Clinical Medication Template

Name: Lindsey Davis

Medication: Lorazepam (Ativan)

Expected Pharmacological Action: Bines to benzodiazepine receptors; enhances GABA effects. Metabolism in liver and excreted through the urine, half-life is 14h.

Therapeutic Uses

Alcohol withdrawal

Chart Documentation

2-6 mg tab

Nursing Interventions

Monitor vital signs

Global assessment for effectiveness

May cause dizziness or drowsiness.

Adverse Effects

Respiratory depression, apnea, respiratory failure, dependency, abuse, seizures, suicidality, tachycardia, hypotension, syncope, blood dyscrasias, jaundice, CNS stimulation, paradoxical, gangrene

Contraindications

Hypersens to drug/class/compon.

Intra-arterial administration

Respiratory impairment

Aboidabrupt withdrawl

Client Education

Pt should be aware of decreased

Response time, slower reflexes and possible sedative effects.

Medication /Food Interactions

Alcohol use

Medication Administration

Oral or IV as order by provider. Normally as a tampered dose

Medication Effectiveness

Withdrawals are lessened until medication is no longer needed.

Clinical Medication Template

Name: Lindsey Davis

Medication: Buspirone (BuSpar)

Expected Pharmacological Action: Exact mechanism of action unknown; binds to serotonin and dopamine D2 receptor. Metabolism in liver and excretion of urine, feces; half-life:2-3h

Chart Documentation

20-30mg tab daily

Therapeutic Uses

Anxiety, social phobia, GAD

Nursing Interventions

Monitor serotonin level.

Watch for side effects of medications.

Adverse Effects

Serotonin syndrome, akathisia, extrapyramidal sx, tardive dyskinesia, dystonia, hostility, depression

Contraindications

Hypersens to drug/class/compon

MAO inhibitor use w/in 14 days.

Caution if hepatic impairment, or renal impairment

Client Education

Should be taken first thing in the morning.

If patient forgets a dose may still take up to 8hrs after missed dose.

Medication /Food Interactions

Serotonin syndrome can result from taking an MAOI and SSRI at the same time.

Medication Administration

Taken orally, once a day, at the same time.

Medication Effectiveness

Patient should feel less anxiety with day to day tasks, can take 3-4 weeks for full effect.

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

Pt. Initials WT Age 49 Gender Female

Other demographic data

Patient lives with girlfriend at a homeless shelter currently. Patient does not work due to mental illness.

DSM –IV Diagnoses

Borderline personality disorder

NANDA Diagnoses:

At risk for disturbed body image related to borderline personality disorder.

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

Appearance- Patient appeared well groomed, dressed appropriately, and consistent diet.

Behavior- Patient was loud and very vocal about her thoughts. But was polite and appropriate for the situation.

Attitude- Patient had a positive attitude in regards to treatment, but was easily swayed to negative attitude when around someone who was negative or upset.

Speech- Normal speech, no impairment, large vocabulary

Mood- Patients mood was constantly change based on surroundings and conversation topics

Affect- Mostly flat, only see change with anger.

Main Thought Content

Ideations- Patient did have thoughts of harming herself on admission and attempted. But denies at this time.

Delusions- Denies at time of interview

Illusions- Denies at time of interview

Obsessions- Denies at time of interview

Compulsions- Denies at time of interview

Phobias- Snakes

Orientation-

Memory

Remote- patient's far away is intact, was able to tell me about her childhood, and schooling. Patient's recent memory is intact, patient was able to describe what she had for breakfast and lunch that day.

Reasoning

Judgment- Good but a work in progress. This patient was able to explain to me why her old group of friends was a bad influence and she shouldn't be around them anymore. However, struggled with the idea of leaving her friends behind.

Intelligence- Patient states she completed the tenth grade. Witnessed the patient reading and writing. Spoke clear English.

Coping Mechanisms (what are they and are they **+ or -)**

Patient uses soft music, imagery and breathing technics when stressed.

Allergies: Aspirin, PCN, Sulfa's, shellfish, latex

Factors that Lead to Treatment: Raped by 6 men on 9/9/19, then attempted suicide by medication ingestion on 9/11/19. Patient was brought to Carle Hospital and then transfer to The Pavilion.

Significant Psychiatric History:	PTSD (sexually abused as a child), was in an abusive marriage, Suicide ideation, Anxiety and dissociation disorder

Family History:	Patient mother passed away at a young age, does not know why. Lived with step father, and bio dad was never in her life.

Strengths:	Out spoken, can voice her problems. So the patient can be her own advocate when she leaves.

Support System:	Girlfriend and sister.

Discharge Plans (YOURS FOR THE CLIENT)

At this time there is no plan on discharge, the patient also expresses she is not ready to leave yet. Notes state, they would like to change medications.

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

Medication list:

Lorazepam, Baclofen, sumatriptan, SMZ/TMP, Nirtrofurantin, Hydroco, Pot CL, Buspirone, Eliquis, Esomepra mag., Loperamide, Ropinirole, Tizanidine, Doxycyc mono, Prednisone, Proair HFA, Sumatriptan, Gabapentin, Tramadol.

References:

Ladwig, G. B., & Ackley, B. J. (2011). *Mosbys Guide to Nursing Diagnosis.* Elsevier Health Sciences.

Videveck, S. L., & Miller, C. J. (2017). *Psychiatric-mental health nursing.* Philadelphia: Wolters Kluwer.

Name : **Date:** **Client Initials**	**CARE PLAN – POC**			**PAGE 2 OF 3**
Nursing Diagnosis (Prioritized)	**Short Term Goal**	**Interventions**	**Long Term Goal**	**Interventions**
1. At risk for suicide related to patient being raped as evidence by patients attempt.	**1.** Not harm them self	**1.** Assess for suicidal ideations. **2.** Assess the patient's ability to enter into a no suicide contract. **3.** Be alert for warning signs of suicide.	**1.** Disclose and discuss suicidal ideas if present; seek help.	**1.** Observe, report, and record any changes in mood or behavior that may signify increasing suicide risk and document results. **2.** Develop positive therapeutic relationships with the client; do not make promises that may not be kept. **3.** Assign a hospitalized patient to a room located near the nursing station.
2. At risk for disturbed body image related to borderline personality disorder.	**1.** Patient will utilize strategies to enhance appearance.	**1.** Encourage patient to verbalize treatment preferences and play a role in treatment **2.** Encourage the clients to write a narrative description of their changes. **3.** Acknowledge denial, anger and depression as normal feels.	**1.** Patient will get involved in appropriate community resources.	**1.** Assess family level of acceptance of patient. **2.** Provide patient with community resource **3.** encourage family and close friends to offer support.

1. Ineffective coping related to patient's anxiety as evidence by patient's suicide attempt.	**1.** Find what coping skill are most effective for patient.	**1.** What for contributing factors of ineffective coping. **2.** Use verbal and nonverbal therapeutic communication approaches including empathy, active listening and confrontation. 2. Encourage the patient to describe previous stressors and the coping mechanisms used.	**1.** Recognize stressor and put in place the effective coping skill previously identified.	**1.** Offer instruction regarding alternative coping strategies. **2.** Offer use of spiritual resources as desired. **3** Provide mental and physical activities within the patients ability.