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| **Assessment: Client Data** *(What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)* | Nursing Diagnosis Statement(NANDA Approved) | | |
| ***Subjective Data:*** *(What did the client say about the issue?)* | ***NANDA Label:***  Imbalanced Nutrition: Less than body requirements  *Definition: Intake of nutrients insufficient to meet metabolic needs* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.] do you have about the issue?)*  Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_ | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * decreased appetite * missing, painful, or poor fitting dentition * repeated vomiting * insufficient funds for nutrition * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are the* ***signs and/or symptoms*** *that prove the NANDA Label is a problem.)* | | |
| **Planning: Client Outcome** |  | | |
| ***Outcome*** *(Only one behavior/response. Needs to be specific, observable, measureable, achievable, realistic and timed for THIS client.)* | | ***Time*** *(When you expect the response to occur. If there is an agency policy for reassessment, such as with pain, utilize that time frame in your outcome to add it to your workflow.)* | |
| **The client will:**   * Maintain current weight * Eat greater than or equal to 75% of meals * Identify 2 measures to improve nutritional intake * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * By the end of hospital day \_\_\_\_\_ *(****1, 2, 3****?)* * By the end of teaching session. * by discharge / transfer *(circle one)* * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **PLANNING:** **Interventions** *(Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)* | **IMPLEMENTATION:** *(Document how you implemented the intervention and the client’s response If you were unable to implement the intervention, state that, and why.)* |
| * Provide good oral hygiene before each meal. *Good oral hygiene enhances appetite increasing the client’s nutritional intake (Ackley, Ladwig, & Makic, 2020).* |  |
| * Provide a calm, peaceful environment for meals, avoid interruptions during mealtimes, and offer companionship. *Client will increase intake if they are not required to do something during a meal or have the companionship of others that are eating (Potter, Perry, Stockert, & Hall, 2017).* |  |
| * Allow for access to meals or snacks during “off times” if the client is not available or hungry at time of meal delivery*. Clients will increase intake if they can eat when they are hungry or as soon as they return from a procedure (Ackley, et al., 2020).* |  |
| * Offer high protein foods to most hospitalized individuals (use caution with those with compromised renal/liver function). *Protein requirements are often not met in hospitalized clients, high protein foods increases the nutrition during one meal or snack (Ackely, et al., 2020).* |  |
| * Administer antiemetics and pain medications as ordered and needed before meals. *Decreasing pain or nausea will increase appetite and increase client nutritional intake (Ackely, et al., 2020).* |  |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
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