

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\*:

- 3+ pitting edema BLE
- Shortness of breath with exertion
- Lung sounds coarse with crackles/rales during inspiratory and expiratory
- Bilateral foot pain 8/10
- Right knee bruising and pain 10/10
- Generalized weakness
- Walker for ambulation
- Decreased appetite
- Mild hearing loss
- Needs assistance with dressing and meal preparation
- High fall risk
- Dizziness

Lab findings/diagnostic tests\*:

- WBC 4.1 on admission (10/30)
- RBC 2.48 (L) on admission (10/30)
- Hgb 7.4 (L) on admission (10/30)
- Hct 23.1 (L) on admission (10/30)
- BUN 26 (H) (10/31)
- Creatinine 1.41 (H) (10/31)
- GFR 36.327 (10/31)
- Glucose 151 (H) (10/31)
- Ca 8.1 (L) (10/31)
- PT 19.4 (H) on admission (10/30)
- Urine occult blood - trace
- Chest x-ray - finding suggesting heart failure (10/30)
- R knee CT - anterior soft swelling with suspected infrapatellar hematoma (10/30)
- EKG - A-fib, rightward axis, low voltage QRS, acute diastolic heart failure (10/30)

Risk factors\*:

- Age 86
- Hx A-fib w/RVR
- Hx pulmonary HTN
- Hx peripheral vascular disease
- Type 2 diabetes
- Esophageal dysphagia
- Hx CKD stage 3
- Hx asthma w/COPD
- Hx CABG
- Hx open heart surgery
- Depression
- Vision Impairment
- Recent fall

Interpretation:  
Prioritizing Hypotheses/  
Generating Solutions:

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

- Decreased activity tolerance
- Risk for ineffective peripheral tissue perfusion
- Acute pain
- Risk for impaired gas exchange
- Risk for adult falls
- Impaired skin integrity
- Excess fluid volume
- Risk for decreased cardiac output
- Bathing, dressing, feeding, toileting self-care deficit

Goal Statement:

Patient will have a decrease in fluid volume.

Potential complications for the top priority:

- Flash Pulmonary Edema
  - Chest pain, Tachycardia, Shortness of breath, wheezing, fast breathing, cough
- Tissue Breakdown
  - Blisters, pain, open sores, Lymphorrhoea
- Cardiac Arrest
  - Chest pain, dizziness, shortness of breath, rapid or irregular pulse, sweating, fatigue, hypotension, nausea, vomiting

## Responding/Taking Actions:

### Nursing interventions for the top priority:

1. Assess vital signs Q4 hours and PRN.
  - To watch for changes that may indicate a decline in patient's status.
2. Assess edema in bilateral lower extremities Q4 hours and PRN.
  - To watch for changes that may indicate worsening fluid volume or improvement of fluid elimination.
3. Assess respiratory rate and pattern Q4 hours and PRN.
  - To monitor if patient is having shortness of breath.
4. Assess lung sounds by auscultation Q4 hours and PRN.
  - To monitor for improvement of worsening of fluid on the lungs.
5. Assess circulation in bilateral lower extremities Q4 hours and PRN.
  - Check pulses, capillary refill, color and temperature to ensure adequate blood flow.
6. Assess intake and output of fluids Q12 hours and PRN.
  - To monitor that patient is eliminating excess fluid
7. Assess John Hopkins fall score Q12 hours and PRN.
  - To maintain proper fall precautions to protect patient from injury.
8. Assess skin integrity Q4 hours and PRN.
  - To watch for signs of skin breakdown from edema.
9. Assess EKG daily and PRN.
  - To monitor heart failure and rhythm for any changes.
10. Assess labs daily and PRN
  - To monitor for changes in kidney function and heart failure.
11. Administer Furosemide (Lasix) 40mg IV-push BID at 0800 & 1600.
  - To increase renal excretion of excess fluid to reduce congestion and edema. (Doenges et al. 2022)
12. Administer Amiodarone (Cordarone) 100mg PO BID.
  - To suppress heart arrhythmias.
13. Administer Potassium Chloride ER (K-Dur) 40 MEQ daily PRN; hypokalemia < 3.3.
  - Treatment of potassium depletion from increased urination.
14. Apply telemetry continuously.
  - To monitor patient's heart rhythm.
15. Implement strict I & O's continuously.
  - To accurately measure patient's output versus intake.
16. Consult dietician on admission and PRN.
  - To collaborate patient's nutritional needs to decrease fluid volume.
17. Elevate patient's legs AAT, if tolerated, while in bed and while in the chair for a minimum of 30 minutes Q3 hours and PRN.
  - To promote blood and fluid circulation.
18. Educate patient on lifestyle changes such as a reduced sodium diet, limit fluids, light exercise, and maintaining a healthy weight. BID
  - To ensure that patient understands ways to help control symptoms.
19. Educate patient to keep a log of their weight and symptoms daily. If weight gain of 3 lbs. in one day or 5 lbs. in a week patient should contact provider. Daily.
  - To ensure patient understands early signs of excess fluid volume.
20. Educate patient to take medications as order by provider. BID
  - To ensure patient understands the importance of following her medication regimen to prevent further complications.



### Reflecting/Evaluate Outcomes:

#### Evaluation of the top priority:

- SOB with exertion
- Lung sounds coarse with crackles/rales during inspiratory and expiratory throughout
- Lung sounds L lower lobe during inspiratory and expiratory
- Edema 3+ pitting BLE
- BUN 26 (H) (10/31)
- Creatinine 1.41 (H) (10/31)
- GFR 36.327 (10/31)
- Chest x-ray findings suggesting heart failure (10/30)
- EKG A-fib, rightward axis, low voltage QRS, acute diastolic heart failure (10/30)
- Age 86

Continue plan of care

#### Reference:

Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2022). *Nurse's pocket guide: Diagnoses, prioritized interventions, and rationales* (16<sup>th</sup> ed). F. A. Davis Company: Skyscape Medpresso, Inc.