Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name Josh Hernandez_____ Date _03/30/2024_____

Noticing/Recognizing Cues:

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

Assessment findings*:

*97.6 temp

*Abnormal Gait

*Spinal Fusion Wound

*Numbness in bilateral legs

*Sp02:96% on room air

*Dry skin

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Lab findings/diagnostic tests*:

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*RBC:3.69 L
*HGB:11.7 L
*HCT:34.4 L
*NA 13.3 L
*K 3.4L
*CL 96 L

Risk factors*:

*68 years old

*Spinal Fusion T9-T11

*C-pap

*Fluid Restriction 1800 mL

*Obesity

*History of DVT

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Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

*Impaired skin integrity

*Impaired physical mobility

*Adult pressure injury and risk for adult pressure Injury

*Impaired Tissue Integrity and risk for Impaired Tissue integrity

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Potential complications for the top priority:

*Infection
-fever
-edema
-erythema
*Bleeding
-hypotension
-elevated heart rate
-pain at the site

Pressure Injury
-odor
-edema
-discoloration of the skin

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Responding/Taking Actions:

Nursing interventions for the top priority:

*.assess vital signs every 2 hours

-check for any signs of infection or any active bleeding from their wound sites

*.assess and perform skin care every 2 hours and minimize moisture

-prevent further breakdown of the skin

*.assess my patient's ability for mobility every 2 hours

-want to be able to shift weight from their bony prominences

*.Assess my patients dietary intake specifically protein every 6 hours

-protein enhances the process of wound healing

*.assess my patients pain level every 2 hours

-to note if I have to administer any PRN pain medications ordered for patient

*.Bed Cradle patient PRN

-to relieve pressure from linens

*.Promote active range of motion exercises every 3 hours

-to improve circulation and prevent DVT

*.avoid spinal fusion site but inspect for drainage or irritation every 2 hours

-prevent further damage to the site but also monitor for signs of infections

*.place C-pap every night when going to bed

-for adequate oxygenation and promote tissue repair

*:educate on stop smoking

-smoking can delay healing and place the patient at risk for infection

10.educate the patient on observing their wound site and notify when discomfort is felt

-can help staff be aware of any changes the patient is having to their wound sites.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

*patient has an unsteady gait

*patients skin has moisture to their skin

*Spinal fusion wound is close and approximated

*patient has a tingling sensation in bilateral legs

-Will continue with plan of care