N323 Care Plan

Lakeview College of Nursing

Olivia Powell

Demographics (3 points)

Date of Admission 2/18/2021	Patient Initials M.B.	Age 53	Gender F
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Divorced	Allergies Augmentin; rash, Aztreonam, Sulfate antibiotics
Code Status Full	Observation Status 15-minute rounding	Height 5'11	Weight 244lbs

Medical History (5 Points)

Past Medical History:

Significant Psychiatric History: Bipolar depression, suicidal ideations. This patient has a history of being admitted to one other psychiatric facility.

Family History: Maternal – hypertension, elevated lipids. The patient denies any family history of her father.

Social History (tobacco/alcohol/drugs): The patient reported she "smokes a bowl every night". She also reported use of crack cocaine for 3 years. Pt stated she "drinks on occasion".

Living Situation: Patient has a stable living situation. She stated, "I live in an apartment in Danville by myself".

Strengths: The patient reported that she "has strength to be committed, flexible, and empathetic".

Support System: The patients support system includer her daughter and mother. Pt reported "I had a best friend, but he died".

Admission Assessment

Chief Complaint (2 points): Pt stated that she was so "close to committing suicide this time"

Contributing Factors (10 points):

Factors that lead to admission: The patient brought herself in to get the help she needed after talking to her daughter on the phone. She was fired from her position at the Salvation Army for homeless Veterans. The patient also reported having a history of depression for years. She felt this was the closest she has ever been to committing suicide. She felt like this was her only option left.

History of suicide attempts: The patient reported no suicide attempts.

Primary Diagnosis on Admission (2 points): Bipolar depression

Secondary Diagnosis on Admission: Not applicable

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:** The patient reported not being a witness to trauma, but seeing her siblings get verbally abused by their father.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	-	-	-	None
Sexual Abuse	-	AGE 7-8	-	The patient stated that she was molested by her babysitter. She remembered what happened and asked

				her mother the recently what had happened and what she did afterwards to the babysitter.
Emotional Abuse	-	AGE 10	The patient stated she witnessed her siblings experience the verbal abuse from their father and she wishes there is something she could have done to protect them.	The patient stated she was "cussed and yelled at" by her biological father all the time.
Neglect	-	-	-	None
Exploitation				
Crime	-	AGE 30-35	-	The patient reported that she and "some friends would write checks for $50 over the amount". She also claimed that she was later arrested for this crime.
Military	-	-	-	None
Natural Disaster	-	-	-	None
Loss	-	AGE 33	-	The patient reported her best friend died in a car accident.
Other	-	-	-	None
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity,**	

			duration, occurrence)
Depressed or sad mood	**Yes**	**No**	
Loss of energy or interest in activities/school	**Yes**	**No**	Patent reports that she is frequently fatigued and uninterested in activities.
Deterioration in hygiene and/or grooming	**Yes**	**No**	
Social withdrawal or isolation	**Yes**	**No**	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	
Difficulty falling asleep	**Yes**	**No**	
Frequently awakening during night	**Yes**	**No**	Patient reports she is unable to remain almost at night and often wakes during those hours.
Early morning awakenings	**Yes**	**No**	Patient frequently wakes up in the morning for several hours before 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 reports overeating in the mornings.
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**	
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**	
Rating Scale			
How would you rate your depression on a scale of 1-10?		4	
How would you rate your anxiety on a scale of 1-10?		3	
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 stated she is unemployed which impacts her financially.
School	**Yes**	**No**	
Family	**Yes**	**No**	Patient stated her mother is overbearing and over adulting in healthcare information. She reported that her mother is trying to understand her diagnosis better, but it just making it more complicated.
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	Patient stated she is unemployed which impacts her financially.
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
Pt stated she could not remember the exact date but claimed she was there "10 years ago".	**Inpatient** Pavilion **Outpatient** **Other:**	Inpatient	Mental Breakdown, depression	**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Patient lives alone.	-	-	**Yes**	**No**
Not applicable	-	-	**Yes**	**No**
Not applicable	-	-	**Yes**	**No**
Not applicable	-	-	**Yes**	**No**
Not applicable	-	-	**Yes**	**No**

If yes to any substance use, explain: Not applicable

Children (age and gender): Pt stated she has one daughter who is 26 years old.

Who are children with now? Pt stated her daughter lives in Bloomington in an apartment and attends ISU

Household dysfunction, including separation/divorce/death/incarceration: Household dysfunction: Patient reported fighting and arguing with her siblings when they were younger. The patient's biological father would "cuss and yell at them". She also stated her mother and father were divorced. Today, the patient is divorced and lives alone.

Current relationship problems: Pt stated she is not in a relationship.

Number of marriages: 1

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

Please describe your religious values, beliefs, spirituality and/or preference:
The patient stated she is Mormon but "not a good one".

Ethnic/cultural factors/traditions/current activity: Tradition

Describe: The patient stated "No, but my daughter and I attend Juneteenth Celebration and Christmas for the right reasons"

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient reports she is divorced. She also stated she was arrested due to check fraud.

How can your family/support system participate in your treatment and care?
Patient stated her family could be "more open and honest with me".

Client raised by:

Natural parents: Mother
Grandparents
Adoptive parents
Foster parents
Other (describe): Biological father was not in the picture. Pt stated, "My mother's significant other was basically my father".

Significant childhood issues impacting current illness: Patient reported that she was molested and "had someone other than the babysitter touching her private parts".

Atmosphere of childhood home:

Loving She claims she had a pretty normal preteen life that was loving.
Comfortable
Chaotic
Abusive Patient stated that before age 12, the atmosphere was verbally abusive.

Supportive Patient reported that they "always had what we needed". **Other:**
Self-Care **Independent:** Patient is able to perform all ADL's independently and remain unaffected by her bipolar depression **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient stated that "Doug raged. I think he has borderline personality disorder." There was no mental illness within the family per the patient's chart. Doug is the patient's biological father.
History of Substance Use: Patients "smokes a bowl a day". She also reported using crack cocaine for 3 years and will "drink plenty of alcohol on occasion".
Education History: **Grade school** **High school** **College:** Patient earned a Masters in Public Health. **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Pt reported she did well in school with little to no problems.
Discharge
Client goals for treatment: Patient reported she wants to continue therapy and use her coping skills outside of the unit.
Where will client go when discharged? Patient will return back to her apartment in Danville.

Outpatient Resources (15 points)

Resource	Rationale
1. **Rosecrance – Danville, IL**	**1.** Rosecrance is an outpatient substance

https://rosecrance.org/locations/rosecrance-danville/	abuse treatment center. Rosecrance's website states, "94% were satisfied with the treatment". This treatment center offer detoxification, self-reflection, and develop ways to prevent a relapse. Rosecrance operates on a weekly basis which would be beneficial to the patient as she enjoys the weekends for herself and family. The patient should arrange an appointment to help with her cannabis abuse.
2. **Hope Counseling, Inc. – Danville, IL** https://www.hopecounselinginc.com/	**2.** Hope Counseling, Inc. is a family-based therapy practice. According to Hope Counseling, Inc. website, "therapy will be different depending on the individual". This incorporation operates weekly until 8:00 pm. This time slot allows plenty of time for the patient and her family member(s) to come together for therapy. The patient should attend a session to help relief the stress her family is bringing on about her diagnosis.
3. **Illume Counseling & Wellness Center**	**3.** Illume Counseling & Wellness center

https://illumewellnesscenter.com/	is a center for worry and difficulty sleeping. Illume Counseling & Wellness Center reports, “we can get you on track to leading a happier, more fulfilling life”. The patient should arrange a meeting due to her worrying of financial standing and loss of employment as well as seeking treatment for difficulty sleeping through the night.

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

Brand/Generic	**Haldol/Haloperid Lactate**	**Gabapentin/ Neurotin**	**Venlafaxine/ Effexor-xr**	**Divalproex/ Depakote**	
Dose	5mg	600 mg	37.5mg	500mg	
Frequency	Every 6 hrs PRN	2x daily	Daily w/breakfast	2x daily	
Route	IM	Oral	Oral	Oral	
Classification	Antipsychotic	Anticonvulsant	Antidepressant	Antidepressant	
Mechanism of Action	Rebalances dopamine to help increase mood, behavior	Gaba inhibits the firing neurons related to seizures	Inhibits the reuptake of serotonin	Restores the normal balance of neurotransmitters in the brain	
Therapeutic Uses	Used to treat psychotic disorders	Used to treat anxiety	Used to treat bipolar depression	Treats manic episodes related to bipolar depression	
Therapeutic	5-16mg/mL	-	-	-	

Range (if applicable)					
Reason Client Taking	Agitation, psychosis	Bipolar disorder	bipolar disorder	Manic episodes related to bipolar depression	
Contraindications (2)	Parkinson's Disease, depression	Hypersensitivity to gabapentin or its components, lactation	Hypersensitivit y to venlafaxine, use of MAO inhibitor within 14 days	Hypersensitivity to divalproex, high amount of ammonium in the blood	
Side Effects/Adverse Reactions (2)	Hypothermia, angioedema	CNS tumors, depersonalization	Atrophic gastritis, hypokinesia	Pancreatitis, thrombocytopenia	
Medication/Food Interactions	Fluoxetine-increased plasma, Alcohol-increased CNS depression	Hydrocodone, alcohol	Digoxin, iron salts	Propofol, warfarin	
Nursing Considerations (2)	Do not stop medication abruptly, Monitor CBC	Capsules may be opened and mixed with applesauce, give drug with food	Monitor blood pressure, assess patient's electrolyte balance	Monitor CBC, obtain liver function	

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Therapeutic Uses					
Therapeutic Range (if					

applicable)					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Medication/Food Interactions					
Nursing Considerations (2)					

Medications Reference (1) (APA):

Divalproex Sodium (Oral Route) Description and Brand Names. (2021, February 01). Retrieved from https://www.mayoclinic.org/drugs-supplements/divalproex-sodium-oral-route/description/drg-20072886

Jones & Bartlett Learning. (2019). *2020 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Well groomed. Sociable with the group, relaxed, interacted freely. Tall, slim Pleasant Clear, logical Patient was active in group therapy and met with her daughter during visitation. Hopeful, happy Alert and oriented, active in socializing with others.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Suicidal ideations Suicidal None None None None None
ORIENTATION: **Sensorium:** **Thought Content:**	A&Ox4 None Thoughts are goal directed and organized .
MEMORY: **Remote:**	Patient showed good memory. She would reconcile specific dates for events, but not all.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 Fair judgement Patient counted down from 7 Appropriate for age None Displayed impulse control
INSIGHT:	Patient has good insight to present events.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 Steady gait with no use of assistive devices Good posture Fair muscle tone Normal Moves all extremities equally.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

1600	**79**	**144/83**	**20**	**97.7 Oral**	**99% Room Air**
1800	**75**	**136/78**	**18**	**97.8 Oral**	**100% Room Air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1730	**Numeric**	**-**	**0/10**	**-**	**Pt reported no pain. No interventions needed**
1400	**Numeric**	**-**	**0/10**	**-**	**Pt reported no pain. No interventions needed**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** Patient reported she ate 100% of her breakfast **Lunch:** Patient reported she ate 100% of her lunch **Dinner:** Patient reported she ate 100% of her dinner.	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 1 cup of apple juice (240mL) **Lunch:** 1 cup of Sprite (240mL) **Dinner:** 1 cup of water (240mL) and ½ cup of water (120mL)

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient will return home to her apartment in Danville. She will reach out to the resources provided to her to continue her therapy. She will find new coping mechanisms to keep her on track. The patient will also find a new job to get her back to her regular routine. Once she secures a job, she will be able to relief her financial stress

due to having an income again to pay her bills. The patient will be prescribed new home medications for her illness as she will take as prescribed.

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 depression as evidenced by patient needing to be admitted to the hospital.	The patient stated that she was the closest to committing suicide than ever before.	**1.**The client will complete a suicide screening assessment. **2.** Start 1:1 monitoring. **3.** Clear the room of any objects that could be used for self-harm.	**1.** Begin a medication regimen. **2.** Perform 15-minute safety rounding. **3.** Patient should join in group therapy sessions.	**1.** Arrangements should be made for client to stay with family after discharge. **2.** Provide/arrange patient with resources for therapy. **3.** Construct a written contract affirming patient will not conduct self-harm.
2. Ineffective coping related to limited support system as evidenced by substance abuse.	The patient reported she "smokes a bowl everyday" to help deal with stressful situations.	**1.** Assess patient's coping techniques that are unsuccessful **2.** Recognize events that spark suicidal ideation. **3.** Monitor and	**1.** Assess the patient's positive coping mechanisms and strengths **2.** Educate the patient that events will occur that are out of their control	**1.** Make arrangements for patient to join group therapy. **2.** Provide patient with resources for support groups in the area.

		document the patient for possible self-harm.	**3.** Assess the patient's supporting system	**3.** Arrange for patient to join a substance abuse therapy to discontinue the use of cannabis.
3. Increased risk for hopeless related to stress as evidenced by patient stated she lost her job.	The patient lost her job and was close to committing suicide. She felt all hope she had was lost.	**1.** Evaluate patient for possible suicide. **2.** Assess the patient's coping mechanisms. **3.** Urge an expression of feelings.	**1.** Assess the patient's reasons to live. **2.** Establish attainable goals. **3.** Permit patient to interact with others.	**1.** Establish patients support system and foundation for hope **2.** Include the family in the treatment plan. **3.** Make arrangements for patient to join group therapy.

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health* (5th ed.). Mosby.

Wayne, G. 2019, January 29. Risk for Suicide – Nursing Diagnosis and Care Plan. Retrieved from https://nurseslabs.com/risk-for-suicide/#risk_for_suicide_nursing_interventions

Concept Map (20 Points):

Subjective Data

The patient stated she was the closest to suicide now more than ever. She stated that she wanted to receive help and get better. Patient feels she is very hopeful and is willing to carry out her therapy techniques when she is discharged.

Objective Data

Height: 5'11
Weight: 244lbs
Age: 53 years old
Gender: Female
Vitals were stable
The patient has a diagnosis of bipolar depression.

Patient Information

53-year-old Caucasian female presented to the mental health unit for suicidal ideation. Pt was admitted 2/18/2021

Nursing Diagnosis/Outcomes

Risk for suicide related to depression as evidenced by patient needing to be admitted to the hospital.
Patient's suicidal ideations will be reduced by using coping mechanisms.
Ineffective coping related to limited support system as evidenced by substance abuse.
Patients' substance abuse will be treated with therapy 3 times a week.
Increased risk for hopeless related to stress as evidenced by patient stated she lost her job.
Patient will find new employment and continue to improve her lifestyle.

Nursing Interventions

The client will complete a suicide screening assessment.
Start 1:1 monitoring.
Clear the room of any objects that could be used for self-harm.
Begin a medication regimen.
Perform 15-minute safety rounding.
Patient should join in group therapy sessions.
Arrangements should be made for the client to stay with family after discharge
Provide/arrange patient with recourses for therapy.
Construct a written contract affirming patient will not conduct self-harm.
Assess patient's coping techniques that are unsuccessful.
Recognize events that spark suicidal ideations.
Monitor and document the patient for possible self-harm.
Assess the patient's positive coping mechanisms and strengths.
Educate the patient that events will occur that are out of their control.
Assess the patient's supporting system.
Make arrangements for patient to join group therapy.
Provide patient with resources for support group in the area.
Arrange for patient to join a substance abuse therapy to discontinue the use of cannabis.
Evaluate patient for possible suicide.
Assess the patient's coping mechanisms.
Urge an expression of feelings.
Assess the patient's reasons to live.
Establish attainable goals.
Permit patient to interact with others.
Establish patient's support system and foundation for hope.
Include the family in the treatment plan.
Make arrangements for patient to join group therapy.