

Los Angeles Harbor College
Associate Degree Nursing Program

Nursing 343

Clinic Syllabus



2019-2020 Edition
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Find the worksheets/data tables below under their respective titles on the clinic webpage Nursing343.com:

PSYCHOTROPIC MEDICATIONS DATA TABLES

TECHNIQUES OF THERAPEUTIC COMMUNICATION TABLES

WEEKLY CLINICAL EVALUATION TOOL (WCET)

FACILITATIVE SKILLS CHECKLIST

DAILY CHARTING/MENTAL STATUS ASSESSMENT FORM

NURSING HISTORY & ASSESSMENT FORM

PRACTICE CARE PLAN FORM

NURSING CARE PLAN FORM

PROCESS RECORDING FORM

PREP/PATHOPHYSIOLOGY SHEET FORM

MEDICATION ADMINISTRATION WORKSHEET FORM

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 and referral 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, practice care plans and comprehensive nursing processes using the Roy Adaptation Model and current age, developmental stage, spiritual values, culture, and customs.
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. The student **must** review ratings of "Needs Improvement: or "Unsatisfactory" on the clinical form and discuss the behavior in the an anecdotal record with documentation of appropriate interventions for improvement.

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

DEL AMO HOSPITAL

(310) 530-1151

23700 Camino del Sol
Torrance, CA. 90505
<http://www.delamohospital.com/>

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 an 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.]

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 (one per patient)
- ❖ Process Recording (one per patient)
- ❖ 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)
- ❖ Practice Care Plans (2 per rotation)
- ❖ Nursing Process- Main Care Plan for your priority diagnosis identified in the Practice Care Plan (2 per rotation)
- ❖ Facilitative Skills Checklist (2 per rotation)
- ❖ Weekly Self-Evaluation (WCET)
- ❖ Community Resource Essay (1)

Community Resource Agencies

Research how to meet your four (4) hours of community experience by contacting the appropriate agency or acquiring that information on the Internet. Describe your experience following the outline located in the clinic syllabus. This assignment is to be turned in to your clinic instructor. **Be sure to arrive at least 15 minutes early so you are not entering a group late.**

1. Alcoholics Anonymous (www.hacoaa.org ; <https://lacoaa.org/> ; <http://www.southbayaa.org/> or search for AA in your local area)
2. Alanon/Alateen (www.al-anon.alateen.org)
3. Families anonymous (<https://familiesanonymous.org/>)
4. Cocaine Anonymous (<http://www.ca4la.org/>)
5. Crystal Meth Anonymous (www.crystalmeth.org)
6. National Alliance for the Mentally Ill (NAMI) (www.namicalifornia.org) click on “find your local NAMI”. ****You can attend the “General Meeting” but unfortunately cannot attend the “Caring and Sharing” group unless you have a family member or loved one will mental health issues.
7. Narcotics Anonymous (www.na.org)
8. Panic Assistance League - <http://panicassistanceleague.com> Support group for anyone with panic and other anxiety disorders. Meetings are in the south bay but you will have to find the location by using the tools on the website. Be aware that a \$5 donation is requested.
9. Depression and Bipolar Support Alliance - <https://www.dbsasouthbay.org> This group is for people who have or think they have bipolar disorder or depression. It is also for supporters of a person with a mood disorder.

Staff/contacts at the above agencies are subject to change. Plan your attendance early in the course. You do not need to contact the 12-step programs for attendance. You are responsible to attend four hours of this activity. In most cases, this means you will have to go on two separate dates.

If you plan on attending a “12 Step” program meeting (Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Alanon, etc.), you must check that the meeting is classified as “open”. You should not attend any 12-step meeting listed as “closed (C)” meetings unless you meet membership criteria (which is that you think you have the problem addressed at the particular meeting). Please check the meeting of choice on website or call to find out if the meeting you want to attend is closed or open to the public. website or call to find out if the meeting you want to attend is closed or open to the public.

Community Experience Paper Criteria

Students are required to visit a community resource agency for a total of four (4) hours and submit a typewritten review of the visit to their clinical instructor (see the previous list or discuss an agency of your choice with your clinic instructor for approval). If you attend a 3-hour meeting, you may spend the other hour investigating the information required below. If you choose a 12-step meeting (which are normally 1-1 1/2 hours in length), you will need to attend two to three meetings and spend the additional hour either talking to participants or investigating information (on location) required for the paper. Use each of the seven topics below as a main heading and discuss the subtopics as appropriate in a **narrative** format (**DO NOT SUBMIT AN OUTLINE**). If a subtopic does not apply, state this in your paper. Thus, you should address each point of the outline below.

Essay Guide

1. Type of Facility/Agency/Group
 - a. Purpose - What is the group trying to do or provide? (rehabilitation, caretaking, support, etc.)
 - b. Origins of group- How or why did the group start or agency come into existence? What need does the agency or group fulfill?
2. Financial Structure
 - a. Non-profit, proprietary, religious affiliate, private, self-supporting?
 - b. If non-profit, is it community based, federal, state, or county facility?
 - c. Type of payment required (MediCal, Medicare, private insurance, self-pay, free, etc.).
3. Location, Physical Structure/Layout of Facility
 - a. Amenities.
 - b. Size and location.
 - c. Safety precautions in facility, security, handicap access.
4. Participant Demographics
 - a. Age, sex, ethnicity, etc.
 - b. Where do the patients come from?
 - c. Requirement for membership/participation.

(continued on next page)

5. Treatment Modalities
 - a. Long-term vs. short-term.
 - b. Cognitive, behavioral, humanistic, psychoanalytic, etc. (many use more than one).
 - c. Rationale for why/how you identified the treatment modality.
 - d. Describe the milieu.
 - e. Adjunct therapies (occupational, vocational, recreational).

6. Staffing/Leadership
 - a. Sufficient staff/volunteers to support therapeutic interactions.
 - b. Level of training, ongoing training needed.
 - c. Level of functioning of staff/volunteer – what does the staff/volunteer do?

7. Personal Reaction
 - a. Stereotypes or biases before and after participation.
 - b. Cultural learning or issues.
 - c. Strengths and weaknesses with this population.
 - d. What did you learned by this experience?
 - e. Any other thoughts, reactions, opinions on your group experience.

NURSING 343 – PRACTICE CARE PLAN INSTRUCTIONS

Review the *Nursing History and Assessment* and other information retrieved from the chart or patient interview. In each mode, identify possible behaviors that lead to a nursing diagnosis that relates to the psychiatric hospitalization. Each mode box needs to have a different nursing diagnosis. The **interventions** are going to drive the selection of which mode to place the diagnosis (see mode descriptions below). Some nursing diagnoses can fit in more than one mode but the requirement for this assignment is to choose four different diagnoses. For nursing diagnoses that could make sense in more than one mode box, careful consideration based on possible interventions will assist in placing the diagnosis in the best mode box for this assignment. Next, identify relevant stimuli for the nursing diagnosis in that mode. The learning goal is to demonstrate critical thinking and a good understanding of the Roy Model deconstructing and compartmentalizing a nursing diagnosis into one mode.

On the second page, identify and list a total of two goals and two corresponding interventions with rationale for each diagnosis (each mode will have a total of two goals and two interventions). The interventions must be specific to the mode. Finally, document patient evaluation and the evaluation method utilized.

Finally, identify the priority diagnosis, place a star on the mode box with this diagnosis and give the rationale for selection. Consider what behavior(s) caused the hospitalization or what would best help the patient stay out of the hospital in the selection of the priority diagnosis. Use the selected priority diagnosis for the main care plan. Include the two goals and interventions completed from the practice care plan and expand this nursing process to include all the behaviors or collected pertinent information from the other modes to create a comprehensive main care plan. Your Cho reference can help you review the differences between the modes.

Physiologic Mode - Responses to stimuli from the environment to meet the survival needs. Interventions in this mode must cause a change in or have an action on **human physiology or environmental safety**. There is a slight chance that a healthy young client does not have any physiologic problems and in this case you need to note and explain this on your practice care plan physiologic mode box. In most cases, anxiety is present and this can be placed in the physiologic mode.

Self-concept mode – An individual's psychic and spiritual integrity. The need to know who one is so that one can be and exist with a sense of unity. This mode is about cognition or brain processes. Interventions in this mode must involve changes in thoughts and feelings and must occur in the brain versus outside the body.

Role-function mode – The need to know whom one is in relation to others so that one can perform a role appropriately. The interventions for this mode will be identifying barriers or strengths in meeting a particular role. It may involve family function and interventions would be planning for effective family function. The interventions for this mode will be about assisting the patient **planning** for effective function. First one needs a plan for success. How will the client be successful in maintain mental wellness?

Interdependence Mode – The need to have relationships with others. The ability to be self-reliant when appropriate and obtain for help when needed. Dysfunction in this mode would lead to isolation or co-dependency. Interventions for this mode need to be about the person carrying out individual actions appropriately, interacting with others as appropriate or using community based services when needed.

See the examples on the course website for further understanding.

NURSING 343 - CARE PLAN CRITERIA**Total points 30**

<i>Element</i>	<i>Points</i>
<p style="text-align: center;"><u>PATIENT ASSESSMENT</u></p> <p>a. Interview patient, review chart, and complete a Nursing History and Assessment. Highlight all ineffective behavior.</p> <p>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.</p> <p>c. Document primary, secondary, and tertiary roles, maturation stage, developmental tasks and stage of illness.</p>	5
<p style="text-align: center;"><u>STIMULI</u></p> <p>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, <u>do not use arrows</u>.</p>	5
<p style="text-align: center;"><u>NURSING DIAGNOSIS</u></p> <p>a. This main care plan diagnosis is the priority diagnosis identified from your practice care plans and is a three-part statement.</p>	3
<p style="text-align: center;"><u>OUTCOMES</u></p> <p>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.</p>	5
<p style="text-align: center;"><u>INTERVENTIONS</u></p> <p>a. For each stimuli listed, formulate one or more nursing interventions move the patient toward positive change or eliminate the cause of the problem.</p> <p>b. State all key interventions that assist the patient in achieving the desired outcomes.</p> <p>c. Specify rationales for all nursing interventions (both on the practice care plans and the main care plan).</p>	7
<p style="text-align: center;"><u>EVALUATION OF PATIENT CARE</u></p> <p>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.</p>	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, kemptness, 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 patient's 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 an 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?