N321 Care Plan # 1

Lakeview College of Nursing

Noredia Asia

Demographics (3 points)

Date of Admission 4/3/22	Client Initials M.A	Age 78	Gender Female
Race/Ethnicity African American	Occupation Retired	Marital Status Widowed	Allergies None
Code Status FULL	Height 5ft 5in	Weight 135lbs	

Medical History (5 Points)

Past Medical History:

- **3 childbirths without complications**
- **Hypertension, Hypothyroidism, Osteoarthritis**

Past Surgical History:

- **Hysterectomy, 1985**
- **Gallbladder, 1990**

Family History:

- **Only child**
- **Mother: diabetes, heart disease**
- **Father: Unknown, died when patient was a baby**
- **3 children, 4 grandchildren**

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

- **Active with children and grandchildren**
- **Volunteers at local hospital**
- **No use of alcohol or tobacco; no illegal drug use**

Assistive Devices:

- **None**

Living Situation:

- **Lives alone**

Education Level:

- **Obtained Associates degree in Business**

Admission Assessment

Chief Complaint (2 points): Abdominal Pain

History of Present Illness – OLD CARTS (10 points): Patient presents to the ED after sustaining injury on right hip after falling off the sided walk this morning during her daily walk this morning. Patient states she has been "having pain in [her] joints for about a year." The right hip appears bruised, tender, red, and swollen upon assessment. Patient states that the pain is radiating in her abdomen with sharp, consistent, and throbbing pain. There are no other symptoms that the patient is experiencing after this fall and states that pain medication helps the main and movement makes the pain worse. This is the patient's first visits to the hospital following the injury.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hip fracture

Secondary Diagnosis (if applicable): Osteoarthritis

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

Osteoporosis is a major cause of hip fracture. Osteoporotic fracture usually occurs in the femoral head or neck, where there is mainly trabecular (nonsolid) bone. Hip fracture caused by osteoporosis often causes a fall in elderly patients. Young adults can sustain hip fracture because

of high-energy trauma caused by accidents or athletic activity. Stress fracture of the hip can also occur in an otherwise healthy person.

The hip is a ball-and-socket joint: the acetabulum within the pelvic bone serves as the socket and the head of the femur as the ball. This region is composed of trabecular bone, which is a composite of nonsolid bone, which is more susceptible to the degenerative changes of osteoporosis than solid bone. In elderly individuals, a common pathological process is osteoporotic degeneration of the hip followed by instability of the joint and consequent fall. The hip becomes unable to bear the individual's weight and gives way, causing a traumatic fall. Femoral neck fractures are common in the presence of osteoporosis, whereas femoral head fractures are more common in younger patients because of trauma.

Hip fractures involve fracture of any aspect of the proximal femur. "They can be classified based on their relation to the hip capsule (intracapsular and extracapsular), location (head, neck, trochanteric, intertrochanteric, and subtrochanteric), and degree of displacement" (Caprotti, 2020). Femoral neck fractures often disrupt the blood supply to the head of the femur. Fractures of the femoral head and neck are intracapsular, whereas those of the trochanteric, intertrochanteric, and subtrochanteric regions are extracapsular. Intracapsular hip fractures frequently have complicated healing. The thick capsule that surrounds these fractures separates them from adjacent soft tissue and capillaries, leading to impaired callus formation.

The patient's vital signs and signs of blood loss should be assessed. The hip and femur position should be inspected, which can provide clues to the type of injury endured. In different types of fractures, the lower extremity assumes different characteristic positions. The abduction or adduction of the leg should be noted as well as the internal or external rotation. In the acute phase the affected leg may appear shorter than the other. Pain and tenderness will be apparent

with any motion of the leg. “If a fracture exists, especially one that is displaced, ROM will be extremely painful; if this happens, movement of the leg should be discontinued” (Caprotti, 2020). A neurovascular examination distal to the site of fracture is essential. Pulses, reflexes, sensation, and motor ability should be assessed as tolerated by the patient. Some common signs and symptoms include “severe pain in hip or groin, shorter leg on the side of the injured hip, and outward turning of the leg on the side of the injured hip” (Mayo Clinic, 2020).

All x-ray views of the extremities and pelvic bones should be completed. If radiographic findings are ambiguous, CT scan or MRI should be considered. A view of the contralateral hip for comparison is necessary. This client had an x-ray completed on the right femur. The patient who complains of hip pain should be immobilized in the supine position. The nurse should perform the ABCDEs of trauma assessment and immobilize the patient’s cervical spine. The patient should be placed on nothing-by-mouth (NPO) status and have supplemental oxygen. Parenteral analgesia is necessary; in addition, a muscle relaxant may be necessary. Surgical ORIF or hip replacement is often required. Anticoagulant therapy is necessary because of the high risk for DVT. Calcium and vitamin D supplements are also needed. This patient underwent hip surgery, is taking anticoagulant medication and also calcium and vitamin D supplements.

Pathophysiology References (2) (APA):

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

Mayo Foundation for Medical Education and Research. (2020, March 27). *Hip Fracture*. Mayo Clinic. Retrieved April 5, 2022, from https://www.mayoclinic.org/diseases-conditions/hip-fracture/symptoms-causes/syc-20373468

Laboratory Data (15 points)

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	3.5-5.2	4.35	4.36	N/A
Hgb	11-16	10	12	Osteoarthritis
Hct	34-47	34.4	36	N/A
Platelets	140-400	356	348	N/A
WBC	4-11	15	12	Infection and inflammation at the site of the fracture
Neutrophils	1.6-7.70	4.5	4.7	N/A
Lymphocytes	1.0-4.9	2.2	2.2	N/A
Monocytes	0.0-1.110	0.5	0.4	N/A
Eosinophils	0.0-0.510	0	0	N/A
Bands	0.0-10	0	0	N/A

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	140	141	N/A
K+	3.5-5.1	3.5	3.6	N/A
Cl-	98-107	98	100	N/A
CO2	22-29	24	25	N/A
Glucose	60-99	118	80	Adrenaline from accident caused increase of production to liver
BUN	10-20	10	11	N/A

Creatinine	**0.55-1.02**	**1.2**	**1.01**	**Hypothyroidisms affect on kidneys**
Albumin	**3.4-4.8**	**3.0**	**3.5**	**Hypothyroidism affect on kidneys**
Calcium	**8.9-10.6**	**7.0**	**7.2**	**Damage to bone causes calcium to be released**
Mag	**1.6-2.6**	**1.8**	**1.8**	**N/A**
Phosphate	**2.8-4.5**	**2.8**	**3.0**	**N/A**
Bilirubin	**0.2-1.2**	**1.1**	**0.7**	**N/A**
Alk Phos	**40-150**	**97**	**104**	**N/A**
AST	**4-34**	**4**	**6**	**N/A**
ALT	**0-55**	**14**	**17**	**N/A**
Amylase	**25-115**	**78**	**77**	**N/A**
Lipase	**73-393**	**212**	**230**	**N/A**
Lactic Acid	**0.5-2.20**	**0.9**	**1.3**	**N/A**

Other Tests 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
INR	**0.9-1.1**	**1.0**	**1.0**	**N/A**
PT	**11.7-13.8**	**12.2**	**12.3**	**N/A**
PTT	**22.4-35.9**	**25.7**	**26.6**	**N/A**
D-Dimer	**<500**	**<500**	**<500**	**N/A**
BNP	**0-100**	**3**	**4**	**N/A**

HDL	**40-60**	**44**	**47**	**N/A**
LDL	**<100**	**<100**	**<100**	**N/A**
Cholesterol	**0-200**	**132**	**116**	**N/A**
Triglycerides	**<150**	**<150**	**<150**	**N/A**
Hgb A1c	**4-6**	**6**	**4**	**N/A**
TSH	**0.350-4.940**	**0.378**	**4.233**	**N/A**

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	**Colorless-yellow; Clear**	**Light yellow; clear**	**Light yellow; Clear**	**N/A**
pH	**5.0-7.0**	**4.6**	**5.2**	**Dehydration; after workout and fall**
Specific Gravity	**1.003-1.035**	**1.005**	**1.007**	**N/A**
Glucose	**Neg**	**Neg**	**Neg**	**N/A**
Protein	**Neg**	**Neg**	**Neg**	**N/A**
Ketones	**Neg**	**Neg**	**Neg**	**N/A**
WBC	**0-25**	**Neg**	**Neg**	**N/A**
RBC	**0-20**	**Neg**	**Neg**	**N/A**
Leukoesterase	**Neg**	**None**	**Neg**	**N/A**

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	**Neg**	**Neg**	**Neg**	**N/A**

Blood Culture	**Neg**	**Neg**	**Neg**	**N/A**
Sputum Culture	**Neg**	**Neg**	**Neg**	**N/A**
Stool Culture	**Neg**	**Neg**	**Neg**	**N/A**

Lab Correlations Reference (1) (APA):

Kee, J. L. F. (2017). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing implications* (8th ed.). Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- X-ray of right femur: Evidence on acute Right Intertrochanteric fracture. A fracture line runs between the trochanters. Comminution with separation of the lesser trochanter. Femoral neck is slightly misplaced.

Diagnostic Test Correlation (5 points):

- The Xray was given for the right femur fracture to confirm the fracture and assess its location and anticipate what surgery to conduct on the patient.

Diagnostic Test Reference (1) (APA):

Kee, J. L. F. (2017). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing implications* (8th ed.). Pearson.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Atenonlol/ Tenormin**	**Levothyroxine Sodium/ Synthroid**	**Hydrocodone/ Hysingla ER**	**Ibuprofen/ Advil**	**Hydromorphone Hydrochloride/ Dilaudid**
Dose	**25mg**	**0.25mcg**	**500mg/5g**	**200mg**	**2mg**
Frequency	**Daily**	**Daily**	**Q6h PRN**	**Q4h-Q6h**	**Q4h-Q6h PRN**
Route	**PO**	**PO**	**PO**	**PO**	**IV**
Classification	**Beta-adrenergic blocker; Antianginal**	**Synthetic thyroxine; Thyroid hormone replacement**	**Opioid; Opioid analgesic**	**NSAID; Analgesic**	**Opioid; Opioid analgesic**
Mechanism of Action	**Inhibits stimulation of beta-receptor sites locates mainly in heart**	**Replaces endogenous thyroid hormone**	**Binds to and activates opioid receptors at sites in gray matter to produce pain relief**	**Blocks activity of cyclooxygenase; reduces inflammatory symptoms and relieves pain**	**May bind with opioid receptors in the spinal cord and higher levels; stimulate kappa and mu receptors this altering perception and emotional response to pain**
Reason Client Taking	**Hypertension**	**Hypothyroidism**	**Osteoarthritis; Abdominal pain**	**Osteoarthritis**	**Severe pain; osteoarthritis**
Contraindications (2)	**Anesthesia, hypotension**	**Hypersensitivity; Uncorrected adrenal insufficiency**	**Acute asthma; Paralytic ileus**	**Pain with CABG surgery; Coagulation defects**	**Acute asthma; Hx of narrowing of the GI tract or blind loops**
Side Effects/Adverse Reactions (2)	**Arrhythmias; Renal failure**	**Myxedema coma; Arrythmias**	**CNS depression; Hypotension**	**GI bleeding; Hepatic failure**	**CNS depression; Hepatotoxicity**
Nursing Considerations (2)	**Monitor for heart failure; Instruct patient not to stop med abruptly**	**Administer before breakfast; Monitor PT of patient who is receiving anticoagulants**	**Be aware that the extended-release form increases risk of overdose and death; Monitor patient for**	**Monitor patient closely for thrombolytic events; Be aware if patient has b one marrow suppression or is receiving an**	**Monitor patient for respiratory depression; Monitor patient for adrenal insufficiency**

			respiratory depression	**anti-neoplastic drug, monitor lab results and watch for evidence of infection**	

Brand/Generic	**Ondansetron/ Zofran**	**Promethazine hydrochloride; Phenergan**	**Ceftriaxone/ Rocephin**	**Azithromycin/ Zithromax**	**Calcitriol/ Calcium + Vitamin D**
Dose	**4mg**	**12.5mg**	**2g**	**500mg**	**1200mg**
Frequency	**Q4h PRN**	**Q6h PRN**	**Q12h**	**Daily**	**Daily**
Route	**IV**	**IV**	**IV**	**IV**	**PO**
Classification	**Selective Serotonin; Antiemetic**	**Phenothiazine; Antiemetic**	**Cephalosporin; Antibiotic**	**Macrolide; Antibiotic**	**Vitamin D analogue; Antihypocalcemic**
Mechanism of Action	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone; reduces nausea and vomiting**	**Competes with histamine for H1-receptor sites; prevents motion sickness, nausea, and vertigo**	**Interferes with bacterial cell wall synthesis, rupturing cells and killing them**	**Binds to ribosomal susceptible bacteria, blocking peptide translocation and inhibiting RNA dependent protein synthesis**	**Binds to specific receptors on intestinal mucosa to increase calcium absorption from intestine**
Reason Client Taking	**Nausea**	**Nausea**	**Infection**	**Soft tissue infection**	**Hypocalcemia**
Contraindications (2)	**Apomorphine; Hypersensitivity**	**Comatose state; Children under 2**	**Allergy to penicillin; hyperbilirubinemic**	**Hx of jaundice or hepatic dysfunction; hypersensitivity**	**Hypercalcemia; Hypersensitivity**
Side Effects/Adverse Reactions (2)	**Hypotension; Pulmonary embolism**	**Bradycardia; Respiratory depression**	**Nephrotoxicity; pancreatitis**	**Stevens-Johnsons syndrome; Hepatic failure**	**Erythema multiforme; Anaphylaxis**
Nursing Considerations (2)	**Monitor closely for serotonin syndrome; Monitor patient for decreased bowel activity**	**Monitor respiratory function; Monitor patient for evidence of neuroleptic malignant syndrome**	**Ask if allergy to penicillin; Be aware that calcium-containing products must NOT be given IV within 48 hours of ceftriaxone**	**Don't give by IV bolus or IM injection; Tell patient taking antacids to take azithromycin I hour before or 2-3 hours after taking an antacid**	**Check to be sure patient receives enough calcium; Store drug at room temperature and protect from heat and direct light**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *Nurse's Drug Handbook* (12th ed.).

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented times four. Well nourished and groomed. Anxious about overall health
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 23** **Drains present: Y☐ N ☒** **Type:**	Skin is dry and intact, no drains noted. Normal distribution, quantity, and texture of hair across all regions. Skin warm upon palpitation. Skin turgor normal mobility. No rashes. Minor wound and bruising on right hip.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with no deviations. Hair is blonde. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. PEERLA is noted. Patient uses glasses regularly. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Dentures noted.
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:** Right extremity	Patient is on telemetry. Normal Sinus Rhythm noted. S1 and S2 heard, radial pulses palpable, pedal pulses palpable, edema 2+ to right extremity. Capillary refill less than 3 seconds.

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breathing normal, breath sounds clear. Not using accessory muscles. Does not need oxygen 96% RA The chest moves equally with respiration and there is no use of accessory muscles with intercostal, subcostal and suprasternal retraction. There are no chest wall deformities. On palpation, chest expansion is equal on both sides. Tactile fremitus is equal on both sides.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** NPO-Clear liquid **Height:** 5ft 5 in **Weight:** 135lbs **Auscultation Bowel sounds:** **Last BM:** 4/3/22 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Abdomen is flat and moves with respiration. Stated pain to the upper abdomen. The liver and spleen were not palpable. There was no organomegaly. Bowel sounds active in all four quadrants. No drains noted.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Foley; w/ balloon **Size:** 16ft	Foley catheter noted 16fr with balloon intact. Urine appears clear yellow without any difficulty or pain with urination. Genitals are without redness, bruises, or sores.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:**	Tested cranial nerves intact. Active range of left hip. Painful right hip. Can move other extremities. Patient placed on bed rest. High risk for falls.

ADL Assistance: Y☐ N ☒ **Fall Risk: Y ☒ N☐** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk X**	
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Awake, oriented to person, place, time, and able to state reason for visit. She speaks and comprehends English well. Pupils are equal and reactive. Equal grips bilaterally in upper extremities and unequal in lower extremities. Hand grips demonstrate equal strength and pedal push 5 out of 5 on left leg, diminished on right leg with a 2 out of 5. Normal sensation upon assessment. Speech is clear.
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):**	Patient handles emotions well and practices remaining calm Appropriate developmental level for age Christianity is important to patient Patient feels well supported by family, friends, and environment

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	86	160/90	22	97.6F	96%
1500	88	150/88	22	98.8F	92% - 2L of O2

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0700	0-10	Abdomen	10	Sharp, consistent, throbbing	Dilaudid 2mg given ED IVP
1500	0-10	Abdomen	7	Sharp, tense, sensitive	Dilaudid 2mg IV

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 18G **Location of IV:** Left hand **Date on IV:** 4/4/22 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** None **IV dressing assessment**: Intact, dry, clean, and dressing in place	No redness, tenderness, drainage, or swelling noted. LR 100 ml/hr. Saline lock in place

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
120 mL – ice chips	300 mL – urine from foley

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was receptive to the care and anxious about surgery, but after speaking with the surgeon, the patient's anxiety decreased. The patient had trouble getting enough O2 after surgery and was put on oxygen

Procedures/testing done: Total Hip Replacement

Complaints/Issues: There were no complaints or issues

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: SCDs, clear liquids until able to handle solids, ROM exercises on lower extremities, assist patient in turning when wanted

Physician notifications: None

Future plans for client: Anticipate client will require some post-operative care and teachings on incentive spirometers, home health needs, equipment, possible transportation back home, teachings on using equipment, safety, medications, and ROM exercises

Discharge Planning (2 points)

Discharge location: Granddaughter will stay with her as she is home from college

Home health needs (if applicable): Pain and nausea meds; go home with home health PT/OT

Equipment needs (if applicable): Patient will go home with walker, needs shower chair, and handrails

Follow up plan: PT/OT

Education needs: Deep breathing and coughing; precautions and safety in home; medication

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions?

• Listed in order by priority – highest priority to lowest priority pertinent to this client				• Client response, status of goals and outcomes, modifications to plan.
1. Risk for Falls related to loss of skeletal integrity like a fracture as evidenced by total hip replacement.	This diagnosis was chosen because the patient may have difficulty understanding the physical imbalance that comes after this type of surgery and be more of a risk because she's normally independent and active.	1.Maintain bed rest or limb rest as indicated. Provide support of joints above and below the fracture site, especially when moving and turning. 2.Support fracture site with pillows or folded blankets. Maintain a neutral position of the affected part with sandbags, splints, trochanter roll, footboard.	1. Client will demonstrate body mechanics that promote stability at the fracture site.	The family responded appropriately to the teachings and prevention methods. It may take some time for the client to gain the habits of asking for help and being more dependent, but the teachings were retained. The goals are for the client to maintain stabilization and alignment of fractures and display callus formation at fracture site as appropriate.
2. Impaired physical mobility related to psychological immobility as evidenced by decreased muscle strength/control and prior pain in joints.	This diagnosis was chosen because the patient could experience some anxiety and depression from the fall and lack of movement that would mentally inhibit her and worsen her prior problems and cause an impairment.	1. Assess the degree of immobility produced by injury or treatment and note the patient's perception of immobility. 2.Auscultate bowel sounds. Monitor elimination habits and provide for a regular bowel routine, Place on bedside commode, if feasible, or use fracture pan. Provide privacy.	1. Client will demonstrate techniques that enable resumption of activities.	The client was anxious with the nurse's actions with ROM and equipment and was saddened. The family was understanding of how important ROM and PT are for the client. The goals are for the client to regain mobility at the highest possible level and increase strength of affected body part.
3. Acute pain related to movement of bone fragments	This diagnosis was chosen because the patient's pain	1.Assess and record the patient's level of pain.	1. Client will demonstrate use of relaxation skills and diversional activities	The client and the family were receptive to the nurse's actions and ultimately want

and injury to the soft tissue as evidenced by reports of pain.	has been above a 7 during her stay which is severe and cause more stress on her body preventing proper healing.	2.Encourage the patient to discuss problems related to the injury.	as indicated for individual situation.	the client's pain to cease as soon as possible. The goals are for the client to verbalize relief of pain and display a relaxed manner.

Other References (APA):

Concept Map (20 Points):

Subjective Data

- 10/10 and 7/10 pain reported
- Pain in right upper abdomen
- "I'm in so much pain"
- Fell off the sidewalk during morning walk
- Reports pain in joints for about a year

Nursing Diagnosis/Outcomes

- Nursing Diagnosis 1: Risk for Falls related to loss of skeletal integrity like a fracture as evidenced by total hip replacement.
- Outcome 1: Client will demonstrate body mechanics that promote stability at the fracture site.
- Nursing Diagnosis 2: Impaired physical mobility related to psychological immobility as evidenced by decreased muscle strength/control and prior pain in joints.
- Outcome 2: Client will demonstrate techniques that enable resumption of activities.
- Nursing Diagnosis 3: Acute pain related to movement of bone fragments and injury to the soft tissue as evidenced by reports of pain.
- Outcome 3: Client will demonstrate use of relaxation skills and diversional activities as indicated for individual situation.

Objective Data

- T: 97.6F-98.8F
- HR: 86-88
- B/P: 160/90-150/88
- RR: 22
- O2: 96%-92% on 2L of O2
- Hip X-Ray
- Abnormal WBC, urine pH, Creatinine, and Albumin labs
- Bruises on right hip
- Edema 2+ on right leg

Client Information

- 78-year-old female
- Associates in Business
- 3 adult children, 4 grandchildren
- Widowed
- Right femur fracture
- 135lbs, 5ft 5 in
- Hypertension, hypothyroidism, osteoarthritis

Nursing Interventions

- Nursing Diagnosis 1 Interventions: 1.Maintain bed rest or limb rest as indicated. Provide support of joints above and below the fracture site, especially when moving and turning. 2. .Support fracture site with pillows or folded blankets. Maintain a neutral position of the affected part with sandbags, splints, trochanter roll, footboard.
- Nursing Diagnosis 2 Interventions: 1. Assess the degree of immobility produced by injury or treatment and note the patient's perception of immobility. 2.Auscultate bowel sounds. Monitor elimination habits and provide for a regular bowel routine, Place on bedside commode, if feasible, or use fracture pan. Provide privacy.
- Nursing Diagnosis 3 Interventions: 1.Assess and record the patient's level of pain. 2.Encourage the patient to discuss problems related to the injury.
-