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.

Patient showed signs of tachypnea, RR 24, pulse ox 100%, chest equally moving, lung sounds were clear and equal bilaterally. I asked her if she was having any difficulty breathing and the patient stated that she "feels like she is having a heart attack", "feels like she is going to die", and reported dyspnea saying that she "couldn't catch her breath" and it "feels heavy when she breathes". Her blood pressure was 150/80, HR 110, tachycardia, heart sounds were regular, no murmurs. Patient reported having no chest pain.

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.

Patient appeared to be extremely distressed and anxious, stating that "she hadn't had a good morning" was "unable to find her medication bundle" and wasn't "able to reach her father". She feels like she can't proceed with the surgery until she finds her bag of medicine. Fears having surgery because her mother passed away from surgery complications. Her family lives far away, but she was reluctant that her cousin, Alice, was able to be there with her. Patient seemed restless stating that it was "hard to sit still". I asked the patient to number her distress on a 0-10 scale but she was unable to do. She seemed to grow impatient as I continued to interview her stating that "all these questions seem to be just wasting time".

3. Referring to your feedback log, document all nursing care provided and Ms. Waterfall's response to this care.

I checked the scene for safety before entering the patient's room. I introduced myself to the patient, performed hand hygiene, identified the patient, asked for any known allergies, asked if it was ok for her cousin, Alice, to stay in the room during our interview, offered to stay with the patient while Alice left the room to get some coffee, took the patient's vital signs, did a focused respiratory and cardiovascular assessment, asked the patient to tell me a little more about what was going on, instructed the patient to perform deep breathing exercises when she seemed to get upset, I actively listened to the patient, supported and advocated for the patient, provided education to the patient, called the provider, and did teaching when the patient was discharged. The patient understood that she could didn't have to proceed with the surgery and could chose to do it another day or not all.

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.

I checked the patient's room for safety, I made sure that the patient was seated at all times, I instructed the patient to do deep breathing exercises to help calm her down whenever she seemed to get upset. I tried asking her about some things that she enjoys doing, in hopes of helping her to focus on doing those things when she was feeling really anxious. I asked her to rate her distress on a scale from 0-10 but she was unable to do so. I offered to give her 2mg of Lorazapam to help calm her nerves before the procedure, but the patient refused. She explained that the only medicine she needed was her medication bundle but she was unable to find it this morning. I actively listened to her concerns and advocated for her by letting her know that I knew how important it was to her cultural needs to have her medicine bag. I

performed patient teaching, letting her know that she could choose to have the procedure done at a different time, or not at all.

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

Situation- Linda Waterfall, 48 year old female patient of Dr. Samuels, scheduled for a left mastectomy this morning at 0830 but is extremely anxious and hesitant to have the surgery.

Background- Linda is a Native American woman who was diagnosed with an aggressive form of breast cancer a few days ago after having a biopsy done. Her family doesn't live near by and wanted her to meet with the tribal healers before scheduling a surgery but she went ahead and scheduled it anyways. She's here now with her cousin Alice, but is extremely nervous about having the surgery done because her mother died of complications of surgery. She said that she hasn't been sleeping well recently and is unhappy about losing her breast.

Assessment- She is in room 2046 and is still trying to make a decision about having the surgery or not. Her consent forms are signed and on the chart, and she has an IV of dextrose 5% lactated Ringer's infusing at 80mL/hr through an 18-gauge catheter in her right forearm. Her last vital signs were: heart rate 110; respiratory rate 24; blood pressure 150/80: pulse ox 100%; temperature 98.6F; and she reports no pain. She has a small incision on her left breast, the stitches were taken out yesterday and it is dry and uncovered. During my focused assessment, she was tachypnea and complained of not being able to catch her breath but her lungs were clear bilaterally, her heart sounds were regular, and she isn't reporting any chest pain. I instructed her to do some deep breathing exercises and that seemed to help a little bit.

Recommendations- She is upset about not having her medication bundle with her and refused the 2mg of Lorazapam I offered to give her to help calm her before the surgery. I don't think she will be willing to take any other medications right now so I would continue trying to get her to do some more deep breathing exercise and possibly give her some oxygen.