N433 Care Plan #2

Lakeview College of Nursing

Twila Douglas

Demographics (3 points)

Date of Admission	Patient Initials	Age (in years & months)	Gender
03/06/2020	E.P.	13 years, 4 months	Female
Code Status	**Weight (in kg)**	**BMI**	**Allergies/Sensitivities (include reactions)**
Full	54.7 kg	23.22	Sulfa

Medical History (5 Points)

Past Medical History: Diabetes type 1

Illnesses: Degenerative joint disease

Hospitalizations: 05/03/18 hyperglycemia

Past Surgical History: No significant past surgical history.

Immunizations: Immunizations include HPV, DTap, influenza, pneumonia, Hepatitis B. And HIB

Birth History: E.P. was delivered via vaginal birth. Child was not premature and had no complications after birth.

Complications (if any): None

Assistive Devices: Insulin pump

Living Situation: Lives at home with parents and siblings.

Admission Assessment

Chief Complaint (2 points): Vomiting

Other Co-Existing Conditions (if any): Nausea and abdominal cramping

Pertinent Events during this admission/hospitalization (1 points): No pertinent events occurred during this admission.

History of present Illness (10 points): Symptoms began about 7 hours before admission. The patient reported abdominal cramping, along with nausea and vomiting. The vomiting is occurring intermittently, and the abdominal cramp is occurring more constantly. The abdominal pain is generalized, and vomiting occurred thirteen times before admission. Vomit was non bloody and non-bilious. The episodes of vomiting have increased exacerbation of the patient's chronic back pain. As of now, nothing this relieving pain. Treatment includes bowel rest, monitor glucose, lactate ringer bolus, and pain relief.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.Bandemia without diagnosis of specific infection.

Secondary Diagnosis (if applicable):. No secondary diagnosis.

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

Bandemia occurs when there are too many white blood cells that are being released by bone marrow into the bloodstream. This condition is usually an indication of an inflammation or an infection. This condition can be caused by leukemia, corticosteroid use, autoimmune disease, cancer, and chemotherapy. Symptoms of bandemia include fever, losing weight, bleeding excessively, night sweats, frequent or unusual infections, and bruising easily.

The diagnosis for bandemia includes taking a blood sample. Before taking the blood sample, certain medications may need to be stopped prior. The complete blood count will show an increased level of band cell.

Treatment will depend on determining the underlying cause and correcting it. The physician will monitor the band cell count to determine how well the treatment is working. Leukemia and other cancers are typically treated with chemotherapy and radiation therapy. Since autoimmune diseases are incurable, treatment will focus on reducing inflammation and help control the overactive immune response.

Pathophysiology References (2) (APA):

Bandemia: Definition, Causes, and Associated Conditions. (2020). Retrieved 26 March 2020, from https://www.healthline.com/health/bandemia

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.**

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:Regular	**Tolerating activity well**

Diet/Nutrition: Diabetic diet	**Appetite is slowly improving**
Frequent Assessments: Vital signs Q8	**Vital signs are stable**
Labs/Diagnostic Tests:CBC, UA, respiratory pathogen panel, and beta hydroxybulate.	**Results are back**
Treatments:Lactate Ringers bolus and monitoring glucose	**Glucose is being monitored and hydration**
Other:	
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	**3.93-4.90**	**4.71**	**N/A**	

Hgb	**10.8-13.3**	**13.6**	**N/A**	
Hct	**33.4-40.4%**	**42.3%**	**N/A**	
Platelets	**194-345**	**341**	**N/A**	
WBC	**4.19-9.43**	**15.84**	**N/A**	**Infection**
Neutrophils	**1.82**	**7.47**	**N/A**	**Infection**
Lymphocytes	**1.16-3.33**	**0.08**	**N/A**	**Infection and inflammation**
Monocytes	**0.19-0.72**	**0.71**	**N/A**	
Eosinophils	**0.02-0.32**	**0.16**	**N/A**	
Basophils	**0.01-0.05**	**0.00**	**N/A**	
Bands	**0.0-10.0%**	**21.5**	**N/A**	**Inflammation and infection**

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**	**139**	**N/A**	
K+	**3.5-5.1**	**4.1**	**N/A**	
Cl-	**21.0-32.0**	**26.2**	**N/A**	
Glucose	**60-99**	**197**	**N/A**	
BUN	**7-18**	**16**	**N/A**	
Creatinine	**0.55-1.02**	**0.81**	**N/A**	
Albumin	**3.4-5.0**	**3.9**	**N/A**	
Total Protein	**6.4-8.2**	**7.6**	**N/A**	

Calcium	**8.5-10.1**	**9.2**	**N/A**	
Bilirubin	**0.2-1.0**	**0.7**	**N/A**	
Alk Phos	**54-369**	**270**	**N/A**	
AST	**10-40**	**12**	**N/A**	
ALT	**12-78**	**22**	**N/A**	
Amylase	**N/A**	**N/A**	**N/A**	
Lipase	**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	**1-13**	**N/A**	**N/A**	
CRP	**8-1000**	**N/A**	**N/A**	
Hgb A1c	**<7**	**6.7**	**N/A**	
TSH	**0.358-3.740**	**2.790**	**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**	**Yellow**	**N/A**	
pH	**5.0-7.0**	**5.0**	**N/A**	
Specific Gravity	**1.003=1.035**	**1.024**	**N/A**	**Diabetes type 1**
Glucose	**Negative**	**50**	**N/A**	

Protein	**Negative**	**Negative**	**N/A**	
Ketones	**Negative**	**20**	**N/A**	**Due to cells not getting enough glucose and body burns fat for energy instead**
WBC	**0-25**	**7**	**N/A**	
RBC	**0-20**	**16**	**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	**No growth**	**Abnormal**	**N/A**	**Infection**
Blood Culture	**No growth**	**N/A**	**N/A**	
Sputum Culture	**No growth**	**N/A**	**N/A**	
Stool Culture	**No growth**	**N/A**	**N/A**	
Respiratory ID Panel	**No growth**	**No growth**	**N/A**	

Lab Correlations Reference (APA): 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): Beta-hydroybutyrate, glucose, Glyco HB A/C beta strep culture, and chromosome analysis

Diagnostic Test Correlation (5 points): Beta strep culture- Negative, chromosome analysis- no abnormalities found, performed to R/O turners syndrome

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	**Naproxen Sodium / Aleve**	**0.9 NaCL w. KCL 20 116 mL/hr**	**ACetaminophen/ Tylenol**	**Continuous subs insulin**	**N/A**
Dose	**550 mg**	**Continuous**	**650 mg**	**Varies**	
Frequency	**BID**	**IV**	**Q4PRN**	**Varies**	
Route	**Oral**	**iv**	**Oral**	**Subcutaneous**	
Classification	**NSAID**	**Sterile, nonpyrogenic solution**	**Analgesic**	**Insulin**	
Mechanism of Action	**Reduces hormones that cause inflammation in the body**	**Electrolyte replenisher**	**It may reduce the production of prostaglandins in the brain**	**Lowers blood sugar by stimulating glucose and inhibiting glucose production and release by the liver.**	
Reason Client Taking	**Control inflammation and pain**	**Hydration**	**Pain**	**Diabetes type 1**	

Concentration Available	**10mg**	**n/a**	**160 mg/5ml**	**n/a**	
Safe Dose Range Calculation	**275/ dose**	**55mg**	**550-825mg**	**n/a**	
Maximum 24-hour Dose	**1100**	**2000**	**3300**	**n/a**	
Contraindications (2)	**1. Hypersensitivity to naproxen 2. Patients with clotting disorders**	**1. Hypervolemia patients 2. Congestive heart failure**	**1. Hypersensitivity to Tylenol 2. Acute liver failure**	**1. low blood sugars 2. Low potassium in the blood.**	
Side Effects/Adverse Reactions (2)	**1. Bruising 2. Headache**	**1.phlebitis 2.Hypervolemia**	**1. Nausea 2. Rash**	**1. Sweating 2. Shakiness**	
Nursing Considerations (3)	**1. May be taken with food or milk 2. Don't mix suspension 3. Do not break, crush or chew tablet**	**1. Monitor I & O 2. Monitor for fluid overload 3. Monitor for phlebitis**	**1. Temporary use 2. Overdose will lead to hepatoxicity 3. May increase risk for bleeding with warfarin therapy**	**1. monitor patients intake 2. Monitor exercise 3. Monitor patients safety needs**	

Client Teaching needs (2)	**1. Swallow extended-release, delayed-release and controlled released tablet whole 2. Take with milk or food if GI upset occur**	**1. Notify of any change in breathing 2. Monitor for leakage from IV**	**1. Acetoadote is the antidote 2. Don't exceed recommended dosage**	**1. Diet for diabetics 2. Signs of hypoglycemia**	

Medication Reference (APA):
Drugs.com | Prescription Drug Information, Interactions & Side Effects. (2020). Retrieved 27 March 2020, from https://www.drugs.com

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert** **Orientation:X4** **Distress: Patient did not appear to be in any stress.** **Overall appearance: Patient skin was pale and patient looked frail**	

INTEGUMENTARY (2 points): **Skin color: Pale** **Character: Skin was intact, warm and moist** **Temperature: warm** **Turgor:skin turgor was less than 3 seconds** **Rashes: No rashes** **Bruises: no bruises** **Wounds no wounds** **Braden Score:** **Drains present: Y☐ N ☐** **Type:** **Size of iv:20 G** **Location : L AC** **Date on IV: 03/06/2020** **Latency of IV: patent, flushed without difficulty** **NO signs of erythema or drainage** **IV dressing assessment: Intact, dry, clean and infusing** **IV fluid rate: 116mL/hr**	
HEENT (1 point): **Head/Neck:atraumatic, normocephalic, neck-supple** **Ears: no signs of drainage or pain Equal** **Eyes: PErrla, EDM intact, conjuctiva clear, eyes equal** **Nose: No spatial deviation, no drainage, normal mucosa** **Teeth: good dentition** **Thyroid:non palpable**	.

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc. s1s2, no murmurs** **Cardiac rhythm (if applicable): n/a** **Peripheral Pulses:present bilaterally 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☐ N ☐no** **Breath Sounds: Location, character** **Bilaterally equal and clear** **No use of accessory muscles or retractions**	.
GASTROINTESTINAL (2 points): **Diet at home: diabetic diet** **Current diet:diabetic diet** **Height (in cm): 153.5 cm** **Auscultation Bowel sounds: active in all quadrants** **Last BM: two days prior to admission** **Palpation: Pain, Mass etc.:nontender and no mass** **Inspection:** **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:yellow** **Character:no odor or sediments** **Quantity of urine: 70mL** **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 are warm** **ROM:ROM with all extremities** **Supportive devices:no supportive devices** **Strength:equal bilateral** **ADL Assistance: Y☐ N ☐ no** **Fall Risk: Y ☐ N☐no** **Fall Score: 3** **Activity/Mobility Status: activity as tolerated** **Independent (up ad lib) yes** **Needs assistance with equipment no** **Needs support to stand and walk-on**	.
NEUROLOGICAL (2 points): **MAEW: Y ☐ yes N☐** **PERLA: Y ☐ yes N☐** **Strength Equal: Y ☐ yes N ☐ if no -** **Legs ☐ Arms ☐ Both ☐both** **Orientation:person, place, time, event** **Mental Status:no deficits** **Speech: spontaneous and logical** **Sensory:intact** **LOC: alert and oriented X4**	.

PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s) of caregiver(s): Watching television and playing games on phone.** **Social needs (transportation, food, medication assistance, home equipment/care): no social needs are needed. Parents will help.** **Personal/Family Data (Think about home environment, family structure, and available family support): Patient will eb discharge to parents and return home with siblings.**	.

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
830	**78**	**105/58**	**22**	**98.6**	**100%**

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

Pulse Rate	**50-90BPM**
Blood Pressure	**116/70 - 124/79**
Respiratory Rate	**12-18**
Temperature	**97.0F -100.3F**
Oxygen Saturation	**97-100%**

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
08:05	**0-10 (0) Denies pain**	**N/A**	**N/A**	**N/A**	**N/A**
Evaluation of pain status *after* intervention	**No pain**	**N/A**	**N/A**	**N/A**	**N/A**
Precipitating factors: N/A Physiological/behavioral signs N/A					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
240 mL	**700 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. **Puberty**
2. **Menstrual cycle**
3. **More independent than previous years**

Age Appropriate Diversional Activities

1. **Video games**
2. **Reading**
3. **Computer**

4. **Bike riding**

Psychosocial Development:

Which of Erikson's stages does this child fit?

Identity vs. Role confusion

What behaviors would you expect?

You would expect the child to begin to form their own identity. Failure to establish their own identity can lead to role confusion. Children may begin to feel uncomfortable about their bodies.

What did you observe? I was able to observe how the patient was establishing their own identity. It was very important to fit in with other children her ages.

Cognitive Development:

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

This child will fit in the formal operational stage.

What behaviors would you expect? They are able to think in abstract manner. They are also able to manipulate ideas in their head.

What did you observe? I was able to observe the patient using her own thoughts when communicating about her condition.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? The child will be able to express their wants and needs. The child will be able to multitask better and start prioritizing task.

Any concerns regarding growth and development?

There were no concerns regarding development. Compared to other girls her age she was a little underweight and height, but 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. Risk for unstable glucose R/T insulin deficiency or excess	**This diagnosis was chosen due to having type 1 diabetes**	**1.Assess for signs of hypoglycemia** **2. Assess blood glucose levels before meals and bedtime**	**Patient and mother was understanding of risk for unstable glucose.**

2. Imbalanced nutrition: less than body requirements R/T decreased oral intake, nausea and abdominal pain AEB reported inadequate food intake and lack of interest in food.	**This diagnosis was chosen due to change in appetite and intake of food.**	**1. Daily weight, or as ordered** **2. Discuss eating habits and encourage diabetic diet as prescribed by the doctor.**	**Patient was understanding and showed an increase in appetite. Patient was able to eat and drink more than prior to admission.**
3. Fatigue R/T decreased metabolic energy production and altered body chemistry: insufficient insulin AEB overwhelming lack of energy, inability to maintain visual routines, decreased performance and accident prone .	**This diagnosis was chosen due to patient being fatigue.**	**1. Alternate activity with periods of rest.** **2**. Assess response to activities.	**Patient stated feeling less fatigue after receiving bolus IV and eating.**
4. Risk for injury R/T hyperglycemia and immune system deficit	**Patient is at risk for hyperglycemia due t shaving diabetes**	**1. assess the patient's skin integrity** **2. Assess for evidence of infection.**	**Patient has an understanding of how to monitor blood glucose to prevent hyperglycemia.**

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

Abdominal pain
Nausea
Vomiting
Fatigue
Back pain

Objective Data

Pale skin
98.6F
78 P
22R
100% room air
105/58

Patient Information

E.P
13 years old
Female
Sulfa allergy
Full code
Diabetic type 1
Lives at home with parents and siblings
Middle school student

Nursing Diagnosis/Outcomes

1. Risk for unstable glucose R/T insulin deficiency or excess
- Patient will have stable blood glucose levels

2.Imbalanced nutrition: less than body requirements R/T decreased oral intake, nausea and abdominal pain AEB reported inadequate food intake and lack of interest in food.
-Patient will have balance nutrition intake

3. **Fatigue R/T decreased metabolic energy production and altered body chemistry: insufficient insulin AEB overwhelming lack of energy, inability to maintain visual routines, decreased performance and accident prone .**

-Will display improved ability to participate in desired activities.

1. **Risk for injury R/T hyperglycemia and immune system deficit**

-Patient is free of injury

Nursing Intervention

1. **Assess for signs of hypoglycemia**
2. **Assess blood glucose levels**
3. **Weigh daily**
4. **Discuss eating habits and encourage diabetic diet**
5. **Alternate activity with periods of rest**
6. **Assess response to activities**
7. **Asses patients skin integrity**
1. **Assess for evidence of infection**