Firelands Regional Medical Center School of Nursing
Nursing Care Map

1/27/2

Student Name ___Melinda Pickens_____ Date _____1/27/23_____

Noticing/Recognizing Cues:

Highlight all related/relevant data from the Noticing boxes that support the top priority problem

Assessment findings*:

- -absent lung sounds on left side
- -wheezing on expiration
- -unsteady gait
- -pulse ox 96% of 2L of O2
- -blood pressure 159/102
- -wears glasses
- -dyspnea on exertion

Lab findings/diagnostic tests*:

- -CXR – Pneumothorax
- -Glucose 278
- -A1C 6.5
- -WBC 18.6
- -Sodium 133
- -CO2 20.2
- -HCO3 22.0
- -Anion Gap 18.9
- -Creatinine 1.04

Risk factors*:

- - Hx hypertension
- -Hx COPD
- -Hx asthma
- -Family history epilepsy
- -Substance abuse Hx cocaine, marijuana
- -Diabetes
- -High BMI 38.7kg/m
- -2nd hand smoke
- Sedentary lifestyle

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

Nursing priorities*: *Highlight the top nursing priority problem*

- Ineffective airway clearance (Myers, E., 2018)
- Glucose control

Potential complications for the top priority:

- Respiratory distress
  1.) Assess level of consciousness
  2.) Assess pulse ox and respirations
  3.) Observe rise and fall of chest for any retractions or use of accessory muscles
  4.) Listen to lung sounds for wheezing, rhochi, or crackles.
- Respiratory failure
  1.) Assess level of consciousness
  2.) Assess pulse ox and respirations
  3.) Observe the rise and fall of chest for depth/ use of accessory muscles
  4.) Listen to lung sounds for wheezing, rhonchi, or crackles.
- Infection
  1.) Elevated WBC
  2.) Elevated temperature
  3.) Elevated BP

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vital signs (HR, BP, Temp, RR, Pulse ox) q4hours and PRN
   -To determine a base line for the patient to allow us to know if our treatments are effective. Also, to let us know if the patient is getting adequate oxygen.
2. Assess respiratory function q4hours and PRN
- To determine if there are secretions in the lungs, and whether the patient can cough those up.
3. Encourage coughing and deep breathing q2hours and PRN
 - To allow for movement of secretions and increased oxygenation.
4. Offer/encourage fluids q2hours and PRN
- To allow for thinning of mucus for better excretion.
5. Administer medication guaifenesin 600mp PO q4h and/or PRN
-To help thin the mucus and allow patient to cough it up.
6. Administer medications albuterol/Ipratropium (combo) 3mL Inhaled q6hours

-For bronchodilation to reduce wheezing and reduce exercise induced bronchospasm.

7. Administer Budesonide nebulizer treatment 2mL inhaled q4hours and PRN – allows for bronchodilation to help the patient breathe better.

8. Provide chest percussion q24h and PRN – To break up mucus in the lungs and allow the patient to cough up mucus easier.

9. Educate patient regarding deep breathing/ coughing and intake of fluids on admission, PRN and prior to discharge.

To promote movement of mucus and allow for better breathing.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Pulse ox 97% of 2L
- Wheezing on expiration
- CXR large pleural effusion
- WBC 20.6
- Pt. states “dyspnea has improved on exertion”
- CO2 - 20.2
- HCO3 – 22.0
- Absent lung sounds on the left side
- Continue Plan of care

Reference: Myers, E. (2018). RNotes: Nurse’s clinical pocket guide (5 th ed). F.A. Davis Company: