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*:

- 126/90- Blood pressure
- 98.3- Temperature
- 16- Respiratory Rate
- 68 - Pulse rate
- 98- Sp02
- Laceration of the left heel
- Left toe staples with dressing
- Numbness and tingling in heel
- Ulcer on left toe with hardware sticking out
- Beef red ulcer
- Scant serosanguineous drainage of wound

Lab findings/diagnostic tests*:

Lab Findings:

- Platelets- 348
- Hemoglobin- 15.1
- Hematocrit- 44.9
- WBC- 14.2 H
- Glucose- 112 H
- RBC- 5.42
- Calcium- 10. 9 H
- Bun- 30 H
- Creatinine- 1.11
- Wound culture- Positive for Gram Negative bacilli
- X-Ray- Showed osteomyelitis in the great toe

Risk factors*:

- 54-year-old male
- BMI- 42.4 kg
- Osteomyelitis
- Staples placed in left toe 30 years ago
- h/o ORIF
- Weight 304
- Cellulitis of left toe
- h/o Diabetes

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

Impaired skin integrity

Risk for sepsis

Risk for delayed surgical recovery

Altered tissue perfusion

Potential complications for the top priority:

Impaired Skin Integrity

- Physical immobilization (Depression, Loss of muscle strength and Contractors)
- Desquamation (Yellow/white crusted rash, Erythema, Blisters)
- Tissue necrosis (Leathery and hard skin, Eschar and Severe pain)

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Responding/Taking Actions:

ame **Date**

Nursing interventions for the top priority:

1. **Assess and monitor temperature, respiratory rate, Spo2 and blood pressure every 4 hours.**
   Rational: To identify temperature changes, respiratory distress, and hypertension.
2. **Assess neurovascular assessment of left foot every shift and PRN.**
   Rationale: To identify early signs and symptoms of acute ischemia or DVT.
3. **Assess need for dressing change or wound care every shift or PRN.**
   Rationale: To identify any changes in the wound as well as promotion for healthy wound healing.
4. **Assess and monitor surgical wound every shift or PRN.**
   Rationale: To identify any unexpected drainage, cellulitis, or wound breakdown.
5. **Assess WBC's every shift and PRN.**
   Rational: To identify WBC's have decreased positively.
6. **Assess ability to ambulate with little to no nursing assistance daily or PRN.**
   Rationale: To identify unsteady gait or need for assistive devices
7. **Turn, reposition, and inspect body every 2 hours and PRN,**
   Rationale: Assist with blood flow and prevention of skin breakdown if bed ridden.
8. **Administer Vancomycin 1.25 gm at 183.333 mL/hr q12H.**
   Rationale: To treat infection, cause by bacteria.
9. **Administer: Maxipime 1 gm at 125 mL/hr every q8H.**
   Rationale: To treat the infection caused by Escherichia coli.
10. **Educated patient on important proper hygiene.**
    Rationale: To prevent further infection during dressings changes, showering or bathing.
11. **Educate patient on importance of proper nutrition.**
    Rationale: To identify need for increase of intake of protein or vegetables to promote healing.
12. **Encourage physical therapy.**
    Rationale: To enhance mobility and independence as well as improve balance and health.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

Blood pressure: 125/84
Pulse: 76
Sp02: 100%
WBC: 7
Wound culture negative for Gram Negative Bacilli
Staples out of left toe
Skin to left toe intact
No numbness and tingling of left foot
X-Ray showing no osteomyelitis

Continue plan of care