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*:

- Failed IVF
- Weight 154 lbs.
- BP 108/70
- Pulse 65
- Spo2 99%
- RR 16
- T 98.6
- Fundus is midline
- Incision WNL
- Epidural site WNL
- IV intact

Lab findings/diagnostic tests*:

- Blood type A+
- GBS negative
- GC/C negative
- HIV negative
- Rubella Immune

Risk factors*:

- Seizure disorder (Keppra 1500mg BID)
- Recent seizure (July 2024)
- History of ovarian cyst
- Age 39
- Cesarean delivery/repeat cesarean delivery
- Received botox in face and lip filler while pregnant

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Risk for infection
- Risk for DVTs
- Risk for pain
- Impaired skin integrity
- Altered tissue perfusion
- Anxiety
- Altered urinary elimination pattern

Goal Statement: Patient will state signs and symptoms of infection and know when to report them to their healthcare provider.

Potential complications for the top priority:

- Sepsis
  - Tachypnea
  - Hypotension
  - Fever or hypothermia
- Altered Mental Status
  - Confusion
  - Incoherent speech
  - Hallucinations/Delusions
- Dehydration
  - Dry mucous membranes
  - Decreased urination
  - Fatigue
  - Weak pulse, low blood pressure

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess for signs of redness q1hr for several hours after surgery.
   - To catch any sign of infection.
2. Assess for signs of swelling q1hr for several hours after surgery.
   - To catch any sign of infection.
3. Assess for signs of discharge q1hr for several hours after surgery.
   - To catch any sign of infection.
4. Assess for signs of odor q1hr for several hours after surgery.
   - To catch any sign of infection.
5. Assess for any pain q1hr for several hours after surgery.
   - To catch any sign of infection.
6. Monitor WBC count daily.
   - To catch any early signs of infection.
7. Assess and monitor oral intake/output every time something is consumed or excreted.
   - To assess the patient's hydration status.
8. Assess immunization status at the start of the admission process.
   - To know what vaccines might be needed and might help with risk of surgical site infection.
9. Administer Motrin 600 mg q4-6hr PO PRN.
   - To alleviate pain and/or inflammation.
10. Educate the patient on routine hand washing and hand washing whenever observing surgical site, before leaving the hospital.
    - To make sure there isn't any bacteria being introduced to the area.
11. Educate the patient on proper wound care and hygiene with the surgical site, before leaving the hospital.
    - To keep the site clean and free from infection.
12. Educate the patient on signs and symptoms of infection and when to notify their healthcare provider, before leaving the hospital.
    - To make sure they are getting the care they need as soon as possible.

Reflecting/Evaluate

Evaluation of the top priority:

- Identify interventions to prevent or reduce risk of infection.
- Achieve surgical site healing without any signs of infection.
- Continue plan of care.

Reference: Doenges, M. E., Moorhouse, M.F., & Murr, A.C. (2022). Nurses' pocket guide: Diagnoses, prioritized interventions, and rationales (16th ed.). F.A. Davis Company: Skyscape Medpresso, Inc.