N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 4/4/2023	**Patient Initials** AJ	**Age** 45	**Gender** Male
Race/Ethnicity African American	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Shellfish & Shrimp
Code Status Full	**Observation Status** Every 15 minutes	**Height** 5 feet 7 inches	**Weight** 185 lbs.

Medical History (5 Points)

Past Medical History: Asthma and Hypertension.

Significant Psychiatric History: The patient consulted a psychiatrist in the past, was hospitalized, and received outpatient treatment. He reported a history of suicide attempts and was treated with medication.

Family History: Noncontributory to psychiatric problems.

Social History (tobacco/alcohol/drugs): Smokes cigarettes and marijuana and uses cocaine.

Living Situation: Homeless

Strengths: The patient is highly motivated to participate in treatment. He reported a history of good responses to medication in the past.

Support System: The patient has no support system.

Admission Assessment

Chief Complaint (2 points): “I tried to commit suicide.”

Contributing Factors (10 points): Forty-five years old male is diagnosed with Bipolar type 1. He was born and raised in Peoria, IL, but lives in Colorado. The patient returned to Illinois in December to see his son for the holidays and his birthday in April. Recently the patient has been homeless and sleeping on public sidewalks or bus stations. He has severe anxiety and depression that have worsened since his mother's passing. The patient's father is still alive and has one

brother. The patient does not have support from his family. The patient has suicidal ideation and admits to auditory hallucinations that he described as voices commanding him to kill himself. The patient has had three suicide attempts since February 3rd, 2023. Each suicide attempt was overdosing on an over-the-counter prescription.

Factors that lead to admission: Suicide attempt. The patient overdosed on Tylenol, Advil, and Aleve.

History of suicide attempts: yes, three suicide attempts.

Primary Diagnosis on Admission (2 points): bipolar disorder type 1, a most recent episode, depression.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient reports no life experience or history of trauma. **Witness of trauma/abuse:** The patient reports no witness of trauma/abuse.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person**	**Describe**

			with trauma)	
Physical Abuse	No	N/A	No	N/A
Sexual Abuse	No	N/A	No	N/A
Emotional Abuse	No	N/A	No	N/A
Neglect	No	N/A	No	N/A
Exploitation	No	N/A	No	N/A
Crime	No	PT denies the age.	No	PT reported he as a criminal recorded of attempt murder and murder.
Military	No	N/A	No	N/A
Natural Disaster	No	N/A	No	N/A
Loss	No	Pt loss his mother at the age 42.	No	The pt. states, "He is having a hard time dealing with the loss of his mother."
Other	No	N/A	No	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Pt. states, "I have depression but today has been good."	

Loss of energy or interest in activities/school	**Yes**	**No**	N/A
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
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**	Pt states, "Most nights I roll over constantly until I'm able to fall asleep."
Frequently awakening during night	**Yes**	**No**	Pt. states, "I wake up couple hours after I fell asleep roll over side to side again. I get about 3-4 of sleep."
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. states, "I have severe anxiety."
Panic attacks	**Yes**	**No**	N/A
Obsessive/compulsive thoughts	**Yes**	**No**	N/A
Obsessive/compulsive behaviors	**Yes**	**No**	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	N/A
Rating Scale			
How would you rate your depression on a scale of 1-10?			3
How would you rate your anxiety on a scale of 1-10?			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**	The patient has a daughter who is 25 years old and a son who is turns 1 in three days. Pt. states, "not seeing his son often causes stress on him."

Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	N/A
Financial	**Yes**	**No**	N/A
Other	**Yes**	**No**	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
2/17/2023	**Inpatient** **Outpatient** **Other:** Kindred	Inpatient	Suicide attempts	**No improvement** **Some improvement** **Significant improvement**
2/3/2023	**Inpatient** **Outpatient** **Other:** OSF HMMC	Inpatient	Suicide attempts	**No improvement** **Some improvement** **Significant improvement**
2/28/2023	**Inpatient** **Outpatient** **Other:** OSF SEMC	Inpatient	Suicide attempts	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**

N/A (pt. is homeless)			**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**

If yes to any substance use, explain: N/A

Children (age and gender): Daughter 25 and Son 1.

Who are children with now? The pt. daughter lives on her own and the son lives with his mother.

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

Current relationship problems: None.

Number of marriages: None.

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

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

Ethnic/cultural factors/traditions/current activity: None.

Describe:

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Pt. states, "I have a criminal recorded for attempted murder and murder."

How can your family/support system participate in your treatment and care? None.

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness: Patient states no.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient reports no known family history of mental health.
History of Substance Use: marijuana and cocaine.
Education History: **Grade school** **High school** Patient reports some levels of High School but dropped out. **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Dropped out of High School.
Discharge
Client goals for treatment: Reduce severity and intensity of mood swings. Prevent episode of mania and depression.

Where will client go when discharged? Patient doesn't have a place to go once discharged.

Outpatient Resources (15 points)

Resource	Rationale
1. American Counseling Association. Please contact the Suicide Prevention Hotline at 800-273-TALK or 800-273-8255.	**1.** This community resources/group therapy. The patient can receive treatment for anxiety, depression, etc.
2. 988 Suicide & Crisis Lifeline: You can call 1-800-273-8255, or text or call 988. You also can contact them through the website.	**2.** Prevention of suicide. This is the hotline number.
3. The Salvation Army of Champaign County, 217-373-7825.	**3.** It offers shelters for the homeless as well as supportive services to those in need.

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/Generic	**Divalproex sodium**	**Docusate sodium**	**Lurasidone**	**Acetaminophen**	**Calcium carbonate**
Dose	500 mg	100 mg	60 mg	325 mg	750 mg
Frequency	BID	HS	HS	Q6H	Q6H
Route	Oral	Oral	Oral	Oral	Oral

Classification	Pharmacologic class: Anticonvulsants	Pharmacologic class: Surfactant Therapeutic class: Laxative stool softener	Pharmacologic class: atypical antipsychotic Therapeutic class: Antipsychotic	Pharmacologic class: Nonsalicylate, paraminophenol derivative Therapeutic class: Antipyretic, nonopioid analgesic	Pharmacological class: Calcium salts Therapeutic class: Antacid, antihypermagnesemic, antihyperphosphatemic, antihypocalcemic.
Mechanism of Action	Stable coordination compound comprised of sodium valproate and valproic acid used to treat manic episodes associated with bipolar disorder, epilepsy, and migraine headaches.	Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces. This action lets more fluid penetrate stool, forming a softer fecal mass.	Possibly mediated through a combination of central dopamine type 2 and serotonin type 2 receptor antagonism to suppress psychotic symptoms.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal system.
Therapeutic Uses	Mood Stabilizer	Laxative, stool softener	Mood Stabilizer	Pain	Provide antacid effects
Therapeutic Range (if applicable)	Mania: 50-125 mcg/mL total.	50 to 400 mg in 1 to 4 divided doses.	160 mg once daily	Do not exceed 3,250 mg in 24 hours.	1,000 to 1,200 mg daily.
Reason Client Taking	The patient is taking this drug for Bipolar type 1.	The patient is taking it for constipation.	The patient is taking it for Bipolar type 1.	The patient is taking this drug to relieve mild to moderate pain.	The patient is taking this drug for GI upset.
Contraindications (2)	1. Liver disease, significant hepatic impairment.	Concomitant use with mineral oil,	Concurrent therapy with strong CYP3A4	Hypersensitivity to acetaminophen or its	Cardiac resuscitation with risk of existing

	2. Hypersensitivity.	fecal impaction. Hypersensitivity to docusate salts or their components.	inducers such as avasimibe, carbamazepine, phenytoin, rifampin, or St. John's wort. Hypersensitivity to lurasidone or its components.	components, severe hepatic impairment, severe active liver disease.	digitalis toxicity or presence of ventricular fibrillation, concurrent use of calcium supplements, hypercalcemia, hypersensitivity to calcium salts or their components.
Side Effects/Adverse Reactions (2)	1. Nausea 2. Vision changes 3. Tremor	Dizziness, syncope Palpitations Abdominal cramps and distention	Neuroleptic malignant syndrome Seizures Suicidal ideation	Hypotension Anaphylaxis Hepatotoxicity	Hypotension Hypercalcemia
Medication/Food Interactions	Sever interactions of divalproex sodium include doripenem, ertapenem, imipenem/cilastatin, and meropenem.	Mineral oil: Increased mineral oil absorption, increased risk of toxicity.	Administer drugs with a meal consisting of at least 350 calories.	Anticholinergics: Decreased onset of acetaminophen action. Propranolol: Possibly increased action of acetaminophen.	Caffeine, high-fiber food: Possibly decreased calcium absorption. Vitamin D (high dose): Excessively increased calcium absorption.
Nursing Considerations (2)	Monitor liver function tests. Administered Depakote ER once daily using a dose 8-20% higher than the total daily.	Expect excessive or long-term use of docusate to cause dependence on laxatives for bowel movements, electrolyte imbalance,	Be aware that lurasidone should not be used to treat dementia-related psychosis in the elderly. Monitor patient closely	Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease. Monitor renal function in	Store at room temperature, and protect from heat, moisture, and direct light. Monitor serum calcium level.

		and vitamin and mineral deficiencies. Assess for laxative abuse syndrome, especially in women with anorexia nervosa.	for neuroleptic malignant syndrome, seizure, and tardive dyskinesia throughout therapy.	patient on long term therapy.	

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

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2011). 2011 Nurse's drug handbook. Jones & Bartlett Learning.

Divalproex sodium. (n.d.). RxList. Retrieved April 13, 2023, from https://www.rxlist.com/consumer_divalproex_sodium_depakote/drugs-condition.htm

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Alert and cooperative** **Inappropriate** **Normal** **Normal** **Soft & normal** **Open & Honest** **Anxious, depressed.** **Flat, sad**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 **Suicidal** **N/A** **N/A** **N/A** **N/A** **N/A**
ORIENTATION: **Sensorium:** **Thought Content:**	 **A&Q x 4** **Average**

MEMORY: **Remote:**	**Short- and long-term memory was intact.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 **Poor** **Poor** **Poor** **Intact** **Pool**
INSIGHT:	**Poor**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 **N/A** **Good posture** **Good muscle tone** **Good strength** **Motor movements intact**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1037	63	139/96	20	97.4 F	95%
1604	78	140/80	18	97.4 F	98%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1050	0-10	N/A	Pt. denies pain during this time.	N/A	N/A
1615	0-10	N/A	Pt. denies pain during this time.	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** Eggs, apple slices, and sausage. **Lunch:** Gyro sandwich, rice, and broccoli. **Dinner:** N/A	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 20 mL juice and 60 mL water **Lunch:** 40 mL power-aide **Dinner:** N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Reduce the severity and intensity of suicidal thoughts. Prevent suicide attempts and self-harming behavior. The unit staff should monitor his behavior up until discharge. Have the patient participate in group activities and individual case management. Offer information about the Salvation Army of Champaign County to help the patient not be homeless. Come up with a medication regimen that works best for the patient.

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 injury related to mania and auditory hallucinations, as evidenced by voices commanding him to kill himself.	This diagnosis was given because the patient admits to auditory hallucinations describing voices to harm himself.	1. Maintain a safe environment with minimal stimulation. 2. Get a complete initial psychological evaluation. 3. Monitor the client every 15 minutes.	1. Regularly assess the client for safety. 2. Teach client about his disorder and medications and review information to promote understanding. 3. Monitor medication administration closely for adherence.	1. Review post-discharge plans with the client, family, and others. 2. Discuss the need to commit to follow-up care and to keep scheduled appointments with the client. 3. Client demonstrates adherence with medication schedule.
2. Disturbed sleep pattern related to lifestyle disruptions of being homeless as evidence by reports of difficulty falling and remaining asleep.	This diagnose was given to the patient because he reported he is having problems falling asleep and staying asleep. The patient is getting 3-4 hours each night.	1. Assess the patient physical health upon arriving. 2. Creating a treatment plan that the client agrees with for improving sleep patterns. 3. Monitor the patient caffeine intake.	1. The nurse will provide a dark, quiet, and comfortable atmosphere for the patient to sleep in. 2.The nurse will assess the patients sleeping pattern and help him develop a sleeping plan. 3. The nurse will discourage caffeine or large meal	1. The nurse will educate the patient on side effects of taking sleep aid prior to discharge. 2. The patient will verbalize techniques how to fall asleep and stay asleep. 3. The patient will verbalize how and

			intake 2 hours before bedtime.	when to take a sleep aid and how they are not to be used on an everyday basis.
3. Risk for suicide related to grief as evidence by loss his mother.	The patient was giving this diagnose because he has three attempts of suicide when grieving his mother.	1. The nurse will make sure the patient is not left alone at any time during the hospitalization. 2. The nurse will remove all items that the patient can use to cause self-harm. 3. The nurse will place the patient near the nurse's station.	1. The nurse will encourage and listen to the patient about the reasons why the patient wants to harm himself. 2. The nurse will educate the patient on three techniques on developing coping skills to help the patient handle stressful situations. 3. The nurse will educate the patient on 3 techniques on developing coping skills to help the patient handle grief.	1. Patient will verbalize how and when to use the 24-hour emergency hot-line. 2. Patient will assist in identifying thoughts, feelings, and behavior that leads up to wanting to commit suicide. 3. Provide the patient with information to the suicide hotline number 988.

Other References (APA):

Philips, L (2020) Sparks & Taylor's Nursing Diagnosis Reference Manual (11th ed.) Wolters Kluwer Medical.

Concept Map (20 Points):

Subjective Data

The patient is diagnosed with bipolar disorder type 1, most recent episode depressed. The pt. was admitted for trying to attempt suicide. The patient admits to auditory hallucinations that he described as voices commanding him to kill himself. He has no support system from his family and his mother pasted aways.

Nursing Diagnosis/Outcomes

Risk for injury related to mania and auditory hallucinations, as evidenced by voices commanding.

Disturbed sleep pattern related to lifestyle disruptions of being homeless as evidence by reports of difficulty falling and remaining sleep.

Risk for suicide related to grief as evidence by loss his mother.

Objective Data

Pulse 63
B/P 139/96
Resp Rate 20
Temp 97.4 F
Oxygen 95%

Patient Information

45 years old
Male
African American
Homeless
Unemployed
Single
Allergic to shellfish and shrimp
185 lbs.
5 feet 7 inches

Nursing Interventions

1. Maintain a quiet environment with minimal stimulation.
2. Get a complete initial psychological evaluation.
3. Monitor the client every 15 minutes.
4. Assess the patient physical health upon arriving.
5. Creating a treatment plan that the client agrees with for improving sleep patterns.
6. The nurse will make sure the patient is not left alone at any time during the hospitalization.
7. The nurse will remove all items that the patient can use to cause self-harm.
8. The nurse will place the patient near the nurse's station.