N321 Adult Health I

Lakeview College of Nursing

Professor Heuerman

Kaleb Kelly

02/18/2024

Demographics

Date of Admission	**Client Initials**	**Age**	**Gender**
02/11/2024	J. S.	53	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Single	None
Code Status	**Height**	**Weight**	
Full Code	72 in	64.0 kg	

Medical History

Past Medical History: Deep Vein Thrombosis (DVT)

Past Surgical History: Bypass Graft Aortofemoral Artery (01/21/2021)

Family History: No family history in the patient's chart. Patient was not aware of any significant illness in his family history.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): Current tobacco and alcohol user for the past 25 years. Drinks 3-5 beers and smokes half a pack of cigarettes daily. Denies use of any recreational drugs.

Assistive Devices: None

Living Situation: Lives at home with girlfriend

Education Level: High school diploma

Admission Assessment

Chief Complaint: Lower right leg pain

History of Present Illness – OLD CARTS: On 02/11/2024, the patient with the initials J. S. was admitted into the hospital. The patient's chief complaint was right lower leg pain due to an unknown injury while being intoxicated from alcohol. Patient stated they had been having this pain since they woke up around 9:00 am, and that it was a constant throbbing pain. When trying

to apply any pressure to the leg the pain travels up his leg and he loses feeling in his foot. He states that he has found nothing to relieve the pain since waking up and that trying to walk or even move causes the pain to intensify greatly. The patient denied having his leg evaluated anywhere before coming to the emergency department. Upon further evaluation and x-ray, it was determined that he had a spiral Tib-Fib fracture of his right leg.

Primary Diagnosis

Primary Diagnosis on Admission: Spiral Fracture of Right Tibia-Fibula, Surgery: Internal Fixation Tibia-Fibula Intramedullary Nail (IM Rod)

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Pathophysiology of the Disease:

There are 206 bones in the adult body that work to support, store minerals, produce blood cells, protect the body's organs, and provide strength in movement. "In the United States, 5.6 million fractures occur annually" (Capriotti, 2020). Not all fractures cause serious injury; however, they may lead to disabilities for people later in life.

In this patient's situation, they were diagnosed with a spiral fracture of the right tibia-fibula, needing surgical intervention by internal fixation tibia-fibula intramedullary nail (IM Rod) for repair. A fracture can occur when the physiological force exceeds the bone, disrupting the bone's structure (Capriotti, 2020). A spiral fracture is unique in that it typically occurs due to a twisting force on the extremity, causing a fracture line that circles the entire shaft of the affected bone. An IM rod is commonly placed in serious fractures of long bones as an internal

splint to help reduce the future risk of fracture in addition to stabilizing any stressors on the bone. After an injury to a bone occurs there are five stages to the bone healing process: the inflammatory phase, granulation tissue formation, callus formation, lamellar bone deposition, and remodeling (Capriotti, 2020). Bleeding of the site of fracture occurs first, creating a hematoma, and inflammation, attracting WBCs to the affected area. During granulation fibroblasts move into the area and it begins to pull in an increased amount of nutrients and oxygen to the site. A callus then begins to form, consisting of osteoblasts to help synthesize and produce new bone material. Once the new bone is forming, ossification begins to form sheets of mineralized bone called lamellae that are stronger than the original formation from the callus (Capriotti, 2020). Finally, bone remodeling occurs, where osteoclasts and osteoblasts work to make the finishing touches to ensure there is adequate strength at the site of injury.

Signs and symptoms of a fracture or bone injury may include stiffness, swelling, bruising, fever, bleeding, pain, numbness, and weakness. Significant pain and the inability to move may indicate the result of a very serious bone injury. In this patient's situation, he has been a smoker of tobacco products for the past 25 years. "Smokers have an increased risk of fracture and experience more complications with delayed bone healing, even if they have already stopped smoking, because some adverse effects persist for a prolonged period" (Hernigou & Schuind, 2019). In addition to this, his alcohol use always has a profound effect on bone healing due to its effect on decreasing bone mineral density (Hernigou & Schuind, 2019).

The attending emergency physician ordered an anteroposterior right tib-fib x-ray to verify the possibility of a fracture due to throbbing pain in his right lower leg. The X-ray verified this finding and ultimately is what got him admitted so that he could be taken in for surgical repair. A traumatic injury such as a fracture is fixed with splinting and surgery; however, it is important to

consider pain management immediately. Pharmacological therapies by use of NSAIDs, opioids, relaxants, or topical anesthetics may be appropriate to help ease acute pain in the injured area. During an open reduction and internal fixation of the bone, the site is properly aligned with a rod and immobilized to support and prevent further injury (Capriotti, 2020). Post-surgery, things such as splinting, limiting weight-bearing activity, massaging, and physical therapy may be utilized to help promote healthy bone healing.

Pathophysiology References (2) (APA):

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

Hernigou, J., & Schuind, F. (2019). Tobacco and bone fractures: A review of the facts and issues that every orthopaedic surgeon should know. *Bone & joint research*, *8*(6), 255-265.

Laboratory Data

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	4.28-5.56 10^6/uL	4.63	4.00	Low RBC due to bleeding and injury bone. Bone marrow injury results in less production of healthy RBCs (Rischer, 2022)
Hgb	13.0-17.0 g/dL	14.9	13.1	*Within normal range
Hct	38.1-48.9%	43.6	38.2	*Within normal range
Platelets	149-393	235	204	*Within normal range
WBC	4.0-11.7	14.4	12.2	Elevated WBCs caused by presence of inflammation at site of fracture (Rischer, 2022)
Neutrophils	2.4-8.4%	8.0	7.3	*Within normal range

Lymphocytes	0.8-3.7%	3.6	3.5	*Within normal range
Monocytes	0.3-1.1%	1.1	1.1	*Within normal range
Eosinophils	0.0-0.5%	0.2	0.2	*Within normal range
Bands	3-5%	*Not indicated	*Not indicated	*Not recorded in the patient chart

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	140	137	*Within normal range
K+	3.5-5.1 mmol/L	3.9	4.2	*Within normal range
Cl-	98-107 mmol/L	106	107	*Within normal range
CO2	22-29 mmol/L	22	24	*Within normal range
Glucose	74-100 mg/dL	57	82	*Within normal range
BUN	8.0-26 mg/dL	10	16	*Within normal range
Creatinine	0.6-1.8 g/dL	0.70	0.79	*Within normal range
Albumin	3.5-5.2 g/dL	3.9	3.8	*Within normal range
Calcium	8.6-10.3	8.1	7.9	Low calcium levels caused by ETOH abuse in addition to injury to bone (Rischer, 2022)
Mag	1.6-2.4 mg/dL	1.8	2.0	*Within normal range
Phosphate	2.5-5.0 mmol/L	3.0	2.8	*Within normal range
Bilirubin	0.3-1.0 mg/dL	0.4	*Not indicated	*Within normal range
Alk Phos	34-104 u/L	71	*Not indicated	*Within normal range

AST	13-39 units/L	20	*Not indicated	*Within normal range
ALT	7-52 units/L	14	*Not indicated	*Within normal range
Amylase	53-123 units/L	*Not indicated	*Not indicated	*Not recorded in the patient chart
Lipase	<=95 units/L	*Not indicated	*Not indicated	*Not recorded in the patient chart
Lactic Acid	0.5-2.2 mmol/L	*Not indicated	*Not indicated	*Not recorded in the patient chart

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	<=1.1	*Not indicated	*Not indicated	*Not recorded in the patient chart
PT	11-15 sec	*Not indicated	*Not indicated	*Not recorded in the patient chart
PTT	25-40 sec	*Not indicated	*Not indicated	*Not recorded in the patient chart
D-Dimer	<=0.50	*Not indicated	*Not indicated	*Not recorded in the patient chart
BNP	0-100	94	*Not indicated	*Within normal range
HDL	23-92	41	*Not indicated	*Within normal range
LDL	<=100	68	*Not indicated	*Within normal range
Cholesterol	<=199	134	*Not indicated	*Within normal range
Triglycerides	0-149	124	*Not indicated	*Within normal range
Hgb A1c	<=5.7%	*Not indicated	*Not indicated	*Not recorded in the patient chart
TSH	0.45-5.33	3.11	*Not indicated	*Within normal range

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	Yellow, clear	*Not indicated	*Within normal range
pH	4.5-8	6.0	*Not indicated	*Within normal range
Specific Gravity	1.005-1.034	1.027	*Not indicated	*Within normal range
Glucose	60-99 mg/d	78	*Not indicated	*Within normal range
Protein	Negative	Negative	*Not indicated	*Within normal range
Ketones	None	None	*Not indicated	*Within normal range
WBC	<=5	1	*Not indicated	*Within normal range
RBC	0-3	2	*Not indicated	*Within normal range
Leukoesterase	Negative	Negative	*Not indicated	*Within normal range

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	**No growth**	*Not indicated	*Not indicated	*Not recorded in the patient chart
Blood Culture	**No growth**	*Not indicated	*Not indicated	*Not recorded in the patient chart
Sputum Culture	**No growth**	*Not indicated	*Not indicated	*Not recorded in the patient chart
Stool Culture	**No growth**	*Not indicated	*Not indicated	*Not recorded in the patient chart

Lab Correlations Reference (1) (APA):

Rischer, K. (2022). *Think like a nurse: Building the knowledge base for professional*

practice (1st ed., Vol. II). KeithRN

Diagnostic Imaging

Diagnostic Tests: Anteroposterior right tib-fib x-ray

Diagnostic Test Correlation:

"X-rays are used to identify fractures, dislocations, tissue derangement, or bony abnormalities after a traumatic event" (Capriotti, 2022). An anteroposterior right tibia-fibula x-ray was ordered and performed to look for a possible fracture. Many times, a provider will take an x-ray of the affected leg in addition to the opposite leg, for means of comparison in looking at abnormal findings. In this patient's given situation, it was discovered to be a spiral fracture that injured both the tibia and fibula. Normal X-ray findings should show healthy intact bone with no evidence of cracking, displacement, or separation.

Diagnostic Test Reference (1) (APA):

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

Current Medications
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	N/A	N/A	N/A	N/A	N/A
Dose	x	x	x	x	x

Frequency	x	x	x	x	x
Route	x	x	x	x	x
Classification	x	x	x	x	x
Mechanism of Action	x	x	x	x	x
Reason Client Taking	x	x	x	x	x
Contraindications (2)	x	x	x	x	x
Side Effects/Adverse Reactions (2)	x	x	x	x	x
Nursing Considerations (2)	x	x	x	x	x

**** No home medications listed in patients' chart****

Hospital Medications (5 required)

Brand/ Generic	ondansetron/ (Zofran)	amLODIPine benzoate/(Katerzia)	atorvastatin/ (Lipitor)	carvetilol/ (Coreg)	ketorolac/ (Toradol)
Dose	4mg=2ml	10mg=2 tabs	80mg=1 tab	12.5mg= 2 tabs	15mg=1ml
Frequency	Q6 PRN	Once a day	Once a day	BID	Q6 PRN
Route	IV	PO	PO	PO	IV
Classification	Pharmacological: Selective serotonin receptor agonist	Pharmacological: Calcium channel blocker Therapeutic:	Pharmacological: HMG-CoA reductase inhibitor Therapeutic:	Pharmacological: Non-selective beta-blocker,	Pharmacological: NSAID Therapeutic: Analgesic

	Therapeutic: Antiemetic	Antianginal, antihypertensive	Antihyperlipidemic	alpha-1-blocker Therapeutic: Antihypertensive, heart failure treatment	
Mechanism of Action	Blocks serotonin receptors in the intestine by blocking signals to the central nervous system (CNS)	Binds to receptor sites on the myocardial cell membrane to prevent calcium ion movement. Inhibits smooth muscle contractions and decreases peripheral vascular resistance.	Decreases lipoprotein and plasma levels in the liver by the reduction of HMG-CoA reductase and cholesterol synthesis.	Lowers cardiac output and tachycardia, peripheral vascular resistance, and overall workload of the heart	Blocks cyclooxygenase to reduce inflammation and temporarily relieve pain
Reason Client Taking	Nausea, vomiting	Hypertension	Control lipid levels	Hypertension	Short-term pain management
Contraindications (2)	Associated use with apomorphine, hypersensitivity	Hypersensitivity to amlodipine	Hepatic disease, breastfeeding	Bronchial asthma, history of anaphylactic hypersensitivity	Active peptic ulcer disease, renal impairment
Side Effects/Adverse Reactions (2)	Agitation, hypotension	Arrhythmias, hypotension	Abnormal dreams, Anemia	Angina, Anaphylaxis	Aseptic meningitis, bronchospasm
Nursing Considerations (2)	Monitor patient for signs and symptoms of	Monitor patient with poor hepatic function,	Should not be taken with cyclosporine or	If the patient has heart failure, then	Avoid patients with recent myocardial

	hypersensitivity, monitor EKG for risk of QT-interval prolongation	monitor patient for low blood pressure	gemfibrozil, monitor glucose levels	have digoxin readily available, monitor glucose levels	infarction (MI), monitor for MI or stroke

Medications Reference (1) (APA):

Learning, J. &. B. (2023). 2023 Nurse's Drug Handbook. Jones & Bartlett Learning

Assessment

Physical Exam – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** Alert x 4 **Orientation:** Oriented x 4 **Distress:** No distress **Overall appearance:** Good	Patient is alert and oriented x 4. Patient is oriented to the current date, time, location, and DOB. Patient is not in any immediate distress. Patient has good hygiene and is clean.
INTEGUMENTARY: **Skin color:** Tan **Character:** Dry **Temperature:** Warm **Turgor:** Normal **Rashes:** None **Bruises:** Bruising on lower right leg Wounds: Closed Tib-Fib fracture of right leg **Braden Score:** 19/23 **Drains present:** **Y**☐ **N** ☒ **Type:** N/A	Patients skin is tan in color, dry, and warm to the touch. Skin turgor is normal as expected, well hydrated, and no rashes. Patient does have bruising on the lower right portion of the leg due to a closed Tib-Fib fracture. Patient has no sensory impairment, rarely moist skin, does require assistance when getting up to the commode or chair, has an adequate diet intake, and has potential for friction and shear due to injury concerning the right leg.
HEENT: **Head/Neck:** Symmetrical **Ears:** Normal **Eyes:** Normal **Nose:** Normal **Teeth:** Normal	Patient's head and neck are symmetrical. No tracheal deviation, carotids palpable. No lumps, lesions, or rashes. Patient responded appropriately to EOMs. No septum deviation. .

CARDIOVASCULAR: **Heart sounds:** Normal **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Normal Sinus **Peripheral Pulses:** Present/Strong **Capillary refill: Normal** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** N/A	Heart sounds normal upon auscultation. S1 and S2 were heard with systole and diastole as expected. Patient is in normal sinus rhythm. No murmurs were heard. Peripheral pulses were present and strong. Capillary refill less than 2 seconds as expected. No jugular vein distension or edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds were clear bilaterally and non-labored. No adventitious lung sounds upon anterior/posterior auscultation. No visible use of accessory muscles or retraction of the chest.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** NPO **Height:** 72in **Weight:** 64.0 kg **Auscultation Bowel sounds:** Normal **Last BM:** 02/12/2024 **Palpation: Pain, Mass etc.:** No pain or abnormal findings **Inspection:** Normal **Distention:** None **Incisions:** None **Scars:** None **Drains:** None **Wounds:** None **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** N/A **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** N/A	Patient follows a regular diet at home but is under strict NPO orders for surgery. No abnormal bowel sounds were heard upon auscultation of all 4 quadrants. No pain or masses were noted upon assessment of the abdomen. No bruises, rashes, scars, or lesions. No distension, incisions, drains, wounds. Patient has no ostomy, nasogastric tube, or feeding/PEG tubes present.
GENITOURINARY: **Color:** Yellow **Character:** Clear **Quantity of urine:** N/A **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** Normal **Catheter: Y ☐ N ☒** **Type:** N/A	Urine is yellow and clear. Patient voided x2, output was not recorded. Patient reports no pain with urination. No dialysis or urinary catheter. No abnormal findings upon inspection of genitals.

Size: N/A	
MUSCULOSKELETAL: **Neurovascular status:** Normal/As expected **ROM:** Limited ROM and pain in right leg **Supportive devices:** None **Strength:** As expected **ADL Assistance:** **Y☐ N ☒** **Fall Risk:** **Y ☒ N☐** **Fall Score:** 25 **Activity/Mobility Status:** Up with 1 assist **Independent (up ad lib)** ☐ No **Needs assistance with equipment** ☐ No **Needs support to stand and walk** ☐ Yes	Patient's neovascular status is normal as expected. Patient has limited ROM in the right leg with pain present. Posterior short leg splint in place for support. Strength is as expected. No ADL assistance. Patient has Morse fall risk score of 25 due to the diagnosis of Tib-Fib fracture and assistance with gait/transfer to a chair.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** Oriented x 4 **Mental Status:** Normal/As expected **Speech:** Normal/As expected **Sensory:** Normal/As expected **LOC:** None	Patient is oriented x4. Patient has PERLA. Not complete MAEW, has limited movement of the right leg. Mental and sensory status normal as expected. Patient speaks clearly and understands well. No LOC.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** None **Developmental level:** As expected for age **Religion & what it means to pt.:** No religious preference **Personal/Family Data (Think about home environment, family structure, and available family support):** Lives at home with girlfriend	Patient reports no therapy or other coping methods. Patient is at a developmental level appropriate for his age. Patient does not actively attend church or have much of a religious preference. Patient lives at home with his girlfriend. Patient has parents, girlfriend, and friends who are available for support if needed.

Vital Signs, 2 sets – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	88	138/78	18	36.6 C	98%
1000	80	128/76	18	36.4 C	99%

Pain Assessment, 2 sets

Time	Scale	Location	Severity	Characteristics	Interventions
0900	6/10	Right leg	Moderate	Throbbing	Toradol IV 15mg
1000	2/10	Right leg	Mild	Throbbing	Comfort measures for leg

IV Assessment

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV:** Right Antecubital **Date on IV:** 2/11/24 **Patency of IV:** IV is patent, no occlusion **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Dressing clean, dry, intact, secured appropriately to the patient	Sodium Chloride 0.9% IV 1000ml 75ml/hr

Intake and Output

Intake (in mL)	Output (in mL)
*No Value Recorded	*No Value Recorded

Nursing Care

Summary of Care

Overview of care: The patient was kept comfortable and prepared for surgery later in the day. Pain medications were given in the morning as scheduled for the patient rating his pain 6/10 and throbbing. Once the pain lessened, the patient was able to fall asleep for over an hour and did not press the call light for any additional needs. The patient was rounded hourly, and no additional care was needed until the patient was sent down for their procedure.

Procedures/testing done: Anteroposterior right tib-fib x-ray, Complete metabolic panel (CMP), Complete blood count (CBC), Urinalysis, IV insertion, Splint applied to the right lower leg

Complaints/Issues: The patient complained of throbbing aching pain. Once the patient was given pain medication, he had us turn off his lights and was able to get some rest. No other complaints were noted from the patient during the shift.

Vital signs (stable/unstable): Vital signs were all stable. No staff had to be notified of any abnormalities or changes in patient status.

Tolerating diet, activity, etc.: The patient had a commode at the bedside if needed to prevent him from having to bear weight on his right leg by going to the bathroom on the other side of the room. The patient stayed in bed during my entire shift with his leg elevated to keep the pain under control.

Physician notifications: The surgeon was consulted to see if it was okay for the patient to have anything to eat or drink. The patient was okay to have clear liquids until 0800, then was placed as NPO.

Future plans for the client: Anticipate the patient to undergo surgery at 1500. The patient was made NPO at 0800 in preparation for surgery, in addition to going through standard pre-op procedures. Should anticipate the use of an assistive device as well as physical therapy post-surgery in preparation for discharge.

Discharge Planning

Discharge location: The patient is being discharged home with his girlfriend from Sarah Bush Lincoln Hospital.

Home health needs (if applicable): Home health needs are not indicated.

Equipment needs (if applicable): Crutches are to be given to the patient upon discharge. The patient should be able to demonstrate back proper crutch mechanics after receiving education from the primary nurse.

Follow-up plan: The patient should follow up with orthopedics if any complications arise regarding the surgical site or additional complications. If serious or life-threatening the patient should immediately seek emergency care.

Education needs: The patient should receive proper education on crutches use, signs/symptoms of infection at the surgical site, and medication use for pain management post-surgery.

Nursing Diagnosis
Must be NANDA-approved nursing diagnosis and listed in order of priority

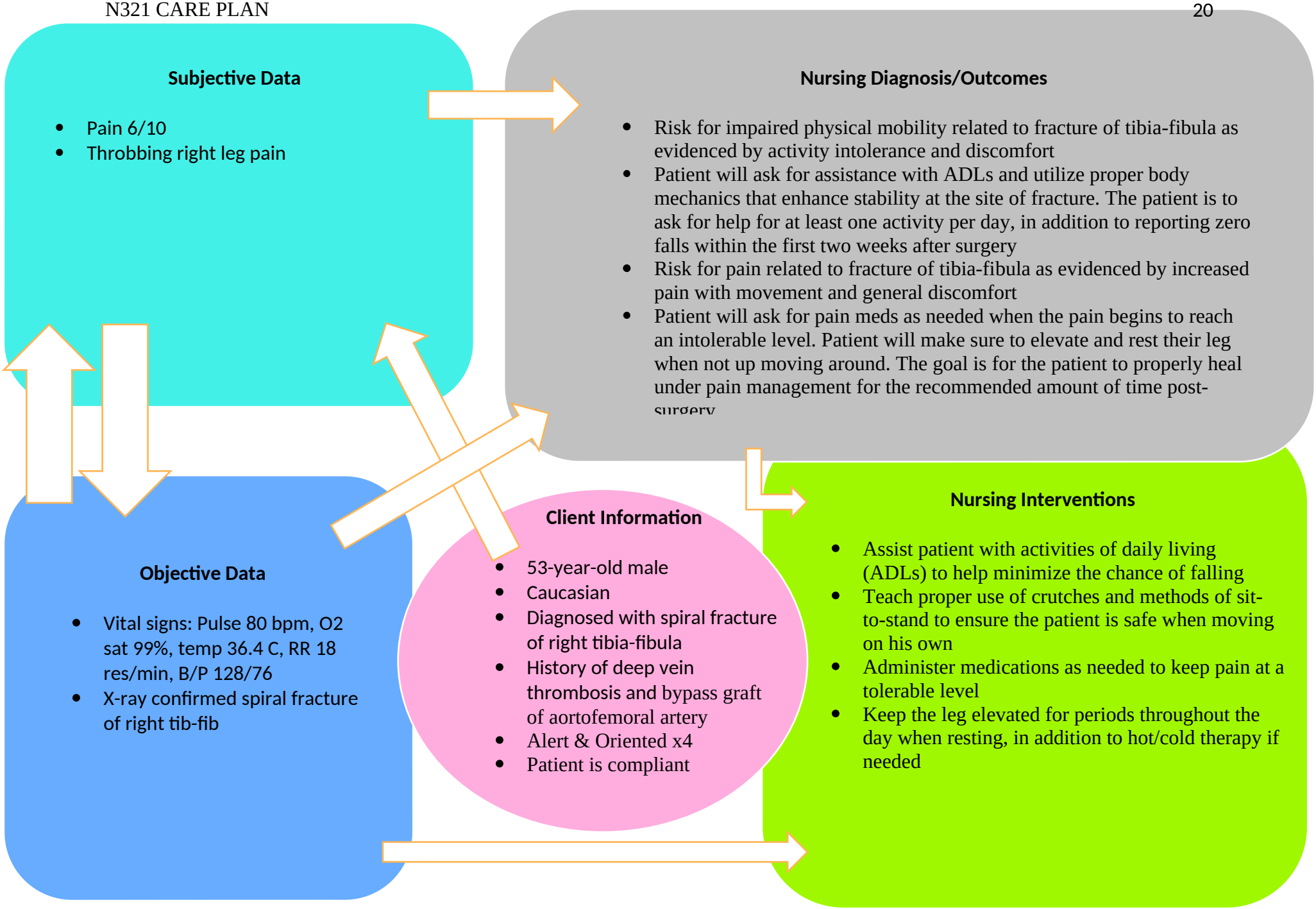
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest	Rationale • Explain why the nursing diagnosis was chosen	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

priority pertinent to this client				
Risk for impaired physical mobility related to fracture of tibia-fibula as evidenced by activity intolerance and discomfort	This nursing diagnosis was chosen because the patient just had surgical repair of their right tibia-fibula by placement of an IM Rod	- Assist patient with activities of daily living (ADLs) to help minimize the chance of falling - Teach proper use of crutches and methods of sit-to-stand to ensure the patient is safe when moving on his own	Patient will ask for assistance with ADLs and utilize proper body mechanics that enhance stability at the site of fracture. The patient is to ask for help for at least one activity per day, in addition to reporting zero falls within the first two weeks after surgery	Patient responded greatly by making sure to have his girlfriend assist him in getting up and back from the bed and couch when needing to use the restroom or sleep. Zero falls occurred over the time it took for his fracture to heal.
Risk for pain related to fracture of tibia-fibula as evidenced by increased pain with movement and general discomfort	This nursing diagnosis was chosen because the patient is a smoker, and this will delay the healing process of bone	- Administer medications as needed to keep pain at a tolerable level - Keep the leg elevated for periods throughout the day when resting, in addition to hot/cold therapy if needed	Patient will ask for pain meds as needed when the pain begins to reach an intolerable level. Patient will make sure to elevate and rest their leg when not up moving around. The goal is for the patient to properly heal under pain management for the recommended amount of time post-surgery	Patient responded as expected by asking for pain meds when needed to keep his pain at a tolerable level. Patient also managed to keep their leg elevated when not moving around to promote blood flow to the site of injury and help the healing process.

Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.

Concept Map:


Subjective Data
Pain 6/10
Throbbing right leg pain
Nursing Diagnosis/Outcomes
Risk for impaired physical mobility related to fracture of tibia-fibula as evidenced by activity intolerance and discomfort
Patient will ask for assistance with ADLs and utilize proper body mechanics that enhance stability at the site of fracture. The patient is to ask for help for at least one activity per day, in addition to reporting zero falls within the first two weeks after surgery
Risk for pain related to fracture of tibia-fibula as evidenced by increased pain with movement and general discomfort
Patient will ask for pain meds as needed when the pain begins to reach an intolerable level. Patient will make sure to elevate and rest their leg when not up moving around. The goal is for the patient to properly heal under pain management for the recommended amount of time post-surgery
Objective Data
Vital signs: Pulse 80 bpm, O2 sat 99%, temp 36.4 C, RR 18 res/min, B/P 128/76
X-ray confirmed spiral fracture of right tib-fib
Client Information
53-year-old male
Caucasian
Diagnosed with spiral fracture of right tibia-fibula
History of deep vein thrombosis and bypass graft of aortofemoral artery
Alert & Oriented x4
Patient is compliant
Nursing Interventions
Assist patient with activities of daily living (ADLs) to help minimize the chance of falling
Teach proper use of crutches and methods of sit-to-stand to ensure the patient is safe when moving on his own
Administer medications as needed to keep pain at a tolerable level
Keep the leg elevated for periods throughout the day when resting, in addition to hot/cold therapy if needed