N323 Care Plan #1

Lakeview College of Nursing

Kelsy Marsh

03/05/2023

Demographics (3 points)

Date of Admission 03/01/2023	Patient Initials B.S.	Age 20	Gender Female
Race/Ethnicity Caucasian	Occupation FedEx	Marital Status Single	Allergies NKA
Code Status Full Code	Observation Status Suicide/Self-Harm	Height 5'5"	Weight 168 lbs.

Medical History (5 Points)

Past Medical History: Asthma, depression, anxiety, migraines, dizziness and fibromyalgia Significant Psychiatric History: The patient consulted a psychiatrist in the past (no reported date). The patient was hospitalized in the past (no reported date). The patient has a history of one suicide attempt (2023). Counseling in the past (no reported date). Treatment was given in the form of Prozac and Mirtazapine.

Family History: The patient's health file claims that the family is significant for psychiatric problems.

Social History (tobacco/alcohol/drugs): The patient did not report of any tobacco use. The patient claims that she just has an occasional alcoholic drink here and there. The patient did not report of any drug use.

Living Situation: The patient lives in a smaller house with her immediate family.

Strengths: The patient believes that she is: pleasant and cooperative. The patient is willing to participate at the treatment sessions, and has good support system from her immediate family.

Support System: The patient reports that her main source of support is from her immediate family and her boyfriend.

Admission Assessment

Chief Complaint (2 points): The patient stated, “I have mental health problems and would like to get help”, and had suicide ideation.

Contributing Factors (10 points):

Factors that lead to admission: Due to the patient’s previous mental/physical abuse from her father in her childhood, that essentially then developed into depression. Due to the depression that this client was having, a lot of stress was also built up in the patient. The patient briefly mentions consulting a psychiatrist in the past, and attending counseling sessions. The patient also quickly mentioned a previous hospitalization. The patient only mentions of one suicide attempt in the past. The patient mentions that what makes her feel even more depressed are the fact that she feels as if her parents do not care about her. Due to the constant depression and the suicidal ideation, the patient was then voluntarily admitted into the Pavilion.

History of suicide attempts: The patient had a previous suicide attempt (2023) by cutting wrists and thighs.

Primary Diagnosis on Admission (2 points): Major depressive disorder (severe/reoccurring), evaluate for unspecified bipolar disorder, social anxiety, and generalized anxiety disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No, has experience **Witness of trauma/abuse: Yes**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from**	**Describe**

			caring for another person with trauma)	
Physical Abuse	**Denies**	**During most of Childhood**	**N/A**	**Patient reports that her father would physically harm her because he was not in the right state of mind or under the influence.**
Sexual Abuse	**Denies**	**During Teenage years**	**N/A**	**Client described past boyfriends being abusive due to drugs/alcohol.**
Emotional Abuse	**Denies**	**During most of childhood**	**N/A**	**Client reports that she grew up her entire life always feeling like her parents never loved her due to their distance from her and their unwillingness to**

				want to be around her.
Neglect	**Denies**	**During teenage years**	**N/A**	**The patient reports feeling neglected by her parents because they would never be around for her.**
Exploitation	**Denies**	**Denies**	**N/A**	**N/A**
Crime	**Denies**	**Denies**	**N/A**	**N/A**
Military	**Denies**	**Never enlisted**	**N/A**	**N/A**
Natural Disaster	**Denies**	**Denies**	**N/A**	**N/A**
Loss	**Denies**	**Denies**	**N/A**	**N/A**
Other	**Denies**	**Denies**	**N/A**	**N/A**

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	**Denies**
Loss of energy or interest in activities/school	**Yes**	**No**	**Denies**
Deterioration in hygiene and/or grooming	**Yes**	**No**	**Denies**
Social withdrawal or isolation	**Yes**	**No**	**Denies**
Difficulties with home, school, work,	**Yes**	**No**	**Patient reports that she has a**

relationships, or responsibilities			**difficult time having a steady/healthy relationship with her biological mother and father, due to the stress that they put her through, within her lifetime.**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**The patient reports sleeping 9-10 hours of sleep instead of 6-7 hours.**
Difficulty falling asleep	**Yes**	**No**	**Denies**
Frequently awakening during night	**Yes**	**No**	**Denies**
Early morning awakenings	**Yes**	**No**	**Denies**
Nightmares/dreams	**Yes**	**No**	**Denies**
Other	**Yes**	**No**	**Denies**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Denies**
Binge eating and/or purging	**Yes**	**No**	**Denies**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**Denies**
Use of laxatives or excessive exercise	**Yes**	**No**	**Denies**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors,	**Yes**	**No**	**Denies**

etc.)			
Panic attacks	**Yes**	**No**	**Denies**
Obsessive/ compulsive thoughts	**Yes**	**No**	**Denies**
Obsessive/ compulsive behaviors	**Yes**	**No**	**Denies**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**Denies**
Rating Scale			
How would you rate your depression on a scale of 1-10?	**7/10**		
How would you rate your anxiety on a scale of 1-10?	**9/10**		
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**	**Denies**
School	**Yes**	**No**	**Denies**
Family	**Yes**	**No**	**Denies**
Legal	**Yes**	**No**	**Denies**
Social	**Yes**	**No**	**Patient misses spending time with her boyfriend.**
Financial	**Yes**	**No**	**Denies**
Other	**Yes**	**No**	**Denies**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/ MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
March 2023	**Inpatient Outpatient Other: The Pavilion**	**Inpatient**	**Suicide ideation/attempt**	**No improvement** **Some improvement** **Significant improvement** **Patient is eager and willing to taking the medications and joining into group activities and therapy. Although the patient said that she does not enjoy the Pavilion, she knows that she needs to get better, and this is a step she needs to take to become healthier.**
2023	**Inpatient Outpatient Other: OSF Hospital**	**Inpatient**	**Suicide ideation**	**No improvement** **The patient just wanted to get out of the hospital. The patient described that her parents didn't respond to her like she thought they would've.** **Some improvement** **Significant improvement**
Personal/Family History				

Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Brandy	**43**	**Mother**	**Yes**	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): N/A **Who are children with now?**				
Household dysfunction, including separation/divorce/death/incarceration: The patient states that at one point in time her father lived with them, but then said he's been gone recently. The patient did not specify whether gone means separated/divorce/death.				
Current relationship problems: N/A **Number of marriages: N/A**				
Sexual Orientation: Heterosexual	**Is client sexually active? Yes No**		**Does client practice safe sex? Yes No**	
Please describe your religious values, beliefs, spirituality and/or preference: Christian Non-denominational				
Ethnic/cultural factors/traditions/current activity: N/A **Describe: N/A**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A				
How can your family/support system participate in your treatment and care? The patient's family can act as a support system by continuing to call her and talk to her on the phone. The patient mentioned that the boyfriend is also very supportive, and asks about her improvement. The patient reported that what helps her treatment the most is				

talking aloud with others and physical touch of others.
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient describes an unloving family life when she was growing up with both her mother and father. The patient consistently describes that she never felt loved as a child from her parents.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic: The patient described that her parents would verbally fight a lot with each other.** **Abusive: Client reports both physical and emotional abuse. Physical abuse was primarily only from her father, but the emotional abuse was from both her mother and father.** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient reports her father having possibly a psychiatric illness.
History of Substance Use: Patient reports that she does not use tobacco products, nor drugs. The patient admits to consuming alcoholic beverages, but not on a daily basis. Patient reported that her father is an alcoholic and from time to time will decide to use drugs.

Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient states that due to past emotional/physical abuse from her parents that it made it difficult for her to be social and have/make friends.
Discharge
Client goals for treatment: Patient reports that she would like to start seeing a therapist on a regular schedule, and develop long-term coping skills for her depression and suicide ideation.
Where will client go when discharged? The patient will go back home after leaving the Pavilion.

Outpatient Resources (15 points)

Resource	Rationale
1. Individual Psyhcoeducational Therapy	**1. This particular kind of therapy would be extremely beneficial for this patient because of the trauma that she has been through with her father being an alcoholic, and his emotional/physical abuse that our**

	patient has been suffering from.
2. Survivor Support Group	**2. This therapy works on counseling of people that have had suicide attempts or suicide ideation. Throughout this group setting, the group leader will analyze the members and make sure that they're maintaining healthy behaviors/feelings.**
3. Carle Psychiatry in Champaign, IL	**3. If the patient has any further problems with medications or suicidal feelings, she can always go see a psychiatrist to be further evaluated.**

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

Brand/ Generic	**Salbutamol sulphate/albuterol sulfate HFA (Proair HFA)**	**Ondansetron/ Zofran**	**Qvar Redihaler/ Beclomethasone dipropioncite**	**Repan/ Butalbital - Acetaminophen- Caffeine**	**Cymbalta/ Duloxetine**
Dose	**90 mcg actuation inhaler**	**4 mg rapid dissolve tablet**	**80 mcg actuation inhaler**	**40 mg capsules**	**60 mg capsule**
Frequency	**2 puffs inhaled**	**1 tablet Q8H**	**1 puff Q12H**	**1 capsule**	**1 capsule**

	Q4H			**Q4-6H PRN**	**DAILY**
Route	**Inhalation Powder**	**PO**	**Inhalation Powder**	**PO**	**PO**
Classification	**Beta 2 Agonists**	**Antiemetic**	**Corticosteroids, inhalants**	**Barbiturate+ analgesic + methyl xanthine**	**Selective serotonin and norepinephrine reuptake inhibitors**
Mechanism of Action	**This medication is used to relax the bronchial muscles. These work by essentially inhaling the medications acts to control the person's asthma and asthma related symptoms.**	**This medication blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine.**	**This medication works by reducing swelling of the airways in the lungs to make breathing easier.**	**This medication mimics the inhibitory effect of gamma-aminobutyric acid (GABA) by binding to a site.**	**This medication inhibits the reuptake of serotonin and norepinephrine in the central nervous system.**
Therapeutic Uses	**Bronchodilator**	**Prevents nausea and vomiting**	**Maintenance treatment of asthma as prophylactic therapy**	**Relieve symptoms of tension (or muscle contraction)**	**To treat depression and anxiety**
Therapeutic Range (if applicable)	**2 inhalations 15-30 minutes before exercise**	**24 mg/day**	**40-80 mcg twice daily**	**300 mg/day**	**40 mg/day**
Reason Client Taking	**Shortness of breath and bronchospasm**	**Nausea/ vomiting**	**Mild intermittent asthma**	**Migraine**	**Depression**
Contraindications (2)	**1. Overactive thyroid gland 2. Diabetes**	**1. Low amount of magnesium in the**	**1. Primary therapy for patients**	**1. Severe liver dis**	**1. Bipolar disorder 2. Abrupt**

		blood **2. Low amount of potassium in the blood**	**with status asthmaticus or other types of acute episodes of asthma.** **2. Acute bronchospasms**	**ease** **2. Abnormal heart rhythm**	**discontinuation**
Side Effects/Adverse Reactions (2)	**1. Tremor** **2. Increased blood pressure**	**1. Headache** **2. Constipation**	**1. Body aches or pain.** **2. Congestion**	**1. Nausea** **2. Abdominal pain**	**1. Difficulty sleeping** **2. Feeling dizzy**
Medication/Food Interactions	• **Beta blockers: inhibited effects of albuterol bronchodilators (sympathomimetics), such as theophylline** • **Possibly adverse CV effects digoxin** • **Decreased serum digoxin level MAO**	• **Apomorphine** • **Serotonin modifiers** • **Tramadol** • **Phenytoin** • **Grapefruit juice**	• **Aldesleukin** • **Azathioprine** • **Cyclosporine**	• **Alcoholism** • **Liver disease** • **Respiratory depression**	• **Duloxetine may cause liver damage** • **Selective serotonin and norepinephrine reuptake**

	inhibitors				**inhibitor antidepressants have been associated with sustained increases in blood pressure.**
Nursing Considerations (2)	**1. Use cautiously in patients with cardiac disorders, diabetes mellitus, digitalis intoxication, hypertension, hyperthyroidism, or history of seizures. Albuterol can worsen these conditions.** **2. Monitor serum potassium**	**1. Be aware that oral disintegrating tablets may contain aspartame, which is metabolized to phenylalanine and must be avoided in patients with phenylketonuria.**	**1. Give daily dose before 9 am to mimic normal peak corticosteroid blood levels** **2. Increase dosage when patient is subject to stress**	**1. Taking caffeine in large amounts can cause cardio problems.** **2. Th**	**1. Use duloxetine cautiously in patients with delayed gastric emptying because drugs' enteric coating resis**

	level because albuterol may cause transient hypokalemia.	**2. Monitor patient closely for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions, including anaphylaxis and bronchospasm, may occur.**		**is medication should not be taken with any tobacco products.**	**ts dissolution unit it reaches an area where pH exceeds 5.5.** **2. Give duloxetine cautiously to patients with a history of mania, which it may activate.**

Brand/Generic	**Flovent/ Fluticasone Propionate**	**Ativan/ Lorazepam**	**Chloromag/ Magnesium Chloride**	**Ritalin/ Methylphenidate**	**Tri-Sprintec/ Norgestima**

					te-Ethinyl Estradiol
Dose	**220 mcg Actuation Inhaler**	**1 mg tablet**	**64 mg tablet**	**10 mg tablet**	**35 mcg tablet**
Frequency	**1 puff BID**	**PRN**	**3 tablets every night at bedtime**	**1 daily**	**1 daily**
Route	**Inhalation**	**PO**	**PO**	**PO**	**PO**
Classification	**Corticosteroids, inhalants**	**Sedative-hypnotic or anxiolytic medication**	**Inorganic compound**	**Schedule II substance**	**Estrogens/ Progestin's; Contraceptives, Oral**
Mechanism of Action	**Affect the action of various cell types and mediators of inflammation**	**Benzodiazepines work by enhancing a very important neurotransmitter called GABA**	**Weak stimulant to cholecystokinin release and inhibits net jejunal water absorption**	**Completely blocks the reuptake of dopamine and noradrenaline into the terminal by blocking dopamine transporter and noradrenaline transporter, increasing the levels of dopamine and noradrenaline in the synaptic cleft.**	**Inhibition of ovulation**
Therapeutic Uses	**Helps prevent asthma symptoms by reducing inflammation in the airways of the lungs.**	**Helps reduce many of the common symptoms of anxiety, including panic attacks.**	**Prevent and treat low amounts of magnesium in the blood.**	**Treatment program to control symptoms of attention deficit hyperactivity disorder.**	**Taken to prevent pregnancy**
Therapeutic Range (if applicable)	**At first, 88 mcg 2 time a day (12 hrs.**	**2-6 mg/day given in divided**	**N/A**	**20-30 mg given in divided doses**	**N/A**

	apart)	**doses**		**2 or 3 times a day**	
Reason Client Taking	**Asthma**	**Anxiety**	**To prevent hypomagnesemia**	**ADHD**	**Prevention of pregnancy**
Contraindications (2)	**1. Active tuberculosis 2. Herpes simplex infection of the eye**	**1. Acute narrow-angle glaucoma 2. Opioids may result in profound sedation**	**1. Renal impairment 2. Significant myocardial disease**	**3. Patients known to have glaucoma 4. Patients with motor tics or with a family history or diagnosis of Tourette's syndrome.**	**1. Hepatic disease or tumors. 2. Undiagnosed abnormal uterine bleeding**
Side Effects/Adverse Reactions (2)	**1. Upper respiratory tract infection 2. Nausea and vomiting**	**1. Confusion 2. Stomach pain**	**1. Respiratory depression 2. Sweating and stupor**	**3. Nervousness 4. Irritability**	**1. Nausea 2. Headache**
Medication/ Food Interactions	**• Aspirin • Antifungals**	**• Benzodiazepines produce additive**	**• Cellulose sodium phosphate • Digoxin**	**It should not be taken with other stimulant drugs or substances such as methampheta**	**• Aromatase inhibitors**

		CNS depressant effects when administered with other CNS depressants such as: barbiturates and antipsychotics	• **Sodium polystyrene sulfonate**	**mine and cocaine.**	
Nursing Considerations (2)	1. **Monitor the patient for cough, and bruising** 2. **Monitor the patient for any changes to their mood.**	1. **Do not administer intra-arterially; arteriospasm or gangrene may result.** 2. **Give IM injections of undiluted**	1. **Monitor serum magnesium level** 2. **Monitor respiratory rate**	1. **Methylphenidate may cause increased blood pressure and increased heart rate.** 2. **Use of stimulants may cause psychotic manic**	1. **Before using this medication, tell your doctor or pharmacist if you are allergic to any estro**

		drug deep into muscle mass, monitor injection sites.		**symptoms in patients with no prior history.**	**2. gens Tell your doctor if you have a medical history of blood clots.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2023). *Nurse's Drug Handbook 2022*.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**The patient was alert and oriented to person, place, time and situation. The patient observed to be well groomed with no acute distress. The patient was wearing gray sweat pants with a blue t-shirt. The patient has a heavyset build. The patient said that she showers every other day. The patient's behavior was somewhat shy and quiet. When the patient would talk during group therapy, she would open up a lot about her life, and why she was at the Pavilion. The patient was cooperative and engaged with the other peers and workers. The patient had a calm affect and mood, but had a very eager outlook on her treatment plan.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:**	**The patient denies having any delusions, illusions, obsessions, compulsions, or phobias currently. The patient's overall thought process was fairly logical. The patient's thought content was realistic.**

Compulsions: **Phobias:**	
ORIENTATION: **Sensorium:** **Thought Content:**	**The patient presented as A&O x4 with logical thinking. Sensorium was not assessed during this assessment.** .
MEMORY: **Remote:**	**The patient reported to have both short and long-term memory intact, and it was normal.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient had logical judgment and the appropriate level of intelligence for the patient's stated age. Impulse control was observed to be normal. Calculation and abstraction were not assessed during this assessment.
INSIGHT:	**Insight was observed to be unimpaired.**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**The patient was using no assistive devices. The posture of the patient was tense during the time of the conversation. Muscle tone, strength, and motor movement were appropriate for the stated age and height of the patient.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0950	**84 bpm**	**114/68 RA**	**16** **breaths/min**	**98.5 F** **Temporal**	**99%**
1400	**97 bpm**	**141/106 RA**	**18** **breaths/min**	**98.4 F** **Temporal**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0950	**Numeric**	**N/A**	**0/10**	**N/A**	**N/A**
1400	**Numeric**	**N/A**	**0/10**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 75%** **Lunch: 100%** **Dinner: N/A**	**Oral Fluid Intake with Meals (in mL):** **Breakfast: 240 ml** **Lunch: 100 ml** **Dinner: N/A**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient wants to go home after being discharged from the Pavilion. The patient would like to have a referral to a psychiatrist. The patient would also like to establish a relationship with a therapist and develop long-term coping skills throughout these visits. It is good for the patient to continue to see a psychiatrist to keep on top of her suicide ideation and depression. I also am proud of my patient for agreeing that she should establish a relationship with a therapist, and work on coping mechanisms to help her throughout life.

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 previous suicide attempt and ideation.	**The patient has a prior history of one suicide attempt.**	**1. Put the patient on 1:1 watch 24/7** **2. Ask the patient about any suicide ideations/plans to commit suicide** **3. Create a short-term contract with the patient that she won't hurt herself.**	**1. Continue to check on the patient every 15 minutes** **2. Use direct, non-judgmental communication when conversing with the patient** **3. Monitor the patient when administering medications and at group time.**	**1. Provide the patient with resources to help her in the future** **2. Confirm that the patient has a therapist to visit with after discharge** **3. Obtain that the patient has secured establishment with a psychiatrist.**
2. Risk for anxiety related to situational crises evidenced by feelings of discomfort and apprehension	**The patient has had anxiety ever since she was a child due to the emotional/physical abuse from her parents.**	**1. Assess physical and behavioral symptoms of anxiety, such as increased heart rate, sweating and restlessness.** **2. Assess the patient's anxiety triggers,**	**1. Have the client discuss feelings of panic, anxiety and dread.** **2. Suggest to the patient using guided imagery, deep breathing, meditation, and progressive muscle relaxation.**	**1. Suggest the patient to practice mediation at home.** **2. Set up for the patient to see cognitive-behavioral therapy.** **3. Instruct the client that**

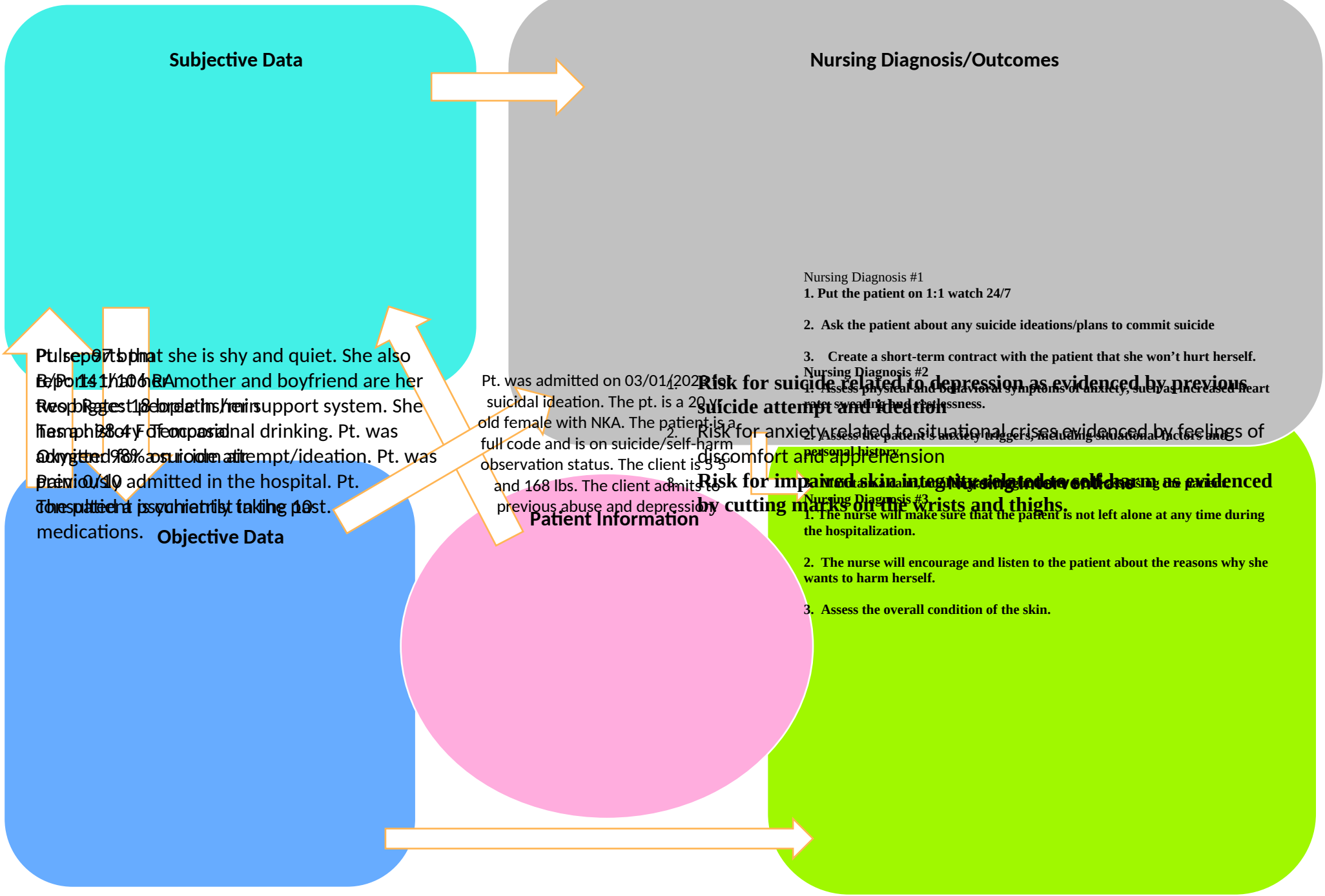
		including situational factors and personal history. **3. Maintain a calm, non-threatening manner while assessing the patient.**	**3. Establish and maintain a trusting relationship by listening to the client; displaying warmth, answering questions directly, offering unconditional acceptance; being available, and respecting the client's use of personal space.**	**PRN medications may be indicated for high levels of anxiety. Watch out for adverse side effects.**
3. Risk for impaired skin integrity related to self-harm as evidenced by cutting marks on the wrists and thighs.	**The patient presents with several marks from self-harm on both wrists and both inner thighs.**	**1. The nurse will make sure that the patient is not left alone at any time during the hospitalization.** **2. The nurse will encourage and listen to the patient about the reasons why she wants to harm herself.** **3. Assess the overall condition of the skin.**	**1. The nurse will educate the family members on ways of how they can recognize levels of impending self-harm that may be committed by the patient.** **2. The nurse will assist in identifying thoughts, feelings, and behaviors that leads up to the patient wanting to commit suicide.** **3. Continue to supervise the patient every 15**	**1. The nurse will supply the patient with the 24 hr. emergency hot-line phone number and when to use it.** **2. Educate the client on understanding that self-harm is a choice, not something uncontrollable at discharge.** **3. The nurse will educate the patient on 3 techniques on developing coping skills to help the patient handle**

			minutes.	**stressful situations.**

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Pt. reports that she is shy and quiet. She also reports that her mother and boyfriend are her support system. She denies any recent drinking. Pt. was admitted for suicide attempt/ideation. Pt. was admitted in the hospital. Pt. denies any current drug use.
Objective Data
Pulse: 97 bpm
B/P: 141/104 RA
Resp Rate: 18 breaths/min
Temp: 98.4 F Temporal
Oxygen: 98% on RA
Pain: 0/10
The patient is currently taking 10 medications.
Patient Information
Pt. was admitted on 03/01/2021 for suicidal ideation. The pt. is a 20 yr. old female with NKA. The patient is a full code and is on suicide/self-harm observation status. The client is 5'5" and 168 lbs. The client admits to previous abuse and depression.
Nursing Diagnosis/Outcomes
1. Risk for suicide related to depression as evidenced by previous suicide attempt and ideation
2. Risk for anxiety related to situational crises evidenced by feelings of discomfort and apprehension
3. Risk for impaired skin integrity related to self-harm as evidenced by cutting marks on the wrists and thighs.
Nursing Diagnosis #1
1. Put the patient on 1:1 watch 24/7
2. Ask the patient about any suicide ideations/plans to commit suicide
3. Create a short-term contract with the patient that she won't hurt herself.
Nursing Diagnosis #2
1. Assess physical and behavioral symptoms of anxiety, such as increased heart rate, sweating, and restlessness.
2. Assess the patient's anxiety triggers, including situational factors and personal history.
3. Provide a calm, supportive environment, encouraging the patient.
Nursing Diagnosis #3
1. The nurse will make sure that the patient is not left alone at any time during the hospitalization.
2. The nurse will encourage and listen to the patient about the reasons why she wants to harm herself.
3. Assess the overall condition of the skin.
Nursing Interventions