

N433 Care Plan # 1

Lakeview College of Nursing

Lindsey Davis

Demographics (3 points)

Date of Admission 1/22/2020	Patient Initials MI	Age (in years & months) 2yrs 39wks	Gender Female
Code Status Full	Weight (in kg) 13.14kg	BMI 17.88	Allergies/Sensitivities (include reactions) Milk & Beef -Anaphylaxis -Hives, nausea, vomiting, and wheezing

Medical History (5 Points)**Past Medical History:**

Illnesses: No prior illness other than the common cold prior to this hospitalization.

Hospitalizations: No other hospitalizations

Past Surgical History: No surgical history

Immunizations: Hep B, RV, DTaP, PCV13, IPV, Influenza, MMR, Varicella, Hep A

Birth History: Delivered at OSF Hospital at 36 weeks normal vaginal birth.

Complications (if any): No complications

Assistive Devices: None needed

Living Situation: Lives at home with both mom, dad and older brother.

Admission Assessment

Chief Complaint (2 points): Right eye deviation and unsteady gait

Other Co-Existing Conditions (if any): None, previously healthy child

Pertinent Events during this admission/hospitalization (1 points): Direct admission to Pediatric unit.

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History of present Illness (10 points): Parent noticed unsteady gait and right eye deviation five days before admission. Patient was taken to PCP, who referred patient to Neurology clinic.

When seen in Neurology clinic provider wanted to direct admit for further testing.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): 6th Nerve Palsy, Right

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points):

Sixth nerve palsy is a rare nerve disorder with damage affecting the sixth cranial nerve. The disorder doesn't allow for the muscles that control the eye to work appropriately. Like this patient who's eye deviates inward and was unable to move the eye toward the ear. Other signs and symptoms could include double vision, headaches, and pain around the eye. Sixth nerve palsy can be caused by things such as stroke, brain aneurysm, diabetic neuropathy, trauma, infection, inflammation, tumors, migraine headaches or intracranial pressure. And then there could be no explanation for the condition.

Regardless of the cause it is imperative that the condition be addressed quickly, if efforts to reverse the symptoms. Test such as eye examinations, blood tests, CT scan, MRI scan or spinal tap may all be done in efforts to find the cause to provide the best treatment. In some cases the sixth nerve palsy will resolve without treatment. However, if inflammation of the sixth nerve is present medications such as corticosteroids will be administered through IV. Other things that can help with the disorder are wearing an eye patch with double vision. If the symptoms do not correct strabismus surgery may be an option.

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Depending on the underlying cause of the condition, the prognosis can change. If due to an illness the symptoms can completely resolve. However, if due to a trauma their may be some residual symptoms for a lifetime.

Pathophysiology References (2) (APA):

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

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Regular activity as tolerated	Up to playroom multiple times
Diet/Nutrition: Regular (except allergies)	Eating (chicken fries) and drinking normally
Frequent Assessments: Vitals q4, Nero q4	Continuing to monitor for improvements
Labs/Diagnostic Tests: No new labs or tests	No changes
Treatments: IV solumedrol 1x daily/q4 nero checks	Patient lost IV at 5:30am, will need it replaced in the afternoon before 5pm dose.
Other:	
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
Oral tylenol	Pain infiltrated IV
Bedside Urine Strip Test	Not completed during clinical
OT evaluation	Due to unsteady gait

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	4.0-5.5 micro/L	4.20		
Hgb	9.5-14 g/dL	11.2		
Hct	30-40%	33.6		

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Platelets	200,000-475,000 mm ³	318,000		
WBC	6,200-17,000 mm ³	10,124		
Neutrophils	2,500-8,000 mm ³	6,004		
Lymphocytes	1,000-4,000 mm ³	1,001		
Monocytes	100-700 mm ³	800		
Eosinophils	50-500 mm ³	455		
Basophils	25-100 mm ³	28		
Bands	.0-1%	.009		

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-	134-150 mEq/L	140		
K+	4.1-5.3 mEq/L	4.6		
Cl-	90-110 mEq/L	109		
Glucose	60-110 mg/dL	82		
BUN	5-18 mg/dL	14		
Creatinine	0.3-0.7 mg/dL	0.38		
Albumin	4.4-5.4 g/dL	3.9		Low albumin can signify malnutrition, due to the patient not being able to have milk or beef this may put the labs at a lower value than normal.
Total Protein	6-6.7 g/dL	7.1		Total Protein can be effect by steroids which the patient is on and might be why its high.

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Calcium	9.0-10.6 mg/dL	9.7		
Bilirubin	0.3-1.0 mg/dL	0.3		
Alk Phos	65-210 Units/L	29		Low Alk phos could possibly have something to do with malnutrition due to the food allergy.
AST	15-60 Units/L	42		
ALT	8-72 Unit/L	29		
Amylase	6-65 units/L	N/A		
Lipase	0-160 Units/L	N/A		

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	up to 10 mm/hr	4		
CRP	1.0-3.0 mg/L	0.52		
Hgb A1c	1.8-4.0%	N/A		
TSH	3-18 micro units/mL	2.130		This level can be related to not enough iodine in a child's diet.

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	Clear/yellow	N/A		
pH	4.6-8.0	N/A		
Specific Gravity	.005-1.030	N/A		

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Glucose	Negative	N/A		
Protein	Negative	N/A		
Ketones	Negative	N/A		
WBC	Negative	N/A		
RBC	Negative	N/A		
Leukoesterase	Negative	N/A		

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

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

Lab Correlations Reference (APA):

Pagana, K. D., & Pagana, T. J. (2018). *Mosby's manual of diagnostic and laboratory test (3rd)*.

St. Louis, MO; Elsevier.

Diagnostic Imaging**All Other Diagnostic Tests (5 points):**

Magnetic Resonance Imaging (MRI) of brain w/o contrast

Lumbar puncture (LP)

Diagnostic Test Correlation (5 points):

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In this patient's case these tests were performed to rule out causes for Sixth nerve palsy. With the MRI they were looking for a tumor/lesions or anything that might be pressing on the Sixth nerve not allowing it to work correctly. The MRI came back with no intracranial abnormalities, unremarkable. The LP was completed to look for infections that could cause this such as meningitis and also increased intracranial pressure. This test also came back with no signs of infection or abnormalities. This leading the medical team to believe the patient was under extreme stress from a recent trip cause this issue.

Diagnostic Test Reference (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

Current Medications (8 points)

****Complete ALL of your patient's medications****

Brand/Generic	famotidine/ Pepcid	methylpred nisolone/ Solu-medrol	acetaminop hen/ Tylenol	epipen/ Epinephrine	D5 0.4500 NaCl w/ Kcl 20 meq
Dose	6.72 mg	400 mg	160 mg	0.15 mg	10 mL/hr
Frequency	2x daily	1x daily	PRN	PRN	Continuous
Route	Oral	IV	Oral	IM	IV
Classification	Antiulcer agent	Synthetic glucocortico id	Analgesics	Anaphylaxi s	Monosacch aride
Mechanism of Action	selectively antagonizes histamine H2 receptors	Exact mechanism of anti- inflammator y action unknown;	Antipyretic effect via direct action on the hypothalami c heat- regulating center	Stimulates alpha and beta adrenergic receptors	Dextrose is readily metabolized and undergoes oxidation to carbon dioxide and water.
Reason Client Taking	Prevent ulcers from	For the treatment of	Pain control for	As needed for allergy	To help keep IV

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	forming due to high doses of steroids.	6th Palsy	infiltrated IV	to Milk and Beef	patent
Concentration Available					
Safe Dose Range Calculation	0.25 mg/kg every 12hr.	0.42-1.67 mg/kg daily in divided doses three times daily or four times daily	80 mg every 4 hrs	10 mcg/kg of 1:1,000 solution repeated every 15min for 3 doses	0.5 to 1 g/kg/dose
Maximum 24-hour Dose	40 mg daily	60 mg/24hr	480 mg in 24 hr	300 mcg/dose	25 g/dose
Contraindications (2)	Hypersensitivity to famotidine, other H ₂ -receptor antagonists, or their components	Fungal infection, hypersensitivity to methylprednisolone or its components	Caution if hepatic impairment. Caution if renal impairment.	Respiratory difficulty, pulmonary edema	Diabetic coma with excessively elevated blood glucose level. overhydration.
Side Effects/Adverse Reactions (2)	Abdominal pain, bronchospasm	Easy bruising, pulmonary edema	Hepatotoxicity, anemia	Palpitations, tachycardia	confusion, glycosuria
Nursing Considerations (3)	Shake oral suspension vigorously 5-10 seconds. Dilute injection form with normal saline solution or other solution to 5-10 ml. Be aware that Pepcid AC chewable tablets	Monitor blood glucose level. Be aware that changes in thyroid function. Arrange for low-sodium diet with added potassium.	Store suppositories under 80 F. Monitor renal function in patients on long term therapy. Monitor the end of a parenteral infusion to prevent possibility of air embolism.	caution if hypertension. caution if coronary artery disease. Shake suspension thoroughly before withdrawing dose; refrigerate it between uses.	assess infusion site regularly. assess patients blood glucose level frequently. Monitor patient for signs of hypervolemia such as jugular vein distention and crackles.

	contains aspartame.				
Client Teaching needs (2)	Advise patient to notify prescriber if she develops pain, has trouble swallowing, or if she has bloody vomit or black stool. Caution patient not to take famotidine with other acid reducing product.	Inform patient that insomnia and restlessness usually resolve after 1 to 3 weeks. Caution patient not to stop taking abruptly or to change dosage without consulting prescriber.	Educate that tablets may be crushed or swallowed. Know that concentrated infant drops are being phased out and are no longer manufactured. Teach family to recognize signs of hepatotoxicity, such as bleeding.	Warn patients not to exceed the recommended dosage. Advise patient to notify prescriber if symptoms don't improve or if they improve but then worsen. Instruct patient to take the day's last dose a few hours before bedtime to avoid insomnia.	emphasize importance of reporting discomfort, pain, or signs of infection at IV site.

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	Awake playing at bedside with parents, orientated to parents. No distressed witnessed, overall appropriate to hospitalization.
INTEGUMENTARY (2 points): Skin color:	Patients skin is pink, soft dry and warm. Patients stomach and back appeared well moisturized, and

Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	no rashes detected. Cap refill normal less than 3 seconds. Skin turgor was normal, 1 second of tenting. No wounds detected. One bruise in right AC from IV start. Swelling in upper right arm due to IV infiltration. Braden score is a 2.
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:	Head and neck appear in normal limits for age. No jugular vein distention, no carotid bruit. Ears are within normal limits pearly grey tympanic membrane. Patients left eye normal, right eye deviates towards center. Right eye does not abduct to right side. Demonstrated by holding up a toy and attempting for patient to follow. Patient has an appropriate amount of teeth for age. Thyroid was unremarkable.
CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:	Regular rate and rhythm. S1 and S2 are normal. No murmurs/rubs/or gallops, point of maximal intensity non displaced. Capillary refill was normal. Edema was noted at IV infiltration site upper right arm, mild +1
RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	.Patient does sound clear in upper and lower lungs bilaterally on auscultation. No rales/rhonchi/wheezes
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:	.Patient follows a normal diet at home with the exception of her allergies milk and beef. Parents brought in all food in efforts to prevent cross contamination. Patients height is 86.5cm. Normal bowel sounds in all four quadrants (sounds heard within 1 minute). Resonant to percussion, soft, non-distended and non-tender, no rebound or guarding, no hepatomegaly. no palpable masses. No scars, incisions, drains or wounds noted. Last bowel movement was 1/24, per parents it was large, brown and soft.

<p>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p>	
<p>GENITOURINARY (2 Points):</p> <p>Color:</p> <p>Character:</p> <p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p> <p>Size:</p>	<p>Patient’s urine is light yellow to clear. No visible sediment, no foul smell. Patient wears diapers and is urinating well.</p>
<p>MUSCULOSKELETAL (2 points):</p> <p>Neurovascular status:</p> <p>ROM:</p> <p>Supportive devices:</p> <p>Strength:</p> <p>ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input checked="" type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	<p>.Patient has complained of pain at IV infiltration site. no signs of pallor, pulses 3+ is within normal range on all extremities. Patient is able to participate in ROM. Patient does need help with ADL which is appropriate for pt age. Patient had a mild gait imbalance putting her at risk for falls. Computer fall risk score was 0. Patient walked on tiptoes, parents stated this was baseline for her. Patient did not require any assistive equipment.</p>
<p>NEUROLOGICAL (2 points):</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</p> <p>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</p>	<p>.Patient had Q4 hours neuro assessments. Patients pupils were equal, round, and reactive to light when assessing with pen light. Right pupil was hard to assess at times due to deviation. Patient was orientated to person and parents, normal for age. Patients level of consciousness was within normal limits, and easily arousable with sleeping.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points):</p> <p>Coping method(s) of caregiver(s):</p> <p>Social needs (transportation, food, medication assistance, home equipment/care):</p> <p>Personal/Family Data (Think about home</p>	<p>Patient coped by cuddling with mom or dad and her favorite blanket. All normal for her age. Patient didn’t require any social needs. Parents were both at bedside the whole stay functioning appropriately.</p>

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environment, family structure, and available family support):	
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Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:50	97	107/70	36	98.7 F	94

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

Pulse Rate	60 to 110/min (depending on activity)
Blood Pressure	Systolic- 83 to 114 Diastolic- 38 to 67
Respiratory Rate	21 to 25/min
Temperature	99.9 F
Oxygen Saturation	90-100 %

Normal Vital Sign Range Reference (APA):

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*. Leawood, KS: Assessment Technologies Institute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:50pm	Faces	Arm /shoulder	3	Ouchy	Heat Pack
Evaluation of pain status <i>after</i> intervention	Faces	Arm /shoulder	3	Still Ouchy	Comfort measures given
Precipitating factors: IV infiltration site Physiological/behavioral signs: Holding are and saying “ouchy”					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
390	470

Developmental Assessment (6 points)

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 & Development Milestones

1. Patient was using multi-word sentences
2. Independence, patient wanted to attempt to do things own her own.
3. Could turn a page in a book.

Age Appropriate Diversional Activities

1. Blowing bubbles
2. Light spinner
3. Shape sorter

Psychosocial Development:

Which of Erikson's stages does this child fit?

Autonomy vs. shame and doubt

What behaviors would you expect?

Separates from parents. Withstands delayed gratification, negativism abounds.

What did you observe?

The patient wanted to try things on her own without parents helping such as dipping her chicken fries in ketchup. She did tend to want mom and dad more than a normal child this age, however I think this may still be appropriate due to the hospitalization regression can happen.

Cognitive Development:

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

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Preoperational

What behaviors would you expect?

Uses all senses to explore environment

imitates domestic chores

starting to think before acting.

What did you observe?

Watch patient play in car and pretend to drive.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

Patient was able to put together multi word sentences "you listen to my heart and belly". Which is normal for this age.

Any concerns regarding growth and development?

This child seemed to be right on track for development.

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. Acute pain related to cellulitis of right arm as evidenced by infiltrated IV site.	Patient was complaining of pain in the morning.	1. Heat pack 2. Tylenol	pt was provided both and responded well.

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<p>2. At risk for infection related to lumbar puncture.</p>	<p>Patient had a LP allowing for bacteria to enter the site into the spine leading to infection.</p>	<p>1. No baths 2. good hygiene</p>	<p>Educated and provided parents with bath wipes</p>
<p>3. At risk for falls related to unsteady gait as evidenced by sixth nerve palsy side effect.</p>	<p>Patient had mild unsteady gait and walked on tip toes.</p>	<p>1. remove tripping hazards 2. Keep parents close by</p>	<p>Patient responded well and had zero fall on my shift.</p>
<p>4. Readiness for enhanced resilience as evidenced by good coping skills.</p>	<p>Patients coping skills.</p>	<p>1. continuing to learn 2. Learning how to cope</p>	<p>Patient is very strong willed and does what she wants when she wants.</p>

Other References (APA):

Ladwig, G. B., & Ackley, B. J. (2016). *Mosbys Guide to Nursing Diagnosis*. Elsevier Health Sciences.

Concept Map (20 Points):

Subjective Data

Parents state: pt deviated eye started 5 days prior to admission. Pt does not seem to complain of pain. No trauma or illnesses leading up to this.

Nursing Diagnosis/Outcomes

Acute pain related to cellulitis of right arm as evidenced by infiltrated IV site.

At risk for infection related to lumbar puncher.

At risk for falls related to unsteady gait as evidence by sixth nerve palsy side effect.

Readiness for enhanced resilience as evidenced by good coping skills.

Objective Data

Patients vitals are within normal limits. Notices mild unsteady gait. Patient has trouble grabbing things. Patients left eye is normal, right eye is deviated towards center.

Patient Information

2yrs 39 wks
Female
13.14kg 17.88 BMI
Height 86.5cm
Allergies to milk and beef

Nursing Interventions

- Heat pack
- Tylenol
- No baths
- good hygiene
- remove tripping hazards
- Keep parents close by
- continuing to learn
- Leaning how to cope

