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Depression with safety assessment Comfort & daily function

Mental 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

28-year-old woman seeking help for persistent low mood. Care stage: During supported recovery and essential daily activity.

Medical history: Low mood, loss of interest and disrupted sleep have persisted for several weeks and reduced daily function. The patient has sought professional help and requires direct safety assessment. 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 person wishes to participate in decisions and prefers permission before others are involved. Assess support, work/study function, substance use and practical access without stigma.

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

Clinical assessment

Subjective: Low mood, loss of interest, poor sleep and feelings of hopelessness.

Objective findings and required checks: Reduced activity and self-care; direct assessment of self-harm risk is essential.

Physical examination and investigations: Use a comprehensive mental-state and safety assessment; review medical/substance contributors and investigations when indicated.

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

Clinical focus and pathophysiology

Depression with safety assessment: Mood disorders involve interacting biological, psychological and social factors affecting function.

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Medical / surgical management

Provide respectful therapeutic engagement, a collaborative safety plan and prescribed psychological or medication treatment.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antidepressant	Treat the assessed depressive disorder	Monitor early worsening, activation, adverse effects and follow-up
no immediate-effect promise	Improvement takes individualized review	Explain the agreed monitoring plan.

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

Nursing process - ADPIE

Assessment

Low mood, loss of interest, poor sleep and feelings of hopelessness. Reduced activity and self-care; direct assessment of self-harm risk is essential. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize immediate safety needs during altered mood, cognition or behaviour; sleep disrupted by symptoms or the care environment; daily self-care needs exceed current ability; 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

Provide respectful therapeutic engagement, a collaborative safety plan and prescribed psychological or medication treatment. 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 directly about safety, self-harm, aggression and access to harmful means. Assess: Assess risk, observation needs and environmental hazards collaboratively.	Immediate safety needs during altered mood, cognition or behaviour. Possible factors: reduced judgment, severe distress or loss of control. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Immediate risks are addressed using the least restrictive appropriate care plan. Longer-term: Before the clinically approved transition or agreed follow-up: A collaborative safety and follow-up plan is documented before transition.	1. Escalate imminent danger immediately and maintain observation according to risk and local policy. Rationale: Timely support protects life and prevents unobserved deterioration. 2. Use de-escalation, respectful communication and proportionate environmental safeguards. Rationale: Dignity and reduced stimulation can support safer engagement. 3. Review risk with the multidisciplinary team and document changes and handover. Rationale: Risk is dynamic and requires continuity across staff and settings. 4. Provide respectful therapeutic engagement, a collaborative safety plan and prescribed psychological or medication treatment. Rationale: Mood disorders involve interacting biological, psychological and social factors affecting function. 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 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 which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	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 treatment follow-up, support access, gradual daily structure and when urgent help is needed. 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 treatment follow-up, support access, gradual daily structure and when urgent help is needed.

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

Imminent self-harm risk, inability to maintain safety, psychosis or severe self-neglect requires urgent professional 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

- Mood disorders involve interacting biological, psychological and social factors affecting function.

- Priority concerns: Immediate safety needs during altered mood, cognition or behaviour; Sleep disrupted by symptoms or the care environment; Daily self-care needs exceed current ability; Learning needs about the condition and care plan.

- Imminent self-harm risk, inability to maintain safety, psychosis or severe self-neglect requires urgent professional assessment.

- Teach treatment follow-up, support access, gradual daily structure and when urgent help is needed.

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

References

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