N323 Care Plan

Lakeview College of Nursing

Haley Shaw

Demographics (3 points)

Date of Admission 2/7/22	Patient Initials S.D.	Age 21	Gender female
Race/Ethnicity Caucasian	Occupation unemployed	Marital Status single	Allergies none
Code Status full	Observation Status intermittent	Height 5'6	Weight 112lbs 3.2oz

Medical History (5 Points)

Past Medical History: Patient states she has no past medical history.

Significant Psychiatric History: Patient has had several inpatient psychiatric admissions in the past. She is on a combination of Pristiq, Vyvanse, BuSpar, and Ritalin.

Family History: Her younger sister has anxiety and depression.

Social History (tobacco/alcohol/drugs): Alcohol heavy for the past few months. Uses cannabis from time to time.

Living Situation: Living with 2 roommates

Strengths: Patient is domiciled and educated.

Support System: Patient has the support of her friends and boyfriend. She also has support from her parents.

Admission Assessment

Chief Complaint (2 points): "I was intoxicated and thinking about suicide"

Contributing Factors (10 points):

Factors that lead to admission: Patient states she was "feeling depressed on and off for the past 2 months." She states she "had a sad mood, no motivation, not sleeping, not eating, easily fatigued, poor concentration, and had a feeling of being overwhelmed and hopelessness." On February 6th she was drinking alcohol and became intoxicated. She felt

overwhelmed and thought about suicide. She grabbed scissors and tried to stab herself. Her boyfriend wrestled the scissors out of her hand and drove her to the ER at Carle BroMenn Hospital in Bloomington, IL then she was transferred here to OSF.

History of suicide attempts: Patient denies any previous suicide attempts. However, she has had multiple ED visits due to suicidal ideation while intoxicated.

Primary Diagnosis on Admission (2 points): bipolar disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse: Patient states she does not have any history of abuse or trauma.**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**None**			
Sexual Abuse	**None**			
Emotional Abuse	**None**			
Neglect	**None**			
Exploitation	**None**			

Crime	**None**			
Military	**None**			
Natural Disaster	**None**			
Loss	**None**			
Other	**None**			
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	**Patient has been feeling sad & depressed on and off for the past 2 months.**	
Loss of energy or interest in activities/school	**Yes**	**No**	**Patient is on medical leave from ISU since fall semester.**	
Deterioration in hygiene and/or grooming	**Yes**	**No**		
Social withdrawal or isolation	**Yes**	**No**		
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**Patient is on medical leave from ISU since fall semester.**	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**		
Difficulty falling asleep	**Yes**	**No**		
Frequently awakening during night	**Yes**	**No**		
Early morning awakenings	**Yes**	**No**		
Nightmares/dreams	**Yes**	**No**		
Other	**Yes**	**No**		
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	

Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	
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**	**Patient has trouble concentrating.**
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**		
How would you rate your anxiety on a scale of 1-10?	**2**		
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**	
School	**Yes**	**No**	**Patient has been on medical leave from ISU since fall semester.**
Family	**Yes**	**No**	

Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
2020	**Inpatient** **Outpatient therapist** **Other:**	**Outpatient**	**To treat depression**	**No improvement** **Some improvement** **Significant improvement**
2021	**Inpatient** **Outpatient facility** **Other:**	**outpatient**	**To treat alcohol abuse**	**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?**

Rachel	**21**	**friend**	**Yes**	**No**
Tia	**21**	**friend**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain: Patient states her friend, Tia, also uses alcohol.

Children (age and gender): N/A

Who are children with now?

Household dysfunction, including separation/divorce/death/incarceration: Patients parents divorced when she was in 5th grade. Patient lived with her mother after that.

Current relationship problems: She has a boyfriend, Matt.

Number of marriages: 0

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

Please describe your religious values, beliefs, spirituality and/or preference: Patient does not state any religious values or beliefs.

Ethnic/cultural factors/traditions/current activity:
Describe: Patient states no ethnic or cultural factors.

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A

How can your family/support system participate in your treatment and care? Talking with them regularly and supporting choice to go to rehab in Chicago

Client raised by:

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

Significant childhood issues impacting current illness: Patient's father struggled with addiction to pain medication, opioids, and heroin. Patient's father has been sober for many years now.

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.) **No**
History of Substance Use: Cannabis and alcohol
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient is on medical leave for her depression and anxiety.
Discharge
Client goals for treatment: Optimized coping skills for life stressors.
Where will client go when discharged? Patient plans to go to a rehab in Chicago.

Outpatient Resources (15 points)

Resource	Rationale
1. Counseling	1. Patient needs counseling for her anxiety and depression.
2. treatment for drug abuse	2. Patient needs treatment for her cannabis use.
3. treatment for alcohol abuse	3. Patient needs treatment for her alcohol use.

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

Brand/Generic	Desvenlafaxine/ succinate	Lorazepam/ Ativan	Lisdexamfetamine Dimesylate/ Vyvanse	Buspirone/ Bustab	Methylphenidate/ ritalin
Dose	25mg	1mg	30mg	5mg	10mg
Frequency	1 tablet daily	1mg every 8 hours PRN	Daily	5mg tablet x3 daily	10mg PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	serotonin and norepinephrine reuptake inhibitors	benzodiazepine	amphetamine	azaspirone	piperidine
Mechanism of Action	thought to be related to the potentiation of serotonin and norepinephrine in the central nervous system, through inhibition of their reuptake	May potentiate the effects of gammaaminobutyric acid and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of CNS.	Produces CNS stimulant effects, probably by facilitating release and blocking reuptake of norepinephrine at adrenergic nerve terminals and by	May act as a partial agonist at serotonin 5-hydroxytryptamine receptors in the brain, producing antianxiety effects.	Blocks the reuptake mechanism of dopaminergic neurons in the cerebral cortex and subcortical structures of the brain, including the thalamus,

			stimulating alpha and beta receptors in peripheral nervous system.		**decreasing motor restlessness, and improving concentration.**
Therapeutic Uses	**antidpressant**	**anxiolytic**	**CNS stimulant**	**anxiolytic**	**CNS stimulant**
Therapeutic Range (if applicable)	**200-400mg daily**	**2-3mg twice or three times daily, increased as needed**	**30mg once daily in the morning, increased as needed in increments of 10 or 20 mg daily every week.**	**20-30mg daily**	**20-30mg given in doses 2 or 3x daily, taken 30-45 mins before a meal**
Reason Client Taking	**Depression**	**Anxiety**	**ADHD**	**Anxiety**	**(Poor focus) ADHD**
Contraindications (2)	**Hypersensitivity to desvenlafaxine succinate, venlafaxine hydrochloride or to any excipients in the desvenlafaxine extended-release tablets formulation. The use of MAOIs intended to treat psychiatric disorders with desvenlafaxine or within 7 days of stopping treatment with desvenlafaxine**	**Acute angle-closure glaucoma; hypersensitivity to lorazepam, other benzodiazepines, or their components, or sleep apnea syndrome**	**Hypersensivity, or idiosyncratic reaction to lisdexamfetamine, other sympathomimetic amines, or their components; MAO inhibitor therapy including intravenous methylene blue and linezolid within 14 days.**	**Hypersensitivity to buspirone or its components, sever hepatic or renal impairment**	**Agitation, marked anxiety, tension; glaucoma; hypersensitivity to methylphenidate or its components**

	is contraindicated because of an increased risk of serotonin syndrome.				
Side Effects/Adverse Reactions (2)	**Increased risk of suicidal thoughts or actions in some children and young adults within the first few months of treatment, serotonin syndrome**	**Seizures, suicidal ideation**	**Agitation, depression**	**Anger, decreased concentration**	**Aggressiveness, anxiety**
Medication /Food Interactions	**The concomitant use of SSRIs and SNRIs including desvenlafaxine with MAOIs increases the risk of serotonin syndrome. Con comitant use of desvenlafaxine with an antiplatelet or anticoagulant drug may potentiate the risk of bleeding.**	**Increased CNS depression and severe respiratory depression with alcohol use.**	**Tricyclic antidepressants: possibly increased antidepressant effects and cardiovascular effects can be potentiated.**	**Any food: possible decreased buspirone clearance Grapefruit juice: increased blood buspirone level**	**Caffeine: increased methylphenidate effects Alcohol: possible increased CNS effects**
Nursing Considerations (2)	**Be alert for new seizures or increased seizure activity, especially at the onset of drug treatment. Document the number,**	**Before starting lorazepam therapy in a patient with depression, make sure he already takes an**	**Monitor patient blood pressure closely; stimulant drugs such as lisdexamfet**	**Use buspirone cautiously in patients with hepatic or renal impairment. Institute safety**	**Stopping drug after long term use may unmask dysphoria, paranoia, severe depression,**

	duration, and severity of seizures, and report these findings immediately to the physician. Be alert for increased depression and suicidal thoughts, especially in the initial period of drug therapy, and in children and teenagers.	**antidepressant, because of the increased risk of suicide in patients with untreated depression. Be aware that the combination of general anesthesia and sedation drugs like lorazepam used during procedures or surgeries in pregnant women in their third trimester is not recommended because it may affect brain development in the fetus.**	**amine may increase it. Know that patient should be screened for psychiatric risk factors such as family or personal history of bipolar disorder, depression, and suicidal ideation because lisdexamfetamine may cause psychiatric adverse reactions.**	**precautions because of possible adverse CNS reactions.**	**or suicidal thoughts. Monitor blood pressure and pule rate to detect hypertension and excessive stimulation.**

Brand/Generic	**Acetaminophen/ Tylenol**	**Benztropine / Mesylate/ Cogentin**	**Haloperidol/ haldol**	**Naltrexone/ Depade**	**trazodone/ desyrel**
Dose	**650mg**	**2mg**	**5mg**	**50mg**	**100mg**
Frequency	**Every 4 hours PRN**	**2x daily**	**Every 4 hours PRN**	**Daily**	**Nightly PRN**

Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Nonsalicylate, paraaminophenol derivative**	**antichlolinergic**	**Butyrophenone derivative**	**Opioid antagonist**	**Triazolopyridine derivative**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.**	**Blocks acetylcholine's action at cholinergic receptor sites.**	**May block postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine, creating an antipsychotic effect**	**Displaces opioid agonist from-or blocks them from binding with-delta, kappa, and mu recepors**	**Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect**
Therapeutic Uses	**Antipyretic, nonopioid analgesic**	**Antiparkinsonian, central acting anticholinergic**	**antipsychotic**	**Opioid and alcohol blocker**	**antidepressant**
Therapeutic Range (if applicable)	**5-20mcg/mL**	**N/A**	**N/A**	**50mg daily**	**N/A**
Reason Client Taking	**Mild/severe pain**	**Movement disorder**	**Agitation breakthrough/psychosis/mania**	**Treat alcoholism**	**sleep**
Contraindications (2)	**Hypersensitivity to acetaminophen or its components, severe hepatic impairment**	**Acute inflammatory lesions of GI tract, coronary artery disease**	**Severe toxic CNS comatose states or depression, hypersensitivity to haloperidol or its components**	**Acute opioid withdrawal, concurrent therapy with**	**Hypersensitivity to trazodone or its component, recovery from acute MI, use**

	, sever active liver disease.			**opioid analgesics; dependency on opioids**	**within 14 days of MOA inhibitor.**
Side Effects/Adverse Reactions (2)	**Agitation, fatigue**	**Headache, hypotension**	**Cardiac arrest, ventricular arrhythmias**	**Depression, anxiety**	**Anxiety, suicidal ideation**
Medication/ Food Interactions	**Alcohol; increased risk of hepatotoxicity Oral contraceptive: decreased effectiveness of acetaminophen**	**Cholinergic drugs: possibly increased effects of bethanechol**	**Alcohol: increased CNS depression and risk of hypotension and respiratory depression Antidepressants: increased plasma concentrations of these drugs with increased risk of adverse reactions**	**Disulfiram: increased risk of hepatoxicity**	**NSAIDS: possible increased risk of bleeding**
Nursing Considerations (2)	**Use cautiously in patients with alcoholism or severe renal impairment. Monitor renal function in patient on long term therapy.**	**Assess urine elimination before starting bethanechol therapy**	**Shouldn't be used to treat dementia related psychosis in the elderly because of an increased mortality risk. Dilute oral solution with beverage, such as apple juice, OJ, tomato juice, or cola**	**Give oral drug with antacids or food to decrease adverse Gi reaction. To avoid withdrawal symptoms, wait 7-10 days after last**	**Use trazodone cautiously in patients with cardiac disease because drug can cause arrhythmias. Give shortly after a meal or light snack to reduce nausea**

				opioid dose, as prescribed, before starting naltrexone	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Patient is wearing yellow scrubs. She is pleasant and cooperative, appears her age. Slightly psychomotor agitated and emotional. She has fair grooming and hygiene. She states her mood is "okay." Her affect is expansive and labile.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**Patient is goal directed and denies suicidal or homicidal ideation. She denies auditory or visual illusions. No delusions. She is alert and oriented and feels hopeless and overwhelmed.**
ORIENTATION: **Sensorium:** **Thought Content:**	**Patient is alert and oriented x3.**
MEMORY: **Remote:**	**Remote memory is fair short and long term.**
REASONING: **Judgment:** **Calculations:** **Intelligence:**	**Her judgement is fair. Intelligence is average on language and fund of knowledge. Her attention span and concentration are fair.**

Abstraction: **Impulse Control:**	
INSIGHT:	**Insight is limited.**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**Normal muscle tone and strength of all 4 extremities. No muscle atrophies. No abnormal movement. Gait strong and steady.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0756	**84**	**112/77**	**12**	**97.6**	**98**
1300	**70**	**117/76**	**18**	**97**	**98**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0756	**1-10**		**0**		
1300	**1-10**		**0**		

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 75%** **Lunch: 75%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: not documented** **Lunch: not documented**

Dinner: 75%	**Dinner: 240mL**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Have a verbal discussion with patients about discharge arrangements. Patient will be going back home to live with her 2 roommates. Patient needs to attend AA and counseling for anxiety and depression. Before being discharged, the patient must plan the first follow-up appointment within 24 to 72 hours, and at least seven days after discharge. After you've been discharged, give out crisis contact information. Make a safety strategy that is unique to the patient.

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	**Patient was experiencing suicidal ideation**	**1. screen for suicide risk** **2. initiate appropriate safety protocols** **3. demonstrate understanding but don't reinforce denial of the**	**1.make a short-term contract with patient on not harming self during a specific period.** **2. provide supervision for patient based on facility policy to ensure compliance with legal requirements to**	**1. help a patient set a goal for obtaining long term psychiatric care.** **2. make appropriate referrals to mental health professionals.**

		current situation.	**protect patient and to reassure patient of staff concern.** **3. use a warm caring non-judgmental manner**	**3. provide patient with telephone numbers and other information about crisis centers, hotlines, and counselors.**
2. anxiety	**Patient is diagnosed with anxiety.**	**1. give patient clear concise explanations of anything that's about to occur.** **2. listen attentively** **3. attend to patients' comfort and needs to increase trust and reduce anxiety.**	**1. spend 10 minutes with patient twice per shift. Convery a willingness to listen.** **2.incldue patient in decisions related to care, when feasible.** **3. accept patient as is.**	**1. help patient develop own techniques for dealing with fears.** **2. give patient facts about fear and anxiety and their consequences.** **3. refer patient to community or professional mental health resources to provide ongoing mental health assessment.**
3. Ineffective coping	**Patient is having a hard time with life stressors.**	**1. explain all treatments and procedures and answer patients' questions.** **2. encourage the patient to make decisions about care** **3. identify and reduce all**	**1. as patient becomes able to express feelings more openly, discuss the relation between feelings and behavior.** **2. arrange to spend uninterrupted time with patient.**	**1. if possible, assign a consistent care provider to patient.** **2. refer patient to professional psychological counseling.** **3. encourage patient to use support**

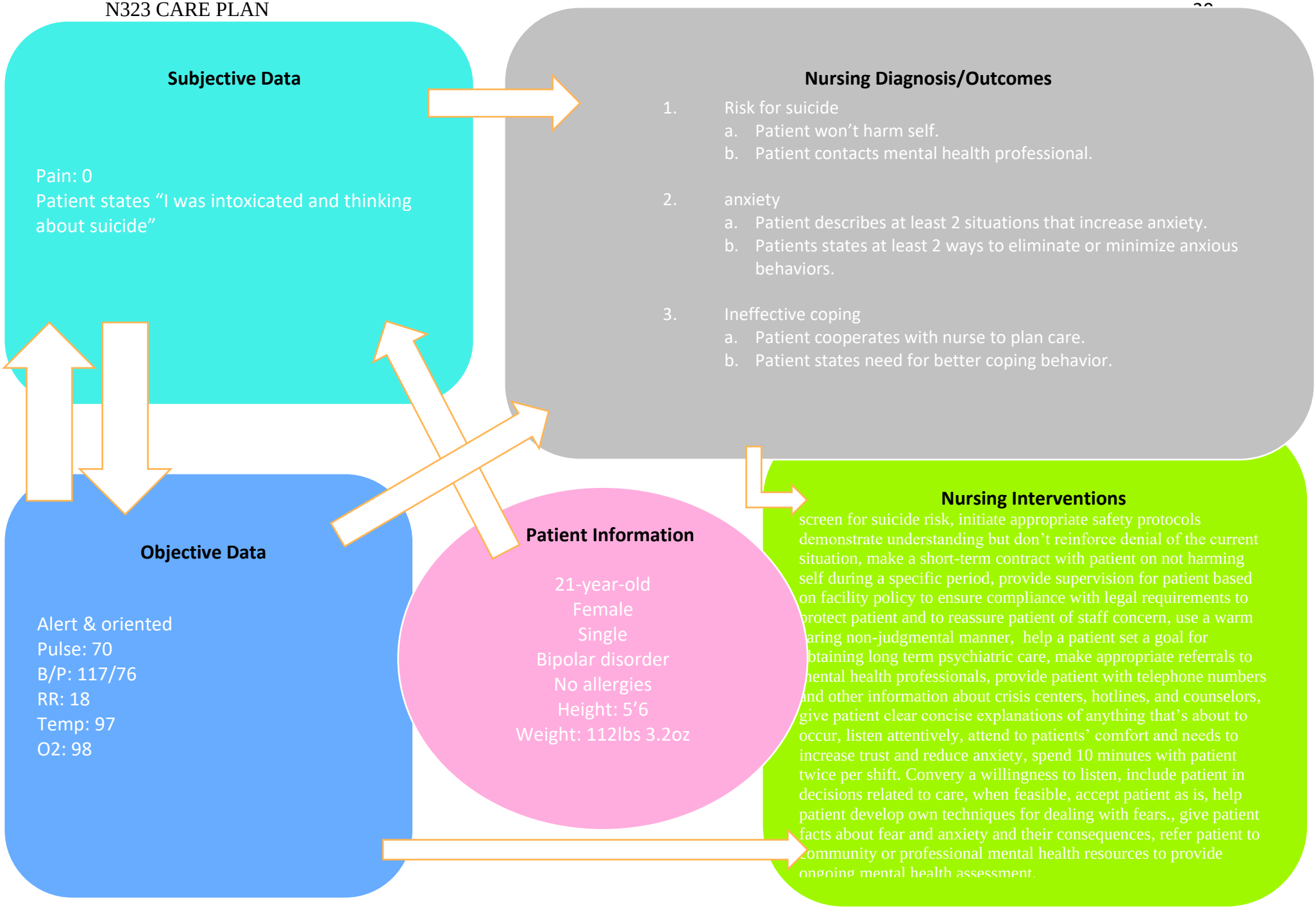
		unnecessary stimuli in the environment.	**3. praise patient for making decisions and performing activities.**	**systems to assist with coping.**

Other References (APA):

Phelps, L.L. (2020*). Sparks and Taylor's Nursing Diagnosis Reference Manual* (11th ed.). Wolters Kluwer

Suicide Prevention Resource Center. (2018). *Continuity of care for suicide prevention: The role of emergency departments*. Waltham, MA: Education Development Center, Inc.

Concept Map (20 Points):


Subjective Data
Pain: 0
Patient states "I was intoxicated and thinking about suicide"
Nursing Diagnosis/Outcomes
1. Risk for suicide
a. Patient won't harm self.
b. Patient contacts mental health professional.
2. anxiety
a. Patient describes at least 2 situations that increase anxiety.
b. Patients states at least 2 ways to eliminate or minimize anxious behaviors.
3. Ineffective coping
a. Patient cooperates with nurse to plan care.
b. Patient states need for better coping behavior.
Objective Data
Alert & oriented
Pulse: 70
B/P: 117/76
RR: 18
Temp: 97
O2: 98
Patient Information
21-year-old
Female
Single
Bipolar disorder
No allergies
Height: 5'6
Weight: 112lbs 3.2oz
Nursing Interventions
screen for suicide risk, initiate appropriate safety protocols demonstrate understanding but don't reinforce denial of the current situation, make a short-term contract with patient on not harming self during a specific period, provide supervision for patient based on facility policy to ensure compliance with legal requirements to protect patient and to reassure patient of staff concern, use a warm caring non-judgmental manner, help a patient set a goal for obtaining long term psychiatric care, make appropriate referrals to mental health professionals, provide patient with telephone numbers and other information about crisis centers, hotlines, and counselors, give patient clear concise explanations of anything that's about to occur, listen attentively, attend to patients' comfort and needs to increase trust and reduce anxiety, spend 10 minutes with patient twice per shift. Convery a willingness to listen, include patient in decisions related to care, when feasible, accept patient as is, help patient develop own techniques for dealing with fears., give patient facts about fear and anxiety and their consequences, refer patient to community or professional mental health resources to provide ongoing mental health assessment.