

N323 Care Plan
Lakeview College of Nursing
Airelle Mitchell

N323 CARE PLAN

Demographics (3 points)

Date of Admission 10/04/2021	Patient Initials M.H.	Age 46	Gender Female
Race/Ethnicity Caucasian	Occupation Child welfare worker	Marital Status Divorced	Allergies NKA
Code Status Unknown	Observation Status Suicide	Height 5'2"	Weight 88.45 Kg

Medical History (5 Points)

Past Medical History: Gallbladder removal, tubes tied (Tubal Ligation), hysterectomy, and fibromyalgia.

Significant Psychiatric History: She does not have a past of psychiatric history. This was her first time in a psychiatric facility.

Family History: N/A

Social History (tobacco/alcohol/drugs): The client denied any use of tobacco, alcohol, or any drug use.

Living Situation: Client lives with her significant other for the last 15 years in a home.

Strengths: She explained that her strengths are hard working and she's very caring.

Support System: Her husband is her support system.

Admission Assessment

Chief Complaint (2 points): Mental breakdown

Contributing Factors (10 points):

Factors that lead to admission: The patient's older children stopped communicating with the patient and would not let her see her grandchildren. This led to the client trying to commit suicide with a gun. Her partner called 911 and the ambulance brought her to Carle. She

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explained she didn't actually know how to use the gun and did not know she would be going to a psychiatric facility. Family was the contributing factor to her mental breakdown.

History of suicide attempts: The patient has no history of suicidal attempts. This was her first attempt (10/04/2021).

Primary Diagnosis on Admission (2 points): Major Depressive Disorder / Suicidal ideation with plan.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A				
Witness of trauma/abuse: N/A				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	N/A	N/A	N/A	N/A
Sexual Abuse	N/A	N/A	N/A	N/A
Emotional Abuse	Yes	N/A	N/A	The patient's older children are not in communication with her and will not let her see her grandchildren.
Neglect	N/A	N/A	N/A	N/A

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Exploitation	N/A	N/A	N/A	N/A
Crime	N/A	Yes	N/A	Patient was charged with a misdemeanor after slapping (assaulted) her ex-husband's gf in the face in 2006.
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	N/A	Yes	N/A	The patient has lost both of her parents and grandparents.
Other	N/A	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	The patient does feel depressed and sad because of how her family is treating her and also she stated she just does not want to be at the pavilion anymore, but she does know it is helping her. She said it is when she is sleeping at night alone when she feels sad and depressed. She stated it doesn't happen every night.	
Loss of energy or interest in activities/school	Yes	No	The patient stated she feels a loss of energy sometimes with how much work load she can take on in her daily life. She states on the weekend she does not wanna even go to the grocery store or clean because she is so exhausted even though those things need to get done. It's recurring every week.	

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Deterioration in hygiene and/or grooming	Yes	No	Not a presenting problem. The client has good hygiene.
Social withdrawal or isolation	Yes	No	She has social withdrawal or isolation when she is exhausted from work, but this is not frequent. Only a few times a week.
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	No
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	Patient claims she only gets a few hours of sleep at night because she is constantly thinking about family and shows a depressed mood more at night time.
Difficulty falling asleep	Yes	No	Always because something is always on her mind.
Frequently awakening during night	Yes	No	Yes, due to her anxiety.
Early morning awakenings	Yes	No	She wakes up early and is not able to go back to sleep.
Nightmares/dreams	Yes	No	Yes, but she does not remember them.
Other	Yes	No	No
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Yes, due to her having dental surgery and she is unable to eat a lot of foods. Loss of appetite.
Binge eating and/or purging	Yes	No	No
Unexplained weight loss?	Yes	No	No
Amount of weight change:			
Use of laxatives or excessive exercise	Yes	No	No

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Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Yes, all the time she is anxious and has OCD. When something doesn't get finished she tends to panic.
Panic attacks	Yes	No	The patient states she has them sometimes, but does not have them a whole lot. They have been occurring due to her family situation.
Obsessive/compulsive thoughts	Yes	No	Yes, she always has thoughts about her family and work. This has occurred almost every day till her mental breakdown.
Obsessive/compulsive behaviors	Yes	No	No
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	Not seeing her family or grandchildren has affected her work intensely, that is why she is working on her issues in this facility.
Rating Scale			
How would you rate your depression on a scale of 1-10?		The patient stated a 6 out of 10 on a numeric scale.	
How would you rate your anxiety on a scale of 1-10?		The patient stated a 7 out of 10 on a numeric scale.	
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	She states her work is very stressful on her because there are so many deadlines and it becomes really stressful and brings her anxiety level up.
School	Yes	No	No
Family	Yes	No	Family is the number one concern she states that is causing her stress. She stresses every day about it and it is mainly at night and loses sleep over her stress.
Legal	Yes	No	No

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Social	Yes	No	No	
Financial	Yes	No	No	
Other	Yes	No	N/A	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
10/04/2021 The Pavillion	<u>Inpatient</u> Outpatient Other:	Inpatient	Mental breakdown and suicidal ideations.	No improvement Some improvement <u>Significant improvement</u>
	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	

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Significant other J.T.	64	Spouse	<u>Yes</u>	No
			Yes	No
If yes to any substance use, explain: The patient's partner has a medical marijuana card that he uses for pain due to neuropathy in the legs and feet.				
Children (age and gender): Oldest 28 Male, Middle 23 Female, Youngest 22 Male. Who are children with now? They live on their own.				
Household dysfunction, including separation/divorce/death/incarceration: The patient is divorced, but in a new relationship. The client has had death in the family from				
Current relationship problems: Patient has problems with her children. Number of marriages: 1				
Sexual Orientation:	Is the client sexually active?		Does client practice safe sex?	
	<u>Yes</u> No		Yes <u>No</u>	
Please describe your religious values, beliefs, spirituality and/or preference: The client is catholic but does not go to church.				
Ethnic/cultural factors/traditions/current activity: N/A Describe: N/A				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The client assaulted another person when she was angry at her ex-husband. She received a misdemeanor and had to do counseling and was on probation. This occurred in 2006.				
How can your family/support system participate in your treatment and care? Her and her significant other have talked about changes that need to be made in order for the patient to become healthier and happier.				
Client raised by: Natural parents <u>Natural parents</u> Grandparents Adoptive parents Foster parents				

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Other (describe):
Significant childhood issues impacting current illness: N/A
Atmosphere of childhood home: <u>Loving</u> <u>Comfortable</u> Chaotic Abusive Supportive: The client's parents did not support her when she became pregnant at 17, but ended up supporting her after a few years. Other:
Self-Care: Independent <u>Independent</u> Assisted Total Care
Family History of Mental Illness (diagnosis/suicide/relation/etc.) None
History of Substance Use: None
Education History: Client received her BS in teaching and she got a license to practice in child welfare. Grade school High school <u>College</u> Other:
Reading Skills: Yes <u>Yes</u> No Limited
Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: Client stated she wants to have a change in relationships by setting boundaries and learning to deal with her issues correctly.

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Where will the client go when discharged? The client will be discharged to her home.

Outpatient Resources (15 points)

Resource	Rationale
1. Group therapy	1. Group therapy would be a good resource to be able to talk with others in a supportive way to help improve your recovery from mental illness. I chose this since the client was very talkative during group sessions and was willing to do the work to improve herself.
2. Suicide Hotline	2. The suicide hotline is a great resource that should be given just in case she ever felt like she wanted to commit suicide again.
3. Counseling / Therapist	3. The patient can be given resources for a counselor/therapist so she could get help on her own time. This is a private setting and the facility can find a few that fit with her insurance. I chose this because sometimes group setting may not work great all the time and with counseling, the patient can have one-on-one time.

Current Medications (10 points)

Complete all of your client's psychiatric medications

Brand/Generic	Colestipol	Sucralfate	Duloxetine	Ropinirole	Pantoprazole
Dose	1 g Tablet	1 mg	60 mg Tablet	0.5 mg Tablet	40 mg Delayed release tablets
Frequency	Daily	Daily	Daily	Daily	Daily

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Route	PO	PO	PO	PO	PO
Classification	Bile acid sequestrant; Antihyperlipidemic (Jones, 2021)	GI protectant (Jones, 2021)	Serotonin and norepinephrine reuptake inhibitor. (Jones, 2021)	Nonergot alkaloid dopamine agonist. (Jones, 2021)	Proton pump inhibitor. (Jones, 2021)
Mechanism of Action	Combines with bile acids to prevent absorption and forming insoluble complexes. (Jones, 2021)	Creates a protective barrier on the ulcer site and can be used to promote healing of an existing duodenal ulcer. (Jones, 2021)	Inhibits dopamine, neuronal serotonin, and norepinephrine to increase mood and inhibit pain signals. (Jones, 2021)	Helping control alteration in voluntary muscle movement like tremors or rigidity. (Jones, 2021)	Interferes with gastric acid secretion. (Jones, 2021)
Therapeutic Uses	Used to lower cholesterol in the blood. (Jones, 2021)	To prevent recurrence of duodenal ulcer. (Jones, 2021)	Antidepressant, neuropathic and musculoskeletal pain reliever. (Jones, 2021)	Antiparkinsonian. (Jones, 2021)	Antiulcer (Jones, 2021)
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	To reduce bad cholesterol. (Jones, 2021)	To prevent recurrence of duodenal ulcer. (Jones, 2021)	To treat major depressive disorder. (Jones, 2021)	To treat signs and symptoms of parkinson's disease. (Jones, 2021)	To treat GERD. (Jones, 2021)
Contraindications (2)	Complete biliary obstruction or hypersensitivity. (Jones, 2021)	N/A	Chronic liver disease including cirrhosis and severe renal impairment. (Jones, 2021)	Hypersensitivity to this medication or its components. (Jones, 2021)	Hypersensitivity to this medication and substituted benzimidazoles. (Jones, 2021)
Side Effects/Adverse Reactions (2)	Headache and abdominal pain. (Jones, 2021)	Drowsiness and bronchospasm. (Jones, 2021)	Abnormal dreams and seizures. (Jones, 2021)	Anxiety and Angioedema. (Jones, 2021)	Anaphylaxis and hyponatremia. (Jones, 2021)
Medication/Food	Have an adequate	Administer	Alcohol use	Do not smoke	Incompatibilities

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Interactions	amount of fluid intake. Interactions with medications so it should be taken on a different schedule from other oral drugs. (Jones, 2021)	on an empty stomach. Drug interaction with digoxin and ciprofloxacin . ciprofloxacin	can lead to severe hepatotoxicity. Interaction can occur with tramadol. (Jones, 2021)	while taking this drug. Drug to drug interaction with ciprofloxacin. (Jones, 2021)	with Midazolam and products containing zinc. Given 30 minutes before a meal. (Jones, 2021)
Nursing Considerations (2)	Give stool softener to prevent constipation. Expect to discontinue the drug if there is no response after 3 months. (Jones, 2021)	Use cautiously for patients with renal impairment because of risk for aluminum toxicity. (Jones, 2021)	Obtain a patient's baseline blood pressure before starting this medication due to orthostatic hypotension. Watch closely for suicidal thinking or behavior. (Jones, 2021)	Monitor patients for hallucinations and orthostatic hypotension. (Jones, 2021)	Administer 30 minutes before a meal mixed with apple juice or apple sauce. Expect to monitor PT and INR. (Jones, 2021)

Brand/Generic	Tramadol				
Dose	50 mg Tablets				
Frequency	PRN				
Route	PO				
Classification	Opioid antagonist. (Jones, 2021)				
Mechanism of Action	Binds with mu receptors and inhibits reuptake of serotonin and norepinephrine for				

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	its analgesic effects. (Jones, 2021)				
Therapeutic Uses	opioid analgesics (Jones, 2021)				
Therapeutic Range (if applicable)	Onset is an hour, peaks at 2-3 hours and lasts for 7-14 hours. (Jones, 2021)				
Reason Client Taking	For pain (Jones, 2021)				
Contraindications (2)	Acute or severe bronchial asthma and hypersensitivity. (Jones, 2021)				
Side Effects/Adverse Reactions (2)	Tremor or suicidal ideations. (Jones, 2021)				
Medication/Food Interactions	Interactions with alpha blockers and norepinephrine / serotonin reuptake. Do not drink alcohol. (Jones, 2021)				
Nursing Considerations (2)	Monitor patients for respiratory depression and too much can lead to abuse or addiction. (Jones, 2021)				

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook*. (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE:	Good hygiene and well groomed. The patient was
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Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:	outgoing, eager to share thoughts and feelings. The client was shorter and overweight. She had a good attitude, cooperative. Nice and friendly. She seemed happy. Appropriate for being happy.
MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:	The client is improving from her admission. She had thoughts of suicidal ideation and had a plan. The client denies any ideations, delusions, & any illusions. The client has phobias of spiders and heights.
ORIENTATION: Sensorium: Thought Content:	Oriented to person, place, situation, & time. A&O x4
MEMORY: Remote:	Client denies any impairment of memory. Memory is intact.
REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:	Client was admitted for suicidal ideation, therefore judgment is somewhat impaired. Client is intelligent. She had impulse control until it became a problem with her family and she could not control it.
INSIGHT:	The patient recognizes that suicide is not the right thing and is wrong. She recognizes that there are better ways to cope with her major depressive episodes.
GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	The patient does not use any assistive devices. She sits upright with good posture. Minimal muscle tone. The client had equal strength in all extremities 5/5. The client can move all extremities well.

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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1450	78 bpm	117/88 mmHg	16 rpm	96.4 F	98%
1630	76 bpm	113/93 mmHg	16 rpm	96.4 F	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1450	Numeric	N/A	0	N/A	Tramadol for pain. PRN
1630	Numeric	N/A	0	N/A	Tramadol for pain. PRN

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: 15%	Breakfast: 240 mL water
Lunch: none	Lunch: 480 mL of juice and water
Dinner: none	Dinner: none

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

The patient will be discharged to her home with her partner and animals. The patient should continue with the resources that are given after her stay at The Pavilion. This includes the suicide outline, group therapy, and counseling / therapist. Patients can follow up with a primary care provider.

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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. Disturbed sleep patterns related to anxiety AEB the patient stays awake at night thinking about family issues.	This was chosen because the patient explained she stays up all night and can't go to sleep due to her thinking about the stress and anxiety her family has caused her	1. Medication 2. Discourage caffeine or meals 2 hours before bed. 3. Calm and quiet environment	1. Medication 2. Discourage caffeine or meals 2 hours before bed. 3. Calm and quiet environment	1. Education for the patient on the proper medications she should be using for insomnia. 2. Educate the client on not drinking or eating 2 hours before bed to help sleep patterns. 3. Education on how to provide a calm and quiet sleeping environment.
2. Stress overload related to mental breakdown AEB family and work stressors.	This was chosen due to her stress overload from work deadlines. Also, family issues that	1. Stress reduction techniques 2. Continuous monitoring 3. Active	1. Stress reduction techniques 2. Continuous monitoring 3. Active listening	1. Educating the patient on coping methods to overcome life stressors. 2. Continuous

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	lead to her mental breakdown.	listening		<p>monitoring so the staff can find her triggers and the root of the stressors.</p> <p>3. Active listening by staff will let the patient know that she is being heard and can help express her emotions.</p>
3. Risk for suicide related to admission for attempted suicide AEB patint planning to kill herself with a gun.	The patients recent attempt of suicide.	<p>1. Medication</p> <p>2. Suicide precautions</p> <p>3. Group therapy</p>	<p>1. Medications</p> <p>2. Suicide precautions</p> <p>3. Group therapy</p>	<p>1. The patient will be given medications upon discharge and it should be taken as directed.</p> <p>2. The patient will be given a suicide hotline prior to discharge.</p> <p>3. The patient should be given resources for outpatient group therapies and counseling.</p>

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient stated she was not in any pain during my pain assessment. Patients states she is improving while being at the pavillion. Patient stated that family issues lead to her mental breakdown and suicidal ideation. Pt states she will not try and harm herself again but if it happens she will seek help.

Nursing Diagnosis/Outcomes

Nursing Diagnosis/Outcomes:
Stress overload related to mental breakdown AEB family and work stressors. The patient outcomes is to be educated on coping methods to overcome life stressors.
Disturbed sleep patterns related to anxiety AEB the patient stays awake at night thinking about family issues.
Educating the client on proper use of medication such a melatonin to help sleeping habits.
Risk for suicide related to admission for attempted suicide AEB patient planning to kill herself with a gun.
The patient should be given resources such as group therapies and counseling to continue care after discharge.

Nursing Interventions

Nursing Interventions:
Education for the patient on the proper use of sleeping medications.
Educate the pt on not drinking caffeine or eating at least 2 hours before bed.
Continuous monitoring to find out the patients triggers.
Educating the patient on coping methods.
The pt will be given medication for depression and anxiety.
The patient will be given a suicide hotline number in case she attempts suicide.

Patient Info: The patient information to the Pavillion because she attempted suidice with a plan to use her gun. This was due to her mentak breakdown of family stress. The patient is improving at the pavillion and is joining all the group therapy sessions and participates in them

Objective Data

Objective Data:
Pt Vital signs are stable with a pulse of 78, BP 117/88, respiration of 16, and 98% O2Sat.
Patient was focused and cooperative during assessment. Pt can MAEW and her strength is a 5/5 with all extremities.



