N433 Care Plan #1

Lakeview College of Nursing

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Professor King, MSN, RN, CPN

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Demographics (3 points)

Date of Admission 1.28.2021	Patient Initials WG	Age (in years & months) 20 Days	Gender Female
Code Status Full	Weight (in kg) 4.56 kg	BMI 17.6	Allergies/Sensitivities (include reactions) NKA

Medical History (5 Points)

Past Medical History:

Illnesses: Hypoglycemia

Hospitalizations: In the NICU for 6 days

Past Surgical History: None

Immunizations: Hepatitis B vaccine

Birth History: C-section at 38 weeks, ECHO done due to low O2, NICU for 6 days

Complications (if any): None

Assistive Devices: None

Living Situation: At home with mom and dad

Admission Assessment

Chief Complaint (2 points): Acid Reflex

Other Co-Existing Conditions (if any): None

Pertinent Events during this admission/hospitalization (1 points): Infant was poorly feeding, vomiting, and lethargy

History of present Illness (10 points):

WG is a 20-day old female born at 38 weeks vis c-section and spent 6 days in the NICU due to hypoxia/ hypoglycemia. GBS was negative presents from her PCP office with poor feeding and increase sleeping. Per mother symptoms started last night on 1.28.2021 when infant was sleeping more and not earing as well. She had spit ups and then had an episode of vomiting. She went to PCP and was informed of abnormal newborn screen and needed to be repeated. Due to increase fussiness and decrease PO, PCP instructed to go in for sepsis evaluation. No fever at home or in the PCP office. She developed a rash on the body. No sick contacts at home. Patient seen in ER, labs were done including, blood culture and urine specimens drawn. She had WBC of 5.23, Hg of 16.5, normal platelets, and CMP was nonconcern. Peds were called discussed getting an RPP and if ill appealing to do a LP. LP attempted x2 but unsuccessful. Per provider and parent was able to take 2 oz of formula and no emesis. Discussed okay to hold antibiotics for now since probably viral and patient looked better. Patient was admitted to Peds for observation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Poor feedings and vomiting

Secondary Diagnosis (if applicable): Lethargy

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

Acid reflux also called GERD. GERD is the most common and most costly GI disorder in the United States (Capriotti & Frizzell, 2016). A functional or mechanical problem that decreases muscular ton eof the LES is the most common cause of GERD (Capriotti & Frizzell, 2016).

Relaxation of the LES allows for regurgitation of stomach contents into the esophagus (Capriotti & Frizzell, 2016).

GERD, the LES is weak and allows the contents of the stomach to reflux up into the esophagus (Capriotti & Frizzell, 2016). Stomach contents are acidic; when refluxed upward, they irritate the esophageal squamous epithelium (Capriotti & Frizzell, 2016). Gastroparesis causes increased gastric distention that leads to increased pressure within the stomach against the LES (Capriotti & Frizzell, 2016). In GERD, the esophageal epithelial cells are not able to withstand the acidity of the refluxed stomach contents (Capriotti & Frizzell, 2016). The gastric acid erodes the protective mucosal epithelial layer and lead to ulceration of the esophagus (Capriotti & Frizzell, 2016).

Signs and symptoms of GERD. The most frequent symptoms associated with GERD are dysphagia, heartburn, epigastric pain and regurgitation (Capriotti & Frizzell, 2016). Individuals often describe regurgitation as a bitter taste in their mouth (Capriotti & Frizzell, 2016). Respiratory complaints, such as chronic dry cough, asthma, and aspiration pneumonia, are also associated with the presence of GERD (Capriotti & Frizzell, 2016).

Expected findings of GERD. Tenderness over the involved are of the abdomen (Swearingen & D, 2019). With perforation, there may be severe pain and rebound tenderness (Swearingen & D, 2019).

Risk factors for GERD include, NSAID use, smoking, use of irritating agents such as caffeine, alcohol, corticosteroids, salicylates, reserpine, indomethacin, or phenylbutazone (Swearingen & D, 2019).

Diagnostic testing used to identify GERD. A person can use an endoscopy, H. pylori testing, barium swallow, CBC, and stool for occult blood (Swearingen & D, 2019).

Treatment for GERD includes focusing on lifestyle changes (Capriotti & Frizzell, 2016). Eating small, frequent meals to prevent abdominal distention (Capriotti & Frizzell, 2016). Not lying down for 2 to 3 hours following a meal; losing weight in those who are obese (Capriotti & Frizzell, 2016). The clinician should also review the patient's medications because the side effects of some can cause LES dysfunction (Capriotti & Frizzell, 2016). The treatment being used for the patient is simethicone 20mg/0.3 mL PRN for gas relief.

Two potential complications associated with GERD. One, Berrett's esophagus, is a precancerous change of cells (Capriotti & Frizzell, 2016). Repeated injury to the epithelial layer commonly causes metaplasia, the change of esophageal epithelial cells into somachlike columnar epithelium (Capriotti & Frizzell, 2016). Esophagitis, an acute or chronic inflammation of the esophagus (Capriotti & Frizzell, 2016). Signs and symptoms of esophagitis, burning sensation in the throat or midsternal chest, dysphagia, odynophagia, and heartburn are other symptoms associated with esophagitis (Capriotti & Frizzell, 2016).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. (1st ed). Philadelphia, PA: F A Davis.

Swearingen, P.L., & D, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	**Feeding, holding, changing diapers, talking with infant, and doing skin to skin**

Diet/Nutrition:	**Formula 3 to 4 hours of oral feeding**
Frequent Assessments:	**Every 8 hours for Vital Signs**
Labs/Diagnostic Tests:	**N/A**
Treatments:	**IV fluids, O2 saturation, and simethicone 20mg**
Other:	**Observation**
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
N/A	**N/A**
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	**3.32-4.80**	**N/A**	**4.84**	**Infant was dehydrated** (Kathleen Deska Pagana et al., 2019)
Hgb	**10.8-14.6**	**N/A**	**16.5**	**Infant was dehydrated**

				(Kathleen Deska Pagana et al., 2019)
Hct	**32.0-44.5**	**N/A**	**46.9**	**Infant was dehydrated** (Kathleen Deska Pagana et al., 2019)
Platelets	**279-571**	**N/A**	**493**	**N/A**
WBC	**8.36-14.42**	**N/A**	**5.23**	**Infant had a dietary deficiency** (Kathleen Deska Pagana et al., 2019)
Neutrophils	**1.23-4.80**	**N/A**	**1.76**	**N/A**
Lymphocytes	**2.42-8.20**	**N/A**	**2.38**	**Infant may have been septic** (Kathleen Deska Pagana et al., 2019)
Monocytes	**0.42-1.21**	**N/A**	**0.70**	**N/A**
Eosinophils	**0.06-0.75**	**N/A**	**0.37**	**N/A**
Basophils	**0.01-0.06**	**N/A**	**0.00**	**Infant possibly had an acute allergic reaction** (Kathleen Deska Pagana et al., 2019)
Bands	**N/A**	**N/A**	**N/A**	**N/A**

(Epic)

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**	**N/A**	**138**	**N/A**
K+	**3.5-5.1**	**N/A**	**5.2**	**Infant was dehydrated** (Kathleen Deska Pagana et al., 2019)
Cl-	**98-107**	**N/A**	**107**	**N/A**

Glucose	**60-99**	**N/A**	**81**	**N/A**
BUN	**7-18**	**N/**	**10**	**N/A**
Creatinine	**0.55-1.02**	**N/A**	**<0.15**	**Infant was dehydrated** (Kathleen Deska Pagana et al., 2019)
Albumin	**3.4-5.0**	**N/A**	**3.3**	**Infant may have been under stress** (Kathleen Deska Pagana et al., 2019)
Total Protein	**6.4-8.2**	**N/A**	**6.1**	**Infant may have been under stress** (Kathleen Deska Pagana et al., 2019)
Calcium	**8.5-10.1**	**N/A**	**9.7**	**N/A**
Bilirubin	**0.2-1.0**	**N/A**	**3.8**	**Infant may have been septic** (Kathleen Deska Pagana et al., 2019)
Alk Phos	**54-369**	**N/A**	**282**	**N/A**
AST	**15-37**	**N/A**	**23**	**N/A**
ALT	**12-78**	**N/A**	**21**	**N/A**
Amylase	**0-6**	**N/A**	**N/A**	**N/A**
Lipase	**>21.0**	**N/A**	**N/A**	**N/A**

(Epic)

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	**0-2**	**N/A**	**N/A**	**N/A**
CRP	**<1.0**	**N/A**	**N/A**	**N/A**
Hgb A1c	**4%-5.9%**	**N/A**	**N/A**	**N/A**
TSH	**0.7-11.0**	**N/A**	**N/A**	**N/A**

(Kathleen Deska Pagana et al., 2019)

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/Clear**	**N/A**	**N/A**	**N/A**
pH	**4.6-8**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.001-1.020**	**N/A**	**N/A**	**N/A**
Glucose	**Negative**	**N/A**	**N/A**	**N/A**
Protein	**0-8**	**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**

(Kathleen Deska Pagana et al., 2019)

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**	**N/A**
Blood Culture	**Negative**	**N/A**	**N/A**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**
Respiratory ID Panel	**Negative**	**N/A**	**Not detected**	**N/A**

(Kathleen Deska Pagana et al., 2019)

Lab Correlations Reference (1) (APA):

Carle Hospital (2020). *Reference Range (Lab Values) Per Epic*. Champaign, IL.

Kathleen Deska Pagana, Timothy James Pagana, & Theresa Noel Pagana. (2019). *Mosby's diagnostic and laboratory test reference*. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): ECHO

Diagnostic Test Correlation (5 points): Show that the infant's heart was normally shaped, size, positioned, and movement of the cardiac valves and heart muscle wall (Kathleen Deska Pagana et al., 2019).

Diagnostic Test Reference (1) (APA):

Kathleen Deska Pagana, Timothy James Pagana, & Theresa Noel Pagana. (2019). *Mosby's diagnostic and laboratory test reference*. Elsevier.

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

Brand/Generic	**Simethicone/ Mylicon**	**Tylenol/ Acetaminophen**			
Dose	**20mg/0.3mL**	**15mg/kg**			
Frequency	**PRN**	**PRN**			
Route	**Oral**	**IV**			
Classification	**Antiflatulents**	**Antipyretic**			
Mechanism of Action	**Decreases the surface tension of gas bubbles thereby disperses and prevents gas pockets in the GI system.**	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.**			
Reason Client Taking	**Gas Relief**	**Given by Instructor**			
Concentration Available	**20mg/0.3mL**	**15mg/kg**			
Safe Dose Range Calculation	**80mg-240mg**	**68.4mg-273.6mg**			
Maximum 24-hour Dose	**240mg**	**273.6mg**			
Contraindications (2)	**Hypersensitivity, GI obstruction**	**Hypersensitivity to acetaminophen or its components, severe hepatic**			

		impairment			
Side Effects/Adverse Reactions (2)	**Diarrhea, rectal flatus**	**Anaphylaxis, hypoglycemic coma**			
Nursing Considerations (3)	**Assess the patient for abdominal pain, distention, and bowel sounds Frequency of belching and passage of flatus should also be assessed Administer after meals and before meals for best results**	**Monitor renal function in patient on long-term therapy. Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease. Know that before and during long-term therapy including parenteral therapy, liver function test results, including AST, ALT, bilirubin and creatinine levels.**			
Client Teaching needs (2)	**Tell the patient what the drug is used for to ease too much gas in the GI tract Have patient watch for signs and symptoms of an allergic reaction even though it may be rare.**	**Tell patient that tablets may be crushed or swallowed whole Know that concentrated infant drops are being phased out and are no longer manufactured, but may still be available**			

(2020 Nurse's drug handbook, 2020)

2020 Nurse's drug handbook. (2020). Jones and Bartlett learning

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**A/O x3** **No distress** **Calm** **Appropriately dressed for place**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:** **IV Assessment (If applicable to child):** **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **IV Fluid Rate or Saline Lock:**	 **Pink** **Dry Intact** **Warm** **Elastic (Came in slightly dehydrated)** **N/A** **N/A** **N/A** **5** **No** **N/A** **24** **Right Hand** **1.28.2021** **Patent** **N/A** **Dry Intact** **N/A**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	 **Symmetrical at rest** **No drainage, TM Gray, Symmetrical** **Symmetrical, no drainage, PERAL** **No deviated septum, nares patent, no drainage** **Pink, moist intact, swallows without difficulty, white on the tongue (Thrush)** **Nonpalpable**
CARDIOVASCULAR (2 points):	

Heart sounds:	
S1, S2, S3, S4, murmur etc.	**Normal, present with S1 and S2**
Cardiac rhythm (if applicable):	**N/A**
Peripheral Pulses:	**160**
Capillary refill:	**Less than 3**
Neck Vein Distention: Y ☐ N ☐	**No**
Edema Y ☐ N ☐	**No**
Location of Edema:	**N/A**
RESPIRATORY (2 points):	
Accessory muscle use: Y☐ N ☐	**Yes**
Breath Sounds: Location, character	**Anterior and Posterior, clear/diminished**
GASTROINTESTINAL (2 points):	
Diet at home:	**Formula**
Current diet:	**Formula**
Height (in cm):	**50.8 cm**
Auscultation Bowel sounds:	**Hyperactive in all four quadrants**
Last BM:	**1.29.2021 at 1545**
Palpation: Pain, Mass etc.:	**N/A**
Inspection:	**N/A**
Distention:	**Yes**
Incisions:	**N/A**
Scars:	**N/A**
Drains:	**N/A**
Wounds:	**N/A**
Ostomy: Y ☐ N ☐	**N/A**
Nasogastric: Y ☐ N ☐	**N/A**
Size:	**N/A**
Feeding tubes/PEG tube Y ☐ N ☐	**N/A**
Type:	**N/A**
GENITOURINARY (2 Points):	
Color:	**Yellow**
Character:	**Clear**
Quantity of urine:	**N/A**
Pain with urination: Y ☐ N ☐	**No**
Dialysis: Y ☐ N ☐	**No**
Inspection of genitals:	**Normal for age**
Catheter: Y ☐ N ☐	**No**
Type:	**N/A**
Size:	**N/A**
MUSCULOSKELETAL (2 points):	
Neurovascular status:	
ROM:	**Normal for age (Good)**
Supportive devices:	**No**
Strength:	**Strong and Equal**

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** ☐	**Yes** **Yes** **2** **20-day old baby does not pertain this patient**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 **Yes** **Yes** **Yes** **Both** **A/O x3** **When infant cries parents answer to infant's needs** **Cries when needs something and is calm when the issue is taken care of** **Recognizes who is mom and dad** **Alert**
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):**	 **Infant is calm and cries when in need of something** **Mother and Father** **Mother and Father**

Vital Signs, 1 set (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1630	**160 beats per minute**	**88/46 mmHg**	**40 breaths per minute**	**98.4 °F (36.8 °C)**	**100% RA**

Vital Sign Trends: Patients vitals have been stable during the time of being on PEDS floor.

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

Pulse Rate	**100-160 beats per minute**
Blood Pressure	**72-104 for systolic and 37-56 for diastolic** **mmHg**
Respiratory Rate	**30-53 breaths per minute**
Temperature	**Axillary 36.5-37.5 ℃**
Oxygen Saturation	**92%-100%**

(Susan Scott Ricci et al., 2021)

Normal Vital Sign Range Reference (1) (APA):

Susan Scott Ricci, Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	**FLACC**	**N/A**	**N/A**	**N/A**	**N/A**
Evaluation of pain status *after* intervention	**N/A**	**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)
1430: 30 mL	**1455: 74 mL**

1530: 30 mL **Total: 60 mL**	**1600: 94 mL** **Total: 168 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. **Lifts and turns head to side in prone position**
2. **Head lag when pulled to sit**
3. **Rounded back in sitting**

Age Appropriate Diversional Activities

1. **Mobile with contrasting colors or patterns**
2. **Soft music via tape or music box**
3. **Soft, brightly colored toys**

Psychosocial Development:

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

What behaviors would you expect? The infant to get fussy or cry when they need something/ or not feeling well. Calm down when a parent or caregiver picks them up and takes care of the issue.

What did you observe? When the infant would cry the parent would go over to the infant and figure out what was going on with them.

Cognitive Development:

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

What behaviors would you expect? The infant is using their senses and motor skills to learn about the environment around them.

What did you observe? That the infant would turn their head from side to side and open their eyes a little bit while awake.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? That the infant will cry, fussy, and calm down when issue is taken care of.

Any concerns regarding growth and development? N/A

Developmental Assessment Reference (1) (APA):

Susan Scott Ricci, Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing*. Wolters Kluwer.

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. Dehydration	**As related to the patient coming into the ED being slightly dehydrated as evidenced by the patient having a 24 gauge in her right hand for IV fluids. Her labs were high such as: RBC, Hgb, Hct, Potassium, and Creatinine**	**1.Assess intake and output every 2 to 4 hour. Weigh all wet diapers.** **2.Assess temperature every 4 hour and treat per the health care provider's directive.**	**Is that the patient will eat every 2 to 3 hours at least 2 ounces of formula to ensure adequate hydration is being maintained.** **The patient's parents will be sure that the patient is having 10-12 wet diapers a day.**
2. Alteration in nutritional status	**Related to insufficient dietary intake as evidenced by inadequate increase in weight.**	**1. Assess how much the patient is eating and for how long the patient is eating.** **2.Assess how the caregivers are holding the bottle**	**The patient will start showing improvement in feeding intake and weight gain.** **The patient's parent's will slowly increase the patient's intake as they feed more frequently.**

		and patient to make sure there is adequate intake.	
3. Eating Disorder	**Related to insufficient sucking and swallowing reflexes as evidence by poor feedings.**	**1. Assess patient while eating to be sure sucking and swallowing reflexes are properly working.** **2. Have speech therapy evaluate the patient for any swallowing issues.**	**The patient's parents will take educational advice from the speech therapist.** **The patient's parents will let staff watch as the patient is being fed to be sure of adequate sucking and swallowing reflexes.**
4. Desire for improved nutrition	**Related to the patient's caregivers showing concern for patient's decrease in feedings as evidenced by bring the patient to the ED and patient being admitted to the PEDS floor for observation.**	**1. Assess patient for appropriate increase in feedings.** **2. Assess patient for appropriate feeding behaviors.**	**The patient's parents will respond appropriately to the patient's need to eat when giving feeding behaviors.** **The patient responds correctly when given formula by the caregivers.**

(*Newborn Nursing Diagnosis/ Nanda Nursing Diagnosis List*, n.d.)

Other References (APA):

Newborn Nursing Diagnosis/ Nanda Nursing Diagnosis List. (n.d.).

http://www.nandanursingdiagnosislist.org/newborn-nursing-diagnosis/

Concept Map (20 Points):

Subjective Data

The patient was admitted to the PEDS floor for observation of poor feedings, vomiting, and lethargy.
Patient has a history of hypoglycemia after birth.
Patient was 38 weeks gestation when mother had a c-section.

Nursing Diagnosis/Outcomes

Dehydration
Is that the patient will eat every 2 to 3 hours at least 2 ounces of formula to ensure adequate hydration is being maintained.
The patient's parents will be sure that the patient is having 10-12 wet diapers a day.

Alteration in nutritional status
The patient will start showing improvement in feeding intake and weight gain.
The patient's parent's will slowly increase the patient's intake as they feed more frequently

Eating Disorder
The patient's parents will take educational advice from the speech therapist.
The patient's parents will let staff watch as the patient is being fed to be sure of adequate sucking and swallowing reflexes.

Desire for improved nutrition
The patient's parents will respond appropriately to the patient's need to eat when giving feeding behaviors.
The patient responds correctly when given formula by the caregivers.

Objective Data

Vitals: Were stable and within normal ranges
Labs:
RBC: level high
Hgb: level high
Hct: level high
WBC: level low
Lymphocytes: level low
Basophils: level low
Potassium: level high
Albumin: level low
Creatinine: level low
Total Protein: level low
Bilirubin: level high

Patient Information

A 20-day old white female admitted to the PEDS floor for poor feeding and increase sleeping. The patient has a history of hypoglycemia when born and was in the NICU for 6 days. The patient has also been having episodes of vomiting and spitting up after feedings. PCP office wanted to go in for a sepsis evaluation due to increase fussiness and decrease PO. No fever at home or at the PCP office. Patient developed a rash on body. Patient was also seen in the ER, where labs were done.

Nursing Interventions

.1. Assess intake and output every 2 to 4 hours. Weigh all wet diapers.
2. Assess temperature every 4 hour and treat per the care provider's directive.
3. Assess how much the patient is eating and for how long the patient is eating.
4.Assess how the caregivers are holding the bottle and patient to make sure there is adequate intake.
5. Assess patient while eating to be sure sucking and swallowing reflexes are properly working.
6. Have speech therapy evaluate the patient for any swallowing issues.
7. Assess patient for appropriate increase in feedings.
8.Assess patient for appropriate feeding behaviors.