Lakeview College of Nursing **Student Name** Laura Graham
N433 Pediatrics Clinical Care Plan

CLINICAL DATE 09/14/2019

Patient's Age ___6 months_____ **Weight** (in kg) **_5.68 kg____** **BMI__14.3____**
Year's months
Allergies/Sensitivities to medications, foods, contact, environmental, etc. Include reactions: No known _____

Chief Complaint (Reason for admission): Altered mental status_____Admit date: 09/04/19_____

Other co-existing conditions: N/A_____

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

5 month old girl born at full term without complications. Patient's dad didn't notice she wasn't acting her normal self, and was rather limp. Dad tried to pick her up and her head fell backwards. He noticed she wasn't looking at him and had a weak cry. He noticed she seemed cold. Patient's dad called 911 and taken to Iroquois Memorial Hospital. She was taken to ED last week because of nausea and vomiting and unable to take food.

Pertinent Events during this Admission and Hospitalization (IV starts, lab test, etc.): Low lactic acid and low bicarbonate laboratory levels.

Past Medical & Surgical History (illnesses, hospitalizations, immunizations, birth history-any complications?) Not up to date on immunizations (4 months). Normal vaginal birth, no complications.

Child's diagnosis: Suspected nonaccidental trauma **Etiology of disease process** (what causes it):_Parent shook patient (suspected), causing brain injury.
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)**

The patient's injuries are suspected to be from one of her parents shaking her from frustration. An infant's neck muscles are weak and get stronger as they grow (Mayo Clinic, 2019). An infant's brain is not fully developed at the patient's age. When an infant is shaken, their brain will bounce between the front and back of its skull, causing the brain to bleed, bruise, and swell (Mayo Clinic, 2019). It only takes a few seconds for the damage to happen. The lesions and hemorrhaging in the patient's brain are from her brain bouncing back and forth on her skull. Due to the hemorrhaging, lesions, and pressure in the patient's brain, her eyesight has also been impaired. She cannot track objects, but both of her eyes still react to light.

Reference

Mayo Clinic. (2019, June 25). What Is Shaken Baby Syndrome? Retrieved from

https://www.webmd.com/parenting/baby/shaken-baby-syndrome#1

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

Fussiness, seizures, vomiting, poor eating, irritability, dilated pupils, lethargic, bruising, breathing problems, coma.
Vital Signs: **(List your source for the Normal ranges)** T: 97.6 F HR: 125 (NL for age): 80-150 RR: 36 (NL for age): 50 B/P: 136/79

(NL for age): 100/70 O2 sat 95 Room Air or Oxygen: Room air

Reference

Ricci, Kyle, T. and Carman, S. (2017). *Maternity and Pediatric Nursing* (3rd ed.). Philadelphia: Lippincott, Williams & Wilkins.

Intake/Output: (IV, PO, Out & Deficits) 230 mL of input, 30 mL through NG tube and 200 mL through IV. 185 mL of urine output.

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

General appearance: No fever, chills or sweat. Patient is lethargic, pale, and irritable.
Head: 2 incisions on patient's head from procedure. Anterior fontanel is not closed.
Ears: TM pearly gray bilaterally. No drainage or lesions noted.
Eyes: PERRL. No accommodation noted. Patient does not track objects. Patient is suspected to be blind in both eyes. Both eyes react to light still.
Thyroid: Nonpalpable, no nodules noted. Trachea is midline.
Chest: Lung sounds are clear and unlabored bilaterally. Patient does not appear in respiratory distress. No wheezing or retractions.
CV: Regular rate and rhythm. Clear S1 and S2 sounds. No murmurs, gallops, or rubs.
Abdomen: Normoactive bowel sounds. Abdomen is soft and nondistended.
GU: Patient wears diapers. Normal amount of wet diapers throughout the day. Urine is yellow in color.
Musculoskeletal: No sprains or stiffness noted.
Extremities: Capillary refill 3 seconds, no edema/cyanosis, purple discoloration on right hand (thumb and index).
Skin: Patient is pale in color, no lesions noted. Incisions healing on head.
Other:

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: FLACC scale was used. FLACC score 4. Face: 1- Occasional grimace or frown, withdrawn, disinterested. Legs: 0- Normal position or relaxed. Activity: 1- Squirming, shifting back/forth, tense. Cry: 1- Moans or whimpers, occasional complaint. Consolability: 1- Reassured by occasional touching, hugging, or 'talking to.', distractible. No medication was given.

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	3.45-4.75	3.45	N/A	
Hgb	9.9-12.4	9.5	N/A	May be due to the excessive bleeding from the procedure to decrease the pressure in the brain or from the hemorrhage in the patient's brain (Mayo Clinic, 2018).
Hct	29.5-37.1	28.8	N/A	May be due to the excessive bleeding from the procedure to decrease the pressure in the brain or from the hemorrhage in the patient's brain (Mayo Clinic, 2019).
MCV	74.8-88.3	83.5	N/A	
MCH	24.4-29.5	27.5	N/A	
MCHC	32.1-34.4	33.0	N/A	
WBCs	6.0-13.25	16.67	N/A	May be due to an infection from the hemorrhage in patient's brain or possibly due to malnutrition (Mayo Clinic, 2018).
Neutrophils	1.04-7.20	6.48	N/A	
Eosinophils	0.02-0.74	0.02	N/A	
Basophils	0.01-0.07	0.04	N/A	
Monocytes	0.24-1.17	1.45	N/A	May be due to an infection from the hemorrhage in patient's brain (Healthline, 2016).

Lymphocytes	2.14-8.99	8.60	N/A	
Platelets	247-580	274	N/A	

TEST	**NORMAL** (specific for age)	**Prior**	**Clinical Day**	**Correlation to current health status & comment on trending**
Glucose	60-99	104	84	
Na^{+}	136-145	141	138	
Cl^{-}	98-107	107	103	
K^{+}	3.5-5.1	3.9	4.8	
Ca^{++}	8.5-10.1	8.9	9.6	
Phosphorus	N/A	N/A	N/A	
Albumin	3.4-5.0	3.1	3.2	May be due to malnutrition because the patient has been having poor oral intake for the past few days (AACC, 2019).
Total Protein	6.4-8.2	5.3	6.1	May be due to malnutrition because the patient has been having poor oral intake for the past few days (AACC, 2019).
BUN	7-18	7	8	
Creatinine	0.55-1.02	0.6	0.6	

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	**N/A**
CT Scan/MRI: of brain. Suspicious for grade 1 diffuse axonal injury.	This correlates with the patient's diagnosis because the force from the injury caused lesions in the brain.
Biopsy/Scope: N/A	**N/A**

Cultures: N/A	**N/A**
Other: X-ray of brain. Trace residual acute subdural blood over bilateral convexities. Small tentorial hematomas.	This also correlates with the patient's diagnosis because

Reference

AACC. (2019, September 16). Total protein and albumin/globulin (A/G) Ratio. Retrieved from https://labtestsonline.org/tests/total-protein-and-albuminglobulin-ag-ratio

Healthline. (2016, August 30). Blood Differential Test. Retrieved from https://www.healthline.com/health/blood-differential

Mayo Clinic. (2018, April 7). Low hemoglobin count. Retrieved from https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/causes/sym-20050760

Mayo Clinic. (2018, November 30). Low white blood cell count. Retrieved from https://www.mayoclinic.org/symptoms/low-white-blood-cell-count/basics/causes/sym-20050615

Mayo Clinic. (2019, February 12). Hematocrit test. Retrieved from https://www.mayoclinic.org/tests-procedures/hematocrit/about/pac-20384728

List of active orders on this patient:

ORDER	COMMENTS/RESULTS/COMPLETION
Activity: N/A	N/A
Diet/Nutrition: NG feedings of formula	**Every 3 hours until discontinued**
Frequent Assessments: vital signs every 4 hours	**Continuous pulse ox**
Labs/Diagnostic Studies: MRI brain with and without contrast	**Discontinued/completed**
Treatments: Administer antiseizure medications	
New Orders for Clinical Day	
ORDER	**COMMENTS/RESULTS/COMPLETION**
N/A	N/A
N/A	N/A
N/A	N/A

Teaching & Learning: Identified teaching need (be specific): Decrease risk for aspiration.

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

Teaching the family on decreasing the risk for aspiration is important because the patient has an NG tube causing the lower esophageal sphincter isn't closed. The feeding could come back up and into the patient's airway since the sphincter isn't closed. I will use the teach back method with the grandparents to ensure they know how to decrease the risk for aspiration. Decreasing the risk for aspiration include assessing the patient's airway for patency, ensuring the patient is not given a bottle while lying down, and monitoring the patient closely while feeding her.

Evaluation of your teaching (establish expected outcomes and describe if met; effectiveness of materials/approach, what next?):
The patient's grandparents will be able to understand ways to decrease the risk for aspiration. Patient's grandparents left, I was unable to give the teaching plan. Patient's mother did not visit and patient's father is not allowed to visit.

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. Releases object in hand to take another
2. Tripod sits
3. No head lag when pulled to sit

Age Appropriate Diversional Activities

1. Different types of music
2. Soft dolls or animals
3. Easy-to-hold toys that do things or make noise

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

What behaviors would you expect? Caregivers respond to the infant's basic needs, creating a sense of trust. Overtime, the infant learns to tolerate small amounts of frustration and trusts gratification will be provided, even if it is delayed.

What did you observe? Patient will develop mistrust with her parents because of the injuries she has sustained. Her parents were not in the room and the nurse couldn't be there every time she cried.

Cognitive Development: Which stage does this child fit, using Piaget as a reference? Sensorimotor

What behaviors would you expect? Infant uses senses and motor skills to learn about the world. Object permanence begins. Infants coordinate previously learned schemes with previously learned behaviors.

What did you observe? Patient's sense of hearing heightened because she is blind from her injuries. Patient will have to adjust to being blind if she doesn't regain her eyesight, it might impair her abilities to develop cognitively. The injuries she has sustained will also impair her cognitive development because she has suffered hemorrhage in her brain.

Vocalization/vocabulary: Development expected for child's age and any concerns? Infants begin squealing and babbling, which I did not observe with my patient. The patient was moaning and whimpering.

Any concerns regarding growth and development? Due to the patient's injuries, I believe it will affect her growth and development because she suffered a brain injury in the most crucial time for growth and development. The patient cannot support her head and cries often and is only comforted by being held.

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

Potential Complication	Signs/Symptoms	Preventative Nursing Actions

1. Seizures	Signs and symptoms include temporary confusion, a staring spell, uncontrollable jerking movements of the arms and legs, loss of consciousness, and cognitive or emotional symptoms.	When patient is having seizures a nurse should maintain airway, assess, monitor and document seizure activity, administer antiepileptics. A nurse should also educate the patient's family on seizure precautions.
2. Serious brain injury	Physical symptoms include nausea, vomiting, fatigue, problems with speech, difficulty sleeping, dizziness, loss of consciousness. Sensory symptoms include sensitivity to light or sound.	The nurse should put the patient closer to the nurses station. Educate the patient's family on prevention of brain injuries. The nurse should screen patients at risk for brain injuries.

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
Risk for aspiration Related to: Nasogastric tube AEB (as evidenced by): In ability to swallow and vomiting	1. Patient is free of signs of aspiration throughout the clinical day 2. Patient maintain a patent airway with normal breath sounds	1. Patient will be monitored closely when her feedings are administered because she could aspirate during the feeding because the sphincter isn't closed. 2. Check placement before feeding because the tube may be displaced, then delivering the feeding to the airway. 1. Monitor respiratory rate, depth, and effort of the patient because this will prevent further aspiration. 2. Assess for presence of vomiting because this is the greatest risk for aspiration.	Outcomes Met/ Partially met/ Not met (with Explanation) 1. The goal was met. The patient did not aspirate during her feeding at 1000. 2. The goal was met. The patient's airway remained patent throughout the clinical day. What next? Follow up with speech therapist to assess the patient's swallowing ability.

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
Impaired parenting Related to: Suspect nonaccidental trauma AEB (as evidenced by): Evidence of physical trauma to patient	1. Patient's father will not visit during the clinical day 2. Maintain safe environment for patient throughout the clinical day	1. Ask security guards to look out for patient's father because she is a confidential patient. 2. Print a picture of patient's father so the other nurses know he is not allowed to visit because it is a suspected child abuse case. 1. Include grandparents in plan of care throughout the day because the parents are not able to visit patient.	Outcomes Met/ Partially met/ Not met (with explanation) 1. The goal was met. The patient's father did not visit or try to visit the patient. 2. The goal was met. The child's safety was maintained throughout the day. What next?

		2. Do not allow any visitors not on the list of approved visitors because this could put the patient in harm.	Follow up with speech therapist and social worker because of the injuries the patient sustained.

N308 Medication Form

Patient Initials: __GW_____ Patient Age: _6 months___ Patient Weight (in kg): __5.68 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 for this child. This is done by multiplying the safe dose range by the child's weight.** **https://www.epocrates.com/liteRegHonorsRegistrationProcess.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) **Contraindications** **Common side effects**
Fentanyl (Abstral) **Opioid** **Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain.**	**5 mcg** **IV push** **Every 2 hours PRN**	**10 mcg/mL** **Patient is taking this medication for pain.**	**0.5 to 2 mcg/kg/dose** **0.5- 2 mcg/ 5.68 kg = 2.84- 11.36 mcg** **The patient is receiving 5 mcg, this is a safe dose for the child** **Maximum dose for a 24 hour period is 60 mcg in a day**	**-Monitor the patient for sedation and respiratory depression because of the head injury** **-Assess patient for evidence of overdose** **-Know an infant may experience neonatal opioid withdrawal syndrome** **-Contraindications include asthma, opioid hypersensitivity, myasthenia gravis** **-Common side effects include confusion, drowsiness, itching, diaphoresis, flushing, and respiratory depression.**
Levetiracetam (Keppra) **Anticonvulsant** **Prevents coordination of epileptiform burst from firing.**	**100 mg** **IV** **Every 12 hours**	**100 mg in 0.9% syringe** **Patient is taking this medication for**	**Initial treatment 7 mg/kg twice daily** **7mg/ 5.68 kg = 39.76 mg twice daily** **The patient is receiving more than the safe dosage range.**	**-Monitor patient for seizure activity** **-Monitor blood pressure in children and infants** **-Monitor for bleeding, fever, and recurrent infections** **-Contraindications include a**

		seizures.	**The maximum dose in a 24 hour period is 79.52mg**	**hypersensitivity to levetiracetam** **- Common side effects include headache, agitation, drowsiness, infection, and neurosis**
Methadone oral solution (Methadose) **Synthetic opiate agonist** **Binds with and activates opioid receptors in spinal cord and higher levels of CNS to produce analgesia and euphoric effects.**	**0.1 mg/kg= 0.5 mg** **Oral** **Every 6 hours**	**0.5 mg** **Patient is taking this medication for pain.**	**0.1 mg/ kg** **0.1 mg/ 5.68 kg = 0.6 kg** **This is a safe for the patient** **No more than 40 mg per day**	**-Monitor patients with head injuries because it may increase ICP** **-Monitor for adrenal insufficiency** **-Monitor patients with seizure activity** **-Contraindications include asthma, significant respiratory depression, and paralytic ileus** **- Common side effects include blurred vision, convulsions, coughing, confusion, and decreased urine output**
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.?**	**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) **Contraindications** **Common side effects**
Midazolam 1 mg/mL (Versed) injection 0.25 mg **Sedative-hypnotic** **May exert sedating effect by increasing activity of gamma-aminobutyric acid.**	**0.25 mg** **IV push** **Every 2 hours PRN**	**0.05 mg/kg** **Patient is taking this medication for seizures/sedation.**	**0.05 mg/kg** **0.05 mg/ 5.68 kg = 0.28 mg** **This is a safe dose for the patient** **No more than 6 mg per day**	**-Assess level of consciousness of patient** **-Know recovery time may be up to 6 hours** **-May be combined with D5W, normal saline, or lactated Ringer's.** **- Contraindications include coma, hypersensitivity to midazolam, and glaucoma** **- Common side effects include headache, nausea, cough, drowsiness, vomiting, and hiccups**

Phenobarbital 15 mg in 0.9% NaCl (Luminal) **Anticonvulsant, sedative-hypnotic** **Inhibits ascending conduction of impulses in the reticular formation.**	**40.9 mL/hr** **Every 12 hours** **IV piggy back**	**15 mg** **Patient is taking this medication for seizures/sedation.**	**1 to 3 mg/kg** **1 to 3 mg/ 5.68 kg = 5.7 to 17 mg** **This is a safe dose for the patient** **Do not exceed 3 doses per day**	**-Monitor blood pressure, heart rate, and rhythm** **-Know that this drug can cause respiratory depression** **-Anticipate that this drug may cause paradoxical stimulation in children** **- Contraindications include hepatic disease, severe respiratory depression, and nephritis** **- Common side effects include dizziness, headache, nausea, vomiting, and drowsiness**
Melatonin oral suspension 1.5 mg **Pineal hormone agents** **Mimics the effects of the natural hormone, sends the messages to the receptor agonist in the brain and other areas in the body to help control the sleep and wake cycles.**	**1.5 mg** **Oral** **At night**	**1.5 mg** **Patient is taking this medication to induce sleep.**	**0.5 mg/ kg** **0.5 mg/ 5.68 kg = 2.8 mg** **This is a safe dose for the patient** **Do not exceed 20 mg per day**	**-Monitor patients with seizure disorders** **-Monitor level of consciousness** **-Maintain a consistent bedtime** **- Contraindications include breast feeding and epilepsy** **- Common side effects include diarrhea, dizziness, headache, and dizziness**

Reference
Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (Eighteenth ed.). Burlington, MA: Jones & Bartlett Learning.

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. **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	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 Divirsional/Distraction activities appropriate for child's age.	6	

	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 must have a desired outcome timeline. (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 must have a desired outcome timeline. (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**	