N323 Care Plan

Lakeview College of Nursing

Name: Shana Stanley

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10-19-21	DC	29	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
WHITE	Brick layer	Married	none
Code Status	**Observation Status**	**Height**	**Weight**
Full		5”11	170lb

Medical History (5 Points)

Past Medical History: The patient has denied any past medical history other than being in a rehab program for cocaine use.

Significant Psychiatric History: Patient sees a therapist for physio social tendencies

Family History: Patient’s grandfather was an alcoholic and uncle has schizophrenia.

Social History (tobacco/alcohol/drugs): Patient smokes cigarettes, drinks twice a week, and uses cocaine on the weekends.

Living Situation: patient lives at home with wife, son, and stepdaughter.

Strengths: patient is educated and has gained skill set in his trade of work. The patient is pleasant, cooperative, and willing to participate in his treatment. He was willing to answer any questions that were asked.

Support System: As of now the only support the patient is receiving is from his mother.

Admission Assessment

Chief Complaint (2 points): “I was made to come here by the courts for cocaine use.”

Contributing Factors (10 points): The patient is a 29-year-old male that was admitted by the courts as a plea deal for the uses of cocaine. The client was arrested for stealing his father-in-law’s guns and was found to be under the influence of alcohol and cocaine at the time. The courts were going to charge the patient with a class X felony, but the patient

attorney was able to get a reduced sentence pending rehabilitation and two years' probation. The patient has been in the facility for six days and appears to be detoxing well.

Factors that lead to admission: Patient stated " my marriage was crumbling and he just kind of lost control."

History of suicide attempts: He denies any suicidal thoughts, intentions, or plans.

Primary Diagnosis on Admission (2 points): Cocaine use with detox.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: **Witness of trauma/abuse:**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Sexual Abuse	**N/A**	**Yes age 8-11**	**N/A**	**Patient claims to have been abused by his uncle for a**

				few years while the family all lived under one roof. Patient stated that it only happened when the uncle was drunk.
Emotional Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Neglect	**N/A**	**N/A**	**N/A**	**N/A**
Exploitation	**N/A**	**Yes**	**N/A**	**Patient feels that his skill level at work has often been exploited and that he has not always been compensated for his work properly.**
Crime	**N/A**	**Yes**	**N/A**	**Patient is currently mandated to be in rehabilitation for drug use after being arrested for**

				theft of a firearm.
Military	**N/A**	**N/A**	**N/A**	**N/A**
Natural Disaster	**N/A**	**N/A**	**N/A**	**N/A**
Loss	**N/A**	**Yes age 2**	**N/A**	**Patient indicated that he lost his father at the age of two.**
Other	**N/A**	**N/A**	**N/A**	**N/A**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	**Patient clams to feel depressed since being in the facility due to his inability to see his son.**	
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 home, school, work, relationships, or responsibilities	**Yes**	**No**		
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Change in numbers of hours/night	**Yes**	**No**		
Difficulty falling asleep	**Yes**	**No**		
Frequently awakening during	**Yes**	**No**		

night			
Early morning awakenings	**Yes**	**No**	
Nightmares/dreams	**Yes**	**No**	
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 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 often paces and taps fingers when in high stress situations.**
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 a scale of 1-10?		**6 out of 10**	
How would you rate your anxiety on a scale of 1-10?		**4 out of 10**	

Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	**The patient has currently lost his job due to this situation.**
School	**Yes**	**No**	
Family	**Yes**	**No**	**The patient is currently going through a divorce and is unable to see his son.**
Legal	**Yes**	**No**	**The patient was court mandated to the facility for detox.**
Social	**Yes**	**No**	
Financial	**Yes**	**No**	
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement**

				Significant improvement
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
N/A	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Wife	**28**	**wife**	**Yes**	**No**
Son	**2**	**son**	**Yes**	**No**
Stepdaughter	**8**	**Stepdaughter**	**Yes**	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: Patient clams his wife also uses cocaine				
Children (age and gender): Male age 2, female age 8 Who are children with now? Children are currently with the wife.				
Household dysfunction, including separation/divorce/death/incarceration: Pending divorce.				
Current relationship problems: Patient feels that his wife is entitled and doesn't want to work for things. He believes they are just different and that they cant keep working on things.				

Number of marriages: 1		
Sexual Orientation: **Heterosexual**	**Is client sexually active?** **Yes No**	**Does client practice safe sex?** **Yes No**
Please describe your religious values, beliefs, spirituality and/or preference: patient was raised catholic, but currently doesn't believe in religion.		
Ethnic/cultural factors/traditions/current activity: Patient does not practice in traditions. **Describe: Stated above.**		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient is currently charged with a class X felony with possibility of reduced charge pending rehabilitation and two years' probation.		
How can your family/support system participate in your treatment and care? **The patients only means of support currently is his mother. She is committed to the health of her son and has arranged for him to come home and live with her while on probation. She also owns a few small businesses and will be employing his upon release.**		
Client raised by: **Natural parents Signal mother** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Significant childhood issues impacting current illness: N/A		
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.) Uncle has schizophrenia.
History of Substance Use: Alcohol and cocaine.
Education History: **Grade school** **High school** **College University of Illinois** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: no
Discharge
Client goals for treatment: Patient wishes to compleat program and go home to start over.
Where will client go when discharged? Pending court approval.

Outpatient Resources (15 points)

Resource	Rationale
1. Lionrock Recovery, 1-800-495-2282 or lionrockrecovery.com.	**1. Lionrock in an online substance abuse counseling. They provide sessions for individuals and families.**
2. Daylight Recovery Center 866-551-3069	**2. this is an inpatient facility that is**

https://help.daylightdetox.com	**certified through the Joint Commissions, and offers a unique approach to drug rehabilitation.**
3. Banyan Heartland (Gilman) **844-516-6398** **1237 E 1600 North Rd, Gilman, Illinois, 60938**	**3. This facility offers inpatient treatment for substance abusers. It is considered community living.**

Current Medications (10 points)
Complete all of your client's psychiatric medications
Theses medications were given by the instructor per student request they are NOT being take by the current client.

Brand/Generic	**Depakote Sodium valproate**	**Zyprexa**	**Vistaril**		
Dose	**500mg**	**5mg**	**25mg**		
Frequency	**BID**	**QHS**	**PRN**		
Route	**PO**	**PO**	**PO**		
Classification	**Anticonvulsant**	**Antipsychotic**	**Anxiolytic**		
Mechanism of Action	**Valproate Sodium is the sodium salt form of valproic acid with anti-epileptic activity. Valproate sodium**	**Aceves effect by antagonizing dopamine and serotonin receptors.**	**Competes with histamines for the receptor to suppress histaminic activity.**		

	is converted into its active form, valproate ion , in blood.				
Therapeutic Uses	**Anticonvulsant**	**Antipsychotic**	**Anxiety**		
Therapeutic Range (if applicable)	**between 50 and 125 g/mL.**	**Maintenance 10mg daily after adjustment.**	**na**		
Reason Client Taking	**Bipolar**	**Antipsychotic**	**Anxiety**		
Contraindications (2)	**suicidal thoughts. depression.**	**Bone marrow depression Coronary artery disease.**	**Breastfeeding Prolonged QT**		
Side Effects/Adverse Reactions (2)	**stomach pain, feeling or being sick. diarrhea.**	**Abnormal gate Euphoria**	**Drowsiness Hallucinations**		
Medication/Food Interactions	**na**	**na**	**na**		
Nursing Considerations (2)	**Monitor ammonia levels Monitor patient carefully for clotting defects**	**Use caution with clients with hepatic impairment. Clients may develop hypertension.**	**Use caution for clients with history of prolonged QT. Monitor if client takes other CNS depressants.**		

Brand/Generic					
Dose					

Frequency					
Route					
Classification					
Mechanism of Action					
Therapeutic Uses					
Therapeutic Range (if applicable)					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Medication/Food Interactions					
Nursing Considerations (2)					

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**Patient appears to be alert and oriented time 4. Patient is friendly, cooperative, maintains appropriate eye contact, appropriate height, and weight. Patient clothing is appropriate for the setting. Patient appears clean, neat, and tidy and no odor present. Patient's attitude is open and pleasant. Patient's speech is clear and normal liveliness and offers information. Patient's mood most of the time was nervous. Patient's affect is appropriate to situation, normal and constricted.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**Patient denies hallucinations, paranoid, delusion, illusions. Patient's thought process is good, relevant to the topic being discussed, and is coherent, and logical. Patient denies delusions or ideations. Patient admits to obsession and compulsive behaviors. Patient denies having phobias. Patient denies having suicidal and homicidal and agrees to remain safe. Patient did not express delusional content.**
ORIENTATION: **Sensorium:** **Thought Content:**	. **Patient is oriented to time, place, person, and situation. Patients' sensorium is normal.**
MEMORY: **Remote:**	. **Patient's memory is good for recent and past experiences.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	**Patient's judgement is good; able to come to appropriate conclusions; realistic decisions. Patient's impulse control is good now as well. Patient was attentive and has adequate concentration.**
INSIGHT:	**Patient's insight is good; recognizes his problems.**
GAIT: **Assistive Devices:**	**Patient denies use of assistive devices. Patient**

Posture: **Muscle Tone:** **Strength:** **Motor Movements:**	**is independent and requires no assistance. Patient demonstrated active range of motion bilaterally throughout. Patient has a low fall risk score. Patient maintains good balance independently. Patient tolerated ambulation well and showed no signs of difficult breathing. Patient needed no cueing and set up assistance. Patient's general motor response was normal. Patient's hang grips and pedal pushes were strong and +2 bilaterally.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1525	**80**	**128/72 right arm**	**18 non labored**	**98.2 oral**	**96% Room air**
1700	**81**	**133/85 left arm**	**18 non labored**	**98.3 oral**	**98% room air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 100% per chart**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: unknown**

Lunch: 100% per chart **Dinner: 100% per observation**	**Lunch: unknown** **Dinner: 710ml**

Discharge Planning (4 points)

Discharge Plans (Yours for the client): the client is to be discharged home to his mother and is to start his probation from there. He has agreed that seeking further drug rehabilitation is a good idea and has written down the places I recommended. It is in the best interest of the client to seek further treatment due to continued drug use.

1. **Equip the patient with the following outpatient resources listed above.**
2. **Follow up with primary doctor.**
3. **Attend an NA meeting at least once a week to help develop effective coping skills.**

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	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. Ineffective denial related to drug use as evidence by patient believing that	**I chose this diagnosis because my client believes that moderate**	**1. Give the client information about cocaine use in a matter-of-fact**	**1. Do not allow the client to blame others or circumstances beyond the**	**1. Encourage other clients in the program to provide**

his use of cocaine is under control. (Phelps et al., 2017).	**use of drugs is ok if he can control it.**	**manner.** **2. Encourage client to recognize current situation as it relates to drug use.** **3. Help client to reflect on past decisions made under the influence**	**client's control.** **2. Use redirection to help client to recognize his own issues.** **3. Avoid allowing client to compare his situation to others in treatment.**	**feedback for each other.** **2. Identify community resources for the patient to be able to use.** **3. The patient to be able to verbalize their acceptance of their responsibility.**
2. Altered Family Processes/Role Performance as evidenced by client's ineffective spousal communication and marital problems	**I chose this diagnosis because the client is currently in the process of getting a divorce due to the current situation.**	**1. Encourage client to recognize current situation as it relates to drug use.** **2. Help client to reflect on past decisions made under the influence** **3. Assist client with good coping skills.**	**1. Do not allow the client to blame others or circumstances beyond the client's control.** 2. Use redirection to help client to recognize his own issues. **3. encourage client to find ways to be a better more present father.**	**1. Encourage other clients in the program to provide feedback for each other.** **2. Identify community resources for the patient to be able to use.** **3. The patient to be able to verbalize their acceptance of their responsibility.**

3. Ineffective Individual Copingas evidenced by client's inability to perceive personal relevance of symptoms to current drug use.	**I chose this diagnosis because the client refuses to take responsibly for the situation he is in and blames it on his wife.**	**1. encourage client to look at current situation and factors leading up to current treatment.** **2. Help client to reflect on past decisions made under the influence** **3. Allow client time to process decisions made while under the influence.**	**1. Do not allow the client to blame others or circumstances beyond the client's control.** **2. Use redirection to help client to recognize his own issues.** **3. Help client to recognize current situation in correlation to cocaine use.**	**1. encourage client to attend group sessions.** **2. Have client evaluated for depression.** **3. Allow client to seek therapy.**

Other References (APA):

Phelps, L. L., Ralph, S. S., & Taylor, C. M. (2017). ***Sparks and Taylor's Nursing Diagnosis Reference Manual*** **(10th ed.). Wolters Kluwer.**

Concept Map (20 Points):

Subjective Data

Client feels he has his drug use under control.

Nursing Diagnosis/Outcomes

1. Ineffective denial related to drug use as evidence by patient believing that his use of cocaine is under control. (Phelps et al., 2017).
Client needs to accept that he has a problem.

2.Altered Family Processes/Role Performance as evidenced by client's ineffective spousal communication and marital problems.
Client needs to work on drug related issues to maintain contact with son.

3. Ineffective Individual Coping evidenced by client's inability to perceive personal relevance of symptoms to current drug use.
Help client develop coping skills.

Objective Data

Client appears to be in denial of current situation. Client tested positive for cocaine and alcohol at the time of the arrest.

Patient Information

29-year-old white male that weighs 170lbs and is 5'11". He is a full code and was admitted on 10-19-2021. Patient has no known history. Patient lives with wife and two children. Patient is currently unemployed but was a brick layer.

Nursing Interventions

1. encourage client to attend group sessions.
2. Have client evaluated for depression.
3. Allow client to seek therapy.
4. Identify community resources for the patient to be able to use.