

Firelands Regional Medical Center School of Nursing Care Map

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Noticing/Recognizing Cues:

Highlight all data from each box relevant to top nursing priority

-Subjective Assessment findings:

- depressed mood
- anxious
- flat affect
- quiet
- poor concentration
- low energy
- alert
- calm

Objective Assessment Findings:

- temperature low, 97.5
- suicide precaution/risk
- command hallucinations
- no appetite/ did not eat breakfast
- heart rate 65
- respiratory rate 14
- 95% O2 room air
- BP 104/64

Lab findings/diagnostic tests:

- high LDL (126)
- low vitamin D (15.5)
- 2+ leukocyte esterase urine (H)
- 10-19 WBC urine (H)
- 5-9 squamous epithelial urine (H)
- 2+ urine bacteria (H)
- elevated creatinine

Risk factors:

- suicidal ideation history
- history of hallucinations
- major depressive disorder
- female
- PTSD
- schizoaffective disorder
- history of seizures
- history of substance abuse
- history of bipolar disorder
- history of anxiety
- history of depression
- history of Epstein Barr virus
- current smoker
- family history of diabetes

Nursing priorities:

- risk for suicide/injury related to suicidal ideation
- ineffective coping related to smoking and substance abuse
- disturbed sensory perception related to auditory hallucinations
- disturbed thought process related to suicidal ideation and hallucinations

Potential complications:

- Death**
 - bradycardia
 - bradypnea
 - hypotension
 - loss of muscle movement
 - difficulty speaking
 - cyanosis
- Exhaustion**
 - headache
 - dizziness
 - muscle weakness
 - moodiness
- Sepsis**
 - fever
 - tachycardia
 - altered mental status
 - fatigue

Potential complications continued:

- malnutrition
 - weight loss
 - brittle hair
 - dizziness
 - anemia
 - electrolyte imbalance
- Violence**
 - aggression
 - pacing
 - clenched fists

Interpreting/Analyzing Cues/Prioritizing Hypotheses/Generating Solutions:

Responding/Taking Actions:

Nursing interventions:

-Assess patient environment and patient PRN

Rationale: To make sure the environment is clear of anything that could harm the patient, or that the patient could use to harm themselves.

-Assess vital signs Q4H

Rationale: To make sure they are within range and to make sure nothing else is going on.

-Administer Hydroxyzine pamoate 50 mg PO Q6H/PRN

Rationale: Given to help the patient with anxiety.

-Administer Buspirone 15 mg PO TID SCH

Rationale: An additional medication to help with anxiety.

-Administer lithium carbonate 600 mg ER PO QHS/SCH

Rationale: This is a mood stabilizing medication.

-Administer paliperidone ER PO QHS/SCH

Rationale: Given to help combat schizoaffective disorder.

-Administer venlafaxine ER 225 mg PO Daily SCH

Rationale: Given to help with depression.

-Establish a trusting relationship with the patient PRN

Rationale: Having this relationship will make the patient more comfortable in sharing their thoughts with you.

-Encourage the patient to express their feelings PRN

Rationale: It gives the patient a safe place to verbalize their feelings and gives them a chance to possibly resolve them.

Reflecting/Evaluate Outcomes:

Evaluation:

-Temperature improved to 97.8

-BP decreased to 92/57

-affect is now calm and appropriate

-no longer experiencing hallucinations

-no longer experiencing suicidal ideation

-has reported a normal appetite and good sleep

-no new labs drawn

Social determinants of health

-on Medicaid

-Is unemployed

-no income

-has a PCP

Continue plan of care