4.1: 4.01-0 Spotlight Application

Let’s review how the nursing process can be applied to Sample Case A introduced in the “Diagnosis” section of this chapter regarding caring for a suicidal client:

Assessment

During an interview with a 32-year-old male client diagnosed with Major Depressive Disorder, the client exhibited signs of a sad affect and hopelessness. He expressed desire to die and reported difficulty sleeping and a lack of appetite. He reports he has not showered in over a week and his clothes have a strong body odor.

Diagnosis

The nurse analyzed this data and created four nursing diagnoses:

- **Hopelessness** related to social isolation
- **Risk for Suicide** as manifested by the reported desire to die
- **Imbalanced Nutrition: Less than Body Requirements** related to insufficient dietary intake
- **Self-Neglect** related to insufficient personal hygiene

The nurse established the top priority nursing diagnosis of **Risk for Suicide** and immediately screened for suicidal ideation and a plan using the Columbia Suicide Severity Rating Scale (C-SSRS).

Outcome Identification

The nurse identified the following SMART expected outcomes:
• The client will verbalize feelings by the end of the shift.
• The client will remain free from injury during the hospitalization stay.
• The client will progressively gain at least one pound per week toward his ideal body weight (180 pounds).
• The client will participate in daily bathing.

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**Planning and Implementation**

The nurse implemented planned nursing interventions for *Risk for Suicide* as previously discussed in Table 4.6.

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**Evaluation**

Day 1: Outcomes partially met. By the end of the shift, the client verbalized feelings related to hopelessness and did not harm himself. He did not agree to participate in taking a bath and only ate 25% of his meal tray. Interventions will be re-attempted on Day 2 and reassessed for effectiveness.

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**Sample Documentation**

0900: 32-year-old male client diagnosed with Major Depressive Disorder admitted for active suicidal ideation with a plan to do so with a gun. He has the means to accomplish this plan at home. He has expressed the desire to die and reports difficulty sleeping and a lack of appetite for the past two weeks. He reports he has not showered in over a week, and his clothes have a strong body odor. Client was placed in a room near the nursing station and assigned a 1:1 sitter. His personal belongings were removed and placed in a secure area. An environmental scan was completed, and all hazards were removed from the room. He agreed to complete a no-harm contract. Dr. Delgado was notified at 0930. She assessed the client at 0945, and new orders for medications were received and administered. —— Zerimiah Alimi, Nursing Student