**FNP Children/OB**

**SOAP NOTE 3**

Presented to:

#### Ms, Lisa Hill, RN, MSN

In Partial Fulfillment of the Requirements for the Course

**FNP GNRS 5670 FNP Children/OB**

Presented by

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The University Of Texas Medical Branch at Galveston School of Nursing

**A. Subjective:**

*Demographic data:*

KAU, SUR 8 year old living with her parents and his younger sister. Dad work as an insurance consultant and Mom works part time as cashier at Wal-Mart.

*Chief Complaint:*

Mom states that she started vomiting last night and noticed fever this morning. She complains of abdominal pain and unable to keep any thing down.

*History of presenting illness:*

Patient came to the clinic started vomiting last night at about 9 pm. She vomited five times and at about 2 am she started with fever and diarrhea. She c/o stomach cramping and unable to keep anything down. She ate soup and salad for dinner at home with her family and nobody else sick at home.

 *Current Health Status*

Patient had no known food & drug allergies. Immunizations up to date and yearly physical done in the clinic regularly. She eats healthy at home and is a cheer leader at school. She denies getting her flu shot last year.

*Past Medical History:*

Mom considers her child as normally healthy, denies any medical problems. She denies any surgeries, blood transfusions and hospitalizations. Have not been involved in any MVA, denies any psychiatric or any serious illness.

*Social History:*

She lives with both her parents in a three bedroom house in Cy-fair. Family and friends is her social support system. She goes to the nearby Catholic Church with her parents. Dad works as insurance consultant and Mom works as cashier at Wal-Mart. Grandmother helps mom in taking care of her kids after school.

*Developmental history:*

Patient was born as full term at 39 weeks by normal vaginal delivery. Birth weight 8 pounds and mom denies any prenatal or postnatal problems. No developmental delays and as a young school interested in real life tasks and activities. She enjoys doing things together with her school mates and good problem solving ability. Tanner stage 1 on sexual development.

*Impact on lifestyle:*

Mom is concerned that she is unable to go the school.

*Patient Explanatory Model:*

Mom is concerned about dehydration and food poisoning.

*Family History*

Father: Denies any medical problems.

Mother: Denies any medical problems.

 Other members of the family: unknown medical history

*Review of Symptoms*:

General: Good sense of well being, no ADL limitations

Skin: Skin is warm and moist.

Head and neck: denies any headache or abnormalities

Eyes: denies visual problems nor wearing any corrective glasses

Ears: denies hearing difficulty

Nose: denies congestion nor difficulty breathing

Throat & mouth: denies dysphagia, gingivitis and sores

Cardiovascular: denies palpitations, chest or back pain

Lungs: denies difficulty in breathing

Gastrointestinal: complain of nausea, vomiting, diarrhea and abdominal pain and cramping. Vomited food particles and yellowish colored vomitus and about 5 times in last 24hrs. Diarrhea three times in last 24 hrs and is foul smelling, yellowish brown in color.

GU: Denies any dysuria, nocturia or frequency

Musculoskeletal: extremities optimal functioning, denies any leg swelling and denies any joint pain

Neuro/Psych: no fainting, seizures, motor or sensory loss.

Endocrine: No known thyroid issues, temperature intolerance, sweating average. No symptoms or history of diabetes.

**B. Objective Information**

Vital signs: BP – 113/59; PP – 67; RR – 18; T – 97.8; Ht 4’0” Wt 77lb; BMI 23.0, 50th percentile on height and 90th percentile on weight.

**General:** Patient observed to be in her normal state of health includes proper grooming and balance gait. No SOB, nail beds are pink in color with capillary refill of less than two second.

HEENT**: Head**: No deformity noted nor any signs of trauma, normal shape, no bumps & scrapes, healthy hair growth, face symmetrical**. Eyes**: noted normal vision, conjunctiva clear, with no abnormal drainage. **Ears**: Bilateral ears normal in appearance, no abnormal drainage, no redness nor swelling noted in the ear canal. **Nose**: No noted mucus running down from the patient’s nose, normal mucosa, midline septum, no noted sinus tenderness. **Throat**: normal color with no swelling in appearance and no abnormal drainage noted, no dysphagia noted

**Neck**: Normal to touch, no jugular vein distension.

**Chest & Back**: Symmetrical chest rise with normal chest expansion upon breathing. Respiratory rate is normal with normal depth & pattern. No depression, bulging & crepitus in palpation. No breast nodules but noted left breast scar due to history of lumpectomy

**Skin:** Pink with no skin rash, sores & lesions noted. Palms cold and moist with good color. Nails without cyanosis and clubbing. Skin turgor less than 2sec.

**Gastrointestinal:** Abdomen protuberant, bowel sounds hyperactive on all quadrants, no tenderness on palpation. Negative on psoas and obturator signs and no rebound tenderness noted. Liver span 7 cm in right midclavicular line, edge smooth and palpable 1 cm below right costal margin. Spleen and kidney not felt and no costovertebral tenderness noted on palpation.

**Genitalia:** External genitalia without erythema, lesions or masses. No inguinal adenopathy. **Musculoskeletal:** No joint deformities and good range of motion noted.

**Assessment:**

**1. Gastroenteritis**

Gastroenteritis is a condition that causes irritation and inflammation of the stomach and intestines (the gastrointestinal tract). The most common symptoms are nausea, vomiting diarrhea and crampy abdominal pain. It can be caused by various viruses, bacteria and parasites. Bacterial agents cause damage to the intestinal mucosa by direct invasion and through release of endotoxins (Berman, 2003).

**2. Appendicitis**

Appendicitis means inflammation of the appendix. It is thought that appendicitis begins when the opening from the appendix into the cecum becomes blocked. The main symptom of appendicitis is abdominal pain. The pain is at first diffuse and poorly localized. A second, common, early symptom of appendicitis is loss of appetite which may progress to nausea and even vomiting. Nausea and vomiting also may occur later due to intestinal obstruction. Appendicitis is the source of abdominal pain most commonly treated with surgery, and its affects four of every 1000 children (McCollough & Sharieff, 2006).

 **3. Irritable Bowel Syndrome**

 Irritable bowel syndrome (IBS) is a disorder that leads to abdominal pain and cramping, changes in bowel movements, and other symptoms such as fullness, gas and alternating diarrhea and constipation. According to (Rasquin et al, 2006) the criteria for IBS must include abdominal discomfort or pain associated with two or more of the following at least 25% of the time

* Improved with defecation
* Onset associated with change in frequency of stool
* Onset associated with change in form of stool
* And no evidence of an inflammatory, anatomic, or neoplastic process

**Plan:**

***1. Diagnostic***

***CBC* and Blood Culture:** A complete blood count with differential may show an increase WBC, with an increased neutrophil count.

**Stool Culture:** Stoolexamination and stool culture for bloody or prolonged diarrhea, suspected food poisoning or recent travel abroad (Banks, 2004).

 **Urinalysis** (UA): UA should be done to check WBC & RBC which signifies infection and blood in the urine. It also checks nitrites which signifies gram (-) bacteria in the urine such as E-coli (Goroll, 2009).

**CMP:** It helps to evaluate dehydration. Steiner (2004) found that CRT, skin turgor, and tachypnea, when considered together, were the most helpful in the determination of dehydration and serum bicarbonate below 15-17 mEq/L was the most valuable laboratory test to make the diagnosis for dehydration.

**Imaging:** Abdominal radiographs to rule out obstruction or foreign body and US to rule out abscess, masses or appendicitis (Burns, 2009).

There are no laboratory markers for IBS and physical examination shows normal physical examination and absence of alarm signs.

 ***2. Therapeutic***

* Zofran 4mg one time dose given in the clinic, antiemetic reduces nausea and reduces the chance of dehydration. (Freedman et al, 2006).
* Rehydrate with small amount of clear liquids every 5-10 minutes and observed if the patient is able to pass the PO challenge. Oral rehydration is not indicated in cases of hemodynamic shock or suspected bowel obstruction (King et al, 2003).
* Monitor urine output
* Tylenol 350mg orally every four hours as needed for fever greater than 101.5F.

***3. Education***

1 Resume maintenance fluid level and pedialyte recommended to parents.

2 Refeeding should be resumed as quickly as possible because the gut needed repair following injury. Patient should return to a regular diet as soon as possible. She could start with bland diet, which includes complex carbohydrates such as bananas, applesauce, pretzels, and rice or rice cereal.

3 Good hand washing and sanitation techniques.

***4. Follow-up***

Return to the clinic immediately if worsening of symptoms such as persistent fever, chills, vomiting diarrhea or sings of dehydration. Otherwise follow up in two weeks. Call for any questions.

***5. Referral***: No referral at this time. Refer if the child as a toxic appearance or moderate to severe dehydration, projectile vomiting, vomiting greater than 12hours, or vomiting blood, bile or fecal matter (Burns, 2009).

**Reference:**

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