

**N323 Care Plan**

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N23 Mental and Behavioral Health

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**Demographics (3 points)**

<b>Date of Admission</b> 02/09/23	<b>Patient Initials</b> JV	<b>Age</b> 14 years old	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian, Non-Hispanic	<b>Occupation</b> Student	<b>Marital Status</b> <b>Single</b>	<b>Allergies</b> No Known Allergies
<b>Code Status</b> Not Assigned	<b>Observation Status</b> Admitted to inpatient mental facility	<b>Height</b> 154.9 cm	<b>Weight</b> 66.5 kgs

**Medical History (5 Points)**

**Past Medical History:** Client denies past medical history. No known past medical history on file.

**Significant Psychiatric History:** Depression

**Family History: Mother:** Bipolar, **Father:** depression, **Brother:** depression.

**Social History (tobacco/alcohol/drugs):** The client used tobacco/ tobacco products, vape, alcohol and unspecified drugs prior to admission to Pavilion.

**Living Situation:** The client lives at home with father in Benton, Il.

**Strengths:** The client states that her strength is skating, and that skating makes her happy.

**Support System:** Father and Therapist.

**Admission Assessment**

**Chief Complaint (2 points):** Suicide with plan to overdose.

**Contributing Factors (10 points):**

**Factors that lead to admission:** The client has self-destructive behavior.

**History of suicide attempts:** Three suicide attempts at the age of 11, 13, and 14.

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

1. Major depressive disorder, severe, recurrent, with psychosis.

- 2. Post- traumatic stress disorder, unspecified
- 3. Anxiety disorder, unspecified.

**Psychosocial Assessment (30 points)**

History of Trauma				
<b>No lifetime experience:</b>				
<b>Witness of trauma/abuse:</b>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
<b>Physical Abuse</b>	Y	N/A	N/A	Patient refused to describe the abuse.
<b>Sexual Abuse</b>	Y	N/A	N/A	Patient refused to describe the abuse.
<b>Emotional Abuse</b>	Y	N/A	N/A	Patient refused to describe the abuse.
<b>Neglect</b>	Y	N/A	N/A	Patient refused to describe the abuse.
<b>Exploitation</b>	N	N/A	N/A	Patient refused to describe the abuse.
<b>Crime</b>	N	N/A	N/A	Patient refused to

				describe the abuse.
<b>Military</b>	N	N/A	N/A	Patient refused to describe the abuse.
<b>Natural Disaster</b>	Y	N/A	N/A	Patient refused to describe the abuse.
<b>Loss</b>	Y	N/A	N/A	Patient refused to describe the abuse.
<b>Other</b>	N/A	N/A	N/A	Patient refused to describe the abuse.

**Presenting Problems**

<b>Problematic Areas</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Depressed or sad mood</b>	<u>Yes</u>	No	Patient refused to describe the problem.
<b>Loss of energy or interest in activities/school</b>	<u>Yes</u>	No	Patient refused to describe the problem.
<b>Deterioration in hygiene and/or grooming</b>	<u>Yes</u>	No	Patient refused to describe the problem.
<b>Social withdrawal or isolation</b>	<u>Yes</u>	No	Patient refused to describe the problem.
<b>Difficulties with home, school, work, relationships, or responsibilities</b>	<u>Yes</u>	No	Patient refused to describe the problem.
<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Change in numbers of hours/night</b>	<u>Yes</u>	No	The client states that number of

			sleeps at night varies.
<b>Difficulty falling asleep</b>	<u>Yes</u>	No	The client states that the temperature in the room is cold.
<b>Frequently awakening during night</b>	<u>Yes</u>	No	Due to the cold room.
<b>Early morning awakenings</b>	<u>Yes</u>	No	The client states that staff awakens her.
<b>Nightmares/dreams</b>	<u>Yes</u>	No	The client states that she has recurring dreams.
<b>Other</b>	<u>Yes</u>	No	N/A
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	<u>Yes</u>	No	<b>The client states that she does not like the food in the facility.</b>
<b>Binge eating and/or purging</b>	<u>Yes</u>	No	<b>States that she sometimes it a lot or not all.</b>
<b>Unexplained weight loss?</b>  <b>Amount of weight change:</b>	<u>Yes</u>	No	<b>The client states that she has gained 6 lbs since admission.</b>
<b>Use of laxatives or excessive exercise</b>	Yes	<u>No</u>	
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	<u>Yes</u>	No	<b>Every day, multiple times a day.</b>
<b>Panic attacks</b>	<u>Yes</u>	No	<b>Every day, multiple times a day.</b>

<b>Obsessive/compulsive thoughts</b>	<u>Yes</u>	No	<b>Every day, multiple times a day.</b>
<b>Obsessive/compulsive behaviors</b>	<u>Yes</u>	No	<b>Every day, multiple times a day.</b>
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	<u>Yes</u>	No	<b>It impacts the relationship with her peers.</b>

**Rating Scale**

<b>How would you rate your depression on a scale of 1-10?</b>	9
<b>How would you rate your anxiety on a scale of 1-10?</b>	8

**Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)**

<b>Problematic Area</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Work</b>	Yes	<u>No</u>	
<b>School</b>	<u>Yes</u>	No	
<b>Family</b>	<u>Yes</u>	No	
<b>Legal</b>	Yes	<u>No</u>	
<b>Social</b>	<u>Yes</u>	No	
<b>Financial</b>	<u>Yes</u>	No	
<b>Other</b>	Yes	<u>No</u>	N/A

**Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient**

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
December 3-15, 2021	<b>Inpatient:</b> Hartgrove Behavioral Health Hospital in Chicago, IL.  <b>Outpatient</b> <b>Other:</b>	Inpatient	Suicide  Attempt	No improvement  <u><b>Some improvement</b></u>  Significant improvement
December 3-15, 2022	<b>Inpatient:</b> Lincoln Prairie Behavioral Health Center in Springfield, IL.  <b>Outpatient</b> <b>Other:</b>	Inpatient	Suicide  Attempt	No improvement  <u><b>Some improvement</b></u>  Significant improvement
September- October 2022	<b>Inpatient:</b> The Pavilion Foundation in Champaign, IL.  <b>Outpatient</b> <b>Other:</b>	Inpatient	Suicide  Attempt	<u><b>No improvement</b></u>  Some improvement  Significant improvement
<b>Personal/Family History</b>				
Who lives with you?	Age	Relationship	Do they use substances?	
Father's Initials: MV	53 years old	Father	<u><b>Yes</b></u>	No
			Yes	No
<b>If yes to any substance use, explain:</b> Father uses tobacco and alcohol every day and multiple				

times a day.		
<b>Children (age and gender):</b> N/A		
<b>Who are children with now?</b> N/A		
<b>Household dysfunction, including separation/divorce/death/incarceration:</b> Father and mother is divorced. Client shared that mother left when she was 3 years old.		
<b>Current relationship problems:</b>		
<b>Number of marriages:</b> Mother-1, Father- 2.		
<b>Sexual Orientation:</b> Bisexual	<b>Is client sexually active?</b> <u>Yes prior to admit</u> No	<b>Does client practice safe sex?</b> <u>Yes</u> No
<b>Please describe your religious values, beliefs, spirituality and/or preference:</b>		
<b>Ethnic/cultural factors/traditions/current activity:</b>		
<b>Describe:</b>		
<b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b>		
<b>How can your family/support system participate in your treatment and care?</b>		
<b>Client raised by:</b>		
<ul style="list-style-type: none"> <li><u>Natural parents</u></li> <li>Grandparents</li> <li>Adoptive parents</li> <li>Foster parents</li> <li>Other (describe):</li> </ul>		
<b>Significant childhood issues impacting current illness:</b> Client shared that she is beaten for 10 years by father.		
<b>Atmosphere of childhood home:</b>		
<ul style="list-style-type: none"> <li>Loving</li> <li>Comfortable</li> <li><u>Chaotic</u></li> <li><u>Abusive</u></li> <li>Supportive</li> </ul>		

Other:
<p><b>Self-Care:</b> Keep up with hygiene every day.</p> <p><b><u>Independent</u></b>                  Assisted                  Total Care</p>
<p><b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b></p> <p>Father: Depression</p> <p>Mother: Bipolar Disorder</p> <p>Brother 1: Depression and suicide attempt</p>
<p><b>History of Substance Use:</b></p>
<p><b>Education History:</b></p> <p><b>Grade school:</b> In Benton, IL.  <b>High school:</b> Johnson City Alternative School  <b>College:</b> N/A  <b>Other:</b> N/A</p>
<p><b>Reading Skills:</b></p> <p><b><u>Yes</u></b>                  No                  Limited</p>
<p><b>Primary Language:</b> English</p>
<p><b>Problems in school:</b> Problem with primary support group and social environmental issue.</p>
<p><b>Discharge</b></p>
<p><b>Client goals for treatment:</b> Client goal for treatment is absence of suicide ideation.</p>
<p><b>Where will client go when discharged?</b> The client shared that she will be returning home and live with father.</p>

**Outpatient Resources (15 points)**

Resource	Rationale
1. Support groups/community organization.	1. Friends and family as well as agencies and organization can help the client.
2. Client's Therapist	2. A therapist is an excellent resource for the client.
3. National Suicide Prevention Lifeline hotline	3. In the event of Crisis, the hotline number 800-273-TALK can prevent suicide.

### Current Medications (10 points)

**\*Complete all of your client's psychiatric medications\***

Brand/Generic	Abilify/ Aripiprazole	Vistaril/ Hydroxyzine	Depo-Provera/ Medroxyprogesteron e	Effexor/ Venlafaxine	
Dose	2.5 mg q AM 5 mg q HS	25 mg q AM 50 mg q HS	150 mg	75 mg	
Frequency	Q AM and Q HS	Q AM and Q HS	Q 3 mos	Q AM	
Route	Oral	Oral	IM Injection	Oral	
Classification	Atypical antipsychotic/ antipsychotic	Piperazine/ Anxiolytic, antiemetic, antihistamine, Sedative- hypnotic	Antineoplastics, Hormones; Progestins	Selective Serotonin and norepinephrin e Reuptake inhibitor (SSNRI)/anti depressant	
Mechanism of Action	May reduce antipsychotic effects through partial agonist and antagonist actions. This	Competes with histamine for histamine 1 receptor sites on surfaces of effector cells. This	Medroxyprogesterone acetate (MPA), a progestin, is similar in structure to naturally occurring progesterone. The mechanism of action	Inhibits neuronal reuptake of norepinephrin e and serotonin, along with its	

	<p>drug acts as a partial agonist at Dopamine receptors and serotonin receptors. The drug acts as an antagonist at 5-HT<sub>2A</sub> serotonin receptor sites (Jones &amp; Bartlett Learning, 2021).</p>	<p>suppresses results of histamine activity, including edema, flare and pruritus'. Sedative actions occur at subcortical level of CNS and are dose related (Jones &amp; Bartlett Learning, 2021).</p>	<p>of progestin involves binding the progesterone receptor in the hypothalamus, female reproductive tract, and the pituitary and inhibiting the secretion of gonadotropin-releasing hormone (GnRH). By decreasing the frequency of release of GnRH, MPA blunts the midcycle LH surge and prevents follicular maturation and ovulation. MPA changes a proliferative endometrium to a secretory one in the endometrium, making it difficult for implantation. Finally, MPA also impairs sperm migration into the uterus by increasing the viscosity of the cervical mucus (Sathe &amp; Gerriets, 2022).</p>	<p>active metabolite. These actions raise norepinephrine and serotonin levels at nerve synapses, elevating mood and reducing anxiety, depression, and panic (Jones &amp; Bartlett Learning, 2021).</p>
<p>Therapeutic Uses</p>	<p>To treat acute schizophrenia; to maintain stability in patients with schizophrenia (Jones &amp; Bartlett Learning, 2021)..</p>	<p>To relieve anxiety and tension associated with psychoneuroses; adjust in organic disease states in which anxiety is manifested (Jones &amp; Bartlett Learning,</p>	<p>An IM contraception that prevents the growth of malignant cells (Sathe &amp; Gerriets, 2022).</p>	<p>To treat and prevent relapse of major depression (Jones &amp; Bartlett Learning, 2021).</p>

		2021).			
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	
Reason Client Taking	To manage symptoms of psychosis such as	To manage anxiety	This medication is used as birth control.	Treatment for depression.	
Contraindications (2)	1. Clients with Diabetes  2. Elderly clients with psychosis (Jones & Bartlett Learning, 2021).	1. Prolonged QT interval.  2. Early Pregnancy (Jones & Bartlett Learning, 2021).	1. Clients with DM  2. In women with history of migraine and seizure disorder (Sathe & Gerriets, 2022).	1. Use of MAO inhibitor  2. Clients taking Linezoid and phentermine (Jones & Bartlett Learning, 2021).	
Side Effects/Adverse Reactions (2)	1. Clients may develop Traditive dyskinesia.  2. Muscle spasm and weakness (Jones & Bartlett Learning, 2021).	1. Torsades de Pointes  2. Seizures (Jones & Bartlett Learning, 2021).	1. Weight Gain.  2. Menstrual irrgeulaities (Sathe & Gerriets, 2022).	1. Abnormal dreams.  2. Abnormal bleeding (Jones & Bartlett Learning, 2021).	
Medication/Food Interactions	May increased risk for orthostatic hypotension with clients taking benzodiazepam (Jones & Bartlett Learning, 2021).	Interaction with CNS depressants may increase CNS depression (Jones & Bartlett Learning, 2021).	In vitro, MPA is metabolized by CYP3A4. Therefore, inducers and inhibitors of CYP3A4 can affect the metabolism of MPA	Increased risk for bleeding when taken with NSAIDS (Jones & Bartlett Learning, 2021)..	

			(Sathe & Gerriets, 2022).	
Nursing Considerations (2)	<p>1. Monitor CBC as ordered, hematologic reactions may occur such as leukopenia, neutropenia and agranulocytosis can occur,</p> <p>2. Advise client to slowly change position from sitting or lying position because of hypostatic hypertension (Jones &amp; Bartlett Learning, 2021).</p>	<p>1. Observe for oversedation if the client takes another CNS depressant.</p> <p>2. Caution the client about drowsiness (Jones &amp; Bartlett Learning, 2021).</p>	<p>1. Obtain a negative pregnancy test before administering this medication.</p> <p>2. Assess the client for feeling of body dysmorphia from the side effect of weight gain (Sathe &amp; Gerriets, 2022).</p>	<p>1. Assess for electrolyte imbalance. This drug may cause hyponatremia.</p> <p>2. Caution client to avoid aspirin, NSAIDs, it may cause bleeding (Jones &amp; Bartlett Learning, 2021).</p>

Medications Reference (1) (APA):

Jones & Bartlett Learning, J. (2021, December 21). *2022 Nurse’s Drug Handbook*. NDH.

Sathe, A. & Gerriets, V. (2022, May 19). *Medroxyprogesterone*. National Library of Medicine.

Retrieved February 20, 2023, from

<https://www.ncbi.nlm.nih.gov/books/NBK559192/#:~:text=Mechanism%20of%20Action%20Medroxyprogesterone%20acetate%20%28MPA%29%2C%20a%20progestin>

%2C,and%20inhibiting%20the%20secretion%20of%20gonadotropin-releasing  
%20hormone%20%28GnRH%29.

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

<p><b>APPEARANCE:</b>  <b>Behavior:</b>  <b>Build:</b>  <b>Attitude:</b>  <b>Speech:</b>  <b>Interpersonal style:</b>  <b>Mood:</b>  <b>Affect:</b></p>	<p>No unusual movements                  Overweight                  Calm and cooperative                  Normal speed, rate, volume, and pressure                  Guarded                  Sad and Depressed                  Flat and blunted</p>
<p><b>MAIN THOUGHT CONTENT:</b>  <b>Ideations:</b>  <b>Delusions:</b>  <b>Illusions:</b>  <b>Obsessions:</b>  <b>Compulsions:</b>  <b>Phobias:</b></p>	<p>Yes                  No                  No                  Yes                  Yes                  Tropolophobia</p>
<p><b>ORIENTATION:</b>  <b>Sensorium:</b>  <b>Thought Content:</b></p>	<p>Registration, Retention and Retrieval intact.                  Active suicidal ideation. No delusion, no grandiosity, and positive paranoia.</p>
<p><b>MEMORY:</b>  <b>Remote:</b></p>	<p>.Short-term intact                  Long term intact</p>
<p><b>REASONING:</b>  <b>Judgment:</b>  <b>Calculations:</b>  <b>Intelligence:</b>  <b>Abstraction:</b>  <b>Impulse Control:</b></p>	<p>Poor                  Able to answer simple mathematical questions.                  Average intellectual functioning                  Able to understand and communicate concept.                  Controlled</p>
<p><b>INSIGHT:</b></p>	<p>Poor. The client does not believe that things will get better for herself.</p>

<b>GAIT:</b> <b>Assistive Devices:</b> <b>Posture:</b> <b>Muscle Tone:</b> <b>Strength:</b> <b>Motor Movements:</b>	N/A Good and aligned. Normal muscle tone. No weakness present. Slowed, rocking back and forth.
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**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	91 bpm	109/55 mmHg	18	98.0 F	98%
1100	80 bpm	119/73 mmHg	16	98.7 F	100%

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

Time	Scale	Location	Severity	Characteristics	Interventions
1000	8	Headache	Acute	Throbbing, dull	Acetaminophen, Tylenol given.
1630	0	N/A	N/A	N/A	N/A

**Dietary Data (2 points)**

Dietary Intake	
<b>Percentage of Meal Consumed:</b>  <b>Breakfast: 90%</b>  <b>Lunch: 70%</b>  <b>Dinner: 90%</b>	<b>Oral Fluid Intake with Meals (in mL)</b>  <b>Breakfast:</b> Approx. 475 mL (2 cups)  <b>Lunch:</b> unable to answer  <b>Dinner:</b> unable to answer

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):**

Upon discharge the client should schedule a follow up appointment with Mental Health practitioner, adhere to medication, join support group, and watch for signs and symptoms of declining mental health.

**Nursing Diagnosis (15 points)**

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

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Immediate Interventions (At admission)</b></p>	<p><b>Intermediate Interventions (During hospitalization)</b></p>	<p><b>Community Interventions (Prior to discharge)</b></p>
<p>1. Ineffective coping related to insufficient support system as evidence by destructive behavior toward self.</p>	<p>The client is unable to cope with school and everyday life due to depression.</p>	<p>1. Monitor suicidal tendencies and risk to harm others.  2. Collaborate with the client to identify strengths such as the ability to relate the facts and to recognize the source of stressors.</p>	<p>1. Assist the client to set realistic goals and identify personal skills and knowledge.  2. Provide mental and physical activities within the client's ability such as word search, puzzles, quizzes.  3. Offer instruction regarding their</p>	<p>1. Build up your confidence to make decisions through peer support.  2. Observe yourself daily and observe your response to other's values, customs, and events.  3. Encourage</p>

		<p>3. Observe for contributing factors of ineffective coping such as lack of support, poor self-concept, lack of problem-solving skills, grief, recent change in life situation, maturational or situational crises (Ackley et al., 2021).</p>	<p>preferred alternative coping strategies (Ackley et al., 2021).</p>	<p>yourself to tackle problems and handle them with the proper plan without getting frustrated (Ackley et al., 2021).</p>
<p><b>Hopelessness related to perceiving future as waited as evidence by loss of interest in life.</b></p>	<p>The client feels that there is nothing out in the real life for her. The client shows signs of unmotivation and discouragement.</p>	<p>1. Assess the client for signs of self-harm.</p> <p>2. Assess and monitor for suicide ideation and ask if he/she have a plan.</p> <p>3. Spend one-on-one time with the client. Use empathy; try to understand what the client is saying and communicate this understanding to the client to create a nonjudgmental trusting environment to develop therapeutic</p>	<p>1. Teach alternative coping strategies such as physical activity, arts, and crafts.</p> <p>2. Encourage adolescent clients to get 9 to 10 hours of sleep nightly.</p> <p>3. Explore the meanings, functions, objects, sources, and nature of hope with patients as relates to their current situation (Ackley et al., 2021).</p>	<p>1. Provide time for client to initiate interaction with others.</p> <p>2. Encourage client to participate in support group or community club.</p> <p>3. Encourage client to volunteer. This may give the client sense of purpose (Ackley et al., 2021).</p>

		relationships with the client (Ackley et al., 2021).		
<b>Risk for suicide related to cluster suicides.</b>	Due to previous history of suicide attempts, the client is placed on high risk for suicide.	<ol style="list-style-type: none"> <li>1. Determine the presence and degree of suicidal risk. Ask client if they have a plan.</li> <li>2. Provide safe environment. Remove potential items that can be used as weapons.</li> <li>3. Limit access to windows and exits unless locked and shatterproof, as appropriate (Ackley et al., 2021).</li> </ol>	<ol style="list-style-type: none"> <li>1. Provide encouragement and positive attitude. Keep discussion oriented to the present and future.</li> <li>2. Observe, record, and report any changes in mood or behavior that may signify increasing suicide risk and document results of regular surveillance checks.</li> <li>3. Educate the client that new medication might take 2 to 6 weeks to fully take effect. Medication compliance is important (Ackley et al., 2021).</li> </ol>	<ol style="list-style-type: none"> <li>1. Involve the adolescent in multimodal treatment programs.</li> <li>2. Ensure that the client will adhere to a follow up plan.</li> <li>3. With the client's consent, facilitate family-oriented crisis intervention. Family oriented crisis intervention can clarify stresses and allow assessment of family dynamics (Ackley et al., 2021).</li> </ol>

**Other References (APA):**

Ackley, B., Ladwig, G., Makic, M., Kratz, M., Zanoliti, M. (2021). *Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care*. (12<sup>th</sup> ed.) Elsevier.

Jones & Bartlett Learning, J. (2021, December 21). *2022 Nurse’s Drug Handbook*. NDH.

**Concept Map (20 Points):**

### Subjective Data

Client is admitted to Pavilion on 2/9/23 for suicide ideation with a plan to overdose. The client has depression, exhibiting hopelessness and ineffective coping. The client does not know her trigger, she states that listening to music and drawing help with anxiety and depression. The client is taking antipsychotic, antidepressants and antianxiety medications.

### Nursing Diagnosis/Outcomes

**Ineffective coping related to insufficient support system as evidence by destructive behavior toward self.**

Outcome: The client will learning effective coping mechanism.

**Hopelessness related to perceiving future as waited as evidence by loss of interest in life.**

Outcome: The client will demonstrate interest in readiness in moving forward.

**Risk for suicide related to cluster suicides.**

Outcome: The client will not be a threat to self and to others.

### Nursing Interventions

**Nursing DX 1:** 1. Monitor suicidal tendencies and risk to harm others.

2. Collaborate with the client to identify strengths such as the ability to relate the facts and to recognize the source of stressors.

3. Observe for contributing factors of ineffective coping such as lack of support, poor self-concept, lack of problem-solving skills, grief, recent change in life situation, maturational or situational crises (Ackley et al., 2021).

**Nursing DX 2:**

1. Assess the client for signs of self-harm.

2. Assess and monitor for suicide ideation and ask if he/she have a plan.

3. Spend one-on-one time with the client. Use empathy; try to understand what the client is saying and communicate this understanding to the client to create a nonjudgmental trusting environment to develop therapeutic relationships with the client (Ackley et al., 2021).

**Nursing Dx 3**

1. Determine the presence and degree of suicidal risk. Ask client if they have a plan.

2. Provide safe environment. Remove potential items that can be used as weapons.

3. Limit access to windows and exits unless locked and shatterproof, as appropriate (Ackley et al., 2021).

### Objective Data

Client's Vital signs include:

80 bpm

119/73 mmHg

RR 16

98.7 F

100%

### Patient Information

14 years old

Female gender assigned at birth.

Student

A+O x4

Lives with Father

Has three brothers

Admitting diagnosis: Suicide ideation with plan to overdose.





