N323 Care Plan

Lakeview College of Nursing

Anita Wilson

Demographics

Date of Admission	**Patient Initials**	**Age**	**Gender**
1/7/21	J.C.	47 years old (2/18/1973)	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Disabled after many years of working as a veterinary technician	Divorced since 2008 (married for 13 years)	Demerol (allergy, hives; 9/28/10) Fentanyl (patch/ topical, nausea; 2/28/18) Morphine (allergy, hives; 9/28/10) Prednisone (allergy, severe agitation; 9/28/10) NSAIDs (intolerance; 9/26/19)
Code Status	**Observation Status**	**Height**	**Weight**
Full	Alerted, talkative, cooperative	5’9”	245 pounds (111.1 kilograms) BMI: 36.18

Medical History

Past Medical History:.
Benign bone tumor, bulge of lumbar disc without myelopathy, chronic midline low back pain without sciatica (10/2/20), chronic kidney disease (stage 3; 11/23), depression, GERD, diarrhea, hypertension, hyperlipidemia, intractable epilepsy, last seizure (6/3/20), migraine, seizure disorder (9/14/20), mild neurocognitive disorder due to epilepsy, left temporal lobectomy in July 2020, history of TBI

Patient denies any childhood illness or infection. Patient was hospitalized prior due to suicide attempt in 2018. Patient denies any past screenings or examinations with the exception of her mammogram which was last completed in 2019. Patient denies any other past surgeries or upcoming surgeries. Patient denies any c-section. Patient has denies surgery dental procedure.

Significant Psychiatric History:
History if suicidal/ homicidal, self-harm behavior, lethality of attempts, psychiatric admission at UIC Medical Center, psychiatry after suicide attempt 2-3 years ago by overdose and walking into traffic, hitting herself in head repeatedly, PTSD, multiple suicide attempts

Family History:
Cancer (mother’s side), patient’s biological father died by suicide on patient’s 9th birthday; patient witness his death by gunshot wound, extensive family history of depression with both parents died by suicide, three other deaths by suicide in immediate family (brother, mother and father), mother (overdosed and died), brother (heroin overdose and died; working for the secret service in Arizona and the Mexican mafia); oldest daughter (overdosed unintentionally at age 22)

Social History (tobacco/alcohol/drugs):
meth, occasional drinks alcohol, pain medication addiction (Vicodin since 9 years old), currently daily smoker (2 packs a day); patient stated she smokes street marijuana to help with her hip pain (patient states this method has been very effective)

Living Situation:
Lives in Carton with boyfriend of 13 years, dog and cat

Strengths:
Patient states her strengths are being creative, artistic, loving and giving second chances

Support System:
Patient states she would consider her boyfriend (sometimes when he's down talking down to her) and Kyle (her boyfriend's son); patient states her coping mechanism include walking, take time to herself and just leaving the house and "getting fresh air and away from the situation"

Admission Assessment

Chief Complaint: "I just want it to be over."

Patient is a 47 year old female who presents to emergency department with her boyfriend for evaluation for suicidal ideation. Patient and boyfriend report increase suicidal ideation over the past six weeks. Patient told boyfriend that she wanted to go back to the UIC where she is close to the lake and can go into the water where she is close to the lake and can go into the water to end her. Patient's boyfriend states that a few weeks ago the patient tried to hurt herself with scissors and a screwdriver. Patient's boyfriend states today she was hitting her head on the table and then took a heavy aluminum bottle and was hitting her head with that. Also tried to take a bottle of muscle relaxer, but boyfriend stopped her. Her boyfriend called the police 3-4 times the past few weeks because she's been violent. Patient's boyfriend also stated that the patient has been violent at home, screaming in people's faces. Per the patient's boyfriend, she has had a long history of trauma since early childhood and multiple plans of interrupted attempts. Boyfriend suspects patient has some hallucinations and believes dead people are talking to her.

Contributing Factors:

- **Factors that lead to admission:** patient stated she got into an argument with her boyfriend because she felt that he kept "talking down to [her]" and not wanting to move to Arizona and marry her after 13 years
- **History of suicide attempts:** one prior suicide attempt (swallowed 3 bottles of prescription medication; her blood pressure and cholesterol medications)

Primary Diagnosis on Admission: bipolar effective disorder (current episode depressed)

Psychosocial Assessment

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse:** patient witness abuse (witness random man and women hitting a little kid and called the police), experienced emotional abuse by ex-husband, sexual abuse in childhood				
	Current	**Past**	**Secondary Trauma**	**Describe**
Physical Abuse	N/A	N/A	N/A	N/A
Sexual Abuse		5-13	N/A	Sexual abuse by two family member (step brother, biological brother) for several years as a young child from the age 5-13
Emotional **Abuse**	N/A	20s-30s	Family violence/ accidents and injuries (witnessing father's suicide with GSW) Loss or and separation from a parent and multiple loved one due to suicide	Patient stated ex-husband was emotional abusive and would often call her a "bitch", "jerk"
Neglect	N/A	N/A	N/A	N/A
Exploitation	N/A	N/A	N/A	N/A
Crime				Police have been called to home, no charges
Military	N/A	N/A	N/A	Current boyfriend was in the military; patient was not a part of boyfriend's life when he was in the military;

				patient's spouse's past history of military experience could impact the way he treats and responds to patient Patient denies being in the military.
Natural Disaster	N/A	N/A	N/A	N/A
Loss		Daughter (late 30s) Mom (28) Dad (9) Brother (25)		Daughter overdosed Mom committed suicide (OD) Dad committed suicide (GSW) Brother committed suicide (OD)
Other	N/A	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Patient states her depression is intermit, it comes and goes every roughly 5-6 days and varies when it last could be from an hour to 2 hours and can sometimes even last two days. Patient states the intensity is medium and is often times brought on by an argument with her boyfriend; the argument topic differs each time. Patient states when she looks back the reasoning for the argument is "petty" and she ends up forgetting the reasoning later on.	
Loss of energy or interest in activities/school	**Yes**	**No**	Patient states when she is having these periods of sadness and depression, it is followed by loss of energy and interest in things pertaining to the house although this occurs on a rarely occurrence; roughly once in eight months at a medium intensity.	
Deterioration in hygiene and/or grooming	**Yes**	**No**	Patient states sometimes when her feelings of sadness takes over, she "doesn't want to brush [her] hair" and	

			will take a shower once every two days instead of her routine once every day. Patient states this can last for up to a week, but states it typically does not persist further due to the importance of hygiene and being clean. Patient goes on to state she hates the presence of odor to prefers to not go longer than two days when she is experiencing sadness or anhedonia.
Social withdrawal or isolation	**Yes**	**No**	Patient describes herself as being a very social able individual and enjoys being surrounded by good company and loved ones, so she does not socially isolate unless it is to take some time to person after an argument with her patient to "cool off" and to no longer perpetuate her anger.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient states she has difficulties with relationships with people close to her in life, due to her habit of talking at her and down to her instead of to her. Patient mentions her ex-husband and current boyfriend portray this habit which makes it difficult to communicate with them and have a healthy relationship with them. Patient states difficulties and hardships with her current boyfriend occurs at least twice a week, sometimes more and can last up to four hours because she does not want to stay upset or angry at him for long. Patient describes their difficulties as being highly intense.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient states for the past 10 years she has not had a good night's rest due to the main in her left hip. Patient states this occurs every night and last as long as she's is sleeping. Patient describes her sleep pattern has being intermit as she goes in and out of sleep and often wakes up through her sleep cycle. Patient states on average she gets 4-6 hours of sleep and goes to bed at 12-2a and often awakes by 6a at the latest.

Difficulty falling asleep	**Yes**	**No**	N/A
Frequently awakening during night	**Yes**	**No**	Patient states she does awakening during the night every night she sleep. Patient states she does not sleep for a consist period of time. Her pain with her left hip suddenly awakens her every night, but when the pain subsides (usually with the help of a topical cream of marijuana) she is able to resume sleep.
Early morning awakenings	**Yes**	**No**	Patient states she wakes up early, often times around 6a, but is fully dependent on the time she goes to bed the night prior. Patient states she enjoys waking up early through, but also takes frequent naps throughout the day (2-3 naps that last in periods of up to an hour and a half)
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**	N/A
Binge eating and/or purging	**Yes**	**No**	N/A
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	N/A
Use of laxatives or excessive exercise	**Yes**	**No**	Patient denies excessive laxative use or exercises or any other extreme measures for weight loss; patient does enjoy going on long walks to clear her heard and spend some time to herself.
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**	Patient states a current obsessive thought that is recent is her excessive worrying about getting back to Arizona and her relationship with her boyfriend. Patient states she worries about this multiple times throughout the day and sometimes it can be intensity because it can start arguments with her boyfriend due to his disapproval of moving with her.
Obsessive/ compulsive behaviors	**Yes**	**No**	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient states the impact the excessively worrying about moving to Arizona, can start arguments with her boyfriend at least one a week and sometimes the intensity of the argument can be severe to when the police are called. Patient states the arrival of the police is not a normal or typically occurrence it just occurs when things "get out of hand with my anger".
Rating Scale			
How would you rate your depression on a scale of 1-10?	7		
How would you rate your anxiety on a scale of 1-10?	7		
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**	Patient describes her boyfriend has being a current stressor as well as her son being that he is moving out with his current girlfriend and her daughter being "just like her father" and not seeking help for heroin addiction. Patient states these

			different stressors occur intermittently and not often (at least once every 2 weeks or so). Patient describes the stressor with her boyfriend is being severely intense and the stressors with her son and daughter as being "mild".
Legal	**Yes**	**No**	Patient denies history of legal problems. Patient's is her own POA.
Social	**Yes**	**No**	N/A
Financial	**Yes**	**No**	Patient states her rent is expensive and electric bill is high, however she receives assistance for paying with those through the government as well as her boyfriend working a full time work and her disability check. Patient describes this stressor as occurring once a month when the bills are due, and can last a couple days. Patient states it is not sometimes she choose to dwell on or excessive worry about because she know there is help and assistance out there.
Other	**Yes**	**No**	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/ MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
2017	**Inpatient** **Outpatient** **Other:**	Patient was hospitalized due to suicidal attempt. Patient's doctor, Dr. Attaluri has appointed an outpatient therapist to J.C. that she is required to	Suicide attempt by overdosing on 17 Tylenols	**No improvement** **Some improvement** **Significant improvement** Patient stated with her previous hospitalization, it helps improve her state of mind

		speak to once a week due to COVID now; prior to that patient was having in person visits with her therapist once every two weeks; patient was prescribes Zoloft 500 mg; ability 5 mg; Wellbutrin		tremendously because it allowed her to get the proper help she needed when she was going through a crisis.

Personal/Family History

Who lives with you?	Age	Relationship	Do they use substances?	
Greg	52	Boyfriend of 13 years	**Yes** Weed and drinks regularly	**No**
Daisy	10	Cat (animal)	**Yes**	**No**
Jango	3	Dog (emotional support animal)	**Yes**	**No**

If yes to any substance use, explain:
Patient boyfriend, Greg, of 13 years smokes weed regularly, almost daily and patient states he drinks alcohol "a lot"

Children (age and gender):
Robert (Male; 24) Abby (Female; 22). Jennifer (Female, 28)

Who are children with now?
Patient children live alone and or their significant other. Patient's boyfriend's children whom she considers to be her step-children all live outside of the home by themselves or with their specific others.

Household dysfunction, including separation/divorce/death/incarceration:
Patient was married for 13 years and is divorced due to according to patient her ex-husband's emotional abuse

Current relationship problems: patient states her main problem with her current boyfriend of 13 years is that he talks down to her instead of to her when leads to a majority of their arguments

Number of marriages: 1; patient states she does have a desire to get married again to her now boyfriend, but he has not asked her to marry her and she does not foresee that occurring

Sexual Orientation: Female	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:
Patient states she identities as being Methodist although she does not follow it; patient denies being spiritual and states she believes in God and was baptized in her 20s; patient states she does not go to church regularly expect for Thanksgiving and Christmas and sometimes on New Year; patient states she grew up Methodist; patient states while being hospitalized, she really enjoys attend the Christian meeting

Ethnic/cultural factors/traditions/current activity: church on Christmas and thanksgiving

Describe: stated above

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):
Past divorced

How can your family/support system participate in your treatment and care?
Patient describes her family and boyfriend as being very support in her recovery and her care and fully support her being hospitalized and receiving the help she needs to become better; patient stated her boyfriend highly encourages her to stay at the hospital

Client raised by:

Natural parents (patient stated she was raised by her biological mother and her step father after the passing of her father when she was 9)
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:

Patient denies any childhood illness or infection. Patient suffered a traumatic brain injury when she was 9 years old due to her falling out of a horse when she was horseback riding. Patient stated her started prescribed her Vicodin shortly after her injury and she stated at one point she was addicted to it and built a tolerance to it. Patient states she no longer takes Vicodin, but instead smokes weed (which is very effective for her) to manage the pain from her accident and her chronic hip pain.

Atmosphere of childhood home:

Loving
Comfortable
Chaotic (patient states she'd most likely describe it as being chaotic due to the sexual abuse she suffered at the hands of her biological brother and step-brother that started at the age of 5 and ended at the age of 13 when she confronted them physically as she described it "beat them")
Abusive
Supportive
Other:

Self-Care:

Independent (patient states her independent in her self-care regimen)
Assisted
Total Care

Family History of Mental Illness (diagnosis/suicide/relation/etc.)
Patient has an extensive family history of suicide; biological father shot himself in the head on patient's 9th birthday in front of her; mother overdosed intentionally and died; brother intentionally overdosed on heroin; oldest daughter overdosed at the age of 28 on heroin

History of Substance Use:
Patient states she had a meth addiction for 10 years and now smokes weed to help with the pain on her left hip; patient states this is very effective for her and gets her weed from the street; patient stated she was addicted to Vicodin since she was 9 to the age of her mid 30s

Education History:

Grade school
High school (patient stated she graduated high school and really enjoyed it although she struggled with math, but enjoyed Arts due to her being able to express her creative side)
College (patient stated she attended college for 2 years, but decided to drop out; patient then obtained her veterinary technician license due to her passion and love for animals and wanting to help them; patient describes a deep wanting of returning back to being a vet and caring for animals when she goes back to Arizona
Other:

Reading Skills:

Yes
No
Limited

Primary Language: English; patient denies being fluent in any other languages

Problems in school: patient denies having any difficulties in school with the exception of

math (algebra) which she stated she has to repeat four times
Discharge
Client goals for treatment: Patient stated her goals for treatment find a medication that helps with her depression and "get it under control", walk away when the stress becomes too much and lastly maintain a level of patience and control when it comes to her family
Where will client go when discharged? When discharged patient says she plans on moving to Arizona despite the fact that her boyfriend is reluctant to move

Outpatient Resources

Resource	Rationale
1. *Crisis Hotline* for her suicidal ideation **217-854-3166**	1. To help provide support services when the patient is suicidal, having thoughts of suicide and family members or friends; also provides information and referral services, crisis intervention and support for people experiencing difficult situations; helps is always provided on a 24 hour bases
2. *Illinois Call4Calm Text Line* **Text TALK to 552020 for English**	2. Being that this service is free and available 24 hours a day, seven days a week allows this patient to a counselor in her area who is knowledgeable about available local resources
3. Illinois Helpline for Opioids & Other Substances **1-833-2FINDHELP**	3. Allows patient to speak to trainline professional for support and provide them with customizes recourses and visit with health care providers when patient is suffering from an opioid use disorder or other substance use disorders

Current Medications

Brand/Generic	**Amlodipine (Norvasc)**	**Baclofen (Lioresal)**	**Benztropine (Cogentin)**	**Gabapentin (Neuraptine)**	**Ondansetron (Zofran)**
Dose	2.5 mg	10 mg	2 mg	900 mg	4 mg
Frequency	Daily	3x Daily PRN	2x Daily PRN	Every morning	PRN
Route	Oral (tablet)	Oral (tablet)	Oral (tablet)	Oral (3 capsules)	Oral (tablet)
Classification	Calcium channel blocker and ACE inhibitor	Muscle relaxants	Anticholinergics	Anticonvulsants	HT3 antagonists
Mechanism of Action	Inhibits the movement of calcium ions into vascular smooth muscle cells and cardiac muscle cells which inhibits the contraction of cardiac muscles and vascular smooth muscle cells	Reduce the releasee of excitatory neurotransmitters and substance P by binding to the GABA-B receptor	Competes with acetylcholine at muscarinic receptor; reduces central cholinergic effects by blocking muscarinic receptors also blocks the uptake and storage of dopamine	Shows a high affinity for binding sites throughout the brain correspondent to the presence of the voltage-gated calcium channels; inhibits the release of excitatory neurotransmitters in the presynaptic area which participate in epileptogenic	Blocks the effects of serotonin at 5HT3 receptor sites located in the vagal nerve terminals and the chemoreceptors trigger zone in the CNS
Therapeutic Uses	Lowers blood pressure	Pain, muscle stiffness and tightness, multiple sclerosis, pain and spinal cord injury	Parkinson's disease and tremors and anxiety	Seizures, nerve pain	Prevents nausea and vomiting
Therapeutic Range (if applicable)	10 mg daily	0.75-2 mg/kg	1-2 mg	600 mg 3 times a day	16 mg
Reason Client Taking	Lower blood pressure	Muscle spasms and pain	Difficulties with movement	Seizures and pain	Nausea and vomiting

			and anxiety		
Contraindications (2)	Hypersensitivity to dihydropyridines, amlodipine, severe hypotension	Confusion, psychotic disorder, stroke, seizures, CKD	Glaucoma	Depression, chronic kidney disease, decreased lung function, COPD, myasthenia gravis	Low amount of magnesium and potassium in the blood, muscle rigidity and serotonin syndrome and confusion
Side Effects/Adverse Reactions (2)	Swelling, headache, fatigue and palpitations, flushing and dizziness	Drowsiness, dizziness, weakness, tiredness, headache, trouble sleeping, nausea, constipation	Constipation, flushing, nausea, dry mouth, blurred vision	Sleepiness, swelling, dizziness, low energy	Headache, constipation, weakness and tiredness, chills, drowsiness
Medication/Food Interactions	Avoid drinks with lots of grapefruit or grapefruit juice as it can increase the concentration of the drug in your body and worsen side effects	Avoid alcoholic drinks as it can increase side effect	Avoid alcoholic drinks	Alcohol can increase the nervous system side effects such as dizziness Give drug with food to prevent GI upset	Can be taken with or without food
Nursing Considerations (2)	Monitor patient's BP, cardiac rhythm and output as it can significantly lower blood pressure Take with meals if upset stomach occurs	Nurse should supervise ambulation as it can affect patient's ability to stand or walk Monitor patient for epilepsy closely as this is a side effect	Assess dizziness and drowsiness that affects gait, balance and other functional activities Monitor confusion, hallucinations, depression and other psychologic problems	Assess for orientation, affect and reflex Assess bowel sounds and intake and output and weight	Assess for nausea, vomiting and abdominal distention and bowel sounds Monitor ECG in patients with hypokalemia or hypomagnesemia, HF, bradyarrhythmia's

Medications Reference:

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Mental Status Exam Findings:

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient appears to be stated chronological age. Patient is friendly, overweight, co-operative, maintains appropriate eye contact, appropriate weight and height for stated age. Patient clothing is appropriate for the setting. Patient appears to be clean, neat and tidy and no odor present. Patient's attitude is open and pleasant. Patient's speech is expansive, low intensity of volume, clear, normal liveliness and offers information. Patient's mood a majority of the time was uplifting and happy and joyful and optimistic and at times sadness and anxiety level is moderate regarding her relationship with her boyfriend. Patient's affect is appropriate to situation, lively, normal and non-constricted.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient denies hallucination, paranoid, delusion, illusions. Patient's thought processes is good, relevant to topic being discussed, coherent, logical. Patient denies delusions and ideations. Patient denies obsession and compulsive behaviors, but admits to obsessive thoughts about her relationship which can negatively impact her life by creating arguments. Patient denies having phobias. Patient denies suicidal and homicidal and agrees to remain safe. Patient did not express delusional content.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient is oriented to time, place and person. Patient's sensorium is normal, no presence of disturbance or fluctuation of conscious. Patient's level of consciousness is normal, alert.
MEMORY: **Remote:**	Patient's memory is average for recent events of last few hours and days, average for remote events of past years. Patient's attention and concentration is sufficient. No acute, inattention, alerted LOC or disorganized thinking .
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Patient's current judgement is good; able to come to appropriate conclusions; realistic decisions. Patient's impulse control is fair at the moment, but can be altered at times due to her use of marijuana and impaired due to her bipolar disorder. Patient was attentive and has adequate concentration.
INSIGHT:	Patient's insight is good; recognizes her problem; intellectual and emotional awareness; patient is hopeful things will get better and willing to

	try things to improve
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Patient denies any use of assistive devices. Patient is independent with ADL assistance, up ad lib. Patient does not require assistance with equipment and support to stand and walk. Patient demonstrated active range of actin bilaterally throughout. Patient has a low fall risk score. Patient states her left hip does not cause her pain while she is up during the day and walking it better, but at night with limited range of motion increases the pain. Patient maintains good balance independently. Patient ambulated throughout the halls and rooms independently. Patient tolerated ambulation well and showed no signs of difficulty breathing. Patient needed no cueing and set up assistance. Patient's general motor response was normal. Patient's hand grip and ankle strength were strong and +2 bilaterally.

Vital Signs, 2 sets

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	98 bpm (right radial)	144/97 (sitting; left upper arm)	18 breaths per minutes (unlabored)	97.0 F (temporal)	97% (room air)
1614	83 bpm (right radial)	159/73 (sitting; right upper arm)	20 breaths per minutes (unlabored)	97.9 F (oral)	97% (room air)

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1433	8/10	Left hip	Very severe	Solid, intense, sharp, pressure, arching	Walking, smoke marijuana, gabapentin, topical cream that she wears at home for joint pain
2100	7/10	Left hip	Frequent	Arching, throbbing	Medication administration

Dietary Data

Dietary Intake	
Percentage of Meal Consumed: 100% **Breakfast:** cold cereal, waffle **Lunch:** rice and salad **Dinner:** chicken and rice	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** milk, coffee, grape juice (850 mL) **Lunch:** water, coffee (450 mL) **Dinner:** chocolate milk, coffee (600 mL)

Discharge Planning:

Discharge Plans:

Being that discharging from a psychiatric hospital is a critical time for many people because it is important to prepare before the patient leaves to ensure they continue their care while supporting them to avoid setbacks and crisis. For discharge plans for J.C. when she leaves the hospital is to continue to work with her therapist and doctors and continue to be competent with her medication regimen that is prescribe to her. My goal is for the patient to collaborate with her current mental health providers to schedule her appointments. I would also like to see this patient seek options for participation in the hospital's outpatient say program where individuals can receive treatment and therapeutic services during the day. I would also like to see the patient's family move involved in her discharge discussion, possibly seeking some sort of family help to decrease the likelihood of setback and another crisis from occurring. This can also be effective for them to advocate for the patient.

Nursing Diagnosis

Nursing Diagnosis	Rational •	Immediate Interventions	Intermediate Interventions	Community Interventions
1. Hopelessness **related to** life stressors, feelings of lost support systems, severe stress events, unresolved grief, long-term stress **as evidenced by** negative perception of future by stated prior to being hospitalized she stated, "I don't think I can move on without my boyfriend.", decreased sleep, lack involvement in care (not showering as often as typically would, reports feeling lost, unable to cope	I chose this nursing diagnosis for this particular patient because due to J.C.'s impairment to cope, it caused her to become hopeless and wanting to take her own life. patent stated she lost hope and desire for the future and agrees that she did not foresee the future being positive.	**1.** monitor and document the potential for suicide by checking on the patient visibly every 15 minutes **2.** Assess for pain and respond with appropriate measures for pain relief. **3.** provide a safe environment so that the patient cannot harm herself	**1.** encourage the patient to participate and attend group activities and meetings **2.** spend one on one time with the patient and use empathy to understand what the patient is saying and communicate tis understanding to the patient **3.** encourage decision making and expression of feelings and acknowledge them in the daily schedule	**1.** teach alternative coping strategies **2.** review the patient's strength with the patient and have her list her own strengths on a note card and carry it around for future references **3.** involve and encourage the family and significant others to express care, hope and love for the patient and involve them in plan of care if seen appropriate for this patient
2. Ineffective coping **related to** difficulty maintaining relationships, lack of follow through or	I chose this nursing diagnosis for this patient because I believe due to her poor ability to cope	**1.** monitor and ensure the patient remains free of destructive behavior toward self	**1.** encourage the patient to verbalize ability to cope and ask for help when needed and communicate	**1.** use distraction techniques during procedures or things that cause the patient to be fearful **2.** demonstrate and come up with a list

participation in treatment or therapy, inadequate level of confidence in ability to cope, uncertainty, inadequate level of perception of control, inadequate resources available, **as evidenced by** patient having difficulties and strains in relationship with boyfriend and children, patient stating she has not followed her recommended therapy sessions that her doctor has suggested patient states the reasoning for this is COVID, patient states she is from a smaller town where there aren't too much resources that she's informed about when it	effectively in stressful situation is the main reason she has been hospitalized for a suicide attempt. Healthy coping mechanism could help J.C. face stressors and trauma. For this patient lacking in this area, she was unable to deal with the demands of the stressor in the relationship with her boyfriend which caused maladaptive coping mechanism that are negative to lead her to harm herself and behavior is a dysfunctional behavior.	or others **2.** use empathic communication and encourage the patient to verbalize fears, emotion **3.** assess for suicidal tendencies	needs **2.** help J.C. set realistic goals and identify personal skills and knowledge **3.** encourage discussion of how recent or ongoing life stressors have overwhelmed normal coping strategies	with the patient of new effective coping strategies that this patient can use when discharged **3.** encourage patient to continue spirituality as a source of support for coping

comes to mental health which is why she was brought to OSF in Urbana, patient states she has a difficult time controlling her anger and expressing her self when she is upset which she said results in her being violent or completely shutting down when people are talking down to her, patient displays inadequate problem solving skills; patient states she has a difficult time verbalizing when she needs help or asking when things are too overwhelming for her which result in her being destructive because she does not want to worry or bother other people in her				

family, especially her children when her issues				
3. Anxiety **related to** interpersonal transmission, situational crisis, change in interaction pattern, conflict regarding essential values/ goals in life, stress overload, decrease social support, history of abuse, change in family unit, poor home environment, lack of resources, maladaptive coping strategies, poor ability to manage anger, depression, family history of mental illness **as evidenced by** dysfunctional family processes and ineffective relationship with children (mainly son) and boyfriend,	Anxiety is something that this patient identifies has something she has struggled with for as long as she could remember, but her anxiety increased after she was sexual abused by two of her siblings and even intensify after witnessing her father commit suicide by a gun at the age of 9. With that being said, this patient has had an anxiety disorder long term which increases her risk of developing a physical illness and other mental health conditions and can increase her depression.	**1.** assess patient's level of anxiety and physical reaction to anxiety like tachycardia , tachypnea **2.** explain all activities, procedures and issues that involve the patient to decrease her anxiety; use nonmedical terms and calm, slow speech; do not advance procedures without validating the patient's understanding **3.** rule out withdrawal from alcohol , sedative or smoking as the cause	**1.** use empathy to encourage the patient to interpret the anxiety symptoms **2.** explain coping skills previously used by patient to relieve anxiety **3.** use therapeutic touch and healing touch techniques	**1.** encourage the client to use positive self-talk such as "anxiety won't kill me, " "I can do this one step at a time," "right now I need to breathe and stretch" **2.** assist family to be supportive of the patient in the face of anxiety symptoms **3.** consider referral for the prescription of antianxiety or antidepressant medication for the patient

suicidal ideation, sleep disturbance, patient states when her boyfriend or anyone talks down to her instead of to you, it makes her anxious, patient states she has a strong desire to move to Arizona and is anxious about the move and the new environment, but most excited but is having difficulties convincing her boyfriend to join her and the thought of moving without him makes her stressed and nervous since they have been together for the past 13 years, patient states she lives in a smaller town so resources are limited that she knows about	Getting this patient's anxiety uncontrol and manageable is essential to her to deal with stressors and challenging situations.	of anxiety 4. approach the patient's anxiety in a nonjudgmental fashion		

Other References:

Ackley, B. J., Ladwig, G. B., & Makic, M. B. (2017). Nursing diagnosis handbook: An evidence-based guide to planning care (11th ed.). St. Louis, MO: Elsevier

Concept Map (20 Points):

Subjective Data

- patient reports having increased episodes of anxiety while arguing with her boyfriend

- patient states this started roughly a couple months ago when their agreement have become more frequent due to their indifference about their move to Arizona

- patient also reports having anger outburst and increased irritability that can sometimes cause her to be violent and destructive

Nursing Diagnosis/Outcomes

Anxiety **related to** interpersonal transmission, situational crisis, change in interaction pattern, conflict regarding essential values/ goals in life, stress overload, decrease social support, history of abuse, change in family unit, poor home environment, lack of resources, maladaptive coping strategies, poor ability to manage anger, depression, family history of mental illness **as evidenced by** dysfunctional family processes and ineffective relationship with children (mainly son) and boyfriend, suicidal ideation, sleep disturbance, patient states when her boyfriend or anyone talks down to her instead of to you, it makes her anxious, patient states she has a strong desire to move to Arizona and is anxious about the move and the new environment, but most excited but is having difficulties convincing her boyfriend to join her and the thought of moving without him makes her stressed and nervous since they have been together for the past 13 years, patient states she lives in a smaller town so resources are limited that she knows about

1. Goal met. Patient stated was able to identify and verbalize that by stating “Everything will be okay” and “I can accomplish any task set before me.” as being two statements that are positive self-talk and a technique she can used to control anxiety and can be used when she is experiencing moments of increased anxiousness by 7pm on 1/11/2021.

2. Goal met. Patient identify and verbalized anxiety percipients, conflicts and threats by 7pm on 1/11/2021. Patient stated her boyfriend talking down to her is a major trigger for her anxiety.

Objective Data

- patient was tearful at times when discussing things that increased her anxiety like her trauma in her childhood, her relationship with her children and boyfriend

- poor eye contact during this time

- elevated blood pressure (159/73) while she is talking to me about her situation

Patient Information

J.C. is a 47 year old female who presents to emergency department with her boyfriend for evaluation for suicidal ideation. Patient and boyfriend report increase suicidal ideation over the past six weeks. Patient told boyfriend that she wanted to go back to the UIC where she is close to the lake and can go into the water where she is close to the lake and can go into the water to end her. Patient’s boyfriend states that a few weeks ago the patient tried to hurt herself with scissors and a screwdriver. Patient’s boyfriend states today she was hitting her head on the table and then took a heavy aluminum bottle and was hitting her head with that. Also tried to take a bottle of muscle relaxer, but boyfriend stopped her. Patient’s boyfriend also stated that the patient has been violent at home, screaming in people’s faces.

Nursing Interventions

1. Encourage the client to use positive self-talk to reduce stress and assist with stress management to help improve the patient’s outlook and cope better in stressful situation by 7pm on 1/11/2021.

2. Encourage the patient to talk about her meaning of the events contributing to her anxiety for at least 30 minutes on 1/11/2021 by 7pm.