N433 Care Plan 1

Lakeview College of Nursing

Kayonna Pinto

Demographics (3 points)

Date of Admission	**Client Initials**	**Age (in years & months)**	**Gender**
10/17/2022	S. O.	1 year and 4 months	Female
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full Code	9.5 kg	17.35 kg/m^2	No Known Allergies

Medical History (5 Points)

Past Medical History:

Illnesses: S.O. has no significant past medical history with no significant prior illnesses

Hospitalizations: S.O. has no previous hospitalizations, besides the initial NICU stay.

Past Surgical History: S.O. has no previous surgeries

Immunizations: S. O. is up to date on her immunizations, per parent

Birth History: S. O.'s birth was a spontaneous vaginal delivery at 37 weeks 1 day. Labor lasted 17 minutes.

Complications (if any): Patient stayed in the NICU for 1 week.

Assistive Devices: S. O. does not use any assistive devices.

Living Situation: S. O. lives at home with parents and siblings.

Admission Assessment

Chief Complaint (2 points): Respiratory Syncytial Virus (RSV)

Other Co-Existing Conditions (if any): None

Pertinent Events during this admission/hospitalization (1 points): In the ED, the patient received a chest x-ray. A peripheral IV access was started. The patient was placed on HHNC. She received ceftriaxone and a bolus of normal saline fluid for decreased PO intake.

History of present Illness (OLD CARTS) (10 points):

S.O. was referred to the Emergency Department (ED) from convenient care clinic for difficulty breathing. According to her mother, cold and cough symptoms started three to four days prior to admission. The patient tested positive for RSV in the clinic two days prior to admission. The patient does have a positive sick contact at home. Symptoms worsened and the patient presented to the clinic this evening with increased breathing difficulty. The patient was hypoxic with imposed work of breathing at the clinic. There, the patient received a nebulizer treatment and a steroid by mouth before being sent to the ED for further evaluation. The patient's fever was 102° F the day before, according to her mother. At the ED, the patient's respirations were in the 50s. The patient had abdominal breathing, with no retractions. She was hypoxic with an oxygen saturation of 82%. Patient was also tachycardic. Patient has no history of asthma/reactive airway disease.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Respiratory Syncytial Virus (RSV)

Secondary Diagnosis (if applicable): Acute Respiratory Distress

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

Respiratory syncytial virus (RSV) is a highly contagious virus spread via direct contact with respiratory secretions or contaminated objects (Ricci et al., 2021). During the acute stage of the RSV infection, the virus manifests in the ciliated cells of the nasopharynx (Hinkle et al., 2022). Then, RSV replicates and spreads to the tracheobronchial tree via secretions from the upper airway (Hinkle et al., 2022). As the RSV infection spreads, the small airways become obstructed with mucus and exudate. The lungs become hyperinflated because the inspiratory volume is adequate, but full expiration is prevented (Ricci et al., 2021). Atelectasis develops, and gas exchange is significantly affected (Ricci et al., 2021). Inadequate pulmonary ventilation and poor perfusion cause arterial hypoxemia and carbon dioxide retention (Ricci et al., 2021).

Upon inspection, a child with RSV may exhibit various degrees of cyanosis and respiratory distress, including tachypnea, accessory muscle use, and retractions (Ricci et al., 2021). The child may also be air-hungry or grunting (Ricci et al., 2021). A nurse may hear coughing and wheezing (Ricci et al., 2021). The child's general appearance may be listless or uninterested (Ricci et al., 2021). Auscultation of the lungs can determine the quality of aeration (Ricci et al., 2021). Wheezes throughout the lung field may be heard early in the illness (Ricci et al., 2021). As the disease progresses, the hyper-expansion of the lungs and poor air exchange may not produce any adventitious sounds (Ricci et al., 2021).

RSV is a viral infection, so treatment does not warrant antibiotics (Hinkle et al., 2022). Therapeutic management of RSV focuses on supportive treatment (Ricci et al., 2021). Treatment can include supplemental oxygen, suctioning, oral or intravenous hydration, and inhaled bronchodilator therapy. O.S. has received all these treatments during her hospitalization. While in the E.D., she received an intravenous bolus of normal saline to supplement her decreased fluid intake by mouth. She was placed on a high-flow nasal cannula for oxygen therapy to maintain an oxygen saturation of 90% or higher. She received BBG suctioning as needed. She was also receiving an albuterol nebulizer every four hours, as needed. Children require hospitalization if they present with severe symptoms of RSV, such as significant retractions, tachypnea, or poor oral intake (Ricci et al., 2021). Many infants are managed at home and do not require hospitalization if they remain adequately hydrated, and their symptoms do not warrant respiratory support (Ricci et al., 2021).,

RSV is detected using nasal swabs (Ricci et al., 2021). The swab is inserted into the nose until it reaches the nasopharynx (Ricci et al., 2021). The insertable length is roughly equal to the distance from the child's nose to ear (Ricci et al., 2021). The swab should be inserted straight back and remain in the nasopharynx for several seconds (Ricci et al., 2021). For young children like O.S., have the parent hold the child in their lap (Ricci et al., 2021). The healthcare worker should stabilize the patient's head because they will likely try to pull away (Ricci et al., 2021). The swab will confirm the presence of invasive organisms, including viral illnesses such as RSV (Ricci et al., 2021). O.S.'s nasopharyngeal swab detected the presence of RSV.

Other diagnostic tests include a chest radiograph (Ricci et al., 2021). This diagnostic imaging can reveal hyperinflation and patchy areas of atelectasis or infiltration (Ricci et al., 2021). O.S.'s chest x-ray corroborated the results of her nasopharyngeal swab. Nurses use pulse oximetry to identify a significant decrease in oxygen saturation. O.S.'s oxygen saturation was 82% in the emergency department. Lastly, nurses obtain blood gases to identify carbon dioxide retention and hypoxemia (Ricci et al., 2021).

One complication of RSV infection is losing airway patency (Ricci et al., 2021). Signs and symptoms of concern for airway patency include changes in respiratory status, such as decreased oxygen saturation (Hinkle et al., 2022). Other signs and symptoms include increased secretions, stridor with breathing, and coughing (Hinkle et al., 2022). Elevating the head of the bed and providing suctioning as needed can help ensure that the airway remains open and clear (Ricci et al., 2021). Another complication of RSV is dehydration. Children with RSV may have poor oral intake (Ricci et al., 2021). Dehydration may present as sunken fontanels in infants, sunken orbits, dry oral mucosa, decreased skin turgor or tenting, and decreased urine output (Ricci et al., 2021). Heart rate may increase in moderate dehydration, but heart rate may progress to

bradycardia in severe dehydration. Blood pressure can progress to hypotension in severe dehydration. The nursing goal is to restore fluid volume and prevent hypovolemia. Children with severe dehydration should receive 20 mL/kg of normal saline or lactated ringer (Ricci et al., 2021). Then, the nurse should reassess their hydration status (Ricci et al., 2021). Patients with mild to moderate dehydration should be encouraged to increase their oral hydration (Ricci et al., 2021).

Pathophysiology References (2) (APA):

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

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

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Increase activity as tolerated	Patient was out of bed and playing with her parents this morning.
Diet/Nutrition: Solids and breastfeeding	S. O. has no dietary restrictions but should eat age-appropriate foods. For breakfast, S.O. ate part of a croissant and breastfed mid-morning. She also drank water throughout the day
Frequent Assessments: - Q2H vital signs - B/P Q8H, while awake only - I & O - Continuous oxygen therapy to keep O2 saturation >90%	Frequent vital signs are implemented to monitor for signs of respiratory deterioration. S.O.'s vital signs remained stable throughout the student's clinical rotation. I & O ensures adequate hydration. S.O.'s intake and output were balanced. Patient's oxygen saturation remained greater than 90%.
Labs/Diagnostic Tests: None	No diagnostic tests or labs were ordered.
Treatments: - Acetaminophen: oral; Q4H, PRN - Ibuprofen: oral; Q6H, PRN - Albuterol sulfate: nebulizer; Q4H, PRN	All medications are PRN. S.O. did not receive any medications during the student's clinical rotation.
Other: - BBG suctioning - Elevate HOB - Reposition PRN	S.O. tolerated BBG suctioning, and her oxygen saturation improved with suctioning. S.O. rested and napped with the head of the bed elevated.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Wean continuous oxygen therapy as tolerated	Oxygen therapy was reduced from 3 L/min and 30% flow to 2 L/min and 21%. Patient tolerated weaning well and oxygen saturation remained greater than 90%. RT will continue to wean her throughout

	the day, as tolerated.

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	4.04	N/A	Within the range of normal values.
Hgb	10.2 – 12.7	10.3	N/A	Within the range of normal values.
Hct	31.2 – 37.8	31.9	N/A	Within the range of normal values.
Platelets	189 – 394	262	N/A	Within the range of normal values.
WBC	4.86 – 13.18	11.52	N/A	Within the range of normal values.
Neutrophils (absolute)	1.60 – 8.29	7.94	N/A	Within the range of normal values.
Lymphocytes	18.0 – 42.0%	25.9%	N/A	Within the range of normal values.
Monocytes	4 – 12%	4.8%	N/A	Within the range of normal values.
Eosinophils	0.0 – 5.0%	0.0%	N/A	Within the range of normal values.
Basophils	0.0 – 1%	0.2%	N/A	Within the range of normal values.
Bands	50 - 65%	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-	136 – 145	137	N/A	Within the range of normal values.
K+	3.51 – 5.1	3.7	N/A	Within the range of normal values.
Cl-	98 – 107	102	N/A	Within the range of normal values.
Glucose	74 – 100	166	N/A	Hyperglycemia may be a response to acute stress (Pagana et al., 2021). Some medicinal preparations, such as ibuprofen oral suspension, contain sucrose, which can increase the patient's glucose level (Jones & Bartlett Learning, 2021).
BUN	5 – 17	7	N/A	Within the range of normal values.
Creatinine	0.55 – 1.02	0.49	N/A	Decreased levels of creatinine may indicate

				debilitation (Pagana et al., 2021). The patient's poor oral intake may contribute to decreased muscle mass and decrease creatinine levels (Pagana et al., 2021).
Albumin	4.0 – 5.9	N/A	N/A	N/A
Total Protein	6.2 – 8	N/A	N/A	N/A
Calcium	9.0 – 11.0	9.8	N/A	Within the range of normal values.
Bilirubin	0.3 – 1.0	N/A	N/A	N/A
Alk Phos	85 - 235	N/A	N/A	N/A
AST	15 - 60	N/A	N/A	N/A
ALT	0 – 55	N/A	N/A	N/A
Amylase	60 – 120	N/A	N/A	N/A
Lipase	0 – 160	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	< 10	N/A	N/A	N/A
CRP	< 1.0	N/A	N/A	N/A
Hgb A1c	4 – 5.6 %	N/A	N/A	N/A
TSH	2 – 10	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	Colorless to yellow, clear	N/A	N/A	N/A
pH	5.0 – 9.0	N/A	N/A	N/A
Specific Gravity	1.000 – 1.030	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	0 - 25	N/A	N/A	N/A
RBC	0 - 20	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	Not collected	Not collected	No findings reported.
Blood Culture	Negative	Not collected	Not collected	No findings reported.
Sputum Culture	Negative	Not collected	Not collected	No findings reported.
Stool Culture	Negative	Not collected	Not collected	No findings reported.
Respiratory ID Panel	Negative	Positive for RSV	Not collected	Patient tested positive fore RSV on 10/15/22.
COVID-19 Screen	Negative	Negative	Not collected	Expected finding. Patient does not have COVID-19

Lab Correlations Reference (1) (APA):

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

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray on 10/17/2022

- Single frontal view of the chest
- Comparison from June 11, 2021
- Normal bony thorax
- Normal pulmonary vascularity and trachea
- Well-inflated lungs, focal LLL parenchymal opacity, increased peribranchial cuffing. No pleural effusion or pneumothorax. Atelectasis on background of viral bronchiolitis.

Diagnostic Test Correlation (5 points):

The findings of the chest x-ray are consistent with the patient's diagnosis. Peribronchial cuffing is a sign of various conditions, including an RSV infection. Peribronchial cuffing occurs when excess fluid or mucus accumulates in the small airway passages of the lungs (Pagana et al., 2021). The parenchymal opacities in left, lower lobe of the lung are indicative of atelectasis in the portion of the lungs involved in gas exchange (Pagana et al., 2021).

Diagnostic Test Reference (1) (APA):

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

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

Brand/Generic	AccuNeb/ Albuterol sulfate	Tylenol/ Acetaminophen	Children's Motrin/ Ibuprofen
Dose	2.5 mg	140.8 mg or 4.4 mL	94 mg or 4.7 mL
Frequency	Q4 hours, PRN	Q4 hours, PRN	Q6 hours, PRN
Route	Nebulizer, PO	PO	PO
Classification	Adrenergic; Bronchodilator	Nonsalicylate, para-aminophenol derivative; Antipyretic, nonopioid analgesic	NSAID, Analgesic; anti-inflammatory, antipyretic
Mechanism of Action	Albuterol binds to the beta 2 receptor which stimulates adenylate cyclase. Adenylate cyclase converts ATP to cAMP, which decreases intracellular calcium levels. This relaxes bronchial smooth-muscle cells and inhibits the release of histamine.	Prostaglandin production is blocked due to the drug's inhibition of the enzyme cyclooxygenase. This interferes with pain impulse generation in the peripheral nervous system.	Blocks cyclooxygenase, an enzyme required for prostaglandin synthesis. By inhibiting the production of prostaglandins, ibuprofen minimizes the inflammatory response and decreases pain, swelling, and vasodilation.
Reason Client Taking	Treats bronchospasm, reducing wheezing and shortness of breath.	Mild to moderate pain relief.	Mild to moderate pain relief.
Concentration Available	2.5 mg/3 mL	160 mg/5 mL	100 mg/5 mL
Safe Dose Range Calculation	2.5 mg three to four times daily, as needed	10 - 15mg/kg/dose = 10 x 9.5 = 95 15 x 9.5 = 142.5 95 - 142.5 mg/dose 95 < 140.8 < 142.5 Safe dosage	20 – 40 mg/kg/daily divided into 4 doses 20 x 9.5 = 190 40 x 9.5 = 380 190 – 380 mg/daily 190/4 = 47.5 380/4= 95 47.5 – 95 mg/dose 47.5 < 94 < 95 **Safe dosage**
Maximum 24-hour Dose	2.5 mg x 4 times/day = 10 mg/day	60 mg/kg/day with minimal dosing interval of 6 hours 60 x 9.5 = 570 mg/day with minimal dosing interval of 6 hours	40 mg/kg/day 40 x 9.5 = 380mg/day
Contraindications (2)	- Hypersensitivity to albuterol or its components	- Hypersensitivity to acetaminophen or its components - Severe hepatic impairment or severe active liver disease	- Angioedema - Nasal polyps
Side Effects/Adverse Reactions (2)	- Arrhythmias - Hypokalemia	- Hepatotoxicity - Hypoalbuminemia	- Pancytopenia - GI bleeding
Nursing Considerations (2)	- Monitor serum potassium level because albuterol can cause transient hypokalemia - Be aware that prolonged use can cause drug tolerance	- Ensure the patient does not receive more than the maximum daily limit from all sources in a 24-hour period. -Monitor patient for signs of hepatoxicity and impaired renal function	- Assess patient's skin regularly for signs of rash or hypersensitivity reactions - Be aware that ibuprofen oral suspension may contain sucrose, which can increase the patient's glucose level
Client Teaching needs (2)	- Instruct parent to report signs of an allergic reaction (difficulty swallowing, itching, rash) immediately - Explain that drug tolerance can develop with prolonged use. Instruct parent to contract provider if doses become less effective.	- Teach parent to recognize signs of hepatotoxicity such as bleeding, easy bruising, and malaise - Teach parent signs of Stevens-Johnson syndrome (rash, redness, and blisters) and to seek emergency treatment if symptoms occur	-Urge parents to contact provider promptly if patient develops headache, high fever, nausea, persistent diarrhea, severe persistent sore throat, or vomiting, or hasn't been drinking fluids - Advise parent to contact provider if the patient develops persistent stomach problems, like heartburn, stomach pain, or stomach upset

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2021). *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:**	S. O. is alert and active. She makes eye contact when addressed and follows age-appropriate, simple commands. She uses speech, language, and motor skills spontaneously. S.O. does not appear to be in acute distress.
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:**	S.O.'s skin color is white, and the tone is appropriate for the patient. Skin is intact and slightly cool, smooth, and dry upon palpation. Skin turgor normal mobility. No visible rashes, wounds, or scars Patient has light bruising on shins bilaterally. Bruising is appropriate for patient's developmental abilities and consistent with the patient's level of coordination/balance. Patient also has light bruising on left antecubital region. No drains or lines are present. Normal quantity and distribution of hair. Nails normal without clubbing or cyanosis. **The patient scored a 5 on the Braden Q Scale.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	S.O.'s head, facial features, and neck are symmetrical. Neck has a full range of motion and no masses palpable. Trachea midline without deviation. Thyroid and lymph nodes are not palpable. Bilateral carotid pulses are palpable, 2+. No visible or palpable deformities or lesions on the auricles of ears. Bilateral sclera white and bilateral cornea clear. No discharge from eyes. The septum is midline, and turbinates are pink and moist with no visible bleeding. S.O. has a small amount of nostril congestion, bilaterally. Congestion is cloudy, white, and thin. Oral mucosa is pink and moist overall, with no signs of bleeding or lesions. Fair dentition. The uvula is midline. The soft palate rises and falls symmetrically. The hard palate is intact.
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:**	Clear S1 and S2 sounds heard without murmurs, gallops, or rubs. Normal rate and rhythm. PMI palpable at 5th intercostal space at midclavicular line. Capillary refill less than 3 seconds on fingers and toes, bilaterally. Peripheral pulses 2+ throughout, bilaterally. No Jugular vein distention or edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and rhythm of respirations. Breath sounds clear, except for left lower lobe and right lower lobe. Patient has coarse crackles in the lower lobes bilaterally, anteriorly and

	posteriorly. Respiratory effort is nonlabored, with no accessory muscle use. Patient does not have any abdominal breathing or retractions.
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:**	S.O. breastfeeds and eats solids at home and at the hospital. Mother breastfed her two times during the student's clinical rotation. S.O. is 74 cm tall. S.O. has a protuberant abdomen, appropriate for age. She has no abdominal scars, incisions, drains, or wounds. The abdomen is soft and non-tender. No organomegaly or masses were noted upon palpation of all four quadrants. Bowel sounds are normoactive in all four quadrants. Her most recent bowel movement was 10/20/22 at 1700. S.O. does not have an ostomy, nasogastric tube, or feeding tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine is yellow, with no foul odor. Skin intact. No rashes present. Normal urinary output. Patient does not show signs of pain with urination. She does not have a catheter, and she does not go to dialysis. Patient's output was 120 mL.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 4** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	No paralysis. All extremities have a full range of motion. Upper and lower extremity strength equal, bilaterally. General mobility is not impaired. Age-appropriate gait. S.O. does not use supportive devices. Patient requires age-appropriate assistance with ADLs. **S.O.'s fall risk score is a 4, putting her at low risk.** Patient's activity is to be increased as tolerated.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	PERRLA. Hand grips demonstrate normal and equal strength, bilaterally. Dorsiflexion and plantarflexion demonstrate normal and equal strength, bilaterally. Patient alert and active. S.O. shows age-appropriate speech and normal sensations. Normal level of consciousness.
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):**	Both parents are present at the bedside. Parents have strong familial support. Both parents are very involved in the patient's care. Parents are married, and patient resides in family home with parents and siblings.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0800	118 bpm	125/64	30 bpm	36.5° C Axillary	93% on HHNC RAM cannula at 3L/min and 30% flow
1000	132 bpm	N/A	30 bpm	36.6° C Axillary	92% on HHNC RAM cannula at 2L/min and 21% flow

Vital Sign Trends: S.O.'s vital signs are stable. Her blood pressure is hypertensive. The patient had difficulty sitting still during the reading and at one point tried to remove the cuff, so this may have affected the reading. Patient's axillary temperature was low, but the patient was not fully clothed. She did not seem uncomfortable. Patient's oxygen saturation indicates that she is tolerating the weaning from oxygen therapy.

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

Pulse Rate	80 – 140/min
Blood Pressure	**Systolic:** 83 – 114 mm Hg **Diastolic:** 38 – 67 mm Hg
Respiratory Rate	25 – 30/min
Temperature	37.2 – 37.7° C
Oxygen Saturation	> 95%

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
0845	rFLACC	N/A	0	N/A	Patient was watching TV with her parents.
Evaluation of pain status *after* intervention	N/A	N/A	N/A	N/A	N/A
Precipitating factors: No precipitating factors of pain **Physiological/behavioral signs:** Nonverbal indicators of pain absent					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
Breastfed for 10 mins Drank 60 mL of water No IV fluids or medications given	120 mL

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. O.S. builds a tower of two blocks (Holman et al., 2019).
2. O.S. walks without help (Holman et al., 2019).
3. O.S. uses a water cup well (Holman et al., 2019).

Age Appropriate Diversional Activities

1. O.S. plays with push-pull toys (Holman et al., 2019).
2. O.S. enjoys looking at books with her parents (Holman et al., 2019).
3. O.S. gently tosses a ball to her parent (Holman et al., 2019).

Psychosocial Development:

Which of Erikson's stages does this child fit? Autonomy versus shame and doubt

What behaviors would you expect? O.S. begins to express autonomy and the desire to do things for herself (Holman et al., 2019). During this stage, O.S. will find comfort in routines and reliability (Holman et al., 2019).

What did you observe? The nursing student observed O.S.'s developing independence while she was eating breakfast. She had a croissant, and her father was breaking off small pieces to feed her. She then decided that she would rather break the pieces off for herself.

Cognitive Development:

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

What behaviors would you expect? At sixteen months, O.S has learned to separate herself from other objects in the environment (Holman et al., 2019). She has also learned that an object exists when it is out of view, a concept known as object permanence (Holman et al., 2019). Additionally, she is developing the ability to recognize and use symbols (Holman et al., 2019).

What did you observe? The nursing student used a pink toy bunny as a distraction while the nurse listened to O.S.'s lungs. The student nurse hid the bunny behind the foot of the patient's bed and out of the patient's sight. O.S. leaned forward to find it, indicating that she knows the object still exists when it is out of her view. This is an example of object permanence.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? The patient uses one-word sentences, which is expected for a one-year-old (Holman et al., 2019).

Any concerns regarding growth and development? No concerns regarding O.S.'s growth and development.

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

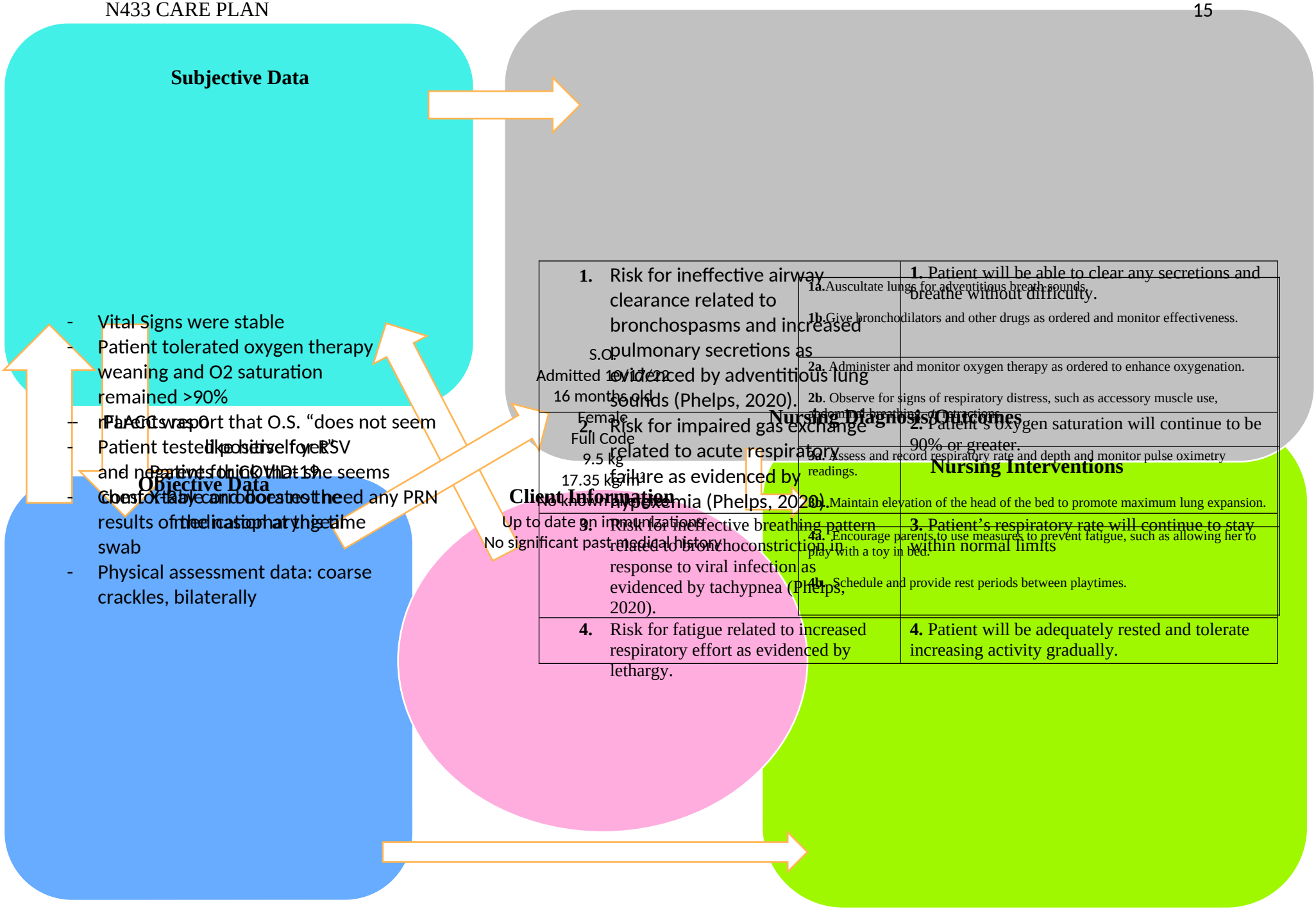
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client.	**Rational** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcomes**	**Evaluation** • How did the Client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for ineffective airway clearance related to bronchospasms and increased pulmonary secretions as evidenced by adventitious lung sounds (Phelps, 2020).	The nursing student heard coarse crackles during the patient's physical assessment.	**1.**Auscultate lungs for adventitious breath sounds. **2.**Give bronchodilators and other drugs as ordered and monitor effectiveness.	**1.** Patient will be able to clear any secretions and breathe without difficulty.	Adventitious sounds will be absent, and the patient's airway will remain patent.
2. Risk for impaired gas exchange related to acute respiratory failure as evidenced by hypoxemia (Phelps, 2020).	The patient presented to the ED with an oxygen saturation of 82% on room air.	**1.** Administer and monitor oxygen therapy as ordered to enhance oxygenation. **2**. Observe for signs of respiratory distress, such as accessory muscle use, abdominal breathing, or retractions.	**1.** Patient's oxygen saturation will continue to be 90% or greater.	The patient's oxygen saturation was greater than 90% even as she was weaned from oxygen therapy. She did not show any signs of respiratory distress, such as accessory muscle use, abdominal breathing, or retractions.
3. Risk for ineffective breathing pattern related to bronchoconstriction in response to viral	The patient presented in the ED with respirations per minute in the 50s.	**1.** Assess and record respiratory rate and depth and monitor pulse oximetry readings.	**1.** Patient's respiratory rate will continue to stay within normal limits	Patient's respiratory rate remained within the normal range, even as she was weaned from oxygen therapy. Patient will continue demonstrating

	infection as evidenced by tachypnea (Phelps, 2020).		**2.** Maintain elevation of the head of the bed to promote maximum lung expansion.		adequate breathing patterns with easy, unlabored respirations.
4.	Risk for fatigue related to increased respiratory effort as evidenced by lethargy.	The patient's parents expressed concern that O.S. was not "acting like herself" yet.	**1.** Encourage parents to use measures to prevent fatigue, such as allowing her to play with a toy in bed. **2.** Schedule and provide rest periods between playtimes.	**1.** Patient will be adequately rested and tolerate increasing activity gradually.	The parent's agreed that O.S. was slowly increasing her level of activity and they understand that it may take more time before she returns to the level she was at prior to hospitalization. O.S. took a nap in her father's arms after her morning playtime.

Other References (APA):

Phelps, L.L. (2020). *Sparks and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):



Nursing Diagnosis	Outcomes	Nursing Interventions
1. Risk for ineffective airway clearance related to bronchospasms and increased pulmonary secretions as evidenced by adventitious lung sounds (Phelps, 2020).	**1.** Patient will be able to clear any secretions and breathe without difficulty.	**1a.** Auscultate lungs for adventitious breath sounds. **1b.** Give bronchodilators and other drugs as ordered and monitor effectiveness.
2. Risk for impaired gas exchange related to acute respiratory failure as evidenced by hypoxemia (Phelps, 2020).	**2.** Patient's oxygen saturation will continue to be 90% or greater.	**2a.** Administer and monitor oxygen therapy as ordered to enhance oxygenation. **2b.** Observe for signs of respiratory distress, such as accessory muscle use, abdominal breathing, retractions. **2c.** Assess and record respiratory rate and depth and monitor pulse oximetry readings. **2d.** Maintain elevation of the head of the bed to promote maximum lung expansion.
3. Risk for ineffective breathing pattern related to bronchoconstriction in response to viral infection as evidenced by tachypnea (Phelps, 2020).	**3.** Patient's respiratory rate will continue to stay within normal limits	**3a.** Encourage parents to use measures to prevent fatigue, such as allowing her to play with a toy in bed. **3b.** Schedule and provide rest periods between playtimes.
4. Risk for fatigue related to increased respiratory effort as evidenced by lethargy.	**4.** Patient will be adequately rested and tolerate increasing activity gradually.	