DOWNLOAD PDF PEDIATRIC NURSING DEMYSTIFIED A SELF-TEACHING GUIDE

Chapter 1 : Erica Glover - Oklahoma City, OK (5 books)

Preface: From pre- to post-birth, here's everything you need to know about the nursing care of mother, child, and family. Maternity Nursing Demystified delivers a detailed, easy-to-follow overview of the essential concepts involved in providing nursing care to the mother and child before, during, and after pregnancy.

Key Impact on Nursing Care Latency stage Sexual interest and social and intellectual skills developed Encourage sibling and peer contact; assess for sex-related disease and pregnancy in older child and adolescents Genital stage Sexual awakening interest in person outside family Industry vs. Sexually active teens may have impaired self-image. Privacy and confidentiality are important to teens for trust building. Gay, lesbian, or bisexual youth may experience barriers in developing self-identity. Mental health problems including depression, suicide, and eating disorders can lead to adolescent death and disability. Poor eating practices and decreased exercise contribute to obesity or malnutrition. Facial and body acne, aggravated by stress and hormones, is common in teens. Monitor for signs and plan interventions to address depression and suicidal ideation. Relate health-enhancing behaviors, such as nutritious eating, regular exercise, and driving safety with use of seat belts, to improved physical appearance and performance in school, athletics, or other activities of interest. Assist teen in planning care for chronic illness to minimize disruption of activities with peers. Provide opportunities for communication with adolescent in absence of parents to allow asking of personal questions. Daily hygiene and treatment with acne medication can reduce outbreak. Ellis, age 13, is admitted after experiencing diarrhea for the past 4 days. He is sullen and speaks only when his mother pushes him to answer questions. What should the nurse keep in mind when assessing Ellis? Ellis likely has a communication deficit due to loss of electrolytes. Ellis would be more responsive to the nurse if his mother were absent. Ellis is an adolescent and may also be quiet and sullen when he is well. A middle school nurse is teaching a class on sexual development to a group of year-old girls. Which physical changes should be expected when the girls reach Tanner stage 3 of development? Select all that apply. Breast buds palpable c. Pubic hair becomes dark, coarse, and spreads over mons pubis d. Adult breast contour e. Acne vulgaris develops 3. Changes in personality and emotions 4. An 8-year-old client is admitted to the emergency department with a broken arm. Which information provided by the nurse is accurate regarding the development of an average 8-year-old client? Requires continuous adult supervision b. Is interested in the opposite sex c. Has little control over small muscles d. Is accident prone, especially on the playground 5. A nurse is assessing the development of a 2-year-old client in a wellness clinic. Which assessment finding is least typical for an average 2-year-old client? Constantly in motion and tires easily b. Plays with other children d. May have an imaginary playmate 30 Pediatric Nursing Demystified 7. Jerry, age 15, is admitted through the emergency department after a car accident with minimal injury. The parents report that for the past months Jerry seems to have difficulty remembering and his grades have dropped. Which question might provide the most related information? Is Jerry a skilled driver based on his driving history? What classes are Jerry currently enrolled in? Does Jerry have a history of drug usage or mental illness? Is Jerry rebellious and less communicative than he was 6 years ago? Adam, age 3, is admitted with anemia and is placed on bedrest. After several days of hospitalization and treatment his parents report that he has wet the bed several times, although he has been potty trained for over a year. Which is the most probable explanation for this situation? Children often revert to an earlier developmental stage when stressed. Adam is being rebellious and letting his anger out by wetting the bed. Johnny, a year-old, has the physical development of a 7- to 8-year-old. Which of the following is referred to as his developmental age? Musical or talking toys are most appropriate at this age. Nasal obstruction due to inhaled or inserted object is likely, so the nurse should examine the nose for an item that might have been inserted. Health assessment provides key information needed for diagnosis of a client condition and for planning of effective care to assist the client and family. Understanding the expected findings normal ranges for the pediatric population will assist you in detecting abnormal findings. Assessment

is used in initial contact with the client and throughout the course of the plan of care to evaluate degree of progress or lack of progress. Information found during the assessment is used to refine the plan of care to increase effectiveness and success in resolving or minimizing the client problem s. After years of practice, the steps of the process might not be outlined distinctly as you proceed but will remain the foundation for care. The process includes assessment of the client and family relative to the problem and related concerns, as well as underlying family and dynamics that could impact support and resources needed by the client. Nursing diagnoses are statements that define the problems and potential problems indicated by the assessment findings. After determining a nursing diagnosis, the desired outcome of care and treatment is identified. Knowing the objective of the care, the desired result or outcome, helps guide the activities needed and gives a basis for evaluating the success of the care. The desired outcome is generally resolution, to the greatest degree possible, of the problem identified by the nursing diagnosis. Nursing interventions are designed to help the client meet the desired outcome of resolving the problem s from their condition. Interventions include care to the client as well as client and family teaching. Continued monitoring and assessment is also an expected nursing intervention for comprehensive client care. Evaluation, and revision as indicated, is the final stage of the nursing process. Data gathered with continued monitoring are used to determine the degree to which outcomes were met and need to revise goals or interventions. New nursing diagnoses may be discovered and old nursing diagnoses may be deleted after reviewing data from continued monitoring and evaluation. To provide family-centered care: Culture alert If English is a second language for the child or family, an interpreter may be needed to ensure that the questions asked and responses given are understood. Communication in the native tongue may be needed for full understanding of client concerns. Key considerations when communicating during a health assessment include the following: Culture alert Be aware of cultural variation in eye contact because direct eye contact might be considered disrespectful or evil. Find time without parents present to allow adolescents to ask questions or state concerns they may be embarrassed to discuss around parents. Culture alert Be aware of cultural variation in physical contact, particularly across genders, which might be considered inappropriate or taboo. Smiling and maintaining a pleasant facial expression reduces client and parent anxiety. Current symptoms determine why the child was brought in for examination. This assessment should include acute or chronic conditions as well as surgical procedures. Sleep pattern, that is, difficulty sleeping or excess sleep could indicate depression, drug reaction, or pain or discomfort from disease. Frequency and type of food intake; can reveal eating dis- orders, obesity, or malnutrition failure to thrive in infant population possibly due to poverty or could reveal abuse or neglect. Drugs, tobacco, or alcohol current or past ; determine frequency and amount or usage. Do not limit assessment to older adolescents because a child as young as age 8 or 9 may be sexually active. It is important to collect data from the child and family members regarding nutrition habits. Inquire about community access to variety of food types and factors impacting food choices, such as location of stores, fast-food choices due to time constraints, and economic barriers to purchase of sufficient quantities of fresh fruits and vegetables and low-fat cuts of meat, as well as fish and fowl choices. If the family practices vegetarianism, inquire about the specific foods allowed and assess adequacy of intake of nutrients from all food groups. Culture alert Assess dietary restrictions due to ethic cultural beliefs and taboos. Weight in kilograms divided by height in meters squared. An economic assessment could indicate a financial deficit that limits ability to buy food, indicating a need for assistance from social services. Family Assessment Family assessment is a most important aspect of the history because the emotional and physical health of the child or adolescent depends on the stability of the family structure and function. There are various definitions for the term family, which broadly means one or more adults living with one or more children in a parentâ€”child relationship. Family also refers to those individuals who are important to the core or nuclear group. Family assessment involves exploration of family structure and composition as well as member relationships, characteristics, interactions, and dynamics. If the child is experiencing a major stressor, such as parental divorce, chronic illness, or death of a family member, or an issue such as behavioral or physical problems, or developmental delays that suggest family dysfunction, they

are noted and an in-depth family assessment is indicated. In performing this assessment, consider the following: Ask about extended family and additional support such as from friends or church members, to determine the extent of resources available to the child and family.

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Chapter 2 : Pediatric Nursing Demystified : Joyce Y. Johnson :

Pediatric Nursing Demystified is a complete yet concise overview of all the important pediatric nursing concepts and the disorders that most often afflict infants to adolescents. You'll also learn how to apply those principles to real-life clinical situations.

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Born Joyce Glassman to a Jewish family in Queens, New York, Joyce was raised on the Upper West Side of Manhattan, just around the corner from the apartment of William S. Burroughs and Joan Vollmer Burroughs.

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