N323 Care Plan 1

Lakeview College of Nursing

Cheyenne Gardner

Demographics (3 points)

Date of Admission 09/30/21	**Patient Initials** J.R.	**Age** 21	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retail	**Marital Status** Single	**Allergies** NKA
Code Status Full Code	**Observation Status** Suicide	**Height** 5'4"	**Weight** 52.9 kg

Medical History (5 Points)

Past Medical History: N/A

Significant Psychiatric History: The client was previously admitted for suicidal ideation in October 2015

Family History: The client says her brother and sister are both diagnosed with bipolar disorder and generalized anxiety and depression.

Social History (tobacco/alcohol/drugs): The client denied using tobacco, alcohol, or any drug use.

Living Situation: The client lives in an apartment with two roommates.

Strengths: The client says she is very compassionate and is good at ice skating.

Support System: The client says she has a sound support system with her friends and family.

Admission Assessment

Chief Complaint (2 points): Suicidal Ideation

Contributing Factors (10 points):

Factors that led to admission: The client said that factors that contributed to her suicidal thoughts were her eating disorder which is anorexia nervosa, and body dysmorphia. The client says that she "put up blockers by giving her roommate her pills, hairdryer and came here for help." The client knew that her thoughts were not okay and self- admitted herself to get help.

History of suicide attempts: The client had one previous attempt of suicide at the age of 15 with a pill overdose.

Primary Diagnosis on Admission (2 points): Major Depressive disorder (severe, recurrent), Suicidal Ideation with a plan, Anorexia Nervosa, Generalized Anxiety Disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse: N/A**				
	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**	**N/A**
Sexual Abuse	**N/A**	**Yes, 14** **years old**	**N/A**	**The client had someone that was 2 years older than her that lived with them. The client did not expand on this. It was not reported.**

Emotional Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Neglect	**N/A**	**N/A**	**N/A**	**N/A**
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**	**Yes, when this happens it can last a couple days to 2 weeks. When it is bad, she just sleeps all day.**	
Loss of energy or interest in activities/school	**Yes**	**No**	**Yes, when she gets into a depressive episode and wants to sleep all day.**	
Deterioration in hygiene and/or grooming	**Yes**	**No**	**Yes, when in a depressive episode forgets to shower, brush her teeth and hair.**	
Social withdrawal or isolation	**Yes**	**No**	**Yes, she will not hang out with friends and wants to be alone in her bedroom.**	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**Yes, client states she has difficulty staying at work and being able to finish her schoolwork. Client has dropped out of college classes due to her depression.**	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	**No**	
Difficulty falling asleep	**Yes**	**No**	**No**	
Frequently	**Yes**	**No**	**Yes, wakes up and colors for**	

awakening during night			**10-15 minutes before falling back asleep.**
Early morning awakenings	**Yes**	**No**	**Yes, the client states gets woken up at 0500 for vitals.**
Nightmares/dreams	**Yes**	**No**	**Yes, but she does not remember them.**
Other	**Yes**	**No**	**No**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Yes, client has a loss of appetite since her eating problems developed in October 2020.**
Binge eating and/or purging	**Yes**	**No**	**Yes, client states she has stages where she binges sweets and will consume 1,400 calories at one time.**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**No** **N/A**
Use of laxatives or excessive exercise	**Yes**	**No**	**Yes, the patient uses excessive exercise for her body dysmorphia. She will use the bike machine, run or ice skate for hours.**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**Yes, when the client is feeling anxious she fidgets, shakes, or has tremors. The client uses excessive scratching to the point where she has open sores on her arms and legs.**
Panic attacks	**Yes**	**No**	**Yes, but the client says they are not often.**
Obsessive/compulsive thoughts	**Yes**	**No**	**Yes, obsessive thoughts about food or her weight.**
Obsessive/compulsive behaviors	**Yes**	**No**	**Yes, the client has obsessive behaviors about using the scale, weighing/ measuring her food.**

			A compulsive behavior she has is scratching her legs and arms when feeling anxious.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**Yes, most days she avoids work or hanging out with friends due to her anxiety level.**
Rating Scale			
How would you rate your depression on a scale of 1-10?			**Client states her depression is usually a 5 on a scale of 1-10.**
How would you rate your anxiety on a scale of 1-10?			**Client states her anxiety is usually an 8 on a scale of 1-10.**
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**	**Yes, will call into work when feeling anxious.**
School	**Yes**	**No**	**Yes, client dropped out of school due to depression.**
Family	**Yes**	**No**	**No**
Legal	**Yes**	**No**	**No**
Social	**Yes**	**No**	**Yes, client stopped hanging out with friends, but still talks to some of them.**
Financial	**Yes**	**No**	**Yes, client says she spends money on clothes/ Knick knacks so she has no money for food. Client stated "this is not completely on purpose"**
Other	**Yes**	**No**	**No**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
October 2015	**Inpatient** **Outpatient** **Other:**	**Inpatient**	**Suicidal** **Ideation**	**No improvement** **Some improvement** **Significant improvement**
September 30, 2021 The Pavillion	**Inpatient** **Outpatient** **Other:**	**Inpatient**	**Suicidal** **Ideation**	**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Roommate	**20**	**Friend**	**Yes**	**No**
Roommate	**22**	**Friend**	**Yes**	**No**
			Yes	**No**
			Yes	**No**

			Yes	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): None **Who are children with now? N/A**				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: Client states currently not having any relationship problems, but does have a girlfriend currently that she has been dating for 4 months. **Number of marriages: None**				
Sexual Orientation: Lesbian	**Is client sexually active? Yes No**		**Does client practice safe sex? Yes No**	
Please describe your religious values, beliefs, spirituality and/or preference: Client states she does not have any religious beliefs.				
Ethnic/cultural factors/traditions/current activity: N/A **Describe: N/A**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Client has had no past legal issues.				
How can your family/support system participate in your treatment and care? Client stated family/ support system can participate in her care by calling, sitting with her at meals and being patient with her.				
Client raised by: Natural parents **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**				
Significant childhood issues impacting current illness: N/A				
Atmosphere of childhood home:				

Loving **Comfortable** **Chaotic:** Client states could be chaotic sometimes with 5 kids **Abusive** **Supportive** **Other:**
Self-Care: Independent **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Sister: Diagnosed bipolar- Suicide and depression Brother: Diagnosed bipolar- Depression
History of Substance Use: None
Education History: **Grade school** **High school** **College** **Other: Some college education**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: Client stated she wants to develop good coping skills, SI resolution, mood stabilization and medication management
Where will client go when discharged? Client will be discharged to her apartment

Outpatient Resources (15 points)

Resource	Rationale
1. Individual/ Group Therapy	**1.** Therapy would be a good place for the client to open up about her feelings. She could also develop better coping skills for whenever she is feeling like she is getting deeper into a depressive episode. The client was willing to write about what she was feeling and open up about her thoughts.
2. Psychiatrist	**2.** Going to see her psychiatrist on a regular basis will help to keep her on track with her medication. The client felt like medication management would be helpful in her progress. The psychiatrist can hold her accountable to see if she has been taking her medication as it is prescribed.
3. Psychoeducation	**3.** The client can use the resource of psychoeducation to acquire structured and systematic ways to treat her illness. This will help to motivate and develop coping skills to help her treatment. This will help with a less chance for a relapse.

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

Brand/Generic	Escitalopram oxalate/ Lexapro	Aripiprazole/ Abilify	Risperidone/ Risperdal	Naproxen	N/A

Dose	5 mg	2 mg	0.25 mg	500 mg	
Frequency	Daily	Daily	HS	BID	
Route	PO	PO	PO	PO	
Classification	Selective serotonin reuptake inhibitor (SSRI) (Jones, 2021)	Antipsychotic (Jones, 2021)	Antipsychotic (Jones, 2021)	Analgesic (Jones, 2021)	
Mechanism of Action	Blocks the reuptake of neurotransmitter serotonin by CNS neurons, increasing the amount of serotonin in nerve synapses (Jones, 2021)	Acts as a partial agonist at dopamine receptors and serotonin receptors (Jones, 2021)	Selectively blocks serotnonin and dopamine receptors in the mesocortical tract of the CNS to suppress psychotic symptoms (Jones, 2021)	Reduces symptoms of inflammation and relieves pain (Jones, 2021).	
Therapeutic Uses	To elevate mood or reduce anxiety and depression (Jones, 2021)	To treat acute schizophrenia and maintain stability in patients with schizophrenia or bipolar I disorder (Jones, 2021)	To treat biopolar mania as monotherapy and schizophrenia (Jones, 2021)	To relieve mild to moderate musculoskeletal inflammation (Jones, 2021)	
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	
Reason Client Taking	To improve mood and decrease depression (Jones, 2021)	To treat depression adjunct since already taking an antidepressant (Jones, 2021)	To improve mood and decrease depression (Jones, 2021)	To treat mild inflammation and pain (Jones, 2021)	
Contraindications (2)	Concurrent therapy with	Hypersensitivity to	Hypersensitivity to	History of asthma,	

	pimozide and hypersensitivity to escitalopram or its components (Jones, 2021)	aripiprazole or its components (Jones, 2021)	risperidone, paliperidone, or its components (Jones, 2021)	urticaria, or other allergic-type reactions induced by aspirin or other NSAIDs and hypersensitivity to naproxen or its components (Jones, 2021)	
Side Effects/Adverse Reactions (2)	Suicidal ideation and seizures (Jones, 2021)	Suicidal ideation and asthma (Jones, 2021)	Bradycardia and sleep apnea (Jones, 2021)	Hypoglycemia and respiratory depression (Jones, 2021)	
Medication/ Food Interactions	Interactions with amphetamines and aspirin (Jones, 2021)	Drug interactions with benzodiazepines such as lorazepam and rifampin (Jones, 2021)	Antihypertensives and rifampin. Do not drink alcohol while taking this medication (Jones, 2021)	Ace inhibitors, beta-blockers, and ARBS (Jones, 2021)	
Nursing Considerations (2)	Monitor client for possible serotonin syndrome which may include agitation, chills, confusion diaphoresis, fever, twitching. Monitor patient espeically elderly for hyperosmolarity of serum and urine and for hyponatremia	Do not have a patient chew or crush tablet, swallow pill whole (Jones, 2021). Use cautiously in patients with conditions that predispose them to hypotension (Jones, 2021).	Should not be used for elderly patients. Use cautiously in patients who have had seizures (Jones, 2021)	Monitor patients for serious GI tract bleeding and make sure the client is hydrated when giving drug (Jones, 2021).	

	(Jones, 2021)				

Brand/Generic	N/A	**N/A**	**N/A**	**N/A**	**N/A**
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)					

The client was only taking 4 medications.

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Good hygiene and well-groomed. The client was engaged and cooperative. The client was thin and of short stature. The client had a positive attitude and was soft-spoken. The client was not speaking and would use a notebook to communicate. She said this was due to the stressful environment. The client's mood was stable, although a little anxious. The client's affect was calm.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The client is improving her thoughts from when she was admitted. The client had suicidal thoughts with multiple plans including overdosing, electrocution and getting hit by traffic. The client stated she does have an obsession with food. The client denies any ideations, delusions, illusions, and phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	Client is oriented to person, place, situation & time. A&O x 4.
MEMORY: **Remote:**	Client denies any impairment in memory. Memory is intact.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Client has poor judgment due to suicidal ideation. Client is intelligent. Client struggles with impulse control when saying that "I tried puking a couple times after eating on an impulse"
INSIGHT:	The client recognizes that her suicidal thoughts were not safe and self-admitted herself to get help. She knows that she needs to find better coping skills for her depression and anxiety.

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The client uses ear plugs to block out background noise. The client has minimal muscle tone. The client sits with her head slightly leaned forward due to poor posture. The client had equal strength in all extremities 5/5. The client can move all extremities with ease.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1430	**69 bpm**	**125/77 mmHg**	**18 rpm**	**98.6 F**	**100 %**
1645	**71 bmp**	**123/ 75 mmHg**	**18 rpm**	**98.7 F**	**100 %**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	**Numeric**	**N/A**	**0**	**N/A**	**Takes Naproxen BID to prevent pain.**
1645	**Numeric**	**N/A**	**0**	**N/A**	**Takes Naproxen BID to prevent pain.**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 33 %**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 480 mL water and orange juice**

Lunch: 50 % **Dinner: none**	**Lunch: 240 mL water** **Dinner: none**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The client will be discharged to her apartment with her two roommates. The patient should continue with the resources that are given here at The Pavillion. The client will continue with individual/ group therapy to help with coping skills, start seeing her psychiatrist again to help with medication management, and start psychoeducation to help with coping skills and to manage her treatment.

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. Risk for suicide due to recent attempt AEB had a plan to overdose, run into traffic, and electrocute herself in the bathtub.	**Her recent plan to commit suicide.**	**1. Medication** **2. Group therapy** **3. Suicidal precautions**	**1. Medications** **2. Suicidal precautions** **3. Group therapy**	**1. She can be given medications after discharge for treating depression and anxiety.** **2. The patient can be given a suicidal hotline as well as having a**

				support system set up. **3. The patient can be given optional resources upon discharge for group therapies.**
2. Impaired verbal communication related to not talking since she was admitted AEB she was communicating through writing in her journal to answer my questions.	**The patient's verbal communication was selective and did not talk to me.**	**1. Evaluate Mental status** **2. Willingness to find alternative communication** **3. Primary preferred means of communication**	**1. Evaluate Mental status** **2. Willingness to find alternative communication** **3. Primary preferred means of communication**	**1. Evaluate the pt's mental health status to find out why she is not verbally talking.** **2. The pt was willing to use a different method of communication such as writing to answer my questions.** **3. The pts primary preferred communication is through writing.**
3. Ineffective coping related to suicide risk AEB recent plan to commit suicide.	**Ineffective coping methods led the pt to make a plan for committing suicide.**	**1. Plan effective coping methods** **2. Identifying specific stressors** **3. Evaluate resources and support systems**	**1. Plan effective coping methods** **2. Identifying specific stressors** **3. Evaluate resources and support systems**	**1. Going to group therapy and learning new ways to cope with depression and the risk for suidide.** **2. The nurse can gain understanding of the clients'**

				life stressors to help manage their coping skills appropriately. **3. The nurses can give resources upon discharge and make sure the patient is leaving with a good support system.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Subjective data

Client states she "Put up blockers by giving her roommate her pills, hairdryer and came here for help."
Client states "I tried puking a couple times after eating on an impulse"
3.). Client states " I used to take scalding hot showers to the point where it burns"

Nursing Diagnosis/Outcomes

Nursing Diagnosis/Outcomes

Risk for suicide due to recent attempt AEB had a plan to overdose, run into traffic, and electrocute herself in the bathtub.
The clients outcome can be taking medications after discharge for treating depression and anxiety.
Impaired verbal communication related to not talking since she was admitted AEB she was communicating through writing in her journal to answer my questions.
The outcome can be the pt's mental health status is evaluated to find out why she is not verbally talking and to find a way to help her communicate verbally again.
Ineffective coping related to suicide risk AEB recent plan to commit suicide.
The clients outcome should be given resources to cope with life stressors through group therapy.

Objective Data

Objective data

The client was thin and of short stature
The client's mood was stable, although a little anxious. The client's affect was calm.
The client's vital signs were stable with pulse rate of 69, Blood pressure 125/77, respirations 18, temperature 98.6 F and oxygen saturation of 100%.

Patient Information

Patient information

The patient is an 21 year old female with history of suicidal ideation. The patient was admitted on 09/30/21 due to suicidal ideation.The patient attends and participates in group therapy and is improving her coping skills during her time at the pavillion.

Nursing Interventions

Nursing intervention
1. Evaluate the pt's mental health status to find out why she is not verbally talking.
2.)The pt was willing to use a different method of communication such as writing to answer my questions.
3.) The pts primary preferred communication is through writing.
4.) Going to group therapy and learning new ways to cope with depression and the risk for suicide.
5.) The nurse can gain understanding of the clients' life stressors to help manage their coping skills appropriately.
6.) The nurses can give resources upon discharge and make sure the patient is leaving with a good support system.