

# MENTAL HEALTH CONCEPT MAP

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**Mental Health History/ Predisposing factors**

**MH Hx:** Depression, anxiety, Hx of alcohol abuse

**Predisposing factors:** Childhood abuse which resulted in broken arm, lack of support from parents, divorced after 22 years of marriage, estranged relationship from 2 children, transgender male

**Mental Health Assessment**

**Appearance:** unkept hair, hood up, sunglasses on, dirt on clothes, face, and hands; laceration on forehead

**Behavior:** States, "Can I have a cigarette?" fidgeting, twitching arms, and legs

**Speech:** Appropriate speech, no slurring, loud volume

**Mood:** States, "Can't have any fun around here"; groaning, eyes shut, labile and annoyed mood

**Disorders of the Form of Thought:** States, "I would prefer a shot"; requesting shots and smoking when attempting to administer medications

**Perceptual Disturbances:** States, "Do you see the bugs"; feels bugs crawling under skin

**Cognition:** States, "I blacked out after I got assaulted, I don't remember anything"; A&Ox3 unaware of situation

**Ideas of harming self or others:** States, "I want to harm you... I'm just kidding"; denies suicidal or homicidal thoughts

**CIWA initially:** 33 (N/V: 4, tremor: 5 [hands shaking significantly], paroxysmal sweats: 4, anxiety: 5, agitation: 4, tactile disturbances: 3 [feels bugs under skin], auditory disturbances: 1, visual disturbances: 3, H/A: 4, orientation: 0)

**CIWA 1 hr after Lorazepam IVP:** 6 (N/V: 1, tremor: 2, anxiety: 1, visual disturbances: 1 [light sensitivity], HA: 1)

**Patient Problem #1**  
**Acute substance withdrawal syndrome**

**Medical Diagnosis:**  
**Acute intoxication/alcohol withdrawal**

**Patient Problem #2**  
**Ineffective coping**

**Labs, Dx Studies**

BAC: 330 (high) d/t alcohol intoxication

AST: 46 (high) d/t chronic alcohol use

ALT: 60 (high) d/t chronic alcohol use

Thiamine: 0.8 (low) d/t chronic alcohol use and malnutrition

Total protein: 5.8 (low) d/t malnutrition

RBC: 4.4 (low) d/t B6, B12, or folate deficiency r/t malnutrition

Hgb: 13.4 (low) d/t B12 or folate deficiency that comes dietary deficiency

Hct: 40.5 (low) d/t dietary deficiency

Urine drug screen: positive for THC and marijuana d/t substance use disorder

**Physical Assessment**

BP: 180/80, HR: 123, RR: 16, T: 99.0, Spo2: 95%

Pt appears unkept, with dirty clothes and dirt on hands and face

Frequent movement of hands and legs

Bandage on right side of forehead from laceration

Patient Problem #1 Acute Su

**Medications/ Treatments/ Therapies**

**Medications:** Prochlorperazine IVPB, Lorazepam 3 mg IVP, Folic acid 1mg PO, 100 mg Thiamine PO, Multivitamin 1 tablet PO

Therapies pt would benefit from: AA, CBT, group therapy

Implemented seizure precautions

## MENTAL HEALTH CONCEPT MAP

<p>EO #1 Pt CIWA score will be &lt; 8 by the end of my time of care. EO#2 Pt HR will remain between 60-100 bpm and BP 120/80 during my time of care.</p>	<p>EO #1 Pt will partake in self-care/hygiene, such as taking a bath, during my time of care. EO #2 Pt will verbalize at least 1 healthy coping mechanism, such as going on walks, during my time of care.</p>
<p style="text-align: center;"><u>Nursing Interventions</u></p> <ol style="list-style-type: none"> <li>1. Administer lorazepam as ordered by provider. Rationale: Administering lorazepam PRN provides a CNS depressant and allows for a calming effect on anxiety.</li> <li>2. Implement seizure precautions, ensure airway protection at bedside q 12 hr. and PRN Rationale: Implementing seizure precautions and having airway protection equipment ready allows for the nurse to be prepared in any emergency and provides protection to the pt if they were to have a seizure.</li> <li>3. Reorient frequently to person, place, time, and surrounding environment as indicated and PRN. Rationale: Helps to reorient pt to what's happening and to reduce anxiety r/t confusion of situation</li> <li>4. Administer Normal Saline at ordered by the provider. Rationale: Administering NSS allows for continuous hydration to prevent dehydration from occurring.</li> <li>5. Administer Prochlorperazine IVPB as ordered by provider. Rationale: Administering Prochlorperazine IVPB is an antiemetic and decreases the amount of nausea and vomiting.</li> <li>6. Provide a quiet environment. Speak in a calm, quiet voice. Regulate lighting PRN. Turn off the TV during sleep. Rationale: Providing a calm and quiet room allows for a low stimulus environment, decreasing anxiety and agitation.</li> </ol>	<p style="text-align: center;"><u>Nursing Interventions</u></p> <ol style="list-style-type: none"> <li>1. Establish rapport and trust q 12 hr and PRN Rationale: Establishing trust with the pt is a priority because the pt will not tell you information and how they are feeling if there is no trust.</li> <li>2. Provide examples of healthy coping mechanisms, such as going on a walk PRN. Rationale: Providing healthy coping mechanisms can help decrease relapses of alcohol use.</li> <li>3. Provide therapeutic communication techniques, such as silence, PRN and q 4 hr. Rationale: Providing therapeutic communication allows for the patient to be open and honest about how they are feeling.</li> <li>4. Provide relaxation Techniques like deep breathing and mindfulness Rationale: Relaxation techniques will help decrease anxiety and calm the patient.</li> <li>5. Educate on events and signs and symptoms that may lead to relapse Rationale: Education on the signs and symptoms of relapse will help prevent future stress, anxiety and will help to recognize when to get help.</li> <li>6. Provide education on alcohol consumption and consideration for risks Rationale: Education allows pt to see the effects of alcohol use, providing this education may also help them to feel inclined to stop when they learn to negative effects</li> </ol>