

**Firelands Regional Medical Center School of Nursing
Nursing Care Map**

Student Name Ava Lawson

Date _____

Noticing/Recognizing Cues:

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

Assessment findings*:

- T: 97.9 F
- HR: 91
- BP: 137/60
- RR: 16
- SpO2:98%
- Generalized Weakness
- Edema in Left Wrist
- Suprapubic catheter
- Abdominal Hernia
- Left foot wound
- Stage 2 pressure ulcer on right ischium
- Urine dark yellow and cloudy

Lab findings/diagnostic tests*:

- Lab Findings:
 - BUN: 48 (H)
 - Creatinine: 4.33 (H)
 - RBC: 2.91 (L)
 - Hgb: 9.1 (L)
 - Hct: 27.0 (L)
 - BNP:634 (H)
- Diagnostic Tests:
 - Chest x-ray: Left base atelectasis
 - Urinalysis: Positive for E-coli, Klebsiella, proteus vulgaris

Risk factors*:

- 75 y/o male
- Hx Colon Cancer
- End Stage Renal Disease
- Right leg below the knee amputation
- Hx smoking/alcohol abuse
- Wheelchair & Prosthetic use



Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- **-Impaired Urinary Elimination**
- -Acute Pain
- -Impaired Skin integrity
- -Ineffective Personal Hygiene
- -Impaired Mobility

Potential complications for the top priority:

- Urinary retention**
 - Bladder stretching
 - Fullness
 - Lower abdominal discomfort
 - Lower abdominal distention
- Bladder Damage**
 - blood in urine
 - excessive/difficulty urinating
 - lower abdominal pain
- Kidney damage**
 - increased BUN
 - increased creatinine
 - Kidney Infection
 - Sudden Urge
 - Frequent urination
 - Difficulty producing urine

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Responding/Taking Actions:

Nursing interventions for the top priority:

- Assess neurological status; note alterations in mental status Q8H and PRN
Rationale: to monitor for confusion due to increased risk for infection
- Assess vital signs Q4H
Rationale: To determine any signs indicating infection
- Assess pain rating regarding urinary elimination, noting location, duration, intensity, back or flank pain
Rationale: To differentiate between bladder or kidney as cause of dysfunction
- Assess patients' pattern of elimination
Rationale: For comparison of current situation
- Assess frequently for bladder distention
Rationale: To reduce the risk of infection/ autonomic hyperreflexia
- Determine patient's usual daily fluid intake
Rationale: To help determine level of hydration and if fluid is being retained
- Encourage fluid intake
Rationale: To maintain renal function
- Demonstrate proper positioning of catheter drainage tubing and bag
Rationale: To facilitate drainage, prevent reflux and complications of infection
- Review medication regimen
Rationale: Determine if patient is on any drugs that can alter bladder or kidney function
- Review labs and urinalysis
Rationale: To determine if there are any metabolic conditions
- Educate patient on proper hygiene of the perineal area
Rationale: To reduce the risk of infection or skin breakdown

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- T: 97.9 HR: 89 RR: 16 SpO2: 99%
Denies abdominal pain; abdomen soft & non-tender.
Creatinine levels decreased: 2.90
BUN levels decreased after hemodialysis.
BNP levels decreased after hemodialysis.
Urine light yellow, clear
*Did not receive another urinalysis while in my care