Analytical skill

CARE PLAN

ON

ASTHMA

Submitted TO.

Mrs. Subhashini
Associate professor
MSN Department
Narayana college
of Nursing

20/5/2020

Submitted by

Ms. Sneha
IIInd BSc(N)
Narayana college
of Nursing

NARAYANA COLLEGE OF NURSING NELLORE 524 003

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Chintharedypalem,
NELLORE - 524 003.

Patient Profile :

Name : Mrs. J. Vasanthi

Age : 26yrs

Sex : Female

Occupation : Teacher

Income : 8000

Marital Status : Unmarried

Religion : Christian

Nationality : Indian

IP No : 147091/20

ward : Pulmonology ward

Diagnosis : Bronchial Asthma

Date of Admission : 8-5-2020

Date of case started : 10-5-2020

Date of case ended : 15-5-2020

Address : Ongole
Nellore

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J. H

Chief complaints:

Ms. Vasanthi . came to pulmonology Op. on 8-5-2020 with severe cough, Shortness of breath and unusual breath sounds. Dr. Shyam has seen the patient and advised for x-ray, Sputum test and has diagnosed it as Bronchial Asthma and advised to get admitted to pulmonology ward.

Past Medical History:

Ms. Vasanthi does not have any past medical history of Diabetes Mellitus and Hypertension

Past Surgical History:

Nil Significant

Allergies

Ms. Vasanthi is allergic to dust and cold drinks

Life style risk factors :

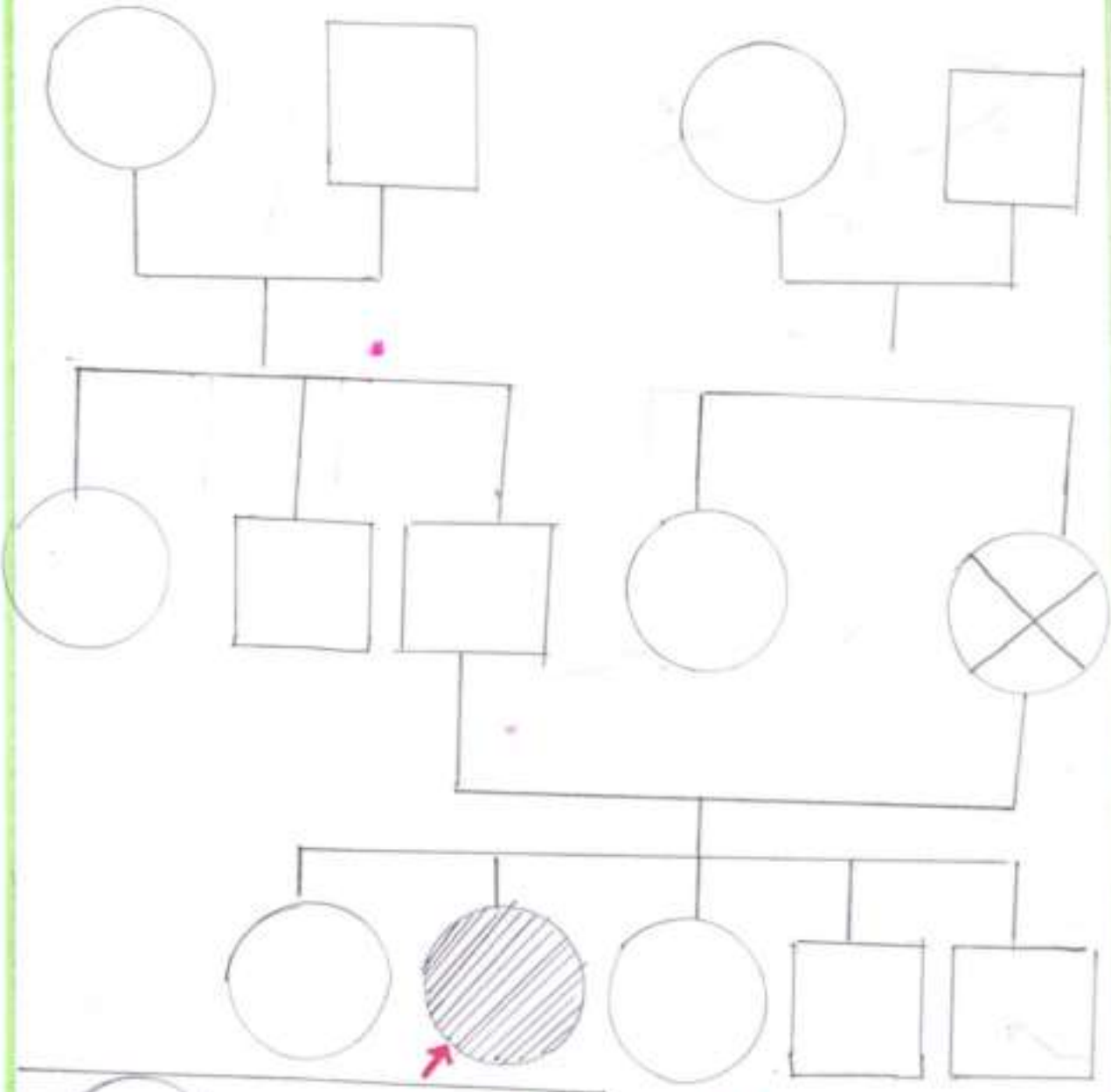
Ms Vasanthi has habit of Swimming and playing in water.

Family History

Sno	Name	Age/Sex	Relation	Education	Occupation	Health status
1.	Mark	62/M	Father	Degree	Teacher	Healthy
2.	Prasanna	48/F	Mother	—	Housewife	Healthy
3.	Shaila	27/F	Sister	B.com	Typist	Healthy
4	Vasanthi	26/F	Patient	TTC	Teacher	unhealthy
5.	Swapna.	24/F	Sister	Degree	—	healthy
6	Vineeth	18/M	Brother	XII std	—	Healthy
7.	Victor.	15/M	Brother	V std.	—	Healthy

Ms. Vasanthi family is a joint family and has no family history of communicable disease

Genogram :



Nutritional Assessment:

a) Height : 158cms

b) weight : 50kgs

c) Body Mass index:

d) Type of diet in hospital and home.

Ms Vasanthi is prescribed with soft and Balanced diet. with protiens and restricting cold drinks

e) problems in eating and digesting foods:

Ms. Vasanthi is having loss of appetite

f) Denbrtion:

Ms. Vasanthi has no dentures she has good oral hygiene

g) Oral mucosa:

Ms. Vasanthi has dry oral mucosa with blisters.

h) Appetite: decreased

i) Taste sensation: Normal.

Blood glucose monitoring :

Fbs : 110mg/dl

RBS : 120 mg/dl.

Type of feeding : Oral

Total parental nutrition : Nil

Type of IV access : Cannula

Input : 1000ml

Output : 900ml

Nails : pinkin colour
Normal shape
No abnormalities found.

General Skin colour :

Skin : Fair

Edema : No edema

Skin turgor : No tenting

III ELIMINATION PATTERN :

a) presence of bowel sound : Normal.

b) Usual bowel - habits : Normal

c) Stool colour : Normal

d) Rectum : Normal.

f) Bladder function : Normal

g) Urine : clear

IV Activity Exercise.

Vital Signs

Date	Temperature	Pulse	Respiration	Blood pressure	SpO_2
10-5-2020	98.6°F	70 bt/mt	24 l/mt	120/80mmHg	95 %
11-5-2020	99°F	72bt/mt	26/mt	110/70mmHg	93 %
12-5-2020	98.8°F	74/mt	20/mt	120/80 mmHg	95 %
13-5-2020	98.6°F	78/mt	24/mt	110/70mmHg	96 %
14-5-2020	98.8°F	74/mt	22/mt	110/70mmHg	96 %
15-5-2020	99°F	76/mt	24/mt.	110/70mmHg	98 %

Apical Rhythm

Capillary refill

Respiratory Depth : Normal

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Difficulty in breathing : present

Cough : present.

Breath Sounds : Abnormal

(Abnormal wheeze sounds present)

Activities of daily living / self care ability

	Score		Score	
Eating / Drinking	1	Bathing	1	Dressing
Toileting	0	Bed mobility	0	Transferring
Ambulating	1		0	

0 - Independent / requires no assistance

1 - Requires use of an active device

2. - Requires one person assistance

3 - Requires one person assistance and an assistive device

4 - Requires 2 person or non assistance dependent.

Self perception:

Developmental Stage : middle adult

Emotional State : calm.

Coping stress tolerance pattern:

Ms. Vasanthi does meditation and listen songs to reduce stress

Values / belief pattern:

Ms. Vasanthi believes on god and is spiritual.

Musculo skeletal:

Gait : Steady

Upper extremities : Equal

ROM : Unlimited

Sleep Rest pattern.

a) Typical home sleep pattern : 4hrs / night

Snaps times / day

b) Typical hospital sleep pattern : 1hr / night

Snap times / day

VI Sexuality Reproductive Pattern :

Breasts : No variations

Genitalia : No Discharge

History of STDs : Not present

contraceptives : No.

VII Cognative perceptual pattern :

Mental status : Oriented

Levels of consciousness : Alert

memory : Intact

Thought process : Answers questions appropriately

Vision : Normal

Hearing : Normal.

Role & Relationship pattern :

Current occupation : Teacher.

Marital status : Unmarried

Socialization : Maintaining good personal relationship

Neurological assessment :

Glasgow coma scale :

Score : 15

Mental status Examination :

Fully oriented
alert

SYSTEMIC EXAMINATION

Respiratory System :

On Inspection of thorax :

Shape : Normal

Any deformity : Nil

Movement of chest : Abnormal.

On palpation :

Tenderness : Nil

Tumor : Nil

Growth of Enlarged
Lymphnodes : Nil

On percussion :

Resonance : Nil

Dullness : Nil

Flat : Nil

Tympany : Nil

Auscultation :

Abnormal breath sounds : present
(Wheeze sounds)

Other finding :

Shortness of breathe : present

Hemoptysis : Nil

Allergies : present

H/o smoking : Nil

Respiratory rate : 24/min.

Discharge plan

Medication :

- Salbutamol
- Routine Nebulization
- Hydrocortisone

INVESTIGATIONS

Name : Ms. Vasanthi Age : 20yrs Sex : Female.

Ipno : 14709/20. Diagnosis : Bronchial Asthma

Investigation	Patient values	Normal values	Remarks
Hb%	13.4	11.0-16.0mg% (F) 13.0-18.0 m% (m)	Normal
WBC	7200	4000 - 10,000 cumm.	Normal
DC :			
Neutrophil	62	40 - 75%.	Normal
Lymphocytes	35	20 - 45%	Normal
Eosinophills	03	1 - 6%	Normal
platelet count (PC)	2,20,000	1,50,000 - 4,50000 (cumm)	Normal
ESR.	13.0	1 - 5 mm/hr (F) 1-7 mm/hr (m)	increased
CPR	120	1-10 m	increased
MP@BO	Negative		
Sr. creatinine	0.6	0.7 - 1.3m 0.4 - 1.2mg (m)	Normal.
Sr. Billirubin	0.8	0.3-1.2mg%	Normal
SGOT	22.9	upto 40%.	Normal

MEDICATION

Sl.no	Drug name	Dose	Action	Indication	Contra indication	Adverse effects	Nurses Responsibilities
1.	Bronchodilator Salbutamol	Salbutamol nebulization n.a.6^{c} po- 1.25mg or 0.63mg, 3or 4 times daily Metered dose inhaler: 8 puffs every 4-6 hours as needed inhalation capsules: 200mcg inhaled every 4-6hr.	Relaxes bronchial uterine and vascular smooth muscle by stimulating beta$_2$ receptors	• To prevent or treat bronchospasm in patients with reversible obstructive airway disease • To prevent exercise induced bronchospasm	• Hypersensitivity to drugs • use cautiously in patients with CV disorders DM coronary insufficiency Hypertension	• Tremor • nervousness • dizziness • insomnia • Headache • Tachycardia • palpitation • nasal congestion • Epistaxis • Heart burn • Nausea • Vomiting • Anorexia • muscle cramp.	→ observed cautions in giving medicine. → warn the mother about possibility of paradoxical bronchospasm. → Tell to stop the drug immediately if any allergic reaction.

Sno	Drug name	Dose	Action	Indication	Contra indication	Adverse effects	Nurses responsibilities
2	Corticosteroid Inj. Hydrocortisone	• Adult: 15-240mg (po/im/iv) every 12hour • children under 12yrs: 2.5-10mg/kg/day po divided every 6-8hrs • IV maintenance 2mg/kg/day iv divided every 6h	Enters target cells and binds to cytoplasmic receptor, initiates many complex reactions that is responsible for anti-inflammatory action	• Severe inflammation • Hematologic disorder	Hypersensitivity to drug	• Flushing • sweating • edema • diarrhoea • tachycardia • vertigo	• Note degree of involuntary movements, muscle spasm • provide patient safety • monitor for consistency of stool • If patient develop urinary hesitancy assess for bladder distention

NANDA NURSING DIAGNOSIS ACCORDING TO PRIORITY

1. Ineffective breathing pattern related to infection as evidenced by recurrent cough
2. Ineffective airway clearance related to ineffective cough as evidenced by wheezing sound on auscultation
3. Disturbed sleeping pattern related to hospitalization as evidenced by verbalization
4. Fluid volume deficit related to insensible fluid loss with hyperventilation as evidenced by dehydration
5. Deficient knowledge related to lack of information sources as evidenced by inability to answer properly.
6. Fear and anxiety related to hospitalization as evidenced by verbalization

Sno	Assessment	Diagnosis	Goal	Intervention	Rationale	Implementation	Evaluation
1.	Subjective data patient says that I am having severe cough. objective data On observation patient saturation is decreased	ineffective breathing pattern related to infection as evidenced by recurrent cough.	To improve breathing pattern and reduce cough.	→ Assess respiratory rate, depth and rhythm → Assess for colour changes in lips nail beds → Monitor and record intake and output → Monitor oxygen saturation → Encourage deep breathing exercise	→ changes in the respiratory rate and rhythm may indicate an early sign of respiratory distress → cyanosis indicates low oxygen supply → Dehydration can contribute in viscous secretion → Saturation less than 90% indicate low oxygen → Helps loosen and expectorate excess.	→ Assessed respiratory rate, depth & rhythm → Assessed for colour changes in lips & beds → Monitored intake & output → Monitored oxygen saturation → Encouraged deep breathing exercise	improved breathing pattern and cough is reduced.

Sno	Assessment	Diagnosis	Goal	Intervention	Rationale	implementation	Evaluation
2.	Subjective data: patient says that I am having shortness of breath. Objective Data: On observation patient looks dyspneic	ineffective airway clearance related to ineffective cough. as evidenced by wheezing sound on auscultation	The patient will be able to maintain airway patency and improved airway clearance	→ Assess the patients vital signs and characteristics of respiration → Suction Secretion as needed → Administer supplemental oxygen → Administer prescribed medications → Elevate the head of bed → Provide nebulization	→ To assist in creating an accurate diagnosis and monitor effectiveness of medical treatment → To help clear thick phlegm that the patient is unable to expectorate → To increase O_2 level and achieve an spo_2 normal value → To dilate or relax the muscle on airway → improve expansion of the lungs.	→ Assessed the patients vital signs and characteristics of respiration → Secretions are Suctioned → Administered Supplemental oxygen. → Administer prescribed medication → Elevated the head of bed → provided nebulization	→ Maintained airway patency and improved airway clearance

Sno	Assessment	Diagnosis	Goal	Intervention	Rationale	Implementation	Evaluation
3.	Subjective data Objective data	Disturbed sleeping pattern related to hospitalization as evidenced by verbalization	To improve sleep and reduce fear	→ Assess the level of anxiety and distress → Provide calm and quiet environment → Elevate the head end of the bed → provide comfortable position → provide nebulization → Educate the client regarding deep breathing exercise.	→ To obtain knowledge regarding clients condition → To improve peacefulness → To increase lung volume → To induce peaceful sleep → To improve clients condition	→ Assessed the level of anxiety. → provided calm and quiet environment → Elevated the head end of bed → provided comfortable position → provided nebulization → Educated the client regarding deep breathing exercises	Improved sleep

Sno	Assessment	Diagnosis	Goal	Intervention	Rationale	Implementation	Evaluation
4	Subjective Data: patient says "I am having dry lips Objective Data: On observation patient has sunken eyes and looks dehydrated	Fluid volume deficit related to ~~hospital~~ insensible fluid loss with hypernatremia as evidenced by dehydration	To improve fluid volume	→ Monitor and record intake and output → Administer prescribed medication → Administer sufficient amount of fluid → Encourage the client to perform deep breathing exercise	→ To improve fluid volume → To improve health conditions client → To improve fluid volume → To improve lung volume	→ Monitored intake output → Administered prescribed medicine → Administered sufficient fluid → Encouraged client to perform deep breathing exercise	improved fluid volume.

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Sno	Assessment	Diagnosis	Goal	intervention	Rationale	implementation	Evaluation
6.	Subjective data eg Patient says that "I am not having knowledge of my condition Objective data On observation patient looks anxious	Deficit knowledge related to lack of information sources as evidenced by inability to answer properly	To improve knowledge and deept clarify the doubts of client	→ Asses the knowledge of client regarding condition → Encourage the client to verbalize the doubts → Maintain interpersonal relationship → Educated the client regarding the disease condition	→ To know the level of understand → To clarify the doubts → To make patient comfortable to share his feeling → To improve knowledge of client	→ Assessed the knowledge of client regarding condition → Encouraged the client to verbalize their doubt → Maintained interpersonal relation → Educatid client regarding the disease condition	improved knowledge and clearified the doubts

NURSES NOTE

Name: Ms. Vasanthi Age: 20yr Sex: f

Diagnosis : Bronchial Asthma

Date/Time	Diet	Medication	Nurses Note
10-5-2020			
8 - 8:15 am			→ Assessed the condition of client
8:15 - 8:45			→ collected history and performed physical examination
9am - 9:15 am			→ Monitored vital signs and Recorded. Temp: 98.6°F Pulse: 72/mt RR : 24/mt
9:15am - 9:30am			→ provided comfortable position to client
9:30 Am - 10 Am		Rup-Asthalin	→ Provided Nebulisation
			→ Administered oxygen
12nd - 12:30	Rice + Dhal.		→ Provided nutritional diet
1pm - 1:15pm		inj. Hydrocortisone	→ Administered medication
		loong.	→ Health education is given
1:15 - 2pm			on diet exercise medication follow up

NURSES NOTE

Name: Ms. Vasanthi Age: 26yr Sex: F

Diagnosis: Bronchial Asthma

Date / Time	Diet	medication	Nurses Note
11-5-2020 8am-8:30am			→ Assessed the general condition of client
8:30am-9am			→ Monitored and recorded vital signs Temp: 99°F Resp: 26/mt pulse: 74/mt
9am- 1:10am	Idly+chutney milk		→ provided nutritional diet
10am			→ Maintained Semifowlers position
10:15am			→ Administered oxygen
10:30am		Asthaline	→ Provided Nebulization
10:30am		Deriline • Inj Hydrocortisone	→ Administered medication
11am			→ Performed Suction
12nd- 1pm			→ Educated client regarding deep breathing exercises

NURSES NOTE

Name : Mr. Vasanthi Age: 26yr Sex: Fe

Diagnosis : Bronchial Asthma

DATE/ TIME	DIET	MEDICATION	NURSES NOTE
12-5-2020			→ Assessed the condition of the client
8am-8:30am			
8:30am-9am			→ Monitored the vital signs and recorded Temp: 99°F Resp: 24/min Pulse: 74/min
9am-9:30am	Rice porridge		→ provided nutritious diet
10am			→ Maintained semifowlers position
10am			→ Administered oxygen
11am			→ provided steam inhalation
12nd		Inj. Hydrocortisone 100mg	→ Administered medication to client
12nd-1pm			→ Educated the client on → Medication, Diet, Exercise

NURSES NOTES

Name: Vasanthi Age: 20y Sex: F

Diagnosis: Bronchial Asthma

DATE / TIME	DIET	MEDICATION	NURSES NOTE
13-5-2020			
8am - 8:15am			→ Assessed the general condition of client
8:15 - 8:30			→ Provided comfortable bed and semifowlers position
8:30 - 9am			→ Monitored the vital sign and recorded Temp:- 98.6 RR - 24/mt Pulse - 72/mt
9am - 9:15	Chappathi + potato curry	Asthaline	→ Provided nutritious diet → Provided Nebulization → Administered oxygen
10am			
10am - 11am			→ Assessed the client on her needs
12md.			→ Educated the client on · medication · Exercise · diet

NURSES NOTE

Name: Ms. Vasanthi Age: 26yr Sex: F

Diagnosis: Bronchial Asthma

Date / Time	Diet	Medication	Nurses Note
14-5-2020			→ Assessed the general condition of client
8am-8:30am			
8:30am-4pm			→ Monitored vital signs and recorded Temp: 98.6 RR - 24/mt PR - 79/mt
4pm-9:30am			
	Idly + chutney		→ Provided nutritious diet
9:30am-11am			→ Assessed needs of client
11am		Asthaline	→ provided nebulization
12nd			→ performed deep breathing exercise
1pm.			→ Educated the client on: diet, Exercise, Follow up.

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HEALTH EDUCATION

Health education is very important for all kinds of patients it include giving education during the stay of patients in hospital and discharge

Medication :

→ patients relatives should be taught about giving medications on time

→ patient's relatives are taught how to give prescribed medication.

→ Asked the patient express any of the complaints

→ Explained about side effects of drugs.

Diet :

→ Advised the patient to take well balanced diet

→ Advised the patient to take small amounts of food in frequent times

→ Encouraged the client to prepare diet plan with high protein diet plan

→ Avoid drinking cold drinks and exposing to cold air

Personal hygiene:

→ particular care to be taken including bathing, brushing keeping skin dry

→ Advised the patient to keep her clothes clean and neat.

→ Educated the client about importance of personal hygiene

Exercise:

→ Encouraged the client to exercise

→ Taught patient regarding deep breathing exercises

Follow up care:

→ Explained the relation and patient about the use of follow up care.

→ Advised the patient to continue medication without fail

→ Helping patient and her relatives through various agencies

Recording & Reporting

Date	Recording	Reporting	Signature
	Problems - patient is having severe pain - patient is having fear of prognosis - patient is weak Intervention: - Assessed & provide Analgetics - Explained the procedure - provided medications Evaluation: - pain reduced due to tution	- Have done all the intervention & plans	

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CREATIVITY:

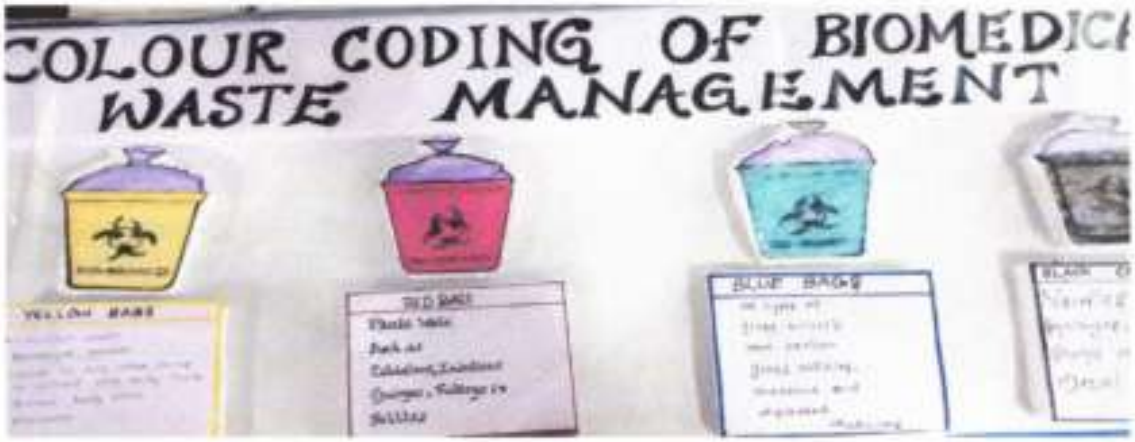

Fig1: Color coding of biomedical waste management in different colored bags

Fig2: view on difference types of restraints

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INNOVATION: Role Play

Given by III year B.Sc. Nursing students

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