

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name Evelyn Zam

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Noticing/Recognizing Cues:

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

Assessment findings*:

- Sacral wound
- Leg and arm contraction
- Garbled speech
- Lox x1
- Limited ROM
- Dry scalp/cradle cap
- Urinary incontinence (pure wick)
- Bowel incontinence
- X2 walker
- Acute pain sacrum (8/10)
- Elevated HR
- Elevated BP

Lab findings/diagnostic tests*:

- Wound culture- Pseudomonas Aeruginosa, Enterococcus Faecalis, yeast like organism
- Hgb 9.6
- Hct 29.5
- RBC 3.67
- Glucose 10.9
- Lactic acid 2.0
- C reactive protein 2.8
- Hip x-ray- heterotopic bone formation
- Urine culture- mixed gram (-) Bacilli

Risk factors*:

- Diabetic
- HTN
- Alcoholism
- Falls
- Scoliosis
- CVA
- Seizure
- Anemia
- Gout

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Impaired Skin integrity
 - Adult pressure injury
 - Self-care deficient
 - Deficient knowledge
 - Impaired physical mobility
 - Acute pain
 - Acute confusion
 - Urinary incontinence
 - Bowel incontinence
 - Risk for adult falls
- Goal Statement:
Pt will have improved skin integrity before d/c

Potential complications for the top priority:

- Infection
- Fever, redness, warmth, elevated WBC
- Osteomyelitis
- Elevated WBC, Positive CT, increased pain
- Tissue necrosis
- Eschar, odor, exudate

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess skin-
q4hr, assess for breakdown, exudate, odor, redness
2. Assess Cognitive function-
q8, ask if pt knows where they are to promote safety
3. Assess mobility-
q8 to see pts self-care and assess how pt turns by himself
4. Assess pain-
q4, try to keep pain limited, ensure pt does not have high pain for comfort
5. Assess vitals-
q8 look for signs of pain indication, look at BP for HTN, ensure pt does not have a fever
6. Assess for infection -
Look for fever, elevated HR, Clammy skin to prevent infection so that skin integrity will improve
7. Medicate with Oxycodone-
for pain PRN q4 hr
8. Medicate with Piperacillin/Tazo-
4.5 IV to ensure pt doesn't acquire infection
9. Change wound dressing
Change dressing daily with Vashe, Honey gel, Polymem ag, Skin prep, 4x4 gauze, Transparent Tegaderm
10. Turn and reposition pt
Q2, to ensure skin integrity and make sure the pts wound does not get worse
11. Educate pt on self-care and pressure ulcer prevention
This ensures the patient has knowledge needed to prevent future pressure ulcer formation

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Unstageable sacral wound
- Bp improved (129/81) from morning
- Elevated HR
- Labs have improved

CONTINUE PLAN OF CARE.

(Doenges et al. , 2022)

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.