Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2025
Nursing Process Study

PROCESS RECORDING DATA FORM

Student Name: Mallory Jamison

Date of Interaction: 6/25/25

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

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

My patient is a 50-year-old, single male. He was admitted for mania with a diagnosis of unspecified psychosis because he got pulled over going 89 in a 50 mile per hour construction zone, driving erratically with paranoid delusions. He was pink slipped, so his admission was non-voluntary.

- List any past and present medical diagnoses and mental health issues. **My patient has no pertinent medical history or mental health diagnoses, but he does have a history of previous inpatient mental health treatments and issues dealing with grief, as well as a history of emotional, mental and physical abuse.**

- Self-assessment of thoughts and feelings prior and during the therapeutic communication interaction. Pre-interaction: **I felt unprepared to be able to mentally handle/follow a conversation as heavy and rapid as one with someone experiencing symptoms of mania. It was hard to think of the appropriate therapeutic response to use on the spot, which is opposite of what I expected. I expected it to be easier to talk with these patients and that I would be able to easily think of the correct therapeutic response to use right away.**

  Post-interaction: **I felt surprised at how quickly you can feel mentally drained when communicating with a manic person, and how hard it can be to follow what they are saying. I had only been communicating with the patient for about an hour and a half, and after that short amount of time of trying to follow such a rapid conversation and constant talking, I felt like I needed a break. I did not expect it to affect me in that way.**

- Describe what is happening in the “milieu”. Does it have an effect on the client? **The milieu kept low stimuli such as dim lights, neutral colors, and minimal decoration. It also had supplies to color for a coping mechanism and a smaller unit with less beds for there to be less people (the back unit). I don’t think it had much of an effect on my client because he was not very interested in coloring, the low stimuli didn’t really help him focus or stay engaged in conversation and on topic, and with there being less people he still tended to pick on the other clients. However, I felt like the milieu impacted my patient as the day went on as we sat as a group facing one another around a round table, and he was able to focus on playing a card game with us and did better about staying on topic. The milieu was also very quiet, which I think had a part to play in his focus improving.**

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DIAGNOSIS/PRIORITY MENTAL HEALTH PROBLEM- Interpreting

- Mental Health Priority Problem (Nursing Diagnosis): (Not client medical diagnosis) (List all nursing priorities and highlight the top mental health priority problem).
  - **Disturbed thought processes**
  - **Risk for self-directed or other-directed violence**
  - **Disturbed sensory perception**

- Provide all the related/relevant data that support the top mental health priority nursing problem. (at list 5)
  - **Impulsivity**
  - **Hyper fixations**
  - **Easily distracted**
  - **Grandiose delusions**
  - **Loose associations**
  - **Picking up other patients**
  - **History of issues dealing with grief**
  - **History of emotional and mental abuse**
  - **History of alcohol abuse**
  - **History of physical abuse**
  - **Previous inpatient mental health treatment**

- Identify all potential complications for the top mental health priority problem. Identify signs and symptoms to monitor for each complication. (at least 5 complications)
  - **Risk for imbalanced nutrition: less than body requirements**
    a. **Body weight below ideal range**
    b. **Lethargy**
    c. **Decreased food intake**
  - **Social withdrawal**
    a. **Despair**
    b. **Fear of rejection**
    c. **Low self esteem**
  - **Lack of control**
    a. **Impulsivity**
    b. **Depression**
    c. **Suicidal thoughts**
  - **Depression**
    a. **Flat affect**
    b. **Social isolation**
    c. **Not eating**
  - **Thoughts of suicide**
    a. **Self-harm**

b. **Mood changes**
c. **Suicide**

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 patient for delusional thinking, distractibility, or other symptoms of disturbed thought processes daily**
   a. **To determine if progress has been made on patient thought processes**
2. **Assess patient's ability to control thought processes daily**
   a. **To determine severity of the thought processes to determine the best next step**
3. **Assess patient's ability to solve problems and attention span daily**
   a. **To determine patient's ability to participate in the plan of care**
4. **Administer Paliperidone Palmitate 6mg PO once, Benztropine 0.5mg IM Q6H PRN, Haloperidol 5mg PO Q8H PRN, and Olanzapine 5mg IM Q6H PRN per medication schedule**
   a. **To aid in treatment of mental symptoms experienced and treat extrapyramidal side effects if they occur (Benztropine).**
5. **Set realistic treatment goals daily**
   a. **To aid the patient in achieving desired goals of their treatment**
6. **Accept the patient's beliefs while indicating you do not share them, at all times**
   a. **To help the patient understand that you do not view the belief as real**
7. **Reinforce reality at all times**
   a. **To avoid aggravating psychosis from discussions about false ideas**
8. **Utilize same staff as much as possible, at all times**
   a. **To promote trust**
9. **Educate on the importance of medication adherence once daily and at discharge**
   a. **To prevent dangerous withdrawal symptoms or worsening of thought process disturbances**
10. **Educate on resources available following discharge; counseling/support groups, at discharge**
    a. **To aid the patient in continuing their plan of care after their admission**

- Identify a goal of the **therapeutic** communication. **A goal of the therapeutic communication with my patient is to enhance his focus and ability to form social relationships/conversations by helping him differentiate distortions of reality from reality. "By time of discharge from treatment, the patient will be able to differentiate between delusional thinking and reality" (Townsend, M. C. et al 2024).**

Reference: Townsend, M. C., & Morgan, K. I. (2024). *Pocket guide to Townsend's psychiatric nursing: Assessment, care plans, medications.* (12th ed.). Philadelphia, PA: F.A. Davis Company. https://www.fadavis.com

IMPLEMENTATION

- Attach Process Recording.

EVALUATION-Reflecting

- Identify strengths and weaknesses of the therapeutic communication.

Strengths: (provide at least 3 and explain)

1. **Built a trusting, therapeutic relationship with the client**: With the use of therapeutic communication, the client conveyed comfort and trust in talking with me by opening up to me with information about himself and appearing to enjoy talking with me.
2. **Bringing the client back into topic**: When the client got distracted and off topic, I was able to reorient him to the task at hand and bring him back into the conversation we were having.
3. **Correcting nontherapeutic behavior**: I was able to orient the client to what is appropriate and what is not appropriate, such as directing him that picking on the other clients was inappropriate.

Weaknesses: (provide at least 3 and explain)

1. **I had a hard time progressing the conversation from small talk, to digging more in depth and asking more personal/deeper questions. For example, I seemed to ask a lot of questions about his breakfast trying to make conversation, and I felt silly doing so.**
2. **I had a hard time being able to tell what the patient was being truthful about, versus what was part of his disorder. For example, he told me he didn't like bacon because he is Jewish, and I was unsure if he is really Jewish or if he was expressing religiosity.**
3. **It was sometimes hard to think of the appropriate therapeutic response to use on the spot. For example, I remember when he told me he was Jewish, I responded with "Oh" because I thought he was being serious rather than trying to define whether that was reality for him or not.**

- Identify any barriers to communication. (provide at least 3 and explain) **One barrier to communication with my patient was that he was easily distractable. For example, he would get distracted by the other patients in the room in the middle of our conversation and start talking to them, therefore getting our conversation off track. Another barrier to communication was that my patient exhibited a clear flight of ideas in his speech. Therefore, this made it hard to follow the conversation and know what he was talking about at times, making my responses hard to formulate. Third, the loose associations of my patient rapidly shifting between unrelated topics also made the conversation hard to follow, along with the flight of ideas.**

- Identify **and** explain any Social Determinants of Health for the client. **My patient had a lot of social determinants of health including that he is single and never married, has a sister and a year-old**

child but failed to report emotional support, history of physical, mental, and emotional abuse, and is a half pack her day smoker. Being single and never married is a social determinant of health with this client because it shows that he is more prone to being alone and feeling isolated, therefore increasing his risks for mental health disorders such as depression. He also has the strain of having a year-old child to care for while being single and having no emotional support, which adds stress and can predispose to mental health disorders as well. In addition, the trauma carried with physical, mental and emotional abuse also makes those things social determinants of health because that can predispose you to the types of things going on with my client as well. Being a half pack per day smoker is another social determinant of health because smoking puts individuals at increased risk for issues such as COPD, asthma, and other respiratory conditions.

- What interventions or therapeutic communication could have been done differently? Provide explanation. **Something that I feel could have been done differently with my therapeutic communication would be to change from small talk sooner and begin to ask my patient more personal questions to try and gain some insight on what he was experiencing mentally. The reason I say this is because I feel like I tended to ask a lot of small talk questions especially over the same things such as breakfast, and it made it hard to get a good understanding of whether some of the things he was understanding were part of his diagnosis or not. If if were to dive into deeper questions sooner and ask things such as "How would you rate your anxiety" and alike questions, I think I would've gotten a clearer understanding of the psych related symptoms he was experiencing.**

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Student's Verbal or Nonverbal Communication	Client'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)**

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"We are nursing students observing today, can I sit with you?"	"Only one more step to be a doctor, doctors do papers, you should be a doctor…like lawyers doctors need ethics."	I had a hard time understanding what he meant and thought this seemed like loose associations.	Therapeutic, offering self: willingness to spend time with the patient and show interest to promote their feelings of self-worth.
"It is a lot more schooling to be a doctor."	*Stared blankly*	I thought maybe he was experiencing delusions that caused him to be distracted from what I said or not understand me.	Nontherapeutic, agreeing or disagreeing indicating that the nurse has the right to pass judgement on whether the patient's actions are right or wrong. I was going along with what he said and disagreed that becoming a doctor is one more step, when I should have attempted to reorient him to reality.
"You seem to like teaching" (to another client speaking about his job)	"I was a teacher! I went to the school board at American University in Washington, D.C., it's the school of the country."	It seemed like a grandiose delusion to me, that he thinks he went to a school board of the school of the country for something.	Therapeutic, making observations: encouraging the patient to develop awareness of how others perceive them.
"I understand you think it is the school of the country, but I have never heard that."	"Yeah, they have a great volleyball team."	It didn't seem like he cameb ack to reality or took my statement as therapeutic.	Therapeutic, presenting reality: expression of the nurse's perception of the environment without challenging the patient's perception.
"How is your breakfast?"	"I put pepper on everything, pepper helps metabolize the body, pepper is peppermint"	This seemed like more loose associations and manic-like behavior.	Nontherapeutic; introducing an unrelated topic: prematurely changing the subject which conveys to the patient that the nurse does not want to discuss the original topic anymore. Silence could have been used as an alternative .
Why did you put pepper in your coffee, you like it like that?"	"Yes, it balances out the other flavors."	I had a hard time seeing where he was coming from as he was doing bizarre/impulsive actions at this time, but thought maybe it could be delusions of	Nontherapeutic, requesting an explanation: asking the patient why they have certain behaviors, thoughts, or feelings which may intimidate them. I could have said " Describe what led up to you mixing pepper in your

		reference.	coffee."
"Do you like creamer in your coffee?"	*Fixating on food and mixing odd combinations"	As said above, at this point in the conversation he was becoming impulsive with mixing his grape juice and coffee together along with other bizarre combinations.	Therapeutic, focusing: encouraging specific discussion is helpful in individuals moving rapidly from one topic to the next.
"Am I understanding correctly that making combinations such as pepper with your food and grape juice with coffee is how you like your food?"	"Yes, the grape helps with the bitter taste of the coffee, you should try it"	I was unable to tell whether this was something he truly likes, or it was part of his disorder process because he was making many other odd combinations.	Therapeutic, seeking clarification and validation: searching for mutual understanding and striving to explain vague statements to increase understanding.
"Did you get enough to eat?"	*Giving a lot of his food away*	I thought maybe he had a lack of appetite as I know in the manic phase individuals eat less, or maybe he was attention seeking.	Therapeutic, focusing. The individual appeared hyper fixated on his food, so although it was a lot of small talk, I wanted to focus on this topic to try and identify why he was fixated.
"I see you are giving your food away, do you not like bacon?"	"I'm Jewish."	I honestly was unsure whether he was telling the truth or could maybe be expressing religiosity. The chart indicated he follows no religion.	Therapeutic, making observations: verbalizing what you observed about an individual's behavior.
"You believe in a religious affiliation that stops you from eating bacon. Will you eat cantaloupe?"	"I am allergic to cantaloupe but watch this, I know my allergens and how my body reacts." *Places cantaloupe in his mouth*	At the moment I didn't think about the fact that he is more than likely not really allergic, so I tried to talk him out of eating it, but afterwards I realized it was likely part of the process he has going on.	Therapeutic, restating: letting the patient know whether the statement has been understood by repeating the main idea.
"I know you think you are allergic to cantaloupe, but I find	*Sitting with tongue out and laughing, continuing to eat the	This is when it became clearer that he does not really	Therapeutic, voicing doubt: A technique with delusional patients where you express

that hard to believe."	cantaloupe*	have an allergy because nothing happened when he ate it, and I figured he was trying to get attention.	uncertainty about validity of perceptions. I found it hard to believe that he had an allergy because dietary would likely be aware and not take it to him.
silence	"Hi captain." (to security as they walked in)	I was unsure whether he just wanted to call security that or if he was having some kind of grandiose delusion.	Therapeutic, using silence: encouraging the patient to organize their thoughts into words.
"I have to go for a bit. Is there anything else you would like to talk about?"	"No, I am going to go shower."	I thought this was an appropriate response and assisted him in getting the things needed to shower.	Therapeutic, giving broad openings: allowing the patient to direct the focus of the interaction.