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Long Term Care Rotation

H&P #3

Chief Complaint:

“Left hip pain status post open reduction with internal rotation.”

History of Present Illness:

Mrs. L.E is a 98-year-old female with a past medical history significant for hypertension, hyperlipidemia, osteoporosis, atrial fibrillation, heart failure with preserved ejection fraction (65%), breast cancer status post lumpectomy in 2006, gastroesophageal reflux disease, type 2 diabetes mellitus, and peptic ulcer disease. The patient was admitted to the skilled nursing facility for continued rehabilitation following a mechanical fall resulting in a left hip fracture. Patient is now status post open reduction and internal fixation (ORIF) of the left hip. Patient reports mild postoperative pain localized to the left hip region, rated 3/10 in severity, and described as a dull aching sensation. Pain is controlled with the current pain regimen. Patient denies fever, chills, nausea, vomiting, chest pain, shortness of breath, or worsening swelling. On examination, the patient has a well-healing surgical wound approximately 10 cm in length along the left lateral thigh with staples in place. The wound appears properly healed with no blood, purulent drainage, erythema, warmth, or signs of infection. Patient is awake, alert, and verbally responsive. Vital signs are stable.

Past Medical History:

- Hypertension
- Hyperlipidemia
- Osteoporosis
- Atrial fibrillation
- Heart failure with preserved ejection fraction (65%)
- Breast cancer status post lumpectomy (2006)
- GERD\
- Type 2 diabetes mellitus
- Peptic ulcer disease

Past Surgical History:

- Left hip ORIF surgery following fracture (02/22/2026)
- Breast lumpectomy (2006)

Medications:

- Eliquis (Apixaban) 2.5 mg PO BID
- Atorvastatin 40 mg PO daily
- Amlodipine 5 mg PO daily
- Lisinopril 10 mg PO daily
- Omeprazole 20 mg PO daily
- Alendronate 70 mg PO once weekly
- Oxycodone 5 mg PO every 6 hours PRN pain
- Acetaminophen 650 mg PO every 6 hours PRN pain
- Lidocaine Patch 5% — apply 1 patch daily (12 hours on, 12 hours off)

Allergies: No known allergies.

Immunizations: Up to date with immunizations.

Family History:

Mother - deceased at an unknown age and cause
Father - deceased at an unknown age and cause
Maternal and paternal grandparents - deceased at unknown age and cause
No siblings or children

Geriatric assessment

Cognitive status: fully intact cognition. Alert to person, place, time AOX3

Ambulation: requires an assistive device

Transferring position: requires one person for physical assistance to the position.

Feeding ability: Requires meals to be prepped and set up

Catheter: none

Social History:

Patient is a long-term care resident at the facility. She is retired. She denies tobacco, alcohol, or illicit drug use. She does not consume caffeine. She reports eating regular facility-provided meals and reports good appetite. She sleeps approximately 7–8 hours per night. Patient requires assistance with ambulation using assistive devices and is currently participating in physical and occupational therapy for strength, balance, and functional mobility. She denies recent travel and is not currently sexually active

Review of Systems:

General: Denies fever, chills, weight loss, fatigue, or night sweats. Reports fair appetite and occasional difficulty falling asleep**.**

Skin: No rashes, itching. Surgical wound approximately 10 cm in length with sutures appears well defined with no blood or purulent discharge to the wound.

Cardiovascular: No chest pain, palpitations, or shortness of breath.

Respiratory: denies any cough, shortness of breath, Dyspnea, orthopnea,

Gastrointestinal: denies constipation, nausea, vomiting, or diarrhea.

Musculoskeletal: Reports unsteady gait and difficulty ambulating without a walker, requiring one person's assistance when ambulating or transferring from bed to chair. Complains of a dull aching pain to the left lower extremity rated as a 3/10.

Neurological: patient is awake, alert, verbally responsive, and oriented to person, place, and time AoX3**.** Denies dizziness, weakness, numbness, tremors, or loss of consciousness.

Endocrine: Denies polydipsia, polyuria, polyphagia, or temperature intolerance.

Hematologic: Denies easy bruising, bleeding, or lymphadenopathy.

Psychiatric: denies anxiety, depression, mood swings, hallucinations, or suicidal ideation.

General: 98-year-old female, well-groomed, awake, alert, and oriented, sitting comfortably in bed in no acute distress. Patient was found in a supine position in bed in a long-term care facility, awake, alert, and oriented, and was verbally responsive with no acute distress.

Vitals:
BP: 123/62

Temperature: 98.2 F
O2 saturation: 99 %
Pulse: 72
Respiratory rate: 18

Cardiovascular: Regular rate and rhythm. No murmurs, rubs, or gallops.

Respiratory: Clear to auscultation bilaterally with no wheezing or rhonchi.

Gastrointestinal: Abdomen soft, non-distended, non-tender. Bowel sounds present.

Musculoskeletal: Left lateral thigh surgical wound approximately 10 cm with staples in place. Wound well approximated with no erythema, warmth, drainage, or infection.

Extremities: distal pulses are present. No cyanosis or clubbing. No pitting edema to lower extremities

Skin: Surgical wound as described above with no signs of infection. Capillary refill less than 2 seconds.

Neurological: Mental status A&O ×3. Cranial nerves II–XII intact. Strength and sensation grossly intact except for expected postoperative left lower extremity limitation due to pain.

Imaging & Labs

X-ray of the left hip demonstrates an intertrochanteric fracture of the proximal femur with a visible fracture line between the greater and lesser trochanter. Presence of a displacement consistent with an acute pathologic fracture

CBC

- WBC: 8.9 K/uL
- Hemoglobin: 11.2 g/dL
- Hematocrit: 34.5%
- RBC: 3.85 M/uL
- MCV: 89 fL
- MCH: 29 pg
- MCHC: 32 g/dL
- RDW: 14.8%

Differential

- Neutrophils: 68%
- Lymphocytes: 22%
- Monocytes: 6%
- Eosinophils: 3%
- Basophils: 1%

Platelets

- Platelets: 280 K/uL

CMP

- Sodium (Na): 138 mEq/L
- Potassium (K): 4.2 mEq/L
- Chloride (Cl): 102 mEq/L
- CO_2 (Bicarbonate): 25 mEq/L
- BUN: 24 mg/dL
- Creatinine: 1.0 mg/dL
- Glucose: 118 mg/dL
- Calcium: 9.0 mg/dL
- Total Protein: 6.8 g/dL
- Albumin: 3.6 g/dL
- AST: 22 U/L
- ALT: 18 U/L
- Alkaline Phosphatase: 95 U/L
- Total Bilirubin: 0.7 mg/dL

Differential diagnosis

1. Expected Postoperative Healing Pain :
The is most likely expected postoperative pain related to surgical trauma and fracture healing is the most likely cause of pain in this patient following open reduction and internal fixation (ORIF) of the left hip related to surgical trauma and fracture healing. Surgical intervention can cause inflammation of surrounding soft tissue, bone, and muscle structures, leading to localized pain, especially during movement, weight-bearing, or physical therapy. In elderly patients, healing may occur more slowly due to decreased bone density and age-related physiologic changes. Pain associated with normal healing is usually controlled with prescribed analgesics and gradually improves with time and rehabilitation therapy.

2. Postoperative Surgical Site Infection:
Postoperative infection must always be considered in patients who have recently undergone orthopedic surgery. Although the patient currently has no evidence of erythema, warmth, or purulent drainage, early infection can present subtly in elderly patients. Concerning symptoms would include worsening localized pain, fever, chills, wound drainage, or delayed wound healing. Patients with multiple comorbidities, such as diabetes mellitus, are at higher risk for postoperative infections due to impaired immune response and wound healing capacity. Continued monitoring of the surgical wound and laboratory markers of infection is warranted.

3. Hardware Complication or Mechanical Irritation:
Pain may also be related to irritation of orthopedic hardware or mechanical stress on fixation devices used during ORIF repair. As the patient participates in physical therapy and increases mobility, hardware may cause localized discomfort due to pressure on surrounding bone and soft tissue structures. Hardware complications may include loosening, improper alignment, or mechanical failure, which would require imaging evaluation if pain worsens or mobility declines. Pain associated with hardware complications may increase with movement and improve with rest.

4. Deep Vein Thrombosis:

Deep vein thrombosis must be strongly considered in postoperative patients due to advanced age, recent surgery, and decreased mobility. The patient is at increased risk for thrombus formation due to venous stasis following surgery and limited ambulation. Clinical signs of DVT would include unilateral lower extremity swelling, warmth, tenderness, or worsening pain in the affected leg. Given the patient is currently on anticoagulation therapy, risk is reduced but not eliminated. Prompt evaluation is necessary if new swelling, redness, or severe leg pain develops to prevent potential pulmonary embolism complications.

Plan

#Postoperative Left Hip ORIF Recovery

- Continue pain management with acetaminophen and oxycodone PRN for breakthrough pain.
- Continue lidocaine patch for localized pain control.
- Monitor surgical wound for signs of infection, including redness, warmth, swelling, purulent drainage, or increased pain.
- Continue physical and occupational therapy to improve mobility, strength, and functional independence.
- Monitor for postoperative complications, including deep vein thrombosis, hardware complications, and impaired wound healing.

#Fall Prevention / Safety

- Implement strict fall precautions given the advanced age, osteoporosis, and recent hip fracture.
- Encourage consistent use of assistive devices during ambulation.
- Provide one-person assistance during transfers and ambulation as needed.
- Ensure proper lighting, remove environmental hazards, and keep frequently used items within reach.
- Continue PT/OT for balance training and gait strengthening.
- Monitor for dizziness or orthostatic hypotension before ambulation.

#Atrial Fibrillation

- Continue Eliquis for anticoagulation unless contraindicated.
- Continue rate control medications as prescribed.
- Monitor heart rate, rhythm, and apical pulses.

#Heart Failure with Preserved Ejection Fraction (HFpEF)

- Monitor daily weights and vital signs.
- Continue cardiac medications as prescribed.
- Monitor for signs of fluid overload, including lower extremity edema, shortness of breath, or orthopnea.

#Hypertension

- Continue amlodipine and lisinopril for blood pressure control.
- Monitor blood pressure regularly.

 # Hyperlipidemia

- Continue atorvastatin for lipid management.

#Type 2 Diabetes Mellitus

- Monitor blood glucose levels as clinically indicated.
- Monitor HbA1c periodically.
- Treat accordingly as per sliding scale

#Osteoporosis

- Continue alendronate therapy.
- Encourage weight-bearing exercises as tolerated.
- Ensure adequate intake of calcium and vitamin D.

#GERD / Peptic Ulcer Disease

- Continue omeprazole therapy.
- Encourage small, frequent meals and avoidance of triggering foods.

Patient education: Patient was educated on the importance of fall prevention given advanced age, history of osteoporosis, and status post left hip fracture treated with ORIF. Patient was instructed to always use assistive devices such as a walker during ambulation and to request assistance when transferring from bed to chair. Patient was advised to change positions slowly to prevent dizziness or orthostatic hypotension. The patient was also instructed to ensure proper lighting in her room, remove environmental hazards, and keep frequently used items within reach. Patient was educated to wear non-slip footwear and continue participating in physical and occupational therapy to improve balance, strength, and mobility. Patient was advised to notify nursing staff if she experiences dizziness, weakness, or unsteady gait.

Patient was educated that mild postoperative pain is expected following left hip ORIF due to surgical trauma, inflammation, and tissue healing. Patient was instructed to take prescribed pain medications, including acetaminophen and oxycodone PRN, only as directed to maintain adequate pain control while minimizing risk of sedation and falls. Patient was advised to use non-pharmacologic pain control methods such as resting, applying the lidocaine patch as prescribed, and using proper positioning with pillows to support the surgical leg. Patient was instructed to notify medical staff if pain becomes severe,

progressively worsens, or is associated with redness, warmth, swelling, or drainage from the surgical wound, as these may indicate complications such as infection or hardware issues.

Red Flag Symptoms Requiring Immediate Medical attention

- Fever or chills
- Increasing hip pain or swelling
- Redness, warmth, or pus-like drainage from the surgical wound
- Sudden inability to bear weight on the affected leg
- Shortness of breath or chest pain
- New onset of confusion, dizziness, or weakness
- Sudden swelling, redness, or severe pain in the calf or leg