

N323 Care Plan
Lakeview College of Nursing
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Demographics (3 points)

Date of Admission 3-23-2022	Patient Initials H.R	Age 21 years old	Gender Female
Race/Ethnicity Half Korean	Occupation Student	Marital Status Single	Allergies No known allergies
Code Status Full code	Observation Status Inpatient observation	Height 4'9"	Weight 90lbs

Medical History (5 Points)

Past Medical History: seasonal allergies, no known surgical history

Significant Psychiatric History: Depression(2016), Bipolar Disorder(2020), Borderline Personality Disorder(2022),

Family History:

Mother: no known medical problems

Father: back problems

Brother: no known medical problems

Maternal Grandmother: no known medical problems

Maternal Grandfather: no known medical problems

Paternal Grandfather: alcoholism, depression

Paternal Grandmother: no known medical problems

Social History (tobacco/alcohol/drugs):

Tobacco: no history of tobacco use

Alcohol: social use, once a week, a few glasses of wine for a year.

Drugs: patient states smoking marijuana every day, one blunt a day

Living Situation: patient was living on her own in a studio apartment but after admission to the hospital patient states she will be moving back home with her parents.

Strengths: patient states she has a good support system with good friend and family. Patient states “music helps me release my stress and worries.”

Support System: patient states “My mom is my best friend and helps me through everything, I also have made a lot of good friends a college who help me too.”

Admission Assessment

Chief Complaint (2 points): suicidal ideations

Contributing Factors (10 points): patient was taken to emergency department after reportedly emailing her ex-boyfriend and his father over 500 emails after a breakup. Patient stated, “I was at my apartment when my ex- boyfriend broke up with me over the phone and blocked my phone number, so I started to feel crazy and sent over 200 emails to my ex-boyfriend and over 500 emails to his father who is my professor.” Patient states “this happened a few days ago and I was turned in to U of I PD and they brought me to the hospital.” Patient states “After he broke up with me, I felt suicidal and I also felt crazy, my mind was racing all over the place, I had no plan of how I was going to kill myself I just kept sending emails.” The patient states once she arrived at the ER she felt better after they gave her some medication. Patient denied anything that made her feel better or worse while at her apartment. Patient stated, “the emails made me feel a little relieved, but my mind was still racing, and I still felt suicidal.” Patient also stated, “once I got to the hospital and talk to the social worker I did not feel suicidal any more I just felt sad.”

Factors that lead to admission: a breakup with her boyfriend

History of suicide attempts: no previous suicide attempts

Primary Diagnosis on Admission (2 points): Depression

Secondary diagnosis: Mania

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: none				
Witness of trauma/abuse: none				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	None	None	None	NA
Sexual Abuse	None	None	None	NA
Emotional Abuse	None	Yes 18-20	None	Patient stated being emotionally abused by father between the ages of 18-20 but states he has changed, and dose not abuse her anymore.
Neglect	None	None	None	NA

Exploitation	None	None	None	NA
Crime	None	None	None	NA
Military	None	None	None	NA
Natural Disaster	None	None	None	NA
Loss	None	None	None	NA
Other	None	None	None	NA
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	NA	
Loss of energy or interest in activities/school	Yes	No	NA	
Deterioration in hygiene and/or grooming	Yes	No	NA	
Social withdrawal or isolation	Yes	No	NA	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	Patient states when having states when having an “episode” she feels distracted and is unable to focus on school. Patient would not say what the episode was and states it only has happened twice within the last month. Patient states when this happens, she can’t do any schoolwork at all because she cannot focus. Patient stated it had never happened before the past few months and it only last a few	

			<p>days.</p> <p>Patient later stated the episodes are episodes of mania.</p>
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	<p>Patient states “I never get the same amount of sleep every night. It changes every day and has been for the past few weeks.” “I usually only get a few hours of a sleep”</p>
Difficulty falling asleep	Yes	No	<p>“I can never fall asleep”</p> <p>Patient would not answer any other questions about falling asleep.</p>
Frequently awakening during night	Yes	No	NA
Early morning awakenings	Yes	No	<p>Patient states when she wakes up in the middle of the night or early morning she cannot go back to bed ever. Stated she has had this forever and it happens all the time.</p>
Nightmares/dreams	Yes	No	<p>Patient stated having nightmares every night but would not answer any other questions about the nightmares.</p>
Other	Yes	No	NA
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	<p>Patient stated “I do not have an appetite and have not had one for a few months. I</p>

			have loss 13 pounds because of it.”
Binge eating and/or purging	Yes	No	NA
Unexplained weight loss? Amount of weight change:	Yes	No	Patient has lost weigh due to loss of appetite and not eating patient stated losing at least 13 pounds in the last month
Use of laxatives or excessive exercise	Yes	No	NA
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patient stated “I had anxiety when he broke up with me and it lasted until I got to the hospital. I just kept sending email.” Patient denies ever having this before.
Panic attacks	Yes	No	NA
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	Patient stated, “I could not do my homework I just kept sending emails. I was having a manic episode.” Stated it only happens when she has manic episodes.
Rating Scale			
How would you rate your depression on a scale of 1-10?	2		
How would you rate your anxiety on a scale of 1-10?	5		

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	NA	
School	Yes	No	NA	
Family	Yes	No	NA	
Legal	Yes	No	NA	
Social	Yes	No	NA	
Financial	Yes	No	Patient states when having episodes of mania she does a lot of online shopping and now has no money due to recent episodes.	
Other	Yes	No	NA	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
September 2021	Inpatient Outpatient Other:	Inpatient at the pavilion	Breakup with ex-boyfriend causing episode of mania	No improvement Some improvement Significant improvement

	Inpatient Outpatient Other:			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?	
Youjin	50	mom	Yes	No
Dad Pt would not say name	51	dad	Yes	No
			Yes	No
			Yes	No
			Yes	No

If yes to any substance use, explain: NA

Children (age and gender):NA

Who are children with now?

Household dysfunction, including separation/divorce/death/incarceration: None

Current relationship problems: Breakup with boyfriend

Number of marriages: 0

Sexual Orientation:	Is client sexually active? Yes No	Does client practice safe sex? Yes No NA
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Please describe your religious values, beliefs, spirituality and/or preference: Patient refused to answer this question.

<p>Ethnic/cultural factors/traditions/current activity: patient refused to answer this question stated, “music is my current activity and that’s all I am going to say.”</p> <p>Describe: NA</p>
<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): none</p>
<p>How can your family/support system participate in your treatment and care?</p> <p>“my mom is very involved and is trying to get me into a therapist when I get home.”</p>
<p>Client raised by:</p> <p>Natural parents Grandparents Adoptive parents Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness: patient stated, “I think my dad’s emotional abuse has caused some of this.”</p>
<p>Atmosphere of childhood home:</p> <p>Loving Comfortable Chaotic Abusive Supportive Other: patient states emotional abuse from father did not start until late teenage years and when she left for college.</p>
<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) None</p>
<p>History of Substance Use: marijuana use daily</p>
<p>Education History:</p>

<p>Grade school High school College Other: current junior on college</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: patient stated she is a good straight A student except when she has episodes of mania.</p>
<p>Discharge</p>
<p>Client goals for treatment: patient stated, “by the time I leave here I hope to not be sad anymore and not have mania anymore. I also want to be able to get over my ex and never go back to him again.”</p>
<p>Where will client go when discharged? Patient will be moving back home with her parents after discharge.</p>

Outpatient Resources (15 points)

Resource	Rationale
1. therapist	1. This gives the patient an opportunity to talk to someone and be able to express her feelings.
2. Suicide hotline	2. This gives the patient a phone number to call 24/7 whenever she starts to have suicidal feelings
3. Crosspoint’s	3. This will help the patient receive the correct psychotherapy needed to manage the mania and

	suicidal ideation.
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Current Medications (10 points)

Complete all of your client’s psychiatric medications

Patient currently only taking 3 prescribed medications and 3 PRN medications.

Brand/Generic	trazodone hydrochloride Oleptro	oxcarbazepine Trileptal	cetirizine hydrochloride Zyrtec	Calcium carbonate Titalac	Ondansetron Zofran
Dose	100mg	300 mg	10 mg	1,000 mg	4 mg
Frequency	Daily	BID	Daily	Every 8 hours PRN	Every 6 hours PRN
Route	PO	PO	PO	Chewable tablet	ODT
Classification	triazolopyridine derivative	Carboxamide derivative	Histamine-1 receptor antagonist	Calcium salt	Selective serotonin receptor antagonist
Mechanism of Action	“Trazodone exerts an alpha-adrenergic blocking action and produces modest histamine blockade, causing a sedative effect.” (Jones and Bartlett 2021)	“By preventing sodium from entering the cell, oxcarbazepine may slow nerve impulse transmission, thus decreasing the rate at which neurons fire.”	“The antihistaminic activity of cetirizine is mediated via selective inhibition of peripheral H 1-receptors to alleviate urticaria.” (Jones and Bartlett 2021)	“Neutralize or buffer stomach acid to relieve discomfort caused by hyperacidity.” (Jones and Bartlett 2021)	“Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at the vagal nerve terminals in the intestines.” (Jones and Bartlett 2021)
Therapeutic Uses	Antidepressant	anticonvulsant	antihistamine	Antacid	antiemetic
Therapeutic Range (if applicable)	Na	NA	NA	NA	NA
Reason Client	For depression	For bipolar disorder	For seasonal allergies	For indigestion	For nausea

Taking		symptoms			
Contraindications (2)	“Hypersensitivity to trazodone or its components, Recovery from acute MI” (Jones and Bartlett 2021)	“Hypersensitivity to oxcarbazepine, eslicarbazepine acetate, or its components.” (Jones and Bartlett 2021)	“Hypersensitivity to cetirizine, hydroxyzine, levocetirizine, or their components.” (Jones and Bartlett 2021)	Hypercalcemia, hypersensitivity to calcium salts or their components.” (Jones and Bartlett 2021)	“Concomitant use of apomorphine, hypersensitivity to ondansetron or its components.” (Jones and Bartlett 2021)
Side Effects/Adverse Reactions (2)	Serotonin syndrome, seizures	Seizures, Suicidal ideations	Fatigue Dizziness	Hypotension hypercalcemia	Hypotension, serotonin syndrome
Medication/Food Interactions	alcohol	alcohol	Alcohol	Calcium High fiber diet	None
Nursing Considerations (2)	“Give trazodone shortly after the patient has had a meal or light snack to reduce nausea.” “Give larger portion of daily dose at bedtime if drowsiness occurs.” (Jones and Bartlett 2021)	“Know that patient with allergic reaction to carbamazepine may have hypersensitivity to oxcarbazepine.” “Monitor serum sodium level for signs of hyponatremia, especially during first 3 months.” (Jones and Bartlett 2021)	“Institute safety precautions, because drug can cause sedation and somnolence.” “Know that Quzyttir is a single-use injectable product for intravenous administration only.” (Jones and Bartlett 2021)	“Store at room temperature and protect from heat, moisture, and direct light.” “Warm solution to room temperature before parenteral administration.” (Jones and Bartlett 2021)	“Place disintegrating tablet or oral soluble film on patient tongue immediately after opening package.” “Use calibrated container or oral syringe to measure dose of oral solution.” (Jones and Bartlett 2021)

Brand/Generic	acetaminophen Tylenol				
Dose	650 mg				
Frequency	PRN every 4				

	hours				
Route	PO				
Classification	Nonsalicylate, Paracetamol derivative				
Mechanism of Action	“Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulses generation in the peripheral nervous system.” (Jones and Bartlett 2021)				
Therapeutic Uses	Antipyretic, nonopioid analgesic				
Therapeutic Range (if applicable)	NA				
Reason Client Taking	For pain				
Contraindications (2)	Severe hepatic impairment Severe active liver disease				
Side Effects/Adverse Reactions (2)	Hypotension, hepatotoxicity				
Medication/Food Interactions	alcohol				
Nursing Considerations (2)	“Use acetaminophen cautiously in patients with hepatic disease.” “monitor renal function in patient on long term therapy.” (Jones and Bartlett 2021)				

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). *2021 Nurse's Drug Handbook* (20th ed.).

Mental Status Exam Findings (20 points)

<p>APPEARANCE: well groomed Behavior: anxious, manic Build: small thin and underweight Attitude: positive Speech: clear Interpersonal style: outgoing Mood: good Affect: appropriate</p>	<p>patient appears well groomed and acting appropriate with occasional manic episodes. Patient makes good eye contact when spoken to some of the time. Patient is of average build. Patient is underweight for her height and age. patient has a good attitude; speech is appropriate for age. Patient is outgoing and enjoys talking. Patient was cooperative and pleasant throughout our conversation. Patient states she is in a good mood.</p>
<p>MAIN THOUGHT CONTENT: Ideations: upon admission Delusions: none Illusions: none Obsessions: none Compulsions: none Phobias: none</p>	<p>patient states upon admission she had suicidal ideations but denies any currently. patient denies delusions, illusions, obsessions, compulsions and phobias.</p>
<p>ORIENTATION: Sensorium: alert Thought Content: racing thoughts</p>	<p>patient is alert and oriented to person place time end event. Senses are intact patient is coherent with logical racing thoughts.</p>
<p>MEMORY: Remote: good</p>	<p>Short- and long-term memory are good.</p>
<p>REASONING: Judgment: fair</p>	<p>patients' judgment is fair. Patient can calculate simple math problems. Patient is of average</p>

Calculations: average Intelligence: average Abstraction: appropriate Impulse Control: fair	intelligence level for her age. Patient can use words in correct manner and patient impulse control is fair
INSIGHT:	patient wants to move back home with parents and get a job at the local pet store.
GAIT: Assistive Devices: none Posture: erect Muscle Tone: low Strength: equal bilaterally Motor Movements: intact	Patient does not use assistive devices. Posture is erect, low muscle tone. Strength is equal bilaterally. Motor movements are intact.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1330	56	99/66	16	96.8 °F	95% ra
1700	60	99/65	16	97.6 °F	99% ra

***Staff states low blood pressure is normal for patient. ***

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1330	1-10	None	None	None	None
1700	1-10	None	None	None	None

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: Breakfast: was unable to assess	Oral Fluid Intake with Meals (in mL) Breakfast: unable to assess

Lunch: 70%	Lunch: 240 mL
Dinner: 100%	Dinner: 480 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

- Patient will be discharged to parents and will move back home with them.
- Patient will demonstrate compliance with any medication or treatment plan within the next two weeks.
- Patients’ parents will be involved in patient safety and follow up plan after discharge.
- Patient will follow up with primary care provider, psychiatrist, and therapist.
- Patient will receive education on suicidal thoughts and ways to seek help when feeling these thoughts.
- Symptom monitoring i.e. identify triggers of beginning stages of manic episode
- Develop suicide prevention plan
- Stay away from ex-boyfriend and his family.

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. Patient at increased risk for suicide related to depression as evidence by suicidal ideation.	Patient is at an increased risk for suicide due to suicidal ideation after a breakup with her boyfriend.	1. Initiate appropriate safety protocols by removing from patient environment anything that could be used to cause self-harm. 2. Provide supervision one on one based on facility policy. 3. Ask patient if	1. Put patient on either suicide precaution, (one on one monitoring), or suicide observation, (every 15 minutes,) to observe behaviors and mood. 2. Listen carefully to patient and don't challenge patient. 3. Supervise the administration of	1. Arrange for client to stay with family or friends upon discharge 2. Provide patient with telephone numbers and other information about crisis centers, hotlines, and counselors. 3. Help patient set

		they have a plan of how they would commit suicide.	medications to ensure patient does not hoard medications.	a long-term psychiatric care goal.
2. patient is at increased risk of ineffective coping related to impulse use of extreme solutions as evidenced by extreme overuse of email after a breakup	patient is at increased risk of ineffective coping after sending over 500 emails to ex-boyfriend and his father, her professor.	<ol style="list-style-type: none"> 1. Assess the anxiety levels of the patient. 2. It's been an uninterrupted time with the patient to encourage the patient to open up and express feelings. Try to identify factors that cause or exacerbate patients' ability to cope. 3. Identify and reduce unnecessary stimuli in the environment. 	<ol style="list-style-type: none"> 1. Praise patient for identifying and using effective coping techniques 2.. Teach strategies that patient can use to develop coping skills. 3. Encourage patient to try coping behaviors 	<ol style="list-style-type: none"> 1. Refer patient to professional psychological counseling. 2. Educate patient importance coping skills. 3. Develop learning goals and educate patient on proper time to use coping skills.
3. Patient is at increased risk for anxiety related to stressors as evidence by the emails sent after being stressed from a breakup.	Patient is at increased risk for anxiety due to stressors in her life causing her to worry.	<ol style="list-style-type: none"> 1. assure patient is in a safe place. 2. attend to patient's comfort needs to increase trust and reduce anxiety. 3. Spend time with patient to convey a willingness to listen. 	<ol style="list-style-type: none"> 1. Give patient opportunities to ventilate own feelings 2. Include patient in decisions related to care. 3. Offer relaxing music for quiet listening periods. 	<ol style="list-style-type: none"> 1. Refer patient to mental health provider for ongoing mental health assistance. 2. help patient develop own techniques for dealing with anxiety 3. Have patient make a list of activities that promote feelings of comfort and encouragement for patient to look at after discharge.

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's Nursing diagnosis reference manual* (11th ed.). Wolters Kluwer

Concept Map (20 Points):

Subjective Data

Patient stated she was brought to hospital after Sending over 500 emails to her ex-boyfriend and his father who is also her professor. Patient stated at the time she had suicidal thoughts.

Nursing Diagnosis/Outcomes

Patient at increased risk for suicide related to depression as evidence by suicidal ideation.
 patient is at increased risk of ineffective coping related to impulse use of extreme solutions as evidenced by extreme overuse of email after a breakup.
 Patient is at increased risk for anxiety related to stressors as evidence by the emails sent after being stressed from a breakup.

Objective Data

1530
 P: 56
 B/P:99/66
 RR:16
 TEMP:96.8
 SPO2: 95% ra
 H:4'9"
 W:90lbs

Patient Information

H. R.
 21 year old female
 Student

Nursing Interventions

1. Initiate appropriate interventions by removing from patient environment anything that could be used to cause self-harm.
2. Provide supervision one on one based on facility policy.
3. Ask patient if they have a plan of how they would commit suicide
 - . Assess the anxiety levels of the patient.
2. It's been an uninterrupted time with the patient to encourage the patient to open up and express feelings. Try to identify factors that cause or exacerbate patients' ability to cope.
3. Identify and reduce unnecessary stimuli in the environment.
 - . assure patient is in a safe place.
2. attend to patient's comfort needs to increase trust and reduce anxiety.
3. Spend time with patient to convey a willingness to listen.



