

IMPAIRED GAS EXCHANGE/SHORTNESS OF BREATH

Subjective Data: _____ **Allergies:** _____

Chief complaint: _____

Onset: _____ New Onset Chronic Recurrence Severity of attack: Scale: (1-10) _____

Precipitating Factors:

Cold air Exercise Air pollutants Chemicals Respiratory infection Emotional situations

Contributing Factors:

Smoke Packs per day: _____ Number of years smoke: _____

Associated symptoms:

Cough Productive Describe: _____

Current Asthma Medications:

_____, _____, _____

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ Peak Flow _____ O₂ sats. _____

Respiration	Lung Sounds	Skin	LOC	Swelling	Appearance
<input type="checkbox"/> Even	<input type="checkbox"/> Clear	<input type="checkbox"/> Warm	<input type="checkbox"/> Awake	<input type="checkbox"/> Tongue	<input type="checkbox"/> No distress
<input type="checkbox"/> Uneven	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Pink	<input type="checkbox"/> Alert	<input type="checkbox"/> Throat	<input type="checkbox"/> Mild distress
<input type="checkbox"/> Labored	<input type="checkbox"/> Wheezes	<input type="checkbox"/> Cool	<input type="checkbox"/> Oriented X_____	<input type="checkbox"/> Facial	<input type="checkbox"/> Moderate distress
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Diminished	<input type="checkbox"/> Pale	<input type="checkbox"/> Confused	<input type="checkbox"/> Extremities	<input type="checkbox"/> Severe distress
<input type="checkbox"/> Shallow	<input type="checkbox"/> Rales	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Generalized	
<input type="checkbox"/> Deep		<input type="checkbox"/> Mottled	<input type="checkbox"/> Comatose		
<input type="checkbox"/> Use of accessory muscles		<input type="checkbox"/> Diaphoretic			

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY.

DO NOT SEND OFFENDER BACK TO CELL WITHOUT NOTIFYING MEDICAL PROVIDER/RN. ASTHMA CAN BE LIFE THREATENING.

- Severe exacerbation
- Unstable
- No improvement after inhalers/medication
- Unresponsive to treatment
- Peak flow less than 100 liter or less than 200 liters higher on assessment after two treatments

Call 911 if altered mental status change
 Emergency department notification time: _____ Transport time: _____

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Impaired gas exchange related to reactive airway disease

Plan:

Nursing Intervention Routine:

- Reassure offender, provide calm, quiet environment
- Use inhaler (usually Albuterol) for symptomatic treatment (**this will require a order from the medical provider if the patient does not have own inhaler**)
- If no improvement in 10 minutes to Albuterol Inhaler administer Hand Held Nebulizer Treatment with Albuterol 0.5 ml prepackaged Normal saline (**this will require a order from the medical provider**)
- Re-evaluate frequently every 15 to 30 minutes, Encourage increase fluids
- Initiate O₂ 12-15 liters/min administered by non-rebreathing mask if in acute distress / shortness of breath
- If offender does not respond to treatment - record ER assessment/treatment, copy and send to emergency department with offender
- Schedule medical provider appointment

Progress Note: _____

Offender Education:

Instructed to increase fluids, factors that trigger asthma attack, correct use of inhaler, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

DOC #