# Knowledge deficit related to shortness of breath

Skip to content Topic: Health Promotion and Maintenance I. ACUTE OTITIS MEDIA Focus Topic: Health Promotion and Maintenance A. Introduction: Acute bacterial ear infection (acute otitis media) is common in young children, mainly because their Eustachian tube is shorter and straighter than that of adults; This allows a ready-made drainage of infected mucus from URIs directly into the middle ear. In some cases, acute otitis media precedes the onset of bacterial meningitis, an extremely serious and potentially fatal disease. Bacterial meningitis is a medical emergency that requires early detection and rapid, aggressive therapy to prevent permanent neurological damage or death. Serous otitis (chronic) can lead to hearing impairment or loss, but is not likely to lead to meningitis. B. Assessment: Focus topic: Health promotion and nursing fever. Pain in the affected ear. An infant who is pre-linguistic cannot complain of pain, but can pull on his ear, cry, shake his head, refuse to lie down. malaise, irritability, anorexia (possibly vomiting). May have symptoms and signs of URI: Rhinorrhea, Coryza, cough. Decreased response to sound. C. Analysis/Care Diagnostics: Focus topic: Health promotion and care Focus: Health promotion and maintenance pain in connection with deminittus/eitrigem material on eardrum. Risk of injury/infection associated with the complication of meningitis. D. Care plan/implementation: Focus topic: Health promotion and care 1. Aim: to eradicate infection and prevent further complications (meningitis). Administer antibiotics as ordered. 2. Goal: to relieve pain and promote comfort. Administer the demarcation funds as ordered. Offer analgesics/antipyretics to provide symptomatic relief and reduce fever. 3. Objective: health education. Teach parents that the child must stop all medication, even though the child appears clinically better within 24 to 48 hours. Check appropriate measures to combat fever: antipyretics, cool sponges. E. Evaluation/result criteria: Priority topic: Health promotion and maintenance infection is eradicated, no complications. Child seems to feel comfortable. II. PEDIATRIC RESPIRATORY INFECTIONS Focus topic: Health promotion and maintenance A. Evaluation: general assessment of infants/children with shortness of breath. Note: More information on specific respiratory infections can be found. Restlessness – earliest sign of hypoxia. Difficulty sucking/eating – Parents can indicate that the child or child has a bad appetite. Expiratory grunt, nasal flicker, retreat. Changes Vital signs: fever, tachycardia, tachypnosia. Cough: productive/unproductive. Wheeze: expiratory/inspiratory. Hoisiness or aphonic crying. Dyspnoea or prostration. Dehydration – associated with an increase in insensitive fluid loss and poor PO uptake. Color change (pallor, cyanosis) – later sign of shortness of breath. B. Analysis/Care Analysis/Care Focus topic: Health promotion and maintenance Ineffective airway clearance related to infection or obstruction. Fluid volume deficit related to excessive losses due to normal routes, discomfort and inability to swallow. Anxiety associated with hypoxia. Risk of injury associated with the spread of the infection. Knowledge deficit related to disease process, infection control, home care and aftercare. C. Care plan/implementation: Focus topic: Health promotion and care 1. Aim: To relieve shortness of breath by reducing swelling and edema and liquefying secretions. Environment: age- and disease-appropriate oxygen supply system. Oxygen as ordered. Position: Semi-Fowler or in the child seat to promote maximum expansion of the lungs; small blanket or diaper roll under the neck to hold airway patent; Change position at least q2h to prevent pooling of secretions. Suction/holding drainage and percussion prn. Tape nappies loose and use only loose fitting clothing to avoid pressure on the abdominal organs, which could penetrate the diaphragm and hinder breathing. Administering medications: antibiotics, bronchodilators, steroids. Monitor temperature q4h/prn; Fever with acetaminophen, cool sponges, reduce hypothermia ceiling. 2. Goal: Observe possible respiratory failure associated with exhaustion or complete respiratory blockage. Space in the room near nurse's ward for maximum observation. Monitor vital signs: q1h during the acute phase, then q4h. Emergency equipment near bedside table prn: endotracheal tube, tracheostomy set. Observe closely for signs of impending respiratory failure: increased rapid, shallow breathing, progressive hoisiness/aphonia, deepening of cyanosis. Report negative changes in the state STAT to the doctor. 3. Goal: Maintain the normal fluid balance. Can be NPO first to prevent aspiration. IVs until severe distress subsides and child is able to suck and swallow. Monitor hydration status: I&O, urine specific gravity, weight. When resuming PO liquids – start by swallowing clear liquids, slowly moving forward as tolerated: pedialyte, clear broth, gelatin, popsicles, fruit juices, ginger ale. Avoid milk/dairy products that can lead to increased mucus production. 4. Goal: Ensure a quiet, safe environment. In acute need: stay with child/family (do not leave unattended). Keep crying to a minimum to prevent severe hypoxia and reduce the body's need for oxygen. If possible, avoid painful/intrusive procedures. Organize care to avoid planned rest periods Allow parents to sit in and encourage their participation in the care of their child to keep the child relatively calm and reduce anxiety. Allow the child to keep favorite toys or safety objects. 5. Goal: To teach parents if necessary. Short-term: Discuss equipment, treatments, procedures; frequent progress reports, answers to parental questions. Long Long how to deal with repetitions, how to check the temperature at home, medication for fever, when to call the doctor for breathing problems. D. Evaluation/result criteria: Priority topic: Health promotion and maintenance No further evidence of shortness of breath. resumption of the normal breathing pattern. Normal fluid balance maintained/restored. Parents verbalize their concerns and express confidence in their ability to look after their child after discharge. III. LONG-TERM RESPIRATORY DYSFUNCTION: ASTHMA Focus Topic: Health Promotion and Maintenance A. Introduction: Asthma is generally considered to be a chronic, lower respiratory disease characterized by increased respiratory reactivity with bronchospasm and obstruction. The exact cause of asthma is unknown; however, it is believed to contain an allergic reaction to one or more allergens or triggers that either trigger or aggravate asthmatic exacerbation. The child usually shows other symptoms of allergy, such as infantile eczema or hay fever; In addition, 75% of children with asthma have a positive family history for asthma. The onset is usually before the age of 5 and the disorder remains with the

child throughout life, although some children experience dramatic improvement in their asthma with the onset of puberty. Most children do not require continuous medication. Early relief of symptoms with a combination of medications can reverse bronchospasm. B. Assessment: Focus topic: Health promotion and conservation-expiratory wheeze. General signs and symptoms of breathing difficulties, including: anxiety, cough, shortness of breath, crackling, cyanosis due to obstruction in the airways, use of accessories of respiratory muscles. Cough: hacking, paroxysmal, unproductive; especially at night. Comfort when breathing: sit straight up, lean forward, this is the position for optimal lung expansion. The maximum exspiration flow rate (PEFR) is in the yellow zone (50%-80% of the personal best time) or in the red zone (<50% of the personal best time). C. Analysis/Care Diagnostics: Focus topic: Health promotion and maintenance Ineffective airway clearance in connection with bronchospasm. Anxiety related to breathlessness. Knowledge deficit, actual or potential risk, related to disease process, treatment and prevention of future asthmatic seizures. Activity intolerance associated with dyspnea and bronchospasm. D. Care plan/implementation: Priority topic: Health promotion and care treatment aims at improving ventilation, correcting dehydration and acidosis and managing concomitant infections. 1. Goal: provide patent respiratory and effective Initiate oxygen therapy (through tent, face mask or cannula), as ordered to relieve hypoxia, with high humidity (to liquefy secretions). Administer bronchodilators as ordered to relieve obstruction: adrenaline (1:1000), misted albuterol, albuterol, Inhalers can be used with dosed inhalers (MGIs) to ensure proper delivery of the drug. Administer corticosteroids as ordered (PO or IV) to reduce inflammation, relieve edema (prednisone, decadron) and reduce bronchial hyperreactivity. Administer antibiotics as ordered; Infection is usually either a trigger or a complication of asthma. Note: Methylxanthines (theophylline, aminophyllin) are third-line agents rarely used to treat asthma. 2. Goal: Alleviating anxiety alleviation of hypoxia (see Objective 1), which is the main source of anxiety. Stay with child, provide support. Manage sedation as ordered. Encourage parents to stay with children. 3. Goal: Teach the principles of prophylaxis. Check home-style medications, including Cromolyn sodium. Check breathing exercises. Discuss precipitation factors (triggers) and suggest how to avoid them. Learn how to use the peak flow meter to monitor the respiratory state and determine the treatment needs. Introducing the need for the child to take control of their own care. E. Evaluation/result criteria: Priority topic: Health promotion and maintenance Adequate oxygen supply, as evidenced by the pink colour of nail beds and mucous membranes and facilitate the airways. Fear is alleviated. Child verbalizes confidence in and shows the mastery of the skills required to take care of his own asthma. IV. CYSTIC FIBROSIS Focus Topic: Health Promotion and Maintenance A. Introduction: Cystic fibrosis is a generalized dysfunction of the exocrindglands that produces multisystem involvement. The fault is inherited as an autosomal recessive defect. The mutated gene responsible for CF is located on the long arm of chromosome 7 (CFTR). The basic problem is thick, sticky, stubborn mucus secretions, which obstruct the channels of the exocrines glands and thus impair their functioning. Cystic fibrosis is found in all races and socioeconomic groups, although there is a significantly lower incidence among Asians and African-Americans. It is a chronic disease with no known cure and guarded prognosis; The median age of death in the United States is 31. Those born in the late 1990s can be expected to survive into their 40s with new therapies. B. Assessment: Focus topic: Health promotion and maintenance of newborns: meconium ileus. Common recurrent lung infections: bronchitis, bronchopneumonia, pneumonia and ultimately chronic obstructive pulmonary disease (COPD) due to mechanical blockage of the respiratory tract thick, stubborn mucous secretions. Malabsorption syndrome: non-weight gain, withered abdomen, thin arms and legs, lack of subcutaneous fat due to impaired nutrient absorption resulting from the inability of pancreatic enzymes to reach intestinal tract. Steatorrhea: bulky, foul-smelling, foamy, fatty stools in increased amounts and frequency rectal prolapse). Parents may find that child tastes salty when kissed, due to excessive loss of sodium and chloride in sweat. The welding test shows high sodium and chloride values in children's sweat, unique for children with cystic fibrosis. 7. Sexual development: boys/men: sterile (due to aspermia). Girls/women: difficulties in conception and childbirth (due to the increased viscosity of the cervix mucus, which acts as a plug in the cervix os and mechanically blocks the entry of sperm). C. Analysis/Care Diagnosis: Focus topic: Health promotion and maintenance Ineffective breathing patterns associated with thick, viscide secretions. Changed diet, less than body-appropriate, related to diarrhea and poor intestinal absorption of nutrients. Decreased cardiac performance associated with COPD and decreased lung compliance. Activity intolerance associated with respiratory problems. Self-esteem disorder associated with body image changes. Knowledge deficit related to disease process, treatments, medications, genetics. Risk of non-compliance with complicated and longer treatment regimens. D. Care plan/implementation: Focus topic: Health promotion and care 1. Goal: Help the child to expect sputum. Perform posture drainage and percussion as prescribed: first thing in the morning, between meals, before bedtime, not after meals to prevent aspiration. Administer nebulizer treatments, mucolytics, bronchodilators. Avoid or limit the use of medications that suppress cough mechanism. Provide exercises that promote position ality changes and keep the sputum moving. Promote a high fluid supply to keep secretions liquefied. Suction, administer oxygen prn. 2. Goal: Prevent infection. Standard precautions for infection. Assess carefully, continuously check for possible infections (especially respiratory tract); immediately report to the doctor. Limit contact with employees or visitors (especially children) with infections. Administer antibiotics as ordered to treat respiratory infections and prevent overwhelming sepsis. Can be placed on prophylactic antibiotic therapy between episodes of infection. Teach the importance of preventing infections at home: adequate nutrition, frequent medical examinations, stay away from known sources of infection. 3. Goal: To maintain adequate nutrition. Nutrition: well balanced, high in calories and high in protein to prevent malnutrition. Fat content in the diet is controversial and needs to be individualised. Administer pancreatic enzyme Ultrase) immediately before each meal and snack to improve the absorption of vital nutrients, especially fats. If child is unable to swallow capsules, take the capsule apart and sprinkle the food at the beginning of the meal or mix with chilled apple sauce. Administer water-mixable preparations of fat-soluble vitamins (A, D, E, K), multivitamins and iron. Promote the additional salt intake in order to sodium loss in sweat (unless there is congestive heart failure [CHF]); especially important in hot weather, after physical exertion, feverish periods. Promote the additional fluid supply (e.g. Gatorade) to prevent dehydration/electrolyte imbalance - thickening of mucus secretions. g. Daily I&O and weights to monitor nutritional and hydration status. Encourage the child to gradually take responsibility for choosing their own food as part of dietary restrictions. 4. Goal: to teach the child and family about cystic fibrosis. Discuss diagnostic procedures: welding tests, stool samples. Check several medications: use, effects, side effects/toxic effects. Stress must take care of the lung system (the main cause of mortality/morbidity). Teach different treatments: posture drainage, nebulizer, oxygen therapy, breathing exercise. Encourage the child to take as much responsibility as possible for their own care: medication, treatments, nutrition. Promoting the development of a healthy attitude towards disease/prognosis (no known cure). A heart-lung transplant can be considered as an option. Contact the relevant Community authorities for home care support. Support you with genetic advice. Discuss sexual concerns with adolescents. 5. Objective: to promote compliance with the treatment regimen. Encourage the child to verbalize anger or frustration that they have different/body image changes. Suggestions of alternativebreast physiotherapy (CPT) (e.g. yoga/standing on the head). Offer rewards for compliance: swimming with friends or other types of peer activities. E. Evaluation/result criteria: Priority topic: Health promotion and maintenance Child can clear his own airways, expectant sputum. The child is kept in an infection-free state. An adequate diet is maintained. Child and family verbalize understanding of the disease. Child meets the rigour of treatment. V. APNEA-RELATED DISORDERS Focus topic: Health promotion and maintenance [sociallocker] A. Apnea of infancy Focus Topic: Health promotion and maintenance 1. Introduction: Childhood apnea is the inexplicable cessation of breathing for 20 seconds or more in a seemingly healthy, full-time infant who is more than 37 weeks of pregnancy. It is usually diagnosed by the second month of life and is usually thought to resolve during the first 12 to 15 months of life. The exact cause is unknown. The link between apnea in infancy and sudden infant death syndrome (SIDS) is still controversial. It will that infants with significant apnea without known cause have an increased risk of SIDS and need to be treated appropriately. Diagnosis of the infant's apnea (AOI) is made if no identifiable cause of the seemingly life-threatening event (ALTE) is found. 2. Rating: Unexplained breath adjustment (apnea) for 20 seconds or more. Bradycardia. Color change: Cyanosis or Pallor. Limp, hypotonic. Diagnostic tests Diagnostic tests cardiopneumogram, pneumocardiogram and polysomnography. 3. Analysis/care diagnosis: Ineffective breathing patterns associated with apnea. Anxiety, anxiety associated with apnea and the risk of infant death. Knowledge deficit regarding the home care of infants on an apnea monitor and cardiopulmonary resuscitation (CPR) in infants. 4. Care plan/intervention: a. Goal: Maintain effective breathing pattern. Apnea monitor on infant at any time, even at home. Place in the room near nurse's ward for maximum observation with a nurse or parent present at any time. Suction, oxygen and resuscitation devices are readily available when required. Watch for apnea or bradycardia; Duration and associated symptoms – color change, change in muscle tone. If apnea occurs, use gentle stimulation to start breathing again. If ineffective, start CPR. If suction is required, do so carefully for the shortest time and the least number of times that are possible to maintain the patented airways. Note: Repeated, vigorous suction is associated with prolonged apnea periods. Medications: Respiratory stimulant drugs (such as theophylline or caffeine) can be given until 2 to 3 months have passed without an episode of apnea. Positions: lying on the side or supine; never vulnerable to prevent SIDS. Feeding: smaller and more frequent; overfeeding, which can lead to reflux and apnea. B. Goal: Teach parents how to care for their child at home. Explain the relief plans to parents in detail; stimulate questions and discussions. Start teaching with the use of apnea monitor and infant CPR techniques several days before discharge; parents to handle the monitor and become thoroughly familiar with its use. Enter parents emergency response numbers and community health nurse referral. Stress requirement for at least 1 year of ongoing care with constant use of the monitor or 2 to 3 months without an episode that requires intervention. Discuss the need for support and contact the local self-help/support group. Encourage parents to take time for themselves when a reliable caregiver is available who is trained in the use of monitor and infant CPR. 5. Evaluation/result criteria: Effective breathing pattern is defined. Parents verbalize their concerns and express confidence in their ability to look after their child at home. B. Sudden Infant Death Syndrome (SIDS) Focus Topic: Health Promotion and Maintenance 1. Introduction: SIDS is the sudden, unexpected death of a seemingly healthy less than 1 year, which remains unexplained after a full postmortem examination. Various theories have been proposed, none proven; Research is under way. It has been suggested that vulnerable sleeping position, cigarette smoke and excessive wrapping may be associated with SIDS. It is the third leading cause of death between one month and one year, affecting almost 2,500 babies a year. 2. Rating: Sudden, unexplained death in other Infant; occurs exclusively during sleep. Note the overall picture of the infant (different from child abuse). Get history from parents - see how parents deal with grief. 3. Analysis/care diagnosis: Dysfunctional grief associated with infant loss. knowledge deficit related to SIDS. 4. Care plan/implementation: a. Immediate objective: to support parents who are grieving. Emphasize that nothing could have been done to prevent death. Allow parents to express feelings of mourning; privacy. Offer parents the opportunity to see keep infant. Explain the purpose of the autopsy (doctor to get consent). Contact of spiritual advisors: priest, rabbi, pastor. Help parents plan what to tell your siblings. B. Ongoing objective: to provide factual information on SIDS. Offer information that is known about SIDS in simple, direct terms. Answer questions honestly. Enter parent printed literature on SIDS. See local/national SIDS Foundation Group. C. Long-term goal: To help families solve grief. (1) Track the progress of other siblings. (2) See local perinatal mourning group. (3) Consider later pregnancy as endangered for: attachment/binding. SIDS repeat. 5. Assessment/result criteria: Parents can express their grief and receive appropriate support. Parents ask questions about SIDS and can understand answers. The grief of the family has been resolved; Over time, normal family dynamics resume. [/sociallocker] READ MORE READING/STUDY: Resources: Resources: