

# Study on comprehensive mental health nursing assessment



**ASSIGN  
BUSTER**

A written account of a comprehensive mental health nursing assessment and plan of care for a selected client who has multiple health problems. This account must critically reflect on communication with other agencies and evidence of working with the client and or family in a collaborative manner. Particular attention should be paid to national policies in this area and evidence of best practice.

In this assignment it will define and discuss a nursing intervention for a client with a long enduring mental health illness. A systematic approach will be used the nursing process and the role of the mental health nurse will be clearly identified in providing care for the client. The nursing process consists of four stages, the assessment, planning, implementing and evaluation. This problem solving approach will be adopted to structure, organise, and present the nursing intervention. A fully detailed client's profile will be given. The "mental health assessment and plan" process will also be addressed. The client will be involved in the whole process as far as possible in order to empower him / her, a plan that is person centred and interventions that are evidence based will be displayed in the assignment. In this profile a pseudonym (James) will be used in accordance with the Nursing and Midwifery Council, (NMC, 2002) to maintain confidentiality. The need of the Multi - Disiplinary Team (MDT) for collaboration will be discussed in order to safe guard the patient to share skills and knowledge and to improve the quality of care.

James is a 65 year old man with a diagnosis of severely depression and excessive alcohol intake. He was detained under section 3 of the mental health act (1983) at a low secure unit. James was admitted into the unit 12

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months ago his index offence being physical assault and attempted suicide through an overdose with his prescribed medication for his depression and insomnia. He shares the house with four other men in the unit. James is potentially active and usually manages his day to day living activities as well as attending day care sessions without much prompting. However, he had recently become very reluctant to attend to his personal hygiene. This became worse when James started going for days without washing or bathing himself. His room was never cleaned hence having a bad odour because of his leg ulcer and he refuses the Tissue Viability Nurse (TV) to change the dressings regularly. Care Programme Approach (1991) which aims to improve the co-ordination of services and collaboration between the various agencies, carers and service user. The introduction of the CPA in (1991) was to provide shape, coherence to what had often been haphazard, uncoordinated attempts to provide support in the care for people with severe mental illnesses (DOH1991). CPA is a statutory framework within which bio-psycho-social needs assessments is carried out (Norman and Ryrie 2004).

This odour was because James would not change allowing the TV nurse to dress his leg ulcer for days. At his previous review meeting, issues around his hygiene had been viewed as hazardous to his health and also the health of staff since there were times when they would have to go into his room now and again. If James had no day care sessions to attend to he would sit and watch television. James also had a fairly huge appetite, he was observed to be frequently asking for more food at meal times. The other factor that proved he had a huge appetite was that he always asked for tea and biscuits several times between meals. This could be seen as poor eating patterns as

Henderson (2001) implied that frequent bingeing is a factor behind poor eating patterns. Concerns about his weight gain had recently been discussed in his review meeting. James had of late become very withdrawn, wanting to be alone all the time. In an interview with him, he expressed how he felt useless and not having any faith in himself.

He said he felt this was because his peers were looking down upon him because of his poor hygiene. James was referred to our team for five day assessment prior to facilitate discharge. James had a psychosocial assessment by the mental health nurse and the student at the day hospital. Good psychosocial assessments could be therapeutic to the client because it might be their first time to be able to discuss different aspects of their problems or a particular problem with anyone (Rose and Barnes 2008). The assessment is important in enabling the development of a care plan that is person centred that could stabilise James's conditions and endeavour to improve his quality of life. Care plans and working practices should be person - centred. The recover model also require a person - centred approach so that clients can explore their thoughts, feelings, lives and to discover more accepting sense of self (Repper & Perkins 2007).

James had a high score of 19 / 21 on the Beck Depression Inventory (Beck et al 1961 cited by Norman and Rylie 2007 pg 201, 438). However, all self - report inventories there is a possibility that clients may exaggerate or under-present symptoms resulting in low score to avoid further interventions (Castillo 2003). In this case the results from the inventory were therefore only be used as a guideline. The Department of Health (DOH 2001) properly targeted assessment and active care management promotes older people's

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independence through preventing deterioration and managing crises. It further states that proper assessments may reduce demand for services through assessing need more accurately and by ensuring services remain appropriate to needs, such systematic assessment is also valued by the older people.

Standard seven of the National Service Framework (NSF) for older adults advises professionals on treatment of depression and National Institute of Clinical Excellence (NICE, 2001) focused in the management of Depression NICE. These guidelines set clear proposals of tackling social exclusion, promotion of partnership working of the NHS and Social services, ensuring high standards of care and provision of quicker treatment, safe, sound and supportive services for people who suffer from depression. According to Redfern and Ross (1997) depression in elderly people is often undetected because elderly people will often complain of physical illness and physical aspects of depression rather than the depressed mood itself; moreover, they are not aware that depression is a distinct disorder which is treatable.

Norman and Rylie (2004) further state that most clinicians perceive depression as a normal ageing process and in this context the writer feels that professionals have to be more educated or increase their knowledge in recognising depression in elderly as they are the main gate keepers and misdiagnosed depression is a serious issue as most people will go untreated or undetected. The DOH (2001) could be seen to be in support with above view when they state that under-detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many older people live alone. Depression in people aged 65 and over is especially under-

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diagnosed and this is particularly true of residents in care homes, mental and physical problems can also interact in older people making their overall assessment and management more difficult and mental health problems may be perceived by older people as well as by professionals and their families, as an inevitable consequence of ageing, and not as health problems which will respond to treatment. These findings call for health professionals to be thorough when working with people with multiple health problems like James.

During the assessment it became apparent that James became severely depressed following the death of his wife and losing his family and the family house. He was struggling to cope with losing his house and moving into a residential home. He expressed feelings of loneliness and that he missed his family and neighbours. Depression in older people is under - detected and under - treated due to the ageist's misconception of thinking it's normal in this group. Symptoms displayed reflected that James was feeling depressed as according to the International Classification of Diseases (ICD - 10) 1992 the key symptoms of depression are depressed mood, loss of enjoyment or interest, lack of concentration, disturbed sleep, ideas of self harm or suicide.

James had made frequent remarks of 'ending his life' but could not further elaborate on how he intends to do this when asked by staff. This is recognised as a serious risk, it is difficult to establish these symptoms. However, older people are more likely than younger people to experience anxiety and memory loss as symptoms of depression (Pillai 1997). James lost contact with his family because they didn't want to know him due to his mental illness. There is a mounting evidence of discrimination experienced  
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by people with mental health problems within their families and in the community (Dunn 1999).

Beck et al (1998) defined health as that which includes dimensions of being, such as biological, social, spiritual and cultural. In this nursing intervention the nurse will be involved in the promotion of James's health and social well-being. Mathews (1996) emphasised that nurses need to follow a problem solving approach when intervening to the care of patients. The mental health nurse will use the nursing process to do a nursing intervention on James's care because Alan (1991) stated that the nursing process is a problem solving approach to care. The four stages of the nursing process will be followed step by step.

The Maslow's (1954) hierarchy of needs will be used to guide the nurse in the care planning. This hierarchy summarizes all human needs. Pillings (1991) mentioned that it is essential that people's needs are satisfied regardless of whether they are ill or well. Abraham Maslow provides us with considerable information about human needs regardless of their well being.

The rationale for using Maslow's hierarchy of needs as an assessment tool is that Maslow expresses that physiological needs must be dealt with first otherwise the person will die. The nurse therefore felt that James lacked mostly the ability to satisfy his physiological needs more than his other needs. Without meeting his physiological needs, in this case poor hygiene and unhealthy eating, James would not be able to gain his self esteem. The priority needs therefore identified during the assessment process were poor hygiene, excessive alcohol intake, poor eating habits and suicidal thoughts.

According to Roper et al (1983) a model is an artefact, which provides growing points for new ideas. Newton (1991) defined a model as a collection of mental images of what nursing should be like, which provides structure and direction to achieve its goal. The nursing model chosen for this intervention was the Roper, Logan and Tierney's (1983) Activities of Daily Living. This model was chosen as it uses a systematic approach and follows Maslow by looking at physiological needs first. The nurse decided to plan health promotion activities so as to improve and prevent any more deterioration to James's health. Kemn and Close (1995) maintained that health promotion is, among many definitions and approaches, defined as encompassing activities meant to prevent disease and illness, and improving the well-being of the community. Prior to the assessment, James was informed of the process. This was done in accordance with Newton (1991) who states that people should be given choice and autonomy and be able where possible to make their own decisions both trivial and important. The nurse worked through the four stages of assessment as required in the Roper, Logan and Tierney (1983) model. This was done by collecting information about James, reviewing the collected information, identifying James's problems then identifying priorities among the problems.

Orem's self care model (1985) could have also been ideal to use in James's assessment. This model emphasizes that individuals initiate and perform activities on their own behalf in maintaining life, health and well-being. As noted earlier, James needed a lot of prompting when it came to his self care therefore this model could be used to help James achieve the need of personal cleansing without much prompting.



Brown (1995) stated that planning is the activity whereby nurses can decide on the necessary actions on the basis of the identified needs. When planning clients' care nurses need to think of the aim, goal and objectives. An aim is a desired long-term outcome to be achieved in a specified time (Ewles and Simnett, 1999). In this case the aim was to help James understand the importance of eating appropriate food in relation to issues surrounding his weight. The other aim was to help him understand the importance of good hygiene in relation to his health and well being. Goals established in this case were to:-

- encourage James to adopt a healthy lifestyle by healthy eating.
- encourage James to prevent diseases by practicing good hygiene.

According to Fawcett et al (1997), objectives should be specific, measurable, achievable, and realistic and time framed. Kiger et al (1995) stated that an objective is what the teacher intends to achieve. In this case James will:-

Eat only reasonable amounts of food during meal times. In order to have a healthy body and to avoid a risk of developing diabetes. Over weight in James situation is bad for his leg ulcer.

Avoid unhealthy binging between meals.

Bath himself daily.

Change his socks daily.

Put all dirty socks for laundry.

Implementation is focused at the actual way the client carries out activities and the intention is to minimise disruptions, (Newton, 1991). James will be empowered with knowledge and confidence by providing him with one to one teaching and written information. James's named nurse would arrange some one to one sessions so as to encourage him to eat healthy. The nurse will also refer James to a dietician concerning issues about his weight. Educative leaflets on healthy eating will also be made available to James. Staffs who work with James will need to go for training on healthy eating. This would widen their knowledge leading to them supplementing biscuits for fruits so that James binges on fruits instead of biscuits. One to one sessions will be offered every time James fails to attend to his personal hygiene. During such sessions the nurse will attempt to work in a way not to force James to attend to his personal hygiene, but encourage him instead. The nurse will also seek to obtain James's own views about issues surrounding his personal hygiene she will achieve this by asking open-ended instead of closed questions. Understanding his own views about the issue will help the nurse work around encouraging him more effectively. James expressed a felt need when he discussed his feelings of uselessness and having no faith in himself.

The nurse then decided to draw up a care plan for James. Ewles and Simnett (1992) stated that the purpose of an action plan is to detail that who is going to do what and when.

Newton (1991) mentioned that evaluation is directly linked with care planning and is best defined as simply determining the extent to which goals have been achieved. According to the World Health Organisation (WHO, <https://assignbuster.com/study-on-comprehensive-mental-health-nursing-assessment/>

1981), evaluation refers to judgement based upon careful assessment and critical appraisal of given situations, which should reach sensible conclusions and useful proposals. It is therefore apparent that evaluation is an important issue in health promotion because it assists to judge the worthiness of an activity. According to Naidoo and Wills (1994), evaluation addresses participants perceptions and reaction to health promotion interventions and identifies the factors that support or impede the activities. They explain impact evaluation as referring to immediate effects whereas outcome evaluation refers more to long term consequences. In James's care plan, evaluating his health promotion activity would involve the following:-

Checking his weight using a body mass index was to check if he is overweight and to refer him to the dietician.

Checking if James has gained any understanding about the importance of good personal hygiene.

Checking if he has adopted any healthy eating habits.

Get feedback from James, other staff and dietician and accept suggestions.

The nurse will ask herself how the process went and what could be done differently to improve the quality of care in her future practice.

According to Rose and Kay (1995), the role of a mental health nurse is a multidimensional in nature which comprises of the assessment of needs, health surveillance, enhanced therapeutic skills, developing personal skills, management and leadership, enablement and empowerment and

coordination of services. An intervention is said to be more effective if it <https://assignbuster.com/study-on-comprehensive-mental-health-nursing-assessment/>

encompasses aspects like choice, empowerment and client involvement together with the client centred approach. Valuing People (2001) would be seen to be supporting this statement by emphasising on person centred planning. Applying person centred planning would help James assert control over his life hence empowerment. Throughout this intervention, the nurse maintained a good rapport with James which reflected the process of empowerment.

According to the (NMC, 2002), nurses have a duty to care. In this intervention, this was practiced when the nurse identified James's needs and used assessment tools and methods that are highly reliable and valid. For interventions to be successful, the smart system should be applied (Brown, 1997). Smart stands for specific, measurable, achievable, realistic, and teachable. This was applied to James's case as the process clearly had specific aims and goals. The nurse asked open-ended questions during the one to one sessions so as to help James feel comfortable and free to say out his own views. This could also be viewed as practising in accordance with Brown (1997) who states that putting the client's feelings, way of thinking and behaviour first helps makes teaching a success. The nurse did not attempt to clean James's room for him but just emphasised on encouraging him. By doing so, independence was being practiced. Brandon and Hawkes (1998) emphasised that independence can be achieved through empowerment and choice. The nurse also practiced partnership working by referring James to a dietician. It could be said that by so doing, the nurse was in recognition of her limitations.

A great knowledge on the different aspects of care planning was gained. This included assessment which had proved to be a vital component of care planning. In the planning stage the nurse gained an understanding of how to address clients' needs and take into consideration any necessary factors. These factors included the cognitive abilities of people with mental illness. The nurse felt that her communication skills for future practice had been enhanced as good interpersonal skills are vital for delivering holistic care. The nurse gained a more depth understanding of the role of the mental health nurse which includes empowering the clients and encouraging them to engage in activities carried out by the general population and not forgetting to take into consideration important issues like their disability.

This essay has detailed the different aspects of care planning. It has also emphasised the imperative role the mental health nurse plays in the health of people with mental illness. This is echoed by the (NMC 2002), which states that nurses should act to

identify and minimise the risk to clients. The whole activity has shown that in a nursing intervention there are a lot of other things to take into consideration. It's been apparent that it's not only the nursing process that helps achieve goals but together with all the other principles which involve the role of the nurse, consent, empowerment and multi-agency working.