

**Lakeview College of Nursing
N433 Pediatrics Clinical Care Plan**

Student Name ____Taniya Varghese_____

CLINICAL DATE__9/6/19__

Patient's Age 2005, January (14 yrs. old)

Weight (in kg) 35.8 kg

BMI 18.29 kg

Allergies/Sensitivities to medications, foods, contact, environmental, etc. Include reactions:

Allergic to Clonazepam, Omeprazole

Chief Complaint (Reason for admission): Sepsis due to unspecified organism **Admit date:** September 5, 2019

Other co-existing conditions: Spastic quadriplegic cerebral palsy, Global developmental Delay, Refractory Epilepsy

History of Present Illness (What events led up to this child being admitted to the hospital, etc.):

Patient was brought to the emergency room on September 5th, 2019 due to a high fever. Patient is diagnosed to be septic with a high lactic acid level.

Pertinent Events during this Admission and Hospitalization (IV starts, lab test, etc.): Patient has a chest x-ray done. The x-ray shows that the patient has some evidence of ride sided plural fluid. An IV was started yesterday on September 5th, 2019 with D5 .9% NaCl with KCl 20 mEq. Patient also has a CBC blood work drawn on September 5th, 2019.

Past Medical & Surgical History (illnesses, hospitalizations, immunizations, birth history-any complications?) Patients past medical and surgical history consists of placement of a tracheostomy and a Gastrostomy tube put in. Patient is diagnosed with intractable seizures, CVA in utero, quadriplegia, scoliosis, chronic lung disease. Patient is trach dependent. Other surgeries include a tonsillectomy and adenoidectomy along with post eye surgeries for cross eyes. The patient also has her post submandibular gland removed. She has a vagus nerve stimulator put in place. She had a left hip arthroplasty and a thoracic and lumbar spinal fusion. Patient does not have a right hip bone. And patient has a history of MRSA.

Child's diagnosis: Septic

Etiology of disease process (what causes it): Cause of the sepsis is unknown

Pathophysiology: (What is the pathophysiology of this disease and what goes on in the body as a result of this disease? Put in your own words & site reference)

Sepsis is can be known as a life-threatening condition is which the body is reacting to a infection. There are specific chemicals that as released into the blood stream as the body's response to the foreign trigger, hence, causing the body to fight the infection. Sepsis is known to occur when the specific balance of the chemicals in the body that is trying to fight the infection is out of balance. Eventually, if the sepsis is not controlled and monitored, there can ultimately damage to multiple organs. Sepsis is an infection to can happen to anyone in any age group. This type of serious infection can be seen in people with general weakened immune system. Common signs and symptoms of sepsis include an altered mental status, change in both blood pressure and even respiratory rate. Sepsis can be caused by either bacterial or viral infections. If not treated in an adequate amount of time, organs such as the brain, heart and the kidneys can be impaired.

Reference

(2018, November 16). Sepsis. Retrieved from <https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214>

Clinical Manifestations of the disease (Highlight those exhibited by your patient) – include lab values, tests, etc:

- patches of discolored skin.

- decreased urination.
- changes in mental ability.
- low platelet (blood clotting cells) count.
- problems breathing.
- abnormal heart functions.
- chills due to fall in body temperature.
- unconsciousness.

Vital Signs: (List your source for the Normal ranges) T 98.1 F NL : 37 C / 98.6 F HR.84 (NL for age) 70 – 100 BPM RR. 12 (NL for age) 12-20

B/P 111/68 (NL for age) 123.9/65.9 O2 sat 94 % Room Air or Oxygen : Room Air

Intake/Output: (IV, PO, Out & Deficits): Inputs and outputs for this patient was not recorded. However, bowel movement was recorded as just one movement for today described as “large, liquid, brown”.

Clinical Day Evaluation Data – Head to toe physical assessment (Do not use WNL or WDL): _____

General appearance: Patient laying down in bed in low Fowlers position. Patients head is flexed back due to trach insertion.

Head: Head is shaped irregularly with cheek bone protruding out.

Ears: Tympanic membrane normal bilaterally and external auditory canal is free of discharge and erythema bilaterally.

Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge.

Thyroid: Thyroid gland is non palpable.

Chest: Increased respiratory rate. No respiratory distress. Coarse rhonchi throughout. No wheezes or rales. No retraction.

CV: Tachycardia, regular rhythm, S1 normal and S2 normal. No murmur heard.

Abdomen: Full and soft. Bowel sounds are normal. Generalized distension. No mass. Slight generalized tenderness with palpation. No guarding. No hernia.

GU: Negative for vomiting, diarrhea, and changes in bowel habits.

Musculoskeletal: Negative for joint swelling

Extremities: No edema, no swelling throughout.

Skin: Skin is warm to touch and clammy. No rash noted. No cyanosis

Pain History & assessment: Type, location, intensity & timing, precipitating factors, relief measures/interventions, rating scale used, physiological and/or behavioral signs, evaluation of pain status after medication is given:

Patient is not in a level of consciousness where she could have answered questions

Lab Tests:

TEST	NORMAL (specific for age)	Prior	Clinical Day	Correlation to current health status & comment on trending (comment only on abnormal lab results)
RBCs	4.2-5.4mcl	5.0	9/6/19	
Hgb	12.0-15.5g	12.5	9/6/19	
Hct	37%-48%	42	9/6/19	
MCV	80-96	83	9/6/19	
MCH	27-33 pg	34	9/6/19	
MCHC	31-37 g/dL	35	9/6/19	
WBCs	4,500-11,000	3,500	9/6/19	Low WBC count due to diagnosis of sepsis with an unknown cause
Neutrophils	1,500 to 8,000/mm ³	2,500	9/6/19	

Eosinophils	30-350	150	9/6/19	
Basophils	0-0.3 k/tul	.3	9/6/19	
Monocytes	0.2–1.0×10 ⁹ /l	.2x10 ⁹	9/6/19	
Lymphocytes	1.0–3.0×10 ⁹ /l	.567	9/6/19	Low Lymphocyte count due to diagnosis of sepsis with an unknown cause
Platelets	150,000 to 450,000	100,000	9/6/19	Low platelets count due to diagnosis of sepsis with an unknown cause
TEST	NORMAL (specific for age)			
		Prior	Clinical Day	Correlation to current health status & comment on trending
Glucose	100 mg/dL	125	9/6/19	
Na ⁺	135-145	140	9/6/19	
Cl ⁻	98-107	100	9/6/19	
K ⁺	3.5-5.1	3.8	9/6/19	
Ca ⁺⁺	8.9-10.9	10	9/6/19	
Phosphorus	2.5-4.5	3.0	9/6/19	
Albumin	3.4-5.4	4.2	9/6/19	
Total Protein	6-8.3	7.3	9/6/19	
BUN	7 – 20 mg/dL	15	9/6/19	
Creatinine	.6 – 1.2 mg	.98	9/6/19	
TEST	NORMAL (specific for age)			
		Prior	Clinical Day	Correlation to current health status & comment on trending
Liver Function Tests	N/A	N/A	N/A	
Urinalysis	N/A	N/A	N/A	
Urine specific gravity	N/A	N/A	N/A	
Urine pH	N/A	N/A	N/A	
Creatinine clearance	N/A	N/A	N/A	
Other Labs:	N/A	N/A	N/A	

Diagnostic Studies:

TEST & RESULTS	Correlation to current health status (if abnormal)
Chest x-ray:	N/A
CT Scan/MRI:	N/A

Biopsy/Scope:	N/A
Cultures:	N/A
Other:	N/A

List of active orders on this patient:

ORDER	COMMENTS/RESULTS/COMPLETION
Activity:	Patient has limited activity and is bed ridden
Diet/Nutrition:	Patient has feeding of 250 ml of Pediasure 3 times a day
Frequent Assessments:	Frequent suction of tracheostomy
Labs/Diagnostic Studies:	NONE
Treatments:	Antibiotics and anticonvulsants
New Orders for Clinical Day	
ORDER	COMMENTS/RESULTS/COMPLETION
NONE	NONE
NONE	NONE
NONE	NONE

Teaching & Learning: Identified teaching need (be specific):

Summarize your teaching (prioritization in care, methods used, materials used, time to provide, etc.):

There is no specific teaching and learning that could be done with this patient. This is because she has an altered mental status that is permanent. She does not have the mental ability to understand her illness and to take preventative measures regarding it.

Developmental Assessment: 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 & Developmental Milestones

1. Have more ability for complex thought
2. Be better able to express feelings through talking.
3. Develop stronger sense of right and wrong

Age Appropriate Diversional Activities

1. Puzzles
2. Telling time on the clock
3. Concentration

Psychosocial Development: Which of Erikson’s stages does this child fit?

This child fits in the “identity vs. Role Confusion

What behaviors would you expect?

Adolescents try on many different selves to see which ones fit, they want to answer the question “who am I?”. They explore various roles and ideas, **set** goals, and attempt to discover their “adult” selves. Adolescents who are successful at this stage have a strong sense of identity and are able to remain true to their beliefs and values in the face of **problems** and other people’s perspectives.

What did you observe?

Due the patient’s various disabilities, is unable to successfully completing this stage of Erikson’s stages of psychosocial development.

Cognitive Development:

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

At this age, this patient should be in the formal operational stage of cognitive development.

What behaviors would you expect?

At this stage, the adolescent or young adult begins to think abstractly and reason about hypothetical problems. Their abstract thought emerges. Most teens begin to think more about moral, philosophical, ethical, social, and political issues that require theoretical and abstract reasoning

What did you observe?

Due the patient’s various disabilities, is unable to successfully completing this stage of Erikson’s stages of psychosocial development.

Vocalization/vocabulary: Development expected for child’s age and any concerns?

The patient did not speak at all.

Any concerns regarding growth and development?

Only concern for this patient would be to be able to properly function and take in nutrients adequately.

Potential Complications that can occur because of this disease/disorder:

Potential Complication	Signs/Symptoms	Preventative Nursing Actions
1. Acute respiratory distress syndrome	<ul style="list-style-type: none">• labored and rapid breathing.• muscle fatigue and general weakness.• low blood pressure.• discolored skin or nails.• a dry, hacking cough.• a fever.• headaches.	Making sure patient is compliant with medication and has a low risk of aspiration.

<p>2. Septic Shock</p>	<ul style="list-style-type: none">• Cool, pale arms and legs.• High or very low temperature, chills.• Lightheadedness.• Little or no urine.• Low blood pressure, especially when standing.• Palpitations.• Rapid heart rate.	<p>Make sure patient is compliant with all medications</p>
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Nursing Care Plan

Nursing Diagnosis <u>Prioritize-most important to least</u>	Outcomes (Patient/Family will: and give time line) (MUST BE MEASURABLE)	Nursing Interventions With rationale (At least 2 nursing interventions per outcome)	Evaluation of <u>EACH</u> outcome
<p>Risk for Deficient Fluid Volume</p> <p>Related to:</p> <p>Dehydration</p> <p>AEB (as evidenced by):</p> <p>Increase in vital signs</p>	<p>1.</p> <p>Increased Respiratory rate</p> <p>2.</p> <p>Decrease in Pulse Ox</p>	<p>1.</p> <p>Assess for dry mucous membranes, poor skin turgor, and thirst.</p> <p>2.</p> <p>Monitor blood pressure and heart rate.</p> <p>1.</p> <p>Palpate peripheral pulses.</p> <p>2. Observe for dependent or peripheral edema</p>	<p>Outcomes Met/ Partially met/ Not met (with Explanation)</p> <p>1.</p> <p>Due to the constant suctioning the respiratory sections patient does not have dry membranes. MET</p> <p>2.</p> <p>Patient has adequate amount of fluids enter through peripheral lines. MET</p> <p>What next? Monitor patient and make sure blood pressure does not drop dramatically</p>

Nursing Care Plan

Nursing Diagnosis <u>Prioritize-most important to least</u>	Outcomes (Patient/Family will: and give time line) (MUST BE MEASURABLE)	Nursing Interventions <u>With rationale</u> <u>(At least 2 nursing interventions per outcome)</u>	Evaluation of <u>EACH</u> outcome
<p>Risk for shock</p> <p>Related to:</p> <p>Damage to multiple organs</p> <p>AEB (as evidenced by):</p> <p>limited body functions</p>	<p>1.</p> <p>Checking lab values for increased or decrease in all components</p> <p>2.</p> <p>Monitor vitals consistently</p>	<p>1. Monitor for signs of bleeding; oozing from puncture sites or suture lines, petechiae, ecchymoses, hematuria, epistaxis, hemoptysis, and hematemesis.</p> <p>2. Assess for changes in sensorium (confusion, lethargy, personality changes, stupor, delirium, and coma).</p> <p>1.</p> <p>Monitor heart rate and rhythm. Note dysrhythmias.</p> <p>2. Monitor trends in blood pressure(BP), especially noting progressive hypotension and widening pulse pressure.</p>	<p>Outcomes Met/ Partially met/ Not met (with explanation)</p> <p>1. MET</p> <p>2.</p> <p>MET</p> <p>What next? Monitor patient and make sure blood pressure does not drop dramatically</p>

N308 Medication Form

Patient Initials: _____

Patient Age: _____

Patient Weight (in kg): _____

Scheduled Medications				
Medication Trade & Generic Names, Pharmaceutical Class Action of the medication (how does the medication work in the body <u>in your own words</u>)	Dose, route, & frequency ordered for this patient	Concentration Available Why is this pt. taking this?	Calculate the safe dose ranges for this child. This is done by multiplying the safe dose range by the child's weight. https://www.epocrates.com/lite/RegHonorsRegistrationProcess.do What is the maximim dose that can be given in a 24 period? (Show Calculations)	Nursing Considerations (at least 3 & must be appropriate for this patient, & include any labs that need to done to monitor pt. while taking this medication) <u>Contraindications</u> <u>Common side effects</u>
Levetiracetam Keppra Anticonvulsant	500mg twice daily though G tube	To control her seizures	$500\text{mg} * 2 = 1000\text{mg}$	Considerations : 1. Monitor BUN and creatinine levels 2. Avoid stopping drug abruptly 3. Monitor for suicidal behaviors Side Effects 1. Confusion 2. Depression 3. apathy
Zonisamide Zonegran Anticonvulsant	250mg twice daily though G tube	To control her seizures	$250\text{mg} * 2 = 500\text{mg}$	Considerations : 1. Monitor for seizure activity 2. Avoid stopping drug abruptly 3. Monitor blood pressure Side Effects 1. Abnormal gait 2. ataxia 3. apathy

<p align="center">Medication</p> <p>Trade & Generic Names, Pharmaceutical Class Action of the medication (how does the medication work in the body <u>in your own words</u>)</p>	<p>Dose, route, & frequency ordered for this patient</p>	<p>Concentration Available</p> <p>Why is this pt. taking this?</p>	<p>Calculate the safe dose ranges by what is given as a safe dose times the child's weight. Do this for a 24 hour period. (Show Calculations)</p> <p>Is this dose safe for this pt.?</p>	<p><u>Nursing Considerations</u> (at least 3 & must be appropriate for this patient, & include any labs that need to be done to monitor pt. while taking this medication)</p> <p><u>Contraindications</u></p> <p><u>Common side effects</u></p>
<p>Ceftriaxone Rocephin Antibiotic</p>	<p>75 mg once a day through G tube</p>	<p>Antibiotic to kill any infectious agents causing sepsis</p>	<p>75 mg</p>	<p>Considerations :</p> <ol style="list-style-type: none"> 1. Obtain culture labs 2. Assess bowel patterns 3. Assess for bleeding <p>Side Effects</p> <ol style="list-style-type: none"> 1. Hearing loss 2. Dyspnea 3. Chills

N308 CARE PLAN GRADING RUBRIC FOR HOSPITAL

Name: _____

Date _____

Grade _____

Section	Definition	Possible Points	Final Points
Age/Weight/BMI	Age is written in years & months. Weight is calculated in kilograms. BMI is written correctly	1	
Allergies & reaction to each	Allergies/sensitivities to food, contact, environmental. Include reactions	2	
Chief Complaint/Medical Diagnosis/Co-existing Conditions	Chief complaint, reason for admission, current primary diagnosis. Are there any other health/medical co-morbidities?	3	
History of Present Illness	Describe what has happened to the child that caused this child to be admitted	5	
Pertinent Events during this Admission	i.e., Surgery, instability during hospitalization, diagnostic tests, IV starts, procedures	1	
Past Medical & Surgical History	Past surgeries, previous health issues and diagnoses	2	
Pathophysiology	Explain in your own words the pathophysiology of the current, primary diagnosis. If a resource is used, please site the reference.	5	
Vital Signs and I & O	All vital signs and document normal vital signs for child's age. <u>All</u> I & O is documented with deficits	2	
Clinical Day Evaluation	Head to toe physical assessment with comments (DO NOT use WNL/WDL) & emphasis on systems affected by chief complaint/medical diagnosis.	8	
Pain Assessment	Pain rating and pain scale used	2	
Lab Tests	Labs day of clinical and prior tests (trend them if numerous test). Give rationale for abnormal lab tests.	2	
Diagnostic Studies	X-rays, biopsies, EKG, CT scans, MRI, scopes, cultures, etc.	2	
Patient Orders Clinical Day	Activity, diet, assessments, labs/studies, treatments, code status, etc.	1	
Clinical Day new orders	Activity, diet, assessments, labs/studies, treatments, code status, etc.	1	
Teaching and learning	Identify teaching need. Summarize teaching. Evaluate teaching.	3	
Developmental Assessment	3 Age appropriate growth and developmental milestones that should be expected for the child's age. 3 Age appropriate Divirisional/Distracton activities appropriate for child's age. Erikson's psychosocial development stage and behaviors expected for child's age. Piaget's cognitive development stage and behaviors expected for child's age. Vocalization/vocabulary development expected for child's age and is the child's language appropriate for that age. Any concerns regarding growth and development for the child.	6	
Potential Medical Complications	Complications that can occur because of primary medical diagnosis/disease/condition. Signs & Symptoms of complication. Preventative nursing actions.	6	

Nursing Diagnosis # 1 Related to or AEB	Nursing diagnosis is pertinent to patient condition/diagnosis. Reflects and supports current primary medical diagnosis R/T the pathophysiology for the current primary diagnosis/condition (not medical diagnosis). AEB: signs and symptoms that support the nursing diagnosis	4	
Expected Outcomes	Patient will/Family will.... and <u>must have a desired outcome timeline</u> . (Must be measurable, specific, & objective) (Ex: patient will ambulate around the nurse's station once during clinical or patient will verbalize 3 signs and symptoms of infection by the end of clinical day).	4	
Nursing Interventions	What nursing interventions will you do to support meeting the patient outcomes and give rationale for each intervention of why this intervention is important? (Need at least 2 interventions per outcome)	8	
Evaluations & What's Next	Goal met/partially met/not met, why or why not, what's next? (Explain your evaluation of outcomes met, partially met, or not met (i.e., patient/family was not able to verbalize 3 signs and symptoms of infection) What's next? (What is/are the next intervention/s for the patient/family to help them meet the intended outcome)?	3	
Nursing Diagnosis #2 Related To and AEB (as evidenced by)	Nursing diagnosis is pertinent to patient condition/diagnosis. Reflects and supports current primary medical diagnosis, MUST prioritize the most important nursing diagnosis to the least important R/T the pathophysiology for the current primary diagnosis/condition (not medical diagnosis). AEB: signs and symptoms that support the nursing diagnosis	4	
Expected Outcomes	Patient will/Family will.... and <u>must have a desired outcome timeline</u> . (Must be measurable, specific, & objective) (Ex: patient will ambulate around the nurse's station once during clinical or patient will verbalize 3 signs and symptoms of infection by the end of clinical day).	4	
Nursing Interventions	What nursing interventions will you do to support meeting the patient outcomes and give rationale for each intervention of why this intervention is important? (Need at least 2 interventions & rationale per outcome)	8	
Evaluations & What's Next	Goal met/partially met/not met, why or why not, what's next? (Explain your evaluation of outcomes met, partially met, or not met for each outcome (i.e., patient/family was not able to verbalize 3 signs and symptoms of infection) What's next? (What is/are the next intervention/s for the patient/family to help them meet the intended outcome)?	3	
Medications			
Scheduled & PRN	Trade/Generic name, Pharmacologic Class & Action of the medication. Indications for this patient.	3	
	Dose, Route, Frequency ordered for this patient	1	
	Concentration available and why is the child taking this medication	1	
	Calculate dose ordered times child's weight (give parameters for this medication if needed) and is this dose that's ordered safe for the child?	2	
	Three nursing considerations/implications for each medication specific to this patient and give Contraindications and Common Side Effects	3	
	Total Points	100	