NURSING CARE MAP GUIDELINES

Firelands Regional Medical Center School of Nursing
Faculty Manual

The nursing care map is intended to guide you through the clinical judgment process of thinking and responding to patient care experiences. The care map will be used throughout the curriculum and the level of complexity will evolve over time from the foundational level to advanced nursing thinking.

Noticing- Recognizing Cues

Assessment Findings:

- Identify ALL abnormal signs and symptoms that the patient is displaying.
- Gather accurate and current information.
- Assess systematically and comprehensively.

Lab Findings/Diagnostic Tests:

- Identify ALL abnormal lab findings &/or diagnostic test results.

Risk Factors:

- Identify ALL risk factors associated with the patient.

Now that you have collected a variety of patient information, it is time to determine which data correlates to each other. This information should be highlighted on the care map. Clustering the relevant data will allow you to determine the nursing priorities.

Interpreting- Analyzing Cues, Prioritizing Hypotheses, and Generating Solutions

Nursing Priorities:

- List ALL nursing priorities.
- Select the top nursing priority patient problem, identifying the most current problem. Highlight the top priority on the care map.
- The identified problems can be a NANDA approved nursing diagnosis (ex. Acute Pain, or Impaired Gas Exchange, etc.) or stated in your own words.
- The nursing priority cannot be a medical diagnosis.

Potential Complications:

- Identify ALL potential complications.
- Highlight the potential complications associated with the top priority problem.
- Identify signs and symptoms to monitor for each complication. This would include new symptoms that the nurse would monitor for to ensure early detection of a developing complication.

- A potential complications list may look like this with a pneumonia patient:

- Sepsis
  - 1. Tachycardia
  - 2. Hypotension
  - 3. Hyper- or hypothermia
  - 4. Confusion, lethargy
  - 5. White blood cells > 12 or < 4
  - 6. Oliguria
  - 7. Lactic acid level > 2
- Respiratory failure
  - 1. Chest wall retractions, increased work of breathing
  - 2. Decreased SpO_2 or PaO_2, increased $PaCO_2$
  - 3. Mental status change and decreased level of consciousness
  - 4. Bradypnea
  - 5. Diaphoresis

<u>Responding- Taking Action</u>

Interventions:

- Include ALL pertinent interventions for your patient.
- Be sure to prioritize your intervention list with <u>assessments taking the highest priority</u>.
- Most care maps will include assessments, interventions that will directly help the problem, medication-related intervention(s), and an education-related intervention.
- Each intervention will state how often the nurse will do something.
- Interventions will be individualized and realistic for your specific patient.
- Each intervention will be relevant to the nursing priority (ex. though a patient's PT/INR is high, would it be appropriate to have an intervention for monitoring the INR if your care map is about Chronic Pain? The answer is no, but it would definitely fit in another care map).
- Include specific medications for your patients individualized care map. Include the name of the medication, dose and frequency, but only include medications that are specific to the patient's nursing priority. For example, if care map is for pain, then include pain medications, but not medications for his/her blood pressure.
- Each intervention will include a rationale or a reason why the nurse is completing the intervention (it is not enough to simply say to check for changes in VS, etc.; explain specifically why you are assessing for these changes).
- Interventions may look like these:
  - 1. Assess the patient's urine (color, odor, concentration, and output) q8h and PRN with each void
    - To determine whether or not the S&S of the UTI are resolving
  - 2. Administer Levofloxacin 500mg IVPB q24h
    - To treat the patients UTI
  - 3. Educate the patient regarding appropriate perineal hygiene daily
    - To promote self-care and prevent future UTI's

<u>Reflecting- Evaluate Outcomes</u>

Evaluation:

- List the reassessment findings associated with the top nursing priority.
- What reassessment findings determine effectiveness of interventions?
- What data shows a need for continued monitoring?
- Does the plan of care require continuing, modification, or termination?
- This is an example of a complete evaluation:
    - Patient describes pain at a 2/10 in right foot.
    - Patient with no facial grimacing during movement of right foot.
    - BP: 150/95
    - HR: 105
    - WBC 12.0 10^3/microL

    Continue plan of care.