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N323 Care Plan

19-2

Lakeview College of Nursing

Taylor Hamilton

Section 1: /5 pts			
Date of Admission 3/21/2020	Client's Initials T.K	Age 49	Gender Female
Race/Ethnicity Caucasian	Occupation Housekeeper	Marital Status Single	Allergies n/a
Observation Status A&O x3	Height / Weight 5'7'' 200lbs	Other Pertinent Information	

Section 2: /5 pts
Admission Assessment
Reason for Admission (In client's own words): "police brought me here because I was causing a scene. A man was following me around the store. I didn't get that loud and he lied to the cops. I think I am depressed, not bipolar"
Admitting Diagnosis: Bipolar disorder
Secondary Diagnosis (if applicable): n/a
Medical Conditions: Breast cancer five years ago, double mastectomy
Factors that Lead to Admission: Patient was brought in by the police after she was uncontrollable at the grocery store. Pt. said that a man was following her and she started to scream and yell. Patient also has severe anxiety because she feels as if he neighbors are spying on her and always watching her.
History of Suicide Attempts (Date/Method): attempted overdose in 2016

History and Current use of Substances: 2-3 cocktails every day, uses marijuana 5-6 times a day
History of Psychiatric Diagnosis: 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
Interpersonal Style	Congenial Withdrawn Engaging Irritable	Open Relaxed Defensive Guarded	Cooperative Shy Resistant Cautious	Compliant Hostile Annoyed
Mood/ Affect Mood as stated in client's own words:	Fearful Anhedonia Indifferent Dysphoric Flat Depressed/	Irritable Anxious Labile Apathetic Constricted	Appropriate Sad Ambivalent Reactive Fixed	Angry Manic Blunt Calm Tearful

	Hopeless/ Helpless			
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 Fair Poor	Short Term Good Fair Poor	Long Term Good Fair Poor	
Gait	Normal	Shuffling	Unsteady	Staggering

Assistive Devices:	Rigid	Trembling	Left side weakness	Right side weakness
Posture/ Muscle Tone/ Strength:	Normal Cogwheel	Rigid Spastic	Slouched Atrophy	Flaccid Other
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		As long as she can remember		By all of her boyfriends throughout her life, her mother, mother's male friends
Sexual Abuse		6		As a child by a babysitter
Emotional Abuse		Lifetime		By mother and men
Neglect		2,8,10		Mother x3 – got taken by DCFS, stayed in foster care with 7 siblings
Exploitation		As an adult		Yes, by men
Crime				N/A

Military				N/A
Natural Disaster				N/A
Loss		1, 3, 15,44		Mother, father, sister x2, boyfriend,
Other				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	Seasonal weather, sometimes all the time, spends a lot of time alone
Loss of energy or interest in activities/school	Yes	No	Work really wears her out
Deterioration in hygiene and/or grooming	Yes	No	
Social withdrawal or isolation	Yes	No	Doesn't have any friends or every hangout with anyone
Difficulties with ability to parent/ or be parented	Yes	No	
Difficulties with home, school, work, relationships or responsibilities	Yes	No	
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in number of hours / nights	Yes	No	Never sleeps very much – only 4-5 hours a night
Difficulty falling asleep	Yes	No	
Frequently awakening during night	Yes	No	Wakes up often to go to the bathroom, then plays video games when she cant fall asleep
Early morning awakenings	Yes	No	
Nightmares/dreams	Yes	No	Dreams when she smokes marijuana – which is

			every night
other	Yes	No	
Eating habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Only drinks coffee until dinner, maybe a couple snacks during the day
Binge eating and/or purging	Yes	No	
Unexplained weight gain/loss? Amount of weight change: _____	Yes	No	Tried to lose weight with a high protein diet, but it was too expensive
Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety Behaviors (pacing, tremors etc.)	Yes	No	Cleans kitchen when the neighbors are watching her or when she is worried about bills to pay
Panic attacks	Yes	No	"sometimes has a racing heart, cant sit, must be doing something"
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	
Rating Scale			
How would you rate your depression on scale of 1-10 6			
How would you rate your anxiety on scale of 1-10 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	Pt. expresses that she enjoys her work and finds it calming
School	Yes	No	

Family	Yes	No	Wishes she had a better relationship with her family
Legal	Yes	No	
Social	Yes	No	Only goes out when necessary
Financial	Yes	No	"I never have any extra money"
Other	Yes	No	Would like to do more with friends / family

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

Dates	Facility/MD/Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
4 years ago	Decatur acute psych unit	Inpatient Outpatient Other: _____	Depression and anxiety – anniversary of boyfriends death Attempted suicide. "accidental" overdose	No Improvement Some improvement Significant Improvement
7/8 years ago	Chicago	Inpatient Outpatient Other: _____	"I lost control and I was yelling at someone"	No Improvement Some improvement Significant Improvement
Curr et	OSF Urbana	Inpatient Outpatient Other: _____	Store incident.	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 – lives alone			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

If yes to any substance use: explain		
Children (age and gender): N/A		
Who are children with now? N/A		
Household dysfunction, including separation/divorce/death/incarceration: Has been single since her boyfriend died 5 years ago		
Current relationship problems: N/A		Number of Marriages: ___0_____
Sexual Orientation:	Is client sexually active? Yes No	Does client practice safe sex? Yes No
Please describe your religious values, beliefs, spirituality and/or preference: Considers herself Christian but doesn't follow or go to church anymore because she felt judged by other people.		
Ethnic /cultural factors /traditions / current activity Describe:		
"I believe there is a god – people should treat people with respect and the way they want to be treated.		
"I'm a hines 57 but my grandparents were Italian. We eat Italian food"		
No traditions and never celebrated Christmas due to the lack of money		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, Probation officers, pending charges, or court dates):		
Had 1 parking ticket. – Only time she has ever gone to court was when she and her siblings were put into foster care by CPS		
She was not arrested when she was taken to OSF by the police.		
How can your family/support system participate in your treatment and care?		
She will let her sister know via letter what is going on but does not want to call her because it will cost too much money. She is her only support system.		
Her brother was her support system but she is mad at him because he said that he would buy her a house. "He was going to buy me a house but he abandoned me to go live with his boyfriend"		
Client raised by – Natural parents Grandparents Adoptive parents Foster parents		
Other: (describe)		
Grandmother stopped helping raise her and her siblings when she was 5. She grew up in a normal		

house but rough atmosphere. Her family often scraped by, lots of people in the home and she felt safe. Only was scared of DCFS.
Significant Childhood issues impacting current illness:
Female babysitter that sexually assaulted her
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.
Mother was bipolar. Sister 1: committed suicide Sister 2: depression
Family History of Substance Use:
“mother drank all the time – with her male friends who we called uncles”
Education History: Grade school High school College Other started some college classes but never graduated college
Reading Skills: Yes No Limited
Primary Language: English
Problems in School: Behaved in school in fear of home punishment
Discharge:
Clients goals for treatment:
“get help with becoming out of control, help with anger, decreasing anxiety, feel more comfortable going out”
Where will client go when discharged?
Home to her dog

Section 9:
/5 pts

Vitals

Time	Pulse	B/P	Resp Rate	Temp	O2
0900	82	137/87	14	98	97
1700	85	134/84	14	98	97

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0	-	-	-	-
1700	0	-	-	-	-

Intake and Output

Intake (in mL)	Output (in mL)
780mL	BMx1 Void “couple times”

Section 10:
/5 pts
Discharge Planning

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

This student nurse would educate the patient on the importance of medication compliance and the time it could take for the medication to take effect. I would tell her who to contact if she does not feel like after 3-4 weeks if her medication still isn’t working, or isn’t working enough. This student nurse would also give coping mechanisms for anxiety and ways to notice when her anxiety is becoming out of control. This nurse would educate on the effects that alcohol use and marijuana use and the adverse effects that

could contradict her psychiatric medication. This nurse would offer support groups for grief when she is struggling with the death of her late boyfriend. This nurse would ensure the patient has work set up and a ride to her home and also a way to get to and from any follow up appointments.

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

Brand/Generic	Trazadone Oleptro	Lorazepam Ativan	Fluoxetine Prozac	N/A	N/A
Dose	100mg	0.5mg	40mg		
Frequency	Before bed	TID 6hrs PRN	daily		
Route	Oral	Oral	Oral		
Classification	Antidepressant	antianxiety	antidepressant		
Mechanism of Action	Blocks serotonin reuptake along the presynaptic neuronal membrane causing an antidepressant	Inhibits excitatory behaviors, which helps control emotional behavior	Inhibits reuptake of serotonin by CNS and increases the amount of serotonin available in		

	effect		nerve synapses.		
Therapeutic Uses	Decrease depression and anxiety	Helps control anxiety and emotional behavior	Treats depression		
Reason Client is taking	Anxiety / depression	Extreme anxiety	depression		
Contraindications	Suicidal thoughts, serotonin syndrome	Psychosis, acute angle-closure glaucoma	Concurrent therapy with pimozide or thioridazine, use within 14 days of MOA inhibitor		
Side effects/ adverse reactions (2)	Drowsiness, arrhythmias	Amnesia, dizziness	Anxiety, weight loss		
Medication/ Food Interactions	Take with food, do not take with aspirin or nonsteroidal anti-inflammatory agents	Do not take with alcohol, additive CNS depression	Increased risk of bleeding with alprazolam and diazepam, increased risk of severe life threatening adverse affects with MAOIs		

Medication References (APA)

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA.

Client Problem List **(Prioritized)**	Desired Client Outcome	Immediate Interventions (at admission)	Intermediate Interventions (during hospitalization)	Community Interventions (prior to discharge)
1. Med compliance	Patient will increase understanding why med compliance is important	1. Figure out why patient stopped taking medication 2. Determine what medications are currently prescribed? 3. Determine when patient was originally taking the medication	1. Provide education on importance of medication compliance. 2. Educate on amount of time it could take for medication to take effect 3. Provide education on potential side effects that could happen due to medications.	1. Ensure patient has assess to getting and paying for medications 2. Ensure patient has the ability to pay for the medication 3. Ensure patient has understanding on why medication compliance is essential.
2.		1. Identify triggers	1. Provide assistance on mending family	1. Anxiety support groups

Anxiety	Client will have decreased anxiety	2. Provide safety 3. Relaxation techniques	relationships for support systems 2. Educate about guided imagery and music for relaxation techniques 3. Educate about benefits of exercise on anxiety	2. Mend relationships for support system is siblings. 3. Give examples of things that could help decrease anxiety when it happens.
3. self-esteem / self worth	Increase self esteem / self worth	1. Establish trusting relationship with client 2. Determine reasons for low self esteem / self worth	1. Help the client find positive aspects of self 2. Have the client determine things she does well and that she is good at 3. Remind patient is past	1. Support groups for low self esteem 2. Get back into church / religion 3. Positive self affirmation

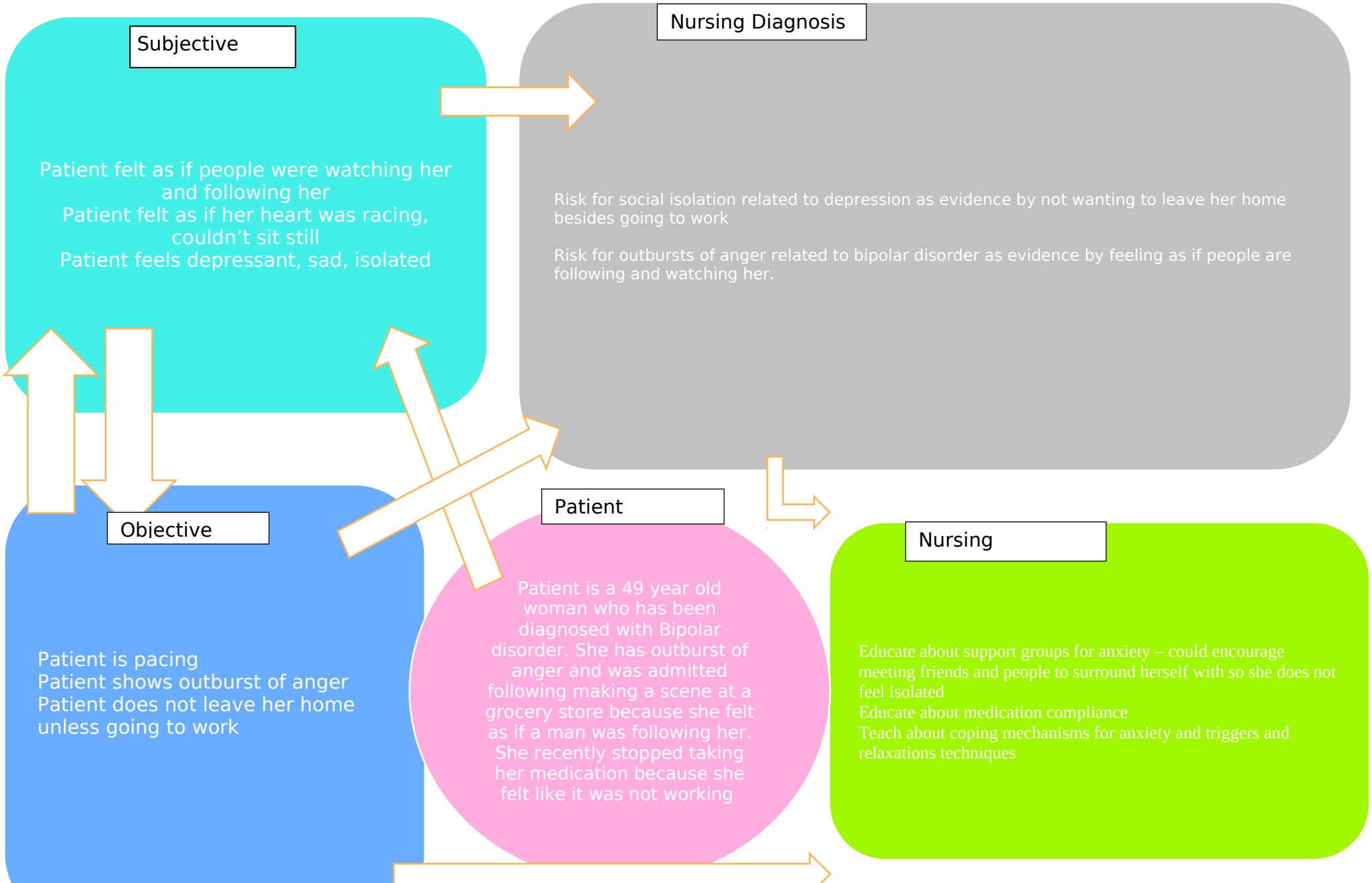
		3. Assess safety of client with low self esteem / self worth	accomplishments / achievements.	

Other References (APA):

Section 13:

/20pts

Concept Map


Subjective
Patient felt as if people were watching her and following her
Patient felt as if her heart was racing, couldn't sit still
Patient feels depressant, sad, isolated
Nursing Diagnosis
Risk for social isolation related to depression as evidence by not wanting to leave her home besides going to work
Risk for outbursts of anger related to bipolar disorder as evidence by feeling as if people are following and watching her.
Objective
Patient is pacing
Patient shows outburst of anger
Patient does not leave her home unless going to work
Patient
Patient is a 49 year old woman who has been diagnosed with Bipolar disorder. She has outburst of anger and was admitted following making a scene at a grocery store because she felt as if a man was following her. She recently stopped taking her medication because she felt like it was not working
Nursing
Educate about support groups for anxiety – could encourage meeting friends and people to surround herself with so she does not feel isolated
Educate about medication compliance
Teach about coping mechanisms for anxiety and triggers and relaxations techniques

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_____ Date: _____