N323 Care Plan

Lakeview College of Nursing

Opeoluwa Babatunde

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/21/2023	TB	29	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Fedex Worker	Single	Poison Ivy Extract
Code Status	**Observation Status**	**Height**	**Weight**
Full	Inpatient, Rounds, Every 15 minutes	5'6	117 lbs

Medical History (5 Points)

Past Medical History: N/A

Significant Psychiatric History: Suicidal Ideations before recent admission, Past Diagnosis of bipolar disorder, Psychosis (October 2020) – jumped out of apartment window

Family History: No family history of mental health disorder

Social History (tobacco/alcohol/drugs): Smokes marijuana every day, vapes some days, drinks alcohol every night (1 pint)

Living Situation: Lives w/ his mother

Strengths: Patient is employed, has good social skills, in good physical health, has plans of furthering education

Support System: Support systems in place are poor, still lives w/ abusive mother; is able to talk to people at work for a little support

Admission Assessment

Chief Complaint (2 points): Alcohol Intoxication & Suicidal Ideations

Contributing Factors (10 points):

   Factors that lead to admission: Patient brought himself to the ER under the influence and stated that he needed help because he was having thoughts of harming himself. Patient doesn't have a good relationship with his mother, who he states is

emotionally and verbally abusive. Patient also recently lost his stepfather, whom he wanted to have a better relationship with. Patient was also sexually abused by his older brother at the age of 7. Patient struggles with alcohol and substance abuse, as we smokes marijuana and drinks about a pint of alcohol a day.

History of suicide attempts: Jumped out of apartment – October 2020

Primary Diagnosis on Admission (2 points): Alcohol intoxication & Suicidal Ideations

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No Witness of trauma/abuse: Yes				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**Denies**	**Denies**	**N/A**	**N/A**
Sexual Abuse	**Denies**	**Yes (Age 7)**	**N/A**	**Patient was reluctant to go into detail. Stated that he and his sister was sexually**

				abused by brother at age 7.
Emotional Abuse	**Yes**	**Yes (All throughout childhood)**	**N/A**	**Patient describes his mother as being very controlling and verbally abusive.**
Neglect	**Denies**	**Denies**	**N/A**	**N/A**
Exploitation	**Denies**	**Denies**	**N/A**	**N/A**
Crime	**Denies**	**21 years old**	**N/A**	**N/A**
Military	**Denies**	**Denies**	**N/A**	**Military denied him due to past DUI**
Natural Disaster	**Denies**	**Denies**	**N/A**	**N/A**
Loss	**Yes**	**N/A**	**N/A**	**Patient's step father recently passed away. Patient seems very said and apologetic. He states that he wishes he had a better relationship with his stepfather before he passed.**
Other	**N/A**	**N/A**	**N/A**	

Presenting Problems		
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**

Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)
Depressed or sad mood	**Yes**	No	**Patient has been feeling a little down every day since the death of his stepfather**
Loss of energy or interest in activities/school	Yes	**No**	**Patient denies**
Deterioration in hygiene and/or grooming	Yes	**No**	**Patient denies**
Social withdrawal or isolation	**Yes**	No	**Every day; Patient states that he naturally is a person that**

	Presenting?		Describe (frequency, intensity, duration, occurrence)
			likes to be alone and leaves people alone the same way he would want to be left alone.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**Patient states that he has difficulties at home w/ his mother, whom he states is verbally and emotionally abusive**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**Patient states that he has been able to sleep as much because of his job. He works overnight at FedEx.**
Difficulty falling asleep	**Yes**	**No**	**Patient states that he had difficulty falling asleep for the past 3 years.**
Frequently awakening during night	**Yes**	**No**	**Patient states that this happens "quite frequently"**
Early morning awakenings	**Yes**	**No**	**Patient reports that he usually wakes up early due to not being able to sleep much**
Nightmares/dreams	**Yes**	**No**	**Patient reports that he's been having night terrors for the past 7 years.**
Other	**Yes**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Patient reports a loss of appetite and that he has lost a good amount of weight recently**
Binge eating and/or purging	Yes	**No**	**Patient denies**
Unexplained weight loss? **Amount of weight change:**	Yes	**No**	**Patient denies**
Use of laxatives or excessive exercise	Yes	**No**	**N/A**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors	**Yes**	**No**	**Patient presenting w/**

(pacing, tremors, etc.)			**trembling/tremors.**
Panic attacks	**Yes**	No	**Patient states that he a has a few panic attacks over the past 2-3 moths**
Obsessive/compulsive thoughts	Yes	**No**	**Patient denies**
Obsessive/compulsive behaviors	Yes	**No**	**Patient denies**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	**No**	**Patient denies**
Rating Scale			
How would you rate your depression on a scale of 1-10?	**0**		
How would you rate your anxiety on a scale of 1-10?	**4**		
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**	**Patient denies**
School	**Yes**	**No**	**Patient denies**
Family	**Yes**	No	**Main stressor for patient in his home is his mother**
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	**N/A**
Financial	**Yes**	No	**Patient wants to save up money to get his own apartment**
Other	**Yes**	**No**	**N/A**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
October 2020	**Inpatient** Outpatient Other:	**Inpatient**	**Suicide attempt**	**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?**	
Rachel	**51**	**Mother**	**Yes**	No
N/A	**N/A**	**N/A**	Yes	No
N/A	**N/A**	**N/A**	Yes	No
N/A	**N/A**	**N/A**	Yes	No
N/A	**N/A**	**N/A**	Yes	No
If yes to any substance use, explain: **Patient's mother is an avid alcohol drinker**				

Children (age and gender): No children **Who are children with now?**
Household dysfunction, including separation/divorce/death/incarceration: Stepfather recently passed away; Patient has been arrested for a DUI, Patient and mother do not get along
Current relationship problems: N/A **Number of marriages:** 0

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

Please describe your religious values, beliefs, spirituality and/or preference: Patient believes that there is a "higher power" that is control of everything and everyone and that can be proven by just looking at the world and how everything has been created.
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): Patient has a past DUI and constantly argues with Mother.
How can your family/support system participate in your treatment and care? Patient states that he feels he can get most of his support from his friends at work. States that they have already started by giving him resources to help for the future

Client raised by:
 	
   Natural parents
   Grandparents
   Adoptive parents
   Foster parents
   Other (describe): Patient moved in w/ friends for a little while when younger

Significant childhood issues impacting current illness: Patient was taken into foster care when he was younger
Atmosphere of childhood home: Loving   Comfortable   Chaotic   Abusive   Supportive   Other: Patient states that it was "a little bit of everything".

Self-Care:
Independent Assisted Total Care

Family History of Mental Illness (diagnosis/suicide/relation/etc.) N/A

History of Substance Use: Patient is an avid marijuana smoker and alcohol drinker

Education History:
Grade school **High school** **College** **Other:**

Reading Skills:
Yes **No** **Limited**

Primary Language: English

Problems in school: N/A

Discharge
Client goals for treatment: Patient wants to return to work and save enough money to move out. Patient also wants to finally stop drinking
Where will client go when discharged? Patient plans on going back home. He was a couple dogs in the household he plans to take care of. Patient also has the option of going to live w a couple good friends

Outpatient Resources (15 points)

Resource	Rationale
1. Alcohol Anonymous	**1. Patient's goal is to stop drinking. This program focuses on the cessation of drinking habits**
2. Refer the patient to a therapist	**2. Patient doesn't realty have an outlet to talk to while living with his mother, who is one of the main aggravating factors of his strife**

3. Keri Powell Therapy	**3. This group focuses on a variety of mental health issues, including depression and addiction which are the two main problems the client is currently dealing with.**

Current Medications (10 points)

Brand/Generic	Abilify/ Aripiprazole	Diazepam/ Valium	Trazadone/ Desyrel	Lorazepam/ Ativan
Dose	5 mg	5 mg	50 mg	1 mg
Frequency	Daily	4x Daily	Nightly	Once
Route	Oral	Oral	Oral	Oral
Classification	Pharmacological: Atypical antipsychotic Therapeutic: Antipsychotic	Pharmacological: Benzodiazepine Therapeutic: Anticonvulsant, Anxiolytic, sedative-hypnotic, skeletal muscle relaxant	Pharmacological: Triazolopyridine derivative Therapeutic: Antidepressant	Pharmacological: Benzodiazepine Therapeutic: Anxiolytic
Mechanism of Action	May produce antipsychotic effects through partial agonist and antagonist actions. Aripiprazole acts as a partial agonist at dopamine receptors and serotonin receptors. The drug acts as an antagonist at 5-HT serotonin receptors.	May potentiate effects of GABA and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of CNS. GABA inhibits excitatory stimulation, which helps control emotional behavior. Limbic system contains a dense area of benzodiazepine receptors, which may explain drug's antianxiety effects. Diazepam suppresses spread of seizure activity caused by seizure-producing foci in cortex, limbic, and thalamus structures.	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect. Trazodone exerts an alpha-adrenergic blocking action and produces modest histamine blockade, causing a sedative effect. It also inhibits the vasopressor response to norepinephrine, which reduces blood pressure.	May potentiate effects of GABA and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of CNS. GABA inhibits excitatory stimulation, which helps control emotional behavior. Limbic system contains a dense area of benzodiazepine receptors, which may explain drug's antianxiety effects. Also, lorazepam hyperpolarizes neuronal vells, thereby interfering w/ their ability to generate seizures.
Therapeutic Uses	Used to treat acute schizrenia/treat depression in patients already taking an antidepressant	Used to relieve anxiety and treat symptoms of acute alcohol withdrawal	Used to treat major depression	Used to treat anxiety and insomnia caused by anxiety
Therapeutic Range (if applicable)	10-30 mgs/day	2-10 mgs 2-4 times a day	0.5-2.5 ug/mL	2-6 mg/day
Reason Client Taking	To help treat depression symptoms along with other antidepressants	To help with alcohol withdrawal	To help with depression symptoms	To help patient sleep

Complete all of your client's psychiatric medications

Medications Reference (1) (APA):

2023 Nurse's Drug Handbook. (2023). . Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Patient was well-groomed. He was a shorter man with a smaller, lean build. Patient was wearing the facility issued yellow scrubs. Patient had a good attitude for the most part. He seemed like he was in a growth period and was becoming enlightened on different areas of life. Patient was to himself for the most part.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:**	**Patient denies any ideations, delusions, illusions, obsessions, compulsions, or phobias currently.**

Phobias:	
ORIENTATION: **Sensorium:** **Thought Content:**	**Patient was AxOx4 with normal and logical thought content. Patient did have a tendency to ramble but was always able to stick to the point he wanted to make** **.**
MEMORY: **Remote:**	**.Short- and long-term memory was intact**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**The patient seems to have good judgement and appropriate level of calculations and intelligence. Patient's impulse control seemed fine**
INSIGHT:	**Insight appeared to be average.**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**Patient had a normal gait, walking with heels touching ground before front of feet. Patient did not use any assistive devices. Muscle tone, strength, and motor movement all seemed normal.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0659	**103**	**151/89**	**18**	**97.4**	**100%**
0945	**104**	**149/98**	**16**	**97.8**	**95%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** **N/A – Not filed** **Lunch:** **N/A – Not filed** **Dinner:** **N/A – Clinical day was over**	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** **N/A – Not filed** **Lunch:** **N/A – Not filed** **Dinner:** **N/A – Clinical day was over**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): **My discharge plans for the client include meeting with a therapist every other week to check in on the patient's mental health. This would allow the patient to have a healthy outlet to speak on his emotions rather than smoking and drinking every day. Patient will also go home w/ a prescription for psychotropic meds to help with mood instability. Patient will receive resources to go to alcohol cessation groups in order to help with the drinking.**

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 primary admission diagnosis as evidenced by PHQ score of 13**	**Patient came because he was having suicidal ideations when admitted to OSF.**	1. **Place patient on 1:1 watch** 2. **Safety Precautions** 3. **Remove items that the patient could use to harm**	1. **Round on the patient every 15 minutes** 2. **Assess patient for suicidal thoughts or ideations** 3. **Use clear,**	1. **Provide resources for the patient** 2. **Refer patient to a therapist** 3. **Encourage patient to**

		himself	concise, yet non-judgmental language when speaking to patient about suicide.	practice self care and self-help techniques.
2. Risk for seizures related to discontinuation of alcohol as evidenced by expression of distress and tremors of the body.	Throughout the assessment, patient was visibly shaking and was a bit jittery, which is consistent with normal alcohol withdrawal symptoms, which seizures are apart of	1. Seizure precautions 2. PRN medications 3. Place handles on the side of bed up and use seizure pads.	1. Round on the patient every 15 minutes 2. Administer medications 3. Observe patient after taking medications	1. Encourage patient to joint AA groups 2. Refer patient to a therapist 3. Prescribe anti-seizure medications
3. Risk for anticipatory grieving related to recent loss in the family as evidenced by patient's expressions of sadness.	During assessments, patient would get visibly teary-eyed when speaking about the recent loss of his stepfather.	1. Place patient on 1:1 watch 2. Console patient 3. Use therapeutic language when speaking to the patient	1. Encourage patient to go to group meetings 2. Encourage patient to shower and brush teeth daily 3. Teach patient healthy coping mechanisms	1. Refer patient to a therapist 2. Ensure that family understand patient's emotions and can be patient with him 3. Teach self-healing techniques

Other References (APA):

Phelps, L. L. (2020). Sparks and Taylor's Nursing Diagnosis Reference Manual (11th ed.).
Wolters Kluwer

Lerick, Vera, M., & Avila, G. J. (2023, August 15). *Grieving & Loss Nursing Care Plan and Management.* Nurseslabs. https://nurseslabs.com/grieving/

Concept Map (20 Points):

Subjective Data

- Patient stated that "cooking was one of his favorite pass times and enjoyed cooking for others".
- Patient self-reports sadness/being depressed
- Patient stated that he stayed at his mother's house to help "keep the peace".
- Patient feels like he is "slowly killing himself" by drinking so much

Nursing Diagnosis/Outcomes

1. Risk for suicide related to primary admission diagnosis as evidenced by PHQ score of 13
2. Risk for seizures related to discontinuation of alcohol as evidenced by expression of distress and tremors of the body.
3. Risk for anticipatory grieving related to recent loss in the family as evidenced by patient's expressions of sadness.

Outcomes: Patient has made steady improvement and seems to be doing well. Patient has had a retrospective attitude where he is thinking about past decisions and how he can improve on decision making in the future.

Objective Data

Vitals: Pulse – 104, B/P – 149/98, RR – 16, Temp – 97.8, O2 – 95%

- Throughout assessment, patient was visibly shaking
- Patient was slightly restless and would ramble but still land on the point he was trying to make
- Patient looked put together and not disheveled

Patient Information

On September 21st, 2023, 29-year-old patient "TB" was admitted to OSF HMMC for alcohol intoxication and suicidal ideated. Patient brought himself to the ER claiming that he needed help and wanted to get better.

Nursing Interventions

Diagnosis 1:
Round on the patient every 15 minutes
Assess patient for suicidal thoughts or ideations
Use clear, concise, yet non-judgmental language when speaking to patient about suicide.

Diagnosis 2:
Administer medications
Observe patient after taking medications

Diagnosis 3:
Encourage patient to go to group meetings
Encourage patient to shower and brush teeth daily
Teach patient healthy coping mechanisms