

N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10.8.20	Patient Initials TD	Age 33	Gender Males
Race/Ethnicity Biracial	Occupation unemployed	Marital Status separated	Allergies NKA
Code Status Full code	Observation Status 15 min. check	Height 72"	Weight 220 lbs

Medical History (5 Points)

Past Medical History: Hepatitis C., colitis, legally blind, back pain, liver disease, suicidal ideation

Significant Psychiatric History: Psychosis (2018), suicidal ideation (2019)

Family History: Hypertension, ADHA, addiction

Social History (tobacco/alcohol/drugs): Tobacco → 1 pack per day for 14 years, Alcohol → rarely, a couple times per month. The last drink was 1.5 weeks ago., Drugs → THC 2g every day for 12 years. Used to be addicted to opioids.

Living Situation: homeless

Strengths: Average or above average intelligence, motivation for treatment and growth, special hobby/interest, religious affiliation

Support System: No current support system

Admission Assessment

Chief Complaint (2 points): Homeless, hopeless, & suicidal

Contributing Factors (10 points): Patient is a 33-year-old male who came to the facility on 10/8. He was referred to the facility by One Hope United. The patient called the police, because he thought there were armed individuals outside of his hotel room. He stated that he was having suicidal thoughts. He plans to overdose on benzo's and Tylenol.

Factors that lead to admission: Plan to overdose on benzos/acetaminophen

History of suicide attempts: Patient denied suicide attempts

Primary Diagnosis on Admission (2 points): Major depressive disorder

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience:</p> <p>Witness of trauma/abuse: Patient witness his mother be severely beaten by her brother.</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	NA	yes, all throughout childhood	NA	Patients states he was abused by his parents and sibling all throughout childhood.
Sexual Abuse	NA	yes, ages 7 and 12	NA	Patient state his older sister molested him at age 7 and an older peer raped him at age 12.
Emotional Abuse	NA	NA	NA	NA
Neglect	NA	NA	NA	NA
Exploitation	NA	NA	NA	NA
Crime	Yes	NA	NA	Patient has charges for drugs, aggregative battery, sexual offense, theft, and disorderly

				conduct.
Military	NA	NA	NA	NA
Natural Disaster	NA	NA	NA	NA
Loss	NA	NA	NA	NA
Other	NA	NA	NA	NA
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No		
Loss of energy or interest in activities/school	Yes	No		
Deterioration in hygiene and/or grooming	Yes	No		
Social withdrawal or isolation	Yes	No		
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	Patient states problems in the home and with relationships. He has 5 children and doesn't have custody of any of them. He has had toxic relationships for most of his life.	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Change in numbers of hours/night	Yes	No	The new medication he is on is helping him sleep longer at night. Patient state 6 hours is his new normal.	
Difficulty falling asleep	Yes	No		
Frequently awakening during night	Yes	No	Patient states that he wakes up 3 – 4 times throughout the night.	
Early morning awakenings	Yes	No	Patient normally wakes up between 3:00am and 5:00am	
Nightmares/dreams	Yes	No		
Other	Yes	No		

Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	
Binge eating and/or purging	Yes	No	
Unexplained weight loss? Amount of weight change:	Yes	No	
Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patient notes pacing when experiencing anxiety
Panic attacks	Yes	No	Patient notes daily panic attacks
Obsessive/compulsive thoughts	Yes	No	
Obsessive/compulsive behaviors	Yes	No	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	Patient notes that anxiety has caused him to lose his job and has contributed to his homelessness.
Rating Scale			
How would you rate your depression on a scale of 1-10?		2	
How would you rate your anxiety on a scale of 1-10?		9	
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	
School	Yes	No	
Family	Yes	No	Patient noted that his relationship with family, especially his

			children, is greatly affected.
Legal	Yes	No	Patient is awaiting trial for current charges.
Social	Yes	No	
Financial	Yes	No	Being homeless creates difficulties for finding resources and he is worried about getting better because of this.
Other	Yes	No	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
2018	Inpatient Outpatient Other:	NA	Substance	No improvement Some improvement Significant improvement
2019	Inpatient Outpatient Other:	NA	Psychiatric	No improvement Some improvement Significant improvement
2019	Inpatient Outpatient Other:	NA	Psychiatric	No improvement Some improvement Significant improvement

Personal/Family History

Who lives with you?	Age	Relationship	Do they use substances?	
Patient lives alone			Yes	No
			Yes	No
<p>If yes to any substance use, explain: Patient notes previous heroin addiction but states he is currently sober.</p>				
<p>Children (age and gender): Patient has 2 boys and 3 girls, ages 15 – 6.</p>				
<p>Who are children with now? Patient does not have custody of children. Four of his children are with foster parents. One child is with his ex-wife.</p>				
<p>Household dysfunction, including separation/divorce/death/incarceration: Patient states experiencing household dysfunction, separation, divorce, death, and incarceration throughout his life.</p>				
<p>Current relationship problems: Patient is currently separated from his wife.</p>				
<p>Number of marriages: 1</p>				
<p>Sexual Orientation: heterosexual</p>	<p>Is client sexually active? Yes No</p>		<p>Does client practice safe sex? Yes No</p>	
<p>Please describe your religious values, beliefs, spirituality and/or preference: Patient states that his religious belief is complicated. It is a mixture between Muslim, Islam, Christianity, and paganism.</p>				
<p>Ethnic/cultural factors/traditions/current activity: Patient denies any ethnic, cultural traditions, or activity. Describe:</p>				
<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient states that both parents have been arrested. Patient has pending charges for disorderly conduct.</p>				
<p>How can your family/support system participate in your treatment and care? Patient denies having any family or support system.</p>				
<p>Client raised by:</p> <p>Natural parents Grandparents</p>				

<p>Adoptive parents Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness: Patient states that abuse and being legally blind significantly affected his depression.</p>
<p>Atmosphere of childhood home:</p> <p>Loving Comfortable Chaotic Abusive Supportive Other:</p>
<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient denies history of mental illness</p>
<p>History of Substance Use: Patient states he was addicted to heroin for 10 years.</p>
<p>Education History:</p> <p>Grade school High school College Other:</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: No</p>
<p>Discharge</p>
<p>Client goals for treatment: Patients states that his goals for treatment are medicine stabilization and placement for living.</p>
<p>Where will client go when discharged? Patient is currently homeless.</p>

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DSM-IV Diagnoses (15 points)

Axis I: Major depressive disorder, Opioid addiction

Axis II: Paranoid personality disorder

Axis III: Hepatitis C

Axis IV: Homeless

Axis V:

Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/ Generic	buprenorphine/ Suboxone	mirtazapine/ Remeron	cyclobenzaprine/ Flexeril	olanzapine/ Zyprexa	citalopram/ Celexa
Dose	8 mg	15 mg	10 mg	5 mg	10 mg
Frequency	BID	HS	BID PRN	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	Chemical: opioid, thebaine derivative	Chemical: piperazinoazepine	Chemical: Tricyclic amine salt	Chemical: thienobenzodiazepine	Chemical: Racemic, bicyclic, phthalate derivative
Mechanism of Action	Binds with CNS receptors to change perception and emotional response to pain. Displaces narcotic agents from	Prevents the uptake of norepinephrine and serotonin in neurons. Increases the action of them in nerve cells which helps to elevate mood	Acts in the brain stem to lessen hyperactivity of muscles without affecting muscle function.	Helps attain antipsychotic effects by provoking dopamine and serotonin receptors	Increases serotonin levels by blocking serotonin reuptake through adrenergic nerves.

	binding sites and stops its actions.				
Therapeutic Uses	Opioid analgesic	Antidepressant	Skeletal muscle relaxant	antipsychotic	Antidepressant
Therapeutic Range (if applicable)	Day 1: 8 mg Day 2-4: 16 mg Maintenance: 4-24 mg, increase in 2-4 mg increments if needed Maximum: 24 mg	NA	NA	NA	1 week
Reason Client Taking	Opioid dependence	Major depression	Back pain	Schizophrenia	Major depression
Contraindications (2)	Acute or severe bronchial asthma, paralytic ileus	Hypersensitivity reactions, use within 14 days of a MAO inhibitor	Arrhythmia, heart block	Hypotension, hepatic dysfunction	Hypersensitivity reaction, use within 14 days of a MAO inhibitor
Side Effects/ Adverse Reactions (2)	Hepatotoxicity, jaundice	anxiety, colitis	Depression, blurred vision	anxiety, hepatitis	Suicidal ideation, hepatic necrosis
Medication/ Food Interactions	Mirtazapine, SSRI's, opioid analgesics, alcohol	Antihypertensives, anxiolytics, hypnotics, MAO inhibitors, IV methylene blue	Anticholinergic, MAO inhibitors, SSRI's, tricyclic antidepressants, SNRI's	Anticholinergic, antihypertensives, benzodiazepines, CNS depressants, alcohol	Antipsychotics, antiarrhythmics, NSAIDs, warfarin, MAO inhibitors
Nursing Considerations (2)	If patient is addicted to opiates, the drug	Administer at bedtime. Watch patient	use cautiously in patients with a history of	Use cautiously in individuals with impaired hepatic	Monitor patient for serotonin syndrome.

	<p>should not be administered until signs of withdrawal are present.</p> <p>Monitor vital signs and response to the drug often. The drug can cause hypotension, including orthostatic hypotension and syncope.</p>	<p>closely for suicidal inclinations, especially during dosage changes</p>	<p>seizure.</p> <p>Avoid giving to elderly if possible due to anticholinergic effects.</p>	<p>function.</p> <p>Monitor BP for orthostatic hypotension.</p>	<p>Use cautiously in patients with hepatic impairment.</p>
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Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook* (18th ed.). Burlington, MA.

Mental Status Exam Findings (20 points)

<p>APPEARANCE:</p> <p>Behavior:</p> <p>Build:</p> <p>Attitude:</p> <p>Speech:</p> <p>Interpersonal style:</p> <p>Mood:</p> <p>Affect:</p>	<p>Patient was unkempt with an anxious behavior. He has a strong build and a relaxed attitude. His speech is soft, and mood is labile. Patient appears to have a blunted affect.</p>
<p>MAIN THOUGHT CONTENT:</p> <p>Ideations:</p> <p>Delusions:</p> <p>Illusions:</p> <p>Obsessions:</p> <p>Compulsions:</p> <p>Phobias:</p>	<p>Patient is suffering from suicidal ideations and paranoid delusions. He denies any current illusions, obsessions, or compulsions. He admits to having phobias but can't think of any specific ones at the moment.</p>

ORIENTATION: Sensorium: Thought Content:	Patient was ANO x 3. Patient stated he was tired from his new medication. He was able to answer questions appropriately but did not expand on many details.
MEMORY: Remote:	Patient denies any memory impairments. He was able to recall information from his childhood without any difficulty.
REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:	Patient had fair judgement, calculations, abstraction, and impulse control. He has average to above average intelligence.
INSIGHT:	The patient's insight is fair.
GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	Patient used glasses and is legally blind. Patient was lying in bed during the assessment. He has good muscle tone, strength, and MAEW.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0732	64	114/62	13	98.2	97%
1612	59	108/56	16	97.8	96%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1520	Number	Back	4	Dull ache	
2030	Number	Back	3	Dull ache	

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: 100%	Breakfast: 237 mL
Lunch: 100%	Lunch: 237 mL
Dinner: 100%	Dinner: 237 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): After leaving the facility patient will stay at shelter while he is homeless. The patient will be provided with resources to contact in order to continue his mental healthcare needs. He should be taught about ways to cope with his moments of anxiety and paranoia. He should also be educated on how to properly care for his diagnosis of Hepatitis C and provided with resources to contact if he cannot afford his medications or treatment. Due to his previous heroin addiction, directing the patient will be directed to narcotics anonymous to help him continue his sobriety.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Immediate Interventions (At admission)	Intermediate Interventions (During hospitalization)	Community Interventions (Prior to discharge)
<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis 			

“as evidenced by” components	was chosen			
<p>1. Risk for self-directed violence due to depression and hopelessness as evidence by suicidal ideation to overdose</p>	<p>Patient admitted to having thought of suicide and wanting to overdose on his medication. He has had previous admissions to mental health hospitals for the same reason.</p>	<p>1. Complete an initial suicide assessment 2. Remove items that could be used for self-harm 3. Administer antidepressant medication and teach the patient the importance of taking medication</p>	<p>1. Encourage the patient to express feelings and come up with alternative ways to handle feelings 2. Monitor patient at least every 15 minutes. 3. Make sure that patient swallow’s medications that are administered</p>	<p>1. Check for the availability of medications for the patient 2. Arrange for crisis counseling and activate links to self-help groups. 3. Implement a no-suicide contract</p>
<p>2. Hopelessness related to losses, stresses, and basic symptoms of depression as evidence by suicidal thoughts</p>	<p>Patient stated he was “homeless, hopeless, and suicidal.”</p>	<p>1. Assess individual signs of hopelessness 2. Assess unhealthy behaviors used to cope with feelings 3. Administer antidepressant medication.</p>	<p>1. Encourage patient to identify and express feelings and insights 2. Help patient identify areas of life that are under his control 3. Express hope to patient in a realistic manner</p>	<p>1. Allow patient to have responsibility for setting goals, scheduling activities, and making decisions. 2. Help the patient to seek spiritual supports that provide hope 3. Educate patient about crisis intervention like the suicide hotline or other resources.</p>
<p>3. Anxiety related to lack of knowledge</p>	<p>Patients anxiety and paranoia led him to believe</p>	<p>1. Move the client to a quiet area with little stimuli</p>	<p>1. Educate patient that anxiety disorders are treatable</p>	<p>1. Determine if patient requires PRN medications for</p>

<p>regarding cause and treatment as evidence by patient expressing feelings of constant anxiety.</p>	<p>that there were people with guns outside his hotel room.</p>	<p>2. Maintain calmness when approaching patient 3. Support the patients initial defenses</p>	<p>2. Stay with the patient during panic attacks. 3. Teach signs and symptoms of increasing anxiety and how to stop the process</p>	<p>high levels of anxiety 2. Avoid forcing the patient to make decisions 3. Instruct patient safe ways to administer anxiety medication at the first signs of a panic attack</p>
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Other References (APA):

Swearingen, P. L., Wright, J.D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, psychiatric nursing care plans*. St. Louis, MO: Elsevier/Mosby.

Concept Map (20 Points):

Subjective Data

“homeless, hopeless, & suicidal”
Anxiety level of 9
Plan to overdose on Benzos or acetaminophen
“People outside of hotel room with guns”

Nursing Diagnosis/Outcomes

Risk for self-directed violence due to depression and hopelessness as evidence by suicidal ideation to overdose
Hopelessness due to losses, stresses, and basic symptoms of depression as evidence by suicidal thoughts
Anxiety due to lack of knowledge regarding cause and treatment as evidence by patient expressing feelings of constant anxiety.

Objective Data

Previous psychiatric hospitalizations
History of physical and sexual abuse
Legally blind
History of substance abuse

Patient Information

Admitted: 10/8/20
Initials: TD
Age: 33
Gender: M
Race: Biracial
Occupation: Unemployed
Marital Status: separated
15 min. observation
Height: 6'
Weight: 220 lbs

Nursing Interventions

Check for the availability of medications for the patient
Arrange for crisis counseling and activate links to self-help groups.
Implement a no-suicide contract
Determine if patient requires PRN medications for high levels of anxiety
Avoid forcing the patient to make decisions
Instruct patient safe ways to administer anxiety medication at the first signs of a panic attack
Determine if patient requires PRN medications for high levels of anxiety
Avoid forcing the patient to make decisions
3. Instruct patient safe ways to administer anxiety medication at the first signs of a panic attack



