

N323 Care Plan
Lakeview College of Nursing
Dakota Clayton

Demographics (3 points)

Date of Admission 01/17/2022	Patient Initials M.F.	Age 18	Gender F
Race/Ethnicity Caucasian	Occupation Cashier	Marital Status Single	Allergies None
Code Status Full Code	Observation Status Q15 minutes	Height 69 in.	Weight 63.6 Kg (140 lbs.)

Medical History (5 Points)

Past Medical History: Anxiety (2021)

Major Depressive Disorder (2021)

Significant Psychiatric History: Patient has been formally diagnosed with anxiety and depression since May 2022. Patient has received treatment for suicidal ideation/self-harm once before in November 2022.

Family History: Diabetes (mother)

Social History (tobacco/alcohol/drugs): Patient reported no substance use

Living Situation: Patient lives with her grandmother whom she has lived with since age 15. At age 15, the patient and her siblings were removed from the care of her mother and placed with their grandmother.

Strengths: School activities; social activities; working with children

Support System: Grandmother; sister; boyfriend; boyfriend's mother

Admission Assessment

Chief Complaint (2 points): Suicidal ideation and self-harm (SI/SH)

Contributing Factors (10 points): Patient has been diagnosed with anxiety and depression since May 2022 and has been experiencing suicidal ideation and self-harm thoughts for the past 4 months. Patient has had two previous plans to commit suicide by

overdose, one in November 2022 and one in January 2023. Patient reported that her depression is continuous and her anxiety differs in severity “day-by-day.” Patient also reported she has not experienced suicidal/self-harm thoughts since being admitted to the facility. Patient reported “sleeping a lot and hanging out with my boyfriend” makes her depression and anxiety better, and that “too much attention” makes her depression and anxiety worse. Patient reported that her anxiety and depression are “definitely related” to physical abuse, emotional abuse, and neglect from her mother during her childhood. Patient is currently under observation every 15 minutes at the facility and participating in group activities. Patient has sought treatment for suicidal ideation and self-harm once before in November 2022.

Factors that lead to admission: Patient reported that she had planned to “overdose on my grandmother’s blood pressure medicine but reached out for help before doing it” which led to her being admitted to the facility on 1/17/2023.

History of suicide attempts: 2 – patient did not carry out either attempt

- 1) November 2022 – planned to overdose on her grandmother’s blood pressure medication
- 2) January 2023 – planned to overdose on her grandmother’s blood pressure medication

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

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No				
Witness of trauma/abuse: Yes – trauma on siblings in childhood home				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	Yes (15)	Yes	Patient reported that her mother “hit and threw things” at her and her siblings in their childhood home.
Sexual Abuse	No	No	No	N/A – patient did not positively report
Emotional Abuse	No	Yes (15)	Yes	Patient reported that her mother “yelled at and degraded” her and her siblings in their childhood

				home.
Neglect	No	Yes (15)	Yes	Patient reported that throughout her childhood, her and her siblings “were not fed and slept on the floor.”
Exploitation	No	No	No	N/A – patient did not positively report
Crime	No	No	No	N/A – patient did not positively report
Military	No	No	No	N/A – patient did not positively report
Natural Disaster	No	No	No	N/A – patient did not positively report
Loss	No	No	No	N/A – patient did not positively report
Other	No	No	No	N/A – patient did not positively report
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	Patient reported that her depressed mood is continuous but	

			is “getting better.” Patient reported her depression as a 3/10. Patient reported her depressed mood has continued for “weeks” and that this has been occurring “on and off for months.”
Loss of energy or interest in activities/school	Yes	No	N/A – patient did not positively report
Deterioration in hygiene and/or grooming	Yes	No	N/A – patient did not positively report
Social withdrawal or isolation	Yes	No	N/A – patient did not positively report
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	N/A – patient did not positively report
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	N/A – patient did not positively report
Difficulty falling asleep	Yes	No	Patient reports that she has difficulty falling asleep “most nights” and this has been happening for “a couple months.” Patient stated that the difficulty falling sleep varies nightly and

			“some nights are harder than others.”
Frequently awakening during night	<u>Yes</u>	No	Patient reported that she mostly sleeps “in 2 hour spurts” and frequently wakes during the night. Patient reported that this happens most nights but has “been better since being admitted.” Patient reported this frequent awakening began a few weeks prior to her November 2022 hospital admittance.
Early morning awakenings	<u>Yes</u>	No	Patient reported that the early morning awakenings are related to her only sleeping “a few hours at a time” and that it happens most nights. Patient reported that if she falls asleep at midnight or 1 A.M., she will awake “around 3 or 4 A.M. and be up all night.” Patient reported this began a few weeks prior to her November 2022 hospital admittance.

Nightmares/dreams	Yes	No	N/A – patient did not positively report
Other	Yes	No	N/A – patient did not positively report
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Patient reported that she has been experiencing a loss of appetite but has been “eating better” since being admitted. Patient reported that prior to being admitted she was only eating one meal a day. Patient reported the loss of appetite had been happening for “about two months.”
Binge eating and/or purging	Yes	No	N/A – patient did not positively report
Unexplained weight loss? Amount of weight change:	Yes	No	Patient reported that she had been experiencing continuous weight loss for about two months, and that she had lost “over 20 pounds” before being admitted to the facility. The patient associated this weight loss with

			her loss of appetite and “not eating.”
Use of laxatives or excessive exercise	Yes	No	N/A – patient did not positively report
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patient reported that she will experience “shakiness” intermittently depending on her level of anxiety. Patient reported that this happens when her anxiety is more severe and that it had happened “a few times” since being admitted. Patient reported her anxious tremors are worse when “thinking about returning home.”
Panic attacks	Yes	No	N/A – patient did not positively report
Obsessive/compulsive thoughts	Yes	No	N/A – patient did not positively report
Obsessive/compulsive behaviors	Yes	No	N/A – patient did not positively report
Impact on daily living or avoidance of	Yes	No	Patient stated that when her levels

<p>situations/objects due to levels of anxiety</p>			<p>of anxiety are severe they will affect her at school and she will become “overwhelmed.” This has led to her leaving school “a couple” times over the last 6 months due to her anxiety.</p>
<p>Rating Scale</p>			
<p>How would you rate your depression on a scale of 1-10?</p>		<p>3/10</p>	
<p>How would you rate your anxiety on a scale of 1-10?</p>		<p>5/10</p>	
<p>Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)</p>			
<p>Problematic Area</p>	<p>Presenting?</p>		<p>Describe (frequency, intensity, duration, occurrence)</p>
<p>Work</p>	<p>Yes</p>	<p>No</p>	<p>N/A – patient did not positively report</p>
<p>School</p>	<p>Yes</p>	<p>No</p>	<p>Patient reported that school is currently affected by her anxiety and depression. Patient reported that these problems are not affecting her grades but her “attendance and after school stuff.” Patient reported that the problems are intermittent and depend on the severity of her anxiety and depression.</p>

Family	Yes	No	Patient reported that she has had continuous problems with her mother “most of her life” and that these problems continued after her removal from her mother’s care. Patient reported that when problems with her and her mother’s relationship are worse, her anxiety and depression worsen as well. Patient reported that she feels like “there’s always something wrong” between her and her mother.
Legal	Yes	No	N/A – patient did not positively report
Social	Yes	No	N/A – patient did not positively report
Financial	Yes	No	N/A – patient did not positively report
Other	Yes	No	N/A – patient did not positively report

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
November 2022	Inpatient - Washington Co. Hospital Outpatient Other:	Inpatient	Suicidal ideation and self- harm	No improvement Some improvement Significant improvement
N/A – patient has sought treatment for issues related to her anxiety and depression once before	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
N/A – patient has sought treatment for issues related to her anxiety and depression once before	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Grandmother	56	Grandmother	Yes	No
M.	21	Sister	Yes	No
C.	14	Brother	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: Patient reported that her grandmother smokes “one or two packs” of cigarettes a day and has been since she was put under her care. Patient also				

<p>reports that her grandmother will drink “a couple Bud Lights” when her grandmother has company over.</p>		
<p>Children (age and gender): N/A – patient does not have any children</p> <p>Who are children with now? N/A – patient does not have any children</p>		
<p>Household dysfunction, including separation/divorce/death/incarceration:</p> <p>Patient reported no current household dysfunction. Patient has a history of physical abuse, emotional abuse, and neglect from her mother in her childhood home. The patient was removed from the home and put under the care of her grandmother at age 15.</p>		
<p>Current relationship problems: Patient reports no current relationship problems between her and her Grandmother, boyfriend, or siblings. Patient reports that the problems between her mother and her/her siblings are “always going to be there” but have been “easier to avoid” since being removed from her mother’s care.</p> <p>Number of marriages: 0 – patient has never been married</p>		
<p>Sexual Orientation: Heterosexual</p>	<p>Is client sexually active? Yes No</p>	<p>Does client practice safe sex? Yes No</p>
<p>Please describe your religious values, beliefs, spirituality and/or preference:</p> <p>Christianity</p>		
<p>Ethnic/cultural factors/traditions/current activity: N/A – patient did not provide any ethnic/cultural factors</p> <p>Describe: N/A – patient did not provide any ethnic/cultural factors</p>		
<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</p> <p>When the patient was 15 years old, CPS removed her and her siblings from the care of her mother and placed them under the care of her grandmother.</p> <p>No other current/past legal issues were reported.</p>		

<p>How can your family/support system participate in your treatment and care?</p> <p>Patient reported that her family can help her by “being there and being understanding” of her mental illness(s). Patient also reported that her and her grandmother will begin going to family therapy together when she is discharged.</p>
<p>Client raised by:</p> <p>Natural parents – until the age of 15 Grandparents – placed in grandmother’s care at age of 15 Adoptive parents Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness:</p> <p>Patient reported that she believes her anxiety and depression are “definitely related” to the physical abuse, emotional abuse, and neglect she experienced from her mother during her childhood.</p>
<p>Atmosphere of childhood home:</p> <p>Loving Comfortable Chaotic Abusive Supportive Other: Patient added “terrible” to “chaotic” and “abusive”</p>
<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</p> <p>Patient reported her mother as having Bipolar Disorder, Attention Deficit Hyperactivity Disorder, and Obsessive-Compulsive Disorder. Patient was unsure if conditions had been</p>

<p>medically diagnosed.</p>
<p>History of Substance Use:</p> <p>Patient reports no history of using alcohol, tobacco, or other drugs</p>
<p>Education History:</p> <p>Grade school High school College Other:</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: Patient did not provide any problems related to school work or school activities. Patient reported that her anxiety and depression “make me miss school or leave school sometimes.”</p>
<p>Discharge</p>
<p>Client goals for treatment:</p> <p>Improve coping skills</p> <p>Control self-harm thoughts</p> <p>“Feel better”</p>
<p>Where will client go when discharged?</p> <p>Patient will be going back home to live with her grandmother</p>

Outpatient Resources (15 points)

Resource	Rationale
1. Individual outpatient therapy	1. The patient does not currently attend individual therapy. Patient could benefit from discussing aspects of her mental illness and related childhood trauma with a psychotherapist.
2. Family outpatient therapy	2. The patient and grandmother attending therapy together would help further their relationship, and provide the grandmother with tools to support the patient.
3. Suicide hotline	3. Since the patient has two former attempts at suicide, providing her with the resources of the suicide hotline would give her a resource to reach out to if considering suicide in the future.

Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/ Generic	Wellbutrin XL/ Bupropion ERT XL	Prozac/ Fluoxetine	Vistaril/ Hydroxyzine hydrochlorid e	Tylenol Acetaminoph en	Tums/ Calcium carbonate
Dose	150 mg	40 mg	10 mg	650 mg	500 mg

Frequency	AM	AM	QID PRN	Q6 PRN	Q4 PRN
Route	PO	PO	PO	PO	PO
Classification (Therapeutic/ Pharmacologic)	T: Antidepressant P: Aminoketones (Vallerand & Sanoski, 2023).	T: Antidepressant P: Selective serotonin reuptake inhibitor (SSRI) (Vallerand & Sanoski, 2023).	T: Antianxiety agent P: Antihistamine (Vallerand et al., 2023).	T: Antipyretic (Vallerand & Sanoski, 2023).	T: Mineral and electrolyte replacements P: Antacids (Vallerand & Sanoski, 2023).
Mechanism of Action	Medication “decreases neuronal reuptake of dopamine in the CNS, and diminishes neuronal reuptake of serotonin and norepinephrine” (Vallerand & Sanoski, 2023, p. 260).	Medication “selectively inhibits the reuptake of serotonin in the CNS” (Vallerand & Sanoski, 2023, p. 606).	Medication “acts as a CNS depressant at the subcortical level of the CNS” (Vallerand et al., 2023, para. 3).	Medication “inhibits synthesis of prostaglandins that may serve as mediators of pain and fever” (Vallerand & Sanoski, 2023, p. 96).	Medication “binds to dietary phosphate to form an insoluble calcium phosphate complex, which is excreted in the feces, resulting in decreased serum phosphorus concentrations” (Vallerand & Sanoski, 2023, p. 276).
Therapeutic Uses	Decreased feelings of depression	Decreased feelings of depression	Decrease feelings of anxiety	Treatment of pain	Treatment of nausea
Therapeutic Range (if applicable)	“150 mg once daily in the morning. Dose may be	“20 mg/day in the morning. After several	“25-100 mg 4 times/day, not to exceed 600 mg/day”	N/A	N/A

	increased after 4 days to 300 mg once daily” (Vallerand & Sanoski, 2023, p. 261).	weeks, may increase dose by 20 mg/day at weekly intervals” (Vallerand & Sanoski, 2023, p. 607).	(Vallerand et al., 2023, para. 8).		
Reason Client Taking	Depression management	Depression management	Anxiety management	Pain management	Nausea and GI aggravation management
Contraindications (2)	1. Anorexia nervosa 2. History of suicide attempts (Vallerand & Sanoski, 2023).	1. History of suicidal ideation 2. Individuals with multiple drug therapy (Vallerand & Sanoski, 2023).	1. Hypersensitivity 2. Hypokalemia (Vallerand et al., 2023).	1. Malnutrition 2. Alcohol use (Vallerand & Sanoski, 2023).	1. Calcium supplementation 2. Hypercalcemia (Vallerand & Sanoski, 2023).
Side Effects/Adverse Reactions (2)	1. Nausea 2. Headache (Vallerand & Sanoski, 2023).	1. Diarrhea 2. Insomnia (Vallerand & Sanoski, 2023).	1. Dry mouth 2. Weakness (Vallerand et al., 2023).	1. Constipation 2. Agitation (Vallerand & Sanoski, 2023).	1. Constipation 2. Arrhythmias (Vallerand & Sanoski, 2023).
Medication/Food Interactions	“Concurrent use with other MAO-inhibitors may increase risk of hypertensive reactions (Vallerand & Sanoski, 2023, p. 261).”	“Discontinue use of MAO-inhibitors for 14 days before fluoxetine therapy; combined therapy may result in confusion, agitation, seizures, hypertension, and hyperpyrexia” (Vallerand &	Concurrent use with kava-kava, valerian root, or chamomile can increase effects of medication. Angel’s trumpet, jimson weed, and scopolia can increase anticholinergic effects. (Vallerand et al., 2023, para. 7).	“Concurrent use with other NSAID pain relievers increases patient risks for renal impairment” (Vallerand & Sanoski, 2023, p. 97).	Use with increased intake of cereals and/or spinach may decrease the absorption of the medication (Vallerand & Sanoski, 2023, p. 275).

		Sanoski, 2023, p. 607).			
Nursing Considerations (2)	<p>1. “Assess mental status and mood changes during initial weeks of use and over dosage changes” (Vallerand & Sanoski, 2023, p. 262).</p> <p>2. Do not administer bedtime doses if patient has history of insomnia (Vallerand & Sanoski, 2023, p. 262).</p>	<p>1. Assess for suicidal ideation during initial use of medication. (Vallerand & Sanoski, 2023, p. 607).</p> <p>2. Monitor appetite and food intake and adjust dosage as needed (Vallerand & Sanoski, 2023, p. 608).</p>	<p>1. “Assess for profound sedation and provide safety precautions as indicated” (Vallerand et al., 2023, para. 10).</p> <p>2. Monitor changes in mental status over initial weeks of use. (Vallerand et al., 2023, para. 10).</p>	<p>1. Assess patient’s nutritional status before initiating use. (Vallerand & Sanoski, 2023).</p> <p>2. “Assess pain severity, location, and characteristics 30-60 minutes after administering dose” (Vallerand & Sanoski, 2023, p. 98).</p>	<p>1. Assess for changes in heartburn, indigestion, and other abdominal pains 30-60 minutes after administration (Vallerand et al., 2023).</p> <p>2. Monitor serum calcium and other electrolyte levels with continuous use of medication (Vallerand & Sanoski, 2023, p. 276).</p>

Brand/Generic	N/A – patient is currently prescribed 5 medications	N/A – patient is currently prescribed 5 medications	N/A – patient is currently prescribed 5 medications	N/A – patient is currently prescribed 5 medications	N/A – patient is currently prescribed 5 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):

Vallerand, A.H., & Sanoski, C.A. (2023). *Davis's Drug Guide for Nurses* (18th ed.). F.A. Davis Company.

Vallerand, A.H., Sanoski, C.A., & Quiring, C. (2023). *HydrOXYzine*. Davis'sDrugGuide.com. F.A. Davis Company.

<https://www.drugguide.com/ddo/view/Davis-Drug-Guide/51389/all/hydrOXYzine>

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:</p>	<p>Patient overall was in no acute distress, well-groomed, and open to assessment. Patient was wearing a tee shirt, sweatpants, and facility-provided sandals. Patient was well-behaved and open to discussing her situation. Patient’s build is as expected for an 18 year old woman. Patient’s attitude was calm and speech was clear during assessment. Patient’s interpersonal style was overall friendly and open, with the patient maintaining some but not sustained eye contact during the assessment. Patient’s mood was stable and affect was broad during the assessment.</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:</p>	<p>The patient’s main thought content centered around returning home with her grandmother and returning back to school. The patient mentioned multiple times how she did not enjoy the amount of school and school-related activities she missed. The patient was also anxious to return to school, and stated “everyone knows why I’ve been gone.” Patient did not report any ideations (specifically suicidal/self-harm ideations), delusions, illusions, obsessions, compulsions, or phobias.</p>
<p>ORIENTATION: Sensorium: Thought Content:</p>	<p>Patient was alert and oriented x4. Patient has normal sensorium. Patient’s thought content was generally positive and focused around being discharged from the facility and resuming her school activities. Patient stated she no longer was having thoughts of suicide/self-harm, and that she had not had suicide/self-harm thoughts since being admitted to the facility.</p>
<p>MEMORY: Remote:</p>	<p>Patient’s memory was overall intact. Patient’s recent memory was intact and she was able to state what she had for breakfast and dinner the night prior. Patient’s remote memory was intact, and she was able to discuss at length the abuse and neglect she experienced in her childhood home.</p>
<p>REASONING: Judgment: Calculations: Intelligence: Abstraction:</p>	<p>Patient discussed hypothetical situations posed to facility residents during group programming and displays good judgement. When asked, “What would you do if you lost a \$10,000 lottery ticket and your roommate said they haven’t seen it?”</p>

<p>Impulse Control:</p>	<p>patient responded, “Believe them and look around my whole house for it.” Patient’s calculations are appropriate and patient displays expected intelligence for an individual about to graduate high school. Patient displays normal abstraction. Patient understands she can be impulsive at times, but also displays good impulse control by reaching out for help when needed.</p>
<p>INSIGHT:</p>	<p>Patient displays good insight. Patient is open and aware of her illness, and states that she does not want to commit suicide and/or self-harm. Patient is open to facility programming and states that she would like to learn better coping mechanisms. Patient also states she will be continuing therapy once discharged from the facility.</p>
<p>GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:</p>	<p>Patient’s gait is smooth and balanced, and the patient uses no assistive devices for her activities of daily living. Patient’s posture is erect and muscle tone firm and as expected for age. Patient’s strength is 5/5 bilaterally in upper and lower extremities. Patient displays active motor movements in upper and lower extremities.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1610	66 bpm	106/63 (Sitting)	16 rpm	97.1 F (36.2 C)	100% (Room air)
1700	70 bpm	108/67	16 rpm	97.1 F	99%

		(Sitting)		(36.2 C)	(Room air)
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Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1605	0/10	N/A	0	N/A	N/A
1705	0/10	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
<p>Percentage of Meal Consumed:</p> <p>Breakfast: 75% consumed</p> <p>Lunch: 75% consumed</p> <p>Dinner: N/A – did not witness</p>	<p>Oral Fluid Intake with Meals (in mL)</p> <p>Breakfast: 480 ml water 240 ml Coca Cola</p> <p>Lunch: 480 ml water 240 ml Coca Cola</p> <p>Dinner: N/A – did not witness</p>

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Upon discharge, the patient will be picked up by and going back home with her grandmother.

The patient will continue to live with her grandmother as she did before admission. The patient

currently needs no home health care needs, but will be continuing on her schedule of medications. The patient has no home health equipment needs. The patient will be followed-up with weekly to assess the effectiveness and adherence to the outpatient therapy resources provided to the patient. The patient does not have any education needs regarding her diagnosis, but has been provided with materials and resources regarding suicide prevention. Her grandmother has been provided with these materials as well and made aware of any potential indicators of suicide.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis 	<p>Immediate Interventions (At admission)</p>	<p>Intermediate Interventions (During hospitalization)</p>	<p>Community Interventions (Prior to discharge)</p>
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“related to” and “as evidenced by” components	was chosen			
<p>1. Risk for self-directed violence related to depression as evidenced by suicidal ideation and suicidal plan.</p>	<p>This nursing diagnosis was chosen because of the patient’s former planning and attempts at suicide and stated self-harm ideation at time of admission.</p>	<p>1. Remove any objects that could be used for self-harm</p> <p>2. Assess patient’s thoughts on killing self and any related plans for suicide or self-harm</p> <p>3. Address all suicide threats as immediate threats</p>	<p>1. Protect patient with supervision according to facility guidelines</p> <p>2. Directly supervise all medication administration and ensure compliance from patient</p> <p>3. Allow the patient to make a contract against self-harm while at the facility</p>	<p>1. Encourage patient to set goals related to cooperating and adhering to psychiatric care</p> <p>2. Help patient and family identify community resources to continue therapy after discharge</p> <p>3. Provide patient and family with resources and contact information regarding suicide hotlines and crisis prevention centers</p>
<p>2. Risk for imbalanced nutrition: less than body requirements related to psychological disorders as evidenced by food intake less than recommended daily allowance and weight loss.</p>	<p>This nursing diagnosis was chosen due to the patient’s reported loss of appetite and weight loss over the last 2-3 months.</p>	<p>1. Obtain patient’s current weight</p> <p>2. Assess patient’s current nutritional status</p> <p>3. Allow patient to identify and provide staff with food preferences</p>	<p>1. Work with patient to set a goal weight and monitor patient’s weight daily</p> <p>2. Assess patient’s personal reasons for inadequate food intake</p> <p>3. Monitor patient’s nutritional status and electrolyte</p>	<p>1. Educate patient and family on proper nutrition</p> <p>2. Provide patient and family with resources regarding meal planning</p> <p>3. Provide patient and family with</p>

			levels and alert provider of changes	community food resources if food insecurity exists.
3. Disturbed sleep pattern related to nonrestorative sleep as evidenced by difficulty initiating sleep and unintentional awakening.	This nursing diagnosis was chosen because of the patient's reported issues with sleep initiation and awakening and the length of time that the patient has been experiencing these issues.	<ol style="list-style-type: none"> 1. Assess patient's current sleep pattern(s) and factors that promote/impair patient's ability to fall asleep 2. Encourage patient to avoid caffeine before bedtime and/or avoid foods that have been identified as interfering with patient's sleep 3. Assess patient's daytime programming schedule and allow for time to rest, if needed 	<ol style="list-style-type: none"> 1. Provide patient with adequate supplies for a consistent nighttime routine 2. Provide patient with materials that promote sleep, such as earplugs and/or an eye cover 3. Discuss relaxation techniques with patient, assess which techniques work best for the patient, and initiate the techniques before bedtime. 	<ol style="list-style-type: none"> 1. Refer the patient for a sleep study to determine the extent of the patient's sleep disorder 2. Provide patient with education regarding nighttime routine changes made during facility stay and provide them with resources to continue with the new routine 3. Provide patient with materials regarding personal and environmental factors that may negatively impact sleep

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

- 1605 & 1705
 - o Pain 0/10
- 1610
 - o Depression 3/10
 - o HR: 66 bpm
- Anxiety 5/10
 - o B/P: 106/63 (sitting)
- "My anxiety and depression are definitely related to abuse from my mom growing up"
 - o RR: 16
 - o Temp: 36.2 C
 - o O2: 100% RA
- Physical abuse, emotional abuse, and neglect in childhood home
- "I've lost 20 lbs in the last 2 months"
 - o B/P: 106/67 (sitting)
- Trouble sleeping/awakening
 - o Temp: 36.2 C
 - o O2: 99% RA

Objective Data

• Patient is an 18 year old female who was admitted to the facility with suicidal ideation/self-harm. Patient had plan to commit suicide by overdosing on her grandmother's blood pressure medication but reached out for help before attempting.

Patient Information

Nursing Diagnosis/Outcomes

1. Risk for self-directed violence related to depression as evidenced by suicidal ideation and suicidal plan.
 - A) Protect patient with supervision according to facility guidelines.
 - B) Remove any objects that could be used for self-harm.

2. Risk for imbalanced nutrition: less than body requirements related to psychological disorders as evidenced by food intake less than recommended daily allowance and weight loss.
 - A) Monitor patient's nutritional status and electrolyte levels and alert provider of changes.
 - B) Work with patient to set a goal weight, and monitor patient's weight daily.

Nursing Interventions

1. The patient will gain 2 pounds by the time the patient is discharged.
 - A) Discuss relaxation techniques with patient, assess which techniques work best for the patient, and initiate the techniques before bedtime.
2. Disturbed sleep pattern related to nonrestorative sleep pattern as evidenced by unintentional awakening.
 - A) The patient will initiate sleep and stay asleep for 6+ hours 2 consecutive nights by the time of discharge.
 - B) Refer the patient for a sleep study to determine the extent of the patient's sleep disorder.

