

Nurse Dx: Impaired Tissue Integrity
Etiology: related to tissue exposed in center and black eschar surrounding the wound.
S/S: tender to touch, redness, localized pain
Expected Outcome: Patient's wound decreases in size and has increased granulation tissue during hospitalization

Interventions:

- Provide tissue care as needed
- Keep a sterile dressing technique during wound care.
- Provide feedings that meet nutritional needs
- Teach parent(s) about skin and wound assessment and ways to monitor for signs and symptoms of infection, complications, and healing.

Evaluations: Goal was unmet. The wound size has not decreased in size nor increased tissue granulation.

Nurse Dx: Risk for Infection
Etiology: related to open wound on right foot.
S/S: redness, eschar around the edges, and pain
Expected Outcome: Patient will remain free from infection during hospitalization.

Interventions:

- Maintain strict asepsis for dressing changes and wound care.
- Provide intake of protein-rich and calorie-rich foods through GT tube
- Do frequent position changes.
- Encourage rest and sleep

Evaluation: Goal was met. Patient remained free from infection during hospitalization.

Past Medical History/Surgical History

- Hypokalemia
- Chromosome 8p23.1 deletion syndrome
- Atrioventricular Canal Repair
- Tracheostomy
- Generalized Intestinal Dysmotility

Medical Dx: Respiratory Failure
Dx Tests: ABG test, CXR, Ventilator
Results: Hgb 10 g/dL o2 sat 100%, CXR (-), vent rate 14 and o2 at 28%
Assessment: I&O, Hydration Status, Neuro Assessment, Wound Care, Tracheostomy Care

Medications:

- Sildenafil (Viagra)
- Collagenase ointment
- Potassium Chloride
- Levetiracetam (Keppra)
- Vigabatrin (Sabril)
- Hydrochlorothiazide

Nurse Dx: Risk for Decreased Cardiac Output
Etiology: related to AV Canal Repair
S/S: oliguria, ashen skin, diminished peripheral pulses
Expected Outcome: Patient will maintain adequate cardiac output as evidenced by vital signs within acceptable limits during hospitalization.

Interventions:

- Encourage active and passive exercises.
- Administer hydrochlorothiazide as ordered
- Monitor for signs and symptoms of fluid and electrolyte imbalances every 4 hours
- Maintain continuous oxygenation via ventilator.

Evaluation: Goal was met. Patient maintained adequate cardiac output as evidenced by normal vital signs during hospitalization.

Nurse Dx: Imbalanced Nutrition
Etiology: related to lengthy NPO status
S/S: GI tract function alterations, poor wound healing.
Expected Outcome: The patient will achieve an adequate nutritional status, as evidenced by normal weight gain.

Interventions:

- Assist in the maintenance of the GT and JT tube.
- Maintain the prescribed rate of TPN.
- Encourage additional oral fluid intake as indicated.
- Collaborate with other nutritional support teams

Evaluation: Goal was met: Patient achieved an adequate nutritional status during hospitalization.