

NURSING CARE PLAN

	Problem	Cause	Suggested Action
1.	Restlessness and / or confusion.	A degree of restlessness may indicate that the patient is regaining consciousness. During this time, there may be a clouding of consciousness with confusion, aggression, uncooperative behaviour and disorientation. Restlessness may also indicate brain damage, cerebral anoxia (when there is a partially obstructed airway), a full bladder or bowel pain or discomfort.	Ascertain, where possible, the cause of the discomfort and rectify as appropriate. Summon help if the patient becomes aggressive or violent. Ensure the patient does not inflict self-injury, e.g. place cot sides in position on the bed.
2.	Seizures	An unconscious patient is a potential candidate for seizures.	Maintain a clear airway. Protect the patient from self-injury. Observe the patient during the seizure and record observations on chart. Administer prescribed drugs.
3.	Cerebrospinal fluid leakage through nose or ears.	May be indicative of base of skull fracture, or some dual damage.	Place sterile swab against nose and ears and collect fluid. Test drainage for sugar [it will be positive if CSF is present]. Inform medical staff.
4.	Vomiting	The unconscious patient is prone to paralytic ileus, or medulla oblongata may be involved.	Maintain a clear airway. Keep stomach empty until ileus resolves.
5.	Distended bladder	Refer to Urinary Catherization procedure.	
6.	Inability to maintain own nutritional intake.	Refer to Nasogastric Intubation procedure.	