N433 Care Plan #1

Lakeview College of Nursing

Matthew Catlett

Demographics (3 points)

Date of Admission 2/5/21	Patient Initials W.N.	Age (in years & months) 2 years, 1 month	Gender Female
Code Status Full Code	Weight (in kg) 15.5 kg	BMI 22.1	Allergies/Sensitivities (include reactions) Apples (rash) Amoxicillin (anaphylaxis)

Medical History (5 Points)

Past Medical History: Single liveborn in hospital via vaginal delivery.

Illnesses: N/A

Hospitalizations: N/A

Past Surgical History: This client has no past surgical history.

Immunizations: This client has received the DTaP, Hib, Hepatitis A, MMR, Pneumococcal, Rotavirus, and Varicella vaccines.

Birth History: Single liveborn in hospital via vaginal delivery.

Complications (if any): No complications occurred during the delivery of this client.

Assistive Devices: N/A

Living Situation: This client currently lives with the father and has visitation with the mother every other weekend.

Admission Assessment

Chief Complaint (2 points): Handprint-shaped bruise on left and right flanks.

Other Co-Existing Conditions (if any): N/A

Pertinent Events during this admission/hospitalization (1 points): This client has required no medical interventions but is staying at the hospital for ongoing DCFS investigation.

History of present Illness (10 points):

2-year-old presented to the Carle emergency department from Paris Community Hospital with bruising on left and right flanks. The bruises are in the shape of a handprint. Father claims bruises came from children at the client's daycare. The mother states that the bruising came from the father and the handprints match the size of the father's hands. An ongoing investigation is being held by the Department of Children and Family Services. The client will be discharged from Carle once the investigation is finished and the client can be discharged with an appropriate caregiver.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Superficial bruising of the chest wall; Non-accidental traumatic injury.

Secondary Diagnosis (if applicable): N/A

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

Non-accidental trauma, or in this case child abuse, is defined as the intentional injury of a child. Non-accidental trauma can include physical harm, neglect, or sexual abuse. Based on this client's physical assessment and electrolyte lab values, the child sustained physical abuse and may have suffered from neglect through dehydration or lack of fluid availability.

While there is no direct pathophysiology of this incident, there are psychological factors within a caretaker that can make them more likely to abuse a child. These factors include their knowledge on parenting, emotional immaturity, and lack self-confidence. Those who are abused as children are also likely to abuse their child when they become parents.

To correctly identify when a child may be experiencing non-accidental trauma, a physical assessment must be performed. Findings within a physical assessment that would show signs of non-accidental trauma include cigarette burns, bruises in the shape of a hand or a belt, or unexplained fractures and hemorrhaging. Other signs of child abuse include unexplained accidents, such as a child being involved in an action, they performed that is not viable per their age and placement of development.

The child that was cared for in this clinical experience did not have any medical needs. The client was being held for supervision while the Department of Children and Family services investigated the incident. While it is not a nurse's place to judge their client's or the client's family, nurses must keep the child's safety as the most important objective during the admission.

Treatment for non-accidental trauma includes finding a different home for the child with another family member or close friend, the family attending counseling or therapy to learn how to properly care for their children or manage their anger, or the child being placed into foster

care. The Department of Children and Family Services are responsible for determining if the child can return home with the primary parent or if an alternative living situation needs to be made for the client.

Pathophysiology References (2) (APA): Videbeck, S. L. (2020). *Psychiatric-mental health nursing*. Wolters Kluwer.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Increase activity as tolerated.	**The client has yet to show signs of increased activity.**
Diet/Nutrition: Regular Diet.	**N/A**
Frequent Assessments: Vitals should be taken Q12H; I&O's should be recorded throughout the stay.	**Client was originally receiving vitals every 4 hours. The client's unease when nurses are near requires the vitals to be taken less frequently.**
Labs/Diagnostic Tests: The client received a brain CT scan and a chest x-ray.	**Brain CT- no signs of hemorrhaging. Arachnoid cysts were discovered upon completion of the CT scan.** **X-ray showed no signs of fracture.**
Treatments: Administer pain meds PRN.	**The client has not required any pain medication.**
Other:	

New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
No new orders have been placed (same day as admission).	

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	**3.84-4.92**		**4.87**	
Hgb	**10.2-12.7**		**13.7**	**High hemoglobin counts can be caused by COPD, congenital heart disease, and dehydration. This client is believed to be dehydrated at the time of admission.**
Hct	**31.2-37.8**		**40.0**	**High hematocrit counts can be caused by dehydration, low availability of oxygen, or lung or heart disease. This client is believed to be dehydrated at the time of admission.**
Platelets	**189-394**		**407**	**High platelet counts can be caused by recent injury, anemia, or infections such as tuberculosis. The cause of this client's anemia is assumed to be recent injury.**
WBC	**4.86-13.18**		**17.48**	**High amounts of white blood cells are caused by an infection within the body.**
Neutrophils	**1.54-7.92**		**4.45**	

Lymphocytes	**1.25-5.77**		**11.2**	**High amounts of lymphocytes in the blood show signs of an infection.**
Monocytes	**0.24-0.92**		**1.5**	**High monocyte counts can be caused by leukemia, lupus, or inflammatory bowel disease. The cause of this clients monocytosis is unknown.**
Eosinophils	**0.03-0.46**		**0.22**	
Basophils	**0.01-0.06**		**0.06**	
Bands	**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**		**137**	
K+	**3.5-5.1**		**4.2**	
Cl-	**98-107**		**107**	
Glucose	**60-99**		**83**	
BUN	**7-18**		**15**	
Creatinine	**0.55-1.02**		**0.24**	**The cause of this client's decreased creatinine is connected to the client's dehydration.**
Albumin	**3.4-5.0**		**4.1**	
Total Protein	**6.4-8.2**		**7.3**	
Calcium	**8.5-10.1**		**10.1**	
Bilirubin	**0.2-1.0**		**0.3**	
Alk Phos	**54-369**		**293**	

AST	**16-37**		**25**	
ALT	**12-78**		**23**	
Amylase	**25-115**		**74**	
Lipase	**73-393**		**106**	

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			**N/A**	
CRP			**N/A**	
Hgb A1c			**N/A**	
TSH			**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	**Colorless or yellow**		**Colorless**	
pH	**5.0-7.0**		**5.0**	
Specific Gravity	**1.003-1.035**		**1.003**	
Glucose	**Negative**		**Negative**	
Protein	**Negative**		**Negative**	
Ketones	**Negative**		**Negative**	
WBC	**0**		**0**	

RBC	**0**		**0**	
Leukoesterase	**Negative**		**Negative**	

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**		**Negative**	
Blood Culture	**Negative**		**Negative**	
Sputum Culture	**Negative**		**Negative**	
Stool Culture	**Negative**		**Negative**	
Respiratory ID Panel	**Negative**		**Negative**	

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): No other diagnostic tests were performed.

Diagnostic Test Correlation (5 points): With non-accidental traumas, hemorrhaging and bone fractures can occur. The brain CT scan that was performed on this client can recognize any intra-cranial bleeding that can occur after a trauma. The x-ray that was performed on the client was performed to identify any fracture ribs that may have

occurred from the trauma. The x-ray looked at the rib cage, which is the same area where the hand-print bruising was identified.

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****

Brand/Generic	**Tylenol/ acetaminophen**	**Cholecalciferol/ Vitamin D3**	**Nayzilam/ midazolam**		
Dose	**233.6 mg**	**2000 units**	**3.9 mg**		
Frequency	**PRN**	**Once daily**	**Once**		
Route	**Oral**	**Oral**	**Intranasal**		
Classification	**Antipyretic**	**Vitamin**	**Anticonvulsant**		
Mechanism of Action	**Inhibits cyclooxygenase which blocks prostaglandin production that causes inflammatory response.**	**Binds to and activates vitamin d receptors that are found in the nuclei of target cells.**	**Increases activity of gamma-aminobutyric acid.**		
Reason Client Taking	**The client is receiving this for any pain or fever the client may be experiencing.**	**Vitamin D3 is a version of vitamin D that allows the body to absorb calcium. This prevents fragile bones or prevents bone loss.**	**The client is receiving this medication for any anxiety or agitation they might experience.**		
Concentration Available	**160 mg/ 5 mL**	**200 mcg/mL**	**5 mg/mL**		
Safe Dose Range	**155-233 mg**	**N/A**	**Unable to find**		

Calculation			**sufficient information on the intranasal version of midazolam for young clients.**		
Maximum 24-hour Dose	**800 mg**	**10 mcg**	**Unable to find sufficient information on the intranasal version of midazolam for young clients.**		
Contraindications (2)	**This medication should not be given to clients with hepatic impairment or severe liver disease.** **This medication should not be given to clients hypersensitivity to acetaminophen.**	**This medication should not be used in clients who have an elevated calcium level.** **This medication should not be given to those who have a hypersensitivity to calciferol.**	**This medication should not be used in clients with acute angle-closure glaucoma.** **This medication should not be used in clients who are currently in a coma.**		
Side Effects/Adverse Reactions (2)	**Side effects include hypotension and hepatotoxicity.**	**Side effects include dry mouth, constipation, and headache.**	**Side effects include cardiac arrest, bradypnea, and respiratory arrest.**		
Nursing Considerations (3)	**Use cautiously in clients with hepatic impairment.** **Monitor renal function in client on long term therapy.** **Liver tests such**	**Be aware of early signs of hypercalcemia, such as headache, weakness, or fatigue.** **Do not administer more than the**	**Determine whether the client takes antihypertensive medications, as this can produce a prolonged sedative effect.** **Assess levels of consciousness**		

	as AST, ALT, and bilirubin should be performed before long term treatment.	**prescribed amount.**	**frequently and change dosage as needed.**		
Client Teaching needs (2)	**Teach parents to recognize signs of toxicity. These include bleeding, malaise, and bruising.** Teach parents not to exceed recommended dosing.	**This medication should be stored away from light and moisture.** **This medication works best when taken after a meal but is not required to be taken with food.**	**Inform the client that they may not remember everything because midazolam can produce amnesia.** **Client should avoid other CNS depressants while on this medication.**		

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Client is alert and oriented to their surroundings.** **Client becomes agitated upon assessment.** **Overall appearance shows minor distress.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 0** **Drains present: Y☐ N ☒** **Type:**	**The client's skin is pink, dry, and warm to the touch.** **Skin turgor < 2 seconds.** **Client has hand-shaped bruises on both flanks.** **Client also has small scrape on left knee.**

IV Assessment (If applicable to child): No IV present. **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **IV Fluid Rate or Saline Lock:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	**Head, neck, and trachea are symmetrical.** **Client's ears are clear from dirt, debris, and drainage.** **Sclera's are white with no hemorrhaging.** **Nose shows no drainage, septum is midline.** **Dentition is present and appropriate for the client's age.**
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 without extra beats or murmurs. The client's cardiac rhythm is regular without deviation.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Client's breath sounds are clear bilaterally.** **Regular depth and pattern present when breathing.**
GASTROINTESTINAL (2 points): **Diet at home: Regular diet** **Current diet: Regular diet** **Height (in cm): 85.5 centimeters** **Auscultation Bowel sounds:** **Last BM: 2/5/21 @ 1300** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:**	**Client has bowel sounds audible in all four quadrants.** **Bowel sounds are normoactive.** **No nausea, vomiting, or diarrhea present.**

Feeding tubes/PEG tube Y ☐ N ☒ **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Client's urine is colorless to slightly yellow.** **Client has voided 950 mL since admission.** **No catheter present.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 0** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Client has full range of motion in all extremities.** **Client shows no muscle weakness.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Client is oriented to place and surroundings.** **Client shows no signs of impaired consciousness.**
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):**	**Home environment may need re-evaluation.** **Admission shows possible signs of abuse and relocation may be necessary.** **Client's family structure is poor.**

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	**124**	**116/57**	**26**	**36.7 C**	**100%**

Vital Sign Trends: N/A

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

Pulse Rate	**80-150**
Blood Pressure	**70/25-106/65**
Respiratory Rate	**24-40 per minute**
Temperature	**35.5-37.5 C (Oral)**
Oxygen Saturation	**97-100%**

Normal Vital Sign Range Reference (1) (APA): Iowa head and NECK PROTOCOLS. (2020, May 20). Retrieved February 08, 2021, from https://medicine.uiowa.edu/iowaprotocols/pediatric-vital-signs-normal-ranges

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1130	**Numeric**	**Flank and chest**	**0**	**N/A**	**PRN acetaminophen**
Evaluation of pain status *after*	**N/A**	**-**	**-**	**-**	**-**

intervention					
Precipitating factors: **Physiological/behavioral signs:**					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
960 mL	**950 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. **At this child's age, the child's weight should be four times their birth weight. Birth weight of this child is unknown per the chart.**
2. **The child's height should be approximately 15.6 cm, assuming they grow 7.5 centimeters per year. This child's height is changing appropriately.**
3. **Children at this age should have no issues walking up and down stairs by placing both of their feet on the step. Evaluation of this was not possible due to the child sleeping during clinical visitation.**

Age Appropriate Diversional Activities

1. **Cause and effect activities.**
2. **Blowing bubbles.**
3. **Providing toys that light up or play sounds/music.**

Psychosocial Development:

Which of Erikson's stages does this child fit? This child fits into the Autonomy vs shame and doubt stage.

What behaviors would you expect? Within this stage, the child should be developing skills that they can perform independently.

What did you observe? Observations could not be made on this client due to the client sleeping.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? This child fits into Piaget's Preoperational Stage.

What behaviors would you expect? At this stage, children will learn to use words, and identify pictures and objects that correlate with those words. Children at this stage also struggle to see other people's perspectives.

What did you observe? Observations could not be made on this client due to the client sleeping.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? Unknown due to circumstances.

Any concerns regarding growth and development? N/A

Developmental Assessment Reference (1) (APA):

Marion, C (2020). ***Growth and Development of Toddlers*** **[PowerPoint Presentation].**

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. Disabled family coping related to aggression towards a child as evidenced by non-accidental trauma.	**This diagnosis was chosen because both parents shows signs of difficulty with coping with anger and aggression.**	**1. Be mindful of the attitude and mannerisms of the caregivers when around the child. Watch for cues of abuse.** **2. Family members can receive therapy to develop skills on coping and anger management.**	**Outcomes for this client are unknown due to ongoing investigation.**

2. At risk for injury related to unsafe housing environment as evidenced by non-accidental trauma.	**This diagnosis was chosen because the mother of the child has been investigated by DCFS previously and the father is now being investigated by DCFS.**	**1. Removal of any persons who may cause non-accidental trauma to the client from the caregiving role.** **2. Removal of any persons who may cause non-accidental trauma from the household in which the client lives.**	**Outcomes for this client are unknown due to ongoing investigation.**
3. Risk for post-trauma syndrome related to physical abuse as evidenced by history of both parents showing aggression towards child.	**This diagnosis was chosen due to a child's high chance of suffering from post-trauma syndrome after physical abuse from parents or those they see as mentors/ caregivers.**	**1. The client should receive counseling to develop coping strategies as they mature.** **2. The client should be placed in the care of a person who is unlikely to cause physical abuse to the client.**	**Outcomes for this client are unknown due to ongoing investigation.**
4. Fear related to traumatic injury as evidenced by hand-print bruises.	**This diagnosis was chosen because the child may have issues with trust in those who are older than them and may fear those who the child sees as caregivers.**	**1. The client should receive counseling to talk about their fears and determine how they can deal and cope with those fears.** **2. The client should receive check-ups do determine progression away from abuse.**	**Outcomes for this client are unknown due to ongoing investigation.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Electrolyte labs show signs of dehydration.

Two hand-print bruises on left and right flanks.

Child being eld at hospital pending results of DCFS investigation.

Nursing Diagnosis/Outcomes

Disabled family coping related to aggression towards a child as evidenced by non-accidental trauma.
At risk for injury related to unsafe housing environment as evidenced by non-accidental trauma.
Risk for post-trauma syndrome related to physical abuse as evidenced by history of both parents showing aggression towards child.
Fear related to traumatic injury as evidenced by hand-print bruises.
Outcomes unknown for this client.

Objective Data

O2 Saturation: 100%
Pulse: 124
Blood Pressure: 116/57
RR: 26
Temperature: 36.7 C
Pain: 0/10
BMI: 22.1

Patient Information

W.N.
2 years 1 month
Non-accidental trauma injury

Nursing Interventions

Be mindful of the attitude and mannerisms of the caregivers when around the child. Watch for cues of abuse.

Family members can receive therapy to develop skills on coping and anger management.

Removal of any persons who may cause non-accidental trauma to the client from the caregiving role.

Removal of any persons who may cause non-accidental trauma from the household in which the client lives.

The client should receive counseling to develop coping strategies as they mature.

The client should be placed in the care of a person who is unlikely to cause physical abuse to the client.

The client should receive counseling to talk about their fears and determine how they can deal and cope with those fears.

The client should receive check-ups do determine progression away from abuse