

Firelands Regional Medical Center School of Nursing  
Nursing Care Map

Student Name \_\_\_\_\_

Date \_\_\_\_\_

Noticing/Recognizing Cues:

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

Assessment findings\*:

- 4+ pitting edema on left lower extremity
- 2+ pitting edema on right lower extremity
- 5L continuous O2 Nasal Cannula
- Neuropathy in left foot
- All toes and part of left foot amputated
- Plantar wound on left foot
- Lung sounds diminished and crackles
- SpO2 - 92%

Lab findings/diagnostic tests\*:

- BUN - 38
- MCHC - 32.2
- RDW - 16.0
- ABG pCO2 - 63.6
- CO2 41.1
- Chest X-Ray

Risk factors\*:

- 64 years old
- Chronic asthma
- Chronic hypertension
- IDDM
- Acute congestive heart failure
- Chronic kidney disease

Interpreting/Analyzing Cues/  
Prioritizing Hypotheses/  
Generating Solutions:

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

- Impaired gas exchange
- Overweight and risk for overweight
- Ineffective breathing pattern
- Decreased activity tolerance
- Risk for electrolyte imbalance
- Excess fluid volume
- Risk for imbalanced fluid volume

Potential complications for the top priority:

- Dyspnea
  1. Nasal flaring
  2. Fast shallow breaths
  3. Chest pain
- Atelectasis
  1. Fever
  2. Coughing
  3. Shortness of breath
- Hypoxia
  1. Restlessness
  2. Headache
  3. Confusion
  4. Fast heart rate

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Responding/Taking Actions:

**Nursing interventions for the top priority:**

1. Assess vital signs q4h → assess for changes/improvements in blood pressure and SpO2 levels
2. Put bed to at least 45-degree prn → helps promote more effective breathing
3. Auscultate lung sounds q4hr/prn → monitor for improved/worsening of crackles
4. Assess amount of labor needed when breathing normally q4hr → provides information on how hard it is for pt to get breaths in
5. Pain assessment q2hr/prn → help to determine if pain is present and to promote pt comfortability
6. Assess level of consciousness q4h → impaired gas exchange can cause decreased levels of consciousness and confusion
7. Assess capillary refill on fingers and toes q4hr → make sure sufficient amount of oxygen is getting to extremities
8. Encourage patient to cough and deep breath daily → helps to clear secretions in lungs
9. Encourage patient to use incentive spirometer 10x per hour → helps to expand and strengthen lungs
10. Educate patient regarding safety due to home oxygen on discharge → reduce risk of falls

Reflecting/Evaluate Outcomes:

**Evaluation of the top priority:**

- SpO2 up to 94%
- Lung sounds still diminished and crackles present
- 5L continuous oxygen nasal cannula
- Continue plan of care