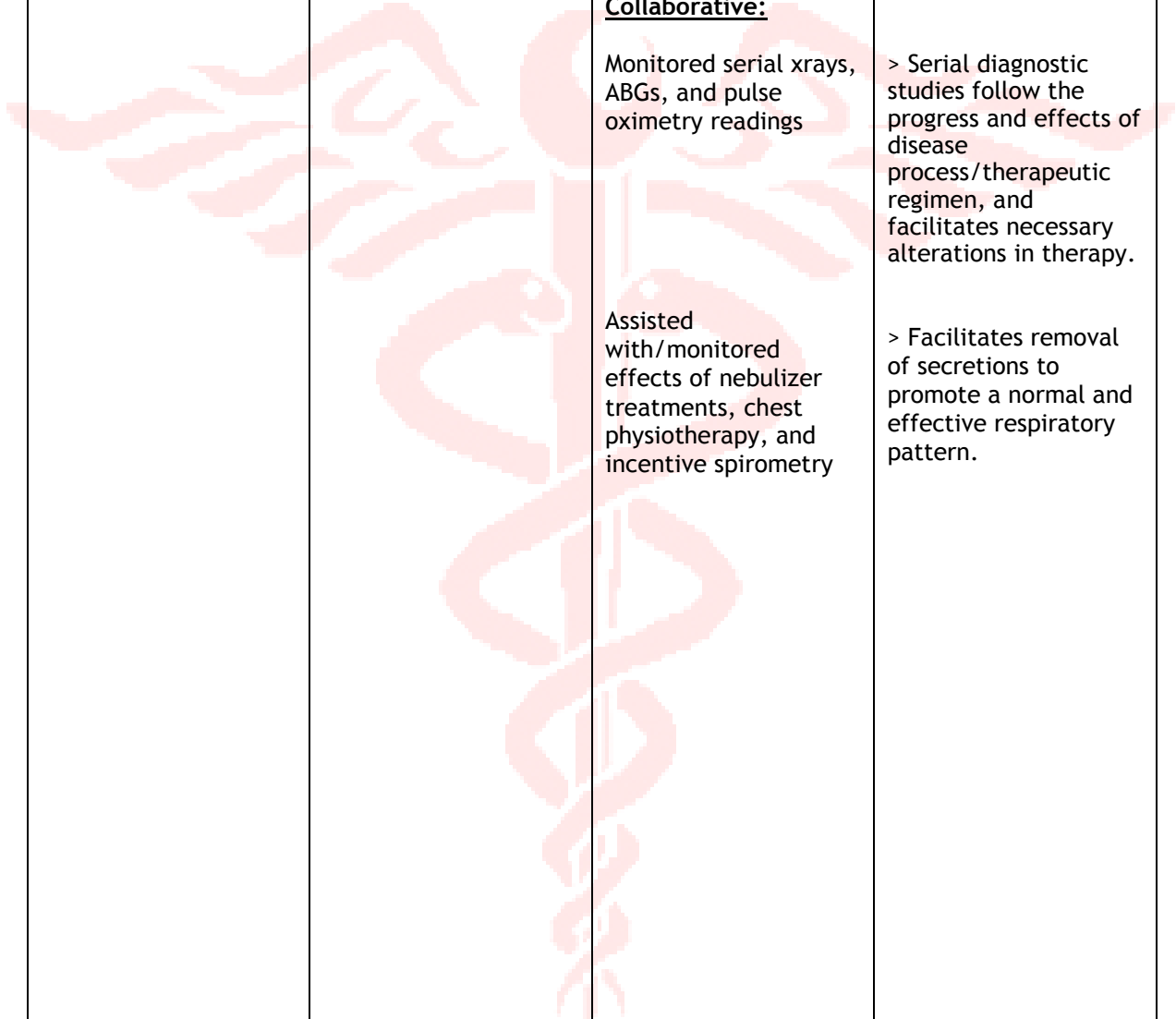


NURSING CARE PLAN

ASSESSMENT	NURSING DIAGNOSIS	PLANNING	NURSING INTERVENTION	RATIONALE	EVALUATION / OUTCOME
<p>Subjective Cues:</p> <p>> Child states, “Mom, my chest feels heavy when I breathe.”</p> <p>Objective Cues:</p> <p>> T= 39.2 °C, P= 150, RR= 46</p> <p>> nasal flaring with shallow breathing</p> <p>> use of accessory muscles</p> <p>> crackles auscultated in @ upper lobe</p> <p>> productive cough with thick purulent sputum</p> <p>> diaphoresis & pallor</p> <p>> increased WBC count</p> <p>> CXR= patchy diffusion in @ upper and middle lobes</p>	<p>Ineffective breathing pattern related to inflammatory effects of pneumonia</p> <p>(A state in which an individual’s inhalation and/or exhalation pattern does not enable adequate pulmonary inflation or emptying.)</p>	<p>Within 8 hours, patient will exhibit normal and effective respiratory pattern as evidenced by:</p> <p>> respirations within acceptable range</p> <p>> absence of signs and symptoms of cyanosis</p> <p>> normal ABG and O2 saturation levels</p>	<p>Independent:</p> <p>Established rapport</p> <p>Obtained resting vital signs</p> <p>Placed patient in a semi-Fowler’s to high-Fowler’s position</p> <p>Repositioned patient q 2h</p> <p>Assessed patient’s vital signs and observed for signs and symptoms of cyanosis q2h</p> <p>Encouraged increase in oral fluid intake; offered warm liquids</p>	<p>> Rapport is important to gain patient’s cooperation and reduce anxiety.</p> <p>> Baseline data is important to help determine patient’s current health status and evaluate efficacy of nursing interventions rendered.</p> <p>> An upright position promotes lung expansion and mobilization of secretions.</p> <p>> Frequent repositioning prevents pooling and stasis for secretions.</p> <p>> Frequent assessment provides information about any improvement or deterioration in patient’s condition.</p> <p>> Warm liquids aid in mobilization of secretions.</p>	<p>Goal met. Patient exhibits a normal and effective respiratory pattern as evidenced by:</p> <p>> respirations within N range</p> <p>> absence of signs and symptoms of cyanosis</p> <p>> normal ABG and O2 saturation levels</p>

		<p>Maintained a quiet, comfortable environment</p> <p><u>Dependent:</u></p> <p>Administered medications as ordered: antibiotics, mucolytics, expectorants, and bronchodilators</p> <p>Administered supplemental oxygen via face mask as ordered</p> <p>Used play to encourage child to cough and deep breathe; involved parents in said activities</p> <p>Provided parents and patient with health teachings on :</p> <ol style="list-style-type: none"> care of used tissues proper handwashing techniques covering of mouth and nose when coughing or blowing nose 	<p>> Promotes rest and sleep and prevents anxiety thereby decreasing the patient's oxygen demands</p> <p>> Bronchodilators aid in reduction of bronchospasm. Mucolytics and expectorants mobilize secretions. Antibiotic therapy is prescribed for pneumonia (except lipid and viral pneumonia).</p> <p>> Supplemental oxygen aids in ventilation and minimizes the risk for hypoxemia.</p> <p>> Play enhances participation. Coughing and deep breathing promotes maximum ventilation. Involving parents promotes active participation.</p> <p>> The patient and parents should be taught the basics of infection control to prevent transmission of microorganisms.</p>
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