Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _____ **Date** _____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Ostomy bag
- Alteration in fluid volume
- Dehiscence wound next to Ostomy
- Speech diminished
- BP 92/66
- Decreased appetite
- HIGH Fall Score
- Uses walker & wheelchair
- Inability to do ADLs
- Mild Weakness
- Altered mental status
- Distended, tender abdomen
- Tachycardia
- Resp Rate- 18
- Non blanchable redness around new ostomy

Lab findings/diagnostic tests*:

- WBC 15.5
- RBC 3.70
- BUN 24 (high)
- Creatinine 1.30 (high)
- Hgb 12.1
- Hct 38.1
- Glucose 124
- Calcium 8.4 (low)
- Urine: Protein-30 & Glucose 100

Risk factors*:

- Diabetes Mellitus
- Reoccurrence of colon cancer
- AFIB
- AKI
- Perforation of Intestine
- Contrast-induced nephropathy
- Leukocytosis
- Cerebral Palsy
- 64-year-old

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Impaired Skin Integrity
- Impaired Mobility
- Risk for Dehydration
- Risk for Surgical site infection
- Impaired nutrition

Potential complications for the top priority:

- Hyperglycemia

-dry mouth, tiredness, recurrent skin infections

- Falls

-leading to fracture, bruising, possible additional surgeries, etc.

- Impaired bowel function

-diarrhea, green stool in ostomy

- Malnutrition

No proper proteins to aid in healing, worsening of wounds, chronic non-healing

- Dehydration

-dry mucous membranes, Orthostatic hypotension, poor skin turgor

- Impaired mobility

-possibility of pressure ulcers, decreased circulation, prolonged healing time

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. **Assess vital signs q4h**- Rationale: to monitor the irregular blood pressure and higher heart rate due to dehydration
2. **Assess pain q2h**- Rationale: to ensure patient stays comfortable
3. **Assess skin q2h**- Rationale: to monitor non blanchable reddened skin around ostomy bag and abdominal wound
4. **Assess nutritional status related to protein intake** - Rationale: Current dehiscence abdominal wound and decreased appetite
5. **Assess distended abdomen/ostomy bag seal daily & PRN**- Rationale: Past incident of leaking ostomy bag causing skin breakdown around stoma site; want to monitor for possible reoccurrence and improvement of skin breakdown. To monitor for improvement or worsening of distention and check stoma site appearance
6. **Change wet to dry sterile dressing daily or PRN if soiled**- Rationale: Promotes wound healing and prevents infection
7. **Administer Sodium Chloride 0.9% 1000mL @100mls/hr IV Q10h**- Rationale: to help treat current dehydration
8. **Administer Cholecalciferol 125mcg PO Daily**- Rationale: to increase their abnormally low calcium levels & promotes skin integrity
9. **Administer Metamucil 3.4 gm 1 packet PO Daily**- Rationale: To harden stool for current diarrhea
10. **Encourage fluids qh**- Rationale: To treat current dehydration and promote skin integrity
11. **Encourage repositioning q2h**- Rationale: Promotes healing, circulation, and prevents pressure ulcer formation
12. **Educate patient and family on wound care, ostomy maintenance, signs of infection, signs of dehydration, nutrition, ambulation, hygiene, medications, infection control using teach back method/ "Chunk and Check" Daily**- Rationale: To ensure and improve patient and family understanding for improving independence

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Goal: Patient continues to have impaired skin integrity as evidenced by non blanchable erythema around ostomy site, same sized dehiscence wound, and dehydration worsening.
- More fluids have been ordered by physician's order and were started
- Appetite has not increased-eating about 25% of meals
- Wound has not decreased in size
- New physicians order for additional Sodium Chloride 0.9% 1000mL @100mls/hr
- New physicians order for Vashe to promote abdominal wound healing
- BP- 122/79
- WBC- 15.4
- Hgb-9.9
- Calcium- 8.1
- Hct-30.7
- PT/OT ambulation in hall & therapy room daily; uses walker
- Ostomy bag changed with new skin barrier method that got rid of some redness around ostomy site

Continue Plan of Care (Possibility of Discharge 2/20)