N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 2/17/25	Patient Initials GM	Age 19	Biological Gender female
Race/Ethnicity white	Occupation Chick filet	Marital Status engaged	Gender Identity male
Code Status full	Height and Weight 5 ft 100 LBS	Allergies none	Pronouns He/him

Medical History (5 Points)

Past Medical History: GERD, eating disorder, wounds (left forearm), low iron, and pots

Psychiatric Diagnosis: major depression disorder and anxiety

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
8 weeks ago	Inpatient	Eating disorder
Was here 5 days ago, was there for 9 days total	Inpatient	Self-harm

Admission Assessment

Chief Complaint (2 points): self-harm

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable): politics, general triggers, and seeing someone with cuts**
- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal): everything and having to come to inpatient care.**

Primary Diagnosis on Admission (2 points): bipolar and borderline

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?		**Emotional/verbal and groomed**	
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-being?		**Aunt in October**	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		**Thought his dad was going to kill him**	
(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**	**dad**
Sexual Abuse	**No**	**No**	**none**
Emotional Abuse	**no**	**Yes**	**Parents**
Verbal Abuse	**No**	**Yes**	**Parents**
Military	**No**	**No**	**none**
Other	**No**	**No**	**None**
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**	**All the time**	

Do you feel tired or have little energy?	**no**	
Do you avoid social situations?	**No**	
Do you have difficulties with home, school, work, relationships, or responsibilities	**Yes**	**All, daily, moderate**
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**	
Do you have difficulty falling asleep?	**Kind of**	
Do you frequently awaken during the night?	**Yes**	
Do you have nightmares?	**No**	
Are you satisfied with your sleep?	**No**	
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**	
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	**No**	
Do you have not eat enough or have a loss of appetite?	**No**	**Good now**
Have you recently experienced unexplained weight loss? **Amount of weight**	**No**	

change:	**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?	**Yes**	**Pace, a lot daily**
Do you experience panic attacks?	**Yes**	**Sometimes**
Do you have obsessive or compulsive thoughts?	**Yes**	**Most, self-harm/ everyday**
Do you have obsessive or compulsive behaviors?	**Yes**	**Sometimes**
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**	
Have you ever tried to kill yourself?	**Yes**	**Not recently**
If the client answered either of the previous questions "yes", you must ask the client: **Are you having thoughts of killing yourself right know?** **(If the client says yes, you must ensure facility staff are aware)**	**No**	
Rating Scale		
How would you rate your depression on a scale of 1-10?		**9**
How would you rate your anxiety on a scale of 1-10?		**5**

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
Mom	**52**	**Mother**	**no**
Dad	**54**	**Father**	**drinks**
Brother	**16**	**Brother**	**no**
If yes to any alcohol or drug use, explain: Dad drinks everyday			
Family Medical History: high Blood pressure, high cholesterol, and cancer			
Family Psychiatric History (including suicide): OCD, ADHD, bipolar, and seasonal depression			
Family alcohol or drug use (not covered by those client lives with): uncle drinks			
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:**			
Are you currently having relationship problems? No			
What is your sexual orientation: asexual	**Are you sexually active? no**	**Do you practice safe sex? Never had sex before**	
Please describe your religious values, beliefs, spirituality and/or preference: Christian			
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect			

your plan of care? **None**
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? Friends, fiancé, and therapist **How can your family/support system participate in your treatment and care? Just** **talking to me**
What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) distracting skills
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) violence, self-harm, politics
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Self-Care: **Independent** **Assisted** **Total Care**
Education History: **Grade school** **High school** **College- currently enrolled** **Other:**
Reading Skills: **Yes** **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: 15 years old** **Last Use: a year ago**	**Everyday (when he was smoking)**
Alcohol	**First Use: NA** **Last Use: NA**	
Prescription Medications (Recreational Use)	**First Use: NA** **Last Use: NA**	
Marijuana	**First Use: NA** **Last Use: NA**	
Heroin	**First Use: NA** **Last Use: NA**	
Methamphetamine	**First Use: NA** **Last Use: NA**	
Other: Specify	**First Use: NA** **Last Use: NA**	

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	**Vraylar Cariprazine**	**Vistaril Hydroxyzine**	**Inderal propranolol**
Dose	**3 mg**	**25 mg**	**10 mg**
Frequency	**Daily**	**Bedtime**	**BID**
Route	**oral**	**oral**	**Oral**
Classification	**Atypical antipsychotic**	**Histamine H1 antagonist**	**Beta blocker**
Mechanism of Action	**Raises dopamine and serotonin levels**	**Blocks histamine and raises serotonin levels**	**Blocks adrenaline**
Therapeutic Uses	**Treat major depression disorder**	**Short term use for anxiety**	**Reduces physical signs of anxiety**
Therapeutic Range (if applicable)	**1.5-6 mg once a day**	**25-50 up to 4 times a day**	**160-240 mg per day**
Reason Client Taking	**Depression**	**Anxiety**	**Anxiety**
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this			

Medication			
Contraindications (2)	**Rash and pruritus**	**Drowsiness and dry mouth**	**Dizzy and trouble sleeping**
Side Effects/Adverse Reactions (2)	**Nausea and dizziness**	**Fast heart rate and headache with chest pain**	**Fatigue and insomnia**
Medication/Food Interactions	**Alcohol**	**Sedatives, narcos, muscle relaxers**	**Alcohol, Adderall, and ibuprofen**
Nursing Considerations (2)	**Change positions slowly and do not drive.**	**Do not take if breast feeding and or older than 65 years old**	**Watch for severe drowsiness and bradycardia**

Medications Reference (1) (APA):

Drugs.com. (n.d.-a). ***Prescription drug information*****. Drugs.com. https://www.drugs.com/**

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming): groomed** **Alertness: person, place, time, location** **Orientation: good** **Behavior: good** **Speech: good** **Eye Contact: yes** **Attentiveness: very attentive**	
MOOD: Great **How is your mood today? Doing good today.** **Affect: seems to be doing really good** **Consistency between mood and affect? Consistent**	
COGNITION: A&O/4 **Alertness: great**	

Orientation: good **Memory Impairment: none** **Attention: paid attention to everything around him**	
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions: no** **Hallucinations: yes** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions: yes, self-harm** **Compulsions: yes, self-harm** **Paranoia: no** **Flight of Ideas: no** **Perseveration: no** **Loose Association: no**	
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?): I would hand it into the police.** **Insight into Illness:**	.
MOTOR ACTIVITY: **Assistive Devices: no** **Gait: great, normal** **Abnormal Motor Activities: none**	

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Na	Na	Na	Na	Na	Na

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
Na	Na	Na	Na	Na	Na

Nursing Care (6 points)

Overview of care provided today: he was good today

Client complaints: none, for today

Participation in therapy / groups: yes

Medication compliance today: yes

Behaviors exhibited today: very kind, talkative

Discharge Planning

Discharge location: home

Follow up plan: seeing a therapist

Education needs: ways of coping with self-harm thoughts.