

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name Josh Hernandez

Date 11/15/2023

Noticing/Recognizing Cues:

Assessment findings*:

- *rhonchi lung sounds
- *sinus tachycardia HR 97
- *Oxygen O2: 4L
- *Crackles and rales
- *BMI:18.7
- *Frequent Falls: score 17
- *generalized weakness
- *Shortness of breath
- *Pain when coughing in their back
7/10

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

Lab findings/diagnostic tests*:

- *RBC 3.80L
- *Hgb 10.2 L
- *Hct 32.1
- *CO2: 35.8 H
- *Glucose 107 H
- *CT Scan -nodule 12 MM LLL
- *Bilateral pleural calcification

Risk factors*: *76 years old male

- *lung cancer
- *COPD
- *Obstructive pneumonia
- *Hypertension
- *Chronic Respiratory Failure w/ hypoxia
- *pulmonary embolism
- *esophageal obstruction
- *home on 2L of oxygen
- *gastritis
- *deep vein blood clot on RLE

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- ***impaired gas exchange**
- *Risk for adult falls
- *Fatigue
- *Impaired physical mobility
- *pain

Potential complications for the top priority:

- *mobility
- abnormal gait
- dizziness
- trouble repositioning
- *Decreased SpO2 levels
- accessory muscle use
- confusion
- Restlessness
- *Decreased vascularity
- non-blanchable erythema
- cyanosis
- deep vein thrombosis

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Responding/Taking Actions:

Nursing interventions for the top priority:

- * assess lung sounds by auscultating every 4 hours
- to note a change in baseline in the lung sounds
- * Assess Vital Signs and O2 with pulse oximeter every 2 hours and PRN
- to monitor and see if there has been a change of status in vital signs and as well as a change in O2 saturation
- * assess skin integrity every 2 hours
- impaired gas exchange can cause risk for cyanosis
- * assess patient's mental status every 4 hours
- impaired gas exchange can cause a patient to have a decreased level of consciousness and can impair their ability to protect their airway
- * assess patient's perception of breathing every 2 hours
- investigate range of symptoms (air, hunger, shortness of breath with speaking, activity or at rest etc.)
- * Reposition patient every 2 hours
- avoid any skin breakdown and promote circulation
- * Provide adequate rest between activities every 6 hours
- helps limit oxygen needs and the consumption
- * administer Proventil every 4 hours
- for the patient's shortness of breath
- * administer Roxicodone every 6 hours PRN
- for when the patient is having pain
- * Encourage coughing and deep breathing every 2 hours
- clearing airway of any secretions the patient may have
- * encourage fluid intake every 3 hours
- increase mobilization of secretions
- * encourage incentive spirometry every hour 10 times
- to improve their lung strength and help expand their lungs
- * educate on the importance of nutrition
- to improve stamina and the work of breathing
- * educate on the importance of stop smoking
- prevent further decline in lung function
- * educate on the importance of home oxygen therapy and safety measures
- this ensures client's safety, especially when used in the elderly.



Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- *Patient's pain is a 5/10
- *Patient's lung sounds are still rhonchi
- *patient is experiencing shortness of breath
- *Patient is able to turn on their own without assistance
- *lab levels are continuing at the same levels RBC 3.80, Hgb 10.2, HCT, 32.2, CO2 35.8
- *patient is now on 3L of oxygen
- *will continue plan of care