N323 Care Plan

Lakeview College of Nursing

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October 10th, 2025

Demographics

Date of Admission	Patient Initials	Age	Biological Gender
9/25/25	SM	30	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Gender Identity**
African American	none	Single	Female
Code Status	**Height and Weight**	**Allergies**	**Pronouns**
Full Code	218lbs. and 5’5	Flonase	She, her

Medical History

Past Medical History: Insomnia, Diabetes Mellitus, depression

Psychiatric Diagnosis: Psychosis

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
2023	Inpatient	Suicide attempt
2014	Inpatient	Suicide attempt

Admission Assessment

Chief Complaint: Patient stated, “I have suicidal thoughts.”

Contributing Factors:

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** Harassed by 3 neighbors because she knows their secret. They tried to kill her because she knows they are sex trafficking children. They implanted a tracker in her teeth. Patient stated she is going through a lot. She feels like her

medication has stopped working. Mother brought her to the ER. She reports feeling paranoid, down, and depressed.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** Client states she cannot hold a job due to her state of mind. Her family is her adopted family, and client states her mother is her only support system but cares more about her boyfriend then the client.

Primary Diagnosis on Admission: Bipolar disorder type 1, rule out schizoaffective disorder bipolar type, psychosis

Psychosocial Assessment

History of Trauma			
Screening Questions:		**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?		"Yes, sexual abuse."	
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?		"Yes. Lost lots of people."	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		"I don't think so."	
(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	**n/a**	**n/a**	**n/a**
Sexual Abuse	"No."	"Yes, 6 or 7 years old."	"My brother."

Emotional Abuse	"Yes."	"Yes, 6 years."	"Right now my mother and her boyfriend. In the past it was mainly my adopted father and brother."
Verbal Abuse	"Yes."	"Yes, 6 years."	"Right now it is my mother and her boyfriend. In the past it was mainly my adopted father and brother."
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?	"No."	**n/a**	
Do you feel tired or have little energy?	"Yes."	"Every day, super drowsy, all day long."	
Do you avoid social situations?	"Not anymore."	**n/a**	
Do you have difficulties with home, school, work, relationships, or responsibilities	"No."	**n/a**	
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	"No.	"Maybe once a week."	

of hours that you sleep each night?	Sometimes I stay awake until 2 am.”	
Do you have difficulty falling asleep?	“Yes.”	“Every day, I think a lot so that stops me from falling asleep, every night.”
Do you frequently awaken during the night?	“Yes.”	“Every day, super intense, every night.”
Do you have nightmares?	“No.”	
Are you satisfied with your sleep?	“Depends.”	“If I nap in the day time, I feel a little better but I think that keeps me up in the night.”
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.”	“Every day, feels like I’m filling a whole that never fills, any time I’m awake.”
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.”	**n/a**
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?	"I shake with bad anxiety."	"Once in a while, really intense, until I get away from the situation."
Do you experience panic attacks?	"Yea."	"Once in a while, super intense, until I get out of the situation."
Do you have obsessive or compulsive thoughts?	"Yeah."	"All the time, takes over my mind a lot, all the time."
Do you have obsessive or compulsive behaviors?	"Yea. I wash my hands a lot."	"All the time, super intense, all the time."
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?	"No."	**n/a**
Have you ever tried to kill yourself?	"Yes, in the past."	"I've attempted twice, the first time was when I was 19."
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)**	"No."	**n/a**
Rating Scale		

How would you rate your depression on a scale of 1-10?	"0."
How would you rate your anxiety on a scale of 1-10?	"0."

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
"Mom."	"55."	"Adopted mother- kind of support system when we are not fighting."	'Yes uses alcohol."
"Mom's boyfriend."	"58."	"I have no relationship with him. I try to avoid him."	"Drinks alcohol and does drugs." (Will not specify what type of drugs.)
If yes to any alcohol or drug use, explain: "Mom drinks everyday either a 12 pack of beer			

or a 5th of something. Mom's boyfriend drinks a 12 pack or a 5th of anything and does drugs." (Client will not state what drugs, she says anything he can get his hands on.)
Family Medical History: "Not sure." Client is adopted.
Family Psychiatric History (including suicide): "Not sure." Client is adopted.
Family alcohol or drug use (not covered by those client lives with):" Not sure." Client is adopted.
Do you have children? If yes, what are their ages? "No." **Who are your children with now?**
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? Divorce **If yes, please tell me more about that: "**Adopted mom and dad got divorced when I was about 10 years old. My adopted dad blamed me for the divorce." Client has lived with adopted mom ever since.
Are you currently having relationship problems? "No. I have no relationships. They are too much trouble."

What is your sexual orientation:	**Are you sexually active?**	**Do you practice safe sex?**
"Bisexual."	"No."	"I don't have sex. That creates problems."

Please describe your religious values, beliefs, spirituality and/or preference: "I am not religious."
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): "No."

Whom would you consider your support system? "Mom. Sometimes when we are not fighting."

How can your family/support system participate in your treatment and care? "She's been communicating over the phone."

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) "Tattoos, piercings, or nature walks."

What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.)
"Long lines in the store, and other people making me late. "

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Self-Care:

Independent
Assisted
Total Care

Education History:

Grade school
High school completed. Diploma. Glenwood, 2013
College
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: n/a** **Last Use: n/a**	
Alcohol	**First Use:** 5 years ago **Last Use: T**he day she came into the ER.	Patient was drinking a 12-pack a day before she came in here.
Prescription Medications (Recreational Use)	**First Use: n/a** **Last Use: n/a**	
Marijuana	**First Use:** 19 **Last Use:** early 20's	She was smoking every day, but felt it made her paranoid, so she quit.
Heroin	**First Use: n/a** **Last Use: n/a**	
Methamphetamine	**First Use: n/a** **Last Use: n/a**	
Other: Specify	**First Use: n/a** **Last Use: n/a**	

Current Psychiatric Medications

Complete all of your client's psychiatric medications

All information listed in this section must be pertinent to your patient.

Brand/Generic	Prozac/ fluoxetine	Abilify/ aripiprazole	Seroquel/ quetiapine	Buspar/ buspirone	Atarax/ hydroxyzine
Dose	40	5mg	100mg HS, 200mg AM, 300mg BID	10mg	25mg
Frequency	daily	Daily HS	QID	BID	TID PRN
Route	oral	oral	oral	oral	oral
Classification	Antidepressant, SSRI	antipsychotic	Antipsychotic, atypical	Antianxiety, sedative	Antianxiety/ antihistamine/ sedative/ hypnotic, antiemetic, piperazine derivative
Mechanism of Action	Inhibits CNS neuron uptake of serotonin but not of norepinephrine (Skidmore, 2024).	Exact mechanism unknown; may be mediated through both DOPamine type 2 and serotonin type 2 antagonism, DOPamine system stabilizer (Skidmore, 2024).	Functions as an antagonist at multiple neurotransmitter receptors in the brain, including 5HT1A, 5HT2, dopamine D1, D2, H1, and adrenergic a1, a2 receptors (Skidmore, 2024).	Acts by inhibiting the action of serotonin; has shown little potential for abuse; a good choice with substance abuse (Skidmore, 2024).	Depresses subcortical levels of CNS, including limbic system, reticular formation; competes with H1-receptor sites (Skidmore, 2024).
Therapeutic Uses	Major depressive disorders, OCD, PMDD, panic disorder	Schizophrenia, bipolar disorder, major depressive disorder, mania	Bipolar disorder, bipolar 1 disorder, depression, mania, schizophrenia	Generalized anxiety disorders	Anxiety, prevention of nausea, vomiting, sedation, pruritus
Therapeutic Range (if applicable)					
Reason Client Taking	Patient is taking this medication	Patient is taking this medication	Patient is taking this medication	Patient is taking this medication	Patient is taking this medication

	for depression.	for bipolar.	for bipolar.	for anxiety.	for anxiety.
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication					Get client to darker quiet room with no one else in the room. Have a nice calm conversation on what is bothering the patient.
Contraindications (2)	Diabetes Mellitus, osteoporosis	Breast feeding, geriatric patients	QT prolongation, torsade's de pointes	Pregnancy, impaired hepatic/ renal function	Pregnancy 1st trimester, acute asthma
Side Effects/Adverse Reactions (2)	Suicidal ideation, bradycardia	Suicidal ideation, tremors	Neuropathic malignant syndrome, rhabdomyolysis	Blurred vision, tachycardia	Seizures, hypotension
Medication/ Food Interactions	Increases SSRIs. Increases NSAIDs.	Increases antihypertension effects. Increases fluoxetine effects.	Increases barbiturates. Decreases effects of dopamine agonists.	Increases MAOIs. Increases alcohol levels.	Increases CNS depression. Increases anticholinergic effects.
Nursing Considerations (2)	Assess mental status. Assess for signs of serotonin syndrome.	Assess affect, orientation, LOC, reflexes, gait, coordination, and sleep pattern disturbances. Assess neurological function.	Monitor for orthostatic blood pressure. Assess for change in mental status.	Monitor mood status, monitor CNS reaction because some may be unpredictable	Assess anticholinergic effects. Assess drowsiness.

Medications Reference 1 (APA):

Skidmore-Roth, L. (2024). *Mosby's 2024 nursing drug reference* (37th ed.). Elsevier.

Mental Status Exam Findings

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	The client was lying down in bed. She was wearing sweatpants, and socks. She got up toward the end of the interview to put on a tie-dyed hoodie. The patient was well-groomed. She is alert and oriented to person, place, time, and situation. Speech is appropriate, calm, and clear. Eye contact was partially made, but the patient was taking a nap prior to the interview, so she kept opening and closing her eyes.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	Patient stated she was in a very good mood today, but is very tired all the time due to her medications. Patient seemed standoffish at first, but then became very cooperative once she noticed I was a nursing student. Affect was very restricted at first, but became very flat.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	Patient is alert and oriented to person, place, time, and situation. No memory impairment. The patient was on and off sleeping while being interviewed. Toward the end of the interview patient woke up and was very attentive.
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile,**	Patient states she is not currently having any homicidal or suicidal ideation, no delusions, or hallucinations. Patient states she obsesses over washing her hands; no signs of paranoia, answers all questions appropriately. No flight of ideas, no

Olfactory **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	perseveration, and no loose association.
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	When I asked the patient this question, she stated she would bring it to the nearest store or police station to try to get it back to the owner.
MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	Patient is fully independent without assistance with all ADLs. Gait is steady and smooth. No abnormal motor activities.

Vital Signs, 1 set

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	86	118/72	16	98.1	99% RA

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
1300	0-10	n/a	0	n/a	n/a

Nursing Care

Overview of care provided today: Patient participated in group therapy today

Client complaints: No complaints.

Participation in therapy / groups: Patient participated in all group sessions. In group, she wrote down appropriate ways to handle stressful situations, and proper ways to cope. She voiced her opinion in group and gave her advice on what has been working for her since she has been at this facility.

Medication compliance today: Patient has been compliant with all medications prescribed to her since she has been at this facility.

Behaviors exhibited today: Patient was very calm. She seemed to have a good outlook for when she gets out of this facility.

Discharge Planning

Discharge location: At discharge patient will go back home with her adopted mother and mother's boyfriend.

Follow up plan: Patient will be following up with a psychiatrist and psychologist, also will be following up with her primary care provider.

Education needs: The Patient needs to be educated on proper coping skills, and ways to handle stress other than alcohol.

Nursing Diagnosis

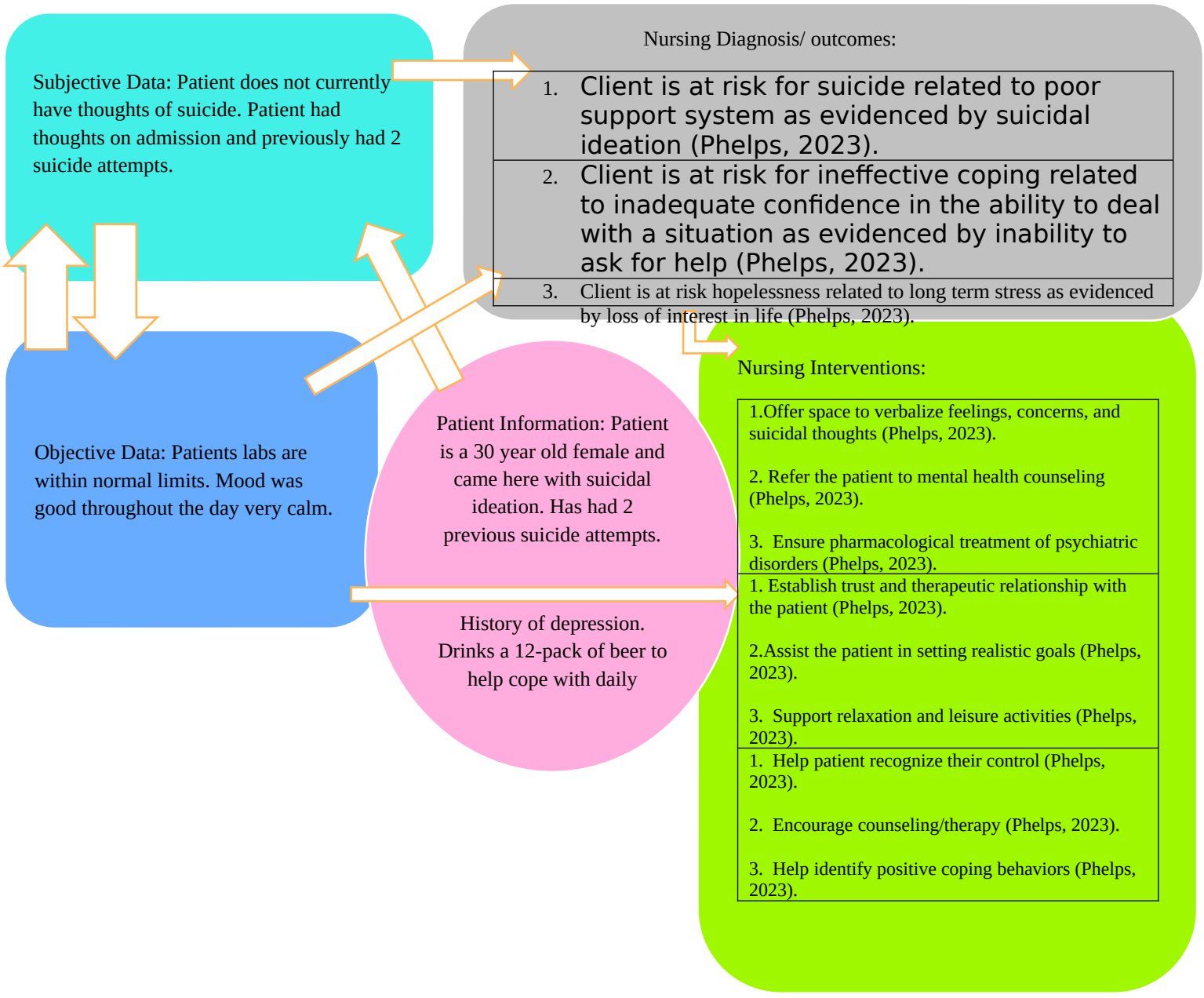
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Client is at risk for suicide related to poor support system as evidenced by suicidal ideation (Phelps, 2023).	I chose this nursing diagnosis due to patient having two previous suicide attempts and had thoughts of suicide on admission.	1. Patient will not use alcohol once discharged to decrease thoughts of suicide (Phelps, 2023).	1. Offer space to verbalize feelings, concerns, and suicidal thoughts (Phelps, 2023). 2. Refer the patient to mental health counseling (Phelps, 2023). 3. Ensure pharmacological treatment of psychiatric disorders (Phelps, 2023).	1. Provide patient with telephone numbers and other information about crisis centers, hot lines, and counselors (Phelps, 2023). Patient will be provided with suicide hotline number, for when the patient is having suicidal thoughts.
2. Client is at risk for ineffectiv e coping	I chose this nursing diagnosis due to the	1. Patient will demonstrate effective coping when faced with	1. Establish trust and therapeutic relationship with the patient	1. Refer patient for professional psychological

related to inadequate confidence in the ability to deal with a situation as evidenced by inability to ask for help (Phelps, 2023).	fact that the patient is having altered thoughts and has had 2 previous suicide attempts.	unfavorable situations (Phelps, 2023).	(Phelps, 2023). 2. Assist the patient in setting realistic goals (Phelps, 2023). 3. Support relaxation and leisure activities (Phelps, 2023).	counseling (Phelps, 2023). Patient will talk with a psychologist and psychiatrist do discuss proper coping methods.
3. Client is at risk hopelessness related to long term stress as evidenced by loss of interest in life (Phelps, 2023).	I chose this nursing diagnosis due to the fact that the patient has a history of depression.	1. Patient will verbalize their feelings regarding hopelessness (Phelps, 2023).	1. Help patient recognize their control (Phelps, 2023). 2. Encourage counseling/therapy (Phelps, 2023). 3. Help identify positive coping behaviors (Phelps, 2023).	1. Refer patient and family members to support groups and outside specialists to discuss illness with others similar affected (Phelps, 2023). Patient will be provided with outpatient therapy to express feelings and concerns.

Other References (APA):

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


Subjective Data: Patient does not currently have thoughts of suicide. Patient had thoughts on admission and previously had 2 suicide attempts.
Objective Data: Patients labs are within normal limits. Mood was good throughout the day very calm.
Patient Information: Patient is a 30 year old female and came here with suicidal ideation. Has had 2 previous suicide attempts.
History of depression. Drinks a 12-pack of beer to help cope with daily
Nursing Diagnosis/ outcomes:
1. Client is at risk for suicide related to poor support system as evidenced by suicidal ideation (Phelps, 2023).
2. Client is at risk for ineffective coping related to inadequate confidence in the ability to deal with a situation as evidenced by inability to ask for help (Phelps, 2023).
3. Client is at risk hopelessness related to long term stress as evidenced by loss of interest in life (Phelps, 2023).
Nursing Interventions:
1.Offer space to verbalize feelings, concerns, and suicidal thoughts (Phelps, 2023).
2. Refer the patient to mental health counseling (Phelps, 2023).
3. Ensure pharmacological treatment of psychiatric disorders (Phelps, 2023).
1. Establish trust and therapeutic relationship with the patient (Phelps, 2023).
2.Assist the patient in setting realistic goals (Phelps, 2023).
3. Support relaxation and leisure activities (Phelps, 2023).
1. Help patient recognize their control (Phelps, 2023).
2. Encourage counseling/therapy (Phelps, 2023).
3. Help identify positive coping behaviors (Phelps, 2023).