

OUR LADY'S CHILDREN'S HOSPITAL, CRUMLIN

Nursing care plan 19

Altered Hydration and Nutrition

This care plan to be used with care plan 9 if commenced on Intravenous fluids

Care plan 19		Ineffective Hydration and Nutrition	Issue date: January 2012
Problem		Goals	Review date: January 2015
† Has altered nutritional intake † Has altered hydrational intake † Has nausea and vomiting Related to.....		1. To maintain hydration status for age and condition 2. To maintain nutrition status for age and condition 3. To relieve nausea and vomiting NB. Loop all enteral feeding tubes when not in use to prevent tubes catching in equipment if not connected to feeding pumps. Special care when moving and handling infants (For example transferring to a buggy, placement in parents arms or weighing)	
Commenced date, time and signature	No	Nursing intervention	Date discontinued, time and signature
	1.	Hydration (encourage parental involvement)	
		<ul style="list-style-type: none"> Offer oral fluids to ensure adequate hydration. Monitor and record intake and output, report deviations. Record type of feed <ol style="list-style-type: none"> Breast Bottle feeds ___ Volume x ___ feeds of ___ formula beakers or cups ___ Volume x ___ feeds of ___ formula Special feed ___ Volume x ___ feeds of ___ formula Observe for signs of dehydration, (<i>reduced urinary output, sunken fontanelle, slow capillary refill, reduced skin turgor,</i> Monitor urinary output: <i>Weigh nappies/measure urinary output</i> and record same, report accordingly. Perform ward urinalysis as required Intravenous fluids as per care plan 9 Consider Blood sugar level in infants 	
	2.	Nutrition (encourage parental involvement)	
		<ul style="list-style-type: none"> Offer small snacks/spoon feeds at regular intervals Offer meals at mealtimes; ensure food preferences are taken into account. Record refusals in intake/output chart Record all vomits, amounts and type Weight (<i>insert frequency</i>) _____ Special diet and feeds/ any feed additives or thickeners included _____ Record bowel motions, amount, frequency, consistency and type Liaise with Speech and Language Therapist for oral stimulation as applicable _____ Liaise with the dietitian if applicable/special feeds ordered _____ Record route of feeds (<i>Please circle</i>) Oral / NG / PEG / NJ/TAT _____ 	

Updated January 2016

Patient Name.....

HCRN.....

Ward.....

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	Date	Date	Date	Date	Date	Date	Date
Type of Tube							
Size							
Location R/L							
Secured with							
If NG insert length in CMs							
Signature							
<ul style="list-style-type: none"> • Ensure tube is free of kinks. • Tape securely, but maintain skin integrity at all times. • Aspirate and test to ensure correct position as per NPC guidelines (2011) <i>Not applicable if TAT or NJ tube</i> • Flush tube post the administration of feeds/medication with sterile water as condition allows • Record types of feeding equipment used, date and time _____ _____ _____ 							
3.	Nausea and Vomiting (Encourage parental involvement)						
	<ul style="list-style-type: none"> • Provide emesis bowl and tissues • Record all vomits, type, amount, consistency, colour and volume • Record on intake and output sheet • Administer anti-emetics as prescribed • Attend to oral hygiene needs • Administer oral fluids as tolerated 						
4.	Psychiatry assessment						
	<ul style="list-style-type: none"> • Review by psychiatry team as ordered • Regular team meetings • See specific care plan for psychiatry care. 						