N433 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 12/23/2019	Patient Initials RC	Age (in years & months) 7 mo, 0 wk	Gender M
Code Status Full	Weight (in kg) 5.74 kg	BMI 21.69	Allergies/Sensitivities (include reactions) NKA

Medical History (5 Points)

Past Medical History: no significant history

Illnesses:

Hospitalizations: no previous hospitalizations

Past Surgical History: no significant history

Immunizations: Hep B at birth

Birth History: 37 weeks gestation, C-section

Complications (if any): Respiratory distress of the newborn

Assistive Devices: NG tube

Living Situation: At home with his mom, dad, and older brother

Admission Assessment

Chief Complaint (2 points): seizure activity

Other Co-Existing Conditions (if any): acute respiratory failure, hypernatremia, feeding difficulty

Pertinent Events during this admission/hospitalization (1 points): he has had multiple seizures since admission

History of present Illness (10 points):.

Patient was brought to the ER on December 23rd for seizure activity. He was given antiseizure medications including benzos as well as a bolus dose of phenobarbital. The seizures persisted and was given propofol and paralytic then was intubated. He was then sent to PICU and now on peds unit. Our main priority is watching for seizure activity and feeding him.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.status epilepticus

Secondary Diagnosis (if applicable):acute respiratory failure, hypernatremia, feeding difficulty

Pathophysiology of the Disease, APA format (20 points): Seizures are abrupt, abnormal, excessive, and uncontrolled electrical discharge of neurons within the brain that can cause alterations in level of consciousness or charges in motor and sensory ability or behavior. Pertinent Common signs and symptoms Can begin with an aura (senses alteration) and can include stiffening of muscles, LOC, confusion, sleepiness, and brief jerking. Labs to obtain include alcohol and illicit substance levels, HIV testing, and presence of excessive toxins. Diagnostic procedures include EEG, MRI, CT, CSF, and PET. Medications to give include antiepileptic and phenytoin. My patient came into the ER with having a seizure for over 10 minutes. He was given antiepileptic medications and is still receiving Keppra BID. He got an EEG and a CT. We are taking his vitals every 4 hours. While he did not have any seizure activity that day, he was sleeping most of the time.

Pathophysiology References (2) (APA):

ATI Nursing education. (2010). *Rn Adult medical surgical nursing*. Place of publication not identified.

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical,*

pediatric, maternity, and psychiatric-mental health. Place of publication not identified: MOSBY.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	**NA**
Diet/Nutrition: consult dietician	On 12/26 for tube feedings
Frequent Assessments: vitals every 4 hours	We assessed every 4 hours as ordered
Labs/Diagnostic Tests: pediatric endocrinology	On 1/9 by routine workup for hypernatremia
Treatments:	**NA**
Other:	**NA**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
No new orders	

Laboratory Data (15 points)

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

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	**4.8-7.2**	**3.3**	**No labs drawn**	**Possible mild type of anemia**
Hgb	**10-17**	**10.1**	**No labs drawn**	
Hct	**44-65%**	**31.0**	**No labs**	**Born by cesarean section**

			drawn	
Platelets	**150,000-300,000**	**408**	**No labs drawn**	**Possible infection**
WBC	**9,000-30,000**	**9.07**	**No labs drawn**	
Neutrophils	**29-47%**	**No labs drawn**	**No labs drawn**	
Lymphocytes	**38-63%**	**59.9**	**No labs drawn**	
Monocytes	**4-9%**	**8.0**	**No labs drawn**	
Eosinophils	**0-3%**	**3.0**	**No labs drawn**	
Basophils	**1-3%**	**1.7**	**No labs drawn**	
Bands	**0-5%**	**No labs drawn**	**No labs drawn**	

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

Lab	**Normal Range**	**Admission or Prior Value**	**Today's Value**	**Reason For Abnormal**
Na-	**135-150**	**141**	**No labs drawn**	
K+	**3.6-5.8**	**4.5**	**No labs drawn**	
Cl-	**94-112**	**109**	**No labs drawn**	
Glucose	**30-80**	**83**	**No labs drawn**	
BUN	**5-15**	**4**	**No labs drawn**	**Low protein diet**
Creatinine	**0.8-1.4**	**0.21**	**No labs drawn**	**Low muscle mass**
Albumin	**<3**	**2.5**	**No labs drawn**	
Total Protein	**4.6-7.4**	**No labs drawn**	**No labs drawn**	
Calcium	**50-60**	**8.9**	**No labs drawn**	

Bilirubin	**1-12**	**No labs drawn**	**No labs drawn**	
Alk Phos	**8.7-28.3**	**24.1**	**No labs drawn**	
AST	**0-140**	**31**	**No labs drawn**	
ALT	**8-72**	**31**	**No labs drawn**	
Amylase	**6-65**	**No labs drawn**	**No labs drawn**	
Lipase	**9-105**	**No labs drawn**	**No labs drawn**	

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
ESR	**0-2**	**No labs drawn**	**No labs drawn**	
CRP	**0**	**No labs drawn**	**No labs drawn**	
Hgb A1c	**<5.7**	**No labs drawn**	**No labs drawn**	
TSH	**1.7-9.1**	**3.580**	**No labs drawn**	

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

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow and clear**	**Clear and colorless**	**No labs drawn**	
pH	**6.0**	**5.0**	**No labs drawn**	
Specific Gravity	**1.010-1.025**	**1.005**	**No labs drawn**	**Possibly hypovolemic**
Glucose	**Negative**	**negative**	**No labs drawn**	
Protein	**Negative**	**Negative**	**No labs**	

			drawn	
Ketones	**Negative**	**Negative**	**No labs drawn**	
WBC	**0-4**	**2**	**No labs drawn**	
RBC	**4**	**1**	**No labs drawn**	
Leukoesterase	**negative**	**Negative**	**No labs drawn**	

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

No cultures obtained

Test	**Normal Range**	**Admission or Prior Value**	**Today's Value**	**Explanation of Findings**
Urine Culture	**Negative**			
Blood Culture	**Negative**			
Sputum Culture	**Negative**			
Stool Culture	**Negative**			
Respiratory ID Panel	**negative**			

Lab Correlations Reference (APA):

Kee, J. L. F. (2018). *Laboratory and diagnostic tests with nursing implications*. NY, NY: Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): barium swallow test, CT, MRI

Diagnostic Test Correlation (5 points): barium swallow test showed no aspiration however some fluid gets suck in pharyngeal airway, CT showed possible chronic subdural hematoma or epidermoid tumor. MRI showed multiple foci of small subcortical and deep white matter

diffusion hyperintensity within the bilateral anterior and superior frontal lobes consistent with parenchymal injuries within cytotoxic edema

Diagnostic Test Reference (APA):

Michinaga, S., & Koyama, Y. (2016, April 30). Pathogenesis of brain edema and investigation into anti-edema drugs. Retrieved January 26, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4463627/

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

Brand/Generic	**Levetiracetam (Keppra)**	**Simethicone oral drops**	**Lorazepam (Ativan)**	**Sucrose 24% (sweet-ease)**
Dose	**150 mg**	**20 mg**	**0.5 mg**	**1 ml**
Frequency	**BID**	**Q6H**	**Q4H PRN**	**PRN**
Route	**NG tube**	**PO**	**IV push**	**PO**
Classification	**anticonvulsant**	**Antiflatulant**	**Sedative-hypnotics**	**Bulk chemicals**
Mechanism of Action	**Prevents coordination of epileptiform burst firing**	**Decreases the surface tension of gas bubbles**	**Potentiates the effects of GABA and other inhibitory neurotransmitters**	**Distracts the baby**
Reason Client Taking	**Seizure activity**	**gas**	**agitation**	**pain**
Concentration Available	**150 mg**	**20 mg/0.3 ml**	**2 mg/ml**	**1 ml**
Safe Dose Range Calculation	**80-241mg**	**20 mg**	**0.5-1.0 mg**	**NA**
Maximum 24-hour Dose	**3,000 mg**	**240 mg**	**4 mg**	**NA**
Contraindications (2)	**hypersensitivity**	**hypersensitivity**	**Glaucoma, hypersensitivity**	**None**
Side Effects/Adverse	**Drowsiness, headache**	**Loose stools, agitation**	**Tachycardia, sleep apnea**	**none**

Reactions (2)				
Nursing Considerations (3)	**Children weighing 20 kg or less should be only given oral solution, monitor patient for seizure activity, monitor BP**	**Shake well before use, can cause false-negative gastric guaiac test**	**Use with caution in children and elderly, for IV use, dilute with an equal amount of sterile water, monitor respirations**	**Give 2 minutes before procedures, give in pacifier or by oral syringe**
Client Teaching needs (2)	**May cause irritability, notify the prescriber at the first sign of a rash**	**Burp the infant every 2 ounces to reduce gas, do not exceed 240 mg/day**	**CNS effects, report nausea or vomiting**	**Give this in pediatrics instead of pain medication**

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A+Ox4 Patient does not show emotional or respiratory distress Appears well-nourished. He was sleeping most of the day.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin appeared pink, warm and dry Temperature was 97.8 degrees No rashes. His face had some minor scratches. No bruising or wounds. Skin turgor was normal, capillary refill less than 3 seconds Braden score of 18 No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Head appeared normocephalic for his age. ears are clear bilaterally Nasal passages are clear and moist no teeth Eyes were rolling back

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Heart sounds appeared normal. No murmurs. Peripheral pulses were normal 3+. Lower extremities showed edema. No neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No adventitious lung sounds. No accessory muscle use needed. Respiratory rate was 32 which is in normal ranges for an infant.
GASTROINTESTINAL (2 points): **Diet at home:** **Current diet:** **Height (in cm):** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Was breast fed before admission, now on formula. Family was consulted numerous times about a g-tube for feedings until the baby gains weight but the family refuses. The patient has an NG tube in right nostril. 32 cm long Bowel sounds active in all four quadrants No pain upon palpation No distention, incisions, scars, drains, or wounds Last BM was this morning No ostomy.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Color of urine was dark amber No output while we were there No pain with urination No dialysis No catheter Normal uranalysis
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:**	Active ROM Moves all extremities Fall risk associated with seizure precautions

Supportive devices: **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	I saw many states of consciousness; deep sleep, light sleep, quiet alert, during assessment he was active alert Moves all extremities Pupils equal, round, and reactive to light Strength was equal in all extremities bilaterally
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s) of caregiver(s):** **Social needs (transportation, food, medication assistance, home equipment/care):** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The mother and father were there the whole time besides stepping out for smoke breaks. They have another son who is staying with the grandparents. Open DCFS case, need to notify the case manager before discharge

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:38	163	103/72	32	97.8	100

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

Pulse Rate	**80-220**
Blood Pressure	**65-78/41-52**
Respiratory Rate	**30**
Temperature	**98.6**
Oxygen Saturation	**95-100**

Normal Vital Sign Range Reference (APA):

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Roland, P., Wilford, K. L., & Barlow, M. S. (2016). *Rn maternal newborn nursing: review module*. Leawood, KS: Assessment Technologies Institute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
07:40	**FLACC**	**na**	**3**	**na**	**pacifier**
Evaluation of pain status *after* intervention	**No pain**				
Precipitating factors: We woke him up to take his vitals and do an assessment **Physiological/behavioral signs:** He made some faces and whimpered when we woke him up					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
280	232

Developmental Assessment (6 points)
Be sure to highlight the achievements of any milestone if noted in y our child. Be sure to highlight any use of diversional activity if utilized during clinical. There should be a minimum of 3 descriptors under each heading

Age Appropriate Growth & Development Milestones

1. Developing fine and gross motor skills
2. Recognizing sounds
3. Focuses on near objects

Age Appropriate Diversional Activities

1. Stimulating senses

2. Short attention span
3. Solitary play

Psychosocial Development:

Which of Erikson's stages does this child fit? Trust vs mistrust

What behaviors would you expect? Trust, engagement with parents and staff

What did you observe? Parents were feeding and holding him, caring for his feeds

Cognitive Development:

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

What behaviors would you expect? Separation, object permanence, mental representation

What did you observe? He was engaging in his toys in his crib

Vocalization/Vocabulary:

Development expected for child's age and any concerns? Speech therapy observed feedings and saw delayed gulping

Any concerns regarding growth and development?

Seizure activity and long hospitalizations keep him from a normal life in his home

N433 Care Plan

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Inadequate nutrition related to difficulty during feeding as evidenced by the baby only taking 1-2 ounces at a time	He is not eating as much as he needs to be	1.Weighing the baby daily and recording intake and output 2.having him eat every 4 hours to make him hungry so he eats more	We started with 4 ounces. He only ate about half by bottle and the rest of the bottle was fed by the NG tube. His net input for my shift was 48 ml.
2. Risk for aspiration related to seizure precautions as evidenced by coughing during feedings	Coughing during feedings	1. teaching the parents to stop and burp during feedings 2.teaching how to properly hold the baby to prevent acid reflux or spitting up	Mom made sure to stop feeding if the baby started to cough and held him upright instead of on her chest
3. Risk for delayed development related to seizure activity as evidenced by multiple seizures since admission	Diagnosed with status epilepticus	1. monitoring for seizure activity 2asses vital signs every 4 hours	The baby did not have any seizures in a few weeks and we avoided any triggers by keeping the lights dim and a calm environment. I assessed his vital signs every 4 hours as ordered
4. Risk for impaired skin integrity related	The tape on his check could	1. asses the check for redness	His cheeks showed no redness or breakdown

to NG tube as evidenced by tape to secure it	cause skin breakdown	2. ensure the placement of the NG tube	

Other References (APA):

Ralph, S. S., & Taylor, C. M. (2014). *Sparks & Taylors nursing diagnosis pocket guide*. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health.

Concept Map (20 Points):

N433 Care Plan

Subjective Data

The parents state he sleeps most of the time.

Objective Data

CT showed possible chronic subdural hematoma or epidermoid tumor
MRI showed parenchymal injuries
Net intake of 48 ml
Coughing during feedings
FLACC scale of 3 assessing vital signs
Barium swallow test showed delayed gulping

Patient Information

Patient is a 7-week-old male who presented at the emergency department for seizure activity. He was diagnosed with status epilepticus.

Nursing Diagnosis/Outcomes

Inadequate nutrition related to difficulty during feeding as evidenced by the baby only taking 1-2 ounces at a time
Outcome: We started with 4 ounces. He only ate about half by bottle and the rest of the bottle was fed by the NG tube. His net input for my shift was 48 ml.
Risk for aspiration related to seizure precautions as evidenced by coughing during feedings
Outcome: Mom made sure to stop feeding if the baby started to cough and held him upright instead of on her chest
Risk for delayed development related to seizure activity as evidenced by multiple seizures since admission
Outcome: The baby did not have any seizures in a few weeks and we avoided any triggers by keeping the lights dim and a calm environment. I assessed his vital signs every 4 hours as ordered
Risk for impaired skin integrity related to NG tube as evidenced by tape to secure it
Outcome: His cheeks showed no redness or breakdown

Nursing Interventions

Monitor vital signs: Pulse oximetry, blood pressure, heart rate, and respiration rate. Report significant findings.
Auscultate breath sounds frequently.
Assess patient's pain.
Monitor for signs of seizure.
Administer Keppra through NG
Teach the parents to hold the baby properly during feedings
Feed through NG
Administer simethicone drops after feedings
Establish honest, therapeutic communication in an empathetic manner
Explain all interventions, diagnostics and medications