N323 Care Plan

Lakeview College of Nursing

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Professor Dr. Backlin

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
4/12/2023	KS	18	F
Race/Ethnicity Caucasian Non-Hispanic/Latino	**Occupation** Part-time server	**Marital Status** Single	**Allergies** No known allergies
Code Status Full Code	**Observation Status** Inpatient	**Height** 5'7"	**Weight** 116 lbs.

Medical History (5 Points)

Past Medical History: Patient has no past medical history

Significant Psychiatric History: N/A

Family History: Father-diabetes mellitus. Her father's mother had a suicide attempt before with no diagnosed psychiatric history. Her mother's brother committed suicide, unknown date, or history. No other history noted.

Social History (tobacco/alcohol/drugs): No drug or tobacco use, including smokeless tobacco. Patient stated she does drink alcohol on occasion. Alcohol use is every month or less and only 3-4 drinks, never exceeding 6 drinks. Last use of alcohol was 2 weeks ago.

Living Situation: Patient lives at home with her mother and father in her childhood home. She has 2 brothers and 2 sisters that live there as well.

Strengths: Patient stated her strengths were "good physical health" and she feels as if she is a supportive friend and very dependable.

Support System: Her mother is very supportive, and she has a good family that is really close. She stated she feels like she has limited support recently due to her "own choices".

Admission Assessment

Chief Complaint (2 points): Drug overdose

Contributing Factors/ Factors that lead to admission: (10 points): The patient stated she has been feeling depressed and overwhelmed for around the last year. The day of admission, her boyfriend broke up with her and this was a big contributing factor. She had been with her boyfriend for 7 months and she felt as if she "gave everything" to him and was always supporting him. She stated her boyfriend breaking up with her really "sent her over the edge", which then caused her to take 20-30 Tylenol and sent to the emergency room.

History of suicide attempts: This is her first suicide attempt (04/12/2023, drug overdose)

Primary Diagnosis on Admission (2 points): Major depressive disorder, single episode unspecified.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse: N/A**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**None**	**None**	**N/A**	**N/A**
Sexual Abuse	**None**	**None**	**N/A**	**N/A**
Emotional Abuse	**None**	**None**	**N/A**	**N/A**
Neglect	**None**	**None**	**N/A**	**N/A**
Exploitation	**None**	**None**	**N/A**	**N/A**
Crime	**None**	**None**	**N/A**	**N/A**

Military	**None**	**None**	**N/A**	**N/A**
Natural Disaster	**None**	**None**	**N/A**	**N/A**
Loss	**None**	**None**	**N/A**	**N/A**
Other: Car wreck	December (5 months ago).	18	Depression and anxiety.	The client stated she left work, and her boyfriend was drinking with her best friend, and believes he cheated on her. Her boyfriend and best friend were in a car wreck and the client went to the scene and she stated her boyfriend was "DOA and then came back". She stated she went to the hospital and has supported him and "gave all of herself" to him.

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Patient has been feeling depressed over the last year, she stated in December, it got worse. She stated "it hasn't really gone away; I could just deal with it"
Loss of energy or interest in activities/school	**Yes**	**No**	She has increased loss of interest and energy when stressed. This has been over the past 6 months. She said she still earns good grades in school but at times it is very challenging to be motivated.
Deterioration in hygiene and/or grooming	**Yes**	**No**	**N/A**
Social withdrawal or isolation	**Yes**	**No**	**N/A**
Difficulties with	**Yes**	**No**	The patient does not have problems with

home, school, work, relationships, or responsibilities			school or work, just decreased motivation and effort. She does know that her family does not like her boyfriend and stated how she thinks her relationship with some of them has changed. Also, her suicide attempt was due to her boyfriend breaking up with her.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**N/A**
Difficulty falling asleep	**Yes**	**No**	Patient stated "I feel as if my mind is racing" which makes it difficult to fall asleep at times, not every night but a few times a week. She said if she had a bad day and is very anxious, this is usually when she feels like she can't stop "overthinking"
Frequently awakening during night	**Yes**	**No**	Every once in a while, she will wake up in the middle of the night and not be able to fall asleep, she stated this does not happen very often.
Early morning awakenings	**Yes**	**No**	**N/A**
Nightmares/dreams	**Yes**	**No**	**N/A**
Other	**Yes**	**No**	**N/A**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	The patient normally only eats one meal a day, but with her increased feelings of being anxious, she doesn't eat at all. She stated while being an inpatient at the pavilion she has ate 3 meals a day which is very unusual for her.
Binge eating and/or purging	**Yes**	**No**	**N/A**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**N/A**
Use of laxatives or excessive exercise	**Yes**	**No**	**N/A**

Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	She bites her nails, shakes legs picks at her face when really anxious and overwhelmed.
Panic attacks	**Yes**	**No**	**N/A**
Obsessive/ compulsive thoughts	**Yes**	**No**	**N/A**
Obsessive/ compulsive behaviors	**Yes**	**No**	**N/A**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	The patient stated how her work ethic and wanting to be at school and the amount of effort she puts in has significantly decreased.
Rating Scale			
How would you rate your depression on a scale of 1-10?	4		
How would you rate your anxiety on a scale of 1-10?	6		
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**	**N/A**
School	**Yes**	**No**	She has a decreased effort in schoolwork and school seems to be causing her more stress.
Family	**Yes**	**No**	**N/A**
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	She has wanted to be alone or with her boyfriend for the past 7 months while dating. She stated how she does think this is a problem and not normal.
Financial	**Yes**	**No**	**N/A**
Other	**Yes**	**No**	**N/A**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/ MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
Unknown dates- Counseling. Only went 3 times, last time was one month ago.	**Inpatient Outpatient Other: Therapist**	**Outpatient**	**Depression/ Anxiety**	**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?**	
Mother- JS	43	Daughter	**Yes**	**No**
Father-MS	46	Daughter	**Yes**	**No**
2 Sister's- KS	16 and 13	Sister	**Yes**	**No**
2 Brother's-KS	26 and 20	Sister	**Yes**	**No**

N/A	**N/A**	**N/A**	**Yes**	**No**

If yes to any substance use, explain: She stated her father will occasionally drink alcohol, not very often and only a drink or two.

Children (age and gender): None

Who are children with now? N/A

Household dysfunction, including separation/divorce/death/incarceration: None

Current relationship problems: Her boyfriend of 7 months broke up with her on the day of suicide attempt and admission (4/12).

Number of marriages: No marriages

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

Please describe your religious values, beliefs, spirituality and/or preference: Spiritual with no specific religion or practice.

Ethnic/cultural factors/traditions/current activity: Her family gets together for holidays to play games and her household takes a family vacation each year. They usually have family reunions every summer. She comes from a close family as she has described. No specific cultural factors noted or specified.

Describe: They play games and "have fun".

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

How can your family/support system participate in your treatment and care? "Just listen and be there, as always"

Client raised by: Mother and Father

Natural parents **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: N/A
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Her mother's brother had committed suicide, date unknown. Her father's mom had a suicide attempt, with an unknown date.
History of Substance Use: She has drank alcohol before with friends, but she stated, "not like crazy or often", no other substance uses or history of substance use.
Education History: **Grade school** **High school** **College** **Other:** Patient is in 12th grade
Reading Skills: **Yes** **No** **Limited**

Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: To love herself more and to learn how to cope with things.
Where will client go when discharged? Home with family and parents.

Outpatient Resources (15 points)

Resource	Rationale
1. Bodhi Counseling and Consulting	1. To help the client continue to make new adaptive cognitive and behavioral patterns**.**
2. Depression and Bipolar Support Alliance (DBSA)- Sten Johansen	2. Family support and consumer support for those with mental illness.
3. Mental health support and crisis text hotline	3. This is important for the patient to have a resource that is available 24/7. The client has friends and family and the therapist and support groups recommended, but this resource is available whenever the client is needing to talk.

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

Brand/Generic	Desogen/ desogestrel	Prozac/ fluoxetine	Tylenol/ acetaminophen	Titralac/Calcium carbonate	

	and ethinyl estradiol	hydrochloride			
Dose	0.15 mg-0.03 mg tablet	10 mg- ½ tab= 5mg	650 mg	750 mg	
Frequency	1x daily	1x daily	Every 6 hours PRN	Every 6 hours PRN	
Route	Oral	Oral	Oral	Oral	
Classification	Estrogen and progestin hormone, contraceptives	Selective serotonin reuptake inhibitor (SSRI), antidepressant	Nonsalicylate, para-aminophenol derivative, antipyretic, nonopioid analgesic	Calcium salts, antacid, antihypermagnesemic, antihyperphosphatemic, antihypocalcemic, calcium replacement, cardiotonic	
Mechanism of Action	"Desogestrel enters the cell passively and acts by binding selectively to the progesterone receptor and generating low androgenic activity. Its binding produces an effect like a transcription factor and thus, it produces modifications in the mRNA synthesis.	"Selectively inhibits reuptake of the neurotransmitter serotonin by CNS neurons and increases the amount of serotonin available in nerve synapses" (Jones & Bartlett Learning, 2021).	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E" (Jones & Bartlett Learning, 2021).	"Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems" (Jones & Bartlett Learning, 2021).	

	The active metabolite of desogestrel, etonogestrel, presents a combination of high pregestational activity with minimal intrinsic androgenicity" (Jones & Bartlett Learning, 2021).				
Therapeutic Uses	Prevent pregnancy, make periods regular, decrease blood loss and painful periods, decreases risk of ovarian cysts, and can treat acne (Jones & Bartlett Learning, 2021).	"to treat acute depression, to provide maintenance therapy for depression, to treat acute obsessive-compulsive disorder (OCD), to treat moderate to severe bulimia nervosa, to treat acute panic disorder with or without agoraphobia, as adjunct to treat acute depressive episodes associated with bipolar I disorder, as adjunct to	"to relieve mild to moderate pain, to manage moderate to severe pain with adjunctive opioid analgesics, to reduce fever" (Jones & Bartlett Learning, 2021)	To treat hyperphosphatemia, to prevent hypocalcemia with oral supplementation, to provide antacid effects, to provide emergency treatment for acute symptomatic hypocalcemia, as adjunct to treat magnesium intoxication, to treat arrhythmias associated with hyperkalemia, hypermagnesemia, or hypocalcemia, to treat beta-blocker overdose that is refractory to glucagon and high dose vasopressor treatment" (Jones & Bartlett Learning, 2021)	

		treat resistant depression, to treat premenstrual dysmorphic disorder" (Jones & Bartlett Learning, 2021)			
Therapeutic Range (if applicable)	N/A	10-20 mg daily	640 or 650 mg every 4 to 6 hours as needed. Maximum 3,250 mg (5 doses) in 24 hours	1,000-1,200 mg daily	
Reason Client Taking	Birth control	Major depressive disorder	Pain	GI upset	
Contraindications (2)	Headaches with focal neurological symptoms, severe hypertension	Concurrent therapy with pimozide or thioridazine, use within 14 days of MAO inhibitor therapy	Severe hepatic impairment, severe liver impairment	Hypercalcemia, hypophosphatemia, renal calculi	
Side Effects/Adverse Reactions (2)	Weight gain, breast tenderness	Altered platelet function, hyponatremia	Angioedema, insomnia	Hypotension, diaphoresis	
Medication/ Food Interactions	"Aromatase inhibitors, barbiturates, carbamazepine, hydantoins, corticosteroids, cyclosporine, insulin, hepatotoxic drugs, insulin, tamoxifen, thyroid	"Alprazolam, diazepam, anticonvulsants, aspirins, NSAIDs, warfarin, benzodiazepines, CNS depressants, buspirone, fentanyl, triptans, tricyclic antidepressants, MAO	"Anticholinergics, barbiturates, carbamazepine, hydantoins, isoniazid, rifampin, sulfinpyrazone dasatinib, imatinib, lamotrigine, oral contraceptives, propranolol, warfarin, zidovudine, alcohol" (Jones & Bartlett Learning, 2021)	"bisphosphonates, calcium supplements, digitalis glycosides, fluoroquinolones, iron salts, levothyroxine, tetracyclines, thiazide diuretics, verapamil, vitamin D, caffeine, high-fiber food, alcohol use, smoking" (Jones & Bartlett Learning, 2021)	

	hormone replacement, warfarin, Grapefruit juice" (Jones & Bartlett Learning, 2021)	inhibitors, olanzapine" (Jones & Bartlett Learning, 2021)			
Nursing Considerations (2)	Assess for melasma. Women with a history of depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.	Know patients with depression should be screened for bipolar disorder before this medication is started, expect to taper drug when getting discontinued	Calculate daily intake of acetaminophen including other products that may contain acetaminophen so maximum daily dosage is not exceeded, use cautious in patients with chronic malnutrition	Monitor serum calcium level, evaluate medications response by checking for Chvostek's and Trousseau's signs which shouldn't appear.	

Patient had no prior home medications besides the birth control. The patient is taking no other medications.

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. (2021). *2022 Nurse's Drug Handbook* (21st ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude: thin** **Speech: normal rate/rhythm** **Interpersonal style:** **Mood:** **Affect:**	The client was well-groomed and displayed calm and co-operative behavior. She is tall and slim with a positive attitude. Her speech was normal and fluent. She was open to discussion and displayed a euthymic mood with an appropriate affect showing some signs of being anxious.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The client denies any delusions, illusions, obsessions, compulsions, or phobias. The client stated they experienced suicidal ideations upon admission, but the ideations have subsided since admission to the Pavilion.
ORIENTATION: **Sensorium:**	The client is alert and oriented to person, place, time, and situation. The sensorium was

Thought Content:	functioning normally, besides the suicidal ideations upon admission.
MEMORY: **Remote:**	The short term and long term memory of the client was intact. She also denied memory impairment.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The client had normal judgement and intelligence for her age. She did seem to have some impulse control impairment due to the attempt at suicide, although she stated, “I know it was stupid and I wouldn’t do it again, I want to live”. Abstract reasoning and calculations not assessed at this time.
INSIGHT:	The client had normal insight.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The client’s gait and posture were normal. The client has an erect posture and defined muscle tone and normal motor movements. The client does not use assistive devices. Strength was not assessed but the client is in good physical health.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1340/ 1:20 pm	87 bpm	118/59	18	98.3 Temporal	100% Room air
1730/ 5:30 pm	83 bpm	110/54	18	97.6 Temporal	100% Room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1340/1:20 pm	Numeric 0-10	N/A	0	N/A	N/A
1730/5:30 pm	Numeric 0-10	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100% **Lunch:** 100% **Dinner:** Not assessed	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 240 mL **Lunch:** 480 mL **Dinner:** Not assessed

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient is going home with her mother, and they will go back to their house and join her father, two sisters and two brothers. I believe she doesn't need any home health needs, or any equipment needs. She will need support at home from her friends and family. She will follow up with therapy and her primary doctor. She will be provided with a journal to continue using at home, to write her thoughts and ideas down. She will see a therapist at least once a week until further improvement.

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 nursin	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**

	g diagnosis was chosen			
1. Ineffective individualized coping related to inadequate coping skills as evidence by attempt of suicide.	The client was admitted due to an attempt at suicide. The client didn't cope well with the thought of losing her boyfriend.	1. Creating a safe environment. 2. Remove belonging and personal items that can cause self-harm. 3. Go through mental assessment.	1. Observation of the client every 15 minutes. 2. Continuous reassessment and use of the PHQ-9. 3. Encourage participation in cognitive behavioral and group therapy.	1. Communication with her support person about her feelings. 2. Actively using the coping strategies learned, like deep breathing, journaling, etc. 3. Explore other coping strategies through others like group sessions, and friends or family.
2. Anxiety related to situational and maturational crisis as evidence by feeling of discomfort/helplessness.	The client stated that her increased anxiety has increased significantly recently.	1. Assess physical and behavioral symptoms of anxiety. 2. Assess anxiety triggers, situational and personal history included. 3. Establish and maintain a trusting relationship with	1. Maintain a calm, non-threatening manner while working with the client. 2. Administer SSRIs as ordered. 3. Encourage the client's participation in relaxation exercises.	1. Continue taking medication. 2. Follow up with primary provider. 3. Attend counseling sessions.

		the client.		
3. Disturbed sleep pattern related to nervousness as evidence by verbal reports of difficulty falling asleep.	The client stated she has a hard time falling asleep due to thinking about everything.	1. Assess client's sleep schedule, pattern and how many hours of sleep each night. 2. Take note of how long it takes the client to fall asleep. 3. Take note of observations of sleep-wake behaviors and the number of hours the client is asleep.	1. Inhibit the client from daytime naps unless needed. 2. Encourage the client to write in a journal regarding problems and the day before bed. 3. Help the client understand the main cause of sleeping difficulties.	1. Educate the client about the use of melatonin if needed. 2. Educate on relaxation activities before bed like warm baths and calm music avoiding the use of phones and television. 3. Encourage the client to go to sleep at the same time and wake up at the same time every day for consistency.

Other References (APA):

Swearingen, P. L. (2018). *All-in-one Nursing Care Planning Resource: Medical-surgical, Pediatric, Maternity, and Psychiatric-mental Health* (P. L. Swearingen & J. Wright, Eds.). Elsevier.

Concept Map (20 Points):

Subjective Data

The patient came from a loving home.
No history of physical, emotional, or sexual abuse.
No substance or tobacco use.
Last alcohol use 2 weeks ago
The attempted suicide was due to her boyfriend breaking up with her.
She rated her depression 4 on a scale 1-10 and anxiety 6.

Nursing Diagnosis/Outcomes

1.Ineffective individualized coping related to inadequate coping skills as evidence by attempt of suicide. / The client will state she feels comfortable with new coping techniques.
2.Anxiety related to situational and maturational crisis as evidence by feeling of discomfort/helplessness. / The client will appear relaxed and report anxiety is reduced to a manageable level.
3. Disturbed sleep pattern related to nervousness as evidence by verbal reports of difficulty falling asleep. / The patient will have an improved sleep experience.

Patient Information

KS
F
18
Caucasian
Full code
No known allergies
5'7"
116 lbs.
Part-time server
Inpatient at Pavilion

Objective Data

Pulse-83 bpm
BP 110/54
Temperature-97.6-Temporal.
Respirations 18
Oxygen saturation-100% Room air
She is 116 pounds and 5'7"
Female
Caucasian

Nursing Interventions

Creating a safe environment. Remove belonging and personal items that can cause self-harm. Go through mental assessment. Observation of the client every 15 minutes. Continuous reassessment and use of the PHQ-9. Encourage participation in cognitive behavioral and group therapy. Assess physical and behavioral symptoms of anxiety. Assess anxiety triggers, situational and personal history included. Establish and maintain a trusting relationship with the client Maintain a calm, non-threatening manner while working with the client. Administer SSRIs as ordered. Encourage the client's participation in relaxation exercises. Assess client's sleep schedule, pattern and how many hours of sleep each night. Take note of how long it takes the client to fall asleep. Take note of observations of sleep-wake behaviors and the number of hours the client is asleep. Inhibit the client from daytime naps unless needed. Encourage the client to write in a journal regarding problems and the day before bed. Help the client understand the main cause of sleeping difficulties.