Patients info label here

Anorexia nervosa

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Imbalanced nutrition: Insufficient *Related factors:* Decreased appetit self-induced vomiting *Symptoms / Risk factors:* Lack of interest in food Loss of weight with adequate food intake Dehydration Excessive loss of hair *Outcome / Goal:* Patient will maintain balanced intake and output Verbalize understanding of nutritional needs		**Nutrition Management** Assess overall nutritional status and history Consult a dietitian Assess current timing and content of meals. Administer enteral or parenteral feedings, as indicated **Weight Gain Assistance** Use a consistent approach and Sit with client while eating Promote pleasant environment and record intake Make selective menu available and client to control choices Maintain a regular weighing schedule Avoid giving laxatives.	
	Risk for deficient fluid volume *Related factors:* Fasting Vomiting Inadequate intake of food and liquids *Symptoms / Risk factors:* Knowledge deficiency related to fluid volume Deviations affecting access, intake, or absorption of fluids Oliguria Medication (e.g., diuretics) *Outcome / Goal:* Patient will maintain balanced fluid intake and output		**Fluid Management** Monitor vital signs Explain reasons for thearpy and it inteded effects to patient and family members Encourage fluid intake by offering fluids regularly Discuss strategies to stop vomiting and laxative/diuretic use. Monitor total fluid intake (and output) every 8 hours	
	Disturbed thought processes *Related factors:* Psychological conflicts *Symptoms / Risk factors:* Inappropriate nonreality based thinking Cognitive dissonance *Outcome / Goal:* Demonstrate behaviors to change/prevent malnutrition		**Reality Orientation** Be aware of client's distorted thinking ability Adhere strictly to nutritional regimen Monitor electrolyte lab tests	
	Disturbed body image *Related factors:* Cognitive/perceptual Preceived body image changes *Symptoms / Risk factors:* Negative feelings about body (e.g., feelings of helplessness Fear of rejection or of reaction by others *Outcome / Goal:* Express positive feelings about self		**Body Image Enhancement** Assess feelings about self and body Assist patient to identify actions that will enhance appearance Establish a therapeutic nurse-client relationship Encourage client to express his feelings Be aware of own reaction to client's behavior. Avoid arguing with client Be alert to suicidal ideation/behavior	
	Impaired parenting *Related factors:* Family conflicts *Symptoms / Risk factors:* Ill-defined family rules, functions, and roles *Outcome / Goal:* Recognize and resolve conflict appropriately		**Parenting Promotion** Identify patterns of interaction Refer to family therapy groups Asses parents understanding and expectations of patients future Encourage and allow expression of feelings by individuals	

Plan created: 2.11.2016 by:_____

signature