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

PROCESS RECORDING DATA FORM

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Date of Interaction: 6/20/25

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

Some abnormal assessment findings were the abrasions all over the patient's face and arms. She had one on her face that was located on the left cheek, and then down both arms. Her mental status seemed to be abnormal as she blankly starred while communicating with people and she just seemed to walk through the halls with empty thoughts, but she wasn't confused. She was lethargic both days throughout the whole day with little interest in her surroundings. This might have been part of her history of depression and her going through a situational crisis. The client also walked with no assistance but has an unsteady gait. Patient has a history of fall that was part of her admission.

- 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?

The client was 70-year-old female who has been married to her husband of many years. Client was admitted to the behavioral unit voluntary. The patient was admitted because she has been feeling depressed for 3 weeks and has experienced chronic illness of pain in her legs. With that she attempted to commit suicide by overdosing on 30 of her prescribed benzodiazepines of Restoril. After she had taken all those pills, she had a fall which caused abrasions on her face and arms. She was first admitted to the ICU to make her medical stable before sending her down to the behavioral unit.

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

My patient's medical history is hypertension, COPD, migraines, Gerd, fibromyalgia, hyperlipidemia, arthritis, osteoporosis, heart murmur, and a nicotine smoker. My patient's psychiatric history is bipolar 1 disorder, depression and anxiety.

- Self-assessment of thoughts and feelings prior and during the therapeutic communication interaction.
  Pre-interaction: I was feeling confident on gaining a therapeutic relationship with her because she seemed to be easily approachable. I thought with her being older it would have been easier to have her open up and make connections. When I first heard her report I thought that this patient is just going through a crisis, and I thought it could be therapeutic to have a person spend a lot of time with you hearing your story.

  Post-interaction: After talking with my client, I found it was hard to get her to talk. She was more focused on going back to her room to rest. She did not want to make small talk, which led to us not

having a big conversation about why she was in her and how she was feeling. It was very hard to keep her attention on our conversation overall. She was more quiet and wanted me to talk and direct her rather than her opening up and talking over the conversation. I felt as if I did not have a trusting relationship with her until the second day of being with her. She seemed to be less drowsy and opened up more about her home life. We did end up building a trusting relationship to have a therapeutic conservation, it just took longer.

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

In the milieu many clients were out of their personal room and in the day room. A group of clients were playing cards, some were wandering around making conversation and some were watching tv. Most clients build relationships with other clients, and they worked in groups to enjoy the activities they were doing. It was a respectful tone in the milieu and patients talked but kept it to a minimal voice level. It was not overstimulating I would say the environment was more relaxed and friendly. There seem to be no patients acting out of character and most greeted with a smile. But as for my client with the different activities going on and all the conversations going on, I felt like it was a distraction to her. She seemed to not keep focus but wanted to wander and would sit through a little bit of an activity and move on to the next. She was more interested in experiencing the environment around her rather than the people. So yes, it affected my clients' focus but not in a negative way were it over stimulated her to act out of character.

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).
  - Chronic pain
  - Risk for suicide
  - Risk for self-harm
  - Disturbed thought process
  - Complicated grieving

- Provide all the related/relevant data that support the top mental health priority nursing problem. (at list 5)
  - Chronic pain
  - Suicidal ideations with attempt
  - Flat Affect
  - Suicide level 1
  - Non-communicative with nurses and other patients
  - Absent from group therapies
  - Restlessness
  - Death of daughter 1 ½ years ago
  - Depression of 6 out of 10

- Identify all potential complications for the top mental health priority problem. Identify signs and symptoms to monitor for each complication. (at least 5 complications)
  - Self-harm- isolated behavior, scar/cuts, challenges in relationships, hopelessness, impaired relationships, death and mood changes.
  - Death- Cyanosis, absent respiratory rate, cold body temperature, and asystole.
  - Social isolation- Increased alone time, no attendance for social gatherings, and impaired relationships.
  - Depression- Sleep disturbances, lack of motivation, increased anxiety levels, suicidal ideations, difficulty concentrating, apathy, and social isolation.
  - Substance abuse- Poor hygiene, weight gain or loss, mood changes, fatigue, anxiety and memory impairment.

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. Create a safe environment for patients daily to ensure patient safety.
2. Assess the patient's mental status as well as suicidal ideations daily to determine the severity of suicide/ depression the patient has.
3. Assess the use or abuse of substance upon admission to determine the need for additional patient care needed during their stay.
4. Assess the patient for change in behaviors and mood daily to address underlying conditions.
5. "Discuss losses client has experienced and meaning of those losses" (Doenges, Moorhouse & Murr, 2022, Para. 22).
6. Implement safety checks on patients every 15 minutes throughout their stay.
7. Administer medications prescribed daily to correctly treat patients.
8. Encourage patients to participate in therapy groups daily throughout their stay.
9. Educate patients on support groups and therapies from admission and daily to help them achieve therapeutic goals
10. Educate patients daily on medications being administered to them.

Work cited: Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2022). *Nurses' pocket guide: Diagnoses, prioritized interventions, and rationales* (16th ed). F. A. Davis Company: Skyscape Medpresso, Inc.

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

The goal of therapeutic communication is to maintain patients' safety while managing symptoms of depression and anxiety.

IMPLEMENTATION

- Attach Process Recording.

EVALUATION-Reflecting

- Identify strengths and weaknesses of the therapeutic communication.

  Strengths: (provide at least 3 and explain)

  One strength of the therapeutic communication I had was giving my patient open-ended questions for her to be able to take the conversation and turn into what she felt comfortable opening up to. This was important so the patient did not feel obligated to answer questions she didn't feel comfortable answering.

  Another strength in my communication was being able to remain judge free with the information given to me and being able to respond with therapeutic communication to keep the conversation going. This helped maintain a trusting relationship for us and ended up making us both feel comfortable to continue our conversation.

  The last strength in my communication was being attentive to her at all times when communicating with her. I never took my attention off the conversation or seemed to be interested in the environment around me. I focused on her and what she was saying with timely responses with help build that connection with her as well.

  Weaknesses: (provide at least 3 and explain)

One of my weaknesses during communication was approaching her for the first time and knowing exactly what to start the conversation with. This was affected because she didn't seem willing to take time to sit there and talk.

Another weakness I had with communication was having a therapeutic response after every response because some of the responses given to me were closed ended and made it very hard to find a specific response that was therapeutic pertaining to the topic.

My last weakness was my lack of working with mental health patients. With the lack of experience, it was hard to maintain conversation and maintain feeling comfortable. At times it was very uncomfortable to continue the conversation.

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

A barrier to communication during this interaction was the patient attention span. She was very restless and focused on the environment around her. So, after minutes of conversation her attention would veer off into other things around us.

Another barrier for communication was the patient was so anxious that her mind wasn't focusing on her but instead of her husband's health. It was hard to get her off the topic of talking about getting home to her husband.

The last barrier to communicating was getting her to open up to me and trust me. She was admitted for 5 days before me coming in so trusting me was difficult. It made it hard for her to open up to me about what had happened and how she was feeling.

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

Some Social Determinants of Health for my client were her having chronic illness of fibromyalgia and arthritis which cause her to have a great amount of pain that she dealt with daily. Also, her daughter died a year and a half ago which cause a lot of depression. She has not been able to cope with the death of her daughter making it hard for her to get over unrelieved sadness and stress. Another one is she has a family history of substance abuse which puts her at greater risk for developing an addiction to the type of medication that she has been prescribed for her major depressive disorder. Finally, the last social determinant of health is a positive one of having a supportive husband throughout her history of suicide attempts and mental illnesses. He has been there to help understand her feelings as well as give her support to get through these times where she feels her lowest.

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

Overall, I felt like my therapeutic communication could have been better to develop a more trusting relationship with my patient. I felt like I did use therapeutic communication for my patient, but I felt like my responses where straight to the point making it seem like I was uninterested in the conversation. I would've had a more meaningful response that open the conversation more that would lead to the trusting relationship with a little more practice. So, I would done my therapeutic communication a little differently to help build that trusting

relationship to gain more insight on my patient as a whole to better understand what my patient is going through.

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	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)**
"Hey, can I come sit with you?"	"Yes, but I am eating breakfast."	I wanted to start a conversation with the patient.	Offering self
"How are you feeling today?"	"I am very tired, and I feel very anxious."	My patient seemed very tight and wanted to know how she felt during this time.	Offering self
"I understand." (nodding)	"I'm just ready to see my husband "	I wanted to show empathy toward her feelings.	Accepting
"I can see you took a shower already"	"My husband is coming to visit me	I wanted to show awareness that she is	Giving recognition

	today."	doing self-care.	
"Are you willing to go to group and sit with me?"	"Yes we can go."	I wanted to offer a chance for her to go to group since she hasn't been going.	Offering self
"Is there anything you would like to discuss?"	"I just feel sad and have been feeling like this for a while. Some days I feel like it would be better if I wasn't here and maybe I could make this sadness go away."	I wanted to learn more about her situation and why she is going through the emotions she was having.	Giving broad openings
"Can you tell me more about this specific point?"	"I have such a loving husband and I have been through depression like this for so long. I just feel like I am going through so much that nobody can understand. My husband is trying to be supportive but I lost my daughter and I just don't know how to keep going."	I wanted to focus on the situation of why she was in the unit seeking help.	Focusing
(Shaking my head with an empathic face)	"I have been having these horrible thoughts in my head for weeks now and I wasn't sure how to make them stop."	I wanted my patient to gather thoughts and time to explain more by being interrupted.	Using silence
"I notice you have smiled today. Are you starting to feel better?"	"Yes, the medication they have been giving me has been giving me the energy I need to take care of what I need too."	I wanted to make notice of my patients' behavior.	Making observation
"Was this episode similar to your last episode you had before coming here?"	"Yes, sometimes I just feel like it would be better if my husband did have to deal with me."	I wanted to help my patient recognize life experiences that keep occurring or her triggers.	Encouraging compassion
"I understand you feel that way, but your	"It just hard to see other people's side."	I wanted to express that her thinking may	Presenting reality

husband is worried about losing you."		be off without challenging or correcting her thoughts.	
"I am not sure I understand. Could you explain what you mean?"	"I just meant when I am feeling like this it hard to hear or understand how other people feel about me. My only thought that I focus on is my own."	I wanted to gain a mutual understanding of what she meant in her respond.	Seeking clarification
"I understand now."	"I am very tired I think I'm going to my room for a nap."	I wanted to show I understood what she meant when explaining herself.	Accepting