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| **Assessment: Client Data** *(What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)* | Nursing Diagnosis Statement(NANDA Approved) | | |
| ***Subjective Data:*** *(What did the client say about the issue?)* | ***NANDA Label:***  Social Isolation  *Definition: Aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.] do you have about the issue?)* | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * Absence of support system * Cultural incongruence * Disabling condition * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are the* ***signs and/or symptoms*** *that prove the NANDA Label is a problem.)* | | |
| **Planning: Client Outcome** |  | | |
| ***Outcome*** *(Only one behavior/response. Needs to be specific, observable, measureable, achievable, realistic and timed for THIS client.)* | | ***Time*** *(When you expect the response to occur. If there is an agency policy for reassessment, such as with pain, utilize that time frame in your outcome to add it to your workflow.)* | |
| **The client will:**   * Participate in 2 activities at level of ability and desire * Meet and interact with 1 new person * Identify 2 feelings of isolation * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * By the end of hospital day \_\_\_\_\_ (***1, 2, 3****?)* * Every day / week / month *(circle one)* * by discharge / transfer *(circle one)* * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **PLANNING:** **Interventions** *(Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)* | **IMPLEMENTATION:** *(****Document how you implemented the intervention and the client’s response*** *If you were unable to implement the intervention, state that, and why.)* |
| * Discuss causes of perceived or actual isolation. *To the client identify the issues that may prevent the client from feeling socially interactive (Varcarolis, 2017).* |  |
| * Provide client with a list or calendar of activities to choose from. *Group activities provide social interaction, get the client out of their room, and choices allows the client to select something they would enjoy (Varcarolis, 2017).* |  |
| * Encourage interactions with others with similar interests*. To allow the client to form new relationships, gather emotional support, reinforce ties, and reduce social isolation (Ackley, Ladwig, & Makic, 2020).* |  |
| * Use a culturally competent, professional approach when working with clients of various groups. *To promote a feeling of respect and belonging with the group (Potter, Perry, Stockert, & Hall, 2017).* |  |
| * Encourage client to have meals in the dining area. *Dining with other clients provides social interaction and gets the client out of their room (Potter, et al., 2017).* |  |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
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