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*:

- Hip pain 10/10
- Limited mobility/weakness
- Cellulitis on right hand (knuckle and finger)
- Yellow and sanguineous drainage from wound, skin temperature is warm
- Skin turgor
- BP 113/72
- RR 18/min
- T – 97.6 F orally
- Sp02 97% on RA
- HR 71
- Thin, fragile skin
- Confusion
- Urinary retention
- Difficulty sleeping
- Bruises on skin
- Walker when ambulating, 2 person assist

Lab findings/diagnostic tests*:

- RBC 3.42 – low
- Hgb 10.8 – low
- Hct 32.0 – low
- RDW 15.2 – high
- MDW 25.07 – high
- Wound culture came back positive for Staphylococcus Aureus, Acinetobacter Radioresistens, Corynebacterium Striatum group

Risk factors*:

- 87 years of age
- Former smoker
- Wound infection
- Decreased ROM and physical activity
- Hypertension and hyperlipidemia
- Inadequate knowledge on repositioning
- Inadequate knowledge on nutrition – specifically protein intake
- History of falls
- History of back surgery and hip replacement
- Refuses physical therapy
- Urinary tract infection
- Pressure on bony prominences - heels

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions

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

- Impaired skin integrity
- Imbalanced nutrition
- Acute pain (wounds and hip)
- Decreased activity tolerance
- Risk for infection
- Impaired physical tolerance
- Impaired bed mobility

Potential complications for the top priority:

1. Infection
   - Bacterial colonization
   - Inflammatory response
   - Systemic signs (elevated WBC, fever, fatigue)
2. Sepsis
   - Heart rate > 90 bpm
   - Fever
   - Hypotension
   - Organ disfunction
   - Tachycardia
   - Confusion, lethargy
   - White blood cells > 12 or < 4
3. Pressure Injury
   - Skin breakdown, disrupted skin surface
   - Tissue Perfusion
   - Immobility consequences
4. Delayed wound healing
5. Prolonged recovery

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess skin every 4 hours, note any edema, skin tears, wounds, and general skin health.
   - To establish a plan of care for patient and a baseline for skin impairment.
2. Assess patients pain level q4h, specifically regarding wounds and hip.
   - To minimize patient discomfort and provide needed interventions.
3. Obtain vital signs: T, HR, BP, RR, SPO2 q4h & prn.
   - To notice elevated vital signs that could indicate infection.
4. Implement dressing changes and wound cleansing TID or per physician order.
   - To ensure wounds heal and promote health for patient.
5. Implement a turning schedule q2h and prn.
   - to redistribute pressure on bony prominences and limit risk of skin breakdown.
6. Monitor drainage present, anatomical location of wound, and the size three times a day.
   - to determine if wounds or skin tears growing or shrinking in size and to provide needed interventions.
7. Monitor WBC daily, provide antibiotic if needed.
   - To notice if an infection occurs, or if the infection gets worse.
8. Evaluate patients' readiness to learn.
   - For health promotion of patient.
9. Collaborate with other health care providers, like physical therapy, wound care, and dietary.
   - To meet patients' needs for health promotion, specifically for adequate nutrition, wound healing, and a faster recovery.
10. Encourage ambulation and protein intake.
    - To promote circulation and ensure patient receives adequate number of calories and nutrients.
11. Educate patient and family on nutrition, repositioning, and proper wound care.
    - To promote health and aid to a faster recovery.
12. Educate patient and family on use of pillows under bony prominences such as heels, elbows, sacrum, hips, and more.
    - To support extremities from skin breakdown and to elevate body parts.
13. Educate patient and family on risk of friction while repositioning or moving patient.
    - To maintain skin integrity and reduce risk for irritation, broken skin, or pain for the patient.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Overall skin health has improved, no new wounds, edema, lesions, bruises, or red marks.
- Wounds has shrunk in size, no odor, no excessive drainage. Wounds are progressed to healing.
- Patient denies pain, rates it a 0/10.
- Patient can reposition and turn themselves in bed independently.

Continue plan of care