N323 Care Plan

Lakeview College of Nursing

Lindsay Cox

Demographics (3 points)

Date of Admission 07/06/21	Patient Initials S.C.	Age 25	Gender Female
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Separated	Allergies NKA
Code Status FULL	Observation Status Every 15 minutes	Height 5'4"	Weight 161 lb

Medical History (5 Points)

Past Medical History: Hypertension (HTN), abortion (8/2020), schizoaffective disorder. The patient denies any childhood illness or infection. She denies any suicide attemps or plans of suicide.

Significant Psychiatric History: The patient admits that she has consulted a psychiatrist in the past and has been hospitalized for schizoaffective disorder. She receives outpatient treatment. The patient denies any suicide attempts or plans of suicide. She does admit to a history of self-harm. The patient denies any other past surgeries or upcoming surgeries. The patient denies surgery dental procedure, but states that they have a dentist appointment in the near future.

Family History: The patient denies any family history of psychiatric problems. The patient denies any family history of suicide.

Social History (tobacco/alcohol/drugs): The patient smokes 0.5 packs of cigarettes per day. She denies any drug or alcohol use, but it has been noted in her chart that she has used meth in the past and drinks 1-2 alcoholic beverages per week.

Living Situation: The patient states that they currently" live alone in an apartment in Vienna, Il."

Strengths: The patient states that sertraline and group therapy "really help her." She states that she can adequately verbalize her feelings, is very motivated to learn coping skills, and proactive in her treatment.

Support System: The patient states that she has a great support system within her family. She states that they try to “understand her feelings” and are “good listeners.”

Admission Assessment

Chief Complaint (2 points): "I have been hearing voices that tell me to hurt myself."

The patient is a 25-year-old female who was at an appointment with her therapist when she admitted to having auditory hallucinations commanding her to hurt herself. She also admitted to being paranoid that people are watching her. The patient denies history of any abuse, but her chart states that she has history of sexual and emotional abuse. Upon admittance, the patient admitted to feeling “hopelessness and very stressed.” She also described her moods as riding a “rollercoaster.” The patient states that her last manic episode was one month ago. She has admitted to an increase in appetite and overeating at least 3 times per week. The patient states that she feels “anxious all the time.” Despite her auditory hallucinations, the patient denies any current intention or plans of self-harm. The patient also denies any past history of suicide attempts.

Contributing Factors (10 points):

Factors that lead to admission: The patient states that she has been dealing with going through a divorce and difficulty finding a job.

History of suicide attempts: The patient denies any suicide attempts.

Primary Diagnosis on Admission (2 points): Major Depressive Disorder (MDD)

Secondary Diagnosis: Schizoaffective disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse: The patient denies any history of witnessing of trauma or abuse, but her chart states that she was emotionally abused by her ex-boyfriend and sexual abused by friends.**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**No**	**N/A**	**N/A**	**N/A**
Sexual Abuse	**No**	**N/A**	**N/A**	**The patient denies any sexual abuse, but her chart states that she was sexual abused by her friends.**
Emotional Abuse	**No**	**N/A**	**N/A**	**The patient denies any emotional abuse, but her chart states that**

				she was emotionally abused by her ex-boyfriend.
Neglect	**No**	**N/A**	**N/A**	**N/A**
Exploitation	**No**	**N/A**	**N/A**	**N/A**
Crime	**A ticket for marijuana.**	**N/A**	**N/A**	**The patient states that she got a ticket in Kansas for having marijuana.**
Military	**No**	**N/A**	**N/A**	**N/A**
Natural Disaster	**No**	**N/A**	**N/A**	**N/A**
Loss	**No**	**N/A**	**N/A**	**N/A**
Other	**No**	**N/A**	**N/A**	**N/A**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	**Patient admits to feeling depressed and hopeless when she first arrived, she now denies any current depression and states that their medication has helped.**	
Loss of energy or interest in activities/	**Yes**	**No**	**Patient denies any loss of energy,**	

school			**stating that she has been trying to exercise because she “heard it was good for mental health.”**
Deterioration in hygiene and/or grooming	**Yes**	**No**	**The patient denies any deterioration in hygiene or grooming, but her hair appears unwashed.**
Social withdrawal or isolation	**Yes**	**No**	**The patient states that she "likes to be around family" but usually needs to be alone "3 or 4 times a day for about 2 hours each to recharge."**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**The patient states that she is having difficulty finding and keeping a job due to her anxiety. She says that she usually worries about this "once a day every day for about 15 minutes," before she makes herself focus on something else. The patient states that she also have difficulty with relationships because she “doesn’t socialize” due to her social anxiety.**

Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	**Yes**	**No**	**The patient states that she gets 4 hours of sleep at least twice a week, and the other five days, she gets about 8 hours of sleep.**
Difficulty falling asleep	**Yes**	**No**	**She says that those two days a week, it is hard for her to fall asleep or wake up and can't fall back asleep. She states that it usually takes her "3 hours to fall back asleep or until the sun comes up."**
Frequently awakening during night	**Yes**	**No**	**The patient admits to occasionally waking up once during the night and being unable to fall back asleep, but denies waking up frequently during the night.**
Early morning awakenings	**Yes**	**No**	**The patient states that she likes to wake up around "7 or 8 in the morning during the weekdays."**
Nightmares/dreams	**Yes**	**No**	**The patient states that she "dreams every night, but only has a nightmare once every two**

			weeks." She rates the intensity "a four or a five."
Other	**Yes**	**No**	**N/A**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**The patient states that she stress eats about three times a week for the past six months, but her stress eating is "only an extra piece of cookie or pizza." But the patient does admit to eating entire servings of family meals at least once a week.**
Binge eating and/or purging	**Yes**	**No**	**The patient admits to feeling guilty about overeating those four days a week but denies any purging. She states that the guilt only lasts about 5 minutes after she has eaten, and the intensity of the shame rates a four.**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**The patient states that she has experienced weight gain in the last six months, due to overeating. The patient is unable to determine how**

			much weight she has gained in the last six months.
Use of laxatives or excessive exercise	**Yes**	**No**	**The patient denies any use of laxatives or excessive exercise.**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**The patient states that she just noticed hand tremors this morning after a nurse pointed it out while receiving medications. She says that she thinks it is due to her medication. She states that the feeling of the shaking is zero because she doesn't notice it until she holds her hand out.**
Panic attacks	**Yes**	**No**	**The patient admits to having panic attacks in the past, but states that she hasn't had a panic attack in over a year.**
Obsessive/ compulsive thoughts	**Yes**	**No**	**The patient denies any obsessive/compulsive thoughts.**
Obsessive/ compulsive behaviors	**Yes**	**No**	**The patient denies any obsessive/compulsive behaviors, but does admit to adhering to a**

			routine.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**The patient states that anxiety impacts everything that she does and makes it harder to do daily tasks. She says that it happens every day and at least three times a day for about an hour each before she forces herself to move on.**
Rating Scale			
How would you rate your depression on a scale of 1-10?		**2**	
How would you rate your anxiety on a scale of 1-10?		**5**	
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**	**The patient states that she worries at least once a day about finding a job to support herself. Right now, she says that her family supports her financially. She rates the intensity of her worry a five and states it occurs at least once a day for about an hour.**
School	**Yes**	**No**	**N/A**
Family	**Yes**	**No**	**The patient states that her family**

			is very supportive.
Legal	**Yes**	**No**	**The patient states that she is worried about paying the ticket they received for marijuana when she was driving through Kansas on her way home from Colorado. She rates the worry a five on intensity and states that she worries about it once each day for about 15 minutes.**
Social	**Yes**	**No**	**But she states that the reason for this is that she doesn't socialize.**
Financial	**Yes**	**No**	**The patient states that she is worried about paying the ticket they received for marijuana when she was driving through Kansas on her way home from Colorado. She rates the worry a five on intensity and states that she worries about it once each day for about 15 minutes. She also worries about having enough money to support herself. Right now, she says that**

			her family supports her financially. She rates the intensity of her worry a five and states it occurs at least once a day for about an hour.
Other	**Yes**	**No**	**N/A**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/ MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
August 2020-present	**Inpatient Outpatient Other:**	**The patient is an outpatient receiving treatment for her mental heath and meets with a counselor once a week.**	**Mental health counseling due to schizoaffective disorder**	**No improvement Some improvement Significant improvement The patient states that talking to someone about her illness has improved her mental well being.**
June 2021	**Inpatient Outpatient**	**Once a month the patient**	**Mental health and**	**No improvement Some**

	Other:	**meets with a psychiatrists to discuss the status of her mental health and make sure that she is taking her medications.**	**medication management**	**improvement** **Significant improvement** **The patient states that the medication has greatly improved her mental wellbeing.**
2019	**Inpatient** **Outpatient** **Other:**	**She was an inpatient for 3 days where she was diagnosed with schizoaffective disorder.**	**Schizoaffective disorder**	**No improvement** **Some improvement** **Significant improvement** **The patient states that the inpatient treatment offered some improvement because it made her aware that she had a mental illness.**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**

N/A	**N/A**	**N/A**	**Yes**	**No**

If yes to any substance use, explain: N/A

Children (age and gender): The patient has a 2-year-old daughter.

Who are children with now? The daughter lives with her father.

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

The patient states that she has been separated for five years and can't bring herself to go through with the divorce.

Current relationship problems: "I don't want to be in a relationship right now."

Number of marriages: The patient has only been married the one time.

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Bisexual	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

The patient states that they "have no religious preference" and that they are "agnostic."

Ethnic/cultural factors/traditions/current activity: None.

Describe: N/A

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient got a ticket in Kansas for having marijuana in her car while driving on her way home from Colorado. She states that she starts a diversion program on August 8 to keep it from going on her record.

How can your family/support system participate in your treatment and care? "They do a lot. They are great at listening and are supportive."

Client raised by:

Natural parents (Patient stated she was raised by both of her biological parents until her parents divorced when she was in the 7th grade)

Grandparents

Adoptive parents **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: The patient denies any childhood illness or infection. She states that her parent's divorce was hard on her but denies the divorce affecting her current condition.
Atmosphere of childhood home: **Loving** (Patient states that her childhood home was very loving and supportive) **Comfortable** **Chaotic** **Abusive** **Supportive** (Patient states that her childhood home was very loving and supportive) **Other:**
Self-Care: **Independent** (the patient states that she is independent in her self-care routine) **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) The patient denies any family history of mental illness or suicide.
History of Substance Use: Patient denies any substance abuse, but meth and alcohol have been noted in her chart.
Education History: **Grade school** **High school** (Patient stated that she graduated high school and that she always felt uncomfortable at school because she was always the oldest of her classmates due to being held back in the first grade) **College** **Other:**
Reading Skills: **Yes** (patient states that she enjoys reading) **No** **Limited**

Primary Language: English, patient denies being fluent in any other language.
Problems in school: The patient denies any difficulties during school with the exception of feeling uncomfortable that she was always the oldest of her classmates.
Discharge
Client goals for treatment: The patient states that her goals for treatment are "to stay on her medications, learn to identify her triggers, and how to cope with stress."
Where will client go when discharged? "Back to my apartment in Vienna."

Outpatient Resources (15 points)

Resource	Rationale
1. National Suicide Prevention Lifeline 1-800-273-8255.	**1. Even though the patient denies any suicide attempts or any plans to commit suicide, but she does admit to voices telling her to harm herself. I feel like this hotline is a beneficial resource for her to call if the voices end up being too much.**
2. Crisis Text Line Text "home" to 741741	**2. If talking isn't an option for the patient, she is able to text this hotline where crisis counselors are available around the clock support. These texts are confidential and free, meaning that the patient won't have to worry about it showing up on her bill or**

	how to pay for it.
3. National Alliance on Mental Illness (NAMI) 1-800-950-6264	**3. The National Alliance on Mental Illness can provide the patient with more information on her disorder and help her find support and resources.**

References:

National Suicide Prevention Lifeline. (n.d.). *Home*. Retrieved July 4, 2021, from https://suicidepreventionlifeline.org

Schizoaffective Disorder. NAMI. (2021). https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizoaffective-Disorder/Support.

Text Us. Crisis Text Line. (2020, April 10). https://www.crisistextline.org/text-us/.

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

Brand/Generic	**Vistaril/ hydrOXYzine pamoate**	**Seroquel/ QUEtiapine**	**Zoloft/ sertraline**	**Desyrel/ traZODone**	
Dose	**50mg capsule**	**200mg tablet**	**100mg tablet**	**50mg**	
Frequency	**TID**	**HS**	**AM**	**HS**	

Route	**PO**	**PO**	**PO**	**PO**	
Classification	**Anxiolytic**	**Antipsychotic**	**SSRI**	**Antidepressant**	
Mechanism of Action	**Sedative actions occur at subcortical level of CNS and are dose related.**	**May produce antipsychotic effects by interfering with dopamine binding to dopamine type 2 (D2)-receptor sites in the brain and antagonizing serotonin 5-HT2, dopamine type 1 (D1), histamine H1, and adrenergic alpha1 and alpha2 receptors.**	**Inhibits reuptake of the neurotransmitter serotonin by CNS neurons and increases serotonin available in nerve synapses. This effect can elevate mood and decrease symptoms of depression.**	**Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect.**	
Therapeutic Uses	**To relieve anxiety associated with psychoneurosis.**	**To treat schizophrenia.**	**To treat major depression.**	**To treat major depression.**	
Therapeutic Range (if applicable)	**50-100mg**	**150-750mg**	**500- 200mg**	**25-100mg**	
Reason Client Taking	**Anxiety**	**Mood stabilizer**	**MDD**	**Insomnia**	
Contraindications (2)	**Early pregnancy; prolonged QT interval.**	**Hypersensitivity to quetiapine or its components.**	**Hypersentitivity; use withing 14 days of MAO inhibitor.**	**Hypersensitivity; recovery from acute MI.**	
Side Effects/Adverse Reactions (2)	**Dry mouth; torsades de pointes.**	**Hypothermia; hyponatremia.**	**Serotonin syndrome; rhabdomyolysis.**	**CVA; hemolytic anemia.**	

Medication/ Food Interactions	**Interactions with quetiapine increase the risk of QT prolongation.**	**Interactions with levodopa can antagonize the effects of these drugs. Alcohol can enhance CNS depression.**	**NSAIDS increases bleeding risk; St. John's wort increases the risk of potentially fatal serotonin syndrome.**	**NSAIDS increases bleeding risk; alcohol use increases CNS depression, risk of hypotension, and respiratory depression.**	
Nursing Considerations (2)	**LOOK-ALIKE/ SOUND-ALIKE; do not give IV route because tissue necrosis may occur.**	**LOOK-ALIKE/ SOUND-ALIKE; monitor the patient for tardive dyskinesia.**	**Monitor the patient closely for serotonin syndrome. Monitor for suicidal tendencies.**	**LOOK-ALIKE/ SOUND-ALIKE; Be aware that trazadone therapy may increase the risk of priapism.**	

Medications Reference (1) (APA):

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Patient appears her age. She is compliant and well mannered. She appears a little disheveled. She appears the appropriate weight and height for her age. She appears to be dressed comfortably. Her hair seems a little unkempt, but no odor is present. Her attitude is pleseant and friendly, but appears to be distracted. Her speech is quiet, but clear. Her mood remained calm the entire time. Her affect seemed appropriate to her situation.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**The patient admits to auditory hallucinations that urge her to harm herself and say other "not so nice things." Patient denies any delusions and fully aware that she is having hallucinations. She also admits to being paranoid that people are watching her. The patient denies any obsession or compulsive behaviors. The patient denies having phobias, but admits to social anxiety. Although she has hallucinations of self-harm, the patient denies any suicidal intentions or plans, agreeing to remain safe. She did not express any delusional content.**
ORIENTATION: **Sensorium:** **Thought Content:**	**The patient is oriented to person, place, and time. Her sensorium is distracted. She tried to answer questions to the best of her ability, but would often get forget to question mid-answer. Her level of consciousness is normal, alert.**
MEMORY: **Remote:**	**The patient's memory seems average for recent events of the last few hours and days. She was able to tell me what she ate for lunch. The patient's remote memory appears average as she was able to tell me about her separation five years ago. The patient's attention and concentration was distracted. There was no acute LOC, but possibly some disorganized thinking.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**The patient's current judgement appears good. She is very focused and motivated on her recovery. She is able to think realistically about her decisions. Her impulse control seems fair at the moment, but may be altered due to her MDD and schizoaffective disorder. The patient tried to be attentive, but appeared to have difficulty concentrating.**

INSIGHT:	**The patient was adequately insightful, she recognizes that she has a mental illness. She is intellectually and emotionally aware of her situation. She is extremely hopeful in the effectiveness of her medication and eager to apply lessons learned in group to improve.**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**The patient denies any use of assistive devices and can perform ADL independently. She is up ad lib. She does not require any equipment or assistance to stand or walk. The patient was able to demonstrate active range of motion bilaterally throughout. The patient has a low fall risk score. The patient states that she has been experiencing lower back pain while we have been talking, but states that it does not affect her ability to move. She is able to adequately maintain her balance without assistance. She ambulates the halls and rooms independently. She states she "likes to walk" and appears to tolerate it well without any difficulty breathing. No cueing or set up assistance was needed for this patient. Her general motor response was adequate. The patient displayed equally strong hand grip and ankle strength, 2+ bilaterally.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1600	**78**	**111/70**	**18**	**98.0**	**100%**
1800	**89**	**130/71**	**18**	**98.1**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	**0-10**	**N/A**	**0, no pain**	**N/A**	**N/A**

1800	**0-10**	**Lower back**	**4, mild pain**	**Stiff, throbbing**	**Stretches**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 100%** **Lunch: 100%** **Dinner: Dinner had not been served yet.**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 240 mL** **Lunch: 480 mL** **Dinner: N/A**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

1. **Reduce suicidal ideation.**
2. **Maintain mood stability.**
3. **Continue outpatient counseling once a week to continue to develop and maintain effective coping mechanisms.**
4. **Adhere to prescribed medications.**
5. **Continue meeting with psychiatrist once a month.**
6. **Equip patient with resources such as crisis hotlines, texting support services, and suicide hotlines. Educate the patient on reaching out when feeling stressed, hopeless, or like things are too much.**

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	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. **Disturbed sensory perception related to psychologic stress as evidenced by auditory hallucinations commanding her to harm herself.**	**I chose this diagnosis for this particular patient because due to S.C's disturbed sensory perception, she feared the voices commanding her to hurt herself.**	**1. Monitor client every 15 minutes.** **2. Make sure that the patient's environment is safe and ensure that she cannot harm herself.** **3. Manage medications as ordered.**	**1. Encourage patient to identify when the hallucinations are more prevalent and help them to decrease the possibility of anxiety that can trigger the hallucination.** **2. Encourage the patient to continue to go to group therapy and apply the skills learned there.** **3. Encourage the patient to directly confront the voices that they hear and tell them to "go away."**	**1. Educate patient on coping skills.** **2. Encourage patient to demonstrate newly learned coping skills.** **3. Encourage the family members to help identify potential triggers and apply coping skills.**
1. **Impaired social interactions related to**	**I chose this nursing diagnosis for this patient**	**1. Keep client in an environment free of**	**1. Encourage the patient to join in group discussions.**	**1. Have a group session where conversational**

feeling threatened in social situations as evidenced by self isolation.	**because I believe due to her impaired social interactions, that she is further isolating herself from others and opening herself up to listen to the auditory voices.**	**stressful stimuli.** **2. Avoid touching the client.** **3. Structure activities that work at the client's pace.**	2. **Encourage the patient to practice socialization skills and work to overcome her fears.** **3. Discuss how stepping out of her comfort zone makes her feel.**	**skills are practiced.** **2.Provide opportunities for the client to learn adaptive socializing skills.** **3. Encourage her family to give acknowledgement and recognition for positive steps the patient takes in increasing social skills.**
1. Risk for self-directed violence related to hopelessness as evidenced by auditory hallucinations.	**I chose this nursing diagnosis for this patient because I believe due to her auditory hallucinations that she may be at risk for self-harm. Although the patient denies any intention of self-harm, she did admit to suicidal ideation prior to admission.**	**1. Encourage client to express their feelings.** **2. Contact the family and arrange for crisis counseling.** **3. Implement a no-suicide contract.**	**1. Ensure a safe environment for the patient.** **2. Encourage group therapy.** **3. Schedule one-on-one counseling with the psychiatrist.**	**1. Encourage positive self-talk.** **2. Encourage patient to directly dismiss the voices that she hears outloud.** **3. Educate family on how they can be supportive when the patient is experiencing auditory hallucinations.**

Other References (APA):

Concept Map (20 Points):

Subjective Data
-Patient admits to auditory hallucinations
-Patient denies any suicide attempts or plans to carry out suicide.
-The client admits to overeating and difficulty sleeping 3 days out of the week.

Nursing Diagnosis/Outcomes

1. Disturbed sensory perception related to psychologic stress as evidenced by auditory hallucinations commanding her to harm herself.
   Outcome: Patient will demonstrate techniques to distract her from the voices. Goal is still ongoing.
2. Impaired social interactions related to feeling threatened in social situations as evidenced by self isolation.
   Outcome: Patient will discuss alternative ways to cope when feeling the need to withdraw. Goal is still ongoing.
3. Risk for self-directed violence related to hopelessness as evidenced by auditory hallucinations.
   Outcome: Patient will not inflict harm on herself or others. Goal is still ongoing.

Objective Data
-Patient was calm throughout the interview.
-Patient maintained appropriate eye contact.
-Patient attended every group therapy session.

Patient Information

S.C is a 25-year-old female admitted for auditory hallucinations commanding her to harm herself.

Nursing Interventions

1. Encourage patient to identify when the hallucinations are more prevalent and help them to decrease the possibility of anxiety that can trigger the hallucination.
2. Encourage the patient to join in group discussions.
3. Provide opportunities for the client to learn adaptive socializing skills.
4. Continue to assess for risk of self-harm.