

Nursing process assignment



**ASSIGN
BUSTER**

Emotional: Subjective: Mr. Smith advised that he often feels mood is very low, this is related to his COOP and coping skills. He can no longer participate in activities that he did previously due to SOB and feeling fatigued. Has no appetite and states he does not feel hungry. Advises he often feels anxious due to threat of death, purposes that are not being met. Coping skills reduced caused by anxiety, lack of solicitation, depression, low activity levels and an inability to work. Objective: Facial expressions are often observed being sad. Spends a lot of time in bed with no solicitation with nursing staff or other patients.

Appears withdrawn and quiet. Does not eat food at mealtimes unless encouraged by his wife. Subjective: Mr. Smith enjoys a daily walk around the lake close to his home and helps his wife around the house. He is retired and receives a government pension to insane his needs. Does not want to eat at meal times as states he has no appetite. He states he would like to participate in social activities and help his wife with daily chores but is unable due to lack of energy and this causes anxiety. Objective: His wife visits him on the ward every day, offering him support and encouragement at his bedside.

She is often present at meal times and encourages her husband to eat.

Spiritual: Subjective: Mr. Smith denies being involved in any religious beliefs but attends Church with his wife on Christmas Eve as a tradition. Objective: Mood and affect appears to be low. Diagnostic Phase: From the assessment information, abnormal data highlighted includes: pneumonia, ineffective breathing pattern related to SOB. Ineffective airway clearance caused by

increased sputum production, ineffective cough, fatigue / lack of energy.

Impaired Gas Exchange related to ventilation perfusion inequality.

Imbalanced Nutrition – less than body requirements. Activity Intolerance related to imbalance between oxygen supply with demand. Anxiety related to threat of death, purposes that are not being met. Ineffective individual coping related to anxiety, lack of solicitation, depression, low activity levels and an inability to take part in social activities and help wife with daily chores. Preventing RAFF In Mr.. Smith Is ten enlist nursing poorly Tort ten next 24 hours as it affects his airway and breathing, is life threatening and can increase mortality significantly (Drills, 2008; , Lines & Kelly, 2013).

Mr.. Smith is at risk of RAFF, as evidenced by his is mildly hypercapnic state with compensated respiratory acidosis and 82% oxygen saturation levels on Room Air (RA). His COOP may cause inadequate gas exchange, resulting in hyperemia and hyperplasia (Lines & Kelly 2013; Moore, 2013). Mr.. Smith's symptoms of COOP deteriorated once he was admitted to emergency. He become confused, agitated, was saturating at 84% via a Hudson mask and his arterial blood gases showed respiratory acidosis and hyperplasia, all of which are signs of RAFF (Lines and Kelly, 2013).

This suggests that Mr.. Smith is oxygen sensitive, and was retaining CO₂ as a result of the TO. Because of this Mr.. Smith requires close monitoring and risk management while on the respiratory ward, especially while receiving TO to avoid hyperemia and hyperplasia leading to RAFF. Oxygen Therapy (TO) increases oxygen in the pulmonary capillary bed and promotes the exchange of gases in the lungs, increasing oxygen levels in the blood, while removing

carbon dioxide (CO) from the body's tissues (Health Quality Ontario, 2012; Simmons and Simmons, 2004).

If uncontrolled high concentration of oxygen is given inappropriately in COOP patients, some may retain CO, which puts them at risk of hyperplasia and respiratory acidosis (Moore, 2013; Stroller, Panics, Churchman & Moore, 2013). It is a fine line between optimal and excessive TO, therefore risk management should always be a nursing priority (Simmons and Simmons, 2004). Lines and Kelly (2013) encourage the use of pulse geometry to establish the needs of a patient with COOP before administering TO.

However they emphasize its limitations, including that false readings can occur due to poor perfusion or patient movement and its inability to detect CO in the blood. Because of this close monitoring of the patient is required for signs of Hyperplasia (Simmons and Simmons, 2004; Lines & Kelly, 2013). Moore (2013) recommends allocating those patients identified as CO retainers or those at risk of hyperplasia, an oxygen alert card to ensure all medical staff are aware that only titrated Oxygen would be administered.

The risk of rebound hypothermia is also present, where due to the sudden cessation of TO, the remaining oxygen is absorbed into the bloodstream resulting in tattletales (Lines & Kelly, 2013; Drilldown, Howard & Davison, 2008,'). Planning Phase: Goals: Mr. Smith is at high risk of developing acute hyperplasia respiratory failure. Immediate: Mr.. Smith's oxygen saturation levels will be maintained between 88-92% at all times during the next 24 hours to avoid oxygen induced hyperplasia and hyperemia leading to RAFF.

Intermediate: Mr.. Smith maintains optimal gas exchange as evidenced by normal

Abs, appears alert and responsive with no reduction in mental status. Long-term: Rater Mr. Smelt to none Neal services Tort nursing care, oxygen management and COOP rehabilitation. Abed and Hunks (2012) found that oxygen saturation levels need to be maintained between 88-92% to reduce the risk of oxygen induced hyperplasia and to avoid hyperemia. Moore (2013) agrees and adds that either 28% or 24% oxygen delivered via TO is ideal to achieve this. Although Lines and Kelly (2013) explain that it is important to realize that individuals will respond to TO differently.

Their declaration hat this is particularly important for those patients over 70 is especially relevant considering Mr.. Smith's age of 74. For this reason, an TO assessment will be performed on Mr.. Smith, using a pulse geometry device, to detect the appropriate oxygen concentration range to maintain his oxygen saturation between 88-92%. Once the assessment is complete, and in conjunction with Mr.. Smith's multidisciplinary medical team, titrating oxygen between 24-28% will be administrated via a Ventura mask. Lines and Kelly (2013), emphasis the importance of selecting the correct delivery device to administer titrated oxygen to COOP patients.

Moore agrees, explaining that a COOP patient at risk of RAFF should only be administrated oxygen via a Ventura mask, which helps to ensure the correct dose of oxygen is administered and prevents the patient rebating CO, reducing the risk of RAFF. Mr.. Smith's will be monitored closely for signs hyperplasia and hyperemia. His respiratory rate, rhythm and depth will be

taken along with observations of My Smith's respiratory effort and his color noted. His oxygen saturation levels will be measured and recorded every 30 minutes using a pulse geometry device to ensure they stay teen 88-92% over the 24-hour period.

These measurements will also be used to determine the success of these interventions in meeting the nursing goal. Planned nursing care to meet these goal include monitoring Mr.. Smith's vital signs and cardiac rhythm. Initial signs of hypoxia and hyperplasia indicate an increase in Blood Pressure (BP), respiratory and heart rate. If either of these conditions progress in severity, BP might drop, a rapid heart rate with arrhythmias endures and respiratory failure may result in Mr.. Smith being incapable of sustaining the rapid respiratory rate.

Tachycardia, BP changes and dysphasia can reflect systemic hyperemia on cardiac function. Maintain Mr.. Smith's airway potency by teaching " huff" coughing techniques to effectively loosen mucus and secretions, reducing fatigue and conserving energy (Brown et al. , 2012). A fluid intake of 2-AL per day will be maintained to keep secretions thin and easy to expectorate. Position Mr.. Smith with proper body alignment elevating head of bed to at least 45 degrees. Oxygen delivery and work of breathing may be improved by upright position decreasing the risk of airway collapse, and dyspepsia. Mr..

Smith will be assessed for any change in behavior or orientation. Early indications of hypoxia include restlessness and anxiety, worsening Arterial Blood Gases (Abs) accompanied by confusion are signs of cerebral

dysfunction. Monitor and investigate changes and assess color of skin and mucous membranes. Indications of cyanogens can be observed peripherally (in nail beds) or centrally (around lips/or earlobes). Signs of advanced hyperemia include darkness Ana central cyanogens. I en respiratory status Ana level AT consciousness AT Mr.. Smith will be assessed every 1 to 2 hours until stable, then at least every 4 hours.

Hyperplasia is caused by low oxygen saturation, symptoms of this include confusion and anxiety and decreased respiratory rate (Brown et al. , 2012). Worsening Abs accompanied by confusion are indicative of cerebral dysfunction due to hyperemia. Mr.. Smith's response to oxygen therapy will be monitored closely oxygen including saturation, sputum consistency, and respiratory rate. Monitor Abs and note any changes, signs of respiratory failure are increasing Apace and decreasing Papa. If this occurs the respiratory rate will decrease and Apace will begin to rise (Kananga, Ninja, Sahara, 2009).

Patients with COOP have a substantial decrease in pulmonary reserves, and any physiological stress may result in acute respiratory failure. Maintain oxygen administration device as ordered, attempting to preserve oxygen saturation at 90% or greater provides adequate oxygenation (Mckenzie & Firth, 2003). Close monitoring is crucial to prevent dangerous increases in the patient's Papa. Administering a high concentration of oxygen to COOP patients should be avoided, as hypoxia stimulates the drive to breathe in chronic CO retainer patients.

Close monitoring is essential to prevent unsafe increases in the patient's Papa, as apneas may occur. Mr.. Smith will be assisted with ambulation, to promote lung expansion, stimulate deep breathing and assist with clearance of mucus and secretions (Hurst, Headache, 2009). Scheduled rest periods and paced activities following treatments and procedures will prevent fatigue. Simple activities during bed rest such as coughing exercises and bathing can cause fatigue and increase oxygen consumption. Deep breathing should be encouraged, reducing alveolar collapse.

Administer medications as ordered and provide mouth care after inhalers. An evaluation of the goals set out should involve observations of Mr.. Smith's ability to cough and deep breathe effectively. Calculate the lungs for adventitious sounds and assess respiratory rate and hydration. Observe color and consistency of sputum and note on the Fluid Balance Chart (Crisp & Taylor, 2008). Implementation Phase: Please put the information in these sections under the ' planning' title where they belong and write a small paragraph indicating that the planned care was actually carried out for Mr. Smith.

In addition, please provide a clear indication of who did what to fulfill the need to address the importance of teamwork and I will be happy to ass this section of your assignment. There is no evidence to demonstrate that these beautiful plans were carried out by the multi-professional health care team with the exception of the paragraph entitled ' expected outcomes' which is a perfect example of implementation of care - (that can stay in this section). The implementation phase usually has a focus on side effects of medication

provided and your extensive considerations related to administration of oxygen certainly achieves that.

Expect EAI outcomes: At the duration of 24 hours Mr.. Smith should demonstrate improved ventilation and adequate oxygenation of tissues with Abs within normal range and symptoms of respiratory distress should have diminished. He will participate in a nursing care plan within his level of ability and demonstrate the use of deep breathing and coughing techniques to clear expectorate and increase lung expansion and be referred to home health services for nursing care or oxygen management. Collaborative Problem: Mr. Smith is at risk of malnutrition due to complications of COOP.

Goals: Immediate: Prevent fluid volume insufficiency and electrolyte imbalance. Intermediate: Consume a high-energy diet and encourage regular eating and rest tatters. Long- term: Consult with dietician in order to plan and implement dietary regime upon discharge. Mr. Smith will be weighed each day to assess nutritional status and determine caloric needs, set weight goal, and evaluate an adequate nutritional plan. Evaluate Body Mass Index (IBM) to assess dietary habits and monitor amount of fluid and food ingested to determine efficiency of intake.

Medications can interfere with the body's absorption of nutrients and loss of appetite can be attributed to lack of taste, or being too fatigued to chew, swallow and/or breathe (Mckenzie & Firth, 2003). Calculate Mr.. Smith for bowel sounds. Hypoactive or diminished bowel sounds may indicate a decrease in gastric motility and constipation related to reduced fluid intake, decreased activity, poor food choices, and hyperemia. Remove expectorated

secretions promptly and provide oral care prior to meals to moisten and clean the mouth and sputum taste.

Noxious tastes, odors, and smells are major deterrents to appetite and can provide a stimulus for nausea and vomiting causing respiratory exertion (Brown et al. , 2012). Select nutritional supplements to provide nutritional between-meal snacks. Provide Mr.. Smith with high protein, high-energy nutritious snacks and drinks that contain adequate energy and protein, and that require minimal effort to consume. Mr.. Smith will be encouraged to rest for a period of 1 hour before and after meals to reduce fatigue during mealtime, and create an opportunity to increase his total calorie intake (Epidermal, 2013).

Eating requires energy and more oxygen will be consumed than at rest. Administer supplemental oxygen during meals as indicated. Oxygen must be administered via a different method during mealtime (e. G. , changing mask to a nasal cannula) decreasing the risk of dyspepsia and increasing energy for eating, enhancing intake. Immediately after meals the original oxygen delivery system should be resumed. Carbonated beverages and gas-producing foods should be avoided; abdominal distension may result, which hinders abdominal breathing and diaphragmatic movement increasing the risk of dyspepsia.

Mr.. Smith will not be given very cold or very hot foods as coughing spasms may be aggravated by extremes in temperature (Brown et al. , 2012). Refer a dietician to provide Mr.. Smith with appropriate information regarding nutritional needs and how to meet them, ensuring nutritional adequacy after

discharge. Evaluation Phase: Evaluation of the 19 actions you planned for Mr. Smith is not valued here. Provision of such clarity ensures that no aspect of patient care gets overlooked which really improves efficiency and the effectiveness of care provision.

The planning and implementation of these nursing interventions was deemed a success due to all goals being achieved. Over a period of 24 hrs Mr. Smith's oxygen saturation levels were measured and recorded every 30 minutes at a level of 88-92%. Over the next day he appeared to remain alert and responsive which indicated optimal gas exchange via oxygen therapy. At the end of 72 hours Mr. Smith's condition was stable and he was discharged and referred to home health services for urgent care and oxygen management for further education and COOP rehabilitation.

His fluid volume and electrolytes were increased and he consumed a high-energy diet and met with a dietician to plan and implement a dietary regime upon discharge. Due to his responsiveness to the planning and implementation of this nursing process, it proves that this was effective as his condition improved. Upon discharge from hospital, Mr. Smith is at risk of readmission due to the chronic of his COOP. One area identified to reduce this risk is health promotion and education through access to comprehensive pulmonary rehabilitation (Assignations, Workman, 010).

Pulmonary rehabilitation is one of the most successful interventions in COOP, enhancing health-related quality of life and self-efficacy, and reducing depression and anxiety, dispensed and the possibility of future hospitalizing (Engel, 2012). Rehabilitation incorporating exercise programs, education and

psychosocial support can provide the greatest benefits firstly by improving cardiovascular fitness, muscle strength and exercise endurance leading to improved functional status and reaching symptoms of COPD; enhancing Mr.

Smith's self-confidence and coping strategies, and improving medication adherence and use of respiratory treatment devices; and lastly by enlightening mood by controlling anxiety and panic, diminishing depression, and reducing social barriers (Squadron, Mandarin, 2009). Mr. Smith and his family will be advised of support groups providing emotional support, social outlets and interaction, new knowledge and coping strategies. These strategies have been administered upon discharge to enhance Mr.

Smith's quality of life and reduce the risk of any further complications resulting from COPD and future hospital admissions. In conclusion, the first priority for Mr. Smith is to maintain adequate oxygen levels via the administration of O₂ therapy and close monitoring of his vital signs and other interventions to maintain optimal breathing and airway clearance. The second priority is to enhance his nutritional intake to encourage increased energy levels needed for function and to restore energy levels diminished by factors relating to his COPD.

Thirdly a plan for post discharge care and support is required for Mr. Smith and his family, to enhance his quality of life and reduce the risk of COPD exacerbation and re-admission to hospital. In relation to your reference list Dates Tort Bases and Burt & Cordage onto tally between the body of the assignment and reference list. Brown et al; (2012), Discoid; (2008) and Stroller, Panics, Karachi & Moor, (2013) don't appear in your reference list.

Stroller, Pens, Churchman, Doherty & Make (2010) don't appear in the body of your assignment.