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*:

- Weak BIL DP and PT pulses (R more severe) via Doppler (pulses were not palpable)
- Wound to the superior R foot
- Erythema and discoloration to R 5th toe
- Ulcer on R heel
- Superficial sacral wound
- Skin tear on L elbow
- Incisional wound on anterior R thigh (from surgery on femur Fx)
- Bedrest
- NPO (waiting for procedure)
- High fall score
- Female external catheter (incontinence)
- R leg pain 3/10 via FLACC pain scale
- Contact precautions

Lab findings/diagnostic tests*:

Labs

- WBC: 16.4 10^3/L (3.8-11.6 10^3/L)
- Na: 131 mEq/L (135-145 mEq/L)
- Troponin: 17 ng/L (0400) to 24.4 ng/L ((0-15 ng/L)
- Albumin: 2.8 g/L (3.5-5.7 g/L)

Diagnostics

- Nasal PCR: + MRSA, + MSSA
- ABI: Right (0.41 and 0.55), Left (0.92 and 0.97) – Moderate to severe peripheral vascular occlusive disease of RLE.
- Venous Duplex: No evidence of DVT in RLE.
- CXR: Enlarged cardio mediastinal silhouette. Perihilar pulmonary vasculature, with interstitial opacities. Possible small effusions layering the posterior costophrenic angle.

Risk factors*:

- Age (90 yo)
- High fall risk (Multiple fall w/in last 6 mo)
  - Recent femur Fx (surgery to correct Fx)
- Limited mobility (bed-bound since surgery)
- DM
- CHF
- CVA
- Dementia

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

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

- **Ineffective tissue perfusion (Poor peripheral circulation to RLE)**
- **Acute pain**
- **Impaired skin integrity**
- **Risk for Infection**

Goal Statement: Pt will regain effective tissue perfusion.

Potential complications for the top priority:

- DVT
  - Discoloration of RLE
  - Unilateral swelling of RLE
  - Increased warmth and redness of RLE
- Tissue ischemia and necrosis
  - Pale, mottled skin of RLE
  - Black or darkened skin of RLE
  - RLE cooler than LLE
  - Absent pulses in RLE (check with Doppler)
  - Foul odor or purulent drainage of RLE
- Infection of RLE
  - Purulent drainage from wounds on RLE
  - Increased WBC
  - Increased pain response to RLE (use FLACC scale)
- Sepsis
  - Fever (> 100.4°F/38°C)
  - Tachycardia (> 90 bpm)
  - Hypotension
  - Increased WBC
- Amputation
  - Persistent or worsening ischemia to RLE
  - Tissue necrosis of RLE
  - Infection not responding to ABX (WBC continues to rise)

Responding/Taking Actions:

Nursing interventions for the top priority:

1) Assess circulation with a Doppler device q2-4h and PRN.
    a. Rationale: Frequent monitoring detects early signs of decreased arterial or venous flow, which can lead to ischemia, necrosis, or loss of limb if untreated.
2) Assess Pain q4h.
    a. Rationale: Pain may indicate worsening ischemia. Monitoring changes helps evaluate tissue oxygenation and the effectiveness of interventions.
3) Assess Skin q4h and PRN.
    a. Rationale: Skin signs (decreased temp, skin breakdown, discoloration, etc) may indicate systemic hypoperfusion, requiring prompt action.
4) Monitor VS q4h.
    a. Rationale: Changes in BP and HR can indicate systemic hypoperfusion or a possible infection, requiring prompt action.
5) Elevate and reposition the RLE q2h.
    a. Rationale: Elevation promotes venous return and reduces edema.
6) Encourage ambulation and active/passive ROM q2h as tolerated.
    a. Rationale: Promotes circulation, prevents venous stasis, and reduces the risk of DVT formation, supporting overall tissue perfusion.
7) Encourage proper nutrition as tolerated.
    a. Rationale: Proper nutrition (increase in protein) will promote wound healing.
8) Maintain limb warmth.
    a. Rationale: Warmth causes vasodilation, improving blood flow. Avoiding any constriction will prevent further compromise of circulation.
9) Administer appropriate medications as ordered (Anticoagulants, antiplatelet agents, vasodilators, etc).
    a. Rationale: The above medications may improve blood flow, prevent clot formation, and support oxygen delivery to ischemic tissues.
10) Educate family on the importance of proper nutrition and RLE positioning, repositioning q2h, and wound care.
    a. Rationale: It is essential to involve the family in the pt's POC as the pt is unable to care for herself at this time. Education will ensure everyone involved in care is on the same page.

Doenges et al. (2022)

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- BIL DP and PT pulses are still weak via Doppler.
- Pain was rated a 3/10 via the FLACC scale due to her inability to answer questions. Facial grimacing when touching any wounds on the R foot.
- No changes to wound integrity. Dressings were assessed and changed.
- Both heels were offloaded with a pillow under each calf.
- Pt repositioned q2h.
- Risk Factors:
    - Age (90 yo)
    - High fall risk (Multiple fall w/in last 6 mo)
    - Recent femur Fx (surgery to correct Fx)
    - Limited mobility (bed-bound since surgery)
    - DM
    - CHF
    - CVA
    - Dementia

Continue with POC

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.