

**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 \_\_\_\_\_ O<sub>2</sub> 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			

Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

**NOTIFY MEDICAL PROVIDER 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 Notified: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Orders Received for Treatment:**  Yes  No

**Assessment:**

- Impaired gas exchange related to reactive airway disease

**Plan: Nursing Intervention Routine:** (check all that apply)

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
- 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 O<sub>2</sub> 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
- Education/Intervention: 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.

**Progress Note:** \_\_\_\_\_

**Medical Provider Signature/Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**QHCP Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Offender Name  
(Last, First)

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