N323 Care Plan

Lakeview College of Nursing

Name

Princess Anne Hernandez

Demographics (3 points)

Date of Admission 01/21/21	**Patient Initials** C.P.	**Age** 24 years old	**Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Unemployed	**Marital Status** Divorced	**Allergies** Aripiprazole- anaphylaxis Lithium intolerance- vomiting Shellfish- hives
Code Status Full Code	**Observation Status** 15- minutes Rounds	**Height** 5'7"	**Weight** 286 lbs.

Medical History (5 Points)

Past Medical History: The patient has a history of Asperger syndrome, autism, diabetes, hypertension, migraine, Class III severe obesity without serious comorbidity (09/28/2019), and seizure disorder.

Significant Psychiatric History: The patient has a history of anxiety, bipolar one disorder, posttraumatic stress disorder, depression, borderline personality disorder, bipolar affective disorder, deliberate self-cutting (02/13/19), intentional drug overdose (09/28/19), night terror (11/12/19), and schizophrenia.

Family History: The patient's mother has heart disease, the father has obsessive-compulsive disorder, and the paternal aunt has posttraumatic stress disorder.

Social History (tobacco/alcohol/drugs): Patient reports quits smoking cigarettes. The patients state she used to smoke half a pack of cigarettes a day for two years. The patient denies the use of alcohol and recreational drugs.

Living Situation: The patient lives in an apartment in Indiana with her boyfriend and boyfriends' mother.

Strengths: Patient states she thinks she does not have any strength to tell, but she likes arts and graphic design. She is an introvert and does not like talking to people.

Support System: The patient reports that her support systems are her boyfriend and counselor.

Admission Assessment

Chief Complaint (2 points): Patient states, "I took some pills. I heard a voice telling me to take pills."

Contributing Factors (10 points):

Factors that lead to admission: The patient went to Champaign via Greyhound bus for legal cases regarding sexual assault in 2019. The trip's constant noises made her irritated and "on edge," which she started hearing voices talking to her. The patient stayed at a hotel with her boyfriend, and somewhat they got into an argument, which then her boyfriend decides to go to sleep. After that, she heard a voice telling her, "take some pill," and took Depakote, Gabapentin, and Risperdal. After her boyfriend discovered it, he called 911, and she was brought to the emergency room of OSF Urbana.

History of suicide attempts: The patient had numerous suicide attempts by overdosing with medication, strangulating herself, and cutting her wrist. Her last attempt before this admission was December 2020, with also overdosing with medication. She reports being hospitalized once a month for the last nine years and attempted suicide at least 20 times.

Primary Diagnosis on Admission (2 points): Intentional Drug Overdose

Secondary Diagnosis: Bipolar Disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient experienced numerous trauma and abuse throughout her life, severely impacting her that causes her numerous mental problems. **Witness of trauma/abuse:** none				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse		12 years old until 18 years old		The patient did not want to talk about any of her trauma to me. Based on her chart, her dad started physically and emotionally abusing her when the dad lost his job.
Sexual Abuse		8 years old and 2019		The patient did not want to talk about any of her trauma to me. Based on her chart, "her brother sexually assaults her when she was 8. In 2019, a man she viewed as friend raped her."
Emotional Abuse	Current	12 years old until 18 years old		She did not want to talk about any of her trauma to me. Based on her chart, her dad started

				physically and emotionally abusing her when the dad lost his job. Recently, her boyfriend's mother emotionally and verbally abuses her by threatening to kick her out of their apartment.
Neglect				None
Exploitation				None
Crime				None
Military				None
Natural Disaster				None
Loss				None
Other				None
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**	She has a hard time taking care of herself every time. She often loses confidence because she does not have any work, and she lives with her boyfriend's mom. She stated that she is nice to her most of the time and will often	

			argue with her.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The patient roughly sleeps 7 hours per day.
Difficulty falling asleep	**Yes**	**No**	She has difficulty falling asleep because she has a hard time breathing when asleep. Right now, since she has been using CPAP, she has been doing fine.
Frequently awakening during night	**Yes**	**No**	**N/A**
Early morning awakenings	**Yes**	**No**	**N/A**
Nightmares/dreams	**Yes**	**No**	She reports often have severe nightmares and terrors of her abuse and parent. This has been ongoing almost her whole life.
Other	**Yes**	**No**	**N/A**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	She eats a lot when she is bored, which most of the time.
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**	N/A
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	N/A
Panic attacks	**Yes**	**No**	She stated she has a severe panic attack at least once a week that can last for an hour. It happens when someone shouts at her or being mean to her

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?	The patient rated her depression 3 out of 10.		
How would you rate your anxiety on a scale of 1-10?	The patient rated her anxiety 5 out of 10.		
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**	The patient does not want to elaborate and talk about her family abuse, which severely affects her.
Legal	**Yes**	**No**	The patient currently trying to get the man who raped her in 2019 criminal charge that why she was here in Champaign
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
Dec 2020 (exact date unknown)	**Inpatient** St. Anthony Hospital, **Chicago IL Outpatient Other:**	Inpatient	Major Depressive Disorder and intentional overdose of medication	**No improvement** **Some improvement** **Significant improvement**
10/22/2020	**Inpatient:** St Anthony Hospital, **Chicago IL Outpatient Other:**	Inpatient	Depression and self-injurious behavior	**No improvement** **Some improvement** **Significant improvement**
09/04/2020	**Inpatient: St. Anthony Hospital Outpatient Other:**	Inpatient	Bipolar	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
The patient is living with her boyfriend	25 years old	Partner	**Yes**	**No**
The patient is living with her boyfriend's mom	The patient does not know	None	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: N/A.				
Children (age and gender): No children				

Who are children with now? N/A		
Household dysfunction, including separation/divorce/death/incarceration: The patient is divorced. She did not state the date/year she got a divorce.		
Current relationship problems: No current relationship problems **Number of marriages:** one		
Sexual Orientation: Heterosexual	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No**
Please describe your religious values, beliefs, spirituality and/or preference: She is a Christian. She believes in God. She participates in the spiritual group session in the facility, and she feels the group session is helping her cope with her problems.		
Ethnic/cultural factors/traditions/current activity: The patient stated the current activities are video games and graphic design. **Describe:** She said playing video games and graphic design relieves her anxiety and stress.		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient is divorced and still communicate to her ex-husband sometimes. She is trying to pursue a rape case that happens in 2019 with a man she "viewed as a friend."		
How can your family/support system participate in your treatment and care? The patient said her boyfriend is always with her. The counselor has helped her talk about things she does not want to talk about. Talking to them makes her happy.		
Client raised by: **Natural parents**- Mother and father **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		

Significant childhood issues impacting current illness: She has a history of being sexual abuse by her brother when she was young. She was emotional and physical abuse as a teen by her father.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic**- The patient does not want to talk about it. **Abusive-** Patient father abuses her. **Supportive** **Other:**
Self-Care: **Independent** **Assisted**- She has a hard time take care of herself, and her boyfriend helps her. **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) The patient states no history of suicide in her family. The patient's father has Obsessive-compulsive disorder, and her paternal aunt has posttraumatic stress disorder.
History of Substance Use: She denies any substance use.
Education History: **Grade school** **High school** **College**- The patient report she is currently studying Graphic design. **Other:** The patient stated she only finished Gr. 10, but she got her GED
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: No problem in school

Discharge
Client goals for treatment: The patient state that her goal was "not to self-harm." She wants to get better and hoping she does not want to have her medication being change frequently.
Where will the client go when discharged? The patient state she will go to her boyfriend's, but at the same time, she does not want to because of her boyfriend's mother being mean to her. She was also thinking about if she can go to a group home.

Outpatient Resources (15 points)

Resource	Rationale
1. Suicide Hotline	1. It is a resource that the patient can use when having suicidal thoughts or emotional distress
2. Psychotherapy groups	2. It will help the patient to learn about their behavior and make positive changes by interacting and communicating with other members of the group
3. Assertive Community treatment program	3. This program will help the patient improve the ability to function in the community and reduce future needs of hospitalization

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

Brand/ Generic	Atarax/ hydroxyzine hydrochloride	Trileptal/ oxcarbazepine	Trileptal/ oxcarbazepine	Risperidone	Desyrel/ trazodone
Dose	25 mg	300 mg	600 mg	90 mg	100 mg
Frequency	QD	QAM	QPM	Every 28 days	PRN
Route	PO	PO	PO	Sub Q	PO
Classification	Antihistamine	Anticonvulsant		Antipsychotic	Antidepressant
Mechanism of Action	Competes with histamine for $histamine_1$ receptor site on the surface of effector cells. Sedative actions occur at the subcortical level of the CNS.	May prevent or halt seizure by blocking or closing sodium channel in the neuron cell membrane. Doing this may slow nerve impulses transmission, thus decreasing the rate at which neurons fire.		Selectively block serotonin and dopamine receptors I the mesocortical tract of the CNS to suppress psychotic symptoms.	Block serotonin reuptake along the presynaptic neuronal membrane, which causes an antidepressant effect
Therapeutic Uses	To relieve anxiety	To treat bipolar disorder and mood stabilizer.		To treat irritability associated with autistic disorder, bipolar mania.	To treat major depression.
Therapeutic Range (if applicable)	N/A	N/A		N/A	N/A
Reason Client Taking	To relieve anxiety	Mood stabilizer to treat the symptoms of bipolar disorder.		To treat schizophrenia and symptoms of bipolar.	For sleep
Contraindications (2)	Pregnancy. Hypersensitivity to	Hypersensitivity to oxcarbazepine or its components.		Hypersensitivity to risperidone or its components	Recovery from acute MI.

	cetirizine, hydroxyzine, or their components	Hypersensitivity to eslicarbazepine or its components		Hypersensitivity to paliperidone or its components	Hypersensitivity to trazodone or its components
Side Effects/Adverse Reactions (2)	Hallucination Seizure	Insomnia Tremors	Suicidal Ideation Fatigue	Aggressiveness Anxiety	Memory impairment Psychosis
Medication/ Food Interactions	Erythromycin Fluoxetine	Rifampin Verapamil	Alcohol use Valproic acid	Antihypertensive medications Paroxetine	Warfarin NSAIDs
Nursing Considerations (2)	Observe for oversedation if the patient takes another CNS depressant. Do not give hydroxyzine by subcutaneous or IV route because tissue necrosis may occur.	Monitor serum sodium level for a sign of hyponatremia. Watch closely for evidence of multiorgan hypersensitivity.	Monitor patient closely for evidence of suicidal thinking. Monitor patient for CNS adverse reaction such as coordination abnormalities, fatigue, and somnolence.	Monitor patient blood glucose and lipid levels as ordered because drugs increase the risk of hyperglycemia and hypercholesterolemia. Administer subcutaneous form into abdomen only after removing excess air from the syringe; inject slowly and steadily.	Gave Trazodone shortly after the patient has middle or less knock to reduce nausea. Give a larger portion of the daily dose at bedtime if drowsiness occurs.

Brand/Generic	Tylenol/ acetaminophen	Ventolin/ albuterol	Cogentin/ benztropine	Haldol/ haloperidol
Dose	650 mg	2-5 g/3 mL	2 mg	5 mg
Frequency	PRN Q4H	PRN Q4H	PRN	PRN Q4H/Q6H
Route	PO	INH	PO	PO/ IM
Classification	non-opioid analgesic	Bronchodilator	Anti-cholinergic	Antipsychotic
Mechanism of Action	inhibits the enzyme cyclooxygenase,	Attaches to bets$_2$ receptors on the bronchial cell	block acetylcholine action at	Block postsynaptic dopamine

	blocking prostaglandin production interfering with pain impulse generation in the peripheral nervous system	membrane stimulate the IC enzyme adenylate cyclase to convert ATP to cAMP.	cholinergic receptor sites	receptors in the limbic system and increase brain turnover of dopamine, which produce an antipsychotic effect
Therapeutic Uses	to relieve mild, moderate pain	To treat bronchospasm	To control extrapyramidal symptoms caused by phenothiazine and another neuroleptic	To treat psychotic episodes
Therapeutic Range (if applicable)	10-25 µg/mL	N/A	N/A	5 to 16 ng/mL
Reason Client Taking	To relieve mild or severe pain	Wheezing	For movement disorder	To relieve agitation, breakthrough, psychosis, or mania
Contraindications (2)	Hypersensitivity to acetaminophen or its component severe hepatic impairment	Only contraindication: Hypersensitivity to albuterol or its component	Hypersensitivity to benztropine or its components Presence of tardive dyskinesia	Hypersensitivity to haloperidol or its component Severe toxic CNS comatose state or depression
Side Effects/Adverse Reactions (2)	Hepatoxicity wheezing	Irritability Nervousness	Euphoria paranoia	Agitation, Depression
Medication/Food Interactions	barbiturates oral contraceptives	MAO inhibitors Digoxin	tetracycline antidepressant Haloperidol	Anticonvulsant medication Alcohol use
Nursing Considerations (2)	Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease. Monitor renal	Monitor serum potassium level because albuterol may cause transient hyperkalemia. Be aware that drug tolerance can develop	Warn patient that the drug has a cumulative effect, increasing risk of adverse reaction and overdose.	Avoid stopping haloperidol abruptly unless a severe adverse reaction occurs. Caution patients avoid skin contact with oral solution

	function in the patient on long term therapy	with prolonged use.	Assess muscle rigidity and tremors at baseline, then monitor them often for improvement, which indicates drug effectiveness	because it may cause a rash.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's drug handbook* (19th ed.).

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	She showered that day but looks disheveled. Cooperative at first, then become agitated. Medium build Friendly and cooperative at first, then become evasive. Slow, hesitant, and mumbled. Little eye contact changes mood quickly. Calm at first, then become anxious. Restricted
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 None None None None None None
ORIENTATION: **Sensorium:** **Thought Content:**	A & O X 4 None Flight of ideas. Asking random questions
MEMORY: **Remote:**	The patient has some impairment in short, remote, and long-term memory.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 Fair N/A Average None Fair

INSIGHT:	Average. Patients know what is going on with her.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Wall/match None Slumping Average Average Average

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	95	117/73 sitting, r. arm	18	98.8 Temporal	96% room air
1521	92	131/75 Sitting, r. arm	18	98.2 Temporal	97% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric 0/10	The patient denies any pain	The patient denies any pain	The patient denies any pain	No intervention implemented
1521	Numeric 0/10	The patient denies any pain	The patient denies any pain	The patient denies any pain	No intervention implemented

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 100%** **Lunch:100%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 240mL** **Lunch: 300 mL**

Dinner:100%	**Dinner:240 mL**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient is going home with her boyfriend. The plan is to help the patient seek weekly outpatient counseling. When possible, help the patient schedule the first follow-up appointment before the patient is discharged. Also, provide crisis cards with contact information to help after discharge. Develop a personalized safety plan with the patient. This plan will include strategies for copping and sources of support that the patient can use in times of mental crises. Educate the patient about all of her medication and the importance of being compliant.

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. Risk for suicide related to the history of numerous suicide attempts evidence by recent intentional drug overdose.	The patient was sent to ER for intentional drinking different medication. She has done this numerous times.	1. Assess patient condition. 2. Call poison control. 3. Put on either suicide precaution or suicide observation.	1. Encourage the client to talk about their feelings and problem-solving alternatives. 2. Keep accurate and timely records, document client's activity,	1. Outpatient Therapy and counseling 2. Assertive community Therapy program 3. Educate the patient about resources such as a crisis hotline.

			usually every 15 minutes. 3. Encourage the patient to participate in group or spiritual therapy	
2. Ineffective coping related to trauma early in life evidence by emotional dysregulation.	While interviewing the patient, she begins to be anxious and agitated while being asking about her trauma.	1. Identify specific stressors. 2. Use empathetic communication. 3. Let the patient express concerns, fears, feeling, and expectations.	1. Consistently approach the patient in all interactions. 2. Teach patient coping skills when the patient is ready and interested. 3. Teach stress-reduction techniques	1.Verify resources and support systems that are available to the patient before discharge. 2. Refer for counseling or Psychotherapy groups 3. Set an appointment for a follow-up appointment.
3. Self-care Deficit related to cognitive impairment evidence by observation of inability to groom self and report of inability to take care of self	The patient looks disheveled, and she stated that she has a hard time taking care of herself.	1. Assess patient cognitive ability. 2. Assess the patient's strength to accomplish ADLs efficiently. 3. Establish short-term goals with the patient.	1. Encourage the patient to participate in activities such as bathing and grooming. 2. Give simple step-by-step reminders for hygiene and dress. 3. Monitor impulsive behavior or actions suggestive of altered judgment.	1. Verify the need for home health care before discharging. 2. Consider the patient's need for assistive devices. 3. Evaluate the patient's living situation to make sure she can take care of herself.

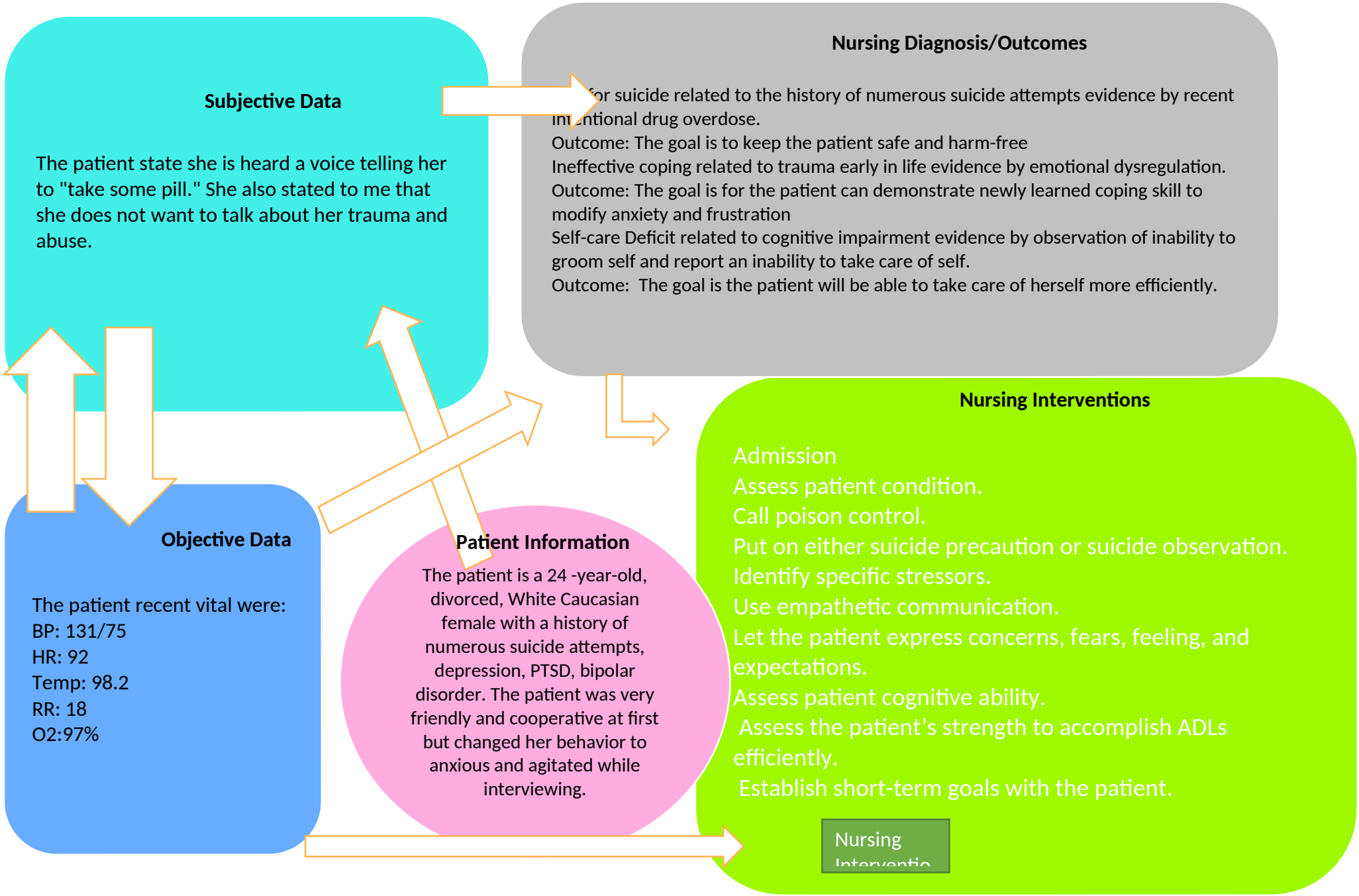
Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier

Vera, M. (2021, January 18). *Nursing Diagnosis: Everything You Need to Know [2020 Guide]*. Nurseslabs. https://nurseslabs.com/nursing-diagnosis/.

Videbeck, S. L. (2020). *Psychiatric-mental health nursing* (8th ed.). Wolters Kluwer.

Concept Map (20 Points


Subjective Data
The patient state she is heard a voice telling her to "take some pill." She also stated to me that she does not want to talk about her trauma and abuse.
Nursing Diagnosis/Outcomes
for suicide related to the history of numerous suicide attempts evidence by recent intentional drug overdose.
Outcome: The goal is to keep the patient safe and harm-free
Ineffective coping related to trauma early in life evidence by emotional dysregulation.
Outcome: The goal is for the patient can demonstrate newly learned coping skill to modify anxiety and frustration
Self-care Deficit related to cognitive impairment evidence by observation of inability to groom self and report an inability to take care of self.
Outcome: The goal is the patient will be able to take care of herself more efficiently.
Nursing Interventions
Admission
Assess patient condition.
Call poison control.
Put on either suicide precaution or suicide observation.
Identify specific stressors.
Use empathetic communication.
Let the patient express concerns, fears, feeling, and expectations.
Assess patient cognitive ability.
Assess the patient's strength to accomplish ADLs efficiently.
Establish short-term goals with the patient.
Nursing
Objective Data
The patient recent vital were:
BP: 131/75
HR: 92
Temp: 98.2
RR: 18
O2:97%
Patient Information
The patient is a 24 -year-old, divorced, White Caucasian female with a history of numerous suicide attempts, depression, PTSD, bipolar disorder. The patient was very friendly and cooperative at first but changed her behavior to anxious and agitated while interviewing.

Nursing Interventions

Hospitalization

1. Encourage the client to talk about their feelings and problem-solving alternatives.
2. Keep accurate and timely records, document client's activity, usually every 15 minutes.
3. Encourage the patient to participate in group or spiritual therapy.
4. Consistently approach the patient in all interactions.
5. Teach patient coping skills when the patient is ready and interested.
6. Teach stress-reduction techniques.
7. Encourage the patient to participate in activities such as bathing and grooming.
8. Give simple step-by-step reminders for hygiene and dress.
9. Monitor impulsive behavior or actions suggestive of altered judgment.

Before Discharge

1. Outpatient counseling and therapy
2. Assertive community Therapy program
3. Educate patient about resources such as crisis hotline.
4. Verify resources and support systems available to the patient before discharge.
5. Refer for counseling or psychotherapy groups.
6. Set an appointment for a follow-up appointment.
7. Verify the need for home health care before discharging.
8. Consider the patient's need for assistive devices.
9. Evaluate patient living situation to make sure she can take care of herself.