N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/04/21	GG	48	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Disabled	Single	Aspirin
Code Status	**Height**	**Weight**	
Full	167.6 cm	67.2 kg	

Medical History (5 Points)

Past Medical History: Type 2 diabetes mellitus, Anxiety, Depression, Schizophrenia, Suicidal Ideation, Suicide attempt.

Past Surgical History: Hernia Surgery (02/29/2004)

Family History: Grandmother- "mental problems", depression

Social History (tobacco/alcohol/drugs): Drugs- n/a

Alcohol- stated "2 beers a night" and then retracted and said "a six pack a month"

Tobacco- smokes cigarettes 3 packs a day, or 60 pack years

Assistive Devices: none

Living Situation: Lives alone.

Education Level: 7th grade

Admission Assessment

Chief Complaint (2 points): "suicidal ideation" and was hearing voices

History of present Illness (10 points): The client began experiences auditory hallucinations about "a month or so" ago, progressively got worse, and began feeling depressed. The voices were not command hallucinations, or violent in nature, but had varying intervals. The voices would "come and go". His depression got worse the longer they went on. The voices would get louder as the volume of the room increased. The client reported bouts of insomnia and fatigue,

but no other symptoms associated with his depression or auditory hallucinations. The client did not attempt to relieve his symptoms. He has seen a provider for his depression and schizophrenia in the past and receives pharmacological treatments for the past “15-20 years”. Client has also gone to an inpatient psychiatric facility before.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Suicidal Ideation; intentional drug overdose

Secondary Diagnosis (if applicable): Hyponatremia

Pathophysiology of the Disease, APA format (20 points):

What is schizophrenia:

Schizophrenia is a disorder recognized by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) as a mental health condition that causes alterations in thoughts, perceptions, emotions, movement and behaviors (Videbeck, 2019). Severely ill schizophrenic clients may become schizoaffective, presenting with psychotic and mood symptoms. The origin of the disease varies from genetics, decreased brain tissue and cerebrospinal fluid, and an excess in dopamine (Videbeck, 2019). Overall, there is a higher prevalence of this disorder in males than in women (Videbeck, 2019).

Signs and symptoms of schizophrenia

The disorder’s behavioral symptoms are categorized as positive or negative. Positive symptoms, also called hard symptoms, are delusions and hallucinations. Negative, or soft, symptoms of the disorder include flat affect, lack of volition, inattention. Delusions consist of one or more of the following: idea of reference, persecution, grandeur, somatic delusions, jealousy, being controlled, thought broadcasting, thought insertion, thought withdrawal,

religiosity magical thinking (Adcock, 2019). Hallucinations consist of symptoms such as: auditory, visual, olfactory gustatory, tactile, and command, which is the most serious of all hallucinations. Other characteristics of schizophrenia may include unusual speech patterns such as clang associations, neologisms, verbigeration, echolalia, stilted language, perseveration, and word salad (Adcock, 2019). These patients may have blunted moods and affects as well as experiencing periods of anhedonia. Lastly, these patients may forget to eat or have a decreased appetite (Adcock, 2019).

Diagnosis of schizophrenia:

Due to the nature of the condition, diagnosis occurs with the onset of symptoms which range from abrupt to insidious. The disorder is statistically diagnosed at different times for men and women; men are diagnosed at fifteen to twenty-five whereas woman receive their diagnosis around ages twenty-five to thirty-five (Videbeck, 2019). Tests that may be performed to aid in the diagnosis of the disorder include testing the levels of dopamine, as well as a computed tomography (CT) to confirm decreased brain tissue and a lumbar puncture for the decreased cerebral spinal fluid (Videbeck, 2019).

Treatment of schizophrenia:

Treatment is based on the management of symptoms, with either immediate or long-term goals. The immediate treatment seeks to relieve ongoing psychosis (Adcock, 2019). Long-term treatment sees a decrease in the severity of the symptoms with age and more control over their behaviors, allowing them to become more independent but still struggling to function in the community (Adcock, 2019). The pharmacologic treatment target positive, negative, or both types of symptoms. First generation drugs that treat positive symptoms include chlorpromazine, haloperidol, fluphenazine, and perphenazine (Adcock, 2019). Second generation treats positive

and negative traits; these drugs include: clozapine, risperidone, olanzapine, quetiapine, ziprasidone (Adcock, 2019). Third generation drugs also treat both positive and negative signs and have a reduced chance of adverse effects (Adcock, 2019). Third generation drugs include: aripiprazole, brexpiprazole and cariprazine (Adcock, 2019). There are six drugs available in injection form to promote compliance, these drugs include: fluphenazine, haloperidol, risperidone, paliperidone, olanzapine, aripiprazole (Adcock, 2019). The drugs listed are not an all-inclusive list.

How schizophrenia relates to the patient:

The client has a history of schizophrenia. The client is a male which is a risk factor for schizophrenia. He has auditory, but not command, hallucinations. He experiences anhedonia and has a mild, blunted affects. The client takes paliperidone via intramuscular injections every three months to stay compliant with his regimen. The client was of normal weight but had a significantly decreased appetite, which is typical for a person with schizophrenia. The client mentioned experiencing blurred vision, although this was not noted during the physical exam, it was noted when assessing the adverse effects of trifluoperazine, a drug taken by the client for his schizophrenia.

Pathophysiology References (2) (APA):

Adcock, S., McKinley, K., Stone, S., Johnson-Schuh, D., & Kongable, L. (2019). *RN Mental Health Nursing* (11th ed.). ATI Nursing, LLC.

Videbeck, S. (2019). *Psychiatric-mental health nursing* (8th ed.). Wolters Kluwer.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.00-6.60**	**3.54**	**3.95**	The client does not have a history of anemia, is not underweight, and has seen an improvement while in the hospital without an iron supplement. Client mentioned that he "drinks a lot of water at home", this may account for his low RBC, low Hgb, and Hct (Lab Tests Online, 2021, Red Blood Cell Count).
Hgb	**14.0-18.0**	**11.7**	**12.9**	The client does not have a history of anemia, is not underweight, and has seen an improvement while in the hospital without an iron supplement. Client mentioned that he "drinks a lot of water at home", this may account for his low RBC, low Hgb, and Hct (Lab Tests Online, 2021, Red Blood Cell Count).
Hct	**42-54**	**31.6**	**37**	The client does not have a history of anemia, is not underweight, and has seen an improvement while in the hospital without an iron supplement. Client mentioned that he "drinks a lot of water at home", this may account for his low RBC, low Hgb, and Hct (Lab Tests Online, 2021, Red Blood Cell Count).
Platelets	**150-450**	**199**	**237**	
WBC	**4.5-10.8**	**7**	**6**	
Neutrophils	**1.5-7.6**	**3.9**	**2.7**	
Lymphocytes	**1-6**	**2**	**2**	
Monocytes	**0.10-1.10**	**0.85**	**1.02**	
Eosinophils	**0.20-0.80**	**0.15**	**0.10**	Eosinophils decrease with stress; the

				client has been stressed over the last month due to the voices in his head (Cheever & Hinkle, 2020).
Bands	**n/a**	**n/a**	**n/a**	**n/a**

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**134-144**	**120**	**133**	The client enjoys drinking "a lot of water" which could account for his hyponatremia (Lab Tests Online, 2021, Red Blood Cell Count). The client takes Depakote; Depakote is known to be a cause of hyponatremia (Yamamoto et al., 2019).
K+	**3.50-5.20**	**4.08**	**4.4**	
Cl-	**96-106**	**85**	**97**	Diabetes is a known reason in low chloride and would account for a low level in this patient (Cheever & Hinkle, 2020).
CO2	**20-29**	**25.1**	**26.2**	
Glucose	**65-99**	**116**	**103**	The client is diabetic, an elevated glucose may indicate mismanagement of his disease (Cheever & Hinkle, 2020).
BUN	**8-27**	**8**	**11**	
Creatinine	**0.57-1.00**	**0.83**	**0.84**	
Albumin	**3.7-4.7**	**NOT DRAWN**	**4.2**	
Calcium	**8.6-10.3**	**9.5**	**9.9**	
Mag	**1.6-2.3**	**n/a**	**n/a**	
Phosphate	**3-4.3**	**n/a**	**n/a**	

Bilirubin	**0.0-1.2**	**NOT DRAWN**	**0.2**	
Alk Phos	**48-121**	**NOT DRAWN**	**71**	
AST	**0-40**	**NOT DRAWN**	**13**	
ALT	**0-44**	**NOT DRAWN**	**12**	
Amylase	**n/a**	**n/a**	**n/a**	
Lipase	**n/a**	**n/a**	**n/a**	
Lactic Acid	**4.50-19.80**	**n/a**	**n/a**	
Troponin	**n/a**	**n/a**	**n/a**	
CK-MB	**n/a**	**n/a**	**n/a**	
Total CK	**n/a**	**n/a**	**n/a**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**1**	**n/a**	**n/a**	
PT	**11-13.5**	**n/a**	**n/a**	
PTT	**22-35**	**n/a**	**n/a**	
D-Dimer	**n/a**	**n/a**	**n/a**	
BNP	**0-100**	**n/a**	**n/a**	
HDL	**n/a**	**n/a**	**n/a**	
LDL	**n/a**	**n/a**	**n/a**	
Cholesterol	**n/a**	**n/a**	**n/a**	
Triglycerides	**n/a**	**n/a**	**n/a**	

Hgb A1c	**4.8-5.6**	**5.7**	**NOT DRAWN**	The lab is only slightly elevated; the client is diabetic, an elevated A1c is suggestive of mismanagement of him disease (Cheever & Hinkle, 2020).
TSH	**n/a**	**n/a**	**n/a**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow Clear**	**n/a**	**n/a**	
pH	**5-7**	**n/a**	**n/a**	
Specific Gravity	**1.001-1.030**	**n/a**	**n/a**	
Glucose	**n/a**	**n/a**	**n/a**	
Protein	**n/a**	**n/a**	**n/a**	
Ketones	**n/a**	**n/a**	**n/a**	
WBC	**n/a**	**n/a**	**n/a**	
RBC	**n/a**	**n/a**	**n/a**	
Leukoesterase	**n/a**	**n/a**	**n/a**	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**n/a**	**n/a**	**n/a**	
PaO2	**n/a**	**n/a**	**n/a**	
PaCO2	**n/a**	**n/a**	**n/a**	
HCO3	**n/a**	**n/a**	**n/a**	
SaO2	**n/a**	**n/a**	**n/a**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**n/a**	**n/a**	**n/a**	
Blood Culture	**n/a**	**n/a**	**n/a**	
Sputum Culture	**n/a**	**n/a**	**n/a**	
Stool Culture	**n/a**	**n/a**	**n/a**	

Lab Correlations Reference (1) (APA):

Cheever, K. H., Hinkle, J. L. (2020). *Brunner and Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Lab Tests Online. (2021, September 10). *Red Blood Cell Count*. https://labtestsonline.org/tests/red-blood-cell-count-rbc

Yamamoto, Y., Takahashi, Y., Imai, K., Ohta, A., Kagawa, Y., & Inoue, Y. (2019). Prevalence and risk factors for hyponatremia in adult epilepsy patients: Large-scale cross-sectional cohort study. *Seizure, 73*, 26–30. https://doi.org/10.1016/j.seizure.2019.10.013

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Toxicology screening was done on admission to assess for illicit drug substances in his blood (Capriotti, 2020).

Diagnostic Test Correlation (5 points): Toxicology screening was done on admission to check for the presence of illegal drugs or alcohol in his blood to assess if it contributed to his suicidal ideation.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F. A. Davis Company.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Stelazine trifluoperazine**	**Molipaxin trazodone**	**Invega paliperidone**	**Klonopin clonazepam**	**Depakote divalproex sodium**
Dose	10mg	100mg	819mg	1mg	1000mg
Frequency	BID	At night	Every 3 months	BID	BID
Route	PO	PO	IM	PO	BID
Classification	Therapeutic class: Antipsychotic, first-generation Pharm: Phenothiazine	Therapeutic: Antidepressant Pharm: Triazolopyridine derivative	Therapeutic: Antipsychotic, second-generation Pharm: Benzoxazole derivative	Therapeutic: Anxiolytic Pharm: Benzodiazepine	Therapeutic: anti-epileptics Pharm: Histone Deacetylase Inhibitors
Mechanism of Action	It blocks postsynaptic dopamine	potentiates CNS serotonergic	lessen psychotic symptoms	reduces anxiety and prevents	Increase levels of GABA, an inhibitory

	receptors, and is an alpha-adrenergic blocker	activity by selectively inhibiting serotonin reuptake	by blocking central dopamine and serotonin receptors	seizures by potentiating the action of the inhibitory GABA	neurotransmitter in the CNS.
Reason Client Taking	Schizophrenia	Depression	mood stabilizers; schizophrenia	anxiety	mood instability
Contraindications (2)	Alcohol; hypersensitivity to trifluoperazine	hypersensitivity to trazodone; John's wort	hypersensitivity to paliperidone; alcohol	Alcohol; Hypersensitivity to clonazepam	Hypersensitivity; suicidal thoughts/behaviors
Side Effects/Adverse Reactions (2)	Blurred vision; tachycardia	suicidal ideation; blurred vision, tachycardia	Tachycardia; hypotension	suicidal ideation; CNS depression	Leukopenia; thrombocytopenia
Nursing Considerations (2)	Monitor for tardive dyskinesia every 6 months; Monitor for extrapyramidal symptoms (EPS) every 3 months	Administer at bedtime if patient experiences substantial drowsiness; Concurrent use with MAOIs is potentially lethal	Monitor fasting blood glucose for hypoglycemia; Monitor fasting lipid levels at baseline and every 5 years throughout therapy	Avoid abrupt discontinuation to prevent withdrawal symptoms; Concurrent use of benzodiazepines and opioids can be lethal.	Assess mood, ideation, and behavior frequently. May interfere with accuracy of thyroid function tests
Key Nursing Assessment(s)/Lab(s) Prior to Administration	assess hepatic function when starting and every six	Monitor for suicidal ideation; assess BP & pulse rate	Assess blood pressure prior to administration	Monitor heart rate and respiration, before administrati	Draw baseline CBCs and monitor periodically; Draw baseline

	months; Assess CBC and at every 6 months		Assess pulse, tachycardia is an adverse reaction.	on due to risk of CNS depression. Assess blood pressure	liver function (LDH, AST, ALT, and bilirubin) and monitor
Client Teaching needs (2)	immediately report fever; immediately report a sore throat	immediately report allergy symptoms; report tachycardia	swallow tablets whole with liquid; report suicidal ideation immediately.	Caffeine decreases effectiveness; Avoid alcohol	Notify provider if having thoughts about suicide Notify provider if they experiencing the signs of hepatoxicity (anorexia, abdominal pain, severe nausea and vomiting, yellow skin or eyes, fever, sore throat, malaise, weakness, facial edema, lethargy, unusual bleeding or bruising)

Hospital Medications (5 required)

Brand/Generic	Lovenox Enoxaparin	Nicoderm CQ nicotine patch	DGlucose Dextrose 10%	Insta-Glucose Glucose	Humalog Insulin Lispro
Dose	40mg	21mg	500mL	Per glucose	Sliding

				level	scale
Frequency	Daily	21mg	PRN	PRN	PRN
Route	Subcutaneous	daily	IV	IV push	Subcutaneous
Classification	Therapeutic class: Anticoagulant Pharm: Low molecular weight heparin	Pharm: Nicotine agonist Therapeutic: Smoking cessation adjunct	Caloric Agents Hypoglycemia Antidotes	Therapeutic: caloric sources Pharm: carbohydrates	Therapeutic: Rapid-acting Insulins Pharm: antidiabetic
Mechanism of Action	inhibits thrombus and clot formation by blocking clotting factors	Provides a source of nicotine during controlled withdrawal from cigarette smoking	oxidation to carbon dioxide and water, and quickly provides fluid and calories	Provides calories. Prevention and treatment of hypoglycemia.	insulin analogue used to reduce glucose by promoting peripheral absorption of glucose
Reason Client Taking	Prevent clots while on bed rest	management of nicotine withdrawal from not smoking while in hospital	In the event of hypoglycemia	Hypoglycemia, as needed.	Diabetes
Contraindications (2)	hypersensitivity to enoxaparin; NSAIDs	Hypertension; Hypersensitivity	Simultaneous administration of dextrose solutions with blood through the same infusion set; Hypersensitivity	Hypersensitivity patients with CNS bleeding	Hypoglycemia; Diabetic ketoacidosis
Side	Anemia;	Tachycardia	injection site	fluid	Hypoglyce

Effects/Adverse Reactions (2)	thrombocytopenia	; drowsiness	infection; Fever	overload; hypokalemia	mia headache
Nursing Considerations (2)	Periodically check stool for occult blood Monitor output for those with renal impairment;	Monitor input and output Do not stop abruptly	Concentrated dextrose solutions should not be given sub-Q or IM injection; Monitor IV site for redness	Monitor intake and output; Monitor IV site frequently for phlebitis and infection	Administer by sub-Q injection or continuous sub-Q infusion; Administer 15 minutes before or immediately after a meal
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain baseline CBC/platelets; Obtain labs from bleeding time	Assess blood pressure Assess pulse	Check glucose level before administration Monitor for symptoms of hyperglycemia	Assess glucose proadministration and during, may cause an elevated serum glucose level Assess serum sodium periodically	adjust dosage regularly based on blood glucose determinations; assess before giving. Assess for hypoglycemia
Client Teaching needs (2)	report allergy symptoms; Use a soft toothbrush and avoid activities that will make you bleed	Apply to clean, dry skin of upper arm or torso free Rotate sites	Alert nurse if they suspect they are developing a fever Alert nurse if they suspect they are developing hyperglycemia: fruity	Instruct diabetic patient on the correct method for self-blood glucose monitoring. Advise patient on when and how to administer	Advise patient not to smoke within 30 minutes after insulin injection; adjust the consumption and/or timing of snacks or exercise to

			breath, confusion	dextrose products for hypoglycemia	avoid hypoglycemic episodes

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point):	

Alertness: **Orientation:** **Distress:** **Overall appearance:**	Alert Oriented x4 Not distressed Clean, well groomed
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Pink Dry Warm Normal, less than 3 seconds None None None BRADEN= 22 No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Symmetrical, trachea midline, lymph nodes nonpalpable, carotid palpable 2+ Bilateral ears intact, clean, no drainage. Bilateral: Sclera white, conjunctiva pink, PERLA intact, no lesions Septum midline, bilateral frontal sinuses are nontender to palpation Oral mucosa pink, moist, intact, dentition clean
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	 Normal rate and rhythm Clear S1& S2, no detectable murmurs Radial 2+ Posterior tibialis, dorsalis pedis, femoral, 2+ less than 3 seconds in upper and lower extremities bilaterally no vein distention no edema n/a
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 No use of accessory muscle Auscultation of 4 anterior spots: Clear vesicular breath sounds Auscultation of 9 posterior spots: Clear vesicular breath sounds
GASTROINTESTINAL (2 points):	

Diet at home:	"Normal" diet
Current Diet	Saturated fat
Height:	167.6 cm
Weight:	67.2 kg
Auscultation Bowel sounds:	Normoactive in all four quadrants
Last BM:	"3 days ago"
Palpation: Pain, Mass etc.:	No pain or tenderness, no organomegaly or mass
Inspection:	
Distention:	None
Incisions:	None
Scars:	None
Drains:	None
Wounds:	None
Ostomy: Y ☐ N ☒	No ostomy
Nasogastric: Y ☐ N ☒	No nasogastric
Size:	n/a
Feeding tubes/PEG tube Y ☐ N ☒	No PEG Tube
Type:	n/a
GENITOURINARY (2 Points):	
Color:	Yellow
Character:	Clear
Quantity of urine:	5x that day
Pain with urination: Y ☐ N ☒	No pain
Dialysis: Y ☐ N ☒	No dialysis
Inspection of genitals:	Clean, pink, no drainage or moisture
Catheter: Y ☐ N ☒	No catheter
Type:	n/a
Size:	n/a
MUSCULOSKELETAL (2 points):	
Neurovascular status:	Intact
ROM:	Full ROM
Supportive devices:	None
Strength:	5/5 upper and lower extremities bilaterally, Strong and equal
ADL Assistance: Y☐ N ☒	No ADL assistance needed
Fall Risk: Y ☐ N☒	Not a fall risk
Fall Score:	FALL SCORE= 35
Activity/Mobility Status:	
Independent (up ad lib) ☐	Independent
Needs assistance with equipment ☐	No assistance needed
Needs support to stand and walk☐	Did not need support to stand or walk
NEUROLOGICAL (2 points):	
MAEW: Y ☒ N☐	
PERLA: Y ☒ N☐	

Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Alert and oriented to person, place, time, and situation Presently intact Intact, vocal Has sensory deficits: auditory No LOC
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	 Plays guitar Appropriate for age Christian, reads the bible every night Lives alone. Relies on his family for support: mother, sister, and cousins.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1552	109	160/104	20	97.8	94
1730	108	156/98	20	97.7	96

Vital Sign Trends: The client consistently had high blood pressure and tachycardia. Although he has diabetes which places him at risk for elevated blood pressure, he does not have a history of hypertension. The client did have 5 cups of coffee which is the most likely cause of his elevated pulse and blood pressure. Several of his medications also list hypertension as an adverse effect such as the nicotine patch, trifluoperazine, trazadone, and paliperidone.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1552	Numeric	n/a	0	n/a	n/a
1730	Numeric	n/a	0	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Right hand
Date on IV:	10/04/2021
Patency of IV:	Patent
Signs of erythema, drainage, etc.:	Clean, no signs of drainage or redness; was not connected to fluids.
IV dressing assessment:	Dry and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Breakfast- 100% Fluids- 1200mls	5x times; client's output was not being measured

Nursing Care

Summary of Care (2 points)

Overview of care: I kept the client company and performed a head to toe assessment. I took his vitals twice and assessed his pain.

Procedures/testing done: none.

Complaints/Issues: none.

Vital signs (stable/unstable): The client had an elevated blood pressure and heart rate. This was most likely cause by his intake of 5 cups of coffee considering he does not have a documented history of hypertension or tachycardia.

Tolerating diet, activity, etc.: The client did not need assistance with his daily activities, feeding, or toileting. He was 100% independent and had urinated "4-5 times" in the last several

hours. He had a decreased appetite, reportedly ate his entire breakfast, did not eat lunch, and did not order dinner.

Physician notifications: The physician did not change or add to the client's plan of care.

Future plans for patient: The client will be discharged to an inpatient psychiatric facility.

Discharge Planning (2 points)

Discharge location: The client will be discharged to an inpatient psychiatric facility; the hospital was working on finding a facility for transfer.

Home health needs (if applicable): The client lives alone, it is not advisable that he goes directly home. He needs a better support system to help monitor him.

Equipment needs (if applicable): none.

Follow up plan: none at this time.

Education needs: The client needs to be educated about his diet considering his A1c was high and low sodium.

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	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for self harm, as evidence by the client's suicidal ideation.	The client has a history of suicide, is male which is a risk factor for suicide, and was considering	1. Group therapy is an effective method for treating people with depression and substance abuse.	The client did not harm himself under the nurse or student nurse's watch.

	ending his life.	2.Monitor the patient every 15 minutes until he is no longer a danger to himself.	
2. Knowledge deficit related to his anxiety, as evidence by his intake of 5 cups of coffee.	Coffee is a stimulant. It will cause palpitations and elevated blood pressure, causing the client's anxiety to feel worse.	1. Offer non-caffeinated alternative beverages. 2.Explain to the client why they should avoid caffeine. Educate about the change in vitals as well as the reactivity to the medications he is on.	The client understood the education and agreed not to drink coffee.
3. Disturbed auditory sensory perception related to schizophrenia, as evidence by hearing multiple voices.	The client was hearing voices due to his condition. Voices can lead to command hallucinations.	1. Assess if the client is hearing any voices and ask what they're saying. 2 If the client is hearing voices, the nurse should focus on reality ant reinforce the hallucination.	The client denied hearing any voices at that time.
4. Ineffective health management as evidence by the client's elevated A1c	An elevated A1c suggests he is eating too much sugar or carbs, and not managing his diabetes well.	1.Educate the client why he needs to eat less carbs. Reducing his glucose will prevent complications that are associated with diabetes. 2. Keep the client on a diabetic diet while in the hospital to reduce his blood	Client understood the education; his blood glucose was reduced while in the hospital.

		glucose.	

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Mosby.

Concept Map (20 Points):

Subjective Data

Was hearing voices
Wanted to kill himself
Feels "depressed"
Client "feels tired"
Has been treated for schizophrenia "15-20 years"
Drank 5 cups of coffee

Objective Data

Client has a flat affect
Client was mentioned
Seemed anxious
Toxicology report was free of substances
Heart Rate: 109; 108
Blood Pressure: 160/104; 156/98
Hyponatremic

Medication:
Trifluoperazine; trazodone, paliperidone, divalproex sodium

Patient Information
GG Male age: 48 yrs
Schizophrenic
Reported experiencing suicidal ideation
Has a history of suicide attempts
Has been to a psychiatric institution before
Has: depression, anxiety, experiences auditory disturbances.

Nursing Diagnosis/Outcomes

1.	Risk for self harm, as evidence by the client's suicidal ideation. Outcome: The client did not harm himself under the nurse or student nurse's watch.
2.	Knowledge deficit related to his anxiety, as evidence by his intake of 5 cups of coffee. Outcome: The client understood the education and agreed not to drink coffee.
3.	Disturbed auditory sensory perception related to schizophrenia, as evidence by hearing multiple voices. Outcomes: The client denied hearing any voices at that time.
4.	Ineffective health management as evidence by the client's elevated A1c Outcomes: Client understood the education; his blood glucose was reduced while in the hospital.

Nursing Interventions

1. Group therapy is an effective method for treating people with depression and substance abuse. 2.Monitor the patient every 15 minutes until he is no longer a danger to himself.
1. Offer non-caffeinated alternative beverages. 2.Explain to the client why they should avoid caffeine. Educate about the change in vitals as well as the reactivity to the medications he is on.
1. Assess if the client is hearing any voices and ask what they're saying. 2 If the client is hearing voices, the nurse should focus on reality ant reinforce the hallucination.
1.Educate the client why he needs to eat less carbs. Reducing his glucose will prevent complications that are associated with diabetes. 2. Keep the client on a diabetic diet while in the hospital to reduce his blood glucose.