N323 Care Plan

Lakeview College of Nursing

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Doctor Backlin

Demographics (3 points)

Date of Admission 4-4-2023	**Patient Initials** M.M	**Age** 42	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Married	**Allergies** No known
Code Status Full code	**Observation Status** Voluntary	**Height** 5'8	**Weight** 175 lbs.

Medical History (5 Points)

Past Medical History: Status post cholecystectomy

Significant Psychiatric History: Patient has never consulted a psychiatrist, never was hospitalized, never received outpatient treatment. Denies any suicide attempts, she was treated with Zoloft, and amitriptyline.

Family History: noncontributory for psychiatric problems or substance use problems.

Social History (tobacco/alcohol/drugs): patient is married, lives with her family (husband, and kids), she is a social worker, she has 3 children.

Living Situation: lives with husband and 2 of her kids (sons).

Strengths: patient stated that being a mom to her kids and working are her strengths.

Support System: patient stated that her family and friends are her support system.

Admission Assessment

Chief Complaint (2 points): "I'm stressed out."

Contributing Factors (10 points):

Factors that lead to admission: She reports herself to the emergency room on March 30th, 2023 for evaluation. During her visit to the emergency room, she referred to outpatient services, however, the appointment was later cancelled, she went again and finally was admitted

to the pavilion. The patient reports feeling guilty with things in the past, the patient report history of postpartum depression, which leads to mood swings. Reports episodes of racing thoughts, irritability, and anger. The patient admits to having auditory hallucinations, she's paranoid, was having flash backs, and nightmares related to her abortion. Patient also admitted to a history of suicidal thoughts but had no plan or intensions.

History of suicide attempts: patient has had suicidal thoughts, there was no intension or plan.

Primary Diagnosis on Admission (2 points): Bipolar type 1 psychotic features**.**

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: patient stated there was no lifetime experiences of trauma. Witness of trauma/abuse: Patient stated she has not witnessed any trauma or abuse.				
	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	Denies	N/A	N/A
Neglect	Denies	11 yrs-old-18 yrs-old	N/A	Mom and dad use to work a lot so patient felt her and her brother wasn't getting attention during this period of time.
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	5 yrs ago	N/A	Grandmother passed away.
Other	N/A	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**		
Loss of energy or interest in activities/school	**Yes**	**No**		
Deterioration in hygiene and/or grooming	**Yes**	**No**		
Social withdrawal or isolation	**Yes**	**No**		
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient stated that she felt a lot of stress 5 years ago from working so much.	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	Close to 5 hours of sleep a day	

Difficulty falling asleep	**Yes**	**No**	
Frequently awakening during night	**Yes**	**No**	Can't sleep more than 3 to 4 hours throughout the night.
Early morning awakenings	**Yes**	**No**	Stated body is programed to wake up early.
Nightmares/dreams	**Yes**	**No**	Has nightmares of her past abortion, feels guilty she didn't keep the baby.
Other	**Yes**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	
Binge eating and/or purging	**Yes**	**No**	
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	
Use of laxatives or excessive exercise	**Yes**	**No**	
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient states she experience anxiety during the holidays from November to January.
Panic attacks	**Yes**	**No**	
Obsessive/compulsive thoughts	**Yes**	**No**	
Obsessive/compulsive behaviors	**Yes**	**No**	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	
Rating Scale			
How would you rate your depression on a scale of 1-10?	**0**		

How would you rate your anxiety on a scale of 1-10?	**1**

Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	5 years ago, patient started experience stress from overworking.
School	**Yes**	**No**	
Family	**Yes**	**No**	Patient stated that her family hovers a lot.
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
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
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?**	
Ryan	42	Husband	**Yes**	**No**
Jackson	14	son	**Yes**	**No**
Tyler	19	son	**Yes**	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain:				
Children (age and gender): has three children, but only two children live in the home with her. **Who are children with now?** at home with her husband**.**				
Household dysfunction, including separation/divorce/death/incarceration: patient admits that the death of her grandparents and her abortion has affected her mental health.				
Current relationship problems: patient states there are no relationship issues. **Number of marriages:** one.				
Sexual Orientation: Heterosexual	**Is client sexually active?** **Yes** **No**		**Does client practice safe sex?** **Yes** **No**	
Please describe your religious values, beliefs, spirituality and/or preference: patient states she grew up a Christian and that is still her religion.				
Ethnic/cultural factors/traditions/current activity: N/A				

Describe: N/A
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): patient denied any current/past legal issues.
How can your family/support system participate in your treatment and care? Patient stated family can support treatment by listening more to her saying she needed help.
Client raised by: **Natural parents:** Patient was raised by both parents, dad left when she was 12 but still was in her life. **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: patient stated her abortion has been a big impact on current illness.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic:** patient stated her dad worked a lot, and her and her brother spent a lot of time alone because of it**.** **Abusive** **Supportive** **Other:**
Self-Care: **Independent:** patient takes care of herself on her own. **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) patient stated she believes there is a history but know one has ever been diagnosed.
History of Substance Use: patient denies any substance use.
Education History:

Grade school **High school** **College:** patient has finished 2 years of college, patient stated she graduated. **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: patient stated no problems in school.
Discharge
Client goals for treatment: patient stated she wants to stay on her medication, and she wants to keep her stress level down.
Where will client go when discharged? Patient will go home with her family.

Outpatient Resources (15 points)

Resource	Rationale
1. mental health counselor	**1.** assess how the patient will respond to medications.
2. Carle psychiatrist	**2.** make sure the patient is taking medication correctly and as proscribes and how important it is to take medication.
3. Keri Powell therapy, Inc	**3.** provided with ways to cope with symptoms and find safe and healthy activities to relieve suicidal thoughts and actions.

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

The client was only taking 5 medications!!!

Brand/Generic	Olanzapine (Zyprexa Relprevv)	Nicotine (NicoDerm CQ)	Trazodone (Desyrel)	Ouetapine (Seroquel)	Hydroxyzine (Atarax)	
Dose	5 mg	21 mg	50 mg	200 mg	50 mg	
Frequency	Q8H	Daily	at bedtime	At bedtime	Q6H/ PRN	
Route	Oral	Transdermal	Oral	Oral	Oral	
Classification	Antipsychotic	Smoking cessation adjunct	Antidepressant	Antipsychotic	Anxiolytic, antiemetic, antihistamine, sedative-hypnotic.	
Mechanism of Action	May achieve antipsychotic effects by antagonizing dopamine and serotonin receptors. Anticholinergic effects may result from competitive binding to and antagonism of the	Binds selectively to nicotinic-cholinergic receptors at autonomic ganglia, in the adrenal medulla, at neuromuscular junctions, and in the brain. By providing a lower dose of nicotine than cigarettes, this	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect.	May produce antipsychotic effects by interfering with dopamine binding to dopamine type 2 (D2)-receptor sites in the brain and by antagonizing serotonin 5-HT2, dopamine type 1 (D1), histamine H1, and adrenergic	Competes with histamine for histamine1 receptor sites on surfaces of effector cells. This suppresses results of histaminic activity, including edema,	

	muscarinic receptors M1 through M5.	drug reduces nicotine craving and withdrawal symptoms.		alpha1 and alpha2 receptors.	flare, and pruritus, sedative actions occur subcortical level of CNS and are dose related.	
Therapeutic Uses	To treat schizophrenia.	Smoking cessation for the relief of nicotine symptoms, including cravings.	Treat depression.	To treat schizophrenia.	Relieve anxiety.	
Therapeutic Range (if applicable)	20-40 ng/ml	N/A	0.5 – 2.5 mg/day	300-800 mg/day	50-100 mg/4 times a day.	
Reason Client Taking	Aggression	Nicotine withdrawals.	To treat insomnia	Mood stabilizer	Anxiety	
Contraindications (2)	Diabetes, Hypersensitivity to olanzapine or its components.	Hypersensitivity to nicotine or its components, including menthol or soy	Hypersensitivity to trazodone or its components, use within 14 days of an MAO inhibitor including intravenous methylene blue and linezolid.	Hypersensitivity to quetiapine and its components, diabetes.	Early pregnancy; hypersensitivity to cetirizine, hydroxyzine, levocetirizine or their component; prolonged QT interval.	
Side Effects/Adverse Reactions (2)	Suicidal ideations, hypotension.	Dizziness, arrhythmia.	Serotonin syndrome, Hypertension.	Abnormal dreams, hypothermia.	Seizures, hypersensitivity reactions.	
Medication/Food Interactions		Acidic beverages	Grapefruit juice	Antihypertensives	Antidepressants such as citalopram or fluoxetine.	
Nursing Considerations	Monitors patients	Emphasizing the patient	Use trazodone cautiously in	Monitor patient for prolonged	Observe for oversedatio	

(2)	blood pressure routinely during therapy because olanzapine may cause orthostatic hypotension. Assess daily weight to detect fluid retention or metabolic changes.	must stop smoking as soon as nicotine treatment starts to avoid toxicity. Advise patient to notify prescriber about other conditions or drugs client is taking.	patients with cardiac disease. Closely monitor depressed patients for suicidal thoughts and tendencies.	abnormal muscle contractions, especially during the first few days of quetiapine therapy, in male patients and in younger patients. Assess patient for hypothyroidism because drug can cause dose-dependent decreases in total and free thyroxine (T4) levels.	n if patient takes another CNS depressant. Tell patient capsules and tablets should be swallowed whole and not chewed, crushed, or split/opened .	

Brand/Generic	**N/A**				
Dose	**N/A**				
Frequency	**N/A**				
Route	**N/A**				
Classification	**N/A**				
Mechanism of Action	**N/A**				
Therapeutic Uses	**N/A**				
Therapeutic Range (if	**N/A**				

applicable)					
Reason Client Taking	**N/A**				
Contraindications (2)	**N/A**				
Side Effects/Adverse Reactions (2)	**N/A**				
Medication/Food Interactions	**N/A**				
Nursing Considerations (2)	**N/A**				

Medications Reference (1) (APA):

Jones & Bartlett Learning, (2023). Nurse's Drug Handbook (22nd ed.). Jones & Bartlett

Mental Status Exam Findings (20 points)

APPEARANCE:	Patient is clean and well-groomed.
Behavior:	Happy, calm and engaging.
Build:	Tall and lean built.
Attitude:	Positive attitude.
Speech:	Presented with no speech impairment.
Interpersonal style:	Honest and open.
Mood:	Calm good mood.
Affect:	Calm affect.

MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient didn't present with any ideations, delusions, illusions, obsessions, compulsions, or phobias. Patient presented positive thinking and wanted to do better going forward.
ORIENTATION: **Sensorium:** **Thought Content:**	The client is A&O x4 Sensorium was not assessed. Thinking was logical.
MEMORY: **Remote:**	Long term and short-term memory intact
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 Judgement was good, and intact Not assessed Normal for age Not assessed Average impulse control/ Normal
INSIGHT:	Insight was seen to be normal.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Normal gate. No assistive devices used. Good and relaxed posture. Normal for age. Appropriate for age. Good motor movement/ appropriate for age.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10:00 am	86	144/91	18	97.3	99
5:00 pm	84	161/91	18	98.1	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10:00 am	**0-10**	**N/A**	**N/A**	**N/A**	**N/A**
5:00 pm	**0-10**	**N/A**	**N/A**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: 100% **Breakfast: 100%** **Lunch: 100%** **Dinner: N/A**	Oral Fluid Intake with Meals (in mL) Breakfast: 240 mL Lunch: 240 mL Dinner: N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The treatment I think is best for the patient is that she's able to maintain another job that's less stressful and healthy for her mental health. Patient should also follow up with healthcare provider to follow up with discharge treatment, and make sure to follow the prescribed treatment by the provider. Patient should go to support groups and check in with your support system when patient is experiencing symptoms and should talk about her stressors. Patient should call the national hotline when patient needs help or assistance.

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. At risk for suicide related to depression as evidence by passive suicidal thoughts	I chose this diagnosis because patient has a history of suicidal thoughts	1. ask if the client has a plan to hurt themselves or others. 2. remove all objects or medication that can harm them 3. one to one suicide watch/ treatment.	1. perform safety evaluations every 15 minutes. 2. assess the clients thought process 3. encourage the client to talk about their stressors	1. make sure the client has someone to live that's save and healthy. 2. make referrals to support groups and provide the suicide hot line 3. educate the client on how to deal with stress and suicidal thoughts.
2. Ineffective individual coping related to ineffective problem-solving strategies/ skills as evidence by patient admitting she hasn't delt with past grief from abortion.	I chose this diagnosis because patient stated she hasn't been able to get over having an abortion.	1. assess the patient's cognitive function, including attention, memory, and decision-making skills 2. ask the client what their triggers are to help not bring up something that's hurtful to the client 3. assure the client this is a safe environment for the client to open	1. encourage the client to communicate openly about their feelings and concerns and provide a nonjudgmental and supportive environment. 2. redirect the clients' thinking process by finding something else for them to talk about.	1. make referrals to go to a support group in a safe and nonjudgmental environment to talk about past grief. 2. encourage the client to talk with a therapist for ongoing treatment if this is still a stressor for them. 3. teach self-healing

		up and have support	3. maintain a low level of stimuli in the client's environment	techniques.
3. Risk for injury related to psychotic feature with diagnosis of bipolar type 1 disorder as evidence by patient hanging out of a moving car window yelling and suicidal thoughts	I chose this diagnosis because patient stated she was hanging out a moving care yelling and because the patient has suicidal thoughts	1. Remove all things to harm the patient or assist them in doing extreme harmful activities. 2. Ask the patient do they have a plan or have ever thought about harming themselves. 3. Assess the clients thought process for why doing extreme activities is okay for them.	1. Redirect violent behavior. 2. Work with the client to develop a safety plan that includes methods to manage mood swings and prevent injury. 3. Encourage the client to engage in activities that are safe and structured, such as exercise or creative activities.	1. Encourage clients to follow up with doctor. 2. Find activities that are safe and are healthy. 3. Provide resources to the client.

Other References (APA): Sparks & Taylors, (2020). Nursing Diagnosis Reference Manual (11th ed.). Linda Lee Phelps

Concept Map (20 Points):

Subjective Data

- Client stated, “she wants to decrease her stress level.”
- The client stated, “she knows she needs to do better, and she wants to.”
- Client stated, “she wants to find another job that doesn’t feel overwhelming.”
- Client stated, “She wants to be better for her kids and she doesn’t want to them be like her.”

Objective Data

- Clients Blood pressure was elevated when I took her vitals.
- 10am- BP- 144/91
- 5 pm- BP- 161/91
- The patient took their medication.
- Patient did activities in group and was engaged.

Patient Information

Date of admission: 04-04-2023
Patient Initials: M.M
Age: 42
Gender: Female
Race: Caucasian
Occupation: social worker
Marital Status: Married
Allergies: No Known
Code Status: full code
Observation status: Voluntary
Height: 5’8 Weight: 175 lbs.

Nursing Diagnosis/Outcomes

1. At risk for suicide related to depression as evidence by passive suicidal thoughts
   - Outcome: patient is stating they want to live and is refraining from having suicidal thought of harming herself.
2. Ineffective individual coping related to ineffective problem-solving strategies/ skills as evidence by patient admitting she hasn’t delt with past grief from abortion.
   - Outcome: patient find health coping habits.
3. Risk for injury related to psychotic feature with diagnosis of bipolar type 1 disorder as evidence by patient hanging out of a moving car window yelling and suicidal thoughts.
   - Outcome: found safe and affective activities that’s beneficial to health.

Nursing interventions

- ask if the client has a plan to hurt themselves or others.
- remove all objects or medication that can harm them.
- one to one suicide watch/ treatment.
- perform safety evaluations every 15 minutes.
- assess the clients thought process.
- encourage the client to talk about their stressors.
- make sure the client has someone to live that’s save and healthy.
- make referrals to support groups and provide the suicide hot line.
- educate the client on how to deal with stress and suicidal thoughts.
- assess the patient’s cognitive function, including attention, memory, and decision-making skills.
- ask the client what their triggers are to help not bring up something that’s hurtful to the client.
- encourage the client to communicate openly about their feelings and concerns and provide a nonjudgmental and supportive environment.
- redirect the clients’ thinking process by finding something else for them to talk about.
- make referrals to go to a support group in a safe and nonjudgmental environment to talk about past grief.
- encourage the client to talk with a therapist for ongoing treatment if this is still a stressor for them.
- Remove all things to harm the patient or assist them in doing extreme harmful activities.
- Ask the patient do they have a plan or have ever thought about harming themselves.
- Assess the clients thought process for why doing extreme activities is okay for them.
- Redirect violent behavior.
- Work with the client to develop a safety plan that includes methods to manage mood swings and prevent injury.
- Encourage the client to engage in activities that are safe and structured, such as exercise or creative activities.