



Student Name: Natalie Marino

Unit: The Plaza

Pt. Initials: MR

Date: 08/11/2021

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKA

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List solution to dilute and rate to push. IVPB – List ml/hr and time to give	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Sertraline Hydrochloride (Zoloft)	-SSRI	-Antidepressant	25mg po QDaily	Y N	IVPB – List ml/hr and time to give	-Intense suicidal ideation -Dry mouth -Drowsiness -Anxiety/agitation	1. Teach patient to take in the morning with food. 2. Teach patient 1-3 weeks to be therapeutic. 3. Immediately report suicidal ideations 4. Teach to never abruptly withdraw from medication
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

Student Name: Natalie Martinez

Date: 08/11/2021

IM6 (Acute Psychiatric) Critical Thinking Worksheet

<p>1. DSM-5 Diagnosis and Brief Pathophysiology (include reference): Schizophrenia is a devastating, chronic brain disease that is prone to recurring psychotic episodes. It is not a single disease, but rather a syndrome that involves cerebral blood flow, neurotransmitter-physiology, neuroanatomy, and neurochemistry.</p> <p>4. Medical Diagnoses: Intellectual disability disorder</p>	<p>2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.):</p> <ul style="list-style-type: none"><li>- Foreclosure</li><li>- Meth use</li><li>- Cannabis</li><li>- Homeless</li></ul>	<p>3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References)</p> <ul style="list-style-type: none"><li>- Delusions *</li><li>- Hallucinations *</li><li>- Disorganized speech *</li><li>- Very disorganized or <del>catatonic</del> catatonic behavior *</li><li>- Negative symptoms: apathy * *anhedonia, depression, amotivational states</li></ul>
<p>5. Diagnostic Tests Pertinent or Confirming of Diagnosis</p> <ul style="list-style-type: none"><li>- Toxicology screen</li><li>- DSM-5 screen</li></ul>	<p>6. Lab Values That May Be Affected:</p> <ul style="list-style-type: none"><li>- Blood levels - make sure Haloperidol is staying in a therapeutic range.</li><li>- WBC - Pyromucocytosis (rare)</li></ul>	<p>7. Current Treatment:</p> <ul style="list-style-type: none"><li>- Haloperidol. Plan is to taper to lowest effective dose.</li></ul>

Adopted: August 2015, revised October 2018

Vaicantolis, E.M., + Vaicantolis, E.M. (2015).

Chapter 9 / Schizophrenia Spectrum and Other Psychiatric Nursing Care Planning: Assessment, guides, diagnoses, psychopharmacology (pp. 217-260), essay, Saunders Elsevier.

Student Name: Natalie Nafine

Date: 08/11/2021

<p>8. Focused Nursing Diagnosis: Impaired verbal communication</p>	<p>12. Nursing Interventions related to the Nursing Diagnosis in #7: 1. Plan short, frequent periods with a client throughout the day.</p>	<p>13. Patient Teaching: 1. Teach patient the importance of abstaining from meth and cannabis as it can potentiate symptoms of schizophrenia. 2. Teach patient about foods high in albumin. Patient has hypoproteinemia. 3. Teach patient the importance of consistently taking her medications and continuing treatment.</p>
<p>9. Related to (r/t): psychosis, disorientation, inaccurate perception, hallucinations, delusions</p>	<p>Evidenced Based Practice: Short periods are less stressful, and periodic meetings give a client a chance to develop familiarity and safety. 2. Look for themes in what is said, even though spoken words appear incoherent.</p>	<p>14. Discharge Planning/Community Resources: 1. Transfer to Sunrise Canyon hospital for continued psychiatric treatment. 2. Refer to Grace campus for housing -</p>
<p>10. As evidenced by (a/e/b): Inappropriate verbalization. Patient states inappropriate statements that does not pertain to the questions.</p>	<p>Evidenced Based Practice: Often client's choice of words is symbolic of feelings. 3. Focus on and direct patient's attention to concrete things in the environment.</p>	<p>3. Refer to Grace campus for housing -</p>
<p>11. Desired patient outcome: Patient will express thoughts and feelings in a coherent, goal-directed manner by 1500 on 08/11/2021.</p>	<p>Evidenced Based Practice: Helps draw focus away from delusions and focus on reality-based things.</p>	<p>3. Refer to substance abuse program for meth use.</p>

## Covenant School of Nursing Reflective Practice

Name: Natalie Martinez

Instructional Module: IM6

Date submitted: 08/11/2021

*Use this template to complete the Reflective Practice documentation. Use only the space provided. Information that is not visible is lost.*

<p><b>Step 1 Description</b></p> <p>I had my clinical day at Covenant Behavioral Health Unit. One of mine and the TPCN patient needed her vitals checked to take her medication. One of the other nurse's tried taking the patient's vitals, and she declined. The TPCN went to go talk to the patient and explained why needed her vitals. The patient agreed to let her take her vitals.</p>	<p><b>Step 4 Analysis</b></p> <p>Therapeutic communication is relevant to this situation. By the TPCN calmly and slowly explaining to the patient, it changed the patient's mind to allowing her take her vitals.</p>
<p><b>Step 2 Feelings</b></p> <p>This was my first time at a mental health hospital, so I was very nervous and scared to be at the facility. When we got report on this patient, they said she was agitated and was on aggressive precautions. The TPCN was very calm and did not seem scared to talk to her. This made me feel more at ease and comfortable interacting with the patient.</p>	<p><b>Step 5 Conclusion</b></p> <p>I could have made this situation better by not being so timid. I don't think there is anything else the nurse could have done to make it better. She did great. I learned that patient's need different types of communicating and staying calm is very therapeutic.</p>
<p><b>Step 3 Evaluation</b></p> <p>I learned that whatever is said during report about a patient doesn't always accurately reflect a patient. The TPCN did really well communicating with the patient about why it is important for us to get her vitals. I expected the patient to get aggressive and angry.</p>	<p><b>Step 6 Action Plan</b></p> <p>Overall, I think this situation was handled very well by the TPCN. The TPCN could have not tried again and just not admin the patient's meds. However, she cared about keeping the patient safe because she knew the patient needed her medication, and that the medication was only safe to give if her blood pressure was higher than 150/50. For my future practice, I learned that</p>

just communicating with your patient makes them more compliant.