

# NURSING CARE PLANS

| STUDENT'S NAME <b>2 pts</b>                                                                                                                                 | Dark Green Team                                                                                                                                                                                                | PATIENT INITIALS <b>2 pts</b> D.M.                               | ROOM NUMBER <b>2 pts</b>                                                                                                                                                                                                         | DATES <b>2 pts</b> 10-18-12                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| ASSESSMENT                                                                                                                                                  | NURSING DIAGNOSIS                                                                                                                                                                                              | PLANNING                                                         | IMPLEMENTATION                                                                                                                                                                                                                   | EVALUATION                                                                                                    |
| (supportive data <b>20 pts</b> )                                                                                                                            | (patient's need <b>20 pts</b> )                                                                                                                                                                                | (the goal/outcomes & criteria to evaluate <b>20 pts</b> )        | (interventions & documentation of rationales <b>20 pts</b> )                                                                                                                                                                     | (status of goal <b>12 pts</b> )                                                                               |
| FACTUAL DATA                                                                                                                                                | PROBLEM STATEMENT                                                                                                                                                                                              | NURSING PLAN FOR PROBLEM                                         | DOING & DOCUMENTING                                                                                                                                                                                                              | STATUS OF THE GOAL                                                                                            |
| <p>Subj: no alcohol abuse, ↑ hallucinations, ↑ agitation, ↓ social interaction.</p> <p>Obj: 60-year-old male, ↑ uncleanness, ↓ attention, ↓ orientation</p> | <p>Nursing Diagnosis: Acute confusion r/t alcohol abuse aeb dysfunctional family structure, pacing, wringing of hands, disoriented x3, hallucinations, inattentive, and beer bottles throughout apartment.</p> | <p>Reorient patient to person, place, and time every 4 hours</p> | <p>surround patient with useful memory aids such as a clock, calendar, and personal photographs; patient will write his name every 4 hours which will be recorded for comparison of neurological and musculoskeletal status.</p> | <p>E1. oriented x3; patient can properly write his name and carry on a full conversation.</p>                 |
|                                                                                                                                                             | <p>Goal: Patient will return to his neurological status baseline of being oriented x3, cooperative family structure, calmness, and attentiveness within 72hrs of admission.</p>                                | <p>Provide safe environment</p>                                  | <p>closer supervision; low, padded bed; non-skid socks; tidy, well-lit, warm, quiet environment; call-light within reach.</p>                                                                                                    | <p>E2. free of injury; remained calm. Room temperature 77 °F (25 °C), open shades, and clean environment.</p> |

# Lesson Plans For Nursing Instructors

**Annelies Wilder-Smith**



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