N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 2/28/21	**Patient Initials** K.D.	**Age** **79**	**Gender** **Female**
Race/Ethnicity **Caucasian**	**Occupation** **Gift shop employee at medodist medical center**	**Marital Status** **Widowed**	**Allergies** **Morphine** **Sulfa antibiotics** **Gabapentin**
Code Status **Full Code**	**Observation Status** **15-minute rounds**	**Height** **5'5" (165.1 cm)**	**Weight** **189 lbs. (85.7 kg)**

Medical History (5 Points)

Past Medical History: Patient has history of breast cancer (1998), gastroesophageal reflux disease (GERD), high cholesterol and irritable bowel syndrome (IBS).

Significant Psychiatric History: Patient has no significant psychiatric history. Patient has never seen a psychiatrist or has been hospitalized due to mental health.

Family History: Patient's mother has a history of breast cancer and a stroke. Patient's brother has a history of hypertension. Patient's sister has a history of hypotension.

Social History (tobacco/alcohol/drugs): Patient denies use of drugs. Patient reports to quit smoking 32 years ago. Patient reports that she drinks about three days a week. Patient reported to drink about 1-2 glasses of wine after work, about three days a week. Patient reported to drink the glasses of wine Friday through Sunday.

Living Situation: Patient is widowed and lives alone in her home.

Strengths: Patient reports she is very good at hiking, and being a good mother/ grandmother to her son and grandkids.

Support System: Patient reports her support system is her son. He lives in Boston but she visits him four times a year for a week at a time.

Admission Assessment

Chief Complaint (2 points): Patient's chief complaint is suicidal ideation with anxious thoughts.

Contributing Factors (10 points):

Factors that lead to admission: Patient was brought to OSF hospital after a call to 911 was made after a altercation over the phone with her brother over politics. The patient texted her son, "I ca no longer do this", and the son called the 911. The patient drank an entire bottle of Italian vermouth which she stated altered her mind and escalated her emotions to attempt suicide.

History of suicide attempts: Patient stated to never have a previous suicide attempt in her life time but this one.

Primary Diagnosis on Admission (2 points): The primary diagnosis upon admission was major depressive disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient denied any history of trauma initially , but further opened up about some traumatic events in her life. **Witness of trauma/abuse:** Patient denied witness of trauma/ abuse.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with**	**Describe**

			trauma)	
Physical Abuse				Patient denied history of physical abuse
Sexual Abuse				Patient denied history of sexual abuse
Emotional Abuse				Patient denied history of emotional abuse
Neglect				Patient denied history of neglect
Exploitation				Patient denied history of exploitation
Crime				Patient denied history of crime
Military	No current trauma	4 years old		Patient lost her father due to WW2 when she was 4 years old. Patient reported she can't exactly remember the factors but knew it really affected her family when he died because they were so close.
Natural Disaster				Patient denied witnessing a natural disaster.
Loss	Sister Husband	24 years old 52 years old		Patient lost her sister to a car accident when she was 24 years old. Patient stated she got a phone call one morning that her sister had passed away during impact of the crash. Patient also lost her husband due to cancer when she was 52 years old.

Other				
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Patient reported to have frequent sad moods due to COVID-19 quarantine. Patient reports the continuous isolation and quarantine due to her age has increased her depression.	
Loss of energy or interest in activities/school	**Yes**	**No**	Patient is not currently experiencing loss of energy or interest in activates/school	
Deterioration in hygiene and/or grooming	**Yes**	**No**	Patient was well groomed and showered that day.	
Social withdrawal or isolation	**Yes**	**No**	Patient lives alone, all of her family lived in Germany and her son lives in Boston. Patient reported she feels withdrawn and isolated due to being alone.	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient does not have any difficulties with home, school, work, relationships or responsibilities	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	Patient reports having her sleep schedule messed up due to being in OSF hospital. Patient reports to either sleep many hours through the night or many hours through the day. Patient said it is not very intense and has days were there was no sleeping issues.	
Difficulty falling asleep	**Yes**	**No**	Patient reports to having difficulty falling asleep. Patient reported she has nights there is no issue but other times she does sue to missing her own home.	
Frequently awakening during night	**Yes**	**No**	Patient reports she only wakes up to go to the bathroom.	
Early morning	**Yes**	**No**	Patient reports no early morning	

awakenings			awakenings
Nightmares/dreams	**Yes**	**No**	Patient reports no nightmares/ dreams.
Other	**Yes**	**No**	N/A
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient reports no changes in eating habits.
Binge eating and/or purging	**Yes**	**No**	Patient reports no binge eating and/or purging.
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Patient reports no unexplained weight loss.
Use of laxatives or excessive exercise	**Yes**	**No**	Patient reports no use of laxatives or excessive exercise
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient reports to be very agitated and keeps moving to try to distract her from being in the facility. Patient reports she is very anxious to get out of the hospital and the uncertainty causes more anxiety.
Panic attacks	**Yes**	**No**	Patient reports to have no panic attacks.
Obsessive/compulsive thoughts	**Yes**	**No**	Patient reports not having any obsessive/compulsive thoughts.
Obsessive/compulsive behaviors	**Yes**	**No**	Patient reports not having any obsessive/compulsive behaviors.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient reports no impact on daily living activities due to high levels of anxiety.
Rating Scale			
How would you rate your depression on a scale of 1-10?			Patient rates her depression a 4/10.
How would you rate your anxiety on a scale of 1-10?			Patient rates her anxiety a 5/10.

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 has no work issues.
School	**Yes**	**No**	Patient has no school issues.
Family	**Yes**	**No**	Patient reports she has issues with her brother. Patient reports they have phones calls about politics that always end up very bad
Legal	**Yes**	**No**	Patient has no legal issues.
Social	**Yes**	**No**	Patient has no social issues.
Financial	**Yes**	**No**	Patient has no financial issues.
Other	**Yes**	**No**	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
Patient has never been previously institutionalized for psychiatric or substance use treatment.	**Inpatient** **Outpatient** **Other: N/A**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History

Who lives with you?	Age	Relationship	Do they use substances?	
Patient is widowed and lives alone.			**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain: N/A

Children (age and gender): Patient has a 56 year old son who lives in Boston, Massachusetts.

Who are children with now? Son is in Boston with his wife and children.

Household dysfunction, including separation/divorce/death/incarceration: Patient is widowed and lives alone in her home.

Current relationship problems: Patient is widowed.
Number of marriages: 1

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

Please describe your religious values, beliefs, spirituality and/or preference: Patient has tried many different religious/ spirituality preferences but is currently Christian.

Ethnic/cultural factors/traditions/current activity: N/A

Describe: None

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): None

How can your family/support system participate in your treatment and care? Patient reported, “My brother and I can stop having political conversations over the phone”.

Client raised by:

Natural parents-
Patient was raised by her natural parents. Patients father passed away in World War 2. Patient has a step father when she was 8 years old and reported they had a good relationship.

Grandparents
Adoptive parents
Foster parents

Other (describe):
Significant childhood issues impacting current illness: Patient reported there was no significant childhood issues impacting current illness.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient reports no family history of mental illness.
History of Substance Use: Patient reports no history of substance abuse.
Education History: Patient went to college at Brady and a Jr. college in Peoria. She graduated and went on to become a nurse. **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: German
Problems in school: Patient reports no problems in school.
Discharge
Client goals for treatment: Patient reports her goal is to discharge and take all the tools she will learn in treatment and use them when she goes home.
Where will client go when discharged? Patient plans to return back home when she is discharged.

Outpatient Resources (15 points)

Resource	Rationale
1. Crisis Hotline/ Suicide Prevention Hotline	**1.** This resource can be used by the client when they have an suicidal thoughts . This hotline is available 24/7.
2. Psychiatric Consult Service	**2.** This resource will provide an opportunity for the patient to find a good psychiatrist she can continuously see upon discharge for medication purposes.
3. Outpatient Therapy	**3.** This resource is still in the works to find the patient a therapist to go see about every week to discuss her current moods and any changes upon discharge.

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

Brand/Generic	**(**Cogentin) benztropine	(Buspar) buspirone	(Remeron) mirtazapine	(Protonix) pantoprazole	(Vivitrol) naltrexone
Dose	2 mg	10 mg	15 mg	40 mg	50 mg
Frequency	BID, PRN	BID	At bed time	BID	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Anticholinergics	Antianxiety agent	Antidepressant	Proton pump inhibitors (PPIs)	Opioid antagonist
Mechanism of Action	It exerts its action through competing with acetylcholine at muscarinic receptors.	Unknown. Has moderate affinity for brain D2-dopamine receptors.	May inhibit neuronal reuptake of norepinephrine and serotonin. Increased neuronal	binds to the sulfhydryl group of H+, K+-ATPase, which is an enzyme implicated in accelerating the	Displaces opioid agonist from or blocks them from binding with- delta, kappa, and

			serotonin and norepinephrine levels may elevate mood.	final step in the acid secretion pathway. The enzyme is inactivated, inhibiting gastric acid secretion.	mu receptors.
Therapeutic Uses	To treat symptoms of Parkinson's disease, tremors, and any involuntary muscle control.	Treat anxiety, think more clearly, relax, worry less, feel less jittery and irritable.	To treat major depression	To treat erosive esophagitis associated with gastroesophageal reflux disease (GERD)	To treat opioid dependence
Therapeutic Range (if applicable)	N/A	20-30 mg per day of divided doses.	N/A	40 mg daily given 30 minutes before a meal for up to 12 months	N/A
Reason Client Taking	To treat imbalances of chemicals that may arise from other medications.	To decrease anxiety and to think more clearly.	To treat depression and sometimes obsessive compulsion disorders and anxiety disorders.	To maintain healing of erosive esophagitis and reduce relapse of daytime and nighttime symptoms in patients with GERD	used to help narcotic dependents who have stopped taking narcotics to stay drug-free. It is also used to help alcoholics stay alcohol-free.
Contraindications (2)	In patients with known benztropine mesylate hypersensitivity, Intestine infection	Renal failure, Hepatic disease	Hypersensitivity, dehydration	Concurrent therapy with rilpivirine-containing problems, hypersensitivity, lansoprazole	Acute hepatitis, acute opioid withdrawal
Side Effects/Adverse Reactions (2)	Dry mouth, constipation	Chest pain, shortness of breath	Agitation, bradycardia	Fatigue, hypersensitivity	Abnormal thinking, agitation

Medication/Food Interactions	Avoid foods high in Calcium, pickled or Fermented foods, Vit. K Rich foods, and Grapefruit.	May be taken with or without food, grapefruit may increase the risk of side effects.	No specific food exclusion for this medication. Do not drink alcohol while taking.	Avoid foods that make symptoms worse such as rich, spicy and fatty foods. It helps to cut down on caffeinated drinks, such as tea, coffee and cola, as well as alcohol.	Opioid analgesics reverse and cause adverse effects, possible withdrawal symptoms
Nursing Considerations (2)	Assess therapeutic effectiveness, monitor I&O ratio and pattern.	Do not administer with grapefruit juice, Instruct patient to avoid alcohol and other CNS depressants.	Use cautiously in elderly patients and in those receiving concurrent medication known to cause hyponatremia because this drug lowers drug serum levels in patients.	Ensure the continuality of gastric acid suppression during transition from oral to suppression during transition from oral to I.V. Administer delayed-release oral suspension 30 minutes before a meal mixed in apple juice or apple sauce.	To avoid withdrawal symptoms, wait 7 to 10 days after last opioid dose, as prescribed, before starting naltrexone. Dilute parenteral form using only diluted supplied in carton.

Medications Reference (1) (APA):

RxList. (2021). WebMD, Medscape, eMedicineHealth, MedicineNet, OnHealth.

Mental Status Exam Findings (20 points)

APPEARANCE:	Clean, showers daily
Behavior:	Stable and calm
Build:	Medium build
Attitude:	Cooperative
Speech:	Spontaneous
Interpersonal style:	Engaged, cooperative, and oriented
Mood:	Irritable
Affect:	Calm

MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 Suicidal (current: none) None None None None None
ORIENTATION: **Sensorium:** **Thought Content:**	A & O x3 N/A Fair and organized
MEMORY: **Remote:**	No impairment
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Sensible Fair N/A Average None Average
INSIGHT:	Fair
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 None Fair Average Average Average

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1600	96 BPM	165/84 mmHg	14 breathes/min	96.8 F	96%
1900	94 BPM	174/85 mmHg	16 breaths/min	98.6 F	95%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	Numerical	N/A	0/10	N/A	N/A
1900	Numerical	N/A	0/10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 50% **Lunch:** 75% **Dinner:** 50%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 240 mL **Lunch:** 240 mL **Dinner:** 187 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient should seek weekly outpatient therapy to rid of suicidal ideations and control her thought process. The patient should also remain on all medications to improve symptoms and to improve any distress. Encourage the client to discuss to her brother that the political issues need to be resolved.

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. Interpersonal conflicts	Related to influence from	**1.**Monitor patient	**1.**Provide information on	**1.** Look for family therapy

between family members	family member, as evidence by attempt suicide	**2.** Assess relationship with brother and other family members **3.** Look to see if the patient acts a certain way when said family member is brought up	how to manage and deal with depression and suicidal ideations **2.** Suggest having a family therapy session to figure out the issues **3.** Encourage patient to write her feelings in a journal	options **2.** Encourage the patient to find someone to confine in when feeling down **3.** Gather resources for patient to interact with about family conflicts
2. Impaired Social Interaction	Related to isolation, as evidence by widowed, and family not living near by	**1.** Monitor patient **2.** Assess what patient does on a daily basis **3.** Look to see if the patient is attempting to make efforts to not be isolated	**1.** Provide information around where patient lives of activities to get out of isolating herself **2.**Suggest having the patient join a club, or organization in her town **3.** Encourage the patient to discuss what she enjoys to do to try and find opportunity to explore options to not be isolated	**1.** Look for activates to interact with other people during COVID-19 **2.**Encourage patient to see a therapist about her isolation/ social impairment issues **3.** Community group therapy
3. Risk for self-harm	Related to feelings of depression, as evidenced by suicide attempts	**1.** Check for an sharps or weapons **2.** Keep the patient engaged and participating **3.** Monitor	**1.** Group therapy **2.** Monitor patient frequently **3.** Make sure all medications are being taken as prescribed	**1.** Community group therapy **2.** Confirm access to medications **3.** Outpatient therapy

		patient		

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient states that she does not feel depressed But does feel anxious to get out of the hospital. Patient states that she made a mistake and was not thinking. For that reason, she was admitted. She states that she is ready to go home and visit her son in Boston.

Nursing Diagnosis/Outcomes

Interpersonal conflicts between family members related to influence from family member, as evidence by attempt suicide.
Impaired social Interaction related to isolation, as evidence by widowed, and family not living nearby.
Risk for self-harm related to feelings of depression, as evidenced by previous suicide attempts.

Objective Data

Patient's vitals:
BP: 174/85
RR: 16
O2:95%
HR: 94 BPM
Temp: 98.6 F

Patient Information

Patient is a 79 year-old, widowed, Caucasian female with no significant psychiatric history. Patient has never seen a psychiatrist or has been hospitalized due to mental health. Patient is currently calm, cooperative and willing to engage in conversation.

Nursing Interventions

1. Outpatient therapy
2. Community group therapy
3. Confirm access to medications
4. Encourage patient to see a therapist about her isolation/ social impairment issues
6. Evaluate patient to explore different activites to get involved in the community
7. Look for family therapy options
8. Encourage the patient to find someone to confide in when feeling down.
9. Obtain resources for patient to interact with when dealing with family conflicts.