

N323: Care Plan

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N323: Mental and Behavioral Health

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Demographics (3 points)

Date of Admission September 23, 2025	Patient Initials W.H.	Age 39 years old	Biological Gender Male
Race/Ethnicity African American	Occupation Maintenance at Peoria Civic Center	Marital Status Single	Gender Identity Male
Code Status Attempt CPR/Full Code	Height and Weight 5ft 7in & 150lbs	Allergies No known drug allergies	Pronouns He/Him

Medical History (5 Points)

Past Medical History: The client has no previous medical history related to being homeless and having no access to healthcare.

Psychiatric Diagnosis: The client has psychiatric diagnoses of unspecified bipolar disorder, moderate to severe alcohol use disorder and moderate to severe cannabis use disorder. This is the first psychiatric treatment the client has received.

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	Inpatient or Outpatient?	Reason for Treatment
N/A		
N/A		
N/A		

Admission Assessment

Chief Complaint (2 points): “I’m having suicidal thoughts”

Contributing Factors (10 points): The client experienced many factors that lead up to his admission. Some of these triggers include being homeless, and no family support. The onset of these triggers began when he got out of prison in 2009 and has been occurring since. The client

stated that being homeless is a major factor in his admission since he does not have a safe place to go home at night. The client also states that his mood has been declining rapidly for the past two weeks this month. He states that the people he is around aggravates his mental health and he paces to make himself feel better. Overall, the client said that he has been working to try to come to the facility sooner however he wanted to “try to kill himself first”. With this failing, he chose to do the right thing and come to the facility that will help him through this rough time in life. He states that he does not have any physical pain during his stay.

Factors that lead to admission (address triggers and coping mechanisms if applicable): The client stated that being homeless is a major factor in his admission since he does not have a safe place to go home at night. The client states that his mood has been declining rapidly for the past two weeks this month. He states that the people he is around aggravates his mental health and he paces to make himself feel better. He says that he “does not want to deal with the bull crap anymore” so he chooses to walk away from it instead. He does not have a family support system which impacts his life as well. He is also not in contact with his daughter, which is his closest family member. His mother is not the best role model, and he chooses to stay away for the purpose of maintaining his mental health.

Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal): The client has a job at the Peoria Civic Center and works in maintenance. He enjoys his job and did not want to leave to come to the facility, however, he wanted to better his mental health. He then stated that when he spoke to the Civic Center, they stated that he would have a job when he returned. This job is the source of his income which allows him to buy a limited amount of food each week. The client truly enjoys his job and the two friends he has in his department which is

why he strives to better his mental health. While he is at the facility, he is not making money which worries him since his paycheck will not come for another week.

Primary Diagnosis on Admission (2 points): Suicidal Ideation

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		Client Answer	
Do you have a history of physical, sexual, emotional, or verbal abuse?		The client declined a history of experiencing physical, sexual, emotional and verbal abuse.	
Do you have a history of trauma secondary to military service?		The client declined a history of experiencing trauma secondary to military service.	
Have you experienced a loss of family or friends that affected your emotional well-being?		The client reports losing his younger cousin during a shooting while the client was in prison.	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		The client declined any other scary or stressful events in the past.	
(If the client answered no to all screening questions for history of trauma, you may skip to “Presenting Problems”. If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)		(If the client answered no to all screening questions for history of trauma, you may skip to “Presenting Problems”. If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)	
	Current?	Past? (what age)	By whom?
Physical Abuse	N/A	N/A	
Sexual Abuse	N/A	N/A	
Emotional Abuse	N/A	N/A	
Verbal Abuse	N/A	N/A	
Military	N/A	N/A	
Other	Yes	20 years old	The client stated that the death of his younger cousin “hit him hard”

			because he believes that it was his fault since he was the suspected target.
Presenting Problems			
Problematic Areas	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.	
Do you feel down, depressed or hopeless?	No		
Do you feel tired or have little energy?	No		
Do you avoid social situations?	Yes	The client chooses to avoid social situations as much as possible, however, he states that sometimes it is difficult regarding his living situation. He chooses to avoid these situations daily during the evening after work, but he states that it is hard to escape from. He has been attempting to avoid these situations since he was released from prison in 2009 and states that he does not "want to deal with that bull crap so I just walk away from it". He described his living situation and stated that it was difficult to escape all of the negative social situations however, he wants to move forward and escape the rough life and find a home to rent.	

Do you have difficulties with home, school, work, relationships, or responsibilities	No	
Sleeping Patterns	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.
Have you experienced a change in numbers of hours that you sleep each night?	No	
Do you have difficulty falling asleep?	No	
Do you frequently awaken during the night?	Yes	The client states that he wakes up during the night about two times each week. He described this trouble as "randomly waking up at night and then falling back asleep soon after". He said it only lasts for a few minutes, and he is able to fall quickly back asleep.
Do you have nightmares?	No	
Are you satisfied with your sleep?	No	The client expressed satisfaction with his sleep besides waking up in the night a couple times each week. He stated that if he was able to sleep "soundly" throughout the night then he would be very satisfied with his rest. Overall, the client did not express any major concern regarding his sleep cycle and appeared to be well rested and alert.
Eating Habits	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe

		objectively.
Do you overeat?	No	
Do you purge after eating? Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.	No	
Do you have not eat enough or have a loss of appetite?	No	
Have you recently experienced unexplained weight loss? Amount of weight change:	No	
Anxiety Symptoms	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.
Do you pace, have tremors, or experience other symptoms of anxiety?	Yes	The client chooses to pace when he feels depressed or bored. When asked about the frequency of pacing he stated, "every once in a while". I noticed him pacing the hallways at the facility however, he was not depressed when asked.
Do you experience panic attacks?	No	
Do you have obsessive or compulsive thoughts?	No	
Do you have obsessive or compulsive behaviors?	No	
Suicidal Ideation	Client Answer	Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe

		objectively.	
In the past week have you wished that you were dead?	No		
Have you ever tried to kill yourself?	Yes	The client stated that he tried to jump in front of a car about a year and a half ago, but the car stopped before it could hit him. He has attempted this about 3 times since.	
If the client answered either of the previous questions “yes”, you must ask the client: Are you having thoughts of killing yourself right now? (If the client says yes, you must ensure facility staff are aware)	No		
Rating Scale			
How would you rate your depression on a scale of 1-10?		5/10	
How would you rate your anxiety on a scale of 1-10?		3/10	
Personal/Family History			
Who lives with you?	Age	Relationship	Do they use alcohol or drugs?
N/A			
If yes to any alcohol or drug use, explain: N/A			

Family Medical History: N/A		
Family Psychiatric History (including suicide): N/A		
Family alcohol or drug use (not covered by those client lives with): The client states that his mother uses marijuana and drinks an average of 12 cans of beer each day.		
Do you have children? If yes, what are their ages?		
Who are your children with now?		
<ul style="list-style-type: none"> The client states that he does have a 13-year-old daughter who lives in Cuba, IL with her mother. 		
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends?		
If yes, please tell me more about that: The client has not experienced parental separation or divorce however, he has experienced the loss of his younger cousin. The clients younger cousin got shot and killed while he was sitting on their front porch playing with his toys when a car drove by shooting. The client stated that the death of his younger cousin “hit him hard” because he believes that it was his fault since he was the suspected target. His younger brother was also incarcerated when he attempted arson towards his ex-girlfriend and her children while they were in the home.		
Are you currently having relationship problems? No		
What is your sexual orientation: Male	Are you sexually active? Yes	Do you practice safe sex? Yes
Please describe your religious values, beliefs, spirituality and/or preference: The client states that he is a Christian and declined further questioning.		
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect		

your plan of care? The client declined to answer.
<p>Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): The client has been incarcerated from 2006 to 2009 when he was arrested for having possession of a 40-caliber gun with high tail bullets. He does not have any current legal issues.</p>
<p>Whom would you consider your support system? The client states that he does not have a support system.</p> <p>How can your family/support system participate in your treatment and care? N/A</p>
<p>What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) The client declined using any coping mechanisms however, previously he stated that he paces when he has anxiety.</p>
<p>What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) The client states that his trigger is “being around bad people”.</p>
<p>Client raised by: The client was raised by his mother.</p> <p>Natural parents: Grandparents Adoptive parents Foster parents Other (describe):</p>
<p>Self-Care: Independent</p> <p>Independent Assisted Total Care</p>
<p>Education History: 9th grade learning level</p> <p>Grade school High school College Other:</p>
<p>Reading Skills: The client is able to read and write.</p> <p>Yes No</p>

Limited		
Primary Language: English		
Personal History of Substance Use		
Screening Questions:		
1. <u>Have you ever used drugs, alcohol, or nicotine?</u>		
(If no, you may skip to “psychiatric medications”. If yes, complete all sections of this chart. Type N/A if not applicable.)		
Substance	First Use and Last Use	Frequency of Use
Nicotine Products (including smoking, chewing, vaping)	First Use: Age 20 Last Use: September 22, 2025	The client smokes two packs of cigarettes each day since the day of his first use.
Alcohol	First Use: Age 26 Last Use: September 22, 2025	The client drinks one fifth of Jose Cuervo Especial each day since the day of his first use.
Prescription Medications (Recreational Use)	First Use: N/A Last Use: N/A	
Marijuana	First Use: Age 16 Last Use: September 22, 2025	The client smokes Marijuana everyday and sometimes two times a day since the day of his first use.
Heroin	First Use: N/A Last Use: N/A	
Methamphetamine	First Use: N/A Last Use: N/A	
Other: Specify	First Use: September 22, 2025	The client states that he tried

	Last Use: September 22, 2025	cocaine one time and that he “did not like it and will never use it again”.
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Current Psychiatric Medications (10 points)

Complete all of your client’s psychiatric medications

All information listed in this section must be pertinent to your patient.

Brand/Generic	Tylenol/ acetamino phen	Tums/ calcium carbonate	Catapres-TTS/ clonidine	Circadin (SP)/melatonin	Visteril/ hydroxyzine pamoate	
Dose	650mg tablet	1,000mg chewable	0.1mg tablet	3mg tablets	50mg tablets	
Frequency	PRN every 4-6 hours	PRN Q8H	PRN morning and night	PRN nightly	PRN 4 times daily	
Route	Oral	Oral	Oral	Oral	Oral	
Classification	Pharmacol ogical class: Nonsalicy late, para- aminophe nol derivative Therapeut ic class: antipyretic , nonopioid analgesic	Pharmacolo gic class: Calcium salts Therapeutic class: Antacid	Pharmacologic class: Centrally acting alpha agonist Therapeutic class: Analgesic, antihypertensiv e, behavior modifier	Pharmacologic class: melatonin receptor agonists. Therapeutic class: sedative/hypnotic	Pharmacologic class: Piperazine derivative Therapeutic class: Anxiolytic, antiemetic, antihistamine, sedative- hypnotic	
Mechanism of Action	Tylenol inhibits cyclooxyg enase which resolves pain and	Tums neutralize gastric acid which may help relieve indigestion and	Catapres-TTS stimulates alpha-2 receptors to release less norepinephrine to slow down	Circadin activates the MT1 and MT2 receptors to help with sleep onset and circadian rhythms.	Visteril blocks the histamine in the body which reduces itching, anxiety, nausea. This may also cause sedation.	

	reduces fevers.	heartburn.	the nervous system.			
Therapeutic Uses	Tylenol is used to relieve mild to moderate pain as well as a fever reducer.	Tums is used to provide antacid effects and reduce indigestion and heartburn.	Catapres-TTS may be used as a hypertension medication and to modify abnormal behavior.	Circadin may be used for difficulty sleeping or difficulty falling asleep.	Vistaril may be used to relieve anxiety.	
Therapeutic Range (if applicable)	1,300mg every 8hrs as needed. Maximum : 3,900mg in 24hrs.	1,000mg up to 4 times a day as needed. Maximum: 6,750mg – 7,500mg daily for up to 2 weeks.	Initial: 0.1mg twice daily, increased by 0.1mg each week to produce the desired response. Maintenance: 0.2mg – 0.6mg daily. Maximum: 2.4mg daily.	One 3mg tablet/day, taken one to two hours before bedtime.	50mg-100mg 4 times daily	
Reason Client Taking	Tylenol should be given when the client presents mild to moderate pain.	The client may take Tums during the occurrence of heartburn or indigestion.	The client may take Catapres-TTS during the occurrence of hypertension or abnormal behavior.	Circadin may be used to help remain asleep at night.	Vistaril may be taken to reduce anxiety.	
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	The client should attempt guided imagery before using Tylenol.	The client should attempt meditation to help calm and relax the nervous system as well as promote digestion.	The client should attempt meditation to help calm and relax the nervous system to help lower blood pressure and the mood changes.	The client should attempt drinking a warm caffeine-free tea or warm milk to help fall asleep.	The client should attempt to use coping methods to reduce their anxiety such as going for a walk or journaling.	

Contraindications (2)	1. Severe active liver disease or impairment 2. Potential risk for renal impairment	1. May result in hypercalcemia from concurrent use of calcium supplements. 2. Do not take more than recommended because it may cause the gastric pH balance to rise and make the stomach contents more acidic.	1. Avoid if using anticoagulant therapy. 2. Avoid during a hypotensive event.	1. Avoid if client has blood pressure issues such as hypertension or hypotension. 2. Avoid if the client is on anticoagulants.	1. Avoid if client has a hypersensitivity to cetirizine, hydroxyzine, levocetirizine. 2. Avoid if the client has a prolonged QT interval.	
Side Effects/Adverse Reactions (2)	1. hypotension or hypertension 2. peripheral edema	1. Potential dehydration 2. lightheadedness and flushed face	1. Arrhythmias 2. Thrombocytopenia	1. Insomnia 2. Daytime drowsiness	1. Seizures 2. Dry mouth	
Medication/Food Interactions	Interactions include: anticholinergic, barbiturates, propranolol, isoniazid.	Interaction include: bisphosphonates, calcium supplements, magnesium-containing preparations, digitalis glycosides, thiazide diuretics, verapamil, vitamin D,	Interactions include: barbiturates, beta-blockers, calcium channel blockers, digoxin, diuretics, epidural local anesthetics, fluphenazine, tricyclic antidepressants and alcohol use.	Interactions include: CNS depressants, anticoagulants, immunosuppressants, anticonvulsants, diabetes medications, antidepressants, antihypertensives, caffeine and alcohol.	Interactions include: antibiotics, antidepressants, antipsychotics, ziprasidone, antiarrhythmics, methadone, and alcohol.	

		alcohol use, caffeine and high-fiber foods.				
Nursing Considerations (2)	1. Use with caution for those with alcoholism. 2. Monitor renal function in clients on long term therapy.	1. Monitor client for possible hypercalcemia. 2. Monitor client or possible aluminum toxicity.	1. It should not be used for those who have severe cardiovascular disease. 2. Use with caution in the elderly population since they may be more sensitive to the hypotensive effect.	1. Implement fall precautions as well as education to take Circadin 30-60mins before bedtime. 2. Use with caution for clients who have depression, bleeding risks or seizures.	1. Monitor clients for seizures and implement seizure precautions. 2. Use with caution for those at risk for QT prolongation.	

Medications Reference **(1)** (APA):

Jones & Bartlett Learning. (2025). *Nurse's Drug Handbook*.

Mental Status Exam Findings (25 points)

OBSERVATIONS: Appearance (i.e.: positioning, posture, dress, grooming): Alertness: Orientation: Behavior: Speech: Eye Contact: Attentiveness:	<p>The client appears alert and oriented x4, well-groomed with no acute distress.</p> <p>The client was sitting down during the interview attentively while happily answering questions clearly. His eye contact was direct and focused during the entire interview.</p>
MOOD: How is your mood today? Affect: Consistency between mood and affect?	<p>The client states that he is in a good mood and he appears to be happy and actively thriving well. The clients mood is congruent with the observations noted.</p>

COGNITION: Alertness: Orientation: Memory Impairment: Attention:	<p>The client appears alert and oriented x4, well-groomed with no acute distress. He has no memory impairment and is able to pay close attention during the interview while questions are being asked.</p>
MAIN THOUGHT CONTENT: Homicidal Ideations or Suicidal Ideation: Delusions: Hallucinations: <ul style="list-style-type: none"> • Specify: Auditory, Visual, Tactile, Olfactory Obsessions: Compulsions: Paranoia: Flight of Ideas: Perseveration: Loose Association:	<p>The client is not currently experiencing homicidal or suicidal ideation. He is not experiencing delusions, hallucinations, obsession, compulsions, paranoia, flight ideas, perseveration or loose association.</p>
REASONING: Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?): Insight into Illness:	<p>The client stated that he would attempt to turn the wallet in to the police station to do the right thing. He demonstrates good understanding to the insight of his illness and understands that it is important to continue focusing on his mental health.</p>
MOTOR ACTIVITY: Assistive Devices: Gait: Abnormal Motor Activities:	<p>The client does not use any assistive device. He has a smooth, well-balanced gait and does not have any abnormal motor activities.</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	62 bpm	126/88	17 breaths	97.2 degrees	99% SpO2
	right radial	mm/Hg	per minute	Fahrenheit	room air
	wrist	upper			
		right arm			

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1039	0-10 numeric	N/A	0	N/A	N/A

Nursing Care (6 points)

Overview of care provided today: The client received continuous care as well as preparation of discharge. He attended group therapy and participated well; however, he did not want to fill out the suggested worksheet. Throughout the day he smiled and laughed with the other clients.

Paperwork was signed by each department verifying that he was able to be discharged and a ride share was arranged to leave for Peoria at 1500 with another client. After he verified all of his personal belongings, he was discharged from the facility at 1445 to continue living a healthy life in Peoria.

Client complaints: The client declined any complaints about his care that was provided throughout his admission.

Participation in therapy / groups: The client participated in group therapy well as they discussed the topic of the day while he ate his snacks. He actively listened and interacted with others however he did not want to fill out the worksheet that was suggested.

Medication compliance today: The client did not take any medications on September 29, 2025.

Behaviors exhibited today: The client expressed happiness, relaxation and respect during the private interview and interacted well with the other clients. After lunch he was heard saying “here kitty, kitty, kitty” repeatedly as well with the other clients laughing.

Discharge Planning

Discharge location: The client plans to return to Peoria to continue his job. He did not state the living location that he was going to.

Follow up plan: There is no follow up plan in place however, he is highly encouraged to seek further guidance and support if he feels suicidal again.

Education needs: The client was educated on the importance of finding a community living space and reaching out to his daughter after he was informed that she wanted to see him.

Nursing Diagnosis (25 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Outcome Goal (1 per diagnosis)	Interventions (3 per diagnosis)	Outpatient Resource with Rationale (1 per diagnosis)
<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 			
1. Self-Neglect related to being homeless as evidence by not having a home with utilities and supplies.	The client expressed that he does not have a home and or public community living space to go to when he needs to shower and change clothing.	1. The client will discuss possible opportunities of living as well as appropriate hygiene needs before he leaves the facility. He will discuss where he will find himself in the next six	1. Educate the client on places to live such as a community living. 2. Educate the client on places to obtain food and clean clothes. 3. Encourage the client to identify internally motivating factors for adhering to a	1. The client listened and helped think of places to go to when he leaves the facility. He stated that he will attempt to get into the community living branch of Peoria to have a safe place to go especially since it is getting colder. The client also emphasize the importance of the

		months as well.	health regimen.	food pantries and we looked for the local ones in his area. Overall, he wants to improve his health and lifestyle, however, he believes that it is going to take some time to do so.
2. Imbalanced Nutrition related to being homeless as evidence by voicing concerns about finding food sources.	The client expressed concern about sometimes not being able to eat dinner because he does not have enough money to buy any.	1.The client will discuss potential food pantry locations to go to at least three times a week in his area. He will also express the need for proper nutrition by 1500 when he will be discharged.	1. Educate the client on the importance of healthy eating and have the client use the teach back method to ensure learning. 2. The client will discuss places to obtain healthy food in his area. 3. The client will express the understanding to save money and have a safe location to keep his money.	1. The client discussed the need for a well-balanced diet and locations of food pantry's in Peoria that he is able to reach. He plans on going to the local food pantry when he gets home. He expressed the need to save money, however he does not know where to keep his money. Together we decided that a good place to keep his money was in his wallet attached to his pants with a chain.
3. Impaired Social Interaction related to inadequate social support as evidence by not wanting to be around	The client said that he does not want to be around the wrong type of people because that leads him to have suicidal ideation.	The client will express other mentally healthy types of social interaction and situations before he	1.Educate the client on the importance of a social aspect of life and how it impacts mental health. 2. Educate how to expand his view of friendship and relationships such	1. The client tolerated the education well and understands the importance of a social life and will choose to meet new people in the lunchroom at his job. He has also agreed to reach out

people and suicidal ideation.		discharges at 1500. These things may include going on a walk, finding a simple hobby or meditation.	as meeting new people in the workplace. 3.The client will reach out to his daughter who has been wanting to see him.	to his daughter after his is discharged at 1500. He will also attempt to attend an outside group therapy to better his overall social interaction.
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Other References (APA):

Phelps, L. (2021). *Nursing Diagnosis Reference Manual*. (12th edition). Wolters Kluwer

The client states that he is from Peoria, IL where he lives alone. He chose to come to the facility when he recently attempted to jump in front of a car. He believes that is around the wrong type of people which leads him to have suicidal ideation. He claims that he was agitated and unstable from his major stressors which include being homeless without any family support. He states that his mood has been declining for the past two weeks as well.

The client presented to the facility with suicidal ideation with a positive drug and alcohol test. His vitals were within range throughout his admission. He was admitted wearing poorly washed clothing and inadequate hygiene. He speaks well in conversation and actively participates in group therapy well. During discharge he appeared happy and ready to start his life again.

Patient Information

The client is a 39-year-old homeless African American male who was admitted for having suicidal thoughts. His psychiatric diagnoses are unspecified bipolar disorder, alcohol use disorder and cannabis use disorder.

Nursing Diagnosis/Outcomes

Nursing Diagnosis 1: Self-Neglect related to being homeless as evidence by not having a home with utilities and supplies.

Outcome: The client will discuss possible opportunities of living as well as appropriate hygiene needs before he leaves the facility. He will discuss where he will find himself in the next six months as well.

Nursing Diagnosis 2: Imbalanced Nutrition related to being homeless as evidence by voicing concerns about finding food sources.

Outcome: The client will discuss potential food pantry locations to go to at least three times a week in his area. He will also express the need for proper nutrition by 1500 when he will be discharged.

Nursing Diagnosis 3: Impaired Social Interaction related to inadequate social support as evidence by not wanting to be around people and suicidal ideation.

Outcome: The client will express other mentally healthy types of social interaction and situations before he discharges at 1500. These things may include going on a walk, finding a simple hobby or meditation.

Nursing Interventions

Interventions 1: Educate the client on places to live such as a community living. Educate the client on places to obtain food and clean clothes. Encourage the client to identify internally motivating factors for adhering to a health regimen.

Interventions 2: Educate the client on the importance of healthy eating and have the client use the teach back method to ensure learning. The client will discuss places to obtain healthy food in his area. The client will express the understanding to save money and have a safe location to keep his money.

Interventions 3: Educate the client on the importance of a social aspect of life and how it impacts mental health. Educate how to expand his view of friendship and relationships such as meeting new people in the workplace. The client will reach out to his daughter who has been wanting to see him.

