

Firelands Regional Medical Center School of Nursing
Nursing Care Map

Student Name: Yasmin Perez

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Noticing/Recognizing Cues:

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

Assessment findings*:

- Auditory hallucinations
- Paranoid states everyone is out to get him
- Paranoid "I had to leave the evil people"
- Paranoid "holy spirit lead him here"
- Racing thoughts
- Anxiety 8/10
- Overwhelmed
- Vision hallucinations- states he gets visions from god
- Insomnia

Lab findings/diagnostic tests*:

- Negative for toxicity screen
- EKG- within normal limits was done to start on medications
- No other lab/diagnostic

Risk factors*:

- History of child abuse
- History of sexual abuse
- History of physical abuse
- PTSD
- Bipolar disorder
- ADHD
- Lives alone at home

Interpreting/Analyzing Cues/
Prioritizing Hypotheses/
Generating Solutions:

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

- Anxiety
- Disturbed thought process
- Disturbed sensory perception
- Ineffective coping
- Maintaining safety
- Defensive coping

Goal Statement: The patient will remain safe and refrain from acting on delusional thoughts during shift

Potential complications for the top priority:

- Extreme mood changes - sad, depressed, empty, bipolar, overly happy, diet changes, sleep
- Risk for violence or aggression- Paranoid delusions, persecutory delusions, aggressive behavior towards staff, patient feels threatened
- Impaired ability to meet basic needs- hygiene, nutrition, hydration, sleep, increasing risk for physical health decline

Responding/Taking Actions:

Nursing interventions for the top priority:

1. **Maintain a calm non-threatening approach and use simple, clear, language (during initial and follow up)**
Rationale: reduces anxiety and prevents misinterpretation of staff actions, which could escalate paranoia
- 2, **Assess for risk of harm to self or others, including potential for elopement (during admission and daily)**
Rationale: Religious delusions can sometimes include command elements or behaviors that place the patient at risk
- 3 **Use therapeutic communication techniques – with every interaction**
Rationale: This will allow the nurse to develop a trusting relationship with the patient and further explore their barriers to coping.
- 4 **Assess current coping mechanisms and identify which are appropriate - on admission**
Rationale: Help the patient determine what coping strategies are currently effective and which could be changed to more positive coping strategies.
- 5 **Identify behaviors that prevent or delay appropriate coping – on admission**
Rationale: The patient may unconsciously display behaviors that interrupt the coping process, and the nurse may help identify what may be getting in the way.
- 6 **Provide stress relieving and relaxation techniques – daily**
Rationale: Introduce the patient to new techniques that can relieve stress and anxiety to decrease the potential for a manic episode.
- 7 **Encourage participation in structured, reality-based activities (groups therapy) daily**
Rationale: Distracts from delusional thoughts and promotes social engagement
8. **Encourage the patient to make decisions regarding treatment daily**
Rationale: Encouraging the patient to make decisions allows them to feel they have some power over themselves
- 9 **Set realistic goals daily (Morgan & Townsend, 2021)**
Rationale: As a nurse it is important to help the patient set short- and long-term goals and to help them achieve them
- 10 **Educate on and refer to counseling and local support groups (prior to discharge)**
Rationale Support groups can help the patient become more aware with their diagnosis and will offer empathy to the patient, so they know they are not going through this alone.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

- Denies auditory hallucinations
- Denies religious hallucinations
- Anxiety 2/10
- Identified coping skill as exercising
- Sleeping 6-8 hours

Continue plan of care

Reference: *Morgan, K.I. and Townsend, M.C. (2021) Pocket guide to psychiatric nursing. Philadelphia: F.A. Davis.*