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# Cleft palate feeding support Initial assessment

Child Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

## Patient profile and history

3-month-old boy with caregiver present. Care stage: At the first supervised assessment.

Medical history: Cleft palate was identified in infancy. Feeding has been prolonged with milk leakage, and the infant is followed by a specialist cleft team. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: A caregiver is available for teaching and assisted care. The family requests plain-language instructions, a practical feeding/activity plan and follow-up. Assess development, immunization record and safeguarding individually.

Scenario: The patient or caregiver wants to know which concern needs attention first.

## Clinical assessment

Subjective: Prolonged feeds, milk leakage and caregiver worry about weight gain.

Objective findings and required checks: Feeding efficiency and growth require specialist assessment; airway and aspiration signs are reviewed.

Physical examination and investigations: Observe feeding, weight, hydration, respiratory symptoms and the cleft-team plan.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

## Clinical focus and pathophysiology

Cleft palate feeding support: An opening in the palate reduces the ability to generate effective suction.



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## Medical / surgical management

Use the specialist feeding method and positioning, support paced feeds and coordinate surgical-team follow-up.

## Illustrative drug and treatment study

| Medicine / treatment | Purpose | Nursing checks |
|---|---|---|
| Prescribed nutritional support | Meet infant needs using the assessed feeding plan | Monitor intake and growth |
| no routine medicine for the cleft itself | Avoid implying a drug corrects the structural problem | Treat separate conditions only when indicated. |

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

## Nursing process - ADPIE

### Assessment

Prolonged feeds, milk leakage and caregiver worry about weight gain. Feeding efficiency and growth require specialist assessment; airway and aspiration signs are reviewed. The patient or caregiver wants to know which concern needs attention first.

### Nursing diagnosis

Prioritize feeding difficulties affecting infant or caregiver well-being; nutritional intake below current needs; emotional distress affecting participation in care; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

### Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

### Implementation

Use the specialist feeding method and positioning, support paced feeds and coordinate surgical-team follow-up. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

### Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met



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using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.



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# Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Ask: Ask about feed frequency, pain, infant behaviour and caregiver concerns. Assess: Observe an entire feed when possible and assess weight, output and clinical stability. | Feeding difficulties affecting infant or caregiver well-being. Possible factors: ineffective attachment, fatigue or a clinical feeding barrier. Validate against the patient's assessment. | Short-term: After the first indicated intervention, at the documented review time: A safe, supported feeding plan is demonstrated during the observation period. Longer-term: Before the clinically approved transition or agreed follow-up: Caregiver describes feeding cues, intake indicators and when to seek help. | 1. Assess both infant stability and caregiver comfort before recommending changes. Rationale: Feeding difficulty can have medical as well as technique-related causes. 2. Support positioning and attachment or the prescribed alternative feeding method. Rationale: Individual support can improve comfort and effective milk transfer. 3. Arrange weight or feeding review and escalate poor intake or dehydration. Rationale: Follow-up helps identify inadequate intake early. 4. Use the specialist feeding method and positioning, support paced feeds and coordinate surgical-team follow-up. Rationale: An opening in the palate reduces the ability to generate effective suction. The condition-specific plan addresses the underlying problem while response is monitored. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |



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| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Ask: Ask about usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings. | Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment. | Short-term: After the first indicated intervention, at the documented review time: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements. | 1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |
| Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions. | Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment. | Short-term: After the first indicated intervention, at the documented review time: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care. | 1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |
| Ask: Ask what the learner already knows and wants to understand. Assess: | Learning needs about the condition and care plan. Possible factors: new | Short-term: After the first indicated intervention, at the documented review time: | 1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few | Record the baseline and reassessed finding, the time |



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| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Use teach-back or demonstration to identify specific gaps. | information, complex treatment or limited prior teaching. Validate against the patient's assessment. | Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs. | condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Demonstrate the recommended feeder, pacing, cleaning and follow-up schedule. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care. | and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |



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## Health education and continuing care

Demonstrate the recommended feeder, pacing, cleaning and follow-up schedule.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

## Urgent warning signs

**Choking, cyanosis, repeated respiratory symptoms or dehydration requires prompt pediatric assessment.**

## Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

## Quick Revision

- An opening in the palate reduces the ability to generate effective suction.

- Priority concerns: Feeding difficulties affecting infant or caregiver well-being; Nutritional intake below current needs; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Choking, cyanosis, repeated respiratory symptoms or dehydration requires prompt pediatric assessment.

- Demonstrate the recommended feeder, pacing, cleaning and follow-up schedule.

**Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?**

## References

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