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

PROCESS RECORDING DATA FORM

Student Name: Patient's Initials:

Date of Interaction: 6/11/24

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?

My patient was a 22-year-old single male that was admitted to the unit due to an ongoing history of mental illness. My patient was admitted this time because he was seen standing by the lake stating that he was going to see God and there was a fear of him walking into the lake and committing suicide. This was a non-voluntary admission.

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

Past medical diagnosis and mental health issues that my patient has had all include religious ideation. One time my patient was in the kitchen of the house and his father was next to him trying to stop him from stabbing himself in the neck "to get to God", having paranoid behavior. Another time my patient stated that the rapture happened and since he was left here there is something he needs to do. Patient has been diagnosed with psychosis, depression, suicide ideation, anxiety, showing signs of schizophrenia (but not yet diagnosed), dysthymic mood, dysphoric affect, disorganized thoughts, poor judgement and insight, and delusional thoughts.

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

  My beginning thought process was that the patient was very young and maybe just got around the wrong crowd. In the report it was stated that he had gone to meet up with some people in Utah that he never met but chatted with online. They (psychiatric healthcare team) thought maybe he was given some drug or did something that caused his psychosis. I also found it odd that my patient was report as seeming like he wants to take his family's life so they can all go see God.

  Post-interaction:

  After meeting my patient, he appeared to me like a very mentally challenged individual that really had more going on than just maybe drug use. He actually came across as a very clean cut, rule following individual that would not do drugs or take something that would harm himself. I felt as though maybe, due to the religious ideation, my patient was truly unaware of what was happening to him. He definitely believes that God is his savior and will guide him to a better life. I truly do not see that he grasps that he will be taking his life to get to God. After meeting my patient and spending two days with him, I believe that the day will come that this patient will follow through and succeed with a suicide attempt. He just does not grasp what is going on in his head and that it is not reality what he is seeing. This kid is actually a truly good-hearted individual and does not see what he feels/thinks as being wrong.

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

The "milieu" was described to us during orientation. To be honest I was truly concerned about going to 1 South. I thought that the patients were going to be trying to hurt us, each other, and selves. In the four days I was there I believe there was only one incident where a patient hurt themselves and that was the last day we were there. The one thing I noticed about the milieu that I didn't really care for, but I am not sure if it is supposed to be this way, is that the nurses mainly stay behind the glass in "the cage". I believe that this affected the patients. The reason I believe this is because there were several patients coming up to the windows telling the nurses that they were having panic attacks or that their anxiety was a 10/10. I absolutely could be wrong because I was only in the milieu for four days, but I believe if the nurses were out with the patients more that maybe the patients would not be so in their heads, at least not as many patients. I also believe that if a patient is feeling anxious or agitated that based on what was going on in the back area of 1 South, it absolutely affects the other patients. It gets them disturbed and acting up or it causes them to get quiet and introverted within themselves. The students being there and interacting with the patients was great for many of the patients. We played cards with them, we talked with them or walked with them if they were feeling anxious. I believe this is a great experience for all involved and so much to learn about people and humbling to understand that these are people like us all and something in their life happened and changed them. It could have been a life experience or a chemical imbalance in their neurotransmitters. Either way I highly recommend this experience for everyone going into the medical field so they can understand mental health on a grander level.

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).

  My patient's Mental Health Priority Problems were Risk for self-directed violence, Ineffective coping, social isolation, and Disturbed sensory perception.

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

  Patient exhibited lack of insight, lack of interest, poor judgement, dysphoric affect, dysthymic mood, suicidal ideation (planning to walk in the water to go to God), Anxiety 10/10, auditory hallucination, poor appetite, and delusions of reference (God).

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

  Potential complications for the top mental health priority problem are death by suicide, anxiety, depression, delusions, insomnia, and anorexia.

  Signs to monitor for with death by suicide are if the patient has suicide ideation, so I would need to ask the patient Q2h if they are having thoughts of suicide. If the patient expresses suicidal ideation, then I

would ask if he has a plan. If the patient has a plan, then I would as if he has the means to carry it out. Symptoms are patient talking about wanting to see God, or "getting to God". I would monitor the patient Q4h for these symptoms.

Signs and symptoms of anxiety are rapid heart rate; chest pain; light-headed; faint; hyperventilation; SOB; sweating palms, face, anywhere; nausea; muscle tension; stating his anxiety is 10/10. I would monitor the patient for these symptoms Q4h or prn.

Signs and symptoms for depression are flat affect, feeling of hopelessness, loss of interest in things that would normally be exciting for patient, feeling restless or frustration, lack of energy. I would monitor the patient daily for these s/s.

Signs and symptoms of delusions are paranoia, aggressive behavior toward others, confused or disturbed thoughts. I would monitor my patient Q6h.

Signs and symptoms of insomnia are trouble concentrating, mood changes, lack of energy. I would monitor my patient for these QD.

Signs and symptoms of anorexia are sudden weight loss, vomiting, using laxatives, exercising excessively, limiting the amount of food they eat (example a cracker for breakfast). I would monitor my patient for this QD.

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.

  Nursing Interventions relevant to the top mental priority problem are maintain a low-level of stimuli, observe patients behavior frequently (every 15 minutes), remove all dangerous objects from patient's environment (Q4h), try to redirect the violent behavior with physical outlets for the patient's anxiety (q24h/prm), staff should maintain and convey a calm attitude toward patient (qd), have sufficient staff available to indicate a show of strength to patient if it becomes necessary (q4h), administer tranquilizing medication as ordered by physician (q6-8h/prn), interact with the patient to better understand thought content, thought processes, and perceptions with particular attention to any content that might suggest risk for violence towards self or others (q6h). For my patient I would dim the lights (Q6h), make sure the noise level is not too high for the patient (maybe remove patient from loud areas prn). The rationale for these interventions is because anxiety levels rise in a stimulating environment. A suspicious or agitated patient may perceive individuals as dangerous.

- Identify a goal of therapeutic communication.

A goal of therapeutic communication for a patient at risk for self-directed violence is to help the patient feel cared for and understood and establish a relationship in which the patient feels free to express any concerns.

IMPLEMENTATION

- Attach Process Recording.

EVALUATION-Reflecting

- Identify strengths and weaknesses of the therapeutic communication.

  Strengths: (provide at least 3 and explain)

  Active listening is a strength in therapeutic communication because it shows genuine interest in what your patient has to say.

  Seek clarification is a strength in therapeutic communication because it keeps the patient engaged and gives the patient a sense of my desire to understand what is important to them.

  Using open-ended questions is a strength in therapeutic communication because it requires the patient to put an effort into their answers and offer more than a yes or no answer. This type of therapeutic communication helps the nurse to gather information from the patient on how they are feeling or what is going on with them.

  Weaknesses: (provide at least 3 and explain)

  A weakness of therapeutic communication with my patient was believing that my patient is too nice to follow through with a suicide. Another weakness of therapeutic communication is family interference. The family being very religious may not understand that it can be a negative impact in the patient taking God too literal. Touching a patient for therapeutic communication can be a weakness because some patients can misinterpret touch communication as something more.

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

  Barriers to communication can be religion, age, and patient's condition. The barrier of religion for my patient and myself was that although I believe in God, my patient saw God in a different way than I do. He sees God as where he has to be with in order to have a great life, where I believe God and Heaven is a wonderful place one can go to after they have lived a life. An intervention I could have done was to suggest to my patient's nurse to see if we could get a pastor/religious director to come see the patient to speak about what he is feeling. Maybe if I sat with the patient and meditated calmly in a quiet space in the therapy room so maybe the patient could relax. Age was a barrier because the patient was 22 years old, and I am 51 years old. There is almost 30 years between the patient and me. It was difficult for me to understand some of the slang that a 22-year-old individual uses. The patient and several of us played

UNO and we had light banter amongst us to ensure all of the patients felt comfortable and could laugh and joke with us. The patient's condition/illness made it difficult for the patient to engage in therapeutic communication at times. Intervention for the patient with his illness can be me explaining some coping skills such as guided imagery or doing puzzles or allowing the patient to feel like he had a part in his treatment by discussing how he feels and what he thinks is best for him considering he has placed himself in harms way on a couple different occasions. The patient was not always clear in his mind to be able to have therapeutic communication.

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

  A Social Determinant of Health for my patient was religious ideation due to early-life adversities. The patient has health problems that make it difficult for the patient to deal with reality. There was concern in TEAM collaboration meeting that the mother may be using God in an inappropriate way with my patient. The mother has been seen holding my patient and rocking him and praying with him. There were times that the patient was completely disconnected from reality and what is real.

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

  A therapeutic communication that could have been done differently is touch therapy. I struggled with the patient's desire to see God being so strong and I felt helpless with how I could help my patient with this so I touched the patient on the shoulder at one point and he spun around quickly. I didn't know if I did something wrong or if the patient felt comforted, I even thought that because I was older maybe the patient saw me in a mothering way. I wasn't sure because he didn't say anything and with me being surprised by his quick movement I wasn't sure how to take his reaction.

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)**
"Hello, how are you today?"	"Hi, I'm not feeling so well."	It was difficult listening to the patient tell me this. I paused and thought about what to say next.	Therapeutic Communication Exploring I was trying to engage with my patient and make him feel comfortable
"Would you like to talk about it?"	"Actually, I would"	I felt relieved when the patient wanted to talk.	Therapeutic Communication focusing, closed-ended question. I was trying to gain trust with my patient and hoping he would confide in me.
"Tell me why you are not feeling so well."	"I just really want to go with my family and get to God"	I wasn't sure where to go from here. So I asked	Therapeutic Communication Exploring I was hoping the patient

			would tell me how he was feeling and if there was something I could do to help then I would do it.
"Are you feeling suicidal today?"	"No, I don't think so"	I was relieved when the patient stated he didn't feel suicidal	Therapeutic Communication Asking a direct, closed-ended question I wanted to see it the patient had suicidal ideation as part of his treatment
"Are you feeling any anxiety today?"	"Yes, I am"	I felt bad, but knew I needed to scale for medication the patient was going to be receiving soon.	Therapeutic Communication Asking a direct, closed-ended question I was trying to see if the patient would share his feelings and knew he was receiving his lorazepam soon
"On a scale from 0-10, how would you rate your anxiety?"	"I would say a 10"	I had to pause because I wanted to think about what we were taught and ask an appropriate question.	Therapeutic Communication Exploring This was because I needed to know for when I give him his medication and I explained that the lorazepam he is receiving at this time was there to help with his anxiety.
"Can you tell me why you are feeling anxious today?"	"I just want Jesus"	I felt like the patient	Therapeutic Communication Focusing I wanted to see if there was anything I could do to explain how to relieve the patient's anxiety.
"Jesus is always in your heart"	"I know he is. I know he is"	I wanted to offer some insight as to what makes me feel better knowing.	Non-therapeutic Communication Presenting reality, Interpreting I was trying to get the patient to realize that you can carry Jesus with you always and you don't have to die to see Him.
"Do you want to talk about it?"	"I don't know, all I know is I want to be with my family and get to God"	Trying to offer myself. Wishing to help the patient	Therapeutic Communication Focusing, close-ended question I wanted to offer myself so that the patient felt comfortable coming to me with his issues and maybe I could find ways to help explain how to relieve it.

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"Does your family visit you?"	"Yes, my Mom and Dad saw me yesterday"	I was trying to get the patient to offer some information about his family	Nontherapeutic Communication Probing I asked this question because I wanted to keep the conversation going and I was uncomfortably feeling bad for the situation.
"How was your visit with your mom and dad?"	"My Mom prayed with me"	I wanted to see how well the patient's relationship is with his parents	Nontherapeutic Communication Probing I was trying to see if the patient was comfortable with his parents because it had been discussed that maybe his parents were good for visiting because they may be hurting the patient's recovery rather than helping.
"How did you feel after you prayed with your mom?	"I just want to go read my Bible"	Hoping the mom would offer some reality to patient	Nontherapeutic Communication Probing I was still trying to see where the patient stood in regards to his parents.
"Would you like me to walk with you?"	"Yes, walking might make me feel better"	I was so happy he wanted me to walk with him so I could continue our conversation	Therapeutic Communication Offering self for trust I wanted to offer myself so the patient would not be alone and we could continue to talk.
"Sometimes walking can help to clear your mind and help you to relax. I understand."	"I just like to read my Bible." "I think I am going to go in my room"	This was difficult because I felt like I failed my patient	nonTherapeutic Communication Conveying empathy I should have said I understand that you want to feel better and I want to be here for him.
"Okay, if you would like to talk more later I will be here"	"Thank you"	I wanted to leave the door open so the patient would think to ask me later	Therapeutic Communication Conveying empathy I wanted the patient to feel safe and comfortable with me now and in the future.
		I felt my conversation could have gone a lot better, but my patient seemed so out of it doped up on his medication.	

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