Clinical Assignment Topic: Schizoaffective Disorder, Depressive

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.

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.

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.

Schizoaffective Disorder, Depressive

PART I

Scenario:

A 25-year-old male named James came into the clinic today with his wife. James has been diagnosed with a schizophrenic depressive disorder when he was 20. His wife said he was having a lot of the symptoms he had when he was diagnosed with schizophrenia. His prescribed medicine for his schizophrenia is chlorpromazine. James has been taking chlorpromazine ever since he was 20. He also is on escitalopram to treat his depression with his schizophrenia. She stated that James has been non-compliant with his medicine because it is so expensive.

His wife states that he has been acting worse as of late. She said day by day; his symptoms keep on getting worse. She stated that James has not been helping me out around the house. He always in his bed lying on the couch. I ask him to help me with the kids, and he says no and lays there. Along with that, he is very depressed because his dad just passed away, and that has not helped his cause. She explained that he has been drinking a lot of alcohol, and that consists of ten beers every night. The wife states that he only sleeps about two to three hours a night at the most. In the middle of the night, I find himself pacing and saying words that do not have any sense to them at all. She said he does this at least two times a night. The wife states he was yelling at me, but none of the words made any sense to me. She said James almost seems frightened about something, but she did not know why he is scared. James's wife believes he hears voices because he covers his ears and yells shut up. Also, James does not care about our family anymore. She stated that she wants her old loving husband back. His wife is the one that brought James to the mental health facility.

Subjective Data: James is very blunt with his speech, and it is hard to understand him. His words are all jumbled together, and it is hard to make out a sentence. I did map out a few sentences he said. When I asked him if he has been taking his medication, he said no, I don't have anything wrong with me leave me alone. When I asked him if he ever thought of committing suicide, he also said no why would I kill myself I have nothing wrong with me. He said that my wife is crazy, and I shouldn't be in this clinic right now. His cognition and thought process seems a little out of place according to what he said.

Objective Data: Ever since James came into the clinic; he hasn't looked at me. He looks like he is very depressed and is showing a lack of energy. James shows no facial expression and seems down on himself. He also appears very weak and is showing no strength. The patient is fully conscious and oriented. He does keep on staring back and forth from one wall to another. I can tell he has not taken a shower in a while, and he is dressed in some odd clothes. It is 70 degrees outside, and he is wearing a winter coat and a stocking hat.

Videbeck, S. L., & Miller, C. J. (2020). *Psychiatric-mental health nursing*. Philadelphia: Wolters Kluwer.

PART II

Plan of Care:

1. Nursing Diagnosis: Medication Compliance

	Immediate	During Hospitalization	Community
Goal 1.1: The client will agree and to remember to take their medications daily.	1. Access the client to see if he is currently on any antipsychotic medications. Rationale: It is essential to assess the client to see if he is now on or has taken psychotic medicine in the past (Videbeck & Miller, 2020).	Access the client for any adverse effects he could be having while on the medicine.	Make sure client has transportation to the pharmacy.
	2. Access the client to what reason he stopped taking his medicine. Rationale: Finding out the reason why the client stopped taking his medication could be reversed so he could get back on his old medicines (Settem et al., 2018).	Inform the patient that the medication is really important for the treatment of schizophrenia.	Give the patient a brochure of all the adverse effects he could possibly have.
	3. Ask the client when his last dose was taken due to being financially unstable. Rationale: Finding out when his last dose was taken could be a reason why he is showing so many	Help the client find different ways to make his prescription more affordable to him.	Give the client directions on how to get to his new pharmacy.

	symptoms (Causes of Medication Noncompliance, 2019).		
Goal 1.2: Teach the client how to avoid adverse effects while on this medication	1. Assess the client if he takes any OTC medicines on a regular. Rationale: Stopping certain OTC medicines could stop his adverse effects he could be experiencing (Swearingen & Wright, 2019).	Teach the client that some medication can cause the adverse effects.	Give the client a list of medications that he should avoid when he leaves the facility.
	2. Assess the patient to see if he drinks alcohol on a regular basis. Rationale: Excessive drinking could be the cause of adverse effects (Videbeck & Miller, 2020).	Educate him how alcohol can cause central nervous system depression.	Have the client set up with an AA meeting to limit his alcohol intake.
	3. Ask the patient what side effects he had while on this medication. Rationale: Figuring out the side effects he is having could help eliminate them from happening (Settem et al., 2018).	Teach the patient that this medication can cause serious side effects like seizures.	Tell the client to call for help if he is ever experiencing serious symptoms.
Goal 1.3:	1.		
	2.		
	3.		

2. <u>Nursing Diagnosis:</u> Help the client feel less depressed

	Immediate	During Hospitalization	Community
Goal 2.1: Decrease the	1. Assess the patient to see if he has been	Assess the patient to see if his medicine	Schedule follow up appointment with

depression in the client.	taking his medicine. Rationale: Being noncompliant with his medication could be why he is feeling depressed (Videbeck & Miller, 2020).	has helped with his depression after taking.	doctor.
	2. Assess the patient what's the reason you are feeling depressed. Rationale: Finding out the reasons for his depression could help eliminate the depression (Yazici et al., (2018).	Spend time with the client during his hospitalization.	Tell the patient to avoid doing the things that make you feel depressed
	3.Teach the client about depression and the symptoms it causes. Rationale: Teaching the client about depression can help him deal with his depression on his own (Swearingen & Wright, 2019).	Teach the patient coping mechanisms.	Have the patient use them coping mechanisms like deep breathing when they feel depressed.
Goal 2.2: Eliminate the suicidal thoughts that the client is experiencing with the depression.	1. Assess the client to see if he has any suicidal thoughts. Rationale: If he is having suicidal thoughts right now, we need to stay with him at all times to keep him safe (Yazici et al., (2018).	Monitor the patient constantly to make sure he is safe.	Help the patient schedule support groups.
	2. Complete a suicidal assessment on the patient. Rationale: Completing an assessment can help find ways to boost the client's self-esteem (Swearingen	Make the patients environment safe to him.	Tell the patient to count on his family for support.

	& Wright, 2019).		
	3. Ask the client if he is hearing any voices that sets off his suicidal ideas. Rationales: We can eliminate the suicidal voices and provide safety to his environment if he admits to hearing voices (Videbeck & Miller, 2020).	Involve the patient when making a safety plan.	Educate the patient to look at the safety plan when he is having suicidal thoughts.
Goal 2.3:	1.		
	2.		
	3.		

APA References:

Causes of Medication Noncompliance Among Seriously Mentally Ill - Study Summaries. (2019, January 23). Retrieved from https://mentalillnesspolicy.org/medical/medication-noncompliance.html

Settem, V., Karanadi, H., & Praharaji, S. (2018). Cognitive deficits, depressive symptoms, insight, & medication adherence in remitted patients with schizophrenia. *Indian Journal of Psychiatry, 64* (4), 335-341. http://ezproxy.lakeviewcol.edu:2088/10.4103/psychiatry.IndianJPsychiatry_17_19.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

Videbeck, S. L., & Miller, C. J. (2020). *Psychiatric-mental health nursing*. Philadelphia: Wolters Kluwer.

Yazici, E., Cimen, Z., Akyollu, IIU., Yazic, AB., Turkman, BA., & Erol, A. (2018). Depressive Temperament in Relatives of Patients with Schizophrenia is Associated with Suicidality in Patients with Schizophrenia. *Korean College of Neuropsychopharmacology, 16* (3) 302-309. https://doi.org/10.9758/cpn.2018.16.3.302.

PART III

NCLEX Questions with Rationale:

Question #1:

A client comes in with schizophrenia and is unsure what medication he is taking for it. What medication is used for a client that has schizophrenia? Select all that Apply

A. chlorpromazine
B. escitalopram
C. sertraline
D. quetiapine
E. perphenazine

Rationale: Chlorpromazine and perphenazine are the correct answers. They are both first-generation antipsychotics. Escitalopram and sertraline are antidepressants, and they are used for depression. Quetiapine is used to treat bipolar disorder.

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Question #2:

A 23-year-old female client comes in with schizophrenia with depression what symptoms the client could be experiencing.

A. Catatonia
B. Hallucinations
C. Mood changes
D. Mania symptoms
E. Flight of Ideas

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Rationale: Catatonia, hallucinations, and flight of ideas are the correct answers. A person diagnosed with schizophrenia can show all of those signs. Mood changes and mania symptoms is incorrect. Those symptoms are experienced more in bipolar disorders.

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Question #3:

A patient comes into the mental health facility with a history of schizophrenia. What are negative symptoms of schizophrenia. Select all that apply.

A. Ideas of reference
B. Delusions
C. Alogia
D. Flat Affect
E. Hallucinations

Rationale: Alogia and flat affect are the correct answers. They are both negative symptoms of schizophrenia. Ideas of reference, delusions, and hallucinations are incorrect because they are positive symptoms.

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