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._______O_2 sats._________ FSBS: ___________

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

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF. *Health care provider must be called if not on site or if after clinic hours.*

❑ 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

DO NOT SEND INMATE BACK TO CELL WITHOUT CONTACTING HEALTH CARE PROVIDER. ASTHMA CAN BE LIFE THREATENING.

Emergency department notification time: ______________________________ **Transport time:** ___________________

Health Care Provider: __________________ **Time Notified:** _______ **Orders Received for Treatment:** ❑ **Yes** ❑ **No**

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

❑ Check in assessment only for health care providers visit.

❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.

❑ Reassure inmate, provide calm, quiet environment.

❑ Use inhaler for symptomatic treatment **(this will require an order from the health care provider if the patient does not have his/her own inhaler)**

❑ If no improvement in 10 minutes to Albuterol/Atrovent Inhaler administer Hand Held Nebulizer Treatment with Albuterol 0.5 ml prepackaged Normal saline **(this will require an order from the health care provider).**

❑ Re-evaluate frequently every 15 to 30 minutes, Encourage increase fluids.

❑ Initiate O_2 12-15 liters/min administered by non-rebreathing mask if in acute distress / shortness of breath.

❑ If inmate does not respond to treatment - record ER assessment/treatment, copy and send to emergency department with inmate.

❑ Schedule health care provider appointment.

❑ Refer to MSRM 140117.01.1.4 “Swelling” (Peripheral and Pulmonary Edema).

❑ Education/Intervention: Instructed to increase fluids (contraindicated with CHF), factors that trigger asthma attack, correct use of inhaler, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: ____

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Health Care Provider Signature/Credentials: ____________________________ **Date:** _________ **Time:** ________

RN/LPN Signature/Credentials: ______________________________________ **Date:** _________ **Time:** ________

Inmate Name
(Last, First)

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