NURS3910 MENTAL HEALTH NURSING

NURSING ASSESSMENT FORM

Student Name: _____Emita Shahbazi_____Date: _____3-9-2020_____

<table>
<tr><td colspan="6">Patient data:</td></tr>
<tr><td>Admission Date: 3-8-2020</td><td>Age: 49 years old</td><td>Gender: Male</td><td colspan="3">Significant Other/marital status and children: Divorced and has 3 children</td></tr>
<tr><td>Employment: Unemployed</td><td>Educational Level: 11th grade</td><td>Pt. Legal Status: 5150,5250</td><td>Legal history: Patient reports they are on 2-year probation and was charged for disturbing the peace</td><td>Primary Language: English</td></tr>
<tr><td colspan="6">Chief complaint: What patient says prompted them to present at the hospital:
His sister stole his car so he decided to call the police and then walked to Doctors Hospital. Once I got to doctors hospital, they sent me back to this place again</td></tr>
<tr><td colspan="6">What is the documented cause for hospitalization?
He was admitted to Doctors Medical Center and said Satan told him to kill the antichrist.</td></tr>
<tr><td colspan="6">Patient’s living situation at time of admission: He is renting a room in Ceres, California</td></tr>
<tr><td colspan="6">DSM IV AXES from chart</td></tr>
<tr><td colspan="3">I: Schizoaffective disorder bipolar type</td><td colspan="3">II: N/A</td></tr>
<tr><td colspan="3">III: Cannabis Use Disorder htn</td><td colspan="3">IV: Divorced, living alone, and unemployed</td></tr>
<tr><td colspan="3">V:(With rationale) 25- Clients behavior is considerably influenced by his delusions and hallucinations.</td><td colspan="3"></td></tr>
<tr><td colspan="6">PATIENT HISTORY</td></tr>
<tr><td colspan="6">Medical History: No medical problems reported. He is allergic to Keflex</td></tr>
<tr><td colspan="6">Current medical issues of importance to nursing management of patient: (present all relevant information from review of systems)
Client is taking medication for his blood pressure. See medication list.</td></tr>
<tr><td colspan="6">Psychiatric history: Client was first admitted to a psychiatric facility at the age of 15 in Modesto.</td></tr>
<tr><td colspan="6">Alcohol and Other Drug Abuse: Client denies alcohol use and admits to using cannabis at least twice a week.</td></tr>
<tr><td colspan="6">Abuse (physical/sexual): Denies</td></tr>
<tr><td colspan="6">FAMILY HISTORY</td></tr>
<tr><td colspan="6">Mental Health: Sister and mother have history of anxiety</td></tr>
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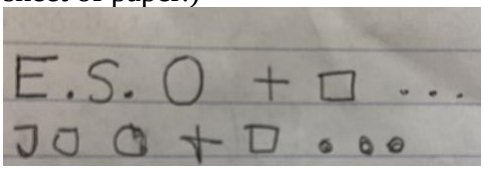
Alcohol and Other Drug Abuse: Unknown

MENTAL STATUS EXAM	
General Appearance:	
Dress & Grooming: He is dressed in black long-sleeved shirt and pants. He is also wearing socks on his feet. He appears to be clean and hygiene is well kempt.	Facial Expression: Client has a smile on his face and is wide eyed.
Posture and Gait: He is sitting up straight. Gait is steady	Physical Characteristics: He is a tall and lean man who appears to be his age.
Motor behavior: (describe) Client is sitting down in chair with occasional feet tapping and hand gesturing.	Attitude toward interview and mood (observed): Excited to talk and to be interviewed
Physiological responses (tremor, nystagmus, sweating): None	
Affect and Mood	
Appropriateness: Appropriate eye contact. Mood is congruent with statements.	Range: Elevated affect , face is bright and slightly agitated when nurse asks questions about what client previously mentioned
Stability (patient's report of swings, and interviewer's observation of changes): Client has short temper. If nurse asks questions to reiterate what the client has said the client gets upset and speaks in angry tone and thinks that no one is listening to him. He also gets upset when anyone else in the room was speaking at a normal sound level. He thought that they were being too loud and disrespectful by the interview that was taking place.	Describe (e.g., anxious, depressed, disengaged, etc.): Client is engaged in the conversation expansive and exhibits signs of being self-inflated during the conversation.
Symptoms (ask Patient) Depression- no Loss of interest - no Guilt/Shame - no Hopelessness - no	Helplessness - no Anxiety/Restlessness - no Anger/Hostility - no Impulse Control - no Command Hallucinations - yes
Speech	
Volume: loud and dramatic	Rate (flow, speed): Rapid and expansive

Thought Content	
Theme: Religion, God, Satan, and his auditory hallucinations which he called it "telepathic communication in his brain"	Delusions (persecution, influence, reference, thought insertion): His sister stole his car from him.
Phobias: Spiders	Obsessions: None
Compulsions: None	De-realization, depersonalization: none
Disorders of Perception (give an example of those that apply)	
Hallucinations (type with description): Auditory: God and Satan talk to him daily. He calls it telepathic communications. They tell him things such as to kill the antichrist, and for him to spread the word of god. He believes he is the messenger of God.	Illusions (described as shadows, or reported as misinterpretation of stimuli): During the interview the client claimed that the lights flickered in the day room and that it was because it was God showing his presence in the room.
Clarity and organization: tangential, disorganized thinking One is orange and the other is red. It is easy to rhyme with apple and not orange. Want to hear me rap? Banana banana banana. I can rap for you later if you want.	Tone/inflection: Clients voice would go from high to low at times. For example, the client would be speaking to me in a regular tone and then would yell at another client in the room to tell them that they were being too loud.

Other unusual experiences	
Hypnogogic phenomena: Denies	Dreams: Cannot remember his dreams
Déjà vu Experiences: Denies	Nightmares/Night Terrors: Denies
Memory & Cognition	
Orientation to self: Able to state who he is	Orientation to Place: Able to state where he is
Orientation to day & date: Knows what day it is	
Attention: ability to count digits forward (provide digits for patient to repeat) Able to count from one to ten	Serial 3s and serial 7's: (count backward from 100 by 3 or 7) Able to count backwards in serial of 7's starting from 100
Recent memory: (assess via memory for how long has been in hospital, memory for recent meal, home address etc.) Can you tell me what you had for breakfast? I had eggs bacon and pancakes.	Confabulation: (ask patient if he has seen the examiner before, assuming he has not or ask for another detail which gives the patient the opportunity to "fill in the gaps" of memory) He remembers me from our first interview.

Hey! You should have asked what the sexiest man here had for breakfast.	
Fund of information: (ask general information such as: how many days in a week, how many months in a year, what makes water boil? Name the four seasons of the year, where does the sun set?) There are 365 but this year is a leap year. You want to know how there is a leap year every year? Its because there are 6 hours more in each day which makes it 366 days each leap year.	Vocabulary: (observe the words used and/or present several words and ask the patient to tell you what they mean) What does happiness mean to you? Happiness means that you accept Jesus as the son of God
Abstraction: ask to tell you what a proverb means What does don't cry over spilled milk mean? It means to get over something and not dwell on it.	Similarities: state two objects (orange and apple) and ask how they are similar or alike One is orange and the other is red. It is easy to rhyme with apple and not orange. Want to hear me rap? Banana banana banana. I can rap for you later if you want.
Judgment and Comprehension: provide examples of common events or situations and ask the pt. what he would do in those situations. What would you do if you found a wallet on the ground? I would take it to the police station	Perception and Coordination: (have patient write his own name, copy a circle, a cross (x), a square, a diamond or a row of dots on a blank sheet of paper.) 

Suicidal Ideation: ❑ Yes ❑No (If yes, complete suicide assessment)
Homicidal Ideation: ❑ Yes ❑ No (If yes, complete homicide assessment)
What does this person do when angry, stressed or uptight? Do breathing techniques to try to calm themselves down.

Patient's description of him/herself. What does she like best best/least about her/himself?
He stated his best attribute is that he is a man of God. His least favorite thing about himself is that he questions why God has chosen him to be the messenger of god. He says that it is exhausting

Include real or potential strengths of the client.
He knows what his medications are for. He is medication compliant. He is in good health

Routine Medications (including category, dose, standard dose, target effects, interactions and side effects)

Quetiapine (Seroquel) Standard dose: 400–800 mg	200 mg 1 tab PO BID	Mood stabilizer for schizophrenia and depressive disorders 2nd generation antipsychotic antagonizes dopamine and serotonin receptors.	Elevates AST and ALT. May also cause anemia, thrombocytopenia, and leukopenia. increases total cholesterol and triglyceride levels. Weight gain Constipation Dizziness- hypotension.
Valproic Acid (Depakene) Standard dose: 60 mg/kg/day	1,000 mg 20 mL syrup PO BID	Anticonvulsants which helps with mood stabilizing	Drowsiness Nausea constipation Toxicity may agitation, dizziness, headache, insomnia, sedation, and confusion. Therapeutic serum levels range from 50–100 mcg/ mL Valproic Acid: May cause leukopenia and thrombocytopenia. Monitor hepatic fxn AST and ALT.

Amlodipine (Norvasc) **10 mg**	10mg 1 tab PO Daily	Calcium channel blocker Antihypertensive	Dizziness from hypotension bradycardia

Pertinent Lab values:

CBC	WNL	N/A	Quetiapine may cause anemia, thrombocytopenia, leukocytosis, and leukopenia Valproic Acid: May cause leukopenia and thrombocytopenia.
Routine Chemistry	WNL	N/A	One of Quetiapine's side effects is elevating AST and ALT. Valproic Acid: Monitor hepatic fxn AST and ALT
Lipids	LDL : 102	LDL <100	One of Quetiapine's side effects is increase in total cholesterol and triglyceride levels.
TSH	WNL	N/A	TSH labs are assessed due to high or low levels can cause symptoms that resemble depression or mania. Lower levels of TSH(hypothyroidism) is linked to depression High levels of TSH (hyperthyroidism) is linked to mania
Valproic Acid Levels	WNL	50– 100 mcg/ mL	I would ask the physician to do a lab screening on valproic acid levels since the client is taking Valproic acid.

			Therapeutic serum levels range from 50–100 mcg/ mL Some sx of toxicity would include CNS depression and lethargy
Drug Screen Urine	THC: Positive	Negative	Drug screens are preformed to see if the client had used any sort of drug prior to being admitted. Drugs can affect many aspects of the pt such as their mood and cause adverse effects of drugs. This client has a hx of marijuana use and stated he smoked prior to being admitted .

Written Summary (Give summary of relevant findings from above. Discuss congruence and incongruence between DSM criteria & patient assessment)

J.J. is a 49 year old male. His legal status is 5150, 5250. He was admitted From Doctor's Hospital in Modesto on March 8th. He stated that Satan told him to kill the Antichrist. His diagnosis is schizoaffective disorder bipolar type. He has cannabis use disorder which he admits to using marijuana at least twice a week. He's divorced, lives alone, and is unemployed. He has no medical issues other than he is taking amlodipine for his blood pressure which is in normal limits. He's also allergic to Keflex. His first psychiatric admissions was at the age of 15 in Modesto. During the interview the client was sitting down in his chair. He would occasionally tap his feet and use hand gesturing. He was dressed in a black long-sleeve shirt and pants you appear to be clean. He was alert and oriented to himself and the room. The client had a short temper and he was very engaged in the conversation. He was expansive and he exhibited signs of being inflated during the interview. He calls his command hallucinations telepathic communications with God or Satan. During the interview he stated that he saw the lights flickering and it was the presence of God. He does not have any suicidal or homicidal ideations however; his auditory hallucinations do tell him to kill the Antichrist. He takes 200 mg twice a day of Seroquel and 1000 mg / 20 ml of Depakene twice a day. His labs are within normal limits. His drug screen urine panel tested positive for THC. Some potential strengths for this client is that he knows what his medications are used for, he is medication compliant and he is in generally good health.

According to the American psychiatric association, schizoaffective disorder may be categorized by sections A through D. Section A states that the client would have an uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a mixed concurrent with symptoms that meet Criterion A for Schizophrenia.

Schizophrenia criterion A states that the client has two or more of the following that each present for a significant portion of time during a 1-month period. At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., affective flattening, alogia, or avolition)

The client does have auditory hallucinations. It was also observed that the client had frequent derailment.

The next section is category B. Category B states that during the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms. The client has had auditory hallucinations for greater than 2 weeks of his life. Criterion C states that symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness. Client was diagnosed with bipolar type. It is unknown if the client had ever experienced a manic or a mixed Episode. Category D states that the disturbance is not due to the direct physiological effects of a substance(e.g., a drug of abuse, a medication) or a general medical condition. Although the client does use marijuana the disturbance is not a direct physiological effect of the substance. Even when he is at the behavior health center and he is not on the drug he is still showing symptoms of the disease.

Three Nursing Diagnoses according to priority (include plan of care for each, expected outcomes.)

1. Risk for injury r/t auditory hallucinations
   - Assess client's auditory hallucinations, provide one to one interview for client, administer medication
   - Client is medication compliant. He verbalizes that he does not want to hurt himself or others. Research article: Providing one on one time with the client allows for them to feel valued and heard.
   - The article found uses various positive methods on how to speak to a client and have them listen to you. Some of the examples in the article included exploring and promoting coping and resources, creating a comfortable setting, and displaying interest in patient's life (John et al., 2015). The client is more likely to listen to the care provider when using these techniques. The care provider will be able to build rapport with the client which in turn may help with deescalating any risks for injury.
2. Risk for medication noncompliance r/t pt past hx of med noncompliance, and lack of social support.
   - Teach pt importance of taking medication. Teach pt what their medications are used for. Allow for time for pt to ask questions.
   - Pt asks for medication to be administered and is med compliant. Pt verbalizes he understands what each medication is for. Pt understands side effects of medications.

- According to Moritz et al. (2013), low illness insight and lack of education on side effects were some of the top reasons found for medication noncompliance. The article emphasizes the importance of educating the patient. If the patient is unaware of their mental illness and do not know much about the prognosis of it they will most likely not take their medications. Clients also will stop taking their medications if they experience negative side effects. The client should be told the side effects so that they are aware of them.

3. Ineffective health maintenance r/t pt living alone AEB pt unable to meet basic needs on own
   - Establish trusting relationship encourage client to verbalize feelings, explore clients support system, ask what client does when they get angry or stressed
   - Client is willing to have one on one time with SN to be interviewed. Client expresses that he smokes marijuana once in a while. Client also uses breathing techniques when they are angry. Client attends group therapy sessions throughout day.
   - According to Blixen et al. (2016), clients who had bipolar disorder had felt a sense of stigma towards their diagnosis and had a lack of social support. These are all barriers to self-support in caring for their diagnosis. Targeted, or personalized, approaches are the best ways to assist a client that is being seen by a medical professional. The article states providing social and peer support, locating resources, optimizing communication with providers and integrating medical and psychiatric care, will help promote self-management in this vulnerable population (Blixen et al., 2016).

Minimum of three peer reviewed references (evidence for interventions planned, from last 10 years of literature).

Please include a separate sheet for references.

Student's response to experience with this patient:

Client J.J. was pleasant to work with. It was interesting to see a client with such expansive behavior. It was also interesting to get into the client's head and hear his take on his condition. The client knew why he was taking his medication however, he did not believe in his diagnosis. He also was very adamant in his beliefs. Overall, I was able to learn a lot about the client's condition and how to care for a client who has a severe mental disorder.

Student Name: Emita Shahbazi, SN

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Blixen, C., Perzynski, A. T., Bukach, A., Howland, M., & Sajatovic, M. (2016). Patients' perceptions of barriers to self-managing bipolar disorder: A qualitative study. *International Journal of Social Psychiatry, 62*(7), 635–644. https://doi.org/10.1177/0020764016666572

John, P., Khanom, H., Cameli, M., McCabe, R., & Priebe, S. (2015). How to value patients with psychosis: An inductive study of psychiatrists' behaviour in routine consultations. *Communication & Medicine, 12*(1), 55-69. doi:http://dx.doi.org/10.1558/cam.v12i1.26363

Moritz, S., Favrod, J., Andreou, C., Morrison, A. P., Bohn, F., Veckenstedt, R., Tonn, P., & Karow, A. (2013). Beyond the usual suspects: Positive attitudes towards positive symptoms is associated with medication noncompliance in psychosis. *Schizophrenia Bulletin, 39*(4), 917–922. https://doi-org.libproxy.csustan.edu/10.1093/schbul/sbs005