Sample Nursing Care Plan - Chapter 6

Recognize Cues

Subjective Data: Per H&P: 83 yo female, long term memory care facility resident, Alzheimer's disease

Objective Data: Alert and oriented to self, intermittently uncooperative, unable to follow commands, decline in ability to provide self-care, wandering and pacing at night, recent fall

Analyze/Cluster Cues	**Prioritize Cluster:**
Relevant data cluster 1: Alzheimer's disease, alert and oriented to self only, unable to follow commands, decline in ability to provide self-care **Relevant data cluster 2:** Alert and oriented to self, wandering and pacing at night, recent fall, Alzheimer's disease, unable to follow commands **Relevant data cluster 3:** intermittently uncooperative, Alzheimer's disease, oriented to self only	**Immediate priority:** Alert and oriented to self, wandering and pacing at night, recent fall, Alzheimer's disease, unable to follow commands **Why this is a priority:** Safety is always a top priority. Mrs. Vang has already fallen and with inability to follow commands and wandering and pacing at night she has serious safety concerns, including a high risk for physical injury.

Nursing Hypothesis (Nursing Diagnosis)	**Related To**
Risk for physical injury	N/A

As Manifested By

Oriented to self, wandering and pacing at night, recent fall, Alzheimer's disease, unable to follow commands

Generate Solutions (Outcome Goal)	**Generate Solutions (SMART Outcome Criteria)**
Client will be free from physical injury	Client will be free from physical injury throughout their stay at the long-term memory care facility.

Plan (Nursing Interventions) **"The nurse will …"**	**Rationale**
1. Use a bed alarm at night to alert staff when the client is getting out of bed.	**1.** Avoiding physical restraints through using sensor alarms helps promote self-mobility and enhances safety.[1]
2. Place the client in a room near the nurses station.	**2.** A room near the nurses station allows for more frequent client observation.[1]
3. Collaborate with family members to engage in reminiscing with the client.	**3.** Understanding the client's past helps enhance communication with the client, possibly leading to decreased uncooperativeness.[1]

Take Action (Implement Interventions)

Evaluating outcomes	**Revision** If the goal was PARTIALLY MET or NOT MET: Identify 2 new interventions based on your analysis.
X Met ■ Partially Met ■ Not Met Client has not sustained a physical injury during stay. Client has remained safe within the care environment and demonstrated no additional decline in thought processes. Her wandering at night has decreased, and the bed alarm alerts staff when she gets out of bed.	**1.** **2.**

Reference:
Ackley, B, Ladwig, G, Makic, M. (2017). Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care, 11th ed.