N433 Care Plan #1

Lakeview College of Nursing

Kristine Johnson

Demographics (3 points)

Date of Admission 02/14/2020	Patient Initials C.D.W.	Age (in years & months) 15 months (13 months CA)	Gender Male
Code Status Full	Weight (in kg) 7.35kg	BMI 12.91 kg/m2	Allergies/Sensitivities (include reactions) Bio patch [chlorhexidine gluconate]

Medical History (5 Points)

Past Medical History: Born with gastroschisis, short gut syndrome, was on TPN for 1st several months of life, history of central lines, premature 32 weeks, developmental history: mildly delayed, hospitalized from 1st year to 1/16/20 prior.

Illnesses: Norovirus and Adenovirus

Hospitalizations: first year of life until 1/16/20 and then again from 2/14/20 to present.

Past Surgical History: G-tube placed 11/29/19

Immunizations: Immunization are up to date.

Birth History: Length: 38 cm, Weight: 1420g, head circumference: 28cm, discharged weight:4050g, gestational age: 32 6/7 weeks, delivery method: primary low transverse C-section.

Complications (if any): Gastroschisis

Assistive Devices: N/A

Living Situation: When not in hospital he would live with mom.

Admission Assessment

Chief Complaint (2 points): Vomiting

Other Co-Existing Conditions (if any): Short gut syndrome due to gastroschisis

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Pertinent Events during this admission/hospitalization (1 points): ER visit 2/13/20 with vomiting

History of present Illness (10 points): Per mom was vomiting every other day and didn't last week but started this week vomiting 2-3 times per day. Mom previously gave elacare but then gave pediasure. She thinks he is making himself throw up. Patient lost 2lbs in past month since discharge 1/16/20. Seen in ED 2/13/20 for vomiting, normal UOP, no fever, rx Zofran given, sent home. Stooled only once today, urinating fine, stools loose, green. Fed via G-tube.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Failure to thrive in pediatric patient

Secondary Diagnosis (if applicable): Norovirus and Adenovirus

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

Failure to thrive

The client has primarily admitted diagnosis with failure to thrive and was then given a secondary diagnosis of norovirus and adenovirus after being admitted (Henry, 2016, p. 280). Failure to thrive when a child is not obtaining or using calories that required to grow. These children would be under the 5th percentile for weight or have a pattern of consistent weight loss (Henry, 2016, p. 280). Some expected findings of this issue would include; malnourishment appearance, no fear of strangers, minimal smiling, decreased activity, withdrawal behaviors, developmental delays, feeding disorders, wide-eyed gaze, and stiff or flaccid body (Henry, 2016, p. 280). While with the client, I did observe the lack of fear of strangers since having never met the child before he was still so easily trusting of me as he saw me every day. Also, the lack of smiling was apparent,

and the feeding disorder can be related to the vomiting reported by the mother when she fed him anything by mouth, which is why he now has a gastrostomy. Complications to be aware of due to failure to thrive are extreme malnourishment. In those cases, the infants or child should be prepared for a feeding tube and/or IV, and another possible complication can be dehydration (Henry, 2016, p. 280). The signs and symptoms of this disease are not gaining weight or losing weight and not growing in height which is shown in the client when he was admitted being 2 pounds lighter than when he was discharged due to the vomiting (Henry, 2016, p. 280). Diagnostic and lab tests would apply for the client that could be done would be testing for gastrointestinal problems since the client was born with gastroschisis, a metabolic panel, blood glucose, and daily weights (Johns Hopkins Medicine, 2020). Treatment for this problem is situational based, but with this client, the primary treatment was to have him gain back the weight he lost with a fat emulsion on continuous IV and Elecare formula at 46 mL/hr continuously.

Pathophysiology References (2) (APA):

Henry, N. E. (2016). Complications of Infants. In M. McMicheal (Ed.), *RN Nursing Care of Children* (10.0 ed., p. 280). Assessment Technologies Institute, LLC.

Johns Hopkins Medicine. (2020). *Failure to Thrive*. Retrieved March 10, 2020, from https://www.hopkinsmedicine.org/health/conditions-and-diseases/failure-to-thrive

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: activity as tolerated	**Enjoys moving and being held**
Diet/Nutrition: Elecare formula	**Mix 3 scoops with 140 mL water at**

	46mL/hr continuously
Frequent Assessments: Blood glucose, daily weight, vital signs q8hr	**Preform cluster care** **Client experiences emotion distress seeing equipment for blood glucose.**
Labs/Diagnostic Tests: TPN, metabolic panel, phosphorus, magnesium, PT, INR, BMP, CMP	**When doing a blood draw, it should be done during cluster care because client experiences emotional distress during procedure.**
Treatments: OT eval and treatment	**Delay due to time in hospital. Needs to be held with standing, walking, etc.**
Other:	
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
Isolation	**Contact and droplet precautions** **Gown, gloves, mask**
N/A	**N/A**
N/A	**N/A**

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	**4.03-5.07**	**5.84**	**N/A**	**The increased red blood cells can be caused by a kidney issue which is**

				shown by the elevated BUN and Creatinine.
Hgb	**10.1-12.5**	**15.4**	**N/A**	**Increased RBC's would increase the overall Hgb**
Hct	**30.8-37.8**	**44.8**	**N/A**	**Increased RBC's would increase the overall Hct**
Platelets	**206-445**	**129**	**N/A**	
WBC	**6.0-13.5**	**10.53**	**N/A**	
Neutrophils	**1.19-7.21**	**N/A**	**N/A**	
Lymphocytes	**1.56-7.83**	**24.8**	**N/A**	
Monocytes	**0-5**	**7.9**	**N/A**	**Can be elevated because of the norovirus sparking the immune system to adapt.**
Eosinophils	**0-3**	**0**	**N/A**	
Basophils	**0-0.1**	**0.1**	**N/A**	
Bands	**5-11**	**N/A**	**N/A**	

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**	**148**	**N/A**	**Slightly above normal could be due to vomiting fluids**
K+	**3.5-5.0**	**3.4**	**N/A**	**Slightly below normal which could be caused my vomiting.**
Cl-	**102-112**	120	**N/A**	**Caused by vomiting and dehydration.**
Glucose	**70-140**	**150**	**80**	**Monitoring the blood glucose and strict diet plan had maintained blood glucose to a safe level.**
BUN	**7-20**	**67**	**36**	**Caused by kidney dysfunction**
Creatinine	**0.19-0.49**	**2.25**	**0.26**	**Indicator of kidney dysfunction. Client may not be expelling all waste at a cellular level.**

Albumin	**3.4-5.4**	**4.0**	**3.2**	
Total Protein	**6-8g**	**N/A**	**N/A**	
Calcium	**9.3-10.6**	**9.3**	**9.0**	
Bilirubin	**12-20**	**N/A**	**N/A**	
Alk Phos	**108-317**	**N/A**	**194**	
AST	**8-60**	**N/A**	**61**	**Slightly above average can indication liver damage can be caused by malnourishment.**
ALT	**7-55**	**N/A**	**106**	**Indicator of liver damage that could be caused by malnourishment**
Amylase	**0-137**	**N/A**	**N/A**	
Lipase	**12-70**	**N/A**	**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	**0-10**	**N/A**	**N/A**	
CRP	**<1.0**	**N/A**	**N/A**	
Hgb A1c	**<7.5**	**N/A**	**N/A**	
TSH	**0.55-5.31**	**N/A**	**N/A**	

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/**	**Yellow/**	**N/A**	

	clear	**hazy**		
pH	**4.5-8.0**	**6.0**	**N/A**	
Specific Gravity	**1.002-1.030**	**1.014**	**N/A**	
Glucose	**Negative**	**Negative**	**N/A**	
Protein	**Negative**	**Negative**	**N/A**	
Ketones	**Negative**	**Negative**	**N/A**	
WBC	**Negative**	**Negative**	**N/A**	
RBC	**Negative**	**Negative**	**N/A**	
Leukoesterase	**Negative**	**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**	**N/A**	
Blood Culture	**Negative**	**Negative**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**Positive**	**N/A**	
Respiratory ID Panel	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (APA):

Capriotti, T., Frizzell, J., (2016), *Pathophysiology Introductory concepts and clinical perspectives*. Philadelphia, PA, F.A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A
Diagnostic Test Correlation (5 points): N/A
Diagnostic Test Reference (APA): N/A

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

Brand/Generic	Acetaminophen (Tylenol)	Baclofen (Ozobax)	Fat emulsion 20% infusion	Ferrous sulfate (Iron supplement)	Pediatric multivitamin no.18
Dose	115.2 mg	1mg	8.052g 3.4 mL/hr	3.4 mg	1mL
Frequency	Q4hr	3x daily	Daily	3x daily	daily
Route	Oral	Tube- gastric	IV	Tube- gastric	Tube- gastric
Classification	Analgesic	Skeletal muscle relaxants	Iv fat emulsion	Iron replacement	Pediatric vitamin preparations
Mechanism of Action	Directly effects heat regulating center and used as analgesic	Exact mechanism of action is unknown; inhibits monosynaptic and polysynaptic spinal reflexes	Increase triglycerides	Provides Iron, an essential component in hemoglobin, myoglobin, and various enzymes	Provides vitamins the body cannot produce on its own.
Reason Client Taking	Pain relief	Relax muscles to reduce stiffness	Gain weight	Low iron	Replace vitamins that body does not produce
Concentration Available	160 mg per 5 mL	5 mg per 5mL	20%	N/A	N/A
Safe Dose Range Calculation	0-551.25mg	2.5-5 mg	N/A	22.05-44.1mg	N/A
Maximum 24-hour Dose	551.25	40 mg	N/A	44.1mg	N/A
Contraindications (2)	Hypersensitivity Caution in hepatic impairment	Hypersensitivity Avoid abrupt withdrawal	Disturbances of normal fat metabolism Normal fat metabolism	Hypersensitivity Primary hemochromatosis	Hypercalcemia Hyper magnesium
Side Effects/Adverse Reactions (2)	Nausea Rash	Drowsiness Dizziness	Nausea Dizziness	Dyspepsia Nausea	Dysrhythmia heart rate Muscle weakness
Nursing	Don't exceed	Cr. at baseline	Avoid use	No routine tests	Monitor

Considerations (3)	4g Monitor temp and pain Do not give with liver damage	EEG if epilepsy Must gradually ween off	of 10% in preterm infants 30% must not be infused directly Check IV site is patent	Can monitor CBC Check clients stool color.	Vital signs and compare to baseline Overdose of Vit. A, D, E,or K can be life threatening Avoid salt substitutes
Client Teaching needs (2)	Do not give is liver impaired Will not give GI upset like aspirin	Interacts characteristics : hyperglycemia and CNS depression	Platelet count should be monitored weekly You will also need your hemoglobin monitored	Take with vitamin C Take between meals	Take missed dose as soon as possible but don't take another dose Do not use salt substitutes since they will increase potassium.

Medication Reference (APA):

Jones & Bartlett Learning. (2019) *2019 Nurse's Drug Handbook, eighth edition.* Burlington, MA, Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert when awake but sleepy Verbal with cooing Dressed appropriately Clean clothes and diaper
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:**	Skin color tan-pink and moist Cool to the touch No tenting No rashes, brushing, or wounds Braden score: 8 PICC double lumen Left brachial 03/05/2020 Gastrostomy/Enterotomy tube in LLQ 02/16/2020

Drains present: Y☐ N ☐ **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Nasal congestion with drainage that is thin and clear Dentin good Ears moist and pink Head and neck midline Thyroid none palpable .
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:**	S1 and S2 +4 clear, no murmurs, normal sinus rhythm, peripheral pulses +3 and cap refill < 3 seconds
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	All fields are clear No rhonchi, wheezing, or crackles No accessory muscle use
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:**	Audible and active in all quadrants Last BM: 03/06/2020; large, loose, and yellow Abdomen flat Gastrostomy/ Enterotomy No distention, incisions, drains, or wounds A dime size scar over the sternum No nasal gastric tube
GENITOURINARY (2 Points): **Color:** **Character:**	No redness Client grabs at diaper in an itching motion Color yellow

Quantity of urine: **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	No indications of pain with urination No catheter or dialysis
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**☐	Full ROM No supportive devices Strength equal bilaterally Fall Score:6 Needs support to stand and walk (unable to walk) Can sit up and turn over independently
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Can say "ouch" when he believes he should feel pain or "toe" when prompted Glasgow coma scale: 15 Can give Hi-5 when prompted and given a demonstration No loss of consciousness He is sleepy
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):**	African American Copes with toy that has a pacifier attached Likes being held/ attention Has a single mom and both grandparents Dads parents recently started visiting after finding out they were grandparents

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**111**	**102/57**	**18**	**97.9** **Axillary**	**100** **Room air**

1400	**104**	**91/57**	**26**	**98.3** **Axillary**	**100** **Room air**

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

Pulse Rate	**70-150**
Blood Pressure	**90-105/55-70**
Respiratory Rate	**25-30**
Temperature	**37.7 C**
Oxygen Saturation	**100%**

Normal Vital Sign Range Reference (APA):

Henry, N.E. (2016) Physical Assessment Findings. RN Nursing Care of Children (10.0 ed., p. 7). Assessment Technologies Institute, LLC.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0805	**FLACC**	**None**	**0**	**None**	**Cluster care**
Evaluation of pain status *after* intervention	**FLACC**	**None**	**0**	**None**	**Cluster care**
Precipitating factors: not moving for a long period of time causing stiffness. Physiological/behavioral signs: Content, no grimacing					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
100 %	**140 mL**

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.uses a cup well

2. Build a tower of blocks

3. walk around

Age Appropriate Diversional Activities

1. playing with blocks
2. looking at picture books
3. filling and emptying containers

Psychosocial Development:

Which of Erikson's stages does this child fit?

Autonomy versus shame and doubt

What behaviors would you expect?

I would expect the 15-month-old to attempting to do everything for themselves and preform ritualism or maintaining routines and reliability

What did you observe?

I observed that the client wasn't interested in preforming tasks but seemed familiar with routines

with the hospital setting to know when he is going to feel pain.

Cognitive Development:

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

At 15 months the child is still in the sensorimotor stage until 19-24 months.

What behaviors would you expect?

Some behaviors I would expect include imitative activities such clapping or waving. Another behavior would be progress in reflexes such as when the child gets scare, they may flinch away from the loud noise.

What did you observe?

The client was able to wave or hi-5 when prompted and he was aware what activities would bring joy or pain so he would say “ouch” before being touched.

Vocalization/Vocabulary:

Development expected for child’s age and any concerns?

The client would only talk when prompted to repeat a word or when he thought he would feel pain by saying “ouch”. This is some what concerning since at 15 months old he should be saying more one-word response to tell others what he wants.

Any concerns regarding growth and development?

Yes, the client is below average for his height and weight which will be concerning long term as he grows and develops because their may be some gross motor delays.

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. Decreased functional ability related to malnutrition as evidence by losing two pounds post discharge and vomiting.	The client was reported to have been vomiting frequently after being fed formula.	1.Preform a through physical assessment and assess for chronic illnesses 2.Preform a through patient history; engage caretakers as needed	The patient was a little upset by all the movement and seemed to be tired. The toy he had helped as a distraction.
2. Potential for	The mom may be	1. Provide care for	The client’s mom was

poor parenting skills related to weight loss post discharge as evidence by mom believing the child was making himself vomit.	lacking education about the cognitive ability of a 15-month-old with the decision-making process.	the child until the parent is ready to provide care. 2.Teach the family what to expect in terms of growth and development for their child through role-modeling and having the parents return demonstrations.	slightly reluctant to listen to the information, but a paper copy was also provided on a printed handout.
3. Risk for infection related to client ill from a virus as evidence by diagnosis was norovirus and adenovirus.	The client was sick with Norovirus and Adenovirus which puts him at risk for other illnesses and increases the risk for infecting others.	1. Monitor vital signs 2. with isolation procedure.	Family would not put on the PPE when going into the client's room which increases the risk of spreading the virus.
4. Fatigue related to being awakened for vital signs and lab testing as evidence by sleeping most of the day.	The client may not be able to have a consistent sleep pattern due to the hospital setting and the labs and vitals that are constantly being done.	1. Preform cluster care as much as possible. 2. Reduce environmenta l stimuli	The client was woken up with all the tasking being performed such as lab draws, vital signs, blood glucose, and weight. Which resulted in being able to sleep a few hours before being checked again.

Other References (APA): Swearingen, P., (2019) *All-in-One Nursing Care Planning Resource*. Fifth edition. St. Louis, MI, Elsevier

Concept Map (20 Points):

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Subjective Data

Seemed to not fear strangers
Seemed to like toy with a pacifier attached
Pain FLACC score of 0

Nursing Diagnosis/Outcomes

Decreased functional ability related to malnutrition as evidence by losing two pounds post discharge and vomiting/ The patient was a little upset by all the movement and seemed to be tired. The toy he had helped as a distraction.
Potential for poor parenting skills related to weight loss post discharge as evidence by mom believing the child was making himself vomit/ The client's mom was slightly reluctant to listen to the information, but a paper copy was also provided on a printed handout.

Objective Data

Vital signs at 0800
Alert, clean clothed

Patient Information

15month old
Male
7.35kg
C.D.W.
Full code

Nursing Interventions

Preform a through physical assessment and assess for chronic illnesses
Teach the family what to expect in terms of growth and development for their child through role-modeling and having the parents return demonstrations.