

**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*:

- Nocturia
- Unsteady gait
- Walker
- BLE Edema
- LLE pain
- Prevena Wound V.A.C.
- Opioid for pain
- Xarelto (anticoag)
- Prednisone Use
- Constipation (Last BM 1/30/24)
- Diminished bowel sounds RLQ
- LLE numbness
- Limited ROM
- Cyclobenzaprine therapy
- Lft arm restriction band
- Muscle weakness
- BP 143/82

Bifocals
Upper dentures
R 24
P 100
Pain 9/10

Lab findings/diagnostic tests*:

- LLE Ultrasound (Baker cysts)
- Hgb 9.3L
- Hct 28.5L
- MCV 78.8L
- Mono# (Auto) 0.9H
- Glucose 142H
- FSBS 237H
- Total Protein 5.9L
- Albumin 3.1L

Risk factors*:

- 74 yr old
- Total LLE knee revision
- Hx Total RLE knee revision
- Type 2 DM
- Hx smoking
- GERD
- Hx tachycardia
- Hx DVT BLE
- Hx Bilat Breast Cancer
- Hx HTN
- Hx Anemia
- Hx partial nephrectomy
- Hx Asthma
- Hx metastasis of liver
- Hx Bunionectomy Bilat Great Toes
- Enoxaparin Allergy
- Cephalexin Allergy
- Chronic coagulation

Hx Hypercholesteremia
Hx cataract surgery
Hx Tubal Ligation
Hx Osteopenia
Hx Rt Wrist Carp Tun
BMI 35.6
Hx Arthritis
Vit D deficiency
Cares for Sibling w/ dementia
IV Contrast Allergy

**Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions**

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

- Acute Pain
- Risk for Adult Pressure Injury
- Caregiver Role Strain
- Disturbed Sleep Pattern
- Impaired Physical Mobility
- Impaired Skin Integrity
- Impaired Urinary Elimination
- Impaired Walking
- Mixed Urinary Incontinence
- Obesity
- Perceived Constipation
- Risk for Adult Falls
- Risk for Adverse Reaction to Iodinated Contrast
- Risk for Injury

Risk for Infection
Risk for Thrombosis
Risk for Unstable Blood Glucose Level
Sleep Deprivation

Potential complications for the top priority:

- Constipation
 - o No BM >48 hrs
 - o Opioid use
 - o Dehydration
- DVT
 - o Edema in BLE/one extremity
 - o Cramping pain in BLE/one extremity
 - o Redness and warmth to the calf area of lower extremity
- Unsteady Gait
 - o Ambulating devices not available
 - o Medications (dizziness, syncope, SOB, etc)
 - o Surgery on lower extremity



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Responding/Taking Actions:

Nursing interventions for the top priority:

- 1. Assess Vital Signs Q4H & PRN**
Rationale: Monitoring Vital Signs for improvement/decline of BP, P, & R
- 2. Assess patient BLE edema Q 4 H**
Rationale: Monitoring edema for signs of increase of pitting/puffiness
- 3. Assess pains Pain level Q2H**
Rationale: Monitoring patients pain level
- 4. Assess patient for skin breakdown/skin abrasions/skin bruising Q4H & PRN**
Rationale: Monitoring patient's skin will prevent ulcers from occurring
- 5. Encourage fluids with patient Q2H & PRN**
Rationale: Helps with constipation and fluid & electrolyte imbalance, promotes BM
- 6. Educating patient using the call light for ambulating and restroom use as needed**
Rationale: This prevents patient from ambulating without assistance which could cause a fall
- 7. Monitor patients labs daily**
Rationale: monitoring patient's lab values for Hgb, Hct, Glucose, and Albumin & protein can prevent patient from elevated/low glucose values which can cause fall, low Albumin & protein levels can cause weakness and fatigue, low Hct & Hgb levels can cause fatigue and SOB due to lack of oxygen to the organs

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- P 80
- BP 117/74
- R 14
- Pain 4/10
- Ensuring Yellow Socks (none skid) are on whenever ambulating
- Patient switched to acetaminophen over opioid

Continue plan of care