Firelands Regional Medical Center School of Nursing
Care Map

Student Name: Abby Woodyard **Date: 3/16/22**

Noticing/Recognizing Cues:

*Highlight all data from each box relevan

Assessment findings:

- Pain 9/10 in right amputated thigh
- Facial grimacing
- Guarding Leg
- FSBS: 204 (Breakfast)
- FSBS: 456 (Lunch)
- 2L Nasal Cannula
- Confused/unable to put words together
- Carb- Consistent diet
- Generalized weakness in arms and leg
- 2 person assist to wheelchair
- High Fall Risk (score:15)
- On Telemetry
- Clear/diminished Lung sounds on exertion

Lab findings/diagnostic tests:

- RBC: 2.92 (Low)
- Hgb: 8.3 (Low)
- Hct:24.9 (Low)
- Na: 133 (Low)
- Glucose: 254 (high)
- BUN: 26 (High)
- Ca: 8.0 (low)

Risk factors:

- Age (64)
- Uncontrolled diabetes
- Impaired nutrition
- Gangrene
- Alcohol abuse
- Cigarette smoker
- COPD
- DVT
- Assistive device (wheelchair)
- Hypertension
- Hyperlipidemia
- A-Fib
- MI
- History of Falls
- High Fall Risk (Score:15)
- Multiple Medications
- Low Social Support

Interpreting/Analyzing Cues/Prioritizing Hypotheses/Generating Solutions:

Nursing priorities:

1. **Acute Pain**
2. **Risk for infection**
3. **Risk for Injury**
4. **Impaired Physical Mobility**

Potential complications:

1. Acute pain- Elevated heart rate, elevated blood pressure, Increase in respiratory rate, restlessness, sleep insomnia, agitation, anxiety
2. Sepsis- Increase HR, Fever, difficulty breathing, mental confusion, reduced urine output, body swelling, and hyperventilation
3. Fractures- intense pain, deformity, swelling, limb out of place, numbness, tingling, bruising
4. DVT(Pulmonary embolism) - Swelling of leg, severe leg pain, bluish skin color, redness, warm skin, and cramping

Responding/Taking Actions:

Nursing interventions:

1. Assess vital signs q 4 hours. **Rationale:** Ensuring that their baseline is staying the same and that heart rate and blood pressure are not increasing or decreasing. This could cause dizziness, fatigue, and weakness
2. Assess and monitor pain q 4 hours or PRN using the 0-10 scale, location, and severity. **Rationale:** This can allow the patient to have pain relief whenever they are feeling pain and sets a baseline for the pain. This can allow care to be evaluated to change or keep the same depending on the management of the pain
3. Assess for the need of pain medication (Tylenol, Norco, and Roxicodone) and administer PRN. **Rationale:** Pain medications are given to relieve pain and allow the patient to succeed in therapy and other daily activities.
4. Reassess pain 30 minutes after giving a pain medication. **Rationale:** Ensures that patient's pain is tolerable and managed
5. Place correct fall precautions in place q 4 hours. **Rationale:** Ensures patient safety and prevents falls and harm to the patient.
6. Reposition pt q 2 hours or PRN. **Rationale:** This will provide comfort and pain relief for patient. This also ensures that patient doesn't develop pressure ulcers.
7. Provide non-pharmacological pain relief PRN. **Rationale:** Ensures patient is distracted from pain and ensures comfort. (ex: heat, ice, massage, relaxation techniques, distraction)
8. Encourage deep breathing and relaxation techniques. **Rationale:** Ensures that patient is properly deep breathing and cough to ensure no complications like pneumonia. Also, relaxation can help with anxiety and decrease pain
9. Educate on pain management and techniques. **Rationale:** This will ensure that they can manage their pain at home or do techniques by themselves when they are experiencing pain. Also, correct education is important on their medication regimen.

Reflecting/Evaluate Outcomes:

Evaluation:

Updated pain: Pain is managed and is 2/10, pain is dull with physical exertion, FSBS: 129, no facial grimacing or guarding site. Patient has been educated on proper pain management. **Continue plan of care**