N323 Care Plan

Lakeview College of Nursing

Angel Roby

Demographics (3 points)

Date of Admission 3/29/2022	**Patient Initials** V.W.	**Age** 40 years old	**Gender** Male
Race/Ethnicity African American	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Penicillin
Code Status Full code	**Observation Status** On suicide precautions	**Height** 5'11"	**Weight** 185 lbs.

Medical History (5 Points)

Past Medical History: Insomnia, hypertension

Significant Psychiatric History: Diagnosed with unspecified bipolar disorder a couple of years ago (does not specify). The patient at admission stated that he had severe depression and suicidal ideation. Patient denies suicide attempt.

Family History: The patient reports that his mother has type 2 diabetes. Father has no known diagnoses, but the patient stated that he was an alcoholic with anger issues. Grandmother had type 2 diabetes, hypertension, and breast cancer.

Social History (tobacco/alcohol/drugs): The patient smokes cigarettes and has a history of methamphetamine, marijuana, and alcohol use. The patient claims that before admission he was drinking every day. The patient does not remember the last time he took methamphetamine or marijuana. During his stay at the facility, he has been sober for 9 days.

Living Situation: The patient is currently homeless.

Strengths: The patient states that his strength is his belief of getting better and sober**.**

Support System: The patient states that his grandmother is his biggest support system. The grandmother is the reason he decided to admit himself to the Pavilion.

Admission Assessment

Chief Complaint (2 points): Depression and suicidal ideation

Contributing Factors (10 points): Bipolar disorder

Factors that lead to admission: Patient stated that his depression has gotten worse over the course of these past couple weeks. The patient states that since his living situation hasn't changed, the conditions of being homeless has really taken a toll on his emotional and physical well-being. Patient stated that his depression and suicidal ideation becomes a lot more prominent during the winter months. Since he doesn't have access to his bipolar medication, his depression triggers his bipolar disorder, and he starts to go into a major depressive manic episode. Patient reached out to his grandmother for help. The grandmother suggested that he get admitted to the inpatient facility, the Pavilion, to seek for help since she isn't in any condition to take care of him herself.

History of suicide attempts: The patient stated that he hasn't had any suicide attempts

Primary Diagnosis on Admission (2 points): Unspecified bipolar disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient has lifetime experience **Witness of trauma/abuse:** N/A				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from**	**Describe**

			caring for another person with trauma)	
Physical Abuse	Denies	8 – 16 years old	N/A	The patient described that the physical abuse started with his father at 8 years old.
Sexual Abuse	Denies	Denies	N/A	N/A
Emotional Abuse	Denies	8 – 16 years old	N/A	The patient did not have a great relationship with his father and suffered emotional and verbal abuse while the physical abuse was happening. The patient stated that his father used to say, “You should have never been born.”
Neglect	Denies	Denies	N/A	N/A
Exploitation	Denies	Denies	N/A	N/A
Crime	Denies	Teenage years	N/A	The patient stated that he used to sell drugs while he was in high school.
Military	Never enlisted	Never	N/A	N/A

		enlisted		
Natural Disaster	Denies	Denies	N/A	N/A
Loss	Denies	Recently (does not specify when)	N/A	The patient stated that he recently lost a good friend of his.
Other	Denies	Denies	N/A	N/A

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Patient states that he feels depressed constantly when he was admitted. His depression has gotten worse over the course of a couple weeks. The depression is getting so bad to the point of suicidal ideation.
Loss of energy or interest in activities/school	**Yes**	**No**	Denies
Deterioration in hygiene and/or grooming	**Yes**	**No**	The patient is currently homeless and did not have the means to groom himself. Since he has come into the facility, his hygiene and grooming has improved.
Social withdrawal or isolation	**Yes**	**No**	When patient was first admitted to the facility, patient was withdrawing and didn't interact with other patients. The patient was so withdrawn, that he missed a group session on 3/30/22. Overall, patient has made

			progress with socializing with other patients during group and activities.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Denies
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The patient is experiencing insomnia for a week and his sleeping patterns have been irregular. The patient states the insomnia as moderate. Sometimes the hours vary, the patient may sleep for 10 hours one day and 4 the next.
Difficulty falling asleep	**Yes**	**No**	The patient states that falling asleep is the hardest part of his sleeping routine. The patient is experiencing insomnia which explains why he is having difficulty falling asleep. The insomnia has been frequent for a couple of years and has been intense.
Frequently awakening during night	**Yes**	**No**	Denies
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**	The patient was homeless so was not getting enough to eat. The patient reports it got bad during the winter months. Since at the facility, the patient has changed his eating habits and has increased his intake of food.
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**	Denies
Rating Scale			
How would you rate your depression on a scale of 1-10?	7/10		
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 currently unemployed and has been unemployed since the pandemic started. The patient is worried that he won't be able to get another job and support himself.
School	**Yes**	**No**	Denies
Family	**Yes**	**No**	Denies
Legal	**Yes**	**No**	Denies
Social	**Yes**	**No**	The patient is experiencing social withdrawal because of his depression. The patient wants to be isolated and has not been socializing with other patients. The patient has slowly opened up to case managers and other patients since his admission.
Financial	**Yes**	**No**	The patient is currently homeless and unemployed. The patient has been homeless for a couple of years now and has no means to live on his own. His grandmother is not able to take care of him in her home.
Other	**Yes**	**No**	Denies

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
2/2/22 – 2/26/22 3/6/22 – 3/12/22 3/29/22 – present	**Inpatient** **Outpatient** **Other:** The Pavilion Behavioral Health System	Inpatient	Bipolar disorder and depression	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Patient is homeless			**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: N/A				
Children (age and gender):				

Daughter – 12 years old

Who are children with now?

The child's mother

Household dysfunction, including separation/divorce/death/incarceration:

N/A

Current relationship problems: N/A

Number of marriages: Has never been married

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Heterosexual	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

Christianity

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 father got arrested and went to jail when the patient was younger and does not have a relationship with him and doesn't know when or if he got released.

How can your family/support system participate in your treatment and care?

The patient stated that his grandmother is the reason why he admitted himself into the facility and his grandmother is his biggest support system. His goal is to make his grandmother proud of his progress and sobriety.

Client raised by:

Natural parents (Just the mother)

Grandparents (Just the grandmother) – Patient claims he was mostly raised by his grandmother. **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: The patient has a history of emotional and physical abuse from his father. The patient stated that, “This is why I’m probably crazy.”
Atmosphere of childhood home: **Loving –** Patient claims he felt love from his grandmother the most **Comfortable** **Chaotic** **Abusive –** From his father **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Denies
History of Substance Use: The patient has a history of using methamphetamine and marijuana, and alcohol abuse. The father has a history of alcohol abuse as well.
Education History: **Grade school** **High school –** Graduated high school, has a diploma **College** **Other:**
Reading Skills: **Yes** **No** **Limited**

Primary Language: English
Problems in school: Patient stated that he barely graduated because he was distracted with selling drugs.
Discharge
Client goals for treatment: To get better with his depression and suicidal thoughts
Where will client go when discharged? Back to being homeless

Outpatient Resources (15 points)

Resource	Rationale
1. Narcotics anonymous	**1.** The patient has been sober for 9 days and will benefit from group therapy after he gets discharged. His goal is to keep his sobriety and get better.
2. Alcohol anonymous	**2.** The patient has been sober for 9 days and will benefit from group therapy after he gets discharged. The patient stated that, “I don’t want to become my father.”
3. Housing for the homeless	**3.** The patient is currently homeless and does not have a place to stay after discharge. The patient will feel safer and secure with a roof over his head.

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

Brand/Generic	Abilify (Aripiprazole)	Depakote (divalproex sodium)	Ambien (Zolpidem)	Prozac (Fluoxetine)	
Dose	5 mg	250 mg	10 mg	20 mg	
Frequency	Daily	Daily	Daily, at bedtime	Daily, in the morning	
Route	PO	PO	PO	PO	
Classification	Antipsychotic	Anticonvulsant	Hypnotic	Antidepressant	
Mechanism of Action	Acts as a partial agonist at dopamine receptors and serotonin receptors. May produce antipsychotic effects.	Causes an increase in brain GABA through a variety of mechanisms to block neuronal sodium channels.	Increases GABA's inhibitory effects, blocks cortical and limbic arousal and preserves deep sleep	Selectively inhibits reuptake of serotonin by CNS neurons and increases the amount of serotonin available	
Therapeutic Uses	To treat acute manic and mixed episodes in bipolar I disorder with or without psychotic features.	To treat manic episodes associated with bipolar disorder	To provide short term treatment of insomnia	To treat acute depression and to provide maintenance therapy for depression	
Therapeutic Range (if applicable)	N/A	N/A	5 to 10 mg at bedtime for 7 days	Dosage increased after 4 to 8 weeks as needed	
Reason Client Taking	Bipolar disorder	Bipolar disorder	Insomnia	Depression	
Contraindications (2)	Hypersensitivity to medication or its components. Does not have a second	Liver problems and hypersensitivity to medication or its components	Severe hepatic impairment and ritonavir therapy	Concurrent therapy with pimozide or thioridazine and hypersensitivity	

	contraindication.			to medication and its components	
Side Effects/Adverse Reactions (2)	Homicidal ideation and Suicidal ideation	Nausea and headache	Suicidal ideation and respiratory depression	Seizures and serotonin syndrome	
Medication/Food Interactions	Medication: Antihypertensives, benzodiazepines, rifampin Food: alcohol use	Medication: Antibiotics and other anticonvulsants Food: None	Medication: antidepressant Food: All foods and alcohol use	Medication: NSAIDs, aspirin, and warfarin Food: None	
Nursing Considerations (2)	1. Be aware that for patients who haven't taken this medication, tolerability must be established 2. May cause tardive dyskinesia and needs to be monitored closely and take safety precautions when needed.	1. Nurses need to be aware of hepatic failure and need to closely monitor labs 2. Discontinue if encephalopathy occurs and check ammonia levels	1. Caution patient to take drug as prescribed and not to increase dosage unless provider prescribes it 2. Contact provider if experiencing abdominal cramps, nausea, flushing, and fatigue	1. Expect to taper drug when being discontinued to minimize adverse effects 2. Monitor patient for potential serotonin syndrome	

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):

Jones & Bartlett Learning. (2021). *2021 nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:**	The patient is calm and collected and pleasant during the interview. The patient's build is

Build: **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	average size, is 5'11" and 185 lbs. The patient's attitude is positive. The patient states that, "I want to become a better person." The patient's interpersonal style is motivated despite the depression and suicidal ideation. The patient's mood during the interview was happy and pleasant. The patient's affect is stable.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient was admitted for suicidal ideation. The patient denies any illusions, obsessions, compulsions or phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	The patient is oriented x4 to time, place, person, etc. The patient displays no type of thought content. It is within expected range.
MEMORY: **Remote:**	The patient's remote memory is intact, shows no signs of memory loss
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient's judgment is intact. The patient's calculations are within expected range. The patient has a high school diploma and displays greater than 5th grade reading level. The patient's abstraction is intact. The patient is afraid that he won't be able to stay sober but is trying his hardest to control his urges.
INSIGHT:	The patient's insight is positive and is motivated to take care of himself and to stay sober for his remaining time in the Pavilion and when he gets discharged.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient's gait is intact and does not have any difficulty walking. The patient's posture does not show any signs of spinal injury or scoliosis. The patient's muscle tone and strength are within normal limits and don't show any signs of weakness in any of his extremities. The patient's motor movements show no signs of delay and are intact.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	95 beats per/min	135/78 mmHg	18	36.8 C	98% (Room Air)
1100	90 beats per/min	136/78 mmHg	16	36.5 C	98% (Room Air)

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	3/10	Headache (temples)	Mild	Throbbing	Tylenol
1100	1/10	Headache (temples)	Mild	Throbbing	Tylenol

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 50% **Lunch:** 80% **Dinner:** 100%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 80 mL **Lunch:** 50 mL **Dinner:** 350 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): For the patient, I would like to educate the patient on his diagnosis and outpatient resources that will help him on his journey.

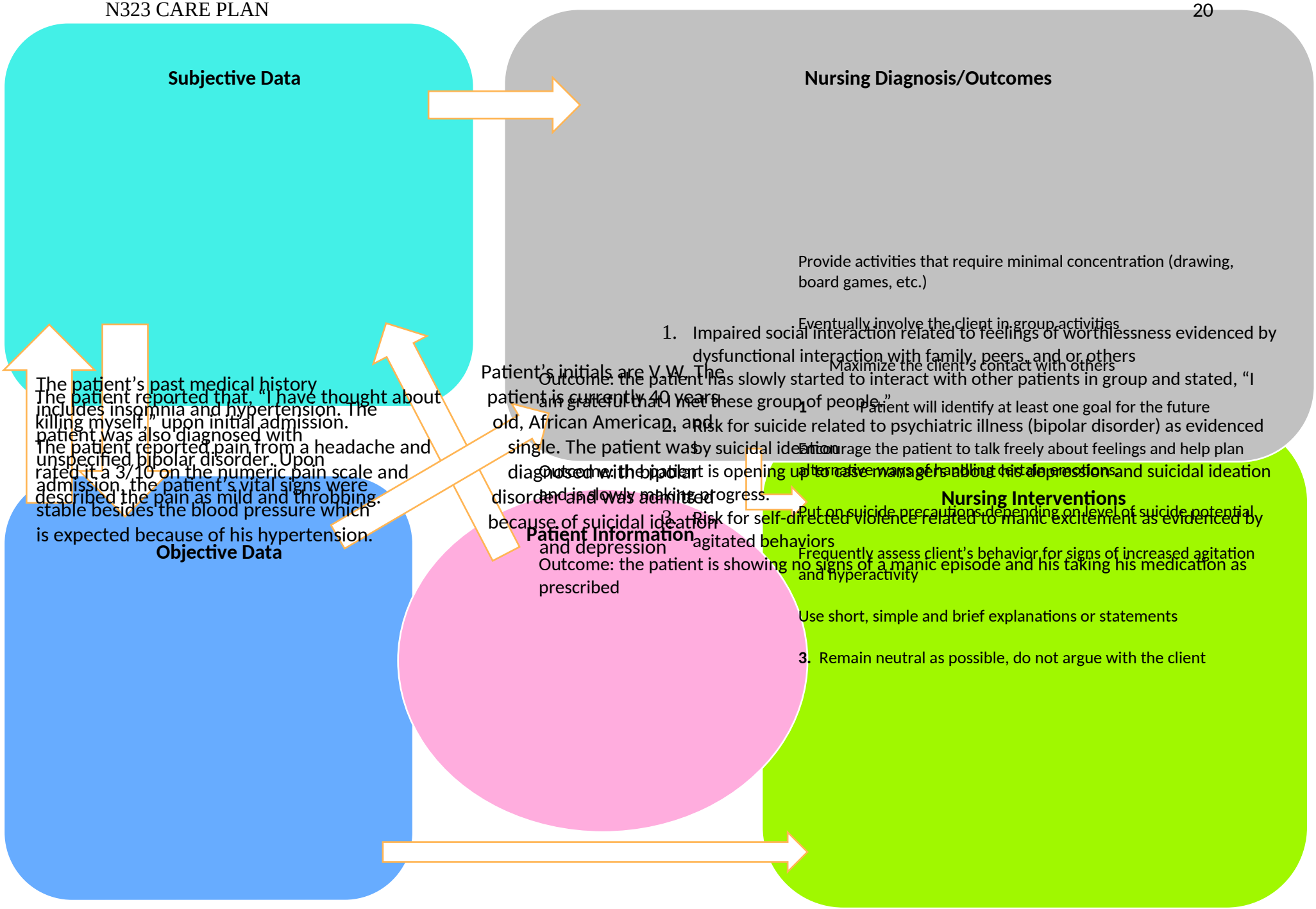
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Impaired social interaction related to feelings of worthlessness evidenced by dysfunctional interaction with family, peers, and or others	The patient is showing signs of isolation since his admission to the facility and was admitted for depression.	1. Make sure that the patient's room is safe without any thing that may harm them or others. 2. Make sure to do a suicide risk assessment as well as a depression assessment 3. Introduce patient to case managers, other patients (if ready) and other people that work in the facility	**1.** Provide activities that require minimal concentration (drawing, board games, etc.) **2.** Eventually involve the client in group activities **3.** Maximize the client's contact with others	**1.** Refer the client and family to self-help groups in the community **2.** Educate the patient on diagnosis **3.** Reach out to outpatient about homeless shelters or outpatient housing
2. Risk for suicide related to psychiatric illness (bipolar disorder) as evidenced by suicidal ideation	The patient stated that, "I've been thinking of killing myself."	**1.** Patient will get an appointment with a crisis counselor **2.** Construct a	**1.** Patient will identify at least one goal for the future **2.** Encourage the patient to talk	**1.** Patient will name two people he can call if thoughts of suicide recur before discharge

		no-suicide contract between suicidal patient and nurse **3.** Follow unit protocol for suicide regarding a safe environment	freely about feelings and help plan alternative ways of handling certain emotions. **3.** Put on suicide precautions depending on level of suicide potential	**2.** Patient will have links to self-help groups in the community. **3.** Patient will state that he wants to live
3. Risk for self-directed violence related to manic excitement as evidenced by agitated behaviors	The patient is diagnosed with bipolar disorder and has a manic episode in the past	**1.** Maintain a consistent approach and provide a structured environment **2.** Decrease environmental stimuli before the interview is constructed to provide a calming environment **3.** Make sure staff is informed of possible violent behavior from the patient	**1.** Frequently assess client's behavior for signs of increased agitation and hyperactivity **2.** Use short, simple and brief explanations or statements **3.** Remain neutral as possible, do not argue with the client	**1.** The patient will be recommended to outpatient facilities for his diagnosis of unspecified bipolar disorder **2.** The patient will try to reach out to a friend or family member to inform them about their discharge **3.** Reach out about possible outpatient housing

Other References (APA):

Concept Map (20 Points):


Subjective Data
The patient reported that, "I have thought about killing myself," upon initial admission.
The patient reported pain from a headache and rated it a 3/10 on the numeric pain scale and described the pain as mild and throbbing.
Objective Data
The patient's past medical history includes insomnia and hypertension. The patient was also diagnosed with unspecified bipolar disorder. Upon admission, the patient's vital signs were stable besides the blood pressure which is expected because of his hypertension.
Patient Information
Patient's initials are V.W. The patient is currently 40 years old, African American, and single. The patient was diagnosed with bipolar disorder and was admitted because of suicidal ideation and depression
Nursing Diagnosis/Outcomes
1. Impaired social interaction related to feelings of worthlessness evidenced by dysfunctional interaction with family, peers, and or others
Outcome: the patient has slowly started to interact with other patients in group and stated, "I am grateful that I met these group of people."
2. Risk for suicide related to psychiatric illness (bipolar disorder) as evidenced by suicidal ideation
Outcome: the patient is opening up to case managers about his depression and suicidal ideation and is slowly making progress.
3. Risk for self-directed violence related to manic excitement as evidenced by agitated behaviors
Outcome: the patient is showing no signs of a manic episode and his taking his medication as prescribed
Nursing Interventions
1
Maximize the client's contact with others
Provide activities that require minimal concentration (drawing, board games, etc.)
Eventually involve the client in group activities
Patient will identify at least one goal for the future
Encourage the patient to talk freely about feelings and help plan alternative ways of handling certain emotions
Put on suicide precautions depending on level of suicide potential
Frequently assess client's behavior for signs of increased agitation and hyperactivity
Use short, simple and brief explanations or statements
3. Remain neutral as possible, do not argue with the client