

Firelands Regional Medical Center School of Nursing  
Nursing Care Map

Student Name Essence Byrd

Date 07/09/2024

Noticing/Recognizing Cues:

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

Assessment findings\*:

- BP: 108/77
- **HR: 104**
- RR: 18
- Temp: 98.5
- SPO2: 97% RA
- Presents overwhelmed
- **Reports decreased interests in activities she use to enjoy**
- **Reports low energy**
- **Reports fatigue throughout the day**
- **Worsening depression**
- **Pt states she found out her boyfriend is cheating on her again**
- **Pt states she had a miscarriage in March 2024**
- **Pt rates depression 8 out of 10**
- **Pt reports feeling worthless**
- **Pt reports high anxiety**
- **Pt reports poor focus and concentration**
- **Pt reports appetite fluctuation**
- **Pt reports poor sleep**

Lab findings/diagnostic tests\*:

- EKG: Sinus Rhythm with sinus arrhythmias with short PR 7/6/24
- Cholesterol: 129 L
- **Vitamin D: 23.9 L**
- Chloride: 111 H 7/8/24

Risk factors\*:

- **Depressed mood**
- **Grief from recent miscarriage**
- **Hx of depression**
- **Plan to commit suicide by motor vehicle accident**
- **No emotional support**
- Poor relationship with mother
- No relationship with father
- **Separated from partner**
- **Struggles in making decision about relationship**
- **Significant loss: miscarriage**
- Trauma: son having heart issues and almost dying at a week old
- Hx of sexual abuse
- **Hx of mental/emotional abuse**
- Hx of severe childhood neglect
- Victim and witness of DV

Interpreting/Analyzing Cues/  
Prioritizing Hypotheses/  
Generating Solutions:

Nursing priorities\*:

\*Highlight the top nursing priority problem\*

- **Risk for Suicide**
- Maladaptive Grieving
- Low self-esteem
- Powerlessness
- Disturbed thought processes
- Imbalanced nutrition, less than body requirements
- Disturbed sleep pattern
- Social isolation/ Impaired social interaction

Goal Statement:

Patient will remain free of harm to self.

(Morgan, 2024)

Potential complications for the top priority:

- Suicide Completion
  - Patient executed plan
  - Patient found unresponsive
  - Death
- Ineffective Parenting
  - Under involvement
  - Withdrawing affection and attention
  - Little or no discipline
- Social Isolation
  - Emotional Numbness
  - Unfulfilling connections with family and friends
  - Feeling dread about social activities

## Responding/Taking Actions:

### Nursing interventions for the top priority:

1. Create a safe environment for patient AAT.  
Rationale: *Patient safety is a nursing priority.*
2. Conduct a thorough, collaborative assessment of risk factors and warning signs for suicide in the context of a therapeutic relationship with the patient throughout care.  
Rationale: *Conveying an attitude of acceptance and willingness to collaborate with patients in maintaining their safety increases the potential for open and honest discussion of their thoughts and feelings.*
3. Administer Sertraline 25mg PO QAM  
Rationale: *To assist in alleviating and managing symptoms of depression.*
4. Spend time with patient throughout care.  
Rationale: *This provides a feeling of safety and security while also conveying the message, "I want to spend time with you because I think you are a worthwhile person."*
5. Encourage patient to seek out staff or a support person if thoughts of suicide emerge or become more intense AAT.  
Rationale: *Discussion of feelings with a trusted individual may provide assistance before the patient experiences a crisis situation.*
6. Maintain close observation Q15min.  
Rationale: *Close observation is necessary to ensure that patient does not harm self in any way.*
7. Make rounds at frequent, irregular intervals throughout shift.  
Rationale: *Prevents staff surveillance from becoming predictable.*
8. Encourage verbalization of honest feelings AAT.
9. Rationale: *Helps patient to identify symbols of hope in their life.*
10. Encourage the patient to express angry feelings within appropriate limits AAT. Provide safe method of hostility release throughout care. Help patient identify true source of anger and to work on adaptive coping skills for use outside of the treatment setting throughout care.  
Rationale: *Depression and suicidal behaviors may be viewed as anger turned inward on the self. If anger can be verbalized in a nonthreatening environment, the patient may be able to eventually resolve these feelings.*
11. Identify community resources and other support systems that the patient may use to maintain their plan for ongoing safety prior to discharge.  
Rationale: *Having a concrete plan for seeking assistance during a crisis may discourage or prevent self-destructive behavior.*

(Morgan, 2024)



## Reflecting/Evaluate Outcomes:

### Evaluation of the top priority:

- Patient verbalizes no thoughts of suicide.
- Patient commits no acts of self-harm.
- Patient vitals are WNL.
- Patient shows improvement in symptoms of depression.
- Patient shows improvement in appetite.
- Patient shows improvement in sleep.

Continue Plan of Care

**Reference:** Morgan, K. I., & Townsend, M. C. (2024). *Pocket guide to Townsend's Psychiatric Nursing, Twelfth edition*. F. A. Davis Company.