N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
9/28/2023	K.L.	20 y.o.	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Server at Texas roadhouse	Single	No known drug allergies
Code Status	**Observation Status**	**Height**	**Weight**
Full	Inpatient, rounds every 15 minutes.	5’ 6.5”	134lbs.

Medical History (5 Points)

Past Medical History: No significant past medical history

Significant Psychiatric History: Depression, Mood disorder, Bipolar 1 disorder

Family History: Mother diagnosed with ADD/ADHD and bipolar disorder. Father diagnosed with unspecific mental health disorder. Maternal Grandfather and maternal uncle diagnosed with unspecified mental health disorder.

Social History (tobacco/alcohol/drugs): Patient reports no tobacco use, slight alcohol use, and patient reports substance use with THC, Benzodiazepine, and LSD regularly for a “few years”.

Living Situation: Patient lives in an apartment with her boyfriend and dog.

Strengths: Patient reports personal strengths are independent living skills, financial stability, family/social support, intellectual/cognitive skills.

Support System: Patient reports having a good support system with boyfriend and patient’s mother.

Admission Assessment

Chief Complaint (2 points): Patient felt “overwhelmed” and felt “everyone would be better without me”

Contributing Factors (10 points):

Factors that lead to admission: Patient is a college student pursing a nursing education. The patient reports that they feel they are experiencing frequent depression and anxiety. Patients mother is undergoing chemotherapy and finds this to be a difficult time for her family. The patient stated “I feel like all I do is hurt people with everything I say. Everyone would be better off without me.” The patient took twenty-eight Lamotrigine tablets in an attempt to committed suicide. The patient’s boyfriend found her in the bathroom crying and brought the patient to her parents’ house where the ambulance was called. The patient was taken to the emergency room and was monitored before being admitted to OSF for psychiatric care/treatment and continued monitoring.

History of suicide attempts: Patient attempted to commit suicide at the age of 15 by substance overdose. Patient also has history of self-harm and cutting themselves from ages 12-16 years old.

Primary Diagnosis on Admission (2 points): Bipolar 1 Disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient reports experiencing abuse in childhood from father, and abuse in relationships with partners. **Witness of trauma/abuse:** Patient reports witnessing abusing from father in childhood.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	Denies	During entire childhood.	N/A	Patient reports remembering experiencing physical abuse from previous relationships as well as family members.
Sexual Abuse	Denies	5 years old.	N/A	Patient reports being sexually abused at age 5 from her babysitters' son. Patient did not go into further detail.
Emotional Abuse	Denies	During entire childhood.	N/A	Patient reports remembering experiencing physical abuse from previous relationships as well as family members.
Neglect	N/A	N/A	N/A	N/A
Exploitation	N/A	N/A	N/A	N/A
Crime	Patient admits to using illegal	16 years old to current.	N/A	Patient reports participating in

	substances.			illegal substance use.
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	Denies	18 years old	N/A	Patient reports losing her maternal grandfather and maternal uncle to suicide.
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**	N/A
Loss of energy or interest in activities/school	**Yes**	**No**	Patient states they "do not feel like I have lost much interest, but I am very tired".
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
Social withdrawal or isolation	**Yes**	**No**	Patient reports they do have social interactions with friend's, but she experiences social anxiety and oftentimes prefers to be alone.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient reports that they feel as though their anxiety contributes to their difficulties with work and school. Patient did not want to further explain.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	N/A
Difficulty falling asleep	**Yes**	**No**	N/A
Frequently awakening during night	**Yes**	**No**	N/A
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**	N/A
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**	Patient states they often feel sweaty and nervous when experiencing anxiety.
Panic attacks	**Yes**	**No**	Patient reports that they do have anxiety attacks, but it is "situational".
Obsessive/compulsive thoughts	**Yes**	**No**	Patient reported that they are very obsessive over their appearance and if they do not look presentable, they will "just have a bad day".
Obsessive/compulsive behaviors	**Yes**	**No**	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient reports a impact on daily living or avoidance of situations because they feel anxious regarding confrontation and prefer not to address others.
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?	**0**		
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**	Patient states “I enjoy my job, but I am not good at interacting with my coworkers and that feels stressful.” Patient reported that they feel as though this is due to their anxiety and avoidance nature.
School	**Yes**	**No**	Patient states that school feels like a problematic area because she has been “feely very depressed” and “just missing a lot of classes.” Patient reports concern for being able to catch up in school upon discharge.
Family	**Yes**	**No**	Patient reports a good relationship with her mother but stated “sometimes we are good and sometimes we don’t get along”, patient would not give any information regarding relationship with her father.
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	Patient states “I do not always socialize because I feel like the things, I say just hurts others.” Patient reports not engaging in much social activity due to “being a burden to others.”
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
Week of 9/18/23	**Inpatient** **Outpatient** **Other:** Dr. Nzinga (Carle Psychiatrist)	Outpatient appointment	Depression and mood disorder.	**No improvement** **Some improvement** **Significant improvement**
Age 15 years old.	**Inpatient** **Outpatient** **Other:**	Inpatient admission	Suicide attempt by substance overdose	**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?**	
Nathan	20 years old	Boyfriend	**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: Patient reports her boyfriend uses the same substances she does, substances such as THC, benzodiazepines, and LSD.

Children (age and gender): N/A

Who are children with now? N/A

Household dysfunction, including separation/divorce/death/incarceration: Patient reports that she has never experienced separation/divorce/death/incarceration.

Current relationship problems: Patient states they "do not have any current relationship problems." Patient reports a good and "healthy" relationship and "supportive" partner.

Number of marriages: 0

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

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

Patient states "I believe there is something higher, but I don't know what. I believe in karma." Patient considers self to be "spiritual."

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): Patients reports illegal substance abuse but denies any other forms of legal issues. Patients parents are divorced, and the patient reports not having a very good relationship with her father but did not want to further explain.

How can your family/support system participate in your treatment and care? Patient believes her family and her boyfriend can be supportive by being "understanding and helping her through her treatment."

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness: Patient did not want to further explain.

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.)
History of Substance Use: hx THC, benzodiazepines, LSD
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient denies any problems in school.
Discharge
Client goals for treatment: Patient states she would "like to be better educated on my diagnosis and improve my mental health."
Where will client go when discharged? Patient will return home with her boyfriend.

Outpatient Resources (15 points)

Resource	Rationale
1. Depression and Bipolar support alliance (DBSA)	**1.** The patient has recently been diagnosed with bipolar 1 disorder and feels overwhelmed with this diagnosis. This support group can assist in providing the patient with proper information and assistance from others that have struggled in similar ways.
2. Carle Daytime Cancer Support Group	**2.** The patient reports feeling overwhelmed and scared due to her mother's diagnosis and current chemotherapy treatment. This support group and others like it may assist her in feeling less lonely, and better informed on coping mechanisms.
3. Carle psychiatrist in Champaign	**3.** The patient reports seeing a psychiatrist at Carle hospital. I think a continued use of this resource is crucial in the patient's treatment. The patient needs continued monitoring and treatment regarding bipolar 1 disorder.

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

Brand/Generic	lithium/ Lithobid	Hydroxyzine/ Atarax	Trazodone/ Desyrel	Zofran/ ondansetron	lorazepam/ Ativan
Dose	300 mg	50 mg	50mg	4mg	1mg
Frequency	2x daily	Every 6 hours PRN	Nightly PRN	Every 6 hours PRN	Every 6 hours PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic class: Alkali metal Therapeutic class: Antimanic (Jones&Bartlett, 2022).	Pharmacologic Class: Piperazine derivative Therapeutic Class: Anxiolytic, antiemetic, antihistamine, sedative-	Pharmacologic Class: Triazolopyridine derivative Therapeutic Class: Antidepressant (Jones&Bartlett, 2022).	Pharmacologic Class: Selective serotonin receptor antagonist Therapeutic Class: Antiemetic (Jones & Bartlett	Pharmacologic Class: Benzodiazepine Therapeutic Class: Anxiolytic Controlled substance schedule: IV (Jones&Bartlett, 2022).

		hypnotic (Jones&Bartlett , 2022).		Learning, 2022).	
Mechanism of Action	Enlarging presynaptic degradation of the catecholamine neurotransmitters hindering the freeing of the neuronal synapses and lessening postsynaptic receptor sensitivity (Jones&Bartlett, 2022).	Engages with histamine for histamine, receptor sets on surfaces of effector cells, resulting in the suppression of histamine activity (edema, flare, and pruritus'). Sedative actions take place at the subcortical level of CNS and are often dose correlated (Jones & Bartlett Learning, 2022).	Stops serotonin reuptake along the presynaptic neuronal membrane, this action allows an antidepressant effect. This medication applies an alpha-adrenergic blocking action and provides modest histamine blockage allowing this to react as a sedative effect (Jones&Bartlett, 2022).	Stops serotonin receptors in the chemoreceptor trigger zone and at vagal nerve terminals in the intestines. These steps assist in decreasing nausea and vomiting by keeping serotonin from releasing in the small intestine and stopping signals to the CNS (Jones&Bartlett, 2022).	May increase the power of gamma aminobutyric acid and inhibitory neurotransmitters by connecting to benzodiazepine receptors in cortical and limbic places of CNS. This helps command behaviors emotionally (Jones&Bartlett, 2022).
Therapeutic Uses	To assist in the treatment of patients with bipolar disorders.	To assist in controlling anxiety and tension related to emotional states.	To assist in treating depression.	To assist in controlling anxiety as well as nausea in patients.	Approved for short term treatment of anxiety disorders.
Therapeutic Range (if applicable)	1.0-1.5 mEq/L	50-100 mg	50-100 mg	4-8 mg	2-6 mg
Reason Client Taking	The patient is taking to treat mania episodes related to bipolar disorder.	Patient is taking for anxiety.	Patient is taking for depression.	Patient is taking for Nausea.	Patient is taking for anxiety.
Contraindications (2)	1.Do not give to patients with severe dehydration. 2.Do not give to patients receiving	1. Do not use in patients with disruptive heart rhythm. 2. May cause confusion which may	1.Do not use in patients with liver or kidney disease. 2.Do not use n patients with heart disease.	1.Do not administer to patients with heart disease. 2.Do not administers to patients with	1.Do not use in patients with respiratory depression. 2.Do not use in women that are pregnant (Jones

	diuretics (Jones&Bartlett, 2022).	increase the risk of patient injury (Jones & Bartlett Learning, 2022).	3.Do not use in patients with a bleeding or blood clotting disorder (Jones&Bartlett, 2022).	liver disease (Jones & Bartlett Learning, 2022).	& Bartlett Learning, 2022).
Side Effects/Adverse Reactions (2)	1.Seizures 2.Disorientation	1.Chest pain/discomfort 2.fast heartbeat	1.Constipation 2.Changes in appetite	1.Agitation 2.hypotension	1.drowsiness 2.dizziness
Medication/Food Interactions	1.ACE inhibitors 2.angiotension receptor blockers 3.diuretics 4.metronidazole 5.neuromusclar blockers	1.aclidinium 2.alcohol 2.amantadine 4.amphetamines	1.antipsychotics 2.gatifloxacin 3.class 3 antiarrhythmics 4. CYP3A4 inducers and inhibitors	1.carbamazepine 2.phenytoin 3.rifampin 4.tramadol	1.aminophylline 2.CNS depressants 3. fentanyl 4.clozpine
Nursing Considerations (2)	1.Monitor the patients' blood lithium level 2-3 times a week during the first month of treatment. 2.Be prepared for the provider to potentially decrease dosage after manic episodes has passed (Jones&Bartlett, 2022).	1. Monitor the patients for respiratory depression. 2. Monitor the patient for adverse reactions that may increase anxiety (Jones&Bartlett , 2022).	1. Monitor patient for increased depression or increased suicidal thoughts. 2. Monitor patients baseline liver function (Jones&Bartlett, 2022).	1.Monitor patient for hypokalemia or hypomagnesemia 2. Monitor patient for myocardial ischemia (Jones&Bartlett, 2022).	1.Monitor the patient's respiratory status. 2. If the patient is receiving long term treatment, monitor CBC, liver function tests and LDH (Jones&Bartlett, 2022).

Medications Reference (1) (APA):

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

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient appeared well-groomed and dressed in yellow scrubs provided by the hospital. The patient had recently showered and had just brushed her hair. The patient's behavior was cooperative and calm. The patient's attitude was positive and open. She had very well-formed speech. The patient was engaging in conversation, and talkative about some topics but did not seem to want to discuss any further topics referring to childhood but would discuss her current situation with her boyfriend. The patient had a positive and calm affect and mood during our conversation.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient denies any delusions, illusions, compulsions, or phobias. The patient reports that she did have suicidal ideation and did attempt to commit suicide. The patient also reports that she no longer wants to commit suicide. The patient also reports that she does feel like she obsesses over her appearance and wants to look presentable.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was A&Ox4 with very formal and logical thought content. The patient seemed to be thinking more positively and hopeful. .
MEMORY: **Remote:**	The patient reports with both short and long-term memory intact.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient appeared with reasonable and sound judgement. The patient seemed the have a proper level of intelligence. Calculations and abstraction were not assessed.
INSIGHT:	Insight was observed to be normal.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Patient does not have any assistive devices. The patient has a slumped posture, but muscle tone, strength, and motor movements appeared normal.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
2225	115	129/70	18	97.1F	96%
0700	78	112/69	18	97.3F	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
2225	0-10	N/A	0	N/A	N/A
0700	0-10	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 50% **Lunch:** N/A **Dinner:** N/A	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** N/A **Lunch:** N/A **Dinner:** N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient plans to go home with boyfriend after discharge. The patient already has an appointment scheduled to follow up with her psychiatrist at Carle Hospital following discharge. I think it would be beneficial to the patient to join a support group for family members of cancer patients. This may help the patient cope with her mother's illness and find comfort. I think the patient should continue to attend schedule psychiatry appointments and have proper resources regarding suicide prevention. The patient should also attend a substance abuse program in order to prevent the patient from continuing illegal drug use.

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

Nursing Diagnosis • Include full nursing	**Rational** • Explain why the nursing	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**

diagnosis with "related to" and "as evidenced by" components	diagnosis was chosen			
1.Risk for suicide related to bipolar disorder as evidence by suicide attempt.	The patient has a history of two suicide attempts prior to admission.	1.Assess the patient for suicidal ideation and/or plan to commit suicide. 2. Ensure the patient is being monitored appropriately 24/7. 3.Enage in a conversation with the patient ensuring the patient will not attempt any self-harm or suicide.	1.Continuous 15-minute checks on the patient. 2. Ensure the patient is following the treatment plan and taking medications as prescribed. 3. Use therapeutic communication with the patient.	1. Ensure that the patient has a follow-up visit scheduled with her psychiatrist. 2. Ensure the patient is as educated as needed and has a full understanding of the importance of treatment. 3. Provide the patient with all needed resources to seek additional assistance.
2.Risk for harming others related to harmful behavior as evidence by aggressive behavior during admission.	The patient was being admitted to the emergency department and was aggressive and violent with staff. The patient hit and bite staff members.	1. Question the patient and ask about any plans to harm others. 2. Speak to the patient about the negative effects of harming others. 3. Remove all objects and materials that could be utilized to hurt others.	1. Assess the patient for any continued intent to hurt others. 2.Continuous rounds on the patient every 15-minutes as indicated. 3. Use therapeutic communication with the patient regarding behaviors and coping with emotions without violence.	1. Provide education to the patient on how to cope and handle emotions without being violent towards others. 2.Provide continued education regarding the negative effect of harmful behavior. 3. Ensure the patient has resources to assist in better handling emotions, such

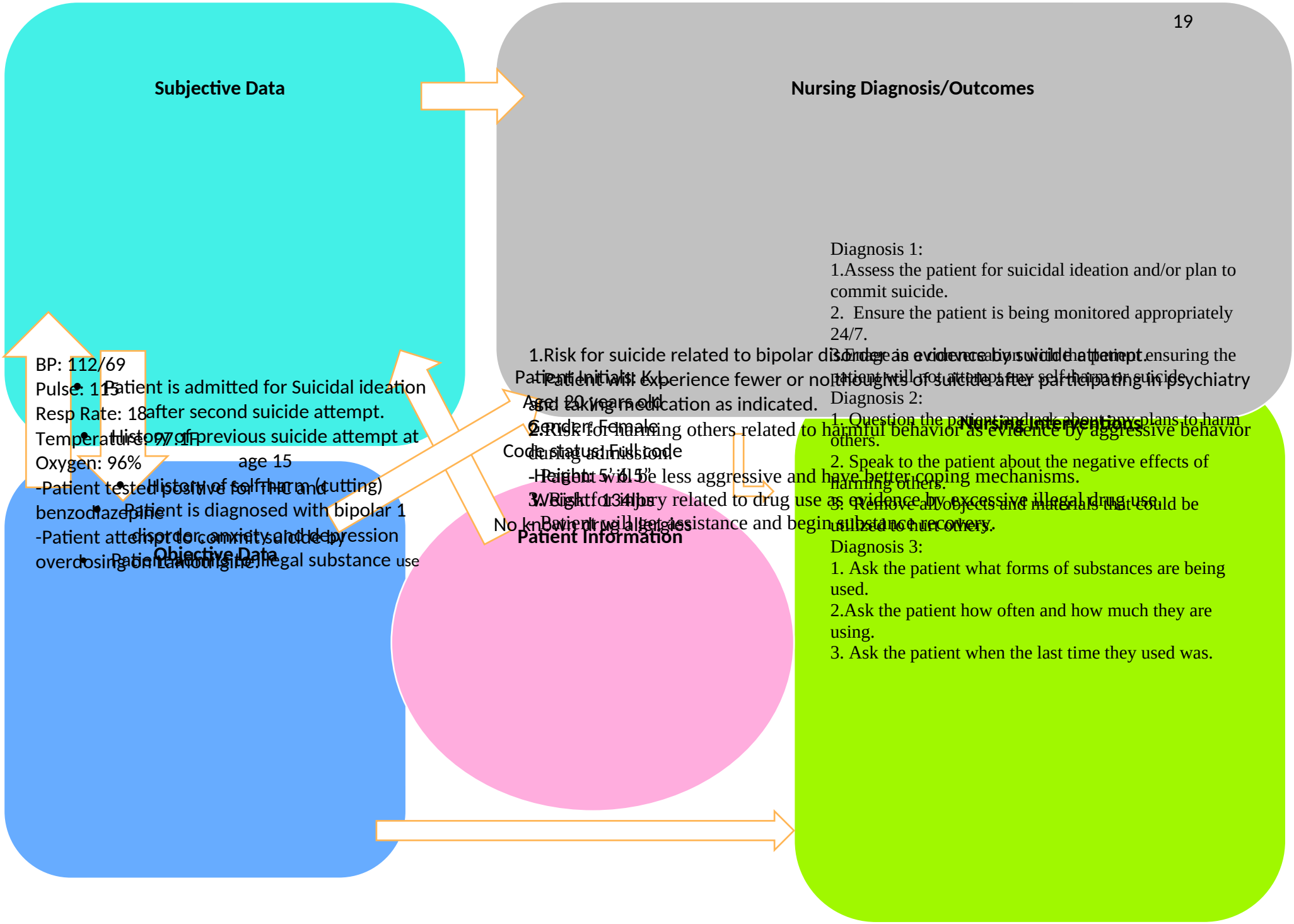
				as counseling groups or ensuring the patient attends a follow-up with her psychiatrist.
3. Risk for injury related to drug use as evidence by excessive illegal drug use.	The patient admits to using Illegal substances regularly for long periods of time.	1. Ask the patient what forms of substances are being used. 2.Ask the patient how often and how much they are using. 3. Ask the patient when the last time they used was.	1. Collect urine or blood test to test for substances in the patient to determine severity. 2. Assess the patient to determine if the patient may be experiencing withdrawal. 3. Provide the patient with other actives to occupy their desire for substance use.	1. Provide education to the patient on the potential risks for substance use. 2. Provide the patient with proper resources for substance recovery. 3. Educate the patient on overdose protocol and helpful guidance with overdoses.

Other References (APA):

Phelps, L.L. (2020). Spark's & Taylor's Nursing Diagnosis Reference Manual 11th ed. Essay.

Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Patient is admitted for Suicidal ideation after second suicide attempt.
History of previous suicide attempt at age 15
History of self-harm (cutting)
Patient is diagnosed with bipolar 1 disorder, anxiety and depression
Patient taking illegal substance use
Objective Data
BP: 112/69
Pulse: 115
Resp Rate: 18
Temperature: 97.1F
Oxygen: 96%
-Patient tested positive for THC and benzodiazepine
-Patient attempt to commit suicide by overdosing on Lamotrigine
Patient Information
Patient Initials: KL
Age: 20 years old
Gender: Female
Code status: Full code
-Height: 5'6.5"
-Weight: 134lbs
No known drug allergies
Nursing Diagnosis/Outcomes
1.Risk for suicide related to bipolar disorder as evidence by suicide attempt.
-Patient will experience fewer or no thoughts of suicide after participating in psychiatry and taking medication as indicated.
2.Risk for harming others related to harmful behavior as evidence by aggressive behavior during admission.
-Patient will be less aggressive and have better coping mechanisms.
3.Risk for injury related to drug use as evidence by excessive illegal drug use.
-Patient will get assistance and begin substance recovery.
Nursing Interventions
Diagnosis 1:
1.Assess the patient for suicidal ideation and/or plan to commit suicide.
2. Ensure the patient is being monitored appropriately 24/7.
3. Engage in a contract by suicide attempt ensuring the patient will not attempt any self harm or suicide.
Diagnosis 2:
1. Question the patient and ask about any plans to harm others.
2. Speak to the patient about the negative effects of harming others.
3. Remove all objects and materials that could be utilized to hurt others.
Diagnosis 3:
1. Ask the patient what forms of substances are being used.
2.Ask the patient how often and how much they are using.
3. Ask the patient when the last time they used was.