

N433 Care Plan 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 1-22-2020	Patient Initials LC	Age (in years & months) 12 weeks	Gender F
Code Status Full Code	Weight (in kg) 3.72 kg	BMI 10.13 kg/m ²	Allergies/Sensitivities (include reactions) NKDA

Medical History (5 Points)

Past Medical History: Late pre-term

Illnesses: Hypoglycemia at birth

Hospitalizations: 10-13-19 Newborn with complications, 1-22-2020 seizure-like activity

Past Surgical History: None

Immunizations: Hepatitis B on 11-05-19

Birth History: Born at 36 weeks, 8 days in NICU after birth, C-Section

Complications (if any): Hypoglycemia, Preterm, Small for Gestational Age (SGA)

Assistive Devices: None

Living Situation: Home with parents and 3 siblings

Admission Assessment

Chief Complaint (2 points): “Stiffening and unresponsiveness”

Other Co-Existing Conditions (if any): None

Pertinent Events during this admission/hospitalization (1 points): None

History of present Illness (10 points): Infant presented to the ED on 1-22-2020 by car with mother and father. Patient is a 12 week old African-American female born at 36 weeks via C-Section. Mother reported that patient was unresponsive, stiff, and foaming at the mouth. The episode would last for a few seconds and would occur a few times a week. Now the episodes have progressed to more frequent and prolonged (2-3minutes per episode).

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Seizures (Neonatal)

Secondary Diagnosis (if applicable): Not applicable

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

The most common cause of neurological dysfunction in newborns are seizures.

Determining the underlying cause of neonatal seizures is critical. Most seizures in newborns only last a few days and fewer than half of affected infants develop seizures later in life. The presence of a seizure is usually the first sign of cognitive dysfunction and developmental impairment (Sheth, 2020). The three main classifications of seizures are clonic, tonic, and myoclonic seizures. Clonic seizures often involve one extremity or one side of the body. The rhythm of a clonic seizure is slow, at one to three movements per second. Tonic seizures may involve one extremity or the whole body. Myoclonic seizures may occur in one extremity or several parts of the body.

During a neonatal seizure energy-dependent ion pumps are compromised, and adenosine diphosphate (ADP) levels rise. A rise in ADP will stimulate glycolysis. In other words, seizures occur when large groups of neurons undergo excessive depolarization.

Clinical manifestations differ depending on the classification of the seizure. However, some prominent signs include random eye movements, sucking, smacking, or chewing tongue, unusual pedaling movements of the legs, and long pauses in breathing (Yozawitz, 2019).

Identifying the underlying cause of a seizure is vital in treatment. Some diagnostic test or procedures to consider are serum glucose and electrolytes. Hypocalcemia is a cause of neonatal seizures. TORCH infection studies are done to rule out rubella, CMV, and herpes. Epilepsy

panel/genetic testing can be performed to identify if the cause is related to a genetic predisposition. The most common diagnostic procedure when seizures occur are long-term EEGs. A long-term EEG has the capability of recording the EEG over long periods of time and not a specific duration.

Treatment of seizures⁴ include antiepileptic drug therapy for three months. After three months, if the patient remains seizure free then the medication can be tapered down.

Pathophysiology References (2) (APA):

Sheth, R. (2020, January 6). Neonatal Seizures Medication: Anticonvulsants, Other, Vitamins, Water-Soluble. Retrieved from <https://emedicine.medscape.com/article/1177069-medication#2>

Yozawitz, E. (2019, July 31). Neonatal Seizures. Retrieved from https://www.medlink.com/article/neonatal_seizures

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	Patient is sleeping majority of visit expect for when she is feeding or being held by parent.
Diet/Nutrition:	Regular diet via formula
Frequent Assessments:	Vital signs and EEG monitoring
Labs/Diagnostic Tests:	LTM EEG and MRI (possibly, if ordered after EEG)
Treatments:	LTM EEG
Other:	Not applicable
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
LTM EEG	Prolonged EEG (overnight) study and then MRI if indicated by physician

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	Admission	Today's	Reason for Abnormal Value
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N433 Care Plan

	Range (specific to the age of the child)	or Prior Value	Value	
RBC	4.8-7.2	n/a	n/a	Labs not available/drawn
Hgb	10-17 g/dL	n/a	n/a	Labs not available/drawn
Hct	44-65%	n/a	n/a	Labs not available/drawn
Platelets	150-300,000	n/a	n/a	Labs not available/drawn
WBC	9,000-30,000	n/a	n/a	Labs not available/drawn
Neutrophils	29-47%	n/a	n/a	Labs not available/drawn
Lymphocytes	38-63%	n/a	n/a	Labs not available/drawn
Monocytes	4-9%	n/a	n/a	Labs not available/drawn
Eosinophils	0-3%	n/a	n/a	Labs not available/drawn
Basophils	1-3%	n/a	n/a	Labs not available/drawn
Bands	0-5%	n/a	n/a	Labs not available/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-	134-150	n/a	n/a	Labs not available/drawn
K+	3.6-5.8	n/a	n/a	Labs not available/drawn
Cl-	94-112 mEq/L	n/a	n/a	Labs not available/drawn
Glucose	60-99 mg/dL	n/a	n/a	Labs not available/drawn
BUN	5-15 mg/dL	n/a	n/a	Labs not available/drawn

N433 Care Plan

Creatinine	0.8-1.4	n/a	n/a	Labs not available/drawn
Albumin	3.4-5 g/dL	n/a	n/a	Labs not available/drawn
Total Protein	4.6-7.4	n/a	n/a	Labs not available/drawn
Calcium	8.5-10.1	n/a	n/a	Labs not available/drawn
Bilirubin	1-12 mg/dL	n/a	n/a	Labs not available/drawn
Alk Phos	54-369	n/a	n/a	Labs not available/drawn
AST	15-37 u/L	n/a	n/a	Labs not available/drawn
ALT	8-71 u/L	n/a	n/a	Labs not available/drawn
Amylase	6-65 u/L	n/a	n/a	Labs not available/drawn
Lipase	9-105 u/L	n/a	n/a	Labs not available/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 mm/H	n/a	n/a	Labs not available/drawn
CRP	0	n/a	n/a	Labs not available/drawn
Hgb A1c	>5.7	n/a	n/a	Labs not available/drawn
TSH	1.7-9.1	n/a	n/a	Labs not available/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
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Color & Clarity	Pale yellow	n/a	n/a	Labs not available/drawn
pH	7.36-7.44	n/a	n/a	Labs not available/drawn
Specific Gravity	1.003	n/a	n/a	Labs not available/drawn
Glucose	Negative	n/a	n/a	Labs not available/drawn
Protein	Negative	n/a	n/a	Labs not available/drawn
Ketones	Negative	n/a	n/a	Labs not available/drawn
WBC	0-4	n/a	n/a	Labs not available/drawn
RBC	Negative	n/a	n/a	Labs not available/drawn
Leukoesterase	4,500-11,000	n/a	n/a	Labs not available/drawn

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	n/a	Labs not available/drawn
Blood Culture	Negative	n/a	n/a	Labs not available/drawn
Sputum Culture	Negative	n/a	n/a	Labs not available/drawn
Stool Culture	Negative	n/a	n/a	Labs not available/drawn
Respiratory ID Panel	Negative	n/a	n/a	Labs not available/drawn

Lab Correlations Reference (APA):

Kee, J. L. F. (2018). *Laboratory and diagnostic tests with nursing implications* (9th ed.). NY, NY: Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EEG only for now

Diagnostic Test Correlation (5 points): EEG shows T5 sharp waves and spikes, slowing temporal plane on the left, primary posterior quadrant.

Diagnostic Test Reference (APA): (Medical Chart, January 24, 2020)

Current Medications (8 points)

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

Brand/Generic	Pediatric Multivitamin	Tylenol/acetaminophen			
Dose	1 mL	15 mg/kg			
Frequency	Daily	Q4hr/PRN			
Route	PO drops	PO			
Classification	Eprescribe	Antipyretic			
Mechanism of Action	Used to treat or prevent vitamin deficiency	Acts on hypothalamus to produce antipyresis			
Reason Client Taking	Vitamin deficiency prevention	Mild pain or fever			
Concentration Available	1 mL	80mg/0.8 mL			
Safe Dose Range Calculation	Minimum: 1mL/dose Maximum: 1mL/day	Minimum: 37.2mg/dose Maximum: 55.8 mg/dose			
Maximum 24-hour Dose	1mL	650 mg			
Contraindications (2)	Alcohol dependence Liver disease	Severe active liver disease Hypersensitivity			
Side Effects/Adverse Reactions (2)	Constipation Upset stomach	Angioedema Disorientation			
Nursing Considerations (3)	Measure the correct amount of liquid medication	Do not exceed 4g/day May increase risk for bleeding in infant			

	<p>Liquid preparations have sugar use cautiously in diabetic patients</p> <p>Assess patient for signs of nutritional deficits</p>	<p>Intended for short term use only</p>			
<p>Client Teaching needs (2)</p>	<p>Take this medication regularly to receive full benefits from it</p> <p>Give medication at the same time each day</p>	<p>Do not give more than five doses in a 24 hour period</p> <p>Do not give medication routinely unless directed by child's provider</p>			

Reference: Jones & Bartlett Learning. (2019). 2019 *Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient is alert and oriented to parents. Responds to environmental stimuli such as lights or toys. No signs of distress. Normal cry is present. 12 weeks (86 days) old, African-American, female infant.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin is pink, warm, and dry. Temperature is 98.4°F which is within normal limits. Skin turgor is good and present less than 3 seconds. No signs of dehydration. No rashes, bruises, or wounds present on infant. Braden score not assessed. No drains present.</p>

<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>Head is molding and sutures are overriding. Neck has normal mobility. Ears are normal configuration. Infant responds to sound. Eyes are symmetrical and open. Nose is symmetrical. No teeth are present yet. Thyroid is palpable.</p>
<p>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 type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Heart sounds are present with regular rate and rhythm upon auscultation. Peripheral pulses are strong with regular rhythm, bilaterally. Capillary refill at palms is present ≤ 2 seconds.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Respirations are easy and quiet. Respirations are within normal limits. No labored breathing.</p>
<p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Infant is on a regular diet at home and inpatient. Height: 21cm Bowel sounds are active and present in all four quadrants. Last bowel movement: This morning No pain upon palpitation. No abdominal distention, incisions, scars, wounds, or drains.</p>
<p>GENITOURINARY (2 Points): Color: Character:</p>	<p>Urine color and character was within normal limits for infant. No noted pain during urinations.</p>

<p>Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Female genitalia has normal configuration.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Infant has equal strength in all four limbs, bilaterally. No supportive devices needed at this time. Equal use to hands and fingers. Grasping reflex present. Fall score: All infants are fall risk without proper safety measures. i.e. safety straps and guardrails</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Infant is oriented to parents and environmental stimuli. No noted altered mental status. Normal cries are present and stopped with personal needs met.</p>
<p>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):</p>	<p>Father seems disengaged in child care while mother is active and asks questions. Infant arrived to facility via parent transportation. Parents brought infants formula to hospital. Parents have three other children of unknown ages at home.</p>

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0906	153 bpm	90/48 mm/ Hg	39/min	98.4°F	100%

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

Pulse Rate	Newborn to 2 months: 80-180 bpm
Blood Pressure	Newborn to 2 months: 60/40 mm/Hg
Respiratory Rate	Newborn to 2 months: 30-60/min
Temperature	Newborn to 2 months: 99.5°F
Oxygen Saturation	Newborn to 2 months: 100%

Normal Vital Sign Range Reference (APA): Henry, N. J. E. (2016). *RN Nursing Care of Children: Review Module* (10th ed.). Leawood, KS: Assessment Technologies Institute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0906	FLACC	n/a	0	n/a	Patient does not display pains of pain according to scale
1445	FLACC	n/a	0	n/a	Patient does not display pains of pain according to scale
Precipitating factors: n/a Patient is resting with no cries Physiological/behavioral signs: n/a					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
20oz (Neosure Formula)	10 oz (urine)

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. Lifts head off mattress when prone

2. Holds hands in an open position, grasp reflex starts to fade
3. Make single vowel sounds at two months

Age Appropriate Diversional Activities

1. Respond to your smile with a smile
2. Wiggle toys and hold a rattle in hand
3. Looking at objects and follow them when they move

Psychosocial Development:

Which of Erikson's stages does this child fit?

Trust vs. Mistrust

What behaviors would you expect?

Quality of relationship between infant and caregiver.

What did you observe?

The infant was alert to who her parents are. I noticed that when mom was holding the infant she was not going towards the breast for feeding. The baby is on formula and her feeding need was met when mom gave her a bottle.

Cognitive Development:

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

Sensorimotor stage

What behaviors would you expect?

The infant should still display reflexive behavior and slowly transitioning into the repetitive/imitative activities.

What did you observe?

N433 Care Plan

Reflexes were still present such as blinking, grasping, and sucking.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

Crying is still the means of communication for child this age. She did not cry often as she was sleeping majority of the time. By 2 months, infant should be able to make single vowel sounds and I did not hear this. However, that could be due to the fact that the infant was sleeping.

Any concerns regarding growth and development?

No major concerns as of right now.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none">• Include full nursing diagnosis with	<ul style="list-style-type: none">• Explain why the nursing		<ul style="list-style-type: none">• How did the patient/family

N433 Care Plan

“related to” and “as evidenced by” components	diagnosis was chosen		respond to the nurse’s actions? <ul style="list-style-type: none"> • Client response, status of goals and outcomes, modifications to plan.
<p>1. Knowledge deficits related to parents AEB patients are not aware of how to care to child during episodes and need seizure precaution information</p>	<p>The patient has seizure like activity and the parents need information for infant seizure precautions. The physician noted that the father seems disengaged in child care</p>	<p>1.Help parents integrate information into daily life 2.Provide clear, thorough and understandable explanations and demonstrations</p>	<p>Both parents were present during any education moments by nurse or physician. The father did not ask any questions or engage in conversation. Mom seems to want to know information.</p>
<p>2. Caregiver role strain related to caregivers have knowledge deficit in care management AEB parents have three other children at home</p>	<p>The parents of the patient are both 22 years old with three other children at home to care for. Evidence shows that there are knowledge deficits.</p>	<p>1. Help parents identify stressors 2.Discuss coping skills</p>	<p>Was not able to really perform interventions during shift. However, mother did engage in conversation with me about her life at home with three other children and she mentioned an interest in nursing school.</p>
<p>3. Risk for injury related to seizure risk AEB prematurity</p>	<p>The patient is a risk for seizures and without proper precautions injury can and will occur.</p>	<p>1.If seizure occurs, remain with client entire time. 2During a seizure lie the infant in crib turned to the side and not do restrain the infant.</p>	<p>The parents will receive information regarding how to care for infant if a seizure does occur. This includes identification of signs of seizure, what to do during a seizure, and management if the infant is diagnosed with seizure or epilepsy.</p>
<p>4. Risk for delayed development</p>	<p>The patient is a risk for delayed development due</p>	<p>1. Provide child with age-appropriate</p>	<p>The parents do not believe their child has a delay right now but are</p>

N433 Care Plan

t related to seizures AEB prematurity	to seizures and it is vital that the parents are aware of any red flags to report early.	communication and activities 2. Investigate cries quickly in order to identify need	willing to monitor closely as possible for any red flags or warning signs.
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Other References (APA):

Concept Map (20 Points):

Subjective Data

Mother reports, "Foaming at the mouth, unresponsive for a few seconds, and stiffness."
Episodes occur a few times a week

Objective Data

Vital signs
T - 98.4°F
R - 39/min
BP - 90/48
P - 153 bpm
O2 - 100%

Patient Information

12 week old
Female
African-American
NKDA
Patient Initials: LC
Wt: 3.72kg
Full code
DOA: 1/22/2020

Nursing Diagnosis/Outcomes

Knowledge deficits related to parents AEB patients are not aware of how to care to child during episodes and need seizure precaution information
By discharge parents will understand signs of a seizure and precautions to take during another episode at home
Caregiver role strain related to caregivers have knowledge deficit in care management
AEB parents have three other children at home
Patients are able to identify some stressors and effective coping mechanisms by discharge.
Risk for injury related to seizure risk AEB prematurity
By discharge parents are able to verbalize an understanding of seizure precautions
Risk for delayed development related to seizures AEB prematurity
By discharge parents have an understanding of possible developmental delays and is able to recognize any warning signs to report to provider

Nursing Interventions

- Help parents integrate information into daily life
- Provide clear, thorough and understandable explanations and demonstrations
- Help parents identify stressors
- Discuss coping skills
- If seizure occurs, remain with client entire time.
- During a seizure lie the infant in crib turned to the side and not do restrain the infant.
- Provide child with age-appropriate communication and activities
- Investigate cries quickly in order to identify need

