N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
1/16/21	**AB**	**33**	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	**Unemployed**	**Single**	**NKA**
Code Status	**Observation Status**	**Height**	**Weight**
Full	**15-minute rounds**	**5'8"**	**127 lbs**

Medical History (5 Points)

Past Medical History: Pt has no known past medical history

Significant Psychiatric History: Patient attempted to hang himself in August of 2020 and then was admitted to the Pavilion**.**

Family History: The patient's family has no know psychiatric history. His mother and father both had alcohol abuse. The patient's grandma on his maternal side had hypertension and grandpa on maternal side had lung cancer.

Social History (tobacco/alcohol/drugs): Patient stated that he "used to smoke cannabis from 2019-2020 every other day and would occasionally (once a month) drink alcohol". The patient as smokes 2-3 cigarettes a day.

Living Situation: Patient currently live in a group home**.**

Strengths: Patient stated that he has "no strength and nothing to live for."

Support System: Patient does not have a support system. His mom has died and has no connection with his siblings or father that are still living.

Admission Assessment

Chief Complaint (2 points): Patient came in because he felt unsafe in himself and the people around him and planned to hang himself.

Contributing Factors (10 points):

Factors that lead to admission: The patient came in the hospital via ambulance because he felt very unsafe at the group home he was at. He felt unsafe with him self and the people around him. The patient said the people that live there can be scary at times. He said he doesn't really mind be there, but he believes he will be happy when he gets back out on his own. Before leaving the group home he told someone to call an ambulance to take him to the hospital because he feels unsafe with himself and wanted to harm himself. He also had complaints of hearing things such as talking and loud noises, but knew that they were not real. He also stated that he "was seeing cars crashing into all the buildings around him even the group home." He then told me that he had planned to hang himself.

History of suicide attempts: Patient attempted to end his life in August of 2020 by hanging himself where he was sent to the pavilion for treatment.

Primary Diagnosis on Admission (2 points): Bipolar affective disorder and major depressive disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patients parents were both alcoholics and his uncle sexually abused him. **Witness of trauma/abuse**: N/A				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for**	**Describe**

			another person with trauma)	
Physical Abuse				
Sexual Abuse		**“little”**		**Pt. was sexually abused by his uncle**
Emotional Abuse				
Neglect		**“all growing up”**		**He said his dad never was around and mom would leave for days sometimes.**
Exploitation				
Crime				
Military				
Natural Disaster				
Loss		**2 years ago (age 31)**		**Death of mother “the only person who was there for him”**
Other				

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	**All the time usually. Patient said he is “always very depressed.”**
Loss of energy or interest in activities/school	**Yes**	**No**	**Occasionally never wants to do nothing**
Deterioration in hygiene and/or grooming	**Yes**	**No**	
Social withdrawal or isolation	**Yes**	**No**	**Recently he feels a lot that he has no one.**
Difficulties with	**Yes**	**No**	**Struggled with school as a child**

home, school, work, relationships, or responsibilities			**due to learning disability. Also lost his job due to depression.**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**1-2 times a week**
Difficulty falling asleep	**Yes**	**No**	**2-3 nights a week**
Frequently awakening during night	**Yes**	**No**	
Early morning awakenings	**Yes**	**No**	
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**	**Often paces for multiple hours a day when "a lot is on my mind".**
Panic attacks	**Yes**	**No**	**Has one every once in a while he stated he had one before coming to OSF.**
Obsessive/compulsive thoughts	**Yes**	**No**	
Obsessive/compulsive behaviors	**Yes**	**No**	
Impact on daily	**Yes**	**No**	**Has troubles sleeping most days**

living or avoidance of situations/objects due to levels of anxiety			**and also lost his job due to his anxiety and depression.**
Rating Scale			
How would you rate your depression on a scale of 1-10?	**6**		
How would you rate your anxiety on a scale of 1-10?	**3**		
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**	**Is unemployed due to his depression "it got so bad I stopped going to work".**
School	**Yes**	**No**	
Family	**Yes**	**No**	**Patien occasionally feels isolated because he does not have family.**
Legal	**Yes**	**No**	
Social	**Yes**	**No**	**Feels as if he has no one there for him**
Financial	**Yes**	**No**	**Patient gets stressed about finances most days because he wants to be independent.**
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
August 2020	**Inpatient: the pavilion/ Dr. Christina Farag Outpatient**	**Inpatient**	**Attempted to commit suicide by hanging**	**No improvement** **Some improvement**

	Other:		**himself**	**Significant improvement**
Currently attending when living at the group home	**Inpatient** **Outpatient: Dr Ian T Nygen** **Other:**	**Outpatient**	**Depression**	**No improvement** **Some improvement** **Significant improvement**
Current hospitalization	**Inpatient** **Outpatient** **Other:**	**Inpatient**	**Suicidal ideations**	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Lives in group home	**Many ages**	**"keep to myself"**	**Yes** **unknown**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain:				
Children (age and gender): N/A **Who are children with now?**				
Household dysfunction, including separation/divorce/death/incarceration: Parents were separated. The patients father lived a couple hours away.				
Current relationship problems: N/A				

Number of marriages: 0		
Sexual Orientation: Homosexual	**Is client sexually active?** **Yes** **No**	**Does client practice safe sex?** **Yes** **No**
Please describe your religious values, beliefs, spirituality and/or preference: He has his "own spiritual ideology's."		
Ethnic/cultural factors/traditions/current activity: None **Describe:**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): None		
How can your family/support system participate in your treatment and care? Patient does not have a family or support system around.		
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: Patient was sexually abused by his uncle and did not have a good support system as a child.		
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic:** He was often left at home by himself for long hours as a child. After a while his mom quit paying rent and he was forced to go get a job at a young age and start providing for the both of him. **Abusive:** Patient was abused by his uncle **Supportive** **Other:**		
Self-Care: **Independent** **Assisted**		

Total Care
Family History of Mental Illness (diagnosis/suicide/relation/etc.) No know family history of mental illness.
History of Substance Use: No history of substance use for him. The patient's parents were both alcoholics.
Education History: He had learning disabilities growing up that made him struggle in school. He wanted to join the military or go to college, but "it just didn't work out." **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Had a learning disability
Discharge
Client goals for treatment: Feel better and not want to hurt himself. He wants to get back on his feet and return to daily activities.
Where will client go when discharged? Patient plans on going back to the group home and then moving out on his own

Outpatient Resources (15 points)

Resource	Rationale
1. Rosecrance in champaign	**1. Patient already lives in a group home at**

	Rosecrance. They have mental health outpatient and inpatient services that he can continue to attend.
2. Crisis hotline	**2. The crisis hotline is a resource that the client can use when they are having suicidal ideations.**
3. Insight therapy	**3. Outpatient counseling where a patient can talk to a psychiatrist.**

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/ Generic	**Acetaminophen/ Tylenol**	**ARIPiprazole/ Abilify**	**Benztropine/ Cogentin**	**Calcium carbonate/ tums**	**Divalproex/ Depakote**
Dose	**2 tabs 325mg**	**5 mg**	**2 mg**	**500 mg**	**500 mg**
TID PRN	**Q4 PRN**	**Daily**	**BID PRN**	**TID with meals**	**QID daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Nonsalicylate, Para**	**Atypical antipsychotic**	**antichloliner gic**	**Calcium salts**	**Anticonvulsants**

	aminophenol derivative				
Mechanism of Action	**Inhibits the enzyme cyclooxygenase blocking prostaglandin production interfering with pain impulse generation in the peripheral nervous system**	**May produce antipsychotic effects through partial agonist and antagonist actions.**	**Blocks acetylcholine's action at cholinergic receptor sites.**	**Increases levels of intracellular and extracellular calcium which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems**	**Blockage of voltage-gated sodium channels and increased brain levels of gamma-aminobutyric acid.**
Therapeutic Uses	**To relieve mild to moderate pain**	**To treat acute schizophrenia**	**Antiparkinsonian central acting anticholinergic**	**To treat hyperphosphatemia**	**Treat certain psychiatric conditions**
Therapeutic Range (if applicable)	**640-650 mg Q4-6 hours**	**10-15 mg daily**	**0.5- 1 mg increase by 0.5 gradually as needed**		**50-100 mcg/mL**
Reason Client Taking	**For pain prn**	**For the voices the patient is hearing**	**Can be used as an antipsychotic**	**Anti acid for meals**	**For bipolar disorder**
Contraindications (2)	**Severe hepatic impairment, severe active liver disease**	**Hypersensitivity to aripiprazole or its components**	**Angle-closure glaucoma, children younger than age 3**	**Hypercalcemia, renal calculi**	**Urea cycle disorders, mitochondrial disorders**
Side Effects/ Adverse Reactions (2)	**Hypotension, leukopenia**	**Neutropenia, respitory failure**	**Agitation, hypotension**	**Inhibits sodium-glucose co-transporter 2 responsible**	**Liver damage, harm to unborn baby**

				for the majority of the reabsorption of filtered glucose from the tubular lumen in the kidneys.	
Medication/ Food Interactions	**Anticholinergics and oral contraceptions**	**Antihypertensives, benzodiazepines**	**Amantadine, phenothiazine**	**Digoxin, insulin**	**Phenytoin, carbamazepine**
Nursing Considerations (2)	**Use cautiously with patients with hepatic impairment or active hepatic disease**	**Shouldn't be used to treat dementia-related psychosis in elderly, use cautiously with patients with cardiovascular, or cerebrovascular disease**	**Expect to administer IV or IM for a more rapid response than oral route. Give drug before or after meals based on patients need and response**	**Use drug cautiously in patients with chronic kidney insufficiency, congestive heart failure, and decreased blood volume.**	**Decrease IQ in unborn children, major seizures**

Brand/Generic	**Haloperidol/ Haldol**	**QUETiapike/ Seroquel**			
Dose	**5 mg**	**200mg**			
Frequency	**Q4 PRN/ Q6 PRN**	**Daily before bed**			
Route	**Oral/ IM**	**Oral**			
Classification	**Butyrophenone derivative**	**Dibenzothiazepine dervitive**			

Mechanism of Action	**May block postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine, producing antipsychotic affect.**	**May produce antipsychotic effects interfering with dopamine binding to dopamine type 2 receptor sites in the brain.**			
Therapeutic Uses	**To treat psychotic disorders**	**To treat schizophrenia**			
Therapeutic Range (if applicable)	**0.5- 5 mg BID or QID0**	**400 to 8000 mg daily in 2 divided doses**			
Reason Client Taking	**PRN incase he goes psychotic**	**For the voices and illusions**			
Contraindications (2)	**Parkinson's disease, severe CNS comatose states or depression**	**Hypersensitivity to quetiapine or its components**			
Side Effects/Adverse Reactions (2)	**Seizures, acute hepatic injury**	**Hypothermia, suicidal ideation**			
Medication/Food Interactions	**Alprazolam, buspirone**	**Antibiotics such as gatifloxacin or moxifloxacin, antipsychotic drugs such as chlorpromazine, thioridazine, ziprasidone**			
Nursing Considerations (2)	**Shouldn't be used to treat dementia-related psychosis in the elderly. Assess patient for fall risks**	**Should not be given to patients who have a history of brady cardia, monitor patient for suicidal ideations**			

Medications Reference (1) (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert. (2020). *2020 Nurse's Drug Handbook.* (Nineteenth ed.). Burlington, MA: Jones & Bartlett learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Well groomed** **Mentally delayed** **Medium** **Distressed** **Good** **Guarded** **Depressed** **Calm and dad**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 **"wanted to die", but feeling better** **Occaisonally hears voices** **Saw cars crashing into buildings** **None** **None** **None**
ORIENTATION: **Sensorium:** **Thought Content:**	**A & O X4** **N/A** **Intact somewhat delayed**
MEMORY: **Remote:**	**Somewhat forgetful**

REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 **Good** **Aware but hopeless** **Impaired** **None** **Average**
INSIGHT:	**fair**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 **None** **Good** **Medium build** **Good** **Good**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	**95**	**122/80**	**16**	**97.2**	**100**
1631	**72**	**130/94**	**18**	**97.6**	**100**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1631	**0-10**	**N/A**	**0**	**N/A**	**N/A**
1420	**0-10**	**N/A**	**0**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	**Oral Fluid Intake with Meals (in mL)**

Breakfast: 100% **Lunch: 100%** **Dinner: 100%**	 **Breakfast: 440** **Lunch: 360** **Dinner: 280**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Patient will discharge to RoseCrance to help get more therapy and get back on his feet. Patient will continue his medications and work on his mental health there.

Nursing Diagnosis (15 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	Rational • Explain why the nursing diagnosis was chosen	Immediate Interventions (At admission)	Intermediate Interventions (During hospitalization)	Community Interventions (Prior to discharge)
1.	**Related to feelings of depression, as evidenced by suicide attempts.**	**1. Monitor every 15 minutes or more** **2. Engage and connect with patient** **3. Check for weapons or tools to harm**	**1.monitor frequently** **2. Group therapy** **3. Take medications when needed**	**1. Find community support to be apart of** **2. Outpatient counseling** **3. Educate on the importance of medications when he leaves.**

		with		
2.	**Risk for suicide as evidenced by different suicide attempts.**	**1. Check for harmful items** **2. Ask patient about there feelings and attempt for suicide** **3. Connect with the patient and gain trust**	**1. Watch patient carefully** **2.Encouage patient to engage in therapy and group activities** **3. Keep a routine schedule for meals and medications**	**1. Have patient go to a mental health rehab.** **2.Since patient has no family or support find someone or a program to check up on him to make sure he is doing okay.** **3. Also have patient go to therapy and maintain taking medications**
3.	**Anxiety as evidenced by patient pacing in the room.**	**1. Give patient room and time.** **2. Give patient medication to help calm.** **3. assess health history**	**1. Give patient plenty of room to pace and think about his emotions.** **2. Talk with patient and help him clear his mind.** **3. Help patient think of ways to help relieve his anxiety.**	**1. Have patient go to group activities in the community so he does not feel isolated.** **2. Encourage patient to find ways to cope with anxiety and have a resource to talk to when it occurs.** **3. Outpatient therapy or inpatient at rosecrane to help express his feelings and emotions.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient stated he “felt like hurting himself.” Patient also said he would “hear voices and see cars crashing into buildings around him, but new it was not true.”

Nursing Diagnosis/Outcomes

Related to feelings of depression, as evidenced by suicide attempts.
Risk for suicide as evidenced by different suicide attempts.
Anxiety as evidenced by patient pacing in the room.

Objective Data

Patient is well groomed with a decent thought pattern. The patient wore sunglasses at all times because “the lights hurt his eyes”. Patients vitals were all within normal range except a slightly high blood pressure of 130/94.

Patient Information

Patient is a 33-year-old single male who presents with bipolar disorder and major depression. Patient was brought in for wanting to attempt suicide.

Nursing Interventions

1. Find community support to be a part of

Outpatient counseling

Educate on the importance of medications when he leaves.

Have patient go to a mental health rehab.

.Since patient has no family or support find someone or a program to check up on him to make sure he is doing okay.

Also have patient go to therapy and maintain taking medications
Have patient go to group activities in the community so he does not feel isolated.

Encourage patient to find ways to cope with anxiety and have a resource to talk to when it occurs.
Outpatient therapy or inpatient at rosecrane to help express his feelings and emotions.