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*:

- Limited mobility – x1 assist with walker
- Wound vac on lower back
- Edema BLE – non pitting
- BLE numbness/tingling
- Generalized weakness
- Limited ROM – mobility score of 6
- Thoracic-lumbar-sacral orthosis) brace

Lab findings/diagnostic tests*:

- WBC 16,000
- Neutrophil 14.3
- Glucose 332
- BUN 49
- Creatine 1.23

Risk factors*:

- Age 75
- History of falls
- History of neuropathy
- Hypertension
- History of stroke
- Diabetes
- Blood clot in leg
- Arthritis
- Screws L4&L5 from Laminectomy
- History of DVT
- High Risk fall score

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Impaired Mobility   * Risk of Loneliness
- Impaired Skin Integrity   * Risk of Falls
- Risk for Infection   * Impaired Comfort

Goal Statement:

Patient will have improved mobility.

Potential complications for the top priority:

Skin breakdown	Limited Range of Motion	Constipation
• Altered skin color or turgor	* Decreased activity tolerance	* Fewer bowel movements
• Blisters	* Decreased muscle control	* Hard stool to pass
• Pain	* Joint stiffness	* Straining
• Itching	* Pain	* Pain
• Decreased tissue perfusion	* Decreased lung function	* Bloating
• Excessive moisture	* Altered gait	* Cramping
• Hyperthermia/Hypothermia	* Prolonged reaction time	* Nausea
• Hematoma	* Difficulty turning/rotating	* Loss of appetite

Nursing interventions for the top priority:

1. Implement fall precautions DAILY
   - Assess fall risk score and apply safety devices to ensure patient safety
2. Assess passive/active range of motion excercises with physical therapy DAILY
   - Encourge and guide patient with ROM exercises with and without assisted devices
3. Assist with ambulating patient down the halls BID
   - To improve circulation, overall body strength, and bowel movements
4. Assess pain Q4H
   - Ensure patient is comfortable before and after performing ROM excercises
5. Provide pain medication (acetaminophen 650mg PO Q4H PRN) before/after ambulation if needed
   - Encourges ambulation and willingness to perform ROM
6. Monitor vitals Q4H PRN
   - Due to limited mobility and high WBC, monitor for fever, respirations etc
7. Assess skin integrity Q2h
   - Checking for any wound drainage, color, odor, temperature, moisture, edema
8. Turn and reposition patient Q2H
   - To prevent skin breakdown and pressure injury
9. Assist patient to chair for meals TID
   - Encouges ambulation and ROM
10. Monitor lab values DAILY
    - Monitor lab values for improvement of WBC and overall health

10. Educate on the importance of ambulating DAILY PRN
    - Improves ROM, lung expansion, bowel movement and reduce risk of skin breakdown
11. Educate on proper nutrition and fluid intake DAILY PRN
    - Ensure a healthy diet with high protein that promotes healing
12. Educate the importance of using assistated devices DAILY PRN
    - Encourges independence when ambulating and safety

Evaluation of the top priority:

- Ambulates with a walker but with limited assistance
- Edema is present in BLE but not as noticeable
- Continues to have numbness/tingling in BLE
- Amublated more and did not experience as much weakness
- Range of Motion score still a 6 but continues to move from bed to chair and unassisted to bathroom
- Wears TLSO brace when up and moving and even sitting in chair

  Continue Plan of Care

Reference: 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