

P — Emotions and mind

29 statements · Recommended tool: CP-MIND Mood & Mind Screen · Validated scales: PHQ-9, GAD-7, C-SSRS

P1 Worry or nervousness

Group: Emotions and mind | Type: Actual problem

Definition: An uneasy feeling with tension, restlessness, fast heartbeat, or trouble focusing.

Possible causes: Illness; uncertain future; pain; hospital stay; past trauma; caffeine

Signs and symptoms: Restlessness; fast heartbeat; sweating; trouble sleeping; says they are worried; poor concentration

Scenario. A man waiting for biopsy results cannot sleep and keeps asking questions.

S: "I can't stop worrying and I can't sleep."

O: Heart rate 104/min; restless; sleeps 3 hours; asks the same questions repeatedly; awaiting biopsy results.

Tools: CP-MIND, CP-SKIN · PHQ-9, GAD-7, C-SSRS, Braden Scale, TIME wound chart **CarePath

diagnosis:** Worry or nervousness related to illness, as evidenced by restlessness and fast heartbeat.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Stay calm. | A calm nurse helps settle the patient, because anxious people pick up on the tone and pace of those around them and become more tense if staff seem rushed. | | Listen. | Listening without hurrying lets the patient put worries into words, which often lowers distress and shows the nurse what he fears most. | | Explain the next steps simply. | Clear, simple information about what happens next reduces fear of the unknown, which is a major driver of worry while waiting for results. | | Teach slow breathing. | Slow breathing activates the body's relaxation response, which can lower heart rate and muscle tension and help the patient wind down for sleep. | | Limit stimulants. | Caffeine and other stimulants can raise heart rate and restlessness and disturb sleep, so limiting them avoids adding to the physical signs of worry. | | Give medicine as ordered. | Prescribed medicine can ease severe worry or help sleep when other measures are not enough, and giving it as ordered keeps dosing safe. | | Involve family. | Family are familiar and trusted, so their presence offers comfort and support, and they can help reinforce coping and explanations. |

****Expected outcomes**** - Within 24-48 hours: rates worry 3/10 or lower, sleeps 5-6 hours, uses two coping methods, says he feels calmer. ****Linking the data to the diagnosis**** The patient is waiting for biopsy results and says, "I can't stop worrying and I can't sleep." The nurse records a heart rate of 104/min, restlessness, only 3 hours of sleep and the same questions asked repeatedly. These are present now, so this is an actual problem rather than a risk. The plan aims, within 24 to 48 hours, for worry of 3/10 or lower, 5 to 6 hours of sleep, two coping methods and a report that he feels calmer.

CarePath diagnosis: Worry or nervousness related to illness, as evidenced by restlessness and fast heartbeat.

Intervention	Rationale
Stay calm.	A calm nurse helps settle the patient, because anxious people pick up on the tone and pace of those around them and become more tense if staff seem rushed.
Listen.	Listening without hurrying lets the patient put worries into words, which often lowers distress and shows the nurse what he fears most.
Explain the next steps simply.	Clear, simple information about what happens next reduces fear of the unknown, which is a major driver of worry while waiting for results.
Teach slow breathing.	Slow breathing activates the body's relaxation response, which can lower heart rate and muscle tension and help the patient wind down for sleep.
Limit stimulants.	Caffeine and other stimulants can raise heart rate and restlessness and disturb sleep, so limiting them avoids adding to the physical signs of worry.
Give medicine as ordered.	Prescribed medicine can ease severe worry or help sleep when other measures are not enough, and giving it as ordered keeps dosing safe.
Involve family.	Family are familiar and trusted, so their presence offers comfort and support, and they can help reinforce coping and explanations.

Expected outcomes: Within 24-48 hours: rates worry 3/10 or lower, sleeps 5-6 hours, uses two coping methods, says he feels calmer.

Linking the data: The patient is waiting for biopsy results and says, "I can't stop worrying and I can't sleep." The nurse records a heart rate of 104/min, restlessness, only 3 hours of sleep and the same questions asked repeatedly. These are present now, so this is an actual problem rather than a risk. The plan aims, within 24 to 48 hours, for worry of 3/10 or lower, 5 to 6 hours of sleep, two coping methods and a report that he feels calmer.

P2 Fear of a specific thing

Group: Emotions and mind | Type: Actual problem

Definition: Fear directed at a clear threat such as a procedure, pain, or situation.

Possible causes: Procedures; needles; pain; darkness; surgery; injections

Signs and symptoms: Trembling; tearful; avoiding the feared thing; fast heartbeat; clinging to a parent

Scenario. A child cries and hides when she sees the injection tray.

S: (Child) "I don't want the needle!"

O: Crying; hiding behind parent; heart rate 130/min; refuses to hold out arm.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Fear of a specific thing related to procedures, as evidenced by trembling and tearful. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Explain in simple words. | Simple, age-appropriate words help the child understand what will happen, and unknown things feel scarier than known ones. | | Let the child hold a toy. | A familiar toy gives comfort and a sense of control, and holding it can distract her attention from the needle. | | Show the equipment. | Letting the child see and touch safe equipment makes it less mysterious, which can reduce fear of the unknown. | | Be honest. | Honest explanations build trust, whereas being told it will not hurt when it will can increase fear at the next procedure. | | Allow a parent to stay. | A parent is the child's main source of security, so their presence lowers distress and helps her stay calmer and more cooperative. | | Praise courage. | Praise reinforces brave behavior and builds confidence, which makes future procedures easier for the child to cope with. | ****Expected outcomes**** - Child allows the procedure with distraction. - Cries less. - Parent helps. - Child says she felt brave. ****Linking the data to the diagnosis**** The child cries and hides behind her parent when she sees the injection tray, saying, "I don't want the needle!" The nurse records a heart rate of 130/min and refusal to hold out her arm. The fear is aimed at one clear threat, the needle, and is present now, so this fits fear of a specific thing rather than general worry. The plan aims for the child to allow the procedure with distraction, cry less, be helped by her parent and say she felt brave.

CarePath diagnosis: Fear of a specific thing related to procedures, as evidenced by trembling and tearful.

Intervention	Rationale
Explain in simple words.	Simple, age-appropriate words help the child understand what will happen, and unknown things feel scarier than known ones.
Let the child hold a toy.	A familiar toy gives comfort and a sense of control, and holding it can distract her attention from the needle.
Show the equipment.	Letting the child see and touch safe equipment makes it less mysterious, which can reduce fear of the unknown.
Be honest.	Honest explanations build trust, whereas being told it will not hurt when it will can increase fear at the next procedure.
Allow a parent to stay.	A parent is the child's main source of security, so their presence lowers distress and helps her stay calmer and more cooperative.
Praise courage.	Praise reinforces brave behavior and builds confidence, which makes future procedures easier for the child to cope with.

Expected outcomes: Child allows the procedure with distraction. · Cries less. · Parent helps. · Child says she felt brave.

Linking the data: The child cries and hides behind her parent when she sees the injection tray, saying, "I don't want the needle!" The nurse records a heart rate of 130/min and refusal to hold out her arm. The fear is aimed at one clear threat, the needle, and is present now, so this fits fear of a specific thing rather than general worry. The plan aims for the child to allow the procedure with distraction, cry less, be helped by her parent and say she felt brave.

P3 Difficulty handling stress

Group: Emotions and mind | Type: Actual problem

Definition: The person's usual ways of coping are not working.

Possible causes: Chronic illness; job loss; family strain; poor support; many changes

Signs and symptoms: Irritable; withdrawn; poor sleep; increased substance use; sense of overload

Scenario. A man with cancer drinks more and refuses to talk about his illness.

S: "I don't want to talk about it. I just need a drink."

O: Drinks more since diagnosis; withdrawn; irritable; poor sleep.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Difficulty handling stress related to chronic illness, as evidenced by irritable and withdrawn. ****Interventions and rationale**** | Intervention | Rationale | |---| | Listen. | Listening without judging shows respect and builds trust, which helps a man who does not want to talk begin to share when he is ready. | | Explore how he copes. | Understanding how he currently copes shows what helps and what harms, such as drinking, so the plan can build on his strengths. | | Teach relaxation. | Relaxation skills calm the body's stress response and give him a healthier option than alcohol when he feels overloaded. | | Encourage support. | Support from family, friends or groups reduces isolation and shares the load, which makes the stress of cancer easier to bear. | | Refer for counseling. | Counselors have training to help people build new coping skills and address alcohol use, which goes beyond what routine ward care can offer. | | Praise coping efforts. | Praise for healthy coping strengthens those behaviors and boosts confidence, making it more likely he will use them again. | ****Expected outcomes**** - Within 1 week: states 2 healthy ways to cope, accepts support, cuts down alcohol, engages with a counselor. ****Linking the data to the diagnosis**** The man with cancer says, "I don't want to talk about it. I just need a drink." The nurse notes he drinks more since the diagnosis, is withdrawn and irritable and sleeps poorly. His usual coping is failing and harmful coping has replaced it, so the problem exists now and is not just a risk. The plan aims, within 1 week, for him to state 2 healthy ways to cope, accept support, cut down alcohol and engage with a counselor.

CarePath diagnosis: Difficulty handling stress related to chronic illness, as evidenced by irritable and withdrawn.

Intervention	Rationale
Listen.	Listening without judging shows respect and builds trust, which helps a man who does not want to talk begin to share when he is ready.
Explore how he copes.	Understanding how he currently copes shows what helps and what harms, such as drinking, so the plan can build on his strengths.
Teach relaxation.	Relaxation skills calm the body's stress response and give him a healthier option than alcohol when he feels overloaded.
Encourage support.	Support from family, friends or groups reduces isolation and shares the load, which makes the stress of cancer easier to bear.
Refer for counseling.	Counselors have training to help people build new coping skills and address alcohol use, which goes beyond what routine ward care can offer.
Praise coping efforts.	Praise for healthy coping strengthens those behaviors and boosts confidence, making it more likely he will use them again.

Expected outcomes: Within 1 week: states 2 healthy ways to cope, accepts support, cuts down alcohol, engages with a counselor.

Linking the data: The man with cancer says, "I don't want to talk about it. I just need a drink." The nurse notes he drinks more since the diagnosis, is withdrawn and irritable and sleeps poorly. His usual coping is failing and harmful coping has replaced it, so the problem exists now and is not just a risk. The plan aims, within 1 week, for him to state 2 healthy ways to cope, accept support, cut down alcohol and engage with a counselor.

P4 Loss of hope

Group: Emotions and mind | Type: Actual problem

Definition: The person sees little chance of improvement and loses motivation.

Possible causes: Poor prognosis; long illness; loss; lack of support; repeated setbacks

Signs and symptoms: Says nothing will help; flat voice; little effort; passive; withdrawn

Scenario. A patient after amputation says there is no point in rehabilitation.

S: "What's the point? I'll never get better."

O: Flat voice; stays in bed; refuses therapy; after amputation.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Loss of hope related to poor prognosis, as evidenced by says nothing will help and flat voice. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Show interest. | Showing real interest tells the patient he matters, which counters the sense of isolation and may open the door to talking about how he feels. | | Set tiny goals. | Very small goals are achievable, and each success rebuilds a sense that effort can lead to change, which is the base of hope. | | Encourage hope. | Encouraging hope, in a realistic way, supports motivation and reminds him that recovery after amputation can progress step by step. | | Point out strengths. | Pointing out strengths he already has helps him see himself as capable, which challenges the belief that nothing will help. | | Involve family and chaplain. | Family and chaplain offer trusted emotional and spiritual support, which can restore meaning and connection when he feels there is no point. | | Assess for depression and suicide risk. | Hopelessness is linked with depression and suicide risk, so asking about these directly and kindly allows the team to keep him safe and get help early. | ****Expected outcomes**** - Within 3 days: sets one personal goal, attends therapy sessions, states a reason for hope. ****Linking the data to the diagnosis**** After amputation the patient says, "What's the point? I'll never get better." The nurse observes a flat voice, staying in bed and refusing therapy. These show hope is already lost, so this is an actual problem. The nurse must also assess for depression and suicide risk, because hopeless statements can signal danger. The plan aims, within 3 days, for him to set one personal goal, attend therapy sessions and state a reason for hope.

CarePath diagnosis: Loss of hope related to poor prognosis, as evidenced by says nothing will help and flat voice.

Intervention	Rationale
Show interest.	Showing real interest tells the patient he matters, which counters the sense of isolation and may open the door to talking about how he feels.
Set tiny goals.	Very small goals are achievable, and each success rebuilds a sense that effort can lead to change, which is the base of hope.
Encourage hope.	Encouraging hope, in a realistic way, supports motivation and reminds him that recovery after amputation can progress step by step.
Point out strengths.	Pointing out strengths he already has helps him see himself as capable, which challenges the belief that nothing will help.
Involve family and chaplain.	Family and chaplain offer trusted emotional and spiritual support, which can restore meaning and connection when he feels there is no point.
Assess for depression and suicide risk.	Hopelessness is linked with depression and suicide risk, so asking about these directly and kindly allows the team to keep him safe and get help early.

Expected outcomes: Within 3 days: sets one personal goal, attends therapy sessions, states a reason for hope.

Linking the data: After amputation the patient says, "What's the point? I'll never get better." The nurse observes a flat voice, staying in bed and refusing therapy. These show hope is already lost, so this is an actual problem. The nurse must also assess for depression and suicide risk, because hopeless statements can signal danger. The plan aims, within 3 days, for him to set one personal goal, attend therapy sessions and state a reason for hope.

P5 Feeling no control over one's situation

Group: Emotions and mind | Type: Actual problem

Definition: The person feels unable to influence events or decisions about their care.

Possible causes: Hospital routines; loss of independence; serious illness; poor information

Signs and symptoms: Says no one asks me; passive; angry; refuses care; leaves all decisions to others

Scenario. A patient says staff decide everything and stops asking questions.

S: "Nobody asks me anything. They just decide."

O: Passive; refuses some care; asks few questions; says he feels trapped.

Tools: CP-MIND, CP-SKIN · PHQ-9, GAD-7, C-SSRS, Braden Scale, TIME wound chart **CarePath** diagnosis: Feeling no control over one's situation related to hospital routines, as evidenced by says no one asks me and passive. **Interventions and rationale** | Intervention | Rationale | | Give information. | Clear information about his condition and care lets him understand what is happening, which reduces feeling trapped and helps him take part in decisions. | | Offer choices. | Offering real choices, even small ones such as timing of care, gives back a sense of control that hospital routines have taken away. | | Involve him in the care plan. | Including him in the care plan treats him as a partner, and people who help set goals are more likely to follow them. | | Respect preferences. | Respecting his preferences, where safe, shows that his views count, which builds trust and reduces anger and refusal of care. | | Set small achievable tasks. | Small tasks he can finish successfully build confidence and show he can influence his situation, which counters passivity. **Expected outcomes** - Takes part in two care decisions daily. - Says he has some control. - Asks questions. **Linking the data to the diagnosis** The patient says, "Nobody asks me anything. They just decide." The nurse observes that he is passive, refuses some care, asks few questions and says he feels trapped. His sense of no control is present now, so this is an actual problem, linked to hospital routines. The plan aims to return some control through information, choices and involvement. The expected outcomes are that he takes part in two care decisions daily, says he has some control and asks questions.

CarePath diagnosis: Feeling no control over one's situation related to hospital routines, as evidenced by says no one asks me and passive.

Intervention	Rationale
Give information.	Clear information about his condition and care lets him understand what is happening, which reduces feeling trapped and helps him take part in decisions.
Offer choices.	Offering real choices, even small ones such as timing of care, gives back a sense of control that hospital routines have taken away.
Involve him in the care plan.	Including him in the care plan treats him as a partner, and people who help set goals are more likely to follow them.
Respect preferences.	Respecting his preferences, where safe, shows that his views count, which builds trust and reduces anger and refusal of care.
Set small achievable tasks.	Small tasks he can finish successfully build confidence and show he can influence his situation, which counters passivity.

Expected outcomes: Takes part in two care decisions daily. · Says he has some control. · Asks questions.

Linking the data: The patient says, "Nobody asks me anything. They just decide." The nurse observes that he is passive, refuses some care, asks few questions and says he feels trapped. His sense of no control is present now, so this is an actual problem, linked to hospital routines. The plan aims to return some control through information, choices and involvement. The expected outcomes are that he takes part in two care decisions daily, says he has some control and asks questions.

P6 Low self-worth

Group: Emotions and mind | Type: Actual problem

Definition: A negative view of oneself, often after illness, loss, or change.

Possible causes: Body change; job loss; illness; criticism; failure

Signs and symptoms: Negative self-talk; avoids eye contact; apologizes a lot; reluctant to try

Scenario. After a stroke, a former teacher says he is useless.

S: "I'm useless now."

O: Former teacher; avoids eye contact; says he is a burden; refuses to try tasks.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Low self-worth related to body change, as evidenced by negative self-talk and avoids eye contact. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Reflect strengths. | Naming the strengths he still has, such as his teaching skills, challenges the belief that he is useless and helps rebuild his sense of identity. | | Praise efforts. | Praising effort, not only results, encourages him to keep trying after a stroke when success may be slow. | | Give him a role in his care. | A role in his own care gives him purpose and responsibility, which counters feeling like a burden. | | Avoid shaming. | Shaming or teasing damages self-worth further and may lead him to withdraw, so avoiding it protects his dignity and trust. | | Set achievable goals. | Goals he can reach build a pattern of success, which gradually improves confidence and willingness to try tasks. | | Offer counseling if needed. | Counseling gives professional support for deep feelings about loss of role and ability, and can also help spot depression. | ****Expected outcomes**** - Within 1 week: names one strength, tries a task with support, shows a brighter mood. ****Linking the data to the diagnosis**** After a stroke, the former teacher says, "I'm useless now." The nurse notes he avoids eye contact, says he is a burden and refuses to try tasks. His negative view of himself is present now, so this is an actual problem related to body change. The plan aims, within 1 week, for him to name one strength, try a task with support and show a brighter mood, by reflecting strengths, praising efforts and giving him a role in his care.

CarePath diagnosis: Low self-worth related to body change, as evidenced by negative self-talk and avoids eye contact.

Intervention	Rationale
Reflect strengths.	Naming the strengths he still has, such as his teaching skills, challenges the belief that he is useless and helps rebuild his sense of identity.
Praise efforts.	Praising effort, not only results, encourages him to keep trying after a stroke when success may be slow.
Give him a role in his care.	A role in his own care gives him purpose and responsibility, which counters feeling like a burden.
Avoid shaming.	Shaming or teasing damages self-worth further and may lead him to withdraw, so avoiding it protects his dignity and trust.
Set achievable goals.	Goals he can reach build a pattern of success, which gradually improves confidence and willingness to try tasks.
Offer counseling if needed.	Counseling gives professional support for deep feelings about loss of role and ability, and can also help spot depression.

Expected outcomes: Within 1 week: names one strength, tries a task with support, shows a brighter mood.

Linking the data: After a stroke, the former teacher says, "I'm useless now." The nurse notes he avoids eye contact, says he is a burden and refuses to try tasks. His negative view of himself is present now, so this is an actual problem related to body change. The plan aims, within 1 week, for him to name one strength, try a task with support and show a brighter mood, by reflecting strengths, praising efforts and giving him a role in his care.

P7 Unhappy with body appearance

Group: Emotions and mind | Type: Actual problem

Definition: Distress about body changes from surgery, injury, illness, or aging.

Possible causes: Surgery; scars; hair loss; amputation; weight change; aging

Signs and symptoms: Hides the body; refuses to look; avoids mirrors; withdraws; negative comments

Scenario. After a mastectomy, a woman will not look at her scar.

S: "I can't look at myself."

O: After mastectomy; refuses to view the scar; covers her chest; avoids her partner.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Unhappy with body appearance related to surgery, as evidenced by hides the body and refuses to look. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Allow her to express feelings. | Being allowed to talk about grief over body change helps her process feelings, and feeling heard reduces shame and isolation. | | Support her at her own pace. | Letting her decide when to look or touch respects her control and avoids shock, which makes later acceptance more likely. | | Involve her partner. | Her partner is an important source of support, and including them can reduce her fear of rejection and ease intimacy concerns. | | Show options. | Information on prostheses, clothing, reconstruction or other options shows practical ways forward and can restore a sense of choice and confidence. | | Refer to a counselor or support group. | Counselors and peer groups offer experience and understanding from women with similar changes, which helps with long-term adjustment. ****Expected outcomes**** - Within 1-2 weeks: looks at the scar with support, discusses feelings, partner included. - States acceptance steps. ****Linking the data to the diagnosis**** After a mastectomy, the woman says, "I can't look at myself." The nurse sees that she refuses to view the scar, covers her chest and avoids her partner. These behaviors show she is already distressed about her body, so this is an actual problem related to surgery. The plan aims, within 1 to 2 weeks, for her to look at the scar with support, discuss her feelings, include her partner and state steps toward acceptance.

CarePath diagnosis: Unhappy with body appearance related to surgery, as evidenced by hides the body and refuses to look.

Intervention	Rationale
Allow her to express feelings.	Being allowed to talk about grief over body change helps her process feelings, and feeling heard reduces shame and isolation.
Support her at her own pace.	Letting her decide when to look or touch respects her control and avoids shock, which makes later acceptance more likely.
Involve her partner.	Her partner is an important source of support, and including them can reduce her fear of rejection and ease intimacy concerns.
Show options.	Information on prostheses, clothing, reconstruction or other options shows practical ways forward and can restore a sense of choice and confidence.
Refer to a counselor or support group.	Counselors and peer groups offer experience and understanding from women with similar changes, which helps with long-term adjustment.

Expected outcomes: Within 1-2 weeks: looks at the scar with support, discusses feelings, partner included. · States acceptance steps.

Linking the data: After a mastectomy, the woman says, "I can't look at myself." The nurse sees that she refuses to view the scar, covers her chest and avoids her partner. These behaviors show she is already distressed about her body, so this is an actual problem related to surgery. The plan aims, within 1 to 2 weeks, for her to look at the scar with support, discuss her feelings, include her partner and state steps toward acceptance.

P8 Sadness after a loss

Group: Emotions and mind | Type: Actual problem

Definition: A natural grief reaction to death, loss of health, or another loss.

Possible causes: Death of a loved one; loss of health; divorce; job loss

Signs and symptoms: Crying; sadness; numbness; sleep and appetite change; yearning

Scenario. A man cries often after his wife died last month.

S: "I miss her so much."

O: Cries often; sleeps poorly; weight down 3 kg; wife died last month.

Tools: CP-MIND, CP-FLUID · PHQ-9, GAD-7, C-SSRS, MUST, fluid chart, glucose ****CarePath diagnosis:**** Sadness after a loss related to death of a loved one, as evidenced by crying and sadness. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Listen. | Listening with full attention shows care and lets him talk about his wife, which is part of normal grieving and reduces loneliness. | | Allow tears. | Tears are a natural release of grief, and allowing them shows that his feelings are accepted rather than something to hide. | | Do not rush. | Grief runs at its own pace, and hurrying a person can make him feel misunderstood and block healthy mourning. | | Encourage rituals and support. | Rituals, faith practices and the support of others give structure and meaning during loss and help him feel connected. | | Watch for complicated grief. | Grief that stays severe, or comes with depression or risk of harm, needs different care, so watching for it allows early help. | | Refer when needed. | Specialist counselors or a doctor can support him if normal grief is not easing, or if his sleep, weight and function worsen. | ****Expected outcomes**** - Within 2-3 weeks: expresses grief openly, sleeps and eats better, names a support person. - No signs of complicated grief. ****Linking the data to the diagnosis**** The man says, "I miss her so much." His wife died last month, and the nurse records frequent crying, poor sleep and a weight loss of 3 kg. These are present now and fit a natural grief reaction, so this is an actual problem and not a risk. It is also not long-lasting grief, because only one month has passed. The plan aims, within 2 to 3 weeks, for him to express grief openly, sleep and eat better, name a support person and show no signs of complicated grief.

CarePath diagnosis: Sadness after a loss related to death of a loved one, as evidenced by crying and sadness.

Intervention	Rationale
Listen.	Listening with full attention shows care and lets him talk about his wife, which is part of normal grieving and reduces loneliness.
Allow tears.	Tears are a natural release of grief, and allowing them shows that his feelings are accepted rather than something to hide.
Do not rush.	Grief runs at its own pace, and hurrying a person can make him feel misunderstood and block healthy mourning.
Encourage rituals and support.	Rituals, faith practices and the support of others give structure and meaning during loss and help him feel connected.
Watch for complicated grief.	Grief that stays severe, or comes with depression or risk of harm, needs different care, so watching for it allows early help.
Refer when needed.	Specialist counselors or a doctor can support him if normal grief is not easing, or if his sleep, weight and function worsen.

Expected outcomes: Within 2-3 weeks: expresses grief openly, sleeps and eats better, names a support person. · No signs of complicated grief.

Linking the data: The man says, "I miss her so much." His wife died last month, and the nurse records frequent crying, poor sleep and a weight loss of 3 kg. These are present now and fit a natural grief reaction, so this is an actual problem and not a risk. It is also not long-lasting grief, because only one month has passed. The plan aims, within 2 to 3 weeks, for him to express grief openly, sleep and eat better, name a support person and show no signs of complicated grief.

P9 Risk of self-harm (needs urgent response) ⚠ URGENT

Group: Emotions and mind | Type: Risk problem

Definition: Thoughts or signs of wanting to end life or cause harm. Needs immediate safety steps and urgent specialist support.

Risk factors: Depression; previous attempt; loss; illness; substance use; access to means

Warning signs: Talk of death; hopelessness; giving away items; sudden calm; withdrawal

Scenario. A patient with depression, who lost his job two weeks ago, says everyone would be better off without him.

S: "Everyone would be better off without me."

O: Hopeless statements; withdrawn; history of depression; previous attempt two years ago; job loss two weeks ago; eating little.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Risk of self-harm related to depression, a previous attempt and recent job loss (risk factors), with hopeless statements and withdrawal (warning signs); needs urgent response. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Take every statement seriously and stay with the patient. | Every statement about wanting to die may signal real danger, and staying with the patient keeps him safe, shows he is valued and reduces the isolation that raises risk. | | Ask directly and kindly about thoughts of suicide and use the structured risk tool required by local policy. | Asking directly does not cause suicidal thoughts and gives permission to talk. A structured tool gives a consistent, policy-based measure of risk to guide the level of observation. | | Remove hazards and keep the patient under the observation level ordered. | Removing hazards limits access to means at a time of crisis, and the ordered observation level makes sure he is watched closely enough to stay safe. | | Alert the team and the doctor immediately and follow the safety policy. | Immediate alerting makes sure a doctor and team can assess risk and act quickly, and following policy makes sure the right protections are in place. | | Arrange urgent specialist mental health review. | A mental health specialist can assess depression and risk in depth and decide on treatment and the level of care he needs. | | Agree a written safety plan before discharge or transfer. | A written plan, made with him, sets out warning signs, coping steps and contacts, so he has a clear guide for moments of crisis after leaving. | ****Expected outcomes**** - Patient remains safe with no self-harm during the stay. - Urgent mental health review completed. - Patient helps write a safety plan and names two people or services to call. ****Linking the data to the diagnosis**** This is an urgent risk diagnosis, so the nurse calls for help and stays with the patient first. He has said, "Everyone would be better off without me," and is withdrawn, eating little and hopeless. Risk factors are depression, a previous attempt two years ago and job loss two weeks ago. Self-harm has not occurred, so the diagnosis rests on risk factors and warning signs, not on harm. The plan aims for safety during the stay, an urgent mental health review and a safety plan he helps write, naming two people or services to call.

CarePath diagnosis: Risk of self-harm related to depression, a previous attempt and recent job loss (risk factors), with hopeless statements and withdrawal (warning signs); needs urgent response.

Intervention	Rationale
Take every statement seriously and stay with the patient.	Every statement about wanting to die may signal real danger, and staying with the patient keeps him safe, shows he is valued and reduces the isolation that raises risk.
Ask directly and kindly about thoughts of suicide and use the structured risk tool required by local policy.	Asking directly does not cause suicidal thoughts and gives permission to talk. A structured tool gives a consistent, policy-based measure of risk to guide the level of observation.
Remove hazards and keep the patient under the observation level ordered.	Removing hazards limits access to means at a time of crisis, and the ordered observation level makes sure he is watched closely enough to stay safe.
Alert the team and the doctor immediately and follow the safety policy.	Immediate alerting makes sure a doctor and team can assess risk and act quickly, and following policy makes sure the right protections are in place.
Arrange urgent specialist mental health review.	A mental health specialist can assess depression and risk in depth and decide on treatment and the level of care he needs.
Agree a written safety plan before discharge or transfer.	A written plan, made with him, sets out warning signs, coping steps and contacts, so he has a clear guide for moments of crisis after leaving.

Expected outcomes: Patient remains safe with no self-harm during the stay. · Urgent mental health review completed. · Patient helps write a safety plan and names two people or services to call.

Linking the data: This is an urgent risk diagnosis, so the nurse calls for help and stays with the patient first. He has said, "Everyone would be better off without me," and is withdrawn, eating little and hopeless. Risk factors are depression, a previous attempt two years ago and job loss two weeks ago. Self-harm has not occurred, so the diagnosis rests on risk factors and warning signs, not on harm. The plan aims for safety during the stay, an urgent mental health review and a safety plan he helps write, naming two people or services to call.

P10 Distress after a frightening event

Group: Emotions and mind | Type: Actual problem

Definition: Flashbacks, nightmares, or feeling constantly on edge after trauma.

Possible causes: Accident; assault; war; disaster; abuse; sudden loss

Signs and symptoms: Flashbacks; nightmares; startling easily; avoiding reminders; irritability

Scenario. A road accident survivor wakes from nightmares sweating.

S: "I keep seeing the crash."

O: Nightmares nightly; startles at noise; avoids driving; sweating.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Distress after a frightening event related to accident, as evidenced by flashbacks and nightmares. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Create a safe place. | Feeling physically and emotionally safe calms the body's alarm system, which helps a person after trauma to relax and begin to heal. | | Listen without pushing. | Pushing someone to relive the event can worsen distress, so listening at his own pace builds trust and lets him share when ready. | | Teach grounding. | Grounding, such as focusing on the senses in the room, brings attention back to the present and can reduce the intensity of flashbacks. | | Encourage routine. | A predictable daily routine restores a sense of order and control and supports better sleep after a frightening event. | | Refer for trauma counseling. | Trauma-focused counselors use proven therapies to treat flashbacks and nightmares, which are more effective than routine support alone. | ****Expected outcomes**** - Within 4 weeks: sleeps through most nights, reports fewer flashbacks, uses grounding. - Accepts counseling. ****Linking the data to the diagnosis**** The road accident survivor says, "I keep seeing the crash." The nurse records nightly nightmares with sweating, startling at noise and avoidance of driving. These signs of ongoing distress are present now, so this is an actual problem related to the accident. The plan aims, within 4 weeks, for him to sleep through most nights, report fewer flashbacks, use grounding and accept counseling. Staff offer a safe place, listen without pushing and refer for trauma counseling to support recovery.

CarePath diagnosis: Distress after a frightening event related to accident, as evidenced by flashbacks and nightmares.

Intervention	Rationale
Create a safe place.	Feeling physically and emotionally safe calms the body's alarm system, which helps a person after trauma to relax and begin to heal.
Listen without pushing.	Pushing someone to relive the event can worsen distress, so listening at his own pace builds trust and lets him share when ready.
Teach grounding.	Grounding, such as focusing on the senses in the room, brings attention back to the present and can reduce the intensity of flashbacks.
Encourage routine.	A predictable daily routine restores a sense of order and control and supports better sleep after a frightening event.
Refer for trauma counseling.	Trauma-focused counselors use proven therapies to treat flashbacks and nightmares, which are more effective than routine support alone.

Expected outcomes: Within 4 weeks: sleeps through most nights, reports fewer flashbacks, uses grounding. · Accepts counseling.

Linking the data: The road accident survivor says, "I keep seeing the crash." The nurse records nightly nightmares with sweating, startling at noise and avoidance of driving. These signs of ongoing distress are present now, so this is an actual problem related to the accident. The plan aims, within 4 weeks, for him to sleep through most nights, report fewer flashbacks, use grounding and accept counseling. Staff offer a safe place, listen without pushing and refer for trauma counseling to support recovery.

P11 Confusion or memory problems

Group: Emotions and mind | Type: Actual problem

Definition: Ongoing trouble thinking clearly, remembering, or knowing time and place.

Possible causes: Dementia; stroke; infection; medicine; brain injury; poor sleep

Signs and symptoms: Forgets names and places; repeats questions; gets lost; wrong time of day

Scenario. An older man cannot remember that he is in hospital.

S: "Where am I?"

O: Disoriented to time and place; repeats questions; forgets names; safe when supervised.

Tools: CP-MIND, CP-OLDER · PHQ-9, GAD-7, C-SSRS, 4AT / CAM, Mini-Cog ****CarePath diagnosis:****

Confusion or memory problems related to dementia, as evidenced by forgets names and places and repeats questions. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Reorient gently. | Gentle reminders of where he is and who people are can reduce fear and confusion, and a calm tone keeps him from feeling corrected or distressed. | | Use clocks and calendars. | Visible clocks and calendars give him constant cues about time and day, which supports orientation without having to ask. | | Keep routines. | Familiar daily routines reduce the mental effort needed to cope and lower anxiety, because he knows what to expect. | | Use simple words. | Short, clear sentences are easier to process when thinking is affected, and they reduce misunderstanding and frustration. | | Keep the area safe. | A clutter-free, safe space lowers the chance of falls, wandering or injury in someone who may not recognize hazards. | | Involve family. | Familiar faces and personal items calm and orient him, and family can teach staff what works best for him. | ****Expected outcomes**** - Oriented using cues. - No wandering. - Safe in the environment. - Family states how to respond. ****Linking the data to the diagnosis**** The older man asks, "Where am I?" The nurse finds he is disoriented to time and place, repeats questions and forgets names, but is safe when supervised. These signs are persistent and linked to dementia, so this is an actual problem, not a risk, and it is not a sudden change. The plan aims for him to be oriented using cues, not wander, stay safe in his environment and have family who can state how to respond to his confusion.

CarePath diagnosis: Confusion or memory problems related to dementia, as evidenced by forgets names and places and repeats questions.

Intervention	Rationale
Reorient gently.	Gentle reminders of where he is and who people are can reduce fear and confusion, and a calm tone keeps him from feeling corrected or distressed.
Use clocks and calendars.	Visible clocks and calendars give him constant cues about time and day, which supports orientation without having to ask.
Keep routines.	Familiar daily routines reduce the mental effort needed to cope and lower anxiety, because he knows what to expect.
Use simple words.	Short, clear sentences are easier to process when thinking is affected, and they reduce misunderstanding and frustration.
Keep the area safe.	A clutter-free, safe space lowers the chance of falls, wandering or injury in someone who may not recognize hazards.
Involve family.	Familiar faces and personal items calm and orient him, and family can teach staff what works best for him.

Expected outcomes: Oriented using cues. · No wandering. · Safe in the environment. · Family states how to respond.

Linking the data: The older man asks, "Where am I?" The nurse finds he is disoriented to time and place, repeats questions and forgets names, but is safe when supervised. These signs are persistent and linked to dementia, so this is an actual problem, not a risk, and it is not a sudden change. The plan aims for him to be oriented using cues, not wander, stay safe in his environment and have family who can state how to respond to his confusion.

P12 Low mood

Group: Emotions and mind | Type: Actual problem

Definition: Persistent sadness, loss of interest, or tearfulness.

Possible causes: Illness; loss; isolation; chronic pain; medicines

Signs and symptoms: Sad; tearful; loss of interest; low energy; sleep and appetite change

Scenario. A woman after retirement stays in bed and cries easily.

S: "I don't enjoy anything anymore."

O: Tearful; stays in bed; poor appetite; not seeing friends; low energy.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Low mood related to illness, as evidenced by sad and tearful. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Listen. | Listening with patience shows that her feelings matter and reduces isolation, and talking may help her understand what she is experiencing. | | Encourage activity. | Gentle, achievable activity improves energy and mood and counters the pull to stay in bed, so it is introduced in small steps. | | Support routine. | A regular daily routine for sleep, meals and activity gives structure, which helps when low mood makes organizing the day difficult. | | Monitor for suicide risk. | Low mood can deepen into thoughts of self-harm, so monitoring and asking about it allows early help if risk appears. | | Refer to the doctor. | A doctor can check for depression or a medical cause and decide whether treatment such as therapy or medicine is needed. | | Offer social support. | Contact with friends and community reduces loneliness, which is a common driver of low mood after retirement. ****Expected outcomes**** - Within 1 week: takes part in one pleasant activity daily and mood improves. - No thoughts of self-harm. - Engaged with support. ****Linking the data to the diagnosis**** The woman says, "I don't enjoy anything anymore." The nurse sees her tearful, staying in bed, with poor appetite, low energy and no contact with friends. These signs of persistent low mood are present now, so this is an actual problem. Monitoring for suicide risk is part of the care, because low mood can worsen. The plan aims, within 1 week, for one pleasant activity daily, improved mood, no thoughts of self-harm and engagement with support.

CarePath diagnosis: Low mood related to illness, as evidenced by sad and tearful.

Intervention	Rationale
Listen.	Listening with patience shows that her feelings matter and reduces isolation, and talking may help her understand what she is experiencing.
Encourage activity.	Gentle, achievable activity improves energy and mood and counters the pull to stay in bed, so it is introduced in small steps.
Support routine.	A regular daily routine for sleep, meals and activity gives structure, which helps when low mood makes organizing the day difficult.
Monitor for suicide risk.	Low mood can deepen into thoughts of self-harm, so monitoring and asking about it allows early help if risk appears.
Refer to the doctor.	A doctor can check for depression or a medical cause and decide whether treatment such as therapy or medicine is needed.
Offer social support.	Contact with friends and community reduces loneliness, which is a common driver of low mood after retirement.

Expected outcomes: Within 1 week: takes part in one pleasant activity daily and mood improves. · No thoughts of self-harm. · Engaged with support.

Linking the data: The woman says, "I don't enjoy anything anymore." The nurse sees her tearful, staying in bed, with poor appetite, low energy and no contact with friends. These signs of persistent low mood are present now, so this is an actual problem. Monitoring for suicide risk is part of the care, because low mood can worsen. The plan aims, within 1 week, for one pleasant activity daily, improved mood, no thoughts of self-harm and engagement with support.

P13 Anger or aggression

Group: Emotions and mind | Type: Actual problem

Definition: Irritability or hostility that may escalate to harmful words or actions.

Possible causes: Frustration; pain; fear; confusion; substance use

Signs and symptoms: Shouting; clenched fists; irritability; blaming others

Scenario. A patient who waited hours shouts at staff and slams the door.

S: "I've been waiting for hours! This is useless!"

O: Shouting; slams the door; clenched fists; red face.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Anger or aggression related to frustration after a long wait, as evidenced by shouting, slamming the door, clenched fists, and a red face. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Stay calm. | A calm voice and body language lower tension, because an angry person often mirrors the energy around them, and staying calm helps prevent escalation. | | Give space. | Extra personal space reduces the feeling of being threatened or cornered and gives him room to cool down, which lowers the chance of violence. | | Listen. | Listening shows he is being taken seriously, and feeling heard often reduces anger faster than arguing or explaining. | | Address the cause. | Dealing with the real cause, such as the long wait or pain, removes the trigger, so the anger is less likely to return. | | Set limits kindly. | Firm but kind limits make clear what is not acceptable while respecting him, which keeps everyone safe without shaming him. | | Keep staff safe. | Staff safety comes first, so positioning, backup and a clear exit let them respond if anger escalates and protect other patients too. | ****Expected outcomes**** - Calms within 15 minutes. - No harm. - Expresses concern verbally. - Waiting times explained. ****Linking the data to the diagnosis**** The patient has waited for hours and is now shouting at staff, slamming the door, clenching his fists, and looks flushed. These behaviors are happening now, so the statement is actual, not a risk. The cause is frustration, not illness, so the nurse stays calm, listens, and deals with the reason for the wait. The plan aims to calm him within 15 minutes, keep everyone safe, and let him voice his concerns in words.

CarePath diagnosis: Anger or aggression related to frustration after a long wait, as evidenced by shouting, slamming the door, clenched fists, and a red face.

Intervention	Rationale
Stay calm.	A calm voice and body language lower tension, because an angry person often mirrors the energy around them, and staying calm helps prevent escalation.
Give space.	Extra personal space reduces the feeling of being threatened or cornered and gives him room to cool down, which lowers the chance of violence.
Listen.	Listening shows he is being taken seriously, and feeling heard often reduces anger faster than arguing or explaining.
Address the cause.	Dealing with the real cause, such as the long wait or pain, removes the trigger, so the anger is less likely to return.
Set limits kindly.	Firm but kind limits make clear what is not acceptable while respecting him, which keeps everyone safe without shaming him.
Keep staff safe.	Staff safety comes first, so positioning, backup and a clear exit let them respond if anger escalates and protect other patients too.

Expected outcomes: Calms within 15 minutes. · No harm. · Expresses concern verbally. · Waiting times explained.

Linking the data: The patient has waited for hours and is now shouting at staff, slamming the door, clenching his fists, and looks flushed. These behaviors are happening now, so the statement is actual, not a risk. The cause is frustration, not illness, so the nurse stays calm, listens, and deals with the reason for the wait. The plan aims to calm him within 15 minutes, keep everyone safe, and let him voice his concerns in words.

P14 Extreme mood swings

Group: Emotions and mind | Type: Actual problem

Definition: Rapid or intense changes in mood that are hard to control.

Possible causes: Mental illness; medicines; stress; brain disease

Signs and symptoms: Laughs then cries; sudden anger; cannot calm down; irritable

Scenario. A patient swings from joy to anger within minutes.

S: "I'm fine one minute and furious the next."

O: Laughs then shouts within minutes; irritable; cannot calm herself.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Extreme mood swings related to mental illness, as evidenced by laughs then cries and sudden anger. ****Interventions and rationale**** |

Intervention | Rationale | |---|---| | Stay calm and consistent. | A calm, steady and predictable approach gives a sense of stability when her own moods are changing quickly, and it avoids feeding the swings. | | Keep stimulation low. | Quiet surroundings with few demands reduce overstimulation, which can trigger or intensify sudden emotional changes. | | Teach coping. | Learning coping skills, such as pausing, breathing or using a quiet space, gives her tools to steady herself when a mood shifts. | | Give medicine as ordered. | Prescribed medicine can help stabilize mood, and giving it as ordered keeps treatment safe and effective. | | Report severe changes. | Severe changes may signal worsening illness, side effects or risk of harm, so reporting them allows prompt review and treatment changes. | ****Expected outcomes**** - Within 1 week: fewer mood swings, uses a calming strategy. - No harm to self or others. ****Linking the data to the diagnosis**** The patient says, "I'm fine one minute and furious the next." The nurse observes that she laughs and then shouts within minutes, is irritable and cannot calm herself. These intense, rapid changes are present now, so this is an actual problem related to mental illness, not a risk. The plan aims, within 1 week, for fewer mood swings and use of a calming strategy, with no harm to herself or others. Staff stay calm, reduce stimulation and give medicine as ordered.

CarePath diagnosis: Extreme mood swings related to mental illness, as evidenced by laughs then cries and sudden anger.

Intervention	Rationale
Stay calm and consistent.	A calm, steady and predictable approach gives a sense of stability when her own moods are changing quickly, and it avoids feeding the swings.
Keep stimulation low.	Quiet surroundings with few demands reduce overstimulation, which can trigger or intensify sudden emotional changes.
Teach coping.	Learning coping skills, such as pausing, breathing or using a quiet space, gives her tools to steady herself when a mood shifts.
Give medicine as ordered.	Prescribed medicine can help stabilize mood, and giving it as ordered keeps treatment safe and effective.
Report severe changes.	Severe changes may signal worsening illness, side effects or risk of harm, so reporting them allows prompt review and treatment changes.

Expected outcomes: Within 1 week: fewer mood swings, uses a calming strategy. · No harm to self or others.

Linking the data: The patient says, "I'm fine one minute and furious the next." The nurse observes that she laughs and then shouts within minutes, is irritable and cannot calm herself. These intense, rapid changes are present now, so this is an actual problem related to mental illness, not a risk. The plan aims, within 1 week, for fewer mood swings and use of a calming strategy, with no harm to herself or others. Staff stay calm, reduce stimulation and give medicine as ordered.

P15 Hearing or seeing things others do not

Group: Emotions and mind | Type: Actual problem

Definition: The person perceives voices or images that are not there.

Possible causes: Mental illness; withdrawal; fever; brain disease; drugs

Signs and symptoms: Talks to someone unseen; frightened; says he hears voices; distracted

Scenario. A patient covers his ears and says voices tell him to run.

S: "The voices are telling me to leave."

O: Covers ears; talks to an unseen person; frightened; paces.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Hearing or seeing things others do not related to mental illness, as evidenced by talks to someone unseen and frightened. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Do not argue. | Arguing about whether the voices are real can increase fear and mistrust, so accepting that they are real to him while not agreeing keeps trust. | | Reassure. | Calm reassurance that he is safe and not alone eases the fear that often comes with hearing voices. | | Ask about the voices and any commands. | Asking about what the voices say, especially commands to harm himself or others, shows how much risk there is and guides what safety steps are needed. | | Ensure safety. | A safe, low-stimulation environment lowers the chance of harm if he acts on fear or commands, such as trying to run. | | Report command voices. | Command voices can lead to dangerous actions, so the team needs to know quickly to assess risk and adjust observation and treatment. | | Give medicine as ordered. | Antipsychotic or other ordered medicine can reduce the voices and distress, and giving it as prescribed keeps treatment safe and effective. | ****Expected outcomes**** - Feels safe. - Commands not acted on. - Voices less distressing within days. - Takes medicine as ordered. ****Linking the data to the diagnosis**** The patient says, "The voices are telling me to leave." The nurse sees him cover his ears, talk to an unseen person, pace and appear frightened. He is experiencing perceptions that others do not, now, so this is an actual problem related to mental illness. The nurse asks about commands because they raise the risk of harm. The plan aims for him to feel safe, not act on commands, find the voices less distressing within days and take medicine as ordered.

CarePath diagnosis: Hearing or seeing things others do not related to mental illness, as evidenced by talks to someone unseen and frightened.

Intervention	Rationale
Do not argue.	Arguing about whether the voices are real can increase fear and mistrust, so accepting that they are real to him while not agreeing keeps trust.
Reassure.	Calm reassurance that he is safe and not alone eases the fear that often comes with hearing voices.
Ask about the voices and any commands.	Asking about what the voices say, especially commands to harm himself or others, shows how much risk there is and guides what safety steps are needed.
Ensure safety.	A safe, low-stimulation environment lowers the chance of harm if he acts on fear or commands, such as trying to run.
Report command voices.	Command voices can lead to dangerous actions, so the team needs to know quickly to assess risk and adjust observation and treatment.
Give medicine as ordered.	Antipsychotic or other ordered medicine can reduce the voices and distress, and giving it as prescribed keeps treatment safe and effective.

Expected outcomes: Feels safe. · Commands not acted on. · Voices less distressing within days. · Takes medicine as ordered.

Linking the data: The patient says, "The voices are telling me to leave." The nurse sees him cover his ears, talk to an unseen person, pace and appear frightened. He is experiencing perceptions that others do not, now, so this is an actual problem related to mental illness. The nurse asks about commands because they raise the risk of harm. The plan aims for him to feel safe, not act on commands, find the voices less distressing within days and take medicine as ordered.

P16 Suspicious or distorted thinking

Group: Emotions and mind | Type: Actual problem

Definition: Strong false beliefs or mistrust that do not match reality.

Possible causes: Psychosis; paranoia; substance use; dementia

Signs and symptoms: Believes people are plotting against him; refuses food or medicine; guarded

Scenario. A patient refuses meals saying the food is poisoned.

S: "The food is poisoned."

O: Refuses meals and medicines; guarded; eyes scan the room.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Suspicious or distorted thinking related to psychosis, as evidenced by believes people are plotting against him and refuses food or medicine.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Stay calm and honest. | Calm, honest communication reduces threat and builds trust, which is hard for someone who feels people are plotting against him. | | Do not argue. | Arguing with a fixed belief rarely changes it and may make him more fearful and guarded, so staying neutral protects the relationship. | | Keep routines. | Predictable routines reduce surprises that might feed suspicion and help him feel safer in an unfamiliar setting. | | Respect feelings. | Acknowledging that he feels afraid, without agreeing with the belief, shows empathy and helps him feel understood. | | Offer choices. | Offering choices, such as which meal or when to take medicine, restores some control and may make accepting food and medicine easier. | | Watch for risk. | Suspicion can lead to refusal of food or medicine, hostility or harm, so close watching allows early action to keep everyone safe. | ****Expected outcomes**** - Eats at least some meals. - Accepts medicines. - Trusts staff gradually. - No aggression. ****Linking the data to the diagnosis**** The patient says, "The food is poisoned." The nurse notes he refuses meals and medicines, is guarded and scans the room with his eyes. The strong false belief is present now and affects his care, so this is an actual problem related to psychosis. The plan aims for him to eat at least some meals, accept medicines, gradually trust staff and show no aggression. Staff stay calm and honest, avoid arguing, keep routines and offer choices.

CarePath diagnosis: Suspicious or distorted thinking related to psychosis, as evidenced by believes people are plotting against him and refuses food or medicine.

Intervention	Rationale
Stay calm and honest.	Calm, honest communication reduces threat and builds trust, which is hard for someone who feels people are plotting against him.
Do not argue.	Arguing with a fixed belief rarely changes it and may make him more fearful and guarded, so staying neutral protects the relationship.
Keep routines.	Predictable routines reduce surprises that might feed suspicion and help him feel safer in an unfamiliar setting.
Respect feelings.	Acknowledging that he feels afraid, without agreeing with the belief, shows empathy and helps him feel understood.
Offer choices.	Offering choices, such as which meal or when to take medicine, restores some control and may make accepting food and medicine easier.
Watch for risk.	Suspicion can lead to refusal of food or medicine, hostility or harm, so close watching allows early action to keep everyone safe.

Expected outcomes: Eats at least some meals. · Accepts medicines. · Trusts staff gradually. · No aggression.

Linking the data: The patient says, "The food is poisoned." The nurse notes he refuses meals and medicines, is guarded and scans the room with his eyes. The strong false belief is present now and affects his care, so this is an actual problem related to psychosis. The plan aims for him to eat at least some meals, accept medicines, gradually trust staff and show no aggression. Staff stay calm and honest, avoid arguing, keep routines and offer choices.

P17 Poor concentration

Group: Emotions and mind | Type: Actual problem

Definition: Difficulty keeping attention on tasks, conversations, or instructions.

Possible causes: Stress; illness; poor sleep; pain; ADHD; medicines

Signs and symptoms: Easily distracted; forgets instructions; cannot finish tasks

Scenario. A student after a head injury cannot follow a lesson.

S: "I can't focus on anything."

O: After head injury; cannot follow a lesson; forgets instructions; fatigue.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Poor concentration related to head injury and fatigue, as evidenced by being unable to follow a lesson, being easily distracted, and forgetting instructions. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give short clear instructions. | Short, clear instructions fit a reduced attention span and are easier to remember, which lowers frustration and mistakes. | | Reduce distractions. | Noise and clutter compete for limited attention, so a quiet, simple space helps him focus on one thing at a time. | | Repeat. | Repeating information gives more chances for it to be taken in and remembered when memory and attention are weak. | | Break tasks into steps. | Smaller steps make a task less overwhelming and let him finish and feel success, which builds focus and confidence. | | Allow rest. | Fatigue worsens concentration, and the brain needs rest to recover after injury, so planned breaks let him do better in the next task. | | Refer if it persists. | Persisting problems may show a lasting injury or another cause that needs specialist assessment and treatment. | ****Expected outcomes**** - Follows a 3-step instruction and completes a short task with support. - Concentration improves over weeks. ****Linking the data to the diagnosis**** The student says, "I can't focus on anything." After a head injury, the nurse notes he cannot follow a lesson, forgets instructions and has fatigue. These difficulties are present now, so this is an actual problem rather than a risk. The listed cause is stress, but the data also point to the head injury and tiredness. The plan aims for him to follow a 3-step instruction and complete a short task with support, with concentration improving over weeks. Staff give short instructions, cut distractions and allow rest.

CarePath diagnosis: Poor concentration related to head injury and fatigue, as evidenced by being unable to follow a lesson, being easily distracted, and forgetting instructions.

Intervention	Rationale
Give short clear instructions.	Short, clear instructions fit a reduced attention span and are easier to remember, which lowers frustration and mistakes.
Reduce distractions.	Noise and clutter compete for limited attention, so a quiet, simple space helps him focus on one thing at a time.
Repeat.	Repeating information gives more chances for it to be taken in and remembered when memory and attention are weak.
Break tasks into steps.	Smaller steps make a task less overwhelming and let him finish and feel success, which builds focus and confidence.
Allow rest.	Fatigue worsens concentration, and the brain needs rest to recover after injury, so planned breaks let him do better in the next task.
Refer if it persists.	Persisting problems may show a lasting injury or another cause that needs specialist assessment and treatment.

Expected outcomes: Follows a 3-step instruction and completes a short task with support. · Concentration improves over weeks.

Linking the data: The student says, "I can't focus on anything." After a head injury, the nurse notes he cannot follow a lesson, forgets instructions and has fatigue. These difficulties are present now, so this is an actual problem rather than a risk. The listed cause is stress, but the data also point to the head injury and tiredness. The plan aims for him to follow a 3-step instruction and complete a short task with support, with concentration improving over weeks. Staff give short instructions, cut distractions and allow rest.

P18 Sudden confusion URGENT

Group: Emotions and mind | Type: Actual problem

Definition: An abrupt change in awareness or thinking, often from infection, medicine, or acute illness.

Possible causes: Infection; dehydration; medicines; surgery; low oxygen; pain

Signs and symptoms: Sudden disorientation; restlessness; drowsiness; hallucinations; symptoms that come and go

Scenario. An older man becomes confused on day 2 after surgery.

S: "Who are you? Where am I?"

O: Day 2 after surgery; sudden confusion; temperature 38.5 C; hallucinating at night.

Tools: CP-MIND, CP-OLDER, CP-INFECT · PHQ-9, GAD-7, C-SSRS, 4AT / CAM, Mini-Cog, qSOFA / sepsis screen
CarePath diagnosis: Sudden confusion related to infection, as evidenced by sudden disorientation and restlessness.
Interventions and rationale: | Intervention | Rationale | |---|---| | Look for the cause. | Sudden confusion is usually a sign of an underlying problem such as infection, pain or low oxygen, so finding and treating the cause is the key to recovery. | | Check vital signs and blood sugar. | Changes in temperature, pulse, blood pressure, oxygen or blood sugar can show infection or other reversible causes that need treatment. | | Reorient. | Gentle reminders of place, time and people reduce fear and help him make sense of his surroundings, without arguing or confronting him. | | Keep safe. | Confusion raises the risk of falls, pulling out tubes and wandering, so close supervision and a safe space prevent injury. | | Avoid restraints. | Restraints increase agitation, injury and the length of confusion, so less restrictive ways to keep him safe are preferred. | | Have family present. | Familiar faces and voices calm and orient him, which can reduce fear and agitation. | | Report quickly. | Sudden confusion can signal a serious illness, so prompt reporting lets the doctor start treatment quickly.
Expected outcomes - Within 24-48 hours: oriented, cause treated, no falls or injuries, sleeps at night.
Linking the data to the diagnosis On day 2 after surgery, the older man asks, "Who are you? Where am I?" The nurse records sudden confusion, a temperature of 38.5 C and hallucinations at night. The abrupt change and likely infection set this apart from ongoing confusion or memory problems, which develop slowly. It is an actual problem, and the nurse reports quickly. The plan aims, within 24 to 48 hours, for him to be oriented, the cause treated, no falls or injuries and sleep at night.

CarePath diagnosis: Sudden confusion related to infection, as evidenced by sudden disorientation and restlessness.

Intervention	Rationale
Look for the cause.	Sudden confusion is usually a sign of an underlying problem such as infection, pain or low oxygen, so finding and treating the cause is the key to recovery.
Check vital signs and blood sugar.	Changes in temperature, pulse, blood pressure, oxygen or blood sugar can show infection or other reversible causes that need treatment.
Reorient.	Gentle reminders of place, time and people reduce fear and help him make sense of his surroundings, without arguing or confronting him.
Keep safe.	Confusion raises the risk of falls, pulling out tubes and wandering, so close supervision and a safe space prevent injury.
Avoid restraints.	Restraints increase agitation, injury and the length of confusion, so less restrictive ways to keep him safe are preferred.
Have family present.	Familiar faces and voices calm and orient him, which can reduce fear and agitation.
Report quickly.	Sudden confusion can signal a serious illness, so prompt reporting lets the doctor start treatment quickly.

Expected outcomes: Within 24-48 hours: oriented, cause treated, no falls or injuries, sleeps at night.

Linking the data: On day 2 after surgery, the older man asks, "Who are you? Where am I?" The nurse records sudden confusion, a temperature of 38.5 C and hallucinations at night. The abrupt change and likely infection set this apart from ongoing confusion or memory problems, which develop slowly. It is an actual problem, and the nurse reports quickly. The plan aims, within 24 to 48 hours, for him to be oriented, the cause treated, no falls or injuries and sleep at night.

P19 Difficulty making decisions

Group: Emotions and mind | Type: Actual problem

Definition: The person is unsure which care option to choose or is torn between choices.

Possible causes: Complex choices; fear; conflicting advice; lack of information

Signs and symptoms: Hesitates; asks many questions; changes mind; distress

Scenario. A woman cannot choose between surgery and medicine.

S: "I don't know if I should have the surgery."

O: Asks many questions; changes her mind; tearful; family disagrees.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Difficulty making decisions related to complex choices, as evidenced by hesitates and asks many questions. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give balanced information. | Fair, balanced facts about benefits and risks of each option let her compare them clearly rather than being pushed toward one. | | Explore her values. | Exploring what matters most to her, such as family, comfort or independence, helps her connect the choice to her own values. | | Allow time. | Rushing a big decision increases stress and regret, so time to think and ask questions supports a choice she is comfortable with. | | Involve family. | Family are part of her support, and including them can ease conflict and let everyone hear the same information, while her wishes stay central. | | Refer to a counselor. | A counselor can help her work through fear and mixed feelings that make it hard to choose. | | Support her decision. | Supporting her decision respects her right to decide about her own care and builds trust, even if others would choose differently. | ****Expected outcomes**** - Within 48 hours: understands options, states her decision and reasons, feels supported. ****Linking the data to the diagnosis**** The woman says, "I don't know if I should have the surgery." The nurse observes that she asks many questions, changes her mind, is tearful and has family who disagree. The difficulty in choosing is present now, so this is an actual problem rather than a risk. The plan aims, within 48 hours, for her to understand her options, state her decision and her reasons, and feel supported. Staff give balanced information, allow time and support whichever choice she makes.

CarePath diagnosis: Difficulty making decisions related to complex choices, as evidenced by hesitates and asks many questions.

Intervention	Rationale
Give balanced information.	Fair, balanced facts about benefits and risks of each option let her compare them clearly rather than being pushed toward one.
Explore her values.	Exploring what matters most to her, such as family, comfort or independence, helps her connect the choice to her own values.
Allow time.	Rushing a big decision increases stress and regret, so time to think and ask questions supports a choice she is comfortable with.
Involve family.	Family are part of her support, and including them can ease conflict and let everyone hear the same information, while her wishes stay central.
Refer to a counselor.	A counselor can help her work through fear and mixed feelings that make it hard to choose.
Support her decision.	Supporting her decision respects her right to decide about her own care and builds trust, even if others would choose differently.

Expected outcomes: Within 48 hours: understands options, states her decision and reasons, feels supported.

Linking the data: The woman says, "I don't know if I should have the surgery." The nurse observes that she asks many questions, changes her mind, is tearful and has family who disagree. The difficulty in choosing is present now, so this is an actual problem rather than a risk. The plan aims, within 48 hours, for her to understand her options, state her decision and her reasons, and feel supported. Staff give balanced information, allow time and support whichever choice she makes.

P20 Trouble controlling impulses

Group: Emotions and mind | Type: Actual problem

Definition: The person acts without thinking in ways that risk harm.

Possible causes: Mental illness; brain injury; substance use; stress

Signs and symptoms: Acts before thinking; breaks rules; risky actions

Scenario. A patient leaves the ward repeatedly without telling staff.

S: "I just wanted some fresh air."

O: Leaves the ward repeatedly; acts on urges; ignores rules.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Trouble controlling impulses related to mental illness, as evidenced by acts before thinking and breaks rules. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Set clear limits. | Clear, consistent limits show what is expected and keep him safe, because acting on urges without boundaries can lead to harm. | | Teach coping. | Teaching ways to pause and manage urges, such as delaying or using a calming activity, gives him a safer choice in the moment. | | Reward self-control. | Positive feedback for self-control strengthens the behavior and builds confidence, which works better than punishment. | | Supervise. | Supervision lowers the chance of unsafe leaving, such as wandering off the ward, while he is still learning to control urges. | | Give medicine as ordered. | Ordered medicine may reduce impulsive urges linked to mental illness, and giving it as prescribed supports safety and treatment. | ****Expected outcomes**** - No unsafe leaving. - Uses a plan to manage urges. - Follows ward rules for 48 hours. ****Linking the data to the diagnosis**** The patient who leaves the ward repeatedly says, "I just wanted some fresh air." The nurse notes that he acts on urges and ignores rules, so poor impulse control is already causing unsafe behavior and is an actual problem. The plan aims for no unsafe leaving, use of a plan to manage urges and following ward rules for 48 hours. Staff set clear limits, supervise, teach coping skills and give medicine as ordered.

CarePath diagnosis: Trouble controlling impulses related to mental illness, as evidenced by acts before thinking and breaks rules.

Intervention	Rationale
Set clear limits.	Clear, consistent limits show what is expected and keep him safe, because acting on urges without boundaries can lead to harm.
Teach coping.	Teaching ways to pause and manage urges, such as delaying or using a calming activity, gives him a safer choice in the moment.
Reward self-control.	Positive feedback for self-control strengthens the behavior and builds confidence, which works better than punishment.
Supervise.	Supervision lowers the chance of unsafe leaving, such as wandering off the ward, while he is still learning to control urges.
Give medicine as ordered.	Ordered medicine may reduce impulsive urges linked to mental illness, and giving it as prescribed supports safety and treatment.

Expected outcomes: No unsafe leaving. · Uses a plan to manage urges. · Follows ward rules for 48 hours.

Linking the data: The patient who leaves the ward repeatedly says, "I just wanted some fresh air." The nurse notes that he acts on urges and ignores rules, so poor impulse control is already causing unsafe behavior and is an actual problem. The plan aims for no unsafe leaving, use of a plan to manage urges and following ward rules for 48 hours. Staff set clear limits, supervise, teach coping skills and give medicine as ordered.

P21 Dependence on alcohol or drugs

Group: Emotions and mind | Type: Actual problem

Definition: Regular substance use that harms health or daily life.

Possible causes: Repeated use; stress; peer pressure; mental illness; easy access

Signs and symptoms: Cravings; failed attempts to quit; neglected duties; tolerance; secrecy

Scenario. A patient drinks daily and cannot stop despite liver problems.

S: "I can stop whenever I want."

O: Daily drinking; high liver tests; shaky in the morning; failed quit attempts.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Dependence on alcohol or drugs related to repeated use, as evidenced by cravings and failed attempts to quit. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess without judging. | A nonjudgmental approach encourages honest answers about use, which gives an accurate picture and keeps him engaged in care. | | Monitor for withdrawal. | Stopping alcohol suddenly can cause dangerous withdrawal, such as tremor, seizures or confusion, so early signs need to be spotted and treated. | | Motivate. | Motivational support helps him see for himself how drinking affects his liver and life, which is more effective than being told to stop. | | Refer to treatment. | Specialist addiction services offer treatment and long-term support that ward care alone cannot provide. | | Teach harm reduction. | Harm reduction advice lowers the risk of serious damage while he is still using, and it keeps the door open for treatment. | | Support the family. | Family are affected by dependence and are often a key support, so helping them improves his chances of recovery. | ****Expected outcomes**** - States a plan to cut down. - Completes detox safely. - Agrees to a treatment referral. - No withdrawal complications. ****Linking the data to the diagnosis**** The patient says, "I can stop whenever I want," yet drinks daily, has high liver tests, is shaky in the morning and has failed quit attempts. These signs show ongoing dependence now, so this is an actual problem, not a risk. It is not yet withdrawal, though the nurse monitors for it. The plan aims for him to state a plan to cut down, complete detox safely, agree to a treatment referral and avoid withdrawal complications.

CarePath diagnosis: Dependence on alcohol or drugs related to repeated use, as evidenced by cravings and failed attempts to quit.

Intervention	Rationale
Assess without judging.	A nonjudgmental approach encourages honest answers about use, which gives an accurate picture and keeps him engaged in care.
Monitor for withdrawal.	Stopping alcohol suddenly can cause dangerous withdrawal, such as tremor, seizures or confusion, so early signs need to be spotted and treated.
Motivate.	Motivational support helps him see for himself how drinking affects his liver and life, which is more effective than being told to stop.
Refer to treatment.	Specialist addiction services offer treatment and long-term support that ward care alone cannot provide.
Teach harm reduction.	Harm reduction advice lowers the risk of serious damage while he is still using, and it keeps the door open for treatment.
Support the family.	Family are affected by dependence and are often a key support, so helping them improves his chances of recovery.

Expected outcomes: States a plan to cut down. · Completes detox safely. · Agrees to a treatment referral. · No withdrawal complications.

Linking the data: The patient says, "I can stop whenever I want," yet drinks daily, has high liver tests, is shaky in the morning and has failed quit attempts. These signs show ongoing dependence now, so this is an actual problem, not a risk. It is not yet withdrawal, though the nurse monitors for it. The plan aims for him to state a plan to cut down, complete detox safely, agree to a treatment referral and avoid withdrawal complications.

P22 Withdrawal symptoms

Group: Emotions and mind | Type: Actual problem

Definition: Shaking, sweating, agitation, or cravings after stopping a substance.

Possible causes: Stopping alcohol or drugs; reduced doses

Signs and symptoms: Shaking; sweating; anxiety; vomiting; seizures; confusion; fast pulse

Scenario. A heavy drinker admitted for surgery develops tremors on day 2.

S: "I feel terrible and I'm shaking."

O: Tremor; sweating; pulse 112/min; anxious; day 2 after admission; heavy drinker.

Tools: CP-MIND, CP-BREATH · PHQ-9, GAD-7, C-SSRS, NEWS2, SpO₂, ECG ****CarePath diagnosis:****

Withdrawal symptoms related to stopping alcohol or drugs, as evidenced by shaking and sweating.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use a withdrawal scale. | A withdrawal scale gives a consistent score of symptom severity, which guides when and how much medicine is needed. | | Give medicines as ordered. | Ordered medicines calm the overactive nervous system and reduce the risk of seizures and confusion, and giving them as prescribed keeps doses safe. | | Monitor vital signs. | Pulse, blood pressure, temperature and other signs can show worsening withdrawal early, so changes can be treated before they become dangerous. | | Keep a safe quiet room. | A quiet, safe, low-stimulation room reduces agitation and the chance of injury if he becomes shaky, confused or has a seizure. | | Report seizures or confusion urgently. | Seizures and confusion are serious complications that need immediate medical treatment, so they must be reported urgently. | ****Expected outcomes**** - Within 72 hours: withdrawal symptoms controlled, no seizures, vital signs stable, patient safe. ****Linking the data to the diagnosis**** The heavy drinker admitted for surgery says, "I feel terrible and I'm shaking." On day 2 the nurse records tremor, sweating, a pulse of 112/min and anxiety. These signs appeared after stopping alcohol, so this is an actual problem, not the underlying dependence. The nurse reports seizures or confusion urgently. The plan aims, within 72 hours, for controlled symptoms, no seizures, stable vital signs and a safe patient.

CarePath diagnosis: Withdrawal symptoms related to stopping alcohol or drugs, as evidenced by shaking and sweating.

Intervention	Rationale
Use a withdrawal scale.	A withdrawal scale gives a consistent score of symptom severity, which guides when and how much medicine is needed.
Give medicines as ordered.	Ordered medicines calm the overactive nervous system and reduce the risk of seizures and confusion, and giving them as prescribed keeps doses safe.
Monitor vital signs.	Pulse, blood pressure, temperature and other signs can show worsening withdrawal early, so changes can be treated before they become dangerous.
Keep a safe quiet room.	A quiet, safe, low-stimulation room reduces agitation and the chance of injury if he becomes shaky, confused or has a seizure.
Report seizures or confusion urgently.	Seizures and confusion are serious complications that need immediate medical treatment, so they must be reported urgently.

Expected outcomes: Within 72 hours: withdrawal symptoms controlled, no seizures, vital signs stable, patient safe.

Linking the data: The heavy drinker admitted for surgery says, "I feel terrible and I'm shaking." On day 2 the nurse records tremor, sweating, a pulse of 112/min and anxiety. These signs appeared after stopping alcohol, so this is an actual problem, not the underlying dependence. The nurse reports seizures or confusion urgently. The plan aims, within 72 hours, for controlled symptoms, no seizures, stable vital signs and a safe patient.

P23 Harmful eating behaviors

Group: Emotions and mind | Type: Actual problem

Definition: Eating patterns such as severe restriction, bingeing, or purging that harm health.

Possible causes: Body image problems; stress; need for control; perfectionism

Signs and symptoms: Severe restriction; bingeing or purging; weight loss; secrecy; fear of gaining weight

Scenario. A teenager skips meals and exercises excessively.

S: "I'm too fat."

O: Teen skipping meals; BMI 16; weight down 8 kg; excessive exercise; secretive about food.

Tools: CP-MIND, CP-FLUID · PHQ-9, GAD-7, C-SSRS, MUST, fluid chart, glucose ****CarePath diagnosis:**** Harmful eating behaviors related to body image problems, as evidenced by skipped meals, excessive exercise, BMI 16, and weight down 8 kg. ****Interventions and rationale**** | Intervention | Rationale |
|---|---| | Build trust. | Trust is the base of care for eating problems, because a person who feels judged tends to hide behaviors and resist help. | | Supervise meals as planned. | Supervised meals make sure planned food is eaten and help her feel supported, which lowers anxiety and the chance of hiding or discarding food. | | Avoid blame. | Blame increases shame and secrecy, so a neutral, caring tone helps her stay engaged in treatment. | | Monitor vital signs and labs. | Severe restriction and weight loss can affect heart rate, blood pressure and body chemicals, so checking them finds danger early. | | Refer to a specialist team. | Specialist teams have training in treating eating disorders and offer therapy, nutrition and medical care together. | | Involve family. | Family can support meals and recovery at home, and including them helps everyone understand and respond well. | ****Expected outcomes**** - Eats planned meals. - Weight stabilizes within 2 weeks. - Vital signs stable. - Accepts specialist care. ****Linking the data to the diagnosis**** The teenager says, "I'm too fat," while skipping meals and exercising excessively. The nurse records a BMI of 16, an 8 kg weight loss and secrecy about food. These signs show harmful eating is present now and already affecting health, so this is an actual problem. The data describe restriction and over-exercise, not bingeing or purging. The plan aims for her to eat planned meals, have weight stabilize within 2 weeks, keep stable vital signs and accept specialist care.

CarePath diagnosis: Harmful eating behaviors related to body image problems, as evidenced by skipped meals, excessive exercise, BMI 16, and weight down 8 kg.

Intervention	Rationale
Build trust.	Trust is the base of care for eating problems, because a person who feels judged tends to hide behaviors and resist help.
Supervise meals as planned.	Supervised meals make sure planned food is eaten and help her feel supported, which lowers anxiety and the chance of hiding or discarding food.
Avoid blame.	Blame increases shame and secrecy, so a neutral, caring tone helps her stay engaged in treatment.
Monitor vital signs and labs.	Severe restriction and weight loss can affect heart rate, blood pressure and body chemicals, so checking them finds danger early.
Refer to a specialist team.	Specialist teams have training in treating eating disorders and offer therapy, nutrition and medical care together.
Involve family.	Family can support meals and recovery at home, and including them helps everyone understand and respond well.

Expected outcomes: Eats planned meals. · Weight stabilizes within 2 weeks. · Vital signs stable. · Accepts specialist care.

Linking the data: The teenager says, "I'm too fat," while skipping meals and exercising excessively. The nurse records a BMI of 16, an 8 kg weight loss and secrecy about food. These signs show harmful eating is present now and already affecting health, so this is an actual problem. The data describe restriction and over-exercise, not bingeing or purging. The plan aims for her to eat planned meals, have weight stabilize within 2 weeks, keep stable vital signs and accept specialist care.

P24 Self-injury

Group: Emotions and mind | Type: Actual problem

Definition: Deliberately hurting oneself. Needs safe, nonjudgmental care and specialist support.

Possible causes: Emotional pain; trauma; shame; mental illness; need for relief

Signs and symptoms: Cuts or burns; hiding wounds; secrecy; long sleeves in hot weather

Scenario. A teenager has fresh cuts on her arms.

S: "I do it to feel something."

O: Fresh cuts on the forearms; wears long sleeves; avoids discussing.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Self-injury related to emotional pain, as evidenced by cuts or burns and hiding wounds. ****Interventions and rationale**** | Intervention | Rationale |
|---|---| | Treat wounds calmly. | Calm, prompt wound care treats injury and shows the patient that she is cared for, which helps her stay open to talking. | | Do not judge. | Judgment can increase shame, which often drives self-injury, so a kind approach keeps her willing to trust and accept help. | | Assess safety and suicide risk. | Self-injury can occur alongside thoughts of suicide, so assessing safety and risk makes sure she gets the right level of protection. | | Teach safe coping. | Safer ways to cope with strong feelings give her alternatives to use when the urge to hurt herself comes up. | | Involve the mental health team. | Mental health professionals can treat the emotional pain behind self-injury and plan longer-term care. | | Limit access to means. | Reducing access to things that could be used for harm lowers the chance of injury during moments of distress. | ****Expected outcomes**** - Wounds heal. - Patient remains safe. - Names two safer coping skills. - Engages with the mental health team. ****Linking the data to the diagnosis**** The teenager has fresh cuts on her forearms, wears long sleeves and avoids discussing them, saying, "I do it to feel something." The harm has already happened, so this is an actual problem, not a risk. The nurse treats wounds, shows no judgment and assesses safety and suicide risk. The plan aims for wounds to heal, the patient to stay safe, name two safer coping skills and engage with the mental health team.

CarePath diagnosis: Self-injury related to emotional pain, as evidenced by cuts or burns and hiding wounds.

Intervention	Rationale
Treat wounds calmly.	Calm, prompt wound care treats injury and shows the patient that she is cared for, which helps her stay open to talking.
Do not judge.	Judgment can increase shame, which often drives self-injury, so a kind approach keeps her willing to trust and accept help.
Assess safety and suicide risk.	Self-injury can occur alongside thoughts of suicide, so assessing safety and risk makes sure she gets the right level of protection.
Teach safe coping.	Safer ways to cope with strong feelings give her alternatives to use when the urge to hurt herself comes up.
Involve the mental health team.	Mental health professionals can treat the emotional pain behind self-injury and plan longer-term care.
Limit access to means.	Reducing access to things that could be used for harm lowers the chance of injury during moments of distress.

Expected outcomes: Wounds heal. · Patient remains safe. · Names two safer coping skills. · Engages with the mental health team.

Linking the data: The teenager has fresh cuts on her forearms, wears long sleeves and avoids discussing them, saying, "I do it to feel something." The harm has already happened, so this is an actual problem, not a risk. The nurse treats wounds, shows no judgment and assesses safety and suicide risk. The plan aims for wounds to heal, the patient to stay safe, name two safer coping skills and engage with the mental health team.

P25 Guilt or shame

Group: Emotions and mind | Type: Actual problem

Definition: Painful feelings of blame or inadequacy about illness or past events.

Possible causes: Past events; blaming oneself for illness; cultural beliefs; family conflict

Signs and symptoms: Self-blame; frequent apologies; withdrawn; fear of judgment

Scenario. A man blames himself for his own heart attack.

S: "It's my fault I had the heart attack."

O: Self-blame; apologizes constantly; avoids family.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS **CarePath diagnosis:** Guilt or shame related to past events, as evidenced by self-blame and frequent apologies. **Interventions and rationale** | Intervention | Rationale | | Listen. | Listening without interrupting lets him express painful feelings and shows that he is respected, which can ease shame. | | Correct unfair self-blame gently. | Gently pointing out that a heart attack has many causes and is not a personal failing counters unfair self-blame and reduces guilt. | | Encourage forgiveness. | Forgiveness of oneself helps people move forward and focus on recovery and healthy changes rather than on past events. | | Offer a chaplain or counselor if needed. | A chaplain or counselor can offer spiritual or professional support for deep guilt that is beyond what routine care can address. **Expected outcomes** - States less self-blame. - Accepts support. - Shares feelings with a counselor or chaplain. **Linking the data to the diagnosis** The man says, "It's my fault I had the heart attack." The nurse notes self-blame, constant apologizing and avoidance of family. These signs of painful guilt are present now, so this is an actual problem related to past events. The plan aims for him to state less self-blame, accept support and share his feelings with a counselor or chaplain. The nurse listens, gently corrects unfair blame and encourages forgiveness, so he can focus on recovery.

CarePath diagnosis: Guilt or shame related to past events, as evidenced by self-blame and frequent apologies.

Intervention	Rationale
Listen.	Listening without interrupting lets him express painful feelings and shows that he is respected, which can ease shame.
Correct unfair self-blame gently.	Gently pointing out that a heart attack has many causes and is not a personal failing counters unfair self-blame and reduces guilt.
Encourage forgiveness.	Forgiveness of oneself helps people move forward and focus on recovery and healthy changes rather than on past events.
Offer a chaplain or counselor if needed.	A chaplain or counselor can offer spiritual or professional support for deep guilt that is beyond what routine care can address.

Expected outcomes: States less self-blame. · Accepts support. · Shares feelings with a counselor or chaplain.

Linking the data: The man says, "It's my fault I had the heart attack." The nurse notes self-blame, constant apologizing and avoidance of family. These signs of painful guilt are present now, so this is an actual problem related to past events. The plan aims for him to state less self-blame, accept support and share his feelings with a counselor or chaplain. The nurse listens, gently corrects unfair blame and encourages forgiveness, so he can focus on recovery.

P26 Long-lasting grief

Group: Emotions and mind | Type: Actual problem

Definition: Grief that stays intense for a long time and blocks daily functioning.

Possible causes: Sudden death; no support; unresolved conflict; trauma

Signs and symptoms: Intense grief lasting beyond a year; cannot function; stuck on the past; withdrawal

Scenario. A woman is still unable to work two years after her child's death.

S: "I can't go on without my child."

O: Two years after loss; cannot work; still grieving intensely; isolated.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Long-lasting grief related to sudden death, as evidenced by intense grief lasting beyond a year and cannot function. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Acknowledge the pain. | Naming and respecting the depth of the loss tells her that her grief is real and valid, which reduces isolation. | | Offer grief counseling. | Grief counselors are trained to help with grief that stays intense and blocks daily life, using approaches beyond ordinary support. | | Encourage support groups. | Other bereaved parents understand her loss and can offer shared experience and hope, which reduces loneliness. | | Monitor for depression. | Long-lasting grief increases the risk of depression, so watching for it allows early treatment and protects her health. | | Involve family. | Family can provide ongoing comfort and practical help, and including them helps them understand what she is going through. | ****Expected outcomes**** - Attends grief counseling. - Takes part in one daily activity. - Screened for depression and risk. ****Linking the data to the diagnosis****
The woman says, "I can't go on without my child." Two years after the loss she still grieves intensely, cannot work and is isolated. Grief this intense and lasting well beyond a year differs from ordinary sadness after a loss, so this is an actual problem related to sudden death. The nurse also screens for depression and risk, because the statement may signal danger. The plan aims for her to attend grief counseling, take part in one daily activity and be screened for depression and risk.

CarePath diagnosis: Long-lasting grief related to sudden death, as evidenced by intense grief lasting beyond a year and cannot function.

Intervention	Rationale
Acknowledge the pain.	Naming and respecting the depth of the loss tells her that her grief is real and valid, which reduces isolation.
Offer grief counseling.	Grief counselors are trained to help with grief that stays intense and blocks daily life, using approaches beyond ordinary support.
Encourage support groups.	Other bereaved parents understand her loss and can offer shared experience and hope, which reduces loneliness.
Monitor for depression.	Long-lasting grief increases the risk of depression, so watching for it allows early treatment and protects her health.
Involve family.	Family can provide ongoing comfort and practical help, and including them helps them understand what she is going through.

Expected outcomes: Attends grief counseling. · Takes part in one daily activity. · Screened for depression and risk.

Linking the data: The woman says, "I can't go on without my child." Two years after the loss she still grieves intensely, cannot work and is isolated. Grief this intense and lasting well beyond a year differs from ordinary sadness after a loss, so this is an actual problem related to sudden death. The nurse also screens for depression and risk, because the statement may signal danger. The plan aims for her to attend grief counseling, take part in one daily activity and be screened for depression and risk.

P27 Stress from illness or hospital stay

Group: Emotions and mind | Type: Actual problem

Definition: Strain from illness, an unfamiliar setting, and loss of routine.

Possible causes: Serious illness; unfamiliar setting; loss of control; many changes

Signs and symptoms: Tense; irritable; poor sleep; withdrawn; cannot cope

Scenario. A patient admitted for the first time is restless and tearful.

S: "I don't know what's happening and I'm scared."

O: First admission; tearful; restless; asks to go home; poor sleep.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Stress from illness or hospital stay related to serious illness, as evidenced by tense and irritable. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Explain the surroundings and routines. | Knowing where things are and what will happen each day reduces fear of the unknown, which is a main source of stress in a first admission. | | Encourage questions. | Encouraging questions shows that her concerns matter and corrects misunderstandings that can fuel fear. | | Allow personal items. | Familiar items from home provide comfort and a sense of identity and control in an unfamiliar setting. | | Teach relaxation. | Relaxation methods calm the body's stress response and can ease tension and help sleep. | | Involve family. | Family are a familiar source of comfort, and their visits can reduce loneliness and fear. | | Give emotional support. | Kind reassurance and attention help her feel safe and cared for, which lowers distress. ****Expected outcomes**** - Within 48 hours: rates stress 3/10 or lower, knows ward routines, sleeps 6 hours, uses two coping methods. ****Linking the data to the diagnosis**** The patient admitted for the first time says, "I don't know what's happening and I'm scared." The nurse notes she is tearful, restless, asks to go home and sleeps poorly. These signs of strain from illness and the hospital setting are present now, so this is an actual problem rather than a risk. The plan aims, within 48 hours, for stress of 3/10 or lower, knowledge of ward routines, 6 hours of sleep and two coping methods. Staff explain routines, welcome questions, allow personal items and give support.

CarePath diagnosis: Stress from illness or hospital stay related to serious illness, as evidenced by tense and irritable.

Intervention	Rationale
Explain the surroundings and routines.	Knowing where things are and what will happen each day reduces fear of the unknown, which is a main source of stress in a first admission.
Encourage questions.	Encouraging questions shows that her concerns matter and corrects misunderstandings that can fuel fear.
Allow personal items.	Familiar items from home provide comfort and a sense of identity and control in an unfamiliar setting.
Teach relaxation.	Relaxation methods calm the body's stress response and can ease tension and help sleep.
Involve family.	Family are a familiar source of comfort, and their visits can reduce loneliness and fear.
Give emotional support.	Kind reassurance and attention help her feel safe and cared for, which lowers distress.

Expected outcomes: Within 48 hours: rates stress 3/10 or lower, knows ward routines, sleeps 6 hours, uses two coping methods.

Linking the data: The patient admitted for the first time says, "I don't know what's happening and I'm scared." The nurse notes she is tearful, restless, asks to go home and sleeps poorly. These signs of strain from illness and the hospital setting are present now, so this is an actual problem rather than a risk. The plan aims, within 48 hours, for stress of 3/10 or lower, knowledge of ward routines, 6 hours of sleep and two coping methods. Staff explain routines, welcome questions, allow personal items and give support.

P28 Loss of sense of identity

Group: Emotions and mind | Type: Actual problem

Definition: The person feels they no longer know who they are after illness, injury, or a change of role.

Possible causes: Amputation; stroke; role change; mental illness; aging

Signs and symptoms: Says he does not know who he is; withdrawn; lost purpose; confusion about roles

Scenario. After retirement and illness, a man says he no longer knows who he is.

S: "I don't know who I am now."

O: Retired and ill; withdrawn; says he has no purpose; refuses visitors.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS **CarePath diagnosis:** Loss of sense of identity related to retirement and illness, as evidenced by saying he does not know who he is, withdrawal, and refusing visitors. **Interventions and rationale** | Intervention | Rationale | | Explore values and strengths. | Helping him name what he values and what he can still do rebuilds a sense of self that illness and retirement have shaken, and shows he is seen as a whole person. | | Encourage meaningful activity. | Taking part in activities that matter to him restores purpose and a feeling of being useful, which counters withdrawal and the belief that he has no role. | | Link to peer support. | Meeting others who have faced similar losses shows him he is not alone and gives real examples of people who rebuilt their sense of who they are. | | Offer counseling. | A trained counselor can help him grieve lost roles and abilities and can screen for depression, which often goes along with loss of identity. | | Praise abilities. | Genuine recognition of what he can still do strengthens self-worth and confidence, helping him see himself as more than his illness. | **Expected outcomes** - Within 2 weeks: names one meaningful role or interest, takes part in activities, engages with support. **Linking the data to the diagnosis** The patient says, "I don't know who I am now," is retired and ill, appears withdrawn, says he has no purpose, and refuses visitors. These data point to a problem with how he sees himself and his roles, not simply low mood or loneliness, so this statement fits better than a social isolation diagnosis. The problem is already present, so it is an actual diagnosis, not a risk one. The plan aims for him, within 2 weeks, to name one meaningful role or interest, take part in activities, and engage with support, which would show his sense of identity and purpose is returning.

CarePath diagnosis: Loss of sense of identity related to retirement and illness, as evidenced by saying he does not know who he is, withdrawal, and refusing visitors.

Intervention	Rationale
Explore values and strengths.	Helping him name what he values and what he can still do rebuilds a sense of self that illness and retirement have shaken, and shows he is seen as a whole person.
Encourage meaningful activity.	Taking part in activities that matter to him restores purpose and a feeling of being useful, which counters withdrawal and the belief that he has no role.
Link to peer support.	Meeting others who have faced similar losses shows him he is not alone and gives real examples of people who rebuilt their sense of who they are.
Offer counseling.	A trained counselor can help him grieve lost roles and abilities and can screen for depression, which often goes along with loss of identity.
Praise abilities.	Genuine recognition of what he can still do strengthens self-worth and confidence, helping him see himself as more than his illness.

Expected outcomes: Within 2 weeks: names one meaningful role or interest, takes part in activities, engages with support.

Linking the data: The patient says, "I don't know who I am now," is retired and ill, appears withdrawn, says he has no purpose, and refuses visitors. These data point to a problem with how he sees himself and his roles, not simply low mood or loneliness, so this statement fits better than a social isolation diagnosis. The problem is already present, so it is an actual diagnosis, not a risk one. The plan aims for him, within 2 weeks, to name one meaningful role or interest, take part in activities, and engage with support, which would show his sense of identity and purpose is returning.

P29 Ready for better coping

Group: Emotions and mind | Type: Actual problem

Definition: The person wants to build stronger coping skills.

Possible causes: Motivation to learn; recent stress; wish to grow

Signs and symptoms: Asks how to cope; uses healthy strategies; seeks support

Scenario. A patient asks how to manage stress better after discharge.

S: "How can I handle stress better?"

O: Asks for strategies; calm; motivated; recent hospital stay.

Tools: CP-MIND · PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Ready for better coping related to motivation to learn, as evidenced by asks how to cope and uses healthy strategies. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Praise readiness. | Recognizing his readiness reinforces motivation and confidence, which makes it more likely he will keep using and building healthy coping skills. | | Teach skills. | Practical skills such as relaxation, problem solving and breathing give him tools he can use at home when stress returns after discharge. | | Set goals. | Clear, personal goals turn a general wish to cope better into specific steps he can try and measure his progress against. | | Link to support groups. | Support groups offer ongoing encouragement and shared experience, so he does not have to manage stress alone once he leaves hospital. | | Follow up. | Follow up checks whether the skills are working, lets problems be fixed early, and keeps his motivation going after discharge. | ****Expected outcomes**** - Describes and practices two stress skills. - Links to a support group. - Sets personal goals. ****Linking the data to the diagnosis**** The patient asks, "How can I handle stress better?", asks for strategies, is calm and motivated, and has had a recent hospital stay. Nothing suggests ineffective coping or crisis; instead he shows a wish to grow, so a readiness statement fits better than a problem statement such as anxiety or poor coping. This is a health promotion diagnosis built on strengths, not a risk. The plan aims for him to describe and practice two stress skills, link to a support group, and set personal goals, building on the motivation he already has after discharge.

CarePath diagnosis: Ready for better coping related to motivation to learn, as evidenced by asks how to cope and uses healthy strategies.

Intervention	Rationale
Praise readiness.	Recognizing his readiness reinforces motivation and confidence, which makes it more likely he will keep using and building healthy coping skills.
Teach skills.	Practical skills such as relaxation, problem solving and breathing give him tools he can use at home when stress returns after discharge.
Set goals.	Clear, personal goals turn a general wish to cope better into specific steps he can try and measure his progress against.
Link to support groups.	Support groups offer ongoing encouragement and shared experience, so he does not have to manage stress alone once he leaves hospital.
Follow up.	Follow up checks whether the skills are working, lets problems be fixed early, and keeps his motivation going after discharge.

Expected outcomes: Describes and practices two stress skills. · Links to a support group. · Sets personal goals.

Linking the data: The patient asks, "How can I handle stress better?", asks for strategies, is calm and motivated, and has had a recent hospital stay. Nothing suggests ineffective coping or crisis; instead he shows a wish to grow, so a readiness statement fits better than a problem statement such as anxiety or poor coping. This is a health promotion diagnosis built on strengths, not a risk. The plan aims for him to describe and practice two stress skills, link to a support group, and set personal goals, building on the motivation he already has after discharge.