Student: Dallas Bradley Date: 3/15/14

Instructor: Professor Atwater

Patient Initials: MP

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| **Assessment Subjective** and **Objective** Data(provide source of information-**chart, client, staff, and family)** **10%** | **Nursing Diagnosis (5)****PES Format****30%** | **Outcome Identification** **Smart Goal****10%** | **Planning and Implementation****Prioritize and Provide Actions with Rationales****20%** | **Evaluation** **Part 1**-was goal met?**Part 2**-what will you do with goal?**30%** |
| **(1) Chart:** The client has been experiencing severe levels of anxiety. | **(1)** Anxiety related to client’s financial situation as evidenced by sinus tachycardia, pacing, talking fast, and patient states “my bills are too much for me to handle right now. They are stressing me out big time.”  | 1. The client will have no more than a mild level of anxiety as evidenced by no sinus tachycardia, no pacing, talking at a normal speed, and pt denies that her “bills are too much for me(her) to handle.”
 | **(1) a.** Assess client’s level of anxiety.***Rationale****: Mild anxiety enhances the patient's awareness and ability to identify and solve problems and limits awareness of environmental stimuli. Problem solving can occur but may be more difficult, and patient may need help. Severe anxiety decreases patient's ability to integrate information and solve problems. Panic is severe anxiety. Patient is unable to follow directions. Hyperactivity, agitation, and immobilization may be observed (Brozek, Gradishar, Gulanick, 2012).***(1) b.** Acknowledge awareness of patient's anxiety.***Rationale****: Since a cause for anxiety cannot always be identified, the patient may feel as though the feelings they are experiencing are counterfeit. Acknowledgment of the* *patient's feelings validates the feelings and communicates acceptance of those feelings (Brozek et al., 2013).***(1) c.** Determine how the client copes with anxiety.***Rationale****: This assessment helps determine the effectiveness of coping strategies currently used by patient (Brozek et al., 2013).***(1) d.** Assist client in recognizing symptoms of increasing anxiety; explore alternatives to use to prevent the anxiety from immobilizing her or him.***Rationale****: The ability to recognize anxiety symptoms at lower-intensity levels enables the client to intervene more quickly to manage his or her anxiety. The client will be able to use problem-solving abilities more effectively when the level of anxiety is low (Brozek et al., 2013).***(1) e.** Assist the client in developing anxiety-reducing skills (relaxation, deep breathing, positive visualization, reassuring self-statements, and others).***Rationale****: Using anxiety-reduction strategies enhances patient's sense of personal mastery and confidence (Brozek et al., 2013).* | **(1) a** The goal was met; the client remained free of severe anxiety levels by the end of shift.**(1) b** Will continue goal with revision on time. |

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| **(2)** **Chart:** The client has been having suicidal thoughts. | **(2)** Risk for suicide related to patient expressing she has suicidal ideations. | **(2)** The client will no longer be at risk for suicide, as evidence by the client no longer has suicidal ideations by the end of shift. | **(2) a.** Follow unit protocol for suicide regarding creating a safe environment (taking away potential weapons-sharp objects, belts, items, and so on).***Rationale****: Provide safe environment during time client is actively suicidal and impulsive; self-destructive acts are perceived as ties, the only way out of an intolerable situation (Varcarolis, 2006, p. 485).***(2) b.** Ask directly if person is thinking of acting on thoughts or feelings of suicide.***Rationale****: Determines intent. Most people will answer honestly, because they actually want help (Doenges, Moorhouse, Murr, 2013, p.923).* **(2) c.** Note behaviors indicative of intent (threats, hallucinations, gestures etc.).***Rationale****:* *Many people signal their intent, especially to help care providers (Doenges et al., 2013, p.923).***(2) d.** Review laboratory findings (ex. blood alcohol and other drug levels).***Rationale****: Drugs may interfere with ability to control own behavior and will require specific interventions to promote safety (Doenges et al., 2013, p.923).***(2) e.** Encourage expression of feelings and make time to listen to concerns.***Rationale****: Acknowledges reality of feelings and that they are okay. Helps individual sort out thinking and begin to develop understanding of situation and look at other alternatives (Doenges et al., 2013, p.925).* | **(2) a** The goal was met; the client remained free of suicidal ideations by the end of shift.**(2) b** Will continue goal with revision on time.  |
| **(3) Chart:** The client is using ineffective ways to cope with stress, hindering her ability to problem solve. | **(3)** Ineffective coping related to lack of coping skills as evidence by cutting self, throwing things, arguing with peers, and patient stating the “stress is too much.” | **(3)** Client will demonstrate one effective coping mechanism as evidence by no self-harm, no arguing with peers, no throwing objects, and pt will deny that her “stress is too much” to handle. | **(3) a.** Identify client’s highest level of functioning in terms of: living skills, learning skills, working skills***Rationale****: Identify client’s potential so that arrangements can incorporate the client’s potential (Varcarolis, 2006, p.435).***(3) b.** Identify the social supports available to the client and client’s family: education about the disease, community supports to help client function optimally, and community supports that offer family support/groups/ongoing psychoeducation***Rationale****: Client and client’s family members need a variety of supports to prevent family deterioration (Varcarolis, 2006, p. 342).***(3) c.** Encourage client to find role models (counselors or other recovering people).**Rationale**: *Role models serve as examples of how client can learn effective ways to make necessary life changes (Varcarolis, 2006, p.343).***(3) d.** Determine previous methods of dealing with life problems.***Rationale****: Identifying successful coping techniques is necessary to overcome the current situation (Doenges et al., 2013, p.285).***(3) e.** Encourage and give positive feedback to the client in evaluating lifestyle, occupation, and leisure activities.***Rationale****: Validates client’s positive steps toward growth and change (Varcarolis, 2006, p. 342).* | **(3)a** Goal was not met; the client has not demonstrated one effective coping mechanism.**(3)b** Goal will be continued as written. |

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| **(4)** **Chart:** The client states that she has “heard different voices talking to her” since she was a little girl and that “sometimes, the voices are my friends and sometimes they tell me to end my life.” | **(4)** Disturbed thought processes related to unknown cause as evidenced by auditory hallucinations, delusions, inappropriate non-reality-based thinking, and patient states “I’ve been hearing voices and having suicidal thoughts.” | **(4)** The client will have no disturbed thought processes as evidenced by appropriate reality-based thinking, no delusions, and client will deny having auditory hallucinations.  | **(4) a.** Utilize safety measures to protect clients or others, if clients believe they need to protect themselves against a specific person. Precautions are needed.***Rationale****: During acute phase of Schizoaffective Disorder, client’s delusional thinking might dictate to them that they might have to hurt others or self in order to be safe. External controls might be needed. (Varcarolis, 2006, pg. 239)***(4) b.** Be aware that client’s delusions represent the way that he or she experiences reality.***Rationale:*** *Identifying the client’s experiences allows the nurse to understand the client’s feelings. (Varcarolis, 2006, pg. 240)***(4) c.** Identify feelings related to delusions. For example: A) If client believes someone is going to harm him or her, client is experiencing fear. B) If client believes someone or something is controlling his/her thoughts, client is experiencing helplessness.***Rationale:*** *When people believe that they are understood, anxiety might lesson. (Varcarolis, 2006, pg. 240)***(4) d.** Do not argue with the client’s beliefs or try to correct false beliefs using facts.***Rationale:*** *Arguing will only increase client’s defensive position, thereby reinforcing false beliefs. This will result in the client feeling even more isolated and misunderstood. (Varcarolis, 2006, pg. 240)***(4) e.** Interact with clients on the basis of their environments. Try to distract client from their delusions by engaging in reality-based activities (cards, simple board games, simple arts and crafts projects, cooking with another person, etc).***Rationale:*** *When thinking is focused on reality-based activities, the client is free of delusional thinking during that time. Help focus attention externally. (Varcarolis, 2006, pg. 240)***(4) f.** Do not touch the client; use gestures carefully.***Rationale:*** *A psychotic person might misinterpret touch as either aggressive or sexual in nature and might interpret gestures as aggressive moves. People who are psychotic need a lot of personal space. (Varcarolis, 2006, pg 240)* | **(4) a** Goal was not met; Although the client denies having suicidal ideations by the end of shift, she still expresses having auditory hallucinations and reports thoughts that are “not of this world.”**(4) b** Will continue with goal as written. |
| **(5)** **Chart:** The client states that she has “heard different voices talking to her” since she was a little girl and that “sometimes the voices are my friends and sometimes they tell me to end my life.” | **(5)** Disturbed auditory sensory perception related to unknown cause as evidenced by auditory distortions, mumbling to self, altered communication pattern, and client states she has “heard different voices” talking to her that tell her to “end my (her) life.” | **(5)** ***Short-term***: Client will demonstrate techniques that help distract him/her when aided by medication and nursing intervention by the end of shift. ***Long-term:*** Client will state, using a scale from 1 to 10, that “the voices” are less frequent and threatening when aided by medication and nursing intervention within one of medication regiment. | **(5) a.** If voices are telling the client to harm self or others, take necessary environmental precautions: A) Notify others and police, physician, and administration according to unit protocol. B) If in the hospital, use unit protocols for suicidal or threats of violence if client plans to act on commands. C) If in the community, evaluate need for hospitalization. Clearly document what client says, and if he/she is a threat to others, document who was contacted and notified (use agency protocol as guide).***Rationale:*** *People often obey hallucinatory commands to kill self or others. Early assessment and intervention might save lives. (Varcarolis, 2006, pg. 235)***(5) b.** Decrease environmental stimuli when possible (low noise, minimal activity).***Rationale:*** *Decrease potential for anxiety that might trigger hallucinations. Helps calm client. (Varcarolis, 2006, pg. 235)***(5) c.** Accept the fact that the voices are real to the client, but explain that you do not hear voices. Refer to the voices as “your voices” or “voices that you hear.”***Rationale:*** *Validating that your reality does not include voices can help cast “doubt” on the validity of his or her voices.***(5) d.** Keep to simple, basic, reality-based topics of conversation. Help client to focus on one idea at a time.***Rationale:*** Client’s thinking might be confused and disorganized; this intervention helps clients focus and comprehend reality-based issues. (Varcarolis, 2006, pg. 236)**(5) d.** Stay with the clients when they are starting to hallucinate, and direct them to tell the “voices they hear” to go away. Repeat often in a matter-of-fact manner. ***Rationale:*** *Clients can sometimes learn to push voices aside when given repeated instruction, especially within the framework of a trusting relationship. (Varcarolis, 2006, pg. 236)* | **(5)a** Goal was met; the client has been successfully distracted in activities and the intensity of auditory hallucinations has lessened by the end of shift.**(5)b** Will continue with goal as written. |