**Firelands Regional Medical Center School of Nursing**
**Nursing Care Map**

**Student Name** _____ **Date** _____

**Noticing/Recognizing Cues:**

*Highlight all related/relevant data from the Noticing box

**Assessment findings*:**

- States his anxiety level was an 8, on a 1-10 scale, on average his anxiety is a 6 or a 7 each day.
- Drinks alcohol to cope with daily stressors.
- Intermittent pacing from his room to the common area.
- Restlessness, feeling on edge
- Bounces legs in response to stress
- Moves eyes frantically around the room during every interaction.
- He gets anxious in large groups and does not like to public speak.
- Tremor of the hands
- Diaphoretic, droplets on forehead.
- Depression and Anxiety due to excessive loss.
- Flat affect

**Lab findings/diagnostic tests*:**

- BP 134/84
- Pulse 78
- RR 16
- Spo2 99% on RA
- Temp 98.4
- WBC 5.6
- RBC 5.01
- RDW 15.9 (elevated)
- Monocyte # 0.9 (elevated)

**Risk factors*:**

- Age 51
- Uses nicotine/ smoker
- Hx: borderline personality disorder, GERD, Ulcer, back pain, HTN, and depression, and schizophrenia. According to the pocket guide, "Medical conditions that have been known to cause anxiety disorders include endocrine, cardiovascular, respiratory, metabolic, and neurological disorders" (Morgan & Townsend 176).
- Hx: hallucinations
- Addiction to alcohol
- Major depressive disorder and recurrent severe psychosis.
- No stable support systems, one is his ex-girlfriend and the other is his current girlfriend who lives with her husband.
- Substance abuse to meth
- No stable income and has had multiple jobs. Alcohol is the reason for job fluctuation.
- Has lost his son, stepdaughter, and wife to substance abuse or a disease.

**Interpreting/Analyzing Cues/ Prioritizing Hypotheses/ Generating Solutions:**

**Nursing priorities*:** *Highlight the top nursing priority problem*

- Anxiety
- Acute substance withdrawal
- Dysfunctional Family Processes
- Impaired social interaction
- Ineffective coping
- Maladaptive grieving

**Goal Statement:** Patient will have no longer experience anxiety and will find three ways to decrease anxiety.

**Potential complications for the top priority:**

1. **Social Isolation**
   - Loneliness, withdrawal from activities, decreased communication
   - Worsened anxiety or depression, mental status changes
   - Poor diet and nutrition, weakened immune system
2. **Suicidal behavior**
   - Hopelessness, negativity, purposelessness
   - Neglect of self, decreased hygiene and nutrition
   - Substance abuse
3. **Fatigue, or exhaustion**
   - Decreased productivity, obesity, and nutritional decline
   - Lowed self-esteem, lack of motivation, depression
4. **Substance Abuse**
   - Mood changes, tolerance, addiction, depression
   - Financial issues, issues in interpersonal relationships

**Responding/Taking Actions:**

**Nursing interventions for the top priority:**

1. Conduct a thorough, comprehensive physical and mental health assessment of the patient on admission. This assessment includes risk factors and warning signs of potential mental illnesses.
   - This assessment establishes a baseline for the patient and allows the nurse to determine the priority problem. This assessment directs the plan of care and will show any improvement or decline in the patient.
2. Assess anxiety level using the 0-10 scale on admission, q4h and PRN, and before discharge, determine if anxiety is mild, moderate, or severe.
   - Conducting a baseline rating of anxiety can determine if the patient has improved or a decline in anxiety, the assessment can determine treatment to improve the patient's overall health.
3. Obtain vital signs HR, BP, RR, T, Pulse, and Spo2 q8h and PRN.
   - This allows the nurse to determine any abnormalities or changes in the patient's baseline health status.
4. Conduct 15-minute checks on the patient during the nursing shift, this includes checks at irregular times when the patient is not expecting, such as shift change, early in the morning, or late at night.
   - This ensures patient safety and maintains the safety of the environment.
5. Establish a therapeutic relationship with the patient on admission and continuing during their stay.
   - This allows the nurse to establish trust, communication, and an understanding of the patient. The nurse will have a better understanding on the patient's needs and stressors to provide better care. Treating the patient with respect and using active listening can encourage the patient to be more honest about stressors.
6. Provide nonpharmacological ways for the patient to manage anxiety and help them find healthy coping mechanisms q4h or PRN.
   - This gives the patients techniques to promote relaxation and manage their stressors. Examples are meditation, art, exercise, deep breathing, or journaling. It can promote healthy choices, independence, and will improve patients' daily functioning.
7. Administer Ziprasidone 20mg IM q6h.
   - This antipsychotic medication can help reduce agitation and can diminish schizophrenic behavior, when these symptoms decrease the patient's anxiety could increase as well.
8. Administer nicotine gum 2 mg buccal q2h or PRN
   - This gum can help with nicotine withdrawals for the patient which can also help relieve some anxiety.
9. Develop a safety plan for the patient once before discharge that consists of support systems, coping mechanisms, family cooperation to lock up risky items in the household, written crisis contact information, and the patient's written warning signs.
   - This ensures the patient is educated on what to do if a future crisis occurs and promotes safety after discharge.

Evaluations on next page

**Reflecting/Evaluate Outcomes:**

**Evaluation of the top priority:**

- Patient reports 0/10 anxiety
- Patient developed and utilized healthy coping mechanisms to deal with his stressors such as reading and music.
- Patient still paces but states he feels comfortable at rest.
- Patient reports he does not feel on edge but continues to bounce his legs.
- Patient does not search the room and feels secure in the environment.
- Patient did not attend therapy group due to the large group interaction anxiety.
- Patient has tremors but the diaphoresis resolved.
- Patient reported no anxiety or depression.
- Patient remained with a flat affect.

Continue plan of care

**Reference:** Morgan, K., Townsend. M., (2021) Pocket Guide to Psychiatric Nursing. F.A. Davis Company