Patients info label here

Brain tumor

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Acute pain *Related factors:* Increased ICP Pressure on brain tissues *Symptoms / Risk factors:* Headache Irritability Facial mask *Outcome / Goal:* Report pain is relieved or controlled		**Pain Management** Asses cause of pain: location, character and duration Instruct patient to relax and rest while occurrence of pain Note factors that aggravate and relieve pain Obs vital signs_____ Administer medication as prescribet Plan for aggressive pain management, as indicated Obs. pain (effectivnes of medication)	
	Disturbed thought processes *Related factors:* Brain tissue destruction Alteration of circulation *Symptoms / Risk factors:* Slowed movement Inaccurate interpretation of environment Cognitive dissonance Memory deficit/problems *Outcome / Goal:* The person will maintain reality orientation and communicate		**Reality Orientation** Assist with diagnostic studies, such as MRI, CT scan, Encourage client to do as much as possible Be aware of client's distorted thinking ability Maintain a pleasant environment with appropriate Keep sentences short and clear Present information as concretely as possible Ask yes,no or multiple choice questions Have specific places for specific items and keep the items in their proper place Correct wrong answers immediately	
	Disturbed sensory perception *Related factors:* Brain tissue destruction Compression of Brain *Symptoms / Risk factors:* paresthesia Change in vision Diminished motor coordination Alterations in sense of balance or gait disturbance *Outcome / Goal:* Patient doesn't experience falls or injury		**Environmental Management** Review pathology of individual condition. Ascertain and validate client's perceptions Evaluate for visual deficits. Note loss of visual field, Adjust environment to promote patients comfort Encourage client to watch feet when appropriate Discuss the need for removing environmental barriers in the home	
	Risk for imbalanced nutrition: Insufficient *Related factors:* Vomiting Decreased intake. *Symptoms / Risk factors:* Weight loss *Outcome / Goal:* The patient will demonstrate increased ability to feed Nutrition maintained		**Nutritional Monitoring** Ascertain from patient/family what food the patient likes or dislikes Assess ability to chew, taste, and swallow. Have patient take meals in the sam setting, with pleasant surroundings Maintain correct food temperatures Provide social contact during eating Provide good oral hygiene before and after meals Monitor input / output _____ weight_____	
	Dressing/grooming self-care deficit *Related factors:* Neuromuscular impairment Perceptual or cognitive impairment Weakness or tiredness *Symptoms / Risk factors:* Impaired ability to fasten clothing Inability to maintain appearance at a satisfactory level Inability to choose clothing Inability to perform ADL's *Outcome / Goal:* The patient will demonstrate increased ability to dress self		**Self-Care Assistance: Dressing/Grooming** Assess patient's ability to dress Allow sufficient time for dressing and undressing Choose clothing that is loose-fitting Lay clothes out in the order in which they will be needed to dress Provide for privacy during dressing routine	

Plan created: 3.11.2016 by:_____

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