N323 Care Plan

Lakeview College of Nursing

Name: Destiny Bell

Demographics (3 points)

Date of Admission 2-17-2023	**Patient Initials** L.M	**Age** 15 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Unemployed/Child	**Marital Status** Single	**Allergies** Azithromycin; causes swelling
Code Status FULL	**Observation Status** Inpatient, rounds every 15 minutes	**Height** 5’6”	**Weight** 188lbs 15oz

Medical History (5 Points)

Past Medical History: Hyperkalemia (resolved) 3-4-2021, Intentional drug overdose (2020 and 2023).

Significant Psychiatric History: ADHD (no reported date), major depressive disorder (no reported date), Post traumatic stress disorder, PTSD (No reported date). Patient reports a previous suicide attempt in 2020 when she ingested bleach and reports her current admission is for an intentional ingestion or suicide attempt by taking nearly 60 of her various prescription medications.

Family History: The patient reports that her father has a medical history of hypotension, depression, schizophrenia, and substance use. Patient’s mother has a history of cervical cancer, bipolar disorder, and substance use. Patient’s maternal grandmother has a medical history of diabetes and cancer.

Social History (tobacco/alcohol/drugs): The patient did not report any tobacco, alcohol, or drug usage.

Living Situation: The patient is currently in DCFS custody and was recently placed with a new foster family in January 2023.

Strengths: The patient states some strengths that will help her post discharge is that she likes her new foster family and that she is determined to improve her quality of life and achieve her goals.

Support System: The patient reports her foster mother, Pam, as her support system. She states that she feels comfortable with foster mom and does like her new foster family.

Admission Assessment

Chief Complaint (2 points): The patient stated, “I overdosed on a bunch of my medications” and was having suicidal ideation.

Contributing Factors (10 points):

Factors that lead to admission: The patient states that the day of her admission to the hospital, she engaged in a phone call, facetime and exchanged text messages with her biological mother and her biological sister. The biological sister stated to the patient that she no longer wanted contact with the patient and identified her as one of her triggers. After the phone call was over the patient stated that she was upset and that she decided to take a bunch of her prescription medications in an attempt to make the pain go away. The patient ingested 27 of her clonidine 0.1mg tablets, 15 benztropine 0.5mg tablets, 21 venlafaxine XR 75mg tablets, and 8 risperidone 1mg tablets.

History of suicide attempts: The patient had a previous suicide attempt in 2020.

Primary Diagnosis on Admission (2 points): Intentional Ingestion

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 caring for another person with trauma)**	**Describe**
Physical Abuse	Denies	Started when she was 5 years old	N/A	Patient reports that her mother's boyfriends were physically abusive
Sexual Abuse	Denies	Started when she was 5 years old	N/A	Patient reports being sexually assaulted by multiple people when she would stay at biological mom's residence.
Emotional Abuse	Denies	Yes, since 7 years old	N/A	Patient states she remembers her family stating they no longer wanted to care for her before leaving her with grandmother.
Neglect	Denies	Yes, date unknown	During childhood	Patient states that her mother left her and did not want to care for her anymore, so she then began living with her grandmother. Patient also states

				that her father did not want her and left her at the pavilion when she was previously admitted.
Exploitation	Denies	Denies	N/A	N/A
Crime	Denies	Denies	N/A	N/A
Military	Denies	Denies	N/A	N/A
Natural Disaster	Denies	Denies	N/A	N/A
Loss	Denies	Yes, in 2019	N/A	Patient states her grandmother who was caring for her passed in 2019.
Other	Denies		N/A	
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	States she gets upset when she talks to biological mom and sister.	
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, relationships, or responsibilities	**Yes**	**No**	Denies	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	Denies	
Difficulty falling asleep	**Yes**	**No**	Denies	
Frequently	**Yes**	**No**	Denies	

awakening during night			
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: N/A**	**Yes**	**No**	Denies
Use of laxatives or excessive exercise	**Yes**	**No**	Denies
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient reports increased anxiety behaviors such as pacing when she speaks to her biological mother
Panic attacks	**Yes**	**No**	Patient states they only occur when talking to biological mother.
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?	**0/10**		
How would you rate your anxiety on a scale of 1-10?	**1/10**		

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**	Patient identified her biological mother and biological sister as stressors in her family.
Legal	**Yes**	**No**	Denies
Social	**Yes**	**No**	Patient states that she finds it hard to talk to people
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**
2020 (x 2 times)	**Inpatient** **Outpatient** **Other:** The Pavilion	Inpatient	Suicide attempt	**No improvement** **Some improvement** Patient states that she likes the pavilion and did start to feel better but she just got upset after speaking with her biological parents. **Significant improvement**
2021 (x 2 times)	**Inpatient**	Inpatient	Self-harm	**No improvement**

	Outpatient **Other:** The Pavilion			**Some improvement** Patient states she feels like she was getting better but then her dad decided he no longer wanted her. **Significant improvement**
n/a	**Inpatient** **Outpatient** **Other:**	**n/a**	**n/a**	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Pam	**54**	**Foster mom**	**Yes**	**No**
Eden	**17**	**Foster sister**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain; n/a

Children (age and gender): Patient is a minor and does not have any children of her own.

Who are children with now? n/a

Household dysfunction, including separation/divorce/death/incarceration:

Patient is currently living with a foster family after the passing of her grandmother and her dad signing over his rights to DCFS after her last admission in the Pavilion.

Current relationship problems: n/a; patient is not currently in a relationship

Number of marriages: n/a, patient has never been married

Sexual Orientation: States she is Questioning her sexuality	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference: N/A

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):
Patient's parents are divorced, both of her parents have a history of substance use. The patient was placed in DCFS custody after her father signed away his rights during her previous admission.

How can your family/support system participate in your treatment and care?
Patient's support system can help her to stay motivated and focused on her goals and with getting continued help or treatment after discharge.

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe): Patient lived with grandmother until her passing in 2019, around 2020 or early 2021 her father signed away his rights after her previous admission in the Pavilion and she was placed into DCFS custody. The patient is still considered to be in DCFS custody but was placed with a new foster family in January 2023 where she was residing during the events that led to her current admission.

Significant childhood issues impacting current illness: Patient has a history of neglect,

emotional, sexual, and physical abuse growing up as a child. She has a diagnosis of PTSD,

Major depressive disorder, and ADHD.

Atmosphere of childhood home:

Loving- Patient reports feeling loved by her grandmother
Comfortable
Chaotic

Abusive- patient reports that her biological mother and father were neglectful and that she suffered abuse at biological mother's house. **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.); Patient reported that her biological mother has a past medical history of Bipolar and substance use. Patient stated that her biological father has a history of schizophrenia, depression, and substance use.
History of Substance Use: Patient's biological mother drinks a heavy amount of alcohol and states that her biological father has used substances such as methamphetamines and heroin. The patient does not use any illegal substances.
Education History: **Grade school** **High school:** currently attending **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient denies any problems at school.
Discharge
Client goals for treatment: The client wants to continue to follow up with a therapist or

medical professional for treatment and therapy.
Where will client go when discharged? As of right now the plan is for the patient to discharge back home with her foster family pending DCFS approval, there has been discussion of her going to a group home instead of back with foster mother though.

Outpatient Resources (15 points)

Resource	Rationale
1. Carle Psychiatrist in Champaign	**1. The patient's insurance should cover her visits at Carle. The patient can obtain second opinion if she wants on her diagnosis of PTSD, ADHD, and major depressive disorder and possibly obtain or update her medication regimen if needed.**
2. Two Roads Wellness Clinic (Danville or Champaign)	**2. Two roads offers medication management for both physical and mental health and I feel the patient would benefit greatly from this. Two roads also offers a trauma-focused therapy, which with the patients diagnosis of PTSD and history of physical, sexual and emotional abuse I believe this type of therapy would allow for her to open up more about those situations and learn how to cope with those past**

	experiences. Also, they have facilities located around where the patient lives.
3. Thriveworks Counseling and Psychiatry Champaign	**3. Thriveworks is local to the patient's area and offers counseling and various psychiatric and mental health services. I feel that weekly counseling would be beneficial to the patient as it would allow her to express what she has on her mind and anything that may be bothering her and get the help she needs.**

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

Brand/Generic	**Benztropine /Cogentin**	**Risperidone Risperdal**	**Clonodine**	**Venlafaxine hydrochloride / Effexor**	**melatonin**
Dose	**0.5mg tablet**	**1 mg tablet**	**0.1 mg tablet**	**75mg**	**5mg**
Frequency	**2 times daily**	**Once a day**	**Three times a day**	**Once a day**	**As needed at bedtime**

Route	**P.O** **By mouth**	**P.O** **By mouth**	**P.O** **By mouth**	**p.o** **by mouth**	**p.o** **by mouth**
Classification	**Anticholinergic**	**Benzisoxazole derivative**	**antihypertensive**	**Selective serotonin and norepinephrine reuptake inhibitor**	**Herbal supplement**
Mechanism of Action	**This blocks acetylcholine's effects at the cholinergic receptor site. This action helps regulate the brain's levels of dopamine and acetylcholine balance to relax muscle movement and decreases drooling, rigidity, and tremor. It also can prolong dopamine's actions by inhibiting dopamine reuptake.**	**Selectively blocks serotonin and dopamine receptors in the mesocortical tract of the CNS to suppress psychotic symptoms**	**Stimulates the pre-synaptic alpha 2 adrenoceptors, thereby decreasing noradrenaline release from both central and peripheral sympathetic nerve terminals.**	**Inhibits neuronal reuptake of norepinephrine and serotonin, along with its active metabolite, O-desmethylvenlafaxine. These actions raise norepinephrine and serotonin levels at nerve synapses, elevating mood and reducing depression.**	**melatonin binds to hormonal receptors throughout the body, including a part of the brain that regulates the body's internal clock.**
Therapeutic Uses	**Antiparkinsonian, central-acting anticholinergic**	**Antipsychotic**	**Antiadrenergic**	**antidepressant**	**Sedatives/hypnotics**
Therapeutic Range (if applicable)	**N/A**	**0.5 – 3mg for adolescents aged 13 - 17**	**N/A**	**n/a**	**n/a**
Reason Client Taking	**To treat acute dystonic reactions**	**To help treat her anxiety and depression related to her diagnosis of PTSD and MDD.**	**To treat her ADHD**	**To treat anxiety**	**To aid in sleep**
Contraindications (2)	**1. Children under the age of 3 years old** **2. Hypersensitivity to benztropine or its components**	**1. Hypersensitivity to risperidone, paliperidone, or its components** **2. Use cautiously in patients with CV disease, pregnancy, renal or hepatic impairment, and hypotension**	**1. Hypersensitivity to clonidine or its components** **2. Patients with a history of alcohol use should be cautious while taking this medication**	**1. Hypersensitivity to desvenlafaxine, venlafaxine, or their components;** **2. use of an MAO inhibitor within 14 days, including intravenous methylene blue and linezolid**	**1. hypersensitivity** **2. pregnancy or lactation**
Side Effects/Adverse Reactions (2)	**1. Hypotension** **2. Constipation**	**1. Seizures** **2. Nausea**	**1. Drowsiness** **2. Insomnia**	**1. Fatigue** **2. Sinus tachycardia**	**1. Hypotension** **2. drowsiness**
Medication/Food Interactions	• **Amantadine** • **Phenothiazines** • **Tricyclic antidepressants** • **Haloperidol**	• **Carbamazepine** • **Clozapine** • **Fluoxetine** • **Levodopa**	• **Cymbalta** • **Lyrica** • **Seroquel** • **Xanax** • **Alcohol**	• **Abilify** • **Adderall** • **Aspirin** • **Cymbalta** • **Ibuprofen** • **Lexapro** • **Seroquel** • **Tramadol** • **Zofloft**	• **Ambien** • **Benadryl** • **Cymbalta** • **Lexapro** • **Seroquel** • **Xanax** • **Zoloft** • **Alcohol**
Nursing Considerations (2)	**1. Assess for muscle rigidity and tremor at baseline and after for improvement** **2. Give drug before or after meals based on patient's need and response**	**1. Monitor patient's blood glucose and lipid levels as it increases the risk of hyperglycemia** **2. Monitor for orthostatic hypotension**	**1. Monitor blood pressure and pulse rate frequently.** **2.**	**1. Do not give to patients with bradycardia** **2. Use cautiously in patients with a history of mania as it can worsen their condition**	**1. Instruct the patient to take at bedtime as directed** **2. Caution the patient to avoid driving and other activities that require alertness**

Brand/Generic	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Dose	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Frequency	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Route	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Classification	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Mechanism of Action	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Therapeutic Uses	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Therapeutic Range (if applicable)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Reason Client Taking	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Contraindications (2)	**N/a**	**n/a**	**n/a**	**n/a**	**n/a**
Side Effects/Adverse Reactions (2)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Medication/Food Interactions	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Nursing Considerations (2)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Patient was observed to be well-groomed and wearing a t-shirt and leggings with a slightly bigger build. The patient's behavior appeared normal as she was very outgoing during our conversation and seemed to show remorse for her actions. When speaking with the patient she would sometimes go off on tangents but always would return back to the original conversation. The patient was engaged, orientated, and talkative.** **The patient had a calm affect and mood and had a positive outlook on her treatment plans for post discharge.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**Patient denies any current suicidal ideations, delusions, illusions, obsessions, compulsions, or phobias. The patient was admitted due to acting on suicidal thoughts but did not bring this up during this part of the assessment.**
ORIENTATION: **Sensorium:** **Thought Content:**	**Patient was alert and orientated x4, all thinking was logical, but she did tend to stray topics and return back to our original conversation.** **Sensorium was not assessed.** .
MEMORY: **Remote:**	**Both short and long-term memory appeared to be intact and normal.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient appeared to have sound judgement and level of intelligence appropriate for the patient's age. **Impulse control was observed to be average.** **Calculation and abstraction were not assessed.**
INSIGHT:	**Insight was observed to be average.**

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**The patient had no assistive devices.** **The patient's posture was relaxed with occasional slouching throughout our conversations.** **Muscle tone, strength, and motor movement are appropriate for age and height.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	**109 bpm**	**122/72 mmHg**	**22 resp**	**98.4 oral**	**96% room air**
1530	**116 bpm**	**116/74 mmHg**	**18**	**98.7 oral**	**99% room air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**Numeric**	**Denies the presence of pain or discomfort**	**n/a**	**n/a**	**n/a**
1530	**Numeric**	**Denies the presence of pain or discomfort**	**n/a**	**n/a**	**n/a**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 75%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 360 mL**

Lunch: 100% **Dinner: 100%**	**Lunch: 360mL** **Dinner: 360 mL**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient voiced that she would prefer to be discharged to a group home and that she would like to continue therapy sessions. I would like to see the patient attend group therapy sessions with individuals her age who are experiencing similar situations as she is as I feel that she has improved greatly while in her group sessions at the Pavilion. It is a good idea for the patient to establish a relationship with a licensed psychiatrist to confirm her diagnosis of post-traumatic stress disorder, adhd, and major depressive disorder. I agree with the patient wanting to regularly continue therapy sessions with a licensed therapist to help with her anxiety, depression, and thoughts of self-harm.

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 evidence by previous suicide attempt and ideation.	The patient has a history of past suicide attempts	**1.** Ask the patient about any past suicidal ideations and/or plans to commit suicide or self-harm. **2.** place the patient	**1.** continue to supervise the patient every 15 minutes. **2.** Monitor the patient closely when administering medications **3.** implement a direct, non-judgmental communication	**1. ensure the patient is referred to a psychiatrist** **2. Ensure that the patient is visiting with a counselor or therapist weekly after discharge** **3. Provide the patient with outside resources that they can utilize if any crises arise**

		on 1:1 observation **3. create a short-term safety plan with the patient**	approach with the patient, use therapeutic communication to help establish trust.	
2. Risk for disturbed thought processes related to anxiety and depression	**Patient has a diagnosis of major depressive disorder and has been experiencing some decreased participation in social interactions in group but has started participating more**	**1. reorientate the patient to person, place, and time as necessary** **2. maintain a calm and quiet environment** **3. teach the patient strategies to help stop negative thinking**	**1. assess the patient for intrusive thoughts and the content of them** **2.round on the patient every 15 minutes** **3. express understanding for the patients emotions towards the thoughts**	**1. educate the patient on how to handle intrusive or negative thoughts** **2. Ensure the patient has a therapist that specializes in mental health** **3. encourage the patient to continue to follow up with their doctor and report any new or continued thoughts**
3. Risk for low self- esteem related to emotional and verbal abuse she endured as a young child	The patient reported that she does not feel good enough because her own father didn't want her	1. encourage the patient to perform adl's such as bathing and grooming 2. Initiate suicide precautions per facility protocol 3. give the patient concise information about decision making skills	1. provide the patient with an hour of free time so she can converse and make friends 2. give the patient a simple but structured daily routine 3. teach the patient how to	1. teach self-healing techniques to the patient such as guided imagery, prayer, or meditation. 2. schedule time to meet with their support system and the patient so they can learn ways to enhance

			incorporate self-healing techniques in her daily activities	their coping skills 3. work with the patient to develop a treatment plan to help with her anxiety and help her schedule her initial appointments

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

Admitted for suicidal ideation after ingesting nearly 60 of her medications
Past medical history of ADHD, PTSD, and major depressive disorder.
Patient denies any current intrusive thoughts, delusions, hallucinations, or suicidal ideation.

Nursing Diagnosis/Outcomes

1. Risk for suicide related to depression as evidence by previous suicide attempt and ideation.
   a. Patient will report decreased suicidal thoughts after 6 months of therapy and medication management
2. Risk for disturbed thought processes related to anxiety and depression
   a. Patient will report decreased negative/intrusive thoughts after 6 months of therapy and counseling
3. Risk for low self- esteem related to emotional and verbal abuse she endured as a young child
   a. Patient will express improved feelings of self-worth after 6 months of therapy and

Objective Data

Most recent vitals;
HR; 116 BPM
BP; 116/74 mmHg
RR; 18 RESP/MIN
T; 98.7 F oral
O2 Sat; 99% room air

No reported lab, abnormal vital, or assessments to diagnose the

Patient Information

On February 17th, 2023, a 15-year-old Caucasian female was admitted into the Pavilion Behavioral health for suicidal ideation with intentional ingestion. The patient's foster family contacted the police after returning home and seen that she ingested nearly 60 pills. The patient had a previous suicide attempt in 2020 in which she ingested bleach and in 2021 where she cut her neck

Nursing Interventions

1. Nursing diagnosis 1;
   a. Ask the patient about any past suicidal ideations and/or plans to commit suicide or self-harm.
   b. place the patient on 1:1 observation
   c. create a short-term safety plan with the
2. Nursing diagnosis 2;
   a. reorientate the patient to person, place, and time as necessary
   b. maintain a calm and quiet environment
   c. teach the patient strategies to help stop negative thinking
3. Nursing diagnosis 3;
   a. encourage the patient to perform adl's such as bathing and grooming
   b. initiate suicide precautions per facility protocol
   c. give the patient concise information about decision making skills