**Firelands Regional Medical Center School of Nursing**
**Nursing Care Map**

**Student Name : Jenna Bauman** **Date 10/30/25**

**Noticing/Recognizing Cues:**

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

### Assessment findings*:

**Initial:**

- Pain 8/10 on back where incision is
- O2 88% RA
- BP- 120/71
- HR- 81
- RR- 20
- T- 98.2 F
- Numbness and tingling in left leg
- Unsteady gait
- Bulky foam dressing
- Back brace when ambulating
- X1 assist with walker
- Anxious

**At 11:30:**

- Became dizzy and lethargic
- BP- 139/73
- HR- 85 BPM
- T- 98.1 F
- O2- 96% RA
- RR- 18

### Lab findings/diagnostic tests*:

**Lab Values**

- Corrected WBC- 14.8 (H)
- Uncorrected WBC- 14.8 (H)

**Diagnostic Tests:**

- Lumbar X-ray -Post L3-L5 spinal fusion with intact hardware
- Mild degenerative spine changes (narrowing, listhesis, and osteopenia) noted
- No acute fracture or complication

### Risk factors*:

- 74-year-old female
- Deep vein thrombosis
- Pulmonary embolism
- Previous herniated disk
- Trouble repositioning
- Trouble ambulating

**Hx of:**

- Diabetes
- Depression
- Hyperthyroid
- GERD

**Interpreting/Analyzing Cues/ Prioritizing**

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

**Acute pain**
- Verbalized 8/10 pain on posterior incision site

**Mobility**
- Impaired physical ability

**Risk for Infection**
- Surgical site has dressing placed but on posterior back, hard to reach and clean independently

**Impaired skin integrity**
- Incision located on posterior back

**Imbalanced Nutrition**
- Went from clear liquid diet previously to advance as tolerated

**Goal Statement:** Patient will verbalize pain relief at a tolerable rate ≤4/10.within the next 24 hours before going home so she can participate in activities of daily living

### Potential complications for the top priority:

**Falls-Mobility**

- Abnormal gait
- History of falls
- Dizziness and episodes of being lethargic

**Worsening of Anxiety / Depression**

- Restlessness
- Loss of appetite
- Increased confusion or acting out

**Constipation**

- Fecal Impaction
- Bowel Obstruction
- Decreased appetite / nausea

**Responding/Taking Actions:**

### Nursing interventions for the top priority:

9. Assess patients' pain and perform a thorough pain assessment
   Rationale: To get patients baseline pain rating and what the pain feels like, if it is radiating anywhere
10. Asses wound dressing every 2-4 hours and PRN
   Rationale: Making sure dressing is not saturated and wound is clean, limits risk of infection
11. Assess patient's vitals and circulation (ex. pulses palpable and capillary refill < 3 seconds)
   Rationale: To determine change in patient status
12. Monitor for nonverbal cues of pain
   Rationale: Facial grimacing and restlessness are some examples of nonverbalized pain
13. Monitor numbness and tingling in less
   Rationale: Identify potential complications
14. Administer pain medication PRN
   Rationale: To promote patient comfort

### Nursing interventions for the top priority:

1. Administer an ice pack as needed
   Rationale: Helps inflammation of incision site
2. Administer still softeners if necessary
   Rationale: Can help reduce the risk of constipation
3. Encouraged patient to lay on the side with a pillow supporting her back
   Rationale: Help take pressure off wound
4. Encourage the use of assistive devices (walker, back brace, cane)
   Rationale: To promote safety
5. Encourage adequate food intake throughout the day and fluid intake. Make sure pt is getting adequate protein
   Rationale: Food and fluid deliver nutrients and oxygen to body and tissues. Protein helps to promote
6. Encourage the patient to engage in personal religious or spiritual practices
   Rationale: Reading her Bible and receiving communion can help soothe her anxiety she is experiencing
7. Educate on incentive spirometer use
   Rationale: Promote oxygenation
8. Educate on proper body mechanics and importance of using back brace when ambulating
   Rationale: Reduce muscle strain

**Reflecting/Evaluate Outcomes:**

### Evaluation of the top priority:

- Vital signs: BP- 139/73, HR- 85 BPM, T- 98.1 F, O2- 96% RA, RR- 18
- Patient experiencing dizziness and is lethargic
- Verbalizes pain is 6/10
- Patient then was self-soothing by reading Bible

**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.