Medications

Iso-vue (iopamidol) 300 61% injection (35 mL)

Classification: Contrast agent

Reason for Pt: Contrast agent injected prior to CT in order to better visualize problems in the back and abdomen.

Key assessment prior to administration: Check for allergies to the drug.

Tylenol (acetaminophen) 300 mg oral suspension

Classification: Non-steroidal anti-inflammatory

Reason for Pt: Given to patient for pain as needed every four hours.

Key assessment prior to administration: Check vital signs including temperature and pain.

Miralax (polyethylene glycol) 34 g Daily Oral Powder

Classification: Osmotic laxative

Reason for Pt: Constipation related to spinal compression injury.

Key assessment prior to administration: 8 med rights, assess for allergies, and assess abdomen.

Demographic Data

Admitting diagnosis: T3-T6 spinal compression fracture.

Psychosocial Developmental Stage: Initiative vs. Guilt

Age of client: 5 years old

Gender: Male

Weight in kgs: 21.8 kg

Cognitive Development Stage: Pre-operational

Allergies: NKDA

Admission History

Pt presented to the emergency room this morning with his mother complaining of abdominal pain, back pain, and lacerations to the tongue after falling from a window 15 feet up. Was given fentanyl for acute pain in the ER before being transferred to the floor.

Pathophysiology

Disease process:

A spinal compression fracture is when trauma or force causes buckling of the vertebral bodies. It can cause pressure or damage to the spinal nerves which can in turn effect body movements, digestion, and breathing (Franzone, 2018). In the pt's case, the compression fracture has slowed his digestion and caused constipation. His breathing and body movements are intact.

S/S of disease:

Severe back pain, acute abdominal pain, paresthesia, and pain is worse while standing and better when laying down (Otsuka, 2020).

Method of Diagnosis:

Compression spinal fractures are diagnosed using diagnostic imaging such as CT, MRI, and X-ray (Otsuka, 2020).

Treatment of disease:

Nonoperative treatment is most common and includes

Relevant Lab Values/Diagnostics

Abdominal CT is negative for injuries. Was ordered due to patient complain of abdominal pain after fall out of a window.

Thoracic CT shows acute T3-T6 compression fracture from falling out the window. Ordered due to patient complain of acute back pain.

Head CT is negative for injuries. Ordered due to possible injury from fall and abrasions on the face.

Chloride levels were 110 which is considered high. High chloride levels can indicate dehydration which is consistent with the nursing diagnosis of constipation (Lab tests online, 2019).

Medical History

Previous Medical History:

Pt was Premature, small for gestational age (SGA), had a hip click as newborn, and a history of eczema.

Prior Hospitalizations:

N/A

Chronic Medical Issues:

N/A

Social needs: Pt was watching a documentary with his mother and sister. Pt's mother is active in care, often sitting on the bed with the pt. The pt clings to her and speaks in quick 3–4-word phrases when responding to me.

Active Orders

Full Code in case pt codes at any point during his stay.

Regular diet with foods high in fiber to increase peristalsis.

Strict bed rest since the thoracic CT showed a T3-T6 compression fracture.

I & O Q4H to monitor constipation and make sure intake of fluids and fiber are adequate.

Neuro checks Q4H since the fall involved face trauma as evidenced by the abrasion on the pt's face and the possibility the compression fracture damaged spinal nerves.

Assessment									
General	**Integument**	**HEENT**	**Cardiovascular**	**Respiratory**	**Genitourinary**	**Musculoskeletal**	**Neurological**	**Most recent VS (highlight if abnormal)**	**Pain and Pain Scale Used**
AOx4 and no acute distress.	Abrasion on the face from fall. Skin is warm, dry, and pink. Normal distribution of hair. Nails without clubbing and capillary refill is less than 3 seconds.	Bilateral sclera white without exudate. PERRLA bilaterally. Tongue is lacerated from biting down from impact of the fall. Good dentition.	S1 and S2 sounds with a normal rhythm. No murmurs, rubs, or gallops to note. Pulses 2+ at brachial, dorsalis pedis, posterior tibial, radial, and carotids bilaterally.	Normal rate and pattern of respirations. Lung sound clear anteriorly and posteriorly bilaterally. No crackles, wheezes, or rhonchi. Respirations are non-labored and symmetrical.	Patient has not had a BM since being admitted. normoactive bowel sounds. Uses a bedside urinal and bed pan related to bed rest orders.	Grip strength is +5 bilaterally. +5 pedal push and pull strength bilaterally.	AOx4 and PERRLA bilaterally. Glasgow coma scale score is 15 with spontaneous blinking, verbal orientation, and obeys commands of small movements.	**Time:** 14:55 **Temperature:** 98.5 F **Route:** Oral **RR:** 26 **HR:** 108 **BP and MAP:** 105/54 and 77 **Oxygen saturation:** 100% **Oxygen needs:** Room Air	Pain score of 2 “hurts a little bit” on the FACES scale.

Nursing Diagnosis 1 Constipation related to thoracic T3-T6 compression fractures as evidenced by the patient's mother stating a change in his elimination habits, the pt stating he feels like he has to go but cannot, and a chloride level of 110.	**Nursing Diagnosis 2** Acute Pain related to thoracic T3-T6 compression fractures as evidenced by abdominal and upper back pain at a rating of 10 "hurts worst" on the FACES pain scale when assessed in the emergency room.	**Nursing Diagnosis 3** Powerlessness related to hospitalization as evidenced by regression in language development responding in 3–4-word phrases and clinging to his mother.
Rationale Pt has not had a bowel movement since being admitted, but claims he feels like he has to go.	**Rationale** Pt reported acute abdominal and upper back pain after falling out an upper-level window.	**Rationale** Pt clings to his mother and responds in 3–4-word phrases.
Interventions **Intervention 1:** MiraLAX (polyethylene glycol) 34 g oral powder Q24H **Intervention 2:** Increase fluid intake and fibrous foods such as a sweet potato.	**Interventions** **Intervention 1:** Bed rest **Intervention 2:** Acetaminophen prescription of 300 mg oral suspension Q4H	**Interventions** **Intervention 1:** Give child and parent input when discussing care plan and scheduling activities. **Intervention 2:** Allow for pt's mother and sister to stay with him consistently.
Evaluation of Interventions Pt drank apple juice with 34 g of MiraLAX mixed into it. Pt was eating a baked potato and drinking water at dinner. Pt was able to have a bowel movement in the bed pan at the bedside.	**Evaluation of Interventions** Dose of fentanyl in the ER before admission, bed rest, and acetaminophen has brought his pain score down to 2 "hurts a little bit" FACES scale from the 10 "hurts worse" that it was at upon presenting to the ER.	**Evaluation of Interventions** Pt and mother agreed on apple juice when picking out a drink to mix his MiraLAX with. Pt's mother gave him the choice of reading a book or watching a documentary.

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