# N323 Care Plan

Lakeview College of Nursing

Berich M Mpoy

## Demographics (3 points)

| **Date of Admission** 9/14/22 | **Patient Initials** A. K | **Age** 22 | **Gender** F |
|---|---|---|---|
| **Race/Ethnicity** African American | **Occupation** Unemployed | **Marital Status** Single | **Allergies** Risperidone |
| **Code Status** Full code | **Observation Status** | **Height** 5’3 | **Weight** 123 |

## Medical History (5 Points)

**Past Medical History:** Cleft lip surgery, chronic bronchitis, anal fissure, and bone graft with hip surgery

**Significant Psychiatric History:** bipolar, unspecified psychosis, insomnia

**Family History:** Patient denied family history

**Social History (tobacco/alcohol/drugs):** No tobacco use, two bottles of beer daily for one year, two to four blunts of marijuana daily for one year.

**Living Situation:** The patient does not have a dedicated living space. The patient stated that she moves from one family member's house to another family member's house.

**Strengths:** The patient was willing to participate during the assessment.

**Support System:** The patient does not have a support system at home

## Admission Assessment

**Chief Complaint (2 points):** The patient stated that she does not have a place to live because of commotion with family members and feels hopeless.

**Contributing Factors (10 points):** The patient reported the onset of the depression of the losing her grandma July of last year. The patient stated that she experiences panic attacks that sometimes causes chest pain. She reported that she started isolating herself from family members and smoking marijuana more than usual since last year after loss of her grandma. The patient did

rate her depression as a 5 on a scale of 1 to 10. The patient stated that her depression gets worse when she remembers about her sexual abuse by her boyfriend and sister's boyfriend. The patient also stated that when she uses marijuana or spend time doing puzzles, she sometimes forgets about her past which reduces her depression. The patient did state that her depression has only gotten worse since last year because she lost her job and has no place to stay because her family kicked her out, which led to her going from one mental health facility to another.

**Factors that lead to admission:** Attempted suicide by hanging and sexual abuse by boyfriend and sister's boyfriend.

**History of suicide attempts:** Suicidal ideation at OSF health care 09/12/2022

**Primary Diagnosis on Admission (2 points):** Unspecified psychosis

**Psychosocial Assessment (30 points)**

| **History of Trauma** | | | | |
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| **No lifetime experience: T**he patient did not feel comfortable discussing the history of trauma in the family. The patient did not disclose any information about the history of trauma.<br>**Witness of trauma/abuse:** | | | | |
| | **Current** | **Past (what age)** | **Secondary Trauma (response that comes from caring for another person with trauma)** | **Describe** |

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| **Physical Abuse** | yes | 22 | N/A | The patient stated that last year she was physically abused by her sister's boyfriend and her boyfriend at the time. The patient also stated that she is woken up forcefully during the night by family members she lived with. |
| **Sexual Abuse** | yes | 22 | N/A | The patient stated that her sister's boyfriend sexually abused her last year, but her sister did not believe her because the boyfriend gives |

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| | | | | her sister gifts. She also stated that her former boyfriend sexually abused her but denies it. |
| **Emotional Abuse** | yes | 22 | N/A | The patient stated that because she does not have a place to live of stay, she moves from one family member house to another, but all her family members have kicked her out because of her problems with substance abuse such as marijuana. |
| **Neglect** | yes | 13 | N/A | The patient stated |

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| | | | | that they started marijuana use at the age of 13 and no interventions were put in place to prevent continual use of marijuana. |
| **Exploitation** | N/A | N/A | N/A | N/A |
| **Crime** | N/A | N/A | N/A | N/A |
| **Military** | N/A | N/A | N/A | N/A |
| **Natural Disaster** | N/A | N/A | N/A | N/A |
| **Loss** | yes | 22 | N/A | The patient stated that last year sometime around August she lost her grandma. |
| **Other** | N/A | N/A | N/A | N/A |
| **Presenting Problems** | | | | |
| **Problematic Areas** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** | |
| **Depressed or sad mood** | **Yes** | **No** | The patient stated that she felt hopeless after losing her grandma last year. she stated that her | |

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| | | | depression only got intensified after losing her job. she tried to stay with family but was this owned. Because of the patients circumstances she is frequently depressed throughout the day. |
| **Loss of energy or interest in activities/school** | **Yes** | **No** | Loss of energy and interest in activities such as school due to the loss of her grandma and her abusive relationship with her ex-boyfriend. After being terminated from her job the loss of energy only intensified. She felt like she had no purpose in life. |
| **Deterioration in hygiene and/or grooming** | **Yes** | **No** | The patient had good hygiene and was well groomed during the assessment as an inpatient. The patient stated that she keeps herself well-groomed and clean daily because she likes to be girly. the patient's own words "I like to take showers and bags and do my makeup because I'm kind of a |

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| | | | girly girl". |
| **Social withdrawal or isolation** | **Yes** | **No** | The patient stated that she stopped communicating with her family members. The patient stated she is not going to associate with her family members any longer because there is always frequent commotions. The patient was sexual abused by ex-boyfriend and sister boyfriend. The patient also Terminator the relationship she had with her sister and her ex-boyfriend. |
| **Difficulties with home, school, work, relationships, or responsibilities** | **Yes** | **No** | The patient faced many difficulties with school, home, work, and relationships along with responsibilities as stated above. |
| **Sleeping Patterns** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** |
| **Change in numbers of hours/ night** | **Yes** | **No** | The patient expressed that she get more than four hours of sleep a night daily because she is woken up by her boyfriend who is now |

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| | | | her ex-boyfriend and her sister's boyfriend during the night. |
| **Difficulty falling asleep** | **Yes** | **No** | The patient stated that she falls asleep easily, but she's often woken up during the night. |
| **Frequently awakening during night** | **Yes** | **No** | The patient stated that she gets about four hours of sleep daily because her sleep is interrupted by the people she lives with daily. |
| **Early morning awakenings** | **Yes** | **No** | Sleep frequently interrupted by periods of abuse when sleeping at sister's house. Prolonged sleep interruptions daily. |
| **Nightmares/ dreams** | **Yes** | **No** | The patient stated she does not remember the last time she had a dream or nightmare. |
| **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 denies poor or irregular eating habits. |
| **Binge eating and/or purging** | **Yes** | **No** | The patient denied binge eating or purging. |
| **Unexplained weight loss?** | **Yes** | **No** | The patient did not notice any |

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| **Amount of weight change:** | | | recent weight changes. |
| **Use of laxatives or excessive exercise** | **Yes** | **No** | The patient denied any use of laxatives and stated she does not engage in any form of exercise. |
| **Anxiety Symptoms** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** |
| **Anxiety behaviors (pacing, tremors, etc.)** | **Yes** | **No** | The patient frequently chewed on fingernails throughout the assessment. This occurs often when put into a stressful situation. |
| **Panic attacks** | **Yes** | **No** | The patient stated she has experiences of panic attacks several times in the past year. Panic attacks have not intensified they remain consistent throughout the year. The patient did claim that panic attacks often occur after traumatic situation. The patient stated that her panic attack lasts up to 10 minutes. |
| **Obsessive/ compulsive thoughts** | **Yes** | **No** | The patient does not show signs of obsessive-compulsive thoughts or behaviors. |
| **Obsessive/** | **Yes** | **No** | The patient does not show signs |

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| **compulsive behaviors** | | | of obsessive-compulsive thoughts or behaviors. |
| **Impact on daily living or avoidance of situations/objects due to levels of anxiety** | **Yes** | **No** | The patient stated she wants nothing to do with her family members. The patient is isolated from family members and unemployed. The patient stated that she has thoughts of suicide. |
| **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?** | | **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** | The patient was fired from her Job last year because of marijuana use. The patient is also not seeking employment at current time. |
| **School** | **Yes** | **No** | Does not apply because the patient has already graduated high school and does not attended college. |
| **Family** | **Yes** | **No** | The patient had multiple bad |

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| | | | confrontations with her family members. All her family members removed her from their homes. The patient stated that her family has disowned her, and she does not want to be involved with them. |
| **Legal** | **Yes** | **No** | N/A |
| **Social** | **Yes** | **No** | The patient is isolated from family. |
| **Financial** | **Yes** | **No** | The patient has been unemployed since the past year and has been living with family members moving from place to place. Unemployment for the patient does not occur often. The patient is not unemployed multiple times a year. The patient stated that the loss of her grandma might have led to her substance abuse and unemployment. |
| **Other** | **Yes** | **No** | N/A |

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| **Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient** | | | | |
| **Dates** | **Facility/MD/ Therapist** | **Inpatient/ Outpatient** | **Reason for Treatment** | **Response/ Outcome** |
| OSF<br><br>09/12/2022 | **Inpatient**<br>**Outpatient**<br>**Other:**<br>MD | Inpatient | The patient Stated she did not have a place to stay so she went to OSF. She was diagnosed with unspecified psychosis. EMT states patient wanted to hang her herself. The patient stated she was | **No improvement**<br><br>**Some improvement**<br><br>**Significant improvement** |

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| | | | thinking about hanging herself but did not know how to and laughed inappropriately about it. | |
| New Choice Center of the pavilion.<br><br>08/2021 | **Inpatient**<br>**Outpatient**<br>**Other:**<br><br>Therapist | Inpatient | The patient stated after the loss of her grandma she needed some place she can receive help because of her depression and increase in marijuana use. The | **No improvement**<br><br>**Some improvement**<br><br>**Significant improvement** |

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| | | | patient was placed in the new choice center for detoxification. | |
| The Pavilion<br>09/14/2022 | **Inpatient**<br>**Outpatient**<br>**Other:**<br>Therapist/<br>Psychologist | Inpatient | The patient was diagnosed with unspecified psychosis and suicide ideation. The patient also struggles with marijuana use. | **No improvement**<br>**Some improvement**<br>**Significant improvement** |

| **Personal/Family History** | | | | |
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| **Who lives with you?** | **Age** | **Relationship** | **Do they use substances?** | |
| Sister | 27 | Sister | Yes | No |

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| 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 stated she uses marijuana daily and started at the age of 13.

**Children (age and gender):** The patient does not have any children.

**Who are children with now?**

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

**Current relationship problems:** The patient is not in a relationship currently.

**Number of marriages:** Zero

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

**Please describe your religious values, beliefs, spirituality and/or preference:** The patient stated she is Christian and goes to church once in a while.

**Ethnic/cultural factors/traditions/current activity:**

**Describe:** The patient stated she does not have any ethnic, cultural or traditions.

**Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):** The patient does not have any legal issues current or past.

**How can your family/support system participate in your treatment and care?** The patient did not want any of the family members involved in her treatment and care because they did not want to be involved with her.

**Client raised by:** The patient did not want to discuss about the family. She claims they have disowned her, and she does want to discuss about them or get them involved. The patient did not want to indicate whether her parents were natural parents' grandparents adoptive parents or foster parents. She did state that she lived with multiple family members in different homes.

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| **Natural parents**<br>**Grandparents**<br>**Adoptive parents**<br>**Foster parents**<br>**Other (describe):** |
| **Significant childhood issues impacting current illness**: The patient stated that her marijuana use began at the age of 13. |
| **Atmosphere of childhood home:** The patient did not want to discuss the details of her family home but from what she said it can be concluded that her home was chaotic and abusive. The patient has no support from her family members.<br><br>**Loving**<br>**Comfortable**<br>**Chaotic**<br>**Abusive**<br>**Supportive**<br>**Other:** |
| **Self-Care:** The patient is independent.<br><br>**Independent**<br>**Assisted**<br>**Total Care** |
| **Family History of Mental Illness (diagnosis/suicide/relation/etc.)** |
| **History of Substance Use:** The patient stated there has been substance abuse in the family but refused to discuss details. |
| **Education History:** The patient attended college for public but did no finish. Dropped out after one year. The patient did state that she wishes she had continued with her education instead of dropping out.<br><br>**Grade school**<br>**High school**<br>**College**<br>**Other:** |
| **Reading Skills:** The patient has a 12th grade reading skill. |

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| **Yes**<br>**No**<br>**Limited** |
| **Primary Language:** English |
| **Problems in school**: The patient stated that she would have loved to have one-on-one teaching back in high school because she found it difficult to comprehend the material. |
| **Discharge** |
| **Client goals for treatment:** The patient will discuss sadness, despair, and other feelings. The patient won't harm herself and will discuss appropriate coping skills to avoid future suicidal episodes. The patient will report decrease desire to kill self and if needed will receive referral to mental health professional. |
| **Where will client go when discharged?** The patient will go to C u at Home in champagne to receive help with homelessness. |

**Outpatient Resources (15 points)**

| Resource | Rationale |
|---|---|
| 1. Rosecrance<br>801 N. Walnut St., Champaign, IL<br>(217) 398-8080<br>Monday-Thursday 8:00am - 5:00pm<br>Friday 8:00am - 4:00pm | 1. After discharge at pavilion behavioral Health Center the Rosecrance is a good facility that the patient can receive outpatient care. This facility provides affordable mental and behavioral health services. Medicaid is accepted. This facility is close to the patient's hometown. This facility will provide the |

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| | patient with outpatient counseling services and community engagement opportunities. This facility will provide the patient with lasting recovery from her substance abuse. The patient stated that she has had difficulties with substance abuse specifically marijuana. |
| 2. COMMUNITY RESOURCE AND COUNSELING CENTER - PAXTON, IL<br>Phone: (217) 379-4302<br>(888) 971-5853 | **2.** due to the patient suicidal ideations this resource is recommended because it provides outpatient services for individuals with suicidal ideation and other mental health disorders. The patient stated that they have been thinking of committing suicide recently but doesn't have a concrete plan to execute action. The patient can attend group therapy and community services. |
| 3. C-U at home in Champaign, IL<br>70 E. Washington Street<br>Champaign, IL 61820<br>Hours<br>Phoenix Drop-In Center<br>Monday-Friday<br>8-5pm<br>Contact | **3.** C-U at Home Helps individuals with homelessness and supports individuals on their journey of healing and restoration. This place is recommended because the patient stated that she is Christian and goes to church occasionally and stated that she has no place to stay because all her family members have disowned her. She also stated that she does |

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| Phoenix/Office<br><br>217-819-4569 | not have any lasting good relationship with individuals. this facility will not only help the patient with homelessness but will help her develop lasting relationship with individuals. |

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

| | | | | | |
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| **Brand/Generic** | Sertraline hydrochloride/Zoloft | N/A | N/A | N/A | N/A |
| **Dose** | 25mg | N/A | N/A | N/A | N/A |
| **Frequency** | PRN as needed | N/A | N/A | N/A | N/A |
| **Route** | PO by mouth | N/A | N/A | N/A | N/A |
| **Classification** | Select two serotonin reuptake inhibitor. | N/A | N/A | N/A | N/A |
| **Mechanism of Action** | "Medication inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in new row synopsis. an elevated serotonin level may result in elevated mood and | N/A | N/A | N/A | N/A |

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| | reduced depression. this action may also relieve symptoms of other psychiatric conditions attributed to serotonin deficiency and premenstrual dysphoric disorder." (Jones 2021). | | | | |
| **Therapeutic Uses** | This medication is given to improve mood, sleep, appetite, and energy. Helps relieve symptoms of depression. | N/A | N/A | N/A | N/A |
| **Therapeutic Range (if applicable)** | 25 mg to 50 mg daily every week. | N/A | N/A | N/A | N/A |
| **Reason Client Taking** | The patient is taking this medication for depression, anxiety and thoughts of suicide. | N/A | N/A | N/A | N/A |
| **Contraindications (2)** | concurrent use of disulfiram or pimozide; hypersensitivity to sertraline or its components: use within 14 days of an Mao inhibitor, including intravenous methylene blue and linezolid." (Jones 2021). | N/A | N/A | N/A | N/A |
| **Side Effects/Adverse Reactions (2)** | abnormal dreams, confusion, hepatic failure, pancreatitis. | N/A | N/A | N/A | N/A |
| **Medication/Food Interactions** | aspirin, antipsychotics chlorpromazine, | N/A | N/A | N/A | N/A |

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| | clopidogrel/cheese, beef, chicken liver, bananas, excessive chocolate. | | | | |
| **Nursing Considerations (2)** | “be aware that sertraline should not be given to patients with bradycardia, congenital long QT syndrome, hypokalemia or hypomagnesemia, recent acute my cardio infarction, oh uncompensated heart failure because of increased risk of prolonged QT interval and torsade de pointes. it should also not be given to patients who are taking other drugs that prolong the QT interval. expect hypokalemia and hypomagnesemia to be corrected before sertraline therapy is begun.” (Jones 2021). | N/A | N/A | N/A | N/A |

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| **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** | N/A | N/A | N/A | N/A | N/A |

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| **Action** | | | | | |
| **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, D.W. (2021). Nurse's drug handbook. (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

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

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| **APPEARANCE:**<br>**Behavior:**<br>**Build:**<br>**Attitude:**<br>**Speech:**<br>**Interpersonal style:**<br>**Mood:** | The patient was alert and oriented X4. The patient was also well groomed. The patient was alert and oriented to the place, time, and situation. The patient's overall appearance had good hygiene. The patient was in no distress. The patient was cautious when answering questions and very talkative. The was slim with a medium |

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| **Affect:** | build with an average height of 5'3. The patient had a cooperative attitude. The patient answered all the questions asked. The patient was well spoken. The patient interpersonal style was hesitant, friendly, Emotional, Non-assertive, Cooperative and Reflective. The patient's mood was dependent on the question asked. The patient felt hopeless, depressed, rejected, uncomfortable, drained and vulnerable. The patient mood and behavior were appropriate with every question and during the assessment. |
| **MAIN THOUGHT CONTENT:**<br>**Ideations:**<br>**Delusions:**<br>**Illusions:**<br>**Obsessions:**<br>**Compulsions:**<br>**Phobias:** | The patient had suicidal ideation without a solid plan to hang herself. The patient is not delusional. No obvious signs of compulsive behaviors or phobias. |
| **ORIENTATION:**<br>**Sensorium:**<br>**Thought Content:** | A&O X4, upon assessment. The patient was calm but when asked certain personal questions her behavior was more agitated. |
| **MEMORY:**<br>**Remote:** | The patient's memory recall is intact. |
| **REASONING:**<br>**Judgment:**<br>**Calculations:**<br>**Intelligence:**<br>**Abstraction:**<br>**Impulse Control:** | The patient has poor impulse control over marijuana addiction. The patient has better reasoning by seeking assistance at OSF. |
| **INSIGHT:** | The knows she does not want to be in an abusive relationship. Continues poor coping skills. |
| **GAIT:**<br>**Assistive Devices:**<br>**Posture:**<br>**Muscle Tone:**<br>**Strength:**<br>**Motor Movements:** | The patient's upright posture with good balance and steady gait when walking. The patient's joints and muscles are symmetrical. The patient has 5+ strength in upper extremities bilaterally and 5+ strength bilaterally in lower extremities against resistance. The patient has active range of motion in both upper and lower extremities. |

**Vital Signs, 2 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| 16:26pm | 97 | 124/58 | 18 | 98 | 98 |
| 14:34pm | 97 | 124/56 | 18 | 97 | 99 |

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

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 4:45pm | 0-10 | N/A | N/A | N/A | N/A |
| 5:00pm | 0-10 | N/A | N/A | N/A | N/A |

**Dietary Data (2 points)**

| Dietary Intake | |
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| **Percentage of Meal Consumed:**<br>**Breakfast:** N/A<br>**Lunch:** N/A<br>**Dinner:** 100% | **Oral Fluid Intake with Meals (in mL)**<br>**Breakfast:** N/A<br>**Lunch:** N/A<br>**Dinner:** 100% |

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):** The patient will not engage in self harm, risky and suicidal behaviors. the patient will demonstrate awareness of distorted thoughts come on if present and will identify alternative balance thoughts. The patient will also identify own goals for care and collaborate with the nurse to create a Wellness recovery plan that includes goals and positive plans for future. The patient will eventually verbalize having hope for the future.

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

| **Nursing Diagnosis**<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components | **Rational**<br>• Explain why the nursing diagnosis was chosen | **Immediate Interventions (At admission)** | **Intermediate Interventions (During hospitalization)** | **Community Interventions (Prior to discharge)** |
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| 1. Risk for self-directed violence related to unspecified psychosis, substance abuse, social isolation as evidenced by verbal cues of suicidal intent. | The patient has lost all interest in social interactions with family members and stated that they have thought of hanging themselves but do not know how to. The patient also stated that she feels hopeless | 1. Take all suicide threats seriously. Ask patients directly "have you thought about killing yourself?" If patient says yes, ask "what do you plan to do?"<br><br>2. Assess for signs of suicidal thinking that warrant further investigation such as holding off meditations come on giving away possessions, sudden interest in guns, and despondent remarks. | 1. Arrange supervision for patient according to facility policy. (Preferably one-on-one).<br><br>2 . Make a contract with patient against self-harm for a specific. Continue negotiating until there is no evidence of suicidal ideations.<br><br>3. Supervise administration of all prescribed medication to be aware of that action and possible adverse effects | 1. Help patient identify community resources to obtain continue therapy and support of the hospitalization<br><br>2. Provide patient and family members with telephone number for crisis prevention centers, suicidal hotlines, counselors, and community support services.<br><br>3. Encourage patient to set a goal of |

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| | | 3. Remove any objects that could be used for self-inflicted injury such as razors, belts, glass objects and pills. | | cooperating with psychiatric intervention. |
| 2. Hopelessness related to social isolation as evidenced by psychological changes. | This nursing diagnosis was chosen because the patient expressed feeling hopeless and stated that her family members have disowned her. | 1. Assess for evidence of self-destructive behavior.<br><br>2. If possible, assign a primary nurse to patient to encourage establishment of therapeutic relationship between patient and nurse<br><br>3. Provide for appropriate physical outlets for expression of feelings. | 1. Convey belief in patients' ability to develop and use coping skills.<br><br>2. Acknowledge the patient's pain. Encourage patient to express feelings of depression, anger, guilt, and sadness. Convey to patient at all these feelings are appropriate.<br><br>3. Identify patient strengths and encourage putting strengths to use. | 1. Teach patient how to manage illness, prevent complications and control factors in the environment that affect patients' health.<br><br>2. Refer patient to other caregivers (such as social worker, clergyman, mental health clinical nurse specialist) or support groups, as necessary.<br><br>3. Provide counseling to patient And involve patients in care planning and allow patient to choose degree of self-involvement on a continuing basis. |

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|---|---|---|---|---|
| 3. impaired mood regulation related to alteration in sleep patterns, loneliness, social isolation, and substance misuse as evidence by unspecified psychosis. | This nursing diagnosis was chosen because the patient is isolated from family members and stated that she uses marijuana daily. | 1. Initiate suicide and of self-home precautions is necessary.<br><br>2. Initiate precautions to reduce risks if any related to this inhabitation<br><br>3. If indicated support measures to resolve effects of substance action or substance withdrawal. | 1. Ensure that area and fluid intake to meet physiologic needs.<br><br>2. Use short, simple phrases to convey instructions or questions. Permit ample time for patient to respond and expect to need to repeat instructions or questions at times. Present tasks to patient for completion one step at a time in small, simple steps.<br><br>3. Convert a non-judgmental, supportive attitude and do not take any irritable statements slash responses personality. Use effective therapeutic communication skills to avoid power struggles. | 1. assist patient with referral to specialty psychotherapy resources, as indicated by patient's presentation and as determined by the clinical team.<br><br>2. Engage patient to develop and enact a Wellness recovery plan in own care.<br><br>3. Assist patient in evaluating the efficacy of patient's strategies to meet goals new solutions for strategies attempted but ineffective to meet goals. |

**Other References (APA):** Phelps, L. L. (2020). Sparks & Taylor's nursing diagnosis reference manual (11th ed.). Wolters Kluwer.

**Concept Map (20 Points):**

## Subjective Data

The patient stated that her pain is 0 on a scale of zero to 10. The patient stated, “I have been thinking of hanging myself, but I do not know how to tie the rope to do it you know what I mean”. The patient stated, “I do not want anything to do with my family leave them out of this”.

## Objective Data

16:26pm Vital signs: P: 97, BP: 124 / 57, RR: 18, T: 98, O2: 98.
14:34pm Vital signs: P: 97, BP: 124/56, RR: 18, T: 97, O2: 99.
The patient was alert and oriented X4. The patient’s upright posture with good balance and steady gait when walking. The patient’s joints and muscles are symmetrical. The patient has 5+ strength in upper extremities bilaterally and 5+ strength bilaterally in lower extremities against resistance. The patient has active range of motion in both upper and lower extremities.

## Patient Information

A.K
female age 22, Caucasian, single, full code, height 63 inches, weight 123 lbs. Past medical history: Chronic bronchitis, Cleft lip pallet, Anal fissure, bone graft hip surgery psychiatric history: bipolar disorder, unspecified psychosis, insomnia, and suicidal ideations. Chief complaint: Feelings of hopelessness, sexual abuse, Unstable and chaotic home.

## Nursing Diagnosis/Outcomes

Risk for self-directed violence related to unspecified psychosis, substance abuse, social isolation as evidenced by verbal cues of suicidal intent.
Outcome: the patient will discuss sadness, despair, and other feelings. The patient won't harm herself and will discuss appropriate coping skills to avoid future suicidal episodes. The patient will report decrease desire to kill self and if needed will receive referral to mental health professional.
Hopelessness related to social isolation as evidenced by psychological changes.
Outcome: the patient will identify feelings of hopelessness and seek help when they are overwhelming. The patient will also identify ways to deal with stress. The patient will develop coping mechanism to deal with feelings of hopelessness and will begin making positive statements about self and others. The patient will resume and maintain as many formal rules as possible and will begin to develop feelings of hope.
impaired mood regulation related to alteration in sleep patterns, loneliness, social isolation, and substance misuse as evidence by unspecified psychosis.
Outcome: the patient will not engage in self harm, risky and suicidal behaviors. the patient will demonstrate awareness of distorted thoughts come on if present and will identify alternative balance thoughts. The patient will also identify own goals for care and collaborate with the nurse to create a Wellness recovery plan that includes goals and positive plans for future. The patient will eventually verbalize having hope for the future.

## Nursing Interventions

1. Take all suicide threats seriously. Ask patients directly “have you thought about killing yourself?” If patient says yes, ask “what do you plan to do?”
2. Assess for signs of suicidal thinking that warrant further investigation such as holding off meditations come on giving away possessions, sudden interest in guns, and despondent remarks.
3. Remove any objects that could be used for self-inflicted injury such as razors, belts, glass objects and pills.
1. Assess for evidence of self-destructive behavior.
2. If possible, assign a primary nurse to patient to encourage establishment of therapeutic relationship between patient and nurse
3. Provide for appropriate physical outlets for expression of feelings.1. Initiate suicide and of self-home precautions is necessary.
2. Initiate precautions to reduce risks if any related to this inhabitation
3. If indicated support measures to resolve effects of substance action or substance withdrawal.