N323 Care Plan

Lakeview College of Nursing

Nathaniel Shick

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/01/2021	D. S.	61	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Nurse Practitioner at OSF	Married	NKA
Code Status	**Observation Status**	**Height**	**Weight**
FULL	Fifteen-minute rounds	170cm	190lbs

Medical History (5 Points)

Past Medical History:

He has a history of Hypertension, GERD, and chronic back pain.

Significant Psychiatric History:

The patient claims that he believes that he has been depressed and higher levels of anxiety for about a year now. He does say that it has never been diagnosed but does say that since COVID-19 hit and the loss of his mother this past august his stress levels and feelings of being down have increased significantly.

Family History:

Patient's mother was diagnosed with anxiety, depression, and she also had attempted suicide when patient was in the second grade. His sister was diagnosed with bipolar disorder and she did commit suicide about four years ago.

Social History (tobacco/alcohol/drugs):

Patient claims to have three to four cigars a month. He also claims that he drinks about six to eight beers per week. These are usually all consumed within a short period of time because he does not drink during the days that he works. He also claims that when he was younger, he smoked a little bit of weed.

Living Situation:

Patient currently resides in a single-story ranch with his wife and son.

Strengths:

Patient has a home to go to upon release. Patient says that his wife and daughter are big supporters in his life. Patient has a positive outlook on what is all happening and is happy to be getting the help that he needs.

Support System:

Patient claims that both his wife and daughter are huge in his life as a support system. He also is attending therapy.

Admission Assessment

Chief Complaint (2 points):

Patient's chief complaint is feeling of no self-worth and suicidal ideation (no plan to carry it out).

Contributing Factors (10 points):

On February 1st, a 61-year-old, Caucasian, married male was admitted to OSF Heart of Mary Medical Center with feelings of no self-worth and suicidal ideations. The patient had an altercation with a newer nurse a couple of weeks prior to admittance. After the altercation he began therapy. Not long after he was talking to a buddy in the hospital who was having problems with the same nurse and the patient explained what had happened between himself and the nurse. The nurse that they were talking about overheard and brought to the manager. The patient states that he knew what he was doing was wrong. Patient states that he was feeling completely worthless and it felt like he was having a panic attack. States that he told his manager "I will just resign and go kill myself". He was immediate brought to the ED from there.

Factors that lead to admission:

The patient's job has had increased stress due to COVID-19, he lost his mother, and the nurse altercation.

History of suicide attempts:

Patient claims to have never tried to commit suicide.

Primary Diagnosis on Admission (2 points):

Suicidal ideation

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse				None
Sexual Abuse				None

Emotional Abuse				None
Neglect				None
Exploitation				None
Crime				None
Military				None
Natural Disaster				None
Loss	Mother this past August	Dad died in 1993 and his sister committed suicide four years ago		Claims that the loss of his mother did hit him hard and increased his depressive state.
Other				None

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	The patient says that he has been in a (self-diagnosed) depressive state for the past year. Claims that it has been pretty steady the entire time at about a 6 on a numeric scale from 0-10 with it being a 10 for the past couple of weeks.
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 claims that work the past year has been more stressful due to COVID-19 and newer nurses. Claims that there are no problems at home or within his relationships.

Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	Patient claims that for the past year he has been only getting 5-6 real hours of sleep. He goes to bed around 2100 and sleeps until 0200-0300 where he wakes up, uses the bathroom and attempts to go back to sleep with little to no avail. He claims that this has become the new usual.
Difficulty falling asleep	Yes	No	
Frequently awakening during night	Yes	No	
Early morning awakenings	Yes	No	Patient claims that for the past year that he awakes nearly every morning around 0200-0300.
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	
Panic attacks	Yes	No	Patient claims that he has had 2-3 panic attacks while at work within the past two months.

			States that it feels as though his chest is being crushed with a heavy weight. They did not last for more than a couple of minutes.
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**	Claims that for the past couple of months his stress levels have impacted his ability to concentrate while at work. He also claims that his wife has noticed that he no longer spends as much time at the gym after work. Says that he has gotten home about 30-45 minutes earlier than he usually does.
Rating Scale			
How would you rate your depression on a scale of 1-10?			Patient claims it to be a steady 6 for the past year up until the past 2-4 weeks where it has gone up to a 10.
How would you rate your anxiety on a scale of 1-10?			Patient claims it to be a steady 6 for the past year up until the past 2-4 weeks where it has gone up to a 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**	Work for the past year has had increased levels of stress due to COVID-19 every day. The new nurses are also a major stressor for the patient as they do not do things correctly.
School	**Yes**	**No**	
Family	**Yes**	**No**	
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**
No previous psychiatric nor substance abuse treatment prior to this.	**Inpatient Outpatient Other:**			**No improvement** **Some improvement** **Significant improvement**
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No previous psychiatric nor substance abuse treatment prior to this.	**Inpatient Outpatient Other:**			**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Wife	56	Wife	**Yes**	**No**
Son	33	Son	**Yes**	**No**

			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain: Patient son uses marijuana.

Children (age and gender):
Son: 33-year-old male
Daughter: 29-year-old female
Who are children with now?
Son currently resides with patient and his wife. While the daughter lives with her husband in Ohio.

Household dysfunction, including separation/divorce/death/incarceration:
Mother attempted suicide when he was young. Claims to have had no other dysfunction in childhood and claims that there is no real dysfunction within his household now

Current relationship problems:
Patient claims that there are no relationship problems.
Number of marriages:
Has been married once for 36 years.

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Heterosexual	**Yes** **No**	**Yes** **No** (wife has had a hysterectomy)

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

Ethnic/cultural factors/traditions/current activity:
Patient claims to not have any.
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's wife goes to therapy with him and is a great listener. Daughter has a psychology degree so she can help with ways to get better.

Client raised by:

Natural parents- Mother and Father
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:
Patient claims that the only big issues he had as a kid was being bullied at school and his

mother's suicide attempt.
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.) Mother attempted suicide when patient was in 2nd grade and his sister was diagnosed bipolar and she did commit suicide 4 years ago.
History of Substance Use: He used to smoke weed right out of highschool
Education History: **Grade school** **High school** **College-Master's degree** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Bullied
Discharge
Client goals for treatment: "To regain my sense of self-worth and regain my integrity".
Where will client go when discharged? Home to his wife and son.

Outpatient Resources (15 points)

Resource	Rationale
1. Therapy	**1.** To help with his stress and anxiety levels and have a place where he can talk it all out.-
2. The National Suicide Prevention Lifeline (800) 273-8255	**2.** To help immediately if he begins to have suicidal ideations again.
3. Group Therapy	**3.** To help reduce stress by talking about stressors with others.

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

Brand/Generic	trazodone /Desyrel	haloperidol /Peridol	haloperidol /Peridol	buspirone /Bustab	benztropine /Cogentin
Dose	100mg	5mg	5mg	10mg	2mg
Frequency	Daily @ night	Q4H	Q6H	BID	BID
Route	PO	PO	IM	PO	PO or IM
Classification	Antidepressant	Antipsychotic	Antipsychotic	Anxiolytic	Anticholinergic
Mechanism of Action	Blocks serotonin reuptake along the presynaptic neuronal	May block postsynaptic dopamine receptors in the limbic system and	May block postsynaptic dopamine receptors in the limbic system and	May act as a partial agonist at serotonin 5-hydroxy tryptamine	Blocks acetylcholine's action at cholinergic sites.

	membrane, causing an antidepressant effect.	increase brain turnover of dopamine, producing an antipsychotic effect.	increase brain turnover of dopamine, producing an antipsychotic effect.	1a receptors in the brain.	
Therapeutic Uses	Depression	To treat psychotic disorders	To treat psychotic disorders	Manage anxiety	Treat Parkinson's, Treat acute dystonic reactions
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Depression	Treatment of psychotic disorder	Treatment of psychotic disorder	Manage his anxiety	Treatment of dystonic reactions
Contraindications (2)	Allergic, recovering from an MI	Allergic, Parkinson's disease	Allergic, Parkinson's disease	Allergic, hepatic/renal impairment	Allergic, children younger than 3
Side Effects/Adverse Reactions (2)	Suicidal ideation, Hyponatremia	Cardiac arrest, Leukopenia	Cardiac arrest, Leukopenia	Angioedema, serotonin syndrome	Hypotension, Agitation
Medication/ Food Interactions	NSAIDs, CNS depressants, MAO inhibs, warfarin	Amphetamines, CNS depressants, alcohol use	Amphetamines, CNS depressants, alcohol use	Food, Grapefruit juice, MAO inhibs	haloperidol, tricyclic antidepressants
Nursing Considerations (2)	Caution with cardiac disease: can cause arrythmias, Give shortly after food.	Do not use for dementia related psychosis in elderly, Dilute oral sol with beverage.	Do not use for dementia related psychosis in elderly, Dilute oral sol with beverage.	Caution if they have hepatic/renal problems, Safety precautions due to CNS reactions.	Give IM if needed to be more rapid, Give before or after meals.

Medications Reference (1) (APA):

Jones & Bartlett. (2020). *2020 Nurse's Drug Handbook (19th ed.).* Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient appears to be clean, well-kept, wearing clean clothes. His behavior was one of acceptance and optimism. Seems to be slightly overweight but still in good shape. Good-spirited Clear and intelligible
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient claims that none of these are rattling his mind.
ORIENTATION: **Sensorium:** **Thought Content:**	A/Ox4 Patient seemed to be of sound mind, goal-orientated, and able to form coherent thoughts.
MEMORY: **Remote:**	Did not -seem to be lacking at all. Was able to tell his entire story on why he is in the behavioral unit and gave his birthdate without pause.
REASONING: **Judgment:**	Good judgement Intelligence is there

Calculations: **Intelligence:** **Abstraction:** **Impulse Control:**	Claims that he knows that what he did was wrong
INSIGHT:	Good
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 None Good posture Good muscle tone Good strength Good motor movements

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	82bpm	138/90mmHg	26rpm	98.4F	96%
1600	77bpm	139/95mmHg	16rpm	97.9F	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	numeric	N/A	0	N/A	N/A
1600	numeric	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 540mL

Lunch: 100% **Dinner:** 100%	**Lunch:** 480mL **Dinner:** 480mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Go to and continue therapy and start group therapy to help with stressors that occur at work. Stay compliant with medications that are prescribed to improve depressive states and help reduce anxiety. Upon release patient will go home to his wife. Patient will set an appointment with therapist within a week of discharge.

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 suicide	Related to high levels of anxiety and depressive thoughts as evidenced by "I will just resign and kill myself".	**1.** Remove anything that may cause self-harm. **2.** Have the client avoid decisions-	**1.** Keep timely records every 15 minutes. **2.** Set up times for family to spend time with client.- **3.** Engage suicide	**1.** Have the patient meet with a therapist regularly. **2.** Encourage the client to begin going to group therapy

		3. Encourage the client to talk about their feelings.—	precautions from start to finish.–	sessions. **3.** Be sure that the client has somewhere to go upon discharge.
2. Chronic low self - esteem **3.**	Related to patient feeling ashamed as evidenced by "I am ashamed of how I reacted towards that nurse".	**1.** Give positive feedback after successful completion of tasks. **2.** Allow patient to perform personal hygiene to increase self-image **3.** Be a role model yourself.~~1.~~ ~~2.~~ ~~3.~~	**1.** Have patient engage in group sessions. **2.** Teach the patient visualization techniques that replace the negative thoughts with positive thoughts. **3.** Evaluate needs for assertiveness training tools.~~1.~~ ~~2.~~ ~~3.~~	**1.** Have the patient meet with a therapist regularly. **2.** Encourage the client to begin going to group therapy sessions. **3.** Start a journal to track thoughts of himself. ~~1.~~ ~~2.~~ ~~3.~~
4. Anxiety	Related to patient's lack of work concentration as evidenced by increased workload from work due to COVID-19.	**1.** Maintain a calm demeanor. **2.** Establish and maintain trust by listening and displaying warmth. **3.** Offer unconditional acceptance and non-judgmental.	**1.** When anxious be sure to be in the room with the patient.- **2.** Maintain a cool and calm head anytime you deal with them.– **3.** Reassure and comfort.-	**1.** Educate the client on how they can reduce anxiety. **2.** Educate the client on how recognize the signs of an oncoming anxiety attack- **3.** Encourage the client to start going to group therapy.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient has been becoming more and more anxious, depressed, and feeling of no self worth.
A couple of weeks it came to a peak and then lead to a heated conversation with his boss where he said "I will just resign and kill myself".

Nursing Diagnosis~~/Outcomes~~

Risk for suicide related to high levels of anxiety and depressive thoughts as evidenced by "I will just resign and kill myself".

Chronic low self-esteem related to patient feeling ashamed as evidenced by "I am ashamed of how I reacted towards that nurse".

Anxiety related to patient's lack of work concentration as evidenced by increased workload from work due to COVID-19.

Objective Data

The patient's most recent vitals:
Pulse-77
B/P-139/95
RR-16
Temp-97.9F
O2-97%

Patient Information

On February 1st, a 61-year-old, Caucasian, married male was admitted to OSF Heart of Mary Medical Center with feelings of no self-worth and suicidal ideations. He has a history of Hypertension, GERD, and chronic back pain.

Nursing Interventions