9.8: Putting It All Together

**Patient Scenario**

Mrs. Charles is a 74-year-old woman admitted to the medical surgical floor with pneumonia. She has a history of right sided hemiplegia (paralysis on one side of the body) and dysphagia (difficulty swallowing) as a result of a cerebral vascular accident three years ago. Upon assessment, the patient has a RR of 22, and rhonchi in her upper lobes. Her oxygenation saturation is 89% on room air, and she is utilizing accessory muscles during respiration.

**Applying the Nursing Process**

**Assessment:** The nurse notes that the patient demonstrates tachypnea, hypoxemia, and abnormal breath sounds. She has a history of hemiplegia and dysphagia.

Based on the assessment information that has been gathered, the following nursing care plan is created for Mrs. Charles.

**Nursing Diagnosis:** Ineffective Airway Clearance related to excessive mucus as evidenced by adventitious breath sounds and alteration in respiratory rate.

**Overall Goal:** The patient will maintain patent airway at all times.

**SMART Expected Outcome:** Mrs. Charles will effectively clear secretions throughout the hospitalization.

**Planning and Implementing Nursing Interventions:**
The nurse will assess the patient's respiratory rate, rhythm, and depth of respiration. The nurse will assess and instruct the patient on the methods of appropriate cough and deep breathing. The nurse will auscultate lung fields to identify areas of worsening airflow. The nurse will elevate the patient's head of bed and encourage hydration to thin secretions. The nurse will instruct the patient regarding proper deep breathing exercises and encourage assisted ambulation to mobilize secretions.

Sample Documentation:

Mrs. Charles has ineffective airway clearance as a result of aspiration pneumonia secondary to dysphagia. The patient has rhonchi in bilateral upper lobes, decreased oxygenation, and tachypnea. In order to enhance airway clearance and mobilize secretions, the patient has received instruction to maintain fluid intake, increase ambulation, and cough and deep breathe. The patient will maintain an elevated head of bed to encourage ease of respiration and will be assessed frequently for worsening respiratory status.

Evaluation:

During the patient's hospitalization, she maintains a patent airway and effectively clears secretions resulting in improved respiratory effort and overall function. The SMART outcome was “met.”