

CARE MAP EXAMPLE

1. Establish Care Map Criteria

The instructor guidelines for this assignment are to only illustrate the relationship of the medical diagnoses, nursing diagnoses, and collaborative problems.* Medical diagnoses are to displayed in green boxes, nursing diagnoses are to be displayed in yellow circles; collaborative problems are to be displayed in blue boxes. Arrows are used to show direction of relationships.

*Keep in mind, concepts maps can be far more complex when supportive data, outcomes, and interventions are illustrated.

2. Data Collection and Problem Identification.

The student in the clinical area collects various data about the patient. Listed below are selected sample data a student collects:

John Grimes is a 50 y/o male was admitted 2 days ago following a motor vehicle crash. Mr. Grimes sustained a right comminuted pelvic fracture. He currently has an external fixation device inserted in his pelvis. Only other medical diagnosis is type 2 diabetes mellitus.

Morning Report Data

The night nurse reports that Mr. Grimes has constantly been asking for pain. He took 2 Vicodin every 4 hours the entire shift; his last dose was 2 hours ago. His pain rating ranged from 3-8 during the night. The night nurse also reports that Mr. Grimes blood glucose level in the evening was 286 and this morning was 251. He also has complained of a great deal of fatigue. The pain and fatigue contribute to his lack of movement.

Chart Data

The nurse briefly reviews the chart and notes the following current orders and lab results:

PHYSICIAN ORDERS	LAB RESULTS ON CHART
Diet – 2000 Kcal, low salt, low fat Vital Signs q 8 hours Activity – Strict bed rest Capillary Blood Glucose before meals and at bedtime IV– Hep Lock Medications: Glucophage 500 mg twice a day Colace 100 mg po daily Vicodin 1 or 2 tablets q 4-6 hours prn for pain	Hbg = 8.2 (14-16 g/dl) Hct = 29.6 (42-52%) WBC = 11.1 (5-10)

Morning Nursing Assessment Data

During the morning assessment, Mr. Grimes tells the nurse he has had a great deal of pain in his pelvis during the night that was not relieved with the pain medication. When asked about pain he indicates it hurts a lot when he moves. His current pain rating is 7/10. The nurse also learns Mr. Grimes has not had a

bowel movement since admission feels “bloated”. Mr. Grimes also expresses a great deal of concern and anxiety about his current situation. Because he works for a construction company, he will be unable to work for many months; furthermore, he cares for his wife who has multiple sclerolosis. He states “I don’t know how I am going to make the house payments and take care of my wife.”

Mental Status: awake, alert, oriented; anxious.

Skin: Overall pallor noted; ecchymosis over entire pelvic area; IV hep lock in dorsal aspect R hand, insertion site is without redness or swelling.

Chest: Respirations even, non-labored. HRRR, S1 and S2 auscultated without murmurs.

Abdomen: Firm, flat contour, nontender with palpation; bowel sound active in all quadrants

Lower Extremities: skin intact, warm and dry; full ROM; quadricep strength +5; cap refill < 2 sec, pedal pulse +2. bilaterally.

Based on the data, the student identifies applicable nursing diagnoses and collaborataive problems.

Medical Diagnoses	Nursing Diagnoses	Collaborataive Problems
Pelvic Fracture Type 2 Diabetes Melluits	Impaired Mobility Pain Constipation Risk for Impaired Skin Integrity Ineffective Role Performace Risk for Imbalanced Nutrition Anxiety	PC: Hyperglycemia PC: Anemia

3. Draw the Concept Map

Based on the instructor guidelines and problems identified, the student illustrates the concepts, and the relationship of those concepts. (See next page)

4. Presentation of the Concept Map

The instructor meets with the student; the student describes the problems, provide rationale for the choice of the problems, and identify and what he/she believes to be the relationships. The student can verbalize goals, and intended interventions.

