N323 Care Plan

Lakeview College of Nursing

Rebekah Moutria

Demographics (3 points)

Date of Admission 3/11/2022	**Patient Initials** J.A.	**Age** 22years	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Carpenter	**Marital Status** Single	**Allergies** NKA
Code Status Full code	**Observation Status** A & O x4	**Height** 6’4	**Weight** 180lbs

Medical History (5 Points)

Past Medical History: Diagnosed with PTSD, Bipolar disorder, generalized anxiety, clinical depression, facial reconstructive surgery after dog attack

Significant Psychiatric History: Diagnosed with PTSD, Bipolar Disorder, Generalized anxiety, clinical depression

Family History: Mother has a history of drug and alcohol abuse, depression, and anxiety. Maternal grandmother has a history of depression.

Social History (tobacco/alcohol/drugs): The patient denies the use of alcohol. The patient smokes half a pack of cigarettes daily. Prior to admission, the patient used heroin and methamphetamine multiple times per day.

Living Situation: The patient is homeless.

Strengths: The patient is goal-oriented, cooperative, and motivated to participate in treatment.

Support System: The patient has a good support system through his treatment program. The patient also has a strong relationship with his mother.

Admission Assessment

Chief Complaint (2 points): The patient presented to the mental health facility with opioid addiction.

Contributing Factors (10 points):

Factors that lead to admission:

The patient has a history of many childhood traumas. At the age of four, the patient witnessed his stepfather commit suicide in front of him. He was very close with his stepfather and struggled with the loss. At the age of ten, the patient was brutally attacked by a rottweiler. He needed facial reconstructive surgery which allowed him the opportunity to take many pain killers. The patient stated, “I remember banging my head against the wall and feeling no pain. It was the best kind of high and gave me a warm feeling inside that I can never forget.”. The patient endured neglect and abuse from his mother throughout his early childhood. His mother was an active heroin addict and used drugs in front of him many times. The patient stated many times he would not eat, and they would have no electricity due to his mother buying drugs instead. At the age of fourteen, the patient was emancipated and became homeless. He turned to selling drugs and robbing people for money. He was homeless or living in hotels and became heavily addicted to heroin and methamphetamines.

History of suicide attempts: The patient had one suicidal attempt at the age of 18. The patient was unsure of the exact date and did not want to specify how he attempted suicide.

Primary Diagnosis on Admission (2 points): Opioid-use disorder

Psychosocial Assessment (30 points)

History of Trauma
No lifetime experience: History of childhood abuse, neglect, and severe dog attack.

Witness of trauma/abuse: The patient witnessed drug abuse as a child.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	No	No	No	N/A
Sexual Abuse	No	No	No	N/A
Emotional Abuse	No	Yes, age 4-14		The patient was emotionally abused by his mother throughout his childhood.
Neglect	No	Yes, age 4-14		The patient was neglected by his mother.
Exploitation	No	No	No	N/A
Crime	No	Yes, age 15-21	No	The patient did not want to disclose.
Military	No	No	No	N/A
Natural Disaster	No	No	No	N/A
Loss	No	Yes, age 4-10	No	The patient lost his stepfather at the age of four. Both patients' grandfathers died of cancer when he was in elementary school.
Other	No	No	No	N/A

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 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 night	**Yes**	**No**	
Early morning awakenings	**Yes**	**No**	The patient states, “I wake up every morning at 6 am.”
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**	
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?	1		
How would you rate your anxiety on a scale of 1-10?	1		
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**	
Legal	**Yes**	**No**	
Social	**Yes**	**No**	
Financial	**Yes**	**No**	The patient is currently not working and is homeless. Due to him stopping his criminal activity, he has no income.
Other	**Yes**	**No**	

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/ MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
September 13th, 2021-January 2022	**Facility:** Central East Alcoholism & Drug Council	Outpatient	Addiction to opioids, heroin, and methamphetamines	**No improvement** **Some improvement-** Allowed the patient to learn better coping skills **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?**	
The patient is homeless.	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**

If yes to any substance use, explain: Before treatment, the patient was a heroin and methamphetamines addict. Currently, the patient is clean.

Children (age and gender): The patient does not have any children.

Who are children with now? N/A

Household dysfunction, including separation/divorce/death/incarceration: No

Current relationship problems: None stated

Number of marriages: 0

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Heterosexual	**Yes** **No**	**Yes** **No**

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

The patient states he grew up a non-denominational Christian but is converting to Islamic religious traditions.

Ethnic/cultural factors/traditions/current activity: None stated

Describe: N/A

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient stated, “I was heavily involved in criminal activity, but I do not want to go into details.”.

How can your family/support system participate in your treatment and care?

The patient stated, “My support system can participate in my treatment by caring for me and listening when I need someone”.

Client raised by:

Natural parents- Mother until age 14
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness: The patient stated, “My mother is an addict had the biggest impact on my addiction. I never knew anything different. I would watch her shoot up next to me in bed when I was in grade school. Being high was the only way I could survive.”.
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.) Mother and maternal grandmother have a history of depression.
History of Substance Use: Tobacco, Narcotics, Methamphetamines
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: The patient stated, “I was bullied a lot throughout elementary school.”
Discharge

Client goals for treatment: The patient states, “I want to get clean and become a better person”.
Where will client go when discharged? The patient stated, “I will go to a halfway house upon discharge.”

Outpatient Resources (15 points)

Resource	Rationale
1. Narcotics Anonymous	**1.** To help with his narcotics addiction and withdrawal symptoms
2. Psychotherapy	**2.** Aid the patient in recovering, practicing coping skills, recognizing triggers, overcoming addiction, and expressing emotions with the help of professionals
3. Central East Alcoholism & Drug Council	**3.** Provide structure and support while living in their own environment

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

Brand/ Generic	Duloxetine/ Cymbalta	Buspirone hydrochloride/ Bustab	Zofran/ Ondansetron	Seroquel/ Quetiapine fumarate	Vistaril/ hydroxyzine pamoate
Dose	20mg	8 mg	4mg	400 mg	25mg
Frequency	BID	BID	PRN	Q1900	BID
Route	PO	PO	Sublingual	PO	PO
Classification	Selective serotonin/norepinephrine reuptake inhibitor (Jones, 2021).	Azaspirone/ Anxiolytic (Jones, 2021).	Selective serotonin receptor antagonist (Jones, 2021)	Dibenzothiazepine derivative/ antipsychotic (Jones, 2021).	Piperazine derivative (Jones, 2021).
Mechanism of Action	Inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrenergic and serotonergic activity in the CNS (Jones, 2021)	May act as a partial agonist at serotonin 5-hydroxytryptamine receptors in the brain, producing anti-anxiety effects (Jones, 2021).	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine (Jones, 2021)	Interferes with dopamine binding to dopamine type 2 receptor sites in the brain by antagonizing serotonin 5-HT 2 and dopamine type 1 (Jones, 2021).	Competes with histamine for histamine receptor sites on surfaces of effector cells (Jones, 2021).
Therapeutic Uses	Antidepressant, neuropathic and musculoskeletal pain reliever (Jones, 2021)	Anxiolytic (Jones, 2021).	Antiemetic (Jones, 2021).	Antipsychotic (Jones,2021).	Anxiolytic, antihistamine (Jones, 2021)
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Depression	Anxiety	Nausea and vomiting related to withdrawal	Depressive episodes of bipolar disorder	Anxiety

			symptoms		
Contraindications (2)	Cirrhosis, hypersensitivity to duloxetine (Jones, 2021).	Hypersensitivity to buspirone or its components, severe hepatic, or renal impairment (Jones, 2021).	Concomitant use of apomorphine, hypersensitivity to ondansetron or its components (Jones, 2021)	Hypersensitivity to quetiapine or its components, low thyroid hormone levels (Jones, 2021).	Hypersensitivity to hydroxyzine or its components, prolonged QT interval (Jones, 2021).
Side Effects/Adverse Reactions (2)	Abnormal dreams, aggression, seizures, syncope, hot flashes, headaches, insomnia, chills, anxiety (Jones, 2021).	Insomnia, nausea, vomiting, tremors, drowsiness (Jones, 2021).	Agitation, syncope, arrhythmias, hypotension, thirst, weakness, dizziness (Jones, 2021)	Dry mouth, hyperglycemia, muscle weakness, cough, dizziness (Jones, 2021).	Drowsiness, dry mouth, seizures, headache, pruritis, rash (Jones, 2021).
Medication/Food Interactions	Avoid the use of alcohol while taking this drug. Avoid drugs such as NSAIDs, warfarin, fentanyl, linezolid, SSRIs, and triptans (Jones, 2021).	Avoid grapefruit juice. Avoid CYP3A4 inducers, CYP3A4 inhibitors, haloperidol, and MAO inhibitors (Jones, 2021).	Avoid 5-HT3 receptor antagonists, SSRIs, and tramadol (Jones, 2021).	Avoid the use of antihypertensives, dopamine agonists, CNS depressants, and CYP3A4 inhibitors (Jones, 2021).	Avoid the use of alcohol. Avoid other drugs such as class 1A antiarrhythmics (Jones, 2021).
Nursing Considerations (2)	Obtain the patient's baseline blood pressure before duloxetine therapy starts and assess for changes. Watch closely	Institute safety precautions due to possible CNS adverse reactions. Use buspirone cautiously in	Monitor the patient closely for signs and symptoms of hypersensitivity to ondansetron. Know that if hypokalemia or	Know that this drug should not be given to patients with a history of cardiac arrhythmias. Monitor patients	Do not give hydroxyzine by subcutaneous or IV route due to possible tissue necrosis. Use cautiously in patients with bradyarrhyth

	for evidence of suicidal thinking or behavior after drug therapy starts (Jones, 2021).	patients with hepatic or renal impairment (Jones, 2021).	hypomagnesemia are present, do not administer this drug until electrolyte imbalances are corrected (Jones, 2021).	closely for suicidal tendencies after the start of drug therapy (Jones, 2021).	mias, congenital, or family history of QT syndrome (Jones, 2021)

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

(2)					

Medications Reference (1) (APA):

Jones, D.W. (2021). *Nurse's drug handbook.* (A. Bartlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Appropriate and cooperative Stable, relaxed, good eye contact Thin build Focused Clear and intelligible Expressive, talkative, engaged, cooperative, oriented Calm Happy, pleasant
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	 None None None None None None
ORIENTATION: **Sensorium:** **Thought Content:**	A&Ox4 N/A Intact, logical, goal-directed, organized
MEMORY: **Remote:**	Intact, immediate recall of what the client had for breakfast and lunch
REASONING:	

Judgment: **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Good judgment N/A The patient appeared to be highly intelligent Abstraction was normal for age Average
INSIGHT:	Insight was fair. The patient is highly motivated to change his life. The patient is motivated to avoid drugs and alcohol following treatment at the pavilion.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	 None Upright, normal for age Average, normal for age Average, normal for age Strong, normal for age

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	87bpm	126/82mmhg	18/min	97.2 F (T)	96% RA
1600	78bpm	122/76mmhg	18/min	97.4 F (T)	97% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1630	Numeric	N/A	0	N/A	N/A
1715	Numeric	N/A	0	N/A	N/A

Dietary Data (2 points)

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

Breakfast: 100% **Lunch:** 100% **Dinner:** Dinner was after the time of the interview	270 mL total **Breakfast:** 180 mL of coffee **Lunch:** 90 mL of root beer **Dinner:** Dinner was after the time of the interview

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Following discharge, the patient will go to a recovery house in Charleston, IL. The patient's home health care needs would include being compliant with all medications to improve symptoms, taking away any possible triggers from the environment, staying active daily with exercises like walking or jogging, focusing on hobbies he enjoys such as music and writing, and eating a balanced diet. The patient will benefit by having a journal to write in daily. The patient's follow-up plans include attending his weekly assigned outpatient counseling services, staying in contact with supportive members of his recovery family and his mother, and an emergency response phone number to call for assistance during temptations. The patient should also maintain his treatment through Narcotics Anonymous and attend all needed psychiatric appointments for maintenance of his medications for his bipolar disorder, depression, PTSD, and anxiety. The patient will need education on triggers for his addiction and how to overcome them. He will also need to be educated on the importance of taking his medications for his mental illnesses. Education on the importance of attending therapy, maintaining his doctor appointments, and implementing a consistent routine at home will benefit this patient as well.

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. Risk for injury related to withdrawal as evidenced by "I felt very dizzy and shaky after I stopped the drugs".	This nursing diagnosis was chosen since the patient was suffering withdrawal symptoms from the drugs which put him at a safety risk.	1. Assess for changes in health status and cognitive awareness. 2. Assess the client's ability to ambulate and identify the risk for falls. 3. Review the client's medication regimen for possible side effects and potential interactions that may increase the risk of injury.	1. Put away all possible hazards in the room. 2. Be alert for signs of increasing fear, anxiety, or agitation. 3. Allow the patient to take scheduled smoking breaks to aid in the recovery process.	1. Validate the patient's feelings and concerns related to environmental risks. 2. Educate the patient on the signs and symptoms of opioid withdrawal. 3. Encourage participation in a Narcotics Anonymous group.
2. Risk for anxiety related to stressors as evidenced by "I am	The diagnosis was chosen because there will be many stressors the patient will face following	1. Establish a trusting relationship with patient. 2. Encourage the patient to	1. Maintain a matter-of-fact attitude during care. 2. Provide information about	1. Reinforce prior information the client has been given. 2. Demonstrate

worried I won't be able to find a job.".	discharge and the history of anxiety the patient struggles with.	verbalize concerns. 3. Verbalize accurate knowledge of the situation.	specific rules and regulations on the unit. 3. Be available to the patient.	problem-solving skills. 3. Encourage the use of resources and support systems.
3. Ineffective coping related to the inadequate support system as evidenced by "I only have my mother and my recovery family to support me".	This nursing diagnosis was chosen because the patient does not have a big support system throughout his recovery journey.	1. Use active listening when interacting with the patient so they feel heard 2. Establish a trusting relationship with patient. 3. Conduct a suicidal assessment to identify potential suicidal risk	1. Be alert for signs of increasing fear, anxiety, or agitation. 2. Maintain a calm, non-threatening manner while assisting the patient 3. Spend quiet and intentional time with the patient.	1. Observe the patient for signs of depression, anxiety, or paranoid behaviors 2. Encourage the use of outpatient services such as group therapy 3. Provide outlets that promote feelings of personal achievement and self-esteem

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient felt determined to act against his opioid addiction.
The patient was worried that if he did not seek help, he would not survive another year.
He stated he was ready to change and better his life for his future.

Nursing Diagnosis/ Outcomes

1. Risk for injury related to withdrawal as evidenced by "I felt very dizzy and shaky after I stopped the drugs".
Goal met: The patient responded well to the invention because he felt his safety was being put first and that he would be able to get his health back on track.

2. Risk for anxiety related to stressors as evidenced by "I am worried I won't be able to find a job.".
Goal met: The patient responded well to the invention and felt that he could openly communicate with his healthcare team.

3. Ineffective coping related to the inadequate support system as evidenced by "I only have my mother and my recovery family to support me".
Goal met: The patient responded well to the invention and felt he could utilize new coping and communication strategies to improve his relationship with himself and with others.

Objective Data

Vital Signs: P: 87, B/P: 126/82, R: 18, T: 97.2 (T), O: 96%, Pain: 0/10

P: 78, B/P: 122/76, R: 18, T: 97.4 F (T), O: 97%, Pain: 0/10

I&O: Percentage of meal consumed for breakfast and lunch = 100% consumed.

Patient Information

22-year-old Caucasian male presented to the mental health facility with opioid addiction. The patient's health history includes bipolar disorder, PTSD, anxiety, and depression. The patient also endured facial reconstructive surgery as a child after a severe dog attack.

Nursing Interventions

Immediate Interventions (At admission)
1. Assess for changes in health status and cognitive awareness.

2. Assess the client's ability to ambulate and identify the risk for falls.

3. Review the client's medication regimen for possible side effects and potential interactions that may increase the risk of injury.
1. Establish a trusting relationship with patient.

2. Encourage the patient to verbalize concerns.

3. Verbalize accurate knowledge of the situation.
1. Use active listening when interacting with the patient so they feel heard

2. Establish a trusting relationship with patient.

3. Conduct a suicidal assessment to identify potential suicidal risk