Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ___Melisa Fahey_____ **Date** ____January 27, 2024_____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Lft Thumb Wound seeping
- PD Catheter
- LLE Edema 1+
- Tingling & Numbness RUE, LUE, LLE
- HTN 160/61
- NPO
- 4L O2 NC
- SpO2 93%
- RLE Prosthetic
- Unsteady Gait
- Burning during urination
- Irregular BP S3
- Adult Pressure Injury
- Walker
- Immobility
- Restlessness
- SOB

Lab findings/diagnostic tests*:

- K+ 5.4 H Hyperkalemia
- Na+ 128
- RBC 2.40 L Anemia
- Hgb 7.9 L
- WBC 17.5 H
- FSBS 220 H
- Hct 23.8 L
- BUN 146 H
- Creatinine 4.51 H
- PTT 14.5 H
- Urine Culture (Ur Protein 100H, Ur Leukocyte 3+ H, Ur WBC 20-49 H, Urine Cloudy)

Risk factors*:

- Gender Female
- Age 61 yr old
- Type 2 DM
- Multiple Amputations
- End-stage Renal Failure
- Chronic Respiratory Failure
- Started 1 L Blood
- Dialysis MWF
- Hx Smoking
- GI Bleed
- Black Emesis
- Black Stool
- Depression
- Anxiety
- Hx Gout
- Hx CHF
- Hx Uterine Cancer
- AV Fistula
- Neuropathy
- OSA
- Morbid Obesity BMI 45.5
- Hx Falls (Late October '23)
- Hx CAD
- Hx Pulmonary HTN
- GERD
- Diarrhea
- Pulmonary HTN
- Hx COPD

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Impaired Gas Exchange
- Anxiety-moderate
- Bathing, dressing, toileting Self-care deficit
- Decreased Activity Tolerance
- Decreased Cardiac Output
- Dysfunctional GI Motility
- Excessive Fluid Volume
- Impaired Bed Mobility
- Impaired Physical Mobility
- Impaired Transfer Ability
- Impaired Urinary Elimination
- Impaired Walking
- Obesity
- Risk for Adult Falls
- Risk for Electrolyte Imbalance
- Risk for Infection

Potential complications for the top priority:

- Asthma
- Abnormal ABG
- Confusion
- Dyspnea
- Cyanosis
- Mental status change and decreased level of consciousness
- Confusion, lethargy

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess Vital Signs, (RR, depth of breathing, BP, capillary refill for all nailbeds, SpO2, Pulse)
2. Assess the patient's breath sounds.
3. Assess Nasal Cannula for proper fitting.
4. Assess wounds for infection.
5. Assess the patient's pressure sores to ensure no advancing skin breakdown.
6. Educate the patient on the importance of taking deep breaths to ensure good oxygenation.
7. Elevate the head of bed to decrease SOB, made sure patient was not slipping down in bed.
8. Educate the patient on the importance of never missing a dialysis appointment.
9. Educate the patient on the importance of eating several small meals throughout the day instead of large meals to help with oxygenation, improving stamina and reducing work of breathing.
10. Educate the patient on the importance of not hyper oxygenating, especially with the history of COPD.
11. Educate the patient on her medications side effects, such as metoprolol causing HF & Pulmonary edema.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- BP 124/64
- SpO2 97%
- HR 66
- Pulse 18
- No Edema
- Patient sitting up to table instead of in bed
- No SOB

Continue Plan of Care