N323 Care Plan

Lakeview College of Nursing

Kaitlyn Loewenstein

Demographics (3 points)

Date of Admission 2/20/23	**Patient Initials** HY	**Age** 25	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Casey general store	**Marital Status** Single	**Allergies** None
Code Status Full code	**Observation Status** Stable	**Height** 5’9	**Weight** 180 lbs

Medical History (5 Points)

Past Medical History: No reported medical history.

Significant Psychiatric History: Social anxiety, bipolar, borderline personality disorder

Family History: Significant for anxiety

Social History (tobacco/alcohol/drugs):

-3-4 drinks every other day

-vapes everyday

Living Situation: The patient lives at home with her mother.

Strengths: The patient is highly motivated and participates in group therapy.

Support System: The pt claims that her mother, father, and boyfriend are her support systems.

Admission Assessment

Chief Complaint (2 points): Increased depression and anxiety

Contributing Factors (10 points):

Factors that lead to admission: The patient has been self-harming on and off for years she states. She has been to two places before to get help with her depression. She states that she had been cutting on her wrists and thighs. She then attempted suicide with pills, then came to the pavilion for help.

History of suicide attempts: The patient attempted suicide in 2016 by overdosing.

Primary Diagnosis on Admission (2 points): Bipolar, borderline personality disorder, and social anxiety

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Pt was emotionally abused by her parents growing up. **Witness of trauma/abuse:** Yes				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	Denies	Denies	N/A	N/A
Sexual Abuse	Denies	Denies	N/A	N/A
Emotional Abuse	Denies	7 yrs old	N/A	Pt stated that her parents emotional abused her at the age of 7.
Neglect	Denies	7 yrs old	N/A	Pt stated that her parents neglected her at the age of 7.
Exploitation	Denies	Denies	N/A	N/A

Crime	Denies	Denies	N/A	N/A
Military	Denies	Denies	N/A	N/A
Natural Disaster	Denies	Denies	N/A	N/A
Loss	Denies	Denies	N/A	N/A
Other	Denies	Denies	N/A	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Pt states that she is sadder at night	
Loss of energy or interest in activities/school	**Yes**	**No**	Denies	
Deterioration in hygiene and/or grooming	**Yes**	**No**	Denies	
Social withdrawal or isolation	**Yes**	**No**	Denies	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Denies	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	Pt usually gets 10+ hours of sleep a night	
Difficulty falling asleep	**Yes**	**No**	Denies	
Frequently awakening during night	**Yes**	**No**	Denies	
Early morning awakenings	**Yes**	**No**	Denies	
Nightmares/dreams	**Yes**	**No**	Pt states that she oftentimes dreams of her funeral	

Other	**Yes**	**No**	N/A
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Denies
Binge eating and/or purging	**Yes**	**No**	Denies
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Denies
Use of laxatives or excessive exercise	**Yes**	**No**	Denies
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Pt paces while speaking in group therapy
Panic attacks	**Yes**	**No**	Pt states having panic attacks when alone at night
Obsessive/compulsive thoughts	**Yes**	**No**	Denies
Obsessive/compulsive behaviors	**Yes**	**No**	Denies
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Denies
Rating Scale			
How would you rate your depression on a scale of 1-10?	7/10		
How would you rate your anxiety on a scale of 1-10?	9/10		
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**	Denies
School	**Yes**	**No**	Denies

Family	**Yes**	**No**	Pt states that conversating with her family is sometimes difficult.
Legal	**Yes**	**No**	Denies
Social	**Yes**	**No**	Pt states she has a hard time holding a conversation with anyone.
Financial	**Yes**	**No**	Pt states that whenever she is stressed, she spends money.
Other	**Yes**	**No**	Denies

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
2014	**Inpatient Outpatient Other:** Texas Health Springwood (Bedford, TX)	Inpatient	Suicide attempt	**No improvement** **Some improvement** **Significant improvement**
2016	**Inpatient Outpatient Other:** The pavilion	Inpatient	Suicide attempt	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient**	N/A	N/A	**No improvement**

	Outpatient **Other:**			**Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Alicia	52 yrs old	Mother	**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): Pt does not have any children. **Who are children with now?** Pt does not have any children.				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: Pt states she has a boyfriend and they do not have any problems. **Number of marriages:** Pt has never been married.				
Sexual Orientation: Straight	**Is client sexually active?** **Yes** **No**		**Does client practice safe sex?** **Yes** **No**	
Please describe your religious values, beliefs, spirituality and/or preference: Pt states that she is not religious.				
Ethnic/cultural factors/traditions/current activity: None **Describe:** N/A				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Pt does not have any past legal issues.				

How can your family/support system participate in your treatment and care? Pt states that her family/ boyfriend can be there and comfort her.
Client raised by: **Natural parents**- Mainly her mother **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient has a history of emotional abuse/ neglect by her father that led to her depression.
Atmosphere of childhood home: Pt states that she was not always emotionally abused and that her parents could be loving when they were not fighting with each other. **Loving**- Pt reports that her mother and father could be loving at times. **Comfortable** **Chaotic** **Abusive**- Pt reports emotional abuse from father. **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Pt reports anxiety is common in her family.
History of Substance Use: Pt reports drinking alcohol.
Education History: **Grade school** **High school-** Patient obtained her GED**.** **College** **Other:**
Reading Skills: **Yes**

No **Limited**
Primary Language: English
Problems in school: Patient claims that she had problems making friends in school and focusing.
Discharge
Client goals for treatment: Manage symptoms of depression and obtain manageability of symptoms of depression without resorting to suicide. Manage medications.
Where will client go when discharged? The pt will go back home and live with her mother.

Outpatient Resources (15 points)

Resource	Rationale
1. Counselor	1. Pt was seeing a counselor before treatment and will continue seeing one.
2. Psychiatrists	2. Pt will be seeing a psychiatrist for further help, and it will be set up after her discharge.
3. N/A	**3.** N/A

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

Brand/Generic	Trileptal	Propranolol	Fluoxetine		

	(Oxcarbazepine)	Hydrochloride	(Prozac)		
Dose	300 mg	10 mg	80 mg		
Frequency	BID	PRN	Daily		
Route	Orally	Orally	Orally		
Classification	Dibenzoazepine anticonvulsants	Pharmacologic class: Beta-adrenergic blocker Therapeutic class: antianginal, antihypertensive	SSRIs		
Mechanism of Action	Decreases nerve impulses that cause seizures and pain.	Prevents arterial dilation and inhibits renin secretion, resulting in decreased blood pressure	Inhibits the presynaptic reuptake of the neurotransmitter serotonin		
Therapeutic Uses	Anticonvulsant	antihypertensive	Antidepressant		
Therapeutic Range (if applicable)	6- 51 mg/ kg	N/A	20- 30 mg		
Reason Client Taking	To treat pain and seizures	To manage hypertension	Treat depression		
Contraindications (2)	Hepatic impairment, urea cycle disorders	Bronchial asthma, cardiogenic shock	Suicidal ideations, Concomitant use in patients receiving MAOI therapy		
Side Effects/Adverse Reactions (2)	Tremors, double vision	Hypotension, depression	Constipation, fatigue		
Medication/Food Interactions	Should not take if you are allergic to eslicarbazepine	Migraine medications, antidepressants and warfarin	Tyramine-Rich Food Products such as cheese, milk, or beef		

		may interact with propranolol	can increase BP		
Nursing Considerations (2)	Do not stop using Trileptal suddenly, most need frequent blood tests when taking this drug	Monitor blood pressure, measure fluid intake and output	Do not use when taking MAOI, concurrent use with certain medications may lead to QT prolongation		

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

Considerations (2)					

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2022 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Appears alert and oriented x person, place, and time, well groomed, no acute distress. Patient is cooperative and calm. Patients' mood was anxious, and her mood was congruent. Speech was coherent. The patient was engaged, oriented, and talkative.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient denies have any delusions, illusions, obsessions, compulsions, or phobias currently. Patient has suicide ideations and is depressed.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was A&O x4 with somewhat scattered thinking but was logical. Sensorium was not assessed. Thought content is realistic logical. .
MEMORY: **Remote:**	.Long and short memory intact

REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	. Pts judgment was intact. Impulse control was observed to be average besides whenever she is stressed out, she states she that she spends money. Calculation and abstraction were not assessed.
INSIGHT:	Insight was observed to be average.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient had no assistive devices. The posture was relaxed and slouched during our conversations. Muscle tone, strength, and motor movement was appropriate for age and height.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1220	97 bpm	111/70 Left arm	18 Breaths/ min	98.4 F temporal	97% Room air
1415	99 bpm	120/75 Left arm	11 Breaths/ min	97.6 F Temporal	98% Room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1220	Numeric	N/A	0/10	N/A	N/A
1415	Numeric	N/A	0/10	N/A	N/A

Dietary Data (2 points)

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

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient plans on going home and living with her mother after discharge. She wants to continue seeing a therapist and potentially see a psychologist. I would like the pt to perform in group activities and try to meet new people. I would also like her to try to do something besides harming herself whenever she is depressed or sad. I agree that the patient should continue seeing a therapist to prevent herself from resulting back to suicidal thoughts. I would like to see the patient really lean on her mother and boyfriend whenever she is feeling depressed or stressed.

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"	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**

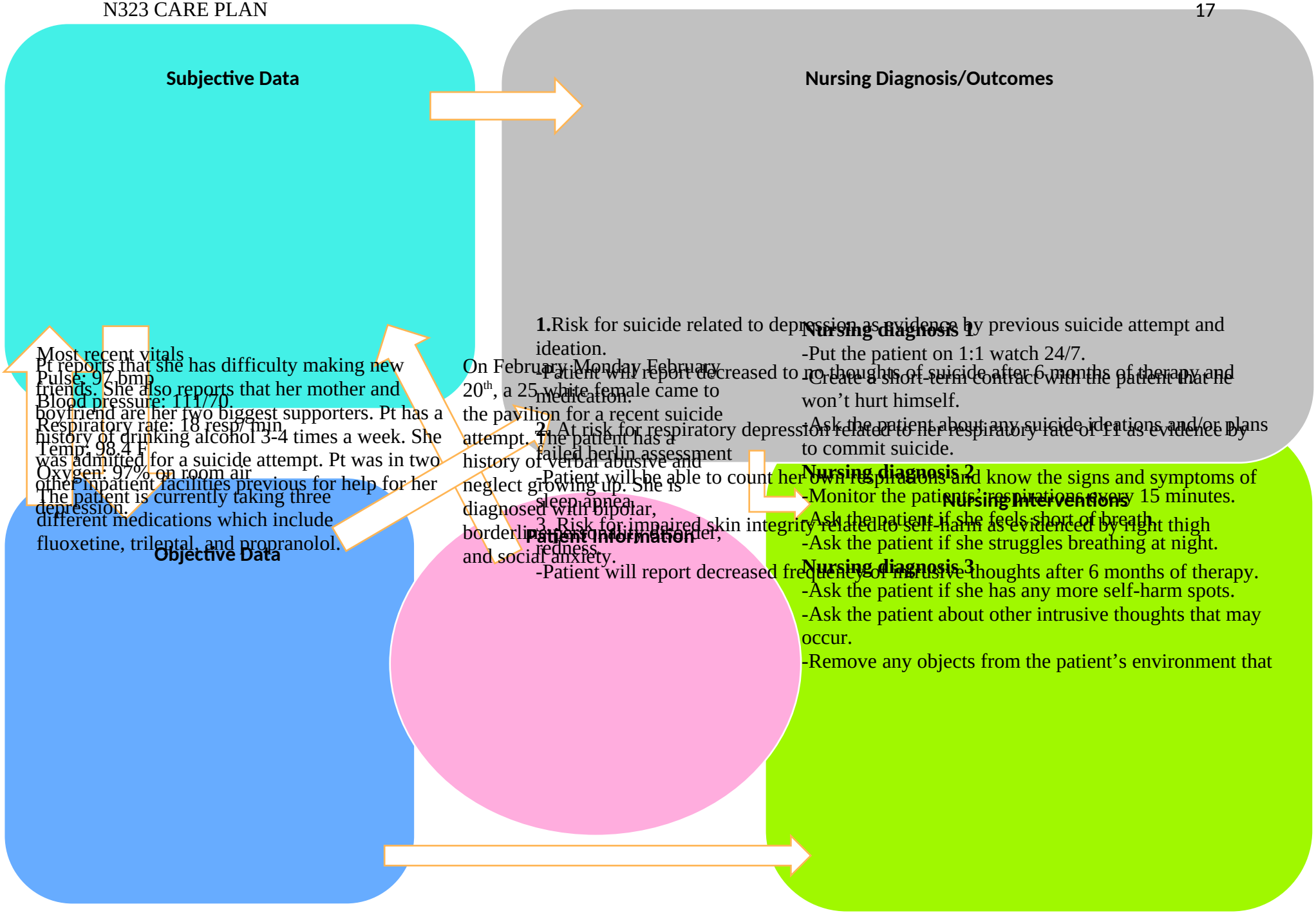
components				
1. Risk for suicide related to depression as evidence by previous suicide attempt and ideation.	The patient has a history of two suicide attempts.	**1.** Put the patient on 1:1 watch 24/7. **2.** Create a short-term contract with the patient that he won't hurt himself. **3.** Ask the patient about any suicide ideations and/or plans to commit suicide.	**1.**Use direct, non-judgmental communication with the patient. **2.** Continue to supervise the patient every 15 minutes. **3.** Monitor the patient when administering medications.	**1.** Provide the patient resources for any crises that might arise. **2.** Ensure the patient is referred to a psychiatrist. **3.** Ensure the patient has a therapist/counselor to regularly visit after discharge.
2. At risk for respiratory depression related to her respiratory rate of 11 as evidence by failed berlin assessment.	Patients respiratory rate was 11.	1. Monitor the patients' respirations every 15 minutes. 2. Ask the patient if she feels short of breath. 3. Ask the patient if she struggles breathing at night.	1. Continue to monitor the patients' respirations every 15 minutes. 2.Watch the patient closely for any other signs. 3. Monitor patient closely when walking.	1. Educate the patient on how to count her own respirations. 2.Educate patient about sleep apnea and the signs and symptoms. 3.Educate the patient on when to call for help
3. Risk for impaired skin integrity related to self-harm as evidenced by right thigh redness.	The patient has several marks from self-harm on her right thigh.	1. Ask the patient if she has any more self-harm spots. 2. Ask the patient about other intrusive thoughts that may occur.	1. Continue to supervise the patient every 15 minutes. 2. Watch the patient closely when using the bathroom. 3. Assess the	1. Educate the patient on how to handle intrusive thoughts. 2. Ensure the patient has a therapist that specializes in intrusive thoughts and how to cope.

		3. Remove any objects from the patient's environment that can be used to harm others.	patient for intrusive thoughts and the content of them.	3. Ensure the patient is referred to a psychiatrist.

Other References (APA):

Phelps, L. L. (2020). Sparks and Taylor's Nursing Diagnosis Reference Manual (11th ed.). Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Pt reports that she has difficulty making new friends. She also reports that her mother and boyfriend are her two biggest supporters. Pt has a history of drinking alcohol 3-4 times a week. She was admitted for a suicide attempt. Pt was in two other inpatient facilities previous for help for her depression.
The patient is currently taking three different medications which include fluoxetine, trilental, and propranolol.
Objective Data
Most recent vitals
Pulse: 97 bmp
Blood pressure: 111/70
Respiratory rate: 18 resp/7 min
Temp: 98.4 F
Oxygen: 97% on room air
Patient Information
On February Monday February 20th, a 25 white female came to the pavilion for a recent suicide attempt. The patient has a history of verbal abusive and neglect growing up. She is diagnosed with bipolar, borderline personality disorder, and social anxiety.
Nursing Diagnosis/Outcomes
1.Risk for suicide related to depression as evidence by previous suicide attempt and ideation.
-Patient will report decreased to no thoughts of suicide after 6 months of therapy and medication.
2. At risk for respiratory depression related to her respiratory rate of 11 as evidence by
-Patient will be able to count her own respirations and know the signs and symptoms of sleep apnea.
3. Risk for impaired skin integrity related to self-harm as evidenced by right thigh redness.
-Patient will report decreased frequency of intrusive thoughts after 6 months of therapy.
Nursing Interventions
Nursing diagnosis 1
-Put the patient on 1:1 watch 24/7.
-Create a short-term contract with the patient that he won't hurt himself.
-Ask the patient about any suicide ideations and/or plans to commit suicide.
Nursing diagnosis 2
-Monitor the patients' respirations every 15 minutes.
-Ask the patient if she feels short of breath.
-Ask the patient if she struggles breathing at night.
Nursing diagnosis 3
-Ask the patient if she has any more self-harm spots.
-Ask the patient about other intrusive thoughts that may occur.
-Remove any objects from the patient's environment that