

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name: Essence Byrd

Date: November 4, 2023

Noticing/Recognizing Cues:

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

Assessment findings*:

- Tremors
- John Hopkins fall score 17
- Wears glasses
- Inability to perform ADLs independently
- Ambulate with walked x Standby assist
- Pulse 94
- Temp 99.3
- Fall Precaution in place
- Seizure precaution in place
- Patient slow to respond
- Patient shows slight confusion
- Reoccurring fever
- No bowel movement since 10/23
- Darkened teeth
- Bruises on skin
- Wound on posterior head

Lab findings/diagnostic tests*:

- Wound culture: + Staphylococcus Aureus
- RBC: 3.50 L most recent
- Hgb: 11.1 L most recent
- Hct: 33.2 L most recent
- RDW: 15.2 H most recent
- Na: 122 L on admission, 132 L most recent
- Glucose: 107 H on admission, 114 H most recent
- Ca: 8.2 L on admission, 8.1 L most recent
- Chloride: 89 L on admission, 96 L most recent
- Albumin: 3.1 L most recent
- Toxicology: Vancomycin peak = 46.4 H

Risk factors*:

- 70 y/o
- History of hypertension
- History of brain surgery
- History of seizures
- History of chronic illness: Autism
- Family history of prostate cancer
- Family history of breast cancer

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

Nursing priorities*:

- Acute confusion
- Risk of adult pressure injury
- Hyperthermia
- Constipation
- Fatigue
- Imbalanced nutrition
- Impaired physical mobility
- Impaired skin integrity
- Risk for adult falls
- Risk for infection

Potential complications for the top priority:

- Skin breakdown
 - No blanchable skin to bony prominences
 - Discomfort
 - Erythema
 - Warmth
- Pneumonia
 - Fever
 - Low SpO2
 - Dyspnea
- Inadequate nutrition
 - Low albumin
 - Poor oral intake
 - Weight loss
 - Non healing wounds
 - Constipation

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess John Hopkins Fall score BID
 - To ensure safety of patient and determine need for fall precaution
2. Assess visual impairment prior to mobility
 - To ensure safety prior to mobility if visual impairment effects mobility
3. Assess vital signs Q4h
 - Determine changes in patient status and safety for mobility
4. Assess patients neurological status prior to mobility
 - Ensure patient is conscious enough to safely perform mobility activities
5. Assess patients skin integrity Q4h
 - To reduce pressure on sensitive areas and prevent development of pressure ulcers
6. Assess patients ability to perform ADLs BID
 - Determine patients need for assistance
7. Determine presence of complications related to immobility
 - The effects of immobility are rarely confined to one body system
8. Demonstrate use of standing aids and mobility devices prior to mobility
 - To promote safety and independence and enhance quality of life
9. Support body parts with pillows throughout time spent in bed
 - To maintain position of function and reduce risk of pressure injuries
10. Encourage adequate intake of fluids and nutritious foods during mealtimes
 - Promotes well-being and maximizes energy production
11. Encourage participation in self-care BID
 - Enhances self-concept and sense of independence
12. Educate patient on reason for fall precaution upon implementation
 - Reduce falls and associated injuries and promote safety of the patient
13. Educate patient on reason for seizure precaution upon implementation
 - To minimize harm and danger



Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Fever decreased from 99.3 to 97.8
- Patient ad bowel movement
- Pulse decreased from 94 to 90
- Na increased from 122 on admission to 132 during hospital stay
- Patient participates in ADLs
- Patient ambulates to bathroom and stands for ADLs

Continue Plan of Care