N433 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Client Initials**	**Age (in years & months)**	**Gender**
3-7-23	RW	4 years and 3 months (51 months)	Female
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full code	15 kg	16.53 kg/m^2	No known allergies

Medical History (5 Points)

Past Medical History: Fetal drug exposure, heart murmur at birth

Illnesses: N/A

Hospitalizations: N/A

Past Surgical History: N/A

Immunizations: Up to date on immunizations per CDC guidelines.

Birth History:

Complications (if any): At birth the patient tested positive for cocaine.

Assistive Devices: N/A

Living Situation: The patient is living at home with her mom, dad, and baby sister.

Admission Assessment

Chief Complaint (2 points): Decreased activity and PO intake.

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

Pertinent Events during this admission/hospitalization (1 points): The patient only needed 1 attempt at an IV stick. During her stay she had a chest x-ray and a KUB x-ray. She is being treated for possible sepsis, Systemic Inflammatory Response Syndrome, and dehydration. She is schedule to go home 3-9-23.

History of present Illness (OLD CARTS) (10 points): The patient came into the Emergency Department due to decrease activity and PO intake. She not acting like herself a couple days prior to going to the ED. Mom stated she just laid around the house and would refuse to eat. There were no aggravating and relieving factors that helped prior. Instead of being treated at home she was treated at the hospital for IV fluids and an antibiotic for possible sepsis.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Systemic Inflammatory Response Syndrome

Secondary Diagnosis (if applicable): Rhinovirus

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

My patient was diagnosed with SIRS, a systemic inflammatory response syndrome. This is an “inflammation triggered by an infectious or noninfectious stimuli sets forth a complex interplay of the humoral and cellular immune response, cytokines, and complement pathway — eventually, systemic inflammatory response syndrome results when the balance between pro-inflammatory and anti-inflammatory cascades tip over towards the former” (Chakraborty & Burns, 2022). A scientist devised five stages to describe how the body is affected. Stage one consists of a local reaction that keeps the injury contained and limits the spread. “Immune effector cells at the site release cytokines that stimulate the reticuloendothelial system promoting wound repair through local inflammation” (Chakraborty & Burns, 2022). The patient is at risk of losing function to allow the body to repair. Stage 2 consists of “stimulating growth factors and recruitment of macrophages and platelets as the level of pro-inflammatory mediators decreases to maintain homeostasis” (Chakraborty & Burns, 2022). Stage 3 involves “end-organ micro thrombosis, and a progressive increase in capillary permeability, eventually resulting in loss of

circulatory integrity" (Chakraborty & Burns, 2022). In stage 4, the patient is in a state of immunosuppression, leaving the patient more susceptible to infections and sepsis. Stage 5 "at a cellular level, noninfectious noxious stimuli, an infectious agent or an endotoxin or exotoxin produced by an infection activates many cells including neutrophils, macrophages, mast cells, platelets, and endothelial cells" (Chakraborty & Burns, 2022). SIRS affects the local reaction but eventually can spread through the bloodstream and affect every body system. Once the patient is in sepsis, it could lead to organ failure if not treated quickly. Signs and symptoms may appear flushed skin at the site of injury, pain or tenderness, swelling, or heat for acute inflammation. Chronic inflammation can include abdominal pain, chest pain, fatigue, fever, and joint pain (Cleveland Clinic, 2023). The patient experienced chronic inflammation due to the ESR being elevated. The patient's symptoms include fatigue and fever. When diagnosed with SIRS, the patient's vital signs will be abnormal. The patient usually has a temperature, elevated heart rate and respirations, and oxygen saturation and blood pressure may vary. The laboratory findings will include elevated WBC and elevated inflammation markers like ESR and CRP. Providers will also look at procalcitonin, which is an indicator of sepsis. Electrolytes may vary as well, depending on the patient. Diagnostic testing for SIRS will include looking at laboratory findings like those listed above. Treatment for SIRS may include supplements, NSAIDs, and antibiotics. The treatment option for my patient was antibiotics such as ceftriaxone. Complications are possible sepsis that could result in organ failure throughout the body. This can result in abnormal vital signs, and preventative measures would include frequent vital signs assessment. Another complication that could occur would be acute respiratory distress syndrome. These symptoms would include abnormal respiratory rates. A preventative measure would be to monitor oxygen saturation continuously.

Pathophysiology References (2) (APA):

Inflammation. Cleveland Clinic. (2023). Retrieved from https://my.clevelandclinic.org/health/symptoms/21660-inflammation

Chakraborty, R., & Burns, B. (2022). *Systemic inflammatory response syndrome*. National Library of Medicine. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK547669/

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	Up without assistance and remained in her room due to droplet precautions.
Diet/Nutrition:	Clear liquid diet
Frequent Assessments:	Neuro assessments Q8H, Vital signs Q4H, and Pediatric airway status
Labs/Diagnostic Tests:	Chest x-ray and KUB x-ray
Treatments:	Ceftriaxone and D5-0.9% NaCl continuous, pushing fluids orally too.
Other:	Patient is on Droplet Precautions due to rhinovirus.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Polyethylene glycol oral powder packet 17g	Patient has not had a bowel movement since 3-5-23.
Ceftriaxone and D5-0.9% NaCl continuous	Patient is starting to get back to herself with

	the help of antibiotics and fluids.
Droplet precautions	Patient test positive for rhinovirus.

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 10^6/uL" (Capriotti & Frizzell, 2020).	4.28 10^6/uL	N/A	N/A
Hgb	"10.2-12.7 g/dL" (Capriotti & Frizzell, 2020).	11.6 g/dL	N/A	N/A
Hct	"31.2%-37.8%" (Capriotti & Frizzell, 2020).	34.3%	N/A	N/A
Platelets	"189-394 10^3/uL" (Capriotti & Frizzell, 2020).	388 10^3/uL	N/A	N/A
WBC	"4.86-13.18 10^3/uL"	25.23 10^3/uL	N/A	The patient has rhinovirus, severe inflammation, and possible sepsis in her body allowing the white blood cell count to increase. (Capriotti & Frizzell, 2020).
Neutrophils	"1.60-8.29 10^3/uL" (Capriotti & Frizzell, 2020).	20.51 10^3/uL	N/A	The patient has rhinovirus, severe, inflammation, and possible sepsis in her body allowing the neutrophils to increase. (Capriotti & Frizzell, 2020).

Lymphocytes	"1.25-5.77 10^3/uL" (Capriotti & Frizzell, 2020).	2.12 10^3/uL	N/A	N/A
Monocytes	"0.24-0.92 10^3/uL" (Capriotti & Frizzell, 2020).	2.24 10^3/uL	N/A	The patient has rhinovirus, severe inflammation, and possible sepsis in her body allowing the monocytes to increase. (Capriotti & Frizzell, 2020).
Eosinophils	"0.03-0.46 10^3/uL" (Capriotti & Frizzell, 2020).	0.04 10^3/uL	N/A	N/A
Basophils	"0.01-0.06 10^3/uL" (Capriotti & Frizzell, 2020).	0.09 10^3/uL	N/A	The patient has rhinovirus, severe inflammation, and possible sepsis in her body allowing the basophils to increase. (Capriotti & Frizzell, 2020).
Bands	N/A	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 mmol/L" (Capriotti & Frizzell, 2020).	131 mmol/L	N/A	The patient was very dehydrated on admission allowing for sodium to decrease due to decreased fluid intake (Capriotti & Frizzell, 2020).
K+	"3.5-5.1 mmol/L" (Capriotti & Frizzell, 2020).	4.2 mmol/L	N/A	N/A
Cl-	"98-107 mmol/L" (Capriotti & Frizzell,	98 mmol/L	N/A	N/A

	2020).			
Glucose	"74-100 mg/dL" (Capriotti & Frizzell, 2020).	58 mg/dL	N/A	The patient is on a clear liquid diet and is not receiving the nutrients she needs to keep the glucose within normal range (Capriotti & Frizzell, 2020).
BUN	"7-17 mg/dL" (Capriotti & Frizzell, 2020).	7 mg/dL	N/A	N/A
Creatinine	"0.55-1.02 mg/dL" (Capriotti & Frizzell, 2020).	0.55 mg/dL	N/A	N/A
Albumin	"3.8-5.4 g/dL" (Capriotti & Frizzell, 2020).	4.1 g/dL	N/A	N/A
Total Protein	"6.0-8.0 g/dL" (Capriotti & Frizzell, 2020).	7.5 g/dL	N/A	N/A
Calcium	"8.8-10.8 mg/dL" (Capriotti & Frizzell, 2020).	10.3 mg/dL	N/A	N/A
Bilirubin	"0.2-1.2 mg/dL" (Capriotti & Frizzell, 2020).	0.4 mg/dL	N/A	N/A
Alk Phos	"9-500 U/L" (Capriotti & Frizzell, 2020).	165 U/L	N/A	N/A
AST	"5-34 U/L" (Capriotti & Frizzell, 2020).	28 U/L	N/A	N/A
ALT	"0-55 U/L" (Capriotti & Frizzell,	11 U/L	N/A	N/A

	2020).			
Amylase	N/A	N/A	N/A	N/A
Lipase	N/A	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	"3-13 mm/h" (Capriotti & Frizzell, 2020).	36 mm/h	N/A	The patient was diagnosed with systemic inflammatory response syndrome and possible sepsis that has been going on for days prior to being admitted that could result in chronic inflammation (Capriotti & Frizzell, 2020).
CRP	"0.00-0.50 mg/dL" (Capriotti & Frizzell, 2020).	16.51 mg/dL	N/A	The patient was diagnosed with systemic inflammatory response syndrome and possible sepsis that has been going on for days prior to being admitted that could result in acute inflammation (Capriotti & Frizzell, 2020).
Hgb A1c	"<5.7" (Capriotti & Frizzell, 2020).	N/A	N/A	N/A
TSH	"0.5-5.0 mIU/L" (Capriotti & Frizzell, 2020).	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 – yellow	Yellow	N/A	N/A
pH	"7.35-7.45" (Capriotti & Frizzell, 2020).	5.0		The patient was severely dehydrated on admission resulting in a low pH (Capriotti & Frizzell, 2020).
Specific Gravity	"1.050-1.030" (Capriotti & Frizzell, 2020).	1.030	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	30		The patient was severely dehydrated on admission which could lead to protein in her urine (Capriotti & Frizzell, 2020).
Ketones	Negative	160		The patient low glucose on admission allows the cells to burn fat instead of glucose which could lead to ketones in urine (Capriotti & Frizzell, 2020).
WBC	"0-25/uL" (Capriotti & Frizzell, 2020).	20	N/A	N/A
RBC	"0-20 u/L" (Capriotti & Frizzell, 2020).	2	N/A	N/A
Leukoesterase	Negative	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	Not Detected	N/A	N/A	N/A
Blood Culture	Not Detected	N/A	N/A	N/A
Sputum Culture	Not Detected	N/A	N/A	N/A

Stool Culture	Not Detected	N/A	N/A	N/A
Respiratory ID Panel	Not Detected	Detected	N/A	The patient tested positive for rhinovirus (Capriotti & Frizzell, 2020).
COVID-19 Screen	Not Detected	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient had a chest x-ray and a kidneys, ureters, and bladder x-ray (KUB).

Diagnostic Test Correlation (5 points):

The patient has an x-ray of kidneys, ureter, and bladder on 3-7.23. The patient was experiencing abdominal and back pain on admission. The test shows the stool volume was normal. This test is performed to assess the reasoning of “abdominal pain, assess the organs and structures of the urinary, and gastrointestinal system” (John Hopkins Medicine, 2021).

The patient had a chest x-ray on 3-7-23 due to possible leukocytosis. The test showed the patient was negative for leukocytosis. A chest x-ray can show the condition of the lungs, size and outline of the heart, blood vessels, calcium deposits, and heart-lung related problems (Mayo Clinic, 2023).

Diagnostic Test Reference (1) (APA):

Kidney, ureter, and bladder X-ray. Johns Hopkins Medicine. (2021). Retrieved from https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/kidney-ureter-and-bladder xray#:~:text=A%20kidney%2C%20ureter%2C%20and%20bladder%20(KUB)%20X%2D,to %20assess%20the%20urinary%20system.

Mayo Foundation for Medical Education and Research. (2023). *Chest X-rays*. Mayo Clinic. Retrieved from https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494#:~:text=Chest%20X%2Drays%20can%20detect,Heart%2Drelated%20lung %20problems.

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

Brand/Generic	ceftriaxone/Rocephin	acetaminophen/Tylenol
Dose	375 mg	160mg/ 5 mL
Frequency	Q12H	Q4H PRN
Route	IV Syringe	Liquid PO
Classification	Pharmacologic class: "Third-generation cephalosporin" (Nurse's Drug Handbook, 2020, p. 239). Therapeutic class: "Antibiotic" (Nurse's Drug Handbook, 2020, p. 239).	Pharmacological class: "Nonsalicylate, para-aminophenol derivative" (Nurse's Drug Handbook, 2020, p. 8) Therapeutic class: "Antipyretic, nonopioid analgesic" (Nurse's Drug Handbook, 2020, p. 8).
Mechanism of Action	"Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in

	strands. Peptidoglycan makes the cell membrane rigid and protective. Without it, bacterial cells rupture and die" (Nurse's Drug Handbook, 2020, p. 241).	the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2" (Nurse's Drug Handbook, 2020, p. 10)
Reason Client Taking	The patient is taking this medication due to possible sepsis.	The patient is taking this medication for pain 1-3 and fevers above 100.4 F.
Concentration Available	375 mg / 18.8 mL	160 mg / 5 mL
Safe Dose Range Calculation	25-75 mg/kg/day	10-15 mg/kg; do not exceed 5 doses
Maximum 24-hour Dose	Maximum 2 g daily	Maximum 75 mg/kg/day not exceeding 3750.
Contraindications (2)	"Hypersensitivity to ceftriaxone, other beta lactam antibacterial or cephalosporins, penicillins, or their components" (Nurse's Drug Handbook, 202, p. 241). "Intravenous administration of ceftriaxone solutions containing lidocaine" (Nurse's Drug Handbook, 202, p. 241).	"Hypersensitivity to acetaminophen or its components" (Nurse's Drug Handbook, 202, p. 10). "Severe hepatic impairment" (Nurse's Drug Handbook, 202, p. 10).
Side Effects/Adverse Reactions (2)	"Dyspnea" (Nurse's Drug Handbook, 202, p. 241). "Fever" (Nurse's Drug Handbook, 202, p. 241).	"Hypoglycemic coma" (Nurse's Drug Handbook, 202, p. 10). "Fever" (Nurse's Drug Handbook, 202, p. 10).

Nursing Considerations (2)	"Obtain culture and sensitivity results, if possible and as ordered, before giving drug" (Nurse's Drug Handbook, 202, p. 241). "Assess for signs of superinfection, such as cough or sputum changes" (Nurse's Drug Handbook, 202, p. 242).	"Calculate total daily intake of acetaminophen including other products so maximum daily dosage is not exceed" (Nurse's Drug Handbook, 202, p. 11). "Monitor renal function in patient on long term therapy" (Nurse's Drug Handbook, 202, p. 11).
Client Teaching needs (2)	"Tell patient to report evidence of blood dyscrasia or superinfection to the prescriber immediately" (Nurse's Drug Handbook, 202, p. 241). "Advise patient to report any hypersensitivity reactions, such as a rash, itching skin, or hives, to prescriber immediately and to stop taking the drug" (Nurse's Drug Handbook, 202, p. 242).	"Caution patient not to exceed recommended dose or take other drugs containing acetaminophen" (Nurse's Drug Handbook, 202, p. 11). "Teach patient/parent to recognize signs of hepatotoxicity, such as bleeding, easy bruising and malaise, which is commonly occurs with chronic overdose" (Nurse's Drug Handbook, 202, p. 11).

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed), p. 8, 10, 11, 239, 241, & 242.

Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented to person, place, situation, and time. Patient appears to be in no acute distress and appearance is appropriate for the setting.
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:**	Patients' skin color is appropriate for ethnicity. Skin is warm and dry upon palpation. No rashes, bruising, and lesions noted bilaterally on upper and lower extremities. There are no wounds or drains present. Nails are without clubbing or cyanosis. Skin turgor is non-tenting. Capillary refill is less than 3 seconds bilaterally on fingers and toes. Patient scores a 23 on the Braden scale which results in a low risk for pressure ulcers. The patient has a 22-gauge right AC IV. The placement of the IV was on 3-7-23. There are no signs of erythema, drainage, infiltration, or phlebitis noted. The patient is receiving D5-0.9% NaCl at 60 mL/hr continuously and ceftriaxone 18.8 mL/hr.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no nodules noted. Bilateral carotid pulses are palpable and 2+. There is no lymphadenopathy noted in the head or neck. Sclera bilaterally white, cornea bilaterally clear, bilaterally conjunctiva clear. There is no visible drainage from the eyes. Lids are moist and pink without lesions bilaterally. PERRLA is intact bilaterally. EOMs are intact bilaterally. Auricles have no palpable lumps or lesions bilaterally. Septum is midline, frontal sinuses are nontender to palpation bilaterally. Nasal condition is patent without discharge. Tonsils are present with +2. Uvula is midline; soft palate rises and falls symmetrically. Hard palate intact. Patient has all of her baby teeth for her age, oral mucosa overall is moist and pink without lesions noted.
CARDIOVASCULAR: **Heart sounds:**	Clear S1 and S2 without murmurs, gallops, or rubs. PMI palpable at 5th intercostal space at midclavicular

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:**	line. Normal rate and rhythm. Pedal pulses are 3+ bilaterally. Radial pulses 3+ bilaterally. Capillary refill is less than 3 seconds bilaterally on toes and fingers. There is no neck vein distention or edema noted.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient had a regular respiratory pattern. Respirations were non-labored, lungs are clear anterior/posterior bilaterally, no wheeze, crackles, or rhonchi noted. Lung aeration is equal bilaterally. There is no ET tube noted.
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:**	Diet at home is regular and for the hospital the patient is on a clear liquid diet. Patient weighs 15 kg and height is 95.3 cm. Bowel sounds are normoactive in all four quadrants. Abdomen is soft, nontender, no organomegaly or masses noted upon palpation. Last bowel movement was 3-5-22. There is no distention, incisions, scars, drains, or wounds noted. There is no ostomy, nasogastric, or feeding tube noted.
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 and clear. Patient intake was 369.38 mL and voided 350 mL. Patient's intake consisted of 120 mL of a watermelon snow cone, 9.38 mL of ceftriaxone, and 240 mL of D5-0.9% NaCl. Patient stated there is no pain with urination. There is no catheter present. Patient is not on dialysis.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:**	Upper and lower extremities have a full active range of motion. Patient has a steady gait. Strength is +4 in upper and lower extremities due to slight weakness. Capillary refill is less than 3

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** ☐	seconds bilaterally. Extremities are warm and dry bilaterally. There is no cyanosis or clubbing noted bilaterally. Patient scored a 3 on the Cummings scale which indicates a low risk for falling. Patient is dependent on parent considering she is only 3 years old. Patient does need assistance with moving her IV pump when walking.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is oriented to person, place, situation, and time. Patient has normal cognition. Speech is clear. Patient is awake and answers questions appropriately. Patient moves the upper and lower extremities well. PERRLA is intact. Hands grips and pedal pushes and pulls demonstrated normal and equal strength for upper extremities. Cranial nerves intact. Sensory is 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):**	Patient enjoys coloring and playing with stickers. Patient expressed to me that she has 2 dogs at home. Patient lives with her mom, dad, and baby sister. Patient does not require home equipment or medication assistance. Parents expressed that their social needs are met with transportation and food.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	84 bpm	125/71 mmHg	20 breaths per minute	36.6 C	100%
1115	105 bpm	124/58 mmHg	18 breaths per minute	36.3 C	97%

Vital Sign Trends: The vital signs for the most part was within range. The patient's blood pressure was elevated due to her pumping her foot while I was taking her blood pressure on her

calf. The last respiration I took was slightly decreased but she also just got done getting in and out of her bed. Otherwise, the patient's temperature, oxygen saturation, and heart rate were within normal range.

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

Pulse Rate	"65-110 bpm" (Ricci et al., 2021, p. 1128).
Blood Pressure	"90/48-94-52 mmHg" (Ricci et al., 2021, p. 1923).
Respiratory Rate	"20-25 breaths per minute" (Ricci et al., 2021, p. 1128).
Temperature	"36.5-38 C" (Ricci et al., 2021, p. 1126).
Oxygen Saturation	"95%-100%" (Ricci et al., 2021, p. 1128).

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

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

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Wong-Baker FACES Scale	N/A	0	N/A	No interventions needed at this time.
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)**
240 mL of D5-0.9% NaCl 120 mL of a watermelon snow cone 9.38 mL of ceftriaxone	Voided 350 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. Name the colors of her crayons.
2. Holds a pencil in writing position.
3. Say sentences with four to five words.

Age Appropriate Diversional Activities

1. Coloring pictures
2. Flipping through books
3. Telling stories about her puppy at home

Psychosocial Development:

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

What behaviors would you expect? The behaviors I would expect to see in this child would be pleasing her parents, making up game to play, and acting out roles. These kids will begin to imitate their parents and use their imagination for games. They begin to develop a sexual identity and a conscience (Ricci et al., 2021, p. 986).

What did you observe? In clinical I observed the child making up games to play and acting out roles. The patient did try to please her parents when coloring. My patient also liked telling stories to me from home.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? Preoperational (Pre-conceptual)

What behaviors would you expect? These patients should be using their active imagination to play games and tell stories. These kids will learn through observing and imitating parent figure or older adults. These kids will have a short attention span and switch activities often (Ricci et al., 2021, p. 986).

What did you observe? My patient likes to use her active imagination and tell stories. She had a short attention span when it came to switching pictures she liked to color. The patient liked to observe what her mom was doing. She liked to imitate the nurses when it came time to listen to her heart, lungs, and bowel sounds.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? The patient should be using four-to-five-word sentences and also have 2100 words in her vocabulary. There are no concerns for this patient.

Any concerns regarding growth and development? The patient is relatively small for her age regarding weight.

Developmental Assessment Reference (1) (APA):

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

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client.	**Rational** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcomes**	**Evaluation** • How did the Client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for sepsis related to lab values and patient presentation as evidenced by procalcitonin of 2.1.	The healthcare team diagnosed her with possible sepsis on admission due to her procalcitonin being 2.1 when normal range is <0.5.	**1.**Monitor vital signs frequently for noticeable changes. **2.**Monitor blood levels in the patient for worsening.	**1.** The patient's possible sepsis and procalcitonin levels will decrease by the time of discharge.	The patient and parent responded well to the goals and verbally acknowledged the status of the goals and outcomes.
2. Risk for imbalanced fluid volume related to fluid and electrolyte imbalance as evidenced by hypoglycemic state on admission with glucose of being 31.	The patient is dehydrated, and the nurse expressed that the patient will stay on a clear liquid diet unless hydration is maintained.	**1.** "Monitor vital signs and intake and output frequently" (Phelps, 2020, p. 245). **2.**"Educate patient and family regarding fluid restrictions or need for increased fluids, depending on underlying	**1.** The patient increased her fluid volume by eating flavored snow cones and clear juices within 12 hours.	The patient and parent responded well to the goals and verbally acknowledged the status of the goals and outcomes.

		condition" (Phelps, 2020, p. 245).		
3. Constipation related to change in eating patterns as evidenced by the patient hasn't had a bowel movement since 3-5-23.	The patient has been on a clear liquid diet since her admission to the hospital. Patient has not had a bowel movement in 4 days which could be induced by the low fluid intake and activity.	**1.** "Assess bowel sounds and check patient for abdominal distention" (Phelps, 2020, p. 115). **2.** "Encourage fluid intake of 2.5 liters daily" (Phelps, 2020, p. 115).	**1.** The patient will have a bowel movement within 12 hours due to the increased fluid intake and MiraLAX.	The patient and parent responded well to the goals and verbally acknowledged the status of the goals and outcomes.
4. Activity intolerance is related to generalized weakness as evidenced by fatigue easily.	The patient was admitted for her generalized weakness and still has slight weakness and not back to her full self as stated by the mom.	**1.** "Identify activities the patient considers desirable and meaningful" (Phelps, 2020, p. 3). **2.** "Teach patient exercises for increasing strength and endurance to improve breathing and promote general physical reconditioning" (Phelps, 2020, p. 3).	**1.** The patient will improve her weakness within 6 hours as she was already starting to get back to herself at the end of the clinical day.	The patient and parent responded well to the goals and verbally acknowledged the status of the goals and outcomes.

Other References (APA):

Phelps, L.L. (2020). *Sparks and Taylor's nursing diagnosis reference manual* (11th ed.), p. 3, 115, & 245. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient has no previous illness history. The patient did not complain of any symptoms and was almost back to herself by the end of the clinical day. Patient expressed several times throughout the day how hungry she was due to her clear liquid diet.

Nursing Diagnosis/Outcomes

1. Risk for sepsis related to lab values and patient presentation as evidenced by procalcitonin of 2.1.
   a. The patient’s possible sepsis and procalcitonin levels will decrease by the time of discharge.
2. Risk for imbalanced fluid volume related to fluid and electrolyte imbalance as evidenced by hypoglycemic stated on admission with glucose of being 31.
   a. The patient increased her fluid volume by eating flavored snow cones and clear juices within 12 hours.
3. Constipation related to change in eating patterns as evidenced by the patient hasn’t had a bowel movement since 3-5-23.
   a. The patient will have a bowel movement within 12 hours due to increased fluid intake and MiraLAX.
4. Activity intolerance is related to generalized weakness as evidenced by fatigue easily.
   a. The patient will improve her weakness within 6 hours as she was already starting to get back to herself at the end of the clinical day.

Client Information

4-year-old female was admitted to the ED for decreased activity and PO intake. She has a history of fetal drug exposure and heart murmur. The patient is compliant due to her parent’s assistance.

Objective Data

The chest x-ray and KUB x-ray showed no concerns. The patient is at a low risk for pressure sores and falling. The patient has not had a bowel movement since 3-5-23. The patient does have some slight weakness still in her upper and lower extremities. The patient’s vital signs are within normal range besides her blood pressure being elevated and respiration slightly decreased due to movement. The patients WBC, neutrophils, monocytes, basophils, ESR, and CRP were elevated. While patient’s sodium and glucose were decreased.

Nursing Interventions

1. Monitor vital signs frequently for noticeable changes.
2. Monitor blood levels in the patient for worsening.

1. “Monitor vital signs and intake and output frequently” (Phelps, 2020, p. 245).
2. “Educate patient and family regarding fluid restrictions or need for increased fluids, depending on underlying condition” (Phelps, 2020, p. 245).

1. “Assess bowel sounds and check patient for abdominal distention” (Phelps, 2020, p. 115).
2. “Encourage fluid intake of 2.5 liters daily” (Phelps, 2020, p. 115).

1. “Identify activities the patient considers desirable and meaningful” (Phelps, 2020, p. 3).
2. “Teach patient exercises for increasing strength and endurance to improve breathing and promote general physical reconditioning” (Phelps, 2020, p. 3).