Olgu Sunumu / Case Report

Faye Abdellah ve 21 Hemşirelik Problemi Teorisine Göre Düşmeye Bağlı Kalça Kırığı Olan Yaşlının Hemşirelik Bakımı: Bir Olgu Sunumu

Nursing Care of an Elderly Person with Hip Fracture due to Fall According to Faye Abdellah and 21 Nursing Problem Theory: A Case Report

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ÖZET

Dünya çapında 65 yaş üstü bireylerin her yıl %30-40'ının düştüğü ve bu oranın yaş ilerledikçe arttığı belirtilmektedir. Kalça kırığı olan yaşlı bireylerin yaşam beklentisinin genel popülasyona göre daha kısa olduğu ve bunların %15-20'sinin kırıktan sonraki bir yıl içinde öldüğü belirtilmektedir.

Bu çalışmada düşmeye bağlı intertrokanterik femur kırığı nedeniyle ortopedi servisinde yatan yaşlı bir kadının bakım gereksinimlerinin Faye Abdellah'ın 21 Hemşirelik Problemi Teorisine göre değerlendirilmesi ve bu gereksinimlere yönelik uygun girişimlerin planlanması amaçlanmıştır. Çalışma olgu sunumudur.

Araştırmanın verileri 16.04.2023-20.04.2023 tarihleri arasında Kıbrıs Lefkoşa'da bulunan devlet hastanesinin ortopedi servisinde toplanmıştır. Planlanan çalışma hasta ve hasta yakınlarına açıklanmış ve izinleri alınmıştır. Veriler toplanırken yüz yüze görüşme tekniği kullanılmış, vaka sunumu tekniği ile planlanan ve uygulanan bakım incelenmiştir. Veriler "Abdellah'ın 21 Hemşirelik Problem Modeli" ve "NANDA Hemşirelik Tanıları" ile değerlendirilmiştir.

Hemşirelik bakımının, fiziksel ve çevresel değişikliklerle birlikte hastaların hem fiziksel hem de duygusal durumlarını sistematik olarak ele almamızı sağlayan Faye Abdellah'ın 21 hemşirelik problem modeline göre uygulanması büyük kolaylık sağlamaktadır.

Hemşirelik bakımı hümanistik bir yaklaşım gerektirir. Hastaların fiziksel (ağrı, immobilizasyon, cerrahi işlem, enfeksiyon vb.) ve duygusal (yalnızlık hissi, sosyal izolasyon vb.) tüm etkilerini, fiziksel ve çevresel değişimlerle yaşadıkları durumları üstlenmemizi sağlayan Faye Abdellah'ın 21 hemşirelik problem modeline göre hemşirelik bakımının uygulanması, sistematik olmasını destekleyerek kolaylık sağlamaktadır.

Anahtar kelimeler: Femur Kırığı, Hemşirelik Bakımı, Hemşirelik Teorisi, Yaşlı

ABSTRACT

Background: It has been reported that 30-40% of individuals over 65 years of age fall every year worldwide and this rate increases with increasing ageing. It has been reported that the life expectancy of elderly individuals with hip fractures is shorter than the general population and 15-20% of them die within one year after the fracture.

Aim: In this study, it was aimed to evaluate the care needs of an elderly woman hospitalized in the orthopedic service due to an intertrochenteric femur fracture caused by Faye Abdellah's 21 Nursing Problems Theory is used for the evalution.

Method: The data of the study were collected between 16.04.2023-20.04.2023 in the orthopedic service of the state hospital in Nicosia, Cyprus. The planned study was explained to the patients and their relatives and their permission was obtained. While collecting the data, face-to-face interview technique was used and the planned and implemented care was examined with the case presentation technique. The data was evaluated using "Abdellah's 21 Nursing Problem Model" and "NANDA Nursing Diagnoses".

Result: The implementation of nursing care according to Faye Abdellah's 21 nursing problem model, which allows us to deal with both the physical and emotional states of patients systematically regarding physical and environmental changes.

Conclusions: Nursing care requires a humanistic approach. The application of nursing care according to Faye Abdellah's 21 nursing problem model, which allows us to undertake all the effects of physical (pain, immobilization, surgical procedure, infection, etc.) and emotional factors (feeling of loneliness, social isolation, etc.) and the situations that patients experience with physical and environmental changes, provides convenience. The model enables us to carry out a systematic care plan for the patients.

Keywords: Elderly, Femur fracture, Nursing Care, Nursing Theory

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INTRODUCTION

Aging is a physiological process that occurs over time at the level of the organism's cells, tissues and systems, and includes all of the functional and structural changes that do not return (Aslan, Hocaoğlu, 2017). The aging process has been affected by individual differences, the development and change of health, developments in technology and science, developments in the field of preventive health. The proportion of the population aged 65 and over in the total population has increased (Özcan, Kapucu, 2014). According to the estimates in the life tables created after the last census in 2011 in Cyprus; In 2021, the average lifespan for women was 83.1 years and 79.0 years for men (ktoeos.org.''Cyprus census, 2011'.'Acces Date: 22.08.2023. https://www.ktoeos.org.).

The aging process, which causes chronic diseases, permanent disabilities, low quality of life and increased environmental dependency, exposes elderly individuals to many risks due to physiological changes, and falls are among the most important of these risk factors. Falls are a universal and geriatric syndrome with many negative consequences for health, economy and social life. It is reported that 30-40% of individuals over the age of 65 fall worldwide and this rate rises up as age increases. One in every 10 falls in the elderly population causes serious consequences such as hip fracture or head injury. (Türk, Gürler, 2020). Hip fractures resulting from falls are a problem of the elderly that require hospitalization and cause permanent injuries (http://apps.who.int.,Access Date: 01.09.2023.). Hip fractures are a common source of morbidity and mortality among elderly individuals worldwide (Cankaya, Ozkurt, Tabak, 2013).

Studies show that, one-year mortality rates due to hip fractures range from 14% to 36%, 23.8% of the patients die within the first year and one in three patients becomes in need of care (Balcı et al.,2019). The number of hip fractures is expected to triple over the next 50 years (Miyamoto et al., 2008)). It has been shown that the mortality rate is seven times higher in patients with poor cognitive functions and hip fractures (Uygur et al., 2015). Intertrochanteric femur fractures usually occur in older people (Malkoç, Kural, 2006). The most important problem with hip fractures is to ensure that the elderly patient returns to the level of physical activity before surgery so that she can perform independently. 50% of these patients need help with daily life activities, and 25% need long-term care after treatment (Görmeli et al., 2015). Approximately one third of the femur is defined as distal femur. Distal femur is anatomically defined as suprachondies and intercondies region (Tokay, 2020).

Nursing, which is based on philosophy and theory, uses many disciplines, theories and concepts based on science (Şengün et al., 2013). The 21 nursing problems of Faye Glenn Abdellah, one of the significant nursing theorists, is an effective model that enables multidimensional evaluation of the patient and helps the patient to realize her own situation and needs. Abdellah's problem-solving approach can be easily used by healthcare providers and practitioners as a guide to various activities within nursing practices (Çoban et al., 2019).

Abdellah's 21 Nursing Problems are enlisted as follows:

1. To maintain good hygiene and physical comfort.

2. To promote optimal activity: exercise, rest, sleep.

3. To promote safety through prevention of accident, injury, or other trauma and through prevention of the spread of infection.

4. To maintain good body mechanics and prevent and correct deformity.

5. To facilitate the maintenance of a supply of oxygen to all body cells.

6. To facilitate the maintenance of nutrition for all body cells.

7. To facilitate the maintenance of elimination.

8. To facilitate the maintenance of fluid and electrolyte balance.

9. To recognize the physiologic responses of the body to disease conditions—pathologic, physiologic, and compensatory.

10. To facilitate the maintenance of regulatory mechanisms and functions.

11. To facilitate the maintenance of sensory function.

12. To identify and accept positive and negative expressions, feelings, and reactions.

13. To identify and accept interrelatedness of emotions and organic illness.

14. To facilitate the maintenance of effective verbal and nonverbal communication.

15. To promote the development of productive interpersonal relationships.

16. To facilitate progress toward achievement and personal spiritual goals.

17. To create or maintain a therapeutic environment.

18. To facilitate awareness of self as an individual with varying physical, emotional, and developmental needs.

19. To accept the optimum possible goals in the light of limitations, physical and emotional factors.

20. To use community resources as an aid in resolving problems that arise from an illness.

21. To understand the role of social problems as influencing factors in the cause of illness (Parisa et al., 2020).

The 21 Nursing Problem Theory proposed by Faye Glenn Abdellah forms the basis of nursing practices and the essence of nursing. It is a suitable model for use in the care of many chronic diseases. The theory is based on health requirements and problem solving approach. While developing the theory, Abdellah was influenced by Maslow's 'Needs Hierarchy' and Henderson's '14 Basic Requirements Theory' (Allam et al., 2016).

This case report intends to make an evaluation of the patient with hip fractures due to falling with a view to 21 nursing problems of Faye Glenn Abdellah, one of the nursing theories providing an in-depth analysis of nursing initiatives. The report aims to present the evaluation in a multi-faceted manner increasing the level of health in the clinical field, thereby improving nursing practices and offering optimal care. In the case report is aimed to serve as a guide in the application areas of the nursing profession.

This case report investigates the answers of the following research questions:

1- What should be the nursing care for individuals with hip fractures due to falls?

2- What are the problems encountered in the care of individuals with hip fractures due to falls?

3- Is Faye Glenn Abdellah's nursing problem-solving model suitable for use in the care of patients with hip fractures due to falls?

METHOD

The data of the study was collected between 16.04.2023 and 20.04.2023 in the orthopedic service of the state hospital in Nicosia, Cyprus. The planned study was explained to the patients and their relatives and their permission was obtained. Face-to-face interview technique was used to collect the data, and the planned and implemented care was examined with the case presentation technique. The data was evaluated based on "Abdellah's 21 Nursing Problem Model" and "NANDA Nursing Diagnoses".

CASE REPORT

Patient Information:

Socio-demographic characteristics: P.K. is a 73 years old housewife, mother of three sons. She lives with her husband and son.

Past Health History: P.K. has a history of hysterectomy and cholecystectomy surgery in 2015. Patient P.K. had bronchitis when she was young and was diagnosed

with bronchiectasis twenty years ago. The patient, who has been receiving treatment for twenty years due to respiratory distress, has been receiving oxygen 2-3 l/min 24 hours a day with the treatments she has received for the last three years. The female patient, who also has HT (Hypertension) and heart rhythm disorder, continues her current treatments and does not have any food or drug allergies.

The patient's routine medications: Beloc Zok tb 2x75mg, Lopin 5mg tb 1x1, Ipratom 500 mcg/2 ml inh. 4x1, pulmicort inh. 0.25 mg/mL inh. 4x1.

Current Health Story: The patient who was admitted to the chest service of the state hospital on April 10-14 with respiratory distress was discharged home on April 15, fell on the morning of April 16 and was brought to the emergency department of the state hospital by ambulance. The patient, who had pain in her left hip and could not move it, was hospitalized in the orthopedic service with a diagnosis of intertrochanteric femur fracture as a result of the examinations. Analgesics for pain, anticoagulant drugs against the risk of embolism, intravenous fluid support and bronchiectasis treatments were continued and oxygen support 2-3 l/min was started.

The preparations for the operation were completed and the patient was operated by the orthopedic team on April 17, 2023. Consultation was requested from Chest Diseases, Cardiology and Anesthesia departments before the operation, and the patient was operated under local anesthesia in accordance with the recommendations of the specialist doctors of the three departments. After the operation, the patient was brought to the orthopedics and traumatology service, and her care and treatment continued in the clinic.

Habits: The patient does not use alcohol or smoke.

Physician's order for treatment: The medical treatment for the patient has been planned as follows: Clexane 0.4 ml 1x1 SC, Parol 100 mg/ml (PRN) 3X1, Contramal 2 ml ampule (PRN) 2X1, Cipro 400mg vial 3x1, Beloc Zok tablet 2x75gr, Lopin 5mg tablet 1x1, Prednol 16mg tablet 1x1, Cortair 0.25 mg/ml neb. 2x1, Ipratom 500 mcg/2 ml neb. 4x1, Reflor sachet 2x1, Isotonic NaCl 1000 ml 1x1.

Physical Examination: The patient İs 1.65 cm and she is above the ideal body with a body mass index (BMI) of 29.41 kg/m². The patient, who is immobilized due to a hip fracture, has their pain intensity assessed using the Visual Analogue Scale (VAS), which is described as 6 out of 10.

Vital Signs: Blood pressure: 90/60 mmHg, pulse rate: 92/min, temperature: 36°C, respiratory rate: 22/min, fasting blood glucose: 120 mg/dl.

Medical Diagnosis: Left Hip Fracture, Hypertension, Cardiac Arrhythmia.

IMPLEMENTATION OF NURSING CARE BASED ON FAYE ABDELLAH'S 21 NURSING PROBLEMS MODEL

1. Basic Maintenance Requirements.

1.1. Hygiene and Physical Comfort: To maintain good hygiene and physical comfort.

Nursing Diagnosis: Deficiency in Fulfillment of Self-Care.

Causes: Previous surgery, Old age, Limitation of movement.

Supportive Data: The presence of pain, limitation of movement due to fracture, in need of help with activities of daily living such as toileting, dressing, bathing and walking.

Aim/Goals: Supporting the patient in managing activities of daily living.

Nursing Interventions: Daily care that the patient could not manage was supported and the caregiver was trained. Patient privacy was protected during care. Cotton clothes were preferred. To prevent infection from dirty to clean areas, sufficient attention is paid during body care procedures, and hematoma areas (upper left part of the vagina, left leg) were supported by applying hirudoid gel.

Evaluation of Expected Outcomes: The patient was supported for activities of daily living and self-care needs were met.

Recorded: Observations, interventions

1.2. Exercise Rest: To promote optimal activity: exercise, rest, sleep.

Nursing Diagnosis: Disrupted Sleep Pattern

Causes: Old age, Pain, Hospital environment, Diarrhea, Noise, light

Supportive Data: Difficulty in falling asleep, Feeling tired, Restlessness, Sleepiness

Aim/Goals: Minimizing physical and environmental stimuli that affect sleep.

Nursing Interventions: It was planned to turn off the room lighting between 12:00 pm and 06:00 at night and illuminate the room along with light from the corridor. Since the patient had pain, pain medication was given 30 minutes before sleep (pain according to Visual Comparison Scale rating; 6 out of 10). Anti-diarrhea diet planning was provided in consultation with dieticians. The patient was supported with relaxing music and sleep eye patch.

Evaluation of Expected Outcomes: The patient's pain was reduced to a level that did not bother her. Watery, odorous stools 7 times a day were reduced to 3 times a day. The pain was re-evaluated with the Visual Comparison Scale and it was determined that it decreased (4 out of 10) compared to the previous value (6 out of 10). It was determined that the patient had a comfortable sleep phase with the statement 'I slept more comfortably tonight'.

Recorded: Observations, interventions

1.3. Safety: To promote safety through prevention of accident, injury, or other trauma and through prevention of the spread of infection

Nursing Diagnosis: Risk of infection

Causes: Invasive procedures, Hospital environment, Diarrhea, Immobility

Supporting Data: Laboratory findings (Wbc ↑, CRP ↑), Long stay in the hospital environment, Lack of knowledge of the caregiver

Aim/Goals: Prevention of hospital infections.

Nursing Interventions: The patient's daily laboratory follow-up (WBC, CRP) and fever follow-up were observed. Hygienic hand washing steps were applied before and after contact with the patient. Relatives of the patient were informed about the importance of visiting her one by one and to keep a distance of 1 meter. Urine was evaluated for color, odor and appearance. The caregiver was informed that the Foley catheter should be below the level of the heart. The intravenous catheter was monitored for signs of infection by making sure that the date of the intravenous catheter did not exceed 72-96 hours and that the dressing was clean and dry.

Evaluation of Expected Outcomes: WBC decreased from 19.67 to 11.68, which was high during hospitalization. There were no signs of local infection at the invasive catheter sites. No infection was observed at the wound site.

Recorded: Observations, interventions

1.4. Body Mechanics: To maintain good body mechanics and prevent and correct deformity.

Nursing Diagnosis: Impaired Physical Mobility.

Causes: Previous surgery, Diagnosis of movement limitation, Pain, Immobility.

Supporting Data: Reluctance to move, Inability to perform actions according to instructions.

Aim/Goals: Ensuring the maintenance of physical activities.

Nursing Interventions: The patient was helped to get used to the idea of remobilization by changing in-bed positions every two hours. Compression areas were

observed for decubitus ulcers. The patient and her relatives were educated and cooperation was established with physical therapists.

Evaluation of Expected Outcomes: The patient was observed to be compliant and willing to in-bed position changes and upper body exercises, the patient stated that she felt stronger with in-bed exercises.

Recorded: Observations, interventions

2. Supportive Care Needs

2.1. Oxygenation: To facilitate the maintenance of a supply of oxygen to all body cells.

Nursing Diagnosis: Risk of Disruption of Tissue Integrity.

Causes: Surgical intervention, immobilization.

Supporting Data: Motion limitation, Risk of redness in pressure areas due to being over ideal weight.

Aim/Goals: To protect and maintain skin integrity

Nursing Interventions: Following admission to the hospital, the patient's risk of developing a pressure ulcer was evaluated and recorded. (Brenden scale score 13- Risk). Bedding should be clean, dry and wrinkle-free. The patient was monitored for diarrheal rash. To ensure the comfort of the patient, loose-fitting and cotton clothes were used. The patient was monitored and recorded daily for edema. An air mattress was used for the patient. The patient's nails were cut straight and appropriate lotions were used to prevent body dryness after bathing.

Evaluation of Expected Outcomes: The patient realized that it was better to lie on her back and in the right side position and change her position ever two hours. Correct position was not given to the surgical site, Patient body integrity preserved.

Recorded: Observations, interventions

2.2. Nutrition: To facilitating the maintenance of nutrition for all body cells.

Nursing Diagnosis: Nutritional Imbalance, Eating Less Than Necessary

Causes: Surgical Intervention, Loss of appetite, Conditions that cause decreased desire to eat (inability to eat hospital food)

Supportive Data: Weakness, Weight loss

Aim/Goals: Eat daily nutrients organized according to the individual's metabolic needs and activity

Nursing Interventions: Daily fluid intake and urine output were monitored. Since the patient had diarrhea, the dietician was contacted for the best diet plan. Electrolytes were monitored with daily blood monitoring.

Evaluation of Expected Outcomes: The patient's weight loss stopped and electrolyte balance was restored. The patient acquired the habit of taking oral nutrition in small amounts and at frequent intervals.

Recorded: Observations, interventions

2.3. Elimination: To facilitate the maintenance of elimination.

Nursing Diagnosis: Diarrhea

Causes: Stress, Medication therapy (antibiotic use)

Supportive Data: Change in color, consistency and frequency of stool, Defecation of large amounts of watery food (7 times a day), Increase in bowel sounds 16/min, Abdominal pain, Evasion.

Aim/Goals: Patient to stool with normal frequency and quantity

Nursing Interventions: Fluid intake and urine output were monitored. Electrolyte values among laboratory findings were closely monitored. She had dark colored stools and was thought to have melena, but after general surgery consultation and necessary laboratory tests (stool amount), it was determined that she did

not have melena. Preliminary signs of dehydration were observed (feeling of thirst, decreased skin turgor, etc.). The patient was fed with non-fiber foods.

Evaluation of Expected Outcomes: Patient stool frequency decreased from 7 to 3. Patient continues to have diarrhea with normal odor, viscous but shapeless and less watery.

Recorded: Observations, interventions

2.4. Fluid and Electrolytes: To facilitate the maintenance of fluid and electrolyte balance.

Nursing Diagnosis: Risk of Fluid Volume Imbalance

Causes: Diarrhea, Infection

Supportive Data: Inadequate oral fluid intake (750 ml). Odorous, shapeless, viscous, very watery stools seven times a day. Weight loss. Drying of the skin.

Aim/Goals: Elimination of fluid volume deficiency. Prevention of complications of fluid volume deficiency

Nursing Interventions: The fluid intake and urine output were monitored daily and noted. The patient was supported in oral intake. Serum electrolytes were monitored. Blood and blood products (3 E.S) were administered following the doctor's order.

Evaluation of Expected Outcomes: Patient fluid intake output was balanced (intake:1500ml, output: 850 ml). Hgb, which was 7.4 after surgery, increased to 10.3. Patient diarrhea decreased from 7 to 3 per day.

Recorded: Observations, interventions

2.5. Reaction to Illness: To recognize the physiologic responses of the body to disease conditions—pathologic, physiologic, and compensatory.

Nursing Diagnosis: Body Image Disturbance

Causes: Incision site as a result of surgical interventions

Supportive Data: Not want to look at or touch the operated area.

Aim/Goals: Patient to accept their appearance by practicing new coping skills

Nursing Interventions: The patient was supported to participate in self-care activities when physically and emotionally ready. The patient was concerned about the fact that she would have difficulty in managing her main life roles. She was informed that she could continue her life with physical therapy and supportive equipment.

Evaluation of Expected Outcomes: It was observed that the patient looked at the wound area during dressing. She stated that she can do her roles with assistive devices such as walker and crutches.

Recorded: Observations, interventions

2.6. Regulatory Mechanisms: Facilitating the maintenance of regulatory mechanisms and functions.

Nursing Diagnosis: Activity intolerance

Causes: Passed surgical intervention, Old age, Difficulty resting related to fear, Sleep difficulties.

Supportive Data: Fear of moving in bed, Hgb and Hct ↓, Expressing tiredness and fatigue

Aim/Goals: Patient's willingness to participate in activities of daily living, Patient's vital signs within normal range during inpatient activity, no cyanosis, sweating, pain during in-bed activity.

Nursing Interventions: In order to prevent decubitus ulcer formation, in-bed position was given every two hours and arm and leg exercises were performed during the supine position so as not to make breathing difficult. The patient was helped in self-care activities. With the approval of the doctor, the SPO2 balance was maintained by increasing the oxygen from 2-3 lt/min to 4 lt/min to prevent respiratory distress during the activity.

Evaluation of Expected Outcomes: Patient adapted. It was observed that she tried to perform the movements on her own, yet they were kept short because of early

fatigue and the patient tried to engage in activity on her own when she was in the supine position.

Recorded: Observations, interventions

2.7. Sensory Functions: Facilitating the maintenance of sensory function.

Nursing Diagnosis: Risk of Impaired Sensory Perception

Causes: Old age, Sleeplessness, Environmental factors (heat, light, etc.).

Aim/Goals: To optimize and prevent sensory perception changes and impairments that may occur to the individual patient.

Nursing Interventions: The patient's sleep pattern was ensured by regulating environmental stimuli. The patient was exposed to relaxing music. The patient was supported to carry out activities she could do on her own. To prevent the patient from feeling lonely, she was allowed to talk to her family on the phone every day.

Evaluation of Expected Outcomes: Patient was oriented and cooperative throughout the care.

Recorded: Observations, interventions.

3.1. Emotions and Reactions: Identification and acceptance of positive and negative expressions, feelings, and reactions.

Nursing Diagnosis: Suffering

Causes: Surgical intervention, Problems caused by surgical intervention (change in body image, disruption in role functioning, etc.).

Supportive Data: Statement of current situation, Sense of guilt, Fear

Aim/Goals: To enable the patient to express her feelings of suffering

Nursing Interventions: An environment where she could express herself comfortably was provided. By informing the patient about the availability of support materials (walker, crutches), the fear of not being able to fulfill their role was reduced. She was reminded that she was a person of her family's love to her. The patient was explained that this was an accident and feelings of guilt were reduced and encouraged.

Evaluation of Expected Outcomes: It was observed that as the patient was reassured that what she experienced was an accident, she no longer felt guilty.

Recorded: Observations, interventions.

3.2. Emotional and Organismal Disease: To identification and acceptance of emotions and organic illness.

Nursing Diagnosis: Impaired Body Image

Causes: Surgical intervention, Invasive interventions.

Supportive Data: Inability to meet self-care needs, Patient expressing anxiety

Aim/Goals: To enable the individual to acquire healthy coping methods related to the situation.

Nursing Interventions: The patient is encouraged to express her feelings, especially what she feels about herself, what she thinks, her perspective of herself. Encouraging the patient to engage in her self-care. The patient's false assumptions about herself were corrected as much as possible. The patient is attended to regarding the negative emotions. The patient's participation in care is ensured.

Evaluation of Expected Outcomes: The patient should be involved in the personal care she can afford and have the self-confidence to receive support when cannot cope with negative emotions.

Recorded: Observations, interventions.

3.3. Communication: To facilitating the maintenance of effective verbal and nonverbal communication.

Nursing Diagnosis: Readiness to strengthen family coping

Causes: Surgical intervention, Immobilization, Pain.

Supportive Data: Patient's expression of feeling inadequate due to their current situation.

Aim/Goals: To make sure that she can cope with family issues.

Nursing Interventions: Coping methods of the family were examined and the patient was supported in family communication. The patient's spiritual needs were identified and supported.

Evaluation of Expected Outcomes: Patients and their relatives were provided with face-to-face and telephone contact during the day, and it was perceived by the patient that the respect and love of the patient's relatives for the patient did not change and the patient's adaptation to the current situation is increased.

Recorded: Observations, interventions.

3.4. Interpersonal Relationships: To promote the development of productive interpersonal relationships.

Nursing Diagnosis: Risk of Ineffectiveness in Relationships.

Causes: Immobilization, Surgical intervention, Treatment process.

Supportive Data: The patient expresses that she does not want to be seen as bedridden and in need, being anxious. Avoid eye contact with family members.

Aim/Goals: To enable effective communication by coping with the patient's situation

Nursing Interventions: The patient was attended to concerning the guilt she felt and informed that this can happen to anyone.

Evaluation of Expected Outcomes: It was observed that the patient communicated with her family and made eye contact.

Recorded: Observations, interventions.

3.5. Spirituality: To facilitate progress towards achievement and personal spiritual goals.

Nursing Diagnosis: Risk of Spiritual Distress

Causes: Treatment process, Pain, The process of being away from normal life (home environment etc.).

Supportive Data: Maintaining spiritual practices

Nursing Interventions: Information was obtained about the patient's religious belief. The patient privacy is ensured. The patient is encouraged to perform rituals that are not hazardous to her health. The patient's beliefs and habits are accepted. For the patient who stated that she burned an olive branch for the removal of evil, the olive branch was burned with permission and the patient was comforted.

Evaluation of Expected Outcomes: The patient stated that she was deist but did not perform any worship. She stated that the olive branch burning increased her belief that it would bring good days.

Recorded: Observations, interventions.

3.6. Therapeutic Environment: Creating or maintaining a therapeutic environment.

Nursing Diagnosis: Acute Pain

Causes: Hip fracture, Surgical intervention, Immobilizaston, Invasive interventions.

Supportive Data: Expressed that she had pain according to the Visual Comparison Scale rating (6 out of 10).

Aim/Goals: Providing comfort by reducing the patient's pain from 10 to 2

Nursing Interventions: Pain level was determined regularly with the pain scale. The patient was allowed to sleep and rest when the pain was low. The effect of methods such as elevation and pillow support help reduce the pain level. Since lavender is a scent she likes, lavender scent was regularly dripped on the pillow edges to make her feel good. Analgesics included in the patient's treatment were administered.

Evaluation of Expected Outcomes: Patient stated that her pain was 4 out of 10.

3.7. Awareness of Self and Personality: To facilitate self-awareness of an individual with varying physical, emotional, and developmental needs.

Nursing Diagnosis: Readiness to strengthen coping.

Causes: Surgical intervention, Concerned, Environmental factors.

Supportive Data: Patient expressing readiness to cope.

Aim/Goals:To learn how to cope with attitudes about the patient's current situation

Nursing Interventions: It was learned how the patient coped with previous difficult processes. The patient was informed about all the procedures. She was exposed to in her care her activities increased day by day and she was supported in realizing the belief of "I can succeed".

Evaluation of Expected Outcomes: It was observed that the patient adapted to the process and asked for help by expressing her need of help comfortably when she had a negative feeling.

Recorded: Observations, interventions.

4. Vital Care Needs

4.1. Acceptance of Limitations: Accepting the optimum possible goals in the light of limitations, physical and emotional.

Nursing Diagnosis: Impaired Social Interaction

Causes: Immobilization, Distortion of body shape, Surgical intervention, Concern.

Supportive Data: The patient avoiding eye contact. The patient sees herself as a burden for her family. While being cared for, she says "If my husband and son do this, I will die''.

Aim/Goals: It was aimed that the patient is aware of her limitations and she is able to provide social interaction.

Nursing Interventions: The patient was given time to express her feelings correctly. The patient was encouraged to ensure the relatives were also involved in the care.

Evaluation of Expected Outcomes: It was observed that the patient was able to make eye contact and smile while talking with her family members.

Recorded: Observations, interventions.

4.2. Resources for Problem Solving: Utilizing community resources as an aid in resolving problems that arise from illness.

Nursing Diagnosis: Risk of Loneliness.

Causes: Being separated from the close environment, being in a different environment, Inability to move, immobilization

Aim/Goals: To prevent the feeling of loneliness

Nursing Interventions: Patient's perception of loneliness was assessed. The patient was involved in her treatment and care as much as possible.

Evaluation of Expected Outcomes: No feeling of loneliness was observed in the patient.

Recorded: Observations.

4.3. The Role of Social Problems in Illness: Understanding the role of social problems as influencing factors in the cause of illness.

Nursing Diagnosis: Social Isolation

Causes: Surgical intervention, Distortion of body image, Immobilization.

Supportive Data: Patient's statement that she does not want anyone to see her like this, not making eye contact. Terminating communication by speaking briefly.

Aim/Goals: To enable the patient to be able to express herself comfortably by leaving social isolation

Nursing Interventions: The factors causing social isolation in the patient were determined and the patient was enabled to express this. The patient's family was included in the care and the feeling of embarrassment was reduced in an environment of trust. An active social environment was created for the patient by providing visits from relatives.

Evaluation of Expected Outcomes: It was observed that the patient communicated making eye contact and smiled during communication.

Recorded: Observations, interventions.

CONCLUSIONS

Nursing care requires a humanistic approach. The application of nursing care according to Faye Abdellah's 21 nursing problem model allows us to undertake all the effects of physical (pain, immobilization, surgical procedure, infection, etc.) and emotion factors (feeling of loneliness, social isolation, etc.) and the situations that patients experience with physical and environmental changes. Providing the care procedure using Faye Abdellah's model in a schematic way allows us to carry out a systematic care plan for patients.

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