I. NCP

Patient: R.C.S.B. Age: 1 yr, 1 mo. Sex: female Hospital No: 060000086199

CUES	NURSING DIAGNOSIS	BACKGROUND KNOWLEDGE	PLANNING	NURSING INTERVENTIONS	RATIONALE	EVALUATION
S> "Nahihirapan yata syang huminga saka lagi na lang sumusuka ng plema," as verbalized by the Pt's grandmother. O> (+) sputum production Rapid, shallow breathing (+) crackles, gargles	Ineffective Airway Clearance related to inability to maintain clear airway as characterized by (+) sputum, (+) crackles, rapid & shallow breathing	Bacterial microorganism enter the airways ↓ Inflammation of the lung/s ↓ Air sacs filled with pus & other liquids ↓ Presence of obstructions in the airways ↓ Inability to breathe properly	After 8 hours of Nursing Intervention, the Pt's breathing will have no more adventitious sounds present (crackles/gargles) when auscultated	> Monitor respiratory patterns, including rate, depth, and effort. > Assist with clearing secretions from pharynx by offering tissues and gentle suction of the oral pharynx if necessary > Provide postural drainage, percussion, and vibration as ordered > Administer medications such as bronchodilators or inhaled steroids as ordered.	> With secretions in the airway, the respiratory rate will increase > It is preferable for the client to cough up secretions. Gentle suctioning of the posterior pharynx may stimulate coughing and help remove secretions > Chest physical therapy helps mobilize bronchial secretions > Bronchodilators decrease airway resistance secondary to bronchoconstriction	After 8 ours of Nursing Intervention, the Pt's breathing had no more adventitious sounds (crackles/gargles) present when auscultated

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S> "May lagnat po yata ang anak ko," as verbalized by the Pt's mother. O> febrile moist skin tachypnea, RR= 33 cpm (+) crackles Age: 1 yr.1 mo.	Altered body temperature related to bacterial invasion in the lungs as manifested by body temperature higher than normal, tachypnea, (+) crackles	Bacterial microorganisms (e.g. pulmonary pathogens) enter the airway ↓ These bacteria/viruses infects the lung/s ↓ Inflammation of the lung/s ↓ Signs and symptoms of Pneumonia (e.g.temperature may be greater than 37.5°C), tachypnea, coughs with greenish secretions	After 2 hours of Nursing Intervention, the Pt's temperature will decrease from 39.8 °C to normal range (36.6 - 37.5 °C) After 2 hours of Nursing Intervention, the Pt's skin will cool off	> Monitor Pt's temperature q1 hr > Encourage Pt to rest > Encourage Pt to increase fluid intake > Encourage the Pt's guardian to do tepid sponge bath > Administer antipyretic medications as prescribed	> To determine if the Pt's temperature is above the normal body temperature > Allows the patient to recuperate physical strength > To maintain hydration status and increased fluid intake helps lessen febrility > Sponge bath with warm water evaporates off his skin, thus, cooling off the Pt > Promotes return of body temperature to normal	After 2 hrs of Nursing intervention, the Pt's temperature had decreased from 39.8 °C to 37.4 °C After 2 hrs of Nursing Intervention, the Pt's skin has cooled off a bit

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S> "Ayaw nyang kumain, yung gatas sinusuka lang naman nya," and "Mas payat sya ngayon, dati ang lakas naman kumain" as verbalized by the Pt's grandmother. O> vomits ingested milk Food aversion Decreased wt weakness	Imbalanced Nutrition due to frequent vomiting and not eating the usual foods taken as manifested by decreased weight, food aversion, and weakness.	Bacteria or virus attacks the lung/s ↓ weakened immune systems ↓ Pneumonia ↓ Symptoms of Pneumonia: nausea or vomiting, may experience profound weakness w/c lasts for a long time.	After 4 hours of Nursing Intervention, the Pt will start taking foods which he usually eat (rice, crackers, chicken breast,etc) After 4 hours of Nursing Intervention, the Pt will not vomit anymore the ingested milk	> Assess for recent changes in physiological status that may interfere with nutrition > Provide companionship at mealtime to encourage nutritional intake > Determine healthy body weight for age and height > Assess client's ability to obtain and use essential nutrients.	> The consequences of malnutrition can lead to a further decline in the patient's condition that then becomes self-perpetuating if not recognized and treated. > Often toddlers will eat more food if other people are present at mealtimes. > Protein-calorie malnutrition most often accompanies a disease process > Cases of vitamin D deficiency have been reported among dark-skinned toddlers who were exclusively breast fed and were not given supplemental vitamin D.	After 4 hours of Nursing Intervention, the Pt started taking foods which he usually eat (crackers) After 4 hours of Nursing Intervention, the Pt didn't vomit anymore the ingested milk