      <b>Drains:</b>      <b>Wounds:</b>  <b>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>      <b>Size:</b>  <b>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b></p>	<p>The patient is on a regular diet at home and here in the hospital.  <b>Height: patient is 5 ft 2 in.</b>  <b>Weight is 63.8 Kg- 140.36 pounds.</b>  Normoactive bowel sounds in all 4 quadrants.  Last BM: 2-4-21 at 8:30am. Stool is liquid, loose, and brown (no more blood in stool).  The patient is tender in the RLQ, RUQ, and LLQ. Associated with nausea &amp; abdominal pain.  No distension &amp; rounded.  No scars, drains, incision, or wounds.</p>

<p><b>Type:</b></p>	
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b></p>	<p><b>Clear, yellow urine.</b>  <b>Client is voiding regularly (it is not being measured).</b>  <b>No pain with urination.</b>  <b>Genitals are normal.</b></p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p><b>Active ROM bilaterally.</b>  <b>The client ambulates to the bathroom independently.</b>  <b>The client does not need/use and assistive devices. The client is weak because she has barely eaten or drank anything since admission.</b>  <b>Fall score: 2.</b></p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b></p>	<p><b>Clients grip strength is equal bilaterally in upper and lower extremities.</b>  <b>Client is oriented.</b>  <b>Mental status is normal.</b>  <b>Speech is clear and normal.</b>  <b>No LOC.</b></p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s) of caregiver(s):</b>  <b>Social needs (transportation, food, medication assistance, home equipment/care):</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p><b>The client is Christian.</b>  <b>The client has a great support system (mother and father were both present and were devoted to her care). The client copes with movies, Netflix, and music. The client does not need any special equipment, medication assistance, or home care.</b>  <b>The client lives in a healthy home environment with her parents and 2 siblings. The client has a wonderful support system. 😊</b></p>

**Vital Signs, 1 set (2.5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>16:00</b>	<b>88</b>	<b>116/82</b>	<b>18</b>	<b>98.2 orally</b>	<b>100% RA.</b>

**Vital Sign Trends:** The patient’s vital signs have been consistent throughout her stay. Her blood pressure was slightly low in the morning, but went up by the afternoon after fluids and rest.

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

<b>Pulse Rate</b>	<b>60-100</b>
<b>Blood Pressure</b>	<b>120/80</b>
<b>Respiratory Rate</b>	<b>12-20</b>
<b>Temperature</b>	<b>Average body temperature is 98.6F.</b>
<b>Oxygen Saturation</b>	<b>95-100%.</b>

**Normal Vital Sign Range Reference (1) (APA):**

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

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<b>16:00</b>	<b>0-10</b>	<b>Lower</b>	<b>5 at rest.</b>	<b>Constant and</b>	<b>Ketorolac.</b>

		abdomen.	6 with activity.	dull.	
Evaluation of pain status <i>after</i> intervention	0-10	Lower abdomen.	4	Constant and dull.	Tylenol was offered, but patient declined.
<p><b>Precipitating factors:</b> The patient is at constant pain even when resting.  <b>Physiological/behavioral signs:</b> When palpating the stomach, the patient verbalizes pain and grabs her stomach.</p>					

**Intake and Output (1 points)**

Intake (in mL)	Output (in mL)
210 (liquid)- the patient is barely consuming any liquids. 1,000ml IV.	1 BM at 8:00am Voiding regularly but not measuring.

**Developmental Assessment (6 points)**

**\*Be sure to highlight the achievements of any milestone if noted in your 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. Adolescents are able to think abstractly (Ricci et al., 2021)
2. Adolescents develop critical thinking skills (Ricci et al., 2021)
3. Adolescents develop realistic goals and career plans (Ricci et al., 2021)

**Age Appropriate Diversional Activities**

1. Movies/Tv shows.
2. Hanging out with friends/family.
3. Sports/clubs/activities.

**Psychosocial Development:**

**Which of Erikson’s stages does this child fit? This child (17 years old) fits in the identity vs. role confusion stage (Ricci et al., 2021)**

**What behaviors would you expect? The expected behaviors would include a focus on body image changes, fitting in with peers and their norms, and being accepted by their peers (Ricci et al., 2021)**

**What did you observe? I observed that this patient fit the “normal” adolescent development.**

**Cognitive Development:**

**Which stage does this child fit, using Piaget as a reference? This child fits under the formal operational stage (Ricci et al., 2021)**

**What behaviors would you expect? Egocentric thinking, increased ability to perform abstract thinking, thinks they are invincible, and likes making independent decisions (Ricci et al., 2021)**

**What did you observe? I observed that this patient fits this category. She did look to her parents for some things, but made her own choices regarding her care.**

**Vocalization/Vocabulary:**

**Development expected for child’s age and any concerns? An adolescent who is 17 years old would be expected to have normal development. There are no developmental concerns for this child.**

**Any concerns regarding growth and development? No concerns.**

**Developmental Assessment Reference (1) (APA):**

**Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.**

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Intervention (2 per dx)</b></p>	<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the patient/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p><b>1. Risk for fluid volume deficit related to C.Diff as evidence by diarrhea and lack of eating.</b></p>	<p><b>The patient has diarrhea and can hardly keep anything down. (Food &amp; fluids).</b></p>	<p><b>1.Encourage the patient to eat/ drink (find out what the patient likes to eat/drink).</b></p> <p><b>2.Monitor blood pressure, and observe the patient.</b></p>	<p><b>1. The patient and family were willing to try these interventions. Goal: increase patient intake. Outcome: the patient ordered Mac ‘n’ cheese and a slushy.</b></p> <p><b>2. The patient and family were willing to help monitor for any signs of changes to the patient. Goal: monitor for any vital sign changes.</b></p>

			<b>Outcome: the patients' blood pressure did go up at 16:00 vitals.</b>
<b>2. Acute pain related to C.Diff as evidence by the patient verbalizing pain and being tender upon palpation.</b>	<b>The patient verbalizes constant pain and is tender abdomen is palpated.</b>	<b>1. Administer pain medication as indicated.  2. Provide different comfort measures like a hot pack.</b>	<b>1. The patient and family were willing to follow these interventions. Goal: reduce pain. Outcome: the patient did report her pain lowering. She used a hot pack on her stomach and she said it helped reduce her pain.</b>
<b>3. Risk for injury related to dehydration as evidence by decreased fluid/food intake.</b>	<b>The patient has not been able to keep solids/liquids down and because of this she is weak.</b>	<b>1. Have the patient eat &amp; drink more.  2. Once the patient has eaten, have her walk down the hall to regain strength.</b>	<b>1. The patient and family were willing to follow these interventions. The parents were encouraging her to eat food and drink more fluids. Goal: increase strength and decrease injury risk. Outcome: patient did order food and planned on walking around the hallway by the end of the night.</b>
<b>4. Diarrhea related to C.Diff as evidence by frequent bowel movements.</b>	<b>The patient is having frequent loose bowel movements.</b>	<b>1. Encourage the patient to report the color and consistency of stool.  2. Observe associated factors like stomach pain, fever, cramping, and chills.</b>	<b>1. The patient and family reported the color and consistency of stool. The parents knew exactly what time the patient went to the bathroom. Goal: monitor these things to see if there is any progress in slowing down these symptoms and to make sure the patient is not getting any worse. Outcome: the patient was very good at</b>

			<p><b>verbalizing her pain and associative factors. The patient also noted the color and consistency of stool. She reported no blood in stool (which changed since admission).</b></p>
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**Other References (APA):**

**Swearingen, P. L., & Wright, J. D. (2020). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.**

**Concept Map (20 Points):**

### Subjective Data

The patient is experiencing pain in her lower abdomen. She reports it as “constant and dull”. The patient states that “the nausea is constant but has decreased since admission and that medication helps”.  
 “The pain is worse when I stand up and walk around”.  
 The patient does not smoke or drink alcohol.

### Nursing Diagnosis/Outcomes

- 1. Risk for fluid volume deficit related to C.Diff as evidence by diarrhea and lack of eating. Outcomes: the patient ordered Mac ‘n’ cheese and a slushy. The patients’ blood pressure did go up at 16:00 vitals.**
- 2. Acute pain related to C.Diff as evidence by the patient verbalizing pain and being tender upon palpation. Outcomes: the patient did report her pain lowering. She used a hot pack on her stomach and she said it helped reduce her pain.**
- 3. Risk for injury related to dehydration as evidence by decreased fluid/food intake. Outcomes: patient did order food and planned on walking around the hallway by the end of the night.**
- 4. Diarrhea related to C.Diff as evidence by frequent bowel movements. Outcomes: the patient was very good at verbalizing her pain and associative factors. The patient also noted the color and consistency of stool. She reported no blood in stool (which changed since admission).**

### Objective Data

Height: 5 feet 2 in.  
 Weight: 63.8 kg.  
 Patient appears to be in discomfort and hold her stomach constantly. Patient is pale and looks like she has little to no energy.  
 Vital signs:  
 Pulse: 88  
 BP: 116/82  
 RR: 18  
 Temp: 98.2F O2: 100% RA.

### Patient Information

The patient is a 17 year old female who was admitted on 2-3-2021 for C.Diff. The patient was experiencing diarrhea, stomach pain, fever, and nausea. Full code.

### Nursing Interventions

- 1. Encourage the patient to eat/ drink (find out what the patient likes to eat/drink). Monitor blood pressure, and observe the patient.**
- 2. Administer pain medication as indicated. Provide different comfort measures like a hot pack.**
- 3. Have the patient eat & drink more. Once the patient has eaten, have her walk down the hall to regain strength.**
- 4. Encourage the patient to report the color and consistency of stool. Observe associated factors like stomach pain, fever, cramping, and chills.**

