**Firelands Regional Medical Center School of Nursing**
**Nursing Care Map**

**Student Name** _____ **Date** _____

**Noticing/Recognizing Cues:**

Briana Busby 02/09/2023

***Highlight all related/relevant data from the Noticing boxes that**

**Assessment findings*:**

Pressure wounds (Bilateral ankles, scrotum, coccyx, rectum),
bilateral foot/ankle edema,
tingling/burning lower body,
pedal pulses (L WNL, R weak),
suprapubic catheter (patent/draining),
neurogenic bladder,
ostomy,
paraplegic,
use of wheelchair/hoyer,
VS: T:97.4, R:18, P:71, BP:130/82, SPO2:97%,
height 5'8",
weight:88.6kg/BMI:29.7,
pain8/10, back/flank pain,
rounded/tender/distended/guarding abd,
diff swallowing,
NPO (ordered and "couple days",
nausea,
lungs clear/diminished,
infusaport

**Lab findings/diagnostic tests*:**

WBC:8.5,
hgb: 8.6,
hct:22.6,
plt:346,
protein:6.4,
albumin:2.9,
AST:23,
ALT:46,
alkphos:105,
bilirubin:0.2,
Na:136,
K:3.7,
Cl:102,
CO2:26.9,
BUN:8,
Cr:0.58,
glucose:84,
PT:12.9,
INR:1.1

+

**Risk factors*:**

Hx: DVT,
Neurogenic bladder,
ankle osteomyelitis,
cellulitis,
MRSA,
ESBL,
HTN,
Neuropathy,
GERD,
paraplegia,
chronic pain,
angioedema,
suprapubic catheter,
sepsis,
UTI,
reflex sympathetic dystrophy,
non-healing wounds/ulcers,
immobility,
refused to reposition

**Nursing priorities*:** ***Highlight the top nursing priority problem***

- Impaired skin integrity,
  impaired nutrition less than body requirements,
  acute pain,
  impaired urinary elimination,
  risk for falls,
  risk for infection
  impaired bowel elimination

**Potential complications for the top priority:**

**Infection:** WBC increased, pulse increased, change in LOC, BP decreased, redness/pus with suprapubic catheter/infusaport.
**Dehydration and/or Fluid/electrolyte imbalance related to NPO status**, abnormal and/or increased/decreased electrolytes and labs, increased pulse, decreased BP, change in LOC, increased albumin
**Constipation/Bowel obstruction:** decreased bowel sounds, hard/no stool, abd pain/firm/distended. **Unrelieved pain:** facial grimacing, verbal numeric pain level, guarding, Increased BP/resp/pulse

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**Responding/Taking Actions:**

1. assessment qshift and PRN to monitor pt level of health and any abnormalities and the healing of pt
2. assess VS q4h &PRN to monitor for infection and pain
3. assess and change dressing/wounds daily and PRN to maintain cleanliness and reduce risk of infection
4. Assess IV q2h and PRN to maintain vascular access and monitor for infiltration, infection, or other IV complications
5. use pressure relieving mattress or pressure-relief device daily while in bed or wheelchair to reduce pressure and encourage healing of wounds
6. Turn/reposition pt q2h and prn to improve healing and circulation of wounds
7. Administer home medication daily per order from provider (scheduled and PRN) to maintain healthy condition of establish disease processes
8. obtain specific labs as ordered by provider daily and PRN to help monitor pt health status (infection, organ functions, fluid and electrolyte level, ect)
9. complete passive/active ROM qshift to decrease muscle spasticity which can be very painful.
10. Elevate feet daily while in bed to reduce edema
11. apply/take off TED/SCDs qAM/qHS to decrease edema and improve circulation
12. Complete I/O qshift, to maintain hydration/reduce risk of constipation/bowel obstruction
13. measure wounds weekly and PRN to monitor the worsening or healing of wounds

**Reflecting/Evaluate Outcomes:**

Assess for healing wounds by decreased redness and size,
maintain WBC within 4.5-11,
temp within normal range,
hgb within 11.8-17,
hct within 34-50,
albumin within 4-6
comply with repositioning q2h,
be able to tolerate fluids and nutrition when diet advances to promote healing

continue plan of care