N323 Care Plan

Lakeview College of Nursing

Shiann Manint

September 26th, 2025

Demographics (3 points)

Date of Admission 9/20	**Patient Initials** T.A.	**Age** 50 years old	**Biological Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Unemployed	**Marital Status** Single	**Gender Identity** Female
Code Status Full Code	**Height and Weight** 5'10" 62.2 kg	**Allergies** Fish (hives, rash)	**Pronouns** She/Her

Medical History (5 Points)

Past Medical History: Patient does not have a medical history or recalls any. The chart did not list any.

Psychiatric Diagnosis: Major Depressive Disorder, Bipolar Disorder, Post-Traumatic Stress Disorder

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
9/16	**Inpatient (New Choice 28-day Treatment)**	**Stimulant Dependence**
9/18	**Inpatient (Went to Detox due to a breakdown on New Choice)**	**Help with a mental breakdown.**
2024 (Patient could not remember the exact date)	**Inpatient**	**Substance abuse**

Admission Assessment

Chief Complaint (2 points): Patient stated, "I was suicidal".

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** Patient was having suicidal ideations from having a major depressive

disorder. Triggers were a relapse of PTSD, and the patient stated she was feeling lonely.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** Patient is currently homeless and does not have a job. Only has connected with only living child who is 24 years old.

Primary Diagnosis on Admission (2 points): Major Depressive Disorder

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?		**"Yes, I was physically abused by my child's father."**	
Do you have a history of trauma secondary to military service?		**"No, I have not been in the military."**	
Have you experienced a loss of family or friends that affected your emotional well-being?		**"No"**	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		**"No"**	
(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)		**(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)**	
	Current?	**Past? (what age)**	**By whom?**
Physical Abuse	**No**	**25**	**Child's father.**
Sexual Abuse	**No**	**N/A**	
Emotional Abuse	**No**	**25**	**Child's father.**
Verbal Abuse	**No**	**N/A**	

Military	**No**	**N/A**	
Other	**N/A**		
Presenting Problems			
Problematic Areas	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**	
Do you feel down, depressed or hopeless?	**"As of right now no. I did before brining myself in here.**	Patient stated as of today (9/22), she was feeling pretty good. She mentioned she often feels down and depressed when she is alone and she is tired of having that feeling which is why she is in treatment right now. She wants to get back with her son and be a better mother. She can't remember when exactly the feeling of being depressed started. It just sort of happened one day. While observing the patient, she did not show any facial expressions of being depressed as of in the morning. When she would be alone and not talking to anyone to often would look down and not say anything. Most of the day, she was cheerful and wanting to talk to everyone.	
Do you feel tired or have little energy?	**"Sometimes I feel tired but today is a good day."**	Patient described that she only feels tired when she does not get a full night's rest or when she is alone on the streets. Observing the patient throughout the day you	

		could not really tell when she was feeling depressed tired. She did not even look tired throughout the day. She was joyful and smiling and very talkative.
Do you avoid social situations?	**"It is hard to enjoy social events when you are homeless."**	Patient did not talk about social situations a lot. She talked about how she tries to go out and do things with others but since she is homeless it can be difficult.
Do you have difficulties with home, school, work, relationships, or responsibilities	**"I do have a difficult situation with my son. He lives at home with this family. I try to connect with them, but it can be hard without being able to drive and talk to them every**	Patient stated she had a job for a long time but within the past 5 years she has not been able to keep a job due to the drug addiction and bouncing from places to live at. She does have a relationship with her son. She try to call him all the time. She said it is hard to go see him and his family since she does not have a home. She tried to keep him informed about everything going on and he is involved with her treatment plan.

	day."	
Sleeping Patterns	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Have you experienced a change in numbers of hours that you sleep each night?	**"The only times I experience issues when I sleep is when I am having my nightmares or PTSD."**	Patient stated she tried to get a full night's rest but with having nightmares it does not help a whole lot. She said about 3-4 times a week does she experience less than 6 hours of sleep. The other days she can get at least 8 hours. The nightmares do not have happen every week but they when they do start, she said it takes a while before they go away.
Do you have difficulty falling asleep?	**"No."**	N/A
Do you frequently awaken during the night?	**"Not normally, I only wake up during the night when my nightmares begin to happen."**	Patient stated like once before she only wakes up during the night when she gets her nightmares. She said they do not happen all the time but recently they have been happening more regularly.
Do you have nightmares?	**"Yes."**	Patient did not want to describe what her nightmares were about because they are very disturbing. She mentioned that they started years

		ago after getting diagnosed with PTSD and the longest she had slept without getting a nightmare was about a month long.
Are you satisfied with your sleep?	**"Right now, yes I am."**	Patient stated as of right now she is satisfied with her sleep because since her breakdown she has not had any more nightmares.
Eating Habits	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you overeat?	**"No."**	Patient stated she does not overeat. She cannot eat too much because her stomach will start to ache, and it makes her sick to her stomach.
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	**"No, never."**	Patient stated she could not make herself throw up after eating food. If she has thrown up it was from drugs but not from eating food.
Do you have not eat enough or have a loss of appetite?	**"No"**	Patient stated she always has food and never has not had enough food.
Have you recently experienced unexplained weight loss? **Amount of weight change:**	**"No"**	Patient stated she has not noticed any weight loss due to not having food or enough to eat. Even with the drug use she has not noticed a change in her weight since she has always been skinny.

Anxiety Symptoms	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.
Do you pace, have tremors, or experience other symptoms of anxiety?	**"Tremors are bad throughout the day when I am not doing anything."**	Patient stated that she has tremors most of the time, but they do get worse with her anxiety and when she is not preoccupied with something. The tremors are only in her hands. She says sometimes it gets hard to hold things especially a pen and she is trying to write. The tremors have been better for the past few days, but they were bad when she first came in for treatment.
Do you experience panic attacks?	**"Yes, I had one last week which is why my treatment just started again on Saturday."**	Patient stated she was used to get panic attacks all the time. The drug use does make them worse. Her last panic attack was last week. Some other patient was being manic and was knocking on her door and screaming. The loud noise causes a trigger which resulted her into having a panic attack.
Do you have obsessive or compulsive thoughts?	**"No"**	**N/A**
Do you have obsessive or compulsive behaviors?	**"No"**	**N/A**
Suicidal Ideation	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
In the past week have you wished that you	**"Yes"**	She said in the past year she has had two separate times when she wanted to kill herself. She said

were dead?		she never has a plan or has the intention to kill herself until this last time. She mentioned this last time she did have a plan. She wanted to go overdose on meth, but she decided to get treatment first. She said she does not want to end up like those people who kill themselves before trying to get the help they need. She said within the past 5 years she has had a few thoughts almost every year. While observing the patient, she seemed calm talking about this matter. She did a little sad when she talked about being having thoughts of overdosing on meth. She started to move around in her chair in circles or move her legs a lot but she shortly stopped when she started talking about joining this treatment program.
Have you ever tried to kill yourself?	**"I have never tried to kill myself. I just have thoughts."**	Patient stated she had never tried to kill herself. She has just had the suicidal thoughts and this admission she had thoughts of overdoing on meth to kill herself but did not attempt.
If the client answered either of the previous questions "yes", you must ask the client: **Are you having thoughts of killing yourself right know?** **(If the client says yes, you must ensure facility staff are aware)**	**"No"**	Patient stated she current does not have any thoughts of killing herself or other sundial thoughts as of today.
Rating Scale		
How would you rate your depression on a scale of 1-10?		**"4"**
How would you rate your anxiety on a scale of 1-10?		**"6"**

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
N/A - Homeless			
If yes to any alcohol or drug use, explain:			
Family Medical History: Patient is unsure about family medical history.			
Family Psychiatric History (including suicide): No family history of psych issues.			
Family alcohol or drug use (not covered by those client lives with): Mother and Father both were alcoholics.			
Do you have children? If yes, what are their ages? Yes. Gave birth to three children. One living son who is 24 years old. **Who are your children with now?** Lives at his own house with wife.			
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? No **If yes, please tell me more about that:**			
Are you currently having relationship problems? No			
What is your sexual orientation: Straight	**Are you sexually active?** No	**Do you practice safe sex?** Yes	
Please describe your religious values, beliefs, spirituality and/or preference: Patient stated			

she is a Christian.

Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? No

Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): No current court dates. No divorce. No issues with CPS.

Whom would you consider your support system? Patient stated her son.

How can your family/support system participate in your treatment and care? My son can be here for me when I need him. We do have a rocky relationship with my issues with drugs, but we do stay in touch when we can.

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) Patient stated that she likes to talk to other people who are going through the same thing. Another coping mechanisms that she likes to do is going to church. She said recently she started going over week when she determines she has had enough with her addiction and depression. She stated by going to church it gives her a new meaning to life and is a way to get help.

What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) Loud noises and people yelling are a big trigger. Nothing else specifically triggers anything.

Client raised by:

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

Self-Care:

Independent
Assisted
Total Care

Education History:

Grade school
High school

College
Other:

Reading Skills:

Yes
No
Limited

Primary Language: English

Personal History of Substance Use

Screening Questions:

1. **Have you ever used drugs, alcohol, or nicotine?**

(If no, you may skip to "psychiatric medications".
If yes, complete all sections of this chart. Type N/A if not applicable.)

Substance	First Use and Last Use	Frequency of Use
Nicotine Products (including smoking, chewing, vaping)	**First Use: 20 years ago** **Last Use: Today**	While in the treatment program, patient is allowed 3-4 smoke breaks. When she is out of the facility, she often smokes a pack a day. It depends on much money she has to get cigarettes.
Alcohol	**First Use: N/A** **Last Use:**	Does not drink.
Prescription Medications (Recreational Use)	**First Use: Years ago** **Last Use: Last year**	Patient stated she would take pain pills like candy but stopped shortly after she realized what it was doing to her.
Marijuana	**First Use: N/A**	Does not smoke marijuana.

	Last Use:	
Heroin	**First Use: N/A** **Last Use:**	Patient stated she never used heroin.
Methamphetamine	**First Use: Years ago** **Last Use: 9/15**	Patient stated she would use 3-4x a day.
Other: Specify	**First Use:** **Last Use:**	

Current Psychiatric Medications (10 points)
Complete all of your client's psychiatric medications
All information listed in this section must be pertinent to your patient.

Brand/Generic	gabapentin (Gralise, Neurontin)	lurasidone (Latuda)	sertraline (Zoloft)	Trazadone	hydroxyzine (Atarax)
Dose	300 mg	60 mg	100 mg	50 mg	50 mg
Frequency	TID	Daily	Bedtime	Daily	Q6 PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic Class: 1-amino-methyl cyclohexaneacetic Therapeutic Class: Anticonvulsant	Pharmacologic Class: Atypical antipsychotic Therapeutic Class: Antipsychotic	Pharmacologic Class: Selective serotonin reuptake inhibitor (SSRI) Therapeutic Class: Antianxiety, Antidepressant, Antiobessive-comulsnat, antipanic, antipostraumatic stress, Antipremenstrual dysphoric	Pharmacologic Class: Triazolopyridine derivative Therapeutic Class: Antidepressant	Pharmacologic Class: Piperazine derivative Therapeutic Class: Anxiolytic, antiemetic, antihistamine, sedative-hypnotic
Mechanism of Action	MOA is unknown.	Suppresses psychotic	Increases the amount of	Has an antidepressant	Competes with histamine for

	GABA inhibits rapid firing of neurons (*2025 NDH: Nurse's Drug Handbook).*	symptoms and elevates mood by combining the antagonism of central dopamine type 2 and serotonin type 2 receptors (*2025 NDH: Nurse's Drug Handbook).*	serotonin accessible at neural synapses by blocking CNS neurons reuptake of the neurotransmitte r (*2025 NDH: Nurse's Drug Handbook).*	effect by preventing serotonin from being reabsorbed (*2025 NDH: Nurse's Drug Handbook).*	effector cell surface histamine 1 receptor sites (*2025 NDH: Nurse's Drug Handbook).*
Therapeutic Uses	Seizures, restless leg syndrome, and postherpetic neuralgia.	Schizophrenia and bipolar 1 disorder	Major depressive disorder, Obsessive-Compulsive disorder, panic dsorder, PTSD, Social Anxiety Disorder, Premenstrual dysphoric disorder.	Major-depressive disorder	Itching, allergies, anxiety, insomnia, nausea, alcohol withdrawal
Therapeutic Range (if applicable)					
Reason Client Taking	Patient is taking gabapentin for PTSD.	Patient is taking lurasidone for bipolar disorder.	Patient is taking sertraline for PTSD and major depressive disorder.	Patient is taking trazodone for anxiety and depression.	Patient is taking hydroxyzine for sleep when needed.
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication					Assess patients' respiratory system. Look for any wheezing or chest tightness.
Contraindications (2)	Hypersensiti vity to medication components	Avasimibe, carbamazepine	Disulfiram and pimozide	Hypersensitivit y to medication components and use within 14 days of an	Early pregnancy, prolonged QT interval

				MAO.	
Side Effects/Adverse Reactions (2)	intracranial hemorrhage, withdrawal precipitated seizure	suicidal ideation, hyponatremia,	Neuroleptic malignant syndrome-like reaction, Serotonin syndrome	Serotonin syndrome, suicidal ideation	Torsades de pointes, prolonged QT interval
Medication/Food Interactions	Morphine, Oxycodone, Aluminum and magnesium containing antacids	CYP3A4 inducers and inhibitors.	Antibiotics, antipsychotics, Class 1A antiarrhythmics, Class III antiarrhythmics, St. John wort, Disulfiram	Clopidogrel, warfarin, phenytoin, rifampin, indinavir, ritonavir, sotalol, disopyramide, gatifloxacin	Antibiotics, quinidine, sotalol, methadone, CNS depressants, alcohol use
Nursing Considerations (2)	Obtain renal function test before gabapentin is taken and have labs checked throughout treatment. Monitor patient closely for suicidal behavior. Monitor patient's blood pressure.	Use cautiously with patient who have cardiovascular disorders/diseases. Monitor patient for signs of tardive dyskinesia.	Ensure patient has been screened for family history of bipolar disorder. Monitor patient for suicidal thoughts/ideations.	Monitor patients' vital signs. Monitor patient are suicidal thoughts/ideations.	Monitor patient for any seizure activity. Monitor patient for oversedation.

Medications Reference (1) (APA):

2025 NDH: Nurse's Drug Handbook. (2024). Jones & Bartlett Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:**	Patient worse sweatpants and hoodie but then changed into pants, a long-sleeve shirt, and shoes. Hair was brushed and had makeup on. Patient sat in a computer chair in the group room

Orientation: **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	talking with the other patients. The patient was very attentive to others and was responsive to them. Speech was clear and concise. Eye contact was made but not consistent. Eyes would wonder to other areas when having a conversation.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	Patient stated she felt happy today and a little anxious. She said she was anxious due to having to restart the program, but she was happy because she was able to get a hold of what is happening to herself and her body. Affect was having an animated expression and smiling. Facial expressions were much more than what they could have been. Tone of voice showed enthusiasm when talking during group and when introducing self and others.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	Patient is alert and oriented x4. Slight memory impairment. Patient is unable to remember a few things from two weeks ago. Patient can keep attention when having conversations but when sitting alone patient seems to do multiple things
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	Patient does not have any homicidal ideations. Patient was admitted for suicidal ideations. Suicidal thoughts have subsided since starting the program at New Choice. Patient denied any delusions or hallucinations at this time. No obsessions or compulsions. No paranoia. No flight of ideas. No perseveration. No loose association.
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	I asked my patient on what she would do if she found a wallet on the side of the road what would she do? She responded with, “I would open the wallet up and see if there is an ID. If there was, I would try to find the person if not then bring it into the police station. If it doesn’t have an ID, then I will also bring it to the police station.”

MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	Patient is fully independent. Patient can do ADLs independent without any supervision or assistance. Giat is smooth and steady. No abnormal motor activities.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0648	62	128/79	16	97.6	97% Room Air

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0-10		0		

Nursing Care (6 points)

Overview of care provided today: Patient participated in group today and has labs drawn at 1000

Client complaints: The only complaint my patient made today was that she could not save her cigarette from the first smoke break in the morning. It was running, and she did not want to waste it by throwing it away, but the case manager told her that they have rules for a reason, and you are unable to bring in partially smoked cigarettes.

Participation in therapy/groups: My patient attended all group sessions besides the 1000 o'clock group due to having labs drawn. Patient was able to attend the opening group and the first main group of the morning. She also attended the AA/NA meeting that was held at noon. She participated in all groups. She was able to answer questions when asked and gave her input from the videos that were shown for the groups.

Medication compliance today: My patient took all her morning medications and took her second dose of Gabapentin during lunchtime. Since the beginning of the treatment plan, not a single dose has been missed, and there were no leftover doses in the pill organizer.

Behaviors exhibited today: My patient seemed excited and happy upon arrival on the unit. She was very talkative and wanted to talk about her day and how she slept the previous night.

Discharge Planning

Discharge location: Discharge plan is to go to another inpatient rehab facility. Applications were sent out for low-income housing.

Follow-up plan: The case manager stated she was going to keep up with the patient after discharge to ensure she has housing before leaving the next facility.

Education needs: The Patient needs to be reeducated about the importance of keeping to yourself and not letting others get into her head. The patient was admitted on the 16th of September to New Choice for the 28-day treatment program. On day 3, another patient had set off a trigger, which resulted in a panic attack/breakdown. The patient had to be sent up to detox/4th floor for a few days to help her calm back down. Patient got readmitted on the 20th of September to New Choice and had to restart the 28-day treatment program.

Nursing Diagnosis (25 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	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**
1. Risk for suicide related to suicidal thoughts as evidenced by admission for major depressive disorder and sundial ideation (Phelps, 2023).	I chose risk for suicide, but my patient has had thoughts of suicide and killing herself by overdosing on meth.	1. Patient will have improved opening up about suicidal thoughts by talking with others about the thoughts and journaling about her thoughts until discharge from facility.	1.Patient will journal for 10 minutes every day until discharge and continue to journal while at the other rehab facility (Phelps, 2023). 2. Patient will openly talk with nurse or case manager if any thoughts occur while in the treatment center (Phelps, 2023). 3. Patient will learn more coping strategies will in the facility and learn how to develop techniques before discharge (Phelps, 2023).	1. Provide patient with resources to facilities and phone numbers to help the patient when the patient is having more suicidal thoughts (Phelps, 2023). I chose providing outside resources for the patient would be better because she does have access to a phone and she would be able to go to another facility if need to help when she is having suicidal thoughts or ideations.
2. Social isolation related to inadequate social skills as evidence	I chose social isolation because my patient is not at home with her son. She	1. Patient will be able to list community resources to help with her social isolation and ways to help	1. Patient will discuss why she does not attend social events and what she could to help attend more before discharge	1. Provide patient with outside resources to facilities that will be able to help the patient with social isolation (Phelps,

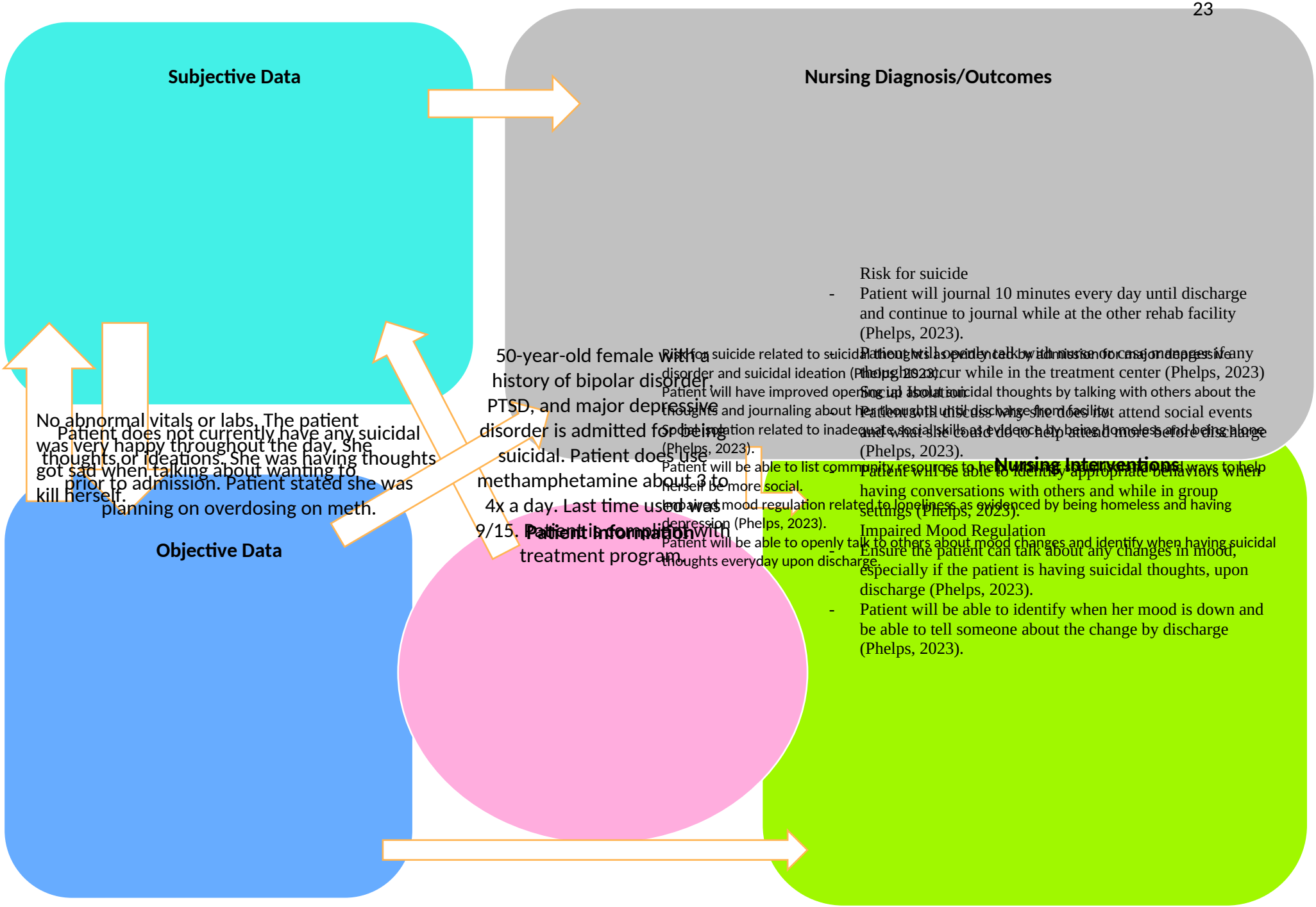
by being homeless and being alone (Phelps, 2023).	is homeless and she has stated that she does not going social events due to being homeless.	herself be more social.	(Phelps, 2023). 2. Patient will be able to identify appropriate behaviors when having conversations with others and while in group settings (Phelps, 2023). 3. Patient will attend all group therapy sessions while in the 28-day treatment (Phelps, 2023).	2023). I chose providing the patient with more outside resources because she would not be around a lot of people while being homeless. By providing the resources it can help the patient more adamant about being around others and maybe she could attend more meetings too to help break the isolation.
3. Impaired mood regulation related to loneliness as evidenced by being homeless and having depression (Phelps, 2023).	I chose impaired mood regulation because my patients has often expressed that she feels lonely and this can alter her mood.	1. Patient will be able to openly talk to others about mood changes and identify when having suicidal thoughts everyday upon discharge.	1. Ensure patient is able to talk about any changes with mood especially if patient is having suicidal thoughts by discharge (Phelps, 2023). 2. Patient will be able to identify when her mood is down and being able to tell someone about it by discharge (Phelps, 2023). 3. Patient is able to get enough sleep every night	1. Provide patient will a journal where she can keep track of her thoughts and mood changes and be able to find a facility or therapist to help with mood regulation (Phelps, 2023). I chose this outcome because it ensures she is keeping track of herself and her feelings. If she is able to get a therapist after discharge she will have a better chance to help

			and be able to do self-care by discharge (Phelps, 2023).	regulate her mood and ensure her thoughts are not to herself.

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer

Concept Map (20 Points):


Subjective Data
Patient does not currently have any suicidal thoughts or ideations. She was having thoughts prior to admission. Patient stated she was planning on overdosing on meth.
Objective Data
No abnormal vitals or labs. The patient was very happy throughout the day. She got sad when talking about wanting to kill herself.
50-year-old female with a history of bipolar disorder, PTSD, and major depressive disorder is admitted for being suicidal. Patient does use methamphetamine about 3 to 4x a day. Last time used was 9/15. Patient is compliant with treatment program.
Patient Information
Nursing Diagnosis/Outcomes
Risk for suicide
- Patient will journal 10 minutes every day until discharge and continue to journal while at the other rehab facility (Phelps, 2023).
- Patient will openly talk with nurse or case manager if any thoughts occur while in the treatment center (Phelps, 2023)
- Patient will discuss why she does not attend social events and what she could do to help attend more before discharge (Phelps, 2023).
- Patient will be able to identify appropriate behaviors when having conversations with others and while in group settings (Phelps, 2023).
Impaired Mood Regulation
- Ensure the patient can talk about any changes in mood, especially if the patient is having suicidal thoughts, upon discharge (Phelps, 2023).
- Patient will be able to identify when her mood is down and be able to tell someone about the change by discharge (Phelps, 2023).
Risk for suicide related to suicidal thoughts as evidenced by admission for major depressive disorder and suicidal ideation (Phelps, 2023).
Patient will have improved openness about her thoughts and journaling about her thoughts until discharge from facility.
Social Isolation related to inadequate social skills as evidenced by being homeless and being alone (Phelps, 2023).
Patient will be able to list community resources to help with social skills and ways to help herself be more social.
Impaired mood regulation related to loneliness as evidenced by being homeless and having depression (Phelps, 2023).
Patient will be able to openly talk to others about mood changes and identify when having suicidal thoughts everyday upon discharge.
Nursing Interventions