

N311 Care Plan 3

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission 10/20/20	Patient Initials NW	Age 09/05/51 (69 y.o)	Gender Male
Race/Ethnicity Caucasian	Occupation Retired (Railroad)	Marital Status Married	Allergies Heparin- palpitations
Code Status Full	Height 6' 0' (182.9 cm)	Weight 183 lbs. (83.3 kg)	

Medical History (5 Points)

Past Medical History: Chronic Myeloid Leukemia, Diabetes mellitus, hypertension, MI, CKD stage 3, Atherosclerosis, CHF, NAFLD

Past Surgical History: Appendectomy (age 14), 3 Myocardial infarctions resulting in stents being placed, first was in 1991.

Family History: (Maternal) diabetes mellitus, (Paternal) hypertension, heart disease (Maternal Grandmother) lung cancer, (Paternal Grandfather) hypertension, diabetes mellitus

Social History (tobacco/alcohol/drugs): Patient stated: "I smoked a little less than a pack a day for 30 years, but I quit when I was diagnosed with Leukemia a few years ago". Patient reports no alcohol or drug use.

Admission Assessment

Chief Complaint (2 points): Shortness of breath

History of present Illness (10 points):(onset) On October 20th, a 69 y.o, distressed, male presented to the ED at OSF with shortness of breath. Patient stated: "I felt like I was suffocating, I couldn't inhale or exhale. I started having coughing fits and a heavy feeling in the middle of my chest" (Location and associated symptoms). Patient stated: "The pain was bad. It was about a 5/10, dull and would come and go (characteristics and duration). Patient reports that he did not try anything to ease the pain (relieving). Patient stated: "My wife talked me into going to the

hospital in Watseka where I live, but they didn't have the equipment to treat me". He was transferred to OSF Urbana. Patient had a chest x-ray done at Watseka which showed fluid around his lungs. He was admitted on 10/20/20. Patient reports this is the first time he has experienced these symptoms (treatment).

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Pleural effusion exudative

Secondary Diagnosis (if applicable): .

Pathophysiology of the Disease, APA format (20 points):

In the lungs there is pleural fluid that keeps the pleural membranes moist to prevent rubbing during respiration. Normally, the amount of fluid that enters the lungs via capillaries is equal to the amount of fluid that leaves the lungs (Capriotti, 2020). However, sometimes there is an abnormal accumulation of fluid within the pleural cavity that presses on the lungs and prevents them from inflating (Capriotti, 2020). When this occurs, it is referred to as a pleural effusion.

Pleural effusions occur when the pressure inside of the lungs (hydrostatic) is greater than the outside pressure (oncotic) causing fluid to leak out of the pleural cells and capillaries into the pleural cavity (Capriotti, 2020). There are two main classification of pleural effusions transudative and exudative. Common causes of transudative pleural effusions are collapsed alveoli in the lungs, liver failure, CHF, hypoalbuminemia, constrictive pericarditis, or peritoneal dialysis (Capriotti, 2020). Transudate fluid is non-infectious, clear, and contains a low amount of protein (Capriotti, 2020). Exudative pleural effusions are commonly caused by inflammation or infection of the lungs. They can also be caused by asbestos exposure, chylothorax, drug use,

malignancy, pancreatitis, parapneumonic causes, sarcoidosis, trauma, or tuberculosis (Capriotti, 2020). Exudate fluid is cloudy and contains a high amount of protein.

Pleural effusions affect 1.5 million people per year (Capriotti, 2020). The people most at risk for developing them are those with heart failure, bacterial pneumonia, lung cancer, pulmonary embolism, hypothyroidism, tuberculosis, rheumatoid arthritis, ovarian tumors, or lupus (“Pleural effusion, 2003). The signs and symptoms of pleural effusions are shortness of breath, increased respiratory rate, sharp chest pain, dry cough, dullness to percussion, and diminished breath sounds (Capriotti, 2020).

Pleural effusions are diagnosed by chest x-ray, CT scan and ultrasound (Capriotti, 2020). Diagnostic thoracentesis is also done which involves removing fluid from the lungs and sending it off for analysis to identify the cause of the pleural effusion (“Pleural effusion”, 2003). The treatment for pleural effusions depends on the amount of fluid in the lungs. Small pleural effusions may resolve on their own (“Pleural effusion”, 2003). Large pleural effusions are drained by inserting a needle or chest tubes into the lungs to drain the excess fluid (“Pleural effusion”, 2003). Surgery may be needed for pleural effusions that do not resolve with drainage (Capriotti, 2020). In addition to removing the excess fluid the underlying cause of the pleural effusion must also be treated.

My patient developed pleural effusion exudative because he acquired bacteria in his lungs (pneumonia). This infection caused inflammation and increased pressure on the inside of the lungs which resulted in fluid leaving the lungs and accumulating in the pleural cavity (Capriotti, 2020). This excess fluid was pressing on his lungs and heart, causing chest pain and shortness of breath. NW’s pleural effusions were classified as exudative because the fluid appeared cloudy when analyzed and they were caused by an infection (Capriotti, 2020). He is currently receiving

Omnicef twice daily to treat the bacterial infection and has bilateral chest tubes in place to drain the fluid.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Davis advantage for pathophysiology: Introductory concepts and clinical perspectives (2nd ed.). F.A. Davis.

Pleural effusion. (2003, May 23). HealthEngine. <https://healthengine.com.au/info/pleural-effusion-3>

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.4-5.80	4.71	4.23	RBCs are decreased in patients with leukemia and renal disease. Leukemia and renal disease reduce bone marrow production (Pagana et al, 2018).
Hgb	13.0-16.5	15.1	13.5	
Hct	38-50	43.5	38.8	
Platelets	140-440	256	255	
WBC	4.00-12.00	8.90	11.10	
Neutrophils	40-60	52.9	68.5	Neutrophilia occurs due to bacterial infections. My patient is currently being treated for a bacterial lung infection (Capriotti, 2020).
Lymphocytes	19-49	35.9	22.5	

Monocytes	3.0-13.0	7.9	7.0	
Eosinophils	0.0-8.0	2.1	1.5	
Bands				

Chemistry **Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal
Na-	133-144	134	133	
K+	3.5-5.1	4.0	4.2	
Cl-	98-107	98	100	
CO2	21-31	28	22	
Glucose	70-99	141	154	My patient has diabetes mellitus which causes elevated blood glucose levels. (Pagana et al, 2018).
BUN	7-25	12	28	My patient has stage 3 CKD which reduces the kidneys ability to filter out nitrogenous waste products (Capriotti, 2020).
Creatinine	0.50-1.20	1.27	1.22	My patient has stage 3 CKD which prevents the glomerulus from filtering creatinine. (Capriotti, 2020).
Albumin	3.5-5.7	4.2	3.0	Albumin levels decrease when the liver cells are affected. My patient has fatty liver disease which has reduced the livers ability to synthesize albumin (Pagana et al, 2018).
Calcium	8.6-10.3	9.8	7.8	Hypocalcemia can be caused by renal failure which prevents the kidneys from synthesizing vit D which helps absorb calcium (Pagana et al, 2018).

Mag	1.6-2.6	n/a	n/a	
Phosphate	n/a	n/a	n/a	
Bilirubin	n/a	n/a	n/a	
Alk Phos	34-104	113	n/a	Increased levels indicate liver damage. My patient has fatty liver disease which has caused alk phos to leak into the blood (Pagana et al, 2018).
Troponin	0.000-0.040	0.030	0.031	

Urinalysis **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity			n/a	Urinalysis not done for NW
pH			n/a	
Specific Gravity			n/a	
Glucose			n/a	
Protein			n/a	
Ketones			n/a	
WBC			n/a	
RBC			n/a	
Leukoesterase			n/a	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	Negative	n/a	
Blood Culture	n/a	n/a	n/a	
Sputum Culture	n/a	n/a	n/a	
Stool Culture	n/a	n/a	n/a	

Lab Correlations Reference (APA): normal values obtained from EMR

Capriotti, T. (2020). Davis advantage for pathophysiology: Introductory concepts and clinical perspectives (2nd ed.). F.A. Davis.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference (Fourteenth edition. ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Histoplasma serum antigen test was done on 10/24/20. Results came back on 10/29/20. Negative for histoplasmosis.

Body fluid, fungus silver stain was done. Results were negative for pneumocystis jiroveci.

Negative for pneumocystis.

Bilateral chest tubes were placed on 10/22. X-ray was done on 10/23 which revealed bilateral pleural effusions. No pneumothorax noted.

On 10/24, a single chest x-ray was done which revealed a small (less than 5%) apical pneumothorax on the right lung, small bilateral pleural effusions containing patchy infiltrates, and atelectasis on the lower lungs bilaterally.

Echocardiogram showed mild mitral valve regurgitation, mild aortic valve regurgitation, and mild tricuspid regurgitation. Impression- small pericardial effusion present, pleural effusion, large bilateral pleural effusion, lipomatous hypertrophy is present.

Abdominal ultrasound revealed small amount of fluid (ascites) on abdomen, mild plaque disease in the aorta, and thickened bladder walls. Impression- fatty change in liver and small amount of ascites.

**Current Medications (10 points, 2 points per completed med)
*5 different medications must be completed***

Medications (5 required)

Brand/ Generic	Lopressor/ Metoprolol tartrate	Atorvastatin calcium/ Lipitor	Clopidogrel bisulfate/ Plavix	Cefdinir/ Omnicef	Dasatinib/ Sprycel
Dose	100 mg	40 mg	75 mg	300 mg	100 mg
Frequency	Once daily	Once daily	Once daily	Twice daily	Once daily
Route	Oral	Oral	Oral	oral	Oral
Classification	Antihypertensive	Antihyperlipidemic	Platelet Aggregation inhibitor	antibiotic	Antineoplastic
Mechanism of Action	Inhibits stimulation of beta1-receptor sites, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. Also helps reduce blood pressure by decreasing renal release of renin.	Reduces plasma cholesterol by inhibiting cholesterol synthesis in the liver and increasing LDL receptors which enhance the uptake and breakdown of LDL.	Binds to ADP receptor on the surface of activated platelets. This action blocks ADP, which deactivates nearby glycoprotein receptors and prevents fibrinogen from attaching to receptors. This prevents platelets from forming thrombi.	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking of peptide-glycan strands. Causes bacterial cells to rupture and die.	Inhibit cell proliferation which leads to cell death.
Reason Client Taking	To manage hypertension	To reduce the risk of cardiovascular events such as angina, or MI. To reduce	To prevent thrombi at stent. To reduce thrombotic events such as	Treat lung infection.	Treat CML

		hospitalization for CHF for patients with coronary heart disease.	MI and stroke in patients with atherosclerosis documented by recent MI or PAD.		
Contraindications (2)	Acute heart failure, cardiogenic shock, hypersensitivity to metoprolol, its components, or other beta blockers	Active hepatic disease, hypersensitivity to atorvastatin or its components, unexplained persistent rise in serum transaminase level.	Active pathological bleeding, including peptic ulcer and intracranial hemorrhage. Hypersensitivity to clopidogrel or its components.	Hypersensitivity to cefdinir, other cephalosporins, or their components.	Leukopenia, thrombocytopenia Hypersensitivity to dasatinib or its components.
Side Effects/ Adverse Reactions (2)	Angina, arrhythmias, arterial insufficiency, cardiac arrest	Arrhythmias, elevated serum CK levels, orthostatic hypotension, phlebitis	Chest pain, edema, hypercholesterolemia, hypertension	Dizziness, drowsiness, abdominal pain, leukopenia	Nausea, vomiting, alopecia

Medications Reference (APA):

2020 Nurse's drug handbook (Nineteenth edition. ed.). (2020). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	<p>Appears alert and oriented X3. No acute distress noted. Well-groomed. Pt's wife helps him clean up on a regular basis.</p>
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type:	<p>Pink, dry, warm Normal, 2+ None Bruise on left arm at IV site. No wounds observed. 20, deducted 2 for activity. Patient can move from the chair to bed but requires 2 assists and a walker. Pt cannot ambulate in the hall yet. Deducted 1 for nutrition, patient ate a little over half of his breakfast and did not order lunch during my shift. He stated his wife would grab him something. Bilateral chest tubes present.</p>
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	<p>Head and neck symmetrical, normal hair distribution. Trachea is midline, no deviation noted. No lymphadenopathy in the head or neck noted. Thyroid is not palpable. Ears pink, no tenderness or drainage. No hearing deficit observed. PERRLA bilaterally, EOMs intact bilaterally. Eye lids pink and symmetrical. Bilateral Sclera white, Bilateral cornea clear, Bilateral conjunctiva pink without discharge. Patient uses reading glasses. Septum midline, nares free of discharge. Patient has dentures, well kept. Throat pink, moist, and without ulcers. Tonsils 1+.</p>
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill:	<p>Clear s1 and S2. No murmur, rubs or gallops noted. Pulses 2+ throughout, bilaterally. Capillary refill less than 3 seconds. +1 pitting edema inspected and palpated on the lower</p>

<p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Location of Edema:</p>	<p>extremities bilaterally.</p>
<p>RESPIRATORY:</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Breath Sounds: Location, character</p>	<p>Pleural friction rub heard in all lung fields bilaterally.</p>
<p>GASTROINTESTINAL:</p> <p>Diet at home:</p> <p>Current Diet</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p> <p>Inspection:</p> <p> Distention:</p> <p> Incisions:</p> <p> Scars:</p> <p> Drains:</p> <p> Wounds:</p> <p>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p> Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p> Type:</p>	<p>Normal</p> <p>Normal</p> <p>6'0"</p> <p>183 lbs.</p> <p>Normoactive in all four quadrants.</p> <p>This morning, pt reports diarrhea.</p> <p>Mild ascites on abdomen. Abdomen soft, slightly tender to palpation.</p> <p>No distention noted.</p> <p>Patient has bilateral chest tubes in place.</p> <p>Large scar on RLQ from appendectomy.</p>
<p>GENITOURINARY:</p> <p>Color:</p> <p>Character:</p> <p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p> Type:</p> <p> Size:</p>	<p>Light amber.</p> <p>Slightly cloudy.</p> <p>Pt stated: "I'm not going much, that's why I have an IV in now. I'm going about half as much as usual".</p>
<p>MUSCULOSKELETAL:</p> <p>Neurovascular status:</p> <p>ROM:</p> <p>Supportive devices:</p> <p>Strength:</p> <p>ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Score:</p>	<p>No neurovascular deficits noted. Normal ROM. Walker used for ambulation. Strength in upper extremities normal, reduced strength in lower extremities. Fall score 35 due to using a walker and having an IV. Patient needs assistance to stand and ambulate to the commode/chair. Patient cannot walk on his own yet but is doing PT.</p>

<p>Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Lower extremities are weaker than pt’s upper extremities. Appears alert and Oriented to person, place, and time. Cognitive with normal speech. Normal sensory response in fingers and toes. No neurological deficits noted. Patient reports no episodes of losing consciousness.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Patient reports watching TV or working on model trains to cope with stress. Normal developmental level. Patient does not practice any religion. Patient states: “It’s just me and my wife, I’d be lost without her. I have kids and they call me several times a day, but they do not live here”.</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	74 (Right radial)	128/83 (RA)	20	97.3 (Temporal)	99% (air)

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1125	Numerical 0-10	Sides from chest tubes	2	Dull ache	Pillow behind back and under arms to ease pain. Pt stated: “It helped a little, it lowered my pain to a 1”.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
75% ham and cheese omelet. 50% white toast with jelly. 236 mL 2% milk 240 mL black coffee. 258.8 mL 0.9 Sodium Chloride (990-731.2= 258.8. Nurse stated IV bags always start at 990 ml)	Voided once during my shift. Had one BM early this morning before my shift. Right chest tube= 70 mL Left chest tube= 150 mL

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 		<ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan.
1.Impaired gas exchange related to altered oxygen supply and alveolar-capillary membrane changes occurring with the inflammatory process and fluid in the pleural cavity as evidenced by shortness of breath	“I felt like I was suffocating, I couldn’t inhale or exhale”.	1.Assess the patient’s mental, respiratory, and cardiac status at frequent intervals to ensure drainage system is working. (Swearingen & Wright, 2020).	Goal met- VS performed at 0700 by the nurse and at 1200 by me. Pulse and respiratory rate were in the normal range. While performing patient care, I observed the patient’s mental and respiratory status. Patient was alert and oriented x3, and his

<p>(Swearingen & Wright, 2020).</p>		<p>2. Assess and maintain the closed chest drainage system by avoiding tubing kinks and ensuring that the bed and equipment are not compressing any component of the system (Swearingen & Wright, 2020).</p>	<p>breathing was non-labored.</p> <p>Patient's chest tubes were assessed before and after bathing, positioning to the chair, positioning to the commode and back to bed. Tubing was free of kinks and fully functional.</p>
<p>Ineffective breathing pattern related to decreased lung expansion occurring with fluid accumulation in the pleural cavity as evidenced by shortness of breath.</p>	<p>Patient's lungs are being compressed by pleural fluid which is preventing them from expanding and causing shortness of breath and difficulty breathing.</p>	<p>1. Elevate the head of the bed and position patient in semi Fowler's position to promote lung expansion and monitor pulse oximeter frequently. Report significant findings to the provider.</p> <p>2. Assess for signs of respiratory distress such as use of accessory muscles, cyanosis, or air hunger and report significant findings (Swearingen & Wright, 2020).</p>	<p>Goal met- Patient was positioned in semi Fowler's position after bathing at 0900 and again when he moved from the chair back to the bed. Pt's oxygen saturation was 96% at 0700 am when the nurse assessed it and 99% at 1200 when I assessed it.</p> <p>Goal met- No signs of air hunger or use of accessory muscles observed while caring for my patient at 0745, 0900, 1030, or 1200. Patient's skin was warm and pink throughout when inspected at 0900 during bathing and at 1200 when performing my assessment.</p>

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

“I felt like I was suffocating, I couldn’t inhale or exhale. I also started having coughing fits”.
 I have pain on both sides from my chest tubes, it’s a dull ache and about a 2/10”.
 “I smoked a little less than a pack a day for 30 years, but I quit when I was diagnosed with Leukemia a few years ago”.

Nursing Diagnosis/Outcomes

1. Impaired gas exchange related to altered oxygen supply and alveolar-capillary membrane changes occurring with the inflammatory process and fluid in the pleural cavity as evidenced by shortness of breath (Swearingen & Wright, 2020).
 Outcome: After interventions/treatment the patient exhibits adequate gas exchange as evidenced by usual mental status, non-labored respirations within the normal range, and a heart rate within his baseline.
2. Ineffective breathing pattern related to decreased lung expansion occurring with fluid accumulation in the pleural cavity as evidenced by shortness of breath.
 Outcome: Within 72 hours of interventions/treatment, the patient demonstrates maximum lung expansion with adequate ventilation, and either verbally or through behavior indicates being comfortable when breathing.

Objective Data

Pleural effusion exudative
 Patchy infiltrates observed in pleural fluid on x-ray
 Large pleural effusions bilaterally
 Audible pleural friction rub
 Neutrophilia
 Ascites on abdomen
 +1 Pitting edema on lower extremities
 Right drain output 70 mL
 Left drain output 150 mL
 VS- P:74, B/P:128/83 RR:20 T: 97.3 O2: 99%

Patient Information

On October 20th, a 69 y.o distressed male with a hx of CML, DM, atherosclerosis, hypertension, MI, and CKD stage 3 presented to the ED with shortness of breath and a heavy feeling in his chest.

Nursing Interventions

.Assess the patient’s mental, respiratory, and cardiac status at frequent intervals to ensure drainage system is working. (Swearingen & Wright, 2020).
 Assess and maintain the closed chest drainage system by avoiding tubing kinks and ensuring that the bed and equipment are not compressing any component of the system (Swearingen & Wright, 2020).
 Elevate the head of the bed and position patient in semi Fowler’s position to promote lung expansion and monitor pulse oximeter frequently. Report significant findings to the provider.
 Assess for signs of respiratory distress such as use of accessory muscles, cyanosis, or air hunger and report significant findings (Swearingen & Wright, 2020).



