

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



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

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

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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

Harding, M., Kwong, J., Hagler, D., & Reinisch, C. (2023). *Lewis's medical- surgical nursing: Assessment and management of clinical problems* (12th ed). St. Louis, MO: Elsevier, Inc.

Reflecting/Evaluate Outcomes:

pressure wounds cleaned and dressing changes with no changes to wounds
bilateral LE edema and circulation improved to +1 and pedal pulses WNL bilaterally by end of shift
maintained no changes of WBC within 4.5-11 at 8.5
temp increased to 99.4 by next day indicating decline and increase risk of infection

- hgb within 11.8-17 maintained at 8.6 indicating no change
- hct within 34-50 maintained at 22.6 indicating no change
- albumin within 4-6 maintained at 2.9 indicating no change
- weight and BMI maintained with no changes

be able to tolerate fluids and nutrition (passed swallow test) and diet advances to promote healing declined upon assessment (increased nausea and decreased appetite but at regular diet), indicated declined status
ostomy and suprapubic catheter remain unchanged, all are draining well and remain free from irritation and infection at sites
pain, burning/tingling and abd findings remain unchanged indicating not improving
paraplegia and wheelchair use remain unchanged
BUN and creatinine remain unchanged

CONTINUE PLAN OF CARE