

Week 7: Altered Mobility

Nursing Care of Mobility

Prepare: The Nursing Care of Mobility

Nursing Intervention – Recognizing Cues

The nurse is caring for a client who was recently injured the right leg while playing basketball. Which symptoms could be consistent with a bone injury? Select all that apply.

- Deformity of the injured extremity
- Ecchymosis around the area of injury
- Capillary refill less than 3 seconds
- Presence of a fever
- Inability to bear weight

Recognizing Cues – Altered Mobility

The nurse is caring for a client with a nerve impingement in the lower back area around L4 and L5. Which symptoms are consistent with nerve injury? Select all that apply.

- Paresthesia
- Erythema at the site of injury
- Deformity
- Acute pain
- Paralysis above the site of the injury

Nursing Intervention – Altered Mobility and Lifestyle

The nurse is preparing a discharge plan for a client being discharged after a left tibial fracture. In suggesting lifestyle changes which can decrease the healing time, which of the following does the nurse review with the client?

- Decrease dietary protein intake
- Avoid any type of exercise even if the fracture is protected
- Stop smoking
- Consider eliminating milk products from the diet

Self-Check: Analyze Cues – Altered Mobility

Review the information and picture to the right. Select the pertinent information below based on your assessment.

Nurses Progress Note

Patient ambulated to the exam room with some assistance. Pedal pulses palpated at +2. Capillary refill less than 3 seconds below the point of the injury. Patient smokes 1 pack daily. Exercises four times a week. Works from home. No family history of illnesses. Past medical history of appendicitis, vitamin D deficiency, and right ulnar fracture. Patient ambulated to the exam room with some assistance. Pedal pulses palpated at +2. Capillary refill less than 3 seconds below the point of the injury.

Gait	Lower Extremity Assessment	Social History	Family History	Past Medical History
<input type="checkbox"/> Normal <input checked="" type="checkbox"/> Partial weight-bearing <input type="checkbox"/> No weight-bearing	<input checked="" type="checkbox"/> No deformity <input type="checkbox"/> Mild deformity <input type="checkbox"/> Gross deformity <input checked="" type="checkbox"/> Ecchymosis <input checked="" type="checkbox"/> Erythema	<input checked="" type="checkbox"/> Smokes 1 pack per day <input checked="" type="checkbox"/> Exercises three times weekly <input type="checkbox"/> Works in an office	<input type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Hypertension <input type="checkbox"/> Lung cancer	<input type="checkbox"/> Asthma <input checked="" type="checkbox"/> Vitamin D deficiency <input type="checkbox"/> Hypertension <input type="checkbox"/> Left radial fracture

Self-Check: Nursing Assessment of Risk – Altered Mobility

The nurse is caring for a client with a femur fracture. Currently the client is on bedrest with the effected leg elevated. Which prescription from the health care provider requires urgent action to prevent complications?

Initiate fall precautions

Sequential compression device

Administer antibiotics as ordered

Physical therapy referral

Self-Check: Nursing Actions – Hematologic Alterations

Nursing Actions – Altered Mobility

Review the nursing actions below. Select the nursing diagnosis that best fits these actions.

Nursing Actions	Diagnosis
<ul style="list-style-type: none"> Cool or warm compresses Distraction (music, reading, etc.) Repositioning Aromatherapy Pain medicine Anti-inflammatory medicine 	<div style="border: 1px solid green; padding: 2px;">Pain</div>
<ul style="list-style-type: none"> Immobilize (splint, brace, cast) 	<div style="border: 1px solid green; padding: 2px;">Impaired tissue integr</div>
<ul style="list-style-type: none"> Therapeutic communication 	<div style="border: 1px solid green; padding: 2px;">Altered coping</div>
<ul style="list-style-type: none"> Assistance with ambulation Handrails up Call-light within reach 	<div style="border: 1px solid green; padding: 2px;">Risk for falls</div>
<ul style="list-style-type: none"> Assistive devices Assistance with movement Passive range of motion Physical therapy referral 	<div style="border: 1px solid green; padding: 2px;">Impaired mobility</div>
<ul style="list-style-type: none"> Support stockings Administer anticoagulant 	<div style="border: 1px solid green; padding: 2px;">Risk of thromboembo</div>
<ul style="list-style-type: none"> Referral to occupational health Assistance with ADLs 	<div style="border: 1px solid green; padding: 2px;">Self care deficit</div>

Self-Check: Outcome – Nursing Evaluation

The nurse is caring for a patient who was involved in a motor vehicle accident. The client is alert and requesting pain medication for a pain level of 8 on a 1 to 10 scale. The client does not have elevated blood pressure or pulse and does not appear to be in distress. Non-pharmacological treatment has not worked. The client is due to receive the pain medication at this time as needed. Which of the following is most appropriate?

Administer normal saline and tell the patient it is pain medicine

Give the pain medicine as ordered

Hold pain medicine

Notify the healthcare provider of your concerns

Self-Check: Analyze Cues – Altered Mobility

The nurse is teaching a class and looks for some examples of different things that can affect treatment of altered mobility. Review the examples below and identify the barrier to each situation from the drop-down choices.

Situation	Barrier
A young bull rider refuses to wear a helmet while competing in the rodeo.	Cultural and tradition
An elderly client will require six weeks in a skilled nursing facility for a hip injury.	Aging
After her son fractured his right arm, his mom insists that he rest all day.	Family dynamics
A homeless client is unable to see an orthopedic surgeon	Access to healthcare

Reflect: The Nursing Care of Mobility

Recognizing Cues – Nursing Assessment

Review the case below and select all assessment items that are risk factors or require priority follow-up.

Ernestine a 69-year-old patient was admitted after falling in her bathroom. She

came in by stretcher, unable to ambulate. Her vital signs: T=97.5,

BP 118/77, P 98, R 20, oxygen saturation 97% on room air. Skin is warm and

dry with normal turgor and capillary refill < 3. Lungs clear in all lobes. Heart is

regular, rate and rhythm with no murmur. No edema is present. Her left leg

is shortened and externally rotated. There is ecchymosis present at the left

lateral hip, but no erythema. No edema present.

Pedal pulses are bilaterally palpable at 2+. She is a non-smoker, retired.

Medical history includes hypertension, osteoporosis, dyslipidemia, and

hypothyroidism. Medications include vitamin C, calcium, ibuprofen,

omeprazole, levothyroxine, atorvastatin, and lisinopril.

Analyzing Cues – Nursing Assessment

In analyzing the client record, which assessment items are consistent with a fractured hip?

Deformity

Partial weight

bearing Pedal pulse

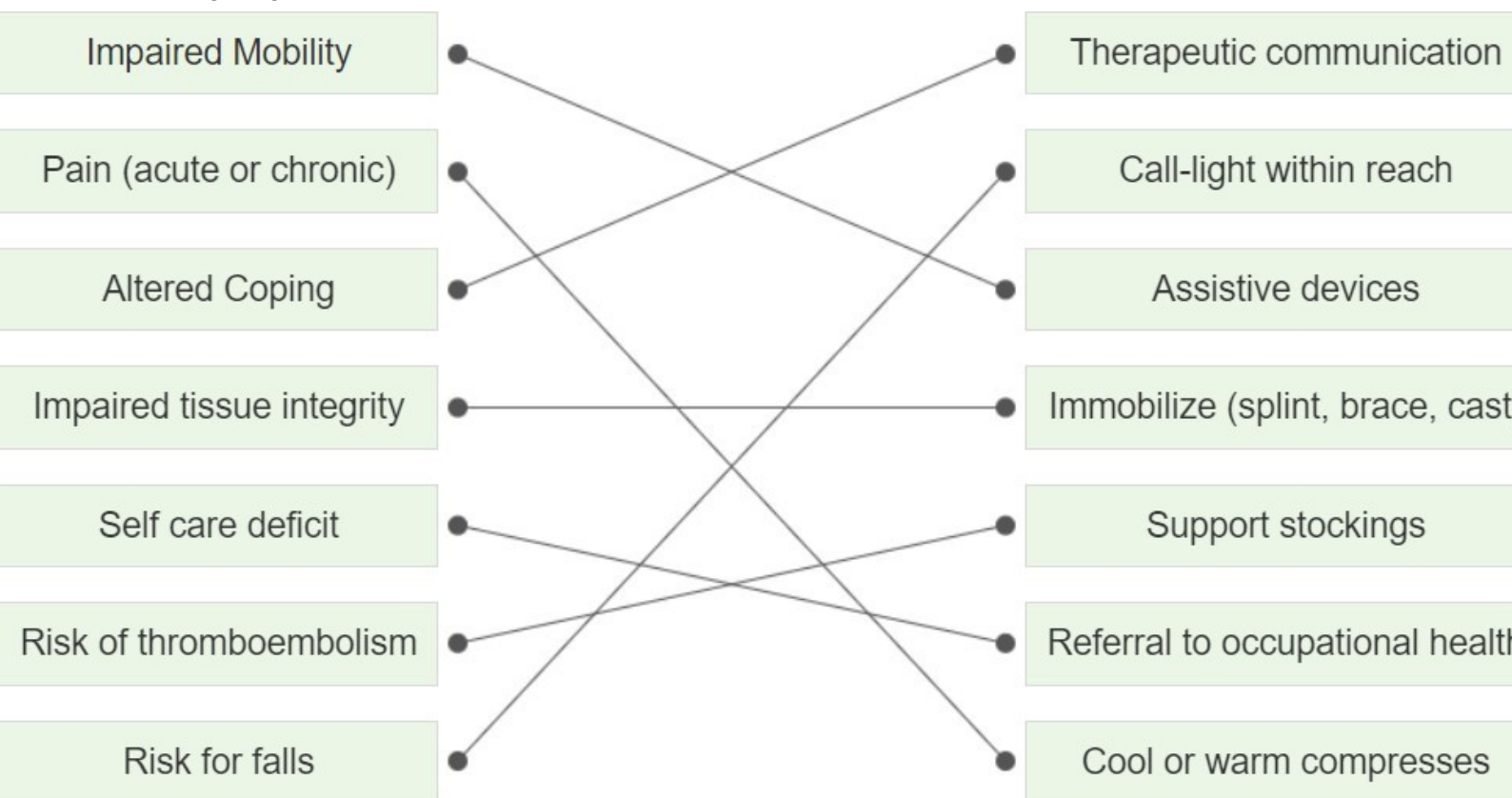
of 2+ Erythema

Ecchymosis

Nursing Diagnoses – Planning Interventions

Ernestine has a fractured hip. In developing the care plan, the nurse identifies some interventions that will help Ernestine.

Match the nursing diagnosis with the most appropriate intervention.



Planning Care – Fracture

Review the nurse's progress note below, and answer the following questions.

Time Nurse's Progress Note

14:00 Ernestine reports pain in her hip. Vitals: BP-152/88, P-102, R-24. Oxygen saturation 96%. She describes it as a soreness with intermittent throbbing. The nurse asks her to identify her pain as a 6 on a numeric pain scale. She received ketorolac 60mg IM at 10:00.

Question 1 / 2

Based on the information available, select the appropriate nursing actions from the prescriptions below. Select all that apply.

- Acetaminophen 500mg PO q4-6 hours for mild pain
- Ketorolac 60mg IM q6 hours for moderate pain
- Play some of her favorite music
- Morphine 4mg q2 hours for severe pain
- Ice pack to the right hip
- Reposition

Question 2 / 2

What is the expected outcome to measure with your interventions?

- Client will have a respiratory rate less than 24
- Client will verbalize that she has no pain
- Client will have a 20 point reduction in systolic blood pressure
- Client will verbalize a reduction of pain on the numeric pain scale
- Client will have decreased pulse rate
- Client will ambulate 100 feet with minimal pain

Recognizing and Analyzing Assessment Cues - Amputation