N433 Care Plan #1

Lakeview College of Nursing

Name: Christine Nlandu

Demographics (3 points)

Date of Admission 10/28/21	Patient Initials RT	Age (in years & months) 3 years and 5 months	Gender F
Code Status Full code	Weight (in kg) 14.6 Kg	BMI 15.84 kg/m2 61 %	Allergies/Sensitivities (include reactions) No known allergies.

Medical History (5 Points)

Past Medical History: Elevated lead levels.

Illnesses: N/A

Hospitalizations: NA

Past Surgical History: N/A

Immunizations: The client is up to date per caregiver. The client received her HepB, RV, DTap, Hib, PCV13, IPV, IIV, MMR, VAR, and Hep A.

Birth History: The child was born at 40 weeks per caregiver. The labor was induced.

Complications (if any): During the induction, there were cord compression, which dropped the fetal heart rate and an emergency cesarian was performed.

Assistive Devices: The client does not use walker, cane, or wheelchair. She ambulates independently.

Living Situation: The client's parents are separate. The patient lives with her father and goes to the mother's house sometimes on the weekends.

Admission Assessment

Chief Complaint (2 points): Right eye swelling and dog bite

Other Co-Existing Conditions (if any): N/A

Pertinent Events during this admission/hospitalization (1 points): The CDEF is involved in this case because the father who takes care of the child did not seek care after the child was bitten by a dog.

History of present Illness (10 points): On October 28th, a 3-year-old and 5-months Caucasian female child was brought to the emergency department (ED) for right eye swelling. About one day early, the mother received a call to pick up the baby because the father was arrested for another reason. When the mother arrived, she found out that the child had right eye swelling with drainage. The child was bitten by a dog on an unknown day, and the father did not report that. The mother brought the child to Paris ED, and they were transferred to Carle Foundation Hospital (CFH) by a pediatric transport team. The Paris team administered Rocephin, vancomycin, and informed the CDEF about the situation. When the child arrived at CFH, she was alert and oriented. The right eye swelling, shut with dried drainage. The right eye had significant periorbital redness and was tender to touch. The client is under clindamycin and waiting on CDEF's decision before discharge.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Periorbital cellulitis of the right eye.

Secondary Diagnosis (if applicable): N/A

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

Cellulitis is the most frequent infectious that causes limb swelling. Although cellulitis mainly occurs in the lower legs, it can also appear in the arms, face, and other body parts.

Cellulitis can appear as a single isolated event or intermittent event. Most causes of cellulitis are streptococcus and staphylococcus. Bacteria enter the skin through surgical sites, punctured wounds, ulcers, dermatitis, cuts, and animal bites, the most common portal of entry of bacteria (Hinkle & Cheever, 2018). When the skin breaks down, it allows opportunistic bacteria to penetrate the wound and release their toxins. After removing toxins, the infection spreads over surrounding subcutaneous tissues. Clinical manifestation of cellulitis includes warmth, malaise, swelling, blisters, skin dimpling, localized erythema, tenderness, pain is linked to systemic signs of fever, sweating, and chills (Frandsen & Pennington, 2018). Erythema is characterized by splitting areas like orange peel appearance (Hinkle & Cheever, 2018).

If the infection is not treated, toxins can enter the lymphatic system and bloodstream. Complications of cellulitis including, sepsis, osteomyelitis, meningitis, endocarditis, lymphangitis, septic shock, recurrent infection of cellulitis, a chronic swelling of the limb, and gangrene. The nursing interventions of sepsis closely monitor signs and symptoms of infection like fever, pulse, redness, tenderness, and swelling. An antibiotic is administered to prevent meningitis and sepsis. Monitoring signs of meningitis such as confusion, stiff neck, headache, fever, sensitivity to light, and numbness. Risk factors of cellulitis include injury, lymphoma, obesity, skin condition, history of cellulitis, immunosuppression, chronic swelling on upper and lower extremities, diabetes mellitus type two, and comorbidity. Diagnostic of cellulitis is done with blood culture to identify the specific organism causing the cellulitis; a complete blood count (CBC) to determine blood count level, physical symptoms, and creatinine to assess kidney function. Preventive methods of cellulitis would be washing the wound every day, Appling a protective cream, covering the wound with a

bandage, and observing signs of infection. Clients with poor circulation and diabetes need to take extra precautions to avoid skin damage. These clients need to trim toenails and fingernails cautiously, inspect their feet every day, treat any superficial skin infect, and moisturize skin regularly. Treatment of cellulitis includes antibiotics, wound care, incision, drainage, and surgery in severe cases (Hinkle & Cheever, 2018).

In this case, the cellulitis was caused by a dog bite. The client presented with right eye swelling, shut with dried drainage. The right eye had significant periorbital redness and was tender to touch. The diagnosis was determined by physical symptoms, and no labs were drawn. The client is under clindamycin. Clinical data correlated to this client is that cellulitis affects one in 40 people each year (Allen, 2021).

Pathophysiology References (2) (APA):

Allen, D. (2021). Cellulitis management and diagnosis: Insect bites and dog bites can often trigger cellulitis infection, but there are also other causes. *Nursing Standard, 36*(10), 67-69. https://Doi.org/10.7748/ns.36.10.67.s25

Frandsen, G., & Pennington, S. S. (2018). *Abrams's Clinical Drug Therapy: Rational for Nursing Practice* (12th ed.). Wolters Kluwer.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	**Increase activity as tolerated.**

Diet/Nutrition:	**Regular diet**
Frequent Assessments:	**Assess vital signs every 4 hours.** **Assess signs and symptoms of sepsis and notify the provider if elevated temperature.**
Labs/Diagnostic Tests:	**Check pulse oximetry per protocol.**
Treatments:	**Clindamycin every 8 hours IVPB** **Acetaminophen every 4 hours PRN for pain.**
Other:	**Follow up appointment with the primary provider 2-3 days after discharge.**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Expected discharge	**Maybe on Monday.**
Strict intake and output per protocol. **Maintain peripheral IV per protocol.**	**Encourage good fluid intake and keep IV patent with normal saline locked between clindamycin infusion.**

Laboratory Data (15 points)

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

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	4.9-5.3 *10*6mm3	N/A	N/A	
Hgb	9.5-14.1 g/dL	N/A	N/A	
Hct	30-40%	N/A	N/A	
Platelets	150-450*10*3/ mm3	N/A	N/A	
WBC	5.0-19.0*103/ mm3	N/A	N/A	
Neutrophils	13-33%	N/A	N/A	
Lymphocytes	46-76%	N/A	N/A	
Monocytes	0-5%	N/A	N/A	
Eosinophils	0-3%	N/A	N/A	
Basophils	0%	N/A	N/A	
Bands	5-11%	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 mEq/L	N/A	N/A	
K+	3.5-5.5 mEq/L	N/A	N/A	
Cl-	95-105 mEq/L	N/A	N/A	
Glucose	70-110 mg/ dL	N/A	N/A	

BUN	**5-25 mg/dL**	**N/A**	**N/A**	
Creatinine	**0.3-0.7 mg/ dL**	**N/A**	**N/A**	
Albumin	**3.4-5.2 g/dL**	**N/A**	**N/A**	
Total Protein	**6.0-8.0**	**N/A**	**N/A**	
Calcium	**8.8-10.1 mg/dL**	**N/A**	**N/A**	
Bilirubin	**0.2-1.0 mg/ dL**	**N/A**	**N/A**	
Alk Phos	**3.5-6.8 mg/ dL**	**N/A**	**N/A**	
AST	**15-50 units/ L**	**N/A**	**N/A**	
ALT	**5-55units/L**	**N/A**	**N/A**	
Amylase	**30-115 units/L**	**N/A**	**N/A**	
Lipase	**25-120 units/L**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	**3-15**	**N/A**	**N/A**	
CRP	**0-1.0 mg/dL**	**N/A**	**N/A**	
Hgb A1c	**4-6%**	**N/A**	**N/A**	
TSH	**0.32-5.0ulu/ ml**	**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	Admission	Today's	Reason for Abnormal

	Range	or Prior Value	Value	
Color & Clarity	**Colorless, yellow, clear.**	**N/A**	**N/A**	
pH	**4-9**	**N/A**	**N/A**	
Specific Gravity	**1.001-1.035**	**N/A**	**N/A**	
Glucose	**Negative**	**N/A**	**N/A**	
Protein	**negative**	**N/A**	**N/A**	
Ketones	**Negative**	**N/A**	**N/A**	
WBC	**0-4/HPF**	**N/A**	**N/A**	
RBC	**0-4/HPF**	**N/A**	**N/A**	
Leukoesterase	**0-4/LPF**	**N/A**	**N/A**	

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

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**N/A**	**N/A**	
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	
Respiratory ID Panel: Covid-19 Virus PCR (2019).	**Negative**	**Not detected**	**N/A**	

Lab Correlations Reference (1) (APA):

Holman, H.C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC.

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The only lab drawn for this client is COVID 19

Diagnostic Test Correlation (5 points): The test came back negative.

Diagnostic Test Reference (1) (APA):

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

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

Brand/Generic	**Clindamycin Hydrochloride/Cleocin** (Jones & Bartlett, 2020, P. 252-254).	**Acetaminophen/ Tylenol** (Jones & Bartlett, 2020, P. 9-12).			
Dose	**194.67 mg**	**217.6 mg**			
Frequency	**Every 8 hours**	**Every 4 hours PRN**			
Route	**IVPB**	**Oral**			
Classification	**Antibiotic/ Lincosamide**	**Antipyretic and analgesic**			
Mechanism of Action	**This drug inhibits protein synthesis in**	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production**			

	susceptible bacteria by binding to the 50s subunits of bacterial ribosomes and preventing peptide bond formation, which causes bacterial cells to die.	**and interferes with pain impulse generation in the peripheral nervous system.**			
Reason Client Taking	**The client is taking it to treat periorbital cellulitis of the right eye.**	**The client is taking it for pain rate from 1-3 and fever of 1004 F.**			
Concentration Available	**300 mg in each 50 ml**	**160 mg in each 5 mL**			
Safe Dose Range Calculation	**20-40 mg/kg equally divided doses tree times daily. 20mg*14.6kg=292mg 40mg*14.6kg=584mg The client is within safe dose range.584/3=194.67mg**	**10.9-15.9 mg/kg every 4 hours. 10.9mg*14.6kg=159.14mg 15.9mg*14.6kg=232.14mg The client is within safe dose range.**			
Maximum 24-hour Dose	**584 mg**	**800 mg/24 hours per drug book.**			
Contraindications (2)	**Hypersensitivity to clindamycin & lincomycin or any of the components.**	**Hypersensitivity to medication & Severe hepatic or renal disease.**			
Side Effects/Adverse Reactions (2)	**Clostridium difficile associated diarrhea & hypotension.**	**Nausea Abdominal pain & Loss of appetite**			
Nursing Considerations (2)	**Check the IV site for phlebitis and irritation & Monitor CBC, liver enzyme, and platelet counts during prolonged therapy.**	**Monitor hepatic and renal function tests. & Use cautiously in patients that have hepatic impairment or active hepatic disease.**			
Client Teaching needs (2)	**Instruct the client to complete the rescripted course of therapy even if she**	**Tablets may be crushed or swallowed whole. & Teach patient to identify**			

	feels better before it is finished. & Urge the client to report bloody watery stools to the provider immediately, even up to 2 months after drug therapy has ended.	**signs of hepatoxicity.**			

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

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The client appears alert and oriented to person, time, and place. The client is well-groomed and speaks English well in short sentences.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:** **IV Assessment (If applicable to child):** **Size of IV: 22 G** **Location of IV: Dorsal venous network on the left hand.** **Date on IV: 10/28/21** **Patency of IV: slightly hard to flushed.** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: Clear, dry, and intact.** **IV Fluid Rate or Saline Lock: 102.6 ml/hr**	**Braden scale: 23** **The client's skin is warm, pink, and dry. Skin turgor is expected because the client is not dehydrated. She does not have rashes, wounds, and no drains noted. She has a little scar at right cheek.**

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	**Head normocephalic and neck is symmetrical, the trachea is midline without deviation, normal thyroid, carotid pulse palpable 2+ bilateral. The ear canal is transparent, and the tympanic membranes are pearly grey bilateral. Pupils: PERLA, Conjunctive pink bilateral. The client does not wear glasses, the nose is midline, no polyp noted. The sclera is red and not tender to touch. Healing scabs surround the right eye.**
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 client is not on telemetry. S1 and S2 are noted. Regular rhythm and apical pulse are present. Peripheral pulses palpable 2+ throughout bilateral, capillary refill is less 2 sec, no cyanosis or murmur. No pitting edema bilateral nor neck vein distention.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Normal rhythm, rate, and respiration are not labored bilateral; no crackles were noted bilaterally.**
GASTROINTESTINAL: **Diet at home:** **Current diet:** **Height (in cm): 155 cm** **Auscultation Bowel sounds: normative bowel sound for all four quadrants.** **Last BM: 10/29 in the afternoon.** **Palpation: Pain, Mass etc.: N/A** **Inspection: Skin is pink with normal size of the abdomen.** **Distention: N/A** **Incisions: N/A** **Scars: little scar in the right cheek.** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**The client is on a regular diet at home and hospital. The client at about 75% of her food. The abdomen is soft, non-tender, no mass noted during palpation for all four quadrants. Normal bowel sounds bilateral, without abdominal cramping.**

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**The caregiver reports that urine is yellow and average quantity. The patient does not have pain during urination. Genital is clean and dry without lesion. The client is using the restroom.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 20 because the client has an IV** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**The client is alert and oriented to person, place, and time. She tested negative for the Homan sign. Normal range of motion, equal strength 5/5, does not use an assistive device. The patient still needs caregiver's assistant for some activities of daily living due to age. The patient is active, able to stand up alone, walk, eats, puts cloths on and takes them off.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patient is awake, oriented PERLA, equal strength, expected level of conscience, no sensory deficit, and an average pace of speech.**
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 uses family support for coping methods, has not attempt school yet and does not have a religious preference. She used to live with her father. The mother is the one will be caring of the patient after discharge.**

Vital Signs, 2 sets (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0800	**79**	**117/59**	**20**	**97.8 F Axillary**	**99% on room air.**
1600	**82**	**N/A**	**21**	**97.5 F Axillary**	**99% on room air.**

Vital Sign Trends: All vital signs are within normal range and no abnormal value were noted.

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

Pulse Rate	**70-120/minute**
Blood Pressure	**Systole: 86-117** **Diastole: 47-76**
Respiratory Rate	**20-25/min**
Temperature	**99.0 F axillary**
Oxygen Saturation	**97-100%**

Normal Vital Sign Range Reference (APA):

Holman, H.C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	**Faces pain scale**	**The client denied any pain**	**N/A**	**N/A**	**N/A**
Evaluation of pain status *after* intervention	**The client denied pain and did not show any signs of pain during clinical.**	**N/A**	**N/A**	**N/A**	**N/A**
Precipitating factors: The client denied any pain. **Physiological/behavioral signs: The patient was awake, calm, watching movies on the phone. The patient did not display nonverbal signs of pain.**					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
1867.3 ml	**801 ml**

Developmental Assessment (6 points)
Be sure to highlight the achievements of any milestone if noted in y our child. Be sure to highlight any use of diversional activity if utilized during clinical. There should be a minimum of 3 descriptors under each heading

Age Appropriate Growth & Development Milestones

1. **The client can walk backward**
2. **The client can balance on a low-balance beam.**
3. **She can walk in a line**.

Age Appropriate Diversional Activities

1. **This client can put puzzles together.**
2. **Ride a tricycle.**

3. **Jump with two feet.**

Psychosocial Development:

Which of Erikson's stages does this child fit?

This patient is in initiative VS. guilt. During this age, children become energetic to learn. When a preschooler cannot accomplish a task, they feel guilty. Also, setting limits is vital during this age.

What behaviors would you expect?

At this age, children ask a lot of questions because they need to understand how things work. They have less separation anxiety, pretend play, they know reality and fantasy.

What did you observe?

The child told me her name, asked questions, wanted to know what I was doing and why I was doing it during the assessment. She allowed me to do the evaluation. The patient told the caregiver that she was angry and afraid of the provider but loved the nursing staff.

Cognitive Development:

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

This child belongs to the preoperational phase, in which the child has magical thinking, animism, centration and understands others' points of view and time.

What behaviors would you expect?

This age focus on one aspect, understanding routine and sequence of daily event. Children of this age understand the difference between happiness, sadness, afraid, and angry.

What did you observe?

The child was happy while watching movies on her mother's phone; however, she became anxious and afraid when connecting the clindamycin to her IV. The child was bothering her mother about the Halloween costume. She wanted to celebrate, but the hospitalization made her sad because she missed the Halloween event.

Vocalization/Vocabulary: Preschoolers speak in three to four words at the tree and four years. During this age, children enjoy talking, and language becomes their first method of communication. This client speaks clearly with a 4-word sentence. She sometimes has incorrect vocabulary, but the caregiver understands the meaning. She was able to answer questions about her identity.

Development expected for child's age and any concerns?

This child does not show any concerns currently.

Any concerns regarding growth and development?

The caregiver does not have concerns about growth and development.

Developmental Assessment Reference (1) (APA):

Holman, H.C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC.

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

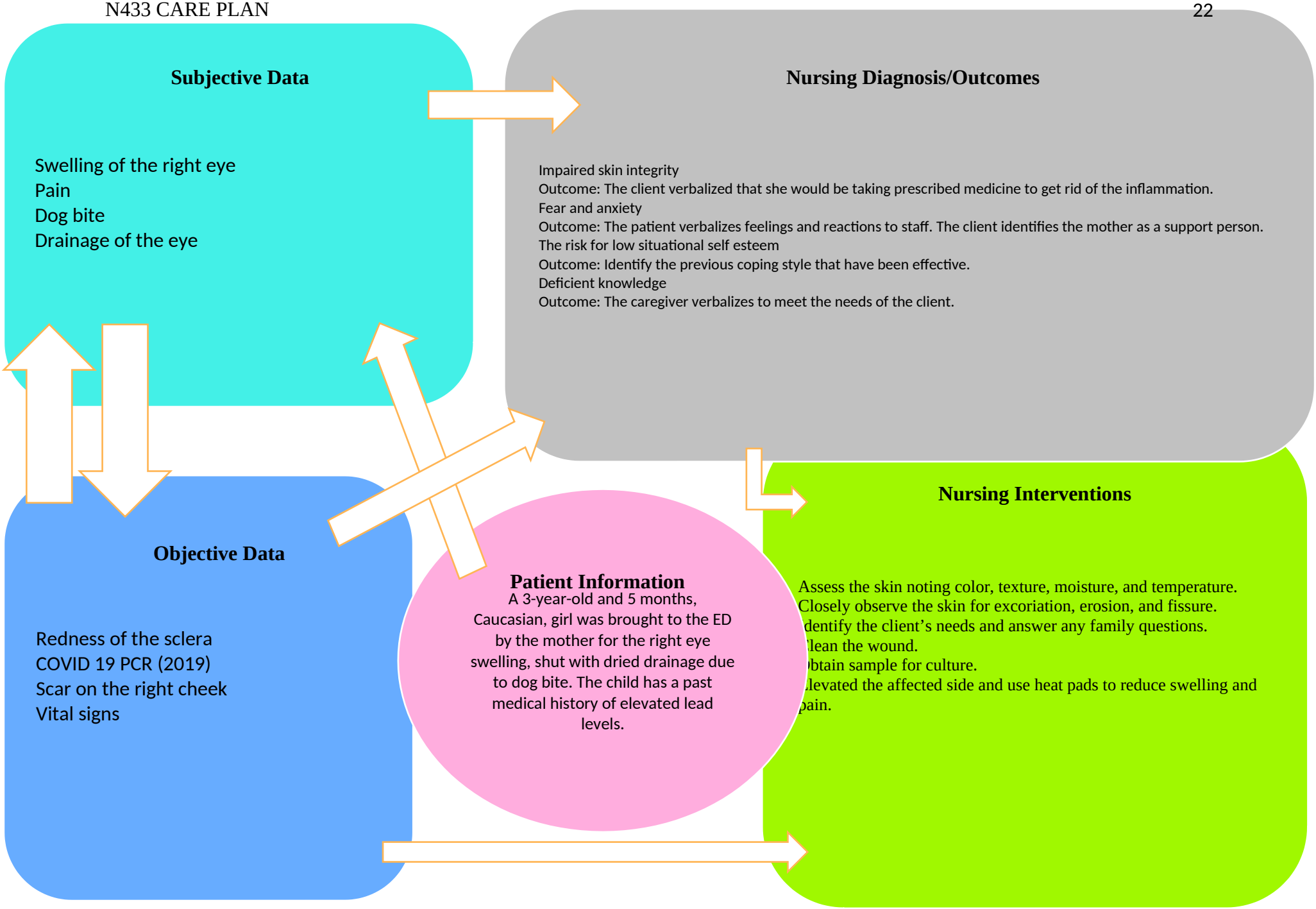
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. **Impaired skin integrity is related to skin inflammation secondary to cellulitis, as evidenced by swelling of the right eye.**	**This diagnosis was chosen because the client exhibited signs of inflammation.**	**1. Assess skin, noting color, moisture, texture, temperature, erythema, and tenderness.** **2. Assess skin for lesions, noting the presence of excoriations, erosions, fissures, or ticking.**	**The client verbalized that she would be taking prescribed medicine to get rid of the inflammation.**
2 Fear and anxiety related to being around the dog as evidenced by the dog bite.	**The patient may refuse to visit a park due to fear of being bitten again by**	**1. Assess the patient's fear and identify the need for education.**	**The patient verbalizes feelings and reactions to staff. The client identifies the mother**

	a dog.	**2. Encourage the client to share feelings with her caregiver.**	**as a support person.**
3 **The risk for low situational self-esteem is related to body image change, as evidenced by the scar on the right cheek.**	**Having a scar on a face can be uncomfortable when the patient is around peers in school.**	**1. Assess patient's and family's responses and reactions to illness and treatment.** **2. Assess usual coping patterns of patient and family members.**	**Identify the previous coping style that has been effective.** **The client's caregiver verbalized the need for counseling to cope with changes.**
4 **Deficient knowledge regarding the condition and treatment related to misunderstanding, evidenced by the father's failure to bring the child to the hospital after a dog bite.**	**The diagnosis is pertinent because child neglect after a dog bite can result in sepsis, meningitis, or death. Also, the CDEF can take the child away from parents, and they will lose the bonding between caregivers and the child.**	**1. Assist the client's caregiver in identifying ways to incorporate changes related to the illness and treatment into the lifestyle.** **2. Educate the caregiver on the consequences of child neglect and the prognosis of a dog bite. Provide oral and written information in the caregiver's appropriate language.**	**The caregiver will verbalize understanding and acceptance to make changes. The caregiver will vernalize to meet the needs of the patient and provide a good parenting style.**

Other References (APA):

Concept Map (20 Points):

Ricci, S.S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.


Subjective Data
Swelling of the right eye
Pain
Dog bite
Drainage of the eye
Nursing Diagnosis/Outcomes
Impaired skin integrity
Outcome: The client verbalized that she would be taking prescribed medicine to get rid of the inflammation.
Fear and anxiety
Outcome: The patient verbalizes feelings and reactions to staff. The client identifies the mother as a support person.
The risk for low situational self esteem
Outcome: Identify the previous coping style that have been effective.
Deficient knowledge
Outcome: The caregiver verbalizes to meet the needs of the client.
Objective Data
Redness of the sclera
COVID 19 PCR (2019)
Scar on the right cheek
Vital signs
Patient Information
A 3-year-old and 5 months, Caucasian, girl was brought to the ED by the mother for the right eye swelling, shut with dried drainage due to dog bite. The child has a past medical history of elevated lead levels.
Nursing Interventions
Assess the skin noting color, texture, moisture, and temperature.
Closely observe the skin for excoriation, erosion, and fissure.
dentify the client's needs and answer any family questions.
lean the wound.
btain sample for culture.
levated the affected side and use heat pads to reduce swelling and
ain.