N311 Care Plan #2

Lakeview College of Nursing

Mackenzie Melton

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
10/16/2020	D.W.	09/02/1935 (85 y/o)	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Retired	Widowed	Codeine
Code Status	**Height**	**Weight**	
Full code	5'7"	135lbs	

Medical History (5 Points)

Past Medical History: Anxiety, Stage 3 chronic kidney disease, Type 2 diabetes mellitus, Hypertension, Anemia

Past Surgical History: Cholecystectomy in 1965, Open reduction internal fixation (ORIF) of left femur in September 2017

Family History: Mother: type 2 diabetes mellitus, Father: heart attacks and lung cancer, Maternal grandma: breast cancer and type 2 diabetes mellitus, Maternal grandpa: type 2 diabetes mellitus, Paternal grandparents: no known health problems, Older sister: type 2 diabetes mellitus, Younger sister: no known health problems, Brother: liver failure, Son: asthma

Social History (tobacco/alcohol/drugs): Patient states that she has a past history of tobacco use. Patient said prior to quitting smoking in 2000, she smoked approximately one pack a day for 40 years. No alcohol or recreational drug use.

Admission Assessment

Chief Complaint (2 points): Pain in left knee as a result of falling due to loss of balance.

History of present Illness (10 points): Onset: On October 16th, an 85 y/o white, widowed female was admitted to Sarah Bush Lincoln Health Center after having arrived at the Emergency Department via ambulance for left knee pain as a result of falling due to loss of balance. Location: Left knee. Duration: The pain has presented itself intermittently since the 16th.

Characteristics: The patient is experiencing sharp, squeezing pain, that is tender to touch. Aggravating: Touching the knee or moving the leg too quickly, with any weight on it at all exacerbates her pain. Relieving: Keeping the knee immobilized and supported in the knee immobilizer brace that was provided, as well as rest and elevation helps to relieve her pain. Treatment: HYDROmorphone helps to treat the pain.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Closed fracture of left lateral tibial plateau

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points):

An acute, closed fracture of the left lateral tibial bone occurs when the continuity of that long bone is cleanly broken through without being exposed by the skin to the outside environment. Fractures that occur in the tibia are most common type of long-bone fractures as it is the weight-bearing bone of the lower leg (Capriotti, 2020). A fracture is formed when the stress and forces put on the bone exceeds biological parameters, weather that be a complete or incomplete break (Swearingen & Wright, 2019). Usually the most common result of fractures is from when the stress that is placed on a bone is a result of trauma or physical stress, like the patient's due to the fall she experienced, however a fracture can also occur as a result of a bone abnormality, such as osteoporosis or even a tumor.

While it typically depends on the type and severity of a fracture to determine what signs and symptoms a person may be experiencing, usually all fractures present with a chronic, progressive pain or an acute and sudden severe pain. Some of the physical findings, signs, and symptoms of fractures can include pain, swelling, inability to bear weight, loss of bony or limb

contours, edema, shortening of the limb, decreased range of motion, false motions of movements outside of a joint, perforated internal organs, and neurovascular damage and dysfunction (Swearingen & Wright, 2019). If you have any of these symptoms and have a known bone deformity or have experienced past trauma, but have yet to have any diagnostic tests, you should still be treated by a medical provider as if you have a fracture. All suspected and confirmed fractures should be treated as the same. Interventions to heal a possible/confirmed fracture should be immobilization of the area and continuous monitoring of the neurovascular function (Swearingen & Wright, 2019). Surgery may also be needs to repair the fracture depending on the severity. On top of a fracture needing to be immobilized, the patient also needs to be closely monitored by a physician to make sure they are not developing compartment syndrome. Compartment syndrome is when tissue pressure exceeds the perfusion pressure of a closed space, such as a closed fracture, due to the swelling or bleeding in that area exerting high pressure and causing the vessels in that area to collapse, which can negatively affect the nerves as well as oxygenated blood flow through that body part (Capriotti, 2020).

There are several diagnostic tests used to confirm a fracture and these include radiographic examination, also known as an x-ray, bone scans, computed tomography (CT) scans, tomograms, stereoscopic films, and arthrograms (Swearingen & Wright, 2019). The most common however are x-rays from different anatomical positions around the fracture. In this patient's case, a CT was performed because an x-ray was not conclusive.

In order for a fracture to heal, the bone must go through five stages of healing which tends to me a lengthy process. Those stages are fracture and inflammatory phase, granulation tissue formation, callus formation, lamellar bone deposition, and remodeling (Capriotti, 2020). Initially, after a bone is broken, macrophages, monocytes, and lymphocytes will swarm to the

area of the fracture in order to facilitate inflammation and formation of a blood clot before fibroblasts arrive 48 hours later to form vascular tissue. It takes approximately two weeks in order for the proper tissue to form before osteoblasts and chondroblasts can arrive to form a callus which eventually turns into a mineralized bone in six weeks. The mineralized, callus bone is then replaced by a sheet of mineralized bone that is stronger and helps to start building back up the needed strength. Finally, after several more weeks, more osteoblasts and now osteoclasts arrive at the site of the fracture and start to remodel the newly formed bone in order to allow for strength conditioning over the next 3 to 6 months (Capriotti, 2020). This process can be hindered and take longer depending on several factors. Those factors that can inhibit bone healing are inadequate nutrition, specifically calcium, the type of fracture, degree of trauma, systemic and local disease, and infection (Swearingen & Wright, 2019).

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis.

Swearingen, P.L., Wright, J.D. (2019). *All-in-one nursing care planning resource* (5th ed). Elsevier.

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value

RBC	3.80-5.41 x10^6/mcL	3.01x10^6/mcL	2.56x10^6/mcL	Anemia, which is a result of a low red blood cell count, can be because of
Hgb	11.3-15.2 g/dL	9.5g/dL	8.0g/dL	Reasons for low hemoglobin can be because of fluid volume excess, hemolytic disorders, hematologic cancers, blood loss, and anemia (Hopkins, n.d.). My patient is anemic.
Hct	33.2-45.3%	27.3%	23.4%	Reasons for low hematocrit levels can be from anemia, chronic disease, blood loss, and fluid volume excess (Hopkins, n.d.). As previously states, my patient has a history of anemia as well as has type 2 diabetes mellitus and stage 3 chronic kidney disease which are both chronic diseases (Capriotti, 2020).
Platelets	149-393 K/ mcL	134K/mcL	132K/mcL	Reasons for low neutrophil levels in my patient could be related to the fact the patient takes metFORMIN, which can have an adverse reaction of thrombocytopenia (Jones & Bartlett, 2020).
WBC	4.0-11.7 K/ mcL	10.5K/mcL	7.1K/mcL	
Neutrophils	45.3-79.0%	85.3%	72.8%	Reasons for high neutrophil infections can be from a bacterial infection, stressful event, or inflammatory reaction (Capriotti,2020). My patient has a broken tibial fracture which resulted from a fall, which can be very stressful. The knee is also very inflamed and bruised in an attempt to heal itself.
Lymphocytes	11.8-45.9%	7.5%	14.6%	Reasons for low lymphocyte levels can be from cancer treatments, physical stress, blood disorders, and

				autoimmune diseases (Capriotti, 2020). My patient has a past medical history of anemia as well as experienced some physical stress related to this hospitalization which could play a role in her low lymphocyte level.
Monocytes	4.4-12.0%	4.8%	7.8%	
Eosinophils	0.0-6.3%	1.9%	3.9%	
Bands	0.0-10.0%	*	*	*Did not run tests to determine the percentage of bands in the blood

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145 mmol/L	139mmol/L	139mmol/L	
K+	3.5-5.1 mmol/L	4.6mmol/L	4.5mmol/L	
Cl-	98-107 mmol/L	108mmol/L	108mmol/L	Reasons for high chloride levels can be associated with diarrhea, dehydration, kidney disease, and hyperthyroidism (Hopkins,n.d.). My patient has stage 3 chronic kidney disease.
CO2	21-31 mmol/L	23mmol/L	23mmol/L	
Glucose	74-109 mg/ dL	195mmol/L	154mg/dL	Reasons for high glucose levels can be associated/caused by diabetes (Hopkins, n.d.). My patient is a type 2 diabetic.
BUN	7-25 mg/dL	38mg/dL	45mg/dL	An elevated BUN level can occur because of most renal diseases, GI bleeding, dehydration, high-protein diet, and heart failure (Hopkins, n.d.). The patient is in

				stage 3 of chronic kidney disease.
Creatinine	.70-1.30mg/dL	2.11mg/dL	2.52mg/dL	Elevated levels of creatine can indicate impaired renal function (Hopkins, n.d.). Stage 3 chronic kidney disease would result in impaired renal function.
Albumin	3.5-5.2 g/dL	*****Did not test for on admission.	2.6g/dL	Decreased albumin levels are caused by renal or hepatic disease, acute infection, malnutrition, cancer, and diabetes (Capriotti, 2020). My patient has chronic kidney disease and diabetes.
Calcium	8.6-10.3mg/dL	8.4mg/dL	8.0mg/dL	Decreased calcium levels are caused by vitamin D deficiency, chronic renal failure, magnesium deficiency, alcoholism, bisphosphonate therapy, leukemia, and tumor lysis syndrome (Hopkins, n.d.). A chronic kidney disease that my patient has is stage 3 chronic kidney disease.
Mag	1.5-2.5 mEq/L	*****	*****	*Did not run a test to obtain Mag values.
Phosphate	2.5-4.5mEq/dL	*****	*****	*Did not run a test to obtain Phosphate values.
Bilirubin	.3-1.0 mg/dL	*****Did not test for on admission.	.4mg/dL	
Alk Phos	34-104 unit/L	*Did not test for on admission.	96unit/L	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value***	**Reason for Abnormal**
Color & Clarity	Yellow & clear	*Did not test for on admission.	Yellow & clear	
pH	5.0-8.0	*****	6.5	
Specific Gravity	1.005-1.039	*****	1.015	

Glucose	Normal	*	Normal	
Protein	Negative	*	Negative	
Ketones	Negative	*	Negative	
WBC	0.0-5.0	*	0.0	
RBC	0.0-3.0	*	1.25	
Leukoesterase	Negative	*	Negative	

*Values obtained on 10/17 and reviewed on 10/20

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative/No growth	*	*	*No cultures completed for this patient
Blood Culture	Negative/No growth	*	*	
Sputum Culture	Negative/No growth	*	*	
Stool Culture	Negative/No growth	*	*	

Lab Correlations Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

Hopkins, T. B. (n.d.). *Lab notes: Nurse's guide to lab and diagnostic tests* (3rd ed). F.A. Davis Company.

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Normal lab values came from SBL Chem DXC700 documentation system within Cerner

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Left knee x-ray: The x-ray taken on 10/16/2020 at 1703 showed no signs or indications of a fracture or deformity.

Left knee CT w/o contrast: The CT that taken on 10/16/2020 at 1939 showed a positive result for an acute, closed fracture of the left lateral tibial plateau. The CT also showed osteoarthritis of the left knee.

Current Medications (10 points, 2 points per completed med)
5 different medications must be completed

Medications (5 required)

Brand/ Generic	Norvasc/AmLODIPine	Flomax/Tamsulosin Hydrochloride	NovoLOG/Insulin Aspart	Dilaudid/ HYDROmorphone	Fortamet/ MetFORMIN
Dose	10mg	.4mg	Low dose sliding scale	.5mg	500mg
Frequency	1x day	1x day	4x day- ACHS	Q2H PRN	2x day
Route	PO	PO	SUBCUT	IV	PO
Classification	Antihypertensive	Benign prostatic hyperplasia agent	Antidiabetic	Opiate analgesic	Antidiabetic
Mechanism of Action	Inhibits an increase in calcium in the cell membrane during cardiac depolarization, relaxes smooth vascular muscle, and dilates coronary arteries to help increase oxygen delivery to the heart during angina.	Improves the rate of urine flow and symptoms of benign prostatic hyperplasia by blocking alpha-adrenergic receptors in the prostate to inhibit the contraction of smooth muscle in the prostate.	Moves glucose into cells and coverts glucose to glycogen to decrease blood glucose	Blocks the pathway for pain to the CNS, increases pain threshold, and alters pain perception.	Reduces glucose production by promoting storage of excess glucose as glycogen in the liver and by increasing glucose transport across cells to improve adipose tissue and skeletal muscle glucose use.
Reason Client	To manage hypertension	To treat benign prostatic	To reduce blood glucose	For pain	To reduce blood glucose for type 2

Taking		hyperplasia			diabetes mellitus
Contraindications (2)	Severe obstructive coronary artery disease, severe aortic stenosis	Hypersensitivity to tamsulosin, prostate cancer	Hypersensitivity to protamine or cresol, pregnancy	COPD, GI obstruction	Advanced renal disease, use of iodinated contrast media within the last 48 hours
Side Effects/ Adverse Reactions (2)	Headache, peripheral edema	Arrhythmia, respiratory impairment	Diabetic ketoacidosis, anaphylaxis	Seizures. Respiratory distress	Hypoglycemia, thrombocytopenia

Medications Reference (APA):

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Skidmore-Roth, L. (2020). *Mosby's 2020 nursing drug reference* (33rd ed). Elsevier.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and orientated to year, place, person, and reason for visit x4. Patient appears to be in no apparent distress at this time as she has recently had PRN pain medication and states she is comfortable. Pt is appropriately dressed and well-groomed.

INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin is very dry, pink, warm, wrinkly, and intact in all areas with no current presentation of open wounds. Pt does appear to have some abnormal redness around areas such as the sacrum, heels, and elbows due to prolonged pressure on those areas. Pt does have a rather large green/blue bruise and swelling around the lower part of the left knee and approximate golf ball size bruise on her stomach where patient states she has been receiving a blood thinner shot each day. When pt skin is pinched to test for skin turgor, the skin returns into place in less than 2 seconds. Braden Score: 12- which indicates patient is at high risk for pressure sores and impaired skin integrity!
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head appears to be round/normal with no obvious contusions or abnormalities. Pt has no tracheal deviation and the thyroid rises and falls during swallowing. There does seem to be a minimal amount of hair loss/thinning on the crown of the patient's head. Ears are placed bilaterally even/equal with the top of the ear lobe lining up straight with the eyes- patient uses hearing aids. Pupils are equal, round, and reactive to light and accommodation- patient uses glasses at all times. Bridge of pt nose is straight with a slight, minimal indent around the upper bridge where the glasses sit. Did not assess the nares or turbinates. No pain on palpitation of the frontal or maxillary sinuses. Did not assess the lymph nodes. Pt uses dentures- had no apparent chipping or staining of the dentures. Gums were pink, firm, and moist. Observed the rise and fall of the soft pallet and pt. still had tonsils present.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	S1 and S2 sounds heard, no detected murmurs or S3 gallops. Pt had a pulse of 72/bpm. No palpitations, slow, or fast heart rhythm was detected Bilateral, equal carotid, brachial, radial, posterior tibial, and dorsal pedis pulses. Only assess the right popliteal pulse. Did not assess the femoral pulses or the left popliteal pulse due to not wanting to disrupt that patients' fracture.

	Capillary refill occurred in less than 3 seconds when nails were pushed on till they blanched- color/blood immediately returned. Pt. did have some pitting edema on the left leg. 1+ pitting edema on the left foot as it was barely detectable, only a slight depression and immediately rebound. 2+ pitting edema on the left ankle as it took a more than 3 seconds for the tissue to fully rebound and was a slightly deeper pit than on the foot.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	. Respirations were even, nonlabored and clear, averaging approx. 16 per minute. No wheezes, crackles, stridor, or rhonchi noted. .
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Pt is on a cardiac, healthy diet as well as a diabetic diet- having to restrict excess of salt, lipids, and lots of sugar when needed. Pt follows this diet at the hospital and as best as she can at home. 5'7" 135lbs Auscultated the bowel sounds with the help of my nurse, pt had decreased bowel sounds, having very minimal gurgling and active sounds within 5 minutes, but didn't quite have no sounds at all to be able to classify as hypoactive bowels. Did not palpate the abdomen. Last BM was on 10/16/20- pt stated it was normal for her to have a BM once a day in the morning and had not had one since being admitted- probably due to not enough fluids as well as the pain medications. No visible distention, incisions, drains, scars, or wounds.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Yellow & clear No abnormal odor Voided 200mL during the shift Pt does experience some incontinence when she can't get to the bathroom as fast as she can and also from time to time randomly- is approximately a 1x a week occurrence. Patient also des experience some hesitancy when starting a stream. She feels like she has to go but has to sit there for a minute to actually be able to go. Did not inspect the genitals.
MUSCULOSKELETAL:	Did not assess the neurovascular status.

Neurovascular status: **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Pt had fluid, nonimpaired, or restricted range of motion in all extremities- with the exception of what is inhibited by her fracture and while in the immobilizer. Patient is still able to wiggle her toes on both extremities- immobilizer is not too tight. Pt does use a walker to ambulate to and from bed/chair/bedside commode and is a 1x standby assist but feels more comfortable when 2 people are present to help. Briggs fall risk assessment score of 11- indicates high fall risk. Pt has bilateral grip and strength in both hands and legs. Patient is equally able to push back against my hands when pushing against her extremities.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Pt had fluid, nonimpaired, or restricted range of motion in all extremities- with the exception of what is inhibited by her fracture and while in the immobilizer. Patient is still able to wiggle her toes on both extremities. Pupils are equal, round, and reactive to light and accommodation. Pt has bilateral grip and strength in both hands and legs. Patient is equally able to push back against my hands when pushing against her extremities. Alert and oriented to year, place, person, and reason for visit x4. Appears to have no current, impaired decision-making abilities. No slurring or stuttering of her speech. Speaks clearly and loudly. Pt reported no numbness or tingling in any of her extremities, fingers, or toes. Was able to feel a soft pinch and poke on her feet as well as below the fracture.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Pt stated she likes to read books as well as talk to her family and family friends to help her cope with her feelings and problems. Pt is mature and well educated- having had 3 years of college education back in her day to become an elementary teacher. Pt is a practicing Christian and it is very important to her- enjoying going to church and

	associated functions. Pt lives in an apartment by herself. She does have two children, whom together have 5 grandchildren in total who the pt loves to see and spend time with. She sees her children and a couple of the younger grandkids a couple times a week as they only live a few blocks away from her apartment.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	72	174/75	16	37.1 deg C	96%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	Numeric 0-10	Left knee	4/10	Sharp, squeezing, and tender to touch	Stabilize with a knew immobilizer, elevate extremity and repeatedly ice knee without direct skin contact for 15 minutes with a 30-minute break in between each round.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
.9% Normal Saline via an IV at 100mL/1 hour x 4 hours= 400mL	Voided 200mL of urine at 0945 Total: 200mL of urine voided

Decaf coffee= 8oz Water= 4oz (Half of an 8oz glass) Total= 12 oz fluid PO= 360mL + 400mL NS IV= 760mL total Food: 2 pieces of toast with strawberry jelly and a small fruit cup. 50% of breakfast consumed.	BM: 0x from 0700-1115

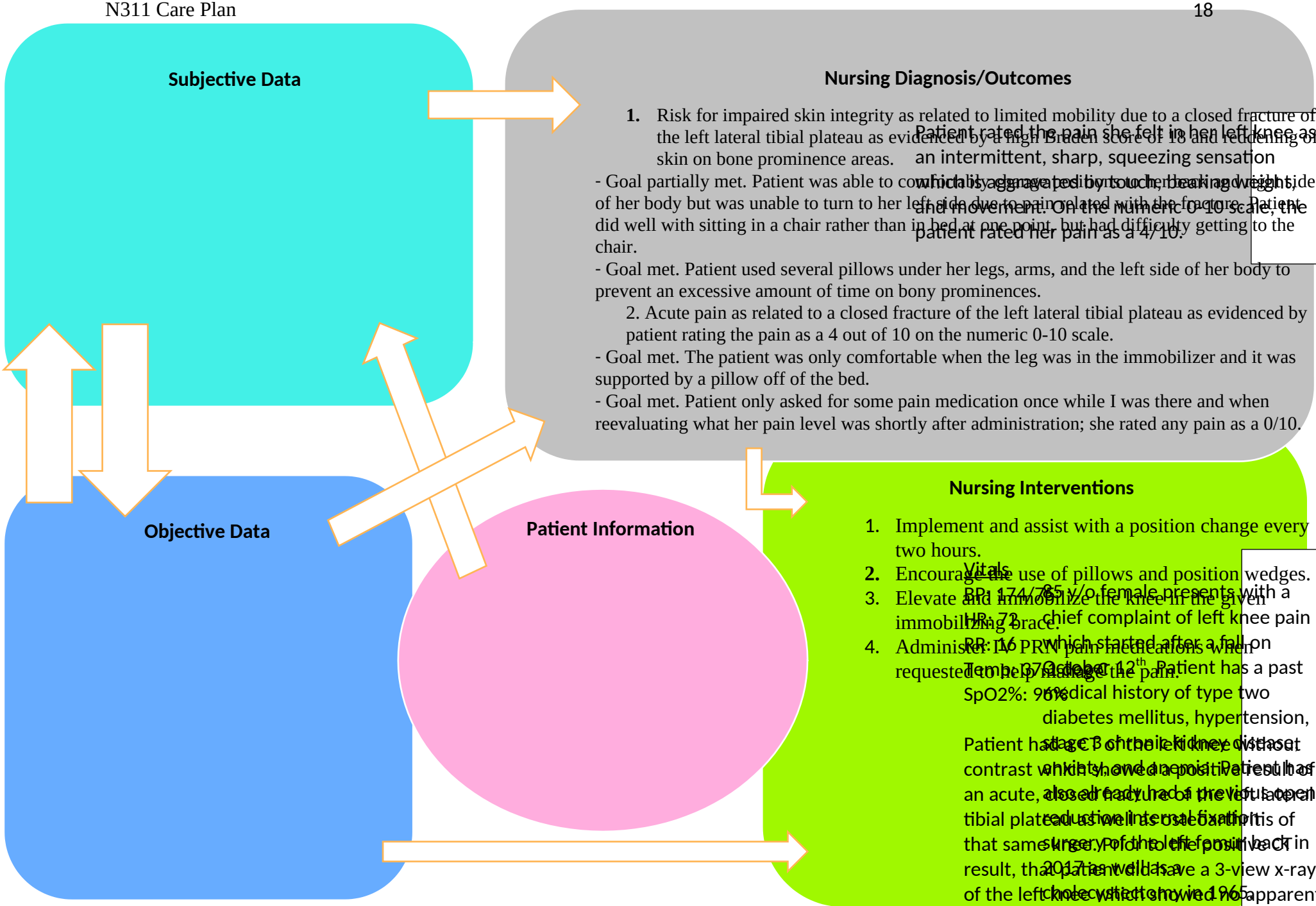
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for impaired skin integrity as related to limited mobility due to a closed fracture of the left lateral tibial plateau as evidenced by a high Braden score of 12 and reddening of skin on bone prominence areas.	This diagnosis was chosen because of red skin on the patient's sacrum, heels, and elbows as well as the assessed Braden score of 18. This patient spends a lot of time in a bed or chair due to having difficulty ambulating and transferring because of her fracture.	1. Implement and assist with a position change every two hours. 2. Encourage the use of pillows and position wedges.	Goal partially met. Patient was able to comfortably change positions to her back and right side of her body but was unable to turn to her left side due to pain related with the fracture. Patient did well with sitting in a chair rather than in bed at one point, but had difficulty getting to the chair. Goal met. Patient used several pillows under her legs, arms, and the left side of her body to prevent an excessive

			amount of time on bony prominences.
2. Acute pain as related to a closed fracture of the left lateral tibial plateau as evidenced by patient rating the pain as a 4 out of 10 on the numeric 0-10 scale.	This diagnosis was chosen because of the patients verbal complaints of pain that she placed for us based on her personal pain tolerance as a 4 out of 10 on the numerical 0-10 scale.	**1.** Elevate and immobilize the knee in the given immobilizing brace. **2.**Administer IV PRN pain medications when requested to help manage the pain.	Goal met. The patient was only comfortable when the leg was in the immobilizer and it was supported by a pillow off of the bed. Goal met. Patient only asked for some pain medication once while I was there and when reevaluating what her pain level was shortly after administration; she rated any pain as a 0/10.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Patient rated the pain she felt in her left knee as an intermittent, sharp, squeezing sensation which is aggravated by touch, bearing weight, and movement. On the numeric 0-10 scale, the patient rated her pain as a 4/10.
Nursing Diagnosis/Outcomes
1. Risk for impaired skin integrity as related to limited mobility due to a closed fracture of the left lateral tibial plateau as evidenced by a high Braden score of 18 and reddening of skin on bone prominence areas.
- Goal partially met. Patient was able to comfortably change positions to the bearing weight side of her body but was unable to turn to her left side due to pain related with the fracture. Patient did well with sitting in a chair rather than in bed at one point, but had difficulty getting to the chair.
- Goal met. Patient used several pillows under her legs, arms, and the left side of her body to prevent an excessive amount of time on bony prominences.
2. Acute pain as related to a closed fracture of the left lateral tibial plateau as evidenced by patient rating the pain as a 4 out of 10 on the numeric 0-10 scale.
- Goal met. The patient was only comfortable when the leg was in the immobilizer and it was supported by a pillow off of the bed.
- Goal met. Patient only asked for some pain medication once while I was there and when reevaluating what her pain level was shortly after administration; she rated any pain as a 0/10.
Objective Data
Patient Information
Nursing Interventions
1. Implement and assist with a position change every two hours.
2. Encourage the use of pillows and position wedges.
3. Elevate and immobilize the knee in the given immobilizing brace.
4. Administer IV PRN pain medications when requested to help manage the pain.
Vitals
BP: 174/78
HR: 73
RR: 16
Temp: 37October 12th
SpO2%: 96%
85 y/o female presents with a chief complaint of left knee pain which started after a fall on [illegible]. Patient has a past medical history of type two diabetes mellitus, hypertension, stage 3 chronic kidney disease, arthritis, and anemia. Patient has also already had a previous open reduction internal fixation surgery of the left femur back in 2017as well as a cholecystectomy in 1965.
Patient had a CT of the left knee without contrast which showed a positive result of an acute, closed fracture of the left lateral tibial plateau as well as osteoarthritis of that same knee. Prior to the positive CT result, that patient did have a 3-view x-ray of the left knee which showed no apparent fracture.