Firelands Regional Medical Center School of Nursing
Nursing Care Map

_____ Date _____

Noticing/Recognizing Cues:

Assessment findings*:

- P- 55
- T- 97.5
- O2 sats on RA- 95%
- BP- 107/50
- RR-12
- Unsteady gait
- Requires use of an assistive device always (walker)
- Generalized weakness
- Unsteady gait
- Functional incontinence
- Dentures
- Acute right sided abdominal pain
- Rates pain 3/10
- Glasses
- Bruising on upper and lower extremities
- 1 person assistance to ambulate

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

Lab findings/diagnostic tests*:

Lab findings:

- Platelets- 116 L
- Hemoglobin- 9.6 L
- Hematocrit- 28.5 L
- WBC- 3.4 L
- Glucose- 93
- RBC- 3.07 L
- Calcium- 8.2 L
- Bun- 30 H
- Creatinine- 1.62 H

Risk factors*:

- 93-year-old male
- Trouble ambulating
- Acute kidney injury
- Gallbladder slough
- Frequent falls
- BMI-16.5 kg/m2
- Height- 5'9
- Weight- 50.6 kg
- h/o - Hypertension
- h/o- Neuropathy
- h/o- Hypercholesteremia
- h/o- Anxiety
- h/o- Depression

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

Impaired physical mobility

Imbalanced nutrition

Risk for Injury

Potential complications for the top priority:

Prolonged bed rest
- Skin breakdown or pressure injury formation (Red nonblanchable spot, blistering, warm to touch)
- Increased weakness (Trouble walking or balancing or gripping)
- Atrophy (Numbness or tingling in limbs)

Impaired gas exchange
- Tachycardia (Abnormal respiratory depth)
- Confusion (changes in alertness, behavioral changes)
- Diaphoresis (Abnormal skin color, perspire)

Decrease in activities of daily living
- Self-feeding deficit (Weight loss, dehydration)
- Poor hygiene (Still damp or soiled skin)
- Toileting self-care deficit (Soiled clothing, constipation)

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Nursing Care Map

Student Name _____ Date _____

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess and monitor blood pressure, respiratory rate and Spo2 every 4 hours.
   Rational: To identify hypertension, respiratory distress, and decrease of oxygenation.
2. Assess ability to change positions per self or walk with little to no nursing assistance daily and PRN
   Rationale: To identify if any positive changes have been made to unsteady gait or generalized weakness.
3. Assess patients range of motion, hand grasp in upper extremities and dorsiflexion and plantar flexion in lower extremities, every 8 hours and PRN
   Rationale: To identify improved muscle weakness in upper and lower extremities
4. Assess weight daily/ per shift.
   Rationale: To identify any positive changes in weight
5. Turn, reposition, and inspect body every 2 hours and PRN,
   Rationale: Assist with blood flow and prevention of skin breakdown.
6. Assess and monitor platelets and WBC's every shift and PRN.
   Rational: To identify if platelets or WBC's have increased positively as well as decreased dangerously low.
7. Administer Heparin 5,000 units twice daily.
   Rationale: To prevent and treat blood clot formations.
8. Administer Pantoprazole 40 mg once a day.
   Rationale: To prevent stomach ulcer formation.
9. Administer Bupropion XL 150 mg twice daily.
   Rationale: To treat and manage depression
10. Administer Lorazepam 1 mg three times a day.
    Rational: To treat and manage anxiety
11. Educate patient on importance of ambulation.
    Rationale: To prevent an increase of generalized weakness
12. Educate patient on importance of proper nutrition.
    Rationale: To help build up and have proper strength in muscles and bones.
13. Encourage physical therapy.
    Rationale: To enhance mobility and independence as well as improve balance and health.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Vital sings: T-98.2 , Spo2- 96%, P-68, RR-16, BP: 122/53
- Labs: Platelets: 128, WBC: 3.4
- Rates pain 0/10
- Requires only standby assistance now
- Ambulation improved with walker

Continue with plan of care