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Community mental-health follow-up Comfort & daily function

Community Health Nursing | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

38-year-old woman recovering from a severe mood episode. Care stage: During supported recovery and essential daily activity.

Medical history: The patient is recovering after a severe mood episode. Returning to study is a personal goal; sleep stability, medicine access and relapse planning remain important. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Wants to return to study but worries about relapse and medicine costs.

Objective findings and required checks: Stable engagement with ongoing sleep, function and safety assessment.

Physical examination and investigations: Review symptoms, risk, medicine effects, access, sleep and functional goals.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Community mental-health follow-up: Recovery depends on clinical treatment, social support and realistic participation goals.

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Medical / surgical management

Coordinate follow-up, collaborative relapse planning and practical support without stigma.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed psychiatric medicine	Maintain the assessed treatment plan	Check drug-specific monitoring and adverse effects
medication reconciliation	Support safe continuity	Discuss barriers with the treating team.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Wants to return to study but worries about relapse and medicine costs. Stable engagement with ongoing sleep, function and safety assessment. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize coping resources strained by illness or social stress; difficulty sustaining the agreed treatment plan; sleep disrupted by symptoms or the care environment; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Coordinate follow-up, collaborative relapse planning and practical support without stigma. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about stressors, strengths, support people and previous coping. Assess: Assess function, engagement and immediate safety needs.	Coping resources strained by illness or social stress. Possible factors: demands exceeding currently available support. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Chooses one feasible coping action and identifies a support person or service. Longer-term: Before the clinically approved transition or agreed follow-up: Has a realistic follow-up and support plan agreed with the care team.	1. Assess strengths and barriers collaboratively. Rationale: An individualized plan builds on resources the person can actually use. 2. Practice a simple coping strategy and divide tasks into achievable steps. Rationale: Small successes support confidence and participation. 3. Coordinate social, psychological or community support as indicated. Rationale: Practical barriers can limit recovery even when clinical treatment is available. 4. Coordinate follow-up, collaborative relapse planning and practical support without stigma. Rationale: Recovery depends on clinical treatment, social support and realistic participation goals. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual sleep, current disruption and daytime fatigue. Assess: Record sleep pattern, symptom triggers and environmental disturbance.	Sleep disrupted by symptoms or the care environment. Possible factors: discomfort, anxiety or interrupted routines. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Reports improved rest during the next planned sleep period. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies practical sleep-supporting routines for recovery.	1. Identify pain, breathlessness, anxiety and medicine-related causes of poor sleep. Rationale: Treating contributors is more useful than assuming a single cause. 2. Cluster non-urgent care and reduce light and noise when safe. Rationale: A predictable environment protects opportunities to sleep. 3. Use relaxation strategies and review prescribed sedating medicines carefully. Rationale: Rest should improve without avoidable oversedation or falls.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach individual early warning signs, sleep routines, affordable access options and agreed support contacts. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach individual early warning signs, sleep routines, affordable access options and agreed support contacts.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Emerging self-harm risk, mania, psychosis, severe medicine reaction or inability to remain safe requires urgent assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Recovery depends on clinical treatment, social support and realistic participation goals.

- Priority concerns: Coping resources strained by illness or social stress; Difficulty sustaining the agreed treatment plan; Sleep disrupted by symptoms or the care environment; Learning needs about the condition and care plan.

- Emerging self-harm risk, mania, psychosis, severe medicine reaction or inability to remain safe requires urgent assessment.

- Teach individual early warning signs, sleep routines, affordable access options and agreed support contacts.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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