N323 Care Plan

Lakeview College of Nursing

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02/22/2022

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
02/17/2022	B. T.	19	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Jimmy Johns General Labor	Single	Oranges/Feathers
Code Status	**Observation Status**	**Height**	**Weight**
DNR- organ donor- not on file, but this is what the patient wants.	Oriented to person, place, time, and situation. Oriented x4	5'8"	260 lb.

Medical History (5 Points)

Past Medical History: Recent miscarriage, Ankle Sprain, sleep apnea, Anxiety, Depression.

No history of previous surgeries.

Significant Psychiatric History: Bipolar type 2 with GAD, Panic disorder without Agoraphobia, history of self-mutilating behavior, suicidal ideations on several occasions

Family History:

Mother- Bipolar, Heart disease (family history), Hysterectomy

Father- heart disease (family history), Hypertension, Diabetes

Social History (tobacco/alcohol/drugs): Social/passive smoker, 7 cigarettes a week, has not used since 02/17/2022. Uses smokeless tobacco on occasion. smokes marijuana recreationally, but not often. Has not used since 02/17/2022. Rarely consumes alcohol. Denies other drug or substance abuse.

Living Situation: Lives with Mother ("40 something") and sister (age 14)

Strengths: Self Awareness. Patient stated, "I know I will be successful if I have therapy services after this visit". Patient mentioned they feel better after being on medication and believes the therapy is essential to their success, however, has not set that up yet.

Support System: Patient lives with Mother and Sister. An ex-boyfriend may also be periodic support. Patient is looking to set up outside therapy/counseling before going home.

Admission Assessment

Chief Complaint (2 points): Depression, Suicidal ideation/self-harm ideation, Patient stated, "need for medication." Specific details of self-mutilation/suicide not disclosed.

Contributing Factors (10 points): Patient admitted on 02/17/2022 @ Pavilion, Champaign, Illinois. Patient presents with self-harm/suicidal ideations accompanied with symptoms of depression and anxiety. Patient suffered a miscarriage within past couple of weeks and an argument with her mother, in which she resides with. In addition, a breakup in relationship more recently. Upon admission, patient rates her depression at 8-9 on a scale of 1-10. Today (02/21/22), patient rates depression at 4/10 and anxiety 6/10. Patient states that "medication makes it better and no medication makes it worse." Patient was not current on medication at admission and mentioned that she, "hears a voice that is identified as "She" that gives her bad advice." Since admission, patient states that "medication makes the depression and anxiety better, and can no longer hear, "She". Therapy services and medication maintenance are the current plan for treatment during the inpatient stay.

Factors that lead to admission: Patient suffered from a recent miscarriage and break-up with boyfriend more recently. Patient has struggled to maintain school at the Tricocci cosmetology school in Urbana, Il. and has also had trouble maintaining steady employment.

History of suicide attempts: Yes, Patient stated, "Too many to count over the past couple years" did not elaborate on what/how they would carry out the plans. Patient suffered from a recent miscarriage and break-up with boyfriend more recently. Patient has struggled to maintain school at the Tricocci cosmetology school in Urbana, Il and dropped out of the program due to her depression. Patient has also mentioned they had trouble maintaining steady employment. Left last position "Due to the environment."

Primary Diagnosis on Admission (2 points): Bipolar type 2 with GAD, Panic Disorder without Agoraphobia, suicidal ideation/self-harm

Psychosocial Assessment (30 points)

History of Trauma				
lifetime experience: Emotional Abuse from Father, Loss of 2 aunts, Bullying while in school grades k-9. **Witness of trauma/abuse: Described Pandemic/Covid as a traumatic experience.**				
	Current	**Past (what age)**	**Secondary Trauma**	**Describe**

			(response that comes from caring for another person with trauma)	
Physical Abuse	**No**	**n/a**	**n/a**	**n/a**
Sexual Abuse	**No**	**n/a**	**n/a**	**n/a**
Emotional Abuse	**NO- Past**	**11-12 home- father. And K-9th grade (At school)**	**n/a**	**Emotional abuse from father aged 11-12(demeaning speech) "Grade school bullying and being picked on from K-9th grade" (Antagonized and laughed at by other kids)**
Neglect	**no**	**No**	**n/a**	**n/a**
Exploitation	**No**	**No**	**n/a**	**n/a**
Crime	**No**	**No**	**n/a**	**n/a**
Military	**no**	**no**	**n/a**	**n/a**
Natural Disaster	**no**	**no**	**no**	**no**
Loss	**Yes- within last 2 years. Loss of 2**	**17-18 years old**	**no**	**Loss of 2 aunts, patient described one as**

	aunts past couple years			**sick for a while and the other was more sudden.**
Other	**Pandemic/ Covid Ongoing since 2020.**	**17-19 years old**	**No**	**“Stressful and changed way of life for everyone around”**

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	**“Started in 7th grade”, A bad day 8-9 on scale of 0/10.**
Loss of energy or interest in activities/school	**Yes**	**No**	**“Recently had trouble holding a job for long term left due to the environment”. “I recently obtained a position at Jimmy Johns”- general labor position. Patient mentioned she dropped out of cosmetology school.**

Deterioration in hygiene and/or grooming	**Yes**	**No**	**"Found little interest in doing hair daily, I really enjoy doing my hair" "They give me a crappy comb here and I can't do nothing with that! No miracles able to be worked with that comb!"**
Social withdrawal or isolation	**Yes**	**No**	**"Have little friends and social life other than mother and sister".**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**"Recently broke-up with Narcissist boyfriend."**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/ night	**Yes**	**No**	**"Either sleep a lot 8 hours or more, or 5 hours or less." Patient says sleeping habits have gotten better with medication.**
Difficulty falling asleep	**Yes**	**No**	**"When anxiety is increased, I find it hard to be calm, I am fidgety." "Several times a week." Patient mentioned this subsided with medication.**
Frequently awakening during night	**Yes**	**No**	**"Some nights I am up and down." "Few times a week". Patient mentioned this has improved since**

			taking medication.
Early morning awakenings	**Yes**	**No**	**"If I wake up during the night, sometimes I cannot fall back asleep." "Few times a week". This has subsided since taking medication.**
Nightmares/ dreams	**Yes**	**No**	**"I have really bad nightmares and cannot go back to sleep." Few times a week. This has subsided since taking medication.**
Other	**Yes**	**No**	**n/a**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Prior to admission, patient described skipping meals and overeating/binging. "Meals are better, I am eating more now and finishing, I did not finish yesterday for breakfast."**
Binge eating and/or purging	**Yes**	**No**	**Patient mentioned that she had history of "binge eating at times." Patient mentioned has not been binge eating since admission.**
Unexplained weight loss? No, but dieting	**Yes**	**No**	**"Diet Tea diet" "I have lost about 30# in last 2 months".**

Amount of weight change: 30#			
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**	**"Fidgeting, rapid hand movements, bouncing legs, jittery, biting nails" "When I am really stressed, I hear a voice that I call "she", with medication I do not hear "she" anymore." Anxiety today rated a 6/10.**
Panic attacks	**Yes**	**No**	**"Had a panic attack yesterday." Patient did not describe the event of the panic attack.**
Obsessive/ compulsive thoughts	**Yes**	**No**	**n/a**
Obsessive/ compulsive behaviors	**Yes**	**No**	**n/a**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**Patient discussed college and employment being a challenge due to the anxiety. "I would like to get my medication figured out. I love doing hair and helping people. I hope to get back to it someday."**
Rating Scale			

How would you rate your depression on a scale of 1-10?	**4**
How would you rate your anxiety on a scale of 1-10?	**6**

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**	**Short time at positions, due to anxiety/depression. Newly obtained a position at Jimmy Johns for general labor.**
School	**Yes**	**No**	**"Left school due to depression/anxiety interfered with performance in previous semester."**
Family	**Yes**	**No**	**"Argue with my mom a lot, I think I am ready to move into my own place."**
Legal	**Yes**	**No**	**n/a**
Social	**Yes**	**No**	**"I have a very small group of friends."**
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**
Counseling/ Therapy- While in school middle-high school	**Inpatient Outpatient Other:**	**Outpatient**	**Anxiety/ depression**	**No improvement Some improvement Significant improvement**
Pavilion Couple years ago	**Inpatient Outpatient Other:**	**inpatient**	**Anxiety/ depression.**	**No improvement** - **No aftercare treatment planned at discharge** **Some improvement Significant improvement**
Pavilion Current stay starting 02/17/22	**Inpatient Outpatient Other:**	**inpatient**	**Current- Bipolar type 2 anxiety/depression, suicidal ideations, self-mutilation ideation.**	**No improvement Some improvement Significant improvement Medication has helped. "Need to look at therapy for when I leave."**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Mother C.T.	**40 something**	**Mother**	**Yes- "Smokes marijuana on**	**No**

			occasion".	
Sister L.B.	**14**	**sister**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: Use Marijuana on occasion- Mother.				
Children (age and gender):no children **Who are children with now? n/a**				
Household dysfunction, including separation/divorce/death/incarceration: Parents do not live together. **Lives with Mother and sister. Patient would see father every other weekend and over the summer for a few weeks growing up.**				
Current relationship problems: single **Number of marriages: never married**				
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: "I believe in God. I am Christian"				
Ethnic/cultural factors/traditions/current activity: Patient denied specific cultural, ethical, traditions, or current activities. **Describe: Patient denied specific cultural, ethical, traditions, or current activities.**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Denies any current or past legal issues.				
How can your family/support system participate in your treatment and care?				

“I have my mother and sister at home” I have my ex-boyfriend that is helpful on occasion” “I hope to get therapy sessions set-up before I get discharged. I’ll figure it out either way.” “If my family is just present, that will help!”
Client raised by: **Natural parents Mother and Father (Every other weekend and summer)** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient denies childhood issues impacting current illness.
Atmosphere of childhood home: Patient mentioned that living at home was loving. Patient would see father every other weekend and a few weeks during the summer. Patient described loving to drop her little sister off at school. Patient described “A great bond with my little sister” **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: Patient can care for self on own without assistance. **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) **Mother- Bipolar** **Patient- Bipolar Type 2 with GAD, Panic order without agoraphobia.**
History of Substance Use:

Marijuana on occasion. Denies use of any other substances
Education History: **Grade school** **High school- graduated** **College- some college Tricocci Cosmetology school.** **Other:**
Reading Skills: Loves to read. Nancy Drew, mystery novels. "I find reading relaxing." **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient denies problems in school
Discharge
Client goals for treatment: "Set up own therapist, continue with medications, and go for a nice walk."
Where will client go when discharged? "Home with Mother and Sister."

Outpatient Resources (15 points)

Resource	Rationale
1. Hotline	**1. Safety is the number one priority. With a history of suicidal ideation/self-mutilation giving the patient a tool to use when the thoughts of suicide come, and the patient may be alone or without support.**
2. Personal Therapist	**2. The patient has a desire to have a**

	committed therapist for treatment once they are discharged. Having a dedicated therapist would be beneficial for the patient for adjustment medications and detecting improvements or decline in their status with recurring visits with the same provider.
3. Group Therapy	**3. Group therapy could be beneficial for another type of support. Going to group meetings can provide additional information, learning opportunities, and interaction with other clients.**

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

Brand/ Generic	**Ibuprofen/ Advil**	**Melatonin/ Pineal Hormone**	**Xulane/ norelgestromin-ethinyl estradiol**	**Ativan/ lorazepam**	**Acetemeta phen/ Tylenol**

		Melatonin	**transdermal system**		
Dose	**200 mg**	**3mg**	**35 mcg**	**1mg**	**650 mg**
Frequency	**prn**	**bedtime**	**1 a week**	**PRN- Given once**	**Q6H PRN**
Route	**PO**	**PO**	**Topical Patch**	**PO**	**PO**
Classification	**NSAIDs/ NSAID (Nursing 2020 Drug Handbook, 2020)**	**Neurology/ Herbal**	**Contraceptive/ Estrogen-Progestin combinations (Nursing 2020 Drug Handbook, 2020)**	**Anxiolytics, benzodiazepines, controlled substance IV. (Nursing 2020 Drug Handbook, 2020)**	**Analgesic, Para-aminophenol derivatives (Nursing 2020 Drug Handbook, 2020)**
Mechanism of Action	**Inhibit prostaglandin synthesis, to produce anti-inflammatory, analgesic, and antipyretic.**	**Regulate circadian sleep cycle. (Cunha, 2021)**	**Ovulation inhibition (Nursing 2020 Drug Handbook, 2020)**	**CNS depressant. (Nursing 2020 Drug Handbook, 2020)**	**Inhibit prostaglandin at pain receptors. (Nursing 2020 Drug Handbook, 2020)**
Therapeutic Uses	**Use for mild or moderate pain relief, anti-inflammatory. (Nursing 2020 Drug Handbook, 2020)**	**To encourage rest/ sleep**	**Pregnancy prevention/ contraceptive (Nursing 2020 Drug Handbook, 2020)**	**Calming anxiety/Panic attack. It is an anxiolytic. (Nursing 2020 Drug Handbook, 2020)**	**Pain relief (Nursing 2020 Drug Handbook, 2020)**
Therapeutic Range (if applicable)	**Peak 1-2 hr, 4-6 hr duration. (Nursing**	**Not available**	**Rapid onset, peak 2 days, duration unknown.**	**Onset: 1 hr Peak: 2 hr Duration: 12-24 hr**	**Onset: less than 1 hour**

	2020 Drug Handbook, 2020)		**(Nursing 2020 Drug Handbook, 2020)**	**(Nursing 2020 Drug Handbook, 2020)**	**Peak 30-60 min** **Duration: 4-6 hr.** **(Nursing 2020 Drug Handbook, 2020)**
Reason Client Taking	**Headache**	**For restlessness- to encourage sleep.**	**To prevent pregnancy**	**Anxiety CNS depressant (Nursing 2020 Drug Handbook, 2020)**	**Pain relief**
Contraindications (2)	**Increases Risk of heart attack. (Nursing 2020 Drug Handbook, 2020)** **May increase risk for GI bleeding. (Nursing 2020 Drug Handbook, 2020)**	**Allergy to melatonin do not take.** **Drug is an immunosuppressant. (Cunha, 2021)**	**Increase risk for thromboembolism (Nursing 2020 Drug Handbook, 2020)** **Cigarette smoking increases the risk heart attack- patient reports smoking on occasion. (Nursing 2020 Drug Handbook, 2020)**	**Use with caution with Serotonergic and dopaminergic drugs. (Nursing 2020 Drug Handbook, 2020)** **May cause serotonin syndrome. (Nursing 2020 Drug Handbook, 2020)**	**Can cause liver failure if exceed 4000 mg a day. (Nursing 2020 Drug Handbook, 2020)** **Can cause Stevens-Johnson syndrome (Nursing 2020 Drug Handbook, 2020)**
Side Effects/ Adverse Reactions (2)	**CNS nervousness, dizziness (Nursing 2020 Drug Handbook, 2020)**	**Decreased alertness and drowsiness (Nursing 2020 Drug Handbook, 2020)**	**Dysmenorrhea and vulvovaginal candidiasis. (Nursing 2020 Drug Handbook, 2020)**	**Drowsiness, sedation (Nursing 2020 Drug Handbook, 2020)**	**Agitation, insomnia (Nursing 2020 Drug Handbook, 2020)**
Medication/ Food	**Other NSAIDs,**	**Sage and sodium**	**Oxcarbazepine, acetaminophen**	**Opioids, Alcohol use**	**Alcohol, carbamaze**

Interactions	**Aspirin, garlic**	**oxidate.**			**pine**
Nursing Considerations (2)	**Monitor B/P can lead to new hypertension. (Nursing 2020 Drug Handbook, 2020)** **Instruct Patient to not take with other NSAIDs- Patient education. (Nursing 2020 Drug Handbook, 2020)** **Give with milk or food. (Nursing 2020 Drug Handbook, 2020)**	**Not for use in patients under the age of 20.** **Caution in patients with depression.** **(Cunha, 2021)**	**Drug may be ineffective in women over 90kg. (Nursing 2020 Drug Handbook, 2020)** **Educate patient on drug-drug and drug- herb interactions that could decrease effectiveness of drug. (Nursing 2020 Drug Handbook, 2020)**	**CNS depressant- Nurse should monitor vital signs and alertness with drug. (Nursing 2020 Drug Handbook, 2020)** **Educate patient of addictiveness of Opioids. (Nursing 2020 Drug Handbook, 2020)**	**Many OTC contain acetaminophen, educate patient to watch this drug in other medications. (Nursing 2020 Drug Handbook, 2020)** **Educate patient to discontinue or alert nurse if rash occurs. (Nursing 2020 Drug Handbook, 2020)**

Brand/ Generic	**Trileptal, oxcarbazepine**	**Trazodone/ trazodone hydrochloride**	**Zyprexa/olanzapine**		
Dose	**300 mg**	**100 mg**	**5mg**		
Frequency	**2 a day PRN**	**QHS**	**Once time**		
Route	**PO**	**PO**	**PO**		

Classification	**Anticonvulsant/ Carboxamide derivative (Nursing 2020 Drug Handbook, 2020)**	**Antidepressant/ Triazolopyridine**	**Antipsychotic/ Dibenzapine derivatives. (Nursing 2020 Drug Handbook, 2020)**		
Mechanism of Action	**Prevent seizure by blocking Sodium-potassium channels and modifying calcium channels. (Nursing 2020 Drug Handbook, 2020)**	**Inhibits CNS neuronal Uptake of serotonin. (Nursing 2020 Drug Handbook, 2020)**	**Block dopamine receptors (Nursing 2020 Drug Handbook, 2020)**		
Therapeutic Uses	**Mood stabilizer for people who do not respond to lithium treatment. (Smith, 2018)**	**Antidepressant (Nursing 2020 Drug Handbook, 2020)**	**Use for manic episodes associated with bipolar disorder. (Nursing 2020 Drug Handbook, 2020)**		
Therapeutic Range (if applicable)	**Variable peak, unknown duration. (Nursing 2020 Drug Handbook, 2020)**	**Peak 1-2 hours Onset and duration unknown.**	**Onset: Unknown Peak: 6 hr Duration: unknown**		
Reason Client Taking	**Bipolar type 2 with GAD. (Smith, 2018)**	**Bipolar type 2 with GAD.**	**Panic Attack- Bipolar type 2 with GAD**		
Contraindications (2)	**Can cause stevens-Johnson syndrome. Dermatologic reactions can occur. (Nursing 2020 Drug Handbook, 2020)**	**Use caution with patients with suicide ideation, Contraindicated for patients sensitive to trazodone. (Nursing 2020 Drug Handbook, 2020)**	**Sedation, Avoid use with Opioid CNS depressant (Nursing 2020 Drug Handbook, 2020)**		
Side Effects/Adverse Reactions (2)	**Agitation and abnormal gait. (Nursing 2020 Drug Handbook, 2020)**	**Drowsiness, orthostatic hypotension (Nursing 2020 Drug Handbook, 2020)**	**Suicide attempts/ somnolence (Nursing 2020 Drug Handbook, 2020)**		
Medication/ Food Interactions	**Hormonal contraceptives: Can decrease effectiveness. Should not be used with Alcohol- may cause**	**SSRI and SSRNI (Nursing 2020 Drug Handbook, 2020)**	**Alcohol and other Opioids due to CNS depression. (Nursing 2020 Drug Handbook, 2020)**		

	CNS depression. (Nursing 2020 Drug Handbook, 2020)				
Nursing Considerations (2)	**Immediate release can be given without food. (Nursing 2020 Drug Handbook, 2020) Educate patient to avoid driving until mental alertness of drug is known. (Nursing 2020 Drug Handbook, 2020)**	**Monitor for signs of orthostatic hypotension with drug use, Drug may increase suicidal action. Monitor patient with this medication. (Nursing 2020 Drug Handbook, 2020)**	**Monitor for metabolic syndrome symptoms Watch for signs of altered mental status. (Nursing 2020 Drug Handbook, 2020)**		

Medications Reference (1) (APA):

Cunha, J. (2021). *Melatonin.* Rxlist. https://www.rxlist.com/consumer_melatonin/drugs-condition.htm

***Nursing 2020 Drug Handbook* (2020). Philadelphia, PA: Wolters Kluwer**

Smith, K. (2018). *Trileptal (oxcarbazepine) for bipolar disorders.* Psycom: Remedy Health Media. https://www.psycom.net/bipolar-medications-trileptal

Mental Status Exam Findings (20 points)

APPEARANCE: Appropriate dress Behavior: Engaged and Calm Build:	**Patient hair was disheveled but pulled back. Patient did mention that she could not comb hair, needed a pick.**

Attitude: Positive **Speech: consistent, not rushed for flighted** **Interpersonal style:** **Mood: Calm/Happy** **Affect: Broad affect**	**Patient was calm, engaged and welcomed conversation. Patient spoke clearly and unpressured speech. Patient was able to accept humor and incorporate appropriate conversation. Presented Calm/ Happy with a broad affect (appropriate to situation)**
MAIN THOUGHT CONTENT: **Ideations:none** **Delusions:none** **Illusions:none** **Obsessions:none** **Compulsions:none** **Phobias:none**	**On day of interview (02/21/22), no suicidal ideations present, no report of delusion, Illusion, Obsessions, compulsions, or phobias. Patient was able to engage in conversation clearly and concisely.**
ORIENTATION: Oriented x4 **Sensorium: Able to concentrate** **Thought Content: Able to communicate effectively, respond to questions/answers appropriately.**	**Patient can concentrate and engage in conversation. Appropriately answered questions. Oriented to person, place, situation, and time. Rational thought process. No hallucinations**
MEMORY: **Remote:WDL**	**Memory: Patient can concentrate and recall information. Appropriate to situation.**
REASONING: **Judgment: WDL** **Calculations:WDL** **Intelligence: appropriate to high school graduate** **Abstraction:WDL** **Impulse Control: under control**	**Patient able to concentrate and utilize abstract thinking abilities.** **Intelligence appropriate to high school graduate. Patient can rationalize situation. Does not place blame on others. Owns all aspects of situation.** **No outbursts or sudden activity that would otherwise present an impulse control issue. Patient actively engaged in conversation.**
INSIGHT: Good insight of situation	**Patient has a clear understanding of situation. Patient was to become levelized on medication, seeking a long-term therapist, and become independent of living with mother. Patient understands the diagnosis of Bipolar 2 disorder with GAD.**

GAIT: Strong and steady gait. **Assistive Devices: none required** **Posture: Strong posture** **Muscle Tone: Even Muscle tone** **Strength: strong** **Motor Movements: good control/ non-impaired**	**Strong and steady gate. Patient did not require the use of assistive devices. Patient leaned in during conversation, was engaged. Muscle tone and strength was strong, patient had good control of motor movements, non-impaired.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
02/17/22 **0240**	**98**	**110/79**	**18**	**98.8 oral**	**95%**
02/17/22 **0644**	**98**	**129/78**	**21**	**Not taken**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
03:40 02/21/22	**0-10**	**0**	**0**	**0**	**0**
0240 02/17/22	**0-10**	**0**	**0**	**0**	**0**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: finished** **Lunch: Finished** **Dinner: Not yet served**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: Not present when patient had** **breakfast, patient mentioned they** **consumed 100% of breakfast meal and**

	drink today 02/21/22. **Lunch: not present when patient had lunch, patient said ate/drank 100% of meal and drink.** **Dinner: Not yet served**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Patient will discharge to home. Patient will be living with Mother and sister. No equipment is required. No home health needs are required. Prior to discharge, patient will have an assigned therapist and appointment times set. Information about suicide prevention hotline will be provided and patient education about suicide prevention addressed as well as patients' family. Educating patient about medication and to not abruptly stop taking medication is important. Group therapy sessions will be discussed and decided prior to discharge. The Pavilion will plan follow-up calls for further patient support and be discussed with patient.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with	**Rational** • Explain why the	**Immediate Interventions (At**	**Intermediate Interventions (During**	**Community Interventions (Prior to**

“related to” and “as evidenced by” components	nursing diagnosis was chosen	**admission)**	**hospitalization)**	**discharge)**
1. At risk for self-harm/mutilation as evidenced by recent admission for treatment and past attempts to harm self. Related to Bipolar type 2 disorder with GAD. (Carpenito, 2017)	**Safety is a top priority for the patient.**	**1. Identify Psychological status 2. Identify if patient has a plan 3. remove items that patient can use to harm self, monitor for safety.**	**1.Identify coping skills 2. Encourage journaling for thoughts, triggers, and record 3. Provide a quite environment and encourage group therapy sessions once patient is ready.**	**1. Educate family how to recognize self-harm, provide intervention techniques. 2. Individual Therapist assigned 3. Educate patient about hotline number.**
2. At risk for Disturbed sleep pattern Related to excessive hyperactivity secondary to Bipolar type 2 disorder with GAD, as evidenced by patterns of insomnia and excess sleeping. (Carpenito, 2017)	**Sleep is important to regulate hormones and overall mental state/well-being. Client does have sleep apnea and a CPAP machine.**	**1. Offer warm shower to calm 2. Provide a low stimuli environment for patient. 3.Educate about avoiding caffeine to prevent insomnia**	**1. Increase daytime activity. 2.Establish sleep schedule 3. Encourage the use of CPAP machine to promote effective sleep cycle.**	**1. Discuss/establish relaxation techniques for patient prior to nighttime ritual. 2. Preplan a routine for home nighttime ritual. 3. Educate patient on establishing/setting sleep goals. Set goals prior to discharge.**
3. At risk for complications of antianxiety therapy adverse affects related to the treatment of Bipolar 2	**Medication management is important to prevent adverse effects from occurring.**	**1. Take medication history 2. Interview health history, if able**	**1. Educate patient on importance of timing and frequency of medication 2. Educate**	**1. Encourage the patient to be actively involved in monitoring medication administration prior to discharge, they**

disorder with GAD, as evidenced by recent visit to the pavilion and suicidal ideation. (Carpenito, 2017)		**3. Medication, herbal, and recreational reconciliation. Time and frequency of all drugs taken.**	**patient of adverse effects of medication.** **3. Educate patients family of adverse effects of medication.**	**are actively involved in medication administration.** **2. Patient teach back, understands adverse reactions to medication and will report when suspected.** **3. Patient and family will be educated and understand signs of medication overdose, not using alcohol with medication, and use caution when driving.**

Other References (APA):

Carpenito, L. J., (2017). ***Nursing Diagnosis: Application to Clinical Practice Fifteen Edition.***

Philadelphia, PA: Wolters Kluwer

Concept Map (20 Points):

Subjective Data

Patient chief complaint: Depression- self harm
8-9/10 on depression on 0/10 scale.
On, 02/21/22 anxiety rated at 6/10 and depression 4/10.

"Medication makes it better; no medication makes it worse"

Nursing Diagnosis/Outcomes

At risk for self-harm/mutilation as evidenced by recent admission for treatment and past attempts to harm self. Related to Bipolar type 2 disorder with GAD. Patient will use hotline if suicidal thoughts or self-harm present. Patient will refrain from self-harm or suicide attempts.
At risk for Disturbed sleep pattern Related to excessive hyperactivity secondary to Bipolar type 2 disorder with GAD, as evidenced by patterns of insomnia and excess sleeping. Patient will establish and continue balanced sleep routine. Maintain a sleep schedule prior to discharge and sleep through the night.
At risk for complications of antianxiety therapy adverse effects related to the treatment of Bipolar 2 disorder with GAD, as evidenced by recent visit to the pavilion and suicidal ideation. Patient and family will understand important of medication time, dose, and side effects. Patient will not discontinue medication suddenly, unless otherwise directed by provider.

Patient Information

19 Year old female, with a history of bipolar type 2 with GAD and Panic disorder without agoraphobia was admitted for depression: Self harm and the need for medication. Patient needs levelized on medication, therapy services set. Patient suffered a recent miscarriage and an argument with mother that brought on the current emotions.

Objective Data

Vitals
b/P110/79, T 98.8, O2 95% RA, R18 P 98
No pain 0/10.
8-9/10 on depression on 0/10 scale.
On, 02/21/22 anxiety rated at 6/10 and depression 4/10.

Nursing Interventions

1. Educate family how to recognize self-harm, provide intervention techniques. Educate the patient about the hotline number.
2. Preplan a routine for home nighttime ritual. Educate patient on establishing/setting sleep goals. Set goals prior to discharge.
3. Encourage the patient to be actively involved in monitoring medication administration prior to discharge, they are actively involved in medication administration. Patient and family will be educated and understand signs of medication overdose, not using alcohol with medication, and use caution when driving.