# Nursing Progress Note

Date of Exam: 5/9/2013
Time of Exam: 2:02:45 PM

Patient Name: Smart, Julie
Patient Number: 1000010649803

**HISTORY:**

Status of patient:
Julie is worse today.

Target Symptoms:
Julie reports that depressive symptoms continue. Her symptoms, she reports, are more frequent or more intense. Anergia is present. Increased symptoms of anhedonia are present. Julie's difficulty with concentrating has not changed. Julie reports that she continues to feel sad. Guilty feelings are described by Julie. "I should have been with my sister, I had no idea she was suicidal." Sleep has improved with the use of PRN Ambien CR at HS. Julie convincingly denies suicidal ideas or intentions.

Basic Behaviors:
Medication has been taken regularly. She needs help with ADLs. When she attends activities participation is minimal. Prn's are used occasionally and are described as effective for her headaches. Impulsive behaviors are occurring, but less frequently. Julie has diminished food and fluid intake. Julie has not been confused. A good night's sleep is described.

Additional Signs or Possible Side Effects:
Sedative effects of the medication are described.
Patient reports a dry mouth.
No other side effects are reported or in evidence.

MENTAL STATUS:
Julie presents as glum, downcast, inattentive, minimally communicative, and looks unhappy. She appears listless and anergic. She appears downcast. Thought content is depressed. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. There are signs of anxiety. Patient is fidgety in a way that is suggestive of anxiety.

Special Circumstances:
Julie continues to have an unsteady gait, especially after midnight. Call light is within her reach. She has been instructed to ring for the nurse to assist her when ambulating to bathroom.

Vital Signs:
Sitting blood pressure is 150 / 85. Sitting pulse rate is 80. Respiratory rate is 18 per minute. Temperature is 98+ degrees F. Weight is 155 lbs. (70.3 Kg).

Nursing Interventions:
The following nursing interventions were performed:
Medication was administered to Julie, compliance, symptoms, and possible side effects monitored and recorded as appropriate. Response to medication is as follows: Julie's response to medication Ambien CR is considered good. Details are as follows: Julie reports being well rested in the morning for the first time in several months.

Level of Care:
Julie needs continued Inpatient treatment. (Julie is voluntary.) Julie did not benefit or could not be managed in an outpatient setting causing exacerbation of psychiatric symptoms and condition is likely to improve with treatment at the current level of care.

Link to the Treatment Plan:
Link to Treatment Plan Problem: **depressed mood**
Short Term Goals: Julie will recognize and report thoughts of death to staff immediately. Target Date: 5/9/2013

Interventions:
Nursing staff will engage in conversation and encourage VERBALIZATION OF FEELINGS.
Nursing staff will engage in friendly conversation and ENCOURAGE SOCIALIZATION with other patients and in activities.
Nursing staff to encourage attention to DRESSING, GROOMING and the maintenance of personal area.
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Moderate progress in reaching these goals and resolving problems seemed present today.
Recommend that the interventions and short term goals for this problem be continued since more time is needed to meet these goals and resolve this problem.

Liz Lobao, RN

Electronically Signed
By: Liz Lobao, RN
On: 5/9/2013 2:03:01 PM