N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
01/25/2021	JLB	44 YO	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Write	Cashier	Divoce	Amoxicillin, Penicillin
Code Status	**Observation Status**	**Height**	**Weight**
Full Code	q15 Minutes	5.3” (160 cm)	160 lbs. (72.6 kg)

Medical History (5 Points)

Past Medical History: PSTD, Anxiety, Abuse (physical and sexually), autism

Significant Psychiatric History: Trying to harm herself.

Family History: Diabetes, hypertension, autism

Social History (tobacco/alcohol/drugs): Cigarette, opiates, Marijuana, and amphetamine.

Living Situation: Homeless

Strengths: she wants to look for a job, so she can stop being homeless.

Support System: The new employee gave her an appartement that will be available 02/01/2021. Methodist church

Admission Assessment

Chief Complaint (2 points): patient called suicide hotline and claimed that she wants to kill herself. She states that she “knows herself when she needs inpatient treatment.”

Contributing Factors (10 points): Homeless, lack of love from kids, she states that “life is not important if no one can trust you and love you”.

Factors that lead to admission: Secondary suicide attempts. Patient is very depressed, and she is afraid she may try to kill herself.

History of suicide attempts: At 2011, patient states that she felt the same way. She cut her wrist, so she can have hemorrhage and died.

Primary Diagnosis on Admission (2 points): Bipolar Disorder with episode mixed.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**40-44 YO** **(4 years)**	**15-20 YO** **(5 years)**		**By her father and friends when she was a teenager. At age adult by the ex-husband.**
Sexual Abuse		**6 yo** **28-44 YO** **(16 years)**		**By teenager neighbor.** **By the ex-husband**
Emotional Abuse	**40-44 YO** **(4 years)**		**30-44 YO** **(14 years)** **Taking care of Autism son**	**By the ex-husband who puts her kids far away to her.**
Neglect	**41-44 YO**	**None**		**By her first child**

	(4 years)			**who treats her as being mentally sick.**
Exploitation	**N/A**	**None**	**none**	
Crime		**1999 (20 years)**		**She was in prison for batterie.**
Military	**N/A**	**None**	**none**	
Natural Disaster	**N/A**	**None**	**none**	
Loss	**N/A**	**None**	**none**	
Other	**N/A**	**None**	**none**	

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**		**Any time that she thinks about her son life, q.d, 30 minutes, can go away only after taking medication. Really hyper difficult to calm down without medication.**
Loss of energy or interest in activities/ school	**Yes**		**She likes to stay alone, q.d.**
Deterioration in hygiene and/or grooming		**No**	
Social withdrawal or isolation	**Yes**		**Every day.**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**		**Homeless. Just get a new job**

Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night		No	
Difficulty falling asleep		No	Medications make her sleep a lot.
Frequently awakening during night		No	
Early morning awakenings		No	
Nightmares/dreams		No	
Other		No	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	Yes		Overeating, she states that eating makes her happy. 5 X a day snack.
Binge eating and/or purging		No	
Unexplained weight loss? Amount of weight change:		No	
Use of laxatives or excessive exercise		No	
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	Yes		Yells when she is agitated t.d.s.
Panic attacks		No	
Obsessive/ compulsive thoughts		No	
Obsessive/ compulsive behaviors		No	
Impact on daily living or avoidance	Yes		t.i.d

of situations/objects due to levels of anxiety				
Rating Scale				
How would you rate your depression on a scale of 1-10?	**8**			
How would you rate your anxiety on a scale of 1-10?	**8**			
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**		**Part time (24 hrs. a week)**	
School		**No**		
Family	**Yes**		**They live in Pennsylvania. She is feeling lonely.**	
Legal		**No**		
Social	**Yes**		**Homeless**	
Financial	**Yes**		**New employment, no car. She says that she is anxious to take a bus when it is cold outside.**	
Other	**Yes**	**No**		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
01/27/2021		**Inpatient**	**Suicide**	

	Behavior and mental disease at OSF/URBANA		**attempt**	**No improvement**
01/20/2021	**Behavior counselor at PRINCETON**	**Outpatient**	**Anxious/ Mood changes**	**Some improvement**
December/2020	**Substance abuse prevention program at PRINCETON**	**Outpatient**	**Amphetamine and cocaine used**	**No improvement Discharged from the program due to non-compliance.**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
None for now			**Yes**	**No**
By Myself			**Yes**	**No**
In the Shelter			**Yes**	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain:

Patient says that on shelter people use cocaine and marijuana to help with stress. They are all age.

Children (age and gender): 21 years old: M, 18 years old: M, and 16 years old: M

Who are children with now? The first son is living with girlfriend, they have 1 child together. Other children live with their father at Pennsylvania.

Household dysfunction, including separation/divorce/death/incarceration: divorce		
Current relationship problems: divorce **Number of marriages: 1**		
Sexual Orientation:	**Is client sexually active?** **No**	**Does client practice safe sex?** **Yes**
Please describe your religious values, beliefs, spirituality and/or preference: None. **She states that she has her "own beliefs, but she knows that God exists".**		
Ethnic/cultural factors/traditions/current activity: **Describe: American India/Write**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): arrests for battery 1999 and divorce 2020.		
How can your family/support system participate in your treatment and care?		
Client raised by: **Natural parents**		
Significant childhood issues impacting current illness: Sexual and physical abuse at age **of 6.**		
Atmosphere of childhood home: **Loving by the mother** **Abusive physically by the father**		
Self-Care: **Independent**		
Family History of Mental Illness (diagnosis/suicide/relation/etc.) **Her 16 years old son has Autism and Bipolar disorder.**		
History of Substance Use: amphetamine, cocaine, and marijuana.		
Education History: High school Diploma		

High school **Passed**
Reading Skills: Yes
Primary Language: English
Problems in school: Physically abuse by classmate.
Discharge
Client goals for treatment: Patient will continue to take medication as prescribe and will attaint all the support group. This will help her to manage her mood changes.
Where will client go when discharged? New apartment.

Outpatient Resources (15 points)

Resource	Rationale
1. Crisis line	**1. Any time if she feels like she wants to attempt suicide**
2. Hope sprig counselling Group	**2. Every two weeks**
3. University of Illinois counseling center	**3. Once a month**

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

Brand/ Generic	**acetaminophen**	**benztropine**	**benztropine**	**haloperidol**	**haloperidol**
Dose	**650 mg**	**2 mg**	**2 mg**	**5 mg**	**5 mg**
Frequency	**PRN**	**PRN. 2 times daily**	**2 Times daily**	**PRN Every 4 hours**	**PRN**
Route	**Oral**	**Injection**	**Oral**	**Oral**	**Injection**
Classification	**Analgesics and antipyretics**	**Anticholinergics**	**Anticholinergics**	**Antipsychotics**	**Antipsychotics**
Mechanism of Action	**Lacks peripheral anti-inflammatory properties**	**Blocking a certain natural substance (acetylcholine). Decrease muscle stiffness**	**Blocking a certain natural substance (acetylcholine). Decrease muscle stiffness**	**Rebalances dopamine to improve thinking, mood, and behavior**	**Rebalances dopamine to improve thinking, mood, and behavior**
Therapeutic Uses	**Mild to sever pain. If request by the patient**	**Movement disorder**	**Movement disorder**	**Agitation**	**Agitation**
Therapeutic Range (if applicable)	**650 – 1000 mg every 6 hrs.**	**0.5 - 6 mg Daily**	**0.5 – 6 mg Daily**	**0.5 – 5 mg 2 or 3 times daily. Maximum of 30 mg daily**	**0.5 - 5 mg 2 or 3 times daily. Maximum of 30 mg daily**
Reason Client Taking	**Mild headache.**	**Balance and controlling behavior**	**Balance and controlling behavior**	**Anxiety and agitation**	**Anxiety and agitation**
Contraindications (2)	**Acute liver failure Renal impairment**	**Glaucoma Chronic heart failure Stomach ulcer**	**Glaucoma Chronic heart failure Stomach ulcer**	**Comatose Pregnancy**	**Comatose Pregnancy**
Side Effects/Adver	**Stomach pain**	**Confusion Hallucinatio**	**Confusion Hallucinatio**	**Sore throat Swollen**	**Sore throat Skin sores**

se Reactions (2)	**Itching Nausea**	**n Blurred vision**	**n Blurred vision**	**gums Fever**	**Fainting Bleeding**
Medication/ Food Interactions	**Warfarin Propranolol methotrexate**	**Alcohol Antacids**	**Alcohol Antacids**	**Clonazepam, gabapentin, Benadryl.**	**Ativan, Depakote, clonazepam**
Nursing Considerations (2)	**Carefully check all OTC medication, avoid using multiple preparations containing acetaminophen**	**Provide safety measure to avoid fall. Monitor intake and output**	**Give if unable to take oral tab. Monitor for dry mouth and any involuntary movements.**	**Monitor signs of hypersensitivity reactions, including pulmonary symptoms such as laryngeal edema, wheezing, dyspnea.**	**Monitor signs of hypersensitivity reactions, including pulmonary symptoms such as laryngeal edema, wheezing, dyspnea**

Brand/Generic	**Nicotine patch**	**risperidone**	**Trazadone**		
Dose	**21 mg**	**2 mg**	**50 mg**		
Frequency	**Daily**	**Daily**	**Every 4 hours PRN**		
Route	**Transdermal**	**Oral**	**Oral**		
Classification	**Stimulant of autonomic ganglia**	**Atypical antipsychotics**	**Antidepressant and a serotonin modulator.**		
Mechanism of Action	**Stimulated of neural nicotinic acetylcholine receptors in the ventral tegmental area of the brain.**	**It helps to restore the balance of certain natural substances in the brain.**	**Inhibited serotonin transporter and serotonin type 2 receptors.**		

	Causing release of dopamine in the nucleus accumbent.		**Blocks the histamine and alpha-1-adrenergic receptors.**		
Therapeutic Uses	**To replace cigarette**	**Mood disorders, bipolar disorder, irritability.**	**Sleep, anxiety, depression**		
Therapeutic Range (if applicable)	**15-22 mg**	**2-3 mg per day**	**150 mg Daily**		
Reason Client Taking	**She is a smoker; she is not able to smoke cigarette. So, she nicotine from the cigarette to the patch.**	**Patient has bipolar disorder, and she is very agitated**	**Anxiety**		
Contraindications (2)	**Uncontrolled high blood pressure Heart attack**	**Diabetes Dehydration patient**	**Patient with increase risk of bleeding, and with low amount of potassium or sodium in the blood**		
Side Effects/Adverse Reactions (2)	**Headache Skin irritation(redness)**	**Dizziness, weight gain**	**Blurred vision dizziness**		
Medication/Food Interactions	**Labetalol prazosin isoproterenol**	**metoclopramide**	**Gabapentin, lisinopril, and metoprolol**		
Nursing Considerations (2)	**Apply patch to non-hairy. Use on intact skin. Assess skin for irritation.**	**Monitor patient for adverse effects. Mix oral solution with 3-4 oz of water, orange juice, or low-fat milk.**	**Monitor pulse rate and regularity before administration. Monitor neurological status.**		

Medications Reference (1) (APA):

"National Library of Medicine - National Institutes of Health." *U.S. National Library of Medicine*, National Institutes of Health, Retrieved January 28, 2021. www.nlm.nih.gov/?ga=2.10986356.1142109804.1611877512-1412537070.1611877512.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior: Agitation** **Build: construct** **Attitude: Talker** **Speech: clear** **Interpersonal style: verbal** **Mood: agitation** **Affect: emotionally affected**	
MAIN THOUGHT CONTENT: **Ideations: Compared herself to other women of 44 y.o.** **Delusions: none** **Illusions: referring to her passed** **Obsessions: none** **Compulsions: none** **Phobias: none**	
ORIENTATION: **Sensorium: none** **Thought Content: Very clear**	
MEMORY: **Remote: She is referring to her past when she was home taking care of her children**	
REASONING: **Judgment: none** **Calculations: none** **Intelligence: She is having a plan to keep her new job, so she can a get money to buy a car.** **Abstraction: none** **Impulse Control: none**	

INSIGHT: none	
GAIT: good **Assistive Devices: none** **Posture: very good. Can stand up without any help. She can walk independently.** **Muscle Tone: 5/5, very strong equally** **Strength: 5/5, strong equally** **Motor Movements: stable patient**	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
15:35	**68**	**116/70**	**18**	**98.2**	**96%**
1725	**72**	**118/68**	**18**	**98.0**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
15:35	**0/10**	**none**	**none**	**none**	**none**
1725	**0/10**	**none**	**none**	**none**	**none**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: She was admitted after breakfast.** **Lunch: Did not eat lunch. Just admitted.**	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** **Lunch: 480 mL** **Dinner: 780 mL**

Dinner: 100%	

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

- **Patient needs to adhere to safety. Maintaining safety measure. Call the suicide hotline any time that she feels mania or having signs of suicide attempts.**
- **Educating patient to importance of taking medication and participating in fallow up services, group support to help her to learn how to manage and deal with stress.**
- **Educate patient to how it is important for her to keep her new job that she just has. This will help her to adjust her financial issue.**

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 of Injury related to physical agitation as evidence by suicide attempt.	**Patient tried to kill herself 2 times. She cut her wrist when she has irritable temperaments.**	**1.Patient is on 15minutes checks.** **2. Patient will take psychotics medication.** **3. Provide quiet environment to the patient**	**1.** **15 minutes checks** **2.** **Psychotics medications have been giving on time as prescribe by the physician.** **3. Participate to support group and Charing feeling with others.**	**1. Maintaining patient safety.** **2. Provide her information about psychological services center and therapy.** **3. Provide Information on suicide precaution,**

				print out copy.
2. **Social Isolation related to risky behavior in relationships with others as evidence by expression of feeling of rejected.**	**Patient stated that the people do not like and love her anymore because she has mental disorder. She is now alone, far away from her family. She is divorce due to her aggressive behavior.**	**1. patient will participate on group support program.** **2. Having time to talk or communicate with the patient.** **3. Show empathy and listening to the patient.**	**1. Check the patient more often and give her time to express her feeling and emotion.** **2. Discussing with the patient about benefit to participate on support group.** **3. Assure the patient that she is not alone. You are with her and you love her.**	**1. Patient will maintain a good relationship with others.** **2. Make sure that patient is feeling comfortable to go to a public place or to visit any community mental disorders group support.** **3. Provide a patient with education materials that she can read to build up social interaction with friends and family.**
3. Ineffective coping related to situation crises as evidence inability to meet basic needs.	**She became homeless. She does not have a money to buy food or pay for housing. She has poorer quality of life.**	**1. Provide foods and drinks to the patient.** **2. Make the patient comfortable by providing her a clean room, bed, or environment.** **3. Make sure that the patient has access to the toilette when she needs it.**	**1. Providing 3 meals and snacks as needed to the patient.** **2. Changing patient bed sheets and closes every day. Let her take a bath as needed to keep herself clean.** **3. Found a safety place that the patient will go live before she can be discharge from the hospital.**	**1. Provide patient with information on jobs research.** **2. Patient promote effective coping strategies to deal with lack of finances.** **3. Patient feels comfortable to go out and founds a job that will fit her.**

Other References (APA):

References

Luciano, M., Steardo, L., Jr, Sampogna, G., Caivano, V., Ciampi, C., Del Vecchio, V., Di Cerbo, A., Giallonardo, V., Zinno, F., De Fazio, P., & Fiorillo, A. (2021). Affective Temperaments and Illness Severity in Patients with Bipolar Disorder. *Medicina (Kaunas, Lithuania)*, *57*(1). https://ezproxy.lakeviewcol.edu:2097/10.3390/medicina57010054

Miklowitz, D., & Johnson, S. (2006, January 29). The psychopathology and treatment of bipolar disorder. Retrieved January 28, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2813703/

Concept Map (20 Points)

Subjective Data

Patient stats that she had a feeling of trying to harm herself because her life does not have any meaning.
Patient claimed that her family judge her as a causing trouble due to her behavior. So, no one wants to be close to her.

Nursing Diagnosis/Outcomes

ing Diagnosis
Risk of Injury related to physical agitation as evidence by suicide attempts.
Social Isolation related to risky behavior in relationships with others as evidence by expression of feeling of rejected.
Ineffective coping related to situation crises as evidence inability to meet basic needs.
Hopeless related poor support system and lack of financial as evidence homeless.
Outcomes
Patient will refrain from attempting suicide.
Patient will make a no-suicide contract with the nurse while she is staying in the hospital.
Patient will remain safe while in the hospital.
Patient will identify at least one future goal.
Patient will have links and information to self-help group in the community.
Patient will join family crisis counseling.
Patient will keep all her appointment after discharge.

Objective Data

Patient has episodes of mania for 40 minutes, she was yelling and screaming. Very agitated.
Patient looks very sad and talking about other do not like her.
Patient is alone, sleeping in the room

Patient Information

44 y.o Female patient with Bipolar disorder. She is divorce and mother of three children. She is homeless because her family scared to live with her due to her behavior of being agitated. She is here today because she wants to kill herself for the second time.

Nursing Interventions

Check patient every 15 minutes to assure safety.
Provide calm environment by reducing noise.
Give psychotic medications as prescribe by the physicians to manage behavior, irritation, and anxiety.
Encourage patient to talk about her feelings and problem solve alternatives.
Encourage patient to participate in the unit support group, so she can socialize. This will avoid loneliness.
Provide education on managing behavior and stress.
Referred patient to the mental illness groups support.
Work together with a socio-worker to find a safety place that the patient will live after being discharge from the hospital.