N433 Care Plan # 1

Lakeview College of Nursing

Mallorie Mason

Demographics (3 points)

Date of Admission 9/15/21	Patient Initials T.D.	Age (in years & months) 13 years 0 months	Gender Female
Code Status Full Code	Weight (in kg) 134.4kg	BMI 47.82 kg/m2	Allergies/Sensitivities (include reactions) KNA

Medical History (5 Points)

Past Medical History:

Illnesses: The patient has a history of diabetes mellitus type II, obesity, sleep apnea, and murmur.

Hospitalizations: The patient was hospitalized last year in 2020 due to a new diagnosis of diabetes mellitus type II.

Past Surgical History: The patient had a tonsillectomy and an adenoidectomy in 2017.

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

Birth History: Normal birth history

Complications (if any): No complications were stated by the mother.

Assistive Devices: No assistive devices are used by the patient.

Living Situation: The patient lives at home with her mother, grandmother, and other siblings.

Admission Assessment

Chief Complaint (2 points): Nausea, Polyuria, and Polydipsia

Other Co-Existing Conditions (if any): Diabetes mellitus type II

Pertinent Events during this admission/hospitalization (1 points): The following labs were

drawn in the emergency room, ABG, point of care glucose, urine sample, CBC, CMP, hemoglobin A1C,

and beta hydroxybutyrate see results per patient's chart.

History of present Illness (10 points): On 9/15/21, a 13-year-old female was admitted to Carle hospital for diabetic ketoacidosis. The patient was recently diagnosed with diabetes mellitus type II last year in 2020. A week before her arrival at the hospital, her blood sugars ranged from 400-500. The patient's mother stated that she believed her daughter had not been compliant with her diabetic medications, which caused the 400-500 mg/dL blood sugars. The patient stated she felt nausea and like, "I was going to throw up". The patient had also been experiencing polyuria and polydipsia. The mother decided to call Carle's endocrine center and explain everything that had been going on. The endocrine center told the mother to bring the patient into the emergency room.

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Primary Diagnosis

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Primary Diagnosis on Admission (2 points): Diabetic Ketoacidosis

Secondary Diagnosis (if applicable): N/A

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

Diabetic ketoacidosis "is caused by the absence or markedly inadequate amount of insulin" (Hinkle & Cheever, 2018, p. 1483). The lack of insulin causes the amount of glucose entering the cells to reduce. The reduction of glucose entering the cells means the production and release of glucose by the liver increases. The kidneys will try to get rid of extra glucose; while doing so, it also takes water and electrolytes during the excretion. The kidneys trying to excrete extra glucose causes polyuria (Hinkle & Cheever, 2018). Also, the lack of insulin causes a defect in the breakdown of fat into glycerol and fatty acids. The fatty acids convert into ketones which accumulate in the blood and can lead to metabolic acidosis.

Since the kidneys are trying to extra glucose, common symptoms are polyuria, polydipsia, and fatigue. TD stated she exhibited two of these before coming into the hospital polyuria and polydipsia. In addition to those symptoms, blurred vision, weakness, and headaches may occur (Hinkle & Cheever, 2018). When the fatty acids convert into ketones, the symptoms are acetone breath, nausea, vomiting, and abdominal pain. TD exhibited nausea before being brought to the emergency room. On the acidosis side of symptoms, a patient will experience hyperventilation and breathing.

The significant finding that can diagnosis diabetic ketoacidosis is ketones in the urine; this is called ketonuria. A urinalysis will determine if ketones are in the urine or not and, if so, how much. TD was getting urinalysis done daily. Every time the patient used the restroom, the nurses were checking for ketones. Another good indicator of diabetic ketoacidosis is blood glucose levels greater than 250 mg/dL (Capriotti & Frizzell, 2020). TD's blood glucose ranges were 400-500 mg/dL. An ABG lab is also another diagnostic lab for diabetic ketoacidosis. The ABG will help determine metabolic acidosis. The pH is lower than 7.3, and the serum bicarbonate is lower than 15 mEq/L (Capriotti & Frizzell, 2020). TD had an ABG lab drawn done in the emergency room. The results of her test were a pH of 7.279 and serum bicarbonate of 10 mEq/L.

The treatment for diabetic ketoacidosis consists of three things, rehydration, restoring electrolytes, and reversing acidosis. Dehydration occurs from polyuria. Normal saline for dehydration runs at a rapid rate of one liter per hour for two or three hours (Hinkle & Cheever, 2018). The loss of electrolytes goes hand and hand with dehydration. The two main common electrolytes that seem to decrease are sodium and potassium. TD was receiving 0.9% NaCl with 20 mEq KCL; this was helping the patient rehydrate and replenish electrolyte loss. The nurse also encouraged my patient to drink more fluids. The way to reverse acidosis is with insulin.

During the patient's hospital stay, she received the correct doses of insulin glargine and insulin apsart.

Cerebral edema is a significant complication of diabetic ketoacidosis. Once cerebral edema severe symptoms start, which are pupillary changes, seizures, respiratory arrest from brain stem pressure, there is a 70 % mortality rate for cerebral edema to develop (Capriotti & Frizzell, 2020). Prevention of cerebral edema includes not overhydrating the patient and slowly reducing blood glucose levels during diabetic ketoacidosis treatment. Another complication that can occur is dysthymias due to electrolyte imbalances. Monitoring is electrolytes and cardiac monitoring are both significant nursing interventions.

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical*

   perspectives (2nd ed.). F.A. Davis Company

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical*

   nursing (14th ed.*)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	The patient is up as tolerated. The only time I saw the patient get up was when she has to use the bathroom.
Diet/Nutrition:	The patient is on a diabetic diet and consistence in carbohydrates. The patient has to count out her own carbohydrates. The patient did have trouble doing this.
Frequent Assessments:	Point of glucose care is performed before the patient eats. The patient blood sugars were taking this morning. A bedside urine specimen is collected every time the patient urinates. The patient is to receive two negative ketones tests. This test was done once this morning on our shift, and the results were negative for ketones, so the patient needs one more negative test. Vital signs are taken every four hours. Blood pressure is obtained every 8 hours. The patient vital signs were completed at nine and twelve o'clock.
Labs/Diagnostic Tests:	A urine culture was ordered on 9/17/21. The results for this test are still pending.
Treatments:	N/A
Other:	N/A
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
There were no new orders given during white board rounding's.	N/A

Laboratory Data (15 points)

CBC <mark>Highlight All Abnormal Labs</mark>**—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	3.93-4.50	<mark>5.43</mark>	N/A	High blood sugars may affect the RBC count (Hinkle & Cheever, 2018).
Hgb	10.8-13.3	12.2	N/A	
Hct	33.4-40.4	40.2	N/A	
Platelets	194-345	255	N/A	
WBC	4.15-9.43	<mark>11.32</mark>	N/A	The patient diabetes is playing a roles in the patient's elevated WBC count. Patient may have infection due to illness (Hinkle & Cheever, 2018).
Neutrophils	45.3-79.0	N/A	N/A	
Lymphocytes	11.8-45.9	30.3	N/A	
Monocytes	4.4-12.0	8.7	N/A	
Eosinophils	0.0-6.3	0.4	N/A	
Basophils	0-1	0.3	N/A	
Bands	0-700	N/A	N/A	

Chemistry <mark>Highlight All Abnormal Labs</mark>**—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	

K+	3.5-5.1	3.7	N/A	
Cl-	98-107	107	N/A	
Glucose	74-100	<mark>348</mark>	N/A	The patient uncontrolled diabetes is what causes high glucose levels (Hinkle & Cheever, 2018).
BUN	8-21	<mark>5</mark>	N/A	The patient uncontrolled diabetes is affecting her kidneys causing low BUN (Hinkle & Cheever, 2018).
Creatinine	0.55-1.02	0.94	N/A	
Albumin	3.-5.4	4.2	N/A	
Total Protein	6-8	<mark>8.1</mark>	N/A	Elevated total protein levels is due to the patient's high blood glucose levels (Hinkle & Cheever, 2018).
Calcium	8.8-10	9.3	N/A	
Bilirubin	0.2-1.2	0.4	N/A	
Alk Phos	40-150	<mark>213</mark>	N/A	High levels of alkaline phosphate may indicate liver problems. The liver producing and releasing more glucose (Hinkle & Cheever, 2018).
AST	5-35	13	N/A	
ALT	0-55	13	N/A	
Amylase	30-110	N/A	N/A	
Lipase	10-140	N/A	N/A	

Other Tests <mark>Highlight All Abnormal Labs</mark>—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	3-15	N/A	N/A	
CRP	0-0.29	N/A	N/A	
Hgb A1c	4.0-7.0	<mark>11.6</mark>	N/A	High Hgb A1c level indicates that the patient diabetes is not controlled (Hinkle &

				Cheever, 201).
TSH	0.4-4.0	N/A	N/A	
pH	7.35-7.45	<mark>7.279</mark>	N/A	Low pH indicates acidic (Hinkle & Cheever, 2018).
PCO2	35-45	<mark>21.9</mark>	N/A	The lungs are trying to get rid of acid which causes hyperventilation (Hinkle & Cheever, 2018).
PO2	8-100	<mark>151.4</mark>	N/A	The body is working harder to produce more oxygen (Hinkle & Cheever, 2018).
HCO3	22-26	<mark>10</mark>	N/A	Low HCO3 indicates metabolic disorder (Hinkle & Cheever, 2018).

Urinalysis <mark>Highlight All Abnormal Labs</mark>—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	Clear	<mark>Cloudy/Red</mark>	The patient was on her menses which is why the urine color was red.
pH	5.0-8.0	5.5	N/A	
Specific Gravity	1.005-1.034	>=1.030	1.020	
Glucose	Normal	<mark>500</mark>	Normal	
Protein	Negative	<mark>>= 300</mark>	<mark>+30</mark>	Large amount of protein can indicate a kidney disease or problem. This would stem from the patient's diabetes (Hinkle & Cheever, 2018).
Ketones	Negative	<mark>>= 160</mark>	<mark>+moderate</mark>	Ketones in the urine especially a high amount indicates diabetic ketoacidosis (Hinkle & Cheever, 2018).
WBC	<=5	N/A	N/A	
RBC	0-3	N/A	N/A	
Leukoesterase	Negative	Negative	Negative	

Cultures <mark>Highlight All Abnormal Labs</mark>—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 Growth	N/A	N/A	The patient did have a urine culture ordered on 9/17/21, but the results are still pending.
Blood Culture	Negative Growth	N/A	N/A	
Sputum Culture	Negative Growth	N/A	N/A	
Stool Culture	Negative Growth	N/A	N/A	
Respiratory ID Panel (COVID)	Negative/Not detective	Not detected	N/A	

Lab Correlations Reference (1) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical*

nursing (14th ed*.)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

Normal lab value were received from Carle.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): There is no diagnostic imaging completed on this

patient. Also there is no diagnostic imagine that helps or confirms diabetic ketoacidosis.

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical*

nursing (14th ed*.)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Brand/Generic	Metformin Fortamet	Insulin Glargine Lantus	Insulin aspart NovoLOG	Acetaminophen Tylenol	Ondansetron Zofran
Dose	1,000mg	65 units	1 unit every 10 mg >100 mg 1 unit every 4 carbohydrates	500mg	4mg
Frequency	Twice a day	Daily at bedtime	Before meals 3 times a day	Every four hours PRN	Every eight hours PRN
Route	Oral	Subcutaneous	Subcutaneous	Oral	IV push
Classification	Pharmacological: Biguanide Therapeutic: Antidiabetic	Insulin	Insulin	Pharmacological: non salicylate Therapeutic: Antipyretic	Pharmacological: selective serotonin receptor antagonist Therapeutic: Antiemetic
Mechanism of Action	"May promote storage or excess glucose as glycogen in the liver, which reduces glucose production. May also improve glucose by adipose tissue and skeletal muscle by increasing glucose transport across cell membrane" (Jones & Bartlett, 2020, p. 765).	"The insulin lower blood glucose levels by increasing glucose uptake by body cells skeletal muscle, and fat cells and by decreasing glucose production in the liver" (Frandsen & Pennington, 2020, p. 882).	"The insulin lower blood glucose levels by increasing glucose uptake by body cells skeletal muscle, and fat cells and by decreasing glucose production in the liver" (Frandsen & Pennington, 2020, p. 882).	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system" (Jones & Bartlett, 2020, p. 10).	" Blocks serotonin receptor centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals" (Jones & Bartlett, 2020, p. 976).
Reason Client Taking	Diabetes Mellitus Type II	Diabetes Mellitus Type II	Diabetes Mellitus Type II	Mild pain on rating scale 1-3	Nausea
Concentration Available	Available in 500 mg tablets.	100 units/mL	100 units/ mL	Available in 325 mg tablets	4mg/ 2mL
Safe Dose Range Calculation	500 to 1,000 mg once daily (Jones & Bartlett, 2020).	"Dosage based off of blood glucose monitoring results, glycemic	"Dosage based off of blood glucose monitoring results,	640 to 650 mg every four hours to six hours as needed (Jones & Bartlett, 2020).	Single does 4mg over two to five minutes (Jones & Bartlett, 2020).

		control goal, and metabolic needs (Jones & Bartlett, 2020, p. 630).	glycemic control goal, and metabolic needs (Jones & Bartlett, 2020, p. 630).		
Maximum 24-hour Dose	2,500 mg	N/A	N/A	3,200mg per day	12 mg per day
Contraindications (2)	1)Hypersensitivity to Metformin 2)Renal disease	1) Hypoglycemia 2)Hypokalemia	1) Hypoglycemia 2)Hypersensitivity	1)Hypersensitivity to acetaminophen 2)Hepatic impairment	1)Hypersensitivity to ondansetron. 2)Use with apomorphine
Side Effects/Adverse Reactions (2)	1)Lactic acidosis 2)Hypoglycemia	1) Blurred Vision 2) Fatigue	1)Weakness 2)Sweating	1)Hepatoxicity 2)Hypotension	1)Headache 2)Diarrhea
Nursing Considerations (2)	1)Monitor patient blood glucose level for the effectiveness of the medication. 2)Give metformin with food to reduce the risk of GI reactions. Do not break or crush E.R. tablets (Jones & Bartlett, 2020).	1)Can not be mixed or diluted with any other solution. 2)Give insulin glargine at bedtime, so that additional insulin can be given in the morning (Frandsen & Pennington, 2020).	1)Give NovoLOG five to ten minutes before the patient eat their meal. 2)Have another nurse check the dose of the insulin before administering (Frandsen & Pennington, 2020).	1) Assess patient's liver function including ALT, AST, bilirubin, and creatine levels. Especially for long-term use of acetaminophen. 2)Use carefully in patients with hepatic, impairment or disease, and renal problems (Jones & Bartlett, 2020).	1)Monitor electrolyte imbalances hypokalemia or hypomagnesemia because these imbalances should be corrected before given ondansetron. Increased risk for QT elevation. 2)Monitor patient for signs and symptoms of hypertension and serotonin syndrome (Jones & Bartlett, 2020).
Client Teaching needs (2)	1)Educate the patient and parent that it is important to take the medication at breakfast and dinner. 2)Emphasize the importance of taking the medication as prescribed, monitoring blood sugars,	1)Educate the client and parent on how to give an insulin injection. 2) Explain the importance or rotating injection sites especially in children.	1) Educate the client and parent on signs and symptoms of hypoglycemia. Explain to always report these systems. 2) Educate the client and parent to take daily blood glucose check and always be monitoring.	1)Explain to the parent and child to not exceed the recommended dosage and do not take other medications containing acetaminophen. 2)Educate the patient/parent to monitor for rash or fever.	1)Educate the patient and parent on sings or hypersensitivity and tell them to report if they have a rash. 2)Educate the patient to report if nausea or vomiting is persistent or worsening.

	following prescribed diet, and exercising.				

Medication Reference (APA):

Frandsen, C. & Pennington, S. S. (2020). *Abrams' clinical drug therapy: Rationales for nursing*

practice (12th ed.). Lippincott, Williams, Wilkins.

Jones & Bartlett Learning. (2020). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett

Learning.

<div align="center">Assessment</div>

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and responsive. The patient is orientated to person, place, time, and situation. The patient does not appear to be in any distress. The patient is dressed appropriately, well-groomed, and the patient has good hygiene.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient's skin color is usual for ethnicity. The character of the patient skin is dry and intact. The temperature of the skin is warm to the touch. Skin turgor was elastic and returned to its normal state in two seconds or less. No rashes No bruises No wounds Braden Score: 20 No drains

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:
	The size of the IV is a 22 gage
	 The location of the IV is left antecubital.
	 The IV was placed on 9/15/2021.
	 The IV is patent and had good blood return, and the line flushed well.
	 No signs of erythema or drainage.
	 The dressing for the IV was intact.
	 The IV fluid rate is 150 mL per hour delivered in 30 minutes.

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	The patient's head is symmetrical with no indentations, deformities, or trauma. The patient's trachea is symmetrical, and no tracheal deviation The patient's ears are symmetrical. No redness or discharge was examined on the external canal. The patient reports no issues with hearing. The patient's eyes are symmetrical. The sclera of the eyes was white, with no conjunctiva or discharge. The patient does not wear glasses. The patient nose is symmetrical. There was no redness, bloody discharge, nasal drainage, and polyps. The patient had good dental hygiene. The mucous was moist and pink. The thyroid and lymph nodes were not palpable.
CARDIOVASCULAR: **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:**	The heart rhythm is sinus rhythm. Sounds S1 and S2 were heard. No murmurs, gallops, S3, or S4 were present. Radial, brachial, and carotid pulses were felt. Each pulse was + 3 normal. Capillary refill time was less than two seconds for the blanched nail to return to normal. No neck vein distention No edema
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient's respirations were regular when the patient was awake. When the patient exhibited snoring while sleeping, this could be due to her sleep apnea. The respiratory pattern is regular. Breath sounds were clear and heard in both anterior and posterior lobes. Lung aeration is equal-no use of accessory muscle.

GASTROINTESTINAL:
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 ☒
	The patient diet at home has been regular.
	The patient diet at the hospital is a diabetic diet.
	The patient height is 167.64 cm.
	Bowel sounds were active in all four quadrants.
	Last BMI: 9/15/21
	No pain was expressed, or masses felt upon palpation of the abdomen.
	No distention
	No incision
	No scars
	No drains
	No wounds
	No ostomy
	No nasogastric
	No feeding tube/PEG tube

Type:	

GENITOURINARY:
 Color:
 Character:
 Quantity of urine:
 Pain with urination: Y ☐   **N** ☒
 Dialysis: Y ☐   **N** ☒
 Inspection of genitals:
 Catheter: Y ☐   **N** ☒
     Type:
     Size:
	The color of the patient urine has been red due to her menses. The character of the urine is cloudy. The patient states they have been urinated normally. The patient voided 400 mL at 1100.
	 The patient stated that she has no pain with urination.
	 No dialysis
	 I did not inspect the patient's genitals
	 The patient did not have a catheter placed.

MUSCULOSKELETAL: **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**☐	The patient's range of motion is active. She can perform range of motion by herself without any assistance. The patient does not use any supportive devices. The patient's strength is a five active motion against full resistance. The patient does not need any ADL assistance Fall score: 2 The patient's activity status is up as tolerated. The patient is independent up ad lib. Yes the patient does need help with equipment. The patient does have an IV that is continuously running with fluids so when the patient has to get up the nurse will need to help with the IV pump. No the patient does not need support to stand or walk.
NEUROLOGICAL: **MAEW: Y** ☒ **N**☐ **PERLA: Y** ☒ **N**☐ **Strength Equal: Y** ☒ **N** ☐ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Yes the patient moves all extremities well. The patient's pupils are equal round and reactive to light and accommodation. Yes the patient's strength is equal in both legs and arms. The patient is orientated to time, place, person, and situation. Normal cognition The patient's speech is clear. The patient is alert and awake,
PSYCHOSOCIAL/CULTURAL: **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):**	The patient likes arts and crafts. The patient lives at home with her mother, grandmother, and other siblings. The patient's mother and father were present at the hospital. The patient needs medication assistance with her insulin pen and counting carbohydrates. The patient has been dealing with her diabetes alone without much help from mom. The patient has been neglecting diabetes treatment.

Vital Signs, <mark>2 sets</mark> (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	84 bpm	138/64 mmHg	18 breaths per minute	98.2 F	98%
1200	90 bpm	N/A	18 breaths per minute	98.3 F	100%

Vital Sign Trends: The vital signs remained stable during the clinical shift. All vital signs are within normal range of child's age.

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

Pulse Rate	50-100 bmp
Blood Pressure	Systolic: 108-138 mm Hg Diastolic: 64-83 mm Hg
Respiratory Rate	12 to 20 breaths per minute
Temperature	> 97.9 F
Oxygen Saturation	95-100%

Normal Vital Sign Range Reference (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters

Kluwer.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	0-10	N/A	0	N/A	Sleeping
Evaluation of pain status *after* intervention	0-10	N/A	0	N/A	Crafts
Precipitating factors: The patient was not in any pain. No precipitating factors were noted. **Physiological/behavioral signs:** The patient showed no physiological or behavioral signs of pain.					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
600 mL 0.9% NaCl with Kcl 20 mL water Patient did not eat breakfast	400 mL urine

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. Adolescents normally stay up late or feel more awake at night and tend to sleep in later in the

    morning (Ricci et al., 2021).

2. Adolescents appear to be more hungry and need regular means and snacks for adequate

    nutrition. Nutritional needs increase during adolescents years (Ricci et al., 2021).

3. Adolescents will start caring about their body image more and their peer groups.

Age Appropriate Diversional Activities

1. Caring for a pet

2. Listen to nonviolent music

3. Reading

Psychosocial Development:

 Which of Erikson's stages does this child fit?

 Identity vs. Role Confusion

 What behaviors would you expect?

Expect to see focuses on body changes, experiences mood swings, importance placed on conformity to peer norms and peer acceptance, strives to mast skills within peer group, defining boundaries with parents, struggles to separate form parents while still desiring dependence on them, and takes more responsibility for own behavior (Ricci et al., 2021).

 What did you observe?

The child is completely independent when it comes to managing her diabetes. The child's parents do not help or assist her with her medication. The child still desires dependence on her parents to help her with her diabetes and management because sometimes the child does not understand how to do things.

Cognitive Development:

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

 Formal operation

 What behaviors would you expect?

 The behaviors you would expect are limited abstract thought process, egocentrical thinking, and eager to apply limited abstract processes to different situations and peer groups (Ricci et al., 2021)

 What did you observe?

I saw that the patient is capable of evaluating the quality of her own thinking. When the patient counts her carbohydrates, she knows that she is not very good at counting those ones that do notspecially give you the number on the box.

Vocalization/Vocabulary:

 Development expected for child's age and any concerns?

Language skills are continuing to develop during adolescents and improving communication

skills and using correct grammar. Slang may develop during this time (Ricci et al., 2021). No concerns for

the patient.

Any concerns regarding growth and development?

The patient's BMI is 47.82 kg/m2 and the patient's weight is 134.4 kg. The normal weight the patient is

supposed to be at for there age is 27.24 kg to 82.47 kg (Ricci et al., 2021).

Developmental Assessment Reference (1) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th 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 with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status

			of goals and outcomes, modifications to plan.
1. Potential for erratic blood glucose levels related to ineffective medication management as evidence by blood sugars ranging from 400-500 (Swearingen & Wright, 2019).	The patient has been having high blood pressure ranging from 400-500 a week before being brought into the emergency room. The mother states that she thinks her daughter has not been taking her diabetic medications very regularly.	**1.** Assess blood glucose levels before bed and meals. **2.** Administer insulin as prescribed and explain the importance of taking insulin to the patient.	The patient blood glucose is lowering during her stay at the hospital. The patient did not feel comfortable with using the syringe to administer her insulin. The patient typically uses a pen. The nurse is trying to get the mother to deliver the insulin pens from home.
2. Risk for fluid volume deficit related to decrease fluid intake as evidence by the patient not wanting to drink anything (Swearingen & Wright, 2019).	The patient has not been drinking very much water. When I was at clinical, I only saw the client drink about 20mL of water.	**1.** Monitor intake and output. **2.** Administer IV fluids as prescribed.	The patient is receiving continuous IV fluids. The fluids are 0.9% NaCl with KCL 20 mEq. The patient is now starting to drink somewhat of fluids on her own. The patient's input and outputs are being recorded.
3. Imbalance nutrition: less than body requirements related to insufficient insulin as evidence by a large amount of ketones in the urine (Swearingen & Wright, 2019).	The patient has not been eating anything or drinking anything because of the patient's nausea. The client has had insufficient insulin, which is noted because of the large amounts of ketones in her urine.	**1.** Assess the patient's nausea **2.** Provide the client with a diet consisting of 60% carbohydrates, 20% fat, and 20% protein.	The client's nausea is better, but the patient is still not eating very much. The patient ate very little for dinner and did not eat breakfast. The patient understands the importance of eating and is learning what a good diet looks like for her.
4. Deficit knowledge related to high blood glucose levels as evidence by the patient not knowing how to count	The patient does not understand how to count her carbohydrates; this is crucial because her insulin aspart dose goes off her insulin.	**1.** Educate the patient on counting her carbohydrates and give her a worksheet on how to count carbohydrates. **2.** Before the patient eats and her insulin is delivered, have her	The client does not like counting her carbohydrates before eating and voices that she does not like this. The client shows She says she still gets confused when they are not right on the box. More education is to be done on counting

carbohydrates (Swearingen & Wright, 2019).		count out the carbohydrates.	carbohydrates.

Other References (APA):

Swearingen, P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-*

   surgical, pediatric, maternity, and psychiatric-mental health. (5 ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

Pain: 0 on a 0-10 scale

Patient stating "I feel nausea"

Patient stating her do not Understand how to count carbohydrates

The mother stating she believes that the daughter has not been compliant with her medication.

Objective Data

Height: 167/64 cm

Weight: 134.4 kg

BMI: 42.8 kg/

Temperature: 98.3 F

Blood pressure: 138/84 mmHg

Respiration Rate: 18 breaths per minute

Pulse rate: 84 bpm and 90 bpm

Oxygen: 98 % and 100 %

Blood glucose:

Urine Output: 400 mL

Patient Information

On 9/15/21, a 13-year-old female was admitted to Care hospital for diabetic ketoacidosis. The patient was recently diagnosed with diabetes type II last week. The patient's blood glucose levels ranged from 400- 500 mg/dL the week before her counting the carbohydrates. The patient has nausea and expressing discomfort.

Nursing Diagnosis/Outcomes

1. Potential for erratic blood glucose levels related to ineffective medication management as evidence by blood sugars ranging from 400-500.
   a. The patient blood glucose is lowering during his stay at the hospital. The patient did not feel comfortable with using the syringe, so they switched her to an insulin pen. The nurse is trying to get the mother to deliver the insulin pens from home.
2. Risk for fluid volume deficit related to decrease fluid intake as evidence by the patient not wanting to drink anything.
   a. The patient is receiving continuous IV fluids. The fluids are 0.9% NaCl with KCL 20 mEq. The patient is now starting to drink somewhat of fluids on her own. The patient's input and outputs are being recorded.
3. Imbalance nutrition: less than body requirements related to insufficient insulin as evidence by a large amount of ketones in the urine.
   a. The client's nausea is better, but the patient is still not eating very much. The patient ate very little for dinner and did not eat breakfast. The patient understands the importance of eating and is learning what a good diet looks like for her.
4. Deficit knowledge related to high blood glucose levels as evidence by the patient not knowing how to count carbohydrates.
   The client does not like counting her carbohydrates before eating and voices that she does not like this. The client shows She says she still gets confused when they are not right on the box. More education is to be done on counting carbohydrates.

Nursing Interventions

1. Monitor intake and output.
2. Administer IV fluids as prescribed
3. Assess the patient for nausea.
4. Provide the client with a diet consisting of 60% carbohydrates, 20% fat, and 20% protein.
5. Educate the patient on counting her carbohydrates and give her a worksheet on how to count carbohydrates.
6. Before the patient eats, monitor the patient blood glucose and have her count out the carbohydrates.
7. Administer insulin prn and explain the importance of taking insulin to the patient.
8. Assess Blood glucose levels before bed and meals.