N323 Care Plan

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Lakeview College of Nursing

N323: Mental and Behavioral Health

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Demographics (3 points)

Date of Admission 10/29/20	**Patient Initials** HO	**Age** 34	**Gender** F
Race/Ethnicity Caucasian	**Occupation** Unemployed (Disability)	**Marital Status** Single	**Allergies** Mucinex (Rash/hives) Dove Soap (Rash/hives)
Code Status Full code	**Observation Status** 15 minutes	**Height** 150 cm	**Weight** 116 kg

Medical History (5 Points)

Past Medical History:

GERD, Insomnia, Asthma, Obesity

Significant Psychiatric History:

Paranoid Schizophrenia, Anxiety, Eating Disorder (Bulimia), Self-harm, Suicidal Ideation

Family History:

Father had heart disease and passed away from a Myocardial Infarction (MI) at age 45

Maternal Grandmother had Lung Cancer, COPD, Emphysema

Paternal Grandmother had Breast Cancer

Social History (tobacco/alcohol/drugs):

Patient denies any and all tobacco, alcohol, and recreational drug use

Living Situation:

Currently lives at home with mother, maternal aunt, and young cousin in mother's residence

Strengths:

"My biggest strength is also my biggest weakness. I care for people more than they care for me."

Support System:

Patient identifies her girlfriend as her strongest supporter.

Admission Assessment

Chief Complaint (2 points):

The voices in her head are getting worse and telling her to harm herself.

Contributing Factors (10 points):

Patient presented to the Emergency Dept at local hospital after sustaining 27 self-inflicted cuts to her person. She insists that the voices are insisting that she does this and have been becoming more and more persistent as of late. The voices she hears are of a male origin and pt states, "I've never heard them before. They talk to me like I know them, but I don't recognize them. If I try to ignore them, they get louder." Pt states that she has attempted suicide by cutting her wrists 3 times in the past. She could not recall the exact dates, but one attempt was in high school while the other 2 attempts have been in the last 10 years.

Primary Diagnosis on Admission (2 points):

Paranoid Schizophrenia

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Pt denies **Witness of trauma/abuse:** Pt denies				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from**	**Describe**

			caring for another person with trauma)	
Physical Abuse	Pt denies	Pt denies	Pt denies	Pt denies
Sexual Abuse	Pt denies	6YO – 12YO	Pt denies	Pt was sexually abused by her older half-brother. “The abuse included penetration and sodomy. When he left when I was 12, I started cutting. Because of his abuse, I still cannot imagine being intimate with a man to this day.”
Emotional Abuse	Pt denies	15YO-18YO	Pt denies	“My high school girlfriend was very controlling and possessive. However, she cheated on me many times and constantly ridiculed me for my weight problem. She was the reason for one of my suicide attempts.”
Neglect	Pt denies	Pt denies	Pt denies	Pt denies
Exploitation	Pt denies	Pt denies	Pt denies	Pt denies
Crime	Pt denies	Pt denies	Pt denies	Pt denies
Military	Pt denies	Pt denies	Pt denies	Pt denies
Natural Disaster	Pt denies	Pt denies	Pt denies	Pt denies
Loss	Pt denies	11YO	Pt denies	**“**My uncle had a stroke and died in the shower. I was

				the one who found him."
Other	Pt denies	Pt denies	Pt denies	Pt denies
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Pt is very depressed and anxious. She feels this way multiple times a day and sometimes for as long as an hour.	
Loss of energy or interest in activities/school	**Yes**	**No**	"My anxiety is exhausting. I feel like I never have very much energy at all."	
Deterioration in hygiene and/or grooming	**Yes**	**No**		
Social withdrawal or isolation	**Yes**	**No**	Pt claims to have severe social anxiety in crowded rooms. This worsens as the size of the crowd grows larger. She prefers to be alone or with 1 or 2 people with whom she is comfortable.	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**		
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	Pt claims to get 5-6 hours of sleep per night and those hours are consistent night to night.	
Difficulty falling asleep	**Yes**	**No**	Pt states that her sleeping medications assist her with her insomnia. Without it, she will always have difficulty falling asleep.	
Frequently awakening during night	**Yes**	**No**	Pt claims they rarely, if ever, sleep all the way through the night. They wake up multiple times every night.	
Early morning awakenings	**Yes**	**No**	Pt will often wake in the early morning hours and be unable to go back to sleep.	

Nightmares/dreams	**Yes**	**No**	Pt has nightmares more than half of the nights that she sleeps. These nightmares of her abusive past are what typically cause her to wake up multiple times per night.
Other	**Yes**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	
Binge eating and/or purging	**Yes**	**No**	Pt is diagnosed with Bulimia nervosa and regularly purges after meals. She claims that she had lost over 100 pounds in this way.
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	
Use of laxatives or excessive exercise	**Yes**	**No**	Pt will occasionally abuse laxatives, but not as often as she purges.
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient will regularly experience hand and leg tremors and paces to distract herself from the voices.
Panic attacks	**Yes**	**No**	Anytime pt is in a large group, she will experience a panic attack. The larger the group, the more severe the attack.
Obsessive/compulsive thoughts	**Yes**	**No**	Will regularly have OCD thoughts on a daily basis, and throughout the day.
Obsessive/compulsive behaviors	**Yes**	**No**	Pt's main behaviors are focusing on numbers. Specifically, "I have to do things an odd number of times. I can't do something just twice, it must be once or three times."

Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Her anxiety leads her to always try to avoid situations that will cause anxiety. She will especially look to avoid large groups anytime possible.
Rating Scale			
How would you rate your depression on a scale of 1-10?			6
How would you rate your anxiety on a scale of 1-10?			7
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	
School	**Yes**	**No**	
Family	**Yes**	**No**	Patient's aunt and her 3YO cousin are moving out of her mother's house. "I know it's because of me and she doesn't want her daughter around me anymore."
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**

2017 or 2018	The Pavilion	Outpatient	Suicide attempt	**No improvement** **Some improvement** **Significant improvement**
Patient does not recall any of the exact dates. She just says, "over the years I was admitted many times."	Patient has spent significant time across multiple psychiatric facilities in the area.	Inpatient AND Outpatient	Self-harm episodes as well as prior suicide attempts.	**Some visits resulted in significant improvement and some visits were not beneficial at all.**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Mother	**62**	**Parent**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain:

Denies any and all substance use.

Children (age and gender): Denies having any children

Who are children with now? NA

Household dysfunction, including separation/divorce/death/incarceration:

<table>
<tr><td colspan="3">Patient is currently dating a married woman.</td></tr>
<tr><td colspan="3">Current relationship problems: Yes, emotional abuse. Girlfriend refuses to leave her spouse.

Number of marriages: None</td></tr>
<tr><td>Sexual Orientation:
“Pansexual”</td><td>Is client sexually active?
Yes No</td><td>Does client practice safe sex?
Denies sexual activity</td></tr>
<tr><td colspan="3">Please describe your religious values, beliefs, spirituality and/or preference:
Pt. Denies</td></tr>
<tr><td colspan="3">Ethnic/cultural factors/traditions/current activity:

Describe: Pt Denies</td></tr>
<tr><td colspan="3">Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):
Mom took her to court for guardianship.</td></tr>
<tr><td colspan="3">How can your family/support system participate in your treatment and care?
Girlfriend could be more supportive of her condition.</td></tr>
<tr><td colspan="3">Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe): Was raised by her aunt</td></tr>
<tr><td colspan="3">Significant childhood issues impacting current illness:
“When my sexually abusive half-brother moved out when I was 12, that was when I started cutting. Cutting releases the pain.”</td></tr>
<tr><td colspan="3">Atmosphere of childhood home:

Loving
Comfortable
Chaotic
Abusive
Supportive
Distant: “My mother was always very emotionally unavailable.”</td></tr>
<tr><td colspan="3">Self-Care:

Independent
Assisted
Total Care</td></tr>
<tr><td colspan="3">Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient is unsure</td></tr>
</table>

History of Substance Use: None
Education History: **Grade school** **High school** **College** **Other:** Some college "I graduated high school then started college because I wanted to become a social worker. I had to put that on hold though."
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Was bullied often in school because of her weight
Discharge
Client goals for treatment: "I just want to continue to be safe, stop cutting, and get the voices under control."
Where will client go when discharged? Client will be discharged to a psychiatric nursing home as soon as a suitable one is found.

DSM-IV Diagnoses (15 points)

Axis I (Clinical Disorders):

Paranoid Schizophrenia, Anxiety Disorder, Insomnia, Bulimia Nervosa, Self-harm, Suicidal Ideation

Axis II (Personality Disorders/Mental Retardation):

None

Axis III (General Medical Condition):

Asthma, GERD, Obesity

Axis IV (Psychosocial/Environmental Problems):

Housing problems, Economic problems, problems with primary support group, problems related to social environment

Axis V (Global Assessment of Functioning):

80: Transient symptoms that are expected reactions to psychosocial stressors

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/Generic	**Haldol Decanoate/ haloperidol decanoate**	**Vivitrol/ naltrexone**	**Cymbalta/ duloxetine HCl**	**AccuNeb/ albuterol sulfate**	**Ativan/ lorazepam**
Dose	2mL	50mg	60mg	2 puffs	1mg
Frequency	Monthly	Daily	Daily	Q6h PRN	BID PRN
Route	IM	PO	PO	Inhalant	PO
Classification	Antipsychotic	Opioid antagonist	Antidepressant	Bronchodilator	Benzodiazepine
Mechanism of Action	Blocks postsynaptic dopamine receptors in the limbic system and increases brain's turnover of dopamine	Receptor blockade reverses the effect of opioids and inhibits their effects	Inhibits dopamine, serotonin, and norepinephrine reuptake to potentiate activity in the CNS. This may elevate mood and inhibit pain signals	Attaches to beta2 receptors on bronchial membranes and stimulates ATP to cAMP conversion. This decreases Ca levels and relaxes bronchial smooth-muscle cells	Potentiates effects of GABA and inhibits emotional behavior.
Therapeutic Uses	Long-term antipsychotic therapy	Treats alcohol or opioid dependence	To treat generalized anxiety disorder	To treat bronchospasms	To treat insomnia caused by anxiety
Therapeutic Range (if applicable)	NA	NA	NA	4-32 mg daily	2-4mg at bedtime
Reason Client Taking	Paranoid Schizophrenia	Unknown; Client denies	Anxiety Disorder	Asthma	Insomnia and Anxiety

		use of any substances			
Contraindications (2)	Parkinson's Disease; depression	Acute hepatitis; hepatic failure	Chronic liver disease; hyper-sensitivity to duloxetine or its components	Hypersensitivity to albuterol or its components	Premature infants; acute angle-closure glaucoma
Side Effects/Adverse Reactions (2)	Seizures; Cardiac Arrest	Suicidal ideation; hepatotoxicity	Seizures; MI	Angina; hypotension	Suicidal ideation; respiratory depression
Medication/Food Interactions	Amphetamines; alcohol	Opioid analgesics; thioridazine	Aspirin, NSAIDs, alcohol	Beta blockers; potassium-lowering drugs	Antihistamines, opioids, alcohol
Nursing Considerations (2)	Assess for fall-risk prior to administration; Avoid stopping abruptly	Give with antacids or food; never give parenteral form IV	Should not be given to pts with renal impairment; avoid stopping it abruptly	Use cautiously in patients with cardiac disorders; monitor serum potassium levels	Not recommended for pregnant women in 3rd trimester; use caution in elderly patients with compromised respiratory function

Brand/Generic	**Atarax Hydroxyzine HCl**	**Ultram/ tramadol HCl**	**Desyrel/ trazadone HCl**	**Topamax/ topiramate**	**Trileptal/ oxcarbazepine**
Dose	25mg	50mg	100mg	100mg	300mg
Frequency	BID	Q6h PRN	Nightly PRN	Nightly	BID
Route	PO	PO	PO	PO	PO
Classification	Anxiolytic	Opioid analgesic	Antidepressant	Anticonvulsant	Anticonvulsant
Mechanism of Action	Blocks histamine receptor sites on effector cells and suppresses histamine activity. Sedative actions occur	Binds with mu receptors and inhibits the reuptake of norepinephrine and serotonin and causes an analgesic effect	Blocks serotonin reuptake causing antidepressant effect. Exerts an alpha-adrenergic blocking effect that causes a	Blocks spread of seizures by reducing the length and frequency of excitatory transmission. Increases availability of GABA by	Blocks Na channels in neuronal cell membrane. This may slow nerve impulse transmission and decrease the rate at which neurons fire.

	at subcortical level of CNS and are dose related		sedative effect. Inhibits vasopressor response to norepinephrine and reduces blood pressure	blocking voltage-sensitive Na channels. This promotes movement of Cl ions into neurons.	
Therapeutic Uses	To treat anxiety; pruritis	Relieve pain	Treats major depression	Seizure treatment	Seizure treatment
Therapeutic Range (if applicable)	UNK	UNK	UNK	UNK	UNK
Reason Client Taking	Anxiety	Tailbone pain	Depression	Unknown; Client never mentioned a history of seizures	Unknown; client never mentioned a history of seizures
Contraindications (2)	Breastfeeding; early pregnancy	Children under age 12; excessive use of hypnotics or opioids	Recovering from acute MI; use within 14 days of an MAO inhibitor	Metabolic acidosis with concurrent metformin use; alcohol use within 6 hours of taking topiramate	Hypersensitivity to oxcarbazepine or its components
Side Effects/Adverse Reactions (2)	Seizures; pruritis	Seizures; suicidal ideation	Arrhythmias; hyponatremia	Bradycardia; hypotension	Suicidal ideation; Pancreatitis
Medication/Food Interactions	Some antibiotics, alcohol use	General anesthetics and alcohol use	Aspirin, NSAIDs; alcohol	Antihistamines, barbituates, alcohol use	Cyclosporine, oral contraceptives, all food, alcohol
Nursing Considerations (2)	Do not give subq or IV; observe for over-sedation	Do not give to children under 12; monitor for allergic reactions and s/s of anaphylaxis	Give shortly after meal or snack; give larger portion at bedtime if causes drowsiness	Do not stop taking this drug abruptly; monitor for bleeding events	Monitor patient's skin closely as reactions may be life-threatening; monitor closely for possible suicidal thinking

Medications Reference (APA):

2020 Nurse's drug handbook (19th ed.). (2020). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Behavior was appropriate and cooperative. Build is extremely obese. Attitude is good/optimistic. Speech was clear and pleasant. Interpersonal style was open, friendly, and talkative. Mood was pleasant. Affect was alert and attentive
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	At the time of patient's assessment/interview, she was experiencing no ideations, delusions, illusions, obsessions, compulsions, or phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was A&O x4 Thought content was clear, detailed, and expressed well.
MEMORY: **Remote:**	Patient shows no memory deficits
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Judgment, calculations, intelligence, and abstraction were all normal for age. Patient struggles with impulse control, especially when her voices tell her to harm herself.
INSIGHT:	Patient is hopeful that being in a nursing home will be extremely beneficial to controlling her condition. Her time in this facility with the staff has been useful for helping her manage voices.

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 Patient uses no assistive devices. Posture is slumped over due to excess weight. Muscle tone is non-existent. Strength is adequate to meet patient's daily needs. Motor movements are within normal limits.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400 10/29/20 (Admission)	103 bpm	120/89 mmHg	16 rpm	36.6º C	99% (RA)
1600 11/11/20 (Interview)	86 bpm	118/84 mmHg	14 rpm	36.8º C	98% (RA)

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400 10/29/20 (Admission)	Numeric	Tailbone	3/10	Dull, achy	Pt. claims she was forced into a chair when being brought in for treatment. Evaluation later determined pt had a bruised tailbone.
1800 11/11/20 (Interview)	Numeric	Tailbone	6/10	Sharp and sometimes dull	Sitting in chairs makes it worse. Rotating side she's laying on makes it better. Has taken Tylenol for pain.

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** Patient typically refuses **Lunch:** Pt consumes approx. 25% of meal **Dinner:** Pt consumes approx. 25% of meal	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** water - 480mL **Lunch:** water/Sprite – 480mL **Dinner:** water/Sprite – 480mL **Between meals:** water – 480mL

Discharge Planning (4 points)

Discharge Plans:

The patient will be transferred to an extended-stay, psychiatric nursing home from this facility. This is a mutual decision agreed upon by the patient and her mother to better care for her mental health requirements. Going forward, her health care needs include consistent adherence to a medication regimen to better control relapses as well as continuous psychiatric therapy. The patient does not have any required equipment needs. Her follow-up plan will be managed by the nursing home and the patient's therapist when a nursing home has been selected.

When considering education needs, the patient must be educated on ways to react when the voices speak to her. She should also be informed about the importance of always taking her medication as prescribed and on a consistent basis. Her mother and girlfriend could also be educated on the ways they can support her throughout her therapy.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rationale** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Self-mutilation related to history of sexual abuse as evidenced by the hundreds of scars on forearms.	The immediate concern with this patient is how she will deliberately injure herself in order to "release tension."	**1.**Treat any open or fresh wounds if they are present. **2.** Remove any contraband that pt could use to harm herself. **3.** Provide support to pt to help her resist the urge to harm herself.	**1.** Monitor pt's activity and mood changes to see if pt intends on hurting herself. **2.** Ensure that pt is unable to gain possession of anything that can be used to harm herself. **3.** Provide constant medicinal and emotional support.	**1.** Help the client to recognize when she is about to self-harm so she can get help. **2.** Encourage client to surround herself with people who are willing to listen and provide support. **3.** Be candid with pt's family and girlfriend about being available to her needs.
2. Risk for suicide related to ineffective coping skills as evidenced by history of multiple suicide attempts	The pt has low self-esteem caused by a difficult childhood that included being sexually abused and constantly bullied for her weight.	**1.** Assess pt's current status and likelihood of committing suicide. **2.** Initiate suicide observation if patient is	**1.** Use paper/plastic plates and utensils for meals and ensure all items are accounted for when pt finishes eating. **2.** When administering oral	**1.** Explore coping mechanisms to help client change method of thinking. **2.** Emphasize that help is available and give the pt

		considered suicidal. **3.** Restrict pt's access to anything that could be used as a weapon on herself.	medications, ensure they are swallowed. **3.** Provide hospital gown and restrict access to personal clothes so as to deter patient from wanting to leave the facility.	multiple numbers to call if she feels suicidal. **3.** Encourage self-esteem building activities and people to improve pt's perception of self-worth.
3. Anxiety related to exposure to uncomfortable situations as evidenced by patient's nervous tremors and pacing	Patient becomes anxious under unfavorable conditions such as new situations or crowds of large people. These situations can often induce states of panic.	**1.** Assess the level of anxiety. **2.** Provide reassurance and comfort. **3.** Speak slowly and calmly while respecting pt's personal space.	**1.** Acknowledge patient's fear and positively reinforce efforts. **2.** During attacks, do not leave client alone or tell client to "relax." Provide support when necessary. **3.** Teach relaxation techniques during nonacute episodes.	**1.** Instruct the patient to stay focused on situations they can control. **2.** Teach anxiety interrupters to use for when the client cannot avoid stressful situations. **3.** Assist in teaching realistic expectations and goals for improving condition.

Other References (APA):

Carpenito, L. (2013). *Nursing diagnosis: application to clinical practice (14th ed.).* Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Patient states she hears male voices and "I've never heard them before. They talk to me like I know them, but I don't recognize them. If I try to ignore them, they only get louder." She insists that lately they have become more persistent that she harm herself.

Nursing Diagnosis/Outcomes

1) Self-mutilation related to history of sexual abuse as evidenced by the hundreds of scars on her forearms.
***Goal for pt:** Continue to protect patient from harming herself and provide emotional support whenever necessary. Instill effective coping mechanisms prior to discharge.

2) Risk for suicide related to ineffective coping skills as evidenced by history of multiple suicide attempts.
***Goal for pt:** Continue to monitor patient for harmful or depressive behavior that could indicate the desire to commit suicide. Teach effective coping mechanisms prior to discharge.

3) Anxiety related to exposure to uncomfortable situations as evidenced by patient's nervous tremors and pacing.
***Goal for pt:** Instill understanding of techniques and coping mechanisms to avoid panic attacks when in uncomfortable, panic-inducing situations.

Objective Data

Patient's vital signs are unremarkable:
Admission vitals (10/29/20 @1400):
P: 103 BP: 120/89 RR: 16
Temp: 36.6ºC O_2: 99%

Assessment vitals (11/11/20 @1600):
P: 86 BP: 118/84 RR: 14
Temp: 36.8ºC O_2: 98%

Pt consumes about 25% of both her lunch and her dinner while usually skipping breakfast. She drinks about 1900 mL of fluid throughout the day.

Patient Information

34-year-old female presents with a psychiatric history of paranoid schizophrenia, anxiety, bulimia, self-harm, and suicidal ideation. She presented to the ED after sustaining 27 self-inflicted wounds to her arms and legs. Pt's medical history includes GERD, insomnia, asthma, and obesity. She denies any and all tobacco, alcohol, or substance use.

Nursing Interventions

1) Monitor patient's activity and mood changes to see if patient intends on hurting herself.
2) Ensure that patient is unable to gain possession of anything that can be used to harm herself.
3) Provide constant medicinal and emotional support.
4) Use paper plates and plastic utensils for meals then account for all items when patient finishes eating.
5) When administering oral medications, ensure they are swallowed.
6) Provide hospital gown and restrict access to personal clothing items in order to deter patient from leaving the facility.
7) Acknowledge patient's fears and positively reinforce efforts.
8) During anxiety attacks, do not leave client alone or tell client to "relax." Provide support whenever necessary.
9) Teach relaxation techniques during nonacute episodes.