NURSING SHIFT ASSESSMENT

DATE: 11-4-25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

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

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☐ Withdrawn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*** 8 ***Locations*** Headache
Is pain causing any physical impairment in functioning today ☐ No ☑ If yes explain low of energy, staying in bed

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 Tylenol

☐ ***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***	
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***	✓

☑ *Low Risk* ☐ *Moderate Risk* ☐ *High Risk*

Nurse Signatures) _____ *Date:* 11-4-25 *Time:* 0742

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ L 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 Kali Today's Date 11-4-25

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.

---

[1]

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

---

[3]

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

---

[0]

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)

0 **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

---

2 **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

---

0 **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: 12
0 - 7 = Normal
(8 - 13 = Mild Depression)
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

---

1 **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 ( )

---

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

---

2 **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.

NURSING SHIFT ASSESSMENT

DATE: 11-5-25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

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

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.
☐ Ind. Support
☐ Monitor Intake
☐ Tx Team
☐ Reality Orientation
☐ Encourage Disclosure
☐ Wt. Monitoring
☐ Toilet Q2 w/awake
☐ Neuro Checks
☐ Elevate HOB
☐ 1 to 1 Observation _____ reason (specify)
☑ Rounds Q2
☐ 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***	✓
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***	✓

☐ ***Low Risk*** ☐ ***Moderate Risk*** ☐ ***High Risk***

Nurse Signatures) _____ *Date:* 11-5-25 *Time:* 0932

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ L 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 Navarro Today's Date 11-5-25

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

---

[4] 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

---

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

---

[2] 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)

0

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

0

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

1

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 ( )

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

1

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.

Andrea Fabela
1M6

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:
Major Depressive disorder

- a serious mental health condition that significantly impacts a person's mood, thoughts & behavior

DSM-5 Criteria for your patient's diagnosis:
Presence of ≥5 of depressive s/s during the same 2-week period

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

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:
active listening
clear / clarification
open-ended questions

Stage of nurse-patient relationship:
Orientation Phase

Therapeutic communication techniques appropriate for this patient:
- using active listening
- showing genuine empathy & warmth
- ASK open-ended questions
- use paraphrasing, restating, exploring techniques

Communication approaches to avoid:
- "Why" questions
- Avoid judgment or criticism
- NO advice
- Arguing
- overpromising
- close-ended questions

Plan of Care:

Patient problem: Risk for suicide

Related to (etiology): At risk for self-inflicted, life-threatening injury.

As evidenced by (signs & symptoms):
N/A

Outcome/Goal:
- NO thoughts of suicide
- no acts of self-harm
- able to verbalize names of helpful resources

Current Treatment & Interventions:

1. Create a safe environment for client by removing all potential harmful objects

Rationale: Client safety is a nursing priority

2. provide a short-term verbal or written contract w/ client stating he or she will not harm themselves

Rationale: Discussion of suicidal feelings w/ trusted person

3. maintain close observation of client

Rationale: close observation is necessary to ensure client does not harm in any way

4. maintain special care in administration of medications

Rationale: prevents saving up to overdose or disscarding & not taking

Student name:

Student Name: Andrea Fabela Unit: Oceans Pt. Initials: KC Date: 11-4-25

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKDA

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

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.)
Venlafaxine	SNRI's	Major Depression	150 mg, 1 cap PO daily	Y N	N/A	HTN, nausea, drowsiness, dry mouth, constipation, sweating	1. MONITOR for mood & suicidal ideation 2.MONITOR for signs of serotonin syndrome 3.Med may take several weeks for full effect 4.DO NOT discontinue abruptly
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

Aspire, AA and Oceans Reflection (300 word minimum)

Safety & Quality Describe anything you accomplished to maintain a safe, quality environment	I maintained safety during both clinical days by ensuring that any potentially harmful items, such as pens, pencils, and lanyards, were left in a secure place.
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 group therapies I attended, I was able to apply my classroom knowledge by using proper therapeutic communication and techniques. Each patient was given time to express their feelings without interruption, judgment, or unsolicited advice. To improve my future practice, I plan to continue treating every patient equally while allowing each individual the time and space to share their emotions—especially when they are in a place where positive change is possible. As well as educating patients about the appropriate relaxation techniques for their health. From this clinical experience, I learned that although many patients shared the same diagnosis, each had a unique reason or experience behind it. What stood out to me most was realizing how even a small trigger in someone's life can lead to long-term challenges. This experience made me feel both sadness and empathy, but also hope—hope that with the right support and interventions, individuals can work toward healing and reducing these painful triggers.
Patient Centered Care Identify one client in the group, what concerns, recommendations/interventions would you suggest?	The patient who stood out to me was my first patient. She was diagnosed with Major Depressive Disorder (MDD). When I completed her Hamilton Depression Rating Scale, her results indicated mild depression. However, after breakfast, she returned to her room and remained there for the rest of my clinical shift. My concern was understanding why she chose not to participate in group therapy or activities, despite initially expressing interest in doing so. My recommendation for her would be to continue taking her prescribed medications while also engaging in more one-on-one therapy sessions with a therapist. Since she appears to be less social, I believe that individual

	therapy might help her feel more comfortable opening up and making progress. Then hopefully she will be able to warm up and participate within a group.
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 when I witnessed an incident involving a patient who had a behavioral outburst triggered by the medication nurse. The patient reacted by throwing his milk at the nurse, which also got other people and items wet. Despite the situation, I remained calm and asked a staff member how I could assist with the cleanup while helping to maintain a calm and safe environment for the other patients.
Communication & Collaboration Describe how you utilized therapeutic communication/collaboration	I utilized proper therapeutic communication by practicing active listening with each individual I interacted with, which included paraphrasing and exploring patients' statements to promote understanding and trust. Through collaboration with patients, I was able to effectively engage by using appropriate communication approaches, such as participating in group activities, coloring, and playing games to encourage social interaction and therapeutic engagement.
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?	At the beginning of my clinical experience, I felt very nervous because I did not know what to expect. However, as time went on and I was able to interact and engage in conversations with patients, I began to feel more relaxed and comfortable. Throughout the two clinical days, I experienced a mix of sadness and hope. It was difficult to hear patients describe themselves using words such as "hopeless," "worthless," and "a piece of crap," which highlighted how deeply depression can distort a person's self-perception. Despite this, I felt hopeful for each individual, as I truly believe that with proper therapy, effective techniques, and consistent support, they can overcome these challenges. The most significant emotion I carried throughout both clinical days was hope.

Evaluation What stood out the most about Aspire, AA, or Oceans	What stood out to me most at Oceans was how supportive and caring the staff and patients were toward one another. I witnessed a moment when a patient who appeared sad and possibly crying walked by, and another patient immediately approached her to ask if she was okay and if she needed anything.