Clinical AssignmentTopic: Schizophrenia with command hallucinations

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.

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:

Subjective Data:

Objective Data:

PART II

Plan of Care:

1. Nursing Diagnosis:

	Interventions	Rationale	Source
Goal 1.1:	1		
	2.		
	3		
Goal 1.2:	1.		
	2.		
	3.		
Goal 1.3:	1.		
	2.		
	3.		

2. Nursing Diagnosis:

	Interventions	Rationale	Source
Goal 2.1:	1		
	2.		
	3		
Goal 2.2:	1.		

	2.		
	3.		
Goal 2.3:	1.		
	2.		
	3.		

APA References:

PART III

NCLEX Questions with Rationale:

Question #1:

Question #2:

Question #3:

PART I: Develop the case

Scenario: Renee was at work getting her to do list in order and knocking them out one by one, until she started hearing voices saying, “you’re in danger, move!” She thought it was just someone trying to prank her so she had gone outside of her cubicle to check it out but everyone else were on their lunch break. She had decided to go on her lunch break because she had thought that she was just hungry and starting to hear stuff. Renee on her lunch break, starts to hear the voices again and this time it’s saying, “you’re in view of the enemy!” So she started to get worried and went of to call the rest of the day off. She headed home to her husband thinking that she’s just tired so she just tried to rest for the rest of the evening. But the voices told her, “the enemy is here, go take them out before they do it to you!” Frightened, Renee started to look at her husband and watch his every step until eventually, she just left the place while he was in the bathroom. Renee’s husband, Makoa, was surprised to find out that his wife had gone without saying anything. He went out to look for her because she left her phone, wallet, and keys. After a couple hours of searching, Makoa found his wife hiding behind a tree with just her pajamas in trying to coax her to get in the car. The voices in Renee’s head are telling her, “don’t get in there, he will hurt you.”

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Renee was raised by her adoptive parents who were great role models and gave her a great life. They helped her to a chance to start a new chapter and fulfill her dreams. Renee never knew her biological parents and she was jumping from foster home to foster home until age 4. Unbeknownst to her, Renee's biological mother had schizophrenia that's why she was put up for adoption.

Objective data: Upon physical examination, Renee showed some signs of distress. Her vitals are as follows:

- P: 110 bpm
- BP: 120/80 mmHg
- Temp: 97.5 F
- Resp: 26 rr
- O2sat: 99% RA

Renee is a 32 year-old Caucasian woman who is married. She is alert and oriented to time, place, and person, but not to situation.

- There is no change in level of consciousness, but she looks like she is in emotional distress. She is able to speak in fluent English but has episodes of word salad and neologisms.
- Renee was brought in to the ED with only her pajamas on with 32 F weather.
- Renee is oriented to her person, time, and place, but could not figure out her situation because she thinks that someone is after her.
- Renee is unable to concentrate other than to answer questions pertaining to "who is after you?"
- Renee is expressing some defense mechanisms with denial of her current situation after further examination as well as projection in feeling aggressive towards people trying to help her because she says that they're trying to hurt her.

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Subjective data: The patient communicates to the nurse that she is not in any physical pain but she reports that, “they are after me.” She uses the term “shiznizz” to describe what she reports are after her saying, “the shiznizz are after me, I have to leave!”

PART II: Develop the Plan of Care

Nursing Diagnosis: Disturbed thought process

- **Goal 1:** The patient will sustain attention and concentration to complete tasks or activities
    - Intervention 1: Be sincere and honest when communicating with the client. Avoid vague or evasive remarks.
        - Rationale: Delusional clients are extremely sensitive about others and can recognize insincerity. Evasive comments or hesitation reinforces mistrust or delusions.
    - Intervention 2: Recognize the client’s delusions as the client’s perception of the environment.
        - Rationale: Recognizing the client’s perceptions can help you understand the feelings he or she is experiencing.
    - Intervention 3: Do not argue with the client or try to convince the client that the delusions are false or unreal.
        - Rationale: Logical argument does not dispel delusional ideas and can interfere with the development of trust.
- **Goal 2:** The patient will respond to reality-based interactions initiated by others.
    - Intervention 1: Interact with the client on the basis of real things; do not dwell on the delusional material.
        - Rationale: Interacting about reality is healthy for the client.
    - Intervention 2: Engage the client in one-to-one activities at first, then activities in small groups, and gradually activities in larger groups.

        - Rationale: a distrustful client can best deal with one person initially. Gradual introduction of others as the client tolerates is less threatening.
    - Intervention 3: Show empathy regarding the client's feelings; reassure the client of your presence and acceptance.
        - Rationale: the client's delusions and can be distressing. Empathy conveys your caring, interest, and acceptance of the client.

Nursing Diagnosis: Risk for other-directed violence

- **Goal 1**: The client will not injure herself or others
    - Intervention 1: Promote safety of client and others and right to privacy and dignity.
        - Rationale: Providing the safety of the client and others because they may be paranoid and suspicious of the nurse and the environment and may feel threatened.
    - Intervention 2: Use therapeutic communication.
        - Rationale: Using therapeutic communication eases the paranoid and suspicious feelings that client is going through.
    - Intervention 3: Help present and maintain reality by frequent contact and communication with client.
        - Rationale: The presence of the nurse is a contact with reality for the client and can also demonstrate the nurse's genuine interest and caring to the client.
- **Goal 2**: The client will interact with others in the environment
    - Intervention 1: Engage client in reality-based activities such as playing cards or listening to music.
        - Rationale: Reality-based activities allows the client to stay in contact with reality.
    - Intervention 2: Elicit description of hallucinations to protect the client.
        - Rationale: The knowledge of the nurse about hallucinations protects the client from danger. This helps the client calm down and be reassured of the situation.

- Intervention 3: Teach social skills through education, role modeling, and practice.
  - Rationale: Engage the client in appropriate activities will lessen inappropriate social behaviors.

References:

Scott, J. E., & Dixon, L. B. (1995). Psychological Interventions for Schizophrenia. *Psychological Interventions for Schizophrenia.*

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.

PART III: NCLEX questions

1. A client present to the facility saying jumbled words that do not make sense and have no connection to each other. What is the client expressing?
   a. Echolalia
   b. Neologism
   c. Clang associations
   d. Word salad

   Answer: D - word salad is a combination of jumbled words and phrases that are disconnected or incoherent and make no sense to the listener.

2. A client comes into the facility stating, “I have to go save the world, you are holding me from doing my job! Let me go or the world will end!” What is the client exhibiting?
   a. Bizarre behavior

b. Ambivalence
c. Delusions
d. Hallucinations

Answer: C - delusions are false beliefs with no basis in reality

3. The provider of a client with schizophrenia has prescribed the client on medications that produces anticholinergic effects. Which one of the following are anticholinergic side effects? (Select all that apply)
    a. Tardive dyskinesia
    b. Orthostatic hypotension
    c. Dystonia reactions
    d. Urinary retention
    e. Dry mouth

    Answer: B, D, E – are expected findings in anticholinergic effects

References:

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