Clinical Assignment   Topic:

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 <u>minimum</u> 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 <u>two</u> priority nursing diagnosis including supporting data from your assessment.

Goals: Develop <u>two </u>goals for each nursing diagnosis above.

Interventions: Next develop <u>three</u> 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 <u>different source</u> 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 <u>three sources</u> 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: Kayla Brown was brought to the ED by a group of close friends after she called them at 2 A.M. screaming, crying hysterically, and mumbling incoherent words over the phone. When they went to her place to check on her, they found her laying in bed crying with an empty bottle of alcohol. Her room was a mess with dirty dishes, empty beer containers, and clothing spread everywhere. Her friends were alarmed, called her mother, and immediately brought her to the ED for help.

Kayla Brown is a 24-year-old senior in college studying biological sciences with the hopes of becoming a doctor. Kayla was diagnosed with depression in high school. Kayla was then diagnosed with Bipolar 1 disorder last year after experiencing an episode of mania. Kayla has not been taking her medication because she does not feel like she has a problem. Kayla is on the university swim team and has her last conference swim meet in two weeks. Kayla states that she is the top swimmer on her team, swims the last legs of her team relay, and is expected to win the meet. Her coach told her a couple weeks ago that scouts are coming to the meet to recruit for professional teams and that if she performs well, they may be interested in her. Kayla also states that as the end of the school year approaches, she has several big projects due. Kayla states that she received the results from her MCAT test 2 weeks ago and she did not do as well as she wanted. Kayla now feels that the last 4 years of school have been worthless because it will be impossible to get into medical school with her score. Since receiving her MCAT score, Kayla has not been attending class, skipping swim team practices, and been going out to the bars almost every night. Kayla stated that she spent the last 4 years staying in to do homework and study and clearly that didn't work. So she has decided to spend the last months of her senior year partying instead because that's what college is

for anyway. Kayla admits that when her friends do not want to go out, she drinks alone in her bedroom. A CAGE assessment was performed to determine is alcohol abuse is an issue, the patient did not answer positive for more than 2 questions. Kayla has lost all interest in swimming and when she does go to practice, she gives minimal effort.

During her interview Kayla admitted that after receiving her poor MCAT score she felt hopeless. She states that she has been sleeping a lot and has not had any desire to go to class or swim practice. She states that she is no longer interested in completing in the conference meet and that they should let someone else take her place. She has lost weight over the past few weeks because she has no appetite, and nothing sounds good to her.

Appearance: Patient is sitting cross legged, slumped in the chair and is looking down at her lap. She appears to have poor hygiene, disheveled hair that is partially in a ponytail, and is dressed in baggy clothing with food stains.

Behavior: Patient is alert and answers questions with hesitance and little response. She speaks quietly, takes time to respond, and only speaks when prompted. Patient has blunt affect, but appears to have red-puffy eyes indicating recent crying.

Cognition: Patient is oriented but shows decreased ability to concentrate, patient exhibits poor insight and judgement, and states that she does not need to be here, is not doing anything wrong, and is perfectly fine.

Thought Process: Patient exhibits denial and states, "I do not know why I was brought here; I do not need to be here." She stated that she feels betrayed by her friends for violating her trust and rights. "My friends drink just as much as I do, I do not see why drinking in my bedroom alone every night is a problem. This is what all college kids do." When prompted about her drinking habits, the patient lashed out and called the nurses ignorant and stated that they didn't know what they were doing, exhibiting denial about her possible drinking problem.

Subjective Data: Feelings of hopelessness, loss of appetite, disrupted sleeping pattern with excessive sleeping, anhedonia with little interest in participating in swimming or studying, drinks regularly when alone, and has been skipping class and practice, empty alcohol containers in her room.

Objective Data: Diagnosis of Bipolar 1 Disorder in past year and a family history of Bipolar Disorder through her mother. Observations of poor grooming, sad, blunt affect, with puffy, red eyes, smell of alcohol on her breath, slumped posture, little effort to interact, and delayed response.

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Vitals: HR: 97, BP: 120/60, Respirations: 20, O2: 98, Temp: 98.8 F

Depression Scale (1-10): 8

Anxiety Scale (1-10): 4

PART II

Plan of Care:

Nursing Diagnosis 1: Potential for harm to self and others due to impulsivity/agitation occurring with manic excitement as evidenced by

- Goal 1: Patient will demonstrate self-control and awareness of situation.
  - o Intervention #1: Assess the environment, remove all objects that could be used to harm self including shoelaces, jewelry, belts, and combs, rearrange room to prevent environmental harm (Swearingen, 2016).
    - ▪ Rational- Depressive episodes associated with bipolar disorder can result in destructive behavior and risk-taking.
  - o Intervention #2: Set limits with the patient by providing feedback on behavior and stating what is appropriate and what is not (Daggenvoorde et al., 2015).
    - ▪ Rational- Setting limits provide clear guidelines of acceptable behavior for the patient to follow.
  - o Intervention #3: Provide early interventions and administer medication as needed if other attempts to deescalate fail (Semahegn et al., 2018).
    - ▪ Rational- Early intervention helps deescalate situations and prevents violence and harm to patients and staff.
- Goal 2: Patient will have increase insight of their disease.
  - o Intervention #1: Use therapeutic communication to help the patient reflect on their own behavior and the consequences of those actions (Daggenvoorde et al., 2015).
    - ▪ Rational: Patients able to recognize behaviors may help them assess actions and their outcomes.
  - o Intervention #2: Assess the patients understanding of their condition including perception of illness, signs of relapse, medication compliance, etc. (Swearingen, 2016).
    - ▪ Rational: Assessing the patients understanding of their condition can help guided needed education and prevent misunderstandings from interfering with treatment.
  - o Intervention #3: Educate patient on prescribed medications and the importance of medication compliance, signs and symptoms of

condition, and treatment options including ECT (Semahegn et al., 2018).

- ▪ Rational- Medication compliance is essential for stable functioning and disease management and increases understanding and acceptance.

Nursing Diagnosis 2: Decreased ability to cope related to perceived inadequate level of control or support in dealing with situational crisis as evidenced by

- Goal 1: Patient can identify ineffective coping behaviors and demonstrate effective coping techniques.
  - o Intervention #1: Assess and discuss history of substance use (Swearingen, 2016).
    - ▪ Rational- Patient may use substances as a coping mechanism which can inhibit their ability to handle stressful situations rationally and effectively.
  - o Intervention #2: Help the patient develop short and long-term goals to focus on life changes and decrease stress (Daggenvoorde et al., 2015).
    - ▪ Rational- Setting goals can help provide direction, increase focus, and decrease stress.
  - o Intervention #3: Teach the patient to utilize positive relaxation techniques and coping mechanisms such as mindfulness meditation, aromatherapy, exercise, journaling, deep breathing (Malini et al., 2011).
    - ▪ Rational- Positive mechanisms reduce stress and provide a sense of control over self and situations.
- Goal #2: Patient demonstrates characteristics of increased self-esteem.
  - o Assess the patient's level of self-esteem (Videbeck, 2017).
    - ▪ Rationale- Identifying poor self esteem can provide insight in order to address the issue.
  - o Help the patient identify areas of life situations that are out of their control (Daggenvoorde et al., 2015).
    - ▪ Rationale- Recognizing the inability to control everything will increase hope and decrease unnecessary self-blame.
  - o Teach thought stopping techniques and positive reframing (Swearingen, 2016).
    - ▪ These techniques can help stop critical thinking and increase positive thoughts about self.

APA References:

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Daggenvoorde, T., Geerling, B., Goossens, P. (2015). A qualitative study of nursing care for hospitalized patients with acute mania. Archives of Psychiatric Nursing, 3 (29), 186-191. doi: 10.1016/j.apnu.2015.02.003

Malini, Srivastava, Uddip, Talukdar, & Vivek, Lahan (2011). Meditation for the management of adjustment disorder, anxiety and depression. Complementary Therapies in Clinical Practice, 17, 241-250. doi: 10.1016/j.ctcp.2011.04.007

Semahegn, A., Tropey, K., Manu, A., Assega, N., Tesfaye, G., & Ankomah, A. (2018). Psychotropic medication non-adherence and associated factors among adult patients with major psychiatric disorders. *Systematic Reviews,* 7(1), 10. doi: 2097/10.1186/s13643.018.0676

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, psychiatric nursing care plans*. St. Louis, MO: Elsevier/Mosby.

Videbeck, S. (2017). *Psychiatric-mental health nursing* (7th ed.). Wolters Kluwer.

PART III

NCLEX Questions with Rationale:

Question #1: While interviewing a patient with a possible alcohol abuse issue, which assessment would the nurse use to assess for an alcohol abuse disorder?

PERRLA

CAGE

Hamilton Rating Scale

C-SSRS

Rational- CAGE questions are used to assess a patients alcohol use. These questions ask "Do you feel like you need to cut back on your drinking?", "Are you annoyed with other's criticism of your drinkning?", "Do you feel guilty about your drinking?", and "Do you feel like you need a drink first thing in the morning?". If the individual answers yes to two or more of these questions, it may indicate that they have an alcohol abuse problem (ATI, 2019).

Question #2: A nurse working on a behavioral health unit is admitting a patient with an increased risk for harm to self or others, which items would not be appropriate for the patient to have? Select all.

Shoelaces

Comb

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Picture of family

A book

<mark>Necklace</mark>

Rationale- Shoelaces, a comb, and a necklace are all items prohibited as they may be used to inflict harm to self or others. A family picture is okay for the patient to have and a book is also allowed if the content is approved (ATI, 2019).

Question #3: A nurse is providing education to a patient about their diagnosis of Bipolar disorder. Which of the following topics would be appropriate to discuss?

<mark>Signs and symptoms associated with mania, hypomania, and depressive states</mark>

<mark>Medication administration and compliance</mark>

<mark>Effective coping mechanisms to relieve stress and excess energy</mark>

ECT is not a treatment option, as it is only used for depression.

Rationale- It is important for nurses to provide education to patients for them to better understand their disease. Educating patients on signs and symptoms will help them identify relapse. Education on medication compliance will help them prevent frequent relapses and increase ability to function with the disease. Effective coping mechanisms can help manage energy and relieve stress to prevent relapse. ECT is a treatment for bipolar disorder and is not exclusive to depression treatment (ATI, 2019).

References:

ATI. (2019). Content Mastery Series RN Mental Health Nursing (11th ed.). Assessment Technologies Institute.