N323 Care Plan

Lakeview College of Nursing

Jayda Davis

Demographics (3 points)

Date of Admission 1/17/2023	**Patient Initials** T.P	**Age** 47	**Gender** Female
Race/Ethnicity African American	**Occupation** FDA Worker	**Marital Status** Single	**Allergies** Sulfur, Turkey, Amlodipine, Doxycycline
Code Status Full Code	**Observation Status** Outpatient (partial programmer)	**Height** 68 in	**Weight** 74 kg

Medical History (5 Points)

Past Medical History: Asthma, Hypertension, Obstructive Sleep Apnea

Significant Psychiatric History: Major depressive disorder with psychotic features

Family History: Mom- Hypertension

Social History (tobacco/alcohol/drugs): The patient reports no drug or tobacco use. The patient is a social drinker and drinks 1-2 drinks per month. The patient has been drinking socially for 15+ years.

Living Situation: The patient is living with family and boyfriend.

Strengths: Pleasant, cooperative, willing to participate in treatment.

Support System: Family (mom, father, siblings, and boyfriend)

Admission Assessment

Chief Complaint (2 points): Auditory hallucinations

Contributing Factors (10 points): The patient reports having increased anxiety and severe depression that is making it “hard to go work, be with family, and do daily activities”. The patient states “I feel like I’m being watched by someone and by my neighbors”. The patient states this because at her job, her computer was hacked, and she has all her important and confidential information in her computer. She now feels like she is being watched and is

constantly paranoid that “something bad” is going to happen to her. The patient has been experiencing auditory hallucinations. The patient says, “I’ve been hearing my neighbor’s voice in my head” and she said this has been happening for the past month. The patient also states, “I have no energy, I am starting to struggle with focusing on my job and watching tv, I struggle with sleeping, and have been overeating due to stress and being depressed”. The patient also states “the hallucinations, paranoia, depression, and anxiety” have been affecting her life to the point where it’s affecting her job, friends and family, and the ability to take care of herself properly.

Factors that lead to admission: The patient reports feeling extremely stressed, having auditory hallucinations, insomnia, and having excessive worrying.

History of suicide attempts: The patient reports having no history of suicide attempts

Primary Diagnosis on Admission (2 points): Depressive Psychosis

Psychosocial Assessment (30 points)

History of Trauma
No lifetime experience: The patient reports that her mother and father are separated and as a child, she struggled to go in between houses. The patient reports that her mother and father used to argue all the time when she was growing up. The patient also reports almost losing her closest friend to suicide and she is affected by that because she feels like she could of helped prevent her from trying to commit suicide.

Witness of trauma/abuse: The patient reports not witnessing any trauma or abuse.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	The patient reports not having any physical abuse in her life.	N/A	N/A	N/A
Sexual Abuse	The patient reports not having any sexual abuse in her life.	N/A	N/A	N/A
Emotional Abuse	The patient reports not having any emotional abuse in her life.	N/A	N/A	N/A
Neglect	The patient reports not	N/A	N/A	N/A

	having any neglect in her life.			
Exploitation	The patient reports not having any exploitation in her life.	N/A	N/A	N/A
Crime	The patient reports not having any crime in her life.	N/A	N/A	N/A
Military	The patient reports not dealing with the military in her life.	N/A	N/A	N/A
Natural Disaster	The patient reports not having any natural disasters	N/A	N/A	N/A

	accidents in her life.			
Loss	The patient reports not having loss that has affected her life.	N/A.	N/A	N/A
Other	The patient was affected by this when she was 5 years old.	The patient stopped being affected by this at 18 years old.	The patient says she feels an extra amount of stress and anxiety when she is around people who are arguing or in confrontation.	The patient reports that growing up she heard her parents argue a lot and then they separated. She mentioned it was difficult going in between households.
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	The patient reports being very depressed and is struggling with	

			depression. The patient says that her depression has gotten worse in the past 2 months. The patient reports that she is having anxiety, hallucinations, and has been very stressed.
Loss of energy or interest in activities/school	**Yes**	**No**	The patient reports having a loss of interest in doing her day-to-day activities. The patient reports this has been happening for the past 4 months.
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
Social withdrawal or isolation	**Yes**	**No**	The patient reports being socially withdrawn due to having severe depression and psychosis. The patient reports being withdrawn for the past 2 months, and she struggles with communicating with her friends and family.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	The patient reports recently in the past two months that she has been struggling with her job. She also reports that she has been struggling

			to maintain family and friend relationships.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The patient reports usually getting two to four hours of sleep on a good night when she can fall asleep. The patient says she has been struggling with insomnia and getting enough sleep for over a year now. Lately, the patient says she usually gets two hours of sleep, and this has been happening for a month now.
Difficulty falling asleep	**Yes**	**No**	The patient reports struggling with falling asleep. The patient has been dealing with this for over a year now and it affects her every night.
Frequently awakening during night	**Yes**	**No**	The patient reports constantly awakening during the night. The patient believes this is because of stress and paranoia. The patient says she is constantly overthinking. The patient says she has been experiencing this for over three

			months now.
Early morning awakenings	**Yes**	**No**	The patient reports usually staying up all night and sleeping throughout the day. The patient says this has become worse for her over the past month and happens at least 4-5 times a week.
Nightmares/dreams	**Yes**	**No**	The patient reports having nightmares 2-3 times a week. The patient says she is stressed, paranoid, and anxious. When she sleeps she deals with nightmares. The patient said she started having nightmares for about a month now.
Other	**Yes**	**No**	The patient reports dealing with insomnia most nights and she has experienced insomnia most nights and has had issues sleeping for over a year.
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	The patient reports that she has been overeating. The patient says she overeats to help her cope with stress

			and to distract her from thinking. The patient reports overeating for the past 5 months and that she snacks a lot during the evening and nighttime.
Binge eating and/or purging	**Yes**	**No**	N/A
Unexplained weight loss? **Amount of weight change:** N/A	**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**	N/A
Panic attacks	**Yes**	**No**	The patient reports having panic attacks 1-2 times per week. The panic attack usually lasts for about 10 minutes and notices that she gets more at nighttime.
Obsessive/compulsive thoughts	**Yes**	**No**	The patient reports hearing voices in her head. Specifically, hearing her neighbor's voice in her head. The patient experiences these hallucinations 3-4 times a day.
Obsessive/compulsive behaviors	**Yes**	**No**	N/A

Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	The patient reports having anxiety daily. The patient says she has anxiety for the whole day and some days her anxiety is worse than other days. She has been having severe anxiety for the past two months.
Rating Scale			
How would you rate your depression on a scale of 1-10?	10		
How would you rate your anxiety on a scale of 1-10?	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 states that 3 weeks ago at her job, her computer and all of her information were hacked into. The patient is worried and stressed that she is being watched and that someone has all of her information.
School	**Yes**	**No**	N/A
Family	**Yes**	**No**	N/A
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	The patient has been hearing her neighbor's voices in her head. She has been socially withdrawn and has

			been constantly paranoid and anxious for the past two months.
Financial	**Yes**	**No**	N/A
Other	**Yes**	**No**	The patient currently resides in another state. She is extremely stressed with the process of getting her house sold.

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
November 2022	**Inpatient** **Outpatient** **Other:**	Inpatient	The patient passed out at work due to severe anxiety. The patient was seen in the hospital but later admitted to the psychiatric floor for depressive	**No improvement** **Some improvement** **Significant improvement**

			psychosis.	
N/A	**Inpatient** Outpatient **Other:**	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Mother (The patient would not share mother's name)	71	Mother	**Yes**	**No**
Boyfriend (The patient would not share the boyfriend's name)	41	Boyfriend	**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: N/A				
Children (age and gender): The patient has no children. **Who are children with now?** N/A				
Household dysfunction, including separation/divorce/death/incarceration: The patient reports that her mom and father are separated.				
Current relationship problems: The patient feels like she can't be a support to her family, friends, and boyfriend. The patient reports struggling with communicating with her loved ones				

and feeling withdrawn from her family and friends.

Number of marriages: N/A

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

Please describe your religious values, beliefs, spirituality and/or preference: The patient goes to church every Sunday and prays.

Ethnic/cultural factors/traditions/current activity: The patient follows religious beliefs.

Describe: The patient has certain dietary restrictions and does not eat beef, pork, or turkey.

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient reports no current or past legal issues.

How can your family/support system participate in your treatment and care? By sharing their perspective of what has been going on with the patient and being a part of decisions regards to the patient's care.

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:

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.) The patient reports no family history of mental illness.
History of Substance Use: The patient reports having no substance use.
Education History: **Grade school** **High school** **College**- has master's degree. **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: The patient reports having no problems in school.
Discharge
Client goals for treatment: To have reduced hallucinations and better coping skills with anxiety and depression.
Where will client go when discharged? The patient is a partial programmer she goes home to her family and boyfriend every day.

Outpatient Resources (15 points)

Resource	Rationale
1. Church groups	**1.** This is an option for her because she is actively involved with the church. The patient mentioned the church is a safe space for her.

	Utilizing church groups and having extra prayer is a good way for her to express her feelings and cope with her depression.
2. Therapy groups	**2**. This is an option for her because the patient has been very stressed and paranoid lately. Going to group therapy will allow her to connect with other people and share her feelings in a safe space. Group therapy could provide the patient with healthy coping skills when she is feeling stressed and having paranoia.
3. Joining a community group	**3.** Joining a community group would be helpful for this patient as it would get her out of her house on the weekends. It would help the patient have the motivation and it would get her involved in something she loves to do. This would be a great resource to help with her depression and distract her from her busy thoughts.

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

Brand/Generic	Geodon/ Ziprasidone Hydrochloride	Lopressor /Metoprolol Tartrate	Cozaar/ Losartan potassium	The patient only takes three medications.	The patient only takes three medications.
Dose	40mg	25mg	50mg	N/A	N/A
Frequency	B.I. D	QD	QD	N/A	N/A
Route	PO	PO	PO	N/A	N/A
Classification	Atypical antipsychotic/ Benzisoxazole	Beta-adrenergic blocker & Antihypertensive	Angiotensin II receptor & Antihypertensive	N/A	N/A
Mechanism of Action	Blocks dopamine 2 receptors which reduce symptoms of psychosis. Blocks serotonin 2A receptors which cause dopamine to be released in certain brain regions. Inhibits the reuptake of norepinephrine and serotonin. (Jones, 2022)	Reduces blood pressure by decreasing the release of renin. Also inhibits the stimulation of beta-receptors sites in the heart. (Jones, 2022)	"It blocks the binding of angiotensin II to the receptor sites in many tissues. Angiotensin II stimulates the adrenal cortex to secrete aldosterone. Then the inhibiting effects of angiotensin II reduce blood pressure". (Jones, 2022)	N/A	N/A
Therapeutic Uses	Is used to treat symptoms of psychotic mental disorders.	Is used to treat high blood pressure.	Is used to treat high blood pressure.	N/A	N/A

Therapeutic Range (if applicable)	10 mg to 80 mg per	25mg to 100 mg	0.7 mg to 50mg	N/A	N/A
Reason Client Taking	Taking for hallucinations, psychosis, and depression.	To manage hypertension	To manage hypertension	N/A	N/A
Contraindications (2)	History of arrhythmias. High or low blood pressure. (Jones, 2022)	Severe bradycardia Hypersensitivity to metoprolol. (Jones, 2022)	African American patients must be careful taking losartan as it does not reduce stroke risk. Renal and liver impairments. (Jones, 2022)	N/A	N/A
Side Effects/Adverse Reactions (2)	Weight gain Dry mouth (Jones, 2022)	Insomnia Anxiety (Jones, 2022)	Dizziness Fatigue (Jones, 2022)	N/A	N/A
Medication/ Food Interactions	Dolasetron can interact with Ziprasidone. Alcohol can also interact with Ziprasidone. (Jones, 2022)	Prozac can interact with metoprolol. Clonidine can interact with metoprolol. (Jones, 2022)	Potassium supplements can interact with losartan. NSAIDs can interact with losartan. (Jones, 2022)	N/A	N/A
Nursing Considerations (2)	Must monitor the patient's weight and lipid panels. Assess for drowsiness and dizziness that could affect balance and gait. (Jones, 2022)	Monitor the patient for bradycardia. Monitor for orthostatic hypotension. (Jones, 2022)	Monitor the patient's blood pressure. Monitor the patient for muscle pain. (Jones, 2022)	N/A	N/A

Brand/Generic	The patient only takes three medications.	The patient only takes three medications.	The patient only takes three medications.	The patient only takes three medications.	The patient only takes three medications.
Dose	N/A	N/A	N/A	N/A	N/A
Frequency	N/A	N/A	N/A	N/A	N/A
Route	N/A	N/A	N/A	N/A	N/A
Classification	N/A	N/A	N/A	N/A	N/A
Mechanism of Action	N/A	N/A	N/A	N/A	N/A
Therapeutic Uses	N/A	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

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

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	The patient's appearance appeared to be well-groomed and taken care of. The patient had good behavior and participated in all activities. The patient had good articulation when speaking and spoke at a normal tone and rate. The patient had a euthymic mood and had an appropriate interpersonal style. The patient was dealing with some anxiety but still was able to communicate and participate in group activities.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient's main thoughts were how she was going to use the new coping skills that she had been given by the psychiatrist she had just seen. The patient reported feeling anxious but was not experiencing paranoia or auditory hallucinations at this time. The patient denied any ideations. delusions, illusions, compulsions, and phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	The patient was alert and oriented x4. The patient was not experiencing any auditory hallucinations at the time nor was she experiencing paranoia. The patient has auditory hallucinations.
MEMORY: **Remote:**	The patient is able to recite stories and life events in her past. The patient has appropriate short-term and long-term memory.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient has good judgment and is actively advocating for herself. The patient has a master's degree and likes to learn new ideas and skills. The patient can reason with new information and can understand complex information. The patient has good impulse control and does not struggle with acting on an impulse. The patient's intelligence is adequate as she has a master's degree.
INSIGHT:	The patient has good insight and judgment. The patient is actively participating in group discussions and in group therapy. The patient acknowledges her illness and is willing to learn and try everything to help make her feel better.

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient does not use any assistive devices. The patient has a good posture and a balanced smooth gait. The patient has 5/5 strength bilaterally in all extremities. The patient has good muscle tone in all extremities bilaterally. The patient has an active range of motion.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	90 bpm	160/88 mmHg	20 resp/min	36.6 ˚C Oral	98% room air
1530	89 bpm	162/90 mmHg	20 resp/min	36.8 ˚C Oral	97% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	Numeric pain scale	N/A	0/10	N/A	N/A
1530	Numeric pain scale	N/A	0/10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 80% **Lunch:** 95% **Dinner:** Did not see the patient eat dinner	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 240 mL of water **Lunch:** 120 mL of water **Dinner:** Did not see the patient's fluid intake

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient goes home to her family and her boyfriend. The patient will continue taking her new dosage of Ziprasidone. The goal for the patient is to have decreased severity of paranoid thoughts and auditory hallucinations. The patient will report to outpatient psychiatric therapy and counseling once she achieves clinical stability. The patient is looking to join a support group at her church to help her cope with her depression and anxiety. The patient will be educated and given a pamphlet or list of her coping skills that she has learned and can use when she is feeling overwhelmed. The patient will leave the program with education on healthy coping skills.

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. Disturbed thought processes relate to depression as evidenced by auditory hallucination	This nursing diagnosis was chosen due to the patient expressing that she has been hearing her neighbor's	**1.** The patient will be evaluated by a psychiatrist right away to determine if she is a harm to herself.	**1.** The patient will see a psychiatrist daily. 2. Identify specific conflicts that are stressing the patient out	1. The patient will be able to use coping strategies to deal with hallucinations and paranoia.

s and paranoia.	voices in her head. She is also paranoid as she feels "she is being watched by someone".	2. Determine if the patient is using alcohol or other drugs. 3. Assess the patient to see if the patient is able to make decisions and problem-solve.	and find possible solutions to the problem. 3. Teach the patient coping skills that can intervene when hallucinations or paranoia thoughts prevail.	2. The patient will be set up with outpatient psychiatric counseling. 3. The patient will be experiencing fewer hallucinations and paranoia.
2.Insomnia related to anxiety as evidenced by changes in sleep pattern.	This nursing diagnosis was chosen as the patient has been struggling with insomnia due to constantly being anxious. The patient has mentioned that her sleep pattern has changed over the past month, and she is only getting about "2 – 4 hours" of sleep every night.	1. Assess environmental factors that may inhibit the patient's sleep. 2. Have the patient discuss concerns that are causing her to not sleep. 3. Assess the patient's dietary intake and physical activity.	1. Have the patient keep a sleep log that identifies sleep disturbances that can be given to the doctor and therapy services. 2. Educate the patient about relaxation and stress-reducing techniques. 3. The patient will see a dietician to discuss healthy food options and dietary habits that will promote sleep.	1. The patient will be able to identify techniques and exercises before bedtime. 2. The patient will be able to identify factors that prevent or disrupt sleep. 3.The patient reports making dietary changes that help promote sleep.
3.Social isolation related to depression as evidenced by the patient stating, "I am socially withdrawn from my friends and family".	This nursing diagnosis was chosen because the patient is feeling withdrawn from her family and friends due to the fact she is	1. Assess the patient's home environment and how it affects the patient's social life. 2. Discuss with the patient about	1. The patient will go to group therapy two to three times a day. 2. Arrange a time to talk with the patient each visit to listen to the patient's concerns and feelings.	1. The patient will report increased social interactions and decreased feelings of isolation. 2. The patient will be referred

	struggling with severe depression.	contributing factors of social isolation. 3. Contact the family and discuss the changes they have seen in the patient's social life.	3. The patient will go to therapy once daily to find healthy coping mechanisms when feeling socially isolated.	to social services in regard to finding community groups that would help influence the patient's social interaction. 3. The patient will be able to identify the causes of social isolation and will be able to write out coping skills to use when feeling socially isolated.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

"I have been hearing my neighbor's voices in my head".

"I would rate my anxiety a 10 out of 10".

"I would rate my depression a 10 out of 10".

"At my job, my computer was hacked and has seen my private information. I feel like I am being constantly watched".

"I have been struggling with sleeping and the past month, I am only sleeping 2-4 hours throughout the night".

"I have been isolated and isolated from my friends and family due to the depression and anxiety consuming my life".

Objective Data

1000: Pulse: 70 bpm B/P: 160/88 RR: 20 resp/min Temp: 36.6 °C O2: 98% RA

1530: Pulse: 89 bpm B/P: 162/90 RR: 20 resp/min Temp: 36.8 °C O2: 98% RA

Patient was alert and oriented x4

Patient Information

On January 17th, 47-year-old female was admitted to the pavilion for a diagnosis of depressive psychosis. The patient is a partial program patient and is in the morning and goes home in the evening. The patient is dealing with auditory hallucinations, paranoia, anxiety, severe depression, and stress.

Nursing Diagnosis/Outcomes

1. Disturbed thought processes relate to depression as evidenced by auditory hallucinations and paranoia.
   - Outcome: The patient will be set up with outpatient psychiatric counseling. The patient will experience fewer hallucinations and less paranoia. The patient will be able to use coping strategies to deal with hallucinations and paranoia.
2. Insomnia related to anxiety as evidenced by changes in sleep pattern.
   - Outcome: The patient will be able to identify factors that can help promote sleep.
3. Social isolation related to depression as evidenced by socially withdrawn from my friends and family.
   - Outcome: The patient will report increased social interactions and decreased feelings of isolation. The patient will be referred to social services in regard to finding community groups that would help influence the patient's social interaction. The patient will be able to identify the causes of social isolation and will be able to write out coping skills to use when feeling socially isolated.

Nursing Interventions

Nursing intervention 1: The patient will see a psychiatrist daily. The patient will identify specific conflicts that are stressing the patient out and find possible solutions to the problem. The patient will be taught coping skills that can intervene when hallucinations or paranoia thoughts prevail.

Nursing intervention 2: Have the patient keep a sleep log that identifies sleep disturbances that can be given to the doctor and therapy services. Educate the patient about relaxation and stress-reducing techniques. The patient will receive education regarding foods, items and dietary habits that will promote sleep.

Nursing intervention 3: The patient will go to group therapy two to three times a day. Arrange a time to talk with the patient each visit to listen to the patient's concerns and feelings. The patient will go to therapy