Lakeview College of Nursing **Student Name** Madisyn Verostko
N433 Pediatrics Clinical Care Plan

CLINICAL DATE 9-21-19

Patient's Age ____0_____6__ **Weight** (in kg) **– 6.22 kg** **BMI- 15.67 kg/m2**
Year's months

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

Chief Complaint (Reason for admission): non-accidental trauma to child **Admit date:** 9-4-19

Other co-existing conditions:

- status epilepticus, increased ICP status post burr holes, retinal hemorrhage bilateral, chronic subdural hematoma, lethargy, rule out sepsis

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

- 25-week old baby girl brought to ED by dad reporting she was limp, had a "blank stare', and was not eating well and vomiting at approximately 3:45 a.m. on 9/4. Dad reports that their older daughter threw a sippy cup and hit her in the eye on 8/28. Parents took pt to ED the previous week when the sippy cup incident supposedly happened and were released. On 9/4, pt was transferred to CFH ED for higher level care. In ED, an abnormal brain CT suggested a subdural hemorrhage and neurosurgery was consulted.

Pertinent Events during this Admission and Hospitalization (IV starts, lab test, etc.):

- burr holes 9/5, optiflow 3LPM 30 Fio2, intubation (9/8), central line (9/8), telemetry monitoring (9/6-9/12), NGT feeding

Past Medical & Surgical History (illnesses, hospitalizations, immunizations, birth history-any complications?)

- Neurosurgery 9/5, previous smoke exposure

Child's diagnosis: Chronic subdural hematoma

Etiology of disease process (what causes it): head trauma, accidental or non-accidental

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)**

Subdural hematomas are among the deadliest of brain injuries. This injuring results in bleeding into the cranial space and compresses brain tissue. A chronic subdural hematoma refers to an "old" collection of blood

on and around the brain. These chronic bleeds can be ongoing for days or weeks. In chronic hematomas, the blood leaks slowly out of the veins and into brain tissue. Thus, the bleed can be ongoing for several days or weeks unknown, and progressively be destroying brain tissue.

Reference

Chronic subdural hematoma: MedlinePlus Medical Encyclopedia. (2019, September 11). Retrieved from https://medlineplus.gov/ency/article/000781.htm.

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

Chronic subdural hematomas can cause change in mental state, lethargy, headaches, vomiting, limp/numb body parts, seizures, loss of consciousness, etc. These brain bleeds can be identified via imaging such as an x-ray or MRI. On a blood test, pt's may have a decreased HH and an increased MCV and MCH due to active bleeding.

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

- T 37.1
- HR- 138, NL for age = 70-150
- RR. – 30, NL for age = 30-60 breaths/min
- B/P – 97/53, NL for age = 60/40 mmHg
- O2 sat- 100 on Room Air

Intake/Output: (IV, PO, Out & Deficits)

- last 24 hours, intake = 1285, output1232

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

- HEENT- edematous, trace 1+, but improving. Otherwise symmetrical. Fontanelles are soft and flat. 2 closed surgical incisions present on top of head where burr holes were drilled to relieve increased ICP. Facial symmetry noted. PERRLA noted but subtle. Pt's eyes are difficult to stimulate (react to light). Pt cannot follow objects with her eyes, and does not notice a hand right in front of her eyes. Pt's hearing appears to be intact as she turns her head toward sounds/voices and is soothed by music.
- Skin- 2 closed incisional wounds on top of head, healing well, no signs of infection. Skin rash present on right side of neck. Skin is rarely moist, warm, and pink.
- Respiratory – breath sounds auscultated x4 anteriorly, and x7 posteriorly- all lung fields clear. No wheezes, crackles, or rhonchi noted. Breathing is unlabored, no retractions noted.
- Cardio – heart sounds auscultated x5. Regular rate and rhythm. No gallops, murmurs, or rubs.
- GI – bowel sounds present in all 4 quadrants. Pt's last bowel movement was today (9/21). Stool is regular in color, odor, and consistency. Pt has good appetite.
- GU – no difficulties voiding.

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:

- Pt scores a 4 on the FLACC scale. Pt scored a 2 in both the "cry" and "consolability" categories, and zeroes in the rest. Pt outbursts in crying consistently even after being fed, diaper change, and multiple attempts to soothe. Pt cries real tears and her cry is constant. She is being weaned off of methadone (last dose today 9/21) and may be experiencing withdrawal and/or the presence of pain. PRN Tylenol was administered.

Lab Tests:

TEST	NORMAL (specific for age)	Prior 9/11	Clinical Day	Correlation to current health status & comment on trending (comment only on abnormal lab results)
RBCs	3.97-5.01	4.26		
Hgb	10.2-12.7	12.0		
Hct	30.9-37.8	36.2		
MCV	74.8-83.3	85		
MCH	23.2-27.5	28.2		"Mean corpuscular hemoglobin can be increased in blood where the total hemoglobin is increased and the RBC count is decreased." (Van Leeuwen & Bladh, 2017, p.389).
MCHC	31.9-34.2	33.1		
WBCs	6.48-13.02	9.6		
Neutrophils	1.27-7.18	3.23		
Eosinophils	N/A	3.9		
Basophils	N/A	0.2		
Monocytes	N/A	10.7		
Lymphocytes	N/A	51.1		
Platelets	214-459	292		

TEST	NORMAL (specific for age)	Prior 9/16	Clinical Day	Correlation to current health status & comment on trending
Glucose	60-99	82		
Na^+	136-145	138		
Cl^-	98-107	106		
K^+	3.5-5.1	4.7		
Ca^{++}	8.5-10.01	9.3		
Phosphorus	54-369	203		
Albumin	3.4-5.0	3.2		Decreased albumin can suggest malnutrition in individuals. This patient is experiencing acute malabsorption and/or malnutrition related to recent tube feedings and intubation. Pt is now feeding well with a bottle and seems to regaining strength. (Van Leeuwen & Bladh, 2017, p.16).
Total Protein	6.4-8.2	5.9		Inadequate dietary intake of protein results in a decreased serum total protein level. My patient is lacking protein likely due to recent tube feedings and lack of various nutrients. Pt is now bottle feeding and value should start trending up. (Van Leeuwen & Bladh, 2017, p.828)
BUN	7-18	6		Decreased BUN is also seen with insufficient dietary intake of protein r/t tube feeding. (Van Leeuwen & Bladh, 2017, p.1178).
Creatinine	0.55-1.02	0.18		Decreased Creatinine is also seen with insufficient dietary intake of protein r/t tube feeding. (Van Leeuwen & Bladh, 2017, p.478)

TEST	NORMAL (specific for age)	Prior	Clinical Day	Correlation to current health status & comment on trending
Liver Function Tests	N/A			
Urinalysis	N/A			
Urine specific gravity	N/A			
Urine pH	N/A			

Creatinine clearance	N/A			
Other Labs:				
INR	0.9-1.1	1.1		
Absolute immature granulocyte	0.0 – 0.14	0.04		

Diagnostic Studies:

TEST & RESULTS	Correlation to current health status (if abnormal)
Chest x-ray: • Endotracheal tube in proper placement • Enteric tube in stomach • Persistent right upper lobe atelectasis, left improving	N/A
CT Scan/MRI: • 9/4 and 9/5 – CT brain without contrast – small bilateral subdural hematoma	Burr holes were drilled on 9/5 to relieve ICP. Blood erupted from skull “like a volcano” per surgical personnel.
Biopsy/Scope: • 9/18 - fluoroscopy – barium swallow = pass, no aspiration	N/A
Cultures: N/A	N/A
Other: • 9/4 – skeletal x-ray – no acute fracture or dislocations • 9/19- skeletal x-ray – slight prominence of sutures and bulging fontanelle • 9/6 – EEG – seizures occurring q. 5 minutes	Prominence of sutures and bulging fontanelles r/t edema following neurosurgery. Problems have since resolved.

List of active orders on this patient:

ORDER	COMMENTS/RESULTS/COMPLETION
Activity: N/A	N/A
Diet/Nutrition: A lib amounts, PO bottle feeding q 3 hr, minimum 120cc	Pt is tolerating feeds well. Consuming approx.. 6 oz. q 3-4 hrs.

Frequent Assessments: vitals q. 4, I&O q shift, weight before breakfast daily, neuro assessment q4, head circumference measured daily, skin care protocol	All completed. Witnessed doctor measure head circumference.
Labs/Diagnostic Studies: N/A	N/A
Treatments: • Speech evaluation and treatment • OT evaluation and treatment • PT evaluation and treatment	

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):

Need for teaching = proper care for child ; reduction of abuse

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

- In this case, there are no subjects to be taught, as mom and dad are not allowed to be actively involved in the child's care. Mom is only allowed to visit supervised and dad is not allowed at all. The extent of the child's injuries is due to purposeful inflicted child abuse. If the parents were to be taught anything, they should be taught about the serious consequences that follow their horrendous acts of violence on their child. Due to the presentation of this child's condition, it is highly suspected that this is a shaken baby injury. It would be important to educate the parents on Shaken Baby Syndrome. After the teaching, before they leave the hospital, the parents should understand what Shaken Baby Syndrome is, how it is caused, how to prevent it, and the possible consequences of shaking a baby. Shaken Baby Syndrome occurs when a baby is shaken, thrown, dropped, or hit often due to the frustration of parents/caregivers. The infant's brain is more or less banged around in their scull. This often causes extensive and often fatal brain injury. This

condition is *very* preventable with the following recommendations; Take a deep breath and count to 10, take time out and let the baby cry alone, call someone for emotional support, call a pediatrician – there may be a medical reason why the baby is crying, never leave a baby with a caregiver, friend or family member in whom there is not complete trust, and always check references carefully before entrusting a baby to a caregiver or daycare center (Shaken Baby Syndrome, 2019).

Reference:

Shaken Baby Syndrome. (2019). Retrieved from https://www.aans.org/en/Patients/Neurosurgical-Conditions and-Treatments/Shaken-Baby-Syndrome.

Evaluation of your teaching (establish expected outcomes and describe if met; effectiveness of materials/approach, what next?):

- Goals would be met when the parents are able to verbalize what Shaken Baby Syndrome is, what actions cause it, how to prevent it, and possible complications it may result in. However, teaching cannot be performed, therefore, goal is not met.

Developmental Assessment: Be sure to HIGHLIGHT 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 minimum of 3 descriptors under each heading.

Age Appropriate Growth & Developmental Milestones

1. sits in tripod position
2. follows object with eyes
3. babbles

Age Appropriate Diversional Activities

1. music therapy
2. swing
3. pacifier

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

- Trust vs. mistrust

What behaviors would you expect?

Delayed gratification, sense of self separate from caregiver, ease of frustrations.

What did you observe?

Child was easily frustrated when receiving care. Other than feeding and sleeping, infant was easily agitated. I think a lot of this had to do with her pain.

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

- Sensorimotor

What behaviors would you expect?

Reflexive sucking, recognition of familiar objects and sounds, thumb sucking, object permanence.

What did you observe?

The child's sucking reflex was evident through well bottle feeding and habitual sucking of her hands and fingers. However, recognizing objects and object permanence were not evident (or able to assess) as the pt is likely experiencing vision loss.

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

By 6 months of age, infants should be cooing, babbling, and making some vowel sounds. This child was not doing any of these vocalizations. The only sounds she made was crying. This infant seems to be very behind in her development.

Any concerns regarding growth and development?

I am very concerned for this child's physiological, cognitive, and verbal developments. Due to her traumatic brain injury, she is suffering deficits and sadly, will likely continue to experience developmental delays throughout her life.

Reference:

Carman, S., Kyle, T., Ricci, S.S. (2017) *Maternity and Pediatric Nursing*. (3rd ed.). Philadelphia: Wolters Kluwer.

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

Potential Complication	Signs/Symptoms	Preventative Nursing Actions
1. Delayed growth and development	Age appropriate developmental milestones are not reached/demonstrated within their normal time frame.	All we can do is help to stimulate the child and provide extra help and assistance in their development. We can also make sure that the child receives all necessary resources for any special needs they may have.

2. Seizures	Sudden change of mental state, jerking movements, loss of consciousness, foaming at the mouth, emesis.	Promote calm, quiet environment. Administer prescribed anticonvulsant medications. Closely monitor patient for any changes in mental status or awareness. Implement seizure precautions. Have crash cart handy.

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 physical mobility Related to: Traumatic brain injury AEB (as evidenced by): Inability to function at recommended developmental level	1. Child will be able to support herself in a sitting position within 3 months 2. Child will be able to support her own head within 1 month	- Help assist child to tripod position and provide support, withdrawing support as allowed - Perform ROM to help increase muscle strength - Make her reach her head slightly for bottle - Consistently work with patient to create muscle memory	Outcomes Met/ Partially met/ Not met (with Explanation) 1. Goal not yet met- will take some PT/OT to help reach this goal. Continue to evaluate and treat. 2. Goal not yet met- will take some PT/OT to help reach this goal. Continue to evaluate and treat. What next? Continue to work with patient as well as have her see physical and occupational therapies to help her catch up to her appropriate developmental level.

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

Disturbed sensory perception Related to: Altered vision AEB (as evidenced by): Bilateral retinal hemorrhages	1. Pt will learn to communicate with her other senses (hearing and touch) within the next year. 2. Pt will regain some visual perception within the next year.	- Speak to her often (this may be her only perception that you are near) - Implement soothing techniques using hearing, touch, and smell (music, comforting toys/stuffed animals, blanket, aromatherapy) - Pt continues to be seen by ophthalmologist - Continue to stimulate eyes with lights and color	Outcomes Met/ Partially met/ Not met (with explanation) 1. Goal not yet met- therapy required. Continue to evaluate and treat. 2. Goal not yet met- therapy required. Continue to evaluate and treat. What next? Continue to work with, evaluate, and treat patient as necessary. Be sure to document progress.

N433 Medication Form

Patient Initials: GW Patient Age: 6 months Patient Weight (in kg): 5.88 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.?**	**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**
acetaminophen/ Tylenol Class: antipyretic / nonopioid analgesic MOA: Inhibits the synthesis of prostaglandins that may serve as mediators of pain and fever, primarily in the CNS.	86.4 mg, oral suspensionq 4 hours	100 mg/ml or 160 mg/5 ml, PRN for mild pain/ fever	10-15 mg/kg/dose 10X5.88= 58.5 mg/dose 15X5.88=88.2 mg/dose This dose is safe.	Nursing Considerations: - assess fever, note signs of presence such as diaphoresis, tachycardia and malaise - evaluate hepatic function before admin -LFTs - evaluate renal function before admin and throughout therapy - BUN and Creatinine Contraindications: - allergy to medication - renal dysfunction - liver dysfunction Common Side Effects: - agitation - atelectasis in children - constipation in children
Lactobacillus reuteri/ Gerber Soothe Class: Probiotic	5 drops 1 X daily Oral drops PO	0.25ml daily, antidiarrheal microorganism agent	5 drops/day/serving This is a safe dose	Nursing: - monitor stool patterns (diarrhea) - monitor for signs of infection - monitor VS for changes indicative of

MOA: Contains different types of microorganisms such as yeast and bacteria that are naturally found in the stomach, intestines, and vagina. Allows for normal flora to produce and assist in fighting off harmful bacteria				infection -fever, tachy, hypotension Contraindications: - weakened immune systems - patients on antibiotics because they may reduce the effectiveness of this drug Common Side Effects: - increase in stomach gas - bloating
levetiracetam/ Keppra Class: Anticonvulsant MOA: Inhibits burst firing without affecting normal neuronal excitability and may selectively prevent epileptic outbursts and seizure activity	100 mg, BID, oral solution	100 mg prefilled syringe, pt taking to treat seizures secondary to brain injury	10mg/kg/day- 30mg-kg/day 10X5.88= 58.8mg/day 30X5.88= 176.4mg/day This is a safe dose	Nursing: - assess location, duration, and characteristics of seizure activity - assess for CNS adverse effects of seizures - monitor for mood changes prior to or post seizures Contra: - hypersensitivity to drug - if mom is breastfeeding it can cross into breast milk Side effects: - weakness - Steven Johnson syndrome
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**
	0.102 mg =	0.2mg/ml,	0.02mg/kg/dose-0.1mg/kg/dos	Nursing:

lorazepam/ Ativan Class: Antianxiety Benzodiazepine MOA: Depresses the CNS by potentiating GABA, an inhibitory neurotransmitter	0.51 ml, PO oral solution, PRN	prescribed to this pt to relax CNS in the event of a seizure	e Do not exceed 2 mg 0.02mgX5.88kg= 0.1176mg/dose 0.1X5.88= 0.588kg/dose This is a safe dose	- Assess for prolonged CNS depression - assess seizure activity and record times - assess renal and hepatic labs to monitor proper function Contra: - respiratory problems in neonates - severe hypotension Side effects: - respiratory depression - bradycardia
methadone/ Dolophine Class: Opioid analgesic MOA: Binds to opiate receptors in the CNS and alters the perception of and response to painful stimuli- also produces generalized CNS depression	0.3mg =.3ml, PRN- wean off, PO oral solution	0.05mg/ml, used for pain related to traumatic brain injury as well as brain surgery	0.05mg/kg/dose-0.2mg/kg/dose 0.05X5.88= 0.294mg/dose 0.2X5.88= 1.176mg/dose This is a safe dose	Nursing: - monitor pain using FLACC scale - assess VS, monitor for CNS depression - monitor bowel function for paralytic ileus Contra: - Use with extreme caution with other sedatives - Do not use if respiratory failure is already an issue Side effects: - urinary retention - psychological dependance
nystatin/ Mycostatin Class: Antifungals (topicals) MOA: Affect the synthesis of the fungal cell wall, allowing leakage of cellular content- therefore killing fungal growth	Liberal amount on top of rash, q6 hours, topical	100,000 units/g, used to treat a candida rash on patients neck	Safe dosing range should not exceed 4 X daily This dose is safe	Nursing: - Monitor rash for growth - provide proper cleansing of rash before applying cream - apply a small amount to cover the entire affected area Contra: - hypersensitivity to the drug - avoid in patients with known intolerance

				Side effects: - burning - itching
phenobarbital/Ancalixir Class: anticonvulsants/barbiturates MOA: Depresses the sensory cortex, decreases motor activity, and alters cerebellar function. Also helps in raising the seizure threshold.	1.5 ml = 2.25mg, PO oral suspension, Q 12 hours	15mg/10ml, used to depress the CNS during surgery and to allow the brain to rest to help with healing and decreasing ICP. Also helped to stop seizure activity from reoccurring	5mg/kg/day-6mg/kg/day 5X5.88= 29.4mg/day 6X5.8835.28 mg/day This is a safe dose	Nursing: - monitor respiratory status - monitor BP and pulse - monitor for seizure activity and assess location, duration, and characteristics Contra: - Hypersensitivity to the drug - comatose patients Side effects: - respiratory depression - constipation

Reference

Sanoski, C.A., & Vallerand, A.H. (2013). *Davis's Drug Guide For Nurses*. (14th ed.). Philadelphia. F.A. Davis company

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. 3 Age appropriate Divirsional/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.	6	
Potential Medical	Complications that can occur because of primary medical diagnosis/disease/condition. Signs & Symptoms	6	

Complications	of complication. Preventative nursing actions.		
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 Possible	**100**	

Total points for this care plan _____