N433 Care Plan 2

Lakeview College of Nursing

Koti York

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
3/21/21	**RB**	**18 weeks**	**Female**
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	**5.4 kg**	**17.85 kg/m2 per chart**	**NKA**

Medical History (5 Points)

Past Medical History: N/A

Illnesses: Current acute bacterial meningitis

Hospitalizations: N/A

Past Surgical History: N/A

Immunizations: Up to date per chart review

Birth History: 39 weeks and 2 days, delivered by C-section.

Complications (if any): N/A

Assistive Devices: No assistive devices

Living Situation: Lives at home with both parents and siblings.

Admission Assessment

Chief Complaint (2 points): Seizure's

Other Co-Existing Conditions (if any): Continuous ventilation through tracheostomy

Pertinent Events during this admission/hospitalization (1 points): An MRI and CT of the brain were performed.

History of present Illness (10 points): My patient's onset began two days before admission with starring spells with eye deviation and posturing, which lasted for one minute. She got taken by

ambulance to Sarah Bush, where she had a seizure during transportation. She was gram-positive cocci on her gram strain, where she was given Ampicillin and transferred to Carle. The seizure location was just in her eyes as she starred, but I was unaware of the ambulance's seizure activity. The duration of her first seizure was one minute and resolved on its own before the arrival of the ambulance. Characteristics of that seizure were eye deviation with posturing, and it was relieved on its own. There were no known aggravating factors, but the Ampicillin seemed to be helping with the positive infection.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Seizure

Secondary Diagnosis (if applicable): Acute Bacterial Meningitis

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

A seizure is a sudden uncontrollable electrical disturbance in the brain (Mayo clinic, 2021). Nerve cells in the brain create, send, and receive electrical impulses, which all the nerve cells communicate (Mayo clinic, 2021). If there is a disruption in the pathway, it can lead to a seizure (Mayo clinic, 2021). It can cause changes in behaviors, movements, feelings, and consciousness levels (Mayo clinic, 2021). Many types of seizures depend on where they begin in the brain and where they spread (Mayo clinic, 2021). Most commonly, seizures last anywhere from thirty seconds to two minutes, but it is an emergency if they last longer than five minutes. Signs and symptoms include temporary confusion, a staring spell, uncontrollable jerking movements of the extremities, loss of consciousness or awareness, fear, anxiety, or déjà vu (Mayo clinic, 2021). Blood tests will look at blood sugar, electrolytes, and elevation in labs

related to infection (Mayo clinic, 2021). Expected findings in vital signs would be an increase in blood pressure and heart rate. Diagnostic tests include a neurological exam, blood test, lumbar puncture, electroencephalogram, MRI, CT, PET, and SPECT (Mayo clinic, 2021). Treatment includes medication, a diet high in fat and low in carbohydrates, lobectomy, multiple subpial transections, corpus callosotomy, hemispherectomy, thermal ablation, vagus nerve stimulation, and responsiveness neurostimulation, and deep brain stimulation (Mayo clinic, 2021). One potential complication of seizures is the inability to ventilate appropriately. Improper ventilation could have signs and symptoms of blue coloration of the skin, difficulty breathing, aspiration, and declining oxygen saturation. Preventative actions would be to have suction available after the seizure, ventilation equipment if needed, oxygen and spot check O2 throughout the day, especially at night. Another complication would be the risk for injury due to uncontrollable movements of the body. Signs of injury could include bleeding, grimacing, crying, guarding, and verbalization when consciousness gets established. Preventative actions would be implementing seizure precautions such as padding on the bed rails, placing a pillow under the head, moving objects away from the patient, and removing restrictive clothing around the neck.

Meningitis is a potentially fatal infectious disease caused by inflammation of the meningeal layers surrounding and protects the brain and spinal cord (Capriotti & Frizzell, 2016). It is caused by viruses or strains of bacteria such as S. pneumoniae, Neisseria meningitides, and H. influenzae (Capriotti & Frizzell, 2016). The most common signs of meningitis are fever, nuchal rigidity, headache, high fever, confusion, seizures, sensitivity to light, no appetite, skin rashes, drowsiness, and difficulty walking (Capriotti & Frizzell, 2016). Signs most common in newborns include high fever, constant crying, excessive sleeping or irritability, difficulty waking from sleep, inactivity or sluggishness, not waking to eat, poor feeding, vomiting, a bulge in the

soft spot, and stiffness in the body and neck (Mayo clinic, 2020). Kernig's and Brudzinski's signs can be used as a diagnostic tool for meningitis if they experience pain when they get performed. Diagnostic procedures include lumbar punctures, blood cultures, CT, MRI, and x-rays (Capriotti & Frizzell, 2016). High doses of antibiotics and corticosteroids through intravenous access are necessary (Capriotti & Frizzell, 2016). Expected findings for bacterial meningitis would be increases laboratory values that correlate to infection, such as blood counts, positive Kernig's and Brudzinski signs, and inflammation of meninges on the MRI. One complication of this disease would be seizures. A seizure has the signs and symptoms of starring, convulsions, muscle contractions, eye deviation, etc. The nursing action would be to put them on seizure precautions and administer an anticonvulsant to reduce the seizure's potential. Another complication would be an increased spike of a fever that could have the signs and symptoms of irritability, increased heat, bulging fontanelle, and cheeks' redness. An appropriate nursing action would be to administer an antibiotic as prescribed or Tylenol if the antibiotic time is not due, but there is an increase in temperature.

My patient was on Ampicillin every six hours to treat her bacterial meningitis. She has prescribed Tylenol as needed but did not receive it during clinical. They performed an MRI and CT scan which could be used to diagnose both her seizures and bacterial meningitis. Her MRI showed minimal change in the brain, and her CT had no comparison, but they did not notice any significant difference within her brain. Her lab values that increased were RBC, Hgb, Hct, Platelets, and WBC. Her decreasing lab values include Lymphocytes, BUN, and Creatinine. Her vital signs were within the normal range during clinical, and she did not have a seizure. She was placed on phenobarbital to control her seizures, and she received this medication every twelve

hours. When she experienced a seizure upon admission, she had a starring spell with eye deviation and posturing that lasted one minute.

Pathophysiology References (2) (APA):

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

Mayo clinic. (2020). *Meningitis*. Retrieved from https://www.mayoclinic.org/diseases-conditions/meningitis/symptoms-causes/syc-20350508

Mayo clinic. (2021). *Seizures*. Retrieved from https://www.mayoclinic.org/diseases-conditions/seizure/symptoms-causes/syc-20365711

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: As tolerated	**She was a very active baby that engaged with her parents and nurses when they talked to her. She was smiling and kicking around during our visits.**
Diet/Nutrition: Similac Advanced ab lib	**She gets fed formula ab lib and tolerates it well.**
Frequent Assessments: Hourly checks, spot check O2, and vitals every eight hours	**She gets hourly rounding, and during her O2 spot checks, she was in the high 90's.**
Labs/Diagnostic Tests: N/A	**She had no diagnostic tests ordered during clinical.**
Treatments: Ampicillin 50.1 mL/hr every 6 hours. Other pain medication is ordered PRN. She also has normal saline running continuously.	**She gets an antibiotic every 6 hours for meningitis. She will be done taking it on Monday and will go into a 48-hour observation.**
Other:	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
None	

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	3.43-4.80 10^6/ uL	3.24	N/A	Her RBC level can be low related to her infections (Pagana et al., 2019).
Hgb	9.6-12.4 g/dL	9.0	N/A	Her Hgb level can be low related to her infections (Pagana et al., 2019).
Hct	28.6-37.2%	27.0	N/A	Her Hct level can be low related to her infections (Pagana et al., 2019).
Platelets	244-529 10^3/ uL	701	N/A	An increase in production could be related to the medication she is on. She is on acetaminophen, but also infection can cause an increase in platelet counts (Pagana et al., 2019).
WBC	6.51-13.32 10^3/ uL	23.28	N/A	Her WBC could be increased due to infection of bacterial meningitis (Pagana et al., 2019).
Neutrophils	31-51%	N/A	N/A	
Lymphocytes	35-61%	32.6	N/A	Her lymphocytes would be low due to her bacterial meningitis (Pagana et al., 2019).
Monocytes	4-7%	7	N/A	
Eosinophils	2-4%	2	N/A	
Basophils	0-1%	0.2	N/A	
Bands	4-12%	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-	**135-145 mmol/L**	**135**	**N/A**	
K+	**3.5-5.1 mmol/L**	**4.3**	**N/A**	
Cl-	**98-107 mmol/L**	**104**	**N/A**	
Glucose	**60-99 mg/dL**	**84**	**N/A**	
BUN	**7-18 mg/dL**	**3**	**N/A**	**Her BUN level may be low because she may not be getting enough protein in her diet (Pagana et al., 2019).**
Creatinine	**0.70-1.30 mg/dL**	**<0.15**	**N/A**	**Her creatinine level can be low due to a low kidney function after seizure activity (Pagana et al., 2019).**
Albumin	**3.4-5.0 g/dL**	**3.4**	**N/A**	
Total Protein	**6-6.7 g/dL**	**N/A**	**N/A**	
Calcium	**8.5-10.1 mg/dL**	**9.2**	**N/A**	
Bilirubin	**0.2-0.8 g/dL**	**0.2**	**N/A**	
Alk Phos	**54-369 u/L**	**93**	**N/A**	
AST	**15-37 u/L**	**18**	**N/A**	
ALT	**12-78 u/L**	**14**	**N/A**	
Amylase	**40-140 u/L**	**N/A**	**N/A**	
Lipase	**0-160 u/L**	**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	**3-13 mm/hr**	**N/A**	**N/A**	
CRP	**0.02-14.4 mg/L**	**N/A**	**N/A**	
Hgb A1c	**4.5-5.7%**	**N/A**	**N/A**	
TSH	**<6 mLu/L**	**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**	
pH	**4.5-8.0**	**N/A**	**N/A**	
Specific Gravity	**1.003-1.030**	**N/A**	**N/A**	
Glucose	**Neg**	**N/A**	**N/A**	
Protein	**Neg**	**N/A**	**N/A**	
Ketones	**Neg**	**N/A**	**N/A**	
WBC	**Neg- 0-2**	**N/A**	**N/A**	
RBC	**Neg 0-2**	**N/A**	**N/A**	
Leukoesterase	**Neg**	**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	**Neg**	**N/A**	**N/A**	
Blood Culture	**Neg**	**Neg**	**N/A**	
Sputum Culture	**Neg**	**N/A**	**N/A**	

Stool Culture	**Neg**	**N/A**	**N/A**	
Respiratory ID Panel	**Neg**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Normal lab values per Carle

Pagana, K.D., Pagana, T.J., Pagana, T.N. (2019). *Mosby's diagnostic and laboratory test reference.* Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT brain without contrast

Technique: 2.5 mm axial scans through the head without intravenous contrast. 0.625 mm axial images were generalized from the 0.5 mm acquisition data set. Sagittal reformatted images were also generated.

Findings: No comparison

No midline shift. The ventricles were small without evidence of hydrocephalous. Mildly prominent CSF spaces over the convexities are nonspecific and can transiently be seen in the normal population.

Brain parenchyma shows no obvious large hemorrhage. There is no definite large acute infarction. However, this could be inapparent. No significant abnormal mass effect.

No definite extra-axial discrete fluid collection. Definite acute hemorrhage or definite mass.

Orbital contents are unremarkable. Imaged paranasal sinuses show patchy mucosal thickening.

The mastoid air cells are clear. No definite acute fracture.

MRI without contrast

Findings: a left temporal subdural collection with restricted diffusion measures 2 mm in maximal thickness (diffusion weighted series 4 images 12-18 and ADC map series 400 images 12-17). There appears to be minimal hemosiderin at the medial margin of this collection (series 10 images 11-13). There also appears to be minimal increased FLAIR signal in the temporal cortex adjacent this collection (series 6 images 13-15). This is also enhancement of the temporal leptomeninges (series 14 images 37-50). Minimal left frontal abnormal leptomeningeal enhancement is also present.

There is no evidence of hydrocephalus. No mass effect or midline shift is seen.

No evidence of acute infarct.

The midline structure demonstrates normal contour without evidence of a Chiari 1 malformation.

The flow voids of the large intracranial arteries are preserved at the level of the Circle of Willis, suggesting patency.

No evidence of marrow signal abnormality.

Diagnostic Test Correlation (5 points):

MRI is a diagnostic tool used to identify structural changes in the brain caused by a seizure (Kuzniecky, 2013). This test can also specify a cause for the seizure, such as a tumor or blood vessel abnormalities (Kuzniecky, 2013). MRIs can also help determine the type of seizure the patient is experiencing (Kuzniecky, 2013). Along with diagnosing seizures and the brain structure, they can help a surgeon decide whether they should undergo surgery or not, depending on the procedure's prognosis if it is performed (Kuzniecky, 2013). CT scans get used to see atrophy, scar tissue, strokes, tumors, or abnormal blood vessels (Kuzniecky, 2013). CT scans

have a lower resolution than MRI, showing the brain's structures (Kuzniecky, 2013). The tricky thing with a CT scan is trying to determine the difference between the gray and white matter of the brain (Kuzniecky, 2013). CT and MRIs of the head can show inflammation or swelling in or around the brain (Mayo clinic, 2020). If a CT of the chest got done, it could also show infection in the chest or sinuses related to meningitis (Mayo clinic, 2020).

Both the CT and MRI got completed on my patient due to her seizure activity. The tests can help determine if she had any brain damage from the seizures, and if she did, it would indicate the location and severity of the damage.

Diagnostic Test Reference (1) (APA):

Kuzniecky, R. (2013). *Computed tomography (CT).* Retrieved from https://www.epilepsy.com/learn/diagnosis/looking-brain/computed-tomography-ct

Kuzniecky, R. (2013). *Why it's performed*. Retrieved from https://www.epilepsy.com/learn/diagnosis/looking-brain/mri/why-its-performed#:~:text=After%20the%20first%20seizure%2C%20MRI,proper%20seizure%20type%20and%20syndrome.

Mayo clinic. (2020). *Meningitis*. Retrieved from https://www.mayoclinic.org/diseases-conditions/meningitis/symptoms-causes/syc-20350508

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

Brand/	**acetaminoph**	**phenobarbit**	**lactobacillus**	**ampicillin**	**D5- 0.45%**

Generic	**en (Tylenol)**	**al sodium (Luminal)**	**reuteri**		**NaCl**
Dose	**76.8 mg**	**15.4 mg**	**0.25 mL (5 drops)**	**500 mg (50.1 mL/hr)**	**5 mL/hr**
Frequency	**Every 4 hrs PRN**	**Every 12 hrs**	**Daily**	**Every 6 hrs PRN**	**Continuous**
Route	**Oral**	**Oral**	**Oral**	**IVPB**	**Intravenous**
Classification	**Antipyretic, nonopioid analgesic**	**Anticonvulsant**	**Probiotic**	**Antibiotic**	**Electrolyte replacement**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system (Jones & Bartlett, 2019, pg 13).**	**Inhibits ascending conduction of impulses in the reticular formation, which controls CNS arousal to produce drowsiness, hypnosis, and sedation (Jones & Bartlett, 2019, pg 965).**	**L. reuteri attaches to mucin and intestinal epithelia. It inhibits the colonization of pathogenic microbes and remodels its composition. (Jones & Bartlett, 2019).**	**Inhibits bacterial cell wall synthesis. The rigid, cross-linked cell wall is assembled in several steps. Ampicillin exerts its effects on susceptible bacteria in the final stage of the cross-linking process by binding with and inactivating penicillin-binding proteins. (Jones & Bartlett, 2019, pg 76).**	**Replenishment of fluid, minimal carbohydrate calories, and sodium chloride as required. Helps control neutrality in the cells (Jones & Bartlett, 2019).**
Reason Client Taking	**Pain**	**To treat seizures**	**To improve digestion**	**To treat GI infections**	**Prevent hypokalemia**
Concentration Available	**Liquid Suspension**	**Liquid Suspension**	**Liquid Suspension**	**Liquid Suspension**	**Intravenous solution**

				through IV	
Safe Dose Range Calculation	**81-486 mg**	**5.4-16.2 mg**	**0.25-1.25 mL**	**270-540 mg**	**5-120 mL**
Maximum 24-hour Dose	**460.8 mg per day**	**30.8 mg per day**	**1.25 mL per day**	**2000 mg per day**	**120 mL per day**
Contraindications (2)	**Hypersensitivity to acetaminophen or its components. Severe hepatic impairment.**	**Hypersensitivity to phenobarbital or other barbiturates. Severe respiratory disease with airway obstruction or dyspnea.**	**Hypersensitivity to lactobacillus reuteri. Hypersensitivity to its components.**	**Hypersensitivity to ampicillin or its components. Infection caused by penicillinase producing organisms.**	**Acute dehydration and renal impairment.**
Side Effects/Adverse Reactions (2)	**Agitation. Diarrhea**	**Drowsiness and constipation**	**Stomach gas and fever**	**Fever and vaginal candidiasis**	**Chills and asystole**
Nursing Considerations (3)	**Monitor renal function. Monitor liver function lab tests. Make sure the dosage does not exceed the maximum limit**	**Anticipate that phenobarbital may cause paradoxical simulation in children. Be aware that drug may cause physical and psychological dependence. Give undiluted or mix with juice, milk, or water.**	**Monitor interaction with antibiotics. Watch for recurring urinary tract infections. If patient has diarrhea for more than two days let the provider know.**	**Monitor patient closely for anaphylaxis which may be life-threatening. Notify provider if patient has evidence of superinfection. Monitor patient closely for diarrhea.**	**Monitor lab values for excessive change in electrolyte balances. Monitor for fluid overload and stop immediately if edema is noted. Monitor output to ensure the fluids are passing appropriately through the body.**
Client Teaching	**Teach the parent the**	**Caution patient**	**Contact the provider if**	**Emphasize the**	**Do not exceed the**

needs (2)	**sign and symptoms of hepatotoxicity. If a skin rash occurs stop using and seek medical attention**	**about possible drowsiness and reduced alertness. Suggest adding the medication with food or fluids.**	**symptoms of infection occur. Contact provider if a rash occurs that could be related to an allergic reaction.**	**importance of taking the full course of antibiotics. Tell parents to monitor for rash and tell the provider if they notice one.**	**normal daily dosage. Teach the family how to take radial pulse.**

Medications Reference:

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook* (18th ed.).

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation:	**Awake and alert. Oriented to self, place, times, and situation. No distress noted, but increased breathing rate**

Distress: **Overall appearance:**	**due to age** **Appearance appropriate for situation.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:** **IV Assessment (If applicable to child):** **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:**	**Skin color is appropriate for race** **Dry** **Warm** **<2 seconds return to normal** **No rashes noted** **No bruises noted** **No wounds noted** **Braden score 2** **No drains present** **No IV present, but has PICC line in left brachial put in on 3/21/20 has no signs of erythema or drainage, dressing intact and dry, fluids running at 5 mL/hr.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	**Head is normocephalic, no posterior fontanelle noted, anterior fontanelle is noted being open, soft, diamond shaped, and flat.** **Ears have patent canals, hearing intact, small, midline, and symmetrical.** **PERRLA, clear, symmetrical, no edema, discharge, redness noted.** **Nares patent, no septal deviation, small, centered.** **No teeth noted.** **No tracheal deviation, tracheostomy present.**
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 heart sounds noted** **No murmurs or gallops noted** **Peripheral pulses are even bilaterally and strong** **Cap refill is less than 3 seconds** **No neck vein distention noted** **No edema noted**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐**	**No accessory muscles in use** **Breath sounds are clear**

Breath Sounds: Location, character	
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:**	**Similac Advanced formula** **Similac Advanced formula** **55 cm** **Bowel sounds present in all four quadrants** **4/8/21** **No pain on palpation** **No masses noted** **No distention noted** **No incisions noted** **No scars noted** **No drains present** **No open wounds noted** **No ostomy present** **No nasogastric noted** **No feeding tubes noted**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Yellow color urine in diaper** **Three incontinent diapers** **Character or urine could not be determined because of diaper use** **No pain with urination** **No dialysis** **Genitals are appropriate** **No catheter noted**
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☐**	**Neurovascular status is appropriate for age** **ROM equal and appropriate** **No supportive devices** **Strength is equal** **ADL assistance plus one because of age** **Fall risk present** **Fall score 2** **Activity is appropriate for age, needs assistance because 18 weeks old** **Moves extremities independently** **No assistance with equipment** **Cannot walk or stand due to age**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐**	**MAEW is present** **PERLA is present**

PERLA: Y ☐ N☐ **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Strength is equal** **Oriented to person, place, time, and situation** **Cognitive** **No speech due to age** **No sensory deficits** **No LOC present**
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):**	**Mother has her husband in her life to help and they talk through situations.** **They do not need any assistance when they leave the hospital.** **There is an older child in the home that is excited for the baby to come home. Parent's state they are well behaved and ready to see their sister.**

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1600	**110**	**Not assessed**	**26**	**98.6**	**96%**

Vital Sign Trends: All vital signs are within normal limits during clinical.

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

Pulse Rate	**80-150**
Blood Pressure	**75-100 over 50-70**
Respiratory Rate	**25-55**
Temperature	**97.5-99.3 F**
Oxygen Saturation	**90-99%**

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

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (2nd ed.). Wolters Kluwer.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	**FLACC**	**N/A**	**0**	**N/A**	**N/A**
Evaluation of pain status *after* intervention	**FLACC**	**N/A**	**0**	**N/A**	**N/A**
Precipitating factors: Child was happy, smiling, kicking indicating no pain Physiological/behavioral signs: Crying if she was in pain					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
210 mL	**286 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. She can push down on her legs when her feet are on hard surfaces.

2. She can smile and interact by using facial expressions.
3. She can bring his hands to his mouth and begins sucking on them if he is hungry.

Age Appropriate Diversional Activities

1. She was given a toy to hold while she is getting examined by the healthcare worker to keep her occupied.
2. Talking to her while giving her a bath or examining her.
3. Having mom participate within the care to calm her down and relax her, knowing we will not hurt her.

Psychosocial Development:

Which of Erikson's stages does this child fit? Trust vs Mistrust

What behaviors would you expect? The caregiver must provide basic needs for the child, such as bathing, feeding, and changing. The child begins to get frustrated, which is shown by crying.

What did you observe? The caregiver provided for the child, and she would cry if she needed to be provided with something. She also sucked on her hands if she was getting hungry.

Cognitive Development:

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

What behaviors would you expect? The infant repeats actions like shaking a rattle to hear the noise. They are purposeful but do not always know a goal they want to achieve.

What did you observe? She grabbed onto toys and made a little movement with them. She has a mobile above her that she focused on and could see her reflection on it.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? A baby can sit up for more extended periods, start to roll from back to tummy, firmer grasp, pull objects to them, begin to pick them up in the palm of their hands, start to sleep through the night, and start to babble.

Any concerns regarding growth and development? At this time, there are no concerns with her growth and development.

Developmental Assessment Reference (1) (APA):

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (2nd ed.). Wolters Kluwer.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis	• Explain why the nursing		• How did the patient/family

with "related to" and "as evidenced by" components	diagnosis was chosen		respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for sudden infant death syndrome related to ineffective airway as evidence by seizure activity.	**This diagnosis was chosen because she is at the age that SIDS is a problem, especially seizure activity.**	**1.Sleeping in a room with her parents 2.Lie on her back with nothing in her crib.**	**The mother understood that having her lay on her back with nothing in the crib was important. She also understood the risk of SIDS in an infant but especially her little one since she has seizure activity.**
2. Ineffective airway clearance related to seizure activity as evidence by uncontrolled body movements.	**This diagnosis was chosen because she is having seizures that could impair her airway. If the seizure does not stop within an adequate amount of time, she could be depleted of oxygen to help her survive.**	**1. Monitor the time of the seizure length. 2.Ensure she is properly ventilating during the seizure.**	**The mother understood that she could lose air during a seizure and when she is having one, she monitors her the whole time. She kept track of the length of the seizure and reported findings to the emergency staff.**
3. Risk for infection related to PICC line as evidence by inadequate primary defense.	**This diagnosis was chosen because she has a new PICC line that breaks skin integrity with an open wound. The line can clot or infiltrate, which could lead to an infection.**	**1. Washing hands and sanitizing during any contact with the baby. 2. Wearing PPE whenever touching her to make sure she does not contract any infection.**	**The mother understood her risk for infection and was very thankful for the precautions we took during her care. She also knows what to monitor for around the insertion site and will report any findings if they go unnoticed by the staff.**

4. Risk for injury related to seizure activity as evidence by uncontrolled disease process.	**This was chosen because one of the risks for this disease is the inability to control body movements. This can lead to serious injury by hitting her head n hard surfaces.**	**1. Lie her on her side when she is actively seizing.** **2. Do not leave alone and if left alone not for a long period of time if she is not secured in a crib, playpen, chair, etc.**	**The mother was grateful for the information and strapped her into her chair or swing if she is in them. She does not leave her alone for an extended period and watches her when she is in the room.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

The onset of her problem began on 3/19/21 and they got admitted for treatment on 3/21/21. She is being treated with antibiotics and anticonvulsants and seems to be feeling better based on her activity. She is eating and voiding appropriately. Based on nonverbal cues she does not appear in any pain. Mom did not verbalize any concerns and did not need anything during my care.

Nursing Diagnosis/Outcomes

Risk for sudden infant death syndrome related to ineffective airway as evidence by seizure activity. The outcome would be ensuring she sleeps alone and has nothing in her crib.

Ineffective airway clearance related to seizure activity as evidence by uncontrolled body movements. The outcome would be ensuring appropriate oxygenation during the day and during sleep.

Risk for infection related to PICC line as evidence by inadequate primary defense. The outcome would be no redness and pain at insertion site.

Risk for injury related to seizure activity as evidence by uncontrolled disease process. The outcome would be no injury during the hospital stay and preventative measures at home.

Objective Data

She had an MRI and CT scan during her stay to look at her brain due to seizures. They did not show significant changes in her brain. Her vitals were normal during clinical and she did not seem like she was in pain as evidence by her smiling, kicking, and interacting during care. Her low lab values were RBC- 3.24, Hgb- 9.0, Hct- 27.0, Lymphocytes- 32.6, BUN- 3, and Creatinine- <0.15. Her high lab values were Platelets- 701 and WBC- 23.28.

Patient Information

18-week-old female admitted inpatient for acute bacterial meningitis and seizures. She has no known allergies. She was born at 39w2d by c-section and currently weighs

Nursing Interventions

1.Sleeping in a room with her parents

2.Lie on her back with nothing in her crib.

1.Washing hands and sanitizing during any contact with the baby.

2. Wearing PPE whenever touching her to make sure she does not contract infection.

1. Monitor the time of the seizure length.

2.Ensure she is properly ventilating during the seizure.

1. Lie her on her side when she is actively seizing.

2. Do not leave alone and if left alone not for a long period of time if she is not secured in a crib, playpen, chair, etc.