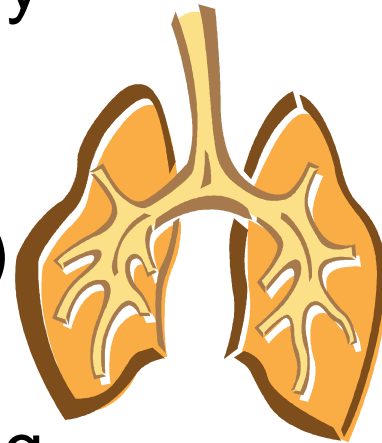


# RESPIRATORY SYSTEM

## COMMON DISORDERS

# DYSPNEA

- SYMPTOM THAT CAN BE CAUSED BY airway obstruction, hypoxia, pulmonary edema, lung diseases, heart conditions, allergic reactions, pneumothorax, poisoning (CO)
- NA should observe resident and report changes in breathing to nurse



# Hyperventilation: Breathing Too Rapidly and Too Deeply

- May have tingling or cramping of arms
- C/o Chest pain
- Anxious
- CO<sub>2</sub> level is too low
- Breathing rapid and deep
- Shallow breathing is not hyperventilation
- Treat by having person rebreath in paper bag

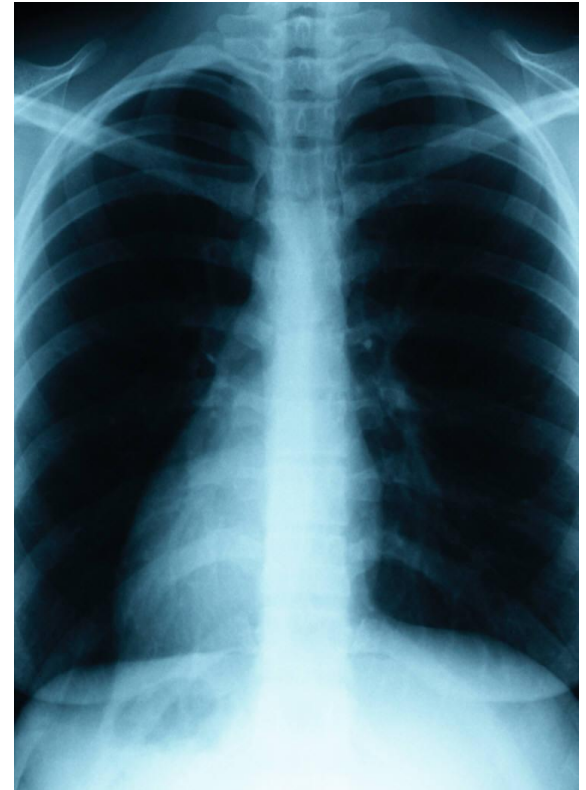
# Upper Respiratory Infection (URI)

- Could be a cold, laryngitis, or sinusitis
- Provide tissues for nasal drainage
- Provide for discarding used tissue
- Encourage to drink fluids
- Report changes in vital signs

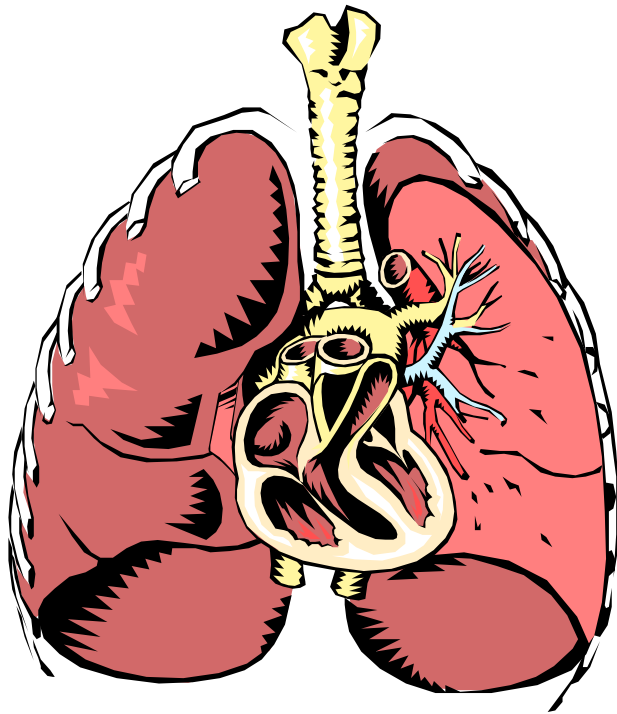


# Pneumonia

- Infection in the lung which may be caused by a virus, bacteria or fungus
- S&S: chills and fever, abnormal respirations, productive cough, thick sputum, muscular aches,
- Tx: antibiotics or antiviral, or antifungal medication, fever meds.
- NA Role: – TCDB, oxygen, monitor resp./temp.
- ↑ HOB, tissue bag on rail, enc. fluids



# Pulmonary Embolus



- Blood clot in blood vessels of lungs
- Serious condition
- Immobility, blood clots in legs can contribute to cause
- Observe for changes in vital signs, report c/o chest pain, report changes in skin color

# Tuberculosis

- Infectious disease of the lungs caused by bacteria; MDR-TB- can be serious problem
- S&S : fever, night sweats, productive cough, may have hemoptysis

# Tuberculosis Care

- Role of NA: Active disease requires use of standard precautions and Airborne precautions when providing care
- monitor vital signs, observe and report sputum, may need to obtain sputum specimens. Promote good hygiene with soiled tissues
- Requires long term treatment with antibiotics -encourage resident to take medicine



# (COPD) Chronic Obstructive Pulmonary Disease

- Group of diseases in this category
- Chronic Bronchitis- bronchiole lining inflamed, persistent cough, SOB, chest tightness, cyanosis occasionally, called “blue bloaters”
- , Emphysema-”Pink puffers”, barrel chest, chronic cough, poor gas exchange, alveoli damaged
- Cystic Fibrosis
- S&S: dyspnea, bronchitis

# Emphysema

- pursed lip breathing helps, Positioning to facilitate breathing such as High Fowlers, pillow on overbed table with resident dangling or sitting in chair sitting and leaning forward on pillow breathing exercises-incentive spirometer
- oxygen therapy in small amounts-1-2LPM
- Encourage fluids, avoid crowds degrees, maintaining, Moist air better

# Suctioning

- residents/patients/clients with a large amount of respiratory secretions and are unable to cough or expectorate the secretions may require suctioning
- Suctioning is generally performed by the nurse. Suctioning may be done orally or nasally
- The nursing assistant should observe and report to nurse excess of secretions, congestion, dyspnea

# Tracheostomy

- If a resident has a Tracheostomy- which is a surgical opening made into the trachea for the resident to breathe, special precautions must be taken
- Avoid fanning linen which may cause aspiration of lint into tracheostomy, observe for and report congestion and difficulty coughing up secretions, avoid covering tracheostomy opening or putting small pieces of cotton or other items that could be aspirated near the trach.

# Diagnostic Test

- The resident may need to have sputum specimens collected
- Review procedure for collecting specimens.
- This may or may not be a nursing assistant is asked to do
- Follow facility guidelines and standard precautions for handling
- If a resident is to have a chest X-Ray, the NA should assist with positioning as needed