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Pneumonia Initial assessment

Adult Health Nursing | Initial assessment

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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

57-year-old man with an acute lower respiratory illness. Care stage: At the first supervised assessment.

Medical history: Cough, fever and poor intake developed during the current illness. No chronic respiratory diagnosis is reported in this fictional history. 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 patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Productive cough, fever, pleuritic discomfort and reduced appetite.

Objective findings and required checks: Fever, crackles and increased respiratory rate; oxygenation and sepsis risk need review.

Physical examination and investigations: Review chest imaging when ordered, blood count, oxygenation and indicated microbiology.

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

Clinical focus and pathophysiology

Pneumonia: Infection and inflammation fill alveolar spaces and impair gas exchange.

Medical / surgical management

Assess severity, support oxygenation and hydration within the plan, and give indicated antimicrobials promptly.

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Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antibiotic	Treat the suspected or identified bacterial infection	Check allergy, timing, renal considerations and response
paracetamol	Relieve prescribed fever or pain symptoms	Check total exposure.

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

Nursing process - ADPIE

Assessment

Productive cough, fever, pleuritic discomfort and reduced appetite. Fever, crackles and increased respiratory rate; oxygenation and sepsis risk need review. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize breathing difficulty affecting oxygenation; difficulty clearing respiratory secretions; raised temperature increasing discomfort and fluid needs; 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

After the first indicated intervention, at the documented review time: 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

Assess severity, support oxygenation and hydration within the plan, and give indicated antimicrobials promptly. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. 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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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: After the first indicated intervention, at the documented review time: 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. Assess severity, support oxygenation and hydration within the plan, and give indicated antimicrobials promptly. Rationale: Infection and inflammation fill alveolar spaces and impair gas exchange. 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: After the first indicated intervention, at the documented review time: 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 about chills, headache, intake and illness onset. Assess: Record temperature site, trend, hydration and other observations.	Raised temperature increasing discomfort and fluid needs. Possible factors: an inflammatory or infectious process. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Temperature-related discomfort improves and clinical deterioration is detected promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Explains monitoring, hydration instructions and warning signs for review.	1. Trend temperature together with circulation, breathing and mental state. Rationale: Temperature alone does not describe illness severity. 2. Provide comfortable clothing and fluids when permitted; avoid extreme cooling. Rationale: Supportive care reduces discomfort without provoking unnecessary stress. 3. Administer prescribed treatment and obtain ordered specimens using correct technique. Rationale: Cause-directed management and reliable samples support recovery.	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: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: 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.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves 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. Discuss treatment completion as prescribed, recovery pacing, respiratory hygiene and vaccination eligibility review. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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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Health education and continuing care

Discuss treatment completion as prescribed, recovery pacing, respiratory hygiene and vaccination eligibility review.

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

Confusion, worsening hypoxia, shock or rapidly increasing respiratory effort requires urgent escalation.

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

- Infection and inflammation fill alveolar spaces and impair gas exchange.

- Priority concerns: Breathing difficulty affecting oxygenation; Difficulty clearing respiratory secretions; Raised temperature increasing discomfort and fluid needs; Learning needs about the condition and care plan.

- Confusion, worsening hypoxia, shock or rapidly increasing respiratory effort requires urgent escalation.

- Discuss treatment completion as prescribed, recovery pacing, respiratory hygiene and vaccination eligibility review.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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