

N323 Care Plan  
Lakeview College of Nursing  
Brayden Percival

**Demographics (3 points)**

<b>Date of Admission</b> 02/20/2023	<b>Patient Initials</b> B.B.	<b>Age</b> 20	<b>Gender</b> Male
<b>Race/Ethnicity</b> White/Caucasian	<b>Occupation</b> Wireman	<b>Marital Status</b> Single	<b>Allergies</b> No Known Allergies
<b>Code Status</b> Full	<b>Observation Status</b> Voluntary Inpatient	<b>Height</b> 6 ft	<b>Weight</b> 140 lbs

**Medical History (5 Points)****Past Medical History:**

GERD

Insomnia

Panic disorder without agoraphobia

Major Depressive disorder, mild to moderate.

**Significant Psychiatric History:**

Depression

Anxiety

ADD/ADHD

**Family History:**

Mom: 50/50 bipolar, depression, and anxiety

Dad: Depression

Sister: Depression, anxiety

**Social History (tobacco/alcohol/drugs):**

Client has never smoked or has used smokeless tobacco.

Client has no current alcohol use.

Client does not use drugs.

**Living Situation:** Lives with parents and sister.

**Strengths:** The client is pleasant, cooperative, and willing to participate in treatment.

**Support System:** Family and friends on the internet.

**Admission Assessment**

**Chief Complaint (2 points):** Headaches and insomnia: “I had a panic attack”.

**Contributing Factors (10 points):** Stress

**Factors that lead to admission:** Recent loss, suicide attempt of mom, sister, and neglect.

**History of suicide attempts:** Two attempts by overdose.

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

**Psychosocial Assessment (30 points)**

History of Trauma				
<p><b>No lifetime experience:</b> “Sexual abuse around 7/8 years old, emotional neglect, physical abuse from father but has gotten better over the years”.</p> <p><b>Witness of trauma/abuse:</b> None</p>				
	<b>Current</b>	<b>Past (what age)</b>	<b>Secondary Trauma (response that comes from caring for another</b>	<b>Describe</b>

			person with trauma)	
<b>Physical Abuse</b>	<b>Negative</b>	<b>14-18 years old</b>	<b>Negative</b>	<b>“Dad used to beat on me, but it no longer happens”.</b>
<b>Sexual Abuse</b>	<b>Negative</b>	<b>Molestation</b>	<b>Negative</b>	<b>Family friend towards client.</b>
<b>Emotional Abuse</b>	<b>Emotional neglect</b>	<b>4-current age</b>	<b>Negative</b>	<b>Father worked all day, mother is in-and-out of hospitals.</b>
<b>Neglect</b>	<b>20</b>	<b>All time</b>	<b>Negative</b>	<b>Father worked all day, mother is in-and-out of hospitals.</b>
<b>Exploitation</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>
<b>Crime</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>
<b>Military</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>
<b>Natural Disaster</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>	<b>Negative</b>
<b>Loss</b>		<b>20 years old</b>	<b>Negative</b>	<b>“Lost a close friend online. Two weeks later mom attempted suicide, grandmother</b>

				passes less than a month ago”.
Other	Negative	Negative	Negative	Negative
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	YES: “It is ongoing”.	
Loss of energy or interest in activities/school	Yes	No	YES: “I am a straight A student but with all this stuff going on I just don’t want to be at school”.	
Deterioration in hygiene and/or grooming	Yes	No	NO:	
Social withdrawal or isolation	Yes	No	NO: “No comment”.	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	YES: “I am an introvert, makes socializing tiresome especially after losing my friend”.	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Change in numbers of hours/night	Yes	No	NO: “No comment”.	
Difficulty falling asleep	Yes	No	NO: “No comment”.	
Frequently awakening during night	Yes	No	YES: “The nurses station is loud and the other patients here can be noisy”.	
Early morning awakenings	Yes	No	NO: “No comment”.	
Nightmares/dreams	Yes	No	NO: “No comment”.	

<b>Other</b>	<b>Yes</b>	<b>No</b>	<b>NO: "No comment".</b>
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	<b>Yes</b>	<b>No</b>	<b>YES: "I had a loss of appetite before I was admitted here but I am okay now".</b>
<b>Binge eating and/or purging</b>	<b>Yes</b>	<b>No</b>	<b>NO: "No comment".</b>
<b>Unexplained weight loss?</b>  <b>Amount of weight change:</b>	<b>Yes</b>	<b>No</b>	<b>NO: "I have been a stable weight of 135-140 lbs, so no issues there".</b>
<b>Use of laxatives or excessive exercise</b>	<b>Yes</b>	<b>No</b>	<b>NO: "No comment".</b>
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	<b>Yes</b>	<b>No</b>	<b>YES: "Spasms in my arms".</b>
<b>Panic attacks</b>	<b>Yes</b>	<b>No</b>	<b>YES: "Yes, it was frequently 3 times a day. Now its only 1 or 2 times a day and I can typically function fine afterwards."</b>
<b>Obsessive/compulsive thoughts</b>	<b>Yes</b>	<b>No</b>	<b>NO: "No comment".</b>
<b>Obsessive/compulsive behaviors</b>	<b>Yes</b>	<b>No</b>	<b>NO: "No comment".</b>
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	<b>Yes</b>	<b>No</b>	<b>NO: "No comment".</b>
<b>Rating Scale</b>			
<b>How would you rate your depression on</b>		<b>"a 5".</b>	

a scale of 1-10?				
How would you rate your anxiety on a scale of 1-10?		"a 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	NO: "No comment".	
School	Yes	No	YES: "I'm not good at English papers and public speaking worsens my anxiety".	
Family	Yes	No	YES: "Loss, neglect, moms attempt at suicide has made it so hard".	
Legal	Yes	No	NO: "No comment".	
Social	Yes	No	NO: "No comment".	
Financial	Yes	No	NO: "No comment".	
Other	Yes	No	YES: Loss of online friend Dad is not home most of the day Friend issues	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
N/A	Inpatient	N/A	N/A	No improvement

	<b>Outpatient Other:</b>			<b>Some improvement</b>  <b>Significant improvement</b>
<b>N/A</b>	<b>Inpatient Outpatient Other:</b>	<b>N/A</b>	<b>N/A</b>	<b>No improvement</b>  <b>Some improvement</b>  <b>Significant improvement</b>
<b>N/A</b>	<b>Inpatient Outpatient Other:</b>	<b>N/A</b>	<b>N/A</b>	<b>No improvement</b>  <b>Some improvement</b>  <b>Significant improvement</b>

**Personal/Family History**

<b>Who lives with you?</b>	<b>Age</b>	<b>Relationship</b>	<b>Do they use substances?</b>	
<b>DAD</b>	<b>52</b>	<b>Father</b>	<b>Yes</b>	<b>No: "No".</b>
<b>MOM</b>	<b>49</b>	<b>Mother</b>	<b>Yes: "Yes."</b>	<b>No</b>
<b>SISTER</b>	<b>16</b>	<b>Sister</b>	<b>Yes</b>	<b>No: "No".</b>
			<b>Yes</b>	<b>No</b>
			<b>Yes</b>	<b>No</b>

**If yes to any substance use, explain: "Mom uses a lot of pain meds and drinks a lot. She is also on so many meds right now it messes with stuff".**

**Children (age and gender): N/A**

**Who are children with now? N/A**

**Household dysfunction, including separation/divorce/death/incarceration: "Mom's**

<b>suicide attempt and her bipolar makes living at home difficult”.</b>		
<b>Current relationship problems: NONE</b>		
<b>Number of marriages: NONE</b>		
<b>Sexual Orientation:</b> <b>Bisexual</b>	<b>Is client sexually active?</b> <b>No</b>	<b>Does client practice safe sex?</b> <b>Yes</b>
<b>Please describe your religious values, beliefs, spirituality and/or preference: “No comment”.</b>		
<b>Ethnic/cultural factors/traditions/current activity:</b>  <b>Describe:</b>		
<b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b>		
<b>How can your family/support system participate in your treatment and care?</b>		
<b>Client raised by:</b>  <b>Natural parents</b>		
<b>Significant childhood issues impacting current illness: Molestation, neglect.</b>		
<b>Atmosphere of childhood home:</b>  <b>Chaotic</b>		
<b>Self-Care:</b>  <b>Independent</b>		
<b>Family History of Mental Illness (diagnosis/suicide/relation/etc.) “Suicidal”.</b>		
<b>History of Substance Use: None</b>		
<b>Education History: College</b>		
<b>Reading Skills:</b>  <b>Yes</b>		

<b>Primary Language: ENGLISH</b>
<b>Problems in school: “None, besides public speaking class, I get straight A’s”.</b>
<b>Discharge</b>
<b>Client goals for treatment:</b>  <b>Patient will no longer have episodes of harm to self, get medicine, take care of anxiety.</b>
<b>Where will client go when discharged?</b>  <b>The client will go back home with his parents.</b>

**Outpatient Resources (15 points)**

Resource	Rationale
<b>1. Psychiatrist</b>	<b>1. Until October of last year</b>
<b>2. Over-the-phone Counselor</b>	<b>2. Until November of last year</b>
<b>3. Friends online - Discord</b>	<b>3. Helps feel like he has friends who he can trust/talk about problems.</b>

**Current Medications (10 points)**

**\*Complete all of your client’s psychiatric medications\***

<b>Brand/Generic</b>	<b>Cymbalta/ duloxetine</b>	<b>Oleptro/ trazodone hydrochloride</b>	<b>TYLENOL/ acetaminophen</b>	<b>TUMS/ calcium carbonat</b>	
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Dose	60 mg capsule	50 mg tablet	650 mg tablet	1000mg
Frequency	Daily	12 hrs PRN	PRN	PRN
Route	PO	PO	PO	PO
Classification	<p><b>Pharmacologic class:</b> Selective serotonin and norepinephrine reuptake inhibitor.</p> <p><b>Therapeutic class:</b> Antidepressant, neuropathic and musculoskeletal pain reliever <b>(Jones and Bartlett Learning, 2022).</b></p>	<p><b>Pharmacologic class:</b> Triazolopyridine derivative</p> <p><b>Therapeutic class:</b> Antidepressant <b>(Jones and Bartlett Learning, 2022).</b></p>	<p><b>Pharmacologic class:</b> Nonsalicylate, para-aminophenol derivative</p> <p><b>Therapeutic class:</b> Antipyretic, nonopioid analgesic <b>(Jones and Bartlett Learning, 2022).</b></p>	<p><b>Pharmacologic class:</b> Calcium salts</p> <p><b>Therapeutic class:</b> Antacid <b>(Jones and Bartlett Learning, 2022).</b></p>
Mechanism of Action	Inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrenergic and serotonergic activity in the CNS <b>(Jones and Bartlett Learning, 2022).</b>	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect. <b>(Jones and Bartlett Learning, 2022).</b>	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in PNS. <b>(Jones and Bartlett Learning, 2022).</b>	Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis <b>(Jones and Bartlett Learning, 2022).</b>
Therapeutic Uses	Elevates mood and inhibits pain signals.	Reduces blood pressure and treats depression.	Reduce pain.	Reduce GI upset
Therapeutic Range (if applicable)	40 mg – 60 mg a day.	About 150 mg a day, doctor may adjust dose as	650 mg	n/a

		<b>needed. (Jones and Bartlett Learning, 2022).</b>		
<b>Reason Client Taking</b>	<b>Depression</b>	<b>Depression</b>	<b>Headaches</b>	<b>For GERD</b>
<b>Contraindications (2)</b>	<b>Cirrhosis.  Intravenous methylene blue (Jones and Bartlett Learning, 2022).</b>	<b>Recent M.I.  Low amount of potassium in blood (Jones and Bartlett Learning, 2022).</b>	<b>Severe hepatic impairment  Severe active liver disease (Jones and Bartlett Learning, 2022).</b>	<b>Hypercalcemia  Cardiac resuscitation with risk of existing digitalis toxicity or presence of ventricular fibrillation (Jones and Bartlett Learning, 2022).</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>CNS: Abnormal Dreams  CV: Hypertension</b>	<b>CNS: Anxiety  GI: Nausea</b>	<b>CNS: Anxiety  GI: Abdominal pain</b>	<b>CNS: Fatigue  GI: Vomiting</b>
<b>Medication/Food Interactions</b>	<b>NSAIDs, warfarin: Increased risk of bleeding. Alcohol use: Increased risk of hepatotoxicity (Jones and Bartlett Learning, 2022).</b>	<b>carbamazepine: Decreased trazodone level.  Serotonergic drugs: Increased risk of serotonin syndrome (Jones and Bartlett Learning, 2022).</b>	<b>Oral contraceptives : Decreased effectiveness of acetaminophen  Propranolol: Possibly increased action of acetaminophen (Jones and Bartlett Learning, 2022).</b>	<b>Caffeine/high fiber foods: Possibly decreased calcium absorption.  Vitamin D (high doses): Excessively increased calcium absorption (Jones and Bartlett Learning, 2022).</b>
<b>Nursing</b>	<b>Do not give to pt.</b>	<b>Can cause</b>	<b>Tell client the</b>	<b>Check IV site</b>

<p><b>Considerations (2)</b></p>	<p><b>with severe renal impairment or end stage renal disease.</b></p> <p><b>Give cautiously to pt. with a history of mania, which may be activated after administration (Jones and Bartlett Learning, 2022).</b></p>	<p><b>arrhythmias to pt. with cardiac disease.</b></p> <p><b>Give after a meal or a snack to reduce nausea (Jones and Bartlett Learning, 2022).</b></p>	<p><b>tablets may be crushed or swallowed whole.</b></p> <p><b>Follow dosage guidelines correctly and do not exceed prescribed dosage (Jones and Bartlett Learning, 2022).</b></p>	<p><b>regularly for infiltration because calcium causes necrosis.</b></p> <p><b>Monitor serum calcium level in all patients. Check Chvostek’s and Trousseau’s signs, which shouldn’t appear (Jones and Bartlett Learning, 2022).</b></p>
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**Medications Reference (1) (APA):**

Jones & Bartlett Learning, LLC. (2022). *2022 NDH: Nurse's Drug Handbook* (20<sup>th</sup> ed).

**Mental Status Exam Findings (20 points)**

<b>APPEARANCE:</b> <b>Behavior:</b> Anxious <b>Build:</b> <b>Attitude:</b> Pleasant <b>Speech:</b> Good <b>Interpersonal style:</b> <b>Mood:</b> Pleasant <b>Affect:</b>	<b>Client is alert and oriented to place, time, and situation.</b>
<b>MAIN THOUGHT CONTENT:</b> <b>Ideations:</b> Suicidal <b>Delusions:</b> N/A <b>Illusions:</b> N/A <b>Obsessions:</b> N/A <b>Compulsions:</b> N/A <b>Phobias:</b> N/A	<b>Client has suicidal ideations but is optimistic about getting better.</b>
<b>ORIENTATION:</b> <b>Sensorium:</b> good <b>Thought Content:</b> Logical/Realistic	.
<b>MEMORY:</b> <b>Remote:</b>	<b>Long-term memory</b>
<b>REASONING:</b> <b>Judgment:</b> Diminished. <b>Calculations:</b> Very well <b>Intelligence:</b> Very well <b>Abstraction:</b> Negative <b>Impulse Control:</b> Very well, does not get overly angry or abuse substances.	.
<b>INSIGHT:</b>	<b>Unimpaired</b>
<b>GAIT:</b> <b>Assistive Devices:</b> N/A <b>Posture:</b> Straight, hands at sides. <b>Muscle Tone:</b> Well <b>Strength:</b> Good 5/5 bilaterally <b>Motor Movements:</b> Has full ROM in all extremities.	<b>Smooth and balanced gait</b>

**Vital Signs, 2 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>10:00am</b>	<b>96</b>	<b>118/78</b>	<b>18</b>	<b>98.3</b>	<b>97%</b>
<b>12:43pm</b>	<b>89</b>	<b>116/80</b>	<b>18</b>	<b>98.5</b>	<b>100%</b>

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale 1-10</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<b>10:05am</b>	<b>0</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>12:50pm</b>	<b>1</b>	<b>Head</b>	<b>Sharp</b>	<b>Headache</b>	<b>Give acetaminophen PRN.</b>

**Dietary Data (2 points)**

<b>Dietary Intake</b>	
<b>Percentage of Meal Consumed:</b>	<b>Oral Fluid Intake with Meals (in mL)</b>
<b>Breakfast: 0%</b>	<b>Breakfast: Water - 240 mL</b>
<b>Lunch: 100%</b>	<b>Lunch: Chocolate Milk 240 mL</b>
<b>Dinner: N/A (Discharged @ 1pm)</b>	<b>Dinner: N/A (Discharged @ 1pm)</b>

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):**

The client will be going home with his mother at 1:00 pm back to his house. The client will receive a prescription for his medicine to treat his depression and anxiety. This will include discharge teaching and future follow-up appointments to be made with a care provider. A crisis prevention plan will be a part of his discharge plans, as well as a list of his medication

and instructions on how to take the medicine. Take medication dosage as prescribed, and do not crush extended-release pills, acetaminophen can be crushed or swallowed whole.

**Nursing Diagnosis (15 points)**

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

<b>Nursing Diagnosis</b> • Include full nursing diagnosis with “related to” and “as evidenced by” components	<b>Rational</b> • Explain why the nursing diagnosis was chosen	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (Prior to discharge)</b>
<b>1. Risk for suicide related to major depressive disorder as evidenced by two past overdose attempts.</b>	<b>The client has a high risk for another potential suicide attempt. There have been multiple losses within his social circle within the last month.</b>	<b>1. Talk to client and build rapport, 2. Evaluate the client for potential self-harm. 3. Observe for risk factors. Assess vital signs (Videbeck, 2019).</b>	<b>1. Determine stressors/triggers. 2. Provide a safe environment for the client. 3. Closely supervise and monitor the client for any changes (Videbeck, 2019).</b>	<b>1. Encourage the client to be open to talking about feelings. 2. Avoid making big decisions while in a time of crisis, decision making may be altered. 3. Go to AA meetings to be with those of similar struggles. (Videbeck, 2019).</b>
<b>3. Risk for panic attacks related to panic disorder</b>	<b>The client may experience symptoms related to anxiety</b>	<b>1. Provide comfort measures during admission.</b>	<b>1. Maintain a trusting relationship with the client. 2. Maintain calm</b>	<b>1. Cognitive-behavior therapy 2. Positive reframing</b>

<p>without agoraphobia as evidence by anxiety.</p>	<p>such as an increased heart rate and blood pressure during anxiety (Phelps, 2020).</p>	<p>2. Avoid having the client make decisions in high anxiety periods. 3. Ask open ended questions and get to know why your client feels anxious (Phelps, 2020).  Assess vital signs.</p>	<p>and non-threatening. 3. Remain with the client when levels are anxiety are in the severe or range (Phelps, 2020).</p>	<p>3. Decatastrophizing (Videbeck, 2019).</p>
<p>4. Risk for hopelessness related to loss of significant support systems as evidence by loss of grandma and best friend in past month.</p>	<p>The client will have less people he can go to talk about feelings and is grieving the recent losses (Videbeck, 2019).</p>	<p>1. Assess emotional state. 2. Assess level of social support (Phelps, 2020). 3. Assess vital signs.</p>	<p>1. Find and assess areas of strength/weakness. 2. Build rapport and trusting relationship. 3. Identify what makes the client feel joyful (Phelps, 2020).</p>	<p>1. Discuss and implement goals. 2. Discuss/teach positive coping strategies. 3. Client will participate in care that is within their control (Phelps, 2020).</p>

**Other References (APA):**

Videbeck, S. (2019). *Psychiatric-Mental Health Nursing*. LWW.

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

**Concept Map (20 Points):**



Subjective Data

Pain Assessment:  
Vitals: -10

HR: 96 bpm

BP: 118/78

LOC: 1/5 "Head"

Temp: 98.3 "Sharp"

Characteristics: "Headache"

Objective Data  
"Loss, neglect, moms attempt at suicide has made it so hard".

Nursing Diagnosis/Outcomes

1. Risk for suicide related to major depressive disorder as evidence by two past overdose attempts.

B.B. a. Encourage the client to be open to talking about feelings. Determine stressors/triggers. Provide a safe environment for the client.

2. Risk for panic attacks related to panic disorder without agoraphobia as evidence by anxiety. Closely supervise and monitor the client for any changes (Videbeck, 2019).

a. Cognitive-behavior therapy. Maintain a trusting relationship with the client.

3. Risk for hopelessness related to loss of significant support systems as evidence by loss of grandma and best friend in past month.

Code status: FULL a. Client will participate in care that is within their control (Phelps, 2020). Maintain calm and non-threatening. Remain with the client when levels are anxiety are in the severe or range (Phelps, 2020).

Patient Information





