N323 Care Plan

Lakeview College of Nursing

Angelina R. Thomas

Mental Health

10/14/2019

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/07/2021	HL	21 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black or African American	Works at Caterpillar	Single	NKA
Code Status	**Observation Status**	**Height**	**Weight**
Full Code	Not on any observations or precautions	5'4"	240 lbs.

Medical History (5 Points)

Past Medical History: None

Significant Psychiatric History: The patient never consulted a psychiatrist in the past. The patient was never hospitalized, she never received outpatient treatment, and has never been medicated prior to her admission in the Pavilion. The patient had multiple suicide attempts and had a history of self-harm.

Family History: The patient reports that her mother has a history of anxiety, and her father has a history of bipolar disorder.

Social History (tobacco/alcohol/drugs): Patient denies the use of tobacco of any kind, and she also denies the use of illicit drugs outside of Marijuana. She smokes Marijuana 1-2 times every-day outside of the Pavilion. The patient denies ever drinking alcohol.

Living Situation: The patient lives alone.

Strengths: The is very pleasant, cooperative, and willing to participate in the assessment and interview. She mentioned that she sings well. She also mentioned that she produced "decent" grades in school.

Support System: Her biological mother, step-father, sister, and close friend.

Admission Assessment

Chief Complaint (2 points): “I was thinking about killing myself”

Contributing Factors (10 points):

Factors that lead to admission: Worsening symptoms of depression, suicidal thoughts, and thoughts of self-harm.

History of suicide attempts: The patient cannot recall the specific amount and it is not presented in the patient’s chart. The patient stated, “I tried to kill myself a lot of times, more than 10 times.”

Primary Diagnosis on Admission (2 points): Suicidal Ideation

Secondary: Unspecified Bipolar Disorder, Social Anxiety, and panic disorder without Agoraphobia

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient has a history of miscarriage which caused her lifetime effects. She felt depressed. Patient stated, “I felt like I will never have kids again.” The patient was also sexually assaulted by an ex-boyfriend’s older brother, which caused lifetime trauma because she expresses trust issues and sleep challenges due to her experience with sexual abuse. **Witness of trauma/abuse:** The patient did not witness any trauma or abuse.				
	Current	**Past (what age)**	**Secondary Trauma**	**Describe**

			(response that comes from caring for another person with trauma)	
Physical Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Sexual Abuse	**N/A**	**Yes at the age of 13**	**The patient has nightmares due to being sexually assaulted at the age of 13 and has not experienced any trauma since then.**	**When the patient was 13 years old, she was raped by her ex-boyfriend's older brother. The patient did not feel comfortable with describing what exactly happened to her.**
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**	**Lost Baby, 2018 (age 18), uncle, 2020 (age 20), grandmother, 2015, (15)**	**N/A**	**The patient felt horrible losing her baby to a miscarriage. She also felt badly losing her uncle and grandmother because she felt like they were her closest family members and the only two people in her world that understood her.**
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**	**The patient stated that she feels sad and depressed every day and the intensity is a 9 out of 10 every day. The patient stated that is worse at night than in the day. She stated that it is a**	

			constant feeling and happens so frequently that she cannot gauge a set length of time it occurs. She stated that when she does engage in conversation with someone, she does not feel sad and depressed. Throughout the week she will feel sad and depressed 7 days out of the week.
Loss of energy or interest in activities/school	**Yes**	**No**	**The patient says this loss of energy may occur for a few hours, 3-4 hours out of the day, every day. The intensity is a 7 out of 10. The patient stated that work can be boring sometimes and causes her to live in her thoughts during the shift.**
Deterioration in hygiene and/or grooming	**Yes**	**No**	
Social withdrawal or isolation	**Yes**	**No**	**The patient stated that this occurs all the time, none stop. The patient stated, "I try not to distance myself, but I am not a**

			people person.”
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**Happens every night, the patient only receives three hours of sleep per night. Seven days out of the week the patient’s sleep patterns changed after her trauma. Ten times out of ten her sleeping patterns are intense.**
Difficulty falling asleep	**Yes**	**No**	**The patient has had difficulty falling asleep her whole life or for as long as she can recall. The patient mentioned that she nine times out of ten she will be able to fall asleep on her own, so she smokes marijuana, and it helps her to fall asleep. Seven days a week she has a challenge with falling asleep.**
Frequently awakening during night	**Yes**	**No**	**Seven days out of the week she awakens throughout the night.**

			She will remain awake for 4-5 hours and then will smoke marijuana to fall back asleep.
Early morning awakenings	**Yes**	**No**	
Nightmares/dreams	**Yes**	**No**	**The patient has nightmares about three nights out of the week. They are hard to tell how long they last according to the patient.**
Other	**Yes**	**No**	**She wakes up hot, sweating, and weak, every night. It lasts for one to two hours and goes away. Seven days out of the week this occurs.**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**The patient eats les, does not have much of an appetite. This occurs about 5-6 days out of the week. It occurs all day. The patient does not eat breakfast and lunch usually and eats ice chips throughout the day and dinner at night, 5-6 days out of**

			the week.
Binge eating and/or purging	**Yes**	**No**	
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**	**This occurs 5-6 days out of the week, 9 out of 10, and lasts for 9-10 hours out of the day, with a resting time of 13-14 hours.**
Panic attacks	**Yes**	**No**	**This occurs 5-6 days out of the week, 9 out of 10, and lasts for 9-10 hours out of the day, with a resting time of 13-14 hours.**
Obsessive/ compulsive thoughts	**Yes**	**No**	**Smoking marijuana every day for sleep and decrease of "problems". This occurs 4-5 days out of the week, 9 out of 10, and lasts for 6-8 hours out of the day, with a resting time of 15-16 hours.**
Obsessive/ compulsive behaviors	**Yes**	**No**	**This occurs 4-5 days out of the week, 9 out of 10, and lasts for 6-**

			8 hours out of the day, with a resting time of 15-16 hours.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**Called off work 5 days out of the week. Happened for one month, and then patient went back to work as scheduled. Smoked marijuana at home because of the anxiety and the anxiety was 9 out of 10. It lasts for 5 hours and rested.**
Rating Scale			
How would you rate your depression on a scale of 1-10?	9 out of 10		
How would you rate your anxiety on a scale of 1-10?	9 out of 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**	**Called off work 5 days out of the week. Happened for one month, and then patient went back to work as scheduled.**
School	**Yes**	**No**	**Stayed home from school 4-5 days out of the week for one full semester and then went back as scheduled.**

Family	**Yes**	**No**	**Often feels like her father is not emotionally supportive throughout her life. Patient stated, "He is only there for me financially."**
Legal	**Yes**	**No**	
Social	**Yes**	**No**	**The often experiences social anxiety about 6 to 7 days out of the week when she is around other people. She experiences social isolation every day.**
Financial	**Yes**	**No**	**Since the patient skipped out of work at one point 5 days in a 7-week period she lost the income that would have come from working those days. It only occurred for 1 month out of 12 months of the year and did not last long.**
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
The patient reports that she never consulted a psychiatrist; never hospitalized, never received outpatient or in-patient treatment, and was never on any medication.	**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?**	
The Patient lives alone	**21**	**patient**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**Yes**	**No**
N/A	**N/A**	**N/A**	**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: The patient lost her grandmother and uncle. No one in her household (patient lives alone) has ever been incarcerated. Her parents were never married, and she did not witness her parents separate because she was a baby.

Current relationship problems: The patient is single.

Number of marriages: The patient has never been married

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:

The patient does recognize herself as a Christian and she believes in God. The patient stated, "Sometimes, I ask is he real because of all that happens to me."

Ethnic/cultural factors/traditions/current activity: None

Describe: N/A

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): None-Does not apply to this patient or her parents.

How can your family/support system participate in your treatment and care? The patient stated that her support system can help her by attending her therapy sessions with her and listen to her when she needs to talk. She believes that they should maintain an open mind and a listening ear.

Client raised by:

Natural parents- Biological mom
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness: The patient was raped at 13 years old and was depressed because of being raped.
Atmosphere of childhood home: **Loving**-The patient stated, “My childhood was decent”. **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent**- The patient lives alone and takes care of herself. **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Paternal father has anger issues and bipolar disorder
History of Substance Use: None
Education History: **Grade school**-Patient has 8th grade diploma and did not complete high-school. **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient struggled with Social Studies and Science, but she excelled at all other subjects.
Discharge

Client goals for treatment: To receive individual case management to prevent suicidal ideations and to participate group therapy to address her social isolation challenges. To stabilize her mood, treatment of Trileptal 150 mg PO BID, as prescribed by physician.
Where will client go when discharged? Home

Outpatient Resources (15 points)

Resource	Rationale
1. Suicide Prevention Resource Center	**1.** Prevention of suicide. The center includes services that involves addressing mental health issues in a community-based setting. This will address her suicidal thoughts and social challenges, too.
2. National Suicide Prevention Lifeline	**2.** Having a listening ear will help the client express her feelings and reduce the need to harm herself from a buildup of anger and anxiety.
3. Roger's Behavioral Health Outpatient Care for Anxiety and OCD	**3.** Patient will receive treatment for Anxiety outside of an in-patient center.

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

Brand/ Generic	Tylenol/ Acetaminophen	Calcium Carbonate/Titralac 500mg tabs	Motrin/ Ibuprofen	Oxcarbazepine/ Trileptal	Cetirizine/ Zyrtec
Dose	325mg-1tab	1000mg-2tabs	400mg-1tab	300mg-1tab	10mg-1tab
Frequency	Q6H, PRN	PRN, Q4H	Q6H, PRN	BID	Every morning
Route	PO	PO	PO	PO	PO
Classification	Anti-pyretic (Jones &Barlett, 2021, p. 8)	Antacid (Jones &Barlett, 2021, p. 157)	Analgesic (Jones &Barlett, 2021, p. 556)	Anticonvulsant (Jones &Barlett, 2021, p. 836)	Antihistamine (Jones &Barlett, 2021, p. 212)
Mechanism of Action	Blocks prostaglandin production and interferes with pain impulse generation in the peripheral nervous system (Jones &Barlett, 2021, p. 9)	Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis (Jones &Barlett, 2021, p. 158)	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins which mediate inflammatory response and cause local pain, swelling, and vasodilation. (Jones &Barlett, 2021, p. 556)	May prevent or halt seizures by blocking or closing sodium channels in neuronal cell membrane (Jones &Barlett, 2021, p. 836)	Inhibits peripheral H1 receptors to alleviate urticaria (Jones &Barlett, 2021, p. 212)
Therapeutic Uses	To relieve mild to moderate pain (Jones &Barlett, 2021, p. 8)	To provide Antacid effects Jones &Barlett, 2021, p. 158)	To relieve pain Jones &Barlett, 2021, p. 556)	To treat partial seizures (Jones &Barlett, 2021, p. 836)	to treat acute urticaria (Jones &Barlett, 2021, p. 212)

Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	PAIN	GI Upset	Pain	MOOD	In case of allergies
Contraindications (2)	Hepatic Impairment and Hypersensitivity to Tylenol (Jones &Barlett, 2021, p. 9)	Renal calculi and Hypophosphatemia (Jones &Barlett, 2021, p. 158)	Asthma and Angioedema (Jones &Barlett, 2021, p. 557)	Eslicarbazepine acetate and hypersensitivity to oxcarbazepine (Jones &Barlett, 2021, p. 836)	Hypersensitivity to hydroxyzine and hypersensitivity to cetirizine (Jones &Barlett, 2021, p. 212)
Side Effects/Adverse Reactions (2)	Hepatotoxicity and Hypotension (Jones &Barlett, 2021, p. 9)	Hypotension and Hypercalcemia (Jones &Barlett, 2021, p. 158)	Seizures and dizziness (Jones &Barlett, 2021, p. 557)	Hypotension and leukopenia (Jones &Barlett, 2021, p. 836)	Dizziness and Fatigue (Jones &Barlett, 2021, p. 212)
Medication/ Food Interactions	Food high in Pectin and anticholinergics (Jones &Barlett, 2021, p. 9)	Caffeine and High-Fiber Foods and thiazide diuretics (Jones &Barlett, 2021, p. 158)	Aspirin and foods high in sodium (Jones &Barlett, 2021, p. 557)	Hormonal contraceptives and all foods (Jones &Barlett, 2021, p. 837)	CNS depressants and theophylline (Jones &Barlett, 2021, p. 212)
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment (Jones &Barlett, 2021, p. 9)	Store at room temperature and Monitor serum calcium levels (Jones &Barlett, 2021, p. 158)	Should be avoided in patients who experienced a recent MI and avoided in pregnant women after 30 weeks **(**Jones &Barlett, 2021, p. 557)	Implement seizure precautions as needed and Monitor patient's skin closely (Jones &Barlett, 2021, p. 837)	Single use injectable product and warn patient not to drink alcohol (Jones &Barlett, 2021, p. 212)

Brand/Generic	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Dose	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Frequency	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Route	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Classification	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Mechanism of Action	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Uses	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Therapeutic Range (if applicable)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Medication/Food Interactions	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Medications Reference (1) (APA):

Jones & Barlett. (2021). *2021 Nurse's Drug Handbook* (20th ed.). Burlington, MA

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**The patient is cooperative and pleasant. She is oriented to person, place, and time. Her speech rate is normal and presented no speech impairment. She describes her mood as depressed Her affect is depressed and restricted. The patient stated, "I am ready for them to increase the dose of medication because I am still feeling depressed. It is not working because I need a higher dose for my weight."**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**As of 10/11/2021 no current thoughts of suicide. The patient denied paranoia, delusions, hallucinations, illusions, and thoughts of suicide. She only obsesses over smoking marijuana. She has no Phobias.**
ORIENTATION: **Sensorium:** **Thought Content:**	**Thought process was clear, linear and goal directed**
MEMORY: **Remote:**	**Patient presented with fair remote memory. She was tested by asking the name of a past president and a historical fact. Patient responded, "President Obama and 9/11 terrorist attack in New York City."**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**The patient does not have impulse control issues. Her intellectual capacity appears to be average based on her language, vocabulary, and history. Her judgement is preserved.**
INSIGHT:	**Fair. The patient was asked about what led to**

	her hospitalization. Patient stated, "I thought about killing myself."
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**The patient has normal psychomotor activity, posture straight up, and muscle tone and strength are equal throughout. She does not use any assistive devices.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**54**	**114/77**	**18**	**98.1F**	**100**
1611	**61**	**146/88**	**18**	**97.7F**	**100**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	**0-10**	**0**	**0**	**0**	**0**
1604	**0-10**	**shoulder**	**5**	**Sharp; "Slept on it wrong"**	**Assisted with keeping it still**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: 100% **Breakfast: eggs and sausage** **Lunch: meatball subs and fries** **Dinner: Had not eaten at the time of the assessment**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 240 ml orange juice** **Lunch: 240 ml coke** **Dinner: Had not eaten at the time of the assessment**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Patient is going home alone. She does not have any home care needs other than taking her medications. She does not have any equipment needs currently. Her follow up plan is to seek primary care doctor 3 days after discharge to go over medication needs, and two weeks after that to discuss how the treatment is going. She will attend an outpatient facility when suicidal thoughts arise, or depression arises. She will take medications as prescribed and use new coping mechanisms when she is feeling anxious, depressed, or suicidal.

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. Insomnia related to anxiety and having nightmares as evidence by receiving only 3 hours of sleep per night	**Getting improper rest contributes to ineffective psychological care and must be addressed to improve thoughts and**	**1. Ask patient to express reason for not being able to sleep** **2. Assess environmental factors affecting sleep**	**1. Group Therapy** **2. Tea at Night** **3. Ask provider to prescribe Melatonin medication to**	**1. Anxiety and OCD outpatient center** **2. Anxiety Hotline** **3. Phone conversation**

	behaviors.	**3. Dim lighting at bedtime**	**promote sleep**	**with close friend**
3. Ineffective coping related to Anxiety as evidence by dependence on marijuana smoking to relieve anxiety	**Patient needs to adopt new coping mechanism to reduce anxiety than smoking marijuana**	**1. Check pockets to remove the marijuana if present** **2. Suggest music to reduce anxiety since she likes to sing** **3. Sit and listen to ways she can come up with ideas to reduce anxiety**	**1. Offer journaling to reduce anxiety** **2. Offer pamphlets on anxiety** **3. Administer medications as prescribed to reduce anxiety**	**1. Anxiety Hotline** **2. outpatient anxiety center** **3. Detoxification centers from Marijuana**
4. Self-care deficit related to suicidal ideation as evidence by patient stating, "I thought about killing myself."	**Prevention of suicide is priority to save her life. Increase her own value within herself will reduce the need to harm herself.**	**1. Explore thoughts of why she wants to kill herself** **2. one-on-one observation** **3. Teach her positive words of affirmation**	**1. Group therapy** **2. Individual therapy** **3. offer journaling her thoughts**	**1. Suicide prevention hotline** **2. suicide prevention center** **3. Have her to tell her friend the positive words of affirmations she came up with so that her friend can remind her to say them.**

Other References (APA):

Rogers Behavioral Health. (2021). *OCD and Anxiety Outpatient Care*. https://rogersbh.org/what-we-treat/ocd-anxiety/ocd-anxiety-outpatient-services

Concept Map (20 Points):

Subjective Data

"I thought about killing myself."
"My dad needs to be there for me emotionally, just like he is there financially."

Nursing Diagnosis/Outcomes

ng only 3 hours of sleep per night
Outcome: Patient be able to sleep for 7-8 hours at least 6 nights out of 7 in one week.
Ineffective coping related to Anxiety as evidence by dependence on marijuana smoking to relieve anxiety

Outcome: Patient will be able to completely cease marijuana and use new coping strategies 7 days out of a week for 1 month and then check in with provi
Self-care deficit related to suicidal ideation as evidence by patient stating, "I thought about killing myself."

Outcome: Patient will not think of killing herself or harming herself less at all for 1 month

Objective Data

B/P-146/88
T-97.7F
O2-100%
P-61
R-18
Patient appeared in no acute distress

Patient Information

HL
African American Female
21 years old
240lbs.
5'4"
No known Allergies
Full code
Thoughts of Suicide
Diagnosis of Anxiety and Depression

Nursing Interventions

Group Therapy
Check pockets to remove the marijuana if present
Offer journaling her thoughts