N323 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 02/19/2022	**Patient Initials** A.H.	**Age** 1/13/1986 (36 years old)	**Gender** Female
Race/Ethnicity African American	**Occupation** Beautician/ Data entry	**Marital Status** Single	**Allergies** Benadryl
Code Status Full	**Observation Status** Suicidal	**Height** 66 in	**Weight** 86.4 kg

Medical History (5 Points)

Past Medical History: Diabetes, asthma and hypertension.

Significant Psychiatric History: n/a

Family History: n/a

Social History (tobacco/alcohol/drugs): The patient denies ever using any tobacco, alcohol or drug products.

Living Situation: The patient lives at home by herself.

Strengths: The patient stated her major strength is being very outgoing.

Support System: The patient support system consists of parents, sister, and friends.

Admission Assessment

Chief Complaint (2 points): Suicide ideation with a plan

Contributing Factors (10 points): The client mentioned that her depression started when she lost her grandparents in 2021 due to a natural disaster and become progressively worse after her dad was diagnosed with cancer this year. Shortly after her dad was diagnoses with cancer, she had suicidal thoughts.

Factors that lead to admission: The patient mention to her parent that she was thinking about suicide and wanted to jump off a nearby cliff to get rid of her pain.

History of suicide attempts: The patient denies of having any previous suicide attempts.

Primary Diagnosis on Admission (2 points): Major Depressive disorder (severe, recurrent) and Suicidal Ideation with a plan

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient denies having any lifetime experiences. **Witness of trauma/abuse: The patient denies having any experience with trauma or abuse.**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**n/a**	**n/a**	**n/a**	**n/a**
Sexual Abuse	**n/a**	**n/a**	**n/a**	**n/a**
Emotional Abuse	**n/a**	**n/a**	**n/a**	**n/a**
Neglect	**n/a**	**n/a**	**n/a**	**n/a**
Exploitation	**n/a**	**n/a**	**n/a**	**n/a**
Crime	**n/a**	**n/a**	**n/a**	**n/a**

Military	**n/a**	**n/a**	**n/a**	**n/a**
Natural Disaster	**n/a**	The patient lost her grandparents when she was 35 to a natural disaster.	**n/a**	The patient is very depressed and suicidal.
Loss		The patient lost her grandparents in 2021.	**n/a**	Depression has grown since she has lost her grandparents.
Other	**n/a**	**n/a**	**n/a**	**n/a**

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	**No**
Loss of energy or interest in activities/school	**Yes**	**No**	**No**
Deterioration in hygiene and/or grooming	**Yes**	**No**	**No**
Social withdrawal or isolation	**Yes**	**No**	Yes, the patient mentioned that since her grandparents died last year, she hasn't been around her friends at all.

Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**No**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Yes, since her dad was diagnosed with cancer this year, the patient has night terrors of him passing away. The patient said she experienced this at least 3 times a week and it is so intense that she cannot even go back to sleep after.
Difficulty falling asleep	**Yes**	**No**	Yes, since her dad was diagnosed with cancer, she has trouble sleeping every night.
Frequently awakening during night	**Yes**	**No**	Yes, since her dad was diagnosed with cancer, she has night terrors that wakes her up at least 3 times a week**.**
Early morning awakenings	**Yes**	**No**	**No**
Nightmares/dreams	**Yes**	**No**	Yes, since her dad was diagnosed with cancer, the patient been having night terrors at least 3 times a week. The night terrors

			are so intense that she cannot fall back to sleep.
Other	**Yes**	**No**	**No**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**No**
Binge eating and/or purging	**Yes**	**No**	**No**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**No**
Use of laxatives or excessive exercise	**Yes**	**No**	**No**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**No**
Panic attacks	**Yes**	**No**	**No**
Obsessive/compulsive thoughts	**Yes**	**No**	Yes, the patient is having obsessive thought about the thought of her dad passing away every day and it is unbearable for her.
Obsessive/compulsive behaviors	**Yes**	**No**	**No**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Yes, the patient started to avoid her dad because it triggers the obsessive thoughts she has.

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?	1		
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**	No
School	**Yes**	**No**	No
Family	**Yes**	**No**	Yes, since her grandparents died and dad been diagnosed with cancer, the patient became very withdrawn from family and friends.
Legal	**Yes**	**No**	No
Social	**Yes**	**No**	Yes, since her grandparents died and dad been diagnosed with cancer, the patient became very withdrawn from her social life with her friends.
Financial	**Yes**	**No**	No
Other	**Yes**	**No**	No

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
02/19/2022 The Pavilion	**Inpatient Outpatient Other:**	**Inpatient**	**Suicidal ideation with plan**	**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?**	
n/a	**n/a**	**n/a**	**Yes**	**No**
n/a	**n/a**	**n/a**	**Yes**	**No**
n/a	**n/a**	**n/a**	**Yes**	**No**
n/a	**n/a**	**n/a**	**Yes**	**No**
n/a	**n/a**	**n/a**	**Yes**	**No**
If yes to any substance use, explain: n/a				
Children (age and gender): n/a				

Who are children with now? n/a		
Household dysfunction, including separation/divorce/death/incarceration: n/a		
Current relationship problems: Single and never been in a relationship **Number of marriages: n/a**		
Sexual Orientation:	**Is client sexually active?** **No**	**Does client practice safe sex?** **Yes**
Please describe your religious values, beliefs, spirituality and/or preference: The patient is Jehovah Witness.		
Ethnic/cultural factors/traditions/current activity: **Describe:** The patient faithfully goes to church 3 times a week with her parents.		
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? The patient believes that going to family therapy will help with her treatment and care.		
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: n/a		
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.) n/a
History of Substance Use: n/a
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: The patient denies of having any problems in school.
Discharge
Client goals for treatment: The patient wants to work on getting a therapist and being more compliant with her medication.
Where will client go when discharged? The patient will go home to her parents for a while until she is better.

Outpatient Resources (15 points)

Resource	Rationale
1. Individual/ Group Therapy	**1.** I believe that therapy will be a good place for client to explore her feelings and open more to a person besides her family.

2. Psychiatrist	**2.** I think the patient might have something deeper going on due to her odd behaviors at time during the interview and her charts. I believe seeing a psychiatrist will help evaluate the client mental health more precisely.
3. Suicidal hotline information	**3.** The patient came to the pavilion due to suicidal ideation with a plan, I believe this will help the client just in case of emergency situations and there is no other help around.

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

Brand/ Generic	**Buspirone**	**Duloxetine/ Cymbalta**	**Paliperidone/ Invega Sustenna**	**Lisinopril/ Prinivil**	**Metformin / Glucophage**
Dose	**10 mg**	**60 mg**	**234 mg**	**25 mg**	**500 mg**
Frequency	**TID**	**BID**	**Every 4 weeks**	**Every morning**	**BID**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Anxiolytics/ Azaspirodecanedione derivatives (Jones, 2021)**	**Antidepressants/ SSNRIs (Jones, 2021)**	**Antipsychotics/ benzoxazole (Jones, 2021)**	**Antihypertensives/ACE inhibitors (Jones, 2021)**	**Antidiabetic/ Biguanides (Jones, 2021)**
Mechanism of Action	**Inhibits neuronal firing and reduce serotonin turnover in cortical (Jones, 2021).**	**Inhibit serotonin and norepinephrine reuptake and is a weak inhibitor of dopamine reuptake in the CNS (Jones, 2021)**	**May antagonize both central dopamine and serotonin receptors (Jones, 2021)**	**Causes decreased production of angiotensin ll and suppression of the RAAS (Jones, 2021)**	**Decreases hepaic glucose production and intestinal absorption of glucose and improves insulin sensitivity (Jones, 2021)**
Therapeutic Uses	**Anxiety disorders (Jones, 2021)**	**To treat MDD, GAD, fibromyalgia, neuropathic pain and chronic musculoskeletal pain (Jones, 2021)**	**In patients with schizophrenia and schizoaffective disorder (Jones, 2021)**	**Hypertension (Jones, 2021)**	**Diabetes (Jones, 2021)**
Therapeutic Range (if applicable)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Reason	**The client**	**The patient**	**The**	**The patient is**	**The**

Client Taking	**came into the pavilion with suicidal ideations (Jones, 2021).**	**was diagnosed with major depressive disorder (Jones, 2021).**	**patient was possible showing signs of schizophrenia or schizoaffective disorder (Jones, 2021).**	**using this drug because of her hypertension (Jones, 2021).**	**patient is using this drug because of her diabetes (Jones, 2021).**
Contraindications (2)	**Hypersensitivity to drug and within 14 days of MAO inhibitor (Jones, 2021).**	**Hypersensitivity to drug or its ingredients and person taking MAO inhibitors (Jones, 2021).**	**Hypersensitivity to paliperidone or risperidone and with patients with history of suicide attempts (Jones, 2021).**	**Hypersensitivity to ACE inhibitors and impaired renal functions (Jones, 2021).**	**Hypersensitivity to drug components and not for type 1 diabetes patients (Jones, 2021).**
Side Effects/Adverse Reactions (2)	**Tachycardia and insomnia (Jones, 2021).**	**Suicidal thoughts and hypoglycemia**	**Elderly patients with dementia and patient who is taking anti-hypertensive drugs**	**Hyperkalemia and angioedema**	**Hypoglycemia and chills**
Medication/ Food Interactions	**Interaction with grapefruit and MAO inhibitors (Jones, 2021).**	**Interactions with aspirin and alcohol use**	**Interactions with alcohol use and St. John Worts**	**Interactions with diuretics and allopurinol**	**Interactions with beta blockers and alcohol use**
Nursing Considerati	**Monitor CNS reactions and**	**Drug may increase risk**	**Monitor patient for**	**Do not confuse this drug with**	**Monitor for lactic**

ons (2)	**do not stop the drug abruptly (Jones, 2021).**	**of suicidal thoughts and severe skin reactions including erythema**	**tardive dyskinesia and drug may cause hyperglycemia**	**the look alike, lioresal and monitor WBC**	**acidosis and times of stress, such as infections , fever, surgery, or trauma**

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

Medications Reference (1) (APA):

Jones, D. W. (2021). Nurse’s drug handbook. (A. Barlett, Ed.) (20th ed.). Jones & Bartlett

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Good hygiene and well-groomed. The client was engaged and cooperative. The client is slightly overweight and short stature. The client had a positive attitude and was soft-spoken. She said this was here due to the depressed environment. The client’s mood was stable, although a little hostile. The client’s affect was calm for the most part.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The client is improving her thoughts from when she was admitted. The client had suicidal thoughts with plans off jumping off the nearby cliff. The client stated she does have obsession thought about her dad dying of cancer. The client denies any current ideations, delusions, illusions, and phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	Client is oriented to person, place, situation & time. A&O x 4. .
MEMORY: **Remote:**	. Client denies any impairment in memory. Memory is intact.
REASONING: **Judgment:** **Calculations:**	.Client has poor judgment due to suicidal ideation. Client is intelligent. The patient does not seem to be struggling with abstraction or

Intelligence: **Abstraction:** **Impulse Control:**	impulsive control.
INSIGHT:	The client recognizes that her suicidal thoughts were not safe and told her parents so she can get help. She knows that she needs to find better coping skills for her depression and obessive thoughts.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient does not use any assistive devices. The patient sat up tall and upright. The client had equal strength in all extremities 5/5. The client can move all extremities with ease.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1430	88	134/80	16	36.5	99%
1700	76	140/82	14	37	100%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	Numerical	n/a	n/a	n/a	n/a
1430	Numerical	n/a	n/a	n/a	n/a

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	**Oral Fluid Intake with Meals (in mL)**

Breakfast: 100% **Lunch: 100%** **Dinner: 100%**	**Breakfast: 240 ml of water** **Lunch: 460 ml of water** **Dinner: 460 ml of water and coffee**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The patient should go home with parents for a while to prevent from staying by herself since she was admitted for suicidal ideation. I think the patient should find a place where she can get some therapy and follow up with a psychiatrist.

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 of suicide related to suicide ideation as evidenced by having	The patient was admitted due to having suicide ideation with plans.	1.) Suicidal precautious 2.) Medication 3.) Group therapy	1.Medication 2. Finding ways to cope with her life stressors. 3. Suicide precautions	**1**. The patient will follow up with a psychiatrist. 2. The patient will continue to take her

a plan to jump off the cliff.				medications. 3. The patient will stay with her family for awhile for support.
2.) Risk for injury related to suicide ideation as evidence by expressing that she wants to jump off a cliff.	If the patient is successful with her suicidal ideation it can result in injuries or even death.	**1.** Suicidal precautious 2. Ensuring the patient is safe from harming herself. 3. Medication therapy	**1**. The patient should figure out the root her of ideations. 2.) Group therapy 3. Medication therapy	1.The patient should continue to practice effective coping skills. 2.) The patient should make sure she has a good support system. 3. The patient should find time to find an individual therapist.
3.) Ineffective coping related to suicide ideation as evidenced by being socially withdrawn from family and friends.	Losing her grandparents and her dad being diagnosed with cancer has played a big part on mental her so she needs to find better ways to cope.	**1.** When the patient is first admitted, safety is a priority since she has suicidal ideation. 2. Medication therapy to help with her symptoms. 3. The patient should be asked about her previous mental health history.	**1.** When the patient is first admitted, safety is a priority since she has suicidal ideation. **2.** Medication therapy to help with her symptoms. **3.** The patient should be able to attend group therapy.	1. The patient should work with a therapist to find effective ways to cope. 2. The patient should probably attend family therapy since family is the root of her mental health. 3. The patient should find support groups with people who go through similar problems.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient stated, “I wanted to jump off the cliff to get rid of my pain”.
The patient stated “I can hardly sleep due worrying about my dad”

Nursing Diagnosis/Outcomes

Risk of suicide related to suicide ideation as evidenced by having a plan to jump off the cliff.
The patient was on suicide precautious which helped her be unsuccessful of plan of committing suicide.
Risk for injury related to suicide ideation as evidence by expressing that she wants to jump off a cliff.
The patient did not have any injuries due to be watched closely by staff.
Ineffective coping related to suicide ideation as evidenced by being socially withdrawn from family and friends.
The patient agreed to go to therapy to find better coping scales.

Objective Data

The patient appeared to be having a flat affect.
The patient was a little hostile during the interview.

Patient Information

The patient is a 36-year-old African American who came in due to suicidal ideation with a plan jumping off a cliff. The patient has no significant psychiatric history but has a past medical history of diabetes, hypertension and asthma. The patient was admitted on 02/19/2022 by her family due to voicing that she wanted to commit suicide.

Nursing Interventions

The patient was put on suicide precautious due to her suicidal ideation.
The patient was also given medication to help manage her symptoms
The patient was close to the nurses’ station to keep an eye on her.
The patient had potential hazardous things taken away from her.
The patient was encouraged to attend group therapy to help with coping skills.
The patient encourage to identify ways of effective coping for her.