**Appendix 1 Nursing Diagnosis**

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| Altered tissue perfusion  Alteration in communication  Risk for altered growth  Risk for altered development  Risk for trauma  Risk for pain  Sleep pattern disturbance  Ineffective breathing pattern  Risk for infection  Risk for impaired skin integrity  Risk for injury  Nausea, perceived  Vomiting, perceived  Constipation, perceived  Diarrhea, perceived  Pain  Family coping, potential for growth  Family processes, altered  Loneliness, risk for  Sensory perception alterations  Caregiver role strain | Parental role conflict Parent/infant/child attachment, altered, risk for Parenting, impaired, risk for impaired Role performance, altered Social interaction, impaired Social isolation  Growth and development, altered Knowledge deficit (learning need) (specify) Noncompliance (compliance, altered) (specify) Therapeutic regimen: families, ineffective management  Alteration in body image  Swallowing, impaired  Nutrition, altered, less than or more than body requirements  Family coping, ineffective |

**Care Plan**

*Assessment:* Three year old pediatric oncology patient at end of life, communication challenges

*Diagnosis:* Potential alteration in communication between health care team and patient/family related to impending death

*Plan/Implementation:*

* Identify one member of the inpatient and home team to facilitate communication
* Coordinate care that is family centered, religiously and culturally competent
* Allow patient and family to verbalize concerns
* Incorporate patient and family preferences into treatment plan
* Facilitate conferences involving the inpatient team, homecare agency nurses, patient and family
* Offer to obtain patient’s hand print using paint and canvas
* Assist in interpretation of plan of care.

*Evaluation*: Family and care givers will effectively communicate providing a supportive environment

*Assessment:* Three year old pediatric oncology patient experiencing pain

*Diagnosis:* Alteration in Comfort

Risk for Pain

*Plan/Implementation*:

* Assess the comfort level of the patient utilizing pain assessment tools and cues that include complaints, wincing, groaning and changes in vital signs
* Consult with the family and physician to determine adequate analgesic that includes opioids, antipyretic, antianxiety and oxygen. Offer integrative therapy. Develop a plan of care.
* Do not continue to take vital signs and monitor oxygen saturation, discontinue monitors
* Adjust hygiene regime such as mouth care and bathing to the wishes of patient and family, assess for incontinence using foley catheter, chucks or depends.

*Evaluation:* Patient is not exhibiting any signs of pain

*Assessment*: Three year old pediatric oncology patient at end of life, complex care

*Diagnosis*: Caregiver role strain

Family processes, altered

Parental Role Conflict

*Plan/Implementation:*

* Assess family interactions
* Notify family’s oncology psychosocial clinician of any concerning interactions or behaviors
* Allow family to verbalize fears, frustrations and concerns.
* Encourage family to rest and take breaks
* Inform family of the changes in status as the patient approaches death

*Evaluation:* Family able to verbalize their fears, frustrations and concerns

*Assessment*: Three year old pediatric oncology patient with a poor oral feeding and gastrointestinal tube

*Diagnosis*: Nutrition, altered, less than or more than body requirements.

Alteration in Skin Integrity

*Plan/Implementation:*

* Obtain a patient history that includes overall assessment of patient, including function and skin integrity around the G-tube site.
* Assess and monitor patient’s skin integrity, input and out put
* Educate and review the elements of caring for the G-tube and enteral feed administration
* Administer feeds through the G-tube. Maintain an input and output record.
* Place split 2x2 gauze around tube insertion.
* If excess leakage or skin irritation is present, apply absorbent topical powder (Stomahesive) and use high absorbency foam dressing (i.e. Allevyn) in place of gauze.
* Change dressing daily and as needed. Date and time the dressing.
* Consider Aveeno soaks as needed for relief of itchy skin, often present with candidal yeast rashes.
* If candidal rash present, use topical antifungal ointment to treat.
* If skin open denuded, use Domeboro soaks (1 packet/6 oz. water).
* Provide diet high in protein and calories throughout the day
* Assess for nausea and vomiting providing antiemetics as ordered.
* Instruct parents on care of the tube and feedings

*Evaluation:* skin integrity remains intact, family able to care for the G-tube (Quigley, S., 2008).

*Assessment*: Three year old pediatric oncology patient at end of life, preparation of patient and family

*Diagnosis:* Family Coping, risk for impaired

Knowledge deficit related to end of life

Family Processes, altered

*Plan/Implementation:*

* Notify the primary care team of changes in patient status or death
* Support the parents in their decision to perform an autopsy and/or organ donation
* Remain with the family unless they request otherwise
* Wash and groom the body allowing the family to participate if they wish
* Remove as much medical equipment from the area
* Allow family to spend as much time as needed alone with the patient
* Offer to make calls
* Explain grief and bereavement support services available
* Participate in bereavement follow-up if desired

*Evaluation*: Patient and family will experience a peaceful death