**BER ZEIT UNIVERSITY**

**Psychiatric Nursing**

**Nursing Process Application**

**FALL 2020**

**Week of experience: 5 weeks Student: Abd AL Hady Amleh**

**Date of admission:** 1995 **Patient (Initials):** F.KH

**Psychiatric diagnosis:** schizophrenia disorder **Ward:** recovery male ward

**1- Identification data:**

**Age:** 60 years old **Sex:** Male **Address: Jenin**

**Religion:** Islam **Education:** 1st grade

**Occupation:**  none **marital status:** Married

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**2- Current problems and chief complaint:**

 After 22 years of illness and progressive case of schizophrenia in the past 3 years, patient has become isolated with bizarre thoughts concerning his wife, his brother and his wife, his son, and their nationality. Patient has hallucinations and delusions such as believing that there is scorpions going to kill him. Patient refrained from completing his treatment, and could not sleep at night. Patient is afraid from darkness, and loneliness. Patient calls for family to stay near him all the time.

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**3- History of the psychiatric illness and admission (hospitalization, medication, therapies** **and compliance with prior care plans):**

History of mental illness has started before approximately 22 years when the patient got free from the prison. Patient was security prisoner for occupations; he was in the prison for 7 years. Patient got free from prison could not recognize or remember family members or friends from the impact of torture and beatings he was subjected to. Patient was screaming and trembling all the time.

Patient was trying to strangle himself and says that there are snakes and scorpions in his abdomen. Patient's family took him to several psychiatric doctors and he took several medications but the only medication remembered by family members is Clonex. Patient had EEG and lab tests done by her psychiatrists but according to them, all lab tests were normal.

3 years ago, according to his brother, patient was experiencing agitation and his mood was constantly changing (MOODY). One night, the brother noticed that the patient was trying to hang himself on a rope but once he saw him, he stopped his action.

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**4- Personal history**

**(Development, education, work history, life events, pre-morbid personality, sociability, neurotic trait)**

Patient was born at full term, normal delivery, and had no developmental problems. Patient developed just like all other healthy children, he was educated 1st grade then left school because of the political conditions and recurrent arrests. Patient did not has any work in his life, but helping his family sometimes without gaining any money.

Patients’ social life said to be a very social and friendly before the illness. He had a lot of friendships with his extended family and some friends. He merged and took part in social occasions, but since 22 years patient became almost dissociable, spent most of his time at home and alone.

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**5- Family history and Genogram:**

( Family of origin, parent's age, education, occupational history, sibling's age, education, occupational history, composition of family during childhood and youth, mental health history and relevant medical history of family members, family response to illness, relevant social history of family members and the quality of family relations)

Patient was living with his family that consists of his father 95 years, he is complaining from severe stroke that prevented him from walking. Patient's mother died when patient was 3 years of age. His father married another woman after his wife's death by one year, he had one male 38 years old, and three females have an age range between (41-37). Patient has one brother from his mother 70 years old and three sisters have an age range (52-63). Patient is the youngest between his brothers and sisters. Social affairs help patient and his family. His family positively accepted his illness and tried to help him standing on his legs before bringing him to the hospital.

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**6- Medical History and admission (allergies, medical illnesses, surgery, medications)**

Patient has no past medical record, no surgical history, and no allergies. Patient was taking clonex for mental illness.

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**7- Social habits and living patterns describe any changes due or after illness:**

**Psychological (e.g. self concept, esteem, coping and defenses…. Etc.)**

1. **Psychological patterns and composition of personality:**

Patient is delusional and speaks about politics very often and family members, he prefers being near the family. He is self-aware and has well self-esteem. He seems to be a smart person but he is a suspicious person too. He used to enjoy playing with family young members before his illness.

**Self-concept and self-esteem.**

Patient maintains good eye contact, and is cooperative. His speech was clear and with normal tone and rate. He spontaneously changed topics especially to political topics. When asked how he is feeling he subjectively says he is good but objectively is irritable. His facial expressions were congruent with his mood and speech. However, the content of his speech was illogical and contained delusions. His self-esteem seems well while he is confident while speaking and has well eye contact and no shakiness. When asked what he thinks about himself he says he is alike all the people but with the goal of freeing Palestine.

**C. Defense mechanisms:**

Patient uses different defense mechanisms such as undoing where he spoke well about his wife after speaking in a very negative way. He also does fantasize about the freedom of Palestine to stay calm towards political issues. He said that he would ignore the problem or ignore the issue when asked about what he will do if he had a problem with someone.

**D. Sleep pattern**

Patient sleeps around 6 hours a night has no problems while sleeping, no breathing problems, no horrifying dreams, and no insomnia.

**E. Eating- Nutritional Patterns**

Patient has2- 3 meals a day

Breakfast consists of bread, boiled egg, and tea.

Lunch: whole meals with meats and vegetables (whatever is available).

Dinner: patient tries to stay away from dinner at night to sleep well

**F. Drugs and substance use**

Patient does not use any medications besides those prescribed for mental illness.

Patient is a heavy smoker.

**G. Elimination**

Patient claims he has no problems with elimination problems and eliminates stool around 2-3 times a week and urinates around 3 times a day with no trouble.

**H. Rest-Exercise**

Before illness patient said he used to walk, but since illness has started he doesn’t do much exercises.

1. **Sexual Activity**

Patient claims that he and his wife sleep in the same room.

**J- Socioeconomic status & living arrangement:**

Patient was living in separate house with his wife and children. Patient did not have a work, so he was getting social affairs. Patient's family was standing behind some of his needs.

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 **9- Mental Status Examination**

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| **MENTAL STATUS** ( (Describe) |
| APPEARANCE: General health, grooming, contact with external environment |  Patient showers almost every two days, dresses neatly, has no odder, and seems to be generally healthy besides mental illness. Patient speaks to the clients that are with him. Patient is socially good. |
| Activity/ behaviorHyperactive☐, Agitation☐, psychomotor retardation ☐, Calm\_\_\_, Tremors☐, Tics☐, Unusual movements/gestures☐,, Catatonia☐,, Akathisia☐,, Facial movements(jaw/lip smacking) ☐,, Other\_\_\_\_\_\_\_\_ | When admitted into the hospital patient was said to be bizarre but is currently found very quiet but easily agitated if asked about politics or things he doesn’t want to answer. It doesn’t seem that patient has any psychomotor disturbances but moves slowly. |
| ALERTNESS: Level of consciousness, concentration, and vigilance |  Patient is aware and conscious to time place and person that are around him. Patient does have delusions such as believing his his son has to die. Patient does take some vigilant acts such as keeping secrets or asking me as his interviewer to keep secrets.  |
| THOUGHT FORM: Loose associations ☐, tangentiality ☐, perseveration ☐, blocking ☐, derailment ☐ |  Patient clearly understands questions but doesn’t answer in details that are clear. Some of his thoughts and believes are abnormal and can’t be believed, but he has correlated thoughts. To one another. He enjoys speaking to people hoping to send him political view for Palestine but is not very talkative. |
| THOUGHT CONTENT: Delusions of grandeur ☐, persecution ☐, somatic delusions ☐,thought control ☐, insertion ☐, withdrawal ☐, broadcasting ☐, preoccupation, obsessions ☐, and phobias ☐ |  Patient is obsessed with politics and the political issues in Palestine and is constantly talking to himself and others about politics. He is not isolated, but talks to himself sometimes. |
| SPEECH: Volume, rate, rhythm; paraphrasia ☐ and neologisms ☐ |  Patient speaks at a calm rhythm and tone. Does not paraphrase or rephrase, and speaks with clear understandable words. |
| PERCEPTION: Hallucinations ☐: auditory ☐, (command?) ☐, visual ☐, olfactory ☐, tactile ☐;Illusions ☐, misperceptions ☐, derealization ☐, depersonalization ☐, fluid boundaries ☐ |  Patient has several hallucinations, such as believing someone is trying to kill his son. His hallucinations were command, patient was hearing commands to kill his son, thats why he cutted his son’s nick.  |
| MOOD: (What patient reports about how they feel) |  He says he doesn’t care about anything or anyone, one week he said he hated his son and his wife and feared them but the following week said they were a good people and got offensive when questioned about. He seems to be a very suspicious patient about those who surround him. He says he feels best when he’s thinking about being out of the hospital and can’t wait to be home. |
| AFFECT: Range, intensity, lability, appropriateness | Patient was labile as he said two different things about his son in the two different interviews and was offensive when the first interview was summarized to him, as if he didn’t like or believe what he said the first time.  |
| VEGETATIVE SIGNS: Suicidality☐, decreased interest X☐, guilty/worthless, decreased energy , decreased concentration ☐, appetite increase x or decrease ☐, weight gain ☐ or loss ☐, psychomotor retardation or agitation ☐, sleep disturbance: increase ☐ or decrease (DFA ☐, EMA ☐ interrupted sleep ☐) |  Patient had no suicidal attempt, he currently didn’t observe that he had any suicidal thoughts, he does have decreased energy compared to before the illness and before treatment. Appetite is good and hasn’t been changed but he says that he thinks that he gained some weight, he has no trouble sleeping or waking up and says he gets enough hours of sleep. |
| COGNITION: Orientation to day, date, year, place, person; memory for 3 words after 5 minutes (mini-mental status if indicated.)Memory: recent and remote |  Patient is oriented to day, date, year, and place.Patients’ short term memory is well as I told him a Palestinian saying and asked him to repeat 5 minutes later.He also remembered who I am, which college and my name which I told him a weeks before. |
| INSIGHT/JUDGMENT: Awareness of condition, own role in difficulties |  Patient doesn’t believe he is sick and told the doctors on admission that he isn’t sick but then accepted saying he was sick and taking medications in order to go home. However, when asked how he was feeling from when he came in until now he said he is a lot better indicating that he does have an acceptance to the fact that he is sick. |
| **DANGEROUSNESS HISTORY:**  |  |
| Current **suicidal** ideation X, intent ☐, plan ☐; means available ☐; previous suicide attempt(s) ☐: precipitants, method, lethality, dates |  Patient had no suicidal attempts. Patient said he do not think about these things. |
| Current **homicidal** ideation ☐, intent ☐, plan ☐,; means available ☐; assault history ☐, legalhistory ☐, predatory behavior ☐ (sexual stalking, kidnapping,) fire-setting ☐ |  He did state that he wanted to kill his son, and he did.He tried to kill his second son, but family prevented him. He spoke about family members that he believes are kidnapping children and killing them. |
| Mood & affect | He is calm but can be agitated; he seems to contraindicate himself a bit. She is not isolated and usually smiles and uses kind words. |
| Ability to abstract | Patient seems smart and mature from the way he ties things together to the way he speaks, and by what told to us from a feedback about him from the nurses. |
| Insight  | Patient gave in full life story, which he is aware about what he knows who he is and what his passions are. However, he isn’t fully accepting the point that he is mentally ill. |

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**Treatment and therapies:**

**Present treatment and observed side effect:**

Patient takes;

* HALIDOL 5 mg tab
* ARTAE 2 mg tab
* LARGACTIL 100 mg
* CIPRALEX 10 mg tab
* MODECATE 2 cc im monthly

She seems to be tired most times which may be caused by medications.

**Psychiatric diagnosis: DSM-IV**

**Axis 1** post prison depression around 23 years ago, schizophrenia since 22 years

**Axis 2** no criteria met

**Axis 3** no criteria met

**Axis 4 – (Mention stressors within the last 2 year).**

His wife is less visiting him

Social political environment getting worse

**Axis 5 – (level of functioning)**

Rating scale called the Global Assessment of Functioning; the GAF went from 0 to 100:

30 Behavior is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment or inability to function in almost all areas

**15) List all possible nursing diagnosis for the care:**

1. **Impaired social interaction**
2. **Disturbed thought process**
3. **Defensive coping**
4. **Interrupted family process**
5. **Impaired home maintenance management**
6. **Risk for self-harm**

**16- Select the three most urgent nursing diagnosis and prepare a nursing care plan for each: List here the most urgent problems.**

1. **Impaired social interaction**

Urgent problem: difficulty with communication

1. **Disturbed thought process**

Urgent problem: delusions

1. **Defensive coping**

 Urgent problems: perceived threat to self

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| **Patient problem**  | **Nursing diagnosis** | **Nursing goal /** **STG****LTG** | **Nursing implementations**  | **Rational**  | **Evaluation**  |
| * Nonrealistic based thinking
* Delusions
* Labile affect
 | Disturbed thought process *(disruption in cognitive operations and activities).* | **STG:** **The patient will:**Be free of injuryRespond to reality based interactions initiated by othersTalk about concrete topics for 5 minutes**LTG:****The patient will:**Interact on reality based topics.Sustain attention and concentration to complete tasks or activitiesBe free of delusions or demonstrate the ability to function without responding to persistent delusions | Be sincere and honest when communicating with the clientAvoid vague remarksDo not make promises that cannot be keptBe consistent in setting, expectations, enforcing rulesEncourage client to speak but don’t cross examine for information | Delusional clients are extremely sensitive about others and can recognize vague or evasive comments.Broken promises reinforce the clients’ mistrust of others.Clear consistent limits provide a secure structure for the clientProbing increases the clients suspicious thoughts | Client was comfortable and confident when speaking too, felt love and concern.A well-defined nurse client relationshipClient was not confused and understood what track we are onClient wasn’t suspicious or frightened was comfortable saying what she wanted to say |

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| **Patient problem**  | **Nursing diagnosis** | **Nursing goal /** **STG****LTG** | **Nursing implementations**  | **Rational**  | **Evaluation**  |
| Perceived threat to selfSuspicious motives of other | Defensive coping(Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard.) | **STG:** **The client will:**Express anger or hostility in a safe mannerBe free from self-inflicted harmEngage in reality based interactions**LTG:****The client will:**Express feelings directly with congruent verbal and nonverbal messagesBe free from psychotic symptomsIdentify a support system | Ask about anger but give rules and limits beforeContinually assess the clients potential for suicideEncourage client to make relationships | When one expresses it helps them relax and helps us understanding what they are thinkingSchizophrenics usually have suicidal thoughts and this client had a previous attemptMaking relations helps in self-concept and self-esteem  | Client spoke about what makes them angry and stressedClient stated they want to live because “life is not so bad after all” |

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| **Patient problem**  | **Nursing diagnosis** | **Nursing goal /** **STG****LTG** | **Nursing implementations**  | **Rational**  | **Evaluation**  |
| Difficulty with communicationImpaired thought process | Impaired social interaction **(**The state in which an individual participates in an insufficient or excessive quantity or ineffective quality of social exchange.) | **STG:****Client will:**Client will seek out supportive social contacts.Client will engage in one activity with a nurse by the end of the day.**LTG:****Client will:**Patient will use appropriate skills to initiate and maintain an interaction.Patient will improve social interaction with family, friends, and neighbors. | Assess if the medication has reached therapeutic levels.Ensure that the goals set are realistic;  whether in the hospital or communityTry to incorporate the strengths and interests the client had when not as impaired into the activities planned. | Many of the positive symptoms of schizophrenia will subside with medications, which will facilitate interactions.Avoids pressure on the client and sense of failure on part of nurse/family.Increase likelihood of client’s participation and enjoyment. | When compared to admission the clients medication seem to be very affectiveClient was eager and hopeful to work on goalsClient was most interactive when speaking about topics she said she was interested in |