

N323 Care Plan #1

Lakeview College of Nursing

Alfonso Crane

03/21/2022

## N323 CARE PLAN

**Demographics (3 points)**

<b>Date of Admission</b> <i>03/21/2022</i>	<b>Patient Initials</b> <i>M.D.</i>	<b>Age</b> <i>43</i>	<b>Gender</b> <i>Female</i>
<b>Race/Ethnicity</b> <i>Caucasion</i>	<b>Occupation</b> <i>Self-employed – Attorney</i>	<b>Marital Status</b> <i>Married</i>	<b>Allergies</b> <i>None (NKA)</i>
<b>Code Status</b> <i>Full Code</i>	<b>Observation Status</b> <i>Q15 minute monitoring</i>	<b>Height</b> <i>5'2"</i>	<b>Weight</b> <i>120 lbs</i>

**Medical History (5 Points)**

**Past Medical History:** *Hypertension | Anorexia | Bulimia*

**Significant Psychiatric History:** *Major Depression Disorder (MDD) | Anxiety | Depression*

**Family History:** *Father (Hypertension) | Mother (Anxiety) | Father's brother (Suicide) |*

*Father's sister (Bipolar)*

**Social History (tobacco/alcohol/drugs):** *Tobacco – cigarettes (1 pk/week) | Alcohol (4x/week; 5-6 drinks/day when drinking; 6+ drinks/week) | Drugs (Partakes in social drug use: marijuana, cocaine, ecstasy).*

**Living Situation:** *Living with husband and children*

**Strengths:** *The client is self-aware and recognizes that they need help. The client also states that the medication that they are currently prescribed with “does not help”. The client recognizes the factors and situation that led her to be at the facility. With treatment, the client is hopeful that she will get back to what's most important to her: her husband and children.*

**Support System:** *Family; consists of parents, husband, children.*

**Admission Assessment**

**Chief Complaint (2 points):** *The client is feeling anxious*

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**Contributing Factors (10 points):** *The client was admitted, willingly and with her parents, to the Pavilion on 03/21/2022. Prior to admission, the client states that she experienced hallucinations and was found in a nearby forested area stating that “people were out to get me, they found out about my Medicare fraud”. Upon admission, the client states that she mixes prescription medications with alcohol and that her favorite thing to do is mix Valium with vodka. The client appears to be slightly anxious and rates her anxiety at a 3 on a scale of 1-10. The client also rates her depression at a 2 on a scale of 1-10. They state that the medication that was prescribed to them does not help and that “nothing seems to be working” for them. The client believes that she is misdiagnosed with MDD and that the reason the medication is not working is due to the misdiagnosis. At the time of assessment, the client stated that nothing makes her anxiety worse. The client is seeking out help so that they can get back to loving their husband and children. Medication adjustment and management and group therapy are the current plans of treatment for the client.*

**Factors that lead to admission:** *The client was found in a nearby forested area and believes that there were officials chasing her because of “Medicare fraud”. The client states that she mixes her prescription medications with alcohol. | Paranoia | Psychosis*

**History of suicide attempts:** *Zero attempts of suicide*

**Primary Diagnosis on Admission (2 points):** *Unspecified psychosis not due to a substance*

### Psychosocial Assessment (30 points)

#### History of Trauma

**Lifetime experience:** *Sexually abused at 14-years-old. Parent’s divorce in client’s 20s (unable to remember what age exactly).*

**Witness of trauma/abuse:** *N/A*

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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>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Sexual Abuse</b>	<i>No</i>	<i>14 years old</i>	<i>N/A</i>	<i>The client was sexual assaulted at 14 years old; developed anxiety and depression as a result of this.</i>
<b>Emotional Abuse</b>	<i>Yes</i>	<i>"20-something"</i>	<i>N/A</i>	<i>The client's parents got a divorce when she was in her 20s.</i>
<b>Neglect</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Exploitation</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Crime</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Military</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Natural Disaster</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Loss</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Other</b>	<i>No</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<b>Presenting Problems</b>				
<b>Problematic Areas</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>	
<b>Depressed or sad mood</b>	<b>Yes</b>	<b>No X</b>	<i>N/A</i>	
<b>Loss of energy or interest in activities/school</b>	<b>Yes</b>	<b>No X</b>	<i>N/A</i>	
<b>Deterioration in hygiene and/or grooming</b>	<b>Yes</b>	<b>No X</b>	<i>N/A</i>	

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<b>Social withdrawal or isolation</b>	Yes <b>X</b>	No	<i>The client states that being newly admitted has increased her anxiety and therefore made her unable to converse with other patients.</i>
<b>Difficulties with home, school, work, relationships, or responsibilities</b>	Yes	No <b>X</b>	N/A
<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Change in numbers of hours/night</b>	Yes <b>X</b>	No	<i>The client states that they sleep around 5-6 hours during the day.</i>
<b>Difficulty falling asleep</b>	Yes <b>X</b>	No	<i>The patient does not sleep at night; feelings of anxiousness keep her awake.</i>
<b>Frequently awakening during night</b>	Yes	No <b>X</b>	N/A
<b>Early morning awakenings</b>	Yes	No <b>X</b>	N/A
<b>Nightmares/dreams</b>	Yes <b>X</b>	No	<i>The client states that they have night terrors frequently. The client did not disclose details of the night terrors, but just that they happen frequently.</i>
<b>Other</b>	Yes	No	N/A
<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 <b>X</b>	No	<i>The client states that they had an eating disorder which developed at the age of 19 years old – anorexia, bulimia. The client explains that the cause of the eating disorder started after her sexual assault at the age of 14.</i>
<b>Binge eating and/or purging</b>	Yes	No <b>X</b>	N/A
<b>Unexplained weight loss?</b>	Yes	No <b>X</b>	N/A
<b>Amount of weight change:</b>			
<b>Use of laxatives or excessive exercise</b>	Yes	No <b>X</b>	N/A
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>

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<b>Anxiety behaviors (pacing, tremors, etc.)</b>	<b>Yes</b> <b>X</b>	<b>No</b>	<i>During the assessment, the client was fidgeting with their hands and was guarded.</i>
<b>Panic attacks</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Obsessive/compulsive thoughts</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Obsessive/compulsive behaviors</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Rating Scale</b>			
<b>How would you rate your depression on a scale of 1-10?</b>		2	
<b>How would you rate your anxiety on a scale of 1-10?</b>		3	
<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>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>School</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Family</b>	<b>Yes</b> <b>X</b>	<b>No</b>	<i>The client states that her drinking affects her family situation and does not want her children to see her in this state.</i>
<b>Legal</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Social</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Financial</b>	<b>Yes</b>	<b>No</b> <b>X</b>	N/A
<b>Other</b>	<b>Yes</b>	<b>No</b>	N/A
<b>Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient</b>			

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<b>Dates</b>	<b>Facility/MD/ Therapist</b>	<b>Inpatient/ Outpatient</b>	<b>Reason for Treatment</b>	<b>Response/Outcome</b>
<i>Ongoing: Therapist</i>	<b>Inpatient</b> <b>Outpatient X</b> <b>Other:</b>	<i>Outpatient</i>	<i>Seeing a therapist to manage anxiety and depression.</i>	<b>No improvement</b> <b>Some improvement X</b> <b>Significant improvement</b>
<i>Current (admitted on 03/21/2022): Pavilion</i>	<b>Inpatient X</b> <b>Outpatient</b> <b>Other:</b>	<i>Inpatient</i>	<i>Psychosis</i>	<b>No improvement X</b> <b>Some improvement</b> <b>Significant improvement</b>
<i>N/A</i>	<b>Inpatient</b> <b>Outpatient</b> <b>Other:</b>	<i>N/A</i>	<i>N/A</i>	<b>No improvement</b> <b>Some improvement</b> <b>Significant improvement</b>
<b>Personal/Family History</b>				
<b>Who lives with you?</b>	<b>Age</b>	<b>Relationship</b>	<b>Do they use substances?</b>	
<i>Husband (B.D.)</i>	<i>43</i>	<i>Husband</i>	<b>Yes</b>	<b>No X</b>
<i>Child (M.D.)</i>	<i>18</i>	<i>Daughter</i>	<b>Yes</b>	<b>No X</b>
<i>Child (B.D.)</i>	<i>15</i>	<i>Son</i>	<b>Yes</b>	<b>No X</b>
<i>Child (R.D.)</i>	<i>11</i>	<i>Son</i>	<b>Yes</b>	<b>No X</b>
<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<b>Yes</b>	<b>No</b>
<b>If yes to any substance use, explain:</b> <i>N/A</i>				
<b>Children (age and gender):</b> <i>Female (18 years old)   Male (15 years old)   Male (11 years old)</i>				
<b>Who are children with now?</b> <i>Husband</i>				
<b>Household dysfunction, including separation/divorce/death/incarceration:</b> <i>Nothing in household; Parents' divorce</i>				
<b>Current relationship problems:</b> <i>None</i>				

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<b>Number of marriages:</b> <i>One</i>		
<b>Sexual Orientation:</b> <i>Straight</i>	<b>Is client sexually active?</b> Yes <b>X</b> No	<b>Does client practice safe sex?</b> Yes <b>X</b> No
<b>Please describe your religious values, beliefs, spirituality and/or preference:</b> <i>“I am a catholic”.</i>		
<b>Ethnic/cultural factors/traditions/current activity:</b> <i>The client denies ethnic/cultural factors/traditions.</i>		
<b>Describe:</b> <i>N/A</i>		
<b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b> <i>The client denies any current/past legal issues.</i>		
<b>How can your family/support system participate in your treatment and care?</b> <i>The family support system is willing to participate in the treatment and care for the client. They want to see the client get the help they need.</i>		
<b>Client raised by:</b>  Natural parents <b>X</b> Grandparents Adoptive parents Foster parents Other (describe):		
<b>Significant childhood issues impacting current illness:</b> <i>Sexual assault (14 years old)   Parents’ divorce (“20-something” years old)</i>		
<b>Atmosphere of childhood home:</b>  Loving Comfortable <b>X</b> Chaotic Abusive Supportive Other: <i>The client states that she grew up “poor” and “with little money”.</i>		
<b>Self-Care:</b>  Independent <b>X</b> Assisted Total Care		
<b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b> <i>Mother (Anxiety)   Father’s brother (Suicide)   Father’s sister (Bipolar)</i>		
<b>History of Substance Use:</b> <i>The client has a hx of social substance/drug use including marijuana, cocaine, and ecstasy.</i>		

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<b>Education History:</b>  <b>Grade school</b> <b>High school</b> <b>College X</b> <b>Other: Attorney – PhD and Master’s (8 years)</b>
<b>Reading Skills:</b> <i>The client enjoys reading</i>  <b>Yes X</b> <b>No</b> <b>Limited</b>
<b>Primary Language:</b> <i>English</i>
<b>Problems in school:</b> <i>None</i>
<b>Discharge</b>
<b>Client goals for treatment:</b> <i>The client states that “I want to be better for my husband and children”.</i>
<b>Where will the client go when discharged?</b> <i>The client will return home with her husband and children.</i>

**Outpatient Resources (15 points)**

Resource	Rationale
1. Group Therapy	1. Group therapy can provide and improve interactive communication, peer interaction, and conversational practice for the client. Attending group therapy will allow the client to hear different perspectives on situations like their own.
2. One-on-one therapy	2. Recurring visits with a licensed therapist, psychiatrist, etc. can be beneficial to the client. Medication adjustments and mental status progression or declination can be recorded. Appropriate measures can be taken when meeting with a professional on a scheduled basis.
3. Narcotics Anonymous (NA)	3. Narcotics Anonymous can provide additional information for the client. NA can also provide the client with information and the ability to learn from others who are in similar situations.

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

(Jones and Bartlett Learning, 2021)

<b>Brand/Generic</b>	<i>bupirone (Buspar)</i>	<i>diazepam (Valium)</i>	<i>paroxetine (Paxil)</i>	<i>alprazolam (Xanax)</i>	<i>N/A</i>
<b>Dose</b>	<i>15 mg</i>	<i>5 mg</i>	<i>25 mg</i>	<i>5 mg</i>	<i>N/A</i>
<b>Frequency</b>	<i>daily</i>	<i>daily</i>	<i>daily</i>	<i>daily</i>	<i>N/A</i>
<b>Route</b>	<i>P.O.</i>	<i>P.O.</i>	<i>P.O.</i>	<i>P.O.</i>	<i>N/A</i>
<b>Classification</b>	<p><b>Pharmacological class:</b> <i>Azapirone</i></p> <p><b>Therapeutic class:</b> <i>Anxiolytic</i></p>	<p><b>Pharmacological class:</b> <i>Benzodiazepine</i></p> <p><b>Therapeutic class:</b> <i>Anticonvulsant, anxiolytic, sedative-hypnotic, skeletal muscle relaxant</i></p> <p><b>Controlled substance schedule:</b> <i>IV</i></p>	<p><b>Pharmacological class:</b> <i>Selective serotonin reuptake inhibitor (SSRI)</i></p> <p><b>Therapeutic class:</b> <i>Antianxiety, antidepressant, antiobsessional, antipanic, premenstrual analgesic</i></p>	<p><b>Pharmacological class:</b> <i>Benzodiazepine</i></p> <p><b>Therapeutic class:</b> <i>Anxiolytic, antipanic</i></p> <p><b>Controlled substance schedule:</b> <i>IV</i></p>	<i>N/A</i>
<b>Mechanism of Action</b>	<i>May act as a partial agonist at serotonin receptors in the brain, producing anti-anxiety effects.</i>	<i>Diazepam suppresses the spread of seizure activity caused by seizure-producing foci in cortex, limbic, and thalamus structures.</i>	<i>Potentiating serotonin activity in CNS and inhibiting serotonin reuptake at presynaptic neuronal membrane.</i>	<i>GABA inhibits excitatory stimulation, which helps control emotional behavior.</i>	<i>N/A</i>
<b>Therapeutic Uses</b>	<i>To manage anxiety</i>	<i>To relieve anxiety</i>	<i>To treat major depression</i>	<i>To control anxiety disorders</i>	<i>N/A</i>
<b>Therapeutic Range (if applicable)</b>	<i>N/A</i>	<i>100-1000 ng/mL</i>	<i>20-60 ng/mL</i>	<i>5-50 ng/mL</i>	<i>N/A</i>
<b>Reason Client Taking</b>	<i>To manage anxiety</i>	<i>To relieve anxiety</i>	<i>To treat major depression</i>	<i>To control anxiety disorders</i>	<i>N/A</i>

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<b>Contraindications (2)</b>	<ol style="list-style-type: none"> <li>1. Hypersensitivity to buspirone and its components.</li> <li>2. Severe hepatic or renal impairment.</li> </ol>	<ol style="list-style-type: none"> <li>1. Hypersensitivity to diazepam or its components.</li> <li>2. Severe hepatic impairment.</li> </ol>	<ol style="list-style-type: none"> <li>1. Hypersensitivity to paroxetine or its components.</li> <li>2. Hypersensitivity to pimozide.</li> </ol>	<ol style="list-style-type: none"> <li>1. Hypersensitivity to alprazolam</li> <li>2. Hypersensitivity to other benzodiazepines</li> </ol>	N/A
<b>Side Effects/Adverse Reactions (2)</b>	<ol style="list-style-type: none"> <li>1. CNS: serotonin syndrome</li> <li>2. CV: chest pain</li> </ol>	<ol style="list-style-type: none"> <li>1. CNS: suicidal ideation</li> <li>2. CV: hypotension</li> </ol>	<ol style="list-style-type: none"> <li>1. CNS: suicidal ideation</li> <li>2. CV: tachycardia</li> </ol>	<ol style="list-style-type: none"> <li>1. CNS: agitation</li> <li>2. CV: hypotension</li> </ol>	N/A
<b>Medication/Food Interactions</b>	<ol style="list-style-type: none"> <li>1. CYP3A4 inducers</li> <li>2. CYP3A4 inhibitors</li> <li>3. diltiazem, erythromycin, itraconazole, nefazodone, nordiazepam, verapamil</li> <li>4. MAO inhibitors</li> <li>5. Any foods can decrease buspirone clearance</li> <li>6. Grapefruit juice</li> </ol>	<ol style="list-style-type: none"> <li>1. Antacids</li> <li>2. CNS depressants</li> <li>3. Opioids</li> <li>4. Phenytoin</li> <li>5. Alcohol use</li> </ol>	<ol style="list-style-type: none"> <li>1. Amphetamines</li> <li>2. MAO inhibitors</li> <li>3. NSAIDS</li> <li>4. digoxin</li> <li>5. Alcohol use</li> </ol>	<ol style="list-style-type: none"> <li>1. Amiodarone, cyclosporine, diltiazem</li> <li>2. Antacids</li> <li>3. Anticonvulsants, antidepressants, CNS depressants</li> <li>4. digoxin</li> <li>5. opioids</li> <li>6. alcohol use</li> </ol>	N/A
<b>Nursing Considerations (2)</b>	<ol style="list-style-type: none"> <li>1. Use buspirone cautiously in patients with hepatic and renal impairments.</li> <li>2. Institute safety precautions because of possible CNS reactions.</li> </ol>	<ol style="list-style-type: none"> <li>1. Use diazepam with extreme caution in patients with a history of alcohol or drug abuse.</li> <li>2. Use diazepam cautiously in patients with hepatic and renal impairments.</li> </ol>	<ol style="list-style-type: none"> <li>1. Do not give enteric-coated form with antacids.</li> <li>2. Watch for akathisia and psychomotor agitation, especially during the first few weeks.</li> </ol>	<ol style="list-style-type: none"> <li>1. Expect to give higher dosage if patient's panic attacks occur unexpectedly or during such activities as driving.</li> <li>2. Plan to reduce dosage slowly when alprazolam is discontinued.</li> </ol>	N/A

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

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

Jones & Bartlett Learning. (2021). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning

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

<p><b>APPEARANCE:</b>  <b>Behavior:</b> Engaged, anxious  <b>Build:</b> Thin  <b>Attitude:</b> Positive, guarded  <b>Speech:</b> Speech is coherent, appropriate for age  <b>Interpersonal style:</b>  <b>Mood:</b> Anxious, happy  <b>Affect:</b> Anxious</p>	<p><i>The client is a 43-year-old female. She is groomed and dressed appropriately. The client was calm, engaged, but guarded. She appeared to be anxious, but her speech was clear and concise. The client was happy to partake in the conversation.</i></p>
<p><b>MAIN THOUGHT CONTENT:</b>  <b>Ideations:</b> None  <b>Delusions:</b> None  <b>Illusions:</b> None  <b>Obsessions:</b> None  <b>Compulsions:</b> None  <b>Phobias:</b> None</p>	<p><i>At the time of assessment (03.21.22), the client did not appear to be experiencing any suicidal ideations, any delusions or illusions, or obsessive compulsions. The client did not state any phobias that they might have.</i></p>
<p><b>ORIENTATION:</b>  <b>Sensorium:</b> Conscious  <b>Thought Content:</b> Realistic, organized/linear</p>	<p><i>The client is alert and oriented x4 (person, place, time, situation). She does not appear to be in any acute distress. Rational thought process</i></p>
<p><b>MEMORY:</b>  <b>Remote:</b> WNL</p>	<p><i>The client's memory is intact and can recall past events in conversation.</i></p>
<p><b>REASONING:</b>  <b>Judgment:</b> WNL  <b>Calculations:</b> WNL  <b>Intelligence:</b> WNL  <b>Abstraction:</b> WNL  <b>Impulse Control:</b> WNL</p>	<p><i>The client's reasoning is intact. The client is aware of why they are at the facility and has come to terms with their diagnosis and appropriate treatment. The client is able to describe the necessary steps in completing treatment and what their long-term goal is.</i></p>
<p><b>INSIGHT:</b> Good insight</p>	<p><i>The client has come to terms with their diagnosis and accepts the fact that they need help.</i></p>
<p><b>GAIT:</b>  <b>Assistive Devices:</b> None  <b>Posture:</b> WNL  <b>Muscle Tone:</b> WNL  <b>Strength:</b> WNL  <b>Motor Movements:</b> WNL</p>	<p><i>The client shows no muscular atrophy in limbs. The client does not need any assistive devices and has great posture. Muscle tone and strength appear to be strong and the client has no difficulty with motor movements.</i></p>

## N323 CARE PLAN

**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>
<i>Admission</i>	<i>79 bpm</i>	<i>128/76</i>	<i>20</i>	<i>97.9°F oral</i>	<i>100% on room air</i>
<i>1745</i>	<i>75 bpm</i>	<i>126/78</i>	<i>18</i>	<i>98.1°F oral</i>	<i>100% on room air</i>

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

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<i>Admission</i>	<i>0</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>1615</i>	<i>0</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>

**Dietary Data (2 points)**

<b>Dietary Intake</b>	
<b>Percentage of Meal Consumed:</b>  <b>Breakfast:</b> <i>0%</i>  <b>Lunch:</b> <i>0%</i>  <b>Dinner:</b> <i>N/A – not yet served</i>	<b>Oral Fluid Intake with Meals (in mL)</b>  <b>Breakfast:</b> <i>240 mL (water)</i>  <b>Lunch:</b> <i>240 mL (water)</i>  <b>Dinner:</b> <i>N/A – not yet served</i>  <b>Total:</b> <i>480 mL</i>

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):** *The client is going to be discharged to her home with her husband and children. No home health care needs or equipment necessary for the client. Prior to admission, the client has a therapist who she will follow up with after discharge. Information regarding possible diagnosis of bipolar disorder will be provided to the client and family with medical and nursing interventions. Educating the patient on the harmful consequences of substance/drug use and mixing alcohol with prescription medications will be provided. The client will be introduced to new medication and will continue sessions with their therapist.*

## N323 CARE PLAN

**Nursing Diagnosis (15 points)****\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"> <li>● Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<b>Rational</b> <ul style="list-style-type: none"> <li>● Explain why the nursing diagnosis was chosen</li> </ul>	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (Prior to discharge)</b>
<ol style="list-style-type: none"> <li><i>1. Risk for self-directed violence related to diagnosis of Major Depressive Disorder as evidenced by hallucinations.</i></li> </ol>	<p><i>The client is at an increased risk for self-directed violence due to their diagnosis of Major Depressive Disorder. Safety is the main priority.</i></p>	<ol style="list-style-type: none"> <li><i>1. Identify the client’s psychological status.</i></li> <li><i>2. Ask the client directly, “Have you thought about killing yourself?” If the client says yes, ask, “What do you plan to do?”</i></li> <li><i>3. Remove items from the client’s personal belongings that they may use to inflict self-directed violence.</i></li> </ol>	<ol style="list-style-type: none"> <li><i>1. Convey a caring, nonjudgmental attitude when talking with the client.</i></li> <li><i>2. Listen carefully as the client talks. Do not challenge the client’s statements or reinforce denial of the current situation.</i></li> <li><i>3. Avoid comparing the client with others.</i></li> </ol>	<ol style="list-style-type: none"> <li><i>1. Help the client identify community resources.</i></li> <li><i>2. Provide the client and family members with telephone numbers for crisis prevention centers, suicide hotlines, counselors, and other community support services.</i></li> <li><i>3. Encourage the client to set a goal of cooperating with psychiatric intervention.</i></li> </ol>
<ol style="list-style-type: none"> <li><i>2. Risk for unstable blood pressure related to hypertension as evidenced by medications.</i></li> </ol>	<p><i>The client is at an increased risk for unstable blood pressure due to their hypertension.</i></p>	<ol style="list-style-type: none"> <li><i>1. Obtain medication list/history.</i></li> <li><i>2. Obtain past medical and surgical history.</i></li> <li><i>3. Teach the client about reportable symptoms of unstable blood pressure problems.</i></li> </ol>	<ol style="list-style-type: none"> <li><i>1. Treat episodes of high or low blood pressure promptly.</i></li> <li><i>2. Encourage the client and family to share concerns regarding outcomes of tests.</i></li> <li><i>3. Collaborate with other members of the health care team to ensure that all underlying medical conditions are being managed effectively.</i></li> </ol>	<ol style="list-style-type: none"> <li><i>1. Provide the client with information regarding modifiable risk factors.</i></li> <li><i>2. Educate the client and family on prescribed diet, medications, prescribed activity level, and stress-reduction techniques.</i></li> <li><i>3. The client will use the teach-back method to report symptoms of unstable blood pressure problems.</i></li> </ol>

## N323 CARE PLAN

<p><b>3.</b> <i>Imbalanced nutrition: less than body requirements related to insufficient dietary intake as evidenced by food aversion.</i></p>	<p><i>The client is at an increased risk for developing health issues secondary to insufficient dietary intake.</i></p>	<p><b>1.</b> <i>Set a target weight and have the client record daily weight.</i></p> <p><b>2.</b> <i>Teach the principles of good nutrition for the client's specific condition.</i></p> <p><b>3.</b> <i>Obtain and record the client's weight and eating habits.</i></p>	<p><b>1.</b> <i>Avoid asking whether the client is hungry or wants to eat. Be positive in offering food.</i></p> <p><b>2.</b> <i>Monitor fluid intake and output.</i></p> <p><b>3.</b> <i>Provide opportunities for the client to discuss reasons for not eating.</i></p>	<p><b>1.</b> <i>Refer the client to a dietician or nutritional support team for dietary management.</i></p> <p><b>2.</b> <i>Depending on the client's resources, help locate soup kitchens.</i></p> <p><b>3.</b> <i>Involve the client's family members in meal planning.</i></p>
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**Other References (APA):**

Phelps, L.L. (2020). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (11th ed.). Wolters Kluwer.

## N323 CARE PLAN

## Concept Map (20 Points):

## Subjective Data

- Chief complaint: The client is feeling anxious.
- Hx of suicide attempts: Zero
- Depression scale: 2/10
- Anxiety scale: 3/10
- The client appears to be in no acute distress.
- The client lives at home with her husband and children.
- The client believes that officials are "chasing her because of medicare fraud".
- The client states that she mixes prescription drugs with alcohol.

## Nursing Diagnosis/Outcomes

- Risk for self-directed violence related of Major Depressive Disorder as evidenced by hallucinations.
  - Outcome: The client will attend therapy sessions with a mental health professional.
- Risk for unstable blood pressure related to hypertension as evidenced by medications.
  - Outcome: The client will verbalize modifiable risk factors for high blood pressure.
- Imbalanced nutrition: less than body requirements related to insufficient dietary intake as evidenced by food aversion.
  - Outcome: The client shows no further evidence of weight loss.

## Objective Data

- Vital signs (admission values): | P: 79 bpm | B/P: 128/76 | Resp Rate: 20 | Temp: 97.9 F oral | Oxygen: 100% room air.
- Vital signs (1745): | P: 75 bpm | B/P: 126/78 | Resp Rate: 18 | Temp: 98.1 F oral | Oxygen: 100% on room air
- Medications:
  - G: buspirone B: Buspar
  - G: diazepam B: Valium
  - G: paroxetine B: Paxil
  - G: alprazolam B: Xanax

## Patient Information

- The client is a 43-year-old female.
- The client is admitted and diagnosed with unspecified psychosis not due to a substance.
- Past Medical History (PMH):
  - Hypertension
- Significant Psychiatric History:
  - Major Depressive Disorder (MDD)
  - Anxiety
  - Depression
- Social History (tobacco/alcohol/drugs):
  - Tobacco – cigarettes (1 pk/week).
  - Alcohol (4x/week; 5-6 drinks/day when drinking; 6+ drinks/week).
  - Drugs (partakes in social drug use: marijuana, cocaine, ecstasy).
- The client is compliant.

## Nursing Interventions

- Some nursing interventions include:
  - Removing items from the client's personal belongings that they may use to inflict self-directed violence.
  - Avoid comparing the client with others.
  - Help the client identify community resources.
  - Obtain past medical and surgical history.
  - Encourage the client and family to share concerns regarding outcomes of tests.
  - Educate the client and family on prescribed diet, medications, prescribed activity level, and stress-reduction techniques.
  - Set a target weight and have the client record daily weight.
  - Monitor fluid intake and output.
  - Involve client's family members in meal planning.