

N323 Care Plan
Lakeview College of Nursing
Lauren McClain

Demographics (3 points)

Date of Admission 09/26/2021	Patient Initials J.K.	Age 18	Gender Female
Race/Ethnicity Caucasian	Occupation Student/ Starbucks	Marital Status In a Relationship	Allergies None
Code Status Full code	Observation Status Alert and conscious	Height 5'2	Weight 158

Medical History (5 Points)

Past Medical History: None

Significant Psychiatric History: History of depression and anxiety; bipolar disorder

Family History: Father: BPD; anger/mood swings; addiction (alcohol) Mother: anxiety; panic attacks; obsessive CD

Social History (tobacco/alcohol/drugs): Tobacco: None; Alcohol: None; Drugs: None

Living Situation: Lives with mother, brother, and grandparents

Strengths: Patient stated that some of her strengths are her good academics, her want to help others, and her patience.

Support System: Her support system is her mother and boyfriend.

Admission Assessment

Chief Complaint (2 points): Suicidal indication

Contributing Factors (10 points): Patient is an 18-year-old female who presents to the Pavilion due to suicidal ideation. The patient has stated that she has struggled with suicidal thoughts and depressions for a while. The patient stated that “she was planning on overdosing on her medications.” She stated that for the past week before being admitted she was severely depressed and not motivated of doing anything. She tried to take her mind off of things by shopping and spending more time with friends, but it was not helping. She talked with her therapist multiple

times before her therapist recommended that she come in since her depression and suicidal thoughts weren't getting better.

Factors that lead to admission: Therapist suggested she come to the Pavilion due to her depression and her suicidal thoughts.

History of suicide attempts: She has previously been admitted due to suicidal thoughts.

Primary Diagnosis on Admission (2 points): Major depressive disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Yes, the patient stated that she had lifetime trauma				
Witness of trauma/abuse: Yes, she has witnessed her father abuse her mother.				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	5-13	No	Her father would beat her.
Sexual Abuse	No	7	No	Her father molested her.
Emotional Abuse	No	5-13	No	Her father would call her names which were very hurtful.
Neglect	No	5-13	No	Her father didn't take care of her.
Exploitation	No	N/A	N/A	N/A
Crime	No	N/A	N/A	N/A
Military	No	N/A	N/A	N/A
Natural Disaster	No	N/A	N/A	N/A

Loss	No	15	No	Her best friend died in a car accident.
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		
Loss of energy or interest in activities/school	Yes	No	She stated that it's not often but only when her depression is bad.	
Deterioration in hygiene and/or grooming	Yes	No	States that lately she hasn't been in the mood to shower.	
Social withdrawal or isolation	Yes	No	N/A	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	N/A	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Change in numbers of hours/night	Yes	No	N/A	
Difficulty falling asleep	Yes	No	N/A	
Frequently awakening during night	Yes	No	She states that she wakes up about 3 to 4 times night	
Early morning awakenings	Yes	No	About the fourth time she wakes up around 0600 she typically just stays up.	
Nightmares/dreams	Yes	No	Lately she has been having really bad nightmares that have been waking her up.	
Other	Yes	No	N/A	
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Changes in eating habits: overeating/loss of	Yes	No	Since being admitted, she hasn't had a great appetite and doesn't feel like eating.	

appetite			
Binge eating and/or purging	Yes	No	N/A
Unexplained weight loss?	Yes	No	N/A
Amount of weight change:			
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	She has tremors, that don't last long and don't always occur.
Panic attacks	Yes	No	Recently she has had panic attacks, but when they do occur, it's due to being overwhelmed.
Obsessive/ compulsive thoughts	Yes	No	N/A
Obsessive/ compulsive behaviors	Yes	No	She stated recently that she noticed if she touches one side of her face, she must touch the other side.
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?		On this day she stated her depression is about a 2	
How would you rate your anxiety on a scale of 1-10?		On this day she stated her anxiety is about a 3	
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	Presenting?		Describe (frequency, intensity, duration, occurrence)
Work	Yes	No	For the past week she has noticed a drag at work, and states that it wasn't making her happy like before.
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
2017	Inpatient Outpatient Other: Harsha	Inpatient	Depression	No improvement Some improvement Significant improvement
2019	Inpatient Outpatient Other: Midwest	Inpatient	Depression	No improvement Some improvement Significant improvement
2021	Inpatient Outpatient Other: Pavilion	Inpatient	Depression/ suicidal thoughts	No improvement Some improvement Significant improvement

Personal/Family History

Who lives with you?	Age	Relationshi	Do they use substances?
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Mother	50		Yes No
Brother	14		Yes No
Grandpa	70s		Yes No
Grandma	70s		Yes No
			Yes No
If yes to any substance use, explain:			
Children (age and gender): No, the patient doesn't have any children			
Who are children with now?			
Household dysfunction, including separation/divorce/death/incarceration: Her parents are divorced.			
Current relationship problems: No relationship problems			
Number of marriages: None			
Sexual Orientation: Bisexual	Is client sexually active? Yes No	Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference: Doesn't practice or believe in anything			
Ethnic/cultural factors/traditions/current activity: The patient stated that currently she doesn't have any traditions but used to go to church on the holidays. Describe: Stated above			
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): No			
How can your family/support system participate in your treatment and care? She stated that her mom and grandparents are very helpful and willing to support her every step of the way. Her therapist is also very supportive.			
Client raised by: Natural parents: Her mother raised her but her father did not really raise her. Grandparents Adoptive parents			

<p>Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness: Due to her being abused when she was younger, she has major depressive disorder and suicidal thoughts.</p>
<p>Atmosphere of childhood home:</p> <p>Loving Comfortable Chaotic Abusive: her father was very abusive, and she didn't feel safe Supportive Other:</p>
<p>Self-Care:</p> <p>Independent: client is able to care for herself without any problems Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.): Father is diagnosed with Bipolar disorder. Her mother has anxiety and OCD.</p>
<p>History of Substance Use: No history of substance abuse</p>
<p>Education History:</p> <p>Grade school High school College Other: Patient is a senior in high school, but is taking college courses at the local community college</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: States that she has no problems in school</p>
<p>Discharge</p>
<p>Client goals for treatment: Upon asking the patient goals regarding her treatment, she</p>

<p>responded by explaining her desires to develop better coping mechanisms and to be able to deal with her past trauma in a manner that isn't destructive to her physically.</p>
<p>Where will client go when discharged? The patient will go back home with her mother and grandparents.</p>

Outpatient Resources (15 points)

Resource	Rationale
<p>1. Illinois Suicide & Crisis Hotline</p>	<p>1. Pt. has suicidal ideations with a plan to overdose of pills; this doesn't mean that the pt. will never attempt suicide or engage in any other self-harm or risky behavior. The hotline will be readily available for the pt. whenever they are in a crisis.</p>
<p>2. Illinois Call4Calm Text Line</p>	<p>2. This service is free and available 24 hours a day, seven days a week allows the patient to a counselor in her area who is knowledgeable about available local resources.</p>
<p>3. PATH'S Directory - Path Crisis 211</p>	<p>3. Allows patient to speak to trainline professional for support and provide them with customizes recourses and visit with health care providers when patient is suffering from an opioid use disorder or other substance use disorders</p>

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

Brand/Generic	Abilify	Lexapro	Buspar	Junel Fe	
Dose	10 mg	5 mg	15mg	20 mg	
Frequency	Daily	Daily	BID	Daily	
Route	PO	PO	PO	PO	
Classification	Atypical antipsychotic	Selective serotonin reuptake inhibitors	anxiolytic agent	Contraceptives	
Mechanism of Action	The antipsychotic action of aripiprazole is likely due to the agonism of D2 and 5-HT _{1A} receptors though the exact mechanism has not been defined.	enhances serotonergic activity by binding to the orthostatic binding site on the serotonin transporter (SERT), the same site to which endogenous 5-HT binds, and thus prevents the re-uptake of serotonin into the presynaptic neuron	mainly derived from its interaction with two major 5-HT _{1A} receptor subtypes that are involved in the brain's anxiety and fear circuitry to enhance the serotonergic activity in these brain areas.	It works mainly by preventing the release of an egg during your cycle. It also makes vaginal fluid thicker to help prevent sperm from reaching an egg (fertilization) and changes the lining of the uterus (womb) to prevent attachment of a fertilized egg.	
Therapeutic Uses	Treat certain mood/mental disorders	Treat depression and anxiety	Treat anxiety	Prevent pregnancy	
Therapeutic Range (if applicable)	Peaks within 3-5 hours	Half-life is 27-32 hours	Half-life about 2-3 hours	N/A	
Reason Client Taking	Major depressive disorder	Major depressive disorder	Anxiety and depression	Birth control	
Contraindications (2)	Diabetes; Low white blood	Manic behavior; low	Renal failure; hypersensitivity	History of blood clots; Severe	

	cell	potassium levels	to Buspirone	migraines	
Side Effects/Adverse Reactions (2)	uncontrolled muscle movements, anxiety	Nausea; drowsiness	Chest pain, confusion	Nausea; vomiting	
Medication/Food Interactions	Avoid alcohol; Benzodiazepine may increase CNS depressant.	Benzodiazepine can increase the risk of adverse effects; avoid alcohol	Buspirone may decrease the excretion rate of Abacavir which could result in a higher serum level.	Taking certain medications like levodopa may affect iron;	
Nursing Considerations (2)	Be alert for seizures; Monitor signs of neuroleptic malignant syndrome	Watch for QT prolongation; monitor for mental changes	management of anxiety; monitor BP	Check BP periodically; Warm about weight gain and acne	

Medications Reference (1) (APA):

Jones, D. W. (2020). *Nurse’s drug handbook*. (19th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:</p>	<p>Confident/cooperative, Short, slightly obese Cooperative Soft spoken Assertive/engaged Stable Normal</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions:</p>	<p>Denies any thoughts of suicide and homicide Denies any delusions Denies seeing any illusions Denies any obsessions</p>

Compulsions: Phobias:	Pt. likes stated "I have to touch one side of my face if I touch the other side" Denies any phobias
ORIENTATION: Sensorium: Thought Content:	ANO x4, logical Pt. endorses passive suicidal ideation Pt. wishes to go back home due to the possibility of failing a class due to being admitted
MEMORY: Remote:	Pt remembers past memories
REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:	Pt. has appropriate and fair judgements, able to think on their own Appropriate calculation Pt has average intelligence Pt. has appropriate abstraction Pt. is able to control their impulses
INSIGHT:	Pt's insight and awareness are intact. Pt. is aware of her illness and wishes to get better.
GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	Pt uses no assistive devices Pt. posture is relaxed Pt. has normal muscle tone Pt. strength is adequate Motor movements is appropriate and relaxed

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
2:30	84	138/90	18	97.5	98
5:00	79	137/88	18	97.6	98

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

2:30	Numeric	N/A	0	N/A	N/A
5:00	Numeric	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: n/a	Breakfast: n/a
Lunch: n/a	Lunch: n/a
Dinner: n/a	Dinner: n/a

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient stated that once discharged, she will go back home with her mother and grandparents. The patient is independent and does not need any assistive equipment. The patient is encouraged to go to meetings, continue to talk to her therapist, and call the suicide hotline if the suicidal thoughts get too serious. The patient should continue to see her therapist about her trauma to help with her depression. The patient should continue to take her daily medications and practicing good coping mechanisms.

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
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nursing diagnosis with “related to” and “as evidenced by” components	why the nursing diagnosis was chosen	(At admission)	(During hospitalization)	(Prior to discharge)
<p>1. Risk for suicide related to self-directed violence as evidence by suicidal ideations.</p>	<p>Due to the patient being admitted because of suicidal ideation.</p>	<p>1. Ensure safety of patient by removing any objects that may be used to self-harm</p> <p>2. Gather information on pt.’s potential suicide plan</p> <p>3. Encourage therapeutic communication to deescalate the situation</p>	<p>1. Monitor and note patients’ mood and behavior changes</p> <p>2. Check in with patients every 15 mins</p> <p>3. Implement therapy and administer prescribed medication</p>	<p>1. Provide outpatient resources and suicide/crisis hotlines</p> <p>2. Encourage attending group therapy to alleviate stress</p> <p>3. Encourage the patient to reach out to others when they are feeling suicidal</p>
<p>2. Self-care deficit related to severe anxiety as evidence by awakening earlier than desired.</p>	<p>Due to the patient stating she has recently been waking up very early.</p>	<p>1. Ensure the patient is comfortable in their environment.</p> <p>2. Ask the patient what will make them feel safe.</p> <p>3. Encourage the patient to talk about reasons on why she wakes up early.</p>	<p>1. Monitor the patient every 15 mins.</p> <p>2. Implement therapy to allow the patient to express concerns.</p> <p>3. Monitor the patient’s mood.</p>	<p>1. Provide the patient with resources to help with nightmares</p> <p>2. Encourage the patient to talk with her therapist.</p> <p>3. Encourage the patient to reach out to others when she has a nightmare</p>

<p>3. Ineffective coping related to inadequate coping skills as evidence by expression of anxiety and depression.</p>	<p>Due to stating that her coping skills weren't helping her depression.</p>	<p>1. Use therapeutic communication to talk to patient about habit</p> <p>2. Asses pt.'s intentions and possible suicide risk</p> <p>3. Allow the patient to talk about her current coping skills.</p>	<p>1. Help patient develop better coping mechanisms</p> <p>2. Encourage positive thinking</p> <p>3. Provide the patient with different activities</p>	<p>1. Evaluate pt's goals and plans after discharge</p> <p>2. Ask the patient what she's learned about effective coping skills.</p> <p>3. Encourage the patient to ask friends to spend time with her as a coping mechanism.</p>
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Other References (APA):

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

- 1. Risk for suicide related to self-directed violence as evidence by suicidal ideations.
Outcome: Patient stated that she wasn't having anymore suicidal thoughts.
Patient states that she really enjoys working at Starbucks but recently has been in a funk.
- 2. Self-care deficit related to severe anxiety and depression as evidenced by shopping earlier than desired.
Outcome: Patient states that she will be open about the nightmare she has the therapist recommended she went to the Pavilion.
Patient stated that she tried to take her mind off the suicidal thoughts by shopping.
- 3. Ineffective coping related to inadequate coping skills as evidence by expression of anxiety and depression.
Outcome: Patient states that she will look into new coping mechanisms and try them out.

Objective Data

Patient Information

Nursing Interventions

Encourage the patient to reach out to others when suicidal thoughts occur

Monitor the patient regularly and ensure they're safe.

18-year-old female who presents to the ER with suicidal ideation. The patient was very engaging! Patient was open about talking about her past. she has struggled with suicidal thoughts and depressions for a while. Patient was comfortable talking and provided eye contact when talking. The patient stated that "she was planning on overdosing on her medications." She stated that for the past week before being admitted she was severely depressed and not motivated of doing anything.



