Mikkel Darzhmeniak

Medical Diagnosis: Failure to thrive
Key assessment: I&O, count calories, motor mobility, asses skin, electrolytes.
Medication: Ergocalciferol 50mcg, Poly-vi-sol 1ml
Past history: N/A

Assessment finding:
1) BP: 98/65, HR: 128, T: 98.8, SpO2: 96%
2) Lung sounds are clear no adventitious sounds.
3) Heart sounds are remarkable, no S3, S4, no murmurs.
4) Skin: warm to touch, dry, skin turgor less 3S.

Nursing Dx: Electrolyte imbalance, related to poor feeding intake, as evidence by infant hyponatremia.

Nursing Interventions:

1) Administer 3% normal saline as per provider order.

2) Monitor vitals signs every 4 hours.

3) Encourage the infant to increase food intake throughout the shift.

4) Educate the parents about methods that they can use to encourage the infant to increase calorie intake.

Expected Outcome: The patient maintains a normal sodium level by the end of the shift.

Evaluation: The patient maintained a sodium level of 133 by the end of the shift.

Nursing Dx: Imbalance nutrition less than body requirements, secondary to low calorie intake as evidence by low weigh of the child.

Nursing Interventions:

1) Assess patient weight and calorie intake throughout the shift.

2) Promote semi-fowler or full fowlers position during every eating.

3) encourage the parent to utilize breast milk and formula as a method to increase the calorie intake of the child during every feeding.

4) educate the parents about the importance of increase feeding frequency throughout the shift.

Expected Outcome: The patient report satisfactory increment of calorie intake by the end of the shift,

Evaluation: The patient slowly increased calorie intake but the goal was not met the patient is just consuming half of his food portion, continue to monitor the patient.

Nursing Dx: Risk for impaired urinary elimination related to dehydration.

Nursing interventions:

1) Monitor the patient's pattern of elimination throughout the shift.

2) Palpate the patient's bladder every 4 hours.

3) weight every diaper to monitor the voided amount throughout the shift.

4) Educate the parents about the importance to keep the infant hydrate.

Expected outcome: The patient exhibits effective urinary elimination throughout the shift.

Evaluation: The patient maintained effective urinary elimination throughout the shift.

Nursing Dx: Risk for falls, related to motor weakness.

Nursing Interventions:

1) Incorporate the appropriate safety measures such as patient free of clutter and crib door up and lock throughout the shift.

2) Assess muscle strength and coordination every 4-6 hours.

3) Assist with physical therapist in methods to involve and educate the parents in ways that they strengthen the infant muscle strengthen throughout the shift.

4) Educate the parents about the importance of assisting the infant to get out bed throughout the shift.

Expected Outcome: The patient remains free of falls throughout the shift.

Evaluation: The patient did not sustain any falls throughout the shift.

Refrences

Herdman, H., & Kamitsuru, S. (2019). Supplement to NANDA International Nursing Diagnoses: Definitions and Classification, 2018-2020 (11th Edition) (1st ed.). Thieme. Retrieved from https://www.perlego.com/book/964105/supplement-to-nanda-international-nursing-diagnoses-definitions-and-classification-20182020-11th-edition-new-things-you-need-to-know-pdf