Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ___Morgan Allison_____ Date _____11/14/2024_____

Noticing/Recognizing Cues:

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

Assessment findings*:

- P-116
- Wheezing in the left lung, clear in the right
- +1 pitting edema
- Unsteady gait
- Glasses
- Short of breath
- Missing teeth with no partials
- Nasal cannula 3L

Lab findings/diagnostic tests*:

- WBC-13,000
- CT positive for present fluid in the lungs
- Chest X-ray present fluid in the left lung

Risk factors*:

- Age-88-year-old female
- h/o lung cancer
- h/o plural cath
- h/o of atrial fibrillation
- h/o hyperthyroid
- High fall score
- h/o of lymphedema

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Oxygenation – impaired gas exchange
- Decreased mobility – impaired physical mobility
- Skin Integrity – risk for pressure injury

Goal Statement: Patient will have improved gas exchange and be on room air & decrease shortness of breath with activity by discharge.

Potential complications for the top priority:

- Sepsis
  - Hypotension, hyperthermic, confusion, lethargy, and oliguria
- Respiratory distress
  - Diminished lung sounds, atelectasis, decrease SpO2, decrease respiratory rate, absence of breath sounds (Davis 2022)
- Impaired skin integrity
  - Pressure injury
  - Redness of bony prominences
  - Altered skin color or turgor

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vital signs Q4 and PRN – to monitor changes such as an increase of decrease & SpO2 to identify any changes.
2. Assess lung sounds Q4 and PRN – to identify any changes within the lungs and monitor wheezing present.
3. Assess skin integrity around ears and bony prominences Q2 and PRN – to eliminate risk for pressure injuries to occur.
4. Assess level of consciousness – to assess any mental status changes along with confusion.
5. Monitor breath sounds Q4 and PRN – avoiding respiratory distress.
6. Monitor nutrition Q6 – having adequate nutrition promotes the healing process.
7. Monitor the use of an incentive spirometer – helps keep the lungs open.
8. Change position Q2 – reduces the risk for pressure injury and impaired skin integrity.
9. Elevate the head of bed at a 45° angle – helps keep the lungs open and engaged.
10. Maintain nasal cannula at 3L per order – helps keep the oxygen saturation from dropping.
11. Administer carvedilol 25mg – helps with a heart rate < 110.
12. Administer morphine IV Q3 or PRN – helps with pain resulting from shortness of breath (Davis 2024)
13. Encourage coughing Q2 – to ensure maximum lung use.
14. Educate on the use of an incentive spirometer when received – helps keep the lungs open and engaged
15. Have the patient demonstrate the use of an incentive spirometer when received – to show an understanding on how to use it properly.
16. Educate on the importance of ambulating by discharge – helps circulation within the body.
17. Educate on the importance of changing positions by discharge – decreases the risk for pressure injury to occur from not ambulating.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Lung sounds clear on both sides
- Patient ambulates to the side of the bed to tangle feet
- Patient states "I don't feel as short of breath"
- P-107
- No new labs or diagnostics pulled

Continue plan of care.

Reference: Doenges, M.E., Moorhouse, M.F., & Murr, A.C. (2022). Nurse's pocket guide: Diagnoses, prioritized interventions, and rationales (16th ed). F. A. Davis Company: Skyscape Medpresso, Inc.

Deglin, J. H., Vallerand, A. H., & Sanoski, C. A. (2024). Davis's drug guide for nurses (19th ed). F. A. Davis Company: Skyscape Medpresso, Inc.