

Firelands Regional Medical Center School of Nursing  
Nursing Care Map

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Date                     Friday Feb 6, 2026                    

Noticing/Recognizing Cues:

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

**Assessment findings\*:**

- Hearing aides
- Watery eye drainage
- **HIGH FALL RISK**
- Vision loss
- Dentures
- **Malnourished**
- Patient on telemetry
- **Limited movement**
- **Inability to care for self**
- **Mepalex on Coccyx**
- **Bruising**
- SpO2 95%

**Lab findings/diagnostic tests\*:**

- Colon cancer
- RBC 2.95
- HgB 10.4
- Hct 30.9
- Glucose 12.1
- Bun 46
- Creatnine 2.53
- Ca 8.0
- **Urine Culture:**
  - o E. Coli
  - o Proteus mirabilis
- **CT-fecal impaction:**
  - o CHF impaction
  - o Constipation

**Risk factors\*:**

- **Age 101**
- HX: Colon Cancer
- History CKD
- Hypertension
- **BMI- 18.2**
- **Impaired mobility**
- **History of fecal impaction**
- **UTI**

Interpreting/Analyzing Cues/  
Prioritizing Hypotheses/  
Generating Solutions:

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

- **Inability to care for self**
- Impaired skin integrity
- Impaired mobility

**Goal Statement:**

Patient will work on becoming more independent before discharge.

**Potential complications for the top priority:**

- Malnutrition
  - o Unintentional weight loss
  - o Muscle weakness/decreased strength
  - o Poor skin integrity delayed strength healing
- Infection
  - o Fever
  - o Redness, swelling, drainage from skin wounds
  - o Increased confusion, lethargy
- Impaired Skin Integrity/Pressure Wound
  - o Redness over boney prominences
  - o Skin breakdown
  - o Pain tenderness in area

## Responding/Taking Actions:

### Nursing interventions for the top priority:

1. **Assess patients ability to preform ADS every shift and PRN.**
  - **Rationale:** Identifies the level of function dependence and need for assistance to prevent injury, malnutrition and further decline.
2. **Assess cognitive status (orientation, attention, ability to follow commands) every shift.**
  - **Rationale:** Metabolic encephalopathy and advanced age increased risk for impaired judgement and inability to safely preform self care.
3. **Asses nutritional intake (percentage of meals consumed) each meal daily.**
  - **Rationale:** BMI of 18.0 and history of fecal impaction place the patient at high risk for malnutrition and weakness.
4. **Assess skin integrity especially coccyx and boney prominences every shift.**
  - **Rationale:** limited mobility, low BMI, and existing mepalex dressing increase risk of pressure injuries.
5. **Assess mobility and fall risk every shift with activity.**
  - **Rationale:** Use of walked advanced age, and weakness, increase risk for falls and injury.
6. **Assist the patient with toileting, hygiene, dressing and transfers as needed every shift.**
  - **Rationale:** supports basic self care needs and prevents falls, infection, and skin breakdown.
7. **Encourage patient participation in self0care activities to the highest level tolerated.**
  - **Rationale:** Promotes independence, preserves functional ability and prevents further decline.
8. **Reposition the patient at least every 2 hours while in bed.**
  - **Rationale:** Prevents pressure injuries in a frail immobile patient.
9. **Ensure assistive devices (walker, bed alarm) are in place and used with all ambulation.**
  - **Rationale:** Reduces fall risk in a patient with impaired mobility and weakness.
10. **Collaborate with physical therapy daily and reinforce PT recommended mobility techniques**
  - **Rationale:** Improves strength ,mobility, and ability to preform self care daily.
11. **Administer bowel medications as ordered and monitor bowel movements daily.**
  - **Rationale:** Prevents constipation and fecal impaction which can impare comfort, nutrition, and ability to preform self care.
12. **Monitor response to antibiotics for UTI (mental status, strength, participation in care) every shift.**
  - **Rationale:** Resolution of infection can improve functional status and inability to care for self.
13. **Educate the patient and caregivers on the importance of calling for assistance with mobility and toileting every shift.**
  - **Rationale:** Prevents falls and injury in a high-risk elderly patient
14. **Educate the patient and family on proper nutrition and hydration daily**
  - **Rationale:** Support strength, wound healing, and energy needed for self care activities.
15. **Educate patient and caregivers on skin care and pressure injury prevention daily.**
  - **Reduces:** risk of skin breakdown in a patient with limited mobility and low BMI.

**Reflecting/Evaluate Outcomes:**



**Evaluation of the top priority:**

- Vital Signs:

BP: 114/61

HR: 76

RR: 20

SpO2: 95% on RA

- Patient Alert & Oriented x4
- Patient is a 1 assist with walker
- Patient able to participate in hygiene and feeding with assistance
- Nutritional intake improving to 75% consumption
- Intact skin with mepilex in place and no new areas of breakdown
- No current pain
- CKD
- Colon Cancer
- Hypertension
- Hearing Aides
- Vision Loss
- Dentures

{ 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.
- Potter, P/A., Perry, A., Stockert, P.A., Hall, A.M., & Ostendorf, W.R. (2026), Fundamentals of nursing (12th ed.). Elsevier.