N323 Care Plan

Lakeview College of Nursing

Julia Bushnell

Mental Health

Professor Irelan

3/8/2024

Demographics (3 points)

Date of Admission 3/7/2024	**Patient Initials** Z.M.T	**Age** 23	**Biological Gender** Male
Race/Ethnicity White/Caucasian	**Occupation** Unemployed	**Marital Status** Single	**Gender Identity** Male
Code Status Full code Presented to ED voluntarily, admitted as involuntary	**Height and Weight** 6’ (182.9 cm) 217 lbs (98.7 kg)	**Allergies** NKA	**Pronouns** He/Him

Medical History (5 Points)

Past Medical History: Autism, depression, diabetes mellitus (DM) type 2, mood and affect disturbances, asthma, restless leg syndrome, bipolar disorder (BPD) unspecified.

Psychiatric Diagnosis: BPD, depression

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
8/17/2023	**Inpatient**	**Suicidal ideation**
10/29/2023	**Outpatient, follow up appointment with Crosspoint**	**Suicidal ideation**
11/5/2023	**Inpatient**	**Suicidal ideation**

Admission Assessment

Chief Complaint (2 points): Suicidal ideation with plan, “I was thinking about electrocuting myself.”

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** The client stated he was having suicidal thoughts for two weeks before coming to the ED. He consistently had these thoughts during these two weeks. Financial issues and lack of stimulation are his triggers for suicidal ideation. Keeping the client occupied helps his depression and he stated, “it makes me feel important.” The client has struggled with his depression off and on for several years, he states “I have bad memories from school and when I think about them I want to hurt myself.”
- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** The client states, “I sit in my room alone without eating when I feel it is getting bad again.” This client does not go to work, school, nor does he have any income. He financially relies on his mom but states, “I feel like a burden to her.” When the client isolates, his mom worries about him.

Primary Diagnosis on Admission (2 points): Bipolar, voluntary (then deemed involuntary) admission

Psychosocial Assessment (30 points)

History of Trauma	
Screening Questions:	**Client Answer**
Do you have a history of physical, sexual, emotional, or verbal abuse?	**Yes, patient’s mother said he experienced physical abuse when he was younger. Has experienced verbal abuse as well.**
Do you have a history of trauma secondary to military service?	**No.**
Have you experienced a loss of family or friends that affected your emotional well-	**The loss of his grandmother and brother.**

being?	
Have you experienced any other scary or stressful event in the past that continues to bother you today?	**The client was bullied throughout grade school and high school.**
(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)	**(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)**

	Current?	Past? (what age)	By whom?
Physical Abuse	**No**	**Yes (age during grade school and high school)**	**Physical abuse by classmates.**
Sexual Abuse	**No**	**No**	**N/A**
Emotional Abuse	**Yes**	**Yes (school age)**	**Stepfather**
Verbal Abuse	**Yes**	**Yes (school age)**	**Stepfather**
Military	**No**	**No**	**N/A**
Other	**No**	**No**	**N/A**

Presenting Problems		
Problematic Areas	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you feel down, depressed or hopeless?	**Yes**	**Sometimes, about once a week and it feels intense when it comes.**
Do you feel tired or have little energy?	**Yes**	**Often feels fatigued.**

Do you avoid social situations?	**Yes**	**Always, prefers to be alone or at home.**
Do you have difficulties with home, school, work, relationships, or responsibilities	**Yes**	**Client states he has poor relationship with stepfather. Also states he has difficulty getting his chores done due to fatigue and lack of motivation.**
Sleeping Patterns	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Have you experienced a change in numbers of hours that you sleep each night?	**Yes**	**The client has been sleeping less being on the unit.**
Do you have difficulty falling asleep?	**Yes**	**Only sometimes does the client have a hard time falling asleep, it may take up to an hour.**
Do you frequently awaken during the night?	**No**	**N/A**
Do you have nightmares?	**No**	**N/A**
Are you satisfied with your sleep?	**Yes**	**N/A**
Eating Habits	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you overeat?	**Yes**	**"I don't pay attention to how much I eat when I am playing video games, it only happens sometimes."**
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	**No**	**N/A**
Do you have not eat enough or have a loss	**No**	**N/A**

of appetite?		
Have you recently experienced unexplained weight loss? **Amount of weight change:**	**Yes**	**The client states he has experienced a loss of 5 lbs in the past month.**
Anxiety Symptoms	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you pace, have tremors, or experience other symptoms of anxiety?	**Yes**	**The client likes to fidget most of the time. I noticed this during the interview, he kept his leg shaking.**
Do you experience panic attacks?	**Yes**	**The client experiences panic attacks sometimes. When they occur, they are described as "usually mild."**
Do you have obsessive or compulsive thoughts?	**Yes**	**"Often but they are not intense."**
Do you have obsessive or compulsive behaviors?	**No**	**N/A**
Suicidal Ideation	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
In the past week have you wished that you were dead?	**Yes**	**The client states they wish they were dead most of the time and it does not feel intense but is in the back of his mind.**
Have you ever tried to kill yourself?	**Yes**	**The client attempted suicide in July of 2023.**
If the client answered either of the previous questions "yes", you must ask the client:	**No**	**N/A**

Are you having thoughts of killing yourself right know? **(If the client says yes, you must ensure facility staff are aware)**			
Rating Scale			
How would you rate your depression on a scale of 1-10?		**Today, 3.**	
How would you rate your anxiety on a scale of 1-10?		**Today, 1.**	
Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
Mother	**50**	**Biological mother, they have a good relationship.**	**The mother smokes cigarettes and sometimes drinks wine.**
If yes to any alcohol or drug use, explain: The mother only drinks wine once or twice a			

month. When she does, she drinks 1-2 glasses.		
Family Medical History: The client is unaware. No FMH on file.		
Family Psychiatric History (including suicide): Maternal grandmother had BPD.		
Family alcohol or drug use (not covered by those client lives with): The client believes his extended family drinks alcohol.		
Do you have children? If yes, what are their ages? No **Who are your children with now?** N/A		
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? **If yes, please tell me more about that:** His parents were divorced when he was young, he does not remember it much. He still speaks to his father but does not see him often since he lives in Arkansas.		
Are you currently having relationship problems? No		
What is your sexual orientation: Bisexual	**Are you sexually active?** No	**Do you practice safe sex?** N/A
Please describe your religious values, beliefs, spirituality and/or preference: Atheist		
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? No		
Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Registered sex offender.		
Whom would you consider your support system? **How can your family/support system participate in your treatment and care?** The client's mother is his support system. She can tell when he is feeling depressed, but he does not like to tell her when he goes to the hospital for help. He thinks he could talk to his		

mom about getting help with his depression.

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.)
The client likes to read, write, and play video games.

What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.)
A trigger for this client is when he is bored and is not occupied doing something. This is when he thinks bad thoughts.

Client raised by:

Natural parents: the client lives with his mother and used to see his dad every other weekend.
Grandparents
Adoptive parents
Foster parents
Other (describe):

Self-Care:

Independent
Assisted: mother financially supports the client, he takes care of himself otherwise.
Total Care

Education History:

Grade school
High school
College: graduated high school and attended some college, did not earn a degree.
Other:

Reading Skills:

Yes: appropriate for stated age.
No
Limited

Primary Language: English

Personal History of Substance Use

Screening Questions:

1. **Have you ever used drugs, alcohol, or nicotine?**

(If no, you may skip to "psychiatric medications".

If yes, complete all sections of this chart. Type N/A if not applicable.)		
Substance	**First Use and Last Use**	**Frequency of Use**
Nicotine Products (including smoking, chewing, vaping)	**First Use:** **Last Use:**	**N/A**
Alcohol	**First Use:** **Last Use:**	**N/A**
Prescription Medications (Recreational Use)	**First Use:** **Last Use:**	**N/A**
Marijuana	**First Use:** **Last Use:**	**N/A**
Heroin	**First Use:** **Last Use:**	**N/A**
Methamphetamine	**First Use:** **Last Use:**	**N/A**
Other: Specify	**First Use:** **Last Use:**	**N/A**

Current Psychiatric Medications (10 points)
Complete all of your client's psychiatric medications
All information listed in this section must be pertinent to your patient.

Brand/ Generic	Depakote/ Divalproex sodium/ Valproate sodium	Seroquel/ Quetiapine	Cogentin/ Benztropine	Haldol/ Haloperidol	Atarax/ Hydroxyzine
Dose	500 mg	100 mg	2 mg	5 mg	25 mg
Frequency	2x daily	1x nightly	2x daily PRN	Q4hrs PRN	3x daily PRN
Route	PO	PO	PO	PO	PO
Classification	Pharmacologic: carboxylic acid derivative Therapeutic: anticonvulsant	Pharmacologic: dibenzodiazepine Therapeutic: antipsychotic (Nurse's drug handbook, 2023).	Pharmacologic: anticholinergic Therapeutic: antiparkinsonian, central-acting anticholinergic (Nurse's drug handbook, 2023).	Pharmacologic: butyrophenone Therapeutic: antipsychotic (Nurse's drug handbook, 2023).	Pharmacologic: piperazine derivative Therapeutic: anxiolytic, sedative-hypnotic, antihistamine, and antiemetic (Nurse's drug handbook, 2023).
Mechanism of Action	Blocks GABA from being reabsorbed in the brain. Inhibits	Interferes with dopamine binding to different receptors in	Benztropine balances dopamine and acetylcholine which	The limbic system postsynaptic dopamine receptors are blocked	Reduces histamine reactions by blocking the histamine I receptor cites

	sodim channels that are voltage-sensitive causing a decrease in seizures and mania (Nurse's drug handbook, 2023).	the brain. This medication also antagonizes serotonin, adrenergic, and histamine receptors which produces an antipsychotic affect (Nurse's drug handbook, 2023).	ultimately decreases tremors and drooling, causing relaxation. Dopamine reabsorption is also decreased, causes prolonging effects (Nurse's drug handbook, 2023).	which increased dopamine reabsorption in the brain cause an antipsychotic reaction (Nurse's drug handbook, 2023).	(Nurse's drug handbook, 2023).
Therapeutic Uses	To treat/prevent acute manic phases of BPD (Nurse's drug handbook, 2023).	Treat BPD mania and depression (Nurse's drug handbook, 2023).	Decrease tremors (Nurse's drug handbook, 2023).	Treats psychosis (Nurse's drug handbook, 2023).	Relieve anxiety (Nurse's drug handbook, 2023).
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Treat BPD (mania) and seizures.	Treat BPD.	Given with haloperidol to decrease side effects.	Agitation, psychosis, mania.	Anxiety.
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	N/A	N/A	A nursing intervention would be to avoid caffeine to decrease tremors or restless legs.	Offer support, establish trust, and reorientate to surroundings.	Take the client to a calm environment and attempt to talk with them.
Contraindications (2)	1.Liver impairment 2.Urea cycle	1.Alcohol use 2.Hypotension (Nurse's	1.Potentially decreases effects of	1.Severe depression 2.Comatose	1.Hypersensitivity to cetirizine

	disorders (Nurse's drug handbook, 2023).	drug handbook, 2023).	haloperidol 2.Taking with an antidepressant can increase risk for anticholinergic effect (Nurse's drug handbook, 2023).	state (Nurse's drug handbook, 2023).	2.Prolonged QT interval (Nurse's drug handbook, 2023).
Side Effects/Adverse Reactions (2)	1.Abnormal dreams 2.Increased appetite (Nurse's drug handbook, 2023).	1.Suicidal ideation 2.Fatigue (Nurse's drug handbook, 2023).	1.Hypotension 2.Muscle weakness (Nurse's drug handbook, 2023).	1.Gynecomastia 2.Dry mouth (Nurse's drug handbook, 2023).	1.Hallucinations 2.Pruritus (Nurse's drug handbook, 2023).
Medication/ Food Interactions	Interacts with alcohol, CNS depressants, carbapenem antibiotics, rufinamide, zidovudine, amitriptyline, nortriptyline, diazepam, lamotrigine, phenytoin, aspirin, topiramate, chlorpromazine, ethosuximide, primidone, and clonazepam (Nurse's drug	Interacts with CYP3A4 inhibitors and inducers, antihypertensives, dopamine agonists, and anticholinergic drugs (Nurse's drug handbook, 2023).	Interacts with tricyclic antidepressants, haloperidol, amantadine, and phenothiazines (Nurse's drug handbook, 2023).	Interacts with buspirone, CNS depressants such as opioids, tricyclic antidepressants, levodopa, diuretics, anticholinergics, and CYP3A4 inhibitors (Nurse's drug handbook, 2023).	Alcohol use, antibiotics such as azithromycin, antipsychotics such as clozapine, and antiarrhythmics (Nurse's drug handbook, 2023).

	handbook, 2023).				
Nursing Considerations (2)	1.Monitor CBC and platelet count 2.May affect thyroid function (Nurse's drug handbook, 2023).	1.Monitor the client for a suicide risk 2.Drug can cause hyperglycemia, assess blood glucose (Nurse's drug handbook, 2023).	1.Assess muscle tremors and strength for a baseline 2.Caution with driving and operating machinery for the adverse effects of drowsiness, blurry vision, and dizziness (Nurse's drug handbook, 2023).	1.Assess for tardive dyskinesia 2.Do not abruptly stop this medication (Nurse's drug handbook, 2023).	1.Assess the client for sedation or severe CNS depression 2.Do not crush or chew this medication (Nurse's drug handbook, 2023).

Medications Reference (1) (APA):

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

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	**The client was alert and orientated to person, place, situation, and time. He appeared well groomed and in no acute distress. The client maintained proper eye contact throughout the entire interview and was attentive to questions. The client spoke at a normal and relaxed tone of voice and was relaxed.**
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	**The client stated his mood today was tired and relaxed. The client seemed consistent with his mood and did not show much emotion other than relaxation.**

COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	**The client was alert and oriented x4 and no memory impairment was indicated. He did not have trouble focusing during the interview and gave me his full attention.**
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	**The client stated he had experienced suicidal ideation frequently in the past week but was not experiencing it during the day of our interview. He stated he was not having any delusions, hallucinations, obsessions, compulsions, or paranoia during the day of our interview.**
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	The client stated he would open the wallet to check for an ID and return the wallet to the owner if he could. He stated he would take cash out of the wallet if there was no ID.
MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	**The client has a strong and steady gait and does not use an assistive devices besides glasses.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**81**	**126/79**	**14**	**97.1**	**98**

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	**Numeric pain scale**	**N/A**	**0/10**	**N/A**	**N/A**

Nursing Care (6 points)

Overview of care provided today: I arrived at the unit and listened to report to decide what client to do my care plan over. I gathered information about this client and then proceeded to interview him. Our interview was quick and after that I wrote down some more information. The clients had lunch and we socialized with a few of them before leaving the unit.

Client complaints: The client stated he wanted to speak with his doctor about his medications. He feels like he is having more tremors and restless legs due to some of the medications he is taking.

Participation in therapy / groups: My client participated in all group and therapy opportunities.

Medication compliance today: My client is compliant and took all his medications.

Behaviors exhibited today: My client was calm, apathetic, and cooperative during my time on the unit.

Discharge Planning

Discharge location: The client will likely be discharged home, there were no current discharge plans discussed in the notes or plans of transferring him to another facility.

Follow up plan: This client has been hospitalized numerous times in the past 6 months for suicidal ideation. He likely needs a stronger outpatient therapy program to help with his depression and occurrences of suicidal ideation.

Education needs: The client should be educated on outpatient therapy and how he can start feeling better so that his depressive episodes are under control.

Nursing Diagnosis (25 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

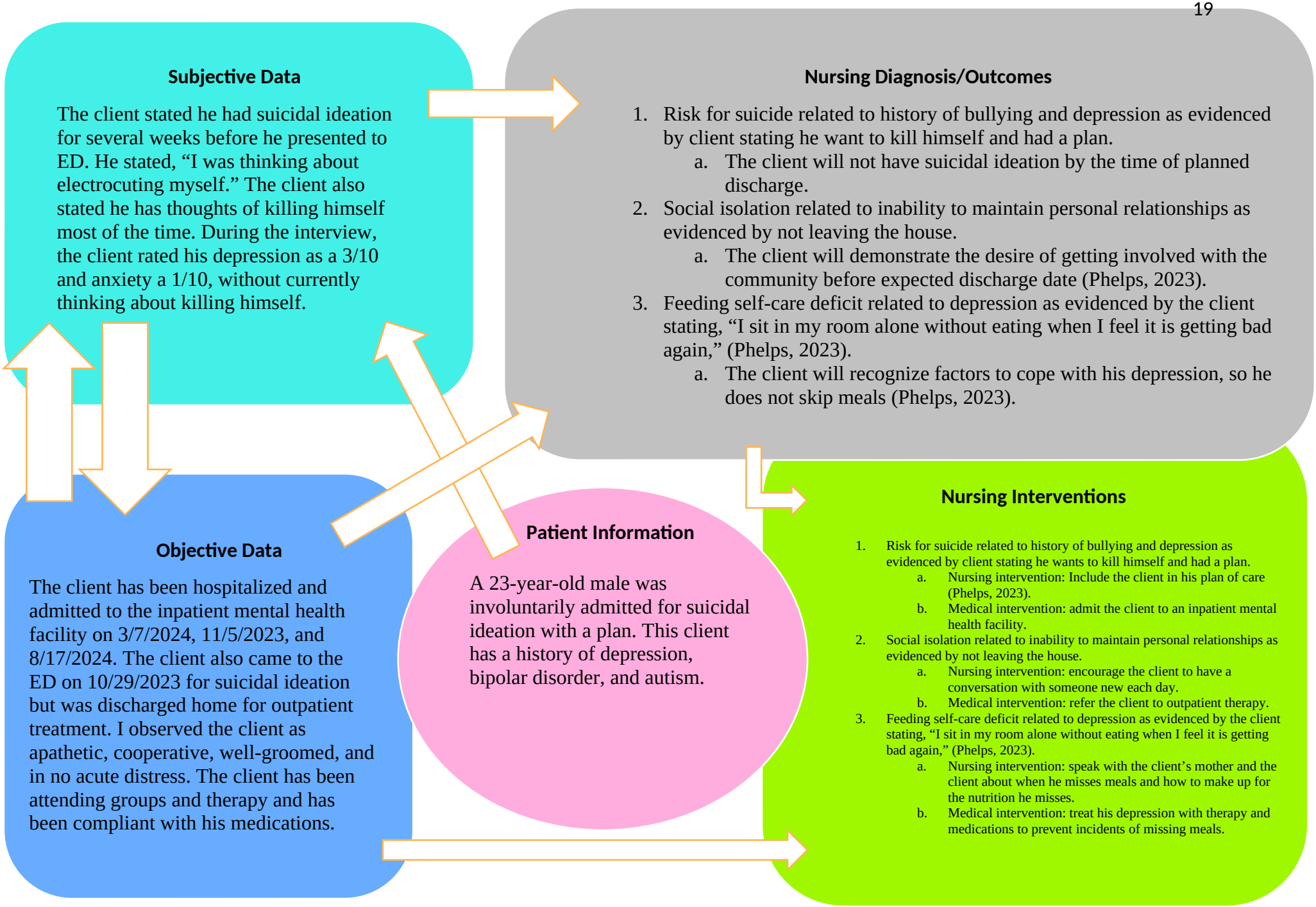
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**
1. Risk for suicide related to history of bullying and depression as evidenced by client stating he wanted to kill himself and had a plan.	The client was admitted due to suicidal ideation and states he has these thoughts most of the time in the back of his mind. This client has also been admitted several times in the past 6 months for suicidal ideation.	**1.**The client will not have suicidal ideation by the time of planned discharge.	**1.**Place the client on a 1:1 observation. **2.** Include the client in his plan of care (Phelps, 2023). **3.** Encourage participation in groups and therapy to keep the client busy.	**1.** The client is from Danville, IL and should be aware of the mental health resources at the health department, OSF SHMC, and Crosspoint services. The client should also be given the crisis hotline phone number.
2. Social isolation related to inability to maintain personal relationships as evidenced by not leaving the	The client stated he prefers to be isolated but also does not like to be bored since this is when his thoughts get bad.	**1.** The client will demonstrate the desire of getting involved with the community before expected	**1.** Encourage the client to have a conversation with someone new each day. **2.**Understand why the client prefers to isolate.	**1.** If the client enjoys sports, he could attend the games at the DACC facility of the baseball field in Tilton, IL. This client enjoys playing video games, so he has

house.	When the client is isolated, he has a higher risk of thinking bad thoughts.	discharge date (Phelps, 2023).	**3.** Refer the client to outpatient therapy (Phelps, 2023).	online access. Offering online resources for chats or groups for him to get interaction.
3. Feeding self-care deficit related to depression as evidenced by the client states "I sit in my room alone without eating when I feel it is getting bad again," (Phelps, 2023).	I chose this diagnosis due to the client stating he does not eat when he feels his depression getting bad again. I also chose this because he financially relies on his mother and if she cannot afford to get food, he may not eat.	**1.** The client will recognize factors to cope with his depression, so he does not skip meals (Phelps, 2023).	**1.** Treat the depression to prevent episodes of not eating (Phelps, 2023). **2.** Encourage a meal plan for home (Phelps, 2023). **3.** Speak with the client's mother and the client about when he misses meals and how to make up for the nutrition he misses.	**1.** One resource could be an online support group for client's who struggle to eat when they are depressed and how to make mealtimes enjoyable.

Other References (APA):

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

Concept Map (20 Points):


Subjective Data
The client stated he had suicidal ideation for several weeks before he presented to ED. He stated, “I was thinking about electrocuting myself.” The client also stated he has thoughts of killing himself most of the time. During the interview, the client rated his depression as a 3/10 and anxiety a 1/10, without currently thinking about killing himself.
Nursing Diagnosis/Outcomes
1. Risk for suicide related to history of bullying and depression as evidenced by client stating he want to kill himself and had a plan.
a. The client will not have suicidal ideation by the time of planned discharge.
2. Social isolation related to inability to maintain personal relationships as evidenced by not leaving the house.
a. The client will demonstrate the desire of getting involved with the community before expected discharge date (Phelps, 2023).
3. Feeding self-care deficit related to depression as evidenced by the client stating, “I sit in my room alone without eating when I feel it is getting bad again,” (Phelps, 2023).
a. The client will recognize factors to cope with his depression, so he does not skip meals (Phelps, 2023).
Objective Data
The client has been hospitalized and admitted to the inpatient mental health facility on 3/7/2024, 11/5/2023, and 8/17/2024. The client also came to the ED on 10/29/2023 for suicidal ideation but was discharged home for outpatient treatment. I observed the client as apathetic, cooperative, well-groomed, and in no acute distress. The client has been attending groups and therapy and has been compliant with his medications.
Patient Information
A 23-year-old male was involuntarily admitted for suicidal ideation with a plan. This client has a history of depression, bipolar disorder, and autism.
Nursing Interventions
1. Risk for suicide related to history of bullying and depression as evidenced by client stating he wants to kill himself and had a plan.
a. Nursing intervention: Include the client in his plan of care (Phelps, 2023).
b. Medical intervention: admit the client to an inpatient mental health facility.
2. Social isolation related to inability to maintain personal relationships as evidenced by not leaving the house.
a. Nursing intervention: encourage the client to have a conversation with someone new each day.
b. Medical intervention: refer the client to outpatient therapy.
3. Feeding self-care deficit related to depression as evidenced by the client stating, “I sit in my room alone without eating when I feel it is getting bad again,” (Phelps, 2023).
a. Nursing intervention: speak with the client’s mother and the client about when he misses meals and how to make up for the nutrition he misses.
b. Medical intervention: treat his depression with therapy and medications to prevent incidents of missing meals.