Assessment and practice of mental health needs

The focus of this assignment is to show an understanding of the assessment process. A brief description of the patients profile and practice setting will be outlined. The setting’s name, location and patient’s name are not disclosed for confidentiality according to the Nursing and Midwifery Council, (NMC2008) hence the name will be fictitious. The patient has consented to the use of their personal information in this assignment. A consent form has been signed by the mentor. The patient’s name will be referred to as Jane. The assignment will discuss the importance of assessment and how the contribution of patient, family, or carer and multi professionals assist the process of assessment. The Mini Mental State Examination, (MMSE) tool will be used in the assessment of a patient and the rationale for using the tool will be discussed. The outcome of the assessment will determine the patient’s needs and future care plan and will therefore be highlighted. An analysis of the efficiency of the assessment tool, its advantages and disadvantages as well as my overall view on my experience of using the tool will conclude the assignment.

Maria is an 81 years old lady who was referred by the Emergency General Hospital to an elderly acute Mental Health hospital for patients with dementia. She was in the Emergency general hospital for treatment of a chest infection following a chest drain. The referral was made after she became uncommunicative and had stopped feeding orally. Whilst she was in the General hospital she had been put on a nasogastric feeding machine and had been bed bound for four months. She was admitted on an informal basis for assessment and treatment with the hope to discharge her back home with a full package of care or into a nursing home with a continuing package

of care. Jane’s past medical and non medical history confirmed that she suffered from anxiety and mild agoraphobia and has over the past few years had Cognitive Behavioral Therapy. She was reported by her son to have been forgetful over the past 3 years and had forgotten him. She has recurrent urinary tract infections. She mobilizes by use of a hoist and needs total nursing intervention. On admission she was found to be withdrawn and uncommunicative, she was diagnosed with depression and psychomotor agitation or pseudo dementia and acute confusion due to infection.

Alongside nursing care and support, she was offered specialist expertise intervention which involved the contribution from nutritionists, Doctors, physiotherapists and other multi professionals and multi agencies.

According to Phillip Barker, (2004), page 7, “ An assessment is described as the process of making a decision, based upon the collection of relevant information, using a formal set of ethical criteria that contributes to an overall estimation of a person and circumstances, while Mosby’s Medical Dictionary (2009), defines assessment as identification of needs, preferences, and abilities of a patient. Phillip Barker, (2004, p6) says that it was suggested by most psychologists that a definition relevant to psychiatric and mental health nursing should focus on estimation of character or person’s worth and what they may become.

An assessment is very important because it provides the scientific basis for a complete care plan. It is considered to be the first step towards treatment of a patient. An assessment has to be precise and accurate because it determines patient’s diagnosis and prescription of medication. An

assessment involves an interview and observation of a patient by the nurse and considers the symptoms and signs of the condition, the patient’s verbal and non verbal communication, the patient’s medical and social history and any other information available. The physical aspects assessed are vital signs, skin color and condition, motor and sensory nerve function, brain function, nutrition, rest, sleep, activity, elimination, and consciousness. The social and emotional factors included in assessment are religion, occupation, attitude towards hospital and health care, mood, emotional tone, and family ties and responsibilities. Medical Dictionary, Mosby, 8th edition, (2009).

There are two forms of assessment methods, which are informal assessment, where information is collected by less structured questions even haphazard methods and formal assessment where structure to questions is emphasized and has been planned and studied carefully through research. However different kinds of assessment tools in form of questionnaires or guidelines where designed in order to assist nurses in carrying out a formal assessment and collect information about the nature and scale of a patient’s problem. A tool is selected and used if the questions meet the individuals assessment needs.

The MMSE was first published in a Journal in 1975 as an appendix in an article written by Dr. Marshal Folstein , Dr Susan E. Folstein, and Dr. Paul R McHugh with the aim to separate individuals with cognitive functions from those without such disturbances. It was found to be highly reliable in detecting cognitive impairment and is now widely used around the world and in many clinical settings, and by General Practioners. The MMSE is a structured questionnaire that includes such categories as orientation to time

and place, registration, attention, calculation, recall, language, ability to follow a three step command and visual construction. It contains standard wording and a total score of thirty points. Any score greater than or equal to 25 points (out of 30) is normal, 9 points and below indicate severity, 10-20 points indicate moderate and 21-24 points indicate mild cognitive decline. According to Folstein, a score below twenty was found in patients with dementia, delirium, schizophrenia, or affective disorder, and not in normal elderly people. He also states that an abnormal score on the MMSE is not diagnostic of dementia or delirium but does reflect the severity of cognitive impairment. Thirty seven studies were carried out over ten years using the MMSE to show progress of patients with dementia and an average change of score was3. 3 points, Tom burgh and McIntyre (1992). The MMSE has its limitations , it is found that cognitive performance as measured by the MMSE varies within population by age and education, with lower scores for oldest age groups and those with less education and it is insensitive to very mild cognitive decline particularly in highly educated individuals, Miller et al: (August 1997). The MMSE was also found to be brief and can be easily administered in ten minutes. The rationale for using this assessment tool is that it is found to be appropriate for assessing elderly people with Dementia by the practice placement. The multi professional team also found the tool reliable and considered it to meet the patient’s needs and ensured clinical effectiveness and evaluation.

In order to prepare for Jane’s assessment, her medical and non medical history was accessed through Rio. Mary received specialist care of a nutritionist for diet intake, and a physiotherapist for aiding with walking since

the tendons of the back of her feet have shortened from being bed bound for four months. Weekly meetings are held by the Multi professional team in order to discuss her progress and review her care. Relatives are involved because they are considered to have an important role in planning of care and helping to evaluate the service and also in consenting for the patient if they do not have an advanced directive or capacity to consent.

Jane’s history explains why she is low in mood and tired most of the time. Therefore, it was important to be very sensitive when building a rapport with her. A professional relationship was built everyday for a period of two weeks during assisting her with personal care, by initiating conversation with her during the day, by assisting her with feeding, and getting involved in her physiotherapy sessions. A lot of empathy and encouragement was demonstrated. A therapeutic relationship built on trust and respect was developed.

When Jane seemed relaxed and less tired, she was asked if she would mind completing an MMSE and she consented. She was taken to a quiet room where an MMSE was administered. A quiet room was selected in order to reserve her privacy and to maintain concentration. Interview skills such as sitting squarely, maintaining eye contact, active listening and having an open posture and pleasant attitude where maintained (SOLAR). The questions were spoken clearly and softly and repeated for clarity when necessary. Jane remained calm, content and pleasant during the assessment and engaged appropriately throughout. Mary’s overall score was 13 out of 30. Jane’s results reflected poor orientation in time and place with a score of 4 out of 10, in registration test she was hesitant of repeating the three

objects but mentioned all 3 very quickly, on attention she could not subtract, she became very confused. On recall she could not remember any of the three objects which is a sign of short term memory. Jane was found not to be very clear in speech but could follow instructions of folding a paper, closing eyes and so on without much confidence. Her drawing and writing was much affected by shaking; she scored 6 out of 9 points.

Jane’s MMSE result is lower than 20 so it reflects poor cognitive function, memory problems, lack of insight and understanding possibly caused by dementia, urinary infections and maybe depression. Total nursing intervention is required. Her care plan requires a holistic approach based on physical, psychological, social, and spiritual needs.

Jane was involved in preparing her care plan. Her care plan outlines,

-Regular physical activities such as walking. Exercise is known to slow down decline in mobility associated with dementia. This will be achieved with the help of a physiotherapist.

-Imply cognitive stimulation by talking to Jane and allowing her to discuss her feelings and thoughts, and introduce recreational activities such as problem solving activities that may enhance quality of life and wellbeing.

-Reality orientation, by giving regular information about times, dates, season, places, or people to keep her oriented.

– Cognitive behavioral therapy known to treat people with depression associated with dementia. This can be achieved with the help of an Occupational Therapist.

-Reminiscence therapy by initiating discussions about her past so she can use her long term memory. This is known to be good in people with mild to moderate dementia.

-Sensory stimulation by use of music, lights, massage, sounds to stimulate the brain; this is known to improve restlessness and lift moods.

-A risk assessment with regular baseline observations to monitor self neglect and poor dietary intake and poor personal hygiene caused by poor cognitive function.

-General observations to be maintained by monitoring improvement or deterioration of mental or physical state.

-Two weekly MMSE’s to be carried out to monitor progress.

-Her son to be involved in weekly care reviews and in deciding her care.

This is important because problems such as hearing, illiteracy, late onset of depression, urinary tract infections, underactive thyroid, drugs such as sedatives and pain killers can cause memory lose and confusion so they can interfere with interpretation of the MMSE, if not properly noted. Patient UK leaflet Print, page 1, Alzheimer’s society,