

N323 Care Plan

Lakeview College of Nursing

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2/12/2025

Professor Betty Mosier-Johnson

Demographics (3 points)

Date of Admission 2/2/2025	Patient Initials G.M.	Age 19	Biological Gender Female
Race/Ethnicity White/Caucasian	Occupation Employed at Chick-fil-a	Marital Status Engaged	Gender Identity Trans Male
Code Status Full	Height and Weight 5'0" & approx. 100#	Allergies Some adhesives (unspecified)	Pronouns He/Him

Medical History (5 Points)

Past Medical History: Postural orthostatic tachycardia syndrome (POTS). Allers-Daniels Syndrome.

Psychiatric Diagnosis: Bipolar, post-traumatic stress disorder (PTSD), borderline personality disorder, eating disorder: anorexia, suicidal attempts/suicidal ideation (SI).

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	Inpatient or Outpatient?	Reason for Treatment
Patient is unclear on exact dates but cites x6-7 separate admissions related to suicidal ideation from age 17-19.	Residential in St. Louis, Outpatient.	SI, self-harm
Patient reports up to x11 separate hospitalizations related to eating disorder.	Inpatient	Unspecified

Admission Assessment

Chief Complaint (2 points): Suicidal Ideation (SI)

Contributing Factors (10 points): Patient reports he was hearing voices contributing to suicidal thoughts subsequent of medications (Trazodone).

- o **Factors that lead to admission (address triggers and coping mechanisms if applicable):** National politics is the largest contributor to his condition – specifically in regard to his sexual identity. Preferred coping mechanisms include writing, poetry, aromatherapy baths, and outpatient therapy.
- o **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** It has caused him to drop out of classes this semester, was going to school to become an elementary educator.

Primary Diagnosis on Admission (2 points): Suicidal Ideation.

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		Client Answer	
Do you have a history of physical, sexual, emotional, or verbal abuse?		Physical – parental. Sexual – was groomed as a minor. (did not wish to elaborate)	
Do you have a history of trauma secondary to military service?		N/A	
Have you experienced a loss of family or friends that affected your emotional well-being?		Aunt died October of last year, caused SI symptoms to flair, has recovered from this being a contributing force at this time.	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		Yes, but client did not wish to elaborate.	
(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	Father. DCFS became involved due

			to teachers becoming aware.
Sexual Abuse	No	Yes	Music teacher- private lessons
Emotional Abuse	No	Yes	Parents
Verbal Abuse	No	Yes	Father
Military	N/A	N/A	N/A
Other	N/A	N/A	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	Every day. Depressive episodes that can last months-to-years
Do you feel tired or have little energy?	No	N/A
Do you avoid social situations?	No	N/A
Do you have difficulties with home, school, work, relationships, or responsibilities	Yes	Episodes interfere with all social domains and impairs ability to manage responsibilities.
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	Improving at this time but has had periods of difficulty. Patient was having significant difficulty at the time of admission.
Do you have difficulty falling asleep?	Yes	Reports it takes up to an hour to fall asleep.
Do you frequently awaken during the night?	Yes	Chronic issue. Made worse by the behaviors of some residents on the unit.

Do you have nightmares?	Yes	During SI episodes his nightmares involve killing himself and his memory of the events of his nightmares become very intense.
Are you satisfied with your sleep?	Yes	Reports sleep quality is improving well, and nightmares are receding, is satisfied at this time.
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?	No	N/A
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 of appetite?	No	He has had anorexia in the past. Not a current issue.
Have you recently experienced unexplained weight loss? Amount of weight change:	No	N/A
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?	Prone to pacing	He finds that it helps bring his anxiety down.
Do you experience panic attacks?	Yes	Episodes related to a phobia of growing up. Episodes will be hours long and go in repeating cycles. Causing significant nausea, crying, freezing, and periods of

		shame.	
Do you have obsessive or compulsive thoughts?	Yes	May obsess over suicide during depressive episodes.	
Do you have obsessive or compulsive behaviors?	“Maybe”	Reports that his therapist has suggested that his cutting is a compulsive behavior performed to suppress SI thought patterns.	
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	Does not wish to elaborate	
Have you ever tried to kill yourself?	Yes	Reports x5 prior attempts involving overdosing, cutting, and use of “equipment that ultimately failed”	
If the client answered either of the previous questions “yes”, you must ask the client: Are you having thoughts of killing yourself right now? (If the client says yes, you must ensure facility staff are aware)	Yes	Staff are aware.	
Rating Scale			
How would you rate your depression on a scale of 1-10?		8/10	
How would you rate your anxiety on a scale of 1-10?		2/10	
Personal/Family History			
Who lives with you?	Age	Relationship	Do they use alcohol or drugs?
Mother	50’s	Parent	No

Father	50's	Parent	Yes: Alcohol
Brother	16	Sibling	No
If yes to any alcohol or drug use, explain: Father has an alcohol problem. Will hide stashes within the house. Is a daily drinker, but does not necessarily get drunk every day.			
Family Medical History: High blood pressure, skin and breast cancers.			
Family Psychiatric History (including suicide): Dad: Anger management issues, seasonal affective disorder (SAD). Brother: obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD). Mother: obsessive compulsive disorder (OCD).			
Family alcohol or drug use (not covered by those client lives with): Father, uncles, and grandfather all have alcohol use problems. No Drug issues.			
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? No			
If yes, please tell me more about that: N/A			
Are you currently having relationship problems? Notes strain with parents, but family is working to reconcile.			
What is your sexual orientation: "Asexual, Biromantic"	Are you sexually active? No	Do you practice safe sex? N/A	
Please describe your religious values, beliefs, spirituality and/or preference: Christian – faith is highly important to him.			
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? Performs prayer to help with coping.			
Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): No			
Whom would you consider your support system? Fiancé and therapist			

How can your family/support system participate in your treatment and care?

Keep one another updated. Continue going to therapy.

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) Prayer, pacing, aromatherapy, baths.

What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.)

Politics and the media. Anything pertaining to or demonstrating acts of suicide. Anything contributing to a perception of abandonment.

Client raised by: Natural parents

Self-Care: Independent

Education History: Some College

Reading Skills: Yes

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: Age 15 Last Use: Age 17	Unspecified. Vaping socially.
Alcohol	First Use: Denies Last Use: N/A	N/A
Prescription Medications (Recreational Use)	First Use: Denies Last Use: N/A	N/A
Marijuana	First Use: Denies Last Use: N/A	Chart demonstrates client admits to marijuana use, tested positive on

		admission.
Heroin	First Use: Denies Last Use: N/A	
Methamphetamine	First Use: Denies Last Use: N/A	Tested positive on admission but may be related to ADHD medication.
Other: Specify	First Use: Denies 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	Hydroxyzine	Trileptal	Propranolol	Trazodone	Vraylar
Dose	25mg	300mg	10mg	50mg	1.5mg
Frequency	TID PRN	TID	BID	HS	QD:AM
Route	N/A	PO	PO	PO	PO
Classification	Pharmacological Class: Piperazine derivative Therapeutic Class: Anxiolytic, antiemetic, antihistamine, sedative-hypnotic	Pharmacological Class: Antiepileptic/ Sodium channel blocker Therapeutic Class: Anticonvulsant	Pharmacological Class: Beta-adrenergic blocker Therapeutic Class: Antianginal, antiarrhythmic, antihypertensive, anti-MI, antimigraine, anti-tremor, hypertrophic cardiomyopathy, and pheochromocytoma therapy adjunct.	Pharmacological Class: triazolopyridine derivative Therapeutic Class: antidepressant	Pharmacological Class: Atypical antipsychotic Therapeutic Class: Antipsychotic

Mechanism of Action	Competes with histamine for receptor sites on effector cells. Suppresses histaminic activity. Sedative actions occur at subcortical level of CNS.	Exact MOA unknown. It is believed to prevent seizure-spread of aberrant synaptic electro activity within the brain that leads to seizure.	Blocks arterial dilation and inhibits renin secretion, resulting in decreased blood pressure and relief of migraines. Decreases heart rate for tachyarrhythmias. Improves heart muscle contractility and oxygenation.	Serotonin reuptake inhibitor, resulting in antidepressant effect. Vasopressive effect on blood pressure. Sedating effect via histamine blocking.	Exact MOA unknown. Believed to provide agonistic activity at dopamine receptors, and antagonistic activity at serotonin receptors, modulating these to a greater normal balance for mood stabilization and treatment of hallucinations.
Therapeutic Uses	Anxiety, nausea, insomnia	Anticonvulsant for seizure management. Also used in treatment of bipolar disorder.	Antihypertensive, antianginal, antimigraine, antianxiety, antihyperthyroid, and treats arrhythmias.	Antidepressant, insomnia treatment	Antipsychotic, treatment for bipolar disorder
Therapeutic Range (if applicable)	Adults: 50-100mg x4/daily Children 6+: 50-100mg daily in divided doses Children under 6 y/o: 50mg daily in divided doses.	Adults: 50-100mg x4/daily Children 6+: 50-100mg daily in divided doses Children under 6 y/o: 50mg daily in divided doses.	Adults: 1.5 mg to 6 mg QD	Adults: 150mg in divided doses BID, increase by 50mg/day every 3-4 days. <i>Maximum for outpatients:</i> 400mg daily in divided doses. <i>Maximum for</i>	Adults: 600 mg BID, do not exceed 1200mg per day. Children ages 4–16: initiate at 8 to 10 mg/kg daily, do not exceed 600 mg/day.

				<i>inpatients experiencing more severe depression: 600mg daily in divided doses.</i>	*Dosing recommendation not thoroughly established, largely varies by what is required to observe a therapeutic change.
Reason Client Taking	Anxiety	Bipolar Disorder	Anxiety	Depression	Bipolar disorder
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	Recommend an increase of activity during the day and use of calming/grounding strategies. These can be beneficial conservative approach's to managing anxiety before the use of Pharmacologics.				
Contraindications (2)	Pregnancy, prolonged QT interval.	Hypersensitivity to Trileptal.	Bronchial asthma, cardiogenic shock, heart failure, sick sinus syndrome, sinus bradycardia (unless a	Use within 14 days of an MAO inhibitor, including IV methylene blue or linezolid.	Hypersensitivities to VRAYLAR.

			pacemaker is present.		
Side Effects/Adverse Reactions (2)	Drowsiness, hallucinations, headaches, involuntary motor activity, seizures, tremor, dry mouth, pruritis, rash, urticaria, injection-site pain.	Dizziness, somnolence, diplopia, fatigue, nausea, vomiting, ataxia, abnormal vision, headache, nystagmus, tremor, and abnormal gait.	Anxiety, depression, dizziness, drowsiness, fatigue, fever, insomnia, lethargy, nervousness, weakness, bradycardia, heart failure, hypotension, dry eyes, laryngospasm, nasal congestion, pharyngitis, hypoglycemia, abdominal pain, constipation, diarrhea, nausea, vomiting, impotence, sexual dysfunction, purpura, myopathy, myotonia, bronchospasm, dyspnea, wheezing, respiratory distress, alopecia, rash, urticaria, anaphylaxis, flu-like or lupus-like symptoms.	Dream alteration, agitation, anxiety, aphasia, ataxia, balance disruption, chills, confusion, CVA's, dizziness/drowsiness, extrapyramidal symptoms, fatigue, hallucinations, headaches, insomnia, memory changes, migraine, paresthesia, paranoia, psychosis, seizure, serotonin syndrome, stupid, SI, syncope, tardive dyskinesia, tremor, vertigo, weakness, arrhythmias, CHF, edema, orthostatic hypotension, vision changes, dry mouth, IADH syndrome, constipation,	Akathisia, dyspepsia, vomiting, somnolence, restlessness, and extrapyramidal symptoms.

				diarrhea, liver dysfunction, priapism, changes to libido, incontinence, leukocytosis, hemolytic anemia, myalgia, back pain, apnea/dyspnea, alopecia, psoriasis, rash	
Medication/ Food Interactions	Antibiotics, CNS depressants, and alcohol.	Phenytoin, carbamazepine, phenobarbital. May decrease effects of hormonal contraceptives.	Consult with physician regarding any/all cardiac meds – significant range of complex interactions with this medication is present. NSAIDs. warfarin, alcohol, and nicotine gum or other smoking-cessation aids.	Antibiotics, barbiturates, CNS depressants, MAO inhibitors, alcohol use.	CYP3A4 inhibitors or inducers.
Nursing Considerations (2)	Be aware of any/all heart rate dysfunction or medications/electrolyte imbalances that could contribute, as this medication carries with it	Inquire if client is pregnant. Be aware of client's seizure history and typology. Monitor electrolyte levels that may contribute to	Be aware if your patient is on any cardiac medications or taking warfarin. Inquire if patient is consuming alcohol, actively quitting	This medication has significant concerns for the elderly and is generally not advised for older populations.	Inquire if patient is actively taking antibiotics. Patients should experience effects within two weeks, otherwise

	QT wave prolongation in the cardiac rhythm. Inquire if patient is actively taking antibiotics.	seizure like activity.	smoking, or regularly takes NSAIDS. Monitor BP, I&O's, daily weights, heart rate and pulses.		discontinue use. Closely monitor for SI.
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Medications Reference (1) (APA):

Nursing Drug Handbook. (2024). *Nurses Drug Handbook* (2024 ed.). Wolters Kluwer.

U.S. Food and Drug Administration. (2015). *Vraylar (cariprazine) capsule, for oral use:*

Prescribing Information. Retrieved from

https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/204370lbl.pdf

U.S. Food and Drug Administration. (2017). *Trileptal (oxcarbazepine) tablet, for oral use:*

Prescribing Information. Retrieved from

https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021014s036lbl.pdf

Mental Status Exam Findings (25 points)

OBSERVATIONS: Appearance (i.e.: positioning, posture, dress, grooming): Alertness: Orientation: Behavior: Speech: Eye Contact: Attentiveness:	Alert and oriented x4, well-groomed and no signs of distress. Overall appearance is calm, pleasant, and cooperative. Behavior and speech appropriate, eye contact normal, patient highly attentive and engaged.
MOOD: How is your mood today? Affect:	Mood: Patient states: “My mood has been up and down. I am excited to maybe discharge home today or tomorrow.” Patients displayed mood at

<p>Consistency between mood and affect?</p>	<p>this time is pleasant, forthcoming, and cooperative.</p> <p>Affect: Broad/normal. Consistent with mood.</p>
<p>COGNITION: Alertness: Orientation: Memory Impairment: Attention:</p>	<p>Patient A&O x4, no signs of memory impairment, good attention to conversation with nursing students, denies pain 0/10.</p>
<p>MAIN THOUGHT CONTENT: Homicidal Ideations or Suicidal Ideation: Delusions: Hallucinations:</p> <ul style="list-style-type: none"> • Specify: Auditory, Visual, Tactile, Olfactory <p>Obsessions: Compulsions: Paranoia: Flight of Ideas: Perseveration: Loose Association:</p>	<p>Patient demonstrates sadness over issues with his family, but positive outlook and motivation on mending their relationship. Is recovering from thoughts of SI, and still struggles with this at times, and with nightmares. Reports they are no longer hearing the voices they were experiencing because of prior meds. Denies ongoing cutting, but many, many prior scars observed on bilateral forearms demonstrates this was a very significant issue. Patient's train of thought is consistent, no significant variation or abnormal deviation or grandiose/morose/delusional statements. Does not perseverate on anything, no loose association noted. Does note that his thoughts begin to race heavily when writing poetry, however, as this is a big emotional outlet for him.</p>
<p>REASONING: Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?): Insight into Illness:</p>	<p>Patient states they would likely hand it in to the police.</p> <p>Patient demonstrates a remarkable degree of awareness of their ongoing battle with depression, the nature of the disease, causes for their subjective conflict with it, and healthy ways to cope and work toward better mental health.</p>
<p>MOTOR ACTIVITY: Assistive Devices: Gait: Abnormal Motor Activities:</p>	<p>Gait normal, no abnormal motor activities, no assistive devices employed.</p>

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0-10	N/A	0/10	N/A	N/A

Nursing Care (6 points)

Overview of care provided today: Social and emotional support provided.

Client complaints: Eager to return home and is wondering if that will be today or tomorrow.

Participation in therapy / groups: Yes.

Medication compliance today: Yes.

Behaviors exhibited today: No concerning behaviors, very appropriate, pleasant disposition and social.

Discharge Planning

Discharge location: To parents home.

Follow up plan: Resume outpatient therapy services.

Education needs: None identified.

