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

PROCESS RECORDING DATA FORM

Student Name: Presley Stang Patient's Initials: RR

Date of Interaction: 06/13/24 and 06/14/24

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

Pertinent background information of 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?

- 22-year-old male
- Single
- Voluntary
- Auditory and visual hallucinations
- Delusional
- Difficulty separating reality from hallucinations
- "Hears voices that are mean & commanding"
- Religiously preoccupied
- Admitted for increased feelings of severe depression, anxiety, and psychosis

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

- Psychosis-not due to a substance or known physiological condition
- Delusional disorder
- Suicidal ideation
- Suicidal attempts
- Anxiety
- Depression

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

- Prior to the interaction I was nervous. I was hesitant to approach him because I didn't know how he would respond. My first clinical experience on the unit I tried to make conversations with the patients, but nobody wanted to talk so it kind of set the tone for how I thought this week would go. Going up and talking to someone I don't know puts me in an uncomfortable situation because I am a little bit shy. Additionally, asking the patient if they are still having thoughts about harming themselves makes me feel uncomfortable too because it is always a hard question to ask.

Post-interaction:

- The interaction went well. Patient was short at first but seemed willing to talk as the conversation progressed. The patient is religiously preoccupied. Everything is centered around God. His thoughts and feelings stem around wanting to meet God.

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

- Most of the patients are sitting in the lounge chairs watching TV or having conversations with the nursing students while the other few are in their rooms. The patients who are watching TV and socializing are the same patients who have been coming to group therapy and participating. The other few have only come out of their rooms for their medications, mealtime, or to use the phone. My patient has been attending groups but does not participate. He has also been interacting with other patients on the unit along with the nursing students. This influences the patient as he can gain positive coping mechanisms and build therapeutic relationships. In addition, he can receive support and encouragement from other members on the unit who are experiencing similar situations. It helps him to realize that he is not alone and that others experience these things too.

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).

1. Ineffective coping
2. Risk for suicidal behavior
3. Acute confusion
4. Disturbed sleep pattern
5. Disturbed thought process
6. Hopelessness
7. Impaired mood regulation
8. Ineffective impulse control
9. Insomnia
10. Spiritual distress
11. Anxiety

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

1. Stabbed self in neck 3x hoping to see God
2. Attempted suicide 2 months ago via MVA
3. Still having thoughts of death to get closer to God
4. Thought that ending his life he could go to God quicker
5. Here because he wants to go to God
6. Satan told him to come here
7. Showered with clothes on to see if that would help him get to Jesus
8. "Parents being used by Satan"

9. Wants Jesus to show him what he did wrong

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. Suicide
    - withdrawing from family or friends, giving away important items, extreme mood swings, changes in eating and/or sleeping patterns, becoming violent, recent suicide attempt, increased alcohol or drug use, recklessness
2. Social isolation
    - depression, poor sleep quality, low energy, loneliness, impaired nutrition, delusions or hallucinations, impaired thinking
3. Substance abuse
    - constricted or dilated pupils, slurred speech, tachycardia or bradycardia, tachypnea or bradypnea, nausea, vomiting, loss of balance, unresponsive, weight gain or loss, tremors
4. Legal and financial problems
    - poor job performance, not showing up to work, unemployment, poverty, homelessness
5. Homicide
    - racist or sexist views, making comments about wanting to hurt or kill others, violent, hopeless, increased loss of temper, threats, rage, isolation, sleep disturbances, substance abuse

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 vital signs: T, HR, RR, SPO2, Q4H & PRN
    - to make sure they are within normal parameters for medication administration
2. Assess mental status Q4H & PRN
    - to identify if mental status is improving or declining
3. Administer Iloperidone (Fanapt) 2 mg PO TID SCH per physicians order
    - to decrease symptoms of schizophrenia
4. Administer Lorazepam (Ativan) 1 mg PO daily SCH per physicians order
    - to decrease anxiety
5. Administer Sertraline (Zoloft) 25 mg PO QAM SCH per physicians order
    - antidepressant action
6. Administer Benztropine (Congentin) 1 mg PO/IM Q6H PRN per physicians order
    - to treat dystonia
7. Administer Hydroxyzine Pamoate (Vistaril) 50 mg PO Q12HR PRN per physicians order
    - to decrease anxiety
8. Administer Olanzapine (Zyprexa) 5 mg PO/IM Q6H PRN per physicians order
    - to decrease agitation

9. Administer Trazodone (Desyrel) 50 mg PO QHS PRN per physicians order
   - to treat insomnia
10. Listen to client's reports or expressions of concern or anger
    - to gain patient's trust and promote better outcomes
11. Set limits on acting-out behavior that is inappropriate or destructive
    - promotes safety for client and helps prevent loss of self-esteem
12. Refer to appropriate resources (e.g., pastoral or parish nurse, spiritual counselor, crisis counselor, psychotherapy)
    - useful in dealing with immediate situation and identifying long-term resources for support to help foster sense of connectedness
13. Educate patient on taking medications as prescribed and not stopping abruptly
    - to prevent new or worsening health problems

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

- To gain my patients trust and establish rapport

IMPLEMENTATION

Attach Process Recording.

EVALUATION-Reflecting

Identify strengths and weaknesses of the therapeutic communication.

Strengths: (provide at least 3 and explain)

One strength was using the "silent" technique. My patient would say some things and I wasn't sure what to say so I stayed silent. Using silence is therapeutic because it allows the patient time to think about their thoughts and feelings. In addition, it allows the patient to break the silence often providing the nursing with the patient's biggest concerns. Another strength was using the "offering self" technique. I invited the patient to color with me and created a conversation with him. I introduced myself and asked him how he was feeling. Offering self is therapeutic because it promotes feeling of self-worth for the patient as you are willing to spend time with them. A third strength was using the "making observations" technique. I pointed things out to him that I noticed. Making observations is therapeutic because it helps the patient to develop awareness of how they are perceived by others.

Weaknesses: (provide at least 3 and explain)

One weakness was using the “probing” technique. In all honesty, I haven’t grasped the therapeutic communication techniques fully. I am not used to phrasing questions differently or think about how what I say may affect these individuals. Probing is nontherapeutic because you’re questioning the patient and pushing for answers that the patient may not wish to discuss. I was just trying to understand the reason for what made him feel this way, but I should have rephrased it. Another weakness was using the “requesting an explanation” technique. I was just trying to pinpoint a reason for what led the patient to feel this way but should have rephrased it. Requesting an explanation is nontherapeutic because it can make the patient feel intimidated and implies that the patient must defend their behavior or feelings. A third weakness was using the “giving advice” technique. I was just providing the patient with things that I do when I am feeling down that may be useful for them. Giving advice is nontherapeutic because it implies that the nurse knows what’s best and discourages independent thinking.

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

One barrier to communication was the environment (physical barrier). We were sitting in the lounge chairs with the TV on. Patient was invested in the TV show which caused a little bit of a distraction. Another barrier was addressing sensitive topics (psychological barrier). I had asked him if he had any thoughts of harming himself and he answered no, but I read the most recent psychiatry progress note in the chart from the physician prior to the interaction that stated he was. Addressing these topics can induce stress and anxiety on the patient blocking effective communication and keeping them from sharing their true thoughts and feelings. A third barrier was gender (social barrier). Studies have shown that males are less likely to share their feelings and seek treatment for mental health issues because of the stigma and stereotypes of masculinity traits. I feel like this was true with our interaction. I felt like the patient was more open and honest with the physician when making his rounds than the patient was with me and our conversation.

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

A social determinant of health for the patient could be economic stability. I was reading through my patient’s chart and noticed that he has been admitted several times on the unit. Medical bills add up quickly and it can be hard to afford for some people if insurance doesn’t cover it.

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

Something that could have been done differently with my communication was not asking yes or no questions. I didn’t do this a lot but there were times I did without even knowing. You want to avoid asking yes or no questions and instead ask open-ended questions because it elicits expanded thinking and requires more than a one-word response.

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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 Presley I'm a student nurse what's your name?" (Sitting facing patient; looking directly at patient)	"Riley." (Sitting; looking directly at student nurse.)	Soft tone. Tired appearance.	Therapeutic: Introducing self by name and role. Working on establishing rapport, patient trust, and a therapeutic relationship.
"Nice to meet you, Riley. How are you feeling today?" (SOLER)	"Iffy." (Sitting; looking at hands in lap.)	Short with answers. Looks very lethargic.	Therapeutic: Offering self. Willing to converse with the patient and ask them how they are feeling to promote feelings of self-worth for the patient.
"Why are you feeling iffy?" (SOLER)	"I'm just feeling really anxious." (Sitting; looking directly at student nurse.)	Starting to feel sorry for him. Can tell something is bothering him.	Non-therapeutic: Requesting an explanation. Asking why a patient feels a certain way can be intimidating and can imply that the patient must defend their feelings.
"Is there something that is making you feel anxious?" (SOLER)	"Not in particular." (Sitting; looking at floor.)	Minimal speech. Confused mood. Curious what is making him feel this way.	Therapeutic: Exploring. Delving further into the situation so patient can develop awareness of thoughts and feelings.
"How long have you been here?" (SOLER)	"Since Friday." (Sitting; looking directly at student nurse.)	Been here for a week. Acute care unit. Wonder how much longer he is going to be here.	Therapeutic: Exploring. Delving further into the situation so patient can develop awareness of event.
(Silent for several seconds) "So, about a week. What brought you in?"	"I started running to the beach to see God." (Sitting; looking at hands in lap.)	He seems to be opening up. More willing to talk.	Therapeutic: Exploring. Delving further into the situation so patient can develop awareness of thoughts, feelings, and events.

(SOLER)			
(Silent for several seconds) “Tell me more about that particular situation.” (SOLER)	“I thought that ending my life I could go to God quicker.” (Sitting; looking down at floor.)	Religiously preoccupied. Wonder why he wants to go to God so badly.	Therapeutic: Focusing. Encourages specific discussion about issue.
(Silent for several seconds) “Do you have any thoughts about harming yourself right now?” (SOLER)	“No.” (Sitting; looking directly at student nurse.)	Felt uncomfortable asking. Sensitive topic.	Therapeutic: Asking a direct, close ended question about suicidal ideation.
“What could you do differently if you are having feelings like this in the future?” (SOLER)	“I can talk to my mom, dad, or sister although I am not as close with my sister as I would like to be. I can also pray to God. If none of this seems to calm me down, I can call the crisis Hotline number and get help.” (Sitting; looking down at floor.)	Glad to hear that he has a plan if faced with this situation again and a backup plan if the first one is ineffective. Seems to have a good support system.	Therapeutic: Formulating a plan of action. Encouraging the patient to identify a plan for coping when faced with a similar situation.
“Life is not easy, and things happen when we least expect, but you have gained positive coping skills.” (Standing. Looking at patient. Smiling.)	“I’m glad I have a plan in case this were to happen again.” (Standing, smiling at student nurse.)	Feeling confident that the interaction went well. Started off slow but opened up as conversation progressed. Glad he has a safety plan.	Therapeutic: Presenting reality and giving recognition to support his coping and safety plan.

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