Name:

Date:

Room: Client Initials:

CLUSTERED DATA	NURSING DIAGNOSIS (Client Problem)	EXPECTED CLIENT OUTCOME (Dated Goal)	NURSING INTERVENTIONS	DATED EVALUATION OF GOALS
diagnosis of major depressive disorder which has worsened over the last few months and has never been treated in the past     recent severe suicide attempt that lead to hospitalization     feelings of happiness, euphoria, and energy after suicidal attempt     verbal statements of helplessness and low self-esteem due to ongoing issues at home and in his mamage     unemployed     increased alcohol use	Risk for suicide rit major depressive disorder, recent suicide attempt, sudden euphoric recovery from major depression, feelings of helplessness and low self-esteem, and poor coping skills	Patient will not harm self throughout his stay in the hospital and will continue to not cause self-harm after he is discharged.  Patient will maintain connectedness in relationships and will utilize his social supports for coping purposes throughout his stay in the hospital and after discharge.  Patient will talk about his feelings and disclose suicidal ideations if present throughout his stay in the hospital  Patient will seek immediate help if he begins to experience suicidal thoughts in the community	perform mental status examinations every shift and assess suicidal ideation every shift and when appropriate (e.g. if client is exhibiting new behaviours)  assess the patient's ability to enter into a no-suicide and no self-harm contract; this gets the subject of suicide out in the open and discussing feelings of self-harm with a trusted person provides relief for the patient  be alert for warning signs of suicide, such as making statements of death, getting affairs in order, behaving recklessly, becoming withdrawn, or even becoming euphoric  assess patient's relationship with social supports and ask him to identify how they can help him  refer patient to mental health counselling and other community resources that will be utilized after discharge  ask client to identify positive coping mechanisms, social supports, and professional help in the event of suicidal thoughts	Patient did not experience thoughts of self- harm by end of shift at 2100 and identified his family as protective factors and excellent support systems. Patient stated that he would inform nurses of any suicidal ideation and would not cause harm to himself. Patient verbalized understanding of the importance to seek help from both his family members and professional help in the event he feels suicidal again in the future.
<ul> <li>when patient was feeling depressed and suicidal, he did not</li> </ul>	ineffective health maintenance nt lack of ability to make good	Patient will discuss fear of or blocks to implementing health	<ul> <li>assess patient's feelings, values and reasons for not seeking health care and assess patient's feelings regarding</li> </ul>	During the mental status exam, the patient verbalized

# **Psychiatric Nursing Care Plans**

**K Morrison** 

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