Nursing Access 2023
Nursing Care Map Assignment
Quiz #4
Place in the "Nursing Care Map" Dropbox by 0800 on Friday 09/22/2023

Instructions: Create a nursing care map using the patient scenario below. Use the sample care map created in class, Nursing Care Map Guidelines, Nursing Care Map Rubric, and the Nursing Care Map Template to organize the care map. **This assignment counts as a quiz grade.**

Reason for Visit: Jillian Johnson, an 82-year-old female is brought to the Emergency Department with complaints of wounds to her lower legs which have not healed in 3 months and have been getting worse over the last few days.

Past Medical History:
- Diabetes Mellitus
- Hypertension
- Hyperlipidemia
- History of falls (patient reports last fall was 1 month ago)
- History of a stroke with right side weakness

Current Medications:
- Lisinopril 5 mg by mouth daily
- Metformin 500 mg by mouth BID
- Ambien 5 mg by mouth at bedtime as needed for sleep

Admission Assessment:

Vital Signs: BP 100/60 mmHg, HR 120/min, RR 14/min, SpO2 95% on room air, T 99.0 °F, Pain 6/10 in bilateral lower legs

Neurological: Alert and oriented to person, place, and time. PERRLA, smile symmetrical, tongue midline, eyebrows lift evenly, speech clear, no difficulty swallowing, numbness and tingling in bilateral lower extremities.

Cardiovascular: Heart rhythm regular, heart sounds S1 & S2, peripheral pulses palpable 2+, no edema noted, capillary refill less than 3 seconds.

Respiratory: No nasal flaring noted, symmetrical chest wall expansion, and no accessory muscle usage noted, clear lung sounds auscultated.

Gastrointestinal/Genitourinary: Abdomen soft, non-tender, non-distended, bowel sounds present X4 quadrants, last bowel movement 2 days ago. Urine is clear, yellow, and without odor. Patient denies any urinary frequency, urgency, hesitancy, or burning. Patient reports incontinence and decreased appetite.

Integument: Skin pink in color, warm, and dry. Skin tenting present.

- 2 X 2 cm open area noted to left shin. Periwound area pink, wound base pink, small amount of serous drainage noted. Patient is unaware of how she obtained the wound.
- 2 X 3 cm open area to right heel. Periwound area edematous, red, hot to touch, wound base red, moderate amount of serosanguineous drainage noted. Patient is unaware of how she obtained the wound.
- Wounds have been present for 3 months and have worsened over the last 2 days.

Musculoskeletal: Moves all 4 extremities without difficulty. Right hand grasp and right push/pull is weaker than left. Gait is unsteady at times. Ambulates with a walker and requires stand by assist to the bathroom. John Hopkins Fall Risk Assessment Score 19 (high fall risk).

Physician Orders:

- Diagnosis: Severe malnutrition, non-healing wounds to left shin and right heel.
- Activity as tolerated
- Diabetic Diet
- Dietitian Consult
- Wound Consult
- CBC, CMP, CXR in AM
- Wound Culture
- Blood Cultures
- ACHS Finger stick
- Wound Dressings Daily
- Vital Signs Q8hr
- Normal Saline @ 100 mL/hr IV
- Medications
    - Continue home medications: Lisinopril 5 mg by mouth daily, Metformin 500 mg by mouth BID, and Ambien 5 mg by mouth at bedtime as needed for sleep
    - Start Vancomycin 500 mg IV Q6 hours

Laboratory Data:

WBC	15,000 10^3/microL
Hgb	12.0 g/dL
Hct	40%
Potassium	4.2 mEq/L
Glucose	200 mg/dL
Albumin	2.8 g/dL

Radiology:

CT scan of bone – no osteomyelitis noted

Evaluation

For the evaluation portion of your Nursing Care Map, please answer the following questions:

1. What reassessment findings would you expect to find that determine effectiveness of nursing interventions?
2. Based on these reassessment findings, would you continue, modify, or terminate your plan of care?

Place your completed care map in the "Nursing Care Map Dropbox" by 0800 on 09/22/2023

NOTE: If a minimum score of 77% is not achieved on the first attempt, the student will be required to revise the assignment to obtain a satisfactory rating. The maximum score a student can obtain after revisions are made is 77%.