



RNSG 2161-101C3
Mental Health Nursing Clinical
Fall 2025
Monday-Wednesday-Friday

Facilitator: Stephanie Griggs, DNP, FNP-BC, sgriggs2@com.edu, 409-933-8920

Adjunct Instructors Information:

Wanda Williams, MSN, RN, CHSE, wwilliams13@com.edu

Dolly Adele, PMHNP-BC, MSN, ladele@com.edu

Victoria Castro, MSN, RN, vcastro@com.edu

Student hours and location: As directed on the calendar and/or clinical grid

Required Textbook/Materials:

Halter, M. (2021). *Varcarolis' Foundations of Psychiatric-Mental Health Nursing* (9th Edition). Elsevier Health Sciences (US).

Simulations - SimChart: Instructor-Led Course

[SimChart 6-Month, 1st Edition](#)

By Elsevier Inc

ISBN: 9781455711734

Course ID: 99331_bketcherside3_1003

Instructor: Benjamin Ketcherside

Recommended Textbooks:

All previous textbooks for the ADN program

Course Description: This clinical experience provides nursing care for mental health patients in multiple health settings. Opportunities are provided for the application of theory, concepts, and skills being acquired (1 Credit hour; Lecture 0, 64 Contact hours, Clin 4, 16 weeks).

Course requirements:

Assignments/Requirements

1. **SimChart Assignment** – During one clinical day, the student will complete daily charting in SimChart. The SBAR segment is like previous clinical courses but is specific to mental health nursing. The SBAR segment contains patient history, diagnoses, priority clinical problems, scheduled activities, any precautions, and

prescribed medications.

2. **Process Recording** – During one clinical day, the student will choose a patient whom 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. Afterward, the student will complete the process recording form with information gathered during the conversation.
3. **Concept Map** – During one clinical day, the student will complete a concept map. The concept map will focus on a priority clinical problem chosen by the student (and faculty as necessary). Some components of the concept map will be documented in SimChart.
4. **Reflection paper**- During the last day of inpatient clinical, students will complete a reflection paper based on their personal opinion and thoughts supporting it with observations and personal experiences.
5. **Volunteer activity** - Students will volunteer eight hours to a local organization that serves individuals or communities in need. The clinical instructor must approve the organization. The student will write a brief paper to summarize their experience and reflect on the importance of civic responsibility as a health care advocate in assessing and promoting safety and quality for patients with mental health needs and their families.
6. **Group Presentation**- Mental Health Across Cultures- Students will investigate how common mental health disorders are perceived, diagnosed, and treated in different cultural contexts. The goal is to understand the impact of cultural beliefs, stigmas, traditions, and healthcare systems on mental health
7. **Clinical Evaluation** – Clinical midterm and final evaluation- The clinical evaluation tool is utilized to formatively and summative evaluate the student's clinical performance based upon all clinical assignments throughout the semester. This is a pass/fail assignment.
8. **Simulation Lab**- Students will participate in hands-on experience in a simulated environment. Simulation experience will count as clinical hours for the student.

Determination of Course Grade/Detailed Grading Formula: (methods of evaluation to be employed to include a variety of means to evaluate student performance)

Assignment of Course Grade	%
Concept Map	20
Process Recording	20
Sim Chart Assignment	15
Volunteer Activity	10
Clinic Paper Assignment	10
Reflection Paper	10
Group Assignment	15
Clinical Performance Evaluation midterm and final	P/F
TOTAL	100%
≥ 75% score required to pass the course	

Grading Scale

A = 90 - 100.00

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.

Late Work, Make-Up, and Extra-Credit Policy: All course assignments are expected to be completed and submitted on the specified due date. See Grade Determination & Calculation in the Nursing Student Handbook. Any assignment turned in within 24 hours of the due date will be given a grade of 50%. Anything turned in after 24 hours post-due date will be given a zero.

Attendance Policy: See the attendance policy in the Nursing Student Handbook

Communicating with your instructor: ALL electronic communication with the instructor must be through your COM email. Due to FERPA restrictions, faculty cannot share any information about performance in the class through other electronic means. (Faculty may add additional statement requiring monitoring and communication expectations via D2L or other LMS)

Course Objectives/Student Learning Outcomes

Upon completion of this course, the student will:

Student Learner Outcome	Maps to Core Objective	Assessed via this Assignment
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1. Demonstrate professional responsibility and accountability by adhering to ADN Program and clinical facility policies, while providing quality nursing care to patients and their families under the supervision of clinical faculty and the assigned primary nurse	EPSLO 2, 3	Midterm and final clinical evaluation form
2. 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	EPSLO 5	Daily charting assignment in SimChart and concept map.
3. Analyze assessment data to prioritize problems that can be addressed by nursing.	EPSLO 1, 4	Daily charting assignment in SimChart and concept map.
4. 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.	EPSLO 1, 2, 4, 6	Daily charting assignment in SimChart, process recording, and volunteer project.
5. 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.	EPSLO 1, 5	Daily charting assignment in SimChart and concept map.

6. Evaluate attainment of patient goals and related nursing interventions and modify the plan of care in response to changing patient needs	EPSLO 1, 4	Daily charting assignment in SimChart and process recording.
7. 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.	EPSLO 1	Reflection paper, Midterm and final evaluation tool
8. Collaborate and communicate in a timely manner using technology to plan, deliver, manage and evaluate patient-centered care, as demonstrated by effective documentation and team engagement.	EPSLO 2, 3, 10	Reflection paper, Midterm and final evaluation tool
9. Serve as a health care advocate in assessing and promoting safety and quality for patients with mental health needs and their families.	EPSLO 4, 5, 11	Reflection paper, Group assignment, volunteer activity, Midterm and final evaluation tool

Academic Dishonesty:

Any incidence of academic policy 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 the Behavior/Conduct policy in the Nursing Student Handbook.

Student Concerns: 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 follow the chain of command and contact the program director, Rachel Fano at rfano@com.edu.

Syllabus Revisions:

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

Course outline:

Assignment /Activity	Due Date/Time
Pre-clinical orientation	August 18, 2025
SIM Chart Assignment	Due two days after clinical
Process Recording Assignment	Due two days after clinical
Concept Map Assignment	Due two days after clinical
Reflection Paper Assignment	Due two days after last inpatient clinical day
Volunteer Activity	November 16 th @ 2359 (11:59 pm)
Harris Center Clinic Paper Assignment	Due two days after clinical
Group Assignment	Due November 24, 2025 @10am, Room 102
Midterm Evaluation	Two days after second inpatient clinical day
Final Evaluation	Two days after last inpatient clinical day

Student Activities during the Clinical Day (SUN Behavioral, HCPC)

During 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 be 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 seeking them out for consultation prudently.
10. Observe the staff and patient interactions in all aspects of the unit activities.
11. Complete a Mental Status Examination (MSE) on chosen pt for the day.
12. You may go to lunch (30 minutes) whenever the charge nurse says you can. You are

- not allowed to leave the facility during clinical time.
13. Consult with your clinical instructor freely.
 14. Arrive and participate in post-conference at the designated time and place.
 15. Come prepared for the post-conference to discuss patient and experience for the day.

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 communicate therapeutically. 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 this 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 dayroom where you both can always be seen. 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 so that you can see the progress.
8. Reading the patient’s chart before interacting will be left up to you. 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 the 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 patients for medication effectiveness is also important to 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 Concept map, Sim Chart, 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 time 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 Facilities

Clinical site locations for this semester will include:

- Harris County Psychiatric Facility (Inpatient facility)
- SUN Behavioral Houston (Inpatient facility)
- The Harris Center for Mental Health and IDD clinics, Houston various locations

Guidelines when attending Harris Center Clinics

Be punctual and arrive on time. Dress appropriately with uniform and badge and maintain professionalism. When you first arrive on the unit or department, introduce yourself to the nursing staff and other team members. Ask for the person of contact, which is listed on the schedule.

Pay attention to the routines, procedures, and interactions between the healthcare team and patients. Observe nursing interventions, patient assessments, and the use of medical equipment. Jot down important information, questions, or thoughts as you observe. This can help you reflect on the experience later and serve as a useful resource for discussions with your instructors and to complete your assignments.

If there is an opportunity for discussion, ask thoughtful questions that demonstrate your interest in learning. For example, you can ask about the rationale behind certain practices or how specific patient care decisions are made.

Never disclose any personal or health information about patients. Always maintain confidentiality in line with HIPAA regulations and institutional policies. After your shift, take time to reflect on what you saw, learned, and how it connects to the course.

Institutional Policies and Guidelines

Grade Appeal Process: Concerns about the accuracy of grades should first be discussed with the instructor. A request for a change of grade is a formal request and must be made within six months of the grade assignment. Directions for filing an appeal can be found in the student handbook https://www.com.edu/student-services/docs/Student_Handbook_2024-2025_v2.pdf. *An appeal will not be considered because of general dissatisfaction with a grade, penalty, or outcome of a course. Disagreement with the instructor's professional judgment of the quality of the student's work and performance is also not an admissible basis for a grade appeal.*

Academic Success & Support Services: College of the Mainland is committed to providing students the necessary support and tools for success in their college careers. Support is offered through our Tutoring Services, Library, Counseling, and through Student Services. Please discuss any concerns with your faculty or an advisor.

ADA Statement: Any student with a documented disability needing academic accommodations is requested to contact Kimberly Lachney at 409-933-8919 or AccessibilityServices@com.edu. The Office of Services for Students with Disabilities is located in COM Doyle Family Administration Building, Student Success Center.

Textbook Purchasing Statement: 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.

Withdrawal Policy: Students may withdraw from this course for any reason prior to the last eligible day for a "W" grade. Before withdrawing students should speak with the instructor and consult an advisor. Students are permitted to withdraw only six times during their college career by state law. The last date to withdraw from the 1st 8-week session is October 1. The last date to

withdraw from the 16-week session is November 14. The last date to withdraw for the 2nd 8-week session is November 25.

FN Grading: The FN grade is issued in cases of *failure due to a lack of attendance*, as determined by the instructor. The FN grade may be issued for cases in which the student ceases or fails to attend class, submit assignments, or participate in required capacities, and for which the student has failed to withdraw. The issuing of the FN grade is at the discretion of the instructor. The last date of attendance should be documented for submission of an FN grade.

Early Alert Program: The Student Success Center at College of the Mainland has implemented an Early Alert Program because student success and retention are very important to us. I have been asked to refer students to the program throughout the semester if they are having difficulty completing assignments or have poor attendance. If you are referred to the Early Alert Program you will be contacted by someone in the Student Success Center who will schedule a meeting with you to see what assistance they can offer in order for you to meet your academic goals.

Resources to Help with Stress:

If you are experiencing stress or anxiety about your daily living needs including food, housing or just feel you could benefit from free resources to help you through a difficult time, please click here <https://www.com.edu/community-resource-center/>. College of the Mainland has partnered with free community resources to help you stay on track with your schoolwork, by addressing life issues that get in the way of doing your best in school. All services are private and confidential. You may also contact the Dean of Students office at deanofstudents@com.edu or communityresources@com.edu.

Nondiscrimination Statement:

The College District prohibits discrimination, including harassment, against any individual on the basis of race, color, religion, national origin, age, veteran status, disability, sex, sexual orientation, gender (including gender identity and gender expression), or any other basis prohibited by law. Retaliation against anyone involved in the complaint process is a violation of College District policy.

Statement of Eligibility for an Occupational Licensure: Effective September 1, 2017, HB 1508 amends the Texas Occupations Code Section 53 that requires education providers to notify potential or enrolled students that a criminal history may make them ineligible for an occupational license upon program completion. The following website provides links to information about the licensing process and requirements: https://www.bon.texas.gov/licensure_eligibility.asp. Should you wish to request a review of the impact of criminal history on your potential Registered Nurse License prior to or during your quest for a degree, you can visit this link and request a “Criminal History Evaluation”: https://www.bon.texas.gov/licensure_endorsement.asp. This information is being provided to all persons who apply or enroll in the program, with notice of the requirements as described above, regardless of whether the person has been convicted of a criminal offense. Additionally, HB 1508 authorizes licensing agencies to require reimbursements when a student fails to receive the required notice.

Process Recording

Continue with the body of the interview so that the interview itself is approximately 3-4 pages. You may add as many pages as you need; this is an expandable table. Include the identified criteria, such as the verbal statements and 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 as indicated on the sheet. The recording is to be made at a meeting with your 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 as indicated on the sheet. Develop a long-range goal that is relevant for this client for your plans for the next session. **Example:** Pt will report having higher self-esteem by continuing to highlight his strengths by 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 a description 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 is 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 in with 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. **Identification and analysis of therapeutic and non-therapeutic communication):** What therapeutic of communication was use during interaction? Silence? Exploring? Offering self? Giving advice? Excessive questioning?
8. **Evaluation (Effective or not effective and why):** Explain how you identified that communication was or was not therapeutic.

Process recording:

- Student's name:
- Patient's initials:
- Patient's age:
- Patient's unit:
- Reason for admission or presenting problem:
- Patient short term goal:
- Patient long term goal:
- Primary clinical problem:
- Purpose of the session:
- Observation: _____
- Setting: _____

RNSG 2161 Mental Health Nursing Clinical

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 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 from 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.

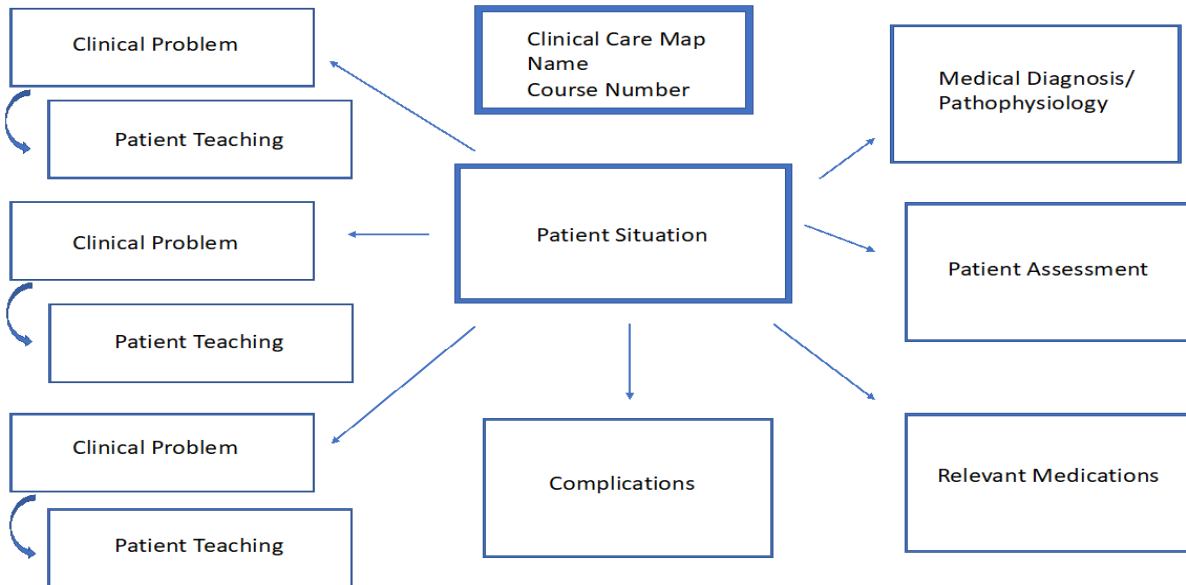
Analysis of Nurse's Communication

- A. State therapeutic or non-therapeutic techniques employed.
- B. Write an analysis of that communication pattern. (Refer to the chapter of text on therapeutic communication).
- C. Evaluate your own participation in the interaction.
- D. Interpret verbal and nonverbal communication to the patient.
- E. Recognize and interpret therapeutic and/or non-therapeutic communications.
- H. Write objectives for self-improvement.
- I. Write your own feelings & interpretation of feelings.

Revise & replace non-therapeutic communication techniques with appropriate therapeutic communication techniques.

Grading Rubric Criteria	Points	Score
Communication between student and client (Verbal and Nonverbal)	30	
Student Nurse Thoughts & Feelings	15	
Analysis of the Interaction <ul style="list-style-type: none"> Identify therapeutic and non-therapeutic communication techniques used by student nurse and analysis of the communication technique. 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 Clinical Problem	10	
Evaluation of therapeutic technique (Effective or Ineffective)	5	
Grammar	5	
Comments:	100	
TOTAL		

Concept Map



- **Patient Situation-** Include pt initials, unit and age. Give a brief description of why the patient is in the hospital.
- **Medical Diagnosis/Patho-**Include disease name, s/s, predisposing factors and treatment options (pharm and non-pharm) **(DIAGNOSIS AND PATHO ALSO TO BE COMPLETED IN SIM CHART)**
- **Patient Assessment-** This should include the patient's history and both subjective and objective data from your assessment. **This section should also include screening tool used for your patient. (ASSESSMENT ALSO TO BE COMPLETED IN SIM CHART)**
- **Labs/Diagnostics:** Pertinent to medical diagnosis. Rational for abnormal labs. Include in assessment.
- **Medications-** List patient meds (no more than 5). Name at least 3 potential side effects. **(MEDS ALSO TO BE COMPLETED IN SIM CHART)**
- **Complications-** What are common complications associated with this medical diagnosis? Make sure to note any of these specific to your patient **(star, highlight, etc.) At least 3-5 complications**
- **Clinical Problems-** Choose three priority nursing clinical problems for your patient. For example, if your patient has depression, a priority problem could be ineffective coping, social isolation, etc. One clinical problem must have a psychosocial focus. Develop one clinical problem with interventions, rationales, and education.
- **General**
 - Must be typed
 - Must be in map form (do not have to use the template provided)
 - Must have a references for patho, medications and rationales.

• **Cite pathophysiology and medication**

• **SUBMIT SIM CHART DOCUMENTATION WITH CONCEPT MAP**

Concept Map Rubric Criteria	Points	Score
Patient Situation	6	
Medical Diagnosis	10	
Assessment	15	
Medications	10	
Complications	8	
Clinical Problems	20	
Patient Education	20	
Grammar/format	5	
SimChart Documentation	6	
TOTAL	100	

Grading Criteria for weekly charting in SimChart		Possible Points	Points Earned
Patient Charting			
Admission History			
	• Health history	2	
	• Full psychosocial screen	2	
	• Alcohol/Smoking screen (include CIWA score if applicable)	2	
System Assessment			
	• Symptom Analysis (chief complaint)	2	
	• Complete physical assessment head-to-toe	2	
Discharge Planning	• Complete section	2	
System Nursing Interventions			
	• Psychosocial	2	
	• Safety	2	
Basic Nursing Care			
	• Safety	2	
	• Activity	2	
	• Hygiene	2	
	• Nutrition (including diet and percentage eaten each meal)	2	
	• Elimination	2	
	• Skin Care	2	
Special Charts			
	• Miscellaneous Nursing Notes- every 2-3 hours and with interventions	10	
	• Scales (HAM-A, mania, mood, aggression) applicable to pt	2	
	• SBAR		
	Situation: <ul style="list-style-type: none"> • What is the problem leading to admission? • Legal Status: Voluntary or Involuntary • Legal Guardian/Power of attorney • Diagnosis • Allergies 	2.5	
	Background (psychiatric hx) <ul style="list-style-type: none"> • Pertinent Medical History • Summary of treatment to date 	2.5	
	Assessment <ul style="list-style-type: none"> • Subjective information • Vital Signs • Treatment given: • Focused assessment (why are you calling physician?) 	2.5	
	Recommendations:	2.5	
	Total	50	
Patient Teaching	This can be by student/nurse or in group		
	Total	10	
Care Plan			

	<ul style="list-style-type: none"> • Priority nursing clinical problem 	5	
	<ul style="list-style-type: none"> • Expected Outcome (SMART goal)- 1 STG and 1 LTG 	5	
	<ul style="list-style-type: none"> • 5 nursing interventions with scientific rationale (cite source in the “enter text” area) 	15	
	Total	25	
Pre-Clinical Manager			
	<ul style="list-style-type: none"> • Pathophysiology 	5	
	<ul style="list-style-type: none"> • Medications- up to 5 medications 	5	
	<ul style="list-style-type: none"> • Labs/Diagnostic test (if applicable) 	5	
	Total	15	
	Total	100	

RNSG 2161 The Harris Center Clinic assignment:

Choose one patient seen at the clinic today.

1. Describe the clinic including name of clinic, location, patient population (adults/children), number of patients seen on a typical day and services offered. Is the clinic assessable by public transportation/bus line/Metrorail? What is the typical flow of the clinic?
2. What important assessment data did you obtain or document on this patient? Include subjective and objective data. What information did you gather from family members or significant others? If family or s/o not available, what history/information would you have obtained?
3. Community health nursing addresses primary, secondary, and tertiary prevention components (refer to the textbook for the definition). Choose one type of prevention and describe how the prevention was met during the patient's visit to the clinic.
4. Define case management and the duties involved. Give a specific example of nursing care today that involves case management duties related to your chosen patient.
5. Community resources play a major role in patients with mental health problems. Identify a resource you would recommend to the patients you chose today and explain why this resource would benefit the client. Give the name of the resource, address, services offered, and a rationale for why this resource would benefit this patient. The resource should be different than the actual facility you are visiting for clinical.
6. What specialized assessment tools/screening would be most beneficial for you to gather assessment data on your patient and why you think this tool would be valuable for you. (Example the Beck depression inventory/ Hamilton depression scale or the geriatric depression scale for someone that is depressed). Include rationale for this particular tool.
7. How would you conclude the visit? What was your overall experience? Would you recommend the facility to your patients?
8. **This assignment should have a title page and reference list in APA format. Please see the rubric for the scoring breakdown. The paper should be uploaded to D2L.**
9. **Complete and submit the Associate Degree Nursing Clinical Attendance with paper.**

Grading Rubric for Clinic Days (the same rubric will be used for both days)

Criteria	Points
Clinic description	20
Assessment data collected	20
Type of prevention	10
Case management	10
Community resources available	10
Screening tools used	10
Conclusion	10
Grammar/title page/references	10
Total	100



Associate Degree Nursing Clinical Attendance Form

(Please Print Information Below)

Name of Student: _____

Clinical Facility: _____

Date: _____ Hours Present: _____ am/pm to _____ am/pm

Clinical Facility Mentor/Preceptor: _____

Clinical Facility Mentor/Preceptor Contact #: _____

Signature of Mentor/Preceptor

Signature of Student

**** This form is to be completed by the assigned mentor/preceptor in the clinical facility attended by students who do not have faculty assigned and present on site with students.**

Volunteer Activity
DUE: November 16, 2025

Objective:

Volunteer eight hours to a local organization that serves the homeless population in our community. Examples include the Houston Food bank, The Jessie Tree, MI Lewis, Salvation Army, Meals on Wheels, etc. After choosing an organization, get approval of this site from your clinical instructor. Take this form with you to get the following information. This assignment is due according to your syllabus calendar.

Student Name: _____

Name of organization: _____

Address of organization: _____

Contact person for the organization: _____

Phone number and email of contact person: _____

Number of volunteer hours: _____

Signature of contact person: _____

Date of attended: _____

A **paper** will be written by the student to summarize their experience and reflecting on the importance of civic responsibility as a health care advocate regarding assessing and promoting safety and quality for patients with mental health needs and their families. Each criteria must be at least a paragraph and address components in the grading criteria. **This signed form should be uploaded with your paper.**

Grading Criteria for Volunteer activity

Criteria	Points	Score
Describe services offered by the organization.	25	
Identify the target population served by the organization. Who benefits from the services?	20	
Explain how nurses can advocate for the population served by this organization.	20	
Describe how nurses can promote safety in the community for individuals with mental health needs.	15	
Reflect on your volunteer experience. How did you feel about volunteering for the organization? Is it something you would do again? Why or why not?	15	
Grammar-Writing is clear, well-organized and free of major errors.	5	
TOTAL	100	

Reflection Paper:

Reflection papers are designed to formally consider what students have been learning and to organize it through writing. The following will help you understand the assignment:

- Papers must be typed
- Papers should be a minimum of one page, no longer than two pages
- Writing should use formal language and correct spelling and punctuation
- Topics reflected upon may include any information covered as it relates to your clinical experience
- When writing, consider the following:
 - What have you found to be most interesting in the clinical setting?
 - What new things have you learned or observed in the clinical setting?
 - How has your clinical experience, in reference to mental health, affected preconceptions or misconceptions you brought with you into class?
 - How does your learning affect your view of the world and the universe?
 - Will what you have learned change your behavior and how you view mental health in the future?

Ultimately writing these papers encourages you to find what is meaningful to you and thus it adds value to your learning. I want to know what clinical experience means to you.

RUBRIC CAN BE VIEWED IN D2L

Assignment Title: Mental Health Across Cultures

Objective:

Students will investigate how mental health disorders are perceived, diagnosed, and treated in different cultural contexts. The goal is to understand the impact of cultural beliefs, stigma, traditions, and healthcare systems on mental health.

Assignment Overview:

Students will be divided into small groups (3–5 students per group). Each group will select or be assigned a **specific culture or country**. Each group will present a 10-15 minute group presentation (PowerPoint). No more than 3-5 slides including reference slide. All sources should be in **APA format** in-text and on a reference slide.

Each group will research the cultural views on mental health disorders and create a presentation addressing the following components:

Cultural Overview

- Briefly describe the chosen culture (geography, language, religion, traditions).
- Outline cultural attitudes toward health and illness.

Perception of Mental Health Disorders

- How is mental illness defined in this culture? How are people with mental health issues viewed? Is there a stigma? If so, how does it manifest?
- What are common cultural beliefs about the causes of mental illness? (e.g., spiritual, biological, social)
- Are there any culturally-specific syndromes?

Traditional and Modern Treatment Methods

- What treatments are traditionally used? (e.g., herbal medicine, prayer, rituals, spiritual healers)
- What is the role of family, community, or religious leaders?
- How accessible are modern mental health services?
- Are there efforts to integrate traditional and Western treatment approaches?

Implications for Nursing Care

- As the nurse, what is your plan to make sure that the patient receives culturally competent care?
- What things would you provide for this patient?
- How would you advocate for a patient whose cultural needs are not being met by the healthcare system?

Group Reflection

- Discuss any surprises or challenges your group encountered while researching.
- What was the most surprising or eye-opening thing your group learned about this culture's view of mental health?
- What would you do differently in a future patient interaction as a result of this assignment?
- What are some lessons nurses can take from this culture's approach to mental health that could improve care in the U.S. or globally?

Group Presentation Rubric	Points
Cultural Overview	10
Perception of Mental Health Disorders	20
Traditional & Modern Treatment Methods	20
Implications for Nursing Care	15
Group Reflection	10
APA Format	10
Organization & Presentation	10
Visual Design & Clarity	5
Total	100

