

Lucretia Shafer
Mental Health Rotation 11/19/05
Mental Status Assessment, Nursing Care Plan, DSM-IV Comparison

Name: patient

Sex: Male

Age: 40

Race/Culture: Caucasian

Occupation: Lawyer for State of WA

Education level: Harvard University Law degree

Significant other: divorced

Living arrangements: apartment in Tacoma

Religious preference: none specified

Allergies: NKA

Special diet considerations: none

Chief complaint: depression, anxiety

Medical diagnosis: depression with suicidal ideation

Mental Status

Patient appears clean but rumpled in sweatshirt and pajama pants and slippers with uncombed hair. Hair is dark with natural gray highlights, clean and fluffy. He is about 5' 10" with medium build, slightly stooped and sad looking. At the present time he is quite labile. Has trouble making eye contact, and tears up each time he begins to speak, occasionally sobs. Frequently wipes eyes and nose with a tissue, which he carries in his hand. No obvious scars, tattoos or other distinguishing marks. Patient presents as

articulate and intelligent but soft-spoken, compliant and friendly. Admits to high anxiety in the mornings, which decrease as the day progresses. Complains of fatigue, 30 lb weight loss since summer, decreased energy, loss of interest, and inability to fulfill duties at work anymore. Denies any auditory, visual, tactile, or olfactory hallucinations. Denies delusions, paranoia, phobias and obsessions. Admits to suicidal ideation, specifically overdose. No prior attempts. Well oriented to person, place, time and situation.

DSM-IV

Axis I: Bipolar type 2, depressed phase (296.89)

Axis II: Deferred

Axis III: 1) possible hypothyroid

2) R/O thyrotoxicosis

3) Hx of irritable bowel syndrome

Axis IV: stressors include increased anxiety, increased depression, increased suicidal ideation, financial difficulties, and inability to function in present employment.

Axis V: GAF score 35 (See page 2 of Modified Global Assessment of Functioning-Revised for justification.)

Medications:

Clonazepam (Klonopin) 0.5 mg 3 times/day anticonvulsant

Lamotrigene (Lamictal) 25mg 1 time/day anticonvulsant

Oxcarbazepine (Trileptal) 300mg 2 times/day anticonvulsant

Propranolol (Inderal) 5mg 3 times/day beta blocker for antianxiety

Duloxetine HCl (Cymbalta) 20mg once a day antidepressant

Lamotrigine (Lamictal) is an anticonvulsant used as a maintenance treatment of bipolar disorder. It decreases the recurrence of mood episodes. It is well absorbed, enters breast milk, is metabolized by the liver, and has a t_{1/2} of 25 hours. Do not use if hypersensitive or lactating. Use cautiously in impaired renal, cardiac and/or hepatic function, pregnancy or children <16 yr. Side effects can include ataxia, dizziness, headache, nausea and vomiting, photosensitivity, and rash. Nursing considerations include frequent assessments for rash which could be the first sign of life threatening Stevens-Johnson syndrome or toxic epidermal necrolysis. Monitor plasma concentrations especially if patient is taking other anticonvulsants. Therapeutic plasma concentration range has not been established. Instruct patient to take exactly as directed. Do not double doses, do not discontinue abruptly. Can cause drowsiness so use caution when driving. Use sunscreen and protective clothing when in the sun (Davis, 2005).

PRN Medicaitons: Tylenol, Mylanta, Imodium, Ativan, milk of magnesia, nicorette gum, trazodone--for sleep

Nursing Diagnosis (Townsend, 2004, p. 122):

Risk for Suicide related to suicidal ideation with plan and means to carry out.

Goals (long-term): Patient will not harm self.

Goals/Objectives (short-term):

1. Patient will make verbal or written contract with nurse not to hurt self. Contract will be reviewed and renewed daily.

Interventions:

* Assess patient's suicide ideations at beginning of shift, "On a scale of zero to ten, how serious are your suicidal thoughts? Are you thinking about killing yourself? If so, what do you plan to do? Do you have the means to carry out the plan?" (The risk of suicide is greatly increased if the patient has the desire, the plan and the means to carry out the plan.) (Townsend, 2003).

* Create a safe environment for the patient by removing all potentially harmful objects from the patient's access (sharp objects, straps, belts, ties, glass items, shoe laces, medications, etc.). (Patient safety is a nursing priority.) (Townsend, 2004).

* Formulate a short-term verbal or written contract with the patient that he will not harm himself during specific time period. When the contract expires, make a new one and so forth. (Discussion of suicidal feelings with a trusted individual provides some relief to the patient. A contract gets the subject out in the open and places some of the responsibility with the patient. An attitude of acceptance of the patient as a worthwhile individual is conveyed.) (Townsend, 2004).

2. Patient will seek out staff when feeling urge to harm self.

Interventions:

* Secure a promise from the patient that he will seek out a staff member if thoughts of suicide emerge. (Suicidal patients are often very ambivalent about their feelings. Discussion of feelings with a trusted individual may provide assistance before the patient experiences a crisis situation.) (Townsend, 2004).

* Encourage verbalizations of honest feelings. Through exploration and discussion, help patient to identify symbols of hope in his life. (Discussing feelings of self-harm provides a degree of relief for the patient.) (Townsend, 2004).

* Encourage patient to express angry feelings within appropriate limits. Provide safe method of hostility release. Help client to identify true source of anger and to work on adaptive coping skills for use outside the hospital. (Depression and suicidal behaviors may be viewed as anger turned inward on the self. If this anger can be verbalized in a non-threatening environment, the patient may be able to resolve these feelings, regardless of the discomfort involved.) (Townsend, 2004).

3. Patient will not harm self during shift.

Interventions:

* Make rounds at frequent, irregular intervals (esp. at night, toward early morning, at change of shift, or other predictably busy times for staff). (Prevents staff surveillance from becoming predictable. Being aware of patient's location is important, especially when staff is busy and least available and observable.) (Townsend, 2003).

* Identify resources that the patient may use as support system and from which he request help if feeling suicidal. (Have a visible, easy to find plan for seeking assistance during a crisis. This may discourage or prevent self-destructive behaviors.) (Townsend, 2004).

* Orient patient to reality, as required. Point out sensory misperceptions or misinterpretations of the environment. Take care not to belittle his fears or indicate disapproval of verbal expressions. (Orients patient to reality. Develops trust.) (Townsend, 2004).

* Spend time with the patient. (This provides a feeling of safety and security, while also conveying the message, “I want to spend time with you because I think you are a worthwhile person.”)

Outcome Criteria:

1. Patient verbalizes no thoughts of suicide during shift.
2. Patient commits no acts of self-harm while in hospital.
3. Patient is able to verbalize names of resources outside the hospital from which he may request help if feeling suicidal.

References

- BehaveNet. (2004). *BehaveNet clinical capsule: DSM-IV and DSM-IV-TR: Bipolar II disorder*. Retrieved from <http://www.behavenet.com/capsules/disorders/bip2dis.htm>
- Deglin, J. H., & Vallerand, A. H. (2005). *Davis's drug guide for nurses* (9th ed.). Philadelphia: F. A. Davis Company.
- Diagnostic and statistical manual of mental disorders* (4th ed.). (1994). Washington, DC: American Psychiatric Association.
- Townsend, M. C. (2003). *Psychiatric mental health nursing: Concepts of care* (4th ed., Rev.). Philadelphia: F. A. Davis Company.
- Townsend, M. C. (2004). *Nursing diagnoses in psychiatric nursing: Care plans and psychotropic medications* (6th ed.). Philadelphia: F. A. Davis Company.