N323 Care Plan

Lakeview College of Nursing

Riley Black

Demographics (3 points)

Date of Admission 09/27/2021	Patient Initials EH	Age 19	Gender Male
Race/Ethnicity White	Occupation Student/UPS	Marital Status Single	Allergies Eggs, Dairy, Gluten
Code Status Full code	Observation Status Suicide	Height Not in chart	Weight Not in chart

Medical History (5 Points)

Past Medical History: N/A

Significant Psychiatric History: Suicide attempt (date unkown)

Family History:

- **Mother – depression, bipolar, anxiety, SI, OCD**
- **Father – substance abuse, depression, anxiety**
- **Grandmother – depression, bipolar**
- **Sister – anxiety, SI**

Social History (tobacco/alcohol/drugs): pt denies use of tobacco, alcohol, or other drugs

Living Situation: lives in apartment with three roommates

Strengths: cooperative, pleasant, willing to work on mental health, sets goals, writes positive coping mechanisms, motivated to get better

Support System: roommates (pt claims to have recently lost his only support system of his girlfriend and her parents)

Admission Assessment

Chief Complaint (2 points): Suicidal ideation with plan / cutting and severe depression

Contributing Factors (10 points):

Factors that lead to admission:

The patient recently broke up with his girlfriend of three years. He claims to have been dating her for three years. He explained that he felt manipulated throughout the relationship and experienced emotional abuse, specifically during the breakup. This included her telling him that he deserves to feel pain, he should kill himself, and he needs to be admitted to The Pavilion so she does not have to feel guilty about his self-harm. The patient claims this lead the patient to starvation followed by cutting. He planned to overdose on his prescription medication and then slit his wrists until his roommate talked him out of it.

History of suicide attempts: Patient said to have attempted suicide in high school but did not specify when or how

Primary Diagnosis on Admission (2 points): unspecified bipolar, generalized anxiety, panic disorder, PTSD

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Pt has experienced abuse **Witness of trauma/abuse: Sister**				
	Current	**Past (what age)**	**Secondary Trauma**	**Describe**

			(response that comes from caring for another person with trauma)	
Physical Abuse	**no**	**18**	**yes**	**Pt describes being beaten as a young child and also recollects being recently "strangled" by his father following a dispute. Pt also witnessed sister being abused by father and mother**
Sexual Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Emotional Abuse	**yes**	**"always"**	**yes**	**Pt claims to have been talked down to by his family and not receiving much parenting from his mother**

				and father
Neglect	**yes**	**“Since I was a teenager”**	**yes**	**Pt claims parents did not raise him. He claims his grandmother raised him for the first half of his life and that he has been independent for several years**
Exploitation	**N/A**	**N/A**	**N/A**	**N/A**
Crime	**N/A**	**N/A**	**N/A**	**N/A**
Military	**N/A**	**N/A**	**N/A**	**N/A**
Natural Disaster	**N/A**	**N/A**	**N/A**	**N/A**
Loss	**N/A**	**N/A**	**N/A**	**N/A**
Other	**N/A**	**N/A**	**N/A**	**N/A**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	**Constant, intensity changes daily, no specific factors determine severity**	
Loss of energy or interest in activities/school	**Yes**	**No**	**Some days feels too distracted or upset to focus on school**	

Deterioration in hygiene and/or grooming	**Yes**	**No**	**N/A**
Social withdrawal or isolation	**Yes**	**No**	**Pt claims to have spent all of his free time with his now ex-girlfriend, feels like he does not have anyone to spend time with so he isolates**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**Lack of motivation to do school work, lack of social interest**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**Claims to average two to six hours of sleep, during major depressive episode leading to admittance he did not sleep for three days**
Difficulty falling asleep	**Yes**	**No**	**Always due to thoughts**
Frequently awakening during night	**Yes**	**No**	**Usually does not sleep for over an hour**
Early morning awakenings	**Yes**	**No**	**Wakes up and cannot fall back asleep**
Nightmares/dreams	**Yes**	**No**	**Recently began having more vivid dreams with some nightmares**
Other	**Yes**	**No**	**N/A**

Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Pt starved himself during major depressive episode**
Binge eating and/or purging	**Yes**	**No**	**Pt claims to binge eat frequently**
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?		**3 current (10 during episode that brought him to inpatient)**	
How would you rate your anxiety on a scale of 1-10?		**5**	
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**	**Usually misses at least one day of classes per week, does not complete all assignments due to inability to control anxiety**
Family	**Yes**	**No**	**Dealing with parents shaming him for needing treatment, bad relationship**
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	**Lost girlfriend and her parents, who he claims were his only support. Claims to have no friends**
Financial	**Yes**	**No**	**Does not work enough to cover expenses and does not receive help**
Other	**Yes**	**No**	**N/A**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for**	**Response/Outcome**

			Treatment	
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
No name given	**19**	**friend**	**Yes**	**No**
No name given	**19**	**friend**	**Yes**	**No**
No name given	**19**	**friend**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: all use alcohol and marijuana				
Children (age and gender): None Who are children with now? N/A				
Household dysfunction, including separation/divorce/death/incarceration: None				
Current relationship problems: Recently had a traumatic breakup with a three-year				

girlfriend

Number of marriages: 0

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

Please describe your religious values, beliefs, spirituality and/or preference:

Not religious

Ethnic/cultural factors/traditions/current activity:

Describe: No significant notes

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?

Family needs to distance, roommates need to keep him busy

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:

Parents were physically and emotionally abusive with pt and his sister

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.) - **Mother – depression, bipolar, anxiety, SI, OCD** - **Father – substance abuse, depression, anxiety** - **Grandmother – depression, bipolar** - **Sister – anxiety, SI**
History of Substance Use: None
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Lack of focus and motivation
Discharge
Client goals for treatment: Develop positive coping skills, become content being independent, regain individuality after manipulative relationship, become autonomous
Where will client go when discharged? Back to his apartment with three roommates

Outpatient Resources (15 points)

Resource	Rationale
1. Group therapy	**1. Pt feels relief when able to share his**

	thoughts verbally. Pt claims it is a new thing for him and it helps him think and process how he feels rather than internalize it and cause self-harm
2. Therapist / Counselling	**2. Pt could benefit from having one person to form a relationship with and monitor his progress. Pt says he feels like he feels great at The Pavilion but fears that he may end up using his old negative coping mechanisms. A therapist would help him to stay on track and further strengthen his mental stability and gain control over his emotions.**
3. Suicide hotline	**3. If pt feels like attempting suicide again, he will have a resource he knows to call when he is at that point again. Even having the knowledge of a suicide hotline may make him rethink his decisions.**

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

Brand/Generic	**Zoloft/ Sertraline hydrochloride**	**Trileptal/ Oxcarbazepine**			
Dose	**50 mg**	**150 mg**			
Frequency	**Daily**	**BID**			
Route	**PO**	**PO**			
Classification	**SSRI**	**Anticonvulsant**			
Mechanism of Action	**Inhibits serotonin reuptake by CNS neurons to increase amount of serotonin available to improve mood and reduce depression**	**Blocks sodium channels in neuronal cell membranes, decreasing the rate at which neurons fire**			
Therapeutic Uses	**Treat major depression, OCD, panic disorder, PTSD, ad social anxiety**	**Treat atrial seizures, treat bipolar disorder**			
Therapeutic Range (if applicable)	**N/A**	**N/A**			
Reason Client Taking	**Treat major depression, panic disorder, and PTSD**	**Treat bipolar disorder**			
Contraindications (2)	**Concurrent use with disulfiram or pimozide / use within 14 days of an MAO inhibitor**	**hypersensitivity**			

Side Effects/Adverse Reactions (2)	**Suicidal ideation / ventricular tachycardia**	**Suicidal ideation / status epilepticus**			
Medication/Food Interactions	**Antibiotics / antipsychotics / Class 1A antiarrhythmics / Class III antiarrhythmics / NSAIDs**	**All food – increases adverse effects / hormonal contraceptives, phenytoin**			
Nursing Considerations (2)	**Watch closely for suicidal tendencies / be aware anti depressive therapy can promote mania**	**Administer XR tablets 1 hour before or 2 hours after meals / implement seizure precautions as needed**			

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):

2021 Nurse's drug handbook **(20th ed.). (2021). Jones & Bartlett Learning.**

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Well groomed, good hygiene** **Outgoing, positive attitude, friendly, talkative** **Tall and underweight** **Cooperative** **Clear without abnormalities** **Friendly, eager to have conversation** **Upbeat and happy** **Smiling most of the time**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:**	**Recent suicidal ideation, seems to be improving, beginning to accept himself and individuality**

Compulsions: **Phobias:**	
ORIENTATION: **Sensorium:** **Thought Content:**	**A&O x 4, clear thinking**
MEMORY: **Remote:**	**All memories intact**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**Somewhat impaired judgement as he feels as if suicide still is a potential solution** **Intelligent** **Has good impulse control when not having a major depressive episode**
INSIGHT:	**Pt recognizes suicidal ideation and behavior during his major depressive episode was negative coping and that there are better options**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**Unassisted** **Upright posture, even gait** **Minimal muscle mass but slightly toned** **Strength 5 equal in all extremities** **MAEW**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0930	**66**	**132/62**	**16**	**97.7**	**98**
1745	**77**	**137/85**	**16**	**97.0**	**95**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0930	**Numeric**	**Cuts (forearm, back, abdomen)**	**4**	**Achy**	**N/A**
1745	**Numeric**	**cuts**	**3**	**Achy**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: <25%** **Lunch: 0%** **Dinner: 100%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 960 ml water** **Lunch: 960 ml water** **Dinner: 1200 ml water**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Pt will return home to live with his three roommates upon discharge. Pt should plan to continue care either through a group therapy setting or an individualized therapy session. Pt lacks support system, so he needs a strong one to keep him stable.

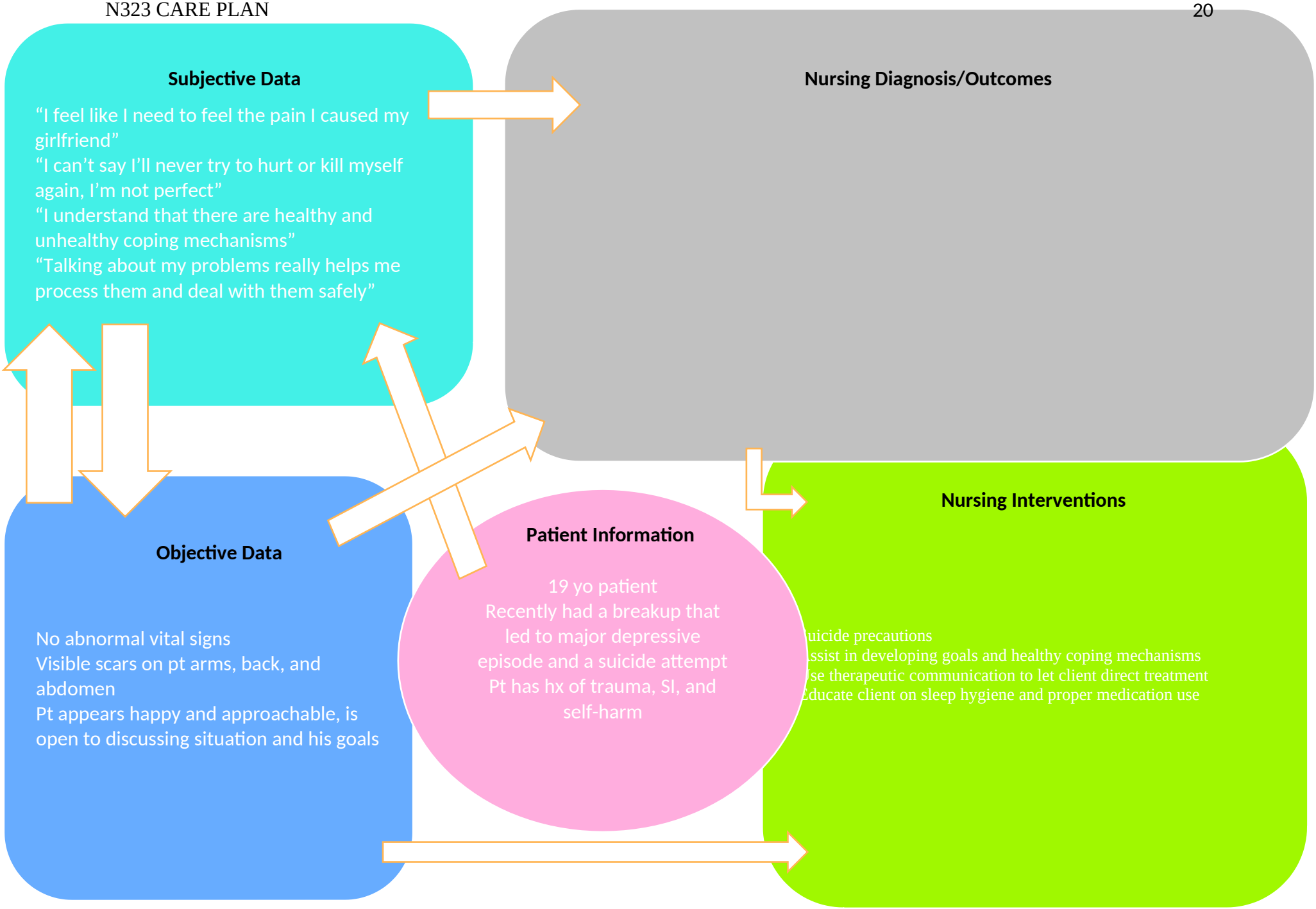
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full	Rational • Explain	Immediate Interventions	Intermediate Interventions	Community Interventions

nursing diagnosis with "related to" and "as evidenced by" components	why the nursing diagnosis was chosen	**(At admission)**	**(During hospitalization)**	**(Prior to discharge)**
1. Risk for suicide r/t depression AEB recent attempt	**Pt had recent attempts and stated "I can't say I'll never do it again"**	**1.suicide precautions** **2. mental health exam** **3. medication**	**1. suicide prevention** **2. Group therapy** **3. medication**	**1. medication** **2. education of resources** **3. development of positive coping mechanisms**
2. Risk for self-directed violence r/t depression AEB scars on pt arms, back, abdomen	**Pt used cutting as a coping mechanism and still needs to work on developing healthy coping mechanisms**	**1. safety/suicide precautions** **2. medication** **3. mental health exam**	**1. safety/suicide precautions** **2. medication** **3. group therapy**	**1. medication** **2. Development of positive coping mechanisms** **3. education of resources**
3. Disturbed sleep pattern r/t anxiety and PTSD AEB vivid dreams and nightmares and client stating to get less than 6 hours of sleep each night	**Pt claims to sleep an average of 2-6 hours each night**	**1. calm environment** **2. medication** **3. proper mealtimes**	**1. calm environment** **2. medication** **3. proper mealtimes**	**1. education on making a calm environment** **2. education on safe sleep supplements or meds** **3. education on relaxation techniques**

Other References (APA):

Concept Map (20 Points):


Subjective Data
"I feel like I need to feel the pain I caused my girlfriend"
"I can't say I'll never try to hurt or kill myself again, I'm not perfect"
"I understand that there are healthy and unhealthy coping mechanisms"
"Talking about my problems really helps me process them and deal with them safely"
Nursing Diagnosis/Outcomes
Objective Data
No abnormal vital signs
Visible scars on pt arms, back, and abdomen
Pt appears happy and approachable, is open to discussing situation and his goals
Patient Information
19 yo patient
Recently had a breakup that led to major depressive episode and a suicide attempt
Pt has hx of trauma, SI, and self-harm
Nursing Interventions
uicide precautions
ssist in developing goals and healthy coping mechanisms
se therapeutic communication to let client direct treatment
ducate client on sleep hygiene and proper medication use