N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 11/14/23	**Patient Initials** A. R. B.	**Age** 58	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Office work	**Marital Status** Separated (5 years)	**Allergies** No known allergies
Code Status Full code	**Observation Status** Inpatient, rounds every 15 minutes	**Height** 5'10" (177.8cm**)**	**Weight** 195lb (88,5kg)

Medical History (5 Points)

Past Medical History: Patient has had HTN, DM, epileptic seizure, denies any brain injury or stroke in the past.

Significant Psychiatric History: Patient denies any psychiatric history. No psychiatric history found in the documents.

Family History: Asthma-brother. Cancer-father, mother. Congestive heart failure- brother. Diabetes mellitus-mother. Heart attack-brother. Hypercholesterolemia-mother. HTN- brother, father, mother. Rheumatoid arthritis-mother. Stroke-brother. Thyroid problems-mother.

Social History (tobacco/alcohol/drugs): Tobacco: Patient started smoking at age 7. Currently smokes 3pk/day. **Alcohol**: Patient started to use at age 16. Currently takes 1.5 cases of beer per day. Uses 7-8 joints per day. **Cannabis**: First use at age 13. Now patient uses 7-8 joints /day for pain. **Cocaine:** First use at 15. Heavy use for five years, but not since then. Denies any other drugs. Denies prescription drugs abuse. Denies detox/rehab history. Denies legal charges associated with drugs or alcohol abuse.

Living Situation: The patient lives in the house with his brother (60), patients' older daughter (38) and her son (4).

Strengths: Patient stated: "God, mother, and brother".

Support System: Patient reports his family as his support system.

Admission Assessment

Chief Complaint (2 points): "I want to kill myself, not here to hurt anyone else."

Contributing Factors (10 points):

Factors that lead to admission: The patient is a 58-year-old white male. His brother brought the patient to the OSF Emergency Department in Danville, IL, on 11/14/23. The reason was that the patient felt increasingly depressed on 11/14/23. The patient stated that he was a little depressed all his life, but lately, he feels increasingly depressed due to a recent event he did not want to talk about. He stated: "I want to kill myself, not here to hurt anyone else." The brother was contacted regarding the stressor event that caused the problem. According to his brother, the patient got in trouble for allegedly talking to a 12-year-old girl online and was making sexual content. Police caught him, and now he has a legal problem. He was admitted to OSF in Danville on 11/14/23 and transferred to OSF in Champaign.

History of suicide attempts: Patient denies suicide attempts in the past.

Primary Diagnosis on Admission (2 points): Bipolar Disorder, in depressive phase.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Has experience **Witness of trauma/abuse:** Yes				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with**	**Describe**

			trauma)	
Physical Abuse	Denies current abuse.	Abused as a child until the age of ten.	N/A	Patient reports physical abuse as a child until the age of 10. He got physical punishments from his father. At the age of 10 he was put in a foster care.
Sexual Abuse	Denies current abuse	Denies sexual abuse	N/A	Patient denies sexual abuse ever.
Emotional Abuse	Denies	During childhood	N/A	Patient had emotional abuse by his father. His father did not have nice words for him.
Neglect	Denies	During childhood	N/A	Patient does cannot explain why, but he thinks that he needed better supervision when he was a child.
Exploitation	Denies	Denies	N/A	Patient denies any exploitation during his life.
Crime	Denies	Denies	N/A	Patient denies being a gang member.
Military	never	N/A	N/A	Patient never enlisted in the army.
Natural Disaster	Never	Never	N/A	Patient denies being in natural disaster.
Loss	Denies current loss	Yes	N/A	When patient was a child the family house burned completely. That was very hard for him.
Other	Denies other trauma	N/A	N/A	None
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad	**Yes** X	**No**	Patient states that he has been sad	

mood			lately, for the last two weeks, due to some problems he had. He did not want to explain what problems he had in mind.
Loss of energy or interest in activities/school	**Yes**	**No** X	Patient states that he has high energy and can perform daily activities.
Deterioration in hygiene and/or grooming	**Yes**	**No** X	Patient states that he maintains his hygiene regularly.
Social withdrawal or isolation	**Yes**	**No** X	Patient denies social withdrawal or isolation. He stated that he likes to communicate/socialise with people.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No** X	Patient denies these difficulties, only "sometimes he gets angry and yells at people."
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No X**	Denies. Patient states that he always sleeps a lot, 10-11 hours.
Difficulty falling asleep	**Yes**	**No X**	Denies
Frequently awakening during night	**Yes**	**No X**	Denies
Early morning awakenings	**Yes**	**No X**	Denies
Nightmares/dreams	**Yes**	**No X**	Denies nightmares.
Other	**Yes**	**No X**	Denies
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No X**	Denies. He likes to eat once a day and his favorite meal is dinner.
Binge eating and/or purging	**Yes**	**No X**	Denies
Unexplained weight loss? **Amount of weight change: N/A**	**Yes**	**No X**	Denies

Use of laxatives or excessive exercise	**Yes**	**No X**	Denies
Anxiety Symptoms	**Presenting?**		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No X**	The patient denies any anxiety problem.
Panic attacks	**Yes**	**No X**	The patient denies panic attacks.
Obsessive/compulsive thoughts	**Yes**	**No X**	Denies
Obsessive/compulsive behaviors	**Yes**	**No X**	Denies
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No X**	Denies
Rating Scale			
How would you rate your depression on a scale of 1-10?		Patient rates his depression on a scale of 1- 10 as 7/10.	
How would you rate your anxiety on a scale of 1-10?		Patient rates his anxiety on scale of 1-10 as 0/10.	
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 X**	N/A Patient does not work.
School	**Yes**	**No X**	N/A Patient is not in school.
Family	**Yes X**	**No**	Patient stated that sometimes gets upset when his daughter asks for money. Patient did not know to describe this problem in details. Regarding intensity, the argue with his daughter could make him very angry. “She makes me so mad I could squeeze her neck.” This happens from time to time.
Legal	**Yes X**	**No**	Patient denies any legal problems at this time. (According to admission data patient is having legal problems at this time. He did some things against the law).

			Patient admits that he has some other problems he needs to resolve. He does not want to talk about that. This is very high stressor for him.
Social	**Yes**	**No X**	Patient denies any social stressors in his life.
Financial	**Yes**	**No X**	Patient denies financial stressors.
Other	**Yes**	**No X**	Patient denied anything else that is stressful in his life.

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
N/A Patient denies any psychiatric or substance use treatment in the past.	**Inpatient** **Outpatient** **Other:**	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**	**N/A**	**N/A**	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				

Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Harry	60	Brother	**Yes**	**No X**
Sheila	38	Daughter	**Yes**	**No X**
Nelson	4	Grandson	**Yes**	**No X**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): Patient has two daughters. They are adults. One is 30 the other is 38. **Who are children with now?** One daughter is married and lives with her husband and four children. The other daughter lives with the patient in the same household, as the patient, with her son.				
Household dysfunction, including separation/divorce/death/incarceration: Patient was married two times. First marriage finished in divorce. The second marriage ended in separation. His second wife left him for another man. His second wife does not communicate with him very much.				
Current relationship problems: Patient denies any relationship problems at this time. Only his daughter always wants money and they argue about that. Patient states "My daughter goes on my nerves. Aways wants money, money. Sometimes I want to squeeze her neck." **Number of marriages:** Patient was married two times.				
Sexual Orientation: Heterosexual	**Is client sexually active?** **X Yes No** Patient stated "so-so"		**Does client practice safe sex?** **X Yes No** Always uses condoms.	
Please describe your religious values, beliefs, spirituality and/or preference: Patient is a Baptist. Patient stated that he is a "strong believer" and that he "believes in in God." He did not say much more on this question.				
Ethnic/cultural factors/traditions/current activity: N/A **Describe: N/A**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient is having some legal issues currently and that is the reason for his psychological problems.				
How can your family/support system participate in your treatment and care? Patient lives with his family and they are willing to help him with whatever he needs. They can take him to				

the doctor or emergency.
Client raised by: **Natural parents** mostly mother took care of him, father was alcoholic. **Grandparents** **Adoptive parents** Foster parents after the age of 10 he was from time to time in a foster care. **Other (describe):** He was in several reformatory institutions from age 10-17.
Significant childhood issues impacting current illness: Very difficult situation at home. Patient was avoiding school. He was disrespectful to teachers, older people, and friends. He was getting in fights. At the ages 10-17 he was locked in several reformatory institutions in Champaign, StCharles, Cuningham.
Atmosphere of childhood home: **Loving:** Mother was nice to him. She took care of him as much she could. **Comfortable** **Chaotic** **Abusive:** Patient said his father beat him very often with a belt when he was a child. **Supportive** **Other:** Atmosphere of childhood home was not good. Nobody gave him any guidance.
Self-Care: **Independent X** Patient can take care of himself, does not need assistance. **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation) Brother has bipolar disorder, and no suicide attempts. Other brother tried to kill himself with knife several times. Also, he jumped in front of a car once.
History of Substance Use: Father was alcoholic. Many family members smoked cannabis**.**
Education History: **Grade school:** Patient finished 9th grade. Left the school after that. **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited:** Patient states he has trouble reading and writing. Reading is little easier.
Primary Language: English

Problems in school: Patient admits he had problems in school. He was not good student. He was disobedient, fighting with other students, running from classes and very disrespectful toward teachers.
Discharge
Client goals for treatment: The goal is to get stabilized with depression and proceed with therapy for bipolar problems. Patient should get counseling for his paraphilia problem. He needs to be checked by a medical specialist and get medical therapy and cognitive behavioral therapy.
Where will client go when discharged? Patient will go home to live with his family, his daughter and his brother.

Outpatient Resources (15 points)

Resource	Rationale
1. Alcoholics Anonymous in Danville IL	1.Patient has alcohol problem and going to these meetings could help him to stop drinking.
2.OSF Medical group- Behavioral & Mental Health in Danville, Il.	2.Patient will get help here with depression and bipolar disorder problems.
3.ThriveWorks counseling & mental health in Champaign, Il.	3.They Provide help with depression.

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

Brand/Generic	**Abilify/ aripiprazole**	**Depakote/divalproex**	**Cogentin/benztropine**		
Dose	5mg	500mg	2mg		
Route	P.O.	P.O. do not crush	P.O.		
Classification	**Therapeutic class:** antipsychotic **Pharmacologic class:** quinolinone derivative	**Therapeutic class:** anticonvulsant **Pharmacologic class:** carboxylic acid derivative	**Therapeutic class:** antiparkinsonian drugs **Pharmacologic class:** anticholinergics		

Mechanism of Action	Partial dopamine D2 agonist and 5-HT1A receptors and antagonist at 5HT2Areceptors.	Blocks reuptake of GABA and suppress the rapid firing of neurons (Jones & Bartlett Learning, 2020).	Blocks acetylcholine at cholinergic receptors balancing dopamine and ach levels, relaxing muscles movement, drooling, rigidity, and tremor. Inhibits dopamine reuptake prolonging its action.		
Therapeutic Uses	Schizophrenia, bipolar I, Tourette, autism.	anticonvulsant	Acute dystonia Parkinsonism Transient extrapyramidal syndrome		
Therapeutic Range (if applicable)	10-30mg/day	85-125mcg/mL	N/A		
Reason Client Taking	Bipolar disorder	Seizures, mania	Movement disorder from haloperidol		
Contraindications (2)	1. For older patients w/dementia 2. For patients with seizure	1. Patients with liver disease. 2. Patients with pancreatitis.	1.tardive dyskinesia 2.prostatic hyperplasia		
Side Effects/Adverse Reactions (2)	1. Anxiety 2. Insomnia 3. Seizures	1.Bone marrow suppression 2.Stevens-Johnson syndrome	1.confusion 2.urine detention		
Medication/Food Interactions	1. Alcohol increase CNS effect. 2. grapefruit increases drug level (Jones & Bartlett Learning, 2020).	1. alcohol use 2. anticonvulsants 3. CNS depressant 4. diazepam	1.reduce dose before giving cholinergic 2.amantadine		
Nursing Considerations (2)	1. NMS 2. Stroke 3. TIA	1.Give with food to protect GI irritation. 2.Liver function watch.	1.Never stop drug abruptly. 2.Watch for constipation, paralytic ileus.		

Brand/Generic	**Haldol/haloperidol**	**Librium/chlordiazepoxide**			
Dose	5mg	25mg caps			
Frequency	Every 4hr PRN	Every 6hr			
Route	P.O.	P.O.			
Classification	**Therapeutic class:** antipsychotics **Pharmacologic class:** butyrophenone derivatives	**Therapeutic class:** anxiolytics **Pharmacologic class:** benzodiazepines **Controlled substance schedule: IV**			
Mechanism of Action	Blocking postsynaptic dopamine receptors in the brain	Increases level of GABA, that slows don neuronal activity.			
Therapeutic Uses	Psychosis, Tourette, hyperactive children	Anxiety, withdrawal symptoms of acute alcoholism, preoperative anxiety			
Therapeutic Range (if applicable)	5.0-20.0ng/mL	5mg is starting dose. The usual therapeutic dose is 30-40mg.			
Reason Client Taking	Agitation, breakthrough psychosis/mania	Withdrawal from alcohol			
Contraindications (2)	1.elderly, risk for falls 2.agranulocitosis	1.pregnancy 2.lactation 3.miasthenia gravis			
Side Effects/Adverse Reactions (2)	1.fever 2.muscle stiffness	1.slured speech 2.clumsines 3.trouble walking 4.uncontrollable movements			
Medication/Food	1.Carbamazepine	1.antihistamines			

Interactions	decreases level. 2.Beta blocker cause hypotension.	2.disulfiram 3.medications for seizures			
Nursing Considerations (2)	1.Monitor for tardive dyskinesia. 2.Watch for NMS (Jones & Bartlett Learning, 2020).	1.risk of abuse and addiction 2.dificulty urination 3.constipation			

Medications Reference (1) (APA):

Jones & Bartlet Learning. (2020). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: Patient appears his age, appropriate hygiene, well groomed, appropriately dressed in patient's uniform. **Behavior:** no unusual mannerism or movements, makes fair eye contact. **Build:** average **Attitude:** good, appropriate **Speech:** spontaneous, normal rate, tone, latency, little high in volume. **Interpersonal style:** uses words "sweety" and "honey", but in appropriate way. **Mood:** euthymic to depressed **Affect:** full, calm	
MAIN THOUGHT CONTENT: **Ideations:** denies suicidal or homicidal ideation at this time of assessment. **Delusions:** denies delusions, no paranoia **Illusions:** denies illusions **Obsessions:** denies **Compulsions:** denies **Phobias:** denies	
ORIENTATION: **Sensorium:** patient is oriented x4 to place, time, date, and situation **Thought Content:** no suicidal or homicidal thoughts at this time. No delusions of paranoia.	.
MEMORY: **Remote:** Good memory. Patient said that sometimes he forgets something and needs to be reminded.	.

REASONING: **Judgment:** sound **Calculations:** not assessed **Intelligence:** fair for patients' level of education**.** **Abstraction:** not assessed **Impulse Control:** appropriate during assessment	.
INSIGHT: fair	
GAIT: **Assistive Devices:** does not need devices, has steady gait **Posture:** relaxed, patient was on the bed **Muscle Tone:** good **Strength:** appropriate for the age **Motor Movements:** Patient walks on his own, has good gait. He does not have tremor. His movements are precise.	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0758	62	111/62	18	97.7	94%
1330	68	138/80	18	98.5	96%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9am	1-10	Lower back	10/10	Constant, dull	Patient is getting pain medication
2pm	1-10	Lower back	10/10	Constant, dull	Patient is getting pain medication

Patient does not look like he is in that much pain. No facial expression that fits his level of pain. He gets up easily from the bed and walks easily.

Dietary Data (2 points)

Dietary Intake

Percentage of Meal Consumed:	**Oral Fluid Intake with Meals (in mL)**
Breakfast: 0%	**Breakfast:** 350mL
Lunch: 0%	**Lunch:** 300mL
Dinner: 100%	**Dinner:** 400mL

Patient stated that he likes to eat once a day and that his favorite meal is dinner.

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

1. If the symptoms of depression get worse and you want to hurt yourself call 911 or 988.
2. Take your medicine as directed. If medicine does not work contact the provider.
3. Try counseling or psychotherapy
4. Try regular physical therapy.

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 depression as evidence by patients' statement (Ackley et al., 2022).	Patient reported wish "I want to kill myself" on admission to OSF.	1.Inquire of patients' plans to commit suicide. 2.Put the patient on 1:1 watch 24/7. 3.Remove all objects from the	1.Check on patient every 15 minutes. 2.Talk to the patient w/o judging him. 3. Be sure the patient takes all his medications**.**	1. Help the patient find a psychiatrist. 2. Help patient find a psychotherapist he could visit regularly.

		patients' room which he can use to harm himself.		3. Provide patient with resources where to ask help if gets into a crisis.
2.Hypersomnia r/t psychological pressure as evidenced that the patient sleeps up to eleven hours daily (Ackley et al., 2022).	Patient reported to sleep too long, 11 hours daily because he feels tired.	1. Take vitals and treat if abnormal. 2. Check lab work. 3. Allow patient to express feelings and reasons for hypersomnia.	1. Help patient stay hydrated. 2.Help patient to make plan for daily activities that will keep him awake longer. 3.Help patient to be socially active and attend daily group meetings.	1. Help patient find a psychotherapist to work on the problems he has. 2. Patient needs family support to take his medications regularly. 3.Check with the provider if some of the medications patient takes cause hypersomnia.
3.Imbalanced nutrition r/t depression as evidenced by the patient's statement that he eats only once a day(Ackley et al., 2022).	Patient reported that he eats only in the evening an he skips breakfast and lunch because he cannot eat.	1.Take vitals, check BMI. 2. Find the reason for this way of eating. 3. Monitor patients eating habits.	1. Help patient eat his meals regularly. 2.Explain the patient the significance of having regular meals. It can cause fatigue, dehydration, even more depression. 3. Offer him snacks and fluids.	1. Help patient to find help with counseling. 2. Advise patient to contact provider if he starts losing weight. 3. Advise regular exercise.

Other References (APA):

Ackley, B. J., Ladwig, G. B., Makic, M. B. F., Martinez-Kratz, M., & Zanotti M., (2022). *Nursing diagnosis handbook. An evidence-based guide to planning care* (12th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data
Patient comes with complaint of depression. He said "I want to kill myself." Family was concerned of his changed behavior; his brother brought him to be checked. Stressor factor determined, legal problems.
Patient c/o of sadness, hopelessness. He is not functioning like before. He is very concerned what will happened.

Nursing Diagnosis/Outcomes
Ineffective individual coping related to stress related depression as evidenced by patient's statement of hopelessness.

Outcomes:

Patient will verbalize his feelings of hopelessness. Patient will make a plan how to stay positive. Patient will learn how to improve feelings of hopelessness.

Objective Data
Labs, vitals checked.
Appearance: looks his age, appropriate hygiene. Well developed. Slightly increased motor activity, eye contact fair. Affect slightly dysthymic, mood fair. Speech spontaneous, normal rate, slightly increased volume. Judgement and insight fair. Cognition grossly intact. Oriented 4X. No acute distress noted. Gait steady, no tremors.

Patient Information
Patient is 58-year-old white male. He was admitted on 11/14/23. He has two adult daughters and five grandchildren. Full code. No known allergies. BW 195lb, height 5'10".

Nurse will assess the patients' coping abilities.
Nurse will assist the patient to deal with the current stressor.
Nurse will promote health and wellness like good rest, hydration, and nutrition. Patient will have psychotherapy. Patient will take his medication.