Focused Assessment of the Lungs and Thorax

Student Name

Program Name, Institution

COURSE CODE: Course Title

Instructor Name

Month, Year

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Explanation of Assessment Conducted and Findings

First, gather data about the patient's history as it is essential to obtain before you begin your examination. According to Kelsey Young, she was at the emergency department the day before visiting the clinic for having an episode of breathing difficulty. Next is to conduct an interview and ask relevant questions regarding the complaint of the patient. As verbalized by Kelsey, "she was at school and was coughing and couldn't stop, and then her chest felt tight and she felt like she could not breathe right". As with her history, she said that it never happened before. Mrs. Young also validates that Kelsey does experience signs and symptoms such as cough in the morning, frequent colds, chest pain, and difficulty breathing. As for other relevant information about the symptoms, the patient pointed on her chest area for the exact location where her breathing feels bad and described that "her chest hurts and her breathing feels 'funny', not like normal" and her coughing "makes her chest feel funny too". For the duration, it has been occurring for a year or so, according to Mrs. Young.

Next is looking for aggravating factors that precipitate the symptoms (Tarasidis & Wilson, 2015). According to the patient, her breathing feels worse when she runs around, coughs and sneezes a lot when she plays with her new kittens, and sometimes experiences chest pain when her father smokes. Whenever she experiences these signs and symptoms, she does nothing as it usually just gets better.

Lastly, ask for any other background information such as family history and their occupational history as this may help get a better diagnosis for the patient.

You may now proceed with your physical exam by using a stethoscope to listen to the patient's breathing. Expiratory wheezes have been detected upon auscultation with normal

findings upon thorax examination. After ruling out other causes, Kelsey is diagnosed with asthma.

Plan of Care

Nursing Diagnosis #1: Inefficient respiratory pattern caused by bronchial tube swelling and spasm in reaction to inhaled allergens, as seen by coughing and trouble breathing

Nursing interventions:

• Listening to breath sounds and unusual noises like wheezes and stridor. This is because unusual sounds might signal a deteriorating condition or the onset of new problems, like pneumonia (Martin, 2020).

• Encouraging the patient to exhale with their lips pursed. Pursed lip exhalation optimizes breathing patterns by enabling fresh air to enter the lungs while removing old air.

Nursing Diagnosis #2: Activity intolerance as a result of an airway condition, as shown by fatigue and an insufficient time to play

Nursing interventions:

• During rest time, encourage activities such as silent play, reading, watching tv, and playing games. This prevents changes in respiratory status and energy loss caused by excess exertion (Martin, 2020).

• Educate parents and children about the need of conserving energy and avoiding weariness. This increases awareness of the impact of activities on breathing and the importance of rest to avoid exhaustion.

Patient Education

In this case, encouraging her dad to stop smoking is very beneficial to Kelsey. As for Kelsey, talking about removing the cats at home will be quite hard for her, but giving her options to choose another pet safer for her would be the best option.

The asthma teaching plan for Kelsey should include the following:

1. The importance of regularly taking her medications and inhalers.
2. Providing options to Kelsey in choosing a new pet instead of a cat.
3. Proper use of the inhaler and knowing when to replace it before being completely consumed.
4. Avoiding activities, food and things that trigger the attack. It is highly advisable to coordinate with the school officials about Kelsey's condition to limit her physical activities at school, especially during PE class.

The best way to help Kelsey learn all these is by reinforcement and letting her be involved in their care itself (Boulet et al., 2015). For example, in teaching how to use an inhaler, there are many fun and child-friendly videos online that can be utilized. Activity books that discuss asthma are also readily available online or in bookstores. If the child can adequately demonstrate the use of inhalers and answer your follow up questions, this is a good indicator that the child could understand the health teaching well. Monitoring the occurrence of asthma after the client education is also vital because it will help the healthcare providers know if the medical and educational intervention is effective. That said, regular follow up's should also be made.

How to Document Findings in the Medical Records

When documenting assessments and findings in a medical record, it should consist of a complete recording of a patient's clinical data, demographics, medical history, diagnoses, medications being taken, allergies, and others that are required to be in a medical record to have

systematic documentation of the patient's condition (Mathioudakis et al., 2016). A medical record should also contain medical notes done by the doctor, nurse, and other healthcare members who attended to the patient's situation. It should include records about the patient's medical history since birth. The documentation of findings in the medical records takes the following format:

- **Patient's information**: It should consist of the patient's complete name, contact number, address, patient's ID number, birth date, status, gender, marital status, race, language, name of the provider, location of care, MRN or the medical record number and all the necessary information needed. A nurse practitioner should also ask and document if there were medical history diagnoses, medications that the patient is taking, allergies, and vaccinations.
- **Chief complaint:** this includes a statement that the patient is coughing and could not breathe right.
- **History of the present illness (HPI):** this should be documented in detail.
- **Review of systems:** this includes all pertinent systems that are related to the patient's health problem. The review of systems is like an inventory of the patient's body systems to determine the signs and symptoms that the patient is experiencing. If the patient denies it, you should also document it precisely.
- **Vital signs: this** consists of the height, weight, temperature and site taken, blood pressure, respiratory rate and pulse rate.
- **Physical examination:** this includes the actual examination findings, which should also be system by system. Normal and abnormal assessments should be documented. If there is no problem with a particular body system, it should also be noted.

- **Impression**: This is the summary of findings after the thorough assessment.
- **Plan**: This consists of the treatments, tests and medications ordered by the physician, follow-up or return visit schedules if necessary and the disposition or the patient be sent after the ER.

References

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Martin, P. (2020, January 9). Nursing diagnosis for asthma: 8 nursing care plans. *Nurseslabs*. https://nurseslabs.com/asthma-nursing-care-plans/

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