

NURSING CARE PLAN FOR ALTERED MENTAL STATUS

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A NURSING CARE PLAN FOR ALTERED MENTAL STATUS IS A COMPREHENSIVE, PATIENT-CENTERED APPROACH DESIGNED TO ASSESS, DIAGNOSE, PLAN, IMPLEMENT, AND EVALUATE INTERVENTIONS AIMED AT STABILIZING AND IMPROVING A PATIENT'S MENTAL CONDITION. ALTERED MENTAL STATUS (AMS) ENCOMPASSES A BROAD SPECTRUM OF COGNITIVE DYSFUNCTIONS, INCLUDING CONFUSION, DISORIENTATION, DECREASED LEVEL OF CONSCIOUSNESS, OR COMA. IT CAN RESULT FROM NUMEROUS UNDERLYING CAUSES SUCH AS INFECTIONS, METABOLIC IMBALANCES, NEUROLOGICAL EVENTS, INTOXICATION, OR SYSTEMIC ILLNESSES. EFFECTIVE MANAGEMENT REQUIRES A SYSTEMATIC APPROACH TO ENSURE PATIENT SAFETY, IDENTIFY UNDERLYING CAUSES, AND PROMOTE OPTIMAL RECOVERY.

THIS ARTICLE PROVIDES AN IN-DEPTH GUIDE ON CREATING AND IMPLEMENTING AN EFFECTIVE NURSING CARE PLAN FOR PATIENTS EXPERIENCING ALTERED MENTAL STATUS, HIGHLIGHTING ASSESSMENT STRATEGIES, NURSING DIAGNOSES, INTERVENTIONS, AND EVALUATION CRITERIA.

UNDERSTANDING ALTERED MENTAL STATUS

DEFINITION AND SIGNIFICANCE

ALTERED MENTAL STATUS IS CHARACTERIZED BY A CHANGE FROM THE PATIENT'S BASELINE MENTAL FUNCTIONING, AFFECTING AWARENESS, COGNITION, OR CONSCIOUSNESS. IT IS A CLINICAL SIGN RATHER THAN A DISEASE ITSELF BUT OFTEN POINTS TO SERIOUS UNDERLYING CONDITIONS REQUIRING PROMPT ATTENTION.

COMMON CAUSES OF AMS

- INFECTIONS: MENINGITIS, ENCEPHALITIS, SEPSIS
- METABOLIC DISTURBANCES: HYPOGLYCEMIA, HYPONATREMIA, HEPATIC OR RENAL FAILURE
- NEUROLOGICAL EVENTS: STROKE, TRAUMATIC BRAIN INJURY, SEIZURE ACTIVITY
- TOXINS AND DRUGS: ALCOHOL INTOXICATION, DRUG OVERDOSE, POISONING
- PSYCHIATRIC CONDITIONS: ACUTE PSYCHOSIS, SEVERE DEPRESSION
- OTHER SYSTEMIC ILLNESSES: HYPOXIA, DEHYDRATION, FEVER

ASSESSMENT OF PATIENTS WITH ALTERED MENTAL STATUS

INITIAL EVALUATION

- ENSURE AIRWAY, BREATHING, AND CIRCULATION (ABCs): IMMEDIATE PRIORITY TO PREVENT DETERIORATION.
- ASSESS LEVEL OF CONSCIOUSNESS: USE STANDARDIZED TOOLS LIKE THE GLASGOW COMA SCALE (GCS).
- IDENTIFY VITAL SIGNS: BLOOD PRESSURE, HEART RATE, RESPIRATORY RATE, TEMPERATURE, OXYGEN SATURATION.
- PERFORM A FOCUSED NEUROLOGICAL ASSESSMENT: PUPILLARY RESPONSE, MOTOR AND SENSORY FUNCTION, REFLEXES.
- GATHER PATIENT HISTORY: RECENT TRAUMA, MEDICATION USE, SUBSTANCE USE, RECENT ILLNESSES, ALLERGIES.
- CONDUCT PHYSICAL EXAMINATION: LOOK FOR SIGNS OF TRAUMA, INFECTION, DEHYDRATION, OR OTHER SYSTEMIC ISSUES.

DIAGNOSTIC TESTS

- BLOOD TESTS: CBC, ELECTROLYTES, BLOOD GLUCOSE, RENAL AND LIVER FUNCTION TESTS, BLOOD CULTURES
- IMAGING: CT SCAN OR MRI OF THE BRAIN
- LUMBAR PUNCTURE: IF INFECTION OR MENINGITIS SUSPECTED
- OTHER ASSESSMENTS: ELECTROENCEPHALOGRAM (EEG), TOXICOLOGY SCREENING

NURSING DIAGNOSES RELATED TO ALTERED MENTAL STATUS

BASED ON ASSESSMENT FINDINGS, NURSES CAN ESTABLISH RELEVANT DIAGNOSES, SUCH AS:

- IMPAIRED LEVEL OF CONSCIOUSNESS RELATED TO (SPECIFIC CAUSE)
- RISK FOR INJURY RELATED TO ALTERED MENTAL STATUS AND DECREASED AWARENESS
- INEFFECTIVE AIRWAY CLEARANCE RELATED TO DECREASED CONSCIOUSNESS
- RISK FOR FALLS RELATED TO UNSTEADY GAIT AND DISORIENTATION
- IMBALANCED NUTRITION: LESS THAN BODY REQUIREMENTS RELATED TO DECREASED CONSCIOUSNESS
- ANXIETY RELATED TO UNFAMILIAR SURROUNDINGS AND ALTERED MENTAL STATE
- RISK FOR INFECTION RELATED TO IMMOBILITY AND COMPROMISED IMMUNITY

NURSING INTERVENTIONS FOR ALTERED MENTAL STATUS

SAFETY AND MONITORING

- MAINTAIN A SAFE ENVIRONMENT: REMOVE HAZARDS, KEEP BEDRAILS UP, AND ENSURE A CLUTTER-FREE SPACE.
- FREQUENT MONITORING: CHECK VITAL SIGNS, LEVEL OF CONSCIOUSNESS, AND NEUROLOGICAL STATUS REGULARLY.
- IMPLEMENT FALL PRECAUTIONS: USE BED ALARMS, NON-SLIP FOOTWEAR, AND ASSIST WITH AMBULATION.
- ENSURE PROPER POSITIONING: TURN PATIENT FREQUENTLY TO PREVENT PRESSURE ULCERS AND FACILITATE AIRWAY PATENCY.

AIRWAY AND RESPIRATORY MANAGEMENT

- MAINTAIN AIRWAY PATENCY: SUCTIONING AS NEEDED.
- OXYGEN THERAPY: ADMINISTER SUPPLEMENTAL OXYGEN IF HYPOXIA IS PRESENT.
- POSITIONING: ELEVATE HEAD OF BED TO FACILITATE BREATHING AND PREVENT ASPIRATION.

SUPPORTING PHYSIOLOGICAL STABILITY

- HYDRATION AND NUTRITION: ASSESS INTAKE AND PROVIDE IV FLUIDS OR ENTERAL NUTRITION IF NECESSARY.
- ELECTROLYTE CORRECTION: COLLABORATE WITH HEALTHCARE TEAM TO CORRECT IMBALANCES.
- TEMPERATURE REGULATION: MANAGE FEVER WITH APPROPRIATE MEASURES.

COGNITIVE AND PSYCHOSOCIAL SUPPORT

- REORIENT THE PATIENT: USE CLOCKS, CALENDARS, AND FAMILIAR OBJECTS.
- PROVIDE REASSURANCE: CALM COMMUNICATION TO REDUCE ANXIETY.
- INVOLVE FAMILY MEMBERS: FACILITATE VISITS TO PROMOTE FAMILIARITY AND COMFORT.

PHARMACOLOGICAL INTERVENTIONS

- ADMINISTER MEDICATIONS AS PRESCRIBED FOR UNDERLYING CAUSES, SUCH AS ANTIBIOTICS FOR INFECTION OR ANTICONSULSANTS FOR SEIZURES.
- MONITOR FOR SIDE EFFECTS OR ADVERSE REACTIONS.

NURSING CARE PLAN GOALS AND EXPECTED OUTCOMES

- ENSURE PATIENT SAFETY BY PREVENTING FALLS AND INJURIES.
- MAINTAIN OR IMPROVE LEVEL OF CONSCIOUSNESS TO THE PATIENT'S BASELINE.
- IDENTIFY AND ADDRESS UNDERLYING CAUSES OF AMS PROMPTLY.
- PROMOTE PHYSIOLOGICAL STABILITY THROUGH APPROPRIATE INTERVENTIONS.
- SUPPORT PATIENT AND FAMILY EMOTIONALLY AND PSYCHOLOGICALLY THROUGHOUT CARE.

EVALUATION OF NURSING INTERVENTIONS

REGULAR ASSESSMENT IS VITAL TO DETERMINE THE EFFECTIVENESS OF INTERVENTIONS:

- MONITOR CHANGES IN MENTAL STATUS: IMPROVEMENT IN GCS OR ORIENTATION.
- ASSESS SAFETY MEASURES: NO FALLS OR INJURIES OCCUR.
- EVALUATE PHYSIOLOGICAL PARAMETERS: STABLE VITAL SIGNS AND LABORATORY RESULTS.
- REVIEW DIAGNOSTIC RESULTS: CONFIRMATION OF UNDERLYING CAUSE AND RESPONSE TO TREATMENT.
- ADJUST CARE PLAN: MODIFY INTERVENTIONS BASED ON PATIENT PROGRESS AND EVOLVING NEEDS.

SPECIAL CONSIDERATIONS IN NURSING CARE FOR ALTERED MENTAL STATUS

PEDIATRIC AND GERIATRIC PATIENTS

- CARE APPROACHES SHOULD BE TAILORED TO DEVELOPMENTAL LEVEL AND BASELINE FUNCTIONING.
- ELDERLY PATIENTS ARE MORE PRONE TO FALLS; EXTRA PRECAUTIONS ARE ESSENTIAL.

CULTURAL SENSITIVITY

- RESPECT CULTURAL BELIEFS AND PRACTICES RELATED TO MENTAL HEALTH.
- USE INTERPRETERS IF LANGUAGE BARRIERS EXIST.

ETHICAL AND LEGAL ASPECTS

- ENSURE PATIENT RIGHTS ARE PROTECTED.
- OBTAIN CONSENT FOR PROCEDURES WHEN POSSIBLE.
- DOCUMENT ALL ASSESSMENTS, INTERVENTIONS, AND PATIENT RESPONSES DILIGENTLY.

CONCLUSION

A NURSING CARE PLAN FOR ALTERED MENTAL STATUS IS A CRITICAL COMPONENT IN THE MANAGEMENT OF PATIENTS WITH COGNITIVE DYSFUNCTION. IT REQUIRES A THOROUGH ASSESSMENT, ACCURATE DIAGNOSIS, TARGETED INTERVENTIONS, AND ONGOING EVALUATION TO ENSURE SAFETY, PROMOTE RECOVERY, AND ADDRESS UNDERLYING CAUSES. NURSES PLAY A PIVOTAL ROLE BY PROVIDING HOLISTIC, PATIENT-CENTERED CARE THAT SUPPORTS PHYSIOLOGICAL STABILITY, PSYCHOLOGICAL WELL-BEING, AND SAFETY. BY FOLLOWING SYSTEMATIC PROTOCOLS AND COLLABORATING WITH MULTIDISCIPLINARY TEAMS, NURSING PROFESSIONALS CAN SIGNIFICANTLY IMPACT OUTCOMES FOR PATIENTS EXPERIENCING ALTERED MENTAL STATUS.

REFERENCES

(FOR COMPLETE AND ACCURATE REFERENCES, CONSULT CURRENT NURSING TEXTBOOKS AND CLINICAL GUIDELINES RELEVANT TO NEUROCOGNITIVE CARE.)

FREQUENTLY ASKED QUESTIONS

WHAT ARE THE ESSENTIAL COMPONENTS OF A NURSING CARE PLAN FOR A PATIENT WITH ALTERED MENTAL STATUS?

THE ESSENTIAL COMPONENTS INCLUDE ASSESSMENT OF MENTAL STATUS, IDENTIFICATION OF UNDERLYING CAUSES, IMPLEMENTATION OF SAFETY MEASURES, MONITORING NEUROLOGICAL STATUS, AND PROVIDING SUPPORTIVE INTERVENTIONS SUCH AS ORIENTATION AND COMMUNICATION STRATEGIES.

How can nurses effectively assess the level of consciousness in patients with altered mental status?

Nurses can use standardized tools like the Glasgow Coma Scale (GCS) or the AVPU scale to evaluate consciousness levels, noting changes over time to inform care and communicate findings accurately to the healthcare team.

What interventions are important in preventing complications in patients with altered mental status?

Interventions include maintaining a safe environment to prevent falls or injuries, ensuring adequate airway protection, monitoring for signs of deterioration, providing nutritional support, and preventing aspiration or skin breakdown.

How should a nursing care plan address the underlying causes of altered mental status?

The care plan should include thorough assessment to identify causes such as infections, metabolic imbalances, or neurological events, and coordinate with the healthcare team for targeted treatments while supporting the patient's neurological status.

What communication strategies are effective when caring for patients with altered mental status?

Using simple, clear language, maintaining eye contact, employing non-verbal cues, and involving family members can help facilitate understanding and reduce anxiety for patients with altered mental status.

Additional Resources

Nursing Care Plan for Altered Mental Status: An In-Depth Review

Altered mental status (AMS) is a critical clinical presentation that often signals underlying severe health issues requiring prompt assessment and intervention. In the nursing domain, developing a comprehensive care plan for patients with AMS is fundamental to ensuring timely diagnosis, stabilization, and management. This article provides a detailed exploration of the nursing care plan tailored for patients experiencing altered mental status, emphasizing assessment strategies, nursing diagnoses, interventions, and evaluation criteria to optimize patient outcomes.

Understanding Altered Mental Status

Definition and Significance

Altered mental status refers to a broad spectrum of cognitive, behavioral, and consciousness disturbances. It encompasses anything from drowsiness and confusion to coma. AMS is a symptom rather than a disease itself, often indicating serious underlying conditions such as infections, metabolic disturbances, neurological insults, or intoxications.

The significance of AMS lies in its potential to signal life-threatening conditions that require immediate intervention. Its presentation varies based on etiology, patient age, comorbidities, and severity, making rapid assessment and tailored nursing care essential.

ETIOLOGY OF ALTERED MENTAL STATUS

THE CAUSES OF AMS ARE DIVERSE AND CAN BE CATEGORIZED BROADLY INTO:

- INFECTIOUS CAUSES: MENINGITIS, ENCEPHALITIS, SEPSIS
- METABOLIC DISTURBANCES: HYPOGLYCEMIA, HYPONATREMIA, HEPATIC OR RENAL FAILURE
- NEUROLOGICAL INSULTS: STROKE, TRAUMATIC BRAIN INJURY, SEIZURE ACTIVITY
- TOXICOLOGICAL CAUSES: DRUG OVERDOSE, ALCOHOL INTOXICATION, POISONING
- PSYCHIATRIC CONDITIONS: DELIRIUM, PSYCHOSIS
- OTHER FACTORS: HYPOXIA, HYPOTHERMIA, HYPERTHERMIA

IDENTIFYING THE ROOT CAUSE IS PARAMOUNT IN FORMULATING AN EFFECTIVE NURSING CARE PLAN.

INITIAL NURSING ASSESSMENT FOR ALTERED MENTAL STATUS

A COMPREHENSIVE AND SYSTEMATIC ASSESSMENT FORMS THE CORNERSTONE OF EFFECTIVE NURSING MANAGEMENT OF AMS. IT INVOLVES SEVERAL KEY COMPONENTS:

1. AIRWAY, BREATHING, AND CIRCULATION (ABCs)

- ENSURE AIRWAY PATENCY, ESPECIALLY IF THE PATIENT IS UNRESPONSIVE.
- ASSESS BREATHING PATTERN, OXYGEN SATURATION, AND NEED FOR OXYGEN THERAPY.
- MONITOR CIRCULATORY STATUS: BLOOD PRESSURE, PULSE RATE, CAPILLARY REFILL.

2. LEVEL OF CONSCIOUSNESS (LOC)

- USE ESTABLISHED TOOLS SUCH AS THE GLASGOW COMA SCALE (GCS) TO QUANTIFY LOC.
- DOCUMENT ANY CHANGES IN RESPONSIVENESS, ORIENTATION, AND ALERTNESS.

3. NEUROLOGICAL EXAMINATION

- ASSESS PUPILS FOR SIZE, EQUALITY, AND REACTIVITY.
- EVALUATE MOTOR AND SENSORY FUNCTION.
- OBSERVE FOR SEIZURE ACTIVITY OR ABNORMAL POSTURING.

4. VITAL SIGNS AND LABORATORY DATA

- RECORD TEMPERATURE, BLOOD PRESSURE, HEART RATE, AND RESPIRATORY RATE.
- COLLECT BLOOD GLUCOSE LEVELS PROMPTLY.
- INITIATE LABS SUCH AS CBC, ELECTROLYTES, RENAL AND LIVER FUNCTION TESTS, BLOOD CULTURES, AND TOXICOLOGY SCREENS.

5. IDENTIFICATION OF UNDERLYING CAUSES

- OBTAIN HISTORY FROM FAMILY OR CAREGIVERS REGARDING RECENT ILLNESSES, MEDICATION USE, SUBSTANCE INTAKE, OR TRAUMA.
- REVIEW MEDICATION LIST FOR SEDATIVES, OPIOIDS, OR OTHER CNS DEPRESSANTS.

NURSING DIAGNOSES RELATED TO ALTERED MENTAL STATUS

BASED ON ASSESSMENT FINDINGS, NURSES FORMULATE SPECIFIC DIAGNOSES TO GUIDE INTERVENTIONS. COMMON NURSING DIAGNOSES INCLUDE:

- IMPAIRED LEVEL OF CONSCIOUSNESS RELATED TO NEUROLOGICAL INJURY, METABOLIC IMBALANCE, OR INTOXICATION.
- RISK FOR INJURY RELATED TO DECREASED LOC AND IMPAIRED PROTECTIVE REFLEXES.
- INEFFECTIVE AIRWAY CLEARANCE RELATED TO DECREASED CONSCIOUSNESS AND DEPRESSED GAG REFLEX.
- IMBALANCED NUTRITION: LESS THAN BODY REQUIREMENTS RELATED TO DECREASED LOC AND INABILITY TO FEED.
- DEFICIENT KNOWLEDGE REGARDING THE CONDITION, MEDICATION, OR CARE NEEDS OF THE PATIENT OR FAMILY.
- ANXIETY RELATED TO UNCERTAINTY ABOUT HEALTH STATUS.

EACH DIAGNOSIS DIRECTS TARGETED NURSING ACTIONS AIMED AT STABILIZATION AND RECOVERY.

CORE NURSING INTERVENTIONS FOR ALTERED MENTAL STATUS

EFFECTIVE MANAGEMENT OF AMS REQUIRES A MULTIDISCIPLINARY APPROACH, WITH NURSING INTERVENTIONS FOCUSING ON STABILIZATION, PREVENTION OF COMPLICATIONS, AND ADDRESSING UNDERLYING CAUSES.

1. ENSURING AIRWAY AND RESPIRATORY PATENCY

- POSITION THE PATIENT IN A LATERAL OR SEMI-FOWLER'S POSITION TO MAINTAIN AIRWAY PATENCY.
- SUCTION SECRECTIONS AS NEEDED, WITH CAUTION TO PREVENT HYPOXIA.
- ADMINISTER OXYGEN THERAPY TO MAINTAIN ADEQUATE OXYGENATION.
- PREPARE FOR ADVANCED AIRWAY MANAGEMENT IF INDICATED.

2. MONITORING AND SUPPORTING CIRCULATORY STABILITY

- REGULARLY MONITOR VITAL SIGNS TO DETECT INSTABILITY.
- ESTABLISH IV ACCESS FOR FLUID RESUSCITATION IF DEHYDRATION OR HYPOTENSION IS PRESENT.
- CORRECT HYPOGLYCEMIA WITH GLUCOSE ADMINISTRATION PROMPTLY.

3. PROTECTING THE PATIENT FROM INJURY

- IMPLEMENT FALL PRECAUTIONS: PADDED SIDE RAILS, CLEAR PATHWAYS.
- USE RESTRAINTS ONLY WHEN NECESSARY AND WITH APPROPRIATE DOCUMENTATION.
- KEEP THE ENVIRONMENT SAFE, QUIET, AND WELL-LIT.

4. MANAGING SEIZURES OR POST-ICTAL ACTIVITY

- OBSERVE SEIZURE ACTIVITY, DURATION, AND CHARACTERISTICS.
- ENSURE SAFETY BY CUSHIONING THE HEAD AND PREVENTING INJURY.
- ADMINISTER ANTICONVULSANTS AS ORDERED.
- DOCUMENT SEIZURE EPISODES THOROUGHLY.

5. SUPPORTING NUTRITION AND HYDRATION

- INITIATE ENTERAL FEEDING IF THE PATIENT IS UNABLE TO SWALLOW SAFELY.
- MONITOR INTAKE AND OUTPUT METICULOUSLY.
- CORRECT ELECTROLYTE IMBALANCES BASED ON LAB RESULTS.

6. CONDUCTING DIAGNOSTIC AND THERAPEUTIC PROCEDURES

- ASSIST WITH NEUROIMAGING (CT, MRI) OR LUMBAR PUNCTURE AS ORDERED.
- PREPARE THE PATIENT FOR LABORATORY TESTS.
- COLLABORATE WITH PHYSICIANS FOR MEDICATION MANAGEMENT.

7. PATIENT AND FAMILY EDUCATION

- EXPLAIN THE CONDITION, CARE MEASURES, AND EXPECTED OUTCOMES.
- ADDRESS FEARS AND ANXIETIES.
- PROVIDE INFORMATION ON MEDICATION ADHERENCE AND FOLLOW-UP CARE.

PHARMACOLOGICAL AND NON-PHARMACOLOGICAL MANAGEMENT

WHILE NURSING CARE IS PIVOTAL, IT OFTEN COMPLEMENTS PHARMACOLOGICAL TREATMENTS AIMED AT ADDRESSING THE UNDERLYING CAUSE:

- MEDICATIONS: GLUCOSE FOR HYPOGLYCEMIA, ANTIBIOTICS FOR INFECTIONS, ANTICONSULSANTS FOR SEIZURES, DIURETICS OR ELECTROLYTES FOR IMBALANCES.
- NON-PHARMACOLOGICAL INTERVENTIONS: MAINTAINING A CALM ENVIRONMENT, ORIENTING THE PATIENT, PROVIDING SENSORY STIMULATION, AND ENSURING ADEQUATE HYDRATION.

EVALUATION OF NURSING CARE EFFECTIVENESS

CONTINUOUS ASSESSMENT IS ESSENTIAL TO GAUGE THE EFFECTIVENESS OF INTERVENTIONS:

- IMPROVEMENT IN LOC AND NEUROLOGICAL STATUS.
- STABILIZATION OF VITAL SIGNS.
- ABSENCE OF INJURY OR COMPLICATIONS.
- LABORATORY VALUES RETURNING TO NORMAL RANGES.
- PATIENT AND FAMILY UNDERSTANDING OF THE CONDITION AND CARE PLAN.

REASSESSMENT GUIDES ADJUSTMENT OF INTERVENTIONS AND INFORMS ONGOING CARE PRIORITIES.

CONCLUSION

NURSING CARE PLAN FOR ALTERED MENTAL STATUS REQUIRES A STRUCTURED, VIGILANT, AND HOLISTIC APPROACH. EARLY RECOGNITION, RAPID ASSESSMENT, AND PROMPT INTERVENTIONS ARE CRUCIAL TO PREVENT DETERIORATION AND PROMOTE RECOVERY. NURSES PLAY A VITAL ROLE IN MONITORING, SUPPORTING, AND EDUCATING PATIENTS AND FAMILIES, ACTING AS KEY AGENTS IN THE MULTIDISCIPLINARY TEAM. AS EACH CASE OF AMS CAN BE COMPLEX AND MULTIFACETED, INDIVIDUALIZED CARE PLANS ROOTED IN THOROUGH ASSESSMENT AND EVIDENCE-BASED PRACTICES ARE ESSENTIAL TO OPTIMIZE PATIENT OUTCOMES AND REDUCE MORTALITY AND MORBIDITY ASSOCIATED WITH THIS CRITICAL CONDITION.

[Nursing Care Plan For Altered Mental Status](#)

nursing care plan for altered mental status: Nursing Care Plans & Documentation Lynda Juall Carpenito-Moyet, 2009 The Fifth Edition of Nursing Care Plans and Documentation provides

nurses with a comprehensive guide to creating care plans and effectively documenting care. This user-friendly resource presents the most likely diagnoses and collaborative problems with step-by-step guidance on nursing action, and rationales for interventions. New chapters cover moral distress in nursing, improving hospitalized patient outcomes, and nursing diagnosis risk for compromised human dignity. The book includes over 70 care plans that translate theory into clinical practice. Online Tutoring powered by Smarthinking--Free online tutoring, powered by Smarthinking, gives students access to expert nursing and allied health science educators whose mission, like yours, is to achieve success. Students can access live tutoring support, critiques of written work, and other valuable tools.

nursing care plan for altered mental status: *Nursing for Wellness in Older Adults* Carol A. Miller, 2009 Now in its Fifth Edition, this text provides a comprehensive and wellness-oriented approach to the theory and practice of gerontologic nursing. Organized around the author's unique functional consequences theory of gerontologic nursing, the book explores normal age-related changes and risk factors that often interfere with optimal health and functioning, to effectively identify and teach health-promotion interventions. The author provides research-based background information and a variety of practical assessment and intervention strategies for use in every clinical setting. Highlights of this edition include expanded coverage of evidence-based practice, more first-person stories, new chapters, and clinical tools such as assessment tools recommended by the Hartford Institute of Geriatric Nursing.

nursing care plan for altered mental status: All-in-One Nursing Care Planning Resource Pamela L. Swearingen, 2015-02-02 The only book featuring nursing care plans for all core clinical areas, Swearingen's All-In-One Nursing Care Planning Resource, 4th Edition provides 100 care plans with the nursing diagnoses and interventions you need to know to care for patients in all settings. It includes care plans for medical-surgical, maternity/OB, pediatrics, and psychiatric-mental health, so you can use just one book throughout your entire nursing curriculum. This edition includes a new care plan addressing normal labor and birth, a new full-color design, new QSEN safety icons, new quick-reference color tabs, and updates reflecting the latest NANDA-I nursing diagnoses and collaborative problems. Edited by nursing expert Pamela L. Swearingen, this book is known for its clear approach, easy-to-use format, and straightforward rationales. NANDA-I nursing diagnoses are incorporated throughout the text to keep you current with NANDA-I terminology and the latest diagnoses. Color-coded sections for medical-surgical, maternity, pediatric, and psychiatric-mental health nursing care plans make it easier to find information quickly. A consistent format for each care plan allows faster lookup of topics, with headings for Overview/Pathophysiology, Health Care Setting, Assessment, Diagnostic Tests, Nursing Diagnoses, Desired Outcomes, Interventions with Rationales, and Patient-Family Teaching and Discharge Planning. Prioritized nursing diagnoses are listed in order of importance and physiologic patient needs. A two-column format for nursing assessments/interventions and rationales makes it easier to scan information. Detailed rationales for each nursing intervention help you to apply concepts to specific patient situations in clinical practice. Outcome criteria with specific timelines help you to set realistic goals for nursing outcomes and provide quality, cost-effective care. NEW! Care plan for normal labor and birth addresses nursing care for the client experiencing normal labor and delivery. UPDATED content is written by practicing clinicians and covers the latest clinical developments, new pharmacologic treatments, patient safety considerations, and evidence-based practice guidelines. NEW full-color design makes the text more user friendly, and includes NEW color-coded tabs and improved cross-referencing and navigation aids for faster lookup of information. NEW! Leaf icon highlights coverage of complementary and alternative therapies including information on over-the-counter herbal and other therapies and how these can interact with conventional medications.

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about 160 care plans in all, covering acute, community, and home-care settings across the life span. Each plan features... Client assessment database for each medical condition Complete listings of nursing diagnoses organized by priority Diagnostic studies with explanations of the reason for the test and what the results mean Actions and interventions with comprehensive rationales NANDA, NIC, and NOC's most recent guidelines and terminology Evidence-based citations Index of nursing diagnoses and their associated disorders

nursing care plan for altered mental status: Nursing Care Plans and Documentation

Lynda Juall Carpenito-Moyet, 2005-11-01 Enter the world of nursing care planning with confidence! This informative guide is the perfect way to build your care planning and documentation skills. Practical and easy-to-read material covers each phase of care plan development and record-keeping for both surgical and non-surgical interventions.

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prioritization strategies and clinical reasoning models Planning: Develop SMART goals using NOC outcomes and evidence-based care coordination Implementation: Execute interventions using NIC classifications with delegation and documentation excellence Evaluation: Measure outcomes and drive continuous improvement in patient care Features 60 Comprehensive Case Studies Including: Pediatric conditions (diabetes, asthma, autism spectrum disorder) Adult acute care (stroke, heart failure, trauma, sepsis) Maternal-child health (high-risk pregnancy, postpartum complications) Geriatric care (dementia, hip fractures, chronic conditions) Mental health scenarios (depression, anxiety, substance use disorders) Critical care emergencies (DKA, respiratory failure, shock) Each case study provides complete patient backgrounds, systematic assessment data, prioritized NANDA-I nursing diagnoses, SMART goals with NOC outcomes, and evidence-based NIC interventions. Learn clinical reasoning through real-world scenarios that prepare you for NCLEX success and professional practice excellence. Perfect for: Nursing students at all levels New graduate nurses developing clinical judgment Advanced practice nurses expanding expertise Nursing educators seeking comprehensive teaching resources Healthcare professionals transitioning to nursing roles Key Benefits: Systematic approach to patient care planning Evidence-based practice integration Cultural competence development Technology-enhanced assessment techniques Quality improvement methodologies Interprofessional collaboration strategies Build confidence in clinical decision-making while mastering the nursing process that forms the foundation of professional practice. This practical guide bridges the gap between classroom theory and bedside application, ensuring you deliver safe, effective, patient-centered care across all healthcare settings.

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