

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*:

- BP: 210/84 mmHg
- 1+ pitting edema in bilateral lower extremities
- BMI of 27.4
- **Diarrhea**
- 20 gauge right antecubital IV (maintenance fluids)
- Generalized weakness
- Loss of appetite
- Depression
- **Distended/firm abdomen**
- **Hyperactive bowel sounds**



Lab findings/diagnostic tests*:

- HCT - 37.9L
- MCV - 80.4L
- MCHC - 36.4H
- RDW - 16.2
- APTT - 46.4H
- Sodium - 134L
- **Potassium - 3L**
- Chloride - 97L
- Creatinine - 1.32H
- Glucose - 65L
- Urine protein - 100H



Risk factors*:

- 83 years old
- Urge incontinence
- **Bowel aide dependence**
- **Pancreatic lesion**
- Decreased physical mobility
- **Dehydration**
- **Decreased appetite**
- Stress
- **Polypharmacy**
- Gout
- Skin cancer
- COVID-19
- End stage renal failure
- Arthritis
- Hypertension
- High cholesterol

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- **Abnormal bowel movements**
- Frequency of bowel movements
- Decreased appetite
- Ensuring adequate hydration
- Management of blood sugars
- Stabilizing blood pressure
- Frequent Ambulation
- Reducing edema in bilateral lower extremities

Potential complications for the top priority:

- Dehydration
 - If the patient is experiencing dehydration, they will not be able to have smooth bowel movements. Observe for tenting of the skin, hard stools, and dark colored urine.
- Imbalanced nutrition
 - If the patient has imbalanced nutrition, they will not void on a regular basis due to inadequate intake. Observe for reduced amount of stool, weight loss, and reduced appetite.
- Bowel obstruction
 - The patient may experience a bowel obstruction if they are dehydrated because their stool will become impacted and hard. Observe for blood in stool, pain in the abdomen, and decreased hemoglobin.

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Implement increased fluid intake by encouraging intake each time nursing staff is in room and PRN to avoid dehydration and hard stool.
2. Offer PRN bowel aids as needed to provide relief of constipation.
3. Implement a high fiber diet for all meals to promote regular bowel movements naturally.
4. Implement a daily physical therapy program to promote peristalsis by working the abdominal muscles.
5. Implement collection of daily stool samples to detect any changes.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Patient will be discharged with a detailed daily regimen to have regular bowel movements and reduce his firm/distended abdomen as well as normal bowel sounds.
- Patient will be discharged with Imodium to reduce diarrhea.
- Patient will frequently get labs done to determine potassium level.
- Patient will have normal bowel sounds in all four quadrants.
- Patient will be educated on diet, and exercise that will promote regular bowel movements.
- Patient will participate in physical therapy on an outpatient basis.
- Patient will maintain a routine at home to avoid imbalance and stressors.
- Patient will consult a physician in regard to depression in attempt to reduce (continuous constipation lead to feeling depressed).
- Patient will be discharged with education on their diagnoses and how to manage at home.
- Patient will understand instructions and continue with the plan of care.