

N433 Care Plan #2

Lakeview College of Nursing

Cidney Hinchman

Demographics (3 points)

Date of Admission 04/08/2021	Patient Initials N.C.	Age (in years & months) 10 years and 7 months old 127 months old	Gender Female
Code Status Full	Weight (in kg) 43kg	BMI 18.73 kg/m ²	Allergies/Sensitivities (include reactions) NKA

Medical History (5 Points)

Past Medical History: This patient has no significant past medical history.

Illnesses: This patient has no significant past illnesses.

Hospitalizations: This patient has no past history of being hospitalized.

Past Surgical History: This patient has no significant past surgical history.

Immunizations: This patient is up to date on all immunizations per the CDC guidelines.

Birth History: This patient was born on 09/02/2010 through a vaginal delivery in Champaign, Illinois.

Complications (if any): This patient had no complications at the time of birth.

Assistive Devices: This patient does not use any assistive devices.

Living Situation: The patient lives at home with both mom and dad.

Admission Assessment

Chief Complaint (2 points): Right hip and side pain

Other Co-Existing Conditions (if any): This patient does not have any other co-existing conditions.

Pertinent Events during this admission/hospitalization (1 points): This patient woke up on the morning of April 8th with a complaint of pain in her right hip. The patient's pain was so severe that it affected her mobility. The mother brought her into the emergency department, where they ran multiple diagnostic tests. The patient was going to be transferred to OSF's children's hospital in Peoria, Illinois, pending the patient's diagnostic tests. The patient had an MRI of the right hip without contrast, a CT of the abdomen and pelvis with contrast, a pelvic ultrasound, an ultrasound of the abdomen and appendix, and an x-ray of the hip bilaterally with the pelvis included, and they all came back with no abnormal findings. Therefore, the patient was not transferred and was instead admitted to the pediatric floor for further observation.

History of present Illness (10 points): Onset: On April 8th, a 10-year-old child came into the emergency department at Carle Foundation Hospital with a chief complaint of right hip and side pain that awoke the patient from sleep. **Location:** The patient stated, "my right hip and side are in pain." **Duration:** The mother stated, "it only started a few hours ago when the pain woke her up out of sleep." **Characteristics:** The patient described the pain in her right hip as uncomfortable and sharp. **Associated Manifestations:** The patient stated, "my hip hurts worse when I move or try to walk." **Relieving factors:** The patient expressed that it helped when she laid down and did not move. **Treatment:** The patient has not reported any previous treatments for the right hip and side pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Right hip and side pain

Secondary Diagnosis (if applicable): Septic arthritis - The primary physician initially thought that this could have been the cause of the pain, but it was later ruled out.

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

Septic arthritis is a painful infection that occurs when an infection spreads through the bloodstream to a joint (Mayo Clinic, 2021). Septic arthritis can be caused by bacterial, viral, or fungal infections, with bacterial *Staphylococcus aureus* being the most common (Johns Hopkins Medicine, n.d.) Septic arthritis can also occur due to a puncture wound, drug injection, or surgery in or near a joint, although it is uncommon (Mayo Clinic, 2021). The lining of joints has a very small capability to protect itself from infection-causing them to become more susceptible to infections (Johns Hopkins Medicine, n.d.)

Septic arthritis causes the uttermost discomfort making it difficult to use the affected joint (Mayo Clinic, 2021). Septic arthritis usually only affects one joint, with the most common being the knee, hip, shoulder, elbow, wrist, and finger (Johns Hopkins Medicine, n.d.) Signs and symptoms of septic arthritis vary by person, but the most common signs and symptoms seen in patients are joint pain, joint swelling, and a fever (Johns Hopkins Medicine, n.d.). My patient came into the emergency department with complaints of right hip and side pain that was so severe it woke her up out of sleep. My patient also explained how it affected and decreased her mobility because walking increased the pain.

Septic arthritis risk factors include existing joint problems, having an artificial joint, taking medications for rheumatoid arthritis, skin fragility, a weakened immune system, and joint trauma (Mayo Clinic, 2021). Septic arthritis needs to be treated as soon as possible because a delay in treatment can lead to complications (Mayo Clinic, 2021). Some complications of septic arthritis include joint degeneration and permanent damage. If you have an artificial joint affected by septic arthritis, it may also cause joint loosening or dislocation (Mayo Clinic, 2021).

Septic arthritis can be diagnosed by the use of multiple tests such as joint fluid analysis, blood tests, or imaging tests (Mayo Clinic, 2021). The joint fluid analysis can be used to determine what organism is causing the infection (Mayo Clinic, 2021). The joint fluid analysis will also show an altered color, consistency, volume, and makeup of the fluid within the joints if an infection is present (Mayo Clinic, 2021). The blood test can determine any signs of infection within the bloodstream (Mayo Clinic, 2021). Lastly, the imaging tests such as an x-ray can assess and determine the extent of the damage within the joint or loosening of an artificial joint (Mayo Clinic, 2021). As for my patient, she had an MRI of the right hip without contrast, a CT of the abdomen and pelvis with contrast, a pelvic ultrasound, an ultrasound of the appendix, and an x-ray of the hip bilaterally with the pelvis included. The patient was then going to be transferred to OSF children's hospital in Peoria, Illinois, pending the results of the diagnostic tests. The patient's diagnostic tests all came back with no abnormal findings. The patient did have some elevated laboratory tests such as the c-reactive protein and ESR, indicating that the patient most likely did have some sort of acute infection or inflammation. Although the patient had some elevated laboratory tests, the diagnostic tests showed no abnormal findings, so the patient was not transferred and was instead admitted to the pediatric unit at Carle for further observation.

Treatment of septic arthritis involves drainage of the joint and antibiotic therapy (Mayo Clinic, 2021). Joint drainage involves the removal of the infected joint fluid by a needle, scope procedure, or open surgery (Mayo Clinic, 2021). Antibiotic medications will first be given through intravenous therapy but may be switched to oral antibiotics towards the end of treatment (Mayo Clinic, 2021). Antibiotic treatments will usually last two to six weeks and depend on the organism and extent of the infection (Mayo Clinic, 2021). Treatment may also involve the replacement or removal of a joint if an artificial joint is infected (Mayo Clinic, 2021). As for my

patient, she was given acetaminophen for mild pain and ketorolac for severe pain. The patient was on 0.9% NaCl continuously for fluid and electrolyte replenishment. The patient was also receiving ceftriaxone once a day intravenously. Ceftriaxone is an antibiotic given for a wide variety of bacterial infections. Although it was not proven that the patient had a bacterial infection, the physician most likely ordered it as a precaution while waiting for the tests to come back since he thought the patient had septic arthritis. The physician also probably knew that if the patient did have septic arthritis, the sooner, you treat it, the better. Therefore, the antibiotic was ordered and given, but septic arthritis was later ruled out, and the ceftriaxone was discontinued.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Human Pathophysiology*. F.A. Davis Company.

Johns Hopkins Medicine. (n.d.). *Septic arthritis*.

<https://www.hopkinsmedicine.org/health/conditions-and-diseases/arthritis/septic-arthritis>

Mayo Clinic. (2021, February 5). *Septic arthritis – symptoms and causes*.

<https://www.mayoclinic.org/diseases-conditions/bone-and-joint-infections/symptoms-causes/syc-20350755#:~:text=Septic%20arthritis%20is%20a%20painful,germs%20directly%20into%20the%20joint.>

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	The patient has no restrictions on activity. According to the patient, since they have

	arrived at the hospital, all the patient has done is color, sleep, and watch cartoons on the television.
Diet/Nutrition:	The patient is on a regular diet with no restrictions. The patient does have an intravenous line of 0.9% NaCl continuously running to help keep the patient's fluid and electrolyte balance up.
Frequent Assessments:	The patient has vital signs assessed every eight hours. The patient also has frequent pain assessments.
Labs/Diagnostic Tests:	The patient had an MRI of the right hip without contrast, a CT of the abdomen and pelvis with contrast, a pelvic ultrasound, an ultrasound of the appendix, and an x-ray of the hip bilaterally with the pelvis included, and they all came back with no abnormal findings. The patient also had a c-reactive protein, an ESR, a CBC, a CMP, a urine culture, a COVID-19 screening, and a blood culture done.
Treatments:	The patient was receiving 0.9% NaCl intravenously to help keep the patient's fluid

	and electrolyte balance up. The patient was also receiving acetaminophen for mild pain or ketorolac for severe pain.
Other:	Not applicable.
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
MRI of the right hip without contrast	The right hip was shown to be at baseline with no effusion present. There was no visible joint tissue damage near the right hip. The patient did not show any evidence of fractures, stress reaction, or avascular necrosis. The patient's growth plates remained open. Overall, there were no abnormal findings to support the indicated diagnosis of septic arthritis.
CT of the abdomen and pelvis	The patient's appendix appeared baseline. The chest base appeared baseline with no pulmonary infiltrate and no pleural effusion. The heart appeared baseline in size. The evaluation of the liver, gallbladder, pancreas, spleen, pelvis, and urinary bladder all appeared baseline with no abnormal findings present. However, the adrenal glands did

	show bilateral pelvocaliectasis, indicating a potentially infectious infection.
Pelvic ultrasound	The right and left ovary measured at baseline and showed no abnormal findings. Arterial and venous waveforms were identified in the ovaries. Bilateral kidneys appeared at baseline with no abnormal findings. Overall, the pelvic ultrasound showed no abnormal findings to support a diagnosis.
Ultrasound of the appendix	The appendix appeared within baseline limits and showed no fecalith, ascites, or abscess. Overall, the findings were baseline with nothing abnormal to support a diagnosis.
X-ray of the hip bilaterally, including the pelvis	There was no marked asymmetry of the soft tissue. There was no evidence of slipped capital femoral epiphysis or of avascular necrosis. Overall, the findings were baseline with nothing abnormal to support a diagnosis.

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	Admission or Prior Value	Today's Value	Reason for Abnormal Value
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	the age of the child)			
RBC	3.90 – 4.96	4.73	N/A	N/A
Hgb	10.6 – 13.2	13.8	N/A	The patient’s hemoglobin is likely elevated due to dehydration (Capriotti & Frizzell, 2016).
Hct	32.4 – 39.5	41.3	N/A	The patient’s hematocrit is likely elevated due to dehydration (Capriotti & Frizzell, 2016).
Platelets	199 – 367	288	N/A	N/A
WBC	4.27 – 11.40	10.50	N/A	N/A
Neutrophils	1.64 – 7.87	7.96	N/A	The patient likely has an increased neutrophil count due to a bacterial infection or inflammation somewhere within the body (Capriotti & Frizzell, 2016).
Lymphocytes	1.16 – 4.28	1.56	N/A	N/A
Monocytes	0.19 – 0.81	0.90	N/A	When monocytes are elevated, it indicates that the body is fighting off something (Capriotti & Frizzell, 2016). The patient likely has an elevated monocyte level in response to chronic infection or an autoimmune disorder (Capriotti & Frizzell, 2016).
Eosinophils	0.03 – 0.47	0.04	N/A	N/A
Basophils	0.01 – 0.05	0.02	N/A	N/A
Bands	N/A	N/A	N/A	N/A

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

Lab	Normal Range	Admission or Prior Value	Today’s Value	Reason for Abnormal
Na-	136 – 145	137	N/A	N/A
K+	3.5 – 5.1	3.6	N/A	N/A

Cl-	98 – 107	104	N/A	N/A
Glucose	60 – 99	110	N/A	This patient likely has an increased glucose level due to the increased stress on the body caused by the patient’s illness (Capriotti & Frizzell, 2016).
BUN	7 – 18	8	N/A	N/A
Creatinine	0.55 – 1.02	0.55	N/A	N/A
Albumin	3.4 – 5.0	3.6	N/A	N/A
Total Protein	6.4 – 8.2	7.9	N/A	N/A
Calcium	8.5 – 10.1	9.5	N/A	N/A
Bilirubin	0.2 – 1.0	0.4	N/A	N/A
Alk Phos	54 – 369	396	N/A	This patient likely has an increased alkaline phosphorus level due to irritation or inflammation within the body (Capriotti & Frizzell, 2016). This patient could also have an increased alkaline phosphorus level due to an autoimmune disease that has yet to be diagnosed in the patient (Capriotti & Frizzell, 2016).
AST	15 – 37	15	N/A	N/A
ALT	12 – 78	22	N/A	N/A
Amylase	23 - 85	N/A	N/A	N/A
Lipase	0 - 160	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today’s Value	Reason for Abnormal
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ESR	3 – 13	39	N/A	The patient likely has an increased ESR level due to inflammation or an autoimmune disorder that has yet to be diagnosed in the patient (Capriotti & Frizzell, 2016).
CRP	0.00 – 0.29	1.27	N/A	These values are consistent with the patient having inflammation or an infection somewhere within the body (Capriotti & Frizzell, 2016).
Hgb A1c	Less than 5.6	N/A	N/A	N/A
TSH	0.55 – 5.31	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	Colorless, yellow, no odor present	N/A	Colorless, yellow, no odor present	N/A
pH	5.0 – 7.0	N/A	5.6	N/A
Specific Gravity	1.003 – 1.035	N/A	1.004	N/A
Glucose	Negative	N/A	Negative	N/A
Protein	Negative	N/A	Negative	N/A
Ketones	Negative	N/A	Negative	N/A
WBC	0 – 25	N/A	53	These values are indicative of inflammation in the urinary tract or kidneys (Capriotti & Frizzell, 2016).
RBC	0 – 20	N/A	0	N/A
Leukoesterase	Negative	N/A	Small trace	These values are indicative of inflammation within the urinary tract or that a urinary tract infection is present (Capriotti & Frizzell, 2016).

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	No growth	N/A	The culture was still in progress.	The culture was still in progress.
Blood Culture	N/A	N/A	N/A	N/A
Sputum Culture	N/A	N/A	N/A	N/A
Stool Culture	N/A	N/A	N/A	N/A
Respiratory ID Panel	COVID-19 not detected	N/A	COVID-19 was not detected.	The results were negative for the presence of the coronavirus disease.

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Human Pathophysiology*. F.A. Davis Company.

Normal laboratory ranges were per Carle's epic system.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Not applicable.

Diagnostic Test Correlation (5 points): Not applicable

Diagnostic Test Reference (1) (APA):

Acr, R. A. (2018, February 14). *Ultrasound - pelvis*. Radiologyinfo.Org.

<https://www.radiologyinfo.org/en/info/pelvus>

Acr, R. A. (2019, January 23). *Computed tomography (CT) – abdomen and pelvis*.

Radiologyinfo.Org. <https://www.radiologyinfo.org/en/info/abdominct>

Mayo Clinic. (2021b, March 30). *Abdominal ultrasound*. <https://www.mayoclinic.org/tests-procedures/abdominal-ultrasound/about/pac-20392738>

Current Medications (8 points)

****Complete ALL of your patient's medications****

Brand/Generic	Acetaminophen (Tylenol)	D5 0.9% NaCl	Ketorolac tromethamine (Toradol)	Ceftriaxone sodium (Rocephin)
Dose	662.4 mg	83mL/hr	22.2mg	2g
Frequency	q.6.h. PRN	Continuous	q.6.h. PRN	q.d.
Route	Oral suspension	Intravenous	IV push	Intravenous
Classification	Nonsalicylate, para-aminophenol derivative, antipyretic, nonopioid analgesic	Sterile, nonpyrogenic solution	Analgesic	Antibiotic
Mechanism of Action	It inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on the temperature-regulating center in the hypothalamus by	This medication is an intravenous solution used to supply water, calories, and electrolytes to the body. It is also used as a mixing solution for other intravenous medications.	Block's cyclooxygenase, an enzyme needed to synthesize prostaglandins. Prostaglandins mediate inflammatory response and cause local vasodilation, pain, and swelling. They also promote pain transmission from the periphery to the spinal cord. By blocking cyclooxygenase and inhibiting	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands. Peptidoglycan makes the cell membrane rigid and protective. Without it, bacterial cells rupture and die.

	inhibiting the synthesis of prostaglandin E2.		prostaglandins, this NSAID reduces inflammation and leaves pain.	
Reason Client Taking	This medication is being given to the patient to treat mild pain.	This medication is being given to the patient for fluid and electrolyte replenishment.	This medication is being given to the patient to treat severe pain.	This medication is being given for a suspected bacterial infection.
Concentration Available	160mg/5mL	1000mL	30mg/mL	50mg/kg
Safe Dose Range Calculation	662.4mg q.6.h.	As directed by a physician.	22.2mg q.6.h.	2 grams once daily
Maximum 24-hour Dose	2649.6 mg	1992mL	88.8mg	2 grams
Contraindications (2)	Severe hepatic impairment, severe active liver disease	Edema with sodium retention, renal insufficiency	GI perforation; peptic ulcer disease	Calcium containing IV solutions, hyperbilirubinemia
Side Effects/Adverse Reactions (2)	Hypotension, hepatotoxicity	Febrile response, infection at the site of injection	Leukopenia, respiratory depression	Seizures, neutropenia
Nursing Considerations (3)	<p>1. Use acetaminophen cautiously in clients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment.</p> <p>2. Acetaminophen can cause hepatotoxicity, so liver function tests need to be ordered and monitored.</p>	<p>1. Monitor changes in fluid balance, electrolyte concentrations, and acid-base balance. Monitor the site of injection for infection.</p> <p>3. Monitor the patient/s vital signs and assess for pain before and after medication administration.</p>	<p>1. Give the intravenous injection over no less than fifteen seconds.</p> <p>2. Notify the provider if the patient's pain relief is inadequate or if breakthrough pain occurs between doses because supplemental doses of an opioid analgesic may be required.</p> <p>3. Monitor the patient's blood pressure closely throughout</p>	<p>1. Never give ceftriaxone by I.V. infusion at the same time as calcium-containing I.V. solutions.</p> <p>2. Monitor BUN and creatinine levels to detect early signs of nephrotoxicity. Also, monitor fluid intake and output.</p> <p>3. assess for signs of superinfection, such as cough or sputum changes, diarrhea, drainage, fever, malaise, pain, perineal itching, rash,</p>

	3. Make sure the dose is based on the patient’s weight in kilograms, and you do not confuse a dose in milligrams with a dose in millimeters.		treatment.	redness, and swelling.
Client Teaching needs (2)	1. Caution parent to not exceed the recommended dosage or give the child other drugs containing acetaminophen at the same time because of the risk of liver damage. 2. Teach the parent to recognize signs of hepatotoxicity in the child, such as bleeding, easy bruising, and malaise.	1. Educate the parent that the child will most likely have increased urine output. 2. Educate the parent to seek immediate medical attention if the child starts complaining of injection pain or if it looks like it’s reddened or beginning to swell.	1. Instruct the patient and the patient’s parents to immediately report blood in urine, easy bruising, itching, rash, swelling, or yellow eyes or skin. 2. Teach the patient and the patient’s parents about the importance of oral hygiene and encourage the patient to use a soft-bristled toothbrush while taking ketorolac.	1. Instruct the patient and the patient’s parents to report evidence of any superinfection or blood stools immediately. 2. Teach the patient and the patient’s parents to watch for signs of fatigue, headaches, light-headedness, skin color change of blue, gray, or pale, rapid heart rate, or shortness of breath. If the patient experiences any of these, they need to notify the provider immediately.

Medication Reference (1) APA:

Dextrose 5% in 0.9% sodium chloride (dextrose and sodium chloride inj): Uses, dosage, side effects, interactions, warning. (2008, October 3). RxList.

<https://www.rxlist.com/dextrose-5-in-9-sodium-chloride-drug.htm#indications>

Drugs.com. (2021, January 21). *Dextrose and sodium chloride injection.* <https://www.drugs.com/pro/dextrose-and-sodium-chloride-injection.html>

Jones & Bartlett Learning. (2019). *2019 Nurse’s drug handbook*.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient is A & O x3 Patient appears content with no distress. The patient was talkative and cooperative.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> 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:</p>	<p>Tan/pink normal for race Patient appears drowsy. Patient appears warm and dry with no signs of skin breakdown present. Normal turgor 2+ The patient does not have any rashes, bruises, or wounds noted. 4 22 gauge Right antecubital 04/08/2021 Patent No signs of erythema or drainage noted. The IV dressing appeared clean, dry, and intact. 83mL/hr of 0.9% NaCl</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>Head and neck symmetrical, no bumps or lesions noted. Trachea is midline. Lymph nodes are nonpalpable. Ears are free of discharge, no bumps or lesions noted, healthy cerumen, and tympanic membrane is a pearly grey. Eyes normal. Upon inspection sclera was white, cornea was clear, conjunctiva was white with no lesions or discharge noted. Normal EOM. Septum midline. No drainage or bleeding noted. No deviation or abnormalities and sinuses are not tender. Patient has natural teeth on top and bottom. Good dentition overall. No lesions or bumps noted. Mouth is pink and moist.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds:</p>	<p>S1 and S2 heart sounds normal, no murmurs or rubs present.</p>

<p>S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Pulse is 109 bpm radial. Capillary refill is within 3 seconds in all extremities.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Client has normal lung sounds with no rales/crackles, rhonchi, or wheezes present. No use of accessory muscles is noted. Respirations are nonlabored.</p>
<p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Regular diet at home. Regular diet during hospitalization. 132.5 cm Bowel sounds are audible. Normoactive in all four quadrants. 1258 04/09/2021 No pain or masses noted on palpation. No abnormalities found upon inspection. No distention, incisions, scars, or wounds present.</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Colorless, clear, and no odor present. One occurrence of urine was noted while I was there. The patient denies any pain with urination. Genitals and bottom showed no signs of a rash, lesions, or skin breakdown.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Patient has no neurovascular deficits noted. ROM is slightly diminished. The patient has a complaint of right hip and side pain that increases when walking. The patient has good upper extremity strength but limited lower extremity strength. No supportive devices are needed.</p>

<p>Fall Score: Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>The patient is able to walk independently as tolerated. The patient has a fall risk score of 3.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>The patient moves both arms well bilaterally. The patient has limited leg strength due to the patient’s right hip and side pain that increases with leg movement. Pupils equal, round, and reactive to light. No neurological abnormalities noted. The patient is A & O x3. The patient shows age-appropriate mental development and speech patterns. No abnormalities with sensory are noted. Patient’s LOC seems to be normal.</p>
<p>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):</p>	<p>The patient keeps occupied by watching cartoons on the television and coloring in a coloring book. Both of the parents were present at the hospital at the time of my assessment. They took time off of work to be there with the patient. The mother’s parents and the patient’s grandparents bring them food and clothes when needed. The patient lives at home with both parents. Overall, the patient seems to come from a supportive family that is willing to help out when needed. The parents also seem to have a good support system with their parents and the patient’s grandparents.</p>

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1600	109 bpm radial	110/59 left arm	16	98.3° F oral	100% room air

Vital Sign Trends: The patient’s vital signs were within the normal limits for the patient’s age.

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

Pulse Rate	70 to 120 bpm
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Blood Pressure	90 to 110/55 to 75 mmHg
Respiratory Rate	12 to 20 bpm
Temperature	98.6° F
Oxygen Saturation	97% to 100%

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

CS Mott Children’s Hospital. (2019, June 26). *Vital signs in children*. Michigan Medicine.

<https://www.mottchildren.org/health-library/abo2987>

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	0 - 10	Right hip and side pain	The patient rated the pain a 4 on a scale of 0 to 10.	The patient complained of sharp pain and discomfort.	The patient was given 662.4mg of acetaminophen for mild pain relief. The patient was watching television to keep occupied.
Evaluation of pain status <i>after</i> intervention	0 – 10	No pain	The patient rated the pain a zero on a scale of one to ten.	The patient denied any pain.	The patient was watching television and appeared drowsy while reassessing the patient’s pain level. The patient was left alone to rest.
Precipitating factors: The patient had right hip and side pain. The patient complained that when walking, the pain would intensify. Therefore, the patient limited her mobility. The patient					

and mother denied having any other precipitating factors.

Physiological/behavioral signs: The patient did not show any physiological or behavioral signs. The patient could receive oral acetaminophen every six hours as needed for mild pain and ketorolac intravenous push every six hours as needed for severe pain.

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
1730 300mL Total input = 300mL	The patient had one urine and bowel movement occurrence during my clinical day at 1645. Total output = one occurrence.

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. The patient should know the complete date, such as the day of the week, day of the month, the month, and the year.
2. The patient should be able to easily have a conversation with people of all different ages.
3. The patient should be proficient in addition and subtraction.

Age-Appropriate Diversional Activities

1. The patient should enjoy reading and may seek out magazines or books on subjects that they are interested in.
2. The patient should have a developed endurance and enjoy running, riding a bike, or any activity that requires physical conditioning.
3. The patient should enjoy being with their friends often of the same gender.

Psychosocial Development:

Which of Erikson's stages does this child fit? This child fits the industry vs. inferiority stage.

What behaviors would you expect? In this stage, you would expect the child to be interested in how things are made, success in personal and social tasks, increased activities outside of the home, increased interactions with peers, increased interest in knowledge, and needs support and encouragement when the child is not successful at a task.

What did you observe? I observed the patient have an increased interest in her health and ask the nurse questions regarding her examinations. I also observed the patient interact with the nurses and myself.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? This child fits the concrete operational stage.

What behaviors would you expect? In this stage, you would expect the child to want to learn by manipulating concrete objects, lack the ability to think abstractly, understand the concepts of time, classify or group objects by their common elements, and start a collection of items.

What did you observe? I observed the patient understanding the concept of time.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? This child should be able to read books with chapters. This child should be able to read and understand a paragraph of complex sentences. This child should also have speech patterns that are similar to an adult level.

Any concerns regarding growth and development? I do not have any concerns regarding this child’s growth and development.

Developmental Assessment Reference (1) (APA):

CS Mott Children’s Hospital. (2020, May 27). *Milestones for 10-year-olds*. Michigan Medicine. <https://www.mottchildren.org/health-library/ue5722>

Ricci, S., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing* (4th ed.). LWW.

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Acute pain related to right hip and side as evidenced by verbalization.</p>	<p>The patient came into the emergency department with a chief complaint of right hip and side pain.</p>	<p>1. Administer acetaminophen for mild pain or ketorolac for severe pain.</p> <p>2. Assess the patient’s vital signs and pain level every four hours and look for any changes since the last time they were checked.</p>	<p>Goal: The goal is to keep the patient comfortable by keeping her pain level under control.</p> <p>While I was there, the patient was given one dose of acetaminophen for pain because the patient-rated her pain a four on a scale of one to ten. The patient’s vital signs remained baseline. The patient took the medication well with no help from either parent. The patient was half asleep when we went to</p>

			reassess thirty minutes later. The patient also rated her pain a zero at the time of reassessment. No modifications need to be made because the patient's goals were met.
2. Impaired physical mobility related to acute pain as evidenced by verbalization.	The patient explained that the pain in her right hip and side made it hard for her to get up and walk because any movement on the right side increased the patient's pain.	<ol style="list-style-type: none"> 1. Perform ROM exercises to all joints throughout the day as tolerated. 2. Check for skin integrity for signs of redness or tissue ischemia. 	<p>Goal: The goal is to get the patient up and moving as much as possible to prevent further complications. Mobilization will also keep the patient's skin from breaking down.</p> <p>The patient was assessed and had no signs of skin breakdown. The patient had her parents help her in and out of bed as needed. The nurse taught the patient the different ROM exercises that she can perform throughout the day. The patient and her parents were compliant and understood what was being taught. No modifications need to be made because the goals were met.</p>
3. Risk for dehydration related to illness as evidenced by elevated hemoglobin and hematocrit.	The patient had an elevated hemoglobin and hematocrit level, indicating that the patient was dehydrated.	<ol style="list-style-type: none"> 1. Administer 0.9% NaCl continuously for fluid and electrolyte replenishment. 2. Monitor the patient's intake and output. 	<p>Goal: Maintain patient's fluid intake status and continue to monitor her intake and output.</p> <p>The patient had her intake and output recorded once while I was there. The intake was 300mL, and the output was one occurrence of urine and bowel. The patient remained on 0.9% NaCl and did not seem to</p>

			bother it. No modifications need to be made because the goals were met.
4. Deficient knowledge related to septic arthritis as evidenced by asking questions.	This patient is ten years old and has no history of past illnesses or hospitalizations. The child and parent lack knowledge of septic arthritis because this is something they have not dealt with yet. The child is also at the stage where she is very interested in herself and wants to know what is going on and why specific things are being done.	1. Assess the patient and parents' understanding of septic arthritis and give them handouts explaining the virus and how it affects the body. 2. Grant a calm and peaceful environment without interruption while educating the patient and the parents.	Goal: To help the child and parents understand what septic arthritis is and how it affects the body. We also want to make sure the environment is calm and quiet while educating the patient and parents. The patient and parents were previously given handouts from the nurse about septic arthritis. The patient and parents understood the information that was being given. The patient was later ruled out for septic arthritis. No modifications need to be made because the goals were met.

Other References (APA):

Wayne, G. B. (2019, March 18). *Impaired physical mobility nursing care plan*. Nurseslabs.

<https://nurseslabs.com/impaired-physical-mobility/>

Wayne, G. B. (2020, September 6). *Acute pain nursing care plan*. Nurseslabs.

<https://nurseslabs.com/acute-pain/>

Wayne, G. B. (2020, September 6). *Fluid volume deficit (dehydration) nursing care plan*.

Nurseslabs. <https://nurseslabs.com/deficient-fluid-volume/>

Concept Map (20 Points):

Subjective Data

The patient stated, "my right hip and side are in pain."

The mother stated, "it only started a few hours ago when the pain woke her up out of sleep." The patient described the pain in her right hip as uncomfortable and sharp.

The patient stated, "my hip hurts worse when I move or try to walk."

The patient expressed that it helped when she laid down and did not move.

The patient rated her pain a four on a scale of one to ten.

Objective Data

Vital signs: 109 bpm radial pulse; 110/59 left arm BP; 16 bpm rr; 98.3° F oral temp; 100% room air SaO₂

The patient's vital signs were within the normal limits for the patient's age.

The patient had an MRI of the right hip without contrast, a CT of the abdomen and pelvis with contrast, a pelvic ultrasound, an ultrasound of the appendix, and an x-ray of the hip bilaterally with the pelvis included, and they all came back with no abnormal findings.

The patient had an increased WBC count and a trace of leukoesterase in her urinalysis.

The patient had an elevated level of hemoglobin, hematocrit, glucose, monocyte, neutrophil, alkaline phosphorus, ESR, and CRP.

Patient Information

On April 8th, a 10-year-old female came into the emergency department at Carle with a chief complaint of right hip and side pain that woke her up out of sleep that morning. The patient has no serious past medical history or surgical history. The patient also has no history of severe illness or hospitalization in the past.

Nursing Diagnosis/Outcomes

1. Acute pain related to right hip and side as evidenced by verbalization.

Goal: The goal is to keep the patient comfortable by keeping her pain level under control. While I was there, the patient was given one dose of acetaminophen for pain because the patient-rated her pain a four on a scale of one to ten. The patient's vital signs remained baseline. The patient took the medication well with no help from either parent. The patient was half asleep when we went to reassess thirty minutes later. The patient also rated her pain a zero at the time of reassessment. No modifications need to be made because the patient's goals were met.

2. Impaired physical mobility related to acute pain as evidenced by verbalization.

Goal: The goal is to get the patient up and moving as much as possible to prevent further complications. Mobilization will also keep the patient's skin from breaking down. The patient was assessed and had no signs of skin breakdown. The patient had her parents help her in and out of bed as needed. The nurse taught the patient the different ROM exercises that she can perform throughout the day. The patient and her parents were compliant and understood what was being taught. No modifications need to be made because the goals were met.

3. Risk for dehydration related to illness as evidenced by elevated hemoglobin and hematocrit.

Goal: Maintain patient's fluid intake status and continue to monitor her intake and output. The patient had her intake and output recorded once while I was there. The intake was 300mL, and the output was one occurrence of urine and bowel. The patient remained on 0.9% NaCl and did not seem to bother it. No modifications need to be made because the goals were met.

4. Deficient knowledge related to septic arthritis as evidenced by asking questions.

Goal: To help the child and parents understand what septic arthritis is and how it affects the body. We also want to make sure the environment is calm and quiet while educating the patient and parents. The patient and parents were previously given handouts from the nurse about septic arthritis. The patient and parents understood the information that was being given. The patient was later ruled out for septic arthritis. No modifications need to be made because the goals were met.

Nursing Interventions

1. Administer acetaminophen for mild pain or ketorolac for severe pain.
2. Assess the patient's vital signs and pain level every four hours and look for any changes since the last time they were checked.

1. Perform ROM exercises to all joints throughout the day as tolerated.
2. Check for skin integrity for signs of redness or tissue ischemia.

1. Administer 0.9% NaCl continuously for fluid and electrolyte replenishment.
2. Monitor the patient's intake and output.

1. Assess the patient and parents' understanding of septic arthritis and give them handouts explaining the virus and how it affects the body.
2. Grant a calm and peaceful environment without interruption while educating the patient and the parents.