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Biopsychosocial Assessment and Nursing Care Plan of the Mentally Ill

Kent State University-Stark Campus

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Part I: Introduction of Client

Diagnosis, Reason for Treatment, Medical History

Patient presents with a DSM-IV Diagnoses of:
Axis I- Schizoaffective, Bipolar disorder
-Alcohol DPND in a control environment
-Cocaine abuse
-Inhalant abuse
-Other or unknown substance abuse
Axis II- N/A
Axis III- Obesity Unsp.
-ACQ Deform Hammer toe
-Hypothyroidism
-OTH/Unsp. Hyperlipidemia
Axis IV- Legal status, unemployed, severe mental illness
-Relationship problem
Axis V- GAF 55

B.A. is a single thirty-seven year old white Caucasian male who was found not guilty by reason of insanity (NGRI) for the murder of his maternal grandparents. The murder took place on the eighth of July in the year two-thousand and six, about five years ago. The patient was delusional at the time of the offense. Based on the patient's chart, B.A. was having auditory command hallucinations and religious delusions. The patient reported that God was talking to him and telling him to kill his maternal grandparents because they were the ones who killed his mother and that everyone would be safe if he killed them. In reality, the patient's biological mother actually committed suicide due to her bipolar disorder. B.A. also reported that the voices of God informed him that heaven would come to earth and that he would be reunited with "Arlene" again if he followed God's request, assuming Arlene was his biological mother.

On June ninth two-thousand and six, the client had gone to a mental healthcare center in Wooster, Ohio. This was about one month before the alleged offenses. He went there with his dad and fiancé named Angie; however, the client's stepmother reported that he was actually

transported there by law enforcement due to bizarre behavior such as running off at night and chasing flying saucers. According to the chart, the patient informed the staff there that he does not hear voices because he didn't want them to think he was "crazy". This incident should have probably been taken more seriously by the patient's family because it was part of the anteceding events to the crime.

B.A. is a transfer patient because he was originally admitted to a different behavioral healthcare facility on the thirtieth of August in the year two-thousand and seven, per order of the Judge. The client was admitted to Heartland due to the need of a less restrictive environment and is currently on level three. It has been four years since the client's initiation of current treatment. He was started on medication at the previous behavioral healthcare facility in the year two-thousand and seven and has been compliant with medications and treatment since. The patient does not report any delusions or hallucinations and denies suicidal/homicidal thoughts. B.A. has no manic symptoms or obsessions/compulsions. According to the patient's chart, the patient has a medical history of poor dental hygiene, hypothyroidism, hyperlipidemia, obesity, myopia and astigmatism corrected with glasses, mild anemia, and history of the chicken pox as a child. He has no known allergies.

Treatment History

The patient had no previous suicide/self injurious attempts and no prior treatment with psychotropic medications or psychiatric hospitalizations. After graduating high school, B.A. had a history of sporadic employment but it is important to note that he became unemployed over the past six months prior to the NGRI offense. The client has an extensive history of polysubstance abuse including marijuana, lysergic acid diethylamide (LSD), stimulants such as cocaine, and alcohol abuse. He had several manic episodes, decreased need for sleep, increased energy, racing

thoughts and grandiose thinking which lasted up to a day or two into his teenage years. Unfortunately, it aggressively worsened into his early twenties, lasting up to three to four weeks at a time. B.A. was treated at a hospital in Wooster in February of the year nineteen-ninety-two when the client was about seventeen or eighteen years old. This was due to overdose of the drug Elavil. The patient had symptoms of acute psychosis. The stepmother reported that the patient made unusual comments over the past two years and has isolated himself from friends and family.

Client Relationship

The relationship with the client started fairly well. Since time was limited, there wasn't much time to chat during the initial meeting. On the other side, the patient seemed open and fine to the idea of visiting him and talking about his progress and goals. That is the idea I got from the very first meeting when only an introduction took place. The second meeting with the patient took place in a group session. He was learning to play the guitar and was learning one-on-one with the instructor, so there was no room for discussion. The following two weeks consisted of special experiences at Mercy Medical Center and Akron Children's Hospital. Finally, there was one last day to engage in a good conversation with B.A.

During our one "good conversation" the patient did give his full attention but his answers were always short and to the point. It was hard to get anything interesting out of him thus many questions were asked to get a good idea about him. The patient never rejected speaking to me or any part of the conversation and always answered all of my questions which demonstrates that we had a fairly good relationship. One concern is that there weren't as many frequent meetings as preferred which makes the trust of the patient a questionable issue. Issues discussed with the client included medication side effects, substance abuse, relationships with others, and social

support on the “inside” and “outside”, for example. During the assessment goals were also reviewed with the client including advancing from the current level three, maintaining sobriety, maintaining his job at Heartland and getting a job in the future, etc.

Part II: Mental Status Examination

General Description, Emotional State

B.A. is a rather larger man who appears quite younger than his actual age of thirty-seven. He appears well groomed because his clothes and body was clean. He was wearing jeans and a t-shirt which demonstrates that he was not carelessly dressed, but rather suitable for his age and occasion. The client’s posture was normal and his facial expression normally expressive upon the first meeting but seemed impassive during our main conversation. For example, he didn’t express much emotion when we discussed various subjects and never used hand gestures or anything of the sort, although he did smile once or twice. He sat in a perfect position during the whole interview, almost perfect. The client always kept direct eye contact with me every time we met throughout the whole conversation. B.A.’s level of activity was normal and he was responsive to the interviewer. He was very pleasant and seemed friendly with me and my partner and. During our meeting he seemed like he would be a very open guy but when we actually held a conversation he didn’t talk so much “on his own”. He was open to everything I had to say or ask but at the same time, seemed somewhat shy. When I was observing him with other people, I noticed he was interacting in the same way he did with me which made me feel better because I thought he was strictly only shy with me because I was someone new. He was never suspicious, defensive or inappropriate.

When asked, B.A. stated that he has been feeling “good” lately with no apparent feelings that could be a problem. The patient’s mood was euthymic and his affect was blunted and at

times incongruent when discussing more serious issues which usually bring sad thoughts. His facial expressions rarely changed, never breaking down or showing signs of concern. For example, when we discussed his relationship with his fiancé and her family's concerns that he was crazy, the patient never illustrated a sad mood or concerned look. Since quite a few years have passed since their breakup, the client has probably had some time to heal which is probably why he didn't break down or cry, as I assumed.

Cognition

The client was alert and oriented to time, place, person, and situation. Recent and remote memories were intact and the patient had absolutely no trouble concentrating or paying attention. B.A. demonstrated abstract thinking when asked about the similarity between a bus and a bicycle. He showed good insight about his diagnosis and told me what the diagnosis schizoaffective meant; however, his judgment was not so great when he informed me that he didn't think he needed to attend alcoholics' anonymous (AA) meetings because he no longer has a drug or alcohol problem. This demonstrates that the client still has learning and work to do to better understand that there is always a chance of relapse. His speech flow rate was normal, and all of his sentences made sense. The client was clear in all that he said and his speech volume was normal.

Thought Content, Thought Process

The focus of B.A.'s conversation was not focused on just one main idea. A majority of it was about his relationships with other people, his past relationships before lockup, hobbies, future goals and his current employment at the library. The patient didn't really display any themes because I had to change the topic many times in order to keep the conversation going and natural since the patient wouldn't talk on his own very much. B.A. appeared very optimistic

about his life at Heartland and hopefully outside of Heartland too. He verbalized his ambition in working as a painter again someday, as he did before the offense but he also verbalized a fear that it would be hard. The patient denies any phobias and obsessions and portrays no depressive characteristics. He denies having any suicidal plans or intent and denies any delusions or unusual thoughts. His thought process was coherent and well-organized, with no flights of ideas, looseness of associations, etc.

Perceptions, Risk to Self and Others

The client denied current experience with any hallucinations or illusions and denies any pain. Patient also denies any suicidal thoughts, plans, or intent. B.A. exhibits quite a few risk factors to himself such as a history of polysubstance abuse such as marijuana, cocaine, LSD, and alcohol abuse. He's had significant losses such as his mother when he was a young boy. The patient also had past attempts when he was about seventeen years old, overdosing on Elavil. He also has a family history of suicide and mental illness. B.A. experienced his mother commit suicide when he was about six years old although he didn't find out until he was eleven—it is still a young age to find out your mother hung herself in a closet. She also had bipolar disorder. The client has a history of command hallucinations which led him to murdering his maternal grandparents because God was "telling him to do it".

Five years ago, the patient had homicidal ideation and intent when he murdered his maternal grandparents due to his command auditory hallucinations telling him to. His past record of convictions and polysubstance abuse also adds to the risk of others. According to the chart, before his offense, the patient's stepmother reported that B.A. had isolated himself from friends and family for the past two years before murdering his maternal grandparents. Although it was only for two years, he does have a history of antisocial traits. Currently, the patient does

not show any antisocial traits. For example, he is the only patient on unit D-2 who had a VCR T.V. and periodically brings it out in the commons room to share it for movie night with other "friends".

All of these formerly explained risk factors put the patient at risk for himself and to others. He is more likely to hurt himself if he has had any previous attempts to do so, if he has a substance abuse problem, and simply for the fact that he has a history of command hallucinations, as previously explained. Some of these factors along with others also put others at risk. For example, since he has already murdered two people in the past, of course he is more likely to do it again and possibly hurt or even murder someone else. His criminal record also puts others at risk. For example, in the year nineteen-ninety-eight he was convicted of hit and run/leave the scene. This is an obvious an obvious example of how a criminal record can put others at risk.

Social Functioning, Substance Abuse

When the patient was about five or six years old his parents divorced so he moved in with his father. The dad divorced the mom because of her mental illness of bipolar disorder. The patient's mom eventually committed suicide by hanging herself in a closet at his grandparents' home when B.A. was only six years old. B.A. did not believe this when his dad told him at the age of eleven! The client could recall his mom yelling at him and locking him in a closet. The father eventually remarried and the patient's stepmom treated her stepson very well but the client was somewhat resentful of her because he wanted his parents to have stayed together. Years later, the client reconnected with an old friend from high school who was in a motor vehicle accident, causing her to become paraplegic. Their relationship ended when he was accused of the offense. The patient's loss of his mother had a big influence on him. Many years later, even

his command hallucinations had something to do with his deceased mother. The voices were telling him to murder his grandparents because they were the ones that killed his mom.

When the patient was younger his social life was normal and he didn't show signs of being antisocial. He had friends, girlfriends, and family that were involved in his life but as he got older, two years before the homicide to be exact, B.A. isolated himself from his friends and family. Currently the patient has no problems forming relationships with the other guys on unit D-2. When asked he even told me that he has female friends, but reassuring me that none of them were girlfriends. B.A. informed me that his family visits him and that he still has a close relationship with one of his two brothers. The client was never married and has no children. Religion is an important part of the client's life, he is a Baptist.

The client has an extensive history of polysubstance abuse including marijuana, lysergic acid diethylamide (LSD), stimulants such as cocaine, and alcohol abuse. His drug of choice is marijuana. Mr. A had several legal difficulties throughout his life. Since he has a history of polysubstance abuse, most of his legal problems dealt with drugs. The patient was convicted of drug paraphernalia, possession of marijuana, driving under the influence, and open container. He also had convictions of hit/leave the scene, trespassing, and tax evasion.

Developmental Level

According to Erikson's developmental theory, Mr. A who is thirty-seven years old, should be at the developmental level called "Generativity vs. stagnation" (Boyd, 2008). The main question of this stage is, "Will I produce something of real value?" It focuses on production and care (Boyd, 2008). This means the individual should be parenting, teaching, and be productive in social involvement. He should be raising his children and being a responsible adult.

B.A. does not meet the developmental stage that he should be at. He is single and not married, let alone raising children. He is not a productive member of society because he is locked up due to his mental illness which caused him to commit murder. He does have some responsibilities but not at the level of which he should. He does voice being proud of some accomplishments such as his current level, and his job at the library. Overall, the client is not at the developmental level which he should be.

Client/family appraisal of health and illness

The patient verbalized understanding of his diagnosis and even informed us that schizoaffective is not the same as schizophrenia. He told us that a group he attends teaches them about all the different diagnosis that the patients have. It is important to note that the patient voiced his opinion that he thinks it's a good idea Heartland has groups such as those because it teaches everyone the real facts about what the diseases. The chart indicates that when the patient was compliant with medications and treatment at the previous healthcare facility. Patient is also compliant with medications and attends all groups at Heartland. He is currently on level three and verbalizes understand that he will need to continue treatment once he gets out. These perceptions and facts affect the client's treatment in a positive way, thus far.

Coping resources seem to be off to a good start for this patient. He has routine "activities" that he partakes in such as attending all the groups, and has a job at the library in the treatment mall. Hobbies such as learning to play the guitar, music in general and painting are a few of his favorite things. These are great coping mechanisms and some are even part of his treatment plan. The client states that his family is also supportive of him and that they often visit. When asked about who is part of this family that is supportive he responded his stepmother, father, and two younger brothers. He admitted that he is only close with one of the

brothers but that he visits him. In contrast, there are also stressors that the patient has such as his legal status and his severe mental status.

Client's Strengths and Needs

The patient has several strengths which assist the patient in coping, managing his illness, and eventually recovery in order to maximize his quality of life. The most obvious strength is that the patient has a support system outside of Heartland Behavioral Healthcare. This is a critical factor that enhances the patient's chances of recovery. There are many patients whose friends and families have given up on him/her which leaves them with no support system. B.A. is very fortunate to have his stepmother, father, and brothers still active in his life.

Another strength the client holds is one that is internal rather than external. The patient understands his diagnosis and accepts that he is ill. This also is a very essential key to managing his illness and maximizing his quality of life. If the client does not believe he is ill and does not understand his illness to the fullest then the client cannot get better. Mr. A showed proof of his understanding of the diagnosis schizoaffective by telling me about it and because of this, he is more self-aware.

Holding a job at Heartland is a great asset for this patient, or any patient of that matter. It demonstrates commitment and motivation. The patient is currently a level three and displays a desire to want to advance to level four. He never skips going to group understands that following the rules will only benefit him. His medication and treatment compliance and desire to progress with this illness is an additional strength the patient possesses.

While Mr. A holds many strengths and assets, he also has needs. He has an apparent problem with substance abuse although he refuses that he would use again. When discussing his history of alcohol dependence and drug use the patient replied, "I'm done with that stuff, I've

been done drinking and drugs, I wouldn't do it again." Although the patient denies any need for these things, it is obvious that it will be different once he is living in the real world where he will have access to drugs and alcohol once again. It is important to note that the patient also voiced his opinion that he doesn't think he needs to attend AA meetings when he will be released. He is aware that he will be *required to,* but he doesn't feel that he needs to. This is a major concern and a priority need for the patient. He needs to understand the seriousness of addiction and dependence. It is obvious that he doesn't fully understand; therefore, he needs to be able to identify reasons not to partake in substance abuse. He must also be educated on how easy it is to relapse. The patient needs to recognize the importance of attending support groups.

Other needs of the patient include weight management due to his obesity, homicidal ideation due to past murder of grandparents, harm to others, the reality of getting a job in the real world including financial issues, education on the areas that may contribute to exacerbation of mental illness, and how to be a productive part of society. Another priority need for this client is for him to identify that schizophrenia/schizoaffective disorder is a chronic condition that will never disappear. The client needs to be educated on this fact and understand every concept of this illness completely. The reason why this is a priority need is because it is essential to the ability to maintain his illness effectively.

The last priority need for B.A. is to manage his health. The client is obese and has hyperlipidemia. The obesity can affect his quality of life so he must lower his body mass index (BMI) to a healthy number and take control of his weight. Psychiatric-based help is indeed the most beneficial for these patients but their health is also a very important underlying factor. Without their health, they have nothing. The patient will need to partake in weight loss interventions.

Part III: Medications

Medication & Dose	Patient Side Effect?	Side Effect	Nursing Implications	Use in Client
Simvastatin 40 mg PO QPM	Complains of none	Drug-induced hepatitis, dyspepsia, erectile dysfunction, pancreatitis, insomnia	-Avoid grapefruits(juice) -Obtain diet hx-regard to fat consumption -Evaluate serum cholesterol & triglyceride levels -Monitor liver function tests -Discontinue if pt. develops ↑CPK levels or myopathy	Mixed hyperlipidemia
Benadryl Capsule (Diphenhydramine) 50 mg PO QPM	Complains of none	Hypotension, palpitations, anorexia, chest tightness, wheezing, drowsiness	-Administer with meals or milk -Administer 20min. before bedtime & schedule activities to minimize interruption of sleep -Assess sleep patterns	For sleep
Divalproex Sodium 500 mg PO BID	Complains of none	*Suicidal thoughts*, agitation, insomnia, sedation, *confusion, depression,* hepatotoxicity, pancreatitis, weight gain, ataxia, *thrombocytopenia*	-Assess mood, ideation, & behavior frequently -Monitor CBC, platelet count -Monitor hepatic function -*May interfere with accuracy of thyroid function tests.*	Bipolar Disorder in remission
Docusate Sodium 100 mg PO BID	Complains of none	Throat irritation	-Administer with full glass of water or juice -Assess for abdominal distention, presence of bowel sounds, bowel function -Assess color, consistency, amount of stool produced	For Constipation
Fenofibrate (Lofibra)	Complains of none	Pulmonary embolism, DVT, arrhythmias,	-Administer with meals -Pt. should be	Mixed hyperlipidemia

160 mg PO QAM		pancreatitis	placed on a triglyceride-lowering diet before therapy & remain on this diet -Monitor serum lipids -Obtain normal serum triglyceride levels with diet, exercise, & weight loss in obese patients	
Acetaminophen 650 mg PO prn	Complains of none	Hepatic failure, hepatotoxicity, renal failure	-When combined with opioids do not exceed the maximum daily dose of acetaminophen	For Fever
Artificial tears/Tears Naturale 1 gtt BID prn	Complains of none	May alter effects of other concurrently administered ophthalmic medications, blurred vision	N/A	To keep the eyes moist
Cepacol sore throat lozenge 1 loz q2hours prn	Complains of none	N/A	N/A	For sore throat
Benztropine Mesylate 1 mg tab PO TID prn	Complains of none	Confusion, depression, hallucinations, arrhythmias	-Patients with mental illness are at risk of developing exaggerated symptoms of their disorder during early therapy -Withhold drug and notify physician if significant behavioral changes occur	Extrapyramidal disease
Robitussin Dm (Guaifenesin) 10 mL PO q6hours prn	Complains of none	Dizziness. nausea	None significant	For cold symptoms
Vistaril Cap (Hydroxyzine Pamoate) 25 mg PO q6hours prn	Complains of none	Agitation, ataxia, wheezing	Assess patient for profound sedation	Anxiety
Risperidone 3 mg PO BID	Patient complains of	Neuroleptic malignant syndrome,	-When switching from other antipsychotics,	Schizophrenia

	tremors	suicidal thoughts, aggressive behavior, extrapyramidal reactions, agranulocytosis	discontinue previous agents when starting Risperidone -Monitor patient's mental status -Monitor closely for notable changes in behavior that could indicate the emergence or worsening of suicidal thoughts or behavior or depression	
Sertraline HcL 200 mg PO QAM	Complains of tremors/shakiness	Neuroleptic malignant syndrome, suicidal thoughts, manic reaction, sexual dysfunction, tremor	-Assess for suicidal tendencies -Assess for serotonin syndrome -Monitor mood changes, suicidal tendencies	Depression
Motrin 600 mg PO q6hours prn	Complains of none	GI bleeding, hepatitis, exfoliative dermatitis, stevens-johnson syndrome, toxic epidermal necrolysis, psychotic disturbances	-Monitor temperature, signs of fever	For fever
Thera-gesic analgesic cream Lea. & pcl BID prn	Complains of none	Skin redness or irritation	-Do not bandage, wrap or cover until after washing the areas where THERA-GESIC has been applied -Don't use on wounds or damaged skin	For muscle spasm-upper back
Peri colace tab PO BID prn	Complains of none	Abdominal cramps	-Assess for abdominal distention, bowel sounds	For Constipation
Synthroid 100 mcg PO QAM	Complains of none	Insomnia, arrhythmias, angina pectoris	-Assess apical pulse & BP -Assess for tachyarrythmias & chest pain	Hyperthyroidism
Niacin 500 mg cap. PO QPM	Complains of none	Hepatotoxicity	-Administer with meals/milk to minimize GI irritation -Obtain a diet	Mixed hyperlipidemia

			history, especially with regard to fat consumption	
Fish oil Lea. PO	Complains of none	Heartburn, diarrhea	N/A	Hypertriglyceridemia
Prilosec 20 mg PO QAM	Complains of none	Dizziness, drowsiness, fatigue	-Assess patient for epigastric/abdominal pain -Monitor CBC	For GERD
Chronulac 20 gm PO QPM	Complains of none	Cramps, distention	-Assess patient for abdominal distention, bowel sounds	Prevent constipation

**All medication information taken from Davis' Drug Guide, Skyscape references, 2011

Part IV: Nursing Care Plan

PRIORITY NURSING DIAGNOSIS	SHORT & LONG TERM GOALS	NURSING INTERVENTIONS	RATIONALE
Potential for noncompliance R/T chronicity of chemical imbalance AEB… -Patient states, "I think I will be fine whenever it's time for me to get out" -Patient states, "Once I'm on the outside, I know I will *have* to be at some sort of halfway house and still get treatment but I know I won't really need it" -Severe mental illness: Schizoaffective , Bipolar disorders	**STG:** The patient will identify that schizophrenia is a chronic condition within one week. **LTG:** The patient will identify the need for outside sources in order to continue managing his illness successfully within two months.	**1.** The patient will self-educate on schizophrenia by reading an article a week dealing with schizophrenia/schizoaffective and bipolar disorder. The patient can discuss his thoughts and feelings with a nurse. Nurse can ask questions and "quiz" the patient with information on the disorders. **2.** Identify three antecedent events prior to arriving at HBH or prior to offense. Patient will verbalize these events to a nurse or write them down in a diary. **3.** Establish therapeutic rapport during every meeting. The nurse will form a trust bond with the patient by keeping her promises, and show concern & understanding. **4.** Assist patient to understand the disorder and its management right after they complete their therapy group about psychological disorders. The nurse should assess the patient's level of understanding of the disease	**1.** Lack of understanding of the mental illness, its complications, and the client's own vulnerability contribute to noncompliance. If the patient does not fully understand his illness and the complications associated with it, he is more likely to be noncompliant since he does not think he needs all of the recommended help. Lack of understanding regarding reasons for therapy and other options available contributes to noncompliance. Open discussion with the nurse about his readings will help the patient identify the chronicity of his disorder (Boyd, 2008, pp. 316-317). **2.** Identifying and realizing the antecedent events will help the patient become more aware of exactly what can be a warning signs of an exacerbation. This will

		frequently.	help him to understand the chronicity of his illness and that it can be brought on by stressful life events. There is evidence in the relationship between antecedent life events and schizophrenia. Helping the patient become of aware of this will attribute to his knowledge about the seriousness and chronicity of his illness (Norman & Malla, 1993, p. 164). **3.** Establishing a trusting relationship with the client is critical. There is emerging evidence that a nurse-patient relationship positively affects patient care. If the patient does not trust the nurse, how else can he open up and in return, receive help from the nurse. Developing rapport is the most important communication concept (Boyd, 2008, p. 148). **4.** By teaching and reinforcing to the patient about the chronicity of the illness it will help him understand his disorder better and the patient can develop different ways to manage his disorder (Boyd, 2008, p. 317).
Potential for relapse R/T prior polysubstance abuse AEB… -Alcohol dependence -Hx. Of LSD, marijuana, cocaine abuse -Inhalant abuse -Convictions of drug paraphernalia, possession, driving under the influence, open container -Patient states, "I don't think it's necessary for me to attend AA meetings whenever I get out" -Patient states, "I don't	**STG:** Patient will identify three reasons **not** to partake in substance abuse by within two weeks. **LTG:** The client will identify the need to partake in outside groups before reaching level four.	**1.** Attend dual diagnosis meetings (SAMI) once a week. **2.** Establish therapeutic rapport during every meeting. The nurse will form a trust bond with the patient by keeping her promises, and show concern & understanding. **3.** Explain to the patient that denial is a common feeling of patients with substance dependence. The nurse's approach will be caring, matter-of-fact, gentle, and	**1.** Patients can admit they have a problem and even thank others for helping them to realize this, but insist that they can overcome the problem on their own and do not need "outside" help. The dual diagnosis meetings are specific to individuals who have a mental disorders *and* substance abuse problems. Attending these meetings will help the patient to identify reasons not to

have a problem anymore, I will never use again" -Patient states, "My drug of choice used to be marijuana"		direct. **4.** Once patient reaches level four or five, he will attend a twelve-step program when he is allowed to leave the grounds. The program should be AA, for example because it focuses not just on alcoholism, which the patient can benefit from, but the program also deals with any other forms of addiction.	partake in substance abuse and how to live a sober life (Boyd, 2008, p. 555). **2.** A therapeutic relationship will provide patient support through the difficulties of addiction. Developing rapport is the most important communication concept. This will only benefit the patient to trust the nurse and more likely to be influenced by her help and comply with treatment plans (Boyd, 2008, p. 148). **3.** Patients must be educated to anticipate and expect relapse and know how to cope with it. Often, patients are in denial about the severity of the problem and about the emotional, social, legal, and other consequences of it. Providing them with the facts about denial will help him to understand the disorder (Boyd, 2008, p. 278). **4.** Community organizations are valuable sources of support. The programs encourage patients to attend community meetings when appropriate. They provide the patient with other real life examples of individuals that are similar to them and influence him on the benefits of living a sober life. This will help the patient to identify reasons not to partake in substance abuse (Boyd, 2008, p. 567).
Imbalanced nutrition: greater than body requirements R/T BMI AEB…	**STG:** The patient will lose five pounds by the one month.	**1.** The patient will receive a dietary consult every week. The dietician will educate the patient on nutrition	**1.** The National Cholesterol Education Panel recommends therapeutic life changes

-Hyperlipidemia -Obesity -HDL Cholesterol: 24↓	**LTG:** The patient will eventually lose fifteen pounds within four months.	information, initiating a change in his diet, and inform him on his progress. For example, the dietician will verbalize to the patient, "you are doing great dealing with your new diet" Dietician will educate the patient on the benefits of eating right. **2.** Patient will walk the track every day with a buddy or by himself possibly every day. Patient will be more likely to walk the track if he has a buddy to do it with and he will also receive a reward from HBH if he walks so many laps . **3.** Patient will increase his physical activity by also working out on the muscle machine to burn fat in combination with the dietary consultant. **4.** There will be a weekly weigh-in to assess the patient's weight and progress. The weigh-in will be done in the mornings, with no shoes and minimal clothing. The nurse will also use positive reinforcement & inform the patient on his progress and let him know if he is losing weight, staying the same, or gaining weight.	for clients with elevated serum cholesterol levels and identified risks, such as obesity. If the diet is not successful for the client, a referral to a dietician is highly recommended. To prevent weight gain, it is also necessary to teach clients better diet management (Black & Hawks, 2009, p. 12). **2.** Many activities that are a part of most people's daily routine can serve as the mode of a physical activity program including walking. Physical activity, such as walking, helps control weight management which in return, is associated with obesity (Black & Hawks, 2009, p. 13). **3.** Obesity is a serious health risk and has been associated with increased risk of mortality and morbidity but with the loss of just 5%-10% of body weight, significant improvement in co-morbid conditions occurs. Diet restriction in combination with an exercise program, compared with diet management alone, is a more successful way to lose weight and maintain the weight loss (Black & Hawk, 2009, p. 591). **4.** Management of overweight and obese patients should include measuring and frequently monitoring their height and weight and calculating the BMI. Clients should also be advised when they fall outside or inside of a healthy weight range. Including the patients in

			their treatment plans helps to motivate them (Black & Hawks, 2009, p. 11).

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