Respiratory Syncytial Virus (RSV)

The nurse is caring for Micah Jones, a 10-month-old male client with excessive nasal secretions.

Review the medical record, then answer the following questions:

1. Which assessment findings do you notice that require immediate follow-up? What does this clinical data mean?

Concerning PRESENT PROBLEM Findings	**Meaning/Interpretation**
Concerning VITAL SIGN Findings	**Meaning/Interpretation**
Concerning NURSE ASSESSMENT Findings	**Meaning/Interpretation**
Concerning DIAGNOSTIC Findings	**Meaning/Interpretation**

2. After interpreting the meaning of clinical data, what problems are possible? Which problem is the priority? State the pathophysiology of the primary problem in your *own* words.

Possible Problems	Priority Problem	Pathophysiology of Priority Problem

3. After identifying the priority problem, the nurse would anticipate which orders. For each order, state the rationale and expected outcome.

Anticipated Orders	Rationale	Expected Outcome

4. After identifying the current problem, what is the nursing priority? List three priority nursing interventions. For each intervention, state the rationale and expected outcome.

Nursing Priority		
Priority Intervention(s)	**Rationale**	**Expected Outcome**

The nurse has implemented all medical orders, including an albuterol nebulizer and the nursing plan of care.
Thirty minutes later, the following assessment data is collected:

5. For each finding, make a clinical judgment by placing an "x" in the appropriate column if the patient's condition has improved, has not changed, or has declined.

Assessment Finding		Improved	No Change	Declined
T: 100.1 F/37.8 C (rectal)				
P: 120 **(**regular)				
R: 46 (regular)				
BP: 100/62				
O2 sat: 96%				
Faces:	1 Occasional grimace or frown, withdrawn, disinterested			
Legs:	0 Normal position or relaxed			
Activity:	0 Lying quietly, normal position, moves easily			
Cry:	1 Moans or whimpers; occasional complaint			
Consolability:	1 Reassured by occasional touching, hugging, or being t			
Mild intercostal retractions, but no nasal flaring noted.				
Coarse breath sounds but expiratory wheezes are not as prominent				
Lying in mom's arms. Tearful but comforts quickly with mother's touch.				

6. Is the *overall* status of the client:

Current Status	Rationale
a. Improved b. No change c. Declined	

7. After evaluating the client, identify the current nursing priority and which action(s) the nurse should take. List interventions by priority and the expected outcome.

Nursing Priority		
Priority Interventions	**Rationale**	**Expected Outcome**

Nurse Reflection

8. To strengthen your clinical judgment skills, reflect on your knowledge and the decisions made caring for this patient by answering the reflection questions below.

Reflection Question	Nurse Reflection
What did you learn?	
What content/concepts do you need to understand to make better judgments?	
How will you apply what was learned to improve patient care?	