NURSING PROCESS FLOW SHEET

Patient's initials J.R. Student Name Ashley D. Burden, SN, AUSON Faculty _____ Date(s) October 2, 2012

ASSESSMENT DATA		DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE	OBJECTIVE	NURSING DIAGNOSIS	GOALS	NURSING INTERVENTIONS RATIONALES	EVALUATION OF GOALS
-Patient verbalized: "No, I haven't. I am afraid I will hurt my other leg." -Patient verbalizes pain level at a score of 7 out of 10	-Patient's non-verbal behaviors indicate a reluctance to move or take part in any activity (including bathing/self-care) -Patient displays expression of concern with the movement of non-injured limbs -Patient specified exact area of pain by pointing to the location -Patient grimaces when shifting weight on his back -Patient remains quiet and does not ask questions during assessment as if he is overwhelmed or anxious	Impaired physical mobility related to activity intolerance, pain and discomfort, and anxiety as evidenced by reluctance to initiate movement of non-injured leg, grimacing when attempting to move all limbs, and positioning of body in a protective manner This is a high priority diagnosis and is linked to Maslow's physiological and safety needs; failure to implement goals for recovery of physical mobility can result in additional problems	**Patient-centered goal:** -Patient will recover with complete functionality of all fractured limbs and be able to ambulate with an operative gait at a moderate pace without pain or difficulty upon completion of therapy **Short-term Outcomes:** -Patient will report a reduced pain level of 3 out of 10 by the end of a 24-hour time period -Patient will maintain functional abilities of non-injured limbs and will cooperate with assistive personnel to perform necessary range of motion movements of fractured limbs over the course of hospitalization **Long-term Outcomes:** -Patient will have mobile functioning with or without the assistance of health care personnel and/or assistive devices that	-Assess the patient's pain level and assist with pain control therapies that the patient is likely to accept. *Rationale*: Acute pain should be reliably assessed both at rest (important for comfort) and during movement (important for function and decreased client risk of cardiopulmonary and thromboembolic events). Decreasing the patient's level of pain will facilitate physical mobility. (Breivik et al, 2008). -Use a gait-walking belt when ambulating the client. *Rationale*: gait belts help improve the caregiver's grasp, reducing the incidence of injuries (Nelson et al, 2003). - Increase independence in ADLs, encouraging self-efficacy and discouraging helplessness, as the client gets stronger. *Rationale*: providing unnecessary assistance with transfers and bathing activities may promote dependence and a loss of mobility (Resnick et al, 2007). -If the client is immobile, perform passive ROM exercises at least twice a day unless contraindicated; repeat each maneuver three times. *Rationale*: inactivity rapidly contributes to muscle shortening and changes in peri-articular and cartilaginous joint structure. The formation of contractures starts after 8 hours of immobility (Fletcher, 2005).	Goal achievement not assessed - patient no longer under my care.

	-Patient has redness, inflammation, tenderness, warmth, and pressure in the area of the left heel -Patient has cast on his right wrist and has a skeletal traction on right leg -Patient has pins inserted in right leg and the insertion site is clean and dry, with no drainage or redness -Pulse: 110 bpm -Resp. rate: 24 -Temp: 101.2 F -BP: 126/76 mmHg		facilitate walking/mobility and also encourage independence while performing activities of daily living -Patient will be properly educated on how to reduce the risk of injuries upon termination of hospitalization	-Consult with physical therapist for further evaluation, strength training, gait training, and development of a mobility plan. *Rationale*: prescribing a regimen of regular physical activity that includes both aerobic exercise and muscle-strengthening activities is beneficial to minimizing impaired mobility. (Yeom, Keller, & Fleury, 2009). -Teach the client to use assistive devices such as a cane, a walker, or crutches to increase mobility; inform the patient about risks that can occur after dismissal from the hospital. Teach family members and caregivers to work with clients actively during self-care activities utilizing a restorative care philosophy for eating, bathing, grooming, dressing, and transferring to restore the client to maximum function and independence. *Rationale*: the use of self-efficacy based interventions results in increased mobility/exercise and reduced risk for injury (Resnick et al, 2007).	

Concept Map: Step 1. Identify the Patient's Main Problems with supporting data if available (add more problems if needed). Use not sure for data you question as a possible problem.

Problem:

-Right femur fracture
-Skeletal traction
-Good sensation – pink toenail beds
-Right wrist fracture (cast)
-Good sensation – not swollen, fingers warm, pink nail beds

Problem:

-Anxiety
-First time to be hospitalized
-Elevated pulse: 110 bpm
-Elevated respiratory rate: 24
-Expression of concern with moving non-injured leg
-Quiet during interview (overwhelmed?)

Problem:

-Pain in stomach
-Indicated that LRQ of abdomen is in pain at a rate of 7/10
-Abdomen is tender to the touch
-Abdomen feels tight

NOT SURE?

Diabetes Mellitus
Smoking history
Cultural barrier

Reason for Seeking Health Care

Fractured femur and wrist (right)
Pain in sites of injuries

Problem:

-Early-stage pressure ulcer
Reddened tissue on the left heel
-Warm and tender to the touch
-Inflammation/pressure on the skin
-Area does nor blanch or turn white when pressure is applied (sign of excess pressure)

Problem:

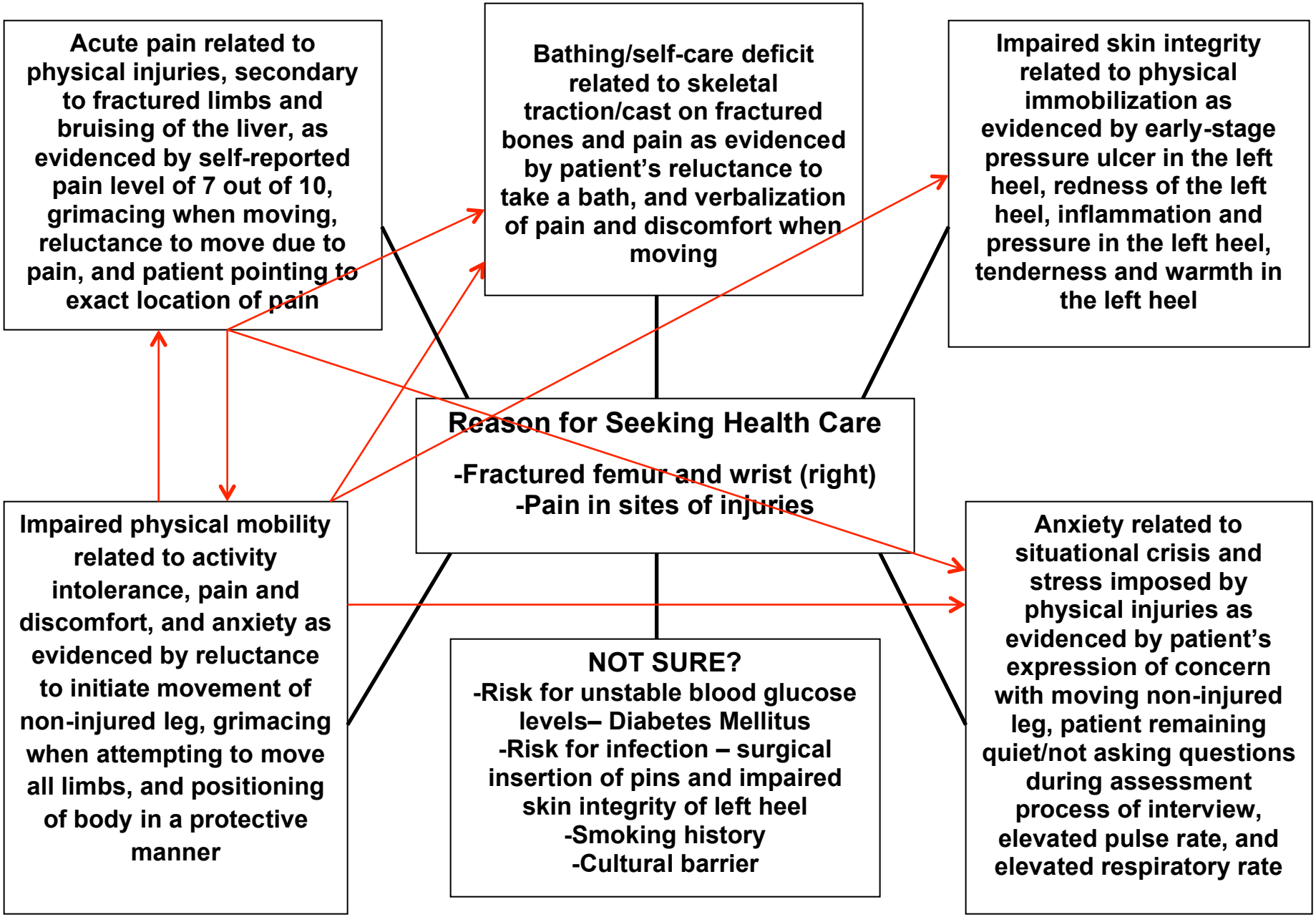
-Bruised liver
-Temperature: 101.2 F (infection?)
-Pulse: 110 bpm
-Blood pressure: 126/76 (hemorrhage?)
-Respirations: 24 breath/min

Problem:

-Impaired immobility
-Grimacing when shifting weight
-Reluctant to have bath
-No movement of left heel
-Risk for pressure ulcers
-Risk for infection
-Risk for impaired circulation

Adapted from C*oncept mapping a critical-thinking approach to care planning. 2nd edition* by P. M. Schuster, 2008, p. 62, Philadelphia, PA: F. A. Davis.

Concept Map: Step 2: Add a Nursing Diagnosis with Related To and As Manifested By or As Evidenced By for Each Problem.



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