# 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*:

- Temperature 97.5 (Low)
- Blood Pressure 138/84 (High for pt)
- SpO2 94% RA (Low)
- Muscle Weakness
- Knee Pain 3/10
- Unable to climb stairs
- Patient is non-weightbearing
- Left knee surgical incision

### Lab findings/diagnostic tests*:

- DVT Left Leg
- DVT Right Leg
- X-ray of left knee
- WBC Corrected 4.5
- BUN 24
- Creatinine 1.02

### Risk factors*:

- Age 71
- h/o Parkinson's
- h/o hypothyroid
- Failed Left TKA
- Left TKA
- Stairs to get into home

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

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

- Impaired Physical Mobility
- Acute Pain
- Fear
- Risk For Falls
- Risk For Infection
- Decreases Activity Tolerance

### Potential complications for the top priority:

- Pneumonia
  - Crackles
  - Decreases SpO2
  - Increase mucous secretions
- Pulmonary Embolism
  - Chest pain
  - Lower limb swelling
  - High BP
- Pressure Ulcers
  - Non-blanchable skin
  - Tenderness of skin
  - Redness of skin

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## Responding/Taking Actions:

**Nursing interventions for the top priority:**

12. Assess Pain- Assess for pain every 2 hours or when doing interventions. This is done to allow the patient to perform at their highest level of ability.
13. Assess Vital Signs- Assess vital signs every 4 hours. This is done to monitor the patient's body and to help us notice things that we cannot see such as blood pressure.
14. Assess ROM and gait- This should be done during your morning assessment and when doing any interventions with the patient. This is done to ensure that there is no unplanned event such as falling.
15. Assess Emotional Status- This should be done throughout your time caring for your patient. This is done to ensure that your patient is happy, how they are feeling about something, or how they make decisions on things.
16. Assess Skin- This should be done every two hours if the patient is unable to get out of the bed or not reposition themselves. This is done to make sure the patient is hydrated, not developing any sores, or retaining any water.
17. Assess Bowels- You should assess your patient at least daily about their bowel movements as well as listening to bowel sounds to make sure that everything is moving.
18. Assess Nutritional Status- This should be done after meals to see what your patient is consuming. This will allow us to see if our patient is getting enough nutrition to heal and prevent future wounds to appear.
19. Assess Respiratory Status- This should be done during the initial assessment as well as when checking vitals. This is done because it is the most important aspect of a patients stay in the hospital because if they are not breathing well or not at all then that can lead to other issues.
20. Patient up to chair for meals- This should be done during all meals. This will help to ensure that your patient is getting up throughout the day while also helping with their bowels moving.
21. Use ambulation devices- This is to help ensure patient safety when ambulating.
22. Q2 turn when in bed- This should be done every 2 hours. This is done to prevent pressure ulcers from forming while the patient is in the hospital.
23. Give medications for pain- This should be done whenever the medication is ordered as due. This is done to provide comfort or the patient.
    a. Acetaminophen (Tylenol) PRN
24. Implement use of incentive spirometer- This should be done a few times every hour. This is done to promote full lung expansion to prevent pneumonia or atelectasis.

1. Give medications for bowels- This will be done per when the medication is ordered. This is done to prevent constipation due to less activity and any pain medications.
    a. Docusate (Colace) 100mg PO BID
    b. Polyethylene Glycol (MiraLAX) 17g
2. Collaborate with PT/OT- This is done throughout the day to have proper mobility when doing ADL's.
3. Encourage pt participation- Encouraging the patient to want to participate will allow them to realize that we are trying to help and only want them to get better.
4. Encourage significant other and other family to be involved in decision making and care- This should be done whenever family is present for them to see the best ways to help their family member who is in the hospital.
5. Educate on importance of exercise- This should be done throughout the patients stay. This will help them to understand that exercising is the best way to maintain or get back their independence so that way they do not have to rely on an aide.
6. Educate on what exercised to do- This should be done throughout the patients stay. This will allow to patient to properly exercise the part of their body that they are wishing to improve upon.
7. Educate on proper way to use ambulation aides- This should be done throughout the patients stay. This will prevent the patient from putting themselves in harms way by not using an ambulatory aide correctly.
8. Educate on importance of pain medication- This should be done during the patients stay. This will help the patient to understand that pain medication is going to keep them comfortable so that way they are able to perform ADL's and other tasks.
9. Educate on importance of deep breathing- This should be done when necessary, during the patients stay to teach them that when they are lying in bed for so long or in pain, they are not breathing as deep which can lead to other complications.
10. Educate On Wound Care- This should be done if the patient develops a wound or has a surgical dressing. This will allow the patient to help their wound heal properly and prevent any infection.
11. Educate On Importance of Proper Hygiene- This should be done as needed but especially if the patient has any reoccurring infections such as a UTI. This will help prevent any skin break down while also preventing bacteria from growing on the skin.

## Reflecting/Evaluate Outcomes:

### Evaluation of the top priority:

- Continue with plan of care
- Vital Signs are WNL
    - HR 65, BP 108/68 (this is WNL per the patient), SpO2 97% RA
- Skin Assessment is WNL
    - Pt L knee healing well, no inflammation, secretions, or tenderness
- Patients pain has improved to a 1/10
- Patient now able to "hop" with use of walker
- Patient is able to bear 5-10% of weight on left foot
- Patient still unable to climb stairs, but use of a ramp was discussed