

N323 Care Plan  
Lakeview College of Nursing  
Alexis Cribbett

## N323 CARE PLAN

**Demographics (3 points)**

<b>Date of Admission</b> 03/31/21	<b>Patient Initials</b> D.C.W.	<b>Age</b> 21	<b>Gender</b> Female
<b>Race/Ethnicity</b> White Non-latino	<b>Occupation</b> Unemployed	<b>Marital Status</b> Single	<b>Allergies</b> Adderall Penicillin
<b>Code Status</b> Full	<b>Observation Status</b> Rounding every 15 minutes	<b>Height</b> 5'5''	<b>Weight</b> 355 lbs

**Medical History (5 Points)**

**Past Medical History:** Asthma

**Significant Psychiatric History:**

Anxiety

Bipolar I

Borderline Personality Disorder

Major Depressive Disorder

Multiple Personality Disorder

**Family History:** Patient states that she is not close with her family, actually very distant, and does not know any significant past medical or psychiatric history.

**Social History (tobacco/alcohol/drugs):**

**Tobacco:** Client states that she is a some day cigarette smoker, but would not go into detail about how frequently or how long she has been smoking. She denies any use of smokeless tobacco.

**Alcohol:** Client states that she is an occasional alcohol drinker; 1-2 times every other week, and usually between 3-4 alcoholic beverages.

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**Drugs:** Client admits to smoking marijuana 6x a week, but would not disclose how much of it she smokes per day.

**Living Situation:** Client states that she is currently homeless.

**Strengths:** Client states that music is her only strength; she states, “I self-taught myself how to sing, and play the guitar and piano”.

**Support System:** Client states that she “has no one”.

### Admission Assessment

**Chief Complaint (2 points):** Client states that she had suicidal thoughts.

#### Contributing Factors (10 points):

**Factors that lead to admission:** Client states that prior to admission, she was homeless and just “couldn't take it anymore”. She says that she has no type of support system, she is currently estranged from her family and has no close friends. She also states that it’s been really hard to find a place to live and to get a job because of her mental illnesses and especially in the past year because of the pandemic. She has a vast history of hospitalizations, over 25, and was even living at The Pavillion from ages 16-18 until she aged out.

**History of suicide attempts:** Client could not remember exact dates about her previous suicide attempts, or even how many times she has attempted in total. She did share with me that she has tried hanging herself, cutting her wrist, and overdosing on pills several times, all without success.

**Primary Diagnosis on Admission (2 points):** Suicidal Ideation

### Psychosocial Assessment (30 points)

#### History of Trauma

**No lifetime experience:** Patient states that she has been subjected to multiple forms of trauma throughout her life.

**Witness of trauma/abuse:** Patient did not disclose if she was a witness to anyone else’s trauma/abuse.

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	<b>Current</b>	<b>Past (what age)</b>	<b>Secondary Trauma (response that comes from caring for another person with trauma)</b>	<b>Describe</b>
<b>Physical Abuse</b>				Client admitted that she was a victim of physical abuse, however would not disclose any information regarding abuse due to the fact that it's a trigger for her.
<b>Sexual Abuse</b>				Client admitted that she was a victim of sexual abuse, however would not disclose any information regarding abuse due to the fact that it's a trigger for her.
<b>Emotional Abuse</b>				Client admitted that she was a victim of emotional abuse, however would not disclose any information regarding abuse due to the fact that it's a trigger for her.
<b>Neglect</b>				Client admitted that she was a victim of neglect, however would not disclose any information regarding abuse due

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				to the fact that it's a trigger for her.
<b>Exploitation</b>	Patient denies exploitation abuse			
<b>Crime</b>	Patient denies crime abuse			
<b>Military</b>	Patient denies military abuse			
<b>Natural Disaster</b>	Patient denies any natural disasters			
<b>Loss</b>	Patient denies any losses.			
<b>Other</b>	Patient doesn't mention any other forms of trauma			
<b>Presenting Problems</b>				
<b>Problematic Areas</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>	
<b>Depressed or sad mood</b>	Yes	No		
<b>Loss of energy or interest in activities/school</b>	Yes	No		
<b>Deterioration in hygiene and/or grooming</b>	Yes	No	Patient states that when she gets into depressive episodes she only showers 4 times a week, and this lasts the entire duration of an episode. The intensity she described as weak.	
<b>Social withdrawal or isolation</b>	Yes	No		
<b>Difficulties with home, school, work, relationships, or responsibilities</b>	Yes	No		
<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>	
<b>Change in numbers of hours/night</b>	Yes	No		
<b>Difficulty falling asleep</b>	Yes	No		

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<b>Frequently awakening during night</b>	Yes	No	
<b>Early morning awakenings</b>	Yes	No	Client states that she gets awoken by staff on the floor very early, every morning and that it's hard for her to fall back asleep once she is woken up.
<b>Nightmares/dreams</b>	Yes	No	Client is currently taking medications that help her sleep, but previously could not sleep, every night due to the nightmares. The intensity of them was very strong.
<b>Other</b>	Yes	No	
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	Yes	No	
<b>Binge eating and/or purging</b>	Yes	No	
<b>Unexplained weight loss?</b>	Yes	No	
<b>Amount of weight change:</b>			
<b>Use of laxatives or excessive exercise</b>	Yes	No	
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	Yes	No	Client states that she has some form of anxiety all the time, she has gotten used to it. The intensity is mild.
<b>Panic attacks</b>	Yes	No	Client states that she gets panic attacks based on the situation, but would not disclose which types of situations causes her to experience panic attacks.
<b>Obsessive/compulsive thoughts</b>	Yes	No	
<b>Obsessive/compulsive behaviors</b>	Yes	No	Client states that she always has to have the TV or radio volume in

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			increments of '5', she has an intense urge and does this all the time.
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	<b>Yes</b>	No	Client states that her anxiety affects her daily living all the time, 7x a week, and that the intensity of it is strong.
<b>Rating Scale</b>			
<b>How would you rate your depression on a scale of 1-10?</b>		Currently: 0 Previous to Hospitalization: 10	
<b>How would you rate your anxiety on a scale of 1-10?</b>		Currently: 0 Previous to Hospitalization: 10	
<b>Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)</b>			
<b>Problematic Area</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Work</b>	Yes	<b>No</b>	
<b>School</b>	Yes	<b>No</b>	
<b>Family</b>	<b>Yes</b>	No	Client states that her family has always been a major stressor in her life, and that it affects her day to day life everyday. She described the intensity as strong.
<b>Legal</b>	<b>Yes</b>	No	Client states that recently she has run into some legal issues regarding the fact that she was charged with domestic battery and arrested. This affects her life everyday. She described the intensity as strong.
<b>Social</b>	<b>Yes</b>	No	Client states that her social life has been a stressor in her life, and that it affects her day to day life everyday. She described the intensity as strong.
<b>Financial</b>	<b>Yes</b>	No	Client states that her financial situation is her biggest current stressor because she is currently homeless and unemployed, this affects her life everyday. She described the intensity as strong.
<b>Other</b>	Yes	<b>No</b>	

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<b>Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient</b>				
Patient states that she has been hospitalized at least 25 times, for miscellaneous reasons. She could not recall any of the facilities or the dates.				
Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
	Inpatient Outpatient Other:			No improvement  Some improvement  Significant improvement
	Inpatient Outpatient Other:			No improvement  Some improvement  Significant improvement
	Inpatient Outpatient Other:			No improvement  Some improvement  Significant improvement
<b>Personal/Family History</b>				
Client is currently homeless, and lives with no one.				
Who lives with you?	Age	Relationship	Do they use substances?	
			Yes	No

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			<b>Yes</b>	<b>No</b>
<b>If yes to any substance use, explain:</b> None				
<b>Children (age and gender):</b> None				
<b>Who are children with now?</b> N/A				
<b>Household dysfunction, including separation/divorce/death/incarceration:</b> None				
<b>Current relationship problems:</b> Client states that she is currently single, and has been for a while now.				
<b>Number of marriages:</b> 0				
<b>Sexual Orientation:</b> Pansexual	<b>Is client sexually active?</b> <b>Yes</b> <b>No</b>		<b>Does client practice safe sex?</b> <b>Yes</b> <b>No</b>	
<b>Please describe your religious values, beliefs, spirituality and/or preference:</b>				
Client states that she is a practitioner of pagen witchcraft; blessings and cleaning are what encompasses her practice. She claims that she is a 'white' or good witch and that she practices spiritual, old age witchcraft. States that she is spiritual and not religious.				
<b>Ethnic/cultural factors/traditions/current activity:</b>				
Client did not state that she had any cultural traditions.				
<b>Describe:</b>				
<b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b>				
Client states that she was arrested in August of 2020 for domestic battery and spent 3 months in jail, was released in November. She denied talking about the details of the arrest; stated that "it was a long story that I don't want to get into".				
<b>How can your family/support system participate in your treatment and care?</b>				
Client currently has no family or support system.				
<b>Client raised by:</b>				
<p><b>Natural parents:</b> Client states that she was raised by her mother from birth to age 16, then she spent ages 16-18 living at The Pavilion residentially.</p> <p>Grandparents Adoptive parents Foster parents</p>				

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Other (describe):
<b>Significant childhood issues impacting current illness:</b> PTSD, Anxiety, Depression, Dissociative Identity Disorder, Borderline Personality Disorder, and Abuse.
<b>Atmosphere of childhood home:</b>  Loving Comfortable <b>Chaotic</b> <b>Abusive</b> Supportive <b>Other:</b> Client states her childhood home was “toxic”.
<b>Self-Care:</b>  <b>Independent:</b> Client is able to fully take care of herself and complete all ADL’s Assisted Total Care
<b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b> Client states that she is not close to her family at all, has no contact and has no knowledge of her family's history with mental illness.
<b>History of Substance Use:</b> Client states that she currently smokes marijuana, and has been for 3-4 years now. She states that she smokes 6-7x a week, but would not disclose how much she smokes per day.
<b>Education History:</b>  Grade school <b>High school:</b> Client graduated highschool in 2018. College Other:
<b>Reading Skills:</b>  <b>Yes</b> No Limited
<b>Primary Language:</b> English
<b>Problems in school:</b> Client is currently not in school, but did state that she had troubles in high school related to learning and bullying. She states that she had difficulty retaining the information that was being taught to her, and that she was bullied for most of her high school years.

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<b>Discharge</b>
<b>Client goals for treatment:</b> Client states that she wants to learn better coping mechanisms, and work on her overall mental health by taking a more active role.
<b>Where will client go when discharged?</b> The client is currently trying to find a nursing home to be discharged to; she stated that she was most likely going to be transferred to Arcadia in Bloomington, IL.

**Outpatient Resources (15 points)**

<b>Resource</b>	<b>Rationale</b>
1. Elliott Counseling Group - Champaign, IL <a href="https://elliottcounselinggroup.com/">https://elliottcounselinggroup.com/</a>	1. Client has some unresolved childhood trauma that has really affected her mental health negatively. If she works through her trauma and finds better ways to cope, she will become better in the long run. It's important that she takes the time to work through her issues from being a child that are still affecting her in her adult life.
2. Salvation Army Safe Harbor Shelter - Bloomington, IL <a href="https://www.homelesshelterdirectory.org/cgi-bin/id/shelter.cgi?shelter=15340">https://www.homelesshelterdirectory.org/cgi-bin/id/shelter.cgi?shelter=15340</a>	2. Client is currently homeless and has nowhere else to go or turn to. Having a secure place to live is a basic human necessity and would help her mental health a lot. In addition, it would be easier to have a job if she had a place to sleep, shower, eat, and had an address. They also offer different assistive programs that would be beneficial to the client.
3. Champaign or Bloomington Job Openings <a href="https://www.glassdoor.com/index.htm">https://www.glassdoor.com/index.htm</a> <a href="https://www.indeed.com/">https://www.indeed.com/</a>	3. Client is currently unemployed which can cause a big strain on her mental health. Both glassdoor and indeed offer tons of new job openings and can match her with something fairly quickly.

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

<b>Brand/Generic</b>	Aripiprazole / Amblify	Haloperidol / Haldol	Benztrapine / Cogentin
<b>Dose</b>	5 mg	5 mg	2 mg
<b>Frequency</b>	Once a day	Every 4 hrs PRN	Twice a day, PRN
<b>Route</b>	P.O.	P.O.	P.O.
<b>Classification</b>	Atypical Antipsychotic	Psycho-Therapeutic	Anticholinergic
<b>Mechanism of Action</b>	Produces antipsychotic effects through partial agonist and antagonist actions. Acts as agonist on dopamine receptors Acts as antagonist on serotonin receptors	Decrease psychotic manifestations Anti Anemic effect	Diminishes excess cholinergic effect associated with dopamine deficiency
<b>Therapeutic Uses</b>	Treat certain mental/mood disorders Can be used in combination with other medications to treat depression	Management of manifestations of psychotic disorders	Supressess muscle rigidity and tremors
<b>Therapeutic Range (if applicable)</b>	Already taking an antidepressant: 2-5 mg/day Not taking an antidepressant: 2-15 mg/day	N/A	N/A
<b>Reason Client Taking</b>	Bipolar I Disorder, and MDD	Agitation Breakthrough Psychosis/ Mania	Movement Disorders
<b>Contraindications (2)</b>	Hypersensitivity to Aripiprazole Low WBC Count	Hypersensitivity to Haloperidol Parkinson's disease	Hypersensitivity to Benztrapine Close-Angle Glaucoma
<b>Side Effects/Adverse Reactions (2)</b>	Heart Failure DVT	Dry mouth Constipation	Loss of appetite Nausea
<b>Medication/Food</b>	Antihypertensives	Alcohol	MAO Inhibitors

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<b>Interactions</b>	Benzodiazepines Carbamazepine Alcohol	CNS Depressants Opiates	Phenothiazines Alcohol Ricylic Antidepressants
<b>Nursing Considerations (2)</b>	Watch patients closely for suicidal tendencies Monitor CBC, can cause agranulocytosis, leukopenia, and neutropenia.	Assess I/Os Increase fluid and fiber intake to combat constipation	Instruct patient not to drive or engage in hazardous activity until response to drug is known Avoid CNS Depressants

<b>Brand/Generic</b>	Prazosin / Minipress	Trazodone / Desyrel	Oxcarbazepine / Trileptal
<b>Dose</b>	1 mg	100 mg	600 mg
<b>Frequency</b>	Once a day	Once a day	Twice a day
<b>Route</b>	P.O.	P.O.	P.O.
<b>Classification</b>	Alpha Blocker	Antidepressant	Anticonvulsant
<b>Mechanism of Action</b>	Selectively and competitively binds to alpha 1 adrenergic receptors, promoting peripheral arterial and venous dilation which lowers blood pressure	Blocks serotonin reuptake along presynaptic neuronal membrane, causing an antidepressant side effect	Decreased propagation of neural impulses Inhibits repetitive neuronal firing
<b>Therapeutic Uses</b>	Eases nightmares and disturbances of sleep	Used to balance chemicals in the brain, can treat depression and anxiety	Singular or adjunctive therapy in the treatment of partial seizures in adults and children 4-6
<b>Therapeutic Range (if applicable)</b>	6-15 mg/day	N/A	N/A
<b>Reason Client Taking</b>	PTSD	MDD Helps with sleep	Seizures
<b>Contraindications (2)</b>	Hypersensitivity to Prazosin Hypersensitivity to Quinazolines	Recovery from acute MI Hypersensitivity to Trazodone	Hyponatremia Suicidal Ideation
<b>Side</b>	Bradycardia	Hyponatremia	Nystagmus

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<b>Effects/Adverse Reactions (2)</b>	Edema	CHF	Low Energy
<b>Medication/Food Interactions</b>	Antihypertensives Beta Blockers Alcohol Epinephrine NSAIDS Phenylephrine Dopamine	NSAIDs MAO Inhibitors Carbamazepine Barbiturates CNS Depressants Digoxin Alcohol Warfarin	Phenytoin Phenobarbital Valproic Acid Carbamazepine Verapamil
<b>Nursing Considerations (2)</b>	Use cautiously in patients with renal impairment Monitor blood pressure regularly	Advise patient to not fast when taking this medication, can cause CNS reactions Medication cannot be stopped abruptly, requires tapering.	Monitor for hyponatremia Don't give to patients that are pregnant or breastfeeding

**Medications Reference (1) (APA):**

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

**Mental Status Exam Findings (20 points)**

<b>APPEARANCE:</b> <b>Behavior:</b> <b>Build:</b> <b>Attitude:</b> <b>Speech:</b> <b>Interpersonal style:</b> <b>Mood:</b> <b>Affect:</b>	<ul style="list-style-type: none"> <li>- well groomed, hair in two ponytails</li> <li>- behavior is outgoing, stable, but the client had some loud outbursts when she got aggravated.</li> <li>- build is morbidly obese</li> <li>- attitude was good for the most part, she participated well in group</li> <li>- speech was clear and understandable.</li> <li>- her mood was positive for the majority of the time, became annoyed with me when I was completing the psychosocial</li> </ul>
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	assessment.
<b>MAIN THOUGHT CONTENT:</b> <b>Ideations:</b> <b>Delusions:</b> <b>Illusions:</b> <b>Obsessions:</b> <b>Compulsions:</b> <b>Phobias:</b>	<ul style="list-style-type: none"> <li>- denies any homicidal or suicidal ideations</li> <li>- none</li> <li>- none</li> <li>- none</li> <li>- number 5 with TV or radio volume</li> <li>- none</li> </ul>
<b>ORIENTATION:</b> <b>Sensorium:</b> <b>Thought Content:</b>	<ul style="list-style-type: none"> <li>- patient is alert and oriented x4</li> <li>- thoughts were clear, made sense, and non descriptive.</li> </ul>
<b>MEMORY:</b> <b>Remote:</b>	<ul style="list-style-type: none"> <li>- patient is able to recall some things about her past, but not dates and places she has been to previously.</li> </ul>
<b>REASONING:</b> <b>Judgment:</b> <b>Calculations:</b> <b>Intelligence:</b> <b>Abstraction:</b> <b>Impulse Control:</b>	<ul style="list-style-type: none"> <li>- judgement was within normal range</li> <li>- client can count down by 5's</li> <li>- client demonstrates age appropriate intelligence</li> <li>- none</li> <li>- patient needs to work on anger impulse control, needs to find better coping strategies.</li> </ul>
<b>INSIGHT:</b>	<ul style="list-style-type: none"> <li>- patient states that she is at the facility to better her mental health and become more active in this role.</li> </ul>
<b>GAIT:</b> <b>Assistive Devices:</b> <b>Posture:</b> <b>Muscle Tone:</b> <b>Strength:</b> <b>Motor Movements:</b>	<ul style="list-style-type: none"> <li>- patient has a steady gait, and has no assistive devices.</li> <li>- posture was good for the most part, sometimes she slouches when she sits</li> <li>- patient had good muscle tone and equal strength, in upper and lower extremities bilaterally</li> <li>- patient freely moves all extremities well, and her movements are voluntarily controlled.</li> </ul>

**Vital Signs, 2 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
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1212	97	130/84 Sitting	16	97.4 Temporal	99 Room Air
1437	96	145/90 Sitting	17	97.0 Temporal	99 Room Air

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
1051	Numeric 0-10 Patient denied any pain				
1437	Numeric 0-10 Patient denied any pain				

**Dietary Data (2 points)**

<b>Dietary Intake</b>	
<b>Percentage of Meal Consumed:</b>	<b>Oral Fluid Intake with Meals (in mL)</b>
<b>Breakfast:</b> 50%	<b>Breakfast:</b> 240 mL
<b>Lunch:</b> 100%	<b>Lunch:</b> 300 mL
<b>Dinner:</b> 100%	<b>Dinner:</b> 240 mL

**Discharge Planning (4 points)****Discharge Plans (Yours for the client):**

Discharge plans include finding a nursing home for the client to be transferred to, and trying to help the client comply with the medication regime. It is also important to set the client up with resources regarding finding a job, and a more permanent place to stay. In addition, finding some

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type of support system is crucial to this client because she needs someone reliable that she can turn to when things get rough for her, so that she won't turn to self-harm or harm of others.

**Nursing Diagnosis (15 points)**

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

<b>Nursing Diagnosis</b> ● Include full nursing diagnosis with "related to" and "as evidenced by" components	<b>Rational</b> ● Explain why the nursing diagnosis was chosen	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (Prior to discharge)</b>
Risk for self harm related to previous suicide attempts	Client has history of multiple suicide attempts, and is currently hospitalized due to suicidal ideations	<ol style="list-style-type: none"> <li>1. Suicide assessment</li> <li>2. Safety plan</li> <li>3. Signed safety contract</li> </ol>	<ol style="list-style-type: none"> <li>1. Setting boundaries</li> <li>2. Close supervision and observation at all times</li> <li>3. Introducing self-expression methods to manage suicidal feelings</li> </ol>	<ol style="list-style-type: none"> <li>1. Individual therapy</li> <li>2. Set a working relationship with patient through continued care</li> <li>3. Assist patient with evaluating their situation and accomplishments</li> </ol>
Ineffective coping mechanisms related to destructive behavior towards self and others.	Client uses self harm and anger tactics when she has no other way to deal with her problems.	<ol style="list-style-type: none"> <li>1. Assess for causes of ineffective coping</li> <li>2. Identify current stressors</li> <li>3. Determine support systems and resources available for patient</li> </ol>	<ol style="list-style-type: none"> <li>1. Verbalization of feelings encouraged</li> <li>2. Positive reinforcement</li> <li>3. Problem-solving facilitated</li> </ol>	<ol style="list-style-type: none"> <li>1. Journaling promoted</li> <li>2. Meditation</li> <li>3. Educate patient on helpful medications to facilitate coping mechanisms</li> </ol>
Violence risk related to lack of anger and impulse control	Client was reported to be easily angered and agitated and has a hard	<ol style="list-style-type: none"> <li>1. Remain in neutral, non-judgemental attitude and approach</li> </ol>	<ol style="list-style-type: none"> <li>1. Self-reflection promoted</li> <li>2. Calm environment</li> </ol>	<ol style="list-style-type: none"> <li>1. Self-responsibility</li> <li>2. Calming mechanisms to relieve anger</li> </ol>

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	time calming down and regaining focus when this happens	<p>2. Decreased environmental and sensory stimuli</p> <p>3. Chart what seems to increase or escalate agitation and interventions to help calm the situation</p>	<p>provided</p> <p>3. Relaxation techniques</p>	3. Anger management therapy
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**Other References (APA):**

6 Bipolar Disorders Nursing Care Plans. (2019, April 11). Nurseslabs.

<https://nurseslabs.com/bipolar-disorders-nursing-care-plans/2/>

Wayne, G. (2017, September 23). Ineffective Coping – Nursing Diagnosis & Care Plan.

Nurseslabs. <https://nurseslabs.com/ineffective-coping/>

Wayne, G., BSN, & R.N. (2019, January 28). Risk for Suicide – Nursing Diagnosis and Care Plan. Nurseslabs.

[https://nurseslabs.com/risk-for-suicide/#risk\\_for\\_suicide\\_nursing\\_assessment](https://nurseslabs.com/risk-for-suicide/#risk_for_suicide_nursing_assessment)

**Concept Map (20 Points):**

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Subjective Data

Nursing Diagnosis/Outcomes

**Subjective Data:**  
 Client states that prior to being admitted to the hospital, she was homeless and unemployed. She states that she 'couldn't take it anymore', and tried to kill herself. Patient admits to having multiple suicide attempts in the past.

**Nursing Diagnosis:**  
 Risk for self harm related to previous suicide attempts -- client has a history of multiple suicide attempts, and is currently hospitalized due to suicidal ideations  
 Ineffective coping mechanisms related to destructive behavior towards self and others -- client uses self harm and anger tactics when she has no other way to deal with her problems  
 Violence risk related to lack of anger and impulse control -- client reported to be easily angered and agitated and has a hard time calming down and regaining focus when this happens

**Objective Data**  
**Objective Data:**

Patient has an extensive history with anxiety, bipolar I disorder, PTSD, multiple personality disorder, major depressive disorder, and borderline personality disorder.

**Patient Information**

**Patient Information:**  
 Initials: D.C.W.  
 21 year old client admitted for suicidal ideation.

**Nursing Interventions**

**Nursing Interventions:**  
**Risk for self-harm:**  
 Suicide assessment, safety plan, signed safety contract  
 Setting boundaries, close supervision and observation, introducing self-expression methods to manage suicidal feelings  
 Individual therapy, set a working relationship with patient through continued care, assist patient with evaluating their situation and accomplishments

**Ineffective Coping Mechanisms:**  
 Assess for causes of ineffective coping, identify current stressors, determine support systems and resources available for patient  
 Verbalization of feelings encouraged, positive reinforcement, problem-solving facilitated  
 Journaling promoted, meditation, educate patient on helpful medications to facilitate coping mechanisms

**Violence Risk:**  
 Remain in a neutral, non-judgemental attitude and approach, decreased environmental and sensory stimuli, chart what seems to increase or escalate agitation and interventions to help calm the situation.  
 Self-reflection promoted, calm environment provided, relaxation techniques.  
 Self-responsibility, calming mechanisms to relieve anger, anger management therapy





