Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2024
Nursing Process Study

PROCESS RECORDING DATA FORM

Student Name: Lindsey Steele Patient's Initials: J.K

Date of Interaction: 06/04/24 and 06/05/24

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

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

J.K. is a 22-year-old man who was voluntarily admitted to the unit. He lives with his dad, is single, and is employed as a diesel mechanic. He attempted self-harm four years ago by cutting his throat. He was admitted due to suicidal ideation and severe depression. J.K. was going through a rough patch and was fighting with his girlfriend at the time. He told his loved ones he was going to say goodbye to his dog and then shoot himself in the woods. He referenced the woods as his "place to end it" multiple times to his girlfriend. He verbalized that he grew up with nothing, was not close with his family, had a toxic relationship with his girlfriend, and had a lot of built-up anger which caused him to snap. His mother and his three best friends are his support system. He resides with his father, but they do not have a good relationship. He has a younger brother and he feels that growing up his father favored his sibling more.

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

J.K. currently has depression, anxiety, and suicidal ideation. He has had a history of depression for eleven years. He denies any voices or hallucinations. He has a surgical history of wisdom teeth removal and cholecystectomy. He is a current smoker and occasionally drinks alcohol, roughly once a month.

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

Pre-interaction: Before the interaction, I felt nervous and uncomfortable. I have never been in a psychiatric setting before and I did not want to accidentally make a patient uncomfortable. During charge-report, I felt overwhelmed by all of the patient's history, and I did not know how to interact with them. I noticed I was demonstrating some anxiety mechanisms of my own, such as bouncing my leg or fidgeting. Before I encountered any patients, I made sure to relax and think about the SOLER acronym I learned in lecture. I had to pass medication on my first day of clinical, so the other students were already talking to patients in the common area. When I saw J.K. my initial feeling was that I felt sorry for him. The rest of my nursing students were huddled together and he was sitting alone.

During- interaction: During the interaction, I became less tense, and I was able to have a conversation with him. I found it hard trying to actively listen to my patient while simultaneously thinking about lecture and the "do's and don'ts of therapeutic communication". I made sure I was aware of his non-verbal communication as well as my own. I was making conversation about the physical things around

me such as the book he was reading, the coloring sheets, and the cards. As we talked more I was able to ask open-ended therapeutic questions to understand him more.

Post-interaction: After the interaction, I felt a sense of relief. I realized that most of the patient's want someone to talk to, and they enjoy the company. I felt more confident in my communication skills as well as my ability to develop a therapeutic relationship. This allowed me to speak to all of the patients and have many good conversations during my time at clinical.

- **Describe what is happening in the "milieu". Does it have an effect on the patient?**

The Milieu is structured around safety and ensuring all aspects are therapeutic. All the patients wear the same clothes, which allows for both safety and equality. They are assigned a room but have free access to the common area where games, books, cards, and television are located. They are given opportunities to interact with one another which can help them tremendously. When they interact, they can share experiences, realize they are not alone, and learn from others. There is a glass border around the nurses' station and the patients only have a small opening to receive their meds. J.K. mentioned to me that the nursing staff are very nice, but he feels disconnected from them. This is because of the glass border and the fact the nurses primarily stay behind it.

It is the patient's job to approach the station when they are ready for their daily medication. This positively affects the patient because it allows them to have a sense of independence and compliance with their medication regime. It can give them a sense of control, and maybe even stability during their time in the facility. The medications they are on can reduce their symptoms and improve their mental health while they are admitted. The patients are given the choice to attend or decline. The group sessions provide support and help the patients explore different thoughts, feelings, and behaviors. I have noticed patients will pace the halls when they feel overwhelmed, will deny medication, and will have outbursts and be sent to the back area. Although the psychiatric unit may not help every single person, I believe the secure environment, professional support available, therapy groups, and distraction activities do have a positive effect on the patients.

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).**
  - Ineffective coping
  - Risk for suicidal behavior
  - Ineffective relationship and risk for ineffective relationship
  - Ineffective impulse control
  - Dysfunctional Family Process
  - Anxiety

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- **Provide all the related/relevant data that support the top mental health priority nursing problem. (at list 5)**

1. Patient attempted suicide by cutting his throat eleven years ago.
2. Patient threatened and/or attempted to shoot himself in the woods
3. Patient struggles with depression and has struggled for 11 years. Severe depression can lead to suicidal ideation if not maintained.
4. Patient had access to guns. His father claimed to lock up all potential weapons, but there is a risk of access.
5. Patient threatened to end his life multiple times to his previous girlfriend.
6. Patient gets aggravated easily at his home and does not have effective coping mechanisms. Patient gets aggravated by work, his family, and large crowds. Patient has family dysfunction and his mom as his support system, but his mom lives an hour away.
7. Patient does not believe he needs the medication and does not want to be reliant on it. This could lead to non-compliance which can result in depression, anxiety, and suicide attempts.

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

1. Self-directed or other-directed violence
   - Monitor patients' behavior frequently for direct or indirect cues, or signs of aggression, guilt, anger, or depression. A nonverbal behavior may be the patient giving away cherished items, mood swings, and withdrawing from friends. Monitor for negative body language such as rigid posture, clenching of fists or jaw, hyperactivity, or breathlessness. Pacing or threatening stances can be an indicator also. Monitor for delusional thinking, hallucinations, or disorientation. Monitor for patient attempting self-harm or harm to others.
2. Suicidal behavior
   - Monitor for depressed mood, hopelessness, and expression of the patient feeling trapped. Another sign would be the patient expressing wanting to die, or feelings of purposelessness. A third sign would be any suicidal gestures or threats. A fourth is destruction of property, displaying extreme rage, or having outbursts of emotions. Changes in eating or sleeping problems or neglecting personal hygiene is another factor as well.
3. Substance abuse
   - Individuals may turn to drugs and alcohol as a coping mechanism, and monitor for withdrawal symptoms such as irritability, cravings, changing moods, insomnia, anxiety, shakes, and more. Substance abuse can lead to addiction which can increase the likelihood of repeated suicidal attempts. A patient may appear with glossy eyes or dilated/constricted pupils. Another sign could be defensiveness when questioned, or suspicious changes in routine. A patient may develop frequent nose bleeds, or marks on their body due to substance abuse.
4. Unsatisfactory parent-child relationship

- Monitor if the patient has visitors or uses the phone to talk to family, a sign can be a lack of communication. A sign can be if patient speaks about their family poorly, or if they are trying to prolong their stay at the facility to avoid going home. A third sign can be yelling, arguing, or any form of fighting while the parent and child are communicating. Suicidal behavior can strain family relationships, which can lead to a lack of support system and social isolation. A sign could be fear or apprehension of the patient when discussing their family. A patient can have low self-esteem as a direct result of family issues.

5. Defensive coping
   - Monitor for low self-esteem, negative role models, or lack of positive feedback. Repeated negative feedback can result in diminished self-worth feelings. Other signs and symptoms can be denial of issues or projection of blame. The patient may display hypersensitivity to criticism from the environment in their household. More signs of hostile laughter, or ridicule of others.
6. Risk for post-traumatic stress disorder
   - Monitor for flashbacks or hallucinations of the traumatic event. Signs can include, nightmares, social isolation, outbursts, or severe anxiety. Observe for restlessness, hypervigilance, or insomnia. The patient can present with chronic headaches or palpitations from the stressor. A fifth sign can be depression or panic attacks.

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. Conduct a thorough and collaborative assessment of the patient on admission. This includes a physical and mental health assessment. Assess for risk factors and warning signs of suicide on admission, q4h, and PRN.
   - By doing a thorough assessment, the nurse can determine the patient's baseline and decide if they improve or decline in function during their time in the facility.

2. Obtain vital signs HR, RR, BP, T, Pulse, and SpO2 q4h and PRN.
   - To determine any fever, abnormalities, or oxygenation issues with the patient. This provides a baseline so any increase or decrease can be determined.

3. Maintain close observation of the patient and conduct 15-minute checks during the nursing shift.
   - This ensures the patient is not attempting to self-harm or harm others. This allows for patient safety and swift intervention from the staff if something was to occur.

4. Educate the patient on their new medication regime and maintain special care in the administration of medication q48 or PRN.

- Ensure the patient understands the new medications prescribed and is compliant. This can allow the patient to control their mental illness, feel better, and work towards getting discharged from the facility. Proper use of medication can manage their condition and limit the risk of attempted suicide.

5. Communicate with the patient to build trust, and rapport, and develop an understanding q1h and PRN.
   - This can reduce a feeling of isolation, hopelessness, or fear. This allows for a therapeutic relationship that can provide a sense of safety, and security, and encourage the patient to be open and honest.

6. Develop a safety plan with the patient within 24 hours of admission and 24 hours prior to discharge.
   - A safety plan consists of numbers to call, hotlines, emergency service numbers, family member numbers that are support systems, and coping strategies. This can give the individual structure if they have feelings of self-harm and reduce the risk.

- **Identify a goal of the therapeutic communication.**

The patient will demonstrate no suicidal ideation and develop adaptive coping strategies for future stressors.

IMPLEMENTATION

- Attach Process Recording.

EVALUATION-Reflecting

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

Strengths: (provide at least 3 and explain)

1. I felt I developed a good rapport with all the patients I talked to. I established a rapport by discussing non-health-related topics and personal topics. I asked about books they were reading, shows, and music, but also how they were feeling and about their mental illness. I tried to demonstrate warmth, kindness, and a nonjudgemental attitude.
2. I demonstrated respect in my therapeutic communication. I made sure to ask a transitioning patient about her preferred name and pronouns to maintain respect. I spent time with the patients and was patient when they were responding. I listened actively and remembered the little details they told me. These little details I used in conversation the next day. I had a patient tell me on Wednesday “Wow, I am surprised you remembered that”.

3. I utilized the therapeutic communication technique of giving broad openings to allow the patient to direct the conversation. I asked questions like “What do you want to talk about today?” or “Is there anything specific you want to talk about today?”

Weaknesses: (provide at least 3 and explain)

1. One weakness I noticed is that I had a hard time asking questions to my patient to maintain a conversation without probing. When I would ask questions such as “Tell me more about that” “Why do you feel that way?” “how are you feeling right now?” I felt as if I was probing and pushing the patient for answers. I tried to find a balance between them but it is something I will need to work on going forward.
2. A second weakness is my body language when communicating. I remembered the SOLER acronym but I often found myself with my arms or legs crossed and I did not look relaxed. In the future, I will reference the Sit facing patient, Open posture, Lean forward, Eye contact, and Relax.
3. A third weakness is introducing an unrelated topic during conversation. I communicated with some people that gave me very short responses and were not overly talkative. Whenever a period of silence came and I did not know what to say, I introduced a new topic to get communication to flow again. Instead, I should have tried using open ended questions.

- **Identify any barriers to communication. (provide at least 3 and explain)**

1. One barrier to communication was that I had no prior experience communicating with patients in a psychiatric facility. I had read the chapters on therapeutic communication and the “do’s and don’ts” of conversating but I had not practiced in the real world prior to this clinical.
2. A second barrier was that I could not relate to my patient in any way, so I was struggling to make conversation. I also grew up in a rough household, and I struggle with anxiety each day, but I did not relate to his feelings of suicide or wanting to die. I actively listened to my patient, and I did understand him, but I struggled to continue the conversation at some points.
3. I found myself using the phrase “I'm glad..” once during clinical. When I said it, I immediately remembered that is nontherapeutic and then started to overthink each word I said. This was a barrier to communication because I was trying to focus on my patient's nonverbal and verbal communication while also focusing on mine.
4. Another barrier for communication was the lack of trust between the patients admitted and the students. I encountered patients who enjoyed talking to me, and were open about their stressors. I also encountered patients who gave me one word responses, or did not feel comfortable telling me about their stressors. This was a barrier because it is difficult to develop trust in the two days we were on the clinical site.

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

One social determinant of health is his lack of a support system at home. My patient lived with his father, but his main support system was his mom, who lived in a different city than him. This is a social determinant of health because without a support system, the patient does not have a person he can vent his stressors to, which can harm his mental health. He does have three friends, but he does not feel the most comfortable opening up to them. A second SDOH would be where my patient lives. He told me he lives in the country and his neighbors are corn. He expressed to me that it is nice living around nobody, but sometimes it gets extremely lonely. This can contribute to the feeling of loneliness, isolation, and even depression.

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

One intervention I could have done differently is giving approval in my conversation. A patient expressed to me how they have a plan after their discharge, a job lined up, and family to support them. I accidentally said, “That is great, I am glad you have a plan.” After I said that, I remembered how nurses should not give approval because it involved judgment on the nurse’s part. I made sure that I did not make that mistake again. Another thing I could have done differently was to make a more natural conversation. I noticed I had a lot of pausing and thinking on my first day of clinical, and It could have been a more natural flow.

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

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 and 5-5 in textbook for reference)**
"Hi my name is Lindsey, do you mind if I sit?"	"Yeah go ahead" (He put the book down he was	He seemed interested in the conversation. I think he enjoyed the	Therapeutic: Introducing myself and becoming acquainted. The orientation

(pointed at the chair next to him and smiled)	reading) “I’m J.K.”	company. I felt bad he was sitting alone. I initially felt nervous.	phase.
“How is your book so far?” (he was reading Buzz Aldrin. I made sure to follow the SOLER acronym- Sit facing pt, open posture, lean forward, eye contact, relax)	“It is alright, I am not the biggest fan of reading.” (The patient was looking at the book and did not make eye contact)	My patient had fair skin and red hair, so his face was noticeably reddened. It made me uncomfortable because I could not gauge how he was feeling.	Nontherapeutic: I should have started with a broad opening such as “Is there anything you want to talk about today?”
“It looks like you have gotten pretty far into the book” (gesturing at the book that was almost fully read)	“It makes the time pass and gives me something to do. I don’t know If I am going to finish reading it.” (He was looking around the room and only making eye contact occasionally, his arms were folding in his lap)	I was trying to establish normal conversation while also thinking of how to formulate a plan of action for the patient. I was beginning to feel more comfortable in the conversation.	Therapeutic: Observing his progress in the book. Developing rapport with my patient by discussing non-health-related topics.
“I heard it has a good ending, you only have a little bit left, you should keep reading.” (continuing SOLER)	“It might, I don’t know if I will. I keep getting distracted” (The patient turned towards me and was making eye contact)	I instantly felt like I had done something wrong after I finished this sentence. The night before clinical I memorized the nontherapeutic communication skills so I knew what to avoid. My patient did not seem to read into my comment.	Nontherapeutic: I should not have given advice; this discourages independent thinking from the patient.
“You are having trouble concentrating.” (I was nodding while he spoke to show I was listening)	“Yeah, reading is boring just like the therapy groups” (The patient gave me a small smile)	I felt like my patient was becoming more comfortable talking to me and a therapeutic conversation was developing.	Therapeutic: Restating the main idea which tells the patient I understand, and I am listening.
“I saw you attended the group this morning. Are you	“I am going to go. I don’t think I need it though; it was only a	Beginning to feel more comfortable, the patient seemed	Therapeutic: Giving recognition and acknowledging the patient’s

going to attend again? I know everyone is going outside afterward." (I gave a soft smile to give a friendly approach)	one-time thing and I just snapped. I don't know if therapy helps" (Picked up cup and took a drink)	willing to talk.	progress without complimenting.
"Do you mind telling me what was happening before you snapped?" (SOLER)	"My girlfriend and I were fighting over something stupid, and I was having problems at home. I just built up a lot of emotions over the years and it all came out at once. I made a stupid mistake and went to the woods with a gun." (patient was fidgeting with cup of water, was looking at the cup instead of making eye contact)	I felt uncomfortable asking this question, I glanced away from my patient after I asked so he did not feel like I was staring, and he was not pressured for an answer.	Therapeutic: Exploring more about the precipitating factors leading up to my patient's priority problem. This also allowed me to gauge my patient's perception of what happened.
"I see, and what happened after that?" (SOLER)	'I realized I needed help." (patient set the cup down, looked down at floor and folded arms in his lap)	I felt unprepared on what to say, I felt like my response came from memorization of the notes and did not have a natural flow to it.	Therapeutic: I gave a general lead to encourage the patient to continue talking
"Tell me more about your thoughts on group therapy, you mentioned that you do not think it helps?" (SOLER)	"I get uncomfortable in large settings; I don't like talking and I like being alone. When I go to the Sandusky fair I only go for the food and I immediately leave, the crowds stress me out."	I felt like the conversation was headed in a therapeutic direction.	Therapeutic: I restated what he said previously to show I was listening and I care about what he has to say.
"I do the same, I grab a funnel cake and immediately leave." (I was nodding while saying this)	He laughed and nodded his head.	I stayed silent for a minute or so to give him a chance to direct the conversation.	Therapeutic: Developing rapport with my patient by discussing non-health-related topics.
"I understand how	"Maybe. I have not	I felt like the patient	Nontherapeutic: This can be

therapy group can be stressful, do you feel like you gain something from it?" (SOLER technique)	put much thought into it. My dad said therapy would help." (was bouncing his leg)	was getting tired of talking to me, I also felt like I asked too many questions.	portrayed as probing; I should have waited until the patient directed the conversation.
I made eye contact and nodded. I used silence because it looked like he had more to say.	"I live with my dad but we used to butt-heads, He favored my younger brother growing up because he was in the military." (still bouncing his leg)	I felt sorry for him	Therapeutic: Silence encourages the patient to organize thoughts
"How is your relationship with your dad now that you are grown up?" (SOLER)	"It is not great. We still butt-heads. I am closer with my mom." (made eye contact)	I felt like he was comfortable opening up to me, it made me comfortable.	Therapeutic: Exploring more about support systems.
"Is mom your support system?" (SOLER)	"Yeah she is, she lives in Port Clinton though, so I barely ever see her. I have three best friends who support me too. I know I can talk to them when I feel like I am going to explode. They understand me." (eye contact remained)	I felt good about the conversation.	Therapeutic: Exploring more about support systems.
"It is good you have them to talk to. What other coping mechanisms do you use to calm yourself down when you feel like you are going to explode?" (SOLER)	"I don't have any, just talking to them." (Shrugged his shoulders, face was red)	I felt like finding coping mechanisms was something therapy could help him with.	Non-therapeutic: I should not have approved or disapproved by using the words "its good that…"
"I am leading a group activity tomorrow and I planned a game around coping mechanisms. We can work together and find one that works for	"Okay thank you" (smiles)	I did not know how to continue conversation, I started to feel uncomfortable"	Therapeutic: Formulating a plan of action.

you.” (SOLER)			
I smiled and nodded	Patient picked book back up and did not speak.	I felt the conversation was over, I felt stressed about remembering the conversation	Therapeutic: Silence encourages the patient to organize thoughts
“Okay, I will see you then. I am going to check on the other nursing students now.” (I smiled and stood up)	“I guess I'll get back to reading then” (slumped down in the chair and nodded)	I felt like a therapeutic conversation was developed and I learned a lot about J.K.	Therapeutic: established an end to the conversation.