P: Increased pressure within the cranial cavity
E: increased volume of brain tissue, blood, or cerebrospinal fluid within the skill as evidenced by cerebral edema, hydrocephalus, hypertension, cerebral vasodilation.

S: altered LOC, pupil changes, babinski reflex, posturing, seizures, cushing's triad, abnormal respirations, wide pulse pressure, bradycardia, elevated temperature.

Nursing Diagnosis:
High Risk for Increased Intracranial Pressure

Expected Outcome: By the end of the shift, measures to minimize intracranial pressure to prevent any damage to nerve tissue and prevent long-term neurological deficits will be taken.

Interventions:
- Frequent neurovascular checks
- Monitor temperature and hemodynamics, including MAP and CPP
- Avoid sedatives or CNS depressants if possible
- Monitor electrolytes and urine output

Evaluation: Goal met: by the end of the shift, measures to minimize intracranial pressure to prevent any damage to nerve tissue and prevent long-term neurological deficits were successful, pt did not exhibit s/s of ICP.

P: Imbalanced Nutrition: Less than Body Requirements
E: as evidenced by GI tract function alterations, lengthy NPO status, increased metabolic rate (or other conditions such as increased intake such as burns, infections, chemotherapy)
S: reduced muscle mass, reduced total protein, transferrin, and serum albumin levels, electrolyte imbalances, poor skin turgor, poor wound healing, weight loss below 20%

Nursing Diagnosis:
Imbalanced Nutrition

Expected Outcome: By the end of shift, the patient will achieved an adequate nutritional status, as evidenced by stable weight and by improved albumin levels.

Interventions:
- Assist with the insertion and maintenance of central venous or peripherally inserted central catheters (PICC).
- Encouraged additional oral fluid intake as indicated.
- Administer the prescribed rate of TPN solution via an infusion pump.
- Collaborate with other nutritional support teams, dieticians, pharmacists, and home health nurses.
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Evaluation: Goal met. By the end of the shift, the patient maintained an adequate nutritional status, as evidenced by stable weight and by improved albumin levels.

Past medical History:
Seizure Disorder
Chronic Respiratory Failure
Dysphagia
Chromosomal Abnormality
Ear anomaly
Feeding difficulty in infant
Periventricular leukomalacia
Undescended left testicle
Ventricular septal defect

Past Surgical History:
- Gastrostomy
- Tracheostomy
- Cleft palate

Medical Diagnosis:

Respiratory Failure w/ Hypoxia or Hypercapnia
Diagnostic Tests and Results:
Flacc Scale

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

- Head to Toe Assessment
- Assessed pain
- VS
- No known Allergies
- Skin Integrity Assessment
- Wound Assessment

- Medications:
- Artificial tears= 1 drop both eyes
- Budesonide: 0.5 mg
- Clobazam: 15 mg GT
- Ferrous sulfate : 45 mg GT
- Levetiracetam : 1000 mg GT
- topiramate : 150 mg GT
- Valproate sodium : 250 mg GT
-

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

P: Risk for Trauma
E: not applicable
S: weakness, balancing difficulties, reduced muscles, poor vision, reduced sensation, cognitive limitations, loss of large or small muscle coordination.

Nursing Diagnosis:
High Risk for Seizure: Risk for Trauma or Suffocation
Expected Outcome:
By the end of the shift, pt will maintain treatment regimen to control or eliminate seizure activity.

Interventions:
- Explore and expound seizure warning signs and usual seizure pattern.
- Use pad side rails with the bed in lowest position
- Avoid using thermometers that can cause breakage. Use Tympanic thermometer when necessary.
- Evaluate the need for protective headgear
- Reassess effectiveness of medications

Evaluation
Goal met: pt was able to maintain treatment regimen to control or eliminate seizure activity.

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.