N323 Care Plan

Lakeview College of Nursing

Name: Chiquita Baker, BSN Student

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
02/08/2023	A.P.	21	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Unemployed	Single	Sulfa Drugs
Code Status	**Observation Status**	**Height**	**Weight**
Full code	Inpatient, rounds every 15 minutes	6’3	190 lbs.

Medical History (5 Points)

Past Medical History: The client reports he has a brain cyst.

Significant Psychiatric History: The client consulted a psychiatrist once. He has never been hospitalized or received outpatient treatment. The client denies any suicide attempts. The client was treated with Prozac in the past.

Family History: The client reports that his mother has bipolar disorder and that he has a close relationship with her. The client reports that his father also has bipolar disorder and that he wasn’t there for him growing up as a kid.

Social History (tobacco/alcohol/drugs): The client denies any tobacco use. The client denies any alcohol use. The client admits to using cannabis daily.

Living Situation: The client lives in a house with his mother. He also stays with his grandparents at times.

Strengths: The client believes that his strength is the courage to keep going and not give up on himself, and working through his problems so that he can get better and function in society.

Support System: The client reports that his mother and grandparents are his support system. He claims they are the reason he came to the Pavilion to get help.

Admission Assessment

Chief Complaint (2 points): The client stated, " I'm feeling down and having suicidal thoughts".

Contributing Factors (10 points):

Factors that lead to admission: The client suffers from major depressive disorder and hasn't worked in over a year because he says he just doesn't have the energy to get out of bed. He struggles to get up and perform activities of daily living. The client states that he doesn't have anyone to talk to and that he doesn't have any friends, he feels like he is alone, and that everyone would be better off without him here. His mother has become worried about him lately because he was cutting himself on his arms and telling her how he has been having thoughts about killing himself. The client stated that he had a plan and has been thinking of creative ways to kill himself. He hasn't attempted to kill himself yet but his mother is afraid to leave him alone because of what he might do. This is why she brought him to the Pavilion so that he can see a doctor and get treatment for his suicidal thoughts.

History of suicide attempts: The client denies any suicide attempts**.**

Primary Diagnosis on Admission (2 points): Major Depressive Disorder

Psychosocial Assessment (30 points)

History of Trauma
No lifetime experience: N/A **Witness of trauma/abuse:** No

	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	Denies	Denies	N/A	
Sexual Abuse	Denies	Denies	N/A	
Emotional Abuse	Denies	Denies	N/A	
Neglect	Denies	Ages 10 - 18	N/A	Dad was never there for him growing up.
Exploitation	Denies	Denies	N/A	
Crime	Denies	Denies	N/A	
Military	Never Enlisted	Never Enlisted	N/A	
Natural Disaster	Denies	Denies	N/A	
Loss	Denies	Denies	N/A	
Other				

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Denies
Loss of energy or interest in activities/school	**Yes**	**No**	Denies
Deterioration in hygiene and/or grooming	**Yes**	**No**	
Social withdrawal or isolation	**Yes**	**No**	Doesn't like to be around people.

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**	7 – 8 hours of sleep a day
Difficulty falling asleep	**Yes**	**No**	The client takes sleeping pills
Frequently awakening during night	**Yes**	**No**	Denies
Early morning awakenings	**Yes**	**No**	Denies
Nightmares/dreams	**Yes**	**No**	Denies
Other	**Yes**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Eating less
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**	Sometimes uses laxatives and exercises sometimes also.
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	The client reports having anxiety and pacing back and forth.
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?		1/10	
How would you rate your anxiety on a scale of 1-10?		2/10	
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 client hasn't worked in a year due to depression.
School	**Yes**	**No**	Denies
Family	**Yes**	**No**	The client is stressed about letting his family down.
Legal	**Yes**	**No**	Denies
Social	**Yes**	**No**	The client wants to have friends and social life.
Financial	**Yes**	**No**	Denies
Other	**Yes**	**No**	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			

Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
N/A	**Inpatient** **Outpatient** **Other:**			**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?**	
Elise	45	Mother	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: The client states his mother uses cannabis.				
Children (age and gender): No **Who are children with now?** N/A				
Household dysfunction, including separation/divorce/death/incarceration: N/A				

Current relationship problems: N/A **Number of marriages:** N/A		
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: Catholic		
Ethnic/cultural factors/traditions/current activity: None **Describe:** N/A		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A		
How can your family/support system participate in your treatment and care? His family has been supportive in every way. They can continue to be supportive after his discharge.		
Client raised by: **Natural parents:** Mainly raised by his mother. **Grandparents:** Grandparents also helped raised him. **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: The client has ADHD which caused him to struggle in school during his childhood.		
Atmosphere of childhood home: **Loving:** The client reports feeling loved by his mother and grandparents. **Comfortable:** The client reports being comfortable growing up at home. **Chaotic** **Abusive** **Supportive:** The client reports his mother always being supportive in his life. **Other:**		
Self-Care: **Independent** **Assisted** **Total Care**		

Family History of Mental Illness (diagnosis/suicide/relation/etc.) The client reported that his mother and father both have bipolar disorder
History of Substance Use: The client reports that he and his mother both use cannabis daily.
Education History: **Grade school** **High school:** The client graduated from high school. **College:** The client reports having gone to college for 1 year and then dropping out. **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: The client reports being distracted and having problems with social engagement.
Discharge
Client goals for treatment: The client will demonstrate mood stability and reduction of psychotic features allowing for safe discharge.
Where will client go when discharged? The client will leave and go stay with his grandparents.

Outpatient Resources (15 points)

Resource	Rationale
1. The University of Illinois Counseling Center	**1.** Evaluate patient response to psychotropic medication
2. Carle Psychiatrist	**2.** Educate the patient on the importance of

	taking medication
3. Ken Powell Therapy	**3.** Provide physical activities to alleviate symptoms, and psychoeducation on the use of physical activities to reduce suicidality with distraction and exercise.

Current Medications (10 points)
Complete all of your client's psychiatric medications
Client Only Has Four Medications

Brand/Generic	Trazodone (Desyrel)	Topiramate (Topamax)	Lamotrigine (Lamicial)	Ariprazole (Ablify)	
Dose	50 mg	25 mg	100 mg	2 mg	
Frequency	Daily	Daily	Daily	Daily	
Route	Bedtime	Bedtime	Oral	Oral	
Classification	Antidepressant	Anticonvulsant	Anticonvulsant	Antipsychotic	
Mechanism of Action	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect.	May block the spread of seizures by reducing the length and frequency of excitatory transmission.	May stabilize neuron membranes by blocking their sodium channels and inhibiting the release of excitatory neurotransmitters.	May produce antipsychotic effects through partial agonist and antagonist actions.	
Therapeutic Uses	Treat	To prevent	To treat seizures	To reduce	

	depression	migraine		delusion hallucinations	
Therapeutic Range (if applicable)	0.5 – 2.5 mg/day	5.0 – 20.0mcg/mL	3 -14 mcg/mL	10 – 30 mg/day	
Reason Client Taking	To treat insomnia	Major depressive disorder	Depression disorder	Mood stabilizer	
Contraindications (2)	Hypersensitivity to trazodone or its components, use within 14 days of an MAO inhibitor including intravenous methylene blue and linezolid.	Hypersensitivity to topiramate or its components, Recent alcohol use is defined as within 6 hours prior to and 6 hours after taking topiramate.	Hypersensitivity to lamotrigine or its components, Low blood counts due to bone marrow failure.	Hypersensitivity to aripiprazole or its components, Diabetes.	
Side Effects/Adverse Reactions (2)	Serotonin syndrome, Hypertension	Seizures, suicidal ideation.	Blurred vision, stomach, back, and joint pain.	Homicidal ideation, CVA (elderly)	
Medication/Food Interactions	Grapefruit juice	N/A	N/A	N/A	
Nursing Considerations (2)	Use trazodone cautiously in patients with cardiac disease. Closely monitor depressed patients for suicidal thoughts and tendencies.	Obtain baseline serum bicarbonate level before topiramate therapy. Use cautiously in patients with impaired hepatic function.	Know that lamotrigine should not be given to patients with myocardial ischemia or depression. Use cautiously in patients with illnesses that could affect the elimination or metabolism of lamotrigine.	Use cautiously in patients with cardiovascular disease, or conditions that would predispose them to hypotension. Use cautiously in elderly patients because of the increased risk of serious adverse cerebrovascular effects, such as stroke	

Brand/Generic	**N/A**				
Dose	**N/A**				
Frequency	**N/A**				
Route	**N/A**				
Classification	**N/A**				
Mechanism of Action	**N/A**				
Therapeutic Uses	**N/A**				
Therapeutic Range (if applicable)	**N/A**				
Reason Client Taking	**N/A**				
Contraindications (2)	**N/A**				
Side Effects/Adverse Reactions (2)	**N/A**				
Medication/Food Interactions	**N/A**				
Nursing Considerations (2)	**N/A**				

Medications Reference (1) (APA):

Jones & Bartlett Learning, (2023). Nurse's Drug Handbook (22nd ed.). Jones & Bartlett

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Well-groomed and clean. Calm, engaged. Lean build. Positive attitude. Normal speech. Open, honest, and genuine. Good mood. Calm affect.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The client denies having any ideations delusions, illusions, obsessions, compulsions, or phobias currently. The client seems to be in a better state of mind thinking positively about his future.
ORIENTATION: **Sensorium:** **Thought Content:**	The client is A&O x4. Sensorium was not assessed. Logical thinking .
MEMORY: **Remote:**	Short-term/long-term memory is intact.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The client has good judgment. Not assessed. Normal for age. Not assessed. Normal /average impulse control.
INSIGHT:	Insight was observed to be average.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Normal gate. No assistive devices. The posture is relaxed. Appropriate for age. Appropriate for age. Normal mobility.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:00 am	71	130/63	18	98.7	99%
2:00 pm	79	137/70	18	98.2	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:00 am	numeric	-	0 - 10	-	-
2:00 pm	numeric	-	0 - 10	-	-

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 75% - 100% **Lunch:** 75% - 100% **Dinner:** 75% - 100%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 240 mL **Lunch:** 600 mL **Dinner:** 600 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The plans I have for this client would be to try and get a job and become more social. I think this client should continue to go to group therapy and talk about his stressors. Think positively about yourself and learn to cope with everyday problems. Make sure you take your medication to help with the intrusive thoughts. The client also plans to get back into school as well as go back to church.

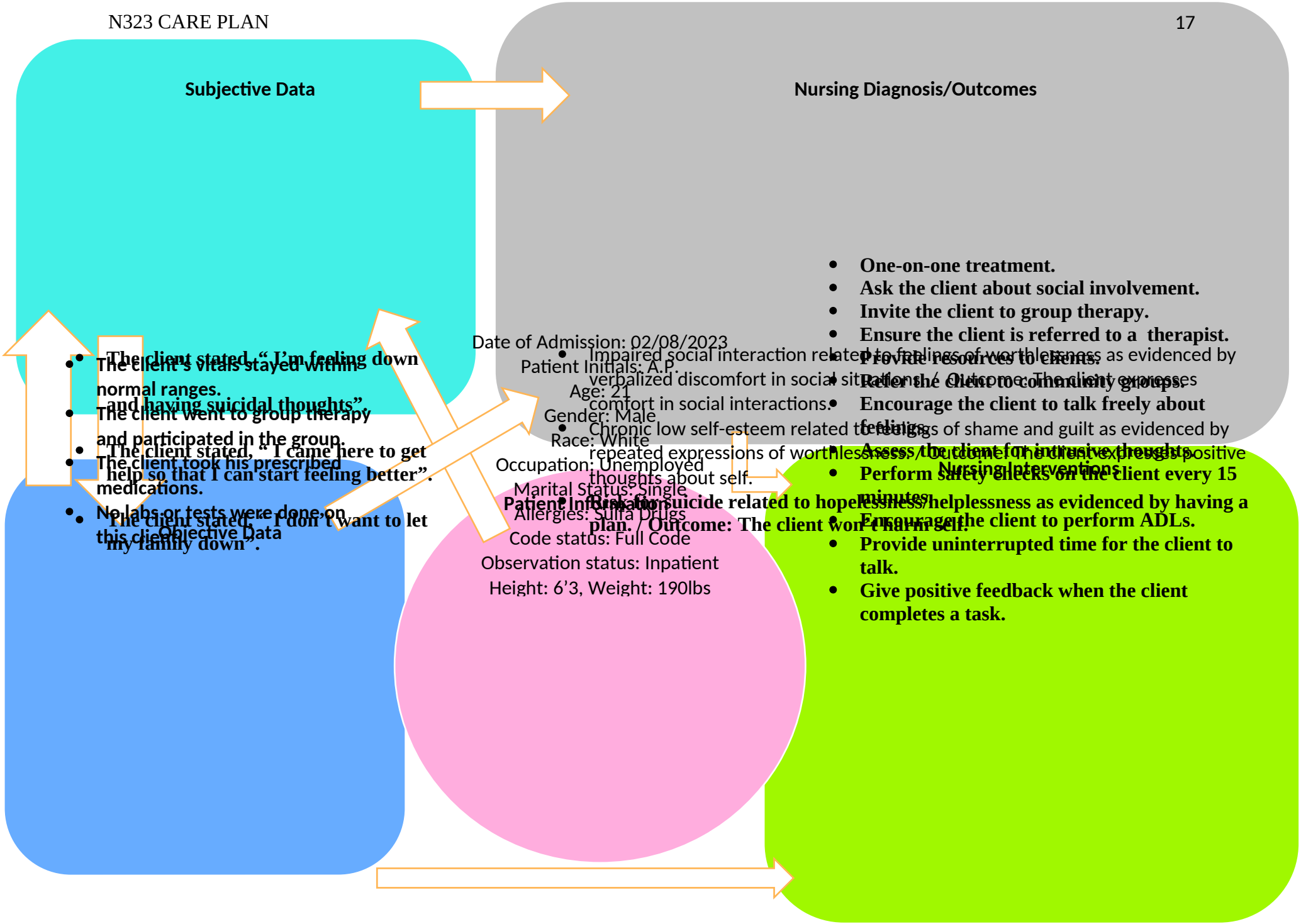
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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 as evidenced by verbalized discomfort in social situations.	The client states feeling uncomfortable in social settings.	1. One-on-one treatment. 2. Ask the client about social involvement 3. Invite the client to group therapy	1. Have the client attend group therapy 2. Provide client with activities. 3. Involve the client in group activities	1. Ensure the client is referred to a therapist. 2. Provide resources to client. 3. Refer the client to community groups
2. Chronic low self-esteem related to feelings of shame and guilt as evidenced by repeated expressions of worthlessness	The client states that he feels worthless.	1. Assess self-esteem level. 2. Assess for neglect of ADLs. 3. Assess the client for intrusive thoughts.	1. Encourage the client to perform ADLs 2. Provide uninterrupted time for the client to talk. 3. Give positive feedback when client completes a task.	1. Teach self-healing techniques. 3. Encourage the client to follow up with a doctor. 3. Encourage community group therapy.
3. Risk for suicide	The client	1. Ask if the	1. Encourage	1. arrange for

related to hopelessness/helplessness as evidenced by having a plan.	states “I’m feeling down and having suicidal thoughts.	client has a plan to harm himself. 2. Remove all weapons or pills 3. Put the client on one-on-one treatment.	the client to talk freely about feelings 2. Assess the client for intrusive thoughts. 3. Perform safety checks on the client every 15 minutes.	the client to stay with family or friends. 2. educate the client on how to handle intrusive thoughts. 3. make appropriate referrals to mental health professionals to help client work through suicidal feelings

Other References (APA): Sparks & Taylors, (2020). Nursing Diagnosis Reference Manual (11th ed.). Linda Lee Phelps

Concept Map (20 Points): Attached


Subjective Data
Nursing Diagnosis/Outcomes
Objective Data
Patient Information
Nursing Interventions
The client stated, “ I’m feeling down and having suicidal thoughts”.
The client stated, “ I came here to get help so that I can start feeling better”.
The client stated, “ I don’t want to let my family down”.
The client’s vitals stayed within normal ranges.
The client went to group therapy and participated in the group.
The client took his prescribed medications.
No labs or tests were done on this client.
Date of Admission: 02/08/2023
Patient Initials: A.P.
Age: 21
Gender: Male
Race: White
Occupation: Unemployed
Marital Status: Single
Allergies: Sulfa Drugs
Code status: Full Code
Observation status: Inpatient
Height: 6’3, Weight: 190lbs
Impaired social interaction related to feelings of worthlessness as evidenced by verbalized discomfort in social situations / Outcome: The client expresses comfort in social interactions.
Chronic low self-esteem related to feelings of shame and guilt as evidenced by repeated expressions of worthlessness / Outcome: The client expresses positive thoughts about self.
Risk for suicide related to hopelessness/helplessness as evidenced by having a plan. / Outcome: The client won’t harm self.
One-on-one treatment.
Ask the client about social involvement.
Invite the client to group therapy.
Ensure the client is referred to a therapist.
Provide resources to clients.
Refer the client to community groups.
Encourage the client to talk freely about feelings.
Assess the client for intrusive thoughts.
Perform safety checks on the client every 15 minutes.
Encourage the client to perform ADLs.
Provide uninterrupted time for the client to talk.
Give positive feedback when the client completes a task.