N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
01/19/2021	J.R.	32	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Single	NKA
Code Status	**Observation Status**	**Height**	**Weight**
Full Code	15-Minute Rounds	5’9”	151 lbs

Medical History (5 Points)

Past Medical History: Patient has a history of mild asthma.

Significant Psychiatric History: Patient has a history of bipolar affective disorder and depression.

Family History: Patient’s fathers side has a history of heart attacks and dementia. Patient’s mothers side has a history of cancer, type is unknown.

Social History (tobacco/alcohol/drugs): Patient denies use of drugs. Patient reports that he smokes half a pack a day, 7 days a week, for the past 20+ years. Patient reports that he drinks ¼ a bottle of liquor up to twice a week.

Living Situation: Patient lives with his fiancé, 9-month-old son, and 9-year-old stepdaughter. They live in a trailer.

Strengths: Patient reports he is good at working out and lifting weights. Patient also states he is a good dad to his kids.

Support System: Patient reports his support system consists of his father, his grandparents, and his fiancé. All of which live close by.

Admission Assessment

Chief Complaint (2 points): Patient’s chief complaint is suicidal ideation without a plan.

Contributing Factors (10 points):

Factors that lead to admission: The patient was originally brought to OSF hospital by his father after saying his goodbyes to his father and his fiancé. The patient has been having relationship issues with his fiancé. The patient states, “My fiancé constantly wanted to talk about her day and his feelings. Apparently, I’m not enough for her as I am.” Patient also lost his job a few months ago due to COVID and having to cut costs in his place of employment.

History of suicide attempts: The patient attempted suicide when he was 12 years old. Patient would not report how or why he did. The patient had a second suicide attempt on January 18th, 2021. Patient reported the loss of his job and the fighting with his fiancé just got to be too much to handle.

Primary Diagnosis on Admission (2 points): The primary diagnosis upon admission is bipolar affective disorder, current episode depressed.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient denied any history of trauma at first, but he opened up about a few parts of his history of trauma. **Witness of trauma/abuse:** Patient denied being a witness of trauma/abuse.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for**	**Describe**

			another person with trauma)	
Physical Abuse				Patient denied history of physical abuse
Sexual Abuse				Patient denied history of sexual abuse.
Emotional Abuse				Patient denied history of emotional abuse.
Neglect				Patient denied history of being neglected.
Exploitation				Patient denied historical feelings of exploitation.
Crime				Patient denied history of crime.
Military				Patient denied being in the military because of asthma, but would have joined if he didn't have asthma.
Natural Disaster				Patient denied witnessing a natural disaster.
Loss	Current	4th grade		Patient lost 10+ friends and family members this year all for different reasons. Patient also lost his best friend in 4th grade due to leukemia very unexpectedly.
Other				None
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad	**Yes**	**No**	Not currently	

mood			
Loss of energy or interest in activities/school	**Yes**	**No**	Not currently
Deterioration in hygiene and/or grooming	**Yes**	**No**	Patient was well groomed and showered that day.
Social withdrawal or isolation	**Yes**	**No**	Patient was seen socializing with other patients the majority of the day.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient denied this question, however lost his job and is currently fighting with his fiancé.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient sleeps schedule changes like normal due to having a baby in the house. States he gets 6-7 hours of sleep a night.
Difficulty falling asleep	**Yes**	**No**	Patient reports no difficulties falling asleep.
Frequently awakening during night	**Yes**	**No**	Patient reports he only wakes up to take care of his son.
Early morning awakenings	**Yes**	**No**	Patient reports no early morning awakenings.
Nightmares/dreams	**Yes**	**No**	Patient reports no night terrors or dreams.
Other	**Yes**	**No**	None
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient reports no changes in eating habits.
Binge eating and/or purging	**Yes**	**No**	Patient reports no binge eating/purging.
Unexplained weight loss? Amount of weight change:	**Yes**	**No**	Patient reports no unexplained weight loss.
Use of laxatives or excessive exercise	**Yes**	**No**	Patient reports no use of laxatives or excessive exercise.

Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient was shaking his leg frequently while talking to him. Also seen doing this during group.
Panic attacks	**Yes**	**No**	Patient reports to having no panic attacks.
Obsessive/compulsive thoughts	**Yes**	**No**	Patient reports no obsessive/compulsive thoughts.
Obsessive/compulsive behaviors	**Yes**	**No**	Patient reports no obsessive/compulsive behaviors.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient reports no impact on daily living activities due to high levels of anxiety.
Rating Scale			
How would you rate your depression on a scale of 1-10?	Patient reports his depression a 5/10.		
How would you rate your anxiety on a scale of 1-10?	Patient reports his anxiety a 1/10.		
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**	Patient recently lost his job.
School	**Yes**	**No**	
Family	**Yes**	**No**	Patient is currently constantly fighting with his fiancé about communication.
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	
Other	**Yes**	**No**	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
2000 (exact dates unknown)	**Inpatient** **Outpatient** **Other:** School Counselor	Outpatient	Depression, suicidal ideation, Suicide attempt	**No improvement** **Some improvement** **Significant improvement**

Who lives with you?	Age	Relationship	Do they use substances?	
Fiancé	27	Fiancé	**Yes**	**No**
Stepdaughter	9	Stepdaughter	**Yes**	**No**
Son	9 Months	Son	**Yes**	**No**

If yes to any substance use, explain: Fiancé is a smoker.

Children (age and gender): Patient has a 9 years old stepdaughter and a 9 months old son.

Who are children with now? Fiancé

Household dysfunction, including separation/divorce/death/incarceration: Patient's parents got divorced once he was living on his own. Patient stated he never thought they would get divorced.

Current relationship problems: Patient currently is fighting with his fiancé because he doesn't want to talk about his feelings and she does.

Number of marriages: None

Sexual Orientation:	Is client sexually active?	Does client practice safe sex?
Straight	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

Patient believes in a higher power but doesn't know what exactly that means to him.

Ethnic/cultural factors/traditions/current activity: None

Describe: N/A

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

states, “They can help me to talk and open up about my feelings when I get home”.

Client raised by:

Natural parents- Both mother and father
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:
Patient had a friend in 4th grade who was his best friends. He passed of leukemia, very unexpectedly. His friend was told he would be able to go home the day he passed. Patient is still in contact with this friends’ parents. Patient reports that this death is where his depression began.

Atmosphere of childhood home:

Loving
Comfortable
Chaotic
Abusive
Supportive
Other:

Self-Care:

Independent
Assisted
Total Care

Family History of Mental Illness (diagnosis/suicide/relation/etc.)

Patient reports his grandmother had dementia.

History of Substance Use:

Current tobacco user, 15+ years ago patient reports trying cocaine, marijuana, shrooms, acid, and meth.

Education History:

Grade school
High school – Pt obtained his GED in his mid 20’s.
College
Other: Trade school MTI, Welding

Reading Skills:

Yes **No** **Limited**
Primary Language: English
Problems in school: Patient reports having bad grades because he “had no energy to work hard”.
Discharge
Client goals for treatment: Patient states he wants to be able to open up and talk about the way he is feelings. Another goal is to dismiss the thought of self-harm.
Where will client go when discharged? Patient will go back home to his fiancé and kids upon discharge.

Outpatient Resources (15 points)

Resource	Rationale
1. Crisis Hotline	**1.** Crisis Hotline is a resource that the client can use when they are having suicidal thoughts, they are available 24/7.
2. Champaign County Bipolar Disorder Therapist	**2.** Outpatient therapy is a resource the client can utilize without having to stay overnight.
3. Home Health Nurse	**3.** Home health nurses can go to the client’s home to discuss their mental health and provide medication.

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

Brand/Generic	(Buspar) buspirone	albuterol	(Trileptal) oxcarbazepine	(Tylenol) acetaminophen	(Cogentin) benztropine
Dose	10 mg	1-2 puffs (18g)	300 mg	650 mg	2 mg
Frequency	BID	PRN, Q4H	BID	PRN, Q4H	PRN, BID
Route	Oral	Inhalation	Oral	Oral	Oral
Classification	Antianxiety Agent	Bronchodilator	Anticonvulsants	Analgesics	Anticholinergics
Mechanism of Action	Unknown. Has moderate affinity for brain D2-dopamine receptors.	Attaches to beta 2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert ATP to cAMP.	They produce blockade of voltage-sensitive sodium channels, resulting in stabilization of hyperexcited neural membranes.	They inhibit the COX pathway in the central nervous system but not peripheral tissues.	It exerts its action through competing with acetylcho at muscarinic receptors.
Therapeutic Uses	Treat anxiety, think more clearly, relax, worry less, feel less jittery and irritable.	To treat bronchospasms	To treat seizures and is used as a mood stabilizer to treat the symptoms of bipolar disorder.	To relieve moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, and reduce fever.	To treat symptoms of Parkinson's disease, trem and any involuntary musc control.
Therapeutic Range (if applicable)	20-30 mg per day of divided doses.	1.25-5 mg	600-2,400 mg/day	5-20 mcg/mL	N/A

Reason Client Taking	To decrease anxiety and to think more clearly.	To treat his mild asthma.	To treat his bipolar disorder.	To treat symptoms of other medications.	To treat imbalances of chemicals that may arise other medications.
Contraindications (2)	Renal failure, Hepatic disease	Hypersensitivity to albuterol or its components, diabetes	Low amounts of sodium in the blood, Depression	Liver failure, caloric undernutrition	In patients with known benztropine mesylate hypersensitivity Intestine infection
Side Effects/Adverse Reactions (2)	Chest pain, shortness of breath	Shakiness, headache	Dizziness, tiredness	Nausea, loss of appetite	Dry mouth, constipation
Medication/Food Interactions	May be taken with or without food, grapefruit may increase the risk of side effects.	Avoid taking with Beta-blockers, MAOIs, diuretics	Take on an empty stomach, do not crush, chew, or break it.	Avoid food high in pectin, carbohydrates, and many cruciferous vegetables that can interfere with acetaminophen absorption.	Avoid foods high in Calcium, pickled or Fermented foods, Vit. K Rich foods, and Grapefruit.
Nursing Considerations (2)	Do not administer with grapefruit juice, Instruct patient to avoid alcohol and other CNS depressants.	Monitor therapeutic effectiveness as indicated by increased pulmonary function, Listen to lung sounds to monitor breathing.	Monitor for and report signs and symptoms of hyponatremia, Monitor phenytoin levels when administered concurrently.	Do not give to patients who are prone to bleed easily, be alert for signs of hepatotoxicity and liver failure.	Assess therapeutic effectiveness, monitor I&O ratio and pattern.

Medications Reference (1) (APA):

RxList. (2021). WebMD, Medscape, eMedicineHealth, MedicineNet, OnHealth.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Clean, showers daily Stable, relaxed, and calm Medium build Focused Clear and intelligible Engaged, cooperative, and oriented Calm Calm and happy, mildly expansive
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 Suicidal None None None None None
ORIENTATION: **Sensorium:** **Thought Content:**	A & O x4 N/A Intact and organized
MEMORY: **Remote:**	No impairment
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Sensible Fair N/A Average None Average
INSIGHT:	Fair

GAIT:	
Assistive Devices:	None
Posture:	Fair
Muscle Tone:	Average
Strength:	Average
Motor Movements:	Good

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1600	80 BPM	129/84 mmHg	17 breaths/min	97.7 F	97%
1900	78 BPM	136/80 mmHg	16 breaths/min	97.3 F	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	Numerical	N/A	0/10	N/A	N/A
1800	Numerical	N/A	0/10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	**Oral Fluid Intake with Meals (in mL)**
Breakfast: 100%	**Breakfast:** 240 mL
Lunch: 100%	**Lunch:** 240 mL
Dinner: 90%	**Dinner:** 240 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient should seek weekly outpatient therapy/counseling to rid of suicidal ideations. The patient should also remain on all medications to improve symptoms and to improve any distress. Encourage the client to go home to his fiancé and found common grounds for them to discuss the next steps.

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. Risk for self-harm	Related to feelings of depression, as evidenced by suicide attempts	**1.**Check for weapons **2.** Monitor patient **3**.Engage with the patient so they participate in treatment	**1**.Monitor frequently **2.** Group therapy **3.** Strictly follow medication regimen	**1.** Outpatient therapy **2.** Community group therapy **3.** Confirm access to medications
2. Ineffective breathing pattern	Related to asthma, as evidenced by diagnosis and use of albuterol	**1.** Assess health history **2.** Assess respiratory status **3.** Confirm presence of	**1.** Provide medications **2.**Frequently assess respiratory status **3.** Provide fluid therapy	**1** Confirm access to albuterol **2.** Confirm access to breathing treatments

		albuterol		**3.** Evaluate patient living situation for environmental pollution
3. Spiritual distress	Related to suicide attempt, as evidenced by "I believe in a higher power, but don't know how that affects my life"	**1.** Assess spiritual history **2.** Look to see if the patient feels any guilt **3.** Assess the patients inability to participate in religious activities	**1.** Encourage client to write feelings in a reflection journal **2.** Suggest spiritual leader of facility to talk to the client **3.** Provide information on referrals to spiritual information	**1.** Look for churches for the patient to get involved with **2.** Encourage the patient to find someone to confide in, spiritually. **3.** Obtain resources based on multiple religious beliefs.

Concept Map (20 Points):

Subjective Data

Patient states that he does not feel depressed nor does he feel anxious. Patient states that he made some wrong decisions without thinking and that is how he got admitted. He states that he is ready to go home to see his fiancé and work through his feelings.

Nursing Diagnosis/Outcomes

Risk for self-harm related to feelings of depression, as evidenced by previous suicide attempts.
Ineffective breathing pattern related to asthma, as evidenced by diagnosis and use of albuterol
Risk for spiritual distress related to suicide attempt, as evidenced by "I believe in a higher power, but don't know how that affects my life".

Objective Data

Patient's most recent vitals were
BP: 136/80 mmHg
RR: 16
O2: 98%
HR: 78 BPM
Temp: 97.3 F

Patient Information

Patient is a 32-year-old, engaged, Caucasian male father, with a history of asthma, suicidal ideation and suicide attempts. Patient is currently calm, cooperative, and talkative.

Nursing Interventions

Outpatient therapy
Community group therapy
Confirm access to medications
1 Confirm access to albuterol
Confirm access to breathing treatments
Evaluate patient living situation for environmental pollution
Look for churches for the patient to get involved with
Encourage the patient to find someone to confide in, spiritually.
Obtain resources based on multiple religious beliefs.