Ward: ________________	Date: ____________
Ward: ________________	Date: ____________

Addressograph

Respiratory Nursing Care Plan			
Problem: Difficulty in breathing due to_____________________________	**S/N Sig:**__________ **NMBI PIN** ____________	**Date:**________________ **Planned By:**___________ **Grade:**________________	**Problem no:** **66**
Goal: a: To alleviate symptoms and return the child to his/her usual breathing pattern (Document usual pattern on admission)			

Nursing care:	**Self / family care**	**Date/signature/grade/NMBI PIN for any changes made to care**
1. Nurse _______________ in a high visibility area with oxygen and suction nearby. Nurse in an upright position supported by pillows. 2. Perform hand hygiene as per 5 moments of Hand Hygiene before and after all care interactions with ________ and his/her parent/guardian. 3. Confirm positive patient identification prior to performing any nursing care intervention by asking ___________ to state his/her full name and date of birth. If __________ cannot reliably confirm his/her name, ask the parent/guardian to state their child's full name and date of birth. Confirm that the response received is identical to that on the child's Identification band. 4. Observe infection control precautions. Nurse in isolation if required in a well ventilated room as appropriate. 5. Record temperature, pulse and respirations (rate, depth, effort), SaO_2on admission and thereafter as condition dictates. Document on age-appropriate PEWS chart. If temperature elevated use pharmacological and non pharmacological measures to reduce same 6. Ensure __________ receives chest physiotherapy if requested 7. Observe for signs of respiratory distress e.g. use of accessory muscles of respiration, wheeze, nasal flaring, tracheal tug, head bobbing, cyanosis, pallor, grunting or stridor. Contact doctor for urgent review should any of these signs occur. 8. Observe for associated neurological deterioration due to decreased oxygenation: e.g. behavioural change, agitation, irritability, restlessness and unresponsiveness		

9. Ensure that the correct size oxygen saturation probe is applied (e.g. neonate, infant, child) and ensure that the probe site is changed if required 4 – 6 hourly / PRN to prevent pressure to the area. 10. Administer oxygen as prescribed via humidifier to maintain oxygen saturation above 92% or as per parameters indicated by medical team ________________ Ensure parameters / limits are checked on the oxygen saturation monitor on each shift. Titrate and wean oxygen according to saturation levels. 11. Administer nebulised medication as prescribed refer to CHI Nursing Practice Guideline on Nebuliser therapy 2023. 12. Administer High Flow Oxygen therapy if condition dictates as prescribed by medical team. Refer to Humidified High Flow Nasal Cannula (HHFNC) Oxygen Therapy Guidelines		

Respiratory Nursing Care Plan continued		
Nursing care:	**Self / family care**	**Date/signature/grade/NMBI for any changes made to care**
13. If Non invasive ventilation is required ensure prescription is in Nursing notes . Refer to NIV care plan 14. Ensure minimal handling to promote rest/comfort 15. Administer medications as prescribed: 16. Observe response and side effects of all medications and document same. 17. Ensure child's inhaler technique is correct where used and provide training to child and family as necessary. 18. Liaise with Respiratory CNS / RANP where appropriate. 19. Assist with investigations. Send sputum for culture and sensitivity where requested. Obtain cough swab and Nasopharyngeal Aspirate (NPA) if ordered. **NPA / Cough swab** taken ____________ **(Date)** **Results _______________** 20. Assess and record type, amount colour and consistency of sputum	Child / parent / carer will assist with administration of medications where appropriate.	

Respiratory Nursing Care Plan continued		
Nursing care:	**Self / family care**	**Date/signature/grade/NMBI for any changes made to care**
21. Assess hydration and feeding status. Enteral feeding may be considered where the infant / child is unable to tolerate adequate volume due to increased respiratory effort. Where this is the case administer on a continuous basis rather than in large bolus feeds. Maintain strict intake and output. 22. Ensure nebuliser sets are changed as required. 23. Ensure that appropriate nebuliser set is used to administer drugs (e.g. PARI LC nebuliser set to administer tobramycin, ventstream nebuliser set to administer colomycin etc.). Refer to Order of Nebulised Treatment for Children with Cystic Fibrosis. 24. Change Oxygen tubing and masks / nasal prongs on alternate days or more frequently if soiled, disposing of equipment appropriately. 25. Provide parents with discharge advice (i.e. exercise, medication administration, avoidance of passive smoking). Furnish with appropriate literature where available. Refer to oxygen supplies order forms regarding home oxygen and nebulisers. 26. For patients with asthma ensure an Asthma Action Plan is provided prior to discharge and Asthma Discharge Checklist is completed and filed. (RF-NUR-143)		