RNSG 2161
Mental Health Clinical
Fall 2023

Instructor Information: Stephanie Griggs, DNP, FNP-BC
sgriggs@com.edu
409-933-8920
Office hours: Tuesday 0900-1430; Thursday 0900-1430

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).https://pageburstls.elsevier.com/books/9780323697095

SimChart- through evolve.elsevier.com. Will be used to document daily charting assignment.
Simulations - SimChart: Instructor-Led Course
Simulation Lab
By Elsevier
ISBN: 9781455711703
Course ID: 99331_tdavis1085_1001
Instructor: TERRI DAVIS

Recommended Textbooks:
All previous textbooks for the ADN program

Course Description

This clinical experience provides nursing care for mental health patients in multiple healthsettings. Opportunities are provided for the application of theory, concepts, and skills being acquired (2 Credit hour; 64 Contact hours, 16 weeks).

Course Requirements

1. **Weekly documentation-** Assesses the understanding of the care of patients with mental health issues. Assesses the ability to collaborate and communicate with the healthcare team. Each student will have three weeks in an inpatient setting and two weeks in an outpatient clinic. The inpatient setting's assignments will include one process recording, one concept map, and one week of documentation using SimChart. For each day in the clinic, a paper will be required.
2. **Simulation Lab-** A hands-on learning experience in a simulated environment.
3. **Volunteer Experience-** A four-hour block of time relating to the welfare of the homeless population.
4. **Clinical Performance-** To assess clinical competency.

Determination of Course Grade/Detailed Grading Formula:

Assignment of Course Grade	%
Daily charting	20
Process Recording	20
Concept Map	30
Volunteer Activity	10
Clinic Assignments	20
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.

Clinical Paperwork Assignments

Clinical Day of the Week	Paperwork due by 2359
Monday	Wednesday
Wednesday	Friday
Friday	Sunday

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.

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.

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
A proper citation, copying directly from a website and pasting it into your paper, and 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 disciplinary action.

Course Objectives/Student Learning Outcomes

Upon completion of this course, the student will:

Student Learner Outcome	Maps to Core Objective	Assessed via this Assignment
1. Demonstrate professional student responsibilities by following the policies and procedures of the ADN Program and the clinical facility practice guidelines.	Outcome 1: Integrate critical thinking when incorporating knowledge from the sciences and humanities in the delivery of professional nursing care.	Midterm and final clinical evaluation form
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.	Outcome 2: Demonstrate principles of collaborative practice within the nursing and interdisciplinary teams fostering mutual respect and shared decision-making to achieve stated outcomes of care.	Midterm and final clinical evaluation tool
3. Assess the physical and mental health status of patients with mentalhealth needs and preferences using astructured data collection tool with primary and secondary sources of information	Outcome 3: Practice beginning leadership skills to include effective delegation; collaboration with the patient, family and members of the health care team; coordination of safe, effective, caring, evidence-based, and therapeutic patient-centered care; and integration of knowledge from the humanities, nutrition, pharmacology, and the psychosocial, biological, and nursing sciences.	Daily charting assignment in SimChart and concept map.
4. Analyze assessment data to prioritize problems that can beaddressed by nursing.	Outcome 3: Practice beginning leadershipskills to include effective delegation; collaboration with the patient, family, and members of the health care team; coordination of safe, effective, caring, evidence- based, and therapeutic patient-centered care; and integration of knowledge from the humanities, nutrition, pharmacology, and the psychosocial, biological, and nursing sciences.	Daily charting assignment in SimChart and concept map.
5. Analyze assessment data to prioritize problems that can beaddressed by nursing.	Outcome 5: Incorporate principles of effective communication and documentation using current nursing technology and informatics in providing patient-centered care.	Daily charting assignment in SimChart and process recording.

6. Develop a plan of care that identifies patient goals/outcomes and nursing interventions using information from evidence-based practice in collaboration with patientswith mental health needs, their families, and the health care team.	Outcome 4: Synthesize principles and techniques of interpersonal communication to implement therapeutic interactions with culturally diverse individuals, families, and groups in a variety of settings.	Daily charting assignment in SimChart, process recording, and volunteer project.
7. Implement the plan of care to provide safe, compassionate, ethical nursing care for adult patients with mental health needs and their familiesin acute care settings.	Outcome 6: Integrate principles of teaching and learning to organize and plan the teaching of patients, family members, and other health care providers with socioeconomic, cultural and spiritual diversity.	Daily charting assignment in SimChart and concept map.
8. Evaluate attainment of patient goalsand related nursing interventions and modify the plan of care in response tochanging patient needs	Outcome 5: Incorporate principles of effective communication and documentation using current nursing technology and informatics in providing patient-centered care.	Daily charting assignment in SimChart and process recording.
9. 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.	Outcome 8: Practice the delivery of safe and cost-effective nursing health care according to established evidence-based standards of practice and within legal/ethical standards.	Midterm and final evaluation tool
10. Collaborate and communicate in atimely manner with patients, their families, and the health care team to plan, deliver, and evaluate patient- centered care	Outcome 8: Practice the delivery of safe and cost-effective nursing health care according to established evidence-based standards of practice and within legal/ethical standards.	Midterm and final evaluation tool
11. Serve as a health care advocate in assessing and promoting safety and quality for patients with mental healthneeds and their families.	Outcome 9: Serve as a patient safety advocate by applying the principle of change theory, quality improvement and outcome measures in the healthcare setting.	Midterm and final evaluation tool

12. Communicate and manage information using technology to support decision making to improvepatient care.	Outcome 5: Incorporate principles of effective communication and documentation using current nursing technology and informatics in providing patient-centered care.	Daily charting assignment in SimChart and process recording.

Student Concerns: If you have any questions or concerns about any aspect of this course, please contact the course faculty using the contact information previously provided. If there are still concerns, please contact the course facilitator. If questions remain after this, please contact the Director of Nursing- Dr. Debra Bauer at dbauer3@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 STEAM Room 102	Thursday, August 31st, 2023 9am-3pm
Daily Charting	Due two days after clinical
Process Recording	Due two days after clinical
Concept Map	Due two days after clinical
Volunteer Activity	November 30, 2023
Harris Center Clinic paper x2	Due two days after clinical
Midterm Evaluation	October 20, 2023
Final Evaluation	December 8, 2023

Student Activities during the Clinical Day
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 cosmeticsor 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, musictherapy, 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 Daily Work Sheet, which will have mostly patient information as well as yourhourly activities.
12. You may go to lunch (30 minutes) whenever the charge nurse says you can. Do not leave thefacility 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 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 yourpatient 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/shewould 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. There are pros and cons to this issue, which we will discuss. However, NEVER discuss anything that you read in thechart unless the patient brings it up first.
9. NEVER ask the patient what has been discussed in group unless the patient brings somethingup, 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.

Assignments/Requirements

1. ***Daily charting*** – 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. If the opportunity for a clinical patient does not happen, you may consult with your clinical instructor to come up with an alternative subject in which you can meet the assignment objectives.

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).
4. ***Volunteer activity*** - Students will volunteer four hours to a local organization that serves the homeless population in the community. The clinical instructor must approve the organization. The student will write a brief paragraph to summarize their experience and reflect on the importance of civicresponsibility as a health care advocate in assessing and promoting safety and quality for patients with mental health needs and their families.
5. ***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.

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 foruse, 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 mayread 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 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 Center, Houston
- SUN Behavioral Houston
- The Harris Center for Mental Health and IDD clinics, Houston various locations

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://build.com.edu/uploads/sitecontent/files/student-services/Student_Handbook_2019-2020v5.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.* https://build.com.edu/uploads/sitecontent/files/student-services/Student_Handbook_2019-2020v5.pdf

Academic Success & Support Services: College of the Mainland is committed to providing students with 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 klachney@com.edu. The Office of Services for Students with Disabilities is located in the 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 10-week summer semester session is July 31st, 2023.

F_N Grading: The F_N grade is issued in cases of *failure due to a lack of attendance*, as determined by the instructor. The F_N 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 F_N grade is at the discretion of the instructor. The last date of attendance should be documented for submission of an F_N 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 and housing, or just feel you could benefit from free resources to help you through a difficult time, please go to 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.

Resource to Assist with Feelings of Depression: College of the Mainland has partnered with UTEAP (UT employee assistance programs). Students may call 713-500-3852 for access to in-the-moment support or to schedule an appointment with a counselor.

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: _____

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 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.

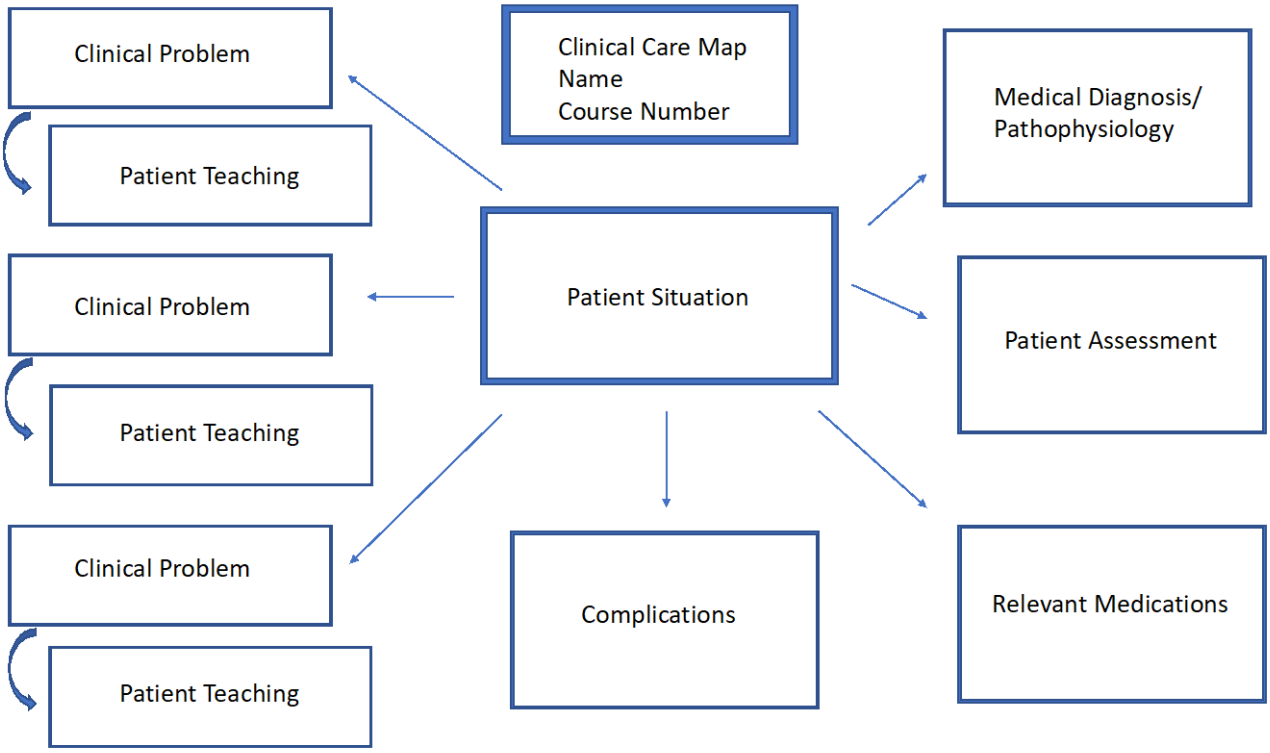
Analysis of Nurse's Communication

A. State therapeutic or non-therapeutic technique employed.
B. Write 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 • Identify therapeutic (Table 6.3) and non-therapeutic (Table 6.4) communicationtechniques used by student nurse and analysis of the communication technique. • Suggest alternate therapeutic communication technique for each non-therapeutictechnique 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	
Comments: **TOTAL**	**100**	

Concept Map



- **Patient Situation**- Give a brief description of why the patient is in the hospital
- **Medical Diagnosis**- What is the primary reason for admission with pathophysiology? This should be the underlying cause, not a symptom. Please verify with the clinical instructor if you are unsure what to write.
- **Patient Assessment**- This should include the patient's history and both subjective and objective data from your assessment. **This section should also include any screening tools used for your patient.**
- **Medications**- What are the medications your patient is taking? How do they relate to the medical diagnosis? Name at least 3 potential side effects.
- **Complications**- What are common complications associated with this medical diagnosis? Make sure to note any of these specific to your patient (star, highlight, etc.).
- **Clinical Problems**- Choose three priority nursing clinical problems for your patient. For example, if your patient has asthma, a priority problem could be ineffective breathing. One clinical problem must have a psychosocial focus.
- **Patient Education**- For each priority clinical problem, what education was provided throughout your shift to the patient? This should include any medication education provided to the patient as it relates to the clinical problem.
- **General**
    - Must be typed
    - Must be in map form (do not have to use the template provided)
    - Must have a reference page
        - Cite pathophysiology and medication
- **See D2L for grading rubric**

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: • What is the problem leading to admission? • Legal Status: Voluntary or Involuntary • Legal Guardian/Power of attorney • Diagnosis • Allergies	2.5	
	Background (psychiatric hx) • Pertinent Medical History • Summary of treatment to date	2.5	
	Assessment • Subjective information • VS • 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			
	• Priority nursing clinical problem	5	
	• Expected Outcome (SMART goal)- 1 STG and 1 LTG	5	
	• 5 nursing interventions with scientific rationale (cite source in the "enter text" area)	15	
	Total	**25**	
Pre-Clinical Manager			
	• Pathophysiology	5	
	• Medications- up to 5 medications	5	
	• Labs/Diagnostic test (if applicable)	5	
	Total	**15**	
	Total	**100**	

RNSG 2161 The Harris Center Clinic assignment:

Choose one patient treated 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? What information did you gather from family members or significant others? If family or s/o not available, what 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 involved 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.
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).
7. **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.**

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	15
Case management	15
Community resources available	10
Screening tools used	10
Grammar/title page/references	10
Total	**100**

Volunteer Activity
DUE: NOVEMBER 30, 2023

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.… 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.

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 theimportance 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

Grading Criteria for Volunteer activity

Criteria	Points	Score
Describe services offered by the organization.	**19**	
Who is the target population served by this agency?	**19**	
How can nurses advocate for the homeless population in theircommunity?	**19**	
How can nurses promote safety in thecommunity for those with mental health needs?	**19**	
How did you feel about volunteering for the organization? Is it something you would do again? Why or why not?	**19**	
Grammar	**5**	
TOTAL	**100**	