N323 Care Plan

Lakeview College of Nursing

Ragin Baker

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/15/23	EA	36 y.o	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Not Hispanic or Latino	Works at Walgreens	Married	Abilify [Aripiprazole] Lamotrigine Buspirone
Code Status	**Observation Status**	**Height**	**Weight**
Full	Inpatient rounds every 15 minutes	5'3"	140lb

Medical History (5 Points)

Past Medical History:

Abnormal pap smear of cervix, Bipolar 1 disorder (HCC), HPV (human papilloma virus) infection, migraines, molar pregnancy, MVP (mitral valve prolapse), postpartum depression, psychosis (HCC), and varicose veins

Significant Psychiatric History:

Patient had one pervious inpatient psychiatric admission in August 2021. Patient was admitted for postpartum psychosis. Patients report she has been seeing a psychiatrist via telepsych service and was prescribed vraylar, Lexapro, propranolol, and Neurontin. On her evaluation day, the patient claims she has not taken any of the medications that were prescribed for at least 9 months.

Family History:

The patient reports her has bipolar disorder, thyroid disease hypertension, and had a miscarriage. Her son has down syndrome.

Social History (tobacco/alcohol/drugs):

The patient reports she has never smoked and was never exposed to tobacco. Patient also reports she has never used smokeless tobacco. Patient reports she does not currently use alcohol and does not use any drugs. Patient does report that she is single (separated) and has been married 3 times. Reports she has 5 biological children, ages 15, 13, 4, 2, and 2 months. She reports she currently works at Walgreens. Patient reports she completed a bachelor's degree in education.

Living Situation:

Patient reports that she lives with her 5 children.

Strengths:

The patient believes her strength is her children, to get better for them.

Support System:

The patient reports that her family as her support system. She stated, "they maybe are even too supportive."

Admission Assessment

Chief Complaint (2 points):

The patient stated, "I am confused, and I do not trust anyone."

Contributing Factors (10 points):

Factors that lead to admission:

When the patient was admitted she was 2 weeks postpartum. The patient went to her scheduled postpartum appointment on 9-14-23. While the patient was at the appointment, she was acting erratically and speaking nonsensically. The patient's obstetrician suggested that she go to the emergency room. The patient was brought to Carle Foundation Hospital's ER by her

mother. The patient then was transferred to OSF Heart of Mary Medical Center 5E inpatient psychiatric unit for further treatment. During her evaluation she was psychomotor agitated, confused, and liable. The patient was angry, dismissive, and emotional. The patient is very guarded and evasive. Within the chart the patient said she recently saw her grandmother, who is deceased, sitting in the back seat of her car with her children. The patient denies any auditory or visual hallucinations.

History of suicide attempts:

The patient denies any suicidal or homicidal ideations. Denies any previous suicidal attempts.

Primary Diagnosis on Admission (2 points):

Bipolar disorder, unspecific

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No, has experience **Witness of trauma/abuse:** No				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	Denies	Denies	N/A	N/A
Sexual Abuse	Denies	Denies	N/A	N/A
Emotional Abuse	Denies	During	N/A	Patient remembers

		childhood		the stories her mother would tell her about her being a hard child to raise. Patient thought that was one reason why she was depressed.
Neglect	Denies	Denies	N/A	N/A
Exploitation	Denies	Denies	N/A	N/A
Crime	Denies	Denies	N/A	N/A
Military	Never enlisted	Denies	N/A	N/A
Natural Disaster	Denies	Denies	N/A	N/A
Loss	Denies	Denies	N/A	N/A
Other	Denies	Denies	N/A	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	Patient stated, “on-and-off.”	
Loss of energy or interest in activities/school	**Yes**	**No**	Denies	
Deterioration in hygiene and/or grooming	**Yes**	**No**	Denies	
Social withdrawal or isolation	**Yes**	**No**	Patient reports withdrawal from social activities and isolating herself.	
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient reports dropping out of her creative writing class.	
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**	Patient reports noticing a change in her sleep pattern.	

Difficulty falling asleep	**Yes**	**No**	Denies
Frequently awakening during night	**Yes**	**No**	Patient reports she does not have trouble falling asleep but does have trouble staying asleep.
Early morning awakenings	**Yes**	**No**	Patient reports she likes to wake up early.
Nightmares/dreams	**Yes**	**No**	Patient reports that she does have nightmares more often than not.
Other	**Yes**	**No**	Denies
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient reports having no appetite at all.
Binge eating and/or purging	**Yes**	**No**	Patient reports that sometimes she has noticed that she eats more than usually, but it is not often.
Unexplained weight loss? **Amount of weight change:**	**Yes**	No	Denies
Use of laxatives or excessive exercise	**Yes**	**No**	Denies
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient reports that she gets uncomfortable around people and it makes her anxious.
Panic attacks	**Yes**	**No**	
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**	Patient reports that her anxiety has impacted her daily living recently.
Rating Scale			

How would you rate your depression on a scale of 1-10?	2/10
How would you rate your anxiety on a scale of 1-10?	3/10

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**	Patient reports that work has been stressful.
School	**Yes**	**No**	Patient reports that she dropped out of her creative writing class.
Family	**Yes**	**No**	Patient reports that the divorce she is going through right now, it very stressful.
Legal	**Yes**	**No**	Denies
Social	**Yes**	**No**	Denies
Financial	**Yes**	**No**	Denies
Other	**Yes**	**No**	Denies

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
August 2021	**Inpatient** **Outpatient** **Other:** Carle BroMenn	Inpatient	Postpartum Psychosis	**No improvement** Patient did not provide information about her last admission. **Some improvement**

				Significant improvement
N/A	**Inpatient** **Outpatient** **Other:** N/A	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**
N/A	**Inpatient** **Outpatient** **Other:** N/A	N/A	N/A	**No improvement** **Some improvement** **Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
N/A	15	Daughter	**Yes**	**No**
N/A	13	Son	**Yes**	**No**
N/A	4	Son	**Yes**	**No**
N/A	2	Son	**Yes**	**No**
N/A	2 months	Son	**Yes**	**No**

If yes to any substance use, explain:

Children (age and gender):

15 (daughter), 13 (son), 4 (son), 2 (son), and 2 months (son)

Who are children with now?

The patient's mother

Household dysfunction, including separation/divorce/death/incarceration:

Separation

Married 3 times

Current relationship problems:

Separation

Number of marriages:

3

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Heterosexual	**Yes** **No**	**Yes** **No**

Please describe your religious values, beliefs, spirituality and/or preference:

Patient reports that she does have some spiritual valves. Patient stated that, “I took a religious class and found it interesting, and I do believe that there is something out there.”

Ethnic/cultural factors/traditions/current activity:

Patient reports that her family is very superstitious.

Describe:

Patient described it as like, “you step on a crack you’ll break your mothers back.”

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

Patient reports no current or past legal issues, other than patient is getting a divorce.

How can your family/support system participate in your treatment and care?

Patient reports that her family can support her by being there for her.

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:

Patient reported one situation from her past about her mother. How the patient was a problem

child and denied at first that the stories aren't why she is depressed, but then stated, "maybe."
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.) Patient reports mother has bipolar disorder.
History of Substance Use:
Education History: **Grade school** **High school** **College:** Patient reports she has a bachelor's degree in education. **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: No
Discharge
Client goals for treatment:

"To get better for her children."
Where will client go when discharged? Patient wants to be discharged home."

Outpatient Resources (15 points)

Resource	Rationale
1. Psychiatrist in Champaign	**1.** The patient could benefit from continuing seeing a psychiatrist. The patient can then get help and continued monitoring on her bipolar disorder that is still unspecific and her postpartum psychosis.
2. Group Therapy	**2.** The patient should attend a group therapy for her anxiety and depression. This will help the patient to be able to talk about certain situations and connect with others.
3. Hotlines	**3.** The patient could contact the suicide hotline if they patient starts to have thoughts about harming themselves or others.

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

Brand/ Generic	Cariprazine (vraylar reagila)	lithium (LITHOBID)	Lorazepam (ATIVAN)	Lurasidone (LATUDA)	Zolpidem (AMBIEN)
Dose	1.5 mg	300 mg	0.5 mg	60 mg	5 mg
Frequency	Daily	2 times daily	3 times daily	Daily after dinner	Nightly
Route	Oral	Oral	Oral	Oral	Oral
Classification	Atypical antipsychotic	Alkali metal	Benzodiazepine	Atypical antipsychotic	Imidazopyridine
Mechanism of Action	Acts as a partial agonist at dopamine receptors and serotonin receptors. Acts as an antagonist at 5-HT2A serotonin receptor sites.	Could increase presynaptic degradation of the catecholamine neurotransmitters dopamine, norepinephrine, and serotonin. Inhibits their release at neuronal synapses and decrease postsynaptic receptor sensitivity.	Could potentiate the effects of gamma-aminobutyric acid (GABA) and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of CNS.	Central dopamine type 2 and serotonin type 2 receptor antagonism to suppress psychotic symptoms and elevate mood.	Could potentiate the effects of gamma-aminobutyric acid (GABA) and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in the limbic and cortical areas of the CNS.
Therapeutic Uses	Antipsychotic	Antimanic	Anxiolytic	Antipsychotic	Hypnotic
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	To treat manic or mixed episodes of bipolar disorder	To treat acute manic episodes on bipolar disorder	To treat anxiety	To treat depressive episodes related to bipolar disorder	To help patient sleep
Contraindications (2)	1. Hypersensitivity to cariprazine 2. Confusion or memory loss	1. Hypersensitivity to lithium 2. Cardiovascular disease	1. Acute angle-closure glaucoma 2. Severe respiratory insufficiency	1. Concurrent therapy with strong CYP3A4 inducers like, avasimibe 2. Concurrent therapy with strong CYP3A4 inhibitors like, clarithromycin	1. Development of complex sleep behaviors 2. Hypersensitivity to zolpidem
Side Effects/Ad	1. Agitation 2. Anxiety	1. Blurred vision	1. Chest pain 2. Dizziness	1. Hypertension 2. Dyspnea	1. Constipation 2. Dyspnea

verse Reactions (2)		2. Muscle twitching and weakness			
Medication/Food Interactions	1. CYP3A4 inducers like carbamazepine, rifampin 2. CYP3A4 strong inhibitors like itraconazole, ketoconazole	1. ACE inhibitors 2. Diuretics	1. Aminophylline 2. Antidepressants 3. Clozapine 4. CNS depressants 5. Antihistamines	1. CYP3A4 inducers 2. CYP3A4 inhibitors	1. Barbiturates 2. CNS depression 3. Tramadol 4. Chlorpromazine
Nursing Considerations (2)	1. Watch patient closely for suicidal tendencies 2. Monitor patient's CBC, because serious adverse hematologic reactions may occur	1. Weigh patient daily to detect sudden weight changes 2. Monitor blood lithium level two or three times weekly during the first month, and then weekly to monthly during therapy	1. Use cautiously in patients with a history if alcohol or drug abuse, or a personality disorder because it could cause an increased risk of dependence. 2. Be cautious when giving this drug to elderly patients. Can cause hypoventilation, respiratory depression, sedation, and unsteadiness.	1. Watch patients closely for suicidal ideations 2. Monitor patients' blood glucose level, can be at risk for hyperglycemia	1. Monitor patient for suicidal ideations 2. Use cautiously in patients with additional disorders because it isn't known if the therapy might aggravate these conditions

Medications Reference (1) (APA):

Jones & Bartlett. (2023). *NDH Nurse's Drug Handbook*. Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient was observed to be well-groomed and wearing yellow scrubs. Fair grooming and hygiene noted. The patient's eye contact was fair. The patient's speech was slow, and the patient seemed to start falling asleep at times during the interview. The patient was somewhat guarded at times, but the patient was still cooperative. It was very challenging to get the patient to engage in conversation during the interview.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	The patient denies any suicidal or homicidal ideations. Patient denies any auditory or visual hallucinations. Patient denies any delusions, illusions, obsessions, compulsions, or phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was A/OX4, with patient starting to fall asleep, but her thoughts her logical .
MEMORY: **Remote:**	Both short term and long-term memory appeared to be fair.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient appeared to have fair judgement and level intelligence for the patient's age. Impulse control observed to be average. Calculation and abstraction were not assessed.
INSIGHT:	Patient's insight observed to be fair.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient has no assistive devices. The patient's posture was hunched over in a chair with her legs crossed. The patient is psychomotor retarred.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	98	105/75	16	97.9F	96
N/A	N/A	N/A	N/A	N/A	N/A

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	Numeric	N/A	0	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** N/A **Lunch:** 10% **Dinner:** N/A	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** N/A **Lunch:** N/A **Dinner:** N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient plans to go home after discharge and wants to go home to her children. The patient is going on with no assistive devices. I would like the patient to continue to see a psychiatrist to continue medications that are needed and for the patient to get a confirmed diagnosis on her unspecific bipolar disorder. I would also like to see the client join a group therapy to possible

work on her social isolation. I also would like the patient to see a therapist about her depression and anxiety. The patient needs to be educated on different deescalating techniques, when she gets overwhelmed. If the patient is prescribed medications to take home, the patient will need to be educated on the different medications.

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 suicide related to depression as evidence by postpartum depression.	The patient has a history of postpartum depression and that could lead the patient wanting to commit suicide.	**1.** Ask the patient directly, about if they have any thoughts about killing themselves. 2. Initiate appropriate safety protocols by removing anything from patient's environment that could be used to harm self or others. **3.** Make a short-term contract with	**1.** Help patient set goals for getting long-term psychiatric help. **2.** Use a caring, nonjudgmental voice and listen carefully to the patient and don't challenge patient to communicate are and support. **3.** Supervise the administration of prescribed medications.	**1.** Make sure the patient is incontact or referred to a psychiatrist. **2.** Provide patient with phone numbers and other information about different crisis hotlines. **3.** Provide patient with different contacts for a therapist or group therapies that they could attend.

		that patient that prevents the patient from harming themselves during a certain period.		
2. Risk for impaired verbal communication related to psychological barriers as evidence by patient being psychomotor retarred and having postpartum psychosis.	The patient is psychomotor retarred and has postpartum psychosis.	**1.** Speak slowly and look at patient when addressing the patient. **2.** Use short simple phrases and yes or no questions when patient is agitated. **3.** Demonstrate communication techniques, like gestures.	**1.** Encourage attempts at communication and provide positive reinforcement. **2.** Remove distractions from the environment during attempts at communication **3.** Allow time for patient to respond. Don't answer questions if the patient is able to respond.	**1.** Ensure that the patient is referred to a therapist. **2.** Provide patient information about a group therapy. **3.** Teach patient some communication techniques to help patient communicate.
3. Risk for imbalanced nutrition related to patient not eating much as evidence by patient stating, "I have no appetite."	The patient stated that she has no appetite, and she hasn't eaten much.	**1.** Obtain a daily weight. **2.** Determine patients food preferences and provide patient within limitations of patient's prescribed diet. **3.** Monitor fluid intake and output.	**1.** Provide patient with high-protein diet. **2.** Monitor electrolytes and report abnormal values. **3.** Avoid asking patient if they are hungry or wants to eat.	**1.** Refer patient to a dietician or a nutritional support team. **2.** Set a target weight for patient and have patient weigh themselves daily to involve them in their treatment. **3.** Ensure patient gets

				referred to a therapist.

Other References (APA):

Phelps, L.L. (2023). Nursing Diagnosis Reference Manual (12th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

- Admitted for postpartum psychosis.
- Pervious inpatient psychiatric admission in Aug. 2021 for postpartum psychosis.
- No history of alcohol or drug use.
- Patient has been diagnosed with bipolar disorder, unspecific.
- Patient reports no current/or pervious suicidal ideations.
- Patient stated, "I have no appetite.
- Patient stated, "I am confused, and I don't trust anybody."

Nursing Diagnosis/Outcomes

- Risk for suicide related to depression as evidence by postpartum depression.
  - Patient will report no thoughts or ideations of suicide prior to discharge.
- Risk for impaired verbal communication related to psychological barriers as evidence by patient being psychomotor retarred and having postpartum psychosis.
  - Patient will report an increase in communication and social interaction prior to discharge.
- Risk for imbalanced nutrition related to patient not eating much as evidence by patient stating, "I have no appetite."
  - Patient expresses more of an appetite and food intake prior to discharge.

Objective Data

- Most recent vital signs
  - HR: 98
  - B/P: 105/75
  - RR: 16
  - Temp.: 97.9F
  - O2: 96
- No abnormal vitals or reported labs.
- Patient is psychomotor retarred.

Patient Information

On September 15, 2023, a 36-year-old black female was admitted to OSF Heart of Mary Medical Center 5E Psychiatric unit for postpartum psychosis. The patient was at her scheduled postpartum appointment when her obstetrician suggested she go to the ED, and she was taken to Carle by her mother, then transferred to OSF. The patient has 1 pervious inpatient admission for postpartum psychosis in August of 2021.

Nursing Interventions

1. Nursing Diagnosis 1
   a. The patient is at risk for suicide with having postpartum depression.
   b. Ask patient if they are having any thoughts any suicidal ideations.
   c. Initiate appropriate safety protocols.
2. Nursing Diagnosis 2
   a. Speak slowly to patient.
   b. Encourage communication and use positive reinforcement.
   c. Demonstrate communication techniques.
3. Nursing Diagnosis 3
   a. Obtain daily weights on the patient.
   b. Monitor food and fluid intake.
   c. Provide patient with foods high in protein.