College *of the* Mainland

RNSG 2161 Mental Health Nursing Clinical

Summer 2021
Monday, Wednesday, Friday

Clinical Hours Vary

Course Facilitator:

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Office Hours: Tuesdays and Wednesdays
9am to 1 pm

Welcome to Mental Health Nursing Clinical,

The main focus of this clinical course is therapeutic communication with clients that are experiencing mental health problems. We will guide you as you master this competency. This clinical experience is different than the medical-surgical clinical courses. However, as you progress through the curriculum you will find that you will use your new therapeutic communication skills in all health care settings and at home!

Sincerely,

The Clinical Faculty

Required Textbook

Halter, M.J. (2018). Varcarolis 'Foundations of Psychiatric-Mental Health Nursing: A clinical approach 8th ed. St Louis: Elsevier.

Halter, M.J. (2019). Varcarolis Manual of Psychiatric Nursing Care Planning: An Interprofessional Approach 6th th ed. St Louis: Elsevier

Recommended Textbooks
All previous textbooks for the ADN program.

A student attending College of the Mainland is not under any obligation to purchase a textbook from the college-affiliated bookstore. The same textbook may also be available from an independent retailer, including an online retailer.

Course Description

This clinical experience provides for the nursing care of mental health patients in multiple health settings. Opportunities are provided for the application of theory, concepts and skills being acquired. (2 Credit hours; 96 Contact hours, 16-weeks)

Course Objectives/Student Learning Outcomes
Upon completion of this course, the student will:

1. Demonstrate professional student responsibilities by following policies and procedures of the ADN Program and the clinical facility practice guidelines.
2. Assume responsibility and accountability for the quality of nursing care provided to patients and their families under the supervision of clinical faculty and assigned primary nurse.
3. Assess the physical and mental health status of patients with mental health needs and preferences using a structured data collection tool with primary and secondary sources of information.
4. Analyze assessment data to prioritize problems that can be addressed by nursing.
5. Develop a plan of care that identifies patient goals/outcomes and nursing interventions using information from evidence-based practice in collaboration with patients with mental health needs, their families, and the health care team.
6. Implement the plan of care to provide safe, compassionate, ethical nursing care for adult patients with mental health needs and their families in acute care settings.
7. Evaluate attainment of patient goals and related nursing interventions and modify the plan of care in response to changing patient needs.
8. Use standards of nursing practice to provide and evaluate patient care by seeking supervision when practice behaviors and judgments fall outside individual knowledge and expertise.
9. Collaborate and communicate in a timely manner with patients, their families, and the health care team to plan, deliver, and evaluate patient-centered care.

10. Serve as a health care advocate in assessing and promoting safety and quality for patients with mental health needs and their families.
11. Communicate and manage information using technology to support decision making to improve patient care.

WECM End-of-Course Outcomes
Explain the roles of the professional nurse in caring for patients and families experiencing mental health problems; use therapeutic communication; utilizes critical thinking skills and a systematic problem-solving process for providing care to patients and families experiencing mental health problems.

Course Policies

Attendance:
See the Attendance policy in the Nursing Student Handbook.

Tardiness:
See the Attendance policy in the Nursing Student Handbook.

Withdrawal:
See Admission, Progression, Dismissal, & Readmission policy in the Nursing Student Handbook.

ADA Statement:
Any student with a documented disability needing academic accommodations is requested to contact Holly Bankston at 409-933-8520 or hbankston@com.edu. The office of Services for Students with Disabilities is located in the student center.

Early Academic Alert Program:

The Counseling Center at College of the Mainland has implemented an Early Warning Program. Students will be referred to the program throughout the semester if they are having difficulty completing assignments or have poor attendance. If referred to the Early Warning Program, students will be contacted by someone in the Counseling Department. As student success and retention is very important to us, someone from the Counseling Department will schedule a meeting with you to see what assistance they can offer in order for you to meet your academic goals.

Classroom Conduct Policy/Student Conduct:

Classroom Conduct Policy: College of the Mainland requires that students enrolled at COM be familiar with the Standards of Student Conduct, which can be found in the on-line Student Handbook. http://www.com.edu/student-services/studenthandbook.php . Students should act in a professional manner at all times. Disruptive students will be held accountable according to college policy. Any violations of the Code of Conduct will result in a referral to the Office for student Conduct and may result in dismissal from this class.

In addition to the Standards of Student Conduct found in the online COM Student Handbook http://www.com.edu/student-services/student-handbook.php, nursing students are expected to demonstrate good professional character as defined in in BON Rule 213.27 (http://bon.texas.gov/rr_current/213-27.asp). See Behavior/Conduct in the Nursing Student Handbook.

COVID-19 Statement:

All students, faculty, and staff are expected to familiarize themselves with materials and information contained on the College of the Mainland's Coronavirus Information site at www.com.edu/coronavirus. In compliance with Governor Abbott's May 18 Executive Order, face coverings/masks will no longer be required on COM campus. Protocols and college signage are being updated. We will no longer enforce any COM protocol that requires face coverings. We continue to encourage all members of the COM community to distance when possible, use hygiene measures, and get vaccinated to protect against COVID-19. Please visit com.edu/coronavirus for future updates.

Academic Dishonesty
Any incidence of academic dishonesty will be dealt with in accordance with college policy and the Student Handbook. Academic dishonesty, such as cheating on exams, is an extremely serious offense. See Behavior/Conduct policy in the Nursing Student Handbook.

Plagiarism
Plagiarism is using someone else's words or ideas and claiming them as your own. Plagiarism is a very serious offense. Plagiarism includes paraphrasing someone else's words without giving proper citation, copying directly from a website and pasting it into your paper, using someone else's words without quotation marks. An assignment containing any plagiarized material will receive a **grade of zero** and the student will be referred to the Office of Student Conduct for the appropriate discipline action. See Behavior/Conduct policy in the Nursing Student Handbook.

Avoiding Plagiarism: Http://www.plagiarism.org

Assignments/Requirements

1. *Clinical Data Sheets* - Students will complete a Daily Clinical Sheet each clinical day. This is similar to the SBAR form used in previous clinical courses, but is specific for mental health nursing. The daily clinical sheet contains patient history, diagnoses, priority nursing diagnosis, scheduled activities, any precautions, and prescribed medications. This sheet will be reviewed by the clinical instructor during the clinical day and submitted with the medication sheets on a date specified by the clinical instructor. Please refer to the grading criteria.
2. *Process Recording* – During the semester, the student will choose a patient which the staff states is appropriate for assignment interaction. The student will establish an agreement with the patient for a 15–20-minute session where the student will interact with the patient practicing therapeutic communication techniques. Afterwards, the student will complete the process recording form with information gathered during the conversation.
3. *Major Care Plan* - Students will create an individualized nursing care plan for one patient using assessment data gathered during the clinical shift. Critical thinking skills will be utilized to analyze the data, create and implement a plan of care as well as evaluate the effectiveness of the nursing care. For grading criteria, please refer to the

Care Plan Evaluation Tool in Blackboard. The Major Care Plan assignment will address the Core Objective: Critical Thinking.

4. ***Volunteer activity*** - Students will volunteer four hours to a local organization that serves

the homeless population in the community. The organization must be approved by the clinical instructor. A brief paragraph will be written by the student to summarize their experience and reflecting the importance of civic responsibility as a health care advocatein assessing and promoting safety and quality for patients with mental health needs and their families. Please refer to the grading criteria. The Volunteer Assignment will address the Core Objective: Social Responsibility.

5. *Professional Journal Article Review* - Students will choose a current evidenced-based professional nursing journal article pertaining to a mental health topic. Students will interpret, analyze and summarize the data in the article, state the implications for nurses and address their personal reactions to the conclusions. Students will present their articleto their clinical group during post-conference. Please refer to the grading criteria.

6. ***Clinical Evaluation*** – The clinical evaluation will be completed in two (2) parts. On the date designated by the clinical faculty, the student will submit a self-assessment on the Clinical Evaluation Tool. Once the self-evaluation has been completed by the student, the clinical faculty will complete the process by doing the faculty portion of the Clinical Evaluation Tool.
7. ***Movie Analysis Project***-Desired Outcome: Students will develop their understanding of the featured mental illness through the analysis and evaluation of the characters' portrayal of mental illness, which will include a discussion of the accuracy of portrayal as well as the diagnosis criteria and treatment of the featured disorder.

Bring Your 'A' Game Anywhere (To be completed online)

Bring Your 'A' Game Anywhere is an engaging e-learning course for developing the seven foundational workplace skills of work ethic. It is estimated that you will need 10 hours to complete this course. Instructionsfor enrollment, the username, and passcode will be sent to you in a confirmation email. The link for this course is located in Blackboard. It is designed to promote awareness and build the seven foundational skills ofwork ethic that include:

- Attitude
- Attendance
- Appearance
- Ambition
- Acceptance

- Appreciation
- Accountability

A passing grade for the exam is 90% or higher. You will have a total of 3 chances to take and pass the exam. If youdon't get a passing grade on you first attempt, a 2nd and different exam will become available to take. If you don't earn a passing grade on that exam, you will have one final time to pass the exam, and again, the questions will be new. If you do not pass the exam on the last attempt, you will not be issued a Certificate of Work Ethic Proficiency,and the grade of that last attempt will be recorded on the grade book.

Make-up Policy/Late Assignments:

All course assignments are expected to be completed and submitted on the specific due date. See Late Assignments policy in the Nursing Student Handbook.

Grading Scale
A = 90-100
B = 80-89.99
C = 75-79.99*
D = 60-74.99
F = < 60
*A minimum final grade of "C" is required to pass this course.

Grade Calculation
All assignments, including pass/fail, must be submitted to pass the course.   See Grade Determination and Calculation in the Nursing Student Handbook.

Assignment of Course Grade	%

Clinical Data Sheets	15
Process Recording	25
Major Care Plan	30
Volunteer Activity	10
Professional Journal Article Review	10
Certificate of Work Ethic Proficiency	10
Movie Analyze: A Beautiful Mind	10
Clinical Performance Evaluation*	P/F
TOTAL	100%
* ≥ 75% score required to pass the course	

Concerns/Questions

If you have any questions or concerns about any aspect of this course, please contact me using the contact information previously provided. If after discussing your concern with me, you continue to have questions, please contact the Course Facilitator. If, after discussing your concerns with the Course Facilitator, you still have questions, please contact Director of Nursing Amanda Ordonez at (409) 933-8425 or mordonez@com.edu.

See the Student Concerns Policy in the Nursing Student Handbook.

Successful Tips for Students
1. Schedule time to study based on the difficulty of the content. Use this table as a guide:

Course Difficulty	Study Hours Per Week Per Hour in Class
High Difficulty Course	3 hours
Medium Difficulty Course	2 hours
Low Difficulty Course	1 hour

http://www.usu.edu/arc/StudySmart/pdf/estimating_study_hours.pdf

2. Read assignments before class or clinical. Here are some strategies for getting the most out of your college textbooks:

- 4 Steps to Reading a Textbook:
  http://www.studyright.net/blog/4-steps-to-reading-a-textbook-quickly-and-effectively/
- Active Reading Strategies:
  http://www.princeton.edu/mcgraw/library/for-students/remember-reading/
  - The Reading Cycle: Plan-Do-Review
  http://www2.swccd.edu/~asc/lrnglinks/txtrdg.html
  - How to Read Your Textbooks More Efficiently College Info Geek (video)
  https://www.youtube.com/watch?v=tgVjmFSx7rg
  - 5 Active Reading Strategies for Textbook Assignments College Info Geek (video)
  5 Active Reading Strategies for Textbook Assignments - College Info Geek

ANA Scope and Standards of Practice:

Students are expected to adhere to established ANA Scope and Standards of Practice (2015). (See Student Handbook and Clinical Evaluation Tool for detailed explanation of standards).

Student Handbooks:
Students are expected to adhere to all policies outlined in the College and Nursing Program Student Handbooks.

Syllabus Revisions:
Faculty reserves the right to make changes to the syllabus as deemed necessary.

The Speaking, Reading, and Writing Center:

The Speaking, Reading and Writing Center provides free tutoring services to students, staff and faculty seeking assistance for writing, reading and oral presentations for academic and non-academic assignments/projects. Located in the Technical Vocational Building, Room 1306, the center provides face-to-face and online tutoring sessions in a welcoming environment. Appointments can be made in person, or on the center scheduler at com.mywconline.com, or by clicking the SRWC icon on the COM website.

Statement of Eligibility for an Occupational Licensure:

IMPORTANT: Eligibility for an occupational license may be impacted by one's criminal history. Students with a criminal history should confer with faculty or the department chairperson. Students have a right to request a criminal history evaluation letter from the applicable licensing agency.

Methods of Instruction
Clinical Lab Skills
Clinical Process Recordings
Clinical Nursing Care Plan
Clinical Conferences
Clinical Court Proceedings
Community Support Group Meeting
                                        Clinical Guidelines

Guidelines for Clinical Experience

Mandatory facility "Orientation" date and time is noted on the course calendar. Additional instructions regarding directions to the assigned facility, parking fees, etc., will be given in class.

Dress code includes the wearing of school uniform.

Wear your school name tag at all times in the clinical setting. You may be required to get an additional photo and badge at some facilities.

Student Activities during the Clinical Day
During the course of a typical clinical day the student will:

1. Arrive at the clinical facility at the designated time, dressed appropriately, and without any dangling jewelry from the ears, neck or wrists (safety issue), and with no excessive cosmetics or perfume, and avoiding any provocative dress or behavior that would call undue attention to oneself.
2. Meet with your clinical instructor at the time and place for pre-conference.
3. Go to your unit and put your books, etc. in the designated place for students. Do not bring anything like your books or backpack, etc., out into the Day Room area of the client units.
4. Do not bring valuables to clinical, e.g., large amounts of money or credit cards or expensive jewelry (leave them locked in your car if brought unintentionally).
5. Meet with the charge nurse/milieu nurse for the shift report.

6. Plan to attend staffing, patient group activities, education group, recreational activities, music therapy etc., during the day with patients. Ask the presiding therapist of any "process group", if you may sit in.
7. The charge nurse/milieu nurse will assign you to an appropriate patient for your "one to one" interaction.
8. Interact with patients presenting a variety of behaviors.
9. Collaborate with the other health care professionals on the unit by sharing pertinent information and seek them out for consultation prudently.
10. Observe the staff and patient interactions in all aspects of the unit activities.
11. Complete a Daily Work Sheet, which will have mostly patient information, as well as your hourly activities.
12. You may go to lunch (30 minutes) whenever the charge nurse says you can. Do not leave the facility without informing your instructor.
13. Consult with your clinical instructor freely.
14. Arrive and participate in post conference at the designated time and place.
15. Have your Daily Work Sheet ready for your clinical instructor as designated.

Guidelines for Selecting Patients
Select patients who are as responsive verbally as possible for you to be able to gain the experience of learning how to therapeutically communicate. The charge or milieu nurse should be consulted and give his/her approval for the selection of a patient for your "one to one" interaction, (which will involve completing a process recording later), and who will remain your patient each day in clinical until the patient is discharged. At which time you will select another patient with charge/milieu nurse input.

Additional guidelines for selecting and interacting with patients:
1. Make yourself available by mingling in the day room with the patients who are up and about. Avoid isolating yourself in the chart room or nurses station.
2. Initiate a conversation gently by introducing yourself and asking the patient's name.
3. Explain why you are there (student nurse learning how to talk to patients).
4. If you decide on a particular patient for a "one to one", then you will ask the patient if he/she would consider talking with you on the days you are there and if the patient is there. Make a contract for the place and time to meet for your 30-45 minute "one to one" interaction each day. The time for your 1:1 will depend on the unit activity schedule. Always meet in the day room where you both can be seen at all times. Never go into a patient's room without a staff member present.
5. Assure the patient that your conversations are confidential except for your clinical instructor, and if the patient shares information that involves safety issues, that would have to be reported to staff.
6. Also, assure the patient that no names are ever used when discussing the patient with the instructor.
7. Try to select a patient that will be there for a period of time so that you can see the progress.
8. Reading the patient's chart before interacting will be left up to you. There are pro's and con's on this issue, which we will discuss. However, NEVER discuss anything that you read in the chart unless the patient brings it up first.
9. NEVER ask the patient what has been discussed in group unless the patient brings something

up, and then you're not to discuss other patient's issues. You can refer the patient to the staff or have patient bring the issue back to the group. Seek staff or instructor assistance as needed.

10. You are not to write anything down on paper or record the conversation you have during your 1:1 interaction. The best way to recall what was said for your Process Recording is to write it down after you are finished and can go to a quiet area, such as the chart room.

11. You are encouraged to interact with other patients on the unit as well however, the patient you have your 1:1 with is different and more focused.

Guidelines for Medication Administration
Nursing students ***DO NOT ADMINISTER ANY MEDICATIONS DURING THIS CLINICAL ROTATION.*** However, psychopharmacology is an important aspect of the clinical experience. So, we will be discussing your patient's medications daily. You will be responsible for knowing about all your patient's medications (both scheduled & prn), classification, action, indications for use, dosage, time, route, side effects, nursing implications, and target symptoms for your client.

You are encouraged to observe the medication nurse administer medications to patients, so that you can see the nurse-patient interactions during this time. Monitoring the patient's for medication effectiveness is also an important aspect of the nurse's role.

Guidelines for Charting
Student nurses do not chart on the patient record during this clinical rotation. However, you may read the patient chart, but do not make photocopies of anything in the patient record without permission from the charge nurse and your instructor. You will be expected to report only pertinent data from any medical and/or lab tests for Care Plans etc., so copying forms from a patient chart is unnecessary.

Student Responsibilities as a Team Member
The student will be held accountable for the responsibilities of a team member as outlined in the Clinical Evaluation Tool.

Clinical Conferences
Students are expected to attend pre and post conferences at the times and place designated by the clinical instructor. Post conference learning activities are at the discretion of the clinical instructor and all students are expected to comply and complete the requested assignments.

Clinical Paperwork Assignments
1. All paperwork must be submitted online.
2. All paperwork must be typed or printed.
3. Assignment due dates are two days following the clinical day (example Clinical day Monday paper work due Wednesday by 2359)

Clinical Facilities
Clinical site locations vary each semester, but typically include:
- Harris County Psychiatric Center, Houston
- St. Joseph Hospital - Houston
- Devereux Hospital- League City

- VA-Hospital-Houston
- Sacred Oaks Hospital
- Sun Behavioral Health

Process Recording

STUDENT'S NAME: _____

PATIENT'S INITIAL: _____

PROBLEM: _____

PATIENT SHORT TERM GOAL: _____

PATIENT LONG TERM GOAL: _____

PATIENT NURSING DIAGNOSIS: _____

PURPOSE OF THE SESSION:

OBSERVATION:

SETTING:

Process Recording

Student nurse's verbal and non-verbal communication	Patient's verbal and non-verbal communication.	Student nurse's thoughts and feelings concerning the interaction	Identification and analysis of therapeutic and non-therapeutic communication	Evaluation (Effective or not effective and why)

Process Recording

Continue with the body of the interview so that the interview itself is **approximately   3-4 page***s. You may add as many pages as you need; this is an expandable table. Include the identified criteria, such as the verbal statements, non-verbal behaviors which may be congruent with or non-congruent with the verbal statements. Clearly identify and state what you heard, saw, thought, felt, etc. Support the statements, behaviors, responses, etc with the theory from the required textbook, and /or Evidence Based Practice from the College of the Mainland Library home page/Search engine/ and identified topics.*

1. Enter the data at the top part of the sheet. The recording is to be made on a meeting withyour client. Develop a short-term goal that is client centered and that will serve as a guideline and purpose for the communication/session.

2. Enter the data at the top of the sheet? Develop a long-range goal, that are relevant for this client for your plans for the next session).

3. The length of time of any given session can vary from 10 minutes to one hour. Refer to your Psychiatric Nursing Textbooks as available in preparation for your process recording with your client (i.e. review of Therapeutic Communication Techniques).

4. **Setting:** Describe the setting and your plans to therapeutically approach the client at the beginning of the session with sufficient clarity and detail so that the instructor will be helped in his/her understanding of the situation. The setting includes adescription of the physical environment, time, position of you and the client and any other pertinent details. The therapeutic approach includes the verbal and nonverbal therapeutic communication techniques you plan to utilize during the interaction.

5. **Columns One & Two/Verbal and Non-Verbal Communication Student and Client:** The nonverbal communication of both you and the client are as important as the verbal communication. Identify the nonverbal communication. Is there congruence between the verbal and nonverbal communication? Recording of verbal communication should be verbatim. If the meeting includes a period of an activity that you participate inwith the client, record only the beginning, the termination, and what you consider significant material in the remaining time.

6. **Column Three/Student's thoughts and feelings concerning the interaction:** Describe your reactions to the communication. What kind of emotions did you feel and why? Were you at ease or uncomfortable? Did you feel you had to struggle to remain objective? Did you feel like you could help the client? Did you feel confident at the end of the communication?

7. **Column Four: Identification and analysis of therapeutic and non-therapeutic communication.**

8. **Column Five**: Based off identification and analysis of therapeutic and non-therapeutic communication. Is the therapeutic technique and communication effective or ineffective for this patient's session?

Process Recording Guidelines & Grading Criteria

Review the following points prior to beginning the process recording with your patient.

Nurse's Communication
A.   Write own responses made to the patient.
B.   Guide the interaction form the superficial to the complex.
C.   Guide the focus of the interaction away from the nurse.
D.   Use open-ended statements to gain information.
E.   Use direct questioning to obtain specifically needed information.
F.   Ask for clarification, restatement, and elaboration.
G.   Wait out silence or allows the patient to feel a pause.
H.   Allow the patient to express an idea.
I.   Encourage reflection of feelings and ideas.
J.   Note changes in subject matter.
K.   Explore pertinent points or gestures.
L.   Identify patient's feelings and underlying meaning of the behaviors.
M.   Encourage the patient to identify problems.
N.   Withhold advice
O.   Withhold approval or disapproval of an idea expressed
P.   Encourage the patient to explore alternatives.
Q.   Close therapeutic interactions & establish opportunity for next interaction.

Analysis of Nurse's Communication
A.   State therapeutic or non-therapeutic technique employed.
B.   Write interpretation of own responses to the patient.
C.   Evaluate own participation in the interaction.
D.   Interpret verbal and nonverbal communication to patient.
E.   Recognize and interpret therapeutic and/or non-therapeutic communications.
H.   Write objectives for self-improvement.
I.   Write own feelings & interpretation of feelings.
Revise & replace non-therapeutic communication techniques with appropriate therapeutic communication techniques.

STUDENT: _____

Criteria	Points	Score
Student Nurse Verbal (Nonverbal)	20	
Client Verbal (Nonverbal)	20	
Student Nurse Thoughts & Feelings	15	
Analysis of the Interaction • Identify therapeutic (Table 6.3) and non-therapeutic (Table 6.4) communication techniques used by student nurse. • Suggest alternate therapeutic communication technique for each non-therapeutic technique used	20 5	
One Short Term Goal- SMART	5	
One Long Term Goal-SMART	5	
Nursing Diagnosis: Psychosocial or Knowledge Deficit	5	
Evaluation of therapeutic technique (Effective or Ineffective)	5	
Comments: **TOTAL**	**100**	

Professional Nursing Journal Article Review Guidelines & Grading Criteria

1. Choose a current evidenced-based professional **nursing journal** article pertaining to a mental health topic from the CINAHL database at the COM library online.
2. Interpret, analyze, and summarize the data in the article **in your own words**.
3. State the implications for nurses **in your own words** citing references to support your position.
4. Include your personal reactions to the conclusions in the article **in your own words**.
5. Include the APA citation and permalink to full-text article in document. Submit to safe assign.
6. Present the summary to the clinical group during post conference.
7. Submit your written review via Bb

Grading Criteria for Professional Nursing Journal Article Review

Criteria	Points	Score
APA Citation & Permalink	5	
Purpose of Article	10	
Summary	30	
Nursing Implications	30	
Impact on Patient Care	15	
Presentation	10	
TOTAL	100	

Journal Article Discussion Board

- **Weekly Student Discussion Leaders:** Must post in group discussion on Blackboard a PDF link to article chosen, and their written presentation. They must also upload the presentation in Blackboard under "Journal Article". This is due on your assigned date. You will be the week leader or co-leader if more than one person is assigned that week. The leaders should be monitoring the discussion for the entire week, and replying to students' questions or observations, remember **YOU ARE LEADING THIS JOURNAL DISCUSSION**.
- **This will be part of your presentation grade for your journal article.**
- **Student Members:** Must read the leader's presentation and comment on the article. **Each student must have at least 1 reply per week! This will be counted as part of your clinical grade.** Reply's must be intelligent, academic, and show thought and depth that you have read the leader's presentation and article. WILL NOT ACCEPT posts such as " great article, without discussion on how YOU could use in practice. Please review https://writingcommons.org/article/online-forums-responding-thoughtfully/ on how to respond to online discussions.
- **Faculty Moderators:** Will be observing your discussions/replies in the forum. Leader's this will be your 'presentation' grade, and student members this will be part of your 'clinical' grade.

Grading Rubric for Major Care Plan

Nursing Process	Key Elements	Sub Elements & Directions	Points	Score	Instructor Grading Comments
Assessment	Shift Assessment	Shift Assessment (documented under "assessment" under flowsheet tab	10		Subtract 1 point for each system or mandatory assessment item not addressed.
	Nutrition	Nutrition –patient diet in relation to disease process	1		
	Care Plan	Subjective Data (Pt stated symptoms)	3		one for each Nursing diagnoses (1 point x 3 =3)
		Objective data (summarized in care plan)	3		one for each Nursing diagnoses (1 point x 3 =3)
Diagnosis **1 Physiological** **1 Psychosocial or knowledge deficit** **Prioritized by ABCs and Maslow's Hierarchy of**	Nursing Diagnosis #1	Based off subjective, objective and assessment data?	3		
	Nursing Diagnosis #2	Based off subjective, objective and assessment data?	3		

needs?					
Planning/ Analyze	Medical Record	Medication Profiles	10		1 point per med (max points = 10). For each point, 0.14 points for each of these elements: Indication, Route, Action, Adverse Effects, Contraindication, Patient Teaching, Nursing Implications. If <10 meds, recalibrate each point component so that complete work can = 10 points.
	Care Plan: Pathophysiology*	Pathophysiology,	2		
		Pre-disposing factors	2		
		Signs and symptoms	2		
		Medical diagnosis and treatment, and nursing interventions (per patient)	2		
	Nursing Dx #1 Short term goal	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		
		Is it time based?	1		
	Nursing Dx #1: Long term goal	Is it specific?	**1**		
		Is it measurable?	**1**		
		Is it achievable and realistic?	**1**		
		Is it time based?	**1**		

NursingProcess	Key Elements	Sub Elements & Directions	Points	Score	Instructor Grading Comments
Planning/Analyze	**Nursing Dx #2** **Short term goal #1***	Is it specific?	**1**		
		Is it measurable?	**1**		
		Is it achievable and realistic?	**1**		
		Is it time based?	**1**		
	Nursing Dx #2 **Long term goal**	Is it specific?	**1**		
		Is it measurable?	**1**		
		Is it achievable and realistic?	**1**		
		Is it time based?	**1**		
Interventions/ Implementation	**Nursing Dx #1** **STG #1***	Intervention #1	**2**		0.50 points: evidence-based, 0.50 rationale, 0.50 reference included, 0.50 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	**2**		
	Nursing Dx #1 **STG #2***	Intervention #1	**2**		0.50 points: evidence-based, 0.50 rationale, 0.50 reference included, 0.50 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	**2**		
	Nursing Dx **#1 LT G**	Intervention #1	**2**		0.50 points: evidence-based, 0.50 rationale, 0.50 reference included, 0.50 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	**2**		
	Nursing Dx #2 **SIG#1***	Intervention #1	**2**		0.50 points: evidence-based, 0.50 rationale, 0.50 reference included, 0.50 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	**2**		
	Nursing Dx #2 **STG #2***	Intervention #1	**2**		0.50 points: evidence-based, 0.50 rationale, 0.50 reference included, 0.50 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	**2**		
	Nursing Dx #2 **LTG***	Intervention #1	**2**		0.50 points: evidence-based, 0.50 rationale, 0.50 reference included, 0.50 documented in nurses notes (tied to specific nursing diagnosis
		Intervention #2	**2**		

					& goal)
Evaluation	**Nursing Dx #1***	Evaluation of STG#1	**2**		1.0 point for documented attainment. If not attained: - 0.50 for documented failure of attainment - 0.50 for documented revision of goal (if applicable), OR reason why it was not attained.
	Nursing Dx #2*	Evaluation of STG#1	**2**		1.0 point for documented attainment. If not attained: - 0.50 for documented failure of attainment - 0.50 for documented revision of goal (if applicable), OR reason why it was not attained.

	Medical record	Nurses' notes (every two hours, a minimum of 4 notes)	7		1.0 point for each note. Max = 4 points
	Communication: SBAR	Situation documented	2		
		Background documented	2		
		Assessment documented	2		
		Recommendation/request documented	2		
		Total Possible Points	**100**		

SBAR/Clinical data sheet (Record in EHR Tutor – Report in post-conference)

Your name:_____Location_____Date_____

Before you speak with your clinical instructor: Assess the patient, review the chart, know the admitting diagnosis, and most recent nursing note.

Have available in your hands or on the computer: Chart, Allergies, Meds, IVs, Labs/result.

S = Situation What is the problem? Legal Status: Voluntary or Involuntary Legal Guardian/Power of attorney: Primary language spoken: Physician: Diagnosis/Chief complaint: Allergies:
B = Background Admitting Diagnosis? Allergies? Pertinent Medical History: Summary of treatment to date: Special needs:
A = Assessment   BP_____P_____R_____T_____O2? Y__N__ Sat____ Medications given: Treatment given: EKG: Skin/wound integrity: Abnormal labs: Orientation to person, place, time, situation: Can person do ADL's: Can person ambulate: Is pt suicidal/homicidal /hallucinating/delusional: Mood: Cooperation: Continence: Last BM:
R = Recommendation Nursing Diagnoses (Potential problems): Outcome/Goal (What you want to happen): Interventions (What you need to do to accomplish goal):

*The acronym SBAR was developed by the navy for quick clear communication, adapted for clinical situations in nursing.

Grading Criteria for weekly charting	Possible Points	Points Earned
Nursing Process: Care Plan		
Assess		
• Chief complaint & history of present illness	**5**	
• Complete behavioral health	**5**	
• Medications including generic/brand name, classification, dosage instructions, indication, under the comment section include major side effects, nursing implications, effectiveness/non effectiveness and data to support this	**5**	
• Completed screening tool for patient's diagnosis	**5**	
• Diagnostic studies- current labs, non-routine and abnormal labs if available, and all diagnostic study results such as chest X-rays, etc	**5**	
Total	**25**	
Documentation/Communication		
Charting Clear (easily understood) Narrative Note- Timely (every 2 -3 hours – at least 4 entries per shift) includes Head to Toe Assessment documentation. (Concise (gets to the point, informative (adds value to patient care)	**15**	
Total	**15**	
Plan of care Nursing diagnosis is priority for patient condition	**10**	
Goals are SMART (Specific, measurable, attainable, realistic and time-lined). 1 STG 1 LTG	**5**	
Interventions are related to the Goal. (4 nursing interventions)	**10**	
Interventions are supported by scientific rationales and the source is documented in APA format	**10**	
Total	**35**	
Reporting (SBAR) S = Situation What is the problem leading to hospital admission? Legal Status: Voluntary or Involuntary Legal Guardian/Power of attorney: Primary language spoken: Physician: Diagnosis/Chief complaint: Allergies:	**5**	
B = Background (psychiatric hx) Admitting Diagnosis? Allergies? Pertinent Medical History: Summary of treatment to date: Special needs:	**5**	
A = Assessment BP_____P_____R_____T_____O2? Y__N__ Sat____ Medications given: Treatment given: EKG: Skin/wound integrity: Abnormal labs: Orientation to person, place, time, situation: Can person do ADL's: Can person ambulate: Is patient suicidal/homicidal /hallucinating/delusional: Mood: Cooperation: Continence: Last BM:	**10**	
Recommendations:	**5**	
Total	**25**	
Total	**100**	

Movie Analysis Project

Desired Outcome: Students will develop their understanding of the featured mental illness through the analysis and evaluation of the characters' portrayal of mental illness, which will include a discussion of the accuracy of portrayal as well as the diagnosis criteria and treatment of the featured disorder.

Assignment: After watching the movie, "A Beautiful Mind."

Each student will review, summarize, and critique an assigned movie related to a mental health nursing.

You will probably need to view the movie two to three times to accurately complete this project.

The movie will portray a character or characters who is/are experiencing a psychological disorder/mental illness. Watch the movie and then please do the following:

1. Write a very brief summary of the movie. Give me some clear evidence that you watched it.
2. Be sure to include an instruction.
3. Write a description of how of the psychological disorder and/or the therapy that was portrayed.
4. Write a critical analysis of how accurate or inaccurate you found the portrayal of the disorder/therapy.
5. Show evidence of your knowledge of the psychological disorder/mental illness or the type of therapy (i.e. include information from class or the text, clinical setting).

Refer to Movie Analysis Project Grading Criteria for
additional details.

Guidelines:
- Your total paper should be 2-3 pages in length, typed, and double-spaced. (Not including a reference page and title page)
- Typeset in Times or Times New Roman 12-point font.
- 1-inch margins all around
- Please format your paper as a MS Word document. To submit your paper, use the **Movie Analysis Project submission link" in our Blackboard classroom**.
- Please cite the 3 references in APA format at the end of your paper. (Textbook, movie, etc.)
- Please cite the 2 evidence-based nursing interventions in APA format at the end of your paper.

Movie Analysis Project Grading Criteria		Possible Points	Points Earned
Chief Complaint	(Why, in his/her "own words", would the client say he/she is being assessed?)	**5**	
History Questions/Answers	**Based on the above information and a close viewing of the movie, what questions would you raise during history taking?** You might base your questions on the: History of your client's present (and presenting) illness. Past psychiatric history, its treatment, and treatment outcomes Psychosocial history Past significant medical history	**10**	
Behavioral Observations	**Observations (what have you observed in the movie, *i.e.* behavior, S&S, enablers, cultural considerations)**	**10**	
Diagnostic Criteria	**What are your supporting assessment criteria for the client's 2 anticipated nursing diagnosis?**	**5**	
Criteria Support Evidence	**What are your supporting assessment criteria for the client's 2 anticipated nursing diagnosis?**	**5**	
Treatment Plan	What kind of treatment would you outline/ suggest for this client? • What level of care appropriate? *Be thorough.*	**30**	
Short Term Treatment Goal	**What are your ST and LT goals for this client?** • **One short goal-** *This must be tied back to the client in the movie.*	**5**	
Long Term Treatment Goal	• **One long term goal-** *This must be tied back to the client in the movie.*	**5**	
Nursing Intervention	**What is your 2-evidence based nursing interventions this client?** **One Nursing intervention -** *This must be tied back to the client in the movie.* • **One Nursing Intervention-** *This must be tied back to the client in the movie.*	**5**	
Accurateness of Portrayal	**What is your impression of the accurateness of the portrayal of the client's diagnosis/symptoms in the movie?** • How did the mental health professional interact with the main character? • What was the unique message about mental illness of the movie for you?	**10**	

Resources in APA format	0 - 2 points: Uses and sites 1or less professional medical resources. **(Book, article, organization) using APA.**	2.1 – 6 points: Uses andsites 2-3 professional medical resources. **(Book, article, organization) using APA.**	6.1- 10 points: Uses and sites 4 or more professional medical resources. **(Book, article, organization) usingAPA.** Total	**10**	
			Total	**100**	

Volunteer Activity

Objective:

Volunteer four hours to a local organization that serves the homeless population in our community. Examples include the Houston Food bank, The Jessie Tree, MI Lewis etc.… Uponchoosing an organization, get approval of this site from your clinical instructor. Take this formwith you to get the following information. This assignment is due according to your syllabus calendar.

Name of organization: _____ Address of organization: _ Contact

person for the organization: _____ Phone number and email of contact

person: _____

_____

Signature of contact person: _____ Date of attended: ____

A brief paper will be written by the student to summarize their experience and reflecting on the importance of civic responsibility as a health care advocate in regard to assessing and promotingsafety and quality for patients with mental health needs and their families.

Grading Criteria for Volunteer activity

Criteria	Points		Score
Describe services offered by the organization.	25		
Who is the target population served by this agency?	25		
How can nurses advocate for the homeless population in their community?	25		
How can nurses promote safety in the community for those with mental health needs?	25		
	100		
TOTAL	**100**		

RNSG 2161 Mental Health Course Calendar

Week	Assignment	Dates
Week 1 6/7/2021 – 6/13/2021	Complex Course Syllabus Acknowledgement Nursing ADN Handbook Mental Health Pre- Clinical Orientation	**Acknowledgement Due 6/12/2021 by 2359**
Week 2 6/14/2021 to 06/20/21	Professional Journal Article Review with discussion board See Blackboard for due date.	Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.
Week 3 6/21/21 to 6/27/21	Professional Journal Article Review with discussion board See Blackboard for due date.	Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.
Week 4 6/28/21 to 7/4/21	Professional Journal Article Review with discussion board See Blackboard for due date.	Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.
Week 5 7/5/21 to 7/11/21	Professional Journal Article Review with discussion board See Blackboard for due date.	Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.
Week 6 7/12/21 to 7/18/21	Professional Journal Article Review with discussion board See Blackboard for due date.	Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.

RNSG 2161 Mental Health Course Calendar

Week 7 **7/19/21 to 7/25/21**	**Volunteer Activity** **Mid-Term Clinical Evaluation** **Professional Journal Article Review with discussion board** **See Blackboard for due date.**	**Volunteer Activity Due on 7/25/2021 at 2359** **Mid-Term Clinical Evaluation Due 7/17/2021 at 2359** **Professional Journal Article Review with discussion board** **See Blackboard for due date.** **Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.**
Week 8 **7/26/21 to 8/2/21**	**Professional Journal Article Review with discussion board** **See Blackboard for due date.** **Bring your A-Game Assignment**	**Clinical Data Sheets due for student in clinical this week-Due 2 days after clinical rotation.** **Bring your A-Game Modules due 7/31/2021 2359.**
Week 9 **8/3/21 to 8/8/21**	**Professional Journal Article Review with discussion board** **See Blackboard for due date.** **Movie Analysis Project**	**No Clinical Data Sheet due to this week** **Movie Analysis Project due 7/30/2021 2359**
Week 10 **8/9/21 to 8/15/21**	**Final Clinical Evaluation**	**Final Clinical Evaluation due 8/6/2021 at 2359** **No weekly documentation due**
Process Recording due on your 4th clinical rotation. **No weekly clinical documentation is due.**		
Major Care Plan due on 3rd clinical rotation. **No weekly clinical documentation is due.**		

RNSG 2161 Mental Health Course Calendar