

N323 Care Plan  
Lakeview College of Nursing  
Bao Cuong Tran

**Demographics (3 points)**

<b>Date of Admission</b> 10/06/21	<b>Patient Initials</b> AB	<b>Age</b> 39	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> unemployed	<b>Marital Status</b> single	<b>Allergies</b> Penicillin
<b>Code Status</b> Full	<b>Observation Status</b> Every 15 minutes	<b>Height</b> 5'5''	<b>Weight</b> 115 lb

**Medical History (5 Points)**

**Past Medical History:** Hypertension

**Significant Psychiatric History:** She consulted a psychiatrist in the past and was hospitalized

**Family History:** Anxiety, depression

**Social History (tobacco/alcohol/drugs):** Patient was admitted because of abusing meth, and stated that no alcohol or tobacco use in the past few years

**Living Situation:** Patient is living alone.

**Strengths:** Patient is highly motivated to get her life back together in order to her children again.

**Support System:** Patient does not have a positive support system.

**Admission Assessment**

**Chief Complaint (2 points):** Patient stated, "I need to stop using drugs".

**Contributing Factors (10 points):**

**Factors that lead to admission:** Patient was clean for 2 years, but due to the stress of one of her friends got shot and died in her house she had a relapse at the start of the year.

Because of this, she lost her job and could not see her children. She was determined to stop using drugs and to rebuild her life; thus, she went to Pavillion.

**History of suicide attempts:** Patient said that she had the thoughts multiple times but never acted on it.

**Primary Diagnosis on Admission (2 points):** Substances use disorder, unspecified bipolar disorder, generalized anxiety, panic disorder, social anxiety, PTSD.

**Psychosocial Assessment (30 points)**

<b>History of Trauma</b>				
<b>No lifetime experience: Pt experienced human trafficking, physical and sexual abusing</b>				
<b>Witness of trauma/abuse: Yes</b>				
	<b>Current</b>	<b>Past (what age)</b>	<b>Secondary Trauma (response that comes from caring for another person with trauma)</b>	<b>Describe</b>
<b>Physical Abuse</b>	N/A	5 - 26	N/A	<b>Domestic violence at home</b>
<b>Sexual Abuse</b>	yes	N/A	N/A	<b>By her partner</b>
<b>Emotional Abuse</b>	yes	5 - 39	N/A	<b>By her family, and her current boyfriend</b>
<b>Neglect</b>	N/A	6	N/A	<b>Mom left one day, leaving her with</b>

				her strict dad
<b>Exploitation</b>	N/A	N/A	N/A	N/A
<b>Crime</b>	N/A	15 - 26	N/A	She was trafficked and was physically, sexually abused
<b>Military</b>	N/A	N/A	N/A	N/A
<b>Natural Disaster</b>	N/A	N/A	N/A	N/A
<b>Loss</b>	yes	N/A	N/A	Friend was shot and killed in front of her
<b>Other</b>	N/A	N/A	N/A	N/A

**Presenting Problems**

Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)
<b>Depressed or sad mood</b>	Yes	No	The patient said that she's depressed everyday but it's getting better.
<b>Loss of energy or interest in activities/school</b>	Yes	No	Patient said that she is highly motivated and filled with energy and ready to start her new life
<b>Deterioration in hygiene and/or grooming</b>	Yes	No	Patient is well-groom.
<b>Social withdrawal or isolation</b>	Yes	No	Patient said she spent 2 or 3 hours alone in her room because talking to people sometimes feels too much for her
<b>Difficulties with home, school, work, relationships, or</b>	Yes	No	N/A

<b>responsibilities</b>			
<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Change in numbers of hours/night</b>	<b>Yes</b>	<b>No</b>	<b>Patient stated that she had trouble sleeping most night, and her sleep pattern changed every day.</b>
<b>Difficulty falling asleep</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Frequently awakening during night</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Early morning awakenings</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Nightmares/dreams</b>	<b>Yes</b>	<b>No</b>	<b>Patient experienced nightmare every night which affect her sleep routine and had to take medication for it.</b>
<b>Other</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Binge eating and/or purging</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Unexplained weight loss?</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Amount of weight change:</b>			
<b>Use of laxatives or excessive exercise</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	<b>Yes</b>	<b>No</b>	<b>Patient kept touching her hands and face many times during the talk.</b>
<b>Panic attacks</b>	<b>Yes</b>	<b>No</b>	<b>She said that she had many</b>

			panic attacks, usually 2 episodes per month
Obsessive/compulsive thoughts	Yes	No	She has obsessive thoughts everyday
Obsessive/compulsive behaviors	Yes	No	She feels the needs to rearrange her clothes and things 3 times per day at least
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	N/A
<b>Rating Scale</b>			
How would you rate your depression on a scale of 1-10?		3	
How would you rate your anxiety on a scale of 1-10?		5	
<b>Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)</b>			
<b>Problematic Area</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
Work	Yes	No	N/A
School	Yes	No	N/A
Family	Yes	No	She is not allowed to talk to her children
Legal	Yes	No	N/A
Social	Yes	No	Patient has anxiety talking to people
Financial	Yes	No	N/A
Other	Yes	No	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
Aug 2018	<b>Inpatient</b> Outpatient Other:	Inpatient	Drugs used	No improvement  Some improvement  <b>Significant improvement</b>
2016	<b>Inpatient</b> Outpatient Other:	Inpatient	Drugs used	No improvement  Some improvement  <b>Significant improvement</b>
2010	<b>Inpatient</b> Outpatient Other:	Inpatient	Drugs used	No improvement  Some improvement  <b>Significant improvement</b>
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Alone			Yes	No
			Yes	No
			Yes	No
			Yes	No

			Yes	No
If yes to any substance use, explain: N/A				
Children (age and gender): 1 son and 1 daughter Who are children with now? With their father				
Household dysfunction, including separation/divorce/death/incarceration: divorce Her mother left her when she was 6. Her father was very strict and controlling. She did not have a good relationship with her siblings.				
Current relationship problems: Abusing boyfriend 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: She states that "I believe in the universe, but do not want to explain it right now". She said it makes her comfortable when she thinks about it.				
Ethnic/cultural factors/traditions/current activity: Describe: The patient did not give me a specific answer to this question. She states, "well, I am Caucasian, that is it"				
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? She thinks no one could care for her right now. She had to count on herself only				
Client raised by:  Natural parents Mother and Father Grandparents Adoptive parents Foster parents Other (describe):				
Significant childhood issues impacting current illness: N/A				

<p><b>Atmosphere of childhood home:</b></p> <p>She felt alone most her childhood. Her mom left, and her dad was very strict on her. Her siblings are all successful in life and not talking to her.</p> <p>Loving                  Comfortable                  Chaotic  <b>Abusive</b>                  Supportive                  Other: Isolated</p>
<p><b>Self-Care: Pt is taking care of herself.</b></p> <p><b>Independent</b>                  Assisted                  Total Care</p>
<p><b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b></p> <p>N/A</p>
<p><b>History of Substance Use: Meth</b></p>
<p><b>Education History: Patient was in high school when she got trafficked</b></p> <p>Grade school  <b>High school</b>                  College                  Other:</p>
<p><b>Reading Skills:</b></p> <p><b>Yes</b>                  No                  Limited</p>
<p><b>Primary Language: English</b></p>
<p><b>Problems in school: N/A</b></p>
<p><b>Discharge</b></p>
<p><b>Client goals for treatment: Pt goal is to stop using drugs</b></p>
<p><b>Where will client go when discharged? Patient will be discharged to home in Missouri.</b></p>

**Outpatient Resources (15 points)**

<b>Resource</b>	<b>Rationale</b>
1. The Pavilion	1. She likes the program, and it helps her get back up on her feet.
2. U of I counseling center	2. They offer group and private therapy. The patient takes time when she answers and asks to repeat the question
3. CROSSPOINT Human Service	3. They offer crisis services 24/7 for people who are experiencing crisis and immediate problems. From assessment to planning and therapy/counseling, so the patient could get help immediately.

**Current Medications (10 points)**

**\*Complete all of your client’s psychiatric medications\***

<b>Brand/Generic</b>	Escitalopram/ Lexapro	Oxcarbazepine/ Oxtellar XR	Prazosin/ Minipress	Trazodone/ Desyrel	Zyprexa/ olanzapine
<b>Dose</b>	10 mg	300 mg	2 mg	150mg	2mg
<b>Frequency</b>	Daily	Daily	Daily	Daily	Daily
<b>Route</b>	PO/	PO	PO	PO	PO
<b>Classification</b>	selective serotonin reuptake inhibitor	anticonvulsants	antiadrenergic agents,	antidepressants	antipsychotics
<b>Mechanism of Action</b>	inhibits the reuptake of the neurotransmitter serotonin	decreasing nerve impulses that cause seizures and pain	crossing the blood-brain barrier and decreasing sympathetic outflow, blocking norepinephrine	restore the balance of a certain natural chemical (serotonin) in the brain	affects chemicals in the brain
<b>Therapeutic Uses</b>	treat major depressive disorder in adults and adolescents at least 12 years old	Oxcarbazepine is used either alone or with other medicines to treat partial seizures	treat hypertension, nightmare	treat major depressive disorder.	treat psychotic conditions such as schizophrenia

					a and bipolar disorder
<b>Therapeutic Range (if applicable)</b>	20 mg orally once a day	600 mg	Max 20 mg daily	Max 600 mg daily	Max 16 mg daily
<b>Reason Client Taking</b>	Treat depression	Mood stabilized	For nightmares	For insomnia	Mood stabilized
<b>Contraindications (2)</b>	You should not use escitalopram you also take pimoziide or citalopram (Celexa)	liver disease, kidney disease	Drinking alcohol with this medicine can cause side effects	Some young people have thoughts about suicide when first taking an antidepressant .	high cholesterol or triglycerides
<b>Side Effects/Adverse Reactions (2)</b>	blurred vision, tunnel vision, eye pain or swelling, or seeing halos around lights	dizziness, drowsiness, tiredness	dizziness, drowsiness	fast or pounding heartbeats, fluttering in your chest, shortness of breath	trouble speaking or swallowing
<b>Medication/Food Interactions</b>	blood thinner such as Warfarin, Coumadin, or Jantoven	opioid medication, a sleeping pill, a muscle relaxer, or medicine for anxiety or seizures	any other blood pressure medication;	MAO inhibitors include isocarboxazid, linezolid, phenelzine, tranylcypromine and others	opioid medication, a sleeping pill, a muscle relaxer, or medicine for anxiety or seizures
<b>Nursing Considerations (2)</b>	Take escitalopram at the same time each day, with or without food.	topping suddenly may cause increased seizures	Avoid getting up too fast from a sitting or lying position	Trazodone is not approved for use in children	Zyprexa may impair your thinking or reactions

<b>Brand/Generic</b>					
<b>Dose</b>					
<b>Frequency</b>					
<b>Route</b>					
<b>Classification</b>					

<b>Mechanism of Action</b>					
<b>Therapeutic Uses</b>					
<b>Therapeutic Range (if applicable)</b>					
<b>Reason Client Taking</b>					
<b>Contraindications (2)</b>					
<b>Side Effects/Adverse Reactions (2)</b>					
<b>Medication/Food Interactions</b>					
<b>Nursing Considerations (2)</b>					

**Medications Reference (1) (APA):**

Loebl, S. (2020). *2020 Nurse's drug handbook*. Burlington, Jones & Bartlett Learning.

Videbeck, L. S. (2020). *Psychiatric Mental Health Nursing* (8<sup>th</sup> ed.). Wolters Kluwer.

**Mental Status Exam Findings (20 points)**

<b>APPEARANCE:</b> <b>Behavior:</b> <b>Build:</b> <b>Attitude:</b> <b>Speech:</b> <b>Interpersonal style:</b> <b>Mood:</b> <b>Affect:</b>	Patient looks good, with good odor and friendly attitude. Speech is clear and easy to understand. Patient constantly touches face and hands with indicates anxiety.
<b>MAIN THOUGHT CONTENT:</b> <b>Ideations:</b> <b>Delusions:</b>	Pt denied suicidal ideation at the moment Pt denied delusion, illusion, and phobias. However, Pt has compulsive behavior and

<b>Illusions:</b> <b>Obsessions:</b> <b>Compulsions:</b> <b>Phobias:</b>	thought.
<b>ORIENTATION:</b> <b>Sensorium:</b> <b>Thought Content:</b>	Pt is oriented to time, place, person, and place. Thought is linear and goal directed
<b>MEMORY:</b> <b>Remote:</b>	Pt's memory was clear such as the year for friends' death.
<b>REASONING:</b> <b>Judgment:</b> <b>Calculations:</b> <b>Intelligence:</b> <b>Abstraction:</b> <b>Impulse Control:</b>	Pt walked into the nurse's station to get a coffee by herself politely. Pt has the good judgment and good impulse control. She is very friendly and eager to answer any questions I have for her.
<b>INSIGHT:</b>	Pt has good insight. Pt takes full responsibility for her actions and tries to change her life
<b>GAIT:</b> <b>Assistive Devices:</b> <b>Posture:</b> <b>Muscle Tone:</b> <b>Strength:</b> <b>Motor Movements:</b>	Pt has a normal gait, no assistive devices, standard postures. Also, Pt has normal muscle tone, strength, regular motor movements.

**Vital Signs, 2 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
1430	84	147/93	16	98.3 F Oral	98% Room air
1730	92	108/74	14	97.9 F Temporal	93% Room air

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>

1430	1-10	N/A	0	No pain	N/A
1730	1-10	N/A	0	No pain	N/A

**Dietary Data (2 points)**

<b>Dietary Intake</b>	
<b>Percentage of Meal Consumed:</b>  <b>Breakfast:</b> 0%  <b>Lunch:</b> 0%  <b>Dinner:</b> 75%	<b>Oral Fluid Intake with Meals (in mL)</b>  <b>Breakfast:</b> 0%  <b>Lunch:</b> 0%  <b>Dinner:</b> 480mL, 2 cups of coffee

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):**

Pt will discharge to her home in Springfield, where she alone. Pt will have a follow-up visit appointment with case management or therapist. Pt has a lack of a supportive system, so educate Pt about the outpatient sources. Moreover, Pt will need group therapy not to fall back to her drugs use routine. Pt is encouraged to have group therapy to reduce suicidal ideation. Medication such as anticonvulsants and antipsychotics will be administered for her disorder. Educate the patient to follow the prescribed medication regimen.

**Nursing Diagnosis (15 points)**

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

<b>Nursing Diagnosis</b>	<b>Rational</b>	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (Prior to discharge)</b>
<ul style="list-style-type: none"> <li>• Include full nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Explain why the nursing</li> </ul>			

diagnosis with “related to” and “as evidenced by” components	diagnosis was chosen		)	
1. acute system withdraw syndrome related to meth use as evidenced by post use nightmare and panic attack	Pt had 2 episodes of panic attack since her admission and had nightmares every night	<ol style="list-style-type: none"> <li>1. Oxcarbazepine/Oxtella r XR</li> <li>2. Zyprexa/ olanzapine</li> <li>3. Provide safe environment</li> </ol>	<ol style="list-style-type: none"> <li>1. Be with the patient when she has an episode</li> <li>2. Music therapy</li> <li>3. Encourage Pt to participate in group therapy.</li> </ol>	<ol style="list-style-type: none"> <li>1. Encourage patient to talk freely about feeling.</li> <li>2. Assess and evaluate pt</li> <li>3. Educate the patient about the outpatient sources when he needs help after discharge.</li> </ol>
2. Disturbed sleep patter related to meth abuse as evidenced by insomnia and nightmare.	Pt stated that she had trouble sleeping and had nightmare every night	<ol style="list-style-type: none"> <li>1. Prazosin/ Minipress</li> <li>2. Trazodone/ Desyrel</li> <li>3. Provide safe environment.</li> </ol>	<ol style="list-style-type: none"> <li>1. Music therapy</li> <li>2. Try to distract client from their delusion by engaging in reality-based activities.</li> <li>3. Do not touch the client but use gestures carefully.</li> </ol>	<ol style="list-style-type: none"> <li>1. Encourage the Pt to take frequent rest</li> <li>2. Engage the client to start from one-to-one activities and move to the small and larger groups.</li> <li>3. Educate client coping skills for nightmare.</li> </ol>
3. Self-care deficit related to the possibility of bipolar type	Patient have not taken enough nutrition and sleep during	<ol style="list-style-type: none"> <li>1. Managing Pt’s personal hygiene.</li> <li>2. Provide adequate water and food.</li> </ol>	<ol style="list-style-type: none"> <li>1. Monitoring I/O, and sleep pattern.</li> <li>2. Trazodone/</li> </ol>	<ol style="list-style-type: none"> <li>1. Educate the client on the importance of maintaining regular sleep,</li> </ol>

<p>disorder evidence by characteristics of bipolar disorder such as patient was severely underweight prior to admission</p>	<p>hospitalization .</p>	<p>3. Implement frequent rest periods.</p>	<p>Desyrel 3. Give a simple step by step reminder for food</p>	<p>meal, and activity pattern. 2. Encourage Pt to join psychotherapy . 3. Give the information of outpatient sources that he could get help. Also, provide follow-up appointments for the Pt with case management.</p>
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**Other References (APA):**

Videbeck, L. S. (2020). *Psychiatric Mental Health Nursing* (8<sup>th</sup> ed.). Wolters Kluwer.

**Concept Map (20 Points):**

### Subjective Data

Pt relapse after 2 years clean on meth. She was determined to stop using drugs and to rebuild her life; thus, she went to Pavillion.

### Nursing Diagnosis/Outcomes

1. Acute system withdraw syndrome related to meth use as evidenced by post use nightmare and panic attack
2. Disturbed sleep patter related to meth abuse as evidenced by insomnia and nightmare.
3. Self-care deficit related to the possibility of bipolar type disorder evidence by characteristics of bipolar disorder such as patient was severely underweight prior to admission

### Objective Data

B/P 108/74  
Pulse 92  
RR 14  
Temp 97.9 F  
Oxygen 93%  
5'5", 115 lb

### Patient Information

AB  
39 years old  
Female  
Full code  
Caucasian

1. Encourage patient to talk freely about feeling.

### Nursing Interventions

2. Assess and evaluate pt
3. Educate the patient about the outpatient sources when he needs help after discharge
4. Encourage the Pt to take frequent rest
5. Engage the client to start from one-to-one activities and move to the small and larger groups.
6. Educate client coping skills for nightmare.
7. Educate the client on the importance of maintaining regular sleep, meal, and activity pattern.
8. Encourage Pt to join psychotherapy.
9. Give the information of outpatient sources that he could get help. Also, provide follow-up appointments for the Pt with case management.



