Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ____katelyn morgan care plan 2 MSN 2024_____ Date _____

Noticing/Recognizing Cues:

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

Assessment findings*:

- SOB with exercise
- 1800 mL fluid restriction
- BLE 2+ pitting edema
- NS lock left antecubital
- Blood sugar 145 (breakfast) & 168 (lunch)
- Low sodium diet
- Anxious
- 2L O2
- Last BM 2/14/24
- 97.5, 59, 18, 118/68, 95% O2
- Diminished right lung sounds

Lab findings/diagnostic tests*:

- CXR: right pleural effusion
- CXR: fractured ribs on right side
- Magnesium 1.7 L
- Bun (33) H
- Cr (1.62) H
- Thoracentesis ordered for this PM
- Echocardiogram showed NSR w/1st degree heart block right bundle branch block and left anterior fascicular block

Risk factors*:

- Male
- 77 yr old
- Diabetes's
- Afib (new onset)
- Pleural effusion
- Hypoxic
- Over weight 113kg
- CHF

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Risk for imbalanced fluid volume
- Ineffective breathing pattern
- Ineffective community coping

Potential complications for the top priority:

- **Anxiety**
  - **Increased HR**
  - **Tachypnea**
  - **Panting**
  - **Sweating**
- **Pleural effusion**
  - **Diminished right lung sounds**
  - **Cyanosis**
  - **Low SpO2**
- **Hypoxemia**
  - **Low SpO2 <95%**
  - **SOB**
  - **tachycardia**

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Monitor VS q4h and prn
    a. To assess overall wellbeing
2. Assess respiratory system q4h and prn
    a. To assess for worsening or improvement. To assess for difficulty breathing or fluid overload
3. Assess edema and monitor for improvement q4h
    a. To assess for worsening or improvement. To also assess for any open areas in the skin from the swelling.
4. Apply oxygen when SpO2 <95%
    a. Assess for s/s hypoxia
5. Measure I&O q shift
    a. To monitor kidney function, and to assess if patient is staying within fluid restriction amount
6. Measure daily weight q morning
    a. To determine if body is holding onto extra fluid
7. Monitor lab and diagnostic results as available/order
    a. To assess if labs are WNL/parameters
8. Administer furosemide 40mg PO BID
    a. Will help decrease edema in BLE and will help with breathing as the heart wouldn't have to work as hard against edema
9. Administer amiodarone 100mg PO daily
    a. Helps the body stay at NRM; patient has a new onset of afib
10. Administer famotidine 20mg PO daily
    a. Helps prevent gastric reflex r/t to anxiety
11. Educate patient on 1800 ml fluid restriction and a low sodium diet on administration and reinforce prn
    a. Patient has CHF – fluid restriction helps to prevent overloading your heart. Low sodium diet prevents extra edema from accumulating
12. Educate patient on distractive technique q shift
    a. To help lessen anxiety

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- SOB with exercise
- Patient staying with in fluid restriction
- BLE 2+ pitting edema
- Pt maintaining low sodium diet
- Pt less anxious
- Diminished lung sounds (rt side)
- NNO CXR or magnesium levels
- Thoracentesis ordered for PM

    - Continue POC