N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
04/19/23	M. F.	40	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Computer Programmer	Single/Divorced	Tetracycline
Code Status	**Observation Status**	**Height**	**Weight**
Full Code	Voluntary Admission	188 cm	127 Kg

Medical History (5 Points)

Past Medical History: The patient has a history of depression, sleep apnea (uses a CPAP machine), Obesity, and Vasectomy (2020).

Significant Psychiatric History: The patient has a history of depression and one suicide attempt in adolescence. The suicide attempt, and following admission, led to a diagnosis of depression at an early age. The patient also has a history of marijuana substance abuse and recent nitrous oxide abuse.

Family History: Paternal-alcohol abuse; Maternal-depression

Social History (tobacco/alcohol/drugs): This patient uses marijuana daily to help with his depression and occasionally combines marijuana and nitrous oxide. The patient denies alcohol or tobacco use.

Living Situation: This patient lives at home alone after his recent divorce. His ex-wife has custody over there 7-year-old son.

Strengths: This patient seems motivated to get better. He cares for his son and ex-wife a lot and wants to do better for them. He participated in groups and in his care throughout the duration of my observation. After talking with this patient throughout the day, he seemed to believe that “there is light at the end of the tunnel.” He is also financially secure with a good paying job and good benefits that pay for his care.

Support System: This patient has friends that he keeps in contact with from his workplace (one is his emergency contact). His ex-wife does not talk to him often, but she is there for him in extreme times of need. He is an only child, his mother lives far away, and his father is deceased.

Admission Assessment

Chief Complaint (2 points): Suicidal ideation (plans to slit his wrists vertically) with increased depression

Contributing Factors (10 points): The patient has been battling with depression since adolescence. As a child, this patient was abused by his alcoholic father for years. His father also abused his mother, leading to her depression. The patient states that seeing this growing up was very hard, and it was constantly on his mind. He was afraid to go home after school growing up because his father would physically and emotionally abuse him nearly every day. He also stated that his depression was improving after he had moved out to go to college when he was 18 and started receiving counseling. However, when the patient had his son with his ex-wife 7 years ago, a lot of those memories from his childhood started to comeback. This led to his increased therapy and prescription for Lexapro. The patient mentioned that this had helped for a few years, but now the depression is getting harder to cope with.

Factors that lead to admission: For this admission, the patient began feeling suicidal after an incident a few days prior (the Monday after easter weekend). The patient had forgot to pick up his son from school because he had been so high after taking marijuana and nitrous oxide. His ex-wife had to be called at 6:00 pm (3 hours after his child was released from school), and she was “very embarred.” This made the patient feel ashamed of himself to the point he wanted to take his own life. He had believed that he was going to lose his right to see his son.

The patient was recommended by his counselor to admit himself here at the pavilion, so he voluntarily admitted himself.

History of suicide attempts: This patient has one suicide attempt in adolescence. The patient was 16 at the time. He stated that he remembers wanting to kill himself because he had felt so worthless to his physically and emotionally abusive father.

Primary Diagnosis on Admission (2 points): Major depressive disorder and suicidal ideation

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient has lifetime experience **Witness of trauma/abuse:** The patient witnessed his father abuse his mother.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**N/A**	**YES**	**YES**	This patient experienced physical abuse from his alcoholic father for years during his adolescence. He also had to care for his mother who was also being physically abused by the pt.'s father.
Sexual Abuse	**N/A**	**N/A**	**N/A**	**N/A**

Emotional Abuse	**N/A**	**YES**	**YES**	This patient experienced emotional abuse from his alcoholic father for years during his adolescence. He also had to care for his mother who was also being emotionally abused by the pt.'s father.
Neglect	**N/A**	**N/A**	**N/A**	**N/A**
Exploitation	**N/A**	**N/A**	**N/A**	**N/A**
Crime	Pt. participates in recreational drug use	Pt. participated in recreational drug use since adolescence	**N/A**	This patient has been using marijuana illegally for about 20 years and recently began using nitrous oxide.
Military	**N/A**	**N/A**	**N/A**	**N/A**
Natural Disaster	**N/A**	**N/A**	**N/A**	**N/A**
Loss	**N/A**	**N/A**	**N/A**	**N/A**
Other	**N/A**	**N/A**	**N/A**	**N/A**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	The pt. has felt depressed and unworthy due to the recent event of forgetting to pick his son up from school because he was high. He feels this way every day and for most of the day.	
Loss of energy or interest in activities/school	**Yes**	**No**	The patient states that he has felt very tired, stating it has been hard to get out of bed in the mornings. The only thing that motivates him to get up is getting drugs. He	

			feels this way every day and for most of the day.
Deterioration in hygiene and/or grooming	**Yes**	**No**	The pt. states that staying well-groomed has helped him see himself in a better light. It helps him get through the day.
Social withdrawal or isolation	**Yes**	**No**	He states that ever since covid, the people at his workplace have been able to work from home entirely. “This has made it hard for me to keep and make friends through work.” He also feels alone because he no longer lives with his ex-wife and son.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	The patient says that he has not been completing his tasks for work on time lately. He contributes this to his increased recent drug use and depression.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The pt. states he tries to go to bed at the same time each night and usually does most days.
Difficulty falling asleep	**Yes**	**No**	The patient does struggle to fall asleep initially, especially as of late. Lately, this occurs most nights of the week.
Frequently awakening during night	**Yes**	**No**	The patient states that he wakes up with the same feeling that he had when he realized that he had forgot to pickup his son from school.
Early morning awakenings	**Yes**	**No**	**N/A**
Nightmares/dreams	**Yes**	**No**	The patient has had recent nightmares of forgetting to pick up his son and never being able to see him again. The pt. states this happens 2-3 times per week.
Other	**Yes**	**No**	The pt. uses a CPAP to help with his sleep apnea. The pt. states that he does sleep somewhat better when he uses it.
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**

Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	The patient says he has had a loss of appetite over the last few weeks after his incident forgetting to pick up his son from school. The pt. states he just does not feel like eating, especially in the mornings.
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**	The pt. states that he does not feel anxiety.
Panic attacks	**Yes**	**No**	The pt. states he has never had a panic attack.
Obsessive/compulsive thoughts	**Yes**	**No**	The patient says that he does have compulsive thoughts to get drugs and has recently had compulsive thoughts to kill himself. These thoughts happen throughout the day and occur daily.
Obsessive/compulsive behaviors	**Yes**	**No**	He also has compulsive behaviors to go out and get drugs and to do drugs. These thoughts happen throughout the day and occur daily.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	He says that it's not anxiety that impacts his daily living, but the depression does.
Rating Scale			
How would you rate your depression on a scale of 1-10?	**6/10**		
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**	The patient states that his is mildly afraid that his work will start punishing him for not completing his tasks on time. He is also worried that if he gets fired, he will no longer have insurance to pay for his treatment and counselling in the future. These thoughts occur daily for him.
School	**Yes**	**No**	**N/A**
Family	**Yes**	**No**	Currently, the patient feels stressed about his relationship with his ex-wife and his son. He wants to make things better, but he says it feels impossible to mend these relationships at this point. He is stressed most days of the week.
Legal	**Yes**	**No**	He is also stressed about legal issues regarding his recent divorce and how his visiting time with his son might be reduced.
Social	**Yes**	**No**	The patient understands that now that his work is completely at home, he needs to find others to build relationships with. He becomes stressed meeting others and building relationships.
Financial	**Yes**	**No**	**N/A**
Other	**Yes**	**No**	**N/A**
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
22 years ago	**Inpatient** **Outpatient** **Other:** Pt. to the ER for suicide attempt and then admitted to the psychiatric unit	**Inpatient**	Suicide attempt	**No improvement** **Some improvement** **Significant improvement**
Recent visit with psychiatrist (would not share location, exact time, or provider)	**Inpatient** **Outpatient** **Other:**	Outpatient	Depression	**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?**	
Pt. lives alone	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**

If yes to any substance use, explain: N/A, pt. does not live with anyone

Children (age and gender): The pt. has 1 7-year-old son.

Who are children with now? The son lives with his mother (the pt.'s ex-wife).

Household dysfunction, including separation/divorce/death/incarceration: The pt. has recently undergone a divorce with his ex-wife.

Current relationship problems: The pt. states that his ex-wife does not trust him with their 7-year-old son because of his drug abuse and recent incident of leaving their son at school because he forgot to pick him up. This has made his ex-wife feel embarrassed to be associated with him now.

Number of marriages: The patient has only been married once.

Sexual Orientation:	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No** **N/A**

Please describe your religious values, beliefs, spirituality and/or preference: The patient states that he does not follow a particular religion but does find spirituality in mindfulness meditation.

Ethnic/cultural factors/traditions/current activity: The patient does not partake in any ethnic, cultural, or traditional activities currently.

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The pt. has recently gone through a divorce. The patient has not other current or past legal issues "other than a few speeding and parking tickets."

How can your family/support system participate in your treatment and care? "It would be nice if my ex-wife would understand my past and help me more, but I understand why she doesn't help. It has been a long and hard journey for me. I can be pretty irritable and hard to help sometimes. My friends do a good job trying to help, but not being able to go into work because of covid has been hard too."

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents

Other (describe):
Significant childhood issues impacting current illness: The patient's father was physically and emotionally abusive to him and his mother throughout his childhood. His mother also had depression, and that was hard for him to see growing up.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.): His father was and alcoholic and his mother had depression.
History of Substance Use: The patient has a history of regular daily marijuana use and recently has been inhaling nitrous oxide once or twice per week.
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: None, the patient states he did very well in school. It was a place where

his teachers and others would be proud of him for accomplishing goals and getting good grades.
Discharge
Client goals for treatment: The pt. states he wants to get help with adjusting his medication to help him deal with his increasing depression, lack of sleep, and lack of energy.
Where will client go when discharged? The client would like to be discharged home after his voluntary admission (signed the 5-day discharge paperwork).

Outpatient Resources (15 points)

Resource	Rationale
1. The Suicide Prevention Hotline (988)	**1.** This resource can be used as a last resort if no one is around when he needs help. This hotline can help talk him through a crisis.
2. Continue Individual therapy (outpatient)	**2.** This outpatient therapy that he has been going to helped him by recommending he come to the pavilion. This is good because the therapist recognized he was having more trouble than before. The pt. should continue going to therapy.
3. Group therapy (outpatient)	**3.** After asking the patient what his thoughts were on the group therapy they have been doing at the pavilion, he stated that he felt like the sessions were very helpful. He said, “It

	was nice to know that others were struggling too, that it's not just me." This patient would benefit from continued outpatient group therapy going forward.

Current Medications (10 points)
Complete all of your client's psychiatric medications
Note: The patient only takes one medication listed in his health record, and it is for his depression. This patient is an otherwise healthy individual.

Brand/Generic	Lexapro/ escitalopram	**N/A**	**N/A**	**N/A**	**N/A**
Dose	20 mg	**N/A**	**N/A**	**N/A**	**N/A**
Frequency	1x daily	**N/A**	**N/A**	**N/A**	**N/A**
Route	PO	**N/A**	**N/A**	**N/A**	**N/A**
Classification	**Therapeutic:** antidepressants **Pharmacologic:** Selective serotonin reuptake inhibitor (SSRIs) (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**	**N/A**
Mechanism of Action	This medication selectively inhibits the reuptake of serotonin in the central nervous system (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Uses	"Major depressive	**N/A**	**N/A**	**N/A**	**N/A**

	disorder, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, post-traumatic stress disorder, social anxiety disorder, and premenstrual dysphoric disorder" (Jones & Bartlett Learning, 2021).				
Therapeutic Range (if applicable)	10 mg to 20 mg per day. (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	The client takes this medication for Major depressive disorder.	**N/A**	**N/A**	**N/A**	**N/A**
Contraindications (2)	Concurrent use of MAO inhibitors or MAO-like drugs and concurrent use of citalopram (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	Suicidal thoughts and insomnia (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**	**N/A**
Medication/Food Interactions	May cause serious, potentially fatal reactions when	**N/A**	**N/A**	**N/A**	**N/A**

	used with MAO inhibitors and increased risk of serotonin syndrome with St. John's wart (Jones & Bartlett Learning, 2021).				
Nursing Considerations (2)	Be sure to monitor mood changes and level of anxiety during therapy and be sure to assess for suicidal tendencies (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**	**N/A**

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. (2021). *2022 nurse's drug handbook* (21st ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	The pt. appeared well-groomed, pleasant smile, and approachable. The patient also seemed quite relaxed and composed. He is a tall man, standing 6' 2", who is also heavier set. The patient had a positive and engaged attitude during our interview together. His speech had normal rate and flow. He sounded intelligent and educated. He did state that he was feeling depressed saying "I might seem pleasant, but I'm feeling quite depressed." Pt. had a euthymic affect.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient was still having suicidal ideation two days into his admission at the pavilion. Denies delusions, illusions, and obsessions. Patient did say he feels like he has compulsions when he feels the need to go get drugs. No phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	A& Ox4 to Person, Place, Date/Time, and Situation. Patient his having troubling thoughts of suicide, but states that the thoughts have been decreasing in frequency.

MEMORY: **Remote:**	Intact short-term and long-term memory. Able to remember breakfast and lunch while also remembering details from childhood.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Judgement seemed fair and was aware of the seriousness of their admission. Pt. is intelligent and educated more than the average person. Pt. can control impulses.
INSIGHT:	Pt. shows positive insight, exhibiting motivation to get better and participate in his care.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient does need assistive walking devices. Good posture, good muscle tone and strength. Coordinated muscle movements.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10:00	76 bpm	112/76 mmHg	16 rpm	36.9 C	98% room air
15:00	70 bpm	109/82 mmHg	16 rpm	36.9 C	98% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10:00	Numeric	N/A	0	N/A	N/A
15:00	Numeric	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake

Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: 50%	**Breakfast: 240 ml 2% milk**
Lunch: 50%	**Lunch: 240 ml water**
Dinner: N/A	**Dinner: N/A**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient should remember what he learned during his stay at the pavilion, reteaching coping mechanisms learned in group if needed. Remind the patient to continue taking all medications as prescribed. The patient should also be setup with a referral to see his therapist again after discharge. The patient should continue to see his therapist regularly, especially if medication were prescribed or adjusted. The patient should be given a handout with all available resources to contact if these suicidal ideations return, including the suicide prevention hotline (988). The patient should be informed of any possible adverse effects that medications can have if medications were adjusted or prescribed (such as increased possible suicidal ideation). The pavilion should provide check-in calls to the patient once per day for 5 days to ensure the patient is feeling well. Encourage the patient to stay motivated through this difficult time.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing	Rational	Immediate	Intermediate	Community

Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen	**Interventions (At admission)**	**Interventions (During hospitalization)**	**Interventions (Prior to discharge)**
1. Risk for suicide related to substance misuse as evidence by forgetting to pick his son of from school due to his drug use (Phelps, 2020).	This diagnosis was chosen because this patient was voluntarily admitted to the pavilion for suicidal ideation. This is a top priority for this patient.	1. Ask patient directly, "Have you thought about killing yourself?" If so, ask, "What do you plan to do?" (Phelps, 2020). 2. Initiate appropriate safety protocols by removing from patient's environment anything that could be used to inflict further self-injury (Phelps, 2020). 3. Provide supervision (one-on-one observation when possible) for patient based on facility policy (Phelps, 2020).	1.Listen carefully to patient and don't challenge patient (Phelps, 2020). 2. Use a warm, caring, nonjudgmental manner (Phelps, 2020). 3. Supervise the administration of prescribed medications. Be aware of drug actions and adverse effects. Make sure that patient doesn't hoard medications (Phelps, 2020).	1. Make appropriate referrals to mental health professionals (Phelps, 2020). 2. Provide patient with telephone numbers and other information about crisis centers, hot lines, and counselors (Phelps, 2020). 3. Help patient set a goal for obtaining long-term psychiatric care (Phelps, 2020).
2. Risk for loneliness related to physical and social isolation as evidenced by living alone	This diagnosis was chosen because this patient is new to living alone and new to working full-time from	1. Inform patient that you'll help with expression of feelings of loneliness and identify ways to increase social	1. Spend sufficient time with patient to allow self-expression of feelings of loneliness (Phelps, 2020).	1. Help patient curb feelings of loneliness by encouraging one-on-one interaction with others whose acceptance is

and working from home (Phelps, 2020).	home. This puts him at high risk for physical and social isolation and has likely contributed to his increased depression and suicidal ideation.	activity (Phelps, 2020). 2. Help patient identify feelings associated with loneliness (Phelps, 2020). 3. Encourage patient to address personal needs assertively (Phelps, 2020).	2.Work with patient to identify factors and behaviors that have contributed to loneliness (Phelps, 2020). 3. As patient's comfort level improves, encourage patient to attend group activities and social functions (Phelps, 2020).	likely, for example, church members or patients with similar health problems (Phelps, 2020). 2. Refer patient and family to social service agencies, mental health center, and appropriate support groups (Phelps, 2020). 3. Work with patient to establish goals for reducing feelings of loneliness after patient leaves health care setting (Phelps, 2020).
3. Hopelessness related to social isolation as evidence by his lack of support system and recent increased depression and suicidal ideation (Phelps, 2020).	This diagnosis was chosen because this patient his at very high risk for hopelessness. He doesn't have a support system, he might lose his job, he is abusing substances, and he had a plan to kill himself.	1. Assess for evidence of self-destructive behavior (Phelps, 2020). 2. If possible, assign a primary nurse to patient to encourage establishment of a therapeutic relationship between patient and nurse (Phelps, 2020). 3. Provide for appropriate	1. Convey belief in patient's ability to develop and use coping skills (Phelps, 2020). 2. Acknowledge patient's pain. Encourage patient to express feelings of depression, anger, guilt, and sadness. Convey to patient that all these feelings are appropriate (Phelps, 2020). 3. Identify	1. Provide positive reinforcement for patient's efforts to participate in self-care activities (Phelps, 2020). 2. Teach patient how to manage illness, prevent complications, and control factors in the environment that affect

		physical outlets for expression of feelings (Phelps, 2020).	patient's strengths and encourage putting strengths to use (Phelps, 2020).	patient's health (Phelps, 2020). 3. Refer patient and family members to other caregivers (such as dietitian, social worker, clergyman, and mental health clinical nurse specialist) or support groups, as necessary (Phelps, 2020).

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

Depression 6/10
Anxiety: 1/10
Disturbed sleep patterns
Pt. feels depressed
Pt. feels ashamed and inadequate to his son and ex-wife for forgetting about picking him of from school

Nursing Diagnosis/Outcomes

1. Risk for suicide related to substance misuse as evidence by forgetting to pick his son of from school due to his drug use (Phelps, 2020).
    a. Pt. will continue his therapy sessions after discharge and will not have thoughts of suicide.
2. Risk for loneliness related to physical and social isolation as evidenced by living alone and working from home (Phelps, 2020).
    a. Pt. will increase his time in social areas such as the grocery store, gym, and library. He will have less feelings of loneliness.
3. Hopelessness related to social isolation as evidence by his lack of support system and recent increased depression and suicidal ideation (Phelps, 2020).
    a. Pt. will continue to take his medications and ask for help when he needs it. He will have less feelings of hopelessness.

Objective Data

Recent vital signs: 70 bpm, 109/82 16 rpm, 39.6 C, 98% on room air.
Mental status exam: well-groomed appearance,
normal and intelligent speech, normal eye contact,
intact motor activity, euthymic affect, seemingly Euthymic mood, No cognitive impairments or attention deficits, Suicidal ideation, Cooperative behavior, fair insight and judgment.
Height and Weight: 188 cm and 127 kg

Patient Information

This patient is a 40-year-old make who lives alone. He has a history of depression and a suicide attempt in adolescence. He is depressed and suicidal, planning to slit his wrists vertically. He recently had an incident where he was using marijuana and nitrous oxide together which led him to forgetting to pickup his son from school. He is motivated to improve his life.

Nursing Interventions (Listed are the top interventions for each nursing diagnosis)

1. Ask patient directly, “Have you thought about killing yourself?” If so, ask, “What do you plan to do?” (Phelps, 2020).
2. Listen carefully to patient and don’t challenge patient (Phelps, 2020).
3. Make appropriate referrals to mental health professionals (Phelps, 2020).
4. Inform patient that you’ll help with expression of feelings of loneliness and identify ways to increase social activity (Phelps, 2020).
5. Spend sufficient time with patient to allow self-expression of feelings of loneliness (Phelps, 2020).
6. Help patient curb feelings of loneliness by encouraging one-on-one interaction with others whose acceptance is likely, for example, church members or patients with similar health problems (Phelps, 2020).
7. Assess for evidence of self-destructive behavior (Phelps, 2020).
8. Convey belief in patient’s ability to develop and use coping skills (Phelps, 2020).
9. Provide positive reinforcement for patient’s efforts to participate in self-care activities (Phelps, 2020).