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				
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. **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.				
	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		Childhood		
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 activities/school	**Yes**		Years of being unable to hold job due to alcoholism
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? **Amount of weight change:**		**No**	
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? Lives alone	**Age**	**Relationship**	**Do they use substances?**	
			Yes	**No**
			Yes	**No**
			Yes	**No**
			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			
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				
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				
Client raised by: **Natural parents**				
Significant childhood issues impacting current illness:				

One of 19 children
Atmosphere of childhood home: **Loving, especially mother** **Chaotic** **Supportive** **Other:**
Self-Care: **Independent**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) None
History of Substance Use: Alcohol at age 22, crack cocaine at 45
Education History: **High school, GED** **Some College** **Other: Mechanic School**
Reading Skills: **Yes**
Primary Language: English
Problems in school: None
Discharge
Client goals for treatment: • Stop drinking • Get clean and live a normal life • Work on self worth • Calm racing thoughts
Where will client go when discharged? The client hopes to transfer to a Gateway Foundation rehab facility.

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	Inhitbits CNS neuron uptake of **serotonin** but not of norepinephrine or dopamnie	Inhitbits CNS neuron uptake of **serotonin** but not of nor-epinephrine	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	MDD, OCD, panic disorder	MDD, OCD in adol-escents	Neuropathic pain	MDD, insomnia

	addiction, alcoholism				
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, brady-cardia	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 pro-longation	Leukopenia, Pruritis	Hyper-tension, 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:	Well groomed
Behavior:	Calm
Build:	Slender
Attitude:	Indifferent
Speech:	Coherent, soft
Interpersonal style:	Open, cooperative
Mood:	
Affect:	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 peron, 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

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 facity 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)**
1. 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.	**1.**Remove all items the patient can use to self harm. **2.** Remove all clothing and have the client change into a disposible hospital gown. **3.** Place patient on constant patient observation.	**1.** Assess the patient for previous suicide attempt or drug overdose. **2.** Supply the patient with plastic utensils for meals or finger foods. **3.** Involve family member if possible.	**1.** Inform the client there are services they can utlize including chaplains. **2.** Participate in care that is within the patient's care (ADL's, making small decisions). **3.** Recognize and verbalize thoughts and feelings with a trusted individual.
2. Impaired social interaction related to lack of support system as evidenced by feelings of seclusion, avoids contact with others and lacks eye contact.	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	**1.** Build rapport with the patient. **2.** The client will state when he feels isolated. **3.** The client will identify three positive emotions he feels when he is with this family.	**1.** Encourage participation in group therapy at least once. **2.**Encourage walks on the unit. **3.** Discuss coping mechanisms.	**1.** Help the client contact daughter. **2.** Discuss which support groups would be most beneficial to attend after discharge. **3.** Help client identify responsibility for their own behaviors and

	not make eye contact.			learn new skills that can be used to enhance social interactions.
3. Chronic low self-esteem related to repeated past failures as evidenced by negative view of self and abilities.	The client stated he "can never doing anything right" and have never been able to hold a job.	**1.** Assess the client's self-esteem level. **2.** Give positive feedback after a task is achieved. **3.** Allow the patient to perform personal care activities.	**1.** Provide the client with positive feedback and support to manage bahaviors to promote self-esteem. **2.** Work with the client to identify cognitive distortions that encourage negative self-appraisal. Ex: self-blame **3.** Teach visualization techniques that can help the client replace negative self -images with more positive images and thoughts.	**1.** Involve the client in activities that he wants to improve by using problem-solving skills. **2.** Evaluate the client's need for assertiveness training. **3.** Encourage the client to participlate in a group therapy where the members share the same situations or feelings they have.

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

The client attempted suicide by intentional overdose of crack cocaine. The client has a history of suicide 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.

Nursing Diagnosis/Outcomes

1. Hopelessness related to eviction from home as evidenced by suicidal thoughts.
   - 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

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, O2 100, respiration rate 18, and pain 4 out of 10 in feet.

Patient Information

66-year-old male with a history of major depressive disorder is admitted from Carle Hospital after suicide attempt by drug and alcohol overdose. The client is also diagnosed with diabetic neuropathy. The client has a history of mood swings and feeling down and depressed.

Nursing Interventions

Nursing care interventions:

- Allow the patient to perform personal care activities.
- Give positive feedback after a task is achieved.

Medication interventions:

- Avoid tyramine-rich foods while taking paroxetine
  Ex: cheese, milk, beef, chicken liver, soy beans, excess chocolate
- Avoid St. John's wort while taking paroxetine