Part #2 Nursing Diagnosis/Problem, Goal, Interventions, Evaluation (10%)

The assignment includes completion of:

1: **One Nursing Diagnosis/Problem**

Select a priority problem from the problem area identified in part 1, and write one nursing diagnosis/problem statement.

List the signs and symptoms that support your choice of priority problem.

2. One short term SMART Goal/expected Outcome

Write one SMART nursing goal/expected outcome for the nursing problem. This is a measurable statement of accomplishment that may be related to physical health or areas that need improvement for your client.

3. Four Nursing Interventions with cited rationale

Write a minimum of 4 appropriate interventions

The interventions are nursing actions (treatments, behaviours, activities and therapies) that nurses perform independently on behalf of clients or in collaboration with other health care professionals. These are individual steps to help achieve the client outcome (goal).

Provide 'evidence based' rationale to support and validate each intervention chosen. Use APA format for all evidence-based rationale supporting the chosen intervention.

4. Evaluation

Reflect on the effectiveness of interventions and the client's progress to achieve the outcome.

Do you believe the interventions would be effective in achieving the client outcome? Because you cannot truly evaluate the outcome it will be important to provide an explanation about what, when and how would you evaluate the nursing interventions?

Nursing Care Plan Part #2 Worksheet (10%)

- Nursing diagnosis/problem
- 1 Short term goal
- 4 nursing interventions with cited rationale
- Evaluation

Nursing Diagnosis/Problem: Review the priority cluster and select the priority nursing diagnosis/problem.

1. In order to select a priority problem and write one nursing diagnosis statement follow these steps:

Look in the Lewis Med/Surg textbook for your original medical diagnosis.

For Morrie Flack it was COPD.

There will be information in the text and/or a care plan with a list of nursing diagnoses/problems.

Then you need to go back to part 2 and look at the priority problem area you chose from your assessment data.

I chose Respiratory for Morrie Flack.

Possible nursing diagnoses for COPD related to respiratory included:

a. Ineffective breathing pattern r/t body position that inhibits lung expansion, fatigue, respiratory muscle fatigue as evidenced by the use of three-point position, pursed lip breathing, use of accessory muscles to breathe

b. Ineffective airway clearance r/t excessive mucus, retained secretions as evidenced by ineffective cough, absence of cough, diminished breath sounds

c. Impaired gas exchange r/t alveolar hypoventilation as evidenced by a headache on awakening, PaCO2 >45 mm Hg, PO2 <60 mm Hg, or SaO2 of < 90% at rest

etc.

Firstly, I underlined the signs & symptoms in the diagnoses that match my assessment data.

a. Ineffective breathing pattern r/t body position that inhibits lung expansion, fatigue, respiratory muscle fatigue as evidenced by the use of three-point position, pursed lip breathing, use of accessory muscles to breathe

b. Ineffective airway clearance r/t excessive mucus, retained secretions as evidenced by ineffective cough, absence of cough, diminished breath sounds

c. Impaired gas exchange r/t alveolar hypoventilation as evidenced by a headache on awakening, PaCO2 > 45 mm Hg, PO2 <60 mm Hg, or SaO2 of < 90% at rest

I can see that most of the signs & symptoms match the diagnosis of Impaired gas exchange.

2. List the signs and symptoms from your data collection that support the chosen diagnosis/problem.

1. Headache on awakening
2. $PaCO_2$ > 45 mm Hg
3. PO_2 <60 mm Hg
4. SaO_2 of < 90% at rest
5. Although there is not a 5th sign and symptom from the diagnosis we know from the outcomes section of the diagnosis that decreased dyspnea is also a problem, which Morrie has.

Priority Nursing Diagnosis/Problem Statement:

Impaired gas exchange r/t alveolar hypoventilation as evidenced by a headache on awakening, $PaCO_2$ >45 mm Hg, PO_2 <60 mm Hg, or SaO_2 of < 90% at rest

Short Term SMART Goal/Expected Outcome:

Once you chose your nursing diagnosis there will be information on goals/outcomes and interventions in the book.

Outcomes/goals included:
Has $PaCO_2$ of 35-45 mm Hg or usual compensated baseline value
Experiences return of PaO_2 to normal range for patient
Reports improved mental status
Reports decreased dyspnea

I chose the outcome/goal
Reports decreased dyspnea
This should be written as a SMART goal

Morrie will report decreased dyspnea when attending to ADLs within 48 hours.

Nursing Interventions:

Identify four appropriate Nursing Interventions with cited rationale.

Next is the choosing of nursing interventions. There are many to choose from in the textbook. Make sure you choose appropriate ones for your case study. And for your client's goal.
You must provide a rationale (reason) for each intervention you have chosen. You will have to

Nursing Intervention	Research-Based Rationale
1. Monitor respiratory and oxygenation status q4h	To assess need for intervention. A study demonstrated that when the resp rate exceeds 30 breaths per min significant respiratory alteration occurs (Hagle, 2008).
2. Assist patient to assume position of comfort (e.g., tripod position) as required	To maximize respiratory excursion. Leaning forward can help reduce dyspnea (Langer et al, 2009).
3. Administer and teach appropriate use of bronchodilators as ordered	To open the airways (Lewis et al, 2019).
4. Teach signs, symptoms and consequences of hypercapnia (e.g., confusion, somnolence, headache, irritability, decrease in mental acuity, increase in respiration, facial flush, diaphoresis)	To recognize problem and initiate treatment. Changes in behaviour and mental status can be early signs of impaired gas exchange. In the later stages the client becomes lethargic and solmnolent (Burns, 2011).
5. Teach avoidance of central nervous system depressants	Because they further depress respirations (Spruit et al, 2013)

Evaluation: Because you cannot truly evaluate the outcomes it will be important to provide

an explanation about what, when and how would you evaluate the nursing interventions.

1. Check respiratory and oxygenation status to ensure adequate oxygenation q4h.

2. Assist to position of comfort as required. Will assess comfort with each patient check.

3. Administer and teach appropriate use of bronchodilators. Will administer bronchodilator as needed. Will monitor inhaler technique and teaching around identifying need for inhalers.

4. Teach signs, symptoms and consequences of hypercapnia (e.g., confusion, somnolence, headache, irritability, decrease in mental acuity, increase in respiration, facial flush, diaphoresis) and observe for symptoms on each patient check.

5. Teach avoidance of central nervous system depressants when administering medications and monitor respiratory status on each patient check.

Use the care plan template below to put your final care plan together.

Assessment Data	Nursing Diagnosis/Problem	Short Term Goal/Outcome	Nursing Interventions	Rationale	Evaluation
1. Headache on awakening 2. PaCO2 > 45 mm Hg 3. PO2 <60 mm Hg 4. SaO2 of < 90% at rest 5. Dyspnea	Impaired gas exchange r/t alveolar hypoventilation as evidenced by a headache on awakening, PaCO2 >45 mm Hg, PO2 <60 mm Hg, or SaO2 of < 90% at rest	Morrie will report decreased dyspnea when attending to ADLs within 48 hours.	1. Monitor respiratory and oxygenation status	1. To assess need for intervention. A study demonstrated that when the resp rate exceeds 30 breaths per min significant respiratory alteration occurs (Hagle, 2008).	1. Check respiratory and oxygenation status to ensure adequate oxygenation q4h.
			2. Assist patient to assume position of comfort. (e.g., tripod position).	2. To maximize respiratory excursion. Leaning forward can help reduce dyspnea (Langer et al, 2009).	2. Assist to position of comfort as required. Will assess comfort with each patient check.
			3. Administer and teach appropriate use of bronchodilators	3. To open the airways (Lewis et al, 2019).	3. Will administer bronchodilator as needed. Will monitor inhaler technique provide and teaching around identifying need for inhalers.
			4. Teach signs, symptoms and consequences of hypercapnia (e.g., confusion, somnolence, headache,	4. To recognize problem and initiate treatment. Changes in behaviour and mental status can be early signs of impaired gas	4. Teach signs, symptoms and consequences of hypercapnia (e.g.,

			irritability, decrease in mental acuity, increase in respiration, facial flush, diaphoresis)	exchange. In the later stages the client becomes lethargic and solmnolent (Burns, 2011).	confusion, somnolence, headache, irritability, increase in respiration) and observe for symptoms on each patient check.
			5. Teach avoidance of central nervous system depressants	5. Because they further depress respirations (Spruit et al, 2013)	5. Teach avoidance of central nervous system depressants when administering medications and monitor respiratory status on each patient check.

Part 2 is now complete