N323 Care Plan

Lakeview College of Nursing

Name: Richard Kumpi

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
03/24/2021	R. F	73	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/ Caucasian	Unemployed	Single	No known allergies
Code Status	**Observation Status**	**Height**	**Weight**
Full	Every 15-minutes	5'10"	59 Kg

Medical History (5 Points)

Past Medical History: RF has a past medical history of PTSD, Renal cystitis, Hemorrhoids, constipation, scrotal mass.

Significant Psychiatric History: Patient denies having a history of suicidal attempt or a plan of self-injury, but he acknowledges having suicidal ideations. Patient states "I've become hopeless and fearful of uncertain future".

Family History: RF couldn't provide any detailed history, also there is no family history on file.

Social History (tobacco/alcohol/drugs): RF acknowledges use of substance abuse. Patient says he used to use tobacco, alcohol, marijuana, and cocaine in the pass not currently.

Living Situation: RF states he is an agricultural engineer he has a bachelor's degree in science and agriculture. He does research projects about agriculture that he posts on YouTube. RF says he lives in a house in Urbana with a friend. He says that he never got married and has no children.

Strengths: Patient states that "I keep my strong faith in God who gives me inspirations and ideas"

Support System: Patient says that he has a good support from his brother who frequently calls and talks with him over the phone. Patient says, "my brother raises me up when I feel going down" Also he says, "I have a good friend, a female who comes visit me".

Admission Assessment

Chief Complaint (2 points): "I have been feeling dizzy, depressed, and tiered. I was being afraid of the future as the world has become more complicated and violent."

Contributing Factors (10 points):

Factors that lead to admission: RF, a 73-year-old Caucasian male with a history of Renal cystitis, Hemorrhoids, constipation, and scrotal mass was brought to the ED of OSF in Urbana complaining about dizziness and depression. Patient states that "since the first week of February I started feeling very depressed and anxious; I stopped going to work because I got tired and worried about not being able to urinate without pain or use the toilet; patient also states that "I can't sleep, anything I try doesn't work, I tried to drink water, prune juice and Iced tea, but it didn't help at all. I've been afraid of the future as the world has become more complicated and violent, and not seeing people smiling because of the pandemic, it destroys our individuality." Furthermore, Patient states that "back in January, I posted my work experience on YouTube to get more viewings from people all over the Country, but it didn't work as it usually does, that takes me down." Patient states that all these bad experiences tremendously have contributed to his depression and dislike of life. Patient states that a friend of him passed by his house and found him depressed and fearful he decided to take him to the ED.

History of suicide attempts: Patient acknowledges having the suicidal ideations but denies any history of suicide attempts.

Primary Diagnosis on Admission (2 points): Bipolar affective disorder, current episode depression.

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Patient states he was physically abused by his father who was beating him at the age of 5. **Witness of trauma/abuse: patient states that he was sexually abused by his 6th grade female instructor. Patient could not be precise at what age.**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**N/A**	**5 years old**	**N/A**	**Pt states his father was beating him up at age of 5.**
Sexual Abuse	**N/A**	**6th grade Pt**	**N/A**	**Pt states his 6th**

		cannot give a specific age		**grade instructor sexually abused him.**
Emotional Abuse	**N/A**	**N/A**	**N/A**	**N/A**
Neglect	**N/A**	**At age 7**		**Pt stated that his father divorced with his mother and left home and never took care of him.**
Exploitation	**N/A**	**N/A**	**N/A**	**N/A**
Crime	**N/A**	**N/A**	**N/A**	**N/A**
Military	**N/A**	**N/A**	**N/A**	**N/A**
Natural Disaster	**N/A**	**N/A**	**N/A**	**N/A**
Loss	**N/A**	**N/A**	**N/A**	**N/A**
Other	**N/A**	**N/A**	**N/A**	**N/A**
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	**Started on the 1st week of February before admission, 1 to 2 times a day. Patient rates his depression 8/10 on a scale of 1-10**	

Loss of energy or interest in activities/school	**Yes**	**No**	**Started on the 1st week of February before admission. Patient states that he just got tired, he wanted to stay home rather than going to work.**
Deterioration in hygiene and/or grooming	**Yes**	**No**	**Patient states he takes care of himself every day, such as taking shower, brushing teeth, and grooming.**
Social withdrawal or isolation	**Yes**	**No**	**Patient states that he does not want to go out and socialize with people, he likes being introverted and distant. Even at the hospital patient states not participating in group therapy.**
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	**Patient states even though he likes to stay home with less contact with people, but he still talks with his brother over the phone and his friend still come to visit him.**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	**Patient states that starting in**

			February, he has experienced hard time falling sleepy. Started one to two times a week, then 3 to 4 times a week and finally I could not sleep almost every day.
Difficulty falling asleep	**Yes**	**No**	**Patient states that starting in February, he has experienced hard time falling sleepy. Started one to two times a week, then 3 to 4 times a week and finally I could not sleep almost every day.**
Frequently awakening during night	**Yes**	**No**	**Patient states having hard time staying sleepy during night. He would wakeup 2 to 3 times at night as he was being awakened by bad dreams.**
Early morning awakenings	**Yes**	**No**	**Patient states that he experienced frequently early morning awakenings around 5 A.M started 2 to 3 times a week and finally almost every day.**

Nightmares/dreams	**Yes**	**No**	**Patient states having bad dreams at night. Frequency is as above.**
Other	**Yes**	**No**	**N/A**
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	**Patient states that he has loss the appetite since early February, which considerably changed his eating habits.**
Binge eating and/or purging	**Yes**	**No**	**N/A**
Unexplained weight loss? **Amount of weight change:**	**Yes**	**No**	**N/A**
Use of laxatives or excessive exercise	**Yes**	**No**	**N/A**
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Patient rated his anxiety is 8/10 on the day he came to the hospital. Patient states he is disappointed because of his failure to fulfill his own life.
Panic attacks	**Yes**	**No**	**N/A**
Obsessive/compulsive thoughts	**Yes**	**No**	**N/A**
Obsessive/compulsive behaviors	**Yes**	**No**	**N/A**
Impact on daily	**Yes**	**No**	Patient states that the anxiety has

living or avoidance of situations/objects due to levels of anxiety			affected his daily living. He states that he was very anxious going to work and be around noisy people while things in his life don't workout.
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?		**8**	
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**	**In early February, patient was stressed from work because he had to work with new noisy co-workers that he couldn't interact with, so he ended up quitting his job.**
School	**Yes**	**No**	**N/A**
Family	**Yes**	**No**	**N/A**
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	**N/A**
Financial	**Yes**	**No**	**Patient is concerned about loss of income and has no way to continue living a life that he**

			expected to live.
Other	**Yes**	**No**	**Patient is overwelled by his health condition because of his painful hemorrhoids, constipation, and the scrotal mass that is taking his peace and joy away.**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
The patient has no prior psychiatric or substance use treatment	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
The patient has no prior psychiatric or substance use treatment	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**
The patient has no prior psychiatric or substance use treatment	**Inpatient Outpatient Other:**	**N/A**	**N/A**	**No improvement Some improvement Significant improvement**

Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Patient states that he lives in a house in	**80**	**Friend**	**Yes**	**No**

Urbana with a male friend.				
			Yes	**No**
			Yes	**No**
			Yes	**No**
			Yes	**No**
If yes to any substance use, explain: None				
Children (age and gender): Patient has no children **Who are children with now? N/A**				
Household dysfunction, including separation/divorce/death/incarceration: **Patient has never got married**				
Current relationship problems: Patient has never got married and doesn't have a **partner.** **Number of marriages: 0**				
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 is a Christian, he believes in Jesus Christ the son of God who gives him inspirations.				
Ethnic/cultural factors/traditions/current activity: Caucasian **Describe:** patient did not comment on any ethnic/cultural/traditional factors**.**				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A				
How can your family/support system participate in your treatment and care? **My brother is a big support for me, he calls me most of the times and takes care of me.**				
Client raised by: **Natural parents:** single mother				

Grandparents **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: Physical abuse at age 5, sexual abuse during his 6th grade school, neglect at age 7.
Atmosphere of childhood home: patient states that he grew up in unfriendly atmosphere because his father had to beat him up constantly. **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) The patient denies family history of mental illness
History of Substance Use: The patient denies history of substance use
Education History: **Grade school** **High school** **College:** patient states he has a bachelor's degree in sciences and agriculture**.** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English

Problems in school: patient is not in school and his not taking any class.
Discharge
Client goals for treatment: Patient's goals are to take his medication to control his depression and anxiety and be comfortable at home.
Where will client go when discharged? The patient will be discharged home where he rents it in Urbana.

Outpatient Resources (15 points)

Resource	Rationale
1. Crisis Residential Center (Respite) 502 N Market St., Champaign IL Phone: 373-2428 Fax: 373-2445 For problems, call Ronia: 773-574-4328	**1.** This resource is close to where the patient lives, also this resource has a personal phone number a patient can contact during emergency situation and get appropriate care.
2. OSF Medical Group Behavioral Health Dr. Lo, Dr. Gait, Cindy Sundeen 1405 W Park St., Suite 306 Champaign, IL Phone: 337-4310 Fax 337-4621	**2.** The resource is where the patient has been hospitalized, they can reach out to him and get his information fastest. Also
3. Mckinley Mental Health Center University of Illinois 1109 S Lincoln Ave. Urbana IL Phone: 333-2705 Fax: 244-6495 Emergency Dean: 333-0050 Campus police: 333-1216	**3.** This resource has more access for the patient to reach out and get treatment. They have a specific orientation for mental health that can benefit to this patient.

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

Brand/Generic	Cogentin/ Benztropine Jones & Bartlett, L, 2020, Jones & Bartlett, L, 2020, Jones &	Haldol/ Haloperidol (Jones & Bartlett, L, 2020)	Trazodone/ Desyrel (Jones & Bartlett, L, 2020)	Olanzapine/ Zyprexa (Jones & Bartlett, L, 2020)	**N/A**

	Bartlett, L, 2020, (Jones & Bartlett, L, 2020)				
Dose	2 mg	5 mg	50 mg	5 mg	**N/A**
Frequency	2x a day	Every 6 hrs PRN	Nightly prn	Nightly	**N/A**
Route	PO	I.M	PO	PO	**N/A**
Classification	Anticholinergic/Anti-parkinsonian.	Antipsychotic	Antidepressant	Antipsychotic	**N/A**
Mechanism of Action	Block acetylcholine's action at cholinergic receptor sites, which relaxes muscle movement and rigidity.	Blocks postsynaptic dopamine receptor in limbic system and increase brain turnover of dopamine, producing an antipsychotic effect.	Blocks serotonin reuptake along the presynaptic neuronal membrane, causing an antidepressant effect.	May achieve antipsychotic effects by antagonizing dopamine and serotonin receptors.	**N/A**
Therapeutic Uses	Treats all Parkinson's disease, acute dystonic reactions, and control extrapyramidal symptoms.	Used to treat psychotic disorder, anxiety, depression, and problems with sleeping.	To treat major depression	To treat schizophrenia, manic phase of bipolar I disorder, agitation associated with schizophrenia and bipolar I mania	**N/A**
Therapeutic	Start with low dose	Adult 0.5-5	Start with	Initial dose	**N/A**

Range (if applicable)	and gradually increase 0.5mg to 1 mg/daily for 5 or 6 days because it has cumulative action.	mg 2 times/day	150 mg once a day and gradually increase by 75 mg daily every 3 days prn.	5 to 10 mg orally once a day with a maintenance of 10 mg daily, which may increase up to 20 mg per day.	
Reason Client Taking	To treat side effect of Haloperidol/ movement disorder.	Agitation, break through psychosis / mania	Sleep and depression	Agitation associated with bipolar I	**N/A**
Contraindications (2)	Angle-closure glaucoma, hypersensitivity to benztropine or its components.	Hypersensitivity to haloperidol Severe toxic CNS depression	Hypersensitivity to trazodone. Recovery from MI.	Blood dyscrasias. Hypersensitivity to olanzapine and its components	**N/A**
Side Effects/Adverse Reactions (2)	- Confusion - delusions	Anxiety Seizure Hypothermia Cardiac arrest	Agitation Abnormal coordination or dreams	Abnormal gait Hypotension	**N/A**
Medication/ Food Interactions	Haloperidol: increase schizophrenic symptoms. Tricyclic anti-depressants: possibly increase adverse anti-cholinergic effects.	Alcohol use increased CNS depression, and risk for hypotension. Use concurrent with haloperidol and anticonvulsant decrease blood drug level of haloperidol	Alcohol use increase risk of CNS depression, hypotension, and respiratory depression. Aspirin increase risk of bleeding.	Carbamazepine, omeprazole: increased olanzapine clearance Fluvoxamine: decreased olanzapine**.**	**N/A**
Nursing Considerations (2)	Administer in IV or IM. Assess muscle rigidity and tremor at baseline.	Haloperidol increases risk of death in elderly. Assess for	Use trazodone cautiously in patient with cardiac	Olanzapine shouldn't be used for elderly patients	**N/A**

		fall risk	disease because it can cause arrhythmias. Give trazodone shortly after meal or light snack to reduce nausea.	with dementia-related psychosis it increases risk of death Use with caution in patient with hepatic impairment.	

Brand/Generic	N/A	N/A	N/A	N/A	N/A
Dose	N/A	N/A	N/A	N/A	N/A
Frequency	N/A	N/A	N/A	N/A	N/A
Route	N/A	N/A	N/A	N/A	N/A
Classification	N/A	N/A	N/A	N/A	N/A
Mechanism of Action	N/A	N/A	N/A	N/A	N/A
Therapeutic Uses	N/A	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Patient's overall appearance is fair, no acute distress noted. Patient is quiet, cooperative, and pleasant. Open minded and no agitation noted. Well-dressed in yellow scrubs. He talks soft and slowly without eye contact. Able to keep the conversation ongoing. Patient's mood is not affected, can fairly smile, patient is without flat affect.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient acknowledges having suicidal ideation. Patient states he never attempted to harm himself. Patient denies having delusions, illusions, or compulsion behaviors. During the interview, patient did not show any signs of delusions, illusions, or compulsions. Also, patient says he does not have phobias.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient is oriented to person, place, and time. No negative thoughts about self were expressed.
MEMORY: **Remote:**	Patient's memory seems to be normal because during the interview patient was able to recall the information when same questions were asked more than once, and he was able to provid same answers**.**
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Patient has poor judgement about himself, he treats himself as a failure. He has his impulsions under control. His reasoning still quite low with average intelligence, but he is able to count. He is dealing with unrealistic ideas rather than reality**.**
INSIGHT:	The patient's insight is appropriate as he was able to understand clearly our conversation.

GAIT:	Patient is fall risk cannot walk by himself
Assistive Devices:	Patient is using a wheelchair
Posture:	Difficult to assess because he is on wheelchair
Muscle Tone:	Normal muscle tone
Strength:	Equal strength throughout bilateral
Motor Movements:	Normal motor movement

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1130	**86**	**126/85**	**18**	**97.6**	**99**
1445	**80**	**128/82**	**18**	**98.1**	**99**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1130	**0/10**	**N/A**	**N/A**	**N/A**	**N/A**
1445	**0/10**	**N/A**	**N/A**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:50%** **Lunch: 75%** **Dinner: 75%**	**Oral Fluid Intake with Meals (in mL)** **Breakfast:1/2 cup of coffee, ½ cup of milk = 240 mL** **Lunch: 1 cup of water 240 mL** **Dinner: 1 cup of water 240 mL**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The patient has a primary diagnosis of bipolar affective disorder, current episode of depression. During the interview with the patient, he denied he has manic behavior. Also, on the EMR there is no information about manic behavior on his file. Because patient has acknowledged having experienced episodes of depression and anxiety, changes in eating habits, suicidal ideations as he is afraid of the future, in this case, my discharge plan for this patient will be listed as following:

1. **patient will be discharged and go back to his home in Urbana.**
2. **Educate him on patient compliance pharmacotherapy to make sure he correctly follows doctor's prescription and adheres to therapeutic regiment.**
3. **Educate patient on signs and symptoms of anxiety and depression. Education him how to overcome anxiety and depression, which will help him change negative thoughts to positive ones and will help him cope with depression and anxiety. Even though the patient has been provided with the suicidal crisis number, he will also be offered some outpatient resources to make sure he can reach out to them and get help at any time. Because he is independent and has no wife or kids to provide a close supervision, even though he lives with an old friend 80 y/o, he is at high risk for relapse and harm himself in the first 3 months or the first 3 weeks right after discharge. I will encourage the patient to call the hotline if his suicidal ideations come back.**
4. **finally, I will ask the patient to set up an appointment within 7 days with his primary provider if he has one if not, I will refer him to a psychiatric for a follow-up and get outpatient service from the hospital.**

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 injury related to depression evidenced by the patient acknowledges having suicidal ideations states "I've become hopeless and fearful of uncertain future and I dislike life"	**This diagnosis was chosen because safety of client is a priority.**	**1. Provide safe environment for client and others.** **2. Frequently assess the client for suicide ideations.** **3. Provide pharmaco-therapy as prescribed.**	**1. Check the patient's status every 15 minutes** **2. Discuss with client about the benefits of participating in group therapy** **3. Reassure client that you are there to help**	**1. Educate the patient his new medications**. **2. Provide information and phone number of suicide hotline at any time client has thoughts to harm self or others.** **3. Provide information on suicide precaution and printed material**
2. Anxiety related to multiple stressors evidenced by patient states "anxiety has	**This diagnosis was chosen because the patient rates his anxiety level 8/10. High level of**	**1. Assess the patient's anxiety level** **2. Monitor patient's vital signs**	**1. Maintain a non-stimulating environment**. **2. Help patient release his anxiety by**	**1. Evaluate patient's anxiety level right before being discharged**

affected my daily living. I was very anxious going to work and be around noisy people while things in my life don't workout."	**anxiety could increase the risk for high blood pressure and heart disease.**	**3. Check patient's personal belongings together with him.**	**providing him reassurance and comfort measures** **3. Remain with the client when levels of anxiety are still high**	**2. Evaluate patient's coping methods** **3. Educate the patient that anxiety is treatable**
3. Ineffective Coping mechanisms Related to Ineffective problem-solving strategies evidenced by substance abuse and quitting his job.	**This diagnosis was chosen because patient exhibit poor coping methods as he states "I started feeling very depressed and anxious I stopped going to work because I got tired and worried about not being able to urinate without pain or use the toilet"**	**1. Assess the patient's previous coping methods** **2. Set up a schedule for ADLs by respecting patient' autonomy.** **3. Establish and maintain a trusting relationship by listening to the client, offering unconditional acceptance**	**1. Discuss patient's anxious feelings to help her find a different way to deal with.** **2. Encourage client's appropriate expression of feeling regarding treatment.** **3. Support and encourage client's efforts to explore the meaning and purpose of the behavior.**	**1. Teach client about coping strategy** **2. Reassess the patient's coping methods by asking the patient to teach me back** **3. Provide positive feedback to each step of the process**

Other References (APA):

Videbeck, L. S. (2020). *Psychiatric Mental Health Nursing* (8th ed.) Wolters Kluwer.

Vera, M. (2019, April 11). 7 anxiety and panic disorders nursing care plans. https://nurseslabs.com/anxiety-panic-disorders-nursing-care-plans/

Concept Map (20 Points):

Subjective Data

I stopped going to work
I have a dislike of life
I've become hopeless and fearful of uncertain future
He rates his anxiety level 8/10
He rates his depression 6/10
Acknowledges use of substance abuse

Nursing Diagnosis/Outcomes

Risk for injury related to depression evidenced by the patient acknowledges having suicidal ideations states "I' ve become hopeless and fearful of uncertain future and I dislike life."
Outcomes: patient will not injury self or others. Patient will show interest to live longer.
Anxiety related to multiple stressors evidenced by patient states "anxiety has affected my daily living. I was very anxious going to work and be around noisy people while things in my life don't workout".
Outcomes: Reduce own anxiety level.
Ineffective coping mechanism related to ineffective problem-solving strategies evidenced by substance abuse and quitting his job.
Outcome: The patient will verbalize signs and symptoms of increasing anxiety and intervene to maintain anxiety at manageable level.

Objective Data

BP: 128/82
PULSE: 80
RR: 18
TEMPERATURE: 98.1
O2: 99%

Patient Information

RF, 73 y/o single Caucasian male, 5'10", 59Kg. An agricultural engineer with a history of Hemorrhoids, Renal cysts, PTSD, Anxiety, and Depression with no known allergies. He lives with a friend in a house in Urbana

Nursing Interventions

1. Provide positive feedback to each step of the process
2. Establish and maintain a trusting relationship by listening to the client, offering unconditional acceptance
3. Reassess the patient's coping methods by asking the patient to teach me back.
4. Encourage client's appropriate expression of feeling regarding treatment
5. Evaluate patient's anxiety level right before being discharged
6. Help patient release his anxiety by providing him reassurance and comfort measures
7. Assess the patient's anxiety level
8. Monitor patient's vital signs
9. Provide safe environment for client and others.
10. Frequently assess the client for suicide ideations.