N431 Care Plan #2

Lakeview College of Nursing

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N431 Care Plan

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/12/19	JDP	69 y.o	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Single	Contrast Media Iodine
Code Status	**Height**	**Weight**	
Full Code	180.3 cm	81.3kg	

Medical History (5 Points)

Past Medical History: Atrial flutter, Anemia, Alcoholic Hepatitis, Arthritis, Gastrointestinal Disorder, Hx irregular heart beat, Hx pain in extremities, HTN, Thrombocytopenia, Seizures, Liver disease, COPD, Systolic Heart Failure

Past Surgical History: Esophagastroduodenoscopy (7/18/18), Excision Lesion Facial (5/9/18), Appendectomy, Cataract Extraction, Circumcision, Colonoscopy

Family History:

Mother: Hx breast cancer, CHF

Sister: Hx cancer, Stroke

Child: Stroke

Social History (tobacco/alcohol/drugs):

Alcohol: Several times per day “all day every day”

Smoker: Pack per day

Substance: Former amphetamines, cocaine, marijuana, heroine, LSD, methamphetamines

Assistive Devices: Walker and cane

Living Situation: At home with significant other

Education Level: Some college

Admission Assessment

Chief Complaint (2 points): Seizure like activity. Family witnessed “shaking”

69 year old Caucasian male presented to the ED via EMS after a family member witnessed seizure like activity at home. Reported the patient was “shaking.” Patient has a past medical history of alcoholic liver disease, alcohol dependence, chronic atrial fibrillation/ flutter, GI bleed, COPD and HTN. Patient reports having his last alcoholic beverage 2 days ago. Patient reports no recollection of the event, no reports of bladder/bowel incontinence, tongue biting, fever, or bleeding. Patient reports lower back pain. Patient post ictal on arrival.

History of present Illness (10 points):

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Seizure

Secondary Diagnosis (if applicable): Hyponatremia, Hypomagnesemia, Thrombocytopenia, Alcohol Withdrawal

Pathophysiology of the Disease, APA format (20 points):

Hypomagnesemia

Hypomagnesemia is an electrolyte disturbance caused when there is a low level of serum magnesium in the blood (Gragossian, 2019). Hypomagnesemia can be caused by a chronic disease, alcoholism, GI loss or renal loss. Lack of magnesium in the body can have a direct effect on other electrolytes including sodium, calcium and potassium. Low levels can occur due to renal and gastrointestinal issues. Hypomagnesemia occurs when homeostasis of magnesium is altered. The electrical activity of the myocardium and vascular tone are effected by hypomagnesemia putting patients at risk for cardiac arrythmias. Hypomagnesemia caused by alcohol dependence can lead to poor dietary intake of mag, increase in urination, liver disease, vomiting, kidney impairment,

pancreatitis and other complications. This effects this patient because he has been affected by alcoholism for a few years.

Signs and symptoms of hypomagnesemia include mild hand tremors, generalized weakness, cardiac ischemia and even death. Neuromuscular manifestations of hypomagnesium include tremors, tetany, seizures, apathy, delirium and coma (Gragossian 2019). Cardiovascular manifestations include widening of QRS complex and peaked T waves, atrial fibrillation, ventricle arrythmias and cardiac ischemia.

Hypomagnesemia is diagnosed through physical exams, blood tests, medical history and overall symptoms. It is recommended to monitor serum magnesium, phosphate, calcium levels, blood glucose, serum creatinine and kidney function when a patient is suspected to have hypomagnesemia (Gragossian, 2019). It is expected for a patient to have hypocalcemia or hypokalemia when experiencing hypomagnesemia.

Treatment for hypomagnesemia depends on the patient's overall kidney function. Hypomagnesemia can be treated by oral supplements or dietary intake. One to two grams of magnesium can be given over one hour and four to eight grams in 12 to 24 hours to a stable patient (Gragossian, 2019). This patient received two grams of magnesium during this shift and also was ordered to have his lab values monitored until this electrolyte levels returned to normal ranges.

Pathophysiology References (2) (APA):

Gragossian, A. (2019, February 23). Hypomagnesemia. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK500003/#targetText=Hypomagnesemia is an electrolyte disturbance,renal losses, and other conditions.

Hypomagnesemia (Low Magnesium). (2018, September 29). Retrieved October 18, 2019, from https://www.healthline.com/health/hypomagnesemia

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.28-5.56	2.88	N/A	Patient has a history of anemia which would cause low red blood cell levels (Hinkle, 2018).
Hgb	13-17	9.9	N/A	Patient has a history of anemia which would cause low red blood cell levels (Hinkle, 2018).
Hct	33.2-45.3	29.2	N/A	Patient has a history of anemia which would cause low red blood cell levels (Hinkle, 2018).
Platelets	149-393	141	N/A	Patient has a history of thrombocytopenia which would cause low platelet levels (Hinkle, 2018).
WBC	4.0-11.7	4.8	N/A	N/A
Neutrophils	45.3-79.0	59.7	N/A	N/A
Lymphocytes	11.8-45.9	16.8	N/A	N/A
Monocytes	4.4-12.0	11.8	N/A	N/A
Eosinophils	0-6.3	3.3	N/A	N/A
Bands		N/A	N/A	N/A

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	125	131	Sodium levels low due to kidney dysfunction caused by patient's history of alcoholism (Hinkle, 2018).
K+	3.5-5.1	4.1	3.5	N/A
Cl-	98-107	93	98	Decreased Cl- can be secondary to decreased sodium levels.

CO2	22-29	20	23	Low CO2 can be caused by kidney disease (Hinkle, 2018).
Glucose	70-99	126	83	Glucose levels high due to liver impairment caused by alcoholism (Hinkle, 2018).
BUN	6-20	10	21	BUN levels elevated due to kidney damage caused by high blood pressure (Hinkle, 2018).
Creatinine	0.7-1.2	0.81	1.08	N/A
Albumin	3.5-5.2	3.5	N/A	N/A
Calcium	8.6-10.4	8.8	7.9	Low calcium effected by hypomagnesemia (Hinkle, 2018).
Mag	1.6-2.4	1.3	1.4	Low magnesium levels effected by history of alcoholism (Hinkle, 2018).
Phosphate	3.0-4.5	N/A	N/A	N/A
Bilirubin	0.0-1.2	2.2	N/A	Elevated bilirubin can be caused by liver dysfunction linked to patien't history of alcoholism (Hinkle, 2018).
Alk Phos	40-130	116	N/A	N/A
AST	0-40	46	N/A	Elevated AST due to liver damage
ALT	0-41	31	N/A	N/A
Amylase	56-90	N/A	N/A	N/A
Lipase	0-110	N/A	N/A	N/A
Lactic Acid	6-16	N/A	N/A	N/A
Troponin	0-0.3	N/A	N/A	N/A
CK-MB	30-170	N/A	N/A	N/A
Total CK	30-170	N/A	N/A	N/A

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.9-1.2	N/A	N/A	N/A
PT	11-14	N/A	N/A	N/A
PTT	16-40	N/A	N/A	N/A
D-Dimer	0.24-2.33mcg/mL	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A
HDL	100	N/A	N/A	N/A
LDL	<100	N/A	N/A	N/A
Cholesterol	<200	N/A	N/A	N/A
Triglycerides	<150	N/A	N/A	N/A
Hgb A1c	4% - 5.6%	N/A	N/A	N/A
TSH	0.4 to 4.0 milli-international units per liter	N/A	N/A	N/A

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, clear	yellow & clear	N/A	N/A
pH	5.0-8.0	6.0	N/A	N/A
Specific Gravity	1.005-1.035	1.006	N/A	N/A
Glucose	Normal	normal	N/A	N/A
Protein	Negative-normal	negative	N/A	N/A
Ketones	Negative	negative	N/A	N/A

WBC	< 5	<1	N/A	N/A
RBC	0-3	1+	N/A	N/A
Leukoesterase	Negative	negative	N/A	N/A

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	N/A	N/A
PaO2	80-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	21-28	N/A	N/A	N/A
SaO2	95-100	N/A	N/A	N/A

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	Negative	Negative	N/A
Blood Culture	Negative	Negative	Negative	N/A
Sputum Culture	Negative	Negative	Negative	N/A
Stool Culture	Negative	Negative	Negative	N/A

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 ed.). Philadelphia, PA: F.A. Davis

Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT of head w/o contrast

Lumbosacral X-ray

Diagnostic Test Correlation (5 points):

Computed tomography of head w/o contrast uses x-ray equipment to assess head injuries. Since patient has history of heparin use this test was done to rule out any potential bleeding in the head. Results came back clear with no abnormalities.

Lumbosacral X-ray uses x-ray equipment to get visualization of the lower back. Patient complains of lower back pain. Results came back showing lower lumbar hypertrophy with boney narrowing, multilevel disc loss, degeneration and mild osteopenia.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). Brunner & Suddarth's Textbook of Medical-Surgical Nursing (14 th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Ferosul-Ferrous Sulfate (Jones &	Lorazepam-Ativan (Jones & Bartlett,	Metoprolol Tartrate-Toprol XL (Jones &	Norco-Hydrocodone/ acetaminophen	Pantoprazole-Protonix (Jones &

	Bartlett, 2017, p.).	2017, p. 649)	Bartlett, 2017, p.)	(Jones & Bartlett, 2017, p.)	Bartlett, 2017, p.)
Dose	325 mg	1 mg	25 mg	5 mg-325 mg	40 mg
Frequency	daily	BID, PRN	BID	BID, PRN	BID
Route	PO	PO	PO	PO	PO
Classification	Antianemic, nutritional supplement	Amnestic, anticonvulsant, sedative	Antianginal, antihypertensive		Antiulcer, gastric acid PPI
Mechanism of Action	Acts to normalize RBC production by binding hemoglobin	Potentiate the effects of GABA and other inhibitory neurotransmitters	Inhibits stimulation of beta1 receptor sites		Interferes with gastric acid secretion
Reason Client Taking	Anemic	Seizures and agitated	Hypertension		Short term GERD
Contraindications (2)	-hemolytic anemias -hemochromatosis	-acute angle closure glaucoma -psychosis	-Acute heart failure -Severe peripheral arterial disorder		-hypersenitivity to pantoprazole -hypersensitivity to benzimidazoles
Side Effects/Adverse Reactions (2)	-Fever -Metallic taste	-Libido changes -Diaphoresis	-Impotence -Alopecia		-anxiety -abdominal pain
Nursing Considerations (2)	-Give with full glass of water/juice -Dilute and administer with a straw	-Extreme caution when giving to elderly -Caution in patients with hx of drug and alcohol	-use cautiously in patients with angina -expect to admin diuretic to stabilize		-ensure continuity of gastric emptying -Give IV over 2 minutes

		abuse	patient		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Monitor BP after each IV dose	-Monitor respirations every 5-15 minutes	-assess ECG because patient may be at risk for AV block		-monitor PT/INR
Client Teaching needs (2)	-Instruct patient not to chew any solid form -Urge patient to eat foods high in Vitamin C	-take exactly as prescribed -avoid hazardous activities until CNS effects are known	-take as directed -Check pulse and BP daily		--swallow tablets whole -expect relief in 2 weeks

Hospital Medications (5 required)

Brand/Generic	**Diltizem-** (Jones & Bartlett, 2017, p.).	**Folic Acid-FA-8** (Jones & Bartlett, 2017, p.).	**Furosemide -Lasix** (Jones & Bartlett, 2017, p.488).	**Heparin-** (Jones & Bartlett, 2017, p.).	**Nicotine XR-Nicoderm** (Jones & Bartlett, 2017, p.).
Dose	60 mg	1 mg	40 mg	5,000 units/1 ml	21 mg/1 patch
Frequency	QID	daily	daily	BID	1 patch per 24 hours
Route	PO	PO	PO	Sub Q inj	transderma l
Classification	Antihyperte nsive		Antihyperte nsive, diuretic	Anticoagula nt	Smoking cessation adjunct
Mechanism of Action	Inhibits transport of calcium into myocardial and smooth muscles		Inhibits sodium and water reabsorption and increases urine formation	Prevents conversion of prothrombin to thrombin	Relieve nicotine withdrawa l symptoms
Reason Client Taking	Hypertensio n		Patient retaining fluid d/t liver disease	Inactivity due to hospitalizati on	Cannot smoke in the hospital

Contraindications (2)	- Hypersensitivity -Sick sinus syndrome		-Anuria unresponsive - Hypersensitivity	- hypersensitivity -severe thrombocytopenia	- hypersensitivity -life threatening arrythmias
Side Effects/Adverse Reactions (2)	-abnormal dreams -Stevens-Johnsons syndrome		- Hyperglycemia -Muscle pain/spasms	-Chills -easy bruising	-increased salivation - abdominal pain
Nursing Considerations (2)	-do not crush or chew - Can give with or without food		-Obtain patient's weight before and regularly -Monitor BP, hepatic and liver function	-use cautiously in alcholics -alternate injection sites	-remove patch before MRI -do not use in patients with diabetes, seizures or peptic ulcers
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor serum potassium		Monitor BUN, blood glucose, creatinine and electrolyte levels	Monitor PTT	Monitor respirations
Client Teaching needs (2)	-change positions slowly -Notify provider if rash occurs		-take at the same time each day -take several hours before bedtime	-explain cannot be taken orally -avoid injuries	-read and follow package directions -avoid toxicity by stopping smoking

Medications Reference (APA):

Jones, & Bartlett. (2017). Nurse's Drug Handbook (16 th ed.). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient A&O x2 with some fluctuation between A&O x3. Patient distressed and hallucinating. Patient experiencing extreme mood swings involving extreme agitation followed by calm.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Braden Scale: 18 Patient is a Caucasian male with a fair complexion. Skin was warm to the touch, dry and pink. Good skin turgor with no abnormal textures. Bruises and scars found on both the left and right arms. No drains are present. Slight skin irritation/redness around the sites of previous IVs after patient ripped them out.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with no deviations. Patient has partial head of grey and brown hair. Patient can hear and comprehend questions when calm and not hallucinating. PERLA is present in right eye. Patient blind in left eye. Conjunctiva and sclera are normal. Nose does not present with any external or internal swelling or discomfort. Multiple teeth missing. Oral mucosa is moist and pink.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Heart sounds were clear. No murmur or bruit auscultated. Controlled Afib on tele. Bilateral pedal peripheral pulses were palpable. Capillary refill was <3 seconds on patient's left index finger. There was no presence of neck vein distention. There was no present edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Use of accessory muscles to assist during respirations not observed. Trachea resides midline. Auscultation of lung sounds observed bilaterally in each lobe results were clear.
GASTROINTESTINAL (2 points):	Current diet regular. Patient is

Diet at home: **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	180.34cm in height and 81.3kg. Bowel sounds are present, active, and within normal limits in all four quadrants. There is no pain stated or demonstrated during palpation of any of the four quadrants. No masses were located upon palpation. Patient does not have an ostomy or any additional tubes. Last bowel movement was not document.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient is continent with urinary urges. No dialysis or catheters present. Urine was yellow and clear. Patient denies any discomfort during urination when asked. Patient is on I&O's.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Fall Risk: 60 Patient is a fall risk based on fall risk rating. Patient utilizes an assistive deice, a cane and walker at home and in the inpatient setting. Patient is able to ambulate with assistance x1. Patient exhibits ROM well and equal bilateral strength in extremities. Patient experiencing mild hand tremors.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -**	Patient is able to speak and portray needs as desired. Primary language is English. Patient can MAEW forage, weight, and present health. Strength is bilaterally equal for extremities.

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Response to PERLA is standard. Patient's speech slurred. Patient experiencing hallucinations and confusion.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient's coping methods not documented. Highest level of education elaborated on was some college. Patient is on track with developmental level for age, gender, and race. Family not heavily involved in care. Living at home with his girlfriend. Religious preferences not documented.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1120	82	105/61	16	37.0 C	98
1554	98	116/69	18	36.5 C	98

Vital Sign Trends:

Vital signs trended slightly elevated potentially due to patient's agitation and multiple attempts to leave the hospital bed as the day progressed.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1120	Numeric	No pain	0/10	No pain	No interventions required
1554	Numeric	No pain	0/10	No pain	No interventions required

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Peripheral IV Right forearm, 22g, dated 10/12/19 IV patent and running NS at 100 No signs of erythema, phlebitis, infiltration or drainage IV dressing clean, dry, intact and wrapped with ace bandage to prevent patient irritation.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1620mL	1524mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient began receiving care 10/12/19 and will continue to stay in the hospital until his labs are stable. Patient was overall agitated and required a sitter throughout the entire shift. Patient experiencing hallucinations with unexpected mood swings.

Procedures/testing done: CT of head and lumbosacral x-ray

Complaints/Issues: Patient complaining of wanting to go home and feeling like he is "being held against his will"

Vital signs (stable/unstable): Vitals stable

Tolerating diet, activity, etc.: Patient is tolerating diet and is eating well. Patient is on bedrest and is urinating regularly.

Physician notifications: Notified during morning shift

Future plans for patient: Patient scheduled for further observation in the hospital setting, plans to continue monitoring labs

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Discharge Planning (2 points)

Discharge location: Home with significant other

Home health needs (if applicable): N/A

Equipment needs (if applicable): Continue with walker and cane

Follow up plan: Not completed until patient is stable

Education needs: Education on living a healthy lifestyle and available resources

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	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Disturbed sensory perception related to disturbance in thought and perception as evidenced by hallucinations	Patient experiencing hallucinations making him agitated and confused throughout the day	1. Evaluate and observe for hallucinations. Redirect back to reality by distracting with conversation 2. Determine when anxiety increases. Stay with patient to ensure safety	Patient did not respond well to redirecting the conversation when experiencing hallucinations. Patient became more agitated the longer we stayed with him during the hallucinations however patient remained safe throughout shift**.**
2. Risk for injury related to altered cerebral function secondary to alcohol withdrawal as evidenced by seizures	Patient admitted after family member observed the patient partake in seizure like activity	1. Identify stage of alcohol withdrawal and severity of symptoms. Monitor vitals, gait and motor coordination, presence and severity of tremors, mental status and electrolyte status 2. Monitor for	Patient experiencing mild hand tremors, altered mental status and electrolyte imbalance. Patient responded well to seizure precautions put in place and patient remained safe throughout duration of shift.

		seizure activity. Institute seizure precautions: bed in lowest position with padded side rails and oral airway at bedside.	
3. Interrupted family processes related to long term pattern of alcoholism as evidenced by lack of patient's family involvement in care	Patient's family seemed displeased and agitated with patient's health status while on the phone	1. Provide family members with an opportunity to discuss their experiences of living with the disabling effects of alcoholism 2. Provide family members with a list of services and treatment options available	Patient's family seemed to be uninterested in the care of the patient. Patient did not seem to be open to conversations about his family situation and was hostile while on the phone with his significant other
4. Self care deficit related to impulsivity and lack of concern as evidenced by patient's history of hospitalization	Patient expresses lack of concern for proper medication uses and side effects of improper use	1. Assess current level of functioning and reevaluate daily 2. Intervene to protect patient from own impulsivity	Patient clearly experiencing a self-care deficit especially while hallucinating. Impulsive decision was attempted while trying to rip out IVs and leave the hospital before being stable

Other References (APA):

Concept Map (20 Points):

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