

Firelands Regional Medical Center School of Nursing  
Nursing Care Map

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Noticing/Recognizing Cues:

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

Assessment findings\*:

- Patient vital signs were within normal limits (unsure of exact numbers due to patient privacy)
- Patient felt less anxious about attending group therapy than she did in previous days
- **Patient reported lack of appetite**
- Patient reported motivation to take all necessary steps to work through suicidal ideation and depression
- Patient reported she does not drink or use substances in any sense
- Patient uses reading as coping mechanisms during stress
- **Patient reports she does not have anyone outside of one coworker to talk to in times of need**

Lab findings/diagnostic tests\*:

- **Vitamin D Total: 26.9 (low)**
- All other lab findings were within normal ranges and no other diagnostic tests were done

Risk factors\*:

- **Lack of support system**
- **History of Generalized Anxiety Disorder**
- **History of Major Depressive Disorder**
- History of occasional smoking
- IBS-D

Interpreting/Analyzing Cues/  
Prioritizing Hypotheses/  
Generating Solutions:

Nursing priorities\*:

- **Risk for suicide**
- Low self-esteem
- Hopelessness

Goal Statement: Patient will not self-harm

Potential complications for the top priority:

- Injury from self-harm
  - Unexplained cuts/burns/bruises
  - Wearing long sleeves in warm weather
  - Bloodstains on clothes or items in room
- Suicide Attempt
  - Sudden calmness in mood
  - Expressing plan to attempt
  - Making arrangements (ex: I want my parents to inherit all my belongings)
- Increased Psychiatric Symptoms
  - Increased isolation
  - Sleep disturbances
  - Lack of appetite

## Responding/Taking Actions:

### Nursing interventions for the top priority:

1. Ask the patient directly: "Have you thought about killing yourself?" and/or "Have you thought about harming yourself? What do you plan to do?" (every hour)
  - a. The risk for suicide is higher in the patient has developed a plan and/or has strong intentions to die
2. Create a safe environment for the patient, removing all dangerous items, and supervise during meals and medication administration (during admission, mealtimes, and med administration)
  - a. Patient safety is a priority
3. Convey an attitude of unconditional acceptance of patient and encourage patient to actively participate in establishing a safety plan (during all encounters with patient)
  - a. A relationship built on trust and acceptance is essential for collaborating with the patient in developing a plan for their safety, it empowers the patient to make decisions for care
4. Maintain close observation of the patient, 15-minute checks, and a room close to the nurse's station (every 15 minutes)
  - a. Ensures the patient does not harm self in any way
5. Maintain special care in administration of medications (during all medication administrations)
  - a. Prevent saving up to overdose or discarding and not taking
6. Make rounds at frequent, irregular intervals (ex: 0010, 0115, 0205, 0300)
  - a. Prevents staff surveillance from becoming predictable
7. Encourage the patient to express honest feelings, including anger (during all therapeutic interactions)
  - a. Depressed and suicidal behaviors may be viewed as anger turned inward on the self, verbalizing may lead to resolution of feelings
8. Identify community resources that the patient can access for support and assistance as needed post discharge (during discharge planning, upon discharge)
  - a. Having a concrete plan for seeking assistance should suicidal ideation recur or intensify after discharge assists in managing symptoms and prevents self-destructive behaviors

(Davis Advantage for Townsend's Essentials of Psychiatric Mental Health Nursing, 2023)

## Reflecting/Evaluate Outcomes:

### Evaluation of the top priority:

- Patient eating more during the day and reports an increased appetite
- Patient able to identify other people in their life they can speak to about their feelings (family, other friends, community resources)
- Patient's Vitamin D levels are within the normal range (30-100 ng/mL)
- Patient able to identify a support system whether that is coworkers, family, friends, or community resources
- Patient continues taking medication for Generalized Anxiety Disorder
- Patient uses appropriate coping strategies and continues taking medication to assist with Major Depressive Disorder
- Patient does not have any suicidal ideations, thoughts of self-harm, or plans to take commit suicide

Continue Plan of Care

**Reference:** Morgan, Karyn I. (2023). Davis Advantage for Townsend's Essentials of Psychiatric Mental Health Nursing: Concepts of Care in Evidence-Based Practice. Susan R. Rhyner.