Patients info label here

Risk for injury

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for injury *Related factors:* Abnormal blood profile Incision Physical trauma Recurrent laryngeal nerve damage Seizure Tissue hypoxia Undetected or untreated congenital anomalies *Symptoms / Risk factors:* Inability to speak Abnormal blood profile (e.g., leukocytosis/leukopenia, alter Anemia Aphonia Aspiration of secretions Biochemical, regulatory function (e.g., sensory dysfunction) Biological (e.g., immunization level of community, microorga Change i consciousness Chemical (e.g., polluants, poisons, drugs, pharmaceutical ag Cyanosis Immune autoimmune dysfunction Physical (e.g., broken skin, altered mobility) Psychological (affective orientation) *Outcome / Goal:* Be free of injury/complications Display homeostasis No sign of speaking /breathing difficulties		**Bleeding Precautions** Frequently monitor surgical site and dressings to detect any signs of bleeding Hematest body fluids—urine, stool, and vomitus—for occult blood Administer blood products, as indicated Administer O2 as prescribed Maintain a safe environment Monitor vital signs and detect any signs of bleeding Monitor vital signs regularly to detect any signs of hypovolemia **Circulatory Precautions** Avoid injury to affected area Check wound dressing and output from drain Chek wound dressing (bleeding) Keep extremity in depended position Maintain adequate hydration to prevent increased blood viscosity Monitor affected extremities for pulse,skin color, temprature and sensations Avoid leg crossing Refrain from taking blood pressure in affected extremity Reduce external pressure points Administer blod, plasma as indicated **Electrolyte Management: Hypocalcemia** Monitor regularly patient 's lab test serum calcium level **Neurologic Monitoring** Assess cerebral perfusion pressure (mean arterial - ICP) Assess change in consciousness(lowered) Assess symptoms of breathing/ speaking difficulties Assess temperature every _____ hour Limit care activities that increase ICP (Intra Cranial Pressure) Maintain patient airway. Obs respiration:rate,depth and rythm Monitor (estimate) bleeding / fluids from wound and tubes(drains) Monitor neurologic status, consciousness, pupillary size, sensory and reflexes Monitor vital signs frequently (direct arterial) Notfy doctor at once if lowered consciousness persists **Newborn Care** Assess the parent's educational needs Clamp umbilical cord approximately ½–1 in. as soon as possible Describe to parents the appropriate rationale for actions taken to prevent injur **Surveillance** Assess movement and sensation of arms and hands (cervical) Assess movement and sensation of lower extremities and feet (lumbar) Assess respiratory effort. Note presence of pallor and cyanosis Assist parents to remain calm during seizure activity of child Check neurological signs periodically Keep client flat on back for several hours, per protocal Do not put any object into child's mouth - use your fingers only if needed Lay the child on his or her side to prevent choking Monitor Dextrostix levels Monitor laboratory studies, as indicated	

Plan created:12.11.2016 by:_____

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