N323 Care Plan

Lakeview College of Nursing

Name: Lindsey Burnett

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/10/22	TD	33	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Manager at McDonalds	Married	Penicillin
Code Status	**Observation Status**	**Height**	**Weight**
Full	Full Admit	5’7”	150lb

Medical History (5 Points)

Past Medical History: Patient states no past medical problems, chart shows a history of abnormal pap smears.

Significant Psychiatric History: The patient has a history of depression, with worsening symptoms after pregnancy.

Family History: Family history of depression on both mother and fathers’ side, history of asthma on mothers’ side, and history of diabetes on fathers side.

Social History (tobacco/alcohol/drugs): The patient denies any use of tobacco, smokeless tobacco, alcohol, and drug use.

Living Situation: The patient lives at home with her husband and two children.

Strengths: The patient states her strengths as being good at making people laugh, being good at deescalating situations, and having excellent family support.

Support System: The patient states her support system includes her husband and mother-in-law.

Admission Assessment

Chief Complaint (2 points): “I’m feeling very depressed”

Contributing Factors (10 points): History of depression with worsening symptoms from postpartum depression.

Factors that lead to admission: Patient having auditory hallucinations-hearing people laughing at her, multiple crying spells out of the normal, and history of mood swings.

History of suicide attempts: No suicide attempts, only thoughts of harming self.

Primary Diagnosis on Admission (2 points): Bipolar disorder type 2, major depressive episode with postpartum, generalized anxiety disorder, and panic disorder.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: N/A **Witness of trauma/abuse:** Witness of abuse to self, friends, and family members.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	No	No	n/a	n/a
Sexual Abuse	No	No	n/a	n/a
Emotional Abuse	No	No	n/a	n/a
Neglect	No	No	n/a	n/a
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	No	Yes at age 15	Patient was very unwilling to go into details.	Patient was very unwilling to go into details.
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**	Patient states she frequently feels depressed and sad, this has increased since having her newborn a couple months ago.
Loss of energy or interest in activities/school	**Yes**	**No**	Patient states she has had a loss of energy due to having a newborn baby, but states before pregnancy had adequate energy.
Deterioration in hygiene and/or grooming	**Yes**	**No**	N/A
Social withdrawal or isolation	**Yes**	**No**	Patient states feeling isolation due to COVID, having a newborn

			baby.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient states having difficulties with not being able to work during pregnancy.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient states not sleeping well frequently due to having a newborn, and thinking to much about little things at night.
Difficulty falling asleep	**Yes**	**No**	Patient states she doesn't have troubles falling asleep, but has frequently had problems sleeping while being at the facility due to feelings of be sad and depressed.
Frequently awakening during night	**Yes**	**No**	Patient states she wakes up frequently at home due to having a newborn waking up during the night, but besides that she sleeps well. She also mentions that she frequently wake up during the night at the facility with feelings of being sad.
Early morning awakenings	**Yes**	**No**	Patient states she wakes up early

			and frequently at home due to having a newborn. She also mentions that she wakes up early at the facility due to the schedule they have.
Nightmares/dreams	**Yes**	**No**	N/A
Other	**Yes**	**No**	N/A
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient states she has a recent loss of appetite, but says she is adopting better and healthier eating habits since being in the facility.
Binge eating and/or purging	**Yes**	**No**	Patient states she does binge eat at home once in a while, but is working on being better about eating healthier and adopting healthier habits.
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Patients states she recently had a newborn baby, but she has lost more than the baby weight, she is unaware of how much weight she has lost.

Use of laxatives or excessive exercise	**Yes**	**No**	N/A
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient states she has frequent episodes of having tremors and pacing quickly.
Panic attacks	**Yes**	**No**	Patient says she has frequent episodes of panic attacks that occur randomly.
Obsessive/compulsive thoughts	**Yes**	**No**	Patient is frequently anxious and things something bad is going to happen but doesn't know what.
Obsessive/compulsive behaviors	**Yes**	**No**	Patient has frequent outbursts of crying and mood changes.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient says she sleeps a lot at a time or doesn't sleep at all, thinks people are laughing at her.
Rating Scale			
How would you rate your depression on a scale of 1-10?		4	
How would you rate your anxiety on a scale of 1-10?		4	
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**	Patient states she has recently not been able to work with a having a

			newborn and sleeping a lot, and not feeling energetic or wanting to do anything.
School	**Yes**	**No**	N/A
Family	**Yes**	**No**	Patient states she frequently doesn't want to care for her family, she says she is sad and stressed.
Legal	**Yes**	**No**	N/A
Social	**Yes**	**No**	Current states not being able to be social frequently with having a newborn, not being able to work, and COVID.
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**
Patient was unaware of dates.	**Inpatient:** Therapist **Outpatient**	Inpatient	Suicidal Ideations	**No improvement** **Some**

	Other:		and mood swings	**improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
AJ	33	Husband	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): 1 son age 4 years old and 1 daughter 2 mo. Old. **Who are children with now?** Children are at home with their father.				
Household dysfunction, including separation/divorce/death/incarceration: Patient is unaware of any dysfunctional problems within her household, she states no separation or divorce between parents or herself personally, and she didn't state any incarceration or deaths.				
Current relationship problems: Patient states no current relationship problems.				

Number of marriages: 1		
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 not religious and doesn't have any special values or beliefs that she has adopted.		
Ethnic/cultural factors/traditions/current activity: Patient states she doesn't have any special traditions or activities that she celebrates or does. **Describe:** N/A		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient states she has not had any current or past legal issues.		
How can your family/support system participate in your treatment and care? Patients says she has a really good support system, and would like more help around the house with the kids, and helping improve her mental health.		
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: Patient states she didn't have any significant childhood issues that are impacting current illness, the only thing she would elaborate on but wouldn't go into detail was having trauma of self-harm and seeing people close to her cause self-harm.		
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive**		

Supportive **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) The patient has a family history of depression on both mother and fathers side.
History of Substance Use: No history of substance use.
Education History: **Grade school** **High school:** Finished 12th grade **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: N/A
Discharge
Client goals for treatment: Goals include getting better adequate sleep, adopting healthier eating habits, and adopting methods to control mood swings.
Where will client go when discharged? Client is going back home when she is discharged.

Outpatient Resources (15 points)

Resource	Rationale
1. Therapy	**1.** It would be good for the patient to attend group therapy and talk to others that are having the same problems as her and get resources on what others are doing to improve.
2. Counseling	**2.** It would be good for patient to attend therapy to talk about her mood swings and hallucinations and what she is doing to help improve these symptoms.
3. Hotline	**3.** Patient states she has postpartum depression after having her daughter, she says she would never hurt her, but it would be good to have a hotline to talk to someone if it's the middle of the night or if there is nobody around for the patient to talk to, it would be good to have this resource to utilize when patient feels she needs someone to talk

	to.

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

Brand/Generic	Clonazepam/ Rivotril	Seroquel/ Quetiapine	Sertraline/ Zoloft	N/A	N/A
Dose	0.5 mg	50 mg	150 mg	N/A	N/A
Frequency	TID/PRN	1x daily at bedtime	1x daily at bedtime	N/A	N/A
Route	Oral	Oral	Oral	N/A	N/A
Classification	Pharmacologic: Benzodiazepine Therapeutic: Anticonvulsant, antipanic controlled substance schedule IV	Pharmacologic: Dibenzothiazepine Therapeutic: Antipsychotic	Pharmacologic: Selective serotonin reuptake inhibitor Therapeutic: Antianxiety, antidepressant, antiobsessant, antipanic, antiposttraumatic stress, antipremenstrual dysphoric	N/A	N/A
Mechanism of Action	Enhances activity of the inhibitory neurotransmitter GABA in the CNS to give its anticonvulsant, skeletal muscle, and anxiolytic	May produce antipsychotic effect by interfering with dopamine binding to dopamine type 2 receptor sites in the brain and by antagonizing	Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available	N/A	N/A

	effects.	serotonin 5-HT, dopamine type 1, histamine, and adrenergic alpha, and alpha receptors.	in nerve synapses. An elevated serotonin level may result in elevated mood and reduced depression.		
Therapeutic Uses	Muscle weakness and confusion	To treat anxiety and bipolar	To treat depression, panic attacks, and PTSD	N/A	N/A
Therapeutic Range (if applicable)	0.02-0.08 ng	200-800 mg	25-50 mg up to 200 mg	N/A	N/A
Reason Client Taking	Client is taking for anxiety	Client is taking for mood and bipolar disorder	Client is taking for depression	N/A	N/A
Contraindications (2)	Acute-narrow-angle glaucoma; and Hepatic disease.	Hypersensitivity to quetiapine or its components.	Concurrent use of disulfiram or pimozide, and hypersensitivity to sertraline or its components.	N/A	N/A
Side Effects/Adverse Reactions (2)	Dizziness and blurred vision	Lethargy and depression	Aggressiveness and amnesia	N/A	N/A
Medication/ Food Interactions	Can be taken with or without food	Cannot take with grapefruit and can be taken with or without food	Can be taken with or without food	N/A	N/A
Nursing Considerations (2)	Monitor blood drug level, CBC, and liver enzymes during long-term or high-dose therapy, as ordered. Monitor patient closely for evidence of suicidal thinking or behavior, especially when therapy starts or dosage changes.	Shouldn't be used for elderly patients with dementia-related psychosis because drug increases the risk of death in these patients. Advise patient to contact prescriber if pulse rate becomes abnormally slow or irregular.	Monitor patient for hypo-osmolarity of serum and urine and for hyponatremia, which may indicate sertraline-induced syndrome of inappropriate ADH secretion. When therapy stops, expect to taper dosage to minimize adverse effects rather than stopping drug	N/A	N/A

			abruptly.		

Brand/Generic	N/A	N/A	N/A	N/A	N/A
Dose	N/A	N/A	N/A	N/A	N/A
Frequency	N/A	N/A	N/A	N/A	N/A
Route	N/A	N/A	N/A	N/A	N/A
Classification	N/A	N/A	N/A	N/A	N/A
Mechanism of Action	N/A	N/A	N/A	N/A	N/A
Therapeutic Uses	N/A	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA): Jones & Bartlett Learning (2021). 2021 Nurses' Drug Handbook. Burlington, MA

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient alert, calm, and cooperative. Patient is quiet and anxious, answers questions appropriately, speaks well. Appears to be in a good mood and willing to get help. Mood: Depressed Affect: Depressed and restricted
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Goal-oriented Denies delusions, obsessions, compulsions, and phobias. The patients' attention was tested by asking the patient to spell a word backward. No speech impairment.
ORIENTATION: **Sensorium:** **Thought Content:**	The patient is aware of her location I asked her where she was and she responded with the Pavilion Champaign, IL.
MEMORY: **Remote:**	Short term memory was tested by giving the patient three words and was later asked to state the words back; long term memory was tested by asking to recall past historical events.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Judgment is fair, this was tested by asking what she would do if she saw someone drop money, she responded with she would pick the money up and give it back to the person. Patients intelligence and calculation is fair, this was tested by asking the patient what 50+75 equals and she responded quickly.
INSIGHT:	The patient performs daily activities independently.

GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	Patient doesn't need any assistive devices to get around. Patient has proper and adequate posture, muscle tone, and good strength, motor movements are strong and equal.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1320	105	120/74	18	97.8 F	97% Room Air
1523	100	109/69	18	96.3 F	100% Room Air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1320	0-10	N/A	0	N/A	N/A
1523	0-10	N/A	0	N/A	N/A

Dietary Data (2 points)

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

Dinner: N/A dinner was being served when we left.	**Dinner:** N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Discharge plans for this client include making sure she attends a therapy session weekly and having access to a hotline or a resource where she can talk to someone when she is going through a tough time and can't talk to her family. Make sure the patient is getting help with her children and getting enough adequate amount of sleep consistently. Have patient follow up with their primary to check-in and update on their well-being and condition.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

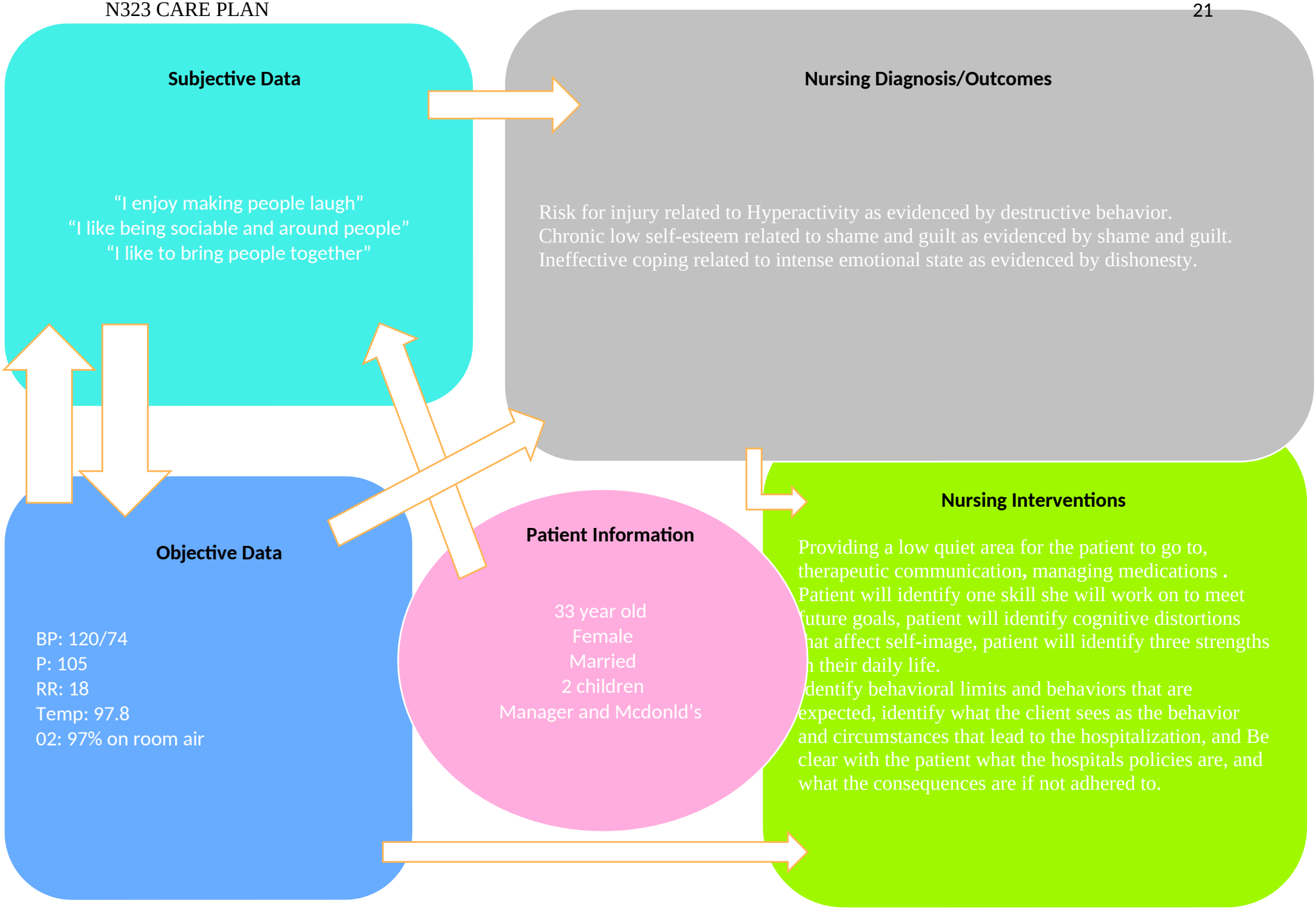
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Risk for injury related to Hyperactivity as evidenced by destructive behavior.	The patient states she is always tired and is not getting enough sleeping with having a newborn and younger child	**1.** Providing a low quiet area for the patient to go **2.** Therapeutic communication **3.** Managing medications	**1.** Cognitive behavioral thinking. **2.** Providing high calorie fluids. **3.** Redirect violent behavior.	**1.** Family-focused therapy. **2.** Education on proper management of medications. **3.** Maintain a low level of

				stimuli in, quieter environment.
2. Chronic low self-esteem related to shame and guilt as evidenced by shame and guilt.	Patient was stating she doesn't feel right and she said she wouldn't harm her baby, but doesn't feel connected to her and doesn't know what to do with her.	**1.** Patient will identify one skill she will work on to meet future goals. **2.** Patient will identify cognitive distortions that affect self-image. **3.** Patient will identify three strengths in their daily life.	**1.** Patient will set one realistic goal with the nurse the she wishes to purse. **2.** Patient will state willingness to work on future goals. **3.** Patient will reframe and dispute cognitive distortion with the nurse.	**1.** Patient will identify one new skill she has learned to help meet personal goals. **2.** Maintain a calm, neutral, and respectful manner. **3.** Encourage client to keep a log of what gets them anxious, mad, and sad.
3. Ineffective coping related to intense emotional state as evidenced by dishonesty.	This was chosen as I was talking to the patient she would tell me one thing and then get really upset, but then come back and say something different related to the topic, this was confirmed in her chart as I asked her questions related to past history and current relationships her responses her chart were different than	**1.** Identify behavioral limits and behaviors that are expected. **2.** Identify what the client sees as the behavior and circumstances that lead to the hospitalization. **3.** Be clear with the patient what the hospitals policies are, and what the consequences are if not adhered to.	**1.** Patient will remain safe while hospitalized. **2.** Patient will learn and master skills that facilitate function behavior. **3.** Patient will not act out anger towards others while hospitalized.	**1.** Patient will identify behaviors leading to hospitalization. **2.** Patient will state that she will continue her treatment on an outpatient basis. **3.** Patient will talk about feelings and perceptions and not act on them.

	what she told me.			

Other References (APA): Swearingen, Pamela L. And Wright, Jacqueline D. All – in – One Nursing Care Planning Resource (2019). St. Louis, MO.

Concept Map (20 Points):


Subjective Data
"I enjoy making people laugh"
"I like being sociable and around people"
"I like to bring people together"
Nursing Diagnosis/Outcomes
Risk for injury related to Hyperactivity as evidenced by destructive behavior.
Chronic low self-esteem related to shame and guilt as evidenced by shame and guilt.
Ineffective coping related to intense emotional state as evidenced by dishonesty.
Objective Data
BP: 120/74
P: 105
RR: 18
Temp: 97.8
02: 97% on room air
Patient Information
33 year old
Female
Married
2 children
Manager and Mcdonld's
Nursing Interventions
Providing a low quiet area for the patient to go to, therapeutic communication, managing medications .
Patient will identify one skill she will work on to meet future goals, patient will identify cognitive distortions hat affect self-image, patient will identify three strengths h their daily life.
dentify behavioral limits and behaviors that are expected, identify what the client sees as the behavior and circumstances that lead to the hospitalization, and Be clear with the patient what the hospitals policies are, and what the consequences are if not adhered to.