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Bronchial asthma Response monitoring

Adult Health Nursing | Response monitoring

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

24-year-old woman with worsening wheeze. Care stage: During review after prescribed initial care.

Medical history: Asthma was diagnosed previously. Dust exposure preceded this episode; the patient has used inhaled treatment but needs technique and adherence review. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

Clinical assessment

Subjective: Chest tightness, cough and breathlessness after dust exposure.

Objective findings and required checks: Expiratory wheeze and increased breathing effort; peak flow and oxygenation need assessment.

Physical examination and investigations: Assess speech, respiratory effort, SpO2, peak flow if feasible and response to treatment.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Bronchial asthma: Airway inflammation, bronchial constriction and mucus reduce expiratory airflow.

Medical / surgical management

Follow the asthma action and emergency plan, provide prescribed inhaled therapy and reassess frequently.

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Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Salbutamol	Prescribed rapid bronchodilation	Monitor response, pulse and tremor
inhaled corticosteroid	Control airway inflammation in the prescribed regimen	Check technique, adherence and mouth care.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Chest tightness, cough and breathlessness after dust exposure. Expiratory wheeze and increased breathing effort; peak flow and oxygenation need assessment. The team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

Nursing diagnosis

Prioritize breathing difficulty affecting oxygenation; difficulty clearing respiratory secretions; emotional distress affecting participation in care; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

At the next scheduled reassessment, with its interval chosen for acuity: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Follow the asthma action and emergency plan, provide prescribed inhaled therapy and reassess frequently. Compare the current assessment with the documented baseline and identify benefit, harm or lack of response. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Compare the current assessment with the documented baseline and identify benefit, harm or lack of response.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about breathlessness, chest tightness and activity tolerance. Assess: Record respiratory rate, effort, SpO2 and mental state against the prescribed target.	Breathing difficulty affecting oxygenation. Possible factors: altered ventilation or gas exchange. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Breathing effort improves and oxygenation remains within the individualized target. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the respiratory action plan and demonstrates the prescribed device technique.	1. Reassess work of breathing and response to each intervention. Rationale: Trend changes identify deterioration earlier than a single reading. 2. Position to ease breathing, cluster care and allow rest. Rationale: This can reduce respiratory demand and distress. 3. Give oxygen and respiratory medicines only according to the clinical prescription or emergency protocol. Rationale: Individualized treatment supports oxygenation without unsafe blanket targets. 4. Follow the asthma action and emergency plan, provide prescribed inhaled therapy and reassess frequently. Rationale: Airway inflammation, bronchial constriction and mucus reduce expiratory airflow. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Report sputum, cough effectiveness and chest discomfort. Assess: Observe airway sounds, cough, secretions and ability to speak.	Difficulty clearing respiratory secretions. Possible factors: retained secretions and reduced cough effectiveness. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Airway remains patent and the patient demonstrates a more effective cough. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed secretion-management technique before discharge.	1. Assess cough, breath sounds and secretion changes. Rationale: Changes can indicate obstruction or worsening infection. 2. Support a comfortable upright position and coached coughing when appropriate. Rationale: Position and an effective cough can help secretion clearance. 3. Provide prescribed inhaled treatment or suction only when indicated and within competence. Rationale: Targeted therapy supports airway clearance while limiting procedural harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: At the next scheduled reassessment, with its interval chosen	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	for acuity: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach device technique, trigger reduction, controller use and the personalized written action plan. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach device technique, trigger reduction, controller use and the personalized written action plan.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Exhaustion, silent chest, cyanosis, inability to speak or reduced consciousness is an emergency.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Airway inflammation, bronchial constriction and mucus reduce expiratory airflow.

- Priority concerns: Breathing difficulty affecting oxygenation; Difficulty clearing respiratory secretions; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Exhaustion, silent chest, cyanosis, inability to speak or reduced consciousness is an emergency.

- Teach device technique, trigger reduction, controller use and the personalized written action plan.

Exam / viva: Which observations demonstrate response, and which findings would require revising or stopping the current intervention?

References

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