Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name ___Colleen Camp _____ Date _____3/19/25_____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Dentures
- Glasses
- X1 assist
- Left sided weakness
- 1300 fluid restrictions
- Heart healthy diet
- BP 117/74
- Confusion
- Aphasia

Lab findings/diagnostic tests*:

- Sodium 133
- Potassium 3.4
- Prolactin 67.7
- Troponin 32
- CT- showed ischemic stroke
- MRI- showed concern for new onset seizure

Risk factors*:

- 65 years old
- h/o HTN
- h/o CKD
- h/o HLD
- Obesity
- Medication non-compliance

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Impaired cerebral tissue perfusion
- Impaired communication
- Risk for unstable blood pressure
- Impaired physical mobility
- Impaired cardiovascular function
- Risk for aspiration
- Impaired physical mobility
- Imbalanced fluid volume
- Risk for self-care deficit
- Risk for adult fall

Goal Statement: Patient will have improved cerebral tissue perfusion by discharge.

Potential complications for the top priority:

- Heart disease
  - Chest pain
  - SOB
  - Edema
  - Persistent cough
- Stroke
  - Facial droop
  - Arm weakness/ numbness
  - Slurred speech
- Aneurysm
  - Sudden severe headache
  - Loss of vision
  - Loss of consciousness

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess vitals Q4hrs and PRN; to establish a baseline and to ensure the patient does not decline.
2. Assess pain Q2hrs and PRN; to ensure the patient is not in any pain.
3. Assess neurological system Q2hrs and PRN; to ensure that the patient's neurological status has not declined.
4. Assess musculoskeletal system Q4hrs and PRN; to ensure the patient does not have a decrease in strength.
5. Assess ABG levels Q 24hrs and PRN; to ensure adequate oxygenation to the brain.
6. Apply SCD's when patient is in bed (0900, 2100); to prevent a DVT from occurring.
7. Apply bed rail foam pads, maintain AAT, to prevent injury if the patient experiences a seizure.
8. Turn and reposition Q2hrs and PRN; to prevent pressure injuries from forming.
9. Assist patient to chair for meals (0800, 1200, 1700); to help decrease the risk for aspiration.
10. Maintain HOB at 30 degrees AAT, to prevent aspiration if the patient experiences a seizure.
11. Administer Aspirin 81mg PO daily, to help thin the blood and prevent clots from forming.
12. Administer Clopidogrel Bisulfate 75mg PO daily, to help prevent blood clots from forming.
13. Educate on medication compliance; to ensure patient understand the importance of taking their medications to prevent further complications.
14. Collaborate with therapy on admission and daily to ensure patient regains strength to return to baseline mobility.
15. Educate on the importance of preforming range of motion exercises; to prevent muscle weakening before discharge.

(Doenges, Moorhouse, & Murr, 2022).

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Mild muscle weakness
- Fall precautions
- Seizure precautions
- Confusion
- Aphasia
- Fluid restriction- 1500
- Potassium level 4.5
- Troponin level- no new lab results
- Prolactin level- no new lab results
- No additional orders for a CT or MRI

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