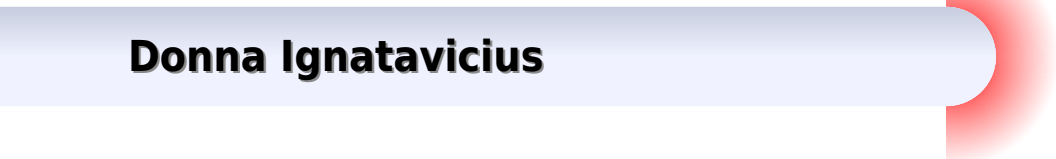


NURSING CARE PLANS

STUDENT'S NAME 2 pts	Dark Green Team	PATIENT INITIALS 2 pts D.M.	ROOM NUMBER 2 pts	DATES 2 pts 10-18-12
ASSESSMENT	NURSING DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
(supportive data 20 pts)	(patient's need 20 pts)	(the goal/outcomes & criteria to evaluate 20 pts)	(interventions & documentation of rationales 20 pts)	(status of goal 12 pts)
FACTUAL DATA	PROBLEM STATEMENT	NURSING PLAN FOR PROBLEM	DOING & DOCUMENTING	STATUS OF THE GOAL
Subj: no alcohol abuse, ↑ hallucinations, ↑ agitation, ↓ social interaction. Obj: 60-year-old male, ↑ uncleanness, ↓ attention, ↓ orientation	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.	Reorient patient to person, place, and time every 4 hours	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.	E1. oriented x3; patient can properly write his name and carry on a full conversation.
	Goal: Patient will return to his neurological status baseline of being oriented x3, cooperative family structure, calmness, and attentiveness within 72hrs of admission.	Provide safe environment	closer supervision; low, padded bed; non-skid socks; tidy, well-lit, warm, quiet environment; call-light within reach.	E2. free of injury; remained calm. Room temperature 77 °F (25 °C), open shades, and clean environment.

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