See Depression: Part 1 for a review of the client data.

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|---|---|
| Nursing Notes | **1940: Ongoing Assessment**<br>The client is in bed and does not come out for dinner. He is awake and is not sleeping. When the PCT rounds and reminds him of dinner, he states, “I am not hungry.” He reports to the nurse that he has no energy, but is unable to sleep and has been having disrupted sleep for the past several days. Prior to that he was sleeping fourteen hours a day.<br>**1255: Intervention**<br>Assess for suicide<br>Promote nutrition<br>Promote sleep<br>**2330: Ongoing Assessment**<br>The client remains awake in bed, and on rounding the nurse notices he is tearful. He states that he just wants to die. |
| Provider’s Orders | 1:1 observation<br>Meal supplement<br>Trazodone 50 mg HS PRN |

3. Based on the recognized cues, the nurse determines the client has symptoms that could indicate suicide risk, insomnia, and poor nutrition. The nurse anticipates that this is due to depression, anxiety, or insomnia. Designate which condition the cue is associated with.

| Cue | Depression | Anxiety | Insomnia |
|---|---|---|---|
| Anxiety | | | |
| Poor sleep | | | |
| Low appetite | | | |
| Low mood | | | |
| Suicidal ideation | | | |
| Withdrawn | | | |

4. What cue would the nurse give priority to in the planning of care for this client?

1. risk of suicide
2. insomnia
3. poor nutrition
4. lack of energy