

Mental Status Exam:

Document subjective & objective data

1. Appearance:
Appeared to be disheveled and lacking self-grooming, odorous. Wearing paper scrubs provided by DBH. Hair unkempt with excessive drooling from mouth. Short and walked with head hung downward. Unfocused on surroundings and displayed confusion during group activities. Relationship between appearance and age (40) were incongruent, developmental/intellectual issue suspected. Stated she lives in female group home in Seaford, DE. Lacks adequate support from sister and stepfather. Mother passed away in 2017.
2. Behavior:
Scanned the environment frequently, often laughing (inappropriate affect), and displayed repetitive hand motions and rocking. Failed to maintain eye contact during conversations with others. Rapid panting with excessive body movements when experiencing anxiety.
3. Speech
Speech slow, soft, slurred, and difficult to understand. Disturbance of articulation and stuttering at times.
4. Mood
Appeared sad and withdrawn prior to initial introduction and conversation. Inappropriate affect (laughing at unfit times), outbursts of crying placing hands over face stating “I can’t deal with this” due to the distractions of other patients during group therapy discussion. Stated, “I can’t do it anymore, but I have to” and “I have so much anxiety”.
5. Disorders of the Form of Thought
Disorganized thought process and circumstantial thinking. Rapidly discussed a variety of topics regarding reason for admission to mental health facility and personal life struggles, often needing to redirect and backtrack. Displayed obsession of constant need for “getting sick” due to anxiety. Sipped water and chewed banana just to spit out into basin.
6. Perceptual Disturbances
Denies hallucinations and/or delusions.
7. Cognition
Alert and oriented to person, place, time, and situation. Reading and vocabulary are at mid-elementary level. Denies memory impairment but has a decreased attention span. Insight and judgement are sound, stated “I had to come here for help” due to suicidal ideation wanting “life to be over”.
8. Ideas of harming Self or Others
Admitted for suicidal ideation Friday 10/6. Stated “I wanted to kill myself” but main reason for living is “for my mom” who passed way in 2017.

Problem #1: Risk for Suicide

Patient Goals:

1. KL will not show evidence of suicidal ideation or self-harm during my time of care.
2. KL will not harm self during my time of care.

Assessments:

- Assess for suicidal ideation q shift, Assess for a plan to carry out suicide q shift, Assess mood and behavior q 2h, Assess for presence support system upon admission.

Interventions (In priority order):

1. Establish trust and rapport by way of consistency of care, keeping promises, and genuineness during my time of care.
2. Maintain a safe milieu by eliminating dangerous objects (sharps, contraband, cords) from mental health unit and provide paper scrubs for the patient q shift.
3. Initiate suicide precautions upon admission to mental health unit. (1:1 sitter included)
4. Utilize therapeutic communication such as showing empathy, having a nonjudgmental attitude, and actively listening to patients to obtain important health information during my shift.
5. Assist in setting realistic goals prior to discharge from mental health unit.
6. Educate on helpful resources such as the suicide hotline, support, groups, and therapists prior to discharge from mental health unit.

Problem #2: Anxiety

Patient Goals:

1. KL will identify signs and symptoms of increasing anxiety during my time of care.
2. KL will have vital signs associated with anxiety within normal limits during my time of care (RR: 10-20, HR: 60-100, BP: 120/80)

Assessments:

- Assess anxiety level q 1h, Assess coping mechanisms q shifts, Assess triggers of anxiety q shift, Assess HR, RR, and BP q 4h.

Interventions (In priority order):

1. Establish trust and rapport by way of consistency of care, keeping promises, and genuineness during my time of care.
2. Maintain a safe milieu by eliminating triggers and providing comfort during my time of care.

3. Decrease excessive stimuli (light, sound, movement) to decrease levels of anxiety during my time of care.
4. Stay with KL during times of anxiety to provide comfort during my shift.
5. Utilize therapeutic communication skills such as active listening and restating so the patient feels understood during my time of care.
6. Administer anxiolytic to decrease anxiety as needed during my time of care.

Patient Teaching

List 2 teaching topics that you taught a client. Were they appropriate for this client, and why?

1. Coping mechanisms for when anxiety and depression begin interfering with well-being. It might be difficult for my client to utilize this teaching due to a developmental delay and intellectual disability.
2. Eat small frequent and bland meals to help with nausea because of anxiety. This is appropriate for my client due to her complaint of "feeling sick" and the availability of small snacks on the unit.

Growth & Development

1. Discuss norms of growth and development, including development stage.

Middle Adulthood (40): generativity vs. stagnation.

Often married with family and has a job, losing parents and experiencing associated grief, launching children into their own lives, adjusting to home life without children, dealing with adult children who return to live at home, becoming grandparents, preparing for late adulthood, acting as caregivers for aging parents or spouses.

2. Discuss any deviations of growth and development and the developmental stage.

Disruption of speech (slurred, under-developed vocabulary), unable to read and write certain words (education level: mid elementary), inappropriate affect (laughing at unfit times). Living in a group home, with no job or partner/children, needs special care from others.

Self-Evaluation: Answer each of the following questions.

1. What is your personal perception of your performance during your clinical day? What did you do well? What could you have done better? Give specific examples.

I feel that today's clinical was a really great experience and awesome learning opportunity. I think I did a great job conveying acceptance and empathy towards the patients as I used therapeutic communication to get to know about them and their story. Something I could have done better is reach out to more patients and not be timid to getting the day started. For example, I kind of stood back when we first entered the room instead of starting conversations right away. I think I could have gone in and sat with a patient and been more comfortable speaking with them since they are normal people just like us! I also only got a few patients story of admission, so tomorrow my goal is to learn more about some new patients! I realized that many of the patients were very open about sharing their story with others, which was great.

2. Give an example of one of the challenges you faced today. What did you do to overcome it?

A challenge I faced today was communicating with my specific patient who had some developmental delays and a difficult time communicating. I overcame it by using simpler terms and being patient as she was telling me her story.