**REFERENCES CARE PLAN: Gastrochisis- Omphalocele**

**PATIENT POPULATION**

A description of the patient population this care plan applies to patients born with an omphalocele or gastrochisis.

**DEFINITIONS**

Gastrochisis is a birth defect that develops in utero in the first trimester. This condition occurs when an opening forms in the baby’s abdominal wall. The baby’s bowel pushes through this hole. It then develops outside of the baby’s body in the amniotic fluid.

Omphalocele is a rare birth defect. It happens in about one in 5,000 births. An omphalocele happens when the bowel, liver and sometimes other organs remain outside the belly protected by a membrane.

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| Alteration in comfort related to birth defect and/or surgical procedure | Child will remain comfortable | - Assess & document pain q1-4h & prn.  
- Use appropriate pain scale  
- Administer analgesia as ordered prn.  
- Assess effectiveness of analgesia (abdominal girth, if distention is an issue) 30-45 minutes post administration  
- If analgesia ineffective contact appropriate service i.e. General Surgery team and/or Acute Pain Service (APS)  
- Use distraction techniques as appropriate. Use: warm blankets, Child Life, pt. specific i.e. personal blanket or stuffy  
- Assist with repositioning q2-4h and prn. | Promotes child’s comfort during procedure, ensures adequate pain and anxiety control; promotes compliance with future procedures. |
| Alteration in nutrition related to birth defect and/ or surgical procedure. | Child will develop adequate feeding regime and gain weight. | - Initiate fluids as ordered  
- Daily weights using same scale  
- Keep HOB elevated if ordered, otherwise nurse flat.  
- Advance diet as ordered/tolerated.  
- Advocate Occupational Therapy as directed by General Surgery  
- Dietician as required to optimize weight gain.  
- Assess and document accurate intake and output | Maintaining adequate nutrition will promote normal growth and development. Using the same scale will reflect accurate weight gain or loss. Healing causes increased metabolic activity = more calories burned, involve nutrition services as needed to support nutritional management. |

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## Reference Care Plan: Gastrochisis-Omphalocele

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| **Alteration in fluid balance related to:** | q1-4h and prn  
- TPN - administer as ordered | Maintain IV as ordered. Check site q 1h and prn  
- Assess IV site using TLC  
- Advance diet as ordered/tolerated  
- Assess and document accurate intake and output q1-4h and prn  
- Maintain NG as ordered  
- Replace NG losses as ordered q4h | Patient is at risk for oral aversion due to delayed feeding initiation. Also OT can help with garments that may be required for ongoing management. |
| Surgery  
- pre-op NPO  
- nausea  
- vomiting | Child will fluid balance will remain stable as evidenced by: | Provides thorough assessment of infusion system so complications can be detected early and immediate interventions can be provided in a timely manner. Educates family on importance of performing the hourly site assessments and engages them in the process |
| **Potential infection related to:** | Child will remain free of surgical infection by discharge as evidenced by: | Assess and document vital signs as ordered and prn  
- Change dressing as ordered and prn  
- Assess and document surgical site with dressing change and prn  
- Notify Enterostomal Nurse (local 7658, or pager 41-01157) for support with dressing changes prn  
- Assess abdomen for tenderness, distention and bowel sounds with vital signs and prn, then q shift when bowel sounds present  
- Maintain HOB at 30°  
- Administer antibiotics as ordered | Provides thorough assessment of patients clinical status including vitals, surgical wound, and comfort to ensure complications can be detected early and immediate interventions can be initiated.  
Hasty removal of dressing can cause trauma to the newly healing and granulating tissues.  
Wound infection causes an inflammatory response that interferes with wound healing. Regular assessment |
| Surgical procedure  
- risk of peritonitis  
- incision site  
- Wound healing of defect | **vital signs within normal limits for age**  
**free of signs and symptoms of infection**  
- No Redness  
- No Heat  
- No Pain  
- No Drainage  
- No Edema | | **Manufacture**

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## Problem/Potential Problem

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| For children who are healing their defect primarily signs and symptoms of wound infection may be more subtle, such as increased drainage, and a reduced rate of skin growth/coverage. Patients may also have more traditional symptoms such as fever, swelling, edema, redness, pain. | | - Orientate family to unit and hospital routines  
- Involve family in patient transfer and establishing patient careplan and routines.  
- Establish autonomy and control by structuring the plan of care with the caregiver at the start of the shift.  
- Encourage questions and discussion  
- Encourage the use of the whiteboard in the patients room to promote communication.  
- Collaborate with family regarding goals for hospitalization  
- Consult lactation services if Mom is planning to breastfeed.  
- Offer support services if required i.e. Social Work, Community Nurse, Pastoral Care, Psychology, Child Life and Volunteer Services, First Nations Advocate, etc. | ensures prompt treatment of wound infection. Wound infection also causes increased caloric consumption, ensure adequate nutrition. |

### Potential for anxiety and disturbance of self and family related to diagnosis and hospitalization.

Patient and family will demonstrate positive coping skills in relation to diagnosis and patient’s condition prior to discharge | | | Promotes communication and decreases anxiety when all members of the core care team understand the plan of care. |
## Patient/Family education and discharge planning

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| Patient/Family education and discharge planning | Family will state an understanding of pts. condition, treatments and medications, and express realistic plans for home care by discharge | - Provide direction to hospital resources  
- Have patient caregivers explain in their own words basic facts about the nature of condition, symptoms, and treatments.  
- Discuss prescribed medications including purpose, action, side effects, and administration.  
- Discuss plans and provide teaching for any home care routines i.e. bathing, feeding, and activity  
- Ensure family is aware of follow up plans  
- Plan for discharge, options for dressings in the community include Community Liaison RN’s, MDU, parent involvement, and/or outpatient clinics. | To ensure the family understands and is prepared to care for the child at home with the necessary equipment and prescriptions as required. Discharge plans must be individualized for each family’s needs, and all families should be sent home with a 2 week supply of dressing supplies. |

## CROSS-REFERENCES

Any related policies/procedures, other care plans, teaching flowsheets, patient/family teaching resources, etc.

**GUIDELINES FOR MAINTAINING INFUSION THERAPY**

**Nursing Assessment and Documentation**

**Patient Teaching Flow sheet: Expressed Breast Milk: safe handling, storage and administration**

**POST-OPERATIVE CARE OF INCISIONS: DRESSING CHANGE**

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REFERENCES

https://www.cincinnatichildrens.org/health/g/gastroschisis

https://www.cincinnatichildrens.org/health/o/omphalocele


http://www.bcchildrens.ca

http://dx.doi.org/10.1016/j.amjsurg.2015.11.009