P: risk for inadequate gas exchange
E: maintains optimal gas exchange as evidenced by usual mental status, unlabored respirations at 12-20 per minute, oximetry results within normal range, blood gases within normal range, and baseline HR for patient.
S: Hypoxemia, abnormal breathing pattern, abnormal arterial blood gases, restlessness, cyanosis, dyspnea, coughing, nasal flaring, hypercapnia, hypoxia, hypoxemia, orthopnea, use of accessory muscle

Nursing Diagnosis:
Impaired Respiratory Function

Expected Outcome: By the end of shift, the patient will maintain clear lung fields and remains free of signs of respiratory distress.

Interventions:
- Position patient with head of the bed elevated, in a semi-fowler's position (head of the bed at 45 degrees when supine) as tolerated.
- Regularly check the patient's position so that they do not slump down in bed.
- If the patient has unilateral lung disease, position the patient correctly to promote ventilation-perfusion.
- Maintain an oxygen administration device as ordered, attempting to maintain oxygen saturation at 90% or greater.
- Administer medications as prescribed.
- Monitor the effects of sedation and analgesics on the patient's respiratory pattern; use judiciously.

Evaluation: Goal met. By the end of the shift, the patient will maintain clear lung fields and remains free of signs of respiratory distress.

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:
- Repositioning pt frequently
- Present a safe environment, having important items nearby
- Give medications as ordered
- Help pt in accepting and understanding limitations
- Reassess effectiveness of medications

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

Past medical History:
Hypertension, Neuropathic Pain, OSA, Obesity, Vitamin D deficiency, Pre-Diabetes, Insulin Resistance, Hepatomegaly, Global Developmental Delay, Exotropia of Left Eye, Decreased Mobility & Endurance, Decreased ADL, Chronic Hip Pain, Contracture of Muscle of Both Ankles

Past Surgical History:
- Chronic Hip Pain
- Insulin Resistant
- Pre-diabetes
- Developmental Delay
- Both Ankles Contractor

Medical Diagnosis:
Metabolic Disorder- Guillain- Barre Syndrome

Diagnostic Tests and Results:
Wong Baker Scale- No Pain

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

- Head to Toe Assessment
- Assessed pain
- VS
  Allergies: Shrimp

- Medications:

Cholecalciferol : 2000 unit PO daily

Famotidine: 20 mg PO BID

Metformin HCl- 500 mg PO

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

P: Risk for high 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:
High Risk Falls
Expected Outcome: By the end of the shift, the patient 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 impaired skin integrity
E: related to physical trauma. Other causes can be related to thermal factors, or chemical injury, injection, nutritional imbalances, fluid imbalances, and altered circulation.
S: affected area hot, tender to touch, damaged or destroyed tissue, mucous membranes, integumentary, local pain, protectiveness toward site, skin and tissue color changes, swelling around the initial injury

Nursing Diagnosis:
Impaired Skin Integrity

Expected Outcome: Within 4 hours, the patient reports any altered sensation or pain at site of tissue impairment.

Interventions:
- Monitor site of impaired tissue integrity at least once daily for color changes, redness, swelling, warmth, pain, or other signs of infection.
- Assess the site of impaired tissue integrity and its condition.
- Assess changes in body temperature, specifically increased body temperature.
- Assess the patient's level of pain.
- Premedicate for dressing changes as necessary.

Evaluation: Goal met. The patient did not report any altered sensation or pain at site of tissue impairment.