Relearning: Clinical Judgment Plan of Care Template

Student Name: Client Initials: V.J. Age/DOB: 91 years old Allergies: NKDA BSA/BMI: 20.6 Code Status: DNR/DNI	Date of Admission: 12/7 Date of Care: 12/7 Admitting Diagnosis: Complex distal femur fracture with hip fracture after a fall at home, requiring surgical hip replacement. Comorbidities: Advanced age, dehydration, anemia, history of hemorrhagic shock, and blood transfusion reaction. Also, high fall risk and weakness related to deconditioning after lying on the floor for many hours. Planned Treatments/Procedures: Post-operative care after hip replacement, pain management, anticoagulation for DVT prevention, IV fluids and treatment for anemia as needed, and continued physical and occupational therapy. Plan for transfer to an inpatient rehab facility for strength building and safe mobility before discharge home.

Nursing and HCP Collaborative Plan for Care: Include a description of priority client specific information, nursing actions, and provider orders	
Cultural/Spiritual: Ask about cultural or spiritual needs and include family in decisions if she wants. Respect her wish to return home but explain safety concerns. Neurological/Cognition/Coping/Adaptation/Function: She is oriented ×3 but very weak and dependent on others. Monitor for confusion or delirium because of age, surgery, and hospitalization. Nutrition/Elimination: She had dehydration and anemia, so monitor intake, labs, and bowel/bladder function. Encourage fluids, protein, and iron-rich foods for healing. Fluid/Electrolytes/Acid-Base: Monitor labs and hydration status since she was dehydrated and had blood loss. Gas Exchange/Perfusion: Lungs clear and heart sounds normal but still monitor because older adults are at risk for complications after surgery and immobility. Glucose Regulation: Check glucose if it is diabetic or stressed from illness/surgery.	Health Promotion/Development: Focus on fall prevention, strength building, and safe discharge planning. Encourage rehab participation. Infection/Immunity/Inflammation: Monitor surgical hip site, temperature, WBC, and signs of infection. Mobility: Very weak (2/5 strength) and unable to transfer alone. Needs PT/OT and assistive devices. Pain/Comfort/Tissue Integrity: Assess hip pain, give meds as ordered, and prevent skin breakdown from immobility. Safety: High fall risk and cannot live alone safely right now. Needs 24-hour supervision. Other: Discharge planning to rehab facility until strong enough to return home.

START of Shift (CJSim™) Priorities (Complete after receiving REPORT AND reviewing the EHR connected to phase 1/Question 1 section)			
Recognize & Analyze Cues	**Prioritize Hypotheses**	**Generate Solutions & Take Actions**	**Evaluate Outcomes**
Priority Assessments/Cues	**Priority Hypotheses for Nursing Care**	**Priority Interventions/Actions**	**Priority Teaching/Discharge Needs**

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START of Shift (CJSim™) Priorities (Complete after receiving REPORT AND reviewing the EHR connected to phase 1/Question 1 section)			
1. Severe weakness and inability to transfer. 2. Recent hip surgery with anemia/dehydration history. 3. High fall risk and living alone.	1. Impaired mobility related to fracture and surgery. 2. Risk for falls and injury. 3. Risk for complications from immobility (DVT, pneumonia, skin breakdown).	1. Assist with transfers and mobility; follow hip precautions 2. Turn/reposition and encourage PT/OT. 3. Monitor labs, hydration, and pain.	1. Need for rehab facility before going home. 2. Fall prevention and use of assistive devices. 3. Importance of nutrition, fluids, and therapy.
Priority Laboratory Tests/ Diagnostic Cues	**Priority Actual & Potential Complications/Cues**	**Priority Medications**	**Priority Collaborative Actions**
1. Hemoglobin/hematocrit for anemia. 2. Electrolytes and hydration labs. 3. Post-op imaging or assessment of hip.	1. Falls or reinjury. 2. DVT or pneumonia from immobility. 3. Infection at surgical site.	1. Pain meds. 2. Anticoagulant for DVT prevention. 3. Iron or fluids for anemia/dehydration	1. PT/OT rehab planning. 2. Case management for discharge placement. 3. Provider follow-up after surgery.

Vital Signs & Pertinent Lab Trends	
START of the Shift (CJSim™) Analysis (phase 1/Question 1 section)	**END** of the Shift (CJSim™) Analysis (phase 3/Question 3 section)
12/7 0905 Temp: 98.2*F, HR 89, RR 16, BP 124/82, Spo2: 98% RA.	**Equipment and Resource Needs for Home Safety:** • Has personal rollator, needs wheelchair, shower chair, and elevated toilet seat at home • Visiting nurse once weekly x 4 weeks. Will need to conduct safety assessment of home in early visit • Physical therapy for twice weekly x 4 weeks • Occupational therapy for once weekly x 4 weeks • Will establish need for home health aide/personal hygiene aide at rehabilitation setting

(CJSim™) MID-SHIFT Purposeful Clinical Judgment (Complete after reviewing EHR/Question 2 section)