N323 Care Plan

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N323 Mental and Behavioral Health

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Demographics (3 points)

Date of Admission 10-16-2023	**Patient Initials** A.Y	**Age** 40	Male **Gender**
Race/Ethnicity Caucasian	**Occupation** Construction/Welder	**Marital Status** Divorced	**Allergies** Codeine - Hives Morphine - Hives
Code Status Full code	**Observation Status** Voluntary, rounds every 15 minutes.	**Height** 6' 0"	**Weight** 180 lbs.

Medical History (5 Points)

Past Medical History: Nerve surgery (no reported surgery date) and bipolar disorder unspecified (no reported diagnosis date).

Significant Psychiatric History: The patient reports substance abuse disorder (no reported date), depression (no reported date), and two previous psychiatric hospital admissions (no reported dates). The Patient states that he "has not seen a psychiatrist or taken psychiatric medications in quite some time". The patient denies previous suicidal or homicidal ideation before current inpatient admission of suicidal ideation. Patient reports he took heroin to try and end his life because at the moment he felt like he "was tired of life".

Family History: The patient reports no family history medically or psychiatric.

Social History (tobacco/alcohol/drugs): The patient denies the use of alcohol. The patient reports current tobacco use in the form of cigarettes and reports smoking 1/2 of a pack daily for 18 years. The patient reports the current use of cocaine daily for the last 18 years. The patient reports the current use of marijuana and heroin once every two weeks.

Living Situation: The patient lives in a house with his mother, father, and 21-year-old biological son.

Strengths: The patient believes his strengths include his ability to seek treatment when necessary and his hands-on abilities including carpentry, welding, painting, mechanical ability, and landscaping. The patient states that his limitations include his "extensive drug use, poor coping skills, family issues, and his impulsive nature".

Support System: The patient reports that he has no support system at home or family involvement concerning his healthcare and the patient stated that he "prefers to keep it that way".

Admission Assessment

Chief Complaint (2 points): The patient stated "I overdosed on heroin. I am tired of life."

Contributing Factors (10 points):

Factors that lead to admission: The patient experienced a divorce within the last several years but stated that but cannot remember how long they were married or when the divorce was finalized. After the patient's divorce, he bounced around from living situation to living situation and eventually moved in with his mother, father, and his adult son. The patient reports "family stress" is the only notable household dysfunction he has experienced within his current living arrangement. The patient prefers that his family that he currently resides with not be involved in his mental healthcare treatment while at the hospital or once he is released. On the date of admission 10-16-2023, the patient reports that he experienced "no specific trigger I just acted on the thoughts in my head due to everything". The patient administered heroin through injection and immediately got into the shower, the family member heard him fall in the shower and called 911 once discovering him unconscious in the shower and administered 2 mg of intranasal Narcan. The patient was transported to OSF in Peoria, IL and administered another dose of Narcan while on route to the hospital. Once the patient's mental status improved the client was

transferred to OSF Urbana and admitted to the hospital's mental healthcare unit. When asked what occurred the patient stated that he "took heroin in an attempt to end his life".

History of suicide attempts: The patient denies previous suicidal ideation before current inpatient admission of suicidal ideation.

Primary Diagnosis on Admission (2 points): Bipolar disorder unspecified (HCC).

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient denies any history of trauma throughout his lifetime. **Witness of trauma/abuse:** Patient denies any history of witnessing trauma or abuse throughout his lifetime.				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	Denies	Denies	N/A	N/A
Sexual Abuse	Denies	Denies	N/A	N/A
Emotional Abuse	Denies	Denies	N/A	N/A
Neglect	Denies	Denies	N/A	N/A
Exploitation	Denies	Denies	N/A	N/A
Crime	Denies	During his teenage years.	N/A	Patient reports being involved in crime related activities that include auto theft only as a

				teenager.
Military	Never enlisted	Never enlisted	N/A	N/A
Natural Disaster	Denies	Denies	N/A	N/A
Loss	Denies	Denies	N/A	N/A
Other	Denies	Denies	N/A	N/A

Presenting Problems			
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Depressed or sad mood	**Yes**	**No**	Patient reports that he has experienced sadness because of being "tired of life" directly before his suicidal ideation occurred leading to this current hospitalization.
Loss of energy or interest in activities/school	**Yes**	**No**	Patient reports decreased energy levels accompanied by low motivation, poor concentration, and feeling fatigued.
Deterioration in hygiene and/or grooming	**Yes**	**No**	Patient denies deterioration in hygiene/grooming.
Social withdrawal or isolation	**Yes**	**No**	Patient states that he "just wants to stay in his room and wants to be left alone".
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	Patient denies any difficulties experienced at home, work, or with any relationships.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	Patient reports sleeping erratically and not being able to sleep before his admission for days at a time. Pt. reports since prescribed trazadone he was able to sleep around 8 hours last

			night and has napped throughout the day today.
Difficulty falling asleep	**Yes**	**No**	Patient reports difficulty falling asleep for a long period of time before his admission. Pt. reports since prescribed trazadone he was able to sleep around 8 hours last night and has napped throughout the day today.
Frequently awakening during night	**Yes**	**No**	Patient denies awakening at night.
Early morning awakenings	**Yes**	**No**	Patient denies early morning awakenings.
Nightmares/dreams	**Yes**	**No**	Patient denies experiencing any nightmares/dreams.
Other	**Yes**	**No**	Patient denies any other issues concerning sleeping patterns.
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	Patient reports not eating well and feeling fatigued.
Binge eating and/or purging	**Yes**	**No**	Patient denies any binge eating or purging.
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	Patient denies any unexplained weight loss or weight gain.
Use of laxatives or excessive exercise	**Yes**	**No**	Patient denies any use of laxative or excessive exercise.
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient denies experiencing any behaviors related to anxiety.
Panic attacks	**Yes**	**No**	Patient denies experiencing panic attacks.
Obsessive/ compulsive thoughts	**Yes**	**No**	Patient denies experiencing obsessive/compulsive thoughts.
Obsessive/ compulsive behaviors	**Yes**	**No**	Patient denies experiencing obsessive behaviors.

Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Patient denies experiencing any impact on his daily living due to anxiety.
Rating Scale			
How would you rate your depression on a scale of 1-10?		Patient denies experiencing depression and states “0/10 because I am not depressed”.	
How would you rate your anxiety on a scale of 1-10?		Patient denies experiencing anxiety and states “0/10 because I do not have anxiety”.	
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**	Patient denies currently experiencing stressors due to work.
School	**Yes**	**No**	Patient denies currently experiencing stressors due to school.
Family	**Yes**	**No**	Patient denies currently experiencing stressors due to family.
Legal	**Yes**	**No**	Patient denies currently experiencing stressors due to any current legal issues.
Social	**Yes**	**No**	Patient denies currently experiencing stressors due to social issues.
Financial	**Yes**	**No**	Patient denies currently experiencing stressors due to financial issues.
Other	**Yes**	**No**	Patient denies currently experiencing stressors due to any other issues.
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient			
Dates	**Facility/MD/**	**Inpatient/**	**Reason for**	**Response/**

	Therapist	Outpatient	Treatment	Outcome
Dates not known.	**Inpatient** **Outpatient** **Other:** Unknown facility in Peoria.	Inpatient	Treatment for bipolar disorder.	**No improvement** **Some improvement** Patient reports that he experienced some improvement when medications were prescribed during hospitalization. Patient states “meds worked until I stopped taking them and then I lost control again”. **Significant improvement**
Dates not known.	**Inpatient** **Outpatient** **Other:** Unknown facility in Peoria.	Inpatient	Treatment for bipolar disorder.	**No improvement** **Some improvement** Patient reports that he experienced some improvement when medications were prescribed during hospitalization. Patient states “meds worked until I stopped taking them and then I lost control again”. **Significant improvement**
N/A	**Inpatient** **Outpatient**	N/A	N/A	**No improvement**

	Other: N/A			**Some improvement** **Significant improvement** N/A
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Mother	66	Father	**Yes**	**No**
Father	70	Father	**Yes**	**No**
Son	21	Son	**Yes**	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): Patient reports that he has two adult sons ages 19 and 21. **Who are children with now?** Patient reports they are adults and that his 21-year-old son lives in his current household and that his 19-year-old son lives with his mother, the patient's ex-wife.				
Household dysfunction, including separation/divorce/death/incarceration: Patient reports "family stress" is his only notable household dysfunction.				
Current relationship problems: Divorced **Number of marriages:** Patient reports one marriage ending in divorce but cannot remember how long they were married or when the divorce was finalized.				
Sexual Orientation: **Heterosexual**	**Is client sexually active?** **Yes** **No**		**Does client practice safe sex?** **Yes** **No**	
Please describe your religious values, beliefs, spirituality and/or preference: Patient prefers not to answer this question.				
Ethnic/cultural factors/traditions/current activity: Patient prefers not to answer this question. **Describe:** N/A				

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient reports only experiencing legal issues as a teen because of charges due to auto theft.
How can your family/support system participate in your treatment and care? Patient states that he "does not want his family to participate in his health care or treatment plan".
Client raised by: **Natural parents** Mother and father. **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Patient states that there are "no childhood issues that he can remember" that impact his current illness.
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic:** Patient states his childhood home "was rocky at times but I was loved". **Abusive** **Supportive:** Patient reports feeling supported emotionally by his family as a child. **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.): Patient reports no family history of mental illness or suicide that he is aware of.
History of Substance Use: Patient reports no family history of substance abuse. The patient reports his history of substance abuse consists of the current tobacco use in the form of cigarettes and reports smoking 1/2 of a pack daily for 18 years. The patient reports the current use of cocaine daily for the last 18 years. The patient reports the current use of marijuana and heroin once every two weeks. The patient denies the use of alcohol.
Education History: **Grade school** **High school:** Graduated and obtained a diploma. **College:** Attended trade school and obtained certification in welding. **Other:**

Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient denies problems while attending school.
Discharge
Client goals for treatment: Patient will progress towards goals once released from current hospitalization. Patient agrees to take medications as prescribed, attend group meetings, and will attend follow up appointments.
Where will the client go when discharged? The patient will go back home with his family after being discharged.

Outpatient Resources (15 points)

Resource	Rationale
1. OSF Psychiatrist Ryan D Finkenbine, MD in Peoria, IL.	**1.** This psychiatrist specializes in the general psychiatry field and offers specialized care for patients suffering from addiction. This location is in Peoria, IL where he currently resides.
2. Illinois Institute for Addiction Recovery in Peoria, IL.	**2.** This addiction recovery program located in the Proctor Hospital in Peoria IL provides outpatient care, partial hospitalization, day treatment, and inpatient hospital care. The primary focus of this program is substance abuse treatment focusing on adults including men and women. This location is in Peoria, IL where he currently resides.
3. Suicide Prevention Services of America Peoria, IL. https://www.spsamerica.org	**3.** This resource is available for in person assistance in Peoria, IL, online at https://www.spsamerica.org, and by dialing 988 from any landline or cellphone. The in-person location is in Peoria, IL where he currently resides.

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

Brand/Generic	trazodone / Desyrel	benztropine / Cogentin	haloperidol/ Haldol	naltrexone / Depade	aripiprazole/ Abilify
Dose	100 mg	2 mg	5 mg	50 mg	400 mg
Frequency	Once at night	Twice daily, PRN	Q4H, PRN	Once daily	Every 28 days
Route	P.O.	P.O.	P.O.	P.O.	Injection
Classification	Pharmacologic Class: Triazolopyridine derivative Therapeutic Class: Antidepressant (Jones & Bartlett, 2022).	Pharmacologic Class: Anticholinergic Therapeutic Class: Antiparkinsonian, central-acting anticholinergic (Jones & Bartlett, 2022).	Pharmacologic Class: Butyrophenone derivative Therapeutic Class: Antipsychotic (Jones & Bartlett, 2022).	Pharmacologic Class: Opioid antagonist Therapeutic Class: Opioid and alcohol blocker (Jones & Bartlett, 2022).	Pharmacologic Class: Atypical antipsychotic Therapeutic Class: Antipsychotic (Jones & Bartlett, 2022).
Mechanism of Action	The medication blocks serotonin reuptake on the presynaptic neuronal membrane. It also has alpha-adrenergic blocking action to produce a histamine blockade to create a sedative effect. It also inhibits the vasopressor response to norepinephrine and reduces blood pressure (Jones & Bartlett, 2022).	The medication blocks acetylcholine's action at the receptor site. This action restores the brain's normal levels of dopamine and acetylcholine which is used to relax muscle movement and decreases drooling, rigidity, and tremor. May also prolong dopamine's actions by inhibiting dopamine reuptake (Jones & Bartlett, 2022).	Effective by blocking postsynaptic dopamine receptors in the limbic system and the dopamine in the brain which produces an antipsychotic effect (Jones & Bartlett, 2022).	Displaces opioid agonists from or blocks them from binding with delta, kappa, and mu receptors. Reverses the effect of opioids and inhibits the effects of endogenous opioids and reduces the craving for alcohol (Jones & Bartlett, 2022).	May produce antipsychotic effects through partial antagonist actions. Acts as a partial agonist at dopamine receptors and serotonin receptors (Jones & Bartlett, 2022).
Therapeutic Uses	Treats major depression: antidepressant (Jones & Bartlett, 2022).	Antiparkinsonian, central-acting anticholinergic (Jones & Bartlett, 2022).	Utilized as an antipsychotic (Jones & Bartlett, 2022).	Opioid and alcohol blocker (Jones & Bartlett, 2022).	To treat agitation associated with bipolar mania or schizophrenia (Jones & Bartlett, 2022).
Therapeutic Range (if applicable)	0.5-2.5 µg/mL (Jones & Bartlett, 2022)	N/A	5 to 16 ng/mL (Jones & Bartlett, 2022).	N/A	300-400 mg monthly (Jones & Bartlett, 2022).
Reason Client Taking	Insomnia and to improve quality of sleep.	To treat any movement disorders the patient may exhibit from the	To treat the patient for agitation, and breakthrough psychosis and	To treat the patient's alcoholism.	To treat bipolar disorder.

		haloperidol.	mania.		
Contraindications (2)	The use of alcohol may increase CNS depression and the use of MAO inhibitors may increase serotonin effects (Jones & Bartlett, 2022).	Increased adverse anticholinergic effects due to antidepressant use and decreased haloperidol effects (Jones & Bartlett, 2022).	Severe toxic CNS comatose states and increased CNS depression (Jones & Bartlett, 2022).	Acute opioid withdrawal and the possibility of forming a dependency on the opioid antagonist (Jones & Bartlett, 2022).	Enhanced antihypertension effects and hypersensitivity to aripiprazole or its components (Jones & Bartlett, 2022).
Side Effects/Adverse Reactions (2)	Seizures and Serotonin syndrome (Jones & Bartlett, 2022).	Hypotension and constipation (Jones & Bartlett, 2022).	Agitation and anxiety (Jones & Bartlett, 2022).	Suicidal ideation and eosinophilic pneumonia (Jones & Bartlett, 2022).	Homicidal ideation and suicidal ideation (Jones & Bartlett, 2022).
Medication/Food Interactions	• NSAIDs and aspirins: increased risk of bleeding. • Barbiturates and other CNS depressants: enhanced effect. • MAO Inhibitors and other serotonergic drugs: increased serotonin effect. • Alcohol use: increased CNS depression (Jones & Bartlett, 2022).	• Haloperidol: decreased haloperidol effects. • Increased adverse anticholinergic effects due to antidepressant use (Jones & Bartlett, 2022).	• CNS depressants: increased CNS depression causing a risk for respiratory depression and hypotension. • Dopamine agonists: possible decreased therapeutic effects of these drugs. • Antidepressants: increased plasma concentration of these drugs with increased risk of adverse reactions. • Alcohol use: increased CNS depression with a risk of hypotension and respiratory depression Effective by blocking postsynaptic dopamine receptors in	• Opioid analgesics: adverse effects of the medication and possible opioid withdrawal symptoms in opioid dependent patients. • Anaphylaxis: injection site reaction, bruising, erythema, induration, pain, tenderness, or thirst (Jones & Bartlett, 2022).	• Benzodiazepine: increased risk of orthostatic hypotension and sedation. • Alcohol use: increased CNS depression (Jones & Bartlett, 2022).

			the limbic system and the dopamine in the brain which produces an antipsychotic effect (Jones & Bartlett, 2022).		
Nursing Considerations (2)	Use cautiously in patients with cardiac disease because the drug can cause arrythmias. Monitor patient's closely with suicidal thoughts or tendencies (Jones & Bartlett, 2022).	Assess muscle rigidity and tremor at baseline and after for improvement. Know that benztropine therapy should not be abruptly discontinued (Jones & Bartlett, 2022).	Assess patient for fall risks with drugs that exacerbate CNS adverse effects such as instability, orthostatic hypotension, and somnolence must be monitored and fall precautions put into place. Watch for tardive dyskinesia in patients that utilize this medication for long term therapy use. These involuntary movements can potentially become irreversible (Jones & Bartlett, 2022).	Use cautiously in patients with hemophilia. Give oral drug with antacids or food to decrease adverse GI reactions (Jones & Bartlett, 2022).	Monitor patient for difficulty swallowing or excessive somnolence which could predispose to accidental injury or aspiration. Monitor patients closely for suicidal tendencies that may occur during new therapy or dosage changes. Depression may be enhanced during this time (Jones & Bartlett, 2022).

Medications Reference (1) (APA):

Learning, J. & B. (2022). *Nurse's Drug Handbook 2023*. Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient appeared well-groomed and wearing a yellow scrub top and yellow scrub bottoms with a lean build. The patient's behavior was withdrawn, and patient appeared drowsy due to the assessment occurring directly after patient was awakened. When talking, the patient's speech appeared soft and slow, and his mood was calm. The patient was minimally engaged in the conversation and expressed that he "just wants to get out of here and get home" while his facial expressions during the assessment remained flat and appeared restricted.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient denies have any delusions, illusions, obsessions, compulsions, or phobias currently or in the past. The patient denies any thoughts of suicidal ideation currently and states he has only experienced suicidal ideation once and occurred prior to this admission stating that "I overdosed with heroin, I am tired of life". Patient denies experiencing any obsessive or compulsive thoughts or behaviors.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was alert and oriented x4, appeared withdrawn, and drowsy due to the assessment occurring directly after patient was awakened. Sensorium was not assessed,
MEMORY: **Remote:**	The patient's short-term and long-term memory appeared to be intact and normal.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	The patient appeared to have sound judgment and an appropriate level of intelligence for the patient's age. Patients impulse control appeared to be average. Calculation and abstraction were not assessed.
INSIGHT:	The patient's insight was observed to be average.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient denied use of assistive devices. The patient's posture was relaxed during the assessment. The patient's muscle tone, strength, and motor movement are appropriate for patient's age and height.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	55 bpm	127/71 RA	16 Breaths/min.	98.8 Temporal	95% RA
1100	70 bpm	134/64 RA	16 Breaths/min.	98.8 Temporal	95% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	Pt. states no pain 0/10.	Pt. states no pain 0/10.	N/A	N/A
1100	Numeric	Pt. states no pain 0/10.	Pt. states no pain 0/10.	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 75% **Lunch:** 100% **Dinner:** N/A	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 280 mL **Lunch:** 360 mL **Dinner:** N/A

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient plans to return home after discharge and a referral will be completed to a psychiatrist of the patient's choosing upon discharge. The patient has been provided with information for an addiction recovery service, a psychiatrist, and suicide prevention services all located in his local area. The suggestion of utilizing all three resources is important to the success of the patient's continued mental health recovery and sobriety. Establishing productive relationships with these resources allows the patient to be properly diagnosed and held accountable for his mental healthcare and sobriety needs and provides him the ability to properly maintain his medication regimen.

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)**
Risk for suicidal behavior related to substance misuse as evidenced by previous suicide attempt.	The patient has a history of 1 suicide attempt before current hospital admittance.	1.Removal of anything that could inflict self-injury from patient's environment. 2. Make a short-term contract with the patient in agreement not to harm themselves for a specific amount of time. Continue negotiating until no evidence of suicidal ideation exists. 3. Ask patient directly, "have you thought about killing yourself and if so, do you have a plan?"	1.Supervise the administration of prescribed medications ensuring the patient is not hoarding medications. 2. Provide supervision for patient based on the facilities policies which may include a one-on-one sitter. 3. Provide understanding and while not encouraging denial of the current situation.	1. Provide the patient with assistance in obtaining a long-term psychiatric care provider. 2. Provide the patient with information and resources to contact upon discharge including crisis centers, counselors, and hotlines/text services. 3. Provide the patient with assistance in finding a long-term counseling service upon discharge.
Risk for acute substance withdrawal syndrome related to substance misuse as	The patient has an extensive history of substance abuse. The current hospitalization admittance is due to the misuse of	1. Perform extensive head to toe assessment and a thorough nursing history to establish patient's baseline. 2. Monitor and	1. Include patient in the plan of care to promote self-care. 2.Provide appropriate safety measures to provide a safe environment and	1. Encourage the patient to attend support groups or therapy regularly to assist in the patient's recovery. 2. Provide referrals

evidenced by patient's extensive history of substance abuse.	substances resulting in a suicide attempt.	record the patient's level of consciousness, and vitals every 4 hours or more often if necessary to detect deterioration. 3. Report complaints of anxiety, confusion, dizziness, or syncope promptly because these may indicate neurological decline.	protect the patient from injury. 3. Provide nonjudgmental care to promote a positive healing environment while assessing patient for any changes in behavior.	for a mental health specialist for follow-up treatment after hospitalization. 3. Assist the patient in assessing their current life situation and the impact of the patient's substance use on themselves and their support system.
Impaired mood regulation related to alteration in sleep pattern as evidenced by current patients report of inability to sleep.	The patient has a history of insomnia and interrupted sleep patterns associated with the patient's diagnosis of bipolar disorder.	1. Ensure dietary and fluid intake meet physiologic needs to prevent dehydration and to maintain homeostasis which includes the patient's ability to maintain the proper amount of sleep. 2. Conduct an assessment and thorough history to establish patient's baseline sleep patterns. 3. Initiate precautions to reduce risks of suicide or self-harm, promoting the patient's safety.	1. Use short simple phrases to convey instructions and questions. 2. Provide aid, cues, and reminders as needed to assist with the completion of the patients ADL's. 3. Assist the patient in identifying their goals and evaluating the strategies to meet those goals.	1. Assist patient with a referral to specific resources that directly specialize in the alteration of sleep associated with mood regulation. 2. Provide the patient with referrals to a mental health specialist for follow-up treatment after hospitalization. 3. Assist patient with psychoeducation resources appropriate for the patient's clinical situation to promote understanding and the ability to provide self-care.

Other References (APA):

Learning, J. & B. (2022). *Nurse's Drug Handbook 2023*. Jones & Bartlett Learning.

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

Concept Map (20 Points):

Subjective Data

- Admitted for heroin overdose and suicidal ideation voluntary 10-16-2023.
- Past and current history of marijuana, cocaine, and heroin use.
- Patient has been diagnosed with bipolar disorder.
- Patient reports substance abuse disorder, depression, and two previous psychiatric hospital admissions.
- Patient denies previous suicidal or homicidal ideation before current admission.
- Patient reports he took heroin to end his life because at the moment he felt like her "was tired of life".

Nursing Diagnosis/Outcomes

- Risk for suicidal behavior related to substance misuse as evidenced by previous suicide attempt.
  - Patient will report decreased to no thoughts of suicide after 6 months of therapy and medication.
- Risk for acute substance withdrawal syndrome related to substance misuse as evidenced by patient's extensive history of substance abuse.
  - Patient will enroll in an inpatient or outpatient substance abuse resource program upon discharge and report decreased to no substance abuse every month for one year.
- Impaired mood regulation related to alteration in sleep pattern as evidenced by current patients report of inability to sleep.
  - Patient will engage in a balanced pattern of activity and rest while utilizing therapy and prescribed medications that assist in proper sleep patterns.

Objective Data

B/P: 134/64 RA
T: 97.9 temporal
O2: 97% RA
HR: 70 bpm
RR: 16 resp/min
Pain level: 0/10
Height: 6' 0"
Weight:180 lb.
Alert and oriented X 4

- No reported labs, abnormal vitals, or abnormal assessments.
- Patient appeared well-groomed, slightly withdrawn, the patient's speech appeared soft and slow, and his mood was calm. The patient's memory, insight, and reasoning skills appear appropriate.
- The patient's primary language is English.

Patient Information

On 10/16/2023 a 40-year-old Caucasian Male was admitted to the OSF Hospital due to a suicide attempt. The patient's family called 911 after finding the patient nonresponsive in the shower and administered Narcan. The patient reported the chief complaint upon admittance as "I overdosed on heroin. I am tired of life." The patient is a Full Code.

Nursing Interventions

Nursing diagnosis 1:

- Removal of anything that could inflict self-injury from patient's environment.
- Make a short-term contract with the patient in agreement not to harm themselves for a specific amount of time. Continue negotiating until no evidence of suicidal ideation exists.
- Ask patient directly, "have you thought about killing yourself and if so, do you have a plan?"

Nursing diagnosis 2:

- Perform extensive head to toe assessment and a thorough nursing history to establish patient's baseline.
- Monitor and record the patient's level of consciousness, and vitals every 4 hours or more often if necessary to detect deterioration.
- Report complaints of anxiety, confusion, dizziness, or syncope promptly because these may indicate neurological decline.

Nursing diagnosis 3:

- Ensure dietary and fluid intake meet physiologic needs to prevent dehydration and to maintain homeostasis which includes the patient's ability to maintain the proper amount of sleep.
- Conduct an assessment and thorough history to establish patient's baseline sleep patterns.
- Initiate precautions to reduce risks of suicide or self-harm, promoting the patient's safety.