

N323 Care Plan

Lakeview College of Nursing

Nnaemeka Uwakwe

Section 1:			/5
pts			
Date of Admission	Client's Initials	Age	Gender

02/22/2020	RS	24	Female
Race/Ethnicity Mixed African American	Occupation CNA	Marital Status Single	Allergies NKA
Observation Status Full	Height / Weight 5'2" 130lbs	Other Pertinent Information Lost 13lbs due to depression	

Section 2: 5 pts	/
Admission Assessment	
Reason for Admission (In client's own words): I am in here because I was having suicidal thoughts of harming myself.	
Admitting Diagnosis: Major depression disorder	
Secondary Diagnosis (if applicable): general anxiety disorder	
Medical Conditions: Asthma	
Factors that Lead to Admission: RS wanted to jump off a bridge into a lake her- best friend contacted the police. They rescued her from the ledge and she was then taken into the hospital. The emergency department was later admitted to the	

mental health facility.

History of Suicide Attempts (Date/Method): 8 years old in (2012) and most recent 02/19/20.

History and Current use of Substances: n/a

History of Psychiatric Diagnosis: Major depressive disorder

Section 3:
/20 pts

Level of Care Assessment

NOTE: If you do not know the definitions look them up!

Appearance	Appropriate Poor Hygiene Needle tracks Poor eye contact	Neat / Well groomed Dental erosion Injured	Good eye contact Dress: Casual Bizarre	Disheveled Clothing not typical of gender
Build	Average Petite	Underweight Obese	Thin Muscular	Overweight
Speech	Normal rate	Loud	Slow	Soft

	Pressured Mumbled Monotone Rapid	Slurred Incoherent Animated/ excited Circumstantial	Garbled Clear Accent Flight of ideas	Stutter Impoverished Difficulty finding words
Interpersonal Style	Congenial Withdrawn Engaging Irritable	Open Relaxed Defensive Guarded	Cooperative Shy Resistant Cautious	Compliant Hostile Annoyed
Mood/ Affect Mood as stated in client's own words:	Fearful Anhedonia Indifferent Dysphoric Flat Depressed/ Hopeless/ Helpless	Irritable Anxious Labile Apathetic Constricted	Appropriate Sad Ambivalent Reactive Fixed	Angry Manic Blunt Calm Tearful
Behavior	Euphoric Drowsy Sullen Depressed Inability to focus	Angry Anxious/panicky Distant Manic/mania	Irritable Paranoid/ suspicious Unconcerned Hyperactive	Hostile Appropriate Negative Hypervigilant
Judgement Comments:	Good	Fair	Poor	

Abstraction	Appropriate	Concrete		
Insight Comments:	Awareness of problem Psychosis Dementia	Partial understanding of illness	Denial of problem/illness	No understanding of illness
Impulse Control	Good	Fair	Poor	
Intelligence	Average	Above Average	Below Average	Unable to ascertain
Orientation	Time Disoriented	Place Poor Concentration	Person	Situation
Sensorium	Alert Clouded	Aware Drowsy	Lethargic Dull	Stupor Uninterested
Thought content	Hallucinations Confused Goal directed Coherent Depersonalization Within normal limits	Delusions Divergent Somatic Logical Dangerous Confabulation	Paranoia Evasive Obsessive Grandiosity Distortion of body image	Racing thoughts Blocking Phobic Tangential Loose associations
Memory	Recent Good	Short Term Good	Long Term Good	

	Fair Poor	Fair Poor	Fair Poor	
Gait	Normal	Shuffling	Unsteady	Staggering
Assistive Devices:	Rigid	Trembling	Left side weakness	Right side weakness
Posture/ Muscle Tone/ Strength:	Normal Cogwheel	Rigid Spastic	Slouched Atrophy	Flaccid Other
Motor Movements	Normal Tics	Restless Continuous movement	Agitated Slow/ psychomotor retardation	tremors

Section 4: /10pts				
Psychosocial Assessment				
History of Trauma				
No lifetime experience/witness of trauma/abuse				
	Current	Past	Secondary Trauma	Describe

		(what age)	a**	
Physical Abuse	none	12-22 years		Beaten by her mother and ex-boyfriend
Sexual Abuse				
Emotional Abuse				"Mom left me emotionally scarred. I saw her overdose on drugs. Ex-boyfriend did not support me when I was down
Neglect				
Exploitation				
Crime				
Military				
Natural Disaster				
Loss				
Other				

**Secondary Trauma is a response that comes from caring for another person with trauma. Also called compassion fatigue or burnout.

Section 5:
/15 pts

Presenting Problems

Problematic areas	Presenting?		Describe (frequency, intensity, duration, occurrence)
Depressed or sad mood	Yes	No	
Loss of energy or interest in activities/school	Yes	No	During depressed state patient states, "she felt drained and lost interest in focusing in school so decided to drop out".
Deterioration in hygiene and/or grooming	Yes	No	
Social withdrawal or isolation	Yes	No	RS at times withdraws and wants to avoid interactions twice a day.
Difficulties with ability to parent/or be parented	Yes	No	
Difficulties with home, school, work, relationships or responsibilities	Yes	No	Was not able to go to classes and focus on school work being depressed during those times just couldn't take it. So I had to drop out of classes.
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in number of hours / nights	Yes	No	4-5 hours of sleep occurs every other night when anxiety or thoughts come into

			my mind.
Difficulty falling asleep	Yes	No	Since coming to this new environment everything is new alot on my mind
Frequently awakening during night	Yes	No	
Early morning awakenings	Yes	No	I am an early morning person.
Nightmares/dreams	Yes	No	Nightmares of seeing my mom overdosing on heroin and pain medications
other	Yes	No	
Eating habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	It only happens when I'm in a depressed state.
Binge eating and/or purging	Yes	No	
Unexplained weight gain/loss? Amount of weight change: <u> 15 </u>	Yes	No	Depression was her cause of weight loss of appetite
Use of laxatives or excessive exercise	Yes	No	

Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety Behaviors (pacing, tremors etc.)	Yes	No	Pacing back and forward to clear my mind and tremors a few times a week
Panic attacks	Yes	No	Anxiety increases my heart rate once a week
Obsessive/compulsive thoughts	Yes	No	
Obsessive/compulsive behaviors	Yes	No	
Impact on daily living or avoidance of situations/ objects due to levels of anxiety	Yes	No	Anxious cancel plans for the day and put off anything for the day shut down and stay home.
Rating Scale			
How would you rate your depression on scale of 1-10 2			
How would you rate your anxiety on scale of 1-10 0			
Section 6: /5 pts Current Stressors or Areas of Life Affected by Presenting Problems (work, school, family, legal, social, financial)			
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)

Work	Yes	No	The week days of work it's a moderate to severe where im unable to focus at work
School	Yes	No	The week days of school it's a moderate to severe where im unable to focus at school
Family	Yes	No	She's had difficulty talking with her mother bring about stress to her and anxiety.
Legal	Yes	No	
Social	Yes	No	
Financial	Yes	No	
Other	Yes	No	

Section 7: **No Data collected under this section**
/5 pts

Previous Psychiatric and Substance Use Treatment - Inpatient/Outpatient

Dates	Facility/MD/ Therapist	Inpatient/Outpatient	Reason for Treatment	Response/ Outcome
		Inpatient Outpatient Other: _____		No Improvement Some improvement Significant Improvement

		Inpatient Outpatient Other: _____		No Improvement Some improvement Significant Improvement
		Inpatient Outpatient Other: _____		No Improvement Some improvement Significant Improvement

<p>Section 8: /20 pts Personal/Family History</p>
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Who lives with you?	Age	Relationship	Do they use any substances	
Child	5	Daughter	Yes	No
Child	2	Daughter	Yes	No
			Yes	No
			Yes	No
			Yes	No

<p>If yes to any substance use: explain</p>

Children (age and gender):5 years and 2 years old female		
Who are children with now? Auntie moms sister		
Household dysfunction, including separation/divorce/death/incarceration: father not around and mother on drugs addicted to drugs		
Current relationship problems: single mother Number of Marriages:0		
Sexual Orientation:	Is client sexually active? Yes No	Does client practice safe sex? Yes No
Please describe your religious values, beliefs, spirituality and/or preference: a spiritual believer		
Ethnic /cultural factors /traditions / current activity Describe: Client does not have a cultural upbringing celebrating eurocentric holidays.		

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Current/Past legal issues (with self/parents, arrests, divorce, CPS, Probation officers, pending charges, or court dates): none available or documented

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How can your family/support system participate in your treatment and care?
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They can help me at times when I'm stressed. I'm far away from home but my immediate family isn't much support. I put myself into the CNA program and raised my kids with the help of my auntie. My grandparents helped me when I was depressed and supported me raising my girls.
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Client raised by – Natural parents Grandparents Adoptive parents Foster parents

Other: (describe)

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Significant Childhood issues impacting current illness:

Atmosphere of Childhood Home:
Loving Comfortable Chaotic Abusive Supportive Other: mom was verbally and physically abusive and it was because of the drugs she kept doing.
Self-Care: Independent Assisted Total Care
Family History of Mental Illness (diagnosis/ suicide/ relation etc.)
None documented
Family History of Substance Use:
Narcotic and pain medications
Education History: Grade school High school College Other
Reading Skills: Yes No Limited
Primary Language: English

Problems in School:
Unable to focus at school work and maintain decent grades for nursing school.
Discharge:
Clients goals for treatment:
Implication of coping mechanisms and identifying what works for patients as well as medication.
Where will the client go when discharged?
Either to her own home or with her auntie where the kids are currently with them.

Section 9:

/5 pts

Vitals

Time	Pulse	B/P	Resp Rate	Temp	O2
5:15 PM	84	98/72	14	97.3	97

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Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
5:15	0				

Intake and Output

Intake (in mL)	Output (in mL)
240 mL	0 mL

Section 10:

/5 pts

Discharge Planning

Discharge Plan (Nurse's (student) for the client)

Patient will get discharged to a family member. Patient has coping mechanisms such as meditations, drawing and witting down in diary to prevent higher risk of suicide because patient is suicidal. Patients will take medications and c in ome back if symptoms do not improve or worsen. Patient will be discharged by mom and be in care of her mother. Continued cognitive behavioral therapy, with remobal of antidepressants or antipschycotics, and suicidal assessment to determine risk and possible suicide watch.

Section 11:

/15 pts

Current Psychiatric Medication

Complete on all your client's Psychiatric medications

Brand/Generic	Trazadone	Trazadone (desynel)	oxcarbazepile (trileptal)	Sertrelina (zoloft)	n/a
Dose	25mg	50mg Higher dose	150mg	50mg	
Frequency	bed time	bed time	BID	morning	
Route	oral	oral	oral	oral	
Classification	antipsychotics	antipsychotics	Antiepileptic	Antidepressant	
Mechanism of Action	Antidepressant that increases serotonin activity in the brain	Antidepressant that increases serotonin activity in the brain	Blocks sodium channel	It affects chemicals in brain with people with	

				anxiety depression	
Therapeutic Uses	Depression anxiety sleep and pain	Depression anxiety sleep and pain	Prevent seizures	Treats panic disorder depression and PTSD	
Reason Client is taking	Risk for self harm insomnia	Risk for self harm insomnia	Mood stabilizer	Depression	
Contraindications	Increased risk of bleeding Suicidal thoughts	Increased risk of bleeding Suicidal thoughts	Decreasing nerve impulses	Taking pimozide	
Side effects/ adverse reactions (2)	Headache Dry mouth	Headache Dry mouth	Mental depression dizziness	Dry mouth insomnia	
Medication/ Food Interactions	Warfarin	Warfarin	abilify(aripiprazole) Ambien (zolpidem)	NSAIDs Ibuprofen	

Patient only has the above medications on file

Medication References (APA)

Jones & Bartlett Learning. (2019). *2019 Nurse’s Drug Handbook*.

Trazodone Uses, Dosage, Side Effects & Warnings. (n.d.). Retrieved from <https://www.drugs.com/trazodone.html>

Section 12: /20 pts				
Client Problem List (Prioritized)	Desired Client Outcome	Immediate Interventions (at admission)	Intermediate Interventions (during hospitalization)	Community Interventions prior to discharge)
Medication Unfamiliarity	1. Client will have an increased understanding of the need for medication.	1. Assess what medications are currently prescribed to client? 2. Assess when and which medications client has been taking? 3. Assess the patients knowledge level regarding the use of medication to improve depression symptoms	1. Provide client education on the need for medication education. 2. Provide client education on strategies to remember to take medications as prescribed a. Take at same time daily (Example: at bedtime) 3. Provide client education on common side effects of medications including interventions to decrease side effects and circumstances to contact the care provider. (suicidal thoughts, anxiety)	1. Assess client’s ability to pay for medications. Provide education on low cost pharmacies. Four-dollar medication list at Walmart or provide information on mail order pharmacies 2. Assess client’s transportation needs to pick up medications from the pharmacy. Or close relative to assist Provide information on possible transportation to pharmacy (bus, senior van, cost of taxi) 3. Assess strength of client’s support system for assistance remembering to take medications. Organize

				calendar reminders on mobile devices. Assist clients in making a written list of phone numbers of support systems and education on when to contact.
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1. Major Depression	Clients will verbalize accurate information about two of the possible causes of depression and use of medications .	<p>1. Assess the patient's knowledge about depression</p> <p>2. Inform the patient about major symptoms of depression</p> <p>3. Assess client for self-harm thoughts</p>	<p>1. Provide client education on common coping methods including interventions to decrease depressed symptoms</p> <p>2. Engage in reality-based interactions with 24 hours.</p> <p>3. The client should showcase a functional level of psychomotor activity.</p>	<p>1. The client will demonstrate compliance with knowledge of medications if there are any.</p> <p>2. Demonstrate and increase in ability to cope with anxiety, depression, and stress</p> <p>3. Patients should be able to identify support systems in the community.</p>
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3.suicidal ideation	Outcome for client is keeping client safe and later developing a new coping skill that excludes self harm	1.Assess patients self-harm thoughts, plans, behaviors, and intent. 2.Assess patients reason for living and plans for the future 3.assess past suicidal behavior	1.Providing patient with a safe environment 2.Denying patient access to materials on cleaning carts, their medication, sharp scissors, and pens. 3.Assess clients coping skills to stress.	1.The patient will receive a list of agencies to develop a support system 2. administer medication perscribed for suicide. 3.The patient will be assessed for suicidal ideation and educated on psychosocial stressors with family
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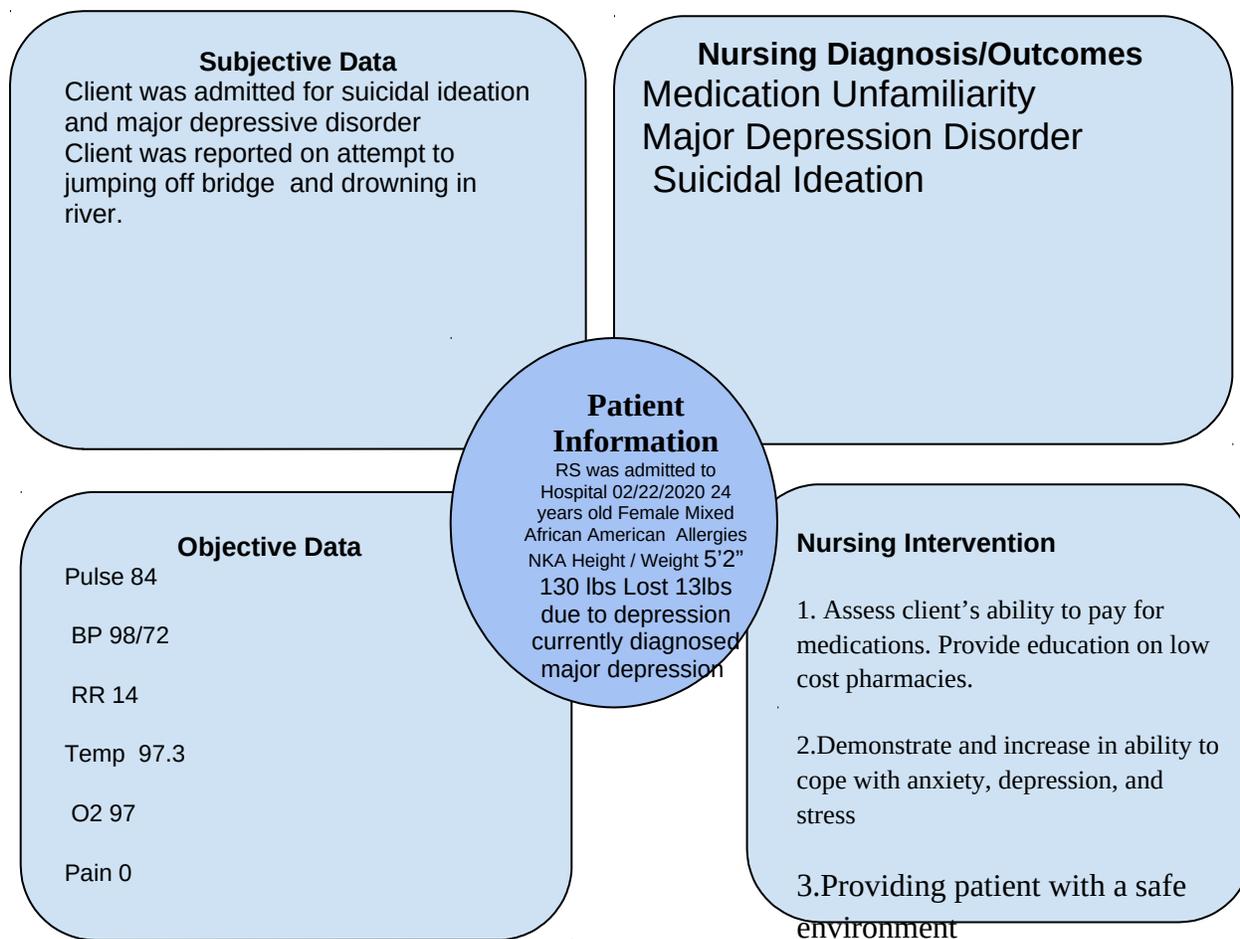
Other References (APA):

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. Elsevier.

Videbeck, S. L., & Miller, C. J. (2019). *Psychiatric-mental health nursing*. Wolters Kluwer.

Section 13:
/20pts

Concept Map



N323 Care Plan Rubric				
Student:				
Date:				
Section	Title	Possible Points	Points Earned	Professor Comments
1	Admission Information	5		
2	Admission	5		

	Assessment			
3	Level of Care Assessment	20		
4	Psychosocial Assessment	10		
5	Presenting Problems	15		
6	Current Stressors	5		
7	Previous Psych/Substance Use	5		
8	Personal / Family History	20		
9	Vitals / Pain / I &O Assessment	5		
10	Discharge Planning	5		

11	Current Psychiatric Medications	15		
12	Client Interventions	20		
13	Concept Map	20		
	APA References	5		
	Total			

Honor Code: "I have neither given nor receive, nor will I tolerate others' use of unauthorized aid".

Signature _____ Date: _____