

### Pediatrics case 5: Charlie snow

1. My initial focused assessment was a respiratory assessment. Because he was having trouble breathing also to confirm the anaphylaxis reaction. Charlie and his aunt came to the emergency room due to believing to be having an anaphylaxis reaction. He has allergies to peanuts and ate a cookie with peanuts. He is having trouble breathing. He is wheezing. He is able to talk with shortness of breath.
2. Ineffective breathing pattern. As evidence by cough, dyspnea, wheezing and respiratory distress.
3. I identified Charlie's aunt and Charlie's. I assessed Charlie's lungs and vitals. I asked about allergies. I asked if Charlie had any past medical health issues. His o2 was low so I applied the nonrebreather at 10/L to get his o2 up to 99%. I then called the doctor, gave sbar. I then proceeded to implement the new orders. I assessed and flushed his IV. I gave the epinephrine. 25 mg of diphenhydramine IV, 10 MG methylprednisolone IV. I reassessed the patient's vitals q 5 until respiratory status improved.
4. I told and educated the patient about signs and symptoms of onset of reaction and importance of keeping an epi pen. I taught the patient and aunt to avoid foods that he is allergic to. I also taught them about the epi-pen and how to use if he experiences another reaction and well as calling 911.

## **GUIDED REFLECTION**

At the beginning of I wanted to just give the patient the medication without even assessing the patient. I felt like if it was a real-life situation, I would have freaked out by the time I was unorganized the patient would have died. After Several attempts, going in and knowing what to do helped me understand what's priority. And why do you have to verify the aunt first before the child. I felt like calling the provider went well because it wasn't an order for what he needed. It like made me realize how important the nursing process is, like assess first.

First thing I want to verify the aunt and patient. Hand hygiene. Then assess the patient. Respiratory was the focused assessment. So set of vitals to evaluated and listening to the patients' lungs, as well as asking the patient are they in any pain, or what issue are they having. As well as the child's history.

Charlie could have been dead very quickly. Not recognizing the breathing issue or not calling the doctor about his airway.

The glucocorticosteriod was given to help alleviate they anaphylaxis. Such as the swelling of the airway to the airway and inflammations it helps healing as well and restore balance. Albuterol or more for bronchospasms.

I could have told them the reason I had to do the assessment first before giving medication. So, they understand why I'm doing things instead of administering something for relief first.

To improve safety, I could have recognized quickly that the patient's respiratory system needed to be assessed. Just because its orders it don't mean necessarily to go in the room task oriented to do these things first without assessing the child needs, like what is priority right now. Such as getting the vitals and respiratory status to use in my sbar to phone the doctor.

It was important to have the consent signed to allow the child to be treated with his parents now being there. Because he was with his aunt.

The role I feel Charlie's guardians have as members if his health care team are being aware of what could happen when Charlies eats something he is allergic to. They could also give the child an allergy bracelet so even when they are not around Charlie can see his bracelet as a reminder to ask or check about things with allergens before he eats them. It's important for them to have an epi pen in case of an emergency. Like I honestly felt the sicario was too long and my patient could have died byt the time I assessed him and called the doctor and did everything correctly.

The key elements I would include in handing off this patient would make sure this patient left the hospital with and epi pen or prescription for one. Also making sure they had to the resources needed to pay for it if they didn't leave with one. I would schedule a follow up appoint with the child primary care provider. I would stress patient and family education in hand off so that they didn't only hear it from me but each nurse in the child's care.

I would prioritize asking how the patient feels. Then swiftly recognizing what I needed to do. If it was a real life scenario, I would have been going in the patients room, leaving to call the doctor, still confused on what to do. Going forward I felt like it helped understand more of the importance of assessing the ABC's and Sbar.