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NURSING CARE PLAN					
ASSESSMENT	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
<p><b>NURSING CARE PLAN</b></p> <p><b>ASSESSMENT:</b> "Nursing care plan for a patient who has had a stroke and is experiencing difficulty with eating and swallowing."  • Decreased intake. • Unintentional weight loss. • Weight loss of 10% in 6 months.</p>	<p><b>INFERENCE:</b> • Patient is experiencing difficulty with eating and swallowing due to stroke.</p> <p><b>PLANNING:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p> <p><b>INTERVENTION:</b> • Help patient develop a plan for managing changes in eating and drinking. • Encourage patient to allow time periods for eating and drinking. • Encourage patient to eat small, frequent meals. • Encourage patient to eat in a quiet environment. • Avoid patient with environmental triggers that cause the patient to feel uncomfortable (monitored).</p>	<p><b>RATIONALE:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p> <p><b>EVALUATION:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p>	<p><b>INFERENCE:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p> <p><b>PLANNING:</b> • Encourage patient to allow time periods for eating and drinking. • Encourage patient to eat small, frequent meals. • Encourage patient to eat in a quiet environment. • Avoid patient with environmental triggers that cause the patient to feel uncomfortable (monitored).</p>	<p><b>INTERVENTION:</b> • Encourage patient to eat small, frequent meals. • Enhance patient's ability to eat by encouraging patient to eat in a quiet environment.</p> <p><b>RATIONALE:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p> <p><b>EVALUATION:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p>	<p><b>INFERENCE:</b> • After hours of nursing intervention, the patient will be able to eat and drink orally or return to a normal sense of energy.</p> <p><b>PLANNING:</b> • Encourage patient to allow time periods for eating and drinking. • Encourage patient to eat small, frequent meals. • Encourage patient to eat in a quiet environment. • Avoid patient with environmental triggers that cause the patient to feel uncomfortable (monitored).</p>

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## Nutrition

### Essential Foods for You

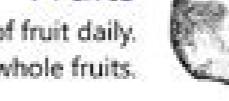
March



#### Vegetables

Eat a variety of vegetables from all subgroups including dark green, red/orange, legumes & starchy.

Fruits



Aim to eat about 2 cup-equivalents of fruit daily.



#### Whole Grains

Eat about 6 ounce-equivalents of grains daily.

Aim for half of those to be whole grains.



#### Lean Protein

Eat about 5 1/2 ounce-equivalents of a variety of protein such as lean meat, poultry, eggs, legumes, seafood, nuts & soy products.



#### Low-Fat Dairy

Consume about 3 cup-equivalents of fat-free or low-fat dairy each day.



#### Nutrition And Your Liver

Green Tea is a good alternative to sugary beverages and full of antioxidants.

Garlic, grapefruit, beets and carrots can help improve overall liver function.

3-4 cups of caffeinated, black, unsweetened coffee can reduce your risk of liver cancer by 41% and your risk of liver-related death by 71%.

#### Doctor's Tip

In general, a heart healthy balanced diet (with meals containing all food groups) as outlined by the American Heart Association is recommended.

-Dr. Pranab Barman, Northwestern University



Get Fit is a campaign provided by the American Liver Foundation, Great Lakes Division. Learn more by visiting us at <http://www.LiverFoundation.org/GreatLakes>

Poster Updated 2/26/18

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Nursing Problem/Cue	Nursing diagnosis	Planning	Nursing Intervention	Rationale	Evaluation
<b>Nursing Problem:</b> Imbalanced nutrition, less than body requirements related to medically restricted intake	Intake of nutrients insufficient to meet metabolic needs.	<p><b>GOAL:</b> After 8 hours of nursing intervention the client will be able to identify causative factors when known and necessary interventions.</p> <p><b>Objectives:</b> A. To assess causative factors. B. To evaluate degree of deficit. C. To establish a nutritional plan that meets individual needs.</p>	<p>Evaluate client's appetite.</p> <p>Encourage bedrest and/or limited activity during acute illness.</p> <p>Record intake and changes in symptomatology.</p> <p>Useful in identifying specific deficiencies and determining GI response to foods.</p>	<p>Appetite may be suppressed because of altered taste, early satiety, nausea, vomiting, cramping, diarrhea, or combinations of these factors.</p> <p>Decreasing metabolic needs aids in preventing caloric depletion and conserves energy.</p>	<p>After 8 hours of nursing intervention the client was able to improve his nutritional intake.</p>

		Promote client participation in dietary planning as able.	Provides sense of control for client and opportunity to select foods desired/enjoyed, which may increase intake.
		Encourage client to verbalize feelings concerning resumption of diet.	Hesitation to eat may be result of fear that food will cease exacerbation of symptoms



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