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*:

- Blood pressure 164/78
- 1+ pitting edema lower extremities
- C collar, limited neck movement
- Limited mobility
- Memory/ cognitive impairment
- Pure wick, urinary incontinence
- High fall risk
- SOB on exertion
- Use of assistive devices

Lab findings/diagnostic tests*:

- Increased calcium 11.8
- UA+, UTI
- C- Spine MRI- nondisplaced fx with bone marrow edema
- C-spine CT- subtle cortical defects in midportion below C1 arch suspicious for nondisplaced fx

Risk factors*:

- Older Adult 76F
- Syncope
- Decreased mobility
- HTN
- High fall risk (recent fall)
- Use of assistive devices

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Impaired mobility
- Risk for falls
- Risk for impaired skin integrity

Goal Statement:

Patient will be able to participate in activities of daily living.

Potential complications for the top priority:

- DVT- reddened area with increased warmth, increased pain, and swelling
- Syncopal episode- diaphoretic, lightheaded, dizziness, nausea
- Pneumonia- productive cough, fever, SOB, crackles/ wheezes upon auscultation

Responding/Taking Actions:

Nursing interventions for the top priority:

1. **Assess patients' mobility and ROM Q4 and PRN**
   - **Assessing current mobility and range of motion ensuring no change.**
2. **Do neuro assessment Q4 and PRN**
   - **checking for numbness and tingling of extremities. To ensure no change in neurological status.**
3. **Assess vital signs (BP, Sp02, RR) Q4 and PRN**
   - **Assessing patient's oxygenation status as well as the patient's hypertension ensuring no changes in status.**
4. **Assess pain level Q4 and PRN**
   - **To ensure the patients comfort, setting a guideline for nursing interventions.**
5. **Implement/ maintain safety and fall risk prevention interventions Q2 and PRN**
   - **To ensure patients safety from further falls and syncopal episodes.**
6. **Consult PT/OT for evaluation once**
   - **PT/OT assessment of patients' mobility and their mobility goals**
7. **Educate patient on fall risk prevention and safety PRN**
   - **Educate patient on the importance of safety and precautions that can be made to prevent further falls that can lead to more or further fractures.**
8. **Educate patient on the importance of mobility PRN**
   - **Educate patient on staying mobile and being able to complete activities of daily living, for prevention of pneumonia, pressure injuries and muscle wasting.**
9. **Educate on the proper use of the c-collar PRN**
   - **Proper fitting and proper use ensure healing for patients' fractures.**

(Doenges, 2022)

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- **ROM and mobility of whole body: upper and lower extremities and head/ neck**
- **Neuro (memory/ cognitive impairment)**
- **Numbness and tingling in extremities**
- **Safety and fall risks**
- **Pain level**
- **No new urine obtained**
- **Observe patient for further syncopal episodes**

Continuing plan of care.

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