FAMILY CASE STUDY AND CARE PLAN

P.S. was born at 25 weeks gestation, weighing 620 grams at birth. She was hospitalized in the NICU for 10 weeks, discharged at 35 weeks corrected gestational age. Her NICU course was uneventful except for the development of Bronchopulmonary Dysplasia (BPD). Her parents, who are married and have no local family support, live in a two bedroom apartment. She is their only child. Both were employed outside of the home, but the mother took an extended leave of absence until P.S. was off oxygen and monitors. The parents were in the NICU daily, and were committed to taking her home as soon as possible with oxygen, nasogastric tube feedings, and multiple medications. A potential discharge date was chosen two weeks in advance, and no changes in care were made during that time. The parents brought a list of potential pediatricians to the NICU for feedback, and chose a community pediatrician near their home as a primary provider. Home nursing visits and in-home occupational therapy were arranged. Follow-up appointments were scheduled with ophthalmology, BPD clinic/pulmonology, and her primary pediatrician. Her parents met all providers before discharge and learned all aspects of her care. They were familiar with her breathing patterns and knew her signs of respiratory distress and actions to take in the event of an emergency. They also completed an infant CPR class. The nutrition team taught the parents how to mix her high-calorie formula, and equipment teaching was completed by the DME provider (oxygen concentrator and tanks, apnea monitor, pulse oximeter, and nebulizer). Respiratory therapists taught the parents to administer MDI and nebulized medications. Prescriptions were filled by the parents, brought to the NICU, and verified by the primary nurse. The parents had a written medication record, their infant’s admission and discharge summaries, appointment scheduling, and emergency information in their discharge packet. Car-seat testing was completed.

Finally, the discharge date arrived and P.S. was discharged home safely. She was receiving oxygen at 1 lpm, respiratory treatments three times daily, multiple daily medications, and nasogastric feedings. Parents were instructed to check her oxygen saturations three times daily and as needed, and to keep her on the apnea monitor when unattended by them. She was bottle feeding partial feedings 2-3 times per day. Her parents were happy and nervous. The home-care nurse visited the day following discharge. All medications were reviewed for correctness, having the parents draw up each medication, and adjustments were made in scheduling. Formula preparation was reviewed, and equipment was verified. A physical assessment was done along with obtaining weight and measurements. The home care nurse phoned the nurse practitioner/coordinator of the BPD clinic to formulate a plan. The primary pediatrician had been contacted prior to discharge, with plans for the home care nurse to provide updates every 1-2 weeks.

No changes in care were planned soon after discharge, allowing the parents time to adjust to her care at home. Unexpectedly, P.S. was re-admitted one week after discharge for laser therapy for her retinopathy of prematurity. She was discharged 24 hours later with the same support and medications. She was seen by her pediatrician within the first week, with plans to see her monthly. Home-health nurse visits were scheduled two times a week initially, moving to weekly after 3-4 weeks. Frequent home nursing visits reduced clinic visitation, especially important in the winter months in the Midwest. She was seen in the BPD clinic one month after discharge, at which time she was found to be very stable, and a weaning plan was formulated, with plans to see her again in clinic in two months. She remained stable, and oxygen and medications were weaned steadily over the next 3 months. Weaning was uneventful, as she steadily improved, gained weight, and did not become ill. Due to her steady weight gain and decrease in respiratory distress, her formula was changed to fewer calories per ounce, at which time weight gain stopped, so calories were again increased. She did not progress initially with bottle feeding, but improved after reflux medications were adjusted. The ng tube was discontinued before her due date. Her parents were elated when the final equipment was removed, but also very anxious, as they had never known her without assistive equipment. The nebulizer was not returned, as it had been purchased by the insurance company, and due to the likelihood of the need for respiratory treatments in the first year of life.

Due to the challenges facing them after discharge, the parents devised a plan for care at home, each taking responsibility for specific care needs. The father took responsibility for maintaining the complex medication schedule, allowing the mother to focus on feeding issues. They devised a documentation system, allowing excellent communication between themselves and the medical team. As their daughter’s condition improved, care was simplified, and the parents each became independent in all aspects of her care. The parents viewed the experience as stressful, but were happy with their decision for discharge at that time rather than closer to her due date. They feel that their daughter thrived at home, and are proud of their accomplishments.

CARE PLAN FOR P.S.

* Assessment: Preterm infant, tachypnea, poor oral feeding

Diagnosis: Risk for altered growth

Plan/implementation: Monitor weight every visit, assess intake, monitor output, consult with dietician and increase feeding volumes weekly

Evaluation: Weight gain 15-30 grams daily. Increased oral feeding over first month at home.

* Assessment: Preterm infant, chronic disease

Diagnosis: Risk for altered development

Infant behavior, disorganized, organized with potential for enhanced,

Plan/implementation: Follow developmental levels monthly. Refer to state 0-3 program for therapies

Evaluation: Developmental levels are age appropriate. Infant is receiving therapies through 0-3.

* Assessment: Preterm infant, tachypnea, requiring oxygen

Diagnosis: Ineffective breathing pattern

Plan/implementation: Follow oxygen saturation trends. Wean oxygen as planned by pulmonologist. Assess respiratory status.

Evaluation: Oxygen saturations remain >95%. Oxygen is weaned every two weeks. Tachypnea improves.

* Assessment: Preterm infant with chronic lung disease

Diagnosis: Risk for infection

Plan/implementation: Meticulous handwashing. Educate parents to avoid crowds and sick children. Arrange RSV prophylaxis injections, provide in-home if possible. Influenza injections for parents, and in infant when 6 months old.

Evaluation: P.S. is cared for in her home, avoiding daycare. Parents wash hands regularly. RSV prophylaxis is received monthly. Parents have influenza injections.

* Assessment: infant takes partial feeding PO three times daily. Chronic lung disease. GE reflux.

Diagnosis: Infant feeding pattern, ineffective

Plan/implementation: Follow GE reflux with GI specialist, adjust medications as ordered and evaluate effectiveness. Speech therapy evaluation and treatment through 0-3 services. Counsel parents to pace feedings, and increase oral feedings as tolerated.

Evaluation: Infant increases oral feedings

* Assessment: Preterm infant with chronic disease. Complex infant care

Diagnosis: Caregiver role strain   
Family coping, potential for growth  
Family processes, altered  
Loneliness, risk for  
Parental role conflict  
Parent/infant/child attachment, altered, risk for  
Parenting, impaired, risk for impaired  
Social isolation

Plan/implementation: Assess family interactions. Maternal depression screening. Referral to parent support group. Referral to psychiatric care. Offer reassurance and support.

Evaluation: Parents maintain communication and marriage remains intact. No depression.

Parents are attached to infant as evidenced by meeting infant’s needs in loving and caring manner.

* Assessment: first child, premature infant with complex medical care in the home

Nursing diagnosis: Knowledge deficit (learning need): infant care, medication administration, infant nutrition, infant growth and development, oxygen care

Plan/implementation: review knowledge and understanding of infant care, medications, oxygen, growth, development, nutrition. Education to knowledge deficit.

Evaluation: Parents competently care for infant.