**THE UNIVERSITY OF TEXAS**

**AT ARLINGTON**

**COLLEGE OF NURSING**

**N5425**

**PSYCHIATRIC MENTAL HEALTH II**

**Spring 2011**

**Classroom #: 4-6pm 220/221; 12-4pm 212**

The University of Texas at Arlington College of Nursing

**Graduate Program**

**N5425 Psychiatric Mental Health II**

**(4 semester hours, (2-6) 2- class hours, 6 clinical hours weekly)**

**Spring 2011**

**Wednesdays, 12-6 p.m.**

**Pickard Hall, Room 220/221 (212 from 12-4pm)**

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| **INSTRUCTORS:** | **Diane Snow, Ph.D., APRN, PMHNP-BC, CARN**  ***Clinical Professor***  Office #: 627 Pickard Hall  Office Hours: Monday AM, other by appointment  Office Phone: (817) 272-7087  Office Fax: (817) 272-5006  Campus Mailbox: 19407  Email: [snow@uta.edu](mailto:snow@uta.edu)  Website: <http://www.uta.edu/nursing/faculty/snow.php>  **Larae Huycke PhD, APRN, PMHNP-BC**  ***Assistant Clinical Professor***  Office #: Pickard Hall RM 626  Office hours: By appointment only  Office Phone 817-272- 2776  Office Fax: (817) 272-5006  Campus Mailbox: 19407  E-mail: [huycke@uta.edu](mailto:huycke@uta.edu)  Website: <http://www.uta.edu/nursing/MSN/psychiatric.php>  **Mary Jo Perley, PhD, RN, PMHNP-BC**  ***Assistant Clinical Professor***  Office: Pickard Hall RM 629  Office Hours: By appointment  Office Phone: (817) 272-2776.  Office Fax: (817) 272-5006  Campus Mailbox: 19407  E-mail: [perley@uta.edu](mailto:perley@uta.edu)  Website: <http://www.uta.edu/nursing/MSN/psychiatric.php> |
| **COURSE WEB SITE OR WORLD WIDE WEB SITE:** | <http://www.uta.edu/nursing> |
| **COURSE PREREQUISITES:** | N5424 and N5328 or concurrent enrollment |
| **REQUIRED TEXTBOOKS & MATERIALS:** | 1. American Psychiatric Association (Text Revision). (2000). 4th ed. *Diagnostic and Statistical Manual of Mental Disorders TR.* Washington, DC: American Psychiatric Association. **ISBN:** 9780890420256. 2. Fuller, M.A. and Sajatovic, M. (2009). 7th ed. *Drug Information Handbook for Psychiatry*. Hudson: Lexi –Comp. **ISBN:** 978-1-59195-253-4 3. Linehan, M.M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*. New York: Guilford Press. **IBSN:**9780898620344. 4. Nichols, M. (2007). *Family Therapy: concepts and Methods*. 8th ed. Pearson Education. **ISBN:** 9780205543205 5. Sadock, B. and Sadock, V. (2007). *Synopsis of Psychiatry.* 10th ed. Philadelphia: Williams &Wilkins. **ISBN:** 9780781773270. 6. Stuart, G.W., Laraia, M.T. (2008). *Principles and Practice of Psychiatric Nursing*. 9th ed. St. Louis: Mosby. **ISBN** 0323052568 7. Stahl, SM (2008) *Essential Psychopharmacology*: *Neuroscientific Basis and Practical Applications (Essential Psychopharmacology Series*. (Paperback). 3rd ed. Cambridge: Cambridge University Press. **ISBN:**9780521673761 8. Corey, G. (2009). *Theory and Practice of Counseling and Psychotherapy*. 8th ed. Florence: Brooks/Cole. **ISBN:** 9780495102083. 9. .Yalom, I. Group Psychotherapy. 10. Khouzam, H. R., Gill, T. S. Tan, D. T. (2007). *Handbook of Emergency Psychiatry.* Elsevier Health Sciences. **ISBN:** 9780323040884 11. Zimmerman, M. *Interview Guide for Evaluating DSM-IV Psychiatric Disorders and the Mental Status Examination.* (1994). East Greenwich: Psych Products Press. **ISBN:** 9780963382139 12. Wheeler, K. (2007). *Psychotherapy for the Advanced Practice Psychiatric Nurse.* Mosby, Incorporated. **ISBN:** 9780323045223 13. Hahn (2009) Psychiatry, 2009 Edition   Current Clinical Strategies **ISBN: 9780465092840** 14. Yalom, I and Leszez, Theory and Practice of Group Psychotherapy 5th ed. **ISBN : 9781934323106** 15. Rosengren, David, Buildig Motivational Interviewing Skills: A practitioner Workbook (Applications of Motivational Interviewing) **ISBN: 9781606232996** |
| **RECOMMENDED TEXTBOOKS**  **AND MATERIALS**  **:** | 1. Connor, DF, & Meltzer, BM. (2006)Pediatric Psychopharmacology Fast Fact. 2006 ISBN 0-393-70461-0   2. Stahl, Stephen M. *Essential Psychopharmacology: The Prescriber's Guide: 3rd ed. (Essential Psychopharmacology Series)*.2009 (Paperback). Cambridge University Press. **ISBN:** 9780521683500 |
| **COURSE DESCRIPTION:** | Focus on diagnosis, pharmacological and non-pharmacological management, and outcomes of individuals, families, and groups experiencing complex mental illnesses and addictions in a variety of settings. |
| **ATTENDANCE AND**  **DROP POLICY:**  **COURSE DESCRIPTION**  **COURSE OUTCOMES** | * Regular class attendance and participation is expected of all students. * Students are responsible for all missed course information.   Graduate students who wish to change a schedule by either dropping or adding a course must first consult with their Graduate Advisor. Regulations pertaining to adding or dropping courses are described below. Adds and drops may be made through late registration either on the Web at MyMav or in person through the student’s academic department. Drops may occur until a point in time two-thirds of the way through the semester, session, or term. The last day to drop a course is listed in the Academic Calendar available at [http://www.uta.edu/uta/acadcal.](http://www.uta.edu/uta/acadcal)   1. A student may not add a course after the end of late registration. 2. A student dropping a graduate course after the Census Date but on or before the end of the 10th week of class may with the agreement of the instructor, receive a grade of W but only if passing the course with a C or better average. A grade of W will not be given if the student does not have at least a C average. In such instances, the student will receive a grade of F if he or she withdraws from the class. Students dropping a course must: (1) complete a Course Drop Form (available online <http://www.uta.edu/nursing/MSN/drop_resign_request.pdf> or MSN office rooms 605 or 606); (2) obtain faculty signature and current course grade; and (3) submit the form to MSN office rooms 605 or 606. 3. A student desiring to drop all courses in which he or she is enrolled is reminded that such action constitutes withdrawal (resignation) from the University. The student must indicate intention to withdraw and drop all courses by filing a resignation form in the Office of the Registrar or by: (1) Completing a resignation form (available online <http://www.uta.edu/nursing/MSN/drop_resign_request.pdf> or MSN office rooms 605 or 606; (2) obtaining faculty signature for each course enrolled and current course grade; (3) Filing the resignation form in the School of Nursing office room 605 or 606; and (4) Filing the resignation form in the Office of the Registrar in Davis Hall room 333. 4. In most cases, a student may not drop a graduate course or withdraw (resign) from the University after the 10th week of class. Under extreme circumstances, the Dean of Graduate Studies may consider a petition to withdraw (resign) from the University after the 10th week of class, but in no case may a graduate student selectively drop a course after the 10th week and remain enrolled in any other course. Students should use the special Petition to Withdraw for this purpose. See the section titled Withdrawal (Resignation) From the University for additional information concerning withdrawal.   **Census Date: - February 2, 2011** Last Date Drop or Withdraw: - April 1, 2011Advanced clinical management of individuals, families, and groups at risk for and experiencing complex psychiatric disorders1.Diagnose individuals with complex acute and chronicpsychiatric disorders, integrating biopsychosocialtheories. (MPO 1) 2. Provide culturally, spiritually, ethnicity, age, gender, and sexual orientation sensitive mental health care in populations with complex acute and chronic psychiatric disorders. (MPO 1,3)  3. Use evidence based psychopharmacological and non-pharmacological interventions in the management of complex acute and chronic psychiatric disorders. (MPO 1,2,3)  4. Evaluate complex acute and chronic mental health care using selected outcomes. (MPO 1,3)  5. Participate in informed legal and ethical decision-making in providing complex acute and chronic mental health care in the primary, secondary, and tertiary care settings. (MPO 1,3)   1. Function as a member of the interdisciplinary health care   team in the delivery of quality mental health care. (MPO |
| **TENTATIVE LECTURE/TOPIC SCHEDULE (COURSE CONTENT):** | Topical OutlinePsychiatric EvaluationLegal and ethical concerns in psychiatryUsing DSM-IV and differential diagnosisProtocols and evidence based practiceNeurobiology of Psychiatric Disorders and AddictionsResearch OutcomesHealth promotion and prevention in psychiatryPsychiatric Disorders: Etiology, Assessment, Diagnosis and ManagementDisorders of infancy, childhood, and adolescenceDelirium, dementia and amnestic and other cognitive disordersMental disorders due to a general medical conditionSubstance related disordersSchizophrenia and other psychotic disordersMood disorders –treatment resistant depression; bipolar disorder in adults and children; depression in childrenAnxiety disorders-refractive PTSD and OCDSomatoform disordersDissociative disordersSexual and gender identity disordersEating disordersSleep disordersImpulse control disordersAdjustment disordersPersonality disordersChronic Pain managementTraumatic Brain Injury  1. Medically ill children and psychiatric problems 2. Medically ill adults and psychiatric problems 3. Metabolic considerations of atypical antipsychotics 4. Co-occurring psychiatric and addictive disorders 5. HIV and psychiatric problems 6. Women’s mental health issues 7. ADHD in Adults and Children |
| **SPECIFIC COURSE REQUIREMENTS:** |  |
| **TEACHING METHODS/STRATEGIES:** | 1. Lecture 2. Guest Speakers 3. Case Study presentations in class 4. Readings 5. Treatment guidelines analysis 6. Objective tests 7. Therapy moment maps 8. SOAP note with online discussion on Blackboard 9. Medication management notes 10. Elogs and clinical notebook |
| **GRADE CALCULATION**  **(COURSE EVALUATION &**  **FINAL GRADING)** | 1. Preceptor Evaluations P/F  2. Clinical notebook including P/F  E-log report  objectives & summary & tally sheet  preceptor agreement & evaluation  4. Final clinical practicum 15%  5. Case presentation on BB/lead discussion 10%  6. Test #1 15%  7. Test #2 15%  8. Comprehensive Final 15%  10. Analysis of treatment guideline paper 10%  11. Therapy moment maps & discussion P/F  12. Medication management write ups (2) 10%  13. Blackboard participation (TMM, cases) P/F  14. Classroom Case Study Presentations 10%  **Total 100%** |
| **CLINICAL EVALUATIONS:** | Students must pass both the didactic and clinical portions of a clinical course in order to pass the course. In order to pass the clinical portion, the student must receive a passing grade (minimum of 83%) on the faculty evaluation of the student’s clinical performance (Nurse Practitioner Clinical Evaluation). Students who fail a faculty evaluation have a one-time option to retake the practicum. A second faculty member will be present during the clinical performance retake. If the student passes the clinical performance retake (minimum of 83%), the **maximum** grade the student can receive for the exam for purposes of grade calculation is 83%. If the student fails the retake, the student will receive a grade of “F” for the course. |
| **STUDENT REQUIREMENT FOR PRECEPTOR AGREEMENTS/PACKETS:** | 1. All Preceptor Agreements must be signed by the first day the student attends clinical (may be signed on that day). 2. **Student** is responsible to ensure that all of his/her preceptor agreements are signed before beginning clinical experience and those agreements are given to Elisha Cotten by the third week of the semester. (This means that even if a student doesn’t start working with a particular preceptor until late in the semester, s(h)e would contact that preceptor during the first 3 weeks of the semester. 3. Elisha Cotten or designated support staff will enter the agreement date into *Partners* database. The Agreement Date” field in *Partners* is the data that the Preceptor signed the Agreement. (This date must be on or before the student’s first clinical day in order for the student to access *E-logs).* If this is the first time a preceptor is precepting a graduate nursing student for The University of Texas at Arlington, please have him/her complete the Preceptor Biographical Data Sheet and submit it with his/her Curriculum Vitae. 4. The signed preceptor agreement is part of the clinical clearance process. Failure to submit it in a timely fashion will result in the inability to access the E-log system. |
| **CLINICAL CLEARANCE:** | All students must have current clinical clearance to  legally perform clinical hours each semester. If your  clinical clearance is not current, you will be unable to  do clinical hours that are required for this course and  this would result in course failure. |
| **E-LOGS** | Students are required to enter all patient encounters into the eLog system.  Elog is both a student learning opportunity and an evaluation method for clinical courses.  Patient encounters include patients the student assesses, diagnoses, and manages as part of their clinical coursework.  Individual clinical courses may have additional guidelines/requirements related to their specific course and will be noted in the course syllabus (e.g. types of encounter required, number of patients required during course).  The student’s eLog data provides a description of the patients managed during the student’s clinical experience, including the number of patients, diagnoses of patients, and the type of interventions initiated.  As a result, eLog data are an essential requirement of the student’s clinical experience and are used to evaluate student clinical performance.  The data are used to meet course requirements and to evaluate student clinical performance.  Upon completion of the Program, students will receive an executive summary of their eLog entries for their professional portfolio.  **Students are expected to enter information accurately so that (if needed) faculty may verify/validate the information provided.  Falsifying and/or misrepresenting patient encounter data is considered academic dishonesty.** |
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| **STATUS OF RN LICENSURE:** | All graduate nursing students must have an unencumbered license as designated by the Texas Board of Nursing (BON) to participate in graduate clinical nursing courses. It is also imperative that any student whose license becomes encumbered by the BON must immediately notify the Associate Dean for the MSN Program, Dr. Mary Schira. Failure to do so will result in dismissal from the Graduate Program. The complete policy about encumbered licenses is available online at: : <http://www.bon.state.tx.us> |
| **MSN GRADUATE STUDENT DRESS CODE:** | **Policy:** The University of Texas at Arlington College of Nursing expects students to reflect professionalism and maintain high standards of appearance and grooming in the clinical setting. **Clinical faculty has final judgment on the appropriateness of student attire and corrective action for dress code infractions.**  **Students not complying with this policy will not be allowed to participate in clinical.**  **Please View the College of Nursing Student Dress Code on the nursing website:** [www.uta.edu/nursing](http://www.uta.edu/nursing)**.** |
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| **UTA STUDENT**  **IDENTIFICATION:** | **MSN Students MUST be clearly identified as UTA Graduate Students and wear a UTA College of Nursing ID in the Clinical Environment.** |
| **UNSAFE CLINICAL BEHAVIORS:** | Students deemed unsafe or incompetent will fail the course and receive a course grade of “F”. **Any of the following behaviors constitute a clinical failure**:  1. Fails to follow standards of professional practice as detailed by the Texas Nursing Practice Act \* (available at [www.bon.state.tx.us](http://www.bon.state.tx.us))  2. Unable to accept and/or act on constructive feedback.  3. Needs continuous, specific, and detailed supervision for the expected course performance.  4. Unable to implement advanced clinical behaviors required by the course.  5. Fails to complete required clinical assignments.  6. Falsifies clinical hours.  7. Violates student confidentiality agreement.  \*Students should also be aware that violation of the Nursing Practice Act is a “reportable offense” to the Texas Board of Nurse Examiners. |
| **BLOOD AND BODY FLUIDS EXPOSURE:** | A Health Verification form was signed by all MSN students at start of the program documenting personal health insurance coverage. All MSN students have mandatory health insurance and will need to manage exposure to blood and fluids. Current CDC guidelines can be found at:<http://www.cdc.gov/> |
| **CONFIDENTIALITY AGREEMENT:** | You signed a Confidentiality Form in orientation and were provided a copy of the form. Please take your copy of this Confidentiality Form with you to your clinical sites. Please do not sign other agency confidentiality forms. Contact your faculty if the agency requires you to sign their confidentiality form. |
| **GRADUATE STUDENT HANDBOOK:** | Students are responsible for knowing and complying with all policies and information contained in the Graduate Student handbook online at: <http://www.uta.edu/nursing/handbook/toc.php> |
| **AMERICANS WITH**  **DISABILITIES ACT:** | The University of Texas at Arlington is on record as being committed to both the spirit and letter of federal equal opportunity legislation; reference Public Law 92-112 - The Rehabilitation Act of 1973 as amended. With the passage of federal legislation entitled *Americans with Disabilities Act (ADA)*, pursuant to section 504 of the Rehabilitation Act, there is renewed focus on providing this population with the same opportunities enjoyed by all citizens.  As a faculty member, I am required by law to provide "reasonable accommodations" to students with disabilities, so as not to discriminate on the basis of that disability. Student responsibility primarily rests with informing faculty of their need for accommodation and in providing authorized documentation through designated administrative channels.  Information regarding specific diagnostic criteria and policies for obtaining academic accommodations can be found at www.uta.edu/disability.   Also, you may visit the Office for Students with Disabilities in room 102 of University Hall or call them at (817) 272-3364. |
| **STUDENT SUPPORT SERVICES** | The University of Texas at Arlington supports a variety of student success programs to help you connect with the University and achieve academic success. These programs include learning assistance, developmental education, advising and mentoring, admission and transition, and federally funded programs. Students requiring assistance academically, personally, or socially should contact the Office of Student Success Programs at 817-272-6107 for more information and appropriate referrals. |
| **STUDENT CODE OF ETHICS:** | The University of Texas at Arlington College of Nursing supports the Student Code of Ethics Policy. Students are responsible for knowing and complying with the Code. The Code can be found in the student Handbook online: <http://www.uta.edu/nursing/handbook/toc.php> |
| **ACADEMIC INTEGRITY:** | It is the philosophy of The University of Texas at Arlington that academic dishonesty is a completely unacceptable mode of conduct and will not be tolerated in any form. All persons involved in academic dishonesty will be disciplined in accordance with University regulations and procedures. Discipline may include suspension or expulsion from the University.   "Scholastic dishonesty includes but is not limited to cheating, plagiarism, collusion, the submission for credit of any work or materials that are attributable in whole or in part to another person, taking an examination for another person, any act designed to give unfair advantage to a student or the attempt to commit such acts." (Regents’ Rules and Regulations, Series 50101, Section 2.2)  As a licensed registered nurse, graduate students are expected to demonstrate professional conduct as set forth in the Texas Board of Nursing rule **§215.8. in the event that a graduate student holding an RN license is found to have engaged in academic dishonesty, the college may report the nurse to the Texas BON using rule §215.8 as a guide.** |
| **PLAGIARISM:** | Copying another student’s paper or any portion of it is  plagiarism. Additionally, copying a portion of  published material (e.g., books or journals) without  adequately documenting the source is plagiarism. If  five or more words in sequence are taken from a source,  those words must be placed in quotes and the source  referenced with author’s name, date of publication, and  page number of publication. If the author’s ideas are  rephrased, by transposing words or expressing the same  idea using different words, the idea must be attributed  to the author by proper referencing, giving the author’s  name and date of publication. If a single author’s ideas  are discussed in more than one paragraph, the author  must be referenced at the end of each paragraph.  Authors whose words or ideas have been used in the  preparation of a paper must be listed in the references  cited at the end of the paper. Students are encouraged to review the plagiarism module from the UT Arlington Central Library via <http://library.uta.edu/tutorials/Plagiarism> |
| **BOMB THREATS:** | If anyone is tempted to call in a bomb threat, be aware that UTA will attempt to trace the phone call and prosecute all responsible parties. Every effort will be made to avoid cancellation of presentations/tests caused by bomb threats. Unannounced alternate sites will be available for these classes. Your instructor will make you aware of alternate class sites in the event that your classroom is not available. |
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| **E-CULTURE POLICY:** | The University of Texas at Arlington has adopted the University email address as an official means of communication with students. Through the use of email, UT-Arlington is able to provide students with relevant and timely information, designed to facilitate student success. In particular, important information concerning department requirements, registration, financial aid and scholarships, payment of bills, and graduation may be sent to students through email. All students are assigned an email account and information about activating and using it is available at [www.uta.edu/email](http://www.uta.edu/email). Students are responsible for checking their email regularly. |
| **NO GIFT POLICY:** | In accordance with Regent Rules and Regulations and the UTA Standards of Conduct, the College of Nursing has a “no gift” policy. A donation to one of the UTA College of Nursing Scholarship Funds, found at the following link:  <http://www.uta.edu/nursing/scholarship_list.php> would be an appropriate way to recognize a faculty member’s contribution to your learning.  For information regarding Scholarship Funds, please contact the Dean’s office. |
| **STUDENT EXCELLENCE AWARD:** | Award for student excellence in clinical nursing. Each semester, students in clinical courses are eligible for consideration. Nominations for the award are made by the clinical faculty in each course with a clinical component. Students are honored at an end-of-the-semester awards ceremony. Detailed information is available at: [www.uta.edu/nursing/handbook/studentexcellenceaward](http://www.uta.edu/nursing/handbook/studentexcellenceaward) |
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| **GRADUATE PROGRAM SUPPORT STAFF:** | **Roshanda Marks,** *Sr. Office Assistant*  Office #610– Pickard Hall, (817) 272-2043, ext 24856  Email: [r.marks@uta.edu](mailto:r.marks@uta.edu)  **Felicia Chamberlain, Administrative Assistant I**  Office #515 – Pickard Hall  (817) 272-0659 Direct Line, (817) 272-0663 Fax  Email: [chamberl@uta.edu](mailto:chamberl@uta.edu)  **Elisha Cotten, Clinical Coordinator**  Office #609-Pickard Hall (817)272-0788  Fax: (817) 272-0663  Email: [ecotten@uta.edu](mailto:ecotten@uta.edu) |
| **LIBRARY INFORMATION:** | **Helen Hough**, Nursing Librarian  (817) 272-7429  [hough@uta.edu](mailto:hough@uta.edu)  Research Information on Nursing:  [**http://libguides.uta.edu/nursing**](http://libguides.uta.edu/nursing) |
| **MISCELLANEOUS INFORMATION:** | Inclement Weather (School Closing) Inquiries:  *Metro (972) 601-2049*  Fax Number - UTA College of Nursing: (817) 272-5006  Attn: Graduate Nursing Programs Office  UTA Police (Emergency Only): (817) 272-3003  Mailing Address for Packages:  UTA College of Nursing  C/O **Dr. Diane Snow, PhD, RN**  411 S. Nedderman Drive, Pickard Hall  Arlington, Texas 76019-0407 |

GRADUATE NURSING WEBSITES

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| **Description** | **Website** |
| University of Texas Home Page | <http://www.uta.edu> |
| Graduate Catalog & Faculty | <http://www.uta.edu/gradcatalog/nursing> |
| Graduate Nursing Programs | <http://www.uta.edu/nursing/MSN/administration.php>  <http://www.uta.edu/nursing/MSN/practitioner.php> |
| Graduate Nursing Courses & **Syllabi** | <http://www.uta.edu/nursing/MSN/grad-courses1.php> |
| Faculty and Staff Email Contacts and Biosketches | <http://www.uta.edu/nursing//faculty.php> |
| Graduate Student Handbook | <http://www.uta.edu/nursing/handbook/toc.php> |
| * **Miscellaneous Graduate MSN Forms:**   + Banking Clinical Hours   + Code of Ethics   + Drop Request   + E-log Consent Form   + Liability Policy   + Master’s Completion Project Forms   + Nurse Admin Preceptor Package   + Nurse Practitioner Preceptor Package   + Personal Insurance Verification Form   + Petition to Graduate Faculty   + Resignation Request   + Student Confidentiality Statement   + Traineeship Statement Forms | <http://www.uta.edu/nursing/MSN/forms.php> |
| * **Clinical Evaluation MSN Forms:**   + Educator Evaluation   + Faculty Evaluation of Preceptor   + NP Clinical Evaluation (Practicum Tools)   + Nurse Admin Faculty Eval of Preceptor   + Nurse Admin Preceptor Eval of Student   + Preceptor Evaluation of Student   + Psych Therapy Preceptor Eval of Student   + Student Evaluation of Preceptor   + Student Self Evaluation |
| Clinical Online Submission (Elogs) | <http://www.totaldot.com/> |
| Criminal Background Check (Group One) | <http://www.dfwhc.org/GroupOne/> |
| **Instructions for E-Reserves** | <http://pulse.uta.edu/vwebv/enterCourseReserve.do>  Select under Library Catalogs  ([UTA Library Catalogs](http://pulse.uta.edu/))  Select Course Reserves  Look for Instructor’s Name, Click Search, Select Article  Use your UTA ID and password |

***Last Revision: January 12, 2011***

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**The University of Texas at Arlington School of Nursing**

**Graduate Nursing Program**

**N5425 Psychiatric Mental Health II**

**Spring 2011 Calendar-DRAFT (subject to change)**

**Wednesdays – Pickard Hall Room 220**

**12-6 pm**

Additional readings will be added on electronic library reserve and blackboard. You are responsible for all these readings plus any class handouts. You will need to subscribe to Medscape, Current Psychiatric online to access some readings. Please share articles you find and related websites with class.

| **Date/Time** | **Topic** | **Reading Assignment** |
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| **January 19,2011** | **Class I** | **Lecture on bipolar disorder posted by Jan. 15, 2011** |
| 12-1pm | Review of Syllabus  Discussion of clinical placement; meet with clinical advisors |  |
| 1-2:30pm | Categories, criteria, specifiers, subtypes of DSM IV disorders  (Bring DSM IV to class)  Billing and Coding in psychiatry  Diane, Larae, Mary Jo | Remission categories & prior history, severity criteria  Substance induced disorders  Define impairment for various disorders  Specifiers for various disorder: impulse, post partum, adjustment, OCD, dementia  Impulse disorders  Longitudinal and seasonal component course specifiers  Describe subtypes of phobias, etc  Diagnostic terms for pain disorder  Factitious disorders vs malingering  Other topics  K & S, 288-318, 229-275, 275-287  DSM IV –pages for each of above  Power point from Parkland provided  Carolyn Buppert’s book –readings will be provided in class.  Review CPT coding articles below  <http://www.aacap.org/galleries/PracticeInformation/CPT%20Codes%20and%20Evaluations%20AACAP%20News%20December%202005.pdf>  <http://www.mnpsychsoc.org/MA.pdf> |
| 2:30- 6pm | **Case Study Bipolar Disorde**r: Neurobiology, Dx and management of Bipolar Disorder-Type I, II, and NOS  Management of bipolar depression  hypomania, mania, mixed episodes  Bipolar disorder across the lifespan | Readings: Sadock & Sadock, -Bipolar Disorder  Stuart & Laraia-bipolar disorder  Stahl-Essential Psychopharm-Anticonvulsants and Antipsychotics, Lithium  Case study provided on Blackboard.  Articles on blackboard., power point with voice available by 1/15  Case study will be read by the student in the reporting group who has the first question. .  **Respond to case study assigned topic.** (8 students present on 8 topics; do presentation then ask at least 2 questions for discussion) Be prepared with power point and readings. |
| **TMM I Jan 29, 2011 (no class)** |  |  |

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| **February 2, 2011** |  | Lecture posted on January 30 on schizophrenia |
| 12-2:30 pm | Case study presentations Schizophrenia (total 8) | See below |
| 2:30-4pm | **Movement Disorders Starla Harrison (TBC** | Sadock and Stahl: EPS, TD,  DSM IV V codes on movement disorders  Power point and practice : AIMS |
| 4-6pm | Schizoprhenia (cont’d)  Case study presentations: schizophrenia (continued)  Schizophrenia  Schizoaffective disorder  Schizophreniform  Delusional Disorder  Differential Diagnosis, Management  Metabolic considerations of atypical antipsychotics | [www.mhc.com/algorithms/schizophrenia](http://www.mhc.com/algorithms/schizophrenia)  Sadock & Sadock chapter on schizophrenia  Stuart & Laraia-schizophrenia  Stahl: Essential Psychopharmacology-antipsychotics and anticholinergics  Articles on blackboard  TIMA guidelines  Sadock and Sadock: 992-999  Expert Consensus Guidelines for patients and families:  <http://www.athealth.com/Consumer/disorders/schizophreniaguide_print.html>  New APA Guideline Watch (Nov 2009)  <http://www.psychiatryonline.com/popup.aspx?aID=501005&print=yes_chapter>  **Case Study 2 Schizophrenia**  **8 student presentations 25 minutes each** |
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| **Feb 3 -9**  **\_\_\_\_\_**  **Feb 10 -16**  **Feb 17-23** | Post case 1: bipolar disorder: at least 4-5 posts per student on each case ( 1 case, one on each group discussion board) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Post Case study 2; Schizophrenia (2 cases, one on each group discussion board**).  **Post case study 3: Addiction (2 cases, one on each group discussion board)** | **2 students assigned to bipolar cases: post your completed SOAP note and discussion questions and moderate the panel daily.**  **Post by 5pm Feb 3. End discussion by 9pm Feb 10th.**  **Group 1 will have one case; Group 2 will have 1 case**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Monday Feb 21 , 2011** | Test 1 | **Blackboard. See instructions** |
| **February 23, 2011 12-7pm** | **Class 3** | **Power point on addictions posted Feb 19, 2011**  **Power point on Eating disorders posted Feb 19, 2011** |
| 12-4 pm | Addiction case study | Sadock & Sadock on drug and alcohol abuse  Articles on blackboard  Others as assigned  **Case study # 3 (8 presentations)**  **Student presentations and lead discussion about case - topics on blackboard (25 minutes each)** |
| 4-6pm | Traumatic Brain Injury; **Delirium Case Studies** Susan Spencer, MSN, RN, BC, PMHNP Guest speaker Dr. Ken Hopper’s group | S & S-delirium; TBI  Articles on blackboard  DSM IV criteria: TBI, Delirium  Powerpoint |
| **Feb 24-Mar 2, 2011**  **Mar 3- Mar 9, 2011** | Case study on line: #4 Traumatic Brain Disorder or “wild card” (your choice) **Case study on line:**  **# 5**  **Eating Disorder** |  |
|  |  |  |
| **March 09, 2011** | Class 4 | Clinical Notebook Due **Lecture on Anxiety Disorders posted March 5, 2011**  **Lecture on TRD posted by March 5, 2011** |
| 12-2pm | Management of chronic pain.  Dr. Howard Cohen,, MD  Guest speaker (TBC)\_ | Sadock and Sadock, articles on blackboard |
| 2-6pm | **Class Case study Anxiety Disorders** | **8 presentations/ 25 minutes each.** |
| **March 23, 2011** |  | Medication Management Note due- post to clinical advisor on blackboard + |
| **Mar 17-23, 2011** | Case studies posted on Bb **#6 Anxiety Disorder** | Monitor daily |
| **Mar 24-30** | Case studies (2) posted on Bb **#7 Treatment resistant depression** | Monitor daily |
| **Mar 31-April 6** | Case studies (2) posted on Bb **# 8 Chronic pain (or wild card)** | Monitor daily |
| **April 4, 2011** | Test 2 | 7am to 12 mn. |
| **April 6, 2011** | Class 5 note time | Lecture posted on dementia and delirium April 2, 2011 **Lecture posted on Adult ADHD April 2, 2011**. |
|  |  |  |
| 12-1:30pm | Hormonal changes during pregnancy, lactation and post partum Geetha Shivakumar, MD (TBC) | Sadock & Sadock  Articles on blackboard |
| 1:30 -5pm | Dementia /delirium case study | Sadock & Sadock  Articles posted  **8 Student Presentations – topics on blackboard**.  20-25 minutes per student |
| 5-7 | Psychiatric Emergencies  Dr. Roger Butler, MD | Psychiatric Emergency Management  Articles on Blackboard |
| **April 7-13** | **Case study (2) on Bb**  **#9**  **Dementia or delirium** | **Monitor daily** |
| **April 11, 2011** | **TMM 2 due on Bb** |  |
|  |  |  |
| **April 14- 20** | **Case study (2) on Bb**  **#10**  **Adult ADHD or Personality disorder** |  |
| **April 20 , 2011**  **Class 6** |  | **Childhood disorders posted April 16** |
| 12-4 | Case Study Childhood disorders | **Student presentations on childhood disorders** |
| 4-6pm | HIV and psychiatric disorder  Dr. Michael Noss, DO  Parkland COPC | HIV dementia: Sadock and Sadock |
| **April 21-27** | **Case study (2) on Bb #11**  **Child with ADHD (complex)** | **Monitor daily** |
| **April 27, 2011** | Analysis of Guidelines Paper Due-Blackboard | Required discussion per blackboard. |
| **April 28-May 4** | Case study (2) on Bb #12 **Child with Autism Spectrum Disorder or Psychosis** | **Monitor daily** |
| **May 4, 2011** | Submit all this date or sooner | Clinical Notebook Due (Elog summary of semester, tally sheet, objectives and summary)  Medication Management Note #2 due  **Evaluation of Preceptors Due**  **Classroom and clinical evaluations online**  **Preceptor evals-both therapy and med management** |
| **May 10, 2011** | Comprehensive Final Exam on Bb |  |
|  |  |  |

**The University of Texas at Arlington**

**School of Nursing**

**Psychiatric Mental Health Nursing II**

**Spring 2011**

# Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Evaluation:**

Preceptor Evaluations 05/04/11 P/F \_\_\_\_\_\_\_\_

Clinical Journal

(Objectives & Summary,

Signed Tally,

Organization, E-Log

Reports) 03/09/11 P/F \_\_\_\_\_\_\_\_

05/04/11 P/F \_\_\_\_\_\_\_\_

Case presentations (class) 5% \_\_\_\_\_\_\_\_

5% \_\_\_\_\_\_\_\_

Final Clinical Practicum 15% \_\_\_\_\_\_\_\_

Case Presentation (Blackboard) 10% \_\_\_\_\_\_\_\_

Test #1 02/24/11 15% \_\_\_\_\_\_\_\_

Test #2 04/04/11 15% \_\_\_\_\_\_\_\_

Comprehensive Final Exam 05/10/11 15% \_\_\_\_\_\_\_\_

Analysis of Guidelines Paper 04/28/11 10 % \_\_\_\_\_\_\_\_

Medication Management note #1 03/23/11 5% \_\_\_\_\_\_\_\_

Medication Management note #2 05/04/11 5% \_\_\_\_\_\_\_\_

Therapeutic Moment 01/9/11 P/F\_\_\_\_\_\_\_\_\_\_

Mapping 04/11/11 P/F \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_

.

**100% \_\_\_\_\_\_\_\_**

**UTA College of Nursing**

**PMHNP Program**

**N5425**

**Case Study Based Class Presentations**

The purpose of this assignment is to analyze a disorder specific case study and to provide guidelines for assessment and management of a specific disorder. There are 6 cases that will be presented in the classroom by a group of 8 students for each: bipolar disorder, schizophrenia, addictions, anxiety disorders, dementia, and child disorders. The power point information for the topic will be posted before class along with readings and other information. Look for the presentation on camtasia recordings or as directed. **Each student has 2 presentations.** All students will be expected to contribute to the discussions led by their peers, and focus on the complexity of the case in terms of diagnosis and management.

Name:\_\_\_\_\_\_\_\_\_

Advisor: \_\_\_\_\_\_\_\_\_\_

Class date:\_\_\_\_\_\_\_\_\_\_\_\_

Case study topic: \_\_\_\_\_\_\_\_\_\_\_\_\_

Question # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Criteria:

1. 10-15 minute presentation on the topic assigned (35 points) \_\_\_\_\_\_\_
   1. Evidence supported response to question
   2. Demonstrates critical thinking about the case
   3. Current and well referenced material (at least 2 references)
   4. Is thorough and complete

Comments:

1. Engages peers in discussion and answers questions well (30 points)\_\_\_\_\_\_\_

Comments:

1. 1-3 page relevant handout provided (35 points)\_\_\_

Comments:

**UTA College of Nursing**

**PMHNP Program**

**N5425**

**Case Study Based Class Presentations**

The purpose of this assignment is to analyze a disorder specific case study and to provide guidelines for assessment and management of a specific disorder. There are 6 cases that will be presented in the classroom by a group of 8 students for each: bipolar disorder, schizophrenia, addictions, anxiety disorders, dementia, and child disorders. The power point information for the topic will be posted before class along with readings and other information. Look for the presentation on camtasia recordings or as directed. **Each student has 2 presentations.** All students will be expected to contribute to the discussions led by their peers, and focus on the complexity of the case in terms of diagnosis and management.

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Name:\_\_\_\_\_\_\_\_\_

Advisor:

Class date:\_\_\_\_\_\_\_\_\_\_\_\_

Case study topic: \_\_\_\_\_\_\_\_\_\_\_\_\_

Question # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Criteria:

1. 10-15 minute presentation on the topic assigned (35 points) \_\_\_\_\_\_\_
   1. Evidence supported response to question
   2. Demonstrates critical thinking about the case
   3. Current and well referenced material (at least 2 references)
   4. Is thorough and complete

Comments:

1. Engages peers in discussion and answers questions well (30 points)\_\_\_\_\_\_\_

Comments:

1. 1-3 page relevant handout provided (35 points)\_\_\_

Comments:

Grade

**UTA School of Nursing**

### Graduate Program

**Spring 2011**

**N5425 --Psychiatric Mental Health Nursing II**

**Clinical Notebook**

**Journal Check #1** **Journal Check #2**

**Grading Sheet**

**Clinical Objectives/Evaluation (P/F)** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Present to each preceptor specific clinical

objectives for the experience and discuss ways to achieve these

objectives. Evaluate each objective and describe

your experiences towards these objectives in journal format.

**E- Log –Print Out (P/F)** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Record all patients seen during your clinical rotations. Include therapy

patients. Should have close to one patient per hr at minimum of clinical time

Axis I. Axis II, III (use ICD-9 codes), Axis IV and V categories

are provided. Include summary print out. Therapy-enter patients such as

2-3 from each group session, all family members from family therapy,

all individual therapy patients. Use correct CPT codes for psychiatry

Summary (aggregate) form in notebook

**Clinical Hours Grid (P/F)** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

This is a record of your clinical time towards your total program hours,

recording in appropriate category. Carry forward hours from other courses

as indicated. These hours are determined based on choice as Family or Adult

PMHNP major. **Must have Preceptor signatures each day. Can put on separate**

**Page.**

**Preceptor evaluation of student (12 hours or more) \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychotherapy evaluation of student (12 hours or more) \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[**www.uta.edu/nursing/MSN/forms**](http://www.uta.edu/nursing/MSN/forms)

**Student Evaluation of All Preceptors**

**Overall neatness and organization (P/F)** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Notebook is organized, assignments are easy to locate. Grading sheets

are included. Send assignments to instructor by blackboard**.** Include all preceptor

agreements copies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Overall grade (Criteria Pass/Fail)** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**The University of Texas at Arlington**

**School of Nursing**

**Psychiatric-Mental Health**

**Nurse Practitioner Program**

**N5425 Spring 2011**

**CASE PRESENTATION (ONLINE)**

The purpose of this assignment is to present, in an on-line format, a case involving a complicated patient with complex diagnostic and management issues. Each student will sign up for one disorder. The assignment is posted by 12 midnight on the assigned due date, to the Case Presentation Page of Blackboard (Class is divided into 2 groups of 12; post only to your group) A SOAP format, as noted below, is used for this assignment. The student whose case is presented is also responsible for posting two or more questions at the end of the SOAP note. These questions should generate discussion amongst the class and may be related to diagnostic challenges, medication selection issues, appropriate treatment goals, target symptoms, etc. It is expected that the case will generate other discussion as well. **The student will manage the on-line discussion over the course of the following week (dates on calendar). You will be graded on the postings given to your peers as well as your presentation and moderating of discussion and summary statement. The patient you pick should have concerns relevant to the topic. For a “wild card” week, you may use any complex, interesting patient (children are especially recommended)**

**Demographic Data and why you chose this particular patient (5 points) \_\_\_\_**

**Comments:**

**Subjective Data: (20 points)\_\_\_\_\_**

Provide key significant positives and negatives in complete SOAP format

**Comments:**

**Objective Data: (20 points)\_\_\_\_\_\_**

Provide key significant positives and negatives in complete SOAP format. **C**

**Assessment: (10 points)\_\_\_\_\_\_**

Differential diagnosis. Diagnostic challenges.

Use theory/rationale to support your diagnostic decisions.

**Comments**:

**Plan: (20 points)\_\_\_\_\_\_**

Pharmacological treatment: identify the treatment decisions that were made, describe the rationale used for your decisions, state the treatment goals

for medication management, cost issues, explain contingency plans for the coming weeks

(i.e. if symptoms worsen, side effects present, or titration of dosing)

Therapy: what the patient is currently receiving, what is needed, and therapy goals

Labs: based on comorbid conditions, current medication management

Teaching plan: what education was provided and rationale; what other education is needed.

Community Resources / Case Management challenges:

Referrals:

Follow up

**Comments**:

**“Presentation” Skills and “Participation”: (15 points)\_\_\_\_\_**

Organized, systematic presentation, patient selection meets grading criteria, key

information is provided, discussion questions are well written and generates

meaningful discussion, and management of on-line dialogue is appropriate. A

Rubric for posts will be provided. You will receive credit here for your posts on others case studies (will delay your grade on this) Have a reference for at least one post on a subject.

Response to case week 1

Responses to case week 2

Responses to case week 3

Response to case week 4

Response to case week 5

Response to case week 6

Responses to case week 7

Responses to case week 8

Responses to case week 9

Responses to case week 10

Responses to case week 11

Responses to case week 12

**Total 100%**

**Format for SOAP Note (see also the template at end of syllabus)**

**A. SUBJECTIVE**

**Client identifying information**

**Chief Complaint**

**History of Present Illness**

Neurovegetative Symptoms:

Sleep

Appetite and weight

Energy

Concentration

Anhedonia

Mood

Diurnal variation of mood

SI/HI

Anxiety-all disorders

Mania

Psychosis

Sexual interest/performance

**Psychiatric History**

**Alcohol and Other Drug use History**

**Current Health Status:**

Allergies

Medical Conditions

Current prescribed medications

Health maintenance behaviors

Last menstrual period

Last physical exam

**Past Health Status:**

Major Childhood Illnesses

Major Illnesses

Accidents

Menstrual & pregnancy hx

Hospitalizations

Surgeries

**Family History**

**Developmental History**

**Social History**

Current health habits/ADLs

Educational History

Hobbies, talents, interests

Legal History

Current Living Situation

Marital and Relationship History

Work History

Financial Status

Military History

Religion/Spirituality

Social network/support system

Sexual History

**Focused Review of Systems**

# B. OBJECTIVE

**Mental Status Exam**

Appearance

Behavior & psychomotor activity

Attitude toward examiner/reliability

Mood

Affect

Speech

Perceptual disturbance

Thought processes

Thought content

Alertness and level of consciousness

Orientation

Memory

Concentration and attention

Capacity to read and write

Visuospatial ability

Abstract thinking, proverbs, and similarities

Fund of information and intelligence

Judgment

Insight

Assets/strengths

Liabilities

Do full MMSE if memory concerns or over age 65 (score 1-30)

**Other objective data**

Vital Signs

Height/Weight/BMI

Lab results

Screening tool results

**Pertinent physical exam**

# C. ASSESSMENT

**Axis I:**

**Axis II:**

**Axis III:**

**Axis IV:**

**Axis V: GAF current and highest in past year (2 scores)**

**Differential diagnoses:** (generally is the medical causes of the symptoms, such as hypothyroidism or brain tumor, for example)

**Rule out diagnoses:** (generally refers to DSM IV diagnoses that you suspect and will continue to evaluate for; e.g. if someone has MDD, then one R/O is Bipolar II Disorder, Most Recent Episode Depressed)

**Nursing diagnoses:** what is priority e.g. risk for harm to self

**DSM-IV TR criteria: (**what criteria are met, what criteria are not met at this time; how arrived at decision re the diagnosis)

**D. NEUROBIOLOGY (include in rationale for treatment plan) )**

**Genetics**

**Neurotransmitters**

**Neuroanatomical changes**

**Current theories of causation**

**Cultural factors**

**PLAN & RATIONALE**

**Labs/ Diagnostic Tests/ Screening Tools**

**Medications**

Dosage & directions

Why this med?

Neurochemistry & MOA

Side effects

Expected benefits

Contraindications

Black Box Warnings

**Therapy prescription**

Type(s), duration, etc

Why this therapy?

Expected benefits

Therapy goals

**Teaching plan**

Safety plan

Diet and exercise

Sleep

Stress management/set goals/ homework

Health promotion

Relationship issues

Resources (bibliotherapy, websites, etc)

Teach about meds, side effects, caution

Other

**Referrals and consultations**

PCP for physical exam or other follow up for symptoms

Psychoneurological assessment (eg. child with learning disorder)

Outpatient substance abuse treatment, etc

Inpatient hospitalization

**Follow up**

Time frame for next appointment based on assessment, safety

**The University of Texas at Arlington School of Nursing**

**N5425 Psychiatric Mental Health Nursing II**

**Tips for SOAP Note**

1. **SOAP note should be completed on a psychiatric evaluation patient.**
2. **Be sure to review and cover all SOAP note grading criteria.**
3. **Follow provided SOAP note format when completing assignment.**
4. **If there is any information that was not obtained during interview, be sure to review chart for that information.**
5. **If information not asked during interview and not obtained through chart, type in italics what you would have asked.**
6. **Review of systems and physical exam should be focused and pertinent ONLY.**
7. **If there was an intervention completed that you would have done differently, please type in italics what you would have done and why.**
8. **Be sure to provide rationale for ALL of your interventions.**

|  |  |
| --- | --- |
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**N5425 Psychiatric Mental Health Nursing II**

### Spring 2011

**Analysis of Treatment Guidelines**

**Presentation and Handout Criteria**

# Objectives

1. Identify available treatment guidelines/protocols/standards/algorithms for a particular disorder.
2. Critically evaluate each treatment guideline/protocol/ standard/algorithm.
3. Utilize critical-thinking and deductive reasoning skills to modify existing treatment guidelines to meet practice and patient needs.
4. Communicate analysis results in a comprehensive, concise, and logical manner.

# Criteria

Select a disorder encountered in your clinical area. You will present your findings to fellow students and write a 10 page paper (maximum) addressing each of the following:

1. Identify the disorder and explain why you selected this topic (e.g. prevalence, what you are seeing in clinical practice sites, etc). Describe the practice setting **(5 points**)

2. List the available treatment guidelines/protocols/standards/algorithms to be analyzed. This should be exhaustive list from multiple sources as available. May include UK or Canadian sources, etc. **(10 points)**

3. Compare and contrast each, with special attention directed to the:

a. Author (organization), year of publication, level of evidence used to support the treatment guideline/protocol/standard/algorithm. Include recommended treatment,

Medications and therapy. Include: what research studies support its use, the quality of

those studies, the sample size, study design, subjects and how they were selected > do they

represent the patient population seen in your clinical area?

b. The relevancy, utility and ease of use in your clinical area.

c. Identify any population, treatment or therapy inadequately covered or ignored. Example: age, gender, or cultural issues that were not addressed; exclusion of a particular therapy

or medication that, if included, would improve their application in your clinical practice.

1. **points)**

4.Select one treatment guideline and explain why you selected the existing protocol and what modifications you will make to this protocol to improve relevancy to PMHNP practice based on critique ( **30 points)**

1. **Include an evaluation from one practicing clinician regarding the relevance to current PMHNP practice and feasibility of implementation in practice setting and barriers to implementation (reimbursability, etc) (20 points)**
2. Provide a comprehensive list of references (APA format) including websites for online guidelines **(5 points)**

(Paper to be uploaded on the Discussion Board in Blackboard).

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**UTA Graduate Nursing**

**PMHNP Program**

**N5425**

**Medication Management Note**

You are to submit minimum of 2 medication management notes using following format; can be in narrative format for subjective; be very descriptive and specific to patient. Adapt to settings/ patient problems.

Date; Clinical site/preceptor

S:

Patient: Demographic: who came with patient; age, gender, race marital status, reliability;

CC: (patient’s words in quotes) (**5 points**)

HPI (**30 points**)

Summary of patient’s explanation of chief complaint, including response of medications on target symptoms, affect on functioning

Sleep:

Appetite:

Energy:

Anhedonia:

Mood:

SI/HI

Anxiety (if anxiety disorder, give progress on each disorder)

Mania

Psychosis

Other targeted symptoms: memory, attention, focus, concentration, agitation, violence, function, alcohol and drug use, weight loss, gain)

Current list of meds

Psych meds (list each with dose) (side effects listed & present or not) any missed doses/reason?

PRN meds (state how often took them and why; excess over prescribed)

Non psych meds and dose and who prescribed meds.

OTC including vitamins and doses-taken daily or only now and then

Herbal or diet treatments (how long, response, effect on psych symptoms)

Current medical problems/new and/or progress of existing ( ROS)

Stressors –old, new and coping skills employed

Emergency meds, restraints, if hospitalized..

Hospital visits

Last time had labs done

Current therapy, classes attending, school progress

Other psychosocial data, e.g. applied for SSI, working on job resume, fired from job

Any new history discovered during the session (e.g. FH data on bipolar disorder)

O: **( 20 points**)

VS Wt/BMI./ waist circumference, etc

Recent Labs and dates: (e.g. record lithium, Depakote levels, WBC, thyroid, relevant lab results and date)

Mental status exam (adapt to patient)

Appearance:

Behavior:

Speech:

Mood : rate

Affect

Perceptual disturbance

Thought content: delusions/SI

Thought process

Alertness and level of consciousness

Orientation

Memory

Concentration and attention

3 stage command

Capacity to read and write

Visuospatial

Abstract thinking

Fund of information

Judgment

Insight:

Assets/strengths

Liabilities

Screenings done

A: (**15 points)**

Axis I-V:

Rule outs, differential?

Progress: (describe summary of progress, or worsening of symptoms, or response to meds and treatment)

Problems: ongoing, new, resolved

(Brief rationale for decisions about diagnosis)

P: ( **30 points**)

1. Medications: (Continue/start, (#mg, schedule), change, discontinue, how to taper, how to titrate, consider at future appointment + rationale, # pills provided, RX , # pills, # refills, samples (#), cost (write prescription)
2. Labs or other tests
3. Therapy: (referral to x, continue with x, goals)
4. Education: (e.g. mood diary, food diary) what bibliotherapy provided, what written information provided (can attach copy). State: instructed patient on side effects, risk of weight gain, setting goals for exercise; etc.
5. Counseling: (e.g. goals: patient agrees to not drink for next 2 weeks)
6. Referral/ consultation
7. Follow up: when to call, next appointment, other instructions given

Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tips for Follow up Medication Management Notes**

:

1. Subjective Data: Focus on what has happened since the last visit-update on symptoms, include relevant quotes from patient . Include significant positives and negatives. Include duration and severity of symptoms/problems. Select patient who you have significant amount of information.
2. Objective data- brief notation of each area-include significant positives and negatives-e.g. denies reckless behavior ( judgment ), rates mood 40/50 (50 being level), no A/V/Hallucinations, note change (more restless, more fidgety), eye contact good
3. Any screenings done (e.g. AIMS), recording of lab and VS e.g. what is most recent lithium level, date of level, last date of thyroid testing, etc. BMI, waist circumference, weight if applicable, other physical symptoms
4. Focus your thinking on “is this the correct diagnosis?” is this the correct medication(s), do we decrease the med, increase a med, change a med, stop a med, or change the dosing schedule of the med (e.g. if taking in AM and is sedating, change to PM)
5. Write Axis I-V diagnosis for this patient, updating for this visit; write current mood or most recent mood if Bipolar

1. Write plan for this patient including all areas. If continuing the same meds, write them down, with the doses and schedule for taking. “Continue Paxil 20 mg qHS.: If new med, write Start Wellbutrin 150mg. XL qam, etc. If giving samples, indicate how many, if given RX, indicate # of pills and # of refills

**University of Texas at Arlington School of Nursing**

**Graduate Program**

**Psychiatric Mental Health Nurse Practitioner Program**

**N5425 Spring 2011**

# THERAPY MOMENT MAP

Name Clinical Advisor\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** # 1, #2 \_\_\_\_\_\_\_\_\_\_\_\_

Select 5 –10 minute segment of a therapy session and present on blackboard in discussion board. **Use power point.** Can be from individual, group or family therapy experience. The focus is on developing skills, self-reflection, application of theory, and developing as a therapist, and provides “peer supervision” as well as faculty supervision. (not required of post masters students with waiver of therapy requirement-will be given alternate assignment) Respond to each classmate’s TMM on blackboard.

Scenario and purpose

Points Actual

1. Client description 10

Describe appearance, mood, affect of client

Age, gender, cultural identity, other identifying factors

2. Setting Description 5

Describe the room and where everyone is placed.

3. Background description 10

What was happening just before the session

What do you know, if anything about emergent situations

between sessions, where the patient was

just before the session, and what the transition was like.

Discuss the circumstances of the therapy session

that led you to the therapy moment

5. Purpose of the interaction. 10

Identify the therapy goal for the session

using an identified theoretical framework

6. Image that depicts your visualized 5

outcome of the therapy session for

the patient.

This should include an image from clip art or

photo or drawing, not just a verbal image.

7. Description of obstacles the patient may have 5

toward meeting the imagined outcome

**Therapy Moment Map Dialogue**

8. Dialogue displays an example of an intervention 5

that can be analyzed to demonstrate students

clinical reasoning process

## Analysis

9.Description of what you are thinking and feeling 15

during the therapy moment

to enlighten others about the

rationale for interventions

10. Analysis of the intervention 10

is accurate and organized according to the

theory of particular therapeutic approach and

the relationship (with references)

11.Image of a future moment 5

that will attract the patient

toward achieving the outcome.

12.Analysis of the client’s perception of **you**

What do you think she/he perceives of you during this 10

therapy moment?

What do you think about yourself as beginning therapist?

13. Discussion Questions: 10

At least two discussion questions to guide

discussion about the therapy moment

References –At least 2 Credit

Total 100

**Practicum Guide**

**Client (age, marital status, gender, race, reliable?)**

**Source of Data:**

**Chief Complaint:** What can I help you with today? (build rapport!) and/or What made you decide to come for help today?

**History of Present Illness: (adjust to the situation, let patient tell you his/her story, validate, get rich detail, quote significant statements).**

**Timing:**

When did symptoms begin?

How were you feeling before that time?

Does the feeling occur daily, or does it come and go?

Did this feeling happen suddenly, or was it a gradual onset that you were unaware of the change in your thinking and feeling?

Is there any time in the day that the feeling is better or worse?

How long has this been going on?

**Quality:**

Is the feeling debilitating or severe?

How would you rate the depression on a numeric scale from 1 to 10?

**Quantity or Severity:**

How does it impact your life?

Does it interfere with your work?

Does it interfere with her daily activities or relationships?

**Setting:**

What was going on in your life when this began?

Were you facing any changes or new challenges in your life?

Have you ever had this before?

**Aggravating/Alleviating Factors:**

Is there anything that makes you feel worse?

Is there anything that makes you feel better?

Any medications that seem to help?

**Associated Symptoms:**

Are there any other symptoms or feelings that you have at this time?

Have you noticed anything that has changed over this time period along with your mood?

**Neurovegetative Symptoms:**

**Sleep:**

Any initial, middle (how long (longer than 30 minutes?), how many times a night), or terminal insomnia (describe)?

When did this start?

What time do you go to sleep and wake up in the morning?

How many hours do you sleep?

Do you wake up before the alarm?

Do you feel rested when you get up?

Do you have nightmares?

Do you take any medications to help you go to sleep?

Do you feel tired during the day?

Do you take naps?

Have you changed your routine?

Do you drink caffeine before going to bed?

Does your mind race when you try to go to sleep?

**Appetite and weight:**

Have you lost or gained any weight?

If yes, over what period of time?

Do you feel that you need to loose weight?

Do you ever binge or fast?

Use any laxatives or vomiting?

Are you afraid of gaining weight?

What do you think about the appearance of your body?

How often do you weigh?

What is your usual food intake in a day?

Does food interest you?

Are you preoccupied with food?

**Energy:**

Is there a certain time of the day that you have more energy?

Do you feel you have more or less energy?

How would you describe your energy level?

**Anhedonia:**

What do you enjoy doing? How has that changed?

Is there anything that you find that gives you pleasure?

Are activities that you use to enjoy still enjoyable?

Are you able to concentrate?

Does what you used to enjoy cause you stress now?

Are you struggling with motivation?

**Mood:**

Rate mood on 1-10 scale with 10 as best

Have you been feeling sad?

Have you felt happy, irritable, or angry?

What would you say is your usual mood now? Is that what it has been in the past?

**Diurnal variation of mood:**

Are there certain times of the day that you feel better or worse than others?

**SI/HI:**

Have you ever thought it would be better if you were dead? Current, past (get details of dates and number and type of attempt; hospitalized?)

Do you have a plan? What would keep you from acting on it?

Do you feel your life is worth living? Or do you feel hopeless?

Have you ever thought that things would be better if someone else was dead?

Plan? Intent? What would keep you from acting on it?

**Anxiety: (if yes to any of these screening questions, you will need to go into the complete criteria for each of the different anxiety disorders; be sure to ask onset and if have occurred when they are not using drugs)**

Have you ever been considered a worrier? Does worry or anxiety interfere with your life such as sleep?

Do you ever feel restless, fidgety, or jittery? Do you have difficulty sitting still or concentrating?

Do you have problems leaving the house? Fear of not being able to escape?

Ever had panic attacks with sudden onset of shortness of breath, feeling sweaty, heart rate increase, feeling as if going to die or go crazy?? (go through symptoms) Sudden onset? Out of the blue? Length of attack?

Trauma or abuse ever experienced? Type? Nightmares, flashbacks, startle easy, hypervigilance, numb to emotions, avoiding talking about the trauma?

Do you have thoughts that occur over and over? Do you constantly go back and check things that you did to see if you did them? Or count things? Other rituals? Do these take up one hour a day?

**Manic Symptoms: (if yes, need thorough details of duration of symptoms to determine if meets criteria for hypomania or mania episodes (BPI or II)**

Can you go days without sleeping or ever feel rested after little sleep? Is that happening now? Recently? If yes, ask if 4 days or more, or ever 7 days or more?

Do you ever have periods of extreme happiness or irritability during these times?

Are you extremely talkative or someone said that you are during these times?

Racing thoughts? More distractible?

Spending sprees ? other impulsive reckless behavior?

Increased sexual activity during these times (infidelity, unprotected sex)

Start projects don’t finish?

Feel you have special talent or gifts during these times (e.g. talent for writing, acting beauty, money and wealth)

**Psychosis**:

Hallucinations? (auditory, visual, olfactory (look for neuro signs) tactile, gustatory) (if thoughts inside head likely are not delusions; if outside their head, likely to be hallucinations; name called, sounds/buzzing, commanding hallucinations asking person to do something harmful, visual: are they friendly visions or evil?) how often, daily? Happening now? Last time?

Delusions? (paranoia: describe, grandiose ideas, extreme confidence “know what people think” delusions of control (read other people’s minds, people can read their mind (broadcasting); religious delusions, somatic delusions)

**Sexual interest/performance:**

Are you sexually active?

How many partners do you currently have?

Change in sex drive?

Disinterested in sex or problems with performance?

**Psychiatric History:**

Have you ever been diagnosed with any psychiatric disorders? (get details)

Have you ever been treated for a mental illness or stress problem?

What meds were tried and did they work?

Ever been hospitalized? (get details)

Ever attempted suicide**? (**get details)

Ever go to counseling? (get details)

**Alcohol and Other Drug use History:**

Tobacco, alcohol, illicit drugs? First use, last use; # drinks on occasion (more than 4 drinks female, 6 drinks male); amount of drugs (cost)

What kind and how often? IV drug use?

Do you feel you may have a problem? (insight)

CAGE questionnaire: Cut down on drinking (repeatedly without success), annoyed by criticism about drinking habits, Guilty feelings about drinking, Eye opener drink needed in the morning

Financial burden?

Caffeine?

Ever took more prescription drugs than prescribed?

OTC drugs like cough syrup (dextromethorphine)

Go through each class; ask about each drug to determine if abuse or dependency;

Marijuana, cocaine, opiates, benzo, hallucinogens, nicotine?

Any consequences of using drugs or alcohol-give example?

Any illegal activities? E.g drink when driving?

Cannot go without drugs or alcohol?

Use more than intended?

Tolerance (need more to get same effect)

Serious withdrawal? How many?

Ever treated? (get details) AA? NA? Last meeting? Ever have sponsor?

**Current Health Status:**

**Allergies:** drugs, environmental, seasonal?

**Medical Conditions:** Head injuries, seizures, trauma

**Current prescribed medications:** OTC and herbal?

**Health maintenance behaviors:** Do you exercise?

How much and how frequently?

When last physical exam?

Last pap and lab work? What were the results?

Childhood immunizations?

What is your diet like?

Birth control?

**LMP:**

**Last physical exam:** When?

Mammogram, Dental check up?

**Past Health Status:**

**Major Childhood Illnesses:** measles, mumps,. Rubella, whooping cough, chicken pox, rheumatic fever, polio

**Major Illnesses:** HTN, High Cholesterol, Heart Disease, Cancer, Seizures. Headaches, Asthma, Respiratory diseases, Arthritis, Hepatitis, Diabetes, Chronic Pain

**Accidents:** broken bones, head injuries, seizures, convulsions?

Lost consciousness?

**Menstrual hx/pregnancy hx,** etc

**Hospitalizations:**

**Surgeries:**

minor or major?

What, where, when, any complications?

**Family History:**

**Social:**

Tell me about your family, who all is in your family?

How many siblings do you have?

What are the ages of your parents and your siblings?

Who all lived in your house when you were growing up?

What kind of relationships did you have growing up with your family members?

**Abuse:**

In your family, was anyone ever neglected or physically or emotionally abused? Did you witness any abuse?

Was there ever any sexual abuse to either you or your siblings?

**Medical and Psychiatric History:**

Has anyone in your family ever had problems with alcohol or drug abuse?

Is there any history of psychiatric or mood disorder? (give example: depression, bipolar disorder, anxiety, ADHD, schizophrenia?) Ever treated? Response to treatment?

Has anyone in your family ever committed suicide or attempted to commit suicide? If so, who was it and when did the action occur?

What is the health status of all members of your family?

Is there a history of hypertension, cancer, high cholesterol, seizures, headaches, neurological disorders, diabetes?

Genogram of family (include parents, siblings, grandparents, aunts, uncles, cousins, offspring)

**Developmental History:**

Normal delivery? Complications? Alcohol or drug use in utero?

Milestones on time?

Problems with learning? Peer relationships? Activities in school? Special classes/schools? Grades?

Who were your primary caregivers?

How did you compare with others?

How many jobs?

Relationship with co-workers?

Lost any family members or friends?

Abuse history (physical, psychological, sexual)

**Social History:**

**Current health habits/ADLs:**

What is your daily routine?

Are you able to take care of your self?

Responsibilities?

Difficulty doing chores?

What do you do to stay healthy?

**Educational History:**

Highest degree/grade level?

School?

Grades?

Truancy?

Problems concentrating or focusing in school?

**Hobbies, talents, interests:**

What kinds?

What did for fun past week?

**Legal History:**

Any charges past or present?

What was the outcome of those charges?

**Current Living Situation:**

Where?

How long?

With whom?

**Marital and Relationship History:**

Live together?

More arguments or disagreements?

Able to work out problems?

How many long term relationships have you had?

How did you handle the breakup of those relationships?

**Relationships:**

Friends? How many?

How often see?

Getting along?

Can you rely on them, turn to them for support?

**Work History:**

Where? How long?

How many hours?

Job- calling in sick or poor performance?

Able to concentrate?

How feel doing?

Is it what you want to be doing?

**Financial Status:**

Support self? Family?

Any stressors?

Any debt? How do you feel about that debt?

**Military History:**

**Religion/Spirituality:**

Attend church? How often?

Religion?

Have spiritual beliefs?

What/Who do you turn to for spiritual support?

**Social network/support system:**

Who? How?

Who can you talk to/Are you comfortable talking to?

**Sexual History:**

How old when first sexually active?

How many partners in your life?

How do you feel about your sexuality?

**Focused Review of Systems:**

**General Condition:** See HPI

usual weight, recent weight changes, weakness, fatigue, fever, general statement of how feel

**Nutrition:** See HPI

**Skin/hair/nails:**

Rashes, itching, dermatitis, eczema, dryness, sweating, color change, changes in texture to hair/skin/nails

**HEENT:**

HEAD: headaches, dizziness, or loss of consciousness

EYES: blurry vision, wear eyeglasses or contacts, or have any blind spots or eye pain.

EARS: changes in her hearing, or any pain, dizziness or ringing in her ears

NOSE: drainage from her nose, or changes in sense of smell

MOUTH & THROAT: any change in taste or texture, sore throats, change in teeth

**Cardiovascular:**

Heart palpitations, arrhythmias, chest pain, dyspnea, or exercise intolerance?

**Peripheral vascular:**

edema, varicosities, phlebitis

**Breasts:**

Tenderness, discharge, lumps, pain

**Respiratory:**

shortness of breath, difficulty breathing, coughing, wheezing

**Gastrointestinal:**

abdominal pain, constipation, diarrhea, difficulty swallowing, heart burn, gas, jaundice

**Urinary:**

Urgency, pain, frequency, nocturia, hematuria, change in force of stream

**Genitalia:**

Discharge, pain, sores, masses, regularity

**Musculoskeletal:**

change in muscle mass, ability to exercise, muscle weakness, muscle pain, joint stiffness, limitation of motion

**Neurological:**

seizures, fainting, weakness, change in sensation or coordination, tingling, tremors, or numbness, dizziness

**Endocrine:**

change in the size of your thyroid gland, sensitivity or intolerance to heat or cold, problems maintaining body temperature, excessive thirst or hunger

**Lymphatic:**

Tenderness, enlargement of lymph nodes in groin, axilla, neck

**Hematological:**

Easy bruising or bleeding, anemia

**Psychiatric:**

See HPI

The following may or may not be helpful

|  |  |  |  |
| --- | --- | --- | --- |
| Disorder | Symptoms | Yes | No |
| Psychosis | Hallucination |  |  |
|  | Delusions |  |  |
|  | Disorganized speech |  |  |
| GAD | Restlessness |  |  |
|  | Worry too much |  |  |
|  | Fatigue |  |  |
|  | Irritability |  |  |
|  | Muscle tension |  |  |
|  | Anxiety |  |  |
|  | Insomnia |  |  |
| Panic | SOB |  |  |
|  | Palpitations |  |  |
|  | Fainting |  |  |
|  | Sweating |  |  |
|  | Trembling |  |  |
|  | Choking |  |  |
|  | Depersonalization |  |  |
|  | Numbness/tingling |  |  |
|  | Chest pain |  |  |
|  | Fear of losing sanity |  |  |
|  | Getting out |  |  |
|  | Fear of being in crowds |  |  |
|  | Excessive worry |  |  |
| OCD | Obsessions |  |  |
|  | Compulsive |  |  |
| Anorexia | Failure to maintain weight |  |  |
|  | Fear of fat |  |  |
|  | Body distortion |  |  |
|  | Amenorrhea |  |  |
| Bulimia | Binge eating/2 x’s/wk for 3 mo |  |  |
|  | Use of laxatives, diuretics, enemas |  |  |
|  | Vigorous exercise |  |  |
|  |  |  |  |

# *OBJECTIVE*

**Do memory test. 3 objects – ball, car, dog. Repeat now and later.**

**Mental Status Exam: (get baseline score of full MMSE if over 65 or older, or if suspect dementia, delirium, TBI or other cause of confusion)**

**Appearance:** Appears stated age

Body build:

thin obese cachetic muscular frail medium

Position:

lying sitting standing kneeling

Posture;

Slumped rigid slouched threatening comfortable

Eye contact:

Good Fair poor

Dress:

appropriate neatness clean

Grooming:

malodorous perfumed dirty unshaven makeup

Manner/attitude:

cooperative angry evasive

Attentiveness:

disinterested preoccupied distractible attentive

Alertness:

alert drowsy stupor comatose

**Behavior and psychomotor activity:**

Slow retarded calm restless tremor lip smacking pacing picking at skin or clothing agitated

**Attitude toward examiner/reliability:**

Cooperative guarded suspicious hostile apathetic defensive uncooperative

**Mood:**

Euthymic depressed sad tearful hopeless angry hostile suspicious sullen anxious belligerent

**Affect:**

Bright constricted blunted (some reaction) flat labile anxious

**Speech:**

slow long pauses hesitant rapid pressured

Monotonous stuttering Loud soft whispered

monosyllabic hypertalkative Clear mumbled slurred pressured foul language

**Perceptual disturbance:**

Hallucinations (auditory, visual, tactile, gustatory) illusions depersonalization

**Thought processes:**

Clear coherent goal directed flight of ideas circumstantial loose associations word salad preservation tangential

**Thought content:**

Normal obsessions compulsions preoccupations phobias delusions paranoia religious somatic grandiose

**Alertness and level of consciousness:**

alert and oriented

**Orientation:**

time, person, place

**Memory:**

Recall objects at 1 min 3 min .

Can you name the last 3 presidents

**Concentration and attention:**

Spell world forward backward serial 7’s (100, 93, 86, 79, 72)

Ask patient to follow a three-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor."

Ask patient to read and obey the following sentence which you have written on a piece of paper: "Close your eyes

**Capacity to read and write:**

Ask patient to write a sentence

**Visuospatial ability:**

correctly copy figure of intersecting pentagons

**Abstract thinking, proverbs, and similarities:**

How are apples and oranges alike?

How are a chair and a table alike? { Better for an older person}

Abstract concrete impaired

Ask about proverb interpretation – A rolling stone gathers no moss.

**Fund of information and intelligence:**

level of education and intelligence

**Judgment:**

what do we know so far, are they drinking and driving, etc. look at whole picture

Can ask: What would you do if you found a letter that was stamped and had address on it?

Can ask: What would you do if you smelled smoke in your apartment?

**Insight:**

What kind of problem do you think that you are having? What kind of help do you think you need?

Good intact fair limited

**Assets/strengths:**

What motivates you? What are your strengths? What are you good at?

**Liabilities:**

Areas you would like to work on?

What I see is ------

**Other objective assessments:**

T: P: R: BP: Wt. Ht:

Lab work. Screening tools

HEENT:

Skin:

Cardiac:

Respiratory:

GI

GU:

Musculoskelal

Neuro:

# ASSESSMENT

**Axis I:**

**Axis II:**

**Axis III:**

**Axis IV:** Problem with primary support group

Problem related to social environment

Educational problems

Occupational problems

Housing problems

Economic problems

Problems with access to health care

Problems related to interaction with legal system/crime

Other psychosocial and environmental problems

**Axis V:** Current GAF: Highest GAF in past year:

**Plan:**

**Labs and diagnostic tests**

**Pharmacologic**

**Teaching plan**

**Counseling plan**

**Referrals and consultation**

**Follow up**

**CLINICAL WORKSHEET FOR E LOGS**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client # (DOB): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_

Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnostics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Axis I – (med dx): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Axis II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis IV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis V: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interventions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nursing Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client complexity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student function: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The University of Texas at Arlington School of Nursing**

**N5425 Psych-Mental Health II (Family) 2011**

**NAME: TOTAL= 720 hr in program (585 psych hours)**

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| **TYPE OF HOURS (Required)** | **Banked hours**  **(therapy)** | **1/19-1/24** | **1/25 -1/31** | **2/1-2/07** | **2/08-2/14** | **2/15-2/21** | **2/22-2/28** | **3/1-3/7** | **3/08-3/14** | **3/15-3/21** | **3/22-3/28** | **3/29-4/4** | **4/5-4/11** | **4/12-4/18** | **4/19-4/25** | **4/26-5/2** | **5/3-5/9** | **Totals**  **Brought**  **Forward from previoussemesters** | **Spri1g 2011**  **(total this semester)** | **Total** |
| **ADVANCED ASSESS.**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADULT PSYCH MT.**  **180 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **CHILD & ADOL PSYCH MT.**  **175 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **GERIATRIC PSYCH MT.**  **20 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADULT MEDICAL**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADDICTION**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **GROUP Therapy**  **50 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FAMILY Therapy**  **40 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **INDIVIDUAL**  **Therapy**  **50 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SEMINARS**  **Practicum**  **25 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Ped. Med Mt.**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Total Hours** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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**The University of Texas at Arlington School of Nursing;**  **N5425 Psych-Mental Health II (Adult PMHNP major )** **Spring 2011 Weekly Clinical Hour Tally Sheet**

# NAME: TOTAL=675 for program (585 psych hours)

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| **TYPE OF HOURS (Required)** | **Banked hours (therapy only)** | **1/19--1/24** | **1/25-2/7** | **2/8-2/14** | **2/15-2/21** | **2/22-2/28** | **3/1-3/7** | **3/8-3/14** | **3/15-3/21** | **3/22-3/28** | **3/29-4/4** | **4/5-4/11** | **4/12-4/18** | **4/19-4/25** | **4/26-5/2** | **5/3-5/9** | **5/10-5/16** | **Totals**  **Brought**  **Forward**  **Previous semesters** | **Spr 2011**  **Total this semester** | **Total** |
| **ADVANCED ASSESS.**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADULT PSYCH MT.**  **305 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **CHILD & ADOL PSYCH MT.**  **20 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **GERIATRIC PSYCH MT.**  **50 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADULT MEDICAL MT.**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ADDICTION**  **45 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **GROUP Therapy**  **50 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FAMILY Therapy**  **40 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **INDIVIDUAL**  **Therapy**  **50 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SEMINARS**  **Practicum**  **25 Required** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Semester:

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| Date | Type of experience | Preceptor name | Signature of preceptor |  |
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