

N323 Care Plan
Lakeview College of Nursing
McKayla Norton

Demographics (3 points)

Date of Admission 4/4/21	Patient Initials NR	Age 66	Gender F
Race/Ethnicity White/Caucasian	Occupation Unemployed	Marital Status Divorced	Allergies Norco
Code Status FULL	Observation Status Every 15 minutes (Q15)	Height 5'4"	Weight 106.6kg

Medical History (5 Points)

Past Medical History: Sleep apnea, GERD, hypertension, hypothyroidism

Significant Psychiatric History: This patient was diagnosed with Bipolar Disorder twenty years ago. She was prescribed Duloxetine and Lamotrigine, but the patient admitted she has not been compliant with her medication.

Family History: Patient stated that her brother committed suicide 14 years ago. Patient stated no other family history.

Social History (tobacco/alcohol/drugs): Patient states she does not drink, smoke, or do any drugs.

Living Situation: The patient states she lives at home by herself.

Strengths: Patient states her strength would be listening.

Support System: Patient says her daughter is a strong support person, and she always confides in her.

Admission Assessment

Chief Complaint (2 points): The patient stated she did not recognize her daughter and grandchildren when they arrived at her house. Her daughter and son-in-law brought her to the emergency department.

Contributing Factors (10 points):

Factors that lead to admission: The patient stated that she has been trying to remodel her house since last year. There have been many setbacks due to COVID-19, and the company she signed a contract with has been elongating the process. This has been causing her mental and financial stress. The patient states she has missed being able to get out of her home and do things with her daughter and grandchildren. The patient stated her daughter and her family were coming to her house to celebrate her birthday but then she began to stress because her home renovations were not complete and she did not want to host. When the daughter and family arrived, the patient stated she “did not recognize” them. She was then brought to the emergency department in her hometown where she was transferred to OSF in Urbana.

History of suicide attempts: This patient’s chart stated she had an attempted overdose suicide when she was a teenager, but the patient denied any attempts when asked about past attempts.

Primary Diagnosis on Admission (2 points): Bipolar affective disorder current, episode mixed.

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: This patient states she has experienced trauma in her life.</p> <p>Witness of trauma/abuse: The patient states when she was growing up, she witnessed her father abuse her older sister.</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse		Patient states she was 60 years old.		Patient states her son has been physically abusive towards her since she was 60 years old. She states “he would punch me in the face whenever he got agitated.”
Sexual Abuse		Patient states she was sexually		Patient states her older brother would abuse her

		abused by her older brother starting at the age of 5 or 6.		and her other siblings and cousins. She states he suffered from PTSD from the war and liked to drink.
Emotional Abuse	Patient states her son will call her and emotionally abuse her.			Patient describes her phone calls with her son as “degrading and constant yelling”.
Neglect	Patient denies neglect abuse.			
Exploitation	Patient denies exploitation abuse.			
Crime	Patient denies crime trauma.			
Military	Patient denies military trauma.			

Natural Disaster	No natural disasters reported.			
Loss		Patient stated when she was around 50, she lost her mother and brother.		Patient stated she lost her mother to cancer and her brother to suicide. She states this was “a very depressing time” for her.
Other				
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	Patient states she often feels depressed/sad in the evening hours when she is alone at home.	
Loss of energy or interest in activities/school	Yes	No	Patient states this feeling “comes and goes”. The patient would estimate she feels like this “40% of the time”.	
Deterioration in hygiene and/or grooming	Yes	No		
Social withdrawal or isolation	Yes	No	Patient states she has been feeling this way,	

			especially “more frequently since COVID started”.
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	
Difficulty falling asleep	Yes	No	
Frequently awakening during night	Yes	No	
Early morning awakenings	Yes	No	Patient often finds herself awake at “3 am” most days of the week.
Nightmares/dreams	Yes	No	
Other	Yes	No	Patient also mentioned she “sleeps to avoid” her stresses. She feels like this has increased in the last week during the day time hours.
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Patient stated she has had a loss of appetite the past week due to her anxiety and not

			feeling like eating.
Binge eating and/or purging	Yes	No	
Unexplained weight loss?	Yes	No	
Amount of weight change:			
Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patient states she has anxiety “almost every day”. She often finds herself pacing when having anxiety about her home renovation or her grandchildren.
Panic attacks	Yes	No	Patient states she estimates “3-4” panic attacks a year when she becomes “overwhelmed”.
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 a scale of 1-10?		Patient rates her depression as a 1-2 on a scale of 1-10.	
How would you rate your anxiety on a scale of 1-10?		Patient rates her anxiety as 5 on a scale of 1-10.	
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	Yes	No	
School	Yes	No	
Family	Yes	No	The patient states she is stressed about her son in West Virginia because he has a history of substance abuse and feels like he is using again. She states she stresses about this daily and it is very intense.
Legal	Yes	No	
Social	Yes	No	
Financial	Yes	No	Patient states she is struggling financially because her home renovation is costing more than expected and this has been going on

			since last year.	
Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
The patient was seen for psychiatric help 20 years ago.	Inpatient: The patient does not recall the name of the facility nor was it in the chart.	Inpatient	The patient was treated for Bipolar disorder.	No improvement Some improvement The patient was prescribed medication and has been compliant until her recent episode. Significant improvement
No other treatments known	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
No other treatments known	Inpatient Outpatient			No improvement Some improvement

	Other:			Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Patient lives alone.			Yes	No
			Yes	No
If yes to any substance use, explain:				
Children (age and gender): Patient states she has a daughter (44), son (34), and son (31).				
Who are children with now? Children live on their own with their families.				
Household dysfunction, including separation/divorce/death/incarceration:				
The patient she has been divorced twice.				
Current relationship problems: The patient states she does not report any current relationship problems.				
Number of marriages: 2				
Sexual Orientation: Straight	Is client sexually active? Yes No		Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference: Patient states she is Baptist and participates				

<p>with a church online in West Virginia.</p>
<p>Ethnic/cultural factors/traditions/current activity:</p> <p>Describe: None reported.</p>
<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient she went through two divorces. Her second divorce was drawn out.</p>
<p>How can your family/support system participate in your treatment and care?</p> <p>Patient states her daughter is the one she confides in the most. Her daughter has “always been there and supported me”.</p>
<p>Client raised by:</p> <p>Natural parents Grandparents Adoptive parents Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness: The patient states she watched her sister be abused by her father and her older brother sexually assaulted her and many of her family members.</p>
<p>Atmosphere of childhood home:</p> <p>Loving Comfortable Chaotic Abusive Supportive Other:</p>

<p>Self-Care:</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</p> <p>Patient stated her little brother committed suicide and she was “pretty sure” her father had a bipolar disorder, but he was never diagnosed.</p>
<p>History of Substance Use: Patient states she does not use or have any history of substanc abuse.</p>
<p>Education History:</p> <p>Grade school: Patient stated she attended the same grade school growing up. High school Patient stated she attended the same high school all four years and graduated high school. College Other:</p>
<p>Reading Skills:</p> <p>Yes No Limited</p>
<p>Primary Language: English</p>
<p>Problems in school: None</p>
<p>Discharge</p>

Client goals for treatment: Patient stated she wants to get on the right medication and find a therapist to help confide in. She would also like to continue to attend group therapy, as she finds it helpful. She would also like help with her finances.

Where will client go when discharged? The patient states she would like to return to her home after discharge.

Outpatient Resources (15 points)

Resource	Rationale
<p>1. Trauma, abuse, and Depression Counselor</p> <p>https://www.betterhelp.com/monique-smith/?start=true&utm_source=Adwordsr&utm_campaign=storefront&utm_term=joliet+%2Bcounseling_b&utm_content=Monique-Smith_08261&gclid=CjwKCAjw07qDBhBxEiwA6pPbHhtQxYdHq7yN3ImMGf5SwyrR1Bl3XL0o_KgNP7QUKV2qb-ZmQIzqghoCpCUQAvD_BwE&not_found=1&gor=rd_monique-smith</p>	<p>1. This patient has endured trauma, abuse, and depression both in the past and currently. A therapist would be beneficial for this patient as she still deals these experiences daily and causes her distress. This therapist is near her hometown, so she is</p>

	<p>able to attend in-person or via the internet.</p>
<p>2. Group therapy</p> <p>https://www.psychologytoday.com/us/groups/bipolar-disorder/il/joliet/29576?sid=606f16c62d10a&zipdist=30&ref=1&tr=ResultsRow</p>	<p>2. The patient verbalized during assessment that she found group therapy to be beneficial. She also stated she would like to learn more about her diagnosis. This group therapy can offer her more insight on her disorder and how to manage this while being able to interact in a group.</p>
<p>3. Financial help</p>	<p>3. The patient also</p>

<p>https://financialgym.com/?keyword=finances&utm_term=finances&utm_source=adwords&utm_campaign=Website+Traffic+June+2019&utm_medium=ppc&hsa_mt=b&hsa_grp=71138540599&hsa_net=adwords&hsa_ver=3&hsa_ad=355991453982&hsa_src=g&hsa_cam=2038651606&hsa_kw=finances&hsa_acc=7883903772&hsa_tgt=kwd-10102946&gclid=CjwKCAjw07qDBhBxEiwA6pPbHnWUBqUf4ZFqu9sa8WpH3cvWCjAxdEYHptK00oJrNz7boPkvZPjyzxoCKAEQAvD_BwE</p>	<p>mentioned she feels overwhelmed financially. Reaching out to someone who can help her with her finances can help lessen the burden she is feeling trying to do this all on her own.</p>
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Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Oxcarbazepine/ Trileptal	Haloperidol/ Haldol	Aripiprazole/ Abilify	Trazadone/ Desyrel
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Dose	300 mg	5mg	5mg	100mg
Frequency	BID	Q4 PRN	Daily	PRN nightly
Route	PO	PO	PO	PO
Classification	Anticonvulsant	Antipsychotic	Antipsychotic	Antidepressant
Mechanism of Action	Inhibits repetitive neuronal firing, and decreased propagation of neuronal impulses.	Decreases psychotic manifestations and exerts strong antiemetic effect.	Acts as a partial antagonist at dopamine and serotonin receptors.	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect.
Therapeutic Uses	Monotherapy or adjunctive therapy in the treatment of partial seizures in adults and children age 4–16.	Management of manifestations of psychotic disorders	To maintain stability with monotherapy treatment of bipolar I disorder.	To treat major depression
Therapeutic Range (if applicable)	n/a	n/a	n/a	n/a
Reason Client Taking	Mood stabilizer	Agitation	Mood stabilizer	Sleep
Contraindications (2)	Hypersensitivity to oxcarbazepine	Alcoholism and severe	Hypersensitivity to	Hypersensitivity to trazodone or

	and pregnancy	mental depression	aripiprazole or its components	its components, use within 14 days of an MAO inhibitor
Side Effects/Adverse Reactions (2)	Fatigue and chest pain.	Parkinsonian symptoms and dystonia	Homicidal ideations, arrhythmias	Serotonin syndrome, congestive heart failure
Medication/Food Interactions	Carbamazepine, phenobarbital, phenytoin, valproic acid, verapamil.	cns depressants, OPIATES, alcohol	Antihypertensives, benzodiazepines, carbamazepine, alcohol	NSAIDS, CNS depressants, MAO inhibitors, warfarin, alcohol
Nursing Considerations (2)	Monitor for and report S&S of: Hyponatremia Periodic serum sodium, T₄ level	Monitor patient's mental status daily. Monitor for neuroleptic malignant syndrome	Not used to treat dementia-related psychosis Monitor patients CBC	Give medication shortly after meals to reduce nausea Monitor depressed patients for suicidal thoughts and tendencies

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's Drug Handbook* (19th ed.).

Mental Status Exam Findings (20 points)

<p>APPEARANCE: well groomed, no distress Behavior: patient seemed shy, stable, uneasy since this is a new environment. Build: larger build Attitude: patient seemed eager to get help and attend group sessions. Speech: speech was clear Interpersonal style: patient exhibited relaxed communication style. Mood: patient seemed hesitant to talk but willingly did once she knew the conversation was going to be kept confidential. Affect: aroused easily.</p>	
<p>MAIN THOUGHT CONTENT: Ideations: denies any current ideations but has had some previously before admission. Delusions: none Illusions: none Obsessions: none Compulsions: none Phobias: none</p>	
<p>ORIENTATION: Sensorium: patient seemed clouded, unable to concentrate at times.</p>	

<p>Thought Content: thoughts tended to be scattered throughout the conversation.</p>	
<p>MEMORY: Remote: patient was able to recall stories and estimated times, but some strange details were added.</p>	
<p>REASONING: Judgment: judgment is slightly off. Calculations: patient exhibited normal calculations. Intelligence: patient demonstrates age-appropriate intelligence. Abstraction: none Impulse Control: patient demonstrates impulse control.</p>	
<p>INSIGHT: patient demonstrated some insight on why she was admitted but some memory seemed foggy.</p>	
<p>GAIT: Assistive Devices: patient uses rolling walker. Posture: patient has good posture for age. Muscle Tone: slightly diminished muscle tone related to age. Strength: patient has normal strength in the upper extremities, bilaterally. Patients right lower extremity is weaker due to previous surgeries. Motor Movements: motor movements are controlled.</p>	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1430	84	127/81 right upper arm, sitting.	18	97.4 F Temporal	96 room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	0-10	Right knee	1	Constant	Patient denied any needs for pain intervention. She said this is tolerable pain since her surgery.
1730	0-10	--	0	--	--

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:	Oral Fluid Intake with Meals (in mL)
Breakfast: -- *was not on shift during breakfast or lunch*	Breakfast: --
Lunch: --	Lunch: --
Dinner: 100%	Dinner: 240mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client): This discharge plan includes the patient continuing her therapy outside of this admission. Further knowledge on her diagnoses and treatment can help with episodes she is having. Being able to attend group therapy can also help with the isolation this patient is feeling. Attending individual sessions can help this patient learn to cope with the traumas she has experienced in the past. Goals for this client include attending therapy, individually and in a group, and being compliant with her medication regiment.

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Immediate Interventions (At admission)</p>	<p>Intermediate Interventions (During hospitalization)</p>	<p>Community Interventions (Prior to discharge)</p>
<p>1. Impaired social interaction related to Bipolar disorder as evidence by poor attention span and difficulty focusing on one thing at a time causing agitation.</p>	<p>This patient has difficulty focusing on one thing at a time, as a result becoming overwhelmed and triggering an episode of agitation.</p>	<p>1. Decrease environmental stimuli that may provoke exacerbation of the patient’s agitation.</p> <p>2. Approach the patient with a calm and respectful attitude to prevent further agitation.</p> <p>3. Remove all</p>	<p>1. Limit patient contact with others during episodes.</p> <p>2. At the earliest signs of agitation, verbally intervene and remove the</p> <p>3. Remove objects in the patient’s immediate environment that has the potential to be used as a weapon towards others to ensure the safety of other patients and healthcare professionals.</p>	<p>1. Arrange for the patient to have access to medication for treatment/ management of episodes.</p> <p>2. Arrange for the patient to visit resource listed above to receive group therapy for management/ control of episodes.</p>

		<p>objects in the immediate environment that could possibly be used as a weapon towards others to ensure the safety of other healthcare professionals</p>		<p>3. Arrange for patient to attend therapy listed above for individual counselling to help with multitasking skills.</p>
<p>2. Ineffective individual coping related to Bipolar disorder as evidence by not being able to cope from past traumas.</p>	<p>This was chosen because this patient still feels a lot of guilt and anger towards the trauma that has happened in her past, like her brother and mother dying during the same year and her older brother sexually assaulting her.</p>	<p>1. Establish trust and rapport.</p> <p>2. Provide strict confidentiality.</p> <p>3. Approach the patient in a nonjudgmental manner.</p>	<p>1. Provide therapy for sexual assault victims.</p> <p>2. Encourage verbalization.</p> <p>3. Explain signs and symptoms that patients experience after a long-term phase of sexual assault.</p>	<p>1. Provide resources for crisis counseling.</p> <p>2. Provide information for a support group of survivors of sexual assault.</p> <p>3. Arrange for individual therapy to discuss past trauma of sexual assault to help with coping.</p>
<p>3. Risk for suicide related to bipolar disorder as evidence by history of prior suicide attempt.</p>	<p>This patient has a known history for suicide attempt by trying to overdose.</p>	<p>1. Establish trust and rapport.</p> <p>2. Remove anything that the patient can use to harm themselves or others.</p>	<p>1. Remind the patient this is temporary.</p> <p>2. Remind the patient help is available.</p> <p>3. Remind the patient</p>	<p>1. Encourage the patient to avoid decision making during the time of crisis.</p> <p>2. Weapons and pills</p>

		<p>3. Encourage the patient to talk freely about feelings and help plan alternate ways of handling disappointment or frustration.</p>	<p>they are not alone.</p>	<p>are removed by friends or relatives.</p> <p>3. Contact family members to arrange for individual crisis counseling.</p>
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Other References (APA):

Martin, P. (2019, April 11). 6 bipolar Disorder's nursing care plans. Nurselabs. <https://nurseslabs.com/bipolar-disorders-nursing-care-plans/>

Concept Map (20 Points):

Subjective Data

Patient said she was admitted due to stress overload. She felt overwhelmed with her family coming to town for her birthday and her house being under renovations. She stated she did not recognize her family when they showed up at her house. Patient stated her pain was a 1/10 but this was tolerable and she experiences it constantly due to her having surgery on her right knee multiple times.

Nursing Diagnosis/Outcomes

Impaired social interaction related to Bipolar disorder as evidence by poor attention span and difficulty focusing on one thing at a time causing agitation.

Outcome: Patient learns how to multitask and develop skills to manage episodes during hospitalization.

Ineffective individual coping related to Bipolar disorder as evidence by not being able to cope from past traumas.

Outcome: Patient learns coping skills during therapy to help use in the future when dealing with trauma during hospital stay.

Risk for suicide related to bipolar disorder as evidence by history of prior suicide attempt.

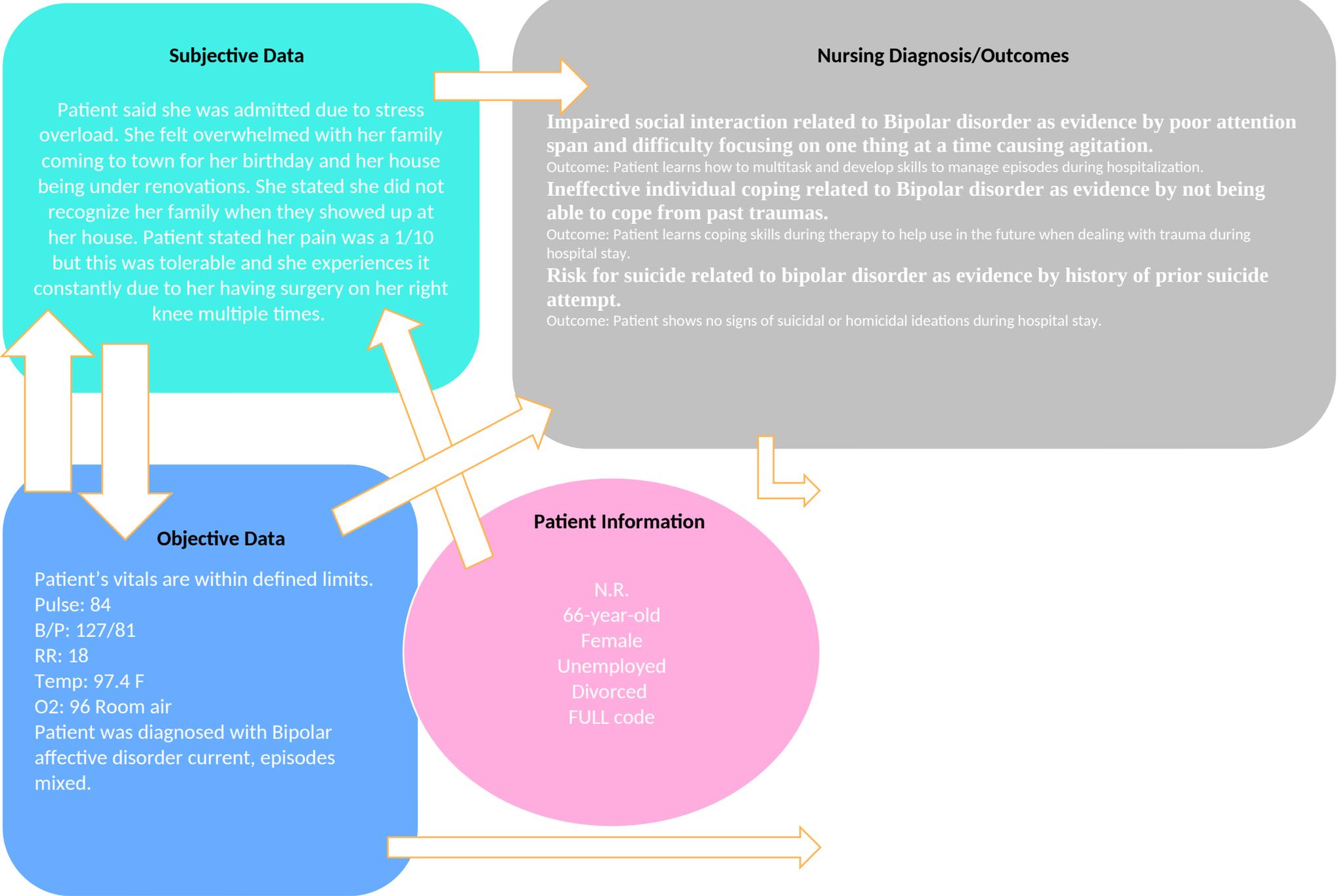
Outcome: Patient shows no signs of suicidal or homicidal ideations during hospital stay.

Objective Data

Patient's vitals are within defined limits.
Pulse: 84
B/P: 127/81
RR: 18
Temp: 97.4 F
O2: 96 Room air
Patient was diagnosed with Bipolar affective disorder current, episodes mixed.

Patient Information

N.R.
66-year-old
Female
Unemployed
Divorced
FULL code



<p>1. Decrease environmental stimuli that may provoke exacerbation of the patient's agitation.</p> <p>2. Approach the patient with a calm and respectful attitude to prevent further agitation.</p> <p>3. Remove all objects in the immediate environment that could possibly be used as a weapon towards others to ensure the safety of other healthcare professionals</p>	<p>1. Limit patient contact with others during episodes.</p> <p>2. At the earliest signs of agitation, verbally intervene and remove the</p> <p>3. Remove objects in the patient's immediate environment that has the potential to be used as a weapon towards others to ensure the safety of other patients and healthcare professionals.</p>	<p>1. Arrange for the patient to have access to medication for treatment/management of episodes.</p> <p>2. Arrange for the patient to visit resource listed above to receive group therapy for management/control of episodes.</p> <p>3. Arrange for patient to attend therapy listed above for individual counselling to help with multitasking skills.</p>
<p>1. Establish trust and rapport.</p> <p>2. Provide strict confidentiality.</p> <p>3. Approach the patient in a nonjudgmental manner.</p>	<p>1. Provide therapy for sexual assault victims.</p> <p>2. Encourage verbalization.</p> <p>3. Explain signs and symptoms that patients experience after a long-term phase of sexual assault.</p>	<p>1. Provide resources for crisis counseling.</p> <p>2. Provide information for a support group of survivors of sexual assault.</p> <p>3. Arrange for individual therapy to discuss past trauma of sexual assault to help with coping.</p>
<p>1. Establish trust and rapport.</p> <p>2. Remove anything that the patient can use to harm themselves or others.</p> <p>3. Encourage the patient to talk freely about feelings and help plan alternate ways of handling disappointment or frustration.</p>	<p>1. Remind the patient this is temporary.</p> <p>2. Remind the patient help is available.</p> <p>3. Remind the patient they are not alone.</p>	<p>1. Encourage the patient to avoid decision making during the time of crisis.</p> <p>2. Weapons and pills are removed by friends or relatives.</p> <p>3. Contact family members to arrange for individual crisis counseling.</p>

Nursing Interventions

