N323 Care Plan

Lakeview College of Nursing

Jackson Powell

Demographics (3 points)

Date of Admission 02/27/23	**Patient Initial** R.O.	**Age** 39	**Gender** Male
Race/Ethnicity White	**Occupation** Unemployed	**Marital Status** Married (Seperated)	**Allergies** Olanzapine
Code Status Full code	**Observation Status** Inpatient	**Height** 6’3	**Weight** 230 lbs.

Medical History (5 Points)

Past Medical History: The client reports he has PTSD, ADHD, Depression, Borderline personality disorder, and severe anxiety.

Significant Psychiatric History: The client has never been hospitalized or received outpatient treatment. However he has had suicide ideation with a plan.

Family History: The client reports that his mother has a history of depression.

Social History (tobacco/alcohol/drugs): The client reports that they smoke a pack and a half of cigarettes everyday.

Living Situation: The client reports he is homeless

Strengths: The client states that he is smart, strong headed, and a survivor.

Support System: The client reports that his wife is his main support system.

Admission Assessment

Chief Complaint (2 points): The client states he is having “Mental health problems”

Contributing Factors (10 points):

Factors that lead to admission: The client suffers from depression, anxiety, borderline personality disorder, ADHD, and PTSD. The client also reports that he is homeless and has recently been separated from his wife. Client has had recent thoughts of suicide and has planned on how he would do it.

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

Primary Diagnosis on Admission (2 points): Suicide Ideation with plan to OD

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No **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	6-9 years old	N/A	Client states his mother would beat him frequently
Sexual Abuse	Denies	Denies	N/A	
Emotional Abuse	Denies	Denies	N/A	
Neglect	Denies	Denies	N/A	
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**	Denies	
Social withdrawal or isolation	**Yes**	**No**	Denies	
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**	Denies	
Binge eating and/or	**Yes**	**No**	Client reports that he eats until he	

purging			cannot any longer
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Denies
Use of laxatives or excessive exercise	**Yes**	**No**	Denies
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Client reports having anxiety and pacing back and forth to keep himself calm.
Panic attacks	**Yes**	**No**	Client reports having a panic attack at least once a day. He states that they are very intense to the point where he cannot breathe. They usually last 5-6 minutes.
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?		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**	Denies
School	**Yes**	**No**	Denies
Family	**Yes**	**No**	Denies
Legal	**Yes**	**No**	Denies

Social	**Yes**	**No**	Denies
Financial	**Yes**	**No**	Client states that he spends his money as fast as he receives it.
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?**	
Client does not live with anyone			**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): Client has a son that is 19 and a daughter that is 13

Who are children with now? Son lives on his own. Daughter lives with her mother

Household dysfunction, including separation/divorce/death/incarceration: Client and his wife are currently separated

Current relationship problems: Married but separated

Number of marriages: 1

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Heterosexual	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference: Christian

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): None

How can your family/support system participate in your treatment and care? His wife calls him everyday to check up on him.

Client raised by:

Natural parents:
Grandparents: Mainly raised by Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness: The client reports that he had a

learning disability growing up.
Atmosphere of childhood home: **Loving:** **Comfortable:** **Chaotic** Client states that his Grandparents were very controlling over him **Abusive** **Supportive:** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Client reports that his mother suffered from depression
History of Substance Use: None
Education History: **Grade school** **High school:** The client graduated from high school. **College:** The client reports he had a year and a half of college education before dropping out **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: None stated
Discharge
Client goals for treatment: The client will get back on the medications prescribed for him
Where will client go when discharged? The client will leave and go stay at a group home

Outpatient Resources (15 points)

Resource	Rationale
1. Group Home- Mental Health Center, Champaign Il	**1.** The client reported that they will be living in a group home once they are released. This will be beneficial for the client because they will no longer have to be homeless, which could help relieve some anxiety.
2. Ken Powell Therapy	**2.** The client could use therapy to their benefit by talking through their anxiety and depression to help with their daily living.
3. The client's wife	**3.** Although the client and his wife are separated she is still his main support system. She still checks up on him everyday so the client may be able to have her help him with some of his mental health problems.

Current Medications (10 points)

Complete all of your client's psychiatric medications

Client Only Has Four Medications

Brand/Generic	Aripiprazole (Abilify)	Fluoxetine (Prozac)	Habitrol (Nicotine Patch)	Calcium Carbonates (Tums)
Dose	5 mg	20 mg	21 mg	750 mg
Frequency	Daily	Daily	Daily	PRN/every 6 hours
Route	Oral	Oral	Transdermal	Oral
Classification	Antipsychotic	Antidepressant	Nicotine replacement therapy	Antacid

Mechanism of Action	May produce antipsychotic effects through partial agonist and antagonist actions.	Increases the amount of serotonin available in nerve synapses	Stimulate nicotinic receptors in the brain to stimulate release of dopamine	Increase levels of intracellular and extracellular calcium
Therapeutic Uses	To reduce delusion hallucinations	To treat acute depression	Treat nicotine withdrawal	Treat hyperphosphatemia
Therapeutic Range (if applicable)	10 – 30 mg/day	20-80 mg/day	N/A	350-1500 mg/day
Reason Client Taking	Depression	Depression	Nicotine withdrawal	GI upset
Contraindications (2)	Hypersensitivity to aripiprazole or its components, Diabetes.	Concurrent therapy with pimozide, hypersensitivity to fluoxetine	Uncontrolled hypertension, and skin conditions	Hypercalcemia, renal calculi
Side Effects/Adverse Reactions (2)	Homicidal ideation, CVA (elderly)	Suicidal ideation, restlessness	Withdrawal symptoms, and skin irritation	Hypotension, and nausea
Medication/Food Interactions	N/A	N/A	N/A	N/A
Nursing Considerations (2)	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	Monitor patient for depression and suicidal tendencies while on fluoxetine. Caution against stopping fluoxetine abruptly because serious side effects can occur.	Remove previous patch before applying a new one. Monitor skin for irritation.	Monitor serum calcium levels. Tell patient to avoid excessive use of tobacco or alcohol.

	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, seemed tired but was still engaged. Bigger in build Positive attitude. Normal and fluent 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, or compulsions. The client did however state that he has a fear of dying at any given moment.
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. Calculations not assessed. Client seemed to be very intellectual. Not assessed. Normal impulse control.
INSIGHT:	Insight was observed to be average.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Normal gate. Client wears glasses. 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
11:30 am	110	125/99	18	98.7	99%
Unable to assess					

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:30 am	numeric	-	0 - 10	-	-
Unable to assess					

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100% **Lunch:** 100% **Dinner:** Unable to assess	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 240 mL **Lunch:** 730 mL **Dinner:** Unable to assess

Discharge Planning (4 points)

Discharge Plans (Yours for the client): The client will go stay at a group home in the area instead of being homeless. The client will also get back on his medications for depression and anxiety. The client will also start to go see a therapist to help with his thoughts of suicide. He

will also either keep a journal to keep his daily thoughts and activities in as well to see how his mental state improves over time.

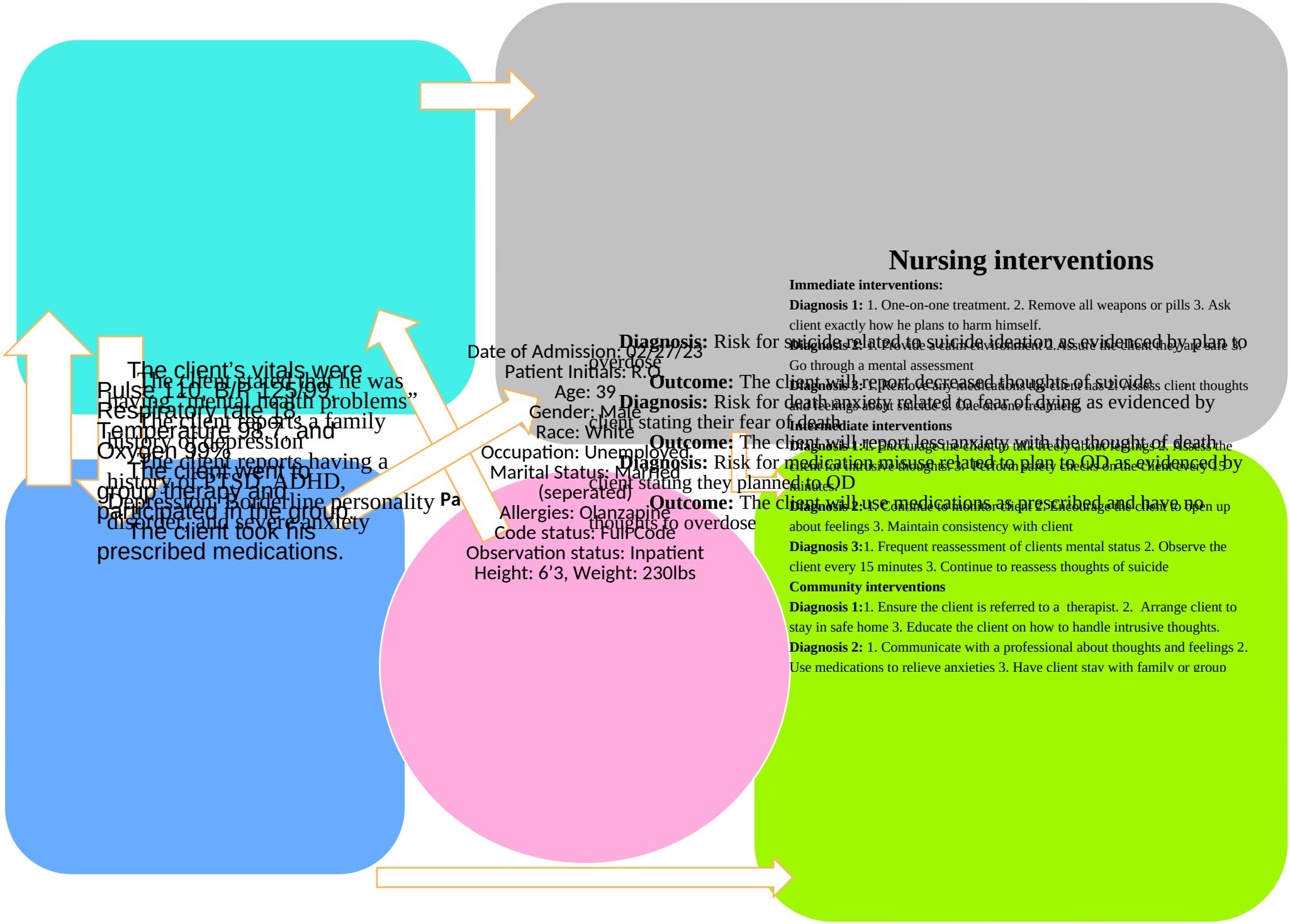
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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 suicide related to suicide ideation as evidenced by plan to overdose	The client states that he was having suicidal thoughts and planned to overdose.	1. One-on-one treatment. 2. Remove all weapons or pills 3. Ask client exactly how he plans to harm himself.	1. Encourage the client to talk freely about feelings 2. Assess the client for intrusive thoughts. 3. Perform safety checks on the client every 15 minutes.	1. Ensure the client is referred to a therapist. 2. Arrange client to stay in safe home 3. Educate the client on how to handle intrusive thoughts.
2. Risk for death anxiety related to fear of dying as evidenced by client stating their fear of death	The client stated that they fear that they could die at any given moment	1. Provide a calm environment 2.Assure the client they are safe 3. Go through a mental	1. Continue to monitor client 2. Encourage the client to open up about feelings 3. Maintain consistency with client	1. Communicate with a professional about thoughts and feelings 2. Use medications to relieve

		assessment		anxieties 3. Have client stay with family or group home
3. Risk for medication misuse related to plan to OD as evidenced by client stating they planned to OD	Client stated that they planned to commit suicide by overdosing on medications	1. Remove any medications the client has 2. Assess client thoughts and feelings about suicide 3. One on one treatment	1. Frequent reassessment of clients mental status 2. Observe the client every 15 minutes 3. Continue to reassess thoughts of suicide	1. Get the client involved in a self-help association. 2. Use a journal to document daily thoughts 3. Communicate with professional about thoughts and feelings

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

Concept Map (20 Points): Attached


The client's vitals were Pulse 110, B/P 125/99, Respiratory rate 18, Temperature 98.7, and Oxygen 99%
The client stated that he was having mental health problems"
The client reports a family history of depression
The client reports having a history of PTSD, ADHD, Depression, Borderline personality disorder, and severe anxiety
The client went to group therapy and participated in the group.
The client took his prescribed medications.
Pa
Date of Admission: 02/27/23
Patient Initials: R.O
Age: 39
Gender: Male
Race: White
Occupation: Unemployed
Marital Status: Married (seperated)
Allergies: Olanzapine
Code status: FullCode
Observation status: Inpatient
Height: 6'3, Weight: 230lbs
Diagnosis: Risk for suicide related to suicide ideation as evidenced by plan to overdose
Outcome: The client will report decreased thoughts of suicide
Diagnosis: Risk for death anxiety related to fear of dying as evidenced by client stating their fear of death.
Outcome: The client will report less anxiety with the thought of death
Diagnosis: Risk for medication misuse related to plan to OD as evidenced by client stating they planned to OD
Outcome: The client will use medications as prescribed and have no thoughts to overdose
Nursing interventions
Immediate interventions:
Diagnosis 1: 1. One-on-one treatment. 2. Remove all weapons or pills 3. Ask client exactly how he plans to harm himself.
Diagnosis 2: 1. Provide a calm environment 2. Assure the client they are safe 3. Go through a mental assessment
Diagnosis 3: 1. Remove any medications the client has 2. Assess client thoughts and feelings about suicide 3. One on one treatment
Intermediate interventions
Diagnosis 1: 1. Encourage the client to talk freely about feelings 2. Assess the client for intrusive thoughts 3. Perform safety checks on the client every 15 minutes.
Diagnosis 2: 1. Continue to monitor client 2. Encourage the client to open up about feelings 3. Maintain consistency with client
Diagnosis 3:1. Frequent reassessment of clients mental status 2. Observe the client every 15 minutes 3. Continue to reassess thoughts of suicide
Community interventions
Diagnosis 1:1. Ensure the client is referred to a therapist. 2. Arrange client to stay in safe home 3. Educate the client on how to handle intrusive thoughts.
Diagnosis 2: 1. Communicate with a professional about thoughts and feelings 2. Use medications to relieve anxieties 3. Have client stay with family or group