Nursing Care Concept Map

Nursing Diagnosis
- **Impaired Physical Mobility**

Nursing Interventions:
a. Reposition patient every 2 hours
b. Assess patient for skin breakdown
c. Provide active range of motion exercises for patient
d. Promote early ambulation as soon as patient can and utilizing assistive devices when appropriate

Nursing Diagnosis
- **Risk for Ineffective Cerebral Tissue Perfusion**

Nursing Interventions:
a. Assess patient neuro status
b. Provide calm environment
c. Evaluate and assess patient vitals
d. Provide oxygen as prescribed by physician

Nursing Assessment, Vital signs, Medical Diagnosis/Surgical Procedure, Lab values , Medications:
- **Assessment: Daily weight: 186 lbs**
  - **Musculoskeletal: patient reports of right sided weakness**
  - **Patient can sit up and eat**
  - **Neuro: Patient is A&O x 3**
    - **PERRLA**
  - **Respiratory: heard rhonchi on auscultation of the lungs**
  - **Cardiac: S1 and S2 heard**
    - **Heart sounds are clear to auscultation**
- **Vital Signs: Temp: 97.7, pulse: 58, RR: 16, BP: 104/72**
- **Medications: - Amlodipine**
  -Apixaban
  -Atorvastatin
  -Losartan
  -Metoprolol tartrate
  -Omeprazole
  -Sennosides
  -Acetaminophen
  -Bisacodyl

Nursing Diagnosis
- **Impaired verbal communication**

Nursing Interventions:
a. Learn and try to understand patients' needs through nonverbal cues
b. Place important objects within patient reach
c. Stand close and make eye contact with patient when speaking to them
d. When teaching, individualize the teaching according to patients' capabilities.

Nursing Diagnosis
- **Impaired swallowing**

Nursing Interventions:
a. Place NPO sign on patient door so anyone entering patient room will know that patient cannot have anything by mouth
b. Avoid providing liquids and any solids until patient can swallow
c. Assist patient in swallowing exercises as directed
d. Provide patient oral care before and after patient is fed