

N323 Care Plan  
Lakeview College of Nursing  
Abbie Morman

## N323 CARE PLAN

**Demographics (3 points)**

<b>Date of Admission</b> 4/7/2022	<b>Patient Initials</b> B.S	<b>Age</b> 50	<b>Gender</b> Female
<b>Race/Ethnicity</b> White	<b>Occupation</b> On disability	<b>Marital Status</b> Divorced	<b>Allergies</b> Ambien, Celebrex, Cox-2 inhibitors, Lyrica, sulfa antibiotics, morphine, and zolpidem
<b>Code Status</b> Full	<b>Observation Status</b> NA	<b>Height</b> 4'11"	<b>Weight</b> 180 pounds

**Medical History (5 Points)**

**Past Medical History:** Anemia, seizures, non-hodgkin's lymphoma, cardiomyopathy

**Significant Psychiatric History:** BPD, anxiety, PTSD, depression

**Family History:** Patient was unaware of any family history.

**Social History (tobacco/alcohol/drugs):** Patient has been in recovery the past two years for alcohol and drug dependence. She abused marijuana and opioids. Patient is one year clean from smoking. She smoked a pack a day for 25 years.

**Living Situation:** Lives at home.

**Strengths:** Patient believes she is a good listener and people come to her for advice.

**Support System:** Her sister and son are her support system. She notes strong relationships with the both of them.

**Admission Assessment**

**Chief Complaint (2 points):** Feeling depressed

**Contributing Factors (10 points):** Patient reported to the hospital with feelings of hopelessness. She states she feels "hopeless and overwhelmed." It has been a persistent feeling for the past month. She has struggled with depression "most of her life" with it peaking in her twenties. Patient reports one of her children is emotionally abusive to her which is a leading factor in why

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she is upset. She has sought out medical treatment for her troubles in the past, though not for this particular incidence.

**Factors that lead to admission:** Worsening depression and passive suicidal ideation

**History of suicide attempts:** Patient has had four previous suicide attempts. Three of them consisted of her overdosing and one was wrist cutting. The dates of these attempts are unknown.

**Primary Diagnosis on Admission (2 points):** Depression

### Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: NA				
Witness of trauma/abuse: NA				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	NA	NA	NA	NA
Sexual Abuse	NA	From ages 7-9 and 16	NA	Patient was sexually abused by a family

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				friend from ages 7-9. She was raped when she was 16.
<b>Emotional Abuse</b>	NA	From ages 7-9 and 16.	NA	Her father was an alcoholic and she reports there was a lot of “fighting and yelling.”
<b>Neglect</b>	NA	NA	NA	NA
<b>Exploitation</b>	NA	NA	NA	NA
<b>Crime</b>	NA	NA	NA	NA
<b>Military</b>	NA	NA	NA	NA
<b>Natural Disaster</b>	NA	NA	NA	NA
<b>Loss</b>	NA	36 years old 39 years old 44 years old	NA	She lost her father in 2008, mother in 2011, and fiance in 2016.
<b>Other</b>	NA	NA	NA	NA
<b>Presenting Problems</b>				
<b>Problematic Areas</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>	
<b>Depressed or sad mood</b>	<u>Yes</u>	<b>No</b>	Patient reports feeling nearly all day, everyday for the past month.	
<b>Loss of energy or interest in</b>	<u>Yes</u>	<b>No</b>	Patient reports an overall sense of	

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<b>activities/school</b>			hopelessness with no motivation.  She has struggled with this the past month, nearly all day, everyday.
<b>Deterioration in hygiene and/or grooming</b>	<u>Yes</u>	<b>No</b>	Patient states that when she's at home "she wouldn't take care of herself." She reports struggling nearly all day, everyday for the past month.
<b>Social withdrawal or isolation</b>	<u>Yes</u>	<b>No</b>	Patient states that she socially withdraws herself from everyone. She reports struggling nearly all day, everyday for the past month.
<b>Difficulties with home, school, work, relationships, or responsibilities</b>	<u>Yes</u>	<b>No</b>	Patient states she "doesn't want to take care of household responsibilities." She reports struggling nearly all day, everyday.
<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Change in numbers of hours/night</b>	<u>Yes</u>	<b>No</b>	Patient states "I only sleep 2-3 hours a night and then sleep most of the day." She reports struggling nearly all day,

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			everyday.
<b>Difficulty falling asleep</b>	<u>Yes</u>	<b>No</b>	Patient states “It is very difficult for me to fall asleep, nothing seems to help.” She reports struggling with this nearly all day, everyday.
<b>Frequently awakening during night</b>	<u>Yes</u>	<b>No</b>	Patient reports “awakening during the night and not being able to fall back asleep.” She reports struggling nearly all day, everyday.
<b>Early morning awakenings</b>	<u>Yes</u>	<b>No</b>	Patient states she awakens very early, even after being awake most of the night. She reports struggling nearly all day, everyday.
<b>Nightmares/dreams</b>	<b>Yes</b>	<u>No</u>	
<b>Other</b>	<u>Yes</u>	<b>No</b>	Patient notes she experiences periods of “increased energy, elevated mood, overspending, and impulsivity.” Patient states she will experience this for “a couple days” before returning to a

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			depression state.
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	<u>Yes</u>	<u>No</u>	Patient states "I don't eat at home, but for some reason while I've been here I do."
<b>Binge eating and/or purging</b>	<u>Yes</u>	<u>No</u>	
<b>Unexplained weight loss?</b>	<u>Yes</u>	<u>No</u>	
<b>Amount of weight change:</b>			
<b>Use of laxatives or excessive exercise</b>	<u>Yes</u>	<u>No</u>	
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	<u>Yes</u>	<u>No</u>	
<b>Panic attacks</b>	<u>Yes</u>	<u>No</u>	Patient states "I had multiple while at home but not here." She also states that the lavender patch she was given helps her tremendously. She reports struggling with this nearly all day, everyday.
<b>Obsessive/compulsive thoughts</b>	<u>Yes</u>	<u>No</u>	
<b>Obsessive/compulsive behaviors</b>	<u>Yes</u>	<u>No</u>	
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	<u>Yes</u>	<u>No</u>	

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Rating Scale				
How would you rate your depression on a scale of 1-10?		10		
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	<u>No</u>		
School	Yes	<u>No</u>		
Family	<u>Yes</u>	No	Patient states she has one son who is not supportive of her and it is hard on her.	
Legal	Yes	<u>No</u>		
Social	Yes	<u>No</u>		
Financial	Yes	<u>No</u>		
Other	Yes	<u>No</u>		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
Patient received inpatient therapy “multiple times.” The dates are unknown.	<u>Inpatient</u> <u>Outpatient</u> <b>Other:</b>	Inpatient	Depression	<b>No improvement</b>  <u>Some improvement</u>

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				<b>Significant improvement</b>
Patient reports one year of outpatient therapy. She can not recall dates.	<b>Inpatient</b> <b>Outpatient</b> <b>Other:</b>	Outpatient	Depression	<b>No improvement</b>  <b>Some improvement</b>  <b>Significant improvement</b>
NA	<b>Inpatient</b> <b>Outpatient</b> <b>Other:</b>	NA	NA	<b>No improvement</b>  <b>Some improvement</b>  <b>Significant improvement</b>
<b>Personal/Family History</b>				
<b>Who lives with you?</b>	<b>Age</b>	<b>Relationship</b>	<b>Do they use substances?</b>	
Patient lives by herself.	NA	NA	<b>Yes</b>	<b>No</b>
NA	NA	NA	<b>Yes</b>	<b>No</b>
NA	NA	NA	<b>Yes</b>	<b>No</b>
NA	NA	NA	<b>Yes</b>	<b>No</b>
NA	NA	NA	<b>Yes</b>	<b>No</b>
<b>If yes to any substance use, explain:</b> NA				
<b>Children (age and gender):</b> Two sons, one is 26 and the other 24.				
<b>Who are children with now?</b> Children are on their own.				
<b>Household dysfunction, including separation/divorce/death/incarceration:</b> Patient is divorced once.				
<b>Current relationship problems:</b> None				
<b>Number of marriages:</b> One				
<b>Sexual Orientation:</b> Male	<b>Is client sexually active?</b> Yes <u>No</u>		<b>Does client practice safe sex?</b> Yes <u>No</u>	

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<p><b>Please describe your religious values, beliefs, spirituality and/or preference:</b> Patient states she “doesn’t have any.”</p>
<p><b>Ethnic/cultural factors/traditions/current activity:</b> Patient states she “doesn’t have any.”</p> <p><b>Describe:</b> NA</p>
<p><b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b> NA</p>
<p><b>How can your family/support system participate in your treatment and care?</b> Patient states “it would be nice to have people to talk to when I am feeling down.”</p>
<p><b>Client raised by:</b></p> <p><u>Natural parents</u>  Grandparents  Adoptive parents  Foster parents  Other (describe):</p>
<p><b>Significant childhood issues impacting current illness:</b> Patient was sexually and emotionally abused in her childhood years.</p>
<p><b>Atmosphere of childhood home:</b></p> <p><u>Loving</u>  Comfortable  <u>Chaotic</u>  Abusive  Supportive  <b>Other:</b> Patient states she was “sheltered” and “it was a little bit of everything.”</p>
<p><b>Self-Care:</b></p> <p><u>Independent</u>  Assisted  Total Care</p>
<p><b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b> NA</p>
<p><b>History of Substance Use:</b> Patient abused drugs, alcohol, and was a smoker.</p>

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<b>Education History:</b>  <b>Grade school</b> <u><b>High school</b></u> <b>College</b> <b>Other:</b>
<b>Reading Skills:</b>  <u><b>Yes</b></u> <b>No</b> <b>Limited</b>
<b>Primary Language:</b> English
<b>Problems in school:</b> Patient reports having trouble in school because of hearing loss.
<b>Discharge</b>
<b>Client goals for treatment:</b> Patient reports “going to see her therapist, visiting her son, and playing with her cat” when she discharges.
<b>Where will client go when discharged?</b> Patient will be discharged to her home.

**Outpatient Resources (15 points)**

Resource	Rationale
1. Therapist	1. It would be important for her to find a professional who would be able to help her negative, intrusive thoughts. She has had previous experiences with therapists and she states it “helped me a lot.”
2. Group therapy	2. It would be important for her to find people with similar issues and thoughts. This may help her realize she is not alone. This will also

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	give her an opportunity to create new bonds.
3. Family/peer support	3. This will help the patient realize they have support and aren't alone. By involving their loved ones in their treatment plan, they may have a better understanding of what the patient is going through.

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

<b>Brand/Generic</b>	Quetiapine Seroquel	Dilantin Phenytoin	Haldol Haloperidol	Duloxetine Cymbalta	Benztropine Cogentin
<b>Dose</b>	100 mg	100 mg	5 mg	30 mg	2 mg
<b>Frequency</b>	at night	twice/day	Q4	Daily	twice/day
<b>Route</b>	oral	oral	oral	oral	oral
<b>Classification</b>	Pharm: Dibenzothiazepine Therapeutic: Antipsychotic	Pharm: hydantoin derivative Therapeutic: anticonvulsant	Pharm: Butyrophenone derivative Therapeutic: antipsychotic	Pharm: selective serotonin and norepinephrine reuptake inhibitor Therapeutic: antidepressant	Therapeutic: Anticholinergic Therapeutic; Antiparkinsonian
<b>Mechanism of Action</b>	May produce antipsychotic effects by interfering with	Limits the spread of seizure activity and the start of new seizures	May block postsynaptic dopamine receptors in the limbic	Inhibits dopamine, serotonin, and norepinephrine reuptake to	Restores the brain's normal dopamine and acetylcholine balance which

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	dopamine binding to receptor sites.	by regulating voltage dependent calcium.	system and increase brain turnover of dopamine.	potentiate serotonergic activity in the CNS.	relaxes muscles.
<b>Therapeutic Uses</b>	Antipsychotic	Anticonvulsant	Antipsychotic	Antidepressant	Antiparkinsonian
<b>Therapeutic Range (if applicable)</b>	NA	NA	NA	NA	NA
<b>Reason Client Taking</b>	BPD	Seizures	BPD	Depression	Parkinson's
<b>Contraindications (2)</b>	Hypersensitivity to quetiapine or its components.	History of prior acute hepatotoxicity attributed to phenytoin. Concurrent use with delavirdine.	Parkinson's disease. CNS comatose states or depression	Chronic liver disease. Severe renal impairment.	Hypersensitivity to Benztropine, Children under three.
<b>Side Effects/Adverse Reactions (2)</b>	Depression Suicidal ideation	Suicidal ideation cardiac arrest	Depression Anxiety	Abnormal dreams Seizures	Confusion delusions depression
<b>Medication/Food Interactions</b>	If patient consumes alcohol it may increase the CNS depression.	Additive CNS depression with increased use of alcohol.	opiates and anesthetics increase the CNS depression and it may cause serious respiratory depression.	NSAIDs increase the risk for bleeding.	Haloperidol possibly decreases its effects and the possibility of tardive dyskinesia.
<b>Nursing Considerations (2)</b>	Should not be used for elderly patients with dementia. Should not be given to patients with a history of cardiac dysrhythmias.	If patient has difficulty swallowing, the pill may be opened and contents mixed with fluid/food. Give with food to decrease GI distress.	Should not be used to treat dementia-related psychosis. Use cautiously in patients with a history of prolonged QT interval.	Should not be given to patients with severe renal impairment. Should be avoided in patients who consume large amounts of alcohol.	Therapy usually begins with a low dose and gradually increases. Assess muscle rigidity and tremor at baseline.

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<b>Brand/Generic</b>	Tylenol Acetaminophen	Lipitor Atorvastatin	Carvedilol Coreg		
<b>Dose</b>	650 mg	20 mg	12.5 mg		
<b>Frequency</b>	Q4	at night	twice/day		
<b>Route</b>	oral	oral	oral		
<b>Classification</b>	Pharm: Nonsalicylate Therapeutic: Antipyretic	Pharm: HMG-CoA reductase inhibitor Therapeutic: Antihyperlipidemic	Pharm: nonselective beta-blocker Therapeutic: antihypertensive		
<b>Mechanism of Action</b>	Inhibits the enzyme cyclooxygenase, blocking the prostaglandin production and interfering with pain impulses.	Reduces plasma cholesterol and lipoprotein levels inhibiting HMG-CoA.	Reduces cardiac output and tachycardia, causes vasodilation.		
<b>Therapeutic Uses</b>	Antipyretic	Antihyperlipidemic	Antihypertensive		
<b>Therapeutic Range (if applicable)</b>	NA	NA	NA		
<b>Reason Client Taking</b>	pain relief	High cholesterol	High blood pressure		
<b>Contraindications (2)</b>	Hypersensitivity to Tylenol. Severe hepatic impairment	Active hepatic disease Unexplained persistent rise serum transaminase level.	Asthma or related bronchospastic conditions Cardiogenic shock		
<b>Side Effects/Adverse Reactions (2)</b>	hemolytic anemia anxiety	Depression abnormal dreams	AV block depression dizziness		

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<b>Medication/Food Interactions</b>	Increased risk for hepatotoxicity if client consumes alcohol	Grapefruit juice increases blood atorvastatin level.	insulin or oral antidiabetics will increase the risk of hypoglycemia		
<b>Nursing Considerations (2)</b>	Use cautiously in patients who consume alcohol. Monitor renal function with long term therapy.	Liver function tests should be performed before therapy. Lipid levels should be measured every two to four weeks after therapy begins.	Monitor patient's blood glucose level during therapy because this drug may alter it. Use cautiously in patients with PVD because it may aggravate symptoms		

**Medications Reference (1) (APA):**

Jones and Bartlett Learning. (2021). *Nurse's Drug Handbook*. Pages 8, 95, 124, 172, 354, 532, 867, 919.

**Mental Status Exam Findings (20 points)**

<b>APPEARANCE:</b> <b>Behavior:</b> <b>Build:</b>	Patient was calm and cooperative. She had normal build and size for her age. She had a regular rate, rhythm, and volume of her speech.
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<b>Attitude:</b> <b>Speech:</b> <b>Interpersonal style:</b> <b>Mood:</b> <b>Affect:</b>	Patient's attitude was pleasant and she communicated well. Her mood and affect were depressed.
<b>MAIN THOUGHT CONTENT:</b> <b>Ideations:</b> <b>Delusions:</b> <b>Illusions:</b> <b>Obsessions:</b> <b>Compulsions:</b> <b>Phobias:</b>	Patient had suicidal ideation with no reports of delusions, illusions, obsessions, compulsion, or phobias.
<b>ORIENTATION:</b> <b>Sensorium:</b> <b>Thought Content:</b>	Patient's thought content was linear and purposeful. She was alert and oriented times three.
<b>MEMORY:</b> <b>Remote:</b>	Patient was able to recall past and present events.
<b>REASONING:</b> <b>Judgment:</b> <b>Calculations:</b> <b>Intelligence:</b> <b>Abstraction:</b> <b>Impulse Control:</b>	Patient's judgment was fair and her insight and intelligence were within normal limits. She was able to control herself and any urges.
<b>INSIGHT:</b>	Patient appeared to have fair and linear insight. She was aware of why she was there and the kind of help she needed.
<b>GAIT:</b> <b>Assistive Devices:</b> <b>Posture:</b> <b>Muscle Tone:</b> <b>Strength:</b> <b>Motor Movements:</b>	Patient didn't use any assistive devices when walking. Her posture was normal and there was no noticeable muscle loss. Her strength was reasonable for her age and her motor movements were equal throughout.

## Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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0800	92	92/64	18	98.0 tympanic	97%
1330	86	94/61	16	97.8 tympanic	98%

**Pain Assessment, 2 sets (2 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
1330	0-10 scale	Patient states she has no pain.			
1715	0-10 scale	Patient states she has no pain.			

**Dietary Data (2 points)**

Dietary Intake	
<b>Percentage of Meal Consumed:</b>	<b>Oral Fluid Intake with Meals (in mL)</b>
<b>Breakfast:</b> 75%	<b>Breakfast:</b> 240 mL
<b>Lunch:</b> 75%	<b>Lunch:</b> 360 mL
<b>Dinner:</b> 100%	<b>Dinner:</b> 280 mL

**Discharge Planning (4 points)****Discharge Plans (Yours for the client):**

My discharge planning for this client consists of finding her a therapist, talking about setting daily goals for self care, and group therapy. A therapist can promote mental health healing through medications and psychological interventions. Helping her set up daily goals may help with providing structure. Talking to her loved ones can help her feel supported and heard.

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

<b>Nursing Diagnosis</b> ● Include full nursing diagnosis with “related to” and “as evidenced by” components	<b>Rational</b> ● Explain why the nursing diagnosis was chosen	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (Prior to discharge)</b>
<b>1.</b> Impaired social interaction related to disturbed thought processes as evidenced by dysfunctional interaction with family.	The patient states she withdraws herself from family, not interacting with anyone for long periods of time.	<b>1.</b> Provide an environment with minimal stimuli.  <b>2.</b> Develop a well established nurse to patient relationship.  <b>3.</b> Ensure boundaries are in place to eliminate any inappropriate behavior.	<b>1.</b> When the patient is less manic, provide activities that involve 1-2 other people that are non stimulating.  <b>2.</b> Provide solitary activities that don’t provide their full attention for a long period of time.  <b>3.</b> Promote attending group therapy to interact with other clients and the therapist.	Help the patient plan social outings when home. Such as attending a church group or volunteering.  <b>2.</b> Help the patient attend group therapy.  <b>3.</b> Ensure the family/friends visit often to prevent isolation.
<b>2.</b> Risk for self directed violence related to social isolation as evidenced by previous attempts of self harm.	This patient had four previous attempts and voiced not wanting to be alive.	<b>1.</b> Eliminate all things from the unit that the patient could potentially harm themselves with.  <b>2.</b> Allow the patient to discuss any emotions with the nurse.  <b>3.</b> Implement frequent roundings and/or one to one observation.	<b>1.</b> Encourage the patient to discuss any intrusive thoughts. <b>2.</b> Remind them that the crisis they have now is only temporary and they aren’t alone. <b>3.</b> Attend group therapy during their stay to prevent isolation.	<b>1.</b> Ensure the patient is aware of the suicide hotline so if/when she has suicidal thoughts she can reach out to them.  <b>2.</b> Help her find a therapist to talk to when she is discharged.  <b>3.</b> Arrange for the client to stay with a family member or close

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				friend to ensure she is not alone.
3. Hopelessness related to the burdensome symptoms of depression as evidenced by decreased affect and abnormal sleeping pattern.	The patient's primary reason for coming to the hospital was feelings of hopelessness and depressed mood.	<ol style="list-style-type: none"> <li>1. Conduct a suicide assessment to identify the level of suicide risk.</li> <li>2. Aid the patient in determining aspects of their life events that are not within control.</li> <li>3. Encourage the patient to examine spiritual supports that may provide hope.</li> </ol>	<ol style="list-style-type: none"> <li>1. Express hope to the client with realistic comments about their strengths and resources.</li> <li>2. Help the patient determine what aspects of her life are under her control.</li> <li>3. Allow the patient to assume responsibility for self-care, such as setting realistic goals and scheduling activities.</li> </ol> <p>independent decisions.</p>	<ol style="list-style-type: none"> <li>1. Educate the patient about crisis intervention hotlines and other resources.</li> <li>2. Encourage family and significant others to display care, hope, and love for patient.</li> <li>3. Strengthen patient's relationship with significant others; allow them to take part in patient's care.</li> </ol>

**Other References (APA):**

**Concept Map (20 Points):**

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## Subjective Data

Sheltered home life.  
Rates depression as a 10 on a 0-10 scale.  
Rates anxiety as a 5 on a 0-10 scale.  
History of sexual and emotional abuse.  
Has "no motivation to get through life."  
Her sister and one of her sons are emotional support.

## Objective Data

History of depression, anxiety, PTSD, and BPD.  
Four past suicide attempts.  
Patient appeared to be nervous.  
Patient's mood and affect were depressed.

## Patient Information

50 year old female with a history of depression and BPD presented to the hospital with worsening feelings of hopelessness.  
Lives alone  
Has two sons  
Divorced once  
Currently single

## Nursing Diagnosis/Outcomes

Impaired social interaction related to disturbed thought processes as evidenced by dysfunctional interaction with family.  
Hopelessness related to the burdensome symptoms of depression as evidenced by depressed affect and abnormal sleeping pattern.  
Risk for self directed violence related to social isolation as evidenced by previous attempts of self harm.  
Patient will engage in group activities by the end of admission.  
Patient will voice her strengths and problems in her life that she can and can not control.  
Patient will remain injury free while hospitalized and will not vocalize any plans to harm herself.

## Nursing Interventions

When the patient is less manic, provide activities that involve 1-2 other people that are non stimulating.  
Provide solitary activities that don't provide their full attention for a long period of time.  
Promote attending group therapy to interact with other clients and the therapist.  
Express hope to the client with realistic comments about their strengths and resources.  
Help the patient determine what aspects of her life are under her control.  
Allow the patient to assume responsibility for self-care, such as setting realistic goals and scheduling activities independent decisions.



