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Concept Map 1  
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Patient initials: NP 9yM

Medical Diagnosis: Epilepsy, chronic respiratory failure, and musculoskeletal deformities due to a gene mutation.

Tests: Waiting on a sleep study

Assessment Findings: Limited ROM 2+, non weight bearing. Sensation felt in limbs but deformed.

PMH: Chronic respiratory failure, seizure disorder, tracheostomy, mickey g tube

Medications:

Acetaminophen 360mg PRN

Albuterol 3mL PRN

Clobazam 10mg

Clotrimazole

Diazepam 5mg PRN

Famotidine 12mg

Fluticasone Propionate 110mcg

Ibuprofen 200mg PRN

Trileptal 450mg BID

Levothyroxine 62.5mcg

Miralax 17g Q2D

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Nursing Dx: Impaired respiratory function related to ineffective breathing pattern as evidenced by hypoxemia

Expected outcome: Patient will have an Spo2 level of 94 or above by the end of the clinical shift.

Interventions:

Evaluate any change in respiratory rate or depth

Auscultate lungs every 4 hours for any adventitious sounds

Monitor patient for any change in mental state

Assess capillary refill and observe for any sign of cyanosis

Evaluate patient's hydration status

Evaluation: Goal met, patient had an Spo2 level of 98 by the end of the clinical shift.

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Nursing Dx: Risk for imbalanced nutrition related to disinterest to eat orally.

Expected outcome: Patient will consume more than 50% or more of meal to eliminate use of enteral feeding by lunch time during the clinical shift.

Interventions:

Monitor a strict input and output

Encourage oral intake of food as much as possible

Collaborate with nutritional support team

Educate patient about importance of eating a balanced meal

Evaluation: Goal met, patient consumed 75% of meal and did not need enteral feeding by lunch.

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Nursing Dx: Risk for aspiration related to oral feeding with a tracheostomy

Expected outcome: Patient will consume food during meal time without choking or coughing by the end of the clinical shift

Interventions:

Assess patient's ability to swallow

Encourage small bites while patient is eating

Educate patient about the foods that are best to it

Have patient maintain upright position while eating

Evaluation: Goal met, patient maintained a clear airway and did not choke or cough during the meal by the end of the clinical shift.

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Nursing Dx: Risk for ineffective airway clearance related to invasive ventilation

Expected outcome: Patient will remain with a clear airway by the end of every clinical shift

Interventions:

Reassess patient breath sounds every 4 hours

Assess ABGs when applicable

Observe quality, quantity, color, and odor of any sputum

Monitor pulse ox. Every 4 hours

Evaluation: Goal met, patient maintained a clear airway by the end of the clinical shift.