**Case Description – Nursing Assessment**

As a result of a car accident, 62-year-old Mrs. S. was admitted last night through the Emergency Department. X-rays confirmed a fractured left hip and a rib fracture on the left side. Vital signs were: BP 130/88, Temp 37.8°C, Pulse 126 (regular). Mrs. S. was alert, well-oriented, and answered all questions clearly. Surgery is scheduled for today. She is currently in the ward awaiting the procedure, which will take place this afternoon. During the anamnesis, she appears restless and agitated, looking around anxiously, crying, and frequently straying from the topic while speaking.

### ****Pattern 1: Health Perception and Maintenance****

**General well-being** – Mrs. S. states that she is never sick. Even with the flu, she keeps going.  
**Previous hospital admissions** – None.  
**Expected hospital stay (according to patient)** – "No idea."  
**Going home after hospitalization** – "I don’t know, can I go home? How will that work? When will I be able to climb stairs again?"  
**Patient’s expectations regarding treatment** – Hopes to fully recover.  
**Allergies** – None known.  
**Medication use** – None.

### ****Pattern 2: Nutrition and Metabolism****

**Eating habits** – Mrs. S. enjoys good food but finds it difficult to limit fat intake due to high cholesterol. She enjoys cooking for friends and family, often accompanied by a glass of wine.  
**Weight** – 85 kg.  
**Height** – 1.68 m.

### ****Pattern 3: Elimination****

**Bowel habits** – Has difficulty with bowel movements. Eats prunes and fiber-rich foods to ease this. Normally goes three times a week; last bowel movement was two days ago.

### ****Pattern 4: Activity****

**Respiration** – Breathing difficulties due to rib fracture; struggles to breathe deeply.  
**Living situation** – Single-family home with bedroom upstairs, but ground-floor access to the house.  
**Mobility** – Normally independent but currently unable to stand or walk.  
**Personal care** – Normally independent.  
**Care agreements during hospitalization** – Nursing staff will assist with personal care until post-surgery, with gradual rebuilding of independence during rehabilitation.  
**Fatigue** – "No more than anyone my age."

### ****Pattern 5: Sleep and Rest****

**Sleep pattern** – Mrs. S. has an inconsistent sleep pattern, has never been a good sleeper, and has been waking up frequently at night recently.

### ****Pattern 6: Perception and Cognition****

**Vision** – Wears reading glasses.  
**Hearing** – Normal.  
**Pain** – Stabbing, aching pain in the left thorax (with breathing) and left hip.

### ****Pattern 7: Self-Perception****

**Patient’s self-description** – Mrs. S. is crying. She says she spent much of the past year at her husband’s hospital bedside. He passed away from cancer two months ago. Being in the same hospital again is upsetting for her, as she was just starting to rebuild her life.  
**Impact of illness on psychological functioning** – Cannot answer.  
**Change in abilities** – "I feel like I can’t do anything right now. Will I get better?"  
**Changed body functions** – "I can’t do anything at all anymore. I even need help to go to the bathroom."  
**Psychological well-being** – "I was just starting to feel better, looking forward to things, and crying less. This has completely overwhelmed me, and I feel scared."

### ****Pattern 8: Roles and Relationships****

**Living situation** – Independent.  
**Family situation** – Mrs. S. has three daughters. The youngest and middle daughter live in the same village and have one and two children, respectively. The eldest lives further away and is expecting her second child. Mrs. S. was on her way to stay with this daughter for a week to help in the final days of her pregnancy. "What will happen now? She was counting on me."  
**Home and social care** – Normally manages everything herself.  
**Social life** – Former elderly caregiver. Worked until age 60 but stopped when her husband became ill. Always took care of others, including her parents and in-laws, and now supports her children with their young families.

### ****Pattern 9: Sexuality and Reproduction****

**Impact of illness/treatment on sexual function** – Not discussed.

### ****Pattern 10: Stress and Coping****

**Major life changes in the past two years** – The death of her husband.  
**Most trusted confidant** – "That was my husband. We talked about everything, and I still talk to him in my thoughts. I can talk to my children, but I don’t want to burden them—they have their own lives and young children to care for."  
**Level of stress** – "What’s happening now scares me. Suddenly, I’m in a hospital bed and can’t do anything."  
**Best coping mechanisms** – Reading and spending time with grandchildren.  
**Need for professional support** – "No, I always solve everything myself."

### ****Pattern 11: Values and Beliefs****

**Beliefs** – Christian, not actively practicing in recent years, only attended church last Christmas.

### ****Pre-Surgery Situation****

When moving in bed, Mrs. S. winces in pain, and tears well up in her eyes. When asked to rate her pain on a 0-10 scale, she struggles but points to an 8 on the facial pain scale. She states she has never experienced such pain before. Her face looks flushed, sweat is visible on her forehead. Temp: 37.5°C, Pulse: 124, Respiration: 26/min. She remains as still as possible and avoids deep breathing due to rib pain. Occasionally coughs, but holding a pillow against her chest provides little relief. The rib fracture is extremely painful but being managed conservatively, as it is not a complicated break.

### ****Post-Surgery Situation****

Mrs. S. received a total hip replacement due to a fracture just below the femoral head. She spent two hours in the recovery room. Pain relief is provided via an epidural catheter with a Marcaine/Sufenta mix, running at 2 ml/hour. When asked, she reports no pain. A wound drain is in place, producing minimal fluid. The wound is covered with an island dressing, which is not soaked through. Her left leg is slightly abducted and supported with a pillow and a sandbag. She has a urinary catheter, producing clear urine in good quantity. She receives IV fluids (Glucose 2.5%/NaCl 0.45%) through a peripheral cannula in her right hand. She called her daughter after returning to the ward and cried during the conversation. She dozes off frequently but wakes up at any noise in the room, looking around anxiously. She verbally responds to conversations in the room, even when not addressed. She repeatedly says she needs to urinate, despite understanding the presence of the catheter each time it is explained. A bladder scan confirms no retention.

### ****Situation After Two Days****

Mrs. S. no longer has an IV, and the epidural pain relief has been stopped. She now receives oral pain medication. The catheter has been removed. Physical therapy is involved, and she is mobilizing according to schedule, but finds it painful. She is anxious about mobilization, stands unsteadily, and moves stiffly. She struggles to take initiative in her rehabilitation. She is worried about being discharged, as she will need to stay in a nursing or rehabilitation facility for further recovery. She is assisted with personal hygiene, washes her upper body in bed but needs encouragement. Her daughters provide significant emotional support, calling daily and visiting in turns. One daughter told a nurse, "I don’t recognize her—she’s so weak and unmotivated. That’s not our mother. She was always the one pushing us forward, even when our father was sick. It’s like she’s given up. I’m worried about her, but when I ask, she just says, 'Oh sweetheart, don’t worry, I’ll be fine. Focus on your own family.'

As a nursing student using the **NANDA-I nursing diagnosis taxonomy**, I recognize several potential nursing diagnoses based on Mrs. S.'s assessment. These diagnoses can be categorized into **physiological**, **psychosocial**, and **safety-related** concerns.

### We will use this to have nursing students recognize nursing diagnoses (according to the NANDA-I terminology) which nursing diagnoses do you recognize acting as nursing student

### ****1. Physiological Nursing Diagnoses****

#### **Acute Pain (NANDA 00132)**

**Related to:**

* Surgical intervention (total hip replacement)
* Rib fracture
* Tissue trauma from accident

**Evidenced by:**

* Verbalization of severe pain (8/10 on the facial pain scale)
* Facial grimacing and crying
* Avoidance of movement and shallow breathing
* Increased pulse (124 bpm) and respiration rate (26/min)

#### **Impaired Physical Mobility (NANDA 00085)**

**Related to:**

* Hip fracture and surgery
* Rib fracture (pain limiting movement)
* Postoperative restrictions

**Evidenced by:**

* Inability to stand or walk
* Wobbly, stiff, and hesitant movements during mobilization
* Need for assistance with basic movements

#### **Ineffective Breathing Pattern (NANDA 00032)**

**Related to:**

* Rib fracture causing pain with deep breathing
* Shallow breathing and avoidance of deep inspiration
* Occasional coughing with minimal relief from pillow support

**Evidenced by:**

* Verbalization of difficulty breathing
* Shallow breathing pattern
* Increased respiratory rate (26 breaths/min)

#### **Risk for Constipation (NANDA 00011)**

**Related to:**

* Reduced mobility
* History of difficulty with defecation (only three times per week)
* Possible opioid pain medication use postoperatively

### ****2. Psychosocial Nursing Diagnoses****

#### **Grieving (NANDA 00136)**

**Related to:**

* Recent loss of her husband (two months ago)
* Emotional distress from being in the same hospital where he was treated

**Evidenced by:**

* Crying frequently
* Expressing feelings of being overwhelmed
* Verbalizing difficulty coping ("I was just starting to feel better, and now this has completely overwhelmed me.")

#### **Risk for Powerlessness (NANDA 00152)**

**Related to:**

* Loss of independence due to hospitalization and injury
* Uncertainty about recovery ("Will I get better?")

**Evidenced by:**

* Verbalization of loss of control over her situation
* Need for motivation to perform basic self-care tasks

#### **Disturbed Sleep Pattern (NANDA 00198)**

**Related to:**

* Anxiety and stress
* Hospital environment and pain
* History of poor sleep

**Evidenced by:**

* Difficulty sleeping
* Easily awakened by noises in the room

#### **Ineffective Coping (NANDA 00069)**

**Related to:**

* Sudden hospitalization and change in routine
* Inability to assist her pregnant daughter as planned
* Perceived lack of control over her situation

**Evidenced by:**

* Repeated distress over canceled plans
* Avoidance of discussing personal emotional struggles
* Statements such as "I solve everything myself" despite appearing overwhelmed

### ****3. Safety-Related Nursing Diagnoses****

#### **Risk for Falls (NANDA 00155)**

**Related to:**

* Postoperative hip replacement
* Wobbly and hesitant movements
* Anxiety about mobilization

#### **Risk for Confusion (NANDA 00128)**

**Related to:**

* Postoperative effects (anesthesia, pain medication)
* Repetitive questions about the urinary catheter
* Unusual behavior (responding to general conversations in the room as if directed at her)

#### **Risk for Disuse Syndrome (NANDA 00040)**

**Related to:**

* Fear of mobilization and rehabilitation
* Limited movement due to pain

**Evidenced by:**

* Hesitancy and stiffness during physiotherapy
* Reduced initiative in rehabilitation exercises

### ****Conclusion****

Mrs. S.’s case presents multiple nursing diagnoses, emphasizing the need for **pain management, emotional support, mobilization encouragement, and psychological well-being interventions**. **Which of these diagnoses would you prioritize first as a nursing student, and why?** 😊