Mental Health Care Plan Name

Institution

Date

Author Note

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# Identify at least five mental health issues based on the client's observation in the film when they were at their lowest point.

Anxiety disorders

Depression

Paranoia

Psychosis

Schizophrenia

# Provide three tentative mental health nursing diagnosis with data to support the diagnosis.

I[mpaired Social Interaction](https://nurseslabs.com/schizophrenia-nursing-care-plans/2/) – One of the mental health nursing diagnoses is impaired social interactions characterized by, Feeling threatened in social situations Excessive response to alerting stimuli, and impaired thought process( hallucinations or delusions). Furthermore, dysfunctional interaction and loneliness, a sign of Schizophrenia id observed from the client's behaviors.

**Disturbed Sensory Perception – Disturbed Sensory Pattern is another mental health** diagnosis observed by the client. Hallucinations, grimacing and frequent blinking of the eye, Auditory distortions, and Altered communication pattern are the observable characteristics from the film that makes Disturbed Sensory Perception a nursing diagnosis on the patient. Tilting the head as if listening to someone is also notable from the film.

**Disturbed Thought Process - It is one of the most common objectives and personal nursing assessment signs and symptoms that denotes** schizophrenia mental health issue. From the film, memory deficit, inaccurate interpretation of the environment, and delusions are notable characteristics that signify the film's disturbed thought process.

# Identify potential labs that would be drawn and expected results, if any.

Mental disorders, such as depression, are typically observed through a physical test, such as asking the client some questions. However, a lab test can also be used to confirm or rule out some diagnoses.

Blood tests are performed to check for therapeutic conditions that may cause mental disorder issues such as depression. Blood tests check for conditions such as thyroid and anemia. Additionally, the lab blood test can check for vitamin D and calcium levels in the body.

Brain MRI and CT scans can also rule out other serious illnesses such as brain tumors.

Electrocardiogram lab tests are performed to diagnose heart complications.

An Electroencephalogram lab test records the electrical activity of the brain.

# Select the top 3 nursing diagnosis in order of highest priority

**Problem-focused diagnosis/ Actual diagnosis**

**Risk nursing diagnosis**

**Health promotion diagnosis**

# Supply factors observed in the film which would support the top three nursing diagnosis.

Depression (Problem-focused diagnosis) – From the film, stressful and traumatic events were observed, and it may require related factors problem-focus to determine the focus of the problem.

Schizophrenia (Risk nursing diagnosis) – The Schizophrenia factors witnessed in the film may result from drugs or some other mind-altering substance.

Anxiety (Healthy promotion diagnosis) –The third nursing diagnosis priority is the health promotion factor whose main objective is to enhance the community's, families, and individual's overall wellbeing. The film's anxiety factor is observed through worriedness, apprehension, fear, and excessive nervousness that requires healthy intervention measures, Heathy promotion diagnosis.

# Select three nursing interventions for each diagnosis, which support each diagnosis (i.e., potential medication, potential alterations in physical/psychological abilities, possible development, and cultural aspects of nursing care).

# ****Problem-focused diagnosis/ Actual diagnosis****

Determine the customer's prior level of emotional functioning (from client, family, past medical records).

Assess the understanding of the patient and the vital knowledge of others about depression and its causes.

Enable the patient to assess aspects that are not beyond their capacity to monitor life events. Discuss emotions associated with this loss of control.

# ****Risk nursing diagnosis****

**Help the customer understand negative thoughts/thoughts. Teach the customer to reframe and disprove divisive theories**

**Enable the customer delay making important big life choices.**

**Work with the client to understand perceptual distortions that foster flawed self-assessment**

# ****Health promotion diagnosis****

Give the customer more time than average to finish everyday daily life tasks (ADL) (e.g., eating, dressing)

Express optimism to the patient with practical remarks on the abilities and resources of the patient

Support to structure an environment for clients and families to restore set schedules and predictable patterns during the extreme depression.

# Document at least three potential outcomes that are measurable and related to the nursing diagnosis.

# ****Problem-focused diagnosis/ Actual diagnosis****

A zest for life and the desire to appreciate the moment can be displayed by the patient.

The patient may convey emotions and acceptance of events in life that they do not have control over.

The patient will display individual life control problem-solving strategies and will not verbalize or indicate suicidality.

# ****Risk nursing diagnosis****

# The patient will recognize and rationally counter negative emotions and, after two weeks, reframe them positively.

# The patient will display better disposition as seen by the Beck Depression Inventory.

# When planning for the nurse, the patient may show a better willingness to make appropriate choices.

# ****Health promotion diagnosis****

Two irrational feelings about themselves and others will be shared with the nurse by the end of the first day.

Patient and significant ones can verbalize detailed information on at least two of the potential causes of depression, three-four of depression signs and symptoms, and medicine, psychotherapy, and electroconvulsive therapy as recovery.

The patient demonstrates the potential to adjust unreasonable self-expectations.