N433 Care Plan # 1

Lakeview College of Nursing

Angel Roby

Demographics (3 points)

Date of Admission 9/27/2022	**Client Initials** N.H.	**Age (in years & months)** 3 y.o. 9 mos.	**Gender** Female
Code Status Full	**Weight (in kg)** 17.5 kg	**BMI** 17.78 kg/m2	**Allergies/Sensitivities (include reactions)** NKA

Medical History (5 Points)

Past Medical History: Adenovirus infection (12/20/2021), ALTE (Apparent Life Threatening Event)(8/20/2021), Heart murmur (6/30/2020), Labial adhesions (6/30/2020), Macrocephaly (6/30/2020).

Illnesses: Bilirubinemia (no known date), Iron deficiency anemia (12/1/2020)

Hospitalizations: Adenovirus infection (12/20/2021 - 12/25/2021)

Past Surgical History: Upper GI endoscopy (5/20/2022)

Immunizations: Up to date

Birth History:

Complications (if any): Born at 36wks gestation, low birth weight (2,000-2,499 grams)

Assistive Devices: N/A

Living Situation: Lives with mom, grandma, and brother. No daycare, 2 dogs, 2 cats, 1 rabbit in the house. There is an order of protection against her father.

Admission Assessment

Chief Complaint (2 points): Food aversion

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

Pertinent Events during this admission/hospitalization (1 points): Patient previously scheduled for surgery.

History of present Illness (OLD CARTS) (10 points):.Nayeli had a surgery done to place the Gastrostomy laparoscopically because she has a history of food adhesion and had trouble with oral intake which started in December of 2021. She had the surgery yesterday (9/27/2022) and is being monitored for improvement of her nutritional intake. The patient has no pain currently and has been asking about eating a chocolate cupcake. Will monitor to ensure she does not have a hypoglycemic episode.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. Weight loss/failure to thrive

Secondary Diagnosis (if applicable):. N/A

Pathophysiology of the Disease, APA format (20 points): Failure to thrive is an inadequate growth resulting from the inability to obtain or use calories required for growth. An infant or child who falls below the fifth percentile for weight or has persistent weight loss is at risk of failure to thrive (Holman et al., 2019). It is by inadequate caloric intake, inadequate absorption, increased metabolism, and defective utilization. Risk factors include preterm birth with low birth weight, parental neglect, poverty, health or child-rearing beliefs, family stress, or feeding resistance (Holman et al., 2019). Manifestations can be a malnourished appearance, poor muscle tone, no fear of strangers, minimal smiling, decreased activity level, withdrawal behavior, developmental delays, feeding disorder, or stiff or flaccid body (Holman et al., 2019). For the nursing actions and care, obtaining a nutritional history and obtaining accurate baseline height and weight is pertinent. Nurses will weigh the child daily without clothing or a diaper during

treatment and maintain I&O and calorie counts as prescribed. Their height and weight for diagnosis at their doctor's appointments. As mentioned before, low weight can be an indication of malnourishment. The patient underwent surgery to get a G-tube placed to help with her nutrition. The feedings are doing well, and the nurses during this clinical course are tracking her I&Os.

Pathophysiology References (2) (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.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Increase activity as tolerated	Going on a walk with her mother and also going to the play room.
Diet/Nutrition: Regular	Has G-tube inserted, but can also eat solids
Frequent Assessments: Vital signs Q4 and cleaning the G-tube port	The G-tube should be cleaned daily. Patient does not like this step, suggesting to have her mother clean it for her.
Labs/Diagnostic Tests: Covid-19 PCR	Covid-19 PCR came back negative
Treatments: G-tube care	Clean daily
Other: N/A	N/A
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**

No new orders	Patient is hopefully going to get discharged after teaching is complete regarding G-tube care.

Laboratory Data (15 points)

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

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	4 - 5.5 mill/mm3	N/A	N/A	N/A
Hgb	11.5 - 14.5 g/ dL	N/A	N/A	N/A
Hct	33 - 43 (%)	N/A	N/A	N/A
Platelets	150 - 450 x 10^3/mm3	N/A	N/A	N/A
WBC	4 - 12 x 10^3/ mm3	N/A	N/A	N/A
Neutrophils	54 - 62 (%)	N/A	N/A	N/A
Lymphocytes	25 - 33 (%)	N/A	N/A	N/A
Monocytes	3 - 7 (%)	N/A	N/A	N/A

Eosinophils	1 - 3 (%)	N/A	N/A	N/A
Basophils	<0.75 (%)	N/A	N/A	N/A
Bands	3 - 5 (%)	N/A	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 mEq/L	N/A	N/A	N/A
K+	3.5 - 5.0 mEq/L	N/A	N/A	N/A
Cl-	95 - 105 mEq/L	N/A	N/A	N/A
Glucose	60 - 100 mg/ dL	N/A	N/A	N/A
BUN	5 - 18 mg/dL	N/A	N/A	N/A
Creatinine	0.03 - 0.5 mg/dL	N/A	N/A	N/A
Albumin	3.4 - 4.2 g/dL	N/A	N/A	N/A
Total Protein	6.1 - 7.9 g/dL	N/A	N/A	N/A
Calcium	9 - 10.9 mg/ dL	N/A	N/A	N/A
Bilirubin	<1 mg/dL	N/A	N/A	N/A
Alk Phos	145 - 420 units/L	N/A	N/A	N/A
AST	20 - 60 units/L	N/A	N/A	N/A
ALT	5 - 45 units/ L	N/A	N/A	N/A
Amylase	30 - 100 units/L	N/A	N/A	N/A

Lipase	145 - 216 units/L	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	0 - 20 mm/hour	N/A	N/A	N/A
CRP	0.05 - 57.6 mg/L	N/A	N/A	N/A
Hgb A1c	4.5 - 5.7 (%)	N/A	N/A	N/A
TSH	0.7 – 6.4 micro units/ mL	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, clear	N/A	N/A	N/A
pH	5.0 - 9.0	N/A	N/A	N/A
Specific Gravity	1.001 - 1.029	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	Negative	N/A	N/A	N/A
RBC	Negative	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	N/A

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

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A
Respiratory ID Panel	Negative	N/A	N/A	N/A
COVID-19 Screen	Negative	Negative	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA): N/A

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

Brand/Generic	Polyethylene glycol/Miralax	Tylenol/ Acetaminophen	Ibuprofen	N/A	N/A
Dose	17 g	260 mg	100 mg	N/A	N/A
Frequency	Once daily	Q4H	Q6H	N/A	N/A

Route	Oral	G-tube	G-tube	N/A	N/A
Classification	Osmotic laxative	Pharmalogic: Nonsalicylate Therapeutic: Antipyretic (Jones & Bartlett, 2020)	Pharmalogic: NSAID Therapeutic: Analgesic, anti-inflammatory, antipyretic (Jones & Bartlett, 2020)	N/A	N/A
Mechanism of Action	Works by drawing water into the colon. The water softens the stool and may naturally stimulate the colon to contract. These actions help ease bowel movements (Jones & Bartlett, 2020).	Inhibits the enzyme cyclooxygenase and interferes with pain impulse generation in the peripheral nervous system (Jones & Bartlett, 2020).	By inhibiting prostaglandins, this NSAID reduces inflammatory symptoms and relieves pain (Jones & Bartlett, 2020)	N/A	N/A
Reason Client Taking	Constipation	Pain	Pain	N/A	N/A
Concentration Available	17 g/pack	160mg/5mL	100 mg/tab	N/A	N/A
Safe Dose Range Calculation	0.8 g/kg/day	10 - 15 kg/mg	4 - 10 mg/kg/dose	N/A	N/A
Maximum 24-hour Dose	17 g/day (Jones & Bartlett, 2020)	1,200 mg (Jones & Bartlett, 2020)	2,400 mg (Jones & Bartlett, 2020)	N/A	N/A
Contraindications (2)	Blockage of the stomach or intestine Hypokalemia (Jones & Bartlett, 2020)	Severe hepatic impairment Severe active liver disease (Jones & Bartlett, 2020)	Angioedema Bronchospasm (Jones & Bartlett, 2020)	N/A	N/A
Side Effects/Adverse Reactions (2)	Abdominal cramping Nausea	Hypotension Hepatotoxicity (Jones & Bartlett,	CVA GI bleeding (Jones &	N/A	N/A

	(Jones & Bartlett, 2020)	2020)	Bartlett, 2020)		
Nursing Considerations (2)	Nurses should conduct an abdominal assessment for discomfort, distention, and decreased bowel sounds before administering this medication. Monitor electrolyte labs and bowel movements (Jones & Bartlett, 2020)	Monitor renal function in patients on long term therapy. Ensure that the daily dose from all sources does not exceed the limits. (Jones & Bartlett, 2020)	NSAIDs such as ibuprofen increase the risk of bleeding and it is important to monitor the patients. Monitor CBC for decreased hemoglobin and hematocrit. Drugs may worsen anemia. (Jones & Bartlett, 2020)	N/A	N/A
Client Teaching needs (2)	Ensure that the powder is completely dissolved in the water/drink. Do not combine with starch-based thickeners used for difficulty of swallowing (Jones & Bartlett, 2020)	Tell patients that tablets may be crushed or swallowed whole. Caution patients not to exceed recommended dosage or take other drugs containing acetaminophen at the same time because of risk of liver damage. (Jones & Bartlett, 2020)	Advise patient to take drug with food or meals to decrease GI distress. Advise patients to report flu-like symptoms. (Jones & Bartlett, 2020)	N/A	**N/A**

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented x4. The patient shows signs of distress during vital signs and G-tube care. Patient's overall appearance is WDL.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 4** **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:**	The patient's skin color is appropriate for ethnicity. The skin is pink, dry, warm and intact. The patient's skin turgor is elastic and shows no signs of tenting. The patient has no rashes, bruises, or wounds. The patient's braden score is at a 4. The patient does not have a drain in place. The patient has a 22G IV at the left lower posterior. The date on the IV was 9/27/2022. The IV is patent and shows no signs of erythema or drainage. The dressing is dry and intact. The patient has a saline lock in place at this time.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	The patient's head is normocephalic and shows no signs of swelling or indication of pain. The trachea is midline. Ears are symmetrical with no abnormal cerumen present. The patient exhibits PERRLA and shows no signs of redness or irritation. The nose is midline with no abnormalities in the nares. Patient did have some mucus. The teeth were symmetrical and are developing on the right track per her age. The thyroid shows no signs of enlargement.
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:**	The S1 and S2 were audible and intact. The patient showed no signs of S3, S4, or murmurs. Cardiac rhythm is WDL. Radial pulses are 3+ followed by the pedal pulses. The capillary refill was less than 3 seconds. Patient does not have neck vein distention and edema.

RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient's lung sounds were equal and showed no signs of wheezing, crackles, or any other abnormalities. Lung sounds were audible in each lobe. Patient did not use any accessory muscles.
GASTROINTESTINAL: **Diet at home: Regular** **Current diet: Regular/tube feeding** **Height (in cm): 94.2 cm** **Auscultation Bowel sounds:** **Last BM: Before admission** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Bowel sounds equal and audible in all four quadrants. The patient's last BM was before admission and has not had a BM in this clinical course. The patient does not have any abnormalities during palpation. Patient shows no signs of distention, scars, drains, or wounds. Patient has an incision on her abdomen related to the G-tube place on 9/26/22. The patient does not have an ostomy or a nasogastric tube. The patient currently has a G-tube in place for feedings.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	The patient's urine is yellow with no odor. The patient had 374 mL of urine as her output. The patient does not have pain with urination. Patient is not on dialysis and does not have a catheter in place. I did not inspect the genitals during this clinical course.
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☐**	Neurovascular status is intact and does not show any signs of tingling or numbness. The patient has full range of motion in all four extremities and has no supportive devices at this time. The patient's strength in all extremities are bilaterally equal. The patient does not need ADL assistance. The patient's fall score is 2 on the cummings scale. The patient's activity is well tolerated with walks with her mother in the hospital hallways. The patient is independent and does not need assistance walking or standing up on her own.
NEUROLOGICAL:	The patient has 5/5 strength in all extremities.

MAEW: Y ☐ N☐ **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient also shows signs of PERLA. The strength is equal in all extremities. The patient is A/O x4 and shows some distress during vital signs and G-tube care. The patient's speech is on track in her developmental age. The patient's sensory system is also intact.
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 coping method of the caregiver is to walk around the hospital and get herself some coffee. The patient's caregiver has the means of transportation and uses a car. Patient's caregiver got educated on the care of the G-tube. The patient lives at home with her mother, grandmother, brother, and animals.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0835	137 bpm	99/52 right arm	30 breaths/min	36.6 C Axillary	100% Room air
Did not collect seconds set of vital signs	N/A	N/A	N/A	N/A	N/A

Vital Sign Trends: None at this moment

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

Pulse Rate	73 - 137 bpm
Blood Pressure	90 to 110/55 mmHg
Respiratory Rate	20 - 30 breaths/min
Temperature	97.4 F - 99.6 F
Oxygen Saturation	92 - 100 (%)

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

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0835	Faces	N/A	N/A	N/A	N/A
Evaluation of pain status *after* intervention	N/A	N/A	N/A	N/A	N/A
Precipitating factors: N/A **Physiological/behavioral signs:** N/A					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
460.1 mL (IV) 10 mL (irrigation/flush) G-tube: 630 mL	374 mL (urine)

Developmental Assessment (6 points)

Be sure to highlight the achievements of any milestone if noted in your child. Be sure to highlight any use of diversional activity if utilized during clinical. There should be a minimum of 3 descriptors under each heading

Age Appropriate Growth & Development Milestones

1. Runs and jumps easily
2. Counting
3. Stacks 10 blocks

Age Appropriate Diversional Activities

1. Playing with blocks
2. Looking at books

3. Filling and emptying containers

Psychosocial Development:

Which of Erikson's stages does this child fit? Autonomy vs. Shame & Doubt

What behaviors would you expect? Independence and trying to do things themselves

What did you observe? The patient wanted to make me a play-doh figure instead of me making it myself after offering.

Cognitive Development:

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

What behaviors would you expect? Domestic mimicry

What did you observe? Anytime anyone would laugh, the patient would laugh as well to join in

Vocalization/Vocabulary:

Development expected for child's age and any concerns? Combining several words to create simple sentences using grammatical rules

Any concerns regarding growth and development? No concerns at this time

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.
Risk of hypoglycemia related to food aversion as evidenced by G-tube being put in place	This was the initial diagnosis before the patient had surgery for the G-tube	1. Ensure that the patient is receiving the prescribed amount of feeding 2. Monitor the I&Os	1. The patient will start to gain weight and not suffer from a hypoglycemic episode	The patient's caregiver understood the importance of staying on track with the feedings. Since the caregiver will be responsible following discharge, education was

				given.
Risk for infection related to G-tube as evidenced by distress when the nurse needs to clean G-tube.	The patient is at risk for an infection because of the new G-tube put in place.	1. Clean G-tube as needed per doctor's orders 2. Utilize a distraction to ensure patient isn't in distress and that the nurse can clean the G-tube properly.	1. Cleaning the G-tube properly while patient is distracted to minimize risk for infection	The patient was still in distress when the nurse tried cleaning the G-tube. The caregiver held her down so that the nurse can clean the G-tube.
Risk for impaired skin integrity related to surgery as evidenced by G-tube	The patient is at risk for impaired skin integrity because of the G-tube. If the tube gets dislodged, the patient could experience irritation.	1. Proper changing of the dressing 2. Ensuring that the tube is in the right place	1. Routine bandage changes and checking placement of the tube will decrease the risk of impaired skin integrity.	The patient was still in distress following the bandage change. The nurse utilized a distraction by bringing in her favorite toy to calm her down.
Risk for inefficient coping related to in and out hospital stays as evidenced by distress when nurses/doctors interact with patient	The patient shows a bunch of distress when nursing/doctors need to check on her.	1. Utilizing a distraction 2. Therapeutic communication such as "no owies."	1. Patient is distracted and is allowing nurse to check vital signs	The patient was in less distress when the nurse utilized therapeutic communication during vital signs. The student nurse also played with the patient while the nurse was giving education to the caregiver and showed less distress.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient is a 3 year old that was admitted to the hospital post-surgery for a G-tube placement.

Nursing Diagnosis/Outcomes

Risk of hypoglycemia related to food aversion as evidenced by G-tube being put in place
The patient will start to gain weight and not suffer from a hypoglycemic episode
Risk for infection related to G-tube as evidenced by distress when the nurse needs to clean G-tube.
Cleaning the G-tube properly while patient is distracted to minimize risk for infection
Risk for impaired skin integrity related to surgery as evidenced by G-tube
Routine bandage changes and checking placement of the tube will decrease the risk of impaired skin integrity.
Risk for inefficient coping related to in and out hospital stays as evidenced by distress when nurses/doctors interact with patient
Patient is distracted and is allowing nurse to check vital signs

Objective Data

Patient had no labs done during this clinical course. The patient's assessment was WDL besides the distress when the nurse checks vitals and cleans G-tube. The patient is hoping to get discharged.

Client Information

Kayeli had a surgery done to place the gastrostomy laparoscopically because she has a history of food adhesion and had trouble with oral intake which started in December of 2021. She had the surgery yesterday (9/27/2022) and is being monitored for improvement of her nutritional intake. The patient has no pain currently and has been asking about eating a chocolate cupcake. Will monitor to ensure she does not have a hypoglycemic episode.

Nursing Interventions

Ensure that the patient is receiving the prescribed amount of feeding
Monitor the I&Os
Clean G-tube as needed per doctor's orders
Utilize a distraction to ensure patient isn't in distress and that the nurse can clean the G-tube properly.
Proper changing of the dressing
Ensuring that the tube is in the right place
Utilizing a distraction
Therapeutic communication such as "no owies."