N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 02/05/21	**Patient Initials** MM	**Age** 35	Gender Female
Race/Ethnicity Caucasian	**Occupation** Disability	**Marital Status** Married	**Allergies** NKDA
Code Status Full	**Observation Status** 15-minute rounds	**Height** 5'7"	**Weight** 154 lb.

Medical History (5 Points)

Past Medical History: Anxiety, Asthma, Bipolar Disorder, Depression, Hypertension, CVA (2016)

Significant Psychiatric History: Anxiety, Bipolar Disorder, Depression. The patient stated that last year she was hospitalized for 5 days at OSF Urbana and was diagnosed with her mental health illnesses then.

Family History: Maternal mother- bipolar disorder, Paternal- dyslipidemia, Paternal grandmother- Cancer & T2DM

Social History (tobacco/alcohol/drugs): Patient denies tobacco/alcohol/drug use, but drug screen performed in ED detected amphetamines.

Living Situation: Patient lives in Urbana with her husband and daughter.

Strengths: Patient stated: "I am a good mother and I'm able to identify when I need help for my mental illness."

Support System: Patient stated: "I have a good support system. My husband is supportive of me getting help and he visits when he can. I have a good relationship with my in-laws and my parents. They help me by watching my daughter or cleaning if I need a break."

Admission Assessment

Chief Complaint (2 points): Patient stated: “I was having intrusive thoughts, and unable to sleep.”

Contributing Factors (10 points):

Factors that lead to admission: Patient stated: “I had my husband bring me to the emergency department because I was having intrusive and disturbing thoughts. I believed that the world was ending and that I was the antichrist. I was seeing strange things and I could not calm myself down. I also could not sleep and was up for 3 days. I took my trazadone and some over the counter cold medicine to help me sleep, but it did not work. I knew that I needed to get some help for my anxiety, so I came here.” Patient’s drug toxicology screening was positive for amphetamines.

History of suicide attempts: Patient stated that she has had suicidal thoughts on and off for the past few years, but she would never act on them because of her religious beliefs.

Primary Diagnosis on Admission (2 points): Amphetamine abuse, Psychosis (unspecified), UTI

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Client stated: “I was bullied from the age of 12 until I graduated high school. I saw a therapist about it, but I did not open up”. **Witness of trauma/abuse:** Patient denied being a witness to abuse.				
	Current	**Past (what age)**	**Secondary Trauma**	**Describe**

			(response that comes from caring for another person with trauma)	
Physical Abuse				n/a
Sexual Abuse				n/a
Emotional Abuse				n/a
Neglect				n/a
Exploitation				n/a
Crime				n/a
Military				n/a
Natural Disaster				n/a
Loss		Ages: 2, 14, 22, 33		All of patient's grandparents are deceased. Patient stated: "It makes me sad that I am not able to share my life or children with them."
Other- Bullied		Age 12-18		Patient stated: "I was bulled a lot when I was 12 until I graduated from high school."
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**		Patient reported feeling sad/depressed at least once a week. Patient stated it is mild but does cause her to have fatigue. She stated: "It usually lasts for a few hours".	

Loss of energy or interest in activities/school	**Yes**		Patient reported energy loss that occurs at least once a week. She reports that for several hours at a time it is difficult to get out of bed or maintain her home.
Deterioration in hygiene and/or grooming	**Yes**		This is not a current issue for my patient. However, she reported that when she is depressed, she goes 1-2 days without showering.
Social withdrawal or isolation		**No**	Patient stated: "I go hang out with my friend when our schedules allow it."
Difficulties with home, school, work, relationships, or responsibilities		**No**	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**		Patient reports that she gets 8-9 hours a night usually, but lately she has only been getting 3-5. She reported experiencing insomnia when she is depressed.
Difficulty falling asleep	**Yes**		Patient stated: "My mind races every night about bills, my family's health, my to-do list for the next day." Patient stated that it takes several hours for her to fall asleep.
Frequently awakening during night	**Yes**		Patient reported that her anxiety causes her to awaken 2-3 times a night. Patient stated: "It takes me several hours to fall back asleep."
Early morning awakenings	**Yes**		Patient reported that she wakes up several times during the night and can not fall back asleep. She also stated that she is usually the first one awake at home and here at OSF.
Nightmares/dreams	**Yes**		Patient reported having nightmares three times a month. She stated that she cannot remember them the next day.
Other		**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**

Changes in eating habits: overeating/loss of appetite	**Yes**		Patient reported that she currently eats less than normal. She also stated that this happens 3-5 times a month and that it lasts for a few days.
Binge eating and/or purging		**No**	
Unexplained weight loss? **Amount of weight change:**		**No**	
Use of laxatives or excessive exercise		**No**	
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**		Patient reported pacing at least once a day when she is feeling restless. She denied experiencing tremors.
Panic attacks		**No**	Patient reported having three panic attacks in the past causing chest pain that lasted for several minutes.
Obsessive/ compulsive thoughts		**No**	
Obsessive/ compulsive behaviors		**No**	
Impact on daily living or avoidance of situations/objects due to levels of anxiety		**No**	
Rating Scale			
How would you rate your depression on a scale of 1-10?			Patient stated preadmission that her depression was a 5/10 and is currently a 3/10.
How would you rate your anxiety on a scale of 1-10?			Patient stated preadmission that her anxiety was a 5/10 and is currently a 5/10.
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work		**No**	

School		**No**	
Family	**Yes**		Patient reports obsessing daily about her family's health because her husband is overweight. She also obsesses over her mother's bipolar disorder and her mother getting older.
Legal		**No**	
Social		**No**	
Financial	**Yes**		Patient stated that she worries about her bills twice a week. She said that it does not trouble her as much as it used to because her husband is financially supporting them. She reported that together they worked through their financial issues and they were able to solve some of them.
Other		**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
Patient did not know the exact day but stated that last year she was hospitalized.	OSF Urbana	Inpatient	She was extremely anxious and experiencing extreme highs and lows. She was diagnosed with anxiety,	Some improvement

			bipolar, and depression here and began treatment.	
Weekly (currently)	Other: Therapist	Outpatient	Counseling	Some improvement
Monthly (currently)	Other: psychiatrist	Outpatient	Counseling	Some improvement

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Husband- Patient did not feel comfortable sharing name.	37	Spouse		**No**
Daughter- Patient did not feel comfortable sharing name.	4	Child		**No**
If yes to any substance use, explain n/a				
Children (age and gender): 4, female **Who are children with now?** Patient's husband or in-laws while he is working.				
Household dysfunction, including separation/divorce/death/incarceration: None.				
Current relationship problems: None, patient stated: "I am happily married, and we have good communication." **Number of marriages:** 1				
Sexual Orientation: Heterosexual	**Is client sexually active?** Yes		**Does client practice safe sex?** No	
Please describe your religious values, beliefs, spirituality and/or preference: Patient stated: "I am Christian and go to church weekly with my family."				
Ethnic/cultural factors/traditions/current activity:				

Describe: Patient goes to church weekly with her family.

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): n/a

How can your family/support system participate in your treatment and care? Patient stated: “My mental health is up to me. They are doing everything that they can.”

Client raised by:

Natural parents, reports having a happy childhood home.

Significant childhood issues impacting current illness: Patient stated: “I have not dealt with the bullying that I experienced from 12-18 years old. It creeps up on me sometimes and has decreased my confidence.”

Atmosphere of childhood home:

Loving
Comfortable
Chaotic- Patient stated: “My parents fought sometimes.”
Abusive
Supportive- Patient stated: “My parents support me in everything that I do”.
Other:

Self-Care:

Independent- Patient is completely independent.

Family History of Mental Illness (diagnosis/suicide/relation/etc.) Patient stated: “My mom has bipolar disorder and my great aunt committed suicide.”

History of Substance Use: Denies using substances

Education History:

Grade school
High school- Diploma
College- Bachelor of Arts
Other:

Reading Skills:

Yes- No limitations
No
Limited

Primary Language: English
Problems in school: Being bullied from 12-18 yo.
Discharge
Client goals for treatment: Patient stated: "I want to get out and spend time with my family and continue working on myself."
Where will client go when discharged? Home

Outpatient Resources (15 points)

Resource	Rationale
1. Depression & bipolar support alliance. (n.d.). DBSA Urbana Champaign. Retrieved February 9, 2021, from http://www.cudbsa.org/	1. Patient could attend group here to build relationships with others and continue learning about her mental illness.
2. Champaign. (n.d.). National Alliance on Mental Health Illness. Retrieved February 9, 2021, from http://namichampaign.org/	**2.** NAMI provides support for those suffering from a mental illness as well as support for their loved ones. This resource would give the patient a place to share her experiences with mental illness and she could include her spouse in her treatment.
3. Meetings. (n.d.). Primary Purpose of Narcotics Anonymous. https://ppana.org/meetings	**3.** The patient can use this resource if she chooses to seek help for her narcotic use.

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/ Generic	Abilify/ aripiprazole	Trileptal/ oxcarbazepine	Cogentin/ benztropine	Haldol/ haloperidol	Atarax/ hydroxyzine

			mesylate		
Dose	10 mg	600 mg	2 mg	5 mg	50 mg
Frequency	Daily	Twice daily	Twice daily PRN	Q4H PRN	Three times daily PRN
Route	Oral	Oral	oral	Oral	Oral
Classification	Antipsychotic	Anticonvulsant	Antiparkinsonian, central-acting anticholinergic	Antipsychotic	Anxiolytic/ sedative-hypnotic
Mechanism of Action	Partially agonizes dopamine and serotonin receptors to produce antipsychotic effects.	Halts seizures by decreasing the rate which neurons fire. This is achieved by blocking sodium channels in neuronal cell membranes.	Blocks ACH at cholinergic receptor sites restoring dopamine and ACH balance. This relaxes muscle movement such as tremors.	Blocks postsynaptic dopamine receptors in the limbic system which increases dopamine turnover producing an antipsychotic effect.	Competes with histamine for receptor sites on effector cells which suppresses histaminic activity. Sedative actions occur at subcortical level of CNS and are dose related.
Therapeutic Uses	To treat agitation associated with bipolar mania. Used in conjunction with antidepressants to treat depression.	To treat partial seizures	To control extrapyramidal symptoms caused by neuroleptic drugs.	To treat psychotic disorders	To relieve anxiety
Therapeutic Range (if applicable)	n/a	n/a	n/a	n/a	n/a
Reason Client Taking	To treat agitation with bipolar mania	To treat partial seizures	Movement disorder	Agitation	To treat anxiety
Contraindications (2)	Hypersensitivity to aripiprazole or its components.	Hypersensitivity to oxcarbazepine, eslicarbazepine acetate, or their components.	Angle-disclosure glaucoma, children younger than 3	Parkinson's disease, Severe toxic CNS comatose states or depression.	Breastfeeding, early pregnancy, hypersensitivity to hydroxyzine or its components
Side Effects/Adverse Reactions (2)	Respiratory failure, suicidal ideations, arrhythmias	Suicidal ideation, seizures, tremors	Hypotension, agitation, bradycardia	Seizures, confusion	Drowsiness, prolonged QT interval
Medication/ Food Interactions	Antihypertensives Enhanced antihypertensive effect. Benzodiazepin	Carbamazepine, phenobarbital, phenytoin- decreased blood oxcarbazepine level, increased	Amantadine, phenothiazines- increased anticholinergic effects. Haloperidol-	CNS depressants- increased risk for respiratory depression. Alprazolam,	Antidepressants such as citalopram or fluoxetine, antipsychotics such as

	es increased risk of orthostatic hypotension and sedation.	blood levels of phenobarbital and phenytoin. Cyclosporine decreased effectiveness of cyclosporine.	development of tardive dyskinesia	buspirone, chlorpromazine- increased blood haloperidol concentration.	chlorpromazine
Nursing Considerations (2)	Watch patients closely for suicidal tendencies especially when beginning therapy. Monitor patients for excessive somnolence which could predispose them to accidental injury or aspiration.	Monitor patient closely for suicidal thinking or behavior. Monitor patient closely for CNS adverse reactions such as somnolence.	Monitor patient's movements closely. Assess muscle rigidity and tremor at baseline and monitor for improvement.	Avoid stopping haloperidol abruptly. Monitor for signs of neuroleptic malignant syndrome, a rare but fatal disorder linked to antipsychotic drugs.	Observe for oversedation if patient takes another CNS depressant. Use cautiously in patients with risk factors for QT prolongation such as electrolyte imbalance or heart disease.

Brand/Generic	Desyrel/ trazodone				
Dose	100 mg				
Frequency	Daily (PC HS)				
Route	Oral				
Classification	Antidepressant				
Mechanism of Action	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing antidepressant effect.				
Therapeutic Uses	To treat major				

	depression				
Therapeutic Range (if applicable)	n/a				
Reason Client Taking	To treat depression				
Contraindications (2)	Recovery from acute MI, use within 14 days of an MAO inhibitor including intravenous methylene blue and linezolid				
Side Effects/Adverse Reactions (2)	Suicidal ideation, anxiety				
Medication/Food Interactions	Barbiturates and other CNS depressants-enhanced effect of CNS depressant. Carbamazepine-decreased trazodone level				
Nursing Considerations (2)	Closely monitor depressed patients for suicidal tendencies. Give at bedtime if drowsiness occurs.				

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's drug handbook*.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Well-groomed Calm, patient kept to herself during group and spent a lot of time sleeping during my rotation. Small build Indifferent attitude Clear speech Cooperative interpersonal style Neutral mood Flat, patient's facial expression and body language did not change at all during interview.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 None currently None currently None currently None currently None currently None currently
ORIENTATION: **Sensorium:** **Thought Content:**	A & O X4 Somnolence- Patient appeared exhausted. Logical
MEMORY: **Remote:**	 Intact, patient was able to recall specific years for losses she has experienced and the year she graduated from high school.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	 Normal Normal Normal Normal Normal
INSIGHT:	Normal

GAIT:	
Assistive Devices:	None
Posture:	Good
Muscle Tone:	Good
Strength:	5/5 bilaterally in all extremities
Motor Movements:	Controlled

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0831	126	141/84	24	97.6 Oral	98 Room Air
1730	109	137/82	16	98.4 Oral	99 Room Air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0831	Numerical	n/a	0/10	n/a	n/a
1730	Numerical	n/a	0/10	n/a	n/a

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 100%- Fruit cup and cereal **Lunch:** 100%- Tuna sandwich and saltine crackers **Dinner:** 100%- Rosemary Chicken and applesauce	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 720 mL **Lunch:** 720 mL **Dinner:** 720 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Patient is returning home with her husband and daughter. The patient should keep attending her regular appointments with her psychiatrist and therapist. The patient will take all medications as prescribed. Patient will be educated on groups for anxiety, bipolar, depression, and narcotic use which she can utilize in the future.

Nursing Diagnosis (15 points)
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	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Hopelessness related to symptoms of depression as evidenced by continuous suicidal ideations and flat affect.	Patient stated: "I have had suicidal thoughts on and off for the past few years". Patient did not exhibit emotion during the interview.	1.Remove any objects that the patient could harm themselves with. 2.Initiate one-on-one monitoring. 3.Contact crisis center for assessment and plan of action.	1.Monitor patient every 15 minutes to assess behavior and mood. 2. Allow the patient to express her feelings and perceptions. 3. Assess behaviors used to suppress feelings of hopelessness such as avoidance and withdrawal.	1. Help patient set realistic goals to help decrease feelings of hopelessness. 2. Help patient create a plan of action for the next time she experiences suicidal thoughts such as involving her family or contacting the suicide hotline.

				3. Involve patient's family in her treatment plan.
2. Anxiety related to maturational crisis as evidenced by pacing, tachycardia, and insomnia.	Patient's anxiety brought her in and is currently decreasing her quality of life. Her anxiety is centered around her family's safety and her parents aging.	1. Lessen sensory stimuli by providing a quiet environment. 2. Administer medications as prescribed to help with her anxiety and insomnia. 3.Interact with patient in a peaceful manner.	1.Familiarize patient to new surroundings and people. 2. Use presence, touch, and verbalization to let patient know they are not alone. 3. Assist the patient in developing new relaxation techniques such as breathing exercises.	1. Provide resources for group therapies for mental illness. 2. Encourage patient to adhere to medication regimen. 3. Help patient create a schedule to manage her daily to-do list. Completing tasks on her to-do list will decrease her anxiety.
3. Ineffective denial related to inadequate coping skills with substitution of drugs as evidenced by patient's denial of substance use and its impact on her life.	Patient was admitted for amphetamine abuse because of delusions and intrusive thoughts. Patient denies using drugs to cope with stressors.	**1.** Move patient to a quiet environment to help with delusions and intrusive thoughts. **2.** Monitor patient's vital signs closely. **3.** Reorient patient to reality and treat withdrawal symptoms.	**1.** In a caring manner, confront and examine denial in peer group. **2.** Discuss current life situation and impact of drug use. **3.** Explore alternative coping strategies such as therapeutic journaling.	**1.** Encourage patient to keep her regular appointments with her therapist and psychiatrist. **2.** Encourage involvement in a self-help group such as NA. **3.** Encourage patient to use new coping strategies to prevent relapse.

				Also help patient come up with a plan to prevent relapse.

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health (5th ed.). Mosby.

Vera, M. (2021, February 11). Nursing Diagnosis: Everything You Need to Know [2020 Guide]. Nurseslabs. https://nurseslabs.com/nursing-diagnosis/.

Concept Map (20 Points):

Subjective Data

Patient stated: “I was having intrusive and disturbing thoughts. I thought I was the Anti-Christ, and that the world was ending. I was up for 3 days”.

Objective Data

The patient was diagnosed with amphetamine abuse and unspecified psychosis. The patient was hospitalized last year for mental illness where she was diagnosed with anxiety, bipolar disorder, and depression.
The patient was tachycardic and hypertensive during my rotation.

Patient Information

On 02/05/21, a 35 yo Caucasian female presented to the ED with intrusive thoughts and difficulty sleeping. She was admitted for amphetamine abuse and psychosis.

Nursing Diagnosis/Outcomes

1.Hopelessness related to symptoms of depression as evidenced by continuous suicidal ideations and fear of loss.
Outcome: Patient demonstrates independent problem-solving techniques to take control of her life.
2.Anxiety related to maturational crisis as evidenced by pacing, tachycardia, and insomnia.
Outcome: Patient displays decreased anxiety level.
3.Ineffective denial related to inadequate coping skills with substitution of drugs as evidenced by patient’s denial of substance use and its impact on her life.
Outcome: Identify ineffective coping strategies such as substance use. Use effective coping strategies.

Nursing Interventions

2.Initiate one-on-one monitoring.
3.Contact crisis center for assessment and plan of action.
1.Monitor patient every 15 minutes to assess behavior and mood.
2. Allow the patient to express her feelings and perceptions.
3. Assess behaviors used to suppress feelings of hopelessness such as avoidance and withdrawal.
1. Help patient set realistic goals for herself to help decrease feelings of hopelessness.
2. Help patient create a plan of action for the next time she experiences suicidal thoughts such as involving her family or contacting the suicide hotline.
3. Involve patient’s family in her treatment plan.
1. Lessen sensory stimuli by providing a quiet environment.
2. Administer medications as prescribed to help with her anxiety and insomnia.
3.Interact with patient in a peaceful manner.
1.Familiarize patient to new surroundings and people.
2. Use presence, touch, and verbalization to let patient know they are not alone.
3. Assist the patient in developing new relaxation techniques such as breathing exercises.
1. Provide resources for group therapies for mental illness.
2. Encourage patient to adhere to medication regimen.
3. Help patient create a schedule to manage her daily to-do list. Completing tasks on her to-do list will decrease her anxiety.
1. Move patient to a quiet environment to help with delusions and intrusive thoughts.
2. Monitor patient’s vital signs closely.
3. Reorient patient to reality and treat withdrawal symptoms.
1. In a caring manner, confront and examine denial in peer group.
2. Discuss current life situation and impact of drug use.
3. Explore alternative coping strategies such as therapeutic journaling.

3. Encourage patient to use new coping strategies to prevent relapse.
Also help patient come up with a plan to prevent relapse.