N323 Care Plan

Lakeview College of Nursing

Fallynne Moores

Dr. Backlin

3-6-2023

Demographics (3 points)

Date of Admission 3-2-2023	**Patient Initials** T. C.	**Age** 38	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Professor at U of I	**Marital Status** Single	**Allergies** Penicillins
Code Status Full	**Observation Status** IP	**Height** 6’3”	**Weight** 223lb

Medical History (5 Points)

Past Medical History: ADHD, Anxiety, Asthma, Depression, GERD, HTN

Significant Psychiatric History: SI with a plan, SH

Family History:

Mother: Living- heart disease, breast cancer

Father: Living- skin cancer

Brother: Living- TBI

Brother: Living- Alcoholism

Sister: Living- Anxiety, Depression

Social History (tobacco/alcohol/drugs):

Patient denies use of alcohol.

Smoking: Former- 1 pack/day from ages 20-34

Patient denies use of illicit drugs.

Living Situation: Lives at home with fiancée, 20-month-old daughter, and pets (dog and cat).

Strengths: The patient is amiable, cooperative, and happy to participate in this assignment. The patient states his strengths are that he is kind and caring.

Support System: Patient states his support system includes his fiancée, his friends, his family, and his AA group.

Admission Assessment

Chief Complaint (2 points): Negative Thoughts; wants to find a therapist.

Contributing Factors (10 points): The patient stated upon admission that they did not like how they felt when they thought their significant other and child would be better without them in the picture. The most significant factor contributing to admission is that the patient wanted a professional to talk to regarding these feelings as they want to be a part of their significant other and child's lives.

Factors that lead to admission: SI with a plan, previous history of suicide ideation with a plan.

History of suicide attempts: No previous attempts but one suicide ideation with a plan in 2018.

Primary Diagnosis on Admission (2 points): SI with a plan to OD

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	None	None	None	N/A

Sexual Abuse	None	None	None	N/A
Emotional Abuse	None	Yes (Beginning at 2yrs)	None	Grew up in a divorced household and was often in the middle of arguments between parents.
Neglect	None	None	None	N/A
Exploitation	None	None	None	N/A
Crime	None	None	None	N/A
Military	None	None	None	N/A
Natural Disaster	None	None	None	N/A
Loss	None	None	None	N/A
Other	None	None	None	N/A

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	N/A
Loss of energy or interest in activities/school	**Yes**	**No**	N/A
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
Social withdrawal or isolation	**Yes**	**No**	N/A
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	N/A
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	***Frequency:*** Intermittent ***Intensity:*** Mild

			Duration: A couple of hours ***Occurrence:*** Occasionally
Difficulty falling asleep	**Yes**	**No**	***Frequency:*** Constant ***Intensity:*** Moderate ***Duration:*** Takes over an hour to fall asleep. ***Occurrence:*** Everyday
Frequently awakening during night	**Yes**	**No**	***Frequency:*** Intermittent ***Intensity:*** Mild ***Duration:*** About 30 minutes ***Occurrence:*** Occasionally
Early morning awakenings	**Yes**	**No**	N/A—patient states they are an early riser.
Nightmares/dreams	**Yes**	**No**	N/A
Other	**Yes**	**No**	N/A
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	N/A
Binge eating and/or purging	**Yes**	**No**	N/A
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	N/A
Use of laxatives or excessive exercise	**Yes**	**No**	N/A
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	***Frequency:*** Intermittent ***Intensity:*** Mild ***Duration:*** About 30 minutes ***Occurrence:*** Occasionally ***Behaviors:*** Fidgety and increased heart rate
Panic attacks	**Yes**	**No**	N/A
Obsessive/compulsive thoughts	**Yes**	**No**	N/A

Obsessive/compulsive behaviors	**Yes**	**No**	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	N/A
Rating Scale			
How would you rate your depression on a scale of 1-10?	2		
How would you rate your anxiety on a scale of 1-10?	4		
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**	***Frequency:*** Intermittent (seasonal) ***Intensity:*** Mild ***Duration:*** A couple of days ***Occurrence:*** Occasionally throughout the month
School	**Yes**	**No**	
Family	**Yes**	**No**	***Frequency:*** Intermittent ***Intensity:*** Mild ***Duration:*** Varies depending on the severity of the situation. ***Occurrence:*** A couple of times a month.
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
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**
2018	**Inpatient** **Outpatient** **Other:**	Outpatient	Substance misuse with a plan for suicide.	**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Fiancee	28 years	Significant Other	**Yes**	**No**
Daughter	20 months	Child	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): 20 month old daughter **Who are children with now?** Daughter is currently with significant other at home.				

Household dysfunction, including separation/divorce/death/incarceration: None.

Current relationship problems: IP status and ineffective medication management/therapy.

Number of marriages: 1

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 states that they believe in a higher power but they don't have a "name" for them.

Ethnic/cultural factors/traditions/current activity: None.

Describe: N/A

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): DUI at 21

How can your family/support system participate in your treatment and care?
The patient states that his family and support systems can participate in his treatment and care by being there for him and listening to him when he needs to talk.

Client raised by:

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

Significant childhood issues impacting current illness:
Patient states that one of his older brothers suffered from a TBI after a MVC that left him debilitated and that experience left a negative impact on him.

Atmosphere of childhood home:

Loving
Comfortable
Chaotic
Abusive
Supportive
Other: "Great upbringing"

Self-Care:

Independent
Assisted
Total Care

Family History of Mental Illness (diagnosis/suicide/relation/etc.) Alcoholism on both sides of the patient's family (grandparents, several uncles, and one of his older brothers). Anxiety and Depression (sister)
History of Substance Use: Yes. Alcohol and prescription medications.
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: Determine medication therapy and therapy.
Where will client go when discharged? The patient will be discharged to home.

Outpatient Resources (15 points)

Resource	Rationale
1. Therapy-Two Roads Wellness Clinic or The Rock Counseling Group in Mahomet	**1.** The patient mentioned that he wanted a therapist to talk to regarding his emotions and thoughts, these are the closest to the patient.
2. Psychiatrist Consult- at Carle or OSF in Champaign	**2.** A psychiatrist can provide a more detailed plain and will know more about medications for the specialty of major depressive disorder, anxiety, and ADHD than a general practitioner will. They can
3. The patient's father	**3.** The patient stated that after he had his negative thoughts, his father was the first person he contacted to talk to and seek advice

	from.

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

Patient is only on 6 medications

Brand/ Generic	Aripiprazole (Abilify)	Bupropion ERT (XL) (Wellbutrin XL)	Buspirone (Buspar)	Desvenlafaxine (Pristiq)	Lisdexamfetamine (Vyvanse)
Dose	5mg	300mg	50mg	100mg	40mg
Frequency	QD AM	QD AM	QD AM	QD AM	QD AM
Route	PO	PO	PO	PO	PO
Classification	P: *Atypical Antipsychotic* (Nurses Drug Handbook, 2023). T: *Antipsychotic* (Nurses Drug Handbook, 2023).	P: *Aminoketone* (Nurses Drug Handbook, 2023). T: *Antidepressant, smoking cessation adjunct* (Nurses Drug Handbook, 2023).	P: *Azaspirone* (Nurses Drug Handbook, 2023). T: *Anxiolytic* (Nurses Drug Handbook, 2023).	P: *SSNRI* (Nurses Drug Handbook, 2023). T: *Antidepressant* (Nurses Drug Handbook, 2023).	P: *Amphetamine* (Nurses Drug Handbook, 2023). T: *CNS Stimulant* Controlled Substance Schedule: ***II***
Mechanism of Action	*May act as a partial agonist at dopamine and serotonin receptors producing antipsychotic effects.* (Nurses Drug Handbook, 2023).	*May inhibit dopamine, norepinephrine, and serotonin by neurons significantly relieving evidence of depression* (Nurses Drug Handbook, 2023).	*Acts as a partial agonist at serotonin 5-hydroxytrptamine₁ A receptors in the brain, producing antianxiety effects* (Nurses Drug Handbook, 2023).	*Inhibits neuronal reuptake of norepinephrine and serotonin raising norepinephrine and serotonin levels elevating mood and reducing depression* (Nurses Drug Handbook, 2023).	*Produces CNS stimulant effects as well as releasing and blocking reuptake of dopamine in the brain allowing for decreased motor restlessness and increased alertness* (Nurses Drug Handbook, 2023).
Therapeutic Uses	*Mood Stabilizer* (Nurses Drug Handbook, 2023).	*To treat depression* (Nurses Drug Handbook, 2023).	*To manage anxiety* (Nurses Drug Handbook, 2023).	*To treat and prevent relapse of major depression* (Nurses Drug	*To treat ADHD* (Nurses Drug Handbook, 2023).

				Handbook, 2023).	
Therapeutic Range (if applicable)	*N/A*	*Onset: 1-3 wk Peak: Unknown Duration: Unknown* (Nurses Drug Handbook, 2023).	*Onset: 1-4 wk Peak: 3-6 wk Duration: Unknown* (Nurses Drug Handbook, 2023).	*Onset: 2 wk Peak: Unknown Duration: Unknown* (Nurses Drug Handbook, 2023).	*Onset: Unknown Peak: 1 hr Duration: Unknown* (Nurses Drug Handbook, 2023).
Reason Client Taking	*To aid in mood stabilization*	*Diagnosis of depression*	*Diagnosis of anxiety*	*Diagnosis of depression*	*Diagnosis of ADHD*
Contraindica-tions (2)	*Diabetes* (Nurses Drug Handbook, 2023). *Low levels of WBCs* (Nurses Drug Handbook, 2023).	*Seizure disorder or conditions that increase risk of seizures* (Nurses Drug Handbook, 2023). *Anorexia nervosa or bulimia* (Nurses Drug Handbook, 2023).	*Severe hepatic or renal impairment* (Nurses Drug Handbook, 2023). *Avoid use of monoamine oxidase inhibitors within 14 day before or after buspirone therapy* (Nurses Drug Handbook, 2023).	*Hypersensitivity to desvenlafaxine, venlafaxine, or their components* (Nurses Drug Handbook, 2023). *Use of MAO inhibitor within 14 days* (Nurses Drug Handbook, 2023).	*Hypersensitivity or idiosyncratic reaction to Lisdexamfetamine , other sympathomimetic amines, or their components* (Nurses Drug Handbook, 2023). *MAO inhibitor therapy within 14 days* (Nurses Drug Handbook, 2023).
Side Effects/ Adverse Reactions (2)	*Suicidal Ideation* (Nurses Drug Handbook, 2023). *Arrhythmias* (Nurses Drug Handbook, 2023).	*Suicidal ideation* (Nurses Drug Handbook, 2023). *Stevens-Johnson Syndrome* (Nurses Drug Handbook, 2023).	*Serotonin Syndrome* (Nurses Drug Handbook, 2023). *Angioedema* (Nurses Drug Handbook, 2023).	*Takotsubo cardiomyopathy* (Nurses Drug Handbook, 2023). *Toxic epidermal necrolysis* (Nurses Drug Handbook, 2023).	*Seizures* (Nurses Drug Handbook, 2023). *Rhabdomyolysis* (Nurses Drug Handbook, 2023).
Medication/ Food Interactions	*Avoid eating grapefruit or drinking grapefruit juice* (*Drug Interactions Checker - for*	*Avoid drinking alcohol as this may increase the risk of uncommon side effects such as delusions,*	*Avoid eating grapefruit or drinking grapefruit juice* (*Drug Interactions Checker - for Drugs, Food*	*Aspirin, NSAIDs, other SNRIs, SSRIs, Warfarin, and other anticoagulants: increased risk*	*Acidifying agents (urinary) such as ammonium choloride, sodium acid phosphate: Decreased blood level and effects of*

	Drugs, Food &Amp; Alcohol, n.d.).	*hallucinations, seizures, paranoia, suicidal thoughts, anxiety, panic attacks, and mood/behavioral changes* (*Drug Interactions Checker - for Drugs, Food &Amp; Alcohol*, n.d.).	*&Amp; Alcohol*, n.d.).	*of bleeding* (*Drug Interactions Checker - for Drugs, Food &Amp; Alcohol*, n.d.).	*Lisdexamfetamine* (Nurses Drug Handbook, 2023).
Nursing Considerations (2)	*Use cautiously in patients with cardiovascular disease, cerebrovascular disease, or conditions that would predispose them to hypotension* (Nurses Drug Handbook, 2023). *When administering in tablet form, have patient swallow tablet whole; do not have patient chew tablets and do not crush or divide tablets* (Nurses Drug Handbook, 2023).	*Monitor depressed patients closely for worsened depression and increased suicide risk, especially when therapy starts or dosage changes* (Nurses Drug Handbook, 2023). *Assess patient's blood pressure before bupropion therapy begins and monitor periodically during therapy because bupropion may cause hypertension* (Nurses Drug Handbook, 2023).	*Institute safety precautions because of possible adverse CNS reactions* (Nurses Drug Handbook, 2023). *Follow closely if patient is being withdrawn from long-term therapy with benzodiazepines or other sedative-hypnotic drugs while starting buspirone because buspirone won't prevent withdrawal symptoms* (Nurses Drug Handbook, 2023).	*Monitor blood pressure often during therapy because it may cause dose-related sustained increase in supine diastolic pressure. Expect to reduce or stop drug, as prescribed if increase develops* (Nurses Drug Handbook, 2023). *Watch patient for suicidal tendencies, especially when therapy starts and dosage changes* (Nurses Drug Handbook, 2023).	*Know that patient should be screened for psychiatric risk factors such as family or personal history of bipolar disorder, depression, or suicidal ideation because lisdexamfetamine may cause psychiatric adverse reactions. Monitor patients with bipolar for mania.*(Nurses Drug Handbook, 2023). *Keep in mind that lisdexamfetamine shouldn't be given to patient with cardiac abnormalities (structural), cardiomyopathy, or other serious*

					heart problems or rhythm abnormalities because even usual CNS-stimulant dosages increase risk of sudden death in patients with these conditions (Nurses Drug Handbook, 2023).

Brand/Generic	Trazodone (Desyrel)	N/A	N/A	N/A	N/A	N/A
Dose	50mg	N/A	N/A	N/A	N/A	N/A
Frequency	QD HS	N/A	N/A	N/A	N/A	N/A
Route	PO	N/A	N/A	N/A	N/A	N/A
Classification	P: *Triazolopyridine derivative* (Nurses Drug Handbook, 2023). T: *Antidepressant* (Nurses Drug Handbook, 2023).	N/A	N/A	N/A	N/A	N/A
Mechanism of Action	*Blocks serotonin reuptake causing an antidepressant effect* (Nurses Drug Handbook, 2023).	N/A	N/A	N/A	N/A	N/A
Therapeutic Uses	*To treat major depression* (Nurses Drug Handbook, 2023).	N/A	N/A	N/A	N/A	N/A
Therapeutic Range	*Onset: 1-2 wk*	N/A	N/A	N/A	N/A	N/A

(if applicable)	*Peak: Unknown Duration: Unknown* (Nurses Drug Handbook, 2023).					
Reason Client Taking	*Diagnosis of depression*	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	*Recovery from acute MI* (Nurses Drug Handbook, 2023). *Use within 14 days of an MAO inhibitor* (Nurses Drug Handbook, 2023).	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	*Suicidal Ideation* (Nurses Drug Handbook, 2023). *Arrhythmias* (Nurses Drug Handbook, 2023).	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	*Barbiturates and other CNS depressants: Enhanced effect of CNS depressants* (Nurses Drug Handbook, 2023).	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	*Monitor patient closely for serotonin syndrome exhibited by agitation, coma, diarrhea, hallucinations, hyperreflexia,*	N/A	N/A	N/A	N/A	N/A

	hyperthermia, incoordination, labile blood pressure, nausea, tachycardia, and vomiting. Notify prescriber immediately because serotonin syndrome may be life-threatening and provide supportive care (Nurses Drug Handbook, 2023). *Give shortly after the patient has a meal or light snack to reduce nausea* (Nurses Drug Handbook, 2023).					

Medications Reference (1) (APA):

Drug Interactions Checker - For Drugs, Food & Alcohol. (n.d.). Drugs.com. https://www.drugs.com/drug_interactions.html

Jones & Bartlett Learning. (2021, December 21). *2022 Nurse's Drug Handbook* (21st ed.).

MRPharmS, H. M. B. (2022, July 14). *Abilify interactions: Alcohol, medications, and other factors*. https://www.medicalnewstoday.com/articles/drugs-abilify-interactions#:~:text=Abilify%20interactions%20with%20food,grapefruit%20juice%20while%20taking%20Abilify.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	The patient's appearance was neat and well-groomed. The patient was quintessential to traditional behavior and maintained a confident, reasonable, and constructive attitude. The patient's pattern of speech had normal volume, rate, and pitch. The patient was forthright, conscientious, and straightforward. They demonstrated a euthymic mood with an affect within defined normal limits.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient denies any delusions, illusions, obsessions, compulsions, or phobias. The patient stated that they experienced some negative ideations regarding their relationships which is what led them to admission. The pessimistic thoughts subsided prior to admission to the Pavilion.
ORIENTATION: **Sensorium:** **Thought Content:**	The patient is awake, alert, and oriented to person, place, time, and situation. Excluding the unfavorable thoughts, the patient's sensorium was normo-functioning.
MEMORY: **Remote:**	Both short-term and long-term memory of the patient was intact: this was demonstrated by them retelling information, stories, and memories that occurred in the past as well as more recent interactions and occurrences.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient appeared to be in sound judgment with above average intelligence. Impulse control is outside normal limits as evidence by admission to the Pavilion. Abstraction and calculations were not accessed.
INSIGHT:	The patient's insight appeared to be normal as evidence by them actively participating in conversations and group activities.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient's gait was smooth and non-antalgic. Their posture was relaxed, and muscle tone and motor movements were normal. They do not use any assistive devices. The patient's strength was not assessed.

Vital Signs, 2 sets (5 points)

Unable to assess second set of vitals as clinical was cancelled prior to obtaining.

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
(3-2-2023) 1700	79	147/96 mmHg	16	98.5℉	96%
N/A	N/A	N/A	N/A	N/A	N/A

Pain Assessment, 2 sets (2 points)

Unable to assess second pain score as clinical was cancelled prior to obtaining.

Time	Scale	Location	Severity	Characteristics	Interventions
(3-2-2023) 1700	0-10	N/A	0	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100% **Lunch:** 80% --Patient stated he didn't finish all of his food because he didn't like the options. **Dinner: Clinical ended prior to dinner**	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 960 mL **Lunch:** 720 mL **Dinner: Clinical ended prior to dinner**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient will have frequent follow-up visits with their general practitioner or other specified professional following discharge from the Pavilion.

Patient will be provided with information on as well as appointments with a therapist and psychiatrist. The patient will be provided with a journal upon discharge to continue writing down thoughts, feelings, emotions, and ideas. The patient will be provided with a reconciled medication list to provide to general practitioner or other medical professional as well as for their own records/knowledge. Patient will be given information regarding their medications including mechanism of action, possible side effects, contraindications, and medication/food interactions.

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. Risk for suicide related to depression as evidenced by pessimistic thoughts stated prior to admission (Martin, 2019).	The patient stated that they had thoughts that their significant other and child would be better without the patient in the picture.	**1.** Create a safe environment. **2.** Removing any items from the patient that could be used to self-harm. **3.** Review the PHQ-9 screening tool with patient (Saab, et al., 2022).	**1.** Place patient on suicide precautions/observation depending on level of suicidal potential and per facility requirements: one-on-on monitoring at arm's length or Q15 min visual checks of mood, behavior, and statements (verbatim) (Martin, 2019). **2.** Reiterate these four points during an acute crisis period: the crisis is temporary, unbearable pain is	**1.** Arrange for patient to stay with family or friends post-discharge to relieve isolation as well as provide safety and comfort (Martin, 2019). **2.** Ensure that weapons and pills are removed from the living situation by friend or

			survivable, help is readily available, and they are not alone (Martin, 2019). **3.** Encourage patient to discuss their feelings and problem-solving alternatives to minimize risk for suicidal attempt (Martin, 2019).	family member to provide a safe environment free from items that the patient may use to harm themselves (Martin, 2019). **3.** Contact family to arrange for individual and/or family counseling during times of crisis to help reestablish social ties and decrease the patient's sense of isolation (Martin, 2019).
2. Risk for ineffective coping related to inadequate available resources as evidenced by lack of therapist and psychiatrist (Martin, 2019).	The patient stated that they wanted to have a therapist to talk to which is what led to admission at the Pavilion.	**1.** Assess the patient's strengths and, positive coping skills to build upon and draw from when planning alternatives to self-deprecating behaviors (Martin, 2019). **2.** Identify any triggers the patient might have to help patient learn to recognize when they	**1.** Encourage patient to express feelings and emotions while actively listening to and providing support and empathy towards patient (Martin, 2019). **2.** Assist patient with identifying and addressing negative thoughts to help patient develop more realistic thinking patterns that can lead to positive coping strategies (Martin, 2019). **3.** Encourage patient to partake in activities that promote a sense of	**1.** Encourage patient to share triggers with family, friends, or other support systems and how to help deescalate the situation when the patient begins to revert to negative coping mechanisms or negative thoughts (Martin, 2019). **2.** Encourage

		need help (Martin, 2019). **3.** Assess and identify patient's ineffective coping mechanisms that result in negative thoughts and actions (Martin, 2019).	purpose and accomplishment: exercising, learning a new skill, attending group sessions (Martin, 2019).	patient to continue medication therapy. **3.** Set up an appointment for the patient with a psychiatrist and therapist outside of the facility to take up, maintain, and adjust medications.
3. Risk for self-directed violence related to major depression as evidenced by previous substance misuse and suicidal ideation with a plan (Martin, 2021)	Patient reports that they have a history with the misuse of prescribed medications as well as having suicidal ideations with a plan.	**1.** Identify level of suicide precautions required. **2.** Implement safety precautions by removing anything that the patient could use to bring harm to themselves. **3.** Identify current medications with side effects that may increase risk for suicidal ideation.	**1.** Encourage patient to express their feeling and come up with other ways to handle negative feelings to help patient dealing with overwhelming emotions to feel a sense of control over their life/situation (Martin, 2021) **2.** Follow unit and facility protocols—Q15 min routine checks or one-on-one's, **3.** Check for the availability and supply of the required medications to prevent withdrawal symptoms that may occur with abrupt discontinuation.	**1.** Keep medication list reconciled and up-to-date to provide the patient with a correct list upon discharge. **2.** Encourage the patient to identify two to three people that they can reach out to for support when they are experiencing self-destructive feelings and emotions (Martin, 2021) **3.** Encourage the patient to demonstrate compliance with medication

				regimen and treatment plan (Martin, 2021).

Other References (APA):

Martin, P. (2021). *9 Major Depression Nursing Care Plans*. Nurseslabs. Retrieved March 4, 2023, from https://nurseslabs.com/major-depression-nursing-care-plans/

Martin, P. (2019). *3 Suicide Behaviors Nursing Care Plans*. Nurseslabs. Retrieved March 3, 2023, from https://nurseslabs.com/suicide-behaviors-nursing-care-plans/

Saab, M. M., Murphy, M., Meehan, E., Dillon, C. B., O'Connell, S., Hegarty, J., Heffernan, S., Greaney, S., Kilty, C., Goodwin, J., Hartigan, I., O'Brien, M., Chambers, D., Twomey, U., & O'Donovan, A. (2022). Suicide and Self-Harm Risk Assessment: A Systematic Review of Prospective Research. *Archives of suicide research : official journal of the International Academy for Suicide Research*, *26*(4), 1645–1665. https://doi.org/10.1080/13811118.2021.1938321

Concept Map (20 Points):

Subjective Data

The patient stated upon admission that they did not like how they felt when they thought their significant other and child would be better without them in the picture. The most significant factor contributing to admission is that the patient wanted a professional to talk to regarding these feelings as they want to be a part of their significant other and child's lives.

Nursing Diagnosis/Outcomes

1. Risk for suicide related to depression as evidenced by pessimistic thoughts stated prior to admission (Martin, 2019).
   Outcome Goals: Patient will remain safe while in the hospital.
   Patient will make a no-suicide contract for next 24-hr.
   Patient with uphold suicide contract.
   Patient will state that they want to live.
   Patient will name at least one alternative to their situation (Martin, 2019).

2. Risk for ineffective coping related to inadequate available resources as evidenced by lack of therapist and psychiatrist (Martin, 2019)
   Outcome Goals: Patient will refrain from using or abusing chemical agents.
   Patient will discuss at least three situations that trigger suicidal thoughts as well as feelings about this situation.
   Patient will state willingness to learn new coping strategies.
   Patient will demonstrate a reduction in self-destructive behaviors (Martin, 2019).

3. Risk for self-directed violence related to major depression as evidenced by previous substance misuse and suicidal ideation with a plan (Martin, 2021)
   Outcome Goals: Patient will seek help when experiencing self-destructive impulses.
   Patient will maintain medication regimen for 2-6 weeks and will report of any pertinent negatives at follow-up visits.
   Patient will demonstrate compliance with treatment plan and medications for the next two weeks.
   Patient will demonstrate alternative ways of dealing with negative feelings and emotional stress (Martin, 2021).

Objective Data

Vitals: ***BP*:** 147/96
***HR*:** 79
***RR*:** 16
***Temp*:** 98.5℉
***PaO2*:** 96% Room Air
***Pain*:** 0

PMH: ADHD
Anxiety
Depression

Significant Psychiatric History: SI with a plan

Primary Diagnosis on Admin: SI with plan to OD, SH

Pertinent Information:
Experienced emotional trauma growing up due to divorced household.
Has difficulties falling asleep and frequently awakens during the night.
Exhibits anxious behaviors such as fidgeting and tremors weekly.
Depression Rating: 2 / 10
Anxiety Rating: 4 / 10
Work and Family life are a source of anxiety.
History of Substance abuse
History of OP treatment for SI with plan to OD.
Patient was exhibiting signs of minimizing.

Patient Information

DOA: 3-2-2023
Pt initials: T. C.
Age: 38 yrs
Gender: Male
Race/Ethnicity: Caucasian
Occupation: Professor at U of I
Marital Status: Single
Allergies: Penicillin's
Code Status: Full
Height: 6'3"
Weight: 223lb
PMH: Asthma, Anxiety, Depression, GERD, HTN
SPH: SI with a plan, SH
Social Hx: Denies use of alcohol and illicit/street drugs. Smoking history of 1p/d from the ages 20-34.
Living Situation: Lives at home with significant other, 20-month-old daughter and pets (dog and cat).
Support System: Includes his family, his friends, and his AA group.
Strengths: Caring and kind
Chief Complaint: Pessimistic thoughts
Contributing Factors: Did not like how they felt when they thought that their significant other and daughter would be better without them in the picture and wanted to speak with a therapist regarding these feelings.
Factors Leading to Admission: SI with plan.
History of Suicide Attempt: No previous attempt, but one SI with plan in 2018
Primary Dx: SI with plan to OD
Current Rx: *Abilify*: 5mg PO QD AM, *Buspar:* 30mg PO BID, *Pristiq*: 100mg PO QD AM, *Trazadone*: 50mg PO QD HS, *Vyvanse*: 40mg PO QD AM, *Wellbutrin XL:* 300mg PO QD AM.
Patient is compliant with treatment.

Nursing Interventions

Immediate Interventions:
Diagnosis 1:
1-Create a safe environment (Martin, 2019).
2-Remove any objects that may be used for self-harm (Martin, 2019).
3-Review PHQ-9 screening tool with patient (Saab, et al., 2022)
Diagnosis 2:
1-Assess patient strengths and positive coping skills (Martin, 2019).
2-Identify triggers (Martin, 2019).
3-Assess and identify ineffective coping mechanisms (Martin, 2021).
Diagnosis 3:
1-Identify level of suicide precautions required (Martin, 2019).
2-Implement safety precautions by removing anything that could be used adventitiously by the patient (Martin, 2021).
3-Reconcile medication list (Martin, 2021).
Intermediate Interventions:
Diagnosis 1:
1-Place patient on suicide precautions/observation per facility protocol (Martin, 2019).
2-Reiterate the four affirmations (Martin, 2019).
3-Discuss feelings and problem-solving alternatives (Martin, 2019).
Diagnosis 2:
1-Actively listen to patient while providing support and empathy (Martin, 2019).
2-Identify and address negative thoughts (Martin, 2019).
3-Encourage participation of group activities (Martin, 2019).
Diagnosis 3:
1-Encourage expression of feelings when overwhelmed (Martin, 2021).
2-Follow unit protocols for suicide/self-harm prevention (Martin, 2021).
3-Check for medication availability and supply.
Community interventions:
Diagnosis 1:
1-Arrange for patient to stay with family/friend post-discharge (Martin, 2019).
2-Ensure a safe home environment free from weapons, pills, and chemicals (Martin, 2019).
3-Arrange for individual or family counseling (Martin, 2019).
Diagnosis 2:
1-Share triggers with family/friends/support groups (Martin, 2019).
2-Continue medication therapy.
3-Set up appointment with a therapist and psychiatrist.
Diagnosis 3:
1-Reconcile medication list to provide with discharge.
2-Identify 2-3 people the patient can reach out to for support (Martin, 2021).
3-Encourage compliance with medication treatment plan (Martin, 2021).