N321 Care Plan # 3

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
4/12/2020	JM	78-year-old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	NKA
Code Status	**Height**	**Weight**	
Full Code	165.1 cm	61.4 kg	

Medical History (5 Points)

Past Medical History: Normal childbirth x3, HTN, hypothyroidism, osteoarthritis

Past Surgical History: Hysterectomy-1985, gallbladder removal-1990

Family History: Maternal- heart disease, diabetes

Social History (tobacco/alcohol/drugs): The patient is a retired business associate. The patient is very active with her 3 children, 4 grandchildren and is in a walking group that she participates in every morning. She volunteers twice a week at the local hospital. The patient denies any alcohol, tobacco, or drug use. The patient lives at home by herself, and her daughter presents at bedside with her.

Assistive Devices: Patient states the only assistive device she uses are glasses.

Living Situation: Independently at home by herself.

Education Level: Associates degree.

Admission Assessment

Chief Complaint (2 points): "Right hip pain."

History of present Illness (10 points): Patient presented to the ED with a complaint of right hip pain. Patient states she was out on her usual morning walk today with her walking group when her food got caught on the side walk causing her to fall approximately 1.5 hours ago. Patient states she is very active and walks 3-5 miles every morning. Patient has had joint pain for the last

year, but that waking has helped her control her medical problems and maintain her weight. While the patient was walking today, she fell off the sidewalk and was unable to prevent the fall. She fell on her right hip and then could not get herself up, which caused her to call EMS for assistance. Pain is stated to be in right leg, but more prominent in her upper abdomen which was alleviated with 2 mg of Dilaudid IV push. Pain was rated 10/10 on the numeric scale and described as a sharp, shooting pain. Patient states aggravating factors is any movement. X-ray was done which demonstrated a right femur fracture. Surgery was consulted based off the x-ray results.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Right femur fracture

Secondary Diagnosis (if applicable): Hypertension

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

The hip is an example of the ball-and-socket join where the trabecular bone is made of a nonsolid bone. The trabecular bone is more at risk for osteoporosis degenerative changes. The patient from today does have a past medical history of osteoporosis. Older adults' hips experience an osteoporotic degeneration which also leads to the instability of the joint. The hip will not be able to bear the individual's weight which will cause a fall. For an individual with osteoporosis, a femur neck fractur is the most common, and that is the fracture our patient from today experienced. A hip fracture will include the fracture of the proximal femur, and will cause the blood flow to be disrupted. Anterior dislocations are connected with a superior femoral head fracture, while a posterior fracture is connected with the inferior femoral head. Hip fractures are divided into classes depending on the relation to the hip capsule, degree of displacement, and

location. A prognosis that is worse is implied when the displacement is considered a higher-grade displacement. An intracapsular fracture involves the head and neck, and extracapsular involve intertrochanteric, trochanteric, and subtrochanteric regions. Complicated healing is usually involved in an intracapsular fracture due to the thick capsule being separated from the adjacent capillaries and soft tissue. The separation causes callous formation being impaired. AVN and nonunion necrosis are usual complications within these fractures (Capriotti, 2016). The clinical presentation of a hip fracture would include a history of an extreme trauma, such as a fall, and osteoporosis. There may also be a history of a wrist or vertebral compression fracture that would have been caused by osteoporosis. The patient that experiences a hip fracture they are usually thin, Caucasian and elderly. If the patient is an older adult, they should be asked what their current medications are, and comorbid conditions such as diabetes, CVD, and hypertension. The patient should also be asked of their family history, specifically about osteoporosis. Range of motion will be extremely painful if there is a fracture. An x-ray of the pelvic bones and extremities will be done to diagnose a patient with a hip fracture. An MRI or CT scan could be done if the x-ray findings are equivocal. The contralateral hip should be viewed to compare the two sides (Capriotti, 2016). The patient from today does have a past medical history of osteoporosis and hypertension which were two risk factors. The patient is also an elderly Caucasian female which are also risk factors; the patient is thin, but not overly thin for her height. An x-ray was performed on this client to confirm the diagnosis of a right femur fracture; the x-ray showed the contralateral hip for comparison.

Treatment for an older adult that experiences a hip fracture would be bed rest, in the supine position, while the treatment plan is being looked over. The ED provider will have a surgical consult to see if the patient is a candidate. If surgery is performed, the patient will be asked to

ambulate as soon as possible—including physical therapy (Penn Medicine, 2016). The patient should be NPO and put on supplemental oxygen while awaiting surgery. Parenteral analgesia and broad-spectrum antibiotics will need to be administered. An anticoagulant therapy is needed for the patient's increased risk for a DVT. The patient will also need to be placed on a calcium and vitamin D supplement (Capriotti, 2016). The patient from today was made NPO and put on supplemental oxygen, and given broad-spectrum antibiotics and Dilaudid through IV while she waited for surgery. The patient has a CBC panel done to help diagnose a right femur fracture. The patient had abnormal laboratory values from CBC that included elevated WBC, and a decrease in both hct and hgb. The patient also had abnormal lab findings of glucose, creatinine, albumin and ALT. SCDs were put on the patient as a prevention for DVTs. The patient is on a calcium + vitamin D supplement at home, which she will likely continue. The patient remained immobile in the supine position while she was awaiting surgery. PT/OT has already been consulted for the patient once surgery is completed, including an order for home health that includes PT/OT. The patient has Dilaudid and Norco ordered for her pain after surgery, and antibiotics to decrease her risk of infection.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P., (2016). *Pathophysiology: Introductory Concepts and Clinical Perspective.* F.A. Davis Company

Penn Medicine. (2016, December 20). *What to Do When A Loved One Has a Geriatric Hip Fracture.* Retrieved April 17, 2020, from https://www.pennmedicine.org/updates/blogs/musculoskeletal-and-

rheumatology/2016/december/what-to-do-when-a-loved-one-has-a-geriatric-hip-fracture

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	3.90-4.98	N/A	4.35	
Hgb	12.0-15.5	N/A	10	The patient has a history of osteoporosis, where hgb level will be lowered due to bone mineral loss (Hinkle, 2018).
Hct	35-45	N/A	34.4	The recently had a significant trauma of falling and breaking her femur; this trauma will cause blood loss and therefore slightly lower her hct level (Hinkle, 2018).
Platelets	140-400	N/A	356	
WBC	4.0-9.0	N/A	15,000	The patient's recent trauma of a femur fracture caused her WBC to be elevated due to inflammation (Hinkle, 2018). The patient is also on antibiotics for surgical prophylaxis.
Neutrophils	40-70	N/A	N/A	
Lymphocytes	10-20	N/A	N/A	
`1Monocytes	5	N/A	N/A	
Eosinophils	0-6.3	N/A	N/A	
Bands	<1	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-	135-145	N/A	140	
K+	3.5-5.1	N/A	3.5	
Cl-	98-107	N/A	98	
CO2	22-29	N/A	N/A	
Glucose	70-99	N/A	118	The patient is under stress from the trauma has caused her, which could have led to the increase in glucose, but the patient also has impaired liver function as demonstrated by her ALT level. The two factors could have contributed to a slight increase in glucose (Hinkle, 2018). The patient has a history of hypothyroidism, which could cause a slight elevation in glucose Hinkle, 2018). The patient have had something to eat before she went on her walk, which could have also elevated her glucose level.
BUN	6-20	N/A	10	
Creatinine	0.6-1.2	N/A	1.2	
Albumin	3.5-5.0	N/A	3.0	Albumin is essential in fluid balance in the peripheral vascular system, and with the fracture the patient endured could have altered the levels. Hepatic function also causes the albumin to decrease, and the patient's ALT level demonstrates the liver dysfunction (Hinkle, 2018).
Calcium	8.4-10.5	N/A	7.0	The patient has a history of osteoporosis, which would cause a calcium deficit (Hinkle, 2018).
Mag	1.5-2	N/A	N/A	

Phosphate	0.8-1.5	N/A	N/A	
Bilirubin	0.0-1.2	N/A	1.1	
Alk Phos	35-105	N/A	N/A	
AST	0-35	N/A	14	
ALT	24-36	N/A	4	The patient experienced trauma to her upper abdomen when she fell, which could have caused her altered levels (Hinkle, 2018).
Amylase	60-160	N/A	N/A	
Lipase	20-180	N/A	N/A	
Lactic Acid	0.5-2	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	0.81-1.20	N/A	N/A	
PT	11.5-15.0	N/A	N/A	
PTT	23.5-37.5-1.20	N/A	N/A	
D-Dimer	<0.5	N/A	N/A	
BNP	<125	N/A	N/A	
HDL	>40	N/A	N/A	
LDL	<100	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	

Hgb A1c	0.0-5.7	N/A	N/A	
TSH	0.5-3.0	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 (light/pale-dark/deep amber) & clear/cloudy	N/A	Light yellow and clear	
pH	4.5-8	N/A	4.6	
Specific Gravity	1.005-1.025	N/A	1.005	
Glucose	<130	N/A	N/A	
Protein	<150	N/A	N/A	
Ketones	0	N/A	0	
WBC	≤2-5	N/A	N/A	
RBC	≤2	N/A	N/A	
Leukoesterase	Negative	N/A	Negative	

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	
Blood Culture	Negative	N/A	N/A	

Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Lakeview College of Nursing lab values sheet

Sarah Bush Lincoln Health Center citation

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-RAY

Diagnostic Test Correlation (5 points):

- X-ray of right femur
    - An x-ray will help show the bone texture, density, erosion, and changes in the relationships between bones. An x-ray with multiple views can make a complete assessment of the structure and show any irregularities (Hinkle, 2018). The patient came in after a fall where she could not get up due to pain. The patient landed on her right hip after falling, and due to the pain, she was experiencing it was decided to have an x-ray to see if there were any fractures in her right femur. Once the x-ray results came in, which also included her left femur, it was determined she had a right femur fracture. The x-ray was able to show exactly where the fracture was located, and what course of treatment would be best for the patient.

Diagnostic Test Reference (APA):

Hinkle, J.L., Cheever,K.H.(2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.) 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	Tenormin/ atenolol (Jones et. Al, 2019, pg 104-105)	Synthroid/ levothyroxine (Jones et. Al, 2019, pg 693-696)	Advil/ ibuprofen (Jones et. Al, 2019, pg 600-604)	Caltrate/ calcium + vitamin D (Jones et. Al, 2019, pg172-175)	Norco/ hydrocodone (RxList, 2017)
Dose	25 mg	0.25 mcg	200 mg	1,200 mg	1 tab (500 mg/5mg)
Frequency	Daily	Daily	Q 4-6 hours PRN	Daily	Q6H PRN
Route	PO	PO	PO	PO	PO
Classification	Beta Blocker	Thyroid hormone replacement	Analgesic, anti-inflammatory, antipyretic	Vitamin supplement	Opioid analgesic
Mechanism of Action	Decrease in cardiac excitability by	The endogenous thyroid hormone is replaced, and	Cyclooxygenase activity is blocked to	Intracellular and extracellular	Exact mechanism is still unknown.

	inhibiting the beta1-receptor stimulation at the site in the heart. Decrease in renin to lower blood pressure.	controls DNA transcription and synthesis of protein. Carries the same action as the endogenous thyroid hormone.	mediate the inflammatory response and local swelling, pain, and vasodilation. Inhibiting prostaglandins will relieve pain and reduce inflammatory symptoms. The antipyretic action is from the medications effect on the hypothalamus, increasing the peripheral blood flow which leads to vasodilation and promotes heat dissipation.	calcium levels increase for maintenance of homeostasis. Regulates the storage and release of neurotransmitters and hormones.	It's believed that it's action on the brain will alter how pain is perceived.
Reason Client Taking	Hypertension	Hypothyroidism	Osteoarthritis	Hypocalcemia	Pain
Contraindications (2)	Sinus bradycardia; cardiogenic shock	Acute MI; uncorrected adrenal insufficiency	Rhinitis; angioedema	Hypercalcemia; renal calculi	Hypersensitivity to either hydrocodone or acetaminophen
Side Effects/Adverse Reactions (2)	Arrhythmias, depression	Hyperthyroidism; angina	Dizziness; epistaxis	Paresthesia; hypotension	Lightheadedness; sedation
Nursing Considerations (2)	Monitor patients for heart failure; Stop medication and inform provider if patient is experiencing bradycardia	Should be used for weight loss or obesity; Patient should go under thyroid function tests while taking the medication	Should be avoided if patient has had a recent MI; know heart failure risks and it's increase with the use of this medication	Needs to be stored at room temperature; Serum calcium levels need to be monitored	Monitor for signs of respiratory distress; renal and liver function tests may need ordered

Hospital Medications (5 required)

Brand/ Generic	Dilaudid/ hydromorphone (Jones et. Al, 2019, pg 591-594)	Zofran/ ondansetron (Jones et. Al, 2019, pg 899-902)	Phenergan/ promethazine (Jones et. Al, 2019, pg 1024-1026)	Rocephin/ ceftriazone (Jones et. Al, 2019, pg 216-218)	Zithromax/ azithromycin (Jones et. Al, 2019, pg 119-121)
Dose	2 mg	4 mg	12.5 mg	2 g	500 mg
Frequency	Q 4-6H PRN	Q4H PRN	Q6H PRN	Q12H	Q24H
Route	IV	IV	IV	IV	IV
Classification	Opioid analgesic	Antiemetic	Antiemetic	Antibiotic	Antibiotic
Mechanism of Action	Binds with opioid receptors to alter the response to pain.	Serotonin receptors are blocked at the vagal nerve terminals to reduce nausea and vomiting by inhibiting serotonin secretion into the small intestine.	Antagonizes histamine effects to reduce allergy signs and symptoms. Motion sickness, vertigo, and nausea are prevented. Sedation promotion and anxiety relief by decreasing stimuli to the brain.	Interferes with the synthesis of the bacterial cell wall and killing the bacteria.	Blocks the peptide translocation and blocking RNA protein synthesis.
Reason Client Taking	Pain	Nausea/ Vomiting	Nausea/vomiting	Surgical prophylaxis	Infection prophylaxis
Contraindications (2)	GI obstruction; acute asthma	Concomitant use of apomorphine; congenital long QT syndrome	Angle closure glaucoma; bladder neck obstruction	Calcium-containing IV solutions; hypersensitivity	History of hepatic dysfunction associated with prior use of the medication; Hypersensitivity
Side Effects/Adverse Reactions (2)	Dizziness; diplopia	Anxiety; chest pain	CNS stimulation; tachycardia	Fever; elevated BUN	Aggressiveness; Hearing loss
Nursing Consideration	Use cautiously in elderly patients for increased risk of	Disintegrating tablet or soluble film	Hematologic status need monitored; used cautiously in	Obtain a C&S; protect from light	Should not used in patients that have bradyarrhythmia;

s (2)	adverse effects; Administer before pain is intense for better pain management	needs placed on patient's tongue immediately after opening the package; Monitor for signs and symptoms of hypersensitivity	elderly patient due to increased sensitivity		monitor the elderly patient for arrhythmias.

Medications Reference (APA):

Jones, et. Al. (2019). *Nurse's Drug Handbook 18th Edition.* Burlington, Massachusetts: Jones & Bartlett Learning.

RxList. (2017, March 15). *Norco.* Retrieved April 16, 2020, from https://www.rxlist.com/norco-5-325-drug.htm#description

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert** **Orientation: A&O x4** **Distress: In pain** **Overall appearance: Well nourished, put together and in a gown.**	Patient was alert and oriented x 4. She appeared in distress due to the pain she was experiencing. Her appearance was appropriate overall.
INTEGUMENTARY (2 points): **Skin color: Pink** **Character: Dry, intact, elastic** **Temperature: Warm** **Turgor:** **Rashes: N/A** **Bruises: Yes** **Wounds: N/A** **Braden Score: 23** **Drains present: Y☐ N ☒**	The patient's skin was pink, dry, warm, and intact with good elasticity. The patient did have some slight bruising to her right hip and up along her right torso on the side. She did not have any rashes, no open wounds, and did not have any drains. Braden score: 23

Type:	
HEENT (1 point): **Head/Neck: Normocephalic** **Ears: Intact** **Eyes: PERRLA** **Nose: Intact** **Teeth: Full dentures**	Patient's head is normocephalic, midline, and no deviations are present. No visible jugular vein distention was noted. The patient has blonde hair and symmetrical blue eyes. The tympanic membrane is visible and pearly grey with no abnormal drainage. PERRLA is noted. The patient uses glasses used regularly. Her nose does not show a deviated septum and turbinates are equal bilaterally. Her oral mucosa is moist and pink with no abnormalities noted. Patient has a full set of dentures.
CARDIOVASCULAR (2 points): **Heart sounds: S1, S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): NSR** **Peripheral Pulses: 2+ bilaterally in all four extremities** **Capillary refill: < 3 secs** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: 2+ in right lower extremity**	Patient is currently on telemetry, and normal sinus rhythm was noted when patient arrived. S1 and S2 heart sounds were noted when auscultated. Radial and pedal pulses were assessed bilaterally with 2+ grade. Capillary refill was noted less than 3 seconds. There was 2+ pitting edema noted to the patient's right lower extremity. There was no neck vein distention noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character Anterior and posterior, rhonchi**	Clear breath sounds were heard in all lobes bilaterally. She did not use her accessory muscles and did not require any oxygen. The patient's oxygen saturation level was 96% on room air.
GASTROINTESTINAL (2 points): **Diet at home: Regular, Patient states she eats "whatever she wants" but tries to stick to a healthy, balanced diet.** **Current Diet: Regular** **Height: 165.1 cm** **Weight: 61.4 kg** **Auscultation Bowel sounds: Active in all 4 quadrants** **Last BM: This morning—4/12/2020** **Palpation: Pain, Mass etc.: guarding to upper abdomen** **Inspection:** **Distention: N/A** **Incisions: N/A** **Scars: N/A** **Drains: N/A**	The patient is on a regular diet at home, and resume the regular diet, as tolerated, after surgery. The patient is currently NPO in the hospital. The patient's height is 165.1 cm and weighs 61.4 kg. There were active bowel sounds in all four quadrants. Her last BM was this morning, 4/12/2020. Upon inspection the abdomen appeared flat and moved with respirations. Upon palpation, patient stated there was pain noted in the upper abdomen. It was noted that the patient's spleen and liver were not palpable, and no drains were present. There were no ostomy, NG or PEG tubes noted.

Wounds: N/A **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color: Yellow** **Character: Clear** **Quantity of urine: 400 cc** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: No abnormalities noted** **Catheter: Y ☒ N ☐** **Type: Foley** **Size:16f**	The patient's urine was a clear yellow appearance. She urinated 400 cc, and denied pain with urination. The patient is not on dialysis. Upon inspection there were no abnormalities noted to the patient's genitals. The patient had a 16f Foley catheter with balloon intact. The patient is on complete bed rest
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: Active in bilateral upper extremities and in left hip** **Supportive devices: Will need a walker after surgery** **Strength: Equal** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib) ☐ No** **Needs assistance with equipment ☐ Yes** **Needs support to stand and walk☐ Yes**	Fall Risk: 15 The patient has active range of motion in upper extremities bilaterally, and in left extremity. Patient was unable to perform any ROM exercises with right lower extremity due to increased pain. The patient currently does not use any supportive devices, but after surgery she will require the use of a walker. She is currently on bed rest at the hospital and needs total assistance with ADLs. The patient is supported by two people and has decreased strength in her right hip. She is a fall risk with a Morse fall score of 15. The patient will need help with equipment after surgery, and also with standing and walking.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: A&O x4** **Mental Status: appropriate to client's baseline** **Speech: Clear** **Sensory: Present in upper and lower extremities** **LOC:**	Patient can move her upper extremities and left lower extremity on her own, but cannot move her right lower extremity due to pain. She is awake and oriented to self, place, time, and can state the reason for visit. She has equal strength in grips bilaterally in upper and lower extremities. Her mental status is appropriate to client's baseline and upon assessment has normal sensation in all four extremities. The patient's speech is clear. The patient speaks and comprehends English well. PERLA is noted.

PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): Relaxes with family or goes on a walk** **Developmental level: Appropriate** **Religion & what it means to pt.: Christian, very significant to patient** **Personal/Family Data (Think about home environment, family structure, and available family support): Lives alone**	The patient copes by relaxing and baking with her children and grandchildren. The patient enjoys spending time with her family. She also copes by going on a nice long walk to clear her head. The patient's developmental status is appropriate for her age. She is a Christian, and uses her religion to help guide her in all aspects of life. She lives at home by herself, but her family is very supportive and involved in her care. The patient's daughter is present at the bedside.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0938	86 bpm	160/90	22 bpm	97.8 F	96% RA
1145	88 bmp	150/88	22 bpm	98.8 F	92% 2L NC

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0938	0-10 Numeric scale	Upper abdomen	10/10	Sharp, shooting, stabbing	Dilaudid 2 mg IV push
1340	0-10 Numeric scale	Upper abdomen and right hip	7/10	Constant stabbing, sharp pain	Dilaudid 2 mg IV

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 G **Location of IV: Left hand** **Date on IV: 4/12/2020 at 0945** **Patency of IV: Patent, stable** **Signs of erythema, drainage, etc.: No redness, tenderness, drainage, or swelling noted** **IV dressing assessment: No phlebitis or infection, flushes easily**	LR 100 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Oral- 59 mL IV- 100 mL Total: 159 mL	Urine- 300 mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was brought up to the floor at 0930, and her vitals were taken at 0938. The patient's pain was rated at a 10/10 at 0938. She was given Dilaudid 2 mg IV to relieve her symptoms. The patient was on a regular diet when she came to the floor, but she has only been able to tolerate 4oz of ice chips during this shift. The patient will have surgery later tonight. We hung an LR running at 100mL/hr. The patient is on bed rest due to inability to move her right lower extremity, or put any pressure on it. The patient's pain was slightly controlled with Dilaudid, but required her dose Q4H.

Procedures/testing done: The patient had an X-Ray done of her right femur.

Complaints/Issues: The patient has complaints of severe, stabbing pain in her right hip and upper abdomen. The patients prescribed pain medication was given with little relief.

Vital signs (stable/unstable): The patient had elevated blood pressure readings that put her in stage 2 of hypertension, but is on an antihypertensive medication that will bring it down and maintain it. Her respirations were slightly elevated, but the patient did state she was anxious for what was currently going on. The provider was not too concerned about her elevated respirations. Her pulse rate, temperature and oxygen levels were within normal limits and stable. The patient did require to go on oxygen while she was on the floor and is currently on 2L via NC.

Tolerating diet, activity, etc.: The patient was able to tolerate ice chips, and had consumed 4 oz. The patient has not wanted to eat anything else during the shift. Patient is currently on bed rest, when care staff adjust her in bed, she is not able to tolerate it.

Physician notifications: There were no physician notifications during this shift.

Future plans for patient: Upon discharge, I anticipate the patient requiring PT/OT to help with her mobility after her surgery. The patient may need to go to a rehab facility to do a rehab-to-home, or if family can help her, she could go back home with home health. I anticipate the patient requiring PT/OT for an extended amount of time, until she is able to perform her ADLs completely on her own and it is safe for her to resume her normal daily activities.

Discharge Planning (2 points)

Discharge location: The patient will discharge to home with home health PT/OT with granddaughter.

Home health needs (if applicable): Patient will require assistance with ADLs and any chores as she will have limited mobility following surgery.

Equipment needs (if applicable): The patient will need a walker and a shower chair that has hand rails if she does not have one. She will need wound care supplies, such as gauze, cleaning spray, and tape in case she or her granddaughter need to change her surgical site dressing.

Follow up plan: The patient needs to follow up with her primary care provider. She will also need to attend physical and occupational therapy upon discharge. The patient will need to attend all appointment following discharge to ensure she does not contract an infection or other post-surgical complications.

Education needs: The patient needs education on how to deep breath and cough, and the importance of the two. She will also need education on the importance of following up with physical and occupational therapy. Medication education, such as compliance and adverse effects need to be given, especially the medications for pain and nausea. The use and importance of SCDs needs to be given to the patient. The patient's family, especially her granddaughter, need education on safety and any precautions at home. The proper use of a walk and how to get in and out of the shower chair will need to be demonstrated to the patient and her family.

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 R/ T right hip fracture, surgical repair, and rehab therapy AEB increased blood pressure, grimacing, and	The patient experienced a right hip fracture which requires surgical repair. The patient is unable to move her limb due to the pain and	1. Assist with coordinating the analgesics peak time of effectiveness when patient is ambulating or taking part in PT/OT.	The patient and family were able to verbalize understanding of when to request pain medication to relieve pain. The administration of analgesics before therapy helped control the patient's pain. The

rates pain 7-10/10	requests her PRN pain medications.	2. Administer NSAIDs and pain meds as prescribed, and assess the effectiveness of the patient's pain management and adverse effects.	patient and family were able to verbalize understand of what signs and symptoms would accompany adverse effects.
2. Decreased mobility R/T musculoskeletal pain AEB fractured right femur.	The patient is unable to move or put weight on her extremity due to the pain she experiences. The patient is currently on bed rest.	1. Educate on proper body alignment. 2. Teach the patient and family how to perform active and/or passive ROM exercises of adjacent joints Q8H as tolerated.	The patient demonstrated proper body alignment throughout her hospital stay. She was able to demonstrate proper use of her walker and verbalize understanding the importance of using it. The patient verbalized understanding of analgesics uses and adjunctive methods to reduce her pain.
3. At risk for constipation R/T immobility AEB opioid use.	The patient is on bed rest but is currently taking two opioid analgesics. The patient is also an older adult, therefore with these two factors she is at an increased risk for constipation.	1. Assess the patient's usual BM pattern and habits to make sure regular elimination continues. 2. Encourage diet items the patient likes that will help with normal bowel elimination.	The patient was able to verbalize understanding of strategies to help her keep a normal bowel pattern within 8 hours of immobilization device being applied. The patient was able to keep her normal bowel elimination pattern.

Other References (APA):

Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER.

Concept Map (20 Points):

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Subjective Data

Patient states she is experiencing a 10/10 and 7/10 pain. She also states she is very anxious about what is going on with her diagnosis. Patient states she is unable to move at all cause “the pain is too much.”

Objective Data

X-Ray showed a right femur fracture. Patient was experiencing stage 2 hypertension. Her UA was negative. Her labs had abnormal values of ALT, Hct, Hgb, and WBC.

Patient Information

The patient is 78-year-old retired female. She is a full code. The patient weighs 61.2 kg and 165.1cm tall. She lives alone, but has 3 grown children and 4 grandchildren she is close to. Patient is still very active, she participates in a walking club and volunteers at the local hospital.

Nursing Diagnosis/Outcomes

Acute pain R/T right hip fracture, surgical repair, and rehab therapy AEB increased blood pressure, grimacing, and rates pain 7-10/10
The patient and family were able to verbalize understanding of when to request pain medication to relieve pain. The administration of analgesics before therapy helped control the patient’s pain. The patient and family were able to verbalize understand of what signs and symptoms would accompany adverse effects.
Decreased mobility R/T musculoskeletal pain AEB fractured right femur.
The patient demonstrated proper body alignment throughout her hospital stay. She was able to demonstrate proper use of her walker and verbalize understanding the importance of using it. The patient verbalized understanding of analgesics uses and adjunctive methods to reduce her pain.
At risk for constipation R/T immobility AEB opioid use.
The patient was able to verbalize understanding of strategies to help her keep a normal bowel pattern within 8 hours of immobilization device being applied. The patient was able to keep her normal bowel elimination pattern.

Nursing Interventions

1. Assist with coordinating the analgesics peak time of effectiveness when patient is ambulating or taking part in PT/OT.

2. Administer NSAIDs and pain meds as prescribed, and assess the effectiveness of the patient’s pain management and adverse effects.

. Educate on proper body alignment.

. Teach the patient and family how to perform active and/or passive ROM xercises of adjacent joints Q8H as tolerated.

1. Assess the patient’s usual BM pattern and habits to make sure regular elimination continues.

2. Encourage diet items the patient likes that will help with normal bowel elimination.

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