continuously via nebulizer (as prescribed).	exchange and to enhance tissue oxygenation
Obtain blood specimen for electrolytes, complete blood count, renal function tests, and arterial blood gases (ABGs).	To determine current status of patient and institute therapy based on results
Obtain intravenous (IV) access and administer corticosteroid, hydration, and electrolytes as prescribed.	To decrease inflammation and correct dehydration, acidosis, and electrolyte disturbances
Educate family about status asthmaticus and treatment underway to resolve condition.	To promote understanding of characteristics and treatment for status asthmaticus
Arrange for social worker to meet with family to assess emotional and financial needs.	To identify and modify stressors associated with acute exacerbation of illness and sudden hospitalization
Transfer patient from the emergency department (ED) to the pediatric intensive care unit (ICU).	To allow for continuous cardiorespiratory monitoring and further treatment

Expected Outcome

Adolescent will breathe easily with nonlabored respirations at a rate within normal limits for age.

Adolescent will maintain patent airway.

Adolescent will maintain adequate gas exchange.

Family will verbalize understanding of condition and treatment.

Prognosis

Although deaths from asthma have been relatively uncommon since the 1980s, the rate of death from asthma increased steadily in the United States until it peaked in the mid-1990s. Asthma-related deaths decreased 2000 to 2009, 84 deaths were noted among children in the United States in 2000 compared to 33 deaths among children in the United States in 2009 (Hasegawa, Tsugawa, Brown, et al, 2013). The rate of hospitalization due to asthma decreased significantly from 2000 to 2009 in children younger than 18 years old; however, the use of invasive and noninvasive mechanical ventilation significantly increased during that time (Hasegawa, Tsugawa, Brown, et al, 2013). African-American children have 2 to 7 times more hospitalizations, emergency department visits, and deaths than those of white and Hispanic children (Liu, Covar, Spahn, et al, 2016). Most asthma deaths in children occur in the home, school, or community before lifesaving medical care can be administered.