1 Patient Information

1 PATIENT DETAILS

Name
Owen J. Castellano

Date of Assessment
05/06/2026

DOB
07/14/2017

Time of Assessment
02:15 AM

Age / Sex
8 / Male

MRN
PED-2026-0814

Unit / Room
Pediatric Unit — Room 412B

Nurse / Provider
RN Sarah K. Mitchell, BSN, PCCN

Reason for Assessment
Admission shift assessment — transferred from pediatric ED for acute asthma exacerbation and T1DM diabetic ketoacidosis (DKA)

GA General Appearance

2 OVERALL CONDITION

Owen is an 8-year-old male who appears acutely ill and in moderate respiratory distress upon admission to the pediatric unit at 02:15 AM. He is awake and alert, responsive to voice, and able to answer simple questions between breaths but tires quickly with prolonged speaking. He is visibly breathing fast and working hard to breathe, using accessory muscles in his neck. He is diaphoretic with mild pallor. He is sitting up in bed in tripod position, leaning forward on both arms — the posture he finds most comfortable. He appears anxious, which his mother states is typical when he has a bad asthma attack. He is thin for his age, consistent with T1DM. His mother (Maria Castellano) is at bedside and is calm but visibly worried. Owen is cooperative with nursing care, though he protests the continuous pulse oximeter probe on his finger. He speaks in short fragmented sentences.

N Neurological

3 NEURO STATUS

Alert and oriented x4 — correctly identifies name, location, date, and that he is in the hospital. GCS 15 (E4V5M6). Speech: fragmented sentences due to respiratory effort but intelligible. No confusion, hallucination, or altered mental status. No focal neurologic deficits. No seizure activity reported by mother or observed during assessment. Pupils assessed at 02:15 AM: bilateral, equal, round, reactive to light (PEARL), approximately 4 mm bilaterally. No headache reported. Motor strength grossly intact in all four extremities — Owen able to reach for items and move legs freely in bed. Sensory intact to gross testing. No behavioral changes from baseline neurologic status per mother's report.

H HEENT

4 HEAD / EYES / EARS / NOSE / THROAT

HEAD: Normocephalic, atraumatic. No scalp lacerations or visible trauma. HEAD: No tenderness on palpation. EYES: Mild periorbital edema (from crying). Conjunctivae mildly injected bilaterally — no discharge. Sclerae clear. Pupils as documented in neuro section. Visual tracking intact. EARS: Bilateral external ears intact. No drainage. No complaints of ear pain. NOSE: Bilateral nasal flaring noted — active sign of increased work of breathing. Mild clear rhinorrhea bilaterally — consistent with upper respiratory infection (URI) that preceded the asthma exacerbation per mother's history (onset 3 days ago). No epistaxis. MOUTH/THROAT: Lips and oral mucosa: dry, with circumoral dryness — dehydration from DKA. Mucous membranes dry. Tongue: dry. No oral lesions. Tonsils: grade 2 bilateral, mildly erythematous (URI-related). No exudate. Uvula: midline. Swallowing: intact but patient refusing oral fluids currently — nauseous. Dentition: appropriate for age.

CV Cardiovascular

5 CV STATUS

Heart rate: 138 bpm — TACHYCARDIA (expected — compensatory for hypoxia, dehydration, and metabolic acidosis). Heart rhythm: Regular. Heart sounds: S1 and S2 present; no murmurs, rubs, or gallops auscultated. Peripheral pulses: radial and dorsalis pedis pulses 2+ bilaterally — adequate perfusion. Capillary refill: 2.5 seconds bilaterally in fingertips — borderline (borderline perfusion consistent with DKA dehydration; not critically prolonged). Skin perfusion: warm, flushed (DKA-related vasodilation). Extremities: no lower extremity edema. No cyanosis of extremities at this time (peripheral SpO2 94% on 2L NC). No chest pain reported. No palpitations reported by patient. No cardiac devices. Telemetry ordered — leads placed and monitoring active.

R Respiratory

6 RESPIRATORY STATUS

Respiratory rate: 36 breaths/min — TACHYPNEA (significantly elevated for age; normal RR for 8-year-old is 18–25 breaths/min). Work of breathing: INCREASED — suprasternal retractions, subcostal retractions, intercostal retractions, and nasal flaring all visible at rest. Tripod positioning. Accessory muscle use: positive (sternocleidomastoid and scalene). O2 delivery: 2L nasal cannula (NC) — placed by ED prior to transfer. SpO2: 94% on 2L NC (goal >95%; currently below goal — physician notification pending). Breath sounds: BILATERAL DIFFUSE WHEEZING on auscultation — expiratory phase prolonged with prominent wheeze throughout all lung fields. Transmitted upper airway sounds present. No crackles or rhonchi. No stridor. Air movement: reduced bilaterally but present in all lung fields — moderate obstruction. Cough: frequent dry/hacking cough, non-productive at this time — productive in ED per notes. Albuterol MDI via spacer last given in ED 01:45 AM (30 minutes ago). Ongoing respiratory treatments ordered (albuterol q20 min x3 doses per respiratory protocol).

GI Gastrointestinal

7 GI STATUS

Abdomen: slightly distended to inspection — mild distention consistent with DKA-related ileus. Soft on palpation (Owen able to tolerate light palpation without guarding). Diffuse mild tenderness on deep palpation — DKA-related abdominal pain is a known and common presentation in pediatric DKA; no rigidity, no rebound tenderness. Bowel sounds: present in all four quadrants, hypoactive — consistent with DKA ileus. NAUSEA: Present — rated 6/10 by Owen (using emoji pain scale). VOMITING: 4 episodes in the past 4 hours prior to arrival per mother — last vomit approximately 11:30 PM; no vomiting since ED arrival. IV antiemetic (ondansetron 0.15 mg/kg IV) given in ED 12:30 AM — moderate effect. Appetite: zero — refusing all oral intake. NPO for now per DKA protocol (no oral intake until DKA resolves and oral tolerance is re-established). Diet: NPO. Gastric motility: assumed reduced — consistent with DKA. No ostomy. No signs of GI bleeding.

GU Genitourinary

8 GU STATUS

POLYURIA: Owen's mother reports marked increase in urinary frequency and volume for the past 3 days — urinating every 45–60 minutes, including nocturia (waking 3–4 times/night). This is consistent with hyperglycemia-induced osmotic diuresis as the DKA developed. Foley catheter: NOT placed — DKA fluid protocol requires strict urine output monitoring (goal >1 mL/kg/hr); catheter insertion is being considered per physician order pending patient/family preference. Currently using urinal with hourly urine output recording per nursing protocol. Urine appearance: UA performed in ED — glucose 4+ (marked glycosuria), ketones 4+ (large ketonuria), protein 1+, WBC 2–3/HPF, no casts, no RBCs. No dysuria reported. Bladder distention: not palpated. Continence: appropriate for age — using urinal.

MS Musculoskeletal / Mobility

9 MOBILITY & FUNCTION

Mobility: significantly limited by respiratory distress — Owen is bedbound at this time. He is unable to safely ambulate given tachypnea, tachycardia, and ongoing DKA. He can reposition himself in bed with assistance. He is sitting up at approximately 45–60 degrees for respiratory comfort. Fall risk: MODERATE — age 8, acutely ill, tachypneic, fatigued, IV lines present. Bed is in lowest position, side rails up x4, call light within reach, night light on. Assistive devices: none used at baseline. Mother at bedside throughout — additional safety measure. Activity: bedrest ordered

per DKA and asthma protocols. ROM: not formally assessed — intact gross motor movements observed. Muscle weakness: Owen appears fatigued but can resist gentle motor testing.

SK Skin / Wounds

10 SKIN INTEGRITY

Skin color: Flushed, warm, and dry except for diaphoresis on the forehead and upper chest — consistent with DKA-related vasodilation and respiratory effort. No pallor or cyanosis of skin at this time. Skin turgor: mildly reduced (tenting noted on hand dorsum x1 second) — consistent with approximately 5–8% dehydration from DKA osmotic diuresis. No jaundice. No rashes or urticaria. No petechiae or purpura. No bruising beyond IV insertion sites. Fruit-scented/acetone breath odor noted by this nurse — consistent with ketonemia (hallmark of DKA). IV ACCESS: Right antecubital IV (18g) placed in ED 12:15 AM — site is patent, no infiltration, no redness, no swelling at insertion site. Dressing intact and clean. CGMS (Continuous Glucose Monitor): Dexterity G7 sensor on right upper arm — sensor reads 482 mg/dL; lab glucose 498 mg/dL. No pressure injuries. No wounds. Genitalia: not assessed. Nails: well-trimmed, appropriate for age.

PA Pain Assessment

11 PAIN

Location
Diffuse abdominal pain + chest tightness from work of breathing

Severity (0–10)
Abdominal: 5/10 (Wong-Baker FACES scale); Chest: 6/10

Quality
Abdominal: crampy, diffuse. Chest: tight, pressure-like

Duration
Abdominal x4 hours; Chest x2 hours with current exacerbation

Aggravating Factors
Deep breathing, coughing, abdominal palpation

Relieving Factors
Albuterol partially relieved chest tightness; IV fluids slightly improved abdominal pain

Interventions Provided
IV hydration ongoing. IV ondansetron x1 dose in ED. Albuterol MDI. Next albuterol treatment in 20 minutes per protocol.

Patient Response
Partial improvement in chest tightness after albuterol. Abdominal pain persistent but stable.

LT Lines / Drains / Tubes

12 INVASIVE DEVICES

PERIPHERAL IV: Right antecubital, 18-gauge, placed 12:15 AM in ED. Site: intact, no erythema, no swelling, no streaking. Patency: confirmed by gravity flush. Running: 0.9% NaCl at 200 mL/hr (DKA rehydration Phase 1 — physician ordered; rate to be reassessed after first-hour fluid bolus). No central lines. No Foley (see GU section). No drains. No NG tube at this time (NPO, no active vomiting, no obstruction). No tracheostomy. No chest tube. Continuous pulse oximetry probe: right index finger — intact, waveform consistent. Cardiac monitor leads x5 — in place and reading. Dexterity G7 CGMS right upper arm — transmitting.

SF Safety / Risk Assessment

13 SAFETY MEASURES

Fall Risk Level
MODERATE — Humpty Dumpty Pediatric Fall Risk Scale score: 14 (High Risk). Measures in place: 4-side rails up, bed in lowest position, call light instructed, mother at bedside, no ambulation.

Aspiration Precautions
NPO for DKA until resolution. HOB at 30–45 degrees. Antiemetic administered in ED.

Seizure Precautions
None currently ordered. No seizure history. Padded side rails not required at this time; reassess if glucose drops below 60 mg/dL or if mental status changes.

Skin Breakdown Risk
LOW at this time. Will reposition Q2h per protocol if prolonged bedrest continues. No pressure injury noted on admission.

Infection Precautions
Standard precautions. URI present — contact precautions not currently ordered; reassess if rapid strep or flu positive. Hand hygiene education provided to mother.

Mobility Restrictions
Bedrest. No ambulation per DKA and asthma protocol until respiratory and metabolic stability achieved.

AS Assessment Summary

14 CLINICAL SUMMARY

Owen J. Castellano is an 8-year-old male admitted from the pediatric ED at 02:00 AM with concurrent moderate-to-severe acute asthma exacerbation and diabetic ketoacidosis (DKA). This is a complex, dual-system emergency requiring simultaneous respiratory and metabolic management. PRIMARY CONCERNS: (1) RESPIRATORY: Current SpO2 94% on 2L NC — below goal of >95%. RR 36, bilateral diffuse wheezing, significant accessory muscle use, tripod positioning. Albuterol treatments ongoing per protocol. Physician aware of below-goal SpO2 (notified at 02:20 AM — Dr. Rachel Kim). (2) METABOLIC/DKA: Blood glucose 498 mg/dL, venous pH 7.19, bicarb 11, anion gap 24, ketones 4+ in urine. IV fluids at 200 mL/hr per DKA protocol. Insulin drip to be initiated pending endocrinology order confirmation. (3) VITAL SIGNS: Tachycardia HR 138, tachypnea RR 36, afebrile (38.0°C — borderline, likely DKA/stress-related). (4) SAFETY: High fall risk per pediatric scale. Mother at bedside. PRIORITY INTERVENTIONS: Optimize O2 delivery, continue albuterol per protocol, confirm insulin drip initiation, strict I/O monitoring, glucose checks Q1h per DKA protocol.

P Plan

15 NURSING INTERVENTIONS & MONITORING

1. RESPIRATORY: Continue albuterol MDI with spacer Q20min x3 doses (next dose 02:35 AM); reassess breath sounds and SpO2 after each treatment. Increase O2 from 2L NC to 4L NC now per physician order (received 02:20 AM). Notify physician immediately if SpO2 <92% or worsening respiratory distress. HOB at 60°. 2. METABOLIC/DKA: IV 0.9% NaCl at 200 mL/hr — monitor for fluid overload (lung sounds Q1h). Await and confirm insulin drip orders from endocrinology (Dr. Sandra Park). Glucose Q1h per DKA protocol. Strict I/O — hourly urine output with urinal; insert Foley if inadequate urine output <1 mL/kg/hr x2 hours. Electrolytes (K, Na, bicarb) per DKA protocol Q2h. 3. VITALS: Q30 min this shift given acuity. 4. SAFETY: Maintain 4-side rails, bed lowest. Mother educated on fall prevention. Night light on. 5. NAUSEA: Monitor for vomiting — maintain NPO and antiemetic PRN. 6. DOCUMENTATION: All nursing care, glucose values, and I/O documented Q1h. 7. FAMILY: Mother educated on DKA and asthma protocols, expected course, and when to call nurse.

F Follow-Up / Reassessment

16 REASSESSMENT PLAN

Reassessment

Full reassessment in 1 hour (03:15 AM) — assess respiratory response to albuterol x3 treatments, SpO2 on 4L NC, glucose trend, urine output adequacy, and overall clinical status. Notify physician if any of the following: SpO2 <92%, HR >150 or <80, glucose <80 or >600, altered mental status, or inability to tolerate respiratory treatments.

TIME DOCUMENTATION & BILLING

Total Time

N/A (nursing assessment)

E/M / Billing Code

Nursing assessment — not separately billed (facility charge)

Counseling / Coordination Time

N/A

Basis for Billing

Nursing — facility/inpatient assessment

Primary ICD-10 Code

J45.31 — Mild intermittent asthma with acute exacerbation (moderate-severe in this case — code updated pending physician confirmation)

Secondary ICD-10 Code(s)

E10.10 — T1DM with ketoacidosis without coma; J06.9 — Acute URI

NURSE / PROVIDER	CREDENTIALS	DATE	TIME
Sarah K. Mitchell, BSN, PCCN	RN — Pediatric Critical Care	05/06/2026	02:15 AM