N323 Care Plan

Lakeview College of Nursing

Brittney Burns

Demographics (3 points)

Date of Admission 10/13/2023	Patient Initials MP	Age 58	Gender M
Race/Ethnicity W	Occupation Disabled/Unemployed	Marital Status Divorced	Allergies Bupropion Hcl-unknown Fluoxetine-Hallucinations Fluphenazine-Dyskinesia, EPS Haloperidol-Unknown Thioridazine-Unknown
Code Status Full	Observation Status Inpatient, rounds Q15.	Height 5'11	Weight 170

Medical History (5 Points)

Past Medical History: COPD, GERD, CVA, Stroke, Abdomen surgery 09/08/2020, STEMI

Significant Psychiatric History: Antisocial Personality Disorder, Post Traumatic Stress Disorder, Alcohol dependence, Schizophrenia, Suicide attempt, Substance induced mood disorder, Hallucinations, Malingering, Schizoaffective disorder, bipolar type, last SI attempt OD on Seroquel 2015

Family History: Mother deceased, Father deceased, Maternal and Paternal Grandmother deceased, Maternal and Paternal Grandfather deceased, estranged from two daughters, divorced.

Social History (tobacco/alcohol/drugs): The patient has a history of alcoholism, history of cocaine use, marijuana smoker, smoked cigarettes for 30 years, drinks heavy every 2 weeks, uses weed and cocaine 4 times a week.

Living Situation: The patient is homeless.

Strengths: The patient believes that he will be successful in recovery and staying on task with his medicine regimen if he was to find placement in a group home or shelter in Bloomington. He believes he was stronger in his faith and had a better spiritual connection with God and the community because they were an actual help as opposed to Champaign.

Support System: Client currently has no support system in place.

Admission Assessment

Chief Complaint (2 points): Suicidal Ideation

Contributing Factors (10 points): Wanted to jump off the top of a parking deck after drinking a 5th of whiskey and smoking cocaine the night prior.

Factors that lead to admission: Cocaine and alcohol use

History of suicide attempts: Client has attempted suicide 7 times, jumping, hanging, and overdose.

Primary Diagnosis on Admission (2 points): Suicidal Ideation/ Bipolar disorder

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: No, has no experience. **Witness of trauma/abuse: Client denies**				
	Current	Past (what age)	**Secondary Trauma**	**Describe**

			(response that comes from caring for another person with trauma)	
Physical Abuse	**Denies**	N/A	**N/A**	**N/A**
Sexual Abuse	**Denies**	N/A	**N/A**	**N/A**
Emotional Abuse	**Denies**	N/A	**N/A**	**N/A**
Neglect	**Denies**	N/A	**N/A**	**N/A**
Exploitation	**Denies**	N/A	**N/A**	**N/A**
Crime	**Prison**	Early twenties	**N/A**	**Client states that being in prison was a learning experience. He shared that though it wasn't traumatizing he would never want to return.**
Military	**Denies**	N/A	**N/A**	**N/A**
Natural Disaster	**Denies**	N/A	**N/A**	**N/A**
Loss	**Divorce**	Late twenties early thirties. Client couldn't remember.	**Client daughters became estranged.**	**Client denies that this has any impact on his life.**
Other	**Drug use**	Late twenties early thirties. Client couldn't remember.	Client daughters became estranged.	**Client denies that this has any impact on his life.**

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Happens often. When asked to elaborate, the client stated that it happens every week.
Loss of energy or interest in activities/school	**Yes**	**No**	**Denies**
Deterioration in hygiene and/or grooming	**Yes**	**No**	**Denies**
Social withdrawal or isolation	**Yes**	**No**	**Denies**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**Denies**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Typically, 8 or more hours a night.
Difficulty falling asleep	**Yes**	**No**	**Denies**
Frequently awakening during night	**Yes**	**No**	**Denies**
Early morning awakenings	**Yes**	**No**	**States that he rises early out of habit.**
Nightmares/dreams	**Yes**	**No**	**Denies**
Other	**Yes**	**No**	**Denies**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Denies**
Binge eating and/or purging	**Yes**	**No**	**Denies**
Unexplained weight loss?	**Yes**	**No**	**Denies**

Amount of weight change: Denies			
Use of laxatives or excessive exercise	**Yes**	**No**	**Denies**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	**Client states this presents in social settings.**
Panic attacks	**Yes**	**No**	**Denies**
Obsessive/compulsive thoughts	**Yes**	**No**	**Denies**
Obsessive/compulsive behaviors	**Yes**	**No**	**Denies**
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	**Denies**
Rating Scale			
How would you rate your depression on a scale of 1-10?		**8**	
How would you rate your anxiety on a scale of 1-10?		**5**	
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**	Client states that he doesn't work because he is disabled.
School	**Yes**	**No**	**Denies**
Family	**Yes**	**No**	Although estranged from his family the client denies any ongoing issues.
Legal	**Yes**	**No**	**Denies**
Social	**Yes**	**No**	Client states that he doesn't wish to be around people as it makes him nervous.
Financial	**Yes**	**No**	Client states he doesn't bring in a livable wage being disabled.
Other	**Yes**	**No**	The client states he has no living

			arrangements and is currently homeless.	
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
09/11/2023	**Inpatient** **Outpatient** **Other:**	**Inpatient**	**Suicidal** **Ideation**	**No improvement** **Some improvement** **Significant improvement**
2015	**Inpatient** **Outpatient** **Other:**	**Inpatient**	**Suicidal** **Ideation**	**No improvement** **Some improvement** **Significant improvement**
	Inpatient **Outpatient** **Other:**			**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
N/A			**Yes**	**No**
N/A			**Yes**	**No**
N/A			**Yes**	**No**

N/A			**Yes**	**No**
N/A			**Yes**	**No**

If yes to any substance use, explain: Client denies substance use outside of alcohol and marijuana use

Children (age and gender): Client has two daughters that are in their 30's.

Who are children with now? The daughters went no contact with their father 5+ years ago

Household dysfunction, including separation/divorce/death/incarceration: Client is divorced and homeless

Current relationship problems: states he doesn't want to date because he is unstable in life.

Number of marriages: 1

Sexual Orientation:	**Is client sexually active?** **Yes No**	**Does client practice safe sex?** **Yes No**

Please describe your religious values, beliefs, spirituality and/or preference: Client state

Ethnic/cultural factors/traditions/current activity:

Describe: N/A

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Client was previously incarcerated and is divorced.

How can your family/support system participate in your treatment and care? Client is adamant that he has no support system.

Client raised by:

Natural parents Mother was present but not consistent, Father was completely absent.
Grandparents' Maternal grandparents primarily raised him.
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness: Client denies childhood issues
Atmosphere of childhood home: Grandparents tried to give a sense of "normal" after the mother left the home and the father was uninterested in raising the patient. Clients' favorite memory was taking family vacations across the US with his grandparents. **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Both Paternal and Maternal grandmothers were diagnosed with schizophrenia.
History of Substance Use: Client denies heavy drug use but does admit to using marijuana and alcohol.
Education History: **Grade school.** **High school** **College** **Other: Highest grade completed was 8th grade**
Reading Skills: Client denies having issues with reading and writing. Stated "I am not dumb I can read and write just fine." **Yes** **No** **Limited**
Primary Language: English

Problems in school: Client denies problems in school
Discharge
Client goals for treatment: Stabilize medication and find housing
Where will the client go when discharged? Client desires to go to Bloomington. He has lived there before and states it was better housing for the homeless population.

Outpatient Resources (15 points)

Resource	Rationale
1. Narcotic anonymous of East central Illinois (NA)	**1. The patient could have the support from others who are struggling with addiction. This may help with the patient's recovery from cocaine use**
2. Alcoholic anonymous (AA)	**2. The patient will have the support from others who struggle with alcohol addiction. Having a mentor could lead this patient on the road to recovery.**
3. Centralized and take for homeless (CIH)	**3. The patient will benefit from this because this can assist with providing permanent placement through housing programs so that the patient isn't without a home.**

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

Brand/ Generic	**divalproex sodium, Depakote**	**gabapentin, Neurontin**	**olanzapine, Zyprexa**	**benztropine mesylate, Cogentin**	**rivaroxaban, Xarelto**
Dose	**500 mg**	**600 mg**	**10mg**	**2mg**	**10 mg**
Frequency	**1 tab 3x daily**	**2 cap 3x daily**	**2x daily PRN**	**1 tab 2x daily**	**1 tab 1x daily**
Route	**Oral**	**Oral**	**Intramuscular**	**Oral**	**Oral**
Classification	**Pharmacologic class: Carboxylic derivative**	**Pharmacologic class: 1-amino-methylcyclohexaneacetic acid**	**Pharmacologic class: Thienobenzodiazepine derivative**	**Pharmacologic class: Anticholinergic**	**Pharmacologic class: Factor XA inhibitor**
Mechanism of Action	**Gamma-aminobutyric acid (GABA), the most prevalent inhibitory neurotransmitter in the brain, may be blocked from reuptake, hence reducing seizure activity. By blocking voltage-sensitive sodium**	**The most common inhibitory neurotransmitter in the brain, Gamma-aminobutyric acid (GABA), shares structural similarities with gabapentin. Although the precise mechanism of gabapentin is uncertain, GABA reduces the fast neuronal firing**	**May have antipsychotic effects via interacting with serotonin and dopamine receptors.**	**This returns the brain's dopamine and acetylcholine levels to normal, relaxing the muscles and reducing tremor, rigidity, and drooling. In essence, benztropine prevents acetylcholine from acting on cholinergic receptor**	**Selectively blocks the active site of factor Xa which plays a central role in the cascade of blood calculation. Without the action of factor Xa blood clotting is impaired**

	channels, GABA reduces the rate at which neurons fire.	**linked to seizures. Additionally, it could stop exaggerated reactions to unpleasant stimuli and reactions that are associated with pain.**		**sites.**	
Therapeutic Uses	**Therapeutic class: Anticonvulsant**	**Therapeutic class: Anticonvulsant**	**Therapeutic class: Antipsychotic**	**Therapeutic class: Antiparkinsonian, central-acting anticholinergic**	**Therapeutic class: Anticoagulant**
Therapeutic Range (if applicable)					
Reason Client Taking	**Acute manic phase of bipolar disorder**	**Partial seizures**	**Agitation, Schizophrenia**	**Movement Disorder**	**DVT**
Contraindications (2)	**Hepatic impairment, hypersensitive to valproic acid**	**Hypersensitivity to gabapentin or its components.**	**Hypersensitivity to olanzapine or its components.**	**Children under the age of 3, Hypersensitivity to benztropine mesylate or its components.**	**Active pathological bleeding, Hypersensitivity to rivaroxaban or its components**
Side Effects/Adverse Reactions (2)	**1. Bradycardia 2. Suicidal Ideation**	**1. Suicidal ideation 2. hepatitis**	**1. Pulmonary embolism 2. Anaphylaxis**	**1. Hypotension 2. Euphoria**	**anxiety Steven Johnson syndrome**
Medication /Food					

Interactions					
Nursing Considerations (2)	**1. Keep a watchful eye on the patient for suicidal thoughts, especially when therapy begins and the dosage is changed because depression may briefly get worse during this period, perhaps leadi**	**1. When therapy begins or the patient's medication is changed, especially, keep a cautious eye out for any indications of suicide behavior or thought.** **2. Routine monitoring of blood gabapentin level is not needed.**	**1. Watch patients closely, especially youth and young adults for suicidal tendencies when therapy begins or the patient's medication is changed, especially.** **2. Monitor patients' blood glucose level routinely because olanzapine may increas**	**1. Benztropine therapy should not be abruptly stopped.** **2. Monitor patient movements as this medicine may cause weakness and the inability to move specific muscle groups. If this occurs expect to**	**Expect. for the medicine to be discontinued if acute renal failure occurs. Be aware that this medication should not be given to patients with prosthetic heart valves or as an alternative to unfractionated heparin in patients with pulmonary embolism who are hemodynamically unable to or may receive pulmonary embolectomy or thrombolysis.**

	ng to suicide thoughts. **2. The medication may affect thyroid function testing and urine ketone tests, so use caution.**		**e risk of hyperglycemia.**	**drop the dosage.**	

Medications Reference (1) (APA):

***2023 Nurse's Drug Handbook*. (2023). Jones & Bartlett Learning.**

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**The client was observed being disheveled and wearing yellow scrubs with a frail build. The patient was wearing an adult diaper that he used as a safety blanket just in case he had an accident. The client's behavior was abnormal as he was very lethargic and wanted to lay down, he was withdrawn and spoke in a monotone tone. The client would close his eyes and only answer questions that he felt was necessary to be answered. The client was calm but anxious with two new people being in the room.**
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	**The client denied having any delusions, hallucinations, compulsions, or phobias. The client stated that he likes to stay away from crowds because it heightens his anxiety. The client reported that now he was not having any suicidal ideation, but he was worried about what the future would hold and feared that if he did not continue taking his medicines as prescribed and did not find stable housing the suicidal ideation would return. The client also denied hard drug use and stated he only used marijuana and alcohol.**
ORIENTATION: **Sensorium:** **Thought Content:**	**client was A&O x3 he was present but withdrawn.** .
MEMORY: **Remote:**	**Both short and long term memory appeared to be normal and intact**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	At the present time the client appeared to have sound judgment and the level of intelligence was consistent with the patient's age. His impulse control was not able to be measured as the patient kept closing his eyes and ignoring questions he did not want to answer. His calculation and abstract could not be assessed at the time of assessment.

INSIGHT:	**The client's insight was observed to be consistent with his age group**
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	**The client use assistive devices such as a Walker and an adult diaper. The client's posture could not be assessed due to the patient lying down during most of the assessment. The client's muscle tone strength and motor movement from what was assessed seemed to be delayed for his age, weight and height.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**72**	**121/78** **134/91**	**18**	**97.8**	**98**
1433	**85**	**101/56**	**18**	**98**	**99**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**10**	**Denies**	**Denies**	**Denies**	**Denies**
1433	**10**	**Denies**	**Denies**	**Denies**	**Denies**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: refused**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 240mL**

Lunch: 75% **Dinner:**	**Lunch: 480mL** **Dinner:**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The client plans to go to Bloomington and find shelter and a church home and wants to stay consistent with his medications. The client didn't give a consistent plan that the nurse couldn't medically agree with. The nurse's fear is that the patient would relapse if he did not have a solid plan. The nurse believes that due to the patient wearing an adult diaper walking with a Walker and with the medical history that he has the patient would do well and either an assistant living or in a long term care facility. This will give the patient the best chance of a successful recovery. The patient will have access to psychiatry and the the nurses will help manage medications and he will have food and shelter.

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. Risk for suicide	**This rationale was**	**1. Assess for signs of**	**1. Encourage patient to set**	**1. Patients will receive a**

related to drug abuse as evidenced by previous suicide attempt and ideation.	**chosen because the client was not always honest and upfront about his struggle with cocaine and alcohol.**	**suicidal thinking that warrant further investigation such as sudden hoarding of medications giving away possessions sudden interest in guns and despond it remarks.** **2. Take all suicide threats seriously.** **3. Remove any objects that the patient could use for self-inflicted injury such as razors belts glass objects and peels to ensure safety**	**goals of cooperating with psychiatry intervention** **2. Set aside time for listening to patient to communicate that you care** **3. Monitor the patient while administering his medications.**	**referral to a mental health professional** **2. Patient will report decreased desire to kill oneself** **3. Patient will report improved feelings of self-worth**
2. Risk for self-directed violence as related to homelessnes s made evidence by patient reporting instability with housing	**This rationale was chosen because the patient reported having anxiety due to lack of shelter and having a home.**	**1. Ask the patient if he has a support system that is willing to let him come stay with them** **2. Encourage the patient to come up with a list of places where they would like placement.** **3. Incorporate**	**1. Assist patient any valuating the efficiency of patient strategies to meet the goals. Emphasize gains made toward recovery goals and assist in problem solving new solutions for strategies attempted but ineffective to meet the goal to**	**1. Patient will investigate group homes that assist with recovery.** **2. Patient will investigate long term health facilities that aligned with his recovery** **3. Patient will discuss events that led up to**

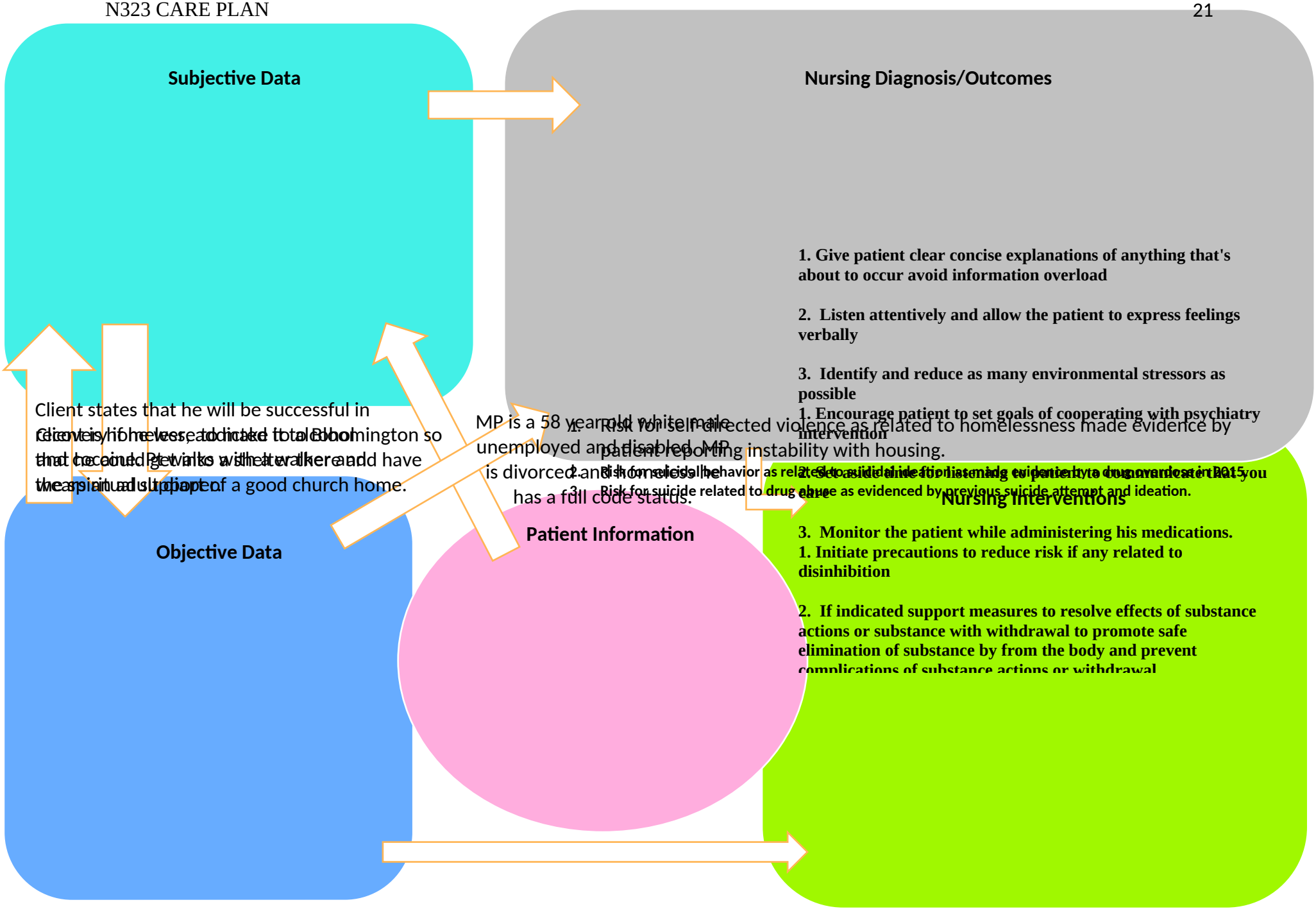
		having liaisons from different living facilities to come in to speak with the patient	**promote self-esteem self-efficiency and development of problem solving skills** **2. Help patient identify community resources to obtain continued therapy and support after hospitalization.** **3. Provide patients with telephone numbers for crisis prevention centers, suicide hotlines counselors and other community services.**	**current crisis**
3. Risk for suicidal behavior as related to suicidal ideation as made evidence by a drug overdose in 2015	**The rationale was chosen because the patient is unaware how the drugs and alcohol combo heightened his anxiety and depression.**	**1. Initiate precautions to reduce risk if any related to disinhibition** **2. If indicated support measures to resolve effects of substance actions or substance with withdrawal to promote safe elimination of substance by**	**1. Give patient clear concise explanations of anything that's about to occur avoid information overload** **2. Listen attentively and allow the patient to express feelings verbally** **3. Identify and**	**1. Patient will discuss feelings that precipitated suicide attempt** **2. Patient will attend sessions with the mental health professional** **3. Patient will discuss appropriate coping skills to**

		from the body and prevent complications of substance actions or withdrawal. **3. Convey A nonjudgmental supportive attitude and do not take any irritable statements responses personally use effective therapeutic communication skills to avoid power struggles**	**reduce as many environmental stressors as possible**	**avoid future suicidal episodes**

Other References (APA):

Phelps, L. L. (2023). ***Nursing diagnosis reference manual*****. Wolters Kluwer.**

Concept Map (20 Points):


Subjective Data
Client states that he will be successful in
Client is homeless, addicted to alcohol
that he could get a shelter there and have
the spiritual support of a good church home.
Objective Data
MP is a 58 year old white male
unemployed and disabled. MP
is divorced and homeless he
has a full code status.
Patient Information
Nursing Diagnosis/Outcomes
1. Risk for self-directed violence as related to homelessness made evidence by patient reporting instability with housing.
2. Risk for suicidal behavior as related to drug overdose in 2015
3. Risk for suicide related to drug abuse as evidenced by previous suicide attempt and ideation.
1. Give patient clear concise explanations of anything that's about to occur avoid information overload
2. Listen attentively and allow the patient to express feelings verbally
3. Identify and reduce as many environmental stressors as possible
1. Encourage patient to set goals of cooperating with psychiatry intervention
2. Set aside time for listening to patient to communicate that you care
Nursing Interventions
3. Monitor the patient while administering his medications.
1. Initiate precautions to reduce risk if any related to disinhibition
2. If indicated support measures to resolve effects of substance actions or substance with withdrawal to promote safe elimination of substance by from the body and prevent complications of substance actions or withdrawal