N431 Care Plan #1

Lakeview College of Nursing

Riley Doran

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/7/19	MRE	70	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired factory worker	Single	Cefprozil, Amlopine, Calcium Channel blockers, Cefadroxil, Cephalosporins, Fish oil, Chlordiazepoxide, Codiene, Fentanyl, Penicillin, shellfish
Code Status	**Height**	**Weight**	
Full Code	180.3 cm	83.9kg	

Medical History (5 Points)

Past Medical History: Carotid artery stenosis, dyslipidemia, CKD (Stage 4), HTN, CAD, hypothyroidism, Parkinson's

Past Surgical History: Total knee arthroplasty, knee arthroscopy (L), cardiac catherization, carotid endarterectomy, total hysterectomy, coronary artery stent

Family History: Mother- Cardiovascular disease, dental disease, heart disease, hyperlipidemia, hypertension

Social History (tobacco/alcohol/drugs): Past alcohol use, former smoker (cigarettes, 47 years), denies any substance use

Assistive Devices: Walker and cane

Living Situation: Nursing home/ rehab facility (at home with grandson before surgery)

Education Level: GED

Admission Assessment

Chief Complaint (2 points): Hip, back, elbow, and knee pain

History of present Illness (10 points): 70 year old female presented to the ED after sustaining multiple falls today and experiencing pain in her back, hip, elbow and knee. Patient states she slipped on the way to the bathroom and hit her head. Patient recently underwent a left knee arthroplasty (9/10/19) and is experiencing wound dehiscence after hitting the knee during a fall. Patient denies chest pain, SOB, dizziness or syncope prior to the fall. Patient has multiple bruises down the right side of her body and a hematoma directly above her right eye, patient claims all injuries were acquired through her falls. Patient does not have full ROM of her right elbow. Pain rated 8 out of 10.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Wound dehiscence

Secondary Diagnosis (if applicable): Closed fracture of right olecranon process

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

Wound dehiscence is the reopening of a surgical wound from the surface level or the entire wound (Winchester, 2019). Causes of wound dehiscence vary. Some causes include wound infection, pressure on sutures, or sutures that are too tight, weak tissue/ muscles around the wound area or new injury. Risk factors for wound dehiscence include being overweight, increased age, poor nutrition, diabetes, smoking, too much exercise/ activity post-surgery and other medical conditions (Sandy-Hodgetts, 2015).

Signs and symptoms of wound dehiscence can vary based on the severity of the wound reopening. Bleeding, pain, swelling, redness, fever, broken sutures and a blatantly opened wound are all signs of wound dehiscence. The main concern when wound dehiscence occurs is infection. Signs of infection include fever, chills, sweats, shortness of breath, cough, redness,

soreness or swelling in any area. The CDC states that “fever is sometimes the only sign of infection.”

To diagnose a wound dehiscence with the possibility of infection a surgeon will examine the wound. If there are signs of infection, a fluid sample will be taken as well as various blood tests to confirm an infection is present. Further testing for deeper or nonhealing wounds includes x-ray, ultrasound or a CT scan. This patient was scheduled for a wound washout after the surgeon evaluated the wound. The severity of the wound dehiscence could not be determined at bedside and the surgeon decided while doing the washout he will determine the depth, severity and further steps of care for this patient.

Treatment for wound dehiscence includes antibiotics to treat and/or prevent infection. Regular dressing changes are important to keeping the wound clean and clear from infections. Leaving the wound open to air will speed up the healing process as well (Winchester, 2019). In some cases surgery may be necessary to wash out as well as reclose the wound. Untreated wound dehiscence can become life threatening.

Pathophysiology References (2) (APA):

CDC - Preventing Infections in Cancer Patients: Know the Signs and Symptoms of Infection. (n.d.). Retrieved from https://www.cdc.gov/cancer/preventinfections/symptoms.htm.

Sandy-Hodgetts K, Carville K, Leslie GD. Determining risk factors for surgical wound dehiscence: a literature review. Int Wound J. 2015 Jun;12(3):265-75.

Winchester Hospital. (n.d.). Wound Dehiscence. Retrieved from https://www.winchesterhospital.org/health-library/article?id=99918.

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	4.28-5.56	3.89x 10^6	N/A	N/A
Hgb	13-17	10.9		Patient hgb levels decreased due to reopened incision bleeding.
Hct	33.2- 45.3	34.3%	N/A	N/A
Platelets	150-400	264	N/A	N/A
WBC	4.5-11	7.2	N/A	N/A
Neutrophils	45.3- 79.0%	67.5%	N/A	N/A
Lymphocytes	11.8-45.9%	19.7%	N/A	N/A
Monocytes	4.4-12.0%	8.9%	N/A	N/A
Eosinophils	0-6.3	3.1%	N/A	N/A
Bands	< 10%	0.9%	N/A	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	137	N/A	N/A
K+	3.5-5.1	4.6	N/A	N/A
Cl-	98-107	103	N/A	N/A
CO2	22-29	23	N/A	N/A
Glucose	70-99	109		Patient with history of diabetes. Glucose slightly elevated due to insulin not being her priority during the day's events
BUN	6-20	21	N/A	N/A
Creatinine	0.7-1.2	1.44		Increased creatinine due to patient's history of impaired kidney function/

				kidney disease
Albumin	3.5-5.2	3.6	N/A	N/A
Calcium	8.6-10.4	9.1	N/A	N/A
Mag	1.6-2.4	N/A	N/A	N/A
Phosphate	3.0-4.5	N/A	N/A	N/A
Bilirubin	0-1.2	0.3	N/A	N/A
Alk Phos	40-130	80	N/A	N/A
AST	0-40	22	N/A	N/A
ALT	0-41	10	N/A	N/A
Amylase	56-90	N/A	N/A	N/A
Lipase	0-110	N/A	N/A	N/A
Lactic Acid	6-16	2.6		I really do not know why lactic acid is low nor could I find causes or the importance.
Troponin	0-0.3	N/A	N/A	N/A
CK-MB	20-170	N/A	N/A	N/A
Total CK	30-170	N/A	N/A	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	0.9-1.2	0.97	N/A	N/A
PT	11-14	13.1	N/A	N/A
PTT	16-40	30.7	N/A	N/A
D-Dimer	0.24-2.33	N/A	N/A	N/A

	mcg/mL			
BNP	< 100	N/A	N/A	N/A
HDL	40-59	N/A	N/A	N/A
LDL	100-129	N/A	N/A	N/A
Cholesterol	< 200	N/A	N/A	N/A
Triglycerides	< 150	N/A	N/A	N/A
Hgb A1c	< 5.7%	N/A	N/A	N/A
TSH	2-10mU/L	8.58	N/A	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	Yellow & clear	Yellow & clear	N/A	N/A
pH	5.0-8.0	7.0	N/A	N/A
Specific Gravity	1.005-1.035	1.01	N/A	N/A
Glucose	Normal	Normal	N/A	N/A
Protein	Negative-normal	Negative	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	<5	Negative	N/A	N/A
RBC	0-3	Negative	N/A	N/A
Leukoesterase	Negative	Negative	N/A	N/A

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

Test	**Normal**	**Value on**	**Today's**	**Explanation of Findings**

	Range	Admission	Value	
pH	7.35-7.45	N/A	N/A	N/A
PaO2	80-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	21-28	N/A	N/A	N/A
SaO2	95-100	N/A	N/A	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	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 th ed.). Philadelphia, PA: F.A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT brain/head without contrast, CT spine without contrast, CT abdomen and pelvis with contrast

Diagnostic Test Correlation (5 points):

CT of head w/o contrast- Patient on dual anticoagulant therapy. Head CT done after patient states she hit her head when she fell. Attempting to rule out any potential bleeding in the head. Results came back clear with no abnormalities.

CT of spine w/o contrast- Spinal CT done to rule out any spinal column damage that occurred during the multiple falls. Results came back clear with no abnormalities.

CT of abdomen w/ contrast- Abdominal CT done to rule out any internal injuries or bleeds. Results came back clear with no abnormalities.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). Brunner & Suddarth's Textbook of Medical-Surgical Nursing (14 th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Home Medications (5 required)

Brand/Generic	Metformin	Gabapentin	Levothyroxine	Lasix (furosemide)	Metoclopramide
Dose	500mg	600mg	137mcg	20mg	10mg
Frequency	BID	TID	Daily	Daily	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antidiabetic	Anticonvulsant	Thyroid hormone replacement	Antihypertensive	Antiemetic

Mechanism of Action	Promote storage of excess glucose as glycogen in the liver, which reduces glucose production	Inhibits rapid firing of neurons associated with seizures	Replaces endogenous thyroid hormone	Inhibits sodium and water reabsorption and increases urine formation	Antagonizes the inhibitory effect of dopamine on the GI smooth muscle, promoting gastric emptying and reduce reflux
Reason Client Taking	Diabetic	Hx of Parkinson's	Hx hypothyroidism	Hx CKD	Heartburn
Contraindications (2)	-advanced renal disease -metabolic acidosis	-hypersensitivity	-uncorrected adrenal insufficiency -acute MI hypersensitivity	-anuria unresponsive -hypersensitivity	-GI hemorrhage -mechanical obstruction/ perforation
Side Effects/Adverse Reactions (2)	-metallic taste -aplastic anemia	-abnormal vision -abdominal pain	-alopecia -weight gain	-hyperglycemia -dehydration	-restless leg syndrome -rash
Nursing Considerations (2)	-never give with severe renal impairment -give with food	-may be opened and mixed with applesauce -give at least 2 hours after antacid	-administer 30-60 minutes before food -monitor blood glucose levels of diabetic patients	-beware of sulfonamides allergy -monitor weight for fluid loss	-assess for signs of intestinal obstruction -give IV drug over 1-2 minutes
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-check blood glucose level before admin	-monitor renal function test results	-monitor blood glucose levels	-daily weight to monitor fluid loss	-abdominal assessment to ensure no obstructions present
Client Teaching needs (2)	-take as prescribed	-do not chew extended release	-life long drug -take with	-take at the same time each day	-avoid alcohol -immediately

	-avoid alcohol	tablets -do not stop abruptly	full glass of water	-take with food or milk	report involuntary movements

Hospital Medications (5 required)

Brand/Generic	Atorvastatin	Bupropion	Carbidopa Levodopa	Pantoprazole	Docusate (Colace)
Dose	40mg	150mg	25-100mg	40mg	100mg
Frequency	Daily	BID	TID	Daily	BID
Route	Oral	Oral	PO	Oral	Oral
Classification	Antihyperlipidemic	Antidepressant, smoking cessation adjunct	Decarboxylase inhibitors	Antiulcer	Laxative
Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels	Inhibit dopamine, norepinephrine and serotonin uptake by neurons	Prevents levodopa break down before reaching the brain	Interferes with gastric acid secretion	Softens stool by decreasing surface tension between oil and water in feces
Reason Client Taking	Hx CAD	Depressive episodes	Parkinson's	Heart burn	Constipation
Contraindications (2)	-active hepatic disease -rise in serum transaminase level	-seizure disorder -hypersensitivity	-closed angle glaucoma - abnormal heart rhythm	-hypersensitivity	-fecal impaction -hypersensitivity
Side Effects/Adverse Reactions (2)	-abnormal dreams -anemia	-acute angle glaucoma -alopecia	-lightheadedness -unusual dreams	-hyperglycemia -abdominal pain	-abdominal cramps -muscle weakness
Nursing Considerations (2)	-used in pt w/o obvious CAD	-use cautiously in pt's with renal	-assess therapeutic response -assess	-don't give within 4 weeks of H.pylori	-long term use can cause dependence

	-increases risk of liver dysfunction	impairment -seizure precautions	mental status	testing - monitor for diarrhea from C.diff	-assess for laxative abuse syndrome
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-liver function tests	-assess BP prior to admin	-baseline BP and mental status	-monitor intake and output -monitor PT/ INR	-long term use check for electrolyte imbalance
Client Teaching needs (2)	-not a substitute for low cholesterol diet -monitor blood glucose closely	-do not cut extended release tablets -take with food	-possible sudden onset of excessive daytime sleepiness -alcohol can increase drowsiness	-swallow tablets whole -expect relief of symptoms within 2 weeks	-do not use if having abdominal pain, nausea or vomiting -increase fiber intake

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is awake and A&O x4 with ability to speak and portray needs as desired. Primary language is English. No sensory or motored deficits. Overall appearance appropriate for situation
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒**	Braden Scale: 17 (low risk) Patient is a Caucasian female with a fair complexion. Skin was warm to the touch, dry and pink. Good skin turgor with no abnormal textures. Open wound on left knee and bruises along right side of body. Hematoma above right eyelid. No drains are present. Scar from previous surgical interventions present.

Type:	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with no deviations. Patient has partial head of grey and brown hair. Patient can hear and comprehend questions. PERLA is present. Conjunctiva and sclera are normal. Nose does not present with any external or internal swelling or discomfort. Teeth are maintained, proper oral hygiene conducted, oral mucosa is moist and pink.
CARDIOVASCULAR (2 points): **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:**	Heart sounds were clear and equal. No murmur or bruit auscultated. Cardiac rhythm is normal with no unusual findings during auscultation. Peripheral pulses were palpable. Capillary refill was <3 seconds No presence of neck vein distention. No edema**.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Use of accessory muscles to assist during respirations not observed. Auscultation of lung sounds were observed bilaterally results clear. Trachea resides midline.
GASTROINTESTINAL (2 points): **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:**	Current diet: 1500-1700 calories per day. Patient is 180.3cm in height and 83.9kg. Bowel sounds are present, active, and within normal limits in all four quadrants. There is no pain stated or demonstrated during palpation of any of the four quadrants. No masses were located upon palpation. Patient does not have an ostomy or any additional tubes. Last bowel movement was on 10/7/19.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient is continent with urinary urges. Inspection of genitals was not conducted. No dialysis or catheters present. Urine was unable to be inspected during clinical time due to the patient not voiding. Urine was unable to be inspected for any sediment, cloudiness, or unusual odor. Patient denies any discomfort during attempted urination when asked. Patient is on I&O's
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 75** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Fall Risk: 75 Patient is a fall risk based on fall risk rating. Patient utilizes an assistive deice, a cane, walker at home and in the inpatient setting. Patient is able to ambulate with assistance x1 and sometimes x2. Patient exhibits ROM well in extremities that are able to be moved.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient can MAEW for age, weight, and present health. Strength is not bilaterally equal for extremities. Left leg weak as well as right arm unable to move, both injuries from falling. Response to PERLA is standard. No signs of any neurological deficits. Mental status appropriate. No speech or sensory deficits.
PSYCHOSOCIAL/CULTURAL (2 points): **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 very supported by family. Developmental level appropriate. Religious preferences not asked. Lives at home with grandson when not at nursing home/rehab center. Family active in patient's care and visiting throughout shift

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0630	74	109/69	18	36.0	97
0830	98	114/68	18	36.2	98

Vital Sign Trends:

Vital signs stayed consistent throughout the shift. Pulse trending upwards due to increased activity as in waking up and interacting with visitors.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	Numeric	Elbow	7	"hard to move and hurts even when doing nothing"	Administered pain medication
1000	Numeric	Elbow	3	"not as much pain, more annoying"	Continue to monitor for change in pain status

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Peripheral IV Right forearm, 20g, dated 10/7/19 IV patent with no signs of erythema

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
350	N/A

Nursing Care

Summary of Care (2 points)

Overview of care: Patient began receiving care early 10/7/19 and will most likely remain in the hospital for a few more days. Patient overall very cooperative and pleasant to tend to. Complains of pain in the elbow and is concerned about a possible infection in the knee wound.

Procedures/testing done: CT of head, spine and abdomen. All clear of abnormalities.

Complaints/Issues: Patient complaining of pain in her elbow especially when trying to lay in bed

Vital signs (stable/unstable): Vitals stable

Tolerating diet, activity, etc.: Patient tolerating diet and is eating well. Moving to bedside commode with assistance

Physician notifications:

Future plans for patient: Patient scheduled for elbow surgery tomorrow as well as a knee washout to determine the severity of the dehiscence**.**

Discharge Planning (2 points)

Discharge location: No tentative plan to discharge d/t fall incident at the current nursing home/rehab facility.

Home health needs (if applicable): Modified walker for elbow cast post surgery, extra possible assistance while ambulating

Equipment needs (if applicable): N/A

Follow up plan: Not completed until patient is stable and new rehab plans in place

Education needs: Education on limited activity and activity adjustments

Nursing Diagnosis (15 points)
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	**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. Impaired tissue integrity due to wound dehiscence as evidenced by left knee wound reopening	Patient's surgical wound reopened when she fell and the healing process is now compromised	1.Monitor vital signs for elevated temperature and heart rate 2. Follow sterile technique when changing dressing	Patient responded well to attempting to maintain the open wound clean. No elevated temperature or heartrate recorded during shift.
2. Acute pain related to elbow injury as evidenced by bruising, wincing in pain and inability to move elbow	Patient's main complaint throughout the shift was the pain in her elbow. Managing this pain will improve overall quality of hospital stay	1. Use a formal patient-specific method of assessing self reported pain when possible, including description, location, intensity, aggravating/alleviating factors 2. Use a preventive approach: administer prn pain meds before pain becomes severe	Patient responded well to the method of rating and describing her pain. Further interventions for pain management were not required and pain remained below a 4 for the remainder of the shift.
3.) Impaired physical mobility related to the use of immobilization devices as evidenced by	Patient's fall in the nursing home resulted in wound dehiscence as well as a	1. Teach patient proper body alignment when applying and using external fixation device 2 Instruct patient and	Patient and family responded well to the education given to them about the proper mechanics and alignment of the

broken elbow in sling	fractured elbow	family in the care of the extremity in traction and on the signs and symptoms of complications	extremity
4.) Ineffective tissue perfusion related to interrupted venous flow secondary to prolonged immobility as evidenced by previous knee surgery and fall history	Patient's healing process prolonged due to the reopening of the knee incision and is not at risk of ITP due to limited mobility	1. Teach patient to report any pain, redness, swelling, edema or unnatural color to the involved area 2. Encourage deep breathing	Patient responded well to the education given and actively participated in ROM exercises to the best of her ability

Other References (APA):

Swearingen, P. L. (2016). *All-in-one care planning resource: medical-surgical, pediatric, maternity & psychiatric nursing care plans*. Philadelphia, PA: Elsevier/Mosby.

Concept Map (20 Points):

Subjective Data

70 year old female presented to the ED after sustaining multiple falls today and experiencing pain in her back, hip, elbow and knee. Patient states she slipped on the way to the bathroom and hit her head. Patient recently underwent a left knee arthroplasty (9/10/19) and is experiencing wound dehiscence after hitting the knee during a fall. Patient denies chest pain, SOB, dizziness or syncope prior to the fall. Patient has multiple bruises down the right side of her body and a hematoma directly above her right eye, patient claims all injuries were acquired through her falls. Patient does not have full ROM of her right elbow. Pain rated 8 out of 10.

Nursing Diagnosis/Outcomes

1.) Impaired tissue integrity due to wound dehiscence as evidenced by left knee wound reopening

Outcome: Patient responded well to attempting to maintain the open wound clean. No elevated temperature or heartrate recorded during shift

2.) Acute pain related to elbow injury as evidenced by bruising, swelling, pain and inability to move elbow

Outcome: Patient responded well to the method of rating and describing her pain. Further interventions for pain management were not required and pain remained below a 4 for the remainder of the shift.

3.) Impaired physical mobility related to the use of immobilization devices as evidenced by broken elbow in sling

Outcome: Patient and family responded well to the education given to them about the proper mechanics and alignment of the extremity

4.) Ineffective tissue perfusion related to interrupted venous flow secondary to prolonged immobility as evidenced by previous knee surgery and fall history

Outcome:

Patient responded well to the education given and actively participated in ROM exercises to the best of her ability

Objective Data

Head, spinal and abdominal CT clear of any abnormalities. Decreased Hgb indicator of bleeding. WBC within normal range, indicating no signs of infection. Vitals stable.

Patient Information

Patient is a 70 y.o Caucasian female with a PMH of Carotid artery stenosis, dyslipidemia, CKD (Stage 4), HTN, CAD, hypothyroidism, Parkinson's, and a past surgical history: Total knee arthroplasty, knee arthroscopy (L), cardiac catheterization, carotid endarterectomy, total hysterectomy, coronary artery stent

Nursing Interventions

1.Monitor vital signs for elevated temperature and heart rate
2. Follow sterile technique when changing dressing

1.Use a formal patient-specific method of assessing self reported pain when possible, including description, location, intensity, aggravating/alleviating factors.
2. Use a preventive approach; administer prn pain meds before pain becomes severe

1. Teach patient proper body alignment when applying and using external fixation device
2 Instruct patient and family in the care of the extremity in traction and on the signs and symptoms of complications

1. Teach patient to report any pain, redness, swelling, edema or unnatural color to the involved area
2. Encourage deep breathing