N433 Care Plan # 1

Lakeview College of Nursing

Shana Stanley

Demographics (3 points)

Date of Admission 4-19-23	**Client Initials** ZA	**Age (in years & months)** 14 months	**Gender** Male
Code Status Full	**Weight (in kg)** 7.04kg	**BMI** 13.92kg/m2	**Allergies/Sensitivities (include reactions)** None

Medical History (5 Points)

Past Medical History: The patient has a history of a lack of weight gain.

Illnesses: None

Hospitalizations: None

Past Surgical History: None

Immunizations: up to date

Birth History: The patient was reported to be born without complications and to term.

Complications (if any): None

Assistive Devices: None

Living Situation: The patient lives at home with his parents and one sibling.

Admission Assessment

Chief Complaint (2 points): PCP and patients had concerns with lack of weight gain.

Other Co-Existing Conditions (if any): None

Pertinent Events during this admission/hospitalization (1 points): The patient was seen by the primary care provider, during this time it was decided that the patient should be admitted to the hospital for observation.

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

ZA is a 14-month-old male who presented to his primary care provider for a follow up appointment regarding his lack of weight gain. He was born term without complications in Texas. It was reported that he had a normal newborn screening. The parents have been concerned with his weight and development. According to the growth charts he has gained 2.5 grams per day on average between May of 2022 and the present day. His current weight would put him in the 50th % for a 3.5-month-old though he is 14 months old. A complete workup up has been completed with no significant findings. He is being admitted to the hospital for three days to monitor weight, I& O, and calorie counting, and to be evaluated by speech, PT, and OT.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.Failure to thrive

Secondary Diagnosis (if applicable):. None

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

Failure to thrive (FTT) in a child refers to inadequate growth and weight gain in infants and young children(Capriotti, 2020). The pathophysiology of FTT can be multifactorial and have various underlying causes. some of the common causes and their pathophysiology are inadequate intakes, increased energy requirements, malabsorption, infections, and endocrine disorders. This child is most likely suffering from inadequate intake. This can result from poor feeding practices, breastfeeding difficulties, oral aversions, or underlying medical conditions that impair feeding. Inadequate intake can lead to malnutrition, which affects the body's metabolism and reduces energy expenditure. Failure to thrive (FTT) can have various consequences and can affect a child's physical, mental, and emotional development. FTT can result in malnutrition, which can

lead to a range of health problems, including delayed growth and development, weakened immune system, anemia, and impaired cognitive function. Inadequate nutrition can affect a child's physical growth, including height and weight, and can result in developmental delays, including delays in motor skills, language development, and cognitive development. FTT can also lead to behavioral and emotional problems, including irritability, lethargy, and decreased interest in social interactions (Hirsch, n.d.).

Pathophysiology References (2) (APA):

Hirsch, L. (n.d.). *Failure to Thrive (for Parents) - KidsHealth*. Kidshealth.org. Retrieved April 25, 2023, from https://kidshealth.org/en/parents/failure-thrive.html

Capriotti, T. M. (2020). *Pathophysiology: introductory concepts and clinical perspectives.* (2nd ed.). F A Davis.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	Increase activity as tolerated
Diet/Nutrition:	On-demand feeding. Limit juice to 4-6 oz. No soda or junk food, 3 meals and 2-3 snacks per day, no grazing, offer solids before liquids, limit mealtime distractions, regular diet.
Frequent Assessments:	Vitals Q4
Labs/Diagnostic Tests:	None
Treatments:	On-demand feeding.

Other:	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Daily weights	The patient was not weighed for the day doctors want daily weights.

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	3.43-4.8		**3.44**	
Hgb	9.6-12.4		**9.8**	
Hct	28.6-37.2%		**31.9**	
Platelets	244-529		**447**	
WBC	6.51-13.32		**6.87**	
Neutrophils	0.97-5.45		**1.17**	

Lymphocytes	2.45-8.89		**63.8**	**An increase in lymphocytes can be an immune response to infections(Capriotti, 2020). The patient recently had a cold.**
Monocytes	0.28-1.07		**6.4**	**An increase in monocytes can be an immune response to infections(Capriotti, 2020). The patient recently had a cold.**
Eosinophils	0.03-0.61		**6.0**	**An increase in eosinophils can be an immune response to infections(Capriotti, 2020). The patient recently had a cold.**
Basophils	0.01-0.06		**0.04**	
Bands	**NA**		**NA**	

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		**142**	
K+	3.5-5.1		**4.3**	
Cl-	98-107		**106**	
Glucose	74-100		**81**	
BUN	5-17		**15**	
Creatinine	0.30-0.70		**0.38**	
Albumin	3.8-5.4		**3.2**	**There are many causes of hypoalbuminemia including, liver disease, heart failure, and malnutrition.**
Total Protein	4.4-7.6		**5.9**	
Calcium	9.0-11.0		**9.7**	

Bilirubin	0.2-1.2		**0.1**	
Alk Phos	9-500		**137**	
AST	5-34		**27**	
ALT	0-55		**17**	
Amylase	N/A		**NA**	
Lipase	N/A		**NA**	

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			**NA**	
CRP			**NA**	
Hgb A1c	<5.7		**NA**	
TSH	0.4-5		**2.960**	

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		**Yellow/clear**	
pH	4.5-8		**8.0**	
Specific Gravity	1.005-1.025		**1.010**	
Glucose	NONE		**Negative**	
Protein	NONE		Negative	

Ketones	NONE		Negative	
WBC	<2.5		Negative	
RBC	<2		Negative	
Leukoesterase	Negtive		Negative	

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		**NA**	
Blood Culture	Negative		NA	
Sputum Culture	Negative		NA	
Stool Culture	Negative		NA	
Respiratory ID Panel	Negative		NA	
COVID-19 Screen	Negative		NA	

Lab Correlations Reference (1) (APA):

Capriotti, T. M. (2020). *Pathophysiology: introductory concepts and clinical perspectives.* (2nd ed.). F A Davis.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): None currently.

Diagnostic Test Correlation (5 points): None currently.

Diagnostic Test Reference (1) (APA): None currently.

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

Brand/Generic	Acetaminophen/ Tylenol	**NA**	NA	NA	NA
Dose	2.5ml	NA	NA	NA	NA
Frequency	PRN	NA	NA	NA	NA
Route	Oral	NA	NA	NA	NA
Classification	Antipyretic, non-opioid analgesic	NA	NA	NA	NA
Mechanism of Action	Blocks prostaglandin production blocking pain impulse generation in the peripheral nervous system. It also works directly with temperature regulation in the hypothalamus.	NA	NA	NA	NA
Reason Client Taking	The client is taking this as needed for fever or pain.	NA	NA	NA	NA
Concentration Available	160mg/5mL	NA	NA	NA	NA
Safe Dose Range Calculation	2.5 ml dose	NA	NA	NA	NA
Maximum 24-hour Dose	10ml	NA	NA	NA	NA
Contraindications (2)	Do not exceed 320 mg per day	NA	NA	NA	NA
Side Effects/Adverse Reactions (2)	Hypersensitivity to acetaminophen or its components and	NA	NA	NA	NA

	hepatic impairment.				
Nursing Considerations (2)	Hepatotoxicity and pulmonary edema	NA	NA	NA	NA
Client Teaching needs (2)	Use cautiously in patients with hepatic or renal impairment. Test liver function prior to long term therapy.	NA	NA	NA	NA

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's Drug Handbook* (19th 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. The patient when awake looks around the room and looks at his mother when his name is spoken. The patient does not appear to be in any distress. The patient's overall appearance is clean and appropriate for his age and situation.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 3** **Drains present: Y☐ N ☒** **Type:** **IV Assessment (If applicable to child):** **Size of IV:NA**	The patient's skin appears pink and dry. The skin is warm upon palpation. Skin turgor appears normal and elastic. No rashes, bruises, or wounds were noted. The patient has a braden score of 3. The patient has no IV at this time.

Location of IV:NA **Date on IV:NA** **Patency of IV:NA** **Signs of erythema, drainage, etc.:NA** **IV dressing assessment:NA** **IV Fluid Rate or Saline Lock: NA**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	The patient's head, neck, and ears are symmetrical, without any wounds, redness, or bruises notes. Eyes are symmetrical bilateral with clear cornea and white sclera noted. PERRLA is present. The nose appears normal without septum deviation. The patient has some dentation and it appears to be normal. The thyroid is non-palpable.
CARDIOVASCULAR: **Heart sounds: normal** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):normal** **Peripheral Pulses:2+** **Capillary refill:<2** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: na**	. The patient's heart sounds were normal with a S1 and S2 sounds present without extra sounds or murmurs. The cardiac rhythm is noted to be normal sinus. The patient's brachial, femoral, popliteal, and dorsalis pedis pulses are 2+ bilaterally. The patient's capillary refill is <2 seconds is both fingers and toes bilaterally. No edema or neck vein distention was noted.
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character clear**	The patient's lung sounds were clear in all quadrants bilaterally. No wheezing, rhonchi, or stridor was 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:**	The patient is on whole milk and some baby food diet at home and a regular diet in the hospital. The patient is 76.2cm in length. Upon inspection of the abdomen, there is no distention noted. No incisions, scars, drains, or wounds are present. Bowel sounds were present and non-reactive. There are no masses or pain noted upon palpation. The patient does not have an ostomy or feeding tube of any kind.

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 appears yellow and clear, averaging 85 oz per diaper weight. The patient does not appear to have any distress or pain while urinating. Inspection of the genitals appears normal.
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 ☐**	The patient neurovascular status appears normal. The patient has a full range of motion in all extremities. The patient can reach out, stretch, and grasp. Strength is equal in all extremities. The patient is not a fall risk as evidenced by the Cumming's fall score of 4. The patient's mobility status is not appropriate for a patient of this age. When the patient stands his left foot and knee bow inward and need to be straightened for standing.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient appears to move all extremities well with equal strength. PERRLA is present in both eyes and normal. The patient appears to be orientated as evidenced by looking around the room, and looking toward their mother when his name is used. The patient does not speak yet but does make noises that are appropriate for their age.
PSYCHOSOCIAL/CULTURAL: **Coping method(s) of caregiver(s):** **Social needs (transportation, food, medication assistance, home equipment/care):** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient's mother is bedside. She is consistently interacting with the patient is participating in patient care. The mother is concerned about the lack of weight and eating of foods her son has. The mother indicated that the father is present, but does not live with them.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

1300	134	113/60	36	37.9c axillary	100 % RA
1630	100	102/62	26	37.9c axillary	98 % RA

Vital Sign Trends: nothing trending

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

Pulse Rate	80–120
Blood Pressure	89–112/46–72
Respiratory Rate	20–28
Temperature	< 100f
Oxygen Saturation	>90%

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

Nall, R. (2017, March 20). *A Mom's Guide to Pediatric Vital Signs*. Healthline; Healthline Media. https://www.healthline.com/health/pediatric-vital-signs#preschoolers

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1630	RFlacc	No pain noted	No pain noted	No pain noted	No pain noted
Evaluation of pain status *after* interventio	NA	NA	NA	NA	NA

n					
Precipitating factors: NA **Physiological/behavioral signs: NA**					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
240oz bottle and 25% solid food	106cc

hgjhg

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. Speak 3-5 basic words
2. Point to body parts
3. Climbing on things

Age Appropriate Diversional Activities

1. Plush toys
2. Push toys
3. Hand-play games

Psychosocial Development:

Which of Erikson's stages does this child fit? Trust vs. Mistrust

What behaviors would you expect?

Expected behaviors include crying out when the caregiver gets too far or when they are hungry and irritated (Ricci et al., 2021). Infants up to 18 months do this because they are expectant of something.

What did you observe?

The patient didn't seem to care if his mom was near, the patient would play with toys in the crib alone.

Cognitive Development:

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

Sensorimotor

What behaviors would you expect?

Behaviors expected during the sensorimotor stage include the infant exploring their ability to affect their soundings. This is done by grasping, moving, and sifting objects or parts of the body.

What did you observe?

This child would grab things and toss toys around.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

The vocabulary of a child at this age should be around 3-5 words with an understanding of more. This child has a vocabulary of 1-2 words and it is not clear if the meaning behind them fits.

Any concerns regarding growth and development?

This child is severely underweight for his age and is not eating solid foods yet, he cannot sit up by himself nor can he pull up to stand.

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

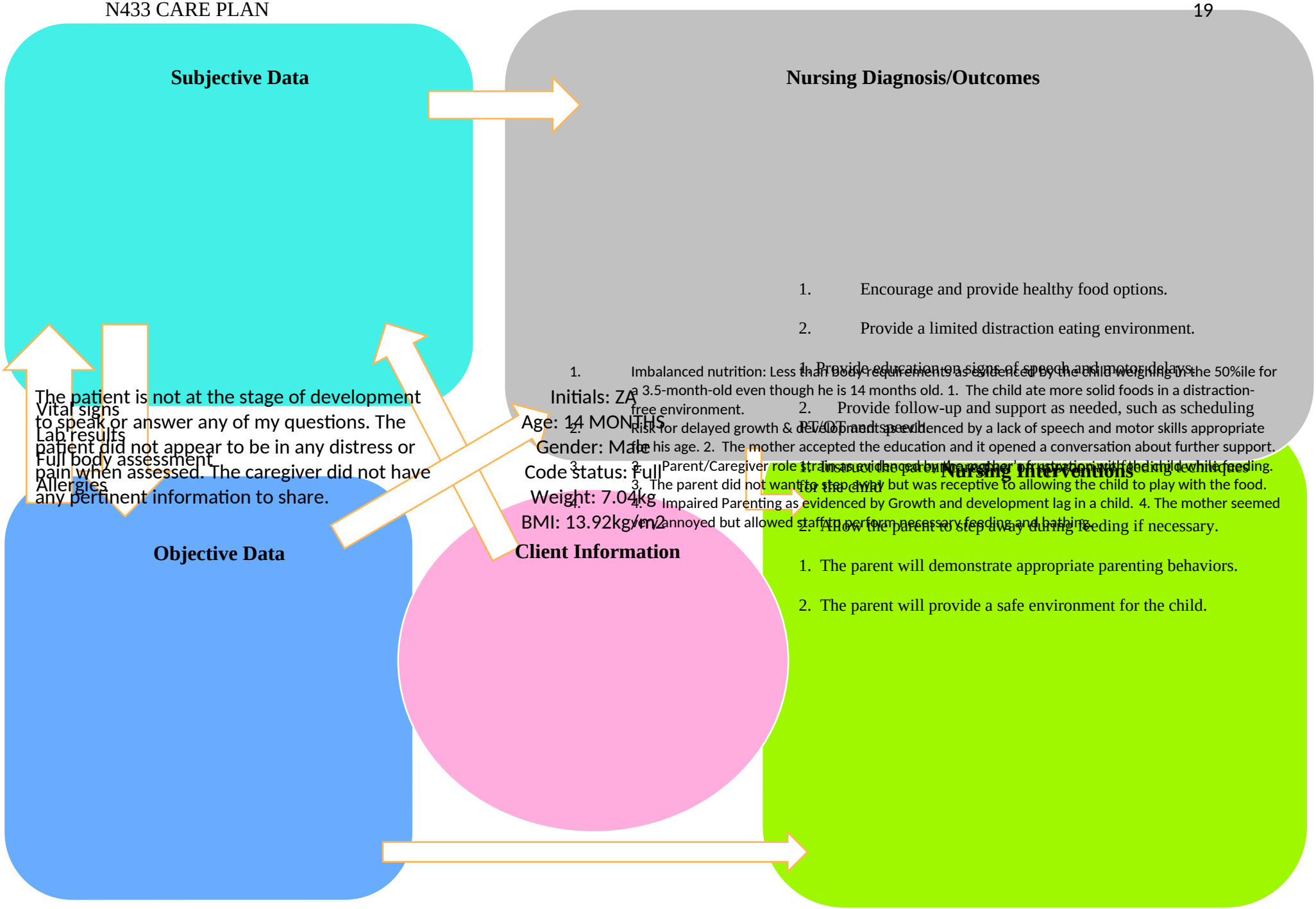
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client.	**Rational** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcomes**	**Evaluation** • How did the Client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Imbalanced nutrition: Less than body requirements as evidenced by the child weighing in the 50%ile for a 3.5-month-old even though he is 14 months old(Linda Lee Phelps, 2020).	I chose this diagnosis because the child is 14 months old and is weighing around 15 lbs. this is underweight for his age.	1. Encourage and provide healthy food options. 2. Provide a limited distraction eating environment. (Linda Lee Phelps, 2020)	1. The child ate more solid foods in a distraction-free environment.	The child seems to do well with healthy options and the limited distraction allowed for optimal one on one feeding.
2. Risk for delayed	I chose this	1. Provide	1. The	The mother was

growth & development as evidenced by a lack of speech and motor skills appropriate for his age(Linda Lee Phelps, 2020).	diagnosis because the child is showing singes of delayed development such as a lack of standing and verbalization	education on signs of speech and motor delays. 2. Provide follow-up and support as needed, such as scheduling PT/OT and speech. (Linda Lee Phelps, 2020)	mother accepted the education and it opened a conversation about further support.	very receptive to the education
3. Parent/ Caregiver role strain as evidenced by the mother's frustration with the child while feeding(Linda Lee Phelps, 2020).	I chose this diagnosis because I witnessed the mother becoming irritated with the child's lack of interest in his dinner.	1. Instruct the parent/caregiver on appropriate feeding techniques for the child 2. Allow the parent to step away during feeding if necessary. (Linda Lee Phelps, 2020)	1. The parent did not want to step away but was receptive to allowing the child to play with the food.	The mother was receptive to learning different techniques but did not need to step away from the child.
4. Impaired Parenting as evidenced by Growth and development lag in a child(Linda Lee Phelps, 2020).	I chose this diagnosis because the mother was not receptive to bathing or feeding techniques offered to her for the child.	**1.** The parent will demonstrate appropriate parenting behaviors. **2.** The parent will provide a safe environment for the child. (Linda Lee Phelps, 2020)	**1.** The mother seemed very annoyed but allowed staff to perform necessary feeding and bathing.	The mother seemed very annoyed but allowed staff to perform necessary feeding and bathing.

Other References (APA):

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

Concept Map (20 Points):


Subjective Data
The patient is not at the stage of development to speak or answer any of my questions. The patient did not appear to be in any distress or pain when assessed. The caregiver did not have any pertinent information to share.
Objective Data
Vital signs
Lab results
Full body assessment
Allergies
Initials: ZA
Age: 14 MONTHS
Gender: Male
Code status: Full
Weight: 7.04kg
BMI: 13.92kg/m2
Client Information
Nursing Diagnosis/Outcomes
1. Imbalanced nutrition: Less than body requirements as evidenced by the child weighing in the 50%ile for a 3.5-month-old even though he is 14 months old. 1. The child ate more solid foods in a distraction-free environment.
2. Risk for delayed growth & development as evidenced by a lack of speech and motor skills appropriate for his age. 2. The mother accepted the education and it opened a conversation about further support.
3. Parent/Caregiver role strain evidenced by the mother's frustration with the child while feeding. 3. The parent did not want to step away but was receptive to allowing the child to play with the food.
4. Impaired Parenting as evidenced by Growth and development lag in a child. 4. The mother seemed overannoyed but allowed staff to perform necessary feeding and bathing.
Nursing Interventions
1. Encourage and provide healthy food options.
2. Provide a limited distraction eating environment.
1. Provide education on signs of speech and motor delays.
2. Provide follow-up and support as needed, such as scheduling PT/OT and speech.
1. Assess the parent's stress and coping techniques for the child.
2. Allow the parent to step away during feeding if necessary.
1. The parent will demonstrate appropriate parenting behaviors.
2. The parent will provide a safe environment for the child.