

Alliance University SON- Concept Map

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Submission Date- 04/27/2023

Nursing Dx

Risk for Trauma r/t weakness, limited muscle coordination, and cognitive limitations

Expected Outcome

Pt will maintain a treatment measurement to control or eliminate seizure activity without injury by the end of 12-hour shift.

Interventions

1. Use/pad side rails with the bed at the lowest position.
2. Turn the head to the side and suction the airways.
3. Do not leave the patient during and after a seizure.
4. Educate foster family information about surgery or electrode implantation if needed.

Evaluation

The goal was met, patient maintained a treatment measurement to control seizure activity without injuries by the end of 12-hour shift.

Nursing Dx

Risk for Infection r/t LVAD placement, compromised cardiac function, and chronic illness of the heart.

Expected Outcome

Pt will be free from infections (redness, discharge, odor) at the site of LVAD placement within 4 hours of care.

Interventions

1. Assess temperature, site of LVAD, and lab values.
2. Wash hands before giving care.
3. Avoid site of LVAD while giving care.
4. Inform foster family to avoid having contact with patient if they are sick.

Evaluation

Goal met, the patient was free from infections (redness, discharge, odor) at the site of LVAD placement within 4 hours of care.

Past Medical History

Arterial Ischemic Stroke MCA, Seizure disorder, Acute Thrombosis of saphenous vein, Foster care, Decreased ADLs, Right-side Hemiparesis, Developmental Delay, Dysphagia, Cardiac Tamponade, Prematurity, Culture-neg Sepsis, Pleural Effusion w/ pulmonary infection, Respiratory Failure, Small intestinal bacterial growth

Medical Diagnosis & Assessment

Fracture, Seizure, Bleeding Precautions
Heart Failure
Autism - Nonverbal
LVAD HeartMate 3™
NG Tube

Temp 97.8; PR 101; RR 20; BP 54/0 L
Doppler; SPO2 97; A&Ox3, LVAD, No pain, No JVD, no cyanosis, cap refill < 2, NKA, Resp WNL, lung sounds clear/bilateral; Cont. pulse ox; No pain; GI WNL; +BS in all quadrants, abdomen soft/nontender, last bowel 4/18; Vomiting/impaired feeding, limited mobility/endurance, full ROM, incontinent - diapered

Medications

Aspirin 81mg NG daily
Calcitol 2,000u NG daily
Cuvposa 0.3mg NG Q6hr
Ferrous sulfate 300mg NG daily@1200
Loperamide Hcl 3mg NH Q8 Rx1
Multivitamin peds 1ml NG daily
Sandostatin 1 syr SQ@000,1200

Nursing Dx

Risk for Aspiration r/t NG tube feedings

Expected Outcome

Pt will not experience any aspiration as observed by clear lung sounds, unlabored breathing, and oxygen saturation within normal limits by the end of 12-hour shift.

Interventions

1. Keep suctioning equipment at the bedside.
2. Assess gag reflex and ability to safely swallow.
3. Keep the head of bed elevated after feedings.
4. Educate foster family about conditions that can cause aspiration.

Evaluation

Goal met, the pt did not experience aspiration as observed by clear lung sounds, unlabored breathing, and oxygen saturation within normal limits by the end of 12-hour shift.

Nursing Dx

Impaired Verbal Communication r/t developmental delay and learning disability as evidenced by aphasia, difficulty expressing emotions, and difficulty comprehending communication.

Expected Outcome

Pt will establish a method to communicate clearly to meet their needs and utilize equipment to augment communication within 6 hours of care.

Interventions

1. Evaluate mental status.
2. Investigate if the patient communicates using charts or visual aid.
3. Pay attention to nonverbal cues and gestures.
4. Educate foster family on different methods to communicate with patient.

Evaluation

Goal met, pt established methods to communicate clearly to meet their needs and utilized equipment/charts to augment communication within 6 hours of care.