Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ____Katelyn Morgan_____ Date ____9/19/23_____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Pt c/o of wounds to her lower legs which have not healed in 3 months and have been getting worse over the last couple days (2 days)
- BP 100/60 mmHG
  - HR 120/min
  - Temperature 99.0F
- Pain 6/10 in BLE
- Numbness and tingling in BLE
- Last BM 2 days ago
- Patient reports incontinence and decreased appetite
- Skin tenting
- 2X2 cm open area to left shin (unaware how we got it); 2X3 cm open area to RT heel, peri-wound edematous, red hot to touch, wound base red, moderate amount of serosanguineous drainage (unaware how she got it)
- RT hand grasp and RT push/pull is weaker than left
- Unsteady gait at times and uses walker to ambulate
- Stand by assistance to bathroom
- John Hopkins Fall Risk Assessment Score 19

Lab findings/diagnostic tests*:

- WBC 15,000 10^3/microL
- Glucose 200 mg/dL
- Albumin 2.8 g/dL
- CT scan of bone ; no osteomyelitis noted

Risk factors*:

- Age 82 year old female
- Diabetes mellitus
- History of falls (last fall was 1 month ago)
  - John Hopkins Fall Risk Assessment Score 19 (high fall risk)
  - Unsteady gait
- history of stroke with right sided weakness
- Hypertension
- Hyperlipidemia
- Decreased appetite

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Health self-management, ineffective
- Nutrition: less than body requirements, imbalanced
- Fluid volume deficit
- Skin integrity, impaired
- Pain, Acute
- Constipation
- Knowledge, Deficient
- Physical mobility, impaired
- Infection, risk for

Potential complications for the top priority:

- Infection
  - Elevated temperature >100.4 -edema
  - Hot to touch - -Redness and Inflammation
  - Elevated WBC >11,000 -Confusion
  - Positive Wound cultures and positive blood cultures
- Dehydration
  - Dry mouth, lips, and eyes
  - Voiding small amounts of urine infrequently (< three or four times per day)
  - Headache
  - Dizziness or light headedness
- Gangrene
  - severe pain followed by numbness
  - cyanosis of skin from poor circulation
  - fever
  - hypotension
  - reduced sensation of touch
  - foul smelling discharge
- Osteomyelitis
  - Swelling
  - Chills
  - Fever
  - Malaise
  - Night sweats
  - Pain in bones or hip
  - redness

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Responding/Taking Actions:

Nursing interventions for the top priority:

1.) Monitor vital signs and pain assessment every four hours and PRN.
   - **Rationale**: Change in vitals can indicate worsening infection and pain
2.) Administer medications as ordered per EMAR
   - **Rationale:** To promote health and wellbeing to the patient. Medications are important for overall health. Medications that are ordered will benefit the patient and promote healing to the wounds.
3.) Nutrition and fluid intake (I&O during shift and PRN) until discharge: Encourage patient to eat adequate protein at every meal. Offer protein supplement <75% of meal consumed. Document meal consumption after every meal and specify if protein supplement was needed and how much was consumed. Nutrition monitoring will be monitored after every meal *until discharge*. Document I&O's during shift and PRN. Offer fluids every hour and PRN.
   - **Rationale:** Consuming adequate protein intake at every meal helps to build muscle and to improve skin integrity. Fluid intake is important to promote hydration and overall maintenance of health.
4.) Skin assessment with every dressing change and PRN. Change dressing BID and PRN
5.) **Rationale:** To assess overall skin integrity. To determine if skin integrity is improving or worsening. Skin assessments are crucial to help identifying potential or further infection(s). To monitor s/s of infection and to promote tissue integrity and wound healing. Cleaning the wounds (per order) will clean the wound and flush out anything harmful to the new tissue that is growing. Be sure to use sterile technique and wear gloves. Wash hands before and after. Document abnormalities such as drainage, the consistency of drainage, if a smell is present, the amount of drainage, and color of drainage. Utilize wound documentation *(COCA)* involving color of wound, if bleeding is present, warmth, inflammation, and edema.
6.) Repositioning q2h and prn
   - **Rationale:** To prevent worsening skin impairment. Utilize body pillow to help alleviate high pressure areas.
7.) Monitor labs daily and PRN until discharge
   - **Rationale:** Check lab values (WBC, CBC, BMP) daily to monitor for worsening or improvement of infection. Checking labs daily will help evaluate if interventions and treatment are working appropriately.
8.) Educate patient during hospital stay and at discharge.
   - **Rationale:** Education is important to maintain overall health and to avoid readmission.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

1. Both wounds are noticed to be improving. Skin is pink and dry, capillary refill <3 seconds, blanchable
2. Wound measurements have decreased to both wounds, no drainage present, no edema present (left skin 0.5 cm x 0.5 cm) (right heel 1 cm x 1 cm)
3. Pt denies pain upon asking, no facial grimacing noted
4. BP 120/80
5. 75 HR
6. Albumin 3.5 g/dL
7. 98.6 degree F Temp

8.) denies numbness and tingling in BLE
9.) No signs of skin tenting
10.) WBC 8,000 10^3/microL
11.) Glucose 95
12.) Albumin 3.5 g/dL
13.) Appetite present. I&O WNL to patient

Continue plan of care