N323 Care Plan

Lakeview College of Nursing

Deanna Braden

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
2/8/21	A. O.	18 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	No Occupation	Single	No Known Allergies
Code Status	**Observation Status**	**Height**	**Weight**
Full	Every 15 Minutes	5'7"	145 lbs.

Medical History (5 Points)

Past Medical History: Patient denies any past medical history.

Significant Psychiatric History: Patient has bipolar affective disorder, anxiety, and depression. Patient also has a history of cutting himself and an attempted suicide.

Family History: Patient denies any family history.

Social History (tobacco/alcohol/drugs): Patient stated that he smokes marijuana daily and drinks up to twelve cans of beer three or four times a week. He states that the beer and marijuana help calm his nerves and take the edge off. Patient denies any use of tobacco products.

Living Situation: Patient currently resides in a dorm at UIUC but stated that he will be dropping out of college upon release from the hospital. He stated that he will then live with his mom and dad who are from Elmhurst, IL but have a home in Florida as well that they will stay at during the winter months.

Strengths: Patient has insurance through his parents for inpatient and outpatient treatment. Patient stated that he currently sees a psychiatrist.

Support System: Patient states that he has his mom and a couple of good friends from college that support him and make him feel better about himself.

Admission Assessment

Chief Complaint (2 points): Patient's chief complaint is anxiety and depression with attempted suicide.

Contributing Factors (10 points):

Factors that lead to admission: Patient is an 18-year-old Caucasian male that was transported by ambulance to the E.R. on 2/7/21 for attempted suicide. The patient stated that he had been feeling very depressed and anxious for over a month and could not get the thoughts out of his head as to why he should still be here on this earth. He stated that he had a troubled childhood, was bullied in school, had an awful relationship with his dad because his dad would snap easily and make him feel as if he were nothing, he felt that he could never live up to his parents expectations, he felt that his parents always compared him to his older sister because she was the perfect child of the family, he felt that he was always walking on eggshells around his dad, and he hated being at college and was not there because he wanted to be but instead because his parents made him be there. He stated that he felt as if he were small and had no control over his life or who he was as a person. He stated that these situations were all aggravating factors that pushed him into a deep depression where he felt that there was no other alternative but to end his life to escape how he was feeling inside. He stated that there were no relieving factors or anything that he could have taken for treatment at that point in time. He stated that he had already made up his mind and that there was no one that he felt comfortable with to talk him through what he was feeling. The patient stated that he was in his dorm room all alone when he swallowed 150 tabs of Tylenol to end his life. He then got scared because he did not know what the Tylenol would do to his insides and did not want to die a painful death, so he called Poison Control which led to him being transported to the Emergency Room by ambulance.

History of suicide attempts: Patient stated that he has only attempted suicide once, but he has thought about ending his life multiple times. He stated that when he was in his early teens that he would cut himself, but he does not know if that would be considered attempted suicide. He stated that he thought about dying while he was cutting himself, but never made a cut that would end it all. He stated that his one true suicide attempt is why he is in the hospital right now. He took 150 tabs of Tylenol, but then got scared and called Poison Control.

Primary Diagnosis on Admission (2 points): Attempted suicide. Patient stated that he wanted to end the way that he felt inside.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient states that he has been bullied for most of his life which was very traumatic for him. The death of his grandma was also traumatic for him because they were remarkably close and she was the only person that he felt understood him. **Witness of trauma/abuse:** Patient states that there were probably several witnesses, but everyone turned the other cheek.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	N/A	N/A	N/A	N/A
Sexual Abuse	N/A	N/A	N/A	N/A

Emotional Abuse	Yes	His entire life.	N/A	Patient states that his father has always been emotionally abusive and easily snaps off anytime the patient did not say or do as his father wanted him to. He stated that his father has broken him down piece by piece throughout his life. He stated that his father's expectations on who he should be is not what he wants to be.
Neglect	N/A	N/A	N/A	N/A
Exploitation	N/A	N/A	N/A	N/A
Crime	N/A	N/A	N/A	N/A
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	N/A	15 years old	N/A	Patient states that his grandma passed away whenever he was 15 years old. He stated that she was the only person that understood him.
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 that he has been depressed for most of his life. He stated that he has felt like he is nothing from the emotional abuse from his father and the bullying by peers.
Loss of energy or interest in activities/school	**Yes**	**No**	Patient stated that he was only at college because that is what his parents wanted him to do, but not what he wanted to do. He stated that all he wants to do is sleep and forget about everything.
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
Social withdrawal or isolation	**Yes**	**No**	Patient stated that he is afraid of being alone but wants to be alone so that people do not make him feel any worse than he already does. He stated that he is very confused about his feelings on this because it does not even make sense to him.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient stated that he has difficulties at home with his father. He stated that his father has a quick temper and that it has ended in altercations of screaming, yelling, and pushing. He stated that there were even two incidents where it got so bad that they ended up falling into a glass coffee table shattering it. Patient stated that his father degrades him and expects him to be someone that he is not. Patient stated that he did not want to be

			in college and was only there because his parents expected him to. Patient also stated that his parents always compare him to his older sister who is the perfect child of the family. He stated that when his parents compare him to his sister that it shreds his heart into pieces because they do not ever see the good things about him. They only see bad.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient stated that he sleeps twelve to fourteen hours every day. He stated that he also takes naps every day.
Difficulty falling asleep	**Yes**	**No**	N/A
Frequently awakening during night	**Yes**	**No**	N/A
Early morning awakenings	**Yes**	**No**	N/A
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**	N/A
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**

Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient stated that when he starts feeling anxious that he will pace sometimes. He also stated that he would feel like he could not breathe and would look for ways to escape if he was in a room full of people.
Panic attacks	**Yes**	**No**	N/A
Obsessive/compulsive thoughts	**Yes**	**No**	N/A
Obsessive/compulsive behaviors	**Yes**	**No**	Patient states that if he does something to one side of his body then he must do it to the other side. He stated that an example of this is that if he had to wash dirt off his right leg then he would have to wash his left leg as well even though it was not dirty.
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?			Patient rates his depression at a 1. He stated that he is not feeling depressed at all right now.
How would you rate your anxiety on a scale of 1-10?			Patient rates his anxiety at a 4. He stated that he rates it at a 4 because of being in the hospital and he wants to leave.
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**	Patient stated that he has been stressed by being at college so that is why he is dropping out. He states that he is only there because his parents want him to be, but not because he wants to

			be there. He stated that it causes him a high amount of stress daily because it causes fights with his dad.
Family	**Yes**	**No**	Patient states that he has a high level of stress because of his dad. He states that some days the stress is worse than others, especially if he must talk to his dad. He states that his dad makes him feel like he is walking on eggshells and that there is something wrong with him. He stated that this has been going on ever since he was a little kid.
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	N/A
Financial	**Yes**	**No**	Patient states that his parents are very well off financially, but it causes him stress because he wants to be financially independent himself. He does not want his parents to have control over him with money. He states that he has felt this way for a couple of years and feels that if he could support himself that things would be better for him.
Other	**Yes**	**No**	N/A
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
January 2019 to Present (Once a week)	**Inpatient** **Outpatient** **Other:**	Psychiatrist	Depression and Anxiety	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Father (Patient asked for me not to write his parents' names)	Patient was unsure of their age	Father	**Yes**	**No**
Mother (Patient asked for me not to write his parents' names)	Patient was unsure of their age	Mother	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): N/A				

<table>
<tr><td colspan="3">Who are children with now? N/A</td></tr>
<tr><td colspan="3">Household dysfunction, including separation/divorce/death/incarceration: N/A</td></tr>
<tr><td colspan="3">Current relationship problems: Patient denies any relationship problems. Patient stated that he would like to have a girlfriend, but girls do not like him.
Number of marriages: N/A</td></tr>
<tr><td>Sexual Orientation:
Heterosexual:
Interested in women.</td><td>Is client sexually active?
Yes No</td><td>Does client practice safe sex?
Yes No</td></tr>
<tr><td colspan="3">Please describe your religious values, beliefs, spirituality and/or preference:

Patient states that his family is Catholic, but he does not attend church.</td></tr>
<tr><td colspan="3">Ethnic/cultural factors/traditions/current activity: N/A

Describe: N/A</td></tr>
<tr><td colspan="3">Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A</td></tr>
<tr><td colspan="3">How can your family/support system participate in your treatment and care?

Patient states that he wishes that his family would be there for him, but he feels that there is no hope with his father.</td></tr>
<tr><td colspan="3">Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):</td></tr>
<tr><td colspan="3">Significant childhood issues impacting current illness:

Patient stated that bullying and mental abuse were contributing factors as to why he felt like he is so messed up right now.</td></tr>
<tr><td colspan="3">Atmosphere of childhood home: Patient stated that his parents were well off financially, so he never had to want for anything. He stated that money cannot buy love and that he did not feel it at times. He stated that his parents were always comparing him to his sister which made him feel worthless. He stated that he could not ever do anything right and his dad would</td></tr>
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always snap off at him so easily. He stated that he felt torn down and defeated throughout most of his childhood.

Loving
Comfortable
Chaotic
Abusive
Supportive
Other:

Self-Care:

Independent
Assisted
Total Care

Family History of Mental Illness (diagnosis/suicide/relation/etc.) N/A

History of Substance Use: Patient has a history of alcohol consumption and marijuana usage ever since he was sixteen.

Education History:

Grade school
High school
College
Other:

Reading Skills:

Yes
No
Limited

Primary Language: English

Problems in school: Patient stated that he always got good grades in school but is dropping out of college because it is not for him. He stated that he was bullied in school.

Discharge

Client goals for treatment: Before discharge, the patient will be able to identify three coping mechanisms for any episodes of anxiety, depression, or suicidal thoughts. The patient will be able to state three outreach programs or resources within his community that he can resort to for support throughout his recovery. The patient will also reframe from actions of self-harm during the remainder of his stay at the hospital. The teach back method will be used to educate the patient on suicide, depression, and anxiety disorders.

Where will client go when discharged? Once the patient is discharged, he will be leaving his

college dorm and returning home to live with his parents in Elmhurst, IL

Outpatient Resources (15 points)

Resource	Rationale
1. National Suicide Prevention Lifeline	**1.** Patient is 18 years old and has a history of inflicting self-harm by cutting himself and by trying to commit suicide by overdosing on 150 tabs of Tylenol. He stated that if he would have had easy access to talk to someone that could understood what he was going through during those moments before he attempted suicide that maybe it would have stopped him from doing it. The National Suicide Prevention Lifeline provides confidential and free support 24/7 for individuals in distress. With this program being available 24/7 it will allow the patient to call for help no matter what time of the day it is.
2. Alcoholics Anonymous Meetings	**2.** Patient is 18 years old and has a history of alcohol abuse by heavily drinking twelve cans of beer or more at least four or five times a week. He states that he would like to figure out another way to cope with things besides drinking alcohol. Alcohol Anonymous meetings are designed to help people recover from alcoholism through sharing strengths, experiences, and hope with one another throughout their recovery.
3. Depression and Bipolar Support Alliance (DBSA)	**3.** Patient is 18 years old and has a history of Bipolar Affective Disorder and depression. Patient stated that he had a Psychiatrist, but it would be better if he had someone that could truly relate to his depression to talk to as well. DBSA support groups provide patients that live with bipolar disorder and depression a place where they can share their experiences that they have had and to also discuss coping

	skills with one another. They also offer these groups online for the ones that feel uncomfortable being around other people.

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

Brand/ Generic	haloperidol HALDOL (Jones, 2020)	Melatonin N-acetyl-5-methoxytrytamine (Jones, 2020)	OXcarbazepine TRILEPTAL (Jones, 2020)	traZODone DESYREL (Jones, 2020)	benztropine COGENTIN (Jones, 2020)
Dose	5 mg tab	6 mg tab	300 mg tab	100 mg tab	1 mg tab
Frequency	Every 4 hours PRN	Nightly	BID	Nightly PRN	2 times daily PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antipsychotic (Jones, 2020)	Neurology and Psychiatry Herbals (Jones, 2020)	Anticonvulsant (Jones, 2020)	Antidepressant (Jones, 2020)	Anticholinergic (Jones, 2020)
Mechanism of Action	May block postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine, producing an antipsychotic effect (Jones, 2020).	Melatonin regulates the sleep-wake cycle by chemically causing drowsiness and lowering the body temperature. (Jones, 2020)	Anticonvulsant drugs are increasingly used as primary or adjunctive agents in the treatment of comorbid affective/anxiety disorders (Jones, 2020)	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect. (Jones, 2020)	Blocks acetylcholine's action at cholinergic receptor sites. This restores the brain's normal dopamine and acetylcholine balance, which relaxes muscle movement and decreases

					drooling, rigidity, and tremor. (Jones, 2020)
Therapeutic Uses	To treat certain mental/mood disorders. Helps you to think more clearly, feel less nervous, and take part in everyday life. It can also help prevent suicide in people who are likely to harm themselves (Jones, 2020).	Management of sleep disorders and jet lag. (Jones, 2020)	Management of anxiety disorders (Jones, 2020)	To treat major depression. (Jones, 2020)	To treat disorders of the nervous system that causes difficulties with movement, muscle control, balance, and tremors caused by other medical problems or medications. (Jones, 2020)
Therapeutic Range (if applicable)	5.0 – 20.0 ng/mL Toxic: > 42 ng/mL (Jones, 2020)	0.5 mg to 3 mg (Jones, 2020)	3 and 35 mcg/mL (Jones, 2020)	50 mg to 100 mg (Jones, 2020)	1 to 2 mg oral, with a range of 0.5 to 6 mg parenterally. (Jones, 2020)
Reason Client Taking	To control feelings of agitation (Jones, 2020)	To help with sleep-wake cycle disorders. (Jones, 2020)	To treat anxiety and bipolar disorder (Jones, 2020)	To treat depression (Jones, 2020)	To treat movement disorders (Jones, 2020)
Contraindications (2)	Hypersensitivity to haloperidol or its components. Severe toxic	Concurrent use with immunosuppressive treatment. Melatonin can make	Suicidal thoughts Depression (Jones, 2020)	Hypersensitivity to trazodone or its components. An increased	Hypersensitivity to benztropine mesylate or its components.

	CNS comatose states or depression. (Jones, 2020).	symptoms of depression worse. (Jones, 2020)		risk of bleeding. (Jones, 2020)	Presence of tardive dyskinesia. (Jones, 2020)
Side Effects/Adverse Reactions (2)	Agitation. Anxiety (Jones, 2020).	Alertness decreased. Daytime fatigue. (Jones, 2020)	Nervousness Acne, diaphoresis. (Jones, 2020)	Agitation Anxiety (Jones, 2020)	Agitation Depression (Jones, 2020)
Medication/ Food Interactions	Alprazolam, buspirone, chlorpromazine, fluoxetine, fluvoxamine (Jones, 2020)	Anticoagulants. CNS depressants (Jones, 2020)	Alcohol use Carbamazepine, phenobarbital, phenytoin, rifampin, valproic acid. (Jones, 2020)	Aspirin, NSAIDs, barbiturates and other CNS depressants. (Jones, 2020)	Amantadine, phenothiazines, tricyclic antidepressant, haloperidol. (Jones, 2020)
Nursing Considerations (2)	Avoid stopping haloperidol abruptly unless severe adverse reactions occur. Monitor for signs of neuroleptic malignant syndrome, a rare but possible fatal disorder linked to antipsychotic drugs. Signs	Caution in patients under 20 years old, or with depression, hypertension, impaired liver function or seizure disorder. Caution patient to avoid concurrent use of alcohol or other CNS depressants. (Jones, 2020)	Monitor serum sodium level for signs of hyponatremia, especially during first 3 months. Monitor patient closely for evidence of suicidal thinking or behavior, especially when therapy starts or dosage changes. (Jones,	Give trazodone shortly after the patient has a meal or light snack to reduce nausea. Give larger portion of daily dose at bedtime if drowsiness occurs. (Jones, 2020)	Give drug before or after meals based on patient's need and response. Assess muscle rigidity and tremor at baseline. Then monitor them often for improvement, which indicates drug's effectiveness (Jones,

	include altered mental status, arrhythmias, fever, and muscle rigidity. (Jones, 2020)		2020)		2020)

Brand/Generic	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Dose	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Frequency	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Route	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Classification	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Mechanism of Action	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Therapeutic Uses	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Therapeutic Range (if applicable)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Reason Client Taking	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Contraindications	N/A (Jones,	N/A (Jones,	N/A (Jones,	N/A (Jones,	N/A

(2)	2020)	2020)	2020)	2020)	(Jones, 2020)
Side Effects/Adverse Reactions (2)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Medication/Food Interactions	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)
Nursing Considerations (2)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)	N/A (Jones, 2020)

Medications Reference (1) (APA):

Jones, D. W. (2020). *Nurse's drug handbook*. (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient is well groomed and appropriately dressed. Patient's behavior was appropriate, cooperative, and pleasant. Patient has a small build and small frame. Patient has a pleasant attitude and was active in answering and asking question. Patient's speech was clear and understandable. Patient's interpersonal style was very verbal and expressive. Patient's mood was pleasant with lots of smiles. Patient demonstrates appropriate affect by matching expressions.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient stated that his suicidal ideation has reduced since being in the hospital. He stated that he wants to find reasons to live. Patient stated that he is only obsessive about what he does to one side of his body that he has to do it to the other side of the body. Patient denies any delusions, illusions, obsessions, or phobias.
ORIENTATION:	A & O x 4

Sensorium: **Thought Content:**	Patients intellectual and cognitive functions are intact and normal. Logical, goal oriented, and intact.
MEMORY: **Remote:**	Patient's memory is intact and remote. He has the ability to remember things and events from his childhood.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 Patient has fair judgement. Patient has the ability to perform calculation reasoning. Patient is highly intelligent for his age. Patient shows abstract reasoning. Patient is average on impulse control.
INSIGHT:	Patient was very insightful to understanding the cause of his suicide attempt.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 Patient denies use of assistive devices. Patient has a good posture that is straight without any curvature or abnormalities. Patient has bilateral muscle tone, strength, and motor movements on upper and lower extremities.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	69 bpm	114/74	18	98.3 F	99% RA
1500	87 bpm	107/70	16	97.3 F	98% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	Numeric Pain Scale	N/A	0 out of 10	N/A	N/A

1800	Numeric Pain Scale	N/A	0 out of 10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 75% **Lunch:** 75% **Dinner:** 75%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** N//A **Lunch:** N/A **Dinner:** 240 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient will be educated and provided information prior to discharge on coping mechanisms for bipolar disorder, suicidal ideation, alcohol abuse, substance abuse, and inflicting self-harm. The patient will be able to teach back what he has learned prior to being discharged. The patient will continue his weekly visits with his psychiatrist and will continue to take his medications as prescribed by his provider. The patient will be provided with resources such as Alcoholics Anonymous, National Suicide Prevention Lifeline, and Depression and Bipolar Support Alliance to help him cope with any depressive, anxiety, or suicidal thoughts. The patient will be instructed to schedule a follow up appointment with his provider after being discharged to see if any modifications in his treatment need to be made.

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

Nursing Diagnosis • Include full nursing	**Rational** • Explain why the nursing	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**

diagnosis with "related to" and "as evidenced by" components	diagnosis was chosen			
1. Risk for suicide "related to" depression "as evidenced by" patient stated that he felt that there was no other alternative but to end his life to escape how he was feeling inside.	Patient has a history of a suicidal attempt along with a history of depression since childhood.	1.Encourage the patient to talk about negative feelings that he may have. **2.** Have patient placed in a room where he can do no harm to himself. **3.**Collect information on what made the patient want to end his life.	**1.**Do 15-minute checks on the patient. **2.**Monitor for any suicidal ideations. **3.** Listen to the patient and offer him comfort and reassurance.	**1.** Plan with the patient some coping mechanisms he can use to refrain from suicidal ideation. **2.** Provide the patient with a 24/7 suicide hotline number. **3.** Encourage the patient to get involved in group discussions to express his feelings.
2. . Risk for self-harm "related to" bipolar disorder "as evidenced by" patient stating that he thought about dying while he was cutting himself, but never made a cut that would end it all.	Patient has a history of bipolar disorder and a history of inflicting self - harm by cutting himself.	**1.** Keep patient away from any items or objects that he could possibly harm himself with. **2.** Encourage patient to talk to staff members if he feels that his moods keep continuously changing. 3. Work with the patient on goals that he can set for	**1.** Have the patient have one on one settings with a counselor. **2.** Have the patient attend group therapy sessions. **3**. Make sure the patient is taking his medications.	**1.** Educate the patient about the signs and symptoms of bipolar disorder. **2.**Educate the patient on the importance of taking the correct medications and correct doses to help keep this disorder under control (Swearingen, 2019).

		himself.		**3.** Encourage the patient to continue seeing his psychiatrist and to get involved in community support groups for bipolar disorder and depression.
3.Ineffective coping "related to" alcohol and drug abuse "as evidenced by" patient stating that beer and marijuana help calm his nerves and take the edge off.	Patient has a history of ineffective coping by the use of excessive drinking of alcohol and drug use.	**1.** Assess the patient and monitor for any adverse effects from withdrawal. **2.** Keep the patient hydrated **3.** Do a self-evaluation on the patient to see what he believes his level of coping is.	**1.** Have the patient write out coping mechanisms with a supervised staff member. **2.** Spend time with the patient in a calm atmosphere. **3.** Educate the patient on positive, relaxing, and healthy coping mechanisms that he could use (Videbeck, 2019).	**1.** Educate the patient on the harmful effects of abusing substances due to ineffective coping. **2.** Have the patient get involved in AA meetings. **3.** Have the patient engage in relaxing coping mechanisms such as yoga or meditation.

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* (5th ed.). Elsevier

Videbeck, S. L. (2019). *Psychiatric-Mental Health Nursing (8th Edition).* Wolters Kluwer

Concept Map (20 Points):

Subjective Data

- Patient rated his anxiety a 4 out of 10.
- Patient stated that he felt worthless
- Patient stated that he has been depressed for most of his life.
- Patient stated that he has had anxiety issues since he was a kid and sometimes feels like he cannot breathe.
- Patient stated that he feels like he is nothing and empty inside

Nursing Diagnosis/Outcomes

Risk for suicide "related to" depression "as evidenced by" patient stated that he felt that there was no other alternative but to end his life to escape how he was feeling inside.
Risk for self-harm "related to" bipolar disorder "as evidenced by" patient stating that he thought about dying while he was cutting himself, but never made a cut that would end it all
Ineffective Coping "related to" alcohol and drug abuse "as evidenced by" patient stating that beer and marijuana help calm his nerves and take the edge off.

Objective Data

Vital Signs:
Pulse: 87 bpm
B/P: 107/70
Resp Rate: 16
Temp: 97.3 F
Oxygen: 98% RA

Patient Information

18-year old Caucasian male with a history of attempted suicide, inflicting self- harm, depression, anxiety, alcohol abuse, substance abuse, and bipolar affective disorder was admitted with the chief complaint of attempting suicide by taking 150 Advil.

Nursing Interventions

Risk for suicide "related to" depression
Do 15-minute checks on the patient
Provide the patient with a 24/7 suicide hotline number and community support groups.
Risk for self-harm "related to" bipolar disorder
Keep patient away from any items or objects that he could possibly harm himself with.
Have the patient attend one on one sessions with a counselor.
Ineffective Coping "related to" alcohol and drug abuse
Do a self-evaluation on the patient to see what he believes his level of coping is.
Have the patient write out coping mechanisms with a supervised staff member.