

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\*:

- 67-year-old male
- 2L O2 Nasal Cannula
- Decreased ADLs
- Urinary Catheter 16 French
- SOB on exertion
- Increased BP (165/81)
- Missing teeth
- Diminished breath sounds
- Uses a walker for ambulation with supervision
- High fall risk - 10
- Urinary retention (395ml post-void residual)

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Lab findings/diagnostic tests\*:

- BUN - 114 (High)
- Albumin - 3.6 (Borderline low)
- Creatinine - 4.41 (High)
- BNP - 674 (High)
- CO<sub>2</sub> - 33.9 (High)
- Hgb - 11.8 (Low)
- Hct - 35.1 (Low)
- Platelets - 133 (Low)
- Ca - 8.4 (Borderline low)
- K - 5.5 (High)
- ACR - 81.63 (High)

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Risk factors\*:

- Age 67
- History of COPD
- History of Panic Disorder
- History of HLD
- History of cholecystectomy
- History of GERD
- History of low Na
- History of low thyroid

Interpreting/Analyzing Cues/  
Prioritizing Hypotheses/  
Generating Solutions:

Nursing Priorities\*: \*Highlight the top nursing priority problem\*

- Impaired Urinary Elimination
- Risk for UTI
- Risk for falls
- Impaired gas exchange

Potential complications for the top priority:

1. Sepsis
  - Tachycardia
  - Hypotension
  - Confusion

**Goal Statement:**

- Patient will have improved independent urinary Elimination

- Lethargy
- WBC >12 or <4
- Fever
- Chills
- Anxiety
- Dyspnea
- Nausea

**2. UTI**

- Frequency
- Burning
- Urgency
- Nocturia
- Blood/pus in the urine
- Flank pain
- Low-grade fever

**3. Electrolyte Imbalances**

- Cramps
- Nausea
- Headache
- Confusion
- Fatigue
- Constipation
- Dizziness Irregular heartbeat

**Nursing/Taking  
Actions:**

**Nursing interventions for the top priority:**

1. Focused GU assessment Q8H and PRN
  - To assess if any S/S are worsening or improving
2. Perform catheter/peri care Q8H and PRN
  - This is to reduce the risk of getting a UTI
3. Strict Intake and Output AAT

- To keep close to an exact idea of how much fluid is going in and out
- 4. Bladder Scan Q6H and PRN with every void
  - To assess for urinary retention/emptying of the bladder
- 5. Vital Signs Q4H and PRN
  - To get any early signs of clinical deterioration
- 6. Repeat labs Q8H PRN
  - Assess for improvement in Creatine, Albumin, and BUN, the most important labs relating to kidney function
- 7. Educate the patient on their condition and promote wellness daily
  - Instruct proper application and care of the appliance for urinary diversion (Foley Catheter)
  - Recognize complications and warning signs
  - Emphasize the importance of keeping the perineal area clean and dry

(Myers, 2023)

### Reflecting/Evaluate Outcomes:

#### Evaluation of the top priority:

If I were able to reassess the patient, I would look for the following:

- Improvement with ADLs independently
- Urinary catheter status
- Ambulation and mobility score
- Amount of urine in the bladder
- Lab results of the following
  - BUN
  - Albumin
  - Creatinine
  - Ca
  - ACR

Continue plan of care

**Reference:**

**Myers, E. (2023). *RNotes: Nurse's clinical pocket guide* (6th ed.) F.A. Davis Company: Skyscape Medpresso, Inc.**