Nursing (Summary)

Name

Institution

Course

Tutor

Date

Nursing (Summary)

**Personal history**

Zina (Currently 15 years) was born in Holland, and soon after, the family relocated to the UK. She is of Iraqi heritage. She was attending London Academy before her original admission to Beacon Centre in March 2020. Zina met the developmental milestones on time. Mom had no concerns regarding Zina’s development or wellbeing. Paternal uncles and paternal grandmothers had a history of mental health illness but could not give a clear account of their diagnosis. At some point, she made allegations about her father forcing her into early marriage and FGM, all of which were dropped. Her school schedule was reduced due to her inability to manage her safety and engage meaningfully in-school sessions. She has been struggling to engage in social interactions and making new friends throughout her life. History of bullying at school has contributed to her trauma.

**Admission**

Zina was first admitted at the Beacon center (5th of March 2020) as a section 3 Patient after being transferred from Seven Unit at Huntercombe Hospital. Prior to being admitted to the Beacon Center, the patient had taken an overdose of 32 Ibuprofens and 32 Paracetamol tablets with an intention to end her life. The patient had run away from her home. After being admitted informally in Section 2 MHA, her condition continued to worsen, and therefore there was a need that she gets admitted in Section 3 MHA when it was determined that her mental health and safety had re deteriorated.

**Assessments done**

The following information was unveiled given the subjection to the ICD-10 code(s) (Mental and Physical Health conditions). There was evidence for Generalized anxiety attachment difficulties, ADHD (Attention deficit and hyperactive disorder), emotional dysregulation with suicidality, NSSI and eating difficulties, Hypercholesterolemia, Difficulties with intra-familial difficulties, a past history of bullying, and struggling with peers interactions. The patient required consistent support and supervision in a clinical environment. However, the intellectual level in mainstream education was formally assessed, and there were no specific disorders of psychological development.

The following findings and conclusions were reached after physical health examinations were done on admission, starting from 17/09/2020 to 04/11/2020. There were no significant intracerebral parenchymal anomalies, no signs of intracranial hemorrhage, the ventricular system is normal, basal cisterns are normal, and Posterior fossa structures are normal as well. There were no other significant findings from the assessments. As such, it was concluded that there were no signs of acute clinically relevant findings.

As for the recommendations for physical health emerging from the assessments, it was established that Zina required ongoing antipsychotic monitoring, monitoring of blood glucose levels and signs of dehydration, regular physical exams, and Liaising with ED and Ped team regarding support with eating difficulties.

**Medical history**

The mental difficulties exhibited by Zina are said to have started when she was in year 7. The condition was earmarked by characteristics such as high levels of anxiety, difficulties with internal negative voices, and risk-taking behaviors.

The patient did not exhibit any physical health concerns. As a result of continuous head-banging, the patient had sustained considerable subgaleal hematomas on many parts of her scalp. She was taken to A&E and was medically cleared. Incidents of food and fluid restriction led to Zina’s admission to a general hospital for emergency treatment during the second admission. On transfer, the following medications were recommended;

Escitalopram 5 mg po od, mane

Haloperidol 2 mg bd (lunchtime and evening time)

*Currently not compliant with prescribed medication for more than 8 weeks*

Ensure, 1 drink TDS (in the past 8 days, Zina refused to take the Ensure on 1 day, took Ensure 1x/24 hours on 2 days, and took Ensure 2x/24 on 5 days)

*- PRN (As the situation arises):*

Haloperidol 1.5 mg PO, PRN, Max OD / 24 hours

Haloperidol 2 mg IM, Max TDS/24 hours

Procyclidine 2.5 mg – 5 mg PO/IM, up to TDS/24 hours for EPSE

Peptic, 10-20 ml, PO. Max QDS/24 hours

Glucose 400mg PO in case of BM less 3mmol/l

Glucagon 1mg, IM- symptomatic hypoglycaemia, confusion, seizures, until the arrival of emergency services

Lorazepam 1 mg IM, max dose 4 mg/24 hours

Promethazine 12.5 mg – 25 mg PO, max 50 mg/24 hours

Ibuprofen 400 mg up to tds PRN t

Paracetamol 1 g, max qds PRN

Ensure, 1 bottle, max TDS/24 hours

**Mental State and Risk assessment on transfers**

She was composed and settled, soft-spoken with n abnormalities in speech, she hallucinates hence affecting her mood, exhibited anxiety, remains preoccupied with a number of prevalent thoughts and beliefs in the context of anxiety, limited insight into the need for treatment, oversleeps in the morning, fluctuating in-take of foods, and limited attention span.

As for risk assessment, she exhibits a high risk of self-harming behavior with limited engagement in coping strategies and de-escalation; hence she should be on constant observation. She struggles to engage in self-care, accept medical treatment when struggling with her mood and mental state and expressive aggression towards staff, and become physically violent.

**Progress on the ward**

On PICU admission, she has been discussing her anxiety and the opportunities to self-harm. She was proud that she was fairing on well at the PICU but also expressed disillusionment that she was going to die when she gets back home anyway. She consistently engaged in self-harming behavior by head-banging and ingesting foreign objects requiring recurrent staff intervention, restrain, and rapid tranquilization. From the CPA on 05/10, she was required to comply with food and fluid restriction on the ward, which led to dehydration, incidents of losing consciousness, and two admissions to A&E requiring urgent treatment. Her level of risk has continuously remained high since she was transferred back from PICU. 927. She was struggling to engage in meaningful and in-depth conversations regarding her past experiences and actively contribute to the formulation of difficulties. Debriefs following short walks and conversations have proved beneficial for her. Complying with medications has remained a challenge, as she sometimes refuses to take medicine completely. She also fidgeted a lot

Soon after her return to PICU, she was willing to explore various coping strategies to help her manage harmful behaviors, e.g., engaging in various activities and games and therapeutic activities such as cooking. She still explores risk opportunities, and her time in and out of school is ratio 1:1. ADHD interventions have been put in place, and she continues to be uncompliant with the medications. She was further assessed by the CAMHS Low Secure Network and was recommended she will benefit from a further period of admission in a CAMHS LSU unit.

**Formulation and progress after medication and follow-ups**

To a greater extent, the patient has been cooperative in complying with the clinical medications. The ongoing therapeutic work with Zina was tailored towards supporting her engagement in developing a clinical formulation and ownership of her recovery. Zina has continued to engage to a deeper level in clinical sessions in reflecting on past experiences with relevance for her life history, experience, sense of identity, and self-esteem. With a lot of support and education, she eventually managed to engage in the ADHD assessment and, more recently, take on board the importance of medication and psychosocial strategies such as EHCP to support her studies.

However, the background where she comes from also makes interventions a bit difficult. There is an important sense of stigma regarding mental health in the family and cultural influences, leaving Zina to feel very vulnerable to criticism should she take on the clinical recommendations. Some things are likely to have happened in the learning context, which is likely to complicate the issue further. She is likely to have experienced more intensively the numerous educational transitions and change in support and teaching styles whilst at the same time the other aspects of her social life has been under immense pressure – complex family dynamics, uncontaining parenting, cultural changes and pressures, experiences of bullying from peers and likely traumatic experiences. These issues are likely to have compounded the situation, even before the medication, especially with regard to ADHD and attachment difficulties.

Soon after admission into the hospital, the risk has continued to increase to a level where her safety had to be ensured in a secure inpatient unit. Initially, Zina remained completely uncompliant with the medication recommended, expressing anxieties regarding the medication removing the voices, which she recognizes as a constant for a lengthy period. However, the trend was slowly improving as she was taken through various therapeutic interventions. She has also been able to cope and understand better the mental health struggles of different family members. Her views and the egodystonic/egosyntonic aspect of her internal experiences continue to fluctuate. She also exhibits some intense pattern of separation anxiety and anticipated rejection to the point of losing contact with self-goals and remaining in charge of risk management. She recognizes these patterns from her life history and contributes to difficulties in forming long last lasting relationships and the escalating sense of anxiety and panic.

Even though she has benefitted from the consistent treatment with SSRI augmented by atypical antipsychotics for her background mood, she remains predisposed to episodes of low mood in the context of emotional dysregulation and the contribution of malnourishment caused by food and fluid restriction. With the management plan in place, she still finds it difficult to control her eating behaviors and still exhibits anxiety.