Clinical Assignment: Hope Dykes Topic: Anxiety Disorder with Hypochondriasis

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:

Client TJ is a 24yo white Caucasian female. She arrives at her appointment well-groomed and dressed appropriately. At the beginning of her appointment, she reports that she has been struggling with constipation, nausea, heartburn, tachycardia, pain in her toe, insomnia, and some other pain "all over". She is speaking quickly, but describes several symptoms fully and clearly. At one point, she says her family thinks she is "crazy" and tells her she is "fine". She says it is frustrating because she knows her symptoms are real, and her family would just let her die before they believe her.

The client reports, "I know the pain in my toe is unbearable. I am sure it is related to gout. Gout is a type of arthritis, so that might explain the pain in my back and my trouble sleeping. I am sure I might need some IV steroids to help me deal with all of this pain. The last doctor that I saw told me my heart was okay, but I feel it racing all the time". Her speech is becoming more and more anxious and panicky. She reports, "listen to my heart right now! You can tell how fast it is beating! I need something to slow it down. I could have a heart attack soon! I could die!!"

The physician comes in and takes the client's vitals. Her temperature is 98.6 F, BP is 130/82, respirations are at 16, and O2 100%. Her pulse is 106bpm. She reports pain "all over" at a 4/10. "See?" the client says, "I'm in tachycardia. I need some labs done. I may need an EKG and MRI to check on my heart." The physician orders an EKG, which comes back as normal sinus tachycardia. He checks the patient's toes, which appear normal with no redness noted. He asks when the patient last had a BM,

and she reports it was "about 2 days ago", but that she knows it is sometimes less than 3 times a week, which means she has "real" constipation. The physician begins to suspect the patient may have anxiety with hypochondriasis. He attempts to calm her and tells her that her tachycardia, nausea, and insomnia can all be caused purely by anxiety. He explains that an MRI may not be needed at this time because these are new symptoms, and that there are no other signs of heart attack that would exist, such as hypertension.

When the nurse returns to the room, the patient is frustrated and insists "You people are just going to let me die! I'm going to die!" because the doctor refused to order "the tests she knows she needs". She screams she is going to get a second opinion as soon as possible. Seeing she is becoming more and more out of control, you recommend an inpatient stay on the psych unit on another floor of the hospital.

The nurse encourages her to keep a journal of times of symptoms while in the hospital. Whenever she feels symptoms of any kind coming on, the nurse encourages her to practice relaxation techniques and see if the symptoms are relieved at all.

Subjective Data: Client reports "unbearable pain" in her toe and "all over". She appears very anxious and frustrated. She says her family would let her "die" before they would believe there is something wrong with her. As the appointment progresses, the client becomes increasingly agitated and loud.

Objective Data: F, 24yo. Dressed appropriately. Well educated, well groomed. Vitals: Temp 98.6 F, BP 130/82, RR 16, P 106bpm, O2 100%, pain reported as 4/10.

PART II

Plan of Care:

1. Nursing Diagnosis: Anxiety with ineffective coping.

	Immediate	During Hospitalization	Community
Goal 1.1: Client will learn some effective coping mechanisms.	1. Actively listen to client's reasons for feeling anxious. Ask open ended	Client will find member of staff if needed to help calm down. Client will acknowledge	1.Client will sit down and deep breathe when she starts feeling anxious.

	questions.	and talk through feelings.	
	2. Nurse will encourage client to deep breathe.	Client will take note when symptoms are lessened when stress levels go down.	2. Client will call counselor/support person if she cannot calm herself.
	3. Client will count to 10, and nurse will reassess how client is feeling.	Client will begin Prozac/ fluoxetine while inpatient. Nurse will educate client on when/ why to take this medication.	3. Client will be take Prozac (fluoxetine) as prescribed.
Goal 1.2: Client will use journal to monitor symptoms.	1.Client will write down how she is feeling.	Vitals will be taken twice per shift.	Client will write symptoms to bring to therapy appointments.
	2. Nurse will ask client to share what has been written and practice open therapeutic communication to assess where feelings might be coming from.	Client will write down vitals.	Client will agree not to look up symptoms prior to appointments.
	3. Client will write outcomes and how they made her feel.	Client will write down outcomes/ “what provider said”	Client will write down outcomes/ “what therapist said”

2. <u>Nursing Diagnosis: Numerous somatic complaints</u>

	Immediate	During Hospitalization	Community
Goal 2.1: Consider and treat each somatic complaint.	1. The client will have vitals taken. Ask for specific somatic complaints and assess each individually.	The client will receive Tylenol/ acetaminophen for mild pain management.	The client will try alternative pain management techniques and use OTC meds as a last resort.
	2. If pulse rate is high, an EKG will be ordered. Results will be	The client will be educated on OTC medications and how they affect	The client will read and follow instructions on pill bottles carefully

	shared and discussed with the client.	the body.	and avoid overdose.
	3. The client may receive a stool softener, like Colace, to help with constipation.	Safe dosage amounts will be taught to the client.	The client will avoid the overuse of OTC medications.
Goal 2.2: Come up with alternative treatments to medications that the client will agree to.	1. Acknowledge the complaint and recognize that the client IS experiencing these symptoms.	Acknowledge the complaint and recognize that the client IS experiencing these symptoms.	Have client write down body responses to alternative interventions. Have her recognize what helps her feel better.
	2. Encourage alternative ways to manage pain like ice on the client's toe, heating pad for back, massage, etc.	Provide comfort. Give a warm blanket, elevate client's foot.	Encourage client to get massages, use heating pads, and elevate/ ice toe at home if pain persists after discharge.
	3. Encourage dietary changes to help with sleep and constipation issues. Increase fiber and fluid intake, don't drink caffeine before bed, etc.	Make sure client has water to drink at all times, offer dietary choices like granola bars, limit or eliminate caffeinated beverages after 5 pm.	Give client a list of foods that will help with sleep and constipation. Encourage client to follow dietary recommendations while at home and monitor what helps.

APA References:

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PART III

NCLEX Questions with Rationale:

Question #1: **While a nurse is assessing a client with hypochondriasis and anxiety, the client screams, ""You people are just going to let me die! I'm going to die!" What is the first action by the nurse?**

A) Firmly tell the client to sit and calm down.
B) Stand in front of the client and yell over her to stop screaming.
C) Stay calm and use de-escalation techniques.
D) Give her a quick injection of Diazepam to calm her down.

Correct answer C

This is the FIRST action the nurse should take. It involves speaking calmly and listening to the client's concern.

A—Incorrect. This answer is confrontational and the client may feel threatened.

B---Incorrect. This will escalate the situation and could lead to injury for nurse and client.

D---Incorrect. Sedation medications should never be a first-line approach.

Question #2: **A nurse is caring for a client with hypochondriasis with anxiety. The client says that her family never takes her problems seriously, but that her problems are actually worse than what she lets on. The nurse should recognize this as the following defense mechanism:**

A. Denial
B. Rationalization
C. Regression

D. Projection

Correct answer B

This is where the client justifies her behavior, even if it is incorrect.

A---Incorrect. Denial is where the client does not believe they have a problem.

C---Regression involves reverting to younger behaviors.

D---Incorrect---Projection involves blaming someone else for problems.

Question #3: **The nurse is talking with a client with hypochondriasis with anxiety. The client tells the nurse she feels comfortable talking to her and would like to meet for lunch after she is discharged. Which is an appropriate response by the nurse?**

A. “That would be great. I’m so glad we have developed that kind of relationship.”
B. “Why would you say that? Don’t you understand I am doing this because I am being paid to talk to you?”
C. “Don’t you have someone else you can talk to after discharge?”
D. “I understand you find it easy to talk to me. Let’s talk about what happens after discharge.”

Correct answer D

This opens up further open communication and acknowledges the client’s feelings.

A---Incorrect. This statement can encourage inappropriate relationship boundaries between nurse and client.

B---Incorrect. This can be viewed as oppositional and may impede the client’s healing process.

C---Incorrect. This statement may be oppositional and does not open therapeutic communication.