N433 Care Plan # 1

Lakeview College of Nursing

Name: Richard Kumpi

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
11/05/21	A.S	16 y.o	Female
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	74.5 Kg	24.89Kg/ 85%	Milk, Mite Extract, Cefdinir

Medical History (5 Points)

Past Medical History: Postural orthostatic tachycardia syndrome POTS, Amplified musculoskeletal pain syndrome, ANA positive, Dysautonomia, Fracture of medial malleolus, GERD,

Illnesses: N/A

Hospitalizations: parents not available and patient cannot provide information

Past Surgical History: Upper GI endoscopy (2016).

Immunizations: The patient's immunization is up to date. She has received COMVAX-HEP B/PEDVAX HIB, DTaP-Daptacel (Diptheria, Tetanus, Pertussis), Human Papillomavirus (Gardasil 9), Measles, Mumps, Rubella (MMR), Meningococcal MENACTRA, Polio Virus, T-dap (BOOSTRIX), Varicella virus (VARIVAX), Pneumonia (PREVNAR).

Birth History: parents not available and patient cannot provide information

Complications (if any): Not available

Assistive Devices: None

Living Situation: The patient lives with the mother and the father. Patient is a junior at High School and is on the dance team.

Admission Assessment

Chief Complaint (2 points): dizziness, syncope.

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

Pertinent Events during this admission/hospitalization (1 points): patient was directed from cardiology clinic

History of present Illness (10 points): On November 5th, 21 a Caucasian adolescent female was directed to the inpatient department directly from Carle cardiology clinic for dizziness and syncope. The client stated that she started feeling dizzy in her head since couple days ago. The patient seemed lethargic and stated not seeming herself to others. Patient acknowledged having episodes of dizziness, fatigue, anxiety, difficulty with sleeping and focusing, chest tightness, shortness of breath causing her to feel unwell and missed school. Patient is concerned that she may be dropped from dance team. At arrival to the hospital, patient was put on 20 gauge IV 0.9% normal saline and bedrest.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): syncope

Secondary Diagnosis (if applicable): None

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

Syncope or fainting is defined as an unexpected loss of consciousness and muscle tone caused by an insufficient short-term supply of blood flow to the brain. With the rapid onset, patients become unresponsive and spontaneously recover completely (Kalischer Wellander et al., 2019). Precursor signs and symptoms include weakness, headache, diaphoresis, blurred vision,

nausea, and vomiting that occur for seconds or minutes before loss of consciousness (Cheshire, 2017). The brain needs to be constantly supplied with blood to function correctly; any interruption to this process for a few seconds causes loss of consciousness or syncope. A complex mechanism connecting cardiac output, arterial pressure, systemic vascular resistance, and intravascular volume maintains cerebral blood flow. Any malfunction in one or more of these systems causes a decreased blood flow to the brain (Cheshire, 2017).

Depending on underlying causes, there are several types of syncope, such as neurally mediated syncope (NMS), which is the most common underlying cause of pediatric syncope. It includes cardio-neurogenic syncope or vasovagal syncope, characterized by a sudden drop in blood pressure, causing a drop in blood flow to the brain as a result of the vagus nerve sending a message to the heart to stop or slow beating; the blood pressure drops and causes the patient to faint (Liao & Du, 2020). Postural orthostatic tachycardia syndrome is caused by an increased heart rate when a patient stands up after sitting or lying down. The patient experiences palpitations, fatigue, and lightheadedness, causing the patient to faint. Situational syncope occurs during situations that affect the nervous system. Some conditions include dehydration, intense emotional stress, anxiety, fear, defecation, micturition, coughing, or sneezing (Liao & Du, 2020).

Depending on circumstances and symptoms, syncope can be diagnosed using a head-up tilt test, electrocardiogram (EKG), Echocardiogram. Some laboratory tests can be done, such as Chloride, BUN for dehydration, and blood pressure readings (Cheshire, 2017). For this particular patient, none of these diagnostic tests were performed to confirm this diagnosis except for labs such as chloride, which is elevated and indicates dehydration.

For treatment, the first intervention is non-pharmacological by educating patients to avoid triggers, increase hydration and sodium intake, and physical counterpressure maneuvers.

Pharmacological interventions include administering drugs such as fludrocortisone, ephedrine, midodrine, propranolol, scopolamine, etc. (Cheshire, 2017). This patient is on continuous normal saline IV infusion. She also takes fludrocortisone and midodrine.

Potential complications of syncope can include injuries from falls and anxiety. The preventive nursing measure for injuries is to monitor the patients and assist them during activities that could cause falls. For anxiety, the preventive nursing measure would be providing reassurance and comfort measures, staying with the patients during a crisis, and giving simple directions (Liao & Du, 2020).

Pathophysiology References (2) (APA):

Cheshire W. P., Jr (2017). Syncope. *Continuum (Minneapolis, Minn.)*, *23*(2, Selected Topics in Outpatient Neurology), 335–358. https://doi.org/10.1212/CON.0000000000000444

Kalischer Wellander, B., Mattsson, G., Lundberg, A., & Magnusson, P. (2019). Differentialdiagnostik och handläggning vid synkope - Riskstratifiering kan underlätta handläggningen, visar nya riktlinjer från europeiska kardiologföreningen [Syncope - contemporary management]. *Lakartidningen*, *116*, FF4P.

Liao, Y., & Du, J. (2020). Pathophysiology and individualized management of vasovagal syncope and postural tachycardia syndrome in children and adolescents: An Update. *Neuroscience bulletin*, *36*(6), 667–681. https://doi.org/10.1007/s12264-020-00497-4

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: UP AD LIB	
Diet/Nutrition: Regular diet	
Frequent Assessments: O2 sat at 92%, VS Q4H, strict I& O	
Labs/Diagnostic Tests: none	
Treatments: none	
Other: none	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
None	

Laboratory Data (15 points)

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

Lab	Normal Range (specific to	Admission or Prior Value	Today's Value	Reason for Abnormal Value

	the age of the child)			
RBC	**3.93-4.90 10^6 uL**	**4.71**	**n/a**	
Hgb	**10.8-13.3g/dL**	**12.7**	**n/a**	
Hct	**33.4-40.4 %**	**38.6**	**n/a**	
Platelets	**194-345 10^3 uL**	**311**	**n/a**	
WBC	**4.19-9.43 10^3/uL**	**8.95**	**n/a**	
Neutrophils		**Not drawn**	**n/a**	
Lymphocytes		**Not drawn**	**n/a**	
Monocytes		**Not drawn**	**n/a**	
Eosinophils		**Not drawn**	**n/a**	
Basophils		**Not drawn**	**n/a**	
Bands		**Not drawn**	**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**	**139**	**n/a**	
K+	**3.5-5.1 mmol/L**	**4.2**	**n/a**	
Cl-	**98-107**	**108>**	**n/a**	**Chloride is elevated during dehydration, acute renal failure, Cushing disease, metabolic acidosis, and respiratory alkalosis. This patient may have been dehydrated (Ricci et al., 2020)**
Glucose	**74-100 mg/dL**	**98**	**n/a**	

BUN	**8-21mg/dL**	**8**	**n/a**	
Creatinine	**0.55-1.02 mg/dL**	**0.83**	**n/a**	
Albumin	**3.5-50 g/dL**	**3.7**	**n/a**	
Total Protein	**6.0-8.0 g/ dL**	**7.9**	**n/a**	
Calcium	**8.9-10.6 mg/dL**	**9.3**	**n/a**	
Bilirubin	**0.2-1.2 mg/ dL**	**0.3**	**n/a**	
Alk Phos	**40-150 U/L**	**85**	**n/a**	
AST	**5-34 U/L**	**18**	**n/a**	
ALT	**0-55 U/L**	**15**	**n/a**	
Amylase		**n/a**	**n/a**	
Lipase		**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		**n/a**	**n/a**	
CRP		**n/a**	**n/a**	
Hgb A1c		**n/a**	**n/a**	
TSH		**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	Today's Value	Reason for Abnormal

		Value		
Color & Clarity	**Colorless, yellow**	**Yellow, clear**	**n/a**	
pH	**5.0-7.0**	**6.0**	**n/a**	
Specific Gravity	**1.003-1.035 unit**	**1.011**	**n/a**	
Glucose	**Negative/dL**	**Negative**	**n/a**	
Protein	**Negative/ dL**	**Negative**	**n/a**	
Ketones	**Negative/ dL**	**Negative**	**n/a**	
WBC	**0-25/ uL**	**6**	**n/a**	
RBC	**0-20/ uL**	**1**	**n/a**	
Leukoesterase	**negative**	**trace**	**n/a**	**This test is done to monitor the presence of WBC in urine, which indicate a possible urinary tract infection (Hinkle & Cheever, 2018).**

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**	**Not drawn**	**n/a**	
Blood Culture	**Negative**	**Not drawn**	**n/a**	
Sputum Culture	**Negative**	**Not drawn**	**n/a**	
Stool Culture	**Negative**	**Not drawn**	**n/a**	
Respiratory ID Panel/ COVID 19	**Negative**	**Negative**	**n/a**	

Lab Correlations Reference (1) (APA):

Lab value ranges per EPIC

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

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Not completed

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.

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

Brand/Generic	**Acetaminophen / Tylenol**	**Fludrocortisone/ Florinef Acetate**	**Midodrine/ ProAmatine**		
Dose	**500 mg**	**Tablet 0.1 mg**	**Tablet 5 mg**		
Frequency	**Every 4 hrs**	**At bedtime**	**TID**		
Route	**PO**	**PO**	**PO**		
Classification	**Analgesic/ antipyretic non salicylate**	**Mineralocorticoids**	**Adrenergic vasopressor agents**		
Mechanism of Action	**Inhibits the enzyme cyclooxygenase,**	**Florinef increases extracellular and intracellular**	**Midodrine forms an active metabolite,**		

	blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	**volume by increasing sodium reabsorption by the kidney.**	**desglyMidodrine , that is an alpha1-agonist, and exerts its actions via activation of the alpha-adrenergic receptors of the arteriolar and venous.**		
Reason Client Taking	**For pain rated 1-3 and or fever 100.4**	**For low BP**	**For hypotension**		
Concentration Available	**500 mg**	**0.1 mg**	**5mg**		
Safe Dose Range Calculation	**1000mg q6hr=3000mg 500mgx4= 2000mg or 2g/24h the dose is safe. * no dosage range available in the meds book.**	**0.1mg /day – 0.2mg/day The dose is safe. * no dosage range available in the meds book.**	**2.5 - 10 mg PO q8hr. 5mg x3= 15 mg the dose is safe. * no dosage range available in the meds book.**		
Maximum 24-hour Dose	**Do not exceed 4 g acet. per 24 hrs**	**Do not exceed 0.2 mg per 24 hr.**	**Do not exceed 30 mg/ day.**		
Contraindications (2)	**Sever hepatic impairment & active liver disease.**	**This drug is contraindicated in patient with fungal infection and those who have sensitivity to its component.**	**This medication is contraindicated in client with severe heart disease & avoid in client with persistent supine hypertension.**		
Side Effects/Adverse Reactions (2)	**Neutropenia & hemolytic anemia**	**Dizziness & insomnia**	**Increase blood pressure & respiratory depression.**		
Nursing Considerations (2)	**Long-term use monitor liver enzyme (AST, ALT) and renal function.**	**Monitor for hypokalemia signs, including lethargy, headache, and**	**Monitor urinary output before and during therapy. Monitor supine and**		

		cardiac dysrhythmias.	**sitting blood pressure.**		
Client Teaching needs (2)	**Teach client to recognize signs of hepatoxicity & do not exceed the prescribed dose, take as directed. (Jones & Bartlett, L, 2020, P. 9-12).**	**Do not stop abruptly and take as directed. (Jones & Bartlett, L, 2020).**	**Take the medicine in an upright position not when lying down. Take the last dose 3 to 4 hours before bed because it can lead to high blood pressure. (Jones & Bartlett, L, 2020).**		

Reference:

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

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The client is alert & oriented to person, place, and time** **No acute distress** **Well groomed**
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: 20 G**	 **Skin was pink and normal for ethnicity.** **Skin was warm to touch, moisture, and intact.** **Temperature is normal on upper and lower extremities bilateral.** **Skin turgor is within normal limits** **Braden score is 23. No rashes, wounds, or bruises noted.**

Location of IV: left hand **Date on IV: 11/05/21** **Patency of IV: IV is patent, no occlusion, no signs of erythema.** **Signs of erythema, drainage, etc.:** **IV dressing assessment: clear, dry, and intact.** **IV Fluid Rate or Saline Lock:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	The head neck is symmetrical, normal cephalic. Ears are symmetrical and free of discharges, no auditory impaired. Eyes are symmetrical, no impaired vision. Nose septum midline, no bleeding, no dentures, patient has natural teeth. Normal thyroid, carotid pulse palpable 2+ bilateral.
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:**	Normal heart sounds, S1 and S2 present. No murmurs, Peripheral pulses are 2+ throughout bilaterally upper and lower extremities. Capillary refill less than 2 seconds, no edema inspected or palpated in both upper and lower extremities
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Clear lung sounds, no shortness of breath, no use of accessory muscles. Normal rate and pattern of respirations, no crackles
GASTROINTESTINAL: **Diet at home:** **Current diet:** **Height (in cm):** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.: n/a** **Inspection:** **Distention:** **Incisions:** **Scars** **Drains: n/a** **Wounds: n/a** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:**	**Regular diet** **Regular diet** **170.7 cm** **Normative bowel sounds, no cramping in all 4 quadrants.** **11/05/21 at 9 am** **No mass noted during palpation in all 4 quadrants. No distended abdomen, no incisions.**

Feeding tubes/PEG tube Y ☐ N ☒ **Type:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type: n/a** **Size: n/a**	Urine within defined levels. Patient voids in the toilet, she has no pain or discomfort related to urination.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices: n/a** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 55** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Negative human sign Patient is feeling dizzy when standing up Active ROM on both upper and lower extremities. Patient's strength is generalized in both upper and lower extremities bilateral. Patient needs help to stand up going to the toilet because of the orthostatic blood pressure
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Patient is awake in bed, oriented, speech and sensory within expected limits, no altered mental status, normal level of consciousness although patient reported dizziness upon getting up.**
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):**	**Caregivers were not available to respond to the question.** **The patient reported that they don't have any social needs regarding transportation, food, home, or medical assistance because both parents work.** **Patient reported that they live in family in a safe environment. The family has a good support.**

Vital Signs, 2 sets (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0810	**80**	**116/77**	**18**	**97.5 F oral**	**99% room air.**
1140	**75**	**122/72**	**18**	**98.2 F oral**	**99% room air.**

Vital Sign Trends: All vital signs are within normal ranges; no abnormal values were noted.

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

Pulse Rate	**50-100/min**
Blood Pressure	**Systolic:108-138 mmhg** **Diastolic: 64-93mmhg**
Respiratory Rate	**16-20/min**
Temperature	**97.9 F**
Oxygen Saturation	**97-100%**

Normal Vital Sign Range Reference (APA):

Holman, H.C., Williams, D., Sommer, S., John, J., 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
0810	**0-10**	**The client denied any pain.**	**The client denied any pain.**	**The client denied any pain.**	**Playing card game watching tv**
Evaluation of pain status *after* intervention	**0-10**	**The client denied any pain.**	**The client denied any pain.**	**The client denied any pain.**	**N/A**
Precipitating factors: N/A **Physiological/behavioral signs: The patient playing card game and watching TV.**					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
240 ml	**Patient voided**

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. **Peer relationships developed. Patient talked with her friends/ classmates over the phone.**
2. **Patient-child relationship change to allow a greater sense of independence. Patient showed independence from parents by staying alone in the hospital.**
3. **Best-friend relationship stable with her boy-friend**

Age Appropriate Diversional Activities

1. **Played games**
2. **Watched TV, a TV show of her choice**
3. **Electronic messaging and social media**

Psychosocial Development:

Which of Erikson's stages does this child fit?

This patient is in identity vs role confusion. During this age, adolescents often try different roles and experiences to develop a sense of personal identity and come to view themselves as unique individuals.

What behaviors would you expect?

At this age, adolescents begin with close, same-sex friendships which sometimes involve sexual experimentation driven by curiosity. Self-exploration through masturbation, stability of emotions and anger management, base their own normality on comparisons with peers.

What did you observe?

Patient corresponded to normal behaviors for children of this age.

Cognitive Development:

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

What behaviors would you expect?

At this age, children are able to think through more than two categories of variables concurrently. Capable of evaluating the quality of their own thinking. Able to maintain attention for longer periods of time, they think beyond current circumstances. Able to think in terms of abstract possibilities and hypothetical situations.

What did you observe?

During my interaction with the patient, she was able to maintain attention for longer time while I was doing my assessment. She also used formal logic to make decisions when we played card game, and answered my questions using intuitive form of thoughts.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

Children at this age should not present any issue about vocalization, their speaking should be clear, with mature voice.

Any concerns regarding growth and development?

This patient doesn't present any concerns regarding growth and development.

Developmental Assessment Reference (1) (APA):

Holman, H.C., Williams, D., Sommer, S., John, J., 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. Ineffective cerebral tissue perfusion related to decrease in the flow of oxygen to the brain as evidenced by the patient loss consciousness.	**During syncope episode there is a temporary interruption of blood flow to the brain, which decreases oxygen perfusion to the brain tissues, resulting in loss of conscience.**	**1.Monitor level of conscience. Rational: The level of conscience is influenced by the perfusion of oxygen to the brain. 2.Monitor vital signs and provide oxygen as ordered. Rational: vital signs are indicator of the general state and patient's circulation. Oxygen prevents brain hypoxia (Ricci et al., 2020).**	**The patient's vital signs are stable. The client is oriented with good communication.**
2. Decreased cardiac output related to disruption of blood flow to the heart muscle as evidenced by	**Elevated blood pressure indicates the increasing in workload to compensate body need.**	**1. Assess the patient's heart ECG. Rational: ECG examination provides an overview of the heart condition**	**The patient will maintain a normal blood pressure and palpable strong pulse.**

patient losing muscle tone and fell.		**and helps determine future treatment. 2.Limit activities adequately. Adequate rest is needed to improve the efficiency of cardiac contraction and lower oxygen con (Ricci et al., 2020).**	
3. Risk for falls related to sudden loss of consciousness as evidenced by the patient experiencing dizziness when standing up.	**This diagnosis was chosen because falls may result in potential injuries that can be life threatening or deadly.**	**1. Assess for circumstance associated to increase the level of fall risk upon administer in the hospital. Rational: Using standard assessment tools, the risk and subsequent fall precautions can be determined. 2. Put the bed in the lower position. Rational: Keeping the bed closer to the floor reduces the risk of falls and serious injury (Ricci et al., 2020).**	**The client will relate controlled falls as evidenced by following instructions. The client will demonstrate selective preventive measures and increased safety measure.**
4. Deficient fluid volume related to decrease level of conscience as evidenced by inadequate fluid intake.	**This diagnosis was chosen because the client exhibits dizziness, which is a sign of hypovolemia.**	**1. Urge the client to drink the prescribed amount of fluid. Rational: Oral fluid replacement is effective for fluid replacement. 2. Encourage the family to increase**	**Patient demonstrates lifestyle changes to avoid progression of dehydration.**

		offering fluid and assist when needed. **Rational: Adolescents maybe unable to meet prescribed intake independently (Ricci et al., 2020).**	

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

The client stated that she started feeling dizzy in her head since couple days ago. The patient seemed lethargic and stated not seeming herself to others. Patient acknowledged having episodes of dizziness, fatigue, anxiety, difficulty with sleeping and focusing, chest tightness, shortness of breath causing her to feel unwell and missed school. Patient is concerned that she may be dropped from dance team.

Nursing Diagnosis/Outcomes

Ineffective cerebral tissue perfusion related to decrease in the flow of oxygen to the brain as evidenced by the patient loss consciousness.

Decreased cardiac output related to disruption of blood flow to the heart muscle as evidenced by patient losing muscle tone and fell.

Risk for falls related to sudden loss of consciousness as evidenced by the patient experiencing dizziness when standing up.

The patient's vital signs are stable. The client is oriented with good communication.
The client will relate controlled falls as evidenced by following instructions. The client will demonstrate selective preventive measures and increased safety measure.
Patient demonstrates lifestyle changes to avoid progression of dehydration

Objective Data

Leukoesterase : trace noticed
Cl-: 108>
BP: 116/77
O2:99%

Patient Information

On November 5th, 21 a Caucasian adolescent female was directed to the inpatient department directly from Carle cardiology clinic for dizziness and syncope. The client stated that she started feeling dizzy in her head since couple days ago. The patient seemed lethargic and stated not seeming herself to others. Patient acknowledged having episodes of dizziness, fatigue, anxiety, difficulty with sleeping and focusing, chest tightness, shortness of breath causing her to feel unwell and missed school. Patient is concerned that she may be dropped from dance team. At arrival to the hospital, patient was put on 20 gauge IV 0.9% **normal saline and bedrest.**

Nursing Interventions

Prevent injury, keeping the bed in the lower position, necessary items within reach, and raise bed side rails.
Educate the client to change the position slowly to avoid orthostatic hypotension.
Reevaluate medications, review any medicine casing the syncope with the provider.
Monitor for change in the level of consciousness.
Promote adequate fluid intake.