N323 Care Plan

Lakeview College of Nursing

Katie Finn

Demographics (3 points)

Date of Admission 4/3/22	**Patient Initials** J.O.	**Age** 33	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Self-Employed Window Washer	**Marital Status** Single	**Allergies** Penicillin – rash
Code Status Full Code	**Observation Status** Inpatient, rounds every 15 minutes	**Height** 6’ 0”	**Weight** 165 lbs

Medical History (5 Points)

Past Medical History: No reported medical history.

Significant Psychiatric History: ADHD (no reported date), depression (no reported date), and bipolar 2 disorder (2011). Patient reports a suicide attempt in November 2011 and suicide ideation right before current inpatient admission. Patient reports intrusive thoughts of touching and harming others.

Family History: The patient reports his mother has OCD and a drug addict. The father was an alcoholic, and his sister has ADHD, bipolar disorder, and OCD.

Social History (tobacco/alcohol/drugs): The patient did not report any tobacco use. The patient claimed that he drinks a six-pack of beer a day since his alcohol relapse, marijuana use, and all other recreational drugs except heroine, including but not limited to methamphetamines, cocaine, and Adderall abuse. The patient claims that he stopped doing drugs 7 years ago.

Living Situation: The patient lives in a house with his 42-year-old roommate.

Strengths: The patient believes his strength is his endurance to move on from his past and his want to improve.

Support System: The patient reports his close friends as his support system. He claims that they are why he came to the inpatient care at OSF Hospital.

Admission Assessment

Chief Complaint (2 points): The patient stated, “I want help” and had suicide ideation.

Contributing Factors (10 points):

Factors that lead to admission: Due to the pandemic, the patient’s window-washing business struggled, and that added to the patient’s depression and self-reported OCD to worsen. The patient also had an engagement that his fiancé broke off and caused a lot of stress and depression on the patient. The patient then discussed going to some scaffolding in Champaign, IL, to hang himself a week or so before coming to OSF. He said he drank alcohol while writing his suicide note but became so drunk that he does not remember climbing off the scaffolding and driving his car into a ditch. On the day of his admission, the patient reported going to Forest Glen, IL, to commit suicide there. He said that he found a tree off the main area and thought about committing suicide but could not follow through due to the thought of a family finding his body. The patient decided to go to a friend that lived in the area to talk. The friend and the patient spoke for a few hours before the patient drove back home. The patient came home and found that there were police officers his roommate had contacted due to the roommate’s concerns for the patient. The police officers then took the patient involuntarily to Carle for mental health care.

History of suicide attempts: The patient had a suicide attempt in November 2011.

Primary Diagnosis on Admission (2 points): Bipolar 2 disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No, has experience **Witness of trauma/abuse: Yes**				
	Current	**Past (what age)**	**Secondary Trauma**	**Describe**
Physical Abuse	Denies	During entire childhood	N/A	Patient reports his father hit him.
Sexual Abuse	Denies	Around 9 years old	N/A	Patient reports remembering recently about someone sexually abusing him. Patient reports not knowing about the memory until recently.
Emotional Abuse	Denies	During entire childhood	N/A	Patient remembers his father telling him "You're no good," when the father would hit the patient as a child. The patient reporting thinking "I'm no good," because of this abuse.
Neglect	Denies	Around 9 years old	During childhood	Patient's father left after his parents' divorce and the mother's side of the family stopped all contact with the patient's immediate family. The patient's mother also used heroine which caused the patient to take care of himself and his sister.
Exploitation	Denies	During entire childhood	N/A	The patient reported that people would manipulate his as a child.
Crime	Denies	16 years old	N/A	Patient reported joining a gang and

				experienced gang violence.
Military	Never enlisted	Never enlisted	N/A	N/A
Natural Disaster	Denies	Denies	N/A	N/A
Loss	Denies	Recently (exact age unknown)	N/A	Patient reported a father figure died.
Other	Denies	6 years old	N/A	Patient's house burned down with all the family belongings.
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Denies	
Loss of energy or interest in activities/school	**Yes**	**No**	Patient feels moderately tired all day from the medication prescribed currently and is still adjusting.	
Deterioration in hygiene and/or grooming	**Yes**	**No**	Denies	
Social withdrawal or isolation	**Yes**	**No**	Denies	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient reports that his bipolar disorder and self-reported OCD is causing irrational thinking that causes conflicts when he voices these thoughts to his friends. This occurred frequently leading up to the hospital admission and the disagreements only got moderately intense at most.	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	The patient reports sleeping 9 hours instead of the usual 5-6 hours. He says he sleeps deeply without dreams or waking throughout the night.	
Difficulty falling asleep	**Yes**	**No**	Denies	
Frequently awakening during	**Yes**	**No**	Denies	

night			
Early morning awakenings	**Yes**	**No**	Denies
Nightmares/dreams	**Yes**	**No**	Denies
Other	**Yes**	**No**	Denies
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Denies
Binge eating and/or purging	**Yes**	**No**	Denies
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Denies
Use of laxatives or excessive exercise	**Yes**	**No**	Denies
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Denies
Panic attacks	**Yes**	**No**	Denies
Obsessive/compulsive thoughts	**Yes**	**No**	Denies
Obsessive/compulsive behaviors	**Yes**	**No**	Denies
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient claims his self-reported OCD causes increased anxiety. The anxiety occurs rarely due to the medications while in the hospital.
Rating Scale			
How would you rate your depression on a scale of 1-10?		**0/10**	
How would you rate your anxiety on a scale of 1-10?		**0/10**	
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**	The patient is worried about not working and his business due to

			being at an inpatient facility. Patient worries about work most of the time but is trying not to focus on that.	
School	**Yes**	**No**	Denies	
Family	**Yes**	**No**	Patient reports missing his mother and sister and being worried about their well-being most of the time. The patient worries about them passively.	
Legal	**Yes**	**No**	Denies	
Social	**Yes**	**No**	Denies	
Financial	**Yes**	**No**	The patient reported losing a major account and taking time from work makes him worry about his finances during his time in the facility.	
Other	**Yes**	**No**	Denies	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
November 2011	**Inpatient** **Outpatient** **Other:** The Pavilion	Inpatient	Suicide attempt	**No improvement** Patient did not like the Pavilion and lied about the medications working. He went back to using drugs and alcohol after leaving. **Some improvement** **Significant improvement**
April 3, 2022	**Inpatient** **Outpatient** **Other:** OSF Hospital	Inpatient	Suicide ideation	**No improvement** **Some improvement** **Significant improvement** Patient wants to improve his mental health after leaving OSF and seek

				continued care.
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Mike	42	Best friend/ roommate	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): **Who are children with now? N/A**				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: N/A **Number of marriages: N/A**				
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: None **Describe: N/A**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient's parents are divorced, and mother was arrested a few times. The patient was also arrested as a minor for being intoxicated and was brought to the "drunk tank"				
How can your family/support system participate in your treatment and care? Patient's support system can continue to support the patient's goal of improving and getting continued help after his discharge.				
Client raised by: **Natural parents** → mainly his mother **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**				
Significant childhood issues impacting current illness: Patient has a history of sexual, emotional, and physical abuse from his father. His ADHD made school harder along with moving around frequently.				
Atmosphere of childhood home: **Loving → patient reports feeling loved by his mother.** **Comfortable** **Chaotic** **Abusive → patient reports verbal and physical abuse from his father.** **Supportive** **Other:**				

Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient reported that his mother has OCD, and his sister has ADHD, OCD, and bipolar disorder.
History of Substance Use: Mother used heroine and the father was an alcoholic. The patient reports using all drugs at one point except for heroine but stopped doing drugs 7 years ago. The patient also has a history of alcohol abuse, stopped 7 years ago, and then relapsed a month or so ago.
Education History: **Grade school** **High school** **College** **Other:** Dropped out of high school at 15 years old and never obtained his GED.
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient claims that he had social troubles due to instability from moving frequently. Patient also says that his ADHD made school harder as well.
Discharge
Client goals for treatment: The client wants to continue to follow up with a therapist for treatment and hopefully gets a referral to a specialist for medications.
Where will client go when discharged? The client will go back home after being discharged.

Outpatient Resources (15 points)

Resource	Rationale
1. Keri Powell Therapy in Champaign	**1.** This therapy group offers counseling for addiction, trauma, abuse, bipolar disorders, and depression. It is in Champaign which in the area the patient lives.
2. Alcoholics Anonymous meetings in Champaign	**2.** The patient could have support from others who struggle with alcohol and may help with the patient's recovery from drinking.
3. Carle Psychiatrist in Champaign	**3.** The patient has insurance that covers care from Carle hospitals. The patient can get a second opinion on his bipolar diagnosis and his self-diagnosis of OCD.

Current Medications (10 points)

Brand/Generic	Trazodone / Desyrel	Naltrexone / Depade	Buspirone / Buspar	Divalproex / Depakote	Benztropine / Cogentin
Dose	100 mg	50 mg	10 mg	500 mg	2 mg
Frequency	Once at night, PRN	Daily	TID, PRN	Twice daily	Twice daily, PRN
Route	P.O.	P.O.	P.O.	P.O.	P.O.
Classification	Triazolopyridine derivative	Opioid antagonist	Azapirone	Carboxylic acid derivative	Anticholinergic
Mechanism of Action	The medication blocks serotonin reuptake on the presynaptic neuronal membrane. It also has alpha-adrenergic blocking action to produce a histamine blockade to create a sedative effect. Lastly, it reduces the blood pressure by inhibiting vasopressor response to norepinephrine.	The medication blocks the opioid agonists from the delta, kappa, and mu receptors. This reduces alcohol cravings.	Has antianxiety effects by being a partial agonist at serotonin-5-hydroxytryptamine 1A receptors in the brain.	This medication blocks reuptake of GABA to suppress the rapid firing of neurons.	This blocks acetylcholine's effects at the cholinergic receptor site. This action helps regulate the brain's levels of dopamine and acetylcholine balance to relax muscle movement and decreases drooling, rigidity, and tremor. It also can prolong dopamine's actions by inhibiting dopamine reuptake.
Therapeutic Uses	Antidepressant	Opioid and alcohol blocker	Anxiolytic	Anticonvulsant	Antiparkinsonian, central-acting anticholinergic
Therapeutic Range	0.5-2.5 µg/mL	N/A	N/A	85 to 125 µg/mL	N/A
Reason Client Taking	To improve quality of sleep	To treat the patient's alcoholism	To treat the patient's anxiety	To treat if the patient enters an acute manic phase	To treat any movement disorders the patient may exhibit from the haloperidol
Contraindications (2)	1. Hypersensitivity to trazodone or its components 2. Recovery from acute MI	1. Acute opioid withdrawal 2. Dependency on opioids	1. Hypersensitivity to buspirone or its components 2. Severe hepatic or renal impairment	1. Hepatic impairment 2. Urea cycle disorders	1. Children under 3 years old 2. Hypersensitivity to benztropine or its components
Side Effects/Adverse Reactions (2)	1. Serotonin syndrome 2. Hypotension	1. Hepatotoxicity 2. Pneumonia	1. Serotonin syndrome 2. Angioedema	1. Encephalopathy 2. Stevens-Johnson syndrome	1. Hypotension 2. Constipation
Medication/Food Interactions	• NSAIDs and aspirins • Barbiturates and other CNS depressants • Carbamazepine • CYP3A4 Inhibitors • Digoxin and phenytoin • MAO Inhibitors • Serotonergic drugs • Warfarin • Alcohol use	• Disulfiram • Opioid analgesics • Thioridazine	• CYP3A4 inducers • CYP3A4 inhibitors • Diltiazem • Erythromycin • Itraconazole • Nefazodone • Nordiazepam • Verapamil • MAO inhibitors • Rifampin • Haloperidol • Grapefruit juice	• Anticoagulants, thrombolytics • Barbiturates, primidone • Carbamazepine, phenobarbital • Chlorpromazine • Cholestyramine • CNS depressant • Diazepam • Tricyclic antidepressants • Alcohol use	• Amantadine • Phenothiazines • Tricyclic antidepressants • Haloperidol
Nursing Considerations (2)	1. Use cautiously in patients with cardiac disease. 2. Give medication shortly after a meal or light snack to avoid nausea.	1. Use cautiously in patients with hemophilia 2. Give oral drug with antacids or food to decrease adverse GI reactions	1. Use cautiously in patients with hepatic or renal impairment 2. Institute safety precautions for possible CNS reactions	1. Give oral drug with good to minimize GI irritation 2. Watch for decreased hepatic function	1. Assess for muscle rigidity and tremor at baseline and after for improvement 2. Give drug before or after meals based on patient's need and response

Brand/Generic	Haloperidol/ Haldol

Dose	5 mg
Frequency	Q4H, PRN
Route	P.O.
Classification	Butyrophenone derivative
Mechanism of Action	Produces an antipsychotic effect by blocking the postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine.
Therapeutic Uses	Antipsychotic
Therapeutic Range (if applicable)	5 to 16 ng/mL
Reason Client Taking	To treat the patient for agitation, and breakthrough psychosis and mania.
Contraindications (2)	1. Dementia with Lewy bodies 2. Parkinson's disease
Side Effects/Adverse Reactions (2)	1. Neuroleptic malignant syndrome 2. Cardiac arrest
Medication/Food Interactions	• Alprazolam, buspirone, chlorpromazine, fluoxetine, fluvoxamine, itraconazole, promethazine, nefazodone, quinidine, sertraline, venlafaxine • Anticholinergics • Carbamazepine, rifampin • CNS depressants • Ketoconazole, paroxetine • Levodopa and other dopamine agonists • Tricyclic antidepressants • Alcohol use
Nursing Considerations (2)	1. Assess patient for fall risk 2. Watch for tardive dyskinesia

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient was observed to be well-groomed and wearing a t-shirt and jeans with a lean build. The patient had some stubble but stated that he showers every day and "feels weird not to be clean shaven." The patient's behavior was somewhat subdued and had mumbled speech. When talking, the patient's train of thought did not always flow, and he would back-track on some of his thoughts. The patient would

	sometimes go on a tangent. The patient was engaged, oriented, and talkative. The patient had a calm affect and mood but was positive about his recovery.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient denies have any delusions, illusions, obsessions, compulsions, or phobias currently. Patient claimed being a germophobe but says that he has overcome that fear. The patient reported having intrusive thoughts of touching and hurting others when admitted but did not mention this during this interview. Patient reported not having any obsessive or compulsive thoughts or behaviors because he is not in a normal surrounding with his personal possessions. He also did not report any suicide ideations.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was A&O x4 with somewhat scattered thinking but was logical. Sensorium was not assessed.
MEMORY: **Remote:**	Both short and long-term memory appeared to be intact and normal.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient appeared to have sound judgement and level of intelligence for the patient's age. Impulse control was observed to be average. Calculation and abstraction were not assessed.
INSIGHT:	Insight was observed to be average.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient had no assistive devices. The posture was relaxed and slouched during our conversations. Muscle tone, strength, and motor movement was appropriate for age and height.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1521	71 bpm	130/83 LA	16	99.4 F	96% RA

			breaths/min	temporal	
1711	90 bpm	119/68 RA	16 breaths/min	99.0 F temporal	96% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1521	Numeric	Right shoulder	10/10 when raising his arm	Sharp	Stretching
1711	Numeric	Right shoulder	10/10 when raising his arm	Sharp	Stretching

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 75% - 100%** **Lunch: 75% - 100%** **Dinner: 75% - 100%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 360 mL** **Lunch: 360 mL** **Dinner: 360 mL**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient plans to go home after discharge and wants to get a referral to a psychiatrist. The patient also wants to find a therapist to continue therapy after leaving OSF. I would like the patient to join Alcohol Anonymous group to help prevent alcohol relapse with the patient. It is a good idea for the patient to establish a relationship with a licensed psychiatrist to confirm or disagree with the bipolar 2 diagnosis and the patient's self-diagnosis of OCD. I also agree with the patient's wanting to regularly see a licensed therapist to help with his depression, anxiety, and intrusive thoughts.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Immediate	Intermediate	Community

		Interventions (At admission)	Interventions (During hospitalization)	Interventions (Prior to discharge)
1. Risk for suicide related to depression as evidence by previous suicide attempt and ideation.	The patient has a history of one suicide attempts and was close to attempting a second time before being admitted.	1. Ask the patient about any suicide ideations and/or plans to commit suicide. 2. Put the patient on 1:1 watch 24/7. 3. Create a short-term contract with the patient that he won't hurt himself.	1. Continue to supervise the patient every 15 minutes. 2. Monitor the patient when administering medications. 3. Use direct, non-judgmental communication with the patient.	1. Ensure the patient is referred to a psychiatrist. 2. Ensure the patient has a therapist/counselor to regularly visit after discharge. 3. Provide the patient resources for any crises that might arise.
2. Risk for harming others related to intrusive thoughts as evidence by patient reported intrusive thoughts of harming others.	The patient reported having intrusive thoughts of harming other when admitted into OSF.	1. Ask the patient if he has a history of harming others. 2. Ask the patient about other intrusive thoughts that may occur. 3. Remove any objects from the patient's environment that can be used to harm others.	1. Assess the patient for intrusive thoughts and the content of them. 2. Round on the patient every 15 minutes. 3. Express understanding for emotions the patient may feel towards the intrusive thoughts.	1. Educate the patient on how to handle intrusive thoughts. 2. Ensure the patient has a therapist that specializes in intrusive thoughts and how to cope. 3. Encourage the patient to go to follow up doctor appointments for medications or reporting continued/new intrusive thoughts.
3. Risk for chronic low self-esteem related to verbal abuse as a child and depression as evidence by patient reporting repeating the phrase "I am no good," that his father would tell him while hitting the patient.	The patient reported repeating the phrase "I am no good," to himself because his father would say that to the patient during physical abuse.	1. Encourage the patient to bath, groom, and other daily hygiene functions. 2. Give the patient concise information about decision-making skills. 3. Institute suicide precautions per the facility's protocol.	1. Provide a specific amount of uninterrupted time each day for the patient to converse so he can self-explore. 2. Give the patient a simple structured daily routine. 3. Teach the patient how to incorporate the use of self-healing techniques in carrying out usual daily activities.	1. Teach self-healing techniques to both patient and family like meditation, guided imagery, yoga, and prayer to prevent anxiety and promote positive decisions. 2. Schedule time to meet with family/support system and patient to listen to ways in which they plan to enhance their coping skills. 3. Work with the patient to develop a treatment plan and schedule appointments.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Admitted for suicide ideation involuntarily by roommate
Suicide attempt in November 2011 and was inpatient at the Pavilion
History of drug use but stopped 7 years ago
History of alcohol abuse, stopped 7 years ago, but relapsed a month or so ago
Patient self-reports having OCD
Patient has been diagnosed with ADHD and bipolar 2 disorder
Patient reports intrusive thoughts of touching and harming others

Nursing Diagnosis/Outcomes

Risk for suicide related to depression as evidence by previous suicide attempt and ideation.

Patient will report decreased to no thoughts of suicide after 6 months of therapy and medication.

Risk for harming others related to intrusive thoughts as evidence by patient reported intrusive thoughts of harming others.

Patient will report decreased frequency of intrusive thoughts after 6 months of therapy.

Risk for chronic low self-esteem related to verbal abuse as a child and depression as evidence by patient reporting repeating the phrase "I am no good," that his father would tell him while hitting the patient.

Patient expresses improved sense of self-worth after 6 months of therapy.

Objective Data

Most recent vitals:
HR 90 bpm
BP 119/68 RA
RR 16 resp/min
T 99.0 F temporal
O2 sat 96% RA
No reported labs, abnormal vitals, or assessments to diagnosis the patient

Patient Information

On April 3rd, 2022, a 33-year-old white, male was admitted to OSF Heart of Mary for suicide ideation and near-attempt. The patient's roommate contacted the police to take the patient to an inpatient facility. The patient has a history of neglect, verbal and physical abuse, and drug and alcohol abuse. The patient also had a suicide attempt in November 2011.

Nursing Interventions

Nursing Diagnosis 1
Ask the patient about any suicide ideations and/or plans to commit suicide.
Put the patient on 1:1 watch 24/7.
Create a short-term contract with the patient that he won't hurt himself
Nursing Diagnosis 2
Ask the patient if he has a history of harming others.
Ask the patient about other intrusive thoughts that may occur.
Remove any objects from the patient's environment that can be used to harm others.
Nursing Diagnosis 3
Encourage the patient to bath, groom, and other daily hygiene functions.
Give the patient concise information about decision-making skills.
Institute suicide precautions per the facility's protocol.