N433 Care Plan 1

Lakeview College of Nursing

Happy Kalavadia

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
11/11/2021	**NC**	**3 years 2 months old**	**Male**
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	**18.2 kg**	**14**	**None**

Medical History (5 Points)

Past Medical History:

Illnesses: Per NC's chart, he had constipation, global developmental delay, sleep disorder, autism spectrum disorder and developmental regression in child disorder .

Hospitalizations: Per NC's chart, he was admitted at Sarah Bush for coughing episodes to rule out pneumonia.

Past Surgical History: None.

Immunizations: All vaccinations are up to date except one vaccine which was not mentioned in the chart . His mother said, " I have no idea about the one vaccine that he did not take".

Birth History: Per NC's chart, he was born full term with no complications.

Complications (if any): None

Assistive Devices: None

Living Situation: Currently NC lives with his parents and one elder sister at home .

Admission Assessment

Chief Complaint (2 points): As per NC's mother verbalization**,** he had fever, difficulty breathing, severe cough , decreased appetite and decreased wet diapers.

Other Co-Existing Conditions (if any): None

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

NC was hospitalized before four months for coughing episode at Sarah Bush, but he was discharged next day as he had no evidence of pneumonia and felt much better.

History of present Illness (10 points): NC with his mother presented to the ED on 11/11/2021 due to severe coughing episodes, difficult breathing, decreased appetite, decreased wet diapers and fever of 102.7 F . His mother stated, " He had cough and fever for twelve hours and he refused to eat anything". The onset of the symptoms started after having evening snack and lasted for about twelve hours. NC did not have any pain and hence there is not specific location of his manifestations. The duration of his symptoms started about twelve hours ago. NC's mother said "His symptoms tend to decrease if he leaned forward". The associated manifestations of his symptoms were few sneezing episodes with rhinorrhea. Patient had mild pain and some discharge from his right ear but his mom said his main concern is difficulty breathing. Patient's mother NC's mother stated, " I did not do any home interventions for him and directly bought him to ED". During this care in ED, NC had SpO2 of 88 % and hence was on nasal cannula with four liters of oxygen. He was also given Tylenol for his fever, 0.9 percent NaCl fluids and transferred to Pediatric floor after his stabilization of his condition.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): NC's provider ordered Respiratory Pathogen Panel and RSV was confirmed.

Secondary Diagnosis (if applicable): None

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

Respiratory Syncytial virus (RSV) is a single stranded RNA virus of the paramyxovirus family. It has two distinct subtypes and has fusion protein A and B (Ricci et al., 2021). Transmission of the RSV infection occurs from nasopharyngeal or oral secretions from affected individuals and hence patient infected with RSV is on droplet precautions (Ricci et al., 2021). RSV virus infects the terminal bronchioles because the fusion protein F and B attaches to the terminal bronchioles and can replicate inside the bronchioles causing signs and symptoms like coughing, difficulty breathing , and increased nasal secretions (Capriotti & Frizzell, 2016) .The humoral and cell mediated immunity are activated by inflamed cells of bronchioles to fight of the viral infection (Capriotti & Frizzell, 2016) . Patient infected with RSV can have upper respiratory symptoms such as rhinorrhea, sneezing , coughing and difficulty breathing (Capriotti & Frizzell, 2016). Apnea is a well-known complication of RSV infection in infants (Capriotti & Frizzell, 2016) .The diagnosis of RSV is based on history and physical findings as well as conducting respiratory pathogen panel which should be positive for RSV infection. Patient presented to the ED with difficulty breathing, coughing, sneezing and fever as the body is attempting to fight off infection. Patient also was in low energy state and had decreased in appetite and had trouble sleeping as well. These signs and symptoms of the patients are consistent with infection from viral pathogen. Respiratory pathogen panel as well as physical assessment further confirmed that patient has RSV virus (Ricci et al., 2021) . Chest x ray was also performed by the provider to rule out RSV infection, but it did not show any pathology related to RSV infection. Typical treatment with RSV is only symptomatic which means treating the underline symptoms (Capriotti & Frizzell, 2016) .Mainstay treatment of RSV is maintaining oxygen saturations as well as giving fluid and encouraging rest periods (Hinkle & Cheever, 2018).The patient was on nasal cannula with 4 liters of O2 in the ED but he is now on room air since midnight. He was

given D5 dextrose 0.9 %Nacl with KCl and was given Tylenol for fever as patient had Otitis media infection of the right ear. Patients condition is quite stable, and his plan of care is to monitor his O2 levels and upper respiratory symptoms.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. 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.

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

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: As tolerated	NC's activity was as tolerated. He was watching games in his iPad and his mother was at the bed side.
Diet/Nutrition: Regular diet**.**	NC had two spoons of yogurt and some goldfish. He stated, " I do not feel like eating now".
Frequent Assessments: Every 4 hours	Vital signs were assessed every 4 hours.
Labs/Diagnostic Tests: Respiratory pathogen panel (RPP), Blood culture and chest x ray	RPP confirmed that he had RSV. Blood culture resulted reveled that he had bacterial infection of *S.aureus* and has otitis media of middle right ear. Chest x ray showed perihilar

	infiltrates. His provider-initiated droplet precautions due to RSV **.**
Treatments:	NC was given Cefdinir and Tylenol as well as Ibuprofen .
Other:	Strict Intake and Output.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Continue Rocephin for pneumonia and Tylenol PRN.	NC had secondary bacterial pneumonia as his chest X ray showed right middle lobe with trace pleural effusion. In addition, he also had right otitis media of right ear and hence on oral antibiotics.
Isolation – droplet precautions	Due to NC's RSV infection.
Vital Signs every 4 hours and strict I/O	It is important to assess NC's vital signs frequently especially his oxygenation status as the virus affects oxygen causing respiratory symptoms.

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	**3.89-4.97 *10^6**	**N/A**	**4.78**	
Hgb	**10.2-12.7**	**N/A**	**13.1**	The hemoglobin is elevated in any bacterial infection because there are more destruction of old RBC leading to new production of RBC (Ricci et al., 2021).
Hct	**31.0-37.7**	**N/A**	**38.0**	Hematocrit is elevated in bacterial infection due to more production of new RBC because there is more destruction of old RBC (Ricci et al., 2021).
Platelets	**202-403**	**N/A**	**556**	There is more destruction of platelets in any infections and hence body is attempting to fight off infection by producing more platelets (Ricci et al., 2021).
WBC	**5.14-13.38*10^ 3**	**N/A**	**10.94**	Within normal range
Neutrophils	**1.54-7.92*10^3**	**N/A**	**6.13**	Within normal range.
Lymphocytes	**1.13-5.52* 10^3**	**N/A**	**3.23**	Within normal range.
Monocytes	**0.19-0.94*10^3**	**N/A**	**1.39**	Monocyte counts are increased when body is attempting to fight an infection (Ricci et al., 2021).
Eosinophils	**0.03-0.53*10^3**	**N/A**	**0.02**	Within normal range
Basophils	**0.03-0.53* 10^3**	**N/A**	**0.04**	Within normal range
Bands	**0-1.0%**	**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	Admission	Today's	Reason For Abnormal

	Range	or Prior Value	Value	
Na-	**136-145**	**N/A**	**138**	Within normal range
K+	**3.5-4.1**	**N/A**	**4.0**	Within normal range
Cl-	**98-107**	**N/A**	**104**	Within normal range
Glucose	**74-100**	**N/A**	**105**	Glucose levels are increased when body is fighting off infection as body produces more glucose as a defense mechanism and due to low energy state during any illness (Ricci et al., 2021).
BUN	**7-17**	**N/A**	**9**	Within normal range
Creatinine	**0.55-1.30**	**N/A**	**0.44**	Within normal range
Albumin	**3.8-5.4**	**N/A**	**3.4**	Within normal range
Total Protein	**6.0-8.0**	**N/A**	**7.4**	Within normal range
Calcium	**8.8-10.8**	**N/A**	**9.5**	Within normal range
Bilirubin	**0.2-1.2**	**N/A**	**0.3**	Within normal range
Alk Phos	**9-500**	**N/A**	**165**	Within normal range
AST	**5-34**	**N/A**	**33**	Within normal range
ALT	**0-55**	**N/A**	**202**	In infection, there is more production of liver enzymes leading to increased production of ALT levels indicating that body is undergoing through an infection (Ricci et al., 2021).
Amylase	**3-155 U/L**	**N/A**	**N/A**	
Lipase	**25-110**	**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	0-20 mmol/l	N/A	N/A	
CRP	< 1.0 mg/ml	N/A	N/A	
Hgb A1c	w/o diabetes 4.0 – 6.8% w/ diabetes 6.0 – 22.0%	N/A	N/A	
TSH	0.32 – 5.00 µIU/mL	N/A	N/A	

Lactic acid - 0.5-2.0 0.8

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	
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	Negative	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**	**Positive**	Blood culture rules out any bacterial infection. Patient's blood culture is positive because he had bacterial infection of Staph aureus (Ricci et al., 2021).
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	
Respiratory ID Panel	**Negative**	**N/A**	**Positive**	Patient had RSV infection and hence RPP was positive for RSV.

Lab Correlations Reference (1) (APA):

Normal reference values obtained from Epic charting system.

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): RPP was done to rule out viral infections. Blood culture and chest x ray was done to rule out any bacterial pathology.

Diagnostic Test Correlation (5 points): RPP rules out any viral infections and NC had symptoms of viral infection such as difficulty breathing, coughing and sneezing episodes. Blood culture rules out bacterial infections as the patient had high fever as well upper respiratory

symptoms. Chest x ray rules out any evidence of pneumonia either bacterial or viral as the patient had difficulty breathing and his oxygenation status is low**.**

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

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

Brand/Generic	**Omnicef/ Cefdinir**	**Tylenol/ Acetaminophen**	**Advil/ Ibuprofen**		
Dose	127 mg	249.6 mg	180 mg		
Frequency	BID	Every 4 hrs PRN	Every 6 hrs		
Route	Oral	Oral	Oral		
Classification	Antibiotics	Antipyretic and Analgesic	Antipyretic and Analgesic.		
Mechanism of Action	It interferes with cell was synthesis and exhibits bactericidal properties.	It reduces the production of prostaglandins receptors in the brain that cause fever, inflammations and pain resulting in decreased pain and fever.	It is a nonselective inhibitor of COX enzyme which converts arachidonic acid to prostaglandins.		
Reason Client Taking	Infection with S.*aureus* bacteria.	Due to fever	Due to fever		
Concentration Available	15mg/ml	N/A	N/A		
Safe Dose Range	120-137 mg	N/A	N/A		

Calculation					
Maximum 24-hour Dose	260 mg	N/A	N/A		
Contraindications (2)	Urticaria Wheezing	Liver failure Renal impairment	Hypersensitivity to Ibuprofen Renal impairment		
Side Effects/Adverse Reactions (2)	Nausea vomiting	Dizziness Bleeding	Bleeding Vomiting		
Nursing Considerations (2)	Give the drug with meals for maximal absorption. Do not take antacids before or after 2 hours of taking the medication.	Do not exceed 4 g of drug per day to prevent the risk of liver impairment in children. It may increase blood glucose levels so monitor it.	Take the medications exactly as directed and do not excess the dose or frequency even if the conditions do not improve. Report any episodes of severe vomiting to the provider.		
Client Teaching needs (2)	Contact provider if there is any severe rash or wheezing episodes. Increase fluid intake while taking this medication.	Take the medication only when needed to control fever. Take the medication exactly as directed and do not exceed the dose if fever is not controlled.	To prevent nausea, do not take the medication with empty stomach. Increase fluid intake while taking this medication.		

Medications References:

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

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	NC is alert, oriented to person, place and time. He is in mild respiratory distress and is ill appearing with coughing episodes.
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:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **IV Fluid Rate or Saline Lock:**	 NC's skin was pink and is normal for her race. Skin was normal, warm and dry with no signs of breakdown. Turgor was normal, +2 NC had no rashes, bruises, wounds, or drains. Braden Score- 3 20g Left antecubital 11/13/2021 No signs of blockage, pain, or swelling No signs of erythema or drainage IV dressing intact and dry D5 W0.9% NaCl with 20 meq KCl at 55ml/hr
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	 NC head and neck are symmetrical, trachea is midline with no deviation. NC ears and nose are free of discharge She had bilateral sclera white, cornea clear, conjunctiva pink with no drainage Her teeth are within normal limits Thyroid were not enlarged.
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:**	.Heart sounds are normal, S1, S2 present No murmurs, gallops, or rubs Pulses are 2+ throughout bilaterally Capillary refill was less than 2 seconds in fingers and toes. No neck vein distention or edema
RESPIRATORY: **Accessory muscle use: Y☐ N ☒**	Diminished air sounds air right lower base, left lung clear, abdominal belly breathing and no

Breath Sounds: Location, character	intercoastal or supraclavicular retractions. No wheezing , crackles and rhonchi.
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 ☒** **Type:**	Diet at home is regular . Current diet is regular . 130 cm Last bowel movement was 11/12. Auscultation of Bowel sounds revealed normal bowel sounds in all four quadrants. Stomach was a little distended, mild bloating No incisions, scars, drains, or wounds. No ostomy, nasogastric or feeding/PEG tubes.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	NC was continent and had one wet diaper which weighed 305 g during my care.
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☐**	 Normal range of motion in upper and lower extremities. CK does not use any supportive devices She has equal strength in extremities bilaterally. Fall score 2
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐**	CK moves all extremities independently and has no neurological abnormalities. Push and pulls were equal bilaterally

Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	He is cognitive to space, time, and location and shows age appropriate mental development and speech patterns.
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):**	**NC is busy watching his iPad. He is little irritated due to his coughing episodes and does not want to eat anything.** **NC has strong support system. His mother is bed side with him .**

Vital Signs, 2 sets (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9:00 am	**98 bpm**	**102/74 mmhg**	**38 respirations/minute**	**98.0 F Axillary**	**92 percent Room Air**
11:00 am	**120 bpm**	**104/78 mmhg**	**36 respirations per minute.**	**98.2 F Axillary**	**98 percent Room Air**

Vital Sign Trends: Vital signs are within normal limits and is age appropriate except O2 saturation . As per NC's nurse she mentioned that although 92 percent is low , patients with viral infection have low oxygen and their normal range is 92 to 100 .

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

Pulse Rate	80 -120 bpm (Ricci et al., 2017).
Blood Pressure	90-107 – 60-71 (Ricci et al., 2017).
Respiratory Rate	24 to 40 respirations per minute (Ricci et al.,

	2017).
Temperature	Greater than 97 F (Ricci et al., 2017).
Oxygen Saturation	92- 100 especially if the patient has viral or bacterial infection (Ricci et al., 2017).

Normal Vital Sign Range Reference (APA):

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

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900 am	**FLACC**	Lungs and entire body	**0**	**N/A**	Patient's pain is well controlled due to Tylenol and Ibuprofen. Monitor patient's vital signs every four hourly.
11:00 am **Evaluation of pain status *after* intervention**	**FLACC**	Lungs and entire body	**0**	**N/A**	Patient's pain is well controlled due to Tylenol and Ibuprofen. Monitor patient's vital signs four hourly.
Precipitating factors: NC's mom verbalized that he is feeling much better and does not have any pain. **Physiological/behavioral signs:** NC is in mild respiratory distress and has coughing episodes due to his bacterial and viral infection.					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)

D5 W 0.9 percent NaCl with 20 KCl meq 55ml /hr . 4 teaspoons of yogurt 6- 7 pieces of goldfish.	1 wet diaper (305 g)

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. Love to play with stuffed toys.
2. Love to talk a lot especially with parents and strangers
3. Love to watch their favorite cartoon and play games.

Age Appropriate Diversional Activities

1. Played with glowing ball while the nurse was doing his IV.
2. Distracted him by his favorite Peppa Pig.
3. Sang ABC song and he loved it.

Psychosocial Development:

Which of Erikson's stages does this child fit? Autonomy versus shame and doubt (Ricci et al., 2021).

What behaviors would you expect?

During this stage, the child wants to be trying doing things by themselves like eating by himself and dressing as well. They enjoy exhibiting negativism and loves talking with strangers (Ricci et al., 2021).

What did you observe? The patient exhibited normal developmental millstones . He was very cute and loved to sing songs with strangers. He also enjoyed talking with his mom and he was not good at taking turns which is age appropriate.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? Pre-operational (Ricci et al., 2021).

What behaviors would you expect? The child at this stage imitates the caregiver, learns through observing and imitating (Ricci et al., 2021).

What did you observe? Patient was imitating his mother and narrating a story in his language which I could not understand. Overall, patient had normal developmental milestones according to Piaget stage**.**

Vocalization/Vocabulary:

Development expected for child's age and any concerns? NC holded a cup while drinking water and he brushed his teeth by himself. He also removed a shirt by himself as he was feeling not comfortable in it**.**

Any concerns regarding growth and development? No concerns regarding growth and development noted.

Developmental Assessment Reference (1) (APA):

Ricci, S. S., Carman, S., & Kyle, T. (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 • 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 gas exchange related to difficulty	NC had severe coughing and difficulty breathing	**1.** Head of bed was elevated to semi-	NC condition improved by elevating bed and he enjoyed breathing exercises and appeared to

breathing and evidenced by decreased in oxygenation levels when the patient was admitted in the ED.	episodes during his admission in ED and hence was given nasal cannula with 4 L of oxygen.	fowler's position. **2.** Patient was given taught deep breathing exercises like blowing cotton balls.	be in good mood.
2. Acute pain related to discharge from right ear and as evidenced by otitis media infection of S *aureus* during his care in ED**.**	NC had mild clear discharge from his ear and had pain when he was admitted to ED **.**	**1.** Patient was given Tylenol for to control his pain. 2.As per his chart, he was given heat pad to put in his ear to help ease the pain.	Patient felt better after his treatment and his mother verbalized that he slept peacefully after taking Tylenol.
3. Increased body temperature related to hyperthermia and evidenced by fever of 102 F during his care in ED**.**	Patient presented to the ED with high fever and coughing episodes.	**1.** Patient was given Tylenol and Ibuprofen for managing fever. 2. Patient was encouraged to drink more fluid from his favorite cup.	Patient's fever is well controlled, and he appears to be in good mood.
4. Impaired skin integrity related to tight patient identification bad and evidenced by minor rash near the band on his arm.	Patient has minor rash due to continuous skin irritation from tight patient identification band on his arm.	**1.** Patient's mother was taught to frequently rotate the band to prevent skin irrigation. 2. Patient's mother was told to apply barrier cream or Vaseline to apply on rash.	Patient's mother verbalized that she followed the instructions and his rash is very minimal now and it does not itch or burn.

Other References (APA):

Swearingen, P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

Patient verbalized " I am having difficulty in breathing"
NC has been " having a nagging cough and has not ate whole day. He only had one wet diaper entire day"
NC had " fever of 102 F since twelve hours"/

Nursing Diagnosis/Outcomes

1.Impaired gas exchange related to difficulty breathing and evidenced by decreased in oxygenation levels when the patient was admitted in the ED.

2. Acute pain related to discharge from right ear and as evidenced by otitis media infection of S aureus during his care in ED.

3.Increased body temperature related to hyperthermia and evidenced by fever of 102 F during his care in ED.
4.Impaired skin integrity related to patient identification bad and evidenced by minor rash near the band on his arm.

Objective Data

Vital signs are stable.
RPP revealed positive RSV infection and blood culture reveled infection of S.*aureus* as he has otitis media of right ear.
Chest x ray showed peri hilar infiltrate and blunting of right costophrenic sulcus which means he has pneumonia.

Patient Information

NC is 3 years old and is transferred from ED to pediatric floor. He had fever, difficulty breathing and cough. He has RSV and is on droplet precautions. He also has Otitis media of right ear and is on antiobtics.

Nursing Interventions

1.Head of bed was elevated to semi-fowler's position.

2. Patient was given taught deep breathing exercises.

3. Patient was given Tylenol for to control his pain.

4.As per his chart, he was given heat pad to put in his ear to help ease the pain.

5 Patient was given Tylenol and Ibuprofen for managing fever.

6. Patient is encouraged to drink more fluid from his favorite cup.

7. Patient's mother was taught to frequently rotate the band to prevent skin irrigation.

8. Patient's mother was told to apply barrier cream or Vaseline to apply on rash.