N323 Care Plan

Lakeview College of Nursing

Professor LeNard

October 17, 2020

Name Ashley Miller

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/06/2020	AD	20	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	N/A	Single	NKA
Code Status	**Observation Status**	**Height**	**Weight**
Full	15- Minute Checks	62 inches	200 lbs

Medical History (5 Points)

Past Medical History: N/A

Significant Psychiatric History: MDD/ Aggression

Family History: N/A

Social History (tobacco/alcohol/drugs): N/A

Living Situation: At home with mother and father

Strengths: Patient likes to cook and sing among other strengths.

Support System: Mother and Father

Admission Assessment

Chief Complaint (2 points): Ideation suicide with a plan of drinking bleach

Contributing Factors (10 points): Sisters, father, family

Factors that lead to admission: Sisters, father, family

History of suicide attempts: Yes

Primary Diagnosis on Admission (2 points): Psychosis NOS

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse: N/A**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**No**	**13**	**N/A**	**Pushing and hitting**
Sexual Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Emotional Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Neglect	**N/A**	**N/A**	**N/A**	**N/A**
Exploitation	**N/A**	**N/A**	**N/A**	**N/A**
Crime	**N/A**	**N/A**	**N/A**	**N/A**
Military	**N/A**	**N/A**	**N/A**	**N/A**
Natural Disaster	**N/A**	**N/A**	**N/A**	**N/A**
Loss	**N/A**	**N/A**	**N/A**	**N/A**
Other	**Verbal**	**10**	**N/A**	**Talking to patient in a rude voice**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity,**	

			duration, occurrence)
Depressed or sad mood	**Yes**	**No**	**N/A**
Loss of energy or interest in activities/school	**Yes**	**No**	**N/A**
Deterioration in hygiene and/or grooming	**Yes**	**No**	**N/A**
Social withdrawal or isolation	**Yes**	**No**	**N/A**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**A whole week of family issues. Took place last week. Now it has ended.**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**N/A**
Difficulty falling asleep	**Yes**	**No**	**N/A**
Frequently awakening during night	**Yes**	**No**	**Three times a night, occasionally**
Early morning awakenings	**Yes**	**No**	**Sometimes**
Nightmares/dreams	**Yes**	**No**	**N/A**
Other	**Yes**	**No**	**N/A**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Every day, more snacking throughout the day rather than eating meals.**
Binge eating and/or purging	**Yes**	**No**	**N/A**
Unexplained weight loss?	**Yes**	**No**	**N/A**

Amount of weight change: N/A			
Use of laxatives or excessive exercise	**Yes**	**No**	**N/A**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**N/A**
Panic attacks	**Yes**	**No**	**N/A**
Obsessive/compulsive thoughts	**Yes**	**No**	**N/A**
Obsessive/compulsive behaviors	**Yes**	**No**	**N/A**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**N/A**
Rating Scale			
How would you rate your depression on a scale of 1-10?	**N/A**		
How would you rate your anxiety on a scale of 1-10?	**N/A**		
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	**N/A**
School	**Yes**	**No**	**N/A**
Family	**Yes**	**No**	**N/A**
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	**N/A**
Financial	**Yes**	**No**	**N/A**
Other	**Yes**	**No**	**N/A**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
AD	**21**		**Yes**	**No**
AD	**20**		**Yes**	**No**
AD	**20**		**Yes**	**No**
LD	**68**		**Yes**	**No**
JD	**54**		**Yes**	**No**

If yes to any substance use, explain: N/A		
Children (age and gender): N/A **Who are children with now? N/A**		
Household dysfunction, including separation/divorce/death/incarceration: N/A		
Current relationship problems: Family **Number of marriages: 0**		
Sexual Orientation: **Straight/ Bisexual**	**Is client sexually active?** **Yes No**	**Does client practice safe sex?** **Yes No**
Please describe your religious values, beliefs, spirituality and/or preference: **Cristian**		
Ethnic/cultural factors/traditions/current activity: Sabbath **Describe: A day of rest and worship**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A		
How can your family/support system participate in your treatment and care? **Help with therapy or go to therapy with the patient.**		
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: **Learning disability/ Parents arguing**		
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic**		

Abusive **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) N/A
History of Substance Use: N/A
Education History: **Grade school** **High school: Diploma** **College: Not started- Will next year in 2021** **Other: N/A**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: N/A
Discharge
Client goals for treatment: Family will be happy/ Going to college
Where will client go when discharged? Home with family (Mother and Father)

DSM-IV Diagnoses (15 points)

Axis I: Psychosis, NOS, Suicidal Ideation

Axis II: N/A

Axis III: Insomnia/ Anemia

Axis IV: Family stress and abuse

Axis V: N/A

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/Generic	**Trileptal/ oxcarbazepine**	**Sertraline Hydrochloride / Zoloft**	**Invega/ Paliperidone**	**Albuterol Sulfate/ Proair**	**N/ A**
Dose	**300mg**	**150mg**	**6mg**	**90mg**	**N/ A**
Frequency	**BID**	**Daily**	**Daily**	**Q6 hour**	**N/ A**
Route	**PO**	**PO**	**PO**	**PO**	**N/ A**
Classification	**Carboxamide derivative**	**SSRI**	**Benzisoxazole**	**Adrenergic**	**N/ A**
Mechanism of Action	**May prevent or halt seizures by blocking or closing sodium channels in neuronal cell membrane. By preventing sodium from entering the cell, oxcarbazepine may slow nerve impulse transmission, thus decreasing the**	**Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapses. An elevated serotonin level may result in elevated mood and reduced depression.**	**The main active metabolite of risperidone paliperidone selectively block serotonin and dopamine receptors in mesocortical tract of CNS to suppress psychotic symptoms**	**Albuterol attaches to beta receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert ATP cyclic adenosine cAMP. Decreases intracellular calcium levels**	**N/ A**

	rate at which neurons fire.			**and increases intracellular levels of Camp. Relaxes bronchial smooth-muscle and inhibit histamine releases.**	
Therapeutic Uses	**Anticonvulsant**	**Antidepressant**	**Antipsychotic**	**Bronchodilator**	**N/A**
Therapeutic Range (if applicable)	**600 mg/day and 2,400 mg/ day.**	**25 mg or 50 mg per ay is the initial therapeutic dosage**	**3 to 12 mg once daily**	**1.25 to 5mg via oral inhalation every 4 to 8 hours as needed for bronchospasm. 0.63 to 1.25mg vis oral inhalation 3 to 4 times daily as needed.**	**N/A**
Reason Client Taking	**Mood Stabilizer**	**MDD**	**Psychosis**	**SOB**	**N/A**
Contraindications (2)	**Hypersensitivity to oxcarbazepine, eslicarbazepine acetate, or their components**	**Concurrent use of disulfiram or pimozide; hypersensitivity to sertraline or its components; use within 14 days of an MAO inhibitor.**	**AV block, cardiac arrhythmias, congenital heart disease, history of congenital long-QT syndrome**	**Hypersensitivity to albuterol or its components**	**N/A**
Side Effects/Adverse	**Seizure, status epilepticus,**	**Abnormal dreams,**	**Agitation, akathisia,**	**Anxiety, dizziness,**	**N/A**

Reactions (2)	**suicidal ideation**	**aggressiveness, agitation, amnesia, anxiety, apathy**	**anxiety, asthenia**	**drowsiness, headache**	
Medication/ Food Interactions	**Zoloft, gabapentin, ibuprofen**	**Aspirin, Ativan, Benadryl**	**Benztropine, clonazepam, gabapentin**	**Caffeine, amoxicillin, Ativan, aspirin**	**N/A**
Nursing Considerations (2)	**Know that patient with allergic reaction to carbamazepine may have hypersensitivity to oxcarbazepine, monitor serum sodium levels for signs of hyponatremia**	**Monitor liver enzymes and BUN and serum creatinine levels, be aware that sertraline should not be given to patients with bradycardia, congenital long QT syndrome.**	**Monitor patient for involuntary, dyskinetic movements, keep in mind dosage adjustment of paliperidone may be needed when carbamazepine therapy is started or discontinued because of carbamazepine's interaction with paliperidone**	**Monitor serum potassium level, beware that drug tolerance can develop with prolonged use.**	**N/A**

Brand/Generic	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Dose	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Frequency	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Route	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Classification	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Mechanism of Action	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Uses	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Range (if applicable)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Medication/Food Interactions	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

(2020 Nurse's drug handbook., 2020).

Medications Reference (APA):

2020 Nurse's drug handbook. (2020). Jones and Bartlett learning.

Mental Status Exam Findings (20 points)

APPEARANCE:	

Behavior: **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Cooperative** **Short and heavy** **Appropriate** **Coherent, soft** **Normal for age** **Depressed and anxious** **Appropriate**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 **Suicide** **Denies** **Denies** **Denies** **Denies** **Denies**
ORIENTATION: **Sensorium:** **Thought Content:**	 **Thought process intact and organized** **A&O x4**
MEMORY: **Remote:**	 **Denies impairment**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 **Fair** **Fair** **Fair** **Fair** **Fair**
INSIGHT:	**Patient thinks of themselves as a beautiful, slime person who has accomplished their dreams**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 **None** **Good** **Good** **Good** **Good**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1445	70 beats per minute	108/58 mmHg	16 breaths per minute	98.0 °F	98%
1600	76 beats per minute	108/62 mmHg	18 breaths per minute	97.8 °F	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1425	0	N/A	N/A	N/A	N/A
1600	0	N/A	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: Breakfast: 30% Lunch: 40% Dinner: 50%	Oral Fluid Intake with Meals (in mL) Breakfast: 240 mL Lunch: 480 mL Dinner: 480 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Client will go to needed appointments, do therapy sessions, do family therapy if the family is willing, writing in a journal when patient is feeling depressed or just wants to clear out feelings, and when patient has feelings of harming self-patient will call the hotline.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Impaired Verbal Communication	**Pt has a diagnosis of Psychosis; it can alter her way of communicating.**	**1. Identify the duration of the psychotic medication for the pt.** **2. Keep environment calm, quiet and as free of stimuli as possible.** **3. Use clear or simple words and keep directions simple as well.**	**1. Use simple concrete, and literal explanations.** **2. Focus on and direct client's attention to concrete things in the environment.** **3. Let the client know that you are having a difficulty time understanding them.**	**1. Seek support for family, or support groups.** **2. Use calming visualization or listen to music.** **3. Read aloud to self.**
2. Disturbed Thought Process	**Pt has previous history of suicidal ideation.**	**1. Identify feelings related to delusions.** **2. Explain procedures and try to be sure the client understands**	**1. Show empathy regarding the client's feelings.** **2. Utilize safety**	**1. Encourage healthy habits to optimize functioning.** **2. Teach**

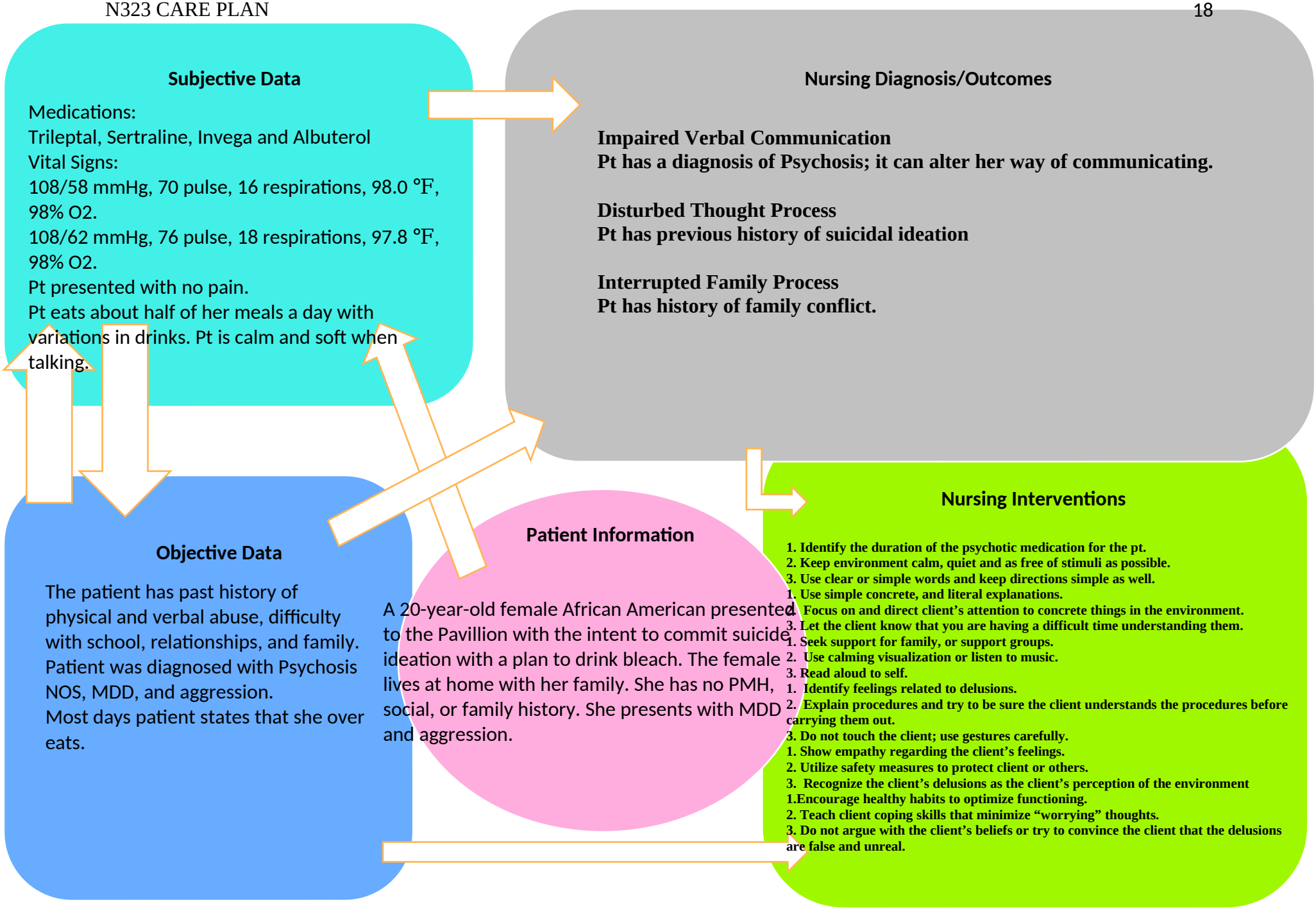
		the procedures before carrying them out. **3. Do not touch the client; use gestures carefully.**	**measures to protect client or others.** **3. Recognize the client's delusions as the client's perception of the environment.**	**client coping skills that minimize "worrying" thoughts.** **3. Do not argue with the client's beliefs or try to convince the client that the delusions are false and unreal.**
3. Interrupted Family Process	**Pt has history of family conflict.**	**1. Asses the client for current level of knowledge about the disease and medications used to treat the disease.** **2. Inform the client family is clear, simple terms about psychopharmacologic therapy.** **3. Identify the family's ability to cope.**	**1. Teach the client and family the warning symptoms of relapse.** **2. Provide information on disease and treatment strategies at the family's level of understanding.** **3. Provide an opportunity for the family to discuss feelings.**	**1. Provide information on client and family community resources for the client and family after discharge.** **2. Written information should be given to client and family members.** **3. Have client demonstrate understanding of their diagnosis prior to leaving.**

(Martin et al., 2016)

Other References (APA):

Martin, P., BSN, & R.N. (2016, September 14). *6 Schizophrenia Nursing Care Plans*. Nurseslabs. Retrieved on October 17, 2020, from https://nurseslabs.com/schizophrenia-nursing-care-plans/#google_vignette.

Concept Map (20 Points):


Subjective Data
Medications:
Trileptal, Sertraline, Invega and Albuterol
Vital Signs:
108/58 mmHg, 70 pulse, 16 respirations, 98.0 ℉, 98% O2.
108/62 mmHg, 76 pulse, 18 respirations, 97.8 ℉, 98% O2.
Pt presented with no pain.
Pt eats about half of her meals a day with variations in drinks. Pt is calm and soft when talking.
Nursing Diagnosis/Outcomes
Impaired Verbal Communication
Pt has a diagnosis of Psychosis; it can alter her way of communicating.
Disturbed Thought Process
Pt has previous history of suicidal ideation
Interrupted Family Process
Pt has history of family conflict.
Objective Data
The patient has past history of physical and verbal abuse, difficulty with school, relationships, and family. Patient was diagnosed with Psychosis NOS, MDD, and aggression.
Most days patient states that she over eats.
Patient Information
A 20-year-old female African American presented to the Pavillion with the intent to commit suicide ideation with a plan to drink bleach. The female lives at home with her family. She has no PMH, social, or family history. She presents with MDD and aggression.
Nursing Interventions
1. Identify the duration of the psychotic medication for the pt.
2. Keep environment calm, quiet and as free of stimuli as possible.
3. Use clear or simple words and keep directions simple as well.
1. Use simple concrete, and literal explanations.
2. Focus on and direct client's attention to concrete things in the environment.
3. Let the client know that you are having a difficult time understanding them.
1. Seek support for family, or support groups.
2. Use calming visualization or listen to music.
3. Read aloud to self.
1. Identify feelings related to delusions.
2. Explain procedures and try to be sure the client understands the procedures before carrying them out.
3. Do not touch the client; use gestures carefully.
1. Show empathy regarding the client's feelings.
2. Utilize safety measures to protect client or others.
3. Recognize the client's delusions as the client's perception of the environment
1.Encourage healthy habits to optimize functioning.
2. Teach client coping skills that minimize "worrying" thoughts.
3. Do not argue with the client's beliefs or try to convince the client that the delusions are false and unreal.