College of the Mainland

RNSG 2161 Mental Health Nursing Clinical III

Fall 2021

Clinical modules and paperwork will be online/ clinicals at outside clinical sites

Course Facilitator:

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Welcome to Mental Health Nursing Clinical,

The 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.

Recommended Textbooks
All previous textbooks for the ADN program.

Required Online learning resources
Shadow Health Digital Clinical Experience- Shadow Health's Digital Clinical Experiences allow nursing students to demonstrate and perfect their clinical reasoning skills through life-like interactions with Digital Standardized Patients. Digital Clinical Experiences are powered by a Conversation Engine and assessed using our proprietary Student Performance Index. (Shadowhealth.com).

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 (1 Credit hours; 64 Contact hours, 16 weeks).

Course Policies

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

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

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 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 Holly Bankston at 409-933-8520 or hbankston@com.edu. The Office of Services for Students with Disabilities is in the Student Success Center in the student center.

Counseling Statement: Counseling Statement: Any student needing counseling services is requested to please contact Holly Bankston in the student success center at 409-933-8520 or hbankston@com.edu. Counseling services are available on campus in the student center for free and students can also email counseling@com.edu to set up their appointment. Appointments are strongly encouraged; however, some concerns may be addressed on a walk-in basis.

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 6. The last date to withdraw from the 16-week session is November 19. The last date to withdraw for the 2nd 8-week session is December 2.

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.

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 always act in a professional manner. 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.

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

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.

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 Blackboard or other LMS).

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.

Assignments/Requirements

1. ***Daily charting*** - Students will complete daily charting in EHR tutor each clinical day unless doing a process recording. The SBAR segment is like previous clinical courses but is specific for mental health nursing. The SBAR segment contains patient history, diagnoses, priority nursing diagnosis, scheduled activities, any precautions, and prescribed medications. Please refer to the grading criteria. You will base this

documentation on shadow health patients if not in the clinical setting. This semester is a combination of online/clinical setting due to the pandemic.

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. This semester is online/and in clinical settings due to the pandemic. You can do the process recording on a patient in the hospital. 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. ***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. You will base this documentation on a patient in the clinical setting or on a shadow health patient if the opportunity for a clinical patient in the clinical setting does not happen (this will need to be approved by the clinical instructor). Please specify the patient in your documentation.

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 in accordance with the grading rubric by the student to summarize their experience and reflecting 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. 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 article to their clinical group on the group discussion board. Students in the clinical group will need to reply to their peers post each submission. Please refer to the grading criteria.
6. ***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.
7. ***Clinic log and journal assignments***- Students will complete a written assignment exploring the nurse's role in case management and the available community resources available for patients experiencing mental health issues. The students will also identify nursing skills and treatments performed by nurses in mental health clinics, as well as, identify primary, secondary, and tertiary prevention. You will choose two out of the four scenarios in blackboard to complete these assignments if clinical sites are not available.
8. Students will complete online avatar assignments in Shadow Health. **Shadow Health modules** will cover patients experiencing anxiety, depression, bipolar illness,

schizophrenia, PTSD, and alcohol use disorder. These avatar scenarios will be used to complete your EHR tutor documentation daily charting and care plan (if clinical opportunities are not available.

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	%
Daily charting	10
Process Recording	25
Major Care Plan	30
Volunteer Activity	7.5
Professional Journal Article Review and Discussion Board Participation	7.5
Shadow Health Modules	10
Clinic log and journal	10
Clinical Performance Evaluation midterm and final*	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.

Always wear your school name tag 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 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 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 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 paperwork due Wednesday by 2359)

Clinical Facilities

Clinical site locations vary each semester, but typically include:

- Harris County Psychiatric Center, Houston
- VA-Hospital-Houston
- Ben-Taub Hospital
- SUN Behavioral Houston

Clinical Forms:

Process recording:

- Student's name:
- Patient's initials:
- Reason for admission or presenting problem:
- Patient short term goal:
- Patient long term goal:

- Primary nursing diagnosis:
- 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

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, 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 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 at the top of the sheet? Develop a long-range goal, that are relevant for this client for your plans for the next session). **Example** Long range goal: Pt will report to have a 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 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 Two & Three/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 Four/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? **Identification and analysis of therapeutic and non-therapeutic communication.**

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 analysis of that communication pattern. (Refer to chapter of text on therapeutic communication).
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.

Grading Rubric Criteria	Points	Score
Student Nurse Verbal and (Nonverbal)	20	
Client Verbal and (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 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 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**. Summary should contain type of study, number, or participants in the study, how was the data analyzed, and key findings of the study.

3. State the implications for nurses **in your own words** citing references to support your position.
4. State impact on patient care citing material found from the study in the article.
5. Include your personal reactions to the conclusions in the article **in your own words**.
6. Include the APA citation and permalink to full-text article in document. Submit to safe assign. **Do not attach the article**.
7. Present the summary to the clinical group in the online group discussion board.
8. 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 and responses to peer group	**10**	
TOTAL	**100**	

Grading Rubric for Major Care Plan

Nursing Process	Key Elements	Points	Score	Faculty Comments
Assess	**Subjective Data** (support dx)	3		
	Objective Data (support dx)	3		
Diagnose	**Nursing Diagnoses**– 2 prioritized according to complexity and Maslow's Hierarchy of Needs (1 physiological, 1 psychosocial or knowledge deficit)	15		
Plan	**1 short and 1 long Term Goals and Evaluation Criteria** (for each dx)	8		
	Goal specific nursing interventions (4 for each nursing diagnosis)	8		
Implement	**Nursing Interventions** include scientific rationale and patient responses to intervention.	15		
Evaluate	**Evaluation of goal attainment & effectiveness of nursing interventions (state goal met, partially met or not met with Procdata to support this)**	5		
	Goal / nursing intervention revision	5		
Narrative Notes (Q 2-3 hours)		10		
Care Plan: Pathophysiology, predisposing factors, signs and symptoms, medical diagnosis and treatment, and nursing interventions (per textbook, DSM5, etc.)		10		
Medication Profiles		5		
Patient Data – Shift report / Assessment		10		
Nutrition –patient diet in relation to disease process. Document a sample meal.		3		
	Total	100		

Student Comments:

Faculty Comments:

_____ _____

Faculty Signature / Date Student Signature / Date

Revised-Spring 2017

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**	

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.… Upon 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: _____

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 regarding assessing and promoting safety 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	

Grading Criteria for Clinic log and journal

Criteria	Points	Score
Identify important assessment data you should obtain or document? Is there any information you should gather from family members or significant others in this situation?	**20**	
Define one of the following concepts from your textbook (Primary/Secondary/Tertiary prevention). Compare how the care you would have provided or recommended in this scenario met the type of prevention you identified.	**20**	
Define case management and the duties involved. Identify case management changes that may have a positive impact for this patient and give rationales to support your suggested changes.	**20**	
Identify resources in this care scenarios demographic location that would best benefit that patient. Be specific and provide a convincing argument on how this resource will benefit the patient or family in the scenario.	**20**	
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 in this scenario. (Ex-Beck Depression Inventory).	**20**	
TOTAL	**100**	

Week Number	Week Date Range*	RNSG 2161 Unit(s)	RNSG 2161 Shadow Health Mental Health DCE	EHRtutor charting	Other clinical assignments
1	08/25/21	**Clinical orientation 08/25 1230-1630**	None	None	None
2	08/25/21 to 09/05/21		Digital Clinical Experience orientation and Conversation concept lab due 09/05/21 by 2355		Journal article discussion per clinical instructor.
3	09/06/21 To 09/12/21	Anxiety and anxiety related disorders	Patient Case John Larsen: Anxiety Due date: 09/12/21 by 2355	**Daily charting** on EHR tutor on John Larsen/or clinical pt. Due date per clinical day.	Journal article discussion per clinical instructor. (Daily charting, unless in clinical site PR or MCP).
4	09/13/21 To 09/19/21	Depression disorders	Patient case Abigail Harris: Depression. Due date 09/19/21 by 2355	**Daily charting** Abigail Harris/or clinical pt. Depression Due date 09/14/21 per clinical day.	Journal article discussion per clinical instructor. (Daily charting, unless in clinical site PR or MCP).
5	09/20/21 To 09/26/21	Bipolar related disorders	Patient case Lucas Callahan: Bipolar disorder. Due date 09/26/21 by 2355	**Daily charting** Abigail Harris/or clinical pt.	Journal article discussion per clinical instructor. (Daily charting, unless in clinical

				Bipolar Due date per clinical day.	site PR or MCP).
6	09/27/21 to 10/03/21	Schizophrenia spectrum disorders	Patient case Eric Ford: Schizophrenia due 10/03/21 by 2355	**Daily charting**. Eric Ford: Schizophrenia/or clinical pt. Due date per clinical day.	Journal article discussion per clinical instructor. (Daily charting, unless in clinical site PR or MCP).
7	10/04/21 to 10/10/21	PTSD	Patient case Nicole Diaz: PTSD. Due date 10/10/21 by 2355	**Daily charting PTSD** Nicole Diaz/or clinical pt. Due date per clinical day.	Journal article discussion per clinical instructor. (Daily charting, unless in clinical site PR or MCP).
8	10/11/21 to 10/17/21		No assignment unless in clinical. If so PR or MCP.		Journal article discussion per clinical instructor. **Midterm clinical evaluation due by 10/17/21 by 2359.**
9	10/18/21 to 10/24/21		No assignment unless in clinical. If so daily, PR or MCP.		Journal article discussion per clinical instructor. (Daily charting, unless in clinical site PR or MCP).
10**	10/25/21 to 10/31/21		No assignment unless in clinical. If so daily, PR or MCP.		Journal article discussion per clinical instructor.

11	11/01/21 to 11/07/21	Addiction use disorders	Patient case Rachel Adler: Alcohol use disorder. Due 11/07/21 by 2355	**Daily charting PTSD** Rachel Adler/or clinical pt. Due date per clinical day.	Journal article discussion per clinical instructor. (Daily charting, unless in clinical site PR or MCP).
12	11/08/21 to 11/14/21		No DCE due	No EHRtutor charting due	**Volunteer activity due by 11/14/21 2359**
13	11/15/21 to 11/21/21		No DCE due	No EHRtutor charting due	**Clinic # 1 assignment due by 11/21/21 by 2359.**
14	11/22/21 to 11/28/21		No DCE due	No EHRtutor charting due	Journal article discussion per clinical instructor.
15	11/29/21 to 12/05/21		No assignments due		**Clinic #2 assignment due by 12/05/21 by 2359. Final evaluation due by**
16	12/06/21 to 12/10/21	Finals Week HESI Exam	No DCE Due	No EHRtutor charting due.	**No assignments due.**

*Weeks 1-17 begin on Monday at 0000 hours and end on Sunday at 2359 hours.