N323 Care Plan

Lakeview College of Nursing

Name

Shivani Patel

Demographics (3 points)

Date of Admission **3/18/2022**	**Patient Initials** **S.C.**	**Age** **33**	**Gender** **Male**
Race/Ethnicity **Caucasian**	**Occupation** **Unemployed**	**Marital Status** **Single**	**Allergies** **Latuda, latex, aspirin, coconut**
Code Status **Full code**	**Observation Status** **1:1**	**Height** **6 ft**	**Weight** **195 lbs**

Medical History (5 Points)

Past Medical History: Patient had a leg fracture and has a right boot. The patient has a history of cholecystectomy and hepatitis.

Significant Psychiatric History: History of previous psychiatric hospitalizations, history of a suicidal attempt by cutting himself, and history of substance abuse.

Family History: His brother died from committing suicide in 2021

Social History (tobacco/alcohol/drugs):

Drugs- meth, marijuana, and heroin. How often the patient uses it is not specified

Alcohol- not using

Tobacco- not using

Living Situation: The patient is homeless and living in a hotel

Strengths: Cooperative, good physical health

Support System: Mother- good relationship/talks on the phone regularly

Admission Assessment

Chief Complaint (2 points): Suicidal ideations and auditory hallucinations. "I am having suicidal thoughts".

Contributing Factors (10 points): The patient has been homeless and has been living in a hotel. He hears voices that tell him to kill himself. He has had paranoid thoughts about people laughing and talking about him. There is no strong support system beside his mom who lives in Florida. He has experienced physical abuse and has witnessed domestic violence in the past, which has played a negative role on his mental health. The patient states he has been experiencing anxiety and depression since the age of 13.

Factors that lead to admission: The patient felt hopeless, helpless, and depressed. He has also been experiencing substance abuse.

History of suicide attempts: He has had a history of one suicide attempt at the age of 13. He tried to commit suicide by cutting himself in 2002.

Primary Diagnosis on Admission (2 points): bipolar disorder, most recent episode depressed, severe with psychotic features, generalized anxiety disorder, and borderline personality disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Yes lifetime experience of trauma **Witness of trauma/abuse: Yes**				
	Current	**Past (what**	**Secondary**	**Describe**

		age)	**Trauma (response that comes from caring for another person with trauma)**	
Physical Abuse	**Yes**	**13 years old**	**N/A**	**The patient was physically abused by men more than once.**
Sexual Abuse	**Yes**	**24 years old**	**N/A**	**The patient was sexually abused twice in 2013 by a homosexual man.**
Emotional Abuse	**Yes**	**13 years old/32 years old**	**N/A**	**The patient was bullied at school and had issues with low self-esteem. The patient was sometimes left alone as a child**

				which caused emotional distress due to having more responsibility. The patient also witnessed a woman getting killed in 2021.
Neglect	**No**	**N/A**	**N/A**	**N/A**
Exploitation	**No**	**N/A**	**N/A**	**N/A**
Crime	**Yes**	**13 years old**	**N/A**	**The patient went to juvenile detention at 13 years old. The reason is not specified.**
Military	**No**	**N/A**	**N/A**	**N/A**
Natural Disaster	**No**	**N/A**	**N/A**	**N/A**
Loss	**Yes**	**32 years old**	**N/A**	**The patient lost**

				his brother who died by committing suicide in 2021.
Other	**Yes**	**13 years old**	**N/A**	**Domestic violence against mom.**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	**The patient is constantly feeling depressed. He experiences moderate depression. This has been an ongoing problem since he was 13. The sudden loss of his brother and being homeless has triggered it even more.**	
Loss of energy or interest in activities/school	**Yes**	**No**	**He feels a loss of energy about half the time on most days. The loss of energy isn't as severe to the point where he is always in bed. The patient dropped out of**	

			college after sophomore year due to his loss of interest, but still wishes to finish it in the future. His loss of interest started after 2nd year of college.
Deterioration in hygiene and/or grooming	**Yes**	**No**	
Social withdrawal or isolation	**Yes**	**No**	**The patient has socially isolated himself from others, and it has become worse since being homeless and depressed. He experiences this most of the time. He fears he will be judged by others and seems to have difficulty connecting with others. This has started at the age of 13.**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**The patient is currently homeless. He is living in a hotel and finds it difficult living without a home. He became**

			homeless a while after he left college.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**It is harder for the patient to fall asleep some days. There are days when he gets enough sleep. This has started ever since he has been homeless.**
Difficulty falling asleep	**Yes**	**No**	**The patient has difficulty falling asleep some days. This is started ever since he has been homeless and more depressed.**
Frequently awakening during night	**Yes**	**No**	**The patient wakes up frequently in the middle of the night. The inconsistent sleep patterns have occurred ever since he has been homeless.**
Early morning awakenings	**Yes**	**No**	**The patient tends to wake up early in the mornings at the crack of dawn ever since he has been homeless and admitted to**

			the pavilion.
Nightmares/dreams	**Yes**	**No**	**The patient does get nightmares/dreams a couple of times a week. This has been occurring ever since he was young.**
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**	
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	
Use of laxatives or excessive exercise	**Yes**	**No**	
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**The patient has an anxiety disorder. The patient has been**

			experiencing pacing since he was young. The patient states that his anxiety has gotten worse ever since he has been homeless.
Panic attacks	**Yes**	**No**	
Obsessive/ compulsive thoughts	**Yes**	**No**	
Obsessive/ compulsive behaviors	**Yes**	**No**	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**The patient's anxiety has caused him to lose interest and become overwhelmed. His interactions with people have decreased more ever since. He has become homeless and does not have a job to fulfill his needs.**
Rating Scale			
How would you rate your depression on a scale of 1-10?	**7**		
How would you rate your anxiety on a	**7**		

scale of 1-10?			
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 currently does not have a job. The patient previously worked at JP Morgan and was an Uber driver in Chicago. The patient experienced stress and anxiety from his previous jobs. The patient had been experiencing stress and anxiety from work very frequently.**
School	**Yes**	**No**	**The patient had to drop out after 2nd year of college. He had taken loans that he needs to pay off. He had been experiencing stress and anxiety that affected school. He lost interest in attending school and completing activities.**

Family	**Yes**	**No**	**The patient's depression is associated with the patient's family in many ways. The patient's brother died by committing suicide in 2021. He also was a part of domestic violence against his mom when he was 13.**
Legal	**Yes**	**No**	**The patient went to juvenile detention for domestic violence against his mom at the age of 13.**
Social	**Yes**	**No**	**The patient states that he has socially isolated himself since the age of 18. He feels that he will be judged by others and feels like he has difficulty connecting with others.**
Financial	**Yes**	**No**	**The patient states that he has had financial issues. He states being homeless and living in a**

			hotel. He currently has to pay off his school loans. He does not have any source of income because he had quit his job. Ever since he dropped out after his second year of college he has been financially unstable.
Other	**Yes**	**No**	**The patient states that the events that have occurred in his life and experiencing loneliness have led him to have suicidal thoughts. Taking drugs has also played a major role in this. He wishes to go to an outpatient rehab program.**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
Approximately 2 years ago, the patient went to an outpatient rehab program in Chicago	**Inpatient Outpatient Other:**	**Outpatient**	**Substance use: Drugs- Marijuana**	**No improvement Some improvement Significant**

			, meth, **and heroin**	**improvement**
N/A	**Inpatient** **Outpatient** **Other: N/A**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement** **N/A**
N/A	**Inpatient** **Outpatient** **Other: N/A**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement** **N/A**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Alone	**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: The patient uses meth, marijuana, and heroin		
Children (age and gender): The patient does not have any children. **Who are children with now? N/A**		
Household dysfunction, including separation/divorce/death/incarceration: Single and living alone. The patient's brother died from suicide last year and his mom is living in Florida.		
Current relationship problems: The patient is single and is not interested in marriage **Number of marriages: 0**		
Sexual Orientation: Homosexual	**Is client sexually active?** **Yes No**	**Does client practice safe sex?** **Yes No**
Please describe your religious values, beliefs, spirituality and/or preference: N/A		
Ethnic/cultural factors/traditions/current activity: N/A **Describe: N/A**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient was charged for domestic violence against his mom. This led him to go to juvenile detention for a couple of weeks at the age of 13.		
How can your family/support system participate in your treatment and care? **Mother is supportive of treatment. The patient calls his mother every day and has a good relationship with her currently.**		
Client raised by: **Natural parents**		

Grandparents **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Physical abuse at a young age and sexual abuse. The patient has experienced emotional abuse after witnessing a woman getting killed and his brother committing suicide. He went to juvenile detention for domestic violence at a young age.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.): Unknown
History of Substance Use: Patient has a history of drugs like meth, marijuana, and heroin.
Education History: **Grade school** **High school**

College- City College of Chicago- up to 2nd year **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Bullying and low self-esteem
Discharge
Client goals for treatment: Improve mental state and reducing thoughts of suicide. The patient also wants to stay sober considering his experience of substance abuse.
Where will client go when discharged? Outpatient rehab program

Outpatient Resources (15 points)

Resource	Rationale
1. Suicide prevention hotline	**1. The patient can call this hotline if they are having thoughts of suicide.**
2. SAMHSA national helpline	**2. The patient can call this helpline for substance abuse. They are open 24/7 and offer treatment referrals and information**

	about mental/substance use disorders.
3. Rosecrance in Champaign, Danville, and Vermillion counties	**3. Rosecrance is a substance abuse rehab center. The patient can call this treatment center if they are experiencing abuse with meth, marijuana, and heroin.**

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

Brand/Generic	**Vistaril/ Hydroxyzine**	**Abilify/ Aripiprazole**	**Buspar/ Buspirone**	**Clonidine/ Catapres**	**N/A**
Dose	**50 mg**	**15 mg**	**20 mg**	**0.2 mg**	**N/A**
Frequency	**1 tablet TID**	**1 tablet morning**	**1 tablet BID**	**1 tablet TID**	**N/A**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**N/A**

Classification	**Pharmacological class: Piperazine derivative Therapeutic class: Anxiolytic, Antiemetic, antihistamine, sedative-hypnotic**	**Pharmacologic class: Atypical antipsychotic Therapeutic class: Antipsychotic**	**Pharmacologic class: Azaspirone Therapeutic class: Anxiolytic**	**Pharmacologic class: Centrally acting alpha agonist Therapeutic class: Analgesic, antihypertensive, behavior modifier"**	**N/A**
Mechanism of Action	**It competes with histamine for histamine 1 receptor sites on surfaces of effector cells. This suppresses results of histaminic activity, including edema, flare, and pruritus. Sedative actions occur at the subcortical level of the CNS and are dose-related.**	**It may produce antipsychotic effects through partial agonist and antagonist actions. Aripiprazole acts as a partial agonist at dopamine receptors and serotonin receptors. The drug acts as an antagonist at 5-HT2A serotonin receptor sites.**	**It may act as a partial agonist at serotonin 5-hydroxytryptamine receptors in the brain, producing antianxiety effects.**	**Stimulates peripheral alpha-adrenergic receptors in the CNS to produce transient vasoconstriction and then stimulates central alpha-adrenergic receptors in the brain stem to reduce heart rate, peripheral vascular resistance, heart rate, and systolic and diastolic blood pressure.**	**N/A**

				Although alpha2 adrenergic receptors in the brain are stimulated, the precise action that calms children with ADHD is unknown. May produce analgesia by preventing transmission of pain signals to the brain at presynaptic and postjunctional alpha2-adrenoreceptors in the spinal cord.	
Therapeutic Uses	**It is used to relieve anxiety**	**To treat acute manic and mixed episodes in bipolar I disorder with or without psychotic features; to maintain stability in patients with bipolar I**	**To manage anxiety**	**Decrease anxiety attacks and psychiatric symptoms**	**N/A**

		disorder; as an adjunct with lithium or valproate in patients with bipolar I disorder			
Therapeutic Range (if applicable)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**The patient is taking this medication because of his anxiety disorder.**	**The patient is taking this medication for bipolar disorder.**	**Manages the patients' symptoms of anxiety**	**Helps to manage anxiety attacks and other psychiatric symptoms**	**N/A**
Contraindications (2)	**-Early pregnancy -Hypersensitivity to cetirizine, hydroxyzine, levocetirizine or their components -Prolonged QT interval**	**-Hypersensitivity to aripiprazole or its components and patients with diabetes -Abdominal gait and blurred vision**	**-Hypersensitivity to buspirone or its components -Severe hepatic or renal impairment**	**-Anticoagulant therapy (epidural infusion); bleeding diathesis; (epidural infusion) -Hypersensitivity to clonidine or its components, including adhesive used in transdermal patch;**	**N/A**

				injection-site infection	
Side Effects/Adverse Reactions (2)	**-Drowsiness -Hallucinations**	**-Confusion -Arrhythmias**	**-Nasal congestion -Chest pain**	**-Nervousness -Constipation**	**N/A**
Medication/Food Interactions	**Erythromycin and alcohol**	**Lorazepam and grapefruit juice**	**Oxymetazoline and grapefruit juice**	**Fluphenazine and hawthorn**	**N/A**
Nursing Considerations (2)	**-Don't give hydroxyzine by subcutaneous or I.V. route because tissue necrosis may occur. -Inject I.M. forms deep into a large muscle, using Z-track method.**	**-Know that aripiprazole shouldn't be used to treat dementia-related psychosis in the elderly an increased risk of death. -Use cautiously in the elderly patients because of increased risk of serious adverse cerebrovascular effects, such as stroke and transient ischemic attack.**	**-Know that butorphanol should be used cautiously, if at all, in patients with depression, suicidal tendency, history of drug abuse, or hepatic or renal dysfunction. -Use it cautiously, if at all, in patients with head injury because drug can raise CSF pressure. Because it can increase cardiac workload, use with extreme caution in patients with**	**-Be aware that clonidine should not be used in most patients with severe cardiovascular disease or in those who are not hemodynamically stable because of the potential for severe hypotension. -Use clonidine cautiously in elderly patients, who may be more sensitive to its hypotensive effect.**	**N/A**

			acute MI, ventricular dysfunction, or coronary insufficiency.		

Brand/Generic	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Dose	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Frequency	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Route	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Classification	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Mechanism of Action	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Uses	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Range (if applicable)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Contraindications (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Medication/Food Interactions	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). 2021 Nurse's Drug Handbook (twentieth).

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior: Cooperative** **Build: Moderate** **Attitude: Positive** **Speech: Coherent and normal quantity** **Interpersonal style: Passive** **Mood: Depressed** **Affect: Depressed**	**The patient is cooperative. The appearance of the patient is moderate size. The patient is calm and has a positive attitude. The patient's speech is coherent and has normal quantity. The patient has a passive interpersonal style. The patient is in a depressed mood and affect.**
MAIN THOUGHT CONTENT: **Ideations: Suicide** **Delusions: N/A** **Illusions: Hearing voices** **Obsessions: N/A** **Compulsions: N/A** **Phobias: N/A**	**The patient has suicidal ideations. The patient reports hearing voices, voices talking about him, and voices telling him to kill himself. The patient states they have no obsessions, compulsions, or phobias.**

ORIENTATION: **Sensorium: Normal** **Thought Content: Normal**	**The patient experienced normal sensorium and a normal thought process.** .
MEMORY: **Remote: Normal**	**The patient has normal remote memory.** .
REASONING: **Judgment: Poor** **Calculations: N/A** **Intelligence: Appropriate** **Abstraction: Normal** **Impulse Control: Normal**	**The patient has poor judgment knowing he has been using drugs. The patient has appropriate intelligence. The patient has normal abstraction and impulse control. The patient has a logical thought process and is goal oriented.**
INSIGHT:	**The patient's behavior and past events explain he has bipolar disorder and borderline personality disorder.**
GAIT: N/A **Assistive Devices: Wheelchair** **Posture: Normal** **Muscle Tone: Weak** **Strength: Weak** **Motor Movements: Normal**	**The patient is currently on a wheelchair. The patient has a good posture and motor movements. The patient has weak strength and muscle tone.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10:00 am	**57**	**129/64**	**18**	**97 F(oral)**	**98%**
4:00 pm	**58**	**130/60**	**18**	**97 F(oral)**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10:00 am	1-10	Left leg	7	Sharp pain	Ibuprofen
4:00 pm	1-10	Left leg	7	Sharp pain	Ibuprofen

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: Breakfast: 100% Lunch: 100% Dinner: 100%	Oral Fluid Intake with Meals (in mL) Breakfast: 480 cc Lunch: 480 cc Dinner: N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient will be discharged from the Pavilion and will go to an outpatient rehab program for the treatment of substance abuse and overall mental health. The patient's treatment will focus on reducing the patient's psychiatric symptoms and educating the patient on ways to prevent excessive substance use. They will also be educated on the effects caused by substance abuse. The patient will not require any equipment. After 1 month of

the program, the patient can go back to his current living spot. The patient will be educated on how to create a calm and positive living environment. The patient will be followed up with a plan to meet up with a psychiatrist once a week. The client will be asked to avoid encountering any form of drugs.

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. Risk for suicide related to substance abuse as evidenced by depression and feelings of helplessness	**The nursing diagnosis was chosen because the patient had previously tried to commit suicide by cutting himself. The patient has a history of**	**1. Check the patient's belongings for any sharp or harmful objects** **2. Form a trusting relationship and encourage the client to be open about**	**1. Remove any harmful objects from the patient's room. Check the patient's room regularly** **2. Put the client on suicide precautions** **3. Maintain 1:1 observation with**	**1. Provide group therapy in the community** **2. Provide education to the patient on ways to prevent substance abuse** **3.**

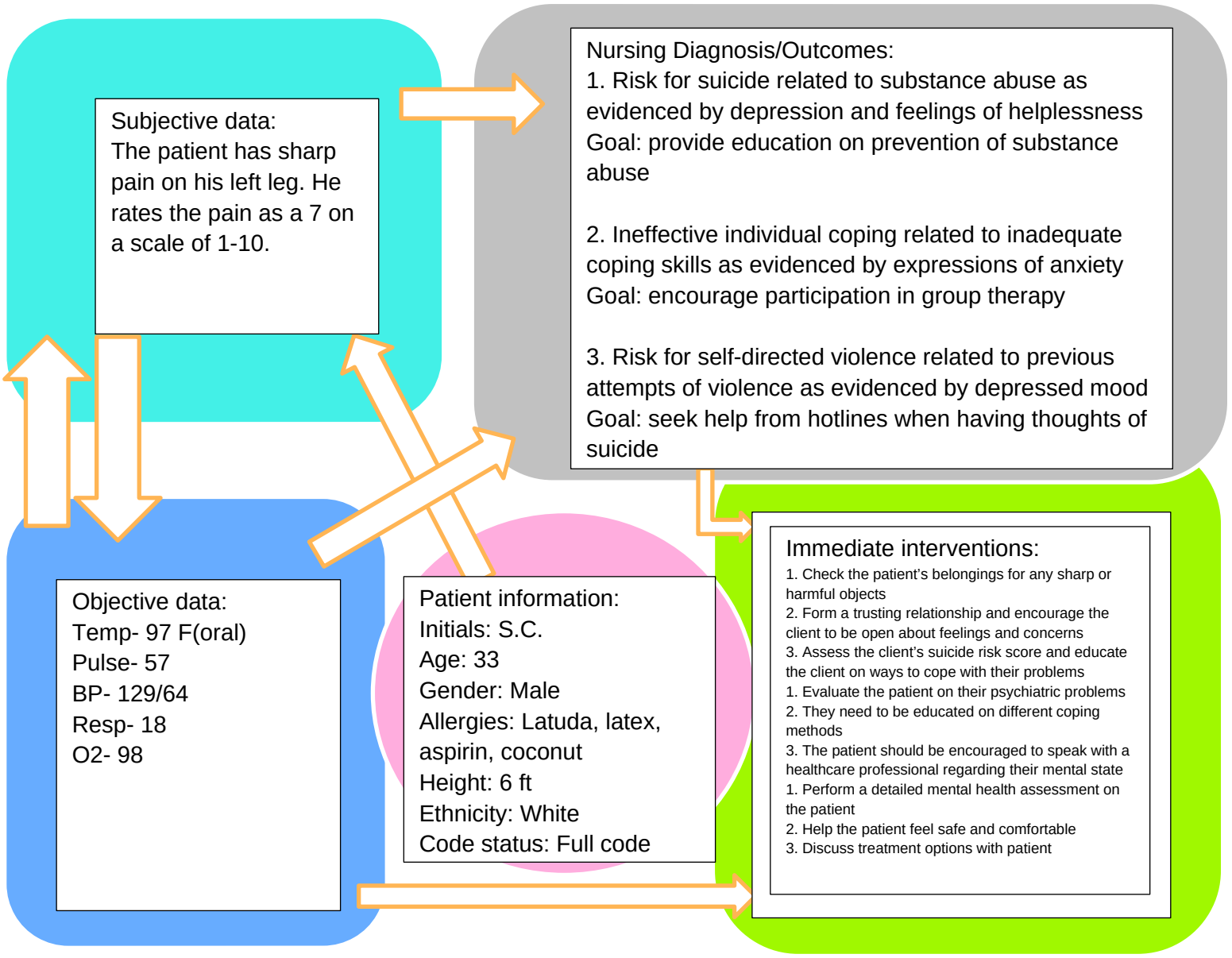
	depression and anxiety related to past events that increase the risk for suicide	**feelings and concerns** **3. Assess the client's suicide risk score and educate the client on ways to cope with their problems**	**the patient**	**Communicate with staff members in outpatient rehab and share feelings of depression**
2. Ineffective individual coping related to inadequate coping skills as evidenced by expression of anxiety	**The nursing diagnosis was chosen because the patient does not have effective coping skills because they have attempted suicide in the past and have had problems dealing with their anxiety**	**1. The patient needs to be evaluated on their psychiatric problems** **2. They need to be educated on different coping methods** **3. The patient should be encouraged to speak with a healthcare professional regarding their mental state**	**1. The patient is required to attend therapy sessions** **2. They are encouraged to participate in group discussions** **3. The patient will also be encouraged to discuss various coping skills and act upon them**	**1. The patient will have access to hotlines for suicide risk** **2. They will be required to meet up with a psychiatrist on a weekly basis** **3. The patient should be encouraged to interact with his support system**
3. Risk for self-directed violence related to previous attempts of	**The nursing diagnosis is chosen because the patient is at risk for suicide because of his**	**1. Perform a detailed mental health assessment on the patient** **2. Help the patient feel safe**	**1. Encourage the patient to be involved in group activities** **2. Allow the patient to express their feelings**	**1. The patient will participate in community-related activities** **2. The patient will be**

violence as evidenced by depressed mood	**depressed mood upon hospitalization**	**and comfortable** **3. Discuss treatment options with patient**	**when emotionally distressed** **3. Implement a wide range of activities at a daily basis**	**encouraged to see a therapist to discuss feelings** **3. He will be provided with education on ways to cope with problems**

Other References (APA):

Phelps, L. L. (2020). ***Sparks & Taylor's nursing diagnosis reference manual*****. Wolters Kluwer.**

Concept Map (20 Points):


Subjective data:
The patient has sharp pain on his left leg. He rates the pain as a 7 on a scale of 1-10.
Nursing Diagnosis/Outcomes:
1. Risk for suicide related to substance abuse as evidenced by depression and feelings of helplessness
Goal: provide education on prevention of substance abuse
2. Ineffective individual coping related to inadequate coping skills as evidenced by expressions of anxiety
Goal: encourage participation in group therapy
3. Risk for self-directed violence related to previous attempts of violence as evidenced by depressed mood
Goal: seek help from hotlines when having thoughts of suicide
Objective data:
Temp- 97 F(oral)
Pulse- 57
BP- 129/64
Resp- 18
O2- 98
Patient information:
Initials: S.C.
Age: 33
Gender: Male
Allergies: Latuda, latex, aspirin, coconut
Height: 6 ft
Ethnicity: White
Code status: Full code
Immediate interventions:
1. Check the patient's belongings for any sharp or harmful objects
2. Form a trusting relationship and encourage the client to be open about feelings and concerns
3. Assess the client's suicide risk score and educate the client on ways to cope with their problems
1. Evaluate the patient on their psychiatric problems
2. They need to be educated on different coping methods
3. The patient should be encouraged to speak with a healthcare professional regarding their mental state
1. Perform a detailed mental health assessment on the patient
2. Help the patient feel safe and comfortable
3. Discuss treatment options with patient