N323 Care Plan

Lakeview College of Nursing

Kathleen Serrano

Demographics (3 points)

Date of Admission 01/15/2021	**Patient Initials** SM	**Age** 58	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Divorced	**Allergies** Lyrica – unknown Promethazine – unknown Risperdal – unknown Wellbutrin – unknown Zolipidem – unknown
Code Status Full Code	**Observation Status** 15-minute Rounds	**Height** 5'4"	**Weight** 175 pounds

Medical History (5 Points)

Past Medical History: Patient has a history of hypothyroid, chronic hypertension, chronic GERD, multiple injuries due to trauma, chronic fibromyalgia, facial droop, arthropathy, asthma, and spinal stenosis of the lumbar region.

Significant Psychiatric History: Patient has a history of bipolar affective disorder, suicidal ideation, anxiety, and current episode depressed (HCC)

Family History: Patient's mother has a history of skin cancer, anxiety disorder, depression, thyroid disease, and hypertension. Patient's father has no history. Patient's brother has a history of schizophrenia.

Social History (tobacco/alcohol/drugs): Patient denies use of tobacco, alcohol, and drugs. Patient has been documented under a controlled substance agreement.

Living Situation: Patient has lived alone for 25 years.

Strengths: Patient reports that her strengths are her caring personality and her family.

Support System: Patient reports that her only support system consists of her mother and her three daughters.

Admission Assessment

Chief Complaint (2 points): Patient's chief complaint is: "I need physical and medical care", after being admitted for a car accident that may have been a suicide attempt. After the patient was treated for her various and serious issues, she was brought to OSF St. Mary's Hospital.

Contributing Factors (10 points):

Factors that lead to admission: The patient was transferred to the hospital from another OSF facility for an alleged suicide attempt via an intentional car accident.

History of suicide attempts: The patient has an extensive history of suicide attempts.

Primary Diagnosis on Admission (2 points): The primary diagnoses upon admission are suicidal ideation, depression, and anxiety.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient denied any history of trauma, but then later admitted to some during her childhood. **Witness of trauma/abuse:**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**

Physical Abuse				None
Sexual Abuse				None
Emotional Abuse		Around mid 20's		**"**My first husband made me feel horrible yelling at me."
Neglect		Approximately around mid 20's		**"**My first husband was never home and never helped me with anything."
Exploitation				None
Crime				None
Military				None
Natural Disaster				None
Loss		Did not want to speak about it or go into details		Lost father years ago
Other				None

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Constantly because of being at the hospital
Loss of energy or interest in activities/school	**Yes**	**No**	Majority of the time feels tired and unmotivated especially when socializing.
Deterioration in hygiene and/or grooming	**Yes**	**No**	Not currently, but admits that sometimes hygiene is not good
Social withdrawal or isolation	**Yes**	**No**	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Mostly at the home since the patient lives alone
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**

Change in numbers of hours/night	**Yes**	**No**	Patient reports it depends, but at times sleeps too little (3 hours) or too much (12+ hours)
Difficulty falling asleep	**Yes**	**No**	
Frequently awakening during night	**Yes**	**No**	Patient reports constantly waking up during most nights
Early morning awakenings	**Yes**	**No**	The doctor comes at 0600 every morning, and patient has difficulty falling back asleep
Nightmares/dreams	**Yes**	**No**	
Other	**Yes**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient has no desire to eat meals even if it is her favorite like mashed potatoes and gravy
Binge eating and/or purging	**Yes**	**No**	
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	
Use of laxatives or excessive exercise	**Yes**	**No**	
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Heart beats fast and the “shakes” or tremors happen when in bed sometimes
Panic attacks	**Yes**	**No**	
Obsessive/compulsive thoughts	**Yes**	**No**	
Obsessive/compulsive behaviors	**Yes**	**No**	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient reports having difficulty speaking up in group therapy because of her anxious feelings
Rating Scale			

How would you rate your depression on a scale of 1-10?	Patient reports depression as 3/10
How would you rate your anxiety on a scale of 1-10?	Patient reports anxiety 2/10 or 3/10

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**	Patient does report being unemployed for years.
School	**Yes**	**No**	
Family	**Yes**	**No**	
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	Patient reports that: "I will have finance issues after this hospital visit."
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
01/15/2021 to current date 01/20/2021	**Inpatient** Urbana OSF St. Mary's **Outpatient Other:**	Inpatient	Potential suicide attempt, depression, axniety, and suicidal ideation	**No improvement** **Some improvement** **Significant improvement**
01/08/2021 –	**Inpatient**	Inpatient	Serious	**No improvement**

01/15/2021	OSF facility (exact name unknown) **Outpatient** **Other:**		injury and trauma for an allegedly intentional car accident	**Some improvement** **Significant improvement**
Patient did not report a third previous inpatient/outpatient facility, and there was none documented	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Patient has lived alone for the past 25 years			**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain:

Children (age and gender): Patient has three daughters who are 40 years old, 34 years old, and 32 years old.

Who are children with now? All three daughters live on their own with their families. One daughter still lives in the patient's residential town and the other two live far away. Originally, the patient stated that she only had two daughters who were 40 years old and 34 years old.

Household dysfunction, including separation/divorce/death/incarceration: Patient lost father years ago (would not say when specifically). Patient has been divorced twice once in the 1990's and the second time around 2001.

Current relationship problems: None

Number of marriages: Two; both of which ended in divorce.

Sexual Orientation:	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No** **N/A**

Please describe your religious values, beliefs, spirituality and/or preference: Christian

Ethnic/cultural factors/traditions/current activity: Patient reports that she has not gone to Church for years and does not follow or have any traditions. Christianity does not really have an effect on the patient **Describe:** N/A
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient denies any current or past legal issues.
How can your family/support system participate in your treatment and care? Patient reports that her daughters and mother help her by calling her, visiting sometimes, and seeking help from professionals when the patient is not doing well.
Client raised by: **Natural parents**- Mother and father **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient denies any significant childhood issues
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic**- Patient states, “My father would come home very drunk a lot, and would fight with my mother.” **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted**- Patient is currently in a wheelchair with a boot on her right leg, but without that the patient has a caregiver who helps her at home **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Mother- anxiety disorder and depression Brother- schizophrenia
History of Substance Use: Patient reports no alcohol, drug, or tobacco use.
Education History:

Grade school **High school** **College**- Patient reports going to college for at least two years for a medical assistant degree **Other:**
Reading Skills: **Yes** **No** **Limited**- Patient states, “It is difficult for me to see and read.”
Primary Language: English
Problems in school: Patient reports algebra being difficult in school
Discharge
Client goals for treatment: Patient states she wants “to get better.” Other than that, the patient stated that “I just want to get out of this place.”
Where will client go when discharged? Patient reports she will be transferred to “an in-care rehabilitation facility” in the city she resides in.

Outpatient Resources (15 points)

Resource	Rationale
1. Crisis Hotline	**1.** The crisis hotline is a valuable resource when the patient has suicidal ideations and does not want to talk to family about it.
2. OSF Saint Francis Behavioral Health	**2.** Weekly group therapy sessions about anxiety, depression, and suicidal ideation would benefit the patient to seek help when needed and to recognize these issues when they occur.
3. UnityPoint Health- Methodist Atrium	**3.** Mental health home that would still give the patient the independence of living alone but would eliminate the loneliness and depression the patient feels due to living alone.

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

Brand/Generic	ARIPiprazole (ABILIFY)	gabapentin (NEURONTIN)	Oxcarbazepine (TRILEPTAL)	Pantoprazole (PROTONIX)	trazodone (DESYREL)
Dose	10 mg	300 mg	150 mg	40 mg	100 mg
Frequency	Once nightly	BID	Mornings before breakfast	BID	Nightly
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antipsychotic	Anticonvulsant	Anticonvulsant	Antiulcer	Antidepressant
Mechanism of Action	Acts as a partial agonist at dopamine and serotonin receptors	Inhibits the rapid firing of neurons associated with seizures	Prevents or halts seizures by blocking or closing sodium channels in neuronal cell membrane	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-ATP enzyme system	Blocks serotonin reuptake along the presynaptic neuronal, causing an antidepressant effect
Therapeutic Uses	To treat acute and manic episodes and maintain stability for depression	To treat partial seizures	To treat partial seizures	To treat erosive esophagitis with GERD	To treat major depression
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	To treat depression	To treat partial seizures	To treat partial seizures	To treat esophagus ulcer due to GERD	To treat major depression
Contraindications	Hypersensitivity	Hypersensitivity	Hypersensitivity	Hypersensitivity	Hypersensitivity

(2)	to aripiprazole or its components	to gabapentin or its components	to oxcarbazepine, eslicarbazepine acetate, or their components	to pantoprazole, concurrent therapy with rilpivirine-containing products	to trazodone or its components, recovery from acute MI
Side Effects/Adverse Reactions (2)	Homicidal ideation, seizures	CNS tumors, intracranial hemorrhage	Suicidal ideation, leukopenia	Hepatic failure, pancreatitis	Arrythmias, congestive heart failure
Medication/Food Interactions	Antihypertensives, benzodiazepines	CNS depressants, hydrocodone	Phenytoin, cyclosporine, verapamil, all food	Ampicillin, cyanocobalamin, digoxin, iron salts, warfarin, nilotinib	Aspirin, NSAIDs, MAO inhibitors
Nursing Considerations (2)	Have patient swallow tablets whole do not have them chew, monitor patient for difficulty swallowing or excessive somnolence	Capsules can be opened and mixed with applesauce, juice, etc. before administration, give drug at least two hours after an antacid	Monitor therapeutic oxcarbazepine levels and dose, accordingly, implement seizure precautions as needed	Monitor patient for diarrhea from C. difficile, expect to monitor PT or INR if the patient is on an anticoagulant	Use drug cautiously in patients with cardiac disease, give drug shortly after a meal or snack to avoid nausea

Brand/Generic	Enoxaparin (LOVENOX)	ferrous sulfate	atenolol (TENORMIN)	benztropine mesylate (COGENTIN)	haloperidol (HALDOL)
Dose	40 mg	325 mg	25 mg	2 mg	5 mg
Frequency	Q24	Daily	Daily	BID PRN	Q4H PRN
Route	Subcutaneous injection	Oral	Oral	Intramuscular injection	Oral
Classification	Anticoagulant	Antianemia, nutritional supplement	Antihypertensive	Antiparkinsonian	Antipsychotic
Mechanism of Action	Potentiates the action of	Acts to normalize RBC	Inhibits stimulation of	Blocks acetylcholine’s	May block postsynaptic

	antithrombin III, a coagulation inhibitor	production by binding with hemoglobin	beta-receptor sites, located mainly in the heart	action at cholinergic receptor sites	dopamine receptors in the limbic system and increase brain turnover of dopamine
Therapeutic Uses	To prevent Deep Vein Thrombosis (DVT)	To prevent iron deficiency	To treat hypertension	To treat all forms of Parkinson's disease	To treat psychotic disorders
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	To prevent blood clots in the right leg	To prevent iron deficiency	To treat hypertension	To treat facial droop	To treat depression, bipolar affective disorder
Contraindications (2)	Active major bleeding, hypersensitivity to benzyl alcohol	Hemochromatosis, hemolytic anemias	Cardiogenic shock, heart block greater than	Angle-closure glaucoma, children younger than age 3	Hypersensitivity to haloperidol or its components, Parkinson's disease
Side Effects/Adverse Reactions (2)	CVA, atrial fibrillation	Hypotension, anaphylaxis	Myocardial infraction, renal failure	Delirium, depression	Cardiac arrest, ventricular arrhythmias
Medication/Food Interactions	NSAIDs, oral anticoagulants	Integrase inhibitors, levodopa	Amiodarone, disopyramide	Haloperidol, antidepressants	Anticonvulsants, amphetamines, CNS depressants
Nursing Considerations (2)	Use enoxaparin with extreme caution in patients with a history of heparin-induced thrombocytopenia, use extreme caution in patients with an increased risk of hemorrhage	Give iron tablets and capsules with a full glass of water, protect liquid form from freezing	Use atenolol cautiously in patients with heart failure, stop atenolol and notify prescriber if patient develops bradycardia, hypotension, or other adverse reactions	Give drug before or after meals based on patient's need and response, assess muscle rigidity and tremor at baseline	Avoid stopping haloperidol abruptly unless severe adverse reactions happen, monitor CBC especially if WBC is low

Medications Reference (1) (APA):

2020 Nurse's drug handbook. (2020). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Disheveled hair, does not shower daily Quiet, slow, calm Medium build Unfocused Soft, slow, delayed speech Cooperative and slow Depressed Flat
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 Suicidal ideations None None None None None
ORIENTATION: **Sensorium:** **Thought Content:**	A & O x 4 N/A Disorganized
MEMORY: **Remote:**	Poor Denies impairment
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 Poor Poor Poor Poor Poor
INSIGHT:	Poor

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 Boot on right leg, wheelchair Poor, slumped down Average Average Average

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1646	72	123/79	12	98.8	95%
1851	68	150/78	14	98.6	96%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1415	Numeric	Right leg	7/10	Sharp pain	Acetaminophen PRN
1840	Numeric	Right leg	2/10	Sharp pain	N/A

Dietary Data (2 points)

Dietary Intake

Percentage of Meal Consumed:	**Oral Fluid Intake with Meals (in mL)**
Breakfast: Patient cannot recall what she ate for breakfast, but she ate all of it; 100% **Lunch:** Patient had a sandwich and mashed potatoes and gravy for lunch and ate 75%. **Dinner:** Patient just had a grilled cheese for dinner and ate all of it; 100%	**Breakfast:** Patient had one cup of water for breakfast (240 mL) **Lunch:** Patient had a cup of tea and two cups of water (720 mL) **Dinner:** Patient drank a cup of Pepsi and a cup of water (480 mL)

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Seek weekly counseling inpatient or outpatient, learn to recognize suicide ideations and call for help, improving on getting rid of suicidal ideations, learning to cope with depression and anxiety better, and to improve self-care both mentally and physically.

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

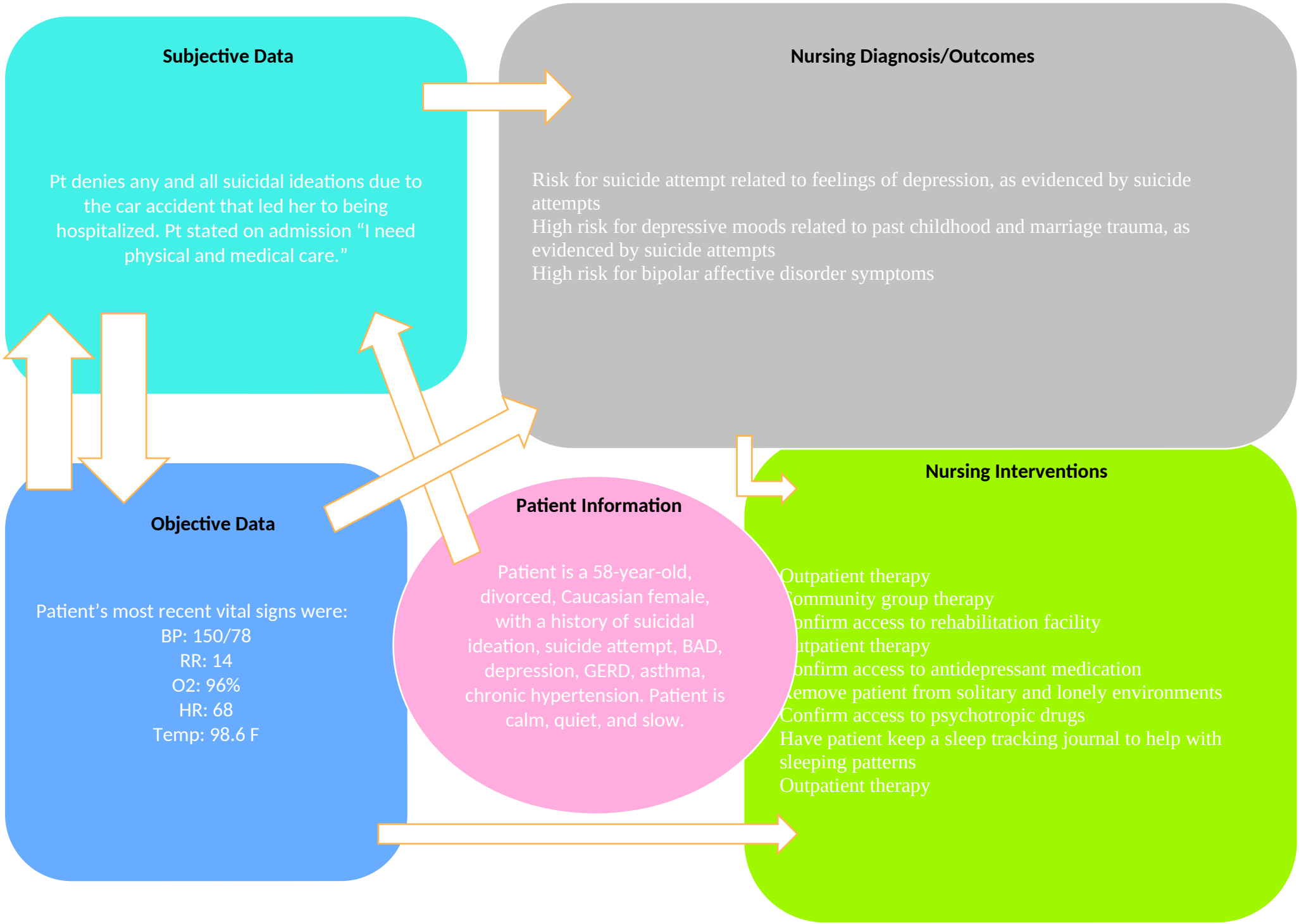
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Risk for suicide	Related to feelings of	**1.** Monitor patient	**1.** Monitor patient every 15 minutes	**1.** Outpatient therapy

attempt	depression, as evidenced by suicide attempts	constantly **2.** Attend to patient's wounds and injuries **3.** Monitor patient's conscious level	 **2.** Socialize and engage with patient to help participate in treatment **3.** Check safety of room- no weapons, or any harmful substances	 **2.** Community group therapy **3.** Confirm access to rehabilitation facility
2. High risk for depressive moods	Related to past childhood and marriage trauma as evidenced by suicide attempts	**1.** Check medications and make sure patient is receiving correct medications **2.** Monitor patient's response to medications old or new **3.** Use active listening to understand what happened and what the client has gone through	**1.** Monitor patient's pain and moods **2.** Check up on patient constantly **3.** Encourage patient to share feelings and moods with therapeutic communication	**1.** Outpatient therapy **2.** Confirm access to antidepressant medication **3.** Remove patient from solitary and lonely environments
3. High risk for bipolar affective disorder symptoms	Related to mania and poor sleeping habits	**1.** Assess health history **2.** Assess psychiatric status **3.** Record patient's sleep patterns	**1.** Group therapy **2.** Adhere to medication regimen **3.** Check that patient is getting adequate sleep	**1.** Confirm access to psychotropic drugs **2.** Have patient keep a sleep tracking journal to help with sleeping patterns **3.** Outpatient

				therapy

Other References (APA):

Concept Map (20 Points):


Subjective Data
Pt denies any and all suicidal ideations due to the car accident that led her to being hospitalized. Pt stated on admission "I need physical and medical care."
Nursing Diagnosis/Outcomes
Risk for suicide attempt related to feelings of depression, as evidenced by suicide attempts
High risk for depressive moods related to past childhood and marriage trauma, as evidenced by suicide attempts
High risk for bipolar affective disorder symptoms
Objective Data
Patient's most recent vital signs were:
BP: 150/78
RR: 14
O2: 96%
HR: 68
Temp: 98.6 F
Patient Information
Patient is a 58-year-old, divorced, Caucasian female, with a history of suicidal ideation, suicide attempt, BAD, depression, GERD, asthma, chronic hypertension. Patient is calm, quiet, and slow.
Nursing Interventions
Outpatient therapy
ommunity group therapy
onfirm access to rehabilitation facility
utpatient therapy
onfirm access to antidepressant medication
emove patient from solitary and lonely environments
Confirm access to psychotropic drugs
Have patient keep a sleep tracking journal to help with sleeping patterns
Outpatient therapy