

N323 Care Plan
Lakeview College of Nursing
Tyrika Walls

Demographics (3 points)

Date of Admission 3.28.22	Patient Initials M.E.	Age 63	Gender Male
Race/Ethnicity African American	Occupation Unemployed	Marital Status Divorced	Allergies None
Code Status Full Code	Observation Status N/A	Height 5'8"	Weight 145lbs.

Medical History (5 Points)

Past Medical History: Hypertension, Substance Abuse (Crack Cocaine), CHF

Significant Psychiatric History: The client states he consulted a psychiatrist in the past but has not been hospitalized.

Family History: Substance Abuse, Hypertension, and Diabetes Mellitus

Social History (tobacco/alcohol/drugs):

Living Situation: The client lives home alone

Strengths: The clients is very friendly and has a good sense of humor, he is also pleasant and very cooperative.

Support System: Ex-wife and adult children

Admission Assessment

Chief Complaint (2 points): The patient states, "I need to stop using drugs."

Contributing Factors (10 points): The patient states being around family and friends who are all substance abusers is a contributing factor in his choice to use illegal drugs. The patient is a very family oriented man who loves to spend time with family. The client cannot think of a time when family events and gathers did not include the use of alcohol or illegal substances. Although the patient has tried to seek treatment for his addiction, he is typically heavily influenced by friends and family after discharge from his treatment programs. Client also states that he is

unable to manage his stress without the use of cocaine, he feels he know the right way to cope but his temptations are stronger and he ends up relapsing.

Factors that lead to admission: Environment including family and friends who are mostly substance users. Stress and anxiety.

History of suicide attempts: None

Primary Diagnosis on Admission (2 points): Severe cocaine use disorder

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: The patient states he does not have any past trauma or abuse experience.</p> <p>Witness of trauma/abuse: The patient denies any past trauma or abuse</p>				
	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	N/A	N/A	N/A
Emotional Abuse	N/A	N/A	N/A	N/A

Neglect	N/A	N/A	N/A	N/A
Exploitation	N/A	N/A	N/A	N/A
Crime	N/A	N/A	N/A	N/A
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	N/A	N/A	N/A	N/A
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	N/A	
Loss of energy or interest in activities/school	Yes	No	The client states for the past couple of months, he has had very little interests and loss of energy for activities he use to enjoy. Client states this occurs when he feels guilty about his substance abuse.	
Deterioration in hygiene and/or grooming	Yes	No	N/A	
Social withdrawal or isolation	Yes	No	N/A	
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	The client states he has had difficulties with home, work, and his relationships. Because of his	

			long time drug use the client feels the difficulties began many years ago and has gone unresolved. He states he can't keep a job due to his addiction, his marriage failed, and his relationship with his son is estranged.
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	N/A
Difficulty falling asleep	Yes	No	N/A
Frequently awakening during night	Yes	No	N/A
Early morning awakenings	Yes	No	N/A
Nightmares/dreams	Yes	No	N/A
Other	Yes	No	N/A
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	N/A
Binge eating and/or purging	Yes	No	N/A
Unexplained weight loss?	Yes	No	N/A
Amount of weight change:			
Use of laxatives or excessive exercise	Yes	No	N/A
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)

Anxiety behaviors (pacing, tremors, etc.)	Yes	No	N/A
Panic attacks	Yes	No	N/A
Obsessive/compulsive thoughts	Yes	No	N/A
Obsessive/compulsive behaviors	Yes	No	N/A
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	N/A
Rating Scale			
How would you rate your depression on a scale of 1-10?	3/10		
How would you rate your anxiety on a scale of 1-10?	1/10		
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	N/A
School	Yes	No	N/A
Family	Yes	No	The patient's relation with his family has been rocky over the past 40 years because of his substance abuse. The client states that while he is in recovery he would like to mend some relationships with family including his son.
Legal	Yes	No	N/A
Social	Yes	No	N/A

Financial	Yes	No	The client states his daughter handle all of his income. The patient admits to using his fixed income to buy drugs and neglect his responsibility of paying rent and other cost of living.
Other	Yes	No	N/A

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient

Dates	Facility/MD/Therapist	Inpatient/Outpatient	Reason for Treatment	Response/Outcome
03/38/2022 to present	Inpatient N/A Outpatient N/A Other:	Inpatient	Substance Abuse	No improvement Some improvement Significant improvement
2005	Inpatient N/A Outpatient N/A Other:	Inpatient	Substance Abuse	No improvement Some improvement Significant improvement
1997	Inpatient N/A Outpatient N/A	Inpatient	Substance Abuse	No improvement Some

	Other:			improvement Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
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
N/A	N/A	N/A	Yes	No
If yes to any substance use, explain: N/A				
Children (age and gender): Daughter (42 years old), Son (43 years old)				
Who are children with now? The children are both grown adults, they each live on their own with their children and significant others.				
Household dysfunction, including separation/divorce/death/incarceration:				
Current relationship problems: The patient states he usually date women who are also substance abusers.				
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: The patient states he believes in a higher power but does not conform to any specific religious beliefs.				
Ethnic/cultural factors/traditions/current activity: N/A				
Describe: N/A				

<p>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The patient is divorced, but still maintains a friendship with his ex-wife. The client also admits to several arrests relating to his drug addiction. The client is not currently on parole or probation.</p>
<p>How can your family/support system participate in your treatment and care? The patient states, “My family can support me by attending NA meetings with me and not using drugs around me.”</p>
<p>Client raised by: The patient was raised by both mom and father, he states both parents held good paying jobs and he lived in a nice community.</p> <p>Natural parents Grandparents Adoptive parents Foster parents Other (describe):</p>
<p>Significant childhood issues impacting current illness: The patient denies any impacting issues that are significant to his current drug addiction..</p>
<p>Atmosphere of childhood home: Client states his home was filled with love and hardworking parents.</p> <p>Loving Comfortable Chaotic Abusive Supportive Other:</p>
<p>Self-Care: The client is fully capable of self care, however, he does admit to his daughter controlling his finances so that he would not spend everything on women and drugs.</p> <p>Independent Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</p>

<p>The client denies mental health issues within his family history. He has consulted a psychiatrist in the past but has never been diagnosed with a mental illness.</p>	
<p>History of Substance Use: The client states he’s been abusing substances for over 40 years, he states his alcohol consumption started at a very young age when he would drink with family during celebration, events, and holiday gatherings.</p>	
<p>Education History: The client openly admits to being “passed” along during elementary and high school. Client does have a high school diploma.</p> <p>Grade school High school College Other:</p>	
<p>Reading Skills: The client stats his reading ability is very limited, he never really got help with his reading skills during his time in school.</p> <p>Yes No Limited</p>	
<p>Primary Language: English</p>	
<p>Problems in school: N/A</p>	
<p>Discharge</p>	
<p>Client goals for treatment: The patient would like to complete 60 days of inpatient treatment without leaving any sooner. He would also like to gain healthy coping skills to manage stressful situations.</p>	
<p>Where will client go when discharged? The client will discharge to a halfway house.</p>	

Outpatient Resources (15 points)

Resource	Rationale
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<p>1. Narcotics Anonymous</p>	<p>1. As a recovering addict, the patient will need a very strong and supportive circle to help him cope with daily life without using drugs. NA can help the patient find healthy friendships with likeminded people. The patient can also find a sponsor within the NA meetings to help him progress in his journey.</p>
<p>2. Safe House (halfway house)</p>	<p>2. The patient states he has in the past completed a treatment program, discharged to family and friends home, where he would be immediately tempted to indulge in substance abuse. The client would need a safe, clean, drug free environment such as the safe house to help continue his sober journey without influence and temptations within his home.</p>
<p>3. Community center for job placement</p>	<p>3. The patient often talks about his time as a Chef, he loved his occupation and would love the opportunity to work as a cook or in a dining establishment. Assisting the client with job placement will help keep him busy, focused, and he will be doing something he's good at and also loves.</p>

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

Brand/Generic	Fluoxetine / Prozac	N/A	N/A	N/A	N/A
Dose	10 mg	N/A	N/A	N/A	N/A
Frequency	Once Daily	N/A	N/A	N/A	N/A
Route	Oral	N/A	N/A	N/A	N/A
Classification	P: Selective serotonin reuptake inhibitor (SSRI) T: Antidepressant	N/A	N/A	N/A	N/A
Mechanism of Action	Selectively inhibits reuptake of the neurotransmitter serotonin by CNS neurons and increases the amount of serotonin available in the nerve synapses (Jones & Bartlett, 2022).	N/A	N/A	N/A	N/A
Therapeutic Uses	To treat acute depression (Jones & Bartlett, 2021).	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	To treat Depression	N/A	N/A	N/A	N/A
Contraindications (2)	Concurrent therapy with pimozide or thioridazine. Use of MAO inhibiting therapy within 14 days (Jones & Bartlett, 2021).	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	Suicidal Ideation and Hypoglycemia (Jones & Bartlett, 2021).	N/A	N/A	N/A	N/A
Medication/Food Interactions	NSAIDS (increased risk for GI bleed), Warfarin (increased risk of bleeding), MAO inhibitor, pimozide, thioridazine (Jones & Bartlett, 2021).	N/A	N/A	N/A	N/A
Nursing Considerations (2)	Monitor patient for possible serotonin syndrome characterized by agitation, chills, confusion, fever, poor coordination, and tremors. Monitor patient for evidence of GI bleed (Jones & Bartlett,	N/A	N/A	N/A	N/A

	2021).				
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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 (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

Jones & Bartlett Learning LLC. (2021). *Nurse’s drug handbook*. (12th edition).

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:</p>	<p>The patient is open and friendly, he has a police attitude and is very hopeful for a successful recovery. The clients pleasant mod helps uplift those around him and his speech is clear and easily understandable..</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:</p>	<p>The patient denies any ideations, hallucinations, delusions, illusions, and obsessions. Client states he has no phobias and no compulsions.</p>
<p>ORIENTATION: Sensorium: Thought Content:</p>	<p>.Normal and expected for the clients age and current situation.</p>
<p>MEMORY: Remote:</p>	<p>.Patient has no abnormal memory deficits. Memory is noted to be normal for client age and situation.</p>
<p>REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:</p>	<p>.The client has good judgement. He can identify right from wrong. The patient does not show any lack of impulse control, his intelligence level is expected for his level of education and age.</p>
<p>INSIGHT:</p>	<p>The client shows good insight.</p>
<p>GAIT: Assistive Devices: Posture: Muscle Tone: Strength:</p>	<p>The patient does not use any assistive devices to walk, sit, or stand. His posture is expected for a 63 year old man, with no abnormalities noted. The clients muscle tone and strength is normal</p>

Motor Movements:	for his age p, height, and weight. Otis movements are all present with no constrictions noted.
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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
10:00 am	67 bpm	135/77 RA	20 bpm	97.5 F Tympanic	97% Room Air
1:35 pm	65 bpm	159/70 RA	18 bpm	97.3 F tympanic	96% Room Air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
10:05 am	0-10	N/A	0/10	The client is not in any pain	N/A
1:25 pm	0-10	N/A	0/10	The client does not have any pain	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: 90% Breakfast: Pancakes and Sausages Lunch: Pizza Dinner: Beef and Noodle	Oral Fluid Intake with Meals (in mL) Breakfast: cup of coffee (300 ml) Lunch: Soda (240 ml), Cup of Water (360ml) Dinner: N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Discharge plans for the client would include moving into the SafeHouse program for a full year of recovery, the patient will establish work and a community outpatient NA support groups. The patient will also be set up with community centers to help him with transportation and food.

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>Risk for Acute substance abuse withdrawal syndrome related to crack cocaine addiction as evidenced by the patient admitting to using drugs for over 30 years.</p>	<p>The patient’s chronic drug use put him at risk for withdrawal syndrome while he is in treatment.</p>	<ol style="list-style-type: none"> 1. Assess the patient to establish a baseline set of vitals and mental status. 2. Use appropriate measures to ensure patient safety. 3. Establish a plan of care for the patient. 	<ol style="list-style-type: none"> 1. Provide non judgmental care to establish a trust relationship with the client. 2. Periodically assess the patient for signs of decline in mental status and health. 3. Encourage patient to attend group meetings. 	<ol style="list-style-type: none"> 1. Refer patient to a mental health specialist 2. Establish a primary physician for the patient healthcare needs. 3. Research local outpatient support groups and NA meetings.
<p>Ineffective coping</p>	<p>The patient is</p>	<p>1. Review</p>	<p>1. Explore</p>	<p>1. Assist</p>

<p>related to previous ineffective coping with use of illegal substances as evidenced by the patient stating, “I use crack cocaine when I feel stressed.”</p>	<p>a voluntary admit to the treatment facility, he is actively wanting to seek help for his drug addiction. The patient states he cannot deal with everyday stress and chooses to relieve his problems using drugs.</p>	<p>program policies, rules, and expectations. 2. Assess the patient’s vital signs, past medical history, and mental status. 3. Assist the patient with orientating to the unit.</p>	<p>alternative coping strategies 2. Encourage verbalization of feelings, fears, and anxiety. 3. Discuss patient’s plans for living without drugs.</p>	<p>patient with finding a local support group. 2. Assist patient with job placement 3. Assists the patient with finding a church home.</p>
<p>Dysfunctional family processes related to substance misuse as evidenced by the patient stating, “ All of my family use drugs, so when I’m around family I tend to use drugs.”</p>	<p>The patient states the majority of his family misuse substances. He states when he has gone through recovery in the past, he would relapse due to his environment of family and friends who use drugs or alcohol.</p>	<p>1. Asses the patient’s childhood for contributing factors to drug addiction. 2. Maintain a quiet, safe environment during withdrawal period. 3. Remove harmful items from the patient room.</p>	<p>1. Teach patient the use of guided imagery to help cope with stress and temptations. 2. Encourage patient to build the courage to talk to family members about their own drug use and how it affects his recovery. 3. Maintain a safe, open, non judgmental environment to promote comfort of the patient.</p>	<p>1. Encourage family members to attend NA and AA meetings with the patient. 2. Assist the patient in finding halfway housing to prevent the need of living with family. 3. Refer the patient to local community therapy program.</p>

Other References (APA):

Phelps, L. L. (2020). *Sparks and Taylor’s : Nursing diagnosis reference manual* (11th edition). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient states , “ I need to stop using drugs”.
The patient says he does not feel depressed with a rating of 1/10 on a scale of1-10. He does feel some anxiety and rates his anxiety a 3/10 on the 1-10 rating scale.
The client states he is in no current pain.

Nursing Diagnosis/Outcomes

Objective Data

The patient is clean and neatly dressed. His hygiene seems to be acceptable for the time of year and his current situation. The patient is cooperative and very welcoming. The client has been observed as being social amongst peers. The patient does have an elevated blood pressure of 159/74, all other vitals are within normal range.

Patient Information

63 year old male patient admitted to New Choice treatment center for severe cocaine use disorder. The client have a past medical history of HTN and CHF, he is not currently taking any medications for his medical diagnosis.

Nursing Interventions

- Assess the patient to establish a baseline set of vitals and mental status.
- 2. Use appropriate measures to ensure patient safety.

- 1.Review program policies, rules, and expectations.
- 2. Assist the patient with healthy and productive coping skills.

- Asses the patient’s childhood for contributing factors to drug addiction.
- Refer patient to outpatient resources for family therapy and NA groups.

