N323 Care Plan

Lakeview College of Nursing

Name

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
Race/Ethnicity	Occupation	Marital Status	Allergies
Code Status	Observation Status	Height	Weight

Medical History (5 Points)

Past Medical History:

Significant Psychiatric History:

Family History:

Social History (tobacco/alcohol/drugs):

Living Situation:

Strengths:

Support System:

Admission Assessment

Chief Complaint (2 points):

Contributing Factors (10 points):

Factors that lead to admission:

History of suicide attempts:

Primary Diagnosis on Admission (2 points):

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				
Sexual Abuse				
Emotional Abuse				
Neglect				
Exploitation				
Crime				
Military				
Natural Disaster				
Loss				
Other				
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**		

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**	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	
Difficulty falling asleep	**Yes**	**No**	
Frequently awakening during night	**Yes**	**No**	
Early morning awakenings	**Yes**	**No**	
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,	**Yes**	**No**	

etc.)			
Panic attacks	**Yes**	**No**	
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**	

Rating Scale	
How would you rate your depression on a scale of 1-10?	
How would you rate your anxiety on a scale of 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**	
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/**	**Inpatient/**	**Reason**	**Response/Outcome**

	Therapist	Outpatient	for Treatment	
	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**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain:				
Children (age and gender): Who are children with now?				
Household dysfunction, including separation/divorce/death/incarceration:				
Current relationship problems:				

Number of marriages:		
Sexual Orientation:	**Is client sexually active?** **Yes No**	**Does client practice safe sex?** **Yes No**
Please describe your religious values, beliefs, spirituality and/or preference:		
Ethnic/cultural factors/traditions/current activity: **Describe:**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):		
How can your family/support system participate in your treatment and care?		
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness:		
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.)		
History of Substance Use:		

Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language:
Problems in school:
Discharge
Client goals for treatment:
Where will client go when discharged?

Outpatient Resources (15 points)

Resource	Rationale
1.	**1.**
2.	**2.**
3.	**3.**

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

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

Brand/Generic					

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

Medications Reference (1) (APA):

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	
ORIENTATION: **Sensorium:** **Thought Content:**	.
MEMORY: **Remote:**	.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	.
INSIGHT:	
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
.					

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

Dietary Data (2 points)

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

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

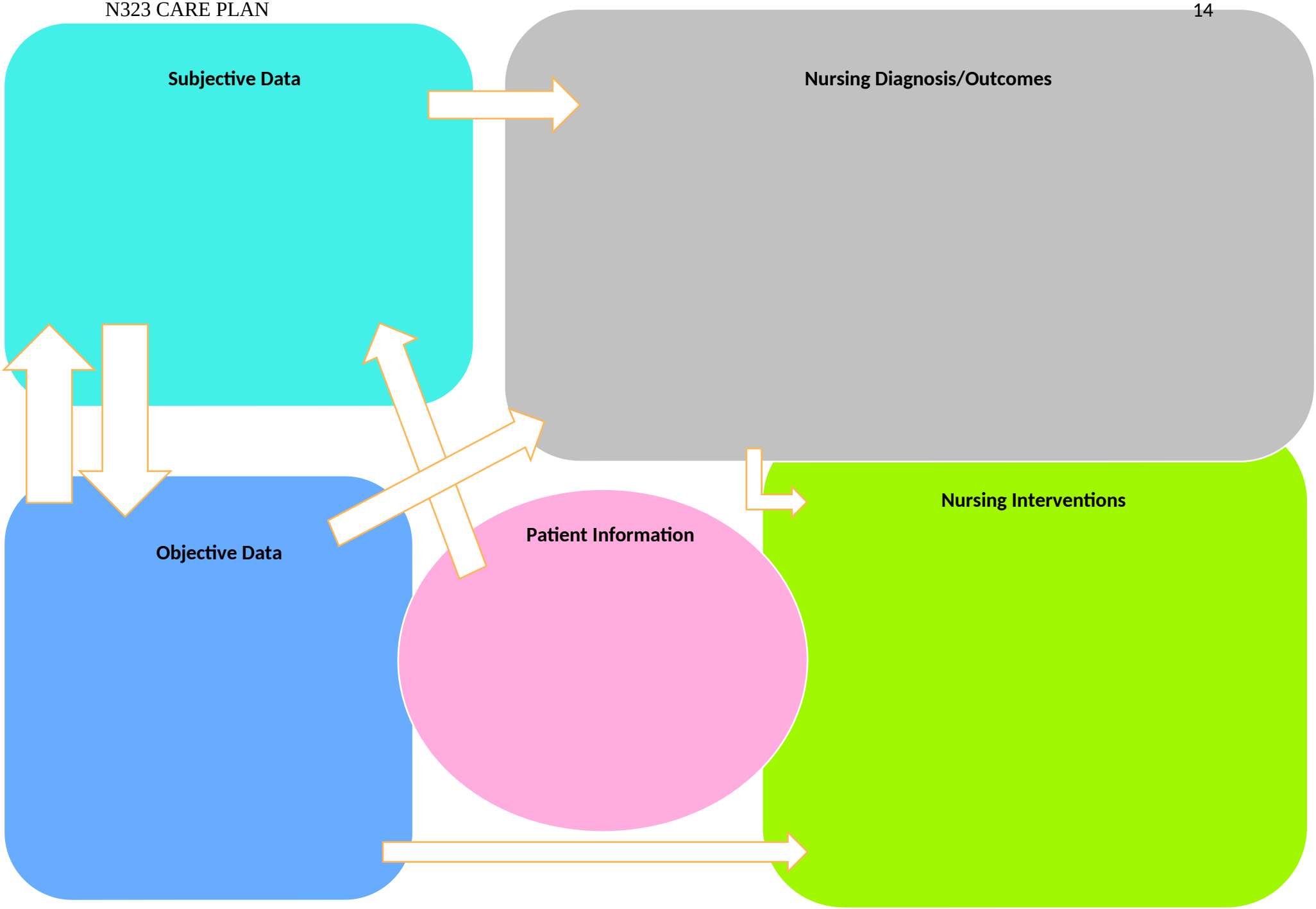
Nursing Diagnosis (15 points)

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.		**1.** **2.** **3.**	**1.** **2.** **3.**	**1.** **2.** **3.**
2.		**1.** **2.** **3.**	**1.** **2.** **3.**	**1.** **2.** **3.**
3.		**1.** **2.** **3.**	**1.** **2.** **3.**	**1.** **2.** **3.**

Other References (APA):

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Objective Data
Patient Information
Nursing Interventions