NURS-FPX4030 Assessment 4

Remote Collaboration and Evidence-Based Care

Evidence-Based Remote Care Plan for a Child With Cystic Fibrosis

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Educational sample notice. This original model demonstrates a rubric-aligned structure for study, planning, research, and revision. It is not affiliated with Capella University and should not be submitted as a learner's own work. Verify the current instructions and scoring guide before using any structure or evidence.

Primary keyword: NURS-FPX4030 Assessment 4 Remote Collaboration and Evidence-Based Care

Related keywords: cystic fibrosis telehealth, remote nursing collaboration, pediatric CF care plan, airway clearance, nutrition, interdisciplinary team, Iowa Model

Presenter Script: Remote Collaboration and Evidence-Based Care

Estimated speaking time: 8-9 minutes. The case and names are fictional and are used only to demonstrate assessment structure.

0:00-0:50 - Introduction and Case Summary

Hello. This presentation proposes an evidence-based care plan for Caitlynn, a two-year-old child who was evaluated for recurrent respiratory symptoms and poor weight gain and was diagnosed with cystic fibrosis. Caitlynn lives far from the regional cystic-fibrosis center. Her parents need specialized guidance, but frequent travel creates financial, work, weather, and childcare barriers. The local pediatric team can provide hands-on assessment, while the specialty center can direct disease-specific care. The central question is how these professionals can collaborate remotely without allowing convenience to weaken safety, physical assessment, infection surveillance, or family support.

0:50-1:45 - Evidence-Based Practice Model

The Iowa Model provides a practical structure for this plan. The trigger is a clinical and access problem: a young child with a complex chronic condition requires coordinated specialty care across distance. The team first determines whether the issue is a priority, forms an interdisciplinary group, searches and appraises evidence, designs a pilot plan, evaluates outcomes, and then sustains or revises the change. The model is useful because it connects research evidence with workflow, patient preferences, available resources, and measurable results. It also prevents the team from adopting telehealth merely because the technology is available.

The interdisciplinary team should include Caitlynn’s parents, a local pediatric nurse and physician, a cystic-fibrosis center nurse coordinator and pulmonologist, a respiratory therapist, dietitian, pharmacist, social worker, and laboratory or microbiology support. One CF nurse coordinator should own the shared plan and confirm that recommendations, test results, and changes reach every participant.

1:45-4:45 - Proposed Evidence-Based Care Plan

The first part of the plan is airway health. The respiratory therapist should teach the parents age-appropriate airway-clearance techniques and observe return demonstration by video and during periodic in-person visits. The schedule must follow the specialty team’s prescription and increase during respiratory illness. Medication timing should be written clearly so that bronchodilators, mucus-directed therapies, antibiotics, and airway clearance are used in the correct sequence when prescribed. The local nurse should assess respiratory rate, work of breathing, oxygen saturation, hydration, cough, activity, and

response to treatment when symptoms change. Because a two-year-old cannot provide reliable home spirometry, symptom trends and direct clinical assessment are more appropriate than making home spirometry a central requirement.

The second part is infection monitoring and prevention. The parents should receive a simple red-flag plan. Urgent evaluation is needed for increased work of breathing, cyanosis, marked lethargy, poor intake, dehydration, persistent vomiting, or a significant decline in oxygen saturation from the child's established baseline. The local clinic should collect cough swabs or other age-appropriate respiratory specimens according to the CF center's protocol and share results through the secure record. Equipment used for respiratory treatments must be cleaned, disinfected, and dried as instructed. Hand hygiene, vaccination, smoke-free air, and avoidance of unnecessary exposure to other people with CF should be reinforced.

The third part is nutrition and growth. Cystic fibrosis can cause pancreatic insufficiency and malabsorption. The dietitian should establish calorie, protein, fat, and growth goals and review weight, length or height, and weight-for-length or body-mass-index percentile. If pancreatic enzymes are prescribed, the parents need exact teaching about dose timing with meals and snacks and instructions not to change the dose without clinical advice. Fat-soluble vitamin supplementation and salt needs must follow the CF team's plan. Zani et al. (2023) emphasize early nutrition support, adequate energy intake, enzyme replacement when indicated, and monitoring across childhood.

The fourth part is coordinated follow-up. I recommend a video visit with the CF nurse within one week of discharge or diagnosis, then scheduled contacts every two to four weeks during the early learning period. The family should have a secure message route for nonurgent questions and a 24-hour number for urgent clinical concerns. At each contact, the team should review respiratory symptoms, treatment adherence and burden, appetite, stool pattern, enzyme use, weight, medication access, caregiver confidence, and upcoming tests. Quarterly specialty review should be maintained, using a hybrid format in which some visits are in person for examination, cultures, growth assessment, and other tests that cannot be completed reliably at home.

4:45-6:10 - Evidence Supporting the Plan

The evidence supports a multidisciplinary and hybrid approach. Current European Cystic Fibrosis Society standards emphasize individualized care that maintains airway health, nutrition, exercise, and long-term health through a specialist multidisciplinary team (Southern et al., 2024). Cystic Fibrosis Foundation guidance for preschool-aged children also addresses surveillance, pulmonary treatment, and

nutritional care. These sources are highly relevant because Caitlynn is two years old and requires both respiratory and growth monitoring.

Telehealth evidence supports access but also calls for caution. Vagg et al. (2023) reviewed CF telehealth literature and identified benefits such as improved access, less travel, and support for ongoing clinical contact, while noting variation in technology, outcomes, and study quality. Fainardi et al. (2023) explain that telemedicine can support clinical review, treatment adherence, physiotherapy, exercise, early recognition of exacerbations, nutrition, and psychological care. However, neither source supports replacing all in-person care. The evidence is most consistent with a hybrid model that uses remote visits for education, monitoring, and coordination while preserving local or specialty examination, microbiology, growth measures, and urgent assessment.

6:10-7:35 - Benefits, Challenges, and Mitigation

Remote collaboration offers four main benefits. First, it reduces travel burden and can connect the family with specialists sooner. Second, video allows the team to see the home treatment process and coach the parents in the environment where care occurs. Third, a shared plan can improve continuity between the local clinic and CF center. Fourth, remote contact may reduce avoidable exposure to infectious organisms in waiting areas, although standard infection-prevention practices remain necessary.

The challenges are equally important. Internet or device problems can interrupt assessment. A camera cannot replace palpation, auscultation, cultures, laboratory tests, or a full evaluation of a deteriorating child. Different organizations may use incompatible records. Unclear roles can produce duplicated advice or missed follow-up. Families may also feel overwhelmed by treatment burden and frequent digital contact. Privacy must be protected through approved platforms rather than personal messaging accounts.

The mitigation plan is specific. The family receives a backup telephone number and a written emergency pathway. The local clinic reserves same-day assessment capacity for red flags. The CF nurse coordinator uses a standardized note that records the problem, assessment findings, decision, responsible person, and follow-up date. A shared medication and treatment list is reconciled at every transition. Monthly interdisciplinary case review is used during the first three months, and the frequency is reduced when the family is stable and confident. Interpreter services, digital-literacy support, and social-work assistance are included when needed.

7:35-8:30 - Evaluation and Conclusion

The team should evaluate clinical, process, and family outcomes. Clinical measures include growth trajectory, respiratory exacerbations, urgent visits, hospitalizations, culture results, and age-appropriate pulmonary measures. Process measures include completed contacts, treatment-plan reconciliation, specimen collection, and response time to yellow- or red-zone symptoms. Family measures include confidence with airway clearance and enzymes, treatment burden, access problems, and satisfaction with communication.

In conclusion, the best plan for Caitlynn is not remote-only care. It is coordinated hybrid care led by a cystic-fibrosis center and supported by a capable local team. Evidence supports structured airway clearance, infection surveillance, nutrition management, family education, and specialist multidisciplinary follow-up. Telehealth improves access and continuity when roles, escalation pathways, privacy, and in-person assessment are clearly defined. The nurse coordinator is central because that role closes communication loops and keeps the plan understandable for the family.

Condensed Care-Plan Checklist

Care domain	Key actions	Responsible team	Measures
Airway care	Age-appropriate airway clearance; return demonstration; prescribed medication sequence; increase plan during illness	Respiratory therapist and CF nurse	Technique observed; adherence and symptom response documented
Infection surveillance	Red-flag action plan; local respiratory specimen collection; equipment hygiene; vaccines and smoke-free environment	Local pediatric team and CF pulmonology team	Cultures obtained when indicated; rapid escalation of deterioration
Nutrition and growth	Growth tracking; dietitian plan; enzymes and vitamins as prescribed; monitor intake and stools	CF dietitian, nurse, and local clinic	Weight-for-length/BMI trend; enzyme understanding; nutrition barriers resolved
Remote coordination	One-week video visit; planned follow-up; secure messaging; shared record; hybrid in-person schedule	CF nurse coordinator	Completed contacts; reconciled care plan; documented next owner/date
Family support	Teach-back; treatment-burden assessment; social work; interpreter and digital support	Whole team with nurse lead	Caregiver confidence and access problems reviewed

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Appendix A: Assessment Coverage Map

The table shows where the sample visibly addresses the central requirements commonly associated with this NURS-FPX4030 assessment. The current scoring guide remains the controlling source.

Assessment requirement	Location in sample
Propose an evidence-based plan to improve the patient's outcomes.	Proposed Evidence-Based Care Plan and checklist
Explain an EBP model used to develop the plan.	Evidence-Based Practice Model
Explain relevant and useful evidence.	Evidence Supporting the Plan
Identify benefits and challenges of remote interdisciplinary collaboration.	Benefits, Challenges, and Mitigation
Present a professional 5-10 minute communication.	Timed presenter script