

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*:

- Oxygen 93%
- Nasal cannula 6 liters OX
- Wheezing
- Bruising both forearms *Foley
- Slurred speech
- Left arm weakness
- Abnormal gait
- +3 pitting edema in feet, ankles, and legs
- telemetry
- strict Input and output
- restricted fluid 1800
- weakness in legs
- standby assist walker
- weak dorsalis pedis
- no pupil reaction in right eye due to work eye injury

Lab findings/diagnostic tests*:

- Platelets 93 L
- Hgb 13.1
- MCV 26.2 L
- MCH 26.2
- MCHC 32.3 L
- RDW 16.9 H
- Chloride 98
- CO 37 H
- Glucose 210 H
- Calcium 8.7
- 3/17 Brain MRI restricted diffusion involve occipital lobe/frontal parietal bilateral, abnormal T2/T3 subacute ischemic cortical atrophy with chronic microvascular ischemic change remote infarction involve cerebellar hemisphere and left thalamus

Risk factors*:

- 71-year-old
- Hypercholesterolemia
- HTN
- COPD
- Myocardial infarction
- Fall risk
- Smoker
- Alcohol 1 bottle a day RUM
- Dietary noncompliance

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Risk for fall
- Ineffective peripheral tissue perfusion and risk for ineffective peripheral tissue perfusion
- Impaired physical mobility
- Impaired verbal communication
- Risk for breakdown
- Impaired gas exchange

Goal Statement: The patient will report signs of perfusion and will get better to be transferred to rehab

Potential complications for the top priority:

Sepsis

- Confusion * rapid breathing
- Fever * increase fatigue

Impaired skin integrity:

- Pressure injury * Redness noted at bony prominence
- Pain associated with pressure injury

Falls-Mobility:

- Presence of injury from falling,
- Abnormal gait,
- Patient reports recent falls,
- Dizziness, syncope.

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess level of consciousness/cognition every 4 hours and PRN
Rationale: To identify potential for stroke
2. Assess and monitor respirations including respiratory rate, depth, use of accessory muscles every 4 hours and PRN
Rationale: To identify respiratory distress, work of breathing, and adequacy of alveolar ventilation.
3. Assess pedal pulses every 2 Hours or PRN
Rationale: To identify decrease circulation and decrease pulses
4. Auscultate breath sounds every 8 hours
Rationale: To determine if ventilatory effort is sufficient to deliver enough oxygen and rid the body of carbon dioxide.
5. Assess patient's cough/gag reflex, amount and type of secretions and swallowing ability every 4 hours and PRN
Rationale: To determine ability to protect own airway
6. Assess pitting edema and swelling every 2HR or PRN
Rationale: To identify potential DVT or decrease circulation
7. Assess arm weakness in both arm every 4hrs or PRN
Rationale: to identify another potential stroke
8. Monitor vital signs and O2 saturations every 4 hours or PRN
Rationale: To determine a change in patients' status
9. Monitor Fluid restriction of 1800 every 4 hours or PRN
Rationale: To make sure patient is not going over the fluid restriction checking Input and Output
10. Monitor diagnostics every 4 hours or PRN
Rationale: To identify any new change in diagnostic from the previous diagnostic
11. Administer Aspirin 81 mg PO daily
Rationale: to prevent blood clots and reduce stroke and heart attack
12. Administer Atorvastatin 40 mg PO daily (1tab)
Rationale: Prevent bad cholesterol
13. Administer Furosemide 40 mg IV push BID
Rationale: To treat fluid retention (edema in lower extremities) in nursing pocket guide it says Lasix "Diuresis and subsequent mobilization of excess fluid edema, and pleural effusions". *Vallerand, A. H et al (2022)*
14. Administer Azithromycin 250 mg PO daily
Rationale: Treats inflammation in acute COPD
12. Encourage deep breathing and coughing exercises every 2 hours
Rationale: to maximize effort
13. Encourage ambulating from bed to chair for meals
Rationale: prevent blood clots and prevent impaired mobility
14. Educate patient on low sodium foods due to being on a healthy heart diet
Rationale: To reduce the risk of future stroke by reducing HTN High Cholesterol

Reflecting/Evaluate

Evaluation of the top priority:

- Oxygen 92% with 5 liters of oxygen
- No wheezing but has coarse in lungs
- Still has slur speech
- Weak dorsalis pedis but palpable
- *No updated diagnostics
- * +3 pitting edema in feet, ankles and legs
- * Restricted fluid 1800
- * No new chemistry labs
- * No weakness in the left arm

Continue plan of care

Reference: Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2022). *Davis's drug guide for nurses (18th ed)*. F. A. Davis Company: Skyscape Medpresso, Inc.