

**P:** risk for inadequate intake or metabolism of nutrients for metabolic needs with or without weight loss.

**E:** may be related to inability to intake enough food because of reflux

**S:** inadequate food intake, weight loss, nausea & vomiting, abdominal pain or discomfort, muscle mass loss.

#### Nursing Diagnosis:

Altered gastrointestinal or urinary function

**Expected Outcome:** By the end of shift, the pt will ingest daily nutritional requirements in accordance to his activity level and metabolic needs.

#### Interventions:

- Accurately measure the patient's weight and height.
- Obtain a nutritional history.
- Encourage small frequent meals of high calories and high protein foods.
- Educate the patient to eat slowly and masticate foods well.

**Evaluation:** Goal met. The patient was on schedule for to ingest daily nutritional requirements in accordance to his activity level and metabolic needs.

#### Past medical History:

L3 Verb fracture, Neurogenic Bowel & Bladder, Short Gut, Colostomy Fistula

#### Past Surgical History:

ON NURSING NOTES: but based on memory

Had two incisions on lower extremities from a surgery on both inner calves.

- GI bag (colostomy)
- NG tube (10 french)

#### Medical Diagnosis: Spinal Cord Injury

#### Diagnostic Tests and Results:

Strict I & O's

150 ml output @ 09:14.

UNABLE TO REMEMBER ON NURSING NOTES

**Assessment:** Performed V/S. Administered medications as needed/ordered.

- Head to Toe Assessment
- Assessed pain
- VS
- Growth & Development Chart:
  - 50% percentile for weight
  - 99% percentile for height (questionable)
- Hitting Milestones:
- Emotional status
- Straight Cath every 4 hrs
- Wound Care on Colostomy Fistula
- Feed overnight via NG tube (10 french)

Assessment outcomes: pt was able to express a decrease in s. Pt VS and labs within normal range.

Medications:

**On nursing note : did not get back last week.**

#### P: Risk for fall

**E:** related to lifestyle sustaining injury (paralyzed from the waist below)

**S:** absence of sensation to lower extremities, weak muscles (especially in the legs), dizziness or lightheadedness

#### Nursing Diagnosis:

Risk for Fall

**Expected Outcome:** By the end of the shift, pt will not sustain a fall.

#### Interventions:

- Provide signs or secure wristband identification for patients at risk for falls to remind healthcare providers to implement fall precaution behaviors.
- Design an individualized plan of care for preventing falls. Provide a plan of care that is individualized to the patient's unique needs.
- Transfer the patient to a room near the nurses' station
- Place items the patient uses within easy reach, such as call light, urinal, water, and telephone.

**Evaluation:** Goal met: by the end of the shift the pt did not sustain a fall.

#### P: Risk for infection

**E:** related to a site for organism invasion as evidenced by invasive procedure and a healing incision on the neck.

**S:** fever, chills & sweats, sore throat or new mouth sore, s.o.b, nasal congestion, and stiff neck

#### Nursing Diagnosis:

Risk for infection

**Expected Outcome:** Within 4 hours, the patient will remain free from infection based on maintaining normal vital signs and the absence of signs and symptoms of infection.

#### Interventions:

- Wash hands/perform hand hygiene before interacting with the patient
- Ensure that any articles used are properly disinfected or sterilized before using them
- Encourage the patient to have a balanced diet and eat protein-rich and calorie-rich foods.
- Educate the patient about appropriate cleaning

**Evaluation:** Goal met. The patient remained free from infection since they had normal vital signs and the absence of signs and symptoms of infection within 4 hours.

**P:** limitation in independent physical movement of the body

**E:** a decrease in muscle function as evidenced by weakness in lower extremities

**S:** limited ROM, reluctance to attempt movement, assistive devices (stretcher), inability to perform action as instructed

#### Nursing Diagnosis:

Impaired Physical Mobility

#### Expected Outcome:

By the end of the shift, pt will be able to demonstrate measures to increase mobility.

#### Interventions:

1. Repositioning pt frequently
2. Present a safe environment, having important items nearby
3. Give medications as ordered
4. Help pt in accepting and understanding limitations

#### Evaluation

Goal met: pt was able increase mobility strength by the end of the shift.