Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _____Destiny Houghtlen_____ Date _____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Dizziness
- Wound vac right hip
- Glasses
- Walker
- Alert and oriented x1 (confused pt has dementia)
- Impaired hearing (mild)
- Weakness right leg

Lab findings/diagnostic tests*:

- RBC = 2.78 (L)
- Hgb = 9.2 (L)
- Hct = 26.9 (L)
- Free Kappa LC. Quant = 22.6 (H)

Risk factors*:

- Age 77 years old
- History of chronic steroids use
- History of polymyalgia rheumatic
- History of hypertension
- History of thyroid disease (hypothyroidism)
- Rheumatoid arthritis

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Chronic confusion
- Bathing, dressing, feeding, toileting self-care deficit
- Decrease activity tolerance and risk for decreased activity tolerance
- Impaired comfort
- Impaired memory
- Impaired physical mobility
- Impaired skin integrity
- Impaired standing
- Impaired walking
- Risk for adult falls
- Risk for latex allergy reaction

Potential complications for the top priority:

- Pressure Ulcer
  -Redness
  -Pain in bony prominence
  -Warmth to touch
- Respiratory Problems
  -Decreased oxygen
  -Dyspnea
- Poor Circulation
  -Poor capillary refill
  -Cyanosis to extremities
  -Edema

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vital Q4h.
   -To ensure vital signs are normal.
2. Assess wound vac Q8h and PRN.
   - To note any drainage or abnormalities with the skin.
3. Assess lung sounds Q6h and PRN.
   -To ensure the patients lung sounds are clear and patient is not in fluid overload.
4. Assess dizziness Q8h and PRN.
   - To determine if the dizziness continues or stops.
5. Assess ROM Q8h.
   - To see if the patient's strength improves or stays the same.
6. Assess pain level Q6H and PRN.
   - To ensure the patient is not in pain and if there is pain medication can be administered.
7. Assess the patient's nutritional status after each meal.
   - To ensure the patient is eating properly.
8. Administer Tylenol PRN.
   -To decrease the patients pain levels.
9. Change the patient's position Q2h.
   - To prevent pressure ulcers.
10. Educate the patient on ROM exercises once a shift.
    - To ensure the patient practices these daily
11. Educate on using a walker when walking daily.
    - To ensure pts safety.
12. Administer the patients vitamins Calcium carbonate, memantine, cholecalciferol, and multivitamin) PRN and when ordered.
    - To ensure the patient is receiving her vitamins properly.
13. Administer Ferrous sulfate when it is ordered.
    - To ensure the patients Iron levels are where they need to be and don't decrease.
14. Administer Prednisone when it is ordered. (Doenges, M.E., 2022)
    - To ensure the patient has good management of her chronic illness.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Dizziness has not changed.
- Glasses
- Walker used to move, SBA
- Weakness has not changed in the right leg
- Wound vac in the right hip
- Hard of hearing
- Alert and oriented x1 (self)

-Continue plan of care

Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2022). *Nurses' pocket guide: Diagnoses, prioritized interventions, and rationales* (15th ed). F. A. Davis Company: Skyscape