Napa Valley College
Associate Degree Program in Nursing
NURS 144 – Mental Health Nursing in the Community
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Napa Valley College
Associate Degree Program in Nursing

COURSE NUMBER AND TITLE: NURS 144 – Mental Health Nursing in the Community

COURSE DESCRIPTION: This course provides an opportunity for students to apply the nursing process and health promotion concepts for individualized groups and communities, and care for clients with actual and potential alterations in mental illness. The focus is on the application of communication skills and mental health concepts.

PREREQUISITES: NURS 141, NURS 142 unless Advanced Placement student (LVN)

NUMBER OF UNITS: 5.5 units. Theory & Seminar: 2.25 u., Clinical/Lab: 3.25 u.

REQUIRED TEXT:

Varcarolis, E. M. & Halter, M. (2011). *Manual of psychiatric nursing care plans* (4th ed.). Philadelphia: Saunders.

Varcarolis, E. M. (2010). *Foundations of psychiatric mental health nursing* (6th ed.). Philadelphia: Saunders.

Evolve case studies: complete RN collection (2007) St. Louis: Mosby/ Elsevier.

RECOMMENDED :

*Evolve reach comprehensive review for the NCLEX-RN examination.(*2nd ed) (2008).St. Louis: Mosby/ Elsevier.

Hogan, M., Gruener, R., Gaylord, C., Rodgers, J., & Zalice, K. (2007). *Mental health nursing reviews & rationales* (2nd ed.). New Jersey: Prentice Hall.

TEACHING METHODS: This class will be taught by didactic instruction, case studies, audiovisual aids, reference reading, computer assisted instruction, demonstrations, small groups and study guides.

EVALUATION:

To pass this course students must achieve:

1. A cumulative average of all tests of a grade of C (75%)
   a) Unit tests account for 95% of grade
   b) Standardized Mastery tests account for 5% of grade – POINTS WILL BE CALCULATED BY MULTIPLYING THE CONVERSION SCORE BY 5%. This will be awarded only if the conversion score is 75% or greater. Students who achieve less than 75% conversion score on the mastery test will receive no points.
2. A satisfactory background clearance
3. A satisfactory summative seminar performance evaluation
4. Documentation up to date health records and CPR certification
5. A satisfactory completion of all written assignments
6. Satisfactory completion of videotape of communication and interviewing skills
7. Satisfactory attendance: as defined as missing no more days than the class meets per week.
8. A satisfactory summative clinical performance evaluation

GRADING:

1. Points earned on written papers will be calculated into the final grade only after first achieving 75% on written tests.
2. Tests and written papers = 95% and standardized mastery test = 5% grade.

Example of Computation:

Exam 1 = 80%, Exam 2 = 83%, Exam 3 = 89%

Standardized Final Exam = 78%

Step one: Add the **percentages** of each exam score, divide by 3, then multiply times .95

Step two: Determine the contribution of the standardized exam by multiplying the **percent correct** by .05. If you get below 75% you receive no points for the 5%.

Step three: Add the totals derived from step one and two to determine the final percentage

Example: Step one: 80%+83%+89%=252 divided by 3=84% x .95=79.8%
Step two: 78% x .05=3.9%
Step three: 79.8%+3.9%=83.7%

Course Grading and Attendance

Grades

3 tests plus mastery test: A cumulative average of 75%

Papers/Project: Up to 15 points will be added *after* achieving a cumulative average of 75% on tests:

Family Interview & Assessment	5 points
Self-Help Group Activity	5 points
Community Exploration Activity	5 points (poster presentation or group paper)

All written papers including care plans must be typed.

Absences:

It is your responsibility to attend all class meetings. If you are late it is your responsibility to let the instructor know you were not absent by signing in on the class attendance list. All clinical absences must be made up. If you miss a clinical day, you must make arrangements with your clinical instructor to make up the clinical experience.

Please review the "Student Handbook" as you are responsible for abiding by the policies to guide you during your ADN program of study.

Students in need of accommodations in the college learning environment:
Any student who feels s/he may need an accommodation based on the impact of a learning disability should contact Diagnostic Learning to schedule an appointment. Accommodations for physical or other types of disabilities should schedule a time to meet with Sheryl Fernandez of the Counseling Department in the Administration building.

There are two components of the course - class and lab (includes skills lab and clinical).
If you are struggling with the course content or clinical issues, please see your faculty member during office hours for help. If you have questions or a disagreement concerning some aspect of the test, please see the instructor within one week of the test

First Class: Review syllabus, calendar and lectures assigned for the first day of classes on the calendar prior to the first class.

Clinical Sites:

Napa State Hospital	St. Helena Center for Behavioral Health
2100 Napa-Vallejo Hwy.	525 Oregon St.
Napa, CA 94558	Vallejo, CA
(707) 253-5000	707-648-2200

NURS 144 Mental Health Nursing in the Community
Course Objectives

1. Use the nursing process to individualize care for individuals across the life span who have alterations in psychosocial function.

2. Assume responsibility to actively participate with individuals, groups, families and health-care team members in accordance with the legal and ethical standards of the nursing profession.

3. Demonstrate therapeutic communication with individuals, families and groups with alterations in psychosocial function.

4. Use theory-based knowledge for making clinical judgments.

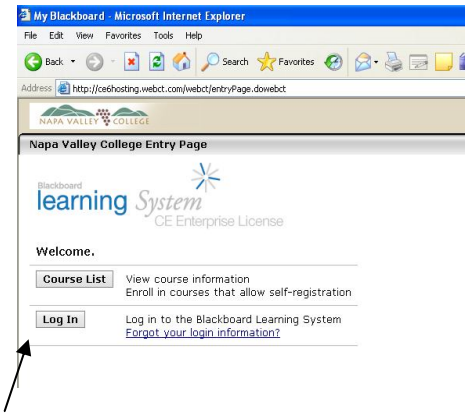
5. Manage the nursing care of adults and children in psychiatric settings.

6. Demonstrate responsibility for continued personal and professional role development.

N144 Blackboard Login Instructions

1) Establish a connection to the internet.
2) Use **Internet Explorer or Netscape Navigator** programs but not AOL browser
3) In the address bar type in: http://online.napavalley.edu/

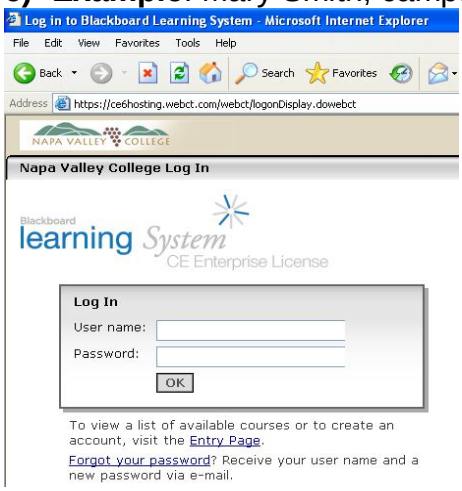
The window should appear as below.



4) Click on **"Log In"**

5) Enter your user name using the first two letters of your first name followed by the first two letters of your last name and the last four digits of your campus ID number.

6) **Example**: Mary Smith, campus ID# 123455 would enter: **MASM3455**



7) **The initial password for all students at the beginning of a class is: STUDENT**

8) Note that the password is in all capitals

9) Click on OK to open the course. If you are enrolled in more than one online course, they will be listed. To enter the course, click on the course name.

10) Call if you need additional technical assistance with Blackboard, please call the Distance Education Coordinator at 707-259-6007.

11) Note: The online content is not available until approximately 1 week prior to the start date of the course.

Due Dates per Clinical Instructor

Due Date	N144 Assignments
Week 1 Clinical	Reflective Journal Seminars – see calendar
Week 2 Clinical	Nursing Assessment including MSE, NCP, and Medication Sheet Process Recording Reflective Journal Seminars – see calendar
Week 3 Clinical	Nursing Assessment, NCP, and Medication Sheet Process Recording Reflective Journal Group Observation and Analysis Paper Seminars – see calendar
Week 4 Clinical	Concept Map and Care Plan Oral Presentation Reflective Journal Seminars – see calendar Community Self-Help Group Activity (5 points)
Week 5 Clinical	Nursing Assessment including MSE, NCP, and Medication Sheet or Psychoeducational Group Development Activity Reflective Journal Seminars – see calendar Community Exploration Poster Activity (5 points)
Week 6 Clinical	Family Assessment and Care Plan (5 points) Seminars – see calendar
See Calendar	Community Mental Health Fair
	Clinical Evaluation Formative and Summative
	Additional Learning Activities (as indicated by instructor)
	Community-Based Activity: Drug Court
	Community-Based Activity: County Mental Health Emergency Response

*__Full Prep__: Include: Assessment, MSE, NCP, and Med Sheet.

Napa Valley College
Associate Degree Program in Nursing
CLINICAL EVALUATION TOOL

Course: NURS 144 Mental Health in the Community

Student: _____

EVALUATION PERFORMANCE CRITERIA

The clinical evaluation tool is used to document the student's progress towards meeting performance standards for the course. The student's clinical performance criteria are derived from the six (6) course objectives as follows: I. Nursing Process, II. Legal Ethical, III. Therapeutic Communication, IV. Theory Based Knowledge, V. Organization of Nursing Care, and VI. Responsibility for personal and professional development.

A formative clinical evaluation will be completed at the instructor's discretion. A summative clinical evaluation will be completed by the nursing instructor at the end of the clinical rotation.

Clinical assignments will be made during the clinical rotation to provide an opportunity for students to meet course objectives in order to achieve a "Satisfactory" evaluation. Any areas identified as "Needs Improvement" by the instructor must be improved to "Satisfactory" by the end of the clinical rotation in order for the student to pass the clinical portion of the course. The evaluation is reviewed with the student during a conference.

The criteria for the tool is:

"NI"	=	Needs Improvement which must be improved to an "S" rating by the summative evaluation at the end of the course in order to achieve a satisfactory summative evaluation.
"S"	=	Satisfactory demonstrates a consistent performance of the objective.
"U"	=	Unsatisfactory or inconsistent demonstration of performance criteria or expected behavior not performed. Any "U" on the summative evaluation indicates a failure in the course.

The satisfactory summative evaluation is a component of the criteria to successfully complete NURS 144 Mental Health in the Community. The student must achieve a "Satisfactory" for each performance criteria listed for the six (6) major categories. The performance criteria are evaluated as being "Satisfactory" when the student consistently demonstrates the behavior designated. In addition, the student must achieve a cumulative average of 75% on exams and successfully complete all required nursing activities.

Clinical Review Policy

Regular conferences with students will be held to review clinical performance when deficiencies in performance occur – for example: when a student is not meeting clinical objectives or is demonstrating unsafe behavior – it will be discussed with the student as soon as possible, with documentation of the identified behavior(s) and a recommended plan for change. The plan will include the actions required to achieve satisfactory performance (ex: required lab practice).

Clinical Skills Performance

Students are expected to maintain a satisfactory level of performance in all previously learned clinical skills from one semester to another. The student is responsible to assess and remediate any skill deficiencies in the nursing skills lab.

Faculty may assign a student to perform these skills without advance notice and the student is expected to perform these skills satisfactorily.

Safe Nursing Practice

The nursing faculty has the responsibility to determine whether practice is safe or whether it is unsafe and unprofessional. They also have an obligation to protect the patient and society against harm. Therefore, if necessary, faculty can send students away from the clinical area and recommend suspension of students from clinical for unsafe, unprofessional, dishonest and/or disruptive conduct.

Unsafe Nursing Practice

The major areas of concern for safe practice are:

1. Medical asepsis is the prevention of transfer or organisms.
2. Physical jeopardy is any action or inaction that threatens a patient's physical health.
3. Emotional jeopardy is any action or inaction that threatens a patient's emotional health.

3. Safety

a. Demonstrates principles of body mechanics.
b. Raises side rails when client is in need of protection.
c. Keeps environment free from potential harmful elements.
d. Protects client from temperature extremes.

4. **Professional Behavior**

Those behaviors expected of all nurses and student nurses which reflect the value, rules and practice of nursing.

NURS 144 Mental Health in the Community	Student Formative	Teacher Formative	Summative Evaluation		Comments
Formative/Summative Evaluation Tool	S NI U	S NI U	S	U	
I. Use the nursing process to care for individuals, families and groups experiencing psychosocial alterations.					
Assessment A. Collects pertinent data from client, chart, DSM IV, staff and appropriate others					
B. Clinical assignments to be typed, organized and submitted in a timely fashion using assigned form					
C. Interprets significance of lab values and diagnostic tests					
D. Synthesizes lab data with medications, nursing diagnoses and DSM-IV					
E. Evaluates need for/readiness for health information and community resources					
F. Adheres to course and agency safety and security measures					
Nursing diagnoses G. Formulates NANDA nursing diagnoses that reflect psychosocial assessment data					
Planning H. Synthesizes assessment data to prioritize nursing diagnoses					
I. Lists measurable expected outcomes with time frame					
J. Applies knowledge of growth and development and Maslow's Hierarchy of Needs when planning care					
K. Analyzes one therapeutic group					
L. Plans organized activities for a group					

NURS 144 Mental Health in the Community	Student Formative	Teacher Formative	Summative Evaluation		Comments
Formative/Summative Evaluation Tool	S NI U	S NI U	S	U	
Implementation M. Selects evidence based interventions to address nursing diagnoses and expected outcomes					
N. Designs Individualized nursing interventions based on evidence and knowledge of desired outcomes and client preferences					
O. Safe performance of all aspects of nursing care					
P. Uses a variety of approaches to deliver care including direct care and milieu management					
Q. Provides rationale for nursing interventions with citation from the literature					
R. Continually measures quality of care (process and outcomes) and implement s best practices					
Evaluation S. Validates client's response to nursing interventions					
T. Verifies client observations, insight and data with appropriate others					
U. Modifies care plan to reflect changes in client's condition and/or staff/faculty recommendations					
V. Evaluates effectiveness of interventions					
II. Apply legal and ethical principles to provide accountable, responsible and professional nursing care					
A. Utilizes school and agency policies and procedures to clarify and guide actions					
B. Recognizes limits of knowledge and skill when providing care					
C. Involves clients, family and health care team in decision making					

NURS 144 Mental Health in the Community	Student Formative	Teacher Formative	Summative Evaluation		Comments
Formative/Summative Evaluation Tool	S NI U	S NI U	S	U	
D. Supports clients in decision making relative to their care					
E. Demonstrates responsible care to clients					
F. Consistently demonstrates advocacy role in protecting client's rights, confidentiality, and care					
G. Prevents one's own values/biases from interfering with care					
III. Apply various models of therapeutic communication.					
A. Respects client's space and territory					
B. Recognizes defense mechanisms used by self, client and others					
C. Communicates with clients to assist them in making decisions and self-care					
D. Interprets verbal and nonverbal communication accurately					
E. Evaluates effectiveness of therapeutic communication with client					
F. Establishes effective and professional communication with faculty and health care team members					
G. Works collaboratively with multidisciplinary team, student group, therapy groups, unit meetings, obtaining/giving report					
H. Maintains professional boundaries and communication with clients, staff, instructor and peer group					
I. Utilizes correct closure techniques					
J. Demonstrates therapeutic communication techniques via role play scenario assignment and self-assessment.					

NURS 144 Mental Health in the Community	Student Formative	Teacher Formative	Summative Evaluation		Comments
Formative/Summative Evaluation Tool	S NI U	S NI U	S	U	
IV. Apply theory and evidence-based knowledge to guide nursing practice					
A. Uses psychosocial theories to understand self/others/environment					
B. Relates signs and symptoms to psychopathology and therapies					
C Applies teach-learn principles to client education					
D. Implements strategies that assist/promote/maintain mental health and basic safety principles					
E. Identifies potential errors and hazards in the administration of drugs, risks, indications, age considerations, and side effects to provide safe care					
V. Manage mental health nursing care to individuals, groups, and families					
A. Makes constructive use of clinical time					
VI. Display professional attitudes, values and behaviors that result in professional growth and self development					
A. Demonstrates evidence of sufficient rest and health					
B. Complies with course and agency dress code					
C. Identifies own strengths and weaknesses					
D. Demonstrates behavior change from experiences and suggestions					
E. Participates in self-evaluation of clinical performance					
F. Contributes in a constructive manner in clinical conferences					
G. Identifies own/client goals for each clinical experience					
H. Identifies whether learning goals were met					

NURS 144 Mental Health in the Community	Student Formative	Teacher Formative	Summative Evaluation		Comments
Formative/Summative Evaluation Tool	S NI U	S NI U	S	U	
I. Synthesizes information obtained from faculty, syllabus, texts, and information technology in making effective clinical decisions					
J. Reflects on clinical experiences, personal, and professional growth via reflective journal					
K. Clinical assignments to be typed, organized and submitted in a timely fashion					
L. Completes any missed clinical/seminar time with an instructor agreed upon clinical make-up activity					
Community Based Clinical Activities					
A. Analyzes two Community Self-Help Groups					
B. Actively participates as a team member in Community Exploration Activity to identify individuals needs and experiences in the home/community					
C. Actively participates as a team member in the Community Mental Health Fair					
D. Develop a health promotion display focusing on determinants of health, linkage between medical care and healthy populations, and professional responses					
E. Completes a Family Interview, Assessment and Family Care Plan					
NURS144 Mental Health in the Community - Seminar					
A. Attends all seminars					
B. Demonstrates consistent evidence of being prepared for seminar activities					
C. Actively participates in seminar discussion & activities					
D. Leads & manages seminar activity as assigned by instructor					

- A final **satisfactory grade** is based on **completion of all required** clinical activities

NVC Associate Degree Program in Nursing
NURS 144 – Mental Health Nursing in the Community

Formative Evaluation (at Instructor's discretion)

Student Comments and Goals:

Instructor Comments:

Date _____ *Student _____ Instructor _____

Summative Evaluation:

Student Comments and Goals:

Instructor Comments:

Date_____*Student_____Instructor_____
* My signature does not mean I agree or disagree, only that I have read this form.

Unit 1 – Orientation to Psychiatric Nursing
Related Activities – Assignments

REQUIRED READINGS AND ACTIVITIES:

Review: Lecture notes from N141 Stress and Adaptation lectures

Theories Lecture

Mental Health & Mental Illness, pp. 2-14.
Conceptual Models, pp. 24-44.
Biological Basis for Understanding Psychotropic Drugs, pp. 45-74.

Legal & Ethical, Violence Lecture

Legal and Ethical Guidelines for Safe Practice, pp. 118-136.
Anger and Aggression, pp. 565-583, 584-589, 607.
Blackboard Article "Understanding Involuntary Psychiatric Hosp"

Roles and Functions Lecture

Professional Performance Standards, pp. 129-130, 138, 793, 794, 845.
Roles & Functions, pp. 2-23, 89-99, p. 845, Appendix B, pp. 792-794
Assessment & the Nursing Process: pp. 138-155, pp. 8-16, pp. 632-633, p. 844, Appendix A.
Symptom & Behavioral Rating Scales in text and care plan book.
Syllabus: Psychosocial NANDA Diagnoses.
Syllabus: Nursing Assessment and Worksheet, Care Plan Form, Medication Form (electronic form).
Syllabus: NCP Case Presentation Guidelines.
Syllabus: NCP Case Presentation Concept Map.

Therapeutic Relationship Lecture

Nurse-Client Relationships: pp. 156-173, 174-194.
Syllabus: Guidelines for Setting up a Client-Nurse Contract.
Syllabus: Video Feedback Communication Activity.
Syllabus: Techniques of Therapeutic Communication.
Syllabus: Process Recording Guidelines, Example, and Form (electronic form).
Syllabus: Shift Report/Discharge.
Syllabus: Writing and Keeping a Reflection Journal (Appendices)
Media Center: View video "Communicating with Clients with Mental Disorders or Emotional Problems. 30"

***Preparation for Physical Safety Training**

Anger, Aggression and Violence pp. 565-608. Read ***before*** attending session with your clinical group

Group Lecture

Group Therapy: pp. 736-748, pp. 506-529.
Syllabus: Group Observation and Analysis Activity. (electronic form)

Theory Objectives	**Content Outline**	**Lab/Clinical Objectives**
The student will (be able to):		The student will (be able to):
1. Differentiate between mental health and mental illness. 2. Discuss the scope of the problem of mental illness in the United States. 3. Describe the major concepts of interpersonal theory of development. 4. Describe the role and functions of mental health care team members. 5. Describe the components of collaboration within the interdisciplinary mental health team. 6. Identify ethical dilemmas in mental health care. 7. Relate mental health legislation to psychiatric nursing practice. 8. Differentiate between voluntary and involuntary admission for the treatment of mental illness. 9. Examine reasons clients become assaultive. 10. Discuss personal and environmental safety factors related to self and client during an episode of violence.	I. Orientation to Psychiatric Nursing A. Definitions of mental health and mental illness. B. Incidence C. Stigma D. Labeling E. Advocacy II. Conceptual models A. Psychoanalysis Freud B. Developmental – Erickson C. Interpersonal Theory - Sullivan D. Maslow Hierarchy of Needs E. Cognitive Theory - Beck F. Behaviorism - Skinner III. Biological Perspectives A. Brain structures B. Brain biology C. Neurotransmitter theories IV. Interdisciplinary mental health team Members and role functions A. Ethical dilemmas in mental health nursing 1. Individual freedom 2. Voluntary vs. involuntary hospitalization B. Legal Standards: ANA Psych Nursing Standards C. Client rights 1. Informed consent 2. Confidentiality/privacy 3. Independent psychiatric examination 4. Habeas corpus 5. Right to treatment 6. Right to refuse treatment 7. Freedom from restraint 8. Definition of insanity	1. Maintain a professional relationship with instructor, peer group, clients and interdisciplinary mental health team. 2. Apply knowledge gained from interdisciplinary team to care of psychiatric clients. 3. Determine client status based on California Welfare and Institutions Codes 5150, 5250. 4. Relate mental health legislation to psychiatric nursing practice. 5. Follow the guidelines of clinical agencies regarding the role of the student nurse in an incident of violent behavior. 6. Participate in Management of Assaultive Behavior Training. 7. Recognize escalating behavior and report to staff. 8. Follow agency protocol for assuring client

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
11. Compare and contrast alternative methods of intervention with violent clients. 12. Explore the legal rights of the individuals diagnosed with a mental illness. 13. Describe the functions of legislation involved in the conservation of mental health client's rights. 14. Explore concepts of self-knowledge and values as it applies to your practice of psychiatric-mental health nursing. 15. Compare the communication process with clients with an alteration in psychiatric function and those without mental illness. 16. Discuss the concepts of the therapeutic relationship as they relate to nurse-client interactions. 17. Describe the steps involved in establishing a one-to-one contract with a client. 18. Discuss the concept of trust as it relates to all nursing interactions. 19. Differentiate between	9. Types of commitment a. 72 hour detention/hold b. Danger to self c. Danger to others d. Grave disability e. Conservatorship, person, finances f. Tarasoff legal decision g. Reese hearing D. Encounters with clients who become violent 1. Clients at risk for violence a. Intoxication b. Withdrawal c. Physical disorders d. Impulse Control disorders e. Psychoses 2. Impact of setting 3. Behavioral responses a. Passive behavior b. Assertive behavior c. Aggressive behavior 4. Theories on aggression 5. Issues of provocation 6. Assessment 7. Preventative strategies a. Self awareness b. Client education c. Assertiveness training 8. Anticipatory strategies a. Communication b. Environmental change c. Behavioral actions d. Pharmacology	rights. 9. Determine threats to client rights. 10. Maintain client confidentiality. 11. Follow agency protocol for phone inquiries. 12. Follow unit policy regarding secure areas and keys. 13. Identify own action, which has potential to harm client. 14. Demonstrate professional behaviors. 15. Practice within limitations based on knowledge and skills. 16. Adhere to agency policy and procedures. 17. Report unsafe conditions immediately to agency staff.

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
social and therapeutic nurse-client interactions. 20. Describe the goals of a therapeutic environment. 21. Discuss the implications of the therapeutic environment for the role of the nurse. 22. Describe the purpose, and process of the mental status exam. 23. Analyze the strengths and limitations of standardized psychiatric rating instruments. 24. Compare and contrast a therapy group with different types of groups. 25. Discuss characteristics of a group. 26. Compare and contrast facilitative and disruptive role functions of group's members (including leader). 27. Distinguish between the group process and group content.	9. Containment strategies a. Crisis management b. Seclusion c. Restraints d. Chemical/ pharmacological e. Self-defense strategies V. Role function in Psychiatric Nursing A. Psychiatric nursing 1. Historical perspectives 2. Contemporary practice 3. Nursing agenda 4. Components of mental health 5. Leading causes of disability 6. Changes in the mental health system 7. Roles of PMHN 8. PMHN Skills/Interventions 9. Standards of Practice 10. Standards of Professional Performance B. Characteristics of therapeutic nurse-client relationship 1. Personal qualities of the nurse a. Awareness of self b. Clarification of values c. Exploration of feelings d. Serving as a role model e. Altruism f. Ethics and responsibility	18. Role model healthy and professional behaviors. 19. Demonstrate behavioral changes as a result of feedback and theory application. 20. Submit completed clinical papers within required time. 21. Identify own strengths and weaknesses. 22. Demonstrate flexibility and adaptability.

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
	2. Phases of the relationship a. Pre-interaction phase b. Introductory phase c. Working phase d. Termination phase 3. Therapeutic communication a. Verbal b. Non-verbal c. Communication process d. Therapeutic techniques 4. Beginning intervention strategies a. Genuineness b. Respect c. Empathic understanding 5. Advanced intervention strategies a. Confrontation b. Immediacy c. Nurse self-disclosure d. Emotional catharsis e. Role playing 6. Therapeutic issues a. Resistance b. Transference c. Counter transference d. Defense mechanisms e. Boundary violation 7. Roles of the nurse a. Socializing agent b. Teacher c. Parent-surrogate 8. Documentation in clinical settings a. P.I.E. format	23. Respect client's space and territory needs. 24. Demonstrate non-judgmental attitude. 25. Identify barriers to communication with clients. 26. Use consistency in setting limits. 27. Validate effectiveness of care plan and limit setting with faculty/staff. 28. Include teaching whenever applicable on written care plan. 29. Communicate correct information related to client care and medications. 30. Follow agency guidelines for charting. 31. Initiate therapeutic communication with clients. 32. Conduct a videotaped interaction demonstrating therapeutic

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
	b. Nursing intake assessment c. Nursing care plans d. Problem lists 9. Qualities of a therapeutic milieu a. Management by nursing staff b. Interventions that promote health c. Socio-emotional climate d. Physical environment and impact on therapeutic community 10. Mental status examination a. Appearance b. Speech c. Motor activity d. Interaction e. Mood f. Affect g. Perceptions h. Thought content i. Thought process j. Level of consciousness k. Judgment l. Insight m. Defense mechanisms n. Impulsivity 11. Symptom & behavioral rating scales a. Uses b. Limitations c. Roles in outcomes and reimbursement VI. D. Group Process and intervention	communication skills 33. Complete a process recording demonstrating evaluation of therapeutic and non-therapeutic communication techniques. 34. Observe & analyze the proceedings of a self-help group in the community setting. 35. Function as an active participant-observer in student and client group experiences. 36. Complete a group observation and analysis. 37. Plan organized activities/recreation for a group of psychiatric clients.

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
	1. Definition 2. Yalom's curative factors 3. Advantages/disadvantage 4. Leadership styles 5. Types of groups 6. Components of small groups 7. Stages of group development 8. Group dynamics 9. Group process-Sociogram 10. Nursing process in group therapy	

Forms and Related Information Included in Unit II

Nursing Process Unit

Syllabus: NANDA Diagnoses.
Syllabus: Nursing Assessment and Worksheet, Care Plan Form, Medication Form.
Syllabus: NCP Case Presentation Guidelines.
Syllabus: NCP Case Presentation Concept Map.

Role Functions

Syllabus: Psychiatric-Mental Health Nursing's Phenomena of Concern

Therapeutic Relationship

Syllabus: Guidelines for Setting up a Client-Nurse Contract.
Syllabus: Video Feedback Communication Activity.
Syllabus: Techniques of Therapeutic Communication.
Syllabus: Process Recording Guidelines, Example, and Form.
Syllabus: Shift Report/Discharge.
Syllabus: Writing and Keeping a Reflection Journal

Unit II Related Activities
Required Readings

Crisis Intervention: Chapter 23, pp. 528-546.

Suicide prevention: Chapter 24, pp. 547-564.

Mood disorders: Chapter 13, pp. 246-278, Chapter 14, pp. 280-304, pp. 66-70.
Evolve case study & test: Major Depressive Disorder

Thought disorders: Chapter 15, pp. 306-342, pp. 68-70.
Evolve case study & test: Schizophrenia, Psychosis

Personality disorders: Chapter 19, pp.433-460.

Anxiety Disorders: Chapter 11, pp. 195-208, Chapter 12, pp. 212-245, 61-65.

Outline & Objectives

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
1. Relate and incorporate the concepts of developmental theories and stress adaptation to mental illness. 2. Define crisis and distinguish between the three types. 3. Identify behavioral and psychological manifestations of a crisis. 4. Give an example of a developmental crisis for each stage of growth and development. 5. Identify useful ways to communicate and intervene in	I. Major Psychopathologies A. Crisis Intervention Theory B. Suicide 1. Predisposing factors 2. Epidemiology of suicide 3. Suicide Assessment 4. Nursing interventions 5. Suicide prevention 6. Psychological autopsy C. Mood disorders 1. Unipolar depression 2. Bipolar affective disorder 3. Assessment 4. Nursing diagnosis 5. Interventions 6. Related medical diagnoses 7. Planning 8. Electroconvulsive therapy 9. Pharmacological agents 10. Outcome evaluation	1. Identify and relate phases of Erickson's psychosocial development to the clients' life stage on preparation sheets. 2. Relate observed behaviors in clients to a theoretical basis of personality development. 3. Apply crisis theory to specific interventions. 4. Select a therapeutic approach for each client and revise appropriately. 5. Plan nursing interventions appropriate for clients with bipolar affective disorder, depression or suicidal ideation. 6. Complete an appropriate symptom rating scale for a selected client.

a crisis. 6. Describe the behavioral characteristics common to depression and mania. 7. Identify therapeutic and untoward effects of commonly used phrarmacological agents. 8. Differentiate between grief and depression. 9. Examine factors that are indicative of suicide risk. 10. Discuss intervention for individuals with suicidal ideation/intent. 11. Compare and contrast the levels of anxiety as they affect the individual. 12. Compare and contrast interpersonal and pharmacological interventions in treatment of anxiety. 13. Identify frequently prescribed antipsychotic, antimanic, and antidepressant medications. 14. List the common side effects of psychotropic agents. 15. Describe the	D. Anxiety Disorders 1. Central features 2. Incidence 3. Prevalence 4. Adaptive/maladaptive responses 5. Etiology 6. Types a. GAD b. OCD c. Phobias d. Panic disorder e. PTSD 7. Somatization disorders a. Somatoform b. Dissociative c. Depersonalization d. Other disorders 1) Factitious 2) Malingering 8. Interventions 9. Medications 10. Application of nursing process E. Schizophrenia 1. Incidence 2. Theories of causation 3. Continuum of psychotic disorders 4. Presentation a. Positive symptoms b. Negative symptoms c. Co-occurring disorders 5. Speech manifestations a. Loose associations b. Clanging c. Incoherence d. Tangential e. Poverty of content 6. Cognitive symptoms a. Memory b. Attention c. Decision making d. Thought content 7. Alteration in sensory function a. Auditory b. Visual c. Olfactory	7. Facilitate clients to verbalize their feelings. 8. Discuss and validate client observations, insight and data with appropriate others. 9. Evaluate the effectiveness of therapeutic communication on anxiety reduction and develop alternate approaches as indicated. 10. Utilize the nursing process in developing care plans for clients experiencing various levels of anxiety. 11. Utilize the nursing process in planning, implementing, and evaluating nursing interventions for an individual experiencing psychotic illness. 12. Identify appropriate boundaries and limit setting techniques during communication with clients. 13. Utilize the nursing process in developing care plans for selected diagnoses related to personality disorders. 14. Set limits on undesirable behaviors and demonstrate consistency.

characteristic alterations in perception, thought process, motivation and affect of an individual with schizophrenia and psychotic disorders. 16. Distinguish between "thought" and "mood" disorders. 17. Discuss the psychomotor behavior of an individual with paranoid ideation. 18. Describe characteristics exhibited by an individual with a personality disorder. 19. Discuss the causative factors associated with personality disorders. 20. Describe behaviors the nurse is likely to observe in an adult with antisocial personality disorder. 21. Discuss nursing interventions likely to be effective with antisocial and borderline personality disorders.	d. Gustatory e. Tactile 8. Abnormal movements 9. General behaviors 10. Assessment 11. Planning 12. Interventions a. Environmental b. Management of delusions c. Safety measures d. Self-care strategies e. Communication 13. Pharmacological intervention a. EPS b. Neuroleptic Malignant Syndrome c. Medication adherence issues F. Personality Disorders 1. Incidence 2. Prevalence 3. Etiology 4. Clusters A, B, C a. Paranoid b. Schizoid c. Schizotypal d. Borderline e. Antisocial f. Narcissistic g. Hystrionic h. Avoidant i. Dependent j. Obcessive-compulsive G. Commonalities H. Interventions 1. Management of splitting 2. Boundary management a. Consistency b. Limit setting c. Trust d. Anxiety reduction e. Consequences f. Relaxation techniques	

2009-2011 NURSING DIAGNOSES
ORGANIZED ACCORDING TO A NURSING FOCUS
BY DOENGES/MOORHOUSE DIAGNOSTIC DIVISIONS

* = New diagnoses
+ = Revised diagnoses

ACTIVITY/REST—Ability to engage in necessary/desired activities of life (work and leisure) and to obtain adequate sleep/rest
Activity Intolerance
Activity Intolerance, risk for
*Activity Planning, ineffective
Disuse Syndrome, risk for
Diversional Activity, deficient
Fatigue
Insomnia
Lifestyle, sedentary
Mobility, impaired bed
Mobility, impaired wheelchair
Sleep, readiness for enhanced
Sleep Deprivation
+Sleep Pattern, disturbed
Transfer Ability, impaired
Walking, impaired

CIRCULATION—Ability to transport oxygen and nutrients necessary to meet cellular needs
Autonomic Dysreflexia
Autonomic Dysreflexia, risk for
*Bleeding, risk for
Cardiac Output, decreased
Intracranial Adaptive Capacity, decreased
*Perfusion, ineffective peripheral tissue
*Perfusion, risk for decreased cardiac tissue
*Perfusion, risk for ineffective cerebral tissue
*Perfusion, risk for ineffective gastrointestinal
*Perfusion, risk for ineffective renal
*Shock, risk for

EGO INTEGRITY—Ability to develop and use skills and behaviors to integrate and manage life experiences
Anxiety [specify level]
Anxiety, death
Behavior, risk-prone health
Body Image, disturbed
Conflict, decisional (specify)
+Coping, defensive
Coping, ineffective
Coping, readiness for enhanced
Decision Making, readiness for enhanced
Denial, ineffective
Dignity, risk for compromised human
Distress, moral
Energy Field, disturbed
Fear
Grieving
Grieving, complicated
Grieving, risk for complicated
Hope, readiness for enhanced
Hopelessness
+Identity, disturbed personal
Post-Trauma Syndrome

Post-Trauma Syndrome, risk for
Power, readiness for enhanced
Powerlessness
Powerlessness, risk for
Rape-Trauma Syndrome
*Relationships, readiness for enhanced
Religiosity, impaired
Religiosity, ready for enhanced
Religiosity, risk for impaired
Relocation Stress Syndrome
Relocation Stress Syndrome, risk for
*Resilience, impaired individual
*Resilience, readiness for enhanced
*Resilience, risk for compromised
Self-Concept, readiness for enhanced
+Self-Esteem, chronic low
Self-Esteem, situational low
Self-Esteem, risk for situational low
Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-Being, readiness for enhanced

ELIMINATION—Ability to excrete waste products
Bowel Incontinence
Constipation
Constipation, perceived
Constipation, risk for
Diarrhea
*Motility, dysfunctional gastrointestinal
*Motility, risk for dysfunctional gastrointestinal
Urinary Elimination, impaired
Urinary Elimination, readiness for enhanced
Urinary Incontinence, functional
Urinary Incontinence, overflow
Urinary Incontinence, reflex
Urinary Incontinence, risk for urge
Urinary Incontinence, stress
[Urinary Incontinence, total-retired 2009]
Urinary Incontinence, urge
Urinary Retention [acute/chronic]

FOOD/FLUID—Ability to maintain intake of and utilize nutrients and liquids to meet physiological needs
Breastfeeding, ineffective
Breastfeeding, interrupted
Dentition, impaired
*Electrolyte Imbalance, risk for
Failure to Thrive, adult
Feeding Pattern, ineffective infant
Fluid Balance, readiness for enhanced
[Fluid Volume, deficient hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
+Fluid Volume, risk for imbalanced
Glucose, risk for unstable blood
+Liver Function, risk for impaired
Nausea
Nutrition: less than body requirements, imbalanced
Nutrition: more than body requirements, imbalanced
Nutrition: risk for more than body requirements, imbalanced

Nutrition, readiness for enhanced
Oral Mucous Membrane, impaired
Swallowing, impaired

HYGIENE—Ability to perform activities of daily living
Self-Care, readiness for enhanced
Self-Care Deficit, bathing
Self-Care Deficit, dressing
Self-Care Deficit, feeding
Self-Care Deficit, toileting
*Neglect, self

NEUROSENSORY—Ability to perceive, integrate, and respond to internal and external cues
Confusion, acute
Confusion, risk for acute
Confusion, chronic
Infant Behavior, disorganized
Infant Behavior, readiness for enhanced organized
Infant Behavior, risk for disorganized
Memory, impaired
Neglect, unilateral
Peripheral Neurovascular Dysfunction, risk for
Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Stress Overload

PAIN/DISCOMFORT—Ability to control internal/external environment to maintain comfort
*Comfort, impaired
Comfort, readiness for enhanced
Pain, acute
Pain, chronic

RESPIRATION—Ability to provide and use oxygen to meet physiological needs
Airway Clearance, ineffective
Aspiration, risk for
Breathing Pattern, ineffective
Gas Exchange, impaired
Ventilation, impaired spontaneous
Response, dysfunctional

SAFETY—Ability to provide safe, growth-promoting environment
Allergy Response, latex
Allergy Response, risk for latex
Body Temperature, risk for imbalanced
Contamination
Contamination, risk for
Environmental Interpretation Syndrome, impaired
Falls, risk for
Health Maintenance, ineffective
Home Maintenance, impaired
Hyperthermia
Hypothermia
Immunization Status, readiness for enhanced
Infection, risk for
Injury, risk for
*Maternal/Fetal Dyad, risk for disturbed
Mobility, impaired physical
Poisoning, risk for
Protection, ineffective
Self-Mutilation

Self-Mutilation, risk for
Skin Integrity, impaired
Skin Integrity, risk for impaired
Suffocation, risk for
Suicide, risk for
Surgical Recovery, delayed
Thermoregulation, ineffective
Tissue Integrity, impaired
Trauma, risk for
Violence, [actual/] risk for other-directed
Violence, [actual/] risk for self-directed
Wandering [specify sporadic or continual]

SEXUALITY—[Component of Ego Integrity and Social Interaction] Ability to meet requirements/characteristics of male/female role
*Childbearing Process, readiness for enhanced
Sexual Dysfunction
Sexuality Pattern, ineffective

SOCIAL INTERACTION—Ability to establish and maintain relationships
Attachment, risk for impaired
Caregiver Role Strain
Caregiver Role Strain, risk for
Communication, impaired verbal
Communication, readiness for enhanced
Conflict, parental role
Coping, ineffective community
Coping, readiness for enhanced community
Coping, compromised family
Coping, disabled family
Coping, readiness for enhanced family
Family Processes, dysfunctional
Family Processes, interrupted
Family Processes, readiness for enhanced
Loneliness, risk for
Parenting, impaired
Parenting, readiness for enhanced
Parenting, risk for impaired
Role Performance, ineffective
Social Interaction, impaired
Social Isolation

TEACHING/LEARNING—Ability to incorporate and use information to achieve healthy lifestyle/optimal wellness
Development, risk for delayed
Growth, risk for disproportionate
Growth and Development, delayed
+Health Behavior, risk-prone
+Health Management, ineffective self
Knowledge, deficient (specify)
Knowledge (specify), readiness for enhanced
Noncompliance [Adherence, ineffective] [specify]
Therapeutic Regimen Management, ineffective
Therapeutic Regimen Management, ineffective family

Student Name: **Date:**

Nursing Assessment and Work Sheet

Client's initials:_____ Age:_____ Sex:_____
Marital Status: _____Ethnicity: _____Education: _____
Occupation (current or former)_____
Legal Status:_____

I. Review of Systems (Describe by reviewing the chart and asking the client)

CV:
Endocrine:
GI:
GU:
Integumentary:
MS:
Neurosensory:
Respiratory:
Diagnostic Tests (EKG, CT, MRI, EEG…):

Labs: Name of Test	Date of Test	Normal Range	Client Values	Significance and Nursing Actions

II. General Information

A. Chief Complaint (per client):_____
_____
B. Reason for hospitalization:_____
_____
C. Pertinent family history: _____
D. Pertinent social history: _____
_____
_____
E. Psychiatric history: _____
_____
_____
F. Spiritual beliefs: (See Nursing Process lecture for questions)._____
_____
_____
G. Cultural practices: (including beliefs regarding mental illness. See Nursing Process lecture for questions)
_____
_____

III. DSM IV Diagnostic Formulation:

Axis I diagnosis:_____
Axis II diagnosis:_____
Axis III diagnosis:_____
Axis IV Psychosocial/Environmental Problems (your assessment): _____
Axis V GAF (your assessment):_____Date:_____Chart GAF:_____Date: _____

List the ***signs* and *symptoms* from the DSM IV** diagnostic formulation, which you have **observed**, or are **documented** for this client:

_____
_____
_____
_____
_____
_____
_____

IV. Mental Status Exam (MSE) Describe your findings in objective terms

General Description

Appearance:
Speech:
Motor Activity:
Response to interviewer:

Emotional State

Mood:
Affect:

Experiences

Perceptions:

Thinking

Thought content:
Thought processes:

Sensorium & Cognition

Level of consciousness:
Memory: STM (short term memory):
LTM (long term memory):
Level of concentration:
Intelligence, logical reasoning, and abstract thought:
Insight:
Judgment:
Impulse control:

V. Relevant History - Personal

Social patterns/interactional ability (friendships, describe a typical day):

_____
_____

Interests and abilities (what good at, what brings pleasure):

_____
_____

Addictive habits and amounts:

_____
_____

Sexual patterns (active, orientation, difficulties, protection Most students find it more comfortable to include questions about sexual patterns in the review of systems section):

_____
_____

Coping strategies (functional and dysfunctional patterns, identify defense mechanisms used):

_____
_____

Support system: _____
_____

Resources:

Developmental stage (Erickson):

Extent of developmental stage fulfillment:

Need level based on Maslow (document rationale for level):

Risk factors (Danger to self, others, impulsiveness, grave disability, flight risk, EPS, seizures, blood and body fluid precautions, special needs, sexually inappropriate behavior):

VI. Clinical impressions based on synthesis of all data gathered (include synthesis of labs, medications and symptom management. Include information regarding compliance to unit activities, medication compliance, relapse prevention):

Napa Valley College
Associate Degree Program in Nursing
Nursing Care Plan

Student's Name: _____**Date:** _____
Client's initials: _____

Prioritize your nursing diagnoses based on Maslow's Hierarchy of Needs and give your rationale.

1. _____
2. _____
3. _____

What does your client identify as their long-term goal?
_____

Nursing Diagnosis **Relate to:** (causes) **Evidenced by**: (S & S)	**Expected Outcomes** (Goals) (Singular, measurable and realistic, dated)	**Evaluation** (Actual Outcomes) (Did nursing interventions lead to expected outcomes?)	**Implementation** (Nursing interventions, actions, teaching, treatments)	**Rationale** (Scientific principles - include source and page numbers, APA format)

Nursing Diagnosis **Relate to:** (causes) **Evidenced by**: (S & S)	**Expected Outcomes** (Goals) (Singular, measurable and realistic, dated)	**Evaluation** (Actual Outcomes) (Did nursing interventions lead to expected outcomes?)	**Implementation** (Nursing interventions, actions, teaching, treatments)	**Rationale** (Scientific principles - include source and page numbers)

Medication Assignment Form – NURS 144

Client's Initials _____ Allergies_____ Student Name _____

Date Ordered	Medication	Time Adm.	1) Class 2) Action	1) Why admin: Target Symptoms 2) Side effects	Nursing implications	Expected outcomes	Evaluations (actual outcomes)
	Trade: Generic: Dose: Route: Frequency: Safe Range: Age Considerations: Children: Pg: Elderly:						
	Trade: Generic: Dose: Route: Frequency: Safe Range: Age Considerations: Children: Pg: Elderly:						
	Trade: Generic: Dose: Route: Frequency: Safe Range: Age Considerations: Children: Pg: Elderly:						

Medication Assignment Form – NURS 144

Client's Initials ____ Allergies :

Date Ordered	Medication	Time Admin	1) Class 2) Action	1) Why administered 2) Side effects	Nursing implications	Expected outcomes	Evaluation
	Trade: Generic: Dose: Route: Frequency: Safe Range: Age Considerations: Children: Pg: Elderly:						
	Trade: Generic: Dose: Route: Frequency: Safe Range: Age Considerations: Children: Pg: Elderly:						

	Trade: Generic: Dose: Route: Frequency: Safe Range: Age Considerations: Children: Pg: Elderly:						

Case Presentation Rubric: Nursing Assessment and Care Plan

Student Name: _____
Instructor Name: _____
Score: ___P ___F

Category	Pass	Pass	Fail	Fail
Preparation	Student is completely prepared and has obviously rehearsed.	Student seems pretty prepared, but might have needed a couple more rehearsals.	Student is somewhat prepared, but it is clear that rehearsal was lacking.	Student does not seem at all prepared to present.
Volume Within Designated Time frame	Presentation is 5-6 minutes long and is loud enough to be heard throughout the presentation.	Presentation is 4 minutes long and is loud enough most of the time.	Presentation is 3 minutes long and is loud enough some of the time.	Presentation is less than 3 minutes OR more than 6 minutes and volume is too soft to be heard.
Discusses Significant Data	Prioritizes data, discussing significant information all (100%) of the time.	Discusses significant (need to know) information most (90%) of the time.	Stays on topic some (75%) of the time. Includes nice to know information that detracts from significant data.	Unable to prioritize significant from insignificant data.
Synthesis	Synthesizes relevant findings integrating I through XI	Synthesizes findings integrating significant findings most of the time	Synthesized some findings from data but not always relevant and somewhat disorganized.	Unable to synthesize relevant findings from data presents or summary of findings is disorganized and lacks integration.

Case Presentation Guidelines: Nursing Assessment and Care Plan

- Directions: Be prepared to discuss <u>all</u> of the following components of a case presentation. Your instructor may ask you to focus on select items.
- Complete a full assessment of your patient using the nursing data base and present your findings.
- Use your critical thinking skills to focus on presenting material that one NEEDS TO KNOW versus what it NICE TO KNOW. Your discussion should focus on MAJOR POINTS versus MAJOR DETAILS or MINOR DETAILS.
- You will be critiqued on your ability to be concise and complete at the same time.

Concept Map and Care Plan Case Presentation

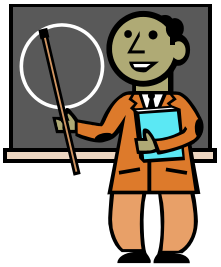
A. Develop a care plan concept map with approximately 1/3 of the content symbols, 1/3 pictures, and 1/3 words. Include significant data from the following:

1. Demographics
2. Review of Systems
3. General Information:
   a) Personal, social, family, psychiatric, history, interests, and abilities
   b) Developmental stage, need level, spiritual and cultural influences
4. Mental Status Assessment
5. Lab values
6. Medications
7. Compliance issues
8. Risk factors
9. DSM-EV diagnosis
10. NANDA Nursing Diagnosis and care plan

B. As part of CPCM include pathophysiology of one of the mental disorders that the client has (include on a separate sheet or back side of concept map care plan).

   a) Describe the disease process
   b) Signs and symptoms
   c) Diagnostic evaluation
   d) Treatment

11. Compare your client to the textbook picture
12. Include a reference and summary of at least one evidenced based practice article related to the nursing care for this disorder (include on a separate sheet or the back side of concept map care plan using APA format).



Concept Map and Care Plan Case Presentation Rubric

Student Name: _____ Instructor Name:

Score: P_____ F_____

Category	Pass	Pass	Fail	Fail
Preparation	Student is completely prepared and has obviously rehearsed.	Student seems pretty prepared, but might have needed a couple more rehearsals.	Student is somewhat prepared, but it is clear that rehearsal was lacking.	Student does not seem at all prepared to present.
Volume Within Designated Timeframe	Presentation is 5-6 minutes long and is loud enough to be heard throughout the presentation.	Presentation is 4 minutes long and is loud enough most of the time.	Presentation is 3 minutes long and is loud enough some of the time.	Presentation is less than 3 minutes OR more than 6 minutes and volume is too soft to be heard.
Concept Map	Concept Map creatively done and comprehensive. Pathophysiology correct and evidenced based article appropriate.	Concept Map is complete. Pathophysiology and evidenced based article included.	Concept Map with some errors, or Pathophysiology not correct, or article missing or not evidence based.	Concept Map incorrect or missing significant content. Pathophysiology incorrect or poorly done, article missing or not evidence based.
Discusses Significant Data	Prioritizes data, discussing significant information all (100%) of the time.	Discusses significant (need to know) information most (90%) of the time.	Stays on topic some (75%) of the time. Includes nice to know information that detracts from significant data.	Unable to prioritize significant from insignificant data.

GUIDELINES FOR SETTING UP A CONTRACT BETWEEN CLIENT AND NURSE

A contract with a client is an agreement between the nurse and the client. For our purposes the contract will be limited to an agreement that you, the student, will be talking with the client every clinical day for a specific period of time. Termination is discussed at the introductory phase of the relationship.

It is part of the contract that you will respect the confidentiality of the client. You must tell the client that what the client tells you and what is written down will be shared only with your instructor and with their treatment team.

Clients may want to see what you have written and should be told that they may read this if they wish. Clients should be told that you have two reasons for talking with them:

1. To help the client gain insight by talking about themselves and their problems.
2. To help you as a student nurse gain practice with therapeutic communication skills.

Clients should be told that the time you spend with them is their time to talk about themselves.

Communication Skill Development Activity

Introduction/Purpose

You will be videotaped to improve your interviewing, and communication skills. Each student will be videotaped during a ten-minute therapeutic interaction with a mock client. The video will then be critiqued by self, peer(s), and a clinical instructor. The purpose of this project is to assist you in mastering interviewing and communication skills by allowing you to see the dynamic process of your own communications on video. The overall goal is to improve your communication skills to enhance your therapeutic interactions with clients.

Objectives

1. Incorporate video recording as a teaching/learning modality to improve assessment, interviewing, and therapeutic communication skills.
2. Evaluate student's perceived effectiveness of videotaping as a learning modality.
3. Improve student's self-awareness of verbal and non-verbal forms of communication.
4. Identify and evaluate interviewing obstacles and resistances which hinder building of nurse/client rapport.

Directions

1. Each team will consist of three students (interviewer, patient, and camera person).
2. Students will sign up for a lab time ahead of time. If you are unable to make this time you should cancel at least 24 hours with the nursing skills lab before your scheduled time.
3. Bring a DVR-R camcorder sized disk (sold in the Napa Valley College Bookstore) to your interview and 3 evaluations to the skills testing, a self, peer and instructor evaluation.
4. Each student will receive a randomly selected scenario for this activity from the list below.

Open the envelope when you are ready to tape and read it out loud while you are being recorded.

5. Complete a self-evaluation and be evaluated by your peer on the evaluation forms immediately following the videotaping. Turn in the 3 forms with your DVD in the envelope provided. Make sure you are facing the camera and speak loudly. Plan to record for at least ten minutes. State your three-part NANDA diagnosis at the end while recording.
6. Do not bring any books or other supplemental materials to the testing area besides a pen.
7. Preparation and practice of all scenarios in relation to the checklist criteria is essential for success.

N144 Clinical Interview Scenarios

1. NANDA Diagnosis: Decisional conflict
Client: "I'm just not sure what I'm going to do. My family will hate me no matter what I decide. There just isn't any good way to resolve this situation. If I move out of the house, they will think I'm deserting them. I'm very torn about what to do. I just can't make a decision about anything."

2. NANDA Diagnosis: Social isolation
Client: "What is the big deal? I just don't feel like being around all these people. My room feels much safer than being out here in the dayroom. Can't you guys all leave me alone? This whole place is really getting on my nerves. My nerves are shot anyway with everything that has been going on."

3. NANDA Diagnosis: Disturbed sensory perception
Client: He or she is expressing delusions and inaccurate perceptions of environment. They are also having conversations with internal voices and at times refuse respond to people around them.

4. NANDA Diagnosis: Violence, [actual/] risk for other-directed
Client: "This whole place is so messed up! I wish they'd let me out of here right now. I hate being confined. This is just like jail." While the client is speaking, they demonstrate hostility and restless physical movements.

5. NANDA Diagnosis: Anxiety
Client: "I have suddenly experienced chest pressure, pounding heart, shortness of breath, and sweating at work. My doctor informed me that my heart is healthy and normal. I am noticing more episodes at work, home, in my care and while shopping. I am very fearful that others might think I am losing my mind."

6. NANDA Diagnosis: Denial, ineffective
Client: While gathering a family history, you find that the client has been drinking heavily (a 12-pack of beer or 2 liters of wine daily). The client is currently on probation for driving under the influence. "My family is exaggerating the amount I drink and I can quit drinking any time I want to: I have just been under a lot of pressure. I just need a drink to sleep and forget my problems."

7. NANDA Diagnosis: Noncompliance [Adherence, ineffective]
Client: "When I take my medications I feel slow and have no energy. I'm embarrassed that I have to be on drugs to function but my family won't take me back home unless I take my meds and attend the day treatment program regularly. Do you think that's fair?"

8. NANDA Diagnosis: Hopelessness
Client: The client presents with sadness, tearfulness, loss of energy and sexual interest, and insomnia. She says, "I feel hopeless about the future and I worry that I will never get better. I have so many problems".

N144 *Self* Evaluation

Therapeutic Communication Evaluation

Student Name_____ **Date**_____
NANDA Diagnosis Scenario_____
Pass_____ **Fail**_____
Evaluation Criteria
0 = Does not include
1 = Is seriously lacking in proficiency and/or accomplished poorly
2 = Does include, but is weak in this area
3 = Does include, is good in this area, and/or was accomplished well.
4 = Does include, and is very good in this area, and/or accomplished with a high degree of proficiency.
Evaluation Criteria:

Grading Criteria	Score	Comments
1. Use of open-ended questions.		
2. Use of clarifying questions.		
3. Use of reflection.		
4. Use of restatement.		
5. Use of techniques to reduce obstacles or resistance.		
6. Use of professional nursing general demeanor.		
7. Use of nonverbal communication.		
8. Use of summary.		
9. In reflecting back, discuss anything you would have done differently?		Answer:
10. Identify one therapeutic communication you did especially well		Answer:
11. Formulate a three-part NANDA Nursing Dx		ND:

Comments on your overall impression of the interaction (mandatory):

N144 Peer Evaluation

Therapeutic Communication Evaluation

Student Name_____ **Date**_____
NANDA Diagnosis Scenario_____
Pass_____ **Fail**_____
Evaluation Criteria
0 = Does not include
1 = Is seriously lacking in proficiency and/or accomplished poorly
2 = Does include, but is weak in this area
3 = Does include, is good in this area, and/or was accomplished well.
4 = Does include, and is very good in this area, and/or accomplished with a high degree of proficiency.
Evaluation Criteria:

Grading Criteria	Score	Comments
1. Use of open-ended questions.		
2. Use of clarifying questions.		
3. Use of reflection.		
4. Use of restatement.		
5. Use of techniques to reduce obstacles or resistance.		
6. Use of professional nursing general demeanor.		
7. Use of nonverbal communication.		
8. Use of summary.		
9. Discuss what you would have done to strengthen the interview if you had been the interviewer		Answer:
10. Identify one therapeutic communication the interviewer did especially well		Answer:

N144 Instructor Evaluation

Therapeutic Communication Evaluation

Student Name_____ **Pass**_____ **Fail**_____ **Date**_____
Faculty Evaluator_____
NANDA Diagnosis Scenario_____

Evaluation Criteria
0 = Does not include
1 = Is seriously lacking in proficiency and/or accomplished poorly
2 = Does include, but is weak in this area
3 = Does include, is good in this area, and/or was accomplished well.
4 = Does include, and is very good in this area, and/or accomplished with a high degree of proficiency.

Evaluation Criteria:

Grading Criteria	Score	Comments
1. Use of open-ended questions.		
2. Use of clarifying questions.		
3. Use of reflection.		
4. Use of restatement.		
5. Use of techniques to reduce obstacles or resistance.		
6. Use of professional nursing and general demeanor.		
7. Use of nonverbal communication.		
8. Use of summary		

Additional comments or observations (optional):

Techniques of Therapeutic Communication

"Broad Openings". Confirm the presence of the client and encourage client to select the topic. Involves questions such as "What shall we discuss today" "Is there something you'd like to talk about?" " What are you thinking about?"

"General leads". Giving a general lead allows the client to select the topic from within a range. Example: "How are you doing today?" "How are you feeling compared with yesterday?"

"Reflection of Feelings". The emotional and/or cognitive component of a client's statement is rephrased in your own words. Signifies understanding, empathy, interest and respect. Brings to focus feelings rather than content to bring the client's feelings into clear awareness. A statement like "I'm really mad that my psychiatrist hasn't come in to see me yet, I guess she has more important things to do. A reflective statement from the nurse could be: "You seem upset with your doctor. Are you feeling that she has more important things to do then see you?"

"Paraphrasing". Similar to reflection, except it is translating the client's words into your own thoughts. It consists of repeating in fewer and fresher words the essential ideas of the client. For example, client says, " I can't study. My mind keeps wandering." The nurse says, " Are you having difficulty concentrating?"

"Restatement". All or part of the client's main thought is repeated. If a client says "I am so scared about this hospitalization I could just cry!" The nurse could respond by restating, "You are scared about this hospitalization and you could just cry?"

"Silence". Attentive listening may be preferred to a verbal response. This gives the client a chance to reflect on feelings and/or continue the conversation. It allows the client to take control of the discussion, if they so desire.

"Informing". Giving information. Provide specific information to answer questions, educate, clear up misconceptions, or help the client evaluate their situation. Example "I think you nee to know more about how your medication works."

"Clarifying". Seeking more information to better understand. "I'm not sure I understand about your arm pain completely. Could you repeat what you said?" Another example is: "I don't follow you. Can you say it another way?"

"Focusing". Taking notice of a single idea or even a single word. An example is "Tell me about what made you upset this morning" or "How has your mood been this week?"

"Probing". Continue to focus and pursue further detail about an area. For example: "On a scale of 1 to 10 how anxious would you say you feel right now?" "On a scale of 1 to 10 how would you rate your feelings of sadness right now?"

"**Summarizing".** Pulls together information for recording. Gives client a sense you understand. Gives client an opportunity to review and add. Example: "It is my understanding that your anxiety is at a level 1 since you've practiced your relaxation techniques an hour ago. Doing your relaxation exercises before you interact with others seems to help you complete the activities the team wants you to do for your rehabilitation. Is this correct?" Client responds "Yes, I find it helpful to practice my relaxation techniques before I do any ward activities. I also take a warm shower in the morning and that helps to reduce the tension I feel in my body."

Non-therapeutic Communication

"False reassurance" Statements such as "Everything will be all right," or "Don't worry," minimize the client's feelings and do not encourage continued communication. Promises something that may not happen.

"Giving advice". Reinforces dependency. Does not encourage problem-solving/decision-making. Imposes nurse's opinion on client. Examples include, "I think you should…", "Why don't you…"

"Asking why questions". Does not encourage further exploration. Elicits a defensive response or excuse making. Examples:" Why do you feel that way?" "Why were you late?"

"Changing the subject". Usually occurs when the nurse isn't listening or is uncomfortable with the subject matter. This discounts the personhood of the client. Example, Client: "I don't have anything to live for. I just want to die." Nurse replies, "Did you have visitors this weekend?"

"Giving approval or disapproval". Okay to acknowledge and support. Implies that the nurse has the right to pass judgment on whether the client's ideas or behaviors are "good" or "bad" and that the client is expected to please the nurse. An example is "That's good. I'm glad that you…" That's bad. I'd rather you wouldn't…"

"Arguing with delusions." Patients with delusions really believe that their perceptions are reality. By negating their perceptions you raise their anxiety and level of distrust. Example: "No, nobody is talking but you and me." "I don't believe the CIA is after you. That is a wrong idea."

Napa Valley College
Associate Degree Program in Nursing
Process Recording Guidelines

Process recordings are a useful tool for examining yours and the clients' communication patterns. Process recordings have some disadvantages, since they rely on memory and are subject to distortions. It is usually best if you can write verbatim (word for word) notes in a private area immediately after the interaction has taken place. Try not to take notes during the interview, as some clients may resent or misunderstand your intent. Attached is an example of a process recording. You record your words, the client's words, identify whether your responses are therapeutic or not, and recall your thoughts and emotions at the time.

You may feel overwhelmed by the severity of the clients' problems and feel responsible for "doing" something to positively affect the client. Studies have shown that the interest shown in the client has been more important than various other factors. This does not deny the importance of clinical training, skill, or experience. It does, however, emphasize the need for you to convey genuine interest in another human being without being patronizing or condescending.

Anxiety during the first interview is to be expected, as in any meeting between strangers. Clients may be anxious about their problems, your reaction to them, concerns about their treatment and so forth. You may be anxious about the client's reaction to you, your ability to provide help, what the instructor will think of you, and how you will do compared to your peers. Two common concerns are (1) how to begin the interview, and (2) what to do in response to client behaviors.

Directions:
1. Schedule a purposeful interaction with your client.
2. Record the interpersonal process according to the indicated format (sample recording on the next page).
3. Analyze the interpersonal process recording according to the indicated criteria for evaluation. Include a statement regarding the purpose and context of the interaction. The purpose statement is nurse centered, written in measurable terms and appropriate for the client.
4. Described the setting; environmental conditions, and the stage of the therapeutic relationship. Verbalizations of both client and nurse are written in the appropriate box exactly as stated--verbatim. Your thoughts, feeling and behaviors during the interaction are described. Nonverbal behaviors are described and interpreted.
5. Therapeutic (effective) responses are recognized. Non-therapeutic (ineffective) responses are recognized and rewritten. This is your chance to state what you would do in that situation that is more therapeutic than what actually happened.

Process Recording Example

Purpose: To establish rapport with a new client
Context of the interaction: Conversation occurred in a corner of the day area at 0930. The setting provided privacy and safety and the only interruptions were the loud intercom announcements. We are in the orientation phase of the therapeutic relationship.

What the Client Said	What I Thought and Felt	What I Said and Did	Principles/Techniques Used	Analysis
START INTERACTION NEXT COLUMN →	I feel overwhelmed. I don't know if I can help this man feel better.	"Good Morning, Mr. L."	Broad opening.	Therapeutic. Acknowledging a client by name can enhance esteem and communicates that he is viewed as an individual by nurse.
		"I am Mrs. V. I am a student nurse from X college, and you are at Mt. Sinai Hospital. I would like to spend some time with you today.	Giving information.	Therapeutic. Informing the client of facts needed to make decisions. Therapeutic. Offering self. Making oneself available to the client.
What am I doing here, how did I get here?" Spoken in a loud, demanding tone.	I feel scared I wish he would lower his voice.	"You were brought in by your wife last night after swallowing a bottle of aspirin. You had to have your stomach pumped."	Giving information.	Therapeutic. Giving needed facts so client can orient himself and better evaluate his situation.
"Oh... yeah." Silence 2 minutes. Shoulders slump, Mr. L stares at floor and drops head and eyes.	He looks so sad it makes me feel sad.	"You look sad and upset, Mr. L."	Reflection.	Therapeutic: Making observations about feelings.
"Yeah, I just remembered... I wanted to kill myself." Said in a low tone almost to self.	I didn't know what to say-his talking about killing himself made me nervous	"Oh, Mr. L, you have so much to live for. You'll get over this. You have such a loving family."	False Reassurance.	Non-therapeutic. Changing the subject. Said something to make me feel more comfortable. I would rewrite it to say: . I could have said, "You must have been very upset" (verbalizing the implied) or "Tell me more about this" (exploring).
"What do you know about my life? You want to know about my wife leaving me... That's what." Faced student nurse with angry expression on face - said in loud angry tones.		"I didn't know. You sound terribly upset by her leaving."	Reflection.	Therapeutic. Observes tone and content of client's message and reflects back client's feelings.

Napa Valley College Associate Degree Program in Nursing
Process Recording of Conversation

Purpose: _____ **Name:**_____
Context of the interaction: _____**Date:**_____

What the Patient Said and Did (Include verbal and nonverbal responses)	**What I Thought and Felt** (As you listened and before you spoke)	**What I Said and Did** (Include verbal and nonverbal responses, behaviors, thoughts, feelings)	**Principles/Techniques Used**	**Analysis** (Therapeutic or nontherapeutic and why. Rewrite nontherapeutic)
START THE INTERACTION IN THE NEXT BOX →				

Process Recording of Conversation p.2

Name:_____ **Date**_____

What the Patient Said and Did (Include verbal and nonverbal responses)	**What I Thought and Felt** (As you listened and before you spoke)	**What I Said and Did** (Include verbal and nonverbal responses, behaviors, thoughts, feelings)	**Principles/Techniques Used**	***Analysis*** (Therapeutic or nontherapeutic and why. Rewrite nontherapeutic)

Reflective Journal Assignment

A journal, like a diary, is a personal recording of observations, opinions and feelings, and responses to ideas, people, events, and situations. It is a document exploring who you were at a certain time and place. You become your own biographer and publisher with YOU as your main topic. You capture some form of definition and experience of yourself, and can return to it at a later date to compare how your present self relates to your past self and your future self.

The emphasis of interpersonal communication centers on an individual evaluation of how you relate to people and how they relate to you – communication – wise. Keeping a journal will, hopefully, help you to more objectively consider the communication process that continually surrounds you, as you are made aware of it by this course and your own realizations.

Tips on journal writing
Journals should be neatly typed and submitted in Blackboard. Try to write with a minimum of mechanical errors, although you will not be graded on your journal.
Write your journal in the first person point of view. Use "I" referring to yourself, of course.

Your journal will be collected weekly and reviewed during the rotation. The quality of your analysis will be reviewed, not the quality of your communication experiences. In other words, don't be afraid to describe something that turned out negatively.

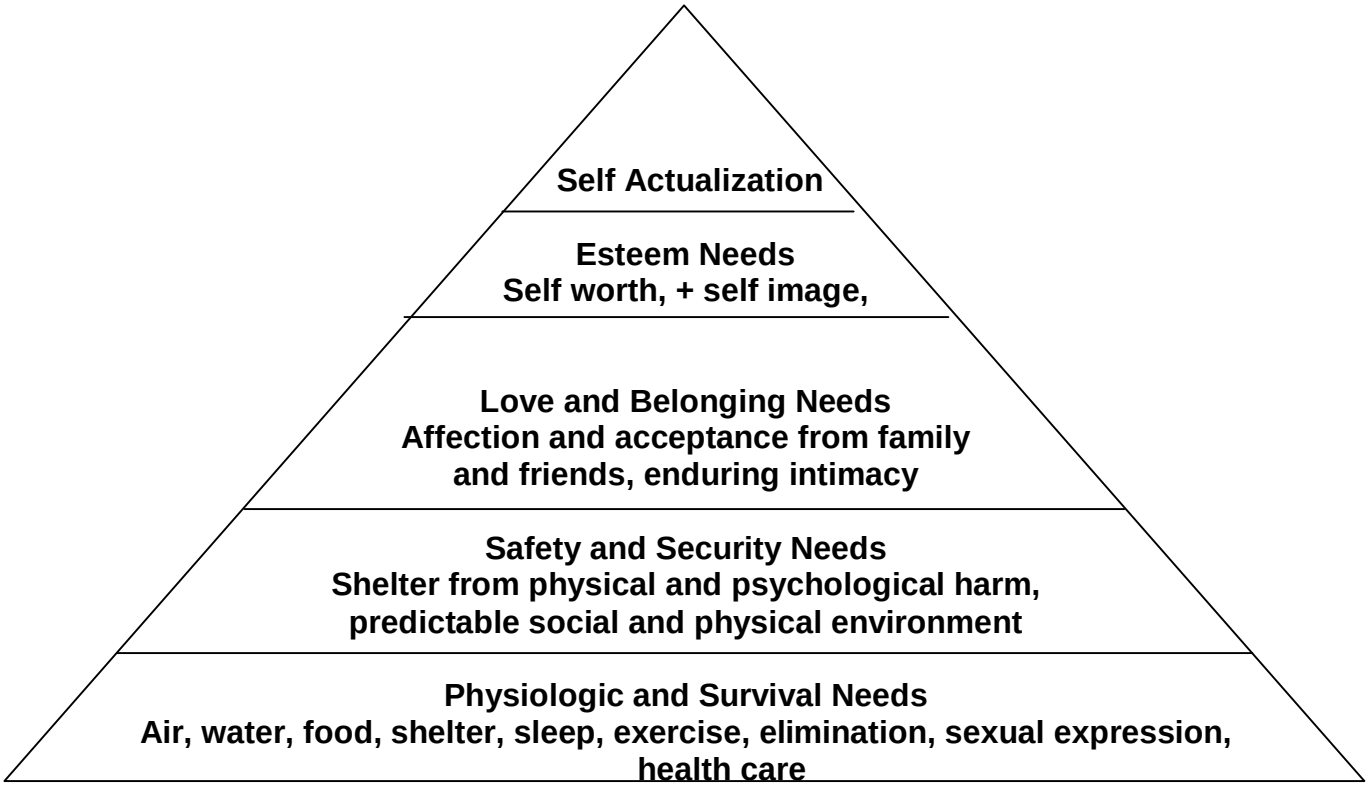
Directions for Reflective Journal
For each entry, date it, give it a title, and a topical focus. Entries should each concern a selected critical experience.
Do not restate the sequence of events for a given day. For each entry you should focus on analyzing the weeks experience possibly addressing one or more of these topics **or another critical or important event:**

1. Significance to self or others – what did this mean to you?
2. Perceptions, assumptions, meaning and/or understanding gained
3. Personal and/or professional questions raised
4. Impact this experience will have on your future nursing practice
5. What objectives did you meet this week?
6. What services and/or interventions did you observe?
7. Describe something you saw in the clinical experience that is exciting to you as a health care professional. How could this make health care more client-oriented in any setting?
8. How did your clinical facility deal with clients of varied ethnic, religious, and/or sexual orientation? What services are available that allow for differences in cultural values regarding health care?

Erikson's Eight Ages of Man

Chronological Age	Developmental Conflict	Long-term Outcome of Successful Resolution
Infant	Basic trust vs. mistrust	Drive and hope
Toddler	Autonomy vs. shame and doubt	Self-control and willpower
Preschool	Initiative vs. guilt	Direction and purpose
School age	Industry vs. inferiority	Method and competence with tasks
Adolescence	Identity vs. role diffusion	Devotion and fidelity
Young adult	Intimacy vs. isolation	Affiliation and love
Adulthood	Generativity vs. stagnation	Productivity and caring
Maturity	Ego integrity vs. despair	Life was meaningful and wisdom

***Successful outcome is evidenced by the development of the characteristic listed first**



Maslow's Hierarchy of Needs

ERIKSON'S EIGHT STAGES OF DEVELOPMENT				
Stage	**Age Resolution**	**Central Task**	**Indicators of Positive Resolution**	**Indicators of Negative Resolution**
Infancy	Birth to 18 months	Trust versus mistrust	Learning to trust others	Mistrust, withdrawal, estrangement
Early childhood	18 months to 3 years	Autonomy versus shame and doubt	Self-control without loss of self-esteem Ability to cooperate and to express self	Compulsive self-restraint or compliance Willfulness and defiance
Late childhood	3 to 5 years	Initiative versus guilt	Learning the degree to which assertiveness and purpose influence the environment Beginning ability to evaluate one's own behavior	Lack of self-confidence Pessimism, fear of wrongdoing Over control and over restricting own activity
School age	6 to 12 years	Industry versus inferiority	Starts to create, develop, and manipulate Developing sense of competence and perseverance	Loss of hope, sense of being mediocre Withdrawal from school and people
Adolescence	12 to 20 years	Identity versus role confusion	Coherent sense of self Plans to actualize one's abilities	Confusion, indecisiveness, and inability to find occupational identity
Young adulthood	18 to 25 years	Intimacy versus isolation	Intimate relationship with another person Commitment to work and relationships	Impersonal relationships Avoidance of relationship, carefree life-style commitments
Adulthood	25 to 65 years	Generativity versus stagnation	Creativity, productivity, concern for others	Self-indulgence, self concern, lack of interests and commitments
Maturity	65 years to death	Integrity versus despair	Acceptance of worth and uniqueness of one's own life Acceptance of death	Sense of loss, contempt for others

DETERMINATION OF ERIKSON'S STAGES OF DEVELOPMENT

Trust vs. Mistrust

Trust

Verbal behaviors	Nonverbal behaviors
"I believe you."	Asking for help with the expectation of receiving it.
"I know I can tell you…"	
"You will help me."	Accepting help from others comfortably.
"You are my friend."	Sharing time, opinions, emotions, and experiences.

Mistrust

Verbal behaviors	Nonverbal behaviors
"I am afraid of you."	Inability to accept help.
"I can't tell you about anything."	Confining conversation to superficialities.
"You cheat."	Rigidly controlling behavior so that only that which is socially approved is exhibited.
	Refusal to share time, experiences, opinions, and emotions.

Autonomy vs. Shame and Doubt

Autonomy

Verbal behaviors	Nonverbal behaviors
"I will."	Tries to dress self or perform other tasks on own.
"I won't."	
"Okay, I'll do it myself."	Accepting group rules but able to express dissent when it is felt.
"This is my opinion."	
"I can wait."	Accepting leadership role when it is appropriate.
	Expressing own opinion.
	Accepting postponement of wish gratification easily.
	Ability to cooperate.
	Demonstrates some self-control.

Shame and Doubt

Verbal behaviors	Nonverbal behaviors
"My opinion doesn't count."	Overly concerned with being clean.
"I never know the answers."	Not maintaining own opinion when opposed. Failing to express needs.
"I don't want to hear what you have to say."	Maintaining own opinion despite adequate proof to the contrary.
"I must be right."	Lacks self-control.
"I should do that."	Unable to wait; hoarding; soiling.
	Being vindictive.

Initiative vs. Guilt

Initiative

Verbal behaviors	Nonverbal behaviors
"Let me try."	Exploring.
"What is it; how does it work?"	Starting new projects with eagerness.
"Where does that road go?"	Expressing curiosity.
"Can I wash my hair?"	Being original.
	Ability to evaluate own behavior.
	Brushes teeth without being told.

Guilt

Verbal behaviors	Nonverbal behaviors
"I'm afraid to do that."	Imitating others rather than developing
"You go first and I will follow."	ideas independently.
"I'm ashamed to make a mistake.	Expressing a great deal of embarrassment over a small mistake.
	Always taking the blame.

Industry vs. Inferiority

Industry

Verbal behaviors	Nonverbal behaviors
"I'm working on this. When it is done I will start on that."	Completing a task once it is started.
	Working well with others.
"I like to be busy."	Using time effectively.
"Group projects are fun."	Feelings of competence.
"I'm going to do my homework now."	Good self-esteem.

Inferiority

Verbal behaviors	Nonverbal behaviors
"I can't work with other people."	Not completing any set tasks.
"I have a lot of things going but nothing finished."	Not contributing to the work of the group.
	Not organizing work.
"I don't thing I can do it."	Avoids responsibility.

Identity vs. Role Diffusion

Identity

Verbal behaviors	Nonverbal behaviors
"I'm going to be a nurse."	Establishing relationships with the same
"I believe in these principles."	sex and then with the opposite sex.
"I think mothers should do this and	Planning realistically for the future.
fathers should do that."	Reexamining values.
"I know where I'm going."	Asserting independence.
"I feel good about myself."	Trying various things.
	Setting goals.

Role Diffusion

Verbal behaviors	Nonverbal behaviors
"I don't know who I am."	Failing to differentiate roles or goals in life.
"Where am I going?"	Failing to assume responsibility for directing own behavior.
"Is it better to be male or female?"	Imitating others indiscriminately.
"I don't know what I mean."	Accepting the values of others without question.

Intimacy vs. Isolation

Intimacy

Verbal behaviors	Nonverbal behaviors
"We are very close friends."	Establishing a close and intense relationship another person.
"I love Dan."	
"My family is very close."	Acting out and accepting appropriate sexual behavior or as desirable.
"I have lots of good friends."	Maintaining a marital or other monogamous relationship.

Isolation

Verbal behaviors	Nonverbal behaviors
"I'm a loner."	Remaining alone.
"I don't need anyone."	Not seeking out others for companionship or help.
"I don't care about anyone."	
"I'm very lonely."	Avoiding sex role by remaining non-descript in mannerisms and dress.

Generativity vs. Stagnation

Generativity

Verbal behaviors	**Nonverbal behaviors**
"John and I have agreed to have two children."	Productive.
"He has his work and I have mine, together we make a team."	Maintaining employment.
"I am raising thee children."	Parenting.
"I am employed at…"	Accepting interdependence.
"I love to sew."	Guiding others.
	Creative.
	Community or church leadership.
	Completes creative endeavors; has hobbies. Performs own self-care and takes responsibility for own health.

Stagnation

Verbal behaviors	**Nonverbal behaviors**
"I can't hold a job."	Not listening to others because of need to talk about oneself.
"I don't want to learn about it."	Constantly losing employment.
"I haven't time to volunteer."	Showing concern only for oneself despite the needs of others.
"You do it; I'm going out."	Self-absorption.
"That's too bad, but it isn't my problem."	Always finds excuses.
	Refuses to learn self-care.

Integrity vs. Despair

Integrity

Verbal behaviors	Nonverbal behaviors
"Life has been very good to me."	Using past experiences to guide others.
"I can't do the things I once did, but I enjoy other things."	Accepting new ideas.
"I enjoy discussing current events."	Accepting limitations.
"I read the newspaper every day."	Maintaining productivity. in some area.
"I love watching the birds at the feeder."	Exploring philosophy of living and dying.
"I enjoy seeing my children and my grandchildren."	Enjoying some aspect of things as they are. Actively participating in own care as much as able.

Despair

Verbal behaviors	Nonverbal behaviors
"I am no use to anyone."	Crying; being apathetic and listless.
"Everyone is gone—my family, my friends."	Not developing any new interests beyond a few routine activities.
"What is the use of living; I can't do anything."	Developing no new relationships.
"Everything I did is gone now. Why did this happen?"	Not accepting changes.
"These new ways are no good."	Limiting interpersonal contacts.
	Demanding unnecessary help and attention.
	Remaining in pajamas & robe all the time.

Unit III – Special Populations & Community Settings
Related activities – Assignments

REQUIRED READINGS AND ACTIVITIES:

Chemical Dependence Lecture

Chemical Dependence: pp. 402-432.
*Evolve reach comprehensive review for the NCLEX-RN examination.(*2nd ed) (2008).St. Louis: Mosby/ Elsevier. **Required activity:** Case Study and Practice Test on Alcoholism

Community Lecture

Community Mental Health, pp. 87-99.
Syllabus: Community Exploration Activity.
Syllabus: Community-Based Mental Health Fair.
Syllabus: Community Self-Help Group Activity.

Children & Adolescent Lectures

Children and Adolescents: pp.626-652, pp. 344-368, pp. 584-608 (read sections on Child Abuse).
Evolve case studies: complete RN collection (2007) St. Louis: Mosby/ Elsevier.
Required activity: Case Study and Practice Test on Attention Deficit Hyperactivity Disorder

Elderly Lecture

Geriatric populations: pp. 653-676, 586-608 (read content on elder abuse).
Evolve case studies: complete RN collection (2007) St. Louis: Mosby/ Elsevier.
Required activity: Case Study and Practice Test on Alzheimer's Disease

Family Lecture

Family Assessment: pp. 749-765, pp. 584-588 (read content on Intimate partner abuse).
Syllabus: Family Assessment and Care Plan (electronic form)

Recommended Readings:

Duffey, J., Miller, M., & Parlocha, P. (1992). Psychiatric home care: A framework for assessment and intervention*. Home Healthcare Nurse*, 11(2), 22-28.

Mc Linden, S. (2002). Crime and punishment: Nurses disciplined for infractions. NurseWeek, retrieved 12/15/03 http://www.nurseweek.com/features/98-12/punish.html

Post, R. (2002). New findings on suicide and substance abuse. *Current Psychiatry*, 1(8), 26-32.

Weiss, R., & Cogley, C. (2002). Pharmacotherapy of alcohol dependence: How and when to use disulfiram and naltrexone*. Current Psychiatry, 1*(2), 51-60.

See Blackboard for additional resources and supplemental readings.

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
1. Describe the goals of the community mental health movement. 2. Describe primary, secondary and tertiary prevention in community based mental health. 28. Differentiate between client-centered and biological models of community health, including interventions, outcomes and the role of the nurse. 29. Describe the components and interventions of clinical case management. 30. Compare community and home-care nursing practice including role components, interventions and client outcomes. 31. Analyze the needs of special populations who can benefit from psychiatric home care intervention. 32. Compare the use of nursing process in community and inpatient mental health settings. 33. Discuss the effects of inability to achieve	A. Community Mental Health Across Continuum 1. Managed care 2. Case management 3. Long term care needs 4. Community based settings 5. Psychiatric homecare 6. Changing reimbursement 7. Psychiatric rehabilitation B. Outpatient and crisis intervention C. Prevention in the community 1. Primary 2. Secondary 3. Tertiary D. Special populations in psychiatric mental health nursing 1. Disorders of infancy and childhood a. Competencies b. Prevalence rates c. Etiology d. Infant Disorders (1) Temperament (2) Attachment (3) Anxiety (4) Eating Childhood disorders (1) Anxiety (2) Thought (3) Mood (4) Tic (5) Elimination	38. Perform a community assessment for an assigned diagnosis and community location. 39. Identify use of community-based models of care in community activities. 40. Plan, implement and evaluate a health promotion display / activity related to mental health. 41. Observe & analyze the proceedings of a self-help group in the community setting. 42. Function as an active participant-observer in student and client group experiences. 43. Complete a group observation and analysis. 44. Plan organized

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
psychosocial tasks at the designated developmental level. 34. Compare and contrast the assessment and interventions for different age populations in various settings. 35. Discuss the sociological and psychological theories relating to abusive behavior and the victim's response. 36. Discuss the role of the nurse related to suspected abusive behavior. 37. Describe the influence of cultural and social attitudes on mental health. 13. Compare the characteristics of functional and dysfunctional families 14. Examine family as a system, including tasks and roles. 15. Identify current therapies used with families. 16. Describe the significant findings of a nursing assessment of	(6) Communication (7) PDD (8) MR (9) Motor skills (10) Learning (11) ADD (12) Substance abuse (13) Violence e. Interventions (1) Play therapy (2) Group therapy (3) Medications (4) Developmental considerations f. Application of the Nursing process 2. Disorders of adolescence a. Tasks b. Issues (1) Sexual activity (2) Mood disorders (3) Anxiety disorders (4) Disruptive behavior (5) Substance use (6) Eating disorders c. Interventions D. Family Interview and Care Plan 1. Emerging changes in families 2. Stages of family development 3. Healthy family	activities/recreation for a group of psychiatric clients. 45. Use the nursing process to identify mental health needs of children and adolescents 46. Evaluate mental status of older adults using age specific observation / rating scales. 47. Utilize therapeutic communication with older adults during assessments and interventions. 48. Identify age related changes in therapeutic approach for older adult clients. 49. Utilize the nursing process in completing a family interview, assessment, and care plan

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
the alcohol-dependent individual. 17. Describe the nursing interventions involved in caring for individuals experiencing delirium tremens and other withdrawal symptoms. 18. Analyze the characteristics of major categories of drug abuse. 19. Discuss the elements of the BRN Diversion Program.	characteristics 4. Troubled families 5. Effects of mental illness on the family 6. Family theories 7. Skill for working with families 8. Family interview and assessment 9. Family violence 10. Application of the nursing process to families E. Substance abuse: alcoholism 1. Definition of alcoholism 2. Persons at risk 3. Diagnostic criteria for substance abuse and dependence 4. Effects of alcohol 5. Assessment 6. Treatment and nursing interventions a. Detoxification b. Alcoholic's Anonymous 7. Confrontation skills 8. Antabuse, Naltrexone 9. Relapse prevention: HALT 10. Psychoactive substance abuse 11. Etiology of drug abuse or dependence 12. Classification of substance abuse disorders 13. Treatment: a. Detox b. Relapse prevention 14. Nursing assessment,	13 Identify appropriate nursing interventions for the individual withdrawing from Alcohol, benzodia-zapines and opiates. 14. Identify manipulative or inappropriate behavior and observe the effects of these behaviors on others. 15. Use confrontation communication techniques at a beginning level. 16. Plan appropriate nursing interventions for chemically dependent individuals. 17. Develop nursing diagnoses that focus on manipulation or acting out behaviors. 18. Identify the procedure a nurse would follow if they suspect a peer is abusing substances at work.

Theory Objectives	Content Outline	Lab/Clinical Objectives
The student will (be able to):		The student will (be able to):
	diagnosis and interventions 15. Board of Nursing Diversion Program components	

Family Assessment and Care Plan Rubric Name:

Rate yourself on meeting the objectives listed below and staple this Rubric to the front of your Family Assessment Paper

Objectives	Exemplary Performance1 point	Average .75 points	Lower Performance .5pt	Unsatisfactory 0 points	Self-Assess	Instr Rating
Conducts a Family Assess-ment	Identifies family structure and relationships, community issues and resources, cultural, socio-economic circumstances. Information well organized with thoughtful reflection and logically presented. ___ ___	Identifies family structure and relationships, community issues and resources, cultural, socio-economic circumstances. Information logically presented but lacks depth. ___ ___	Identifies family structure and relationships, community issues and resources, cultural, socio-economic circumstances. Information vague and confusing. ___ ___	Information missing or insufficient in amount , depth and organization. ___ ___		
Family Specific Concepts	Responses to family structure, communication and interaction style, multigenerational transmission process and emotional cutoff or enmeshment and family life stage show thoughtful reflection and correctly addressed. ___ ___	Responses to family structure, communication and interaction style, multigenerational transmission process and emotional cutoff or enmeshment and family life stage correct, but missing some detail ___ ___	Some incorrect responses to family structure, communication and interaction style, multigenerational transmission process and emotional cutoff or enmeshment and family life stage ___ ___	Many incorrect responses to family structure, communication and interaction style, multigenerational transmission process and emotional cutoff or enmeshment and family life stage. ___ ___		
Family Function Checklist	A clear, complete analysis is included summarizing significant findings indicating adaptive and maladaptive coping observations with nursing interventions addressing both adaptive and maladaptive functioning. ___ ___	Summarizes most significant findings indicating coping observations and relevant nursing interventions. ___ ___	Summarizes findings indicating coping observations, but vague and lacking depth. Nursing interventions lack depth. ___ ___	Summarizes findings indicating coping observations. Some categories not addressed or did not document important findings. Nursing interventions lack sufficient information ___ ___		
Develops & Imple-ments a Family-	Addresses a psychosocial problems, goals, interventions and the effectiveness of	Addresses a psychosocial problem, goals and interventions and the	Addresses a psychosocial problem, goals, interventions and outcomes,	Information insufficient in amount and organization. Did not correctly		

based Care plan.	outcomes in depth. ___ ___	effectiveness of your outcomes, but lacks depth. ___ ___	however does not include or prioritize most relevant NANDA. ___ ___	write or document diagnoes, Interventions, Outcomes or Evaluation. outcomes.___ ___		
Spelling, Organization, and grammer	**Paper**: typed, complete and easy to read. Free from spelling/grammatical errors ___ ___	**Paper**: typed, some misspellings, grammar okay. ___ ___	**Paper**: typed, multiple misspellings, poor grammar, difficult to read. ___ ___	**Paper**: typed, but little attention to spelling, punctuation and grammar. ___ ___		
				Total Points out of 5:		

Name_____ **Date**_____

Family Assessment and Care Plan

Client First Name :_____ **Age:**_____

Ethnicity:_____ **Sex:**_____ **Marital Status:**_____

Personal Information: (Career, education, interests, etc.)

Partner:_____ **Age:**_____

Ethnicity:_____ **Sex:**_____ **Marital Status:**_____

Personal Information: (Career, education, interests, etc.)

Children	**Age** (Career, education, interests, etc.)	**Grade**	**Personal information**

Past or current involvement with alcohol or drugs? Yes No
Comments:

Medical History of Family Members:

Family Stresses (within the past year)

Death _____

_____

Divorce _____

_____

Trouble with Law _____

_____

Financial Strain _____

_____

Job/Career _____

_____

School _____

_____

Illness/Operation _____

_____

Mental Illness _____

_____

Physical Abuse _____

_____

Sexual Abuse _____

_____

Describe Family Life Cycle Stage and document supporting evidence: _____

_____

_____

_____

Relationships With Outside Systems

Extended family/family of origin information:

Is the family involved with any social services?

Outside resources for support: (e.g. friends, religious organization, support groups, clubs)

FAMILY FUNCTION CHECKLIST
Describe Your Observations of the Following Family Functions

Family Functions	Describe Your Observations	Suggested Nursing Interventions
A. Use of power for all family members		
B. Rule making clear, accepted		
C. Clear individual/family/generational boundaries		
D. Straight messages (no manipulation)		
E. Safe expression of positive and negative feelings		
F. Mutual positive regard		
G. Deals with conflict effectively		
H. Children growing & developing in a healthy pattern		

l. Parents feeling good about parenting		

Additional Student Nurse Observations

Family structure observations:

Parenting style observations:

Communication and interaction style:

Multigenerational transmission process observations:

Emotional cutoff or enmeshment observations:

Observations regarding family strengths and coping:

Observations regarding areas for family improvement:

Your over all impression of the interview including any highlights on what you learned about families. Compare an interview with a family versus an individual:

Family Nursing Care Plan

Identify three <u>family</u> nursing diagnoses based on data collected in your interview and prioritize based on Maslow with rationale

1.

2.

3.

Develop a nursing care plan for <u>one</u> of the three <u>family</u> nursing diagnoses

Nursing Diagnosis Relate to: (causes) Evidenced by**: (S & S)**	**Expected Outcomes** (Goals) (Singular, measurable and realistic, dated)	Evaluation **(Did nursing interventions lead to expected outcomes?)**	**Implementation** (Nursing interventions, actions, teaching, treatments)	**Rationale (Scientific principles - include source and page numbers)**

Community Exploration Group Poster Presentation Rubric

Group Members:

_____

Presentation Topic: _____Self-Assess Score_____Instructor Score____

Category	Excellent (1 Point)	Good (.5 Point)	Fair (.25 Point)	Poor (No Points)	Self-Ass. Points	Instr Points
Turn this form in and have your group do a self-assessment and indicate the total points in the "Self-Assessment Column" for each category and then the total group points/score						
Overall Organiza-tion of Presentation	Well structured and presented in a logical sequence, used time wisely . _____ _____	Mostly structured, precise but parts may be unconnected to the rest of the presentation. _____ _____	Somewhat structured but too much time spent on unimportant material. Disjointed sequence. _____ _____	Unstructured, strays from the subject. Much of the presentation out of logical order. Goes over time limit. _____ _____		
Comprehen-sibility of Presentation	Clear and easily understood. Demonstrates rehearsal of sections. _____ _____	Mostly clear but some confusion in the presentation. _____ _____	Somewhat clear but leaves the listener a little lost. _____ _____	Unclear and confusing. Not understood. Rehearsal not apparent. _____ _____		
Overall Presentation of Topic	Shows depth of thought. _____ _____	Certain areas show depth of thought. _____ _____	Some understanding of subject but little depth. _____ _____	Shows a surface knowledge only. _____ _____		
Use and Variety of Presentation Materials	Each individual covered concerns raised by the concept, as well as individual process. Personal experience was integrated where relevant and appropriate. _____ _____	Most materials were of high quality with some questionable sources. Some variety. _____ _____	Some material was of high quality. _____ _____	No presentation materials or material that was, inadequate or too small to see. _____ _____		
Team Coverage of Required Topics	Each individual covered concerns raised by the concept, as well as individual process. Personal experience was integrated where relevant and appropriate. _____ _____	Most individuals covered concerns raised by the concept, as well as individual process. _____ _____	A Few of the individuals covered the material. Audience was left with minor questions. _____ _____	The team did not present the paper production in such a manner that the audience could follow or understand the process or the concept. _____ _____		

Additional Comments:

COMMUNITY EXPLORATION

1. In groups of three, complete the following community clinical experience.

2. Each group will be assigned to investigate a diagnosis of one of the following: severe depression with suicidal ideation, bipolar affective disorder, chronic schizophrenia, attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, or eating disorders. Additional diagnoses can be assigned at the discretion of your clinical instructor.

3. Identify 5 NANDA diagnoses that you could associate with this disorder (1 point).

4. Using a variety of information sources such as telephone directory, the internet, mental health directories and community agency listings, identify a minimum of 8 agencies in a county identified by your instructor that would assist in the deficits/needs you have identified. Contact **at least five agencies** via telephone and explore a) scope of services offered, b) eligibility to receive services, and c) financial considerations. Identify agency clinical/social outcomes (1 point).

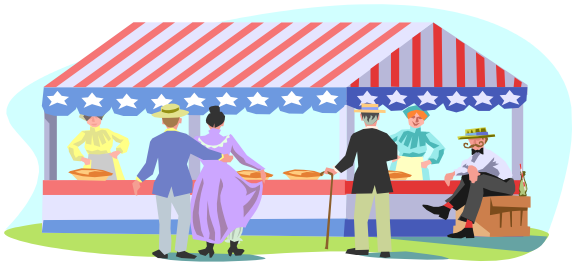
5. Arrange to visit at least two of the five agencies contacted. Collect information about the clients actually served, services actually available, and collect printed materials to share with your instructor and peers. Evaluate the scope/availability of services offered by the agencies you visited. Were there gaps or duplication of community services? (1 point)

6. In response to your observations from your visit, describe how you would apply a $500,000 grant to provide community mental health services in the community you explored? Provide a justification for your response (1 point).

7. At the discretion of your instructor, develop a poster **or** write a 4-5 page group paper incorporating items 3-6 to describe your findings. Plan to summarize your findings in a clear interesting manner. Do not read the information word for word from your poster. Text should be large enough for others to read from a distance, include only text that is absolutely necessary, and remember handouts are welcome (1 point).

8. A group grade will be given.

Community Mental Health Fairs



1. Decide on a mental health topic: A mental health alteration or a health maintenance or health promotion activity.
2. State your objectives.
3. Identify your audience/participants needs (age, sex, culture etc.).
4. Select appropriate information, including:
    a. Risk factors
    b. Assessments: Standardized assessment tools, warning signs
    c. Materials needed: Display boards, fliers, literature (hard copy), pictures, chairs, tables (optional ideas: prizes and refreshments)
    d. Interventions: How to get help, referral sources
5. Obtain internet resource information, self-help and professionally organized community resources on your topic
6. Presentation
    a. Develop display, resource information and informational brochures
    b. Coordinate with agency (schedules, times for setup, display, disassembly)
    c. Develop a form to log demographics, mental health education conducted, assessments performed, referrals made, and resource materials distributed.
7. **If required by your instructor**, write a 2-3 page team paper or conduct an oral group presentation documenting the following:
    a. Were your objectives met? Why or why not?
    b. Evaluate appropriateness and usefulness and of materials used.
    c. Recommendations for future nursing groups in a similar setting or activity?

Community Self-Help Paper Rubric

Staple and submit this rubric with your paper

Student Name: _____

Instructor Name: _____

Category	Points 1	Points .75	Points .5	Points .0	Final
Organiza-tion	Information is very organized with well-constructed paragraphs and subheadings.	Information is organized with well-constructed paragraphs.	Information is organized, but paragraphs are not well-constructed.	Information disorganized.	
Amount of Informa-tion	All topics are addressed and all questions answered with at least 2 sentences about each.	All topics are addressed and most questions answered with at least 2 sentences about each.	All topics are addressed, and most questions answered with 1 sentence about each.	One or more topics were not addressed.	
Quality of Informa-tion	Information clearly relates to the main topic. It includes several supporting details and/or examples. It has substantial content and clear focus.	Information clearly relates to the main topic. It provides 1-2 supporting details and/or examples. Strengths outweigh weaknesses. It has solid development and clearly focused	Information clearly relates to the main topic. No details and/or examples are given. The development of ideas is not complete, focus not as clear	Information has little or nothing to do with the main topic. The paper is weak, underdeveloped, poorly focused, and too general.	
Mechanics	No grammar, spelling or punctuation errors.	Almost no grammar, spelling or punctuation errors	A few grammar spelling, or punctuation errors.	Many grammar, spelling, or punctuation errors.	

Additional Comments: Total _____

Community Self-Help Group Activity

1. Attend two different self-help groups such as Alcoholics Anonymous, N.A., Alanon, Cocaine Anonymous… in the community of your choice.
2. Upon identification of a group you plan to attend (when, where and meeting times etc.) call the leader or information line to assure that the meeting is open to the general public. Inform the contact person that you are a student nurse attending the meeting to learn about treatment activities in the community. Assure them that you are bound by confidentiality and will not take notes during the group session.
3. Information about meeting times and locations can be found at:
   http://www.aanapa.org or
   http://www.aanapa.org/pages/meetings/english.htm#day0
   Additional links are listed in Web CT.
4. Attend the group, participating if warranted by the group process, such as introducing yourself etc. Dress in a professional but not overly formal manner, similar to your attire for your in-patient clinical. Do not wear your name tag or lab coat to the self-help groups unless specifically requested by the group leader.
5. Write a 3-5 page paper using APA format (samples on-line) including the following items:
   a. Include an introductory paragraph to your paper. Then summarize the events of the meeting. Describe any shifts in addictive or dependent behavior you observed (1 point).
   b. Compare and contrast the DSM-IV and the AA/NA/Alanon definitions of chemical dependence (1 point).
   c. Identify how support is given during and outside meeting times (1 point).
   d. Differentiate between this type of "peer support group" and a therapist run "psychotherapy group" (1 point).
   e. Describe how this activity affected or challenged your beliefs, or preconceived ideas about treatment offered by the group you visited. Add a final paragraph summarizing the main points of your paper and include 2-3 current references (within 5 years old) incorporating APA format.
   f. Format 3 – 5 pages, APA format, double-spaced, typed, 12-point font. Please pay careful attention to spelling, grammar and punctuation. (1 point for e and f).
6. Grading: 5 points total.

NURS 144 Mental Health Nursing in the Community
Seminar Preparation Packet

This packet of material is to facilitate the learning experience in seminar.
Please refer to your calendar for the specific dates for each topic and activity. Since seminar is an active learning experience, it is critical that you come prepared. Note advanced required sign-ups and preparation.

Seminar: Self-disclosure & Boundaries

Seminar: Schizophrenia Case Study

Seminar: Depression Case Study

Seminar: Bipolar Affective Disorder Case Study

Seminar: Anxiety Disorder Case Study

Seminar: Assessment Tools Exercise

Seminar: Medication Teaching Activity

Seminar: Chemical Dependence Case Study

Seminar: Family Assessment and Care Plan

Seminar: Self-Disclosure & Boundaries

1. Review related materials in Varcarolis main text.

2. Complete the "Nursing Boundaries Index Self-Check" found in Varacarolis, 2010, p.161, and bring it to seminar.

3. Come prepared to disclose some unknown fact about you to your seminar group.

4. Begin the process of self-analysis by answering the following questions and setting specific goals for your future growth:
   a. Who am I?
   b. What is important to me, and what do I value?
   c. Am I open to my feelings, and can I express them?
   d. What type of role model am I?
   e. Why do I want to help others?
   f. What are my personal beliefs about client welfare and social responsibility, and do I act on these beliefs?

5. Engage in a role-playing exercise in groups of three. One student (in the role of a client) will ask direct and somewhat personal questions. The second student will attempt to maintain appropriate boundaries no matter how inappropriate or intrusive the questions become. The third student will observe the exchange, making notes on the changes in communication, both verbal and non-verbal. At 5-minute intervals, shift roles until everyone has experienced each role.

   As a group of three, answer and share your thoughts on the following items:
   a. What emotions did you experience when personal questions were asked?
   b. How did you respond verbally and non-verbally?
   c. In what ways were you congruent and incongruent with your self-concept analysis?

If time permits share your answers to the following questions:

1. Identify some of your own feelings, fantasies, and fears about working with psychiatric clients.
2. Think back to the last time you needed to ask someone for help. How did you feel at the time? What things would have made you feel more or less comfortable?
3. What can you change about your own behavior to more effectively communicate with clients based on peer feedback?

Seminar: Schizophrenia Case Study

Aaron is a 45 year old male admitted 12 hours ago with a diagnosis of schizophrenia, acute exacerbation. He was placed on a 5150 due to danger to self and grave disability. He is intermittently very angry, asking to be released. His symptoms include lack of interest in activities of daily living, weight loss, ideas of reference. He reported hearing voices telling him "you would be better off dead."

While in the hospital, Aaron is generally cooperative, but slow to respond both verbally and in actions. Sometimes he appears preoccupied and unable to follow directions. He is easily overwhelmed by noises and close interpersonal contact. His participation in group therapy is very limited. In the inter-disciplinary team meeting, the psychiatrist indicated that he would start a clinical trial of clozaril.

1. How would you respond to his request to be released?

2. What questions would you ask Aaron and his support system or caregivers?

3. Analyze his symptoms according to positive and negative symptoms. Compare and contrast Aaron's diagnosis with Schizoaffective Disorder.

4. Which symptom rating tools would be useful in rating symptoms and tracking progress?

5. How would you modify your communication style to accommodate his needs?

6. What obstacles contribute to medication adherence difficulties?

7. Design or obtain client information for the drug clozaril including special monitoring considerations. What other medications might be appropriate for symptom management?

8. Describe the short and long term goals for Aaron.

9. Develop and present a teaching plan to aid in medication adherence and overall self-care to prepare Aaron for improved successful outcomes in the hospital and community settings.

10. What community resources would best serve Aaron's needs upon discharge?

11. What cultural factors might influence care of individuals with schizophrenia?

12. How would the plan of care be different the client was female, child or older adult?

13. Research and present family and community resources from the Alliance for the Mentally Ill (AMI) as they relate to schizophrenia.

14. Discuss the complications of schizophrenia and treatments such as neuroleptic malignant syndrome, agranulocytosis, liver involvement, elevated glucose and lipids, or other co-morbid conditions.

Seminar: Depression Case Study

Joe is a 49 year old married male who is complaining of lack of motivation, low energy, increasing anxiety, insomnia and weight loss. His wife and 15 year old son report that Joe has not been the same since losing his job 2 months ago. He frequently refers to the approach of his 50th birthday and views his life "more than half over." Joe is requesting an antidepressant prescription, "So that I can be happy again."

1. What symptoms indicate presence of a depressive disorder?

2. What additional questions would you ask?

3. ID symptom rating tools useful in rating symptoms and tracking progress?
4. Is the request for an antidepressant appropriate? Why or why not?

5. Describe specific medications that might be considered, giving a rationale.

6. What situational factors contribute to his alteration in mood?

7. How would your approach be different if Joe was female, 72 or 16 years old?

8. What role would his culture play in his alteration in mood or treatment?

9. What self-care interventions/measures would you teach Joe?

10. How do the short and long term goals for Joe differ? Develop a teaching plan.

11. What signs and symptoms of relapse would you teach Joe about?

12. How might Joe's depression affect the family?

13. Joe continues to have signs of depression despite the implementation of your nursing interventions, he is started on 10 mg of Fluoxetine (Prozac). He has less depression at subsequent appointments. Joe comes in for a follow-up appointment complaining of restlessness, a fast heartbeat, a temperature of 101, stomach pain and diarrhea. He reveals to you he has been taking St. John's Wort for the past six months. What might be going on? What should you do?

14. Present a discussion of the pro's and con's of cognitive-behavioral versus biochemical interventions for depressive disorders.

Seminar: Bipolar Affective Disorder
Case Study

Madeline is a 68 year old divorced female who has been placed on an involuntary hold following an episode of yelling at a cashier at the grocery market, not sleeping for a week and speaking rapidly with loose associations. Her sister and daughter report that Madeline has not been taking her medication (depakote) since the New Year holiday. Madeline explains her 30# weight loss due to being "too busy to eat." She frequently refers to her medications as being a form of "thought control" and robbing her of her energy and creativity. Despite multiple hospitalizations for manic episodes, she does not take her medications once she finishes her partial hospitalization program.

1. What symptoms indicate the presence of a bipolar affective disorder?
2. If you were interviewing Madeline, what additional questions might you ask?
3. What physical assessment is important for this client?
4. Who are the other informants you might use for your assessment?
5. Is the involuntary hold appropriate and necessary? Why or why not?
6. What situational factors contribute to her alteration in mood?
7. What factors negatively contribute to relapse for Madeline?
8. Describe specific medications that might be considered, giving rationale for each agent.
9. Which symptom rating tools would be useful in rating symptoms and tracking progress?
10. How would your approach be different if Madeline was male, or 80 years old or 19 years old?
11. What role would culture play in her treatment? What are some culture based health care practices that address this particular mental health problem?
12. What self-care interventions/measures would you teach Madeline?
13. How do the short and long-term goals differ for Madeline?
14. Develop a teaching plan for a client with bipolar affective disorder.
15. Develop and present a plan for management of weight gain associated with long-term use of lithium. Identify other possible adverse effects the nurse needs to monitor for regarding the nervous, GI, cardiac, fluid and electrolyte and endocrine systems?
16. Compare the nursing observations and compliance issues for clients receiving Lithium versus Depakote for the treatment Bipolar illness.

Seminar: Anxiety Disorder Case Study

Tom Smith, a 27-year-old winery tour guide complains of dizziness, sweating palms, heart palpitations, and ringing of the ears of more than eighteen months' duration. He has also experienced dry throat, periods of uncontrollable shaking, and a constant "edgy" and watchful feeling that often interfered with his ability to concentrate. These feelings have been present most of the time over the previous two years; they have not been limited to discrete periods.

Because of these symptoms he has seen a family nurse practitioner, a neurologist, a neurosurgeon, a chiropractor, and an ENT specialist. He has been placed on a hypoglycemic diet, received physiotherapy for a pinched nerve, and told he might have "an inner ear problem."

For the past two years, Tom has had few social contacts because of his nervous symptoms. Although he has sometimes had to leave work when the symptoms become intolerable, he continues to work for the same winery for which he has worked since high school. He tends to hide his symptoms from his wife and children, to whom he wants to appear "perfect," and reports few problems with them as a result of his nervousness. He has been drinking wine to help calm him down, but lately that doesn't even help much anymore.

1. What symptoms indicate GAD?
2. If you were interviewing Tom, what additional questions might you ask?
3. Who are other informants you might use in your assessment?
4. How could you intervene if Tom's culture views his anxiety as a problem to fix, such as a disease, taboo, personal fault, or a curse?
5. What self-care interventions/measures would you teach Tom? What interventions would be appropriate for mild to moderate levels of anxiety, versus severe to panic levels of anxiety?
6. Which symptom rating tools would be useful in rating symptoms and tracking progress?
7. Describe specific medications that might be considered, giving rationale for each.
8. How might Tom's illness affect the family and what teaching needs does the family have?
9. Describe the short and long term goals appropriate for Tom based on Maslow's Hierarchy of Needs.
10. Conduct a relaxation technique with your client and report the outcomes in seminar.

Additional Critical Thinking Questions

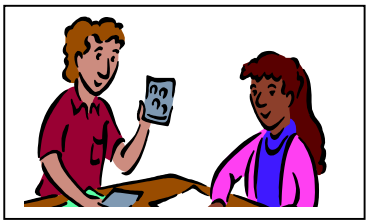
1. Tom has consulted numerous health care providers for his symptoms. Identify symptoms of GAD and explain why Tom does not have Hypochondriasis.
2. Justify why Tom does not have a diagnosis of Panic Disorder.
3. Differentiate Phobic Disorder from GAD.

Anxiety Reduction Group Teaching Plan

Develop a teaching plan for one of the following relaxation techniques with two peers and implement it with your seminar group. Sign-up one week before this seminar. Incorporate at least one internet resource.

	Sign-up
Deep-Breathing Exercises	_____
Meditation	_____
Mental Imagery	_____
Progressive Muscle Relaxation	_____

Seminar: Assessment Tools Activity



Sign up for one of the following Assessment Tools and or Behavioral Rating Scales on the <u>attached list the week before the Seminar</u> on "Assessment Tools".

1. Review the Varcarolis, (2010) main text and care plan book (2006) for psychiatric assessment tools.
2. Select a tool that relates to your client's diagnosis, behavior or symptoms from the list provided. You may use another "assessment tool" with your instructor's prior permission.
3. If the results are out of the normal range please contact your instructor.
4. Include the following in your presentation:
    a) Rationale for selecting this particular assessment tool for your client
    b) Strengths of the tool.
    c) Limitations of the tool (i.e., age, diagnosis, developmental level, special population considerations).
    d) Did the tool seem to measure what it was supposed to measure?
    e) Did the tool measure the extent of the client's problems?
    f) Did the tool help to make an accurate diagnosis?
    g) Would this tool be used to track client progress over time?
    h) Does this tool document the effectiveness of treatment?
    i) Does this tool demonstrate any type of cultural bias? In other words, does this tool involve items that would be more familiar to one cultural group than to another?
    j) Other observations

Look in the index of your main text * and care plan book ** for the corresponding page numbers

Abnormal Involuntary Movement

_____AIMS *
_____BARS (Behavioral Akasthesia Rating Scale)

Anxiety Disorders
_____Hamilton Rating Scale for Anxiety **

Cognitive Functioning
_____Functional Dementia Scale

Eating Disorders
_____ The Body Shape Questionnaire

Mood Disorders
_____Mania Questionnaire
_____ Zung's Self-Rating Depression Scale
_____ Geriatric Depression Scale
_____ Mood Disorder Questionnaire

Psychiatric Functioning (overall)
_____Brief Psychiatric Rating Scale

Substance Abuse Assessments
_____Drug Abuse Screening Test (DAST)
_____Michigan Alcohol Screen Testing
_____Michigan Alcohol Screen Testing – Geriatric Version
_____ CAGE-AID Screening Tool

Self-Harm Assessment
_____Suicide Self-Restraint

Violence Assessment
_____Overt Aggression Scale
_____Agitated Behavior Scale (http://www.ohiovalley.org/agitation/agbe.html)

Other Assessment Tools
_____Other Assessment tool (prior approval by your instructor) _____
_____Life Changing Events Questionnaire
_____Brief Quality of Life Questionnaire

References

Varcarolis, E. M. (2010). Foundations of psychiatric mental health nursing a clinical approach 6th ed.). Philadelphia: W. B. Saunders Co.
Varcarolis, E. M. (2010). Manual of psychiatric nursing care plans (3nd ed.). Philadelphia: W. B. Saunders Co.

Seminar: Medication Teaching Activity

1) Read: Chapter on medication in Varcarolis and Halter (2010, main text) prior to seminar.

2) Choose a psychopharmacological agent from the list provided.

3) Sign up for a 5-minute teaching session during this seminar.

4) Prepare a 5-minute medication overview for your **nursing peer group**. Include the following items in your handout:

a) Purpose: primary and secondary uses
b) Therapeutic action
c) Side effects (common, allergic, rare, life threatening, minor, major, etc.), signs of overdose/toxicity
d) Specific considerations for special populations as well as any gender differences and age considerations)
e) Ethnic or cultural differences or considerations
f) Drug/drug/food interactions; drug/herbal interactions
g) Boxed warnings
h) Describe how use of ETOH interacts with med
i) Develop your own sample handout for clients and families (clear, understandable and accurate). Bring enough copies to distribute to your clinical/seminar group.
j) Strategies to establish and increase compliance with this agent.
k) A list of references, including articles, on-line searches etc.

5) **Please note that a print out from the internet does not meet the sample handout requirement.**

6) During your clinical experience, teach your client about their psychotropic medications. Report the outcome of this activity during post-conference/seminar.

Seminar: Sign-Up for Medication Teaching

Note: This is a potential list for the medication teaching seminar session. Agents may be added or removed at the instructor's discretion.

Sign-up

1. **Antidepressants**
   a. Paroxetine / Paxil _____
   b. Sertraline / Zoloft _____
   c. Venlafaxine / Effexor _____
   d. Phenelzine Sulfate / Nardil _____
   e. Nefazodone / Serzone _____
   f. Bupropion / Wellbutrin _____
   g. Citalopram / Celexa _____
   h. Escitalopram oxalate/ Lexapro _____
   I. Duloxetine Hydrochloride/Cymbalta _____
   j. Selegiline transdermal/Emsam _____

2. **Anti-manic agents**
   a. Lithium carbonate / Lithobid _____
   b. Carbamazepine / Tegretol _____
   c. Valporic acid / Depakote _____
   d. Gabapentin /Neurontin _____
   e. Lamotrigine / Lamictal _____
   f. Oxcarbazepine / Trileptal _____
   g. Topiramate / Topamax _____
   h. Symbax (olanzapine/fluoxetine) _____
3. **Antipsychotic agents**
   a. Fluphenazine / Prolixin (PO & IM, Decanoate) _____
   b. Haloperidal / Haldol (PO & IM, Decanoate) _____
   c. Clozapine / Clozaril _____
   d. Risperdone / Risperdal / (M-Tab, Consta) _____
   e. Olanzapine / Zyprexa _____
   f. Aiprasidone / Geodon _____
   g. Quetiapine / Seroquel _____
   h. Aripiprazole / Abilify _____
   i. Paliperidone / Invega _____
4. **Antianxiety**
   a. Aprazolam / Xanax _____
   b. Clonazepam / Klonopin _____
   c. Buspirone / Buspar _____
5. **Chemical Dependence**
   a. Disulfram/Antabuse
   b. Naloxalone (Narcan)
   c.
6. **Stimulants/misc. agents**
   a. Methylphenidate / Ritalin _____
   b. Dextroamphetamine / Adderal _____
   c. Guanfacine / Tenex _____
   d. Atomoxetine / Strattera _____

Chemical Dependence Seminar

Case scenario #1: Pat is a 45-year-old client admitted to the crisis unit due to agitation and alcohol intoxication. Presenting behavior is yelling at staff, calling them "punks and using profanity." His gait is unstable, mood irritable, speech slurred.

1) What additional clinical information would you seek during your nursing assessment for safety?
2) How would you know that this client is experiencing acute ETOH withdrawal?
3) What symptoms require immediate interventions?
4) After completing you assessment, you call the physician to obtain medical orders. What should you request?
5) What interventions should be implemented immediately to assure client and staff safety?
6) Does this client meet the criteria for a 5150 as danger to self, others or grave disability?
7) How would you intervene if the patient demonstrates denial?
8) What impact does ETOH abuse typically have on family relationships?
9) Describe the considerations and patient teaching essential for the safe administration of antabuse and naloxalone (Narcan)
10) How would the presentation and interventions differ if the client was 10, 16, 80, male or female?
11) Identify short and long-term goals for a client experiencing chemical dependence.
12) Describe the role of Alcoholics Anonymous, Alanon and other community resources in the role of recovery/treatment.
13) How would you identify potential co-occurring addictions in this client?
14) If this client had a dual diagnosis, such as depression and ETOH dependence, how would it affect your nursing care plan interventions?

Case #2: A 28-year-old male is admitted with a diagnosis of psychosis and methamphetamine abuse. His symptoms include paranoia, anger, irritability, lack of sleep for 3 days, weight loss of 25 pounds. His skin appears quite dry, and has multiple 1 cm round scabs on his forearms and face. His teeth are in disrepair.

1. Which of the symptoms listed above are due to methamphetamine use?
2. Describe interventions to create a safe environment for a client experiencing psychosis due to methamphetamine use?
3. What laboratory findings would you anticipate due to his diagnosis?
4. Identify nursing diagnoses and <u>interventions</u> for the following problems:
    a. Paranoia
    b. Anger and irritable mood
    c. Lack of sleep
    d. Impaired skin integrity
    e. Weight loss
    f. Poor dentition / oral care
5. Identify desired outcomes for individuals with substance use disorders.
6. What are some reasons that nurses have high risk for substance use disorders? What would you do if you were working with a chemically impaired nurse?

Family Assessment and Care Plan

Prepare a 5 to 10-minute presentation from your “Family Interview and Assessment” for your peer group. You may be asked to present any or all of the following items in your presentation:

a) Summary of your family assessment and care plan

b) Explain the significance of family structure and function from a theoretical perspective

c) List developmental tasks of the family’s life cycle stage and significant transitions

d) Describe the family communication and interaction style

e) Explain any ethnic or cultural differences or considerations

f) Indicate adaptive and maladaptive coping responses

g) Briefly summarize the significant findings from the “Family Function Checklist”

h) Explain how interviewing this family has helped you to rethink your ideas and beliefs about community-based nursing

i) Discuss your three NANDA nursing diagnosis and describe the care plan for one diagnosis