

N323 Care Plan
Lakeview College of Nursing
Whitney Simlin

Demographics (3 points)

Date of Admission 4/13/23	Patient Initials C.D.	Age 28	Gender Female
Race/Ethnicity Caucasian	Occupation Stage Manager	Marital Status Married	Allergies N/A
Code Status Full	Observation Status Inpatient- 5-day hold	Height 5'4"	Weight 140 lb.

Medical History (5 Points)

Past Medical History: The patient indicated that she has bipolar II, PTSD, and anxiety.

Significant Psychiatric History: Patient was admitted to Chicago Northwestern in May of 2022 for a suicide attempt.

Family History: Substance abuse- Father

Social History (tobacco/alcohol/drugs): Patient uses cannabis daily(smokes at least 4 joints daily) and consumes alcohol a few times a week(approx.. 6 drinks).

Living Situation: Patient lives with husband.

Strengths: Patient is good at her job and is funny.

Support System: Patient has support from her spouse and brother.

Admission Assessment

Chief Complaint (2 points): Patient had a dissociative episode.

Contributing Factors (10 points): The patient struggles daily with anxiety, PTSD, and bipolar. The patient thought everyone would be better off without her here. On the day of admission, she was found by her husband in the shower with the water running. She had taken all of her prescribed meds. She was rushed to the Emergency Room and received care at Carle hospital.

Factors that lead to admission: Acute mania- suicidal attempt

History of suicide attempts: The patient has one previous suicide attempt that resulted in hospitalization in May of 2022.

Primary Diagnosis on Admission (2 points): Suicidal attempt

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: -				
Witness of trauma/abuse: yes				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	N/A	N/A	N/A	N/A
Sexual Abuse	No	Yes, age 4-10	N/A	Patient was sexually abused by her cousin as a child.
Emotional Abuse	No	No	No	N/A
Neglect	No	No	No	N/A
Exploitation	No	No	No	N/A

Crime	No	No	No	N/A
Military	No	No	No	N/A
Natural Disaster	No	No	No	N/A
Loss	No	Yes, 5- grandfather	No	Patient lost her grandfather at the age of 5.
Other	No	No	No	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No		
Loss of energy or interest in activities/school	Yes	No	Patient says she, at most, has one good day per week	
Deterioration in hygiene and/or grooming	Yes	No		
Social withdrawal or isolation	Yes	No	Patient feels being alone causes less problems.	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	Patient indicated that she has no desire to work most days.	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Change in numbers of hours/night	Yes	No		
Difficulty falling asleep	Yes	No		
Frequently awakening during night	Yes	No		

Early morning awakenings	Yes	No	
Nightmares/dreams	Yes	No	
Other	Yes	No	
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	
Binge eating and/or purging	Yes	No	
Unexplained weight loss? Amount of weight change:	Yes	No	
Use of laxatives or excessive exercise	Yes	No	Patient uses laxatives frequently to control weight
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	
Panic attacks	Yes	No	
Obsessive/compulsive thoughts	Yes	No	
Obsessive/compulsive behaviors	Yes	No	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	
Rating Scale			
How would you rate your depression on a scale of 1-10?		Patient indicated her depression was an 1-2 out of 10.	
How would you rate your anxiety on a scale of 1-10?		Patient indicated that her anxiety was a 9 out of 10.	

		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		
School	Yes	No	N/A	
Family	Yes	No		
Legal	Yes	No		
Social	Yes	No	Patient has severe social anxiety	
Financial	Yes	No		
Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
May '22	Inpatient Outpatient Other:	Chicago Northwestern	Attempted suicide	No improvement Some improvement Significant improvement
April '23	Inpatient Outpatient Other:	The Pavilion	suicide	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?	
J.D.	35	Spouse	Yes	No
			Yes	No
If yes to any substance use, explain:				
Children (age and gender): N/A				
Who are children with now?				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: N/A				
Number of marriages: 1				
Sexual Orientation:	Is client sexually active?		Does client practice safe sex?	
	Yes No		Yes No	
Please describe your religious values, beliefs, spirituality and/or preference: Atheist				
Ethnic/cultural factors/traditions/current activity: N/A				
Describe:				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A				

<p>How can your family/support system participate in your treatment and care?</p> <p>Couples counseling w/ spouse, open and honest communication w/ spouse and brother</p>
<p>Client raised by:</p> <p>Natural parents Grandparents Adoptive parents Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness:</p> <p>Patient was sexually abused several times at an early age and is triggered often by smells and voices</p>
<p>Atmosphere of childhood home:</p> <p>Loving Comfortable Chaotic Abusive Supportive Other:</p>
<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.):</p> <p>Father- functioning alcoholic</p>
<p>History of Substance Use: Alcohol</p>
<p>Education History:</p> <p>Grade school High school College- College graduate Other:</p>

<p>Reading Skills:</p> <p>Yes</p> <p>No</p> <p>Limited</p>
<p>Primary Language: English/ Some sign language</p>
<p>Problems in school: Patient indicated she almost failed high school but ended graduating with class.</p>
<p>Discharge</p>
<p>Client goals for treatment: Patient would like to get a medication regimen that works for her.</p>
<p>Where will client go when discharged?</p> <p>Patient will be going back home with her husband.</p>

Outpatient Resources (15 points)

Resource	Rationale
<p>1) Carle Addiction Recovery Center 1813 W Kirby Ave Champaign, IL 61821</p>	<p>1. Carle Addiction Recovery provides substance abuse counseling. They provide sessions for individuals and families.</p>
<p>2) AA, 217-373-3200 8 Henson Place Champaign, IL 61821</p>	<p>2. The patient identifies as an alcoholic. AA (Alcoholic Anonymous) offers a 12-step spiritual program that helps alcoholics recover.</p>
<p>3) Rosecrance, http://rosecrance.org, 888-928-0010</p>	<p>3. Rosecrance on Moreland in Champaign is a company here in town that strives to</p>

	<p>meet the needs of those struggling with addiction by providing treatment in a welcoming environment.</p>
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Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Prozac (fluoxetine)	Catapres (clonidine)				
Dose	25 mg	.2 mg				
Frequency	Once daily	Once daily				
Route	PO	PO				
Classification	Antipsychotic	Anxiolytic				
Mechanism of Action	Aceves effect by antagonizing dopamine and serotonin receptors.	Competes with histamines for the receptor to suppress histaminic activity.				
Therapeutic Uses	Antipsychotic	Anxiety				
Therapeutic Range (if applicable)	Maintenance 10mg daily after adjustment.	N/A				
Reason Client Taking	Antipsychotic	Anxiety				
Contraindications (2)	Bone marrow depression Coronary artery disease	Breastfeeding Prolonged QT				

Side Effects/Adverse Reactions (2)	Abnormal gate Euphoria	Drowsiness Hallucinations				
Medication/Food Interactions	N/A	N/A				
Nursing Considerations (2)	Use caution with clients with hepatic impairment. Clients may develop hypertension.	Use caution for clients with history of prolonged QT. Monitor if client takes other CNS depressants.				

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Therapeutic Uses					
Therapeutic Range (if applicable)					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					

Medication/Food Interactions					
Nursing Considerations (2)					

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). 2020 Nurse's drug handbook (19th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:</p>	<p>Alert and oriented x 4. Patient is friendly, cooperative, maintains appropriate eye contact, appropriate height, and weight. Patient clothing is appropriate for the setting. Patient appears clean, neat, and tidy. Patient has no body odor present. Patient’s attitude is open and pleasant. Patient’s speech is clear and normal liveliness and offers information. Patient’s mood was calm. Patient’s affect is appropriate to situation, normal and constricted.</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:</p>	<p>Patient denies hallucinations, paranoid, delusion, illusions. Patient’s thought process is good, relevant to the topic being discussed, and is coherent, and logical. Patient denies delusions or ideations. Patient admits to obsession and compulsive behaviors. Patient denies having phobias. Patient denies having suicidal and homicidal and agrees to remain safe. Patient did not express delusional content.</p>
<p>ORIENTATION: Sensorium: Thought Content:</p>	<p>.Patient is oriented to time, place, person, and situation. Patients’ sensorium is normal.</p>
<p>MEMORY: Remote:</p>	<p>.Patient’s remote memory is bad and she struggles to provide details about some events from childhood.</p>
<p>REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:</p>	<p>Patient’s judgement is good. Patient was able to come to appropriate conclusions and realistic decisions. Patient’s impulse control is good. Patient was attentive and adequately focused.</p>

INSIGHT:	The patient has good insight.
GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	Patient denies use of assistive devices. Patient is independent and requires no assistance. Patient demonstrated active range of motion bilaterally throughout. Patient has a low fall risk score. Patient maintains good balance independently. Patient tolerated ambulation well and showed no signs of difficult breathing. Patient needed no cueing and set up assistance. Patient's general motor response was normal. Patient's hand grips and pedal pushes were strong and +2 bilaterally.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0930	70	117/78	18	98.6 F Oral	98% Room air
1400	75	120/75	20	98.7 F Oral	99% Room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0-10	none	none	none	none
1400	0-10	none	none	none	none

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)

<p>Breakfast: 0%</p> <p>Lunch: 100%</p> <p>Dinner: N/A</p>	<p>Breakfast: 480 mL</p> <p>Lunch: 480 mL</p> <p>Dinner: N/A</p>
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Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The client is to be discharged home to her husband and will seek further medical treatment in Champaign. She has agreed that seeking further alcohol rehabilitation is a good idea. It’s in the best interest of the client to seek further treatment due to continued attempts of suicide and alcohol abuse.

- 1. Equip the patient with the following outpatient resources listed above.**
- 2. Follow up with psychiatrist.**
- 3. Attend a therapy session at least once a week to help develop effective coping skills.**

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Immediate Interventions (At admission)	Intermediate Interventions (During hospitalization)	Community Interventions (Prior to discharge)
<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 			

<p>1. Risk for self-harm related to mania as evidenced by suicidal attempts.</p>	<p>Suicidal attempts should always be taken seriously.</p>	<p>1. Lock personal items up 2. Encourage patient to attend group counseling. 3. Monitor patient every 15 minutes</p>	<p>1. Monitor patient every 15 minutes 2. Encourage patient to attend group therapy 3. Follow medication regimen closely</p>	<p>1. Set up outpatient appointment with psychiatrist. 2. Continue access to anxiolytic and antipsychotic medications. 3. Have patient meet for group therapy</p>
<p>2. Anxiety/ Fear related to feeling of hopelessness as evidenced by alcohol use and dependence</p>	<p>Alcohol abuse can cause severe anxiety and trigger fear.</p>	<p>1. Monitor and document seizure activity. Maintain patent airway. Provide environmental safety (padded side rails, bed in low position). 2. Check deep-tendon reflexes. Assess gait, if possible. 3. Assist with ambulation and self-care activities as needed.</p>	<p>1. Continue to monitor gait and assess as needed. 2. Assess patient with CIWA protocol. 3. Follow medication regimen closely</p>	<p>1. Set patient up with counselor to discuss and monitor alcohol cessation. 2. Set patient up with sponsor and meetings for Alcoholics Anonymous 3. Continue access to medications through patient insurance</p>
<p>3. Ineffective individual coping related to learned response patterns as</p>	<p>Patient needs to adopt new coping mechanism to reduce anxiety</p>	<p>1. Search patient and have patient place all personal belongings in a lock environment. 2. Encourage patient to speak with counselor</p>	<p>1. Provide counseling relating to drug use. 2. Begin medication</p>	<p>1. Educate patient on smoking cessation. 2. Continue monitoring</p>

evidenced by marijuana usage	other than smoking marijuana.	regarding stress. 3. Assist patient to create a smoking cessation plan to help her quit with an achievable quit date goal.	regimen. 3. Develop a trusting relationship with patient and encourage transparency.	patient and checking in that she is continuing medication regimen for smoking cessation. 3. Educate patient on stress management
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Other References (APA):

Phelps, L. L., Ralph, S. S., & Taylor, C. M. (2017). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (10th ed.). Wolters Kluwer.

Concept Map (20 Points):

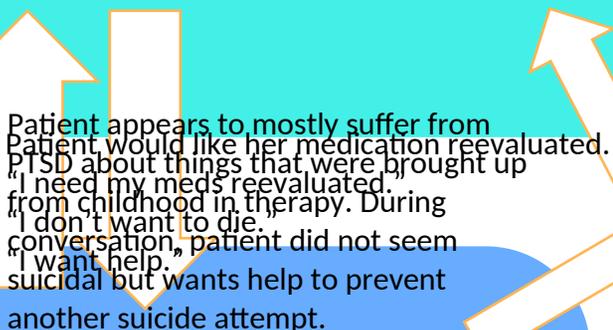
Subjective Data



Nursing Diagnosis/Outcomes

Patient appears to mostly suffer from PTSD about things that were brought up from childhood in therapy. During conversation, patient did not seem suicidal but wants help to prevent another suicide attempt.

Objective Data



The patient is a 28-year-old Caucasian female that was admitted on 4/13/2023 to The Pavilion in Champaign, IL. The patient currently lives with husband. The patient has had one pervious suicide attempt in May of 2022 that resulted in hospitalization.

1. Risk for self-harm related to mania as evidenced by past attempts of suicide.
--Patient will utilize support system and resources provided to prevent another suicide attempt.

2. Anxiety and fear related to feeling of hopelessness as evidenced by alcohol use and dependence.
1. Have client evaluated for depression.
2. Encourage client to seek therapy.

3. Ineffective Individual coping related to learned response patterns as evidenced by smoking marijuana.
1. Nursing Interventions
2. Patient will take medications as prescribed.
3. Identify community resources for the patient to be able to use.

--Patient will attend group therapy weekly to discuss other ways to cope.



