

N323 Care Plan 1

Lakeview College of Nursing

Name Brianna Lilly

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Demographics (3 points)

Date of Admission 4/13/2022	Patient Initials MD	Age 58	Gender Male
Race/Ethnicity Caucasian	Occupation Not employed	Marital Status Single	Allergies NKA
Code Status Full	Observation Status 15 min. checks	Height 167.6 cm	Weight 51.8kg

Medical History (5 Points)

Past Medical History: HTN, partial finger amputation

Significant Psychiatric History: Patient reports long period of depression, although not formally diagnosed.

Family History: Mother had “intense mood swings” but was never formally diagnosed with a mental illness.

Social History (tobacco/alcohol/drugs): Smokes cigarettes 1 pack per day for “at least 20 years”, Smokes cannabis occasionally, long history of heavy alcohol use which started when he was a musician (17 yrs old).

Living Situation: Currently homeless.

Strengths: Patient has a strong desire to find work and be independent

Support System: patient reports being close to his sister who lives in California, but he does not want to take advantage her for housing or money.

Admission Assessment

Chief Complaint (2 points): Suicidal ideation

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Contributing Factors (10 points): Patient left apartment in Arthur, IL. He came to Champaign to work for a friend who told him he had some work for him (patient is both a cook and a painter but usually works as an independent contractor). The patient was planning on staying with the friend but when the friend stated, “he was not needed” my patient “started walking” when the friend asked where he was walking patient reports he told his friend, “I am going to the hospital, I am ready to get help”. Patient walked to OSF and went to the ER first reporting chest pain, then suicidal ideation. The ER work up showed no cardiac issues and the patient was admitted to the psychiatric unit due to his suicidal ideation (4/13/22).

Factors that lead to admission: financial issues, social isolation, homelessness, patient reported long history of depression

History of suicide attempts: 1 previous suicide attempt “over 30 years ago, I was young and stupid and messed up with a good girl”.

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

Psychosocial Assessment (30 points)

History of Trauma
No lifetime experience: Patient reported none when interviewed
Witness of trauma/abuse: Patient reported none

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	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	None	N/A	N/A	N/A
Sexual Abuse	None	N/A	N/A	N/A
Emotional Abuse	None	N/A	N/A	N/A
Neglect	None	N/A	N/A	N/A
Exploitation	None	N/A	N/A	N/A
Crime	None	N/A	N/A	N/A
Military	None	N/A	N/A	N/A
Natural Disaster	None	N/A	N/A	N/A
Loss	None	16 years	N/A	Severed the top of his right ring finger in a table saw accident.
Other	None	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	

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Depressed or sad mood	Yes	No	Patient states that he feels numb and empty. Patient reported long history of on and off again periods severe depression.
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	Patient reports that he has had trouble getting to sleep these last couple of night in the hospital, but took trazodone for it and was fine.
Frequently awakening during night	Yes	No	
Early morning awakenings	Yes	No	

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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?	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	
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?	7/10		
How would you rate your anxiety on a scale of 1-10?	1/10		

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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	Within the last month he has had difficulty being able to support himself with his independently found jobs. He is somewhat worried about finding a job after discharge.
School	Yes	No	
Family	Yes	No	
Legal	Yes	No	Patient reports 1 previous DUI, but stated that this did not affect his work as a painter or a cook and does not stress him out anymore.

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Social	Yes	No	Patient reported that he had been feeling socially isolated in Arthur because it seemed as if all he did was work and go home. He said that he feels like his life would be better with a serious relationship of some sort.	
Financial	Yes	No	Patient reported issues affording a place to stay. He works gig jobs so his finances are unpredictable.	
Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome

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Patient reports that he has never been previously hospitalized for psychiatric or substance use treatment.	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 Outpatient Other:	N/A	N/A	No improvement Some improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Patient is homeless, lives alone	58yrs	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: patient uses tobacco (cigarettes), alcohol (beer) and cannabis (flower).				
Children (age and gender): 1 son 18 years old lives on his own in Texas.				
Who are children with now? Independent				

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Household dysfunction, including separation/divorce/death/incarceration: Patient's parents divorced when he was 13 yrs old. He separated from his girlfriend and mother of his child when he was 23yrs old. His older brother passed away from cancer 15 years ago.		
Current relationship problems: none		
Number of marriages: none		
Sexual Orientation: Heterosexual	Is client sexually active? Yes No	Does client practice safe sex? Yes No N/A
Please describe your religious values, beliefs, spirituality and/or preference: Patient identifies as Christian		
Ethnic/cultural factors/traditions/current activity: Patient has been in the music and restaurant industry for a long time. The cultures of these industries has affected my patient.		
Describe: Patient appears to prefer gig work instead of a steady job. Patient reported feeling depressed by only going to work, maybe going to the bar after close then going home to be alone. Patient reflects extensively on the "glory days" of playing shows, doing drugs, and being around "groupies".		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient has 1 previous DUI "over 15 years ago". No other legal issues.		
How can your family/support system participate in your treatment and care? His sister is emotionally supportive and offers assistance. Patient prefers to be independent and not take advantage of his sister for housing or finances.		

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Client raised by:**Natural parents****Grandparents****Adoptive parents****Foster parents****Other (describe):****Natural parents and eventual step-parents as both got remarried.**

Significant childhood issues impacting current illness: Mother had significant “mood swings” and frequently dated different men at one time. Both parent’s moved frequently so the patient never felt stable.

Atmosphere of childhood home:**Loving****Comfortable****Chaotic****Abusive****Supportive**

Other: Patient describes his childhood “like anyone else’s, I never saw anything really wrong till I got older”. Patient felt loved and supported but it was also chaotic as he moved frequently. Patient also reported that he dropped out of high school in the 11th grade because he was old enough to make money and get away from his mother’s constant mood swings. Patient also stated that the house felt too crowded with his 5 siblings and “whichever step-siblings were there at the time”.

Self-Care:**Independent****Assisted****Total Care**

Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient reports, “My mother had mood swings”; however, no formally diagnosis of mental illness in the family.

No encounter of suicide.

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History of Substance Use: Patient has a long history of cigarette and cannabis smoking, as well as heavy alcohol use. Patient also reports having used cocaine in his 20's.
Education History: Grade school High school College Other: 11th grade education
Reading Skills: Yes No Limited
Primary Language: English
Problems in school: Just “wasn’t interested”, felt as though he was bullied somewhat in school.
Discharge
Client goals for treatment: Patient has a goal to become employed and financially stable
Where will client go when discharged? Patient is homeless but states there is a program at Rosecrances he can attend.

Outpatient Resources (15 points)

Resource	Rationale
1. A.A.	1. Patient has a long history of heavy alcohol use
2. Rosecrances	2. Patient is homeless and this program assists finding housing

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<p>3. C-U at home</p>	<p>3. Patient is homeless and this resource assists at finding jobs, having an address for mail/job applications, temporary housing, etc.</p>
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Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Acetaminophen/Tylenol	Benzotropine/Cogentin	Cyclobenzaprine/Flexeril	Divalproex/Depakote	Haloperidol/Haldol
Dose	650mg	2mg	10mg	250mg	5mg
Frequency	X4hrs PRN	BID PRN	TID PRN	BID	X4hrs PRN
Route	PO	PO	PO	PO	PO
Classification	Nonsalicylate	Anticholinergic	Skeletal muscle relaxant	Anticonvulsant	Antipsychotic

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Mechanism of Action	Interferes “with pain impulse generation in the peripheral nervous system” (Jones, pp. 9, 2021)	“Blocks acetylcholine’s action at cholinergic receptor sites” (Jones, pp. 124, 2021)	“Acts in the brain stem to reduce or abolish tonic muscle hyperactivity” (Jones, pp. 269, 2021)	Blocks GABA reuptake (Jones, pp. 1107, 2021).	“May block postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine, producing an antipsychotic effect” (Jones, pp. 533, 2021).
Therapeutic Uses	Mild to moderate pain relief, to reduce fever	Parkinson’s, to control extrapyramidal symptoms, to treat acute dystonic reactions	Depression, muscle spasms	Seizures, migraines, bipolar mania	Psychosis, schizophrenia, agitation
Therapeutic Range (if applicable)	“1,300mg every 8 hour. Maximum: 3,900 mg in 24 hrs” (Jones, pp. 8, 2021)	1-4mg BID	5-30 mg daily	60/mg/kg max daily	30mg max daily
Reason Client Taking	Mild to moderate pain	Extrapyramidal symptoms	Muscle spasms	Bipolar affective disorder	Agitation

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Contraindications (2)	Hypersensitivity, severe renal impairment	Children younger than 3, hypersensitivity	Heart block, hyperthyroidism	Hepatic impairment, urea cycle disorders	Dementia with leeway bodies, hypersensitivity
Side Effects/ Adverse Reactions (2)	Hypotension, hepatotoxicity	Hypotension, nausea	MI, leukopenia	Bradycardia, anemia	Hepatitis, nausea
Medication/Food Interactions	Alcohol use, propranolol	Antidepressants, haloperidol	MAO inhibitors, SSRIs	Aspirin, CNS depressants	Alcohol use, CNS depressants
Nursing Considerations (2)	Monitor renal function, monitor hepatic function	Monitor patient's movements, watch for worsening psychiatric symptoms	Not recommended for elderly, safety precautions due to possible dizziness	Avoid in females of childbearing age, give with food	Assess fall risk, not used to treat dementia related psychosis

Brand/Generic	Naproxen/ Naprosyn	Nicotine/ Nicoderm CQ	Thiamine/ vitamin B1	Trazodone/ desyrel	Vitamin B12/ cyanocobalamin
Dose	500mg	21mg	100mg	50mg	500mcg
Frequency	Daily	Daily	Daily	Nightly PRN	Daily
Route	PO	Transdermal	PO	PO	PO

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Classification	NSAID	Smoking cessation adjunct	Dietary supplement	Antidepressant	Dietary supplement
Mechanism of Action	“Blocks cyclooxygenase” (Jones, pp. 776, 2021)	“Binds selectively nicotinic-cholinergic receptors at autonomic ganglia...in the brain” (Jones, pp. 792, 2021).	Helps energy production in the body (Jones, pp. 1209, 2021).	“Blocks serotonin reuptake... alpha-adrenergic blocking action and produces modest histamine blockade... reduces blood pressure” (Jones, pp. 1094, 2021).	Involved in red blood cell production
Therapeutic Uses	Mild to moderate pain, arthritic inflammation	Smoking cessation	Vitamin B1 deficiency, Wernicke’s encephalopathy	To treat major depression	Insufficient dietary intake or malabsorption of B12
Therapeutic Range (if applicable)	Maximum 1,250mg daily	14-21 mg a day	5-100 mg daily	375mg max daily	N/A
Reason Client Taking	Mild to moderate pain	Nicotine use disorder	Alcohol use disorder	Insomnia	Alcohol use disorder
Contraindications (2)	History of asthma, hypersensitivity	Hypersensitivity to nicotine, hypersensitivity to menthol	Hypersensitivity, excessive dietary intake	Hypersensitivity, recovery from acute MI	Hypokalemia, hypersensitivity

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Side Effects/ Adverse Reactions (2)	Heart failure, respiratory depression	Dizziness, dream disturbances	GI bleeding, throat tightness	CVA, hypotension	Dizziness, nausea
Medication/Food Interactions	Alcohol, smoking use	Caffeine, oxazepam	Barbiturates , citrates	Aspirin, MAO inhibitors	Metformin , antibiotics
Nursing Considerations (2)	Avoid with recent MI, use cautiously in patients with hypertension	Use with caution in patients with hyperthyroidism, avoid irritated skin when applying patch	Protect from light exposure, know that I.M. administration may be painful	Use cautiously with cardiac diseases, monitor for S.I.	Do not administer with other drugs, protect from light exposure

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's Drug Handbook (19th ed.)*. Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:	M.D appears older than stated age, scars on his face, dry skin. Hair appears disheveled and dry. Good dentition. Slim build, carries himself cautiously. Avoidant eye contact. Appropriate behavior. Pleasant and hopeful attitude. Soft slow, clear and methodical speaker. Polite and non offending. Movements are slowed. Full affect. Established good rapport with nursing student.
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MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:	Patient does not report any ideations as of current. No delusions, illusions, obsessions, compulsions or phobias assessed.
ORIENTATION: Sensorium: Thought Content:	Patient is alert and oriented x4. Patient is mainly occupied on thinking about finding a jobbed getting stable after discharge. When interviewed he often spoke fondly of “the good old days” when he was a bassist for a roc band
MEMORY: Remote:	Some short term memory impairment, would repeat stories. Long term memory intact.
REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:	Good judgement, normal attention span, good impulse control, calculations are adequate, intelligence is WDL
INSIGHT:	Patient seems to have poor insight on his diagnosis
GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	No assistive devices used. Patient slightly hunched over posture. Little muscle tone, seems frail. 5/5 strengths, psychomotor retardation

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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	72 bpm R radius	114/71 R arm sitting	20 Rpm	97.5 F temporal	99% RA
1700	95 bpm R radius	136/83 R arm sitting	20 Rpm	97.0 F temporal	97% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	0-10	N/A	0/10	N/A	N/A
1700	0-10	N/A	0/10	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: 80%	Breakfast: 300mL water
Lunch: 85%	Lunch: 240mL juice
Dinner: 85%	Dinner: 480mL tea

Discharge Planning (4 points)

Discharge Plans (Yours for the client): My discharge plans for the patient are as followed;

My patient should walk to C-U at home and obtain consulting. My patient should ask

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about what is available for him in regards to temporary housing. My patient reported that he likes to look for jobs in the newspaper and he may do that there, or additionally they can assist him in finding and interviewing for work. Once he becomes employed he should save up enough money to get his own place to live. My patient should attend A.A. and stop his substance use. Hopefully, being sober throughout his hospitalization will make it easier for him to quit drinking alcohol.

Nursing Diagnosis (15 points)

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

<p style="text-align: center;">Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p style="text-align: center;">Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p style="text-align: center;">Immediate Interventions (At admission)</p>	<p style="text-align: center;">Intermediate Interventions (During hospitalization)</p>	<p style="text-align: center;">Community Interventions (Prior to discharge)</p>

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<p>1. Risk for self directed violence related to bipolar affective disorder as evidenced by patient reports, “ I feel numb and empty inside”</p>	<p>Safety is the number one concern for psychiatric patients</p>	<p>1. Determine what led up to the patient feeling the way they do.</p> <p>2. Assess for suicidal ideation</p> <p>3. Suicidal precautions in place</p>	<p>1. Administering ordered medication</p> <p>2. Monitor emotions</p> <p>3. Make self-harm contract</p>	<p>1. Followup appt. with social services to encourage medication compliance</p> <p>2. Refer to group therapy</p> <p>3. Crisis lines’s numbers</p>
<p>2. Ineffective coping related to financial and social stressors as evidenced by long history of substance abuse</p>	<p>Patient has clearly not healthily coped with stressors in the past, this has begun to catch up with my patient and he will do himself greater harm if he doesn’t find an alternative coping mechanism t</p>	<p>1. Assess substance abuse</p> <p>2. Alcohol detox protocol</p> <p>3. Nicotine patch</p>	<p>1. Have patient identify stressors</p> <p>2. Identify patient’s strengths</p> <p>3. Have patient set goals</p>	<p>1. Evaluate goal progress</p> <p>2. Teach relaxation/ healthy coping techniques</p> <p>3. Refer to substance abuse treatment centers/ counseling</p>

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<p>1. Hopelessness related to financial stressors as evidenced by patient reports of feeling too overwhelmed by his financial situation to cope independently</p>	<p>Patient's feelings of hopelessness is ultimately what he reported as why he presented to the hospital. This feeling is distressing to the patient and he is wanting help.</p>	<p>1. Assess cause of hopelessness</p> <p>2. Assess suicidal ideation</p> <p>3. Assess self-care ability</p>	<p>1. Have patient describe what would bring them fulfillment</p> <p>2. Establish good rapport with the patient</p> <p>3. Positively reinforce group therapies and enjoyable diversional activities</p>	<p>1. Refer to support groups</p> <p>2. Identify support system and encourage asking for help when it is needed.</p> <p>3. Refer to C-U at home</p>
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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

overwhelmed by financial situation, homelessness
 Reported long history of substance abuse
 Feels "numb and empty inside"

Feels**Nursing Diagnosis/Outcomes**

1. Risk for self directed violence related to bipolar affective disorder as evidenced by patient reports, " I feel numb and empty inside"
2. Ineffective coping related to financial and social stressors as evidenced by long history of substance abuse
3. Hopelessness related to financial stressors as evidenced by patient reports of feeling too overwhelmed by his financial situation to cope independently

Objective Data

72bpm, 114/71, 20rpm,
 97.5 f temporal, 99%O2
 RA
 1 previous suicide attempt (scar down left forearm)

Patient Information

White 58 yr old male,
 Unemployed, homeless
 Diagnosed with bipolar affective disorder

Nursing Interventions

1. Administering ordered medication
 2. Monitor emotions
 3. Make self-harm contract
- Assess substance abuse
2. Alcohol detox protocol
 3. Nicotine patch
1. Assess cause of hopelessness
 2. Assess suicidal ideation
 3. Assess self-care ability

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