Philadelphia University
Faculty of Nursing

Psychiatric Nursing (Clinical Course)

Course Syllabus
2009- 2010

Philadelphia University
Faculty of Nursing
First Semester, 2009/2010

Course Syllabus

Course Title: Psychiatric nursing (Clinical)	**Course code: 940336**
Course Level: Fourth level **Course coordinator: Dr. Hania Dawani DNSc., MPH, RN**	**Course prerequisite(s): Psychiatric and mental health nursing (Theoretical course)**
Clinical Time: Sunday & Tuesday **Monday & Wednesday 8:00 – 2:00**	**Credit hours: 3 hours**

Academic Staff Specifics

Name	Rank	Office Number and Location	Office Hours	E-mail Address
Hania Dawani	Assistan Professo	first floor Faculty of nursing	Monday And Wednesday 8 - 2	drhania@jnc.gov.jo
Rabiaa Allari	Lecture	Second floor Faculty of nursing	Sunday And Tuesday 8 - 2	Rabia_allari@hotmail.com

Course Description:

This course is concurrent with the theory course o Mental Health Nursing. It is designed for senior nursing students and provides them with the opportunity to implement the concepts and theoretical background in the practice setting, and in simulation situations designed by the course facilitator. The students will spend the majority of the practicum in an inpatient acute or chronic setting. The students will learn the nursing role and nursing

contribution to the treatment team, and the management of the psychiatric ward. The students will utilize the nursing process to assess patients and plan their nursing care. They will have the opportunity to implement principles of health problems and while implementing appropriate therapeutic interventions to variety psychiatric disorders in clinical area.

The course will focus on the development of competencies necessary for the practice of mental health nursing with emphasis on the use of self in relationships with patients and health team members.

This course will assist the students to further consolidate their theoretical knowledge and their understanding of psychiatric disorders, its manifestation, identification and management.

Clinical Objectives / Psychiatric Hospital:

Intended Learning outcomes (competencies, evaluations)

1.1 Accountability

Competency:					
Elements	*Rating Scale*			***Mid***	***Final***
- ***Accepts accountability & responsibility for ones own professional judgment &actions***	***3***	***2***	***1***		
- ***Recognizes the limits of one's own role & competency***	***3***	***2***	***1***		
- ***Consults with a registered nurse who has the required expertise, when care required expertise beyond the current competencies***	***3***	***2***	***1***		
- ***Consults with other health professionals when individual needs fall outside the scope of nursing practice***	***3***	***2***	***1***		
Comments:					

1.2 Ethical Practice

Competency: Adhere to professional standers of practice within legal, ethical& regulatory						
Elements	*Rating Scale*				***Mid***	***Final***
- ***Utilizes the nurse ethical code to guide practice***	***3***	***2***	***1***	***0***		
- ***Maintains patient's confidentiality wit in legal & regulatory parameters***	***3***	***2***	***1***	***0***		
- ***Interacts with peers & other health care providers in a nonjudgmental & nondiscriminatory manner***	***3***	***2***	***1***	***0***		
- ***Acts as a patient's advocate to protect human right***	***3***	***2***	***1***	***0***		
- ***Respects the patient's right to access information***	***3***	***2***	***1***	***0***		
- ***Respects the value, customs, spiritual belief & practices of individuals &groups***	***3***	***2***	***1***	***0***		
- ***Respects the patient's right to privacy***	***3***	***2***	***1***	***0***		
- ***Provides culturally sensitive care***	***3***	***2***	***1***	***0***		
- ***Identifies unsafe practice & take appropriates actions***	***3***	***2***	***1***	***0***		
- ***Delivers care in a manner that preserves patients autonomy, dignity, & rights***	***3***	***2***	***1***	***0***		
Comments						

1.3 Legal Practice

Competency: Acts with in the legal aspects limits						
Elements	*Rating Scale*				***Mid***	***Final***
*- **Practices in accordance with relevant legislation***	***3***	***2***	***1***	***0***		
*- **Practices in accordance with national & local policies & procedural guidelines***	***3***	***2***	***1***	***0***		
*- **Recognizes & acts upon breaches of law relating to nursing & professional code practice***	***3***	***2***	***1***	***0***		
Comments:						

2 Care Provision

2.1 Key Principles of Care Provision & Management

Competency:						
Elements	*Rating Scale*				***Mid***	***Final***
*- **Applies knowledge & skills to nursing practice***	***3***	***2***	***1***	***0***		
*- **Incorporates valid & relevant research findings & other evidence into practice***	***3***	***2***	***1***	***0***		
*- **Applies critical thinking, & problem-solving skills***	***3***	***2***	***1***	***0***		
*- **Applies sound clinical judgment & decision making process across the range of professional & care delivery contexts***	***3***	***2***	***1***	***0***		
*- **Initiates & enters into discussion about innovation & changes in nursing & health care***	***3***	***2***	***1***	***0***		
*- **Provides rational for nursing care delivered***	***3***	***2***	***1***	***0***		
*- **Prioritizes workload & manages time effectively***	***3***	***2***	***1***	***0***		
*- **Acts as a resource for individuals, families in coping with change in health, disability & death***	***3***	***2***	***1***	***0***		
*- **Presents information clearly & briefly***	***3***	***2***	***1***	***0***		
*- **Accurately interprets subjective & objective data & their significance for safe delivery of care***	***3***	***2***	***1***	***0***		
Comments:						

2.2 Assessment

Competency: Conduct a comprehensive & systematic nursing assessment						
Elements	*Rating Scale*				***mid***	***Final***
- Uses effective interview techniques in data collection	*3*	*2*	*1*	*0*		
- Uses appropriate sources in collecting data	*3*	*2*	*1*	*0*		
- Uses correct techniques for health assessment of:						
• Psychosocial health	*3*	*2*	*1*	*0*		
• physical examination	*3*	*2*	*1*	*0*		
• mental status assessment	*3*	*2*	*1*	*0*		
- Assesses clients strengths & weakness	*3*	*2*	*1*	*0*		
- Validate data collected	*3*	*2*	*1*	*0*		
- Assesses patient's in timely & efficient manner	*3*	*2*	*1*	*0*		
- Assesses the needs of patient's, family, anticipated changes in health status based assessments	*3*	*2*	*1*	*0*		
- Adapts assessment techniques based on patient characteristic(age, mental status, illness)	*3*	*2*	*1*	*0*		
- Analyzes the relationship between normal physiology & specific system alteration associated with mental health problems, psychiatric disorder &treatment	*3*	*2*	*1*	*0*		
Comments:						

2.3 Diagnosis

Competency: Participates in problem identification						
Elements	*Rating Scale*				***mid***	***Final***
- Derives from assessment data	*3*	*2*	*1*	*0*		
- Able to analyze data & draw inferences	*3*	*2*	*1*	*0*		
- Are priorities & based on clients perception of needs	*3*	*2*	*1*	*0*		
- Facilitates plan of care & determination of outcomes	*3*	*2*	*1*	*0*		
- Are documented in using NANDA terminology	*3*	*2*	*1*	*0*		
Comments:						

2.4 Expected Outcomes

Competency: Proper identification of patient outcomes						
Elements	Rating Scale				mid	Final
- are realistic in relation to patient/ client condition	3	2	1	0		
- are attainable in relation to available resources	3	2	1	0		
- includes a time & amount estimation	3	2	1	0		
- are documented as measurable goals	3	2	1	0		
Comments:						

2.5 Planning

Competency: Plan nursing care in consultation with individuals & health team						
Elements	Rating Scale				mid	Final
- Is derived from diagnosis	3	2	1	0		
- Developed through effective communication with all appropriate parties (patient(/client, family, health care providers)	3	2	1	0		
- Are prioritized	3	2	1	0		
- Are individualized for each patient	3	2	1	0		
- Culturally appropriate	3	2	1	0		
- Provides continuity of care	3	2	1	0		
- Regularly reviews & revised	3	2	1	0		
Comments:						

2.6 Intervention

Competency: Provides comprehensive, safe, effective nursing care to achieve outcomes						
Elements	Rating Scale				mid	Final
- Supports clients independence	3	2	1	0		
- Assists clients with ADLs	3	2	1	0		
- Applies knowledge relevant to patients needed care	3	2	1	0		
- Completes care on an organized & timely manner	3	2	1	0		
- Adapts priorities in response to changing needs	3	2	1	0		
- Organizes clients care activities to meet client & agency needs	3	2	1	0		
- Provides feedback regarding performance of care	3	2	1	0		
- Demonstrates principle of safety & infection control	3	2	1	0		
- Encourages patient & family participation in care	3	2	1	0		
- Advocates for patients & family rights regarding involuntary treatment & other issues	3	2	1	0		
Comments:						

2.7 Medication administration

Competency: Participates in safely medication administration						
Elements	Rating Scale				mid	Final
- Recalls patient medication information including classification, indication, dosage, side effects, interaction& nursing implications	3	2	1	0		
- Calculates medication dosage & IV rates correctly	3	2	1	0		
- Checks five rights prior to medication administration	3	2	1	0		
- Performs appropriate assessment prior to, during, after medication administration	3	2	1	0		
- Follows correct procedure in preparing & administration medication	3	2	1	0		
- Evaluates effects of medications administered	3	2	1	0		
- Relates patients´ medications to their health status	3	2	1	0		
Comments:						

2.8 Therapeutic communication and interpersonal relationships

Competency: Use effective therapeutic communication skills						
Elements	Rating Scale				Mid	Final
- Complies with agency, school polices, state law and regulation	3	2	1	0		
- Treats all individuals with dignity and respect	3	2	1	0		
- Protects clients rights (privacy, autonomy, confidentiality	3	2	1	0		
- Demonstrates appropriate behaviors:						
▪ Attendance	3	2	1	0		
▪ Appearance	3	2	1	0		
▪ Attitudes	3	2	1	0		
▪ Punctual	3	2	1	0		
▪ Demonstrates accountability for action and delegation	3	2	1	0		
▪ Accepts responsibility	3	2	1	0		
- Uses intrapersonal skills						
▪ active listening	3	2	1	0		
▪ verbal and non-verbal communication	3	2	1	0		
▪ eyes contact	3	2	1	0		
▪ giving feedback	3	2	1	0		
▪ working with others	3	2	1	0		
- Provides accurate information to patient and family	3	2	1	0		
- Establishes work relationship with peers, staff and instructors	3	2	1	0		
- Adapts communication strategies based on patient age, developmental level, disability and culture	3	2	1	0		
Comments:						

2.9 Evaluation

Competency: Evaluate progress toward individual health outcomes						
Elements	*Rating Scale*				***mid***	***final***
- ***Determines progress of individual toward planned outcomes***	***3***	***2***	***1***	***0***		
- ***Documents patient response to interventions***	***3***	***2***	***1***	***0***		
- ***Revises the plan of care & determines further outcomes in accordance with evaluated data***	***3***	***2***	***1***	***0***		
- ***Uses appropriate terminology, spelling & grammar in written communication***	***3***	***2***	***1***	***0***		
- ***Documents complete accurate care plan***	***3***	***2***	***1***	***0***		
- ***Completes documentation according to agency guidelines(format, timing, abbreviation)***	***3***	***2***	***1***	***0***		
Comments:						

2.10 Health Education

Competency: Provides effective individual, family education						
Elements	*Rating Scale*				***Mid***	***Final***
- ***Applies knowledge of effective interprofessional working practice***	***3***	***2***	***1***	***0***		
- ***Establishes & maintain conductive working with nursing & other colleagues***	***3***	***2***	***1***	***0***		
- ***Contributes to effective multidisciplinary teamwork by maintaining collaborative relationships***	***3***	***2***	***1***	***0***		
- ***Values the roles & skills of members of the health & social care teams***	***3***	***2***	***1***	***0***		
- ***Participates with members of the health & social team in decision making concerning patients***	***3***	***2***	***1***	***0***		
- ***Reviews & evaluates care with members of the health & social care team***	***3***	***2***	***1***	***0***		
- ***Takes account of the views of patients & carers in decision making by the interprofessional team***	***3***	***2***	***1***	***0***		
Comments:						

2.11 Care Management

1. Safe Environment

Competency: Provides safe healthy environment						
Elements	*Rating Scale*				***Mid***	***Final***
- ***Creates & maintains a safe environment of care through the use of quality assurance & risk management strategies***	***3***	***2***	***1***	***0***		
- ***Uses appropriates assessment tools to identifies actual & potential risks***	***3***	***2***	***1***	***0***		
- ***Ensures the safe administration of therapeutics substances***	***3***	***2***	***1***	***0***		
- ***Implements infection control procedures***	***3***	***2***	***1***	***0***		
- ***Communicates & records safety concerns to a relevant authority***	***3***	***2***	***1***	***0***		
Comments:						

2. *Delegation &Supervision*

Competency: Manage care using principle of delegation						
Elements	*Rating Scale*				***Mid***	***Final***
- ***Delegates to others, activities suitable to their abilities & scope of practice***	***3***	***2***	***1***	***0***		
- ***Uses a range of supportive strategies when supervising aspects of care delegated to other***	***3***	***2***	***1***	***0***		
- ***Maintains accountability & responsibility when delegating aspects of care to others***	***3***	***2***	***1***	***0***		
Comments:						

3. Inter professional Health Care

Competency: Manage care to facilitates continuity within & across health care settings						
Elements	*Rating Scale*				***Mid***	***Final***
- ***Applies knowledge of effective interprofessional working practice***	***3***	***2***	***1***	***0***		
- ***Establishes & maintains conductive working relationship with nursing & other colleagues***	***3***	***2***	***1***	***0***		
- ***Contributes to effective multidisciplinary teamwork by maintaining collaborative relationships***	***3***	***2***	***1***	***0***		
- ***Values the roles & skills of members of the health & social care teams***	***3***	***2***	***1***	***0***		
- ***Participates with members of the health & social team in decision making concerning patients***	***3***	***2***	***1***	***0***		
- ***Reviews & evaluates care with members & the health & social care team***	***3***	***2***	***1***	***0***		
- ***Takes account of the views of patients & careers n decision making by the inter professional team***	***3***	***2***	***1***	***0***		
Comments:						

Professional Development

3.1 Professional Enhancement

Competency: Demonstrates professional continuous self enhancement						
Elements	*Rating Scale*				*Mid*	*Final*
- ***Promotes & maintains the professional image of nursing***	***3***	***2***	***1***	***0***		
- ***Advocates for his right to participate in health policy development & program planning***	***3***	***2***	***1***	***0***		
- ***Contributes to the development of professional nursing practice***	***3***	***2***	***1***	***0***		
- ***Acts as an effective role model***	***3***	***2***	***1***	***0***		
- ***Values research in contributing to developments in nursing as a means to improving standards of care***	***3***	***2***	***1***	***0***		
- ***Takes on leadership responsibilities where relevant in the delivery of nursing & health care***	***3***	***2***	***1***	***0***		
Comments:						

3.2 Quality Improvement

Competency: Monitoring & enhancing quality of health care practice						
Elements	*Rating Scale*				***Mid***	***Final***
- Uses valid evidence in evaluating the quality of nursing practice	*3*	*2*	*1*	*0*		
- Participates in quality improvement & quality assurance procedures	*3*	*2*	*1*	*0*		
Comments:						

3.3 Continuing Education

Competency: Demonstrates continues						
Elements	*Rating Scale*				***Mid***	***Final***
- Carriers out regular review of own practice	*3*	*2*	*1*	*0*		
- Assumes responsibility for life long learning & maintenance of competence	*3*	*2*	*1*	*0*		
- Takes opportunity to learn together with other contributing to health care	*3*	*2*	*1*	*0*		
- Acts as an effective mentor	*3*	*2*	*1*	*0*		
- Takes actions to meet continuing education needs	*3*	*2*	*1*	*0*		
Comments:						

3.4 Therapeutic use of self

Competency: demonstrates therapeutic use of self						
Elements	*Rating Scale*				***Mid***	***Final***
- Recognizes the effect of one's behavior on others (patient, family staff)	*3*	*2*	*1*	*0*		
- Understands the dynamics of human behaviors	*3*	*2*	*1*	*0*		
- Recognizes & identifies own feelings	*3*	*2*	*1*	*0*		
- Recognizes & identifies feelings of others	*3*	*2*	*1*	*0*		
- interprets behavior of self & others	*3*	*2*	*1*	*0*		
- takes appropriates actions in nursing situations	*3*	*2*	*1*	*0*		
- demonstrates empathy, warmth & respect during goal – oriented interaction	*3*	*2*	*1*	*0*		
- demonstrates non-judgmental attitudes	*3*	*2*	*1*	*0*		
- utilizes as appropriate, problem solving techniques during interactions	*3*	*2*	*1*	*0*		
- identifies individuals` communication limitations & utilizes alternative form of communication as appropriates	*3*	*2*	*1*	*0*		
Comments:						

Rating scale:

3 Consistently exceeds expectation

2 Performing as expected for this level

1 Unsatisfactory, but not unsafe

0 Unsafe, not meet minimal level of expectation

Course Components:

Orientation:
October, Group 1, 18, 20
Group 2, 19, 21

Required prior to attending clinical area, it is designed to prepare students for their clinical experience.

Clinical areas:

*** Alrashid (private psychiatric and mental health hospital)**

*** The National Hospital for Mental Health (Al-Fuheis).**

Textbook:

Psychiatric Nursing Care Planes. Katherine M. & Patricia A. Worret (2003)
Mosby, California. ISBN: 0-323-01482-8
In addition to the above, the students will be provided with handouts.

Module References:
Students will be expected to give the same attention to these references as given to the Module textbook(s)
1. Basic Concepts of Psychiatric-Mental Health Nursing. Shives R. Louise (2005)
6th Edition. Lippincott Williams & Wilkins.
2. Psychiatric-Mental Health Nursing. Videbeck L. Sheila (2006) 3rd Edition. Lippincott Williams & Wilkins.

Teaching Methods:

1. Direct interaction with patients
2. Clinical Supervision.
3. Attending nursing care plan meeting
4. Attending multi disciplinary and treatment team.
5. Observing L group meeting.
6. Assignments
7. Audio visual aids.
8. Individual and group discussions.

Learning Outcomes:

- **Knowledge and understanding**

- Discuss current trends in the treatment of people with mental illness.
- Discuss the nurse's role in educating clients and families about current neurobiologic theories and medication management.
- Identify client responses that indicate treatment effectiveness.

- Integrate the knowledge (evidence) into management of patient(s) care.

- **Cognitive skills (thinking and analysis).**

Demonstrating critical thinking in clinical decision- making when planning and delivering client care.

- **Communication skills (personal and academic).**

- Demonstrate accountability, responsibility, professionalism, and increased level of independence when working with the clients and other health team members.

- Apply therapeutic communication skills, collaborate, and cooperate to establish effective professional relationship with patients, health team members, college, and instructor.

- **Practical and subject specific skills (Transferable Skills).**

Manage safety and comfort principles and psychomotor skill competencies with clients with variety of behavioral and emotional disorders.

Course calendar:

Weekly activities

Weeks	Visits	
First week	**Visit 1** 1. Orientation to unit 2. Meeting patient; assignment to patient /rehashing instructors expectation **Visit 2** 1. Interview patient/ document assessment consult with instructor on meaning/interpretation of patient's behavior and communication/nursing progress note. 2. Asking about admission policy	
Second week	**Visit 3** 1. Complete assessment/read chart 2. Summarize assessment data 3. Identify appropriate NANDA diagnosis 4. Spend structured time with patient with an activity 5. Learn about safety procedure on the unit **Visit 4** 1. Write plan for intervention 2. Choose a nurse from floor and discuss plan for implementation 3. Check the medication kardex 4. Read about your patient's medication 5. Learn about, check for safety routine, privileges	

Third week	**Visit 5+6** 1. Write an admission note consider each patient as anew admission, follow admission procedure 2. Spend time with your patient (time should be structured and aims at intervention) 3. Prepare to present in a case conference-complete your plan if not complete	
Fourth week	**Visit 7+8** 1. Record communication dialogue with your patient (to be analyzed at home) 2. Evaluate the change in patient's behavior in response to care plan document evaluation in nurses notes + kardex 3. Spend time with patient individually 4. Spend time with patient in a group (with other patients) 5. Case conference(divided between students; 7^{th} 8^{th} visits) 6. Mid term evaluation for students	
Fifth week	**Visit 9+10** 1. Choose your second patient assess and demonstrate special assessment according to patient case 2. Write care plan (same day of assessment) 3. Write admission note 4. Meet with staff to explain plan and delegate responsibilities 5. Ask for staff help to make appointment with your patient family 6. Plan an educational session with the family (if meeting not possible in this week plan for the next weeks)	
Sixth week	**Visit 11+12** 1. Visit with your patient (write second process recording) 2. Case conference on all patients 3. Explore discharge policies 4. Practice to write nursing note on your patient	
Seventh week	**Visit 13+14** 1. Catch up week 2. Make sure you have at least a contact of one hour with your patient individually or in groups (activities) 3. Submit second care plan	
Eighth week	**Visit 15+16** 1. Produce standardized care plans for patients with:	

	• Schizophrenia • Psychosis • Major depression • Mania /hypomania • Suicide • Aggression • Sever anxiety • Compulsive behavior	
Ninth week	• (divide into three groups each group will report on all care plans and discuss with other groups) • Submit typed care plans	
Week ten to twelve	• Integration of activities of all weeks • Final practicum exam.	

Course Evaluation

Modes of Assessment:	**Score**
Nursing care plan	20 %
Concept analysis paper	10 %
Clinical daily journal	5 %
Documentation sheets(Kardex, nurses notes)	15 %
Process recording	10 %
Comprehensive mid term exam (Oral exam) (Competency)	20 %
Comprehensive final Exam (oral exam) (Competencies)	20 %
Total	100 %

Attendance Policy:

Absence from lectures and/or tutorials shall not exceed 15%. Students who exceed the 15% limit without a medical or emergency excuse acceptable to and approved by the Dean of the relevant college/faculty shall not be allowed to take the final examination and shall receive a mark of zero for the course. If the excuse is approved by the Dean, the student shall be considered to have withdrawn from the course.

- 2 late considered by 1 day absent.
- Make-up exams will be offered for valid reasons only with consent of the Dean.

Make-up exams may be different from regular exams in content and format.

Documentation and Academic Honesty:

Submit your home work covered with a sheet containing your name, number, course title and number, and type and number of the home work (e.g. tutorial, assignment, and project).

Any completed homework must be handed in to my office (502) on the due date. After the deadline "zero" will be awarded. You must keep a duplicate copy of your work because it may be needed while the original is being marked.

You should hand in with your assignments:

- A printed listing of your test programs (if any).
- A brief report to explain your findings.
- Your solution of questions.

- **Protection by Copyright**
  1. Coursework, laboratory exercises, reports, and essays submitted for assessment must be your own work, unless in the case of group projects a joint effort is expected and is indicated as such.
  2. Use of quotations or data from the work of others is entirely acceptable, and is often very valuable provided that the source of the quotation or data is given. Failure to provide a source or put quotation marks around material that is taken from elsewhere gives the appearance that the comments are ostensibly your own. When quoting word-for-word from the work of another person quotation marks or indenting (setting the quotation in from the margin) must be used and the source of the quoted material must be acknowledged.
  3. Sources of quotations used should be listed in full in a bibliography at the end of your piece of work.

- **Avoiding Plagiarism**
  1. Unacknowledged direct copying from the work of another person, or the close paraphrasing of somebody else's work, is called plagiarism and is a serious offence, equated with cheating in examinations. This applies to copying both from other students' work and from published sources such as books, reports or journal articles.
  2. Paraphrasing, when the original statement is still identifiable and has no acknowledgement, is plagiarism. A close paraphrase of another person's work must have an acknowledgement to the source. It is not acceptable for you to put together unacknowledged passages from the same or from different sources linking these together with a few words or sentences of your own and changing a few words from the original text: this is regarded as over-dependence on other sources, which is a form of plagiarism.
  3. Direct quotations from an earlier piece of your own work, if not attributed, suggest that your work is original, when in fact it is not. The direct copying of one's own writings qualifies as plagiarism if

the fact that the work has been or is to be presented elsewhere is not acknowledged.

4. Plagiarism is a serious offence and will always result in imposition of a penalty. In deciding upon the penalty the Department will take into account factors such as the year of study, the extent and proportion of the work that has been plagiarized, and the apparent intent of the student. The penalties that can be imposed range from a minimum of a zero mark for the work (without allowing resubmission) through caution to disciplinary measures (such as suspension or expulsion).
5. Further Instruction:
    - The university bus will leave the university campus at 8 a.m. Any student who misses the bus is expected to reach the clinical area at his \ her expenses.
    - The bus will leave the clinical area at 1:30 p.m. Therefore, all students should be on the bus by this time. Smoking is not allowed during clinical hours or on bus.
    - Students' appearance is expected to be appropriate (clean neat clothes, 1st name tag, etc…).
    - Keep the bus and hospital clean and maintained.
    - Information about patients (users) should remain confidential and not discussed with others.
    - Students not allowed leaving the premises of the clinical area during clinical hours
    - Evaluation is the responsibility of the clinical instructor.
    - The student however, is encouraged to ask for formal evaluation at midterm and before the final evaluation.

Assignments

1- Clinical Daily Journal
2- Nursing Care Plans (2 \ semester)
3- Process Recording (2\ semester)
4- Competency evaluation sheet (midterm and final exam)
5- Nursing progress Notes
6- Concept analysis paper

Clinical Daily Journal / Reflection Paper:

- Describe a significant situation or event that occurred in your clinical day. Explain why the event was important to you as related to developing understanding of the nursing care of a client who has (a) mental health condition(s). Note that "significant event" differs from "critical incident;" i.e. the event or situation about which you write your journal entry should reflect your specific personal learning\development of insight, as opposed to an evaluation of the event\situation as "minor" or "major" to clinical practice in general.

- Discuss how this event might have been perceived by others involved (e.g .the client, staff, classmates) and those external to the event. For example, pretend you are someone else (a client, staff nurse, teacher, classmate, etc.) and react to something you did today in your clinical practice; i.e. If you attempted to communicate with a client who had aphasia today, write about the situation from the perspective of the client, etc. Explore alternative ways of interpreting and responding to the event including an evaluation of the feasibility and acceptance of each of these alternatives.

- Identify what specific learning has occurred for you in reflecting about this event. What specific thing(s) did you learn today and how will you apply that learning in your practice as a nurse? Identify some differences in what you learned today from what you learned previously. How will you apply this learning in your practice as a nurse?

As appropriate, you may wish to re-read a journal entry from a previous week and write a reaction to what you wrote in relation to new learning

Clinical Assessment and Nursing Care Plan

PURPOSE: to provide the learner the opportunity to complete an assessment of the biopsychosocial needs of an individual receiving services in the mental health care delivery system, and to design a plan of care to respond to the assessed needs.

OBJECTIVE: To provide the learner with the skills to complete an assessment of the biopsychosocial needs of the client in the mental health clinical setting.

FORMAT:
Assessment:

1. Biopsychosocial History of the Client.
2. DSMIV-TR diagnosis: Provide multiaxial assessment{axis I-IV} if possible.
3. Physical Assessment as Appropriate.
4. Mental Status Exam
    a. Level of awareness and orientation.
    b. Appearance and behavior (Speech and Communication)
    c. Mood or affect.
    d. Thought process.
    e. Perception.
    f. Insight
    g. Risk of self harm or harm to others.
    h. Medications-Prescribed drugs, over the counter and street drugs.

Nursing Care Plan:

1. Nursing Diagnosis

a. Based on the above assessment, state NANDA nursing diagnoses
b. Examples:
c. Disturbance in self concept/self esteem related to death of spouse evidenced by withdrawal and feelings of hopelessness
d. Ineffective individual coping related to mistrust of others evidenced by refusal to take medication

2. Outcome Criteria:
    a. State at least three outcomes related to each defined nursing diagnosis.
3. Nursing Interventions:
    a. Provide nursing interventions which comprehensively address defined outcomes
    b. Include scientific rationale for each intervention
4. Evaluation:
    a. Evaluate the potential or effectiveness of each intervention
    b. Were the goals achieved? If you have been unable to implement the interventions, describe how effective you think they'll be in meeting the goals and why.

Nursing / Client Communication Process Recording

PURPOSE:

The Process Recording provides the learner with a verbatim and progressive recording of the nurse/client interaction in the clinical setting during a given time. The process recording provides the nurse with a vehicle to critique verbal/non-verbal communication and client therapeutic interactions.

OBJECTIVES:

To provide information that will enhance the effectiveness of the nurse/client therapeutic interaction.

To increase knowledge and understanding about the learner's own behavior in the clinical interaction with the client.

The Process Recording is most effective when completed as soon as possible after the interaction. A ten minutes interaction is reflected in approximately ten pages.

Instructions:

1- Write down verbalize statements made by yourself and your patient in a conversation (2 – 3 pages).
2- Analyze the documentation into communication skills using the format below.
3- Evaluate the effectiveness your skills.
4- Suggest alternative strategies that you consider appropriate.
5- Write a small discussion to indicate the impact of communication on the patient.

Process Recording Format

_____ Site: _____

Student Name: _____ Date: _____

Client Initials: _____ Diagnosis: _____

Goal of Interaction: _____

Patient:	Behaviors (Verbal/Non Verbal)	(20)
Nurse:	Behaviors (Verbal/Non Verbal)	(20)
Nurse:	Thoughts/Feeling	(20)
Analysis:	Theory, Intuition, Issues, Conclusion	(20)
Evaluation:	Effective/Ineffective, Impact on Process, Alternative Strategies.	(20)

ASSIGNMENT II

MENTAL HEALTH NURSING CLINICAL CONCEPT PAPER

PURPOSE: The purpose of this paper is to provide the opportunity for students to demonstrate knowledge of and apply psychiatric mental health nursing principles.

OBJECTIVES:

- Analyze a concept/behavior related to psychiatric mental health nursing from a theoretical model.
- Select a client through whom you can apply this concept/behavior.
- Discuss the effects of this concept on the population from a biopsychosocial perspective.

OUTLINE OF PLAN:

1. **Concept/behavior Analysis**
    a. Introduction: Give overview of the paper, including your rational for selecting client, concept/behavior.
    b. Client assessment: Provide relevant history of the client in chronological order; i.e.; events of psychological significance, developmental, sociocultural and family factors. Include history of present illness, DSM-IV diagnosis and any other significant data i.e.; medical illnesses medications etc;
2. **Impact on the Individual, Family and Community**
    a. What is the impact of this concept/behavior on those living in the situation?
    b. How do the providers of care for these individuals manage the holistic needs of those involved?
3. Review of Literature: Include at least two theorists in your review.
4. Discussion of relevant nursing interventions based on the above areas.

5. Summary and Conclusions
6. Format: 10-12 pages in length. Grammar clarity organization and spelling. Bibliography and Footnotes (APA format) Sources should include nursing and other publications. At least four nursing references, exclusive of your textbook, should be included. Please do not use nonprofessional sources
7. Reminder: Clients' names, caregivers' names and names of agencies should not appear in your paper.
8. Oral Presentation: you are expected to give a brief oral presentation of your paper to your clinical group. The time will be designated by your clinical instructor.

Nursing progress Notes

Use the adopted model of Nursing Notes (POMR).

1- Write clearly
2- Do not leave spaces.
3- Scratch errors you make while leaving the error legible.
4- Sign your Nursing Notes.

Thank you and good luck

Patient's Daily Progress Notes

Date: / /

Problem	*Time*	*Nursing Notes*
No. 1	---------	**S** ---------- **O** ---------- **A** ---------- **P** ----------
No. 2	---------	**S** ---------- **O** ---------- **A** ----------

Problem	*Time*	*Nursing Notes*
		P ---------- ---------- ---------- ----------
No. 3 ⋮	----------	**S** ---------- ---------- ---------- ---------- **O** ---------- ---------- ---------- ---------- **A** ---------- ---------- ---------- ---------- **P** ---------- ---------- ---------- ----------
No. 4 ⋮	----------	**S** ---------- ---------- ---------- ---------- **O** ---------- ---------- ---------- ----------

Problem	*Time*	*Nursing Notes*
		A ---------- ---------- ---------- ---------- **P** ---------- ---------- ---------- ----------
No. 5	---------	**S**

S: ***Subjective Data***
O: ***Objective Data***
A: ***Assessment\Analysis***
P: ***Planning***