

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*:

- Right sided weakness
- Hard of Hearing wears Bilat hearing aids
- Modified walker for ambulation
- Left below the knee amputee- prosthesis
- Ulcer right ankle
- Irregular heart rate
- Wears glasses
- Poor gait
- Right neck pain 7/10

Lab findings/diagnostic tests*:

- CT Head/Neck- Near occlusion left carotid artery.
- CXR-No acute findings
- EKG- Sinus rhythm with 1st degree AV block
- BUN-29
- Creatnine-3.09
- GFR-18.7
- PTT-11.9

Risk factors*:

- Left knee/hip replacement
- Afib with ablation X2
- ESRD
- HX smoking a pipe
- HX NSTEMI
- GERD
- Aortic stenosis
- CKD
- BPH
- PVD

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Impaired gait/mobility
- Impaired tissue perfusion
- Risk for fall
- Disability associated urinary incontinence.
- Risk for imbalanced fluid volume
- Nutrition less than body requirements
- Unilateral neglect
- Risk for injury
- Self-care neglect
- Impaired comfort

Potential complications for the top priority:

- Fracture: Pain, Swelling, Bruising, deformity, decreased ROM, abnormal imaging
- Pneumonia: Fever, Cough, shortness of breath, Elevated WBC greater than 12, Abnormal imaging.
- Bowel obstruction: Nausea, vomiting, diarrhea, absence of bowel sounds, abdominal pain
- DVT: Pain in the calf, foot or leg, redness, swelling, Positive doppler results.

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Responding/Taking Actions:

Nursing interventions for the top priority:

1. Vital signs every 8 hours (to monitor for signs of infection, or HTN)
2. Pain assessment every 8 hours (Patient has pain to right neck)
3. Neurological assessment every 8 hours (monitor for worsening/improving symptoms from stroke)
4. Monitor I & O every shift (patient is in ESRD, and is on dialysis)
5. Monitor meal intake at breakfast, lunch, dinner, record amount of each meal consumed by percentage(Ensure patient is getting proper nutrition)
6. Built up utensils at meals (assists patient to be independent with feeding, and encourages consumption of meal independently)
7. Maintain clear walking path to bathroom of frequently ambulated to areas (to prevent falls, or injury)
8. Encourage patient to use modified walker for ambulation (safety, and promotes independence)
9. Utilize pain management: Tylenol 650 mg every 6 hours as needed for pain, or lidocaine patch on 12 hours off 12 hours. (Control pain, and ease of ADLS)
10. Patient to go to dialysis M-W-F (End stage renal disease)
11. Patient to utilize LLE prosthesis when ambulating.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Right sided weakness remains unchanged.
 - Utilizing Hearing aids when out of bed
 - Patient is able to ambulate with ease utilizing modified walker
 - Patient wears prosthesis to left lower leg to assist with independence and ambulation.
 - Ulcer right lateral ankle measures 0.4cm X 0.4cm
 - Irregular heart rate AFIB continues
 - Utilizes glasses when out of bed
 - Improved gait with use of modified walker
 - Improved neck pain 2/10 pain
 - CT- Not repeated.
 - EKG- not repeated
 - Creatinine 3.12
 - BUN 25
 - GFR - not repeated.
 - Patient able to ambulate without pain to left hip, knee
 - Patient compliant with dialysis M-W-F
 - Patient had quit smoking pipe.
- Continue current plan of care.