Nursing assessment

NA Nursing Assessment Monica Jones was admitted because she was experiencing severe shortness of breath or dyspnoea. Crackles were present upon lung auscultation and she was diagnosed with pulmonary oedema, wherein the inter-spaces of her lungs are filling-up with fluid due to cardiac failure. The nursing assessments for Monica Jones below were based on all information gathered – that were both volunteered and observed. The collated findings will be the basis for physician diagnosis and care treatment plan in relation to the physiological and psychological problems manifested by the patient (Ellis, Janice Rider, Nowlis, Elizabeth Ann, Bentz, Patricia M., 1996).

Having noted all the foregoing findings, the three immediate nursing actions for Miss Jones would be: 1) To assess causative and precipitating factors, 2) to evaluate degree of excess fluids and 3) to promote mobilization/elimination of excess fluids (Doenges, Marilyn E., Moorhouse, Mary Frances, pp. 224-225. Assessing the causative and precipitating factors will involve the anticipation of cardiac failure, so it is essential to regularly monitor her breathing along with oxygen level infusion. Aside from this, the fact that a rapid infusion of IV fluids could transpire, the drip rate of the patient’s IV fluids must be checked constantly and adjusted to normal limits (Olsen, June Looby, Giangrasso, A. P., 2000). All fluid intakes must be noted as to its source and volume. Similarly, the amount of sodium and potassium intake must be observed and noted in relation to ingested food, drugs and IV infusion.

The second immediate nursing intervention is: to evaluate degree of excess fluids present within the individual. This second nursing action requires constant monitoring of vital signs (Medline Plus, 2007) to observe whether a

change has occurred from the last charting schedule.

Should a change be noted, it is imperative that the attending physician be informed to be aware

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of any related complications that may occur. In relation to this, the present weight of Monica Jones must be compared to previous stated or admission weight since increase of weight could indicate that fluid is being retained in the body. Regular auscultation of the lungs for the presence of crackles must be done and charted during this phase of intervention to see whether the crackling sounds that were previously heard have increased or diminished. Recording the occurrence of dyspnoea is equally essential within this secondary phase of nursing intervention, to note whether hard labour breathing is continuous or takes place only when triggered by an environmental stimuli. In accordance with this, if dyspnoea is observed due to certain environmental factors, then said stimuli must be eliminated. Monitoring Monica Jones's feet or ankles for signs of swelling must be done from time to time when she is ambulatory or sitting down on a chair – because swelling is a sign of fluid accumulation.

The third nursing action is to promote mobilization or elimination of excess fluids from the patient's body. Within this intervention phase, the schedule for sodium and fluid intake, which includes fluid infusion for Monica Jones must be controlled as advised by the physician and should be strictly adhered to. At the same time, her weight must be taken at regular intervals so that a baseline for comparison could be provided to determine improvement. Changing of sitting and lying positions must be done at regular intervals to prevent pressure sores and skin must be observed in

detail for signs of oedema. In case Miss Jones experiences difficult or laboured breathing, she must be positioned in a semi-Fowlers position to improve respiratory effort. She must also be allowed a quiet environment to avoid stress that might trigger bouts of dyspnoea. Relevant to all the stated nursing interventions or actions for Monica Jones is the continuous and strict adherence to the schedule of giving prescribed medicines by the physician.

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References

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