# Pleural Effusion Nursing Care Plan

**Patient Information**

Full Name: Sarsh Smith

Date of Birth: 09 / 09 / 1951

Gender: F

Patient ID: /

Contact Number: +00 000 0000

Email Address: sarahsmith@email,com

**Transudative:**

*A state in which decreased protein leads to pressure changes in the blood vessels causing leakage of protein-poor fluid into the lung space.*

- [x] Heart failure
- [ ] Hepatic cirrhosis
- [ ] Malnutrition
- [ ] Nephrotic syndrome

**Exudative:**

*Inflammatory process leading to leakage of protein-rich fluid into the lung space.*

- [ ] Pneumonia
- [ ] Cancer
- [ ] Tuberculosis
- [ ] Autoimmune disease

**Indicate symptoms:**

- [x] Sharp, stabbing pain in the chest on inspiration
- [x] Dyspnea
- [ ] Orthopnea
- [ ] Dry, non-productive cough (fluid leakage is outside of the lung in the pleura, hence no productive cough)
- [ ] Diminished breath sounds
- [x] Tachycardia
- [ ] Unrelated symptoms of the condition causing pleural effusion
- [ ] Possible mediastinal shift on x-ray

**Care Plan**

## *Impaired Gas Exchange r/t decreased function of lung tissue*

**Expected Outcome:** The patient will have improved gas exchange as evidenced by blood gas values within the normal range.

| Assesment / Rational | Notes and Referral |
|---|---|
| **Assess the lung sounds for adventitious breath sounds.**<br>*An initial assessment provides baseline information*. | assessment completed 08.02 |
| **Observe the patient's characteristics of breathing. Monitor rate, depth, and rhythm of respirations.**<br>*Changes in respiration may be an indication of worsening respiratory status.* | Shortness of breath and tightness in chest, Dyspnea present. monitoring charted for on every half hour. |
| **Review the patient's past medical history.**<br>*This might reveal information about the underlying cause of the pleural effusion.* | High BP and cardiovascular health concerns. |
| **Place the patient in a high-Fowler's position.**<br>*Sitting upright promotes lung expansion and facilitates breathing. This promotes gas exchange in unaffected lung tissues.* | positioning monitored. |
| **Encourage to cough and perform deep breathing exercises.**<br>*These exercises help clear and maximize the functions of remaining healthy lung tissue.* | nursing team to encorage this on rounds. |
| **Monitor blood gases regularly.**<br>*These values allow for the early detection of deterioration or improvement in gas exchange.* | ABG sould be at: pH: 7.35-7.45. Partial pressure of oxygen (PaO2): 75 to 100 millimeters of mercury (mmHg). Partial pressure of carbon dioxide (PaCO2): 35 to 45 mmHg. |
| **Monitor pulse oximetry continuously.**<br>*With pulse oximetry, one can monitor oxygen saturation and detect early changes in oxygenation.* | 08.02 1400<br>08.02 1600 |
| **Provide oxygen therapy.**<br>*The patient may require supplemental oxygen to maintain oxygen saturation above 90%.* | n/a |
| **Administer diuretics as ordered.**<br>*Diuretic medications rid the body of fluid, hence may help reduce fluid accumulation in the lung spaces.* | charted for, not administered as ABG's improved. |

| | |
|---|---|
| **Administer medications treating the underlying cause for pleural effusion.**<br>*Treatment of the diseases that caused the pleural effusion should be included in the care plan.* | potential heart failure care plan in place. |

### *Ineffective Breathing Pattern r/t compromised lung expansion*

**Expected Outcome:** The patient will maintain an effective breathing pattern as evidenced by respiration rate, depth, and rhythm being within normal limits.

| Assessment and Rationale | Notes and Referral |
|---|---|
| **Note the patient's respiratory rate, rhythm, and depth.**<br>*Changes in breathing patterns may indicate a deterioration in respiratory status.* | no change in pattern. remains short and shallow |
| **Prepare the patient for possible thoracentesis.**<br>**Explain what to expect and be sure the physician talked to the patient as well.**<br>*It is important that the physician explained the procedure before obtaining informed consent. Knowing what to expect may lower anxiety.* | procedure outlined and consent given. |
| **Monitor vital signs before, during, and after the procedure.**<br>*Removing a large amount of fluid in a short period can lower blood pressure.* | BP monitoring priority. |
| **Review anticoagulation studies before the procedure.**<br>*It is helpful to know when the patient last received blood-thinning medication and the coagulation values before the procedure. Anticoagulation studies show the amount of time for blood to clot, hence how likely it is for the patient to bleed during or after the procedure. Anticipate chest tube placement for large fluid volumes in the lung space.* | No blood thinning medication history, bleeding minimal |
| **Anticipate chest tube placement.**<br>**Use best practice guidelines to manage chest tube care:**<br>**Check the skin condition of the tube insertion site.**<br>*Any insertion site poses a risk for infection. Interruption of the skin barrier makes it easier for bacteria to invade the body.* | insertion site prepped pre-procedure |
| **Check for crepitus around the tube insertion site.**<br>*The presence of subcutaneous air indicates that air is escaping into the tissues.* | no subcutaneous air present |

| | |
|---|---|
| **Assess for a tracheal shift.**<br>*A tracheal shift is one sign of a possible tension pneumothorax.* | no shift |
| **Keep the drainage system below the patient's chest.**<br>*Having the chest tube box below the patient's chest enhances gravity and promotes drainage.* | education and assistance offered for this |
| **Maintain the level of the water in the water seal chamber at the recommended level.**<br>*The water seal allows fluid and air to escape from the lung space but prevents air from entering.* | charted for, included in rounds |
| **Monitor amount, color, and consistency of drainage. Note changes.**<br>*Changes in characteristics of drainage may require different or additional interventions.* | no changes present |
| **Review chest-x rays daily.**<br>*With x-rays, the healthcare team can follow whether treatments are working and check the placement of chest tubes.* | 1300 daily. |

### *Acute Pain r/t inflammatory process*

**Expected Outcome**: The patient will report an acceptable pain level of 3 or less on a pain scale of 0 to 10, as evidenced by vital signs that are within normal range and verbalization of comfort.

| Assessment and Rationale | Notes and Referral |
|---|---|
| **Assess the patient's pain level at least every four hours and one hour after giving pain medication. Note characteristics of pain.**<br>*Frequent assessment of pain level helps to identify whether treatment is effective or if adjustments are necessary.* | effective pain management in place. |
| **Administer pain medication as ordered.**<br>*Pain medicine is one tool to control pain.* | charted |
| **Assist the patient with non-pharmacological methods of pain relief.**<br>Splinting the chest when coughing<br>Frequent repositioning<br>Heat or cold therapy<br>Guided imagery<br>*These methods may help as an additional treatment to pain medication.* | frequent repositioning encoraged |

| | |
|---|---|
| **Align activities with times when pain medication has been administered.** *Carrying out activities during times when pain medication is most effective makes it the least painful for the patient.* | OT notified of pain medication timing, sessions planned accordingly. |

**Physician's Notes and Recommendations**

**Physician's Signature: _____ Date: ____ / ____ / _____**