Firelands Regional Medical Center School of Nursing
Nursing Access
Online Discussion #4
Musculoskeletal Case Study (Fall)

Original Post Due by 1200 on Thursday 10/14/2021
Response Due by 1200 on Friday 10/15/2021

All online discussion groups will be found under the "Discussions" tab of the course in Edvance360. Your original post for each discussion group is to be completed by Thursday at 1200 and must consist of at least 250 words. All students are expected to respond substantively to at least one other student posting by Friday at 1200. A substantive response consists of at least a 100 word response and includes more than simply agreeing with or restating another peers' comments. Please refer to the Online Discussion Grading Rubric for details on requirements for online discussions.

Instructions: Read the patient profile and case study below. After reading the information, answer the accompanying questions by 1200 on Thursday 10/14/2021. Respond to one of your peers in a substantive manner by 1200 on Friday 10/15/2021. You are allotted 1-hour **total** of theory (online) time for your original post and your substantive response. You may use journal articles, Skyscape, or your textbooks as resources to assist you in answering the questions.

Patient Profile

Mrs. O'Brien is an alert and oriented 81-year-old female admitted to the hospital with reports of dizziness and syncope. Her blood pressure (BP) on admission is 80/43. At the long-term care facility where she lives, she ambulated with a walker independently but, since her episode of syncope, she has reported weakness. As a fall precaution, she requires another person to assist her when ambulating.

Case Study

Mrs. O'Brien is admitted with prescriptions that include assessment of orthostatic vital signs every shift and fall precautions. The nurse explains to Mrs. O'Brien how to use the call light and instructs her to call before getting out of bed so that someone can assist her with ambulation. The nurse completes a set of orthostatic vital signs. Her orthostatic vital signs are lying: BP 120/84, HR 73; sitting: BP 114/73, HR 83; standing: BP 96/61, HR 92, and she complains of feeling light headed and dizzy. When the assessment of orthostatic vital signs is complete, Mrs. O'Brien is settled in bed. The nurse raises two side rails at the head of the bed, and the bed alarm is turned on so that if Mrs. O'Brien tries to get out of bed without assistance, an alarm will notify staff. Later in the shift, Mrs. O'Brien's bed alarm sounds. The nurse quickly goes to her room to find Mrs. O'Brien lying on the floor on her right hip. She is alert and oriented and states, "I had to go to the bathroom. I know I should have called for help but the nurses are busy. I figured I could go myself. Only two more steps and I could have reached my walker. I just slipped is all."

Case Study Questions

1. Which patients are at an increased risk for falls in the acute care setting? (Consider physiological and environmental risk factors for falls)
2. Identify areas of a fall risk assessment.
3. Discuss the **initial** nursing assessments and interventions when the nurse enters Mrs. O'Brien's room and finds her lying on the floor.
4. List at least three interventions that may be performed to prevent falls in older adults.
5. List one appropriate nursing diagnosis for Mrs. O'Brien.

Case Study Update

Mrs. O'Brien was assisted back to bed with a Hoyer lift and two assists. Her vital signs remained within her baseline throughout the remainder of the shift and she is afebrile. An X-ray of her right hip was negative for a fracture. There is no physical deformity of the right hip or other injuries apparent, but a moderate amount of ecchymosis of her right hip that extends around to her lower back and right upper buttock is noted. Her health care provider, Dr. Payne, prescribed one tablet of oxycodone/acetaminophen 5/325 by mouth (PO) that decreased Mrs. O'Brien's pain to a "2/10" within forty minutes of administration. She remains alert and oriented, continues on bed rest, and used the bedpan once for 200 mL of clear yellow urine. The bed alarm is on, the call bell is in reach, and there are two side rails up. Mrs. O'Brien has verbalized an understanding of how and when to use the call bell.

6. Write a nursing progress note regarding the fall to enter into Mrs. O'Brien's chart.