N433 Care Plan #1

Lakeview College of Nursing

Claire Guyon

Demographics (3 points)

Date of Admission 10/13/2021	**Patient Initials** KJ	**Age (in years & months)** 2 years and 4 months	**Gender** Male
Code Status Full Code	**Weight (in kg)** 10 kg	**BMI** 14.27 kg/m2	**Allergies/Sensitivities (include reactions)** Dextrose- unknown

Medical History (5 Points)

Past Medical History: hypopituitarism, ventriculomegaly of the brain, porencephalic cysts s/p fenestration, seizures

Illnesses: Diabetes insipidus, Growth hormone deficiency

Hospitalizations: He was admitted previously for constipation.

Past Surgical History: eye surgery, gastrostomy (2019)

Immunizations: N/A there were no immunizations recorded for this patient.

Birth History: Patient was born at 39 weeks and 2 days and was a spontaneous vaginal birth

Complications (if any): No complications

Assistive Devices: G-tube and patient is not able to walk so he has a wheelchair

Living Situation: Patient lives at home with his mother.

Admission Assessment

Chief Complaint (2 points): Weight loss and vomiting

Other Co-Existing Conditions (if any): hypopituitarism, ventriculomegaly of the brain, porencephalic cysts s/p fenestration, seizures, feeding only through G-tube

Pertinent Events during this admission/hospitalization (1 points): Vomiting after G-tube feedings

History of present Illness (10 points): A 2-year-old African American male came into the Emergency department with weight loss over the past 9 months and vomiting. Patient has a complex medical history of hypopituitarism, ventriculomegaly of the brain, porencephalic cysts s/p fenestration, seizures, feeding only through G-tube. He is on a ketogenic diet and sometimes he vomits and sometimes he just gags.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Failure to thrive

Secondary Diagnosis (if applicable): placement of a GJ-tube

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

Hypopituitarism is a pituitary insufficiency. There is a hyposecretion of one or more of the pituitary hormones (Capriotti, 2020). There could be multiple reasons for an insufficient pituitary gland: a pituitary tumor, complications following brain surgery or radiation of a brain tumor, or radiation from a brain tumor. A complete and sudden loss of pituitary function is most often caused by trauma, ischemia, infarction, or hemorrhage. The hormones secreted by the anterior pituitary gland are thyrotropin or TSH, Gonadotropins or FSH or LH, Somatropin or GH, Corticotropin or ACTH, and Prolactin or PRL (Capriotti, 2020). The posterior pituitary does not secrete any hormones, but it does store hormones. In hypopituitarism, tropic hormone production is reduced, and target gland hormones are decreased. In congenital hypopituitarism, there are mutations in the POU1F1, PROP1, and LHX4 genes (Capriotti, 2020). Mutations in these genes can cause multiple pituitary hormone deficiencies leading to GH, PRL, and TSH. The lack of these hormones causes body-wide effects such as growth failure, weakness, diminished muscle mass, poor bone density, poor memory, and depression. When women have hypopituitarism, they can have amenorrhea, infertility, and deficient lactation can also occur

(Capriotti, 2020). The signs and symptoms of hypopituitarism depend on the hormone not being secreted. Some symptoms include severe hypotension, weakness, and weight loss. The onset is often gradual but also can be very rapid. The most severe concerns are diabetes insipidus, hypothyroidism, and adrenal insufficiency (Capriotti, 2020). The infant mainly experiences growth failure, developmental delay, various visual and neurological symptoms, seizure disorder, and congenital malformations. A patient with hypopituitarism can show hypotension and abnormalities in electrolyte levels, glucose levels, body temperature, and heart rate (Capriotti, 2020).

There are multiple ways to diagnose hypopituitarism. One way is to find low serum levels of pituitary hormones in the bloodstream such as TSH, ACTH, FSH, LH, GH, PRL, ADH, low corresponding endocrine hormones such as thyroxine T4, cortisol, and estrogen (Capriotti, 2020). There is a corticotropin stimulation test that evaluates the hypothalamic, pituitary-adrenal axis. This test measures the serum cortisol levels before and after administration of ACTH. The cortisol level should rise after 30-60 mins (Capriotti, 2020). CT and MRI scans are also used to show a pituitary tumor or empty sella syndrome. Treatment of the disease depends directly on which hormones the patient is lacking. Treatment would include hormone replacement of the hormones missing or surgery to remove the tumor if there is one (Capriotti, 2020).

Two complications that can occur because of hypopituitarism are visual defects and growth failure (Mayo Foundation for Medical Education and Research, 2021). My patient had both growth defects and visual defects. They were treating his hypopituitarism with infections of growth hormone. The patient also has developmental delays and a past medical history of seizures, symptoms, and complications of hypopituitarism.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis.

Mayo Foundation for Medical Education and Research. (2021, February). *Hypopituitarism*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/hypopituitarism/symptoms-causes/syc-20351645.

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Patient is a high fall risk and is on fall precautions.	Patient is not able to walk so he is on fall precautions. He is light enough to be carried everywhere. Continued until discharge.
Diet/Nutrition: Patient is on a ketogenic diet through a G tube feed.	Patient is vomiting frequently after G tube feeds, so he is on continuous 45 mL/hour feeds. Feeds are working well, and patient is tolerating the feeds well during my shift. Continued until discharge.
Frequent Assessments: Vitals every four hours, decompress stomach every 2 hours for retained air, weight BID, strict input and output, continuous pulse oximeter.	We are doing all these assessments to make sure we are improving with our treatments. These will be done until discharge.
Labs/Diagnostic Tests: XR of the abdomen	This showed free filled gas in the abdomen, this was done to show the reason for his

	frequent vomiting. This test was done when he was first admitted to the hospital.
Treatments: Continuous G-tube feed 45 mL/ hr, growth hormone injection, glucose control	All of these treatments are done to help the patient grow and gain weight. Patient's weight is increasing. Continued to be done until surgery on Monday to get a GJ-tube
Other: Patient is going to surgery on Monday to get a placement of a GJ-tube to help the patient not vomit during feedings.	Surgery will be done on Monday and the results are N/A until then.
New Order(s) for Clinical Day	
Order(s)	**Comments/Results/Completion**
N/A there were no new orders for today	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	Admission or Prior Value	Today's Value	Reason for Abnormal Value

	the age of the child)			
RBC	3.89-4.97x106/u	3.44	N/A	RBC can be low due to malnutrition and this patient is malnourished because he is vomiting up all of his feedings (Cafasso, 2018).
Hgb	10.2-12.7g/dL	10.5	N/A	
Hct	31-37.7%	31.6	N/A	
Platelets	202-403/uL	95	N/A	Medications such as Banzel can cause platelet counts to be decreased (RxList, 2020).
WBC	5.14-13.38x103/uL	5.25	N/A	
Neutrophils	1.54-7.92%	1.24	N/A	Neutrophils can be low in patients with nutritional deficiency (Metcalf, n.d.).
Lymphocytes	1.13-5.52%	2.21	N/A	
Monocytes	0.19-0.94%	0.23	N/A	
Eosinophils	0.03-0.53%	0.20	N/A	
Basophils	0.01-0.06%	0.01	N/A	
Bands	0-1.0 %	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-	136-145 mmol/L	142	N/A	N/A
K+	3.5-5.1 mmol/L	4.9	N/A	N/A
Cl-	98-107 mmol/L	106	N/A	N/A
Glucose	70-100 mg/dL	71	N/A	N/A

BUN	5-17 mg/dL	6	N/A	N/A
Creatinine	0.55-1.30mg/dL	0.56	N/A	N/A
Albumin	94-156 mg/dL	N/A	N/A	N/A
Total Protein	6-8 g/dL	N/A	N/A	N/A
Calcium	8.8-10.8 mg/dL	9.9	N/A	N/A
Bilirubin	0.2-1 mg/dL	N/A	N/A	N/A
Alk Phos	145-320 U/L	N/A	N/A	N/A
AST	15-50 U/L	N/A	N/A	N/A
ALT	6-45 U/L	N/A	N/A	N/A
Amylase	30-115 U/L	N/A	N/A	N/A
Lipase	25-120 mg/dL	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	0-15 mm/hr	N/A	N/A	
CRP	<1.0mg/mL	N/A	N/A	
Hgb A1c	4.0-5.6%	N/A	N/A	
TSH	0.32-5.00µIU/mL	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	Admission	Today's	Reason for Abnormal

	Range	or Prior Value	Value	
Color & Clarity	Yellow, clear	N/A	N/A	
pH	5.0-8.0	N/A	N/A	
Specific Gravity	1.005-1.034	N/A	N/A	
Glucose	0-0.8 mmol/L	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.0-5	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/no growth	N/A	N/A	
Blood Culture	Negative/no growth	N/A	N/A	
Sputum Culture	Negative/no growth	N/A	N/A	
Stool Culture	Negative/no growth	N/A	N/A	
Respiratory ID Panel	Negative/no growth	N/A	N/A	

Lab Correlations Reference (1) (APA):

Alvarado, E. (2021). *Laboratory-reference-ranges* [PDF].

https://www.abim.org/Media/bfijryql/laboratory-reference-ranges.pdf

Cafasso, J. (2018, November). *Red Blood Cell Count (RBC): Purpose, procedure, and preparation*. Healthline. https://www.healthline.com/health/rbc-count#low-count.

Metcalf, E. (n.d.). *Neutropenia: Causes, symptoms, and treatment*. WebMD. https://www.webmd.com/a-to-z-guides/neutropenia-causes-symptoms-treatment#2-4.

RxList. (2020, August). *Banzel (Rufinamide tablets): Uses, dosage, side effects, interactions, warning*. https://www.rxlist.com/banzel-drug.htm.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): XR KUB: gas filled stomach.

CT Brain: irregularly enlarged ventrical system and large right procephalic cyst appear grossly stable in their respective sizes. No evidence of intracranial hemorrhage.

Diagnostic Test Correlation (5 points): The X-ray of KUB stands for kidneys, ureter, h bhand bladder which is the abdominal areas (John Hopkins Medicine, n.d.). The XR KUB was done because of the recent frequent vomiting and the CT of the brain was done to make sure there was no intracranial hemorrhage.

Diagnostic Test Reference (1) (APA):

Johns Hopkins Medicine. (n.d.). *Kidney, ureter, and bladder X-ray*. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/kidney-ureter-and-bladder-xray.

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

Brand/ Generic	Glycopyrrolate/ Cuvposa	Hydrocortisone/ Cortef	DDAVP/ desmopressin	Banzel/ rufinamide	Somatropin/ genotropin
Dose	200 mcg	2.5 mg	0.05 mg	100 mg in the morning and 200 mg at night	0.6 mg
Frequency	3 times daily	Every 8 hours	2 times daily	Daily morning and night	Every night at bedtime
Route	G-tube	G-tube	G-tube	Oral	Sub-Q injection
Classification	Anticholinergic, antiarrhythmic, bronchodilator, cholinergic adjunct	Glucocorticoid, adrenocorticoid replacement anti-inflammatory	Posterior pituitary hormone, antidiuretic hemostatic	Triazole derivative, anticonvolsant	Immune modulators
Mechanism of Action	inhibits acetylcholine's action on post ganglionic muscarinic receptors throughout the body. Depending on the receptors location	Binds to intracellular glucocorticoid receptors and suppresses inflammatory and immune responses by inhibiting monocyte and neutrophil accumulation at inflammation	exerts an anti diuretic effect similar to that of a depressant by increasing cellular permeability of renal collecting ducts and	Unknown, this medication is known to slow sodium channel recovery from inactivation after prolonged prepulse and to limit	binds to dimeric growth hormone receptors located within the cell membranes of target tissue cells resulting in intracellular

	glycopyrrolate produces various effects such as reducing the volume in activity of gastric secretions, controlling excessive bronchial pharyngeal in tracheal secretions in dilating the bronchi, inhibiting vagal stimulation of the heart, relaxing smooth muscle in the GI GU respiratory tracts	site and suppressing their bactericidal and phagocytic, stabilizing lysomal membranes, suppressing antigen response of helper T cells and macrophages, inhibiting synthesis of cellular mediators of inflammatory response such as cytokines interleukins and prostaglandins	distal tubules thus enhancing water reabsorption reducing urine flow and increasing osmolality as a hemostatic drug increases blood level of clotting factor VIIII an activity of von willebrand factor it also may increase platelet aggregation and adhesion at injury sites by directly affecting blood vessel walls	repetitive firing of sodium dependent action potentials in neurons in the brain these actions might help limit the seizure activity	signal transduction and a host of pharmacodynamic effects
Reason Client Taking	to reduce chronic severe drooling in patients with neurological conditions	To treat acute adrenal insufficiency	To control symptoms of central diabetes insipidus	Treatment for seizures	Treats growth failure
Concentration Available	1mg/5mL	10mg/5mL	4mcg/mL	40mg/mL	1.33mg/mL
Safe Dose Range Calculation	1.5-3mg/kg per dose	2.5-10mg/kg/day	0.1-0.8 mg/dose	5mg/kg twice daily	0.06/kg/dose
Maximum	9mg	15-240mg	1.2mg	1600mg	0.47mg/kg/

24-hour Dose				twice daily	week
Contraindications (2)	Angle closure glaucoma, asthma	Hypersensitivity, idiopathic thrombocytopenia	History or presence of hyponatremia, hypersensitivity	Familial short QT syndrome, hypersensitivity	Malignancy, carpal tunnel syndrome
Side Effects/ Adverse Reactions (2)	Bradycardia, prolonged QT interval	Anaphylaxis, hypocalcemia	CVA, MI	Leukopenia, neutropenia	Headache, fatigue
Nursing Considerations (2)	-give tablets 30-60mmins before meals -be aware that closure system contains dry natural rubber that may cause hypersensitivity reaction if handled by or used to inject someone with a latex allergy.	Give dose with food or milk to avoid GI distress Shake the container vigorously for 10-15 seconds before each administration	-check blood pressure often during therapy -monitor patient closely for hyponatremia	Administer with food -taper the dosage off when it is no longer needed	-monitor thyroid function -monitor calcium levels
Client Teaching needs (2)	-make sure this medication is administered 30-60 minutes before meals -caution patient about potential drowsiness	-instruct the patient to take the daily dose at 9 am -inform the patient that they might bruise easily	-teach patient or caregiver how to administer -urge patient to report adverse reactions	-tell patient to report a rash accompanied by fever -advise patient to avoid hazardous withdrawal symptoms	-record accurate height measurement in regular intervals and report to them to the doctor

	or dizziness				

Reference:

2020 Nurse's drug handbook. (2020). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented time 3. Patient shows no signs of acute distress. Patient is well groomed and appropriately dressed.
INTEGUMENTARY: **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:**	Patients skin color is normal for race and is warm, dry, and intact. Patient's skin has a scaly feel to it but otherwise normal. Patient's skin is elastic and no tenting. There are no rashes, bruises, or wounds. Patients Braden score is 17. Patient does not have an IV.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Patient's head and neck are symmetrical, normocephalic, supple, and no JVD is present. Patient's tympanic membranes are pearly gray. Patient's eye is PER and sclera is clear. Patient's nose is patent, with no septum deviation. Patient shows no signs of dental cavities and gums are normal. Thyroid is midline.
CARDIOVASCULAR: **Heart sounds:**	Patient is in normal sinus rhythm, with S1 and S2 sounds present. Patient's pulse is 96. Patients

S1, S2, S3, S4, murmur etc. **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	pedal and radial pulses are strong and equal bilaterally. Patient's capillary refill is less than 3 seconds. Patient has no neck vein distention or edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Patient's breath sounds are wheezy in upper lobes and coarse crackles in patients left lung. Patients breathing is unlabored, but he is coughing. He sometimes needs suctioning for clearance. All other lobes are clear.
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 ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☒ N ☐** **Type: G-tube with balloon.**	Patients diet at home is ketogenic diet with tube feeds. Patients diet in the hospital is ketogenic as well. Patient's height is 83.7 cm. Patient's bowel sounds are present in all 4 quadrants. Patients last bowel movement was on 11/5/21. Patient has a feeding tube with is a G-tube with balloon. Patient does not have any distention, incisions, scars, or drains. Patient does have a wound where is G-tube insert is.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patients urine is clear yellow. Quantity of urine was 189mL per my shift. Patient does not have pain with urination. Genitals were normal for age and race. Patient does urinate and defecate in a diaper.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:**	Patient can move all extremities well. All extremities are strong bilaterally. Patient is not able to walk. Patient needs help with all ADL's. He did have a wheelchair in his room whenever he is leaving the room. Patient does have a G-

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** ☐	tube to help with feedings. Patient does not communicate with words and will cry whenever he is in need. Patients fall score is 30 which is moderate risk but I would say patient is very high fall risk because patient is not able to get around on his own at all.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☐ N☒** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient can MAEW, patient only has PER for eyes. Patients' strength is strong in all extremities bilaterally. Patient is not able to communicate, but patient is awake and looking around. Patient is not able to speak but is able to cry when something is wrong. No reported loss of consciousness.
PSYCHOSOCIAL/CULTURAL: **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):**	Mother copes by talking with her boyfriend. Patient needs help with all ADLs. Such as transportation, food, medication assistance, home equipment and care. Patient is a total care assist. Patient's mother is his primary care giver and comes to the hospital when she can. He lives at home with his mother and does not have any siblings.

Vital Signs, 2 sets (2.5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1130	123	N/A	24	37.1 degrees Celsius (axillary)	98% room air
1400	98	N/A	24	37.1 degrees Celsius (axillary)	99% room air

Vital Sign Trends:

Patient's vital signs are all within normal limits and seem to be stable. Patient's pulses were 123 and 98. Patient was not having blood pressures done. Patient's respiratory rate was 24 both times. Patient's temperature was 37.1 degrees Celsius both times and was done in the axillary. Patients' oxygen stats were 98% and 99% both on room air. All of these vital signs are stable and within normal limits.

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

Pulse Rate	98-140 beats per minute
Blood Pressure	Systolic: 86-106 diastolic:42-63
Respiratory Rate	22- 37 breaths per minute
Temperature	98.6 degrees F
Oxygen Saturation	92-100%

Normal Vital Sign Range Reference (APA):

Nall, R. (2017, March 20). *Pediatric vital signs: A mom's guide*. Healthline. https://www.healthline.com/health/pediatric-vital-signs.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1200	rFlACC	N/A	0	N/A	Holding in chair
Evaluation of pain status *after* intervention	rFLACC	N/A	0	N/A	Continuing hold in chair

Precipitating factors: patient is in his room all by himself and mom is not with him. **Physiological/behavioral signs:** Patient cries whenever he is in need. Holding him helps him relax.

Intake and Output (1 points)

Intake (in mL)	**Output (in mL)**
45 mL/hr feeding Total: 270 mL	189 mL of urine Total: 189 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. Copies others, especially adults and other children (Ricci et al., 2021)
2. Says sentences with 2 to 4 words (Ricci et al., 2021)
3. Shows more and more independence (Ricci et al., 2021)

Age Appropriate Diversional Activities

1. Builds towers of 4 or more blocks (Ricci et al., 2021)
2. Points to things or pictures when they are named (Ricci et al., 2021)
3. Begins to sort shapes and colors (Ricci et al., 2021)

Psychosocial Development:

Which of Erikson's stages does this child fit?

Autonomy vs. shame and doubt (Ricci et al., 2021)

What behaviors would you expect?

Children in this stage express the need for independence and control over themselves. They want to be independent. They start toilet training, picking the foods they want to eat, toy preferences, and picking what they want to wear every day (Ricci et al., 2021).

What did you observe?

My patient has developmental delays due to hypopituitarism and so I observed my patient crying whenever he was laying in his room all alone. I was able to hold the child and comfort him during my clinical day. He was not able to communicate with words, but he did cry when he wanted to be held. He was not showing any of these milestones.

Cognitive Development:

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

Sensorimotor stage (Ricci et al., 2021)

What behaviors would you expect?

Child may suck their thumb, they use their senses to learn things about themselves (Ricci et al., 2021).

What did you observe?

My patient did use his senses because he knew that whenever he upset he cries and someone will be there to comfort him. He also knew that he loves to be held and being held helps him relax and provides him comfort.

Vocalization/Vocabulary:

Development expected for child's age and any concerns?

Children at this age should be able to speak in sentences that are 2-4 words and should be able to point to something whenever it is named (Ricci et al., 2021).

Any concerns regarding growth and development?

Yes, patient does have known developmental delays and is receiving care for help with all his ADL's. Patient is also receiving growth hormone to help him grow and develop.

Developmental Assessment Reference (1) (APA):

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

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status

			of goals and outcomes, modifications to plan.
1. Potential for aspiration related to patient vomiting after feedings as evidenced by patient vomiting and coughing frequently (Swearingen & Wright, 2019).	This nursing diagnosis was chosen because the patient gags, coughs, and vomits frequently so patient can aspirate easily.	**1.** turning the patient to the side whenever they are lying in bed, or someone is holding him (Swearingen & Wright, 2019). **2.** assess the patients lung sounds frequently (Swearingen & Wright, 2019).	Patient is responding well to laying on his side while in bed or in someone's arms. He is not aspirating on his vomit. Nurses are assessing his lung sounds frequently looking for signs of aspiration. Nurses are suctioning secretions out of the patient's mouth. Goals: no aspirating So far the goal is being met and the interventions are working.
2. Patient is at risk for weight loss related to frequent vomiting as evidenced by patient losing weight over the past 9 months (Swearingen & Wright, 2019).	This nursing diagnosis was chosen because this patient has been losing weight due to vomiting up feedings and patient continues to vomit up feedings.	**1.** Patient is on a continuous feeding (Swearingen & Wright, 2019). 2. patient is scheduled to receive a GJ tube (Swearingen & Wright, 2019).	Patient and family are responding well to these actions. He is gaining weight slowly. Patient has yet to have GJ tube insertion surgery but this surgery will help the patient keep down his feedings in hopes to gain weight. Goals: weight gain Patient should show weight gain after this surgery because the patient should not be vomiting up his feedings.
3. Patient is at risk for injury related to falls as evidenced by patient is unable to walk and unable to communicate with words (Swearingen & Wright, 2019).	This nursing diagnosis was chosen because this patient is not able to walk or take care of himself, but he is able to move around. He could easily roll off a bed if the side	1. Side rails on the bed are up whenever patient is lying in bed (Swearingen & Wright, 2019). 2. When transferring the patient make sure we have our	Patient's family was very cooperative with these interventions. Nurses were also cooperative. Patient always had the side rails up and when they were transferring him, they made sure they had good footing and had a good grip. Goals: Patient does not

	rails are not up.	footing, and we have a good grip on him, so he does not push out of our arms (Swearingen & Wright, 2019).	fall and injury themselves. Goal has been met so far and patient will continue to be a fall risk until discharge.
4. Potential for communication barrier related to patient not being able to communicate through speaking as evidenced by patient does not say any words but cries whenever he is in need (Swearingen & Wright, 2019).	This nursing diagnosis was chosen because the patient is not able to speak making it difficult to understand how the patient is feeling and what they need is a challenge.	**1.** Announce whenever a person is in the room and let the patient know whenever you are caring for them (Swearingen & Wright, 2019). **2.** Maintain eye contact with the patient whenever you are talking to them (Swearingen & Wright, 2019).	Patient's family is responding well to these interventions. These intervention help ease the patient's anxiety. Goals: the patient's frustration is eased due to effective communication. Goals have been met so far and the nurses do well with anticipating what the patient wants and do everything they can to help ease his frustration.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

-Patient was vomiting and gagging after his feeding through the G-tube.
-The patient has a surgery scheduled for a GJ-tube that will hopefully help with the patients gagging and vomiting.
-The patient's mother reported that the patient has been losing weight for the past nine months.

Nursing Diagnosis/Outcomes

1. Potential for aspiration related to patient vomiting after feedings as evidenced by patient vomiting and coughing frequently (Swearingen & Wright, 2019).
   - Outcome: Patient will not aspirate on his vomit.
2. Patient is at risk for weight loss related to frequent vomiting as evidenced by patient losing weight over the past 9 months (Swearingen & Wright, 2019).
   - Outcome: Patient will not loss anymore weight but will gain weight.
3. Patient is at risk for injury related to falls as evidenced by patient is unable to walk and unable to communicate with words (Swearingen & Wright, 2019).
   - Outcome: Patient will not fall and injury themselves.
4. Potential for communication barrier related to patient not being able to communicate through speaking as evidenced by patient does not say any words but cries whenever he is in need (Swearingen & Wright, 2019).
   - Outcome: Patient will not get frustrated about not being able to communicate. We will be able to anticipate what he will need.

Objective Data

Patients VS
-Pulse: 98
-RR: 24
-Temp: 37.1 degrees Celsius
-O2: 99%
Patient's vital signs were within normal limits.
He does have G-tube that will soon be a GJ-tube.
XR KUB: air filled in the abdomen

Patient Information

Patient was a 2-year-old African American male with a past medical history of diabetes insipidus, growth hormone deficiency, and hypopituitarism. Patient has a G-tube for feedings and came into the ED with complaints of vomiting and gagging after feedings.

Nursing Interventions

1.turning the patient to the side whenever they are lying in bed, or someone is holding him (Swearingen & Wright, 2019).
2. assess the patients lung sounds frequently (Swearingen & Wright, 2019).
3. Patient is on a continuous feeding (Swearingen & Wright, 2019).
4. patient is scheduled to receive a GJ tube (Swearingen & Wright, 2019).
5. Side rails on the bed are up whenever patient is lying in bed (Swearingen & Wright, 2019).
6. When transferring the patient [illegible], and we have a good grip on him, so he does not push out of our arms (Swearingen & Wright, 2019).
7. Announce whenever a person is in the room and let the patient know whenever you are caring for them (Swearingen & Wright, 2019).
8. Maintain eye contact with the patient whenever you are talking to them (Swearingen & Wright, 2019).