Alliance University SON- Concept Map

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Nursing Dx
Imbalanced Nutrition: Less than Body Requirements r/t GI tract function alterations as evidenced by no muscle mass, electrolyte imbalances, and NG tube feedings.

Expected Outcome
Pt will maintain nutritional status within the next 7 days.

Interventions
1. Monitor food intake. Record percentage of food eaten.
2. Observe client's ability to eat.
3. Weight pt daily.
4. Educate family members what food groups to encourage.

Evaluation
The goal was met and pt maintained nutritional status within 7 days.

Nursing Dx
Risk for Impaired Skin Integrity r/t immobility (wheelchair)

Expected Outcome
Pt will maintain skin integrity (dry/intact) and prevent skin breakdown by end of 12-hour shift.

Interventions
1.Asseess skin and document findings.
2. Reposition the client every 2 hours.
3. Implement a written prevention plan.
4. Educate family members on how to position pt and how often.

Evaluation
Goal met, pt maintained skin integrity (dry/intact) and prevented skin breakdown by end of 12-hour shift.

Past Medical History

Unspecified Metabolic Disorder, Neurogenic bladder, DVT femoral, Dysphagia, Narcotic dependence (episodic use), Cryptorchidism

Medical Diagnosis & Assessment

Prune Belly Syndrome
Trach Tube status, NG Tube status
CBC all w/in normal values

BT 97.2; PR 122; RR 22; BP 91/54; SPO2 100; A&Ox3, CTA, RRR, normal S1, S2, NO JVD, no cyanosis, cap refill < 2, +BS in all quadrants, last bowel 3/28, abdominal binder; limited mobility/wheelchair use, ROM, Pt voided 100mL in diaper - incontinent

Medications
Citric Acid NG @BR x1
Collagenase TP daily
Docusate 30mg NG daily
Ferrous Sulfate 45 mg NG daily
Omeprazole 10 mg NG daily
Phenobarbital 25.6 mg NG Q12R

Nursing Dx
Risk for Infection r/t inadequate primary defenses

Expected Outcome
Pt will not experience any signs of infection (redness, abnormal discharge, odor) by end of 12-hour shift.

Interventions
1. Assess for tenderness, redness, swelling, odor, purulence.
2. Monitor vital signs correlated with fever.
3.Carefully cleanse perineal area of any urine or stool.
4. Educate family members how to carefully change pt's diaper.

Evaluation
Goal met: Pt was free from any signs of infection (redness, abnormal discharge, odor) by the end of 12-hour shift.

Nursing Dx
Ineffective Breathing Pattern r/t respiratory muscle fatigue and conditions that impair inspiration and expiration as evidenced by absent abdomen muscles, hypoplastic lungs, and having FiO2 28%.

Expected Outcome
Pt will demonstrate a regular respiratory rate and rhythm by end of 12-hour shift.

Interventions
1.Monitior respiratory symptoms (irregular breathing, nasal flaring, grunting).
2. Promote bronchodilation and administer medication as ordered.
3. Apply oxygen as ordered.
4. Educate family members on how to look for S/S of respiratory distress.

Evaluation
Goal met, pt demonstrated a normal respiratory rate and rhythm by the end of 12-hour shift