

N433 Care Plan 1

Lakeview College of Nursing

Marianna Craighead

**Demographics (3 points)**

<b>Date of Admission</b> 5/24/2022	<b>Client Initials</b> JW	<b>Age (in years &amp; months)</b> 1 month and 10 days	<b>Gender</b> Male
<b>Code Status</b> Full	<b>Weight (in kg)</b> 3.3kg	<b>BMI</b> 12.9	<b>Allergies/Sensitivities (include reactions)</b> NKA

**Medical History (5 Points)****Past Medical History:** NA**Illnesses:** NA**Hospitalizations:** NA**Past Surgical History:** NA**Immunizations:** Hep. B on 5/13/24**Birth History:** length: 20", Weight: 2.4kg, Head circumference: 11.61", Apgar: one min. 8, five min. 9, Spontaneous vaginal delivery, and Labor of 8 hrs. and 37 minutes**Complications (if any):** NA**Assistive Devices:** NA**Living Situation:** NA**Admission Assessment****Chief Complaint (2 points):** Difficulty of breathing**Other Co-Existing Conditions (if any):** NA**Pertinent Events during this admission/hospitalization (1 points):** NA**History of present Illness (OLD CARTS) (10 points):**. The mother stated that he always has made a funny noise while breathing since he was born. She said on 5/24/22 the noise got worse, and he seemed to be breathing harder. She also states that his feeding has decreased. Mother hasn't sought any previous treatment for the difficulty of breathing. Doesn't notice if anything really makes it worse or better. So mother decided to bring him into the ED to get checked out.

**Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Acute Respiratory Failure

**Secondary Diagnosis (if applicable):** Sleep apnea

**Pathophysiology of the Disease, APA format (20 points):**

Acute respiratory failure is defined by an acute onset of noncardiogenic pulmonary edema, hypoxemia, and the need for mechanical ventilation (Matthay et al., 2019). The mortality rate of acute respiratory failure is approximately 40% and they present in about 10% of all ICUs worldwide (Matthay et al., 2019). According to Matthay acute respiratory failure occurs approximately 5.7 per 100,000 children a year.

Risk factors for acute respiratory failure are the following being male, pneumonia, viral infection, and gastric aspiration (Matthay et al., 2019). Signs and symptoms of acute respiratory failure are the following severe shortness of breath, labored and unusually breathing, low blood pressure, confusion, and fatigue (Matthay et al., 2019). Some of these signs may present differently in a child, for example, a mother may notice the labored breathing and decreased intake in feedings. Complications that may occur from acute respiratory failure are the following blood clots, pneumothorax, infections, pulmonary fibrosis, future respiratory issues, and death (Matthay et al., 2019). A future respiratory illness could be for an example would be asthma. This would cause a person to have chronic issues with many flare ups. Another complication would be pulmonary fibrosis. This would result in lungs not being able to fully expand due to the scarring. This then turns into the person not being able to get enough oxygen increasing their respiratory rate.

Some diagnostic tests that may be performed are chest x-ray, CT, ABGs, CMP, and CBC (Hinkle and Cheever, 2022). A chest x-ray and a CT will allow for a physician to be able to examine the lungs and detect abnormalities in the lungs. ABGs, CMP and CBC will allow for a physician to be able to determine if there are any molecular issues that are occurring within the

body (Hinkle and Cheever, 2022). Treatment can include the following oxygen supplementation, mechanical ventilation, fluids, and steroids (Matthay et al., 2019).

**Pathophysiology References (2) (APA):**

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner & suddarth's te book of medical-surgical nursing (15th ed.)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

Matthay, M. A., Zemans, R. L., Zimmerman, G. A., Arabi, Y. M., Beitler, J. R., Mercat, A., ... & Calfee, C. S. (2019). *Acute respiratory distress syndrome*. Nature reviews Disease primers

**Active Orders (2 points)**

Order(s)	Comments/Results/Completion
<b>Activity:</b> Supine position	Avoid laying on your stomach to prevent airway closers
<b>Diet/Nutrition:</b> Formula q3hrs	G-tube feeding through kangaroo pump q 3hrs
<b>Frequent Assessments:</b> q4hrs	Assessment q4hrs with vitals, B/P is q 8hrs
<b>Labs/Diagnostic Tests:</b> NA	NA
<b>Treatments:</b> Dressing change, Oxygen	Dressing change q 3 days to LUQ g-tube Oxygen @ 3L high flow to maintain O2 STAT greater than 92%
<b>Other:</b> NA	NA
<b>New Order(s) for Clinical Day</b>	
Order(s)	Comments/Results/Completion
NA	NA
NA	NA
NA	NA

**Laboratory Data (15 points)**

**CBC Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab</b>	<b>Normal Range (specific to the age of the child)</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal Value</b>
<b>RBC</b>	3.10-5.30	NA	NA	NA
<b>Hgb</b>	10.7-17.1	NA	NA	NA
<b>Hct</b>	33-55	NA	NA	NA
<b>Platelets</b>	150-450	NA	NA	NA
<b>WBC</b>	6.0-17.5	NA	NA	NA
<b>Neutrophils</b>	49-74	NA	NA	NA
<b>Lymphocytes</b>	41-71	NA	NA	NA
<b>Monocytes</b>	4-14	NA	NA	NA
<b>Eosinophils</b>	0-3	NA	NA	NA
<b>Basophils</b>	0-1	NA	NA	NA
<b>Bands</b>	0-11	NA	NA	NA

**Chemistry Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason For Abnormal</b>
<b>Na-</b>	136-145	137	NA	NA
<b>K+</b>	3.5-5.1	4.2	NA	NA

<b>Cl-</b>	98-107	106	NA	NA
<b>Glucose</b>	84-100	117	NA	Elevation due to the stress of breathing
<b>BUN</b>	5-17	5	NA	NA
<b>Creatinine</b>	0.55-1.30	0.44	NA	Decrease value due to the exertions of muscles to work to breathe
<b>Albumin</b>	3.8-5.4	3.2	NA	Respiratory distress
<b>Total Protein</b>	4.4-7.6	5.5	NA	NA
<b>Calcium</b>	9-11	9.9	NA	NA
<b>Bilirubin</b>	0.2-1.2	1.2	NA	NA
<b>Alk Phos</b>	82-383	NA	NA	NA
<b>AST</b>	5-34	26	NA	NA
<b>ALT</b>	0-55	12	NA	NA
<b>Amylase</b>	30-115	NA	NA	NA
<b>Lipase</b>	0-160	NA	NA	NA

**Other Tests** **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Admission or Prior Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>ESR</b>	0-2	NA	NA	NA
<b>CRP</b>	2-5	NA	NA	NA
<b>Hgb A1c</b>	7-8.5%	NA	NA	NA
<b>TSH</b>	20-40	NA	NA	NA

**Urinalysis Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Admission or Prior Value	Today's Value	Reason for Abnormal
<b>Color &amp; Clarity</b>	Clear/pale yellow	NA	NA	NA
<b>pH</b>	5-7	NA	NA	NA
<b>Specific Gravity</b>	1001.-1.035	NA	NA	NA
<b>Glucose</b>	Negative	NA	NA	NA
<b>Protein</b>	Negative	NA	NA	NA
<b>Ketones</b>	Negative	NA	NA	NA
<b>WBC</b>	0-2	NA	NA	NA
<b>RBC</b>	0-2	NA	NA	NA
<b>Leukoesterase</b>	Negative	NA	NA	NA

**Cultures Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Admission or Prior Value	Today's Value	Explanation of Findings
<b>Urine Culture</b>	Negative	NA	NA	NA
<b>Blood Culture</b>	Negative	Negative	NA	NA
<b>Sputum Culture</b>	Negative	NA	NA	NA
<b>Stool Culture</b>	Negative	NA	NA	NA
<b>Respiratory ID Panel</b>	Negative	Negative	NA	NA
<b>COVID-19 Screen</b>	Negative	Negative	NA	NA

**Lab Correlations Reference (1) (APA):**

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner & suddarth's textbook of medical-surgical nursing (15th ed.)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

Capriotti, T. (2020). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives (2nd ed.)*. F.A. Davis.

### **Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):** Chest X-Ray

**Diagnostic Test Correlation (5 points):** Chest X-Ray showed no structural abnormalities to cause the stridor. This is important to be able to determine the type of treatment that should be performed on my patient.

**Diagnostic Test Reference (1) (APA):**

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner & suddarth's textbook of medical-surgical nursing (15th ed.)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

### **Current Medications (8 points)**

**\*\*Complete ALL of your Client's medications\*\***

<b>Brand/Generic</b>	Budesonide Entocort	Famotidine Pepcid	Simethicone Phazyme	NA	NA
<b>Dose</b>	0.25 mg	1.52 mg	20 mg	NA	NA
<b>Frequency</b>	BID	Daily	PRN qid	NA	NA
<b>Route</b>	Nebulizer	PO	PO	NA	NA
<b>Classification</b>	Glucocorticoid	Antiulcer agent	Antiflatulent	NA	NA
<b>Mechanism of Action</b>	Reduces inflammation in the respiratory airway	Histamine-2 blocker	Reduces the buildup of gas	NA	NA
<b>Reason Client Taking</b>	Ineffective respiratory airway	GERD	Fussiness and gassiness	NA	NA

<b>Concentration Available</b>	0.5mg/mL	0.5mg/mL	20mg/0.3mL	NA	NA
<b>Safe Dose Range Calculation</b>	0.5mg daily or divided into to equal doses	0.5mg/kg	Less than age of 2 years 20mg. After meals and before bed	NA	NA
<b>Maximum 24-hour Dose</b>	0.5mg daily	40mg/day	240mg/day	NA	NA
<b>Contraindications (2)</b>	Hypersensitivity to budesonide Septal ulcers	Hypersensitivity to famotidine or other h2-receptors NA	Hypersensitivity NA	NA	NA
<b>Side Effects/Adverse Reactions (2)</b>	Hypertension Bronchospasm	Agitation Bronchospasm	Nausea Constipation	NA	NA
<b>Nursing Considerations (2)</b>	Closely monitor growth Milk allergy	Shake or suspension for 5-10 seconds Monitor for constipation	Assess the abdomen for any abnormalities Asses for how often gas is being passed	NA	NA
<b>Client Teaching needs (2)</b>	Watch for the thrush This isn't a rescue inhalation	Oral suspension stored at room temperature Must be shaken for at least 10 seconds	Shake medication before use Take it as direct do not take more than necessary	NA	NA

**Medication Reference (1) (APA):**

Jones & Bartlett Learning. (2021). *2021 Nurse's Drug Handbook (20th ed.)*. Jones Bartlett Learning

Assessment

Physical Exam (18 points) **Highlight Abnormal Pertinent Assessment Findings**

<p><b>GENERAL:</b>  <b>Alertness:</b> Consolable by the nurse  <b>Orientation:</b> Response to staff  <b>Distress:</b> No signs of distress  <b>Overall appearance:</b> appropriate for the location</p>	<p>The infant appropriately interacts with staff and is easily consolable by the nurse when crying. He smiles at staff when staff communicates with him. Currently shows no signs of distress at this time.</p>
<p><b>INTEGUMENTARY:</b>  <b>Skin color:</b> Brown  <b>Character:</b> Dry  <b>Temperature:</b> Warm to touch  <b>Turgor:</b> less than 3 seconds  <b>Rashes:</b> NA  <b>Bruises:</b> NA  <b>Wounds:</b> G-tube LUQ  <b>Braden Score:</b> 7  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>IV Assessment (If applicable to child):</b>  <b>Size of IV:</b> NA  <b>Location of IV:</b> NA  <b>Date on IV:</b> NA  <b>Patency of IV:</b> NA  <b>Signs of erythema, drainage, etc.:</b> NA  <b>IV dressing assessment:</b> NA  <b>IV Fluid Rate or Saline Lock:</b> NA</p>	<p>Skin is warm and dry upon palpation. Skin turgor is less than two seconds, normal mobility. Nails are without clubbing. There are no rashes upon inspection. The client's capillary refill is less than 3 seconds between fingers and toes bilaterally. Dressing on G-tube is clean dry and intact.</p>
<p><b>HEENT:</b>  <b>Head/Neck:</b> Skull is normocephalic. Thin hair. Trachea midline.  <b>Ears:</b> WNL  <b>Eyes:</b> WNL  <b>Nose:</b> WNL  <b>Teeth:</b> No present  <b>Thyroid:</b> Not palpable</p>	<p>The client's head and neck are symmetrical. The trachea is midline and there are non-palpable lymph nodes and lobes. The uvula is midline. There is no visible abnormality of ears or palpable deformities. The sclera is white bilaterally. The client's cornea is clear b/l. Their conjunctiva is pink b/l with no mucus. PERRLA b/l. The client's septum is midline. No irritation from tape is present on the infant's face. Anterior fontanel is present.</p>
<p><b>CARDIOVASCULAR:</b>  <b>Heart sounds:</b> S1 and S2  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b> Normal sinus rhythm  <b>Peripheral Pulses:</b> 2+  <b>Capillary refill:</b> less than 3 seconds</p>	<p>. Upon auscultation, there are clear S1 and S2 without murmurs. The client's PMI is palpable in the 5th intercostal space at the MCL. There is a normal rate and rhythm. The client's pulses are 2+ b/l. Their capillary refill is less than 3 seconds between fingers and toes b/l.</p>

<p><b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	
<p><b>RESPIRATORY:</b>  <b>Accessory muscle use:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Breath Sounds: Location, character</b>  <b>Course with the present of stridor</b></p>	<p>.The anterior and posterior breath sounds are course. Stridor can be heard from across the room. Abdominal and sternal muscles are retracting upon the infant taking breaths.</p>
<p><b>GASTROINTESTINAL:</b>  <b>Diet at home:</b> Bottle feed  <b>Current diet:</b> G-tube feeding  <b>Height (in cm):</b> 21”  <b>Auscultation bowel sounds:</b> active q 4 quadrants  <b>Last BM:</b> 6/22/22  <b>Palpation: Pain, Mass etc.:</b> NA  <b>Inspection:</b>              <b>Distention:</b> NA              <b>Incisions:</b>NA              <b>Scars:</b>NA              <b>Drains:</b> NA              <b>Wounds:</b>NA  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>              <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>              <b>Type:</b> Enterostomy Fr 12 location LUQ</p>	<p>. Upon inspection, the client’s abdomen was round. There are active and normal bowel sounds and no tenderness after palpation of all four quadrants. quadrants. G-tube present in LUQ and dressing is dry and intact. The last BM was on 6/22/22 and was small loose and brown.</p>
<p><b>GENITOURINARY:</b>  <b>Color:</b> Pale straw yellow  <b>Character:</b> Clear no odder  <b>Quantity of urine:</b> 66mL  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b> WNL  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>              <b>Type:</b>              <b>Size:</b></p>	<p>No pain with urination and there is no discharge upon inspection. There were no sores located on the genitals. Both testicles are descended. The infant is in a clean dry diaper. Infant voided 66 mL throughout the clinical day</p>
<p><b>MUSCULOSKELETAL:</b>  <b>Neurovascular status:</b> Intact  <b>ROM:</b> Active  <b>Supportive devices:</b> NA  <b>Strength:</b>5/5  <b>ADL Assistance:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Risk:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Score:</b> 2  <b>Activity/Mobility Status:</b> Dependent on</p>	<p>The client shows no signs of muscular atrophy in the limbs. The client’s arm muscle strength is rated at a 5/5 and their leg muscle strength is rated at a 5/5. The infant is able to turn his head from side to side</p>

staff <b>Independent (up ad lib)</b> <input type="checkbox"/> <b>Needs assistance with equipment</b> <input type="checkbox"/> <b>Needs support to stand and walk</b> <input type="checkbox"/>	
<b>NEUROLOGICAL:</b> <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> <b>if no -</b> <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/> <b>Orientation:</b> The infant is consolable <b>Mental Status:</b> Appropriate for age <b>Speech:</b> makes appropriate noises for age <b>Sensory:</b> Intact <b>LOC:</b> Alert and orientated	The patient is alert and orientated. The infant interacts appropriate with staff. Smiles when nurse interacts with him. Listens to nurse and smiles as story books are being read.
<b>PSYCHOSOCIAL/CULTURAL:</b> <b>Coping method(s) of caregiver(s):</b> <b>Social needs (transportation, food, medication assistance, home equipment/care):</b> <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b>	The mother currently isn't present in the child's care. The mother will need training and evaluation on the care she will be providing care. Mother has other children and works midnights. Evaluation of the home environment will be needed to see if the mother is able to properly care for the infant.

**Vital Signs, 2 sets – (2.5 points) Highlight All Abnormal Vital Signs**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	166	100/65	44	97.8	98% 3L of High flow O2
1600	176	92/45	45	98.0	96% 3L of High flow O2

**Vital Sign Trends:** Stable

**Normal Vital Sign Ranges (2.5 points)**  
**\*\*Need to be specific to the age of the child\*\***

<b>Pulse Rate</b>	80-150
<b>Blood Pressure</b>	60/40-100/50
<b>Respiratory Rate</b>	22-55
<b>Temperature</b>	98.6
<b>Oxygen Saturation</b>	95-100%

**Normal Vital Sign Range Reference (1) (APA):**

Ricci, S. S., Kyle, T.,; Carman, S. (2021). *Maternity and pediatric nursing (4th ed.)*. Wolters Kluwer.

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
rFLACC	No crying	NA	NA	NA	NA
<b>Evaluation of pain status <i>after</i> intervention</b>	NA	NA	NA	NA	NA
<b>Precipitating factors:</b> NA					
<b>Physiological/behavioral signs:</b> Baby is calm and quite					

**Intake and Output (1 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
90mL	66mL

**Developmental Assessment (6 points)**

**\*Be sure to highlight the achievements of any milestone if noted in your child. Be sure to highlight any use of diversional activity if utilized during clinical. There should be a minimum of 3 descriptors under each heading\***

### Age Appropriate Growth & Development Milestones

1. Begins to look at parent and smile.
  - a. Patient looks at staff and smiles when staff communicates with him.
2. Head lag when the infant is pulled to sit.
3. Reflexive sucking when nipple or finger is placed in infant's mouth.
  - a. Patient sucked on a pacifier when placed in his mouth.

### Age Appropriate Diversional Activities

1. Mobile with contrasting colors
2. Mirror
3. Brightly colored toys

### Psychosocial Development:

**Which of Erikson's stages does this child fit?** Trust Vs. Mistrust

**What behaviors would you expect?** Crying when not being touched, diaper changes and when hungry. Respond with sounds upon communication.

**What did you observe?** The patient did not cry much. He cried once during a change that I was performing. The patient responds to me when I was reading story books to him.

### Cognitive Development:

**Which stage does this child fit, using Piaget as a reference?** Sensorimotor

**What behaviors would you expect?** The infant sucking on a pacifier constantly and the infant grabbing objects and holding on to them.

**What did you observe?** The infant was not sucking on his pacifier a lot and he would spit the pacifier out after about 1 minute of sucking on the pacifier. The infant would try

to grab a hold of his nasal cannula on his face when swaddled while being changed.

**Vocalization/Vocabulary:**

**Development expected for child's age and any concerns?** The patient should be able to coo and make other sounds. Should be able to tell a difference in the type of crying done by the patient. The patient did make cooing sounds when communicating with the patient. I was on able to witness much crying from the patient. The patient did cry when agitated with changing of the diaper.

**Any concerns regarding growth and development?** Appears to be growing at a slower rate.

**Developmental Assessment Reference (1) (APA):**

Ricci, S. S., Kyle, T.; Carman, S. (2021). *Maternity and pediatric nursing (4th ed.)*. Wolters Kluwer.

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>• Listed in order by priority – highest priority to lowest priority pertinent to this client.</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Interventions (2 per dx)</b></p>	<p><b>Outcomes</b></p>	<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the Client/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p>Ineffective airway related to neuromuscular defect as evidenced by stridor.</p>	<p>This nursing diagnosis was chosen because of the severity of patient’s stridor</p>	<ol style="list-style-type: none"> <li>1. Oxygen at 3L high flow continuously</li> <li>2.Suctioning to remove secretions as needed</li> </ol>	<p>The client will be able to maintain an O2 stat above 90%.</p>	<p>The client was able to leave the oxygen on and not remove it. The client’s oxygen level stayed above 95%.</p>
<p>Ineffective airway clearance is related to the inability to maintain a clear airway as evidenced by drops in oxygen levels while sleeping.</p>	<p>This nursing diagnosis was chosen because of the client’s secondary diagnosis of sleep apnea.</p>	<ol style="list-style-type: none"> <li>1. Budesonide 0.25mg BID</li> <li>2.Positive airway pressure</li> </ol>	<p>To reduce the irritation of the airway and allow for it to remain clear.</p>	<p>The client is taking Budesonide as prescribed. Client oxygen level occasionally drops while sleeping</p>
<p>Ineffective breathing patterns related to neuromuscular defect as evidenced by accessory muscle use.</p>	<p>This nursing diagnosis was chosen because of the use of accessory muscle upon my assessment of the client</p>	<ol style="list-style-type: none"> <li>1. Place the client in a supine position</li> <li>2. Small frequent meals</li> </ol>	<p>Placing the client in a supine position will allow the client’s lungs to expand fully. Small frequent meals will prevent crowding of the diaphragm</p>	<p>Client is able to tolerate the small frequent feedings. Client is stilling using accessory muscles while breathing.</p>
<p>At risk for imbalance nutrition related to accessory muscle use evidenced by a patient’s weight</p>	<p>I chose this diagnosis due to the patient having a low birth weight.</p>	<ol style="list-style-type: none"> <li>1. G-tube feeding q3hrs</li> <li>2. 30 degrees supine during feeding</li> </ol>	<p>The client will gain an appropriate amount of weight and not aspirate on feedings.</p>	<p>The patient is able to tolerate his feedings without difficulty. The patient also is able to maintain a position of at least 30 degrees during his feedings.</p>

**Other References (APA):**

Phelps, L.L. (2020). *Sparks and Taylor's nursing diagnosis reference manual (11th ed.)*.

Wolters Kluwer.

**Concept Map (20 Points):**

**Subjective Data**

The mother stated the child made a funny noise while breathing since he was born. She said on 5/24/22 the noise got worse, and he seemed to be breathing harder. She also states that his feeding has decreased. Mother hasn't sought any previous treatment for the difficulty of breathing. Doesn't notice if anything really makes it worse or better. So mother decided to bring him into the ED to get checked out.

**Nursing Diagnosis/Outcomes**

Ineffective airway related to neuromuscular defect as evidenced by stridor.  
 The client will be able to maintain an O2 stat above 90%.  
 Ineffective airway clearance is related to the inability to maintain a clear airway as evidenced by drops in oxygen levels while sleeping.  
 To reduce the irritation of the airway and allow for it to remain clear.  
 Ineffective breathing patterns related to neuromuscular defect as evidenced by accessory muscle use.  
 Placing the client in a supine position will allow the client's lungs to expand fully.  
 Small frequent meals will prevent crowding of the diaphragm.  
 At risk for imbalance nutrition related to accessory muscle use evidenced by a patient's weight.  
 The client will gain an appropriate amount of weight and not aspirate on feedings.

**Objective Data**

Vital signs: P-176, B/P-92/45, R-45, T-98.0, O2- 96% 3L of high flow O2. Client has a G-tube placed in LUQ. The dressing is clean dry and intact. The patient has use of abdominal and sternal muscles while breathing and has the present of stridor. The clients intake was 90mL and output was 66mL.

**Client Information**

J.W (Male) admitted on 2/24/2022 for acute respiratory failure He is a full code that is 1 month and 10 days. Weight is 3.3kg with a BMI of 12.9. Client has no know allergies.

- Nursing Interventions**
1. Oxygen at 3L high flow continuously
  - 2.Suctioning to remove secretions as needed
  3. Budesonide 0.25mg BID
  - 4.Positive airway pressure
  5. Place the client in a supine position
  6. Small frequent meals
  7. G-tube feeding q3hrs
  8. 30 degrees supine during feeding