excessive diarrhea, bleeding, prolapse, or failure to pass flatus or stool) is brought to the attention of the physician, nurse, or stoma specialist. The same principles are applied as discussed earlier in this chapter for compliance, especially in terms of education, and in Chapter 19 for discharge planning and home care.

Procedures for Maintaining Respiratory Function

Inhalation Therapy

Oxygen Therapy

Oxygen is administered for hypoxemia and may be delivered by mask, nasal cannula, face tent, hood, face mask, or ventilator. The mode of delivery is selected on the basis of the concentration needed and the child's ability to cooperate in its use. Oxygen therapy is frequently administered in the hospital, although increasing numbers of children are receiving oxygen in the home. Oxygen is dry and therefore must be humidified.

Oxygen delivered to infants is well tolerated by using a **plastic hood** (Fig. 20-23). At least 7 L/min of flow is necessary to maintain oxygen concentrations and remove the exhaled carbon dioxide. The humidified oxygen should not be blown directly into the infant's face. Older, cooperative infants and children can use a **nasal cannula** or **prongs**, which can supply a concentration of oxygen of about 50%. High flow nasal cannula (5 to 8 L/min using pediatric tubing) may be used to avoid intubation, post-extubation, in palliative care, and as a mode of ventilatory support in very low birthweight infants. Care with prong size, placement, and maintenance is important to prevent breakdown of the nasal alae.