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 lowpitched). 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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