N323 Care Plan

Lakeview College of Nursing

Angelina R. Thomas

09/15/2022

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
09/08/2022	SZ	20 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black/African-American	Customer Service Representative at Walmart in Champaign, IL	Single	No known allergies
Code Status	**Observation Status**	**Height**	**Weight**
Full Code	Every 15 minutes	5 feet 2 inches	150 pounds

Medical History (5 Points)

Past Medical History: Patient has a history of GERD and severe depression

Significant Psychiatric History: Patient was admitted to a psychiatric hospital at the age of 13. Patient could not recall the specific hospital or date she was admitted there. Location and dates of admission were not in the patient's chart.

Family History: Patient has a family history of cancer; paternal grandmother died of stomach cancer and biological father died of brain cancer. Patient has a family history of diabetes, heart attack; paternal uncle and two of her cousins died from having heart attacks.

Social History (tobacco/alcohol/drugs): Patient denies using tobacco or alcohol at the present moment. However, she did have an extensive history of drinking alcohol seven days per week at least once per day for two years from 2019-2021. Patient mentioned drinking approximately twenty ounces of Jack Daniels at the time. Patient denies ever taking any illicit drugs. Patient has a current habit and history of smoking marijuana every day, two-three times per day for seven days per week. She has been smoking marijuana for the past five years.

Living Situation: Patient stated, "I live alone, I have my own apartment." However, according to patient's chart, she lives with twenty-year-old boyfriend and a cat.

Strengths: Patient mentioned that she enjoys helping others, organizing, planning, and problem-solving. She was responsive with a strong vocabulary. She had a strong remote memory, she recalled dates from her childhood that caused her trauma. She actively participated in the discussion with valid feedback and actively listened, by nodding and leaning inward showing interest. She articulated her feelings well.

Support System: Patient mentioned that her only support system involves her boyfriend and paternal great uncle.

Admission Assessment

Chief Complaint (2 points): Patient stated, “I tried to kill myself by overdosing on Melatonin.”

Contributing Factors (10 points):

Factors that lead to admission: The patient mentioned that on September 8, 2022, she was at home and reminiscing on the years her 14-year-old male cousin molested her while she was only nine. During this time, she felt extremely depressed and alone. To cope with her depression, patient mentioned that she usually smokes marijuana every day. However, on this day marijuana did not relieve her of the intense feeling of depression she felt. She began taking multiple Melatonin pills just before her phone rang, and it was her friend on the line calling to check in on her. The patient’s friend said she didn’t sound well and told the patient she would call the police. When the police arrived, the patient told the police that she had tried to overdose, and they called an ambulance to take her to the emergency department. When she began treatment in the emergency department, the doctor felt she needed evaluation for depression and anxiety and treatment at a mental health facility. The patient stated, “I don’t think I need to be in that kind of place.” The doctors realized that it was not her first attempt. She tried to harm herself once before at the age of 13 when she tried overdosing on Tylenol.

She was admitted to a psychiatric hospital at that age, but the chart did not have the dates. Doctors gave her fluids to flush her system and hydrate her. Medications given at that time were not noted in the chart. The patient did not have any at-home continuous medication prescribed. The doctors determined she needed to be admitted to the Pavilion after her evaluation. She arrived at the Pavilion on 09/08/2022 complaining of a headache, and her mood presented as depression. She appeared anxious, nervous, and angry. She also appeared with slits on her wrist from the same suicide attempt. She denied any hallucinations, illusions, or compulsions. She denied wanting to harm others. Patient-reported that upon admission, she had difficulty falling asleep. However, when she finally fell asleep, she slept all night. Upon admission to the Pavilion, she was prescribed acetaminophen for pain PRN as a universal medication for all those admitted. Her focused medications were Lexapro for her depression, Desyrel for Insomnia, Tums because she has a history of GERD, and Vistaril for anxiety. The patient stated upon our assessment on 09/14/2022, “I did not think I belonged here, but after receiving treatment, I knew that I needed to be here, and hopefully, when I leave, I can attend another place like this but have the option to go home every night. I enjoy learning different coping mechanisms and talking to people who understand what I go through.” The patient’s expected discharge date is 09/17/2022.

History of suicide attempts: The patient has a two total suicide attempts. Once at the age of thirteen when she tried overdosing on Tylenol (dates were not in chart) and again at the age of twenty, on 09/08/2022, when tried overdoing on Melatonin and slitting her wrist.

Primary Diagnosis on Admission (2 points): Suicidal Ideation

Secondary diagnosis: Major Depressive Disorder, Unspecified Anxiety Disorder; Marijuana Use Disorder, and GERD

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient described being molested at nine by her male fourteen-year-old cousin. The molestation last two to three years long. Patient lost her father from brain cancer and grandmother from stomach cancer in the same year, 2017. **Witness of trauma/abuse:** Patient mentioned watching her mother beaten by her boyfriend when she was nine-years-old.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	No expressed abuse	Does not apply	No secondary traumas. Noted	Does not apply
Sexual Abuse	**Yes**	9-years-old	No secondary traumas.	Patient was molested by her 14-year-old male cousin when she

			Noted	was 9 years-old for 2-3 years of her life.
Emotional Abuse	No expressed abuse	Does not apply	No secondary traumas. Noted	Does not apply
Neglect	**Yes**	20-years-old	No secondary traumas. Noted	Patient feels neglected by her mom, step-father, and other family members. Since her only support comes from her boyfriend and great uncle.
Exploitation	No expressed abuse	Does not apply	No secondary traumas. Noted	Does not apply
Crime	No expressed abuse	Does not apply	No secondary traumas. Noted	Does not apply
Military	No expressed	Does not	No	Does not apply

	abuse	apply	secondary traumas. Noted	
Natural Disaster	No expressed disaster trauma	Does not apply	No secondary traumas. Noted	Does not apply
Loss	No current losses. However, patient presents with pass losses.	15 years-old	No secondary traumas. Noted	Patient loss her father to brain cancer and her grandmother to stomach cancer. Both passed away in 2017.
Other	No other expressed abuse or trauma	Does not apply	No secondary traumas. Noted	Does not apply
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	During the assessment patient expressed that she did not feel depressed and have not felt	

			depressed in days prior to assessment. Patient does have a history of depression. When patient was depressed, she described it being 4 times per week, it would last for a half a day at a time, the intensity felt like a 7 out of 10 and it occurred over the course of a year.
Loss of energy or interest in activities/school	**Yes**	**No**	Patient does not currently present with a loss of energy. Patient is not in school. However, patient described when she was in school, her loss of energy made her drop out of college. She would feel this loss of energy two days out of seven days in the week. It would be for half of the day long and approximately 6 weeks at a time 3 times per year from 2020-2021. She described the loss of energy an intensity of

			6 out of 10.
Deterioration in hygiene and/or grooming	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Social withdrawal or isolation	**Yes**	**No**	Patient described that she used to feel social withdrawal months ago. However, during the assessment she did not present socially withdrawn. She was active with her peers and willingly participated in being interviewed. When she did feel socially withdrawn, she described it as once per week for a year, 2020, half the day, and a 5 out of 10 for intensity.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient stated that she experienced variations in hours of sleep (6 hours some nights, 5

			hours of sleep on other nights, 4 hours of sleep on some nights as well)5 hours per night for 10 weeks out of the year. The intensity she described is 5 out 10
Difficulty falling asleep	**Yes**	**No**	Patient described that she has difficulty falling asleep 7 days per week. She described it as a 6 out of 10 and it occurs 6-7 months throughout the year. When she finally falls asleep, she does not awaken during the night and can remain sleeping.
Frequently awakening during night	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Early morning awakenings	**Yes**	**No**	Patient used to have a job at UPS, and it required her to wake up at 5 am. Patient explained that her body is now accustomed to waking up that early. She gets up at 5am 7 days per week and it occurs for the whole year, she

			described the intensity as 10/10 because it occurs every day.
Nightmares/dreams	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Other	**Yes**	**No**	Does not apply
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient described having a loss of appetite three times per week, lasting a full day, for one year, (2020), She described the intensity as a 7 out of 10.
Binge eating and/or purging	**Yes**	**No**	Patient described having episodes of binge eating 2 times out of a week lasting for 2 hours long and the intensity is a 8 out of 10, 3 months out of a year (2020).
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Use of laxatives or excessive exercise	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.

Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Panic attacks	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Obsessive/compulsive thoughts	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Obsessive/compulsive behaviors	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient described avoiding prior conversations concerning her cousin who molested her. She described avoiding rooms that he is in. Patient describes this as an everyday occurrence and lasts the whole year. The intensity is a 9 out of 10. It lasts for 30 minutes to an hour or however long he is around her.

Rating Scale			
How would you rate your depression on a scale of 1-10?	**4/10**		
How would you rate your anxiety on a scale of 1-10?	**1/10**		
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**	Does not apply because patient does not currently present with these difficulties.
School	**Yes**	**No**	Patient described that she did not have challenges or stressors in school directly; she only felt a loss of energy for school which she felt for a short time (listed under the loss of energy section).
Family	**Yes**	**No**	Patient described not living with her family in Chicago anymore because they are not supported to her and her challenges. She describes feeling unheard and left by her mom and stepfather.
Legal	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.

Social	**Yes**	**No**	Does not apply because patient does not currently present with these difficulties.
Financial	**Yes**	**No**	Patient described having financial challenges every day, year-round. She described the intensity as being an 8 out of 10. She works but does not make enough money to tackle her debts.
Other	**Yes**	**No**	Does not apply

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
The patient could not recall the dates and the dates were not present in the patient's chart. She was admitted at the age of 13.	**Inpatient** **Outpatient** **Other:**	Inpatient	Patient attempted suicide by trying to overdose on	**No improvement** **Some improvement** **Significant improvement**

			Tylenol.	
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
According to patient, she lives alone	20 y/o	Self	**Yes**	**No**
According to patient's chart she lives with her boyfriend	20 y/o	Boyfriend	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: Patient smokes marijuana, every day.				
Children (age and gender): N/A **Who are children with now?** N/A				
Household dysfunction, including separation/divorce/death/incarceration: Patient's stepfather was incarcerated many times, and entire family relocated every time he was transferred to a different correctional facility. This contributed to patient transferring schools a lot. Patient does not get along with mom and siblings. Patient mentioned that her immediate family is meant to her which contributed to her moving to Champaign alone and				

meeting her boyfriend.

Current relationship problems: Patient mentioned that she does not have any relationship challenges at the current moment.

Number of marriages: Patient has never been married.

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Heterosexual/Straight	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

Patient mentions being a Christian-Baptist.

Ethnic/cultural factors/traditions/current activity:

Patient's mom, stepfather, uncle, grandmother, one sister, and two brothers in Chicago would gather for the holidays and separate afterwards.

Describe: Patient mentions that her only family traditions are for Thanksgiving and Christmas. During this time her whole family gathers for dinner at the dinner table and shares stories and afterwards disappears from one another for the remainder of the year.

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

Patient does not have any current or past legal issues. However, her stepfather was incarcerated multiple times.

How can your family/support system participate in your treatment and care?

Patient mentioned that her family could contribute to her treatment and care by apologizing for the trauma they've caused in her life, taking accountability, and stop picking her apart. Patient feels belittle by her family and if they stopped doing that it would contribute to her care. Patient also mentioned that they can participate in her care by attending therapy services with her.

Client raised by:

Natural parents-Biological Mother **Grandparents-Paternal Grandmother** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient was molested at nine years old which largely contributes to her depression. She still has thoughts of the times she was molested and causes her to smoke marijuana and attempt suicide.
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.) Patient mentioned her biological mom suffers from anxiety and depression and her biological father suffered from depression before he passed away.
History of Substance Use: Patient used to drink alcohol, Jack Daniels, but it made her feel made after drinking it so she stopped. Patient currently smokes marijuana every day.
Education History: **Grade school** **High school** **College** **Other:** Patient has some college experience, one full year.

Reading Skills: **Yes** **No** **Limited**
Primary Language: Patient's primary language is English.
Problems in school: Patient denies any direct problems in school. She currently does not attend school.
Discharge
Client goals for treatment: Patient's goals are to learn different coping strategies, gain more hours of sleep per night, cease marijuana usage, learn how to handle emotions better by expressing herself and journaling, and to be open to talking with her family about her treatment and how they can help. Patient wants to attempt at least 8 hours of sleep per night. Patient wants to use the strategy we discussed, counting to 100 when suicide thoughts hit her mind and seek help right away. Patient want to maintain 3 meals per day and two healthy snacks. Patient wants to maintain 64 oz of water per day to maintain hydration and flush system while she is taking medications. Patient will feel more confident to express one change per month to her family that she expects in order for her to feel better about their relationship.
Where will client go when discharged? Patient will go to her apartment where she will live with her boyfriend.

Outpatient Resources (15 points)

Resource	Rationale
1. Crisis Line-Community services/non-	Patient will have immediate help with

profit-1801 Fox Dr. Champaign, IL 61820 217-359-4141	someone to talk to about thoughts of self-harm or suicide when she is thinking of past traumas or feeling alone. The hope is that these professionals while comfort her and provide her psychological support right away.
2. Charlie Health-An intensive outpatient program Intensive Outpatient Program (IOP) for Teens | Charlie Health	Charlie health is a virtual intensive outpatient program that helps younger people overcome mental health challenges before it advances to self-harm. Patient will have ongoing support outside of the inpatient treatment center during challenging times. She will be able to learn new techniques and strategies, exercise strategies learned at the Pavilion, and receive quick help wherever she is. Since, it is online.
3. Suicide Awareness Voices of Education (SAVE) SAVE: Suicide Prevention, Information, and Awareness	SAVE offers training and counseling, grief support, merchandise such as discs for relatability purposes, they offer public awareness, and they will give the client an opportunity to speak to others that understand what she goes through.

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

Brand/ Generic	Lexapro/ Escitalopram Oxalate (Jones & Bartlett, 2021, pg. 401)	Desyrel/ Trazadone (Jones &Barlett, 2021, p. 1094)	Calcium Carbonate/Titralac 500mg tabs (Jones &Barlett, 2021, p. 157)	Vistaril/ Hydroxyzine Pamoate (Jones &Barlett, 2021, p. 552)	Tylenol/ Acetaminophen (Jones &Barlett, 2021, p. 8)	
Dose	10mg	50mg	1000mg-2tabs	50mg	325mg-1tab	
Frequency	Daily in the morning	Daily at night, PRN	PRN, Q4H	Every 6 hours, PRN	Q6H, PRN	
Route	PO	PO	PO	PO	PO	
Classification	Antidepressant (Jones & Bartlett, 2021, pg. 401)	Antidepressant (Jones &Barlett, 2021, p. 1094)	Antacid (Jones &Barlett, 2021, p. 157)	Anxiolytic, Antiemetic, antihistamine, and sedative-hypnotic (Jones &Barlett, 2021, p. 552)	Anti-pyretic (Jones &Barlett, 2021, p. 8)	
Mechanism of Action	Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapse. Elevated serotonin level will elevate mood and reduce depression (Jones & Bartlett,	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect (Jones &Barlett, 2021, p. 1094) It also exerts an alpha-adrenergic blocking action and produces modest histamine	Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis (Jones &Barlett, 2021, p. 158)	Competes with histamine for histamine 1 receptor sites on surfaces of effecter cells. This suppresses results of histaminic activity, including edema (Jones &Barlett, 2021, p. 552)	Blocks prostagland in production and interferes with pain impulse generation in the peripheral nervous system (Jones &Barlett, 2021, p. 9)	

	2021, pg. 401)	blockade, causing a sedative effect (Jones &Barlett, 2021, p. 1094)				
Therapeutic Uses	To treat severe depression and generalized anxiety disorder (Jones & Bartlett, 2021, pg. 401)	To treat major depression (Jones &Barlett, 2021, p. 1094)	To provide Antacid effects Jones &Barlett, 2021, p. 158)	To relieve anxiety (Jones &Barlett, 2021, p. 552)	To relieve mild to moderate pain (Jones &Barlett, 2021, p. 8)	
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A	
Reason Client Taking	Depression	Insomnia	GI Upset	Anxiety	PAIN	
Contraindications (2)	Concomitant therapy with pimozide and hypersensitivity to escitalopram (Jones &Barlett, 2021, p. 401)	Hypersensitivity to Trazadone and recovery from an acute MI (Jones &Barlett, 2021, p. 1094)	Renal calculi and Hypophosphatemia (Jones &Barlett, 2021, p. 158)	Early pregnancy and hypersensitivity to Hydroxyzine (Jones &Barlett, 2021, p. 552)	Hepatic Impairment and Hypersensitivity to Tylenol (Jones &Barlett, 2021, p. 9)	
Side Effects/ Adverse Reactions (2)	Serotonin syndrome and seizures (Jones &Barlett, 2021, p. 401)	Suicidal ideation and seizures (Jones &Barlett, 2021, p. 1094)	Hypotension and Hypercalcemia (Jones &Barlett, 2021, p. 158)	Seizures and prolonged QT interval (Jones &Barlett, 2021, p. 552)	Hypotension and Hepatotoxicity (Jones &Barlett, 2021, p. 9)	

Medication/ Food Interactions	NSAIDS and amphetamines; there are no food interactions but should avoid alcohol while taking medication (Jones &Barlett, 2021, p. 401)	Aspirin and digoxin; no direct food interactions found (Jones &Barlett, 2021, p. 1094)	Caffeine and High-Fiber Foods and thiazide diuretics (Jones &Barlett, 2021, p. 158)	Antibiotics such as azithromycin and erythromycin; no food interactions found (Jones &Barlett, 2021, p. 552)	Food high in Pectin and anticholinergics (Jones &Barlett, 2021, p. 9)	
Nursing Considerations (2)	When dosage increases, monitor patient for serotonin syndrome (agitation, chills, diaphoresis, confusion, diarrhea, fever, hyperactive reflexes, restlessness, and poor coordination). Also, should not be given to patients with Bradycardia (Jones &Barlett, 2021, p. 401)	Trazadone can cause arrythmias, use cautiously in patients with cardiac disease. Give shortly after the patient has had a meal to reduce nausea (Jones &Barlett, 2021, p. 1094)	Store at room temperature and Monitor serum calcium levels (Jones &Barlett, 2021, p. 158)	Don't give by subcutaneous or I.V. route because tissue necrosis may occur. Use cautiously in patients with risk factors for QT prolongation such as concomitant arrhythmogenic drug use, electrolyte imbalance, or preexisting heart disease. (Jones &Barlett, 2021, p. 553)	Use cautiously in patients with hepatic impairment and monitor renal function in patients on long tern therapy (Jones &Barlett, 2021, p. 9)	

Medications Reference (1) (APA):

Jones & Barlett. (2021). *2021 Nurse's Drug Handbook* (20th ed.). Burlington, MA

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient was calm, attentive, and cooperative. Patient appeared well groomed, upright posture, her attitude was positive and she appeared ready for the assessment. She did not present with a flat Affect. She responded to questions appropriately. Her mood was pleasant and well. She was informative and forthcoming. She spoke maturely and used vocabulary appropriate for her age. Her interpersonal style was expressive, she was neither passive or aggressive.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient any current ideations, although she has a history of them and was admitted to the Mental Health Unit for having ideations. Patient currently denies any delusions, illusions, obsessions, or compulsions. Patient mentioned having a phobia for small groups of things such as a group of “dots”, or a group of ants.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was alert and orient to time, place, and person. She expressed her name and age. She mentioned that it was Wednesday, once asked the day of the week. She mentioned that she was at

	the Pavilion a treatment center to receive help with her thoughts and behaviors. Her thoughts were logical and goal oriented.
MEMORY: **Remote:**	Patient's remote memory is intact. Patient was able to recall the year she graduated from grade school when asked. Patient stated, "I graduated from grade school in 2016."
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Patient's judgement was appropriate for her developmental level. She stated, "being in the pavilion helped me become better, I needed to be here to be healthier. I need to have more places like this that can help me when I go home." Patient was able to count backwards and forwards by 5s from 100. Patient's intelligence was average based on language, high school education, and vocabulary used. Patient's abstraction was acceptable. She was able to understand the phrase, "The sky is the limit." Patient responded, "you can have anything you want if you put your mind to it." Patient has challenges with impulse control, as she attempted suicide twice.
INSIGHT:	Patient was asked, "Do you know why you're here?" Patient responded, "I need help with my mental state."
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Patient walks appropriately without any assistance or assistive devices She can perform ADLs without assistance. Her posture was straight. She can live independently. Muscle tone and Strength was tested by giving a hand shake. It was firm. Motor movements were tested as she walked hands and legs swung oppositely, without prompting.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

14:38	**68**	**131/76 (Left upper arm)**	**12**	**98.0F (temporal)**	**100%**
17:00	**72**	**128/72**	**14**	**98.5F (temporal)**	**100%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
14:38	**0-10**	**0**	**0**	**0**	Patient mentioned that she was not in any pain. If she was in pain the nurse would have provided her the prescribed Tylenol in her med list. Also, monitor her for improvement of pain after the Tylenol was given to see if it worked.
17:00	**0-10**	**0**	**0**	**0**	Patient mentioned that she was not in any pain. If she was in pain the nurse would have provided her the prescribed Tylenol in her med list. Also, monitor her for improvement of

					pain after the Tylenol was given to see if it worked.

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100% **Lunch:** 50% **Dinner:** 100%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 240ml **Lunch:** 120ml **Dinner:** 240 ml

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Patient will be going home to her boyfriend in their shared apartment. Patient mentioned feeling alone so I recommend her seeking an outpatient support group to discuss her challenges with. Patient doesn't have any immediate equipment needs. Follow up plan is for her to seek her Psychiatric Doctor within 7-14 days of discharge to discuss coping skills used during the weeks, discuss the medications used to see if they're effective. Patient should also be informed of the side affects of medications upon discharge so that she can report any of them to her provider right away or call 911 if she begins feeling allergic reactions to new medications prescribed. Patient will be educated on the importance of taking medications as prescribed, and also why she should not stop taking the medications when she begins feeling better. Patient will be encouraged to maintain all coping skills while at home including, but not limited to, journaling. Patient will be encouraged to cease marijuana usage and to call support numbers when she feels helpless or hopeless. Patient is independent and does not require any home healthcare needs.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Risk for suicide related to the patient stating, "I felt depressed and alone at home thinking about what my cousin did to me, so I tried to kill myself," as evidence by patient having visible slit marks on her wrist.	This is a priority diagnosis because if it is not addressed the patient will continue to try to harm herself and result in death.	1. Provide patient an assessment 2. Administer prescribed antidepressant medications 3. Take away any potential harmful objects from patient	1. Bring patient to support group in the milieu 2. Actively listen to the patient and check on the patient every 15 minutes of the day 3. Teach patient words of affirmation	**1.** Group Therapy **2.** Case Management **3.** Group Activities such as going outside in the back yard of facility to shoot basketball with peers or watching movies, limited time alone in room.
2. Ineffective Coping related to patient	This is a priority diagnosis because the	**1.** Gather information about the coping skills patient normally	**1.** Teach patient new coping skills such as journaling and counting	1. Encourage patient to attend groups discussing a

attempting suicide trying to cope with the pain of her childhood trauma as evidence by patient stating, "I tried to kill myself by overdosing on Melatonin, because my thoughts were constantly racing. I usually smoke weed but that didn't work."	patient needs to learn new coping skills to prevent self-harm.	uses **2.** Identify any of the patient's triggers **3.** Reassure client that her statements will be held in the utmost confidentiality	backwards by 5s from 100 when she feels like she wants to harm herself. **2.** Help patient detoxify from Marijuana **3.** Test the patient's knowledge of coping skills used while in the treatment facility and identify which ones were effective for the patient to use at home.	list of coping strategies, specifically. Also, including games with coping strategies. 2.Integrate coping strategies in the community outings. Such as when the groups visit high school and college games. A coping strategy could be to leave current environment and go attend a sporting event. 3. Allow patient to have phone calls to those she feels support her the most.
3. Insomnia related to anxiety and having thoughts of molestation as evidence by receiving only 4-6 hours of sleep per night and patient	This is important because patient's physiological needs are not being met. Not having enough sleep effects brain development, judgement, and the metabolism	**1.** Gather information about factors contributing to sleep variation. **2.** Introduce "thought-stopping" technique to promote sleep **3.** Set a goal for client to receive	**1.** Administer prescribed trazadone **2** Address patient thoughts about what happened to her through conversation and active listening **3.** Evaluate goals set upon	1. Encourage patient to attend "group" meetings at the Pavilion that discuss ways to promote sleep while battling Anxiety. 2. Allow patient to have visits from the people she

stating, "My thoughts were racing thinking about what happened to me at nine."	of the medications she takes.	7-8 hrs. of sleep while treating	admission to promote sleep	feels support her the most, she will have thoughts of her visit and how great it made her feel to see them prior to sleeping. 3. Encourage the patient to join a mood and anxiety program.

Other References (APA):

Frauenfelder F., Achterberg T., Müller Staub M. (2018). Nursing diagnoses related to psychiatric adult inpatient care. *J Clin Nurs*. 463-475. doi: 10.1111/jocn.13959.

Concept Map (20 Points):

Patient Stated, “I tried to kill myself by overdosing on Melatonin.”
Patient was brought into Mental Health Unit complaining of headache, feeling depressed, and having difficulty falling asleep.
Patient stated, “I was molested at nine years old by my male older cousin who was fourteen years old.”
Patient stated, “I smoke marijuana every day because my thoughts race and cannot stopping thinking about what happened to me at nine.”
Patient stated, “I have a hard time falling asleep at night because of my thoughts racing, but when I fall asleep, I don’t wake up in the middle of the night. I only get 4-6 hours of sleep every night.”

Nursing Diagnosis/Outcomes

Risk for suicide related to the patient stating, “I felt depressed and alone at home thinking about what my cousin did to me, so I tried to kill myself,” as evidence by patient having visible slit marks on her wrist.
Outcome: Patient will attend an outpatient support group 2-3 time per week following discharge and call the support hotline on days she feels like harming herself.
Ineffective Coping related to patient attempting suicide to cope with the pain of her childhood trauma as evidence by patient stating, “I tried to kill myself by overdosing on Melatonin, because my thoughts were constantly racing. I usually smoke weed but that didn’t work.”
Outcome: Patient will use the new coping strategies learned including journaling once per day for 7 days after discharge and report to counselor when she feels techniques are not effective to acquire more.
Insomnia related to anxiety and having thoughts of molestation as evidence by receiving only 4-6 hours of sleep per night and patient stating, “My thoughts were racing thinking about what happened to me at nine.”
Outcome: Patient be able to sleep for 7-8 hours at least 6 nights out of 7 in one week.

B/P-128/72
P-72
R-14
T-98.5F
O2-100%
Patient did not appear in any present danger to herself or others
Patient was well groomed, alert and oriented to place, time, and person.
Patient’s eyes appeared low with darkening around the bottom lid

Objective Data

Patient Information

S7
19 years old
5 foot 2 inches
150 pounds
African American female
No known allergies
Full code
Admitted to Mental unit for attempting suicide
Primary Diagnosis: Major Depressive Disorder
Secondary Diagnosis: Unspecified Anxiety

Nursing Interventions

Focused Assessments:
For Suicide Risk
For Depression
For Anxiety
Administer Prescribed Medications
Teach Coping Strategies
Promote Sleep
Set Realistic Goals for Patient
To promote Safety
To promote Sleep
Provided Out patient resources for client
Therapeutic Communication
Active Listening
Restating
Asking for clarification on what was stated
Maintaining Confidentiality