

N323 Care Plan
Lakeview College of Nursing
Alyssa Brooks

Demographics (3 points)

Date of Admission 2-17-22	Patient Initials A.H.	Age 35	Gender Male
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Single	Allergies Haldol- anaphylaxis reaction
Code Status Full	Observation Status Calm	Height Not listed	Weight Not listed

Medical History (5 Points)

Past Medical History: Asthma and Hepatitis C

Significant Psychiatric History: Schizoaffective disorder, bipolar disorder, alcohol use disorder, marijuana use disorder, methamphetamine use disorder, suicidality, and major depressive disorder.

Family History: Mother: bipolar disorder

Social History (tobacco/alcohol/drugs): Client reports alcohol use, a pint at most since 16 years old, marijuana since early adulthood, methamphetamine would not describe how much or when the client started, and tobacco use did not say how much but did start around 16 years old.

Living Situation: Homeless

Strengths: Able to verbalize feelings.

Support System: Patient reports no support system.

Admission Assessment

Chief Complaint (2 points): Client states paranoia that “other people out to get me”.

Contributing Factors (10 points): The client presents to the pavilion after a suicide attempt.

The client reveals that they have major depression and bipolar disorder. The client states he was “in a manic phase and wanted to kill himself.” The client reports that he was intoxicated at the

time of the suicide attempt. The client states that he wants to “figure out a good medication regimen.” This is the second suicide attempt.

Factors that lead to admission: Suicide attempt and alcohol use.

History of suicide attempts: The client has a history of two suicide attempts.

Primary Diagnosis on Admission (2 points): Major depressive disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A				
Witness of trauma/abuse: Yes				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	Yes, on and off from the age of four.	No	Mother and stepfather physically abused since childhood.
Sexual Abuse	No	No	N/A	N/A

Emotional Abuse	No	Yes, since the age of 4 years old.	N/A	Mother would blame client for things not of his doing.
Neglect	Yes, family	Yes, from the age of 4 years old.	N/A	Mother would leave him by himself.
Exploitation	No	Yes, does not know exact year.	N/A	This happened a couple of time in his life.
Crime	Yes	Yes, since the age of 17 years old.	N/A	The client has 2 DUI's, several battery and assaults, and domestic assault charges.
Military	No	No	N/A	N/A
Natural Disaster	No	No	N/A	N/A
Loss	Yes	Yes	N/A	Both parents and brother recently.
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	Constantly.
Loss of energy or interest in activities/school	Yes	No	
Deterioration in hygiene and/or grooming	Yes	No	
Social withdrawal or isolation	Yes	No	Comes and goes often.
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	Believes it is due to medication. 5-6 hours at night.
Difficulty falling asleep	Yes	No	Believe it is due to medication. Every night difficulty falling asleep.
Frequently awakening during night	Yes	No	At least three times a night waking up.
Early morning awakenings	Yes	No	Yes, because the doctor sees him at 0630.
Nightmares/dreams	Yes	No	Occurs every once and awhile.
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?	Yes	No	
Amount of weight change:			
Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Client has had tremors a few days ago.
Panic attacks	Yes	No	Client had one panic attack in life.
Obsessive/compulsive thoughts	Yes	No	Occurs on and off.
Obsessive/compulsive behaviors	Yes	No	Client blames suicide attempts on compulsive behaviors.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	Client avoids places and people due to anxiety.
Rating Scale			
How would you rate your depression on a scale of 1-10?	8		
How would you rate your anxiety on a scale of 1-10?	7		
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	Anxiety makes it hard to go to work and client reports hearing “people are plotting against him.”
School	Yes	No	
Family	Yes	No	Client reports “family hates him”

			and contributed to the depression.
Legal	Yes	No	Client is depressed and participates in illegal activities to alleviate depression.
Social	Yes	No	Client avoids social activities due to anxiety.
Financial	Yes	No	Client has a challenging time working due to anxiety.
Other	Yes	No	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
N/A	Inpatient Outpatient Other:	N/A	N/A	No improvement Some improvement Significant improvement
N/A	Inpatient Outpatient Other:	N/A	N/A	No improvement Some improvement Significant improvement
N/A	Inpatient	N/A	N/A	No improvement

	Outpatient Other:			Some improvement
				Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
If yes to any substance use, explain: N/A				
Children (age and gender): one child, female, age five.				
Who are children with now? Child lives with grandparents.				
Household dysfunction, including separation/divorce/death/incarceration: Clients parents and brother are deceased.				
Current relationship problems: No relationships. Client reports, “every relationship ending in failure.”				
Number of marriages: none				
Sexual Orientation: heterosexual	Is client sexually active? Yes No		Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference: Christian				
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): Client is currently on probation. Client did not report why				

<p>they are on probation.</p>
<p>How can your family/support system participate in your treatment and care? Client reports no support system.</p>
<p>Client raised by:</p> <ul style="list-style-type: none"> Natural parents Grandparents Adoptive parents Foster parents Other (describe):
<p>Significant childhood issues impacting current illness: Physical and emotional abuse by client's parents.</p>
<p>Atmosphere of childhood home:</p> <ul style="list-style-type: none"> Loving Comfortable Chaotic Abusive Supportive Other: toxic
<p>Self-Care:</p> <ul style="list-style-type: none"> Independent Assisted Total Care
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) Mother bipolar disorder</p>
<p>History of Substance Use: Alcohol, marijuana, methamphetamine, and tobacco use.</p>
<p>Education History:</p> <ul style="list-style-type: none"> Grade school High school College Other: did not complete high school. Went to grade 10.
<p>Reading Skills:</p> <ul style="list-style-type: none"> Yes

No Limited
Primary Language: English
Problems in school: yes
Discharge
Client goals for treatment: figure out a good medication regimen
Where will client go when discharged? Client does not know, possibly the St. louis area.

Outpatient Resources (15 points)

Resource	Rationale
1. Rosecrance on Moreland	1. This is a recovery house that offers outpatient counseling services for anxiety and depression in Champaign IL.
2. Ascend	2. This has intensive outpatient therapy for anxiety and depression in Champaign IL.
3. PATS	3. Provides substance abuse counseling in Urbana IL.

Current Medications (10 points)

Complete all of your client's psychiatric medications

Brand/Generic	Risperdal/ risperidone	Invega Sustenna/ paliperidone	Trileptal/ oxcarbazepine	Flonase/ fluticasone	AccuNab/ albuterol
Dose	1 mg	156 mg	300 mg	100 mg	90 mcg
Frequency	Twice a day	Every four weeks	Twice a day	Every morning	Every six hours as needed
Route	By mouth	Intramuscular	By mouth	Powder inhale	Oral
Classification	Benzisoxazole derivative (Jones & Bartlett, 2020).	Benzisoxazole derivative (Jones & Bartlett, 2020).	Carboxamide derivative (Jones & Bartlett, 2020).	Corticosteroid (Jones & Bartlett, 2020).	Adrenergic (Jones & Bartlett, 2020).
Mechanism of Action	Selectively blocks serotonin and dopamine receptors (Jones & Bartlett, 2020).	Selectively blocks serotonin and dopamine receptors (Jones & Bartlett, 2020).	May prevent or block seizures by blocking or closing sodium channels in neural cells (Jones & Bartlett, 2020).	Inhibits cells involved in the inflammatory response of asthma (Jones & Bartlett, 2020).	Attaches to beta two receptors causing bronchodilation (Jones & Bartlett, 2020).
Therapeutic Uses	Antipsychotic (Jones & Bartlett, 2020).	Antipsychotic (Jones & Bartlett, 2020).	Anticonvulsant (Jones & Bartlett, 2020).	Antiasthmatic (Jones & Bartlett, 2020).	Bronchodilator (Jones & Bartlett, 2020).
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Bipolar disorder	Schizoaffective disorder	To treat partial seizures (Jones & Bartlett, 2020).	Asthma	Asthma
Contraindications (2)	Hypersensitivity to risperidone (Jones & Bartlett,	History of cardiac arrhythmias and congenital	Hypersensitivity to oxycarbazepine (Jones & Bartlett,	Hypersensitivity to milk and untreated nasal mucosal	Hypersensitivity to albuterol and cardiac disorders

	2020). Hypersensitivity to paliperidone (Jones & Bartlett, 2020).	heart disease (Jones & Bartlett, 2020).	2020). Hypersensitivity to eslicarbazepine acetate (Jones & Bartlett, 2020).	infection (Jones & Bartlett, 2020).	(Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Hypoglycemia and pulmonary embolism (Jones & Bartlett, 2020).	Neuroleptic malignant syndrome and seizures (Jones & Bartlett, 2020).	AV block and aplastic anemia (Jones & Bartlett, 2020).	Bronchospasm and adrenal insufficiency (Jones & Bartlett, 2020).	Hypotension and arrhythmias (Jones & Bartlett, 2020).
Medication/Food Interactions	Alcohol use can add to CNS depressant (Jones & Bartlett, 2020).	Interacts with beta blockers causing an increased risk of hypotension (Jones & Bartlett, 2020).	Can interact with alcohol use causing additive CNS depressant (Jones & Bartlett, 2020).	Interacts with strong CYP3A4 inhibitors because of an increased risk of adverse effects (Jones & Bartlett, 2020).	Beta blockers inhibits the effects of albuterol (Jones & Bartlett, 2020).
Nursing Considerations (2)	Notify the provider immediately if changes in mental status (Jones & Bartlett, 2020). Caution patients that sleepwalking may occur (Jones & Bartlett, 2020).	Use cautiously in patients with cardiac diseases and check CBC often in the first few months of therapy (Jones & Bartlett, 2020).	Monitor the patient's skin closely and monitor for suicidal ideation (Jones & Bartlett, 2020).	Know if the patient takes systemic corticosteroids and notify provider for vision differences (Jones & Bartlett, 2020).	Use cautiously in those with cardiac disorders and monitor serum potassium levels (Jones & Bartlett, 2020).

Brand/Generic	N/A	N/A	N/A	N/A	N/A
Dose	N/A	N/A	N/A	N/A	N/A
Frequency	N/A	N/A	N/A	N/A	N/A
Route	N/A	N/A	N/A	N/A	N/A
Classification	N/A	N/A	N/A	N/A	N/A
Mechanism of Action	N/A	N/A	N/A	N/A	N/A
Therapeutic Uses	N/A	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

Jones & Bartlett. (2020). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: engaged Build: appropriate for age Attitude: engaged Speech: clear, normal rate Interpersonal style: focused Mood: calm Affect: calm</p>	<p>The client’s behavior and attitude are engaged. The client’s speech is clear at a normal rate. The client’s interpersonal style is focused. The mood and affect are calm at this time. The client’s build is appropriate for age.</p>
<p>MAIN THOUGHT CONTENT: Ideations: suicidal Delusions: Client states “people are plotting against me.” Illusions: Client states “people are plotting against me.” Obsessions: N/A Compulsions: N/A Phobias: N/A</p>	<p>The client has suicidal ideation and has delusions/illusions of voices saying, “people are plotting against me.” The client reports no obsessions/ compulsions/ or phobias at this time.</p>
<p>ORIENTATION: Sensorium: Alert and oriented x4 Thought Content: Focused on treatment.</p>	<p>The sensorium is alert and oriented times four. The thought contents are focused on treatment at this time.</p>
<p>MEMORY: Remote: intact</p>	<p>The client’s remote memory is intact.</p>
<p>REASONING: Judgment: Intact Calculations: reasonable Intelligence: appropriate for developmental level Abstraction: appropriate for developmental level Impulse Control: low impulse control</p>	<p>The client’s judgment is intact, and calculations are reasonable for developmental age. Intelligence and abstraction are appropriate for developmental level. The client reports having” low impulse control.”</p>
<p>INSIGHT: Fair</p>	<p>The client’s insight is fair.</p>
<p>GAIT: appropriate for age Assistive Devices: none Posture: adequate Muscle Tone: appropriate for age Strength: 5/5 in all extremities Motor Movements: equal bilaterally.</p>	<p>The client’s gait is appropriate for age with no use of assistive devices. The posture is adequate and muscle tone is appropriate for age. The client has a strength of 5/5 in all extremities with motor movements equal bilaterally.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1530	57 beats per minute	110/56 mmHg	18 breaths per minute	98.2°F	97% room air
1630	59 beats per minute	112/58 mmHg	18 breaths per minute	98.4°F	97% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1530	Numeric	N/A	0/10	N/A	N/A
1630	Numeric	N/A	0/10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: 85% Breakfast: N/A Lunch: N/A Dinner: 85%	Oral Fluid Intake with Meals (in mL) Breakfast: N/A Lunch: N/A Dinner: 240 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Client should be educated on outpatient resources, medication management, support groups, and if possible be discharged to a halfway house type of rehab program.

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Immediate Interventions (At admission)</p>	<p>Intermediate Interventions (During hospitalization)</p>	<p>Community Interventions (Prior to discharge)</p>
<p>1. Risk for suicide related to grieving as evidenced by psychiatric disorder (Phelps, 2020).</p>	<p>The client has had two suicide attempts after a close family member has died. Client blames suicide attempt on bipolar disorder.</p>	<p>1. Ask patient directly if they have thoughts or plans of suicide (Phelps, 2020). 2. Use a warm, caring, nonjudgmental manner (Phelps, 2020). 3. Listen carefully to patient (Phelps, 2020).</p>	<p>1. Initiate appropriate safety protocols (Phelps, 2020). 2. Supervise the administration of medications (Phelps, 2020). 3. Provide supervision (Phelps, 2020).</p>	<p>1. Make appropriate referrals (Phelps, 2020). 2. Provide patient with telephone numbers for crisis centers (Phelps, 2020). 3. Demonstrate an understanding of the situation (Phelps, 2020).</p>
<p>2. Chronic low self-esteem related to ineffective coping of loss as evidenced by indecisive behavior</p>	<p>The client reports “unable to decide what to do next after loss of family members.”</p>	<p>1. Institute suicide precautions (Phelps, 2020). 2. Provide emotional support (Phelps, 2020). 3. Provide patient with concise information about decision-making skills (Phelps, 2020).</p>	<p>1. Provide patient with a structured routine (Phelps, 2020). 2. Teach self-healing technique to patient (Phelps, 2020). 3. Provide patient with positive feedback (Phelps, 2020).</p>	<p>1. Assist patient in resources for after discharge (Phelps, 2020). 2. Refer to community resources (Phelps, 2020). 3. Provide emotional support (Phelps, 2020).</p>
<p>3. Anxiety related to stressors as evidenced by tremors (Phelps, 2020).</p>	<p>The client has expressed a history of anxiety and tremors related to anxiety.</p>	<p>1. Listen attentively allowing patient to express feeling’s (Phelps, 2020). 2. Include</p>	<p>1. Spend 10 minutes with patient twice per shift (Phelps, 2020). 2. Remain with patient during</p>	<p>1. Refer patient to a community or professional resource to provide mental health assistance</p>

		<p>patient on plan of care (Phelps, 2020).</p> <p>3. Explore factors that may contribute to anxiety (Phelps, 2020).</p>	<p>severe anxiety (Phelps, 2020).</p> <p>3. Attend to patient's comfort needs (Phelps, 2020).</p>	<p>(Phelps, 2020).</p> <p>2. Give facts about fear and anxiety (Phelps, 2020).</p> <p>3. Answer questions patient may have prior to discharge (Phelps, 2020).</p>
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Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

The client reports hearing voices that say, "people are plotting against you." Client reports "low impulse control." The client presents to the pavilion after a suicide attempt. The client reveals that they have major depression and bipolar disorder. The client states he was "in a manic phase and wanted to kill himself." The client reports that he was intoxicated at the time of the suicide attempt. The client states that he wants to "figure out a good medication regimen." This is the second suicide attempt.

Subjective Data

Objective Data

1530
 HR: 57 beats per minute
 BP: 110/56 mmHg
 RR: 18 breaths per minute
 Temp: 98.2°F
 O2 Sat: 97% room air
 1630
 HR: 59 beats per minute
 BP: 112/58 mmHg
 RR: 18 breaths per minute
 Temp: 98.4°F
 O2 sat: 97% room air

Patient Information

35-year-old male with a medical history of asthma and hepatitis C. Client is admitted for major depressive disorder following a suicide attempt. Patient has a history of alcohol, tobacco, marijuana, and methamphetamine use.

1. Risk for suicide related to grieving as evidenced by psychiatric disorder (Phelps, 2020). Outcome: Help the client through the grieving processes and lower the risk of suicide.
2. Chronic low self-esteem related to ineffective coping of loss as evidenced by indecisive behavior Outcomes: Improve self-esteem and decision-making skills.
3. Anxiety related to stressors as evidenced by tremors (Phelps, 2020). Outcomes: Reduce anxiety through the medication regimen and calming techniques.

Nursing Diagnosis/Outcomes

Nursing Interventions

1. Listen attentively allowing patient to express feeling's (Phelps, 2020).
2. Include patient on plan of care (Phelps, 2020).
3. Explore factors that may contribute to anxiety (Phelps, 2020).
 1. Spend 10 minutes with patient twice per shift (Phelps, 2020).
 2. Remain with patient during severe anxiety (Phelps, 2020).
 3. Attend to patient's comfort needs (Phelps, 2020).
1. Refer patient to a community or professional resource to provide mental health assistance (Phelps, 2020).
2. Give facts about fear and anxiety (Phelps, 2020).
3. Answer questions patient may have prior to discharge (Phelps, 2020).
 1. Institute suicide precautions (Phelps, 2020).
 2. Provide emotional support (Phelps, 2020).
 3. Provide patient with concise information about decision-making skills (Phelps, 2020).

Nursing interventions Continued.

1. Provide patient with a structured routine (Phelps, 2020).
2. Teach self-healing technique to patient (Phelps, 2020).
3. Provide patient with positive feedback (Phelps, 2020).
1. Assist patient in resources for after discharge (Phelps, 2020).
2. Refer to community resources (Phelps, 2020).
3. Provide emotional support (Phelps, 2020).
1. Ask patient directly if they have thoughts or plans of suicide (Phelps, 2020).
2. Use a warm, caring, nonjudgmental manner (Phelps, 2020).
3. Listen carefully to patient (Phelps, 2020).
1. Initiate appropriate safety protocols (Phelps, 2020).
2. Supervise the administration of medications (Phelps, 2020).
3. Provide supervision (Phelps, 2020).
1. Make appropriate referrals (Phelps, 2020).
2. Provide patient with telephone numbers for crisis centers (Phelps, 2020).
3. Demonstrate an understanding of the situation (Phelps, 2020).

