N431 Care Plan #2

Lakeview College of Nursing

Meet Khatri

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/29/2019	MS	86 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	married	No Known Allergies
Code Status	**Height**	**Weight**	
Full Code	5’8	77.8 kg	

Medical History (5 Points)

Past Medical History: Past medical history of A -fib, Congestive heart failure, coronary artery disease, elevated PSA, Hyperlipidemia, Hypertension, anemia, and osteoarthritis in knees

Past Surgical History: Patient has coronary artery bypass, cataract removal, abdominal aortic aneurysm repair.

Family History: Patients family is noncontributory

Social History (tobacco/alcohol/drugs): Patient reports that he has quit smoking. He has never used smokeless tobacco. He reports that he does not drink alcohol or use drugs.

Assistive Devices: Patient does use an assistive devices patient uses a walker.

Living Situation: Patient lives in Champaign with his great granddaughter.

Education Level: Patient does have a high school diploma.

Admission Assessment

Chief Complaint (2 points): Left Hip Pain

History of present Illness (10 points):.

Patient is a eighty six year old male with a past medical history of Afib, Congestive heart failure, coronary artery disease, elevated PSA, Hyperlipidemia, Hypertension, Anemia and Osteoarthritis of left knee. Patient’s past surgical history consists of a coronary artery bypass, cataract removal, abdominal aortic aneurysm repair. Patient was brought to the emergency room

by EMS. Patient lost control of his balance and fell on his buttocks. The fall occurred at 10 pm at night. Once he fell, patient rated the pain a 10/10 and the pain is localized in the left hip where the pain is constant. Patient denied having fever chills, no nausea or vomiting. In the emergency room patient had an X-ray of the hip where a fracture was found. His lab work reveals baseline chronic anemia and thrombocytopenia.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Fracture in left hip

Secondary Diagnosis (if applicable):. N/A

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

A hip fracture is a break that is particularly located in the proximal end of the femur. Although, a hip fracture can occur at any age, it is commonly seen in elderly patients. Elderly patients who encounter a recent fall is more prone to a hip fracture due to weak bones, bone loss or even osteoporosis. Patients over the age of sixty- five maybe unsteady on their feet for many reasons. Some factors that can alter balance and gait in elderly patients are often certain medications, dementia, and frailty. A patient suffers from a hip fracture when they are supporting all their weight on one leg or when they are moving their hips in a twisting motion it can also happen due to a trauma like a sudden fall. Some symptoms of a hip fracture include Severe pain in your hip or groin, Stiffness, bruising and swelling in and around your hip area, and even Inability to move immediately after a fall (Mayo Clinic, 2018).

Treatment of a hip fracture usually consists of surgery to manually insert a bone plate or even a hip replacement. Once after the surgery is completed, the patient is encouraged to begin walking with aids as soon as possible. This will prevent future problems like the promotion of blood clots, especially a DVT. Recovery may take longer in elderly patients. To properly

diagnose a hip fracture X- rays are used to show exactly where the fracture is in your bone (Van Leeuwen, 2017).

Patient fractured his left hip when he lost control of his balance and fell on his buttocks. He has experienced Stiffness and bruising around the left hip. He also experiences inability to move immediately after the fall, along with severe pain. Due to the patients age, he has significantly low bone density and muscle mass. Patient has a past medical history of Osteoarthritis in his left knee which lead him to have less balance on his left leg. Patient had an X - ray done to confirm a broken left hip fracture. Patient will have surgery to align the hip.

Pathophysiology References (2) (APA):

Mayo Clinic. (2018, May 11). Hip fracture. Retrieved from https://www.mayoclinic.org/diseases-conditions/hip-fracture/diagnosis-treatment/drc-20373472

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

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	**3.8-5.30**	**N/A**	**3.01**	**Low red blood cell count because of age and previous diagnosis of anemia.** (Van Leeuwen & Bladh, 2017, p. 496)
Hgb	**12.0-15.8**	**N/A**	**10.2**	**Low hemoglobin count because of previous diagnosis of anemia.** (Van Leeuwen & Bladh, 2017, p. 496)

Hct	**36.0-47.0**	**N/A**	**28.5**	**Low hematocrit count because of previous diagnosis of anemia.** (Van Leeuwen & Bladh, 2017, p. 496)
Platelets	**140-440**	**N/A**	**103**	**Low platelet count because of disturbance in the bone marrow from broken hip bone.** (Van Leeuwen & Bladh, 2017, p. 496)
WBC	**4.00-12.00**	**N/A**	**8.70**	
Neutrophils	**47.0-73.0%**	**N/A**	**56.8%**	
Lymphocytes	**18.0-42.0**	**N/A**	**14.0%**	
Monocytes	**4.0-12.0**	**N/A**	**4.8%**	
Eosinophils	**0.0-5.0**	**N/A**	**0.0%**	
Bands	**na**	**N/A**	**na**	

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-	**133-144**	**N/A**	**134**	
K+	**3.5-5.1**	**N/A**	**3.6**	
Cl-	**98-107**	**N/A**	**100**	
CO2	**21-31**	**N/A**	**26**	
Glucose	**70-99**	**N/A**	**92**	
BUN	**7-25**	**N/A**	**23**	
Creatinine	**0.5-1.20**	**N/A**	**1.19**	
Albumin	**3.5-5.7**	**N/A**	**3.6**	
Calcium	**8.6-10.3**	**N/A**	**8.5**	

Mag	**1.6-2.6**	**N/A**	**1.8**	
Phosphate		**N/A**	**N/A**	
Bilirubin	**0.2-0.8**	**N/A**	**.23**	
Alk Phos	**34-104**	**N/A**	**78**	
AST	**13-39**	**N/A**	**20**	
ALT	**7-52**	**N/A**	**8**	
Amylase		**N/A**	**N/A**	
Lipase	**11-82**	**N/A**	**N/A**	
Lactic Acid	**0.5-2.0**	**N/A**	**N/A**	
Troponin	**0 - 0.4**	**N/A**	**N/A**	
CK-MB	**N/A**	**N/A**	**N/A**	
Total CK	**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	**N/A**	**N/A**	**N/A**	
PT	**N/A**	**N/A**	**N/A**	
PTT	**N/A**	**N/A**	**N/A**	
D-Dimer	**N/A**	**N/A**	**N/A**	
BNP	**N/A**	**N/A**	**N/A**	
HDL	**N/A**	**N/A**	**N/A**	
LDL	**N/A**	**N/A**	**N/A**	

Cholesterol	**N/A**	**N/A**	**N/A**	
Triglycerides	**N/A**	**N/A**	**N/A**	
Hgb A1c	**N/A**	**N/A**	**N/A**	
TSH	**N/A**	**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	**N/A**	**N/A**	**N/A**	
pH	**N/A**	**N/A**	**N/A**	
Specific Gravity	**N/A**	**N/A**	**N/A**	
Glucose	**N/A**	**N/A**	**N/A**	
Protein	**N/A**	**N/A**	**N/A**	
Ketones	**N/A**	**N/A**	**N/A**	
WBC	**N/A**	**N/A**	**N/A**	
RBC	**N/A**	**N/A**	**N/A**	
Leukoesterase	**N/A**	**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 Range	Value on Admission	Today's Value	Explanation of Findings
pH	**N/A**	**N/A**	**N/A**	
PaO2	**N/A**	**N/A**	**N/A**	
PaCO2	**N/A**	**N/A**	**N/A**	
HCO3	**N/A**	**N/A**	**N/A**	
SaO2	**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	**N/A**	**N/A**	**N/A**	
Blood Culture	**N/A**	**N/A**	**N/A**	
Sputum Culture	**N/A**	**N/A**	**N/A**	
Stool Culture	**N/A**	**N/A**	**N/A**	

Lab Correlations Reference (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EKG , Chest X-ray , X-ray of the hip

Diagnostic Test Correlation (5 points):

This patient had a few several diagnostic exams done due to his past medical history. An electrocardiogram is done to detect irregularities in the patient's heart rhythm. For this patient with a history of coronary artery bypass, an EKG will rule out any dysrhythmias or heart complications. An X-ray was done for this patient to obtain a better image of the broken bone and to rule out any other medical conditions.

Diagnostic Test Reference (APA):

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

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

Home Medications (5 required)

Brand/Generic	Atorvastatin / Lipitor	Carvedilol / Coreg	Ferrous Sulfate	Furosemide / Lasix	
Dose	40 mg	3.125 mg	30 mg	40mg	
Frequency	once daily	once daily	once daily	once daily	
Route	Po	Po	Po	Po	
Classification	Antihyperlipidemic	Antihypertensive	Iron supplement	Diuretic	
Mechanism of Action	To control lipid levels	To manage hypertension	To prevent iron deficiency	To reduce edema	
Reason Client Taking	Pt. has history of hyperlipidemia	Pt. has history of hypertension	Pt. has history of anemia	Pt. has history of hypertension	
Contraindications (2)	Breastfeeding Hepatic Disease	Asthma Stevens-Johnson's syndrome	Hemolytic Anemia Hypersensitivity to iron	Anuria Hypersensitivity	
Side Effects/Adverse Reactions (2)	Acne Amblyopia	Depression Back pain	Fever Wheezing	Dizziness Blurred vision	
Nursing Considerations (2)	Expect to measure lipid levels 2 - 4 weeks after therapy Monitor pt. blood glucose levels	Monitor pt. blood glucose levels Avoid abruptly stopping the drug	Give iron tablet with a glass of water Give one hour before or 2 hours after meals.	Obtain weight Monitor blood pressure	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Lipid levels Hepatic enzymes	Lipid levels Blood	CBC Hepatic function	Potassium Hepatic enzymes	

		glucose levels			
Client Teaching needs (2)	Tell pt to take drug at the same time everyday. Advise pt with diabetes to monitor blood glucose levels carefully	Tell pt to take drug at the same time everyday. Advise pt with diabetes to monitor blood glucose levels carefully	Instruct patients not to chew any solid pills Urge patient to eat chicken, fish, lean meat	Tell pt to take at the same time every day Keep up follow up appointments with doctor	

Hospital Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol	Ascorbic acid	Morphine injection	Ondansetron/ Zofran	
Dose	650 mg	500mg	1 mg	4 mg	
Frequency	Once daily	Once daily	Once daily	Once daily	
Route	PO	PO	PO	injection	
Classification	Antipyretic	Vitamin Supplement	Analgesic	Antiemetic	
Mechanism of Action	To relieve mild to moderate pain	Used to prevent or treat low levels of vitamin C	To relieve severe pain	Prevent nausea and vomiting	
Reason Client Taking	Pain due to broken hip	Due to compromised immune system	Pt. has pain due to broken hip	Pt. has nausea due to extreme pain	
Contraindications	Hepatic	sickle cell	Alcoholism	Long QT	

(2)	impairment Liver Disease	disease, and hemochromatosis	Acute abdominal disorders	syndrome Hypersensitivity	
Side Effects/Adverse Reactions (2)	Fatigue Stridor	stomach cramps headache.	Increased CNS depression Anxiety	Agitation Abdominal pain	
Nursing Considerations (2)	Monitor at the end of parenteral infusion Monitor renal function in pt with long term therapy	Monitor for skin reactions Monitor renal function	Store morphine at room temperature Extreme caution in patients with COPD	Monitor patients EKG Monitor signs for hypersensitivity	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	AST , ALT , creatine	Monitor estrogen levels in women	AST , ALT	Potassium Levels AST, ALT	
Client Teaching needs (2)	May be crushed or chewed Caution Pt. not to exceed the recommended dose	Take on an empty stomach Take 30 mins prior to eating	Change positions slowly Take exactly the amount that is prescribed	Instruct patient to place disintegrating tablet on tongue immediately after opening Report signs of hypersensitivity	

Medications Reference (APA):

Jones & Bartlett Learning., & Jones & Bartlett Publishers. (2019). *Nurse's drug handbook*.

Sudbury, MA: Jones and Bartlett Publishers

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Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). Davis's Drug Guide for Nurses (15 ed.).

Philadelphia, PA: F.A. Davis Company.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is awake in bed , patient exhibits no signs of drowsiness. Patient does not seem annoyed or agitated. Patient speaks English fluently and at a normal pace. Patient has equal strength is equal bilaterally on upper extremities. There are no signs of neurological damage.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Braden Score : 15 Patient is Caucasian and has a light skin tone. Skin is normal and warm to touch, there are no signs of infection or drainage from anywhere on the skin. There are no lesions present and no signs of skin breakdown. Patient's hair is white. There are no rashes or bruises present. There is no notable skin turgor. Patient has slight redness and erythema present around left hip.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient shows no sign or hair loss. Head is midline and no signs of deviation. Patient has a midline trachea, there is no sign of deviation. There is no sign of drainage from her ears and tympanic membrane is pearly grey. There are no lesions on the patient's ears. PEERLA is noted and positive. Patient does not wear glasses. Patient's oral mucosa is pink and moist with no lesions and no notable abnormalities. Teeth are whiteish yellow.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐**	Clear S1 and S2 heard in patient and has a normal sinus rhythm. Patient is not monitored by a telemetry. Radial and pedal pulses are assessed. They are strong bilaterally, graded at 2+. Capillary refill is assessed and noted at less than 2 seconds on fingers and toes. Patient does not have neck vein distention. Patient does not have a central line put in.

Edema Y ☐ N ☐ **Location of Edema:**	
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Clear lung sounds heard bilaterally. Both anterior and posterior lungs are auscultated. No crackles or wheezing noted. Patient does not use accessory muscles during respirations. Patients trachea is midline with not deviations. Patient does show signs of shortness of breath. Patient does not use oxygen therapy
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:**	Pt. does not have tenderness with palpation in any quadrants. Patient does not have rebound tenderness is not present. Normoactive bowel sounds present upon auscultation. Patient is on a cardiac diet and last bowel movement was this morning. It was loose in consistency and coloring was dark green/black.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Pt. gets up to use the bathroom with the use of assistive devices. Bowel movements are frequent, loose, watery, and dark in color due to C.diff infection. Urine is normal in color and frequency. Pt. denies the presence of pain during urination.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:**	Fall Risk Score : 23 Pt. does not have full ROM throughout extremities due to injured hip. Hand grip and strength are equal and strong throughout. Pt. is unable to complete activities of daily living alone

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☐**	at home. Pt. is up ad lib and does not use assistive devices and does not need support to stand and walk. Pt. is considered a fall risk due to recent episode of falling and breaking left hip bone.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.Pt is A&O x4 and is oriented to person, place and time. Pt. follows commands and has purposeful and equal strength/motor response throughout all extremities. Speech is clear. Pupils are equal, round, and reactive and accommodate to light.
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):**	Pt is 86 year old Caucasian male. He is a high school graduate. Pt. does identify as a Christian He lives with his long-time partner and has no children. Pt. has support at home from his wife. She is able and willing to care for him. Pt. has siblings that live close by and a good support system. Pt. is a current everyday smoker and drinks alcohol occasionally. He states he gets upset when he is not in control. Patient is now compliant with plan of care.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1250	**89**	**116/68**	**18**	**100.3**	**98**
1540	**82**	**106/80**	**18**	**99.8**	**98**

Vital Sign Trends:

Patient does not have significant vital sign declines or accelerations. Heart rate is high due patient in pain due to hip fracture.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	numeric scale 7/10	Lower left hip	7/10	“band like and a lot of pressure.”	Pt. repositioned and denied pain medication
1100	numeric scale 9/10	Lower left hip	9/10	“band like pain and a lot of pressure.”	Pt. given 2mg IV morphine injection

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:**	IV is placed on right antecubital fossa vein. Site is free of redness and swelling. Appears dry and intact. Pt. has a hep lock and IV flushed successfully with 10 mL of D5W saline solution.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
350ml	**n/a**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient shows distress due to a broken left hip. Patient is due for a surgery the next day.

Procedures/testing done: X-ray

Complaints/Issues: Left hip pain

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Diet is cardiac but will be NPO due to surgery

Physician notifications: No specific physician notifications

Future plans for patient: Identify triggers and avoid them

Discharge Planning (2 points)

Discharge location: Patient's home in Danville

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: physical therapy

Education needs: Pain management and assistance with ADLs.

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. **Acute pain related to**	**This diagnosis is important**	**1. Encourage patient to discuss**	**Patient's family is cooperative. Both the**

movement of bone fragments as evidence by guarding	**because evaluating the patient's pain will help treatment plans for patient and allow compliance.**	**problems related to injury** **2. Apply cold or ice pack first 24-72 hr. and as necessary**	**client and the client's family want to reduce pain levels in the patient.**
2. **Impaired skin integrity related to physical immobilization as evidence by reports of pressure in the affected area**	**Skin integrity is important in all aspects of care for a patient. Preventing skin breakdown and omit infection and the formation of ulcers.**	**1. Examine skin for open wounds, foreign bodies, rashes, blanching** **2. Reposition the patient frequently**	**Patient's family is cooperative. Both the client and the client's family want to prevent skin breakdown and the formation of pressure ulcers.**
3. **Deficient knowledge related to lack of recall as evidence by frequent questions.**	**This nursing diagnosis is important because of the patient's age. Being an older patient, they may not always both hear or understand everything that is being said.**	**1. Discuss dietary needs** **2. Review pathology, prognosis, and future expectations**	**Patient's family is cooperative. Both the client and the client's family want to understand the complications and learn to better the patient with their fracture.**
4. **Impaired physical mobility related pain and discomfort as evidence by limited ROM**	**This nursing diagnosis is due to the fact that the patient should not be strained.**	**1. Assess the degree of immobility in the patient.** **2. Assist with self-care activities**	**Patient's family is cooperative. Both the client and the client's family want to help the patient to not strain all extremities.**
5. **Constipation related to immobility as evidence by straining with defecation**	**This diagnosis is important because the lack of movement will lead to a secondary problem like constipation.**	**1. Assess patient's bowel sounds** **2. Encourage patient's fluid intake.**	**Patient's family is cooperative. Both the client and the client's family want to help the patient to not strain while passing stools.**

Other References (APA):

Ricci, S., Carman, S. and Kyle, T. (2017). Maternity and pediatric nursing. 3rd ed. Philadelphia: Wolters Kluwer.

Sorenson, M., Quinn, L., Klein, D. (2019). Pathophysiology: concepts of human disease. Hoboken, NJ: Pearson, Education, Inc

Swearington, P. (2018). All-In-One Nursing Care Planning Resource. [S.I.]: MOSBY.

Concept Map (20 Points):

Subjective Data

Patient feels pain "band like and a lot of pressure."

Nursing Diagnosis/Outcomes

Acute pain related to movement of bone fragments as evidence by guarding
Impaired skin integrity related to physical immobilization as evidence by reports of pressure in the affected area
Impaired physical mobility related pain and discomfort as evidence by limited ROM

Objective Data

Patient states pain is a 7/10

Heart rate of 89
BP: 116/68
X-ray shows fracture of hip

Patient Information

Patient is a eighty six year old male with a past medical history of Afib on Xarelto, Congestive heart failure, coronary artery disease, elevated PSA, Hyperlipidemia, Hypertension, Anemia and Osteoarthritis of left knee. Patient is here due to falling down on and fracturing his hip

Nursing Interventions

Assess the degree of immobility in the patient.
Assist with self-care activities
Apply ice packs
Give medications as prescribed
Frequent vital signs (check for pain)