N323 Care Plan

19-2

Lakeview College of Nursing

Hope Marie Dykes

Section 1: /5 pts			
Date of Admission 03/21/20	Client's Initials TK	Age 49	Gender F
Race/Ethnicity C/W	Occupation House Cleaner/ Home Care	Marital Status S	Allergies Strawberries/ NKDA
Observation Status Inpatient	Height / Weight 5'7"	Other Pertinent Information Doesn't like to be around people	

Section 2: /5 pts **Admission Assessment**
Reason for Admission (In client's own words): The cops brought her in because she "caused a scene"
Admitting Diagnosis: Bipolar
Secondary Diagnosis (if applicable): N/A
Medical Conditions: Breast Cancer, prior double mastectomy 5 years ago
Factors that Lead to Admission: Client reports she was being followed by a man in public and was being "too loud telling him to get away". The police were called and brought her in. She has a past diagnosis as bipolar, and she reports not taking her lithium in the past 3 weeks.
History of Suicide Attempts (Date/Method): ~2016, client overdosed on pills, unsure of type or amount
History and Current use of Substances: 2-3 cocktails/ day. Smoked pot 5-6 times a day "until 2 days ago"
History of Psychiatric Diagnosis: Bipolar

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Interpersonal Style	Congenial Withdrawn Engaging Irritable	Open Relaxed Defensive Guarded	Cooperative Shy Resistant Cautious	Compliant Hostile Annoyed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/ Hopeless/ Helpless	Irritable Anxious Labile Apathetic Constricted	Appropriate Sad Ambivalent Reactive Fixed	Angry 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	Hallucinations	Delusions	Paranoia	Racing thoughts

content	Confused Goal directed Coherent Depersonalization Within normal limits	Divergent Somatic Logical Dangerous Confabulation	Evasive Obsessive Grandiosity Distortion of body image	Blocking Phobic Tangential Loose associations
Memory	Recent Good Fair Poor	Short Term Good Fair Poor	Long Term Good 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
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		0-18		Mother physically abused client. Client was removed from home and placed into varying foster care homes at ages 2, 8, and 10.
Sexual Abuse		6		Female babysitter sexually abused client when she was 6 years old
Emotional Abuse		0-18		Mother emotionally abused client. Client was removed from home and placed into varying foster care homes at ages 2, 8, and 10.
Neglect				
Exploitation				
Crime				
Military				
Natural Disaster				
Loss		44		Boyfriend died. Mother died, Lost 2 sisters.
Other				Client had 7 brothers and sisters, also suffered abuse.
**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	
Loss of energy or interest in activities/school	Yes	No	
Deterioration in hygiene and/or grooming	Yes	No	
Social withdrawal or isolation	Yes	No	
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	
Difficulty falling asleep	Yes	No	
Frequently awakening during night	Yes	No	Client gets up to urinate 4-5 times/ night
Early morning awakenings	Yes	No	
Nightmares/dreams	Yes	No	"Depends on how much pot I smoke"- just dreams more than nightmares.
other	Yes	No	
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	Client cleans her kitchen, heart races, and she feels like she can't sit still
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	
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	
School	Yes	No	
Family	Yes	No	
Legal	Yes	No	
Social	Yes	No	
Financial	Yes	No	
Other	Yes	No	

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

Dates	Facility/MD/Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
~3/16	Adult Acute Unit	Inpatient Outpatient Other: _____	In for 4 days due to depression/ anxiety around the anniversary of when her boyfriend died	No Improvement Some improvement Significant Improvement
~2012/2013	Chicago Hospital	Inpatient Outpatient Other: _____	In for 2 weeks due to "losing control and yelling at someone"	No Improvement Some improvement Significant Improvement
		Inpatient Outpatient Other: _____		No Improvement Some improvement Significant Improvement

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

Who lives with you?	Age	Relationship	Do they use any substances	
Just self			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

If yes to any substance use: explain **Smoked pot 5-6 times per day, but "haven't in probably 2 days"**

Children (age and gender): None.

Who are children with now? N/A

Household dysfunction, including separation/divorce/death/incarceration: **Boyfriend died a few years ago. Has been single since then. One sister committed suicide. Client's mother was diagnosed as bipolar, and client spent time in foster cares since her mother was not always fit to care for her.**

Current relationship problems: None. Number of Marriages: ___0_____

Sexual Orientation: N/A	Is client sexually active? Yes No	Does client practice safe sex? Yes No N/A

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

Ethnic /cultural factors /traditions / current activity Describe: **Grandparents Italian. Client does not go to church because she feels judged. She believes in God and that people should be respected. She does not have any family traditions she knows of.**
Current/Past legal issues (with self/parents, arrests, divorce, CPS, Probation officers, pending charges, or court dates):
She reports she has only ever had 1 parking ticket. She was in the court system when she was young and taken away from her mother.
How can your family/support system participate in your treatment and care?
Client writes letters to her sister. She reports she used to have a good relationship with her brother and that he bought her a home, but they are currently fighting because she does not support the fact that he is gay. In response, he has stopped paying her bills.
Client raised by – Natural parents Grandparents Adoptive parents Foster parents
Other: (describe)
Significant Childhood issues impacting current illness: Female babysitter sexually abused client at age 6. She has a significant distrust in men. She spoke of mother's "uncles" with negativity.
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. **Mom: Bipolar; Sister: Depression; Sister (2): Suicide**
Family History of Substance Use: **Client reports her mother "always drank alcohol" and had male friends who she called "uncles" over to drink with her.**
Education History: Grade school High school College Other
Reading Skills: Yes No Limited
Primary Language: **English**
Problems in School: **No behavioral problems in school.**
Discharge:
Clients goals for treatment: **Client would like to get out of the hospital and "feel more comfortable"**
Where will client go when discharged? **Client will be discharged to Home**

Section 9:
/5 pts

Vitals

Time	Pulse	B/P	Resp Rate	Temp	O2

0530	82	137/87	14	98.0F	97%
1500	86	128/82	16	98.2F	98%

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0530	0	N/A	N/A	N/A	N/A
1500	0	N/A	N/A	N/A	N/A

Intake and Output

Intake (in mL)	Output (in mL)
240mL	1xBM, 2xVoid

Section 10:
/5 pts
Discharge Planning

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

The client will be taught about medications she will be taking at home. She will be given follow up appointments with her therapist and/or psychiatrist. The student nurse will provide the client times and locations for support groups as well.

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

Brand/Generic	Desyrel/ trazodone	Ativan/ lorazepam	Prozac/ fluoxetine
Dose	100mg	0.5mg	40mg
Frequency	qhs	TID prn	qd
Route	PO	PO	PO
Classification	SNRI (antidepressant)	Benzodiazepine Sedative hypnotic anxiolytic	SSRI (antidepressant)
Mechanism of Action	Works to balance serotonin levels in the brain	Depress the CNS to relieve anxiety	Works to increase serotonin levels in the

			brain
Therapeutic Uses	Major Depression, Depression r/t bipolar	Relieve panic and anxiety	Major Depression Depression r/t bipolar
Reason Client is taking	Depression related due bipolar disorder	Anxiety reliever	Depression related due bipolar disorder
Contraindications	Cardiac disease	Liver disease, hx of substance use disorder, sleep apnea	Sexual Dysfunction, Weight Gain, CNS Stimulation
Side effects/ adverse reactions (2)	Hyponatremia, Insomnia	Drowsiness, Lightheadedness	Nausea, Headache
Medication/ Food Interactions	Alcohol/ MAOI's/ St. John's Wort	Alcohol, Opioids, Barbiturates	Alcohol/ MAOI's/ TCA's/ St. John's Wort

Medication References (APA)

Assessment Technologies Institute, LLC. (2019). *Content mastery series review module: RN mental health nursing edition.*

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. Stress relief	Client will find	1. Assess with client	1. Educate client on	1. Have client write

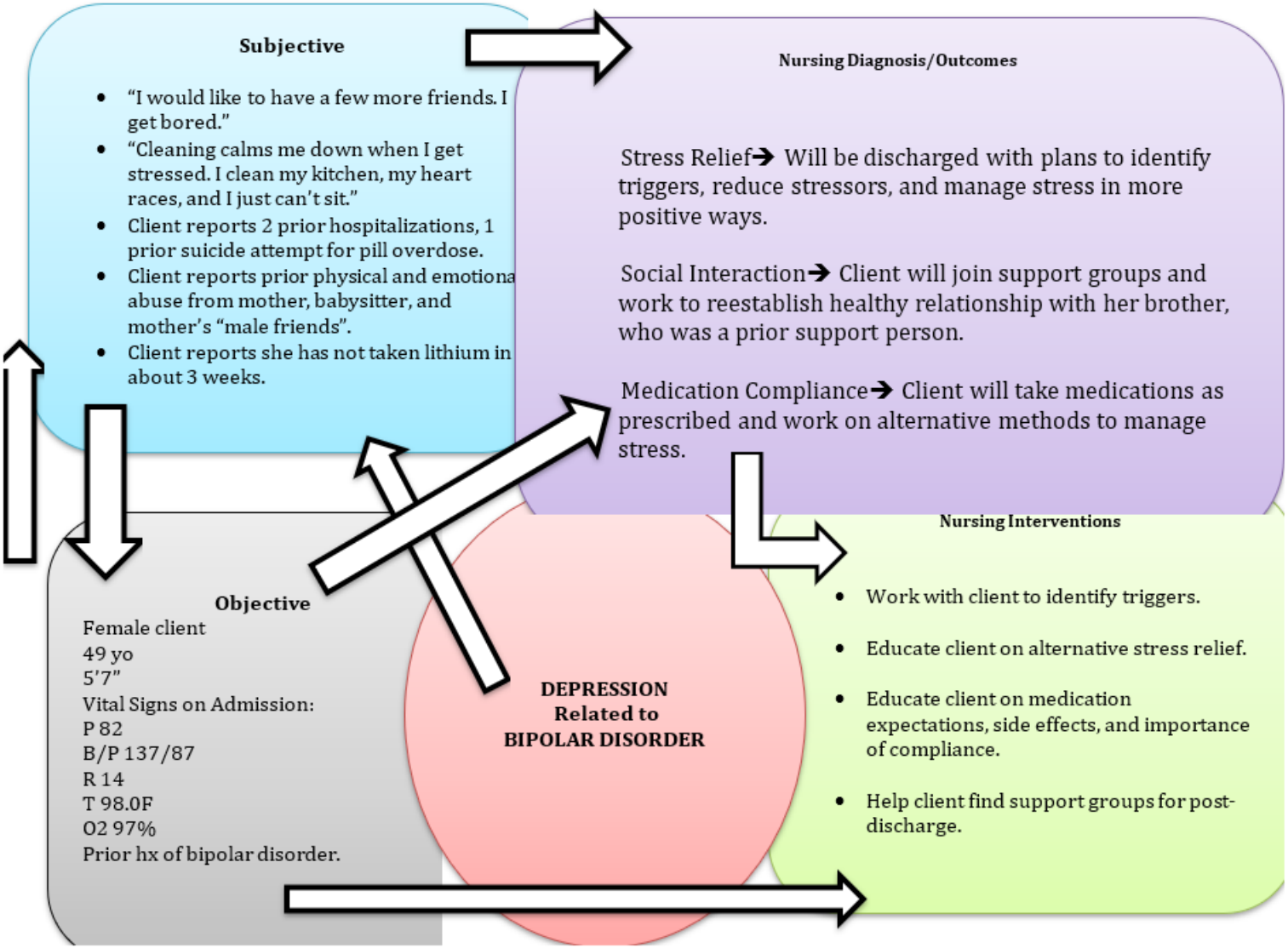
	positive ways to deal with anxiety that will keep her out of trouble and help her depression improve.	what types of stress relief has worked in the past. 2. Assess vital signs and conversation to determine level of anxiety at admission. 3. Assess and identify triggers for anxiety. During initial conversation, ask what happened PRIOR to the client yelling at the man following her. Were there any circumstances leading up to the situation that might have exacerbated it?)	stress interventions like deep breathing. 2. Educate client on sleeping habits. Have client lay down at the same time each night, keep lights down, and keep TV turned off). 3. Client has a prescription for lorazepam three times a day as needed. Administer at early signs of anxiety to reduce symptoms.	out a list of what interventions have worked for her in the past and during hospitalization. 2. Build on client's statement that "cleaning calms her". Encourage her to volunteer somewhere when she needs to without the "expectations" of her job. 3. Come up with a de-escalation plan if client starts to feel like yelling in public again. Have client help develop this plan. (Suggest "thought stopping" or counting to 10).
2. Social Interaction	Client will find ways to interact with people in a positive manner outside of the treatment center.	1. Assess reasons why client is yelling at people in public places. 2. Assess reasons for	1. Discuss consequences of "making scenes" (client's words) in public places.	1. Client will join a support group for people dealing with long-term loss. 2. Client will join a

		client's lack of a support system. 3. Assess whether client lives alone by choice and if it is something she would like to change.	2. Talk about positive ways to communicate and rebuild relationships. 3. Encourage client to participate in groups at the facility if available. Discuss what went well and develop a future plan with client.	support group for people dealing with childhood sexual trauma. 3. Client will have a conversation with brother and try to work things out. (* It sounded to me like the issues were more on her end than his in this situation, and that he had been a prior strong source of support).
4. Medication compliance	Client will begin taking lithium again and antidepressants to maintain a more stable mood.	1. Assess reasons client has not taken her lithium in 3 weeks. 2. Assess whether patient has only stopped lithium or has skipped her other meds, too. 3. Ask client whether she wants to work toward getting back	1. Educate client on side effects and how to manage. Lithium should usually be taken 2-3 times a day with food to reduce side effects. 2. Educate client on what side effects are expected and "okay" and which	1. Ensure client has resources to get medications. 2. Make sure client has follow-up appointments with prescribing physicians. 3. Schedule a time to call and check in

		onto medications or if she would prefer to focus on alternative therapies.	require her to contact her physician. 3. Discuss alternative therapies like deep breathing and counting to 10.	on client, follow up according to facility guidelines. (*I don't know if this is done in mental health facilities… At Carle, I get follow-up phone calls now after every appointment, so it seems logical someone would call to check on these clients, too?)

Other References (APA):

Section 13: **Concept Map**
/20pts


Subjective
"I would like to have a few more friends. I get bored."
"Cleaning calms me down when I get stressed. I clean my kitchen, my heart races, and I just can't sit."
Client reports 2 prior hospitalizations, 1 prior suicide attempt for pill overdose.
Client reports prior physical and emotiona abuse from mother, babysitter, and mother's "male friends".
Client reports she has not taken lithium in about 3 weeks.
Nursing Diagnosis/Outcomes
Stress Relief➔ Will be discharged with plans to identify triggers, reduce stressors, and manage stress in more positive ways.
Social Interaction➔ Client will join support groups and work to reestablish healthy relationship with her brother, who was a prior support person.
Medication Compliance➔ Client will take medications as prescribed and work on alternative methods to manage stress.
Objective
Female client
49 yo
5'7"
Vital Signs on Admission:
P 82
B/P 137/87
R 14
T 98.0F
O2 97%
Prior hx of bipolar disorder.
DEPRESSION
Related to
BIPOLAR DISORDER
Nursing Interventions
Work with client to identify triggers.
Educate client on alternative stress relief.
Educate client on medication expectations, side effects, and importance of compliance.
Help client find support groups for post-discharge.

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 Hope Marie Dykes Date: 04/25/2020