

Firelands Regional Medical Center School of Nursing
Nursing Care Map

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Noticing/Recognizing Cues:

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

Assessment findings*:

- Memory impairment
- Talking to people not there
- Hallucinating with response
- Delusional
- Disorganized
- Flight of ideas
- Paranoia
- Poor intake
- Nausea
- Talking to self

Lab findings/diagnostic tests*:

- BUN 32
- Creatinine 1.99
- FSBS 106
- Vitamin D 92.3

Risk factors*:

- Unsteady
- Increased BP
- Multiple medications
- Altered kidney function
- h/o MI
- Lives in a 2 story home

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

Nursing priorities*:

- Risk for physical trauma
- Chronic confusion
- Self care deficit
- Disturbed sensory perception

Goal Statement:

“Patient will show no physical injury”

Potential complications for the top priority:

- Falls
 - Weakness
 - Disorientation
 - Unsteady gait
- Recurrence of psychotic episode
 - Confusion
 - Agitation
 - Memory impairment
- Decreased Medication elimination
 - Confusion
 - Arrhythmias
 - Increase BUN and Creatinine

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess level of disorientation and confusion to determine safety requirements
2. Assess vital signs as needed
3. Monitor for signs of confusion or psychosis
4. Put proper safety measures in places such as:
 - a. Putting furniture in an arrangement that is best for the patient
 - b. Store items that the pt uses in easy to reach places
 - c. Remove dangerous items from the room (cigarettes, matches, lighters, sharp objects, etc.)
5. Observe patient behaviors frequently and assign 1:1 observation if needed
6. Administer medications:
 - a. Brexpiprazole (Rexulti) 0.25 mg PO Daily (antipsychotic/antidepressant)
 - b. Fluoxetine (Prozac) 40 mg PO Daily (antidepressant)
 - c. Hydroxyzine (Vistaril) 50 mg PO PRN (anxiety)
 - d. Olanzapine (Zyprexa) 5 mg IM or PO PRN (agitation)
 - e. Zolpidem (Ambien) 5 mg PO PRN (insomnia)
7. Frequently orient patient so surroundings
8. Use tranquilizing medications or soft restraints per doctor order if needed to prevent patient harm during periods of excessive hyperactivity
 - a. Make sure to assess patient frequently so restraints can be removed as soon as possible
9. Help patient to attend all group therapies
10. Educate caregivers on what has been successful in preventing patient injury
11. Educate family on signs of psychosis
12. Educate on adverse effects of medications
13. Educate family and patient on proper use of walker and other ambulation devices
14. Educate family on proper medication administration

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Discontinue plan of care due to pt being discharged
- Pt now alert to time and place
- Pt demonstrating little confusion
- Pt demonstrating proper use of ambulatory aide
- Pt no longer talking to things that are not there
- Pt no longer hallucinating
- Pt intake has improved
- Pt still has flight of ideas
- BUN 38
- Creatinine 1.51
- FSBS 121
- GFR 34.949

Reference:

Morgan, K. I., & Townsend, M. C. (2020). *Pocket Guide to Psychiatric Nursing (11th ed.)*. F. A. Davis Company.
<https://bookshelf.vitalsource.com/books/9781719645133>

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