N433 Care Plan #

Lakeview College of Nursing

Name

Demographics (3 points)

Date of Admission 6/10/22	Client Initials KM	Age (in years & months) 20 weeks old	Gender Male
Code Status **Full Code**	**Weight (in kg)** **5.68 kg**	**BMI** **15.78 kg/m^2**	**Allergies/Sensitivities (include reactions)** **No known allergies**

Medical History (5 Points)

Past Medical History:

Illnesses: No known previous illnesses.

Hospitalizations: 18-day stay in the NICU due to premature birth at 34-weeks gestation.

Past Surgical History: Right inguinal hernia repair (4/15/22)

Immunizations: Hepatitis B (2 doses), rotavirus (2 doses), DTaP (2 doses), Hib (2 doses), PCV13 (2 doses), and IPV (2 doses).

Birth History:

Complications (if any): Infant was born at 34-weeks gestation (6 weeks premature) via cesarean. The birth was unremarkable otherwise.

Assistive Devices: None

Living Situation: Lives at home with two parents and two siblings.

Admission Assessment

Chief Complaint (2 points): Dyspnea and increased effort to breath

Other Co-Existing Conditions (if any): N/A

Pertinent Events during this admission/hospitalization (1 points): No known pertinent events

History of present Illness (OLD CARTS) (10 points):. A 20-week-old infant born via cesarean at 34 weeks gestation with his twin brother was brought to the Emergency Room by twins'

parents. The parents reported to the ED that KD had been doing well at home until after his 4-month vaccination. The infant had a fever for two days prior and developed nasal congestion and a cough. Additionally, there had been two episodes of post-tussive vomiting. On the day the infant was brought to the ED, he had increased work breathing with severe subcostal retractions. The infant was put on high flow nasal cannula oxygen (HFNCO2) with 8 L/min at 40% concentration, then increased to 12 L/min at 60% concentration, and currently on 3 L/min at 25% concentration. The patient was given racemic epinephrine twice, budesonide once, and dexamethasone at 0.6 mg/K/dose orally while in the ED. The patient tested positive for rhino enterovirus and parainfluenza A, but negative for COVID-19. He was in the PICU and then was moved to the general pediatric unit two days ago. No treatments or aggravating factors were reported.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute respiratory failure

Secondary Diagnosis (if applicable): None

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

Acute respiratory failure (ARF) in pediatric patients is a very common admission diagnosis due to the smaller airways. The secretions, edema, and bronchoconstriction further decrease the airways' diameter in children that have a respiratory disease. Respiratory infections cause infants to have those signs listed previously which can lead to ARF. Constricted airways lead to oxygenation and ventilation impairment which leads to respiratory failure (Friedman & Nitu, 2018). This infant tested positive for rhino enterovirus and parainfluenza Athat caused secretions which constricted the airways caused ARF in the infant.

The decreased oxygenation and ventilation will give rise to tachypnea, hypoxemia, retractions, grunting, head bobbing, nasal flaring, and belly breathing in infants. When auscultating the lungs, wheezes, crackles, and stridor may be heard. This infant had severe subcostal contractions on admission and some subcostal contractions noted today. When auscultating the lungs, crackles were heard in the bottom lobes bilaterally.

ARF can be diagnosed by cultures of respiratory secretions, blood gas analysis, chest radiography, and a thorough history of the signs and symptoms. The culture of secretions helps diagnose the source of the respiratory failure (Friedman & Nitu, 2018). This infant had a respiratory secretion culture that tested positive for rhino enterovirus and parainfluenza virus that are the root cause of his respiratory failure. The infant also needed to be put on HFNXO2 to maintain adequate perfusion.

The focus for ARF is to administer supportive respiratory care. This can include endotracheal intubation, mechanical ventilation, HFNCO2, continuous positive airway pressure, and bi-level positive airway pressure (Friedman & Nitu, 2018). Research has found that non-invasive oxygen delivery systems decrease the hospital stay compared to invasive oxygen delivery systems (Kyle et al., 2022). Children can also be given nitric oxide to help dilate the pulmonary arterioles. Bronchodilators and anti-inflammatory drugs are common to help decrease the effort needed to breath as well (Friedman & Nitu, 2018). This infant is on HFNCO2 at 3 L/min at 25% concentration and on albuterol sulfate nebulizer (bronchodilator) (Friedman & Nitu, 2018).

Complications that can evolve from ARF include pulmonary embolism (PE), pulmonary fibrosis, pneumonia, and other complications that can follow invasive mechanical devices (Kyle et al., 2022). Pulmonary embolisms manifest as shortness of breath, chest pain, and a productive

cough with bloody sputum. Nurses should prevent venous stasis, turn and reposition frequently, and manage oxygen therapy of the patient to prevent a PE (Friedman & Nitu, 2018).

Pneumonia can manifest as chest pain with breathing and coughing, fatigue, fever, night sweats, nausea, vomiting, and shortness of breath. Nursing interventions to prevent pneumonia includes education on avoiding smoke/smoking, obtaining a pneumonia vaccine, ambulation, and using an incentive spirometer (Lanks et al., 2019).

Pathophysiology References (2) (APA):

Friedman, M. L., & Nitu, M. E. (2018). Acute respiratory failure in children. *Pediatric Annals*, *47*(7). https://doi.org/10.3928/19382359-20180625-01

Lanks, C. W., Musani, A. I., & Hsia, D. W. (2019). Community-acquired Pneumonia and Hospital-acquired Pneumonia. *Medical Clinics of North America*, *103*(3), 487–501. https://doi.org/10.1016/j.mcna.2018.12.008

Kyle, J. M., Sturza, J. M., Dechert, R. E., Custer, J. R., Dahmer, M. K., Saba, T. G., & Flori, H. R. (2022). Clinical outcomes of acute respiratory failure associated with noninvasive and invasive ventilation in a pediatric ICU. *Respiratory Care*, *67*(7). https://doi.org/10.4187/respcare.09348

Active Orders (2 points)

Order(s)	Comments/Results/Completion
Activity: Ad lib	Parents and providers are allowed to take the patient out of the crib
Diet/Nutrition: Alimentum formula	Via nasogastric tube at 135 ml every 3 hours
Frequent Assessments: IV and lungs	Ensure patency and no filtration or phlebitis. Auscultate lung fields to monitor patient's condition.
Labs/Diagnostic Tests: N/A	N/A
Treatments: Albuterol nebulizer and simethicone	Albuterol is every 4 hours PRN Simethicone is every 6 hours PRN
Other: Speech therapy and pediatric pulmonary consultation.	Evaluate feeding and evaluate lungs.
New Order(s) for Clinical Day	

Order(s)	Comments/Results/Completion
Contact and droplet precautions	Positive rhino enterovirus and parainfluenza A tests
Nothing by mouth/No feeding	Bowel rest

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Values on the day of clinical were not posted.

Lab	Normal Range (specific to the age of the child)	Admission or Prior Value	Today's Value	Reason for Abnormal Value
RBC	3.34 – 4.80 x 10^6/mcL	4.39	*N/A	N/A
Hgb	9.6 – 12.4 g/dL	10.5	*N/A	N/A
Hct	28.6 – 37.2%	33.8%	*N/A	N/A
Platelets	244 – 529 x 10^3/mcL	478	*N/A	N/A
WBC	6.51 – 13.32 x 10^3/mcL	13.12	*N/A	N/A
Neutrophils	0.97 – 5.45 x 10^3/mcL	6.66	*N/A	The neutrophils were elevated due to the acute infection diagnosed by the nasal secretion culture. This is also caused by inflammation in the lung tissue from the acute respiratory infection (Van Leeuwen & Bladh, 2019).
Lymphocytes	2.45 – 8.89 x 10^3/mcL	4.71	*N/A	N/A
Monocytes	0.28 – 1.07 x 10^3/mcL	1.32	*N/A	Monocytes are elevated due to the acute respiratory infection diagnosed by a nasal secretion culture. It's also related to acute inflammation in the lungs (Van Leeuwen & Bladh, 2019).
Eosinophils	0.03 – 0.61 x 10^3/mcL	0.36	*N/A	N/A
Basophils	0.01 – 0.06 x 10^3/mcL	0.02	*N/A	N/A
Bands	0.2 – 2.4%	N/A	*N/A	N/A

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

Lab	Normal Range	Admission or Prior Value	Today's Value	Reason For Abnormal
Na-	136 – 145 mmol/L	140	*N/A	N/A

K+	3.5 – 5.1 mmol/ L	4.7	*N/A	N/A
Cl-	98 – 107 mmol/ L	106	*N/A	N/A
Glucose	74 – 100 mg/dL	88	*N/A	N/A
BUN	5 – 17 mg/dL	11	*N/A	N/A
Creatinine	0.55 – 1.30 mg/dL	0.40	*N/A	Creatinine is decreased due to inadequate protein intake related to the infant's vomiting episodes and decreased nutritional intake (Van Leeuwen & Bladh, 2019).
Albumin	3.8 – 5.4 g/dL	4.3	*N/A	N/A
Total Protein	4.4 – 7.6 g/dL	8.0	*N/A	Elevated total protein can be related to the inflammation from the acute respiratory infection and dehydration from inadequate oral intake (Van Leeuwen & Bladh, 2019).
Calcium	9.0 – 11.0 mg/dL	11.2	*N/A	The slightly elevated calcium levels can be related to dehydration from vomiting increasing the concentration. It can also be related to respiratory infection causing macrophage in the epithelium that interfere with vitamin D regulation which increases circulating calcium levels (Van Leeuwen & Bladh, 2019).
Bilirubin	0.2 – 1.2 mg/dL	0.6	*N/A	N/A
Alk Phos	9 – 500 units/L	656	*N/A	Alkaline phosphatase levels are elevated due to the acute respiratory infection that causes liver-involved inflammation process (Van Leeuwen & Bladh, 2019).
AST	5 – 34 units/L	372	*N/A	AST levels are elevated due to the acute respiratory infection that causes liver-involved inflammation process (Van Leeuwen & Bladh, 2019).
ALT	0 – 55 units/L	483	*N/A	ALT levels are elevated due to the acute respiratory infection that causes liver-involved inflammation process (Van Leeuwen & Bladh, 2019).
Amylase	6 – 40 units/L	N/A	*N/A	N/A
Lipase	0 – 60 units/L	N/A	*N/A	N/A

Other Tests 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
ESR	3 – 13 mm/hr	N/A	N/A	N/A
CRP	6 – 20 mg/L	N/A	N/A	N/A
Hgb A1c	4.0% – 5.5%	N/A	N/A	N/A
TSH	0.7 – 6.4 micro units/mL	N/A	N/A	N/A

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
Color & Clarity	Yellow, amber, clear, translucent	N/A	N/A	N/A
pH	5.0 – 9.0	N/A	N/A	N/A
Specific Gravity	1.001 – 1.029	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	< 20 mg/dL	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	< 5/hpf	N/A	N/A	N/A
RBC	< 5/hpf	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	N/A

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
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A

Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A
Respiratory ID Panel	Negative	Positive	N/A	Patient tested positive for parainfluenza A and rhino enterovirus.
COVID-19 Screen	Negative	Negative	N/A	

Lab Correlations Reference (1) (APA):

Normal Values per Epic.

Van Leeuwen, A. M., & Bladh, M. L. (2019). Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication (8th ed.). F. A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): No other diagnostic tests ordered or completed.

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA): N/A

Current Medications (8 points)
****Complete *ALL* of your Client's medications****

Brand/Generic	Albuterol Sulfate / AccuNeb	Simethicone / Mylanta
Dose	2.5 mg	20 mg
Frequency	Q4H PRN	Q6H PRN
Route	Inhaled nebulizer	Nasogastric tube
Classification	Beta2 adrenergic / bronchodilator (Jones & Bartlett, 2021)	Antacid / gastrointestinal agent
Mechanism of Action	The albuterol attaches to beta2 receptors on the bronchial tissue cells to decrease intracellular calcium levels. This relaxes the bronchial smooth muscles and inhibits histamine release Jones & Bartlett, 2021).	The alkaline mixture of aluminum hydroxide and magnesium hydroxide neutralizes the stomach acid to decrease gas bubbles to reduce GI discomfort (Jones & Bartlett, 2021)
Reason Client Taking	To dilate the patient's airways to improve ventilation, increase oxygen saturation, and decrease work to breathe.	The client has been very frequently passing gas and has had a distended stomach.

Concentration Available	2.5 mg / 0.5 mL	20 mg / 0.3 mL
Safe Dose Range Calculation	2.5 mg/dose – 10 mg/dose (Frandsen & Pennington, 2020)	40 mg/day – 240 mg/day (Frandsen & Pennington, 2020)
Maximum 24-hour Dose	15 mg for this patient	240 mg
Contraindications (2)	1. Hypersensitivity to albuterol 2. Hyperthyroidism (Jones & Bartlett, 2021)	1. Any signs of appendicitis 2. Renal failure (Frandsen & Pennington, 2020)
Side Effects/Adverse Reactions (2)	1. Tremors 2. Hypotension Jones & Bartlett, 2021)	1. Constipation 2. Hypermagnesemia (Frandsen & Pennington, 2020)
Nursing Considerations (2)	1. Check for history of cardiac disorders 2. Check for history of seizures Jones & Bartlett, 2021)	1. Assess for any medication interactions with this antacid 2. Assess for decreased epigastric pain (Frandsen & Pennington, 2020)
Client Teaching needs (2)	1. Report any symptoms of allergic reaction immediately 2. Inform patient to check with prescriber before using other inhaled medications Jones & Bartlett, 2021)	1. Elevate the head of the bed to minimize acid reflux 2. Take medication as directed (Frandsen & Pennington, 2020)

Medication Reference (1) (APA):

Frandsen, C. & Pennington, S. S. (2020). *Abrams' clinical drug therapy: Rationales for nursing practice* (12th ed.). Wolters Kluwer.

Jones & Bartlett Learning. (2020). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) Highlight Abnormal Pertinent Assessment Findings

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient responds to pain, sound, and spontaneously opens his eyes (A&O x3). The patient is asleep and well groomed. He appears to be a healthy weight and size for his age.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:** **IV Assessment (If applicable to child):** **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **IV Fluid Rate or Saline Lock:**	The patient's skin color is normal for ethnicity. Skin is warm, dry, and intact with elastic turgor. No bruises, rashes, ulcers, or wounds. There are no drains present. He has a Braden score of 12 indicating no risk for pressure ulcer and no drains present. The iv IS 24 gauge in the back of the left hand. It was placed on 6/22/22 and was noted to be patient with no erythema or drainage. The IV dressing is clean, dry, and intact with normal saline going at 22 mL/hr.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:** **Thyroid:**	Patient's head is normocephalic with the trachea midline. Ears are symmetrical with no visible drainage or cerumen. Patient's pupils are 3 mm when exhibiting PERRLA. Eyes display full extraocular movements and are symmetrical with no drainage or inflammation. Conjunctiva is pink and moist. Nose is midline with no deviated septum and patent nares with some translucent mucus. Patient's tongue and buccal mucosa is moist, pink, and has no lesions. There was some excess saliva production when coughing. The posterior fontanel is firm like the rest of the skull. The anterior fontanel is soft and flat.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:**	S1 and S2 heart sounds were audible with no S3/ S4 or murmurs sounds. Cardiac rhythm is regular and steady. Brachial and pedal pulses bilaterally exhibit +3 strength and are regular. Capillary refill is <3 seconds on fingers and toes bilaterally.

Capillary refill: **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	No jugular vein distention or edema observed.
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Crackles auscultated in the lower anterior lobes bilaterally. The upper and middle anterior and posterior lobes have clear breath sounds bilaterally. Some subcostal retracts noted bilaterally. Breathing appeared somewhat labored but symmetrical.
GASTROINTESTINAL: **Diet at home:** **Current diet:** **Height (in cm):** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	The patient is formula-fed with Alimentum formula. The patient was being fed with the same formula via NG tube at a rate of 135 mL every 3 hours. The NG tube was taken out during the night before due to the infant vomiting. He is now NPO for bowel rest. The patient is 60.0 cm long. Clicks and gurgles were auscultated in all four quadrants. The abdomen is soft and non-tender with a protuberant belly. No major distention, incisions, scare, drains, wounds, ostomies, NG, or feeding tubes noted. The last bowel movement was 6/22/22.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient's urine was light yellow with no odor. The patient had two incontinent voids of 60 mL and 49 mL The patient did not appear to have pain with urination and does not have a catheter and is not on dialysis. The genitals appeared to be within defined limits.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒**	Neurovascular status is intact and the patient senses touch in all four extremities. The patient has full range of motion with general moto response that is purposeful. The patient cannot walk and has a Cumming's Fall score of 4 indicating a low fall risk. The patient is needs help with ADLs and is up ad lib indicating

Fall Score: **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	providers and parents are allowed to pick the infant out of the crib.
NEUROLOGICAL: **MAEW: Y** ☒ **N** ☐ **PERLA: Y** ☒ **N** ☐ **Strength Equal: Y** ☒ **N** ☐ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient has 5/5 strength in the upper and lower extremities bilaterally and can sense touch over each extremity. The eyes exhibited MAEW and PERLA. The infant is oriented to self and responds to pain and sound. (A&O x3).
PSYCHOSOCIAL/CULTURAL: **Coping method(s) of caregiver(s):** **Social needs (transportation, food, medication assistance, home equipment/care):** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient's parents were not at the hospital during this clinical but planned to come that afternoon. The patient lives with his two parents and two siblings. There may be a financial need for hospital stay and any medications prescribed after discharge. No other needs are known.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0818	131 bpm	124/72 right calf	61 resp/min	36.5 C axillary	93% NC 3L 25%
1125	140 bpm	125/57 right calf	56 resp/min	36.7 C axillary	94% NC 3L 25%

Vital Sign Trends: The vitals stayed constant during this clinical shift. Respiratory rate and blood pressure is elevated.

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

Pulse Rate	90 – 120 bpm
Blood Pressure	72 – 104 / 37 – 56
Respiratory Rate	30 – 53 resp/min
Temperature	36.5 – 37.5
Oxygen Saturation	92% – 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)

Time	Scale	Location	Severity	Characteristics	Interventions
0818	rFLACC	N/A	N/A	N/A	N/A
Evaluation of pain status *after* intervention	N/A	N/A	N/A	N/A	N/A
Precipitating factors: **Physiological/behavioral signs:**					

Intake and Output (1 points)

Intake (in mL)	Output (in mL)
110 mL via IV	60 mL incontinent void 49 mL incontinent void

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. Can raise the head to 45 degrees in the prone position.
2. Has a slight head lag in the pull-to-sit motion.
3. Can lift the head and look around.

Age-Appropriate Diversional Activities

1. Apply anesthetic cream on the venipuncture site beforehand.
2. Oral stimulation via a bottle or pacifier

3. Playing different sounds and/or songs

Psychosocial Development:

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

What behaviors would you expect? The infant will cry when he needs something

What did you observe? The infant cried when he was uncomfortable, or his pacifier fell out of his mouth

Cognitive Development:

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

What behaviors would you expect? The infant will use his senses and motor skills to discover the world. He will have a sucking reflex and recognize familiar objects and sounds.

What did you observe? The patient would automatically suck on the pacifier when it was introduced to the mouth.

Vocalization/Vocabulary:

Development expected for child's age and any concerns? Cooing and crying at this age. No concerns.

Any concerns regarding growth and development? No concerns regarding growth and development.

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

Nursing Diagnosis	Rational	Interventions (2 per dx)	Outcomes	Evaluation
1. Impaired gas exchange	The patient is not	**1.**Supplemental	**1.** Keep an oxygen	The patient's oxygen

	related to acute respiratory infection as evidenced by ventilation-perfusion imbalance.	able to keep an oxygen saturation above 92% without supplemental oxygen.	oxygen **2.**Continuous oxygen monitoring	saturation level above 92%	saturation stayed above 92% during this shift. Goal was met.
2.	Ineffective airways clearance related to excess airways secretion as evidenced by crackles in the lungs.	The patient has crackles in the bases of the lungs and does not cough up anything.	**1.** Assess respiratory status at least every 4 hours. **2.** Suction as ordered to stimulate cough and clear airways.	**1.** The patient will have reduction to no crackles in the lungs.	At the end of the shift, crackles were diminished the base of the lungs.
3.	Imbalanced nutrition related to insufficient dietary absorption as evidenced by vomiting episode the night before.	The infant's NG tube had to be removed due to him vomiting and the physician putting him as NPO for bowel rest.	**1.** Monitor fluid intake and output. **2.** Monitor electrolyte levels and report abnormal values.	**1.** The patient will tolerate oral feedings.	These interventions were not implemented during this shift. Goal not met.
4.	Risk for inefficient coping related to long-term hospital stay as evidenced by the patient being hard to console.	The patient is hard to console and upsets easily.	**1.** Assign a consistent care provider to the patient. **2.** Identify and reduce unnecessary stimuli in the environment.	**1.** The patient will be easier to console and will upset less frequently.	These interventions were not implemented during this shift. Goal not met.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient had increased work breathing, fever, and two post-tussive vomiting episodes.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to acute respiratory infection as evidenced by ventilation-perfusion imbalance.

Keep an oxygen saturation level above 92%

Ineffective airways clearance related to excess airways secretion as evidenced by crackles in the lungs.

The patient will have reduction to no crackles in the lungs.

Imbalanced nutrition related to insufficient dietary absorption as evidenced by vomiting episode the night before.

The patient will tolerate oral feedings.

Risk for inefficient coping related to long-term hospital stay as evidenced by the patient being hard to console.

The patient will be easier to console and will upset less frequently.

Objective Data

Positive for rhino enterovirus
Positive for parainfluenza A
Elevated neutrophil and monocyte count
Elevated calcium and liver labs

Client Information

20 week old male infant born prematurely is admitted for increased labor of breathing and acute respiratory failure.

Nursing Interventions

Impaired gas exchange

Supplemental oxygen

Continuous oxygen monitoring

Ineffective airways clearance

Assess respiratory status at least every 4 hours

Suction as ordered to stimulate cough and clear airways.

Imbalance nutrition

Monitor fluid intake and output.

Monitor electrolyte levels and report abnormal values.

Risk for ineffective coping

Assign a consistent care provider to the patient.

2. Identify and reduce unnecessary stimuli in the environment.