N323 Care Plan

Lakeview College of Nursing

Vanessa Jackson

Demographics (3 points)

Date of Admission 9/27/23	**Patient Initials** BB	**Age** 26	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Quality Inspector	**Marital Status** Single	**Allergies** Estrogens
Code Status Full	**Observation Status** Inpatient, q15 checks	**Height** 5’2	**Weight** 141 lbs.

Medical History (5 Points)

Past Medical History: Dry eye syndrome, prothrombin gene mutation (CMS-HCC), and sinus tachycardia.

Significant Psychiatric History: ADHD (no reported date), depression (no reported date), anxiety (no reported date).

Family History: Mother; lupus, diabetes, substance abuse. Father; schizophrenia and current substance abuse.

Social History (tobacco/alcohol/drugs): Alcohol; not currently using. Drugs; marijuana use 3x a week. Tobacco; None

Living Situation: Resides alone in her apartment.

Strengths: The patient is optimistic, a multi-tasker, critical thinker, and has independent living skills.

Support System: The patient recently lost her 15-year-old cat (April 2023) that was her primary form of support. She reports that she has friends in Bellflower.

Admission Assessment

Chief Complaint (2 points): Suicidal ideation and depression; “severe amount of loneliness”.

Contributing Factors (10 points):

Factors that lead to admission: The patient reports feelings of “severe amounts of loneliness”. She states that she cannot get her routines down around her apartment, and as a result it leaves her feeling distressed. Earlier this year, she had to euthanize her cat and it continues to weigh heavily on her. The patient also reports stress from her work/life and feels shame, but could not elaborate. She also reports having inconsistent sleep where she is waking up multiple times sweating. The patient also cares for her mother who is currently battling lupus. She says her mother is “difficult to deal with”, which makes it hard to take care of her.

History of suicide attempts: The patient denies any previous suicide attempts.

Primary Diagnosis on Admission (2 points): Depression

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient has experience **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**	Throughout childhood; then again at 23-26.	**N/A**	Patient reports having head trauma from a fall (bloody skull) and her parents never sought medical care. The patient was also involved

				in a “toxic” relationship that involved abuse.
Sexual Abuse	**Denies**	Intermittently during childhood, and again at 25.	**N/A**	Patient states her father was “sexually inappropriate” with her during childhood. The patient was sexually assaulted within the past year by an acquaintance.
Emotional Abuse	**Denies**	Throughout childhood; then again at 23-26.	**N/A**	Patient states she was emotionally abused by both parents during childhood. The patient was also involved in a “toxic” relationship that involved emotional abuse.
Neglect	**Denies**	Throughout childhood	**N/A**	Patient reports having head trauma from a fall (bloody skull) and her parents never sought medical care. Patient also states being left alone often as a child.
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	**Yes**	**Denies**	**N/A**	Earlier this year the patient had to euthanize her cat.
Other	**Denies**	**Denies**	**N/A**	**N/A**
Presenting Problems				

Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Patient reports constant loneliness and lack of motivation to get done what she needs to do.
Loss of energy or interest in activities/school	**Yes**	**No**	Patient states it is difficult to get out of bed every day.
Deterioration in hygiene and/or grooming	**Yes**	**No**	**Denies**
Social withdrawal or isolation	**Yes**	**No**	Patient reports “severe amounts of loneliness”. She says she has friends in Bellflower but sometimes feel like they are not really her friends.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient admits that her apartment is inhabitable because she has not taken care of it. She says she’s able to function at work and complete her duties there but that is it.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The patient reports only getting 2-4hrs of sleep a night.
Difficulty falling asleep	**Yes**	**No**	The patient reports constant difficulty falling asleep.
Frequently awakening during night	**Yes**	**No**	Patient reports waking up almost every hour during the night.
Early morning awakenings	**Yes**	**No**	**Denies**
Nightmares/dreams	**Yes**	**No**	**Denies**
Other	**Yes**	**No**	Patient reports waking up constantly in a sweat.
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	The patient reports an appetite disturbance (eating less).
Binge eating and/or	**Yes**	**No**	**Denies**

purging			
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**	The patient endorses the feeling of being "keyed-up".
Panic attacks	**Yes**	**No**	She reports only having 4 in her lifetime, but they did not begin until her 20's.
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**	She states her anxiety makes it difficult to do a task because she does not know where to start and that the task is too big.
Rating Scale			
How would you rate your depression on a scale of 1-10?		She reports it's usually at a 10, but since arriving to the facility it's at a 7.	
How would you rate your anxiety on a scale of 1-10?		Patient reports 5/10.	
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**	The patient says work has been stressful as of lately, but she still manages to complete her duties.
School	**Yes**	**No**	**Denies**
Family	**Yes**	**No**	The patient's mother is sick, so she is her primary caregiver. She states her mother is "difficult to deal with", which makes it harder to care for her.
Legal	**Yes**	**No**	**Denies**

Social	**Yes**	**No**	The patient feels that the constant social isolation is making her depression worse.
Financial	**Yes**	**No**	She states that her monthly car loan payments are stressing her especially because the car isn't even working. She said it makes her feel "down".
Other	**Yes**	**No**	**Denies**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
1/6/23	**Inpatient Outpatient Other: Heritage Behavioral Health**	**Outpatient**	Counselling for "passive thoughts of suicide but will not act on them".	**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?**	
N/A	**N/A**	**N/A**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): None **Who are children with now?** N/A				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: N/A **Number of marriages:** None				
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 reports she is a "spiritual being who lost her way".				
Ethnic/cultural factors/traditions/current activity: **Describe:** Christian but not actively practicing				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): None				
How can your family/support system participate in your treatment and care? Although the patient reports a dysfunctional relationship with her parents, she said they have agreed to help her clean out her apartment. (She stated several times her apartment is very chaotic and it's a burden on her because she does not know where to start).				
Client raised by:				

Natural parents; both mother and father **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: None
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other: "Imbalanced"**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Mother; severely anxious. Father; severe depression, schizophrenia, previous suicide attempts
History of Substance Use: The patient reports that her mother used to abuse "crack" but not currently using. She also reports that her father has always struggled with substance abuse and still is. His choice of drug according to the patient is "crack".
Education History: **Grade school** **High school** **College** **Other:** Some trade school for radiology
Reading Skills: **Yes** **No** **Limited**
Primary Language: English

Problems in school: She reports “blacking out” or “locking up” during exams. She said it led to her cheating on exams.
Discharge
Client goals for treatment: She wants to be able to organize her thoughts better and clean her home. She genuinely feels a cleaner environment will help her depression.
Where will client go when discharged? The patient will return to her apartment.

Outpatient Resources (15 points)

Resource	Rationale
1. Kurtz Counseling	1. There are two women therapists here that specialize in mental health and loss. They can teach the patient social and coping skills.
2. Suicide Intervention Team	2. The patient can contact this hotline at any time 24/7 if she has suicidal thoughts again and needs immediate help.
3. The American House Cleaners Association	3. This charity provides free & low-cost cleaning services to those in need (mental health included). This can provide the patient with a healthier environment.

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

Brand/Generic	**Desyrel / trazodone**	**Atarax / hydroxyzine**	**Ativan / lorazepam**
Dose	50 mg	50 mg	1 mg
Frequency	Daily; before bed	Daily; every 6 hrs.	Daily; every 6 hrs.
Route	Oral	Oral	Oral
Classification	Triazolopyridine derivative	Piperazine derivative	Benzodiazepine
Mechanism of Action	This medication inhibits serotonin reuptake on the presymnaptic neuronal membrane, causing an antidepressant effect. Trazadone utilizes an alpha-adrenergic blocking action and generates a histamine blockade, causing a sedative effect. It also inhibits the vasopressor response to norepinephrine, which reduces blood pressure.	This medication competes with histamine for histamine receptors on effector cells. In result, this suppresses histaminic activity; edema, flare, and pruritus.	This medication may potentiate the effects of GABA and other inhibitory transmitters that control emotional behavior.
Therapeutic Uses	Antidepressant	Anxiolytic	Anxiolytic
Therapeutic Range (if applicable)	0.5-2.5 μg/mL	50-100 mg	2-6 mg
Reason Client Taking	To treat the patient's depression.	To treat the patient's anxiety.	To treat the patient's anxiety.

Contraindications (2)	1. Hypersensitivity to trazadone or its components 2. If a MAO inhibitor was utilized within the past 14 days.	1. Early pregnancy 2. Hypersensitivity to hydroxyzine, cetirizine, levocetirizine or its components	1. Acute angle-closure glaucoma 2. Hypersensitivity to lorazepam, other benzodiazepines, or their components
Side Effects/Adverse Reactions (2)	1. Psychosis 2. Agitation	1. Hallucinations 2. Headache	1. Fatigue 2. Nervousness
Medication/Food Interactions	• Avoid alcohol • NSAID's • Any other antidepressants; phenytoin, St. John's wort, and tramadol • Diuretic • Blood thinners; warfarin • Migraine headache medicine; sumatriptan • MAO inhibitors	• Antibiotics • Antidepressants • Antipsychotics • Class IA & II antiarrhythmics • CNS depressants	• Valproate • Probenecid • Aminophylline • Theophylline • Medicine that contains antihistamine • Vitamins • Alcohol usage
Nursing Considerations (2)	1. Closely monitor depressed patients for suicidal thoughts and tendencies. 2. Beware that adverse CNS reactions usually improve after patient completes a few weeks of therapy.	1. Observe for over sedation if patient takes another CNS depressant 2. Use cautiously in patients with risk factors for QT prolongation.	1. Prior to starting lorazepam therapy in a patient with depression make sure they already take an antidepressant, because of the increased risk of suicide in patients with untreated depression. 2. Use cautiously in patients with a history of alcohol or drug abuse or a personality disorder because there is an increased risk of physical and psychological dependence.

Brand/Generic	**Zofran / ondansetron**	**Zyprexa / olanzapine**
Dose	4 mg	5 mg
Frequency	PRN	PRN
Route	Oral	Oral
Classification	5-HT3 receptor antagonist	Thienobenzodiazepine
Mechanism of Action	This medication blocks the actions of serotonin receptors that trigger nausea and vomiting.	This medication may achieve antipsychotic effects by antagonizing dopamine and serotonin receptors.
Therapeutic Uses	Antiemetic	Antipsychotic
Therapeutic Range (if applicable)	8-24 mg	5-20 mg
Reason Client Taking	To treat the patient's nausea	Agitation
Contraindications (2)	1. Concomitant use of apomorphine 2. Hypersensitivity to ondansetron or its components	1. Hypersensitivity to olanzapine or its components 2. If you are lactose-intolerant to Zypreza because it contains lactose
Side Effects/Adverse Reactions (2)	1. Restlessness 2. Anxiety	1. Nervousness 2. Insomnia
Medication/Food Interactions	• Tramadol • Phenytonin • Rifampin • Serotonin and noradrenaline reuptake inhibitors	• Anticholinergic drugs • Antihypertensives • Carbamazepine • Rifampin • CNS depressants • Diazepam • Fluoxetine • Lorazepam (parenteral) • Avoid alcohol
Nursing Considerations (2)	1. Make sure the patient's electrolytes	1. Use cautiously in patients with a

	are balanced prior to medication because it can increase the risk for QT prolongation. 2. Monitor patient's ECG because ondansetron therapy can result in life threatening arrhythmias.	current or history of constipation 2. Monitor the patient's blood pressure routinely

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	The patient appears stated age and well-groomed. She makes good eye contact and is cooperative. Patient has a lean build, and was following the facility's dress protocol. She has an optimistic attitude, and a spontaneous and conversational value. Her mood was euthymic and a little anxious. Her affect is full.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient denies any auditory, delusions, illusions, obsessions, compulsions, and phobias. Although she was admitted for suicidal ideations, she reports not having any at the moment.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient is A&Ox4. Her thought content is linear and goal directed. .
MEMORY: **Remote:**	The patient's short- and long-term memory is intact.
REASONING: **Judgment:**	The patient has fair judgement. Her intelligence is observed to be appropriate for age or more

Calculations: **Intelligence:** **Abstraction:** **Impulse Control:**	mature. Her impulse control seemed average and calculation/ abstraction was not assessed.
INSIGHT:	The patient's insight was observed to be partial.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient had a strong and steady gait. She did not require any assistive devices. During the assessment her posture was relaxed and she sat on the bed with her legs crossed. Her muscle tone, strength and motor movement were appropriate for age and build.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9/27 1455	101 bpm	125/64	16 breaths per min	98.0 ^{O}F Temporal	97% Room air
9/29 1010	88 bpm	116/76	16 breaths per min	97.2 ^{O}F Temporal	99% Room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	N/A	0	N/A	N/A
1030	Numeric	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast**: **N/A** (it was not charted and I did not witness the tray after consumption)	**Oral Fluid Intake with Meals (in mL)** **Breakfast**: **N/A**

Lunch: N/A (it was not charted and I did not witness the tray after consumption) **Dinner: N/A** ***The patient stated she ate breakfast and lunch.**	**Lunch: N/A** **Dinner: N/A**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

I want the patient to utilize the therapist referral. Therapy can be very beneficial for her depression and anxiety. It can provide her with new coping mechanisms and goals to help her mental health. The patient is open to seeing a therapist and seeking further treatment. I want the patient to use the suicide hotline if she needs immediate help and has no one to talk to. Having emergent help is crucial to my patient's mental health. Lastly, although the patient's parents have agreed to help her clean her apartment, but I'd like her to use the free professional services. It would provide her with full professional help and alleviate the burden of a "messy apartment" quickly.

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 suicidal ideation	The patient made comments in the ED of "blowing her brains out" and having violent images in her mind.	1. Asses for signs of suicidal thinking that warrant further investigation (Phelps, 2020). 2. Remove any objects that could be used for self-	1. Schedule time for listening to the patient to communicate that you care 2. Discuss the contributing factors that led the patient to this episode of SI and	1. Encourage the patient to set a goal of maintain psychiatric help. Educate on the importance of consistency. 2. Provide

		inflicted injury or injury to others to ensure safety 3. Assign the patient a 1:1 sitter	depression 3. Avoid comparing patient with others to reduce stereotyping and foster individuality (Phelps, 2020).	patient and their family with crisis prevention centers 3. Provide therapy referrals to make it easier for the patient
2. At risk for severe loneliness related to social isolation and depression as evidence by the patient stating she has no real support system	The patient's primary form of support was her cat who she lost earlier this year. The patient feels like she has no "real friends" and her immediate family is dysfunctional.	1. Spend sufficient time with the patient to allow self-expression of feelings of loneliness to establish a trusting relationship (Phelps, 2020). 2. Help the patient identify factors and behaviors that contributed to the loneliness 3. Identify ways to increases social activity to help the patient understand that you want to help (Phelps, 2020).	1. As the patient's comfort level increases, encourage them to attend group activities 2.Collaborate with the patient to create goals and explore new coping mechanisms 3. Encourage the patient to have one-on-one interactions with others in the group whose acceptance is likely (Phelps, 2020).	1. Provide the patient and family with referrals for support groups/ mental health centers and schedule appointments 2. Establish goals for reducing feelings of loneliness to focus energy on specific objectives (Phelps, 2020). 3. Help patient identify social activities that the patient can initiate to foster feelings of control and increase social contacts (Phelps, 2020).
3. At risk for anxiety related to decreased productivity		1. Provide patient with clear explanations about plan of	1. Allow the patient to state what activities promote feelings of comfort and	1. Provide and educate the patient on relaxation techniques;

as evidence by constant insomnia		care without information overload 2. Make no demands of patient to avoid a reaction of hostility (Phelps, 2020). 3. Attend to patient's comfort needs to increase trust and alleviate anxiety (Phelps, 2020).	encourage patient to perform them (Phelps, 2020). 2. Do not force any changes on the patient before they are ready to avoid panic 3. Support the patient with desensitization techniques (Phelps, 2020).	meditation, music, imagery etc. 2. Help the patient develop their own techniques for dealing with fears 3. Allow the patient extra visiting times with family to alleviate the patient's anxiety (Phelps, 2020).

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

- Admitted to 5E for suicidal ideation voluntarily
- No history of previous SI attempts
- Reports no current alcohol use but smokes marijuana 3x a week
- Patient reports seeing violent images in head often but just ignores them
- No access to firearms

Nursing Diagnosis/Outcomes

1. At risk for suicide related to depression as evidence by suicidal ideation
   a. Patient develops coping skills to remain harm free or utilizes the crisis hotline if she needs help.

2. At risk for severe loneliness related to social isolation and depression as evidence by the patient stating she has no real support system
   a. Patient learns social and communication skills to improve relationships and spend less time in isolation

3. At risk for anxiety related to decreased productivity as evidence by constant insomnia
   a. Patient utilizes relaxation techniques to reduce anxiety levels and demonstrate problem-solving skills

Objective Data

- Labs were positive for marijuana, but no other substances
- Has not participated in group as of yet
- A&Ox4
- Patient is considered an acute imminent potential risk of harm to self or others and requires inpatient hospitalization
- Patient demonstrates independent living skills
- Current vitals:
  - Pulse: 88
  - B/P: 116/76
  - Resp rate: 16
  - Temp: 97.2 F
  - O2: 99%

Patient Information

A 26 year-old female with previous psychotic diagnosis of unspecified mood disorder and ADHD was admitted to the 5E inpatient unit due to suicidal ideation. While in the ED, she reportedly made comments of "blow my brains out" and having "dark thoughts". The patient reports her home is almost unlivable and the entire floor is covered with items.

Nursing Interventions

Nursing Diagnosis 1

a. Asses for signs of suicidal thinking that warrant further investigation (Phelps, 2020).
b. Remove any objects that could be used for self-inflicted injury or injury to others to ensure safety
c. Assign the patient a 1:1 sitter

Nursing Diagnosis 2

a. Spend sufficient time with the patient to allow self-expression of feelings of loneliness to establish a trusting relationship (Phelps, 2020).
b. Help the patient identify factors and behaviors that contributed to the loneliness
c. Identify ways to increases social activity to help the patient understand that you want to help (Phelps, 2020).

Nursing Diagnosis 3

a. Provide patient with clear explanations about plan of care without information overload
b. Make no demands of patient to avoid a reaction of hostility (Phelps, 2020).
c. Attend to patient's comfort needs to increase trust and alleviate anxiety (Phelps, 2020).