N323 Care Plan

Lakeview College of Nursing

Toni Andres

Demographics (3 points)

Date of Admission 01-06-2023	Patient Initials B.B.	Age 31	Gender F
Race/Ethnicity W	Occupation Disability	Marital Status Single	Allergies Amoxicillin, Penicillin, latex, strawberries
Code Status Full	Observation Status Inpatient	Height 65”	Weight 330

Medical History (5 Points)

Past Medical History:
Sleep apnea
Diabetes
Cauda Equina
Gastric sleeve
Cholecystectomy
Appendectomy

Significant Psychiatric History:
Anxiety
Depression
Borderline personality disorder
PTSD

Family History:
Diabetes
Obesity
High blood pressure
High cholesterol
Cardiac issues

Social History (tobacco/alcohol/drugs): Patient denies any use of tobacco/alcohol/drugs.

Living Situation:
Resides with her mother

Strengths:
Supportive family and friends
Ability to verbalize feelings
Motivated to improve
Cooperative
Willing to receive help

Support System:
Mother and stepfather
Church/church family

Admission Assessment

Chief Complaint: Suicidal ideation and self-harm

Contributing Factors (10 points):

Factors that lead to admission: The patient is a pleasant 31-year-old female who was admitted for suicidal ideation and self-harm. From the age of 9 through 13 she had been sexually molested by her biological father. She was also engaged to a man whom she had been living with for approximately 2.5 years. He became abusive, mentally, and emotionally and they broke up. She stated, “he was just not a good person he abused me mentally and emotionally and made me feel bad about myself”. She moved out of their apartment and in with her mother, which is who she will be staying with. Her grandmother whom she was very close with, passed away approximately 2 years ago. She was primarily raised by her grandmother and has had a difficult time coping with her death. The combination of the abuse from her ex-fiancé, the breakup, and grandmothers passing, she stated “It all just overwhelmed me. I had thoughts of walking into traffic and driving my car into a pole. I realized I needed help and called the crisis line. They told me to go to the nearest emergency room and get admitted”.

History of suicide attempts: The patient stated when asked about the history of suicide attempts “I had only attempted suicide 1 other time and it was years ago, like over 10 years ago”. The patient’s records indicate multiple suicide attempts by overdose and self-harm and of numerous hospitalizations but no data regarding dates of admission or detail of admissions.

Primary Diagnosis on Admission (2 points): bipolar disorder (also called manic-depressive illness): A mood disorder that can cause intense mood swings, changes in behavior, energy levels, and activity levels (MedlinePlus, 2021).

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:** Sexual molestation from the ages of 9 through 13 by her biological father. In 2021 her grandmother, whom she resided with for most of her life passed away.				
	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	9 through 13	NA	The patient was sexually molested by her biological father from the age of 9 through 13.
Emotional Abuse		29 through 31	NA	The patient was engaged to a man who emotionally and mentally abused her by demeaning her and

				making her feel bad about herself.
Neglect	NA	NA	NA	NA
Exploitation	NA	NA	NA	NA
Crime	NA	NA	NA	NA
Military	NA	NA	NA	NA
Natural Disaster	NA	NA	NA	NA
Loss	X	29	NA	
Other		29	NA	The patients' grandmother passed away in 2021. She resided with her grandmother for most of her life and they had a close relationship.
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**		
Loss of energy or interest in activities/school	**Yes**	**No**	The patient sometimes has a loss of energy and just feels as she describes it" blah". The feeling does not occur every day, it comes and goes, some days are better than others	
Deterioration in hygiene and/or grooming	**Yes**	**No**		
Social withdrawal or isolation	**Yes**	**No**		
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	The patient within the last few weeks has had difficulties with her relationship with her ex-fiancé.	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	

Change in numbers of hours/night	**Yes**	**No**	
Difficulty falling asleep	**Yes**	**No**	
Frequently awakening during night	**Yes**	**No**	The patient for as long as she can remember has had issues with being able to stay asleep. She states, “I am able to get to sleep but then I wake up and cannot go back to sleep”.
Early morning awakenings	**Yes**	**No**	
Nightmares/dreams	**Yes**	**No**	
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 feels like she has a racing heart, she gets sweaty hands and cries when her anxiety level seems to be uncontrollable.
Panic attacks	**Yes**	**No**	The patient believes she has had numerous panic attacks in the past with the feeling of the racing heart and sweaty hands but has not been clinically diagnosed with a panic disorder.
Obsessive/compulsive thoughts	**Yes**	**No**	
Obsessive/compulsive	**Yes**	**No**	

behaviors			
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	The patient does not like to do things socially that involve group activities, it makes her feel very uncomfortable. She does not mind group therapy as much and realizes it helps her cope with her situation and her past.
Rating Scale			
How would you rate your depression on a scale of 1-10?		On a number scale the patient rates her depression as a 2.	
How would you rate your anxiety on a scale of 1-10?		On a number scale the patient rates her anxiety as a 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**	
School	**Yes**	**No**	
Family	**Yes**	**No**	
Legal	**Yes**	**No**	
Social	**Yes**	**No**	The patient has stressors regarding her relationship and past relationship with her ex-fiancé. She knows that he is not a good person to be around, and he makes her feel bad about herself, yet she struggles with wanting to get back with him.
Financial	**Yes**	**No**	
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
Unknown	**Inpatient Outpatient Other:**	Inpatient	Attempted suicide by overdose	**No improvement** **Some improvement** **Significant improvement**
Unknown	**Inpatient Outpatient Other:**	Inpatient	Self harm by way of cutting	**No improvement** **Some improvement** **Significant improvement**
Unknown	**Inpatient Outpatient Other:**	Inpatient	Aggressive behaviors	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Lisa	55	Mother	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: NA				
Children (age and gender): None				

Who are children with now? NA

Household dysfunction, including separation/divorce/death/incarceration:
Patient had been living with a fiancé (at the time) and they separated 01-01-23, she then moved out of their apartment and in with her mother.

Current relationship problems:
Patient had a relationship and was engaged to a man, they separated 01-01-23. He was mentally and emotionally abusive.

Number of marriages: 0

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

Please describe your religious values, beliefs, spirituality and/or preference:
Belongs to the Saint Paul United Church of Christ, has a strong relationship with church members and believes strongly in her faith.

Ethnic/cultural factors/traditions/current activity: None

Describe:

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient denies any current/past legal issues

How can your family/support system participate in your treatment and care?
Her mother is very supportive of her treatment and will help her get to appointments and therapy. “She is letting me stay there until I get back on my feet”.

Client raised by:

Natural parents
Grandparents Raised my maternal grandmother for most of her life.
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:
Patient was sexually molested by her biological father between the ages of 9 through 13.

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.) Father: Suicide attempts and depression Mother: Depression
History of Substance Use: Patient denies history of substance use.
Education History: **Grade school** **High school** **College** Associates in Arts, Heartland Community College **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient denies any problems in school.
Discharge
Client goals for treatment: Patient is being discharged today, she said her goals are "to have better coping skills and to deal better with her mental health".
Where will client go when discharged? The client will reside with her mother upon discharge.

Outpatient Resources (15 points)

Resource	Rationale
1. Church and church family	**1.** The patient has very strong ties to her church. There are groups that she can join to help her with her coping skills and to help her stay on track with dealing with her mental health.
2. Community based counseling services	**2.** Her community offers a counseling service

	that is familiar with her and her medical and mental health history. They are also available 24 hours a day and would be able to help advise and guide her.
3. Grief group counseling	**3.** A grief group counseling group can provide a safe space. They will be able to provide thoughts about similar struggles to hers and provide feedback that she can learn from. These types of groups can promote social skills and would cost less than individual counseling sessions.

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

Brand/ Generic	Amrix/ cyclobenzaprine	Carafate/ sucralfate	Abilify/ aripiprazole	Wellbutrin XL/bupropion ERT	Vistaril/ hydroxyzine pamoate
Dose	10 milligrams	1 gram	20 milligrams	300 milligrams	25 milligrams
Frequency	daily PRN	Daily BID	daily AM	daily AM	daily QID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic: tricyclic antidepressant like agent Therapeutic: skeletal muscle relaxant	Pharmacologic: GI protectant Therapeutic: anti ulcer	Pharmacologic: atypical antipsychotic Therapeutic: antipsychotic	Pharmacologic: aminoketone Therapeutic: antidepressant, smoking cessation adjunct	Pharmacologic: piperazine derivative Therapeutic: antiemetic, and a histamine, sedative-hypnotic, anxiolytic

Mechanism of Action	Acts in the brain stem to reduce or abolish tonic muscle hyperactivity. Because it doesn't act at the neuromuscular junctions or directly on skeletal muscle, it relieves muscle spasm without disrupting muscle function.	Reacts with hydrochloric acid in the stomach to form a complex that buffers acid. The complex adheres two proteins on the ulcers surface and creates a protective barrier at the ulcer site. Inhibits back diffusion of hydrogen ions and absorbs bile acids and pepsin, actions that promote healing of an existing duodenal ulcer and prevent reoccurring ulcer formation.	May produce antipsychotic effects through partial agonist and antagonist actions. Acts as a partial agonist at dopamine (D2)receptors and (5-HT 1A)serotonin receptors. Acts as an antagonist at 5-HT2A serotonin receptor sites.	May inhibit dopamine, nor epinephrine, and serotonin uptake by neurons, which significantly relieves evidence of depression.	competes with histamine for histamine 1 receptor sites on surfaces of effector cells. This suppresses results of histaminic activity, including edema, flare, and puritus. sensitive actions occur at subcortical level of central nervous system and are dose related.
Therapeutic Uses	As adjunct to rest and physical therapy for relief of muscle spasm associated with acute, painful musculoskeletal conditions	To prevent reoccurrence of duodenal ulcer. To treat active duodenal ulcer	To treat acute schizophrenia; to maintain stability in patients with schizophrenia. To treat acute manic and mixed episodes in bipolar one disorder with or without psychotic features; to maintain stability in patients with bipolar one disorder; as adjunct with lithium or valproate in patients with bipolar one disorder. To maintain stability with monotherapy	To treat depression. To aid in smoking cessation. To prevent seasonal major depressive episodes in patient with seasonal affective	to relieve anxiety and tension associated with psychoneurosis; Adjunct inorganic disease states in which anxiety is manifested.

			treatment of bipolar one disorder. As adjunctive treat depression in patients already taking an antidepressant. To treat irritability associated with autistic disorder. To treat Tourette's disorder. To treat agitation associated with bipolar mania or schizophrenia.	disorder.	To treat pruritus due to allergic conditions. Used as a sedative when used as premedicatio n and following general anesthesia.
Therapeutic Range (if applicable)	30 milligrams daily for no more than three weeks	1 gram twice daily	Maximum 30 milligrams daily	Maximum 450 milligrams daily	50 to 100 milligrams four times daily
Reason Client Taking	Muscle spasms	GERD	Mood improvement	Major depressive disorder	Anxiety
Contraindic ations (2)	1.Acute recovery phase of myocardial infarctions; arrhythmias, including heart block and other conditioned disturbances. 2.Heart failure	1.Impaired swallowing and gag reflex 2.End stage renal disease	1.Hypersensit ivity to aripiprazole 2.Hypersensit ivity to components of Aripiprazole	1.Hypersens itivity to bupropion or its component. 2.Seizure disorder or conditions that increase risk of seizures. 3.Anorexia nervosa or bulimia	1.Early pregnancy 2. Prolonged QT interval
Side Effects/Adv erse Reactions (2)	1.Aggression, agitation, anxiety, confusion 2.Arrhythmias, including tachycardia, hypertension, myocardial infarction	1.Dizziness, drowsiness, headache, vertigo 2.Pureitis, rash	1.Homicidal/ suicidal ideation, intracranial hemorrhage, insomnia, lethargy 2.Seizures, paranoia, arrhythmias, bradycardia, cardio	1.Abnormal EEG, arrythmias, chest pain, complete AV block, hypertension, myocardial infarction, palpitations, tachycardia. 2. Agitation anxiety, decreased concentration or memory, delirium, delusions, depression, dream abnormalities, emotional liability, euphoria,	1.Drowsiness hallucinations , headache 2.Seizures, involuntary motor activity, tremors

			pulmonary arrest, deep vein thrombosis	general or migraine headache, hallucinations, homicidal ideation, suicidal ideation.	
Medication/ Food Interactions	Anticholinergics, antidyskinetics	Digoxin, quinidine, fluoroquinol 1 antibiotics	Antihypertensives, benzodiazepines	Hypersensitivity to bupropion or its components, seizure disorder or conditions that increase risk of seizures, anorexia nervosa or bulimia.	Antibiotics such as azithromycin, erythromycin, clarithromycin. antidepressants, antipsychotics, class 1A anti arrhythmics, methadone
	1.Use cautiously in patients with a history of low seizure threshold. 2.Monitor patient closely if cyclobenzaprine is being given with other serotonergic drugs, especially when treatment is started and during dosage increases, because of the potential for life threatening serotonin syndrome to develop. Assess patient for autonomic instability, mental status changes, and nervous system abnormalities. If present stop both cyclobenzaprine and other serotonergic drugs immediately and notify provider, provide supportive care as ordered (Jones &	1.Use cautiously in patients with chronic renal failure due to increased risk of aluminum toxicity 2.Administer drug to patient on an empty stomach 3.Monitor diabetic patients blood glucose level due to sucralfate may cause hyperglycemia (Jones & Bartlett, 2022).	1.Understand that aripiprazole should not be used to treat dementia related psychosis in the elderly because of an increased risk of death. 2.Use cautiously in patients with cardiovascular disease, cerebral vascular disease, or conditions that would predispose them to hypertension. 2.Be aware that Abilify my site is a drug device combination product comprised of aripiprazole tablets embedded with an ingestible event marker sensor intended to track drug ingestion. There is a mysite app, with a smartphone application used with a compatible smartphone to display information for the patient and web-based portal for healthcare professionals and caregivers to track compliance 3.Watch patients closely especially children, adolescents,	1.Understand that certain forms of bupropion are not approved for smoking cessation treatment. 2.Use cautiously in patients with renal impairment; Drug as excreted by kidneys (Jones & Bartlett, 2022).	1.Use cautiously in patients with risk factors for QT prolongation, and patients with bradyarrhythmias, congenital or family history of long QT syndrome, or other conditions that predispose patient to QT prolongation and ventricular arrhythmia, recent myocardial infarction, or uncompensated heart failure. 2. Observe for over sedation if patient takes another central nervous system depressant (Jones & Bartlett, 2022).

	Bartlett, 2022).		and young adults for suicidal tendencies particularly when therapy starts and dosage changes, because depression may worsen temporarily during these times. 4.Monitor patients CBC due to possible serious adverse hematologic reactions such as leukopenia and neutropenia (Jones & Bartlett, 2022).		

Brand/Generic	Neurontin/ gabapentin	Bustab/buspirone hydrochloride			
Dose	400 milligrams	15 milligrams			
Frequency	daily TID	daily BID			
Route	Oral	Oral			
Classification	Pharmacologic: 1-amino-methyl cyclohexaneacetic acid Therapeutic: anticonvulsant	Pharmacologic: Azaspirone Therapeutic:Anxiolytic			
Mechanism of Action	Gabapentin's exact mechanism of action is unknown, GABA inhibits the rapid firing of neurons associated with seizures. It also may prevent exaggerated responses to painful stimuli and pain related responses to a normally innoxious stimulants to account for its effectiveness in relieving postherpetic neuralgia and restless leg syndrome symptoms.	May act as a partial agonist at serotonin 5-hydroxytryptamine receptors in the brain producing anti anxiety effects.			

Therapeutic Uses	To manage postherpetic neuralgia As adjunct to treat partial seizures To treat moderate to severe primary restless legs syndrome	To manage anxiety			
Therapeutic Range (if applicable)	Up to 600 milligram three times daily/ 18,000mg maximum daily	20 to 30 milligrams daily			
Reason Client Taking	Pain relief	Anxiety			
Contraindications (2)	1.Hypersensitivity to gabapentin 2.Hypersensitivity to gabapentin components	1.Hypersensitivity to Buspirone 2.Hepatic or renal impairment			
Side Effects/Adverse Reactions (2)	Agitation, delusions, CNS tumors, intracranial hemorrhage, subdural hematoma, seizures, suicidal ideation	1.Confusion/decreased concentration 2.Gastric distress			
Medication/Food Interactions	Aluminum and magnesium containing antacids, Hydrocodone, Morphine	CYP 3A4 drugs/phenobarbital dexamethasone			
Nursing Considerations (2)	1.Give the drug at least two hours after an antacid 2.Don't exceed 12 hours between doses on a three times a day schedule 3.Administer initial dose for Neurontin brand at bedtime to minimize adverse reactions (Jones & Bartlett, 2022).	1.Use cautiously in patients with hepatic or renal impairment 2.Institute safety precautions due to possible adverse central nervous system reactions (Jones & Bartlett, 2022).			

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). Nurse's drug handbook (21st ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: well dressed, clean, appropriate for situation **Behavior: cooperative and willing to participate in discussion, calm and pleasant** **Build: larger build** **Attitude: pleasant attitude, happy to be discharged** **Speech: tone and volume are appropriate, softspoken, language skills appropriate for age, spoke with a normal rate of speech and was articulate** **Interpersonal style: clothing was casual and neat hair was combed, no piercings or tattoos evident and looked normal for her age** **Mood: client's mood was good, somewhat energetic and positive** **Affect: client seemed to be happy and willing to answer questions**	
MAIN THOUGHT CONTENT: client was not experiencing any of the following criteria. **Ideations: none** **Delusions: none** **Illusions: none** **Obsessions: none** **Compulsions: none** **Phobias: none**	
ORIENTATION: client's orientation to her environment was appropriate **Sensorium: the client had clear sensorium; was able to function normally,**	.

concentrate and to think clearly, the client was focused and alert **Thought Content: clients thought content contains thoughts of recovery, help, ways to cope with negative situations and positive affirmations.**	
MEMORY: clients memory displayed no impairment and had normal attention span **Remote:**	.
REASONING: **Judgment: the client shows fair judgment** **Calculations: the client was not asked to perform calculations** **Intelligence: the client seemed of above average intelligence based on discussion of academia** **Abstraction: there were now abstractions noted** **Impulse Control: client had normal impulse control**	.
INSIGHT: the client had good insight. She was very aware of her situation and why she was in therapy. She did acknowledge she had an issue and realized it could be and would be continuous. She noted numerous ways of recognizing when her situation became overwhelming and how she could better handle her thought process.	
GAIT: client had a slight limp due to unknown origin **Assistive Devices: none** **Posture: upright and attentive** **Muscle Tone: appropriate for client** **Strength: appropriate for client** **Motor Movements: client had no issues with movement was able to stand sit and walk normally**	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1030	**75**	**133/96**	**18**	**98.7ºF**	**99**
1305	**108**	**142/92**	**18**	**98.3ºF**	**98**

Pain Assessment, 2 sets (2 points)

*Patient denies having any pain anywhere

Time	Scale	Location	Severity	Characteristics	Interventions
1030	**Number scale 0**	**NA**	**NA**	**NA**	**NA**
1330	**Number scale 0**	**NA**	**NA**	**NA**	**NA**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** **Lunch:** 100% of Small portion of meat and vegetables (Pt is on a restrictive diet due to gastric surgery) **Dinner:**	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** **Lunch:** 120mL water **Dinner:**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient will be leaving the facility to reside with her mother. She had no known health care needs or equipment needs. Her treatment plan encourages her to identify and use healthy therapeutic coping skills to manage negative thoughts. She is encouraged to go to group therapy and stay involved in her church and with church

activities. She will manage her medication with her doctor to keep her mood stabilized and utilize outpatient individualized therapy as well as community group therapy.

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. At risk for suicide related to loss of an important relationship as evidenced by suicidal thoughts (Martin, 2022).	**The client had recently broken up with her fiancé after a 2 1/2 year relationship and had lost her grandmother recently whom she was very close with, following this breakup she had feelings of despair with planning and talk of suicidal behavior**	**1. Create a safe and welcoming environment for the client (Martin, 2022).** **2. Have a one-on-one conversation with the client to determine demeanor of client (Martin, 2022).** **3. Remove weapons, pills, and harmful objects from client (Martin, 2022).**	**1. Encourage the client to go to group therapy and talk freely about their situation (Martin, 2022).** **2. Emphasize to the client that help is available and that they are not alone (Martin, 2022).** **3. Keep accurate and thorough records of the clients physical and verbal behaviors and all provider actions (Martin, 2022).**	**1. Construct a no suicide contract between the client and the nurse (Martin, 2022).** **2. Encourage the client to continue therapy (Martin, 2022).** **3. Encourage the client to avoid situations or decisions that could lead to harmful thoughts (Martin, 2022).**

2. At risk for ineffective coping, related to situational crisis evidenced by destructive thoughts towards self (Martin, 2022).	**The client has had numerous hospitalizations due to behaviors such as overdosing and thoughts of self harm**	**1. Assess the clients coping behaviors that resulted in admission (Martin, 2022).** **2. Identify situations that trigger suicidal thoughts or self harm (Martin, 2022).** **3. Clarify with the client things that are not under the person's control such as another's actions and behaviors (Martin, 2022).**	**1. Identify client's strengths and positive coping skills by encouraging engagement and therapy by talking to others and use of problem solving abilities (Martin, 2022).** **2. Assess and assist the client in assertiveness training that can help to develop a sense of balance and control (Martin, 2022).** **3. Teach the client positive problem solving techniques (Martin, 2022).**	**1. Encourage the patient to discuss effective ways to handle stressful situations that could lead to self harm (Martin, 2022).** **2. Encourage the patient to continue positive avenues such as counseling therapy of coping with negative thoughts And make available possible resources for their area (Martin, 2022).** **3. Have the patient demonstrate two behaviors in dealing with emotional pain (Martin, 2022).**
3. At risk for hopelessness related to long term stress and severe stressful	**The client had discussed her past regarding stressors. She discussed this situation of her grandmother's**	**1. Identify physical and psychological changes that affect the client (Martin,**	**1. Help the client identify their strengths (Martin, 2022).** **2. Encourage the patient to**	**1. Have client demonstrate ability of their strengths (Martin, 2022).**

events evidenced by harmful judgment and thoughts (Martin, 2022).	**passing and the overwhelming loss**	**2022).** **2. Take time to listen to the patient to understand what lead to their admission (Martin, 2022).** **3. Help the patient recognize what they are doing is they positive step to overcome the feeling of hopelessness (Martin, 2022).**	**learn ways to cope with their mental health (Martin, 2022).** **3. Encourage the patient to join group therapy to discuss ways to cope with stress (Martin, 2022).**	**2. Discuss and identify things that are important or have meaning to the client (Martin, 2022).** **3. Have client practice coping mechanisms prior to discharge (Martin, 2022).**

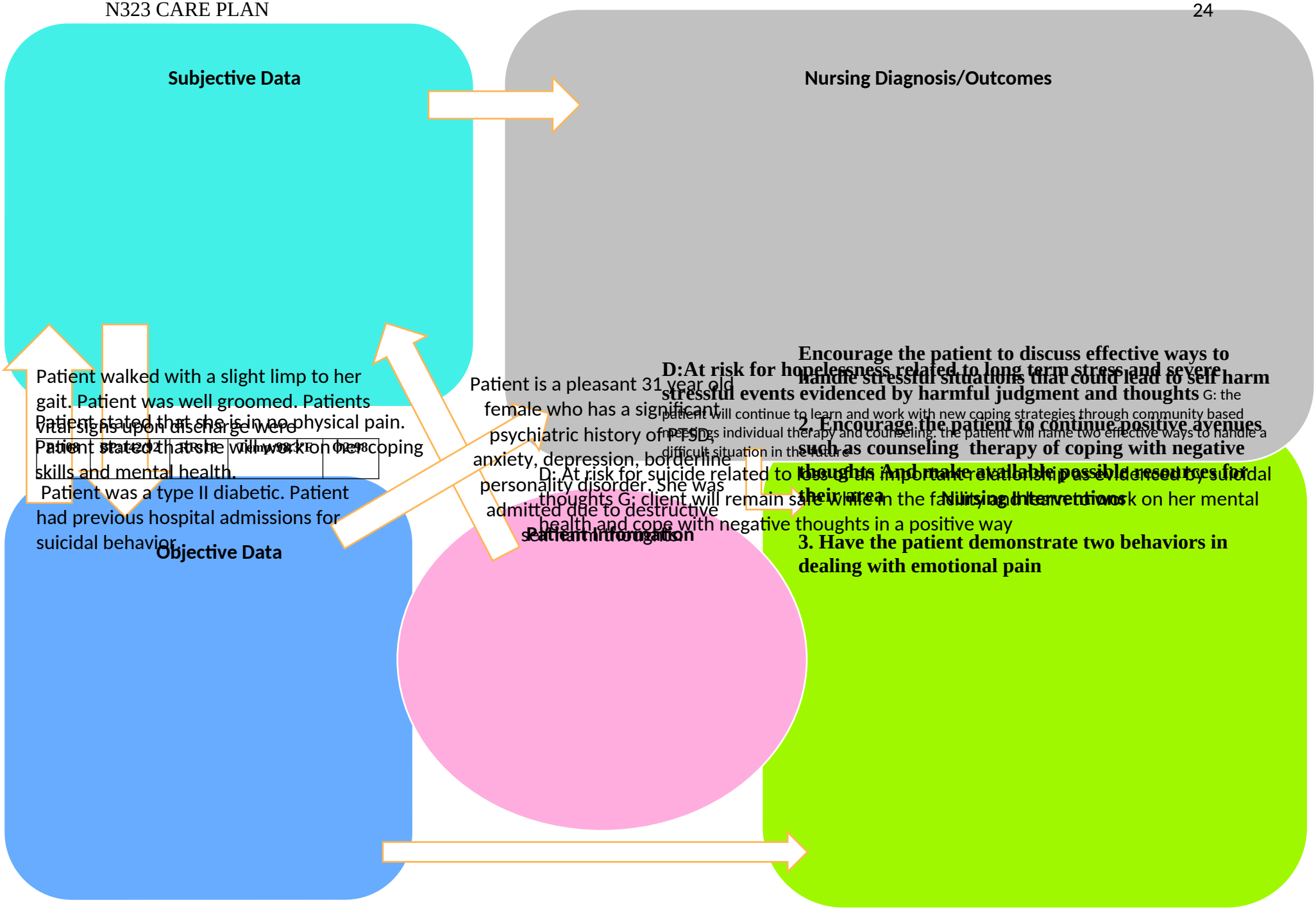
Other References (APA):

Martin, P. (2022, March 18). *3 suicide behaviors nursing care plans*. Nurseslabs. Retrieved January 15, 2023, from https://nurseslabs.com/suicide-behaviors-nursing-care-plans/

Phelps, L.L. (2020). Sparks and Taylor's nursing diagnosis reference manual (11th ed.). Wolters Kluwer.

U.S. National Library of Medicine. (2021, February 22). *Bipolar disorder*. MedlinePlus. Retrieved January 11, 2023, from https://medlineplus.gov/bipolardisorder.html

Concept Map (20 Points):


Subjective Data
Patient walked with a slight limp to her gait. Patient was well groomed. Patients vital signs upon discharge were
Patient stated that she is in no physical pain.
Patient stated that she will work on her coping skills and mental health.
Patient was a type II diabetic. Patient had previous hospital admissions for suicidal behavior.
Objective Data
Patient is a pleasant 31 year old female who has a significant psychiatric history of PTSD, anxiety, depression, borderline personality disorder. She was admitted due to destructive
Patient Information
Nursing Diagnosis/Outcomes
D:At risk for hopelessness related to long term stress and severe stressful events evidenced by harmful judgment and thoughts G: the patient will continue to learn and work with new coping strategies through community based meetings individual therapy and counseling. the patient will name two effective ways to handle a difficult situation in the future
D: At risk for suicide related to loss of an important relationship as evidenced by suicidal thoughts G: client will remain safe while in the facility and learn to work on her mental health and cope with negative thoughts in a positive way
Nursing Interventions
Encourage the patient to discuss effective ways to handle stressful situations that could lead to self harm
2. Encourage the patient to continue positive avenues such as counseling therapy of coping with negative thoughts And make available possible resources for their area
3. Have the patient demonstrate two behaviors in dealing with emotional pain