PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:

Major Depressive Disorder (MDD)

A disturbance of mood involving depression or loss of interest or pleasure in usual activities and past times.

DSM-5 Criteria for your patient's diagnosis:

Fatigue and loss of energy nearly everyday.

Psychosocial Stressors (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)

Thoughts of loss.

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:

Patient centered, one on one

Stage of nurse-patient relationship:

Working Phase

Therapeutic communication techniques appropriate for this patient:

-Genuineness
-Empathy
-Demonstrating Positive Regard
  -attitudes
  -actions
  -attending
  -validating
-Suspending Value Judgements

Communication approaches to avoid:

-Inconsistency
-Unavailability
-Agruing, minimizing, or challenging the patient
-Criticism

Plan of Care:

Patient problem:

Complicated Grieving

Related to (etiology):

Thwarted grieving response to loss

As evidenced by (signs & symptoms):

Reliving of past experiences with little or no reduction of intensity of the grief.

Outcome/Goal:

Client will be able to recognize his or her position in the grief process.

Current Treatment & Interventions:

1. Determine the stage of grief in which the client is fixed. Identify behaviors associated with the stage.

Accurate baseline assessment data are necessary to effectively plan care for the grieving client.

Rationale:

2. Convey an accepting attitude and encourage the client to express feelings openly.

An accepting attitude conveys to the client that you believe he or she is a worth while person. Trust is enhanced.

Rationale:

3. Help the client to discharge pent-up anger through participation in large motor activities (eg. brisk walks, jogging, punching bag, exercise bike)

Physical exercise provides a safe and effective method for discharging pent-up tension.

Rationale:

4. Encourage the client to review relationship with the lost entity. With support and sensitivity, point out the reality of the situation in areas where misrepresentations are expressed.

Rationale:

The client must give up an idealized perception and be able to accept both positive and negative aspects about the lost entity before the grief process is complete.

Student name: Amanda Miller

Amanda Miller

Aspire, AA and Oceans Reflection (300 word minimum)

Safety & Quality Describe anything you accomplished to maintain a safe, quality environment	I was calm, quiet, and welcoming in an attempt to maintain a safe and positive environment.
Clinical Judgment As you listened during group, how were you able to integrate classroom knowledge with what the patient/therapist were discussing: • What can you apply to this situation from your previous knowledge? • Can you apply these learnings to other events? How can you use this to further improve your practice in the future? • What have you learned from clinical?	During the different groups and activities, I noticed a lot of focus on addressing emotions and although everyone was at a different stage in their treatment, everyone all seemed to agree on one thing. It is okay to not be okay. That was really nice to see first hand. Everyone was very supportive of each other and no one seemed to judge anyone else. I got to see a few people get discharged and the genuine 'good luck out there' send offs are very moving. Although everyone has their own battle they are fighting, they didn't seem to hesitate to lend a hand or some words of encouragement if someone needed it.
Patient Centered Care Identify one client in the group, what concerns, recommendations/interventions would you suggest?	There was one individual who I believe needs significant help beyond what Oceans may be able to provide. This individual needs some intensive therapy for substance abuse as well as mental health. I believe this individual has a long way to go, once they decide they would like help.
Professionalism How did you maintain professionalism? You can review your clinical evaluation for ideas (What has this taught you about professional practice? About yourself?	I maintained professionalism by arriving on time, clean, without wrinkles in my clothes. I followed the rules of the facility as well as school. I maintained healthy boundaries with my peers and patients, allowing for optimal growth and learning.
Communication & Collaboration Describe how you utilized therapeutic communication/collaboration	I really tried to utilized the time to practice talking points and the do's / don'ts we learned throughout lecture. I felt like the patients appreciated me.
Feelings • How were you feeling at the beginning? • What were you thinking at the time? • How did the event make you feel? • What did the words or actions of others make you think? • How did this make you feel? • How did you feel about the outcome? • What is the most important emotion or feeling you had?	I was excited to see what it was like because I have never seen inpatient treatment. I was a little nervous about everything being locked, from a personal standpoint, but I completely understand why it locked down. Hearing the positive stories being told in group and seeing smiles made me happy, and hopeful for their futures. Inclusion. I felt included, welcomed, and wanted. The staff were friendly and the patients were very open to talking about their stories and the way their diagnoses affected them.
Evaluation What stood out the most about Aspire, AA, or Oceans	All of the locked doors. Oh and the crayons, West unit has the better bucket of crayons. They even have some with glitter and I was told that coloring makes them happy.

NURSING SHIFT ASSESSMENT

DATE: 8/26/25 tues SHIFT: ☒ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: _____
MR#: _____ D.O.B. _____

Amanda Miller Happy!

Orientation
☒ Person
☒ Place
☒ Time
☒ Situation

Affect
☒ Appropriate
☐ Inappropriate
☐ Flat
☐ Guarded
☐ Improved
☐ Blunted

ADL
☒ Independent
☐ Assist
☐ Partial Assist
☐ Total Assist

Motor Activity
☒ Normal
☐ Psychomotor retardation
☐ Psychomotor agitation
☐ Posturing
☐ Repetitive acts
☐ Pacing

Mood
☐ Irritable
☐ Depressed
☐ Anxious
☐ Dysphoric
☐ Agitated
☐ Labile
☐ Euphoric

Behavior
☐ Withdrawn
☐ Suspicious
☐ Tearful
☐ Paranoid
☐ Isolative
☐ Preoccupied
☐ Demanding
☐ Aggressive
☐ Manipulative
☐ Complacent
☐ Sexually acting out
☒ Cooperative
☐ Guarded
☐ Intrusive

Thought Processes
☒ Goal Directed ☐ Tangential ☐ Blocking
☐ Flight of Ideas ☐ Loose association ☐ Indecisive
☐ Illogical ☐ Delusions:) (type)_____

Thought Content
☐ Obsessions ☐ Compulsions ☐ Suicidal thoughts
☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes (No) **Pain scale score** _____ **Locations** _____
Is pain causing any physical impairment in functioning today ☒ No ☐ If yes explain _____

Nursing Interventions:
☒ Close Obs. q15 ☒ Ind. Support ☒ Reality Orientation ☐ Toilet Q2 w/awake ☐ 1 to 1 Observation _____ reason (specify)
☒ Milieu Therapy ☐ Monitor Intake ☒ Encourage Disclosure ☐ Neuro Checks ☐ Rounds Q2
☒ V/S ☐ O2 sat. ☐ Tx Team ☒ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☒ Nursing group/session (list topic): _____
☐ ADLs assist ☒ I&O ☐ PRN Med per order _____

☐ DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES (violence, suicide, elope, fall, physical health) DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted	Since Last Contact	
Ask Question 2*	YES	NO
2) Have you actually had thoughts about killing yourself?	LOW	X
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Have you been thinking about how you might do this?	MOD	
4) Have you had these thoughts and had some intention of acting on them? E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."	HIGH	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? As opposed to "I have the thoughts, but I definitely will not do anything about them."	HIGH	
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	HIGH	X

Low Risk Moderate Risk High Risk

Nurse Signatures: SN Date: 8/26/25 Time: 0750

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐WNL ☐Elevated B/P ☐↓ B/P
☐Chest Pain
☐Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☐Clear ☐Rales ☐Crackles ☐Wheezing
☐Cough ☐S.O. B ☐Other: _____
☐ O2 @____l/min ☐Cont. ☐ PRN
Via ☐ nasal cannula ☐ face mask

Neurological / L.O.C.:
☐Unimpaired ☐Lethargic ☐Sedated
☐Dizziness ☐ Headache ☐Seizures
☐Tremors ☐ Other_____

Musculoskeletal/Safety:
☐Ambulatory ☐ MAE ☐ Full ROM
☐Walker ☐W/C ☐Immobile
☐Pressure ulcer ☐Unsteady gait
☐Risk for pressure ulcer
☐Reddened area(s)

Nutrition/Fluid:
☐Adequate ☐Inadequate ☐Dehydrated
☐ Supplement ☐Prompting ☐Other_____
new onset of choking risks assessed

Skin:
☐ Bruises ☐ Tear ☐ No new skin issues
☐ Wound(s) (see Wound Care Packet)
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
☐ Continent ☐ Incontinent ☐ Catheter
☐ Diarrhea ☐ OTHER_____

Hours of Sleep: ____ ☐ Day ☐ Night

At Risk for Falls: ☐ Yes ☐ No

At Risk for FALL Precautions:
☐ Arm Band ☐Nonskid footwear
☐BR light ☐ ambulate with assist
☐Call bell ☐Clear path
☐Edu to call for assist ☐Bed alarm
☐ Chair alarm ☐ 1:1 observation level
☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____

Student Name: Amanda Miller Unit: West Pt. Initials: _____ Date: 08/26/2025

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: Penicillin

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
	Isotonic/ Hypotonic/ Hypertonic			

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.)
Thiamine HCL	B Vitamin	Alcohol Abuse	100 mg PO Daily	Y N	NA	-nausea -bloating -bitter taste	1. Neuro checks to monitor for signs of confusion, ataxia, nystagmus, memory loss 2. Monitor mental status compared to baseline to evaluate effectiveness of medication. 3. Monitor for signs of allergic reaction (rash, itching, anaphylaxis). 4. Educate ETOH cessation due to the effect it has on absorption.
Folic Acid	B Vitamin	Alcohol Abuse	1 mg PO Daily	Y N	NA	-rash -dizziness -trouble breathing	1. Signs of folate deficiency (fatigue, pallor, irritability, glossitis, poor appetite). 2. Give with or without food, but encourage with food to reduce GI upset. 3. Monitor CBC and H&H 4. Educate ETOH cessation due to the effect it has on absorption.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

Amanda Miller
8/26/25

Quick Screening for Psychotic Symptoms (QSPS)

Ask:		Yes	No	Unsure/Did not answer
1	Have you had any strange or odd experiences lately that you cannot explain?		/	
2	Do you ever feel like people are bothering you or trying to harm you?		/	
3	Has it ever seemed like people were talking about you or taking special notice of you?		/	
4	Are you afraid of anything or anyone?		/	
5	Do you ever have visions or see things that other people cannot see?		/	
6	Do you ever hear things that other people cannot hear, such as noises, or the voices of other people that are whispering or talking? **If yes, ask:**		/	
	If you hear voices, can you understand what the voices are saying? **If yes, ask:**			
	Are the voices telling you to do anything that could harm yourself or someone else? **If yes, ask:**			
	What are the voices telling you to do? **(Record response here):**			

Answering "yes" to any of these questions indicates the need for a more detailed assessment and follow-up questions.

Nutrition Education Check-Off Form

Participant Initials: ___

Date: 8/26/25 Student name: Amanda Miller

Topics Covered

(*Check each item as it is completed or discussed*)

#	Topic	Completed	Comments
1	Eat homemade meals	☑	
2	Skip sugary drinks	☑	
3	Stop eating when full	☑	
4	Eat less salt	☑	
5	Drink 8 glasses of water a day	☑	
6	Include a healthy fat	☑	
7	Practice portion control	☑	
8	Choose low sugary snack	☑	
9	Eat without distractions	☑	
10	Stick to your prescribed diet	☑	
11	Eat complex carbs and protein	☑	
12	Eat whole grains	☑	
13	Eat a dairy source	☑	

The Vitamin Book

NURSING SHIFT ASSESSMENT

DATE: 8/27/25 wed

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: _____
MR#: _____ D.O.B. _____

Amanda Miller

Orientation
- ■ Person
- ■ Place
- ■ Time
- ■ Situation

Affect
- ■ Appropriate
- ☐ Inappropriate
- ☐ Flat
- ☐ Guarded
- ☐ Improved
- ☐ Blunted

ADL
- ■ Independent
- ☐ Assist
- ☐ Partial Assist
- ☐ Total Assist

Motor Activity
- ■ Normal
- ☐ Psychomotor retardation
- ☐ Psychomotor agitation
- ☐ Posturing
- ☐ Repetitive acts
- ☐ Pacing

Mood
- ■ Irritable
- ☐ Depressed
- ■ Anxious
- ☐ Dysphoric
- ☐ Agitated
- ☐ Labile
- ☐ Euphoric

Behavior
- ☐ Withdrawn
- ☐ Suspicious
- ☐ Tearful
- ☐ Paranoid
- ☐ Isolative
- ☐ Preoccupied
- ☐ Demanding
- ☐ Aggressive
- ☐ Manipulative
- ☐ Complacent
- ☐ Sexually acting out
- ■ Cooperative
- ☐ Guarded
- ☐ Intrusive

Thought Processes
- ■ Goal Directed ☐ Tangential ☐ Blocking
- ☐ Flight of Ideas ☐ Loose association ☐ Indecisive
- ☐ Illogical ☐ Delusions:) (type)_____

Thought Content
- ☐ Obsessions ☐ Compulsions ☐ Suicidal thoughts
- ☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
- ☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical
- ☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes / No **Pain scale score** _____ **Locations** _____

Is pain causing any physical impairment in functioning today ☐ No ☐ If yes explain _____

Nursing Interventions:
- ☑ Close Obs. q15
- ☑ Milieu Therapy
- ☑ V/S ☐ O2 sat.
- ☑ Nursing group/session (list topic): _____
- ☐ ADLs assist
- ☑ Ind. Support
- ☐ Monitor Intake
- ☐ Tx Team
- ☑ I&O
- ☐ Reality Orientation
- ☑ Encourage Disclosure
- ☑ Wt. Monitoring
- ☐ Toilet Q2 w/awake
- ☐ Neuro Checks
- ☐ Elevate HOB
- ☐ PRN Med per order _____
- ☐ 1 to 1 Observation _____ reason (specify)
- ☐ Rounds Q2
- ☐ MD notified _____

☐ DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES (violence, suicide, elope, fall, physical health) DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted	Since Last Contact	
Ask Question 2*	YES	NO
2) Have you actually had thoughts about killing yourself?	LOW	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Have you been thinking about how you might do this?	MOD	X
4) Have you had these thoughts and had some intention of acting on them? E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."	HIGH	X
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? As opposed to "I have the thoughts, but I definitely will not do anything about them."	HIGH	X
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	HIGH	X

☐ Low Risk ☐ Moderate Risk ■ High Risk

Nurse Signature(s) _____ SN Date: 8/27 Time: 0938

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ ↓ B/P
☐ Chest Pain
☐ Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☐ Clear ☐ Rales ☐ Crackles ☐ Wheezing
☐ Cough ☐ S.O. B ☐ Other: _____
☐ O2 @ ____ l/min ☐ Cont. ☐ PRN
Via ☐ nasal cannula ☐ face mask

Neurological / L.O.C.:
☐ Unimpaired ☐ Lethargic ☐ Sedated
☐ Dizziness ☐ Headache ☐ Seizures
☐ Tremors ☐ Other _____

Musculoskeletal/Safety:
☐ Ambulatory ☐ MAE ☐ Full ROM
☐ Walker ☐ W/C ☐ Immobile
☐ Pressure ulcer ☐ Unsteady gait
☐ Risk for pressure ulcer
☐ Reddened area(s)

Nutrition/Fluid:
☐ Adequate ☐ Inadequate ☐ Dehydrated
☐ Supplement ☐ Prompting ☐ Other _____
new onset of choking risks assessed

Skin:
☐ Bruises ☐ Tear ☐ No new skin issues
☐ ~~Wound(s)~~ (see Wound Care Packet)
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
☐ Continent ☐ Incontinent ☐ Catheter
☐ Diarrhea ☐ OTHER _____

Hours of Sleep: ____ ☐ Day ☐ Night

At Risk for Falls: ☐ Yes ☐ No

At Risk for FALL Precautions:
☐ Arm Band ☐ Nonskid footwear
☐ BR light ☐ ambulate with assist
☐ Call bell ☐ Clear path
☐ Edu to call for assist ☐ Bed alarm
☐ Chair alarm ☐ 1:1 observation level
☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

~~Patient~~ Name Amanda Miller Today's Date 8/27/25

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

[2] 1. DEPRESSED MOOD
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

[0] 2. FEELINGS OF GUILT
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

[0] 3. SUICIDE
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

[0] 4. INSOMNIA - Initial
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

[0] 5. INSOMNIA - Middle
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

[0] 6. INSOMNIA - Delayed
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

[0] 7. WORK AND INTERESTS
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

[0] 8. RETARDATION
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

[2] 9. AGITATION
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

[3] 10. ANXIETY - PSYCHIC
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

[1] 11. ANXIETY - SOMATIC
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

[0] 12. SOMATIC SYMPTOMS - GASTROINTESTINAL
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

[0] 13. SOMATIC SYMPTOMS - GENERAL
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

[0] 14. GENITAL SYMPTOMS
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

[0] 15. HYPOCHONDRIASIS
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

[2] 16. WEIGHT LOSS
0 = No weight loss
1 = Slight
2 = Obvious or severe

[0] 17. INSIGHT
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: 10
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

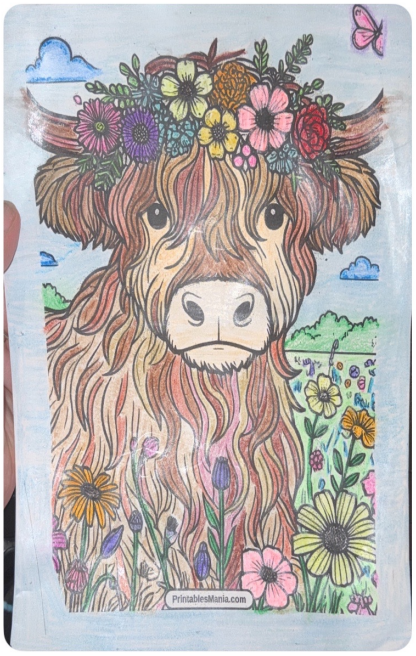
[2] 18. DIURNAL VARIATION
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation; AM ( ) PM ( )
2 = Severe variation; AM ( ) PM (X)

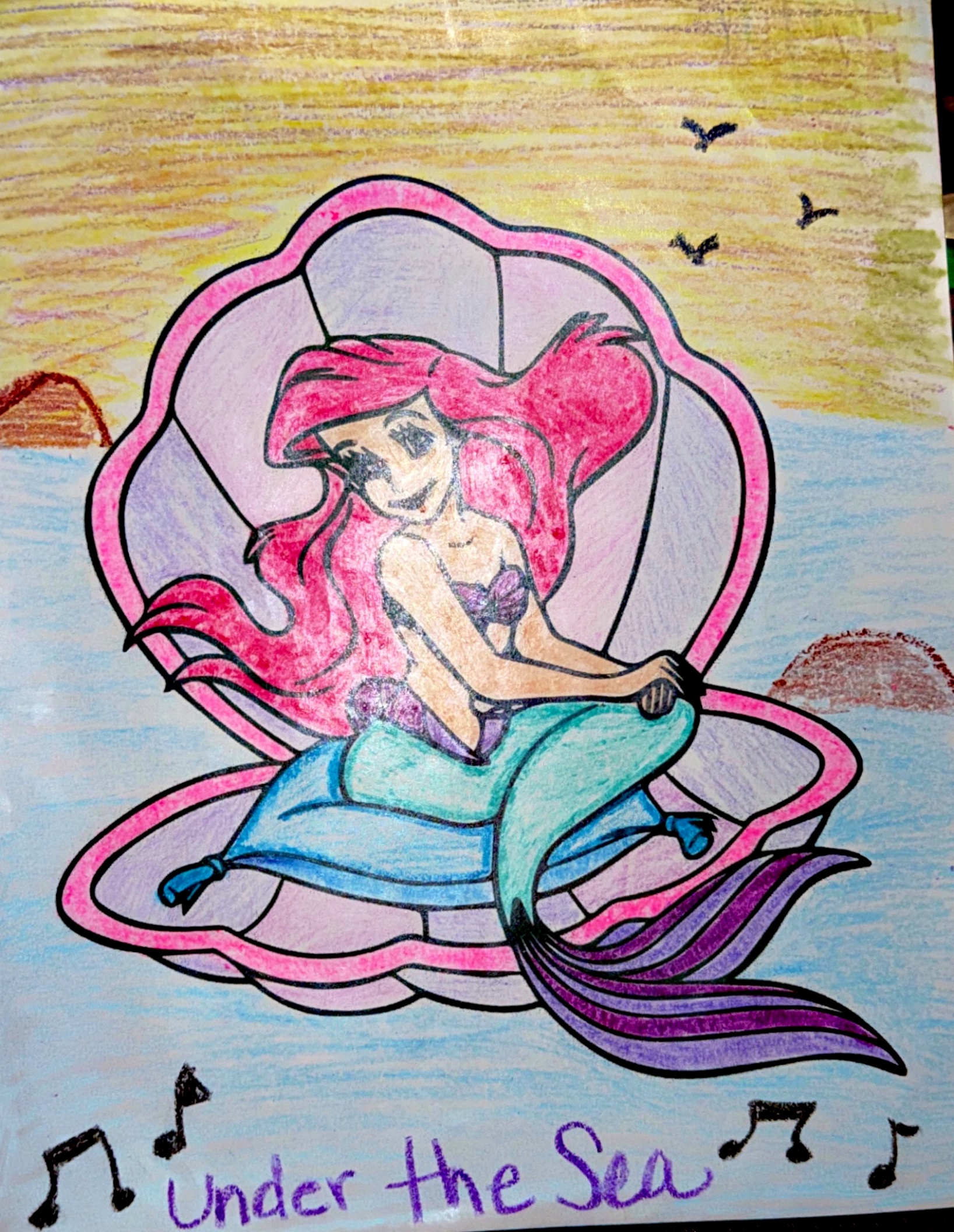
[0] 19. DEPERSONALIZATION AND DEREALIZATION
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

[0] 20. PARANOID SYMPTOMS
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

[0] 21. OBSESSIONAL SYMPTOMS
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry*. 23:56-62, 1960.


PrintablesMania.com


Under the Sea