**NURS 222 ADULT NURSING CARE 1**

NURSING PROCESS

(Student’s Copy)

SCENARIO:

Patient M is a 33-year-old married woman was admitted to the hospital with an elevated temperature, a productive cough, and rapid, labored respirations. While taking a nursing history, the nurse finds that the patient has had a non productive cough for 2 weeks and has been experiencing shortness of breath upon exertion. Yesterday she developed an elevated temperature and began to experience chest pain when coughing

Physical assessment reveals that the patient’s vital signs are: Temperature, 39.4°C (103°F); pulse 92 beats/min; respirations 28/min; and blood pressure, 122/80 mmHg. The nurse observes that the patient’s skin is dry, her cheeks are ﬂushed, and she is experiencing chills. Auscultation reveals inspiratory crackles with diminished breath sounds in the right lung

The nurse and the patient collaborate to establish goals (e.g., restore effective breathing pattern and lung ventilation); set outcome criteria (e.g., have a symmetrical respiratory excursion of at least 4 cm, and so on); and develop a care plan that includes, but is not limited to, coughing and deep-breathing exercises q3h, ﬂuid intake of 3,000 mL daily, and daily postural drainage.

The nurse performs the following: monitor respiratory status q4h: rate, depth, effort, skin color, mucous membranes, amount and color of sputum; results of blood gases, chest x-ray studies, and incentive spirometer volume as available; level of consciousness. Auscultate lungs q4h. Vital signs q4h (TPR, BP, pulse oximetry, pain). Instruct in breathing and coughing techniques. Remind to perform, and assist q3h. Maintain Fowler’s or semi-Fowler’s position . Administer prescribed expectorant; schedule for maximum effectiveness.. Administer prescribed analgesics. Notify primary care provider if pain not relieved. Administer oxygen by nasal cannula as prescribed. Provide portable oxygen if client goes off unit (e.g., for x-ray examination) Assist with postural drainage daily at 09:30 am. Administer prescribed antibiotic to maintain constant blood level. Observe for rash and GI or other side effects

The patient agrees to practice the deep-breathing exercises q3h during the day. In addition, she verbalizes awareness of the need to increase her ﬂuid intake and to plan her morning activities to accommodate postural drainage.

Upon assessment of respiratory excursion, the nurse detects failure of the client to achieve maximum ventilation. She and the patient reevaluate the care plan and modify it to increase coughing and deep-breathing exercises to q2h

**FORMULATING NURSING CARE PLAN**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Assessment** |  |
| **Subjective** |
| **Objective** |  |
| **Nursing Diagnosis (see NANDA)** |  |
| **Planning** |  |
| **Implementation** |  |
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| **Evaluation** |  |