N433 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 3/9/22	**Client Initials** ZJ	**Age (in years & months)** 2 years old	**Gender** Female
Code Status Full code	**Weight (in kg)** 11.9 kg	**BMI** 14.73 kg/m^2	**Allergies/Sensitivities (include reactions)** N/A

Medical History (5 Points)

Past Medical History: constipation, elevated WBC count, eczema

Illnesses: sickle cell anemia, Rhinovirus

Hospitalizations: Patient has been in and out of the hospital consistency due to chronic illness.

Past Surgical History: rectal biopsy

Immunizations: Patient's immunizations up to date according to parent.

Birth History: Birth weight: 2900 g

Birth height: 50 cm (19.69 in)

Gestational age: 41 weeks

Apgar: 1 minute: 8 5 minutes: 8

Delivery method: primary low transverse c-section

Complications (if any): N/A

Assistive Devices: N/A

Living Situation: Patient lives at home with parents and siblings.

Admission Assessment

Chief Complaint (2 points): fever, cough, URI

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

Pertinent Events during this admission/hospitalization (1 points): fever, wheezing, URI, respiratory distress, hypoxia, sickle cell disease

History of present Illness (OLD CARTS) (10 points): The patient's family was not at the bedside, so the information was taken from the nurse and chart. On 3/6/22, the patient's mother took her to the hematologist's office for having a fever, rhinorrhea, and cough for the past four days with diminished oral intake and urine output. The patient has been in contact with her sick sister. On 3/7/22, the 2-year-old female came to the emergency department for ongoing symptoms but was returned home. On 3/9/22, the mother took the patient back to the hematologist for no improvement of symptoms. The patient was directly admitted to the pediatric unit. The patient does not display any pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): sickle cell disease

Secondary Diagnosis (if applicable):.

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

Sickle cell disease is an inherited blood disorder that compromises red blood cells. The red blood cells in sickle cell disease tend to have mainly hemoglobin S, which is abnormal (Capriotti, 2020). The cells themselves become a sickle shape or crescent shape, making it difficult to pass through small blood vessels (Capriotti, 2020). When the sickle cells block the vessels, less blood can reach different parts of the body (Capriotti, 2020). If the tissue does not receive enough blood, that tissue will eventually become damaged.

Signs and symptoms of sickle cell disease include pain, jaundice, or fatigue (Capriotti, 2020). The symptoms genuinely depend on the complication of the disease. Other complications may include anemia, infections, or organ damage. Dehydration is a factor that can bring on pain, and my patient is dealing with dehydration. My patient would become irritable in some moments due to missing her family, which can be a symptom of sickle cell disease. When sickle cell disease happens, red blood cells, hemoglobin, and hematocrit decrease due to the defective substance and change in the shape of the cells (Capriotti, 2020). My patient displays low red blood cells, hematocrit, and hemoglobin with her disease. The red blood cells are low in my patient due to the cells dying faster than the body can reproduce new cells (Capriotti, 2020). This disease makes the blood sticky and causes the cells to pile up and block the vessels.

To diagnose sickle cell disease, you can do a blood test to check for the form of hemoglobin that is associated with the disease. My patient would receive blood tests to view the progression of blood levels and how they are trending for her disease. My patient also had a chest Xray down to rule out any other associating factors to the disease. Treatment of the disease depends on age, health, the disease's extent, and tolerance. In early diagnosis, preventative measures are in place to prevent infection, organ damage, and stroke (Hinkle & Cheever, 2018). My patient took Tylenol to reduce her fever to prevent infection; my patient also had a blood transfusion done when she was admitted due to her dangerously low hemoglobin levels. You must focus on two specific signs and symptoms of this disease before they turn into a severe complication. If the patient states they have a headache, you must contact the doctor due to the risk of stroke. If the patient has acute chest pain, it is also vital to call the doctor. The nurse needs to intervene quickly to prevent further complications or even death.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for 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*. Wolters Kluwer.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: as tolerated	
Diet/Nutrition: regular	
Frequent Assessments:	Monitor temperature
Labs/Diagnostic Tests:	No labs ordered for patient.
Treatments: suctioning, O2 spot check: keep at >92%	
Other: N/A	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Possible discharge later today	

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	3.84- 4.92	2.04	N/A	A decrease in red blood cells can indicate anemia which is a result of not enough oxygen getting to the body's cells and tissues. This is also called hypoxia. Hemoglobin is responsible for carrying oxygen to red blood cells. Patient has chronic illness of sickle cell anemia (Capriotti, 2020).
Hgb	10.2- 12.7	6.8	10.9	A decrease in hemoglobin indicates the patient has a low red blood cell count. The decrease value of red blood indicates the reason for the low hemoglobin value. Patient has chronic illness of sickle cell anemia, which can associate with low hemoglobin (Capriotti, 2020).
Hct	31.2- 37.8%	18.4	30.7	The decrease in hematocrit can indicate there is not enough supply of healthy red blood cells. The patient has a decrease in red blood cells which is the cause of low hematocrit. Patient has chronic illness of sickle cell anemia, which can associate with low hematocrit (Capriotti, 2020).

Platelets	189- 394	254	N/A	There are no abnormal values. The lab is within normal range.
WBC	4.86- 13.18	13.17	N/A	There are no abnormal values. The lab is within normal range.
Neutrophils	1.60-8.29	6.24	N/A	There are no abnormal values. The lab is within normal range.
Lymphocytes	0.25- 5.77	5.31	N/A	There are no abnormal values. The lab is within normal range.
Monocytes	0.24- 0.92	2.13	N/A	An increase number of monocytes is associated with the patient's illness of sickle cell disease. Monocytes are activated and enhance vaso-occlusion through an inflammatory response (Capriotti, 2020).
Eosinophils	0.03- 0.46	0.17	N/A	There are no abnormal values. The lab is within normal range.
Basophils	0.01-0.06	0.03	N/A	There are no abnormal values. The lab is within normal range.
Bands	0.00-0.04	N/A	N/A	There are no abnormal values. The lab is within normal range.

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	136	N/A	There are no abnormal values. The lab is within normal range.
K+	3.5-5.1	4.0	N/A	There are no abnormal values. The lab is within normal range.
Cl-	98-107	103	N/A	There are no abnormal values. The lab is within normal range.
Glucose	74-100	97	N/A	There are no abnormal values. The lab is within normal range.
BUN	5-17	8	N/A	There are no abnormal values. The lab is within normal range.
Creatinine	0.45-1.02	0.45	N/A	There are no abnormal values. The lab is within normal range.
Albumin	3.8-5.4	N/A	N/A	There are no abnormal values. The lab is within normal range.
Total Protein	6.0-8.0	N/A	N/A	There are no abnormal values. The lab is within normal range.

Calcium	8.8-10.8	9.2	N/A	There are no abnormal values. The lab is within normal range.
Bilirubin	0.2-1.2	N/A	N/A	There are no abnormal values. The lab is within normal range.
Alk Phos	9-500	N/A	N/A	There are no abnormal values. The lab is within normal range.
AST	5-34	N/A	N/A	There are no abnormal values. The lab is within normal range.
ALT	0-55	N/A	N/A	There are no abnormal values. The lab is within normal range.
Amylase	30-100	N/A	N/A	There are no abnormal values. The lab is within normal range.
Lipase	10-140	N/A	N/A	There are no abnormal values. The lab is within normal range.

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	N/A	N/A	There are no abnormal values. The lab is within normal range.
CRP	0-0.29	N/A	N/A	There are no abnormal values. The lab is within normal range.
Hgb A1c	4-7%	N/A	N/A	There are no abnormal values. The lab is within normal range.
TSH	0.4-4.0	N/A	N/A	There are no abnormal values. The lab is within normal range.

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	There are no abnormal values. The lab is within normal range.
pH	5.0-7.0	N/A	N/A	There are no abnormal values. The lab is within normal range.
Specific Gravity	1.003-1.035	N/A	N/A	There are no abnormal values. The lab is within normal range.
Glucose	negative	N/A	N/A	There are no abnormal values.

				The lab is within normal range.
Protein	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
Ketones	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
WBC	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
RBC	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
Leukoesterase	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.

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	There are no abnormal values. The lab is within normal range.
Blood Culture	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
Sputum Culture	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
Stool Culture	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
Respiratory ID Panel	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.
COVID-19 Screen	negative	N/A	N/A	There are no abnormal values. The lab is within normal range.

Lab Correlations Reference (1) (APA):

Carle Foundation Hospital (2021). *Epic.* Patient Portal - Login Page (mycarle.com)

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray: The chest x-ray was used to rule out pneumonia. The patient's airway appeared normal, with no focal consolidations, no pneumothorax or pleural effusion, and no evidence of pneumonia.

Diagnostic Test Correlation (5 points):

The chest x-ray was performed on admission due to a persistent cough and drainage coming from the patient's nasal passageway. The x-ray is used to rule out pneumonia (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

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

Brand/Generic	Albuterol sulfate (Proair) Nebulizer solution	Azithromycin (Zithromax)	Cefdinir (Omnicef)		
Dose	3 mL= 2.5 mg	60mg	83.3mg		
Frequency	RT PRN	daily	Every 12 hrs		
Route	nebulizer	PO	PO		
Classification	Pharmacologic: Adrenergic Therapeutic: Bronchodilator	Pharmacological: Macrolide antibiotics therapeutic: pregnancy category B	Pharmacological: Third generation Cephalosporin Therapeutic: Antibiotic		

Mechanism of Action	Albuterol attaches to beta receptors on the bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine monophosphate.	Azithromycin binds together with 23S rRNA and stops the bacterial protein to be able to synthesize by inhibiting the translocation step of protein synthesis	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking peptidoglycan strands which makes the cell membranes ridged and protective.		
Reason Client Taking	The patient is taking albuterol sulfate to treat wheezing in the patient.	The patient has an URI, so the medication is used to treat the infection inside the body.	This patient is having a URI, so this medication is used to treat the infection going on in her body. This patient is also dealing with other respiratory issues.		
Concentration Available	2.5 mg/3mL	100mg/5mL	250mg/5mL		
Safe Dose Range Calculation	0.63-2.5 mg Q4-6 PRN	5-12mg/kg/dose	14mg/kg/day		
Maximum 24-hour Dose	12.5 mg	12mg	600mg/day		
Contraindications (2)	Hypersensitivity to albuterol, high blood pressure	Bleeding disorders, hypersensitivity	Hypersensitivity to cephalosporins, carnitine deficiency		
Side Effects/Adverse Reactions (2)	Purities, dry mouth	Constipation, dizziness	Hepatic dysfunction, anemia		
Nursing Considerations (2)	Monitor serum potassium level because albuterol may cause transient	Monitor patient for signs of anaphylaxis, may lead to pseudomembranous	Obtain culture and sensitivity test results before administering		

	hypokalemia Be aware that drug tolerance can develop with prolong use	colitis, pain, diarrhea, or nausea so watch for signs and symptoms	Monitor BUN and Cr levels for early signs of renal dysfunction		
Client Teaching needs (2)	Make sure to use medication as prescribed Make sure the nebulizer is kept clean- the mouthpiece is soaked to prevent administration of bacteria	Take medication how prescribed and for the full length of time even if symptoms resolve Make sure to store at room temperature away from heat and moisture	Educate to take with meals to enhance drug absorption Instruct to report severe diarrhea to prescriber immediately		

Medication Reference (1) (APA):

Jones & Bartlett learning (2020). *2020 Nurse's Drug Handbook*.

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x 3. Patient does not display any distress and responds appropriately. Patient is cooperative, well-groomed and has a clean appearance.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 6** **Drains present: Y☐ N ☒** **Type:** **IV Assessment (If applicable to child):**	Patient's skin color is normal for ethnicity. Patient's skin is dry, warm, and elastic without discoloration. No presences of rashes, bruises, wounds. Braden score is 6. Patient does not have an IV present.

Size of IV: N/A **Location of IV:** N/A **Date on IV:** N/A **Patency of IV: N/A** **Signs of erythema, drainage, etc.:** N/A **IV dressing assessment:** N/A **IV Fluid Rate or Saline Lock:** N/A	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Patient's head is symmetrical with movement. Ears are bilateral and symmetrical. Ears are at appropriate height. Eyes are PERLA. The patient's nose is symmetrical, bilateral nose congestion with thick yellow drainage. No redness present under nose. Teeth are appropriate for age. Patient able to focus and respond to sounds. Patient able to swallow without difficultly.
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:**	Patient's heart displays S1 and S2 sounds. Peripheral pulses 2+ on upper and lower extremities bilaterally. Cap refill less than 2 seconds. No presence of jugular vein distention or edema.
RESPIRATORY: **Accessory muscle use: Y☒ N ☒** **Breath Sounds: Location, character**	Breath sounds are coarse and equal in all lobes bilaterally anterior and posterior. Patient has use of accessory muscle, labored breathing. Patient is on room air. Patient has occasional wheezing in all lobes equally anteriorly and posteriorly.
GASTROINTESTINAL: **Diet at home:** regular **Current diet:** regular **Height (in cm):** 83.2 cm **Auscultation Bowel sounds:** **Last BM:** 3/11/2022 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒**	Patient is on a regular diet. Patient is on a regular diet currently. Patient's height is 83.2 cm. Patient's last bowel movement was 3/11/22. Patient's abdomen is soft, non-tender, non-distended. Bowel sounds are active and audible in all four quadrants. No presence of mass, incisions, scars, drains, wounds, or pain.

Size: **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:** **Size:**	Patient did not void when I was on the floor. In the chart at 0630, patient voided, and color was yellow with no pain with urination. No dialysis, abnormalities of genitals or catheter.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score:** 2 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	The patient's skin was warm on upper and lower extremities bilaterally. Patient has active range of motion in upper and lower extremities bilaterally. Patient shows equal strength in upper and lower extremities bilaterally. The patient ADL assistance is appropriate with age. Patient has elimination assistance, using a diaper. The patient repositions herself in bed. The patient has a fall risk score of 2.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is alert and oriented x 3. Patient's follows commands. Patient's speech is clear, and understandable for age. Patient has sensation in right and left upper/lower extremities equally. Patient behavior is appropriate for age and situation. Level of consciousness patient is alert, awake and responsive.
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):**	The patient did not have any family members at the bedside. The child expressed she missed her mother and sister. The child used coping mechanisms like playing with toys and watching television.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	137	104/63	26	38.2 C (100.7 F)	98
1100	135	104/63	26	98.2 F	98

Vital Sign Trends: The patient had an increase in temperature at the beginning of the shift. The patient was given Tylenol. After reassessing the patient after 30 minutes, the temperature decreased.

Normal Vital Sign Ranges (2.5 points)

****Need to be specific to the age of the child****

Pulse Rate	80-150 bpm
Blood Pressure	86/106 (systolic) 42/63 (diastolic)
Respiratory Rate	22-37
Temperature	97-100.4
Oxygen Saturation	97-99%

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

Carle Foundation Hospital (2021). *Epic*. Carle Health | Your care starts here.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	rFLACC	Face, legs,	0,0,0,0,0	N/A	N/A

		activity, cry, consolability			
Evaluation of pain status *after* intervention	The patient did not experience any pain, so no interventions were needed.	The patient did not experience any pain, so no interventions were needed.	The patient did not experience any pain, so no interventions were needed.	The patient did not experience any pain, so no interventions were needed.	The patient did not experience any pain, so no interventions were needed.
Precipitating factors: The patient did not experience any pain, so there were no precipitating factors. **Physiological/behavioral signs:** The patient did not experience any pain, so no physiological or behavioral signs shown.					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
0900: 75% half of yogurt container 4 bites of pancake	Patient did not have an output during my time on the floor.

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. The patient shows independence.
2. The patient uses two-word phrases.
3. The patient points to things and interacts with a book.

Age Appropriate Diversional Activities

1. The patient watches television.
2. The patient plays make believe with her stuffed animal cat and plays tea party.
3. The patient plays with a ball.

Psychosocial Development:

Which of Erikson's stages does this child fit?

This patient is in the Autonomy versus shame and doubt stage.

What behaviors would you expect?

You can expect the patient to do activities alone. In this stage, toddlers usually do not take turns in games until three years old. The toddler may show spontaneous affection.

What did you observe?

I observed that my patient would mainly play with her toys and did not want to share them with me. The patient attempted to imitate how I would spin the fidget spinner toy.

Cognitive Development:

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

This patient is the preoperational stage.

What behaviors would you expect?

In this stage, you would expect the toddler to imitate people. The toddler would also use their imagination skills, for example, pretending a stick is a sword. These toddlers are very into symbolic play in this stage of development.

What did you observe?

I observed my patient attempt to imitate me when I would play with her toys; she would try to do the same thing.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

The patient was vocalizing in two-word phrases appropriate for her age group. There were no concerns about her vocalization or vocabulary.

Any concerns regarding growth and development?

The patient was appropriate for her age group, there were no concerns about her growth and development.

Developmental Assessment Reference (1) (APA):

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

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Interventions (2 per dx)	Outcomes	Evaluation
• 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.	• Explain why the nursing diagnosis was chosen			• How did the Client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Ineffective airway clearance related to sickle cell disease as evidence by adventurous breath sounds and wheezing.	This nursing intervention was chosen due to the patient having nasal drainage and a persistent cough that cannot remove airway sections without suction.	**1.**Position the patient upright if tolerated. Regularly check the patient's position to prevent sliding down the bed **2.**Perform nasotracheal suctioning as necessary	**1.** The patient will be able to exhibit optimal lung expansion and improve air exchange. When suctioning, the patient will be able to have the mucus removed for airway clearance.	The patient's family was not present. The patient was able to stay in an upright position, and when she laid down, she was propped up on pillows to allow her to stay in the upright position. Suction was not performed during my time on the floor. The patient's goal was partially met.
2. Hyperthermia related to upper respiratory infection as evidenced by temperature of 38.2 C, with shallow breathing and flushed skin	This nursing intervention was chosen because the patient has an upper respiratory infection which can interfere with the patient's ability to heal correctly.	**1.** Remove excessive clothing, blankets, and linens. Adjust the room temperature **2.**Administer the prescribed antibiotic and anti-pyretic medications	1.When removing the extra linens and reducing the temperature in the room, the patient's temperature will decrease. When administering the antibiotic and Tylenol, the patient's temperature will decrease, and the upper respiratory infection shows signs of improvement.	The patient's goal was met. The patient seemed a lot livelier once a good amount of linens were removed and the temperature in the room was decreased. After an administration of Tylenol, the patient's temperature also decreased significantly. The patient's labs were not taken today. I could not detect if the antibiotic were working to its full effect.
3. Ineffective tissue perfusion vaso-occlusive nature of sickling,	This nursing intervention was chosen because my patient has sickle cell anemia and	**1.** Maintain room temperature and body warmth without overheating	**1.** Patient was able to keep tissue perfusion to vital organs by warm and dry skin;	The patient's goal was semi meet due to the evidence of skin warmth and dryness. The patient still has no void. The patient is trying to

inflammatory response as evidence by anuria and respiratory distress.	respiratory distress.	**2.** Maintain adequate fluid intake and monitor urine output	peripheral pulses were shown. The patient still does not void.	intake more fluids through the bottle.
4. Ineffective coping skills related to constant hospital stays as evidence by voicing she misses her mother and sister	This nursing diagnosis was chosen because of her constant hospital stays due to her illness. My patient states that she wants to be home with her mother and sister.	**1.** Accept the patients' feelings and avoid fake reassurances **2.** Be supportive in coping behaviors; give patient time to relax	**1.** The patient was able to use toys and television to distract her feelings. The patient's mood changed when I accepted. She missed her family and let her know her valid feelings instead of stating she would see mom today. The patient would switch back and forth from playing to relaxing and watching tv.	The patient did meet her goal by being able to voice her feelings and used nonpharmacological technics like watching tv and playing video games to cope with her disease.

Other References (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of Medical-Surgical Nursing*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient stated she missed her mother and sister.

The patient was voicing how excited she was when playing with her toys.

The patient's family was not present to give any information on the patient.

Nursing Diagnosis/Outcomes

1. Ineffective airway clearance related to sickle cell disease as evidence by adventurous breath sounds and wheezing.
   Outcome: The patient will be able to exhibit optimal lung expansion and improve air exchange. When suctioning, the patient will be able to have the mucus removed for airway clearance.

2. Hyperthermia related to upper respiratory infection as evidenced by temperature of 38.2 C, with shallow breathing and flushed skin
   Outcome: When removing the extra linens and reducing the temperature in the room, the patient's temperature will decrease. When administering the antibiotic and Tylenol, the patient's temperature will decrease, and the upper respiratory infection shows signs of improvement.

3. Ineffective tissue perfusion vaso-occlusive nature of sickling, inflammatory response as evidence by anuria and respiratory distress.
   Outcome: Patient was able to keep tissue perfusion to vital organs by warm and dry skin; peripheral pulses were shown. The patient still does not void.

4. Ineffective coping skills related to constant hospital stays as evidence by voicing she misses her mother and sister
   Outcome: The patient was able to use toys and television to distract her feelings. The patient's mood changed when I accepted. She missed her family and let her know her valid feelings instead of stating she would see mom today. The patient would switch back and forth from playing to relaxing and watching tv.

Objective Data

The patient's breathing displays wheezing and advantageous breath sounds on inhalation and expiration.

The patient has yellow-purulent sputum draining from her nose.

The patient's rFLACC score was a zero. The patient is not in any pain.

Client Information

The patient is a 2-year-old African American, female with a history of constipation, elevated WBC count, eczema. She is currently in the hospital for a sickle cell crisis. The patient's illness is chronic and keeps the patient coming in and out of the hospital.

Nursing Interventions

1.Position the patient upright if tolerated. Regularly check the patient's position to prevent sliding down the bed

2.Perform nasotracheal suctioning as necessary

1. Remove excessive clothing, blankets, and linens. Adjust the room temperature

2.Administer the prescribed antibiotic and anti-pyretic medications

1. Maintain room temperature and body warmth without overheating

2. Maintain adequate fluid intake and monitor urine output

1. Accept the patients' feelings and avoid fake reassurances

2. Be supportive in coping behaviors; give patient time to relax