NURSING CASE STUDY

NYAHURURU MEDICAL TRAINING COLLEGE (NMTC)

NAME: **NAHASHON MACHAKA ELIJAH**
ADMISSION **123210**
CASE TITLE: **SCHIZOPHRENIA**
CASE PERIOD: **OCT 2021 TO JAN -2022**
LECTURER: **OBADIAH KIMEI**
SEMESTER: **1st Semester 2022/2023**
DATE: **8/9/2022**

PATIENTS INFORMATION

Introduction

Was first diagnosed with diabetes on 2007 on which she has been controlling it with diet and medications only

Personal data

Name; M.N.J

IP NO; 37/21

Age; 55 years

Gender; Female

Occupation; famer

Next of kin; 0720552470/0703342378 (Daughter)

Marital status; Single

Nationality; Kenyan

Date of admission;6/6/2022

Time of admission;3:00pm

Mode of admission

Involuntary admission. Patient was brought up by two daughters and a nephew held by hands . they filled MOH 614 and the doctor signed the MOH 615.

Allegations

The patient is an admission of with a diagnosis of schizophrenia with complains of;

Loss of appetite

Pressured speech

Walking at night

Fighting two weeks ago

Wounds under the breast

Mutism for *1/52

Onset of conditions;

The onset has been gradual as the patient was displaying the above symptoms for a whole week and worsened before admission date.

Patient reaction to allegations

The patient was in stupor and mutism, does not agree or denies the allegations. Was admitted for monitoring and further management.

Duration

It has taken about one month before the admission day.

Onset; gradual

History of presenting illness

She is a known psychotic patient. The symptoms were seen one month ago when she stopped taking medications, the injection.

Past psychotic illness

The illness started when she was 19yrs. she has been admitted once. She has been on follow up in psychiatric clinic.

Past medical-Surgical history

No history of any chronic illness

No history of any surgical procedure

No history of blood transfusion

No history of any food allergy

No history of hospitalization

No history of drug allergy

Family History

She is the last born in a family of 4 children and a psychiatric patient. Both of her parents died due to unknown cause

First born a female and she's alive

Second born a female and she's alive

Third born died, she was a female and a psychiatric patient.

She is a fourth born and a psychiatric patient.

There is a family history of mental illness in the third born

No history of diabetes in the family or any chronic illness

There is a family history of mental illness, the third born

Personal history

She was born in Kiambu County in 1973.

Childhood history

She started working at a small age of 12yrs as a house help

Education history

She studied up to class seven.

Social and marital status

She is not married. She is a single mother with three living children.

No history regarding smoking and alcohol intake

The patient is married and all children are alive

She is antisocial; she only associates with family members

She is a Christian and she listens to music when she is not occupied

Premorbid personality history

She is an introvert; she was only speaking to family members

She does not leave home

She was productive before the onset of illness

She was aware that she's a psychiatric patient and took medication

Occupational history

The patient has been practicing farming as a source of income and livelihood

Forensic history

The patient has never been jailed in police custody before

PHYSICAL EXAMINATION

Hair; the hair is well distributed, fine texture and the colour is black 'no lice and its clean

Eyes; Well aligned / symmetrical, no discharge, the conjunctiva IS pink in colour, white sclera, good visual acuity, no catarax

Nose; No discharge, no nasal polyps and no nose bleeding

Ears; no discharge, deformities and there is good hearing, no sign of inflammation

Mouth; The lips are moist , no dentures , no odor , the tongue is pink , no bleeding gums, no dental carries.

Neck; No neck stiffness, thyroid glands are not palpable , carotid pulsation are present and the lumph nodes are not swollen

Arms; normal capillary refill , no signs of excessive alcohol intake no oedema and good general hygiene

Chest; normal respirations of 20 breaths per minute, uniform skin color of the chest, no discharge from the nipples

Abdomen; Uniform color, no tenderness on pulsation, liver and spleen not palpable

Lower limbs; No abnormality, no edema, good hygiene of the limbs, no signs of deep venous thrombosis

Back; no sacral edema, no sores, the vertebral column is continuous, no injury

Mental status examination

General appearance

She is well groomed

She stands upright

Gait, she steady

Nutritionally she is well nourished

She is anxious and agitated

Eye contact is not well maintained

She is restlessness

Rapport is not established as she does not respond

Speech; she's mute

Emotions; mood was dysphoric

Affect was blunted

Thought content; the patient is mute

Thought process; was not wee described, she was mute

Perception; visual hallucinations present, she speaks with her dead mother as if she can see her.

Auditory hallucinations present; she hears the voice of her mother and responds to it

No derealization

Cognition; concentration, poor concentration as she follows but doesn't respond as has aphasia

Judgment; was not well established as the patient was mute

Orientation; does not respond on where she is, who she is or time of the day

Insight; insight not well established as she doesn't respond to questions

Observations

Blood pressure; 115/75mmHg

Pulse; 82 b/min

Temperature; 36.2°c

Respirations; 22b/min

Impression; schizophrenia

Plan

Admission to ward 6 with diagnosis of schizophrenia

IM chlorpromazine 200mg stat

IV diazepam 20mg stat

PO haloperidol 10mg BD

PO carbamazepine 200mg BD

PO benhexol (Artane) 5mg PRN

Schizophrenia

A functional disease, a collection of signs and symptom (syndrome)

Positive symptom of schizophrenia- delusion, hallucinations, thought disorders, they response to antipsychotics better

Negative symptom- affective flattening, speech incoherent, thought block, anhedonia, alogia/poverty of speech, poor grooming, lack of motivation, social withdrawal.

General symptoms of schizophrenia

1. Mood changes →patient experience increased anxieties, tension and irritations. With drawn and aloof about important issues, isolate themselves from others, are confused and alone, unable to harmonize and balance emotions. Pressure of speech and disconnected.

2. Blunted affect- patient's emotional expression is flat e.g. loss of a relative but no emotion. 3. Anhedonia- no pleasure form anything

4. Mutism and stupor- patient not able to talk or move

5. delusion- the patient finds every thing strange

6. Cognitive changes- the patient gradually loses the ability to present a logical relevant series of thoughts. Thought process is fragmented, illogical and with loosely associated elements.

7. Loss of concentration- looses concentration and focus on ideas, people or objects around him.

8. disturbance in thought form/ process

a) looseness of association- the patient presents ideas wq shift from one subject to another with incoherent speech

b) over inclusiveness- patient adds irrelevant materials within normal flow of thought and never return to the main idea

c) neologism- coining of new words

d) thought block- flow of speech is interrupted by forgetting, then they can return to normal flow

e) clanging- the patient rhymes words without caring about the meaning

f) echolalia- repeats words and phrases without caring about meaning

g) impoverished thought- patient talks but communicates little

9. Disturbance in thought content- Exhibited in patient's delusions- false beliefs (in the acute phase of schizophrenia, they may be disorganized and non systematized). In paranoid schizophrenia, the delusions are organized with a single theme.

10. perceptual changes

a) hallucination- most frequent type of perception disturbance (auditory, visual, olfactory and tactile) b) Illusion- misinterpretation of stimuli in the environment e.g. movt of curtain and the patient thinks it is a spirit entering the room.

11. Disturbance in motor functioning →catatonic motor disturbance, behavior of rigid posture.

Types of schizophrenia

1. **Catatonic schizophrenia**

It is characterized by bizarre motor behavior where patient is either in a stupor or excitement state.

2. **Disorganized/ hebephrenic schizophrenia**

Usually begins in adolescence before 20 years of age. The person regresses to a very primitive behavior, has minimal ability to execute activities of daily living, has no inhibition and has disorganized behavior. The patient is withdrawn with sloppy eating habits, may use neologism (own made words) and experience hallucinations. Patient may giggle or be silly inappropriately. Instead of having delusions, the patients tend to be disorganized and fragmented in their thinking. Features: incoherence of speech, marked loosening of association, grossly disorganized behavior, flat or grossly inappropriate affect and poor grooming

3. **Paranoid schizophrenia/ intellectual schizophrenia**

Preoccupied with one or more systematized delusions or frequent auditory hallucinations related to a single theme The patient has unfocussed anxiety, anger, argumentative and violent. Onset is later in life and may be more stable with time. Prognosis is better than other types.

4. **Simple schizophrenia**

Progressive deterioration and increasing eccentricity, develop in the absent of overt psychotic symptoms.

5. **Residual schizophrenia**

There is inappropriate or flat affect behavior and illogical or magical thinking may persist. The original psychotic symptoms have died away, leaving only apathy and emotional blunting

6. **Undifferentiated schizophrenia**

Characterized by delusion, hallucinations, incoherence and grossly disorganized behavior that can be classified in other schizophrenic types.

Medical management

Drug	Classification	Indications	Mode of action	Side effects	Dosage
Chlorpromazine	low potency antipsychotic/ major tranquillizers or neuroleptics	schizophrenia, brain damage, mania, toxic delirium, or agitated depression, alleviate severe anxiety, an antiemetic in palliative care	The drugs are thought to work by blocking dopamine receptors causing a decrease in psychotic symptoms.	drowsiness and orthostatic hypotension, Extrapyramidal side effects, anticholinergic effects	25-50mg
Diazepam	Anxiolytics or Anti-anxiety Drugs (benzodiazepines)	Given to a patient having generalized anxiety disorder, are able to provide relief.	It depresses the CNS by potentiating GABA an inhibitory neurotransmitter, producing skeletal muscle relaxation	Dizziness, headache, nervousness, insomnia, light headedness, dry mouth, nausea, vomiting, abdominal and gastric distress and diarrhea.	2-20mg IM or IV & 2-10 mg PO
Haloperidol	High potency antipsychotic	Schizophrenia, mania, drug induced psychosis, agitated patient or aggressive patient	The drugs are thought to work by blocking dopamine receptors in the CNS Has anticholinergic and alpha adrenergic blocking activity	drowsiness and orthostatic hypotension, Extrapyramidal side effects, anticholinergic effects	10mg
benhexol (Artane)					5mg PRN

Patient response to medications.

The patient is slightly improving

Nursing activity

a. Promoting safety of client and others and right to privacy and dignity
b. Establishing therapeutic relationship by establishing trust
c. Using therapeutic communication (clarifying feelings and statements when speech and thoughts are disorganized or confused)
d. Interventions for delusions: Do not openly confront the delusion or argue with the client. Establish and maintain reality for the client. Use distracting techniques. Teach the client positive self-talk, positive thinking, and to ignore delusional beliefs.
e. Interventions for hallucinations: Help present and maintain reality by frequent contact and communication with client. Elicit description of hallucination to protect client and others. Engage client in reality-based activities such as card playing, occupational therapy, or listening to music.
f. Coping with socially inappropriate behaviors: Redirect client away from problem situations. Deal with inappropriate behaviors in a non-judgmental and matter-of-fact manner; give factual statements. Reassure others that the client's inappropriate behaviors or comments are not his or her fault. Do not make the client feel punished or shunned for inappropriate behaviors. Teach social skills through education, rolemodeling, and practice.
g. Client and family teaching
h. Establishing community support systems and care

Assessment data	Nursing diagnosis	Expected outcome	interventions	rationale	implementation	evaluation	sign
Inability to perform daily activities	Deficient self-care deficit related to poor memory as evidenced by Inability to perform daily activities	The patient will be able to show self-care maintenance	Patient to be assisted to perform activities	Assisting the patient will improve self-care	Patient assisted in her daily activities	Patient showed an urge to perform on activities	
Patient unable to speak properly	Impaired verbal communication related to disorganized semantic memory as evidenced by the patient unable to speak properly.	Patient will be able to communicate effectively by time of discharge	Engage the patient as much as possible by speaking to the patient	Will help the patient express herself improving her verbal communication	Patient actively engaged	Patient speaking a few word	

Summary of the case study

The effects of schizophrenia on the client may be profound, involving all aspects of the client's life: social interactions, emotional health, and ability to work and function in the community.

The clinical picture, prognosis, and outcomes for clients with schizophrenia vary widely. Therefore, it is important that each client is carefully and individually assessed, with appropriate needs and interventions determined.

Careful assessment of each client as an individual is essential to planning an effective plan of care.

Failure to comply with treatment and the medication regimen and the use of alcohol and other drugs are associated with poorer outcomes in the treatment of schizophrenia.

biography

Recomendations

Careful assessment of each client as an individual is essential to planning an effective plan of care.

Visualize the client not on her worst but as she gets better and symptoms become less severe.

Interact with the client on the basis of real things; do not dwell on the delusional material.

The nurse also may be genuinely frightened or threatened if the client's behavior is hostile or aggressive. The nurse must acknowledge these feelings and take measures to ensure his or her safety. This may involve talking to the client in an open area .

Families must be educated about the disorder, the course of the disorder, and how it can be controlled. Families of clients with schizophrenia may experience fear, embarrassment, and guilt in response to their family member's illness.