N323 Care Plan

Lakeview College of Nursing

Mackenzie Melton

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/27/21	M.B.	24 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Swim instructor	Single, but engaged	No known allergies
Code Status	**Observation Status**	**Height**	**Weight**
Full	15-minute rounds	5’4” (162.6cm)	220 pounds (99.8 kg)

Medical History (5 Points)

Past Medical History: Anemia, asthma, constipation, type 2 diabetes mellitus, otitis media, migraines, umbilical hernia, and upper respiratory infection.

Significant Psychiatric History: Patient has a history of anxiety and depression.

Family History: Patient was adopted when she was five years old and does not know her biological family psychiatric health history.

Social History (tobacco/alcohol/drugs): Patient stated that she has no previous or current tobacco use, however she does consume alcohol and uses marijuana. The patient reports that she consumes approximately two glasses of wine twice a week and has been doing so for three years and smokes marijuana two to three time a month when her anxiety is very extreme.

Living Situation: Patient lives in a two bed, one bath house with her Fiancé and two children.

Strengths: Patient stated that her strengths are that she is very good at talking to and helping people, even if she doesn’t feel like she is in a good mood herself. She also stated that “making other people feel better, makes her feel better and is comforting”. Patient’s inpatient stay is insured.

Support System: Patient’s main support comes from her Fiancé, her adoptive father, and one close friend that she only sees once a month.

Admission Assessment

Chief Complaint (2 points): Patient's chief complaint is depression, thoughts of suicidal ideation without plans to carry out, and "not wanting to be a mom or live anymore".

Contributing Factors (10 points): On February 27th, a 24-year-old African American, single female was admitted to OSF Heart of Mary Medical Center with depression, thoughts of suicidal ideation without the plan to carry out, and "not wanting to be a mom anymore". The patient had been feeling very anxious and depressed on and off since December 2020 and has been seeing a counselor but has had no improvement. The patient has also been experiencing frequent panic attacks and a constant feeling of being overwhelmed on top of her depression due to having less help with the kids at home. Patient stated prior to arriving at the ER, she had been at a monthly doctor's appointment for her 7-month-old daughter and was advised to seek inpatient psychiatric care after filling out a questionnaire. The patient has had depression since prior to having her first child two years ago, but it has been worsened since having her 7-month-old daughter. The patient was admitted to the behavioral health floor to further evaluate her and to help control her depression, anxiety, and bipolar disorder. The patient is compliant with attending scheduled appointments with her counselor.

Factors that lead to admission: Patient's adoptive father had been diagnosed with stage four Leukemia in November of 2020 and "nothing can be done for him, he has a year left" as well as not having much help with the children at home recently due to her Fiancé working overtime at his job.

History of suicide attempts: Patient attempted suicide on February 16th, 2021 by taking approximately 25 tablets of acetaminophen.

Primary Diagnosis on Admission (2 points): The primary diagnosis upon admission is bipolar disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient has and currently does experience emotional abuse at the hands of her adoptive mother. **Witness of trauma/abuse:** None.				
	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	None
Sexual Abuse	N/A	N/A	N/A	None
Emotional Abuse	Currently	Beginning at 13 years old	N/A	Patient's adoptive mother is negative towards her. Patient states "She be littles me and does not believe anything I say. It's like she doesn't trust me." Patient only talks to her mother once a week for about 15 minutes and this happens during

				every conversation. Patient says this response from her mother has caused her to not socialize with her as frequently.
Neglect	N/A	N/A	N/A	None
Exploitation	N/A	N/A	N/A	None
Crime	N/A	N/A	N/A	None
Military	N/A	N/A	N/A	None
Natural Disaster	N/A	N/A	N/A	None
Loss	N/A	14 years old	N/A	Patient experienced loss as her Grandma passed away at this age. Patient felt "very sad and lonely for at least a month".
Other	N/A	N/A	N/A	None

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	For the past two years but more severe since having her daughter 7-months ago. The patient experiences these depressed or sad moods three to four times a day and they tend to add up to approximately six to eight hours a day and are very intense. The intensity varies depending on the day "sometimes I barely want to get out of bed, other days, like yesterday I didn't want to live".
Loss of energy or interest in activities/school	**Yes**	**No**	Every day for the past two months. Patient finds herself going to take a nap at least once a day for an hour or longer due to

			being tired and not wanting to do anything else.
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A.
Social withdrawal or isolation	**Yes**	**No**	N/A
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient knows that if she lets her feelings affect any of these aspects that she may end up risking her relationship with her fiancé or her kids well-being, so she keeps from letting things affect these aspects of her life as much as possible.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	For about 8 months prior to admission, the patient has had difficulty getting a full night's rest, averaging about 4 to 6 hours a night, every single night. Since being admitted, the patient has gotten approximately 9 hours of sleep a night due to taking a sleep aid.
Difficulty falling asleep	**Yes**	**No**	Patient does not experience any difficulty falling asleep in the hospital due to a sleep aid, but prior to admission the patient would have difficulty falling asleep about 4 times a week as her "mind won't shut off". Most nights she would lay in bed for an hour till she finally fell asleep.
Frequently awakening during night	**Yes**	**No**	For about 8 months and currently while admitted, the patient has had difficulty staying asleep throughout the night as she wakes up three to four times a night, every single night, either to pump breast milk or just randomly and is up for around half an hour to an hour every time.
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 resorts to biting her finger nails when she has a lot of anxiety. She has been biting her finger nails off and on since she was around 14 years old, finding herself doing it to the point where they are almost raw about two times a month. Patient does currently have one finger nail that is raw and scabbing around the cuticles from her most recent episode on Monday.
Panic attacks	**Yes**	**No**	Patient has frequent panic attacks when she is very stressed, overwhelmed, and tired. Patient has 4 to 5 panic attacks a week that last duration of approximately 15 minutes each time. Patient's last panic attack was on Monday 3/1 and she had a total of two that day- one in the morning around 1100 and one around 2015 at night.
Obsessive/compulsive thoughts	**Yes**	**No**	N/A

Obsessive/compulsive behaviors	**Yes**	**No**	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	N/A
Rating Scale			
How would you rate your depression on a scale of 1-10?	Patient reports her depression level as a 6/10.		
How would you rate your anxiety on a scale of 1-10?	Patient reports her anxiety level as an 8/10.		
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	N/A
School	**Yes**	**No**	N/A
Family	**Yes**	**No**	N/A
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	N/A
Financial	**Yes**	**No**	N/A
Other	**Yes**	**No**	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
December 3rd, 2020-current	**Inpatient Outpatient:** Patient has been	Outpatient	Patient has been seeing her	**No improvement** **Some**

	seeing a counselor by the name of Joy Mitchell in Peoria once a week since her first appointment back December. **Other:**		counselor to help with her depression and anxiety. Having thought that talking to someone will help decrease any negative moods or thoughts.	**improvement**: Patient states she has some improvement in her depression, but says it really just depends on the day how much it helps. She states she felt like talking to her counselor helped a lot originally, but now not as often or for as long. **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Zachary	21 years old	Fiancé	**Yes**	**No**
Benjamin	2 years old	Son	**Yes**	**No**
Zoey	7 months old	Daughter	**Yes**	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: Patient's fiancé smokes two cigarettes a day and has for				

the last three years and drinks alcohol socially, approximately four times a month.
Children (age and gender): Patient has two children. Benjamin, male and 2 years old, and Zoey, female and 7 months old. **Who are children with now?** Patient are currently with their paternal grandma and great grandma until their father, Zachary, gets off work around 1800 to pick them up and take them home.
Household dysfunction, including separation/divorce/death/incarceration: None- patient states no household dysfunction other than her father's recent terminal diagnosis and having been adopted at a young age.
Current relationship problems: Patient states that her relationship with her Fiancé is very healthy for the most part. They have been together for seven years and he is very supportive, but has recently stopped helping out as much with the kids and house hold chores due to working so much over time to provide/support the family. **Number of marriages:** 0

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

Please describe your religious values, beliefs, spirituality and/or preference: Christian
Ethnic/cultural factors/traditions/current activity: Patient states she is not a practicing Christian and her religious beliefs do not affect the client's activities or moods. **Describe:** N/A
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient was put up for adoption by her biological mother when she was 5 years old and later adopted by her current parents. Patient states no other legal issues currently or since then.
How can your family/support system participate in your treatment and care? Patient states her adopted mother could stop being so negative and belittling her as those cause her to be more depressed since it is what makes her not talk to her as often. Patient also believes that her panic attacks, depression, and anxiety can be reduced if her Fiancé helped even just a little bit more at home- other than that he is super supportive and helps anyway he can with calming her down.
Client raised by: **Natural parents**- Patient was raised by biological mother till around the age of five, then she was put up for adoption and adopted by a family shortly after. **Grandparents** **Adoptive parents**- Patient was primarily raised by her adoptive mother and father since the age of 5. **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient states "not being wanted by my birth mom probably doesn't help my mental health".
Atmosphere of childhood home: After having been adopted

Loving **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient does not know her biological family so she is unsure of any family history of mental illness.
History of Substance Use: Patient has no previous or current tobacco use, however she does consume alcohol and uses marijuana. The patient reports that she consumes approximately two glasses of wine twice a week and has been doing so for three years and smokes marijuana two to three time a month when her anxiety is very extreme.
Education History: **Grade school** **High school**- Patient graduated and obtained her high school diploma in 2015. **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient was not good at studying, could never retain important information for long periods of time, and procrastinated doing her homework which resulted in lots of late or missing assignments.
Discharge
Client goals for treatment: "To be happy and enjoy being a mom again."
Where will client go when discharged? Patient will go back to living at her house with her Fiancé and two kids when she is discharged.

Outpatient Resources (15 points)

Resource	Rationale
1. Mothers Offering Mothers Support Group in Peoria	**1.** To provide and receive emotional and physical support from other moms who sometimes have their doubts or need some advice when overwhelmed with their children. Gives the patient an ability to form supportive relationships with other women who may be experiencing similar stressors.
2. Grief support group at Northwoods Community Church in Peoria	**2.** Allows the patient to connect, talk, and express her feelings and emotions about her father's terminal illness with other people who are experiencing similar losses.
3. Depression and Bipolar Support Alliance (DBSA) Peoria	**3.** To help her understand and comply with the importance of taking her medications and to help her find ways to cope and calm herself during exacerbations.

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

Brand/ Generic	Trileptal/ oxcarbazepine	Haldol/haloperidol	Tylenol/ acetaminophen	Desyrel/trazodone	Proventil/ albuterol
Dose	300mg	5mg	60mg	100mg	2.5mg/3mL
Frequency	TID	Q4H PRN	Q4H PRN	Daily HS	Q6H PRN
Route	PO	PO/IM	PO	PO	Inhalation/ Nebulization
Classification	Anticonvulsant	Antipsychotic	Nonopioid analgesic	Antidepressant	Bronchodilator
Mechanism of Action	Blocks sodium channels in neuronal cells in order to slow nerve impulses and prevent seizures (Jones & Bartlett	Produces an antipsychotic effect by blocking dopamine receptors in limbic system and increased brain turnover of	Interferes with pain impulse generations in the peripheral nervous system by blocking prostaglandin and	Produces an antidepressant effect by blocking the reuptake of serotonin by the presynaptic neuronal membrane (Jones	Attaches to beta 2 receptors on bronchial cell membranes to stimulate the

	Learning, 2020).	dopamine (Jones & Bartlett Learning, 2020).	cyclooxygenase production (Jones & Bartlett Learning, 2020).	& Bartlett Learning, 2020).	conversion of ATP to cAMP to relax bronchial smooth muscle cells (Jones & Bartlett Learning, 2020).
Therapeutic Uses	Prevent/treat seizures; also prescribed "off-label" for nerve pain and as a mood stabilizer	Treat psychotic episodes and Tourette's syndrome	To relieve mild or moderate pain	To treat major depression and insomnia	To prevent exercise induced bronchospasm and treat bronchospasms with reversible obstructive airway disease
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Mood stabilizer for bipolar disorder	Bipolar disorder	To relieve migraine pain	Depression and as a sleep aid	Asthma
Contraindications (2)	Hypersensitivity, pregnancy or breast feeding	Depression, CNS comatose states, hypersensitivity	Hepatic impairment, liver disease	Use within 14 days of a MOA inhibitor, recovery from acute MI	Hypersensitivity, arrythmias
Side Effects/ Adverse Reactions (2)	Drowsiness/ fatigue, suicidal ideation	Seizures, hepatitis	Hypotension, Insomnia	Serotonin syndrome, suicidal ideation	Anxiety, pulmonary edema
Medication/ Food	Alcohol, oral contraceptives, lorazepam,	Alcohol, anticonvulsants	Alcohol, carbamazepine	NSAIDs, Alcohol	MOA inhibitors, beta

Interactions	carbamazepine				blockers
Nursing Considerations (2)	Monitor patient for suicidal behavior or thinking, educate patient that taking oxcarbazepine will make oral contraceptives ineffective, monitor for rash	Educate patient to not stop taking abruptly unless severe reactions occur, Monitor CBC	Teach patient to monitor for signs of hepatotoxicity such as bleeding, malaise, and easy bruising, educate patient to not exceed prescribed or recommended dose	Monitor closely for serotonin syndrome exhibited by agitation, coma, hallucinations, etc., Give after eating a a meal or light snack	Monitor potassium levels, rinse mouth and mouth piece after use.

Brand/Generic	MiraLAX/polyethylene glycol	Feosol/ferrous sulfate	N/A	N/A	N/A
Dose	17g	325mg	N/A	N/A	N/A
Frequency	Daily PRN	BID	N/A	N/A	N/A
Route	PO	PO	N/A	N/A	N/A
Classification	Laxative	Antianemic	N/A	N/A	N/A
Mechanism of Action	Attracts water into the colon by PEG 2250 hydrates to help soften stool to unblock a person's system (Jones & Bartlett Learning, 2020).	Normalizes RBC production by binding with hemoglobin	N/A	N/A	N/A
Therapeutic Uses	Treats constipation	To prevent iron deficiency	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A

Reason Client Taking	Constipation	Anemia	N/A	N/A	N/A
Contraindications (2)	Bowel obstruction, appendicitis	Hemolytic anemias, Hemochromatosis	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	Diarrhea, rectal bleeding		N/A	N/A	N/A
Medication/Food Interactions	Furosemide, diphenhydramine	Coffee, eggs, milk products, levothyroxine	N/A	N/A	N/A
Nursing Considerations (2)	Do not use for more than 7 days consecutively, take with a full 8oz glass of water	Give with a full glass of orange juice to increase absorption, monitor patient's blood pressure	N/A	N/A	N/A

Medications Reference (1) (APA):

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

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Dressed appropriately in a hooded sweatshirt and some black leggings. Patient looked well-groomed and had fair hygiene. **Behavior:** calm, quiet, and appears to be relaxed. Patient was tearful at one point during conversation. **Build:** Overweight **Attitude:** Focused **Speech**: Clear, thoughtful, well-explained, and intelligent. **Interpersonal style**: Very talkative and in tuned to the conversation, receptive to questions and has great eye contact and expressions, cooperative. **Mood:** Depressed, anxious **Affect**: Appropriate to context
MAIN THOUGHT CONTENT:	

Ideations: **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient experiences suicidal ideations. Patient has no delusion, illusions, obsessions, compulsions, or phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	 **Sensorium**: Alert and orientatedx4 4 to person, place, time, and situation. **Thought Content**: Intact, goal-directed, organized
MEMORY: **Remote:**	Intact! Patient quickly able to recall and verbalize memories and emotions from the last several years. Had no difficulty answering any past medical or mental health history for herself.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 **Judgement:** Good **Calculations:** Fair **Intelligence:** Average **Abstraction:** Average **Impulse Control:** Average
INSIGHT:	Very insightful- patient is aware and wants help. Patient did state during conversation that she "does not feel ready to leave. She wants to stay here longer."
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 **Assistive devices:** None **Posture:** Good **Muscle tone:** Average **Strength**: Average, bilateral grips **Motor Movements:** Good, clean, fluent

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1427	96 bpm	127/81 mm Hg	18 breaths/min	98.7 F	97%
1834	98 bpm	132/84 mm Hg	18 breaths/min	98.4 F	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1427	Numeric	N/A	0/10	N/A	N/A
1839	Numeric	N/A	0/10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100% (per patient) **Lunch:** 100% (per patient) **Dinner:** 100% (per observation)	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 120 mL (per patient) **Lunch:** 360 mL (per patient) **Dinner:** 240 mL (per observation)

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Prior t discharge, patient will be educated on her new diagnosis of bipolar disorder as well as reeducated on her previous depression and anxiety diagnoses. There are no home health care or equipment needs but patient would benefit from several different types of counseling or appointments. The patient will return to her home with her fiancé and two children. The patient needs to obtain a follow-up appointment with a psychiatrist to try and get on/establish potential maintenance medications to help stabilize her emotions and moods as well as go to see a counselor. The patient would also benefit from attending a couple's therapy session with her fiancé to try and work out fair household and child responsibilities to help reduce the client's stress. One other type of counseling hat would be

recommended to the client is some sort of grief counseling in order to help cope with the impact of her father's terminal diagnosis.

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. Decreased ability to cope related to increased stress within the family and her father's terminal diagnosis as evidenced by "my dad is my best friend; I don't know what I'll do without him- he helps me calm down".	Patient is visibly upset while talking about her father and his diagnosis. She is the closest to her father and he is a big part of her support system as he will watch her kids when needed so she can rest. Patient has stated multiple times that he is the one person able to really help her calm	**1.** Assess patient's previous coping skills and strategies **2.** Assess patient for feelings of grief associated with the expected loss **3.** Encourage client to make decisions in regard to care and coping mechanisms used during and after visit	**1.**Provide opportunities for individual and group therapy **2.** Monitor for risk of self-harming as a way for patient to negative cope with emotions **3.** Use active listening and empathetic communication to help client express emotions.	**1.** Refer and provide information on local grief counselors **2.** Educate patient on the importance of coping strategies to help reduce stress **3.** Provide patient and family with helpful resources to utilize in order to promote coping during times of stress

	down and makes her feel better.			
2. Stress overload as related to increased workload as evidenced by her Fiancé working overtime at his job and "never helping with the kids or housework anymore".	The frequency and intensity of the patients anxiety attacks, depressed moods, and thoughts of self-harm have increased within the last seven months since she is doing all of the housework and taking care of the kids as her Fiancé has been working overtime to try and make more money to support the new babies needs and is not helping with the home and kids.	**1.** Assess patient's stress levels with vital signs and pain assessment. **2.** Assist patient in determining goals and ways to reduce stress **3.** Utilize active listening and therapeutic communication in order to allow for client to verbally express her stressors	**1.** Determine and teach relaxation techniques the patient would benefit by using in order to decrease stress **2.**Administer medication as prescribed to help reduce associated feelings and emotions **3.** Act as role model for patient in healthy ways to reduce stress and effective relaxation techniques	**1.** Educate patient on how to divide responsibilities into more manageable section in order to reduce stress 2 Encourage patient to discuss when stress, stressors, and work load becomes overwhelming with Fiancé and other members of her support system 3. Help the family identify ways in which they can help reduce the patients stress and work load
3 Risk for self-harm related to depression	Patient has recently had a failed suicide attempt and	**1.** Assess if patient has a plan to self-harm and why	**1.** Have patient attend group therapy sessions	**1.** Educate patient on the importance of taking

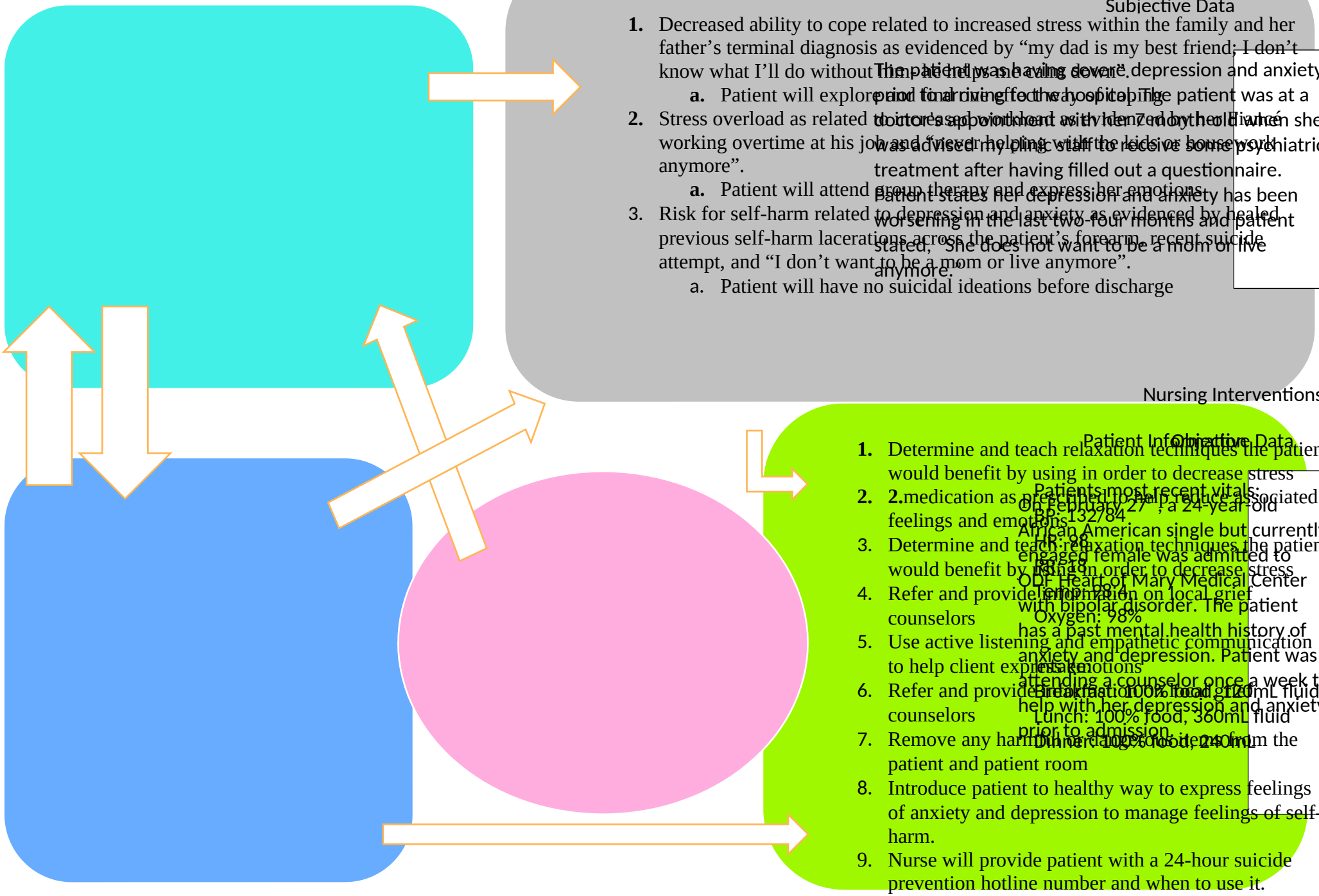
and anxiety as evidenced by healed previous self-harm lacerations across the patient's forearm, recent suicide attempt, and "I don't want to be a mom or live anymore".	has increased thoughts of suicidal ideations as she's thought about "not wanting to be a live" multiple times within the last week alone. Patient's scars on her fore arms are from previous acts of self-harm, resulting in an even greater chance of self-harming again.	she is feeling the way she is **2.** Remove any harmful or dangerous items from the patient and patient room **3.** Help patient establish personalized goals to work towards during and after admission	**2.** Implement and check on patient every 15 minutes. **3.** Introduce patient to healthy way to express feelings of anxiety and depression to manage feelings of self-harm.	prescribed medications as indicated. **2.** Nurse will provide patient with a 24-hour suicide prevention hotline number and when to use it. **3.** Encourage and provide resources on outpatient therapy and counseling services

Other References (APA):

Swearingen, P.L., Wright, J.D. (2019). *All-in-one nursing care planning resource* (5th ed).

Elsevier.

Concept Map (20 Points):



Subjective Data

The patient was having severe depression and anxiety and was driving to the hospital. The patient was at a doctor's appointment with her 7 month old when she was advised my pmg staff to receive some psychiatric treatment after having filled out a questionnaire. Patient states her depression and anxiety has been worsening in the last two-four months and patient stated, "She does not want to be a mom or live anymore."

1. Decreased ability to cope related to increased stress within the family and her father's terminal diagnosis as evidenced by "my dad is my best friend; I don't know what I'll do without him" and "I'm just breaking down".
   a. Patient will explore and find a healthy coping mechanism prior to discharge
2. Stress overload as related to increased workload as evidenced by her fiancé working overtime at his job and "never helping with the kids or housework anymore".
   a. Patient will attend group therapy and express her emotions
3. Risk for self-harm related to depression and anxiety as evidenced by healed previous self-harm lacerations across the patient's forearm, recent suicide attempt, and "I don't want to be a mom or live anymore".
   a. Patient will have no suicidal ideations before discharge

Nursing Interventions

Patient Information

Objective Data

Patients most recent vitals:
BP: 132/84
HR: 88
RR: 18
Temp: 98.4
Oxygen: 98%
Breakfast: 100% food, 120mL fluid
Lunch: 100% food, 360mL fluid
Dinner: 100% food, 240mL

On February 27th, a 24-year-old African American single but currently engaged female was admitted to ODF Heart of Mary Medical Center with bipolar disorder. The patient has a past mental health history of anxiety and depression. Patient was attending a counselor once a week to help with her depression and anxiety prior to admission.

1. Determine and teach relaxation techniques the patient would benefit by using in order to decrease stress
2. 2.medication as prescribed to help reduce associated feelings and emotions
3. Determine and teach relaxation techniques the patient would benefit by using in order to decrease stress
4. Refer and provide information on local grief counselors
5. Use active listening and empathetic communication to help client express emotions
6. Refer and provide information on local grief counselors
7. Remove any harmful objects/items from the patient and patient room
8. Introduce patient to healthy way to express feelings of anxiety and depression to manage feelings of self-harm.
9. Nurse will provide patient with a 24-hour suicide prevention hotline number and when to use it.