

BABA SCHOOL OF

NURSING

MEDICAL

NURSING CARE PLAN

ON

ASTHMA

SUBMITTED TO

MRS. IRENE MA'AM

TUTOR

Baba school of
Nursing

SUBMITTED BY

SHALU KUMARI
B.N.M^{II}nd ^{Yr}

Baba school of
Nursing

24/7/19

Good

SUBMITTED ON

24 | 07 | 19

IDENTIFICATION DATA

Name	Mr. Rakesh Mishra
Age	45 yrs
Sex	male
Religion	Hindu
Occupation	Teacher
Income	30,000 Rs/month
Marital status	married
Address	Chinhati, Lucknow
Bed No	2
Ward No	Seven
Registration No	3251
Date of Admission	8/04/19
Diagnosis	Asthma
Doctor concerned	Dr. Emnam Khan
Date of discharge	15/04/19
Name of Hospital	Dr. Ram Manohar Lohia Hospital, L.P.

CHIEF COMPLAINT'S

Msr. Rakesh Mishra is admitted in the Lohia hospital with chief complaints of -

- Dyspnea
- Restlessness
- Coughing
- Weakness
- Anorexia

MEDICAL HISTORY

Present medical History :- Msr. Rakesh Mishra is admitted in the Hospital with the Present medical History of -

- Cyanosis, chest tightening, wheezing sound
- Thick sputum

Past Medical History :- Msr. Rakesh Mishra is admitted in the hospital with the Past medical History of .

- Shortness of breath, Anorexia, Diaphoresis
- Weakness

Surgical History

Present Surgical History :- there is no any evidence of present surgical history

Past Surgical History :- there is no any evidence of past surgical history

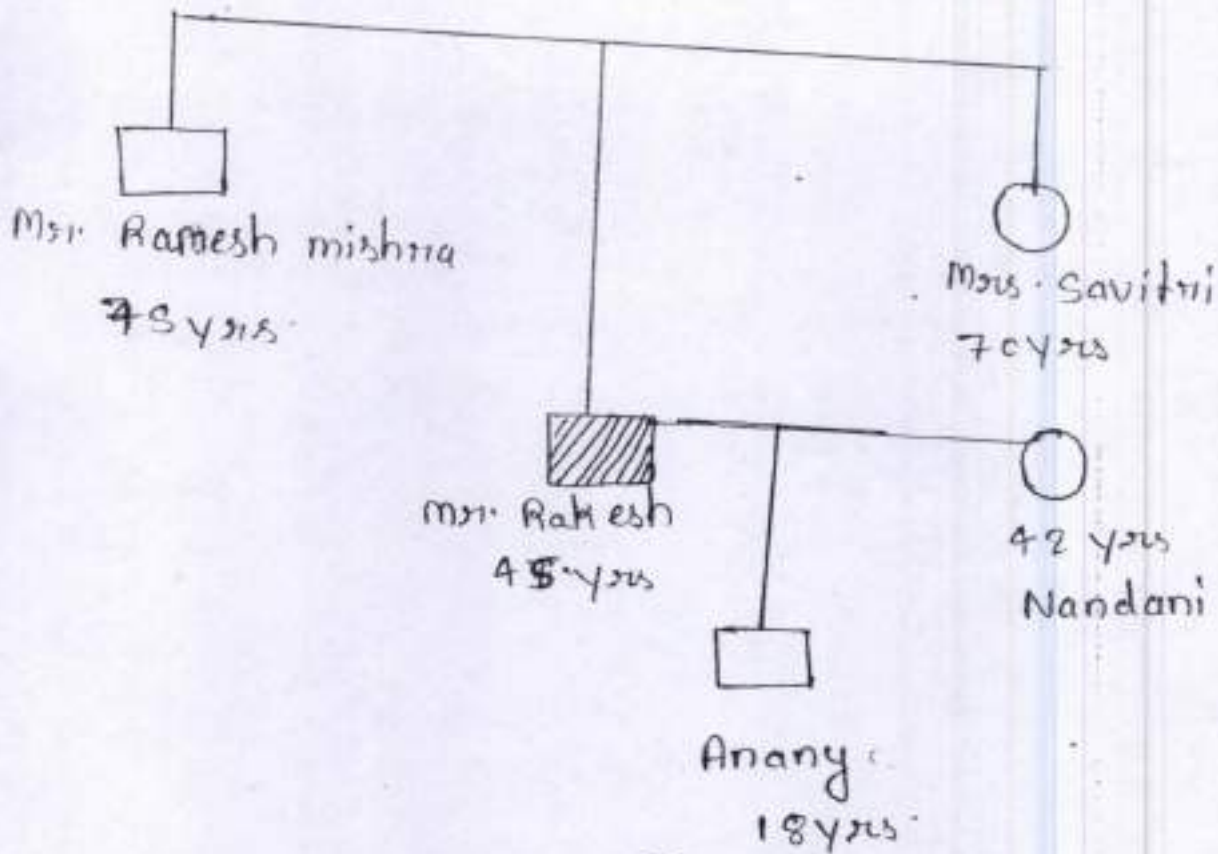
PERSONAL HISTORY

my pt is a non-vegetarian his personal history is good and his bowel and bladder pattern is abnormal and his sleep pattern and bad habits like smoking is present

FAMILY HISTORY :-

my pt's family member is consist of five members and there are no any type of communicable disease like cholera, malaria and etc. It is a nuclear family and they are healthy except Mr. Rakesh Mishra

FAMILY TREE :-



FAMILY CHART

Name	Relation with Pt	Age	Sex	Education	Occupation	Health Status
Ramesh Mishra	Father	75y	male	12th pass	employees	Healthy
Savitri	Mother	70y	female	8th pass	Housewife	Healthy
Rakesh	Patient	45y	male	B.A pass	Teacher	unhealthy
Nandani	wife	42y	female	12th pass	Housewife	Healthy
Anany	Son	18y	male	12th pass	student	Healthy

ENVIRONMENTAL HISTORY

My Patient lives in his own home. there are facility of water supply and electricity and drainage are open and there is the facility of toilet

SOCIO-ECONOMIC HISTORY

My Patient is a farmer and his family monthly income is 30,000 Rs/month. they belong to middle class family.

PHYSICAL EXAMINATION

1. General Appearance :-

Nourishment - Nourished

Body build - Normal

Hygiene - Good

Health status :- unhealthy

Activity :- Dull

2. Mental status :-

Consciousness :- Conscious

Look :- worried

3. Posture :-

Body curves :- Normal

movement :- Normal

Height :- 5 feet

Weight :- 65 kg

4. Head and face:-

Hair colour - Black

Scalp:- clean

Face:- Pale

shape:- Normal

Hair condition - Loss of hair

5. Eye:-

eyebrows:- Normal

eyelashes - Infected

eyelids - Normal

eyeballs - Symmetrical

conjunctive - yellowish

Sclera - Normal

Pupils - constricted

Lens - Normal

vision - Normal

6. Ear:-

External ear - No any discharge present

Tympanic membrane - No Pain

Hearing:- Hearing capacity is Normal

7. Nose:-

External Nose:- No discharge

Nostrils:- No inflammation of membrane

- Lips: - Dry
- Teeth - No discoloration
- Tongue - Normal
- Throat and Pharynx - Redness
- mucus membrane: - Swelling is present

9. Neck: -

- Lymph Node - Enlarge
- Thyroid gland: - Enlarge
- Range of motion: - Normal

10. Chest: -

Inspection: - Shape of thorax - Normal

Auscultation: - Breath sound - Normal

Palpation: - Normal

Observation: - Colour of skin - Pale

~~Nipple size - 2cm~~

Aeneola - Black

11. Abdomen: -

Observation - weakness

Palpation - Pain abdomen

Percussion - enlarge liver, spleen

Auscultation - Abnormal bowel sound

12. Extremities: -

Extremities and movement of joint
is Normal



13. Back: -

No bed sore and any type of spinal cord is present

14. Genital & Rectum: -

Potency of urine - Normal

Genital sore - absent

Haemorrhoids - absent

Rectal Prolapse - present

15. Neurological Test: -

It is the assessment of sensory neuron and motor responses especially reflexes

VITAL SIGN'S

S.No	vital signs	Normal Range	Patient's value	Remarks
1.	Temperature	98.6°F	102°F	Abnormal
2.	Pulse	72-80bt/min	80bt/min	Normal
3.	Respiration	16-20br/min	24br/min	Abnormal
4.	Blood Pressure	120/80 mm of Hg	140/90 mm of Hg	Abnormal

S.No	Drug Name	Pharmaceutical Name	Frequency	Dose	Action	Contraindication	Indication	Side effects	Nurses' Risk
1	Salbutamol sulphate.	Ambudrol	Mouth TDS	2.5 mg-5mg in a single dose	Salbutamol is a beta-2 adrenergic agonist and it relaxes adenosine monophosphate cycle cause relaxation of bronchial smooth muscles	Hyper-sensitivity of the pt	<ul style="list-style-type: none"> wheezing Shortness of breath Asthma chronic obstructive pulmonary disease Broncho-constrictors 	<ul style="list-style-type: none"> Nervousness Tremors Headache dizziness Shaking Chest Pain Allergic reaction 	<ul style="list-style-type: none"> Review the lung sound and Blood Pressure and heart rate prior to use and during use of drug

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S.No	Drug Name	Pharmacology	Formulation	Dose	Action	Contraindications	Indication	side effect	Nursing points
1	Theophylline	methylxanthine	oral BD	2.5mg	It is act on smooth muscles relaxation and suppression of the response of the airway to stimuli	Hypothyroidism diabetes cystic fibrosis alcoholism Heart attack	Asthma Broncho spasm COPD Long disease	convulsions Diarrhoea Allergic Reaction Sleeplessness Increased urination frequency Elevated liver enzyme	Nausea irritates the Hypersensitivity to any drug and other any severe Severe

NURSING DIAGNOSIS

Impaired Gas exchange related to Asthma as evidence by shortness of breath, restlessness

Anxiety related to asthma as evidence by restlessness

Fluid and electrolyte imbalance related to asthma

Nutritional level is less than requirement related to asthma

Restlessness and Insomnia related to asthma

Assessment	Nsg dx's	Goal	Nsg Intervention	Rationals	Implementation	evaluation
Subjective data pt. says that he feels breathing difficulty	Ineffective breathing pattern related to impaired gaseous exchange	To maintain breathing pattern of the pt	1) Assess the general condition of the pt 2) check the vital sign	1) st help to collect the information about pt condition 2) st help to the pt general condition	1) Assessed the general condition of the pt 2) checked the vital sign of the pt	New, the patient condition is improve to some extent
objective data on my observation pt's seems to be in anxious and discomfort	gaseous exchange are evidence by discomfort		3) Provide comfortable position 4) Provide high Fowler position 5) Provide medication as prescribed by physician	1) Pt's feel relax 2) To improve breathing pattern 3) It is used to relieve suffocation	3) Provided comfortable position 4) Provided high Fowler position 5) Prescribed medication to the pt	


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Assessment	Nsg diagnosis	Goal	Nsg Intervention	Rationale	Implementation	Evaluation
<p>Subjective data Pt complains that he feel anxious</p> <p>Objective data: on my observation pt seems to be in discomfort</p>	<p>Anxiety related to disease condition as evidenced by discomfort</p>	<p>To reduce anxiety of the patient</p>	<ol style="list-style-type: none"> 1) Assess the general condition of the pt 2) check the vital sign 3) Provide comfortable position 4) Provide calm and quite environment to the patient 5) Provide Psychological Support 	<ol style="list-style-type: none"> 1) st help to collect the information about pt condition 2) st help to know the pt general condition 4) pt is feel relax 5) pt is relief of scared 	<ol style="list-style-type: none"> 1) Assessed general condition of the pt 2) checked vital sign 3) Provided comfortable position 4) Provided calm & quite environment 5) Provided Psychological Support 	<p>New, the patient condition is improved to some extent</p>

Assessment	Nsg Diagnosis	Goal	Nsg Intervention	Rationale	Implementation	Evaluation
<p>Assessment Subjective data Pt is complains that he feels very weakness and fatigue</p>	<p>Activity intolerance related to imbalance or below o₂ Supply</p>	<p>Increase in activity tolerance</p>	<p>1) Assess the baseline data of the pt 2) check the vital signs before and after activity</p>	<p>2) To know the general condition of the pt 2) Fatigue is the side effect of some drugs</p>	<p>1) Assessed the baseline data of the pt 2) checked the vital sign of the pt 3) Assessed the other precipitatory or causes of fatigue eg - Pain</p>	<p>New Patient Condition to enter</p>
<p>Objective data: on my observation Patient look dull, anxious and weak</p>			<p>3) Assess the other causes of the fatigue eg - Pain</p>	<p>3) Pain and stressful energy and produce fatigue</p>		

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SUMMARY

Asthma is a chronic disease involving the airways in the lungs. These airways or bronchial tubes, allow air to come in and out of the lungs. This makes it difficult for air to move in and out of the lung, causing symptoms such as coughing, wheezing, shortness of breath and / or chest tightness.

CONCLUSION

Asthma is an important chronic disease resulting in clinically significant morbidity, missed days of work or school, substantial costs for emergency care and hospitalization and sometimes death. Current therapy can control asthma and may prevent development of irreversible airway changes in asthmatic patients.

Date - 13/02/2020

7- Questions

(i) Definition—: Nursing define as
act of utilizing
the environment of the
patient to assist him in
his recovery.

(ii) Characteristic of profession

- It should be self governing.
- Service orientent.
- It should promote development
personal and economic security
for its member.
- Extended education to its
members as well as basic level
education.
- Theoretical body of knowledge
level

(iii) Concept of nursing :-

The word
nursing comes from the word
nurtitious means nourish to
cherish to protect to support
to sustain it. also means, etc.

Learn to educate to supply the essentials of growth.

According to Coit and Spalden →

nursing is the science and art dominated by social services. It is a science as it is based on scientific principles of medical and health sciences and art as it combines intelligent observation skill communication skill and provide services in a fine manner for care of the indigent.

2-

3-

2. Question - (i)

Definition (Fever) → Fever or pyrexia is defined as the rise in body temperature above 99°F (37.2°C).

4-

(ii) Types of fever.

- 1- Constant or continuous fever :- A continuous fever is one in

which the temperature rises and more than 2°C between morning and evening, but the temperature does not come to normal during the day.

2- Remittent fever :- The variation is more than 2°C between morning and evening but fever does not reach normal.

3- Intermittent fever :- An intermittent fever shows large variation that is the temperature rises from normal to high temperature and comes down at regular intervals. The temperature may vary from just above to 4°C or more day.

4- Inverse fever :- Highest temperature is in the morning and lowest in the evening.

5- Relapsing fever :- This case
short febrile
periods followed one or more
days of normal temperature.

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Evolution (Herrick)

Pathology (Parsons)

Immunology (Herrick)

Pharmacology

Genetics

Neurology (Parsons)

Pathology

3 Ques - (i) Hospital.

2-

(a) Definition → Hospital is a place where we allow the patient to stay in the hospital for his treatment.

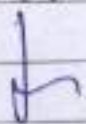
(c) Admission procedure :-

- (i) Receive the patient carefully identify the patient with the admission card check the advance stage and with the id to be admitted make a patient with comfortable.
- (ii) prepare the patient card with all necessary information like name hospital number unit ward in each separately.
- (iii) Check the patient weight with sign and record in.
- (iv) Give the history and give a simple physical examination.

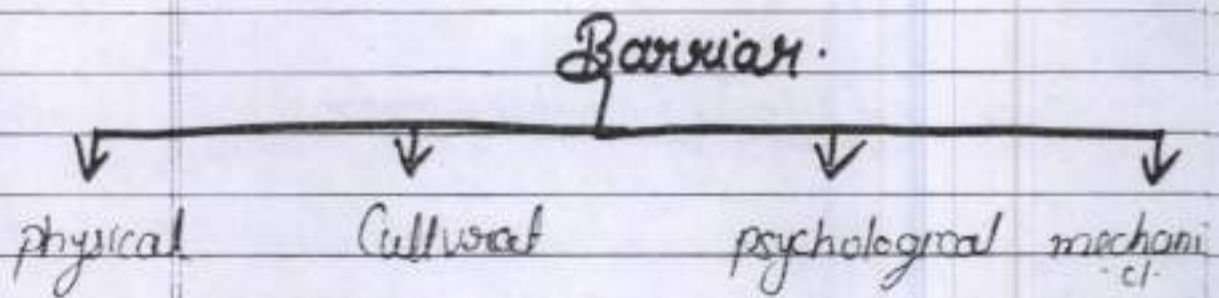
2- Ques - (i)

Code of ethics →

The code of ethics will state what kind of conduct is expected from the members of its members towards those with whom they come into contact in the profession and the society as a whole. The nurse will adjust better if we understand what exactly right means in different situations is the international code of nursing ethics was adopted by the general council of International Council of nurses at a paulo natal in 1953. It was later revised in Frankfurt Germany in 1965 and then became known as ICN code of ethics.



(i) Only -



Physical barrier:

The competing stimulus - & It become difficult to pass on the message orally if another communication giving information simultaneously within hearing distance sometime. Loud music or communication process.

Subjective stress - & Due to sleeplessness all health conjunction of drug maintel Straine etc.

2(iii) Orders -

- i) Check the doctors orders for discharge with date and signature.

- (ii) Inform the patient about the discharge.
- (iii) Fill up the discharge card with the date, time, department, from ward/facilities obtained extra provision, need for further etc.
- (iv) Send charge to relevant department for evidence if required.

2. in Outlets

Vital Signs

Introduction :- Importance of vital signs in the help sign vital include the physiological measurement of temperature, pulse, blood pressure (B.P) and respiration while sign are well efficient way of monitoring patient

condition or identifying problem
 meaning danger while sign
 influence characteristic of
 other while sign.

White sign and normal values-

- 1- Temperature 98.6 F and (37°C)
- 2- pulse 72
- 3- respiration 16-22 beat
- 4- Blood pressure 120/80

Normal body temperature

- Oral 37°C or 98.6 F
- Rectal 37.0°C or 99.6 F
- Axilla 36.4°C or 97.6 F

~~Handwritten scribble~~

(2)

1- One-(i)

Definition :- Nursing define as act of utilizing the enlightenment by the patient to access them in his recovery.

2- Characteristic of profession

- It should be self governing

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