

Nursing Problem Worksheet

Name: Olivia Creamer, SNB

Anticipated Patient Problem and Goals	Relevant Assessments (Prewrite) What assessments pertain to your patient's problem? Include frequencies	Multidisciplinary Team Intervention (Prewrite) What will you do if your assessment is abnormal?
Problem: Acute Pain Reasoning: Evidenced by a pain score >5 on a 0-10 scale, limited mobility, and facial grimacing Goal: Will rate pain <4 on a 0-10 scale after intervention by the end of my care. Goal: Will be able to ambulate from bed to bedside chair or commode with assistance by the end of my care.	Will assess pain score (on a scale of 0-10) q2h or PRN.	Will administer oxycodone or morphine as ordered for pain >6 on a 0-10 scale.
	Identify aggravating and alleviating factors of pain at the beginning of my shift & q2hr.	Will provide with comfort measures: Ice (as tolerated) therapy , position change (off affected extremity), or pillow support.
	Assess activity level at the onset of care. - Are coordination & gait WNL? - Does pt. show disinterest in ambulation due to pain?	Assist with ADLs ad lib. (Bed bath, oral care, ambulation to bedside commode/ chair, use of a bedpan)
	Monitor VS q4hr. Remain alert for tachycardia, HTN, or tachypnea	Assist in deep breathing exercises/ IS use. Utilize therapeutic communication to provide emotional comfort during distressing times.
	Inspect & palpate surgical site/ affected region for swelling, tenderness, bruising, and redness q2hr.	Maintain neutral alignment of surgical extremity. Educate on the importance of avoiding flexion & internal rotation of the leg unless prompted to by PT/OT.

Anticipated Patient Problem and Goals	Relevant Assessments (Prewrite) What assessments pertain to your patient's problem? Include frequencies	Multidisciplinary Team Intervention (Prewrite) What will you do if your assessment is abnormal?
Problem: Impaired Mobility Reasoning: Evidenced by pain (>5 on a 0-10 scale), generalized weakness, & declination of position change/ disinterest in getting OOB. Goal: Will ambulate from bed to bedside chair/ commode with assistance by the end of my care. Goal: Will verbalize the importance of position changes & ambulation to prevent pressure injuries & promote healing by the end of my care.	Assess motivation to ambulate/ participate in activities q2hr or PRN.	Encourage periods of rest (approx. 30 min.) before & after activities/ PT/OT/ ambulation
	Assess coordination, muscle tone/ strength, and gait at the onset of care and PRN.	Utilize assistive devices ad lib. and maintain 2 persons assist. Provide encouragement without disregarding pt's wishes & allow adequate time for rest periods.
	Assess b/l pedal pulses & b/l capillary refill on lower extremities q4h or PRN.	Notify primary RN & physician and consider vascular consult/ imaging. Maintain SCD therapy as/ if ordered.
	Assess skin integrity (Redness, swelling, or abrasions) q2hr or PRN.	Reposition the client to relieve pressure off of the impaired skin & apply non-scented moisturizer to keep the skin hydrated PRN. Encourage mobilization.
	Monitor CBC, BMP, CRP (C-Reactive Protein), and ESR (Sed. Rate) results at the onset of care and PRN.	Notify physician to consider performing additional Dx testing including Duplex US and CTA. - Maintain SCD therapy as ordered - Encourage hydration & adequate intake of protein, Vit. D, and Ca+.