Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _yasmin perez_____ Date _____

Noticing/Recognizing Cues:

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

Assessment findings*:

- BP 99/60
- Fundus height +1
- Incision from c section
- Scant bleeding
- Fundus firm at midline, at umbilicus
- Pain 6 out of 10
- Edema +1
- Swelling

Lab findings/diagnostic tests*:

- NA 103
- RBC 3.9
- WBC 8.5
- HGB 12.8
- HCT 36
- PLT 216
- K 3.9
- Cl 107
- BUN 8
- Creatine 0.5
- PT 10.5
- CA 19
- INR 0.94
- PTT 27.6

Risk factors*:

- Previous csections
- H/X of severe preeclampsia
- Nephritis
- H/X of spontaneous abortion
- Anxiety
- Depression
- Family h/x of HTN

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Risk for bleeding
- Risk for infection
- Risk for postpartum hemorrhage
- Impaired body image

* impaired wound healing
*acute pain

Goal Statement: Patient will remain hemodynamically stable with vitals signs within normal range until discharge

Potential complications for the top priority:

1. Infection

Fever Uterine tenderness on palpation
Chills Foul smell or purulent lochia

2. Hypovolemic shock

Hypotension Cool clammy
Tachycardia Altered mental status
Decrease urine output

3. Wound Dehiscence

Redness Swelling or warmth incision
Drainage
Separation of edges
Severe localized pain

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess fundal and lochia assessment (every 15 min 1st hour, 30 min every 2nd hour, and hourly after that)
   Rationale: To prevent excessive bleeding and prevent severe blood loss
2. Monitor BP every q hour or as needed
   Rationale To prevent symptoms of hypotension due to shock
3. Montor Hear rate q hour or as needed
   Rationale Tachycardia is a symptom of hypovolemic shock
4. Monitor urine output hourly
5. Assess bladder every 2-4 hours
   Rationale: To prevent displacement of uterus
   To monitor signs of preeclampsia and prevent infection, maintain a urine output of >30 ml/hr
6. Assess pain using 0-10 scale every 2-4 hours or PRN
   Rationale To prevent pain and discomfort
7. Assess incision of c section every 4 hours or PRN
   Rationale To prevent wound infection at incision
8. Administer acetaminophen-oxycodone 1-tab q6hrs pain 8-10
   Rationale To decrease pain
9. Administer Ibuprofen 600mg q4hours
   Rationale To decrease pain and discomfort
10. Encourage early ambulation within 12-24hrs or PRN
    Rationale To prevent blood clots
11. Encourage fluids and fiber
    Rationale to prevent constipation and to prevent dehydration
12. Encourage frequent bladder emptying
    Rationale to promote uterine involution
13. Educate patient to report heavy bleeding, passing of large clots, or dizziness

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Pain 3 out of 10
- BP 119/67
- No more edema noted
- No swelling noted
- Fundus firm at midline, at umbilicus

Continue plan of care

Reference: Linnard-Palmer., L., & Coats, G. (2025) ***Safe Maternity And Pediatric nursing care*** **(3rd ed). F.A. Davis**