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Childhood asthma Comfort & daily function

Child Health Nursing | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

9-year-old girl with caregiver present. Care stage: During supported recovery and essential daily activity.

Medical history: Asthma was diagnosed previously. The caregiver reports recent missed controller treatment and cough/wheeze during play and at night. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: A caregiver is available for teaching and assisted care. The family requests plain-language instructions, a practical feeding/activity plan and follow-up. Assess development, immunization record and safeguarding individually.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Wheeze during play and nighttime cough after missing controller treatment.

Objective findings and required checks: Expiratory wheeze and reduced activity; severity and device technique need assessment.

Physical examination and investigations: Assess speech, work of breathing, oxygenation and peak flow when age and ability permit.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Childhood asthma: Inflammation and bronchoconstriction narrow airways and cause variable airflow obstruction.

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Medical / surgical management

Follow the child's asthma action plan, give prescribed inhaled therapy and reassess response.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed reliever inhaler	Relieve acute bronchoconstriction	Check technique, spacer use and response
prescribed controller	Reduce airway inflammation	Review adherence, technique and adverse effects.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Wheeze during play and nighttime cough after missing controller treatment. Expiratory wheeze and reduced activity; severity and device technique need assessment. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize breathing difficulty affecting oxygenation; emotional distress affecting participation in care; difficulty sustaining the agreed treatment plan; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Follow the child's asthma action plan, give prescribed inhaled therapy and reassess response. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about breathlessness, chest tightness and activity tolerance. Assess: Record respiratory rate, effort, SpO2 and mental state against the prescribed target.	Breathing difficulty affecting oxygenation. Possible factors: altered ventilation or gas exchange. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Breathing effort improves and oxygenation remains within the individualized target. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the respiratory action plan and demonstrates the prescribed device technique.	1. Reassess work of breathing and response to each intervention. Rationale: Trend changes identify deterioration earlier than a single reading. 2. Position to ease breathing, cluster care and allow rest. Rationale: This can reduce respiratory demand and distress. 3. Give oxygen and respiratory medicines only according to the clinical prescription or emergency protocol. Rationale: Individualized treatment supports oxygenation without unsafe blanket targets. 4. Follow the child's asthma action plan, give prescribed inhaled therapy and reassess response. Rationale: Inflammation and bronchoconstriction narrow airways and cause variable airflow obstruction. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Have child and caregiver demonstrate inhaler/spacer use and explain school and home action plans. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Have child and caregiver demonstrate inhaler/spacer use and explain school and home action plans.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Difficulty speaking, exhaustion, cyanosis, silent chest or reduced consciousness is an emergency.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Inflammation and bronchoconstriction narrow airways and cause variable airflow obstruction.

- Priority concerns: Breathing difficulty affecting oxygenation; Emotional distress affecting participation in care; Difficulty sustaining the agreed treatment plan; Learning needs about the condition and care plan.

- Difficulty speaking, exhaustion, cyanosis, silent chest or reduced consciousness is an emergency.

- Have child and caregiver demonstrate inhaler/spacer use and explain school and home action plans.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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