Client Information Cover Sheet to be used for Care Plan. Attach as a cover sheet when turning in for grading.

Pt. Initials T. H. Age 19 Gender Female

Other demographic data

Patient lives with a foster mom and dad in Danville IL.

DSM –IV Diagnoses: Bipolar disorder type 2, posttraumatic stress disorder, evaluate for borderline personality disorder.

NANDA Diagnoses:

Risk for suicide related to depression as evidence by suicidal ideations triggered by sexual abuse history.

Mental Status Exam Findings (be sure to be VERY descriptive)

Appearance- Patient was well groomed, clean, and wearing a hospital gown.

Behavior- Patient was alert, cooperative, and pleasant.

Attitude- Patient was hopeful to get better and had a positive attitude during group and and a depressed attitude during my assessment.

Speech- Patient had normal psychomotor activity and a normal speech rate with no impairments.

Mood- Patient described her mood as “blah” and depressed, but during group seemed hyper and spastic.

Main Thought Content

Ideations- Patient has suicidal ideations.

Delusions- Denies

Illusions- Denies

Obsessions- Denies

Compulsions- Denies

Phobias- Denies

Orientation-

Patient is A&O X 4 to name, place, age, and time. Patients though process is linear and goal oriented.

Memory

Remote- Patients remote memory is intact she can recall memories from when she was a child.

Recent- Patients recent memory is intact she was able to recall what she ate for breakfast

Reasoning

Judgment- Patients judgment is preserved.

Calculations- Patient is able to perform simple calculations.

Intelligence- Patients intellectual capacity is average based on language and vocabulary. Patient can perform daily living activities individually.

Insight: Patients insight is fair. Patients insight was tested by asking how she feels about previous hospitalizations.

Allergies: No known drug allergies.

Factors that Lead to Treatment: Patient has a history of PTSD and was admitted for suicidal ideations. Suicidal thoughts were triggered by the discussion of sexual abuse at school. Patient reports she became suicidal with a plan to hang herself. Patient brought herself to the Pavilion. Patient admits to feeling stressed at school and depressed and anxious most of the time. Patient also admits a history of mood swings with irritability and anger with episodes of sadness.

Significant Psychiatric History:	Three suicide attempts in the past. ADHD, bipolar disorder, and PTSD.
Family History:	Noncontributory for psychiatric problems.
Strengths:	Patient is pleasant, cooperative, and willing to participate in treatment.
Support System:	Patient states that her support system is her foster parents.

Discharge Plans (YOURS FOR THE CLIENT)

Discharge plans that I would make for this client include keeping her in outpatient care, and having meetings with her psychiatrist weekly. I would also create coping methods for her to use and make sure she understood and knew how to implement them before leaving. I would also give her an updated list of her medications and when to take them and educate her on the importance of taking them as prescribed and not stopping the medications abruptly.

Medication list:

- Lexapro 20 mg PO q am
- Seroquel 50 mg PO q am
- Trazodone 150 mg PO at bedtime

Medications (Attach Medication Grid): ***Medication grid is included in this packet*

Clinical Medication Template

Name: Alexis Wormsley

Medication: Seroquel (Quetiapine)

Expected Pharmacological Action: It is an antagonist for D2 receptors and HT2, D1, H1, A1, and A2 receptors. Quetiapine blocks M1 receptors. It is used in the treatment of schizophrenia and acute manic episodes associated with bipolar disorder.

Chart Documentation

Patient is prescribed 50 mg PO q in the am. Patient has been compliant with this medication.

Therapeutic Uses

Treatment of acute manic episodes associated with bipolar disorder.

Nursing Interventions

Monitor patients blood pressure while on this medication.

Monitor patient for adverse reactions to the medication.

Adverse Effects

Constipation, dysphagia, hypotension, abdominal pain, nausea, vomiting, dizziness, drowsiness, and tiredness.

Contraindications

Coma, severe CNS depression, allergy to quetiapine, severe hypotension, and seizures.

Client Education

Take the drug exactly as prescribed.

This drug should not be used during pregnancy.

Maintain adequate fluid intake.

Report adverse reactions.

Medication /Food Interactions

Alcohol, CNS depressants, phenytoin, thioridazine, carbamazepine, phenobarbital.

Medication Administration

Can be given in tablets ranging from 25mg- 300 mg.

Medication Effectiveness

Patient has shown signs of improvement since starting this medication according to psychiatrist notes.

References for drug template:

2018 Nurses drug handbook (17th ed.). (2018). Burlington, MA: Jones & Bartlett Learning.

References for nursing diagnosis:

Swearingen, P. L., & Wright, J. D. (2016). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

Name : Alexis Wormsley **CARE PLAN – POC** **PAGE 2 OF 3**

Date: 11/6/19

Client Initials T.H.

Nursing Diagnosis **(Prioritized)**	**Short Term Goal**	**Interventions**	**Long Term Goal**	**Interventions**
1. Risk for suicide related to depression as evidence by suicidal ideations.	**1.** Patient will demonstrate cognitive and emotional stability avoiding suicidal ideations for at least 72 hours.	**1.** Evaluate patient's mood and behavior while at the Pavillion. **2.** Provide support for the patient. **3.** Encourage patient to focus on mindfulness and recognizing suicidal ideations.	**1.** Patient will remain free of suicidal ideations for at least a month.	**1.** Teach patient coping skills when PTSD occurs. **2.** Teach patient to recognize when suicidal ideations are occurring and to reach out. **3.** Instruct patient to continue follow up visits with a psychiatrist.
2. Deficient knowledge related to bipolar disorder as evidence by recurrent admissions to the pavilion.	**1.** Patient will adhere to medications as prescribed during her stay at the pavilion.	**1.** Evaluate client's response to medications. **2.** Educate client on the desired effects of her prescribed medications. **3.** Educate client to report any adverse reactions to her medications.	**1.** Patient will adhere to medications as prescribed for at least two months after discharge from the pavilion.	**1.** Evaluate client's response to medications after discharge. **2.** Educate client to contact her psychiatrist if symptoms of her bipolar disorder begin to worsen. **3.** Educate client not to stop her medications

				abruptly.

3. Feelings of hopelessness related to post traumatic stress disorder as evidence by flashbacks of sexual assault.	**1.** Client will demonstrate ability to deal with emotional reactions appropriately during her stay at the pavilion.	**1.** Assist patient in developing coping skills when PTSD episodes occur. **2.** Stay with patient and provide comfort during flashbacks. **3.** Develop a trusting relationship with patient.	**1.** Patient will renew significant relationships and establish goals for the future to cope with PTSD after her discharge from the pavilion.	**1.** Educate patient on the importance of continuing meetings with her psychiatrist after her discharge. **2.** Encourage patient to discuss feelings of vulnerability with trusted family members or her psychiatrist. **3.** Assess patient's relationships with family members or significant others after her discharge.

Nursing Care Plan/Concept Map Rubric - 50 Points Total

Name: **Grade:**

	1-4	**5-7**	**8-10**	**15**
Assessment (Cover Page) Includes subjective, objective and historical data that support actual or risk for nursing diagnosis.	Incomplete Assessment portion is incomplete. APA References are incorrect or not used.	Poor Does not include all pertinent data related to nursing diagnosis. May also include data that does not relate to nursing diagnosis. Some APA references are correct	Fair Includes all pertinent data related to nursing diagnosis, but also includes data not related to nursing diagnosis. Most APA references are correct.	Good Includes all pertinent data related to nursing diagnosis and does not include data that is not related to nursing diagnosis.
	1-2	**3**	**4**	**5**
Diagnosis Includes the most appropriate diagnosis for patient and ordinal number that includes all appropriate parts (stem, related to or R/T, and as evidenced by AEB for actual diagnosis) and is NANDA approved	Incomplete Diagnosis portion is incomplete. APA References are incorrect or not used.	Poor Diagnosis is not appropriate for patient and ordinal level (first diagnosis, second diagnosis, etc.). May also not be NANDA and may not include all parts. Some APA references are correct	Fair Diagnosis is appropriate for patient and ordinal level, and diagnosis is NANDA approved, but does not include all parts or information is listed in wrong part of diagnosis. Most APA references are correct.	Good Diagnosis is appropriate for patient and ordinal level, and diagnosis is NANDA approved. Diagnosis also includes all parts and information is listed in correct part of diagnosis.
Planning (Short Term Goal) Includes a patient or family goal that is most appropriate for the patient/family and the nursing diagnosis. Goal should be	Incomplete Goal portion is incomplete. APA References are incorrect or not	Poor Goal statement is not patient or family oriented and may not have measurable criteria or a	Fair Goal statement is patient or family oriented and contains at least one measurable criterion or a target	Good Goal statement is patient or family oriented and contains two measurable criteria and a

measurable by at least two criteria and have a target date or time.	used.	target date or time. Some APA references are correct	date/time. Most APA references are correct.	target date or time.
Implementation **(Short Term Interventions)** Includes interventions or nursing actions that directly relate to the patient's goal which are specific in action and frequency.	Incomplete Interventions portion is incomplete. APA References are incorrect or not used.	Poor Interventions portion does not include adequate number of interventions to help patient/family meet goal. Interventions may also not be specific, labeled or listed with rationales. Some APA references are correct	Fair Interventions portion contains adequate number of interventions to help patient/family meet goal, but interventions may not be specific, labeled or listed with rationales. Most APA references are correct.	Good Interventions portion contains adequate number of interventions to help patient/family meet goal, and interventions are specific in action and frequency.
Planning (Long Term Goal) Includes a patient or family goal that is most appropriate for the patient/family and the nursing diagnosis. Goal should be measurable by at least two criteria and have a target date or time.	Incomplete Goal portion is incomplete. APA References are incorrect or not used.	Poor Goal statement is not patient or family oriented and may not have measurable criteria or a target date or time. Some APA references are correct	Fair Goal statement is patient or family oriented and contains at least one measurable criterion or a target date/time. Most APA references are correct.	Good Goal statement is patient or family oriented and contains two measurable criteria and a target date or time.
Implementation (Long Term Interventions) Includes interventions or nursing actions that directly relate to the patient's goal which are specific in action and frequency.	Incomplete Interventions portion is incomplete.	Poor Interventions portion does not include adequate number of interventions to help patient/family meet goal. Interventions may also not be specific, labeled or listed with rationales.	Fair Interventions portion contains adequate number of interventions to help patient/family meet goal, but interventions may not be specific, labeled or listed with rationales. Most APA	Good Interventions portion contains adequate number of interventions to help patient/family meet goal, and interventions are specific in action and frequency.

		Some APA references are correct	references are correct.	
Medications All patients' medications are listed, the student has discussed in his/her words how the medications interact with the clinical presentation of the patient. Student has done medication template on 1 of the patient's medications.	Incomplete No medication information is included in the care plan.	Poor Medications not listed. Medication template incomplete and/or inaccurate information.	Fair Medication section missing medications. Medication template complete.	Good Medication section is complete. The medication template is complete in its entirety with appropriate APA references.
APA format Students should utilize references where appropriate and cite utilizing correct APA format.	Incomplete No APA references utilized. More than 5 APA errors.	Poor 3-5 errors in APA format. References not utilized in all appropriate places	Fair 1-3 errors in APA format, references are utilized where appropriate.	Good No errors in APA format, references are utilized where appropriate.
Additional Comments:				