

## Concept Map

<p><b>Nursing Diagnosis</b> Activity Intolerance Etiology; Respiratory failure. S/S: Cyanosis, Weakness, inability to perform IADLs, <b>Expected Outcome</b> Patient will be able to maintain complete ADL without shortness</p>	<p>Medical Diagnosis: acute Respiratory failure with tracheostomy Ventilator. Assessment: Temperature: 97.1 F Pulse 113BPM, RR 40, BP: 94/54, Pulse Ox: 99%, Tracheostomy with ventilator. Medication: Acetaminophen 180MG Albuterol Sulfate Cetirizine HCl 2.5 mg Famotidine hydrochlorothiazide spironolactone <b>Diagnostic test:</b> Arterial blood gas Blood exam Xray</p>	<p><b>Nursing Diagnosis</b> Ineffective Airway Clearance Etiology: Respiratory failure S/S: Dyspnea, Hypoxemia, Copious mucus production <b>Expected outcome</b> The patient will maintain a clear airway as evidenced by clear lungs sounds throughout hospitalization in 3 hours</p>
<p><b>Nursing Interventions</b> 1. Ensure adequate oxygen 2.reposition patient as needed 3.Assess activity intolerance 4.Monitor weight 5. assess vital every 4 hours. <b>Evaluation: Goal met, Patient shown normal vital sign, no dyspnea, no respiratory distress during activity within 2 hours</b></p>	<p><b>key problem</b> impaired verbal communication Etiology: Tracheostomy S/SDisorientation, inability to use body expression. <b>expected outcome</b> the patient will demonstrate a form of communication to get their needs met in 2 hours,</p>	<p><b>Nursing Interventions</b> 1.Monitor breathing pattern and sounds. 2. Administer medications as prescribed, Albuterol Sulfate. 3.Suction patient as needed 4.Assess Vitals every 4 hour and auscultate the lungs 5. Reposition patient frequently. <b>Evaluation</b> Goal met, Upon Auscultation, patient was able to maintain a clear breath sounds with a oxygen saturation of 99% within 3 hour of hospitalization.</p>
	<p><b>nursing intervention</b> 1.place the patient room close to nurse station 2. ensure call lights near reaching distance for patient and family. 3.allow different method for communication 4.educate parents about communication device <b>Evaluation</b> <b>Goal met</b> Patient able to nod yes to get their needs met within 2 hours.</p>	<p><b>Nursing Diagnosis</b> Anxiety Etiology: Changes Related to patient's health. S/S: Restlessness, sweating, hyperventilation <b>Expected outcome</b> The Parents will verbalize reduced anxiety in 2 hours</p>
		<p><b>Nursing intervention</b> 1. Suction tracheostomy tubes and mouth 2.Education parents about the purpose and care of tracheostomy 3.allow family to bring toys for patient to have hands on experience. 4. Allow the parents to express fear and concern they have about their child diagnosis. <b>Evaluation</b> Goal met, Parents demonstrate understanding and no sign of frustration within 2 hour.</p>

Christie Benoit