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*:

- Pain 5/10
- BP 153/69
- Fall risk
- Hearing deficit
- Foley present
- Unsteady gait
- hematuria
- Skin intact
- Colostomy present RUQ
- Pacemaker present
- Prior CBI running to irrigate bladder

Lab findings/diagnostic tests*:

- Urine culture positive for ESBL
- Urine occult blood – positive
- RBC 3.11 L
- Hgb 9.5 L
- Bun 41 H
- Creatine 1.51 H

Risk factors*:

- Presence of foley catheter
- Age 78
- H/O hematuria X2 years
- H/O of previous cystoscopy
- H/O of laser surgery for BPH
- Sick sinus syndrome

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- Bleeding
- Infection
- Acute pain

Goal Statement:

Patient will have no bleeding

Potential complications for the top priority:

- Hypovolemic shock – tachycardia, hypotension, cool pale clammy skin
- Anemia – low RBC and Hgb levels, sob, fatigue
- Respiratory distress – tachypnea, increased work of breathing, cyanosis or low oxygen saturation
- Organ ischemia – reduced blood flow can impair kidney, brain, or cardiac function. Altered mental status, chest pain, weakness

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess patients' pain and comfort level every 4 hours and PRN
    a. Rationale – To make sure the patient is not retaining large clots that might block the catheter from draining properly
2. Vital signs every 4 hours and PRN
    a. Rationale - To assess for any changes and catch them early
3. Assess for bleeding
    a. Rationale- to prevent any further complications like hypovolemic shock
4. Flush catheter as needed to break up an clots and keep the catheter patent
    a. Rationale – To keep the patient comfortable and allow the CBI to clean out the bladder
5. Assess CBI bags and make sure they are continuously flowing every 2 hours and PRN
    a. Rationale – to keep the bladder irrigated and free of clots
6. Ensure the foley bad is emptied and urine inputs and outputs are recorded every 2 hours and PRN
    a. Rationale – to monitor urine for any worsening symptoms
7. Monitor vital signs and hemodynamic stability every 4 hours and PRN
    a. Ongoing bleeding may cause hypervolemia or anemia
8. Encourage oral or IV fluid intake as appropriate and PRN
    a. Fluids help flush the urinary tract
9. Provide comfort and pain management PRN
    a. Controlling pain supports rest and healing
10. Continue to monitor laboratory results every 2 hours
    a. To monitor for any changes and possible problems
11. Assess for bladder distention every 4 hours and PRN
    a. To prevent bladder rupture and urinary retention if foley would become blocked
12. Provide patient education on what symptoms to look for that need to reported to the nurse immediately
    a. Promotes self-awareness and includes that patient in their care

(Deglin et al., 2024)

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Urine is now red and color and large clots are present
- Hgb continues to drop
- RBC continue to drop
- CBI has been restarted
- Patient reports pain level is now a 5 out 10 with pressure and urgency to urinate with clot build up
- Continue 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.