

SANDRA OAS HEALTH CARE PLAN 3-2024

DIAGNOSIS: Bipolar affective disorder with manic and depressive episodes/anxiety; Malignant neoplasm upper right quadrant right breast; Small sliding scale hiatal hernia (GERD); Reflux esophagitis; Intestinal metaplasia; Hx of IBS; Hyperlipidemia; Questionable prediabetes; Overactive bladder; Occasional urinary incontinence; Spondylosis of lumbar region without myelopathy or radiculopathy with back pain/muscle spasms; Obstructive sleep apnea; Constipation; History of C-Diff infection with diarrhea; Vision impairment with severe cataract right eye - cataract removal 9/11/23; Mild mental retardation; Hx of galactorrhea with hyperprolactinemia; Seborrhic Dermatitis/Benign melanocytic nevi; Excessive appetite with history of obesity; Thrombocytopenia - medication induced; History of vaginitis with hx of vaginal bleeding. Cavovarus deformity (turning inward) of both feet requiring bilateral foot orthotics; Osteoarthritis both knees; had otitis media to both ears 6/8/23 (resolved).

NO KNOWN ALLERGIES

1) Bipolar affective disorder with manic/depressive episodes and anxiety: Admitted to Cedar South on 6/27/23 as an emergency admit due to being in a manic state and stated she needed a break from husband; Dr. Wu, psychiatry, manages bipolar disorder with last appointment on 11/10/23 with no changes made - F/U appointment 5/9/24. Dr. Brenda King sees her for psychiatric therapy with her last appointment on 2/16/24 - F/U on 4/18/24. She was being seen on a monthly basis but due to being stable stating she is happy with her life and enjoys her new job will decrease visits to every 2 to 3 months. Therapist felt Sandra was still slightly manic. In the past Dr. King stated she does support Sandra living on her own but has concerns regarding her drinking alcohol (had incident in past) as well as being taken advantage of by males. The Clonazepam for anxiety was d/c'd by Dr. Brandt on 7-5-23 - Sandra told physician that she wasn't anxious anymore.

2) MALIGNANT NEOPLASM RIGHT BREAST: Had a 2.7cm mass removed from right breast and a lymph node from right axilla on 5-3-23. Radiation treatments began on 7-5-23 with a total of 20 treatments and completed on 8-1-23. Had no skin breakdown from radiation treatments. Started on Tamoxifen Citrate daily on 8-16-23. Dr. Panwalkar, Altru oncologist, follows her for the breast cancer with last appointment on 10/26/23 requesting complete blood counts every 3 months, continue with Tamoxifen and to have an annual mammogram. He will F/U with Sandra on 4/25/24. Saw Nicole Hylden, oncology, on 10/31/23 - stated breast area healing well after radiation treatments and requested she continue to massage Vitamin E oil from a broken capsule to her scars on breast and armpit pushing upward to soften tissue and eliminate fluid from area. F/U appointment with Nicole Hylden on 5/7/24 at Altru oncology. Last mammogram completed on 2/5/24 and to be completed annually. Had colorectal screen done 5-26-21 and with next screen due in 10 years.

3) HIATAL HERNIA WITH REFLUX ESOPHAGITIS AND INTESTINAL METAPLASIA/HX OF IBS : Initial endoscopy by Dr. Baig on 2-27-23 due to c/o bloating, burping, and being gassy. Endoscopy showed a hiatal hernia, reflux esophagitis and intestinal metaplasia. A biopsy was obtained from esophagus and small bowel. F/U appointment on 3-13-23 stated he noted no masses, celiac disease or infection but that she did have esophagitis. She

was put on Protonix which she quit taking stating she couldn't tolerate it. She c/o diarrhea stools with a positive test for C-Diff on 6-8-23. Saw Megan Kipp N PA-C, Altru gastroenterology, for consult 6-9-23- stated she needed to complete course of antibiotic and placed her on Omeprazole daily. Saw her on 6-23-23 as F/U for C-Difficile. She ordered an endoscopy be done to evaluate improvement due to underlying eosinophilic esophagitis and for gastric emptying due to intestinal metaplasia. Endoscopy completed on 11/8/23 with Dr. Aldoreidi, Altru, hiatal hernia noted and several biopsies taken. She F/U with Megan Kipp, gastroenterology, on 12/19/23 stating Sandra needs to continue with Omeprazole indefinitely and to F/U with an EGD and office visit on 12/17/24. Results of the endoscopy showed inflammation of stomach lining and a small area of intestinal metaplasia (cell changing in appearance). The esophagus was normal in appearance.

4) HYPERLIPIDEMIA: To have an annual lipid panel drawn. Last panel drawn on 6-5-23 with all values WNL as follows: Cholesterol - 142 (<200mg/dl); Triglycerides - 36 (<150mg/dl); HDL - 81 (>40mg/dl) and LDL - 54 (<100mg/dl). To have lipid panel done annually.

5) OVERACTIVE BLADDER WITH URGENCY AND RETENTION/OCC URINARY INCONTINENCE: A urinalysis done on 6-13-23 was normal. To EGF Sanford clinic on 6-30-23 with c/o burning/bleeding upon urination - UA negative for UTI with a trace of blood. A wet prep done -this was negative. Recommended she increase her fluids. Followed by Nicole Straus at Altru urology with last appointment on 10/6/23 with an ultrasound done - all looked good and to F/U on 10/11/24. Dr. Straus stated Sandra has tried several meds overactive bladder but they have been unsuccessful. She started her on Tropsium Chloride and this seems to be working well. At times is incontinent of urine when on outings or appointments - wears pull-ups.

6) SPONDYLOSIS OF LUMBAR REGION: Saw Dr. Rose Brandt, her PCP on 7-5-23. Had a physical exam done. Flonase and Zyrtec d/c'd as well as fish oil and borage oil. To take a combination fish-flax-borage oil combination softgel daily. Her last appointment with Dr Brandt was 10/20/23 stating her labs were good and started her on a daily multivitamin. Sandra c/o occasional back pain especially at night- has order for Cyclobenzaprine PRN for back pain and muscle spasms as well as a PRN pain med which seems to give her relief. To F/U on 4/19/24. Had a chiropractic appointment with Dr. Howson on 2/28/24 with adjustments made to back and neck.

7) OBSTRUCTIVE SLEEP APNEA: Wears C-Pap daily at night. Sandra manages C-Pap per self with staff oversight. Had appointment with Tara Baudin at Altru Pulmonology and Sleep Services on 10-2-23 stating she needs to continue her C-Pap every night and was given instructions for cleaning and care of machine. She is to F/U in 1 year.

8) CONSTIPATION: Receives stool softener 2 x daily. Independent with toileting. Has not required rectal suppositories or enemas since admit to MCGH.

9) VISION IMPAIRMENT WITH HX OF SEVERE CATARACT RIGHT EYE: Wears corrective lenses daily. Independent in care of eyeglasses. Annual eye exam at Opticare vision in East Grand Forks, Mn. Appointment on 6-28-23 noted a significant cataract to right eye. Consult with Dr. Sczypanski of North Dakota Eye Clinic was on 7-27-23. Cataract surgery was on 9-11-23 followed with post-op eye drops completed on 10/8/23. She was seen by optometrist Dr.

Storhaug the following day stating the eye looked good and she could d/c the right eye shield. He saw her for F/U On 10/17/23 stating the right eye looked good and new glasses were ordered. She received her last pair of new glasses on 1/5/24 from Opticare.

10) MILD INTELLECTUAL DISABILITY: Has difficulty with tasks regarding problem solving, planning, judgement, perception awareness and money. Has some difficulty with speech delay and putting thoughts into sentences. Will pause between words when speaking.

11) GALACTORRHEA WITH HYPERPROLACTINEMIA/HX OF EXCESSIVE APPETITE WITH OBESITY AND QUESTIONABLE PREDIABETES: On medication daily 2 x/week to decrease prolactin levels. Her prolactin level on 7-7-23 was 22.17 (5.18-26.53). Followed by Dr. Zak, endocrinology, at Altru Health Center. Last appointment was on 1/5/24 as F/U for drug induced hyperprolactinemia secondary to antipsychotic medication. Her last prolactin level in July 2023 was WNL. He stated her TSH was minimally abnormal but that it has fluctuated in the past. He does not believe this represents true hypothyroidism but more likely due to a sick euthyroid related to medications and will not treat her unless her level is over 10 (normal 0.4 to 4.0ml/dl). She is to continue on the Cabergoline as this is working well for her. She is to F/U on 7/8/24 with recheck of labs. Dr. Zak has requested Sandra consume 3 carb choices/meal and 1 carb choice for snack. Weight on 7/28/23 was Had high serum TSH on 10-15-21. TSH level drawn on 4-29-22 was 6.60 (0.35-4.94). Last TSH level drawn on 1-6-23- 3.66 (0.49-4.67). To be completed annually. Weight on 7-7-23 was 164.3lbs and on 7-28-23 was 156.4lbs; on 8/29/23 was 168.8lbs; on 10/25/23 was 178.2lbs and on 2/26/24 she was 174.4lbs. Her ideal weight is 122 to 150lbs. Her height is 5'7".(Excess prolactin levels and thyroid disorders are both associated with weight gain.) Was prescribed Topiramate for weight loss - Dr. Wu in psychiatry does not believe it is helpful for weight loss. Diabetic screen is completed every 3 years with last screen completed on 6-5-23.(Fasting glucose-69 and A1C 4.9). On 10/21/23 Dr. Brandt indicated her labs showed she is in prediabetic stage, her protein and platelet levels were low and her thyroid level was slightly off and was mildly anemic. She requested Sandra increase protein in her diet. A recheck of her labs on 1/9/24 showed anemia improved, platelets still low (not sure if med related or an immune system issue) and TSH was OK. Dr Brandt plans to recheck labs in 3 months with a F/U appointment on 4/19/24.

12)SEBORRHOEIC DERMATITIS WITH EPISODES OF RASH/ITCHING AND MELANOCYTIC NEVI (NON-CANCEROUSCONDITION OF PIGMENT PRODUCING SKIN CELLS: Followed by Dr. Chet Maingi of Sanford clinic with last appointment on 8-23-23. She is to F/U in 6 months. He completed a skin screen for cancer and refilled the Triamcinolone 0.1% cream to be used 2 x daily as needed for flare-ups of dermatitis.

13) HX OF THROMBOCYTOPENIA - MEDICATION INDUCED: Low platelet count induced by use of Geodon (Ziprasidone) used to treat bipolar diagnosis. Her platelet count done on 7-28-22 was 102 (140-400K/dl). Her platelet count on 3-20-23 was 160 (140-400K/ul). This is monitored by Dr. Panwalkar who is an oncologist and a hematologist with last appointment on 10/26/23 and to F/U on 4/25/24. Blood counts are to be done every 3 months. Platelet counts on 10/21/23 and 1/5/24 were noted to be low. (Dr. Zak commented unknown etiology (questions immune system response vs drug side effect).

14) HISTORY OF VAGINITIS WITH VAGINAL BLEEDING: Vaginitis probe done on 4-13-23 which was positive for Candida (yeast). She had an ultrasound of pelvis on 4-24-23 with no masses noted other than showing a simple 3.6cm cyst to left ovary. Recommendation that if bleeding persists to consider direct visualization and tissue sampling. A vaginal wet prep was done 6-30-23 due to c/o bleeding - that was normal. Pap smear done 4-29-22 with next pap smear due on 4-29-27. No bleeding detected since admit to Cedar North.

15) CAVOVARUS DEFORMITY OF BOTH FEET WITH PAIN (HIGH ARCHES WITH HEELS TURNING INWARD): She sees Dr. Yuska, podiatrist, manages her orthotics. She was custom fitted for bilateral foot orthotics on 5-23-23.

16) OSTEOARTHRITIS OF BILATERAL KNEES: Does occasionally c/o knee pain.

17) DENTAL CARE: Sees Dr. Saylor for her dental care with last appointment for exam/cleaning on 8-17-23. Next appointment scheduled for 4-8-24. She had no cavities. Completes dental brushing/flossing independently.

18) IMMUNIZATIONS: Covid-19 (Pfizer) vaccine: 1-23-21 and 2-13-21; Covid-19 (Moderna) vaccine: 12-4-21; 4-21-22; 10-7-22 and 10/19/23. Flu vaccine on 10/12/23; PCV 20 (Prevnar) on 4-7-23; PPS V23 (Pneumococcal) on 5-21-20; Shingrix 5-21-20 and 8-12-20; TD on 11-2-2001 and 9-21-2007; Tdap on 10-16-2017 (due on 10-16-2027); Hep B vaccines 2-9-2015, 3-10-15 and 6-2-15. Hep C screen completed on 4-7-2014.

19) OPTIMAL HEALTH: Can be left at home without supervision up to 4 hours at a time. Enjoys making her own meals at times as well as cooking for her housemates. She enjoys reading, watching TV, visiting, going for walks, bible study, going on outings, shopping, going out to eat, calling/visiting her children, putting together puzzles, coloring/drawing and reading to housemates. Is able to make needs known but has some difficulty with speech at times. She loves dancing. On 1/10/24 she began working (cleaning) at the Argyle Building Center thru vocational training 2 days per week for 3 to 4 hours per day. She states she enjoys her job.

Individual Name
Date of Birth

Sandra Oas
04/04/1970



Individual Care Plan

Form ID	ICP-MCGHMN-N5H4QNMWYEKQ3
Status	In Prep
Time Zone	US/Central
Individual	Sandra Oas
Provider	Marshall County Group Homes, Inc., MCGH-MN
Entered By	Sabrina Deschene, RPC on 03/15/2024 01:22 PM
Last Updated By	Henrietta Linder, Nurse on 03/15/2024 05:19 PM

Care Plan Details

Care Plan Name	Sandra Oas Annual Careplan Goals
Start Date	03/01/2024
End Date	03/31/2025
Problem(s)	see other plan for problems
Goal(s)	<p>1) MONITOR BEHAVIORS FOR CHANGES: Give medications as ordered. Keep appointments with psychiatry and therapist as scheduled. Encourage daily routine with bedtime, meals and getting up in am. Reassure her that she is in a safe place. Honor her request not to see or speak with her husband. Watch for mania warning signs: sleeping less, elevated mood, restlessness, speaking rapidly, increase in activity level, irritability or aggression. Warning signs of depression: fatigue/lethargy, sleeping more, trouble concentrating, loss of interest in activities, withdrawing from others, or change in appetite. Encourage visits and phone calls with her children/loved ones per her wishes. Provide a calm and stress-free environment. Be patient and respectful allowing her to share feelings.</p> <p>2) TO DISPLAY OPTIMAL HEALING OF SKIN IN SURGICAL AREA WITHOUT SIGNS OF INFECTION OR SWELLING: Do not take blood pressures on right arm. To apply vitamin E oil to surgical scars of right breast and armpit massaging in an upward motion daily. Watch for swelling or tightness of right arm or armpit areas. Watch for any redness or irritation in areas of radiation. Watch for side effects of Tamoxifen (hot flashes, decrease in bone density, leg cramps, leg swelling or shortness of breath. Encourage a well-balanced diet. Complete monthly breast checks per facility nurse. Resume annual mammograms per recommendation of PCP.</p> <p>3) CONTROL SYMPTOMS OF REFLUX IE: HEARTBURN, ACID INDIGESTION, SOUR TASTE OF ACID, BAD BREATH, TROUBLE SWALLOWING, COUGH, FEELING OF FOOD IN THROAT, SORE THROAT, HOARSE, VOMITING, REGURGITATION AND CHEST PAIN: Limit foods such as dairy, spicy foods, fried foods, garlic, onion, chocolate, coffee, carbonated drinks, citrus fruits, and gravies. Administer acid blocker medication per doctor order. Maintain a healthy weight. Eat small frequent meals rather than large meals. Sit upright when eating/drinking. Avoid eating at least 3 hours before going to bed. Avoid tight clothing in belly area. Raise the head of the bed 6 to 8 inches (pillows do not work).</p> <p>4) IMPROVE/MAINTAIN GOOD CHOLESTEROL LEVELS: Avoid serving foods with saturated and trans-fats. Increase fiber in diet. Avoid high sugar drinks. Avoid weight gain - maintain healthy weight. (ideal weight is 122 to 150lbs) Encourage exercise such as walking. Eat fruits vegetables, beans and good fats such as plant oils like olive, avocado, canola or sunflower oils. Avoid/limit foods with solid fats found in cakes, cookies, pizza, sausages, hot dogs, bacon or ice cream. To have annual lipid panel.</p> <p>5) LENGTHEN TIME BETWEEN TRIPS TO THE TOILET/DECREASE EPISODES OF URINARY INCONTINENCE: Urologist states she has tried several meds for the urgency without success. On 7/31/23 she was started on Trosipium for urgency and this seems to be working well. Remind her to toilet at least every 2 hours during day rather than wait for urgency to urinate. To take extra clothing/underwear when going to appointments/outings. Assist as needed after incontinent episodes. Remind her to complete Kegel exercises several times daily - urologist to teach her how. Maintain healthy weight as this will help ease symptoms. To wear absorbent pads in underwear if needed. To schedule appointments with urologist annually and as needed. Administer medications as ordered. Encourage adequate fluid intake.</p>

6) **KEEP PAIN AT A TOLERABLE LEVEL:** Administer medications for pain/muscle spasms as indicated. Report complaints of increased pain to physician. Encourage exercise such as walking. Remind not to lift heavy objects. If sleeping on her side, encourage putting pillow between legs at night. To sleep on a comfortable firm mattress. Encourage good posture and not to sit for long periods without getting up to stretch. Applying ice/heat may be beneficial - check with physician if needed. Physical therapy as needed per doctor referral.

7) **WILL HAVE A RESTFUL SLEEP AT NIGHT:** Use distilled water in reservoir - be sure cover is latched when in use. Empty remaining water from reservoir every morning. Wash reservoir, conjugated tubing and all areas that come in contact with facial skin daily using warm, soapy water. Use mild soap like Joy or Dove - do not use Dawn. Change disposable filters, nasal cushions, nasal pillows and full face cushion monthly. Change filter every 2 weeks (blue goes toward the outside). Change tubing and mask frame every 3 months. Change headgear, humidifier chamber and chin strap every 6 months. Wash entire mask including velcro straps 1 x weekly. Check to be sure mask is applied correctly at night. Check during night to be sure her mask is still on. Keep a copy of cleaning instructions available in Sandra's room to follow.

8) **WILL BE FREE OF IMPACTED STOOL:** Document bowel movements as they occur as well as size. Administer stool softeners as ordered. Follow bowel protocol. Serve high fiber foods daily. Keep well hydrated. To have 2500cc's liquid per day. Encourage exercise. Warm liquids are beneficial especially in the morning. Add fruits and vegetables to her diet.

9) **VISION HEALTH:** To have an annual eye exam and as needed. To wear corrective lenses daily. Cue her to clean lenses as needed.

10) **ENCOURAGE INDEPENDENCE/ASSIST WITH TASKS AS NEEDED:** Listen actively and attentively. Staff to assist her with money management - allowing her to make purchases with oversight. Always praise her efforts. Never condemn or scold. Remind her that you are there to assist as she needs. Allow her plenty of time to finish sentences and to find words she is looking for. Do not finish sentences for her.

11) **PROLACTIN LEVELS TO BE WITHIN NORMAL RANGE/ATTEMPT TO KEEP PREDIABETES FROM BECOMING TYPE 2 DIABETES:** Administer medication to decrease prolactin level 2 x weekly as ordered. Monitor for any leakage of milk from breasts as well as change in size. Take to appointments with endocrinologist as scheduled. Complete labs as ordered by physician. Check weight monthly. Encourage her to eat a healthy well-balanced diet to include protein at each meal. Encourage watching carb intake (3 carb choices for each meal and 1 for snack). Serve foods low in fat, sugar and calories. Encourage foods high in fiber content. Encourage fruits, vegetables, whole grains and olive oil. Encourage physical activity such as walking. She is able to go on walks independently.

12) **SKIN TO REMAIN FREE OF RASH/ITCHING:** Skin screen to be done annually by dermatology. Take to dermatology appointments as scheduled. Apply Triamcinolone cream PRN as needed. Report skin rashes as they occur to nurse.

13) **PLATELET COUNT TO BE MONITORED AND MANAGED BY HEMATOLOGIST:** Last platelet count documented on 3-20-23 was within normal range. Use aspirin and Nsaids with caution. Avoid alcohol. Avoid activities that could cause injury. Watch for any unusual bruising or bleeding. Report any blood in urine or stool. Report any prolonged bleeding from cuts. Take to scheduled appointments with hematologist.

14) **TO BE FREE OF VAGINITIS:** Report any of the following to nurse/physician: odorous discharge from vagina, vaginal itching or irritation, painful urination, light vaginal bleeding or itching, and feeling of having to urinate more often. Wash vaginal area well daily and dry well. Avoid tight underwear - (cotton is best). Avoid vaginal powders and perfumed bath/vaginal products/sprays. Encourage her to wipe front to back when toileting.

15) **TO BE FREE OF FOOT PAIN:** To wear shoe orthotics daily. Report complaints of foot pain. Make appointment with podiatry as needed.

16) **TO BE FREE OF KNEE PAIN:** Administer pain medication as needed. Report any recurring complaints of knee pain to nurse. Maintain healthy weight (every pound of weight you gain adds 3 to 4 lbs of extra weight on knees). Encourage mild nonstrenuous exercise like walking.

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17) TO MAINTAIN GOOD DENTAL HEALTH: Take to appointments as scheduled. To brush/floss teeth using fluoride toothpaste at least 2 x daily. Eat healthy well-balanced diet. Avoid or limit high sugar foods, desserts and drinks like sodas.

18) IMMUNIZATIONS TO BE KEPT CURRENT: Immunizations to be reviewed by PCP at least annually at physical exam.

19) MAINTAIN OPTIMAL HEALTH: Staff to administer medications daily as ordered. Staff to transport to/from appointments/lab as scheduled. Facility nurse to complete monthly assessment and nail care. Allow her to cook meals if she chooses but needs supervision (has in past forgotten to shut stove burner off). Allow her to complete tasks at facility that she enjoys if choosing to do so (helping prepare a meal, baking, sweeping, doing her laundry, getting mail etc.). To have staff supervision as needed. To utilize MCGH standing orders per policy with orders to be reviewed by physician annually. To provide a safe environment. To provide activities/outings she enjoys. Staff to be familiar with and follow careplan as completed by nurse.

Approach(es)

Attachment(s)

Reviews

Team Meeting Discussions

