

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _____ Cora Meyer _____

Date _____ 8/27/25 _____

Noticing/Recognizing Cues:

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

Assessment findings*:

- Spinal headache 5/10
- Foley
- IV left forearm
- Breastfeeding
- Epidural
- Temperature 36.6 C orally
- Nonpitting edema
- HR 84
- RR 16
- BP 120/79
- SpO2 97%
- Facial grimacing
- Using table for steadying
- Light sensitivity

Lab findings/diagnostic tests*:

- WBC- 14.5
- HGB- 14.3
- Platelets- 316
- GBS- negative

Risk factors*:

- 30 age
- Gestational diabetes
- Succenturiate placenta
- Blood patch
- Multiple attempts Epidural
- 1st pregnancy
- 14.95-hour pregnancy

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Acute pain
- Risk for infection
- Risk for postpartum hemorrhage

Goal Statement:

Patient verbalizes and expresses improved pain levels by discharge.

Potential complications for the top priority:

- Infection- increased WBC, fever, decreased blood pressure, increased heart rate
- Postpartum hemorrhage- boggy uterus, increased lochia, bright color, lochia color change
- Pneumonia- fever, SOB, fever, sharp pain in the chest
- DVT- edema, leg warm and red in a spot

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Vital signs Q4 and PRN
 - To assess for changes in condition.
2. Assess for pain Q4 and PRN
 - To monitor pain and help maintain it at a tolerable level.
3. Assess and assist with blood patch per Dr. order
 - Assist in monitoring/ treating epidural complications (headache 5/10).
4. Assess for hemorrhage Q1 hour and PRN
 - Monitor fundus for proper placement and firmness. To discover postpartum hemorrhage early to prevent severe complications.
5. Assess lochia Q1 hour and PRN
 - To assess for hemorrhage, clot sizes, and changes in color.
6. Assess for infection Q4 hour and PRN
 - Assess temperature and site (spine/ epidural site) for infection (heat, redness, drainage).
7. Assess and maintain IV access Q4 and PRN
 - To ensure IV access is available for possible IV antibiotics for infection and emergency purposes.
8. Administer Ibuprofen Q6 600mg
 - To maintain or decrease pain to a moderate level.
9. Administer Tylenol Q8 975mg
 - To maintain or decrease pain to a moderate level, and to medicate for fever.
10. Repeat labs Q am
 - To assess for any changes in WBCs and other important changes in condition (infection/bleeding)
11. Educate on signs/ symptoms of infection Q shift
 - To ensure the patient is aware of infection risk and early detection. Increased HR, heat, redness, drainage, fever, etc.
12. Educate on activity Q shift
 - To ensure patient is aware of potential complications such as DVT/PE/pneumonia from decreased activity. Encourage movement and walking for prevention.
13. Educate on verbalizing pain Q shift
 - Educate on the importance of communicating and treating pain to keep it at a manageable level.

(Doenges 2022)

Evaluation of the top priority:

- Headache- improved 0/10
- Blood patch/ epidural area- no signs of infection at the site
- WBC- 18 increased
- Hgb- 12.6 decreased
- Platelets- 275 decreased
- No light sensitivity- improved
- Improved walking and no facial grimacing- Expressed and verbalized pain improvement-

Discontinue 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 Medpresso, Inc.