

N323 Care Plan
Lakeview College of Nursing
Gabrielle Doss

Demographics (3 points)

Date of Admission 6/8/22	Patient Initials JB	Age 33 y/o	Gender F
Race/Ethnicity White/Caucasian	Occupation Student	Marital Status Single	Allergies Penicillin and Codeine
Code Status Full code	Observation Status Normal/ q15	Height 5'5"	Weight 160lb

Medical History (5 Points)

Past Medical History: CVA 2021, Seizures 2015, C-Section 2013

Significant Psychiatric History: Bipolar, voluntary stay at Pavilion in 2021, has been within the Pavilion since May 2022.

Family History: Alcohol abuse on mother's side.

Social History (tobacco/alcohol/drugs): Cocaine/crack, heroin, amphetamines, tobacco, and no alcohol.

Living Situation: Homeless

Strengths: Empathetic and caring.

Support System: Dad has become supportive and mother is only supportive when she is doing well.

Admission Assessment

Chief Complaint (2 points): Suicidal ideation with plan to swallow pills. Auditory command hallucinations telling her to kill herself, take clothes off, and other "wild things". Visual hallucinations.

Contributing Factors (10 points): Drug use and sexual/physical abuse.

Factors that lead to admission: Suicidal ideation, visual/auditory hallucinations.

History of suicide attempts: One previous attempt in 2021.

Primary Diagnosis on Admission (2 points): Schizoaffective disorder, unspecified.

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: Sexual abuse at age 4 and 16.</p> <p>Witness of trauma/abuse: N/A</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	N/A	N/A	N/A
Sexual Abuse	No	Yes 4 and 16y/o	N/A	At 4 y/o experienced sexual abuse by family friend. At 16 experienced sexual violence from 6 people.
Emotional Abuse	No	N/A	N/A	N/A
Neglect	No	N/A	N/A	N/A
Exploitation	No	N/A	N/A	N/A
Crime	No	Yes 30y/o	N/A	At 30 y/o set fire to her own house during drug use.
Military	No	N/A	N/A	N/A

Natural Disaster	No	N/A	N/A	N/A
Loss	No	Yes. 16y/o	N/A	At 16 y/o pt. lost grandfather on mom and dads side.
Other	N/A	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	Mildly depressed mood on occasion.	
Loss of energy or interest in activities/school	Yes	No	N/A	
Deterioration in hygiene and/or grooming	Yes	No	Only when feeling “psychotic”.	
Social withdrawal or isolation	Yes	No	N/A	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	N/A	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Change in numbers of hours/night	Yes	No	N/A	
Difficulty falling asleep	Yes	No	Sometimes has issues falling asleep at because of napping throughout the day or medications.	
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	Pt. reports anxiety when doing group activities.
Panic attacks	Yes	No	Pt. sometimes has panic attacks during group.
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?	0		
How would you rate your anxiety on a scale of 1-10?	5 or 6		
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	N/A
School	Yes	No	N/A
Family	Yes	No	N/A
Legal	Yes	No	N/A

Social	Yes	No	Pt. states she sometimes has a hard time getting along with others.
Financial	Yes	No	Pt. currently does not have a job and reports being “broke”.
Other	Yes	No	Pt. current living situation is problematic. She is homeless and has no where else to go.

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
2021	Inpatient Outpatient Other:	Inpatient- Pavilion	Suicidal ideation and hallucinations	No improvement Some improvement Significant improvement
May 2022	Inpatient Outpatient Other:	Inpatient- Pavilion	Suicidal ideation and hallucinations	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?	
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
N/A	N/A	N/A	Yes	No
If yes to any substance use, explain: N/A				
Children (age and gender): Yes. 9y/o daughter				
Who are children with now? With the child’s father and his parents. Visits with pt. parents as well.				
Household dysfunction, including separation/divorce/death/incarceration: Parents divorced				
Current relationship problems: No. Single.				
Number of marriages: None				
Sexual Orientation: Straight	Is client sexually active? Yes No		Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference:				
Ethnic/cultural factors/traditions/current activity: Believes in Ananda and states she is considered “Marga”. Consists of meditation and yoga.				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Set fire to own house while taking drugs in 2019.				
How can your family/support system participate in your treatment and care?				
Continue to be supportive and help keep sober/follow treatment plan.				
Client raised by:				
Natural parents Grandparents Adoptive parents Foster parents Other (describe):				
Significant childhood issues impacting current illness: Sexual abuse and violence at ages 4				

and 16y/o.
<p>Atmosphere of childhood home:</p> <p>Loving- Father was loving and caring (mother not so much). Comfortable Chaotic Abusive Supportive Other:</p>
<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) None.</p>
<p>History of Substance Use: Alcohol abuse on mother’s side. Pt. abused cocaine/crack, heroin, and amphetamines in past.</p>
<p>Education History:</p> <p>Grade school High school College- 1 year Other:</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: None</p>
<p>Discharge</p>
<p>Client goals for treatment: Getting into housing.</p>
<p>Where will client go when discharged? Homeless shelter.</p>

Outpatient Resources (15 points)

Resource	Rationale
1. Merci’s Refuge (217) 378-4045 Champaign Illinois	1. Help with housing for women in crisis at no cost.
2. Housing Authority of Champaign County (217) 378-7100	2. Help with finding housing at low cost.
3. NAMI Champaign County (217) 419-5345	3. Public awareness, education, support, and advocacy for mental health in Champaign County.

Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Benztropine / Cogentin	Gabapentin / Neurontin	Haloperidol/ Haldol	Hydroxyzine/ Vistaril	Trazodone/ Desyrel
Dose	0.5mg	300mg	15mg	50mg	50mg
Frequency	BID	TID	BID	TID	Bedtime
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharm. Class: anti-cholinergic Therap Class: Anti-parkinsonian	Pharm. Class: 1-amino-methyl-cyclo-hexaneacetic acid Therap. Class: Anti-convulsant.	Pharm. Class: Butyrophenone derivative Therap. Class: Antipsychotic	Pharm. Class: Piperazine derivative. Therap. Class: sedative-hypnotic.	Pharm. Class: Triazolopyridine derivative. Therap. Class: Anti-depressant
Mechanism of Action	Blocks acetyl-	Inhibits the rapid firing	May block postsynaptic	Competes with	Blocks serotonin

	choline's action at cholinergic receptor sites.	of neurons associated with seizures.	dopamine receptors in the limbic system and increase brain turnover of dopamine, producing an antipsychotic effect.	histamine for histamine receptor sites on surface of effector cells.	reuptake along the presynaptic neuronal membrane.
Therapeutic Uses	To treat all forms of Parkinson's disease.	To manage postherpetic neuralgia.	To treat psychosis and schizophrenia.	To control anxiety and tension.	To treat major depression.
Therapeutic Range (if applicable)	0.5-1mg daily	300mg, increased to 300mg twice daily.	0.5-2mg every 8-12hr.	50-100mg four times daily.	150mg daily
Reason Client Taking	EPS	Schizo-affective disorder	Psychosis	Anxiety	Insomnia
Contraindications (2)	Children younger than 3 and hypersensitivity to benztropine .	Hypersensitivity to gabapentin and hypersensitivity to its components .	Dementia with Lewy bodies and Parkinson's disease.	Early pregnancy and hypersensitivity to cetirizine.	Recovery from acute MI and hypersensitivity to trazodone.
Side Effects/Adverse Reactions (2)	Agitation and hypotension .	CNS tumors and delusions.	Cardiac arrest and extrasystoles.	Hallucinations and seizures.	Abnormal coordination and hallucinations
Medication/Food Interactions	Amantadine and tricyclic anti-depressants.	Aluminum and magnesium containing antacids.	Alprazolam, buspirone, chlorpromazine, and fluoxetine.	Depressants: Increased CNS depression. Antibiotics: Increased risk of QT prolongation.	NSAIDs: Increased risk of bleeding. Barbiturates: Enhanced effect of CNS depressants.
Nursing Considerations (2)	Typically starts with a low dose	May be opened and mixed with	Shouldn't be used to treat dementia-	Use cautiously with patients	Use cautiously with patients

	followed by a gradual increase. Assess for muscle rigidity and tremors.	applesauce. Give at bedtime to minimize adverse effects.	related psychosis in the elderly. Use cautiously in patients with history of prolonged QT interval.	who have pre-existing heart disease and patients with bradyarrhythmias and do not give by subcutaneous or I.V. route; may cause tissue necrosis.	that have cardiac disease; can cause arrhythmias. Give after meal to decrease chance of nausea.
--	---	--	---	--	---

Brand/Generic	N/A	N/A	N/A	N/A	N/A
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)

APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:	Patient is well-groomed. Average build. Good attitude. Coherent speech. Social interpersonal style. Good mood. Affect: Mood congruent.
MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:	Suicidal ideations. Auditory and visual hallucinations. No obsessions. No compulsions. No phobias.
ORIENTATION: Sensorium: Thought Content:	Patient is alert and oriented. Logical thought content.
MEMORY: Remote:	Remote memory intact.
REASONING: Judgment: Calculations: Intelligence:	Patient reasoning intact. Judgement intact. Calculations and intelligence are age appropriate. Patient has a difficult time understanding abstract

Abstraction: Impulse Control:	thoughts. Good impulse control.
INSIGHT:	Pt. insight unimpaired.
GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	Pt. has steady gait. No assistive devices. Straight and unimpaired posture. Average muscle tone. Average strength. Complete ROM. Fall score of 53.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1020	82	126/96	18	98.2F	98
1700	92	124/76	16	98.1F	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	0	N/A	N/A	N/A	N/A
1600	0	N/A	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: 100%	Breakfast: 180mL
Lunch: 100%	Lunch: 360mL

Dinner: 100%	Dinner: 180mL
---------------------	----------------------

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Client will be discharged to herself and return to a homeless shelter. Client will continue to go to therapy, follow-up with psychiatrist, and continue to take her medications as prescribed.

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)
<ol style="list-style-type: none"> Risk for suicide related to psychiatric disorder as evidenced by suicidal ideation and command hallucinations 	<p>The patient admits to command hallucinations that tell her to kill herself and suicidal ideation with plans.</p>	<ol style="list-style-type: none"> Remove anything that could be used to inflict further self-injury. Make a short-term contract with patient on not harming self during a specific period. Supervise the administration 	<ol style="list-style-type: none"> Use a warm, caring, non-judgmental manner to show unconditional positive regard. Demonstrate understanding, but don't reinforce denial of the current situation. Make appropriate referrals to mental health professionals to 	<ol style="list-style-type: none"> Group therapy. Mental health professional help. Telephone numbers for telehealth help when needed.

		of prescribed medications.	help patient work through suicidal feelings.	
2. Risk for infection related to open wounds as evidenced by needle/drug use.	Patient admits to sharing needles during drug use.	<ol style="list-style-type: none"> 1. Blood work for any current infections or diseases. 2. Clean and bandage any current open wounds. 3. Educate patient on sanitation and cleanliness. 	<ol style="list-style-type: none"> 1. Monitor WBC count, as ordered. 2. Follow the facility's infection control policy to minimize the risk of infection. 3. Assist patient with cleaning and re-bandaging any open wounds. 	<ol style="list-style-type: none"> 1. Education of drug use and risk for infection. 2. Community help to decrease chances of relapse. 3. Substance abuse group therapy.
3. Risk for low self-esteem related to sexual abuse as evidenced by prostitution.	Patient admits to being involved with prostitution and sexual violence/abuse.	<ol style="list-style-type: none"> 1. Screen for sexually transmitted diseases. 2. Implement a structured daily routine. 3. Encourage patient to express feelings about self (past and present). 	<ol style="list-style-type: none"> 1. Provide time for uninterrupted conversation with patient and staff. 2. Encourage bathing, grooming, and other hygiene functions for patient every day as needed. 3. Teach patient self-healing techniques. 	<ol style="list-style-type: none"> 1. Refer patient to self-healing groups. 2. Refer patient to group therapies for women who experienced sexual abuse. 3. Help patient learn different coping techniques and produce a daily routine schedule.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

- P: 82bpm
- B/P: 126/96
- RR: 18
- T: 98.2F
- O2: 98%
- C/O: 100% alcohol use, per patient.

Objective Data

Nursing Diagnosis/Outcomes

1. Remove anything that could be used to inflict further self-injury.
2. Make a short-term contract with patient on not harming self during a specific period.
3. Supervise the administration of prescribed medications.

- 33 y/o female
- 5'5"
- Medical history: CVA 2021, seizures, and c-section.

Patient Information

1. Blood work for any current infections or diseases.
2. Clean and bandage any current open wounds.
3. Educate patient on sanitation and cleanliness.

1. Screen for sexually transmitted diseases.
2. Implement a structured daily routine.
3. Encourage patient to express feelings about self (past and present).



