N433 Care Plan #1

Lakeview College of Nursing

Kathleen Serrano

Demographics (3 points)

Date of Admission	Client Initials	Age (in years & months)	Gender
03/08/2022	KP	4 years	Female
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	13.6 kg	12.57	No Known Allergies

Medical History (5 Points)

Past Medical History:

Illnesses: KP has a past medical history of asthma, bronchiolitis, pneumonia, and right ear infection. In addition, it is noted that KP has a missing nasal bridge bone.

Hospitalizations: KP has been admitted for respiratory distress and all the illnesses listed above except for the missing nasal bridge bone.

Past Surgical History: KP has no significant past surgical history.

Immunizations: KP is up to date for all her immunizations.

Birth History: KP was delivered vaginally to term at 38 4/7 weeks.

Complications (if any): No complications occurred during labor or birth.

Assistive Devices: KP does not utilize any assistive devices

Living Situation: KP lives at home with her single mother.

Admission Assessment

Chief Complaint (2 points): The patient did not state a chief complaint but was admitted due to refusing any fluid or food orally.

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

Pertinent Events during this admission/hospitalization (1 points): KP was first admitted to the Carle Emergency Room, where a 24 gauge IV was inserted via the right antecubital vein. In the emergency room, KP received a few fluid boluses via IV. Eventually, KP was transferred to the Pediatrics Unit where she has received stomatitis cocktails and ibuprofen frequently.

History of present Illness (OLD CARTS) (10 points): O: KP was admitted to Carle Emergency Room with her mother due to refusal of oral fluids and food. The patient's mother reports the patient's lip swelling, sores in the mouth, and lesions forming on the hands, feet, arms, buttocks, and legs. In addition, KP presented with a 101 F fever, which occurred for the past three days prior to admission. L: The main source of the patient's pain is the ulcers in the mouth. D: KP is not in pain until she intakes fluids or foods orally. After intaking any oral substance, KP is in pain for at least thirty minutes to an hour. C: When eating or drinking, KP is in constant, sharp pain to the point where she refuses any oral intake even medications. A: Associating factors to the patient's pain are the mouth ulcers that formed in the mouth related to hand-foot-and-mouth disease. Aggravating factors include drinking or eating any oral liquids or foods. R: Prior to admission, KP's mother attempted to relieve pain with cool liquids. T: KP's mother administered Tylenol and Motrin to relieve the pain in KP's mouth. KP was given Tylenol every four to six hours, whereas KP was given Motrin every six to eight hours. S: KP had severe pain that equals an 8/10 on the numeric pain scale.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hand-foot-and-mouth disease

Secondary Diagnosis (if applicable): Dehydration

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

Hand-foot-and-mouth disease is a viral infection common in infants and younger children, such as toddlers (Capriotti & Frizzell, 2020). Children usually contract hand-foot-and-mouth disease at daycares, schools, or even summer camps (Capriotti & Frizzell, 2020). However, hand-foot-and-mouth disease is contagious to children and adults (Capriotti & Frizzell, 2020). The most common cause of hand-foot-and-mouth disease is coxsackievirus, part of the Enterovirus family (Capriotti & Frizzell, 2020). Head-foot-and-mouth disease occurs when the virus spreads through oral ingestion, either through the gastrointestinal tract or the upper respiratory tract of an infected host (Capriotti & Frizzell, 2020). Sometimes the virus causing hand-foot-and-mouth disease can even be spread via oral secretions or fluid-filled vesicles (Capriotti & Frizzell, 2020). When ingestion of the virus occurs, the virus will replicate in the lymphoid tissue and spread to other lymph nodes throughout the body (Capriotti & Frizzell, 2020). After the lymph nodes, the virus can potentially invade all the organs, including the heart, liver, kidneys, and other vital organs (Capriotti & Frizzell, 2020).

Signs and symptoms of hand-foot-and-mouth disease are fever, sore throat, general malaise, painful lesions on the hands, feet, arms, buttocks, legs, decreased appetite, irritability, red rash on the hands, feet, around the mouth, and runny nose (Hinkle & Cheever, 2018). Typically, the first symptom is fever, which happens with the patient (Hinkle & Cheever, 2018). KP had a 101 F fever for three days before admission to the Carle emergency department. A few days following the beginning of a fever, the infected individual will develop painful sores in the mouth and a rash on the hands, feet, arms, legs, or buttocks (Hinkle & Cheever, 2018). KP also had painful mouth sores, lesions, a red rash, runny nose, increased irritability, general malaise, and decreased appetite.

Generally, there are no specific vital signs, tests, or laboratory results to directly diagnose hand-foot-and-mouth disease (Capriotti & Frizzell, 2020). The provider can determine the presence of hand-foot-and-mouth disease via the age of the infected individual, signs and symptoms, and the formation of the red rash or painful mouth sores (Capriotti & Frizzell, 2020). KP had no special tests, laboratory results or diagnostic tests completed to determine the presence of hand-foot-and-mouth disease. One common finding is a high temperature or fever, but fever is common in most illnesses and infections (Capriotti & Frizzell, 2020). In addition, there are no specific diagnostic tests to distinguish hand-foot-and-mouth disease from other illnesses and infections (Capriotti & Frizzell, 2020).

Treatment for hand-foot-and-mouth disease includes adequate fluids, adequate rest, proper nutrition, acetaminophen, ibuprofen, sucralfate, or a stomatitis cocktail (Capriotti & Frizzell, 2020). KP received acetaminophen, ibuprofen, sucralfate, and the stomatitis cocktail. Nonpharmacological treatment for KP included encouraging oral fluid intake, adequate rest, and proper nutrition. However, the patient refused any oral intake, which impaired hydration status and proper nutrition.

Two potential complications of hand-foot-and-mouth disease are dehydration and viral meningitis (Capriotti & Frizzell, 2020). Signs and symptoms of dehydration are dry mucosae, no tears when crying, sunken eyes and cheeks, listlessness, irritability, dark-colored urine, fatigue, and dizziness (Hinkle & Cheever, 2018). Some preventative nursing actions to avoid dehydration are encouraging oral fluid intake based on the child’s weight in kilograms, strict monitoring of intake and output, assessing vitals, especially blood pressure and heart rate, and beginning intravenous therapy as prescribed (Hinkle & Cheever, 2018). Viral meningitis signs and symptoms are high fever, headache, stiff neck, nausea, vomiting, irritability, seizure, and

decreased appetite and thirst (Hinkle & Cheever, 2018). Preventative nursing actions to evade viral meningitis include assessing up-to-date vaccination status and history and consistent and proper handwashing (Hinkle & Cheever, 2018).

Pathophysiology References (2) (APA):

Capriotti, T. M. & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

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

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Up ad lib, independent	KP is up ad lib, independently, without restrictions. The patient is encouraged to increase activity as tolerated.
Diet/Nutrition: Regular diet	KP has no dietary restrictions. However, since admittance KP has refused food and fluids numerous time due to the pain related to the ulcers in the mouth.
Frequent Assessments: Q4 hour vital signs, strict I&O monitoring	Vital signs are assessed every four hours. KP needs strict input and output monitoring to assess fluid and nutritional requirements and potential discharge.
Labs/Diagnostic Tests: BMP, Beta Streptococcal culture	Obtain blood samples for a BMP to assess electrolytes and other necessary metabolic components. Swab KP for a Beta Streptococcal culture to assess whether the patient is positive or negative.
Treatments:	The two medications given during rotation were the stomatitis cocktail and ibuprofen. KP never denied pain. However, it was clear that KP had severe pain in the mouth due to screaming and hitting while receiving the stomatitis cocktail via the mouth.

Other:	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Replace and restart IV in patient	If KP continues to refuse fluids and food a new IV must be started.
Administer IV Toradol	If a new IV is established due to refusal to intake oral fluids, then administer IV Toradol to provide pain relief.

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	3.96-5.03 x10^6/uL	N/A	N/A	
Hgb	10.7-13.4 g/dL	N/A	N/A	
Hct	32.2-39.8%	N/A	N/A	
Platelets	206-369 x10^3/uL	N/A	N/A	
WBC	4.31-11.0 x10^3/uL	N/A	N/A	
Neutrophils	1.63-7.55 x10^3/uL	N/A	N/A	
Lymphocytes	0.97-3.96	N/A	N/A	

	x10^3/uL			
Monocytes	0.19-0.85 x10^3/uL	N/A	N/A	
Eosinophils	0.03-0.52 x10^3/uL	N/A	N/A	
Basophils	0.01-0.06 x10^3/uL	N/A	N/A	
Bands	0.00-0.04 x10^3/uL	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-	135-145 mmol/L	N/A	N/A	
K+	3.5-5.1 mmol/L	N/A	N/A	
Cl-	98-107 mmol/L	N/A	N/A	
Glucose	74-100 ng/dL	95		
BUN	7-17 mg/dL	7		
Creatinine	0.55-1.30 mg/dL	0.43		
Albumin	3.8-5.4 g/dL	3.8		
Total Protein	6.0-8.0 g/dL	7.6		
Calcium	8.8-10.8 mg/ dL	9.5		
Bilirubin	0.2-1.2 mg/dL	0.2		
Alk Phos	9-500 u/L	297		
AST	5-34 u/L	77		KP may have an elevated AST level due to liver irritation or inflammation related to hand-foot-mouth disease and refusal of oral intake (Hinkle & Cheever, 2018).

ALT	0-55 u/L	50		
Amylase	30-100 u/L	N/A		
Lipase	10-140 u/L	N/A		

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	3-15 mm	N/A		
CRP	0-0.29 mm	N/A		
Hgb A1c	4-7%	N/A		
TSH	0.4-4.0 mcIU/mL	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, clear	N/A	N/A	
pH	5.0-7.0 pH	N/A	N/A	
Specific Gravity	1.003-1.035	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0-25 u/L	N/A	N/A	
RBC	0-20 u/L	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/ No growth	N/A	N/A	
Blood Culture	Negative/ No growth	N/A	N/A	
Sputum Culture	Negative/ No growth	N/A	N/A	
Stool Culture	Negative/ No growth	N/A	N/A	
Respiratory ID Panel	Negative/ No growth	N/A	N/A	
COVID-19 Screen	Negative	Negative	N/A	

Lab Correlations Reference (1) (APA):

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): **KP had no diagnostic tests or imaging done during her admission.**

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 Client's medications****

****Unable to find sufficient data and information about the stomatitis cocktail suspension****

Brand/Generic	**sucralfate (Sulcrate)**	**ibuprofen (Advil)**	**acetaminophen (Tylenol)**	
Dose	500 mg	200 mg	160 mg/5 mL	
Frequency	Three times daily before meals	Q 8 hours PRN	Q 4 hours PRN	
Route	Oral	Oral	Oral	
Classification	Pharmacological: GI protectant Therapeutic: antiulcer	Pharmacological: NSAID Therapeutic: Analgesic, anti-inflammatory, antipyretic	Pharmacological: nonsalicyate Therapeutic: antipyretic	
Mechanism of Action	Reacts with HCL acid in the stomach to protect the ulcer site, promote ulcer healing, and prevent reoccurring ulcer formation (Jones & Bartlett Learning, 2019).	Blocks cyclooxygenase, which reduces the inflammatory response and relives pain (Jones & Bartlett Learning, 2019).	Inhibits cyclooxygenase and interferes with the pain impulse of the peripheral nervous system (Jones & Bartlett Learning, 2019).	
Reason Client Taking	For preventative action to protect the patient from stomach ulcers	For pain related to ulcers in the mouth	For pain related to ulcers in the mouth or fever greater than 100.4 F	
Concentration Available	500 mg/	200 mg/	160 mg/5 mL	
Safe Dose Range Calculation	0-2,000 mg/day (Jones & Bartlett Learning, 2019)	20-60 mg/kg/day (Jones & Bartlett Learning, 2019)	160 mg every four hours (Jones & Bartlett Learning, 2019)	
Maximum 24-hour Dose	2,000 mg	816 mg	960 mg	
Contraindications (2)	Impaired swallowing/gag reflex,	Asthma, bronchospasm	Hypersensitivity to acetaminophen,	

	uncontrolled diabetes mellitus		diazepam use	
Side Effects/Adverse Reactions (2)	Dizziness, bronchospasm	Seizures, heart failure	Hypotension, stridor	
Nursing Considerations (2)	Administer sucralfate to patient on an empty stomach (Jones & Bartlett Learning, 2019). Monitor patient's blood glucose especially if the patient is a diabetic (Jones & Bartlett Learning, 2019).	Use ibuprofen cautiously with any kidney issues or impairment (Jones & Bartlett Learning, 2019). Assess kidney function prior to administration of ibuprofen (Jones & Bartlett Learning, 2019).	Use acetaminophen cautiously with liver impairment (Jones & Bartlett Learning, 2019). Confirm that dose is based on patient's weight (Jones & Bartlett Learning, 2019).	
Client Teaching needs (2)	Teach patient and patient's family to not take antacids within 30 minutes of sucralfate administration (Jones & Bartlett Learning, 2019). Instruct the patient and patient's family to take sucralfate on an empty stomach at least an hour before each meal (Jones & Bartlett Learning, 2019).	Instruct the patient to try and take ibuprofen with a full glass of water (Jones & Bartlett Learning, 2019). Urge and advise the patient and patient's family to avoid taking two NSAIDs at the same time (Jones & Bartlett Learning, 2019).	Educate patient that for pediatric patient's acetaminophen will take around 45 minutes for pain/fever relief (Jones & Bartlett Learning, 2019). Educate patient and patient's family to not go over the daily dosage based on child's age (Jones & Bartlett Learning, 2019).	

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert, responsive, and oriented to time, place, and person; oriented to person, place, situation, and time, x4** **No acute distress** **Well-groomed and appropriately dressed**
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:**	 **Appropriate and normal for ethnicity.** **Skin character is dry.** **Skin temperature is warm.** **Skin turgor is elastic and less than 1.5 seconds.** **Lesions are present on the hands, feet, arms, and legs.** **Round rashes are present on the arms, feet, and around the mouth.** **Braden score is 5.** **No drains present.** **The patient ripped out the IV.** **24 gauge** **Right antecubital** **03/08/2022** **IV was patent and adequate** **No complications or abnormal signs of erythema, drainage, etc. were present** **Dressing was clean, dry, and intact** **Saline lock**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	**Head is normocephalic; head and neck are symmetrical; neck is symmetrical, active, and equal movement, and no abnormalities detected in the trachea, thyroid, vessels, or lymph nodes. Ears free of any discharge and hearing appropriate and equal in both ears. Eyes symmetrical and good extra ocular movement; Nose deformity present related to missing nasal bridge bone, deviation present in the left nostril, no nasal drainage or discharge present; teeth well-maintained and no signs of decay**

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 S1 and S2 auscultated, no murmurs, no gallops or rubs detected** **Cardiac rhythm is normal sinus rhythm** **Radial, brachial, carotid, femoral, popliteal, dorsalis pedis, tibialis posterior and abdominal aorta all palpated; all peripheral pulses were 3+**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Regular and unlabored respirations, and clear breath sounds auscultated in both lungs bilaterally, in upper and lower lobes both anteriorly and posteriorly.** **Lung aeration is equal in both lungs bilaterally, in both upper and lower lobes, and anteriorly and posteriorly.**
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:**	**Regular diet at home.** **Current diet is regular.** **Height is 104 cm** **Normoactive bowel sounds auscultated in all four quadrants of the abdomen; last bowel movement was 03/10/2022** **Palpation of the stomach revealed soft, non-tender abdomen, no guarding present, and no masses found. Upon inspection no abnormalities such as distention, incisions, scars, drains, and wounds were present.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Patient refused oral intake and was unable to urinate during the rotation** **N/A**
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☐**	**Nail bed is pink, clean, and well-maintained, extremities are well-groomed, maintained, and skin is appropriate for ethnicity; Temperature is warm.** **Patient has active and equal range of motion in all extremities.** **Patient has no assistive devices. Adequate strength in all extremities, upper and lower.** **Fall risk score is 4.** **Patient is independent, or up ad lib.** **Patient does not need any assistance with equipment or support to stand and walk.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Cognitive and oriented to person, place, situation, and time, x4; Patient is adequately cognitive and mature** **Non-articulative and unclear speech** **Alert** **No gross focal neurological deficits. Patient is alert, awake and able to answer questions appropriately**
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):**	**KP copes through the support of her single mother and aunt. KP is the expected level of maturity for developmental age. Patient can read, write, and form full structured sentences according to developmental age. KP is unable to fully make informed decisions at the age of 4 years. KP lives with her single mother and will discharge back home with her mother.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0348	**72**	**N/A**	**20**	**97.6 F**	**100%**
0857	**79**	**112/69**	**24**	**98.1 F**	**99%**

Vital Sign Trends:

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

Pulse Rate	**65-110** (Ricci et al., 2021)
Blood Pressure	**112/72** (Novak & Gill, 2018)
Respiratory Rate	**20-25** (Ricci et al., 2021)
Temperature	**95.9-99.5 F** (Novak & Gill, 2018)
Oxygen Saturation	**95-100%** (Novak & Gill, 2018)

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

Novak, C., & Gill, P. (2018). *Pediatric vital signs reference chart*. Peds Cases. Retrieved March 16, 2022, from https://www.pedscases.com/pediatric-vital-signs-reference-chart

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
0800	**Numeric**	**No pain**	**0/10**	**N/A**	**No interventions needed.**
Evaluation of pain status *after* intervention	**Numeric**	**No pain**	**0/10**	**N/A**	**No interventions needed.**
Precipitating factors: KP was not in pain. No precipitating factors noted. **Physiological/behavioral signs:** Grimacing, screaming, yelling					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)

120 mL of chocolate milk	**No output recorded for the rotation because the patient is refusing oral intake. Also, the patient is refusing to urinate.**

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

1. A 4-year-old is aware of the rewards of behaving well and is capable of learning good manners (Ricci et al., 2021).
2. Routine is vital to the preschooler as routine develops a sense of time, and routine builds structure, which increases the preschooler's sense of safety and security (Ricci et al., 2021).
3. Preschoolers begin playing cooperatively with peers. Cooperative play encourages the preschooler to develop and maintain social skills such as being attentive, communicating, and sharing by taking turns (Ricci et al., 2021).

Age-Appropriate Diversional Activities

1. Reading with a caregiver
2. Drawing with crayons and paper
3. Watching favorite movies and cartoons

Psychosocial Development:

Which of Erikson's stages does this child fit?

KP is in the halfway point of the initiative vs. guilt stage (Ricci et al., 2021).

What behaviors would you expect?

During the initiative vs. guilt stage, one would expect cooperative play, the building of self-confidence and assertiveness, social skills improving with more interaction with peers, and lots of questions related to increased curiosity (Ricci et al., 2021).

What did you observe?

KP was quiet, withdrawn, and mostly mumbled during the rotation. When administering medications, KP was in extreme pain related to the mouth ulcers. KP kicked, screamed, hit, and threw a tantrum when the nurse administered the medications (Ricci et al., 2021).

Cognitive Development:

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

Using Piaget as a reference, KP is in the beginning of the preoperational stage (Ricci et al., 2021).

What behaviors would you expect?

During the preoperational stage expect imitation or mimicry, symbolic imaginary play, drawing pictures, and constant talking about past experiences (Ricci et al., 2021). Also, children in the preoperational stage are increasing abstract thoughts and language development (Ricci et al., 2021).

What did you observe?

Again, KP was withdrawn, silent, and mumbling until medication administration. While administering KP's medications, she was hitting, yelling, and clearly distressed and in pain.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

KP did not speak much, but while screaming she said kept repeating the bad word mother fucker. Given that KP is only 4 years old, the use of such as bad word is concerning (Ricci et al., 2021).

Any concerns regarding growth and development?

No developmental delays or other abnormalities are noted minus the usage of a bad word. KP is withdrawn and quiet related to the acute pain related to the mouth ulcers.

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

Nursing Diagnosis • 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.	**Rational** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcomes**	**Evaluation** • How did the Client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. At risk for acute pain related to painful mouth ulcers evidenced by grimacing, screaming, and pain rating (Swearingen & Wright, 2018).	**For KP, the pain related to the mouth ulcers is the main priority. The mouth ulcers are so painful, it is hindering the patient from intaking any oral fluid or food (Swearingen**	**1. Administer acetaminophen 160 mg every four hours as needed to decrease pain (Swearingen & Wright, 2018).** **2. Administer stomatitis cocktail three times daily before meals**	**1. The patient will take 160 mg Tylenol every four hours as needed for pain. The patient's pain will decrease based on verbal confirmation. No grimacing or screaming**	**1. The patient and patient's mother responded well to the administration of Tylenol. Tylenol 160 mg was given every four hours as needed. Pain was decreased and patient did not present with**

	& Wright, 2018). Without adequate nutrition, the patient's status will continue to decline (Swearingen & Wright, 2018). It is vital to decrease the pain in the mouth, so that KP can eat without pain and receive proper nutrition (Swearingen & Wright, 2018).	**to allow patient to eat without pain (Swearingen & Wright, 2018).**	**will be present.** **2. KP will swish or have the nurse swab the mouth with the stomatitis cocktail before each meal. The stomatitis cocktail will significantly decrease pain and enable KP to eat without pain and maintain adequate nutrition.**	**grimacing or screaming. Goal met. No modifications needed.** **2. The patient responded okay with the stomatitis cocktail. First, the patient refused the stomatitis cocktail, but the mother helped with administration. The stomatitis cocktail decreased the pain enough for the patient to eat some eggs and fruit. Goal met. Re-educating the patient and the patient's mother on how the stomatitis cocktail will decrease pain and allow the patient to eat an adequate meal is necessary as a modification.**
2. At risk for imbalanced nutrition related to decreased appetite as evidenced by painful	**Due to KP's refusal to intake any substance orally, this puts her at high risk for imbalanced**	**1. Monitor the patient's intake and output strictly (Swearingen & Wright, 2018).** **2. Administer**	**1. KP's intake and output will be monitored strictly and tracked accurately.**	**1. The patient and patient's mother respond well to strict and accurate monitoring of intake and output. Goal**

mouth ulcers and refusal of oral intake (Swearingen & Wright, 2018).	**nutrition (Swearingen & Wright, 2018). Without eating, KP is not receiving the necessary nutrients especially at such a young age, where nutrients are a major influence on growth and development (Swearingen & Wright, 2018). The mouth ulcers are preventing KP from eating due to the pain that occurs when any food or liquid is consumed via the mouth (Swearingen & Wright, 2018).**	**sucralfate 500 mg three times daily before meals (Swearingen & Wright, 2018).**	**2. Sucralfate 500 mg will be administered three times daily before meals.**	**met. No modifications needed.** **2. The patient does not respond well to sucralfate administration. While administering the medication, the patient threw a tantrum and was unable to be consoled. Goal met. Distraction may be a necessary modification to help the patient remain calm and cooperative while administering sucralfate in the future.**
3. At risk for impaired skin integrity related to lesions on the hands and feet as evidenced by the spread of the lesions to the buttocks, legs, and	**KP has itchy lesions covering a good portion of all her extremities and even the buttocks. Due to the itchiness and spread of the lesions, the**	**1. Assess skin integrity via the Braden scale to observe for worsening skin integrity (Swearingen & Wright, 2018).** **2. Assess the overall**	**1. KP will have her skin assessed via the Braden scale to observe for any changes in skin integrity especially where the lesions are**	**1. The patient and patient's mother respond well to the Braden assessment. The patient was cooperative and calm. Braden scale assessed and completed. Goal met. No**

arms (Swearingen & Wright, 2018).	**lesions put KP at risk for impaired skin integrity (Swearingen & Wright, 2018). The more KP scratches and agitates the lesions the more likely the lesions will begin to bleed, and the skin will break due to constant irritation (Swearingen & Wright, 2018).**	**condition of the skin (Swearingen & Wright, 2018).**	**located on the hands, feet, arms, legs, and buttocks.** **2. The patient will have her overall skin condition assessed for baseline data and to observe for rash, spread of lesions, and any other alterations in skin integrity.**	**modifications needed.** **2. KP and her mother responded well to the overall assessment of KP's skin condition. Baseline condition was recorded and observation for any changes such as rash and spreading lesions. Goal met. No modifications needed.**
4. At risk for infection related to related to decreased immunity as evidenced by fever, poor nutrition, and no improvement in status (Swearingen & Wright, 2018).	**KP is at mild risk for infection related to the decrease in immunity due to the stress on the body from hand-foot-and-mouth disease (Swearingen & Wright, 2018). KP's immunity is not fully developed and already fighting off the virus that caused hand-foot-and-mouth disease (Swearingen**	**1. Assess vitals every four hours, especially temperature (Swearingen & Wright, 2018).** **2. Assess immunization status and history (Swearingen & Wright, 2018).**	**1. KP's vital signs will be assessed every four hours. Alterations in temperature will be assessed closely.** **2. Immunization status and history will be assessed as up-to-date and complete.**	**1. The patient and the patient's caregiver respond well to the vital signs assessment every four hours. Temperature alterations are strictly monitored. The patient is calm and cooperative. Goal met. No modifications needed.** **1. KP and her mother respond well to questioning about**

	& Wright, 2018). In addition, the patient has been battling again fever, receiving poor nutrition due to refusal of oral intake, and not making much improvement (Swearingen & Wright, 2018).			**immunization status and history. The patient's mother confirms that KP is fully immunized, and up-to-date.**

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Mosby.

Concept Map (20 Points):

Subjective Data

KP is in severe pain with oral intake related to mouth ulcers.
According to KP's mother, KP is in constant, sharp pain to the point where she refuses any oral intake even medications.
KP presented to the ED with swollen lips, poor oral intake, and a 101 F fever. The patient had the 101 F fever for three days prior to admission.

Nursing Diagnosis/Outcomes

At risk for acute pain related to painful mouth ulcers evidenced by grimacing, screaming, and pain rating (Swearingen & Wright, 2018).
The patient will take 160 mg Tylenol every four hours as needed for pain. The patient's pain will decrease based on verbal confirmation. No grimacing or screaming will be present.
2. KP will swish or have the nurse swab the mouth with the stomatitis cocktail before each meal. The stomatitis cocktail will significantly decrease pain and enable KP to eat without pain and maintain adequate nutrition.
At risk for imbalanced nutrition related to decreased appetite as evidenced by painful mouth ulcers and refusal of oral intake (Swearingen & Wright, 2018).
KP's intake and output will be monitored strictly and tracked accurately.
Sucralfate 500 mg will be administered three times daily before meals.
At risk for impaired skin integrity related to lesions on the hands and feet as evidenced by the spread of the lesions to the buttocks, legs, and arms (Swearingen & Wright, 2018).
KP will have her skin assessed via the Braden scale to observe for any changes in skin integrity especially where the lesions are located on the hands, feet, arms, legs, and buttocks.
The patient will have her overall skin condition assessed for baseline data and to observe for rash, spread of lesions, and any other alterations in skin integrity.
At risk for infection related to related to decreased immunity as evidenced by fever, poor nutrition, and no improvement in status (Swearingen & Wright, 2018).
KP's vital signs will be assessed every four hours. Alterations in temperature will be assessed closely.
Immunization status and history will be assessed as up-to-date and complete.

Objective Data

Vital signs are stable.
AST level was 77 at the time of admission.
Lesions on the hands, feet, legs, arms, and buttocks noted.
Rash around the mouth, and on the hands and feet noted.
Nose deformity related to missing nasal bridge bone noted.

Client Information

KP is a 4-year-old African American female that presented to the Carle ED for refusal of oral intake. The patient presented with lesions on the hands and feet, with a 101 F fever. KP's lips were swollen, and sores were present in the mouth upon admission. KP has past medical illness of asthma, pneumonia bronchiolitis, and right ear infection. She has no significant past surgical history

Nursing Interventions

1. Administer acetaminophen 160 mg every four hours as needed to decrease pain (Swearingen & Wright, 2018).
2. Administer stomatitis cocktail three times daily before meals to allow patient to eat without pain (Swearingen & Wright, 2018).
1. Monitor the patient's intake and output strictly (Swearingen & Wright, 2018).
2. Administer sucralfate 500 mg three times daily before meals (Swearingen & Wright, 2018).
1. Assess skin integrity via the Braden scale to observe for worsening skin integrity (Swearingen & Wright, 2018).
2. Assess the overall condition of the skin (Swearingen & Wright, 2018).
1. Assess vitals every four hours, especially temperature (Swearingen & Wright, 2018).
2. Assess immunization status and history (Swearingen & Wright, 2018).