

N433 Care Plan 1

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date of Admission</b> 2/20/2020	<b>Patient Initials</b> ENM	<b>Age (in years &amp; months)</b> 5 yrs. 10 mos.	<b>Gender</b> Male
<b>Code Status</b> Full code	<b>Weight (in kg)</b> 28.3 kg	<b>BMI</b> 18.1 kg/m <sup>2</sup>	<b>Allergies/Sensitivities (include reactions)</b> NKA

**Medical History (5 Points)**

**Past Medical History:** TB lung, latent

**Illnesses:** Tested positive for Influenza A 02/04

**Hospitalizations:** Previously hospitalized for seizures in Congo at 1 yr. old

**Past Surgical History:** No past surgical history

**Immunizations:** Immunizations up to date

**Birth History:** Denied any perinatal complications except prolonged labor

**Complications (if any):** No complications

**Assistive Devices:** None needed

**Living Situation:** Patient lives at home with his mom, dad, and two little sisters.

**Admission Assessment**

**Chief Complaint (2 points):** Seizure-like activity (CMS-HCC)

**Other Co-Existing Conditions (if any):** No co-existing conditions

**Pertinent Events during this admission/hospitalization (1 points):** Cardiac monitoring, CBC, and a metabolic panel were ran in the emergency department (ED)

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**History of present Illness (10 points):** Patient is 5 yrs. 10 mos. old and came into the ED on 2/20 with complaint of syncopal episode and seizure. The father stated that the duration and characteristics of the seizure are unknown because it occurred during gym class while he was at school. Aggravating factor to the condition would be when the patient is febrile. Patient has been without fever since admission to the unit on 2/20. Patient was treated with acetaminophen in the ED.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Complex seizures related to fever and seizure like activity.

**Secondary Diagnosis (if applicable):** Adenovirus infection

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

My patient is a male who presented with Febrile seizures. Febrile seizures are the most common type of seizure seen in children 5 years and less. These seizures more commonly affect boys. My patient's sister also has a history febrile seizure. According to a source, children who have a family history of seizures puts them at a higher risk of also having febrile seizures (Ricci, 2017). These seizures occur due to a spike in temperature that is normally related to a viral infection (Ricci, 2017). My patient tested positive for adenovirus. These seizures are normally ruled benign but can be dangerous which is why a full workup is needed. Complications that can occur include, "status epilepticus, motor coordination deficits, intellectual disability, and behavioral problems" (Ricci, 2017, pg. 1398).

The signs and symptoms of febrile seizures include a fever higher than 39 C, loss of consciousness, and shaking or jerking arms and legs (Febrile seizure, 2019). My patient had a fever and a syncopal episode. Expected findings associated with febrile seizures include a, "rapid

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rise in core temperature to 39 C or higher, seizure lasting less than 15 minutes in a 24-hr. period and is accompanied by fever without any CNS infection present” (Ricci, 2017). My patient had a fever the morning of 2/20 that spiked during gym class causing his seizure. A diagnosis is made by determining source of fever, completing a thorough assessment and ruling out other possible causes such as epilepsy or meningitis (Ricci, 2017). ECG, EEG, CBC, and metabolic panels are ran in order to rule out any underlying cause of the seizure other than a febrile state (Ricci, 2017). My patient’s results are still pending. Once results are reviewed if patient’s labs and test are clear he will be discharged on 2/21. Patient was treated with acetaminophen in order to reduce his fever. Patient was also treated with ceftriaxone for prevention of meningitis.

### Pathophysiology References (2) (APA):

Febrile seizure. (2019, June 18). Retrieved February 24, 2020, from

<https://www.mayoclinic.org/diseases-conditions/febrile-seizure/symptoms-causes/syc-20372522?page=0&citems=10>

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

### Active Orders (2 points)

Order(s)	Comments/Results/Completion
<b>Activity:</b> ab and lib	Patient would leave his bed to use the restroom without assistance
<b>Diet/Nutrition:</b> Normal diet	No reported nausea, vomiting, or diarrhea (N/V/D)
<b>Frequent Assessments:</b> Neurological and IV access check every 4 hrs.	Strict I&O. Patients recorded input was 890 mL Patient did not void on my shift.
<b>Labs/Diagnostic Tests:</b> Blood and culture,	Specimen, EEG, and CT results are pending.

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EEG, CT without contrast	
<b>Treatments:</b> NA	NA
<b>Other:</b> NA	
<b>New Order(s) for Clinical Day</b>	
<b>Order(s)</b>	<b>Comments/Results/Completion</b>
No new orders to be acknowledged	NA

**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
<b>RBC</b>	3.96-5.03 10 <sup>6</sup>	4.48 10 <sup>6</sup>	NA	WNL
<b>Hgb</b>	10.1-13.4 g/dL	12.2 g/dL	NA	WNL
<b>Hct</b>	32.2-39.8%	36%	NA	WNL
<b>Platelets</b>	206-369 10 <sup>3</sup> k/mcl	262	NA	WNL
<b>WBC</b>	4.31-11 10 <sup>3</sup> mL	12.4 10 <sup>3</sup> mL	NA	My patients WBC count was elevated because he tested positive for the adenovirus.
<b>Neutrophils</b>	1.6-8.29%	NA	NA	NA
<b>Lymphocytes</b>	4-10.5%	11.7	NA	WNL
<b>Monocytes</b>	<0.6%	8.2	NA	WNL
<b>Eosinophils</b>	<0.3%	0.0	NA	WNL
<b>Basophils</b>	0.5-1%	0.1	NA	WNL
<b>Bands</b>	45-74%	0.2	NA	WNL

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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-	136-145 mmol/L	136 mmol/L	NA	WNL
K+	3.5-5.1 mmol/L	4.0 mmol/L	NA	WNL
Cl-	98-107 mmol/L	105 mmol/L	NA	WNL
Glucose	60-99 mg/dL	83 mg/dL	NA	WNL
BUN	7-18 mg/dL	11 mg/dL	NA	WNL
Creatinine	0.70-1.30 mg/dL	0.58 mg/dL	NA	Results are low d/t dehydration and lower muscle mass
Albumin	3.4-5.0 g/dL	3.5 g/dL	NA	WNL
Total Protein	6.4-8.2 g/dL	8.0 g/dL	NA	WNL
Calcium	8.5-10.1 mg/dL	9.2 mg/dL	NA	WNL
Bilirubin	0.2-1.0 mg/dL	0.5 mg/dL	NA	WNL
Alk Phos	54-369 units/L	221 units/L	NA	WNL
AST	15-37 units/L	17 units/L	NA	WNL
ALT	12-78 units/L	19 units/L	NA	WNL
Amylase	6.5-48 units/L	NA	NA	NA
Lipase	9-105 units/L	NA	NA	NA

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
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		<b>Value</b>		
<b>ESR</b>	<b>0-10</b>	NA	NA	NA
<b>CRP</b>	<b>0.00-0.29</b>	NA	NA	NA
<b>Hgb A1c</b>	<b>1.5-4</b>	NA	NA	NA
<b>TSH</b>	<b>1.7-9.1</b>	NA	NA	NA

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Color &amp; Clarity</b>	<b>Yellow/clear</b>	NA	NA	NA
<b>pH</b>	<b>5.0-8.0</b>	NA	NA	NA
<b>Specific Gravity</b>	<b>1.005-1.035</b>	NA	NA	NA
<b>Glucose</b>	<b>Normal</b>	NA	NA	NA
<b>Protein</b>	<b>Negative</b>	NA	NA	NA
<b>Ketones</b>	<b>Negative</b>	NA	NA	NA
<b>WBC</b>	<b>&gt;5</b>	NA	NA	NA
<b>RBC</b>	<b>0-3</b>	NA	NA	NA
<b>Leukoesterase</b>	<b>Negative</b>	NA	NA	NA

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

<b>Test</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>Urine Culture</b>	<b>Negative</b>	NA	NA	NA
<b>Blood Culture</b>	<b>Negative</b>	In progress	In progress	In progress
<b>Sputum Culture</b>	<b>Negative</b>	NA	NA	NA

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<b>Stool Culture</b>	<b>Negative</b>	NA	NA	NA
<b>Respiratory ID Panel</b>	<b>Negative</b>	Currently positive for adenovirus	NA	NA

**Lab Correlations Reference (APA):**

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

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):** A CT w/o contrast was completed 02/20, an ECG was ran on 02/20, and an EEG was completed on 02/21.

**Diagnostic Test Correlation (5 points):** The CT was ran in order to rule out neurological issues or epilepsy. The ECG was ran d/t patients syncopal episode on 02/21. An EEG was ran to rule out abnormal intracranial activity (Doenges, 2010). Results for these diagnostic tests were still pending at the end of my shift on 02/21.

**Diagnostic Test Reference (APA):**

Doenges, M. E., Moorhouse, M. F., & Geissler-Murr, A. (2010). *Nursing care plans: guidelines for individualizing client care across the life span* (Eight). Philadelphia: F.A. Davis Co.

**Current Medications (8 points)**

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

<b>Brand/ Generic</b>	<b>Isotamine/ Isoniazid</b>	<b>Rocephin/ Ceftriaxone</b>	<b>Ativan/ Lorazepam</b>	<b>Tylenol/ Acetaminophen</b>
<b>Dose</b>	300 mg	1,500 mg in 0.9% NaCl 50 mL	1 mg	444.8
<b>Frequency</b>	Daily	Every 24 hrs.	PRN	Every 4 hrs. PRN

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<b>Route</b>	Oral	IV PB	IV push	Oral suspension
<b>Classification</b>	Antitubercular Agents	Cephalosporins, 3 <sup>rd</sup> Generation	Antianxiety	Analgesics
<b>Mechanism of Action</b>	MOA is unknown.	Broad-spectrum gram-negative activity. Stops bacterial growth by inhibiting penicillin-binding proteins.	Sedative hypnotic which may depress all levels of the CNS, including limbic and reticular formation.	Produces antipyresis by acting on the hypothalamus.
<b>Reason Client Taking</b>	D/T patients inactive TB	Prevention for meningitis	Administration only if tonic/colonic phase	Pain relief and fever reducer
<b>Concentration Available</b>	300 mg	2 g	2 mg/mL	160 mg/ 5 mL
<b>Safe Dose Range Calculation</b>	10-15 mg/kg/day	50-75 mg/kg/day every 12-24 hrs.	0.1 mg/kg 4mg/dose	10-15 mg/kg every 4-6 hours
<b>Maximum 24-hour Dose</b>	300 mg	2,122 mg	2.83 mg	5 doses/day
<b>Contraindications (2)</b>	Hypersensitivity and previous INH hepatic injury are contraindications.  The contraindications do not pertain to my patient.	Hypersensitivity is a contraindication.  The contraindication does not pertain to my patient.	Severe respiratory depression and sleep apnea are contraindications.  The contraindications do not pertain to my patient.	Hypersensitivity and severe active liver disease are contraindications.  The contraindications do not pertain to my patient.
<b>Side Effects/Adverse Reactions (2)</b>	Nausea and vomiting may occur,	Fever and rash may occur.	Sedation and dizziness may occur.	Angioedema and dizziness may occur.
<b>Nursing Considerations (3)</b>	1.Use in caution with other anti-TB agents.  2.Predisposition to neuropathy.	1.Monitor patient for fever  2.Adjust dose for patients with anemia.	1.Diluted with sterile water for injection, NS. Dilute in equal volumes.	1.Oral solutions, round doses.  2.Monitor for hepatotoxicity.

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	3.Predispotion to malnourished.	3.Monitor for GI adverse effects.	2.Mix thoroughly, do not shake vigorously.  3.Do not exceed 2 mg/min	3.Do not confuse milligrams with milliliters.
<b>Client Teaching needs (2)</b>	1.Take 1 hr. before or 2 hrs. after meal  2.Take exactly as prescribed	1.Report watery, bloody stools.  2.Report rashes.	1. Teach about the risk of respiratory depression.  2.Take with full glass of water.	1.Do not exceed recommended dose.  2.Report bleeding, bruising, or malaise.

**Assessment**

**Physical Exam (18 points)**

<b>GENERAL (1 point):</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	AOx4 Patient is well nourished, no acute distress, cooperative, judgement is intact.
<b>INTEGUMENTARY (2 points):</b> <b>Skin color:</b> <b>Character:</b> <b>Temperature:</b> <b>Turgor:</b> <b>Rashes:</b> <b>Bruises:</b> <b>Wounds:</b> <b>Braden Score:</b> <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> <b>Type:</b>	Intact; pink Warm and dry Oral: Elastic, <3 No noted rashes/petechia, bruising, wounds  23
<b>IV Assessment (If applicable to child):</b> <b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b>	22g Anterior, lower, right, forearm 2/20/20 Catheter patent, infusing w/o difficulty, flushes easily, and good blood return.

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<p><b>Signs of erythema, drainage, etc.:</b>  <b>IV dressing assessment:</b></p> <p><b>IV Fluid Rate or Saline Lock:</b></p>	<p>No erythema/phlebitis/infiltration present.          Transparent, dry and intact          D5-0.9% NaCl w/ KCl 20 mEq</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b>  <b>Thyroid:</b></p>	<p>Normocephalic, atraumatic, normal hearing, moist oral mucosa, no sinus tenderness, no oral lesion, tonsil grade 1 without erythema or exudate, uvula midline. Patient did complain of a sore throat          Patient did not have all his teeth          Not palpated</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>No chest pain, palpations, or syncope since admission. Regular rhythm.          S1&amp;S2 noted          No noted murmurs, or rubs          3+ bilaterally          &lt;3</p> <p>No noted edema</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>No shortness of breath. Patient has a productive cough          Chest expansion symmetric, no obvious accessory muscle use.          Normal in all four quadrants. Lungs are clear upon auscultation bilaterally, no crackles, wheezes, SOB, or stridor.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current diet:</b>  <b>Height (in cm):</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>          <b>Distention:</b>          <b>Incisions:</b>          <b>Scars:</b>          <b>Drains:</b>          <b>Wounds:</b>  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>          <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>          <b>Type:</b></p>	<p>No nausea, vomiting, or diarrhea          Normal diet          Normal diet          109.1 cm          Bowel sounds are active in all four quadrants.          Patient could not recall          No pain upon palpation</p> <p>No distension of the abdomen          No noted incisions          No noted scars          No noted drains          No noted wounds</p>

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<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b></p>	<p>Patient did not void on my shift</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Score:</b> 5  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input checked="" type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>No back pain, neck pain, joint pain, muscle pain, or decreased ROM.          Neurovascular status intact          UE and LE normal range of motion. No tenderness or swelling.          Muscle strength is 5/5 in all extremities upper and lower.          Fall risk d/t seizures          Up ad lib</p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b></p>	<p>CN II-XII intact. Sensation is intact to light, and touch. Speech is clear, follows commands, recent and remote memory intact.</p> <p>AOx4          Recent and remote memory intact          Speech is clear, and follows commands          Sensation is intact to light, and touch          Glasgow Coma Scale – 15: alert, attentive, oriented, and obeys commands.</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s) of caregiver(s):</b>  <b>Social needs (transportation, food, medication assistance, home equipment/care):</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>Playing on his iPad and watching the Lego movie.          Social needs of the child are met.</p> <p>Patient feels safe at home and has ample support from mom, dad, and sisters.</p>

**Vital Signs, 1 set (2.5 points)**

Time	Pulse	B/P*	Resp Rate	Temp**	Oxygen
0948	122 bpm	112/54 mmHg	16 bpm	98.7	99%
1230	111 bpm	115/55 mmHg	16 bpm	98.7	99%

\*Left arm, automatic

\*\*Oral

**Normal Vital Sign Ranges (2.5 points)**

**\*\*Need to be specific to the age of the child\*\***

<b>Pulse Rate</b>	60-110 bpm
<b>Blood Pressure</b>	Around 86-117/47-76 mmHg
<b>Respiratory Rate</b>	21-25 bpm
<b>Temperature</b>	37.0 C
<b>Oxygen Saturation</b>	95-100%

**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
0836	FACES	Throat	3	Patient unable to identify	Distraction: put on a movie
<b>Evaluation of pain status <i>after</i> intervention</b>	FACES	No pain	NA	NA	NA

**Precipitating factors:** Patient had a productive cough and congestion causing a sore throat.  
**Physiological/behavioral signs:** Patient would hold his throat when he coughed.

**Intake and Output (1 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
120 mL (orange juice) 50 mL (ceftriaxone) 720 mL (D5-0.9 NaCl with KCl mEq)	Patient did not void on my shift.

Balance: 890 mL

**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. Bones continue to ossify
2. Will gain 2-3 lbs./year
3. Permanent teeth will begin to erupt

**Age Appropriate Diversional Activities**

1. Simple board games and number games
2. Jump rope
3. Ride bicycles

**Psychosocial Development:**

**Which of Erikson's stages does this child fit?**

Industry vs inferiority

- Child feels that they can provide meaningful contributions to society.

**What behaviors would you expect?**

- Ability to complete task or skills
- Cooperate and compete with others

**What did you observe?**

- My patient enjoyed play games and always wanted me to join him.

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- My patient was very cooperative during his EEG.

**Cognitive Development:**

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

- Concrete observation

**What behaviors would you expect?**

- Able to solve problems

**What did you observe?**

- Patient was able to build a simple Lego model which involves visualizing an object and being able to recreate it.

**Vocalization/Vocabulary:**

**Development expected for child’s age and any concerns?**

- Talking is the primary method of communication
- Should be able to talk in full sentences and use simple grammar

**Any concerns regarding growth and development?**

- No concerns were presented with my patients’ growth and development.

**Nursing Diagnosis (15 points)**

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

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"><li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li></ul>	<b>Rational</b> <ul style="list-style-type: none"><li>• Explain why the nursing diagnosis was chosen</li></ul>	<b>Intervention (2 per dx)</b>	<b>Evaluation</b> <ul style="list-style-type: none"><li>• How did the patient/family respond to the nurse’s actions?</li><li>• Client response, status of goals and outcomes, modifications to plan.</li></ul>
1. Anxiety R/T unknown cause of seizures AEB febrile	Patient is anxious during care.	1. Assess activities that reduce stress level.	1. Patient loved to play on the tablet and watch the different Lego movies.

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seizures.		2. Involve patient in plan of care.	2. Patient would ask what was next and ask how he could help.  3. Patient's goal was to be able to cooperate without reward of iPad by discharge.
2. Ineffective airway clearance R/T excess mucus AEB productive cough.	Patient has a sore throat and productive cough.	1. Assess respiratory every 4 hrs.  2. Turn patient every 2 hrs.	1. Patient was cooperative with assessments and interventions.  2. Patient was repositioned or ambulated every 2 hrs. during my shift on 2/20.
3. Risk for trauma R/T obstructed passageways AEB febrile seizures.	Patient was admitted D/T febrile seizures.	1. Monitor and record patient's neurological status to detect changes.  2. Keep bedrails raised to ensure safety. Maintain bed at lowest position possible to prevent further injury.	1. Patient was cooperative with assessment and intervention.  2. Patient's bed remained in the lowest position with the bedrails raised to prevent injury during my shift on 20/20.
4. Risk for fall R/T seizures like activity AEB syncopal episode.	Patient was admitted D/T febrile seizures.	1. Bed at lowest position.  2. Wear proper nonskid socks.	1. Patient's bed remained in the lowest position and wore the proper socks during my shift 2/20.

**Other References (APA):**

Doenges, M. E., Geissler-Murr, A., Moorhouse, M. F. (2010). *Nursing care plans: guidelines for individualizing client care across the life span* (Eight). Philadelphia: F.A. Davis Co.

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**Concept Map (20 Points):**

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**Subjective Data**

Patient stated at 0836 on 02/20 that that he had pain rated a 3/10 on the FACES scale.  
After intervention pain was eliminated.

**Nursing Diagnosis/Outcomes**

Anxiety R/T unknown cause of seizures AEB febrile seizures.  
Ineffective airway clearance R/T excess mucus AEB productive cough.  
Risk for trauma R/T obstructed passageways AEB febrile seizures.  
Risk for fall R/T seizures like activity AEB syncopal episode.

**Objective Data**

Abnormal lab values:  
ECG, EEG, and CT results are still pending.  
Vital signs:

**Patient Information**

Patient is 5 yrs. 10 mos. old and came into the ED on 2/20 with complaint of syncopal episode and seizure. The father stated that the duration and characteristics of the seizure are unknown because it occurred during gym class while he was at school. Aggravating factor to the condition would be when the patient is febrile. Patient has been without fever since admission to the unit on 2/20. Patient was treated with acetaminophen in the ED.

**Nursing Interventions**

Assess activities that reduce stress level.  
Involve patient in plan of care  
Assess respiratory every 4 hrs.  
Turn patient every 2 hrs.  
Monitor and record patient's neurological status to detect changes.  
Keep bedrails raised to ensure safety.  
Maintain bed at lowest position possible to prevent further injury.

