

PROCESS RECORDING DATA FORM

Student Name: Emily Litz

Patient's Initials: CH

Date of Interaction: 7/13-7/14, 7/18-7/19

ASSESSMENT- (Noticing- Identify all abnormal assessment findings (subjective and objective); include specific patient data.)

- **Pertinent background information of the patient (age, sex, marital status, etc.), a description of why the patient was admitted to the Behavioral Unit. Was this a voluntary or non-voluntary admission?**

CH is a 41-year-old female who came into 1-South involuntarily. CH was arrested for DUI and was brought to Fisher Titus ER. From there, she was transferred to 1South after admitting she was depressed and had suicidal plans. She is unmarried but did have a significant other. CH has a h/o self-mutilation and major depressive disorder. She was recently diagnosed with bipolar disorder and borderline personality disorder. She also has a h/o dysfunctional relationships and non-compliance in her medicinal and behavioral treatment.

She also has a h/o of intermittent behavioral treatment with the same pattern of non-compliance. She also has a history of suicidal ideations and suicide attempts. CH had a h/o of using marijuana and alcohol to help her cope with her dysfunctional relationships. CH was struggling with her mental health and had a pattern of ineffective coping. She admitted to manipulating her family around her; exploiting them for money and admitted to carrying a lot of guilt and shame with her because of this. The most recent attempt at suicide by CH is jumping out of her boyfriend's moving vehicle.

Upon meeting CH, I could tell immediately that she had textbook symptoms of depression. She was tearful, exhibited slow speech, had issues formulating sentences and thoughts, was tangential, had intermittent negative self-talk, had healing cuts up and down her arms, and exhibited verbal retardation. CH made several attempts to manipulate the conversation; attempting to advance our interactions into more than a professional relationship. Although she admitted that she was trying to inhibit manipulative behaviors, I was able to quickly pick up these tactics and divert the conversation back toward her mental health. I could tell that these tactics were used to stall conversation surrounding her mental health. From noticing this, I was able to continue my conversation with her to fruition.

CH admitted that she struggled with maintaining healthy relationships due to her manipulative abilities. From speaking with her, she had severe compounded trauma early on. We discussed how she went about handling these traumatic experiences, which came to find, she didn't. Instead, she exploited others (whether it be family or friends) to fill voids and project, instead of sitting with and understanding her feelings about the experiences. With these interactions, she was hard to follow. This is where her tangential speech was exhibited the most. This fragmented speech pattern was relentless and repetitive throughout the entirety of my first day of interactions with her.

- **List any past and present medical diagnoses and medical health issues.**

CH had a h/o medicinal and behavioral non-compliance. Before 1South, she had intermittent treatment for her depression. She had been previously diagnosed with MDD. Her recent diagnoses included bipolar disorder and borderline personality disorder. CH had minimal physical health issues being limited to a Vitamin D deficiency.

- **Self-assessment of thoughts and feelings prior to and during the therapeutic communication interaction.**

Pre-interaction:

Some thoughts and feelings I had before my first interaction with her included shock and disbelief. I had these feelings because of the unnerving thought that she was pushed so far mentally that she jumped out of a moving car to kill herself. My other thought was how severe and isolated she must've felt that suicide seemed like the only way to achieve any sort of relief. My other feelings included feelings of familiarity when it came to her h/o depression, comparing those feelings to my personal mental health journey. Due to this familiarity, I knew that I had the skills and tools to not only therapeutically speak with her but educate her on healthy coping skills and boundary setting.

Post-interaction:

After my first interaction with her, I was flooded with feelings of empathy and motivation. I felt this because how she described her struggles was all too familiar to my personal journey. However, motivation came into play and helped in focusing my efforts on working with her. I made sure to give her homework to do that would then be discussed the next day; this gave me a sense of security because even though she had a h/o non-compliance, I was able to maintain compliance with her and achieved the ability to set a minimal goal and a goal achieving mindset with her.

- **Describe what is happening in the “milieu”. Does it influence the patient?**

The milieu was peaceful. They had patients watching TV and other patients sitting at the tables talking with one another and coloring. I feel that this peaceful environment was able to help CH sit with her feelings and focus on the reason why she was there. She even admitted that the environment was welcoming in the sense that she didn't feel judged for her mental illness but welcomed with open arms to start the journey of healing.

DIAGNOSIS/PRIORITY MENTAL HEALTH PROBLEM- Interpreting

- **Mental Health Priority Problem (Nursing Diagnosis): (Not patient medical diagnosis) (List all nursing priorities and highlight the top mental health priority problem. Provide all the related/relevant data that support the top mental health priority nursing problem.)**

All the nursing priorities for CH included the **risk of suicide**, impaired cognitive function, dysfunctional family relationships, and impaired relationships. Some relevant data that supports the risk for suicide include beginning new anti-depressant treatment for her depression. This is the most important piece of data because, as we've learned in class, the start of a new anti-depressant medication can make someone have increased suicidal ideations, creating a major safety issue. Some other data that supports the risk of suicide include her h/o suicidal ideations and attempted suicide, h/o medication and treatment non-compliance, and difficulty expressing her thoughts and emotions.

- **Identify all potential complications for the top mental health priority problem. Identify signs and symptoms to monitor for each complication. (at least 5 complications)**

Some potential complications that support the top mental health priority problem include death, self-mutilation, limb deformities, manipulative behaviors, and ineffective coping. **Death:** heightened relationship issues, unresolved consequences, and inability to properly address trauma. **Self-mutilation:** scarring, internal and external bleeding, and triggers. **Limb deformities:** impaired limb functioning, nerve damage, and impairment in ADL functioning and execution. **Manipulative behaviors:** exploitation of others, inability to form healthy and stable relationships, and continuous low self-esteem.

Ineffective coping: refusal to acknowledge responsibility in their mental health, inability to set boundaries, and worsening of their mental health.

PLANNING-Responding

- **Identify all pertinent Nursing Interventions relevant to the top mental health priority problem. List them in priority order including rationale and timeframe. (At least 5 interventions). Interventions must be individualized and realistic.**
 - 1) **Assess/rate depression on a 0-10 scale QAM, daily.** Their depression severity should be assessed every day to monitor improvement or decline in their treatment progression.
 - 2) **Assess the need for self-harm QAM, daily.** Their self-harm should be assessed every day to monitor for an increased need to harm themselves.
 - 3) **Assess a possible plan of suicide QAM, daily.** A possible plan should be assessed every day to monitor the effectiveness of behavioral treatment and increased safety risk.
 - 4) **Assess cognitive functioning: verbal retardation, tangential speech pattern, ability to formulate thoughts and sentences, and ability to comprehend feelings and treatment QAM, daily.** Their cognitive functioning should be assessed every day to monitor for improvement or decline in their thought processing and improvement or decline in their ability to vocalize and understand their thoughts and feelings surrounding their mental illness.
 - 5) **Implement therapeutic communication including a plan for healthy coping skills, formulating boundaries, and encouragement of stable relationships q.d.** Therapeutic communication should be implemented in their plan of care daily to promote the formation of stable relationships. Their ability to formulate healthy coping skills and boundaries should be monitored and assessed every day for a trend in improvement or decline.
- **Identify a goal of therapeutic communication.**

A goal of therapeutic communication for me and CH was to develop healthy coping skills to help her healthily handle times of distress.

IMPLEMENTATION

- **Attach Process Recording.**

EVALUATION-Reflecting

- **Identify strengths and weaknesses of therapeutic communication.**

Strengths: (provide at least 3): Three strengths of therapeutic communication include building trust and rapport with the patient, creation of a safe place to discuss sensitive topics, and a healthy environment to promote healing.

Weaknesses: (provide at least 3): Three weaknesses of therapeutic communication include sparking triggers in the patient, inducing defense mechanisms, and the inability for the patient to comprehend and apply therapeutic conversation.

- **Identify any barriers to communication. (Provide at least 3)**

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Psychiatric Nursing 2023
Nursing Process Study

- 1) Delayed thought processing and intermittent tangential speech.
- 2) Difficulty in forming sentences and ability to vocalize feelings.
- 3) Distractibility of the patient.

- **Identify and explain any Social Determinants of Health for the patient.**

Some SDOHs that are applicable to my patient include financial instability, loss of family including her parents and aunt, dysfunctional family processes, minimal education, and minimal job opportunities. **Financial stability** is an SDOH because CH had mentioned that she was nervous about getting her finances in order and anxious about this once she was discharged. She mentioned that people in her family have been distant and hesitant to help due to her exploitation of those relationships. **Loss of family** close to her is another SDOH because the losses and inability to cope with them partly contributed to her drinking and substance abuse. **Dysfunctional family processes** are another SDOH because CH mentioned her manipulative behaviors have driven others away. She expressed anxiety over fixing this once she was discharged. **Minimal education** is another SDOH because she expressed anguish over not having a proper education which led to a decline in her mental health. **Minimal job opportunities** are another SDOH because she expressed anxiety and struggles with keeping a job, partly due to her ability to have been influenced by dysfunctional relationships.

- **What interventions or therapeutic communication could have been done differently? Provide explanation.**

I feel that on the third day of working with her, I could feel a sense of frustration and circular conversation occurring with her. I spoke to one of the nurses about this. The nurse mentioned that much of the treatment done for the patients can become repetitive, but that continued therapeutic measures were proven to be helpful, no matter how many times treatment occurs. I feel that I should've diverted the conversation to a different topic and gathered others for a group project. I feel this change in motion and scenery would've been more productive in her treatment than continuing the conversation.

- **Note: Students as you type in the cells the cells will expand. Reference table 5-5 pg. 120 in the textbook for sample process recording**

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Student's Verbal or Nonverbal Communication	Patient's Verbal or Non-Verbal Communication	Student's Thoughts and Feelings Concerning the Interaction	Student's Analysis of the Interaction (use Table 5-3, 5-4 in the textbook for reference)
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<p>*knocks on the door frame* “Hi, CH?”</p>	<p>“Oh, yeah!” *Distracted and taken by surprise*</p>	<p>I’m a little anxious and excited at the same time. I’m ready to work with her and get to know her.</p>	<p>Therapeutic; asking a direct, closed-ended question. Identifying the right patient.</p>
<p>“Hi, my name is Emily and I’m a student nurse. I’m going to be working with you today. I wanted to come and meet you to become acquainted”. *Trying to capture body language and mindset*</p>	<p>“Oh okay! Hi, nice to meet you. I’m just getting up and around....not much going on, ya know”. *Breathes a heavy sigh of relief and smirks*</p>	<p>I was still nervous because I needed to understand how she was. This was going to help me understand how to direct the conversation.</p>	<p>Therapeutic; formulating a plan of action. Introducing myself and the reasoning for my presence. I’m also gaining verbal and nonverbal consent from the patient to work with her.</p>
<p>“Okay! Do you mind if I join you?” *picks up on the elephant in the room and the tension*</p>	<p>“Oh no, not at all!” *Wipes away hair draping over her face, still distracted*</p>	<p>Immediately I could tell how guarded she was; distracted and a little in shock. She was troubled by her thoughts; I could tell by her eyes.</p>	<p>Therapeutic; focusing and asking a direct closed-ended question. I’m also reaffirming consent to join her in activities.</p>
<p>“Okay, awesome! How are you feeling this morning?”</p>	<p>“Ya know, I’m feeling okay, just all right. Ya know..I could be better..it’s..it’s just that I have so much guilt...it’s so much, ya know?...no...no I don’t know. It’s just a lot”. *CH breathes another heavy sigh, walks closer to me, and starts fidgeting with her hands* *Her eye contact is distracted by this*</p>	<p>Picking up on the immediate tension, I started the interaction off with an icebreaker. A question that was simply worded and seemingly easy to answer. I was a little anxious to hear her response.</p>	<p>Therapeutic; exploring. I am trying to gauge how willing and cooperative she is to conversation starters.</p>
<p>“Yeah, I’m just so glad that you’re here today. You’re here taking the next steps, and I’m proud of you for that”. *While being cognizant to maintain active listening, I can notice her mild discomfort*</p>	<p>“Oh yeah..I mean..no I’m really a monster..ya know I’ve done some terrible things in my life...I just need to fix it...have to fix it...”. *Scratches her head and puts a hand on</p>	<p>Immediately I can tell that she was stuck in a negative mindset. I wanted to comfort her through this and validate her anguish.</p>	<p>Therapeutic; Attempting to translate words into feelings. I’m validating her feelings without judgment. This helped build trust and rapport.</p>

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Psychiatric Nursing 2023
Nursing Process Study

	her hip. She starts to become tearful when she's describing the "terrible things" *		
<p>"Let's go talk over breakfast".</p> <p>*Immediately notices this as shutting down and changes the topic*</p>	<p>"Okay! Yeah..yeah..I'm sorry, yeah....yeah let's go, I'm sorry, I'm sorry". *Holds her head in her hands and slaps both of her arms down*</p>	<p>From this slight change in mood, I diverted the conversation to a different topic. This seemed to help her tearfulness.</p>	<p>Therapeutic; focusing. I am redirecting the conversation to a task that she can mentally handle; as she cannot with her home life. I'm also focused and sensitive to her changes in mood.</p>
<p>"How did you sleep?"</p> <p>*Starts walking, maintaining the same tone as before*</p>	<p>"Oh yeah no I slept great..yeah". *CH finally makes good eye contact with me and smiles*</p>	<p>I can immediately tell that she was attempting to minimize her experiences and was attempting to mask them. Her smile wasn't genuine, more like she did it because she knew it was something people like to see. She was more relaxed though.</p>	<p>Therapeutic; asking a direct, closed-ended question. I am starting to build trust in the relationship by her sharing something vulnerable with me.</p>
<p>"Well, that's good to hear! That's always a positive". *Smiles and directs her into the activities area*</p>	<p>"Oh yeah, no I don't have issues with sleep usually....it's...it's just that...okay okay..it's just that I've used..I've manipulated a lot people...Ya know..people that I care about..and I...I should've never done that..I mean really, I am a monster...I'm sorry..it's just really hard to explain". *Holds her head in her hands again, intermittent eye contact and distracted*</p>	<p>The immediate mood changes again into dread and tearfulness. At this point, I'm trying to navigate what I can and can't talk to her about yet. I'm not used to the extreme shifts in mood, so I was trying to tread carefully. I was doing this to prevent her from shutting down again.</p>	<p>Non-therapeutic; I feel as if I gave her false reassurance and didn't actively engage in my answer.</p>
<p>"I hear you; emotions can be difficult to</p>	<p>"Yeah! Yeah they can be...these are</p>	<p>The dread and sorrow became</p>	<p>Therapeutic; attempting to translate words into feelings</p>

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Psychiatric Nursing 2023
Nursing Process Study

<p>process at times”. *Empathizing in a softer tone*</p>	<p>just really painful ya know...Just... I’m...I’m sorry this isn’t really making sense...”. *CH becomes tearful again and starts to cry a little*</p>	<p>immense, and I realized I may have put too much on her before she was ready.</p>	<p>and conveying empathy. I made it a point and emphasized the validation of her feelings. This reassured her of her safety and security.</p>
<p>“I’m just so happy that you’re here to talk to me about it. I want to remind you; we will only talk about things at your pace and when you’re ready to”. *Notices her starting to shut down again, reassures her of security and safety*</p>	<p>“Thank you, yeah thank you. Yeah... yeah no, I’m just glad I have people like yourself here...ya know?”. *Starts smiling again and breathes another heavy sigh. Looks at her breakfast tray*</p>	<p>From this, I wanted to reassure her of her safety, security, and confidentiality. When I brought this up, this gave her a sense of peace and calmed her down.</p>	<p>Therapeutic; formulating a plan of action and conveying empathy. I am building trust and rapport with the patient to have an efficient conversation.</p>
<p>“Absolutely! I’m glad to be working with you. Wow! They made a really nice breakfast for you”. *Notices her change in body language*</p>	<p>“Oh yeah! Oh yeah I know they have some good options here. You know I love to cook? It’s one of my favorite things to do. Breakfast..it’s...it’s like my favorite. I could have it at any time in the day”. *Immediately perks up and makes efficient eye contact. Sentences start to become more direct*</p>	<p>Another immediate shift in mood into happiness. I’m now slightly understanding how quickly she can shift her moods. I also noticed that this has possibly been used as a manipulation tactic in the past. I quickly gathered this and maintained professional boundaries.</p>	<p>Therapeutic; presenting reality, making observations, and giving recognition. I am observing how the patient reacts to my words, continuously gauging the amount she can handle.</p>
<p>“Is it really? I wish I could say the same, but I’m not a huge breakfast person to begin with”. *Notices the positive change in her tone and body language. Starts to bond over cooking*</p>	<p>“Really? Oh yeah no I could eat this all the time”. *Body language is still perked up*</p>	<p>At this point, I’m trying to play the conversation safe, as I’m also trying to gauge how long her moods last. So far, less than five minutes.</p>	<p>Therapeutic; reflecting and exploring. I started to bond with the patient over cultural cooking, this hobby brought her happiness so I explored it further.</p>
<p>“Do you cook often at home?” *Attempts to start building trust and rapport*</p>	<p>“Oh yeah, cooking is huge in my family. I...I can’t really remember what I liked to cook..I’m</p>	<p>I immediately regretted asking her this question because I suddenly realized any reference to her</p>	<p>Non-therapeutic; I feel that this is borderline probing, I feel that I referenced home way too early, and it set her off.</p>

