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Blythedale Clinical  
2/15/23

Patient initials: SF 5yF

Medical Diagnosis: Feeding difficulty and dysphagia related to esophageal stricture

Tests: no tests ordered at this time

Assessment findings: NPO diet, last BM 2/13/23 (2 days prior)

PMH: Persistent asthma, atrial septal defect, esophageal stricture, congenital tracheoesophageal fistula

Medications:

Acetaminophen 325mg PRN

Albuterol Sulfate PRN

Cetirizine Hcl 5mg

Famotidine 11mg

Fluticasone Propionate 44 mcg

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Nursing Dx: knowledge deficit related to confusion about tube feedings as evidenced by moms anxiety about bringing patient home with ND tube.

Expected outcome: by the end of the clinical shift mom will understand how to set up a feeding in the pump

Interventions:

- Demonstrate how to use feeding pump with mom
- Educate what to do if ND tube dislodges
- Have mom perform the next feeding and teach back to the nurse
- Educate about positioning during feeds and checking for residual

Evaluation: Goal met. Mom was able to demonstrate knowledge about ND tube and feeding.

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Nursing Dx: Risk for deficient fluid volume related to inability to respond to thirst mechanism due to NPO status

Expected outcome: Patient will have a urinary output of at least 30 mL per hour by the end of clinical shift.

Interventions:

- Assess for s/s of deficient fluid volume
- Inspect urine for color and clarity

- Educate patient about importance of hydration
- Infuse 10% dextrose in water as ordered
- Assess skin turgor

Evaluation: Goal met. Patient voided 60mL before 12:00.

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Nursing Dx: Risk for aspiration related to enteral nutrition

Expected outcome: patient will show no signs of choking during clinical shift

Interventions:

- Assess LOC before feeding
- Keep patient in fowlers during feeds
- Check residual before another feeding
- Check placement of tube before feedings

Evaluation: Goal met. Patient showed no signs of choking by the end of the clinical shift.

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Nursing Dx: Risk for infection related to site for organism invasion

Expected outcome: Patient will remain free of infection by showing normal vital signs and absence of s/s of infection by the end of the clinical shift

Interventions:

- Reassess vitals every 4 hours
- Assess for any redness or pain around nares or in abdomen
- Monitor for any s/s of infection
- Monitor for elevated temperature
- Assess color of any respiratory secretions

Evaluation: Goal met. Patient remained free of s/s of infection by the end of the clinical shift.