

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name Anthony Drivas

Date _____

Noticing/Recognizing Cues:

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

problem*

Assessment findings*

- Heart Rate elevated at 120/min
- RR 14, SpO2 95%, BP 100/60, T99.0
- Pain in Bilateral lower leg 6/10
- Numbness and Tingling in Bilateral lower extremities
- Incontinence and decreased appetite
- 2x2 cm open area to left shin, Periwound area pink, wound base is pink with a small amount of serous drainage
- 2x3 cm open area on right heel, Periwound area edematous, red and hot to touch, wound base red, moderate amount of serosanguineous drainage
- Right hand grasp push/pull weaker than left
- Gait unsteady at time and ambulates with a walker to the bathroom
- Skin tenting present

Lab findings/diagnostic tests*:

- WBC-15,000
- Glucose-200
- Albumin-2.8

Risk factors*:

- 82 years old
- Diabetes Mellitus
- HTN
- HLD
- Hx of Falls
- Hx of CVA with right sided weakness
- 2x2 cm open area on left shin
- 2x3 open area on right heel

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- **Risk for Impaired Skin Integrity**
- Risk for Infection
- Adult Pressure injury
- Impaired physical mobility
- Impaired Bowel continence
- Impaired urinary elimination
- Risk for deficient fluid volume
- Less than body requirements, imbalanced nutrition

Potential complications for the top priority:

- Sepsis-Tachycardia, Hypotension, WBC >12 or <4, Hyperthermia or Hypothermia, Confusion, L.A>2
- Pressure injuries-Tenderness and Pain, Discoloration of skin, Swelling, warm or cool to touch, purulent drainage, change in skin texture
- Dehydration-Headache, Tiredness, Tachycardia with Hypotension, Loss of appetite, Dry mouth or dry cough, Generalized weakness, small infrequent episodes of urination.

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Responding/Taking Actions:

- 1-promote fluid and nutrient intake to provide body with needed nutrients to promote wound healing**
- 2-Assess skin thoroughly checking for proper circulation and normalization of turgor to make sure no other contributors of impaired skin integrity**
- 3-Change dressing daily and PRN to reduce moisture and monitor for signs of developing or worsening of a infection**
- 4-If unable to ambulate assist patient to turn every 2 hours to reduce pressure on coccyx the sight with highest chance of sore formation**
- 5-Elevate feet of a pillow to reduce pressure on heels and allow sore to start healing**
- 6-Monitor boney prominences and keep supported with pillows to reduce pressure and formation on new sores and keep bed below 30 degrees**
- 7-Ask patient if they need to use to the restroom to reduce episodes of incontinence and the irritation on the skin**
- 8-Monitor vital signs every 8 hours, that the HR is staying between 60 and 100, Temp is staying between 97.6 - 99.6, BP is staying with normal range of 120/80 to monitor for signs of sepsis**
- 9-Monitor blood sugar to regulate back into normal range because hyperglycemia can slow the healing process of wounds**

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- 1-WBC returning to normal range of 5,000-10,000. Blood Glucose maintaining closer to normal range of 80-110. Increase in appetite and increase in fluid too 1500-2000 ml per day and a caloric intake of at least 1600 calories per day. The reducing of the generalized Redness and Edema, Hot to touch and the amount of serosanguineous drainage from the 2x3 wound on the Right heel. The reduction of or complete elimination of the pain in the bilateral lower extremities and monitor for any worsening of bilateral lower extremity numbness and tingling. Skin turgor to be no longer tenting and be able to when pinched to lay flat again in less than 2 seconds.
- 2-Continue plan of care to focus on the healing and also prevention of wounds and monitoring boney prominences, monitoring for any sings of infection and also regulating levels for blood glucose. Reducing possible episodes of incontinence and increase daily fluids and nutritional intake