

**Nyack College  
School of Nursing  
NUR 393 Clinical  
Respiratory Assessment**

**Student's name:** Sristi Maharjan

**Patient's Initials:** R.A. **Date of care:** 09/27/'21 **Age** 77 **Gender** M  
**Preferred language** English **Ethnicity** Other **Religion** Other

**Chief complaint:**

Permanent Catheter placement and ischemic stroke which was complicated  
by an acute kidney injury

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**Allergies:**

Medications: Penicillin

Food: None

Environmental: None

**Medical history:** A-flutetr, A-fib, CAD S/P PCI, DM, HTN, Seizure, CMY CEF 30-35%, CID,  
Coronary atherosclerosis, HLD, ischemic cardiomyopathy, old myocardial infraction, Post PTCA,  
sinus arrhythmia, systolic dysfunction, transient cerebral ischemia

**Surgical history (list date and type):** CABG (2009), inguinal hernia, Meningioma resection 2016,  
acute respiratory failure tracheostomy since 8/17/2021

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**Psychiatric history:**

Patient is currently on Fluoxetine

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**Lactation Status:** N/A **Pregnancy Status** N/A

**Immunizations:**

Mandatory Childhood vaccinations UTD Unable to determine

Tetanus (date-year) Unable to determine

Pneumococcal (date-year) Unable to determine

Influenza (date-year) Unable to determine

**Medications (patient takes at home)**

Name	Dose	Route	Frequency	Use
Acetaminophen	650 mg	Rectum	Q6h	Pain
Aspirin	81 mg	Nasogastric	Once daily	Fever/pain
Dextrose 25 g	25 mL	IV push	Once prn	Low blood sugar 50-70 mg/dL, cannot take PO & have IV
Dextrose 40% gel	15 g	Mouth	Once prn	Blood sugar
Pantoprazole	40 mg	IV Push	Once daily	GERD
Insulin Lispro	100 units/mL	Subcutaneous		DM
Brilinta	90 mg	NG tube	Q12h	Blood thinner
Glucagon injection	1mg/mL	IM	Once prn	Blood sugar <50 mg/dL cannot take PO & have IV
Carvedilol	3.125 mg	Oral	BID	Blood Pressure
Levothyroxine	25 mcg	Oral	Once daily	Hypothyroidism
Levofloxacin	250 mg/50 mL	IV route	Q24h	Antibiotics

(If more space is required, write on a separate paper)

**Health History**

**Does the patient have:** Patient was awake, A&O x 4 but non-verbal

**Dyspnea:** YES or NO → N/A

at rest \_\_\_ mild activity \_\_\_ moderate activity \_\_\_ strenuous activity \_\_\_

supine position N/A Orthopnea N/A

worsens while walking? N/A O2 therapy at home? N/A

If yes, describe \_\_\_\_\_  
\_\_\_\_\_

**Cough:** YES or NO → N/A

In the morning \_\_\_\_\_ at night \_\_\_\_\_ supine position \_\_\_\_\_

audible wheezing \_\_Yes\_\_ hemoptysis (describe) \_\_\_\_\_

**Sputum production:** YES or NO → YES

productive \_\_Yes\_\_ if yes, COCAF white, no odor, copious, and thick

non productive \_\_\_\_\_

**Chest pain or discomfort:** YES or NO → N/A

Location N/A onset (date & time) N/A

quantity (pain scale 0-10) N/A quality N/A

Contributing factors N/A

Aggravating factor(s) N/A Alleviating factor(s) N/A

**Social Factors**

**Smokes:** YES or NO → Unable to determine  
Frequency \_\_\_\_\_ How many years? \_\_\_\_\_ Pack years \_\_\_\_\_  
Alcohol use: YES or No → Unable to determine  
Frequency \_\_\_\_\_ How many years? \_\_\_\_\_  
Drug Use: YES or No → Unable to determine  
Name (s) \_\_\_\_\_ Frequency \_\_\_\_\_ How many years? \_\_\_\_\_

**Any difficulty(ies) performing activities of daily living (describe)?** \_\_\_\_\_  
Patient is dependent, cannot perform any ADLs without assistance, has tracheal collar and PEG tube, heel injury on both legs  
\_\_\_\_\_  
\_\_\_\_\_

Does the patient have any special needs? (hard of hearing, legally blind...) \_\_\_\_\_  
Patient is non – verbal

**Physical Exam**

Describe the patient’s general appearance Received patient awake and alert in bed but non-verbal, tracks with eyes. Permanent catheter on right subclavian, bioclusive on right cheek from fall injury, tracheal collar, PEG tube, had mittens on both hands, leg boots for heel injury

**Vital signs:** T 97.1° F, HR 68, RR 16, bp 121/59, O2 sat 100%  
Height N/A Weight N/A

**Skin color** homogenous cyanosis (central / peripheral) None  
Nose intact, no membrane breakage, no signs of deviation  
Sinuses non-tender  
Mouth & Pharynx Mouth droopy on Right side with secretions, pink with no ulcers  
Trachea Stoma, intact, secretions  
Chest symmetry, equal rise and fall bilaterally, rales on lower lobes of lungs bilaterally

Describe breathing pattern irregular  
Breath sounds: unclear bilaterally rhonchi absent rales on lower lobes of lungs  
wheezes stridor friction rub

Extremities  
Capillary refill < 3 seconds via toepad clubbing unable to determine, nails thick with paronychia  
O2 therapy (type, L/min, % of O2) trachea mask, 7.5 L/min, 50% FiO2

**Dependent/ Independent/ Collaborative Orders:**

Activity: Dependent  
Diet: PEG tube  
Consults: PT and Neurological consults

Therapies/ Treatments: \_\_\_ Unable to determine \_\_\_\_\_

### Diagnostic Tests

CBC: abnormal results \_Hgb 8.9, HCT 28.4\_\_\_\_\_

BMP/ CMP: abnormal results \_\_ unable to determine \_\_\_\_\_

PT/PTT/INR: abnormal results \_\_ unable to determine \_\_\_\_\_

ABG interpretation: \_\_ unable to determine \_\_\_\_\_

Pulmonary function tests: \_\_\_\_\_ unable to determine \_\_\_\_\_

Cultures: \_\_\_ unable to determine \_\_\_\_\_

Sputum studies: \_\_\_\_\_ unable to determine \_\_\_\_\_

BNP results: \_\_\_\_\_ unable to determine \_\_\_\_\_

Other Laboratory Data: \_\_\_\_\_ BUN 51, Creatinine 1.84, Ca 8.0, ALK phosphate 37%, Protein total 5.5 \_\_\_\_\_

CXR results: 09/14/2021 worsening left lung opacification which may reflect a combination of atelectasis and associated left pleural effusion. New mucous plugging. No pneumothorax \_\_\_\_\_

CT/ MRI/ V/Q scan: \_\_\_\_\_ unable to determine \_\_\_\_\_

Biopsy \_\_\_\_\_ unable to determine \_\_\_\_\_

ECG 12 lead: \_\_\_\_\_ 09/12/2021 Normal sinus rhythm RR 66 \_\_\_\_\_

Other Diagnostic Studies: \_\_\_\_\_ 09/27/2021 Finger stick 149 (06:00) \_\_\_\_\_

### Medications (prescribed since admission):

Name	Dose	Route	Frequency	Use
Acetaminophen	650 mg	rectum	q6H	Pain
Aspirin	81 mg	NG	QD	Fever/pain
Dextrose	25g/25mL	IV push	Once prn	Fluid loss
Dextrose 40% gel	15g	Mouth	Once prn	Blood sugar
Dextrose 5% with	50 ml	IV	Q12h	Fluid balance
Ceftriaxone	2 g	IV	Q12h	antibiotic
Eptifibatide	76.2 mcg/min	IV	continuous	Blood clots
Glucagon	1 mg/ml	IM	Once prn	Blood sugar
Albuterol	2.5 mg/3 mL	Nebulizer IV	Q6 prn	Asthma
Atrovent	0.5mg	Nebulizer	Q6h	Wheezing, SOB
Humalog insulin	Sliding scale	Subcutaneous	Q6h	DM
Alfa-epdx	3000 units	Subcutaneous		anemia
Neurotin	100mg		BID	Epileptic seizures
Keppra	500mg		Q12h	seizures
Brilinta	90 mg	NG	Q12h	Blood thinner
Amiodarone	200 mg	NG		Ventricular arrhythmias and A-fib
Artificial tear drops	2 drops	Each eye	Q4h	Moisture to eyes

PEG	125 ml	tube	Q4h prn	feed
Albumin 25%	12.5 g		Once prn	hypovolemia
Synthroid	25 mcg		Before Breakfast	hypothyroidism
Lopressor	12.5		Q6h	High BP
Miralax	17g	PEG mix w/ water	Q12h	Constipation
Sennoside	17.6 mg		Bedtime	Constipation

(If more space is required, write on a separate paper)

**Patient Education**

Patient barriers to learning? \_\_\_\_\_ Unable to determine \_\_\_\_\_

Topic	Method (verbal, demonstration, video, pamphlet.....)	Evaluation of learning (Did pt verbalize or demonstrate understanding or does pt require reinforcement)

(If more space is required, write on a separate paper)

**Additional Comments:**

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