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 6/19/2023	Client Initials DJ	Age (in years & months) 14 Years Old	Gender Male
Code Status FULL	Weight (in kg) 60.7	BMI 19.76 kg/m2	Allergies/Sensitivities (include reactions) N/A

Medical History (5 Points)

Past Medical History: Burn.

Illnesses: The patient burn his chest as an infant.

Hospitalizations: Yes, in 2013, the patient burned his chest. The mom reports his broth; he was eating a hot sandwich and dropped it on his chest. The patient was taken to the hospital to get it evaluated.

Past Surgical History: N/A.

Immunizations: The immunization is up-to-date per the chat and the mother's statement.

Birth History: The mom reports there were no complications during birth. The patient was born at 39 weeks naturally.

Complications (if any): N/A.

Assistive Devices: N/A

Living Situation: The patient lives in a two-story home with his mom, younger brother, and cousin.

Admission Assessment

Chief Complaint (2 points): Burn.

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

Pertinent Events during this admission/hospitalization (1 points): This patient has multiple burns on his body. The patient's mother reports that he was cooking and dropped grease all over him. The patient has approximately burned 4% of his body. The mother brought the patient to the ED for further evaluation. Upon arrival, the patient was in pain and was distressed. The patient has an IV 20 gauge on his left arm.

History of present Illness (OLD CARTS) (10 points): A 14-year-old male comes to the emergency department due to an injury caused by the burn. The patient reports he was cooking breakfast, and the pot caught on fire, and he picked up the pot and took it outside. While taking the pot outside, he dropped the grease on him. The patient burned his right hand, right shoulder, right thigh, left hand, left thigh, chin, and both feet. The patient's mother reports this burn happened two days ago, and she took him to OSF, and they sent him home with ointment, and she didn't like how the burns were healing, so she wanted to get him checked out at a Carle. The patient denies any pain. The patient was admitted to the pediatric floor for further evaluation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Partial thickness burns of 4% of the body.

Secondary Diagnosis (if applicable): N/A.

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

Second-degree burns, also known as partial-thickness burns, can be either superficial or profound, depending on the extent of dermal layer tissue necrosis. Edema and the development of epidermal blisters result from superficial partial thickness burns that char the epidermis and

papillary dermal layer (Capriotti, 2020). There is profound partial-thickness burn damage from the epidermis through the papillary and reticular layers of the dermis. The skin has a similar appearance to a superficial partial-thickness burn, albeit the color of the skin may be more mottled depending on how much blood is flowing into the area. Depending on how well the nerve tissue functions, the patient may or may not describe discomfort. In severe partial-thickness burns, blisters are frequently present but should not be ruptured because doing so could spread infection (Capriotti, 2020). Burned skin is moist and raw. There might be blisters, redness, wet and shiny, painful to the touch, and white or discolored in an irregular pattern. Blisters it blanches on pressure. These severe burns typically happen from coming into touch with hot liquids, scalding, chemicals, flash, or an open flame. This 14-year-old male patient reports he was cooking breakfast, and the pot caught on fire, and he picked up the pot and took it outside. While taking the pot outside, he dropped the grease on him. The patient burned his right hand, right shoulder, right thigh, left hand, left thigh, chin, and both feet. This nursing student could not see the burnt areas due to bandages. A degree of scarring and a change in skin color is likely, even though superficial partial-thickness burns can spontaneously heal in 3 to 6 weeks without surgical intervention **(**Haffman & Sullivan, 2020). Healing from severe second-degree burns could take more than three weeks. The child's doctor will decide on the best course of therapy for a second-degree burn depending on the child's age, general health, medical history, the depth of the burn, the location of the burn, the origin of the burn, and the child's tolerance for particular drugs, procedures, or therapies. Second-degree burns that do not cover more than 10% of the skin's surface can be treated without hospitalization. Depending on the extent of the burn, the recommended course of treatment may include antibiotic ointments, dressing changes once or twice daily, daily cleansing of the site to remove ointment or dead skin, and sometimes

systemic antibiotics **(**Haffman & Sullivan, 2020). Cleaning the wound and changing the dressing can hurt. Analgesic medication may be required in these circumstances. Additionally, any developed blisters should not be ruptured. However, skin grafting and excision may be required if the risk of infection is a concern. The provider did put an order for the patient to get a skin graft. The patient also takes Acetaminophen, fentanyl, and Methocarbamol for comfort measures. The doctor also checks it as needed and puts in the prescribed ointment.

Pathophysiology References (2) (APA):

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

Hoffman, J. J., & Sullivan, N. J. (2020). *Davis advantage for medical-surgical nursing: Making connections to practice*. F.A. Davis

Active Orders (2 points)

Order(s)	**Comments/Results/Completion**
Activity:	**Increase as tolerated.**
Diet/Nutrition:	**Regular**
Frequent Assessments:	**Vitals every 4h, and continuous pulse ox.**
Labs/Diagnostic Tests:	**N/A**
Treatments:	**Wound care by provider/medical students on the floor, I&O, vitals every 4h, and OT.**
Other:	**N/A**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**

Skin Graft.	The patient will get a skin graft to heal the burnt areas faster.
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	4.50 – 5.30	5.11	N/A	N/A
Hgb	13.0 – 15.0	12.8	N/A	N/A
Hct	36 – 45	39.9	N/A	N/A
Platelets	140 – 400	218	N/A	N/A
WBC	4.50 – 13.50	6.87	N/A	N/A
Neutrophils	47.0 – 73 %	N/A	N/A	N/A
Lymphocytes	25.0 – 48.0 %	N/A	N/A	N/A
Monocytes	4.0 – 10.0 %	N/A	N/A	N/A
Eosinophils	0.0 – 3.0 %	N/A	N/A	N/A
Basophils	0 – 1 %	N/A	N/A	N/A

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-	**135 – 145 mmol/L**	**138**	**N/A**	**N/A**
K+	**3.5 – 5 mmol/L**	**3.6**	**N/A**	**N/A**
Cl-	**98 – 107 mmol/L**	**105**	**N/A**	**N/A**
Glucose	**70 – 110 mmol/L**	**127**	**N/A**	**PT has high glucose due to stress (Pagana et al., 2018).**
BUN	**2 – 20 mg/dL**	**9**	**N/A**	**N/A**
Creatinine	**0 – 1.2 mg/dL**	**0.78**	**N/A**	**N/A**
Albumin	**3.5 – 5.6 mg/dL**	**N/A**	**N/A**	**N/A**
Total Protein	**4.5 – 10 g/dL**	**N/A**	**N/A**	**N/A**
Calcium	**8.9 – 10.3 mg/dL**	**9.3**	**N/A**	**N/A**
Bilirubin	**0 – 1.5 mg/dL**	**N/A**	**N/A**	**N/A**
Alk Phos	**100 - 525 U/dL**	**N/A**	**N/A**	**N/A**
AST	**02-08 U/dl**	**N/A**	**N/A**	**N/A**
ALT	**40 - 150 U/L**	**N/A**	**N/A**	**N/A**
Amylase	**5 - 34 U/l**	**N/A**	**N/A**	**N/A**
Lipase	**0-55 U/**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	< 10	N/A	N/A	N/A
CRP	< 10	N/A	N/A	N/A
Hgb A1c	< 5.7%: normal 5.8 - 6.4%: pre-diabetes > 6.5%: diabetes	N/A	N/A	N/A
TSH	0.5 – 5 U/mL	N/A	N/A	N/A

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	Bright Yellow/Clear	N/A	N/A	N/A
pH	5.0 - 9.0	N/A	N/A	N/A
Specific Gravity	1.003 - 1.030	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	Negative	N/A	N/A	N/A
RBC	Negative	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	N/A

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

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
Urine Culture	**10,000 CFU/mL**	**N/A**	**N/A**	**N/A**
Blood Culture	**Negative**	**N/A**	**N/A**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**
Respiratory ID Panel	**Negative**	**N/A**	**N/A**	**N/A**
COVID-19 Screen	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

Diagnostic Imaging

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

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

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

Brand/Generic	Acetaminophen/ Tylenol	fentaNYL/ Abstral	Methocarbamol/ Robaxin	Polyethylene Glycol/MiraLAX	N/A

Dose	**500 mg**	**25 mcg**	**500 mg**	**17 g**	**N/A**
Frequency	**Every 4h**	**Every 2h PRN**	**Every 6h**	**As needed**	**N/A**
Route	**Oral**	**IV**	**oral**	**Oral**	**N/A**
Classification	**Pharmacologic Class: Nonsalicylate, Para-aminophenol Derivative Therapeutic Class: Antipyretic, Nonopioid analgesics**	**Pharmacologic class: Opioid Therapeutic class: Opioid analgesic Controlled substance schedule: II**	**Pharmacologic class: Carbamate derivative Therapeutic class: Skeletal muscle relaxant**	**Pharmacologic class: Osmotic Therapeutic class: laxatives.**	**N/A**
Mechanism of Action	**Inhibits the enzymes cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. It can also act directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E_2 (Jones & Bartlett,**	**Inhibits ascending pain pathways in CNS, increases pain threshold, alters pain perception by binding to opiate receptors (Jones & Bartlett, 2021).**	**May depress CNS, which leads to sedation and reduced skeletal muscle spasms. Methocarbamol also alters perception of pain (Jones & Bartlett, 2021).**	**Osmotic laxatives contain substances that are poorly absorbable and draw water into the lumen of the bowel.9 Polyethylene glycol functions is an osmotic laxative that causes increased water retention in the lumen of the colon by binding to water molecules, thereby producing loose stools**	**N/A**

	2021).			**(Jones & Bartlett, 2021).**	
Reason Client Taking	**To relieve mild pain.**	**Relief of pain.**	**To relieve discomfort caused by acute, painful musculoskeletal conditions.**	**PT is taking this to treat constipation.**	**N/A**
Concentration Available	**500 mg/tab**	**0.05mg/mL**	**500mg/ 750mg**	**119g – 850g/day**	**N/A**
Safe Dose Range Calculation	**15 – 20 mg/kg**	**0.05 – 0.1 mg/kg**	**1 – 3 g/day**	**17g/day**	**N/A**
Maximum 24-hour Dose	**4g/day**	**300mcg/day**	**6 – 12 g/day**	**17g/day**	**N/A**
Contraindications (2)	**-Hepatic impairment -Liver transplant**	**-Airway obstruction -Alcohol abuse**	**-CNS depressant -Hepatic disease**	**-Kidney disease -Inflamed bowel disease.**	**N/A**
Side Effects/Adverse Reactions (2)	**-Difficulty breathing -Loss of appetite**	**-Bradycardia -Respiratory depression**	**-Blurred vision -Hypotension**	**-Swollen abdomen -Rectal hemorrhage**	**N/A**
Nursing Considerations (2)	**Use cautiously due to risk of hepatic impairment. Monitor Renal Functions if in long-term therapy.**	**Monitor CNS changes. Monitor VS.**	**Administer meds at the same time. Administer med with food.**	**Assess patient for abdominal distention, presence of bowel sounds, Usual pattern of bowel function. - Assess color, consistency, and amount of stool produced.**	**N/A**
Client Teaching needs (2)	**Take as directed on the package. Do not exceed 4g of medication**	**Avoid any CNS depressants. Tell patient to increase fiber and**	**Tell patient to take drug exactly as prescribed. Inform patient urine may**	**Avoid whole grains. Take it in an empty stomach.**	**N/A**

	within 24 hours.	**fluid intake.**	**turn black/brown/ green.**		

Medication Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). *2021Nurse's drug handbook*. (21st ed).

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented X4 to person, place, time, and situation. No distress appeared at the moment and was resting/laying in bed with HOB elevated at 60 degrees. Patient is alert and responsive to verbal and painful stimuli. Overall appearance was appropriate for the setting/situation.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 2** **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:**	Skin color is dark brown and was dry/warm upon palpation. The patient has multiple second-degree burns: Right shoulder, right thigh, right forearm, right foot, left hand, and chin. The burns are covered in bandage. There are no signs of erythema or drainage on the site. No signs of contusions, rash, or wounds in the trunk areas and upper/lower extremities. Braden Score QD is 2 (no risk - no need for pressure ulcer prevention). Patient had a 20g IV in the left Anterior area. The date that it was initiated on was 06-19-2023. The IV was able to flush with no difficulties or resistance (Nursing flush 5mls to ensure it was still good). IV site area was clean with no sign of erythema or drainage. No IV fluid running at this time. 1
	Head/Neck: Skull and face are symmetrical. Trachea is midline with no deviations. Upon palpation

	trachea movement is present when patient swallows. Carotid artery is palpable and is +2 bilaterally. All cervical lymph nodes are nonpalpable bilaterally. Eyelids have no visible discoloration, lesions, or swelling bilaterally. *Eyes*: Sclera is white and clear bilaterally. Conjunctiva is pink and moist bilaterally. Pupils (PERRLA) are round and equal, reactive to light, and are able to accommodate bilaterally. 6 Extraocular movements are present in both eyes with no deviations bilaterally. *Ears*: No present ear tenderness upon palpation with no visible drainage or discoloration bilaterally. No visible impaction in ears bilaterally. *Nose*: Nose septum is midline. Turbinates are moist and pink in the nose bilaterally with no visible signs of bleeding. Frontal sinuses are nontender to palpation bilaterally. *Teeth:* Uvula is midline. Soft palate and hard palate are present. Swallow reflex is present with a soft palate able to move upward. Buccal mucosa is moist. Teeth are present and are a yellow/white color and are consistent in the top section and bottom section of the mouth.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Sinus Rhythm is present along with S1 and S2 sound present. No signs of S3, S4, or murmurs. Heart rhythm is regular (Normal sinus Rhythm). All upper and lower peripheral pulses were a +2. Apical pulse auscultated at the midclavicular line at the 5th intercostal space (rhythm/rate is regular). Cap refill is less than 2 seconds. No signs of neck vein distention or edema in the upper/lower extremities.
RESPIRATORY:	No use of accessory muscles during respiration.

Accessory muscle use: Y☐ N ☒ **Breath Sounds: Location, character**	Normal rate and regular pattern of respirations. Respirations are symmetrical and non-labored. Lung sounds clear throughout the anterior/posterior in the upper section bilaterally. No wheezes, crackles, or rhonchi present. No use of accessory muscle or signs of breathing distress. Lung aeration is equal bilaterally.
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. Height is 175.3 cm Weight is 60.7 kg. Normoactive bowel sounds in all 4 quadrants. Last BM was the day prior in the morning. No pain/tenderness or mass upon palpation in all 4 quadrants. No signs of distention, scars, drains, or wounds upon inspection. No redness, hot to touch, drainage, or swelling present. No ostomy or nasogastric tube present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine is yellow and clear based on the patient statement. Urine output was not able to be assessed due patient using the toilet. Patient stated that there is no pain with urination. No use of dialysis or catheter.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 25 (PT fell when he was taking the pot outside).** **Activity/Mobility Status:**	Neurovascular is intact with no impaired blood flow or damage to the peripheral nerves in the extremities bilaterally. Patient is able to perform all ROM actively in upper and lower extremities bilaterally. Muscle strength is 5/5 in upper and lower bilaterally. No need of ADL assistance. Client is able to ambulate by themselves. Fall risk score is a 2 which is low risk - implementing standard fall precautions such as mats on the floor and wearing grip socks when ambulating.

Independent (up ad lib) ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW is intact and PERRLA is equal, round and reactive. Muscle Strength is 5/5 in both upper/lower extremity bilaterally. Oriented x4 to person, place, time, and situation. Mental status is normal with behavior appropriate to their responses. No deficits with speech or sensory. LOC is 15 with patient alert and awake to question and answer appropriately.
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 way of coping is playing games on his phone. No deficit was noted at the development level. The patient stated that he believes in spirituality, meaning that everything is universal for the benefit of all. The patient does have a mother, siblings, and cousin who support him. The support system is excellent due to the mother being there for him.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	**77**	**117/61**	**14**	**36.7**	**100% Room Air**
1130	**62**	**119/58**	**16**	**36.6**	**100% Room Air**

Vital Sign Trends: The vitals are within the normal range.

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

Pulse Rate	60 - 100 (Ricci et al., 2020)
Blood Pressure	100 - 120/70-80 (Ricci et al., 2020)
Respiratory Rate	12 - 20 (Ricci et al., 2020)
Temperature	97.6 - 99.6°F (Ricci et al., 2020)

Oxygen Saturation	95 - 100% (Ricci et al., 2020)

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

Ricci, S., Ricci, S. S., Kyle, T., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing*. LWW.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	**Numeric**	**N/A**	**N/A**	**N/A**	**N/A**
1130 Evaluation of pain status *after* intervention	**Numeric**	**N/A**	**N/A**	**N/A**	**N/A**
Precipitating factors: No pain. **Physiological/behavioral signs: No signs of pain.**					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
Did take 100% of breakfast. **480 mL of Orange Juice** **480 mL of Apple Juice**	**1x Occurrence (Unmeasurable)**

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. **Has some independence to an extent.**

2. **Has capacity to socialize with others in similar ages.**
3. **Show more interest in the opposite sex (in the same age group).**

Age Appropriate Diversional Activities

1. **The patient watches movies**
2. **The patient plays games on his phone.**
3. **The patient watches TV Shows.**

Psychosocial Development:

- **Which of Erikson's stages does this child fit?**
  - The patient is in the identity vs Confusion Stage where adolescence explores independence while developing a sense of self (Ricci et al., 2020).
- **What behaviors would you expect?**
  - The patient may exhibit behaviors such as insecurity to themselves and begin to ponder how they fit into society (Ricci et al., 2020). They may seek social interactions to develop a sense of themselves (Ricci et al., 2020).
- **What did you observe?**
  - I did observe that the patient does show evidence of social interactions with those in similar age. I also observed that the patient is somewhat insecure of themselves physically.

Cognitive Development:

- **Which stage does this child fit, using Piaget as a reference?**
  - This patient is in the Concrete Operational stage.
- **What behaviors would you expect?**
  - The patient would use logic into the concrete thinking to become better aware of how to view a certain aspect (Ricci et al., 2020).

- **What did you observe?**
    - I observed that the patient was able to understand how his diagnosis works and what certain actions can be done to improve overall quality of life and prevent complications (Ricci et al., 2020).

Vocalization/Vocabulary:

- **Development expected for child's age and any concerns?**
    - The patient's current development is on track with no current concerns.

Any concerns regarding growth and development?

- No concerns with growth/development.

Developmental Assessment Reference (1) (APA):

Ricci, S., Ricci, S. S., Kyle, T., Kyle, T., & Carman, S. (2020). *Maternity and pediatric nursing*. LWW.

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. **Impaired skin integrity related to burns as evidence by scattered partial thickness burns total body surface area, approximately 4% (Phelps, 2020).**	**This is relevant to my patient because of the burns on 4% of his body.**	**1. Inspect patient's skin every eight hours described and document skin condition and report changes to provider evidence of the effectiveness of skin care regimen (Phelps, 2020).** **2. Encourage patient to express feelings about skin condition to enhance coping (Phelps, 2020).**	**Patient doesn't experience further skin breakdown or other complications (Phelps, 2020).**	**Patient and family members demonstrate skin care regimen (Phelps, 2020).**

2. **Acute pain related to dressing change as evidenced by self-report of intensity using a standardized scale during admissions (Phelps, 2020).**	**This is relevant to my patient because patient reports pain at admission.**	**1. Assess patient's file asked if there is a pain, behavioral cues and administer pain medication as prescribed. Use a pain scale when assessing pain (Phelps, 2020).** **2. Although pain is subjective when using the scale, compare patient's perception of pain from one assessment to another (Phelps, 2020).**	**Patient will rate pain 0 on a scale of 1 to 10 on a standardized scale (Phelps, 2020).**	**Patient identifies most effective pain relief measures (Phelps, 2020).**
3. Risk for infection related to alterations skin integrity as evidenced by burn (Phelps, 2020).	**This is relevant to my patient because of the burns on 4% of his body, and they can become infected if it's not taken care of properly.**	**1. Follow the facilities, infection control policy to minimize the risk of nosocomial infection (Phelps, 2020).** **2. Ensure adequate nutrition intake to promote**	**Patient white blood cell count remain within normal range (Phelps, 2020).**	**Patient reports he does not experience any signs and symptoms of infection (Phelps, 2020).**

		wound healing (Phelps, 2020).		
4. Risk for electrolyte related to compromised regulatory mechanism as evidenced by partial thickness burns (Phelps, 2020).	**This is relevant to my patient because he lost fluid because of the burns on 4% of his body.**	**1. Monitor patient for physical signs of electrolyte imbalance (Phelps, 2020).** **2. Assess patient's fluid status. assess patient's fluid status (Phelps, 2020).**	**Patient's electrolyte levels remain within normal limits (Phelps, 2020).**	**Patient verbalizes signs and symptoms that require immediate intervention by a healthcare provider (Phelps, 2020).**

Other References (APA):

Phelps, L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). LWW.

Concept Map (20 Points):

Subjective Data

Patient reports he was cooking and dropped grease on him. Patient reports pain at admission.

Objective Data

RBC - 5.11
Hgb - 12.8
Hct - 39.9
Platelets - 218
WBC - 6.87
Na - 139
K+ - 3.6
Cl- - 105
Glucose - 127
Creatinine - 0.78
Bun - 9
Calcium - 9.3
BP- 119/58, pulse- 62, resp- 16, temp- 36.6, and o2- 100 room air.

Client Information

A 14-year-old male comes to the emergency department due to an injury caused by the burn. The patient reports he was cooking and dropped a pot caught on fire, and he picked up the pot and took it outside. While taking the pot outside, he dropped the grease on him. The patient burned his right hand, right shoulder, right thigh, left hand, left thigh, chin, and back feet. The patient's mother reports this burn happened two days ago, and she took him to OSF, and they sent him home with ointment, and she didn't like how the burns were healing, so she wanted to get him checked out at a Carle. The patient denies any pain. The patient is transferred from the emergency department for further evaluation.
- PT is FULL CODE.
Weight:60.7 kg; Height: 175.3 cm

Nursing Diagnosis/Outcomes

1. Impaired skin integrity related to burns as evidence by scattered partial thickness burns total body surface area, approximately 4%.
- Patient doesn't experience further skin breakdown or other complications.

2. Acute pain related to dressing change as evidenced by self-report of intensity using a standardized scale during admissions.
- Patient will rate pain 0 on a scale of 1 to 10 on a standardized scale.

3. Risk for infection related to alterations skin integrity as evidenced by burn.
- Patient white blood cell count remain within normal ranges.

4. Risk for electrolyte related to compromised regulatory mechanism as evidenced by partial thickness burns.
- Patient's electrolyte levels remain within normal limits.

Nursing Interventions

1. Inspect patient's skin every eight hours described and document skin condition and report changes to provider evidence of the effectiveness of skin care regimen.
2. Encourage patient to express feelings about skin condition to enhance coping.
3. Assess patient's file asked if there is a pain, behavioral cues and administer pain medication as prescribed. Use a pain scale when assessing pain.
4. Although pain is subjective when using the scale, compare patient's perception of pain assessment to another.
5. Follow the facilities, infection control policy to minimize the risk of nosocomial infection.
6. Ensure adequate nutritional intake evidenced by wound healing.
7. Monitor patient for physical signs of electrolyte imbalance.
8. Assess patient's fluid status. assess patient's fluid status.