Christie Benoit

Concept Map

Key Problem
Risk for Aspiration
Expected Outcome
Parentsdemonstrate techniques to prevent aspiration 3/10/2023

Nursing Interventions
1. Assess the Level of consciousness
2.Keep head of the bed elevated to 30-45 degrees
3.Educate parents about the sign and symptoms of aspiration
4.Check placement of ND tube before feeding
5. Monitor respiratory rate
Evaluation:
Patient shows no signs of aspiration within 8 hours. 3/10/2023

Medical Diagnosis: Atresia of Esophagus with Tracheo-Esophageal Fistula
Assessment: Temperature: 98 F Pulse 77BPM, RR 18, BP: 97/66, Pulse Ox: 99%,Esophageal Obstruction, Feeding difficulties. risk for infection, aspiration, and impaired gas exchange
Medication: Acetaminophen 325MG
Albuterol Sulfate
Cetirizine HCl 5 mg
Famotidine11 mg
Fluticasone44 mcg
Ondansetron2.4 mg
Sodium Chloride 3mL

Key problem
Impaired swallowing
Expected outcome
The Patient demonstrate swallows gastric feeding without aspiration.

Nursing Intervention

1.Assess the patient strength of facial muscles.
2.Assess for signs of aspiration and pneumonia
3. auscultate lung sounds before and after feeding
4. Assess patient weight daily.
5.Maintain the patient in high fowlers Position
evaluation
The patient swallow gastric feeding without aspiration.

Key Problem
Risk for infection
Expected outcome
The mother states ways to prevent and reduce the risk and spread of infection within 5 hours of teaching session

Nursing Interventions
1.Monitor patients vital sign every 4 hours
2. Educate parents about the importance of hand washing techniques
3.Assess the patient's changes in breathing Patterns, decreased breath sounds, and color of secretion
4.Educate Parents about
Evaluation
Goal met,
Parents demonstrate proper hand hygiene and patient maintain temperature 98 F throughout hospitalization.

Key Problem
Impaired Gas Exchange
Expected outcome
The patient will maintain clear lung fields and show no sign and symptoms of respiratory distress throughout hospitalization.

Nursing intervention
1. Encourage frequent position changes. Every 2 hours and elevate head of the bed
2.Monitor Vital every 4 hours
3.Assess patient for signs of cyanosis in the skin
4.Monitor ABGs every 4 hour and note changes
5.Monitor oxygen saturation continuously.
Evaluation
Goal met , patient shows clear lungs sounds bilaterally and oxygen Saturation 99%

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