N433 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 1/30/2020	Patient Initials ZD	Age (in years & months) 19 months	Gender M
Code Status full	**Weight (in kg)** 10.3	**BMI** 18.36	**Allergies/Sensitivities (include reactions)** NKA

Medical History (5 Points)

Past Medical History: dairy product intolerance, ETD bilateral, lower leg shaking

Illnesses: acute bacterial conjunctivitis, vital URI with cough

Hospitalizations: no previous hospitalizations

Past Surgical History: myringotomy with tubes (bilateral)

Immunizations: DTAP/IVP/HEPB, BIB, Hepatitis B, Influenza, MMR, Pneumococcal, rotavirus

Birth History: born on 6/19/2018 at 1434 and weighed 2739 g

Complications (if any): no complications

Assistive Devices: none

Living Situation: at home with mom, dad, and older sister

Admission Assessment

Chief Complaint (2 points): shortness of breath

Other Co-Existing Conditions (if any):

Pertinent Events during this admission/hospitalization (1 points): He uses abdominal muscles in his breathing

History of present Illness (10 points):.

Patient is a 19-month-old male who presents to the ED due to respiratory distress. Mom states that he was laying down at daycare and not wanting to do much. He started to sound wheezy and have increased work of breathing 2 hours prior to arrival. NO fever. He has been having a cough. Mom states he is using his belly to breathe. He is up to date on vaccinations. He was admitted to the pediatric hospitalist service in stable condition.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): bronchiolitis

Secondary Diagnosis (if applicable): acute respiratory failure with hypoxia

Pathophysiology of the Disease, APA format (20 points): Bronchiolitis is a common lung infection in young children and infants. It causes inflammation and congestion in the small airways (bronchioles) of the lung. Bronchiolitis is almost always caused by a virus. Typically, the peak time for bronchiolitis is during the winter months. It is mostly caused by RSV and occurs at the bronchiolar level. Expected findings begin with rhinorrhea, intermittent fever, pharyngitis, coughing, sneezing, wheezing, and possible ear or eye infections. As the illnesses progresses you may see increased coughing or sneezing, fever, tachypnea, refusal to eat, and copious secretions. Severe illness includes respiratory rate greater than 70/min, listlessness, apneic spells, poor air exchange, poor breath sounds. Complications include cyanosis and dehydration. Lab test done is from nasopharyngeal secretions. The patient did not have a fever but did have coarse lung sounds, rhinorrhea, and a nonproductive cough. When they screened the respiratory panel, he tested positive for the rhinovirus. His respiratory rate is in within normal limits for his age.

Pathophysiology References (2) (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* (10th ed.). Assessment Technologies Institute, LLC.

Bronchiolitis. (2020, January 15). https://www.mayoclinic.org/diseases-conditions/bronchiolitis/symptoms-causes/syc-20351565

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	Increase activity as tolerated
Diet/Nutrition:	Regular diet
Frequent Assessments:	Q4H
Labs/Diagnostic Tests:	Chest x-ray, respiratory pathogen panel
Treatments:	Acetaminophen 153.6 mg Q4H PRN, ibuprophen 104 mg Q6H PRN, lidocaine 4% topical cream PRN
Other:	Full code, isolation/droplet precautions
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	**4.0-5.2**	**No labs obtained**	**No labs obtained**	
Hgb	**M: 14-16**	**No labs obtained**	**No labs obtained**	
Hct	**M:35-47**	**No labs obtained**	**No labs obtained**	
Platelets	**140-440**	**No labs obtained**	**No labs obtained**	
WBC	**4.0-11.0**	**No labs obtained**	**No labs obtained**	
Neutrophils	**45-75%**	**No labs obtained**	**No labs obtained**	

Lymphocytes	**20-40%**	**No labs obtained**	**No labs obtained**	
Monocytes	**4-6%**	**No labs obtained**	**No labs obtained**	
Eosinophils	**<7%**	**No labs obtained**	**No labs obtained**	
Basophils	**<3%**	**No labs obtained**	**No labs obtained**	
Bands	**<3%**	**No labs obtained**	**No labs obtained**	

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-	**135-145**	**No labs obtained**	**No labs obtained**	
K+	**3.5-5.0**	**No labs obtained**	**No labs obtained**	
Cl-	**98-107**	**No labs obtained**	**No labs obtained**	
Glucose	**70-100**	**No labs obtained**	**No labs obtained**	
BUN	**0.6-1.3**	**No labs obtained**	**No labs obtained**	
Creatinine	**6-20**	**No labs obtained**	**No labs obtained**	
Albumin	**3.4-5.4**	**No labs obtained**	**No labs obtained**	
Total Protein	**6.0 to 8.3**	**No labs obtained**	**No labs obtained**	
Calcium	**8.5-10.5**	**No labs obtained**	**No labs obtained**	
Bilirubin	**<1.5**	**No labs**	**No labs**	

		obtained	**obtained**	
Alk Phos	**20-140**	**No labs obtained**	**No labs obtained**	
AST	**10-30**	**No labs obtained**	**No labs obtained**	
ALT	**10-40**	**No labs obtained**	**No labs obtained**	
Amylase	**23-85**	**No labs obtained**	**No labs obtained**	
Lipase	**60-160**	**No labs obtained**	**No labs obtained**	

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 obtained**	**No labs obtained**	
CRP	**0**	**No labs obtained**	**No labs obtained**	
Hgb A1c	**<5.7**	**No labs obtained**	**No labs obtained**	
TSH	**1.7-9.1**	**No labs obtained**	**No labs obtained**	

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**	**No labs obtained**	**No labs obtained**	
pH	**6.0**	**No labs obtained**	**No labs obtained**	
Specific Gravity	**1.010-1.025**	**No labs**	**No labs**	

		obtained	**obtained**	
Glucose	**0-0.8**	**No labs obtained**	**No labs obtained**	
Protein	**0-20**	**No labs obtained**	**No labs obtained**	
Ketones	**Negative**	**No labs obtained**	**No labs obtained**	
WBC	**4.5-11**	**No labs obtained**	**No labs obtained**	
RBC	**4**	**No labs obtained**	**No labs obtained**	
Leukoesterase	**2-5**	**No labs obtained**	**No labs obtained**	

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**	**No labs obtained**	**No labs obtained**	
Blood Culture	**Negative**	**No labs obtained**	**No labs obtained**	
Sputum Culture	**Negative**	**No labs obtained**	**No labs obtained**	
Stool Culture	**Negative**	**No labs obtained**	**No labs obtained**	
Respiratory ID Panel	**negative**	**positive**	**No labs obtained**	**Rhino/enterovirus detected**

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): chest x-ray

Diagnostic Test Correlation (5 points): The patient got a chest x-ray for his cough that showed no pulmonary abnormalities.

Diagnostic Test Reference (APA):

Chest X-rays. (2018, April 26). Retrieved from https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494

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

Brand/Generic	**acetaminophen (Tylenol) (8)**	**Lidocaine**	**Ibuprofen (542)**
Dose	153.6 mg	4%	104 mg
Frequency	Q4H PRN	PRN	Q6H PRN
Route	PO	topical	PO
Classification	analgesic	Anesthetic	Analgesic
Mechanism of Action	Inhibits prostaglandin synthesis in CNS and PNS (blocks pain impulse)	Inhibits conduction of nerve impulses from sensory nerves	Reduces inflammatory symptoms by vasodilation
Reason Client Taking	pain	Pain with IV starts	Pain
Concentration Available	160 mg/ 5 ml	NA	10 mg/ kg
Safe Dose Range Calculation	128.75-153.6 mg	NA	41.2-104 mg
Maximum 24-hour Dose	200 mg	3 times daily	200 mg
Contraindications (2)	PUD, GI bleeds	Application to large areas, infants <1 year old	Asthma, nasal polyps
Side Effects/Adverse Reactions (2)	Abdominal pain Heartburn	Rash, irritation	Dizziness, epigastric pain
Nursing Considerations (3)	Risk for stroke increases the longer ibuprofen is used, monitor renal function in patient on long term therapy, if given IV, ensure infusion pumps are programmed properly	Assess pain before and after giving, if signs of toxicity, call physician, watch for respiratory depression	Risk for serious thrombotic events such as stroke for MI increases the longer ibuprofen is used, monitor for chest pain, slurring of speech, or SOB; monitor labs (WBC) and watch for signs of infection
Client Teaching	Do not exceed	Avoid contact with	Take with food or after

needs (2)	recommended dose, recognize the signs of overdose: bleeding, fever, sore throat	eyes, avoid prolonged use over 1 week	meals; avoid alcohol, aspirin, and corticosteroids

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook*. Burlington, MA.

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 watching TV and played all morning and had a nap in the afternoon.
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 97.4 degrees, afebrile No rashes. His face had a scab on his left eyebrow. No bruising or wounds. Skin turgor was normal, capillary refill less than 3 seconds Braden score of 5 No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Head appeared normocephalic ears are clear bilaterally bilateral nostril congestion, the drainage is clear
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 ☒**	Heart sounds appeared normal. No murmurs. Peripheral pulses were normal 3+. Lower extremities showed no edema. No neck vein distention.

Location of Edema:	
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Breath sounds were coarse in all lung fields. Abdominal muscles used with breathing
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:**	Regular diet Bowel sounds active in all four quadrants No pain upon palpation No distention, incisions, scars, drains, or wounds Last BM was before admission which is abnormal for him 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:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐**	Active ROM Moves all extremities Strength equal bilaterally Fall risk score of 2 He can get up independently

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:**	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. They have another child who is staying with a family member. I taught the parent how to prevent spread of infection, no further education needed.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	130	119/59	22	97.4	100

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

Pulse Rate	**70-120**
Blood Pressure	**95/58**
Respiratory Rate	**25-30**
Temperature	**37.7 (99.9)**
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*. Assessment Technologies Institute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0845	**FLACC**	**NA**	**0**	**NA**	**NA**
Evaluation of pain status *after* intervention					
Precipitating factors: **Physiological/behavioral signs:**					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
150	**171**

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. Walks independently
2. Uses a spoon or cup
3. Stacks blocks

Age Appropriate Diversional Activities

1. Likes to be with other kids
2. Imitates
3. Pretend plays

Psychosocial Development:

Which of Erikson's stages does this child fit? Autonomy vs shame and doubt

What behaviors would you expect? Independence, negativism, ritualism and routines

What did you observe? He was exploring his surroundings

Cognitive Development:

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

What behaviors would you expect? Object permanence is developed, domestic **mimicry, memories**

What did you observe? Playing with bubbles

Vocalization/Vocabulary:

Development expected for child's age and any concerns? 7-20 words, no concerns

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. Impaired gas exchange related to respiratory distress as evidenced by acute viral bronchiolitis	Diagnosed with bronchiolitis	1.monitor oxygen saturation 2. Gave him bubbles to encourage deep breathing	he started with 8 L of oxygen but ripped off the mask but his oxygen saturation levels stayed within normal limits
2. Pain control related to respiratory distress as evidenced by bronchiolitis	We need to treat the symptoms of this virus since antibiotics do not apply	1. administer PRN pain medications 2.Assess pain level musing the FLACC scale	He showed no evidence of pain with the FLACC scale, therefore he did not need any of his pain medication
3. Risk for infection related to compromised immune system as evidenced by rhinovirus	Tested positive for rhinovirus	1. droplet/contact precautions 2Educated the parent on how to stop the spread of infection since he has an older sister at home and goes to daycare	The parents understood the precautions and to stop the spread of infection
4. Risk for impaired skin integrity related to optiflow as evidenced by tape to secure it	Tape can cause skin breakdown	1. assess the skin or redness or breakdown 2. ensure proper placement of optiflow	His cheeks showed no redness or breakdown and he ripped his oxygen off

Other References (APA):

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

Concept Map (20 Points):

N433 Care Plan

Subjective Data

The mom stated that before admission he wasn't wanting to do much at daycare, wasn't eating or drinking much, and seamed lethargic

Nursing Diagnosis/Outcomes

Impaired gas exchange related to respiratory distress as evidenced by acute viral bronchiolitis
Outcome: He started with 8 L of oxygen but ripped off the mask but his oxygen saturation levels stayed within normal limits
Pain control related to respiratory distress as evidenced by bronchiolitis
Outcome: He showed no evidence of pain with the FLACC scale, therefore he did not need any of his pain medication
Risk for infection related to compromised immune system as evidenced by rhinovirus
Outcome: The parents understood the precautions and to stop the spread of infection
Risk for impaired skin integrity related to optiflow as evidenced by tape to secure it
Outcome: His cheeks showed no redness or breakdown and he ripped optiflow off

Objective Data

Chest x-ray showed no abnormalities
Respiratory panel detected rhinovirus
Net intake of -21 ml
Coughing
FLACC scale of 0

Patient Information

Patient is a 19-month-old male who presented at the emergency department for shortness of breath. He was diagnosed with bronchiolitis and was put on contact/droplet precautions

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 respiratory distress
Follow contact/droplet precautions
Teach the parents on how to prevent spread of infection
Establish honest, therapeutic communication in an empathetic manner
Explain all interventions, diagnostics and medications