

N433 Care Plan # 1

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N433: Infant, Child, & Adolescent Health

Professor King

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Demographics (3 points)

Date of Admission 06/13/2023	Client Initials SS	Age (in years & months) 8 years & 1 month or 97 months	Gender F
Code Status Full	Weight (in kg) 18 kg	BMI 18.6	Allergies/Sensitivities (include reactions) Ibuprofen-High severity- Anaphylaxis Amoxicillin-Unknown severity, mother reported in history

Medical History (5 Points)

Past Medical History: Dysphagia, pulmonary hypertension, tracheostomy ventilator dependable, acute on chronic respiratory failure, acute tracheitis, neurogenic bladder, gastrostomy in place

Illnesses: Bacterial tracheitis, RSV, Sepsis, Septic shock, hydronephrosis, Streptococcal sore throat, anemia

Hospitalizations: Recent-April 2023

Past Surgical History: Myringotomy with tubes bilaterally x2, bronchoscopy, tracheostomy x2, esophagogastric fundoplication, gastrostomy feeding

Immunizations: Up to date on all vaccinations

DTap/IPV/HepB (07/20/15, 11/11/15), DTap (08/23/2016), Hep B (06/18/2015), HIB (07/20/15, 11/13/15, 08/23/16), Hep A (08/23/16, 11/22/17), Influenza Pediatric (12/02/15, 01/11/16, 11/22/17), Measles Mumps Rubella (05/23/16), DTap/IPV/HIB (12/11/15), Palivizumab (11/11/15, 12/10/15, 01/08/16, 02/07/16), Pneumococcal conjugate 13 (07/20/15, 11/13/15, 12/11/15, 08/23/16), Varicella (05/23/16)

Birth History: Unable to obtain due to birth history, mother not at bedside

Complications (if any): N/A

Assistive Devices: Tracheostomy and G-tube

Living Situation: Patient lives at home with full-time care provided by her mother. The patient's grandmother plans to start taking care of her at night.

Admission Assessment

Chief Complaint (2 points): Hypoxic, Respiratory distress

Other Co-Existing Conditions (if any): Tracheostomy, anemia

Pertinent Events during this admission/hospitalization (1 points): The patient came to the emergency room from a hematology follow up appointment due to hypoxia and tachypnea.

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

On 06/13/23, an eight-year-old female with a complex medical history including developmental delay, hydronephrosis, G-tube and tracheostomy dependency was presented to the ER following a hematology clinic appointment for an anemia follow-up. The patient was recommended to be seen in the emergency room due to her oxygen saturation levels ranging between 91% and 93%. The mother of the patient stated the patient had been having intermittent fevers for the past one month ranging between 99-101.9 F that they were treating with Tylenol. The mother reported no signs of hypoxia at home. The mother stated she wouldn't notice anything to cause the fever but the only thing that would help was Tylenol. Upon admission the patient was tachycardic, tachypneic, and shortness of breath.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Upper respiratory distress

Secondary Diagnosis (if applicable): Urinary tract infection

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

Acute respiratory distress (ARDS) is often an inflammatory response that causes fluid to leak into the lungs causing alveoli to collapse and narrow airways, which decreases lung compliance resulting in hypoxemia and hypercapnia (Capriotti, 2020). Risk factors for ARDS include sepsis, lung injuries, aspiration of gastric contents, systemic illnesses, and acute pancreatitis.

ARDS will cause respiratory dysfunction symptoms, such as pulmonary edema, decreased level of consciousness, compensatory tachycardia, decreased circulation in extremities, restlessness, and anxiety. Fluid leaking into the pleural interstitial area causes crackles heard upon auscultation in the lungs.

The diagnosis of ARDS is affected by what manifestations are present. Capriotti (2020) discusses with ARDS that administering oxygen will improve arterial hypoxemia. A chest X-ray will visualize the lungs to find effusion, infiltration, or atelectasis. An arterial blood gas test will determine how hypoxemic a patient is. Diagnosing respiratory distress is based on observation and assessment and can be a secondary cause of an underlying illness (Ricci et al., 2020). It is essential to rule out potential heart problems that could cause the manifestations of ARDS, an Electrocardiogram or echocardiogram can do this.

The primary treatment of ARDS is to improve oxygen levels in the blood. Supplemental oxygen or mechanical ventilation can be a method of treatment to improve the patient's respiratory status (Capriotti, 2020). Monitoring the intake and output in patients with ARDS is

crucial because too much fluid can cause an increase in the fluid in the lungs, but too little can cause stress on the heart or other organs (Ricci et al., 2020). Treating ARDS requires treating the potential cause by administering medications to treat infections and relieving pain. Other treatment measures can help with shortness of breath, such as increasing the head of the bed to promote optimal lung expansion, chest physiotherapy to help break up secretions, and promoting coughing and deep breathing techniques.

The patient this student nurse provided care for was presented with hypoxia, shown by decreased oxygen saturation levels. Upon admission, the patient had elevated blood pressure, tachycardia, tachypnea, elevated temperatures, and accessory muscle use. The respiratory therapist humidified the patient's tracheostomy, which helped thin airway secretions. An x-ray showed an increased thickening in the airway with opacities and chronic lung changes. Blood tests showed decreased red blood cells related to shortness of breath and anemia. The white blood cells and lymphocytes elevation indicates an infection. The treatment for this patient was to keep the bed elevated with humidification on the tracheostomy and continuous pulse oximetry. Chest physiotherapy was performed, as well as frequent suctioning of the excess secretions, administering albuterol via inhalation and antibiotics for infection. The health care team was focused on treating the underlying infection while keeping the respiratory status stable, hoping the respiratory dysfunction would improve once the infection was treated.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F. A. Davis Company.

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: as tolerated, q 2 hour turns	To avoid skin breakdown.
Diet/Nutrition: Pediatric feeding- q4h- 30 ml flush before and after, 150 ml PediaSure 1.0 with fiber or Nutren with fiber plus 90 ml water. Can give medications through G-tube, feedings at 0800, 1200, 1600, 2000, 0000	Patient tolerated well, volume per feeding 210 ml through G-tube. Upon SBAR from previous nurse and grandmother, they have been skipping the 0000 feeding and letting the patient sleep.
Frequent Assessments: IV assessment, vital signs with BP and rectal temp q4hr, neuro checks q8 hr, continuous pulse oximetry	Routine to keep patient stable and monitor Oxygen saturation due to respiratory distress, tracheostomy with excessive secretions and fevers.
Labs/Diagnostic Tests: Folate, B12, Iron/TIBC, CBC, C-reactive protein	For potential discharge. Labs were drawn and not resulted yet. Patient tolerated well, the nurse used a sonogram machine and a 23-gauge butterfly needle for the blood draw.
Treatments: PT/OT	To help with posturing, patient tolerates well.
Other: N/A	N/A
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
N/A	N/A
N/A	N/A
N/A	N/A

Laboratory Data (15 points)

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

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	3.90-4.96 mcL	3.65 mcL	3.32 mcL	The decreased red blood cells levels can be due to the patient having anemia, in relation to decreased oxygen saturation (Pagana et al., 2020). The patient may have a slight dietary deficiency from only receiving formula through the gastrostomy tube.
Hgb	10.6-13.2 g/dL	10.3 g/dL	9.3 g/dL	The decreased hemoglobin level is due to the patient having a decreased red blood cell count from anemia (Pagana et al., 2020). The patient having a decreased hemoglobin can cause the shortness of breath in the patient. Antibiotics can also cause a decreased hemoglobin level.
Hct	32.4-39.5%	33.2%	30.6%	Hematocrit levels closely reflect the hemoglobin and red blood cell levels, because it is a percentage of total blood volume that is made from red blood cells (Pagana et al., 2020). The decreased hematocrit level in this patient is due to the patient having anemia and shortness of breath.
Platelets	199-367 mcL	600 mcL	462 mcL	The elevated platelet levels can be due to the patient having anemia (Pagana et al., 2020). Infection can also elevate these levels.
WBC	4.27-11.40 mcL	12.10 mcL	11.57 mcL	A white blood cells main function is to fight infection. The patient having an elevated white blood cell count can be due to the urinary tract infection and the body's response to stress (Pagana et al., 2020).
Neutrophils	1.64-7.87 mcL	8.46 mcL	7.24 mcL	Neutrophils are responsible for the killing and digestion of bacteria (Pagana et al., 2020). The patient has an infection which causes the stimulation of neutrophil production,

				increasing the levels of neutrophils.
Lymphocytes	1.16-4.28 mcL	2.57 mcL	3.42 mcL	WNL
Monocytes	0.19-0.81 mcL	0.74 mcL	0.54 mcL	WNL
Eosinophils	0.03-0.47 mcL	0.26 mcL	0.32 mcL	WNL
Basophils	0.01-0.05 mcL	0.02 mcL	0.01 mcL	WNL
Bands	0-5	N/A	N/A	Test not performed.

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	140 mmol/L	N/A	WNL
K+	3.5-5.1 mmol/L	4.2 mmol/L	N/A	WNL
Cl-	98-107 mmol/L	103 mmol/L	N/A	WNL
Glucose	74-100 mg/dL	93 mg/dL	N/A	WNL
BUN	7-17 mg/dL	12mg/dL	N/A	WNL
Creatinine	0.55-1.02 mg/dL	0.71 mg/dL	N/A	WNL
Albumin	3.8-5.4 g/dL	3.3 g/dL	N/A	The low albumin level can be due to malabsorption or malnutrition in the patient from the need for the gastrostomy and formula feeding. This can also be due to dehydration (Pagana et al., 2020).
Total Protein	6.0-8.0 g/dL	8.5 g/dL	N/A	High protein can be due to chronic inflammation or dehydration (Pagana et al., 2020).
Calcium	8.8-10.8 mg/dL	10.4 mg/dL	N/A	WNL
Bilirubin	0.2-1.2 mg/dL	0.2 mg/dL	N/A	WNL

Alk Phos	65-210 U/L	155 U/L	N/A	WNL
AST	5-34 U/L	17 U/L	N/A	WNL
ALT	0.55 U/L	16 U/L	N/A	WNL
Amylase	60-120 U/L	N/A	N/A	Test not performed.
Lipase	8-78 U/L	84 U/L	N/A	Lipase is an enzyme that helps the body digest fats produced by the pancreas (Pagana et al., 2020). This elevated level could be due to the pancreas not working at it should or an underlying kidney disease.

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	<10 mm/hr	N/A	N/A	Test not performed.
CRP	1.0-3.0 mg/dL	26.95 mg/dL	16.73 mg/dL	The level of c-reactive protein (CRP) in the blood measures how much inflammation is in the body (Pagana et al., 2020). The patient has elevated CRP levels due to chronic inflammation from fevers, infection, acute respiratory distress and urinary tract infection.
Hgb A1c	4-5.9%	N/A	N/A	Test not performed.
TSH	0.8-6mU/L	N/A	N/A	Test not performed.

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/slightly cloudy	N/A	Slight cloudy urine is caused from high white blood cell count in the urine, the patient

				has a urinary tract infection that is causing this (Pagana et al., 2020).
pH	4.6-8	7.0	N/A	WNL
Specific Gravity	1.000-1.030 arbitrary unit	1.015 arbitrary unit	N/A	WNL
Glucose	Negative	Negative	N/A	WNL
Protein	Negative	Negative	N/A	WNL
Ketones	Negative	Negative	N/A	WNL
WBC	0-25 U/L	192 U/L	N/A	High levels of white blood cells in the urine indicate the infection is in the urinary system because leukocytes will accumulate here to fight off the infection (Pagana et al., 2020). This is due to the patient having a urinary tract infection.
RBC	0-20 U/L	90 U/L	N/A	The high red blood cells in the urine can be due to chronic inflammation from the urinary tract infection (Pagana et al., 2020).
Leukoesterase	Negative	LARGE	N/A	Leukoesterase is a specific count of the white blood cells in the urine from infection (Pagana et al., 2020). This is due to the patient having a urinary tract infection.

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	>100,000 cfu/mL	N/A	The urine culture grows bacteria from the urine sample to diagnose urinary tract infections (Pagana et al., 2020). This elevated result means that the infection is present and needs treatment.

Blood Culture	Negative	No growth at 5 days	N/A	WNL.
Sputum Culture	Negative	Negative	N/A	Test not performed.
Stool Culture	Negative	Negative	N/A	Test not performed.
Respiratory ID Panel	Negative	Negative	N/A	Test not performed.
COVID-19 Screen	Negative	Negative	N/A	Test not performed.

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

X-Ray AP or PA only: Findings: Central airway thickening as can be seen with viral or inflammatory etiology- Perihilar opacities most likely reflect subsegmental atelectasis and chronic lung changes. No focal consolidation or significant pleural effusion.

Diagnostic Test Correlation (5 points):

The X-Ray was done to visualize the lungs to inspect any abnormalities causing shortness of breath. The central airway thickening and perihilar opacities are indicating a problem resulting from some type of unknown illness such as infection, inflammation, and fluid in the lungs (Capriotti, 2020).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F. A. Davis Company.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

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

Brand/ Generic	Acetaminophen/ Tylenol	Tobramycin (Tobramycin can be brand name as well or Tobii)	Sulfamethoxazole/ trimethoprim/Sulfatrim	Albuterol sulfate/ AccuNeb
Dose	268.8 mg	300 mg	60 mg	2.5 mg (3mL)
Frequency	Every 4 hours PRN	RT 2x/day	Every 8 hrs.	RT 2x/day
Route	Gastric Tube	Inhalation	IVPB (IV push)	Inhalation
Classification	Pharmacologic: Non-salicylate, para-aminophenol derivative Therapeutic: Antipyretic, nonopioid analgesic (Jones & Bartlett Learning, 2023)	Pharmacologic: Aminoglycoside Therapeutic : Antibiotic (Jones & Bartlett Learning, 2023)	Pharmacologic: Sulfonamide Therapeutic: antibiotic (Jones & Bartlett Learning, 2023)	Pharmacologic: Adrenergic Therapeutic : Bronchodilator (Jones & Bartlett Learning, 2023)
Mechanism of Action	“Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of	“Inhibits bacterial protein synthesis by binding irreversibly to one of two aminoglycoside-binding sites on the 30S ribosomal subunit, resulting in bacteriostatic effects”	“Blocks 2 consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria” (Jones & Bartlett Learning, 2023).	Attaches to beta 2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate to cyclic

	prostaglandin E2” (Jones & Bartlett Learning, 2023).	(Jones & Bartlett Learning, 2023).		adenosine monophosphate” (Jones & Bartlett Learning, 2023).
Reason Client Taking	For mild pain 1-4 or fever 100.4 or greater	For urinary tract infection	For urinary tract infection, this also treats acute otitis media which the patient has	For shortness of breath, open airways, help eliminate mucus
Concentration Available	160mg/5ml	300 mg q 12h every 28 days	10 mg/kg/day	2.5mg/3ml
Safe Dose Range Calculation	10-15mg/kg/dose (Jones & Bartlett Learning, 2023)	300 mg q 12h every 28 days	8-12 mg TMP/kg/day	2.5 mg three to four times daily, as needed by nebulization over 5-15 mins
Maximum 24-hour Dose	No more than 5 doses in 24 hours. 1600 mg in 24 hours (Jones & Bartlett Learning, 2023)	600 mg	160mg TMP/dose	No more than 4 times daily
Contraindications (2)	Severe hepatic disease, severe liver disease	Use with potent diuretics, use with other nephrotoxic drugs	Severe hepatic impairment, severe liver impairment, creatinine clearance less than 15 ml/min	Abnormal heart rhythm, hypokalemia
Side Effects/Adverse Reactions (2)	Hypotension, leukopenia, atelectasis	Neurotoxicity, renal failure, nephrotoxicity	Urticaria, hyperkalemia, agranulocytosis	Pulmonary edema, angina, hypotension

<p>Nursing Considerations (2)</p>	<p>Check when the last dose was given to be sure not to exceed the daily limit.</p>	<p>Monitor serum calcium, magnesium, potassium, and sodium to detect imbalances (Jones & Bartlett Learning, 2023). Expect dehydration to increase risk of nephrotoxicity. Keep medication in fridge, don't administer <6 hrs. apart</p>	<p>Use a 0.2-micron filter, don't refrigerate, expires 6 hours after preparation, dilute well</p>	<p>Administer prior to chest physiotherapy, Monitor serum potassium level</p>
<p>Client Teaching needs (2)</p>	<p>Teach to read manufacturers label of other medications that could contain acetaminophen to avoid exceeding daily limit. Educate to recognize signs of hepatotoxicity such as bleeding, bruising, and malaise. (Jones & Bartlett Learning, 2023)</p>	<p>Educate how to administer drug by inhalation. Notify prescriber if severe diarrhea occurs longer than 3 days. To keep in the fridge and not to administer less than 6 hours apart.</p>	<p>Limit child exposure to sun while on this medication, administer at the same time every day for better therapeutic effect of the medication, and fully finish the medication.</p>	<p>Dilate before use, do not exceed prescribed dose, and how to properly clean.</p>

Medication Reference (1) (APA):

Jones & Bartlett Learning. (2023). *2022 Nurse's drug handbook* (21st ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) **Highlight Abnormal Pertinent Assessment Findings**

<p>GENERAL: Alertness: stimulation Orientation: unable to assess @ baseline Distress: no acute distress Overall appearance:</p>	<p>Responds to stimulation with localized muscle spasticity. Unable to assess orientation but patient is at baseline and appears in no acute distress. Overall appearance is appropriate for patient.</p>
<p>INTEGUMENTARY: Skin color: white/pink Character: dry Temperature: warm Turgor: decreased/slow Rashes: patches of dry eczema Bruises: none Wounds: none Braden Score: 12 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p> <p>IV Assessment (If applicable to child): Size of IV: 20 gauge Location of IV: L Date on IV: 06/16/23 Patency of IV: patent, flushes well, no blood return Signs of erythema, drainage, etc.: none IV dressing assessment: clean, dry, intact IV Fluid Rate or Saline Lock:</p>	<p>Skin color is white/pink which is usual for ethnicity. Skin is warm and dry with a few patches of eczema upon palpitation. Turgor is slow to return to normal state. No bruises, wounds, other abnormal rashes besides dry spots. Braden score is 12. No drains present.</p> <p>IV assessment- Patient has a 20 gauge in the anterior lower right forearm placed on 06/16/23. The IV is currently infusing with no complications or signs of erythema/drainage. There is no blood return but the IV flushes well. Dressing is clean, dry, and intact with a transparent dressing.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>Head and neck are symmetrical, ear and eyes are symmetrical and inline. Eyes are round, equal and sluggish with no tracing. Right pupil is slightly dilated. Nose is midline with no visible drainage. Tooth decay and broken teeth. Tracheostomy presents excess secretions. Thyroid not assessed at this time.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2 auscultated S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): normal rate and rhythm</p>	<p>Heart sounds S1 and S2 auscultated with normal rate and rhythm. No murmurs or gallops present. Peripheral pulses +2 bilaterally, capillary refill <2 seconds bilaterally, no neck vein distention or edema inspected.</p>

<p>Peripheral Pulses: +2 Capillary refill: < 2 secs Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: N/A</p>	
<p>RESPIRATORY: Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Upon inspection use of abdominal muscles are noted. Respirations are unlabored with a normal rate and rhythm. Anterior Coarse lung sounds auscultated bilaterally, posterior not accessed at this time due to trying to keep patient comfortable.</p>
<p>GASTROINTESTINAL: Diet at home: Formula via G-Tube Current diet: Formula via G-Tube Height (in cm): 98.5 cm Auscultation Bowel sounds: Last BM: 06/20/23 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: 14 French-internal balloon in the LUQ</p>	<p>Upon inspection the abdomen is round and nondistended. Normoactive bowel sounds auscultated in all four quadrants. There is no ostomy or nasogastric tube present. There is a 14-french feeding tube into the LUQ which is used for feedings and administration of some medications. The last bowel movement was 06/20/23, formed and brown and the child is incontinent.</p>
<p>GENITOURINARY: Color: yellow Character: unable to assess Quantity of urine: 233 cc in diaper Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>The urine appeared yellow in the diaper. The child does not seem to have pain from urination. There was one diapered weight to have 233 cc. No dialysis or catheter is present.</p>
<p>MUSCULOSKELETAL: Neurovascular status: warm, cap refill <3 secs ROM: significantly impaired Supportive devices: no supported devices besides the tracheostomy and feeding tube</p>	<p>The nail beds are without cyanosis and capillary refill is less than 3 seconds. Range of motion is significantly impaired and has very limited strength. Upon stimulation, motor response is present and inspected by localized spasticity withdraws. Fall score is 12. The patient is not</p>

Strength: very limited ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 12 Activity/Mobility Status: none/passive Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	mobile and cannot stand or walk.
NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: at baseline Mental Status: baseline Speech: unable to speak Sensory: local spasticity LOC: unable to assess	The patient's cognition is unable to assess. The patient has some localized spasticity. Strength is very limited and impaired, unable to assess whether the strength is equal. The pupils are round, equal, and slightly sluggish and dilated bilaterally. The eyes do not track or follow light and no accommodation. Orientation, mental status, and level of consciousness is unable to assess but at baseline. The patient is nonverbal and has a tracheostomy present.
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 mother of the patient provides full-time care with the help of the grandmother. The patient requires medical assistance, home equipment for feeding and tracheostomy care. The caregivers seem to be coping well and appear very positive.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0744	105 bpm	97/67	30 bpm	97 F/ 36 C-rectal	98% room air HME
1200	149 bpm	149/90	40 bpm	99.3 F/ 37.4 Rectal	92% room air

Vital Sign Trends: The patient's vitals were more stable in the morning. The vitals in the morning can be considered to be abnormal but does not cause any concern for this nursing student. The patient's vitals worsened in the afternoon due to not having humidification added to supplement room air oxygen, which is concerning. The patient needed to have humidification to

aid in tinning airway secretion. Overall, the vitals are still stable and the patient is not deteriorating.

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

Pulse Rate	60-100 bpm
Blood Pressure	100-120/60-75
Respiratory Rate	14-20 bpm
Temperature	Oral-97.6–99.3°F (36.4–37.4°C) Rectal-98.6–100.3°F (37–37.9°C) Axillary-96.6–98.3°F (35.9–36.83°C)
Oxygen Saturation	95-100%

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	rFLACC	N/A	0	0	clustered care, position adjustment, pillow support, quiet environment
1200	rFLACC	N/A	0	0	clustered care, position adjustment, pillow support, quiet environment
Precipitating factors: N/A					

Physiological/behavioral signs: Non-verbal indicators absent/decreased; patient is awake → sleep/rest/relaxation

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
240 mL	233 cc- 1 voided urine diaper

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

School-Age

1. Height normally increases in school age years 6 to 7 cm per year, Weight gain is 3 to 3.5 kg per year, losing baby teeth that start to get replaced by permanent teeth.
2. Begins gaining team playing skills (soccer)
3. Can follow several directions in a row

Age-Appropriate Diversional Activities

1. Watching Television
2. Coloring
3. Playing with board games

Psychosocial Development:

Which of Erikson's stages does this child fit? Industry versus Inferiority

What behaviors would you expect? The child becomes interested in learning how things work and their interaction with peers and outside of home activities (Ricci et al., 2020).

What did you observe? The child still requires basic needs provided for and is totally dependent on their caregiver, similar to the trust versus mistrust stage. The child's developmental delays would typically be a concern but is baseline for this patient and expected.

Cognitive Development:

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

What behaviors would you expect? The child learns to think abstractly, understands concept of time, and can classify objects by similar elements. They start to be able to visualize different points of view (Ricci et al., 2020).

What did you observe? The child's cognition is unable to assess. The child could still be in the sensorimotor stage which is birth to two years. This is when they develop sensory and motor capacities. The child responds to pain and stimulation but has no other motor movement and is nonverbal.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? A school-age child usually improves their reading skills and has increased reading exposure. They begin to learn plurals and pronouns and how to properly use them. The patient is not meeting the expected language development however the child is nonverbal. This would normally be a concern but is a baseline for this patient and it is not expected for the child to be able to verbally communicate.

Any concerns regarding growth and development? This student nurse has concerns that the patient will never elevate in developmental stages. The patient is not delayed due to the current hospitalization. The patient presents at her baseline which causes no developmental concerns for this current interaction.

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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Interventions (2 per dx)	Outcomes	Evaluation <ul style="list-style-type: none"> • How did the Client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. “Impaired gas exchange related to ventilation perfusion imbalance as evidence by hypoxia and tachycardia”	This nursing diagnosis was chosen due to having decreased oxygen saturation which effects perfusion.	1. “Assess and record pulmonary status every 4 hours or more frequently if patient’s condition is unstable” (Phelps, 2020). 2. “Place position in place that best facilitates chest	3. Patient will have normal breath sounds and maintain adequate ventilation.	Patient’s respiratory status remained within normal limits without dyspnea. Patient tolerated interventions well with no signs of discomfort.

		expansion to enhance gas exchange” (Phelps, 2020).		
2. “Ineffective airway clearance related to excessive mucus as evidence by ineffective cough and excessive sputum” (Phelps, 2020).	This nursing diagnosis was chosen due to patient having excessive secretions which impairs the airway clearance.	<ol style="list-style-type: none"> 1. “Suction as ordered to stimulate cough and clear airways” (Phelps, 2020). 2. “Provide adequate humidification to loosen secretions” (Phelps, 2020). 	1. “Patient will remain patent. The crackles in the lungs will be absent and oxygen level will be in normal range” (Phelps, 2020)	The patient’s oxygen status remained within normal range, however the crackles in the lungs were still present. The patient tolerated the humidification administration well.
3. “Ineffective breathing pattern related to neurological impairment as evidence by use of accessory muscles when breathing” (Phelps, 2020)	This nursing diagnosis was chosen due to the patient presenting with labored breathing.	<ol style="list-style-type: none"> 1. “Perform chest physiotherapy to aid mobilization and secretion removal per order” (Phelps, 2020). 2. “Monitor ABG values and continuous pulse oximetry readings per order to detect oxygenation and respiratory status” (Phelps, 2020). 	1. “Patient will demonstrate adequate breathing pattern with easy, unlabored respirations without the use of accessory muscles” (Phelps, 2020).	The patient’s pulse oximetry remained within normal limits. The patient started demonstrating minimal accessory muscle use with respirations. Chest physiotherapy was tolerated well.
4. “Risk for impaired skin integrity related to alteration in sensation as	This nursing diagnosis was chosen due to the patient	1. “Change the patient’s position every 2 hours and monitor frequency of turning and skin condition” (Phelps,	1. “The patient will not exhibit skin breakdown	The patient’s skin remains intact with no signs of skin breakdown. The patient’s

evidence by neurocognition” (Phelps, 2020)	remaining in bed which has potential to cause inadequate skin circulation which results in skin breakdown.	2020). 2. “Inspect patient’s skin every 8 hours, documenting the skin condition and report changes” (Phelps, 2020).	n. The patient’s family will take preventative skin care measures” (Phelps, 2020).	family understood the importance of providing skin care at home.
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Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

VS@1200: Rectal temp-37.4 C, 40 breaths/min, HR-149bpm, BP-149/90, 02 sat-92% room air

Admission Labs:

Albumin-3.3 g/dL
Total Protein-8.5 g/dL
Lipase-84 U/L
CRP-26.95 mg/dL
RBC-3.65 mcl
Hgb-10.3%
Hct-30.6%
Platelets- 600 mcL
WBC-12.10 mcL
Tracheostomy present
G-tube

Objective Data

collect.

Nursing Diagnosis/Outcomes

1. Diagnosis: Impaired gas exchange related to ventilation/perfusion imbalance. Evidence by hypoxia and tachypnea. Patient tolerated interventions well with no signs of discomfort. Outcome: Patient's respiratory status remained within normal limits without dyspnea. Patient tolerated interventions well with no signs of discomfort. **Assess and record pulmonary status every 4 hours or more frequently if patient's condition is unstable. Provide chest physiotherapy to aid mobilization and expansion to enhance gas exchange. Suction as ordered to stimulate cough and clear airways. Provide adequate humidification to loosen secretions. Perform chest physiotherapy to aid mobilization and secretion removal per order.**
2. Diagnosis: Ineffective airway clearance related to excessive mucus as evidence by ineffective cough and excessive sputum. The patient's oxygen status remained within normal range, however chest physiotherapy to aid mobilization and tolerated the humidification administration. **Monitor ABC's. Nursing interventions: pulse oximetry readings per order to detect oxygenation and respiratory status. Change the patient's position every 2 hours and monitor frequency of turning and skin condition. Inspect patient's skin every 8 hours, documenting the skin condition and report changes.**
3. Diagnosis: Ineffective breathing pattern related to neurological impairment as evidence by abnormal breathing pattern. Outcome: The patient's pulse oximetry remained within normal limits. The patient started demonstrating minimal accessory muscle use with respirations. Chest physiotherapy was tolerated well.
4. Diagnosis: Risk for impaired skin integrity related to altered consciousness and immobility by neurocognition. Outcome: The patient's skin remains intact with no signs of skin breakdown. The patient's family understood the importance of providing skin care at home.

SS

8 yr old, Female
Caucasian
Full Code

W:18 kg H:98.5cm BMI:18.6

Allergies- Ibuprofen

Amoxicillin

Admission date: 06/13/23

Client Information