Firelands Regional Medical Center School of Nursing

Nursing Care Map

Student name: Presley Stang **Date: 1/23/25**

Noticing/Recognizing Cues:

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

Assessment findings*:

- High fall risk per John Hopkins Fall Risk Assessment Tool
- Generalized weakness
- Bruising on all four extremities
- Patient reports feeling "sore"
- BLE +1 pitting edema
- 79.8°F temp obtained via squad - 1/2O/25
- Patient s/s on admission in ER: moaning, not answering questions, not following commands – 1/20/25
- Altered mental status upon arrival to ER via squad – 1/20/25
- Atrial fibrillation
- Unsteady gait

Lab findings/diagnostic tests*:

- Cervical spine CT: no active cervical spine injury. Degenerative changes are noted in the cervical spine as above.
- Head CT: no active intracranial pathology. Chronic age-related neurodegenerative changes are noted above.
- Chest X-ray: no acute cardiopulmonary injury.
- Abdomen/Pelvis CT: no acute traumatic injury. No acute intra-abdominal pathology.
- Chest CT: no acute cardiopulmonary pathology.
- Urine culture: + E-coli
- Blood culture: + Staphylococcus Epidermidis, Gram + cocci in clusters
- Lactic acid: 11.5 H - 1/20
- WBC: 20.3 H – 1/20
- Na: 131 L – 1/20
- K: 3.7 - 1/20
- Cl: 97 L – 1/20
- C02: 10.9 L – 1/20
- BUN: 41 H – 1/20
- Creat: 1.83 H – 1/20
- Glu: 455 H – 1/20
- Hgb: 13.2 – 1/20
- Hct: 41.1 – 1/20
- Plt: 225 – 1/20
- ABG pH: 7.24 L 1/20
- ABG pCO2: 32.6 L 1/20
- ABG PO2: 140.8 H 1/20
- ABG HCO3: 13.7 1/20
- ABG total CO2: 14.7 L 1/20
- ABG O2 saturation: 98.5 1/20
- ABG O2 content: 7.8 1/20
- ABG base excess: -12.5 L 1/20

Risk factors*:

- 90-years-old
- Lives alone
- High fall risk
- 2-person-assist
- Utilizes a cane and walker at home
- H/O mixed hyperlipidemia
- H/O bladder cancer
- H/O primary hypertension
- H/O breast cancer (left)
- H/O skin cancer
- H/O arthritis
- H/O atrial fibrillation
- H/O CVA

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Hypothermia
- Ineffective peripheral tissue perfusion
- Impaired thermoregulation
- Acute confusion
- Risk for impaired skin integrity

Goal Statement: The patient's core body temperature will be restored to within the normal range, as evidenced by a temperature reading of 36.5-37.5°C (97.7-99.5°F) (MUHORAKEYE, 2024)

Potential complications for the top priority:

Cardiac arrest
- SOB, palpitations, chest discomfort, loss of consciousness, weakness, sudden collapse

Respiratory failure
- SOB, tachypnea, fatigue, heart palpitations, cyanosis, excessive sweating, restlessness, hemoptysis

Shock
- Cool, clammy skin, tachycardia, tachypnea, fatigue, dizziness, excessive sweating, blue or gray lips and fingernails, confusion, low blood pressure

Coma
- Unconsciousness, lack of eye response, lack of motor (movement) response

Rhabdomyolysis
- Muscle swelling, weak muscles, tender and sore muscles, dark urine, dehydration, decreased urination, nausea, loss of consciousness

Frost bite
- Cold, sore, painful, skin red and purple, pins and needles, patches of peeling skin, numbness, hard, black skin forms

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vital signs: T, HR, RR, BP, SPO2 Q1H & PRN
   - To identify if the patient's overall health has improved or declined
2. Perform a through head-to-toe assessment on admission then Q4H & PRN thereafter
   - To assess the patient for potential injuries from falling and to gather a baseline of the patient's current health status
3. Perform neurological examinations q1h & PRN
   - To orient the patient and quickly identify any changes in neurological status
4. Initiate fall precautions upon admission and maintain for the length of the patient's hospital stay
   - To maintain patient safety and prevent the patient from falling
5. Administer 2L of warm saline IV bolus per physician's order
   - To address potential fluid volume depletion and help raise the patient's core body temperature
6. Initiate the Bair Hugger device per physician's order PRN
   - To keep the patient warm and restore the patient's core body temperature
7. Educate the patient on getting a life alert device system PRN
   - To improve patient safety and allow for a quick way to access emergency assistance in case patient were to fall again, or another medical emergency occurs

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Patient is still deemed high fall risk per John Hopkins Fall Risk Assessment Tool as evidenced by history of more than one fall within 6 months before admission
- Patient is still weak as evidenced by difficulty performing ADLs, poor balance, and fatigue
- Bruising is still present on all four extremities as evidenced by skin discoloration due to blood pooling under the skin
- Patient still reports feeling "sore"
- Temperature: 98.6°F – 1/22/25
- Gait is still unsteady as evidenced by use of cane/walker
- Lactic acid: 2.7 H – 1/21/25
- No updated ABG results

Continue plan of care

Reference: MUHORAKEYE, M. G. (2024, November 19). *Hypothermia & Cold Injuries Nursing Care Plan and Management*. Nurseslabs. https://nurseslabs.com/hypothermia/#:~:text=Here%20are%20the%20common%20goals,within%20%5Bspecified%20time%20frame%5D.

FDC/fb/12/2024 Reviewed
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