**Comprehensive Case Study: Week X**

Name X

School of Nursing, Regis College

NUR643: Advanced Psychopharmacology

Instructor

Month Day, 20XX

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**Introduction and Differential Diagnoses**

*DO NOT COPY and PASTE data directly from the case. For each case study, we want you to summarize the information and synthesize your thoughts in APA paper format. “Synthesizing requires the reader to****take that summary or retelling of the case and add in their assessments, interpretations and connections to generate a working clinical treatment plan (classroom nook).”***

In one paragraph, (a paragraph is a minimum of 3 fully developed sentences!!!), in your own words, discuss the chief complaint and history of present illness. Include a problems list: (list main problems patient is being seen for from chief complain and characteristics of sx)

**Differential Diagnosis List** (formulated as first thought after hearing the Chief complaint, and continued to be investigated and differentiated throughout history and exam)

**1.**

**2.**

**3.**

**Rationale: Pertinent Positive, Negatives, DSM5 Criteria**

What pertinent positive and negatives were in the case to help narrow down the diagnosis and select these differentials? **Use your own words, do not copy, and paste from the case.**

*What are pertinent positive and negative? “(Pertinent positives and negatives are targeted descriptions of relevant symptoms, essential to a thorough history. For example, in a patient with a fever, pertinent positives point to the diagnosis (“The patient described chills, cough, rusty sputum, and right-sided chest pain that worsened with inhalation”). Pertinent negatives point away from diagnosis (“He denied shortness of breath”) and rule out other diagnoses (“He denied headache, neck stiffness, nausea, vomiting, diarrhea, dysuria, and rash”* [*(Yale School of Medicine, 2020)*](https://medicine.yale.edu/news-article/notes-on-notes/)*.”*

**Narrative Mental Status Exam**

This section will simply be a *narrative format* (paragraph form) of the mental status exam information. You should all begin practicing the narrative format of MSE documentation. It is your objective data for the case. (Minimum of one full paragraph with all MSE criteria/components included) Here are a few links to help you with Narrative Format MSE.

[Sample of Narrative format MSE.](https://johnsommersflanagan.com/2012/08/10/two-sample-mental-status-examination-reports/)

[MSE Definitions and Verbiage.](https://www.admsep.org/subpages/eresourcesrepository/modules/MSE/story_content/external_files/MSE%20Definitions.pdf)

**Variations from Normal and Monitoring Needs**

Additionally, discuss any variations from normal you noted in the case; patient labs that are not normal etc… Are there any specific concerns in relation to past or current history, diagnoses, including medical, vitals, and any contraindications or possible drug to drug interactions to monitor?

if none, place, “No concerns noted” in this section.

**Assessment**

Discuss what tools or instruments you would use to confirm your assessment and describe scoring of the instrument. Note what a positive score would be to confirm the diagnosis based on the tool. (Minimum of 2-3 paragraphs) This can then later be used in subsequent visits as a one quantitative measure of efficacy of treatment and remission of symptoms—an outcomes measure.

Here is a link to many [psychometric screening instruments/tools](https://www.psychologytools.com/download-scales-and-measures/) to help you.

**Primary Diagnosis and Coding (**include DSM 5 diagnosis with any specifiers and ICD 10 code)

**Plan of Treatment and Rx**

Develop a plan of care for your chosen diagnoses, including the following subcategories in your treatment plan.

Pharmacological Intervention and Rx:

* including dosage, route, and frequency, any special instructions for patient or pharmacy or titration instructions
* Drug Class
* Describe the mechanism of action (MOA) for the medication
  + What neurotransmitters are affected;
    - increase or decrease?
    - What enzymes are involved?
    - Where is medication metabolized (ex: liver, kidneys, etc...)
* Correlation to Diagnosis as it related to symptoms management and targeting of surplus or deficits in neurotransmitters involved. When is medication expected to reach a therapeutic level? How long after initiation?
* Is lab monitoring required with this medication? If so what labs and how often?
* Is this FDA approved (label or off label) for the diagnosis given?
* If off label what is rationale for proceeding with this treatment?
* List a minimum of 3 possible side effects and what the causes of these are.
* Are there any contraindications or interactions of concern? Any drug-to-drug interactions from current medications list for patient? If yes, how will you monitor?

**Nonpharmacologic Interventions**

* including modality and frequency with rationale for specific modality

**Patient Education:**

* Explain diagnosis, prevalence, expectations, and course of illness
* Medication education
  + Any side effects?
  + What side effects would warrant the patient to contact provider or go to ER immediately?
  + Any current drug to drug interactions patient should know of? If yes, explain interaction to patient with risk versus benefits.
  + Is there any concern for a patient who is pregnant or breastfeeding with this medication?
  + Are there any conditions or other medications that cause this medication to be contraindicated?
  + When can patient expect relief from symptoms?

**Safety Plan:**

This section should be well developed, and every patient should have a safety plan. Considerations:

* Did you previously ask about
  + SI/HI/and a/v/t/H?
  + Access to weapons?
* Is this medication a controlled substance?
* Does this medication carry a black box warning?
* Where are medications kept?

Use the [Stanley-Brown safety plan](https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf) questions here.

* + Warning signs
  + Review current coping strategies and identify protective factors in life to give value and hope
  + Identify a support person if needed
  + Know clinic numbers and closest ER, 911, Suicide hotline
  + Weapons, medications, etc… locked

**Follow-up and Outcomes:**

* What is level of care placed? (IOP/PHPP/RTC/Inpatient/Outpatient)
* When will patient follow-up? Exact timeframe and where?
* How will you determine outcomes of treatment plan on follow-up? Specifically, what quantitative and qualitative data will be documented to indicate an observable decrease in symptoms?

**Billing Code for visit:** considered this as an initial intake, are there any additional codes for add on psychotherapy, patient education, assessment testing and analyzing, etc...

**Approach to Care and Clinical Guidelines**

For this section, you will summarize the unique aspects of the case and include a minimum of one evidence-based guideline for treatment that you used to determine your treatment plan.

**References**

Case assignment should incorporate a minimum of four evidence-based practice articles and one evidence-based guideline for treatment.