N433 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
01/21/2020	MG	17 weeks	Female
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	5.78	15.5	NKDA NKFA

Medical History (5 Points)

Past Medical History: Born on 09/23/19 with no complication, vaginal birth.

Illnesses: Pt has been healthy until her most recent visit, diagnosis of Bronchitis due to respiratory syncytial virus (RSV.)

Hospitalizations: 09/23/19- Birth 01/21/20- Bronchitis due to RSV

Past Surgical History: N/A

Immunizations:

Birth History: Born on 09/23/19 with no complication, vaginal birth.

Complications (if any):

Assistive Devices: N/A

Living Situation: Pt lives at home with her Mom and Grandma

Admission Assessment

Chief Complaint (2 points): Shortness of breath (SOB)

Other Co-Existing Conditions (if any):

Pertinent Events during this admission/hospitalization (1 points): Pt on contact and airborne precautions. Pt is also on 4L of oxygen at 28% humidification, with a ng tube to help for feedings.

History of present Illness (10 points): Pt was taken to convenient care by mom for SOB. Pt was tested for influenzas A and B but was negative. Pt was also seen weeks before for ear infections in both ears. Pt prescribed antibiotics and sent home. Mom later called a pt advisory nurse and was told to bring the pt to the ED for respiratory depression.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Bronchitis

Secondary Diagnosis (if applicable): RSV

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

Bronchiolitis is an acute viral infection of the lower respiratory tract affecting infants <24 mo and is characterized by respiratory distress, wheezing, and crackles (Bhatia, 2018, para. 1). The virus spreads from the upper respiratory tract to the medium and small bronchi and bronchioles, causing epithelial necrosis and initiating an inflammatory response. The developing edema and exudate result in partial obstruction, which is most pronounced on expiration and leads to alveolar air trapping. Complete obstruction and absorption of the trapped air may lead to multiple areas of atelectasis, which can be exacerbated by breathing high inspired oxygen concentrations(Bhatia, 2018).

Pathophysiology References (2) (APA):

Bhatia, R. (2018, August). Bronchiolitis - Pediatrics. Retrieved January 27, 2020, from https://www.merckmanuals.com/professional/pediatrics/respiratory-disorders-in-young-children/bronchiolitis

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	**Normal activity for a 17 week old31**
Diet/Nutrition:	Breast milk 3ml Q 4 hours
Frequent Assessments:	Assessments Q 1 hour and vitals Q4
Labs/Diagnostic Tests:	No active labs or diagnostic
Treatments:	Oxygen 4L with 28% humitifier
Other:	

New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Decreasing oxygen given	Wean off of 4L down to room air, decreasing 1L Q 8 hours

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	288-598			
Hgb	7-39%			
Hct	31.2-37.1%			
Platelets	288-598			
WBC	6.1-17.5			
Neutrophils	1.9-5.4 31%			
Lymphocytes	3.7-10.7 61%			
Monocytes	0.3-0.8 4.8%			
Eosinophils	0.2-0.5 2.6%			
Basophils	0-0.1 0.5%			
Bands	0.2-0.5 3.1%			

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-	135-148			
K+	3.5-5.0			
Cl-	96-111			
Glucose	30-100			
BUN	4-15			
Creatinine	0.31-0.51			
Albumin	2.6-3.6			
Total Protein	4.4-6.6			
Calcium	4.4-5.3			
Bilirubin	<1.0			
Alk Phos	115-460			
AST	9-80			
ALT	13-45			
Amylase	25-101			
Lipase	0-160			

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	Today's Value	Reason for Abnormal

		Value		
ESR	<10-20			
CRP	2-5			
Hgb A1c	5.7			
TSH	1.7-9.1			

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/clear			
pH	4.6-8			
Specific Gravity	1.005-1.025			
Glucose	<130			
Protein	<150			
Ketones	none			
WBC	<2.5			
RBC	<2			
Leukoesterase	negative			

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				
Blood Culture				
Sputum Culture				

Stool Culture				
Respiratory ID Panel				

Lab Correlations Reference (APA):

M., V. L. A., & Bladh, M. L. (2019). *Daviss comprehensive handbook of laboratory & diagnostic tests with nursing implications*. Philadelphia: F.A. Davis Company.

UI Healthcare. (n.d.). Retrieved January 27, 2020, from https://www.healthcare.uiowa.edu/path_handbook/appendix/heme/pediatric_normals.html

Diagnostic Imaging

All Other Diagnostic Tests (5 points): No diagnostic imaging taken

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (APA):

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

Brand/Generic	Sodium chloride Neb solution	Tylenol/ acetaminophen	Albuterol sulfate	(Baby Ayr) sodium chloride	Sugar water /surcrose
Dose	3mL	160 mg/ 5mL oral suspension 15mg/kg	2.3mg/3mL 2.5mg	0.6% 1 drop PRN	24%
Frequency	Q 8 hrs	Q 4 hrs prn	Q 3 hrs prn		prn
Route	Oral	Oral	Oral		Oral
Classification	Salt	Analgesics	Bronchodialtor	Salt	Sugar
Mechanism of Action		Unknown			
Reason Client	SOB	For prn fevers	Prn with SOB		Prn when

Taking					the baby needs distracted with taste
Concentration Available	3mL	160 mg/ 5mL	3 mL	1 bottle	1 tube
Safe Dose Range Calculation					
Maximum 24-hour Dose	9mL				
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (3)					
Client Teaching needs (2)					

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&Ox4, over all the baby is calm and collective. She is in no overall distress and appearance is normal
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:**	Skin is warm, dry, and pink. Skin turgor bounces back within 3 seconds, there is no rashes, bruises, or wounds.

Drains present: Y☐ N ☐ **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Pt has an NG tube and oxygen, there is no notable skin breakdown. Cilla seen with moist mucosa, mouth is a normal red and also moist. No notable deviation, with active PERLA
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:**	Pt heart sounds are present and normal S1, S2. No edema, peripheral pulses all normal, no neck vein distensions, and cap refill within 3 seconds
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Pt is currently being weaned down from 8mL since admission on the 21st. Accessory muscles are still occasionally being uses.
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:**	Pt is on her moms breastmilk at home and in the hospital. Baby is 61 cm, bowel sounds are present, last BM was 0937 01/24/20
GENITOURINARY (2 Points): **Color:** **Character:**	Pt has a normal light-yellow urine, with no malodor, no notable pain with urination. No rashes, wounds, or skin break down upon

Quantity of urine: **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	inspection of genitals.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **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**☐	Active PERLA
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.
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):**	.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	148	122/87	52	36.7C	97%

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

Pulse Rate	100-160 bpm
Blood Pressure	65-90/45-65 Systolic/diastolic
Respiratory Rate	30-60
Temperature	98.6F
Oxygen Saturation	93-97%

Normal Vital Sign Range Reference (APA):

Kim, S. C., Husney, A., Romito, K., Pope, J., & Messenger, D. (18AD, September 23). Vital Signs in Children. Retrieved January 27, 2020, from https://www.mottchildren.org/health-library/abo2987

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0845	Flacc		1- Baby is calm, relaxed, or sleeping		
Evaluation of pain status *after* intervention	Flacc- 0 pain no intervention needed				
Precipitating factors: Baby being in no distress **Physiological/behavioral signs:** smiling or sleeping baby					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
65mL	417mL

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. Smiling spontaneously at people
2. Begins to babble
3. Cries to show hunger, pain, being tired

Age Appropriate Diversional Activities

1. Bubbles
2. Toys that light up
3. Peek a boo
4. Different sounds/songs

Psychosocial Development:

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

What behaviors would you expect? Teething to begin, giving chewable toys.

What did you observe? I observed this baby being most calm in her mother or grandmothers' arms.

Cognitive Development:

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

What behaviors would you expect? You would expect sensory curiosity about the world

What did you observe? I observed the baby being curious with funny voices and sounds

Vocalization/Vocabulary: Babbles, crying

Development expected for child's age and any concerns? Vocabulary will become better as the baby ages, seems to be on track and a healthy baby otherwise.

Any concerns regarding growth and development? No concerns

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. Air way clearance related to excessive mucus as evidence by wheezes	This is an important diagnosis because air way clearance is our number one priority	1.Suction 2.Monitor infant for feeding intolerance	Pt would be in less distress with a clear airway and less mucus
2. Breastfeeding, interrupted related to infant illness as evidence by coughing fits	This is important because the baby breastfeeds but would have coughing fits resulting in emesis of the breastmilk	1. Identify causative factors 2.Assist mother to help get desired result	Upon assistance it was helpful to suction the baby first.
3. Nutrition imbalance related to inability to keep down food as evidence by emesis	It is important that the baby is getting the right nutrition to promote wellness and healing	1.Identify if pt is at risk for malnutrition 2evaluate degree of deficit	Pt's mother understand the importance of her baby getting and keeping fluids and nutrition down.
4. Caregiver role strain related to infant illness as evidence by acquiring less sleep	This is important because the mother needs to be able to function to be there for the baby	1. identify resources within self to minimize strain 2. Asses caregivers current state of functioning	Caregiver states "She is grateful for her mom being able to care for the baby while she gets sleep."

Other References (APA):

Doenges, M. E., Moorhouse, M. F., & Geissler-Murr, A. (2004). *Nurses pocket guide: diagnoses, interventions, and rationales*. Philadelphia, Penns.: F.A. Davis.

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and pediatric nursing*. Philadelphia: Wolters Kluwer.

Concept Map (20 Points):

N433 Care Plan

Subjective Data

-Baby crying and being in distress before being admitted

Nursing Diagnosis/Outcomes

1. **Air way clearance related to excessive mucus as evidence by wheezes**
2. **Breastfeeding, interrupted related to infant illness as evidence by coughing fits**
3. **Nutrition imbalance related to inability to keep down food as evidence by emesis**
4. **Caregiver role strain related to infant illness as evidence by acquiring less sleep**

Objective Data

-Lung sounds, crackles in the begging of the admission process
-Needing 8L O2 in the ED and a lower oxygen saturation
-Positive for RSV

Patient Information

17-week-old baby girl with no previous complications. SOB and ear infection for a week before admission. Pediatrician thinking the symptoms were cold like due to negative influenza. Pt is being weaned off of 4L currently until on room air and able to leave. No appreciable distress.

Nursing Interventions

1.Suction

2.Monitor infant for feeding intolerance

1. Identify causative factors

2.Assist mother to help get desired result

1.Identify if pt is at risk for malnutrition

2evaluate degree of deficit

1. identify resources within self to minimize strain

2. Asses caregivers current state of functioning