Nursing Diagnosis	**Patient Goals (Short and/or long term)**	**Nursing Interventions (Including rationale)**	**Evaluation**
YOUR SELECTED NANDA-I® NURSING DIAGNOSIS r/t stroke aeb impaired gag reflex, difficulty swallowing, altered mental status, and facial paralysis.	1. The patient's lungs will be clear by discharge. 2. The patient will swallow without aspiration by 1900 on the day of care. 3. The patient will be assessed by a speech language pathologist and develop a plan of care to prevent aspiration by 1700 on the day of care. 4. By discharge, the patient will agree to follow the discharge plan to prevent aspiration after they go home.	1. The nurse will assess the patient's ability to eat without aspiration. 2. The nurse will encourage the patient to sit up straight while eating. 3. The nurse will monitor the patient during meals. 4. The nurse will assess the patient's lung sounds every 4 hours. 5. The nurse will advocate for the patient to be evaluated by a speech language pathologist. 6. The nurse will educate the patient and their family on techniques to prevent aspiration while eating. Include evidenced based rationales for each nursing intervention using your textbooks.	State whether or not the goal was met. If the goal wasn't met, what progress did they make, and what changes do you need to make to the care plan. Give your recommendations for changing the care plan to improve patient outcomes.