**Ackley: Nursing Diagnosis Handbook, 10th Edition**

Clinical Reasoning and Critical Thinking: Use of the Nursing Process

**Case Study - Mrs. Bohne (Fractured Hip)**

**Case Scenario**

“Help, someone help.” Mrs. Bohne’s voice was weaker now. She had been calling for almost an hour, hoping her neighbor would hear, but she was still by herself, lying on the kitchen floor where she had fallen. She rested her head down and began to pray for someone to find her.

**Nursing Assessment Including the Client Story**

Mrs. Bohne is an 85-year-old woman who was a schoolteacher for 40 years of her life. She is now widowed and lives at home with her son. She uses a walker to ambulate, but her mobility is limited. Mrs. Bohne spends most days in a recliner watching television. Her son provides three meals for her and snacks as requested, but her intake has been decreasing. Her son has been providing “soft” foods because of her complaints about her dentures hurting and slipping. When he would question her about her intake, she always responded “I’m just not that hungry” and promised to eat more later.

Her son stated that he returned home after work to find his mother on the floor complaining of right-side pain. When the paramedics lifted her off the floor, a red spot on her right hip was evident. In the emergency department, Mrs. Bohne was diagnosed with a broken hip and dehydration. Her laboratory results were mostly unremarkable with the exception of her serum albumin at 3.2 g/dl. Mrs. Bohne is in pain but takes pain medication sparingly. She is often unwilling to change position in bed. Her son was surprised and embarrassed to learn that his mother’s weight had decreased from approximately 140 pounds a year ago to 124 pounds, which was determined from bed scales in the emergency department. Mrs. Bohne stated her height to be 5’5”. Her son said he knew she had lost weight but did not realize how much.

1. **ASSESS**
2. Identify the significant symptoms by underlining them in the above nursing assessment.
3. List the symptoms (those you have underlined) that indicate the client has a health problem.
4. Group the symptoms that are similar.
5. **DIAGNOSE**
	1. Select possible nursing diagnoses for this client.

Review the list of nursing diagnoses in the handout or in Ackley and Ladwig: *Nursing Diagnosis Handbook: A Guide to Planning Care.* Look up the diagnosis of hip fracture in Section II of the book or in the handout in the reference section. In addition, look up the symptoms of immobility, malnutrition, and weight loss.

(The information can be copied and pasted from the EVOLVE site into the area below.)

**Possible nursing diagnoses:**

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1. Validate the possible nursing diagnoses.

Compare the signs and symptoms (i.e., defining characteristics) that you have identified from your client assessment with the defining characteristics for the nursing diagnosis that you have selected. In addition, read the diagnosis definition and determine whether this diagnosis fits this client.

**Validated nursing diagnoses include:**

(The information can be copied and pasted from the EVOLVE site into the area below.)

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1. Write a nursing diagnostic statement for one of the nursing diagnoses by combining the nursing diagnosis label with the “related to” (r/t) factors.
	1. The label is the title of the nursing diagnosis as defined by the North American Nursing Diagnoses Association (NANDA).
	2. An r/t statement describes the factors that may be contributing to or causing the problem that resulted in the nursing diagnosis.

(The information can be copied and pasted from the EVOLVE site into the areas below.)

**NANDA label:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Related to (r/t) factors:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The complete nursing diagnostic statement is:**

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1. **PLAN**
	1. Write an outcome to help Mrs. Bohne resolve the symptoms (i.e., defining characteristics). Refer to Section III of the handouts for the above diagnosis.

**Outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. Select appropriate interventions from the Section III care plan on the above nursing diagnosis that you think will be appropriate for Mrs. Bohne and that will enable the nurse to accomplish the chosen outcome.

**Nursing interventions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. **IMPLEMENT**

The next step in the nursing process is to provide the nursing care using the nursing interventions.

* 1. **EVALUATE**

After the nursing interventions are implemented, the results of the care should be evaluated by determining whether the outcome was met. If the outcome was met, then the care plan is resolved. If the outcome has not been met, then further assessment should be made to answer the following questions:

* Was the correct nursing diagnosis chosen?
* Was the outcome appropriate?
* Were the interventions appropriate in this situation?
* What other interventions might have been helpful?

Changes in the nursing diagnosis, goals, and interventions should be made as needed. The continued use of critical thinking will ensure appropriate nursing care is given.

Click here to access the Ackley and Ladwig care plan constructor for assistance in formulating your care plan: [EVOLVE](http://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH10e/careplanconstructor/)