Mental Health Case: Linda Waterfall

Documentation Assignments

1. Document your findings related to the focused assessments of Ms. Waterfall's signs and symptoms of respiratory and/or cardiac distress. Include her responses to your assessment. I asked the pt if she had diffictulty breathing, assessed pulso oximetry, and auscultated her breath sounds. She stated that she couldn't catch her breath and felt like she was having a heart attack. I responded by reassuring her she was safe here and that I would sit with her while we took deep breaths together. I later asked if she had any chest pain to where the pt stated that she had none.

2. Document your findings related to the focused assessment of Ms. Waterfall's signs and symptoms of acute anxiety. Include her responses to your assessment. I aske the pt what was going on with her today and she responded by letting me know what a bad morning she had and she feels like her life is falling apart. I responded with a response that reflected her feelings she just told me about. As far as signs and symptoms of acute anxiety I asked her questions about when she felt her best over past year and assessed her breathing and heart rate. I believe her respirations were 24 and HR was slightly over 100.

3. Referring to your feedback log, document all nursing care provided and Ms. Waterfall's response to this care. -I got consent that it was ok for her cousin to stay in room for interview. – Her cousin wanted to get coffee so I assured Linda I would stay with her while she got coffee. – I confirmed pt identity. – I asked her about what was going on with her today and she replied with details on what a bad morning she had. – I asked her when she felt her best over the past year. Her response was that she felt that we were all out to get her since we were making her have surgery. I responsed by reassuring her we were not trying to hurt her and are only looking out for her best interests. – I assessed her vital signs and auscultated her heart and breath sounds. I also asked if she had any chest pain and she stated no. – I supported her in taking deep breaths. – I assessed her IV and tried to administer lorazepam to ease her anxiety but she refused. – I supported the patient in medicine bundle and taking more deep breaths.

4. Document all interventions associated with the management of Ms. Waterfall's anxiety as they are included into her plan of care. Include interventions especially focused on her spiritual and cultural needs, as well as those demonstrating nursing advocacy. To help manage Ms. Waterfall's anxiety I tried to administer lorazepam but pt refused. I introduced myself and never left her side to try to ease anxiety. I reassured her when she was worried about her medicine bundle which seemed very important to her.

5. Document your handoff report in the SBAR format to communicate Ms. Waterfall's future needs.

Situation: Linda Waterfall is 48 year old patient of Dr. Samuels. She is scheduled for a left mastectomy this morning around 0830.

Background: Linda is a Native American woman who has been diagnosed with breast cancer after having a biopsy a few days ago. She is here with her cousin. She is nervous and mentioned having a bad morning today. She stated wanting to not go through with surgery this morning. I called the physician and he is on his way.

Assessment: Her consent forms are signed and I have assessed her IV where dextrose 5% Lactated Ringer's is running at 80mL/hr. The IV is running in an 18 guage catheter in her right forearm. Her recent vitals are as follows: HR 110bpm;

respiratory rate 24 breaths/min; blood pressure is 150/80; and temperature is 98.6 degrees. Her breath sounds are equal clear bilateral. She is not taking medications at this time and refused her preoperative Lorazepam.

Recommendation: Like I mentioned before, she is nervous and stating that she does not want to go through with surgery. I recommend introducing yourself and staying by bedside until the Dr. arrives.