

N323 Care Plan
Lakeview College of Nursing
Tirae Littles

Demographics (3 points)

Date of Admission 9-5-22	Patient Initials T.M	Age 50	Gender F
Race/Ethnicity White/Caucasian	Occupation N/A	Marital Status Single	Allergies Penicillin
Code Status Full	Observation Status Pt was to be monitored q15	Height 5'1	Weight 126lbs

Medical History (5 Points)

Past Medical History: Anxiety, Arthritis, COPD, Depression, Gerd, Hypertension, Choroiditis, Osteoporosis, and Uveitis.

Significant Psychiatric History: Pt has history of hospitalizations for suicide, and overdose.

Family History: Father has a history of cancer, Maternal grandmother has a history of cancer, maternal grandfather has a history of stroke, paternal and maternal grandparents both had cancer.

Social History (tobacco/alcohol/drugs): Patient smokes two pack of cigarettes daily, 6-12 beers a day, and daily cannabis use. Patient does not use smokeless tobacco.

Living Situation: Patient lives in her apartment alone.

Strengths: Patient gets along with everyone and attends group meetings; Patient is also calm and cooperative through the day.

Support System: Patient does not have a good support system, but does have a son, daughter. And three grandchildren.

Admission Assessment

Chief Complaint (2 points): Drug OD, Suicide. Patient stated, "I woke up two days ago feeling so overwhelmed & took a couple bottle of pills".

Contributing Factors (10 points):

Factors that lead to admission: Patient admitted to the ER due to suicide attempt by drug overdose. My Patient lacks mental stability and states she doesn't want to live anymore and has decreased motivation. Patient came from home with her boyfriend. Patient has been feeling like this most of her life, but she stated it has gotten worse over the last two years. Patient feels hopeless and feels like she is going to have a panic attack. Patients associated factors are History of depression and substance misuse. Patient drinks to cope with anxiety and depression. Patient experiences depression and anxiety majority of the time. Patient rates condition at a 10.

History of suicide attempts: Patient attempted to commit suicide March of 2022, and September 4th, 2022. Both instances are by taking an excessive amount in pills.

Primary Diagnosis on Admission (2 points): Major depressive disorder.

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: Patient experienced trauma at the age of 17 from her boyfriend abusing her until the age of 21. Patient then turned to alcohol and drugs.</p> <p>Witness of trauma/abuse: Patient was a witness to her daughter being molested by her grandfather when she was 30.</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for	Describe

			another person with trauma)	
Physical Abuse	N/A	17	30	Patient experienced her daughter getting abused by her grandfather when her daughter was 16. Patient was almost beat to death by her first boyfriend.
Sexual Abuse	N/A	32-35	30	Patients' daughter was molested by her grandfather, and patient was sexually abused by her first husband and was forced to have sexual intercourse after she was beat.
Emotional Abuse	N/A	17-35	N/A	Patient experienced emotional abuse from all her

				boyfriend's, patient did not want to get into detail.
Neglect	N/A	21	N/A	Patient experienced neglected when her boyfriend up and left her and took everything.
Exploitation	N/A	N/A	N/A	N/A
Crime	N/A	35	N/A	Patient was arrested for methamphetamine in 2006 and was put on probation for 2 years.
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	N/A	30	N/A	Patients' grandmother shot herself in the head. Patient is still affected by this, and it makes her want to

				commit suicide.
Other				
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	Patient is not presenting with any depression or sadness. Patient states she feels less depressed while at the pavilion.	
Loss of energy or interest in activities/school	Yes	No	Yes, patient experiences loss of energy in activities. Patient states she feels like this anytime there is an activity. It is extremely intense she states her interest is at a 0.	
Deterioration in hygiene and/or grooming	Yes	No	Patient states when she is depressed, she never wants to shower this occurs three times out of the week patient feels this way every week. It is extremely hard for her to motivate herself to take a shower.	
Social withdrawal or isolation	Yes	No	No, patient states she never has a hard time when socializing with people.	

<p>Difficulties with home, school, work, relationships, or responsibilities</p>	<p>Yes</p>	<p>No</p>	<p>Yes, patient has a difficult relationship with her children it has been difficult since she started drugs in 2014. The situation is intense, and it makes the patient feel like a bad mother. Her children make her feel like this every time she tries to talk to them which is about 3-4 times a week.</p>
<p>Sleeping Patterns</p>	<p>Presenting?</p>		<p>Describe (frequency, intensity, duration, occurrence)</p>
<p>Change in numbers of hours/night</p>	<p>Yes</p>	<p>No</p>	<p>Patient has the same sleeping pattern every night, patient states she sleeps 6 hours a note.</p>
<p>Difficulty falling asleep</p>	<p>Yes</p>	<p>No</p>	<p>Patient states she does not have difficulty falling asleep.</p>
<p>Frequently awakening during night</p>	<p>Yes</p>	<p>No</p>	<p>Patient states that she does not wake up throughout the night.</p>
<p>Early morning awakenings</p>	<p>Yes</p>	<p>No</p>	<p>Patient states she does not have early morning awakenings.</p>
<p>Nightmares/dreams</p>	<p>Yes</p>	<p>No</p>	<p>Patient states she does have nightmares 2-3 times a week. Patient states that her dreams are</p>

			always bad and the dreams only last about 5 minutes until a new one.
Other	Yes	No	
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Patient states her eating habits are the same for the most part, besides when she gets depressed. About 3 times a week usually in the mornings she won't eat breakfast. Patient states the intensity rate at a 5.
Binge eating and/or purging	Yes	No	Patient does not binge eat or purge.
Unexplained weight loss? Amount of weight change:	Yes	No	Patient does not have unexplained weight loss.
Use of laxatives or excessive exercise	Yes	No	Patient takes two stool softeners once a day and it isn't intense at all.
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patient does not experience any of these behaviors.
Panic attacks	Yes	No	Patient states she does have panic

			attacks once a week for about 10 minutes. Patient states the intensity rate is about an 8.
Obsessive/compulsive thoughts	Yes	No	Yes, Patient states she has suicidal thoughts throughout the day, the thoughts last for about five minutes and the intensity rate is at a 10.
Obsessive/compulsive behaviors	Yes	No	Patient does not have compulsive behaviors in the pavilion, but she does at home about 2-3 times a day for 20 minutes. Patient states the intensity rate is at a 10.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	Yes, patient states it is hard for her to focus on daily activities because she gets discouraged, this occurs every day of the week and it lasts for hours. Patient states the intensity rate at a 10.
Rating Scale			
How would you rate your depression on a scale of 1-10?		Patient rates her depression at a 6 using a scale 1-10.	
How would you rate your anxiety on a scale of 1-10?		Patient rates her anxiety at a 9 using a scale 1-10.	

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	N/A	
School	Yes	No	N/A	
Family	Yes	No	This occurs every time the patient speaks on the phone with her family members. This has been going on since the patient turned to an alcoholic and a drug user. The situation is intense for the patient.	
Legal	Yes	No	N/A	
Social	Yes	No	N/A	
Financial	Yes	No	N/A	
Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
Patient is unsure of the actual month and day, but the first outpatient visit was in 2007.	Inpatient Outpatient Other: Pt attended a	Outpatient	Pt was treated for	No improvement Some improvement

	hospital in Carbondale when she began going through withdrawals.		alcohol withdrawal.	Significant improvement
Patient is unsure of the actual month and day, but the second outpatient visit was in 2008	Inpatient Outpatient Other:	Outpatient	Pt was treated for substance abuse.	No improvement Some improvement Significant improvement
Patient is unsure of the actual month and day, but the third outpatient visit was in 2014.	Inpatient Outpatient Other:	Outpatient	Pt was treated for substance abuse.	No improvement Some improvement Significant improvement

Personal/Family History

Who lives with you?	Age	Relationship	Do they use substances?	
Patient does not live with anybody	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): Patient has a daughter that is 32 and a son that is 21
Who are children with now? Both children live by themselves in Carbondale.

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

Current relationship problems: Patient is not in an intimate relationship but does have relationship problems with her children not wanting to deal with her because she attempted to

<p>commit suicide.</p> <p>Number of marriages: 2</p>		
<p>Sexual Orientation:</p>	<p>Is client sexually active? Yes No</p>	<p>Does client practice safe sex? Yes No</p>
<p>Please describe your religious values, beliefs, spirituality and/or preference: Patient is a Christian.</p>		
<p>Ethnic/cultural factors/traditions/current activity:</p> <p>Describe: The only tradition the patient practices' is going to church on Sundays when she can.</p>		
<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient did not have any legal issues with herself or parents, patient was married but never legally divorced she stated. Patient did not have any issues with CPS and does not have any pending charges. Patient was put on probation for two years for using methamphetamine in 2006.</p>		
<p>How can your family/support system participate in your treatment and care? Patient stated "There is no way for my family to contribute to my treatment and care I have to do this alone" .</p>		
<p>Client raised by: Client was raised by her birth parents.</p> <p>Natural parents Grandparents Adoptive parents Foster parents Other (describe):</p>		
<p>Significant childhood issues impacting current illness: Patient stated she lived in a peaceful home; she was not mistreated by her parents; however, her mom was an alcoholic.</p>		
<p>Atmosphere of childhood home: Patient stated the atmosphere of childhood home was Comfortable.</p> <p>Loving</p>		

<p>Comfortable Chaotic Abusive Supportive Other:</p>
<p>Self-Care: Patient is Independent</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patients' grandmother shot herself in the head in 2014. Patient did not state any other mental illnesses from her family.</p>
<p>History of Substance Use: Patient stated she did crack, heroin, meth, smoked weed and drank alcohol from years 2006-current.</p>
<p>Education History: Patient only completed 11th grade, patient stated she hated school and did not get good grades.</p> <p>Grade school: completed High school: 11th grade only College: did not attend Other:</p>
<p>Reading Skills: Patient states she can read without any issues.</p> <p>Yes No Limited</p>
<p>Primary Language: English.</p>
<p>Problems in school: Patient didn't experience any bullying, but she stated she always skipped class and didn't make good grades.</p>
<p>Discharge</p>
<p>Client goals for treatment: Client stated she would like to overcome her depression and get</p>

back on the right track with her children.
Where will client go when discharged? Client will go to Aspen nursing home.

Outpatient Resources (15 points)

Resource	Rationale
1. Group therapy	1. Group therapy helps this patient be able to realize that she isn't the only one going through the same things. Group therapy also helps with improving social skills.
2. Personal Therapist visits	2. Personal therapy visits are useful as it helps with developing the client's self-esteem and allowing them to talk about their problems one-on-one.
3. Substance use and mental health services	3. This improves the patients' coping skills for handling stress and it creates better coping mechanisms for mental health issues.

Current Medications (10 points)

Complete all of your client's psychiatric medications

Brand/Generic	Bupropion/ Wellbutrin	Chlorpromazine/ Thorazine	Paroxetine/ Aropax		
Dose	150mg	50mg	20mg		
Frequency	1x a day	1x a day at bedtime	1x in the morning		
Route	oral	oral	oral		
Classification	Aminoketone	Phenothiazine	SSRI		
Mechanism of Action	May inhibit dopamine, norepinephrine, and serotonin uptake by neurons. Which significantly relieves evidence of depression. (Jones and Barlett 2022).	Depresses brain areas that control activity and aggression. (Jones and Barlett 2022).	Exerts anti-anxiety, antidepressant and anti-panic effects as well as relieving factors associated with premenstrual dysphoric disorder. (Jones and Barlett 2022).		
Therapeutic Uses	Antidepressant, Smoking cessation.	Manages symptoms of psychotic disorders.	Treats depression, and panic disorder, and social anxiety disorder.		
Therapeutic Range (if applicable)	N/A	N/A	N/A		
Reason Client Taking	To treat depression	Mood stabilizer	To help treat OCD.		
Contraindications (2)	Hypersensitivity, and Seizure disorders	Possibly lowered convulsive threshold, may also result in CNS depression.	Use within 14 days of MAO inhibitor, and pregnancy is a contraindication.		
Side Effects/Adverse Reactions (2)	Abnormal coordination, & Abnormal EEG.	Motor restlessness, and Tardive dyskinesia.	Decreased concentration, and insomnia.		
Medication/Food	Phenytoin, and	Avoid lithium and	Do not use this		

Interactions	Tamoxifen interact with this brand.	levodopa.	medication with buspirone, and fentanyl		
Nursing Considerations (2)	Provide client with medication information and ensure that the client isn't taking anything to interact with this drug.	Stay alert for possible suppressed cough reflex and notify provider if altered mental status occurs.	Watch patient closely for suicide attempt and monitor patient closely for GI bleed.		

Brand/Generic	Polyethylene glycol/MiraLA X	Gabapentin/Neurotin	Pantoprazole/Pantoloc		
Dose	17mg	800mg, 400mg per dose	40mg		
Frequency	2x a day	2x a day	1x a day before meals		
Route	Oral	Oral	oral		
Classification	Osmotic laxatives	1-amino-methyl cyclohexane acetic acid	Proton pump inhibitor		
Mechanism of Action	Increases the number of bowel movements and softens the stool	Inhibits the rapid firing of neurons associated with seizures. It also prevents exaggerated response to stimuli.	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system in gastric parietal system.		
Therapeutic Uses	Treats occasional constipation.	Prevents seizures and relieves pain.	Treats erosive esophagitis associated with GERD.		
Therapeutic Range (if applicable)	N/A	N/A	N/A		
Reason Client	Manage	Anxiety	GERD		

Taking	constipation				
Contraindications (2)	Patients with suspected bowel instruction, and appendicitis.	Hypersensitivity to gabapentin or its components. Vision changes and swelling of the face.	Substituted benzimidazoles, and concurrent therapy with rilpivirine containing products.		
Side Effects/Adverse Reactions (2)	Bloody diarrhea, and increased sweating.	CNS tumors, and disappearance of aura.	Anxiety and vertigo.		
Medication/Food Interactions	Herbal products and vitamins.	Avoid taking morphine, and naproxen.	Avoid using atazanavir, and iron salts.		
Nursing Considerations (2)	High doses may produce excessive stool frequency, additionally patients may also develop urticaria.	Remember that routine monitoring of blood gabapentin level isn't needed. Monitor renal function test results. Monitor patient for suicidal thoughts.	Monitor PT or INR during therapy if patient takes is taking oral anticoagulant (Jones and Barlett 2022). Monitor patients' urine output.		

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). NDH nurses drug handbook (21st ed.). World Headquarters
 Jones and Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: Behavior: Build: Attitude:	Patient looks tired and lonely Patients' behavior is calm and assertive Patients build appears normal without disturbed body image
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<p>Speech: Interpersonal style: Mood: Affect:</p>	<p>Patients’ attitude is positive, patient smiles a few times. Patients’ speech is normal without slurred words, and she can complete sentences fluently. Patients interpersonal style included active listening. Patients’ mood was a down but still managed to laugh and smile. Patients affect was normal patient did not display any emotion she appeared to have a typical affect.</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:</p>	<p>Patients’ ideas are spontaneous, and she states her opinions, but doesn’t’. Patient is not having any delusions or illusions. Patient is obsessed with playing in her hair. Patient compulsions is constantly cleaning. Patient did not present with any phobias or stated any.</p>
<p>ORIENTATION: Sensorium: Thought Content:</p>	<p>Patient did not present with any confusion or altered mental status. Patient was able to complete her thoughts and was completely oriented. Patients thinking process was sufficient.</p>
<p>MEMORY: Remote:</p>	<p>Patient remote memory was intact and was able to remember things from years ago.</p>
<p>REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:</p>	<p>Patients’ judgment was appropriate and positive. Judgement was fair Patient was able to count and give me the correct answer to simple addition problems. Satisfactory. Patients’ intelligence level is average, patient is able to comprehend. Patient was able to understand the meanings of all words I used. Abstraction is normal. Impulse control is normal</p>
<p>INSIGHT:</p>	<p>Patient was understanding and aware of her mental illness.</p>
<p>GAIT:</p>	

Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	Patient does not use any assistive devices, and posture is normal. Patients muscle tone is normal and not resistant upon movement. Patients’ strength is equal bilaterally. Patients motor movements are active and normal without disturbances.
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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0200	78	109/70	18	97.6F	96%
0400	74	117/66	18	98.4F	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0200	1-10	Head	9	Dull pain	Pt was given Tylenol
0400	1-10	N/A	0	N/A	Pt does not have any pain

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: 100% Breakfast: Patient stated she ate all her breakfast 100% Lunch: Patient ate all her lunch 100% Dinner: Patient ate all her dinner 100%	Oral Fluid Intake with Meals (in mL) 500ml total. Breakfast: Patient stated she had 2 cups of Kool-Aid the whole day. Lunch: Patient stated she had 2 cups of Kool-Aid the whole day.

	<p>Dinner: Patient stated she had 2 cups of Kool-Aid the whole day.</p>
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Discharge Planning (4 points)

Discharge Plans (Yours for the client):

1. Provide my client with helpful resources and to establish a better relationship with family, so patient can rely on a support system.
2. Ensure that my patient is getting involved with daily activities to decrease risk of being depressed.
3. Give advice on smoking cessation to promote healthier lifestyle
4. Continued therapy for my patient
5. Ensure my patient is going to a helpful nonjudgmental place of residency

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. Risk for acute substance withdrawal	This nursing diagnosis was chosen because the	1. Head to toe assessment 2. limit noise	1. Assess patient's support system 2. Ask patient	1. Endure the client with encouraging motivational

<p>syndrome Related to developed dependence to alcohol as evidence by drinking alcohol excessively to cope with problems.</p>	<p>patient is an alcoholic and if not controlled patient is at risk of going through withdrawal again.</p>	<p>and environmental stimulation 3. Provide nonjudgmental care</p>	<p>open ended questions 3. Identify possible med that should be given to client to decrease symptoms</p>	<p>words. 2. Refer patient to a mental health specialist. 3. Advise the patient to continue therapy</p>
<p>2. Risk for unstable blood pressure related to substance abuse as evidence by drug overdose</p>	<p>This nursing diagnosis was chosen because increased substance use creates a rise in blood pressure causing possible hypertension.</p>	<p>1. Gather patients' information 2. Reduce patients anxiety level 3. Monitor patient mental status</p>	<p>1. Monitor patients vital signs 2. Assess hemodynamic status 3. Get labs done on patient</p>	<p>1. Encourage patient to share concerns regarding health 2. Provide patient with information regarding risk factors 3. Collaborate with members of the healthcare team to ensure patients' needs are meant</p>
<p>3. Risk for defensive coping related to insufficient support system as evidence by children not wanting to keep in contact with patient</p>	<p>This nursing diagnosis was chosen because the patient has been having difficulty with keeping in contact with her children due to her habits.</p>	<p>1. Pay attention to patient mental status. 2. Ensure patient is not having suicidal thoughts 3. Encourage patient to evaluate self</p>	<p>1. Establish an environment of mutual trust and respect between patient and care giver. 2. Use therapeutic communication throughout hospitalization process 3. Provide empathy for the patient. And</p>	<p>1. Refer patient to social worker for follow-up treatment. 2. Provide positive feedback when patient accepts responsibility for actions 3. Help patient make treatment related</p>

			support patient feelings regarding support system.	decisions.
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Other References (APA):

Jones & Bartlett Learning. (2023). NDH nurses drug handbook (21st ed.). World Headquarters Jones and Bartlett Learning.

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

Concept Map (20 Points):

Subjective Data

Patient states she is depressed and has anxiety, Patient states she wants to better herself and live a normal life. Patient states she wants to stop drinking; so she is able to be in her children and grandchild's life.

Nursing Diagnosis/Outcomes

Risk for acute substance withdrawal syndrome
Related to developed dependence to alcohol as evidence by drinking alcohol excessively to cope with problems. Goal: Patient will not experience withdrawal symptom complications.
Risk for unstable blood pressure related to substance abuse as evidence by drug overdose. Goal: Patient remains hemodynamically stable
Risk for defensive coping related to insufficient support system as evidence by children not wanting to keep in contact with patient. Goal: Patient accepts responsibility for actions and is persistent to make a change.

Objective Data

Patient appears tired and overwhelmed; patient does manage to communicate with others well and is positive throughout the day. Patients' vital signs are normal for her age. First attempt diastolic was a bit elevated.

Patient Information

50-year-old female patient weighing 126 lbs. 5'1 with a chief complaint of attempting to commit suicide. Patient does not have a support system but hopes to get better so she can make things right for her children. Patient will be going to a nursing home after discharge.

Nursing Interventions

Monitor and record level of consciousness of patient.
Include patient in plan of action which can help patient develop a sense of responsibility.
Treat episodes of high and low blood pressure promptly
Assign consistent care provider to patient to provide continuity of care and create a therapeutic relationship.



