

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name: Hannah Baum

Date: 10/25/23

Noticing/Recognizing Cues:

Assessment findings*:

- BP 143/68
- Pulse 69
- Respirations 14
- Pulse Ox (RA): 92%
- Temperature (oral) 98.9
- Weak, moist, productive cough
- White and thick sputum
- Ronchi throughout anterior and posterior bilateral lungs
- Missing teeth and upper dentures
- 2nd toe on left foot amputated
- SOB on exertion
- Unable to lie flat
- Edema, pitting 2+ on right ankle, 1+ left ankle
- NG tube on intermittent suction
- Abnormal movement
- Generalized weakness
- Lethargic/fatigue
- Muscle weakness
- Limited movement
- Stage 1 pressure ulcer on right heel, stage 2 on sacrum
- Urinary and bowel incontinence
- Foley Catheter
- Abdomen - round, distended, firm
- Hoyer lift

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

Lab findings/diagnostic tests*:

- Hgb: 8.4 (L)
- Hct: 24.6 (L)
- Na: 130 (L)
- Cl: 96 (L)
- BUN: 52 (H)
- Glucose: 141 (H)
- Ca: 7.2 (L)
- Total protein: 6.1 (L)
- Albumin: 3.5 (normal)
- WBC: 3.9 (L)
- Abdomen/Pelvic CT
 - Atrophic left kidney
 - Prominent atherosclerotic disease
 - Dilated small bowel, suspicion for partial distal SBO
- Abdomen x-ray on 10/24
 - Small Bowel Obstruction
- CX-ray
 - Confirm Picc line and NG placement
- Abdomen x-ray on 10/25
 - Confirmed NG placement
 - Dilated small bowel loops

Risk factors*:

- 72 years old
- Colorectal Cancer
- Small Bowel Obstruction
- Recent chemotherapy
- History of
 - Abdominal Aortic Aneurysm
 - Benign Prostatic Hyperplasia
 - Cerebrovascular Accident
 - Diabetes
 - Hypertension
 - Myocardial Infarction
 - Transient Ischemic Attack
 - Chronic Kidney Disease, Stage 3

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Decreased Activity Tolerance
- Impaired Bowel Continence
- Impaired Physical Mobility
- Impaired Skin Integrity
- Impaired Urinary Elimination
- Risk for Adult Falls
- Risk for Infection
- Imbalanced Nutrition
- Risk for impaired Gas Exchange

Potential complications for the top priority:

- Musculoskeletal deconditioning
 - o Loss of muscle mass, fatigue, decreased strength, loss of balance
- Atelectasis
 - o Breathing difficulty, chest pain, cough, wheezing
- Skin breakdown
 - o Areas of nonblanchable redness in pressure points (sacrum, elbows, coccyx, heels, etc), pain in pressure areas, slough, partial or full thickness skin loss

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Pain assessment Q4 hrs and PRN, pain management may improve patient's desire to increase mobility
2. Vital signs Q4 hrs, monitoring blood pressure, respirations, pulse, temperature, and oxygen saturation for changes
3. Assist patient with completion of mobility goals Q12 hrs, to increase muscle strength, tone, ROM, and endurance
4. Evaluate ROM and muscle strength Q6 hrs, to assess for strengths and deficits in mobility to refine or improve mobility goals
5. Determine diagnosis that will contribute to immobility as needed and available, to determine how conditions will impact goals and outcomes
6. Assess the patient's perception of activity and exercise needs and expectations Q12 hrs, determine patient's expectations in regards to mobility and to address any barriers or fears the patient may have
7. Evaluate emotional and behavioral responses to difficulties in mobility - PRN, to address emotions and behavior that may hinder/prevent the patient in completing mobility goals
8. Turn patient and check patient for incontinence Q2 hrs, prevention of skin breakdown and promotion of hygiene
9. Perform focused skin assessment Q6 hrs and PRN, to assess for skin breakdown and need for pressure relief devices
10. Assess NG tube Q4 hrs, to ensure placement and suction
11. Maintain HOB at least 30 degrees at all times, for NG tube placement to prevent aspiration
12. Assess foley catheter Q8 hrs and PRN, to ensure urine output and cleanliness of catheter and monitor for urine changes
13. Monitor nutrition intake with each meal, to prevent or address nutritional deficiencies that are impacting the patient's mobility
14. Monitor lab values as available, to ensure low values improve
15. Record I/O's Q12hrs, monitoring hydration status which can indicate changes in electrolytes, deficits of which can impair mobility
16. Encourage coughing and deep breathing Q2 hrs, to encourage expelling sputum and to open airways to prevent atelectasis
17. Educate patient on use of walker or other assistive devices Q12 hrs, patient will be able to safely and effectively use assistive devices to assist in mobility
18. Educate patient on importance of increasing mobility Q12 hrs, to encourage patient to participate in activities that will mitigate complications of immobility

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Continued SOB on exertion
 - Continued abnormal movement
 - Continued generalized weakness
 - Continued muscle weakness but improved from previous day
 - Continued limited movement but improved from previous day
 - Pressure sore stage 1 on right heel and stage 2 on sacrum
 - Continued urinary and bowel incontinence
 - Continued ronchi throughout bilateral lungs and productive cough
 - Decreased lethargy, continued fatigue
 - Use of walker to stand - hoyer to chair
 - Vital signs 10/26: Pulse - 89, Blood pressure - 178/91, Oxygen saturation - 92%, Temperature - 98 F, Respirations - 16
 - Lab values 10/26: WBC - 3.2 (L), Hgb - 8.3 (L), Hct - 24.6 (L), Ca - 7.1 (L), RBC - 2.56 (L)
- **CONTINUE PLAN OF CARE**