N323 Care Plan

Lakeview College of Nursing

Presley King

Demographics (3 points)

Date of Admission 10-20-2023	Patient Initials DZ	Age 18	Gender Male
Race/Ethnicity Asian	Occupation College Student	Marital Status Not married but in a relationship	Allergies No Allergies
Code Status Full	Observation Status Voluntary; Q15s Wellness Checks	Height 5'8"	Weight 165 lbs

Medical History (5 Points)

Past Medical History: The Patient had a slight fracture in his femur in 2021 from playing football.

Significant Psychiatric History: The patient has no prior psychiatric history. This is his first admission for suicidal ideation or anything mental health related. He has no other diagnosis.

Family History: The patient's mother has diabetes.

Social History (tobacco/alcohol/drugs): The patient reports that he just started drinking 2-3 times on the weekend. He denies using tobacco products. He smokes marijuana occasionally.

Living Situation: The patient attends U of I and lives in a dorm room on campus. Prior college, the patient lived with his parents.

Strengths: The patient reports that being athletic is one of his top strengths.

Support System: The patient's parents are very involved and are his support system, including his girlfriend.

Admission Assessment

Chief Complaint (2 points): The patient stated, " I was thinking about jumping off a parking garage."

Contributing Factors (10 points):

Factors that led to admission: The patient was brought into the hospital by police on October 20th due to suicidal ideation. He threatened to jump off a parking garage and called 988 for the suicidal hotline. The patient has been feeling severely down and depressed for 2-3 weeks but has had these feelings that have been constant since August when school started. He reports moderate depression started in 2018 when he moved with his parents and had to “start over” in a new city. The night prior, he had a fight with his girlfriend, pushing him to suicidal ideation. He has been anxious about school, too. He cut himself 10 days ago to help relieve his anxiety but stated that it did not help.

History of suicide attempts: The patient has no prior suicide attempts

Primary Diagnosis on Admission (2 points): Depression, Bipolar disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: The patient denied lifetime experience. **Witness of trauma/abuse the patient denied trauma or abuse.**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from**	**Describe**

			caring for another person with trauma)	
Physical Abuse	**Denies**	**N/A**	**N/A**	**N/A**
Sexual Abuse	**Denies**	**N/A**	**N/A**	**N/A**
Emotional Abuse	**Denies**	**N/A**	**N/A**	**N/A**
Neglect	**Denies**	**N/A**	**N/A**	**N/A**
Exploitation	**Denies**	**N/A**	**N/A**	**N/A**
Crime	**Denies**	**N/A**	**N/A**	**N/A**
Military	**Denies**	**N/A**	**N/A**	**N/A**
Natural Disaster	**Denies**	**N/A**	**N/A**	**N/A**
Loss	**Denies**	**N/A**	**N/A**	**N/A**
Other	**Denies**	**N/A**	**N/A**	**N/A**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Patient reports feeling severely sad that has been going on for 6 year and still feelings that currently. He has a few bad days throughout the week	
Loss of energy or interest in activities/school	**Yes**	**No**	Patient reports a loss of energy that has been going on since August and it is constant throughout the day. It is a moderate loss of energy.	
Deterioration in hygiene and/or grooming	**Yes**	**No**		
Social withdrawal or	**Yes**	**No**	Patient reported he has been	

isolation			withdrawn from is family since August and is closed off completely. Still feels closed off currently
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient reports difficulties with school and relationship that he is currently struggling with. It is a constant feeling and is severe.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient reports decrease amount of sleep that has happened since August due to from him feeling stressed from school and relationship. The loss of sleep is moderate.
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**	
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors,	**Yes**	**No**	The patient reports anxiety from his schooling and his relationship.

etc.)			The anxiety is severe and has been constant since August.
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**	Patient reports feelings of constant depression and anxiety has affected daily living. It is moderate because he still goes to class and participate in class activities but effects his moods.
Rating Scale			
How would you rate your depression on a scale of 1-10?	**7/10**		
How would you rate your anxiety on a scale of 1-10?	**3/10**		
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**	Patient report shaving school every day and then homework on the weekends. The school is severe in causing his stress because it takes up most of hi since August.
Family	**Yes**	**No**	
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
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**
First time in in-patient psychiatric treatment	**Patient has no prior patient treatment**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**
First time in in-patient psychiatric treatment	**Patient has no prior patient treatment**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**
First time in in-patient psychiatric treatment	**Patient has no prior patient treatment**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Roommate that lives with him in the dorms on campus	**19**	**Room mate**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: Patient drinks 2-3 times weakened. Smokes				

marijuana twice a year. Denies tobacco use or other drugs.		
Children (age and gender): No children **Who are children with now? No children**		
Household dysfunction, including separation/divorce/death/incarceration: **No dysfunction**		
Current relationship problems: Patient had a fight with his girlfriends but has no **problems regarding his parents.** **Number of marriages: o**		
Sexual Orientation: **Hetersexual**	**Is client sexually active?** **Yes No**	**Does client practice safe sex?** **Yes No**
Please describe your religious values, beliefs, spirituality and/or preference: Atheistic		
Ethnic/cultural factors/traditions/current activity: Denies ethnic, cultural, traditions, or **any current activity** **Describe: Has no traditions that he practices**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient has no past or currents issues.		
How can your family/support system participate in your treatment and care? **Patients reports that family should continue to call and check up on him.**		
Client raised by: **Natural parents- Mother and Father** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: No issues impacting current illness		
Atmosphere of childhood home: **Loving- Patient reports he was from a "loving home that supports me" in everything**		

that he does. He was comfortable growing up in his home. **Comfortable -** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent- Patient had no assistive device and can move independently** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) **Patient denies family history of mental illness**
History of Substance Use: **Patient had no history of substance use**
Education History: **Grade school- Finished grade school** **High school- graduated high school** **College- Patient just started college this past fall** **Other:**
Reading Skills: **Yes- Patient is a reading level appropriate for his age and school.** **No** **Limited**
Primary Language: English
Problems in school: Student reports he is struggling to juggle all his classes and **relationship**
Discharge
Client goals for treatment: Patient wants to go back to school to finish classes for the **semester.**
Where will client go when discharged? The patient will go back to his dorm room that is

located on the campus.

Outpatient Resources (15 points)

Resource	Rationale
1. Planet Fitness in Champaign, IL	1. The patient reports he liked to work out to help his stress but stopped going when he came to college and turned to cutting himself. This would provide the patient with a healthier choice to help his stress
2. Mindful Care in Champaign, IL	**2.** This is a place the patient can go to see a psychiatrist if he feels his suicidal ideation coming on or even to prevent it. He can get a second opinion for his diagnoses of bipolar and depression.
3. Illinois Suicidal prevention	**3.** The patient called 988 prior to him stating "I am going to jump off a parking garage". The patient should continue to utilize this outpatient resource because it already proved to be helpful for the patient.

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

Brand/ Generic	**Apriprazole (Abilify)**	**Trazadone (Desyrel)**	**Oxcarbazepine (Trileptal)**	**Benztropine (Cogentin)**	**Haloperidol (Haldol)**
Dose	5mg	50mg	150mg	2mg	5mg
Frequency	Daily	Nightly	2x daily	2x Daily PRN	Every 4 hours PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	**Pharmacological:** Atypical antipsychotic **Therapeutic:** Anti-psychotic (*NDH*, 2023)	**Pharmacological:** triazolopyridine **Therapeutic:** Antidepressant (*NDH*, 2023)	**Pharmacological:** Carboxamide derivative **Therapeutic:** anticonvulsant (*NDH*, 2023)	**Pharmacological:** anticholinergic **Therapeutic:** Antiparkinsonian (*NDH*, 2023)	**Pharmacological**: Conventional anti-psychotic **Therapeutic:** Conventional anti-psychotic (*NDH*, 2023)

Mechanism of Action	Produce antipsychotic effects through partial agonist and antagonist actions (*NDH*, 2023)	Blocks serotonin reuptake along the presynaptic neural membrane, causing an antidepressant effect (*NDH*, 2023)	May prevent or halt seizures by blocking or closing sodium channels In neuronal cell membranes. (*NDH*, 2023)	Blocks acetylcholine at cholinergic receptor sites. (*NDH*, 2023)	May block postsynaptic dopamine receptors in the limbic system and increase brain turnover of dopamine, producing an antipsychotic effect (*NDH*, 2023)
Therapeutic Uses	Anti-psychotic (*NDH*, 2023)	Antidepressant (*NDH*, 2023)	Anti-Convulsant (*NDH*, 2023)	Antiparkinsonian (*NDH*, 2023)	Antipsychotic (*NDH*, 2023)
Therapeutic Range (if applicable)	N/A	0.5-2.5 ml	N/A	N/A	5-16 ml
Reason Client Taking	To treat acute schizophrenia	To treat moderate depression to aid in sleep	To help treat bipolar	To help reduce side effects of other medications.	To help his anxiety
Contraindications (2)	1.Hypersensitive to aripiprazole 2.dependency (*NDH*, 2023)	1. hypersensitive to trazodone and its components 2. seizures (*NDH*, 2023)	1. Hypersensitive to oxcarbazepine 2. hypersensitive to eslicarbazepine (*NDH*, 2023)	1.hypersesicity to benztropine 2.Childre under 3 years old (*NDH*, 2023)	1. Parkinson's disease 2. dementia with Lewy bodies (*NDH*, 2023)
Side Effects/Adverse Reactions (2)	1.constipation 2.dizziness (*NDH*, 2023)	1.anxitey 2.confusion (*NDH*, 2023)	1. agitation 2. confusion (*NDH*, 2023)	1. confusion 2. depression (*NDH*, 2023)	1.confusion 2. depression (*NDH*, 2023)
Medication/ Food Interactions	1.antihypertensives medication	1. antibiotics 2.anticoagulants	1. hormonal contraceptives 2.phenytion	1.amantadine 2.anti-depressents	1.anticholinergics 2.busprine

	2.benzodiazepines 3.carbamazepine 4.paroxetine 5.alochol use (*NDH*, 2023)	3.St. Johns wort 4.Clarithromycin 5. ketoconazole 6. digoxin 7. MAO inhibitors 8. alcohol use (*NDH*, 2023)	3.all foods 4.UGT inducers 5. carbamazepine 6.alcolol use (*NDH*, 2023)	3. haloperidol (*NDH*, 2023)	3. citapram 4.alcohol use 5. paroxetine 6. quinidine 7. CYP3A4 inhibitor (*NDH*, 2023)
Nursing Considerations (2)	1.Use cautiously in patients with cardiovascular disease 2. Monitor the patient for difficulty swallowing or excessive somnolence (*NDH*, 2023)	1.Exepct patients to respond to medication withing the end of the second week 2.closely monitor patient who has suicidal ideation and tendencies (*NDH*, 2023)	1. monitor serum sodium levels for signs of hyponatremia 2. Monitor therapeutic oxcarbazepine clarence. (*NDH*, 2023)	1. assess muscle rigidity and tremor baseline 2.know that benztropine therapy should not be abruptly discontinued (*NDH*, 2023)	1. assess patients for fall risk 2. avoid stopping abruptly unless severe adverse effects occur (*NDH*, 2023)

Medications Reference (1) (APA)

Nurse's drug handbook. (2023). Jones & Barlett Learning

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:**	Patient is well groomed wearing the yellow scrubs the hospital acquired. He is not ill-appearing or diaphoretic He is in no acute distress and observed to be clean and tidy. Normal appearance and in a normal mood that appears to be calm. The patient was

Mood: **Affect:**	closed and guarded when questioned and answered in a slower manner.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient denies any delusions, illusions, and compulsions. The patient reported having suicidal thoughts and that he would sometimes cut himself when he felt depressed or anxious. Patient said he fears small spaces.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient is alert and oriented X4. Patient was aware of what was happening and was logical. Sensorium was not assessed.
MEMORY: **Remote:**	The patient had intact memory remembrance including short term and long term.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	.The patient had good and sound judgment. The patients seemed to be at adult intelligence. Impulse control seemed to be average. The abstraction and calculations were not assessed. Insight:
INSIGHT:	Patient had average insight.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient had a normal gait with no shuffling of the feet. He has no assistive devices. Posture was relaxed and straight. Muscle tone and strength was average for his body weight and age. Motor movement was appropriate for his age.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0008	**62**	**139/78**	**16**	**37.3 C**	**98**

0900	**54**	**116/75**	**16**	**36.4 C**	**98**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0008	**Numeric**	**0**	**0**	**0**	**0**
0400	**Numeric**	**0**	**0**	**0**	**0**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** Patient was offered breakfast but denied it. 0% **Lunch:** 60% **Dinner-** Patient came in before dinner was served. He came early in the morning	**Oral Fluid Intake with Meals (in mL)** Breakfast: 300ml Lunch:200ml Dinner: 0ml

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient will be discharged and return to his door room, which is on campus. The patient wants to continue mental illness care, meet with his counselor, and set up appointments with a

psychiatrist. I want the patient to join a gym to have a healthy hobby to help destress compared to cutting himself. I would like the patient to visit his family more often and will schedule to see his parents. I would like the patient his have time slotted for each day to take a break from school and homework to help him focus on his mental well-being.

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)
1. Risk for self-mutilation related to his depression as evidenced by him cutting himself (Phelps, 2023)	The patient cut his hand 10 days prior to his plans of jumping off a parking garage.	1.Ask the patient when his most previous cut was 2. put the patient with a sitter 3. Remove any items in the room that the patient can use to harm himself	1. Check on the patient every 15 minutes 2. do room checks every 4 hours 3. sit and listen the patients about his emotions if willing	1. Refer the patient to a therapist 2. teach coping methods that do not involve self-harm 3. contact family if the patients approve to include them in discharge plans
2. Risk for stress over-load related to his schooling as evidence by the patient stating that he is very stressed out and pushed him into suicidal	The patient stated that he has suffered from anxiety with his relationship and his schooling.	1. Ask the patient about sleeping habits 2. encourage the patient to share his feelings and his triggers 3. Ask the patient about any other emotions that	1. Perform any spiritual rituals that the patient maya must help reduce the stress 2.Provide a calming and stress-free environment 3. Ask the patient what helps with stress and provide	**1.** Patient will engage in things that will help distress. The patient stated the gym helped, so getting him connected with a gym 2.Encourage the patient to continue to talk

ideation (Phelps, 2023)		he may have.	that. For example, a book if the patient like to read to destress.	with therapist. 3. Schedule time with patient to take time to not do schoolwork to have a needed break
3. Risk of hopelessness related to his depression as evidence as the patient stating that he does not feel like his life has no meaning (Phelps, 2023)	The patient feels hopelessness after his fight with his girlfriend and feels like he is not going anywhere in life.	1. Asses the mental status including energy levels 2. Communicate the with the patient using verbal and non-verbal communication skills and why he has those feelings 3. Ask the patient if he has ever thought about suicide.	1. Provide the patient with a planned day with activities so he feels like he is needed. 2. Encourage positive thinking 3. Identify patient strength and encourage putting strengths to use.	1. work with the patient to come up with a plan after discharge 2. Schedule a time to meet up with family too help with the hopeless feeling because they are his support system 3. Provide the patient for any out-side resources like a counselor

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer

Concept Map (20 Points):

Subjective Data

Patient drinks 2-3 times on the weekends
Depression was rated 7/10
Anxiety was rated 3/10
Patient has been stressed out about college and classes
Patient had a fight his girlfriend prior to admission

Objective Data

Patient had drug screen completed and they were all negative
MSE
Scheduled Medications: Aripiprazole and trazadone
Has not participated in any group activity

Patient Information

Patient is an 18-year-old Asian male. He attends college and is majoring in engineering. He lives in a dorm on campus with his roommate. The patient was admitted to OSF on October 20 earlier in the early morning for suicidal ideation. The patient says he has some friends, but he would not consider having any close friends. He is in a relationship with his girlfriend and had a fight prior to him threatening to jump off the parking garage. The patient has no history of hospitalization for his mental health.

Nursing Diagnosis/Outcomes

Risk for self-mutilation related to his depression as evidence by him cutting himself (Phelps, 2023) 1. Outcome- Patient will refrain from harming self
Risk for stress over-load related to his depression and schooling as evidence by the patient stating that he is very stressed out and pushed him into social ideation (Phelps, 2023) 2. Outcome- Patient will experience reduced signs and symptoms of stress-overload
Risk of hopelessness related to his depression as evidence as the patient stating that he does not feel like his life has no meaning (Phelps, 2023) 3. Outcome- Patient will regain and maintain self-esteem

Nursing Interventions

1.Ask the patient when his most previous cut was 2. put the patient with a sitter 3. Remove any items in the room that the patient can use to harm himself
1. Ask the patient about sleeping habits 2. encourage the patient to share his feelings and his triggers 3. Ask the patient about any other emotions that he may have.
1. Asses the mental status including energy levels 2. Communicate the with the patient using verbal and non-verbal communication skills and why he has those feelings 3. Ask the patient if he has ever thought about suicide.