Assessment Framework	***DATA/ CUES / S&S:*** *Objective/Subjective*
Neurological CNS	Temp 37.2˚C Pain score 7/10 NRS
Cardiovascular CVS	BP 135/85mmHg HR 94bpm
Respiratory	RR 26bpm SpO2 99% RA
Genitourinary Renal	
Musculoskeletal	Left ankle pain + swelling Restricted movement Discomfort
Gastrointestinal GIT	
Integument	Redness Heat Swelling
Endocrine/ Metabolic	
Psychosocial/other	

HYPOTHESES: *Symptoms, Areas of Risk, Alteration in function*

INFLAMMATION

LEARNING NEEDS:

Pancreatitis

- Alcohol
- Mechanical obstruction

PROBLEM *(Actual/Potential)*	***Rationale – Why is it a problem?***	**NURSING INTERVENTIONS**	***Rationale for nursing interventions***	**EVALUATION CRITERIA**
Acute pain r/t inflammation of foot Goal of Care: Reduce pts. pain	Pain is causing the pt. discomfort – leads to slower recovery	• Review medication chart – administer as prescribed/required • Assist with positioning for comfort • Monitor response to pharmaceutical interventions • Elevate limb to reduce inflammation • Ice • Relaxation	Understand type + severity of pain	Pain assessment (at rest + with movement) Pt. reports decrease in pain
Potential for impaired skin integrity r/t inflammatory process Goal of Care:	Inflammatory process can compromise skin integrity	• Repositioning – elevate limb • Assess for wound + dress wound if appropriate • Immobilisation of leg	Protect the limb from friction/rubbing with the bed	Reassess skin integrity
Potential for increased risk of falls r/t unsteady gait, painful weight bearing, medication effects, unfamiliar environment Goal of Care: Prevent falls	Restricted mobility of the foot could lead to a fall	• Falls risk assessment • Low lying bed • Provide mobility aids • Call bell in reach • Fall precaution sign above bed • Bed alarms • Provide urine bottle • Provide education about falls risk • De-clutter pts. room (remove obstacles) • Vital signs/monitor for light-headedness and dizziness	These measures ensure that the patient is close to the ground, so a fall is impossible and also ensure that he has extra stability/support when mobilising.	Nil reported falls

Risk of dehydration Goal of Care: Increase fluid	Fluid shift due to vasodilation/capillary leakage	• Increase fluid intake • Electrolyte management • Fluid management		Good skin turgor, moist mucous membranes
Risk of impaired mobility r/t restricted movement Goal of Care: Increase mobility	Pt. experiences pain when weight bearing	• Pain relief • Walking aids	Decreased pain level can allow pt. to mobilise with more comfort	Pt. ambulates, attends to ADLs
Actual or potential anxiety r/t • Potential lack of self care • Lack of knowledge of injury/environment • Admission to hospital Goal of Care: Reduce pts. level of anxiety		• Education regarding injury/admission process/environment • Comfort/support pt. (e.g. talk with pt., cup of tea) • Refer to allied health member (e.g. physio, social worker) • Assess for possible pharmaceutical intervention (e.g. diazepam)	Provide pt. with adequate education to reassure them and reduce anxiety levels	