

N323 Care Plan
Lakeview College of Nursing
Cindy Ho

Demographics (3 points)

Date of Admission 6/5/2022	Patient Initials IS	Age 66	Gender M
Race/Ethnicity White	Occupation Unemployed	Marital Status Legally married	Allergies NKA
Code Status Did not see on chart	Observation Status None, ended 6/16	Height 175.3 cm	Weight 68 kg

Medical History (5 Points)

Past Medical History: History of mood swings and feeling down and depressed

Significant Psychiatric History: Major depressive disorder (MDD), severe with psychotic factors, general anxiety disorder, alcohol disorder, cocaine use disorder, insomnia, auditory hallucinations and paranoid delusions

Family History: Alcoholism, brother

Social History (tobacco/alcohol/drugs): Alcohol and crack cocaine

Living Situation: Eviction from apartment due to breaking lease agreement for having a pet cat

Strengths: Longest period of sobriety: 3 weeks

Support System: None. Does not like to involve daughter who just had a baby.

Admission Assessment

Chief Complaint (2 points): Suicidality, Substance abuse

Contributing Factors (10 points):

Factors that lead to admission: Eviction and suicide attempt by drinking 1/5 of alcohol and a large amount of cocaine, loneliness

History of suicide attempts: Previous suicide attempt 30 years prior

Primary Diagnosis on Admission (2 points): Major depressive disorder

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: One of 19 children. It was not a bad childhood but not great either. Being in the middle of 19 children, he did not have much fun when his older siblings were old enough to leave the home and he was charged with helping care for the younger siblings.</p> <p>Witness of trauma/abuse: Witnessed father beating younger brother a tree branch and retaliation, he threatened his father with a 2x4, “if he ever tried that again.” Years later that same brother died in a drunk driving accident due to alcohol.</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe

Physical Abuse	None			
Sexual Abuse	None			
Emotional Abuse	None			
Neglect		Child hood		
Exploitation	None			
Crime	None			
Military	None			
Natural Disaster	None			
Loss		22		Younger brother died in a drunk driving accident.
Other	None			
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes		Unable to make changes	
Loss of energy or interest in	Yes		Years of being unable to hold job due to alcoholism	

activities/school			
Deterioration in hygiene and/or grooming		No	
Social withdrawal or isolation	Yes		No support system
Difficulties with home, school, work, relationships, or responsibilities	Yes		Unable to hold a job
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes		Average 5 hours/night
Difficulty falling asleep		No	
Frequently awakening during night	Yes		Wake up up to 5 times/night due to dreams
Early morning awakenings	Yes		Normally up and drinking by 7am
Nightmares/dreams	Yes		Frequent dreams of being able to hold a steady job or of burned bridges
Other	Yes	No	
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)

Changes in eating habits: overeating/loss of appetite	Yes		Loss of appetite
Binge eating and/or purging		No	
Unexplained weight loss?		No	
Amount of weight change:			
Use of laxatives or excessive exercise		No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes		Excessive worrying
Panic attacks		No	
Obsessive/compulsive thoughts		No	
Obsessive/compulsive behaviors		No	
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes		Excessive worrying leads to drinking and putting off goals
Rating Scale			
How would you rate your depression on a scale of 1-10?	9		

How would you rate your anxiety on a scale of 1-10?		9		
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		No		
School		No		
Family	Yes		No family support Doesn't want to bother people	
Legal		No		
Social		No		
Financial		No		
Other		No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/ MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/ Outcome
30 years prior	The Pavilion	Inpatient	Suicide attempt	Some improvement
Personal/ Family History				
Who lives with you?	Age	Relationship	Do they use substances?	

Lives alone		p		
			Yes	No
If yes to any substance use, explain:				
Children (age and gender):				
Who are children with now?				
Household dysfunction, including separation/divorce/death/incarceration:				
Separated but not divorced from wife for 30 years				
Current relationship problems:				
Number of marriages: 1				
Sexual Orientation: Heterosexual	Is client sexually active? No			Does client practice safe sex? Yes No
Please describe your religious values, beliefs, spirituality and/or preference: Atheist				
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):				

None
<p>How can your family/support system participate in your treatment and care? Offering a place to stay, help get personal belongings from apartment before eviction</p>
<p>Client raised by:</p> <p>Natural parents</p>
<p>Significant childhood issues impacting current illness:</p> <p>One of 19 children</p>
<p>Atmosphere of childhood home:</p> <p>Loving, especially mother Chaotic Supportive Other:</p>
<p>Self-Care:</p> <p>Independent</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.) None</p>
<p>History of Substance Use: Alcohol at age 22, crack cocaine at 45</p>
<p>Education History:</p> <p>High school, GED Some College Other: Mechanic School</p>
<p>Reading Skills:</p> <p>Yes</p>
<p>Primary Language: English</p>
<p>Problems in school: None</p>
<p>Discharge</p>
<p>Client goals for treatment:</p>

<ul style="list-style-type: none"> • Stop drinking • Get clean and live a normal life • Work on self worth • Calm racing thoughts
<p>Where will client go when discharged?</p> <p>The client hopes to transfer to a Gateway Foundation rehab facility.</p>

Outpatient Resources (15 points)

Resource	Rationale
1. Gateway Springfield	1. Alcohol and Drug Treatment Program
2. Rosecrance	2. Residential treatment program and outpatient counseling services
3. Champaign Treatment Center	3. Residential Addiction Treatment Services

Current Medications (10 points)

Complete all of your client’s psychiatric medications

Brand/Generic	Naltrexone	PARoxetine Paxil	Celexa Citalopram	Neurontin (gaba- pentin)	Trazadone (Desyrel)
Dose	50 mg	10 mg	30 mg	100mg	50 mg
Frequency	Daily	Daily	Daily	qPM	qPM PRN
Route	Oral	Oral	Oral	Oral	Oral

Classification	Opioid antagonist	SSRI	SSRI	Anti-convulsant	Anti-depressant
Mechanism of Action	Competes with opioids at opioid receptor sites	Inhibits CNS neuron uptake of serotonin but not of norepinephrine or dopamine	Inhibits CNS neuron uptake of serotonin but not of norepinephrine	Mechanism unknown, may increase seizure threshold	Selectively inhibits serotonin reuptake by brain, potentiates behavioral changes
Therapeutic Uses	Blockage of opioid analgesics, used for treatment of opiate addiction, alcoholism	MDD, OCD, panic disorder	MDD, OCD in adolescents	Neuropathic pain	MDD, insomnia
Therapeutic Range (if applicable)				Diabetic neuropathy pain Adult PO 900 mg/day divided doses TID	Geriatric: PO 25-50 mg qAM
Reason Client Taking	Alcoholism	MDD	MDD	Diabetic neuropathy pain	MDD
Contraindications (2)	Hyper-Sensitivity, Opioid dependence	Pregnancy, MAOI use	Recent MI, bradycardia	Geriatric patients, renal disease	Cardiac/hepatic disease, bleeding
Side Effects/Adverse Reactions (2)	Stimulation, suicidal ideation	Stevens-Johnson syndrome, neuroleptic malignant syndrome	Suicide attempt, QT prolongation	Leukopenia, Pruritis	Hypertension, paralytic ileus
Medication/Food Interactions	Hepatotoxicity – disulfiram Bleeding risk – Anti-coagulants	Possible serotonin syndrome: St. John's wort, tryptophan	Serotonin syndrome – St. John's Wort, SAM-e	CNS depression – chamomile, kava, valerian, antacids	Serotonin syndrome – SEM-e, St. John's wort, CNS depression – hops,

					kava, lavender
Nursing Considerations (2)	Hepatic status, respiratory depression	Mental status, postural hypotension	AV block, Beers	Mental status, Seizures – do not discontinue quickly after long-term use	B/P lying, standing, pulse q4h; if systolic B/P drops 20 mm Hg, hold product

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):

Skidmore-Roth, L. (2022). *Mosby's 2022 nursing drug reference*. Elsevier.

Mental Status Exam Findings (20 points)

APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:	Well groomed Calm Slender Indifferent Coherent, soft Open, cooperative Flat
MAIN THOUGHT CONTENT: Ideations: Delusions: Illusions: Obsessions: Compulsions: Phobias:	Client stated to Jamal, "Aliens are around."
ORIENTATION: Sensorium: Thought Content:	Alert and oriented to person, place, time, situation
MEMORY: Remote:	Ex-wife's boyfriend introduced her to crack cocaine. The client wanted to get back with ex-wife and got addicted to crack cocaine.
REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:	Logical Intact Difficulty with impulse control
INSIGHT:	Clear

GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:	Unsteady due to diabetic neuropathy No Normal Normal Some weakness Shuffling gait due to diabetic neuropathy
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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0850	80	128/70	18	36.8	100
Left the adult inpatient unit, went back to detox before second set vitals were taken					

Pain Assessment, 2 sets (2 points)					
Time	Scale	Location	Severity	Characteristics	Interventions
0850	Number	Feet	4	Numbness, burning	Rest and acetaminophen
Left the adult inpatient unit, went back to detox before second set vitals were taken					

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: Breakfast: 75% Lunch: 75% Dinner:	Oral Fluid Intake with Meals (in mL) Breakfast: 240 ml Lunch: 240 ml Dinner:

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The client will be transferring to a rehabilitation facility for further treatment and support for alcohol addiction and substance abuse. The Pavilion staff will help the client contact the client’s daughter to help with gathering belongings from apartment where the client was evicted. The client will need education on alcohol and substance abuse. Education will also need to be given for management of diabetes, including diet and pain management. The follow up plan will be to complete a rehabilitation program and find a support group.

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)
<ol style="list-style-type: none"> Hopelessness related to eviction from home as evidenced by suicidal thoughts. 	The client attempted to end his life by drug and alcohol overdose after receiving an eviction notice for having a pet.	<ol style="list-style-type: none"> Remove all items the patient can use to self harm. Remove all clothing and have the client change into a disposable hospital gown. Place patient on constant patient observation. 	<ol style="list-style-type: none"> Assess the patient for previous suicide attempt or drug overdose. Supply the patient with plastic utensils for meals or finger foods. Involve family member if possible. 	<ol style="list-style-type: none"> Inform the client there are services they can utilize including chaplains. Participate in care that is within the patient’s care (ADL’s, making small decisions). Recognize and verbalize thoughts and

				feelings with a trusted individual.
<p>2. Impaired social interaction related to lack of support system as evidenced by feelings of seclusion, avoids contact with others and lacks eye contact.</p>	<p>The client stated to me no one was aware of his whereabouts. He did not want to tell his daughter or sister because he did not want to bother them. Throughout the interview, the client did not make eye contact.</p>	<p>1. Build rapport with the patient.</p> <p>2. The client will state when he feels isolated.</p> <p>3. The client will identify three positive emotions he feels when he is with this family.</p>	<p>1. Encourage participation in group therapy at least once.</p> <p>2. Encourage walks on the unit.</p> <p>3. Discuss coping mechanisms.</p>	<p>1. Help the client contact daughter.</p> <p>2. Discuss which support groups would be most beneficial to attend after discharge.</p> <p>3. Help client identify responsibility for their own behaviors and learn new skills that can be used to enhance social interactions.</p>
<p>3. Chronic low self-esteem related to repeated past failures as evidenced by negative view of self and abilities.</p>	<p>The client stated he “can never doing anything right” and have never been able to hold a job.</p>	<p>1. Assess the client’s self-esteem level.</p> <p>2. Give positive feedback after a task is achieved.</p> <p>3. Allow the patient to perform personal care activities.</p>	<p>1. Provide the client with positive feedback and support to manage behaviors to promote self-esteem.</p> <p>2. Work with the client to identify cognitive distortions that encourage negative self-appraisal. Ex: self-blame</p> <p>3. Teach visualization techniques that can help the client</p>	<p>1. Involve the client in activities that he wants to improve by using problem-solving skills.</p> <p>2. Evaluate the client’s need for assertiveness training.</p> <p>3. Encourage the client to participate in a group therapy where the members share the same</p>

			replace negative self-images with more positive images and thoughts.	situations or feelings they have.
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Other References (APA):

Haugen, N., Galura, S., & Ulrich, S. P. (2021). *Ulrich & Canale's Nursing Care Planning Guides: Prioritization, Delegation, and Critical Thinking*. Saunders/Elsevier.

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

1. Hopelessness related to evidence from attempted suicide by intentional overdose of crack cocaine. The client has a history of suicidal attempts. The client states he "feels it is not safe to discharge because worried about relapsing and possibly overdosing again." The client also stated, "aliens are around." The client also explained he was shuffling because of the mild pain from his diabetic neuropathy. Pain was 4 of out 10.
 - Participate in care that is within the patient's care (ADL's, making small decisions).
2. Impaired social interaction related to lack of support system as evidenced by feelings of seclusion, avoids contact with others and lacks eye contact.
 - Participate in conversation on one topic during group therapy.
3. Chronic low self-esteem related to repeated past failures as evidenced by negative view of self and abilities.
 - Practice visualization technique each time the client has negative self-images and replace with positive images.

Objective Data

Patient Information

Nursing Interventions

Nursing care interventions:

- Allow the patient to perform all activities of daily living. The client was well-groomed and in disposable hospital scrubs and had a shuffling gait. Vitals were taken at 0850: Temperature 36.8, BP 128/70, pulse 80, RR 18, with diastolic rate 18, and pain 4/10.
- Give positive feedback from hospital after a suicide attempt by drug and overdose. The client is also on paroxetine 40mg daily. This client has a history of mood swings and feeling down and depressed. Ex: cheese, milk, beer, chicken liver, soy beans, excess chocolate
- Avoid St. John's wort while taking paroxetine



