

N433 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/29/21	Patient Initials KB	Age (in years & months) 13 years 4 months	Gender Female
Code Status FULL	Weight (in kg) 48.4 kg	BMI 20.84 kg/m ²	Allergies/Sensitivities (include reactions) No known allergies

Medical History (5 Points)

Past Medical History: The patient does not have any previous diagnoses.

Illnesses: The patient does not have any previous illnesses according to her mother.

Hospitalizations: The patient has no previous hospitalizations.

Past Surgical History: The patient has not had any past surgeries.

Immunizations: The patient is up to date on all her immunizations per patient's mother. The patient does not have their Covid-19 vaccine, but they are considering it.

Birth History: The patient and her mother were discharged 2 days after delivery.

Complications (if any): There were no complications.

Assistive Devices: The patient wears glasses.

Living Situation: The patient lives in an apartment with her mother and older sister.

Admission Assessment

Chief Complaint (2 points): Poor energy

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

Pertinent Events during this admission/hospitalization (1 points):

The patient, a 13-year-old female, was transferred from Saint Mary's Hospital in Kankakee with severe anemia. The patient was transfused with 150 mL of packed red blood cells

from the referring hospital. The patient tolerated the transfusion without any adverse reactions. Her hemoglobin improved to 5.7. The patient was given 1 unit of packed red blood cells after her transfer and her hemoglobin improved to 7. The patient was also given venofer for iron deficiency anemia. The patient's vitals remained stable during her hospital stay. The physician ordered a fecal occult blood test, but the patient did not stool during her hospital stay.

History of present Illness (10 points):

O: The patient, a 13-year-old female, was transferred from Saint Mary's Hospital in Kankakee with severe anemia. L: The patient was seen in the clinic for her "body always feeling tired, but not being tired." D: The patient states that she has been feeling this way for "the last nine months" but that it got worse after she moved from Arizona to Illinois. C: The patient states that she "couldn't keep up with friends" and always felt out of breath. A: The patient denies any chest pain, coughing, or fever. The patient also denies any body aches or pain. R: The patient states that nothing relieves her symptoms. Sleep does not help improve her energy level. T: The patient was seen at a clinic before being admitted to Saint Mary's Hospital and then transferred to Carle's pediatric intensive care unit.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Severe anemia

Secondary Diagnosis (if applicable): N/A

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

Anemia is denoted by the decline in red blood cells' volume due to loss or destruction. The decrease in red blood cells results in the blood cells no longer having the ability to keep up

with the body's demand for oxygen. Iron deficiency anemia arises due to the body not having enough iron in the blood to produce hemoglobin. Bone marrow relies on iron for the production of hemoglobin, a reduction of iron leads to a decrease in hemoglobin production. The body requires an adequate intake of dietary iron to ensure the production of hemoglobin to make alterations in cell structures, repair malfunctioning bone marrow, and aid in the body's immune response. Without an adequate amount of hemoglobin, the body will begin to show signs of weakness and fatigue from the body's reduced oxygen-carrying capacity in the blood (Ricci et al., 2021).

In addition to weakness and fatigue, a child can have growth and cognitive delay, behavioral changes, diminished quality of life, increased risk for thromboembolic events, headaches, restless legs syndrome, and pica. Hemoglobin levels can change throughout childhood. For this reason, it is essential to monitor their growth and development. Iron deficiency anemia is the most common type of anemia in children due to their picky eating causing insufficient intake of specific nutrients. Children may also have gastrointestinal complications that may inhibit the absorption of iron. When assessing a child with anemia, look for symptoms of irritability, headache, dizziness, weakness, shortness of breath, pallor, and fatigue. More subtle signs to note include difficulty feeding, pica, muscle weakness, or unsteady gait. The nurse should also inspect mucous membranes, palms, soles, and skin for pallor. Fingernails may have a spooned appearance. Vitals that need to be obtained include oxygen saturation, heart rate, heart sounds, and abdominal assessment. Pulse oximetry reading is performed to ensure the patient is getting enough oxygen. Monitoring the heart rate is to ensure the patient is not experiencing tachycardia. Auscultation of the heart is performed to ensure the

patient does not have a flow murmur. Palpation of the abdomen is performed to assess for splenomegaly (Ricci et al., 2021).

The measurement of hemoglobin and hematocrit levels in the blood is used to identify anemia. Abnormally low hemoglobin, hematocrit, reticulocytes, serum iron, and ferritin levels are indicators of anemia. The patient may also have increased levels of free erythrocyte protoporphyrin. Low levels of hemoglobin include anything below 11g/dL. Low levels of hematocrit include anything below 35%. Low serum iron includes levels below 30mcg/dL. Low ferritin is serum levels below 100 mg/dL (Ricci et al., 2021).

Treatment for a patient with anemia aims to eliminate symptoms, correct the deficiency, and replenish iron provisions. The recommended intake of iron for children ages 9 to 13 is 8 milligrams. The treatment may be accomplished by iron supplementation. For moderate cases of iron deficiency anemia over the counter ferrous sulfate or ferrous fumarate tablets can be taken. For severe cases of iron deficiency anemia, transfusions of packed red blood cells may be needed. Blood bank guidelines must be followed for packed red blood cell administration. Laboratory results need to be monitored to determine if the treatment is having a therapeutic effect (Ricci et al., 2021).

Nurses should educate the patient and parents on the importance of adhering to drug therapy and a diet of iron-rich foods. The patient may need to be educated on foods rich in iron, such as peanut butter, whole grains, iron-fortified cereals, dried fruits, leafy green vegetables, and meats. Red meats seem to be the easiest for the body to absorb. Inform the patient to take iron tablets with orange juice to promote absorption. Taking iron on an empty stomach also aids in iron absorption but can cause adverse effects such as upset stomach, nausea, vomiting, diarrhea, metallic taste, anorexia, and constipation. Iron can be taken with meals to prevent these

effects of the medication. Increased fluid intake, dietary fibers, or stool softeners may also be needed to aid patients who experience constipation. Advise patients to limit intake of cow's milk, tea, coffee, chocolate, and high fiber foods, which can inhibit iron absorption. Inform the patient's parents that decreased oxygen supply to the brain can potentially cause changes in neurological functioning and affect the patient's energy levels and appetite. Manifestations that the parents should look out for to protect the child from injury are unsteady gait or dizziness. Parents should also be taught to measure iron in liquid form, and that liquid iron can stain teeth (Ricci et al., 2021).

The patient was admitted with severe anemia and complained that her body "always feels tired without being tired." She had a hemoglobin of 5.7 upon admittance. The patient was given packed red blood cells for her severe anemia. The patient's vitals were monitored every hour. The patient's hemoglobin increased to 7. The patient was educated on iron-rich foods and that she will need to take iron supplements to prevent her hemoglobin from decreasing.

Pathophysiology References (2) (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. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: The patient has not activity	N/A

orders.	
Diet/Nutrition: Regular diet	The patient is on a regular diet per protocol.
Frequent Assessments: vital signs every hour (q1h), I&O q2h, neuro checks and Glasgow Coma Scale q1h x3, skin care protocol, elevate head of bed, maintain IV access.	Notify provider if pulse <45. >120; temperature >39 degrees Celsius; RR >35, <8; systolic BP >160, <90; MAPm<50; urine output <mL/kg for 6 hours.
Labs/Diagnostic Tests: Blood glucose monitoring before meals and at bedtime (AC/HS), leuko-reduced RBC (type and cross), CBC with differential, Von Willebrand profile.	Labs have been ordered to monitor therapeutic effect of treatment.
Treatments: 1 unit of packed red blood cells	The patient received the packed red blood cells without complication.
Other: fecal occult blood test, iron, and total iron-binding capacity	The patient did not stool during her hospitalization.
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
Weigh daily before breakfast.	To ensure patient is maintaining adequate fluid intake.
N/A	N/A
N/A	N/A

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	3.95-4.9	3.47	3.76	These low values may be due to the patient's iron deficiency anemia (Ricci et al., 2021).
Hgb	10.8-13.3	5.7	7	These low values may be due to the patient's iron deficiency anemia (Ricci et al., 2021).
Hct	33.4-40.4	21.5	24.7	These low values may be due to the patient's iron deficiency anemia (Ricci et al., 2021).
Platelets	194-345	N/A	1334	These low values may be due to the patient's iron deficiency anemia (Ricci et al., 2021).
WBC	4.19-9.43	N/A	7.5	This lab value is within range (Ricci et al., 2021).
Neutrophils	32-54	N/A	N/A	N/A
Lymphocytes	27-57	N/A	20.4	This low level may be due to stress of being in the hospital (Ricci et al., 2021).
Monocytes	0-5	N/A	10.5	This low level may be due to the patient's iron deficiency anemia or stress of being in the hospital (Ricci et al., 2021).
Eosinophils	0-3	N/A	0.8	This lab value is within normal range (Ricci et al., 2021).
Basophils	0-1	N/A	0.7	This lab value is within normal

				range (Ricci et al., 2021).
Bands	5-11	N/A	N/A	N/A
Ferritin	7-140	2.1	N/A	These low values may be due to the patient's iron deficiency anemia (Ricci et al., 2021).
Reticulocyte	0.9-1.49	0.42	N/A	These low values may be due to the patient's iron deficiency anemia (Ricci et al., 2021).

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	N/A	N/A	N/A
K+	3.5-5.1	N/A	N/A	N/A
Cl-	98-107	N/A	N/A	N/A
Glucose	74-100	N/A	N/A	N/A
BUN	5-17	N/A	N/A	N/A
Creatinine	0.55-1.3	N/A	N/A	N/A
Albumin	3.8-5.4	N/A	N/A	N/A
Total Protein	6-8	N/A	N/A	N/A
Calcium	8.8-10.8	N/A	N/A	N/A
Bilirubin	0.2-1.2	N/A	N/A	N/A
Alk Phos	9-500	N/A	N/A	N/A
AST	5-34	N/A	N/A	N/A
ALT	0-55	N/A	N/A	N/A
Amylase	30-155	N/A	N/A	N/A

Lipase	25-120	N/A	N/A	N/A
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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	3-13	N/A	N/A	N/A
CRP	0-0.50	N/A	N/A	N/A
Hgb A1c	4.5-5.7	N/A	N/A	N/A
TSH	0.350-4.94	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	Yellow and clear	N/A	N/A	N/A
pH	4-9	N/A	N/A	N/A
Specific Gravity	1.001–1.035	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	<5	N/A	N/A	N/A
RBC	<5	N/A	N/A	N/A
Leukoesterase	Negative	N/A	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	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A
Respiratory ID Panel	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient did not have any diagnostic testing during her hospital stay.

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA):

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

Current Medications (8 points)

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

Brand/ Generic	0.9% NaCl w/ KCl 20 mEq	Famotidine/ pepcid	Ondansetron HCl (PF)	Iron sucrose/ venofer 300mg in 0.9% NaCl	The patient was only on 4 medicati ons
Dose	5 mL/hr	20 mg	4 mg	300 mg	N/A
Frequency	Continuou s	q12h	As needed, may repeat x1	177 mL/hr once	N/A
Route	IV	IV push	IV push	IVPB	N/A
Classificatio n	Electrolyte supplemen t	Histamine H2- receptor inhibitor	Antiemetic/ antivertigo agent	Iron mineral/ hematinic	N/A
Mechanism of Action	This drug is capable of inducing diuresis depending on the clinical condition of the patient.	Reduces HCl formation by preventing histamine from binding with H2 receptors on the surface of parietal cells. This prevents peptic ulcers from forming and helps heal existing ones.	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action prevents nausea and vomiting.	Normalizes RBC production by binding with hemoglobin or being stored as ferritin in reticuloendot helial cells of the bone marrow, liver, or spleen.	N/A
Reason Client Taking	To provide potassium replaceme nt	To prevent indigestion	To prevent Nausea, vomiting, dizziness	To treat iron deficiency anemia	N/A
Concentratio n Available	20mEq	20 mg/mL	4mg/2mL	300mg	N/A
Safe Dose Range Calculation	2-4mEq/ kg/day= 96.8-193.6 mEq Dose is safe.	1mg/kg/ day=48.4mg Dose is safe.	2mg/kg/ day=96.8mg Dose is safe	25-500mg/ dose Dose is safe.	N/A
Maximum 24-hour Dose	100mEq	40 mg	16mg/dose	Dose should not exceed 7mg/kg or	N/A

				500 mg	
Contraindications (2)	Allergy to corn or corn products. Hyperkalemia.	Hypersensitivity to famotidine, other H2-receptors, or their components.	Concomitant use of apomorphine, hypersensitivity to ondansetron or its components.	Anemia other than iron deficiency, hypersensitivity to iron components, iron overload.	N/A
Side Effects/ Adverse Reactions (2)	Cardiac arrhythmia. Pulmonary edema.	Agranulocytosis. Laryngeal edema.	Hypotension. Arrhythmias.	Hypertension . Anaphylaxis	N/A
Nursing Considerations (2)	-Do not administer undiluted or IV push as this can cause cardiac arrest. -Verify dosage before administering.	-Give over 2 minutes. -Dilute 20mg with 5-10 mL normal saline.	-Know that if hypokalemia or hypomagnesemia is present, these electrolyte imbalances should be corrected before ondansetron is administered because of the increased risk for QT-interval prolongation. -Monitor patient closely for hypersensitivity.	Cannot be given IM. Monitor Vital signs.	N/A
Client Teaching needs (2)	-Have labs checked often. -Take as prescribed .	-Instruct patient to chew tablet thoroughly before swallowing. -Caution the patient to avoid alcohol and smoking during famotidine therapy because they	-Advise patient to immediately report signs of hypersensitivity, such as rash. -Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours.	-Inform patient that symptoms of iron deficiency may include decreased stamina, fatigue, learning problems, and shortness of breath. -Instruct	N/A

		irritate the stomach and delay ulcer healing.		patient to report any of the following signs and symptoms of an allergic reaction that may develop during and following the infusion of iron sucrose: breathing problems, dizziness, itching, light-headedness, rash, and swelling.	
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Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient was alert and oriented to person, place, time, and reason for visit. The patient was in no apparent distress. The patient was well groomed.</p>
<p>INTEGUMENTARY: Skin color: tawny Character: warm, dry Temperature: 98.3F Turgor: elastic Rashes: No Bruises: No Wounds: No Braden Score: 28 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p> <p>IV Assessment (If applicable to child): Size of IV: 20 gauge Location of IV: right hand Date on IV: 10/29/21</p>	<p>The patient’s skin is tawny colored and normal for ethnicity. Her skin is warm, dry, and intact. Her skin turgor is elastic. The patient is free of any rashes, bruises, and wound/incisions. The patient’s Braden score is 28. There are no drains present. The patient has a 20-gauge I.V. in her right hand metacarpal vein that was placed on 10/29/21 as indicated by the tape over the insertion site. Her I.V. is flushing without complications. No drainage, swelling, warmth, or redness was present. The dressing was clean, dry, and intact. The patient is currently receiving iron sucrose and normal saline.</p>

<p>Patency of IV: flushes without difficulty Signs of erythema, drainage, etc.: No signs or erythema or drainage. IV dressing assessment: clean, dry, intact IV Fluid Rate or Saline Lock: iron sucrose and normal saline.</p>	
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>The patient's head and neck are both midline and symmetrical. There is no deviation of the trachea. Her ears are symmetrical bilaterally. The patient wears glasses. Both of the patient's eyes were symmetrical and proportionally placed. The patient's nares are equal bilaterally with no deviation of the septum. There was no drainage of her eyes, ears, or nose upon inspection. The patient's teeth were intact. No nose bleeds or gum bleeds. Lymph nodes were nonpalpable.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: 2+ bilaterally Capillary refill: < 3 seconds 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>S1 and S2 sounds were present with normal sinus rhythm. No S3 sounds, S4 sounds, or murmurs were heard. Both carotid pulses were palpated one at a time and 3+. Radial, brachial, posterior tibial, popliteal, dorsalis pedis pulse sites were 3+ bilaterally. The patient's capillary refill was less than 3 seconds on their fingers and toes bilaterally. No pitting edema was present when assessing the patient's extremities.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Upon auscultation, the patient's breath sounds were clear and even bilaterally without any use of accessory muscles.</p>
<p>GASTROINTESTINAL: Diet at home: Current diet: regular Auscultation Bowel sounds: Last BM: yesterday Palpation: Pain, Mass etc.: Inspection: Distention: No Incisions: No Scars: No Drains: No Wounds: No Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>The patient states that she eats a lot of red meat, veggies, and fruit. The patient states that she dislikes drinking milk. The patient on a regular diet during her hospital stay. The patient states that she is "hungry one minute and then all of the sudden lose my appetite." The patient denies any dark tarry stools. The patient states her last bowel movement was yesterday. Her bowel sounds are normoactive in all four quadrants. No masses were noted upon palpation. The patient does not have any distention, drains, or wounds.</p>

<p>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>GENITOURINARY: Color: yellow Character: clear 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: N/A Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>The patient states that her urine is yellow and clear. She can use the bathroom independently. The patient denies any pain with urination.</p>
<p>MUSCULOSKELETAL: 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"/> Fall Score: 2 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’s neurovascular status is intact. The patient moves all extremities without difficulty. The patient does not utilize any supportive devices. The patient displays equal strength bilaterally. The patient has a fall score of 2 on the Cummings Pediatric Fall Assessment Scale.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: clear and concise Sensory: reactive LOC: No</p>	<p>The patient moves all extremities without difficulty and with equal strength. Her pupils are equal, round, and reactive to light and accommodation. She is alert and oriented to person, place, time, and reason for the visit. The patient does not seem to have an impaired mental status. Her speech started clear and concise. The patient has not lost consciousness.</p>
<p>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):</p>	<p>The patient moved to Illinois from Arizona in April. The patient is in 8th grade. Her favorite subject is math and her least favorite is science. The patient uses music as a coping method. The patient states that she has a good support system and is very close to her mom and sisters. The patient’s mother and older sister were in the room with the patient. They were laughing and joking.</p>

Vital Signs, 2 sets (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	97	101/67	31	98 F	100%
1030	97	100/60	18	98.3 F	100%

Vital Sign Trends: The patient’s vitals stayed within normal range throughout her hospital stay. The patient did have an increase of respirations to 31, but the provider did not need to be notified unless the breaths per minute exceeded 35.

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

Pulse Rate	55-100 beats per minutes
Blood Pressure	<120/80
Respiratory Rate	12-18 breaths per minute
Temperature	97.6-99.6 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
800	Numeric scale	The patient denies pain	0/10	The patient denies pain	The patient played video games.

Evaluation of pain status <i>after</i> intervention	Numeric	The patient denies pain	0/10	The patient denies pain	No interventions needed.
<p>Precipitating factors: The patient was not in any pain. Physiological/behavioral signs: The patient was content playing video games.</p>					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
480 mL of water and juice	500 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. **Developing her own identity.**
2. **Development of secondary sexual characteristics.**
3. **Peers become most important.**

Age Appropriate Diversional Activities

1. Team sports
2. **Video games**
3. Choir

Psychosocial Development:

Which of Erikson’s stages does this child fit? The child fitd Erikson’s identity vs. role confusion or diffusion.

What behaviors would you expect? For the patient to focus on bodily changes, experience frequent mood changes, and strive to master skills within peer groups.

What did you observe? The patient was self-conscious, her mood stayed consistent, and she wanted to be accepted by her older sister.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? The patient fit Piaget's formal operations.

What behaviors would you expect? The patient would be expected to have a limited abstract thought process, ego central thinking, and eager to apply limited abstract process to different situations and to peer groups.

What did you observe? I observed the patient eager to apply her limited abstract process to her diagnosis.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? The patient's vocabulary met the expectations of her age. The patient used correct grammar and communicated effectively. There were no concerns.

Any concerns regarding growth and development? There were no concerns regarding the patient's growth and development.

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

<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. Ineffective tissue perfusion related to severe anemia as evidenced by decreased amount of hemoglobin to transport oxygen.</p>	<p>I chose this nursing diagnosis because the patient has a hemoglobin level of 7.</p>	<p>1. Monitor and document vital signs, especially blood pressure and oxygen saturation.</p> <p>2. Provide oxygen as ordered.</p>	<p>The patient responded positively to the interventions. The patient is breathing on her own. The status is ongoing.</p>

<p>2. Fatigue related to decreased hemoglobin and diminished oxygen-carrying capacity of the blood as evidenced by reports of fatigue and lack of energy.</p>	<p>I chose this nursing diagnosis, because the patient complained of not being able to keep up with her friends.</p>	<p>1. Give packed red blood cells as prescribed.</p> <p>2. Educate on energy conserving techniques.</p>	<p>The patient responded well to packed red blood cells without any adverse complications. The mother and sister were supportive. The status is ongoing.</p>
<p>3. Deficit knowledge related to new condition as evidenced by questioning members of the healthcare team.</p>	<p>I chose this nursing diagnosis because the patient was unfamiliar with her diagnosis</p>	<p>1. Assess client's and family's understanding of the new medical vocabulary.</p> <p>2. Explain the importance of diagnostic procedures.</p>	<p>The patient and family were appreciative of the explanations and demonstrated an adequate understanding of the new diagnosis. The status is ongoing.</p>
<p>4. Knowledge deficit of medication administration related to severe anemia as evidenced by new diagnosis.</p>	<p>I chose this nursing diagnosis because the patient has never taken iron tablets before.</p>	<p>1. Advise patient to take with orange juice to increase absorption.</p> <p>2. Educate the patient and mother that the medication may cause constipation and that they should increase their dietary fiber intake.</p>	<p>The patient and mother responded well to the goal. The patient ordered orange juice with her breakfast. The status is still ongoing.</p>

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

The patient denies having any pain. The patient denies having to stool. The patient denies any nausea, vomiting, shortness of breath, or feeling faint.

Nursing Diagnosis/Outcomes

1. Ineffective tissue perfusion related to severe anemia as evidenced by decreased amount of hemoglobin to transport oxygen
 - The patient responded positively to the interventions. The patient is breathing on her own. The status is ongoing.
2. Fatigue related to decreased hemoglobin and diminished oxygen-carrying capacity of the blood as evidenced by reports of fatigue and lack of energy.
 - The patient responded well to packed red blood cells without any adverse complications. The mother and sister were supportive. The status is ongoing.
3. Knowledge deficit related to new condition as evidenced by questioning members of the healthcare team.
 - The patient and family were appreciative of the explanations and demonstrated an adequate understanding of the new diagnosis. The status is ongoing.
4. Knowledge deficit of medication administration related to severe anemia as evidenced by new diagnosis.
 - The patient and mother responded well to the goal. The patient ordered orange juice with her breakfast. The status is still ongoing.

Objective Data

Abnormal labs during clinical rotation:

RBC: 3.76
 Hgb: 7
 Hct: 24.7
 Platelets: 1334
 Lymphocytes: 20.4
 Monocytes: 10.5

Last set of vitals taken:

Temperature: 98.3 F
 RR: 18
 Pulse: 97
 B/P: 100/60
 O2: 100%

Patient Information

KB, a female patient is 13 years and 4 months old. She is up to date on all of her immunizations and has no known allergies. The patient wears glasses and lives with her mother and older sister. For severe anemia, the patient was transferred from Saint Mary's Hospital to Carle's pediatric intensive care unit. The patient was transfused with 150mL of packed red blood cells on her way to the hospital. Her hemoglobin improved to 5.7. After her transfer, the patient was given 1 unit of packed red blood cells, which improved her hemoglobin to 7. The patient is currently being given venofer for iron deficiency anemia.

Nursing Interventions

1. Monitor and document vital signs, especially blood pressure and oxygen saturation.
2. Provide oxygen as ordered.
3. Give packed red blood cells as prescribed.
4. Educate on energy conserving techniques.
5. Assess client's and family's understanding of the new medical vocabulary.
6. Explain the importance of diagnostic procedures.
7. Advise patient to take with orange juice to increase absorption.
8. Educate the patient and mother that the medication may cause constipation and that they should increase their dietary fiber intake.