

**By: Ashlynn McConaha**

**Assignment:** Develop a Case Study similar to those found in your textbook (NOT the same scenario, you will make up your own). \*See example Care Plans in your textbook or utilize the Internet to visualize the appearance of a care plan. Put your case study on the page following the instructions.

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**Part I: Develop the Case**

**Scenario:** A detailed patient description. Tell a thorough, descriptive story about the patient and the problem(s) they are having. Include descriptions of the environment, patient actions, family involvement, communication, and nurse actions. Include assessment data from below. This should be a minimum of 2 paragraphs and will likely be longer depending on your attention to detail. \*You will find the more detailed your scenario the easier it will be to complete the remainder of the assignment.

**Assessment data:** Next clearly list (A) Objective data and (B) Subjective data based upon your scenario. Identify associated pathophysiology related to the topic. Include at least two ways that the patient is using defense mechanisms in their disease process. Include ABCT assessment guidelines when describing your patient: Appearance (age, posture, body movements, dress, grooming), Behavior (LOC, speech, mood, affect), Cognition (orientation, concentration, recent and remote memory, judgment, insight), and Thought Processes (content, process, perception). \*Be sure to use mental health based describing words for patient behaviors/assessment and quote what the patient with that disease might say.

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**Part II: Develop the Plan of Care**

**Nursing diagnosis:** Provide two priority nursing diagnosis including supporting data from your assessment.

**Goals:** Develop two goals for each nursing diagnosis above.

**Interventions:** Next develop three interventions you will implement to meet each goal (\*in your overall plan of care for this patient, your interventions must include each of the following: medications most commonly utilized for the disorder, communication techniques, teaching point(s), major safety issue(s), and continuing assessment).

**Rationale:** You need to have a rationale (including source) for each intervention you develop.

**\*Sources:** You must use a different source for each intervention rationale per goal. For example, for one goal with three interventions you can use (1) your textbook, (2) evidence-based article, and (3) the Internet. You can use the same three sources for your other goal interventions, but there is a minimum total number of three sources for this assignment. \*At least 2 sources on your reference list must be EBP articles.

**Reference page:** Include your references in APA format.

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**Part III:**

Last, you will develop three exam questions based upon your scenario. DO NOT copy an exam question from a NCLEX book or your textbook (I can tell, trust me). Your questions should be specific to your scenario (the answer should be discernible from your assessment data, nursing diagnosis, goals, interventions, or rationale). \*Include the correct answer **and** the rationale for the correct answer (including a source) after each question you develop.

**PART I**

**Scenario:**

## Clinical Assignment Topic: Schizoaffective Disorder, Bipolar Type

A 30-year-old female arrived to OSF Urbana experiencing a manic episode. She appeared hyperactive, and was talking very fast and loud about how she could “see him, he won’t leave me alone.” She has a history of multiple hospital admissions for bipolar schizoaffective disorder. The nurse takes the client back to a quiet room to talk with her. The patient paces around the room looking all around her. She looks at the nurse and yells “Get him out of here! I want him to leave me alone!” The nurse tells her she is in a safe place and asks about what she is seeing. She explains that sometimes she sees a scary man who is very mean to her and tells her to hurt herself. She has a previous suicide attempt a year ago, she took a bunch of Advil. When the nurse asks the client about any medications she takes she says she doesn’t like the way they make her feel so she doesn’t take them. When asked about her family, she said her mother lives out of state and “wants nothing to do with her.”

The client is 30-years-old, she has poor posture and is slouched, and has frequent hand movements. She is dressed in her pajamas and poorly groomed and disheveled. The client says she has been seeing this angry man a lot lately and doesn’t like to get out of bed most days because of him. Upon assessment the nurse finds the client underweight. When asked about her diet, the client says that her previous medications made her feel sick when she ate, and that she doesn’t like to eat because she doesn’t want to feel sick. The client appears alert, with disordered speech and mood. The client has a blunted affect by showing her emotions and feelings verbally and by her body movements. The client is oriented to place, person, and situation, but not time. The client’s concentration is poor but her remote and past memory is good. Her judgement is fair and insight is fair with partial understanding of her illness. The client is experiencing hallucinations with a disturbed thought process, and poor perception. She said that she doesn’t know why she sees this man but thinks it has something to do with her diagnosis of schizoaffective bipolar disorder.

### **Subjective Data:**

The client sees a man who won’t leave her alone. She tells the nurse that the man is angry with her and he tells her to hurt herself. She tells the nurse about her previous suicide attempt a year ago with Aspirin. The client explains she doesn’t take her medications because she doesn’t like the way they make her feel. Also her medications make her feel nauseous so she doesn’t eat a lot of the time. She doesn’t get out of bed on days she sees this man.

### **Objective Data:**

She is slouched indicating poor posture. She appears hyperactive and talks very fast and loud. Her speech and mood are disordered. She appears alert and oriented but not to time. The client cannot focus and is pacing around the room looking around. Her appearance is also poor, with poor grooming and her clothing is disheveled.

## **PART II**

### **Plan of Care:**

1. Nursing Diagnosis: Disturbed thought process

Supporting Information: The client is having hallucinations of a man telling her to hurt herself. She can’t concentrate and has disordered mood and speech.

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	Interventions	Rationale	Source
Goal 1.1: Patient will stick with the medication regime as prescribed by the doctor.	1. Assess client for adverse and therapeutic effects of medication therapy.	Some side effects are scary and upsetting to client, these are primary reasons the client may discontinue medication use.	Videbeck, S. L., & Miller, C. J. (2020). <i>Psychiatric-Mental Health Nursing</i> (Eighth). Philadelphia: Wolters Kluwer.  Pg. 260
	2. Educate the patient on the time it takes for certain medications to have a therapeutic effect in the body.	Teaching about the duration of time therapeutic levels take can help create clear thinking and prevent stoppage of medication compliance.	Martin, P. (2019, April 11). 6 Schizophrenia Nursing Care Plans. Retrieved from <a href="https://nurseslabs.com/schizophrenia-nursing-care-plans/">https://nurseslabs.com/schizophrenia-nursing-care-plans/</a>
	3. Discuss methods and ways to stick to a medication regime. For example using a mobile app or calendar.	Helps the client to be reminded to take medications to ensure medication compliance daily and reduction of missing doses.	Steinkamp, J. M., Goldblatt, N., Borodovsky, J. T., LaVertu, A., Kronish, I. M., Marsch, L. A., & Schuman-Olivier, Z. (2019). Technological Interventions for Medication Adherence in Adult Mental Health and Substance Use Disorders: A Systematic Review. <i>JMIR mental health</i> , 6(3), e12493. <a href="https://doi.org/10.2196/12493">https://doi.org/10.2196/12493</a>
Goal 1.2: Patient will verbalize control of	1. Decrease environmental stimuli.	Will help to decrease feelings of anxiety and manic	Martin, P. (2019, April 11). 6 Bipolar Disorders Nursing Care Plans. Retrieved from <a href="https://nurseslabs.com/bipolar-disorders-nursing-care-">https://nurseslabs.com/bipolar-disorders-nursing-care-</a>

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feelings.	2. Introduce group or individualized therapy.	symptoms. Give the client an opportunity for social contact and create relationships, which ultimately can help for more effective function in the community.	plans/2/ Videbeck, S. L., & Miller, C. J. (2020). <i>Psychiatric-Mental Health Nursing</i> (Eighth). Philadelphia: Wolters Kluwer.  Pg. 263
	3. Establish a therapeutic nurse-client relationship.	Consistent focus on the client can encourage communication and help discuss problem-solving alternatives with the client.	Holman, H. C., McMichael, M. S., Johnson, J. undefined, Williams, D. undefined, Sommer, S. undefined, & Ball, B. undefined. (2019). <i>Rn Mental Health Nursing: Review Module</i> (11.0 ed.). Leawood, KS: Assessment Technologies Institute.  Pg. 25

2. Nursing Diagnosis: Self-care deficit

Supporting Information: Patient appears with poor grooming and disheveled clothes. She expresses she doesn't eat that much and appears underweight. She expresses that when she has her hallucinations of this man it is hard to get out of bed.

	Interventions	Rationale	Source
Goal 2.1: Patient will wear appropriate attire each day in the hospital	1. Give simple reminders for hygiene and dress.	Helps the patient to focus when giving simple direction	Martin, P. (2019, April 11). 6 Bipolar Disorders Nursing Care Plans. Retrieved from <a href="https://nurseslabs.com/bipolar-disorders-nursing-care-plans/6/">https://nurseslabs.com/bipolar-disorders-nursing-care-plans/6/</a>

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and bathe at least every other day. Also client will perform hygiene practices every day.	2. Assess the clients daily living skills and functional abilities.	Determine areas that need teaching or discussion over to improve clients hygiene and grooming.	Videbeck, S. L., & Miller, C. J. (2020). <i>Psychiatric-Mental Health Nursing</i> (Eighth). Philadelphia: Wolters Kluwer.  Pg. 269
	2. Assess client's economic status.	Poor grooming and hygiene practices may come from not having enough money to buy necessities.	Jarl, J., Cantor-Graae, E., Chak, T., Sunbaunat, K., & Larsson, C. A. (2015). Trauma and Poor Mental Health in Relation to Economic Status: The Case of Cambodia 35 Years Later. <i>PloS one</i> , 10(8), e0136410. <a href="https://doi.org/10.1371/journal.pone.0136410">https://doi.org/10.1371/journal.pone.0136410</a>
Goal 2.2: The client will maintain an adequate routine for food and fluid intake.	1. Assessment of the clients eating patterns.	Will help the nurse determine what assistance and teaching the client needs.	Videbeck, S. L., & Miller, C. J. (2020). <i>Psychiatric-Mental Health Nursing</i> (Eighth). Philadelphia: Wolters Kluwer.  Pg. 277
	2. Encourage high calorie and protein foods and finger foods.	The client may not be aware of the	Martin, P. (2019, April 11). 6 Bipolar Disorders Nursing Care Plans. Retrieved from <a href="https://nurseslabs.com/bipolar-disorders-nursing-care-plans/6/">https://nurseslabs.com/bipolar-disorders-nursing-care-plans/6/</a>

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		need to eat and is possible distracted.	
	3. Teach the importance of maintaining adequate intake of food and fluids daily.	If a client refuses to eat, drink, or sleep it can become a serious medical emergency and lead to physical exhaustion or possible death.	Holman, H. C., McMichael, M. S., Johnson, J. undefined, Williams, D. undefined, Sommer, S. undefined, & Ball, B. undefined. (2019). <i>Rn Mental Health Nursing: Review Module</i> (11.0 ed.). Leawood, KS: Assessment Technologies Institute.  Pg. 75

**APA References:**

**Websites:**

Martin, P. (2019, April 11). 6 Bipolar Disorders Nursing Care Plans. Retrieved from <https://nurseslabs.com/bipolar-disorders-nursing-care-plans/6/>

Martin, P. (2019, April 11). 6 Bipolar Disorders Nursing Care Plans. Retrieved from <https://nurseslabs.com/bipolar-disorders-nursing-care-plans/2/>

Martin, P. (2019, April 11). 6 Schizophrenia Nursing Care Plans. Retrieved from <https://nurseslabs.com/schizophrenia-nursing-care-plans/>

Legg, T. J. (2018, February 15). Understanding Bipolar Schizoaffective Disorder. Retrieved from <https://www.healthline.com/health/bipolar-schizoaffective-disorder>

Felman, A. (2018, December 17). What is Schizoaffective Disorder? Retrieved from <https://www.medicalnewstoday.com/articles/190678>

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**Books:**

Holman, H. C., McMichael, M. S., Johnson, J. undefined, Williams, D. undefined, Sommer, S. undefined, & Ball, B. undefined. (2019). *Rn Mental Health Nursing: Review Module* (11.0 ed.). Leawood, KS: Assessment Technologies Institute.

Videbeck, S. L., & Miller, C. J. (2020). *Psychiatric-Mental Health Nursing* (Eighth). Philadelphia: Wolters Kluwer.

**Journals:**

Jarl, J., Cantor-Graae, E., Chak, T., Sunbaunat, K., & Larsson, C. A. (2015). Trauma and Poor Mental Health in Relation to Economic Status: The Case of Cambodia 35 Years Later. *PloS one*, *10*(8), e0136410. <https://doi.org/10.1371/journal.pone.0136410>

Steinkamp, J. M., Goldblatt, N., Borodovsky, J. T., LaVertu, A., Kronish, I. M., Marsch, L. A., & Schuman-Olivier, Z. (2019). Technological Interventions for Medication Adherence in Adult Mental Health and Substance Use Disorders: A Systematic Review. *JMIR mental health*, *6*(3), e12493. <https://doi.org/10.2196/12493>

**PART III**

**NCLEX Questions with Rationale:**

**Question #1:**

What would be an appropriate response to a client expressing thoughts of suicide?

- a. "Why are you thinking of committing suicide?"
- b. "Did someone in your mind tell you to hurt yourself?"
- c. "How do you plan to commit suicide?" CORRECT - if a client expresses thoughts about committing suicide the first priority is finding out how they would do it.
- d. "You don't want to do that! How will your mom feel about this?"

Reference:

Holman, H. C., McMichael, M. S., Johnson, J. undefined, Williams, D. undefined, Sommer, S. undefined, & Ball, B. undefined. (2019). *Rn Mental Health Nursing: Review Module* (11.0 ed.). Leawood, KS: Assessment Technologies Institute.

**Question #2:**

A client presents to the ER and is having a manic episode. Which of the following findings should the nurse expect? (Select all that apply)

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- a. Agitation CORRECT-
- b. Restlessness CORRECT-
- c. Good judgement
- d. Inappropriate behaviors CORRECT
- e. Decrease in talking

For this question I used the expected findings in the ATI book on page 74.

Reference:

Holman, H. C., McMichael, M. S., Johnson, J. undefined, Williams, D. undefined, Sommer, S. undefined, & Ball, B. undefined. (2019). *Rn Mental Health Nursing: Review Module* (11.0 ed.). Leawood, KS: Assessment Technologies Institute.

**Question #3:**

What medication is a first-generation antipsychotic used for bipolar disorder?

- a. Risperidone
- b. Lurasidone
- c. Fluoxetine
- d. Loxapine CORRECT - listed in the book under first gen antipsychotics pg. 74. Also used for mood disorders works in the brain by restoring the balance of certain substances such as dopamine.

Reference:

Loxapine Oral : Uses, Side Effects, Interactions, Pictures, Warnings & Dosing. (n.d.). Retrieved from <https://www.webmd.com/drugs/2/drug-5557/loxapine-oral/details>