

N323 Care Plan
Lakeview College of Nursing
Kaitlyn N. Holycross

Demographics (3 points)

Date of Admission 10/21/21	Patient Initials KE	Age 18	Gender Female
Race/Ethnicity Caucasian	Occupation Tutors other college students. She is a student herself.	Marital Status Single	Allergies None
Code Status Full code	Observation Status Q15 minute checks	Height 5'3"	Weight 105 lbs.

Medical History (5 Points)

Past Medical History: None

Significant Psychiatric History: Anxiety and depression.

Family History: Major background of depression and anxiety on almost all of maternal side.

Social History (tobacco/alcohol/drugs): Patient does not use tobacco, alcohol, or illicit drugs.

Living Situation: Lives with a friend in a dorm at her college.

Strengths: She loves school. She is good at math, chemistry, history, reading, and helping others.

Support System: Has supportive family and friends. Her parents and sisters are very supportive.

Admission Assessment

Chief Complaint (2 points): The patient was admitted voluntarily. Patient came in stating "I don't want to be alive". Patient has felt better since being admitted.

Contributing Factors (10 points):

Factors that lead to admission: Patient was experiencing panic attacks, having nightmares and trouble sleeping. Patient was triggered of the incident due to her attacker being present on campus. Patient stated "I feel like I am constantly reliving the attacks". Patient felt like being admitted would help her potentially not feel like hurting herself.

History of suicide attempts: No attempts. Patient just has thoughts two to three days prior to admission.

Primary Diagnosis on Admission (2 points):

Suicidal ideation

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: Sexual assault one month ago. The first time happened when she was doing laundry on campus, the second time he forced her into his car.</p> <p>Witness of trauma/abuse: No witnesses</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	14 years old, and 18	NA	Pt did not mention this, but was found in chart that she has a history of cutting in 8 th grade.

				Pt was raped at 18 years old, and experienced bruising on neck which also caused swelling. Pt stated "he choked me".
Sexual Abuse	No	18	NA	Pt was raped by a male acquaintance who lived on campus with her. The abuse happened two times.
Emotional Abuse	No	18	NA	Emotionally feeling shame, anger, sadness, violation, and being scared from the incident's.
Neglect	NA	NA	NA	NA
Exploitation	NA	NA	NA	NA
Crime	NA	NA	NA	NA
Military	NA	NA	NA	NA

Natural Disaster	NA	NA	NA	NA
Loss	NA	NA	NA	NA
Other	NA	NA	NA	NA
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	Pt was feeling depressed but stated “I have not felt depressed in the past two days”.	
Loss of energy or interest in activities/school	Yes	No	Pt missed classes approximately 5 times a week. Pt felt like not getting out of bed almost every day.	
Deterioration in hygiene and/or grooming	Yes	No	Pt didn’t shower every day. The pt showered once every 2 days.	
Social withdrawal or isolation	Yes	No	Pt stated “I probably spent around 16 hours a day alone. I put headphones on when I am in my dorm so I don’t have to talk to my roommate”.	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	Pt was having difficulty with grades. Her grades were slipping which is unlike her according to pt. Pt stopped talking to most of	

			her family due to the attack. Pt stated “I just felt so angry at the world”.
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	Pt’s sleep patterns changed. Often her sleep alternates from sleeping for 15 hours straight, to sleeping for only 2 hours. Pt stated “I usually sleep for only 2 hours a night around 5 of the 7 nights a week”.
Difficulty falling asleep	Yes	No	Pt struggles to fall asleep every night of the week.
Frequently awakening during night	Yes	No	Pt wakes up sometimes around two to three nights a week.
Early morning awakenings	Yes	No	Pt wakes up around 6 am every day, but stays in bed.
Nightmares/dreams	Yes	No	Pt stated “I have violent dreams around one to two times a week”.
Other	Yes	No	NA
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Pt stated “I have a loss of appetite all the time”.

Binge eating and/or purging	Yes	No	NA
Unexplained weight loss? Amount of weight change:	Yes	No	Pt stated "I could've lost weight, but have not weighed myself or noticed".
Use of laxatives or excessive exercise	Yes	No	NA
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Pt stated "hands are shaking all the time". Pt rated her anxiety behaviors a "7-8 out of 10".
Panic attacks	Yes	No	Her last panic attack was on Saturday night (10/16).
Obsessive/compulsive thoughts	Yes	No	NA
Obsessive/compulsive behaviors	Yes	No	NA
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	Avoids situations
Rating Scale			
How would you rate your depression on a scale of 1-10?		Pt stated "I would rate it a 5 now that I feel a little better".	
How would you rate your anxiety on a scale of 1-10?		Pt stated anxiety is a 7-8/10.	
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	Pt tutors other students on campus. Pt has been tutoring

			since the second week of class. Pt stated “I feel very stressed tutoring or doing anything on campus since the incidents”.
School	Yes	No	School provides a lot of stress and anxiety due to the incidents happening on campus. This has caused stress since being assaulted.
Family	Yes	No	Her family is very supportive, they just “annoy” her sometimes.
Legal	Yes	No	Currently fighting to have charges on the guy who sexually assaulted her. They are getting a lawyer and working on a title 9.
Social	Yes	No	NA
Financial	Yes	No	NA
Other	Yes	No	NA
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
NA	Inpatient Outpatient Other: NA	NA	NA	No improvement Some improvement Significant improvement
NA	Inpatient Outpatient Other: NA	NA	NA	No improvement Some improvement Significant improvement
NA	Inpatient Outpatient Other: NA	NA	NA	No improvement Some improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Roommate 1	18	Friend/dorm roommate	Yes	No
Roommate 2	18	Friend/dorm roommate	Yes	No
NA			Yes	No
NA			Yes	No
NA			Yes	No
If yes to any substance use, explain: NA				
Children (age and gender): NA				

Who are children with now? NA		
Household dysfunction, including separation/divorce/death/incarceration: Her parents are divorced, but no issues family related.		
Current relationship problems: Single		
Number of marriages: None		
Sexual Orientation: Pansexual	Is client sexually active? Yes No	Does client practice safe sex? Yes No
Please describe your religious values, beliefs, spirituality and/or preference: Pt does not have any particular beliefs.		
Ethnic/cultural factors/traditions/current activity: NA.		
Describe: Pt stated "I'm just white".		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): NA		
How can your family/support system participate in your treatment and care?		
Pt stated "Giving space when I need it, and just listen to me".		
Client raised by:		
Natural parents Grandparents Adoptive parents Foster parents Other (describe):		
Significant childhood issues impacting current illness: None		
Atmosphere of childhood home: Pt described her family as very supportive and loving.		
Loving Comfortable Chaotic Abusive Supportive Other:		

<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</p> <p>The pt has depression and anxiety on her mother’s side of the family.</p>
<p>History of Substance Use: None</p>
<p>Education History: Pt currently attends IUPUI in Indianapolis</p> <p>Grade school High school College Other:</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: Pt stated she is a very good student, the incidents just made her struggle.</p>
<p>Discharge</p>
<p>Client goals for treatment: Coping skills to not end up at the Pavilion again. Pt stated “Feel like I got a lot of coping skills already that I didn’t have”.</p>
<p>Where will client go when discharged? Back to her dorm at college.</p>

Outpatient Resources (15 points)

Resource	Rationale
1. SAMHSA national helpline (1-800-662-	1. Service is confidential. Trained specialists

HELP (4357).	transfer callers to appropriate intake centers based on their area to connect them to local assistance and support.
2. Better help therapy	2. Online therapist for support and counseling.
3. National suicide hotline (800-273-8255)	3. 24 hour hotline for someone who is having suicidal thoughts or attempts. Helps provide someone to talk to in case of that specific situation.

Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Fluoxetine/Prozac	Levonor- eth estrad	NA	NA	NA
Dose	20 mg	0.15 mg			
Frequency	QD	Evening QD			
Route	Oral	Oral			
Classification	SSRI’s (selective serotonin reuptake inhibitors)	Birth control, prevents pregnancy			
Mechanism of Action	Blocks the reuptake of	Prevention of the sure of			

	serotonin into presynaptic serotonin neurons	luteinizing hormone which prevents ovulation.			
Therapeutic Uses	Treats depression, anxiety, sometimes OCD, and bulimia	Prevents pregnancy			
Therapeutic Range (if applicable)	Doses range from 20-60mg per day	NA			
Reason Client Taking	Anxiety/depression	Birth control			
Contraindications (2)	Diabetes, people with low amounts of sodium in the blood, people with an increased risk of bleeding	Diabetes, being over 35 years old.			
Side Effects/Adverse Reactions (2)	Difficulty falling or staying asleep, nausea, diarrhea, nervousness	Nausea, vomiting, breast tenderness, bloating, etc.			
Medication/Food Interactions	Tyramine-Rick food products (cheese, milk, beef, avocados, bananas. Etc.). Major drug interactions include amino acids L-dopa and L-tryptophan.	Caffeine. There are several medications that could interact, the major one is antibiotics such as amoxicillin because it can inhibit the therapeutic effect of the medication.			
Nursing Considerations (2)	Monitor/follow up to ensure proper effects are successful, and notify physician if	Take the medication at the same time every day to			

	any adverse effects occur.	ensure efficacy, and make sure to contact provider if any side effects occur.			
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Brand/Generic	NA	NA	NA	NA	NA
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):

Mayo Clinic. (September 1, 2021). *Levonorgestrel And Ethinyl Estradiol (Oral Route)*.

<https://www.mayoclinic.org/drugs-supplements/levonorgestrel-and-ethinyl-estradiol-oral-route/side-effects/drg-20406441?p=1>

Mayo Clinic. (November 1, 2021). *Fluoxetine (Oral Route)*. <https://www.mayoclinic.org/drugs-supplements/fluoxetine-oral-route/precautions/drg-20063952?p=1>

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Appropriate Behavior: Calm, very nice Build: Petite Attitude: Happy to talk to me Speech: Clear Interpersonal style: Smiles “Spunky” Mood: Happy Affect: Normal</p>	<p>Pt stated “I am happy today”.</p> <p>Pt was alert, cooperative, pleasant, oriented to place and time, attention was preserved.</p>
<p>MAIN THOUGHT CONTENT: Ideations: Had thoughts of suicide Delusions: NA Illusions: NA Obsessions: NA Compulsions: NA Phobias: NA</p>	<p>Pt has no phobias, no hallucinations, no social anxiety.</p>
<p>ORIENTATION: Sensorium: Appropriate Thought Content: Appropriate</p>	<p>Pt was tested by asking who the current president is. Pt stated “Biden”</p>
<p>MEMORY: Remote: Proper</p>	<p>Pt was tested by asking what her elementary school was called. Pt stated “Villa Grove</p>

	Elementary School”.
REASONING: Judgment: Preserved Calculations: Intelligence: Abstraction: Impulse Control: Proper	Pt was asked to count back from 70. Pt could count back from 70. Judgement is clear Pt stated she has good impulse control Intellectual capacity appears to be average based on her language, vocab, and history of academic performance.
INSIGHT:	Pt understands why she is admitted (Pt wanted to be admitted).
GAIT: Assistive Devices: None Posture: Appropriate Muscle Tone: Even, proper Strength: Strong, equal Motor Movements: Appropriate	Pt has good strength in all extremities, normal/equal posture, equal pulses, strong motor movements.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1614	73	117/67	18	97.9	100
1700	74	117/66	18	97.9	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1614	0/10	NA	NA	NA	NA
1700	0/10	NA	NA	NA	NA

Dietary Data (2 points)

Dietary Intake	
<p>Percentage of Meal Consumed: 100%</p> <p>Breakfast: Bagel (Ate whole bagel)</p> <p>Lunch: 2 chicken strips and bag of apples (Ate all of it)</p> <p>Dinner: NA (I left before they ate dinner)</p>	<p>Oral Fluid Intake with Meals (in mL)</p> <p>Breakfast: Water 240 mL</p> <p>Lunch: Water 240 mL</p> <p>Dinner: NA</p>

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

I believe the best thing for this patient is to first, attend some form of counseling. Regular counseling is critical for continuation of coping methods, and communicating what is on her mind. Talking to a professional on the regular will provide consistency with her treatment. I would also suggest she continue her Fluoxetine for anxiety and depression as long as her provider prescribes it and finds it necessary. Lastly, I would recommend she keep up with her hygiene, school, and keeping in touch with friends and family to help support her through this time.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Immediate Interventions (At admission)	Intermediate Interventions (During hospitalization)	Community Interventions (Prior to discharge)
<ul style="list-style-type: none"> • Include full nursing 	<ul style="list-style-type: none"> • Explain why the nursing 			

diagnosis with “related to” and “as evidenced by” components	diagnosis was chosen			
<p>1. Risk for self-harm</p>	<p>Risk for self-harm related to suicidal ideation by patient stating “I thought about killing myself” and patient began cutting wrist in 8th grade.</p>	<p>1. Regular monitoring 2. Counseling services 3. Ensuring no objects be near pt that could be a potential to aid in self harm</p>	<p>1. Limiting stimulation 2. Have her support system if need be 3. Evaluation to understand reason for state she is in</p>	<p>1. Family and friends can show their support 2. Ensuring her living environment is safe for her to return to 3. Have a person constantly checking in on her after discharge</p>
<p>2. Rape-trauma syndrome</p>	<p>The pt is clearly in the acute phase of the trauma involved in her assaults. The pt is experiencing emotional and disbelief that it happened. Pt cried while telling me about her story. Pt stated “the first time it happened it didn’t feel real and I tried to pretend it didn’t happen”.</p>	<p>1. Counseling services 2. Safe environment 3. Low stimulation to hopefully lower stress</p>	<p>1. Allow pt to explain how she is feeling 2. Allow pt to understand that she is being heard and people care 3. Ensure pt remains stable</p>	<p>1. Provide a safe environment to return to after discharge 2. Parents and friends show support so pt knows she has a support system 3. Ensure counselor appointments are in place for after discharge to ensure pt continues working through the trauma</p>

	Now the pt has major anxiety when having anything to do with her attacker or where it happened.			
3. Ineffective coping	Pt was struggling to cope. One of the reasons the pt admitted herself is to hopefully develop coping skills. Pt stated “I came to the pavilion to hopefully get better coping methods”.	<ol style="list-style-type: none"> 1. Safe environment 2. Therapy or counseling 3. Taking her medication for depression/anxiety 	<ol style="list-style-type: none"> 1. Allow pt to remain calm by providing a calm environment 2. Provide food/water to hopefully boost mood. Ensure pt has a schedule for sleeping and eating 3. Allow support system to be present 	<ol style="list-style-type: none"> 1. Set up a counseling service for after discharge 2. Help pt recognize her triggers 3. Have a way to calm herself down when problems arise. Support system for after discharge is essential

Other References (APA):

Health Conditions. (2018). *NANDA nursing diagnoses*.

<https://ar.israa.edu.ps/uploads/documents/2020/02/4gcM0.pdf>

Concept Map (20 Points):

Subjective Data

Pt stated "I felt depressed"
 Pt stated "I felt like harming myself prior to admission"
 Pt stated "I want to develop coping mechanisms while I am here"
 Pt stated "I was raped by a friend twice, one month ago"

Nursing Diagnosis/Outcomes

Pt is at risk for self-harm due to suicidal ideation by pt stating "I thought about killing myself". The ideal outcome would be for the pt to no longer have suicidal thoughts.

Pt is going through something called rape trauma syndrome. This syndrome is common for people who experience something as traumatic as rape. An ideal outcome for this would be to be able to deal with triggers and hopefully be able to move forward in a healthy way.

Pt has ineffective coping skills. Pt stated "I came in to develop good coping skills". The ideal outcome would be for the pt to be able to recognize triggers and be able to move on from them in a calm manor. It is critical for the pt to be able to be able to work through her trauma in a safe and effective way.

Objective Data

Pt was very sad and angry over the attack that happened to her
 Pt cried while telling me her story
 Pt was very nice, intelligent, and willing to tell me her story

Patient Information

Pt is a 18 year old Caucasian female who weighs 105 lbs and is 5'3". Pt came in with a chief complaint of "not wanting to be alive". Pt had a voluntary admission. Pt was diagnosed with suicidal ideation.

Nursing Interventions

One of the most important interventions is to have a counselor or some form of a professional therapist to help her find coping skills, work through her pain and trauma, and live life not feeling depressed. Also, they could help to prevent suicidal thoughts and how to properly deal with them.
 Another intervention is to provide a safe environment for her to not feel like she could see her attacker at any point, or feel threatened.
 Taking her medication to ensure control of her anxiety and depression would be beneficial
 Pt should keep a proper eating and sleep schedule to help provide consistency and set her up for success with her coping skills. If pt is tired or hungry, it would make it harder to deal with her emotions.



