

N433 Care Plan # 1

Lakeview College of Nursing

Name: Kaniqua Barnes-McMillian

Demographics (3 points)

Date of Admission 03/032022	Client Initials A.W.	Age (in years & months) 2 years old & 5 months	Gender Female
Code Status Full	Weight (in kg) 12.8 kg	BMI 14.98	Allergies/Sensitivities (include reactions) No known allergies

Medical History (5 Points)

Past Medical History: Congenital hip laxity (10/07/2019) and RSV (Respiratory syncytial virus)

Illnesses: RVS

Hospitalizations: 12/16/2019 for 2 months for RVS

Past Surgical History: n/a

Immunizations: Update on all immunizations besides the full shot.

Birth History: Vaginal birth but no complication during labor and born on time.

Complications (if any):3 n/a

Assistive Devices: n/a

Living Situation: Living at home with parents and have a brother.

Admission Assessment

Chief Complaint (2 points): mild diarrhea and nonblood emesis

Other Co-Existing Conditions (if any): n/a

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

History of present Illness (OLD CARTS) (10 points):The patient came into the hospital presenting with mild diarrhea for two days before being brought to the hospital by her parents. The patient complained of stomach pain to her parents and began to vomit. The diarrhea and stomach pain lasted for two days and continued to worsen. The only thing that came with the stomach pain was diarrhea and vomiting. The mother tried to give the patient food, but she couldn't keep anything down. There was nothing that made the patient feel better, so the mother eventually took the patient to the emergency department in Danville. The patient was noted to have a CO2 of 17, and urinary analysis showed WBC, LE, and ketones. The patient was transported to Carle Hospital

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Urinary tract infection

Secondary Diagnosis (if applicable):Dehydration

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

A Urinary tract infection (UTI) is an infection of the lower tract that causes pain and burning upon urination (Capriotti, 2020). Since the patient is only two years old, she could not specify the pain but complained of pain in the abdomen area. Also, since the patient is a toddler, the symptoms are slightly different such as a fever, vomiting, and being fussy. The patient was vomiting and had a fever for two days. If the infection persists, the symptoms can progress to cloudy, strong-smelling urine (Capriotti, 2020). Upon initial assessment, urine was collected, and the patient had slightly cloudy urine. UTIs are more common in women than men, not addressing

a concern unless there were additional factors. UTIs happen when the sterile urinary tract becomes affected due to being very close to the rectum (Capriotti, 2020). Bacterium invades the urinary epithelium cells causing irritation and inflammation of the cells. If left untreated, the infection can start in the urethra and progress its way up to the bladder, ureters, or kidneys. As little was mentioned before, some clinical presentations of UTI are frequency, pain or burning on urination, and occasional hematuria (Ricci et al., 2020). The patient complained of abdomen pain related to pain or burning on urination. The cause of frequency is that the bladder does not empty due to inflammation and edema of the urethra and bladder (Ricci et al., 2020). Lower UTI is diagnosed by a urinalysis and urine culture. The patient initially had a urine analysis done, followed by a second one that was pending. Once it is confirmed which bacteria are invading the UTI, the patient receives an antibiotic. Medication such as nitrofurantoin, fluquinolones, and phenazopyridine (Capriotti, 2020). The patient was taking ceftriaxone that was administered IV over 24 hours. Some additional nonpharmacologic treatments include staying hydrated, and studies show that drinking cranberry juice is helpful.

Pathophysiology References (2) (APA): Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts*

and clinical perspectives (2nd ed.). F.A. Davis.

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 should increase activity as tolerated.
Diet/Nutrition:	Regular diet but strict input and output monitoring
Frequent Assessments:	The patient vital signs need to be measured every 4 hours. The nurse should notify the doctor if temperature is elevated.
Labs/Diagnostic Tests:	Urine culture pending.
Treatments:	The patient is receiving IV fluids and antibodies.
Other:	
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
n/a	Waiting for results; continue to monitor patient status
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	4 – 5.5	n/a	4.0	n/a
Hgb	10 – 15.5	n/a	10.0	n/a
Hct	32 – 44	n/a	30.7	n/a
Platelets	150 – 400	n/a	n/a	n/a
WBC	5 – 10	n/a	4.7	Low due to infection from UTI (Pagana et al, 2021).
Neutrophils	55 – 70	n/a	56	
Lymphocytes	20 – 40	n/a	42.2	
Monocytes	2 – 8	n/a	3	
Eosinophils	0 – 4	n/a	2	
Basophils	0.5 – 1	n/a	.6	
Bands	0.2 – 1.6	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	n/a	138	n/a
K+	3.4 – 4.7	n/a	3.8	n/a
Cl-	90 – 110	n/a	110	n/a
Glucose	70 – 110	n/a	77	n/a
BUN	5 – 18	n/a	7	n/a
Creatinine	0.3 – 0.7	n/a	.43	n/a
Albumin	4 – 5.9	n/a	4.5	n/a
Total Protein	6.2 – 8	n/a	7.3	n/a
Calcium	8.8 – 10.2	n/a	9.5	n/a
Bilirubin	0.3 – 1.0	n/a	n/a	n/a
Alk Phos	9 – 500	n/a	n/a	n/a
AST	10 – 50	n/a	n/a	n/a
ALT	4 – 36	n/a	n/a	n/a
Amylase	60 – 120	n/a	n/a	n/a
Lipase	0 – 160	n/a	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	<10	n/a	n/a	n/a
CRP	<1.0	n/a	n/a	n/a

Hgb A1c	4.5 – 5.7	n/a	n/a	n/a
TSH	2 – 10	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	Clear pale yellow	n/a	slightly cloudy/ straw	The patient is slightly cloudy due to be diagnosed with an UTI (Pagana et al, 2021).
pH	5.0-7.0	n/a	5.5	n/a
Specific Gravity	1.003 – 1.035	n/a	1.030	n/a
Glucose	Negative	n/a	negative	n/a
Protein	Negative	n/a	trace	UTI causes protein to be in the urine (Pagana et al, 2021)
Ketones	Negative	n/a	3 +	The patient has not been able to keep food down so body start breaking down ketones for energy (Pagana et al, 2021)
WBC	Negative	n/a	6-10	The patient was diagnosed with an UTI.
RBC	Negative	n/a	negative	n/a
Leukoesterase	Negative	n/a	negative	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
COVID-19 Screen	Negative	n/a	n/a	n/a

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby’s diagnostic & laboratory test reference* (15. ed.) Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): No diagnostic test was performed while the patient was in the hospital. If a diagnostic was to be perform it will be KUB, Xray and VCUG.

Diagnostic Test Correlation (5 points):

KUB is a test that views the kidney, ureter and bladder (Pagana et al, 2021). The patient could have gotten this test to see if the urinary tract infection traveled upward. The patient could of have also received a Xray to see the structure of her kidneys. One additional test the client could have received is a voiding cystourethrography (VCUG). The VCUG examines the client urethra and urinary bladder while patient urinates (Pagana et al, 2021). It can be used to diagnosed incontinence and other voiding dysfunction.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby’s diagnostic & laboratory test reference* (15. ed.) Elsevier.

Current Medications (8 points)

****Complete ALL of your Client’s medications****

Brand/Generic	Acetaminophen/ Tylenol	Ceftriaxone/ Rocephin			
Dose	192 mg	640 mg			

Frequency	Every 4 hours PRN	100ml/24 hours			
Route	Oral	IV			
Classification	Nonsalicylate/ antipyretic, nonopioid	Third generation cephalosporin/ antibiotic			
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan.			
Reason Client Taking	The patient was taking this the medication to help relieve pain and reduce temperature.	The patient was taking this medication for her UTI.			
Concentration Available	160mg/ 5 ml	640mg/ 50 ml			
Safe Dose Range Calculation	128-192 mg/kg	640- 960 mg/day			
Maximum 24-hour Dose	640-960 daily	640-960 mg/day			
Contraindications (2)	Hypersensitivity to acetaminophen and severe hepatic impairment	Hyperbilirubinemia or premature neonate, and other beta lactam antibacterial or cephalosporins			
Side Effects/Adverse Reactions (2)	Hypotension and hepatotoxicity	Seizure and C.diff.			
Nursing Considerations (2)	Use cautiously in patients with hepatic	Calcium containing products must not give IV and ask			

	impairment and monitor renal function in patient on long term therapy.	patient if they have any allergic reaction.			
Client Teaching needs (2)	Tell patient that tablets can be crushed and caution patient not to exceed recommended dosage or take other drugs containing acetaminophen.	Urge patient to report watery, bloody stools to prescriber immediately and advise patient to report any hypersensitivity reactions, such as rash, itching skin, or hives.			

Medication Reference (1) (APA):

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>The patient was alert and orient times 4. The patient did not seem to be in distress. The overall patient appearance was well groomed.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Type:</p> <p>IV Assessment (If applicable to child): Size of IV: 22-gauge needle Location of IV: Right forearm Date on IV: 03/03/2022 Patency of IV: Patent Signs of erythema, drainage, etc.: No</p>	<p>The patient skin was appropriate for ethnicity. The patient skin is warm and moist to touch. The skin turgor is elastic and less than 3 seconds. The patient had no rashes, bruises, wounds. Braden score : 16</p>

<p>signs of erythema or drainage IV dressing assessment: Clean, dry and intact. IV Fluid Rate or Saline Lock: The patient have Ceftriaxone in 100 ml/24 hours.</p>	
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>Head and neck were normocephalic, symmetrical, and within normal range of motions. The client’s ears had no signs of drainage or inflammation. Both the left and right eyes were 3mm, equal, round, and reactive to light. The sclera was white, and conjunctiva was pink. The nose was midline and asymmetrical with no drainage. The patient had 18 baby teeth.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: 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>Heart sounds were heard S1 and S2, no murmur or gallops noted. Peripheral pulses palpable +3 bilaterally in all extremities and the carotid arteries. Capillary refill was less than 3 seconds.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>The client’s breath sounds are slightly congested. The client has unlabored breathing and no accessory muscle use.</p>
<p>GASTROINTESTINAL: Diet at home: Regular Current diet: Regular Height (in cm): 30.2 Auscultation Bowel sounds: Bowel sounds are active in all quadrants. Last BM: 03/03/2022 Palpation: Pain, Mass etc.: The client had no pain abdomen. Inspection: n/a Distention: n/a Incisions: n/a Scars: n/a Drains: n/a Wounds: n/a Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>.</p>

<p>Type:</p>	
<p>GENITOURINARY: Color: Yellow Character: unconcentrated Quantity of urine: 80 ml 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: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</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: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>The patient was able to show active range of motion in all extremities. I did not witness the child walking or using any supportive devices. The patient fall score is 35 which is low risk. The patient does use any supportive devices. The patient is bilateral in all extremities. The patient does require assistance with ADL due to age.</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: Sensory: LOC:</p>	<p>The patient is alert and oriented and is developmentally for her age. Speech and sensory development are appropriate for a school age child. The client is alert with no difficulties. No development delays are noted.</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 has support of both parents at home. The patient will need assistance with social needs due to age. The patient seems to have a good support system due to both parent staying the hospital.</p>

Vital Signs, 2 sets – (2.5 points) Highlight All Abnormal Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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1100	122	104/58	24	99	100%
1600	118	110/70	22	98.3	100%

Vital Sign Trends: The patient vital signs were in normal range compared to the reference range.

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

Pulse Rate	60-100 bpm
Blood Pressure	95-110 systolic 60-73 diastolic
Respiratory Rate	14- 20
Temperature	98.6 (37.0)
Oxygen Saturation	Greater than 92%

Normal Vital Sign Range Reference (1) (APA):

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
	Faces scale	n/a	n/a	n/a	n/a
Evaluation of pain status <i>after</i> intervention	Faces scale	n/a	n/a	n/a	n/a
Precipitating factors:					
Physiological/behavioral signs:					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
n/a	80 ml of urine

Developmental Assessment (6 points)

Be sure to highlight the achievements of any milestone if noted in your 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

- At 2 years the vocabulary of the child continues to grow on regular basis.**
- At 2, the patient is now at the age when they are walking, talking, climbing, jumping, running and full of energy.
- At this age, the child likes to copy adults and other children.

Age-Appropriate Diversional Activities

- Coloring can be an appropriate diversional activity**
- Watching TV is a diversional activity.**
- Stacking blocks is appropriate for this child age group.

Psychosocial Development:

Which of Erikson's stages does this child fit? Autonomy vs. shame doubt

What behaviors would you expect? The child will try to do things on their own to feel a sense of personal control and when accomplished they will feel rewarded and if failed, they will shame and doubtful.

What did you observe? When I was taking the vital signs, the patient initiated all of the vital signs and eventually tried to do them herself.

Cognitive Development: Sensorimotor stage.

Which stage does this child fit, using Piaget as a reference? The patient fit this stage due to her age and also, she recognizes the ability to control objects ad acts intestinally

What behaviors would you expect? The patient will be more self-center and focusing on her own abilities and conquering them.

What did you observe? The patient was taking over the vital signs while I was there.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? There were no concerns for the patient's age.

Any concerns regarding growth and development? There are no concerns regarding 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 • Listed in order by priority – highest priority to lowest priority pertinent to this client. 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Interventions (2 per dx)</p>	<p>Outcomes</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the Client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Acute pain related to burning with urination as evidenced by patient report of pain.</p>	<p>Pain interacts with many ADLs and reduces the quality of life.</p>	<p>1.The patient will be monitored to see if Tylenol is needed ever 4 hours.</p> <p>2.The patient watched TV</p>	<p>1. The patient will be relieved of pain by the end of the clinical shift.</p>	<p>The patient was not really involved as much they just viewed from a far. The patient was in a great mood, talkative and enjoyed the movie.</p>

		to distract from pain.		
2. Risk for infection related to UTI as evidenced by urine reflex time.	The UTI can spread to the kidneys which is a more severe and can cause many complications .	1. Ensure the patients drinks adequate liquids. 2. Make sure the patient diaper is changed frequently.	1. The patient will not show signs of infections by the end of the shift.	The patient was cooperative in a good mood.
3. Risk for hypothermia a related to UTI as evidenced by abnormal UA results.	The infection can spread into bloodstream which is a severe situation.	1. Monitor vital signs every 4 hours to check vital signs. 2. Administer Tylenol as prescribed.	1. The patient will not become hypothermic while on the shift.	The patient enjoyed getting her vital signs checked every 4 hours.
4. Readiness for enhanced parenting related to first UTI as evidenced by parent willingness to learn how to avoid UTI's.	Preventing a UTI is very important due to the discomfort and potentially more severe complications .	1. Print out some documents that the patient parents can take home. 2. Allow the parents to teach back what they learned	1. The patient parents will be able to correctly answer the questions about the teaching at the end of the clinical day.	The parents were cooperative and were able answers the question from the documents.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient complained for 2 days until were sent to the hospital for complaining of stomach pain

Nursing Diagnosis/Outcomes

**Acute pain related to burning with urination as evidenced by patient report of pain.
The patient will be relieved of pain by the end of the clinical shift.
Risk for infection related to UTI as evidenced by urine reflex time
The patient will not show signs of infections by the end of the shift
Risk for hypothermia related to UTI as evidenced by abnormal UA results
The patient will not become hypothermic while on the shift
Readiness for enhanced parenting related to first UTI as evidenced by parent willingness to learn how to avoid UTI's.
The patient parents will be able to correctly answer the questions about the teaching at the end of the clinical day.**

Objective Data

The patient have traces of WBC, ketones and protein.

Client Information

The patient is 2-year-old little girl who came in for diarrhea and vomiting that consistently got worse. The patient had a trace of WBC, ketones and protein

**Nursing Interventions
Nursing Interventions**

**The patient will be monitored to see if Tylenol is needed ever 4 hours.
The patient watched TV to distract from pain.
Ensure the patients drinks adequate liquids.
Make sure the patient diaper is changed frequently.
Monitor vital signs every 4 hours to check vital signs.
Administer Tylenol as prescribed.
Print out some documents that the patient parents can take home.
Allow the parents to teach back what they learned.**

