N323 Care Plan

Lakeview College of Nursing

Tresne McCarty

Demographics (3 points)

Date of Admission 06/09/2021	Patient Initials CT	Age 65	Gender Female
Race/Ethnicity Caucasian	Occupation Retired Nurse Practitioner	Marital Status Divorced	Allergies None
Code Status Full	Observation Status No risk	Height 5'5"	Weight 110 lb

Medical History (5 Points)

Past Medical History: Patient does not have any past medical history.

Significant Psychiatric History: Depression, anxiety, and previous alcohol abuse

Family History: Mother (deceased) → heart disease, Father (deceased) → stroke, Brother (alive) → healthy

Social History (tobacco/alcohol/drugs): Patient has previous history of alcohol abuse 13 years ago. She was unable to describe how many drinks per day she consumed. She stated it was so long ago she doesn't remember that far back.

Living Situation: Patient has a significant other of whom she has a house with in Champaign, IL.

Strengths: Her strengths include being able to self-talk.

Support System: Patient's support system is her family and significant other.

Admission Assessment

Chief Complaint (2 points): "I was overwhelmed with stress and anxiety. My medications weren't right. Finally during COVID I was able to go see my therapist who is a Licensed Clinical Social Worker. They convinced me to seek help."

Contributing Factors (10 points):

Factors that lead to admission: During the assessment, the patient stated, “I know my medications are messed up. It was also the first time seeing my therapist since COVID because my previous therapist retired. I’m trying to get my finances together with my pension and everything. It was just overwhelming for me.” The patient felt it was too much to handle everything at once. She did feel like COVID was also a contributing factor because she was unable to see a therapist.

History of suicide attempts: Patient does not have any suicide attempts.

Primary Diagnosis on Admission (2 points): Major Depressive Disorder, General Anxiety Disorder, and Alcohol use disorder in remission

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: n/a **Witness of trauma/abuse:** Client experienced sexual abuse and childhood neglect. As an adult she experience alcohol abuse, loss of jobs, and her therapist retired.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with**	**Describe**

			trauma)	
Physical Abuse	**NO**	YES, patient unsure of age, but it was during her childhood.		Pt described her mother being very abusive as a child because she was an alcoholic. After some years, her mother was no longer abusive. During this time her and her brother were around 10 years old.
Sexual Abuse	**NO**	YES, patient unsure of age, but it was during her childhood.		**Pt refused to discuss further.**
Emotional Abuse	**NO**	YES, patient unsure of age, but it was during her childhood.		Pt described her mother being very abusive as a child because she was an alcoholic. After some years, her mother was no longer abusive. During this time her and her brother were around 10 years old.
Neglect	**NO**	YES, patient unsure of age, but it was during her childhood.		Pt described her mother being very abusive as a child because she was an alcoholic. After some years, her mother was no longer abusive. During this time her and her brother were around 10 years old.
Exploitation	**NO**	**NO**	**N/A**	**N/A**
Crime	**NO**	**NO**	**N/A**	**N/A**

Military	**NO**	**NO**	**N/A**	**N/A**
Natural Disaster	**NO**	**NO**	**N/A**	**N/A**
Loss	**YES**	**YES**	**N/A**	Pt went through job loss and her therapist retired which was overwhelming for her.
Other	**N/A**	**N/A**	**N/A**	**N/A**

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	~~**No**~~	Pt described frequency being 7 days a week. It was out of control initially during admission, but was controlled as of 06/11/2021.
Loss of energy or interest in activities/school	**Yes**	~~**No**~~	Pt described loss of interest being at least 3-4 days out of the week. The patient described it as some intense and it can last all day.
Deterioration in hygiene and/or grooming	~~**Yes**~~	**No**	**N/A**
Social withdrawal or isolation	~~**Yes**~~	**No**	**N/A**
Difficulties with home, school, work, relationships, or responsibilities	~~**Yes**~~	**No**	**N/A**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	~~**No**~~	Pt states she gets 4-5 hours of sleep a night. Previously, she was getting 7-8 hours of uninterrupted sleep. As of 06/09/2021 her sleep is very interrupted. She states a contributing factor to sleep loss is also being in the facility.
Difficulty falling asleep	~~**Yes**~~	**No**	

Frequently awakening during night	**Yes**	**No**	Patient states she awakens frequently during the night because she's in the facility. She states she wasn't getting much sleep because of worrying at least 5 days a week.
Early morning awakenings	**Yes**	**~~No~~**	Patient is a natural early riser. She stated she does awaken earlier than usually due to the activity in the facility.
Nightmares/dreams	**~~Yes~~**	**No**	
Other	**~~Yes~~**	**No**	
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**~~No~~**	Patient has daily appetite loss. She stated, "I'll finish my plate, but I won't ask for seconds."
Binge eating and/or purging	**Yes**	**No**	
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Patient denies unexplained weight loss, but she has lost between 5-7 lbs over the last 3 months.
Use of laxatives or excessive exercise	**Yes**	**No**	Patient states her medications can cause constipation so she uses laxatives as needed to prevent constipation.
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient states she paces a lot. She says at least 3-4 days she paces. She uses this to manage her stress. She denies any tremors.
Panic attacks	**Yes**	**No**	Patient stated she had a panic attack 06/09/2021. It was very intense and lasted for a few hours. Once she was admitted to the Pavilion, they were able to medicate her properly. Panic attacks have not been common in 10 years according to the patient.
Obsessive/compulsive	**Yes**	**No**	

thoughts			
Obsessive/compulsive behaviors	**Yes**	**No**	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient states paying bills became more stressful. This was a contributor to her admission to the Pavilion.
Rating Scale			
How would you rate your depression on a scale of 1-10?		**7/10**	
How would you rate your anxiety on a scale of 1-10?		**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	**Yes**	**No**	N/A
School	**Yes**	**No**	N/A
Family	**Yes**	**No**	Patient stated she spends a lot of time with friends and family. They hang out a lot and go shopping.
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	Patient denies any issues with social life. During my time at the Pavilion I observed her intermingling with others from time to time. She would not be extensively involved, but enjoyed the company of others.
Financial	**Yes**	**No**	Patient stated how her retirement and pension caused a lot of stress. She was trying to figure out how to handle her money and what to do with it. It became too much for her and she became overwhelmed.
Other	**Yes**	**No**	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
04/09/2003	**Inpatient** **Outpatient** **Other:** **Pavilion**	Inpatient	Depression	**No improvement** **Some improvement** **Significant improvement**
01/29/2008	**Inpatient** **Outpatient** **Other:** **Pavilion**	Inpatient	Depression	**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Significant Other (no name was provided)	72	Boyfriend	Yes	No
			Yes	**No**
			Yes	**No**
			Yes	**No**

			Yes	**No**
If yes to any substance use, explain:				
Children (age and gender): NONE **Who are children with now?**				
Household dysfunction, including separation/divorce/death/incarceration: Patient grew up in a single parent household. Her mother was an alcoholic who died at an early age. Patient was divorced 25 years ago.				
Current relationship problems: NONE **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: **Patient has spiritual beliefs of a higher power**				
Ethnic/cultural factors/traditions/current activity: **Describe: NONE**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient denies any legal issues				
How can your family/support system participate in your treatment and care? Patient states her brother and his family spend a lot of time together. She states she and her brother walk together all the time. They have family dinners and they go shopping together.				
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):** The patient's mother passed away when she was a teenager. She and her brother lived with friends most of the time until they moved on their own.				
Significant childhood issues impacting current illness:				

The patient states she experienced guilt, shame, and undeserving of good things in life growing up. This was due to the sexual abuse she experienced at a young age.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:** The patient stated there was early abuse, but then the home environment was comfortable because the abuse wasn't happening anymore.
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) The patient states her mother was an alcoholic that was untreated and she suffered from depression.
History of Substance Use: The patient stated she suffered from alcohol abuse and her mother also suffered from alcohol abuse.
Education History: **Grade school** **High school** **College** **Other:** The patient has 2 Master's degrees, one as a Primary Care Nurse Practitioner and one in Health Services Management
Reading Skills: **Yes** **No** **Limited**
Primary Language: ENGLISH
Problems in school:

Discharge
Client goals for treatment: The client wants her medications regulated properly so she can manage her daily life. She also wants to implement more coping skills to assist with the medication.
Where will client go when discharged? The client will go home upon discharge

Outpatient Resources (15 points)

Resource	Rationale
1. Call 2-1-1	1. This resource has many different facets to help people in the community. This includes personal financial management for older adults.
2. Carle	2. They have new therapy methods such as Eye Movement Desensitization and Reprocessing (EMDR) to help patients manage a wide range of mental health conditions
3. Calm App	3. The calm app assists those with stress and sleep deprivation. They're certified in sleep, meditation, and relaxation.

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

Brand/Generic	**Gabapentin Neurontin**	**Mirtazapine Remeron**	**Polyethylene Glycol Miralax**	**Clonazepam klonoPIN**	**Acetaminophen Tylenol**
Dose	**100 mg tab**	**15 mg tab**	**17g**	**0.5 mg tab**	**650 mg tab**
Frequency	**BID**	**DAILY**	**QAM**	**TID**	**Q6H**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Anticonvulsant**	**Antidepressant**	**Laxative**	**Anticonvulsant Anti-anxiety**	**Antipyretic/ Non-opioid analgesic**
Mechanism of Action	GABA inhibitor of rapid firing neurons associated with seizures	Inhibits neural uptake of norepinephrine and sertonin	Draws water into the stool to ease bowel movements	GABA medication that binds to benzodiazepine receptors to inhibit brain activity	It inhibits the enzyme cyclooxygenase and interferes with pain generation. It also regulates temperature in the hypothalamus.
Therapeutic Uses	Used for neuralgia	Used for initial treatment for depression	Prevent constipation	Used for panic disorder and myoclonic seizures	Moderate pain and fever reduction
Therapeutic Range (if applicable)	300-600 daily Max = 3,600 mg daily	N/A	Max = 34 g/day	Initial = 0.25 mg BID Max = 4 mg daily	Max = 3,900 mg for tablets
Reason Client Taking	Treat panic disorder	Depression	Constipation	Treat panic disorder	Moderate pain
Contraindications (2)	Hypersensitivity Depression Driving or lifting machinery	Hypersensitivity Nausea Vomiting Agitation	Abdominal pain Renal disease pregnancy	Hepatic disease Benzodiazepines Acute-narrow angle glaucoma	Hypersensitivity, severe hepatic impairment, severe liver disease
Side	Anxiety	Bradycardia	Anaphylaxis	Suicidal ideation	Anxiety,

Effects/Adverse Reactions (2)	Depression Seizures	Hypotension Ventricular arrhythmias	Urticaria Nausea Vomiting	Coma Visual impairment	insomnia, headache, and agitation
Medication/Food Interactions	Aluminum and magnesium containing antacids CNS Depressants (alcohol) Hydrocodone	Anxiolytics CNS depressants Alcohol use	Acetaminophen Atropine Hydrocodone	Alcohol use, constipation, anxiety, suicidal ideation	Alcohol use, barbiturates, and carbamazepine
Nursing Considerations (2)	Capsules can be open & mixed with applesauce, pudding, or water Give drug at least 2 hours after an antacid	Use cautiously in elderly patients Administer before bedtime Expect disintegrating tablet to dissolve on patient's tongue within 30 seconds	Assess client for abdominal distention Assess color of stool Assess bowel sounds	Use cautiously in patients with mixed seizure disorder Monitor blood drug level, CBC, and liver enzymes	Monitor renal function for patients on long term therapy Use cautiously in patients with renal impairment

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Therapeutic Uses					
Therapeutic					

Range (if applicable)					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Medication/Food Interactions					
Nursing Considerations (2)					

Medications Reference (1) (APA):

PDR Search. PDR.Net. (n.d.). https://www.pdr.net/.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Patient is alert and oriented x4. She appears well groomed and content. Patient was very friendly and cooperative. She appeared poised and willing to participate.**
MAIN THOUGHT CONTENT:	**Patient's thoughts were very intact. She was**

Ideations: **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**oriented to person, place, and time. She did not exhibit any ideations of suicide, self-harm, or harm to others. She denied ideations of suicide. No evidence of delusions, illusion, obsessions, compulsions, or phobias.**
ORIENTATION: **Sensorium:** **Thought Content:**	**The patient was oriented to person, place, and time. Her senses were fully intact. This patient thought precisely and accurately.**
MEMORY: **Remote:**	**The patient was able to recall recent memories with family and friends. She had some trouble remembering issues in her past, but tried to recall them to the best of her knowledge.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**The patient's judgements were aligned with he situation and questions asked. She was very intelligent and no developmental delays were observed. Patient was not distracted by outside noises or people. She remained focused and did not deviate from the topic at hand.**
INSIGHT:	**Patient had great insight. She was very intelligent and exhibited such intelligence during the assessment.**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**Patient was able to ambulate independently throughout the hallway and room without difficulty. The patient did not need any assistance with grooming or feeding. Her muscle strength was equal in every extremity. No motor deficiencies observed. Muscle tone was normal.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1429	**86**	**107/72**	**18**	**98.6**	**98**
1700	**80**	**107/70**	**18**	**98.6**	**99**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1429	**0**	**N/A**	**N/A**	**N/A**	**N/A**
1700	**0**	**N/A**	**N/A**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 50-75%** **Lunch: 50-75%** **Dinner: N/A**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 500 mL** **Lunch: 500 mL** **Dinner: N/A**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

My plans are for the client to continue to recognize when her medication is no longer therapeutic. She also does a great job recognizing triggers and therapeutic coping strategies to maintain her mood. I would like for her to remain social to help lighten her mood and energy around her. She enjoys being around her family and that seems to make her happy. She has been sober from alcohol for 13 years. I would like for her to continue her sobriety to ensure she does not add anymore contributing factors. She sees a Licensed Clinical Social Worker for psych therapy. I believe she’s on a great path back to normalcy. She’s aware of her actions and is willing to be cooperative and compliant with the discharge instructions given.

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. Disturbed sleep pattern related to anxiety as evidenced by the patient stating, "I don't uninterrupted sleep. I get about 4-5 hours a night."	The patient isn't able to get an adequate amount of sleep at night due to her anxiety level and being in the facility.	1. Medications were administered after admission. 2. Patient was documented as suicide risk, but soon was taken off. 3. Vitals were obtained every shift.	1. 2. 3.	1. Patient attends daily group with other clients. 3. Patient has identified triggers to her anxiety. 4. Patient is able to facilitate deep breathing exercises to relax.
2. Impaired mood regulation related to depression as	The patient stated she	1. Vital signs were	1. 2.	1. Patient attends daily group sessions.

evidenced by the patient's primary diagnosis being major depressive disorder.	has lack of interest with daily activities.	obtained every shift. 2. Patient was given medications 3.	3.	3. Patient remains socially active with other clients in the facility. 3. Patient was able to recognize when her medication therapeutic.
4. Stress overload related to anxiety as evidenced by the patient stating, "I was overwhelmed with stress and anxiety."	The patient stated she came to the Pavilion because she was overwhelmed and needed to seek help.	1. Patient was assessed for suicide precautions upon admission. 2. Patient was provided medication to reduce anxiety. 3. Patient was assessed for suicide precautions.	1. 2. 3.	1. Patient interacted with staff and other clients in the facility. 3. Patient does not have any other community interventions besides family. 4. Patient utilizes her significant other as support upon discharge.

Other References (APA):

About Parkland. Parkland College | Go Ahead. (n.d.). https://www.parkland.edu/Main/About-Parkland/Department-Office-Directory/Counseling-Services/Mental-Health-Counseling/Community-Resources.

Concept Map (20 Points):

Subjective Data

Patient states, "I was overwhelmed with stress and anxiety. My medications weren't right. The Licensed Clinical Social Worker convinced me to seek help."
Patient has been sober from alcohol for 13 years
Patient describes her childhood as being abusive until she reached her teens
Patient has been divorced for 25 years

Nursing Diagnosis/Outcomes

Disturbed sleep pattern related to anxiety as evidenced by the patient stating, "I don't [illegible]nterrupted sleep. I get about 4-5 hours a night."
[illegible]ient attends daily group with other clients.
Patient has identified triggers to her anxiety.
Patient is able to facilitate deep breathing exercises to relax.
Impaired mood regulation related to depression as evidenced by the patient's primary diagnosis being major depressive disorder
Patient attends daily group sessions.
Patient remains socially active with other clients in the facility.
Patient was able to recognize when her medication therapeutic.
Stress overload related to anxiety as evidenced by the patient stating, "I was overwhelmed with stress and anxiety."
Patient interacted with staff and other clients in the facility.
Patient does not have any other community interventions besides family.
Patient utilizes her significant other as support upon discharge.

Objective Data

Patient was admitted as inpatient to the Pavilion in 2008 and 2003 for depression

Patient currently takes Remeron, Neurontin, and Clonazepam for depression and anxiety
Patient was disheveled and disoriented upon admission
During the assessment on 06/11/2021, patient was alert and oriented x4

Patient Information

Patient is a 65 year old white Caucasian female who voluntarily admits herself to the Pavilion. She stated, "I was overwhelmed with stress and anxiety. My medications weren't right. The Licensed Clinical Social Worker convinced me to seek help."

Nursing Interventions

Medications were provided to the patient to [illegible]educe anxiety
[illegible]Vital signs were obtained every shift
[illegible]Nurse ensured patient attended group sessions