N323 Care Plan

Lakeview College of Nursing

Beatriz Amaya

Demographics (3 points)

Date of Admission 9/10/22	**Patient Initials** H.S	**Age** 21	**Gender** Female
Race/Ethnicity Korean American	**Occupation** Former Student/Unemployed	**Marital Status** Single	**Allergies** Amoxicillin (Rash)
Code Status Full	**Observation Status** 15 Minute Rounds	**Height** 5'2	**Weight** 100 lbs.

Medical History (5 Points)

Past Medical History: Major depressive disorder, Heart Murmur, Seizures (July 2022)

Significant Psychiatric History: Major depressive disorder, attempted overdose in July 2022 with Wellbutrin.

Family History: Unknown as the patient is adopted.

Social History (tobacco/alcohol/drugs): Denies use of alcohol or drugs. Admits to alcohol use 2 shots of whiskey at most every two days since the age of twenty (about a year).

Living Situation: The patient lives with her parents Heather and Brenean.

Strengths: Fast learner, Good at communicating,

Support System: Mother-"Heather" , Friend-"Forrest"

Admission Assessment

Chief Complaint (2 points): "Attempted to jump off roof"

Contributing Factors (10 points): The patient attempted suicide on September 9th, 2022. The patient stated she attempted to jump off the roof of her house "I've wanted to die for as long as I can remember". Lasted for several minutes until the mother was able to calm her down and take her down from the roof. Characteristics that played a role are patients feeling hopeless, depressed, and helpless. An aggravating factor was the patient feeling lack of a support system

from the father's side. Treated with admission to the Pavilion on September 10th, 2022 and following steps to monitor patient every 15 minutes and participating in group sessions.

Factors that lead to admission: Patient-reported poor sleeping habits and not being able to sleep. As well as a poor concentration in school causing her to drop out of school. Loss of job due to inability to focus on work. The patient believes she has undiagnosed ADHD.

History of suicide attempts: On July 2022 patient tried to overdose on Wellbutrin.

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

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse: N/A**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Sexual Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Emotional Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Neglect	**Yes**	**"I can't remember"**	**N/A**	**"My father is not there for me when I need him**

				emotionally".
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	**N/A**	**N/A**	**N/A**	**N/A**
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**	**Patient describes her depression coming and going like mood swings. It gets most intense when her menstrual cycle is about to begin. Can last up to a few hours to several days occurs mostly when menstrual cycle is about to begin. Patient is currently content and genuinely happy at the time of interview.**
Loss of energy or interest in activities/school	**Yes**	**No**	**Patient has frequent loss of energy. It came to be intense to where the patient decided to**

			drop out. The duration of this feelings lasted weeks and occurrence was so often to where she could no longer catch up on assignments so she felt it would be better to drop out.
Deterioration in hygiene and/or grooming	**Yes**	**No**	**N/A**
Social withdrawal or isolation	**Yes**	**No**	**Patient feels every so often she isolates herself from others. It feels intense when she is in a crowded area, she feels overwhelmed and decides to isolate herself. The duration is only when overstimulated and feeling the need to be on her own. Mostly occurs when patient feels overstimulated and anxious when too many people are around her or when having to participate in family activities.**
Difficulties with home, school, work, relationships, or	**Yes**	**No**	**Patient reports lately feeling so overwhelmed with home,**

responsibilities			**school, and work as well as with relationships. It was intense to where patient dropped out of school and left her receptionist job. As for relationship wise, she expresses it is frustrating her father is "not emotionally there" for her. These feelings occur way to often for her liking.**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**Patient reports frequent changes in sleep. Intensity of having to switch sleeping schedules and falling asleep at around four a.m. and waking up at ten in the morning. Only lasts several days occurs when menstrual cycle is about to start then goes back to regular eight hours of sleep afterwards.**
Difficulty falling asleep	**Yes**	**No**	**N/A**
Frequently awakening during	**Yes**	**No**	**N/A**

night			
Early morning awakenings	**Yes**	**No**	**Patient does not frequently wake up early in the morning. Intensity of only awoken around six in the morning if need be. Lasts for only the hour needed to get up at the time with unusual occurrences.**
Nightmares/dreams	**Yes**	**No**	**Patient has dreams daily with intensity of feeling like being in "another dimension". Duration of dreams is while she is asleep but unsure how long it lasts with regular occurrences each time she sleeps.**
Other	**Yes**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**N/A**
Binge eating and/or purging	**Yes**	**No**	**N/A**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**N/A**
Use of laxatives or excessive exercise	**Yes**	**No**	**N/A**

Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**Patient reports feeling anxious often comes with tremors. She feels it gets intense when talking to strangers It lasts for several minutes or until overstimulation passes. It occurs when patient is in a crowded room or having to continue a conversation where she no longer knows what to say next.**
Panic attacks	**Yes**	**No**	**Patient reports frequent panic attacks along with her anxiety attacks. It is intense when she is overstimulated. Lasts for several minutes or until overstimulation passes. It occurs when patient is anxious.**
Obsessive/compulsive thoughts	**Yes**	**No**	**N/A**
Obsessive/compulsive behaviors	**Yes**	**No**	**N/A**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**N/A**

Rating Scale			
How would you rate your depression on a scale of 1-10?	"My depression I would rate it a zero , a negative if I could right now"		
How would you rate your anxiety on a scale of 1-10?	"I would rate my anxiety a 2 out of 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 felt work stress every day, with an intensity that made her quit her job. She lasted at her job for several months and the stress would occur daily.
School	**Yes**	**No**	The patient felt school stress every day while she was still a student. The intensity heightened within the last few weeks causing her to fall back on assignments which she then decided to drop out. This stress lasted for a few weeks and would occur weekly until she dropped out.
Family	**Yes**	**No**	The patient felt family stress daily with an intensity aimed mostly at her father. Her father

			would constantly yell at her as well as not emotionally be there when she needed him. She does not recall how long she has had family stress for, but it would occur anytime she was around her father.
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	Patient felt social stress every time she was in a crowded area or when attention was mostly on her. The intensity happened when she felt overstimulated in social events. The duration lasted until the stimulant was gone and occurred anytime she felt anxious.
Financial	**Yes**	**No**	Patient feels in financial stress every day with intensity of having three thousand dollars of debt to college. The duration is for however long she will have the debt for, and occurrence is

			while the debt is still standing.
Other	**Yes**	**No**	Patient feels everyday as if she has ADHD that has yet to be diagnosed. It is intense to where she feels the need to find a doctor to evaluate her to get mood stabilizers. It's duration is unknown according to the patient. This occurrence is daily as to where she feels "I am not making any progress".

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
N/A	**Inpatient** **Outpatient** **Other:** **N/A**	**N/A**	N/A	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:** **N/A**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**	**N/A**	**N/A**	**No improvement** **Some improvement**

	N/A			**Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Heather Summers	**50**	**Mother**	**Yes**	**No**
Brenan	**51**	**Father**	**Yes**	**No**
Brevan	**18**	**Brother**	**Yes**	**No**
"Pepper"	**18**	**Brothers** **Girlfriend**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): N/A **Who are children with now? N/A**				
Household dysfunction, including separation/divorce/death/incarceration: Patient feels like her parents are "hovering over me" ever since her first suicide attempt in June 2022. She expresses her relationship with her father as strained due to not being able to come out as pansexual to him being "very conservative" and expresses "he gets on my nerves a lot". Her relationship with her mother is pleasant and loving as she can open to her mom a lot more than to her father. Patients' family is going to couples therapy to see if they can save their marriage but are on the verge of separating. "My mother did not want to leave my father until we all grew up because she did not want us to grow up without a father". Her mother was also afraid she would not get full custody of her children if she did separate from her husband.				
Current relationship problems: Patients main relationship problem is with her father				

describing him as “He is a bitch”. She feels like he needs to be more present in her life emotionally and understanding of her.

Number of marriages: N/A

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

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

“I used to be Christian, but my father ruined it as he is very conservative”

Ethnic/cultural factors/traditions/current activity:

Patients’ ethnicity is Korean American. N/A for cultural factors, traditions, or activities.

Describe: Patient was adopted from Korea. Patient expressed she did have any cultural factors nor traditions within her family.

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):
N/A

How can your family/support system participate in your treatment and care?

She expressed that as for support her mom can do, “Whatever makes my mom comfortable, and thinks is safe for me as for my dad he can fuck off”.

Client raised by:

Natural parents
Grandparents
Adoptive parents: At the age of two and a half months old.
Foster parents
Other (describe):

Significant childhood issues impacting current illness:

“Don’t remember much of my childhood issues if I had to guess it’d have to do with my dad”

Atmosphere of childhood home:

Loving
Comfortable
Chaotic

Abusive **Supportive** **Other: Strained** Strained with mom only when she is hovering. Dad it is a constant strained relationship and with her brother it is a 50/50 situation with him.
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Brother Brevan attempted suicide in October 2021.
History of Substance Use:N/A
Education History: **Grade school** **High school** **College** **Other:** Attended some college for a technology degree but dropped out.
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient expressed difficulty staying focused in school and completing assignments on time before they pile up.
Discharge
Client goals for treatment: Client's goal is to get a hold of her primary care provider to discuss issues of having trouble maintain focus in school and work. Client's goal is to better her relationship with her father as well as cut down on drinking.
Where will client go when discharged? Patient will return home with parents.

Outpatient Resources (15 points)

Resource	Rationale
1. Group Therapy	1. This was an option due to her having lots of overwhelming feelings with school and work recently. Hopefully group therapy will provide her with healthy coping mechanisms when feeling overwhelmed. Also too be able to see how other people may have the same problems as her and hopefully form a connection with them and express her feelings as well.
2. Suicide Prevention Hotline: #968	2. This was a choose option as patient seems to have now two attempts within this past year of suicide. This hotline can be helpful and ease the patient when she is in a crisis episode. Having someone to listen to and know they are not alone helping people usually come into realization of the gravity of mistake they are about to commit.
3. AA	**3.** This is a recommendation as the patient expressed drinking two shots of whiskey at least every two days. The patient would

	benefit from attending a meeting and seeking help to cut down on her drinking as it can cause lifelong effects. At such a young age and with a only a year of experiencing this issue I feel like the patient will have a positive outcome with attending these meetings.

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

Brand/Generic	Abilify/ Aripiprazole	Zoloft/Sertraline	**N/A**	**N/A**	**N/A**
Dose	5 mg.	50 mg	**N/A**	**N/A**	**N/A**
Frequency	Once a day at night time 19:00 only	PRN	**N/A**	**N/A**	**N/A**
Route	PO	PO	**N/A**	**N/A**	**N/A**
Classification	Pharmacologic: Atypical antipsychotic	Pharmacologic: Selective serotonin re-uptake inhibitor (SSRI)	**N/A**	**N/A**	**N/A**

Mechanism of Action	It May produce anti-psychotic through partial agonist and antagonist actions. Acts as a dopamine and serotonin receptor (Jones, 2021,p.79)	Increasing the amount of serotonin available in nerve synapses. May relieve psychiatric conditions attributed to serotonin deficiency and premenstrual dysphoric disorder (Jones, 2021, p.991).	**N/A**	**N/A**	**N/A**
Therapeutic Uses	Therapeutic Anti-psychotic	Therapeutic: Antianxiety, Antidepressant	**N/A**	**N/A**	**N/A**
Therapeutic Range (if applicable)	"10 to 15 milligrams daily increase to 30 milligrams daily as needed with dosage adjustments at two week intervals" (Jones, 2021,p.77)	50 mg daily increase by 25 mg daily every week as needed maximum 200 mg (Jones, 2021,p.991)	**N/A**	**N/A**	**N/A**
Reason Client Taking	Client takes it as her mood stabilizer	This medication is an antidepressant patient takes it for her major depressive disorder.	**N/A**	**N/A**	**N/A**
Contraindications (2)	hypersensitivity to Aripiprazole hypersensitivity to its components	Current use of disulfiram, Current use of pimozide	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	Homicidal ideation, depression, mania.	Suicidal ideation, depression	**N/A**	**N/A**	**N/A**
Medication/Food	Possibly	Antibiotics,	**N/A**	**N/A**	**N/A**

Interactions	enhanced antihypertensive effect (Jones 2021, p.79). If used with alcohol use increases CNS depression (Jones 2021, p.79).	Antipsychotic			
Nursing Considerations (2)	"Be aware that for patients who have never taken Aripiprazole tolerability must be established with oral form prior to initiating parenteral therapy" (Jones, 2021, p.80) "Know that you may give oral solution on a milligram per milligram basis in place of tablets up to twenty-five milligrams" (Jones, 2021, p.80)	"Sertraline should not be given with patients who have bradycardia" (Jones, 2021, p.993). "Monitor liver enzymes and BUN and serum creatinine levels as appropriate in patient with hepatic and renal failure" (Jones, 2021, p.993)	**N/A**	**N/A**	**N/A**

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

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patients shows no signs of distress, overall appears well-groomed hair is symmetrical pulled back in a bun. Behavior is well-behaved and engaging in every question asked. Attitude is calm, appeared bubbly and smile on her face with an upright posture. The interpersonal style is moderate eye contact, friendly, eager to answer the questions. The patient was in a content mood

	even expressed to be feeling a lot better than when she first arrived rated her depression a 0/10. The patient positive affect showed throughout her posture and willingness to answer questions.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patients' main thoughts were how she missed her family and was excited to go see her mom as she was told her mother was going to make chili as soon as she was released. Patient at the time denied any ideations, delusions, illusions, obsession, compulsion, and phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient is alert and oriented x4 . Sensorium as well with great concentration with no limitations. Patients' thoughts were all positive at the time as her facial expression showed a smile as well as her language was in a positive attitude. Her thoughts were in a happy place and no longer expressed any thoughts of suicide. The patient was open to conversing about more than just the interview opened up about her life and vacations she recently took to New York. .
MEMORY: **Remote:**	Memory is intact able to recall three words asked to prior to interview starting. Remote memory slightly impaired as she was not able to recall her childhood when asked questions about her past stating "I do not remember much of my childhood issues if I had to guess it'd have to do with my dad".
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient reasoning's is well judged as asked if given a letter what would you do with it responded well with, "I would mail it to whom it needed to be delivered, or if it was written for me I would read it". Calculations are well intact as asked to count backward by five starting from one hundred and the patient was able to count backward well. Intelligence is adequately graduating with high honors in high school and abstract thoughts. The patient can be impulsive at times before thinking thoroughly about her actions hence her she references her suicide attempt.
INSIGHT:	Patient is aware of her illness and how her attempt on suicide will also affect other people's life's as well. Open to trying healthy coping

	mechanisms. The idea of possibly having ADHD due to severe lack of focus with school and work. She states being open to seeing a psychiatrist to hopefully put her on medication to help her focus.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Patients gait is stable with no need for assistive device. Posture is erect and upright shoulders no signs of disinterest. Muscle tone is firm and healthy no weakness. Strength is rating at a 5 both on upper and lower extremities with no difficulty performing any activity of daily livings. Motor movements are all active in upper and lower extremities.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
14:30	**83 bpm**	**109/66**	**18**	**98.5 °F**	**98% RA**
17:45	**88 bpm**	**124/64**	**18**	**98.6 °F**	**98% RA**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
14:30	**0-10**	**N/A**	**0/10**	**N/A**	**N/A**
17:45	**0-10**	**N/A**	**0/10**	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 100%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 240 mL (carton of milk)**

Lunch:100% **Dinner:N/A**	**Lunch: 240 mL (cup of root beer)** **Dinner:N/A**

Discharge Planning (4 points)

Discharge Plans (Yours to the client):

Discharge plan is for the patient to return home to a safe environment with her parents. Home health care needs addressed as well as reminder when medications should be taken. Follow up with primary care provider to get a referral to set an appointment to see a psychiatrist to discuss possibilities of new medication due to her inability to keep focus at her former school and job. As well as address her drinking problem. Proper education is attained as well as pamphlets are given that represent healthy coping mechanisms when the patient feels overwhelmed again. No equipment is needed. Discussed the idea of journaling her feelings and the patient seemed to be fond of this being her new coping mechanism. The patient and family members will hopefully attend a family therapy session to address the strain in the patient's relationship within the family. The patient will leave with proper education on healthy coping mechanisms.

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

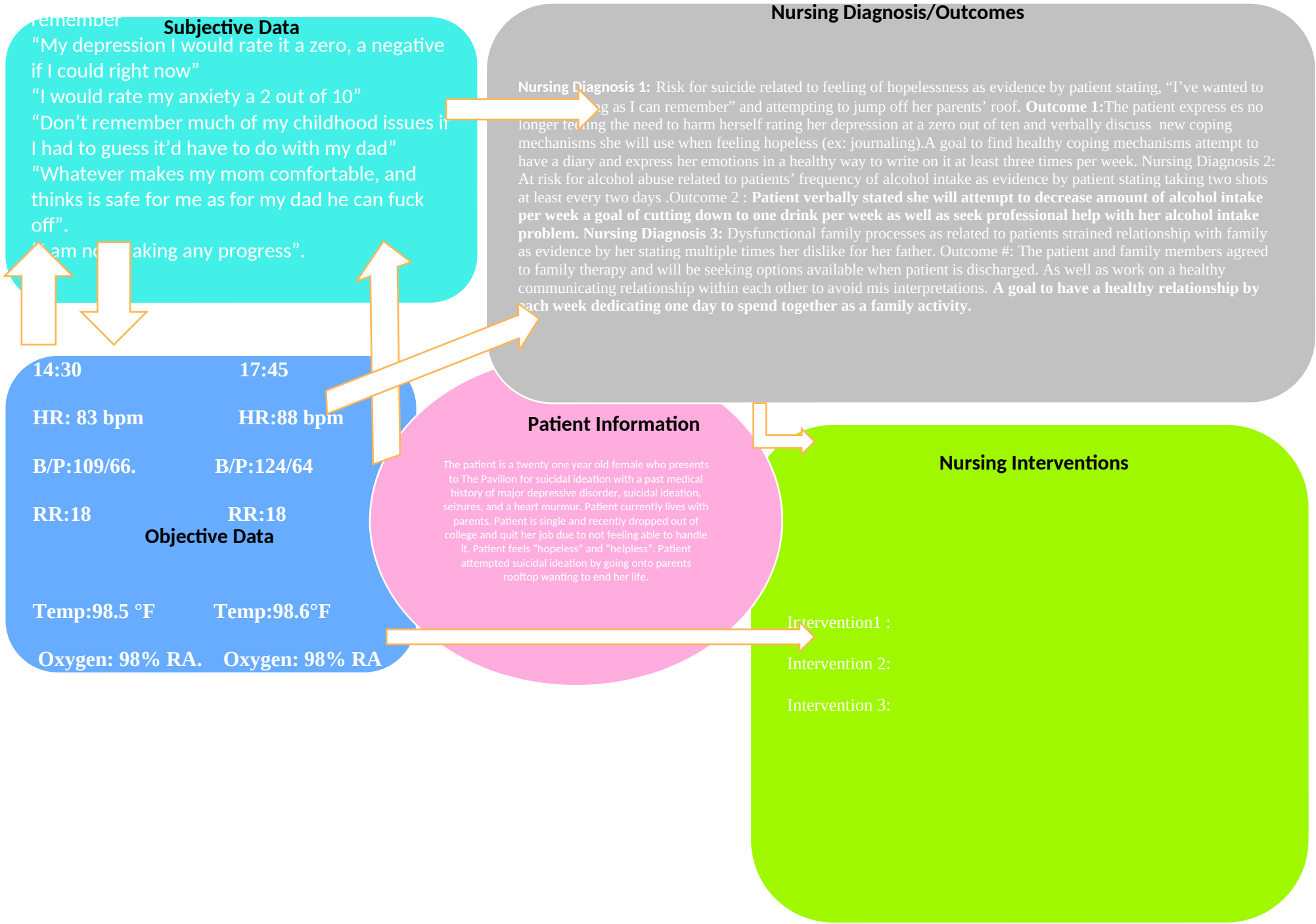
Nursing Diagnosis • Include full nursing diagnosis	**Rational** • Explain why the nursin	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalizati**	**Community Interventions (Prior to discharge)**

with “related to” and “as evidenced by” components	g diagnosis was chosen		**on)**	
1. Risk for suicide related to feeling of hopelessness as evidence by patient stating, “I’ve wanted to die for as long as I can remember” and attempting to jump off her parents roof.	This nursing diagnosis was chosen due to patient expressing herself in a despair state of mind feeling “helpless” with a lack of a supportive father. As well as expressing she attempted to jump off her parents roof.	1. Patient will have a one-on-one nursing observation. 2. Patient will be separated from any harmful situations. 3. Patient will be stripped to check for any harmful items hidden in body or clothes.	1.Patient will be checked on every fifteen minutes. 2.Patient will attend group therapy and express positive feelings with no longer feelings of causing self-harm. 3. Remain non-judgmental and form a therapeutic relationship by communication with the patient.	**1**.Provide constant safe environment for the patient and as well as make sure home environment is a safe place as well. **2.** Encourage the client to avoid decisions during the time of crisis until alternatives can be considered. 3. Encourage client to speak up about alternative healthy coping mechanisms when having thoughts of self-harm.
2. At risk for alcohol abuse related to patients’ frequency of alcohol intake as evidence by patient	This nursing diagnosis was chosen due to patient admitting to alcohol use 2	**1.** Check for blood alcohol concentration test in system. **2.** Check for any signs of	**1.** Provide information regarding effects of long-term alcohol use effects on mood and personality. **2.**Educate	**1.** Form a trsutworhty therapeutic relationship with the patient **2.**Have the patient educate me on

stating taking two shots at least every two days.	shots of whiskey at most every two days since the age of twenty (about a year).	withdrawals. **3.** Put patient on CIWA precautions**.**	patient on alternative coping mechanisms instead of drinking. **3.** Discuss patients current life situation and what makes her feel the need to drink and how it makes her feel.	what was taught about alcohol dependence **3.** Encourage family members to seek help for patient as well and give out pamphlets of places to go seek help
3. Dysfunctional family processes as related to patients strained relationship with family as evidence by her stating multiple times her dislike for her father.	This was chosen due to her family expressing a possible separation foreseen in the future and the patient expressing her father's absence when she emotionally needs him.	**1.** Removing family disturbances from scene. **2.** Interview patient about family issues at home. 3. Ask patient if she feels safe at home.	**1.** Provide active listening as to why patient dislikes her father. 2. Form a trusting therapeutic relationship with patient so she feels comfortable to express her feelings. 3. Provide a warm safe environment for patient making sure patient does not feel uncomfortable at any given time.	**1.** Encourage family to attend family counseling. **2.** Educate patient about ways to help reinforce the family's relationship. **3.** Assist in helping patient discover what causes the relationship to be strained and how communication can go a long way so there is no misinterpretation**.**

Other References (APA): N/A

Concept Map (20 Points):


remember
Subjective Data
"My depression I would rate it a zero, a negative if I could right now"
"I would rate my anxiety a 2 out of 10"
"Don't remember much of my childhood issues if I had to guess it'd have to do with my dad"
"Whatever makes my mom comfortable, and thinks is safe for me as for my dad he can fuck off".
aking any progress".
Nursing Diagnosis/Outcomes
Nursing Diagnosis 1: Risk for suicide related to feeling of hopelessness as evidence by patient stating, "I've wanted to g as I can remember" and attempting to jump off her parents' roof. Outcome 1:The patient express es no longer feeling the need to harm herself rating her depression at a zero out of ten and verbally discuss new coping mechanisms she will use when feeling hopeless (ex: journaling).A goal to find healthy coping mechanisms attempt to have a diary and express her emotions in a healthy way to write on it at least three times per week. Nursing Diagnosis 2: At risk for alcohol abuse related to patients' frequency of alcohol intake as evidence by patient stating taking two shots at least every two days .Outcome 2 : Patient verbally stated she will attempt to decrease amount of alcohol intake per week a goal of cutting down to one drink per week as well as seek professional help with her alcohol intake problem. Nursing Diagnosis 3: Dysfunctional family processes as related to patients strained relationship with family as evidence by her stating multiple times her dislike for her father. Outcome #: The patient and family members agreed to family therapy and will be seeking options available when patient is discharged. As well as work on a healthy communicating relationship within each other to avoid mis interpretations. A goal to have a healthy relationship by ach week dedicating one day to spend together as a family activity.
14:30 17:45
HR: 83 bpm HR:88 bpm
B/P:109/66. B/P:124/64
RR:18 RR:18
Objective Data
Temp:98.5 °F Temp:98.6°F
Oxygen: 98% RA. Oxygen: 98% RA
Patient Information
The patient is a twenty one year old female who presents to The Pavilion for suicidal ideation with a past medical history of major depressive disorder, suicidal ideation, seizures, and a heart murmur. Patient currently lives with parents. Patient is single and recently dropped out of college and quit her job due to not feeling able to handle it. Patient feels "hopeless" and "helpless". Patient attempted suicidal ideation by going onto parents rooftop wanting to end her life.
Nursing Interventions
Intervention1 :
Intervention 2:
Intervention 3:

17:45