

Study Guide:

Key Topics to Review:

- **Assessment Techniques:** Focus on the skills needed to perform a thorough respiratory assessment.
- **Breath Sounds:** Understanding normal and abnormal breath sounds.
- **Assessment Findings:** What to look for in inspection, palpation, and percussion of the thorax.
- **Nursing Considerations:** Common nursing diagnoses related to oxygenation issues.
- **Nursing Interventions:** Strategies to promote effective respiratory function.

Important Concepts:

1. Respiratory Assessment Techniques:

- **Inspection:** Observe the patient's breathing pattern, chest symmetry, use of accessory muscles, and overall respiratory effort. Look for signs of distress, such as nasal flaring or cyanosis.
- **Palpation:** Feel for expansion of the chest and assess tactile fremitus by having the patient say "ninety-nine" while you palpate different areas of the thorax.
- **Percussion:** Tap on the thorax to determine the presence of air or fluid in the lungs; dull sounds may indicate fluid accumulation, while hyperresonance could suggest air trapping.

2. Breath Sounds:

- **Auscultation:**
- **Expected lung sounds:** Recognize vesicular sounds (soft and low-pitched). Clear to auscultation throughout bilaterally
- **Abnormal Sounds:**
 - **Wheezing:** Indicates narrowed airways (asthma, COPD).
 - **Crackles:** Suggests fluid in the lungs (heart failure, pneumonia).
 - **Stridor:** A sign of upper airway obstruction.

3. Assessment Findings:

- **Expected Findings:** Regular respiratory rate (12-20 breaths/min), clear lung sounds, and O₂ saturation > 92%.
- **Abnormal Findings:** Increased respiratory rate, abnormal lung sounds, and low O₂ saturation (< 92%).

4. Nursing Considerations:

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