9. The Client with Pneumonia

Nursing Diagnosis 1: Impaired Gas Exchange related to presence of infectious exudate in the left lower lobe of the lung.

The expected outcome is...

Mrs. Johnson, 72-year-old, complains of a persistent cough and an occasional pain to her left chest associated with coughing, fever, and shortness of breath. Prior to this admission, she has been healthy and independent.

Data clues indicate

Your objective assessment data includes

Assessment data lead to secondary

Nursing Diagnosis 2: Imbalanced Nutrition: Less than Body Requirements related to decreased oral intake and increased metabolic requirements.

The expected outcome is...

Mrs. Johnson reports that she has not been eating as much as she usually does.

The client will:

- Report relief of dyspnea.
- Demonstrate return of respiratory rate to 20/minute or less and heart rate to 100/minute or less.
- Be able to speak comfortably.

Nursing intervention and rationale include

1. Teach client effective techniques for coughing, such as sustained maximal inspiration and "huffing." Increases the clearance of exudates.
2. Assist with chest physiotherapy and postural drainage as indicated. Promotes the clearance of exudates by using gravity, percussion, and vibration of the chest wall.
3. Humidify inspired oxygen, and encourage oral fluid intake. Promotes liquefaction of pulmonary secretions, which facilitates expectoration.
4. Encourage client to be on right side while in bed. Positioning with the unaffected lung down provides the best match of ventilation and perfusion.
5. When assessing for dyspnea, do so not only with the client at rest but also during activities such as talking, eating, and moving. Clients who appear to be breathing comfortably at rest may become dyspneic with minimal activity.

ASSESSMENT DATA
Respiratory and Cardiac Symptoms:
- Dyspnea (subjective)
- Tachypnea
- Tachycardia
- Cough
- Chest pain (subjective)
- Fever
Her respiratory rate is 28 breaths/minute. Her pulse is 100 beats/minute and regular. Blood pressure is 140/90 mm Hg. Skin warm, dry, and pale pink with brisk capillary refill. No edema. She is receiving oxygen by nasal cannula at 6 L/minute. Decreased oral intake.

Success of nursing interventions can be measured by...

- A visible increase in the client's comfort and ease of speaking and a decreased effort at the work of breathing.
- The client will report that dyspnea has been relieved and will have respiratory and heart rates within the normal range. Ongoing evaluation will be needed to monitor client's weight to ensure that intake is adequate to meet client's caloric requirements.
- Improved respiratory and cardiac symptoms.
- Increased oral intake.

Success of nursing interventions can be measured by...

1. Provide oral care after coughing, after respiratory treatments, and before meals. Coughing and the expectoration of secretions can create an unpleasant taste in the mouth, which interferes with appetite.
2. Assess fluid intake and provide supplements if intake is insufficient to meet caloric needs. Dietary supplements may provide increased calories and nutrients.
3. Encourage liberal fluid intake. Clients with fever and dyspnea lose excess body fluids through the skin and lungs. Adequate hydration will help liquefy pulmonary secretions and prevent decreases in circulating blood volume. Always check for contraindications such as heart failure, kidney disease, or a physician-ordered fluid restriction before encouraging increased fluids.
4. Weigh daily. Monitor progress to goal so that plan can be modified as needed. Daily gains or losses in excess of 1 pound are often due to fluid balance alterations. Slower gains or losses may be due to nutritional alterations.

KEY

1. Expected Outcome
2. Interventions and Rationales
3. Evaluation

Case Scenario
Assessment Data
Nursing Diagnosis Prioritized as 1, 2, etc.