N433 Care Plan # 1

Lakeview College of Nursing

Kati Davis

Demographics (3 points)

Date of Admission 9/20/22	**Client Initials** P. T	**Age (in years & months)** 6yr 8mo	**Gender** Female
Code Status Full	**Weight (in kg)** 34.5kg	**BMI** 23.24 kg/m2	**Allergies/Sensitivities (include reactions)** NKA

Medical History (5 Points)

Past Medical History: The patient displays a developmental delay.

Illnesses: The patient does not have any significant previous illnesses.

Hospitalizations: The patient has no previous hospitalizations.

Past Surgical History: The patient has no previous surgical history

Immunizations: Per caregiver, immunizations are up to date.

Birth History: Mom and baby were discharged home together @ 2 days.

Complications (if any): N/A

Assistive Devices: No use of assistive devices.

Living Situation: The patient lives at home with parents, one sibling, and paternal grandmother**.**

Admission Assessment

Chief Complaint (2 points): Labored respirations

Other Co-Existing Conditions (if any): Respiratory distress

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

(9/21/22) The patient was tachycardic and visually anxious. Upon assessment, there was tracheal tugging, xiphisternal retractions, poor air exchange, respirations sitting in the 60s and O2

saturations in the 80s. At this time the patient was receiving continuous nebulizer treatments and started BIPAP.

(9/22/22) The patient did well on BIPAPA overnight and remained afebrile. She was weened to 15L of High flow oxygen at 30%. Her nebulizer treatments were reduced to Q2.

History of present Illness (OLD CARTS) (10 points): The patient is a 6 year old female who presented to the emergency department with cough, fevers, wheezing, and rapid breaths for 1 day. Per mom, the patient was febrile for one day and experienced cough, and rapid breathing which cause discomfort in the chest. These symptoms began 9/19/22. The patient had a productive cough at time of admission, 9/20/22. It was reported that the patient was experiencing some hemoptysis. The patient had been administered Motrin every 6 hours as needed which helped relieve her chest discomfort. Her last dose before admission was 1:00 pm on 9/20/22. Dad has also been sick with viral symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Rhinovirus

Secondary Diagnosis (if applicable):.

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

Long recognized as the primary causative agent of “common colds,” rhinovirus (RV) has been linked to signs and symptoms including rhinorrhea, nasal congestion, cough, sore throat, headache, and generalized malaise. Most human rhinoviruses are discovered during the first six days of the beginning of symptoms. A nasopharyngeal swabbing is most sensitive in the instance of upper respiratory infections. The Picornaviridae family of viruses, which includes nine genera although only six of them are diseasing causing to people, includes the enterovirus, rhinovirus,

hepatovirus, parechovirus, cardiovirus, and kobivirus (Bizot, et al., 2022). Transmission of RV mostly happens through direct contact with and inhalation of respiratory droplets, while it can also happen through germs (infected surfaces), including immediate person-to-person contact (Vandini et al., 2019). The common cold, an ear infection, bronchiolitis, pneumonia, and asthma are among the frequent clinical manifestations of rhinovirus (Bizot, et al., 2022).

Since there is currently no antiviral therapy, managing a human rhinovirus infection is limited to supportive care, rest, and ample hydration. The patient is following these measures. She is resting in bed with mom and grandma at bedside. She attempts to drink water and has IV access if fluids become necessary. On top of those three treatment measures the patient is receiving oxygen via nasal cannula. Although rhinovirus is frequently linked to the common cold, new advances in molecular techniques have shown the human rhinovirus (HRV) is also implicated in serious respiratory illness (Bizot, et al., 2022). In her case, the rhinovirus was resulting in respiratory distress and the oxygen was necessary to raise her oxygen saturations out of the 80s. In the event of rhinovirus, a chest x-ray may be ordered to rule out pneumonia or pneumonitis. The patient did have a chest x-ray and the physician was able to visualize mild left basilar airspace disease. This is detecting potential early pneumonitis, which is inflammation of the lungs.

The patient will continue to rest and recover with support and hydration. The goal is to continue weaning oxygen support via nasal cannula and ensure the lungs remain without infection. There is no preventive drug treatment to dodge the virus, so we must remember the importance of hand hygiene and appropriate social distancing to prevent HRV infections.

Pathophysiology References (2) (APA): of

Bizot, E., Bousquet, A., Charpié, M., Coquelin, F., Lefevre, S., Le Lorier, J., Patin, M., Sée, P., Sarfati, E., Walle, S., Visseaux, B., & Basmaci, R. (1AD, March 22). *Rhinovirus: A narrative review on its genetic characteristics, pediatric clinical presentations, and pathogenesis*. Frontiers. Retrieved September 27, 2022, from https://www.frontiersin.org/articles/10.3389/fped.2021.643219/full

Vandini, S., Biagi, C., Fischer, M., & Lanari, M. (2019). Impact of rhinovirus infections in children. *Viruses*, *11*(6), 521.

Active Orders (2 points)

Order(s)	**Comments/Results/Completion**
Activity: None specified	N/A
Diet/Nutrition: Regular diet as of 9/22/21	Patient tolerating OK. Ate ½ banana and 1/3 donut in the morning (9/23/22).
Frequent Assessments: Pulse oximetry	Continuous monitoring
Labs/Diagnostic Tests: No labs or diagnostic tests ordered for this tie	N/A
Treatments: High flow nasal cannula	12 L @ 30%
Other: Isolation **–** droplet	This is a continuous order.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Vitals Q4	This was weaned from the night before.
Nebulizer treatment every 4 hours	This was continuous the day prior, this has been weaned.
22g L forearm saline lock	To keep IV access

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	3.90 – 4.96 10^6/uL	5.06 ^	N/A	Her body may be producing more red blood cells to make up for the ailment that is causing her lowered O2 levels (Beacon Health System, 2022). Her O2 saturations got as low as in the 80s.
Hgb	10.6 – 13.2 g/ dL	13.6 ^	N/A	Hemoglobin is the red blood cell protein that transports oxygen throughout the body. This lab value will trend the same way the RBC does. With an increased RBC, Hgb will be increased as well.
Hct	32.4 – 39.5%	39.8 ^	N/A	HCT reflects the percentage of blood volume that makes up the RBC. Again, this will trend in the same direction as Hgb and RBC.
Platelets	199-367 10^3/uL	330	N/A	
WBC	4.27 – 11.40 10^3/uL	20.45 ^	N/A	WBC count may be raised during the first 2-3 days of a rhinovirus infection (Buensalido, 2022).
Neutrophils	40 – 60%	N/A	N/A	
Lymphocytes	28 – 48%	10.6%	N/A	A prominent cause of low lymphocyte count is malnutrition or undernutrition. (Iftikhar, 2019). The patient's mom stated the patient vomited after eating a couple days prior so is now scared to eat. This has diminished her appetite and has potentially caused a lack of needed proteins and other nutrients.
Monocytes	4 – 10%	7.6%	N/A	
Eosinophils	0 – 3%	2.1%	N/A	

Basophils	0 – 1%	0.2%	N/A	
Bands	0 – 3%	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 mmol/L	142	N/A	
K+	3.5 – 5.1 mmom/L	3.9	N/A	
Cl-	98 – 107 mmol/L	108 ^	N/A	I am unable to identify a reason for this abnormal lab. Hyperchloremia can occur if a patient consumes too much saline solution while hospitalized (Cafasso, 2018). However, this was her admission value. Even if she immediately ingested fluids, I doubt it would have a significant impact on her chloride levels this early on.
Glucose	74 – 100 mg/dL	109 ^	N/A	This is a slight elevation. Glucose levels can elevate in moments of stress. The child is a previously healthy child with no prior illness or hospitalization, I am sure she is anxious and stressed, wanting to go home which can result in an elevated glucose level.
BUN	7 -17 mg/dL	8	N/A	
Creatinine	0.31 – 0.61mg/dL	0.53	N/A	
Albumin	3.8 – 5.4 g/dL	4.3	N/A	
Total Protein	6.0 – 8.0 g/dL	7.7	N/A	
Calcium	8.8 – 10.8 mg/dL	10.0	N/A	

Bilirubin	0.2 – 1.2 mg/dL	0.5	N/A	
Alk Phos	9 – 500 u/L	332	N/A	
AST	10 – 40 u/L	N/A	N/A	
ALT	10 – 40 u/L	N/A	N/A	
Amylase	40 – 140 u/L	N/A	N/A	
Lipase	0 – 160 u/L	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 mm/hr	N/A	N/A	
CRP	0.00 – 0.50 mg/dL	6.56 ^	N/A	An increase in the C-reactive protein measurement indicates inflammation (Healthwise Staff, 2021). This inflammation could be residing in her airway from the mucus obstruction and productive cough.
Hgb A1c	< 8%	N/A	N/A	
TSH	0.8 – 6.0 mU/L	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	Pale to dark yellow/ clear	N/A	N/A	
pH	4.6 - 80	N/A	N/A	
Specific Gravity	1.005 –	N/A	N/A	

	1.030			
Glucose	1 -25 mg/dL	N/A	N/A	
Protein	None	N/A	N/A	
Ketones	None	N/A	N/A	
WBC	0 – 5	N/A	N/A	
RBC	0 – 2	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	No growth	No growth at 24hr	N/A	
Blood Culture	No growth	N/A	N/A	
Sputum Culture	No growth	N/A	N/A	
Stool Culture	No growth	N/A	N/A	
Respiratory ID Panel	Not detected	Detected!	N/A	This means the pathogen was found and this detection is likely causing the patient's signs and symptoms.
COVID-19 Screen	Not detected	Not detected	N/A	

Lab Correlations Reference (1) (APA):

Beacon Health System. (2022). *High Red Blood Cell count*. Beacon Health System. Retrieved September 27, 2022, from https://www.beaconhealthsystem.org/library/symptoms/high-red-blood-cell-count/

Buensalido, J. (2021, October 16). *Rhinovirus (RV) infection (common cold) workup: Approach considerations, Viral Testing, other studies*. Rhinovirus (RV) Infection (Common Cold) Workup: Approach Considerations, Viral Testing, Other Studies. Retrieved September 27,

2022, from https://emedicine.medscape.com/article/227820-workup#:~:text=In%20general%2C%20the%20white%20blood,3%20days%20of%20the%20infection.

Cafasso, J. (2018, September 18). *Hyperchloremia (high chloride levels): Treatment and causes*. Healthline. Retrieved September 27, 2022, from https://www.healthline.com/health/hyperchloremia#causes

Healthwise Staff. (2021). *C-Reactive Protein (CRP) test: About your child's test*. MyHealth.Alberta.ca Government of Alberta Personal Health Portal. Retrieved September 27, 2022, from https://myhealth.alberta.ca/health/AfterCareInformation/pages/conditions.aspx?hwid=aci5045#:~:text=CRP%20levels%20rise%20when%20there,and%20location%20of%20the%20inflammation.

Iftikhar, N. (2019, February 4). *Lymphocytopenia: Causes, symptoms, and treatment*. Healthline. Retrieved September 27, 2022, from https://www.healthline.com/health/lymphocytopenia

Diagnostic Imaging

All Other Diagnostic Tests (5 points): (9/20/22) Xray chest AP or PA only

Diagnostic Test Correlation (5 points): The chest Xray was performed because the patient presented an acute onset fever. Chest x-rays can detect infection or air in the space surrounding the lung. A chest X-ray may be done to rule out pneumonia or asthma (Cleveland Clinic, 2022). The patient’s x-ray results determined mild left basilar airspace disease. This could represent early pneumonitis, or inflammation of the lungs, in appropriate clinical setting.

Diagnostic Test Reference (1) (APA):

Cleveland Clinic. (2022). *Chest X-ray: What to expect, diagnosis, safety, results*. Cleveland Clinic. Retrieved September 24, 2022, from https://my.clevelandclinic.org/health/diagnostics/10228-chest-x-ray

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

Brand/Generic	Albuterol/ (salbutamol sulphate)	Ceftriaxone sodium	Pepcid/ (Famotidine)	Methylprednisolone/ (Medrol)
Dose	5mg	800mg	17.28 mg	30mg
Frequency	Q4 hours	Every 12 hours	BID	Every 6 hours
Route	Inhale	IVPB	Oral	IV Push
Classification	Pharmacologic Class: Adrenergic Therapeutic Class: Bronchodilator	Pharmacologic Class: Third-generation cephalosporin Therapeutic Class: Antibiotic	Pharmacologic Class: H2 antagonist Therapeutic Class: H2 blockers	Pharmacologic Class: Glucocorticoid Therapeutic Class: Corticosteroid
Mechanism of Action	Acts on the receptors to relax the bronchial smooth muscle.	Works by inhibiting the mucopeptide synthesis in the bacterial cell wall.	Inhibition of gastric secretion	Suppresses inflammatory and immune responses.
Reason Client Taking	To prevent and treat difficulty breathing with wheezing, SOB, coughing, and chest tightness	Possible bacterial infection (leukocytosis/fever)	To treat acid reflux or a "sour" stomach	Used for Asthma and to reduce inflammation.
Concentration Available	2.5mg / 3mL	50 to 75 mg/kg daily	0.5mg/kg/day	1mg/1mL
Safe Dose Range Calculation	0.63mg – 1.25mg 3 to 4 times daily	1,725 – 2,587.5mg/day	0.5mg Xs 34.5kg = 17.25mg	1-2mg/kg/daily 34.5mg – 69mg/day
Maximum 24-hour Dose	24mg/day	2g/day	40mg/day	60mg/day
Contraindications (2)	Hypersensitivity to albuterol or its components.	Hyperbilirubinemia or premature neonates	Stomach cancer	Hypersensitivity to cow's milk or other dairy products.

	Albuterol inhalation powder is contraindicated in patients with severe milk protein hypersensitivity because the formula contains lactose.	Hypersensitivity to ceftriaxone, other beta lactam antibacterial or cephalosporins	Kidney disease with likely reduction in kidney function	Systemic fungal infections.
Side Effects/Adverse Reactions (2)	Angina Hypotension	Seizures Pancreatitis	Blistering, peeling, or loosening of the skin Bloody, back, or tarry stools.	Increased intracranial pressure with papilledema Adrenal insufficiency
Nursing Considerations (2)	Monitor serum potassium level Be aware that drug tolerance can develop with prolonged use.	Always ask patient if an allergic reaction was ever experienced when given other antibiotics. The nurse must ensure a calcium containing I.V. solution is not given at the same time as the antibiotic; these are not compatible.	If administering one dose, give at bedtime Decrease doses in patient with renal failure.	Caution patient not to stop taking this drug abruptly or to change dosage without contacting provider. Tell patient to take a missed dose as soon as she remembers unless it is nearly time for the next dose. Caution against double-dosing
Client Teaching needs (2)	Tell the patient to immediately report S/S of allergic reaction, such as difficulty swallowing, itching and	Advise patient to report any hypersensitivity reactions, such as a rash, itching skin, or hives to prescriber immediately and	Instruct patient to take exactly as directed. Instruct to take with a full glass of	

	rash. Instruct patient to wash the mouthpiece after each use to prevent thrush.	to stop taking the drug Urge patient to report watery, bloody stools to prescriber immediately, even up to 2 months after drug therapy has ended.	water	

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook 2021*. Jones & Bartlett Learning.

(Original work published 2021)

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient appears clean, well-kept, and without body odor. She makes eye contact when addressed and follows simple commands such as lifting arm to take axillary temperature. She appears well-nourished and is pleasant and playful.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 19 **Drains present:** **Y☐** **N ☒** **Type:** **IV Assessment (If applicable to child):** **Size of IV:** 22 **Location of IV:** Left forearm **Date on IV:** 9/22/22 **Patency of IV:** No redness, swelling, or	Skin is white, intact, warm, and dry without jaundice or oils. Turgor is < 2 seconds and exhibits good hydration. (-) for lesions. (-) for rashes. (-) for bruises and wounds. Braden Score of 19.

pain at the IV site. Flushed w/o difficulty. **Signs of erythema, drainage, etc.:** **None** **IV dressing assessment:** Clean, dry, and intact. **IV Fluid Rate or Saline Lock:** Saline lock	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Normocephalic, white sclera, moist mucous membranes, no oral lesions. The head and neck are symmetrical. Trachea is midline without deviation. Oral cavity pink moist and clear. Auricles are bilateral no visible deformities. The septum is midline no visible bleeding. Mild nasal congestion.
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:**	(-) for chest pain at the time of assessment. Rate and rhythm S1, S2 are normal without murmur, click, rub, or gallops. Capillary refill < 2 seconds. No neck vein distension. No edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Slightly tachypneic during assessment. Fair lung expansion and appears symmetrical. Anterior and posterior chest walls have no tenderness, masses, or crepitus upon palpation. Breath sounds clear without wheezing or crackles. Mild cough.
GASTROINTESTINAL: **Diet at home: →** **Current diet: →** **Height (in cm):** 119.4 cm **Auscultation Bowel sounds: →** **Last BM: →** **Palpation: Pain, Mass etc.: →** **Inspection:** **Distention: N/A** **Incisions: N/A** **Scars: N/A** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒**	Per mom at bedside, home diet is considered "normal." Current diet in the hospital setting is general. Bowel sounds normoactive in all four quadrants. The abdomen is soft, flat, and non-tender (-) for distention, incisions, scares, drains, and wounds Last BM: 9/21/22

Type:	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The urine is yellow and clear. The patient was continent x 1 with a pamper weighing 105mL.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 20** **Activity/Mobility Status**: Appropriate for age **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Joints are stable and symmetric with full range of motion and no crepitus or redness. Not able to assess gait as patient was either in the bed or the chair at bedside. Not a fall risk.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is alert and awake. Unaided sight. Unaided hearing. The patient has appropriate affect, good eye contact. Speech delay detected from observation
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):**	For coping, the patient has mother and paternal grandmother at bedside. They play on the phone and watch TV together. The patient colors and talks about her brother at home. No social needs detected or discussed. Mother, father, grandmother, and brother all mentioned to play an active role in the patient's life.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0708	112	112/66	38	97.7	96
0915	106	110/82	32	97.5	98

Vital Sign Trends:

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

Pulse Rate	60 – 110/min
Blood Pressure	Systolic 91-122 diastolic 54-83
Respiratory Rate	20-25/min
Temperature	98.2
Oxygen Saturation	97-99%

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

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0920	FLACC	N/A	2/10	Mild discomfort	Express positivity while taking vital signs and administering medication.

Evaluation of pain status *after* intervention	FLACC	N/A	0/10	Zero discomfort.	No interventions needed at this time. The patient demonstrated bravery during this vital sign check.
Precipitating factors: The patient exhibited fear and anxiousness to go home; using her mom at the bedside for comfort. **Physiological/behavioral signs:** Based on my observation, the patient did not appear to be in pain, but demonstrated uneasiness and discomfort. She is a 6 yo with an observed developmental delay; I believe without a complete understanding of her illness and the hospital setting, she was just unsure of what may hurt or what may be uncomfortable. She looked to her mom many of times for comfort.					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
ceftriaxone (50 mL) 1.5 cups of water (360 mL)	105 mL (One weighed Pamper)

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. By 5-years-old the child should be able to jump rope
2. This preschool age should be able to dress independently
3. Should be able to display the gross motor skill of walking backwards with heel to toe

Age-Appropriate Diversional Activities

1. Role Playing
2. Playing dress-up activities
3. Reading books

Psychosocial Development:

Which of Erikson's stages does this child fit? Initiative vs. Guilt

What behaviors would you expect? Despite not having all the physical skills necessary to succeed at everything they try, you would anticipate this age group to become enthusiastic learners. When these children believe they have behaved badly or when they are unable to complete a task, guilt may develop. Setting boundaries and helping toddlers to try things within their capacities is appropriate**.**

What did you observe? Helping and guiding your child to try new activities is very limited in the hospital setting so it is hard to observe these assumed behaviors in the clinical setting. From my small window of observation, I would not say that the patient was an enthusiastic learner. Each time I entered the room the patient had a cell phone or the TV playing; this seemed to be her comfort or coping method. I was not able to visualize her attempting activities within her capability. But again, this is a limited observation because of our setting.

Cognitive Development:

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

What behaviors would you expect? At this stage, young children can think about things more symbolically. Judgements are made based on visual appearances. Some methods of thinking include magical thinking and animism. When looking at language development, speaking becomes their primary method of communication.

What did you observe? We're looking at a phase of "preschoolers," between the ages of 3-6. I observed a developmental delay in my 6-year-old patient, but this does not mean she is not hitting all the milestones appropriate for her age group. By 4 years old, a child is mostly understood as language becomes their primary method of communication. Often, I could not understand my patient. Mainly the mom was more or so translating what the child was saying. The patient was wearing a pull-up – which tells me, she has not shown signs of being ready to potty train. The mom mentioned, "they are going to start trying to potty train soon." I do believe she would be successful at many of the age-appropriate activities, such as painting and hand-puppets. During my clinical shift, she was drawing pictures and coloring. An example of activities I do not think she is ready to achieve would be skating and simple sewing.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? At ages 3 and 4, preschoolers talk in sentences of three to four words, and at ages 4 and 5, they speak in sentences of four to five words. There is a concern that the patient's vocabulary is not as matured as it should be at 6 years of age. She was extremely hard to understand.

Any concerns regarding growth and development?

Preschoolers should be able to dress themselves and display activities like copying figures on a piece of paper. There is concern as I do not believe the patient would be able to display these activities of fine and gross motor skills.

Developmental Assessment Reference (1) (APA):

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Wheless, L., Wilford, K., & McMichael, M. G. (2019). *RN nursing care of children review module* (11th ed.). Assessment Technologies Institute, LLC

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • 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. Impaired gas exchange related to respiratory distress as evidenced by prescribed high flow nasal cannula.	I chose this nursing diagnosis because ABCs should be priority. Impaired gas exchange will cause poor circulation.	1.Maintain an oxygen administration device as ordered, attempting to maintain O2 sat at 90% or greater. 2.Position patient with head of the bed elevated, in a semi-Fowler's position as tolerated.	1. The Patient maintains optimal gas exchange as evidenced by normal mental status, unlabored respirations at 12-20 per minute, O2 sat 97-100, and baseline HR for patient (60-110).	- The mom and grandmother were understanding of the importance of the nasal cannula and bed positioning. - At the end of my clinical shift, the patient was still on high flow oxygen running 12L @ 30 %. Her O2 saturation remained appropriate but her respirations remained above 30s.
2. Ineffective breathing pattern related	I chose this nursing diagnosis again	1. Place patient with proper body alignment	1. The patient's respiratory	- The mom displayed understanding of

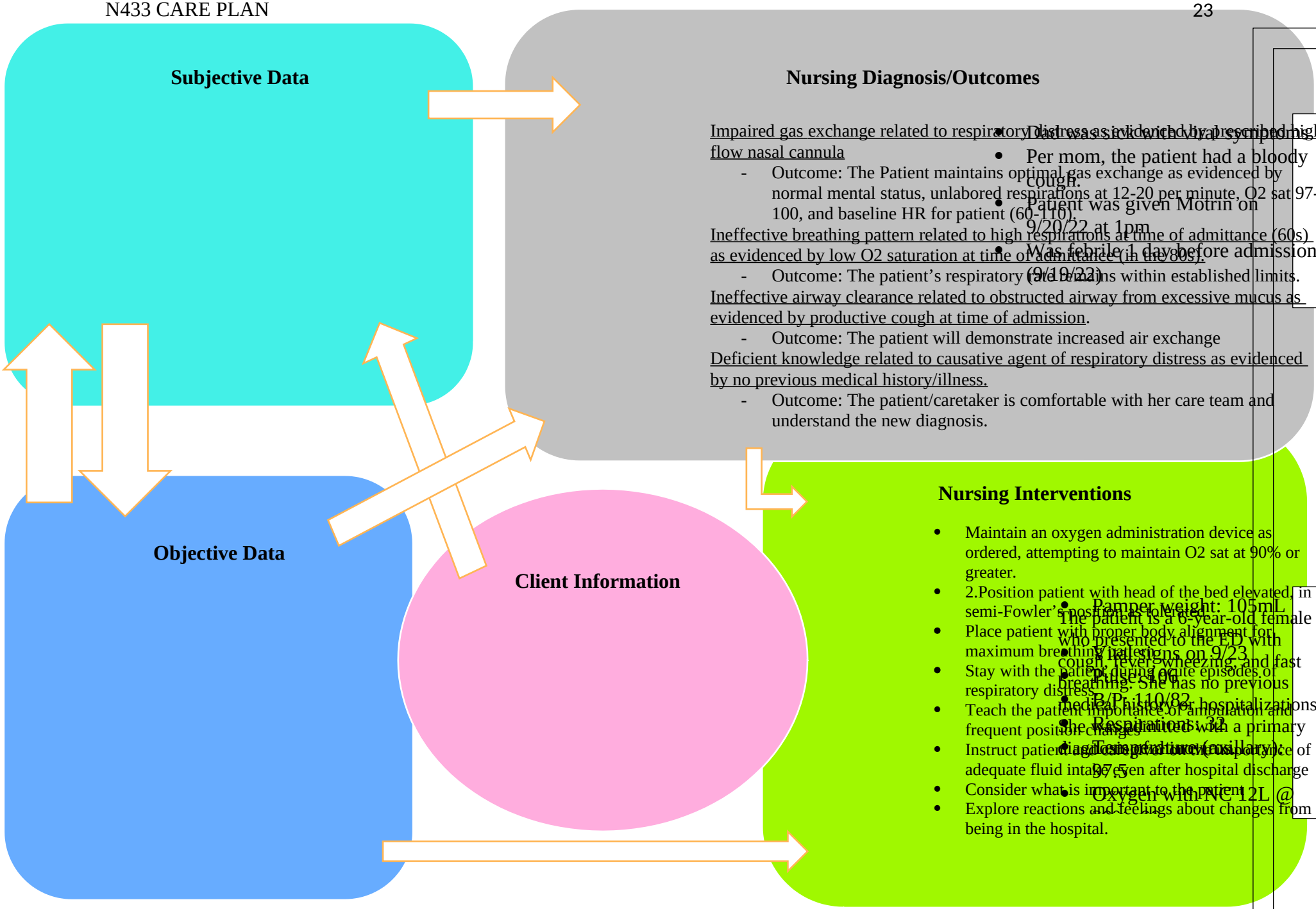
to high respirations at time of admittance (60s) as evidenced by low O2 saturation at time of admittance (in the 80s).	because ABCs are important. We want to make sure with inhalation and exhalation that the body is getting adequate oxygenation.	for maximum breathing pattern **2.** Stay with the patient during acute episodes of respiratory distress.	rate remains within established limits.	keeping the patient in a sitting position. - I was not able to implement the intervention of staying with the patient during acute episodes of respiratory distress as she did not have an episode during my clinical shift.
3. Ineffective airway clearance related to obstructed airway from excessive mucus as evidenced by productive cough at time of admission.	This was chosen once again for that ABC priority. Airway is important.	1. Teach the patient importance of ambulation and frequent position changes 2. Instruct patient and caregiver on the importance of adequate fluid intake even after hospital discharge	1. The patient will demonstrate increased air exchange	- The mom and grandmother displayed understanding on important of positioning changes and adequate water intake. - During my clinical hours the patient moved from bed to chair 3 times and even when she did not have the appetite for her full meal, made an effort to drink her water
4. Deficient knowledge related to causative agent of respiratory distress as evidenced by no previous medical history/illness.	This was chosen because the patient was considered a healthy kid prior to this hospitalization. She has no previous medical or surgical history.	1. Consider what is important to the patient 2. Explore reactions and feelings about changes from being in the hospital.	1. The patient/care taker is comfortable with her care team and understand the new diagnosis.	- The caregiver displayed thankfulness as she expressed relief with my patience when it came to caring for her daughter. -I considered what was important to the patient which was just to “feel better.” I provided a

				safe and positive space for her during my clinical time, and it seemed to be appreciated by observing her mannerisms. She even told me to have a nice day after I thanked her for letting me be a part of her care team for the day.

Other References (APA):

Linda Lee Phelps. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual.* Wolters Kluwer Medical

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Impaired gas exchange related to respiratory distress as evidenced by prescribed high flow nasal cannula
- Outcome: The Patient maintains optimal gas exchange as evidenced by normal mental status, unlabored respirations at 12-20 per minute, O2 sat 97-100, and baseline HR for patient (60-110).
Ineffective breathing pattern related to high respirations at time of admittance (60s) as evidenced by low O2 saturation at time of admittance (in the 80s).
- Outcome: The patient's respiratory rate remains within established limits.
Ineffective airway clearance related to obstructed airway from excessive mucus as evidenced by productive cough at time of admission.
- Outcome: The patient will demonstrate increased air exchange
Deficient knowledge related to causative agent of respiratory distress as evidenced by no previous medical history/illness.
- Outcome: The patient/caretaker is comfortable with her care team and understand the new diagnosis.
Dad was sick with viral symptoms
Per mom, the patient had a bloody cough.
Patient was given Motrin on 9/20/22 at 1pm
Was febrile 1 day before admission (9/19/22)
Objective Data
Client Information
Nursing Interventions
Maintain an oxygen administration device as ordered, attempting to maintain O2 sat at 90% or greater.
2.Position patient with head of the bed elevated, in a semi-Fowler's position as tolerated.
Place patient with proper body alignment for maximum breathing capacity.
Stay with the patient during acute episodes of respiratory distress.
Teach the patient importance of ambulation and frequent position changes while on a primary caregiver on the importance of
Instruct patient and caregiver on the importance of adequate fluid intake even after hospital discharge
Consider what is important to the patient.
Explore reactions and feelings about changes from being in the hospital.
Pamper weight: 105mL
The patient is a 6-year-old female who presented to the ED with cough, fever, wheezing, and fast breathing. She has no previous medical history or hospitalizations. She presented with a primary diagnosis of acute hypoxic
Vital signs on 9/23
P: 118
B/P: 110/82
Respirations: 33
Temperature (axillary): 97.5
Oxygen with NC 12L @