

N323 Care Plan  
Lakeview College of Nursing  
Mason Coon

## N323 CARE PLAN

**Demographics (3 points)**

<b>Date of Admission</b> 2/14/23	<b>Patient Initials</b> C. W.	<b>Age</b> 33	<b>Gender</b> Male
<b>Race/Ethnicity</b> Caucasian, non-Hispanic	<b>Occupation</b> Unemployed, recently fired from bartending	<b>Marital Status</b> Single, divorced twice	<b>Allergies</b> Halidol, Lorazepam
<b>Code Status</b> Full Code	<b>Observation Status</b> Inpatient	<b>Height</b> 5' 10"	<b>Weight</b> 165 lbs

**Medical History (5 Points)**

**Past Medical History:** Four year history of fentanyl use. Stitches in right hand from accidental chainsaw cut (2016). Hypertension, Opioid use disorder, Bipolar disorder

**Significant Psychiatric History:** Multiple hospitalizations for suicide attempts. Prior admission to the Pavillion.

**Family History:** Significant for psychiatric problems. Father was an alcoholic, 13 years sober according to the client. Client mentioned two successful suicides from uncles and one murder-suicide.

**Social History (tobacco/alcohol/drugs):** Admits to alcohol, marijuana, opioid, and fentanyl use.

**Living Situation:** Currently lives alone, will be going to a group home for rehabilitation.

**Strengths:** The client is pleasant, cooperative, and willing to participate in their treatment.

**Support System:** The client states his father is his biggest supporter, and he also has friends who can help.

**Admission Assessment**

**Chief Complaint (2 points):** Suicidal Ideations; wants to stop using drugs

**Contributing Factors (10 points):** The client stated "everything" was a contributing factor upon admission. The most significant factor was getting into an argument with his boss and being fired, contributing to recent drug use.

## N323 CARE PLAN

**Factors that lead to admission:** Fentanyl use, previous attempts of suicide, recent loss of job

**History of suicide attempts:** Several previous attempts; most recent in December 2022 from fentanyl overdose

**Primary Diagnosis on Admission (2 points):** Detox; and three specified diagnoses.

- 1) Unspecified bipolar disorder, severe, depressed
- 2) Stimulant use disorder, severe (methamphetamines)
- 3) Opioid use disorder, severe (fentanyl)

**Psychosocial Assessment (30 points)**

History of Trauma				
No lifetime experience: N/A				
Witness of trauma/abuse: N/A				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
<b>Physical Abuse</b>	N/A	Childhood	N/A	The client described his father as abusive due to him being an alcoholic.
<b>Sexual Abuse</b>	N/A	N/A	N/A	N/A
<b>Emotional Abuse</b>	N/A	Childhood	N/A	Along with physical abuse was emotional abuse from his father. Said his father was

## N323 CARE PLAN

				degrading.
<b>Neglect</b>	<b>N/A</b>	Childhood	<b>N/A</b>	His mother was not around for him, and his father was difficult during the client's childhood.
<b>Exploitation</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Crime</b>	<b>N/A</b>	25-Present	<b>N/A</b>	The client described an incident where he and his wife were being carjacked, and the client was arrested and charged with unlawful possession of a firearm and unlawful discharge.
<b>Military</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Natural Disaster</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Loss</b>	<b>N/A</b>	Recent Years	<b>N/A</b>	The client spoke of losing friends to overdose in recent years.
<b>Other</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Presenting Problems</b>				
<b>Problematic Areas</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>	
<b>Depressed or sad mood</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	
<b>Loss of energy or interest in activities/school</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	
<b>Deterioration in hygiene and/or grooming</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	
<b>Social withdrawal or isolation</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	
<b>Difficulties with home, school, work, relationships, or responsibilities</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	

## N323 CARE PLAN

<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Change in numbers of hours/night</b>	Yes	No	N/A
<b>Difficulty falling asleep</b>	Yes	No	N/A
<b>Frequently awakening during night</b>	Yes	No	The client experiences nightmares from past trauma.
<b>Early morning awakenings</b>	Yes	No	N/A
<b>Nightmares/dreams</b>	Yes	No	The client has nightmares nearly every night due to childhood trauma.
<b>Other</b>	Yes	No	N/A
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	Yes	No	N/A
<b>Binge eating and/or purging</b>	Yes	No	N/A
<b>Unexplained weight loss?</b>	Yes	No	N/A
<b>Amount of weight change:</b>			
<b>Use of laxatives or excessive exercise</b>	Yes	No	N/A
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	Yes	No	N/A
<b>Panic attacks</b>	Yes	No	N/A
<b>Obsessive/compulsive thoughts</b>	Yes	No	N/A
<b>Obsessive/compulsive behaviors</b>	Yes	No	N/A
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	Yes	No	N/A

## N323 CARE PLAN

Rating Scale				
How would you rate your depression on a scale of 1-10?			N/A	
How would you rate your anxiety on a scale of 1-10?			N/A	
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	The client was recently fired from their job as a bartender for arguing with their boss.	
School	Yes	No	The client states they are currently pursuing a degree in Business Administration, and school is somewhat stressful.	
Family	Yes	No	N/A	
Legal	Yes	No	The client is currently on probation. The client likes their probation officer and thinks they are helpful.	
Social	Yes	No	N/A	
Financial	Yes	No	N/A	
Other	Yes	No	N/A	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Inpatient / Outpatient	Facility / MD / Therapist	Reason for Treatment	Response/Outcome
December 2022	Inpatient Outpatient Other:	Pavilion / Dr. Repetto	Fentanyl Overdose	No improvement Some improvement

## N323 CARE PLAN

				<b>Significant improvement</b>
<b>December 2022</b>	<b>Inpatient</b> <b>Outpatient</b> <b>Other:</b>	Carle and OSF	Fentanyl Overdose	<b>No improvement</b> <b>Some improvement</b> <b>Significant improvement</b>
N/A	<b>Inpatient</b> <b>Outpatient</b> <b>Other:</b>	N/A	N/A	<b>No improvement</b> <b>Some improvement</b> <b>Significant improvement</b>
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): N/A Who are children with now? N/A				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: N/A Number of marriages: Two				
<b>Sexual Orientation:</b> Heterosexual	<b>Is client sexually active?</b> <b>Yes</b> No		<b>Does client practice safe sex?</b> Yes <b>No</b>	
<b>Please describe your religious values, beliefs, spirituality and/or preference:</b> Spiritual, no specific practice; believes in a higher power				
<b>Ethnic/cultural factors/traditions/current activity:</b> The client did not specify.				

## N323 CARE PLAN

<b>Describe:</b> N/A
<b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b> Currently on probation for unlawful firearm possession and unlawful discharge.
<b>How can your family/support system participate in your treatment and care?</b> The client states that his father is his biggest supporter now, and he can confide in him for advice.
<b>Client raised by:</b> His father  <b>Natural parents</b> <b>Grandparents</b> <b>Adoptive parents</b> <b>Foster parents</b> <b>Other (describe):</b>
<b>Significant childhood issues impacting current illness:</b> Multiple types of trauma. The client's father was an alcoholic and abusive. Their childhood environment was not beneficial. The client grew up in St. Louis and went to Roosevelt High School, where they were in fights nearly every day.
<b>Atmosphere of childhood home:</b> <b>Loving</b> <b>Comfortable</b> <b>Chaotic</b> <b>Abusive</b> <b>Supportive</b> <b>Other:</b>
<b>Self-Care:</b> The client relies mostly on themselves; states they can confide in their father when needed. <b>Independent</b> <b>Assisted</b> <b>Total Care</b>
<b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b>  The client's father abused alcohol when the client was younger. States their father is 13 years sober. Suicide ideation has affected their family. Two uncles have successfully committed suicide. Another one did a murder/suicide.
<b>History of Substance Use:</b> The client has abused opioids (fentanyl) for four years. Admits to using marijuana, alcohol, and methamphetamine.
<b>Education History:</b> The client states they are currently pursuing a degree in Business Administration. <b>Grade school</b> <b>High school</b> - Roosevelt High School (St. Louis) <b>College</b>

## N323 CARE PLAN

<b>Other:</b>
<b>Reading Skills:</b> <b>Yes</b> <b>No</b> <b>Limited</b>
<b>Primary Language:</b> English
<b>Problems in school:</b> Fighting in high school
<b>Discharge</b>
<b>Client goals for treatment:</b> Detox, reduce suicidal ideations, stabilize mood, quit using drugs
<b>Where will client go when discharged?</b> The client is going to Recovery Happens to live in a group home with other individuals recovering from substance abuse.

**Outpatient Resources (15 points)**

Resource	Rationale
1. Recovery Happens - Tom Holmes	1. The client stated they are going to live in a group home, and they have been in touch with the coordinator. This can be beneficial to the client, as they will live with others recovering from substance abuse and will have people to relate to.
2. Other members of the group home	2. The client will be living with others that have experienced exactly what they are going through. The client can relate to and refer to them when they need help.
3. The client's father	3. The client stated that their father is their biggest supporter. Although their father was abusive growing up, the two have rekindled their relationship. The client now feels that they can rely on their father.

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

<b>Brand/Generic</b>	Depakote	Neurontin	Seroquel	Habitrol	Circadin
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## N323 CARE PLAN

	Divalproex	Gabapentin	Quetiapine	Nicotine Patch	Melatonin
<b>Dose</b>	250 mg	300 mg	200 mg	21 mg	2 mg
<b>Frequency</b>	BID	BID	Bedtime	Daily	Bedtime
<b>Route</b>	Oral	Oral	Oral	Transdermal	Oral
<b>Classification</b>	Anticonvulsants Other ( <i>RxList</i> , n.d.)	Anticonvulsants ( <i>RxList</i> , n.d.)	Antipsychotic, 2nd Generation; Antimanic Agent ( <i>RxList</i> , n.d.)	Nicotine replacement therapy ( <i>RxList</i> , n.d.)	Melatonin receptor agonists ( <i>RxList</i> , n.d.)
<b>Mechanism of Action</b>	Increase brain concentration of gamma-aminobutyric acid ( <i>RxList</i> , n.d.)	Binds to calcium channels to reduce abnormal electrical channels ( <i>RxList</i> , n.d.)	Acts on various neurotransmitters to reduce dopaminergic effect ( <i>RxList</i> , n.d.)	Stimulate nicotinic receptors in the brain to stimulate release of dopamine ( <i>RxList</i> , n.d.)	Receptor agonist for melatonin MT1 and MT2 receptors to assist with circadian rhythm ( <i>RxList</i> , n.d.)
<b>Therapeutic Uses</b>	Treat seizures, bipolar disorder, mood stabilizer	Treat partial seizures, restless leg syndrome, pain from damaged nerves	Reduce/Eliminate hallucinations, delusions, hearing voices, aggressive behaviors	Treat nicotine withdrawal	Maintain normal sleep patterns, dietary supplement
<b>Therapeutic Range (if applicable)</b>	50 - 100 mcg / mL ( <i>RxList</i> , n.d.)	N/A	N/A	N/A	N/A
<b>Reason Client Taking</b>	Mood stabilizer	Anxiety	Mood Stabilizer	Nicotine withdrawal	Regulate sleep patterns
<b>Contraindications (2)</b>	1. Client taking aspirin/blood thinners 2. Poor liver function	1. Antacid use (wait two hours to take after antacid use) 2. Alcohol use (cause very low BP)	1. Hot weather (skin irritation) 2. Other medications with sedative effects	1. Uncontrolled hypertension 2. Skin condition	1. Autoimmune conditions 2. Clients with impaired liver function

## N323 CARE PLAN

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<b>Side Effects/Adverse Reactions (2)</b>	1. Jaundice / Liver problems 2. Indigestion	1. Emotional changes 2. Urinary changes	1. Sexual dysfunction 2. Worsening of depression	1. Withdrawal symptoms 2. Local skin irritation	1. Behavior changes 2. CNS effects
<b>Medication/Food Interactions</b>	Aspirin, Anticoagulants, Contraceptives ( <i>RxList</i> , n.d.)	Opioids, Antiepileptics, Alcohol ( <i>RxList</i> , n.d.)	CYP3A4 inhibitors and inducers, Grapefruit, Alcohol ( <i>RxList</i> , n.d.)	Tricyclic Antidepressants ( <i>RxList</i> , n.d.)	Fluvoxamine, Rifampin, CYP3A4 inhibitors, Donepezil, Contraceptives, Alcohol ( <i>RxList</i> , n.d.)
<b>Nursing Considerations (2)</b>	1. Get baseline liver function 2. Assess for other meds (Aspirin / Anticoagulants)	1. Baseline kidney function 2. Assess client's use of alcohol	1. Make sure client is not using alcohol 2. Avoid antihistamines / make sure client has not taken any	1. Disposal precautions 2. Removal of previous patch before application of new patch	1. Baseline behavior of the client 2. Assess for autoimmune conditions

<b>Brand/Generic</b>	N/A	N/A	N/A	N/A	N/A
<b>Dose</b>	N/A	N/A	N/A	N/A	N/A
<b>Frequency</b>	N/A	N/A	N/A	N/A	N/A
<b>Route</b>	N/A	N/A	N/A	N/A	N/A
<b>Classification</b>	N/A	N/A	N/A	N/A	N/A
<b>Mechanism of Action</b>	N/A	N/A	N/A	N/A	N/A
<b>Therapeutic Uses</b>	N/A	N/A	N/A	N/A	N/A
<b>Therapeutic Range (if applicable)</b>	N/A	N/A	N/A	N/A	N/A

## N323 CARE PLAN

<b>Reason Client Taking</b>	N/A	N/A	N/A	N/A	N/A
<b>Contraindications (2)</b>	N/A	N/A	N/A	N/A	N/A
<b>Side Effects/Adverse Reactions (2)</b>	N/A	N/A	N/A	N/A	N/A
<b>Medication/Food Interactions</b>	N/A	N/A	N/A	N/A	N/A
<b>Nursing Considerations (2)</b>	N/A	N/A	N/A	N/A	N/A

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

*RxList*. (n.d.). RxList - The Internet Drug Index for prescription drug information, interactions, and side effects. Retrieved February 18, 2023, from <https://www.rxlist.com/>

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

<b>APPEARANCE:</b> <b>Behavior:</b> <b>Build:</b> <b>Attitude:</b> <b>Speech:</b> <b>Interpersonal style:</b> <b>Mood:</b> <b>Affect:</b>	The client was well-groomed and displayed typical social behavior. The client is stocky in build and appears fit. They reflected a positive attitude. Their speech was normal and fluent. The client was open and authentic in discussion, and not afraid to disclose information. The client demonstrated an euthymic mood, and affect was within normal range.
<b>MAIN THOUGHT CONTENT:</b> <b>Ideations:</b> <b>Delusions:</b> <b>Illusions:</b> <b>Obsessions:</b> <b>Compulsions:</b> <b>Phobias:</b>	The client denies any delusions, illusions, obsessions, compulsions, or phobias. The client stated they experienced suicidal ideations upon admission. The ideations have subsided since admission to the Pavillion.
<b>ORIENTATION:</b> <b>Sensorium:</b> <b>Thought Content:</b>	The client is alert and oriented to person, place, time, and situation. The sensorium of the client was functioning normally, besides the suicidal ideations upon admission.
<b>MEMORY:</b> <b>Remote:</b>	The short-term and long-term memory of the client was intact, as they spoke of instances that

## N323 CARE PLAN

	occurred recently and many years ago.
<b>REASONING:</b> <b>Judgment:</b> <b>Calculations:</b> <b>Intelligence:</b> <b>Abstraction:</b> <b>Impulse Control:</b>	The client's seemed to have sound judgment and intelligence for their age. Their impulse control is abnormal, as it led to them being admitted into the Pavillion. Abstract reasoning and calculations were not assessed.
<b>INSIGHT:</b>	The client's insight appeared normal, as they participated and contributed in the group sessions.
<b>GAIT:</b> <b>Assistive Devices:</b> <b>Posture:</b> <b>Muscle Tone:</b> <b>Strength:</b> <b>Motor Movements:</b>	The client's gait and posture were normal. The client has an erect posture and defined muscle tone. They do not use any assistive devices. Their motor movements were normal. Strength was not tested, but is assumed to be normal.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Admission 2323	95	99/55	18	98.7 temporal	94% room air
1453	92	124/61	18	98.0 temporal	97% room air

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

Time	Scale	Location	Severity	Characteristics	Interventions
Admission 2323	Numerical	N/A	Zero	N/A	N/A
1453	Numerical	N/A	Zero	N/A	N/A

**Dietary Data (2 points)**

Dietary Intake	
<b>Percentage of Meal Consumed:</b>  <b>Breakfast:</b> 100%	<b>Oral Fluid Intake with Meals (in mL)</b>  <b>Breakfast:</b> 240 mL

## N323 CARE PLAN

<b>Lunch:</b> 100%	<b>Lunch:</b> 480 mL
<b>Dinner:</b> Unable to assess	<b>Dinner:</b> Unable to assess

**Discharge Planning (4 points)**

**Discharge Plans (Yours for the client):** The client will have frequent check-ins with their provider following discharge from the Pavillion. They will be provided relocation to a group home for recovery, where the house members are all recovering from substance use. Also, the client will be provided with a journal to document daily ideas, activities, and how they feel they have improved throughout the recovery process.

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<b>Nursing Diagnosis</b>	<b>Rational</b>	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (Prior to discharge)</b>
<ul style="list-style-type: none"> <li>● Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<ul style="list-style-type: none"> <li>● Explain why the nursing diagnosis was chosen</li> </ul>			
1. Risk for suicide related to hopelessness as evidenced by statements made upon admission to the Pavillion (Martin, 2022).	The client stated that “everything” contributed to their suicidal ideations and the recent use of fentanyl.	1. Creating a safe environment. 2. Removal of belongings/things that can cause self-harm. 3. Go through the PHQ-9 to assess current SI (Martin, 2022).	1. Observation of the client (Q15). 2. Continued reassessment of risk for suicide. 3. Participation in group therapy (Martin, 2022).	1. Communicate with a professional about thoughts and feelings. 2. Have the client stay with a friend/family/group home. 3. Use medication to relieve SI symptoms (Martin, 2022).

## N323 CARE PLAN

2. Risk for violence: self-directed related to suicidal ideation as evidenced by verbal threats against self and previous attempts (Martin, 2022).	The client is at risk for harming themselves due to a change in recent situations and previous attempts.	1. Go through a mental assessment. 2. Providing a calm environment. 3. Using a calm and firm approach (Martin, 2022).	1. Frequent reassessment of the client's mental status. 2. Maintaining a consistent approach. 3. Remaining as neutral as possible with the client (Martin, 2022).	1. The client must stay with at least one person. 2. Use medications to stabilize their mood. 3. Frequent check-ins with a professional (Martin, 2022).
3. Ineffective individualized coping related to instability, as evidenced by the client getting fired from their job and using fentanyl to cope (Vera, 2022).	The client was recently fired from their job for arguing with their boss. To cope, the client went back to using fentanyl.	1. Removal of belongings to check for substances. 2. Administer detoxification medication. 3. Provide a safe, non-threatening environment (Vera, 2022).	1. Participation in group therapy and discussion. 2. Exploration of alternate coping strategies. 3. Discuss plans for living without drugs (Vera, 2022).	1. Get the client involved in a self-help association. 2. Move into a group home with other people recovering from substance use. 3. Use a journal to document daily thoughts (Vera, 2022).

**Other References (APA):**

Martin, P. (2022, March 18). *6 Bipolar Disorders Nursing Care Plans*. Nurseslabs. Retrieved

February 19, 2023, from <https://nurseslabs.com/bipolar-disorders-nursing-care-plans/2/>

Martin, P. (2022, March 18). *3 Suicide Behaviors Nursing Care Plans*. Nurseslabs. Retrieved

February 19, 2023, from <https://nurseslabs.com/suicide-behaviors-nursing-care-plans/>

Vera, M. (2022, March 18). *Nursing Diagnosis for Substance Abuse: 8 Care Plans*. Nurseslabs.

Retrieved February 19, 2023, from <https://nurseslabs.com/substance-abuse-nursing-diagnosis-care-plan/2/>

**Concept Map (20 Points):**

### Subjective Data

The client admitted that the client's has contributed to their Unspecified depressive disorder. The client was depressed, felt hopeless and argument severe (with his family) and a history of Opioid use, the most recent being in (December 2022). Family history is significant for: BIPolar, Schizophrenia, 18 Family members, and 02 relatives commit 9% of them, another one committed a murder-suicide.

Objective Data

### Client Info

The client is a 33-year-old Caucasian male that stands 5'10" and weighs 165 pounds. The client has a history of suicide attempts and substance use (alcohol, marijuana, cocaine, and fentanyl). The client states that his father is his support system.

### Diagnosis 1)

Risk for suicide related to hopelessness, as evidenced by statements made upon admission to the Pavilion (Martin, 2022).  
 Outcome 1) The client will report decreased thoughts of suicide after 60 days of medication and communication with a professional.

### Diagnosis 2)

Risk for violence self-directed related to suicidal ideation as evidenced by verbal threats against self and previous attempts (Martin, 2022).  
 Outcome 2) The client will report decreased thoughts of suicide and effective coping strategies 60 days after medication and living with another individual.

### Diagnosis 3)

Ineffective individualized coping related to instability, as evidenced by the client getting fired from their job and using fentanyl to cope (Vera, 2022).  
 Outcome 3) The client will report effective coping strategies and no drug use after 60 days of living in a group home and participating in a self-help association.

### Nursing Interventions

#### Immediate Interventions:

Diagnosis 1: 1. Creating a safe environment. 2. Removal of belongings/things that can cause self-harm. 3. Use through the client to assess current SI (Martin, 2022).

#### Nursing Diagnosis/Outcomes

Diagnosis 1: 1. GI through mental assessment. 2. Provide a calm environment. 3. Using a calm and firm approach (Martin, 2022).  
 Diagnosis 2: 1. Removal of belongings to check for substances. 2. Administer detoxification medication. 3. Provide a safe non-threatening environment (Vera, 2022).

#### Long-term professional.

Diagnosis 1: 1. Observation of the client (Q15). 2. Continued reassessment of risk for suicide. 3. Participation in group therapy (Martin, 2022).

Diagnosis 2: 1. Frequent reassessment of the client's (normal) status. 2. Maintaining a consistent approach. 3. Remaining as neutral as possible with the client (Martin, 2022).

Diagnosis 3: 1. Participation in group therapy and discussion. 2. Exploration of alternate coping strategies. 3. Discuss plans for living without drugs (Vera, 2022).

#### Individualized coping

Diagnosis 1: 1. Communicate with a professional about thoughts and feelings. 2. Use the client's journal to document thoughts and feelings. 3. Use medication to relieve SI symptoms (Martin, 2022).

Diagnosis 2: 1. The client must stay with at least one person. 2. Use medications to help with symptoms of SI. 3. Use a journal to document thoughts and feelings (Vera, 2022).

Diagnosis 3: 1. Get the client involved in a self-help association. 2. Move into a group home with other people recovering from substance use. 3. Use a journal to document daily thoughts (Vera, 2022).

### References

Martin, P. (2022, March 18). *6 Bipolar Disorders Nursing Care Plans*. Nurseslabs.

Retrieved February 19, 2023, from <https://nurseslabs.com/bipolar-disorders-nursing-care-plans/2/>

Martin, P. (2022, March 18). *3 Suicide Behaviors Nursing Care Plans*. Nurseslabs.

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*RxList*. (n.d.). RxList - The Internet Drug Index for prescription drug information, interactions, and side effects. Retrieved February 18, 2023, from

<https://www.rxlist.com/>

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Nurseslabs. Retrieved February 19, 2023, from <https://nurseslabs.com/substance-abuse-nursing-diagnosis-care-plan/2/>