

N323 Care Plan

19-2

Lakeview College of Nursing

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Section 1: /5 pts			
Date of Admission 3/26/2020	Client's Initials ES	Age 54	Gender Male
Race/Ethnicity Hispanic	Occupation Disabled	Marital Status Divorced	Allergies Sulfa Risperidone
Observation Status Suicide watch	Height / Weight 5'5" 180 lbs	Other Pertinent Information N/A	

Section 2: /5 pts
Admission Assessment
Reason for Admission (In client's own words): "Was going to cut my wrists"
Admitting Diagnosis: Major Depressive Disorder
Secondary Diagnosis (if applicable):
Medical Conditions: HTN, high cholesterol, depression
Factors that Lead to Admission: homeless, not taking medication, PTSD, schizoaffective, bipolar, drug abuse, in a gang
History of Suicide Attempts (Date/Method): Tried to jump off bridge, cut wrist, overdose, and wreck car. No dates for the attempts, but he began to try when he was 44 years old.
History and Current use of Substances: Cocaine- started at 44 years old, snorts 1-2x a month. Marijuana- started at 16 years old, occasionally smokes it.
History of Psychiatric Diagnosis: Client states that he has experienced auditory hallucinations before, they began at 44 years old. "Tell me to do drugs and kill myself"

Section 3:

/20 pts

Level of Care Assessment

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

Appearance	<p>Appropriate</p> <p>Poor Hygiene</p> <p>Needle tracks</p> <p>Poor eye contact</p>	<p>Neat / Well groomed</p> <p>Dental erosion</p> <p>Injured</p>	<p>Good eye contact</p> <p>Dress:</p> <p>Casual</p> <p>Bizarre</p>	<p>Disheveled</p> <p>Clothing not typical of gender</p>
Build	<p>Average</p> <p>Petite</p>	<p>Underweight</p> <p>Obese</p>	<p>Thin</p> <p>Muscular</p>	<p>Overweight</p>
Speech	<p>Normal rate</p> <p>Pressured</p> <p>Mumbled</p> <p>Monotone</p> <p>Rapid</p>	<p>Loud</p> <p>Slurred</p> <p>Incoherent</p> <p>Animated/excited</p> <p>Circumstantial</p>	<p>Slow</p> <p>Garbled</p> <p>Clear</p> <p>Accent</p> <p>Flight of ideas</p>	<p>Soft</p> <p>Stutter</p> <p>Impoverished</p> <p>Difficulty finding words</p>
Interpersonal Style	<p>Congenial</p> <p>Withdrawn</p> <p>Engaging</p> <p>Irritable</p>	<p>Open</p> <p>Relaxed</p> <p>Defensive</p> <p>Guarded</p>	<p>Cooperative</p> <p>Shy</p> <p>Resistant</p> <p>Cautious</p>	<p>Compliant</p> <p>Hostile</p> <p>Annoyed</p>
<p>Mood/Affect</p> <p>Mood as stated in client's own words:</p>	<p>Fearful</p> <p>Anhedonia</p> <p>Indifferent</p> <p>Dysphoric</p> <p>Flat</p> <p>Depressed/</p> <p>Hopeless/ Helpless</p>	<p>Irritable</p> <p>Anxious</p> <p>Labile</p> <p>Apathetic</p> <p>Constricted</p>	<p>Appropriate</p> <p>Sad</p> <p>Ambivalent</p> <p>Reactive</p> <p>Fixed</p>	<p>Angry</p> <p>Manic</p> <p>Blunt</p> <p>Calm</p> <p>Tearful</p>
Behavior	<p>Euphoric</p> <p>Drowsy</p> <p>Sullen</p> <p>Depressed</p> <p>Inability to focus</p>	<p>Angry</p> <p>Anxious/panicky</p> <p>Distant</p> <p>Manic/mania</p>	<p>Irritable</p> <p>Paranoid/suspicious</p> <p>Unconcerned</p> <p>Hyperactive</p>	<p>Hostile</p> <p>Appropriate</p> <p>Negative</p> <p>Hypervigilant</p>
Judgment	<p>Good</p>	<p>Fair</p>	<p>Poor</p>	
Comment				

S:				
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 Fair Poor	Short Term Good Fair Poor	Long Term Good 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 (what age)	Secondary Trauma* *	Describe
Physical Abuse	N/A	N/A	N/A	
Sexual Abuse	N/A	N/A	N/A	
Emotional Abuse	N/A	N/A	N/A	
Neglect	N/A	N/A	N/A	
Exploitation	N/A	N/A	N/A	
Crime	N/A	N/A	N/A	
Military	N/A	N/A	N/A	
Natural Disaster	N/A	N/A	N/A	
Loss	No	19	N/A	Mom was murdered by father, client found the body
Other	N/A	N/A	N/A	

**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	"Have been feeling depressed for about 10 years now"
Loss of energy or interest in activities/school	Yes	No	
Deterioration in hygiene and/or grooming	Yes	No	

Social withdrawal or isolation	Yes	No	
Difficulties with ability to parent/ or be parented	Yes	No	No contact with his children
Difficulties with home, school, work, relationships or responsibilities	Yes	No	Homeless and disabled
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in number of hours / nights	Yes	No	"Haven't been sleeping for the past few nights, get about 4 hours of sleep"
Difficulty falling asleep	Yes	No	Lays awake for hours before dozing off
Frequently awakening during night	Yes	No	Claims he wakes up about every 2 hours
Early morning awakenings	Yes	No	
Nightmares/dreams	Yes	No	
other	Yes	No	Snores very loud, has sleep apnea
Eating habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	
Binge eating and/or purging	Yes	No	
Unexplained weight gain/loss? Amount of weight change: _____	Yes	No	
Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety Behaviors (pacing, tremors etc.)	Yes	No	
Panic attacks	Yes	No	One month ago when he got out of a Chicago behavioral center
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	
Rating Scale			

How would you rate your depression on scale of 1-10 **0/10**

How would you rate your anxiety on scale of 1-10 **0/10**

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	Client is disabled
School	Yes	No	
Family	Yes	No	Client has no contact with his children
Legal	Yes	No	Client has court date for inhalants on 6/2020.
Social	Yes	No	
Financial	Yes	No	
Other	Yes	No	

Section 7:

/5 pts

Previous Psychiatric and Substance Use Treatment - Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
2019	New Choice	Inpatient Outpatient Other: _____	Substance abuse	No Improvement Some improvement Significant Improvement
2019	New Choice	Inpatient Outpatient Other: _____	Substance abuse	No Improvement Some improvement Significant Improvement
2020	Chicago Behavioral Center (was not in chart but was told by client, he did not specify the name)	Inpatient Outpatient Other: _____	Substance abuse	No Improvement Some improvement Significant Improvement

Section 8:

/20 pts **Personal/Family History**

Who lives with you?	Age	Relationship	Do they use any substances	
N/A	N/A	N/A	Yes	No

N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
N/A	N/A	N/A	Yes	No
If yes to any substance use: explain				
Children (age and gender): Daughter that is 26, son that is 19, daughter that is 15.				
Who are children with now? With their mother				
Household dysfunction, including separation/divorce/death/incarceration: One divorce				
Current relationship problems: Client has no contact with kids Number of Marriages: ____1____				
Sexual Orientation: Heterosexual	Is client sexually active? Yes No		Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference: Catholic				
Ethnic /cultural factors /traditions / current activity Describe:				
Client goes to church and reads the bible.				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, Probation officers, pending charges, or court dates):				
One divorce, arrested for intoxication of inhalants, DUI, disorderly conduct, and domestic "MS"				
How can your family/support system participate in your treatment and care?				
Client's brother provides food and shelter to him. He can help by listening to the client when needed and to be of help.				
Client raised by - Natural parents Grandparents Adoptive parents Foster parents				
Other: (describe)				

Significant Childhood issues impacting current illness:					
When client was 19 years old, his father killed his mother and chopped her up to hide the body. Client found part of her body.					
Atmosphere of Childhood Home:					
Loving	Comfortable	Chaotic	Abusive	Supportive	Other:
Self-Care:	Independent	Assisted	Total Care		
Family History of Mental Illness (diagnosis/ suicide/ relation etc.)					
No family history of mental illness					
Family History of Substance Use:					
No family history of substance use					
Education History:	Grade school	High school	College	Other	"Some college"
Reading Skills:	Yes	No	Limited		
Primary Language:	English but is also fluent in Spanish				
Problems in School:	No problems in school				
Discharge:					
Clients goals for treatment:					
Stay off drugs, stay off the street					
Where will client go when discharged?					
Go back to his brother's in Galesburg					

Vitals

Time	Pulse	B/P	Resp Rate	Temp	O2
3/8/2020 5:26 pm	73	146/93	16	96.9 F	98%
3/9/2020 6:44 pm	90	188/99	18	97 T	96%

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
3/8/2020 5:26	0-10	Head	"10/10"	Aching	Take medicine, get some rest
3/9/2020 6:41 pm	0-10	Head	"7/10"	Aching in front	Take Tylenol

Intake and Output

Intake (in mL)	Output (in mL)
750 mL	700 mL

Section 10:

/5 pts

Discharge Planning

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

Upon the client's discharge, he will return to his brother's house in Galesburg. This nursing student believes that is important for the client to attend AA meetings weekly. The client should take in consideration that it may be helpful for him to keep a journal to write in daily. It may be best for him to find a therapist that he is able to see whenever

needed. If the client begins to have any suicidal ideations again it is very important for him to receive help as soon as possible.

Section 11:

/15 pts

Current Psychiatric Medication
Complete on all your client's Psychiatric medications

Brand/ Generic	Quetiapine Seroquel	Trazodone	Fluoxetine	Divalproex Sodium	Amlodipine
Dose	300 mg	150 mg	10 mg	500 mg	5 mg
Frequency	HS	HS	Daily	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	Antipsychoti c	Antidepres sant	Antidepress ant		Antihyperten sive
Mechanism of Action	May produce antipsychoti c effects by interfering with dopamine binding to dopamine type 2 receptor sites in the brain.	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepres sant effect.	Selectively inhibits reuptake of the neurotrans mitter serotonin by CNS neurons and increases the amount of serotonin		Binds to dihydropyrid ine and nondihydrpy ridine cell membrane receptor sites on myocardial and vascular smooth- muscle cells and inhibits

			available in nerve synapses.		influx of extracellular calcium ions across slow calcium channels.
Therapeutic Uses	To treat schizophrenia	To treat major depression	To treat depression	To treat manic phase of bipolar disorder	To control hypertension
Reason Client is taking	Insomnia	Depression	Depression	Mood stabilizer	Hypertension
Contraindications	Hypersensitivity to quetiapine or its components	Hypersensitivity to trazodone or its components	Concurrent therapy with pimozide or thioridazine, hypersensitivity to fluoxetine	Depression, suicidal thoughts, decreased blood platelets	Aliskiren therapy in patients with diabetes or renal impairment, hypersensitivity to amlodipine
Side effects/adverse reactions (2)	Chills, cold sweats	Headache, Dizziness	Insomnia, vision changes	Nausea, vomiting	Dizziness, fatigue
Medication/Food Interactions	Alcohol use-possibly enhanced CNS depression, Antihypertensives-possibly enhanced antihypertensive effects of these drugs	Alcohol use-increased CNS depression, NSAIDs-possible increased risk of bleeding	NSAIDs-increased anticoagulant activity and risk of bleeding, Phenytoin-increased blood phenytoin level and risk of toxicity	Alcohol can increase the nervous system side effects of divalproex sodium such as dizziness, drowsiness, and difficulty concentrating.	Beta blockers-possibly excessive hypotension, cyclosporine-possibly increased blood cyclosporine levels of these drugs.

Medication References (APA):

Amlodipine: Drug Uses, Side Effects & Dosage. (n.d.). Retrieved from <https://www.drugs.com/amlodipine.html>

Divalproex sodium and Alcohol / Food Interactions. (n.d.). Retrieved from <https://www.drugs.com/food-interactions/divalproex-sodium.html>

Fluoxetine: Drug Uses, Dosage & Side Effects. (n.d.). Retrieved from <https://www.drugs.com/fluoxetine.html>

Jones & Bartlett Learning (2019). 2019 Nurse's drug handbook.

Seroquel: Drug Uses, Dosage & Side Effects. (n.d.). Retrieved from <https://www.drugs.com/seroquel.html>

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

Client Problem List (Prioritized)	Desired Client Outcome	Immediate Interventions (at admission)	Intermediate Interventions (during hospitalization)	Community Interventions (prior to discharge)
1. Suicidal Ideation	Keep client safe and later developing a new coping skill that excludes self harm	<ol style="list-style-type: none"> 1. Assess client's self-harm thoughts, plans, behaviors, and intent 2. Assess any past suicidal behavior 3. Assess client's reason for living and plans for the future 	<ol style="list-style-type: none"> 1. Providing patient with a safe environment 2. Assess clients coping skills to stress 3. Denying patient access to materials on cleaning carts, their medication, sharp scissors, and pens 	<ol style="list-style-type: none"> 1. The patient will be assessed for suicidal ideation and educated on psycho-social stressors with family 2. The patient will receive a list of agencies to develop a support system. 3. Administer medication prescribed for suicidal ideations
2. Addiction	Overcome the need for drugs, and to stay drug free from here on out	<ol style="list-style-type: none"> 1. Prepare the client for the withdrawal he will most likely go through 2. Review program rules, philosophy expectations 3. Assess understanding of current situation, previous, 	<ol style="list-style-type: none"> 1. Use peer support to examine ways of coping with drug binges 2. Use peer support to examine ways of coping with drug hunger 3. Assist client to learn and 	<ol style="list-style-type: none"> 1. Discuss patient's plans for living without drugs 2. Encourage involvement in therapeutic writing. Have patient begin journaling or writing autobiography.

		and other methods of coping with life's problems.	encourage use of relaxation skills, guided imagery, visualizations.	3. Discuss current life situation and impact of substance use.
3. Hopelessness	Client sets goals consistent with optimism, meaning in life, and belief in self and others.	<ol style="list-style-type: none"> 1. Assess physical appearances such as the grooming, posture, and hygiene. 2. Assess the patient's understanding of the situation, belief in self, and his or her own abilities. 3. Assess patient's willingness to eat, sleeping patterns, and daily activities. 	<ol style="list-style-type: none"> 1. Encourage a positive mental perspective, discourage negative thoughts, and brace patient for negative results. 2. Provide openings for the patient to verbalize feelings of hopelessness. 3. Encourage the patient to recognize his or her own strengths and abilities. 	<ol style="list-style-type: none"> 1. Assist the patient in establishing realistic goals by recognizing short-term goals and revising them as needed. 2. Present opportunities for the patient to manage care setting. 3. Refer patient to self-help groups such as I Can Cope and Make Today Count.

Other References (APA):

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

Section 13:
/20pts

Concept Map

