Los Angeles Harbor College

Associate Degree Nursing Program

Nursing 343

Clinic Syllabus

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LOS ANGELES HARBOR COLLEGE
Associate Degree Nursing Program
NURSING 343 CLINICAL OBJECTIVES

STUDENT LEARNING OUTCOMES/COMPETENCIES:

At this level, which comprises courses in the third and fourth semester of the nursing program, students are expected to continue to apply and adapt medical surgical nursing concepts to patients across the life span in a variety of health care settings, modify plan of care and make decisions for patients at a variety of developmental stages on the basis of general guidelines or principles derived from previous experiences, organize and prioritize nursing interventions with supervision, and use appropriate resources to assist in solving patient problems. The student can adapt to different age groups basic skills and develops new skills applying guidelines that are based on cues from experts. They attempt to correlate and build on medical surgical theory and practice.

Program Learning Outcomes for level three are:

1. **Apply** the nursing process using the Roy Adaptation Model in caring for individuals and groups across the lifespan and in various developmental stages.
2. **Practice** professional behavior standards of nursing practice.
3. **Demonstrate** clinical decision making that is accurate and safe.
4. **Provide** safe, patient-centered care.
5. **Function** effectively within nursing and interprofessional teams utilizing effective communication strategies.
6. **Incorporate** evidence-based practices, which support clinical reasoning.
7. **Identify** areas for improvement in quality and safety of health care systems.
8. **Utilize** technology to research patient information, communicate with interprofessional teams, manage knowledge, mitigate error, and support decision-making.

CLINICAL COURSE OUTCOMES/COMPETENCIES:
At the end of this course, with appropriate study and practice in the classroom and clinical experience, the fourth semester student nurse will be able to assess, analyze and contribute to the medical and psychosocial needs of the mental health patient in the psychiatric setting. The student will focus on the patient as a whole while meeting nursing needs in the Physiological Mode, as well as therapeutic needs in Self-concept, Role Function and Interdependence Modes. Refer to the list of Student Learning Outcomes (1-8) above that will be identified and matched to its related course outcome at the end of each competency in parentheses. The nursing student will be able to:

1. Demonstrate behaviors consistent with the Behavioral Health Care National Patient Safety Goals and Patient Rights under the Lanterman-Petris-Short Act for clients in a mental health setting (1,2 3,4, 5, 6, 7,8).
2. Differentiate between social and therapeutic communication (2,4,5).
3. Internalize therapeutic communication techniques consistently during patient interactions (2,3,5,8).
4. Establish and maintain nurse-patient boundaries (2, 3, 4).
5. Relate overt patient behavior to covert stimuli and recognize manipulative behavior (1,3,4,5).
6. Appropriately manage the phenomenon of transference and countertransference in the therapeutic relationship (2, 3, 4).
7. Differentiate between giving advice and assisting the problem-solving process (3, 4, 6).
8. Recognize and challenge personal biases and stereotypes related to people with mental health challenges (2, 4, 7).

9. Process personal responses and patterns of coping in relation to the nurse-patient relationship and exposure to the psychiatric environment (2, 3, 4).
10. Appraise personal strengths and weaknesses in the psychiatric setting.
11. Evaluate information systems including the Internet and other computer assisted learning methods to research psychiatric conditions and locate the most current evidence-based information on each condition.
12. Compile Psychiatric Pathophysiology Sheets and Nursing History and Assessments that including medical and psychiatric history, laboratory data, diagnostic procedure reports, etiology, pathophysiology and detailed assessments of all four modes (1, 3, 4, 6, 8).
13. Conduct Mental Status Assessments competently and accurately (1,3, 4).
14. Demonstrate concise, accurate, and complete written or electronic documentation skills avoiding terms included in the national do not use list (2, 4, 5, 8).
15. Develop cultural awareness and growth in cultural competence (3, 4, 6, 7, 8).
16. Collaborate with the patient, significant others, faculty and staff in planning care and goal setting (3, 4, 5, 8).
17. Integrate patient's age, sexuality, ethnicity, culture, and spiritual components in the planning and implementation of patient outcomes (1, 4, 6, 8).
18. Demonstrate critical thinking ability by creating and prioritizing Nursing Care Plans that identify ineffective behaviors, manipulatable stimuli, nursing diagnoses, outcomes and evidence-based interventions with a focus on psychological problems related to physiologic, self-concept, role function and interdependence modes (1,3, 4, 6).
19. Assesses the patient's teaching-learning needs, identify teaching opportunities, implement appropriate, accurate short-term teaching and information giving and evaluate patient learning (1, 4, 6, 8).
20. Promote patient safety by seeking supervision and assistance when unfamiliar with or lacking knowledge of an intervention, policy or procedure (2, 3, 4, 5, 6, 7, 8).
21. Report significant clinical findings immediately to the appropriate persons in a timely manner including suicidal ideation and any form of self-harm (1, 2, 3, 4, 5).
22. Intervene to orient the patient to reality, assist in re-establishing the patient's socialization and decision-making capabilities (1, 3, 4, 5, 6).
23. Teach stress management techniques to patients including behavioral approaches (meditation, guided imagery, breathing exercises, muscle relaxation, and biofeedback) and cognitive approaches (journal keeping, priority restructuring, cognitive reframing, humor, assertiveness training) (3, 4, 5, 6, 8).
24. Differentiate sympathy versus empathy.
25. Objectively evaluate the patient's responses to care and to the effectiveness of the therapeutic interventions utilized to enhance wellness (1, 3, 4, 5, 6, 8).
26. Relate knowledge of the mechanism of action, dosage range, routes, drug interactions, therapeutic effect, side effects, and nursing implications of all medications prescribed to the patient (2, 3, 4, 5, 6, 7, 8).
27. Identify the location and correct use of alarm codes, alarms and emergency equipment, phone systems, evacuation plan and means to call an appropriate code (2, 3, 4, 5).
28. Maintain the safety and integrity of the locked status of the units (2, 3, 4).
29. Report, record, and document all care, responses and events accurately and in a timely manner, completing all the required forms correctly (2, 3, 4, 5).
30. Report all pertinent patient care given, and patient responses to care, to the primary nurse prior to leaving the unit (2, 3, 4, 5).

CLINICAL PERFORMANCE STANDARDS:

The Student will:

1. Participate in the daily activities of assigned patients, attending all unit meetings, groups, and activities.
2. Seek out opportunities to practice therapeutic communication with all types of patients in addition to assigned patient(s).
3. Document therapeutic communication interactions on assigned patients correctly identifying therapeutic or blocking techniques and proposing alternative therapeutic solutions to identified blocks.
4. Identify individual and group needs, assist as needed in the group setting.
5. Research and facilitate an educational or therapeutic group for patients as the facility permits.
6. Plan and implement therapeutic nursing interventions to promote adaptive behavior by focusing on reality orientation and by assisting with socialization, decision-making, relaxation techniques and problem solving.
7. Continually self-evaluate and discuss personal emotional responses to providing care in the psychiatric setting.
8. Seek out mentorship when experiencing challenges in therapeutic communication, patient interaction, or nursing interventions.
9. Demonstrate knowledge of the therapeutic actions, drug interactions, side effects, mechanism of action, related laboratory values, and nursing implications of all medications administered to the patient and utilize that knowledge when assessing the patient and planning care.
10. Give accurate, ongoing health teaching and information to the patient and significant others to promote health and/or reduce health risks. Teaching methods are to be adapted to the patient's level of understanding and needs.
11. Research and educate the patient/significant others about community-based outpatient support resources relevant to their situation.
12. Demonstrate the ability to initiate a rapid response or BLS/CPR as appropriate.
13. For each assigned unit be familiar with the location of the fire alarm(s), fire extinguisher(s), evacuation plan, emergency exits, means to call appropriate codes, location of emergency cart, use of the phone system, and location of emergency buttons in patient rooms.
14. During clinical care, verbally relate to the instructor pertinent assessment findings, primary problems and diagnoses with specific, behaviorally stated goals, planned therapeutic interventions, and evaluation of the effectiveness of interventions.
15. Accurately report and record patient behaviors, findings and care given on patient records. Communicate these verbally to other involved health care personnel and instructor on an ongoing basis during the assigned clinical period.
16. Report suicidal ideation, aggressive or self-destructive behaviors immediately.
17. Complete charting process per agency protocol and rules related to student charting.
18. Prepare medication sheets, mental status assessments, and process recordings for each patient.
19. Formulate two written psychiatric nursing history and assessments along with comprehensive nursing processes using the Roy Adaptation Model.
20. Appraise personal performance by self-reflection in the weekly clinical evaluation tool.
21. Complete all patient care/clinical assignments and as scheduled. If, for any reason care is incomplete, or the assignment cannot be completed, the instructor and the responsible staff person are to be notified as soon as the problem/delay is apparent.
22. Report on duty at least 10 minutes prior to the beginning of the shift to the location to which assigned by the clinical instructor.
23. If tardy or unable to report on duty, notify both the instructor and the unit to which assigned prior to the time required to report on duty.

24. Students in the psychiatric nursing clinical area will wear appropriate, professional non-uniform clothing, closed toed, closed heeled and low-heeled footwear. No jeans, t-shirts or non-collared shirts, tight, short, or suggestive, clothing, necklaces, rings (other than a wedding band), earrings, bracelets, facial jewelry or body piercing may be worn. All clothing will be clean and neat at all times. Effective personal hygiene will be maintained. Nametags with photo ID must be worn at all times.
25. Maintain professional nurse-patient boundaries.
26. Adhere to the strictest ethical principles of confidentiality and protection of the privacy of each individual patient at all times.

CLINICAL EVALUATION:

Weekly clinical evaluation performance will be graded on the following scale:
Satisfactory: Clinical performance demonstrates continued growth towards course competencies. Behaviors are consistent, safe, and performed at expected learner level described in the student competency behavior descriptors for satisfactory performance.
Needs Improvement: Behaviors manifested have potential for causing harm. Student requires excessive prompting and direction to perform safely and at expected learner level.
Unsatisfactory: Behaviors performed are unsafe. Omits student behaviors required to achieve course competencies. Student behaviors lack knowledge base and skill competencies expected.

Each clinical day is evaluated according to the criteria in the clinical evaluation tool. The form is submitted to the instructor at the end of the clinical experience for the week. Documenting nursing behaviors by the student and the clinical instructor on the tool each week supports the performance ratings. The student must receive a "Satisfactory" performance rating for all criteria on the weekly clinical evaluation form for **a minimum of seventy-five percent (61 hours)** of the clinical days of the course. Therefore, students attending clinics involving 12-hour shifts may not receive more than one clinical day rating at "Needs Improvement or "Unsatisfactory" and those students in 8-hour clinics no more than two clinic days rating at "Needs Improvement or "Unsatisfactory. Numbers greater than these will result in failure of the course regardless of the theory grade.

Note: Any student behavior that puts a patient in jeopardy (including, but not limited to, emotional, physical, environmental jeopardy), has the potential to cause harm, results in actual harm or injury, or that is life-threatening, will result in immediate removal of the student from the clinic. The semester faculty team together with the Chairperson of the Health Sciences Division will review student behaviors. Such behaviors will result in clinical failure, withdrawal from the course with a grade of "F" and possible suspension or expulsion from the Nursing Program.

CLINICAL AGENCIES

HARBOR UCLA MEDICAL CENTER (310) 222-2345
1000 W. Carson St.
Torrance, CA. 90502

http://www.harbor-ucla.org/

PROVIDENCE LITTLE COMPANY OF MARY – SAN PEDRO (310) 832-3311
1300 W. 7th Street
San Pedro, CA. 90732

https://california.providence.org/san-pedro/Pages/default.aspx

SELF DISCLOSURE

Definition: Letting others know one's true self, one's inner experience honestly.

Purpose: Decreases the mystery of that individual; alters one's preconceptions/beliefs about him/her. In a professional relationship it is patient centered.

Consequences: When people disclose their real selves, one to another, what happens?
We may learn the extent to which we are similar to one another and the extent to which we are different in thoughts, feelings, attitudes, values, hopes, and reactions.
We may learn of other individual's needs, which can enable one to help meet those needs or to ensure that they will not be met.
We may learn the extent to which the other individual accords with or deviates from the norm, moral/ethical standards, etc.

The Nurse and Self-Disclosure
Self-disclosure may be used to build trust and understanding, and to facilitate the patient's self-understanding. It is not aimed at making another person improve their behavior. The nurse is there to listen, accept and understand and to communicate understanding and acceptance of the patient. The patient is free to be and to self-disclose in the presence of another who has good will toward him/her. The nurse employs skills in the service of the patient's well being. This means honest responses and personal self-disclosure WHEN APPROPRIATE. Novices in therapeutic communication should always discuss self-disclosure with and instructor/supervisor first as caution must be taken with those who have poor ego boundaries or are severely dysfunctional.

Empathy is facilitated by self-disclosure. As the nurse, you use self-disclosure to **help the patient** achieve a particular therapeutic goal, not to make yourself feel good or decrease your discomfort. Since you use it to help the patient achieve certain specific goals, your self-disclosure is a response to a patient's needs. It must therefore be used with care. You do not self-disclose each time the patient does. This is not 'sharing time.' It is not appropriate to share your life history.

Questions for Evaluating Self-Disclosure

- What is the purpose of the revelation?
- Who is this self-disclosure for?
- Does this self-disclosure meet the patient's therapeutic goals, or does it meet my needs?
- Will this self-disclosure take the focus away from the patient?
- Does this self-disclosure foster the development of a more productive therapeutic relationship?
- Will it encourage the patient to disclose what the patient has withheld or suppressed?
- Will it encourage the patient's cooperation?
- Will it help the patient to consider another point of view?
- Will it support the patient's positive movement in addressing life problems?
- Will it encourage empathetic understanding?

[From Kneisl, Carol A. (2004). *Contemporary psychiatric-mental health nursing.* Upper Saddle River, N.J: Pearson/Prentice Hall.]

ADAPTATION NURSING- Roy Guidelines

Use to fill out your Nursing History and Assessment

ADAPTATION: The process of coping with changes in one's internal and external environment. The process of responding positively to environmental stimuli to maintain integrity.

BEHAVIORS: May be subjective or objective.
Subjective: arising out of or identified by means of one's perception of one's own states and processes and not observable by another (e.g. statements by patients, descriptions of internal senses).
Objective: phenomenon or symptoms that can be observed or assessed by another without patient input (e.g. vital signs, breath sounds, palpable mass, etc.).

FOUR MODES OF THE ROY ADAPTATION MODEL:
Identify the area of behavior within each Mode

I. PHYSIOLOGICAL MODE – Identify something related to their psychiatric condition

Needs Areas are:

- Oxygenation Needs (Ex: hyperventilation due to pain or anxiety)
- Nutritional Needs (Ex: appetite changes due to medications or psychiatric conditions)
- Need for Exercise and Rest (Ex: sleep changes due to medications or psychiatric conditions)
- Need for Fluid and Electrolyte Balance (Ex: dehydration or fluid overload related to a psychiatric condition)
- Elimination Needs (Ex: constipation related to medications or hospitalization)
- Protection (Ex: Inability to maintain physical safety due to mental status changes)
- Neurosensory Needs (Senses) – (Ex: Pain, anxiety due to dysregulation in the neurosensory system)

II. SELF-CONCEPT MODE

Self-concept is formed early in life. What may change from time to time is one's self-esteem. Self-esteem is the total appraisal of the components of the self-concept; total self-evaluation: an individual's perception of his/her worth.

1. Physical Self: The perception of one's physical appearance, how one feels about the physical self, bodily functions, size, or wholeness. Example: "How my body feels or looks to me." Threats to the physical self may result in feelings of LOSS (e.g. depression following a mastectomy).
    a. Somatic Self: How one feels about his/her body and physical self (e.g. complaints of pain, statements of feeling things crawling on the skin, etc.).
    b. Body Image: How one perceives the appearance/wholeness/acceptability of the physical body (e.g. fat/thin/pretty/ugly/scarred/disabled).

2. Personal Self: The perception of what and who I am, expresses one's personality, what do I want to become, what should I be?
    a. Self-Consistency: The part of the self that strives to maintain uniformity and organization in daily life for adaptation.
    Threats to the self-consistency result in ANXIETY with feelings of HELPLESSNESS, INSECURITY, ISOLATION (e.g. the patient in pain may express worry about inability to control behavior).

b. Self-Ideal: The part of self that is concerned with what one can be or expects to be and do.
Threats to the self-ideal result in feelings of POWERLESSNESS AND HOPELESSNESS (e.g. adolescent in cast unable to try out for the varsity team).

c. Moral-Ethical Self: The part of the self-concerned with the formation of conscience, the knowledge of right and wrong, the setting of standards, religious feelings and evaluating the degree to which "I am who and what I say I am." Threats to the moral-ethical self can result in feelings of GUILT and SHAME (e.g., a child with a broken arm blames the injury on disobeying his mother).

III. ROLE FUNCTION MODE

Role function affects satisfaction in life and is where one experiences self-actualization.
Role may be:

1. Ascribed: patterns of behavior that are present from birth onward and are not related to one's abilities or differences
2. Achieved: patterns of behavior that are attained through special effort, experiences or other personal qualifications.

For each role assessed (e.g. 'patient role', 'mother', 'head of household', 'student', etc.) consider:

1. Instrumental behaviors – task related, goal oriented, have achievement or action outcome, do not have immediate gratification.
2. Expressive behaviors – related to emotional satisfaction, feeling responses, have An emotional or gratifying outcome, immediate gratification

Types of Roles:

1. Primary Role: Based on the developmental stages of life, essentially one's age and sex (e.g. adolescent, generative adult). Consider instrumental and expressive behaviors.
   Example: Mother – Instrumental – washes clothes
   Expressive – hugs her child
2. Secondary Role: Relatively permanent roles that are assumed to carry out the tasks associated with a developmental stage of life (e.g. teacher, doctor, etc.).
3. Tertiary Role: Temporary roles, freely chosen or short term, that have little influence, or a temporary influence on other roles (e.g. patient, shopper, etc.).

Under Primary, Secondary or Tertiary roles, may have disturbances, for example diagnoses such as:

1. Role Failure: perceived inability to perform behaviors related to role (e.g. amputee, former truck driver, concerned about ability to support family).
2. Role Conflict: perceived expectations of others regarding role behaviors differ from own expectations (e.g. wife with threatened abortion whose husband expects sexual relations).
3. Role Confusion: unclear perception of role boundaries and expectations (e.g. cardiac patient does not understand activity restrictions).
4. Role Distance: perceived limited ability to perform behaviors related to role (e.g. new employee who requires repeated explanations related to procedures although performs correctly when supervised).
5. Role Mastery: Role performance meets expectations of self and others.

IV. INTERDEPENDENCE MODE:

Affiliative/aggressive needs. Deals with relationships one enters into; must always involve two or more people; interactions. Underlying need is for affectional integrity and nurturance.

1. Dependence Needs: behavior indicating feelings of love, of being nurtured or cared for that is derived from other people.
   a. Help-seeking: acting to obtain assistance from another
   b. Attention-seeking: acting to gain notice and/or response from another

c. Affection-seeking: acting to obtain approval, praise, affection, or emotional satisfaction from another.

2. Independence Needs: behavior indicating feelings of self-reliance and satisfaction from achievements.
   a. Initiative-taking: beginning and working on a task by oneself
   b. Obstacle-mastery: completing tasks or overcoming barriers to achieve a goal by oneself.

May have the following diagnoses:

1. Dysfunctional Independence: insists on autonomous behavior to the detriment of own well-being.
2. Functional Independence: autonomous behavior enhances one's well-being and adaptation.
3. Dysfunctional Dependence: fails to initiate autonomous behavior when it is feasible for well-being and adaptation.
4. Functional Dependence: seeks assistance, affection, or attention appropriately when needed to facilitate adaptation.
5. Dysfunctional Interdependence: inability to maintain a balance between dependence and independence so maladaptation occurs.
6. Functional interdependence: ability to maintain a comfortable balance between independence and dependence so individual adapts to internal and external environmental stressors.

Relate the steps of the Nursing Process as follows:

1st level Assessment Behaviors Subjective Objective	2nd level Assessment Stimuli Multifactorial in psych (make a list – do not use arrows)	Nursing Diagnosis r/t: (2nd level stimuli – always multifactorial in psych) AEB: (1st level behaviors)	Outcomes: Behaviors and critical time (Positive restatement of the Nsg. Diagnosis then look at level 1 behaviors for changes that can be measured)	Interventions: These should relate to manipulating the level 2 stimuli	Evaluation: of behaviors stated in the outcomes, follow-up plans, revisions

Nursing 343

Required Clinical Paperwork

Clinical papers are used to evaluate the student's clinical preparation, planning and performance. The student must pass both theory and clinic independently, to pass the course. All of the following required clinical assignments must be rated **Satisfactory** and/or **Pass** at the 75% level.

- Daily Charting/Mental Status Assessment (1-2 per day)
- Process Recording (1-2 per day for a total of 10)
- Medication Sheets (one per patient)
- Prep/Pathophysiology Sheets for: depression, bipolar mania/hypomania, schizophrenia, and substance use disorder (due first day of clinic)
- Psychiatric Nursing History and Assessment -Use Adaptation Nursing Guideline
    - (2 per rotation)
- Nursing Process- Main Care Plan for your priority diagnosis identified in the Practice Care Plan (2 per rotation)
- Weekly Self-Evaluation (WCET)

**continued on next page

NURSING 343 - CARE PLAN CRITERIA Total points 30	
Element	***Points***
PATIENT ASSESSMENT a. Interview patient, review chart, and complete a Nursing History and Assessment. Highlight all ineffective behavior. b. Use the History and Assessment to identify adaptive and ineffective behaviors, both objective and subjective, in all four modes. Collect, identify and analyze data from all other appropriate resources. Include appropriate lab results. c. Document primary, secondary, and tertiary roles, maturation stage, developmental tasks and stage of illness.	5
STIMULI a. Correctly identify manipulatable stimuli related to ineffective behaviors. Identify five or more stimuli for your main care plan. All stimuli should be supported by behaviors from the first level assessment. The stimuli should be in list format, do not use arrows.	5
NURSING DIAGNOSIS a. This main care plan diagnosis is the priority diagnosis identified from your practice care plans and is a three-part statement.	3
OUTCOMES a. For the main care plan, create a long-term outcome (start with a positive restatement of the nursing diagnosis). Then, Identify realistic, obtainable and measurable short-term outcomes, specifying the critical time to achieve outcomes and observable, measurable outcome behaviors for each stated outcome. Involve patient, his/her significant others and staff in outcome setting. Critical time in the psychiatric setting can range from 72 hours to two weeks (do not use the 24-hour critical time). Change takes time in the psychiatric setting. Look at first level behaviors and consider a change these behaviors to create your outcomes.	5
INTERVENTIONS a. For each stimuli listed, formulate one or more nursing interventions move the patient toward positive change or eliminate the cause of the problem. b. State all key interventions that assist the patient in achieving the desired outcomes. c. Specify rationales for all nursing interventions (both on the practice care plans and the main care plan).	7
EVALUATION OF PATIENT CARE a. Evaluate patient progress towards expected outcomes. Identify behaviors that indicate achieved and unachieved outcomes. Modify and/or add follow-up as needed. State if nurse should continue with interventions or modify them. If the outcome is not observable during the clinical experience, state the expected outcome.	5

MENTAL STATUS ASSESSMENT GUIDELINES

APPEARANCE

Presenting appearance including chronologic age and apparent age (does the person appear older/younger or at stated age), ethnicity, apparent height and weight (thin, cachectic, muscular, frail, overweight, average, stocky, healthy, petite), grooming and hygiene (malodorous, highly perfumed, dirty, unshaven, hairstyle, makeup), clothing (what they are wearing, cleanliness and condition of clothes, neatness, appropriateness of garments), physical characteristics (tattoos, scars, missing teeth, bandages, jaundice, amputation, etc.)

BEHAVIOR & MOTOR ACTIVITY

Mannerisms, patterns of movement, speed of movement.
Abnormal mannerisms include echopraxia (involuntarily copies others' movements), catatonia, waxy flexibility (stuporous but takes body position physically imposed by examiner), akathisia (inner driven motor restlessness), lethargic, hyperactive, aggressive, assaultive, compulsive, withdrawn, isolative, manipulative, disruptive, intrusive, socializes, preoccupied, restless, etc.

SUBJECTIVE MOOD

Ask the client about their overall mood for the day. Compare this with the affect displayed during the same time period and record concordance in the affect section.

OBJECTIVE AFFECT

Describe what you see in their facial expressions, body language, laughter, use of humor, tearfulness. Describe appropriateness to circumstances and content of speech. Expansive (contagious- you can't help from smiling yourself), full range or broad (normal), flat (no expression), blunted (few emotions, low intensity), constricted (limited variability), labile (extreme variation), concordance (expressed emotion seems to fit what the client is saying or doing), anxious, irritable, neutral, angry, pleasant, etc.

ATTITUDE

Next, record the client's attitude toward the examiner. Note whether the client appeared interested during the interaction or, perhaps, if the client appeared bored. Record whether the client is hostile and defensive or friendly and cooperative. Note whether the client seems guarded and whether the client seems relaxed with the interview process or seems uncomfortable. Other descriptors include uncooperative, hostile, suspicious, or belligerent. This part of the examination is based solely on observations made by the health care professional.

SPEECH

Document information on all aspects of the client's speech. Include evaluation of quality, quantity, rate, rhythm, and tone. For example, note if the client is speaking at a fast pace or is talking very quietly, almost in a whisper. Other descriptors include clear/normal, pressured, slow, soft, mute, fast, loud, slurred, hyperverbal, pressured, or perseverate.

THOUGHT PROCESSES (How ideas fit together)

Normal thought process is logical, coherent and goal directed. Variations include: tight associations (one thought sensibly leads to another reasonable thought), looseness of association (one thought leads to another somewhat less reasonable or loosely related thought), flight of ideas (rapidly changing topics), racing (rapid thoughts), circumstantial (being vague, i.e., "beating around the bush" - giving irrelevant details but eventually returns to the main idea), tangential (departure from topic with no return), word salad (nonsensical responses), neologism (creating new words), clang association (rhyming words – I want to say the play of the day, ray, stay, may I pay), thought blocking (speech is halted), poverty (limited content), preservation (continues to repeat the same thought or phrase), confabulation (filling in of a memory gap with a detailed fantasy), rumination (obsessive thought over a certain topic).

THOUGHT CONTENT (Topic of thought)

- **Suicidal Ideation** – If the client has suicidal ideation, inquire about any specific plans, evaluate the potential for carrying out the plan and report this immediately to the nurse or instructor.
- **Homicidal Ideation** – Same as above
- **Perception** – Ideas of reference (false idea that outside events have special meaning for oneself), ideas of influence (false belief that outside events can have influence on one's behavior), depersonalization (person feels detached, unreal, physically altered – out of body, body part altered, cut off from other people), derealization (parts of the environment feel unreal, somehow altered), illusions (a wrong perception of a real physical external stimulus).
- **Hallucinations** –Types of hallucinations include: auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things). Ask some of the following questions: "Do you hear voices when no one else is around?" "Can you see things that no one else can see?" "Do you have unexplained sensations such as smells, sounds, or feelings?" If a person has auditory hallucinations, inquire what the voices are telling them and if they recognize the voice. If the voices are commanding them to do something, ask them if they normally obey the voices or are they able to ignore them? Report any harmful command hallucinations to the nurse or instructor.
- **Delusions** – To determine if a client is having delusions, ask some of the following questions, "Do you have any thoughts that other people think are strange?" "Do you have any special powers or abilities?" "Does the television or radio give you special messages?"

CULTURAL ASSESSMENT

Assess the patients cultural using your book as a guide for point of identity, time orientation, non-verbal communication pattern. Research and discuss the common health beliefs and practices of the patient's culture including the attitude toward mental illness.

SPIRITUAL ASSESSMENT

Assess the spiritual needs of the client. Are they being met in the hospital setting? Referral needed?

NURSING DIAGNOSIS AND INTERVENTIONS

List the top three priority nursing diagnoses and most important nursing interventions for your client.

LEARNING NEEDS OR TEACHING DONE

Evaluate any learning needs and carry out teaching. Topics include pain management, food/drug interaction, diet, disease process, medications, safety, discharge planning.

EVALUATION OF TEACHING/LEARNING RESPONSE

Evaluation includes: teach-back method, verbalizes understanding or repeat demonstration. Learning response includes, asked questions, difficulty understanding, expressed denial, resistant, lacking motivation.

NURSING 343 – PROCESS RECORDING CRITERIA

- Process recording is written documentation of interactions between the nursing student and patient in a designated clinical setting that is an evidence-based way to improve your therapeutic communication skills.
- Find a private area after your communication to write down notes immediately after the interaction.
- It is expected that you will include BOTH therapeutic and non-therapeutic techniques.
- You need all 20 boxes on the form complete. This includes five comments made by you and five responses from the client. If you or your clinic instructor want or require you to include a student introduction or initial social greeting, you will need to increase your process recording to six student comments and six patient responses.

Criteria

1. IDENTIFYING INFORMATION:
   a. State goal of interaction
   b. Record name, date and patient's initials and age

2. STUDENT VERBAL AND NON-VERBAL COMMUNICATION
   a. Record communications from the core/essence of the interaction.
   b. Do not include a superficial greeting phase such as "Good Morning. How are you today"? with a response "I'm fine. How are you"? or "Good." unless this leads to a substantial answer beyond these social responses.
   c. You can include and introduction of who you are as instructed by your clinical preceptor but this would not count as one of the five boxes.
   d. Record both verbal communication and non-verbal communications (describe position, distance, posture, facial expression, gestures, eye contact, etc.).

3. COMMUNICATION TECHNIQUE USED AND ANALYSIS
   a. Assess whether the technique was therapeutic or blocking.
   b. List the specific technique used (see the tables in the syllabus and in your textbook).
   c. If the technique was non-therapeutic or a block, record an alternate that would have been therapeutic (i.e. if you asked a "why" question, create an alternate of that question without using the word "why" and record).

4. PATIENT VERBAL AND NON-VERBAL COMMUNICATION
   a. Again, record both verbal and non-verbal communication from the patient.

5. STUDENT'S THOUGHTS AND FEELINGS
   a. Identify and describe personal thoughts and feelings about the client's response.
   b. Was the response appropriate?
   c. What feelings were you having during this time?