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*:

- Clear lung sounds
- Sweating
- Flushed skin
- Gain 24lbs in 1 month
- Headache
- Urine dark amber color and cloudy
- Fetal HR 130-140s with decelerations to the 70s
- BP 180-200/90-110

Lab findings/diagnostic tests*:

- Proteinuria 2 +
- Urine trace Ketones, bilirubin, blood
- WBC 10.5
- Fibrinogen 347
- BUN 17
- Creatinine 0.8
- pH 7.8
- Uric Acid 7.9
- K 4.0
- NA 137
- Hgb 12.2

Risk factors*:

- Socioeconomic Status
- Fetal demise
- Smoker
- 2-3 cups of caffeine daily
- Family Hx breast and cervical cancer
- Hx depression
- 1st pregnancy

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Acute kidney failure
- Excess fluid volume (Myers, E., 2018)
- Risk for magnesium sulfate toxicity

Potential complications for the top priority:

- Fluid and electrolyte imbalance
  1.) neck vein distention
  2.) Arrhythmias
  3.) Headache
  Respiratory distress
  1.) SOB
  2.) Crackles upon auscultation
  3.) Low sp02
  4.) Use of accessory muscles
  Risk for injury
  1.) Impaired balance
  2.) Blurred vision
  3.) dizziness

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess VS q4hr and PRN
   -To determine changes in blood pressure and whether treatment is working or not.
2. Assess daily weight q24hr and PRN
   -To determine amount of excess water and whether there are any changes that the HCP needs notified about.
3. Assess oral intake, presence of neck vein distention, and presence/location of edema. Q4hr and PRN
   -To determine the amount the patient is intaking is the amount that is coming out. As well as monitor for possible fluid and electrolyte imbalances to notify the HCP. To determine if edema is improving or getting worse.

4. Auscultate lung sounds q4hr and PRN
-To determine if excess fluid volume is affecting the lungs or if the patient may need further treatment.
5. Monitor lab values q8hr and PRN
-To determine if further treatment is needed and if treatment is being effective.
6. Administer Labetalol 100mg BID
-To help maintain and lower the patients' blood pressure
7. Administer hydralazine 5mg PRN
-For blood pressure that is still elevated after taking the Labetalol, to help bring it down to a more controlled number.
8. Administer magnesium sulfate 2mg/hour (50mL/hour) q24hr
-To reduce the risk of seizures due to preeclampsia possibly becoming eclampsia.
9. Encourage bed rest and SCD use
-To minimize fall risk and prevent the formation of DVTs.
10. Educate to limit sodium and fluid intake
- To aid in preventing further weight gain from excess fluid volume and prevent further electrolyte imbalances.

Evaluation of the top priority:

- VS – Blood pressure improved after administer magnesium sulfate, labetalol, and hydralazine. Initial starting was 200-190 systolic over 110-90 diastolic and is now 150-140 systolic over 90-70 diastolic.
- No change in lung sounds, they are still clear throughout.
- WBC went from 10.5 to 11.7.
- Proteinuria went from 2+ to 3+
- Fibrinogen went from 347 to 417.
- BUN from 17 to 21
- Creatinine from 0.8 to 1
- Sodium from 137 to 136
- Potassium from 4.0 to 4.6
- Uric acid from 7.9 to 8.3
- Level of consciousness there was no change.
- Edema remained the same with 2+ pitting edema bilaterally.
- No added weight gain from the time of admission, so this remained the same.
- Will continue to monitor and continue plan of care.

References: Morgan, K. I., & Townsend, M. C. (2020). Pocket Guide to Psychiatric Nursing. (9th ed) F.A. Davis Company
Myers, E. (2018). RNotes: Nurse's clinical pocket guide (5 th ed). F.A. Davis Company