**Case Study for Simulation Hours 1**

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NURS5078: Lab

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Case Study

Richard is a 62-year-old single man who says that his substance dependence and his bipolar disorder both emerged in his late teens.  He says that he started to drink to “feel better” when his episodes of depression made it hard for him to interact with his peers.  He also states that alcohol and cocaine are a natural part of his manic episodes.  He also notes that coming off the cocaine and binge drinking contribute to low mood, but he has not responded well to referrals to AA and past inpatient stays have led to only temporary abstinence.  Yet, Richard is now trying to forge a closer relationship to his adult children, and he says he is especially motivated to get a better handle on both his bipolar disorder and his substance use.  He has been more compliant with his mood stabilizing and antidepressant medication, and his psychiatrist would like his dual diagnoses addressed with psychotherapy.

SYMPTOMS

* Alcohol Use
* Depression
* Elevated Mood
* Impulsivity
* Mania/Hypomania
* Mood Cycles
* Substance Abuse

**KING UNIVERSITY MSN/NP PROGRAM CLINICAL SOAP NOTE FORMAT PSYCHIATRIC MENTAL HEALTH**

**Student:** Tonya Buchanan **Course:** NURS5078 **Date:** 4/20/2022

**SOAP Note # Simulation Hours 1**

**Type of Visit:**

* New/ Initial Psychotherapy Intake

**Start Time:** 11:00 AM **End Time:** 12:00 AM

**Billing Codes:** 99204

# Patient Information

**Initials:** R **Age:** 62 **Gender:** Male **DOB:** 3/30/60

**Accompanied by:** Self

**Informed Consent Given**: Self

# Subjective Data

## *CC:* Psychiatrist referred for psychotherapy for Bipolar and Substance Use Disorder.

***HPI:*** 62-year-old single, white male looking for help for his substance use and bipolar diagnoses. His goal is to reconnect with his adult children.

***Onset****:* Developed bipolar and substance use in teens.

***Location****:* Low mood.

***Duration:*** Over 45 years.

***Character****:* Hard to interact with others.

***Aggravating/Associated:***Manic episodes

***Relieving****:* Drinking alcohol and using cocaine.

***Temporal****:* Coming off alcohol and cocaine binges.

***Severity:***Has lost relationship with adult children.

***Past Medical History****:* No medical history.

***Psychiatric History****:* Previous diagnosis of substance use and bipolar.

***Inpatient****:* Previous admissions to psychiatric hospitals.

***Therapy:***He has attended AA with no success but no individual therapy.

***Past Psych Diagnoses****:* Patient states that he has been diagnosed with bipolar and substance use. The diagnosis listed on the psychiatrist referral does not list bipolar. There are diagnoses of impulsivity, depression, mood cycles, mania/hypomania, elevated mood, alcohol, and substance use.

***Past Medication Trials****:* Mood stabilizer and antidepressant.

***Developmental History:*** Patient is unaware if he was born premature.

 ***Developmental delays?*** Unknown

***How were they managed?*** N/A

***What therapies were used, and did they help?*** N/A

***Medications:*** Mood stabilizer and antidepressant.

## *Allergies & Reactions:* NKDA

## *Preventative Care*: Following guidelines for psychiatric visits currently and sees PCP once a year.

## *Immunizations & Travel*: Vaccines are up to date including flu and COVID.

## *Family History:* Unsure of family medical or menta history.

***Social History:*** The patient is retired, does not go out in public, has no close friends.

***Trauma History:*** No previous trauma.

**Review of Systems (ROS)**

***General Constitutional:*** States that he feels good today but anxious about moving forward.

***Skin, Hair & Nails:*** Denies cutting or self-harm.

***Chest and Lungs:*** Denies heart problems.

***Heart & Blood Vessels:*** Feels heart racing at times.

***Nutrition/Diet:*** Regular diet, working on adding more protein and fewer carbs
***Gender Related:*** Always uses a condom when sexually active.

***Neurologic:*** No weakness noted bilaterally in face or extremities.

**Psychiatric Review of Systems (PROS)**

***General Constitutional:*** Dressed appropriately for weather. Clean clothes and hair. Hair cut in short fashion and styled neatly.

***Mood:***  Excited and eager to start the process of therapy. He admits to fear of failing and letting his children down. Denies suicidal or homicidal ideations. Denies better off dead feelings.

***Sleep:*** Endorses trouble sleeping. This has become better with the use of medications from his psychiatrist. He has trouble falling asleep but once asleep does not awake till morning. Denies hypersomnia.

***Feelings:*** Denies hopelessness, helplessness, hostility. Endorses low self-esteem, feelings of guilt and shame in abandoning his children. Fear that he will disappoint them again.

***Interests:*** Does not have current hobbies. He used to enjoy golfing and listening to music.

***Energy:*** Does have some low energy when his mood is “low.” He gets perked up when he has communication with his children.

***Concentration:*** Endorses difficulty in concentrating and this is increased if it is quiet.

***Appetite:*** Denies changes in appetite or weight. ***Self-Harm/Suicide Risk:*** Denies.

***Homicidal Thoughts:*** Denies.

***Psychosis:*** Denies.

***Eating Disordered Behavior:*** Denies.

***Attention and Behavior:*** Denies difficulty with attention or organization, hyperactive or impulsive behavior, vandalism, setting fires, violent behaviors towards humans or animals, or bullying.

***Precipitating Factors***: Time alone in quiet spaces. Needs background noise at all times.

**Objective Data**

*Vital signs: Temp:* 98.4 *HR:84 RR:16 BP:136/78 Pain scale:0/10 HT:*70 inches *WT:170 BMI: 24.4*

***Physical Exam***

***General:*** Alert and oriented X 4. Appearance, speech, behavior, and thoughts appropriate. Remote and recent memories are intact. Good eye contact.

***Movement:*** No tremor or tics, normal gait and stance, no involuntary movement.

***Speech:*** Clear and organized.

***Mood:*** Admits to times when he feels low, and this is usually when he turns to substance use to help self-medicate. Denies feeling elevated or anxious today but does have “manic” moments.

***Affect:*** Full ranging, not constricted or flat, and congruent with current mood.

***Language:*** No language abnormalities, speech is fluent without stutter. Good sentence structure.

***Cognition:*** Alert and orient X 4, oriented, no signs of short-term memory impairment, no cognitive disfunction, states he does have trouble concentrating at times.

***Thought Process:*** No thought deficits noted.

***Thought Content:*** No thought content impairment, no suicidal or homicidal ideations, no paranoia, poverty of thought, thought insertions, hallucinations, delusions. He admits to fear of his relationship with his children not lasting.

***Insight and Judgement:*** Insight and judgement with no deficits.

***Skin:*** No unusual scarring or markings. No discolorations, rashes, healing wounds, scabs noted on observable skin.

***Neck:*** No striations, bruising, swelling, or pulsations noted.

***Chest:*** Chest rises and falls bilaterally and equally.

***Neurologic:*** No neurological deficits with body movement or language.

**Assessment**

1. Bipolar I (F31.12)

2. Cocaine Use Disorder (F14.20)

3. Alcohol Use Disorder (F10.20)

Differentials: (this includes any diagnoses considered when forming final diagnosis listed above)

1. PTSD (F43.10)

2. Non-adherence to Medical Treatment (Z91.19)

3. Antisocial Personality Disorder (F60.2)

 *Rule Ins/Rule Outs (further investigation or testing needed)*

1. Personal History of Psychological Trauma (Z91.49)

2. Unavailability or Inaccessibility of Other Helping Agencies (Z75.4)

3. Hallucinogen Disorder (F16.20)

*Treatment options:* Interpersonal and Social Rhythm Therapy (IPSRT) and Motivational Enhancement Therapy (MET)

*Patient input regarding treatment options:* The patient is willing to try therapy to develop better skills to help replace the alcohol and cocaine with better coping techniques. Motivation is a better relationship with his adult children.

*Obstacles to treatment options*: The patient’s own fear and long-time reliance on substance use as his coping mechanism.

*This section should be well developed. This section of the SOAP note is* ***not*** *something you would include in your notes in clinical practice; however, this shows faculty your analysis of the presenting problems throughout the clinical decision-making process. As well as your knowledge about the specific diagnoses you are choosing. In this section, use APA format to cite research and national standards of care or information.*

**Etiology/Possible causes:** Bipolar I can be genetic with 10 times likely risk if other family members have diagnosis of bipolar I or II (DSM-5, 2020). The closer the relative the more likely the risk (DSM-5, 2020).

**Prevalence of disease:** Prevalence per DSM-5 (2020) is equal in male and female.

DSM5 criteria met: The patient was diagnosed by a psychiatrist and has self-reported manic episodes that he self-treats with cocaine and alcohol.

**Rule ins (minimum of 1-3 based on symptoms and DSM diagnosis criteria, what are your** i**nitial thoughts and why did you rule these in):** Bipolar I, alcohol and cocaine use are self-reported and diagnosed by referring psychiatrist. A good history is always necessary before treating a patient to verify that the psychiatrist and self-diagnosis are indeed on point.

**Rule outs (minimum of 1-3 based on symptoms and DSM diagnosis criteria, what are your initial** **thoughts and why did you rule these out):** An in depth initial interview will rule out the history of possible trauma, other substance use can be identified by drug testing and good interviewing techniques, and there needs to be a determination that the client has access and knowledge to community services that he made need assistance with for food, utilities, and/or transportation.

**Plan**

## Treatment(s):

## *Pharmacological:* Patient has a psychiatrist that is prescribing medication. Vivitrol should be considered to help since the patient is at a point of wanting to develop a relationship with his children. Vivitrol (Naltrexone) 380 mg injection is given once a month and helps to lessen the enjoyable effects of alcohol and opioids and the cravings that can develop. The psychiatrist will be contacted to determine if this is an appropriate consideration for the patient. A prior authorization can be obtained once the psychiatrist agrees to the use of Vivitrol.

## *Nonpharmacological:* IPSRT, MET as it is more likely to be successful with therapy and pharmacologic care for this patient’s diagnoses.

***Lab work ordered****:* Verify a recent drug screen has been done by psychiatrist to determine if there are any other substances being used. This will also need to be done before Vivitrol can be prescribed.

**Therapy recommendations**: *Interpersonal and Social Rhythm Therapy:* “Drawing on research demonstrating that sleep and schedule disruption is an important component of bipolar disorder, the original interpersonal psychotherapy approach has been expanded to provide techniques for enhancing the regularity of daily routines and schedules. The treatment also includes a focus on mourning the losses associated with bipolar disorder. The interpersonal components of therapy involve focusing on resolution of current interpersonal problems, such as unresolved grief, interpersonal disputes, role transitions, and interpersonal isolation” (American Psychological Association, 2018).

*Motivational Enhancement Therapy*: Motivational enhancement is done is a lesser number of sessions and will address concerns about abstaining from substance use and finding alternative coping strategies. The therapy does not ramp up but instead addresses the concerns immediately and frankly. This type of therapy has been found to be somewhat more productive than a twelve-step program (US Dept. Health and Human Services, 2020). It will need to be discussed as to why AA was not successful as it may help develop answers and directions to which his therapy will need to go.

**Holistic options:** Meditation and breathing exercises to develop skills to stop the client from turning to alcohol or cocaine to cope with difficulties.

**Complimentary therapies:** The patient can keep a log of his moods on a mood app on his cell phone to help understand what he is dealing with on a day-to-day basis. This will also help to determine how long the manic episodes are lasting.

## Patient Education: Start making healthy choices with vitamins and diet. Start an exercise program that is approved by primary care physician and take a multivitamin. Keep journal of how many drinks are had and the emotions when drinking and using cocaine. The patient is a binge drinker, so the directions are to just not to have that first drink since there is not a necessity to taper since the alcohol use is not every day. A Clinical Institute Withdrawal Assessment for alcohol will be completed prior to initiating the necessity of tapering the alcohol and if the score is above 15 the patient is having severe withdrawal symptoms and would need to be hospitalized for taper. This assessment tool can be used at each session. The patient can also be aware of the tool, so he is able to determine if he needs to seek care for withdrawal. The patient does not wish to enter rehab for withdrawal care but promises to follow instructions on symptoms that may require hospitalization.

**Referrals:** Nutritionist if the insurance approves. Prior authorization will be initiated, and the patient will be contacted once a determination is made.

**Ordered Diagnostic Tests and Labs:** No testing other than drug screen is necessary.

**Safety Plan:** Symptoms of alcohol withdrawal will be irritability, muscle spasms, tremors and the patient would need to report to the nearest emergency room for treatment. Cocaine withdrawal symptoms that will need attention are psychological such as restlessness, vivid dreams, suicidality, tremors, muscle aches and pain and the patient would need to go to the nearest emergency room for treatment. Alcohol and cocaine together can increase the necessity for inpatient treatment for withdrawal. Contact 911 if you feel suicidal with plan.

**Follow-up instructions**: Weekly therapy sessions will be anticipated for the first 3 months and the plan will be discusses at each office visit to verify that the client is still in agreement and comfortable with the plan.

# Competency Reflections

**TN Pain Competency**

Review the core competencies for pain and addiction at the website below. Identify a competency and how it was addressed while providing care for this patient https://www.tn.gov/content/dam/tn/opioids/documents/PAME\_Report\_July2018.pdf

Pain is addressed at every visit and done so with no intent of judgement or shame.

**NONPF Competencies**

Discuss how you addressed at least 3 NONPF competencies during this visit. **Identify the competency area and the specific core competency for each.** (See NONPF competency list available at [https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/20170516\_NPCoreComp](https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/20170516_NPCoreCompsContentF.pdf) [sContentF.pdf](https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/20170516_NPCoreCompsContentF.pdf) )

1. Help patients and caregivers understand conditions and treatments (Technology and Information Literacy Competencies).

2. Uses clinical experiences to inform practice and improve patient outcomes (Practice Inquiry Competencies).

3. Considers the complex relationships between cost, safety, access, and quality in healthcare delivery (Quality Competencies).

## Interprofessional Collaboration Competencies

Provide a brief reflection for one of the competencies listed below. Discuss how you addressed or would address collaboration with another member of the health care team in relation to your patient’s care. Optimally, this should be someone other than a primary care provider and reflections should be completed on different interprofessional roles throughout the program.

Interprofessional Education Collaborative. (2016). *Core Competencies for Interprofessional Collaborative Practice: 2016 update*. [https://nebula.wsimg.com/2f68a39520b03336b41038c370497473?AccessKeyId=DC06780E69E](https://nebula.wsimg.com/2f68a39520b03336b41038c370497473?AccessKeyId=DC06780E69ED19E2B3A5&disposition=0&alloworigin=1) [D19E2B3A5&disposition=0&alloworigin=1](https://nebula.wsimg.com/2f68a39520b03336b41038c370497473?AccessKeyId=DC06780E69ED19E2B3A5&disposition=0&alloworigin=1)

**Competency 1 Values and Ethics for Interprofessional Care (VE1, VE3, VE4, VE5)** Discuss how cultural diversity, individual values, and interests of the health care team (including the patient) may have impacted care decisions.

It is important to understand how culture, religion, and family work in each patient’s life. There may be triggers within either. It is important to know the foundation of each patient to be able to know how to proceed.

## Competency 2 Roles/Responsibilities (RR2 & RR4)

Recognizing your own scope of practice, what elements of treatment, health promotion or disease prevention could another member of the health care team offer your patient that you can’t?

Knowing that the referring psychiatrist has known this patient longer and can provide incredibly important insight in his care.

## Competency 3 Interprofessional Communication (CC2 & CC3)

What communication strategies can be used to ensure understanding of information, treatment, and care decisions between patients, families, and other health care team professionals?

Referring physicians should always get a review note to determine what steps were taken in the client’s care. Providing the clients with a review of visit and what the plan of care will be can lessen the frustration of trying to remember once the client leaves the office.

## Competency 4 Team/Teamwork (TT1, TT3. TT7, TT11)

What principles of teamwork can be used to effectively plan, deliver, and evaluate care given to the patient?

The psychiatrist only wanted therapy addressed. This means that the PMHNP should not overstep the bounds and stay in their lane for the care given. That does not mean a suggestion cannot be made in the best interest of the client.

**References**

American Psychiatric Association. (2020). *Diagnostic and statistical manual of mental disorders: dsm-5*.

Boland, R. J., Verduin, M. L., Ruiz, P., & Sadock, B. J. (2022). *Kaplan & sadock's synopsis of psychiatry*. Wolters Kluwer.

*Competencies report - tennessee state government - tn.gov*. (n.d.). Retrieved April 21, 2022, from https://www.tn.gov/content/dam/tn/opioids/documents/PAME\_Report\_July2018.

Corey, G. (2021). *Theory and practice of counseling and psychotherapy*. Cengage.

*Interpersonal and social rhythm therapy (IPSRT) for bipolar disorder: society of clinical psychology*. Society of Clinical Psychology | Division 12 of the American Psychological Association. (2018, March 8). Retrieved April 20, 2022, from <https://div12.org/treatment/interpersonal-and-social-rhythm-therapy-ipsrt-for-bipolar-disorder>.

*Motivational interviewing, motivational enhancement therapy (MET), and met plus CBT for mixed substance abuse/dependence: society of clinical psychology*. Society of Clinical Psychology | Division 12 of the American Psychological Association. (2018, March 8). Retrieved April 20, 2022, from https://div12.org/treatment/motivational-interviewing-motivational-enhancement-therapy-met-plus-cbt-for-mixed-substance-abuse-dependence.

*Order any lab test or blood tests online - walk-in lab*. (n.d.). Retrieved April 21, 2022, from https://www.walkinlab.com.

*Prescription prices, Coupons & pharmacy information*. GoodRx. (n.d.). Retrieved April 21, 2022, from https://www.goodrx.com.

Stahl, S., Grady, M. M., & Muntner, N. (2021). *Stahl's essential psychopharmacology: prescriber's guide*. Cambridge University Press.

U.S. Department of Health and Human Services. (2020, June 1). *Motivational enhancement therapy (alcohol, marijuana, nicotine)*. National Institutes of Health. Retrieved April 21, 2022, from <https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies/motivational-enhancement-therapy>.

*Vitamins for alcoholics - what are the best?* The Alcoholism Guide. (n.d.). Retrieved April 24, 2022, from https://www.the-alcoholism-guide.org/vitamins-for-alcoholics.html.

*What are the nurse practitioner core competencies?* Nurse Journal. (2022, January 20). Retrieved April 21, 2022, from https://nursejournal.org/resources/what-are-the-nurse-practitioner-core-competencies.

Wheeler, K. (2022). *Psychotherapy for the advanced practice psychiatric nurse: A how-to guide*

 *for evidence-based practice*. Springer Publishing Company.

**Case Analysis**

 It is hard to analyze a case with only one paragraph of information. The education, information, safety plan, and how the gaps would be filled in the story would come from clinical experience that had been obtained this semester. The patient seemed like he would be more complex than what was seen in those few sentences. Admitting to a problem and seeking help with a clear goal in mind though seems like a patient bound to be successful. Even if the patient is just a made-up name and story on paper. This patient does exist out there and we will care for him/her/them over and over.

 When reviewing this case, the concern was if the patient had bipolar or if the substance use mimicked the signs and symptoms of bipolar (Hashmi et al., 2018). Though it is also known that those with mental illness abuse drugs more often than those without mental illness (Hashmi et al., 2018). The symptoms of the patient’s bipolar developed about the same time that he began using cocaine and alcohol and this is criteria for substance induced bipolar disorder (DSM-5, p.142, 2020). This has also caused impairment with his relationship with family (DSM-5, 2020).

 Prevalence for substance induced bipolar has not been studied and there are no numbers to report at this time (DSM-5, 2020). The prevalence of bipolar in men versus women is equal (DSM-5, 2020).

 The treatment for alcohol and cocaine use is not one that is talked about often, Naltrexone can be used to treat both though it is considered off label for cocaine use treatment (Blitzstein et al., 2022). Vivitrol injection for alcoholism is just another form of naltrexone (Stahl, 2021). The case study revealed information that will help me to treat patients that will be encountered often in my time in practice.

**References**

American Psychiatric Publishing. (2013). *Diagnostic and statistical manual of mental disorders: dsm-5*.

Blitzstein, S., Ganti, L., & Kaufman, M. S. (2022). *First aid for the psychiatry clerkship*. McGraw Hill.

Hashmi, A. M., Czelusta, K.-L., Jabbar, Q., Siddiqui, S., & Shah, A. A. (2018). Psychiatric illness in the emergency department. *Psychiatric annals*, *48*(1), 21–27.

Stahl, S., Grady, M. M., & Muntner, N. (2021). *Stahl's essential psychopharmacology: prescriber's guide*. Cambridge University Press.

**Reflection of Case Study**

 It is no secret that East Tennessee has issues regarding substance use. The substance use for the entire state of Tennessee is expected to be more than 12% higher than the national average (Cernasev et al., 2022). There are many factors in Tennessee being one to the worst impacted states with the opioid epidemic but what they believe is the diverse socioeconomic status from one end of the state to the other (Cernasev et al., 2022).

 Having worked in healthcare in this area for so long, stigma regarding patients that use drugs has always been obvious. Physicians have been witnessed telling patients they would not be taken care of due to positive drug screens. Some patients were told they were a waste of the health community’s time. Having come from a family of addicts, I was quick to remind physicians that these were someone’s family. Someone loved that person sitting in front of them, track marks and all. Sometimes providers had to be reminded of their own faults and “acceptable” addictions. Stigma needs to be removed for appropriate care to be given to those that struggle and suffer and this is why the DSM-5 (2020) changed the diagnosis from addiction to substance use disorder (p. 485).

 John 13:34 A new commandment I give unto you, That ye love one another; as I have loved you, that ye also love one another (Bible Online, 2015). People know God is in us when we show Him in our behavior and words. We reflect Him in everything we do and speak. People are more likely to seek care and be successful with that care when met with respect and genuine care for their bodies and spirits.

**References**

American Psychiatric Publishing. (2013). *Diagnostic and statistical manual of mental disorders: dsm-5*.

Cernasev, A., Kline, K. M., Barenie, R. E., Hohmeier, K. C., Stewart, S., & Forrest-Bank, S. S. (2022). Healthcare Professional Students’ Perspectives on Substance Use Disorders and stigma: A qualitative study. *International journal of environmental research and public health*, *19*(5), 2776.

Online, K. J. B. (2015, September 20). *King James Bible online*. BIBLE VERSES ABOUT LOVING OTHERS. Retrieved April 24, 2022, from https://www.kingjamesbibleonline.org/Bible-Verses-About-Loving-Others