The University of Texas at Arlington

**College of Nursing**

**N5425 Psychiatric Mental Health II**

**Spring 2015**

**Instructor(s):**

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| **Diane Snow, PhD, APRN, PMHNP-BC, FAANP, FIAAN**  ***Clinical Professor***  Director, PMHNP Program  Office Number: Pickard Hall Rm. # 627  Office Phone: (817) 272-7087  Office Hours: By Appointment  E-mail Address: [snow@uta.edu](mailto:snow@uta.edu)  Faculty Profile: <https://www.uta.edu/mentis/profile/?357> |
| **Carol Lieser, PhD, APRN, PMHNP-BC, SFO, MTS**  ***Assistant Clinical Professor***  Office Number: Pickard Hall Rm. # 617  Office Phone : (817) 272-2776  Office Hours: By Appointment  Email Address: [clieser@uta.edu](mailto:clieser@uta.edu)  Faculty Profile: <https://www.uta.edu/mentis/profile/?2801> |
| **Linda Trowbridge, MSN, APRN, PMHNP-BC**  ***Clinical Instructor***  Office Number: Pickard Hall, Rm. # 626  Office hours: By appointment  Email Address: [lstrowbridge@uta.edu](mailto:lstrowbridge@uta.edu)  Faculty profile: TBA |
| **Debra Lamont, MSN, APRN, PMHNP-BC**  ***Clinical Instructor***  Office Number: Pickard Hall, Rm. #626  Office Hours: By appointment  EmailAddress:[drlamont@uta.edu](mailto:drlamont@uta.edu)  Faculty Profile: TBA |

**Section Information:**

N5425 Sections 001-012

**Time and Place of Class Meetings:**

Time: Wednesdays 12-6pm

Place: Pickard Hall Rm. TBC

**Description of Course Content:**

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. Advanced clinical management of individuals, families, and groups at risk for and experiencing complex psychiatric disorders.

**Student Learning Outcomes:**

Upon completion of the course, the student will be able to:

1. Diagnose individuals with complex acute and chronic psychiatric disorders, integrating biopsychosocial theories.
2. Provide culturally, spiritually, ethnicity, age, gender, and sexual orientation sensitive mental health care in populations with complex acute and chronic psychiatric disorders.
3. Use evidence based psychopharmacological and non-pharmacological interventions in the management of complex acute and chronic psychiatric disorders.
4. Evaluate complex acute and chronic mental health care using selected outcomes.
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.
6. Function as a member of the interdisciplinary health care team in the delivery of quality mental health care.

**Required Textbooks and Other Course Materials:**

1. American Psychiatric Association, (2013). *Diagnostic and Statistical Manual of Mental*

*Disorders (DSM-5).* (5th ed.). Washington, DC: American Psychiatric Association **ISBN:**

**9780890425558**

1. Nichols, M. (2012) *Family Therapy: Concepts and Methods*. (10th ed.). Allyn & Bacon, Inc. **ISBN: 9780205827190**
2. Sadock, B. and Sadock, V. (2014). *Kaplan and Sadock's Synopsis of Psychiatry.* (11th ed.). Philadelphia: Lippincott Williams &Wilkins. **ISBN:**
3. Stahl, S. (2013). *Stahl’s Essential Psychopharmacology*: *Neuroscientific Basis and Practical Applications.* (4th ed.). Cambridge: Cambridge University Press **ISBN: 9781107686465**
4. Corey, G. (2012). *Theory and Practice of Counseling and Psychotherapy*. (9th ed.). Cengage Learning. **ISBN:** **9780840028549**
5. Wheeler, K. . *Psychotherapy for the Advanced Practice Psychiatric Nurse*.(2nd ed)Springer Publishing Company. **ISBN: 9780826110008**
6. Corey, MS, Corey, G and Corey, C. (2013). *Groups: Process and Practice*. (9th ed.). Cengage Learning. **ISBN: 9781133945468**
7. Stahl, S. *Prescriber’s Guide,* (5th ed.), Cambridge University Press. **ISBN: 9781107675025**
8. Stein, et al, *Essential Evidence-Based Psychopharmacology.* (2nd ed.). Cambridge University Press. **ISBN: 9781107400108**

**Recommended:**

1. Zimmerman. *Interview Guide for Evaluating DSM-5 Psychiatric Disorders & the Mental Status.* Psych Products Press. **ISBN: 9780963382115**
2. Linehan, M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder.* New York: The Guilford Press **IBSN: 9780898620344**
3. Carlat. *Psychiatric Interview* (3rd ed.). Lippincott Williams & Wilkins. **ISBN: 9781451110197**
4. Burdick. *Mindfulness Skills Workbook for Clinicians & Clients.* CMI. **ISBN: 9781936128457**
5. Yearwood. *Child & Adolescent Behavioral Health.* John Wiley & Sons, Incorporated. **ISBN: 0813807867**

**Other Requirements:**

Prerequisites: N5424 and N5328 or concurrent enrollment

Classroom and blackboard participation is required in this course. Required 90 hours of clinical time with chief focus this semester on differential diagnosis and medication management. Continue with therapy clinical hours in group, family and individual therapy. Grid tally sheet is for total program. The student keeps track weekly and brings forward hours from previous semester(s).

**Descriptions of major assignments and examinations with due dates:**

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| --- | --- | --- |
| Preceptor Evaluations | P/F | Due 5/6/15 |
| Clinical Notebook including E-log report, objective, summary, tally sheet, self reflection journal (therapy) preceptor agreement & evaluation | P/F | 3/4/15 and  5/06/15 |
| Final clinical practicum | 15% | Faculty evaluates student doing psychiatric evaluation or multiple medication management visits and student’s primary preceptor site. Schedule with faculty and preceptor SOAP note due in 48 hr |
| Case presentation on BB/lead discussion | 10% | Student posts disorder-specific SOAP note (sign up 1st class) on assigned discussion board and monitors posts from peers for 5 days. 1 SOAP per student, total 8 weeks of postings 2/16 Bipolar; 2/23 Schizophrenia; 3/2 addiction/;co-occurring, 3/23 eating disorder or TRD 3/30 OC or anxiety disorder 4/6 PTSD; 4/13 Geri , 4/20 Child ADHD or Autism |
| Test 1 | 12.5% | Date 2/11/15 online test; 2 hour, 7am to 11:59pm |
| Test 2 | 12,5% | Date 3/16/15 online test, 2 hour, 7a to 11:59pm |
| Comprehensive Final | 15% | Date 5/11/15 online test; 3 hour 7am to 11:59pm |
| Analysis of treatment guidelines paper | 10% | Due 4/22/15 posted to assignment page and discussion page. Sign up for topic on discussion board (see guidelines) |
| Therapy moment maps & discussion | 2.5% | 2 TMMs due 2/16/15 and 3/30/15 One week of discussion with clinical group to follow; minimum of 1 post per student and moderator responds to each post |
| Medication management write ups (3) | 7.5% | Due 2/25; 3/25; 4/15 ( 48 hr after practicum) post on assignment page |
| Classroom quizzes (5) | 5% | Drop one quiz grade if requested |
| Blackboard participation (cases) | 7.5% | Respond to peer’s case presentation on blackboard; |
| Classroom Participation | 2.5% | Participate, well prepared for topics of discussion |

**Grading Policy:**

Students are expected to keep track of their performance throughout the semester and seek guidance from available sources (including the instructor) if their performance drops below satisfactory levels.

Course Grading Scale

A = 92 to 100

B = 83 to 91

C = 74 to 82

D = 68 to 73 – cannot progress

F = below 68 – cannot progress

**Make-up Exams:**

Please contact your faculty for make-up exam scheduling.

**Test Reviews:**

Test reviews may be scheduled up to two weeks after grades have been posted to blackboard for the current exam. Due to time constraints, you will only be allowed 30 minutes to review your test. Unfortunately, we will not be able to allow multiple test reviews. Contact Sonya Darr to schedule at sdarr@uta.edu. Please allow a 24 hour advance notice when scheduling. May schedule with lead teacher also as instructed in class.

**Expectations of Out-of-Class Study:**

Beyond the time required to attend each class meeting, students enrolled in this course should expect to spend at least an additional 9 hours per week on their own time in course-related activities, including reading required materials, completing assignments, preparing for exams, etc.

**Grade Grievances**: Any appeal of a grade in this course must follow the procedures and deadlines for grade-related grievances as published in the current University Catalog. <http://catalog.uta.edu/academicregulations/grades/#graduatetext>.

**Attendance Policy:**

At The University of Texas at Arlington, taking attendance is not required. Rather, each faculty member is free to develop his or her own methods of evaluating students’ academic performance, which includes establishing course-specific policies on attendance. As the instructor of this section, [insert your attendance policy and/or expectations,.

**Drop Policy:** 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 can continue through a point two-thirds of the way through the term or session. It is the student's responsibility to officially withdraw if they do not plan to attend after registering. **Students will not be automatically dropped for non-attendance**. Repayment of certain types of financial aid administered through the University may be required as the result of dropping classes or withdrawing. Contact the Office of Financial Aid and Scholarships at <http://www.uta.edu/fao/> . The last day to drop a course is listed in the Academic Calendar available at <http://www.uta.edu/uta/acadcal.php?session=20146>

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) Contact course faculty to obtain permission to drop the course with a grade of “W”.

(2) Contact your graduate advisor to obtain the form and further instructions.

**Census Day: February 4, 2015**

**Last day to drop or withdraw April 3, 2015**

**Americans with Disabilities Act:**  The University of Texas at Arlington is on record as being committed to both the spirit and letter of all federal equal opportunity legislation, including the *Americans with Disabilities Act (ADA)*. All instructors at UT Arlington are required by law to provide "reasonable accommodations" to students with disabilities, so as not to discriminate on the basis of that disability. Any student requiring an accommodation for this course must provide the instructor with official documentation in the form of a letter certified by the staff in the Office for Students with Disabilities, University Hall 102. Only those students who have officially documented a need for an accommodation will have their request honored. Information regarding diagnostic criteria and policies for obtaining disability-based academic accommodations can be found at [www.uta.edu/disability](http://www.uta.edu/disability) or by calling the Office for Students with Disabilities at (817) 272-3364.

**Title IX:** The University of Texas at Arlington is committed to upholding U.S. Federal Law “Title IX” such that no member of the UT Arlington community shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity. For more information, visit [www.uta.edu/titleIX](http://www.uta.edu/titleIX).

**Academic Integrity**: All students enrolled in this course are expected to adhere to the UT Arlington Honor Code:

*I pledge, on my honor, to uphold UT Arlington’s tradition of academic integrity, a tradition that values hard work and honest effort in the pursuit of academic excellence.*

*I promise that I will submit only work that I personally create or contribute to group collaborations, and I will appropriately reference any work from other sources. I will follow the highest standards of integrity and uphold the spirit of the Honor Code.*

Per UT System Regents’ Rule 50101, §2.2, suspected violations of university’s standards for academic integrity (including the Honor Code) will be referred to the Office of Student Conduct. Violators will be disciplined in accordance with the University policy, which may result in the student’s 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."

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. Copying a portion of published material (e.g., books or journals) without adequately documenting the source is plagiarism. Consistent with APA format, 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, according to APA format. 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 expected to review the plagiarism module from the UT Arlington Central Library via <http://library.uta.edu/plagiarism/index.html>

**Student Support Services**:UT Arlington provides a variety of resources and programs designed to help students develop academic skills, deal with personal situations, and better understand concepts and information related to their courses. Resources include tutoring, major-based learning centers, developmental education, advising and mentoring, personal counseling, and federally funded programs. For individualized referrals, students may visit the reception desk at University College (Ransom Hall), call the Maverick Resource Hotline at 817-272-6107, send a message to [resources@uta.edu](mailto:resources@uta.edu), or view the information at [www.uta.edu/resources](http://www.uta.edu/resources).

**Electronic Communication:**  UT Arlington has adopted MavMail as its official means to communicate with students about important deadlines and events, as well as to transact university-related business regarding financial aid, tuition, grades, graduation, etc. **All students are assigned a MavMail account and are responsible for checking the inbox regularly.** There is no additional charge to students for using this account, which remains active even after graduation. Information about activating and using MavMail is available at <http://www.uta.edu/oit/cs/email/mavmail.php>.

If you are unable to resolve your issue contact the Helpdesk at [helpdesk@uta.edu](mailto:helpdesk@uta.edu).

**Student Feedback Survey:** the end of each term, students enrolled in classes categorized as lecture, seminar, or laboratory shall be directed to complete a Student Feedback Survey (SFS). Instructions on how to access the SFS for this course will be sent directly to each student through MavMail approximately 10 days before the end of the term. Each student’s feedback enters the SFS database anonymously and is aggregated with that of other students enrolled in the course. UT Arlington’s effort to solicit, gather, tabulate, and publish student feedback is required by state law; students are strongly urged to participate. For more information, visit <http://www.uta.edu/sfs>.

**Final Review Week:** A period of five class days prior to the first day of final examinations in the long sessions shall be designated as Final Review Week. The purpose of this week is to allow students sufficient time to prepare for final examinations. During this week, there shall be no scheduled activities such as required field trips or performances; and no instructor shall assign any themes, research problems or exercises of similar scope that have a completion date during or following this week *unless specified in the class syllabus*. During Final Review Week, an instructor shall not give any examinations constituting 10% or more of the final grade, except makeup tests and laboratory examinations. In addition, no instructor shall give any portion of the final examination during Final Review Week. During this week, classes are held as scheduled. In addition, instructors are not required to limit content to topics that have been previously covered; they may introduce new concepts as appropriate.

**Emergency Exit Procedures:** Should we experience an emergency event that requires us to vacate the building, students should exit the room and move toward the nearest exit. When exiting the building during an emergency, one should never take an elevator but should use the stairwells. Faculty members and instructional staff will assist students in selecting the safest route for evacuation and will make arrangements to assist individuals with disabilities.

**Librarian to Contact:**

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| **PEACE WILLIAMSON**  **STEM LIbrarian**  CENTRAL LIBRARY  702 Planetarium Place  Office #216, Arlington, TX 76019  [http://www.uta.edu/library/](http://www.uta.edu/library/sel/) | [peace@uta.edu](mailto:peace@uta.edu)  Research Information on Nursing:  <http://libguides.uta.edu/nursing> |

Library Home Page <http://www.uta.edu/library>

Subject Guides <http://libguides.uta.edu>

Subject Librarians <http://www.uta.edu/library/help/subject-librarians.php>

Database List <http://www.uta.edu/library/databases/index.php>

Course Reserves <http://pulse.uta.edu/vwebv/enterCourseReserve.do>

Library Catalog <http://uta.summon.serialssolutions.com/#!/>

E-Journals <http://pulse.uta.edu/vwebv/searchSubject>

Library Tutorials <http://www.uta.edu/library/help/tutorials.php>

Connecting from Off- Campus <http://libguides.uta.edu/offcampus>

Ask A Librarian [http://ask.uta.edu](http://ask.uta.edu/)

**UTA College of Nursing Additional Information:**

**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.

**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.

**Student Requirement For Preceptor Agreements/Packets:**

1. Preceptor Agreements must be **signed and dated** by the student and the preceptor the first day the student attends clinical (may be signed on that day), scanned and emailed to [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu).
2. **Student** is responsible to ensure that all of his/her preceptor agreements are signed and complete including their student 1000 number and course number before beginning clinical experience and those agreements are scanned and emailed to Kim Hodges @ [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu) or Janyth Arbeau at [arbeau@uta.edu](mailto:arbeau@uta.edu) by the third week of the semester. (For instance, if a student starts working with a particular preceptor late in the semester, he/she would contact that preceptor during the first 3 weeks of the semester.
3. 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. If he/she is a returning preceptor have them fill out the phone number and email address section of the preceptor agreement.
4. The signed/completed preceptor agreement is part of the clinical clearance process. Failure to submit in a timely fashion will result in the inability to access the E-log system.
5. All communications to the NP Clinical Coordinator should be made to the following email address: [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu). This includes scanned copies of preceptor agreements, preceptor evaluations of the student, and student evaluations of the preceptor.

**Clinical E-Logs:** Students are required to enter all patient encounters into the E-Log system.  E-Log 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).

Students can access their Elogs by entering their own unique Elogs username and password which will be accessible their first clinical semester. <http://totaldot.com/> The username consists of the student’s first, middle, and last initials (in CAPS) with the last four digits of their 1000#. Example: Abigail B. Cooper, 1000991234 is ABC1234. If the student does not have a middle initial, then only two initials will be used. The student’s password is simply their last name. Example: Cooper (note first letter is a capital letter).

The student’s E-Log 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, E-Log 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 E-Log 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.**

**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 Dr. Mary Schira, Associate Dean, Department of Advanced Practice Nursing. The complete policy about encumbered licenses is available online at: [www.bon.state.tx.us](http://www.bon.state.tx.us)

**MSN Graduate Student Dress Code:** 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:<http://www.uta.edu/nursing/msn/msn-students> **.**

**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/msn/msn-students>

**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/msn/msn-students>

**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: is <http://www.uta.edu/nursing/student-resources/scholarship> 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.

**Online Conduct:** The discussion board should be viewed as a public and professional forum for course-related discussions. Students are free to discuss academic matters and consult one another regarding academic resources. The tone of postings should be professional in nature.

It is not appropriate to post statements of a personal or political nature, or statements criticizing classmates or faculty. Inappropriate statements/language will be deleted by the course faculty and may result in denied access to the Discussion boards. Refer to UTACON Student Handbook for more information.

***For this course Blackboard communication tools, discussion boards, and UTA MAV email will be used extensively and should be checked often.***

The Writing Center provides the workshops below to help guide graduate students through the demands of writing at the graduate level. In order to sign up for workshops, students must register with the Writing Center at <http://uta.mywconline.com/> . Workshops are listed on the regular appointment schedule. If you experience any difficulty signing up for any of these, please call (817) 272-2601 and one of our staff will be happy to assist.

All Workshops hosted by the Writing Center are held in 411 Central Library and are offered at 6 p.m. on Mondays, Tuesdays, Wednesdays or Thursdays. These are not recorded and are not available online.

**Department of Advanced Practice Nursing Support Staff**

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| **Jennifer Gray,** PhD, RN  Associate Dean  Graduate Studies Nursing  Email: jgray@uta.edu |
| **Rose Olivier**  Administrative Assistant I  Pickard Hall Office # 605  (817) 272-9517  Email address: [olivier@uta.edu](mailto:olivier@uta.edu) |
| **Janyth Arbeau**  Clinical Coordinator  Pickard Hall Office # 610  (817) 272-0788  Email address: [Arbeau@uta.edu](mailto:Arbeau@uta.edu) or  [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu) |
| **Sonya Darr**  Support Specialist I  Pickard Hall Office # 609  (817) 272-2043  Email address: [sdarr@uta.edu](mailto:sdarr@uta.edu) |
| **Kimberly Hodges**  Support Specialist II  Pickard Hall Office #612  (817) 272-9373  Email address: [khodges@uta.edu](mailto:khodges@uta.edu) or [npclinicalclearance@uta.edu](mailto:npclinicalclearance@uta.edu) |

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| **Graduate Advisors:** | |
| **Students with last Name A-L:**  Sheri Decker  Graduate Advisor II  Pickard Hall Office # 611  (817) 272-0829  Email: [s.decker@uta.edu](mailto:s.decker@uta.edu) | **Students with Last Name M-Z:**  Luena Wilson  Graduate Advisor I  Pickard Hall Office # 613  (817) 272- 4798  Email: [lvwilson@uta.edu](mailto:lvwilson@uta.edu) |

**Emergency Phone Numbers**: In case of an on-campus emergency, call the UT Arlington Police Department at 817-272-3003 (non-campus phone), 2-3003 (campus phone). You may also dial 911.

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

**Graduate Nursing Program**

**N5425 Psychiatric Mental Health Nursing II**

**Spring 2015 Calendar-DRAFT (subject to change)**

**Wednesdays– Pickard Hall Room 12-6pm**

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 Psychiatry online to access some readings. Please share articles you find and related websites with class.

*As the instructor for this course, I reserve the right to adjust this schedule in any way that serves the educational needs of the students enrolled in this course. –Diane Snow*

| **Date/Time** | | **Topic** | | **Reading Assignment** | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Jan. 21, 2015** | | **Class I** | | **Lecture on bipolar disorder posted by Jan. 20,, 2015** | | |
| 12-1pm | | Review of Syllabus  Discussion of clinical placement; meet with clinical advisors | |  | | |
| 1-2pm | | Categories, criteria, specifiers, subtypes of DSM 5 disorders and DSM 5 Trivia  (Bring DSM 5 to class)  Diane, Carol, Linda, Debra | | Remission categories & prior history, severity criteria  Substance related disorders  Coding and Reporting Procedures (page 23)  Elements of a diagnosis (pg 21)  Specifiers for various disorder:  Dimensional  Anxious specifier  Functional consequences of disorders  Longitudinal and seasonal component course specifiers  Describe subtypes of phobias, etc  Diagnostic terms for pain disorder  Factitious disorders vs malingering  Neurocognitive disorders- mild, major  K & S, 290-,99  DSM 5 –pages for each of above | | |
| 2-3 pm | | **Neurogenetics and Neurobiology with focus on patient teaching**  **Diane** | | Readings:  Sadock: Chapter 1 Neurogenetics, 71-84  Sadock: Chapter 1: Chronobiology: 88-92  Sadock: Psychoneuroendocrinology 63-67  Sadock: Immunnesystem 67-71  Sadock : Neurophysiology and neurochemistry 35-63  Stahl, Chapter 1 , 2, 3 (review)  Power point on Blackboard | | |
| 3-3:30 | | **Coding and Billing**  **Linda, Debra, Carol** | | ICD 9, Psychiatric E & M codes; Psychotherapy codes  ICD 10  Blackboard readings/handouts | | |
| 330 -4:30  4:30-6pm  (Cont.) | | **Bipolar Disorde**r: Workship Lecture on diagnosing and medication decision making  Specifiers  Management of bipolar depression  hypomania, mania  Bipolar disorder across the lifespan | | Readings: Sadock & Sadock, Bipolar Disorder ( in chapter on Major Depression and Bipolar Disorder)  Stahl-Essential Psychopharm-Anticonvulsants and Antipsychotics, Lithium  Stein Lerer and Stahl: Chapter 2: EB Pharmacotherapy of Bipolar Disorder  Articles on blackboard., power points with voice over  Focus on diagnostic evaluation for bipolar disorder .  and medication choices; teacching patient about the disorder | | |
|  | |  | | We will have special guest from 3:30- 4:15. We will do a practice med management visit with her and have her discuss her experiences with clozapine , Abilify and lithium. This will not be recorded. Please bring 1 “burning” question you have about bipolar I disorder on a card for her to answer if she has time.  We will then do classroom presentation and possible small group work. | |
|  | |  | |  | | |
| **Feb 4, 2015** | | Class 2 | | Lectures posted on Feb 2, 2014 on schizophrenia/metabolic disorders | | |
| 12-2:30 pm | | Quiz on diagnosis and medications for schizophrenia | | Review antipsychotic medications , management of side effects; clozapine guidelines; Long acting injectibles. | | |
| 1:30-3 | | Movement Disorders  Starla Harrison  (TBC) | | Sadock/Stahl: EPS, TD, DSM 5 V Codes on Movement Disorders  PowerPoint and Practice: AIMS  TBC | | |
| 12:30-1:30 and  3- 4pm  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4-6pm | | Workshopon schizophrenia/  Schizophrenia  Schizoaffective disorder  Differential Diagnosis, Management ]  Switching antipsychotics  Side effects  Clozapine  LAI  Case studies  Metabolic and cardiac considerations of atypical antipsychotics  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice doing medication management visit with a case study in clinical groups  Medication challenge  (each student picks a card with a question and lead discussion and arrive at consensus | | [www.mhc.com/algorithms/schizophrenia](http://www.mhc.com/algorithms/schizophrenia)  Stahl: Essential Psychopharmacology-antipsychotics and anticholinergics  Stein et al Evidence Based Psychopharm: Schizophrenia chapter 2 18-38  Articles on blackboard  Sadock and Sadock: Chapter 7. pp300- 346  Expert Consensus Guidelines for patients and families:  <http://www.athealth.com/Consumer/disorders/schizophreniaguide_print.html>  APA Guideline Watch (Nov 2009)  <http://www.psychiatryonline.com/popup.aspx?aID=501005&print=yes_chapter>    Bring Stahl Prescribers Guide, Epocrates, Sadock | | |
| |  |  | | --- | --- | | **TMM I Feb 16, 2015 (no class** | May post early. Let group know when posted Monitor x 1 week | | |  | |  | | |
| **Feb 16-Feb 20, 2015** | | Post online soap case study # 1: bipolar disorder: at least 4-5 posts per student on each case ( 1 case, one on each group discussion board) | | 1 student in each group assigned to bipolar disorder,: post your completed SOAP note and discussion questions and moderate discussion daily. Monday through Friday  Post by 9am Feb 16. . End discussion by 11pm Feb 20  See grading sheet for grading moderating; see rubric for grading responses  SOAP is based on student’s patient from clinical experience | | |
| **Feb 23 -27, 2015** | | Post online Case study # 2; Schizophrenia (2 SOAPs, one on each group discussion board). | | 1 student in each group assigned to schizophrenia ,: post your completed SOAP note and discussion questions and moderate the discussion daily.  Post by 5pm Feb 7. Finish discussion by 11pm Feb 14  See rubric for grading  SOAP is based on student’s patient from clinical experience. | | |
|  | |  | |  | | |
| **Feb. 18, 2015** | | Class 3 | | PowerPoint on addictions posted Feb. 16. 2015  PowerPoint on Eating disorder posted Feb. 16, 2015 | | |
| 12-12:30 | | Quiz on addiction and eating disorders | | Medications for detox, craving, prevention of relapse, anorexia, bulimia, BED, nicotine use disorder | | |
| 12:30-4 pm | | Addiction workshop  Co occurring disorders  SBIRT  Medications  Case study  Practice assessing and advising patient of choices with co-occurring disorder  Medication challenge game  (each student picks a card with a question and lead discussion and arrive at consensus | | Sadock & Sadock Chapter 20 on drug and alcohol use disorders  Stein et al: Chapters 11, 12  Stahl chapter 14  Review Stahl Prescribers Guide on Antabuse, Naltrexon/Vivitrol, Acamprosate,Suboxone, Methadone; Chantix,  Bring Stahl Prescribing Guide, other references/ web  Epocrates/ articles | | |
| 4-6pm | | Eating disorders  Lecture and workshop | | DSM 5 329-354  Sadock Chapter 15 Eating Disorder  Articles on blackboard  Stein et al, chapter 10 on Eating disorders  Stahl on SSRIs | | |
| **March 2 –March 6 , 2015** | | Case study on line: Post online case study # 3: Addiction/co-ccurring ( one on each group discussion board) | | 1 student assigned to addiction/co-occurring cases for each group;: post your completed SOAP note and discussion questions and moderate daily.  Post by 9am March 2; finish by 11 PM March 6 | | |
|  | |  | |  | | |
| **March 23--March 27, 2015** | | #4 Case study to post discussion board  Eating disorder or Treatment resistant depression | | 1 student assigned to eating disorder or Treatment Resistant Depression case in each group ;: post your completed SOAP note and discussion questions and moderate daily.  Post by 9a, March 23; complete 11 pm March 27 | | |
|  | |  | |  | | |
| **March 4, 2015** | | Class 4 | | Clinical Notebook Due  Lecture on Anxiety Disorders posted March 2, 2015  Lecture on TRD posted by March 2, 2015 | | |
| 12 – 12:30 | | Quiz on Anxiety /OC and Trauma /TRD | | Medications to treat anxiety disorders, OC disorders and trauma and TRD | | |
| 12:30 -2pm | | Management of chronic pain.  Dr. Howard Cohen,MD  Guest speaker (TBC)\_ | | Sadock and Sadock Chapter 13, 14  articles on blackboard  DSM : Pain Disorders | | |
| 2-5pm | | Anxiety Disorders, OC and Trauma related disorders  Lecture and group work | | Lecture and group work.  Sadock chapter 9, 10, 11  Stahl Chapter 9  Stein Leher and Stahl: Chapter 5, 6, 7, 8, 9  DSM 5 Anxiety, OC and Related Disorders, Trauma | | |
| 5-6pm | | TRD pharm management panel  TBC | | Articles on blackboard  Stein, Leher, Stahl Chapter **4**  Stahl: chapter 6  DSM 5 Depressive Disorder | | |
|  | |  | |  | | |
| **March 30-April 3, , 2015** | | Case studies posted on Bb  #5 Anxiety Disorder or OC disorder | | Monitor daily,. Dates for monitoring : March 30 9am to 11 pm April 3rd. | | |
|  | |  | |  | | |
| **April 6-April 10 - 2015** | | Case studies posted on Bb  #6 PTSD | | Monitor daily (see guidelines above) Post by 9am April 6, complete by 11pm April 10 | | |
|  | |  | |  | | |
| **April 16, 2015** | | Test 2 | | 7am to 11:59 midnight | | |
|  | |  | |  | | |
| **March 18, 2015** | | 12-6pm  Class 5 | | Lecture posted on dementia and delirium March 16, 2015  Lecture posted on Adult ADHD March 16, 2015 | | |
| 12-12;30 | | Quiz on medications for dementia/delirium and Adult ADHD | | l | | |
| 12:30-2 pm | | Hormonal changes during pregnancy, lactation and post partum  Traumatic Brain Injury  Geetha Shivakumar, MD (TBC) | | S & S  Readings on blackboard  S & S- p. 240  Articles on blackboard  DSM 5 criteria: mild or moderate neurocognitive changes due to TBI  Guidelines for treating TBI | | |
| 2 -4pm | | Dementia /delirium case study. Focus on assessing deficits | | Sadock & Sadock chapter 33  Stein Chapter 13: EB Pharmacotherapy of Alzheimers Disease | | |
| 4-6pm | | Psychiatric emergencies, Dr. Roger Butler, MD (TBC) | | Sadock : Psychiatric Emergency Management Chapter 23 | | |
| **March 25, 2015** | | Med management paper due #2 | |  | | |
| **April 13-17, 2015** | | Case study on Bb  #7  Dementia or delirium or depression in the elderly | | Moderate and respond to daily  Post by 7am April 13, finish by April 17, 2015 | | |
| **April 20-24, 2015** | | Case study on Bb  #8  Child with ADHD (complex) or autism | | Monitor daily. Post SOAP note by 9a April 20. Complete discussion by 11 pm April 24, 2015. | | |
| **March 30, 2015** | | TMM 2 due on Bb | | Post to clinical g`roup and assignment page; 1 week of discussion with peers, moderator responds to each post | | |
| **April 15, 2015** | | Med management 3 due | | Post on assignment page, blackboard; can be SOAP for practicum evaluation l; post 48 hours after practicum | | |
|  | |  | |  | | |
| **April 1 , 2015** | | Class 6 | | Childhood disorders posted March 30 , 2015 | | |
| 12-12:30 pm | | Quiz #5 Childhood disorders | |  | | |
| 12:30- 2 pm | | Children with comorbid disorders; complex medication management | | Stein Chapter 1,  Sadock Chapter 31  DSM 5 Chapter 1  Stahl Chapter 12 | | |
| 2-5pm | | Childhood disorders lecture and group work | | See above | | |
| 5-6pm  (Cont.) | | HIV and Psychiatric Disorders  Dr. Michael Noss, DO Parkland COPC (TBC) | | HIV Dementia:  Sadock page 711, 733 | | |
| **April 22,2015** | | Analysis of Guidelines Paper Due-Blackboard Assignment page, post for peers on discussion board | |  | | |
|  | |  | | 6 | | |
| **Monday May 11, 2015** | | Comprehensive Final Exam on Bb | |  | | |
| **May 6, 2015** | | Submit all by this date or sooner (preferably April 30 ) | | Clinical Notebook Due (Elog summary of semester, tally sheet, objectives and summary)  Reflective journaling  Evaluation of Preceptors Due  Classroom and clinical evaluations online  Preceptor evals-both therapy and med management; Reflection journal | | |

**The University of Texas at Arlington**

**College of Nursing**

**Psychiatric Mental Health Nursing II**

**Spring 2015**

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

**Evaluation:**

Preceptor Evaluations 5/6/15 P/F \_\_\_\_\_\_\_\_

Clinical Journal

(Objectives & Summary,

Signed Tally,

Organization, E-Log

Reports, Reflective journaling 03/4/15 P/F \_\_\_\_\_\_\_\_

05/6/15 P/F \_\_\_\_\_\_\_\_

Final Clinical Practicum with SOAP Note

(due 48 hour after practicum) 15% \_\_\_\_\_\_\_\_

Case Presentation (Blackboard) 10%\_\_\_\_\_\_\_\_\_\_  
Blackboard discussion/participation 7.5% \_\_\_\_\_\_\_\_

Test #1 02/11/15 12.5% \_\_\_\_\_\_\_\_

Test #2 03/16/15 12.5% \_\_\_\_\_\_\_\_

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

Analysis of Guidelines Paper 04/22/15 10 % \_\_\_\_\_\_\_\_

Medication Management note #1 02/25/15 2.5 % \_\_\_\_\_\_\_\_

Medication Management note #2 03/25/15 2.5 % \_\_\_\_\_\_\_\_

Medication Management note #3 04/15/15 2.5%\_\_\_\_\_\_\_\_

(48 hr after practicum)

Therapeutic Moment 2/16/15 1.25 %\_\_\_\_\_\_\_\_

Mapping 03/30/15 1.25 % \_\_\_\_\_\_\_\_

Quizes (5 ) Class 2-6 5%

Classroom participation 2.5%

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

.

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

**UTA College of Nursing**

### Graduate Program

**Spring 2015**

**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.

Reflective Journaling

**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

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 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)** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

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**Nurse Practitioner Program**

**N5425**

**CASE PRESENTATION (disorder specific SOAP note)**

The purpose of this assignment is to present online 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 7am on the assigned due date, to the Case Presentation Page of Blackboard (Class is divided into 4 groups) 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 among the group members 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 week (5 days- 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.**

**Demographic Data and why you chose this particular patient**

**Subjective Data: (25 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.

**Comments**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assessment: (15 points)\_\_\_\_**

Diagnoses. Rule out diagnosis/differential diagnoses  
Differential diagnosis. Diagnostic challenges. Use theory/rationale to

support your diagnostic decisions and briefly describe neurobiology including the genetic risk for   
the assigned disorder based on the patients family history, cultural factors  
and environmental risk factors

**Comments**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Plan:**

**(25 points)\_\_\_\_**

Pharmacological treatment: identify the treatment decisions that were made,

Medications and doses; neurobiological action of the meds, 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 (evidence based)  
Labs: based on comorbid conditions, current medication management.  
Teaching plan: what education was provided and rationale; what other  
education is needed (e.g. this section should include side effects if have not  
already included them, Community Resources / Case Management challenges:

Referrals:

Follow up

**Comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Moderator Presentation skills (15 points)\_\_\_**

Points for moderating will be given for the following:

* The moderator asks well written questions, using critical thinking and generating meaningful discussion. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The moderator keeps the discussion going and responds to peers in a timely manner (within 24 hours) with substantive comments and additional questions, as appropriate.

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

* The moderator uses at least 1 current (last 6 years) clinical and/or peer reviewed research reference in majority of responses. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The moderator uses correct APA format, good grammar and clarity of responses throughout the discussion. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The moderator writes a relevant summary statement at the close of the discussion

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

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**N5425 Spring 2015**

**Blackboard Discussion of Case Presentations**

Substantial posts for each case presentation. Use at least one reference per each case presentation. Be sure to use APA format for your references. Faculty will monitor discussion and may ask additional questions. Please keep discussions going for each presentation. This grade will be calculated at the completion for all presentations after all are completed. , Grading will be according to posted rubric on blackboard.

**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

**Diagnoses**

**Medical diagnoses**

**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 5 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)

**DSM-5 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

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**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.**

**N5425 Psychiatric Mental Health Nursing II**

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**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 and write a 10-12 page paper 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 and briefly describe 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 ( **20 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) (10 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 for peers and Assignment page for grading).

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**Medication Management Note**

You are to submit minimum of **3** medication management notes using following format; use narrative format for subjective; be very descriptive and specific to patient. Adapt to settings/ patient problems. This is meant to be for patient visit that you do mostly all independently, so that you can focus on covering all of the areas listed that are relevant to this patient. This soap outline below is not necessarily complete . If you submit a psychiatric evaluation, use the SOAP note format from 5424. You may submit your actual notes as well but you must complete this format.

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, effect on functioning,

Sleep:

Appetite/weight gain or loss:

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 (get full details)

Current list of meds

Psych meds (list each with dose) (side effects - list & 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)**

Diagnoses

Medical diagnoses

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 all diagnoses using DSM 5 criteria)

P: ( **30 points) PROVIDE RATIONALE FOR ALL DECISIONS**

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

Can indicate what you would have done if some of the areas not done.

**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 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

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

**N5424 Psychiatric Mental Health Nursing I**

**Fall 2014**

**Therapy Moment Map**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # 1, #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select 5 –10 minute segment of a therapy session and present on blackboard in My Group under your clinical advisor discussion board. **Use Powerpoint.** 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. Respond to each classmate’s TMM on blackboard x 1 week. Moderate the discussion.

Scenario and purpose

Points Actual

1. Client description 10 ­­\_\_\_\_\_\_

Describe appearance, mood, affect of client

Age, gender, cultural identity, other identifying factors

Therapy location and preceptor, type (individual, family/group)

Date and time of therapy moment.

2. Setting Description 5 \_\_\_\_\_\_

Describe the room and where everyone is placed.

Are there distractions?

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 and rationale for selecting

this theory to use in the intervention.

6. Image that depicts your visualized 2.5 \_\_\_\_\_\_

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 10 \_\_\_\_\_\_

that can be analyzed to demonstrate your

clinical reasoning process. Use dialogue of your intervention

not therapist’s intervention when at all possible. When possible, include at least 5-10 minutes

of dialogue to be analyzed. Dialogue should reflect the type of therapy identified in #5.

## Analysis

9. Description of what you are thinking and feeling 10 \_\_\_\_\_\_

during the therapy moment. Share any anxiety, frustration, etc

demonstrating self -reflection and self -awareness.

Post an image that describes your feelings

.

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 that will attract the 2.5 \_\_\_\_\_\_

patient toward achieving the outcome

12. Analysis of the client’s perception of **you** 10 \_\_\_\_\_\_

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

therapy moment?

What do you think about yourself as beginning therapist?

13. Discussion Questions and Moderating 10 \_\_\_\_\_\_

At least two relevant discussion questions to guide

discussion about the therapy moment.

1. 14. Response to peers posts online 5 \_\_\_\_\_\_\_

Stimulate discussion

References –At least 2

Total Credit 100 \_\_\_\_\_\_\_

**UTA College of Nursing**

**PMHNP Program**

**Psychiatric Evaluation Guide**

**The following is a suggested format for Psychiatric Evaluation of Patient-Please note that this is only a template, not a cookbook approach. For child, adjust language to developmental level of child, and add developmentally specific questions on parenting, discipline, ADHD etc. For older adult or disabled, add functional assessment and additional questions on cognitive function, memory, executive function, MMSE or MOCA score. Remember to tailor questions to the patient if you use this template. If you have questions for sections you don’t see here then address those questions in the proper area.**

**Patient(age, marital status, gender; ethnicity; reliable?)**

**Source of Data:**

**SUBJECTIVE DATA**

**Chief Complaint:** What can I help you with today? (build rapport!) put answer in quotes

**History of Present Illness: (explore issues in depth-get details of patient’s story and validate patient’s feelings. Do symptom analysis of each area of concern)**

**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: (get full details of duration, etc if problems)**

How many hours do you sleep?

Do you wake up before the alarm?

Do you feel rested when you get up?

Do you have problems going to sleep or staying asleep? How many times do you get up at night? How long does it take to fall back to sleep?

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

Have you changed your routine?

Do you drink caffeine before going to bed? Exercise before going to bed?

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

Any nightmares?

What is your normal amount of sleep?

Do you take naps?

**Appetite and weight: (recent)**

How is your appetite? Increased? Decreased?

Have you lost or gained any weight? If yes, over what period of time?

Do you feel that you need to lose weight?

Do you ever binge or fast? (if yes, then get full details)

Use any laxatives or vomiting to lose weight? (if yes, then get details)

Do you use exercise to lose weight?

Are you afraid of gaining weight?

Are you afraid you won’t be able to stop eating if you start?

What do you think about the appearance of your body?

What is your usual food intake in a day?

**Psychomotor Agitation or Retardation**

Feel body is in constant motion, feel agitated?

Or sluggish / slow/ not wanting to get out of bed?

**Energy:**

How would you describe your energy level?

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

Do you have more energy lately? Or less energy recently? For how long?

**Anhedonia:** What do you enjoy doing?

Are activities that you use to enjoy still enjoyable?If not then, is there anything that you still enjoy and can feel pleasure from doing?

How long have you not been able to enjoy things you once enjoyed?

**Concentration:** Are you able to concentrate? (give examples: remember what you read, concentrate on movie, pay attention to conversations)

**Guilt/Worthlessness**

**Mood:** Rate mood on 1-10 scale with 10 as best (or 1-100 with 50 being “level or stable mood” if suspect bipolar disorder, and below 50 depressed and above 50 manic)

Have you been feeling sad? Irritable? Angry? Happy?

(get details… most days.. how long.. 2 weeks or more? Is this is a change for you?)

**Diurnal variation of mood:** Are there certain times of the day that you feel better or worse than others?

**Suicidal ideation;** (concern is recent/current thoughts, but also, history of suicideal thoughts and suicidal attempts

Have you ever thought it would be better if you were dead?

Have you ever wanted to hurt yourself or kill yourself? Are you having these thoughts now? Have you ever hurt yourself or made a suicide attempt?

How often do you these thoughts of wanting to hurt or kill yourself occur? (every day, twice a week, etc) When was the last time? What do you do when these thoughts occur?

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

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

**Homicidal ideation :** Have you ever thought that things would be better if someone else was dead?

Current Plan? Intent?

**Anxiety/OC and related disorders/Trauma : ( Ask at least 3 key screening questions for each disorder; if yes to any of the screening questions, you will need to assess all the criteria for that disorder to arrive at diagnosis using DSM 5 criteria (not all criteria are listed here); if no’s then no further questions needed re that disorder.**

**Anxiety:**

**Separation anxiety disorder:** Do you feel distress thinking about being away from home or from family? Do you worry about harm happening to family members? Do you have fear of leaving home because of fear of separation?

**Selective mutism:** Do you have trouble speaking when spoken to?

**Specific phobia:** Do you have fear or anxiety about a particular situation or object, such as heights, animals, seeing blood or receiving an injection?

**GAD:** Do you worry a lot? Is it difficult for you to control the worry? Do you ever feel restless, fidgety, or on edge? Muscle tension, feel the worse thing will happen? Fatigue? Mind goes blank? Irritability? Sleep disturbance? Lasting 6 months or more?

**Panic disorder**: Ever have short burst (abrupt surge) of anxiety that comes on very fast (within 10 minutes) when you feel you can’t breathe, your heart is racing, you get sweaty and feel like you are going to die? How long do they last? (less than 1 hour?) Do these attacks ever happen out of the blue like in middle of night? (unexpected) Do you fear another one will happen? Avoid things that might bring on another panic attack? Go through the 13 symptoms,

**Agoraphobia:** Do you have fear or anxiety about situations where you might not be able to escape or that you won’t be able to get the help you need or if you have panic like symptoms? Do you have fear or anxiety about using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, being outside of the home alone?

**Social Anxiety Disorder (Social Phobia):** Do you feel uncomfortable around people in social situations (e.g. social interactions, being observed, and performing in front of others? ) and think that they are scrutinizing you? Do you avoid certain social situations? Feel you will say or do something embarrassing or lead to rejection or offend others? Has this lasted at least 6 months?

**OC and Related disorders**

**OCD:** Do you constantly go back and check things that you did to see if you did them or feel the need to wash your hands? Or any other kind of rituals that you feel compelled to do? Do you have thoughts that are intrusive, and unwanted and that you try to ignore, suppress or neutralize with a compulsion? Does this take up an hour or more of your day?

**Body Dysmorphic Disorder**; Are there parts of your body that you feel are defective? Do you stand in front of mirror for long periods of times or do excessive grooming, or compare yourself to others?

**Trichotillomania:** Do you frequently pull out your hair resulting in hair loss?

**Hoarding:** Do you have difficulty letting go of possessions, throwing things away? Is your house very cluttered by these items that you accumulate?

**Skin Picking:** Do you frequently pick on your skin and cause skin lesions?

**Trauma:**

**PTSD**: Were you exposed to actual or threatened death, serious injury, or sexual violence (witness, directly experiencing, learning a violent or accidental event occurred to close family member, repeated exposure to details of the event), If yes, then ask: Do you have nightmares, flashbacks of any traumatic events in your life? Startle easily, avoid talking about the trauma? Feel numb or detached from others, or hypervigilant? Inability to experience positive emotions? Sleep disturbance? Verbal or physical aggression? Reckless or self destructive behavior? Experience hearing voices or seeing things when falling asleep? Length of time 1 month or more/

**Manic Symptoms: (Ask at least 5 screening questions to rule out mania; if yes to any, need thorough details of duration of symptoms and severity to determine if meets criteria for hypomania or mania episodes (BPI or II) using DSM 5.**

Do you ever have periods of extreme happiness or elevated mood or irritability? How long do they last? Can ask how high do the ups go (scale of 1-100 with 50 as level mood) and how low do the lows go? Where you are today?

Can you go 4-7 days without sleeping or ever feel rested after little sleep? Is that happening now? When was the last time?

Are you extremely talkative or has someone told you that you were during these times? (or extreme texting)

Racing thoughts? Feel agitated?

Spending sprees? other reckless behavior? Increased sexual activity during these times? Sexual indiscretion? Drugs or alcohol?

Start lots of projects, don’t finish, and jump from one thing to another..

Get started with something and won’t stop even if it is hurting you or someone else?

Consequences of these episodes? (look for financial, legal, occupation, educational, and relational)

**Psychosis**: Hallucinations? See things that others don’t see? Hear things that others don’t’ hear? Hear your name called or strange sounds? Smell things? Feel something crawling on your skin? Taste strange things in your mouth,, Do they happen only when you are Summering asleep?

Delusions? Ever think people are planning to hurt you? Ever feel that you have special talents or gifts? Ever have the idea that you can read people’s minds or they can read yours? Ever feel you can put thoughts in someone’s head or they can put thoughts in yours? Feel the TV is talking just to you? (paranoia, grandiose ideas, delusions of control, ideas of reference)

**Focus and attention**: (screening for ADHD when appropriate) Problems with inattention/ listening and remembering what was said? Daydreaming as child? Trouble understanding what you read or finishing a book?? Trouble with procrastination. Easily distracted? Late for meetings, misplace things? (adjust questions to age of patient) hyperactive as child? Impulsive-blurting out answers? Finishing others sentences? Trouble getting started with challenging project? Trouble finishing details of project? Happen before the age of 7?

**Consequences of any of the + symptoms**: (e.g. what problems have these symptoms caused for you in your relationships, in your job, etc.

**Psychiatric History:** Have you ever been diagnosed with any psychiatric disorders such as ….

Have you ever been treated for a mental illness or stress problem? Get details; who treated; Ever have problem you think should have had treatment for?

What meds were tried and did they work? (get medication history)

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? **(Make sure to ask about each specific drug in this section. This also includes prescription drugs as well (e.g. Soma, Vicodin, Xanax) ; if HPI includes drugs and alcohol, cover in HPI; can say see HPI.)**

What kind and how often? IV drug use?

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

Ask if has used more than 3 drinks in one occasion (women) in past year (more than 4 drinks for men). See the guidelines or asking these questions in Clinicians Guide. More than 14 drinks a week for men, 7 drinks a week for women is considered problem use. (ask about size of drink :

CAGE questionnaire (not as useful as AUDIT (or CRAAFT with teen) or questions about # drinks)

For any use of drugs/alcohol, ask questions to identify symptoms of intoxication, withdrawal, abuse, and dependency

Have you ever had 3 or more drinks at one time? (female, males over 65) 4 or more drinks at one time ? (males) How many times in past month? # drinks per week? (most used, use standardized drink chart for size of drink, 12 oz beer, 1 ½ oz liquor, 5 oz wine =`1 drink

When did you have first drink/drug, last? (look for symptoms of withdrawal), Do you have blackouts, withdrawal symptoms (ask about specifics for drugs/alcohol has been using)? Ever been through detox? How many times? Seizure?

Financial burden? Drink when driving? Arrested for? Medical problems.

Go through each class of drugs (Current, past, first use, last use, consequences) illicit /street drugs

Marijuana, cocaine, methamphetamine, opiates (Vicodin, Lortab, Oxycodone), benzos, hallucinogens, inhalants, ecstasy? (ask the questions about abuse and dependency, withdrawal and intoxication of any drugs admitted to using)

What are consequences of using drugs or alcohol-give example.. e.g. losing relationships, losing job?

Any illegal activities? Steal to get drugs? Arrested for possession or sales?

Cannot go without drugs or alcohol? Tried to stop? Need more to get high or same effect? Withdrawal symptoms if try to stop? Use more than intended?

Ever took more prescription drugs than prescribed? Such as Lortab, Vicodin, Xanax? (get details –now, in past, etc)

Abuse OTC such as dextromethorphine, bath salts?

Ever treated? (get details) 12 step? Last meeting? Formal treatment?

Nicotine use? # packs per day, how long, cigars, smokeless tobacco, SNUS, plans to change smoking habits?

Caffeine use per day (Red Bull, coffee, etc)

**Current Health Status:**

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

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

**Current prescribed medications:** OTC and herbal? ( doses)

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

How much and how frequently?

When last physical exam?

Last pap and lab work? What were the results?

Immunizations (include Pneumovax, shingles, if over 60)

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 (dates, etc)

**Accidents:** broken bones, head injuries, seizures, lost consciousness?

**Menstrual hx/pregnancy hx,**

**Hospitalizations:**

**Surgeries:** What, where, when, any complications

**Past med history**: Any past prescription, OTC, herbal medications? What kind? What did you

take them for?

**Family History:**

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 (parent, sibling, grandparent, aunt, uncle, cousin, children) 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? Was Mom using drugs or alcohol during pregnancy?

Milestones on time?

Birth through 3 years, childhood, adolescence: social relationships, cognitive, motor development;

Problems with learning? Peer relationships? Activities in school? Special classes? Diagnosed with learning disability? Odd behavior? Stereotypic behaviors (e.g. head banging,)

How many jobs? Relationship with co-workers?

Lost any family members or friends?

Abuse history (physical, psychological, sexual)

**Social History:**

**Current health habits/ADLs:** Functional assessment of geriatric pt ( ADL’s, IADLS)

What is your daily routine?

Are you able to take care of yourself?

Responsibilities?

Difficulty doing chores?

What do you do to stay healthy?

**Educational History:**

Highest degree/grade level?

School?

Grades?

Truancy?

**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:**

Combat?

**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?

**Review of Systems: (focus on systems relevant to history)**

**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

# OBJECTIVE DATA

**Do memory test. 3 objects – ball, car, dog. Repeat now, 1 minute and 5 minutes.**

**Mental Status Exam:**

Appearance:

Appears stated age

Body build:

Position:

Posture;

Eye contact:

Dress:

Grooming:

Manner/attitude:

Attentiveness:

Alertness:

Behavior and psychomotor activity: Mannerisms, ticks, gestures, twitches, hyperactivity, agitation, combativeness, etc.

Attitude toward examiner/reliability: cooperative, friendly, attentive, interested, frank, seductive, defensive, apathetic, hostile, evasive, etc.

Mood: Euthymic depressed sad tearful hopeless angry hostile suspicious sullen anxious belligerent; elated

Affect: normal, constricted, blunted, flat, labile (shifts rapidly); euphoric

Speech: quantity, rate, volume, and tone. Rapid, slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, mumbled; foul language; rhyming/punning

Perceptual disturbance: Hallucinations (auditory, visual, tactile, gustatory) illusions depersonalization

Thought processes: Clear coherent goal directed flight of ideas circumstantial loose associations word salad perseveration tangential thought blocking

Thought content:

Normal obsessions compulsions preoccupations phobias delusions paranoia religious somatic grandiose suicidal

Alertness and level of consciousness: alert, disoriented, lethargic, clouded, stuporous, comatose.

Orientation: person, place, time, and situation.

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

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." (state all 3 commands and then hold paper out)

Capacity to read and write: Ask patient to write a sentence (say Write any 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?

Abstract concrete impaired

Ask about proverb interpretation; e.g. Have you heard the expression: A bird in the hand is worth 2 in the bush?; (if no then try another: Have you heard The grass is always greener on the other side? What does that mean to you?

Fund of information and intelligence: level of education and intelligence; e.g. Ask to say who current President is; then ask to name president before him and keep going; or Ask to name 3 large states; Ask Who is Jonas Salk? Ask current events;

Judgment: what do we know so far, are they drinking and driving, etc. look at whole picture; Can ask: What would you do if found a stamped letter with address lying on street: or What would you do if you found a child who lost her parent in the mall: or What would you do if you heard fire alarm in the movies?

Good; fair; poor and give example

Insight: What kind of problem do you think that you are having?

Good intact fair limited

Assets/strengths: motivation? What are you good at?

Liabilities: What things do you think you need help with?

Other objective assessments:

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

**Focused Physical Exam pertinent to patient’s presenting problems.**

**(always include heart and lungs; most always, need neuro exam)**

# ASSESSMENT

# Diagnosis: (list all )

Medical problems; include unexpected weight loss; hypersomnia; arthritis, DJD, Diabetes, etc

**Contexual factors**

R/O (Rule out are diagnoses that you are considering as possibilities; just need more information: e.g. MDD would be Rule out Bipolar Disorder;

Differential (medical, and more unlikely causes of symptoms) e.g. hypothyroidism; brain tumor; B12 deficiency; substance induced mood disorder; substance induced anxiety disorder; HIV;

**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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Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical diagnoses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

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

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

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

N5425 Psych-Mental Health II (Family) 2015

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TOTAL= 675 hr in program (585 psych hours)**

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| **TYPE OF HOURS (Required)** | **1/18-1/24** | **1/25-1/31** | **2/1-2/7** | **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** | **Hrs. From Previous Semester** | **Hours this semester** | **TOTAL** |
| **Adult Psych Mgmt.**  **180 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Child & Adol. Psych Mgmt.**  **175 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Geriatric Psych Mgmt.**  **20 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Adult Medical Mt.**  **45 Required**  **(N5305)­­** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Addiction**  **45 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Group Therapy**  **50 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Family Therapy**  **40 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Individual**  **Therapy**  **50 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Seminars**  **Practicum**  **25 Required** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Pedi. Medical Mgmt.**  **45 Required**  **(Pedi Mgmt.)** |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Total Hours:** |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Semester:

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