# N323 Care Plan

Lakeview College of Nursing

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Approved: 1/6/2021

## Demographics (3 points)

| **Date of Admission** | **Patient Initials** | **Age** | **Gender** |
|---|---|---|---|
| 9-5-22 | T.M | 50 | F |
| **Race/Ethnicity** | **Occupation** | **Marital Status** | **Allergies** |
| White/Caucasian | N/A | Single | Penicillin |
| **Code Status** | **Observation Status** | **Height** | **Weight** |
| Full | Pt was to be monitored q15 | 5’1 | 126lbs |

## Medical History (5 Points)

**Past Medical History:** Anxiety, Arthritis, COPD, Depression, Gerd, Hypertension, Choroiditis**,** Osteoporosis, and Uveitis.

**Significant Psychiatric History:** Pt has history of hospitalizations for suicide, and overdose.

**Family History:** Father has a history of cancer, Maternal grandmother has a history of cancer, maternal grandfather has a history of stroke, paternal and maternal grandparents both had cancer.

**Social History (tobacco/alcohol/drugs):** Patient smokes two pack of cigarettes daily, 6-12 beers a day, and daily cannabis use. Patient does not use smokeless tobacco.

**Living Situation:** Patient lives in her apartment alone.

**Strengths:** Patient gets along with everyone and attends group meetings; Patient is also calm and cooperative through the day.

**Support System:** Patient does not have a good support system, but does have a son, daughter. And three grandchildren.

## Admission Assessment

**Chief Complaint (2 points):** Drug OD, Suicide. Patient stated, “I woke up two days ago feeling so overwhelmed & took a couple bottle of pills”.

**Contributing Factors (10 points):**

**Factors that lead to admission:** Patient admitted to the ER due to suicide attempt by drug overdose. My Patient lacks mental stability and states she doesn't want to live anymore and has decreased motivation. Patient came from home with her boyfriend. Patient has been feeling like this most of her life, but she stated it has gotten worse over the last two years. Patient feels hopeless and feels like she is going to have a panic attack. Patients associated factors are History of depression and substance misuse. Patient drinks to cope with anxiety and depression. Patient experiences depression and anxiety majority of the time. Patient rates condition at a 10.

**History of suicide attempts:** Patient attempted to commit suicide March of 2022, and September 4th, 2022. Both instances are by taking an excessive amount in pills.

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

**Psychosocial Assessment (30 points)**

| **History of Trauma** | | | | |
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| **No lifetime experience:** Patient experienced trauma at the age of 17 from her boyfriend abusing her until the age of 21. Patient then turned to alcohol and drugs.<br>**Witness of trauma/abuse:** Patient was a witness to her daughter being molested by her grandfather when she was 30. | | | | |
| | **Current** | **Past (what age)** | **Secondary Trauma (response that comes from caring for** | **Describe** |

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| | | | **another person with trauma)** | |
| **Physical Abuse** | **N/A** | **17** | **30** | Patient experienced her daughter getting abused by her grandfather when her daughter was 16. Patient was almost beat to death by her first boyfriend. |
| **Sexual Abuse** | **N/A** | **32-35** | **30** | Patients' daughter was molested by her grandfather, and patient was sexually abused by her first husband and was forced to have sexual intercourse after she was beat. |
| **Emotional Abuse** | **N/A** | **17-35** | **N/A** | Patient experienced emotional abuse from all her |

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| | | | | boyfriend's, patient did not want to get into detail. |
| **Neglect** | **N/A** | **21** | **N/A** | Patient experienced neglected when her boyfriend up and left her and took everything. |
| **Exploitation** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Crime** | **N/A** | **35** | **N/A** | Patient was arrested for methamphetamine in 2006 and was put on probation for 2 years. |
| **Military** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Natural Disaster** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Loss** | **N/A** | **30** | **N/A** | Patients' grandmother shot herself in the head. Patient is still affected by this, and it makes her want to |

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| | | | | commit suicide. |
| **Other** | | | | |
| **Presenting Problems** | | | | |
| **Problematic Areas** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** | |
| **Depressed or sad mood** | **Yes** | **No** | Patient is not presenting with any depression or sadness. Patient states she feels less depressed while at the pavilion. | |
| **Loss of energy or interest in activities/school** | **Yes** | **No** | Yes, patient experiences loss of energy in activities. Patient states she feels like this anytime there is an activity. It is extremely intense she states her interest is at a 0. | |
| **Deterioration in hygiene and/or grooming** | **Yes** | **No** | Patient states when she is depressed, she never wants to shower this occurs three times out of the week patient feels this way every week. It is extremely hard for her to motivate herself to take a shower. | |
| **Social withdrawal or isolation** | **Yes** | **No** | No, patient states she never has a hard time when socializing with people. | |

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| **Difficulties with home, school, work, relationships, or responsibilities** | **Yes** | **No** | Yes, patient has a difficult relationship with her children it has been difficult since she started drugs in 2014. The situation is intense, and it makes the patient feel like a bad mother. Her children make her feel like this every time she tries to talk to them which is about 3-4 times a week. |
| **Sleeping Patterns** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** |
| **Change in numbers of hours/night** | **Yes** | **No** | Patient has the same sleeping pattern every night, patient states she sleeps 6 hours a note. |
| **Difficulty falling asleep** | **Yes** | **No** | Patient states she does not have difficulty falling asleep. |
| **Frequently awakening during night** | **Yes** | **No** | Patient states that she does not wake up throughout the night. |
| **Early morning awakenings** | **Yes** | **No** | Patient states she does not have early morning awakenings. |
| **Nightmares/dreams** | **Yes** | **No** | Patient states she does have nightmares 2-3 times a week. Patient states that her dreams are |

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| | | | always bad and the dreams only last about 5 minutes until a new one. |
| **Other** | **Yes** | **No** | |
| **Eating Habits** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** |
| **Changes in eating habits: overeating/loss of appetite** | **Yes** | **No** | Patient states her eating habits are the same for the most part, besides when she gets depressed. About 3 times a week usually in the mornings she won't eat breakfast. Patient states the intensity rate at a 5. |
| **Binge eating and/or purging** | **Yes** | **No** | Patient does not binge eat or purge. |
| **Unexplained weight loss?**<br><br>**Amount of weight change:** | **Yes** | **No** | Patient does not have unexplained weight loss. |
| **Use of laxatives or excessive exercise** | **Yes** | **No** | Patient takes two stool softeners once a day and it isn't intense at all. |
| **Anxiety Symptoms** | **Presenting?** | | **Describe (frequency, intensity, duration, occurrence)** |
| **Anxiety behaviors (pacing, tremors, etc.)** | **Yes** | **No** | Patient does not experience any of these behaviors. |
| **Panic attacks** | **Yes** | **No** | Patient states she does have panic |

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| | | | attacks once a week for about 10 minutes. Patient states the intensity rate is about an 8. |
| **Obsessive/compulsive thoughts** | **Yes** | **No** | Yes, Patient states she has suicidal thoughts throughout the day, the thoughts last for about five minutes and the intensity rate is at a 10. |
| **Obsessive/compulsive behaviors** | **Yes** | **No** | Patient does not have compulsive behaviors in the pavilion, but she does at home about 2-3 times a day for 20 minutes. Patient states the intensity rate is at a 10. |
| **Impact on daily living or avoidance of situations/objects due to levels of anxiety** | **Yes** | **No** | Yes, patient states it is hard for her to focus on daily activities because she gets discouraged, this occurs every day of the week and it lasts for hours. Patient states the intensity rate at a 10. |

| **Rating Scale** | |
|---|---|
| **How would you rate your depression on a scale of 1-10?** | Patient rates her depression at a 6 using a scale 1-10. |
| **How would you rate your anxiety on a scale of 1-10?** | Patient rates her anxiety at a 9 using a scale 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** | This occurs every time the patient speaks on the phone with her family members. This has been going on since the patient turned to an alcoholic and a drug user. The situation is intense for the patient. |
| **Legal** | **Yes** | **No** | **N/A** |
| **Social** | **Yes** | **No** | **N/A** |
| **Financial** | **Yes** | **No** | **N/A** |
| **Other** | **Yes** | **No** | |

| Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient | | | | |
|---|---|---|---|---|
| **Dates** | **Facility/MD/ Therapist** | **Inpatient/ Outpatient** | **Reason for Treatment** | **Response/Outcome** |
| Patient is unsure of the actual month and day, but the first outpatient visit was in 2007. | **Inpatient**<br>**Outpatient**<br>**Other:**<br>Pt attended a | Outpatient | Pt was<br><br>treated for | **No improvement**<br><br>**Some improvement** |

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| | hospital in Carbondale when she began going through withdrawals. | | alcohol withdrawal. | **Significant improvement** |
| Patient is unsure of the actual month and day, but the second outpatient visit was in 2008 | **Inpatient**<br>**Outpatient**<br>**Other:** | Outpatient | Pt was treated for substance abuse. | **No improvement**<br>**Some improvement**<br>**Significant improvement** |
| Patient is unsure of the actual month and day, but the third outpatient visit was in 2014. | **Inpatient**<br>**Outpatient**<br>**Other:** | Outpatient | Pt was treated for substance abuse. | **No improvement**<br>**Some improvement**<br>**Significant improvement** |

| **Personal/Family History** | | | | |
|---|---|---|---|---|
| **Who lives with you?** | **Age** | **Relationship** | **Do they use substances?** | |
| **Patient does not live with anybody** | **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):** Patient has a daughter that is 32 and a son that is 21<br><br>**Who are children with now?** Both children live by themselves in Carbondale. | | | | |
| **Household dysfunction, including separation/divorce/death/incarceration: N/A** | | | | |
| **Current relationship problems:** Patient is not in an intimate relationship but does have relationship problems with her children not wanting to deal with her because she attempted to | | | | |

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| commit suicide.<br><br>**Number of marriages:** 2 | | |
| **Sexual Orientation:** | **Is client sexually active?**<br>**Yes No** | **Does client practice safe sex?**<br>**Yes No** |
| **Please describe your religious values, beliefs, spirituality and/or preference:** Patient is a Christian. | | |
| **Ethnic/cultural factors/traditions/current activity:**<br><br>**Describe:** The only tradition the patient practices' is going to church on Sundays when she can. | | |
| **Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):**<br>Patient did not have any legal issues with herself or parents, patient was married but never legally divorced she stated. Patient did not have any issues with CPS and does not have any pending charges. Patient was put on probation for two years for using methamphetamine in 2006. | | |
| **How can your family/support system participate in your treatment and care?** Patient stated "There is no way for my family to contribute to my treatment and care I have to do this alone" . | | |
| **Client raised by:** Client was raised by her birth parents.<br><br>**Natural parents**<br>**Grandparents**<br>**Adoptive parents**<br>**Foster parents**<br>**Other (describe):** | | |
| **Significant childhood issues impacting current illness:** Patient stated she lived in a peaceful home; she was not mistreated by her parents; however, her mom was an alcoholic. | | |
| **Atmosphere of childhood home:** Patient stated the atmosphere of childhood home was Comfortable.<br><br>**Loving** | | |

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| **Comfortable**<br>**Chaotic**<br>**Abusive**<br>**Supportive**<br>**Other:** |
| **Self-Care:** Patient is Independent<br><br>**Independent**<br>**Assisted**<br>**Total Care** |
| **Family History of Mental Illness (diagnosis/suicide/relation/etc.)** Patients' grandmother shot herself in the head in 2014. Patient did not state any other mental illnesses from her family. |
| **History of Substance Use:** Patient stated she did crack, heroin, meth, smoked weed and drank alcohol from years 2006-current. |
| **Education History:** Patient only completed 11th grade, patient stated she hated school and did not get good grades.<br><br>**Grade school: completed**<br>**High school: 11th grade only**<br>**College: did not attend**<br>**Other:** |
| **Reading Skills:** Patient states she can read without any issues.<br><br>**Yes**<br>**No**<br>**Limited** |
| **Primary Language:** English. |
| **Problems in school:** Patient didn't experience any bullying, but she stated she always skipped class and didn't make good grades. |
| **Discharge** |
| **Client goals for treatment:** Client stated she would like to overcome her depression and get |

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| back on the right track with her children. |
| **Where will client go when discharged?** Client will go to Aspen nursing home. |

**Outpatient Resources (15 points)**

| Resource | Rationale |
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| **1. Group therapy** | **1.** Group therapy helps this patient be able to realize that she isn't the only one going through the same things. Group therapy also helps with improving social skills. |
| **2. Personal Therapist visits** | **2.** Personal therapy visits are useful as it helps with developing the client's self-esteem and allowing them to talk about their problems one-on-one. |
| **3. Substance use and mental health services** | **3.** This improves the patients' coping skills for handling stress and it creates better coping mechanisms for mental health issues. |

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

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|---|---|---|---|---|---|
| **Brand/Generic** | Bupropion/ Wellbutrin | Chlorpromazine/ Thorazine | Paroxetine/ Aropax | | |
| **Dose** | 150mg | 50mg | 20mg | | |
| **Frequency** | 1x a day | 1x a day at bedtime | 1x in the morning | | |
| **Route** | oral | oral | oral | | |
| **Classification** | Aminoketone | Phenothiazine | SSRI | | |
| **Mechanism of Action** | May inhibit dopamine, norepinephrine, and serotonin uptake by neurons. Which significantly relives evidence of depression. (Jones and Barlett 2022). | Depresses brain areas that control activity and aggression. (Jones and Barlett 2022). | Exerts antianxiety, antidepressant and antipanic effects as well as relieving factors associated with premenstrual dysphoric disorder. (Jones and Barlett 2022). | | |
| **Therapeutic Uses** | Antidepressant, Smoking cessation. | Manages symptoms of psychotic disorders. | Treats depression, and panic disorder, and social anxiety disorder. | | |
| **Therapeutic Range (if applicable)** | N/A | N/A | N/A | | |
| **Reason Client Taking** | To treat depression | Mood stabilizer | To help treat OCD. | | |
| **Contraindications (2)** | Hypersensitivity, and Seizure disorders | Possibly lowered convulsive threshold, may also result in CNS depression. | Use within 14 days of MAO inhibitor, and pregnancy is a contraindication. | | |
| **Side Effects/Adverse Reactions (2)** | Abnormal coordination, & Abnormal EEG. | Motor restlessness, and Tardive dyskinesia. | Decreased concentration, and insomnia. | | |
| **Medication/Food** | Phenytoin, and | Avoid lithium and | Do not use this | | |

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| **Interactions** | Tamoxifen interact with this brand. | levodopa. | medication with buspirone, and fentanyl | | |
| **Nursing Considerations (2)** | Provide client with medication information and ensure that the client isn't taking anything to interact with this drug. | Stay alert for possible suppressed cough reflex and notify provider if altered mental status occurs. | Watch patient closely for suicide attempt and monitor patient closely for GI bleed. | | |

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| **Brand/Generic** | Polyethylene glycol/MiraLAX | Gabapentin/Neurotin | Pantoprozole/ Pantoloc | | |
| **Dose** | 17mg | 800mg, 400mg per dose | 40mg | | |
| **Frequency** | 2x a day | 2x a day | 1x a day before meals | | |
| **Route** | Oral | Oral | oral | | |
| **Classification** | Osmotic laxatives | 1-amoino-methyl cyclohexane acetic acid | Proton pump inhibitor | | |
| **Mechanism of Action** | Increases the number of bowel movements and softens the stool | Inhibits the rapid firing of neurons associated with seizures. It also prevents exaggerated response to stimuli. | Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system in gastric parietal system. | | |
| **Therapeutic Uses** | Treats occasional constipation. | Prevents seizures and relieves pain. | Treats erosive esophagitis associated with GERD. | | |
| **Therapeutic Range (if applicable)** | N/A | N/A | N/A | | |
| **Reason Client** | Manage | Anxiety | GERD | | |

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| **Taking** | constipation | | | | |
| **Contraindications (2)** | Patients with suspected bowel instruction, and appendicitis. | Hypersensitivity to gabapentin or its components.<br>Vision changes and swelling of the face. | Substituted benzimidazoles, and concurrent therapy with rilpivirine containing products. | | |
| **Side Effects/Adverse Reactions (2)** | Bloody diarrhea, and increased sweating. | CNS tumors, and disappearance of aura. | Anxiety and vertigo. | | |
| **Medication/Food Interactions** | Herbal products and vitamins. | Avoid taking morphine, and naproxen. | Avoid using atazanavir, and iron salts. | | |
| **Nursing Considerations (2)** | High doses may produce excessive stool frequency, additionally patients may also develop urticaria. | Remember that routine monitoring of blood gabapentin level isn't needed.<br>Monitor renal function test results.<br>Monitor patient for suicidal thoughts. | Monitor PT or INR during therapy if patient takes is taking oral anticoagulant (Jones and Barlett 2022).<br>Monitor patients' urine output. | | |

**Medications Reference (1) (APA):**

Jones & Bartlett Learning. (2022). NDH nurses drug handbook (21st ed.). World Headquarters

Jones and Bartlett Learning.

**Mental Status Exam Findings (20 points)**

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| **APPEARANCE:**<br>**Behavior:**<br>**Build:**<br>**Attitude:** | Patient looks tired and lonely<br>Patients' behavior is calm and assertive<br>Patients build appears normal without disturbed body image |

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| **Speech:**<br>**Interpersonal style:**<br>**Mood:**<br>**Affect:** | Patients' attitude is positive, patient smiles a few times.<br>Patients' speech is normal without slurred words, and she can complete sentences fluently.<br>Patients interpersonal style included active listening.<br>Patients' mood was a down but still managed to laugh and smile.<br>Patients affect was normal patient did not display any emotion she appeared to have a typical affect. |
| **MAIN THOUGHT CONTENT:**<br>**Ideations:**<br>**Delusions:**<br>**Illusions:**<br>**Obsessions:**<br>**Compulsions:**<br>**Phobias:** | Patients' ideas are spontaneous, and she states her opinions, but doesn't'.<br>Patient is not having any delusions or illusions.<br>Patient is obsessed with playing in her hair.<br>Patient compulsions is constantly cleaning.<br>Patient did not present with any phobias or stated any. |
| **ORIENTATION:**<br>**Sensorium:**<br>**Thought Content:** | Patient did not present with any confusion or altered mental status.<br>Patient was able to complete her thoughts and was completely oriented. Patients thinking process was sufficient.<br>. |
| **MEMORY:**<br>**Remote:** | Patient remote memory was intact and was able to remember things from years ago. |
| **REASONING:**<br>**Judgment:**<br>**Calculations:**<br>**Intelligence:**<br>**Abstraction:**<br>**Impulse Control:** | Patients' judgment was appropriate and positive.<br>Judgement was fair<br>Patient was able to count and give me the correct answer to simple addition problems. Satisfactory.<br>Patients' intelligence level is average, patient is able to comprehend.<br>Patient was able to understand the meanings of all words I used. Abstraction is normal.<br>Impulse control is normal |
| **INSIGHT:** | Patient was understanding and aware of her mental illness. |
| **GAIT:** | |

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| **Assistive Devices:**<br>**Posture:**<br>**Muscle Tone:**<br>**Strength:**<br>**Motor Movements:** | Patient does not use any assistive devices, and posture is normal.<br>Patients muscle tone is normal and not resistant upon movement.<br>Patients' strength is equal bilaterally.<br>Patients motor movements are active and normal without disturbances. |

**Vital Signs, 2 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| 0200 | 78 | 109/70 | 18 | 97.6F | 96% |
| 0400 | 74 | 117/66 | 18 | 98.4F | 98% |

**Pain Assessment, 2 sets (2 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 0200 | 1-10 | Head | 9 | Dull pain | Pt was given Tylenol |
| 0400 | 1-10 | N/A | 0 | N/A | Pt does not have any pain |

**Dietary Data (2 points)**

| **Dietary Intake** | |
|---|---|
| **Percentage of Meal Consumed:** 100%<br><br>**Breakfast:** Patient stated she ate all her breakfast 100%<br><br>**Lunch:** Patient ate all her lunch 100%<br><br>**Dinner:** Patient ate all her dinner 100% | **Oral Fluid Intake with Meals (in mL)**<br><br>500ml total.<br><br>**Breakfast:** Patient stated she had 2 cups of Kool-Aid the whole day.<br><br>**Lunch:** Patient stated she had 2 cups of Kool-Aid the whole day. |

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|---|---|
| | **Dinner:** Patient stated she had 2 cups of Kool-Aid the whole day. |

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):**

1.Provide my client with helpful resources and to establish a better relationship with family, so patient can rely on a support system.

2.Ensure that my patient is getting involved with daily activities to decrease risk of being depresses.

3. Give advice on smoking cessation to promote healthier lifestyle

4.Continued therapy for my patient

5. Ensure my patient is going to a helpful nonjudgmental place of residency

**Nursing Diagnosis (15 points)**
***Must be NANDA approved nursing diagnosis and listed in order of priority***

| **Nursing Diagnosis**<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components | **Rational**<br>• Explain why the nursing diagnosis was chosen | **Immediate Interventions (At admission)** | **Intermediate Interventions (During hospitalization)** | **Community Interventions (Prior to discharge)** |
|---|---|---|---|---|
| 1. Risk for acute substance withdrawal | This nursing diagnosis was chosen because the | 1.Head to toe assessment<br><br>2.limit noise | 1. Assess patients support system<br><br>2. Ask patient | 1. Endure the client with encouraging motivational |

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| syndrome Related to developed dependence to alcohol as evidence by drinking alcohol excessively to cope with problems. | patient is an alcoholic and if not controlled patient is at risk of going through withdrawal again. | and environmental stimulation<br><br>3.Provide nonjudgmental care | open ended questions<br><br>3. Identify possible med that should be given to client to decrease symptoms | words.<br><br>2. Refer patient to a mental health specialist.<br><br>3.Advise the patient to continue therapy |
| 2. Risk for unstable blood pressure related to substance abuse as evidence by drug overdose | This nursing diagnosis was chosen because increased substance use creates a rise in blood pressure causing possible hypertension. | 1. Gather patients' information<br><br>2. Reduce patients anxiety level<br><br>3. Monitor patient mental status | 1. Monitor patients vital signs<br><br>2.Assess hemodynamic status<br><br>3. Get labs done on patient | 1. Encourage patient to share concerns regarding health<br><br>2.Provide patient with information regarding risk factors<br><br>3.Collaborate with members of the healthcare team to ensure patients' needs are meant |
| 3.Risk for defensive coping related to insufficient support system as evidence by children not wanting to keep in contact with patient | This nursing diagnosis was chosen because the patient has been having difficulty with keeping in contact with her children due to her habits. | 1. Pay attention to patient mental status.<br><br>2.Ensure patient is not having suicidal thoughts<br><br>3. Encourage patient to evaluate self | 1. Establish an environment of mutual trust and respect between patient and care giver.<br><br>2. Use therapeutic communication throughout hospitalization process<br><br>3. Provide empathy for the patent. And | 1. Refer patient to social worker for follow-up treatment.<br><br>2.Provide positive feedback when patient accepts responsibility for actions<br><br>3. Help patient make treatment related |

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| | | | support patient feelings regarding support system. | decisions. |

**Other References (APA):**

Jones & Bartlett Learning. (2023). NDH nurses drug handbook (21st ed.). World Headquarters Jones and Bartlett Learning.

Phelps, L.L. (2020). Sparks and Taylor's nursing diagnosis reference manual.(11th ed.). Wolters Kluwer

**Concept Map (20 Points):**

**Subjective Data**

Patient states she is depressed and has anxiety, Patient states she wants to better herself and live a normal life. Patient states she wants to stop drinking; so she is able to be in her children and grandchild's life.

**Nursing Diagnosis/Outcomes**

Risk for acute substance withdrawal syndrome
Related to developed dependence to alcohol as evidence by drinking alcohol excessively to cope with problems. Goal: Patient will not experience withdrawal symptom complications.
Risk for unstable blood pressure related to substance abuse as evidence by drug overdose. Goal: Patient remains hemodynamically stable
Risk for defensive coping related to insufficient support system as evidence by children not wanting to keep in contact with patient. Goal: Patient accepts responsibility for actions and is persistent to make a change.

**Objective Data**

Patient appears tired and overwhelmed; patient does manage to communicate with others well and is positive throughout the day. Patients' vital signs are normal for her age. First attempt diastolic was a bit elevated.

**Patient Information**

50-year-old female patient weighing 126 lbs. 5'1 with a chief complaint of attempting to commit suicide. Patient does not have a support system but hopes to get better so she can make things right for her children. Patient will be going to a nursing home after discharge.

**Nursing Interventions**

Monitor and record level of consciousness of patient.
Include patient in plan of action which can help patient develop a sense of responsibility.

Treat episodes of high and low blood pressure promptly

Assign consistent care provider to patient to provide continuity of care and create a therapeutic relationship.