-

N323 Care Plan

19-2

Lakeview College of Nursing

Elizabeth Pasieta

Section 1: /5 pts			
Date of Admission 3/20/2020	Client's Initials TK	Age 49	Gender Female
Race/Ethnicity Caucasian	Occupation Maid-cleans houses	Marital Status Single	Allergies Strawberries NKDA
Observation Status N/A	Height / Weight 170 cm Patient refuse to discuss her weight	Other Pertinent Information N/A	

Section 2: /5 pts **Admission Assessment**
Reason for Admission (In client's own words): "Cops brought me in. Said I caused a scene at the grocery store. Guy was following me around the store. Told him to get away from me. The staff told me I was being too loud."
Admitting Diagnosis: Bipolar
Secondary Diagnosis (if applicable): N/A
Medical Conditions: Breast cancer, double mastectomy 5 years ago, depression, anxiety
Factors that Lead to Admission: Patient was being disruptive at the grocery

store and argued with the police.
History of Suicide Attempts (Date/Method): 2016, Patient states she was depressed. Patient states she was in pain and accidentally took too many Tylenol.
History and Current use of Substances: Patient states that she smokes marijuana 5-6 times per day. Patient states that she drinks 2-3 cocktails daily.
History of Psychiatric Diagnosis: Patient states she was diagnosed with Bipolar disorder.

Section 3:
/20 pts

Level of Care Assessment

NOTE: If you do not know the definitions look them up!

Appearance	**Appropriate** Poor Hygiene Needle tracks Poor eye contact	Neat / **Well groomed** Dental erosion Injured	Good eye contact Dress: **Casual** Bizarre	**Disheveled** Clothing not typical of gender
Build	Average Petite	Underweight **Obese**	Thin Muscular	**Overweight**
Speech	**Normal rate** Pressured **Mumbled** **Monotone** Rapid	Loud Slurred Incoherent Animated/excited **Circumstantial**	Slow Garbled **Clear** Accent Flight of ideas	Soft Stutter Impoverished Difficulty finding words: **NO**
Interpersonal Style	Congenial Withdrawn **Engaging** Irritable	**Open** **Relaxed** Defensive Guarded	**Cooperative** Shy Resistant Cautious	**Compliant** Hostile Annoyed
Mood/ Affect	Fearful	Irritable	**Appropriate**	Angry

Mood as stated in client's own words:	Anhedonia Indifferent Dysphoric **Flat** **Depressed**/ Hopeless/ Helpless	**Anxious** Labile Apathetic Constricted	Sad Ambivalent Reactive Fixed	Manic **Blunt** **Calm** Tearful
Behavior	Euphoric Drowsy **Sullen** **Depressed** Inability to focus	Angry **Anxious**/panicky Distant Manic/mania	Irritable **Paranoid/ suspicious** Unconcerned Hyperactive	Hostile **Appropriate** Negative Hypervigilant
Judgement Comments:	Good	**Fair**	Poor	
Abstraction	**Appropriate**	Concrete		
Insight Comments:	Awareness of problem Psychosis Dementia	Partial understanding of illness	**Denial of problem/illness**	No understanding of illness
Impulse Control	Good	Fair	**Poor**	
Intelligence	Average	Above Average	**Below Average**	Unable to ascertain
Orientation	**Time** Disoriented	**Place** Poor Concentration	**Person**	**Situation**
Sensorium	**Alert** Clouded	**Aware** Drowsy	Lethargic Dull	Stupor Uninterested
Thought content	Hallucinations Confused Goal directed Coherent Depersonalization **Within normal limits**	Delusions Divergent Somatic **Logical** Dangerous Confabulation	**Paranoia** Evasive Obsessive Grandiosity Distortion of body image	Racing thoughts Blocking Phobic Tangential Loose associations
Memory	Recent **Good**	Short Term **Good**	Long Term **Good**	

	Fair Poor	Fair Poor	Fair Poor	
Gait Assistive Devices:	**Normal** Rigid	Shuffling Trembling	Unsteady Left side weakness	Staggering Right side weakness
Posture/ Muscle Tone/ Strength:	Normal Cogwheel	Rigid Spastic	**Slouched** Atrophy	Flaccid Other: Poor posture
Motor Movements	**Normal** Tics	Restless Continuous movement	Agitated Slow/psychomotor retardation	tremors

Section 4: /10pts **Psychosocial Assessment**				
History of Trauma				
No lifetime experience/witness of trauma/abuse				
	Current	Past (what age)	Secondary Trauma**	Describe
Physical Abuse	No	Yes Around age 3	N/A	Patient states she experienced physical abuse from her past boyfriends, physical abuse from mother for as long as she can remember, and physical abuse sometimes from her friends during childhood.
Sexual Abuse	No	Yes Age 6	N/A	Patient states she was sexually abused by female baby sitter around age 6.
Emotional Abuse	No	Yes	N/A	Patient states that she has experienced

				emotional abuse most of her life from her mother and boyfriends.
Neglect	No	Yes	N/A	Patient states that her and her 7 siblings were taken away multiple times and placed in foster care.
Exploitation	No	Yes	N/A	Patient states, “Men take advantage of women.”
Crime	N/A	N/A	N/A	
Military	N/A	N/A	N/A	
Natural Disaster	N/A	N/A	N/A	
Loss	No	Yes	N/A	Patient states she never had a father, mother passed away, 2 sisters have passed away and her boyfriend passed away 5 years ago.
Other	N/A	N/A	N/A	
**Secondary Trauma is a response that comes from caring for another person with trauma. Also called compassion fatigue or burnout.				

Section 5:
/15 pts

Presenting Problems

Problematic areas	Presenting?		Describe (frequency, intensity, duration, occurrence)
Depressed or sad mood	**Yes**	No	Patient states she feels depressed because of the winter weather. Patient states she keeps to herself and is sad majority of the time.
Loss of energy or interest in activities/school	**Yes**	No	Patient states she does not have a lot of energy. She states that work wears her out. Patient states that she wakes up 4-5 times per night to use the bathroom and has a hard time falling back to sleep.
Deterioration in hygiene and/or grooming	Yes	**No**	
Social withdrawal or isolation	**Yes**	No	Patient states that she does not have friends and keeps to herself.
Difficulties with ability to parent/ or be parented	Yes	**No**	

Difficulties with home, school, work, relationships or responsibilities	**Yes**	No	Patient states that she does not have any friends, but would like to make friends.
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in number of hours / nights	**Yes**	No	Patient states she wakes up 4-5 times during the night to use the bathroom and cannot fall back asleep.
Difficulty falling asleep	**Yes**	No	Patient states she has difficulty falling asleep after waking up
Frequently awakening during night	**Yes**	No	Patient states she wakes up 4-5 times during the night to use the bathroom.
Early morning awakenings	Yes	**No**	
Nightmares/dreams	**Yes**	No	Patient states she has vivid dreams when she smokes marijuana.
other	Yes	No	N/A
Eating habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	**No**	
Binge eating and/or purging	Yes	**No**	
Unexplained weight gain/loss? Amount of weight change: _____	Yes	**No**	
Use of laxatives or excessive exercise	Yes	**No**	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety Behaviors (pacing, tremors etc.)	**Yes**	No	Patient is rubbing her hands together and asks when she can go home.
Panic attacks	Yes	**No**	
Obsessive/compulsive thoughts	**Yes**	No	Patient states she feels like her neighbors are constantly watching her because they are nosy.
Obsessive/compulsive behaviors	**Yes**	No	Patient came in to hospital due to yelling in the grocery store because someone was following her.

Impact on daily living or avoidance of situations/ objects due to levels of anxiety	**Yes**	No	Patient states she does not have any friends. Patient goes to work and comes home. Patient is paranoid about patients watching her and people following her.
Rating Scale			
How would you rate your depression on scale of 1-10. **Patient rates her depression at a 6.**			
How would you rate your anxiety on scale of 1-10. **Patient rates her anxiety at a 6.**			
Section 6: /5 pts **Current Stressors or Areas of Life Affected by Presenting Problems (work, school, family, legal, social, financial)**			
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)
Work	Yes	**No**	Patient states that she finds her work as calming.
School	Yes	**No**	
Family	**Yes**	No	Patient states that her family sends her letters which causes stress.
Legal	Yes	**No**	
Social	**Yes**	No	Patient states that she has no friends. Patient only goes out to go to work and to the store.
Financial	**Yes**	No	Patient states that she worries about being able to pay all of her bills on time.
Other	**Yes**	No	Patient states she wants to have friends and participate in activities.

Section 7:
/5 pts
Previous Psychiatric and Substance Use Treatment - Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
2012 2 week s	Psych unit in hospital in Chicago, IL. Patient cannot recall the name	**Inpatient** Outpatient Other: _____	Patient states she had “lost control” and was found yelling loudly at a person who “wasn’t listening.”	**No Improvement** Some improvement Significant Improvement
2016	Acute psych unit in	**Inpatient**	Patient was	No Improvement

4 days	Decatur, IL	Outpatient Other: _____	anxious and depressed as a result of her boyfriend's death.	**Some improvement** Significant Improvement
2020 9 days	Psych unit at OSF Hospital in Urbana, IL	**Inpatient** Outpatient Other: _____	Patient admitted for being disruptive and paranoid. Patient also argued with a police officer.	No Improvement **Some improvement** Significant Improvement

Section 8:
/20 pts **Personal/Family History**

Who lives with you?	Age	Relationship	Do they use any substances	
N/A			Yes	No
N/A			Yes	No
N/A			Yes	No
N/A			Yes	No
N/A			Yes	No

If yes to any substance use: explain. Patient that she smokes marijuana 5-6 times per day.

Children (age and gender): N/A

Who are children with now? N/A

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

Current relationship problems: N/A Number of Marriages: __0___

Sexual Orientation:	Is client sexually active?	Does client practice safe sex?
Patient states that she is interested in men.	Yes **No**	**Yes** No

Please describe your religious values, beliefs, spirituality and/or preference: Patient states that she is Christian, but not religious. Patient believes in God and that people should treat others with respect and the way that they want to be treated.

Ethnic /cultural factors /traditions / current activity Describe: Patient states that she is Italian

and grew up eating Italian food. Patient states there are no other traditions that she partakes in.
Current/Past legal issues (with self/parents, arrests, divorce, CPS, Probation officers, pending charges, or court dates):
Patient states she has received 1 parking ticket. Patient states that she attended court as a child when she was taken away from her mother.
How can your family/support system participate in your treatment and care?
Patient states that her sister is her support system. Patient states she will notify sister of her treatment and care by letter. Patient states she does not want her brother involved in her care.
Client raised by – **Natural parents** Grandparents Adoptive parents Foster parents
Other: (describe) Patient states that she was raised by her mother, but her and her siblings were taken away several times and placed into foster care as well.
Significant Childhood issues impacting current illness:
Patient was taken away from her mother several times as child. Patient experienced sexual, physical and emotional abuse starting in childhood.
Atmosphere of Childhood Home:
Loving Comfortable **Chaotic** Abusive Supportive Other: **Tough**
Self-Care: **Independent** Assisted Total Care
Family History of Mental Illness (diagnosis/ suicide/ relation etc.
Mother: Bipolar
Sister: depression and suicide
Family History of Substance Use:
Mother: alcohol abuse, patient is unsure about drug abuse
Education History: Grade school High school **College** Other: Patient attended

some college
Reading Skills: **Yes** No Limited
Primary Language: English
Problems in School: Patient states High School was hard. Patient states she dropped out of college because she could not pass Biology. Patient states Biology was very hard.
Discharge:
Clients goals for treatment:
Patient states her goal is to go home to her dog.
Where will client go when discharged?
Client will go home.

Section 9:
/5 pts

Vitals

Time	Pulse	B/P	Resp Rate	Temp	O2
0530	82	137/87	14	37.0	97%
1130	84	130/84	14	37.1	96&

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0530	0-10 pain scale	N/A	0	N/A	N/A

1130	0-10 pain scale	N/A	0	N/A	N/A

Intake and Output

Intake (in mL)	Output (in mL)
480 mL with dinner	Patient states she has voided twice this evening

Section 10:
/5 pts
Discharge Planning

Discharge Plan (Nurse's (student) for the client)

Client will be discharged to her home. Client will be set on a regimen medication schedule and will attend a follow up appointment with the psychiatrist in 1 week.

Section 11:
/15 pts Current Psychiatric Medication
Complete on all your client's Psychiatric medications

Brand/Generic	Oleptro/ Trazadone	Ativan/ lorazepam	Prozac/ fluoxetine hydrochloride		
Dose	100 mg	0.5 mg	40 mg		
Frequency	daily	Q6 PRN	Daily		
Route	PO	PO	PO		
Classification	Antidepressant	antianxiety	Antidepressant		

Mechanism of Action	“Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect”(Jones & Bartlett, 2019p.1227).	“May potentiate the effects of gamma aminobutyric acid (GABA) and other inhibitory neurtotransmitters by binding to specific benzodiazepine receptors, which may explain drug’s antianxiety effects”(Jones & Bartlett, 2019, p.721).	“Selectively inhibits the reuptake of the neurotransmitter serotonin by CNS neurons and increases the amount of serotonin available in nerve synapses”(Jones & Bartlett, 2019, p.518).		
Therapeutic Uses	To treat major depression	To treat anxiety	To treat depression		
Reason Client is taking	Client has depression	Client has anxiety	Client has depression		
Contraindications	Hypersensitivity to trazadone or its components.	Acute angle-closure glaucoma; hypersensitivity to lorazepam, its components or benzodiazepines.	Concurrent therapy with pimozide or thioridazine ; hypersensitivity to fluoxetine, other selective serotonin reuptake inhibitors or their components.		

Side effects/ adverse reactions (2)	Dizziness Back pain	Apnea diaphoresis	Anxiety Yawning		
Medication/ Food Interactions	NSAIDs digoxin Take trazadone on an empty stomach.	Tramadol SSRIs	MAO inhibitors Olanzapine NSAIDs		

Medication References (APA)

Jones & Bartlett (2019) *Nurse's drug handbook* (18th ed.) Burlington: Jones & Bartlett

Section 12: /20 pts **EXAMPLE**				
Client Problem List **(Prioritized)**	Desired Client Outcome	Immediate Interventions (at admission)	Intermediate Interventions (during hospitalization)	Community Interventions prior to discharge)
Example: Medication Compliance	Client will have increased understanding of need for medication compliance.	1. Assess what medications are currently prescribed to client? 2. Assess when and which medications client has been taking? 3. Assess why client has not been taking medications as prescribed.	1. Provide client education on the need for medication compliance. 2. Provide client education on strategies to remember to take medications as prescribed a. Take at same time daily (Example: while making coffee in AM) 3. Provide client education on common side effects of medications including interventions to decrease side effects and circumstances to contact the care provider. (Example: Dry mouth – suck on sugar free hard candy)	1. Assess client's ability to pay for medications. Provide education on low cost pharmacies. (Example: Four-dollar medication list at Walmart or provide information on mail order pharmacies) 2. Assess client's transportation needs to pick up medications from pharmacy. Provide information on possible transportation to pharmacy (bus, senior van, cost of taxi) 3. Assess strength of client's support system for assistance remembering to take medications. Assist client in making a written list of phone numbers of support system and education on when to contact.

Client Problem List **(Prioritized)**	Desired Client Outcome	Immediate Interventions (at admission)	Intermediate Interventions (during hospitalization)	Community Interventions (prior to discharge)
1. Patient has depression.	Client will report an improvement in depressive mood.	1.Assess for signs of hopelessness. 2.Assess patient to see if she has thoughts or plan for suicide. 3.Assess unhealthy behaviors used to cope.	1.Encourage patient to identify and verbalize feelings and perceptions 2.Help the patient identify areas of life that are under her control. 3.Help the patient identify areas or life situations that are not within her ability to control. Discuss feeling associated with this lack of control.	1.Have patient attend support group for support and education on how to cope with depression. 2.Have patient attend therapy to discuss thoughts and feelings that are weighing on their mind. 3.Have patient make lists of situations that are and are not under her control. Use techniques learned to improve outlook on these

				situations.
2. Patient has anxiety.		1.Assess for triggers. 2.Determine what is causing immediate anxiety. 3.Ensure patient is aware that they are safe and provide comfort.	1. Teach relaxation techniques; assist with practicing imagery, deep breathing, progressive relaxation, and use of relaxation tapes. 2.Provide information regarding different ways to deal with situations that promote anxious feelings, for example, identification and appropriate expression of feelings and problem solving. 3.Assist with identifying some short- and long-term goals focused on making	1.Have patient look into getting a therapy animal to help ease anxiety. 2. Have patient continue to use relaxation methods to reduce anxiety. 3.Have patient start each day with a reflective journal on what they are grateful for that day.

			life changes and decreasing anxiety.	
3. Patient has lack of knowledge about bipolar disorder.		1.Assess patient's level of knowledge regarding bipolar disorder. 2. Assess the patient's knowledge of current medications that are prescribed to treat bipolar disorder. 3.Assess patient's willingness to learn about bipolar disorder.	1.Teach patient about bipolar disorder. 2. Teach patient about medication regimen to help maintain bipolar disorder and the importance of taking their medications 3.Teach patient using multiple learning styles and incorporate patient interests.	1.Have patient attend a support group among other people who have been diagnosed with bipolar disorder. 2.Have patient journal to reflect upon their thoughts and feelings. 3.Have patient attend counseling to work through internal problems.

Other References (APA):

Swearingen, P.L., Wright, J.D., (2019) *All in one: nursing care planning resource* (5th ed).

Elsevier.

Section 13:
/20pts

Concept Map

Subjective Data:
Patient was admitted after yelling in the store because she was paranoid she was being followed.

Nursing Diagnosis/Outcomes
Risk for hopelessness related to history of depression as evidenced by patient stating she feels sad majority of the time.
Patient will states and demonstrate and improvement in mood before discharge.
Decreased ability to cope due to history of anxiety as evidenced by patient stating and acting nervous.
Patient will demonstrate coping strategies to help gain control of anxiety.
Need for health teaching related to bipolar disorder as evidenced by patient stating she doesn't know what bipolar disorder is.
Patient will state understanding of bipolar disorder and be able to list signs, symptoms, and causes.

Objective Data
Patient came into the ER in a flustered manner. Her vitals were stable. BP 150/90, P 100, rr.18, O2 saturation 98%, temp 37. Patient was cooperative and states she wants to go home. Patient appears nervous and continuously rubbed her hands together.

Patient Information:
TK is a 49 year old female with a history of a double mastectomy due to breast cancer, depression and anxiety. Patient has history of depression and anxiety. Primary diagnosis is bipolar disorder.

Nursing Interventions
1.Assess for signs of hopelessness.
2.Assess patient to see if she has thoughts or plan for suicide.
3.Assess unhealthy behaviors used to cope.
1.Assess for triggers.
2.Determine what is causing immediate anxiety.
3.Ensure patient is aware that they are safe and provide comfort.

N323 Care Plan Rubric

Student: **Date:**

Section	Title	Possible Points	Points Earned	Professor Comments
1	Admission Information	5		
2	Admission Assessment	5		
3	Level of Care Assessment	20		
4	Psychosocial Assessment	10		
5	Presenting Problems	15		
6	Current Stressors	5		
7	Previous Psych/Substance Use	5		
8	Personal / Family History	20		
9	Vitals / Pain / I &O Assessment	5		
10	Discharge Planning	5		
11	Current Psychiatric Medications	15		
12	Client Interventions	20		
13	Concept Map	20		
	APA References	5		
	Total			

Honor Code: “I have neither given nor receive, nor will I tolerate others’ use of unauthorized aid”.

Signature_____Elizabeth Pasieta_____ Date: _____03/29/2020_____