

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*:

- Post-op spinal fusion (T5-T10)
- X2 assist with walker
- TLSO brace ordered
- Hemovac drain
- 2L nasal cannula
- SCDs
- Confusion/hallucinations
- High fall risk
- Limited mobility
- SpO2 97-99%
- BP 138/63
- Full code
- Pain rating 10/10 in back

Lab findings/diagnostic tests*:

- WBC 4.9
- RBC 2.98
- Hgb 8.9
- Hct 26.2
- Platelets 95
- T4-T5 & T7 fracture

Risk factors*:

- Age 80
- Recent spinal surgery
- Limited mobility
- Confusion/hallucinations
- Low Hgb/Hct
- SCDs
- Nasal cannula
- Hx of GERD, HTN
- Type 2 diabetes
- medications

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Risk for falls/injury due to impaired mobility and post-surgical weakness
- Impaired mobility
- Acute pain
- Ineffective breathing pattern
- Risk for impaired skin integrity/pressure injury

Goal Statement:

Patient will remain free from falls and physical injuries with proper spinal precautions.

Potential complications for the top priority:

- Worsening fractures
 1. Additional injury before fully healing
 2. Increased lack of stability of affected area
- Internal bleeding
 1. Low Hgb/Hct
 2. Possible hypovolemic changes
 3. Swelling or firmness of surgical site
- Delayed surgical recovery
 1. Impaired mobility
 2. Increased pain
 3. Longer healing period
- Hypoxia
 1. Ineffective ventilation
 2. Decreased oxygenation due to pain or position
- Infection
 1. If incision or Hemovac drain become disrupted
 2. Bacterial contamination, usually develops within 2-3 days
 3. Systemic signs:
 - a. Fever
 - b. General malaise
 - c. Elevated WBC count
- Spinal hardware displacement
 1. Misalignment after movement or trauma
 2. Increased pain or neurological changes

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Implement fall precautions after fall risk assessment (bed alarm, non-skid socks, call light, bed in lowest position, room clean)
Rationale: Ensure all fall precautions are in place to prevent patient from falling and getting any further injuries
2. Maintain x2 assist with walker during transfers and ensure TLSO brace is applied before ambulating
Rationale: To provide full safety for the patient and avoid any injuries, TLSO brace for proper spinal support
3. Reorient patient frequently, q4h, PRN (name, place, time, situation)
Rationale: To avoid confusion or hallucinations
4. Monitor lab trends (Hgb/Hct), assess for dizziness or fatigue, daily labs and PRN symptoms
Rationale: Low Hgb/Hct can indicate internal bleeding or post-op blood loss progression
5. Ensure nasal cannula is in place and on 2L, ensure IV lines are secured, every shift and PRN
Rationale: Maintains oxygenation and prevents accidental dislodgement of IV access
6. Assess pain and vitals, q2h
Rationale: Adequate pain control improves mobility, breathing, and surgical recovery. Ensure vitals and oxygenation are WNL
7. Collaborate with PT/OT for safe mobility and strength training, daily or per therapy schedule
Rationale: Promotes functional recovery and prevents deconditioning
8. Ensure SCDs are applied when in bed, q4h when resting, remove when ambulating
Rationale: Reduces risk of DVT in post-surgical and decreased-mobility patients
9. Maintain close observation during toileting and ambulating
Rationale: Prevents falls, especially with weakness, pain, brace use, and impaired balance
10. Educate patient on spinal precautions and fall precautions, with each care interaction until patient proves understanding
Rationale: Reinforces safe practices, prevents reinjury, and increases patient adherence
11. Administer prescribed medications at prescribed times and PRN
Rationale: To ensure blood glucose levels are maintained as well as pain as needed.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- | | |
|---------------------------------------|--|
| - Patient verbalizes pain improvement | - IV lines secure |
| - BP 138/68 | - Communicated with PT |
| - SpO2 97%, 2L nasal cannula | - Patient closely observed |
| - RR 16 | - SCDs applied |
| - Fall precautions in place | - Patient educated |
| - TLSO brace applied when ambulating | - Medications administered |
| - Patient oriented x3 | - No further hallucinations |
| - Hgb 8.9 | - Age 80 |
| - Hct 26.2 | - Allergies reviewed |
| - IV lines secure | - Patient has no further falls or injuries |
| - Communicated with PT | |
| - SCDs applied | Continue plan of care |

Reference: Potter, P. A., Perry, A. G., Stockert, P.A., Hall, A. M., & Ostendorf, W. R. (2026). *Fundamentals of Nursing* (12th ed.). Elsevier.