Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _____Kenny Seibold_____ Date _____2/16/23_____

Noticing/Recognizing Cues:

Highlight all related/relevant data from the Noticing boxes that support the top priority problem

Assessment findings*:

- Dry skin and mucosa
- Ileostomy bag leaking
- Spo2 93%
- BP 101/67
- Radial pulse 100 beats at 1130
- Wound dehiscence in abdomen
- Pressure wound on coccyx
- Cognitive Impairment

Lab findings/diagnostic tests*:

- BUN 24
- Creatinine 2.22
- Glucose 143
- Hemoglobin 9.9
- Hematocrit 30.7
- WBC 15.4
- RBC 3.01
- Pulse 94
- RR 26

Risk factors*:

- Age
- Alert to self only
- Bowel
- Lack of Fluid intake (50mL in 2hr)
- Medications
- Lethargic

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Malnutrition
- Dehydration
- Immobility
- Fluid Imbalance

Potential complications for the top priority:

- Vertigo
  Dizziness, hypernatremia, Lethargy

Hypovolemia

Increased Pulse, Decreased BP, Increased RR

Acute kidney injury

Bun level increased, Creatinine Increased, Low urine osmolarity, color/ smell of urine

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vital signs q2h and PRN
   a. To assess BP and HR for any changes
2. Assess patient intake and output q4h and PRN
   Determine amount of Fluid intake and loss
3. Administer NS bolus per physician STAT order
   due to dry mucosa in the oral cavity
4. Assess patient weight q1 per day and PRN
   To determine weight loss due to dehydration
5. Administer Medication Imodium 4mg at 0900
   To help with Chronic Diarrhea
6. Educate the patient on importance to measure I/O
   To keep a running diary and keep track of fluid output

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Evaluate patient BP 98/67 with HR 100
  Evaluate patient Lab values BUN 24, Cr 2.22, glucose 143, Na 137, K 4.7, HCO3 27.1
  Evaluate patient mobility and LOC
  To determine orthostatic hypotension

Evaluate patient dry oral mucosa and skin turgor was negative.
To check for physical signs of hydration

Continue Plan of Care