Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name: Presley Stang **Date: 11/15/2023**

Noticing/Recognizing Cues:

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

Assessment findings*:

- Diminished lung sounds
- SPO2 94%
- 2+ pitting edema bilateral legs
- 1+ pitting edema bilateral foot
- Soft, distended abdomen
- Melanoma on bilateral legs
- Squamous cell carcinoma on LLE
- SOB on exertion
- 77kg on admission → 79.1kg the next day

Lab findings/diagnostic tests*:

- Paracentesis ultrasound- large pleural effusion
- Chest x-ray- complete white out of hemithorax
- Electrocardiogram
- Thoracentesis
- Paracentesis
- Platelet count 15.8H
- PT 14.3H
- Total Bilirubin 1.8H
- Alkaline Phosphatase 117H
- B-Natriuretic Peptide 225H

Risk factors*:

- 77-year-old female
- Cirrhosis of liver
- Previous smoker
- Previous heavy drinker
- Melanoma
- Squamous cell carcinoma
- Ascites
- History of hypertension
- Pleural effusion
- High fall risk

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Excess fluid volume
- Activity intolerance
- Ineffective breathing pattern
- Ineffective tissue perfusion
- Impaired skin integrity
- Risk for infection
- Risk for adult falls

Potential complications for the top priority:

- Pulmonary edema
  - Pallor, cyanosis, dyspnea
- Heart failure
  - SOB, chest pain, heaty palpitations, swelling in legs, ankles, and feet
- Delayed wound healing
  - Drainage, odor, redness or warmth around the wound site, swelling, pain, change in appearance
- Tissue breakdown
  - Pain, stiffness, swelling, hematoma, tissue exposure below epidermis, decreased muscle strength
- Decreased bowel function
  - Cramping, abdominal pain, vomiting, inability to pass a bowel movement
- Pericarditis
  - Chest pain, fever, pericardial rub

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vital signs: T, HR, RR, BP, SPO2 Q4H & PRN
   - to monitor for abnormal vital signs associated with excess fluid volume
2. Assess body weight at the same time daily and compare with weight upon admission when excess fluid volume was present
   - To see if the patient has gained any weight since the thoracentesis & paracentesis procedure
3. Assess abdominal girth daily
   - To assess for changes that may indicate abdominal distention
4. Perform a focused respiratory assessment Q4H & PRN
   - to assess for changes in respiratory status post thoracentesis procedure
5. Perform a focused GU assessment Q4H & PRN
   - to assess for any abdominal distention, symmetry, or pain
6. Auscultate lung sounds Q4H & PRN
   - To assess for changes in diminished lung sounds and note if any crackles are present that may indicate fluid
7. Monitor lab values
   - To assess for abnormal values associated with excess fluid volume
8. Administer 40 mg of Furosemide PO daily 8A SCH per physicians order
   - to reduce excess fluid volume and promote fluid loss through urination
9. Administer 100 mg of Spironolactone PO daily SCH per physicians order
   - to reduce excess fluid volume through urination while sparing potassium
10. Encourage patient to cough and deep breathe Q1H
    - to help with lung expansion
11. Raise the head of bed to 45 degrees
    - To promote lung expansion of the left lung that collapsed during the thoracentesis procedure
12. Implement a turning schedule Q2H & PRN
    - to promote circulation to tissues as edematous patients are at high risk of skin breakdown
13. Restrict sodium intake
    - to avoid fluid retention
14. Restrict fluids
    - to prevent the patient from taking in too much fluid

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- **T-98.1 PR-75 BP-117/71 SPO2-95% RR-18**
- **Weighs 67.7kg (lost 11.4 lbs.)**
- **Denies SOB on exertion**
- **Soft, round abdomen**
- **Total Bilirubin level decreased to 1.5**

Continue plan of care