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.
- Reassess GI & GU system

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

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 to demonstrate measures to increase mobility strength by the end of the shift.

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)
- GI Tube= 80 cc/hr

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.

- **aspirin - 81 mg PO**
- **Imodium- 2 mg PO**
- **Methylphenidate- 18 mg PO**
- **multivitamin - 1 each PO**
- **Oxybutynin chloride- 15 mg PO**
- **Potassium citrate- 15 mEq PO**

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.