N323 Care Plan

Lakeview College of Nursing

Ginaveve Jessup

Demographics (3 points)

Date of Admission 10/29/2024	Patient Initials A.G.	Age 22 years old	Biological Gender Female
Race/Ethnicity White	Occupation Student	Marital Status Single	Gender Identity Other
Code Status Full	Height and Weight 5'10" and 170 lbs.	Allergies none	Pronouns They/Them

Medical History (5 Points)

Past Medical History: Self-harm. Overdose attempt in high school and 2 years ago.

Psychiatric Diagnosis: Bipolar disorder, depression, severe without psychotic features.

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
The patient was not able to provide dates, and they were not in the electronic health record. This was when the client was in high school	**Inpatient**	**Attempted overdose**
This date was not specified by the client, and it was not in the chart, but the client stated "2 years ago"	**Outpatient**	**Attempted overdose**

Admission Assessment

Chief Complaint (2 points): Overdose on 30 tablets of Seroquel.

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable): Their therapist told them they "needed to be hospitalized due to her mental illness." The client stated this.**
- **Chief Complaint Impact on Life (i.e., work, school, family, social, financial, legal): "I am in control of my life." The client is away from their family since they are a student at the University of Illinois Champaign-Urbana. The client has been feeling a sense of loneliness.**

Primary Diagnosis on Admission (2 points): Bipolar.

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?		**"Yes, verbal and emotional."**	
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?		**"No."**	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		**" Yes, my mom was an alcoholic and bipolar and was on medication."**	
(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	**N/A**	**N/A**	**N/A**
Sexual Abuse	**None**	**16**	**The client did not specify by**

			who.
Emotional Abuse	**None**	**“Young”**	**“By my mom”**
Verbal Abuse	**None**	**“Young”**	**“By my mom”**
Military	**N/A**	**N/A**	**N/A**
Other	**N/A**	**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?	**“No.”**	**N/A**	
Do you feel tired or have little energy?	**“Tired”**	**“I just had no sleep last night”**	
Do you avoid social situations?	**“Yes.”**	**“I normally avoid large, crowded areas as much as possible.”**	
Do you have difficulties with home, school, work, relationships, or responsibilities	**“No.”**	**N/A**	
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?	**“Yes.”**	**“It constantly changes, depending how my day went.”**	
Do you have difficulty falling asleep?	**“Yes.”**	**“Only sometimes do I have trouble sleeping, only if I have something on my mind.”**	
Do you frequently awaken during the night?	**“Yes.”**	**“Normally I wake up a couple times at night and can’t stay asleep.”**	

Do you have nightmares?	**“No.”**	
Are you satisfied with your sleep?	**“No.”**	**“I just have trouble falling asleep.”**
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 over and under eat.”**
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	**“No.”**	**N/A**
Do you have not eat enough or have a loss of appetite?	**“Yes.”**	**“I normally just forget to eat, or I don’t think to eat.” “I have to force myself to eat sometimes.”**
Have you recently experienced unexplained weight loss? **Amount of weight change:**	**“No.”**	**N/A**
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?	**“Yes.”**	**“I have a neck twitch that happens sometimes, and I normally pace a lot when I am anxious.” I observed the client had limited eye contact.**
Do you experience panic attacks?	**“Yes.”**	**“Normally once a month, just because of everyday life.”**
Do you have obsessive or compulsive thoughts?	**“Yes.”**	**“I have both, it normally lasts all throughout the day.”**

Do you have obsessive or compulsive behaviors?	**"Yes."**	**"I get frozen from time to time."**	
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?	**"Yes."**	**"It is frequent, but it comes goes, and when I am anxious."**	
Have you ever tried to kill yourself?	**"Yes."**	**"When I was 16/17 and 22." "That is why I am here."**	
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)**	**"No."**	**N/A**	
Rating Scale			
How would you rate your depression on a scale of 1-10?		**"3/10."**	
How would you rate your anxiety on a scale of 1-10?		**"4/10."**	
Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
"Alone and with my cat."	**22**	**self**	**"They smoke weed rarely."**

If yes to any alcohol or drug use, explain: They rarely smoke weed.			
Family Medical History: N/A			
Family Psychiatric History (including suicide): The patients mother has a history of bipolar disorder. Their maternal aunt had committed suicide.			
Family alcohol or drug use (not covered by those client lives with): Mother is an alcoholic.			
Do you have children? If yes, what are their ages? No **Who are your children with now? N/A**			
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? **The client could not recall but in the health record, I observed their maternal aunt had committed suicide.** **If yes, please tell me more about that: Since I found this information in the chart, I was not able to ask the client about the death of their aunt since they were discharged.**			
Are you currently having relationship problems? "No."			
What is your sexual orientation: "Queer."	**Are you sexually active? "Yea."**	**Do you practice safe sex? "Yes."**	
Please describe your religious values, beliefs, spirituality and/or preference: "Agonist."			
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? "No."			
Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): "My mom was on probation for a DUI."			
Whom would you consider your support system? "Family and friends."			

How can your family/support system participate in your treatment and care? "They are very supportive and they are good at distracting me during tough times."

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.)
"I like to listen to music and take a walk."

What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) "I feel other emotions, so when they are upset, I notice it and get upset myself."

Client raised by:

Natural parents and a sister who is 10 years older
Grandparents
Adoptive parents
Foster parents
Other (describe):

Self-Care:

Independent
Assisted
Total Care

Education History:

Grade school
High school
College. In college for computer science.
Other:

Reading Skills:

Yes
No
Limited

Primary Language: English.

Personal History of Substance Use

Screening Questions:

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

(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**	**N/A**
Alcohol	**First Use: "17."** **Last Use: "Monday."**	**"Just socially, every couple of months."**
Prescription Medications (Recreational Use)	**First Use: N/A** **Last Use: N/A**	**N/A**
Marijuana	**First Use: "2 years ago."** **Last Use: "Last week."**	**"Every week and when I have a break from school."**
Heroin	**First Use: N/A** **Last Use: N/A**	**N/A**
Methamphetamine	**First Use: N/A** **Last Use: N/A**	**N/A**
Other: Specify	**First Use: N/A** **Last Use: N/A**	**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	**Atarax/ hydroxyzine**	**Abilify/ aripiprazole**	**Trileptal/ oxcarbazepine**	**Desyrel/ trazadone**
Dose	**25 mg**	**5 mg**	**300 mg**	**100 mg**
Frequency	**Every 6 hours**	**Daily**	**Twice a day**	**Nightly**
Route	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic class: Piperazine derivative (Jones & Bartlett, 2023). Therapeutic class: Anxiolytic, antiemetic, antihistamine, and sedative-hypnotic (Jones & Bartlett, 2023).**	**Pharmacologic class: Atypical antipsychotic (Jones & Bartlett, 2023). Therapeutic class: Antipsychotic (Jones & Bartlett, 2023).**	**Pharmacological class: Carboxamide derivative (Jones & Bartlett, 2023). Therapeutic class: Anticonvulsant (Jones & Bartlett, 2023).**	**Pharmacological class: Triazolopyridine derivative (Jones & Bartlett, 2023). Therapeutic class: Antidepressant (Jones & Bartlett, 2023).**
Mechanism of Action	**There are histamine suppression actions from this medication (Jones & Bartlett, 2023). This occurs at the subcortical level of the central nervous system (Jones & Bartlett,**	**Uses agonist and antagonist actions that produce antipsychotic effects (Jones & Bartlett, 2023). Agonist at dopamine and serotonin receptors (Jones & Bartlett, 2023).**	**This medication closes sodium channels to prevent or stop seizures (Jones & Bartlett, 2023). This also decreases the rate the neurons fire (Jones & Bartlett, 2023).**	**This medication blocks serotonin reuptake causing an antidepressant affect (Jones & Bartlett, 2023). This also produces a modest histamine**

	2023).			**block (Jones & Bartlett, 2023). It can also reduce blood pressure (Jones & Bartlett, 2023).**
Therapeutic Uses	**This medication can be used to relieve anxiety and tension (Jones & Bartlett, 2023). This medication can also be used to treat pruritic, nausea, and vomiting associated with pregnancy (Jones & Bartlett, 2023).**	**This medication can be used for acute schizophrenia, mania, bipolar, autism, and Tourette's (Jones & Bartlett, 2023).**	**This medication to treat partial seizures (Jones & Bartlett, 2023).**	**This medication is used for major depression (Jones & Bartlett, 2023).**
Therapeutic Range (if applicable)	**50-100 mg four times a day (Jones & Bartlett, 2023).**	**Daily of 10-15 mg (Jones & Bartlett, 2023).**	**Twice daily at 300 mg (Jones & Bartlett, 2023).**	**150 mg divided in half daily (Jones & Bartlett, 2023).**
Reason Client Taking	**This client is taking this medication for their anxiety**	**This client takes this medication for their diagnosis of bipolar disorder and depression. It is a mood stabilizer.**	**This client takes this medication for their diagnosis of bipolar disorder and depression. It is a mood stabilizer.**	**This medication is for the clients insomnia.**
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted	**N/A**	**N/A**	**N/A**	**N/A**

Prior to Use of this Medication				
Contraindications (2)	**Early pregnancy and hypersensitivity to the medications like it (Jones & Bartlett, 2023).**	**Hypersensitivity to this medication and hypersensitivity to its components (Jones & Bartlett, 2023).**	**Hypersensitivity to Oxcarbazepine or eslicarbasepine (Jones & Bartlett, 2023).**	**Hypersensitivity to trazadone and linezolid (Jones & Bartlett, 2023).**
Side Effects/Adverse Reactions (2)	**Drowsiness and hallucinations (Jones & Bartlett, 2023).**	**Suicidal ideation and pulmonary edema (Jones & Bartlett, 2023).**	**Seizures and suicidal ideation (Jones & Bartlett, 2023).**	**Serotonin syndrome and hypotension (Jones & Bartlett, 2023).**
Medication/ Food Interactions	**Azithromycin and citalopram (Jones & Bartlett, 2023).**	**Alcohol use and benzodiazepines (Jones & Bartlett, 2023).**	**Contraceptives and phenytoin (Jones & Bartlett, 2023). Alcohol as well (Jones & Bartlett, 2023).**	**Alcohol, antipsychotics, amiodarone, clopidogrel, and St. John's wort (Jones & Bartlett, 2023).**
Nursing Considerations (2)	**Monitor for oversedation and use cautiously in clients who have prolongation of the QT interval (Jones & Bartlett, 2023).**	**Use cautiously in patients with cardiovascular disease and monitor for dysphagia (Jones & Bartlett, 2023).**	**Implement seizure precautions and monitor serum sodium level (Jones & Bartlett, 2023).**	**This medication will show effect at the end of the second week of the medication administration and monitor for suicidal thought (Jones & Bartlett, 2023).**

Medications Reference (1) (APA):

Jones and Bartlett. (2023). *Nurses drug handbook.* Jones and Bartlett Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	**This client was AOx4. They were a little guarded, well-groomed, calm, and willing to help. You can understand them well, yet they maintain limited eye contact. They are attentive.**
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	**They were in a good mood and fair affect when we were having a conversation. The client was in a chill mood. The are consistent between mood and affect.**
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	**This client was alert and orientated to their environment. They had good memory and held attention well.**
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	**This client has had thoughts of suicide, but not currently. This client has no hallucinations, delusions, obsession, compulsions, paranoia, preservations, or loose association.**
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	**This client has good morals and judgement. They are well informed about their illness and care a lot about themselves. They have a good support system.**

MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	**This client has no assistive devices or abnormal motor activities. They have normal and steady gait.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**88 bpm**	**116/83 mmHg**	**18 breaths per minute**	**99 F**	**99% on room air**

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	**Numeric**	**N/A**	**0/10**	**N/A**	**N/A**

Nursing Care (6 points)

Overview of care provided today: I sat and talked with the patient on their plan for when they go home and prepared them to go home.

Client complaints: Their only complaint was that they were tired.

Participation in therapy / groups: They were well involved in the group and verbalized their goal for the day well, per my observation.

Medication compliance today: They complied well to their medication.

Behaviors exhibited today: They were calm and ready to go home and see their family.

Discharge Planning

Discharge location: The discharge location for this client is their home in Plainfield, IL.

Follow-up plan: The client plans to meet with their therapist and psychiatrist. The client informed me that their father locks up their medication, so they will not be able to try and overdose while at home.

Education needs:

Nursing Diagnosis (25 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	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**
1. Suicide ideation.	**I chose this nursing diagnosis because the client was admitted on the unit for this. The patient has attempted suicide.**	**1. The client will seek help if they have thoughts and try to depress those thoughts by distracting themselves.**	**1.Help identify characteristics that can lead to suicide ideations.** **2. Establish a therapeutic relationship.** **3. Help the client assess for signs of distress and anxiety and to get help**	**1. Talk to friends when they are feeling down and a sense of killing themselves.**
2. Depression.	**I chose this nursing diagnosis because the**	**1. The outcome for this client will be to lower their depression**	**1. Encourage client to express feelings**	**1. Indulge in some activities that can help reduce**

	client expressed, they were depressed and unhappy as well as their diagnosis of depression.	**and help them find ways to cope with their depression.**	**2. Promote safety.** **3. Help the client determine aspects of their life they are in control of.**	**the feeling of depression such as watching a happy movie and listening to good music.**
3. Anxiety.	**I chose this nursing diagnosis because the client expressed, that they were anxious and they talked about having a lot of anxiety.**	**1. The outcome for this client will be to help the client to reduce stressors and relieve anxiety.**	**1. Provide education on anxiety.** **2. Educate on reducing environmental stressors.** **3. Encourage relaxation techniques and self-care.**	**1. It can help by trying to reduce stressors in everyday life by taking a step back once in a while. Taking a step back and help you realize what is stressing you out and cause you anxiety so you can try and reduce that in the future.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

This patient has a history of 2 overdose attempts before their admission as well as self-harm, as stated by the patient. They verbalized having a history of bipolar and depression. They verbalized that they wanted to be “in control of their life,” so they overdosed on medication. They stated they were a student at the nearby college and had felt lonely and were away from family. They have a history of verbal, emotional, and sexual abuse. They told us their mother is an alcoholic and is bipolar, as well as verbally and emotionally abusing them. The client avoids social situations and has trouble sleeping/staying asleep. They forget to eat. They have a neck cramp and pace. They have experienced panic attacks and have obsessive and compulsive thoughts. The client identifies as queer and is Agnostic. They express suitable coping mechanisms and can explain triggers. They use weed frequently and alcohol socially.

Nursing Diagnosis/Outcomes

Suicidal ideation

- The client will seek help if they have thoughts and try to depress those thoughts by distracting themselves.

Depression

- The outcome for this client will be to lower their depression and help them find ways to cope with their depression.

Anxiety

- The outcome for this client will be to help the client to reduce stressors and r[illegible]

Objective Data

I observed the client playing with their hands while we were interviewing them. The client also had minimal eye contact when speaking. I observed the client was well groomed, AOx4, guarded, calm, and willing to help. Their mood was good, and there was a consistency in mood and affect. No memory impairments and had good attention. They seemed they know about their illness and understood what was going on. Good judgment was observed, and they walked with a normal gait. Vitals were taken at 0700 with a pulse at 88 bpm; blood pressure was 116/83 mmHg, respirations at 18 bpm, the temperature was 99 degrees, and oxygen was 99% on room air. Pain assessment was done at 0827, and the patient-rated their pain 0/10 on a numeric scale. We observed the patient seemed tired but ready to go home.

Patient Information

On 10/29, A.G. was admitted to the mental health unit. This patient is a biological female who uses the pronouns they/them. They are 22 years old and are of white ethnicity. Their gender identity is other. This patient is 5’10” and 170 pounds. They have no allergies and were admitted because of an attempted overdose of 30 tablets of Seroquel. They have a history of other suicidal attempts and bipolar.

Nursing Interventions

Help identify characteristics that can lead to suicide ideations.
Establish a therapeutic relationship.
Help the client assess for signs of distress and anxiety and to get help
Encourage client to express feelings

Promote safety.

Help the client determine aspects of their life they are in control of.
Provide education on anxiety.
Educate on reducing environmental stressors.
Encourage relaxation techniques and self-care.