

N433 Care Plan #2

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date of Admission</b> 4-6-21	<b>Patient Initials</b> CW	<b>Age (in years &amp; months)</b> 2years and 4 months	<b>Gender</b> Male
<b>Code Status</b> Full code	<b>Weight (in kg)</b> 11.1 kg	<b>BMI</b> 16.17 kg/m	<b>Allergies/Sensitivities (include reactions)</b> Peanuts—an anaphylactic reaction occurs.

**Medical History (5 Points)**

**Past Medical History:** gastroschisis, short gut syndrome, thrombocytopenia, respiratory distress, retinopathy from prematurity, and oral aversion.

**Illnesses:** Short gut syndrome.

**Hospitalizations:** on 2-14-20 the patient was admitted for 78 days for failure to thrive.

**Past Surgical History:** circumcision, repair of gastroschisis as a neonate, G-tube placement, and a bowel resection.

**Immunizations:** All immunizations are up to date per CDC guidelines.

**Birth History:** The patient was born at 32 weeks gestation via cesarean section. The patient's mother was 17 years old.

**Complications (if any):** The patient was in the NICU, had non-reassuring FHT (fetal heart tones), hydramnios, and meconium.

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

**Living Situation:** The patient lives with his mother in Rantoul Illinois.

**Admission Assessment**

**Chief Complaint (2 points): Pain (gunshot wound).**

**Other Co-Existing Conditions (if any): Short gut syndrome, feeding issues (G-tube), and retinopathy from prematurity.**

**Pertinent Events during this admission/hospitalization (1 points): The patient came into the emergency department on 4-6-21 due to a gunshot wound to the right neck. The patient was admitted and is being treated.**

**History of present Illness (10 points): Onset: Tuesday, April 6th, 2021, in the evening.**

**Location: trauma to the right neck and jaw area. Duration: The pain and discomfort are constant. Characteristics: The patient is uncomfortable and irritable. The patient often uses facial grimacing and cries. Associated factors: There are no related factors/symptoms.**

**Relieving factors: Tylenol seems to help the patient feel better. Treatment: The patient has not sought any previous treatment until the date of the trauma occurrence (4-6-21).**

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points): Gunshot wound.**

**Secondary Diagnosis (if applicable): Short gut syndrome.**

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

**Trauma can include bone fractures, soft tissue injury, skeletal muscle injury, and neurovascular damage. The healing process depends on the extent or "grade" of injury (Capriotti and Frizzell, 2016). A grade I injury is when there is no tearing of the ligament and no lost joint function, but there is swelling, tenderness, and bruising (Capriotti and Frizzell, 2016). Signs and symptoms of trauma include swelling, tenderness, wounds,**

painful sensations, paresthesia's, loss of muscle strength, weak pulse, radiation of pain, a change in skin color, and bleeding (Capriotti and Frizzell, 2016). Upon a physical exam, some expected findings related to trauma include pain, tachycardia, and an elevation in blood pressure and temperature (Capriotti and Frizzell, 2016). To diagnose trauma (specifically to the neck/head region), chest radiography may be done (Alao, 2021). Chest radiography is going to look for any pneumothorax or other complications from a wound to the neck. An angiography may be done to assess for vascular injury, and an esophagography may be done to assess esophageal perforation (Alao, 2021). A CBC and CMP will also be done to check the patient's electrolyte and fluid status (Capriotti and Frizzell, 2016). Potential complications of trauma (gunshot wound) include airway obstruction and pneumothorax (Alao, 2021). Signs of a pneumothorax include chest pain, dyspnea, and an increased respiratory rate (Capriotti and Frizzell, 2016). Signs of airway obstruction include cyanosis, gasping for air, panic, difficulty breathing, agitation, and confusion (Kivi, 2019). Treatment of trauma focuses on ABCDE's (airway, breathing, circulation, deep vein thrombosis, and embolism) (Capriotti and Frizzell, 2016). In the patient's case, there has been a focus on the airway because the trauma is to his neck area. The patient was intubated to protect his airway (he is not intubated currently), and wound care is being done to his neck and jaw area on the right side. Preventing infection is also important for a gunshot wound or internal injury, and the patient is receiving cefazolin.

#### Pathophysiology References (2) (APA):

Alao, T. (2021, February 10). Neck Trauma. StatPearls [Internet].

<https://www.ncbi.nlm.nih.gov/books/NBK470422/>.

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

**Kivi, R. (2019, August 2). What Causes an Airway Obstruction, and How Is It Treated? Healthline. <https://www.healthline.com/health/airway-obstruction#symptoms>.**

**Active Orders (2 points)**

<b>Order(s)</b>	<b>Comments/Results/Completion</b>
<b>Activity: Up and independent. Advance activity as tolerated.</b>	<b>The patient is to undergo regular activity. The patient rests a lot and does not walk around much. The patient has been laying on his mother's lap.</b>
<b>Diet/Nutrition: The patient is on tube feedings and PO feedings as tolerated.</b>	<b>The patient has not been eating or drinking much PO. The patient has been receiving his normal number of G-tube feedings.</b>
<b>Frequent Assessments: Frequent weights and vitals.</b>	<b>The patient's vital signs have been within normal range.</b>
<b>Labs/Diagnostic Tests: Cardiac monitoring.</b>	<b>The patient is on continuous cardiac monitoring.</b>
<b>Treatments: Cefazolin and wound care.</b>	<b>The patient is receiving cefazolin antibiotic and wound care to his neck/face.</b>
<b>Other: NA.</b>	
<b>New Order(s) for Clinical Day</b>	
<b>Order(s)</b>	<b>Comments/Results/Completion</b>
<b>No new orders.</b>	


**Laboratory Data (15 points)**

**CBC Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format. **\*Normal ranges per epic system at carle\***

<b>Lab</b>	<b>Normal Range (specific to the age of the child)</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal Value</b>
<b>RBC</b>	<b>3.89-4.97</b>	<b>4.82</b>	<b>NA</b>	
<b>Hgb</b>	<b>10.2-12.7</b>	<b>12.7</b>	<b>NA</b>	
<b>Hct</b>	<b>31.0-37.7%</b>	<b>37.3%</b>	<b>NA</b>	
<b>Platelets</b>	<b>202-403</b>	<b>288</b>	<b>NA</b>	
<b>WBC</b>	<b>5.14-13.38</b>	<b>10.12</b>	<b>NA</b>	
<b>Neutrophils</b>	<b>1.60-8.29</b>	<b>4.47</b>	<b>NA</b>	
<b>Lymphocytes</b>	<b>1.13-5.52</b>	<b>4.26</b>	<b>NA</b>	
<b>Monocytes</b>	<b>0.19-0.98</b>	<b>0.98</b>	<b>NA</b>	
<b>Eosinophils</b>	<b>0.03-0.53</b>	<b>0.26</b>	<b>NA</b>	
<b>Basophils</b>	<b>0.01-0.06</b>	<b>0.05</b>	<b>NA</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.

Lab	Normal Range	Admission or Prior Value	Today's Value	Reason For Abnormal
Na-	136-145	135	139	The patient's sodium level was off upon admission and this could have been caused from trauma (Capriotti and Frizzell, 2016).
K+	3.5-5.1	4.0	4.1	
Cl-	98-107	105	111	The patient's chloride level could be high from dehydration or fluid shifts (Capriotti and Frizzell, 2016).
Glucose	60-99	92	98	
BUN	7-18	11	9	
Creatinine	0.70-1.30	0.44	0.28	The patient's creatinine could be low from trauma. The patient experienced a trauma and that can cause a shift in kidney function (Capriotti and Frizzell, 2016).
Albumin	3.4-5.0	3.9	2.8	Albumin can be low from malnutrition or shock (Capriotti and Frizzell, 2016).
Total Protein	6.4-8.2	6.8	5.0	Total protein can be low from dehydration or malnutrition (Capriotti and Frizzell, 2016).
Calcium	8.5-10.1	9.4	8.5	
Bilirubin	0.2-1.0	0.4	0.4	
Alk Phos	54-369	222	148	
AST	15-37	39	33	The patients AST could have been off due to trauma and fluid shifts (Capriotti and Frizzell, 2016).
ALT	12-78	29	22	

<b>Amylase</b>	<b>23-85 u/L</b>	<b>NA</b>	<b>NA</b>	
<b>Lipase</b>	<b>12-70 u/L</b>	<b>NA</b>	<b>NA</b>	
<b>PT</b>	<b>12.1-14.9 seconds</b>	<b>14.1</b>	<b>NA</b>	
<b>INR</b>	<b>0.9-1.1</b>	<b>1.1</b>	<b>NA</b>	
<b>Alcohol serum</b>	<b>None detected</b>	<b>None detected</b>	<b>NA</b>	

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>ESR</b>	<b>1-20 mm/hr</b>	<b>NA</b>	<b>NA</b>	
<b>CRP</b>	<b>0.00-0.29</b>	<b>NA</b>	<b>NA</b>	
<b>Hgb A1c</b>	<b>4% and 5.6%</b>	<b>NA</b>	<b>NA</b>	
<b>TSH</b>	<b>0.4 and 4.0 milliunits per liter</b>	<b>NA</b>	<b>NA</b>	

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Color &amp; Clarity</b>	<b>Clear &amp; yellow.</b>	<b>Clear &amp; yellow</b>	<b>NA</b>	
<b>pH</b>	<b>4.2-8.0</b>	<b>6.0</b>	<b>NA</b>	
<b>Specific Gravity</b>	<b>1.005-1.030</b>	<b>1.039</b>	<b>NA</b>	<b>An elevated specific gravity can indicate the patient is not getting enough fluids (Capriotti and Frizzell, 2016).</b>

Glucose	Negative	Negative	NA	
Protein	Negative	Negative	NA	
Ketones	Negative	20	NA	Ketones in the urine can indicate that the patient is not getting enough fluids (Capriotti and Frizzell, 2016).
WBC	0-25	0	NA	
RBC	0-20	1	NA	
Leukoesterase	Negative	Negative	NA	

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-no growth	NA	NA	
Blood Culture	No growth-negative	NA	NA	
Sputum Culture	No growth-negative	Staph Aureus	NA	The patient has a common cold.
Stool Culture	Negative	NA	NA	
Respiratory ID Panel	Not detected	Rhino/Enterovirus is positive.	NA	The patient has a common cold.

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): The patient had a chest X-ray and a CT of the brain.

**Diagnostic Test Correlation (5 points):** The chest X-ray indicated a normal heart size, normally expanded lungs, and no signs of a pneumothorax. The CT of the brain indicated no fracture or intracranial hemorrhage.

**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>	Cefazolin / Ancef	Ondansetro n / Zofran	Senokot / Senna-lax	Acetaminophen/ Tylenol	Albuterol Sulfate / AccuNeb
<b>Dose</b>	280 mg	1.2 mg	88mg (2.5ml)	166.4 mg	2.5 mg
<b>Frequency</b>	Every 8 hours (3X daily)	PRN 1X daily	1X daily	Every 4 hours PRN	Every 4 hours PRN
<b>Route</b>	IV piggyback	IV	G-tube	orally	Oral nebulizer
<b>Classificatio n</b>	antibiotic	Antiemetic	Laxative	Antipyretic, nonopioid analgesic	Bronchodil ator
<b>Mechanism of Action</b>	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross linking of peptidoglyc an strands.	Block’s serotonin receptors centrally in the chemorecep tor trigger zone and peripherall y at vagal nerve terminals in the intestine.	Senna-Lax stimulates the intestines, which creates a bowel movement.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Albuterol attaches to beta2 receptors on bronchial cell membrane, which stimulates the intracellula r enzyme adenylate cyclase to convert adenosine

					triphosphate (ATP) to cyclic adenosine monophosphate (camp).
<b>Reason Client Taking</b>	The patient is taking to prevent a bacterial infection.	The patient is taking to prevent nausea.	The patient is taking to reduce constipation.	The patient is taking to relieve mild to moderate pain.	The patient is taking to open his airway. He is congested.
<b>Concentration Available</b>	1 gram	2mg/ml	176 mg/5ml	160mg/5ml	2.5mg/3ml
<b>Safe Dose Range Calculation</b>	25-30 mg/kg daily divided equally and given three or four times daily for severe infections.	0.1 mg/kg X11.1 kg	2.5-3.75 ml daily for ages 2-6.	15mg/kg X 11.1 kg	Age under 5 every 4 hours.
<b>Maximum 24-hour Dose</b>	1,000 mg	1X daily	3.75ml	5 doses / 24 hr.	6 nebulizer treatments in 24 hours.
<b>Contraindications (2)</b>	Hypersensitivity to cefazolin, other cephalosporin's, or their components.	Congenital long QT syndrome, hypersensitivity to ondansetron or its components.	Hypersensitivity to senokot or its components, GI, or rectal bleeding.	Hypersensitivity to acetaminophen or its components, severe hepatic impairment.	Hypersensitivity to albuterol or its component.
<b>Side Effects/ Adverse Reactions (2)</b>	Seizures, anaphylaxis.	Hypotension, intestinal obstruction.	Abdominal pain, diarrhea.	Hypotension, Hepatotoxicity.	Bronchospasm, angina.
<b>Nursing Considerations (3)</b>	Use cefazolin cautiously in patients with impaired	Place disintegrating tablet or oral soluble film on patients	Long term use of laxatives can cause dependence and cause	Use acetaminophen cautiously in patients who have hepatic impairment,	Monitor serum potassium level because albuterol

	renal function or a history of GI disease, obtain culture and sensitivity test results, if possible and as ordered before giving the drug, monitor BUN and serum creatinine for early signs of nephrotoxicity.	tongue immediately after opening the package, use calibrated container or oral syringe to measure dose of oral solution, dilute drug in 50 ml of D5W or normal saline solution when indicated.	the bowels to not function properly, do not give laxative if the patient is experiencing diarrhea, long term use can cause changes in electrolytes, kidney function, or heart function.	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.	may cause transient hypokalemia, be aware that drug tolerance can develop with prolonged use, administer pressurized inhalations of albuterol during second half of inspiration, when airway is open wider and aerosol distribution is more effective.
<b>Client Teaching needs (2)</b>	Instruct patient to complete the prescribed course of therapy, tell patient (or patient's parents) to report watery, bloody stools to prescriber immediately, even up to 2 months after therapy has	Advise patient to use calibrated container or oral syringe to measure oral solution, advise patient to immediately report signs of hypersensitivity, such as rash.	Instruct the patient to report diarrhea, Instruct the patient to report any adverse effects like abdominal pain.	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.	Teach the patient how to use the nebulizer. Advise the patient to wait at least 1 minute between inhalations if dosage requires more than one inhalation.

	ended.				
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**References:**

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>The patient is alert &amp; oriented times 4.</b>  <b>The patient opens his eyes when he is being talked to. The patient’s voice is hoarse because he was intubated.</b>  <b>The patient does not seem to be in any distress.</b>  <b>The patient looks tired overall. The patient is clean and well groomed.</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>  <b>Signs of erythema, drainage, etc.:</b>  <b>IV dressing assessment:</b>  <b>IV Fluid Rate or Saline Lock:</b></p>	<p><b>The patient’s skin is dry and intact.</b>  <b>The patient’s skin is dark brown (African American).</b>  <b>Skin is warm.</b>  <b>Normal turgor: 2+</b>  <b>No rashes.</b>  <b>The patient has a wound on the right side of his neck and jaw. The wound is intact, swollen, edematous, and ecchymotic.</b>  <b>Braden score: 7.</b>  <b>No drains present.</b></p> <p><b>Proximal peripheral anterior left lower IV.</b>  <b>22gauge</b>  <b>Date on IV: 4-6-21</b>  <b>IV is patent, no signs of erythema or drainage.</b>  <b>Dressing is intact.</b>  <b>IV fluids 0.9% sodium chloride at 125ml/dr.</b></p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b></p>	<p><b>The patients head is symmetrical (midline with no deviations).</b>  <b>The patient has dark black hair with no patches or balding.</b></p>

<p><b>Nose:</b>  <b>Teeth:</b>  <b>Thyroid:</b></p>	<p>Ears are clear and pink with no drainage.  Tympanic membrane is visible, pearly grey.  <b>PEERLA is present.</b>  No nasal deviation (turbinate's equal bilaterally). The patient has a runny nose.  Oral mucosa is pink and moist (no abnormalities).  The patient's right jaw and neck is swollen and tender.  Teeth present and in good condition.  Thyroid within normal limits.</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  S1, S2, S3, S4, murmur etc.  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <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.  No neck vein distension.</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>The patient's breath sounds are coarse in all fields.  100% oxygen on room air.  The patient is congested.  No use of accessory muscles.</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:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>      <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>      <b>Type: G-tube</b></p>	<p>The patient is on a regular diet with G-tube feedings at home and here in the hospital.  <b>Height: 83cm</b>  Bowel sounds audible and normoactive in all four quadrants.  Last BM: 4-9-21 at 08:00am  No distension, incisions, drains, or wounds.  No pain or tenderness upon palpation.  The patient has a G-tube.</p>
<p><b>GENITOURINARY (2 Points):</b></p>	<p>Clear, yellow urine.</p>

<p><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>The patient is voiding regularly. The patient's diapers are being weighed.                  No pain with urination.                  Genitals are clean and intact.</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>Active ROM bilaterally.                  The patient can walk independently but has been resting/laying on mom's lap.                  The patient does not use any supportive devices.                  The patient has moderate strength bilaterally.                  Fall score: 2</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 checked="" type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b></p>	<p>The patients grip strength is moderate and equal bilaterally in upper and lower extremities. The patient is oriented.                  Mental status is normal for age.                  Speech is clear and normal (slightly hoarse).                  No LOC.</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>The patient's religion was not mentioned/discussed with the mother. The patient lives at home with his mother and grandmother. Mother and father have been at the patient's bedside. Coping methods of caregivers was not discussed.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:00 am	120	116/83	43	98.1 Axillary	100% RA

<b>16:00pm</b>	<b>124</b>	<b>118/86</b>	<b>34</b>	<b>98.2 Axillary</b>	<b>100% RA</b>

**Vital Sign Trends: The patient’s vital signs have been consistent. At 16:00 the patient was calm and laying on his mother’s lap.**

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

<b>Pulse Rate</b>	<b>70-120</b>
<b>Blood Pressure</b>	<b>105/60</b>
<b>Respiratory Rate</b>	<b>20-30</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):**

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

**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>13:37</b>	<b>faces</b>	<b>Right neck and jaw</b>	<b>4- hurts a little</b>	<b>discomfort</b>	<b>Tylenol.</b>
<b>Evaluation of pain status <i>after</i> intervention</b>	<b>faces</b>	<b>Right neck and jaw</b>	<b>1- hurts on occasion</b>	<b>discomfort</b>	<b>NA</b>
<b>Precipitating factors: The patient is in continuous discomfort/pain. Physiological/behavioral signs: The patient grimaces and frowns. The patient also cries often.</b>					

**Intake and Output (1 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
<b>PO 290 ml</b>	<b>Urine 1000 ml</b>
<b>IV 1400 ml</b>	
<b>G-tube 388 ml</b>	
<b>Total: 2,078</b>	

**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. Learns through observing and imitating (Ricci et al., 2021).**
- 2. Has a short attention span and active imagination (Ricci et al., 2021).**
- 3. Can climb onto and down from furniture without assistance (Ricci et al., 2021).**

**Age-Appropriate Diversional Activities**

- 1. Movies/Tv shows.**
- 2. Playing with toys.**
- 3. Playing outdoors with things like kick balls.**

**Psychosocial Development:**

**Which of Erikson's stages does this child fit? This child (2 years old) fits the autonomy vs. shame and doubt stage (Ricci et al., 2021).**

**What behaviors would you expect? In a patient who is in autonomy vs. shame and doubt you would expect a patient who achieves autonomy and self-control, separates from**

parent, imitates adults and playmates, shows affection, and withstands delayed gratification (Ricci et al., 2021).

What did you observe? The patient wanted to put the blood pressure cuff on his leg by himself and was cuddling his mother.

**Cognitive Development:**

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

What behaviors would you expect? In this stage you can expect the toddler to have a short attention span. The toddler will also learn through imitating and observing. The toddler has an active imagination during this stage (Ricci et al., 2021).

What did you observe? The patient was watching a movie and then started playing with his toys.

**Vocalization/Vocabulary:**

Development expected for child's age and any concerns? At this patient's age (2 years old) they are beginning to talk. This patient talks to his mother a little bit. The patient's voice is hoarse, so he has not said much. 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 ineffective airway related to injury as evidence by being intubated.</b></p>	<p><b>The patient was intubated because of the injury to his neck/face region.</b></p>	<p><b>1.Frequently assess the airway and breathing pattern.</b></p> <p><b>2.Frequently assess oxygen saturation.</b></p>	<p><b>Goals: Maintain the patients airway.</b></p> <p><b>Outcomes: The patient was willing to be assessed. The patient’s mother was willing to let frequent assessments happen.</b></p>
<p><b>2. Risk for fluid volume deficit related to short gut syndrome as evidence by G-tube feedings.</b></p>	<p><b>The patient is small for his age and receives most of his feedings through a G-tube.</b></p>	<p><b>1. Encourage the patient to eat/drink outside of his G-tube feedings.</b></p> <p><b>2.Weigh the patient frequently.</b></p>	<p><b>Goals: maintain the patient’s weight and increase oral intake.</b></p> <p><b>Outcomes: The patient’s mother was feeding the patient food from home and apple juice. The patient seemed to</b></p>

			<b>tolerate the extra intake.</b>
<b>3. Risk for trauma related to violence as evidence by the patient's gunshot wound.</b>	<b>The patient got involved in a drive by shooting.</b>	<b>1. Instruct the caregiver to recognize harmful situations and how to avoid them.</b>  <b>2. Refer a social worker to get involved to help manage the needs of the child.</b>	<b>Goals: Protect the patient from future injury and minimize risks of trauma.</b> <b>Outcomes: There is a social worker involved and the mother is planning strategies to ensure the patients safety.</b>
<b>4. Imbalanced nutrition related to small gut syndrome as evidence by malnutrition.</b>	<b>The patient is small for his age.</b>	<b>1. Assess for signs and symptoms of malnutrition (pale and dry skin, red and swollen tongue).</b>  <b>2. Encourage small, frequent feeds high in carbs and protein.</b>	<b>Goals: maintain nutrition.</b> <b>Outcomes: The patient was frequently assessed for malnutrition. The patient's mother was trying to get him to eat/drink extra meals.</b>

**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 his neck on the right side as well as his chin. The patient cries often and uses facial grimacing. The patient does not talk much because his voice is hoarse, but he expresses pain with facial grimacing and crying.

**Nursing Diagnosis/Outcomes**

1. Risk for ineffective airway related to injury as evidence by being intubated. Outcomes: The patient was willing to be assessed. The patient's mother was willing to let frequent assessments happen.
2. Risk for fluid volume deficit related to short gut syndrome as evidence by G-tube feedings. Outcomes: The patient's mother was feeding the patient food from home and apple juice. The patient seemed to tolerate the extra intake.
3. Risk for trauma related to violence as evidence by the patient's gunshot wound. Outcomes: There is a social worker involved and the mother is planning strategies to ensure the patients safety.
4. Imbalanced nutrition related to small gut syndrome as evidence by malnutrition. Outcomes: The patient was frequently assessed for malnutrition. The patient's mother was trying to get him to eat/drink extra meals.

**Objective Data**

The patient is laying with his mother and seems tired.

Vital signs:

Pulse: 120

BP: 116/83

RR:43

Temp: 98.1

Oxygen: 100% on RA.

Height: 83cm

Weight: 11.1kg

**Patient Information**

This patient is a 2-year-old male admitted to the unit on 4-6-21 for a gunshot wound to the right neck. The patient was intubated because of risk of losing the airway and is now improving. He does show signs of pain (facial grimacing and crying).

**Nursing Interventions**

1. Frequently assess the airway and breathing pattern. Frequently assess oxygen saturation.
2. Encourage the patient to eat/drink outside of his G-tube feedings. Weigh the patient frequently.
3. Instruct the caregiver to recognize harmful situations and how to avoid them. Refer a social worker to get involved to help manage the needs of the child.
4. Assess for signs and symptoms of malnutrition (pale and dry skin, red and swollen tongue).Encourage small, frequent feeds high in carbs and protein.