

N323 Care Plan
Lakeview College of Nursing
Hayley Barrie

Demographics (3 points)

Date of Admission 4/8/2022	Patient Initials E.B.	Age 18	Gender Female
Race/Ethnicity White/ Caucasian	Occupation Student	Marital Status Single	Allergies No known allergies
Code Status Full code	Observation Status: Observation	Height 172.2 cm	Weight 72.5 kg

Medical History (5 Points)

Past Medical History: This patient has a past medical history of tonsilitis during early childhood. This patient also has been diagnosed with migraines and acid reflux.

Significant Psychiatric History: This patient has been diagnosed with bulimia, panic disorder, general anxiety disorder (GAD), post traumatic stress disorder (PTSD), and bipolar type 1.

Family History: The patient's paternal grandfather has a history of bipolar disorder and depression.

Social History (tobacco/alcohol/drugs): Patient states that she smokes occasionally, but is in the process of quitting. She claims that when she is smoking, she smokes approximately 5 cigarettes daily. She started smoking when she was 15 years old and goes through periods of smoking cessation, usually lasting a few months, then after those few months, she starts smoking again.

Living Situation: The patient is currently living with her parents and her sister.

Strengths: The patient states that she believes her "diligent" attitude is her strength.

Support System: The patient states that her mentor, Stephanie, is her support system. The patient sees Stephanie as a maternal figure.

Admission Assessment

Chief Complaint (2 points): The patient had suicidal thoughts about ingesting a whole bottle of prescribed medication.

Contributing Factors (10 points):

Factors that lead to admission: The patient says that on 4/4/22 she was sexually assaulted by one of her close male friends. The patient trusted this friend and was alone with him after being at a party with alcohol involved. The patient says that she was then taken to the assailant's residence and that's where the sexual assault occurred. The patient states that she felt extremely guilty about the sexual assault and blamed herself. She was feeling guilty and had suicidal ideations 4 days before being admitted to the hospital. The patient then had suicidal ideations to take an entire bottle of her prescribed medication. The patient stated that she thought the suicidal ideation really accelerated on Friday, because during the week she is busy with school, but on the weekends, she has a lot of time to think. The patient stated that at the time of admission, nothing could make her stop thinking about committing suicide. The patient then decided to go to the hospital and seek assistance with her mental health. The patient is being treated pharmaceutically and therapeutically.

History of suicide attempts: This patient has attempted suicide multiple times. The first attempt was in 2017 at the age of 13. Her second attempt was in 2019 at the age of 15. In the year 2020, at the age of 16, the patient attempted suicide twice. In the year 2021, at the age of 17, the patient attempted suicide twice. She was admitted to the hospital each time and says that

while she was impatient, she felt that there was some improvement, but shortly after discharge, she begins to feel depressed again. For all of the suicide attempts the patient took a significantly higher dose of her prescribed medications.

Primary Diagnosis on Admission (2 points): Bipolar Unspecified

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: This patient has been sexually abused her cousins and her cousins friends from the age of 6 until 13.</p> <p>From the age of 8-11 the patient was physically abused by multiple family members and emotionally abused by her mother.</p> <p>Most recently the patient was sexually abused by a close male friend.</p> <p>Witness of trauma/abuse: The patient has not witnessed any trauma and abuse of others.</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	Patient claims that she is not experiencing	Patient states that she has been	The patient does not have known	From the ages of 8-11 the patient was

	physical abuse currently	abused physically from ages 8-11.	secondary trauma relating to physical abuse.	physically abused
Sexual Abuse	The patient was recently sexually abused by her close male friend.	The patient has been sexually abused starting at the age of 6.	The patient does not have known secondary trauma related to sexual abuse	From the age of 6 until most recently the patient has experienced sexual abuse. The patient was sexually abused by cousins and friends while being unsupervised as a young child. Family sexual abuse happened frequently until she was about 13. Recently she was sexually abused by a close, male friend, causing feelings of unworthiness and hopelessness.
Emotional Abuse	The patient states that her mother is currently emotionally abusing her.	The patient states that her mother is emotionally abusing her currently. The patient also states that her sister emotionally abuses her as well.	The patient does not have known secondary trauma related to emotional abuse.	From a young age the patient's mother has been "manipulative" and "controlling". The patient's sister has also been emotionally abusive to her, however the patient mentions that this is due to the sister's autism diagnosis.
Neglect	The patient states that	The patient states	The patient does	From a young age the

	she is not currently being neglected.	that she was neglected in the past, by her father who she says, “didn’t care”. However, the patient says that her father has now wanted to be an active participant in her life.	not have known secondary trauma related to neglect.	patient has been neglected by her father, especially emotionally. Recently the father has wanted to be there, emotionally, for the patient.
Exploitation	The patient denies currently being exploited.	The patient denies being exploited in the past.	The patient denies having known secondary trauma related to exploitation.	The patient denies being exploited currently, in the past, and denies having secondary trauma related to exploitation.
Crime	The patient denies currently being involved with crime.	The patient denies being involved with crime in the past.	The patient denies having known secondary trauma related to crime.	The patient denies being involved with crime currently, in the past, and denies having secondary trauma related to exploitation.
Military	The patient denies currently having any involvement with the military.	The patient denies any involvement with the military in the past.	The patient denies having secondary trauma related to the military.	The patient has no current involvement, past involvement, or secondary trauma related to the military.
Natural Disaster	The patient denies currently having any involvement with natural disasters.	The patient denies having any involvement with natural disasters	The patient denies having secondary trauma related to natural disasters.	The patient denies having involvement with natural disasters currently or in the

		in the past.		past. The patient also denies having secondary trauma related to natural disasters.
Loss	The patient denies currently having any involvement with loss.	The patient denies having any past involvement with loss.	The patient denies having secondary trauma related to loss.	The patient denies currently experiencing loss, experiencing loss in the past and denies having secondary trauma related to loss.
Other	The patient denies having any other current history of trauma not previously stated.	The patient denies having any other past trauma not previously stated.	The patient denies having other secondary trauma not previously stated.	The patient denies having any other trauma currently or in the past. The patient also states that she has no secondary trauma. All accounts of trauma has been previously stated.

Presenting Problems

Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)
Depressed or sad mood	Yes	No	The patient says when she is depressed or sad it feels "lingering". It is something that she says she can't force to go away. She says sometimes it lasts a couple of weeks and sometimes it lasts a couple of months. Her depression happens after a traumatic moment, but she says her depression can "be random" and come on spontaneously.
Loss of energy or interest in	Yes	No	The patient states that she "enjoys" her

activities/school			classes. The patient is really focused on her goal to become a psychologist and help others similar to herself.
Deterioration in hygiene and/or grooming	Yes	No	The patient appears clean and well groomed.
Social withdrawal or isolation	Yes	No	The patient is interacting with other patients in the group room. The patient was also seen walking in the hallway on the phone talking to her friends.
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	The patient has relationships issues with her mother. The patient states that her mother has been “controlling” and that they fight “almost every day”. These fights involve shouting but are not physical. When the patient is actively fighting with her mother, the fight lasts until “someone goes to bed”.
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	The patient states that she is sleeping normally, however she feels exhausted all day. She says that no matter how much she sleeps, she feels tired.
Difficulty falling asleep	Yes	No	The patient claims to have no difficulty falling asleep. She says when she first got to the hospital, she had trouble her first night, but she is now able to fall asleep normally.
Frequently awakening during night	Yes	No	The patient denies waking up during the night. She sleeps from the time she falls asleep till the time she wakes up in the morning.
Early morning awakenings	Yes	No	The patient says that she does not wake up early and typically wakes up at 0800.
Nightmares/dreams	Yes	No	The patient says that she is not currently

			experiencing any nightmares or dreams. The patient is currently on medication to prevent nightmares, since in the past the patient had vivid PTSD related nightmares. The patient claims that since on the medication, she hasn't had a single nightmare.
Other	Yes	No	The patient does not have any other presenting sleep difficulty.
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	The patient states that she has had a low appetite. She doesn't feel hungry and nibbles on a few pieces of food during mealtimes. The patient says when she feels depressed, she typically doesn't eat very much and it lasts as long as she feels depressed.
Binge eating and/or purging	Yes	No	The patient denies currently binge eating and purging.
Unexplained weight loss? Amount of weight change:	Yes	No	The patient states that she is at her typical weight and has not experienced any unexplained weight loss. The patient stated that if she did lose weight, it is extremely minimal and is most likely from not having an appetite.
Use of laxatives or excessive exercise	Yes	No	The patient denies using laxatives or excessively exercising.
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	The patient has not displayed any anxiety behaviors. The patient was sitting still and held appropriate eye contact. She seemed at ease and did not appear anxious.
Panic attacks	Yes	No	The patient had one panic attack when first

			admitted. She said that she wasn't quite sure how long the panic attack lasted, but guessed 10 minutes. She said that she frequently gets panic attacks and that they are very intense.
Obsessive/compulsive thoughts	Yes	No	The patient denies having any obsessive or compulsive thoughts.
Obsessive/compulsive behaviors	Yes	No	The patient did not appear to have any obsessive or compulsive behaviors. When asked if she had experienced these behaviors, she stated that she did not.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	The patient says that she has anxiety when interacting with males, due to her past trauma. She says that she has significant trust issues which has interfered with some of her relationships.
Rating Scale			
How would you rate your depression on a scale of 1-10?		On 4/11/22 at 1300 the patient rated her depression at a 3 out of 10.	
How would you rate your anxiety on a scale of 1-10?		On 4/11/22 at 1300 the patient rated her anxiety at a 5 out of 10.	
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	Presenting?		Describe (frequency, intensity, duration, occurrence)
Work	Yes	No	The patient states that she has no stressors related to work. She enjoys her time socially interacting with her co-workers and looks forward to going to work.
School	Yes	No	The patient enjoys her school. She stated that she had many goals related to her education such as her plan to become a

			psychologist.
Family	Yes	No	The patient states that she has family conflict with her mother. She says her mother is “narcissistic”. She claims her mother purposely initiates conflict with her and tries to control every aspect of her life. The patient states that the conflict has been going on since she was approximately 14.
Legal	Yes	No	The patient denies having any legal stressors affecting her life.
Social	Yes	No	The patient says that she is currently stressed about a close friend leaving to go to a different college. She has been friends with this person since elementary school and is very sad she is not going to be seeing her as much. She says she feels better that she can use “snapchat” or other social media platforms to keep in contact, but still misses her friend immensely.
Financial	Yes	No	The patient denies any financial stressors.
Other	Yes	No	The patient denies any other current stressors.
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
2017	<p>Inpatient – The patient was seen as inpatient. She does not remember the name of the therapist or facility.</p> <p>Outpatient – The patient was seen by a therapist after being discharged. The patient does not remember the name of the therapist or facility.</p> <p>Other:</p>	<p>The patient was inpatient at a mental health facility. The patient states that she does not remember the name of the facility because she was so young when she was admitted.</p>	<p>The patient attempted suicide by taking a bottle of medication. The number of pills is unknown. The patient stated that she took a small handful and swallowed them. She then told her mother that she took the pills.</p>	<p>No improvement</p> <p>Some improvement – The patient said she was prescribed medication which helped her improve, but she felt it wasn't a significant improvement.</p> <p>Significant improvement</p>
2021	<p>Inpatient – The patient was seen as inpatient at Carle Bromenn Medical Center. The patient says she doesn't remember the therapist's name.</p> <p>Outpatient: N/A</p> <p>Other: The patient says that she has used "Talkspace online therapy" and a few other online programs that track mood.</p>	<p>The patient was admitted to Carle Bromenn in Bloomington, IL. She doesn't remember the therapist's name of the facility. She says she also has used applications on her phone to try and help her work through her mood. She says she has talked to a therapist on "Talkspace", which she says</p>	<p>The patient was being treated for a suicide attempt. The patient injected a large amount of prescription medication. The patient forced herself to throw up and called an ambulance after she ingested the pills.</p>	<p>No improvement</p> <p>Some improvement – The patient felt that after discharge she felt more improved when it came to her mood.</p> <p>Significant improvement</p>

		she likes because she is able to talk to someone anytime. She also likes using a mood tracker to see when she is sad and what triggers her moods.		
N/A	Inpatient: N/A Outpatient: N/A Other: N/A	N/A	N/A	No improvement: N/A Some improvement: N/A Significant improvement: N/a
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Mom	50	Mother	Yes	No
Dad	54	Father	Yes	No
Sister	16	Sibling	Yes	No
N/A	N/A	N/A	Yes: N/A	No: N/A
N/A	N/A	N/A	Yes: N/A	No: N/A
If yes to any substance use, explain: N/A				

<p>Children (age and gender): The patient has no children.</p> <p>Who are children with now? The patient has no children.</p>		
<p>Household dysfunction, including separation/divorce/death/incarceration: The patient says that her household is dysfunctional and that she feels her parents are emotionally abusive at times, especially her mother. The patient also feels that a lot of dysfunction is surrounding her sister. Her sister has been diagnosed with autism and has extreme behavioral issues and that causes a lot of household conflict.</p>		
<p>Current relationship problems: The patient denies any current relationship problems.</p> <p>Number of marriages: The patient has never been married.</p>		
<p>Sexual Orientation: The patient says she does not want to label herself under any orientation.</p>	<p>Is client sexually active? Yes No</p>	<p>Does client practice safe sex? Yes No Other: The patient is not currently sexually active. When sexually active, patient uses safe sex methods.</p>
<p>Please describe your religious values, beliefs, spirituality and/or preference: The patient states that she is Christian and enjoys going to church.</p>		
<p>Ethnic/cultural factors/traditions/current activity: The client states that she doesn't have any ethnic or cultural factors. She says that her family doesn't really have any traditions. At the time of the interview with the patient, the patient's currently activity was relaxing in her room.</p> <p>Describe: The patient doesn't believe to have any traditions within her family and denies any cultural or ethnic factors. The patient had just awoken from a nap and at the time of the interview, her current activity was relaxing in her room before interacting with other patients.</p>		
<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient states that she has no legal issues currently or in the past.</p>		

<p>How can your family/support system participate in your treatment and care? The patient states that she does not know how her family can better support her.</p>
<p>Client raised by:</p> <ul style="list-style-type: none"> Natural parents Grandparents Adoptive parents Foster parents Other (describe):
<p>Significant childhood issues impacting current illness: The patient has had numerous sexual assaults from family members starting by the time she was 6. The patient experiences frequent episodes of PTSD related to the many incidences of the sexual assaults and has extreme anxiety and trust issues because of this.</p>
<p>Atmosphere of childhood home:</p> <ul style="list-style-type: none"> Loving Comfortable Chaotic Abusive: The patient states that her home life as a child was physically, emotionally, and sexually abusive. Supportive Other:
<p>Self-Care:</p> <ul style="list-style-type: none"> Independent: The patient is able to perform daily tasks and care for herself properly. Assistance is not needed. Assisted Total Care
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) The patient says that both of her grandparents on her maternal side are alcoholics. The patient also states the her paternal grandfather has been diagnosed with Bipolar type 1.</p>
<p>History of Substance Use: The patient denies the use of substance abuse</p>
<p>Education History:</p> <ul style="list-style-type: none"> Grade school: The patient has completed grade school

<p>High school: The patient has completed high school. College: The patient is currently in her freshman year of college. Other: N/A</p>
<p>Reading Skills:</p> <p>Yes – The patient can read. No Limited</p>
<p>Primary Language: The patient’s primary language is English.</p>
<p>Problems in school: The patient claims she has had no problems in school behaviorally or academically.</p>
<p>Discharge</p>
<p>Client goals for treatment: The patient’s goal for treatment is to name an acceptable alternative to the situation that does not involve suicide.</p>
<p>Where will client go when discharged? The client will be discharged home with her parents.</p>

Outpatient Resources (15 points)

Resource	Rationale
<p>1. Cognitive behavioral therapy</p>	<p>1. Cognitive behavioral therapy can help the patient manage stress and can help reduce manic and depressive symptoms caused by stressful situations (Marzani & Neff, 2021). This patient has been upset by stressful situations in her life and CBT can help her manage her feelings related to the stressors.</p>

2. Family therapy	2. Family therapy can be beneficial because family conflict is very common in patients diagnosed with bipolar disorder. Family therapy can help the patient and their family work on communication and conflict resolution techniques (O'Donnell et al., 2020).
3. Acceptance and commitment therapy (ACT)	3. ACT helps the patient accept difficulties associated with bipolar disorder and helps the patient focus on personal goals (O'Donoghue et al., 2018). This therapy may be helpful to the patient because it can help her focus on her personal goal of being a psychologist and her values related to that.

Marzani, G., & Neff, A. P. (2021). Bipolar disorders: Evaluation and treatment. *American Family Physician*, 103(4), 227-239.

O'Donnell, L.A., Weintraub, M. J., Ellis, A. J., Axelson, D. A., Kowatch, R. A., Schneck, C. D., & Miklowitz, D. J. (2020). A randomized comparison of two psychosocial interventions on family functioning in adolescents with bipolar disorder. *Family Process*, 59(2), 376-389. <https://doi.org/10.1111/famp.12521>

O'Donoghue, E., Clark, A., Richardson, M., Hodsoll, J., Nandha, S., Morris, E., Kane, F., O'Keeffe, D., Butler, L., & Jolley, S. (2018). Balancing ACT: Evaluating the effectiveness of psychoeducation and acceptance and commitment therapy (ACT) groups for people with bipolar disorder. *Trials*, 19(1), 436. <https://doi.org/10.1186/s13063-018-2789-y>

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

Brand/Generic	Abilify/aripiprazole	Lamictal/ lamotigrine	Trileptal/ oxcarbazepine	Minipress/prazosin	N/A
Dose	5 mg	50 mg	300 mg	2 mg	N/A
Frequency	Daily	BID	BID	q.h.s.	N/A
Route	Orally	Orally	Orally	Orally	N/A
Classification	Atypical antipsychotic (Frandsen & Pennington, 2020).	Anticonvulsant (Jones & Bartlett Learning, 2021).	Anticonvulsant (IBM Micromedex, 2022).	Antihypertensive (Jones & Bartlett Learning, 2021).	N/A
Mechanism of Action	Abilify stabilizes dopamine and acts as an antagonist when there is too much dopamine and acts as a	Lamictal blocks sodium channels which stabilizes neuron membranes and stops the release	Trileptal binds to sodium channels and then stops repetitive neurons from	Prazosin blocks norepinephrine at alpha-1 receptors (Peters, 2020).	N/A

	partial agonist when there is low dopamine (Jones & Bartlett Learning, 2021).	of excitatory neurotransmitters (Jones & Bartlett Learning, 2021).	firing (IBM Micromedex, 2022).		
Therapeutic Uses	Abilify is used to maintain stability in patients who have bipolar 1 disorder (Jones & Bartlett Learning, 2021).	The patient is taking this to reduce mood episodes (Jones & Bartlett Learning, 2021).	Trileptal frequently used as a mood stabilizer.	Prazosin is used off label to prevent nightmares in patients who have PTSD (Peters, 2020).	N/A
Therapeutic Range (if applicable)	Abilify is typically started at 15 mg daily and is increased to 30 mg daily (Jones & Bartlett Learning, 2021).	Lamotrigine is usually started at 25 mg once per day for about 14 days. Then the dosage is increased to 50 mg for 14 days. The dosage goes up by 25 mg and then needs to be monitored for another 14 days. The maximum dose allowed is 200 mg (Jones & Bartlett Learning, 2021).	Trilpetal is usually started at 600 mg once per day. The therapeutic dose should not exceed 2400 mg per day (IBM Micromedex, 2022).	Prozosin is typically started at 2 mg and then cautiously increased 1mg after 2 months. The dosage typically is not prescribed over 4 mg often (Khaw & Argo, 2019).	N/A
Reason Client Taking	The patient is using this medication as a	This patient is taking	The patient is taking	The patient is taking this	N/A

	long-term mood stabilizer.	lamotrigine to treat bipolar mood.	Trileptal to prevent fluctuations in mood.	medication to relieve nightmares related to PTSD (Peters, 2020).	
Contraindications (2)	<p>1. The medication is contraindicated in patients who have dementia-related psychosis (Thorton, 2021).</p> <p>2. The medication is contraindicated in patients with a hypersensitivity to aripiprazole (Jones & Bartlett Learning, 2021).</p>	<p>1. This medication is contraindicated in patients with patients who are pregnant (Betchel et al., 2022).</p> <p>2. This medication is contraindicated in those who have a hypersensitivity to lamotrigine or its counterparts (Betchel et al., 2022).</p>	<p>1. This medication is contraindicated in patients experiencing hyponatremia (IBM Micromedex, 2022).</p> <p>2. This medication is contraindicated in patients who have neutropenia (IBM Micromedex, 2022).</p>	<p>1. Prazosin should not be taken by patients who have had previous reactions to prazosin (Peters, 2020).</p> <p>2. Prazosin should be avoided in patients who had cataract surgery (Peters, 2020).</p>	N/A
Side Effects/Adverse Reactions (2)	<p>1. This medication can cause prolonged QT intervals (Jones & Bartlett, 2021).</p> <p>2. The medication can cause neutropenia (Jones & Bartlett, 2021).</p>	<p>1. This medication can cause hepatic failure (Jones & Bartlett Learning, 2021).</p> <p>2. This medication can cause Stevens-</p>	<p>1. This medication can cause change in vision (IBM Micromedex, 2022).</p> <p>2. This medication can cause</p>	<p>1. Prazosin can cause drowsiness (Peters, 2020).</p> <p>2. Prazosin can cause nausea (Peters, 2020).</p>	N/A

		Johnson syndrome (Jones & Bartlett Learning, 2021).	decreased urination (IBM Micromedex, 2022).		
Medication/Food Interactions	<p>1. Abilify taken with antihypertensives can cause enhanced hypertensive effects (Jones & Bartlett, 2021).</p> <p>2. Abilify taken with benzodiazepines can cause increased hypotension and sedation (Jones & Bartlett, 2021).</p> <p>3. Abilify taken with alcohol can cause an increase in CNS depression (Jones & Bartlett, 2021).</p>	<p>1. Lamotrigine taken with carbamazepine can cause decreased blood lamotrigine level so its important to frequently monitor the patient if they are on carbamazepine (Jones & Bartlett Learning, 2021).</p> <p>2. Lamotrigine taken with valproic acid can increase the lamotrigine level (Jones & Bartlett Learning, 2021).</p>	<p>1. This medication should not be taken with rilpivirine (IBM Micromedex, 2022).</p> <p>2. This medication should not be taken with cabotegravir (IBM Micromedex, 2022).</p>	<p>1. Prazosin should not be taken concurrently with propranolol (Multum, 2021)</p> <p>2. Prazosin should not be taken with any diuretics (Multum, 2021).</p>	N/A
Nursing Considerations (2)	<p>1. Monitor the patient for difficulty swallowing (Jones & Bartlett Learning, 2021).</p>	<p>1. Assess for presence of a rash frequently and report any findings to the physician (Jones & Bartlett</p>	<p>1. Educate patient to not abruptly stop the medication (IBM Micromedex, 2022).</p>	<p>1. Educate patient to avoid standing up too quickly (Multum, C).</p> <p>2. Educate patient that if they miss a</p>	N/A

	2. Monitor the patient’s glucose level (Jones & Bartlett Learning, 2021).	Learning, 2021). 2. Monitor patient for seizure activity (Jones & Bartlett Learning, 2021).	2. Educate patient that oral contraceptives may not work properly when taken concurrently with Trileptal (IBM Micromedex, 2022).	dose to take medicine as soon as they remember, unless it is almost time for the next dose. In that case just skip the missed dose and take the next dose. It is important to tell the patient not to take 2 doses (Multum, C).	
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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

NOTE: The patient was on 4 psychiatric medications.

Medications Reference (1) (APA):

Betchel, N. T., Fariba, K. A., & Saadabadi, A. (2022). Lamotrigine. *National Library of Medicine*.

<https://www.ncbi.nlm.nih.gov/books/NBK470442/>

C, Multum. (2021). *Minipress*. Drugs.com. <https://www.drugs.com/mtm/minipress.html>

IBM Micromedex. (2022). *Oxcarbazepine*. Mayo Clinic. <https://mayoclinic.org/drugs-supplements/oxycarbazepine-oral-route/side-effects/drg-20067615?p=1>

Khaw, C., & Argo, T. (2019). Prazosin initiation and dose titration in a patient with posttraumatic stress disorder on concurrent carvedilol. *Mental Health Clinician*, 9(5), 326-330. <https://doi.org/10.9740/mhc.2019.09.326>

Peters, B. (2020). *Minipress (prazosin) for stress nightmares in PTSD*. Verywell Health. <https://www.verywellhealth.com/prazosin-treats-nightmares-in-ptsd-3015222>

Thorton, P. (2021). *Abilify*. Drugs.com. <https://www.drugs.com/abilify.html>

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood:</p>	<p>The patient appeared well groomed and clean The patient seemed calm and social. The patient has a mesomorphic build. The patient had a friendly attitude. The patient’s speech was clear. The patient seemed passive. The patient displayed a content mood.</p>
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<p>Affect:</p>	<p>The patient had appropriate affect.</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:</p>	<p>The patient had suicidal ideations about taking a bottle of her medication, however since she was being treated at the facility, felt that she wasn't suicidal. The patient has no delusions. The patient has no illusions. The patient has no obsessions. The patient has no compulsions. The patient has no phobias.</p>
<p>ORIENTATION: Sensorium: Thought Content:</p>	<p>The patient's sensorium is functioning normally. The patient's thought content is currently mostly positive with a hope for the future. This is an improvement from her current state of suicidal ideation.</p>
<p>MEMORY: Remote:</p>	<p>The patient was able to display remote memory.</p>
<p>REASONING: Judgment: Calculations: Intelligence: Abstraction: The patient is able to use abstract thinking. Impulse Control: The patient is not impulsive and shows expected impulse control.</p>	<p>The patient shows clear judgement. The patient is able to calculate as expected. The patient shows appropriate intelligence for age and development.</p>
<p>INSIGHT:</p>	<p>The patient understands that her low lows and</p>

	<p>high highs are related to her bipolar diagnosis. She understands that she needs to take her medication to improve these symptoms and that this disorder is something that can be managed with pharmaceutical and psychotherapy treatments.</p>
<p>GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:</p>	<p>The patient does not use any assistive devices. The patient displays good posture. The patient stands straight. The patient has average muscle tone. The patient shows equal strength in all extremities. The patient displays full motor movements for all extremities and joints.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	112	101/64	17	36.6 C Oral	100%
1730	86	110/72	18	37.1 C Oral	100%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

1400	Numeric 1-10: Patient rates pain at a 0	The patient denies pain.	The patient denies pain.	The patient denies pain.	Frequently assess for pain.
1730	Numeric 1-10: Patient rates pain at a 0.	The patient denies pain	The patient denies pain	The patient denies pain	Check for pain often.

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: N/A	Breakfast: N/A
Lunch: N/A	Lunch: N/A
Dinner: 75%	Dinner: cup of grape juice = 240 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Before discharge the patient will have a safety plan set in place. They will need to have a barrier set or pills monitored and away from the patient so that there is an interruption in means to commit suicide. It is also essential to do a suicide assessment

before the patient is discharged. The patient would then need to follow up with her provider and comply with the treatments prescribed by the physician. I would also educate the patient about coping mechanisms with the patient and help her learn how to find a support system. Once these take place, the patient is able to return home to her parents. The patient is not in need of any home health care needs. The patient also does not need any equipment. The patient should follow up and receive outpatient care, for individual, group, and family therapy.

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 violence: self-directed related to being a victim of sexual trauma as evidenced by	This nursing diagnosis was chosen because the patient has been experiencing thoughts of harming	1. Check the patient for any drugs or weapons. 2. Put on suicide observation.	1. Encourage the patient to discuss feelings and how to work through current stressors. 2. Keep record of what	1. Discuss ways the patient can deal with handling anxiety or stress, so the patient has more control over her life when

<p>suicidal ideation.</p>	<p>herself.</p>	<p>3. Construct a no suicide contract.</p>	<p>the client’s activity is every 15 minutes per unit protocol.</p> <p>3. Create a safe environment free of sharp objects, belts, shoe laces, etc.</p>	<p>discharged.</p> <p>2. Encourage the client to avoid decision making when involved in a crisis situation at home.</p> <p>3. Arrange for the client to have information about community therapy resources from case management before discharge.</p>
<p>2. Hopelessness related to recent sexual trauma as evidenced by verbalizations of feeling “unworthy of life”.</p>	<p>This nursing diagnosis was chosen because the patient feels discouraged and depressed over a recent sexual assault.</p>	<p>1. Encourage the patient to verbalize feelings related to hopelessness</p> <p>2. Use an empathetic approach to communicate with the patient.</p> <p>3. Encourage patient to acknowledge inner strengths and capabilities.</p>	<p>1. Work with patient on establishing attainable goals.</p> <p>2. Spend time communicating with the patient to get an understanding of their feelings.</p> <p>3. Allow patient to have choices related to their care.</p>	<p>1. Allow the use of spiritual resources.</p> <p>2. Encourage use of therapeutic activities at home such as horticultural therapy or art therapy.</p> <p>3. Give the patient resources about self help groups in her community.</p>
<p>3. Chronic low self esteem related to feelings of guilt as evidenced by</p>	<p>This nursing diagnosis was chosen because the patient states that</p>	<p>1. Assess the patient’s self-perception by asking about strengths and</p>	<p>1. Encourage the patient to perform individual care activities, such as grooming to promote a</p>	<p>1. Before discharge, review positive reframing techniques with the patient to use</p>

<p>verbalization of feeling at fault for sexual assault.</p>	<p>she feels “partly responsible” for the sexual assault that happened to her. These emotions of guilt cause feelings of low self-esteem.</p>	<p>weaknesses</p> <p>2. Identify thoughts that lead to negative self-image, such as self-blaming or overgeneralizing situations.</p> <p>3. Provide reassurance to the patient to help reduce the patient from having negative feelings about themselves.</p>	<p>positive self-image.</p> <p>2. Discuss alternative ways of thinking to have a more positive outlook on self.</p> <p>3. Discourage the patient from making negative remarks or self-blaming.</p>	<p>when home.</p> <p>2. Before discharge, review deastrophizing techniques to assist the patient to think more realistically about situations in the community.</p> <p>3. Encourage patient to join self help groups or other community resources focused on building healthy self-esteem.</p>
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Other References (APA):

Marzani, G., & Neff, A. P. (2021). Bipolar disorders: Evaluation and treatment. *American Family Physician*, 103(4), 227-239.

O'Donnell, L.A., Weintraub, M. J., Ellis, A. J., Axelson, D. A., Kowatch, R. A., Schneck, C. D., & Miklowitz, D. J. (2020). A randomized comparison of two psychosocial interventions on family functioning in adolescents with bipolar disorder. *Family Process*, 59(2), 376-389. <https://doi.org/10.1111/famp.12521>

O'Donoghue, E., Clark, A., Richardson, M., Hodsoll, J., Nandha, S., Morris, E., Kane, F., O'Keeffe, D., Butler, L., & Jolley, S. (2018). Balancing ACT: Evaluating the effectiveness of psychoeducation and acceptance and commitment therapy (ACT) groups for people with bipolar disorder. *Trials*, 19(1), 436. <https://doi.org/10.1186/s13063-018-2789-y>

Concept Map (20 Points):

Subjective Data

Patient says that she likes that she is “diligent”.
The patient feels that her mother is “manipulative and “controlling and that is affecting her home life.
The patient says she has “lingering” depression.
The patient says she “enjoys college”.
The patient claims that she fights with her mother daily.

Nursing Diagnosis/Outcomes

Risk for violence: self-directed related to being a victim of sexual trauma as evidenced by suicidal ideation. The outcome is to verbalize feelings of violence towards oneself. This patient goal was met.
Hopelessness related to recent sexual trauma as evidenced by verbalizations of feeling “unworthy of life”. The outcome is for the patient to think more positively about her future. This goal was met. The patient discussed plans for moving to Florida and working at Disney while going to school.
Chronic low self esteem related to feelings of guilt as evidenced by verbalization of feeling at fault for sexual assault. The outcome is to think of oneself in a more positive way. The goal was partially met.

Objective Data

The patient appears well groomed.
The patient’s heart rate was 112 bpm.
The patient’s spo2 was 100%.
The patient’s temperature was 36.6 C (Oral)
The patient’s blood pressure was 101/64
The patient ate 75% of her dinner.
The patient consumed 240 mL intake at dinner.
The patient is 172.2 cm tall.
The patient weights 72.5 kg.

Patient Information

The patient is a 18 year old, Caucasian, female. He was admitted on 4/8/2022. The patient has been previously diagnosed with PTSD, bipolar, general anxiety disorder, and depression. She was recently experiencing suicidal ideation related to a sexual assault.

Nursing Interventions

Encourage the patient to discuss feelings and how to work through current stressors.
Discourage the patient from making negative remarks or self-blaming.
Encourage patient to join self-help groups or other community resources focused on building healthy self-esteem.
Spend time communicating with the patient to get an understanding of their feelings.
Use an empathetic approach to communicate with the patient.
Arrange for the client to have information about community therapy resources from case management before discharge.

