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N323

Assessment and Reflection 1

Patient S.W. is a forty-six-year-old Caucasian female. She was admitted to the hospital because of a recent event that occurred in her life. The patient has struggled with a past medical history of depression and anxiety. Her son had told her that she should kill herself. Shortly after that conversation with her son, she overdosed on Flexeril and Xanax. The patient was interviewed and was given a mental status examination. There were a few things I noticed about the patient during the interview. Her disheveled appearance was the most obvious thing you could see; however, I noticed a few other smaller notes. She spoke in a monotone voice, but her affect was still full. She also did not have the best eye contact with the interviewer either. When the patient was asked about her mood, she described her mood as being “homesick.” The findings from this assessment didn’t seem to show anything abnormal. Considering the environment the patient is in, the patient having a disheveled appearance is not uncommon, and feeling homesick is not unusual either.

Interviewing the patient will help to determine other assessment tools that could be utilized and could benefit the patient in the end. Considering patient S.W., assessment tools such as the Patient Health Questionnaire (PHQ-9), the Drug Use Questionnaire (DAST-20), and the CAGE Questionnaire could benefit the patient, allowing us to understand better what she might be dealing with. As nursing students, we could give them those assessment tools to further our learning of the material, but we could also look at their physical files and digital records to see their history. I gave the patient S.W. the Patient Health Questionnaire (PHQ-9) to better

understand her struggle with depression. I utilized good eye contact, open-ended questions, active listening, restating, and silence. I learned that speaking to patients was much easier than I thought it would be. In the future, I might practice asking questions listed in the various tools provided to us beforehand to know how to ask the patient best when the time comes. During the interview, my therapeutic technique of restating went well. I think practicing asking different questions will benefit me in the future. Before this clinical, I had never been exposed to a mental health floor, so I wasn't sure what to expect. I only had presumptions and misconceptions of what it was like based on movies, which is always never realistic. I feel more confident after the first day, and I know the patients there want to improve like any other patient at a hospital.

I reviewed patient S.W.'s medical history before interviewing her and saw that she has struggled with depression and anxiety. While interviewing patient S.W. for the mental status examination, I learned that she has not been experiencing any suicidal ideations. Therefore, I chose to do the Patient Health Questionnaire (PHQ-9) as the additional assessment for this patient. The patient chose nearly every day for five out of the nine questions on the questionnaire. During this assessment, I noticed the patient was much more detailed with her answers. One of her answers that stood out to me was that nearly every day, she felt like she had failed or let down her family members. Another answer that stood out was whether she felt tired or had little energy. She mentioned that she had fallen a couple of times while at home and had hurt her hip. While in the hospital, she said some days she can't find the energy to walk without a cane or walker, but there are other days when she can walk without any assistive devices.

Patient S.W. has struggled with depression and anxiety for a while now. The patient and her son exchanged words before the event, leading to patient S.W. being admitted to the hospital. I believe that when she heard her son say, go kill yourself, and it threw her into a depression

spiral that she was desperate to escape. I also think the issues she had been experiencing with her hip caused her to become even more depressed. These ultimately led her to overdose on Flexeril and Xanax. I have no similar experiences or situations like this one to link them; this is my interpretation of her situation. Additional assessment information for the patient might be the Drug Use Questionnaire (DAST-20) since the patient overdosed on prescription medications. During the PHQ-9 assessment, the patient could be asked a few more questions about her family demographics and what has caused her to feel like a failure to them. As a nursing student, I could have asked her a few more detailed questions about her family and what has caused her to feel like a failure. I also could have given her the DAST-20 questionnaire to learn more about the patient. I asked her if she had any good support outside of her family, and she mentioned that she has a few close friends she talks to often. As a nurse, I could do all the relevant assessments on her and possibly find her community resources to help with sobriety, family counseling, financial assistance, etc.

While doing the PHQ-9 questionnaire, I learned how to properly score that specific assessment. The patient scored a 15 on the PHQ-9 questionnaire. A score anywhere from 15 – 19 categorizes the patient as having moderately severe depression (Kroenke et al., 2021). Just to familiarize myself with the questions on all the possible assessments, I think I will review the questions before interviewing the patient. I maintained a good sense of silence and active listening toward the patient during the PHQ-9 assessment. I feel more confident with the PHQ-9 assessment and the mental status examination, having done it on one patient so far. I will only become more confident and comfortable as I assess more patients.

Reference

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2021). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x