



Because
consistent
information is a
vital part of his
treatment

Case Study: The breathless patient

Real Scenario

You're a float nurse (casual nurse) rostered to the respiratory department. It's been over 9 months since you were here. Handover is delayed due to an incident with a patient. You briefly do a ward check and find a patient struggling to breathe.

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The patient's temperature was 37.6 °C and he had an irregular pulse, with an apical rate of 125 beats/min. His oxygen supply was changed to 24% by face mask, but his saturations on pulse oximetry decreased to 75%. Immediate physiotherapy helped him to cough up moderate amounts of green sputum and, after an air-driven nebuliser of ipratropium 0.5 mg, he appeared less drowsy. His arterial blood gases on admission, breathing room air, were pO_2 4.5 kPa, pCO_2 10 kPa, pH 7.25. An ECG confirmed atrial fibrillation and a chest film showed over-inflation but no evidence of pneumonia.

You identify yourself and ask the patient to confirm his name and ask about current condition. He confirms his name as what is on his ID band, however he is too breathless to speak.

You are not confident in the appropriate actions as you don't have a history of the patient and it has been a while since you were on this ward.

You take a set of physical observations:

- Pulse 102
- Respirations 27
- O_2 Saturation 89%
- BP 140/95



You add the information to the EMR which alerts you to the need for a clinical review so you look up the hospital policy directive on the deteriorating patient. The policy is six years old and due for review. You remember in orientation that you have access to a nursing survival guide in ClinicalKey for Nursing.

You search "breathless patient" and scan the following content.

Real Evidence

The Breathless Patient: The General Approach

Is this patient's breathlessness due to his heart or his lungs? The two most important and most difficult questions in a breathless patient are always: is this cardiac or respiratory breathlessness?

Critical Nursing Observations

1. Peak flow rate
2. Pulse rate
3. Sputum colour
4. Temperature (a sign of respiratory infection)
5. Will the patient cooperate with the oxygen mask?

Real difference

You confirm your concerns, raise the head of the bed and check the airway for an occlusion and add apply an oxygen mask. You encourage the patient to take deep slow breaths and monitor.

O_2 sats return to normal and you refer this issue to the previous shift nurse and document in the patient notes.



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real difference, visit clinicalkey.com/nursing