

Care plan

Business



Nursing Diagnosis| Expected outcomes| Interventions| Rationale| Evaluation|

Nursing Diagnosis: Sleep deprivationR/t: Age related sleeping problems and dementia. A. E. B: Verbal report of not sleeping well. Also maybe be caused by dementia.

Nursing Diagnosis: Risk of hopelessnessR/t: Client's loss of family members in the past. A. E. B: Lack of eye contact, passive attitude, and deteriorating physical and mental condition. | Client will take part in relaxation techniques such as massage therapy and aroma therapy at least one time a week. Caffeine intake will be decreased.

Client will not have any caffeine after 2 pm.

Client will avoid the uses of loud T. V. ' s and radios every night. Client will use a sound generator to generate sounds of the ocean and waterfalls to improve sleep every night.

Client will use the bed only for sleeping, avoid afternoon naps, and try to go to bed only when sleeping every day. Client will spend time with a caregiver or family member one-on-one at least one time a week. A family member of the client will be expected to visit at least one time a week and spend time with the client. Client will make at least 2 simple decisions every day. Client will engage in group activities at least one time a week. Assess level of anxiety.

If client is anxious, use relaxation techniques. Assess and evaluate the client's diet and caffeine intake. Keep environment quiet for sleeping. Use soothing sound generators. Follow guide lines for good sleep habits.

Spend one-on-one time with the client. Involve family and significant others in Clients life. Encourage decision making in the daily schedule. Encourage client to participate in group activities. | The use of relaxation techniques to promote sleep in people with chronic insomnia has been shown to be effective. Caffeine often interferes with sleep.

Caffeine after the use of 2 pm is associated with poor sleep. Attention to environmental noise can reduce or eliminate sleep. Ocean sounds promote sleep. Guidelines on sleep hygiene have been shown to effectively improve quality of sleep. Physical presence and active listening inspires hope in the client. Social support is a significant variable related to hope.

Hopelessness may be an outgrowth of a previewed loss of control. Group activities provide social support and help the client identify alternative ways to solve problems. ** Source for rationale: Nursing Diagnosis Handbook. Betty J. Ackley and Gail B.

Ladwig.

**| Client responded well to the relaxation treatments used to improve sleep deprivation. Client is well after decreasing unneeded caffeine in diet and is expected to sleep better. Client's sleep improved once excessive noise has been diminished. Client responded well to the sound generator. Client is finding it hard to follow the guidelines. Client responds well to one-on-one time and appears happy during the session.

Client enjoys having family around more often. Client makes decisions on what to where and what to eat each day. Client enjoys spending time with other residents. | | | |

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