N3481 Assignment Packet

NURS3481 FACULTY

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Office Hours: Varies by instructor

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ALLOCATION OF CREDIT FOR CLINICAL HOURS Spring 2018

Activity	Hours	Setting/Requirement
Clinical Activities	50	Psych Inpatient Setting (Documentation required)
Simulation	12	Documentation required - Clinical Prep
10 vSIM Scenarios	10	Benchmark 90% - Clinical Prep
Weekly Prep-u Quizzes	8	Benchmark Level 4 - Clinical Prep
Clinical Prep Videos	2	Documentation required - Clinical Prep
Evidenced -Based Poster Presentation	4	Documentation required - Clinical Prep
AA 12-Step Support Group Meeting	4	Community Activity - Clinical Prep (Documentation required)

Clinical **pre and post-conference*** and evaluation times are incorporated into above hours as determined by clinical instructor.

***Pre-Conference** - The pre-conference is a brief review of the clinical day's activities. Clinical instructors assist the group in identifying learning opportunities, assignment priorities and organizational needs.
***Post Conference** - Students are expected to attend all clinical conferences, with the following goals:
1) Students and clinical faculty discuss clinical experience goals, turn in paperwork, discuss upcoming assignments
2) Debrief or discussion of the events of the clinical experience. Students report learning that they have accomplished as well as problems, needs, and concerns that need to be addressed. Faculty provide theoretical content to support student experiences, and assist students to problem-solve using critical thinking skills.
3) Students provide support to peers in clinical group; demonstrate collegiality while working as a member of the health care team.
4) Students apply nursing theory to their clinical practice setting.

Clinical Times are scheduled according to the best experiences available and thus will vary according to group, day and experience.
During Post-Conferences, the SBAR technique provides a framework for communication. An SBAR Worksheet will be used to organize information about your patient in preparation for communicating during post conference.
Students will use the SBAR and the **following Objectives as a Guide for Post-Conference Discussion:**
1. Identify the patient
2. State client needs.
3. Describe observations using a systems-review approach.
4. Report potential or real problems experienced during the clinical.
6. Identify psychotropic medications and state the action, desired effect, and potential side effects
9. Identify pertinent labs and discuss how they relate to your patient.

Video Assignment Questions

Clinical Communication Lab, Simulation Day and Clinical Preparation: Effective Communication Videos; Recognizing Extrapyramidal Symptoms; Involuntary Mental Health Commitment Video

I. Purpose: To explore and further expand knowledge of assigned concepts through reflection and critical thinking.
II. Description: Students will view assigned videos and post a reflection on each video on black board **using the specific questions for that video as a guide.**
III. Link to Course Objectives:
a. Employ informatics in the planning, delivery, and evaluation of psychiatric-mental health care of individuals, families, and groups.
IV. Steps to Follow for the Three Video Assignments (Weeks 1, 2, 3)
1. Click the video link in the appropriate week to open the video.
2. View assigned video and write a reflection on the content, using the questions for that video to guide your focus.
3. Copy and Paste the questions posed in a word doc, answer and save to your computer and post your completed entry on blackboard in the appropriate weekly assignments.
V. Due Dates: Video Assignment postings are due as assigned (see calendar); submit in Blackboard on or before 2359 Sunday. The clinical instructor will determine any exceptions for late or incomplete assignments - 10 points will be deducted each day past the due date with a maximum of 30 points, without **prior arrangement.**
VI. Grading: Must achieve a minimum of 70% on all clinical assignments to pass clinical.

Use the rubric to guide your work on this assignment.
Pass: 70-100 points
Fail: 0-69

Video Questions

Please answer these questions as a basis for your assignment on the videos.

Involuntary Mental Health Commitment Video
Reflect on what you learned from viewing ***Involuntary Mental Health Commitment Video -*** What are your feelings about Mental Health Court being an effective way to help patients with psychiatric mental health disorders who may present as a danger to self/others? Did your opinion change after listening to the video?
Submit on Blackboard, see calendar

Effective Communication Videos
Video A: Identify a) personal qualities, b) essential attitudes, c) external factors and d) attending skills necessary for The Helping Interview.
Video B: Compare & contrast the type of questions that assist the client in identifying/exploring ideas and feelings with those that disrupt the flow of ideas/feelings.
Video C: Identify a) the use verbal and nonverbal techniques to prompt the client to continue talking and b) techniques for closing the interview.
Submit on Blackboard, see calendar

Recognizing Extrapyramidal Symptoms
A. Identify the psychotropic medications that cause movement disorders and discuss the etiology for these disorders.
B. Compare and contrast the symptoms of dystonia, akathisia, parkinsonism, and tardive dyskinesia
C. Identify and discuss the use of specific EPS treatment medications and how they work to alleviate each of these EPS symptoms. **Submit on Blackboard, see calendar**

Rubric for Video Assignment

Description

Video Assignments

Rubric Detail

	Target	Acceptable	Unacceptable
Written Response	All required components are fully addressed and all components of each part of a question are answered. Provides at least 2 supporting details for each point. All elements have sufficient detail. Expresses opinions based on facts with clear evidence of support. 76 - 80 points	One element lacking sufficient detail. Topics not fully addressed and not all questions are fully answered. Provides at least 2 supporting details for each point. One element lacking sufficient detail. Most a opinions seem factual but evidence of support is lacking. 60 - 79 points	Incomplete detail on most elements; minimally addresses or does not address all components. Does not provided adequate supporting detail. 0-59 points
Mechanics (accuracy of writing), APA References	Videos and responses are referenced. Accurate use of quotation marks, correct spelling, references in APA format. 16 - 20 points	Missing a component of videos and/or response reference. Accurate grammar, but several inaccuracies in spelling, APA, quotations. 11 - 15 points	Numerous errors in grammar, missing key components, reference for video missing. 0 - 10 points

Initial Patient Interview

I. **Purpose: To overcome the apprehension of the first interaction with a client experiencing a Mental Illness, and to practice: documentation; mental status exam assessment; therapeutic communication; self-awareness.**

II. **Link to Course Objectives:**
Practice life-long learning, self-reflection and awareness in the provision of psychiatric-mental health care of individuals, families, and groups.

III. **Steps to Follow:**

a. Select a client that fits your learning needs for the day. **Use the Initial Patient Interview to collect detailed data** for this assignment. After your interaction reflect on the patient's appearance, behavior and communication to practice your documentation skills.

b. Document both the Patient's Psychiatric Diagnosis and Medical Diagnosis.

c. Objectively describe the patient's appearance, behavior and communication.

d. Reflect on and document both your thoughts and feelings as you interviewed your patient.

e. Reflect on and rate your anxiety level on a scale of 1 to 10, documenting your anxiety level both prior to and after the interview. Discuss your thoughts regarding why it may have changed.

f. Identify at least one therapeutic communication technique that you used during the interview **and** discuss how and why it worked or did not work:

IV. **Due Dates:** You will complete 1 initial patient interview as directed by your clinical instructor on your 1st onsite clinical day.

Use the rubric to guide your work on this assignment

Pass: 70-100
Fail: 0-69

Student Name_____Date _____Patients Initials _____
Unit_____

INITIAL PATIENT INTERVIEW (To be completed at clinical site 1st day at clinical site and presented during post conference)

Patient's Psychiatric Diagnosis:

Patient's Medical Diagnosis:

Describe the patient's appearance:

Describe the patient's behavior:

Describe the patient's communication:

What were your thoughts as you interviewed the patient?

What were your feelings as you interviewed the patient?

On a scale of 1 to 10, with 1 being low level of anxiety, how would you rate your anxiety level prior to the interview? After the interview, how would you rate your anxiety level and why did it change?

Give at least one example of a therapeutic communication technique that you used during the interview **and** explain how and why it worked or did not work:

Rubric for Initial Patient Interview

Description

Initial Patient Interview

Rubric Detail

Criteria	Target	Acceptable	Unacceptable
Selects client, collects data and includes on form	Selects appropriate client, completes all fields on the initial patient interview form. 18 – 25 points	Selects appropriate client. All components addressed, but lack detail, depth, thoroughness. 10 – 19 points	Selects inappropriate client, and/or minimally addresses or does not fully complete all fields on initial patient interview form. 0 - 9
Describes client's Appearance, Behavior, Communication and all assessment fields.	Provides a detailed description of their client's appearance, behavior, and communication; accurately differentiates between these concepts. Addresses all assessment fields. 18 – 25 points	Provides a description of their client's appearance, behavior, communication, all assessment fields but lacks detail and/or has difficulty accurately differentiating between these concepts. 10 – 19 points	Limited description, no detail and /or incorrectly differentiates between these concepts. 0 – 9 points
Describes thoughts, feelings during initial interview and all assessment fields. identifies anxiety level.	Provides a detailed description of their own thoughts and feelings during the interview and accurately differentiates between the two. Assigns a numeric value to anxiety level both before and after interview and puts into words factors that contribute. 18 – 25 points	Provides description of their own thoughts and feelings during the interview lacks detail and/or has difficulty differentiating between the two. Assigns a numeric value to anxiety levels but description of factors that contribute to these levels lack detail. 10 – 19 points	Evidence of lack of self-awareness, unable to differentiate between thoughts/feelings. Failed to assign numeric value to anxiety levels, and description of factors that contribute to levels is limited or missing. 0 – 9 points
Therapeutic Communication Technique	Identifies a minimum of one therapeutic communication technique used during the initial interview and accurately describes how and why it worked. 18 – 25 points	Identifies a minimum of one therapeutic communication technique used during the initial interview, but description of how and why it worked lacks detail. 10 – 19 points	Inaccurate or missing description of therapeutic communication technique used during the initial interview, and/or description of how and why it worked inaccurate or missing. 0 – 9 points

Critical Thinking Journal and Reflections on Clinical Activities:

I. **Purpose:** Reflective journaling provides an opportunity for you to focus upon your course and career goals, and also to enhance and reinforce your learning. For each journal entry, you should write your reflective comments, making connections to your prior experiences, this course, and beyond. Keeping dated entries of your experience as a psychiatric nursing student can also help you gauge the progress you are making and provide an outlet for emotions, confusions, or frustrations.

II. **Description:** Examine your thoughts and feelings. Describe what insights you gained, what you learned about yourself, and how you can use what you learned to enhance patient care as well as your personal and/or professional growth. Your journal entry should reflect your personal learning and development of insight, as opposed to an evaluation of the event or clinical situation. Identify specific learning that has occurred for you as you reflect on your day. What did you learn today and how will you apply that in your nursing practice? What is different about what you learned today from previous days.

III. Link to Course Objectives:
a. Use analytical and critical reasoning for clinical judgment and nursing decision-making.
b. Relate core professional values and legal/ethical principles in the provision of holistic psychiatric-mental health care of individuals, families, and groups.

IV. Steps to Follow: Use any type of book/notebook that you like. Write a journal entry for each clinical day and include answers to the following questions.

1. **Describe a situation that you observed or participated in. What were the surrounding circumstances and the outcome?**
2. **What were your thoughts and feelings about the event?**
3. **What one thing from today's clinical is most significant to your personal learning?**
4. **How will you manage your stressors this week?**
5. **Optional - My creative depiction of my feelings: After you write your journal entry, draw/insert a picture, write a poem or use another creative way to 'illustrate' your feelings about your day. Be creative! Make this exercise fun - remember, this is <u>your</u> journal**

IV. **Due Dates:** One journal entry is due for each clinical day, submit as directed by clinical instructor.

V. **Grading:** Must achieve a minimum of 70% on all clinical assignments to pass clinical.

Use the rubric to guide your work on this assignment
Pass: 70-100
Fail: 0-69

Student Name_____ Date _____

Today's Reflection on My Clinical Activities Journal Entry

Observation of an event, the surrounding circumstances and outcome:

My thoughts and feelings about the event:

What I learned from today's clinical that is most significant to my personal learning:

My plan for managing my stressors this week:

Rubric for Reflection-Critical Thinking Journal

Description
Reflection-Critical Thinking Journal Rubric

Rubric Detail

Criteria	Target	Acceptable	Unacceptable
Describes Event	Detailed description of event, and the outcome for self and client. 20 – 30 points	Basic description of event or leaves out outcome for self or client. 10 – 19 points	Limited description of event. Omits outcome. 0 – 9 points
Includes Thoughts and Feelings	Includes several thoughts and feelings related to the event/outcome. 20 – 30 points	Includes thoughts or feelings, but not both. 10 – 19 points	Does not include thoughts or feelings. 0 – 9 points
Plan for Self Care	Includes realistic plan to manage stress. Includes a creative expression of feeling about day. 16 – 20 points	Plan to manage stress is vague, unrealistic. Missing creative element. 10 – 15 points	Does not include stress management plan or creative element. 0 points
Most Important Thing Learned and Relationship to Career Goal	Detailed and clear description of the most important thing learned and its relationship to career goal. 16 – 20 points	Description of the most important thing learned and its relationship to career goal lacks some detail. 10 – 15 points	Description of the most important thing learned and its relationship to career goal is not clear or detailed or missing entirely. 0 – 9

AA 12-STEP SUPPORT GROUP MEETING REPORT

I. **Purpose:** Attending and observing support groups that are available in the community for your patients and their families will serve to emphasize the value of including these community resources in your discharge plan.

II. **Description:** Unobtrusively observe a support group in action and describe what you observed.

III. **Link to Course Objectives:**

a. Use therapeutic communication techniques and effective interpersonal skills in the provision of psychiatric-mental health care of individuals, families, and groups.

b. Employ collaboration between individuals, families, and others in establishing priorities for the provision of competent and cost-effective psychiatric-mental health care that promotes health and prevents illness.

c. Practice life-long learning, self-reflection and awareness in the provision of psychiatric-mental health care of individuals, families, and groups

IV. **Steps to Follow:** **Call and secure permission to attend. Some meetings are closed to outsiders. No more than 3** students may attend a group together. Some groups may only allow 1-2 students.

1. Before going to your meeting: Check with the group to verify meeting time, location or any other requirements/specifics. Make sure it is not a phone or internet group.

2. Wear business casual clothes. You must attend a group in person with members attending in person. Phone or internet groups or groups with phone or internet components will not count. Remember that you are representing UTA nursing while there, so be sure to maintain professional behavior that does negatively affect the group dynamics (arriving late, talking, text messaging etc.). Do not wear your uniform or name tag

3. Arrive early so that you can touch base with the contact person for any last minute suggestions. If you find that you are going to be late - **Do not attend - RESCHEDULE! Failure to follow guidelines will result in NO CREDIT for the assignment. DO NOT TAKE NOTES OR WRITE IN THE MEETING!**

4. Observe the group, interacting if advised by the contact person. Do not do anything to alter the group process. Complete the Support Group Assignment Form after you leave the group (Do not write or take notes during the group.

V. **Due Dates:** Support group papers are due as assigned by your clinical instructor, posted to Blackboard.

VI. **Grading:** Must achieve a minimum of 70% on all clinical assignments to pass clinical.

Use the rubric to guide your work on this assignment
Pass: 70-100
Fail: 0-69

AA 12-STEP SUPPORT GROUP MEETING REPORT

Name_____ Clinical Instructor_____
Date_____

Name/Type of Group: _____ _____
(Alcoholics Anonymous Support Group Meeting)

Location/address_____
(Specific to Group)

Date Attended_____ Time and Length of Meeting_____

Number of Members in Group_____ Number of Students attending_____ **(MUST BE 3 OR LESS!)**

Why did you select this group?

How did your presence affect the group?

Briefly describe how the meeting was conducted: How did it open and close? Was there a discussion of a particular topic? Describe sharing between/among members of successes, difficulties, challenges, etc. (Use nothing that could identify individuals.)

What were the overall themes expressed in the group? (joy, relief, support, happiness, anger, frustration, burdens, sadness, etc.)

What criteria would you use to determine if a client/patient would be appropriate to refer to this group?

Describe your thoughts and feelings related to experiencing this meeting.

What **meaning** did this experience have for you personally?

In what ways will this group experience be useful in your practice of nursing?

Note: Many meeting listings are available on the Internet World Wide Web. *You must attend meetings in person. You cannot attend a phone or an on-line meeting.* To protect confidentiality, it may be advisable to attend a meeting outside your home community. **No more than 3** students may attend a group together. Some groups may only allow 1-2 students.

Rubric for Support Group

Description

Support Group

Rubric Detail

Criteria	Target	Acceptable	Unacceptable
Selection of Group	Clearly follows guidelines for selection of group and attendance of no more than 3 per group and posts on Blackboard. 40 – 50 points	Clearly follows guidelines for selection of group and attendance of no more than 3 per group but doesn't post on Blackboard. 20 – 39 points	Does not follow guidelines of 3 per group and does not post or posts late on Blackboard. 0 – 19 points
Group Attendance	Dresses and acts professionally. Wore business casual attire. Arrives on time (Prior to call to meeting call to order) or arrived early to speak to group leader. 8 – 10 points	Dresses and acts professionally. Wore business casual attire. Arrived after the meeting was called to order (per report from Group). 5 – 7 points	Is unprofessional and arrived late (per report from Group). 0 – 4 points
Written Report	All areas in report are fully addressed. Report reflects detail, depth of engagement and knowledge of the meeting in all areas. 30 – 40 points	All areas addressed, but not fully; report reflects a lack of detail and knowledge of the meeting and of depth, thoroughness in several areas. 20 – 29 points	Numerous area are not fully addressed; report reflects a lack of detail knowledge of the meeting and of depth, thoroughness in most areas. 0 – 19 points

NURSING CARE PLAN ASSIGNMENT

I. Purpose: The nursing care plan is a systematized description of the care that will be provided for a client which reflects the use of the nursing process, including assessment (whether it be a full psychosocial history or a mental status examination), nursing diagnoses, planning (including short-term and long-term goal setting), implementation, and evaluation of the client's goal attainment. The overall goal of a nursing care plan is to ensure that care provided for a client is consistent with the client's needs and progress toward identified expected outcomes. The care plan should include:

a. A thorough psychosocial assessment and mental status assessment.
b. Two prioritized 3-part nursing diagnoses which reflect your analysis of the mental status of the client and the both the predisposing and precipitating events surrounding hospitalization, progress toward overall outcomes and so forth.
c. A list of one short-term/shift goal and one long-term/discharge client-centered goals for each of the nursing diagnoses. Note that these should be SMART Goals.
d. Three relevant nursing interventions with rationales for both the short-term/shift goal and the long-term/discharge client-centered goal with an evaluation of whether each of those interventions were achieved and how they impacted the client meeting the goals that you set.
e. An overall evaluation of the effectiveness of the plan of care and a description of modifications that may be needed to the current care plan.

II. Description: Steps to Follow:

a. Select a client that fits your learning needs for the day. **Use the NCP guide to collect detailed data** for the NCP form assigned. Use a variety of sources (chart, client, nurse, psychiatrist, mental health technician, social worker, DSM V)
b. Identify prioritized psych related problems based on the collected data. Include your rationale for prioritization.
c. Formulate a plan of care based on the prioritized psych related problems. Include realistic, measurable, timed goals – one for the shift and one for discharge for each problem. Include any other needed plan such as teaching and discharge planning
d. **Meet** with the client during your day to **implement** your planned interventions
e. Evaluate the success of your interventions and document a problem oriented note about the progress of the identified problem and any needed revisions.

III. Link to Course Objectives:
a. Apply knowledge from the art and science of nursing and other scientific and humanistic disciplines in the provision of holistic psychiatric-mental health care of individuals, families, and groups.
b. Use analytical and critical reasoning for clinical judgment and nursing decision-making.
c. Relate core professional values and legal/ethical principles in the provision of holistic psychiatric-mental health care of individuals, families, and groups.
d. Use therapeutic communication techniques and effective interpersonal skills in the provision of psychiatric-mental health care of individuals, families, and groups.

IV. Due Dates: You will complete 1 (one) **satisfactory** NCP on a client; if the NCP is deemed unsatisfactory, you will be required to correct your care plan based on instructor feedback. You will have 1 (one) week to correct and resubmit (must be submitted before next clinical day). The corrected care plan grade will be averaged with the 1st care plan grade to replace the original grade. **If your 2nd submission of the care-plan is not satisfactory, you may be asked to select a new patient and complete an additional care plan.**

Use the rubric to guide your work on this assignment:
Pass: 70-100; Fail: 0-69

NURSING CARE PLAN ASSIGNMENT GUIDELINES

One successful Care Plan is to be completed during the semester. Gather data about your client and develop an individualized, realistic, data-supported plan of care which can be implemented and evaluated according to stated goals/objectives and expected outcomes.

Below is a set of basic instructions for using this tool to guide nursing care.
Use primary reference materials: Boyd 5th ed. Chapters 9, 10; textbook chapters relevant to your client's diagnosis; Nursing Plan of Care MUST BE INDIVIDUALIZED and not a copy of quotes or paraphrases from the text or a care plan book.

As you gather your data, use the check boxes to record information that you will use to formulate your plan of care for your patient. If you check a box, you must provide supporting data/evidence in the blank area of that section.

Patient Demographics and Psychosocial Information ONLY USE CLIENT INITIALS, NOT NAMES.
Admission date, Initials, age, gender, ethnicity, marital status, children, diagnosis (psychiatric, medical), psychosocial stressors, living situation, employment, education level, family psychiatric history, history of family violence/abuse, legal issues, type of admission - voluntary/involuntary, reason for admission/precipitating event

Mental Status Assessment
As you do your data collection determine how you arrived at the assessment data or the source of the assessment data. In addition to interviewing and observing the client and consulting the written record, you need to consult health team members who know the client/family.
Appearance: Describe patient's overall appearance, grooming, dress, eye contact.
Grooming: Reflects a loss of interest in caring for oneself or an inability to perform self-care or ADL's
Attitude: Describe the patient's approach/response to the therapeutic encounter/assessment/interview process, the ease of obtaining the information and the quality of the responses and information obtained.
Psychomotor: Describe the subject's ability to perform voluntary movements/motor responses including level of activity, gait, movements, level of interaction with others.
Speech: Speech provides information about the patients thought process. Listen and describe rate, rhythm, volume, clarity, enunciation, etc. Is there evidence of slurring, mutism, stuttering, hesitancy, latency of response, dysarthria, aphasia, etc.
Mood: A person's predominant feeling state. (Mood is subjective. Therefore, it is described as one or more quotes from the client).
Affect: The external manifestation of a patient's emotion or feeling state. It may be congruent or incongruent with the patient's mood or thought content. (Affect is objective: describe what you observe. Ex: Pt. is sad and becomes tearful when discussing her husband's death.)
Thought Process: Are associations clear, coherent, logical and goal directed? Is there evidence of loose associations, flight of ideas, blocking, tangential associations, circumstantiality, clang associations, neologisms, word salad, etc.
Thought Content: Describe predominant themes that emerged during interview. Note presence or absence of suicidal and homicidal thoughts. Note topics of greatest concern to client including preoccupations, obsessions, ruminations. Describe delusions and irrational thoughts in detail. USE QUOTES LIBERALLY!
Insight: Refers to patient's ability to comprehend the meaning and significance of his/her symptoms, the need for treatment, factors that contribute to symptoms/illness
Judgment: Refers to patient's ability to anticipate the consequences of choices and behaviors and make rational decisions accordingly (quality of decision making).
Cognition: Refers to patient's level of consciousness, orientation, memory, attention, abstract ability. Helps you to identify issues related to clouding of consciousness, confusion or organic mental conditions.
Intellectual Ability: Patient's ability to take in, compare and recall information in a meaningful way

Risk Assessment
Suicide Risk Assessment: Psychiatric co-morbidity increases your patient's suicide risk. The highest predictor is previous attempts. Other events such as recent negative life events (losses, legal issues, relationship problems Financial problems) chronic or catastrophic illnesses, extreme psychological states of distress are predictors of suicide risk. It's important that you ask about hopelessness, reckless/risky activities, feeling trapped, isolating, changes in sleep/appetite, mood changes, anhedonia, loss of purpose. Ask about a plan, how detailed, is it soft or hard method (lethality).

Homicide Risk Assessment: Determine the risk for the potential for homicide. A past history homicide, serious acts of violence; substance abuse, psychological factors such as paranoia, acute symptom clusters such as psychosis, manias, comorbid substance use and nonadherence to treatment protocols as well as a serious head injury are risk factors. Ask about a plan, how detailed, is it soft or hard method (lethality).
Aggression Risk Assessment: Determine variables associated with a prediction of violence and aggression risk. Describe history of aggression, current behaviors, past history of aggression and serious acts of violence; issues like substance abuse, psychological factors such as paranoia, acute symptom clusters such as psychosis, manias, comorbid substance use and nonadherence to treatment protocols as well as a serious head injury are also risk factors. Ask about a plan, how detailed, is it soft or hard method (lethality). Given the data that you have collected, determine if the risk is low, medium or high?
Substance Use Risk Assessment: Identify current use and at-risk behaviors. It's important that you determine a patient's use and whether it is maladaptive and causes distress or adversely impacts their ability to navigate life successfully (causes problems with: their role, relationships, legal issues, their health, decision making, finances). You also want to determine what they use, amount and the length of use; have they unsuccessfully tried to quit, do they experience physical or mental symptoms if they decrease or cease the substance . Given the data that you have collected, is the risk low, medium or high?
Psychosis Risk Assessment: Recognizing a psychotic episode creates an opportunity for intervention. Ask questions about unusual things, like seeing visions or hearing voices. Determine if the patient is experiencing a distortion of reality (reality testing impairment), loss of contact with reality (rational thought impairment), delusions and hallucinations. Is there evidence of thought disorder, social withdrawal, impaired role functioning? Do the patient's labs indicate drug intoxication or metabolic causes? Does the patient have a diagnosis of Schizophrenia, Bipolar disorder or Schizoaffective disorder? Is there a family history of psychosis, does the patient have a history of psychosis? Given the data that you have collected is the risk low, medium or high?
Falls Risk Assessment: Falls are due to many factors in an inpatient psychiatric population, and assessment of risk and quick intervention is imperative. Some predictors of falls include conditions such as delirium and a diagnosis of dementia or Alzheimer's disease. Medications associated with a higher risk of falls include benzodiazepines, anticholinergics, lithium, conventional antipsychotics, atypical antipsychotics, alpha-blockers, H2-blockers, atypical antidepressants, mood stabilizers and anticonvulsants. Besides medication and diagnosis, important factors to assess are age, history of falls, mobility and gait issues, visual or auditory impairment, cognition, lack of awareness of the immediate environment impulsivity and lack of understanding of physical or cognitive limitations. Given the data that you have collected, determine if the risk low, medium or high?

Patient's Perspective

What are your patient's priorities and goals for treatment (may be different from health care provider, family, student nurse)? Can they identify challenges that may impact their ability to achieve their goals? Do they understand their diagnosis, disease process, their medication and treatment plan? Do they have the ability to implement treatment plan (financial, transportation, other resources needed, lack of knowledge)?

Prioritizing Nursing Diagnosis

Developmental Stage: According to Erikson, which developmental stage and side of stage is this client on, and what is your supporting evidence (identify which stage patient is functioning in and describe behavior to support your findings).
Maslow's Hierarchy of Needs: What are your safety concerns, prioritized problems/needs and the rationales based on Maslow's Hierarchy of needs (what level is the patient on and what is your supporting evidence for this – use this stage to assist you in prioritizing your nursing diagnosis!).

Nursing Process

Psychiatric Nursing Diagnoses (not medical) with Rationale for prioritization (2 minimum) (Use identified Maslow stage to prioritize) Answer the question, **"What are the most important problems this client needs to solve?" Identify the top 2 needs/problems that you have identified for your patient based on the data from your patient assessment.** List at least 2 nursing diagnoses (**include related to/as evidenced by**) for which you have provided rationale for your prioritization. Data collected must match diagnoses/problems. Entire process must be INDIVIDUALIZED to client. Prioritize your SMART Goals/Objectives/Outcomes Both Short Term (This Shift) and Long Term (Discharge) for Both Diagnoses: Address solution of problem/nursing diagnosis. Word phrases in client behaviors/changes to be observed or reported. Give time frame. Must be realistic, measurable and individualized. "(Client will_____ by _____." Address issues related to: (for example) client harm to self (suicide, mutilation) or others, elopement, safe environment/milieu, avoidance of triggers of poor coping behaviors, physical harm due to physical limitations, potential harmful medication side effects. Plan/Interventions - **You must do a literature review on each of the 2 problems you identify and reference a peer reviewed article that supports the specific interventions that you have identified to facilitate your patient achieving the associated goals/outcomes for each (minimum 1 article for each problem identified).** What nursing interventions will be carried out to facilitate the client achieving the goals?
Specific, individualized plans/interventions for THIS client. Be sure to include: Key interventions (3 shift & 3 discharge) for

this diagnosis. Always include any key intervention specific to this diagnosis. For example, you ALWAYS evaluate suicidal ideation by asking the client directly about his thoughts about harming self. Safety: Special precautions/actions to insure safety.

CHARTING PIE NOTE:
Write a nursing note using problem oriented charting in PIE format. **This is the documentation of your actual nursing intervention for the identified problem.**
P: Problem/Nursing DX: What is the priority need(problem) you identified and addressed in your nursing care plan?
I: Intervention What interventions/actions did you carry out to help your client meet the goals and resolve the problems.
E: Evaluation: Describe **client specific responses** to your interventions/actions; did your interventions help? How will you revise your plan if needed?

Medications
Trade and generic for ALL **psych related** MEDS. Include the med name, dose, frequency, route, why (mental health reason) this client is taking (**expected therapeutic effect)**, key side effects to look for/teach about. **Describe also the actual effect and side effects observed and or reported by client for each psychotropic medication.** Identify teaching that needs to take place and formulate a plan to address deficits in knowledge; teach your patient and document what you taught and the time teaching took place.

Discharge/Teaching Plan
You are the advocate for your patient and as such must do everything you can to ensure your patient's success post discharge. Creating a thorough and comprehensive discharge plan often makes a difference in the patient's ability to overcome obstacles encountered and minimize stressors that impact the transition from inpatient to outpatient status thereby increasing the odds that the patient can circumnavigate the many challenges they may face. Your discharge plan must identify stressors and address needs; discuss lifestyle changes that should be implemented to ensure optimal recovery. **Always include the disorder, meds and safety teaching.** Address barriers? Does client/family recognize/acknowledge learning needs? Give specific teaching needed about this specific disorder (key components), specifics of meds, and safety – what specifically needs to be taught, not just general.

SELF-ASSESSMENT:
Summarize the highlights of your experience with this patient. What aspects of the diagnosis in your client are challenging for you to work with? What steps can you take to act objectively and effectively with clients experiencing this condition? What did you learn and how will you apply this to your professional practice? How do you think what you did affected your patient?

RESOURCES:
Include all references used in APA format.

NURSING CARE PLAN DOCUMENTATION FORM

Student Name: _____ **Unit:** _____ **Date:** _____

Students are responsible for thoroughly assessing their patient in order to provide safe care during current and future clinical experiences. Students are responsible for planning, implementing, and evaluating their own nursing interventions each day during their assigned rotation.
Provide supporting behavioral examples for any categories checked below—you can expand and type in the boxes below

PATIENT DEMOGRAPHICS and PSYCHOSOCIAL ASSESSMENT (Check applicable fields and provide supporting data/evidence for each checked item)	
Patient Initials: Age: Date of admission: Psych Diagnosis: Medical Diagnosis: **Gender:** Male __Female__ **Status:** Voluntary __Involuntary __ Legal Problems Y__N__Type:	
Ethnicity	Caucasian __Hispanic __Black __Asian __Native American __Other:
Symptoms	Anxiety__ Depressed Mood __Anhedonia __Sleep disturbance __ Fatigue __ Appetite Change __ Racing thoughts __ Guilt__ Grief __Hopelessness __Worry __ Hallucinations __Crying Spells __Risky behavior __Irritability__ Other:
Psychosocial Stressors	Support __Family __Abuse __Housing __Economic __Employment__ Trauma __ Education __Life-cycle transition __Healthcare access ___ Other:
Family History	Depression __Suicide __Violence __Anger __Homicide __Bipolar __ ADHD __ Schizophrenia __PTSD __Anxiety __Alcohol abuse __ Other substance abuse __ Personality Disorder __ Dementia's___ Psychosis____ Other:
Healthy Behaviors	Diet __Exercise __Spiritual Practice __Socialization __Traditions __ Other:
Substance Use Behaviors	Caffeine: Y__N__amt: __Tobacco: Y__N__amt: __Alcohol: Y__N__amt: __ Street Drugs: Y__N__amt: __type ___ Prescription Drugs: Y__N__amt: __ type ___

MENTAL STATUS ASSESSMENT	
Appearance	Appears younger __older than age __Scars __Piercings __Tattoos __ Well-nourished __Malnourished __Obese __ Other: Supporting Data:
Grooming	Well-kempt __Self neglect __Disheveled __Malodorous__ Flamboyant __Other: Provide Supporting Data:
Attitude	Cooperative __Uncooperative __Hostile __Aggressive __Inappropriate __Other: Provide Supporting Data:
Speech	Clear __Coherent __Normal __Pressured __Soft-spoken __Stuttering __Profanity __ Impoverished __Monotone __Mumbled __Slurred __Animated/Excited __ Abrupt __ Difficulty finding words __Spontaneous speech __Confabulation __ Loud__ Soft __ Impressionistic __ Little detail ___ Hesitant/Halting __Slurring words __No speech __ Poor articulation ___ Perseveration ___ Other: Provide Supporting Data:
Psychomotor	Normal gait __Propulsive gait __Shuffling gait __ Ataxic __Uncoordinated __ Grimaces __ Abnormal movements __ Tics _Hand wringing __Posture stooped __Hyperactive __ Bradykinesia__ Retarded __Agitated __Clumsy __ Unsteady __Falls easily__ Other: Provide Supporting Data:
Mood	Euthymic __ Depressed __Elevated __Reserved __Irritable __Sad __ Angry __ Despondent ___ Anxious __ Blunted__ Melancholic __ Tearful __ Other: Provide Supporting Data:
Affect	Normal Range__ Flat __Tearful __Labile __Normal Range__ Blunt __Constricted__ Sad __ Depressed __Bright __ Broad __Restricted __Inappropriate __ Congruent __ Provide Supporting Data:
Thought Process	Organized __ Clear/understandable__ Logical __ No formal thought disorder __ Concrete __ Illogical __Paranoia __ Simplistic __ Strained __ Loose associations __ Preoccupations __Perseveration __Some disorganization __ Disorganized __

	Suspiciousness __ Obsessive thoughts__ Tangential __Circumstantial __ Neologisms __ Clang associations __Word salad__ Difficult to follow __ Other: Provide Supporting Data:
Thought Content	Delusions __Illusions __Audio Hallucinations __Visual Hallucinations __ Phobias __Compulsions __Obsessions __ Preoccupations __Suicide __ Homicide __Aggression __Paranoid ideation __Depersonalization ___ Other: Provide Supporting Data:
Insight	Good __ Fair __ Poor __ Awareness of behavior and impact on others: Y__ N__ Understanding problems related to illness: Y__ N__ Agrees that illness requires treatment Y__ N__ Other: Provide Supporting Data:
Judgement	Good __ Fair __ Poor __ Difficulty predicting results of choices Y__ N__ Able to learn from some experiences Y__ N__ Able to anticipate outcomes Y__ N__ Able to use feedback & learn from mistakes Y__ N__ Other: Provide Supporting Data:
Cognition	Alert and oriented Y__ N__ No distractibility __Distracted __High distractibility __ Short-term memory intact Y__ N__ Long-term memory intact Y__ N__ Other: Provide Supporting Data:
Intellectual Ability	Average __Above average __Below average __ Intellectual Disability Diagnosis Y__ N__

RISK ASSESSMENT	
Suicide	Denies __Ideation: Y__ N__ Plan: Y__ N__ Lethality: Y__ N__ Past History: Y__ N__ **Suicide Risk:** Low__ Medium __High__
Homicide	Denies __Ideation: Y__ N__ Plan: Y__ N__ Lethality: Y__ N__ Past History: Y__ N__ **Homicide Risk:** Low__ Medium __High__
Aggression	Denies __Ideation: Y__ N__ Plan: Y__ N__ Lethality: Y__ N__ Past History: Y__ N__ **Aggression Risk:** Low__ Medium __High__
Substance Use	Denies __Current Use __Past History __ Past Treatments __ Previous 12-Step Group___ Current Use Y__ N__ Type _____Amount_____ Frequency_____ **Substance Use Risk:** Low__ Medium __High__
Psychosis	Distortion of reality __ Loss of contact with reality __ Delusions __ Hallucinations __ Thought disorder __ Social withdrawal __ Impaired role functioning __ Drug intoxication __ Metabolic causes __ Schizophrenia __ Bipolar disorder __ Schizoaffective disorder __ Family history of psychosis __ Patient history of psychosis __ **Psychosis Risk:** Low__ Medium __High__
Falls	**Age:** <59__ 60 - 69 years _70 -79 years __80 + years __ Fall History__ **Medications:** On 1 high fall risk drug __ On 2 or more high fall risk drugs __ **Mobility:** Requires assistance or supervision for mobility, transfer, ambulation __ Unsteady gait __ Visual or auditory impairment affecting mobility __ **Cognition:** Altered awareness of immediate environment __ Impulsive __ Lack of understanding of physical/cognitive limitations __ **Falls Risk:** Low__ Medium __High__

PATIENTS PERSPECTIVE (use quotes)	
Chief Complaint (per client)	
Beliefs regarding mental illness	
Identifies/Describes diagnosis	

Identifies/Describes Meds & purpose	
Perceived personal strengths & resources	
Patients goals for this treatment	

Maslow's Hierarchy of Needs: What are your safety concerns, prioritized problems/needs and the rationales based on Maslow's Hierarchy of needs?	
Erikson Stages of Development: identify which stage patient is functioning in and describe behavior to support your findings. Example: Intimacy vs. isolation	

NURSING PROCESS 1st Priority	
What is your priority need for this patient?	
What psych nursing diagnosis aligns with this priority?	
What are the patient goals for your priority diagnosis (How will you know if your plan is working)?	Shift goal(Short-Term): Discharge goal(Long-Term):
What nursing interventions are needed to help your patient achieve each goal and resolve the priority need (Nursing Diagnosis)? Provide an evidenced based rationale for each intervention.	**Shift goal** 1. Rationale: 2. Rationale: 3. Rationale: **Discharge goal** 1. Rationale: 2. Rationale:

	3. Rationale:
DOCUMENTATION 1st Priority	
P. Patient Problem: Your assessment of the identified nursing priority and related behaviors, emotional status, etc.	
I. Nursing Interventions: how you addressed your patient's problem. This includes the specific nursing interventions implemented, teaching provided to your patient	
E. Evaluation/Patient response to care. Describes the actual response of your patient after you have implemented your interventions for each problem. Was the goal met and if not, what do you need to do now?	

NURSING PROCESS 2nd Priority	
What is your second need for this patient?	
What psych nursing diagnosis aligns with this priority?	
What are the goals for your priority diagnosis (How will you know if your plan is working)?	Shift goal(Short-Term): Discharge goal(Long-Term):
What nursing interventions are needed to help your patient achieve each goal and resolve the priority need (Nursing Diagnosis)? Identify a rationale for each intervention.	**Shift goal** 1. Rationale: 2. Rationale: 3. Rationale: **Discharge goal** 1.

	Rationale: 2. Rationale: 3. Rationale:
DOCUMENTATION 2nd Priority	
P. Problem **Your assessment of the identified nursing priority and related behaviors, emotional status, etc.**	
I. Interventions **how you addressed your patient's problem. This includes the specific nursing interventions implemented, teaching provided to your patient**	
E. Evaluation **Describes the actual response of your patient after you have implemented your interventions for each problem. Was the goal met and if not, what do you need to do now?**	

MEDICATIONS				
Generic/Trade Name Dose/Route/Time	**Classification / Therapeutic Effect of Med**	**Side, Adverse Effects/ Nursing Actions**	**Identify teaching Needed for each psych med**	**Time You Completed Teaching your patient about their Meds**

DISCHARGE/TEACHING PLAN (Identify Each Parameter)	
Current Stressors and What You Will Teach To Help Patient Adapt	
Potential Barriers to Change & How to Minimize	
Patient/Family Teaching	

SELF ASSESSMENT

Summarize the highlights of this clinical day: What did you learn and how will you apply this to your professional practice?
How do you think what you did affected your patient?

References (including peer reviewed article that supports the specific interventions):

Rubric for Nursing Care Plan

Description

Nursing Care Plan

Rubric Detail

Criteria	Target	Acceptable	Unacceptable
Selects client and collects data and includes on form	Selects appropriate client, uses all available resources to collect comprehensive data completing all data collection components (Mental health medical diagnoses /history, MSE, Suicide ideation, Homicide ideation, Aggression, Psychosis, Falls, Substance use, Patients perception of illness and medications). 14 – 20 points	Selects appropriate client. All components addressed but not fully; or not all components addressed (Mental health medical diagnoses /history, Predisposing factors, Precipitating factors, Labs, MSE, Suicide ideation, Homicide ideation, Aggression, patient's perception of illness and medications). 7 – 13 points	Selects inappropriate client, minimally addresses or does not address components (Mental health medical diagnoses /history, Predisposing factors, Precipitating factors, Labs, MSE, Suicide ideation, Homicide ideation, Aggression, patient's perception of illness and medications). 0 – 6 points
Prioritizes problems and includes on form	Identifies 2 priority needs for selected patient based on data collection and accurate interpretation of client needs (Maslow). 8 – 10 points	Identifies 2 psych related nursing problems /other intervention areas based on data collection but not accurate interpretation of client needs (Maslow) or does not include meaningful rationale. 4 – 7 points	Problems/other intervention areas, not connected to data collected. Interpretation or rationale inaccurate or not included. Any areas of form left blank. 0 – 3 points
Formulates appropriate nursing diagnosis	Accurately interprets information gathered in the comprehensive data collection, MSE, and Maslow's to develop 2 nursing diagnoses that align with the identified priority needs. 12 – 15 points	Interprets information gathered in the comprehensive data collection, MSE, and Maslow's to develop accurate nursing diagnoses with few inaccuracies. 6 – 11 points	Interpretation of information gathered in the comprehensive data collection, MSE, and Maslow's to develop accurate nursing diagnoses contains numerous inaccuracies. 0 – 5 points

Formulates Plan of Care and includes on form	Identifies individualized plan of care clearly based on the 2-prioritized psych related problems by including 2 clearly realistic, measurable, timed goals – one for the shift and one for discharge for each identified problem. Includes 3 key interventions for each. Completes Discharge Plan 12 – 15 points	Formulates a plan of care not clearly based on 2-prioritized psych related problems or not clearly individualized Includes 2 goals not clearly realistic, measurable, and timed. Includes 3 key interventions. Completes a discharge plan but lacks detail/ missing key information 6 – 11 points	Plan of care not based on 2-prioritized psych related problems or not clearly individualized. Does not include both goals and/or they are not realistic, measurable, or timed; missing key interventions. Discharge plan missing. 0 – 5 points
Completes client interventions and includes on form	Meets with the client during day and therapeutically completes planned interventions or completes realistic revisions based on new data. Seeks input from instructor if problem arises. 12 – 15 points	Meets with the client during day but does not complete plan or make entirely realistic revisions based on client status. Seeks input from instructor in a timely manner if problems arise. 6 – 11 points	Fails to meet with client during day or fails to revise plan as needed based on client status. Does not seek input from instructor in a timely manner. 0 – 5 points
Documents and Evaluates results of interventions and includes on form	Evaluates the success of interventions by completely and accurately documenting a PIE note about the interventions and progress of both identified problems and any needed revisions in plan. Includes the patient's perspective. 12 – 15 points	Evaluates the success of interventions by documenting a PIE note about the interventions and progress of identified problems and needed revisions in plan. Note has basic components, but is not thorough or well written. Patient's perspective not fully addressed. 6 – 11 points	Does not evaluate the success of interventions by either not documenting or incorrectly documenting a PIE note about the interventions and progress of both identified problems and any needed revisions in plan. Areas of form left blank. Does not include patient's perspective. 0 – 5 points
Self-Assessment and References	Includes self-assessment. Accurately references materials researched in APA format. 8 – 10 points	Includes self-assessment but some information is missing or lacks detail. Accurately references materials researched in APA format. 4 – 7 points	References are missing, incorrect order, misspelled, mislabeled. Does not include self-assessment 0 – 3 points

PROCESS RECORDING ASSIGNMENT

I. **Purpose:** A process recording provides a means of collecting, interpreting, analyzing, and synthesizing data gathered during a nurse-patient therapeutic encounter. The purpose is to critically evaluate your communication with your patient and its impact on behavioral change, leading to improved quality of therapeutic communication patterns with your patients.

II. **Description:** Students will conduct an approximately 15 min therapeutic interview with an assigned client noting all of the critical details and analyzing the interaction after completion. One satisfactory process recording is required.

III. Link to Course Objectives:

a. Apply knowledge from the art and science of nursing and other scientific and humanistic disciplines in the provision of holistic psychiatric-mental health care of individuals, families, and groups.
b. Use analytical and critical reasoning for clinical judgment and nursing decision-making.
c. Use therapeutic communication techniques and effective interpersonal skills in the provision of psychiatric-mental health care of individuals, families, and groups.
d. Employ collaboration between individuals, families, and others in establishing priorities for the provision of competent and cost-effective psychiatric-mental health care that promotes health and prevents illness.

IV. **Steps to Follow:**

a. Introductory/orientation phase: Set a time to meet with your client. Select a setting that is conducive to a therapeutic interaction. Decide on a therapeutic goal for the session. Share the parameters with your client. Help your patient feel comfortable and establish rapport. Use therapeutic communication techniques such as a broad opening to begin your therapeutic encounter on a feelings level, focusing on the patients' issues, stressors, problems and concerns
b. Working Phase/Termination phases: Begin your therapeutic interview, carefully observing the client and yourself for verbal and non-verbal behavior. Use therapeutic communication techniques such as a broad opening to begin your therapeutic encounter on a feelings level, focusing on the patient 's issues, stressors, problems and concerns
c. Complete at least 15 - 20 back and forth exchanges (each Nurse said/Pt. said = 1 interaction). You will use a minimum of 1 orientation phase exchange, 10 working phase exchanges and 1 termination/summary phase exchanges for the IPR paper.
d. Terminate the interview therapeutically, summarizing the highlights of the encounter.
e. The process recording has a disadvantage as it relies on memory and may be subject to distortions. It is best if you write verbatim (word for word) notes in a private area immediately after the therapeutic encounter takes place. Go to a quiet place to record as much as possible of the client, setting, introduction, verbal, non-verbal, thoughts, feelings and content from memory. Identify verbal with "quotes", non-verbal with "NV", thoughts with "T" and feelings with "F".
f. Use your text and notes to fully complete the analysis of the interview, your feelings, identifying which specific techniques you used, rationale for use, blocks, alternative techniques that might have been more therapeutic. Include an analysis for each interaction and the summary.

II. **Due Dates:** Submit on Blackboard. The clinical instructor will determine any exceptions for late or incomplete assignments

III. **Grading:** Must achieve a minimum of 70% on all clinical assignments to pass clinical.

IV. The process recording has a disadvantage as it relies on memory and may be subject to distortions. It is best if you write verbatim (word for word) notes in a private area immediately after the therapeutic encounter takes place.

Use the rubric to guide your work on this assignment
Pass: 70-100
Fail: 0-69

PROCESS RECORDING GUIDELINES

INTRODUCTION

Communication is an essential component of the nurse-patient relationship. It impacts the nurse's ability to positively influence the therapeutic relationship, moving clients towards an exploration of their feelings and attainment of their treatment goals. The process recording is a written record and analysis of the therapeutic communication (both verbal and nonverbal) between the nurse and her client. This exercise affords the student nurse an opportunity to analyze communication in an objective manner and examine the content and the process of the nurse-client interaction. Benefits include: learning to pay attention to the communication process; reflecting on the significance of nonverbal behaviors, and becoming comfortable using a variety of therapeutic communication techniques; becoming more self-aware by reconstructing and analyzing both your responses and those of your clients; and developing the ability to purposefully guide the process of the nurse-client relationship.

OBJECTIVES

- Identify 2 specific goals and teaching for your therapeutic encounter.
- Initiate the nurse-client relationship using therapeutic communication techniques.
- Identify and describe both verbal and nonverbal data.
- Identify and describe therapeutic communication techniques used and rationale for use.
- Analyze blocks and alternatives to therapeutic communication techniques.
- Identify and analyze the nurse's thoughts and feelings.

Include the following when filling out the Process Recording Form:

Objectives for Interaction with Client: **You must plan, identify and state your specific goals for your therapeutic encounter with the specific patient you have identified for your process recording assignment. This is a planned professional therapeutic encounter, not a random interaction, and as such must have specific objectives.** Prior to your therapeutic encounter with the patient for whom you will do a process recording, you identify two objectives for the meeting. Record your objectives prior to beginning your process recording to turn in to your clinical instructor. The objectives must be specific and measurable and identify a change in the client's behavior and function as a result of your interaction with your patient.

Setting: Describe your client including initials, age, diagnosis, ethnicity, and appearance. The orientation phase should be identified in the setting, including your initial efforts to establish rapport and identify goals of the communication. Describe the setting and environmental factors that affect the interaction including temperature, intrusions, noise level, distractions and lighting. Nurse and Client Interactions: **FOR EACH EXCHANGE,** record and analyze the words spoken by you and your client verbatim from memory **(you may not take notes or record conversations).** Also, observe and record nonverbal cues for both the nurse and the patient such as body posture, quality of eye contact, tone of voice, rate of speech, affect, mood and changes in facial expressions. Every communication (Student nurse said-patient said) will be referred to as "an exchange." You must record a minimum of ten exchanges in the working phase, plus one introductory exchange and one termination exchange. This content should encompass the working phase of the nurse-client relationship and not include any exchanges that take place in the orientation phase (i.e. introductions, small talk, ice breakers) as any **exchanges that are not in the working phase will not be counted as part of the minimum 10 exchanges.**

Analysis: FOR EACH EXCHANGE identify the therapeutic communication techniques utilized and rationale for use in each of the exchanges between you and your client. Identify any blocks and evaluate what you might have said and done differently to elicit communication at a feelings level (write in direct quotes what should have been said to change this from a non-therapeutic to therapeutic communication) and further the therapeutic communication process. Reflect after each exchange and identify your thoughts and your feelings (distinguishing between the 2) that occurred during that exchange.

Summary: Summarize your overall impressions of the therapeutic encounter, and assess the role that the setting played in the communication process. Critically evaluate the effectiveness and therapeutic value of your exchanges and how you managed termination of the therapeutic encounter. Discuss therapeutic communication techniques that were most useful and lessons learned from this interaction. Identify areas for improvement for the next interaction and any themes which you would continue to explore with your client. **Thoughtfully address the goal you set for the therapeutic encounter with your patient and discuss whether you were able to achieve that goal and what could you have done differently.**

The Process Recording is a learning tool and is supposed to be a critical analysis of your encounter. It does not have to be perfect; it is evaluated according to whether you thoughtfully and critically analyzed the interaction, correctly and comprehensively recorded all information, made corrections when there were actual or potential blocks, identified therapeutic techniques used and appropriate rationales, and identified your references.

Student Name_____ **Date**_____ **Unit of Interaction**_____

PROCESS RECORDING

Client, Diagnosis, Setting and Introductory/Orientation Phase

Client's Initials: **Age:** **Ethnicity:** **Gender**: **Client's Diagnosis**:

What are your objectives for this interaction?
1.
2.

Client's Appearance:

Description of the Setting:

Introductory/Orientation Phase

Student Nurse	Client	Analysis
Verbal:	**Verbal:**	**Specific Technique Used**: **Rationale**: **Any blocks and/or examples of better wording or behavior**:
Nonverbal:	**Nonverbal:**	**Student's Thoughts:** **Student's Feelings**:

Working Phase

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #1
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #2
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #3
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #4
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #5
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #6
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #7
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #8
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #9

Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Nurse Interaction: Verbal and Nonverbal **Verbal in quotes**	Client Interaction: Verbal and Nonverbal **Verbal in quotes**	Analysis of Exchange #10
Verbal: **Nonverbal**:	**Verbal**: **Nonverbal**:	**Specific Technique Used**: **Rationale**: **Any blocks and examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Termination (Closing) Exchange:

Student Nurse	Client	Analysis
Verbal:	**Verbal:**	**Specific Technique Used**: **Rationale**:

Nonverbal:	**Nonverbal:**	**Any blocks and/or examples of better wording or behavior**: **Student's Thoughts:** **Student's Feelings**:

Summary:

Overall Impressions of the therapeutic encounter:

Role the Setting played in the encounter:

Evaluation (effectiveness and therapeutic value of exchanges):

Identify techniques that were most useful and discuss why they worked or didn't:

Describe how you met the goals/objectives that you set for the therapeutic encounter with this patient?

Areas for self-improvement:

Lessons learned:

References:

Rubric for Process Recording

Rubric Detail

Criteria	Target	Acceptable	Unacceptable
Sets up interview therapeutically. Identifies diagnosis. Gives a description of setting and client. States a specific goal for the interaction. Includes the 'Introductory' interaction.	All required components of setting and summary are fully and thoughtfully addressed. Identifies goals. 20 – 25 points	All components addressed, but not fully or not all components addressed. 10 – 19 points	Minimally addresses or does not address components. 0 – 9 points
Records verbal and non-verbal conversation of the working phase with a minimum of 10 interactions.	Clearly records and identifies a minimum of 10 verbal and 10 nonverbal 'working phase' interactions. Includes both the introductory and termination exchange. 20 – 25 points	Most components clearly recorded; a minimum of 9 verbal and 9 nonverbal 'working phase' interactions and the introductory and termination exchange included. 10 – 19 points	Missing components or conversation is not clearly recorded. Missing more than 2 exchanges. 0 – 9 points
Analyzes Interaction	Correctly identifies each therapeutic communication technique used and the rationale for the use of each (use table in text), identifies blocks and an example of a more therapeutic verbal (must have a minimum of 1) with example. Both student's thoughts and feelings are addressed. 20 – 25 points	Correctly identifies most techniques used, blocks, alternative action correctly identified with example. Thoughts and feelings not complete for each interaction. 19 – 19 points	Incorrect identification of correct technique, blocks, alternative actions, no examples. Doesn't distinguish between thoughts feelings. 0 – 9 points
Summary Page	Includes a thoughtful and substantive response with depth of detail on each field of the termination page. Thoroughly addresses goal and teaching 16 – 20 points	All areas addressed, but not adequately; lacks depth of detail. 10 – 15 points	Not all areas are addressed, or are addressed inadequately and / or erroneously. 0 – 9 points

Mechanics (accuracy of writing), References	Accurate use of quotation marks, correct spelling, references in APA format. 5 - 5 points	Mostly accurate grammar, but several inaccuracies in spelling, APA, quotations. 2 – 4 points	Numerous errors in grammar, missing key components. 0 – 1 points

Evidence-Based Practice in Psychiatric Mental-Health Nursing Clinical Poster

I. Purpose: To provide an opportunity to evaluate recent literature related to a relevant and effective intervention for clients with a psychiatric diagnosis. A poster presentation will also provide you with an experience that will facilitate professional nursing role development. Posters are a strategy used to communicate relevant ideas and important data.

II. Description: The poster should summarize key concepts with less use of narrative text than a paper and should make use of illustrations, outlines, tables, and diagrams. The poster should be visually appealing and easy to read. Your poster should be the size of a standard piece of poster board and have a title and your name on it. Use this link for more information on creating a poster: http://www.ncsu.edu/project/posters/
For more online poster creation tutorials see:
• Poster Production Show (http://www.dartmouth.edu/~wisp/PosterShow/index.html): Online tutorial with examples, created for Dartmouth's Women in Science Project (WISP). Although the tutorial contains some information specific to WISP, it provides extensive general guidelines on poster content and design.
• UW School of Public Health, "Creating a Presentation Using MS PowerPoint" (http://depts.washington.edu/mphpract/ppposter.html): Advice on poster sections, potential organization schemes, and layout. Also includes detailed instructions on using PowerPoint to create your poster
Link to Course Objectives:

a. Use analytical and critical reasoning for clinical judgment and nursing decision-making.
b. Employ collaboration between individuals, families, and others in establishing priorities for the provision of competent and cost-effective psychiatric-mental health care that promotes health and prevents illness.
c. Employ informatics in the planning, delivery, and evaluation of psychiatric-mental health care of individuals, families, and groups.

III. Steps to Follow:
I. Your clinical instructor will assign you one of the following interventions: (you must pull in literature beyond the course syllabus). Topics may include(discuss others with your clinical instructor): Trauma Informed Care; Collaborative Problem Solving; Comfort and Sensory Rooms; Eye Movement Desensitization and Reprocessing (EMDR); Dialectical Behavior Therapy (DBT); Use of Genetics and Epigenetics in Psychiatry; Mindfulness-based cognitive therapy (MBCT); Schema-focused therapy; Solution-focused brief therapy (SFBT); Narrative Therapy; Impact of physical punishment on Mental Health of Children and Impact of violent video games on mental health of children
II. Create a poster that addresses the following questions:
a) Describe the intervention, include the key components that must be present in order for the intervention to have reliability and validity.
b) What are the targets, the goals and the desired outcomes of this intervention; how is progress toward these outcomes monitored and achieved?
c) Describe the evidence that supports this intervention (summarize key relevant peer-reviewed literature in an APA pinch-table (evidence table) format that includes author, sample, study objectives, interventions tested and outcome measures, design, results, study limitations, results, implications.
http://researchguides.ebling.library.wisc.edu/c.php?g=293229&p=1953450 The literature review for this assignment must extend beyond all required and recommended readings for N3481).
d) Describe additional research emphasis that is needed to enhance the level of empirical support for this intervention, or to demonstrate its effectiveness with key populations?
e) Create a poster reprint that includes all the content in your poster with enough copies for everyone in your clinical group including faculty (you can provide a version that reads like a professional paper).
f) Create and include an American Psychological Association (APA) reference list (this should be taped to the back of your poster along with the clinical handout).

IV. Due Dates as assigned by clinical instructor.
The clinical instructor will determine any exceptions for late or incomplete assignments.

V. Grading: Must achieve a minimum of 70% on all clinical assignments to pass clinical.

Use the rubric to guide your work on this assignment
Pass: 70-100, Fail: 0-69

Evidenced-Based Poster Presentation Planning and Objectives Form

GROUP MEMBERS (NO MORE THAN 3)	PROJECT RESPONSIBILITY
1.	
2.	
3.	

Topic of Evidenced-Based Poster Presentation:

Describe Target Group: (Who is your target group, and what characteristics are important to know to teach this group effectively?)

Identified Learning Needs: (Include why you chose this topic for this group?)

Smart Objectives/Outcomes: (List 3-5 specific, realistic, measurable outcome behaviors the target group will display at end of teaching . Example: As a result of this **Evidenced-Based Poster Presentation**, clients will …….

Description of Evidenced-Based Poster Presentation Handout (include pictures etc.):

References (include minimum of 5 evidence based research articles on topic in APA format)

Topic Approved by Clinical Instructor: Instructors Initials_____ **Date** _____

This portion of the form must be turned in to instructor two weeks prior to presentation and also submitted on Blackboard with the Evidenced-Based Poster Presentation group Evaluation Form and Handout after the presentation.

Rubric for Evidenced-Based Poster Presentation

Description

Evidence-Based Practice in Psychiatric Mental-Health Nursing Clinical Poster Presentation

Rubric Detail

Criteria	Target	Acceptable	Unacceptable
Use of Professional Literature	Appropriate and effective information is present to address the topic and justify use of the intervention. 17 – 20 points	Lacks some detail but sufficient information is present to address the topic and justify use of the intervention. 10 – 16 points	Fields are missing, inadequate and / or erroneous. 0 – 9 points
Comprehensive Pinch-table of all Evidenced-based Studies	Each field is complete, detailed and relevant. Demonstrates ability to critically assess, synthesize, and organize the information gathered in a completed pinch-table. 17 – 20 points	Most fields are complete, fairly detailed and relevant. Demonstrates ability to critically assess, synthesize, and organize the information gathered in a completed pinch-table. 10 – 16 points	Fields are incomplete, not detailed or relevant. Limited ability to critically assess, synthesize, and organize the information gathered in a completed pinch-table. 0 – 9 points
Poster Presentation Board of Selected Topic	Submission is visual appealing. Excellent use of illustrations, outlines, tables & diagrams. Demonstrates clarity and specificity of the content presented on the poster. Poster is readable, well-organized. Attached reference list and synopsis for peers/instructor affixed to the back of the poster. Minimum of 5 peer-reviewed references included in the pinch-table. 30 – 40 points	Poster is somewhat visually appealing. Competent use of illustrations, outlines, tables & diagrams. Demonstrates clarity and specificity of the content presented on the poster. Poster is readable, well-organized. Attached reference list and synopsis for peers/instructor affixed to the back of the poster. Minimum of 5 peer-reviewed references included in the pinch-table. 20 – 20 points	Poster is not visually appealing or easy to read. limited use of illustrations, outlines, tables & diagrams. Lack of clarity and specificity of the content presented on the poster. Poster not well-organized. Reference list and synopsis for peers/instructor affixed to the back of the poster but incomplete. Less than 5 peer-reviewed references included in the pinch-table. 0 – 19 points
Grammatical Quality of the Poster	Content is well organized, no typos, excellent grammar, follows APA guidelines for all citations and referencing. 9 – 10 points	Content is somewhat well organized, fair grammar, 2 or less typos, follows APA guidelines for all citations and referencing. 5 – 8 points	Content is not well organized, 3 or more typos, poor grammar, APA guidelines for citations and referencing incomplete or missing. 0 – 4 points

Verbal Poster Presentation	The presenter gives a clear, organized, succinct summary of his/her project's contents and adequately answers viewer questions. A poster handout is provided for each group member and the clinical instructor. 9 – 10 points	The presenter gives a clear, organized, succinct summary of his/her project's contents and adequately answers viewer questions. Poster handouts are provided for group members but missing 1. 5 – 8 points	The presentation is not clear, organized, succinct; summary of his/her project's contents is inadequate and/or unable to answer viewer questions. Poster handouts are provided for group members but missing more than 1. 0 – 4 points

Poster-Presentation Group Work Evaluation

Description: Group-members evaluations of the poster-presentation group work.
Step-by-Step Procedure:

1. Overall, how effective did your group work together on this assignment? (Check the appropriate response)
   • Poorly • Adequately • Well • Extremely well
2. How many of the group members participated actively most of the time? (Check the appropriate response)
   • 0 • 1 • 2 • 3 • 4 • 5
3. How many of you were fully prepared for the group-work most of the time? (Check the appropriate response)
   • 0 • 1 • 2 • 3 • 4 • 5
4. Give one specific example of something you learned from the group that you probably wouldn't have learned working alone.
5. Give one specific example of something the other group members learned from you that they probably wouldn't have learned otherwise.
6. Give one specific change that the group could make to improve its performance.

Clinical Evaluation of Nursing Student: Formative (Midterm) and Summative (Final)

Name_____ **Semester** _____**Year**_____
Clinical Instructor_____
Directions: Follow guidelines Include comments page 2. **Key: S = Satisfactory N = Needs Improvement U = Unsatisfactory**

			Formative	
Summative				
	Student	**Instructor**	**Student**	**Instructor**
Professional Accountability: Follows university, College of nursing, and agency policies for behavior and dress. Follows guidelines for expected clinical behaviors in course syllabus and clinical packet. Demonstrates civility in all interactions with faculty, peers, staff and patients. Maintains confidentiality. Maintains appropriate boundaries. Communicates appropriately. Demonstrate collegiality while working as a member of the mental-health care team. Articulate awareness of standards and scope of practice related to personal level of competency. Meets expected time frame for clinical practice. Turns in assignments on time. Behaves ethically. Seeks help appropriately. Takes responsibility for own learning. Responsibly participates as a group member. Evaluates self, therapeutic use of self, experiences, and agency. Related Clinical Objectives #s 6, 8, 10, 11. Related Student Learning Outcomes: 1,2, 3, 5, 6, 7, 8, 9				
Nursing Process: Applies the Nursing Process in the care of patients, families, and groups encountered in clinical experiences.				
Assessment: Reflecting holistic and biopsychosocial considerations, **t**horoughly gathers data by interviewing skills, observations of behavior, and review of records. Seeks input from health care team and family where indicated and possible. Related Clinical Objectives #s 1, 2, 3, 7, 8, 9. Related Student Learning Outcomes: 1, 2, 3, 4, 5, 7, 9				
Problem Diagnosis, Patient Objectives/Outcomes/Goals, Plan of Care: Develop and implement nursing care plans that meet the needs of assigned psychiatric/mental health clients. Uses critical analysis to prioritize patient problems based on data collected. Plans realistic, individualized, measurable short term and/or long term objectives/outcomes/goals. Includes patient in planning of care. Plans nursing interventions. Related Clinical Objectives #s 1, 2, 3, 4, 5, 7, 8, 9. Related Student Learning Outcomes: 1, 2, 3, 4, 6, 7, 9				
Implementation of Care: Safely provides care including use of effective verbal and non-verbal communication, observation of therapeutic effects and side effects of medications; maintenance of therapeutic milieu, and maintenance of environment. Develop and implement teaching and learning plans that meet the needs of assigned psychiatric/mental health clients Related Clinical Objectives #s 3, 6, 7, 8, 9, 10. Related Student Learning Outcomes: 1,2, 3, 4, 5, 7				
Evaluation of Patient objectives/outcomes/goals: Evaluates whether patient achieved objectives/outcomes/goals. Adjusts plan accordingly. Evaluates process of interventions and determines changes needed. Related Clinical Objectives #s 10, and all others. Related Student Learning Outcomes: 1,2, 3, 5, 6, 7, 9				

I have read and understand the criteria by which I am evaluated.

_____
Student Signature **Date**

Midterm Review Signatures: **Final Review Signatures:**

Faculty	**Date**	**Faculty**	**Date**
Student	**Date**	**Student**	**Date**

Formative (Midterm) Comments:

Student:
Faculty:

Summative (Final) Comments:

Student:			
Faculty:			
Student has Completed all ten essential skills for this clinical course and all clinical assignments are completed.	**Met standard**	**Did not meet standard**	**List of missing skills:**

Guidelines for Clinical Evaluation of Nursing Student Midterm and Final in NURS 3481
1. Evaluation of student's clinical performance progress is carried out by student and instructor and is based on the student's behaviors and written clinical work. Standards for behaviors and performance are found in the course syllabus, course textbook, clinical packet, and student handbook.
2. Students are to submit their self-evaluation at the time designated and prior to the instructor's evaluation.
3. A designation is made of Satisfactory, S; Needs Improvement, N; or Unsatisfactory, U. Unsatisfactory behavior or performance is that which is failing. Behaviors are critiqued based on the level of behaviors expected of the student for the level of the course and the time in the semester. Behaviors acceptable at midterm may not be acceptable at the time of final evaluation. Some behaviors are critical. For example, a breach in safety that jeopardizes the health of a client is a critical behavior. Failure to meet the expectations of a critical behavior may result in course failure. **Unsatisfactory performance in any area at the end of the course results in failure of meeting clinical objectives and failure of the course.**
4. During the semester, unsatisfactory student performance or behavior will result in a contract for improvement being made with the student. Criteria for improvement and resolution of the problem must be completed in order to receive a satisfactory designation.
5. Supporting comments are recorded above by students and faculty.

SBAR

End of Shift/Post Conference Report

Student Name: _____ Date: _____

<table>
<tr><td colspan="8">Client initials/Age/Sex/Ethnicity:</td></tr>
<tr><td>S:
Situation</td><td>Psychiatric Diagnoses</td><td colspan="3">Medical Dx</td><td colspan="3">Current issue</td></tr>
<tr><td>B:
Background</td><td>Reason for admission</td><td colspan="2">Psych History</td><td>Precautions</td><td colspan="3">Psychosocial/Environmental Info</td></tr>
<tr><td>A:
Assessment</td><td><u>MSE Info</u>
• Appearance
• Behavior
• Speech
• Mood/Affect
• Thought Process
• Thought Content
• Perceptual Disturbances
• Insight/Judgment</td><td>SI</td><td>HI</td><td>Vitals</td><td>Meds (including PRN’s given)</td><td>Relevant Labs & Additional Info</td></tr>
<tr><td>R:
Recommended Actions</td><td colspan="7">Suggested plan of care: Provide PSYCH nursing diagnosis with 2 key <u>NURSING</u> interventions</td></tr>
</table>

Guidelines: Complete during your clinical day, bring to post-conference and use to report on your patient to clinical group. Turn-in to clinical instructor at the end of post-conference. You will verbally report what a new nurse needs to know to provide continuity of care for your patient.