

N321 Care Plan #1
Lakeview College of Nursing
Tresne McCarty

Demographics (3 points)

Date of Admission 06/19/2021	Patient Initials BS	Age 22	Gender F
Race/Ethnicity Caucasian	Occupation Student/Cashier	Marital Status Separated	Allergies Adhesive tape Shellfish
Code Status Full	Height 167 cm	Weight 115.6 kg	

Medical History (5 Points)

Past Medical History: anxiety, concussion, migraines, morbid obesity, psuedoseizures

Past Surgical History: Cesarian section 12/16/2020, cholecystectomy 01/10/2021

Family History: Mother (alive) → anxiety, bipolar disorder, depression, thyroid disorder, fibromyalgia, Hypertension

Father (alive) → Heart disease

Maternal grandma → stroke, heart attack

Maternal Grandpa → No known problems

Paternal Grandpa → No known problems

Social History (tobacco/alcohol/drugs): Pt is sexually active, smokes cigarettes occasionally, vapes daily, and does not use alcohol.

Assistive Devices: Prescription glasses and a gait belt for ambulation

Living Situation: Pt lives with a roommate and she has a 6 month old child and a boyfriend

Education Level: Pt currently attends Purdue Global for business administration

Admission Assessment

Chief Complaint (2 points): “I have no memory. My boyfriend said I had 3 seizures on Friday so he called 9-1-1 and I was brought here by the ambulance.”

History of present Illness (10 points): A 22-year old Caucasian female presents to the ED after having 3 seizures reported by her boyfriend on 06/19/2021. Pt arrived by ambulance. Past history includes anxiety, concussions, morbid obesity, migraines, and psuedoseizures.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Seizures

Secondary Diagnosis (if applicable): Seizure-like activity

Pathophysiology of the Disease, APA format (20 points):

My patient presented to the Emergency Department via ambulance after her boyfriend stated she had 3 seizures on 06/19/2021. Her diagnosis upon admission was seizure-like activity with previous diagnoses of pseudoseizures and borderline personality disorder. Pseudoseizures can be described as non-epileptic seizures with a psychiatric etiology. "Pseudoseizures, psychogenic seizures, and hysterical seizures are older terms used to describe events that clinically resemble epileptic seizures but occur without the excessive synchronous cortical electroencephalographic activity that defines epileptic seizures" (Huff, 2021). This means the patient is not actually experiencing a seizure. Instead, the patient is experiencing a psychiatric event that leads them to believe they are having seizures. During my observation, the patient underwent an Electroencephalograph test. This test monitors for synchronous cortical activity within the brain. This test often detects the presence of an actual seizure or seizure-like activity. Unfortunately, I was not able to obtain the results of the test because they had not been interpreted by the Physician. Along with the diagnosis of pseudoseizures, this patient had a previous history of borderline personality disorder. Borderline personality disorder is an illness marked by an ongoing pattern of varying moods, self-image, and behavior that can be accompanied by intense episodes of anger, depression, and anxiety that can last for a few hours to days (U.S. Department of Health and Human Services, 2017). It is suggestive that when my patient is experiencing episodes of anger or anxiety, she then triggers the psychogenic nonepileptic seizures, or pseudoseizures.

Pseudoseizures are thought to be a conversion disorder where the patient is not aware and is not consciously feigning events (Huff, 2021). The etiology is unknown and there are no clear factors that trigger these spells. Adult women are affected more often, and other psychiatric comorbidities can be seen in combination with pseudoseizures as well. Ultimately for my patient, having a previous diagnosis of borderline personality disorder could possibly explain why she began to experience pseudoseizures.

Pathophysiology References (2) (APA):

Huff, J. S. (2021, January 28). *Psychogenic Nonepileptic Seizures*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK441871/>.

U.S. Department of Health and Human Services. (2017, December). *Borderline Personality Disorder*. National Institute of Mental Health. <https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/>.

Laboratory Data (15 points)

CBC **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.8 – 5.41	4.2	N/A	
Hgb	11.3 – 15.2	11.5	N/A	
Hct	33.2 – 45.3	35.6	N/A	
Platelets	149 – 393	199	N/A	
WBC	4.0 – 11.7	7.8	N/A	
Neutrophils	45.3 – 79	59.3	N/A	
Lymphocytes	11.8 – 45.9	30.6	N/A	
Monocytes	4.4 – 12.0	7.1	N/A	
Eosinophils	0 – 6.3	2.5	N/A	

Bands	0.2 – 1.6	0.5	N/A	
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Chemistry **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136 – 145	139	N/A	
K+	3.5 – 5.1	4.3	N/A	
Cl-	98 – 107	109	N/A	This level is not significantly high. A slight elevation of chloride could indicate possible dehydration in this case (Lab Tests Online, n.d.)
CO2	21 – 31	26	N/A	
Glucose	74 – 109	86	N/A	
BUN	7 – 25	14	N/A	
Creatinine	0.6 – 1.2	0.74	N/A	
Albumin	N/A	N/A	N/A	
Calcium	8.6 – 10.3	8.6	N/A	
Mag	N/A	N/A	N/A	
Phosphate	N/A	N/A	N/A	
Bilirubin	N/A	N/A	N/A	
Alk Phos	N/A	N/A	N/A	
AST	N/A	N/A	N/A	
ALT	N/A	N/A	N/A	
Amylase	N/A	N/A	N/A	

Lipase	N/A	N/A	N/A	
Lactic Acid	N/A	N/A	N/A	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	N/A	N/A	N/A	
PT	N/A	N/A	N/A	
PTT	N/A	N/A	N/A	
D-Dimer	N/A	N/A	N/A	
BNP	N/A	N/A	N/A	
HDL	N/A	N/A	N/A	
LDL	N/A	N/A	N/A	
Cholesterol	N/A	N/A	N/A	
Triglycerides	N/A	N/A	N/A	
Hgb A1c	N/A	N/A	N/A	
TSH	N/A	N/A	N/A	

Urinalysis **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	N/A	N/A	N/A	
pH	N/A	N/A	N/A	
Specific Gravity	N/A	N/A	N/A	

Glucose	N/A	N/A	N/A	
Protein	N/A	N/A	N/A	
Ketones	N/A	N/A	N/A	
WBC	N/A	N/A	N/A	
RBC	N/A	N/A	N/A	
Leukoesterase	N/A	N/A	N/A	

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	N/A	N/A	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference **(1)** (APA):

Lab Tests Online. Patient Education on Blood, Urine, and Other Lab Tests. (n.d.).

<https://labtestsonline.org/>.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Pt had a MRI with and without contrast test done on 06/21/2021. Results showed no abnormalities. Pt also had an Electroencephalogram test done 06/21/2021. I was not present for the results of this test.

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (1) (APA):

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

Brand/Generic	Hydroxyzine	SUMATriptan	Ondansetron Zofran	Promethazine Phenergan	Acetaminophen Tylenol
Dose	50 mg tab	50 mg tab	4 mg IV	12.5 mg IM	1,000 mg tab
Frequency	TID	PRN Repeat dose after 2 hours. Pt should not take more than 100 mg in 24 hours.	Q6H PRN	Q4H PRN	Q6H PRN
Route	Oral	Oral	IV Push	Intramuscular injection	Oral
Classification	Anxiolytics/ Antiemesis	Serotonin Receptor	Antiemetic	Antiemetic	Antipyretic/ Non-opioid analgesic
Mechanism of Action	Actions occur as subcortical level of the CNS and includes anticholinergic actions	Sumatriptan stimulates presynaptic 5- HT1D receptors to reduce migraines	ondansetron blocks the 5- HT3 receptor site at the chemoreceptor trigger zone, stopping the vomiting reflex produced by the vomiting center.	Relieves motion sickness and nausea and reduces stimuli to the brain.	Acetaminophen is believed to increase the pain threshold by inhibiting prostaglandin (PG) synthesis through the cyclooxygenase (COX) pathway, similar to nonsteroidal anti- inflammatory drugs (NSAIDs).
Reason Client Taking	Anxiety	Migraines	Nausea	Nausea	Pain
Contraindications (2)	Hypersensitivity, asthma, bradycardia, cardiac disease, electrolyte imbalance	Latex hypersensitivity, angina, smoking, hypertension	Hepatitis, alcoholism, bradycardia, females	Seizure disorder, asthma, children, dehydration, hepatic	Hypersensitivity, alcoholism, hepatitis, renal disease, tobacco smoking

				disease	
Side Effects/Adverse Reactions (2)	Seizures, thrombosis, impaired cognition, confusion, hallucinations	Hypertensive crisis, suicidal ideation, bronchospasm , seizures	Seizures, constipation, hypokalemia, hypotension	Seizures, visual impairment, cyanosis, apnea, angioedema	Anaphylactic shock, oliguria, constipation, hypokalemia
Nursing Considerations (2)	Do not, under any circumstances, inject subcutaneously or intravenously. Can take orally without food.	Take with fluids. Do not crush or chew. Swallow whole.	Visually inspect parenteral products for particulate matter and discoloration prior to administration.	Instruct the patient to immediately report any pain, burning, or discomfort, and also ask the patient and watch the area for any signs or symptoms such as swelling, blisters, or erythema during and after intravenous administration	Can be taken without meals. Do not exceed more than 4g/ day.

Brand/Generic	ARIPiprazole Abilify	FLUoxetine Prozac	Heparin Heparin Sodium	Pantoprazole Protonix	LORazepam Ativan
Dose	(2) 2 mg tabs	(2) 2 mg caps	5,000 units	40 mg tab	1 mg tab
Frequency	QHS	QHS	BID	Daily	Every 5 mins PRN
Route	Oral	Oral	Subcutaneous	Oral	IV Push
Classification	Anti depressant	Selective Serotonin Reuptake Inhibitor	Anticoagulant	Proton-Pump Inhibitor	Anticonvulsant/Benzodiazepine
Mechanism of Action	Mechanism of action was not fully explained. Research	The therapeutic action of SSRIs in treating anxiety disorders is thought to occur from	Accelerating the activity of antithrombin III (ATIII) to inactivate thrombin	Suppresses gastric acid secretion by inhibiting the gastric (H ⁺ ,K ⁺)-	Produce any level of CNS depression required including sedation, hypnosis, skeletal muscle relaxation, anticonvulsant activity, and coma

	suggests it's possible mechanism of action.	potent central serotonin reuptake blockade although the exact mechanism is unknown		ATPase enzyme pump	
Reason Client Taking	Depression	Depression	Blood clot prophylaxis	GERD	Anxiety
Contraindications (2)	Bipolar disorder, mania, HIV, dysphagia	Abrupt discontinuation, seizure disorder, bipolar disorder, hepatic disease	Asthma, aneurism, bleeding, hypertension	Gastric ulcer, diarrhea, vitamin b12 deficiency	Bipolar disorder, mania, psychosis, suicidal ideation
Side Effects/Adverse Reactions (2)	Seizures, myocardial infarction, constipation, hyperglycemia	Visual impairment, seizures, proteinuria, pancreatitis, cholecystitis	Bone fractures, hematemesis, stroke, anaphylactic shock	GI bleeding, seizures, cholecystitis, heart failure, thrombosis	Coma, seizures, suicidal ideation, hearing loss, heart failure, pulmonary edema
Nursing Considerations (2)	May administer without regard to meals. Swallow tablets whole; do not divide, crush, or chew.	Immediate-release capsules or tablets: Initially, administer in the morning.	Inject by deep subcutaneous injection into the lower abdomen; do not aspirate or massage injection site	The safe and effective use of pantoprazole for long-term maintenance therapy of gastric ulcer disease has not been established.	Chronic use of this administration route is not well-supported.

Hospital Medications (5 required)

Medications Reference (1) (APA):

PDR Search. PDR.Net. (n.d.). <https://www.pdr.net/>.

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness:	Pt was alert and oriented x4. Overall appearance was well groomed. Pt seemed
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<p>Orientation: Distress: Overall appearance:</p>	<p>content and happy. No distress was noted.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin was warm and intact. Skin turgor was normal, no tenting or looseness. No rashes, bruises, or wounds present. Pt's braden score was 23.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Pt's head and neck were symmetrical. No tracheal deviation present. Ears clean of debris. Eyes PERLA. No septum deviation observed. Teeth were clean and free of plaque buildup.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>S1 and S2 audible. Peripheral pulses were palpable with capillary refill at +2. No neck vein distention or edema.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Pt's lung sounds were vesicular bilaterally. Rise and fall of the chest was symmetrical. No use of accessory muscles upon inhalation and exhalation was observed.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions:</p>	<p>Pt's diet at home is regular. Pt's current diet inpatient is regular. Her height is 167cm and weight is 115.6 kg. Bowel sounds were active in a quadrants. Last bowel movement was 06/20/2021. No pain, masses, distention, incision, scars, drains, or wounds present upon inspection.</p>

<p>Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Pt's described urination as yellow and clear with no pain. Pt was able to independently ambulate herself to the restroom. Pt's urinary output was approximately 500 mL.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 35 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Pt had equal strength in all extremities. No weakness or assistance was needed for ambulation or ADL's. Pt ambulated independently without the use of a gait belt. No supportive devices were used. Pt's fall risk was 35. Pt exhibited good ROM upon observation.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Pt was A&O x4. Her eyes PERLA. Equal strength in all extremities. Pt's mental status was consistent as it was upon arrival. No suggestion of possible suicide or change in mental status. Pt's speech was articulate. Pt did not have any episodes of LOC during my shift.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level:</p>	<p>Pt is a current student with Purdue Global studying business administration. She also is employed as a cashier at a gas station. Her hobbies include spending time with her 6</p>

Religion & what it means to pt: Personal/Family Data (Think about home environment, family structure, and available family support):	month old son. She is not associated with any religious organization. Her coping methods include spending time with her son and her boyfriend. She has family support from her parents and step parents.
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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0743	68	121/79 Rt arm, sitting	18	36.1 C	98 RA
1344	69	122/77 Rt Arm, sitting	18	36.1 C	98 RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0940	0	n/a	n/a	n/a	n/a
1344	0	n/a	n/a	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge Location of IV: Left midline upper arm Date on IV: 06/19/2021 Patency of IV: No phlebitis, signs of infiltration, catheter was patent Signs of erythema, drainage, etc.: No signs of erythema, or drainage IV dressing assessment: IV dressing was changed 06/21/2021	Pt did not have any IV infusion, but an IV site was available if needed.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
~ 240 mL – breakfast	Pt does not have urinary catheter. She was

~ 240 mL - lunch	independent ambulating. Urinary output was approximately 500 mL.
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Nursing Care

Summary of Care (2 points)

Overview of care: During the clinical the patient was content and cooperative. She was given antidepressants and anxiolytics. She was placed on a regular diet, which she tolerated well. She was able to ambulate independently. She received her medications during the scheduled times. Upon possible discharge, she was referred to a neurologist. The physician wanted to place her on Keppra, but the decision was still in the air. Overall care included observation for possible pseudoseizure episodes.

Procedures/testing done: An EEG was done and a MRI. The MRI showed no abnormalities and the EEG results were not interpreted during clinical.

Complaints/Issues: No complaints were made by the patient on any occasion.

Vital signs (stable/unstable): Vital signs were stable during the shift. On previous day they were stable as well.

Tolerating diet, activity, etc.: Pt tolerated a regular diet well.

Physician notifications: Physician was notified of neurologist referral. I would also suggest a psychiatric referral. I was not present for the final decisions on the patient's care.

Future plans for patient: Pt plans on going back home with her boyfriend and baby boy. She will continue to work and go to school full time. She believes her pseudoseizures will be resolved once she sees the neurologist.

Discharge Planning (2 points)

Discharge location: Pt will be discharged home.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Pt will follow up with a neurologist, Dr. Allao within the next months.

Until then, there is no specific type of treatment for psuedoseizures. Doing a combination of behavioral therapy and medication regulation would be most effective.

Education needs: Most important for this patient would include teaching her different coping skills to handle stress. Also, educating her on mental health resources in the community and any support groups would be beneficial as well. Maintaining a well balanced diet, staying hydrated, and getting rest could also be education points to make to the client. Sometimes these factors can play a role in mental health.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired memory related to possible memory loss as evidenced by the	The pt experienced memory loss upon experiencing a stressful situation after she arrived to	1. Ask open ended questions during the assessment to possibly bring the situation back to remembrance. 2. Possibly educate	The client insisted that she did not remember the events leading up to her arrival to the hospital. Her boyfriend also believes the patient has no recollection.

<p>patient stating, “I have no memory.”</p>	<p>the hospital.</p>	<p>patient on defense mechanisms and how they can affect her memory.</p>	
<p>2. Disturbed personal identity, related to ineffective coping skills as evidenced by the patient’s diagnosis of borderline personality disorder.</p>	<p>The pt was diagnosed with borderline personality disorder and has a history of being admitted to inpatient behavioral health on several occasions.</p>	<p>1. Educate patient on coping skills and engage in conversation on she can use them on a daily basis. 2. Use therapeutic communication to explain what her diagnosis means and how it affects her life.</p>	<p>Pt was very open to learning how to use coping skills. She was still unable to understand what her diagnosis was and what it meant. She still believes she has a medical diagnosis of seizures.</p>
<p>3. Ineffective coping skills, related to stressful situations as evidenced by the patient’s past history of depression and anxiety.</p>	<p>The pt lacks appropriate coping skills when dealing with stressful situations that lead to psuedoseizures.</p>	<p>Educate patient on coping skills and engage in conversation on she can use them on a daily basis. 2. Use therapeutic communication to explain what her diagnosis means and how it affects her life.</p>	<p>Pt expressed how she was going through a divorce and having a 6 month old baby. Identifying triggers and providing resources helped her better understand how to deal with every day life.</p>

Other References (APA):

Concept Map (20 Points):

Subjective Data

Pt states, "I have no memory. My boyfriend said I had 3 seizures on Friday so he called 9-1-1 and I was brought here by the ambulance."
 Pt rates pain 0/10 on a numeric scale on 06/21/2021.
 Pt's past medical history includes anxiety, concussion, migraine, morbid obesity, psuedoseizures, and borderline personality disorder

Nursing Diagnosis/Outcomes

Impaired memory related to possible memory loss as evidenced by the patient stating, "I have no memory."
 The client insisted that she did not remember the events leading up to her arrival to the hospital. Her boyfriend also believes the patient has no recollection.
 Disturbed personal identity, related to ineffective coping skills as evidenced by the patient's diagnosis of borderline personality disorder. Pt was very open to learning how to use coping skills. She was still unable to understand what her diagnosis was and what it meant. She still believes she has a medical diagnosis of seizures.
 Ineffective coping skills, related to stressful situations as evidenced by the patient's past history of depression and anxiety.
 Pt expressed how she was going through a divorce and having a 6 month old baby. Identifying triggers and providing resources helped her better understand how to deal with every day life.

Patient Information

Pt is a 22 year old Caucasian female who comes to the ED via ambulance. She states, "I have no memory. My boyfriend said I had 3 seizures on Friday so he called 9-1-1 and I was brought here by the ambulance." Pt has previous history of anxiety, borderline personality disorder, psuedoseizures, and a concussion from a motor vehicle accident in 2015. Pt also has previous inpatient history on the behavior health unit of Sarah Bush.

Objective Data

Date of admission 06/19/2021
 Age: 22 yrs
 Gender: Female
 Ethnicity: Caucasian
 MRI results: no abnormalities
 CBC results: within normal range
 BMP results: within normal range;
 Chloride = 109 (possible indication of dehydration)
 Patient medications: Hydroxyzine, SUMAtriptan, FLUoxetine, LORazepam, and ARIPiprazole

Nursing Interventions

- Ask open ended questions during the assessment to possibly bring the situation back to remembrance.
- 2. Possibly educate patient on defense mechanisms and how they can affect her memory. Educate patient on coping skills and engage in conversation on she can use them on a daily basis.
- 2. Use therapeutic communication to explain what her diagnosis means and how it affects her life. Educate patient on coping skills and engage in conversation on she can use them on a daily basis.
- 2. Use therapeutic communication to explain what her diagnosis means and how it affects her life.



