BOROUGH OF MANHATTAN COMMUNITY COLLEGE

Concept Map Care Plan #2

Nursing 211-131: Prof. Braga

Chinweokwu Enekwechi

12/1/2011

BOROUGH OF MANHATTAN COMMUNITY COLLEGE
Department of Nursing

PATIENT PROFILE: **Student Name:** Chinweokwu Enekwechi **Nursing 211-131 (Prof. Braga)**

DATABASE

ADMISSION INFORMATION

1. Date of Care:	2. Patient Initials:	3. Age:	4. Gender:	5. Admission Date:
11/03/2011	R.G.	33 y/o	Female	09/26/2011

6. Reason for Hospitalization:
Suicidal ideation x3 months

8. Surgical Procedures:
None

7. Medical Diagnoses: (present diagnoses, past diagnoses):
Schizophrenia, schizoaffective disorder—Bipolar type, diabetes mellitus, obesity, hypertension, hyperlipidemia, hypothyroidism.

9. ADVANCE DIRECTIVES (NURSE'S ADMISSION ASSESSMENTS):

Living will:	Power of attorney:	Do not resuscitate (DNR) order:
☐ yes ☑ no	☐ yes ☑ no	☐ yes ☑ no

10. LABORATORY DATA

Test	Norms	On Admission	Current value	Test	Norms	On Admission	Current value
White blood cells	4.8 – 10.8	7	NI	**Creatinine:**	0.6 – 1.1	0.6	NI
Differential		NI	NI	**Phosphate:**	1.2 – 2.6	3.8	NI
Hemoglobin	14 – 18	10	NI	**Magnesium:**	1.5 – 2.5	1.7	NI
Hematocrit	36 – 46	30.8	NI	**Aspartate aminotransferase:**	9 – 25	20	NI
Platelets	150 – 400	220	NI	**Alanine aminotransferase:**	7 – 30	13	NI
Prothrombin time (PT)	NI	NI	NI	**Alkaline phosphate:**	25 – 100	60	NI
International normalized ratio (INR)	NI	NI	NI	**Total bilirubin:**	0.3 – 1.0	0.4	NI
Activated partial thromboplastin Time (aPPT)	NI	NI	NI	**Direct bilirubin:**	0.0 – 0.2	0.2	NI
Blood glucose	60 – 110	85	NI	**Protein:**	6.0 – 8.3	7.1	NI
Sodium	135 – 145	137	NI	**Albumin:**	3.5 – 4.8	3.8	NI
Potassium	3.5 – 5.0	4.0	NI	**Acetamin:**	NI	<0.300	NI
Chloride	98 – 106	107	NI	**Salycilate:**	NI	<2.0	NI
Calcium	8.5 – 10.5	8.5	NI	**Valproate:**	NI	108.0	NI
Blood urea nitrogen	10 – 20	10	NI	**Other:** NI	NI	NI	NI

11. DIAGNOSTIC TESTS

Chest x-ray: NI	**EKG:** Normal sinus rhythm	**Other:** NI
Other: NI	**Other:** NI	**Other:** NI

12. MEDICATIONS ***List medications, times of administration, and therapeutic use***

Medication/Time of Administration/Assessment	Therapeutic Use/Side or Adverse Effects	Medication/Time of Administration/Assessment	Therapeutic Use/Side or Adverse Effects
Divalproex 750 mg DR tab po bid *Assessment: Monitor patient alertness, lab tests: baseline platelet count, bleeding time, and serum ammonia; repeat at least every 2 months.*	This anticonvulsant depresses abnormal neuron discharges in the CNS, thus decreasing seizure activity. It is also used for treatment of manic episodes of bipolar disorder, and long term prevention of manic and depressive phases of bipolar disorder | Side effects may include: sedation, drowsiness, N&V, transient indigestion, deep coma or death (w/ overdose), liver failure, pancreatitis, bone marrow depression.	**SitaGLIPtin 100 mg tab po daily** *Assessment: Monitor for S&S of significant GI distress, including NV&D. Monitor for S&S of hypoglycemia. Labs: Baseline and periodic creatinine clearance, periodic fasting and postprandial plasma glucose, and HbA1C.*	This antidiabetic tablet lowers both fasting and postprandial plasma glucose levels | Side effects may include: headache, nasopharyngitis, upper respiratory tract infection, acute pancreatitis.
Levothyrox 25 mcg tab po daily *Assessment: Monitor HR and BP for tachycardia or suspected arrhythmias. Monitor for symptoms of angina or cardiac failure (suggests that metabolism has increased too rapidly).*	This thyroid hormone replacement drug replaces decreased or absent thyroid hormone. It restores metabolic rate of a hypothyroid individual | Side effects may include: insomnia, irritability, nervousness, tremors, nausea, diarrhea, weight loss.	**Acetaminophen 650 mg tab po q6h prn (Max: 4 g/day)** *Assessment: Monitor client for S&S of hepatotoxicity, especially if the client has poor nutrition. Check liver labs periodically.*	This analgesic provides temporary relief for mild to moderate pain and reduces fever by enhancing heat dissipation through vasodilation | Side effects may include: nausea, vomiting, dizziness, hypoglycemia, hepatotoxicity.
Lisinopril 5 mg tab po daily *Assessment: Patient should be in supine position. Notify MD if severe hypotension occurs. Measure BP prior to dosage admin. Monitor for angioedema of extremities, face, lips, tongue, glottis, and larynx (monitor airway obstruction until swelling resolves). Monitor for hyperkalemia and hyponatremia.*	This antihypertensive and ACE inhibitor lowers BP, and improves cardiac output and exercise tolerance. It also ↓ aldosterone, permitting a potassium-sparing effect | Side effects may include: headaches, dizziness, fatigue, hypotension, chest pain, nausea, vomiting, constipation, hyperkalemia, increased BUN & creatinine levels.	**Haloperidol 2-5 mg IM repeated q4h prn** *Assessment: Monitor for effectiveness (decrease in hallucinations, insomnia, hostility, agitation, delusions). Monitor patient's mental status. Monitor for neuroleptic malignant syndrome, and discontinue drug if NMS is suspected. Monitor for parkinsonism, and tardive dyskinesia. Be alert to behavioral changes. Observe closely for rapid mood shift to depression. Labs: WBC with differential, LFT.*	This antipsychotic drug decreases psychotic manifestations and exerts strong antiemetic effect | Side effects may include: extrapyramidal reactions (e.g. parkinsonian symptoms, dystonia, insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, mental depression, lethargy, tremors, headache, confusion), hyperthermia, dry mouth, constipation, NV&D, tachycardia, hypertension, diaphoresis.

Metformin 500 mg tab po bid *<u>Assessment:</u> Monitor VS and fasting and postprandial blood glucose values. Monitor cardiopulmonary status (insufficiency may predispose to lactic acidosis). Report signs of lactic acidosis (malaise, myalgia, respiratory distress, abdominal distress).*	This antihyperglycemic suppresses hepatic production of glucose, as well as increasing the binding of insulin to its receptors in muscle tissue. Both of these effects lower glucose levels | Side effects may include: headache, dizziness, agitation, nausea, vomiting, abdominal pain, bitter or metallic taste, diarrhea, bloatedness, anorexia.	**Lorazepam 2-6 mg tab po prn (Max: 10 mg/day)** *<u>Assessment</u>: Supervise patient who exhibits depression with anxiety closely; possibility of suicide, particularly when there is apparent improvement in mood.*	This antianxiety and sedative-hypnotic drug is an antianxiety agent that also causes mild suppression of REM sleep, while increasing total sleep time | Side effects may include: drowsiness, sedation, dizziness, weakness, disorientation, restlessness, confusion, hypertension or hypotension, N&V, blurred vision.
Risperidone 2 mg tab po bid *<u>Assessment</u>: Monitor diabetics for loss of glycemic control. Monitor cardiovascular status closely and assess for orthostatic hypotension. Assess degree of cognitive and motor impairment, and assess for environmental hazards. Periodic labs: blood glucose, serum electrolytes, liver function, and CBC.*	This antipsychotic med is effective in controlling symptoms of schizophrenia, as well as other psychotic symptoms | Side effects may include: sedation, drowsiness, headache, agitation, extrapyramidal symptoms (e.g. pseudoparkinsonism), hyperglycemia, diabetes mellitus, dry mouth, constipation.	**Milk of Magnesia 30-60 mL/day in 1 or more divided doses prn** *<u>Assessment</u>: Evaluate patient's continued need for drug. Prolonged and frequent use may lead to dependence. Drug may raise urinary pH; assess for UTI. Labs: Serum magnesium with signs of hypermagnesemia (e.g. bradycardia), especially w/ frequent use or any degree of renal impairment.*	This drug acts as an antacid in low doses, and at higher doses, it acts as a mild saline laxative | Side effects may include: NV&D, abdominal cramps, hypotension, bradycardia, alkalinization of urine, electrolyte imbalance (with prolonged use).
Simvastatin 40 mg tab po daily *<u>Assessment</u>: Assess for and report unexplained muscle pain. Determine creatine phosphokinase level at onset of muscle pain. Labs: Baseline and periodic liver function, cholesterol levels.*	This statin or antihyperlipemic drug decreases serum triglycerides and LDL cholesterol, and slightly increases HDL cholesterol | Side effects may include: angina, dizziness, headache, vertigo, fatigue, insomnia, nausea, diarrhea, vomiting, abdominal pain, constipation, cough, transient elevations in CPK, elevations in liver transaminases.	**Trazodone 150 mg tab po prn (Max: 400-600 mg/day)** *<u>Assessment</u>: Monitor BP, HR, and rhythm. Report tachycardia, bradycardia, or palpitations. Monitor for orthostatic hypotension, especially in pt. taking concurrent antihypertensives. Report if pt. appears to be increasing towards sleeplessness and agitation (possible manic episode). Look out for vomiting, lethargy, drowsiness, exaggerated anticholinergic effects (S&S of overdose).*	This antidepressant increases the total sleep time. It also decreases the number of awakenings in depressed patients. This drug also treats anxiety | Side effects may include: Drowsiness, light-headedness, dizziness, impaired memory, [orthostatic] hypotension, hypertension, SOB, dry mouth, nausea, vomiting, flatulence, hematuria, anemia.

ALLERGIES/OTC PRODUCTS/HERBAL MEDICINES/Herbs/ PAIN

13. Allergies
NKDA

14. OTC Products/Herbal Medicines/Herbs
None

15. How much pain is the patient in on a scale from 0-10?
No pain

15. Where is the pain?
None

15. When was the last pain medication given?
NI

TREATMENTS

16. Treatments:
Medication, milieu therapy.

17. Support Services:
Grandmother, social worker, case worker.

18. Consultations:
Dietician

19. DIET/FLUIDS

Type of Diet:	Restrictions:	Gag reflex intact:	Appetite: Breakfast	Lunch	Dinner
2gNa, 1800 diab, 225 chol.	Sodium, sugar	☑ yes ☐ no	100%	100%	100%

Circle those problems that apply

Fluid intake:
8 hours: Drinking ad lib
24 hours: Drinking ad lib

Tube feedings:
type and rate

None

- **Problems swallowing, chewing, dentures**
- **Needs assistance with feeding**
- **Nausea or vomiting**
- **Overhydrated or dehydrated (evaluate total intake and output on I & O sheet)**
- **Belching**
- **Other**

20. INTRAVENOUS FLUIDS (IV therapy record)

Type and rate:

No IV

Location: None

IV dressing dry, no edema, redness of site:
☐ yes ☑ no

Other: NI

21. ELIMINATION

Last bowel movement:
Previous day (according to patient)

8-hour urine output: Voids freely
24-hour urine output: Voids freely

Foley/condom catheter
☐ yes ☑ no

Circle those problems that apply

- **Bowel: constipation diarrhea flatus incontinence belching**
- **Urinary: hesitancy (frequency) burning incontinence odor**
- **Other:** Patient reports no problems with bowel elimination; reports frequent urination due to frequent ingestion of water; may be related to psychosis-induced polydipsia.

22. ACTIVITY

Ability to walk (gait):	Type of activity orders:	Use of assistive devices: cane, walker, crutches, prosthesis:	Falls-risk assessment rating:
Steady gait	Nonrestricted, movement ad lib	None	1, No Risk for Fall (See Risk for Falls Assessment tool).

No. of side rails required:	Restraints:	Weakness:	Trouble sleeping:
☐ yes ☑ no	☑ yes ☐ no Note: There is an order in the chart dated 9/26/11. Use of restraints not observed on the day of care.	☐ yes ☑ no	☐ yes ☑ no

PHYSICAL ASSESSMENT DATA

23. BP:
104/66

23. TPR:
T= 98.0° **P=** 70 bpm **R=** 20

24.
Height: 5'4 **Weight:** 196 lb

REVIEW OF SYSTEMS: Write WNL (within normal limits) if normal and describe abnormalities in space provided:

25. NEUROLOGICAL/MENTAL STATUS:

LOC: alert and oriented to person, place, time (A&O x 3), confused, etc. Patient A&O x3 on admission but could not recall current day of the week on the day of care.		**Speech: clear, appropriate/inappropriate** Patient speech is clear, appropriate, and relevant; speaks In a child-like voice.	
Motor: ROM x 4 extremities WNL, obeys commands	**Sensations: 4 extremities** WNL	**Pupils: PERRLA** WNL x2 eyes	**Sensory deficits for vision/hearing/taste/smell:** None
Other: Patient speaks in a child-like voice. Although the patient's responses are appropriate and relevant, she changes subject frequently. On admission, patient's orientation was A&O x3. On the day of care, the patient could not recall the current day of the week; therefore only alert and oriented to person and place (A&O x2).			

26. MUSCULOSKELETAL SYSTEM:

Bones, joints, muscles (fractures, contractures, arthritis, spinal curvatures, etc.): None	**Extremity circulation checks (pulses, temperature, sensation, edema):** WNL
TED hose/compression devices: type: None	**Casts, splints, collar, brace:** None
Other: Patient stands and walks with an appropriate spinal curvature, but slumps while sitting.	

27. CARDIOVASCULAR SYSTEM:

Pulses (radial, pedal, etc.) (to touch or with Doppler): WNL	**Capillary refill (<2-3 sec):** ☑ **yes** ☐ **no**	**Edema, pitting vs. nonpitting:** None
Neck veins (distention): WNL	**Sounds: S_1 S_2 regular, irregular** Regular	**Any chest pain?** No
Other:		

28. RESPIRATORY SYSTEM:

Rate, rhythm, depth: 20, regular, normal breaths	**Breath sounds: clear, crackles. wheezes:** Clear	**Skin color:** WNL	**Cough: productive, nonproductive:** No cough	**Sputum: amount, color, odor, consistency:** None	**Use of accessory muscles:** No
Use of oxygen: nasal cannula, mask, trach collar: No	**Flow rate of oxygen:** None	**Pulse oximeter:** **__NI__% oxygen saturation**		**Smoking:** ☐ **yes** ☑ **no** **If yes: number of cigarettes/packs per day and number of years of smoking:** No smoking	
Other:					

29. GASTROINTESTINAL SYSTEM:

Abdominal pain, tenderness, guarding, distention, soft, firm: None	**Bowel sounds x 4 quadrants:** WNL	**NG tube: describe drainage** **Other:** None
Ostomy: describe stoma site and stools: None		**Other:**

30. SKIN AND WOUNDS:

Color, turgor: WNL	**Rash, bruises:** None	**Describe wounds (size, location):** None	**Edges approximated:** N/A ☐ **yes** ☐ **no**	**Type of wound drains:** None
Characteristics of drainage: None	**Dressings (dry, clean, intact):** None	**Sutures, staples, steri-strips, other:** None	**Risk for pressure ulcer-assessment rating:** 23, Not at risk (See Braden Scale)	

Other: No rashes noted; however patient scratches often.

31. EYES, EARS, NOSE, THROAT (EENT):

Eyes: redness, drainage, edema, ptosis None	**Ears: drainage** None	**Nose: redness, drainage, edema** None	**Throat: sore** No
Other:			

PSYCHOSOCIAL AND CULTURAL ASSESSMENT

32. Religious preference: Baptist	**33. Marital status:** Single	**34. Occupation:** Unemployed	**35. Emotional state:** Calm, joyful, mild level of anxiety

Other: R.G. is a 33 y/o homeless, African American woman, suffering from schizoaffective disorder—Bipolar type. She states that she is a devout Baptist who enjoys praying and reading the Bible. Ms. G also states that she is a member of an extended family, with her maternal grandmother as the head of household. She has a questionable family dynamic. It seems to be dysfunctional. She states that she "does not like her father's side of the family", that her mother "did drugs and died," her grandmother "raised her," and that her uncle also "does drugs and is bipolar." Ms. G currently does not have many friends and stated that she did not have many friends as a child, except her half-sisters Arielle and Nakiah. She had a few friends in high school until she "got sick" and was diagnosed with schizophrenia (she actually has a schizoaffective disorder). She is fond of one out of four of her roommates, Michelle, whom she says "prays a lot." Ms. G was in a very pleasant mood, unlike her mood on the day of my initial assessment. She stated that she is in a good mood because her doctor told her she will be discharged next week and she cannot wait to see her grandmother. According to her, she lives with her grandmother, her uncle and his girlfriend, and her cousin; but her grandmother is her main support system. She says that her grandmother calls her from time to time. Ms. G has been hospitalized in different psychiatric hospitals at least 10 times. She has a tendency to take her SSI checks and elope to different states, stating that she "travels all over" because she's lonely. She recollects taking a bus to California and Chicago. She stated that she has not been home for long periods [in Jersey City] for about 10 years; but she does go home from time to time. Ms. G has no history of substance or alcohol abuse. She has a history of self-mutilating/suicidal behaviors—She cut her wrist 3 times in suicide attempts. Ms. G has no children and says that she has never been in an intimate relationship, nor does she plan to in the future.

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♦ **Adapted from Schuster, P.M. (2002). Concept Mapping: A Critical-Thinking Approach To Care Planning. Philadelphia: F.A. Davis**

RISK FOR FALLS ASSESSMENT TOOL

Directions: Place a check mark in front of elements that apply to your client. The decision of whether a client is at risk for falls is based on your nursing judgment.

Guidelines: A client who has a check mark in front of an element with an asterisk (*) or four or more of the other elements would be identified as at risk for falls.

Tool 1 Risk Assessment Tool For Falls

General Data:

___ Age over 60

___ History of falls before admission *****
___ Postoperative/admitted for operation
___ Smoker

Medications:

___ Diuretics or diuretic effects

✓ Hypotensive or CNS suppressants (e.g., narcotic, **sedative**, **psychotropic**, **hypnotic**, tranquilizer, **antihypertensive**, **antidepressant**)

Physical Condition

___ Dizziness/imbalance

___ Unsteady gait

___ Diseases/other problems affecting weight-bearing joints

___ Weakness

___ Paresis

___ Seizure disorders

Impairment of:

___ Vision

___ Hearing

___ Diarrhea

___ Urinary frequency

Ambulatory Devices Used:

___ Cane

___ Crutches

___ Walker

___ Wheelchair

___ Geriatric (geri) chair

___ Braces

Mental Status:

___ Confusion/disorientation *****

___ Impaired memory or judgment

___ Inability to understand or follow directions

Adapted from Brians LK and others: the development of the RISK tool for fall prevention, *Rehabil Nurs* 16 (2):67,1991.

BRADEN SCALE – For Predicting Pressure Sore Risk

HIGH RISK: Total Score ≤ 12 **MODERATE RISK:** Total Score 13 – 14
LOW RISK: Total Score 15 – 16 if under 75 years old OR 15 – 18 if over 75 years old

RISK FACTOR	SCORE/DESCRIPTION				DATE OF ASSESS.→ 1	2	3	4
SENSORY PERCEPTION Ability to respond Meaningfully to pressure-related discomfort	**1. COMPLETELY LIMITED –** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, **OR** Limited ability to feel pain over most of body surface.	**2. VERY LIMITED-** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, **OR** Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. SLIGHTLY LIMITED-** Responds to verbal commands but cannot always communicate discomfort or need to be turned, **OR** Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. NO IMPAIRMENT-** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				✓
MOISTURE Degree to which skin is exposed to moisture	**1. CONSTANTLY MOIST-** Skin is kept moist almost constantly by perspira-tion, urine, etc. Dampness is detected every time patient is moved or turned.	**2. OFTEN MOIST-** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. OCCASIONALLY MOIST –** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. RARELY MOIST-** Skin is usually dry; linen only requires changing at routine intervals.				✓
ACTIVITY Degree of physical activity	**1. BEDFAST –** Confined to bed.	**2. CHAIRFAST –** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. WALKS OCCASIONALLY-** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. WALKS FREQUENTLY-** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				✓
MOBILITY Ability to change and control body position	**1. COMPLETELY IMMOBILE-** Does not make even slight changes in body or extremity position without assistance.	**2. VERY LIMITED-** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. SLIGHTLY LIMITED –** Makes frequent though slight changes in body or extremity position independently.	**4. NO LIMITATIONS –** Makes major and frequent changes in position without assistance.				✓
NUTRITION Usual food intake pattern: [1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition	**1. VERY POOR –** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, **OR** Is NPO[1] and/or maintained on clear liquids of IV[2] for more than 5 days.	**2. PROBABLY INADEQUATE –** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, **OR** Receives less than optimum amount of liquid diet or tube feeding.	**3. ADEQUATE –** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, **OR** Is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. EXCELLENT-** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				✓
FRICTION AND SHEAR	**1. PROBLEM –** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. POTENTIAL PROBLEM –** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. NO APPARENT PROBLEM –** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.				✓	
TOTAL SCORE	**Total score of 18 or less represents PATIENT-AT-RISK**						2	3

ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS.	DATE	EVALUATOR SIGNATURE/TITLE
1	11/03/11	Chinweokwu Enekwechi (SN)	3	/ /	
2	/ /		4	/ /	

NAME – Last, First, Middle R. G. | **ATTENDING PHYSICIAN** | **ID NUMBER**

PSYCHOSOCIAL CULTURAL ASSESSMENT TOOL

1. Emotional State:

What is the patient's mood?

On the first day of assessment, Ms. G appeared depressed, and with general sadness (nothing in particular made her feel this way). She exhibited mild to moderate anxiety, manifested by fidgeting, finger tapping, and restlessness. Ms. G often isolated herself, and refused to join any groups that day. During the clinical interview, she only answered questions she was asked and did not initiate any conversation.

On the second day of care, Ms. G's mood improved. She was calm, happy, and excited with mild anxiety. She was more talkative, maintained eye contact for the most part, and sounded joyful. She initiated conversation. Ms. G stated that she was happy because her doctor informed her that she would be discharged the following week.

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2. Patient's Life Experience:

How have previous life experiences affected the patient's perception of the current health problems?

Ms. G perceives her health problems as sicknesses, including her schizoaffective disorder. She is aware of her disorder, but refers to it as schizophrenia. She is aware that medication is necessary to control the symptoms she experiences and she is compliant with her medication. Ms. G is also fully aware of her hypothyroidism, diabetes and hypertension, but does not really understand the medication she takes for diabetes. She also stated that she knows she is not supposed to eat certain foods, nor is she supposed to ask visitors for snacks, but she does so anyway.

How has life changed as a result of the current health problem?

As a result of her disorder, Ms. G has been in and out of psychiatric hospitals since she was "about 19 or 20 years old". She has not spent a long period of time at home in "about ten years." She has only held one job in her lifetime. Ms. G stated that she often checks herself into hospitals because she's lonely. She enjoys the activities she participates in and the people she meets in psychiatric hospitals. Ms. G is lonely, yet very withdrawn amongst a group of people. Ms. G has also never been in an intimate relationship and has no children. This suggests that her schizoaffective disorder has prevented her from maintaining friendships and other social, interpersonal relationships.

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3. Family:

What is the patient's and family's perception of the situation?

Ms. G's family is aware of her disorder and views it as a sickness. Her maternal grandmother is her caretaker. According to Ms. G, her grandma knows she is sick and calls her sometimes. She is also her payee for her SSI checks. Ms. G has an uncle with bipolar disorder and her mother was a substance abuser who died 9 years ago. Her family has experience with mental disorders. Ms. G says her father is in jail and does not speak to him at all.

How has family life changed?

Family life has been disrupted. Ms. G was unable to maintain friendships as a child and an adolescent. She stated that she used to hang out with her half-sisters Arielle and Nakiah, but she has not seen them since she's "gotten sick." She remains close to her grandmother but no longer associates with her father whom she met at 19. Ms. G told me numerous times that she does not like her father, but would not really explain why; she only stated that "he treated her bad." She has auditory hallucinations and mentioned that the voices she hears tell her bad things, and that one of the voices she hears is that of her father. This could be the reason for disliking her father. She may be associating the hurtful things that the voice tells her with her father.

How are family members coping?

Ms. G is not really aware of how her family is coping. She only speaks to her grandmother from time to time and does not keep in contact with the rest of the family. There is no information on how her family is coping.

Are family members supportive?

Ms. G is only in contact with her grandmother. This is her only psychosocial support system in her family. She mentions that her uncle and cousin live with her grandmother, but she is not in contact with them and they do not call or visit her. She is has not spoken to her half-sisters since she was an adolescent. The only supportive person in her family is her grandmother.

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4. Growth and Development:

What tasks are appropriate?

According to Erik Erikson's stages of development, the patient should be in the Adulthood stage. The developmental task of this stage is Generativity vs. Self-absorption. During this stage, an interest in nurturing subsequent generations creates a sense of caring, contributing, and generativity. The developmental task is to achieve life goals, and also to obtain concern and awareness for the future generations. If this task is not fulfilled, there is a lack of generativity, which leads to self-absorption and stagnation.

How has this health problem interfered with accomplishing tasks?

Ms. G has not accomplished this task. She is not in the appropriate developmental stage. She lacks interest in starting a family, having a career, and planning for her future. She does not anticipate caring for herself, stating that her grandmother will take care of her and that she does not know what she will do if her grandmother doesn't do so. All of these observations suggest that Ms. G's current developmental stage is School Age (6 to 12 years). She was unable to fulfill the developmental task of Industry vs. Inferiority. She is very child-like and even speaks in a child-like voice. She has a lack of self-confidence and relies on others, namely her grandmother to care for her. It is not clear if her fixation in this stage resulted from her mental disorder or her childhood experiences. It may be her childhood experiences because Ms. G's mother was a substance abuser and she has reported physical abuse in prior interviews, stating that her family "treated her bad." She now denies the abuse. It is unclear whether or not the abuse occurred, or if the abuse did occur and she is repressing the memories. The patient therefore never fulfilled the developmental tasks of adolescence or young adulthood. As a result, she has no secure sense of self. With no secure sense of self, she has been unable to establish intimacy with herself, with others, and with the opposite sex. Failure to achieve the expected level of interpersonal, academic, or occupational achievement is one of the characteristics of individuals with schizoaffective disorder in adolescence (Ms. G stated that she got sick at 19). This is due to the negative symptoms associated with the disorder, such as avolition and social withdrawal or isolation.

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5. Health Care Providers:

What is the patient/family current level of understanding?

The patient has a high school level of education. She currently understands her psychotic disorder. She understands that medication is necessary to control the symptoms she experiences and that she must be compliant to her medication regimen. She is aware that in order to remain out of the hospital, she must continue taking her medication after discharge. The family's level of understanding is unknown.

What type of relationship exists with health care providers?

She is cooperative with her health care providers but has an unjustified belief that her case worker does not like her; this may be due to misinterpretation of her case worker's speech or nonverbal communication.

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6. Self-Esteem and Body Image?

How is the patient's self-esteem threatened by this situation?

The patient's self esteem seems to already have been compromised during childhood. She does not have any self-confidence in her ability to care for herself. Her mental disorder further threatens her self-esteem. The negative symptoms of schizophrenia such as flat/blunted affect, anergia, and anhedonia, can lead to social isolation. Impaired hygiene and anxiety further reduce interaction and increase feelings of loneliness. Social isolation and loneliness can cause one to feel worthless, compromising one's self esteem. Also, there are stigmas attached to people with any psychotic disorder. This can worsen isolation. Acceptance from others is important in building self-esteem. During the interview on the second day of care, the patient informed me that she would be going home the following week. She stated that this made her feel "proud of herself." Compliance with medication and alleviation of symptoms associated with her disorder contribute to building a more positive perception of self as she sees herself making progress.

How is body image changed?

The patient never expressed feelings of shame concerning her body or perceived her body in a negative way. Ms. G also does not experience depersonalization. She is overweight, but she attends the exercise groups instead of attending music therapy. She has more of an issue with her self-esteem and self-confidence rather than her body image. It is her social withdrawal that has caused her self-esteem to be diminished, not her body image. Her chronic low self-esteem is more related to her lack of interpersonal relationships.

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7. Culture:

Ethnic Background?

The patient is African-American.

Which communication factors are relevant and why do you think so? (touch, personal space, eye contact, facial expressions, body language)

The relevant communication factors include eye contact, personal space, facial expressions, and body language. Touch is not so relevant because patients with psychotic disorders have a tendency to misinterpret things, including touch. However, when Ms. G extended her hand for a handshake, I followed through with it in order to prevent feelings of rejection in the patient that may further compromise her self-esteem. For African-Americans, handshakes are common in the beginning and end of an interaction.

For African-Americans, it is important to maintain eye contact during conversation; avoidance of eye contact may be interpreted as disinterest, lying, or deceitfulness. It is important to maintain a comfortable

amount of personal space between the patient and myself; not only because she is African-American but also because she often exhibits physical manifestations of anxiety during interviews. Sitting next to her is also more therapeutic that standing above her or sitting in front of her because this may cause her to feel interrogated. Facial expressions should be congruent to your words when speaking to an African-American patient. Body language should also be congruent to one's speech. African-Americans express their feelings in body language as well, so it is important to pay close attention and look for signs of boredom, anxiety, or anger.

Who is the dominant family member? What role does each of the family members play?

The dominant family member is the patient's grandmother. In African-American families, it is common for the dominant family member to be a matriarch. Ms. G's mother was alive and living with her during most of her life, but due to substance abuse, she was unable to care for Ms. G, thus her grandmother is the family's matriarch.

Who is responsible for care of a sick family member at home?

The grandmother is responsible for sick family members at home. In addition to raising and caring for the patient, the grandmother cares for Ms. G's uncle who suffers from bipolar disorder.

PSYCHIATRIC NURSING CARE PLAN

Using your handout "LEVELS OF ANXIETY" as a guide, identify your patient's anxiety level in the following areas and discuss your patient's behaviors, defense mechanisms, verbatim statements etc., which support the level you choose.

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1. **LEVEL OF ANXIETY OF YOUR PATIENT:** Mild to moderate
2. **SUPPORTIVE DATA:** Patient changed positions several times and exhibited mild tension-relieving behaviors such as fidgeting and finger tapping. There were no somatic complaints, voice tremors, difficulty concentrating, or any other signs of an escalation beyond moderate anxiety. The level of anxiety Ms. G exhibited is normal for any person interacting with a stranger for the first time.

AWARENESS: The patient is fully aware of her environment. She is alert and oriented to person, place, and time. She had a slightly heightened perceptual field, observing me closely in the beginning of the interview from head to toe. The patient is also fully aware of her disorder, the symptoms, her auditory hallucinations, and her medications/treatment.

FOCUS: The patient was focused for the majority of the interview. She stopped speaking mid-sentence a couple of times and would occasionally look towards the door.

BEHAVIOR: The patient was calm and quiet on the first day of care and often seemed depressed. She was withdrawn and made very little eye contact with me. On the second day, she was more joyful and excited. She made much more eye contact, seemed more alert and focused, and showed less physical manifestations of anxiety.

RECEPTIVENESS: The patient was very receptive to me and to the conversation. She did not show disinterest and she was eager to express herself. She did not demonstrate selective inattention.

PHYSIOLOGICAL MANIFESTATIONS: The physiological manifestations of mild anxiety expressed by the patient are: Frequent postural/positional changes, finger tapping, fidgeting, slight restlessness, and slight discomfort.

3. **NAME FOUR NURSING INTERVENTIONS THAT ARE APPROPRIATE FOR A PATIENT IN THIS LEVEL OF ANXIETY**
   - **a.** Help the patient identify anxiety by asking questions such as "Are you comfortable right now?"
     (Rationale: It is important to validate observations with the patient, name the anxiety, and start to work with the patient to lower anxiety.)
   - **b.** Use nonverbal language to demonstrate interest, such as maintaining eye contact, leaning forward, and nodding your head as appropriate to the patient's culture.
     (Rationale: Verbal and nonverbal language should be consistent. The presence of an interested person provides a stabilizing focus.)
   - **c.** Encourage the patient to talk about her feelings and concerns.
     (Rationale: When concerns are stated out loud, problems can be discussed and feelings of isolation are decreased.)
   - **d.** Provide a safe, calm environment by decreasing environmental stimuli, and listening and reassuring the patient that she can feel more in control.
     (Rationale: Being heard in an atmosphere of calm helps to foster a sense of connectedness with someone and control over what will happen.)

BEHAVIOR TO BE OBSERVED	CHECK APPROPRIATE BEHAVIORS		DESCRIBE SPECIFIC BEHAVIOR OBSERVED
APPEARANCE PERSONAL HYGIENE	☐ CLEAN ☐ BODY ODOR ☐ REQUIRES HELP	☒ DIRTY ☒ BATHES SELF	The patient bathes herself but she does not bathe often. However, she had no body odor. Her clothing was ridden with food stains. Instead of combing her hair, she tied a T-shirt around her head. The patient stated that she had a wig, but she threw it out "for no reason."
DRESS	☒ APPROPRIATE ☐ NEAT ☐ REQUIRES HELP IN DRESSING	☐ INAPPROPRIATE ☒ UNKEPT ☐ DRESSES SELF	
GENERAL BEHAVIOR	☒ QUIET ☐ OVERACTIVE ☒ DEPRESSED ☐ VERBALLY AGGRESSIVE ☐ PHYSICALLY AGGRESSIVE ☐ BITES NAILS ☐ MASTURBATES ☐ IN STAFF ☐ EXPRESS SUICIDAL IMPULSES ☐ HOMICIDAL IMPULSES ☐ SHOWS FEAR OF OTHERS ☐ LABILE	☐ LOUD ☐ ANGRY ☐ SULLEN ☐ LISTLESS ☒ ANXIOUS ☐ PACING ☐ OBSCENE LANG. ☐ SEXUALLY INTERESTED ☐ OTHER PATIENTS ☒ WITHDRAWN ☐ EUPHORIC ☐ SAD ☐ EXITABLE	During the initial assessment, the patient was anxious, spoke quietly, and seemed very depressed overall (during the second assessment, she confirmed that she was "feeling depressed"). While on the rooftop, when a group of patients gathered to have conversation, she would stray from the group and sit by herself. On the second day of care, the patient expressed that she was no longer feeling depressed; however, she still exhibited some signs of mild anxiety such as frequent position changes and fidgeting. She was more joyful and stated that she was happy because the doctor informed her that she would be discharged the following week.
BODY BEHAVIOR	☒ STARING INTO SPACE ☐ MOVEMENTS ☐ MOVEMENTS (TICS) ☐ OBVIOUSLY TENSE ☒ SLUMPS WHEN SITTING ☐ GOOD GENERAL POSTURE ☒ COORDINATED MOTOR BEHAVIOR ☐ STAGGERS	☐ RIGID STIFF ☐ JERKING SPASTIC ☐ FALL ☐ HOLDS ONE POSITION ☐	While speaking, the patient would often stare into space and make very little eye contact. The only time she made eye contact was when she spoke about her desire to travel to Europe. During the second assessment, the patient made eye contact during the majority of the interview. She sat slumped on both days of care.
VERBAL BEHAVIOR **SPEECH**	☒ SLOW ☐ RAMBLING ☐ TALKS TO SELF ☒ REPEATS WORDS/ PHRASES OVER & OVER ☐ LOGORRHEA ☐ NOT AT ALL	☐ RAPID ☐ SLURRED ☐ UNINTELLIGIBLE ☐ TALKS VERY LITTLE	The patient speaks in a child-like voice and responds slowly. She repeats words and phrases over and over. Her responses are appropriate and relevant, but her level of speech is very child-like, as well as her voice.

THOUGHT PROCESSES **ANSWERS TO QUESTIONS:**	☒ **RELEVANT** ☐ **RAMBLING** ☐ **INCHOHERENT**		Ms. G's answers to questions are relevant. Her speech is clear and appropriate.
THOUGHT PROCESSES	**HEARS VOICES:** ☒ **THREATENING** ☐ **DELUSIONS** ☐ **PERSECUTION** ☐ **DEVINE MISSION** ☒ **ABLE TO RECOGNIZE STAFF** **SHORT TERM MEMORY:** ☒ **GOOD** ☐ **POOR** ☐ **FORGETS WHO HE/SHE IS**	☐ **ORDERING** ☐ **IDEAS OF REFERENCE** ☐ **DELUSIONS OF GRANDEUR** ☐ **UNUSUAL POWERS** ☒ **ACCUSING** ☐ **OTHER PATIENTS** ☐ **BAD**	Ms. G stated that she hears threatening voices, one of them being the voice of her father whom she is not fond of. According to her, she heard voices for the first time at "about age 19 or 20 when she got sick." She can recognize the voices of the staff and has very good short term memory. Ms. G accuses people of not liking her, namely her father and her caseworker. When asked why she believes that they do not like her, she responded "I don't know."
INTERPERSONAL RELATIONSHIPS	☐ **SEEKS CONTACT** **PROVOKES FEELINGS OF:** ☐ **ANGER** ☒ **EMPATHY** ☐ **OTHER**	☒ **AVOIDS CONTACT** ☒ **ANXIETY** ☐ **FEAR** ☐ **FRUSTRATION** ☐ **HOPELESSNESS**	The patient appears to have little ability in maintaining interpersonal relationships. On the second day of care, she stated several times that she "lies to get into the hospital" so that she is "not by herself." Yet, while observing her amongst the other patients, she often isolated herself. She is very withdrawn and avoids eye contact. When in a large group of people, she quickly walks away and sits by herself, usually in a corner and with a magazine.
YOUR FEELING WHILE WORKING WITH THIS PATIENT	**DO YOU TEND TO FEEL** ☐ **CONFUSED** ☐ **FRUSTRATED** ☐ **HOPELESS** ☐ **DEPRESSED** ☐ **STRONG FEELINGS** ☐ **OTHER**	☒ **UNCOMFORTABLE** ☒ **SYMPATHETIC** ☐ **ANGRY** ☐ **BORED**	The interviews with the patient were free of disruptions or acting out. When the patient discussed her family, especially her father, sadness would come upon here, followed by long silences. This made me uncomfortable until the silence was over. It also made me sympathetic because of personal experiences; however, since I was aware of these feelings, I was able to avoid countertransferance in my interactions with the patient.

RECORD THE VERBAL AND NON-VERBAL INTERACTION THAT TOOK PLACE BETWEEN YOU AND THE CLIENT	**YOUR THOUGHTS**	**YOUR FEELINGS**	**STATE IF THERAPEUTIC OR NON-THERAPEUTIC NAME THE TECHNIQUE AND IF NON-THERAPEUTIC REWRITE WHAT COULD BE DONE/SAID INSTEAD**
Reshimah: Hi, I'm Reshimah *(patient extends hand for handshake)*.	I should shake the patient's hand so that she doesn't feel rejected.	I'm scared and anxious to touch the patient because I don't yet know her diagnosis and she may be paranoid.	**Therapeutic:** Self-awareness of my anxiety.
CE: *(extending my hand to shake the patient's)* Hi, Reshimah. My name is Chinweokwu. I'm a student nurse at the Borough of Manhattan Community College, and I am here doing my clinical rotation. I'll be your nurse for the next four Thursdays if you are still here.	I hope the patient will be able to trust me.	I'm nervous about the orientation phase because I'm not sure of how the patient will receive me.	**Therapeutic:** Giving recognition, giving information.
Reshimah: *(smiling, nodding her head, and looking down)* Okay.	I notice that she does not make eye contact.	The lack of eye contact makes me a bit uncomfortable but I understand that it is a characteristic of some mental illnesses.	
CE: How would you like for me to address you?	Asking the patient how to address her will facilitate the therapeutic relationship.	I want the patient to feel respected.	**Therapeutic:** Conveying respect, giving patient direct control.
Reshimah: Reshimah is fine.			
CE: Okay, let's have a seat and talk.	I should find a quiet spot to sit down.	I want the patient to feel secure during the interview because speaking with a stranger has the potential to elevate her anxiety level.	**Therapeutic:** Establishing setting that enhances feelings of security. **Therapeutic:** Offering self.
Reshimah: Okay *(patient and I walk to the community room and sit down next to each other).*	Sitting down next to each other, rather than in front of each other is more therapeutic.	I'm a little nervous about sitting this close to the patient.	**Therapeutic:** Establishing setting that enhances feelings of security.
CE: Reshimah, for the next four Thursdays, I will come and get you from your room and we can attend the community meetings together. After medications, we can meet in the community room again and discuss your feelings and your progress. Is that okay?	Consistency of approach is important.	I want to be consistent with the patient so that she will trust me.	**Therapeutic:** Establishing a verbal contract.

Reshimah: Yes, that's fine.			
CE: I also want to let you know that I may discuss some of what we talk about with my clinical instructor, my peers, and the staff is necessary. Is that okay with you?	It is important to let her know that some of what we discuss may be shared with others.	I hope that telling her this will not thwart my efforts to build a therapeutic relationship with the patient.	**Therapeutic:** Confidentiality.
Reshimah: Umm, yes, that's okay. *(Looking at my head)* You have very pretty hair. Is it all yours?	The pt. is trying to divert attention away from herself.	I'm not sure how I can redirect conversation to focus on her without seeming rude.	
CE: Thank you, Reshimah, but this time is for you and we should focus on you.	I will allow the pt. to take the lead while diverting the focus back to her.	I hope the pt. responds well to me.	**Therapeutic:** Refocus attention.
Reshimah: You're welcome. I used to wear a wig. *(Looking at my ID)* That's a pretty name. Are you African?	The pt. is still trying to place the focus of the conversation on me.	I need to find another way to divert the attention back to her because I don't want this to become a social relationship.	
CE: Yes, I am. What is your ethnic background?	Asking the patient the same question she asked me should be effective.	I am trying to redirect the interaction to focus on the patient again.	**Therapeutic:** Refocus attention, exploring.
Reshimah: I'm just African-American.	She did not ask me another question about herself.	I can continue to facilitate this relationship and learn more about my patient.	
CE: Oh, where is your family from?	Learning more about the patient's family will help me with my assessment.		**Therapeutic:** Exploring.
Reshimah: My mother's side of the family is from North Carolina. I'm from New Brunswick, New Jersey. You ever heard of New Brunswick? You never been to Jersey? I'm from Jersey.	I wonder why she asks several questions at one time without allowing me time to respond.	I don't want to ignore the patient's questions; however I also don't want to answer them because that would make this a social relationship.	**Therapeutic:** Prevent role switching.

CE: Oh okay, interesting. How do you like New Brunswick?	I am allowing the pt. to take the lead by asking questions related to her responses.		**Therapeutic:** Exploring.
Reshimah: Umm, I like it a lot. I like the movies, and the pizza shops and … *(stops mid-sentence and stares into space, then opens her mouth as if she wants to speak again but does not speak).*	I should allow the patient some time to gather her thoughts.	I wonder if the pt. needed time to gather her thoughts or if she was hearing voices.	
CE: *(Nodding)* Go on.	I don't want to use platitudes, so I will offer a general lead.	The period of silence makes me uncomfortable.	**Therapeutic:** Offering general leads.
Reshimah: Yeah, I like the pizza shops and the movies. *(The patient continued to stare into space for the majority of the discussion.)*	I wonder what caused her to suddenly start staring into space.		
CE: Oh okay. What other things did you like to do in New Brunswick?	I need to find out how what life was like for her outside of the hospital.		**Therapeutic:** Exploring.
Reshimah: I liked reading, and going on the YouTube. I like the YouTube. *(Makes eye contact)* I like music. I like to listen to music.	I notice that when the pt. is discussing her hobbies, she makes eye contact.		**Therapeutic:** Making observations.
CE: Okay, so tell me about how you got to New York. **Reshimah:** Well, I ran away from home. I lived in New Brunswick. You know New Brunswick?	Why did she run away from home?	Whatever made her run away from home must have been really bad.	**Therapeutic:** Exploring.
CE: I've never been there before but I know about it. But go on.	She is asking me about myself again, so I have to refocus her once again.	I am more comfortable with helping the pt. to focus now.	**Therapeutic:** Focusing, offering general leads.
Reshimah: Yeah, so I ran away from home and I got on a bus. And I came here.			
CE: Oh, you ran away from home.	I still need to find out why she ran away but I will allow her to pace this interaction.	I want to acknowledge what the patient has just told me.	**Therapeutic:** Restating.
Reshimah: Yes. I didn't like it there.	I wonder what happened to her at home.		**Therapeutic:** Exploring.

CE: What didn't you like about it?	I am suspecting abuse, so I need to explore further.		**Therapeutic:** Exploring, seeking clarification.
Reshimah: I didn't like it there. My family was mean to me and they treated me bad *(looks down).*	I want her to tell me details about her relationship with her family.	I feel so bad for her. How can her family be mean to her knowing that she has a mental illness? Do they know?	
CE: What were some of the things they did to you?	Maybe she cannot remember what they did in particular.	I don't want to make her uncomfortable but this question is necessary for my assessment.	**Therapeutic:** Exploring.
Reshimah: They were just mean to me. They treated me bad.	She is looking down, she is sad.	Whatever happened to her might be so traumatic that she has repressed the memory.	
CE: I see. Did anyone in particular treat you badly?	That's odd.	It seems odd that she knows she was treated badly by her family, but does not know who in particular treated her badly.	**Therapeutic:** Accepting, encouraging description of perception.
Reshimah: No. *(Still looking down).*			
CE: You seem sad, Reshimah. Do you miss your family?			**Therapeutic:** Making observations.
Reshimah: No. I don't really miss them. I kind of miss my grandmother. My mom… she died 9 years ago. She was on drugs. My father… I don't really like him. I met him when I was about 19. And my sisters… I'm the only child by my mom. My sisters from my father's side, I miss them.	She is opening up to me now.	I think she is starting to trust me more.	
CE: When was the last time you saw your family?	Her family dynamic seems unstable & dysfunctional.		**Therapeutic:** Placing the events in time or sequence.
Reshimah: Umm, I think a couple months ago.	Wow, her family has not seen her for months. That is a long time.	She must feel lonely.	
CE: Do you speak to them often?			**Therapeutic:** Exploring.
Reshimah: No. Well my grandmother… *(pauses)*… She calls me sometimes… That's about it.	I think her grandmother is her main support system.	Her parents' have substance abuse issues must have really affected their relationship.	

CE: And how does that make you feel?	Being in the hospital & not hearing from her family often must be very upsetting.	I am beginning to sympathize with her but became aware of this to prevent countertransference.	**Therapeutic:** Encouraging evaluation.
Reshimah: Umm, I don't really feel anything *(starts fidgeting more).*	I think she is getting anxious.	I hope I haven't made her uncomfortable. Maybe I should change the subject.	
CE: I see. So Reshimah, you mentioned that you don't like your father. Tell me more about that.	I ask her about something else because the previous topic was making her anxious.	This should be a good topic change because we're still on the subject of her family.	**Therapeutic:** Summarizing, exploring.
Reshimah: Well I met him when I was 19. My mom introduced me to him. And then I met my half-sisters. Umm, I don't speak to him. He lives in Jersey too *(moving her fingers around)*. *(Long pause)*	I see now that her anxiety level is increasing due to an increase in physical manifestations (e.g. fidgeting).	At this point I think it will be better to talk about something other than her family because I am also getting a little anxious.	
CE: So Reshimah, I told you earlier that I'm going to be with you for the next four Thursdays. I would like to get to know you in this time. Tell me everything you think I need to know about you.	I hope this effort to keep her anxiety level from escalating further will work.		**Therapeutic:** Offering general leads.
Reshimah: *(Smiling)* Well I'm 33 years old. I'm from Jersey. I like to watch movies and listen to music. I like to go to church.	She's already told me these things.	It's a little frustrating that she repeats the same things.	
CE: What is your religion?			**Therapeutic:** Exploring.
Reshimah: I'm Baptist. I want to go to Europe. Maybe London. *(Makes eye contact)* Do you think they have schools in London?	She switched subjects very quickly.		
CE: Yes, there are schools in London. Are you interested in going to school?	I am interested in knowing if she has any plans.		**Therapeutic:** Verbalizing the implied.
Reshimah: No… Well yes. Maybe to be a medical assistant or a nurse's assistant *(giggling)*.	She is giggling, so I cannot tell if she's serious about this.	I don't believe that it will be possible for her to be a medical or nurses' assistant. I don't want to give her false reassurance nor do I want to make her feel like she can't do anything with her life.	
CE: Oh, I see, I see. Have you ever had a job before?			**Therapeutic:** Accepting, exploring.

Reshimah: One time, when I was about 20. I worked in the factory. That was the only job I had.	She is 33 and has only worked one job, wow.	Maybe she has been unable to hold a job due to the mental illness	
CE: Oh, okay. Continue to tell me more about yourself.			**Therapeutic:** Offering general leads.
Reshimah: I went to New Brunswick high school.	Her long-term memory seems to be intact.		
CE: Can you describe your high school experience?	I noticed that when I asked her to go into detail about her family, her anxiety increased. I hope this question does not also increase her anxiety.		**Therapeutic:** Exploring.
Reshimah: Umm, it was okay… It was okay.	She gave me a very short worded answer.	Maybe I did not phrase my question properly.	
CE: Yeah? Tell me more about it.			**Therapeutic:** Exploring.
Reshimah: Well I went to high school in New Brunswick. It was okay. I didn't have too many friends.	Now I see why she just said "it was okay." Her high school experience must not have been the best.	Mental illnesses can impair social interactions. I sympathize with her.	
CE: How did that make you feel?	I can only imagine how she felt as an adolescent without many friends.		**Therapeutic:** Exploring.
Reshimah: Umm, I didn't really feel anything. Just a little lonely. I got sick in high school.	She says she didn't feel anything, yet she felt lonely.	Maybe the pt. is confused about how to translate her feelings.	
CE: What did you have?			
Reshimah: The doctor told me schizophrenia.	I had no idea that she was referring to her mental illness when she said she got sick.	I now see that the pt. refers to her illness as a sickness.	
CE: Oh, and how old were you when the doctor told you this?			**Therapeutic:** Placing events in time or sequence.
Reshimah: I was about… *(Pauses and straight ahead)* 19 or 20.	She was diagnosed with schizophrenia at 19 or 20? But she said this was in highschool.	She must have been held back in school before to be 19 in high school. This must be embarrassing for her, so I rather not ask.	

CE: Did you go to a psychiatric hospital?	I just asked a closed-ended question, which is non-therapeutic.	How can I ask about the voices? I hope she trusts me enough to tell me the truth.	**Nontherapeutic:** closed-ended question; **More therapeutic:** Tell me what happened after you went to the doctor.
Reshimah: Yeah, I went to a hospital in Secaucus. And they told me I have schizophrenia.	She has schizophrenia. I wonder if she is hearing voices whenever there is a break or a pause in her speech.	This must have been so traumatizing for her.	
CE: What kind of symptoms did you have?			**Therapeutic:** Exploring.
Reshimah: Well I would hear voices, and I tried to kill myself.	Do the voices tell her to kill herself? I want to know details about the voices.	I'm not sure if I believe that her family treated her badly anymore.	
CE: What kind of voices would you hear? Tell me about them.			**Therapeutic:** Encouraging description of perception.
Reshimah: Bad voices. They would tell me bad things. One of them sounded like my father.	This may be the reason why she dislikes her father.		
CE: That must be very upsetting for you.	Acknowledging her feelings will let her know that I am listening to her.		**Therapeutic:** Attempting to translate into feelings.
Reshimah: … Yeah… *(pauses and looks down)*.	I don't want to increase her anxiety again.		
CE: Is it the voices that made you try to hurt yourself?	I need to know why she attempted suicide.		**Nontherapeutic:** Probing. **More therapeutic:** What kinds of things would the voices tell you?
Reshimah: Umm… No, I think I was just depressed.	It seems that depression is the major issue here and not hallucinations.		
CE: Oh okay, are you still feeling depressed?		We might be able to engage in an activity if she's bored.	**Therapeutic:** Attempting to translate into feelings.
Reshimah: A little.			
CE: Reshimah, I notice that you keep looking towards the door. Is there somewhere you would like to go?	She continues to look towards the door, so maybe she is getting bored.		**Therapeutic:** Verbalizing the implied.
Reshimah: No, I just wanted to see… *(trails off and doesn't complete sentence).*	Could she have been seeing a visual hallucination? This is not common with schizophrenics.		

CE: Are you comfortable?	I just want to make sure she is not getting anxious again.	I feel bad whenever I ask her questions that make her uncomfortable.	**Therapeutic:** Attempting to translate into feelings.
Reshimah: Yes.			
CE: Okay. Earlier you mentioned that you ran away from home and came to New York. Tell me more about that.	I need to know why she was admitted now.		**Therapeutic:** Focusing, exploring.
Reshimah: I ran away. I was going to the hospital in Secaucus but I came to New York. I travel a lot. I've been to San Francisco… *(pauses)* … San Francisco… Chicago… San Francisco…	Why was she going to a hospital?	I wonder if she's telling the truth.	
	I have allowed the patient to avoid telling me about how she was admitted.	I'm afraid of making her feel like I am interrogating her.	**Nontherapeutic:** Changing the subject. **More therapeutic:** Restating that she was going to a hospital in Secaucus to refocus her.
CE: Oh, interesting. What was San Francisco like?	I'm curious to see if she is lying about going to San Francisco. Maybe she is delusional.		
Reshimah: *(smiling, makes eye contact)* It was nice. It was warm. But I came to New York. I got on a bus and I was in Times Square.	Oh, thank goodness she refocused herself. .	She is smiling & making eye contact. I notice that she prefers not to talk about her life, history, or admittance to the hospital, but I need this information.	
CE: *(nodding)* Oh okay, so how did you get here [to Bellevue]?	She must have been admitted for suicidal ideation.	I wonder if she was hearing voices that made her want to kill herself.	**Therapeutic:** Exploring.
Reshimah: I was in Times Square. & I told a cop that I felt like killing myself. So he called a ambulance and the ambulance brought me.		I can't believe that she actually told a cop she was thinking of hurting herself, rather than actually doing it.	
CE: Oh, the cop called an ambulance and they brought you here to Bellevue.	I want to know if this is the cause for her most recent admission, but I should have clarified the reason why she wanted to kill herself first.		**Therapeutic:** Placing events in time or sequence. Restating.
Reshimah: Yeah, 'cause I told him that I wanted to kill myself.			

CE: When did this happen? **Reshimah:** Ummm… two months ago. **CE:** I see; so you've been here since September. **Reshimah:** Yes, I got here in September. It's okay here. **CE:** Okay Reshimah, it is 12 o'clock so my classmates and I have to go to lunch now. You'll be getting your lunch soon as well. I'll be at lunch from 12 to 1. At 2 o'clock, I'll come and get you from you're room and we will attend the music group together. Is that okay? **Reshimah:** *(smiling)* Yes, that's fine. **CE:** Okay Reshimah, I'll be back for you at 2 o'clock.	I have to make sure that I am back at 2 o'clock to establish rapport with the pt.	This is a long time to be in the hospital.	**<u>Nontherapeutic:</u>** Minimizing the patient's feelings. **<u>More therapeutic:</u>** What made you want to kill yourself? **<u>Therapeutic:</u>** Giving information.

BOROUGH OF MANHATTAN COMMUNITY COLLEGE
Department of Nursing

CONCEPT MAP: Psychiatric Mental Health Nursing

STUDENTS NAME: Chinweokwu Enekwechi

SEMESTER/ TERM/ YEAR: Fall '11

CLINICAL INSTRUCTOR: Prof. Braga

PATIENTS INITIAL: R.G.

1) Risk for suicide R/T command auditory hallucinations.
- Patient verbalized that she hears voices that tell her to do "bad things."
- Patient has attempted suicide three times.
- Patient has low self-esteem and feelings of loneliness.
- Possible abuse in childhood.

2) Social isolation R/T self-concept disturbance AEB dysfunctional and lack of interaction with peers.
- Socially withdrawn; often removes herself from her peers.
- Refuses to attend groups, such as music therapy.
- "I don't really have many friends here. I talk to Michelle. She prays a lot.
- Tendency to feel like a person does not like her without explanation.

3) Disturbed sensory perception: Auditory.
- Patient verbalized that she hears voices; one of them being the voice of her dad.
- Patient occasionally stops speaking mid-sentence and appears to be listening to something else.

4) Chronic low self-esteem R/T possible physical abuse & command auditory hallucinations
- Possible physical or sexual abuse.
- Patient avoids social interactions, interactions with other patients.
- Patient's family is dysfunctional.
- Patient verbalized that her family "treated her badly."

REASON (S) FOR SEEKING HEALTH CARE
Suicide ideation x3 months
Medical Diagnoses:
Schizoaffective disorder—Bipolar type, DM, Htn, obesity, hyperlipidemia, hypothyroidism.

5) Risk for loneliness R/T Impaired social interactions.
- Patient verbalized that she does not have many friends. She has one friend, Michelle, on the unit.
- Patient verbalized feelings of loneliness.
- "Sometimes I check myself in to a hospital so I don't feel lonely.

6) Ineffective family coping R/T distant and unsupportive family members.
- Patient says she ran away from home because they treated her badly.
- Patient's only support system is her elderly grandmother.
- Patient is disconnected from all family members other than her

7) Self-care deficit: Grooming, dressing.
- Patient ties an old T-Shirt around her head instead of combing her hair.
- Patient showers but puts back on dirty clothing AEB clothing with nonpermanent food stains.

EVALUATION OF PATIENT RESPONSES

Problem #1: Risk for suicide related to command auditory hallucinations, and depression, and low-self esteem as evidenced by verbal acknowledgment of hallucinations and suicide ideation.

General Goal: The patient will name two people she can call if thoughts of suicide recur after discharge.

Behavioral Outcome: The pt. will remain safe while in the hospital with the aid of nursing interventions & support on the day of care.

Nursing Interventions/*Rationale*	Patient Responses (Evaluation)
1. Follow unit protocol for suicide regarding creating a safe environment for the patient. This measure may include taking away potential weapons—belts, sharp objects, etc. *(Rationale: Provide a safe environment because self-destructive acts are perceived as the only way out of an intolerable situation)*	**1.** The patient did not harm herself.
2. Encourage patient to talk freely about feelings and help plan alternative ways of handling intense emotions. *(Rationale: Gives patient alternative ways of deal with overwhelming emotions and gaining a sense of control over their lives)*	**2.** The patient verbalized feelings of loneliness and depression.
3. If anxiety is high, or patient has not slept in days, a tranquilizer might be prescribed. *(Rationale: Relief of anxiety and restoration of sleep loss can help patient thinking more clearly and might help restore some sense of well-being)*	**3.** The patient is complaint with Trazodone hydrochloride 150 mg tab po prn administration. Patient's anxiety level is reduced.
4. Encourage patient to avoid decisions during the time of crisis until alternatives can be considered. *(Rationale: During crisis situations, people are unable to think clearly or evaluate their options)*	**4.** The patient verbalized that she understands that she should not make decisions when in a time of crisis. The patient verbalized that she should alert someone when she has self-destructive impulses.
5. Put on suicide observation (15-minute visual check of mood, behavior, and verbatim statements). *(Rationale: Protection and preservation of patient's life)*	**5.** The patient did not display any signs or behaviors of suicide ideation.

Summarize impressions (observations) of patient's progress toward outcomes: The patient is compliant with all the nursing interventions. She does not express suicide ideation, and her anxiety was successfully controlled. The patient met the goal for the day.

References: Varacolis, E. (2011). *Manual of Psychiatric Nursing Care Planning* (4th Ed.) (pp.484-486). New York, NY: Saunders Elsevier.

EVALUATION OF PATIENT RESPONSES

Problem #2: Social isolation related to self-concept disturbance as evidenced by dysfunctional and lack of interaction with peers, discomfort in social situations, and poor self-confidence in own abilities.

General Goal: The patient will demonstrate the ability to interact with family, friends, and the community; and will participate in social activities by discharge.

Behavioral Outcome: The patient will participate in one activity with the nurse, by the end of the day.

Nursing Interventions/*Rationale*	**Patient Responses (Evaluation)**
1. Assess whether medication has reached therapeutic levels. *(Rationale: Many of the positive symptoms of the disorder will subside with meds, which will facilitate interactions)*	**1.** The patient verbalizes that she is no longer depressed and she is not currently hearing voices (auditory hallucinations).
2. Keep the patient in an environment as free of stimuli as possible. *(Rationale: Patient might respond to noises and crowding with agitation, anxiety, and increased inability to concentrate on outside events)*	**2.** The patient remains calm in the community room and does not exhibit any signs of escalating anxiety.
3. Avoid touching the patient. *(Rationale: Touch can be misinterpreted as a sexual or threatening gesture)*	**3.** The patient extends her hand for a handshake and does not feel rejected when the handshake is followed through with. No additional touch occurs & the patient remains calm and comfortable in the presence of the nurse.
4. Structure activities that work at the patient's pace and ability. *(Rationale: Patients can lose interest in activities that are too ambitious, which can increase a sense of failure)*	**4.** The patient refused to attend music therapy.
5. Try to incorporate the strengths and interests the patient had when not as impaired into the activities planned. *(Rationale: Increases likelihood of the patient's participation and enjoyment)*	**5.** The patient refused the nurse's suggestions and decided to go exercise by herself.

Summarize impressions (observations) of patient's progress toward outcomes: The patient remained calm and comfortable when alone with the nurse, but refused to attend social interactions with the nurse such as music therapy. The patient did not fulfill this goal for the day.

References: Varacolis, E. (2011). *Manual of Psychiatric Nursing Care Planning* (4th Ed.) (pp.228-229). New York, NY: Saunders Elsevier.

EVALUATION OF PATIENT RESPONSES

Problem #3: Disturbed sensory perception: auditory, command hallucinations.

General Goal: The patient will learn ways to refrain from responding to hallucinations, state that the voices are no longer threatening, and be able to maintain role performance by discharge.

Behavioral Outcome: The patient will demonstrate one stress-reduction technique on the day of care.

Nursing Interventions/*Rationale*	Patient Responses (Evaluation)
1. If voices are telling the patient to harm self or others, take necessary environmental precautions. *(Rationale: People often obey hallucinatory commands to kill self or others. Early assessment and intervention might save lives)*	**1.** The patient was admitted for suicidal ideation and has admitted to having command auditory hallucinations. This has been documented. The patient denies currently hearing voices.
2. Decrease environmental stimuli when possible. *(Rationale: Decrease potential for anxiety that may trigger hallucinations. Helps calm patient)*	**2.** When there is a crisis, the patient and I continue our interaction in a quiet area, such as the day room, with the doors closed. The patient's anxiety level did not increase.
3. Accept the fact that the voices are real to the patient, but explain that you do not hear the voices. Refer to the voices are "your voices" or "the voices that you hear." *(Rationale: Validating that your reality does not include voices can help patient cast doubt on the validity of her voices)*	**3.** When interacting with the patient, I refer to her voices as "the voices you hear." She associates one of them with her father, and her anxiety level increases. I ask the patient another question to prevent her anxiety level from increasing further.
4. Explore how the hallucinations are experienced by the patient. *(Rationale: Exploring the hallucination and sharing the experience can help give the person a sense of power that he or she might be able to manage the hallucinatory voices)*	**4.** The patient verbalized agreement that the voices are very upsetting for her.
5. Be alert for signs of increasing fear, anxiety, or agitation. *(Rationale: Might herald hallucinatory activity, which can be very frightening to patient, and patient might act of command hallucinations)*	**5.** When I notice the patient's anxiety level rising, I move the patient to a more calming environment or refocus her onto a less anxiety triggering topic during our interactions. The patient responds positively to these interventions by not exhibiting signs of increasing anxiety.

Summarize impressions (observations) of patient's progress toward outcomes: The patient verbalized that she hears command auditory hallucinations. She responds well to decreased stimuli in the environment. Efforts aimed toward preventing her anxiety level from increasing were successful. The pt. is still unable to identify triggering events to her hallucinations, but denies currently experiencing any hallucinations.

References: Varacolis, E. (2011). *Manual of Psychiatric Nursing Care Planning* (4th Ed.) (pp.232-235). New York, NY: Saunders Elsevier.

EVALUATION OF PATIENT RESPONSES

Problem #4: Chronic low self-esteem related to possible physical or sexual abuse, and auditory hallucinations.

General Goal: The patient will demonstrate the ability to reframe negative self-thoughts into more realistic appraisals by discharge.

Behavioral Outcome: The patient will identify one skill he or she will work on to meet future goals by the end of the day.

Nursing Interventions/*Rationale*	Patient Responses (Evaluation)
1. Maintain a neutral, calm, and respectful manner. *(Rationale: Helps patient see herself as respected as a person)*	**1.** The patient responds positively to my use of calm mannerisms. She is receptive of me.
2. Assess with patients their self-perception. Identify with patient realistic areas of strength and weakness. *(Rationale: Patient and nurse can then work on the realities of the self appraisal & target those areas of assessment that do not appear accurate)*	**2.** The patient verbalized the fact that she did not have many friends growing up, that the voices she hears tell her "bad things," and that her family treated her "badly."
3. Focus questions in a positive and active light; helps pt. refocus on the present and look to the futue. *(Rationale: Allows pt. to look at past behaviors differently, and gives pt. a sense that she has choices in the future)*	**3.** The patient responded well to positively framed questions about the future. She remained uncomfortable while talking about the past and her anxiety level increased. .
4. Set goals realistically, and renegotiate goals frequently. Remember that patient's negative self-view took years to develop. *(Rationale: Unrealistic goals can set up hopelessness in patients and frustration in nurses)*	**4.** The patient agreed to attend music therapy at first. This would have facilitated her social interaction skills. However, whenever it was time to go, she changed her mind.
5. Discuss with patient plans for the future. *(Rationale: Looking toward the future minimizes dwelling on the past and negative self-rumination)*	**5.** The patient has realistic plans for the future, but relapsed to unrealistic, delusional plans after a crisis involving her grandmother.

Summarize impressions (observations) of patient's progress toward outcomes: The patient was able to identify possible reasons for her low self-esteem. Before we could discuss her strengths, she relapsed as a result of a crisis. She reverted to making unrealistic goals for the future. The patient never attempted to interact with her fellow patients in group activities, nor did she want to participate in any activities with me.

References: Varacolis, E. (2011). *Manual of Psychiatric Nursing Care Planning* (4th Ed.) (pp.284-287). New York, NY: Saunders Elsevier.

BOROUGH OF MANHATTAN COMMUNITY COLLEGE
Department of Nursing

METHOD DAILY TEACHING PLAN

Patient Name: R. G.

Diagnosis: Schizoaffective disorder—Bipolar type

Teaching Technique(s): Explanation, one-to-one discussion.

AXIS I: Schizoaffective disorder—Bipolar type

AXIS II: Mild retardation

AXIS III: Hypertension, diabetes mellitus, hypothyroidism, hyperlipidemia.

AXIS IV: Chronic medical conditions, homeless, lack of psychosocial support.

AXIS V: GAF = 30.

M (Medications): Ms. G takes numerous medications to control the positive symptoms of schizophrenia she experiences and to control her chronic medical conditions. Divalproex 750 mg is a tablet given by mouth two times a day. This medication is given to prevent manic and depressive phases of her disorder. The side effects include sedation, drowsiness, nausea, vomiting, and transient indigestion. The patient should report feeling lethargic and drowsy and gastric discomfort. Risperidone 2 mg tablet is given twice a day. This medication controls psychotic symptoms. Side effects may include: sedation, drowsiness, headache, and agitation. Lorazepam is an antianxiety drug administered by mouth as needed.This medication may cause sedation. Trazodone is another medication given as needed. It is an antidepressant that is effective in treating anxiety. Sitagliptin 100 mg is a tablet that is give once daily. It is an antidiabetic medication that lowers glucose levels. Metformin 500 mg is a tablet given twice a day that also lowers glucose levels. These medications may cause hypoglycemia, so the patient should report tiredness, light-headedness, and headaches. Lisinopril 5 mg is a tablet that is also given once daily to control the patient's hypertension. Hypotension may occur, so the patient should report headaches, dizziness, nausea, and vomiting. The patient should also sit on the edge of the bed in the morning before getting out of bed to make sure she is not dizzy. She should make postural changes slowly. Simvastatin 40 mg is a tablet given once a day to reduce serum triglycerides in the patient who has hyperlipidemia. Milk of Magnesia is an antacid given as needed when the patient experiences gastric discomfort. Other medications given as needed are Acetaminophen for physical pain and Haldol for psychotic episodes. The patient also receives Levothyrox 25 mcg once a day for her hypothyroidism. This medication replaces the thyroid hormone thyroxine.

E (Environment): Ms. G should remain in environments without excessive stimuli in order to prevent increased anxiety. It is important that she be surrounded by supportive people. Psychosocial support is necessary to remain on treatment and prevent relapses. Psychosocial support is also a factor in building self-esteem. Having supportive people around that she can discuss her feelings with will promote social interactions and build her self-esteem. When Ms. G feels like she may do something self-destructive or has suicide ideation, she should alert someone.

T (Treatments): Ms. G's treatments include medications and milieu therapy. The medications are essential in alleviating the positive symptoms of schizophrenia that she experiences with her schizoaffective disorder. She is also given medications to manage her chronic illnesses, which are stressors for her. Milieu therapy provides safety, useful activities to promote social interactions, resources for resolving conflicts, and opportunities for learning social and vocational skills. These are all necessary in order for Ms. G to be able to assimilate into the community after discharge. Safety is an important part of milieu therapy. The patient with schizoaffective disorder can go through acute phases and manic or depressive episodes. It is important to assure that the patient does not harm herself or others if she is in an acute [aggressive] phase.

H (Health knowledge of disease): The patient is aware that she has a disorder. She refers to is as schizophrenia, while her actual diagnosis is schizoaffective disorder—bipolar type. The patient is aware that her disorder causes her to experience the auditory hallucinations and other symptoms. She is not really aware of the social isolation caused by the symptoms of the disorder, but she is aware of her feelings of loneliness. The patient understands that medication is necessary for treatment of her disorder. She is aware of all her medications and their side effects.

O (Outpatient/inpatient referrals): The patient is required to see a dietician because of her hypertension and hyperlipidemia. Upon discharge, she will be required to meet with a case worker.

D (Diet): Ms. G is hypertensive and therefore eats a low sodium (2g Na) diet. This diet helps maintain normal BP in hypertensive patients. Decreasing the overall sodium intake to 2 grams a day can prevent congestive heart failure in clients with cardiac issues. Her diet is also an 1800 diabetic diet. This diet helps maintain a normal blood glucose level, and decreasing the intake of sugar can aid in maintaining normal blood glucose levels. Lastly, Ms. G also eats a 225 cholesterol diet aimed at maintaining appropriate cholesterol levels in cooperation with the medication she takes.

BOROUGH OF MANHATTAN COMMUNITY COLLEGE
Department of Nursing

SUPPLEMENTAL MEDICATION SHEET

Generic Name: Ferrous sulfate **Brand Name:** Feosol, Femiron, Feostat

Drug Classification: Antianemic, Iron supplement

Reason your patient is receiving medication: Ms. G has low hemoglobin and Hematocrit levels, which compromise iron levels.

Usual Dosage: 325 mg tab tid **Route:** PO

What you will need to assess before, during, and after giving medication: Check the labs for the Hematocrit and hemoglobin levels. Assess the patient for constipation.

Evaluate effectiveness of medication: Hematocrit and hemoglobin levels should normalize.