

N323 Care Plan

Lakeview College of Nursing

Name: Byron Grant

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Demographics (3 points)

Date of Admission 11/7/21	Patient Initials M.D	Age 43 years old	Gender Male
Race/Ethnicity White	Occupation Warehouse worker	Marital Status Single	Allergies None noted
Code Status Full code	Observation Status Observable	Height 5'7	Weight 146

Medical History (5 Points)

Past Medical History: Chronic back pain

Significant Psychiatric History: Hospitalized on multiple occasions, received outpatient treatment and has a history of suicide attempts

Family History: Mother side has a history of depression

Social History (tobacco/alcohol/drugs): Does Not smoke tobacco, does not drink alcohol, has an addiction to opioids.

Living Situation: Patient lives alone.

Strengths: Sense of humor, Patient is determined and does not give up.

Support System: Patient he does not have any support system.

Admission Assessment

Chief Complaint (2 points): Suicidal/depression/Opioid withdrawal

Contributing Factors (10 points):

Factors that lead to admission: Patient has relapsed on heroin and also stated that he uses cocaine. Stated the death of his friend and his substance use issues as the major stressors. Patient has no coping skills and has been using drugs since the age of twelve. Patient mood was sad and has trouble going to sleep.

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History of suicide attempts: Patient has attempted suicide three times

Primary Diagnosis on Admission (2 points): Admitted for worsening symptoms of depression and suicidal thoughts.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience:				
Witness of trauma/abuse: Patient stated he seen his best friend get killed recently				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	none	5 years old	None	Father and uncle beat on him to make him tougher
Sexual Abuse	None	None	None	None
Emotional Abuse	None	5 years old	None	Father was a war veteran who did not show any

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				feelings.
Neglect	None	10 years old	None	Mother worked multiple jobs.
Exploitation	None	None	None	None
Crime	None	20 years old	None	Patient did 4 years in prison for armed robbery.
Military	None	18 years old	None	Patient got a dishonorable discharge.
Natural Disaster	None	None	None	None
Loss	Lost a close friend.	43 years old	None	Watch a murder take place of his close friend
Other				
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	Patient has been distant for the past three days. Patient says it	

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			has been a 7 on a 1-10 scale. Patient believes it is due to withdrawals.
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	Patient says he has lost 3-4 hours of sleep since being in the program.
Difficulty falling asleep	Yes	No	Patient cannot fall asleep due to withdrawals
Frequently awakening during night	Yes	No	Patients believe this is due to withdrawals.
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?	Yes	No	
Amount of weight change:			

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Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patients pace in a room every night.
Panic attacks	Yes	No	Patients says he has panic attacks 3x a week
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	Patient socially isolates from people in the facility, carries guns outside of the program.
Rating Scale			
How would you rate your depression on a scale of 1-10?	3		
How would you rate your anxiety on a scale of 1-10?	6		
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	
School	Yes	No	
Family	Yes	No	Patient says his mother is sick.
Legal	Yes	No	Patient has court date on the 29th regarding a case
Social	Yes	No	
Financial	Yes	No	

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Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/Outcome
2014	Inpatient Outpatient Other: Hopes for change/ Unity point	Inpatient	opioids	No improvement Some improvement Significant improvement
	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
	Inpatient Outpatient Other:			No improvement Some improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
N/A			Yes	No
N/A			Yes	No
N/A			Yes	No

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N/A			Yes	No
N/A			Yes	No
If yes to any substance use, explain:				
Children (age and gender): 26 year old daughter, 6 year old boy				
Who are children with now? The 26 year old daughter is independent, and the 6 year old boy is with his grandmother.				
Household dysfunction, including separation/divorce/death/incarceration: Never married				
Current relationship problems: None, Patient is single				
Number of marriages:0				
Sexual Orientation: Straight	Is client sexually active? Yes No		Does client practice safe sex? Yes No	
Please describe your religious values, beliefs, spirituality and/or preference:				
Chirstian				
Ethnic/cultural factors/traditions/current activity: None				
Describe:				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient has a pending case for domestic abuse, claims he did not hit her.				
How can your family/support system participate in your treatment and care?				
Patient said his family does not know he is in the program.				
Client raised by: Mother and older siblings Natural parents Grandparents Adoptive parents Foster parents Other (describe):				
Significant childhood issues impacting current illness: None				

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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.) Depression on the mother's side of the family.
History of Substance Use: Patients is addicted to opioids.
Education History: Grade school High school College Other:
Reading Skills: Yes No Limited
Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: Become sober before hitting the streets
Where will the client go when discharged? Patients want to go to a halfway house in

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champaign instead of going back to peoria.

Outpatient Resources (15 points)

Resource	Rationale
1. Suicide Hotline	1. Patient has tried to commit suicide three different times.
2. Terrapin station sober living	2. Patient wants to stay in champaign and get into a halfway house to help with addiction.
3. Drug prevention meetings	3. To help patient not relapse.

Current Medications (10 points)***Complete all of your client's psychiatric medications***

Brand/Generic	Trazodone (Desyre)	Habitrol (Nicotine)	venlafaxine (Effexor)	Calcium carbonate	Hydroxyzone (Vistaril)
Dose	50 mg	21 mg	37.5 mg	500 mg	50 mg
Frequency	daily	Every 24 hours	Daily	daily	Every 8 hours
Route	oral	Patch	Oral	oral	oral
Classification	Antidepressant	Cholinergic	SNRI	inorganic salt	antihistamines

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Mechanism of Action	Low dose trazodone use exerts a sedative effect for sleep through	Nicotine is released from the patches and absorbed through the skin	increasing serotonin levels, norepinephrine, and dopamine in the brain by blocking transport problems.	acts by directly increasing calcium stores within the body.	is a potent and selective histamine H1 receptor inverse agonist
Therapeutic Uses	Treat depression	Nicotine treatment.	Treat depression	GI relief	relieves itching
Therapeutic Range (if applicable)	50 mg-100mg	N/A	400-1500 nmol/L	N/A	50-100mg
Reason Client Taking	depression	Nicotine addiction	depression	upset stomach	itching
Contraindications (2)	Low amount of sodium in the blood. Low amount of potassium in the blood.	Overactive thyroid gland. Type 1 diabetes.	Suicidal ideation, worsening depression	Hypersensitivity. High calcium levels in the urine	Low amount of magnesium in the blood, Heart attack
Side Effects/Adverse Reactions (2)	Headache Nausea	Mild itching redness, burning.	headaches, dizziness	Stomach pain constipation	Dizziness, Drowsiness
Medication/Food Interactions	Do not take grapefruit juice, MAOIs inhibitors	Beta blockers bronchodilators.	MAOIs NSAIDs	Do not take 1- 2 hours with other medications	Lexapro lisinopril.
Nursing Considerations (2)	Assess dizziness and drowsiness.	concurrent smoking, use of other nicotine products.	Watch for heart rate can increase	Assess what the patient is taking do not continue beyond one week or two.	Monitor respiratory problems increased anxiety

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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 & Bartless Learning. (2019). 2019 Nurse's drug handbook (18th ed.). Burlington, MA.

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Patient appeared to be in a normal state of mind. Build:Skinny Attitude: Good attitude Speech: Normal speech Interpersonal style:Assertive Mood: Happy/thankful Affect:</p>	
<p>MAIN THOUGHT CONTENT: Ideations: None Delusions: None Illusions: None Obsessions: None Compulsions: None Phobias: has a phobia of needles</p>	
<p>ORIENTATION: Sensorium: Patient can think clearly Thought Content: Normal</p>	
<p>MEMORY: Remote: Patient can recall memories from early childhood till now.</p>	
<p>REASONING: Judgment: Patient had good judgement, chose to be in program Calculations: Normal Intelligence:Normal Abstraction: None Impulse Control:Normal</p>	
<p>INSIGHT: Good</p>	

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GAIT: Assistive Devices: None Posture: Normal Muscle Tone: Built Strength: Normal Motor Movements: Normal	
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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	87bpm	125/82	14	96 F	99
1730	89bpm	122/77	12	96.4 F	98

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1500	0	N/A	N/A	N/A	N/A
1530	0	N/A	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed:100 % Breakfast: Lunch: Dinner: Chicken sandwich, sweet potato fries	Oral Fluid Intake with Meals (in mL) 240 ml Breakfast: Lunch: Dinner: 240 mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

I want the patient to go into a halfway house after completing rehab to help with his addiction on the streets. I want him to get back to his job and slowly progress while in the world.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> ● Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> ● Explain why the nursing diagnosis was chosen 	<p>Immediate Interventions (At admission)</p>	<p>Intermediate Interventions (During hospitalization)</p>	<p>Community Interventions (Prior to discharge)</p>
<p>1. Ineffective coping related to situational crisis evidenced by relapse</p>	<p>Patient relapsed after a event took place</p>	<p>1. Assess clients level of anxiety</p> <p>2. investigate the type of situations that increase anxiety</p> <p>3 Assess ritualistic behaviors</p>	<p>1. Initially meet the client dependency needs as necessary</p> <p>2. Gradually limit the amount of time allotted for ritualistic behavior</p> <p>3. provide positive</p>	<p>1. Teach patient different coping methods</p> <p>2. Give patient outpatient options to seek for help</p> <p>3. Support and encourage</p>

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			reinforcement for non ritualistic behaviors	clients efforts to explore the meaning and purpose of behavior .
2. Anxiety related to situational crisis evidenced by pacing		1. Support the client's defense initially 2. Maintain calmness in your approach to the client 3. Move the client to a quiet area with minimal stimuli.	1. Provide reassurance and comfort measures. 2. Stay with patients during panic episodes. 3. Avoid asking or forcing the client to make choices.	1. Teach signs and symptoms of escalating anxiety 2. Encourage the patient to participate in relaxation exercises such as deep breathing. 3. Help the client see that mild anxiety can be a positive catalyst for change.
3. Social isolation related to past experiences of difficulty in interaction with others evidenced by withdrawal.		1. Show unconditional positive regard 2. Maintain a calm non threatening manner while working with the client 3. Be cautious with touch.	1. Be with the client to offer support during group activities that may be frightening or difficult for him or her. 2. Convey an accepting and positive attitude 3. Be honest and keep all promises	1. Teach patient the signs of being withdrawn 2. Give patient outpatients options 3. encourage patient to do group activities

Other References (APA):

Concept Map (20 Points):

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Subjective Data

Patient stated “ seen bestfriend shot up close in the head and got his brain matter” “ That made me relapse after six years.

Nursing Diagnosis/Outcomes

Ineffective coping
related to situational crisis
evidenced by relapse

Anxiety related to
situational crisis
evidenced by pacing

Social isolation
related to past experiences
of difficulty in interaction
with others evidenced by
withdrawn.

Nursing Interventions

Assess clients level of anxiety

investigate the type of situations
that increase anxiety

Assess ritualistic behaviors
Support the client's defense
initially

Maintain calmness in your
approach to the client

Move the client to a quiet area
with minimal stimuli.

Show unconditional positive
regard

Maintain a calm non threatening
manner while working with the
client

Objective Data

Patient was brought in for suicidal
ideations and opioid addiction.

Patient Information

Patient initials are M.D, patient is
a white male 43 years old, Patient
is 5,7 and 146 pounds.



