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*:

- Skin Breakdown on the buttocks
- Wheezes in the lungs
- Dry mucous membranes
- Abdomen pain of 5/10
- Abdomen distention
- Unsteady Gait
- The use of a walker
- Large amounts of loose stool
- Edema that appears puffy
- Syncope
- Poor skin turgor
- Muscle weakness
- Clear liquid diet
- Normal Saline drip

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Lab findings/diagnostic tests*:

- Abdomen CT shows colitis.
- VBG O2 saturation of 52.3L
- White blood cell counts of 11.4H
- Red blood cell counts of 3.64L
- Total Bilirubin of 1.2H
- Glucose of 117 H
- Hgb of 10.7L
- HcT of 33.3L
- Urine specific gravity of 1.050H

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Risk factors*:

- 82-year-old man
- Diabetes- type 2
- Obesity
- Gerd
- Hypertension
- Chronic kidney disease
- Stroke
- Hernia
- Congestive heart failure
- Hyperlipidemia
- Myocardial Infarction
- Acute epididymitis

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Dysfunctional Gastrointestinal Motility
- Deficient Fluid Volume
- Excess Fluid Loss
- Impaired Bowel Continence

Potential complications for the top priority:

- Dehydration
  - Dry oral cavity
  - Dark yellow, odor urine
  - Dizziness
- Imbalance nutrition
  - General weakness
  - Reduced appetite
  - Longer periods of healing time
- Impaired skin integrity
  - Non-blanchable areas of skin
  - Pain on areas of high pressure
  - Formation of pressure ulcers

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess the stage of skin breakdown.
   - Rationale- To treat stage of breakdown correctly.
2. Assess oral cavity dry dryness or cracks.
   - Rationale- To prevent any further dehydration.
3. Assess the abdomen for any distention/ bloating.
   - Rationale- To prevent any further digestion issues.
4. Assess the patient's bowel movements.
   - Rationale- To assess the loss of any water and the normal stool patients have.
5. Assess skin tenting to skin turgor.
   - Rationale- To identify the patient's dehydration status.
6. Assess the IV therapy site.
   - Rationale- To make sure there no complications and the patient is getting the medication needed.
7. Implement the use of antidiarrheals.
   - Rationale- To prevent further fluid loss.
8. Assist with early ambulation with the patient.
   - Rationale- To prevent any lung complications.
9. Implement a clear liquid diet till the GI tract is within normal limits.
   - Rationale- To prevent anymore inflammation to the GI tract.
10. Encourage patient to wear TED hose.
    - Rationale- To prevent lower extremities from further edema or blood pooling.
11. Encourage patient to cough and deep breath.
    - Rationale- To prevent pneumonia.
12. Encourage patient to increase fluid intake.
    - Rationale- To prevent further dehydration
13. Education the patient on early amulation
    - Rationale- To prevent further muscle weakness.
14. Education the patient on coughing and deep breathing
    - Rationale- To prevent pneumonia.
15. Education the importance of the patient's diet

Evaluation of the top priority: Continue Plan of Care.

- Skin breakdown on the buttocks is slowly starting to heal.
- Dry mucous membrane remains the same.
- The patient's abdomen pain of 5/10 is improving.
- Abdomen distention has remained the same.
- Large amounts of loose stool have improved.
- Poor skin turgor is increasingly improving.
- Muscle weakness has been maintained.
- The edema that appears puffy is maintained.
- The normal saline drip is being maintain at its rate.
- The patient's syncope has remained maintained.
- The diet of clear liquids has been maintained.