**Asthma** (Please delete or add any nursing diagnosis, interventions or outcomes that you feel are appropriate for your student).

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| **Nursing Diagnosis***Include those that apply based on the nursing assessment* | **Nursing Interventions***Include those that are achievable in your school district* | **Client Outcomes***Include those that are tangible goals for the student in question* |
| **1) Ineffective breathing pattern**Risk factor🡪 anxiety | * Monitor respiratory rate, depth, and ease of respiration
* Note pattern of respiration
* Note amount of anxiety associated with dyspnea
* Attempt to determine if student’s dyspnea is physiological or psychological in cause
 | Student will report ability to breathe comfortably; to perform purse-lip breathing and controlled breathing. |
| **2) Impaired gas exchange** | * Monitor vital signs
* Administer medications as directed
* Monitor respiratory rate, depth, and ease of respiration
* Note pattern of respiration
* Note amount of anxiety associated with dyspnea
 | Student will demonstrate improved ventilation and adequate oxygenation as evidenced by blood gas levels within normal parameters; maintain clear lung fields and remain free of signs of respiratory distress; verbalize understanding of oxygen supplementation and other therapeutic interventions.  |
| **3) Ineffective airway clearance**Risk factors🡪 tracheobronchial narrowing, excessive secretions | * Auscultate breath sounds
* Monitor respiratory patterns, including rate, depth, and effort
* Monitor pulse oxygen saturation levels if pulse oximeter is available
* Position the student to optimize respiration
* Help the student breathe deep and perform controlled coughing
* Have the client inhale deeply, hold breath for several seconds, and cough two or three times with mouth open while tightening the upper abdominal muscles
* Administer medications such as bronchodilators or inhaled steroids as needed
* Observe sputum, noting color, odor and volume
* Educate parents about the risk factors for ineffective airway clearance such as passive smoke exposure
* Educate students and parents on the proper use of nebulizer and spacer usage
* Educate students and parents on the importance of adherence to peak expiratory flow monitoring for asthma self-management
 | Student will demonstrate effective coughing and clear breath sounds; maintain a patent airway at all times; explain methods useful to enhance secretion removal; explain the significance of changes in sputum to include color, character, amount, and odor; identify and avoid specific factors that inhibit effective airway clearance. |
| **4) Anxiety**Risk factors🡪 inability to breathe effectively, fear of suffocation | * Assess the student’s level of anxiety and physical reactions to anxiety
* Identify and be aware of the use of any stimulants such as caffeine, theophylline, terbutaline, sulfate, and other prescription medications the student is taking
* Intervene when possible to remove source of anxiety by having student do slow, deep breathing
* Explain all activities, procedures, and issues that involved the student, use nonmedical terms and calm, slow speech. Do this in advance of procedures if possible
* Use therapeutic touch and healing touch techniques
* Guided imagery can be used to decrease anxiety
* Provide students with a means to listen to music of their choice or audiotapes to help them calm themselves
 | Student will identify and verbalize symptoms of anxiety; identify, verbalize, and demonstrate techniques to control anxiety; verbalize absence of or decrease in subjective stress; have vital signs that reflect baseline or decreased sympathetic stimulation; have posture, facial expressions, gestures, and activity levels that reflect decreased distress; demonstrate improved concentration and accuracy of thoughts; identify and verbalize anxiety precipitants, conflicts, and threats; demonstrate return of basic problem-solving skills; demonstrate increased external focus; demonstrate some ability to reassure self. |
| **5) Activity intolerance**Definition: fatigue; energy shift to meet muscle needs for breathing to overcome airway obstruction | * Determine the cause of activity intolerance and determine whether cause if physical, psychosocial, or motivational
* When getting a student up, observe for symptoms of intolerance such as nausea, pallor, dizziness, visual dimming, and impaired consciousness, as well as changes in vital signs
* Monitor and record the student’s ability to tolerate activity: note pulse rate, blood pressure, monitor pattern, dyspnea, use of accessory muscles, and skin color before, during or after the activity
* Instruct the student to stop the activity and report the following symptoms to the school nurse: new or worsened intensity or increased frequency of discomfort; tightness or pressure in chest, back, neck, jaw, shoulders, and/or arms; palpitations; dizziness; weakness; unusual and extreme fatigue; excessive air hunger
* Observe and document skin integrity, if applicable
* Provide emotional support and encouragement to student to gradually increase activity
 | Student will demonstrate ability to state symptoms of adverse effects of exercise and report onset of symptoms immediately; maintain normal skin color and temperature with rigor of the activity; verbalize an understanding of the need to gradually increase activity based on testing, intolerance, and symptoms; demonstrate increased tolerance to activity. |
| **6) Ineffective coping**Definition: personal vulnerability to situational crisis | * Observe for contributing factors of ineffective coping
* Use verbal and nonverbal therapeutic communication approaches including empathy, active listening, and confrontation to encourage the student and family to express emotions such as sadness, guilt and anger; verbalize fears and concerns; and set goals
* Collaborate with the student to identify strengths such as the ability to relate the facts and to recognize the source of stressors
* Encourage the student to describe previous stressors and coping mechanisms used
* Be supportive of coping behaviors; allow the student time to relax
* Provide opportunities for the student to discuss the meaning the situation might have for the student
* Assist the student to set realistic goals and identify personal skills and knowledge
* Provide information regarding care before care is given
* Discuss changes with the student before making them
* Discuss the student’s and family’s power to change a situation or need to accept a situation
* Offer instruction regarding alternative coping strategies
* Encourage use of social support resources
* Refer for additional of more intensive therapies as needed
* Monitor the student’s risk of harming self or others and intervene appropriately
* Support adolescent and children’s individual coping styles
* Encourage moderate aerobic exercises
 | Student will use effective coping strategies; use behaviors to decrease stress; report decrease in physical symptoms of stress; report increase in psychological comfort; seek help from a health care professional as appropriate. |
| **7) Sleep deprivation** Risk factors🡪 ineffective breathing pattern, cough | * Obtain a sleep history including bedtime routines, sleep patterns, use of medications and stimulants, use of complementary/alternative medicine practices, responsibilities that limit sleep time, and daytime sequelae suggestive of sleep deprivation
* From this history assess the factors leading to sleep deprivation
* Assess for underlying physiological illness causing sleep loss
* Assess for chronic insomnia
* Encourage the student to create a quiet sleep environment when at home
* Monitor caffeine intake
 | Student will wake up less frequently during the night; awaken refreshed and be less fatigued during the day; fall asleep without difficulty; verbalize plan that provides adequate time for sleep; identify actions that can be taken to improve quality of sleep. |
| **8) Ineffective self-health management** | * Establish a collaborative partnership with the student/family for purposes of meeting health-related goals
* Listen the student’s/family’s story about his or her illness self-management
* Explore the meaning of the person’s illness experience and identify uncertainties and needs through open-ended questions
* Help the student identify the “self” in self-management; show respect for the student’s self-determination
* Help the student’s enhance self-efficacy or confidence in his or her own ability to manage the illness
* Involve family members in knowledge development, planning for self-management, and shared decision making
* Use various formats to provide information about the disease or self-management to the student and parent’s
* Help the student to identify and modify barriers to effective self-management
* Help the student maintain consistency in therapeutic regimen management for optimal results
* Review how to contact health providers as needed to address issues and concerns regarding self-management
 | Student will demonstrate the ability to describe activity/exercise patterns that meet therapeutic goals; describe scheduling of medications that meets therapeutic goals; verbalize ability to manage therapeutic regimens.  |
| **9) Readiness for enhanced self-health management** | * Acknowledge the expertise that the client and family bring to self-management
* Review factors that contribute to the likelihood of health promotion and health protection
* Further develop and reinforce contributing factors that might change with ongoing management of the therapeutic regimen
* Support all efforts to self-manage therapeutic regimens
* Review the clients strength in management of the therapeutic regimen
* Collaborate with the client to identify the strategies to maintain strengths and develop additional strengths as indicated
* Identify contributing factors that may need to be improved now or in the future
* Provide knowledge as needed related to pathophysiology of the disease or illness, prescribed activities, prescribed medications, and nutrition
* Support positive health promotion and health protection behaviors
* Help the client maintain existing support and seek additional supports as needed
 | Student will understand integration of therapeutic regimen into daily living; Demonstrate continued commitment to integration of therapeutic regimen into daily living routines. |
| **10) Disturbed body image**  | * Incorporate psychosocial questions related to body image as part of nursing assessment to identify students at risk for body image disturbance
* If student is at risk for body image disturbance, consider using a tool such as the Body Image Quality of Life Inventory, or Body Area Satisfaction Scale which quantify both the positive and negative effects of body image on one’s psychosocial quality of life
* Assess for possibility of muscle dysmorphia and make appropriate referrals
* If nursing assessment reveals body image concerns related to a disfiguring condition, assist student in voicing his/her concerns if appropriate, coaching the client how to respond to questions from other social situations
* Acknowledge denial, anger, or depression as normal feelings when adjusting to change in body and lifestyle. Allow students/family to share emotions as ready
* Encourage the student to discuss interpersonal and social conflicts that may arise
* Explore opportunities to assist the student to develop a realistic perception of his or her body image
* Encourage student to verbalize treatment preferences and play a role in treatment decisions
* Encourage student to participate in regular aerobic exercise when feasible
* Provide the student/family with a list of appropriate community resources
 | Student will demonstrate adaptation to changes in physical appearance or body function as evidenced by adjustment to lifestyle change; identify and change irrational beliefs and expectations regarding body size or function; demonstrate social involvement rather than avoidance and utilize adaptive coping and/or social skills; utilize cognitive strategies or other coping skills to improve perception of body image and enhance functioning. |