**Ackley: Nursing Diagnosis Handbook, 10th Edition**

**Clinical Reasoning and Critical Thinking: Use of the Nursing Process**

**Case Study - Morrie Flack (COPD)**

**Case Scenario**

“I can’t breathe.” Morrie gasped for breath. “Help me.” Morrie looked up at you, his nurse, with eyes filled with fear. He raised the head of the bed further with the control and continued to gasp for breath. You could feel your own anxiety increasing; it felt like Morrie’s anxiety was contagious. You pushed the overbed table so that Morrie could lean forward on it; you sat on his bed and worked with him to breathe using the pursed-lip technique and to slow his breathing. You have given him all the medications he can have, and you pray that he will get better.

**Nursing Assessment Including Client Story**

Morrie is on disability from his previous work as a bricklayer. He is married and has two children, one who is grown and the second who is a teenager living at home. Morrie loves his family, sports, and “hanging out” with his buddies at the local bar. He has chronic obstructive pulmonary disease (COPD). He has been suffering for 5 years and is frequently a client admitted to the respiratory nursing unit. He stopped smoking when he was first diagnosed but, unfortunately, still has significant lung disease. His vital signs are blood pressure: 180/92 mm Hg; temperature: 100.2º F; pulse: 116 beats per minute (bpm); and respirations: 28 breaths per minute. His lung sounds are wheezing with loud crackles throughout. The oxygen saturation is 84%. He is receiving oxygen via a Venturi mask. His arterial blood gasses are oxygen partial pressure (Po2): 72 mm Hg; carbon dioxide partial pressure (Pco2): 48 mm Hg, and pH 7.24. His toes and fingers are cyanotic, as are his oral mucous membranes.

1. **ASSESS**
	1. Identify the significant symptoms by underlining them in the above nursing assessment.
	2. List the symptoms (those you have underlined) that indicate the client has a health problem.
	3. Group the symptoms that are similar.
2. **DIAGNOSE**
	1. Select possible nursing diagnoses for Morrie.

Review the list of nursing diagnoses in Ackley and Ladwig: *Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care* or by accessing the care plan constructor at the [EVOLVE](http://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH10e/careplanconstructor/) site and viewing the nursing diagnoses listed.In addition, look up symptoms such as wheezing in Section II of your text.

(The information can be copied and pasted from the EVOLVE site into the areas below.)

**Possible nursing diagnoses:**

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* 1. Validate the possible nursing diagnoses.

Compare the signs and symptoms (i.e., defining characteristics) that you have identified from your client assessment with the defining characteristics for the nursing diagnosis that you have selected. In addition, read the diagnosis definition and determine whether this diagnosis fits this client. This information is found in Section II of the Ackley and Ladwig text.

**Validated nursing diagnoses include:**

(The information can be copied and pasted from the EVOLVE site into the areas below.)

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* 1. Write a nursing diagnostic statement for one of the nursing diagnoses by combining the nursing diagnosis label with the “related to” (r/t) factors.
		1. The label is the title of the nursing diagnosis as defined by the North American Nursing Diagnoses Association (NANDA).
		2. An r/t statement describes the factors that may be contributing to or causing the problem that resulted in the nursing diagnosis.

(The information can be copied and pasted from the EVOLVE site into the areas below.)

**NANDA label:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Related to (r/t) factors:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The complete nursing diagnostic statement is:**

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1. **PLAN**

Click here to access the Ackley and Ladwig care plan constructor to assist you in formulating your care plan: <http://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH10e/careplanconstructor/>

1. Write an outcome to help resolve the symptoms (i.e.,

**Client outcome:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Select interventions from the Section III care plan on the previously mentioned nursing diagnosis that you think will be appropriate for this client and that will enable the nurse to accomplish the outcome.

**Nursing interventions and *rationales*:**

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# IMPLEMENT

The next step in the nursing process is to provide the nursing care using the nursing interventions.

1. **EVALUATE**

After implementing the nursing interventions, the results of the care should be evaluated by determining whether the outcome was met. If the outcome is resolved, then the care plan is resolved. If the outcome has not been met, then further assessment should be made to answer the following questions:

* + Was the correct nursing diagnosis chosen?
	+ Were the outcomes appropriate?
	+ Were the interventions appropriate in this situation?
	+ What other interventions might have been helpful?

Changes in the nursing diagnosis, outcomes, and interventions should be made as needed. The continued use of critical thinking will ensure appropriate nursing care.

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