

N433 Care Plan #2

Lakeview College of Nursing

ADELE MOANDA

Demographics (3 points)

Date of Admission 10/29/2021	Patient Initials O E	Age (in years & months) 3 years and 8 months (44 months old)	Gender M
Code Status Full code	Weight (in kg) 9.08 Kg (20 Lbs. 0.3 oz)	BMI 15.13 Kg/m ²	Allergies/Sensitivities (include reactions) No known allergies

Medical History (5 Points)**Past Medical History:**

The patient has a history of hepatoblastoma since the age of eleven months, global development delay, history of seizure, functional constipation, and dysphasia.

Illnesses: WOLF-HIRSCHHORN is a genetic disorder characterized by abnormality on chromosome 4.

Hospitalizations: The patient was hospitalized on 01/08/2019 for surgery of trisegmenctomy and 02/18/2019 for hepatoblastoma. He also had many hospitalized periods due to seizure episodes.

Past Surgical History: SL Broviac placement X2, the patient had a mild pulmonary stenosis removal and trisegmentectomy in 01/08/2019.

Immunizations: The daddy stated that the patient is updated on immunization.

Birth History: The patient was a preterm baby with 36 weeks and two days gestations. Also, he was born with 4 lbs. and 4 oz. His mother had a history of thyroids and type two diabetes mellitus. The mother's prenatal genetic screen showed that the fetus had many congenital abnormalities, including Dandy's walker malformation of the brain and missing right hand. Moreover, the prenatal ultrasound showed that the baby was in breech presentation.

Complications (if any): During labor, the baby was in breech presentation. So, the doctor did a c-section to deliver the baby.

Assistive Devices: The patient did not use any walker, cane, or wheelchair.

Living Situation: The patient lives home with his mother, father, and two older brothers, and one younger sister. The father works, but the mother is unemployed.

Admission Assessment

Chief Complaint (2 points): Poor weigh gain and feeding difficulty due to dysphasia.

Other Co-Existing Conditions (if any): WOLF-HIRSCHHORN

Pertinent Events during this admission/hospitalization (1 points): The patient was scheduled for G-tube feeding placement, and everything went well. The patient tolerated the procedure without any complications. The prescriber ordered the patient to receive 20 mL/hr. for 4 hours first and increased to 40 mL/ hr. for another 4 hours.

History of present Illness (10 points): A three-year-old Caucasian male patient was born with many genetic disorders. He has growth, cognitive, and development delays. The patient has had difficulty swallowing since birth that it did not allow him to consume enough nutrition. Therefore, the mother observed that the patient did not gain weight since 2020. She told the doctor to install a G-tube in the child to help him gain nutrients and reduce weight loss. That is the reason why the patient was in the hospital on a clinical day. A new G-tube was placed on 10/29/2021.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):G-tube feeding placement due to dysphasia

Secondary Diagnosis (if applicable): WOLF-HIRSCHHORN syndrome

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

According to the National Organization for Rare Disorders (2020), Wolf-Hirschhorn syndrome (WHS) is a rare chromosomal disorder due to the partial missing of the short arm of chromosome 4. The WHS affects many parts of the body because there are different chromosomal abnormalities. The deletion of chromosome 4 ranges from 1,3 Mb to 34,7 Mb in size (Yamamoto-Shimajima et al., 2019).

Wolf-Hirschhorn Syndrome is rare, with an estimation of 1 in 50 000 births. It is mainly seen in females than boys (Berrocoso et al., 2020). The more the size is, the more serious the person will present many symptoms. The symptoms can also vary based on the location of the missing piece of chromosome 4. This genetic disorder showed a vast space between the eyes, a small head, low-set malformed ears, and a flat nose (NORD, 2020). According to Ricci et al. (2020), a patient with Wolf-Hirschhorn Syndrome can have delayed growth and development, seizures, and low muscle tone at birth. The patient might also present with an intellectual disability (Berrocoso et al., 2020).

Moreover, some common findings in patients with WHS include droopy eyelids, cleft lip, or palate. Furthermore, the abnormalities of the penis, testicles, or vagina; the patients can also have abnormalities of the kidneys, the problems with bones and teeth (NORD, 2020). According to National Organization for Rare Disorders (2020), congenital disabilities of the heart are common in individuals with WHS. However, they are usually simple, such as a hole between the two top chambers of the heart (atrial septal defect or ASD), and the surgeries can do surgery to correct it.

Those patients have a severe feeding issue; they cannot swallow correctly due to severe gut problems and absorb nutrients. Mostly those patients end up with a tube feeding. It is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, swallow safely, or need nutritional supplementation. The cytogenetic or chromosome test is a diagnosis to confirm the Wolf-Hirschhorn syndrome critical region (WHSCR). For this patient, the congenital abnormality of the missing right hand was detected during the prenatal ultrasound of the mother.

Dysphasia is a difficulty or pain when swallowing (Ricci et al., 2020). The dysphasia can be due to cranial nerve IX, X, and XII dysfunction. The patient has incapability of regurgitation of food and fluids. They might also have an impairment on the esophagus that does not allow them to pool the foods from the back of the throat. Some patients with dysphasia may have to drool from the mouth. To test for dysphasia, the doctor ordered a test called barium swallow test. The dysphasia can put the patients at risk of aspiration pneumonia (Capriotti & Frizzell, 2019).

Moreover, *dysphasia* is an impairment in swallowing due to abnormal delay during the food transition in the esophageal phase. Some complications might occur if the patient cannot swallow, including Choking and coughing, aspiration, and weight loss (Azer, 2021).

Pathophysiology References (2) (APA):

Azer, S. A. (2021). *Dysphagia*. StatPearls [Internet]. Retrieved November 2, 2021, from <https://www.ncbi.nlm.nih.gov/books/NBK559174/>.

Berrocso, S., Amayra, I., Lázaro, E., Martínez, O., López-Paz, J. F., García, M., Pérez, M., Al-Rashaida, M., Rodríguez, A. A., Luna, P. M., Pérez-Núñez, P., Blanco, R., & Nevado, J. (2020). Coping with Wolf-Hirschhorn syndrome: quality of life and psychosocial features

of family carers. *Orphanet Journal of Rare Diseases*, 15(1), 293. <https://doi.org/10.1186/s13023-020-01476-8>

Capriotti, T., & Frizzell, J. P. (2019). *Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

NORD (National Organization for Rare Disorders) (2020). *Wolf-Hirschhorn syndrome* Retrieved November 2, 2021, from <https://rarediseases.org/rare-diseases/wolf-hirschhorn-syndrome/>.

Ricci, S. S., Carman, S., & Kyle, T. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Yamamoto-Shimajima, K., Kouwaki, M., Kawashima, Y., Itomi, K., Momosaki, K., Ozasa, S., Okamoto, N., Yokochi, K., & Yamamoto, T. (2019). Natural histories of patients with Wolf-Hirschhorn syndrome derived from variable chromosomal abnormalities. *Congenital Anomalies*, 59(5), 169–173. <https://doi.org/10.1111/cga.12318>

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity:	increase activity as tolerate until discontinue.
Diet/Nutrition :	Formula pediaSure with fiber 1.0 via G-tube feeding.
Frequent Assessments:	G-Tube site frequently and vital signs.
Labs/Diagnostic Tests:	N/A
Treatments:	Consult dietitian.
Other:	Consult case manager for durable medical

	<p>equipment (DME) supplies for newly G-Tube placement.</p> <p>Home health arrangement for wound nurse to help with the G-tube site care.</p>
New Order(s) for Clinical Day	
Order(s)	Comments/Results/Completion
N/A	There is no new order currently.

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	3.89-4.99	N/A	N/A	
Hgb	10.2-12.7	N/A	N/A	
Hct	31.0-37.7	N/A	N/A	
Platelets	202-403	N/A	N/A	

WBC	5.10-13.40	N/A	N/A	
Neutrophils	34.0-79.0	N/A	N/A	
Lymphocytes	11.0-50.0	N/A	N/A	
Monocytes	3.0-14.0	N/A	N/A	
Eosinophils	0.0-2.0	N/A	N/A	
Basophils	0.0-1.0	N/A	N/A	
Bands	3-7	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-	135-145	N/A	N/A	
K+	3.5-5.1	N/A	N/A	
Cl-	98-107	N/A	N/A	
Glucose	60-99	N/A	N/A	
BUN	9-21	N/A	N/A	
Creatinine	0.20-0.70	N/A	N/A	
Albumin	3.5-5.0	N/A	N/A	
Total Protein	6.3-8.2	N/A	N/A	
Calcium	8.8-10.8	N/A	N/A	
Bilirubin	0.2-1.2	N/A	N/A	
Alk Phos	9-500	N/A	N/A	

AST	5-34	N/A	N/A	
ALT	0-55	N/A	N/A	
Amylase	19-76	N/A	N/A	
Lipase	7-59	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	3-15	N/A	N/A	
CRP	0-0.29	N/A	N/A	
Hgb A1c	<7.5	N/A	N/A	
TSH	0.45-4.5	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, Clear	N/A	N/A	
pH	6-8.0	N/A	N/A	
Specific Gravity	1.005-1.030	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	0.8	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.4	N/A	N/A	

RBC	0.3	N/A	N/A	
Leukoesterase	Negative	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	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	
Respiratory ID Panel/Covid 19	Positive/ Negative	Negative	N/A	

Lab Correlations Reference (1) (APA):

Lab value ranger per Carle’s EPIC.

Ricci, S. S., Carman, S., & Kyle, T. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A

The patient did not have any diagnostic tests done during his hospital period.

Diagnostic Test Correlation (5 points):

X-rays can be used to confirm the placement of the tube feeding (Capriotti & Frizzell, 2019).

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2019). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Current Medications (8 points)

****Complete ALL of your patient's medications****

Brand/Generic	Acetaminophen (Tylenol)	Ketorolac (Toradol)	Levetiracetam (Keppra)	Polyethylene Glycol (MiraLAX)
	(Skidmore-Roth, 2018)	(Skidmore-Roth, 2018)	(Skidmore-Roth, 2018)	(Skidmore-Roth, 2018)
Dose	4.3 mL (137.6 mg)	4.5 mg	200 mg	2.5 g
Frequency	Every 4 hr.	Every 6 hr.	X2 daily	daily
Route	Oral (tablet)	IV push	Oral (tablet)	Oral (powder)
Classification	Nonopioid analgesic/ Nonsalicylate	NSAID/ Acetic acid	Anticonvulsant /	Osmotic laxative
Mechanism of Action	It inhibits the enzyme cyclooxygenase, blocking prostaglandin production, and interferes with pain impulse generation in the peripheral nervous system (Skidmore-Roth, 2018).	It inhibits prostaglandin synthesis by decreasing an enzyme needed for biosynthesis, analgesic, inflammatory, antipyretic effects (Skidmore-Roth, 2018).	It inhibits nerve impulses by limiting the influx of sodium ions across cell membrane in the motor cortex. It decreased abdominal excitement in the brain (Skidmore-Roth, 2018).	It acts as osmotic, drawing water into the GI tract to soften the stool, stimulating the colon to contract, and increasing bowel movement (Skidmore-Roth, 2018).
Reason Client Taking	Pain and fever	Mild to moderate pain	Tonic-clonic seizure	Constipation
Concentration Available	160 mg/5mL	30 mg/mL	100 mg/mL	2.5 g
Safe Dose Range Calculation	10.0-15 mg/kg/dose q4hr.	15-30 mg	500-1000 mg/day	0.2-0.8 g/kg/day
Maximum 24-	681 mg/day	30 mg	500-1500	17 g/day

hour Dose			mg/day	
Contraindications (2)	Hepatic disease Anemia	GI bleeding. Cardiac disorder.	Renal disease Psychosis	Hypersensitivity to medication. Excessive vomiting
Side Effects/Adverse Reactions (2)	Nausea vomiting	Tremors Flushing	Chills Skin rash	Nausea Diarrhea
Nursing Considerations (2)	Monitor liver function studies: AST, ALT, bilirubin, and creatinine. Monitor I&O. Assess for fever and pain.	Monitor for bleeding sign in the urine, purpura, and pallor. Assess for edema.	Assess seizure activity including type, duration, and provide seizure precautions. Assess CBC	Assess client for abdominal distention. Assess color, consistency, & amount of stool produced by the child.
Client Teaching needs (2)	Teach the parents that the child's urine may become dark brown. Advise the parent to do not give OTC products to the child without prescriber approval.	Caution the parents to report any new bruises when the patient is taking this medication. Instruct the parents to report any excessive fatigue and malaise in the child.	Teach parents of a child to give the child medication as prescribed and to do not double. Teach the parents of the child to do not to discontinue the medications quickly after long-term use.	Instruct the parents of the child that prolonged, frequent, or excessive use may result in electrolyte imbalance and dependence. Teach the parents of the child to dissolve the medication in 120-140 mL of water.

Reference

Skidmore-Roth, L. (2018). *Mosby's drug guide for nursing students*. Elsevier.

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>The patient is a 3-year-old Caucasian male. He has development delayed, and he was not alerted or oriented. The patient did not use hearing aids or glasses. The patient was undressed by his father. He is awake, resting in the bed with a diaper only. The patient is not showing any distress.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p> <p>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:</p>	<p>The patient's skin was warm, pink, and moist. No lesions, no erythema, or bruises, no clubbing, or cyanosis. Skin turgor normal mobility with normal elasticity. The patient did not have a foley catheter drainage in place. The patient had a new G-tubing placement. The patient did not have any IV therapy currently. IV dressing appeared dry, no erythema, no drainage.</p> <p>Braden score is a 10 (High risk)</p> <p>The placement date/ time was 10/29/2021 at 1008. Location: left foot site Gauge/ length: 24 gauge</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth: Thyroid:</p>	<p>The Head is in the midline with no deviation. No trachea deviation. No lymph node was palpable. The thyroid was not palpable. The carotid pulse was regular. The patient had astigmatism. PERRL was present, but the resident was not following the instruction to check for accommodation because he could understand. No drainage from the eye bilaterally. Auricle pink without lesion. The septum was midline. Oral mucosa was pink and moist. Mouth with some teeth without lesion noted.</p>
<p>CARDIOVASCULAR: Heart sounds:</p>	<p>The patient's heart sounds are present with S1 and S2 with Normal rhythm. No gallop or</p>

<p>S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>murmur listening. He did not show signs of acute distress. The peripheral pulse was strong 2+ and equal bilaterally with no edema. The patient had a palpable bilateral radial pulse and strong 2+. He did not have neck vein distention.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>The patient was generally breathing at room temperature with normal rhythm without distress. His lung sounds were clear in auscultation for a full minute. There was no wheezing.</p>
<p>GASTROINTESTINAL: Diet at home: Current diet: Height (in cm): Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>The patient just had a new G-tubing placement on 10/29/21. He was formula feeding via the G-tube. The patient used a diaper, and he is incontinent to bladder and bowel movements. His last BM was on 10/30/21 at 0436. A form stools.</p> <p>The patient's abdomen appeared clean. No bruises, no drains. Only G-tube feeding intact in the abdomen. The patient's bowel sounds are hypotony in all four quadrants. His abdomen was soft without masses upon light and deep palpation in all four quadrants. The patient did not have an ostomy bag in the abdomen.</p> <p>Yes, the patient had a feeding tube.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>The patient's urine was void in the diaper because he was incontinent. It was not easy to assess the character. It appeared colorless, without any odor. His genitals appear to be intact, without abnormalities noted. The patient did not show any pain during urination. The patient is not on dialysis currently. Also, the patient was not using a catheter.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p>	<p>The patient's ROM of arm and leg strength bilaterally, 3/4 passive. It was challenging to assess actively because the patient was not able to follow orders. The patient was active in bed, moving self-laying in a supine position. He did not use any supportive devices. The patient was</p>

<p>Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	<p>dependent on ADLs. He never stood up or walked. The patient did not have any equipment used on a clinical day.</p> <p>Fall score: 60 (High fall risk)</p>
<p>NEUROLOGICAL:</p> <p>MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>PERLA: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no -</p> <p>Legs <input type="checkbox"/> Arms <input checked="" type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</p>	<p>The patient has development delayed, and he was not alerted or oriented to the situation, person, time, and place. The patient did not know what was going on around him. The patient had astigmatism. PERRL was present, but the resident did not follow the instruction to check for accommodation due to multiple diseases. The strength equals on foot bilaterally, and the patient is missing right hand. However, he was able to move all other extremities.</p>
<p>PSYCHOSOCIAL/CULTURAL:</p> <p>Coping method(s) of caregiver(s):</p> <p>Social needs (transportation, food, medication assistance, home equipment/care):</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>The mother claimed that they need assistance only to learn the feeding tube because it is a new experience for them. Otherwise, they were okay because it was three years since they were dealing with the child's disease. The mother's parents help them to afford the patient's care. They also receive help from the brothers and sisters from their church.</p>

Vital Signs, 2 sets (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0850	84	105/59 Mean cuff: 75	24	97.6 (armpit)	100% on room air
1105	89	108/64 Mean cuff: 75	24	97.0 (armpit)	98% on room air

Vital Sign Trends:

All the patient's vital signs are within the average value, except for his age. The patient was resting in bed in the morning when we took his VS. He was drinking his formula milk. The second time we took the patient's VS., He was playing with the toys in the bed, lying supine.

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

Pulse Rate	65-110
Blood Pressure	Systolic: 98-129 Diastolic: 55-88
Respiratory Rate	20-25
Temperature	98.1 oral
Oxygen Saturation	95 to 100% on room air

Normal Vital Sign Range Reference (APA):

Ricci, S. S., Carman, S., & Kyle, T. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0850	rFLACC	N/A	N/A	N/A	N/A
Evaluation of pain status <i>after</i> intervention	Not applicable. The patient was showing no sign of pain.	N/A	N/A	N/A	N/A

Precipitating factors: N/A. The patient did not show any sign of pain. He was calm and resting in the bed.

Physiological/behavioral signs: The patient showed a delay in growth and development compared to the child of his age. He was able to talk, stoop up, and walk independently. The patient was incontinent on urine and bowel at three-year-old. Moreover, the patient was moving his hands and feet. He was shaking more often.

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
PO intake (formula): 180 mL	325

Developmental Assessment (6 points)

Be sure to highlight the achievements of any milestone if noted in your 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. The children of three years old should gain an average weight of about 4 to 6 pounds per year. However, this patient had delayed development with severe weight loss. There is no achievement noted.
2. The children of three years old should gain height growth of about 2 to 3 inches per year.
3. The children of three years old should be able to Walk upstairs independently. This child is not able to walk.

Age-Appropriate Diversional Activities

1. The children of three years old use constructions toys when playing. **This patient was playing with a pull-pushed** car that can usually use for an 18-years-old child. He has delayed development.
2. The children of three years old can blower the bubbles.
3. The children of three years old throw the ball.

There is no achievement noted compared to his age.

Psychosocial Development:

Which of Erikson's stages does this child fit? Initiative vs Guilt

What behaviors would you expect?

The children at that stage like to explore new things. Also, they make up a game using an imaginary friend. They play the roles of other people in the game. Those children practice communication skills when they are playing. Moreover, children at this age understand the concept of time, food, and money (Ricci et al., 2021).

What did you observe?

During a clinical day, the patient was not talking when holding the car because he had a speech delay due to neonatal disease.

Cognitive Development:

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

Preoperational substage: preconceptual phase

At this phase, children exhibit egocentric thinking when playing with toys. They learn through observation and imitation of others, including parents and sublimates. They are trying to understand the world using curiosity, and they understand the process of counting (Ricci et al., 2020).

What behaviors would you expect?

On a clinical day, the patient did not pay attention to anything around him. He was disinterested. However, he was holding a toy with his left hand. The patient had cognitive delays.

What did you observe?

The patient had growth, development, and cognitive delays. He was not talking or following any instructions given. The nurse offered many toys to the patient to play with, but we observed him

holding the toys with his left hand. Those toys were not constructions toys. They were pull-push toys. The patient was not able to use the toys appropriate for his age. He was holding the toys equivalent for infants.

Vocalization/Vocabulary: The patient was not able to communicate with others. He does not know anything around him. He cannot communicate in short phrases

Development expected for child’s age and any concerns?

The patient is three years old, but he looks like an infant of 18 months. According to Ricci et al. (2021), children at three years old will undress themselves, turn book pages one at a time, copy a circle, run efficiently, and walk up and downstairs. However, the patient showed delayed development. He was dressed and toileted by the parents

Any concerns regarding growth and development?

There is a big concern for the patient’s development. The patient is three-year-old, but he does understand simple instructions. The mother stated that the patient is not walking in the stairs as other kids can do.

Developmental Assessment Reference (1) (APA):

Ricci, S. S., Carman, S., & Kyle, T. (2021). *Maternity and pediatric nursing* (4th ed.).

Wolters Kluwer.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
---	---	---------------------------------------	--

<p>1. Imbalanced nutrition: Less than body requirements related to child’s powerlessness to eat as evidenced by the resident weights 9.08 kg.</p>	<p>The patient was not eating enough orally. His mother stated that he had lost much weight since last year. That was why the patient had the G-tube placement to help him receive sufficient nutrients.</p>	<p>1. Check feeding tube placement before each feeding to verify tube placement in the GI tract rather than in the lung (Phelps, 2027).</p> <p>2. Provide small, frequent feedings to reduce fatigue and improve intake.</p>	<p>The patient tolerated the feeding well via G-tube. The parents were happy to see that the patient did not have any reaction or vomiting after the first feedings.</p>
<p>2. Risk for infection related to alteration in skin integrity as evidenced by new G-tubing placement.</p>	<p>The patient had a new G-tube placement that would need a daily dressing change. Keeping the patient's tubing site clean and dry reduce the risk of irritation and infection (Phelps, 2027).</p>	<p>1. Monitor WBC</p> <p>2. Ensure to handwash with soap and water to prevent infection before checking the tube placement, giving nutrition, giving medicines, or cleaning the site.</p>	<p>The patient's healthcare professionals were doing proper handwashing before and after the care. The parents were using hand sanitizer before they touched the patient.</p>
<p>3. Knowledge deficit related to a deficiency on information about the G-tube feeding, as evidenced by the patient's father verbalized that they would need education about the G-tubing feeding and the care</p>	<p>Some patient and caregivers may have difficulty learning new skills and require repeated reinforcement (Phelps, 2027). The patient's caregiver stated that it is a new experience to take care of a child with G-tube feeding.</p>	<p>1. Encourage the patient's caregiver to participate in the care and to be open to asking questions.</p> <p>2. Teach the patient to change the site dressing as ordered or whenever it becomes wet or soiled to reduce infection risk.</p> <p>3. Teach the parents the correct</p>	<p>The caregiver communicated the need to learn about their child's new change and verbalized positivity to take care of the patient. The home health arrangement for wound care and case management visit for durable medical equipment is scheduled to help the family.</p>

<p>of the site.</p>		<p>techniques for maintaining G-tube feeding at home to ensure the parents continue the regimen after discharge (Phelps, 2027).</p>	
<p>4. Risk for delayed development related to genetic disorder as evidenced by an inability to communicate.</p>	<p>The patient was born with Wolf-Hirschhorn syndrome (WHS). He never talked, and he was not able to walk independently. The patient has development delays with impairment in cognition, language, and growth.</p>	<p>1. Inform parents about age-appropriate activities and toys that encourage the child to move freely (Phelps, 2027). 2. Refer to case manager/social worker to ensure that the patient receives appropriate care at home (Phelps, 2027).</p>	<p>The mother was played with his son using push-polling toys during hospitalization. The family will meet with the case manager before being discharged from the home.</p>

Other References (APA):

Phelps, L. L. (2027). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient was not able to talk or express his feeling on a clinical day. However, his parents reported that they were in the hospital because they requested a tube feeding placement for their son. Furthermore, the patient had a new G-tube feeding.

Nursing Diagnosis/Outcomes

1. Imbalanced nutrition: Less than body requirements related to child's powerlessness to eat as evidenced by the resident weights 9.08 kg.
2. Risk for infection related to alteration in skin integrity as evidenced by new G-tubing placement.
3. Knowledge deficit related to a deficiency on information about the G-tube feeding, as evidenced by the patient's father verbalized that they would need education about the G-tubing feeding and the care of the site.
4. Risk for delayed development related to genetic disorder as evidenced by an inability to communicate.

Outcomes

1. Patient will show no further evidence of weight loss.
2. Patient will remain free from signs and symptoms of infection.
3. Patient's parents will demonstrate the ability to feed their son via the tube feeding.
4. to his Patient will grow and play the activities related to his age.

Objective Data

The patient's skin was warm, pink, and moist. No erythema, or bruises, no clubbing, or cyanosis. Skin turgor normal, capillary refill less than 3 sec. S1 and S2 with Normal rhythm. No gallop or murmur listening. He did not show signs of acute distress. The lung sounds were clear in auscultation for a full minute. Soft abdomen with last BM was on 10/30/21 at 0436. The patient tolerated the formula well via tube feeding VS: B/P: 105/59, R24, P 84, and T: 97.6 F. There is no abdominal lab or diagnostic currently.

Patient Information

A three-year-old Caucasian male patient was born with many genetic disorders. He has growth, cognitive, and development delays. The patient has had difficulty swallowing since birth that it did not allow him to consume enough nutrition. Therefore, the mother observed that the patient did not gain weight since 2020. She told the doctor to install a G-tube in the child to help him gain nutrients and reduce weight loss. That is the reason why the patient was in the hospital on a clinical day. A new G-tube was placed on 10/29/2021.

Nursing Interventions

1. Check feeding tube placement before each feeding to verify tube placement in the GI tract rather than in the lung (Phelps, 2027).
2. Provide small, frequent feedings to reduce fatigue and improve intake.
3. Monitor WBC
4. Ensure to handwash with soap and water to prevent infection before checking the tube placement, giving nutrition, giving medicines, or cleaning the site.
5. Encourage the patient's caregiver to participate in the care and to be open to asking questions.
6. Teach the parents the correct techniques for maintaining G-tube feeding at home to ensure the parents continue the regimen after discharge (Phelps, 2027).