

N323 Care Plan
Lakeview College of Nursing
Taylor Brooks

Demographics (3 points)

Date of Admission 5-31-2022	Patient Initials E.W	Age 30	Gender F
Race/Ethnicity White	Occupation Bartender	Marital Status Single	Allergies None
Code Status Full	Observation Status Inpatient	Height 5'7"	Weight 185 lbs

Medical History (5 Points)

Past Medical History: Hepatitis C (2020), Degenerative Disc Disease (2017)

Significant Psychiatric History: Anxiety, Depression (2007)

Family History:

Mom – depression, lung cancer, alcoholism

Father – no known medical problems

Maternal Grandmother – no known medical problems

Maternal Grandfather – no known medical problems

Paternal Grandmother – no known medical problems

Paternal Grandfather – no known medical problems

Social History (tobacco/alcohol/drugs):

Tobacco – Patient smokes cigarettes every day (half a pack) she started smoking at the age of 15

Alcohol – patient states she drinks two twelve packs of beer a week, she started drinking at age 15

Drugs – Patient states heroin and meth use every day, she started using when she was 17

Living Situation: Patient was living with her parents

Strengths: patient states she has a good support system with her family. Patient says she wants to stay sober and get her life back

Support System: Patient says her family will be helping her through everything and are 100% behind her in her recovery.

Admission Assessment

Chief Complaint (2 points): Suicidal ideation

Contributing Factors (10 points): The patient was taken to the emergency department due to meth-induced psychosis. The patient states, “I was in my room and just started to freak out.” The patient said, “she thought people were coming after her and started freaking out on her parents.” She would tell them that people were outside watching her, and they were plotting to kill them all. The patient also stated, “I was itching like crazy because I felt like I had bugs crawling all over me.” The patient stated during this psychosis “I wanted to kill myself so people wouldn’t come after me.” The patient said once she was out of her psychosis, she started to just feel sad and lost. The patient also stated “since I’ve been in here and off drugs, I feel so much better about myself”

Factors that lead to admission: meth-induced psychosis

History of suicide attempts: 1 suicide attempt in 2020, patient purposely tried to OD on heroin

Primary Diagnosis on Admission (2 points): Substance induced psychosis

Secondary Diagnosis: Methamphetamine use disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Physical abuse, Domestic violence				
Witness of trauma/abuse: Death of a boyfriend				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	None	16 - 25	None	Patient was abused by an ex-boyfriend between the ages of 17-25
Sexual Abuse	None	None	None	N/A
Emotional Abuse	None	None	None	N/A
Neglect	None	None	None	N/A
Exploitation	None	None	None	N/A
Crime	None	18	None	At the age of 18 patient was caught aiding a fugitive
Military	None	None	None	N/A
Natural Disaster	None	None	None	N/A

Loss	None	25	None	Patient stated at 25 her boyfriend died.
Other	None	None	None	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No		
Loss of energy or interest in activities/school	Yes	No	Patent says she feels off because of her anxiety and lack of motivation	
Deterioration in hygiene and/or grooming	Yes	No	N/A	
Social withdrawal or isolation	Yes	No	N/A	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	Patient says she lacks responsibilities because she lives at home and does not have to have the responsibilities most people her age have.	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Change in numbers of hours/night	Yes	No	Patient says since she's been off drugs she's getting a normal 8 hours of sleep now.	
Difficulty falling asleep	Yes	No	N/A	

Frequently awakening during night	Yes	No	N/A
Early morning awakenings	Yes	No	N/A
Nightmares/dreams	Yes	No	N/A
Other	Yes	No	N/A
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	N/A
Binge eating and/or purging	Yes	No	N/A
Unexplained weight loss?	Yes	No	N/A
Amount of weight change:			
Use of laxatives or excessive exercise	Yes	No	N/A
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	The patient has tremors in her hands due to anxiety
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?	5		
How would you rate your anxiety on a scale of 1-10?	7		

Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)				
Problematic Area	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Work	Yes	No		
School	Yes	No		
Family	Yes	No		
Legal	Yes	No		
Social	Yes	No	The patient says she has social anxiety every day.	
Financial	Yes	No		
Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
November 2020	Inpatient Outpatient Other:	Inpatient at Methodist Hospital	Suicide	No improvement Some improvement Significant improvement
February 2021	Inpatient Outpatient Other:	New leaf Rehab	Substance use	No improvement Some improvement Significant improvement

May 2022	Inpatient Outpatient Other:	The pavilion	Substance use/Suicide	No improvement Some improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Mom	63	mom	Yes	No
Dad	66	dad	Yes	No
			Yes	No
			Yes	No
			Yes	No
If yes to any substance use, explain: Patient said her mom is an alcoholic				
Children (age and gender): N/A				
Who are children with now?				
Household dysfunction, including separation/divorce/death/incarceration: None				
Current relationship problems: None				
Number of marriages: 0				
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:				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient said parents can help by not giving her money and just be there for her				

How can your family/support system participate in your treatment and care?
Client raised by: Natural parents Grandparents Adoptive parents Foster parents Other (describe):
Significant childhood issues impacting current illness: Patient said it started with her mom being an alcoholic
Atmosphere of childhood home: Loving Comfortable Chaotic Abusive Supportive Other:
Self-Care: Independent Assisted Total Care
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Depression
History of Substance Use: Alcohol
Education History: Grade school High school College Other:
Reading Skills: Yes No Limited

Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: Patient stated, “When I leave ill continue to go to meetings, and finish the 12 steps, and complete my sober living.”
Where will client go when discharged? Patient will be going to a sober living house

Outpatient Resources (15 points)

Resource	Rationale
1. Therapist	1. This gives the patient an opportunity to talk to someone and be able to express her feelings
2. Suicide hotline	2. This gives the patient a phone number to call 24/7 whenever she starts to have suicidal feelings
3. Substance abuse hotline	3. This gives the patient a phone number to call 24/7 whenever she wants to use drugs.

Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Gabapentin/Neurontin	Clonazepam/Clonazepam	Sertraline/Zoloft		
Dose	100 mg	0.5 mg	100 mg		
Frequency	TID	BID	Daily		
Route	Oral	Oral	Oral		
Classification	1 – amino-methyl cyclohexaneacetic acid	Benzodiazepine	SSRI		
Mechanism of Action	“Gabapentin is structurally like gamma-aminobutyric acid (GABA), the main inhibitory neurotransmitter in the brain.” (Jones and Bartlett 2021)	“Unknown, drug is thought to prevent panic attacks and seizures by potentiating the effects of gamma-aminobutyric acid (GABA) which is an inhibitory neurotransmitter.” (Jones and Bartlett 2021)	“Inhibits reuptakes of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapse.” (Jones and Bartlett 2021)		
Therapeutic Uses	Anticonvulsant	Anticonvulsant, antipanic	SSRI		
Therapeutic Range (if applicable)	Na	Na	Na		
Reason Client Taking	Degenerative disc disease	antianxiety	Antidepressant		
Contraindications (2)	“Hypersensitivity to gabapentin or its components” (Jones and Bartlett 2021)	“Acute-narrow-angle glaucoma, hypersensitivity to clonazepam” (Jones and Bartlett 2021)	“Concurrent use of disulfiram, Hypersensitivity to sertraline or its components” (Jones and Bartlett 2021)		
Side Effects/Adverse Reactions (2)	Hypotension, Steven-Johnson syndrome	Respiratory depression, anorexia	Serotonin syndrome,		

			Ventricular tachycardia	
Medication/Food Interactions	Aluminum-and magnesium-containing antacids, CNS depressants, hydrocodone, morphine	MAOI, Opioids	Antibiotics, NSAIDs	
Nursing Considerations (2)	Don't exceed 12 hours between doses on a TID schedule Give drug at least 2 hours after an antacid	Monitor patient closely for evidence of suicidal thinking or behavior, especially when therapy starts or dosage changes, Use clonazepam cautiously in patients with mixed seizure disorder	Be aware that sertraline should not be given to patients with bradycardia, congenital long QT syndrome, hypokalemia or hypomagnesium , Watch closely for suicidal tendencies especially when therapy starts and dosage changes and especially in children and adolescents	

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, LLC. (2021). *2021 Nurse's Drug Handbook* (20th ed.).

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Well groomed Behavior: anxious Build: average size and weight for a woman her age Attitude: positive Speech: clear Interpersonal style: introvert</p>	<p>Patient appears well groomed and active appropriate with occasional anxiousness. Patient makes good eye contact when spoken to. Patient is average build and weight for her size and age. Patient has a good attitude; speech is appropriate for age. Patient is an introvert. Patient was cooperative and</p>
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Mood: good Affect: appropriate	<p>pleasant throughout our conversation patient said she was in a good mood</p>
MAIN THOUGHT CONTENT: Ideations: upon admission Delusions: upon admission Illusions: none Obsessions: none Compulsions: none Phobias: none	<p>Patient states upon admission she had suicidal ideations but denies any currently, patient also said she had delusions people were after her but denies any currently, patient denies illusions, obsessions, compulsions and phobias</p>
ORIENTATION: Sensorium: alert Thought Content: normal	<p>Patient is alert and oriented to person, place, time and event. Senses are intact patient is coherent with normal thought proves</p>
MEMORY: Remote: good	<p>Short and long-term memory are good</p>
REASONING: Judgment: fair Calculations: average Intelligence: average Abstraction: appropriate Impulse Control: fair	<p>Patients judgement is fair. Patient can calculate simple math problems. Patient is of average intelligence level for her age. Patient can use words in correct manner and patient impulse control is fair.</p>
INSIGHT:	<p>Patient wants to go to sober living and get her life back</p>
GAIT: Assistive Devices: none Posture: erect Muscle Tone: low Strength: equal bilaterally Motor Movements: intact	<p>Patient does not use assistive devices. Posture is erect, low muscle tone. Strength is equal bilaterally. Motor movements are intact</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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10:00	111	118/70	20	98.3 °F	98% room air
1600	98	112/78	20	98.7 °F	98% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10:00	1-10	None	None	None	None
1600	1-10	None	None	None	None

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: unable to assess	Breakfast: unable to assess
Lunch: 100%	Lunch: 240mL
Dinner: unable to assess	Dinner: unable to assess

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

- **Patient will be discharged to a sober living home**
- **Patient will demonstrate compliance with any medication or treatment plan**
- **Patient will be involved in patient safety and responsibility to follow up plan after discharge**

- Patient will follow up with primary care provider, psychiatrist, and therapist.
- Patient will receive education on suicidal thoughts and ways to seek help when feeling these thoughts
- Patient will receive education on methamphetamine use and ways to seek help when wanting to use
- Symptom monitoring i.e identify triggers
- Develop suicidal prevention plan
- Stay away from drugs and those who encourage that behavior

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. Patient at increased risk for suicide related to depression as evidence by suicidal ideation	Patient is at an increased risk for suicide due to suicidal ideation after a meth induced psychosis	1. Initiate appropriate safety protocols by removing patient from environment anything that could be used to	1. Put patient on either suicide precaution, (one on one monitoring) or suicide observation, (every 15 minutes) to observe behaviors and mood	1. Arrange for client to go to sober living upon discharge 2. Provide patient with telephone numbers and other information about crisis centers,

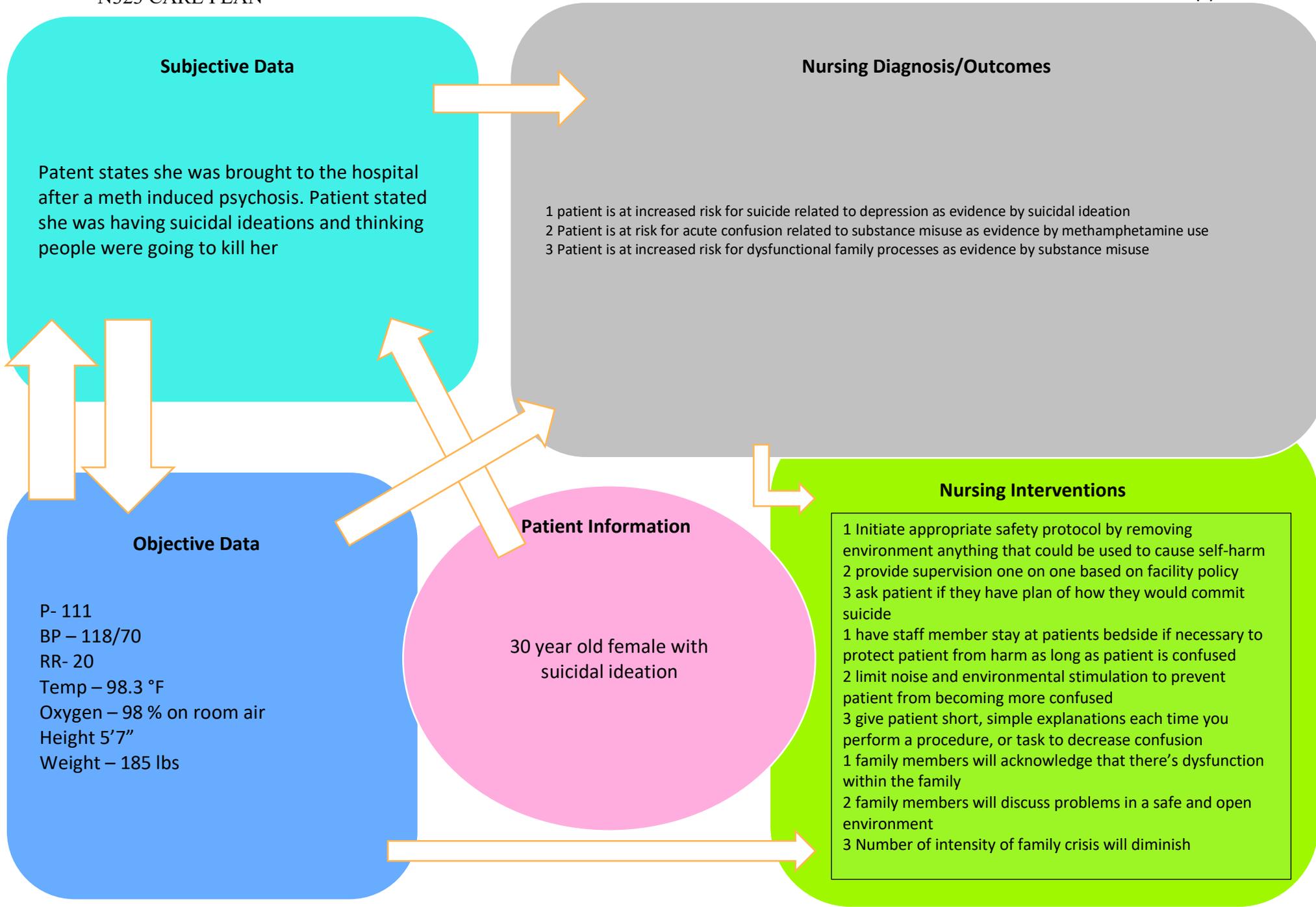
		<p>cause self-harm</p> <p>2. provide supervision one on one based on facility policy</p> <p>3. ask patient if they have a plan of how they would commit suicide</p>	<p>2. Listen carefully to patient and don't challenge patient</p> <p>3. Supervise the administration of medications to ensure patient does not hoard medications</p>	<p>hotlines, and counselors</p> <p>3. Help patient set a long term psychiatric care goal</p>
<p>2. Patient is at risk for acute confusion related to substance misuse as evidence by methamphetamine use</p>	<p>Patient is at an increased risk for substance misuse due to methamphetamine use</p>	<p>1. have a staff member stay at patients bedside, if necessary to protect patient from harm as long as patient is confused</p> <p>2. limit noise and environmental stimulation to prevent patient from becoming more confused</p> <p>3. give patient short, simple explanations each time you perform a procedure or task to decrease confusion</p>	<p>1. Praise patient for identifying and using effective coping skills</p> <p>2. teach strategies that patient can use to develop coping skills</p> <p>3. encourage patient to try coping behaviors</p>	<p>1. Educate patient on appropriate coping skills</p> <p>2. Educate patient on methamphetamine use</p> <p>3. Educate patient on withdraw coping skills</p>
<p>3. Patient is at increased risk for</p>	<p>Patient is at an increased risk for</p>	<p>1. Family members will acknowledge</p>	<p>1. Family members will be there</p>	<p>1. Family members state plans to</p>

<p>dysfunctional family processes as evidence by substance misuse</p>	<p>dysfunctional family process due to the misuse of methamphetamines</p>	<p>that theres dysfunction within the family</p> <p>2. family members will discuss problems in a safe and open environment</p> <p>3. Number of intensity of family crises will dimisish</p>	<p>for the patient in time of need</p> <p>2. Family members will remain calm and have a positive attitude with the family member seeking treatment</p> <p>3. Family members sign contracts stating that they wont engage in abusive behaviros</p>	<p>continue to seek counseling and attend support groups</p> <p>2. Educate both patient and family on appropriate resources for substance misuse</p> <p>3. All family mebers acknowledge there is dysfunction in the family due to substance misuse</p>
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Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's Nursing diagnosis reference manual* (11th ed.). Wolters Kluwer

Concept Map (20 Points):



Subjective Data

Patent states she was brought to the hospital after a meth induced psychosis. Patient stated she was having suicidal ideations and thinking people were going to kill her

Nursing Diagnosis/Outcomes

- 1 patient is at increased risk for suicide related to depression as evidence by suicidal ideation
- 2 Patient is at risk for acute confusion related to substance misuse as evidence by methamphetamine use
- 3 Patient is at increased risk for dysfunctional family processes as evidence by substance misuse

Objective Data

P- 111
 BP – 118/70
 RR- 20
 Temp – 98.3 °F
 Oxygen – 98 % on room air
 Height 5’7”
 Weight – 185 lbs

Patient Information

30 year old female with suicidal ideation

Nursing Interventions

- 1 Initiate appropriate safety protocol by removing environment anything that could be used to cause self-harm
- 2 provide supervision one on one based on facility policy
- 3 ask patient if they have plan of how they would commit suicide
- 1 have staff member stay at patients bedside if necessary to protect patient from harm as long as patient is confused
- 2 limit noise and environmental stimulation to prevent patient from becoming more confused
- 3 give patient short, simple explanations each time you perform a procedure, or task to decrease confusion
- 1 family members will acknowledge that there’s dysfunction within the family
- 2 family members will discuss problems in a safe and open environment
- 3 Number of intensity of family crisis will diminish

