Patient's Age: 7 years, 4 months of age   **Weight** (in kg): 24.8 kg   **BMI:** 17.51 kg/m^2

Allergies/Sensitivities to medications, foods, contact, environmental, etc. Include reactions: No known allergies.

Chief Complaint (Reason for admission): Patient's mother states that the patient "hasn't pooped in 10 days" and complains of "occasional abdominal pain".

Admit date: 09/18/19

Other co-existing conditions: Chronic constipation

History of Present Illness (What events led up to this child being admitted to the hospital, etc.): Patient's mother is the historian source for the patient. The historian estimates that the onset of constipation occurred about five days ago, but states that the patient "hasn't pooped in 10 days". The historian states that the location of constipation is central to the abdomen. The patient is not able to describe the pain, but says that it is intermittent, stating that it is "not all the time, just sometimes." The patient has a history of chronic constipation and has been hospitalized before due to fecal impaction. The historian states that the patient does take MiraLAX daily to help soften her stools, but it did not treat the patient's symptoms. The patient's pain level was assessed upon admission using the FACES pain scale, and the patient chose the smiley face, 2, which indicates that it hurts a little bit.

Pertinent Events during this Admission and Hospitalization (IV starts, lab test, etc.): IV started on 09/20/19 with a 24-gauge sized needle, placed on the right wrist.

Past Medical & Surgical History (illnesses, hospitalizations, immunizations, birth history-any complications?) The patient's mother states that the patient has a history of chronic constipation and has been hospitalized for fecal impaction multiple times in the past. The patient's mother denies a surgical history; no surgeries are listed in the patient's chart.

Child's diagnosis: Fecal impaction
Etiology of disease process (what causes it): The etiology behind fecal impactions are related to chronic constipation. Dietary considerations, predisposing factors, and family history places children at risk for developing chronic constipation. Diets that are high in processed foods and low in fruit, vegetables, and fiber are contributing factors. The predisposing conditions involve autism spectrum disorders, while familial predispositions are usually due to a family history of constipation.

Reference (etiology): Bisanz, A. (2007). Chronic Constipation. *AJN, American Journal of Nursing, 107*(4). doi: 10.1097/01.naj.0000271190.05316.d5

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 & cite reference)**: The most likely reason for fecal impactions is due to chronic constipation. Feces are impacted when hard stools cannot pass through the colon and become lodged in

the sigmoid and rectum (Capriotti & Frizzell, 2016). Defecatory disorders are usually caused by issues with the pelvic floor or anal sphincters. This type of constipation can develop in patients who keep ignoring the need to defecate. Symptoms of this condition are characterized by abdominal pain, infrequent bowel movements, excessive straining, hard stools, the feeling of incomplete elimination, bloating, pain, and malaise (Capriotti & Frizzell, 2016). To diagnose fecal impactions, a patient has to have less than two defecations per week, at least one episode of fecal incontinence per week, a history of suppressing the urge to defecate, and a history of painful or hard bowel movements. My patient was experiencing abdominal pain due to fecal impaction from chronic constipation, categorizing it into a defecatory disorder. Additionally, she met diagnostic criteria for having a previous history of chronic constipation, familial tendencies, and not having at least two bowel movements a week.

Reference (pathophysiology): Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Clinical Manifestations of the disease (circle those exhibited by your patient) – include lab values, tests, etc: The clinical manifestations displayed by my patient was abdominal pain, history of chronic constipation, two or fewer defecations per week. Her hemoglobin and hematocrit levels were also elevated prior to admission, suggesting that the red blood cells were high in blood due to the inability to release them in stools.

Vital Signs: (**List your source for the Normal ranges)**

T: 36.6˚ C (97.9˚ F)   (NL for age): 36.8 C (98.2)

HR: 82 bpm   (NL for age): 60-110 bpm

RR: 19 breaths/min   (NL for age): 19-21 breaths/min

B/P: 115/59 mm Hg   (NL for age): <122 / <83 mm Hg

O2 sat: 96%   Room Air or Oxygen: Room Air

Reference (vital signs): Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Elkins, C. B., Holman, H. C., … Barlow, M. S. (2016). *Rn nursing care of children: review module* (Vol. 10). Leawood, KS: Assessment Technologies Institute.

Intake/Output (IV, PO, Out & Deficits): Intake: 320 mL; Output: 332 mL without deficits.

Clinical Day Evaluation Data – Head to toe physical assessment (Do not use WNL or WDL):
HEENT: Patient's head is normal cephalic in size and shape for patient's age. Ears are clean bilaterally without any visible drainage or discharge. Eyes are with normal conjunctiva, without discharge. Nose is symmetrical without bleeding or polyps. Oral mucosa is moist without lesions or bleeding.
Neurological: The patient is alert and oriented to person, place, time, and situation. Speech is clear. PERRLA is present. Patient's sensory level is in tact and able to detect on the back of hands, fingertips, and feet bilaterally. Patient displays 5/5 musculoskeletal strength bilaterally in upper and lower extremities.
Musculoskeletal: Patient is able to perform range-of-motion exercises including flexion, extension, and side-to-side rotation of her cervical spine without difficulties.

Cardiovascular: Heart sounds S1, S2 auscultated; no murmurs, gallops, or rubs present. Bilateral radial and pedal pulse grades are present, both rated as 3+. Capillary refill in upper and lower extremities fill within 3 seconds. No noted neck vein distention or edema.

Respiratory: Breath sounds clear to auscultation in all lung fields without crackles, wheezes, or rubs. Patient does not appear to be in respiratory distress and denies difficulty breathing.

Gastrointestinal: Auscultation of abdomen performed. Bowel sounds present and audible with clicks and gurgles in RLQ, RUQ, LUQ, and LLQ without distention, incisions, scars, or wounds. Patient denies abdominal pain at this time, no facial grimacing or guarding noted during assessment. Patient has been passing stools since day of admission and says that it has helped to eliminate abdominal pain experienced prior to admission.

Genitourinary: Urine is light yellow in color with normal odor. Patient states that she has been having to urinate a lot since drinking the Nulytely bowel prep mixture, but denies any issues when using the bathroom.

Integumentary: Skin is pink, warm, and dry. Skin turgor is present and elastic without tenting. Braden Q scale rating is a 27, suggesting there is no risk for this patient developing a pressure ulcer.

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 denies experiencing any pain at this time. The patient was asked to choose a face on the FACES pain scale to rate her pain, and she chose the happy face indicating a rating of "1" which suggests the child is not experiencing pain.

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	4.0-5.20	4.79	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Hgb	11-13	**13.5 (↑)**	N/A	Hemoglobin is high due to poor hydration status and in this patient. Not enough data in patient's chart to trend.
Hct	36-40%	**40.5 (↑)**	N/A	Hematocrit is high due to poor hydration status in this patient. Not enough data in patient's chart to trend.
MCV	77-95	84.6	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
MCH	25-33	28.2	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
MCHC	32-36	33.3	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
WBCs	5.0-14.5	8.86	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Neutrophils (absolute)	3.9-6.2	5.48	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Eosinophils	0-3	0.9	N/A	Not enough data in patient's chart to trend. Labs within desired limits.

Basophils	0-1	0.2	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Monocytes	3-6	6.2	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Lymphocytes	26-48	30.7	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Platelets	150-450	204	N/A	Not enough data in patient's chart to trend. Labs within desired limits.

TEST	NORMAL (specific for age)	Prior	Clinical Day	Correlation to current health status & comment on trending
Glucose	60-105 mg/dL	87 mg/dL	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Na^+	135-145 mEq/L	140 mEq/L	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Cl^-	102-112 mmol/L	104 mmol/L	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
K^+	3.5-5.0 mEq/L	4.0 mEq/L	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Ca^{++}	8.5-10.2 mg/dL	10.0 mg/dL	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Phosphorus	2.4-4.1 mg/dL	N/A	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Albumin	3.4-5.4 gm/dL	4.6 gm/dL	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Total Protein	6.0-8.3 gm/dL	7.9 gm/dL	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
BUN	7-20 mg/dL	13 mg/dL	N/A	Not enough data in patient's chart to trend. Labs within desired limits.
Creatinine	0.6-1.2 mg/dL	0.42 mg/dL	N/A	Not enough data in patient's chart to trend. Labs within desired limits.

TEST	NORMAL (specific for age)	Prior	Clinical Day	Correlation to current health status & comment on trending
Liver Function Tests	ALT: 10-35 U/L AST: 13-35 U/L	N/A	N/A	N/A
Urinalysis	Negative	N/A	N/A	N/A
Urine specific gravity	1.002 – 1.030	N/A	N/A	N/A N/A
Urine pH	4.5-8.0	N/A	N/A	N/A
Creatinine clearance	0.5 – 1.0 mg/dL	N/A	N/A	N/A
Other Labs:	N/A	N/A	N/A	N/A

Diagnostic Studies:

TEST & RESULTS	Correlation to current health status (if abnormal)
Chest x-ray: N/A	N/A
CT Scan/MRI: N/A	N/A
Biopsy/Scope: N/A	N/A
Cultures: N/A	N/A
Other: KUB x-ray of the abdomen. Results: The results listed in the patient's chart by the physician read "Gas was noted in the proximal descending colon. Otherwise, no change. Minimal stippled gas and soft tissue density of stool in the ascending colon and rectosigmoid".	A KUB is typically used to investigate GI conditions such as bowel obstruction. This test was ordered by the physician due to the patient experiencing constipation.

List of active orders on this patient:

ORDER	COMMENTS/RESULTS/COMPLETION
Activity: Up ad lib	Patient is up independently and likes to play in the play room often.
Diet/Nutrition: NPO	Patient remained NPO after 0930.
Frequent Assessments: Vital signs every 4 hours.	Vital signs were assessed every 4 hours and were within normal ranges.
Labs/Diagnostic Studies: Colonoscopy	Patient was scheduled for a colonoscopy but did not leave for it during my shift.
Treatments: Nulytely	Patient did not like Nulytely even though it was mixed with yellow Gatorade. However, the patient did drink most of it, with only 200 mL remaining prior to NPO status.
New Orders for Clinical Day	
ORDER	COMMENTS/RESULTS/COMPLETION
Diet: NPO status after 0930	Patient remains NPO after 0930 until after scheduled colonoscopy procedure in the afternoon.
N/A	N/A
N/A	N/A

Teaching & Learning: Identified teaching need (be specific): Summarize your teaching (prioritization in care, methods used, materials used, time to provide, etc.): The patient and I discussed the different foods that she could eat to help her defecate easier more often, such as oatmeal, fruits, and vegetables. Also, I educated the patient on the importance of not ignoring the urge to defecate and the importance of drinking fluids to help the patient pass softer stools.

Evaluation of your teaching (establish expected outcomes and describe if met; effectiveness of materials/approach, what next?): The patient appeared to comprehend the teaching, as she was able to repeat the information back to me. Effectiveness of approach was met. The next plan of action will include following up with the primary care provider in 7-14 days after discharge.

Developmental Assessment: Be sure to <mark>HIGHLIGHT</mark> the achievements of any milestone if noted in your child. Be sure to circle any use of diversional activity if utilized during clinical. There should be a <u>minimum</u> of 3 descriptors under each heading.

Age Appropriate Growth & Developmental Milestones

1. Possesses an awareness of themselves in relation to others, as well as an understanding of personal values, abilities, and physical characteristics (Henry et al., 2016).

2. Confidence is gained by establishing a positive self-concept, which leads to feelings of worthiness and the ability to provide contributions (Henry et al., 2016).

3. Judgment is guided by rewards and punishments (Henry et al., 2016).

Age Appropriate Diversional Activities

1. Play simple board and number games.

2. Play hopscotch.

3. Jump rope.

Psychosocial Development:

Which of Erikson's stages does this child fit? Industry vs. Inferiority (Henry et al., 2016).

What behaviors would you expect? Needs to be challenged and feel a sense of accomplishment (Henry et al., 2016).

What did you observe? The nurse challenged the patient to drink her bowel prep down to the "200 mL" line, and the patient accepted the challenge and accomplished it within the time allotted.

Cognitive Development:

Which stage does this child fit, using Piaget as a reference? Concrete operations (Henry et al., 2016).

What behaviors would you expect? Conceptual thinking, able to tell time, able to solve problems (Henry et al., 2016).

What did you observe? Patient was able to understand the procedures being explained to her, the need for them, and what would happen during the process. The patient understood that she was going to "go to sleep" during the scheduled colonoscopy and expressed that she didn't like that and wanted to be awake during the procedure.

Vocalization/vocabulary:

Development expected for child's age and any concerns? Strangers should be able to understand 90-100% of the child's vocabulary at age 7 years (Speech and Language Kids, 2019). There are no concerns for the vocabulary development of this patient. She is meeting the milestones for a 7-year-old and does not express any deficits at this time. She is able to write her first and last name, read, and express her feelings to parents and staff members when placed in different situations.

Any concerns regarding growth and development? <u>There are no concerns regarding growth and development at this time.</u>

Reference (developmental assessment):

<u>Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Elkins, C. B., Holman, H. C., … Barlow, M. S. (2016). *Rn nursing care of children: review module* (Vol. 10). Leawood, KS: Assessment Technologies Institute.</u>

<u>Speech and Language Kids. (2019). 7 Year Old Speech And Language Skills. Retrieved from https://www.speechandlanguagekids.com/what-speech-and-language-skills-should-my-7-year-old-have/</u>

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

Potential Complication	Signs/Symptoms	Preventative Nursing Actions
1. GI perforation	Severe abdominal pain and tenderness, rigid board-like abdomen, tachycardia, hypotension, diaphoresis (Capriotti & Frizzell, 2016).	NPO status, NG decompression, vital signs, fluid resuscitation, stool softener, ambulation (Capriotti & Frizzell, 2016).
2. Hemorrhoids	Extreme itching, irritation, or pain around the anus; itchy or painful lump near the anus; fecal leakage, painful bowel movements, blood on tissue after wiping (Capriotti & Frizzell, 2016).	Stool softeners, avoid straining or increasing internal sphincter pressure, adequate hydration, high fiber diet (Capriotti & Frizzell, 2016).

Nursing Care Plan

Nursing Diagnosis **Prioritize-most important to least**	Outcomes (Patient/Family will: …... and **give time line**) **(MUST BE MEASURABLE)**	Nursing Interventions **With rationale** **(At least 2 nursing interventions per outcome)**	Evaluation of **EACH** outcome
Altered bowel elimination: constipation Related to: inadequate diet, abdominal pain, ignoring the urge to defecate AEB (as evidenced by): hard formed stool on KUB x-ray, palpable impaction, and historian stating patient "hasn't pooped in 10 days".	1. The patient will have soft formed stool by time of discharge and every 2 days thereafter. 2. The patient and family will verbalize an understanding of methods for preventing fecal impactions and how to treat constipation prior to discharge.	1. Assess abdomen for distention, bowel sounds every 2 hours. Rationale: Abdominal distention can indicate that treatment is not working. Assessing for bowel sounds displays that there is movement in the GI tract. 2. Encourage a regular period for bowel elimination. Rationale: Establishing a routine can help patients remember to poop. 3. Encourage the patient ambulate. Rationale: Movement promotes GI motility.	Outcomes Met/ Partially met/ Not met (with explanation) 1. Outcome achieved. Patient is passing soft stools prior to discharge. 2. Outcome achieved. Patient and her mother were able to teach back methods for reducing constipation through modifying diet, and acknowledged that the patient should go to the bathroom when she has the urge to poop. What next? At time of discharge, schedule a follow-up appointment with primary care provider in 7-14 days.

Nursing Diagnosis **Prioritize-most important to least**	Outcomes (Patient/Family will: …... and **give time line**) **(MUST BE MEASURABLE)**	Nursing Interventions **With rationale** **(At least 2 nursing interventions per outcome)**	Evaluation of **EACH** outcome
Knowledge deficit Related to: frequent hospitalization, inadequate nutrition, and colonoscopy procedure AEB (as evidenced by): patient's mother bringing in food from Burger King, expressing anxiety for colonoscopy procedure by repeatedly stating that she does "not want to go to sleep" during the procedure, and verbalizes a deficiency in knowledge of healthy foods to help pass stools more frequently and easily.	1. The patient will be able to identify 2 foods that are high in fiber by end of shift today. 2. The patient will be able to list 2 things that will help decrease her risk of developing future fecal impactions by end of shift today.	1. Assess patient's readiness to learn by assessing her emotional response to accepting her illness. Rationale: Assessing if a patient is ready to learn new information will help her retain the information for practice outside of the hospital. 2. Assess patient's desire to learn. Rationale: Assessing the patient's desire to learn indicates that the patient is interested in learning new material and is more inclined to remember the information taught. 3. Examine patient's health beliefs. Rationale: Examining a patient's health beliefs can help the nurse establish a baseline on which corrective teaching methods to teach to the patient.	Outcomes Met/ Partially met/ Not met (with explanation) 1. Outcome achieved. Patient was able to identify that "apples and bananas" are foods that are high in fiber. 2. Outcome achieved. Patient was able to list that going to the bathroom when she gets the feeling is important, as well as needing to drink more water every day. What next? At time of discharge, schedule a follow-up appointment with primary care provider in 7-14 days.

N433 Medication Form

Patient Initials: N.F.   **Patient Age:** 7 years, 4 months   **Patient Weight (in kg):** 24.8 kg

Scheduled Medications				
Medication **Trade & Generic Names,** **Pharmaceutical Class** **Action of the medication** (how does the medication work in the body **in your own words**)	**Dose, route, & frequency ordered for this patient**	**Concentration Available** **Why is this pt. taking this?**	**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)** **Is this dose safe for this pt.?**	**2 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) **3 Contraindications** **Common side effects**
Peg-electrolyte solution (NuLytely) powder Action: This medication helps soften stools by absorbing more water which makes it easier to move through the digestive tract.	1,984 mL, Oral, once	80 mL/kg Patient is scheduled for a colonoscopy, bowel prep needed for visualization.	25 mL/kg/hour → 25 mL x 24.8 kg = 620 mL/hr… x 24 hr = 14,880 mL per 24 hours Yes, the patient's prescribed dosage of 1,984 mL is within the safe dose to give to the patient.	Nursing considerations include making sure that the patient drinks all of Nulytley bowel prep to ensure bowel visualization during colonscopy; when this medication is reconstituted, it should be used within 48 hours; and use 2 grams of NuLYTELY with 4 liters of clear liquid solution without adding any additional flavorings. The nurse should educate the patient about the importance of not consuming any solid foods or liquids that are not clear during the bowel prep procedure. Contraindications for this patient would be complete GI obstruction, ileus, or gastric retention, bowel perforation, or toxic colitis. Common side effects include: fluid/electrolyte abnormality, nausea, bloating or abdominal fullness, and vomiting (Swearingen, 2016).
D5- 0.9% Nacl with KCl 20 mEq/L (potassium chloride in 5% dextrose) Action: This medication solution helps	64 mL/hr, IV, continuous	Potassium replacement due to frequent stools due to bowel prep and	20 mEq x 250 mL = 5,000 mL/day Yes, this is within the	Nursing considerations include monitoring labs for electrolytes such as sodium and potassium prior to administering; assessing for signs of fluid volume excess

| replace fluid electrolytes in the body. | | colonoscopy. | dosage range for the patient. The patient is only scheduled 1,536 mL/day (64 mL/hr x 24 hr). | such as venous neck distention, crackles in bases of lungs, and edema; and monitoring cardiac status prior to and during treatment. No contraindications are pertinent to this patient specifically. The only contraindications include those who are allergic to corn and corn products, and those who are taking medications that are high in potassium. Common side effects include: infection at the site of injection, venous thrombosis or phlebitis extending to the injection site, extravasation, and hypervolemia (Swearingen, 2016). |

Reference:

Swearingen, P. L. (2016). *ALL-IN-ONE NURSING CARE PLANNING RESOURCE: Medical-surgical, pediatric, maternity, and ...*
    psychiatric-mental health (4th ed.). St. Louis, MO: Mosby.

N433 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. **All** 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	OLDCART, 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.	6	

	3 Age appropriate Diversional/Distraction 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.		
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, **<u>MUST</u>** 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 Possible	**100**	

Total points for this care plan   _____