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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?)*  Pt.is unable to communicate. | ***NANDA Label:***  Impaired Physical Mobility  *Definition: limitation in independent, purposeful physical movement of the body or of one or more extremities* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.] do you have about the issue?)*  Pt. has uncontrollable movements in extremities. Unable to evaluate PERRLA due to eyes rolled back and eyelids shut tight. | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * decreased muscle strength * decreased endurance   x musculoskeletal impairment  x neuromuscular impairment  x sensory-perceptual impairment   * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are the* ***signs and/or symptoms*** *that prove the NANDA Label is a problem.)*  Pt. is unable to control body movements. Sporadically will raise both arms perpendicular to body and move legs as if imitating walking. | | |
| **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:**   * Participate in 2 activities outside of the client’s room * Walk or move self with wheelchair 20 ft * Reposition self 3 times   X Be able to respond to verbal commands of shaking head or move hands/feet | | * Daily * Every 4/ 8/ 12/ 24/ hrs. *(circle one)*   X 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).* ***Make sure to cite the source (Ackley book) and add the page number at the end of each rationale in the box(es) below.*** | **IMPLEMENTATION:** *(****Document how you implemented the intervention and the client’s response*** *If you were unable to implement the intervention, state that, and why.)* |
| Monitor and record the clients response to activity.  (Ackley pg 656) | Repeatedly asked client to shake head or squeeze hand. Initially there was no response but was able to eventually shake head when asked. |
| Screen for mobility skills in the following order: bed mobility, dangling and supported and unsupported sitting(Ackley pg 656) | Pt move a great deal in bed but not in a controlled manner meaning there is a high chance of falling from bed. |
| Use one-forth to one-half length side rails only and maintain bed in low position.(Ackley pg393) | Bed was always placed in lowest position when leaving room with 4 side rails up. |
| Place a fall-prone client in a room that is near the nurses’ station. | Pt room is directly across from nurses’ station |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
| Pt is able to intermittently respond to specific commands of shaking head but not squeezing of hand. Have | |
| not witnessed Pt be able to respond positively to consecutive commands. | |
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