N433 Care Plan #1

Lakeview College of Nursing

Twila Douglas

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
03/05/2020	S.L.	41 weeks	Male
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	10.5 kg	N/A	NKA

Medical History (5 Points)

Past Medical History: Past medical history includes right acute otitis media and no hospitalization prior to current hospitalization.

Past Surgical History: Patient does not have any significant surgical history.

Immunizations: Immunization that have been given include DTAP/IPV, Hep B, HIB-PRP-OMP/Pedvaz, influenza virus vaccine, pneumococcal and rotavirus.

Birth History: Patient's birth history include weight at 3440 grams, length 50.8 cm and head circumference 35 cm. APGAR scores include one at 8.0, five at 9.0 and ten is unknown. Discharge weight of patient was 3340 grams and delivery methods was vaginal and spontaneous. Gestation age was 41 weeks. Duration of the first part of labor was 5 hours and 32 minutes and the second part was 1 hour and 28 minutes. Information about hospitalization during birth was not listed in the patients record. The information also was not able to be received from parents during the recent hospitalization.

Complications (if any): No complications occurred during pregnancy or birth.

Assistive Devices: No assistive devices were needed.

Living Situation: Patient currently lives at home with parents and siblings. Patient has own room at home.

Admission Assessment

Chief Complaint (2 points): Patient was admitted because of a fever.

Other Co-Existing Conditions (if any): Other coexisting conditions that occurred was upper respiratory infection, cough, congestion and runny nose.

Pertinent Events during this admission/hospitalization (1 points): Pertinent events that occurred during this hospitalization is the IV insertion that failed two attempts.

History of present Illness (10 points): Fever was reported to have begun on 03/05/2020 and reached a max of 106.1 degrees Fahrenheit. Three days before admission, an upper respiratory infection, cough, runny nose, and congestion occurred. The patient was reported by mom not as active as usual. The patient has also had a decrease in appetite. The mother gave Tylenol and ibuprofen and was able to bring the temperature down to 99.5 degrees Fahrenheit. Mom stated the baby was more alert and playful than before. Baby tested positive for rhinovirus and will be treated with Rocephin.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Primary diagnosis on admission was rhinovirus infection.

Secondary Diagnosis (if applicable): There was no secondary diagnosis.

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

Rhinovirus is the most common cause of the common cold. This infection is most common in the fall and the spring, but can also occur year-round. Rhinovirus can infect lower airways and cause severe extra pulmonary and pulmonary complications. Mostly the nasopharynx and the nose are affected. Other complications that can occur include chronic bronchitis, otitis media, sinusitis, and asthma.

A child who has this infection typically will not have signs and symptoms until 2-3 days later. After the onset of symptoms, it can last about 10-14 days. Rhinovirus signs and symptoms include sneezing, sore throat, muscle ache, headache, fever, and a decrease in appetite. The parent should notify the physician if the child becomes very tired, nails or lips turn blue, persistent cough, and ear pain occurs.

The viruses can survive a few hours on an inanimate object; inanimate objects will cause the infection to be transferred to eyes, nose, or mouth. This virus replicates when the temperatures are lower, and they will not survive in the stomach due to the acidic environment. Standard laboratory tests include WBC, ESR, and CBC. PCR testing can be used with securely immunocompromised patients.

No medications are needed for treatment; treatment focuses on the prevention of spread and symptomatic relief. Rest and hydration are essential with healing. Antihistamines and nasal decongestants are used to treat symptoms. It is necessary to disinfect the environment and provide a comfortable temperature and humidity. Children with rhinovirus should avoid people who are sick or have respiratory infections. Diagnostic for rhinovirus are sensitive cell culture. Vital signs may show an increase in respiration and pulse due to breathing difficulties. An

increase in temperature can be seen in this infection. Blood pressure may be increased due to pain that may be associate with symptoms of rhinovirus.

Pathophysiology References (2) (APA): Rhinovirus Infections. (2020). Retrieved 10 March 2020, from https://www.healthychildren.org/English/health-issues/conditions/ear-nose-throat/Pages/Rhinovirus-Infections.aspx

Rhinovirus (RV) Infection (Common Cold): Practice Essentials, Background, Pathophysiology. (2020). Retrieved 10 March 2020, from https://emedicine.medscape.com/article/227820-overview

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Normal activity as tolerated	**Completed and was tolerated**
Diet/Nutrition: Regular diet with strict I&O	**Completed- Diet and nutrition was tolerated**
Frequent Assessments:Vitals Q8 hour	**Completed and stable.**
Labs/Diagnostic Tests: Urine- pending, Beta Strep negative, and blood culture pending.	**Test are still pending results**
Treatments: Rocephine	**Completed**
Other: Consult child life specialist	**Completed - assisted with distractions for IV insertion**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
PIC IV access	**Completed**

Laboratory Data (15 pointsCBC 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	4.74	N/A	N/A
Hgb	4.03-5.07	11.9	N/A	N/A
Hct	30.8-37.8	35.8	N/A	N/A
Platelets	206-445	264	N/A	N/A
WBC	5.998-13.51	8.77	N/A	N/A
Neutrophils	1.19-7.21	4.98	N/A	N/A
Lymphocytes	1.56-7.83	2.31	N/A	N/A
Monocytes	0.25-1.15	1.42	N/A	Elevated due to infection
Eosinophils	0.02-0/82	0.0	N/A	Reaction due to immune system reacting to infection
Basophils	0.01	0.2	N/A	N/A
Bands	N/A	N/A	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-	136-145	137	N/A	N/A

K+	**3.5-5.1**	**4.2**	**N/A**	**N/A**
Cl-	**21.0-32.0**	**106**	**N/A**	**N/A**
Glucose	**60-99**	**121**	**N/A**	**Virus caused glucose to increase due to augmented glucose uptake**
BUN	**7-18**	**18**	**N/A**	**N/A**
Creatinine	**0.70-1.30**	**0.44**	**N/A**	**Due to dehydration**
Albumin	**3.4-5.0**	**4.1**	**N/A**	**N/A**
Total Protein	**<10.0**	**N/A**	**N/A**	**N/A**
Calcium	**8.5-10.1**	**9.3**	**N/A**	**N/A**
Bilirubin	**0.2-1.0**	**0.2**	**N/A**	**N/A**
Alk Phos	**54-369**	**49**	**N/A**	**Due to decrease in appetite and decrease in nutrients**
AST	**12-780**	**30**	**N/A**	**N/A**
ALT	**N/A**	**N/A**	**N/A**	**N/A**
Amylase	**N/A**	**N/A**	**N/A**	**N/A**
Lipase	**N/A**	**N/A**	**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	**3-13**	**N/A**	**N/A**	**N/A**
CRP	**N/A**	**N/A**	**N/A**	**N/A**
Hgb A1c	**<5.7**	**N/A**	**N/A**	**N/A**
TSH	**0.8-6.4**	**N/A**	**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	Colorless-yellow	N/A	N/A	N/A
pH	6	N/A	N/A	N/A
Specific Gravity	1.002-1.030	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	Negative	N/A	N/A	N/A
RBC	Negative	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	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	No growth	Pending	N/A	N/A
Blood Culture	No growth	Pending	N/A	N/A
Sputum Culture	No growth	N/A	N/A	N/A
Stool Culture	No growth	N/A	N/A	N/A
Respiratory ID Panel	No growth	N/A	N/A	N/A

Lab Correlations Reference (APA): (2020). Retrieved 9 March 2020, from https://www.childrensmn.org/references/lab/hematology/cbc-reference-value-table.pdf

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest Xray, strep, urinalysis, respiratory pathogen panel, blood, urine and straight catheter.

Diagnostic Test Correlation (5 points): Chest X ray performed to assess lungs. Strep and respiratory pathogens panel was performed to assess infections of the respiratory tract. The straight catheter was performed to obtain a urine sample for testing. Blood was drawn to asses for any out of range findings.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner & Suddarth's Textbook of Medical-Surgical Nursing*** **(14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.**

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

Brand/Generic	**Benadryl/ Diphenhydramine**	**Albuterol sulfate**	**Hydrocortisone 2.5 %**	**N/A**	**N/A**
Dose	**12.5 mg/mL**	**2.5 mg/ 3 mL**	**2.5%**	**N/A**	**N/A**
Frequency	**QID**	**Q4 hr PRN**	**BID**	**N/A**	**N/A**
Route	**Oral**	**Inhalation**	**Topical**	**N/A**	**N/A**
Classification		**Bronchodial**	**Glucocortic**	**N/A**	**N/A**

	Antihistamine	**ator**	**oid**		
Mechanism of Action	**During an allergic reaction it will block certain natural substances.**	**Causes bronchdialatio and vasodilation which helps with breathing.**	**This horomone blocks certain proteins in the body that will decrease inflammation and prevent certain immune responses.**	**N/A**	**N/A**
Reason Client Taking	**Itching**	**Help with breathing**	**Decrease inflammation**	**N/A**	**N/A**
Concentration Available				**N/A**	**N/A**
Safe Dose Range Calculation				**N/A**	**N/A**
Maximum 24-hour Dose	**6 doses**	**24mg**		**N/A**	**N/A**

Contraindications (2)	**1. Hypersensitivity to benadryl 2. Patients with certain breathing problems**	**1. Hypersensitivity to albuterol 2. Use cautiously with pattens with diabetes mellitus 3. Use cautiously in patients with tachycardia**	**1. Cushing syndrom 2. Hypersensitivity to hydrocortisone 3. Skin abrasion**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**1. Constipation 2. Dry nose**	**1. Restlessness 2. CNS stimulation**	**1. Itching 2. Hives**	**N/A**	**N/A**
Nursing Considerations (3)	**1. Monitor for side effects 2. Monitor for allergic reactions. 3. Use cautiously in pattens with severe liver disease.**	**1. Assess vital signs. 2. Assess for adventitious sounds 3. Monitor blood and urine glucose.**	**1. Observe for edema 2. Monitor weight 3. Monitor vital signs**	**N/A**	**N/A**

Client Teaching needs (2)	**1. Can cause excitation in children. 2. Teach sleep hygiene techniques.**	**1. Do not exceed recommended dosage 2. Monitor for side effects 3. Read the instructions**	**1. Monitor skin for irritation 2. Follow physician order for administration**	**N/A**	**N/A**

Medication Reference (APA): Drugs.com | Prescription Drug Information, Interactions & Side Effects. (2020). Retrieved 10 March 2020, from https://www.drugs.com

Assessment

GENERAL (1 point): **Alertness: alert** **Orientation:** **Distress: Patient did not appear to be in any distress** **Overall appearance: Patient was pale and attempted to be friendly**	
INTEGUMENTARY (2 points): **Skin color: Pale** **Character:Skin was intact, moist and warm** **Temperature: warm** **Turgor: skin turgor was less than 3 seconds** **Rashes:No rashes** **Bruises: No bruises** **Wounds: No wounds** **Braden Score: 6** **Drains present: Y☐ N ☐ NO** **Type:N/A**	

HEENT (1 point): **Head/Neck: atraumatic without JVD, normocephalic** **Ears: ears appeared equal, without any drainage** **Eyes: PERRLA, eye lids equal and conjunctivae clear** **Nose: Normal mucosa, clear drainage, no septal deviations** **Teeth: two bottom teeth and two upper teeth** **Thyroid: non palpable**	.
CARDIOVASCULAR (2 points): **Heart sounds: S1S2 without murmurs S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): N/A** **Peripheral Pulses: bilaterally present 2+** **Capillary refill: less than 3 seconds** **Neck Vein Distention: Y ☐ N ☐ NO** **Edema Y ☐ N ☐NO** **Location of Edema: N/A**	.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ NO** **Breath Sounds: Location, character Equally clear with expiratory wheezes in lower lungs. No retractions**	.

GASTROINTESTINAL (2 points): **Diet at home: Regular table food** **Current diet:Regular table food** **Height (in cm): Current height wasn't document in chart** **Auscultation Bowel sounds: Active in all quadrants and normative** **Last BM: 03/06/2020** **Palpation: Pain, Mass etc.:Non tender and no mass** **Inspection: abdomen is non distended and skin is intact** **Distention: No distention** **Incisions:No incisions** **Scars: No scars** **Drains: No drains** **Wounds: No wounds** **Ostomy: Y ☐ N ☐NO** **Nasogastric: Y ☐ N ☐NO** **Size:N/A** **Feeding tubes/PEG tube Y ☐ N ☐NO** **Type:N/A**	.
GENITOURINARY (2 Points): **Color: clear-yellow** **Character: No sediments or no odor** **Quantity of urine: 50mL** **Pain with urination: Y ☐ N ☐NO** **Dialysis: Y ☐ N ☐NO** **Inspection of genitals: N/A** **Catheter: Y ☐ N ☐ NO** **Type:N/A** **Size:N/A**	

MUSCULOSKELETAL (2 points): **Neurovascular status: Pulses present and extremities warm** **ROM: ROM with all extremities** **Supportive devices:No supportive devices** **Strength: equal bilaterally** **ADL Assistance: Y☐ N ☐ YES** **Fall Risk: Y ☐ N☐YES** **Fall Score: 3** **Activity/Mobility Status: Activity with parent and able to crawl** **Independent (up ad lib) NO** **Needs assistance with equipment N/A** **Needs support to stand and walk: Needs assistance with standing and walking**	.
NEUROLOGICAL (2 points): **MAEW: Y ☐ YES N☐** **PERLA: Y ☐YES N☐** **Strength Equal: Y ☐ YES N ☐ if no - Legs ☐ Arms ☐ Both ☐BOTH** **Orientation:** **Mental Status: no deficits** **Speech: appropriate for age 3-5 words** **Sensory: intact** **LOC: Alert and oriented**	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s) of caregiver(s):Playing with child and watching videos on tablet.** **Social needs (transportation, food, medication assistance, home equipment/care): No social needs are needed.** **Personal/Family Data (Think about home environment, family structure, and available family support): Patient will go home with mother and father. Patient also has siblings at home. Patient's parents believe the patient will be more comfortable at home than in the hospital.**	.

Physical Exam (18 points)

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
805	**129**	**95/56**	**38**	**98**	**Room air** **97%**

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

Pulse Rate	**100-150**
Blood Pressure	**80/55-100/65**
Respiratory Rate	**30-55**
Temperature	**97.0F-100.3F**
Oxygen Saturation	**>93%**

Normal Vital Sign Range Reference (APA):

Almali, O. (2020). Pediatric Vital Signs Reference Chart | PedsCases. Retrieved 9 March 2020, from https://www.pedscases.com/pediatric-vital-signs-reference-chart

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10:50	**RFLACC 0**	N/A	N/A	N/A	N/A
Evaluation of pain status *after*	N/A	N/A	N/A	N/A	N/A

intervention					
Precipitating factors:N/A **Physiological/behavioral signsN/A**					

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
120mL	**50mL**

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. **At 2 months the child was able to lift head off the mattress**
2. **First teeth around 6-8 months**
3. **Standing up against furniture at 11 months**

Age Appropriate Diversional Activities

1. **Reading to the child**
2. **Use of positive reinforcement to support good behavior.**
3. **Playing with tablet with child**

Psychosocial Development:

Which of Erikson's stages does this child fit? Trust VS Mistrust

What behaviors would you expect?

The infant will begin to learn delayed gratification.

Trust can be developed by feeding and comforting.

What did you observe? I was able to see the child show trust in the nurse when the nurse comforted him during the assessment.

Cognitive Development:

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

What behaviors would you expect? You would expect the mental representation in the child and object prominence at age 10 months.

What did you observe? I was able to observe the child being observant in the crib full of toys. I was able to see the child play with toys on the floor. The child seem to be very curious about the things around him.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? This child should be able to say 3-5 words by the age of 1.The child was able to say a 3-5 words.

Any concerns regarding growth and development? There were no concerns regarding growth and development.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

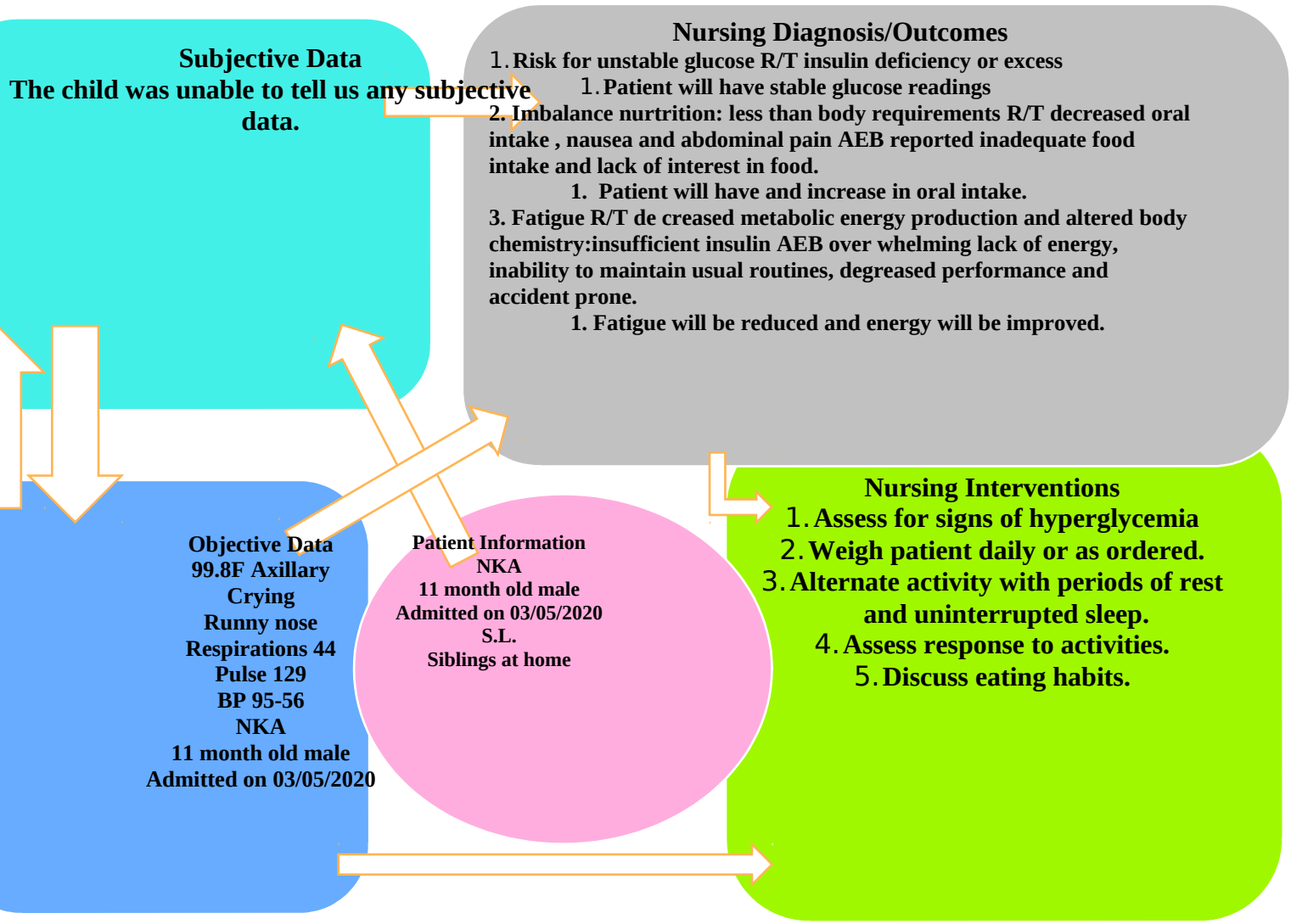
Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Ineffective airway clearance R/T tracheal bronchial and nasal secretions AEB rhinorrhea, changes in respiratory rate and depth and production of sputum.	**This nursing diagnosis was chosen due to patient having nasal secretions that was effecting breathing.**	**1. Assess respiratory status for rate, depth, ease and use of accessory muscles and work of breathing.** **2. Auscultate the lung fields for. The presence of wheezes, crackles, rhonchi or decreases breathe sounds.**	**Patient and family responded well to the interventions.** **Client responded well to interventions and goals were accomplished**
2. Ineffective breathing pattern R/T inflammation from viral infections AEB coughinh, tachypnea, warm flushed skin, abdmormal chest X ray, fever and sputum.	**This diagnosis was chosen due to patient having warm flushed skin, fever and ineffective breathing pattern.**	**1. Administer oxygen as order** **2. Auscultate breathe sounds evert 2-4 hours and as needed.**	**Patient and family responded well to the interventions and was able to see an improvement in breathing.** **Client responded well to interventions and goals were accomplished.**
3. Acute pain R/T coughing and influenza virus AEB fever, cough, and malaise.	**This diagnosis was chosen due to patient having fever, cough, malaise and coughing.**	**1.Provide restful and quiet environments.** **2. Assess and monitor changes in vital signs.**	**Patient and family responded well to the interventions and temperatures were decreased.** **Client responded well to interventions and goals were accomplished**

4. Risk for infection R/T knowledge deficit about infection in children AEB irritability and pulling of ear.	**This diagnosis was chosen due to patient having a previous infection.**	**1. Encourage increased fluid intake, good nutrition and adequate rest.** **2. Advice family member on hand washing techniques and importance of covering their mouths and nose when coughing and sneezing.**	**Patient and family responded well to the interventions.** **Client responded well to interventions and goals were accomplished**

Other References (APA): Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner & Suddarth's Textbook of Medical-Surgical Nursing*** **(14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.**

Concept Map (20 Points):


Subjective Data
The child was unable to tell us any subjective data.
Nursing Diagnosis/Outcomes
1. Risk for unstable glucose R/T insulin deficiency or excess
1. Patient will have stable glucose readings
2. Imbalance nurtrition: less than body requirements R/T decreased oral intake , nausea and abdominal pain AEB reported inadequate food intake and lack of interest in food.
1. Patient will have and increase in oral intake.
3. Fatigue R/T de creased metabolic energy production and altered body chemistry:insufficient insulin AEB over whelming lack of energy, inability to maintain usual routines, degreased performance and accident prone.
1. Fatigue will be reduced and energy will be improved.
Objective Data
99.8F Axillary
Crying
Runny nose
Respirations 44
Pulse 129
BP 95-56
NKA
11 month old male
Admitted on 03/05/2020
Patient Information
NKA
11 month old male
Admitted on 03/05/2020
S.L.
Siblings at home
Nursing Interventions
1. Assess for signs of hyperglycemia
2. Weigh patient daily or as ordered.
3. Alternate activity with periods of rest and uninterrupted sleep.
4. Assess response to activities.
5. Discuss eating habits.