N323 Care Plan

Lakeview College of Nursing

Tracy Donaldson

N322 Mental Health

Professor Irelan

2/26/24

Demographics (3 points)

Date of Admission 2/20/24	Patient Initials K.M.	Age 27	Biological Gender Female
Race/Ethnicity African American	Occupation Unemployed	Marital Status Single	Gender Identity Female
Code Status Full	Height and Weight 5'4" 120 lbs	Allergies None	Pronouns She

Medical History (5 Points)

Past Medical History: Asthma and Ectopic pregnancy

Psychiatric Diagnosis: Bi-Polar-rule out Schizoaffective Disorder

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
11/29/20	Inpatient	Bi-Polar – Schizoaffective Disorder
2/4/24	Inpatient	Delusional/ Hallucinations

Admission Assessment

Chief Complaint (2 points): "I was just praying."

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** On 2/19/24 the patient denied anything happened. The patient says she "was just praying." According to the patient, there was no onset, except when "her mother leaves her alone." The characteristics were "praying." No

aggravating or alleviating factors. The treatment was “a bunch of medication” and she was in no pain.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal): The patient states** “I just want to see my kids.”

Primary Diagnosis on Admission (2 points): Bi-Polar-rule out Schizoaffective Disorder

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?		“Yes, all of the above.”	
Do you have a history of trauma secondary to military service?		No	
Have you experienced a loss of family or friends that affected your emotional well-being?		“Yes, Father at 9 years old.”	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		“My mother is in nursing but does not contribute to nursing.”	
(If the client answered no to all screening questions for history of trauma, you may skip to “Presenting Problems”. If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)		**(If the client answered no to all screening questions for history of trauma, you may skip to “Presenting Problems”. If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)**	
	Current?	**Past? (what age)**	**By whom?**
Physical Abuse	No	Until 17 years old	Mother and Father
Sexual Abuse	No	26	Sister’s boyfriend's brother

Emotional Abuse	Yes	Today	"By you." (meaning the student nurse)
Verbal Abuse	Yes and no	During the current hospital stay	A patient
Military	N/A	N/A	N/A
Other	No	N/A	N/A
Presenting Problems			
Problematic Areas	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**	
Do you feel down, depressed or hopeless?	Down	"Sophisticated, present in the moment, I've grown a lot."	
Do you feel tired or have little energy?	Yes	"Since having a baby, maybe all the time."	
Do you avoid social situations?	No	"I'm a Sagittarius and a social butterfly."	
Do you have difficulties with home, school, work, relationships, or responsibilities	Yes	"White and black difficulties."	
Sleeping Patterns	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**	
Have you experienced a change in numbers of hours that you sleep each night?	No 8-9 hours	"I wake up early and go to bed early."	
Do you have difficulty falling asleep?	No	No issues	
Do you frequently awaken during the night?	Yes	"I wake up 3-4 times a night moving my legs a lot	

		because I was sexually violated."
Do you have nightmares?	Not recently	"Nothing bad recently."
Are you satisfied with your sleep?	Yes	"For the most part, yes."
Eating Habits	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you overeat?	Yes	"I have been eating more lately."
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	Sometimes	"I used to 1-3 times a week, by gagging myself with my toothbrush or sticking my finger down my throat."
Do you have not eat enough or have a loss of appetite?	No	"I have been eating normally."
Have you recently experienced unexplained weight loss? **Amount of weight change:**	Yes, up and down	"I am 120 pounds now; I was 130-140 pounds. I was only 126-128 eight months pregnant." Weight change- approximate 10-20 pounds
Anxiety Symptoms	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you pace, have tremors, or experience other symptoms of anxiety?	Pacing	"I drink green tea; green tea helped me one time."
Do you experience panic attacks?	Yes	"Only one time." The patient could not describe it.
Do you have obsessive or compulsive thoughts?	Yes	"With food throwing up."
Do you have obsessive or compulsive behaviors?	Yes	"Throwing up by my toothbrush or finger."

Suicidal Ideation	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.
In the past week have you wished that you were dead?	**No**	"I wish my symptoms were."
Have you ever tried to kill yourself?	**No**	N/A
If the client answered either of the previous questions "yes", you must ask the client: **Are you having thoughts of killing yourself right know?** **(If the client says yes, you must ensure facility staff are aware)**	**N/A**	N/A

Rating Scale	
How would you rate your depression on a scale of 1-10?	"Diagnosed post-partum, 2 or 3."
How would you rate your anxiety on a scale of 1-10?	4

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
Trish	30's	Friend	No My observation- in the medical chart it shows the patient living at "Esther House," which is a homeless shelter in Peoria, Illinois.

If yes to any alcohol or drug use, explain: N/A

Family Medical History: The Patient said "none" but mentioned liver problems in Psychiatric History.

Family Psychiatric History (including suicide): "Aunt has Schizophrenia, Grandmother has a spiritual battle and liver problems." "My cousin Jose committed suicide."

Family alcohol or drug use (not covered by those client lives with): "Aunts and Uncles drink alcohol."

Do you have children? If yes, what are their ages? Yes, son Nylan age 6, and daughter Esben age 18 months."

Who are your children with now? "With my grandmother and their dad."

Have you experienced parental separation or divorce, loss/death/ or incarceration of family or friends? "Yes, lost Father at 9 and I have 1 or 2 family members who are in prison."

If yes, please tell me more about that: "Not sure."

Are you currently having relationship problems? "No, just Nylan."

What is your sexual orientation: Gay	**Are you sexually active?** No	**Do you practice safe sex?** Yes

Please describe your religious values, beliefs, spirituality, and/or preference: "I am religious, spiritual, and was raised Pentecostal."

Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? "I do not like to be looked at as black."
Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): **"**No, I had a DUI from 2019 that is being resolved."
Whom would you consider your support system? "My lawyer, my grandmother, Catherine, and my mom could be if she stepped up her nursing game." **How can your family/support system participate in your treatment and care?** "They need to acknowledge spiritual symptoms before medications."
What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) "My love for medicine. I like to have my feet in the mud."
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) "My mom."
Client raised by: Natural mom, natural grandmother, and natural great-grandmother. **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Self-Care: Independent self-care **Independent** **Assisted** **Total Care**
Education History: Dropped out of high school in 12th grade and then obtained a GED. Started school as a medical assistant but did not complete it. **Grade school** **High school** **College** **Other:**
Reading Skills: The patient says, "I love to read and study."

My observation- the patient did have 2 books open on her bed.

Yes
No
Limited

Primary Language: English

Personal History of Substance Use

Screening Questions:

1. **Have you ever used drugs, alcohol, or nicotine?** Yes

(If no, you may skip to "psychiatric medications".
If yes, complete all sections of this chart. Type N/A if not applicable.)

Substance	First Use and Last Use	Frequency of Use
Nicotine Products (including smoking, chewing, vaping)	**First Use:** N/A **Last Use:** N/A	
Alcohol	**First Use:** 21 **Last Use:** 23	The patient stated, "I used to drink a whole bottle on the weekend."
Prescription Medications (Recreational Use)	**First Use:** Unknown **Last Use:** Unknown	The patient stated, "I used Percocet for 3-4 months of my life."
Marijuana	**First Use:** N/A **Last Use:** N/A	
Heroin	**First Use:** N/A **Last Use:** N/A	
Methamphetamine	**First Use:** N/A **Last Use:** N/A	
Other: Specify	**First Use:** N/A **Last Use:** N/A	

Current Psychiatric Medications (10 points)
Complete all of your client's psychiatric medications
All information listed in this section must be pertinent to your patient.

Brand/ Generic	Haldol/ haloperidol	Desyrel/ Trazodone	Risperdal/ risperidone	Trileptal/ oxcarbazepine	Ativan/ lorazepam
Dose	5 mg	50 mg	2 mg	300 mg	25 mg
Frequency	Every 4 hours PRN	Nightly	Nightly	3 times daily	3 times daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharm class-Butyrophenone/Therapeutic class-Antipsychotic (NDH, 2023).	Pharm class-Triazolopyridine/Therapeutic class-Antidepressant (NDH, 2023).	Pharm class-Benzisoxazole derivative/ Therapeutic class-Antipsychotic (NDH, 2023).	Pharm class-Carboxamide derivative/Therapeutic class-Anticonvulsant (NDH, 2023).	Pharm class-Benzodiazepine/Therapeutic class-Anxiolytic (NDH, 2023).
Mechanism of Action	Blocks postsynaptic dopamine receptors in the limbic system and increases the brain turnover of dopamine which produces an antipsychotic effect (NDH, 2023).	Exerts an alpha-adrenergic blocking action and histamine blockage which produces a sedative effect (NDH, 2023).	Blocks serotonin and dopamine selectively in the mesocortical tract of the central nervous system to suppress psychotic symptoms (NDH, 2023).	Prevents sodium from entering the cell and might slow nerve impulses which will decrease the rate at which neurons fire (NDH, 2023).	May potentiate effects of gamma-aminobutyric acid and other neurotransmitters. GABA inhibits excitatory stimulation and can help control emotional behavior (NDH, 2023).
Therapeutic Uses	Can alleviate hallucinations, delusions, and agitation (NDH, 2023).	For major depressive disorder (NDH, 2023).	To treat schizophrenia (NDH, 2023).	To treat partial seizures (NDH, 2023).	To treat anxiety (NDH, 2023).

Therapeutic Range (if applicable)	0.5-2 mg (NDH, 2023).	25-100 mg for insomnia (NDH, 2023).	4-8 mg daily (NDH, 2023).	1200 mg daily (NDH, 2023).	2-3 mg daily and increase as needed (NDH, 2023).
Reason Client Taking	Breakthrough psychosis/mania	Sleep	Breakthrough psychosis/ mania	Mood stabilization	Anxiety
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	Have a therapeutic conversation with the patient to try and calm them down.	Not PRN- patient takes nightly	Not PRN- patient takes nightly	Not PRN- patient takes 3 times per day	Have the patient practice relaxation techniques such as meditation.
Contraindications (2)	Parkinson's Disease and Depression (NDH, 2023).	Hypersensitivity to trazodone or its components and use within 14 days of an MAO inhibitor (NDH, 2023).	Hypersensitivity to risperidone, paliperidone, or its components (NDH, 2023).	Hypersensitivity to oxcarbazepine, eslicarbazepine acetate, or their components (NDH, 2023).	Acute angle form glaucoma or hypersensitivity to lorazepam or other benzodiazepines or their components (NDH, 2023).
Side Effects/Adverse Reactions (2)	Diaphoresis and blurred vision (NDH, 2023).	Abnormal dreams and indigestion (NDH, 2023).	Tachycardia and alopecia (NDH, 2023).	Abnormal coordination or gait and increased suicidal ideation (NDH, 2023).	Chest pain or increased salivation (NDH, 2023).
Medication/ Food Interactions	Anticholinergics and buspirone (NDH, 2023).	St. John's Wort and Digoxin (NDH, 2023).	Antihypertensives and CNS depressants (NDH, 2023).	Hormonal contraceptives and phenytoin (NDH, 2023).	Clozapine and aminophylline (NDH, 2023).
Nursing Considerations (2)	Monitor CBC due to possibly dropping and avoid stopping abruptly (NDH, 2023).	Use cautiously in patients with cardiac disease and monitor depressed patients for suicidal thoughts (NDH, 2023).	Monitor the patient's glucose and lipid levels and monitor for orthostatic hypotension (NDH, 2023).	Monitor sodium levels for signs of hyponatremia and monitor for evidence of suicidal thinking (NDH, 2023).	Use with caution if the patient has a history of alcohol or substance abuse because of the risk of dependence and stopping the medication abruptly can increase withdrawal

					symptoms (NDH, 2023).

Medications Reference (1) (APA):

2023 Nurse's Drug Handbook. (2023). Jones & Bartlett Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	The patient was well groomed, alert, and oriented, with Dutch braids in her hair. She is petite with a comfortable posture. The room was neat, and she sat on the other end of the bed as we did the interview, a little guarded. She had good eye contact and was attentive. Her speech was slightly fast, and her behavior was friendly but seemed superficial. Her thought process was somewhat illogical as she was making no sense at times.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	Her mood was happy, somewhat euphoric. Her affect was mostly consistent with her mood, but she did have a moment of irritability. As mentioned previously, the happiness seemed superficial.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	The patient's attention was off when she started another illogical thought process, which most of the time was about religion. I would describe it as tangential.
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	No homicidal or suicidal ideations. No current delusions or hallucinations. The patient was obsessed with religion, had no compulsions, and did not seem paranoid. Flight of ideas was noticed.

REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	The patient said, “I would find the owner.” However, I believe the patient’s judgment is very distorted. Her ability to make wise decisions is off.
MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	Motor activity and the gate were appropriate for the patient’s age and size.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	92	112/72	16	97.7	99%

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	0-10	N/A	0	N/A	N/A

Nursing Care (6 points)

Overview of care provided today:

Client complaints: The patient's only complaint was she was “ready to leave and go see her kids.”

Participation in therapy / groups: The patient participated in the social work group.

Medication compliance today: The patient was compliant with medication.

Behaviors exhibited today: The patient was cooperative and seemed friendly with the other patients.

Discharge Planning

Discharge location: Mother's house, Grandmother's house, or Esther House, which is a Women's shelter in Peoria, Illinois.

Follow up plan: The patient will need a support system to help stay compliant with her medications and appointments. I also suggest she get a good social worker or therapist that she can work with to help her stay stable.

Education needs: The patient needs a great amount of education on her medical condition and how important it is to take her prescribed medication and seek therapy.

Nursing Diagnosis (25 points)
Must be NANDA-approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis	Rationale • Explain why the	Outcome Goal (1 per	Interventions (3 per diagnosis)	Outpatient Resource with Rationale

with "related to" and "as evidenced by" components	nursing diagnosis was chosen	**diagnosis)**		**(1 per diagnosis)**
1. Risk for suicidal behavior related to anxiety, depression, and mental disorders as evidenced by the patient' saying she has post-partum depression and anxiety rated at a 4 (Phelps, 2023).	The patient is mentally unstable and was admitted previously for hallucinations and delusions. The patient also stated that she has post-partum depression.	**1.** The patient will not commit suicide (Phelps, 2023). The patient will discuss any feelings related to suicidal ideation once a day for 10 minutes while inpatient.	**1.** Initiate appropriate safety protocols by removing any harmful items from the patient's environment (Phelps, 2023). **2.** Use a warm, caring, nonjudgmental manner to show unconditional positive regard (Phelps, 2023). **3.** Help the patient set a goal for obtaining long-term psychiatric care (Phelps, 2023).	**1.** Advise the patient to call 988 if they are having thoughts of suicide. They will help talk them through moments of crisis.
2. Risk for impaired mood regulation as related to hypervigilance as evidenced by the client's change in verbal behavior during assessment (Phelps, 2023).	The patient clearly changed her mood and became irritated with a smile when asked about emotional abuse.	**1.** The patient will collaborate with the nurse to create a wellness recovery plan that includes goals and positive plans for the future. (Phelps, 2023). A meeting will occur every day	**1.** Convey a nonjudgmental, supportive attitude and do not take any statements personally, and use therapeutic communication to avoid power struggles (Phelps, 2023). **2.** Engage the patient to develop and enact a wellness recovery plan in their own care, which	**1.** Give the patient resources for at home therapy such as mindfulness meditation. This will help calm her mood when needed.

		for 30 minutes while the patient is inpatient.	includes positive goals for the future (Phelps, 2023). **3.** Assist the patient with referral to specialty psychotherapy resources, as indicated by the patient's presentation and determined by the clinical team (Phelps, 2023).	
3. Risk for defensive coping related to insufficient resilience as evidenced by the patient's alteration in reality testing. (Phelps, 2023).	1. The patient was brought into the hospital in a psychosis state acting erratically saying that "she was just praying."	**1.** The patient will demonstrate follow-through in decisions related to health care (Phelps, 2023). The patient will let the nurse know of follow-through decisions once a day while inpatient.	**1.** Help the patient make treatment-related decisions and encourage follow-through (Phelps, 2023). **2.** Refer the patient to a mental health specialist or social worker for follow-up treatment (Phelps, 2023). **3.** Arrange for interaction between patients and others, and observe interaction pattern (Phelps, 2023).	**1.** Give the patient material for social workers and therapists in her area. This will help with managing her mental health conditions.

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient was brought to the emergency department on 2/19/24 due to acting erratically on the bathroom floor. She was very excited, animated, talkative, and euphoric, but also said she was depressed. The patient said that she "was just praying."

Nursing Diagnosis/Outcomes

Nursing diagnosis 1- Risk for suicidal behavior related to anxiety, depression, and mental disorders as evidenced by the patient' saying she has post-partum depression and anxiety rated at a 4 (Phelps, 2023).
Outcome- The patient will not commit suicide (Phelps, 2023).

Nursing Diagnosis 2- Risk for impaired mood regulation as related to hypervigilance as evidenced by the client's change in verbal behavior during assessment (Phelps, 2023).
Outcome- The patient will collaborate with the nurse to create a wellness recovery plan that includes goals and positive plans for the future (Phelps, 2023).

Nursing Diagnosis 3- Risk for defensive coping related to insufficient resilience as evidenced by the patient's alteration reality testing. (Phelps, 2023).
Outcome-1 The patient will demonstrate follow-through in decisions related to health care (Phelps, 2023).

The patient is a 27-year-old petite female with the initials K.M. who is 5'4" and weighs 120 pounds. She is single with 2 children, a son who is 6, and a daughter who is 18 months. She is admitted for bipolar disorder- ruling out schizoaffective disorder. She was living at a women's shelter in Peoria, Illinois before this admission.

Patient Information

Objective Data

The client's primary diagnosis upon admission was bipolar-rule-out schizoaffective disorder. The patient's vital signs were stable at 0800 with pulse 92, blood pressure 112/72, respirations 16, temperature 97.7, and O2 at 99% on room air. She had no pain at 1000.

Nursing Interventions

1a Initiate appropriate safety protocols by removing any harmful items from the patient's environment (Phelps, 2023).

1b Use a warm, caring, nonjudgmental manner to show unconditional positive regard (Phelps, 2023).

1c Help the patient set a goal for obtaining long-term psychiatric care (Phelps, 2023).

2a Convey a nonjudgmental, supportive attitude and do not take any statements personally, and use therapeutic communication to avoid power struggles (Phelps, 2023).

2b Engage the patient to develop and enact a wellness recovery plan in their own care, which includes positive goals for the future (Phelps, 2023).

2c Assist the patient with referral to specialty psychotherapy resources, as indicated by the patient's presentation and determined by the clinical team (Phelps, 2023).

3a Help the patient make treatment-related decisions and encourage follow-through (Phelps, 2023).

3b Refer the patient to a mental health specialist or social worker for follow-up treatment (Phelps, 2023).

3c Arrange for interaction between patients and others, and observe interaction patterns (Phelps, 2023).