

Dover Behavioral Health
Clinical Assignment
2023

Student Name: Gracie Brewster Date: 10/11/23

Patient's Initials: P.H Age: 40's Sex: F

Psychiatric Diagnosis(es): Depression, Attempted Suicide, Anxiety, Bipolar

Pathophysiology of the main Psychiatric Diagnosis:

Depression: Decrease in dopamine, serotonin, and norepinephrine neurotransmitters

Anxiety: Increase in GABA neurotransmitter.

Bipolar: Depression and Maic symptoms. When depressed, there is a decrease in dopamine, serotonin, and norepinephrine. When manic, increase in dopamine, glutamate, and norepinephrine.

Medications

Medication Name, Classification/Action	Rationale	Side Effects	Nursing Implications
<p>Fluoxetine (Prozac)</p> <p>SSRI Antidepressant</p> <p>Blocks reuptake of serotonin in synaptic space allowing for an increase in serotonin level.</p>	<p>Treatment of depression and depressive mental health disorders.</p>	<p>Sexual dysfunction</p> <p>Insomnia</p> <p>CNS stimulation</p> <p>Nausea</p> <p>Dizziness</p> <p>Dry mouth</p>	<p>*Monitor for suicidal ideation*</p> <p>Monitor for signs and symptoms of serotonin syndrome.</p> <p>Do not take with a MAOI's.</p> <p>Limit caffeine intake.</p> <p>Take in the A.M.</p> <p>Don't stop abruptly.</p>

Mental Status Exam:

Document subjective & objective data

1. Appearance

Dressed appropriately in DBH provided paper scrubs and socks, disheveled with hair unkempt, nails long but dirty, no odor, maintained eye-contact without wandering, facial expression neutral, relationship between age and appearance is appropriate.

2. Behavior

Body movements consistent without peculiarity, maintained eye contact throughout the conversation. Denied repetitive gestures and abnormal behaviors.

3. Speech

Speech normal and soft, no disturbances.

4. Mood

Affect appropriate, mood content, shared during group time she is “optimistic and hopeful” as she is being discharged on Thursday 10/12. Skeptical about the discharge plans due to homelessness and uncertainty of security moving forward. Progress noted in mood since admission to present time. Upon admission stated “hopeless, helpless, lonely, and feels worthless.

5. Disorders of the Form of Thought

Thought process organized, no delusions or obsessions.

6. Perceptual Disturbances

No hallucinations of illusions present.

7. Cognition

Alert and oriented to person, place, time, and situation, no memory impairment, her attention, abstraction, insight, and judgment is sound. She is aware of her illness, behaviors, and mental health problems and is accepting the treatment and participating in the steps to get better.

8. Ideas of harming Self or Others

Upon admission, had attempted suicide by overdose by taking bottle of Unisom and vodka. Stated her attempt was due to domestic verbal and mental abuse of 17 years. No suicidal ideation presents upon most recent examination.

Problem #1: Risk for Suicide

Patient Goals:

1. P.H will report any thoughts of suicidal ideation and plan to healthcare professional if occurring during time of care.
2. P.H. will refrain from self-harm 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, homeless shelters/housing prior to discharge from mental health unit.

Problem #2: Readiness for Enhanced Self-Management

Patient Goals:

1. P.H. will verbalize self-care management techniques that will be beneficial following discharge such as medication compliance and coping mechanisms during my time of care.
2. P.H. will verbalize at least one resource that can help with access to housing options, food availability, and employment opportunities during my time of care.

Assessments:

- Assess plan of living arrangements following discharge, assess willingness to set new goals during q shift, assess access to healthcare following discharge during my care.

Interventions (In priority order):

7. Encourage P.H. to consult with assigned social worker for planning discharge during my time of care.
8. Identify the variety of methods to maintain medication compliance following discharge during my time of care.
9. Identify housing and transportation availability following discharge during my time of care.
10. Provide resources for maintaining sobriety (such as AA meetings) during my time of care.
11. Provide resources for employment opportunities for life after discharge during my time of care.
12. Encourage group therapy to build a support network while managing new life obstacles 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. Teach about the variety of resources available for housing, transportation, sobriety maintenance, and mental health support. These are appropriate for my client due to her sudden break in sobriety of 8mo at time of suicide attempt, impending homelessness, and diagnosis of depression, bipolar, and anxiety.
2. Teach about coping mechanisms to use during times of severe depression and anxiety. This is appropriate for my clients due to her dual diagnosis of depression, anxiety, and bipolar disorder.

Growth & Development

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

Middle Adulthood (40's): 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.

Deviations include homeless, unemployed, not married with any children. Lacks a support system or family of her own. Intellectual stage within normal limits for middle adulthood.

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.

Today was a great clinical day. Since it was day 2 at Dover Behavioral Health, I felt more comfortable jumping right into having conversations and assessing the patients at breakfast time and then in the day rooms. It came with ease due to knowing the patients better since we had already met them the day before. I feel that I did well asking questions in a therapeutic way and making the patients feel accepted and understood. I could have done better during my chart research for my patient. It is very difficult to understand the patient charts due to handwritten notes and an abundance of papers. Overall, I felt confident with my nursing strategies and pleased with the outcome of my day, and I am thankful for the great experience at the facility.

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 not extremely difficult, however there was a slight struggle in the flow of conversation with P.H. during breakfast time. She was talking and answering questions that I asked her; however, her responses were slightly short and hesitant. I had to think a bit harder about my responses so that she didn't feel overwhelmed by my questions and our conversation. I also facilitated the use of silence as a therapeutic communication skill. The longer we spoke, the easier it was to connect and start the flow of a beneficial conversation.