Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name _____ **Date** _____

Noticing/Recognizing Cues:

Highlight all related/relevant data from the Noticing boxes that support the top priority problem

Assessment findings*:

- Temperature of 97.5 F L
- Pain rating of 2/10
- Patient is positive and participating
- Patient is eager to be discharged
- Patient denies hallucinations
- Patient denies current suicidal thoughts
- Admitted with suicidal ideations
- Admitted with depression
- Admitted with thoughts of self-harm

Lab findings/diagnostic tests*:

- Cholesterol – 212 H
- LQL cholesterol, calc – 153 H
- Electrocardiogram
- Sinus bradycardia
- 25-OH vitamin D total – 70.4
- TSH 3rd generation – 3.81

Risk factors*:

- PTSD
- Bipolar disorder
- Grief
- Substance abuse
- Depressed mood
- Hopelessness
- Threats of killing himself
- Mental abuse
- Emotional abuse

Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:

Nursing priorities*: *Highlight the top nursing priority problem*

- Risk for suicidal behavior
- Powerlessness
- Acute pain

Goal Statement: The patient will engage in his or her established plan to maintain personal safety.

Potential complications for the top priority:

- Suicide
  - Monitor for a plan for suicide, resources to complete it, and giving away their valuable materialistic items.
- Depression
  - Monitor for profound despair, anorexia or weight loss, and presence of delusions and/or hallucinations.
- Anxiety
  - Monitor for insomnia, increased heart rate, and restlessness.

Responding/Taking Actions:

Nursing interventions for the top priority:

1. Assess for warning signs of suicide every 15 minutes to avoid self-harm.
2. Assess patient location in the milieu every 15 minutes to keep track of their activities and whereabouts.
3. Assess patient mouth for pocketing of medications every time a medication is given to avoid patients hiding and abusing medications.
4. Create a safe milieu, ensure environment remains up to standards Q12H to promote a therapeutic environment.
5. Implement safe medication administration every time a medication is given to avoid medication administration errors.
6. Encourage patient to seek out support if thoughts of suicide emerge as needed.
7. Help patient to identify adaptive coping skills.
8. Listen attentively to patient.
9. Encourage verbalizations of honest feelings AAT.
10. Educate patient to seek help if they are experiencing suicidal thoughts daily to provide support and empathy.
11. Educate patient on how to express emotions through coping mechanisms during therapy groups and PRN promotes healthier strategies.
12. Educate patient on community resources that are available daily to help the patient remember what is out there if they need assistance.
13. Educate patient on what is happening within the milieu: "Orient patient to reality, as required" (X). PRN as needed if patient is disoriented to help reorient.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Patient denies suicidal ideations.
- Patient expresses no feelings of anxiety.
- Patient denies depression symptoms.
- Patient denies thoughts of self-harm.
- Patient denies hallucinations.
- Patient is compliant with medication regimen.
- Terminate plan of care as patient was discharged on 6/11/24

Reference: Morgan, K., Townsend. M., (2021) Pocket Guide to Psychiatric Nursing. F.A. Davis Company