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Nursing 412: Practicum in Psychiatric/Mental Health

Spring 2007

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Introduction

This is a Level III Practicum course. This course is 3 (0-9) credit hours.

Course Description

Theoretical perspectives of behavior will be applied to mental health nursing in a practice setting. Advanced concepts of communication, use of self, group, and milieu are used to define the nurse's role with clients and agencies in which mental health nursing is practiced. Maladaptive emotional and behavioral expressions are studied in the context of a mental health continuum and a social systems framework.

Clinical Objectives

<table>
<thead>
<tr>
<th>Nursing Process Domain</th>
<th>Clinical Objective</th>
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3
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Assessments accurately reflect clients' holistic health status.</th>
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<tbody>
<tr>
<td></td>
<td>Analysis of client database yields prioritized, relevant nursing diagnoses.</td>
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<tr>
<td>Planning</td>
<td>Sets realistic goals in collaboration with clients, which are client-centered, target-specific expected outcomes with specific time frames for achievement, and which are derived from prioritized nursing diagnoses.</td>
</tr>
<tr>
<td>Implementation</td>
<td>Interventions are formulated to achieve specific, individualized, and theoretically sound outcomes (goals), and to reflect a cooperative effort involving other health care professionals. These will include: counseling, therapy, promotion of self-care activities and health care activities, psychobiological intervention, health teaching, and case management.</td>
</tr>
<tr>
<td></td>
<td>Uses therapeutic communication skills appropriately.</td>
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<tr>
<td>Evaluation</td>
<td>In collaboration with the client and other health care professionals accurately evaluate the extent to which expected outcomes in relation to client goals have been met with appropriate modifications/revisions of specific nursing actions.</td>
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<tr>
<td></td>
<td>Demonstrates (verbally and in writing) the willingness to evaluate own thoughts, feelings, strengths, and limitations.</td>
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<tr>
<td>Professional Role</td>
<td>Demonstrates the use of critical thinking and independent judgment in clinical decision making.</td>
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<tr>
<td></td>
<td>Assumes responsibility for own learning; i.e. assertively seeks out learning experiences in the clinical setting, initiates participation in milieu activities, and actively participates in clinical conferences.</td>
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<tr>
<td></td>
<td>Works effectively with other professionals, peers, and instructor within the clinical setting, seeks and provides feedback, and documents care accurately and appropriately.</td>
</tr>
<tr>
<td></td>
<td>Reflects respect and sensitivity to milieu through appropriate dress, deportment, identification of self and role, promptness to groups, meetings, and activities.</td>
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*Note: These Clinical objectives reflect the standards of care currently drafted for psychiatric mental health.*
General Information

Special Needs

Any student who has special needs should contact his/her clinical instructor within the first week of clinical to discuss his/her needs.

Instructional Model

Eight (8) hours per week will be spent in a clinical practice setting. Psychiatric nursing orientation day counts for the first eight hours of clinical. The specific timing of hours spent in a clinical practice setting will vary by the clinical site. All students will participate in supervised clinical nursing practice and clinical conference seminars each week. Clinical conference seminars count as part of clinical hours.

The overall purpose of the clinical seminar is to assist students to integrate theoretical concepts and clinical experiences. There will be discussion of clinical issues, clinical case studies, short didactic presentations, and other clinical experiences. The format will vary to fit the topic discussed. All students are expected to be consistently active participants in clinical seminars.

Clinical instructors will provide students with information about specific assignments that will be required for a given setting during the first week of clinical. Nursing care plans, process recordings, and reflective journals are required for all students. Specific frequency of paperwork and required revisions of previously submitted paperwork will be at the discretion of an individual clinical instructor. Paperwork guidelines and sample forms are provided; however, an instructor may provide students with modified versions of forms to use. Clinical instructors may provide specific examples of paperwork to students for reference at their own discretion.

Other required assignments will vary by clinical site, and may include other forms of clinical documentation such as progress notes, forms of clinical pathway-type documentation, annotated bibliographies, case presentations, role-playing, attendance at special workshops/conferences related to the course objectives, other observational experiences, and review of audio-visual media.

Clinical placements will use both in-patient and out-patient experiences. In-patient experiences are closely supervised by faculty. Students will focus on assessment of the major psychiatric problems, clinical management of disorders, medications, the treatment team, milieu and group therapy, and beginning therapeutic communication. Students will also practice advanced communication skills.

Students will be provided with specific details about the model of clinical instruction used at their clinical site prior to the first week of on-site clinical.
Clinical Preparation and Professional Behavior

The implementation and professional development aspects of Nursing 412 are heavily emphasized (weighted 35% and 25% respectively in the clinical evaluation tool) reflecting the status of Nursing 412 as a capstone clinical course. As soon-to-be-licensed health care professionals, students are expected to be active and assertive learners throughout the semester in order to maximize personal learning experiences during clinical. Using the instructor as a resource person, students will be expected to seek out and structure their own learning experiences during the clinical day in collaboration with facility staff; i.e. actively participating in interdisciplinary team meetings and care planning meetings with clients, co-leading/leading therapeutic groups for clients, and engaging in other professional-level experiences which are available within a given clinical setting. Students are expected to approach their clinical instructors and facility staff for consultation regarding specific interventions with individual clients and groups of clients, as appropriate, as well as to provide regular updates on activities throughout the clinical day. In approaching a clinical instructor or staff for consultation a student is expected to verbalize an initial plan of action that is based on theoretically-sound rationale and appropriately individualized to the client and/or situation. Specific preparation and professional behavior, which is expected at all times (regardless of setting), includes the ethics, preparation for clinicals and conferences noted below.

Ethics

Nursing’s respect for the patient’s dignity, autonomy, cultural beliefs, and privacy is of particular concern in psychiatric-mental health nursing practice. The nurse serves as an advocate for the patient and is obliged to demonstrate nonjudgmental and nondiscriminatory attitudes and behaviors that are sensitive to patient diversity. An essential aspect of the patient’s response is the right to exercise personal choice about participation in proposed treatments. The responsible use of the nurse’s authority respects the patient’s freedom to choose among existing alternatives and facilitates awareness of resources available to assist with decision making.

Nurses working with psychiatric-mental health patients are prepared to recognize the special nature of the provider-patient relationship and take steps to assure therapeutic relationships are conducted in a manner that adheres to the mandates stipulated in the ANA Code for Nurses (ANA 1985). Unethical behavior (e.g., omission of informed consent, breach of confidentiality, undue coercion, boundary infringement) and illegal acts can increase the patient’s vulnerability and demand special vigilance on the part of the psychiatric-mental health nurse. (Standards of Care of Psychiatric Mental Health Nursing by American Nurses Association 2000.)

Preparation for Clinical

- Appropriate attire (should meet agency standards.) To be discussed in Orientation.
- MSU nametag is required. Students are not permitted to attend clinical without this.
- On time, present throughout, and an active participant in all meetings.
- Should have done all reading/other preparation required by the clinical instructor, prior
to the clinical experience. This may include additional reading, writing, research assignments; i.e. reading ahead in textbook regarding specific clinical issues, mental health disorders, and so forth. **Students are expected at all times to be fully prepared to provide safe and effective nursing care for clients.** Clinical faculty may at their own discretion assess student preparation for clinical at any time, either verbally and/or in writing. Any demonstrated lack of preparation for clinical, as judged by either the clinical instructor or agency staff, is grounds for immediate dismissal from the clinical experience. A student who is dismissed from a clinical experience due to lack of clinical preparation is not eligible to make up the clinical experience.

Students may also be dismissed from clinical experiences due to patterns (repeated instances) of other performance deficiencies (performance on clinical objectives of < 2.0) which have not been adequately re-mediated by the student in a timely fashion in response to instructor and/or agency staff feedback/directions for performance improvement. Examples of patterns of performance deficiencies include (but are not limited to): repeated lateness to clinical experiences, excessive un-excused absences (including experiences for which a student has been dismissed for lack of preparation), lateness in submitting required paperwork for clinical, and failure to apply feedback/follow directions of the clinical instructor and/or agency staff regarding clinical requirements/professional behaviors.

**Professional Behavior during Clinical Experiences and Conferences**

- Assertiveness in expressing own thoughts, feelings, needs, and concerns (student should be able to initiate and carry out with instructor and agency staff)
- Creation and direction of own clinical learning experiences in collaboration with staff and clinical instructor; i.e. each student is responsible for "creating his or her own day"
- High involvement in activities within the clinical setting; i.e. it is an expectation that students will work together with staff in a meaningful way in the work to be done within the setting
- Active collaboration with staff and instructor to carry out work in the setting; i.e. students should not be waiting to be directed at what to do by agency staff, clinical instructor
- Active evaluation of own experience together with staff and instructor (student should be able to initiate and carry out)

**Attendance Policies**

Attendance at all clinical experiences is required. Any student who cannot fulfill this requirement for a clinical experience must be excused prior to the clinical experience by assigned clinical instructor. Any student whose absence from a clinical experience is not excused in advance of the clinical experience is not eligible to make up the missed time from clinical. Student make-up of clinical experiences for excused absences is at the discretion of the student's clinical instructor.
Clinical instructors will provide students with information by the first day of clinical for how to notify the instructor of an anticipated absence from a clinical experience. A student who misses a clinical experience may be required to provide appropriate written documentation of the reason for his absence to his/her clinical instructor; i.e. a written excuse from a health care provider may be required for incidents of illness/injury. However, provision of health documentation does not assure that the student will be excused from a clinical experience.

Students who are in jeopardy of failing to meet course objectives due to excessive amounts of absence from clinical or other clinical performance deficiencies will be referred to the Student Affairs Office (refer to College of Nursing undergraduate student handbook).

Any student who is not prepared to provide safe nursing care at a given clinical experience for any reason (including previous absence from clinical experiences) will be sent home from that clinical experience.

Bad Weather Procedures

Clinical instructors will provide students with information the first day of clinical regarding procedures for the event of severe inclement weather.

Required Self-Study Medication Module

In some Nursing 412 clinical settings, students will have the opportunity to assist with medication administration. Clinical instructors will provide site-specific guidelines for student involvement in medication administration procedures. All students (regardless of clinical site) should be prepared at all times to answer clinical instructor questions about medication side effects, adverse reactions, and nursing interventions, for assigned clients. A required self-study module for psychotropic medications is included in the Nursing 409 Psychiatric Nursing syllabus. Students should use this module as the primary basis for learning about psychotropic medications. Materials/information provided by clinical agencies may also be used, but these materials should not be used in place of the psychopharmacology material included in the Nursing 409 syllabus module. **Students are required to have passed the medication quiz pertaining to the medication they wish to dispense before doing so.**

Students may wish to consult these and other references (i.e. assigned and recommended reading for lectures in Nursing 409 syllabus) for additional information about clinical topics:

Universal Precautions and Exposure Guidelines

Refer to the College of Nursing Undergraduate Student Handbook for additional information. In providing nursing care, students are required to uphold universal precaution standards at all times to prevent possible contraction/transmission of pathogens. Exposure incidents should be reported immediately to the clinical instructor and agency staff.

Methods of Evaluation and Grading

The standard University numerical grading system will be used to assign course grades. A student must obtain a course grade of >2.0 in order to pass the course. A 0.0 grade will be given for either unsafe or dishonest behavior. The grade will be determined by observation of student performance in the clinical setting (by instructor and by staff), student performance on written assignments, and student achievement of professional practice objectives (refer to clinical evaluation tool in Nursing 412 syllabus.)

A mid-semester and a final evaluation conference will be held with each student by the student's clinical instructor. At mid-semester, a progress report will be given by the student's clinical instructor to the student. This evaluation is not graded and is intended to foster growth in targeted areas. The final clinical grade will reflect progress over the entire clinical experience and will include grades from seminar presentations, written work, and clinical evaluation grades.

Computation of Final Grade

The final grade is computed using selected, graded clinical assignments and the clinical evaluation form. For assignment description and evaluation criterion, see Paperwork Guidelines and Sample forms and the worksheet for Computation of Final Grade.

Grading Scale

<table>
<thead>
<tr>
<th>Grade on 100-point Scale</th>
<th>Grade on University Grading Scale</th>
</tr>
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<tbody>
<tr>
<td>94-100</td>
<td>4.0</td>
</tr>
<tr>
<td>89-93</td>
<td>3.5</td>
</tr>
<tr>
<td>84-88</td>
<td>3.0</td>
</tr>
<tr>
<td>79-83</td>
<td>2.5</td>
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</tbody>
</table>
### Student Progress

Any student who has a concern about his/her progress in clinical or his/her course grade is responsible for approaching his/her clinical instructor to discuss the concern. Students who believe they may be experiencing academic difficulty are urged to consult promptly with course faculty in order to obtain faculty guidance in proposed remedial activities (refer also to the College of Nursing undergraduate student handbook).

Throughout the semester, a student is expected to apply promptly all feedback (verbal and written) from his/her clinical instructor to future performance in clinical. Failure to apply instructor feedback will result in loss of points from the student's course grade, may result in dismissal from clinical experiences, and/or may result in removal from clinical for the remainder of the semester and a grade of 0.0 for the course.

Any student who has a concern related to the course is expected to approach his/her clinical instructor to discuss the situation. Resolution of a concern on an informal basis between the student and instructor is encouraged. However, if the concern is not resolved at this level, the student should then contact the Nursing 412 course chairperson to discuss the situation. The student should be prepared to discuss a proposed solution to the concern, during the meeting with the course chairperson. A joint meeting between the clinical instructor, student, the Student Affairs representative, and the Nursing 412 course chairperson may be required. If the situation is still not successfully resolved following consultation with the course chairperson, the student should then contact the College of Nursing Student Affairs Office for further guidance (refer also to the College of Nursing undergraduate student handbook).

### Health Documentation Requirements

Prior to the first day of Nursing 410 or 412 clinical on site, please verify that you:

1. Still have your MSU student nurse name tag. Use of identification tags from other agencies or improvised identification will not be permitted at any time. If you have misplaced your MSU name tag, please check at the Student Affairs Office regarding procedures for obtaining a new name tag.

2. Have current CPR certification. If your CPR certification will expire any time during Spring semester, please contact the Student Affairs Office for information about registering for a class in advance of when your certification will expire. Students who have expired certification will need to arrange attendance at a recertification class and provide documentation to the Student Affairs Office that the class was successfully completed prior to the first day of clinical on site.
3. Are completely up-to-date on all required immunizations and health testing. This means that all required information is on file with the Student Affairs Office. Even if you are certain that you have had an immunization/test or have an appointment scheduled to have it done, your documentation will still be considered incomplete until it is submitted to the Student Affairs Office. If you are missing any required documentation or cannot readily obtain documentation of immunizations/testing which have been done, contact Olin Health Center to obtain the required immunizations and health testing prior to the first day of clinical on site.

It is the personal responsibility of each student to be in compliance with the above requirements. The Student Affairs Office will also provide clinical instructors with a list of students whose health documentation information is incomplete or out of date. Students who lack identification, CPR certification, or health documentation will not be permitted to attend clinical until they are in compliance with requirements listed above (unless documentation of an approved waiver is on file with the Student Affairs Office.)

**Required Orientation Sessions for Psychiatric and Community Health Nursing**

There will be required orientation session for Psychiatric/Mental Health Nursing on Monday January 8, 2007, in Room TBA from 8:30 a.m. – 4:30 p.m. It mandatory that everyone signed up for Nursing 409 and 412 attend this orientation day.

**Paperwork Guidelines and Sample Forms**

- Clinical Journal
- Nursing Care Plans (4 per semester)
- Presentation at weekly clinical conf. (1/semester)
- Process Recordings (2/semester)
- Concept Analysis paper (1/semester)
- Clinical Evaluation procedure (midterm & final)

This document contains guidelines and tools for preparation and evaluation of weekly seminars, daily nursing care planning logs, journals, process recordings, and the Concept Analysis Paper. It also includes clinical evaluation guidelines and tool.

**Daily Nursing Care Plans**
A nursing care plan should be completed daily based on the presentation of the client, the long-term goals for treatment, and the therapeutic opportunities of the setting. Whether in-depth or daily, the nursing care plan is a systematized description of the care that will be provided for a client which reflects the use of the nursing process, including assessment (whether it be a full psychosocial history or a mental status examination), nursing diagnoses, planning (including short-term and long-term goal setting), implementation, and evaluation of the client’s goal attainment. The overall goal of a nursing care plan is to ensure that care provided for a client is consistent with the client’s needs and progress toward identified expected outcomes.

The key elements of a daily nursing care plan are:

1. A thorough mental status examination
2. A list of two prioritized nursing diagnoses which reflect analysis of the mental status of the client, progress toward overall outcomes, events of the last few days, new data gathered by the health care team, and the like
3. A list of one long-term, client-centered goals for each of the nursing diagnoses. Note these are time sensitive.
4. A list of one short-term goal for each of the nursing diagnoses. Note these are time sensitive.
5. A list of three relevant nursing interventions with rationales. Along with an evaluation of whether those interventions were achieved.
6. An evaluation of the effectiveness of the care plan and description of modifications made to the care plan, as appropriate.

A daily care plan or log must be written for each clinical day unless deemed inappropriate by negotiation between the student and the clinical instructor. (In those cases where a care planning log is inappropriate, a journal will be used – see below.) Each plan must include all of the key elements identified above. Instructors will also provide relevant site-specific information about the preparation of nursing care plans. A total of five care plans must be written for the Fall semester.

**Short-term, client-centered goals:** Outcomes should be measurable and include specific time frames for accomplishment. Examples of inappropriate and appropriate expected outcomes are:

**Inappropriate:** Client will socialize more with others [describes an overall goal.]

**Appropriate:** By 02/03/2007, the client will report that he/she has spent at least 30 minutes, at least once a day, every day, with at least one other client, watching TV, talking, or working together on a jigsaw puzzle [describes a measurable outcome.]

**Specific Nursing Interventions:** The list of interventions should include specific things that the nurse and the client will do to meet expected outcomes. The interventions
constitute a "road map" for how the client will get from where he/she is currently to the expected outcome. Thus, the interventions should be highly specific and individualized to your client. Examples of inappropriate and appropriate interventions are:

Nursing Diagnosis: Social isolation related to anxiety associated with meeting new people as evidenced by a verbalized reluctance to interact with others and a refusal to attend therapeutic group meetings.

Inappropriate: Promote social interaction with others [describes a nursing strategy.]

Appropriate: After appropriate teaching with client about the relationship between social isolation and depressive symptoms, contract with client to play checkers with one other patient each afternoon following lunch [describes a specific intervention which is individualized to the client.]

Evaluation: Include comments about the extent to which the expected outcomes were or were not attained. If not attained, include comments about why the care plan was ineffective and any subsequent modifications which were made to the key elements of the care plan.

Log Format & Medication Cards

See end of syllabus.

Clinical Journal

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 that has occurred over time.
Weekly Seminars

Students are expected to attend all clinical conferences, which will be comprised of three general aims: 1) The first aim is operational. Students and faculty discuss clinical experience goals, turn in paperwork, discuss upcoming assignments, and the like; 2) The second aim is informal discussion of the events of the clinical experience. Students report learning that they have accomplished as well as problems, needs, and concerns that need to be addressed. Here the faculty may provide theoretical content, and students provide problem solving and support to peers; and 3) The third aim of the clinical conference is to apply theory learned to practice in clinical settings. In order to accomplish this goal, each student is expected to make one presentation each semester on a selected concept.

The requirements for the weekly seminar student presentation are as follows: Students will: 1) research this theoretical concept and make a presentation about their findings to their peers and provide handouts about relevant information; and 2) present the theoretical cause of the problems and the nursing interventions that can lead to resolution of the problem (see grading criterion below). This can be the same topic as your concept paper (see below). Additional topics can be negotiated based on student interest, clinical experiences, etc. Please also refer to concept paper suggestions for additional possible topics. Each student is expected to lead one of these seminars. The faculty might also lead some discussions as warranted or desired.

1. Use of Defense mechanisms
2. Low Self Esteem
3. Crisis state
4. Sensory overload
5. Inability to identify and express feelings
6. Value conflict
7. Dependence
8. Unresolved grief
9. Limited decision making ability
10. Chaotic family of origin
11. Cognitive distortion
12. Impaired identity
13. Mistrust
14. Hopelessness
15. Helplessness
16. Learned Optimism
17. Stress Management
18. Other area of interest as arranged with clinical faculty

This presentation will include:

1. Clear definition of the problem, concept or issue. (20%)
2. Oral discussion of at least two non-internet sources of information about the topic. (30%)

3. Two to three clearly generated theory based nursing interventions that address the cause of the nursing problem. (20%)

4. Generation of at least one discussion question to be considered by the clinical group. (10%)

5. Provision of relevant handouts summarizing main points with references. (10%)

6. Clear and concise presentation (about 10 minutes before discussion). (10%)

*Note: This activity comprises 10% of the student’s clinical grade.*

**Process Recordings**

A process recording is a systematic method of collecting, interpreting, analyzing, and synthesizing data collected during a nurse-client interaction. The major purpose of doing a process recording is to critically analyze communication and its effects on behavior to modify subsequent behavior, resulting in improved quality of therapeutic communication and psychiatric nursing care. Each process recording is comprised of five (5) components (described in detail below). Students should prepare process recordings using as a guideline the copy of the form that is provided below. Process recordings should be prepared on the Process Recording Form.

1. **Objectives for Interaction with Client.** Prior to meeting with a client for whom you will do a process recording, you should have in mind one to three specific objectives for the meeting. You will record your specific objectives at the beginning of your process recording to turn in to your clinical instructor. An objective should indicate a specific, readily measurable change in the client's behavior and function as a guide for your interaction with the client.

2. **Context of the Interaction.** Describe where the interaction took place, activities involving the client that occurred before the interaction, the client's physical appearance, and how the interaction began; i.e. Did the client approach you, or did you initiate the interaction? Also record any other information which you think could have influenced your interaction with the client; i.e. unusual room temperature, interruptions, noise level, and so forth.

3. **Verbatim Nurse-Client Interaction.** Record a verbatim account of what was said on the part of the nurse and the client, but also nonverbal cues for both the client and the nurse; such as, tone of voice, rate of speech, body posture, quality of eye contact, and changes in facial expressions. Each time the nurse and client communicate once with each other is referred to as “an exchange.” Periods of silence are also important to record. Following the record of the conversation should be a brief description of events involving the client that transpired immediately after the interaction. For example, did the client return to his/her previous activity or perhaps choose to isolate him/herself by going outside or to another room?
4. Interpretation of the Interaction and Your Reactions to the Interaction. Use this column to record your thoughts and reactions to the interaction. The emphasis in this part of the process recording is on analyzing that which is not explicit, understanding the probable meaning of the data as recorded in the previous column, and recognizing relevant nursing actions. For example, an analysis might focus on identifying a client's apparent underlying anger, speculating as to the possible causes of the anger, and clarifying why you reacted the way you did, or what prompted you to say or do a particular thing during the interaction. The process of interpretation may well begin during the interaction itself; however, an in-depth interpretation of what occurred during the interaction should take place after the interaction with the client. Your interpretation should reflect knowledge of theoretical concepts and psychiatric nursing care principles for work with clients. Include references here.

5. Nursing Care, Rationale, and Modifications. In the final column you should apply relevant theoretical nursing concepts and psychiatric nursing care principles to stating rationale for why you did what you did in the interaction at each exchange. Alternatively, if there is something that you would have done differently within a given exchange, you should state rationale for why the alternative action would have been better. Rationale stated for each intervention should be drawn from the literature as opposed to documenting your opinion only. Again, cite references. Specific examples of what you could have said or done differently should be included for each exchange. For example, you might explain how anger can adversely affect a client if not dealt with in an appropriate fashion by the client as a rationale for reflecting to the client that he/she seems angry (rationale drawn from literature). Finally, you should include a brief summary to evaluate whether or not your initial objectives for the interaction were met. If your objectives were not met, provide a brief analysis of why. Note that this section of the process recording provides you the opportunity to think about how you would rework/modify a conversation when you can devote undivided time to think over what transpired in the interaction with the client; i.e. You have the chance to "do the conversation twice" (once as it occurred, and again as you think it should have occurred).

Process recordings are a learning tool. They are not supposed to be perfect; they are supposed to be critical. They are evaluated according to whether the interaction was analyzed critically, corrections were suggested with appropriate rationale, and references were used appropriately.

Note: Unless negotiated differently with an individual clinical instructor, all process recordings should be typed. (Tip: you can click on the form, highlight it, copy it, and paste it into Microsoft Word to give you a template in which to type the recording.)
Concept Analysis Paper

The concept analysis paper is a formal writing assignment. It requires you to identify a concept in psychosocial nursing and write a library research paper about it. Drafts of your paper may be reviewed by the instructor three weeks prior to the due date.

A concept is an idea, problem, or theoretical term that is used in psychiatry, psychology, or psychiatric nursing. These concepts will come from experience with clients. They might be the "related to" statements in a nursing diagnosis statement. They might also be found in vocabulary lists in the course or in conceptual models in your book. Examples of concepts are:

1. Low Self-Esteem
2. Dependency
3. Counter Transference
4. Therapeutic Relationship
5. Autonomy
6. Cognitive Distortion
7. Manipulation
8. Hopelessness
9. Value Conflict

Concepts are generally the causes of mental health problems or the consequence of mental health problems. They are not mental illnesses, like schizophrenia or depression. This is not a paper about medical disorders. It is a paper about the causes of mental problems and what nurses can do to prevent them or intervene with them.

The paper will include:

1. A clear definition of the concept. (10%) At least three non-internet, non-textbook references that represent three different ways to look at the same problem or concept. (30%)
2. Synthesis of these divergent literature presented as a summary of the contrasting literatures. This will usually relate to theorists either in the psychology, social science, or nursing fields. (10%)
3. Nursing interventions directly related to the review of literature presented in the paper with citations. (30%)
4. A carefully written, college-level paper. (10%)
5. APA (5th edition) citations and reference list, pagination, cover sheet, margins. (10%)
Note:  This paper is worth 20% of your overall clinical grade.

Clinical Evaluation Procedure

A copy of the Clinical Evaluation Form must be filled out and submitted to a student's clinical instructor prior to each evaluation conference (midterm and final).

The student will rate progress towards meeting each objective using the criterion in the table below. Student self-ratings should reflect an objective assessment of both strengths and areas for growth.

Students will be expected to provide a minimum of two specific examples of how they have made progress toward meeting each objective; i.e. Specific experiences within the clinical setting in relation to particular clients and other specific learning experiences should be cited (refer to appropriate/inappropriate documentation examples below).

Inappropriate (assessment objective):

"always used client charts to obtain further data about my clients"

"talked to staff about clients every week"

Appropriate (assessment objective):

"read H&P from client J.W.'s chart to compare her self-reported psychiatric history with history provided by her family members"

"attended a family meeting between J.W. and her community case worker to obtain data about J.W.'s baseline functioning"

Clinical instructors will provide written feedback for each section of the clinical evaluation form at the midterm and final clinical conferences; however, no numerical ratings of objectives or grade will be give at midterm. At the final evaluation clinical conference, faculty will provide written feedback, numerical ratings of objectives, and a numerical grade.

The obtained clinical evaluation grade is used in addition to seminar presentation grade, process recordings, and concept analysis paper to compute final grade.

Note:  Final clinical evaluation grade is worth 60% of the total course grade.
## Computation of Final Grade Worksheet

<table>
<thead>
<tr>
<th>Graded Clinical Assignment</th>
<th>Points Achieved (out of 100 pts. possible)</th>
<th>Percent of Final Grade (points X %)</th>
<th>Total Points Toward Final Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seminar</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Process recording</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Concept Analysis Paper</td>
<td></td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Clinical Evaluation</td>
<td></td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Totals:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Clinical Objective Rating Scale

**Performance Definitions**

4.0 Exceptional/outstanding performance: consistently, skillfully, and with early and progressive independence meets all clinical objectives

3.5 Very good performance: meets all clinical objectives with skillful and progressive independence, requiring very minimal guidance

3.0 Good performance: with limited guidance meets all clinical objectives

2.5 Fair performance: with moderate guidance meets all clinical objectives

2.0 Minimal performance: with ongoing guidance meets all clinical objectives

1.5 Unsatisfactory performance: inconsistent in meeting clinical objectives

1.0 Unsatisfactory performance: fails in meeting clinical objectives
Process Recording Form – Sample

Student ____________________  Client Initials _____  Age ______
Date ___/___/___   Time ___:___ a.m./p.m.

Objectives for the Interaction:

1.
2.
3.

Context of the Interaction:

<table>
<thead>
<tr>
<th>Verbatim dialog between client and nurse</th>
<th>Interpretation of the Interaction (include citations)</th>
<th>Nursing Care, Rationale, and Modifications (include citations)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summarize interaction; were your goals met?

What did you learn from this experience?

What are two or three goals for future interactions with this patient?
Clinical Evaluation Form – Sample

Student Name _______________________ Date ___/___/___

Evaluation Period (circle one)    Midterm/Final

Clinical Instructor ___________________________

Agency _______________________________________________________________________

Assessment  (20% of final grade)_________

    Student Examples and Rating:

    Faculty Comments and Rating:

Planning  (10% of final grade)

    Student Examples and Rating:

    Faculty Comments and Rating:

Implementation  (35% of final grade)

    Student Examples and Rating:

    Faculty Comments and Rating:
**Evaluation** (10% of final grade)

Student Examples and Rating:

Faculty Comments and Rating:

---

**Professional Role** (worth 25% of final grade)

Student Examples and Rating:

Faculty Comments and Rating:

---

**Specific Strengths in Clinical Performance**

1.
2.
3.

Instructor Comments:

---

**Areas for Continued Development in Clinical Performance**

1.
2.
3.

Instructor Comments:
Specific Strategies for Improving Clinical Performance

1.
2.
3.

Instructor Comments:

Student Signature _______________________  Date ____/____/____

Faculty Signature _______________________  Date ____/____/____
Psychiatric Patient Assessment – Sample

Student___________________________  Date____/____/____
Patient_________________ Age____

History

1. Chief Complaint (patient’s statement put into quotes):

2. Present Symptoms

   3. Admission date and reason for admission

   4. History of Present Illness (onset of problems; duration of problems; psychological symptoms)

3. Health History (Including past psychiatric hospitalizations when/where; history of counseling)

4. Family History

6. Personal History (married ,divorced, single)

Mental Status Examination

1. General Behavior, Appearance, and Attitude (dress,grooming,posture,attitude toward interviewer)

2. Eye contact

3. Speech

4. Affect

5. Mood
6. Thought
   a. Process (Rate and flow of ideas i.e. loose associations, flight of ideas, tangentiality)
   b. Content (i.e. Delusions, ideas of reference, obsessions, preoccupations, suicidal ideations)

7. Perceptual Disturbances
   a. Illusions
   b. Halluciantion (i.e. Auditory hallucinations, visual hallucinations)

8. General Intellectual Level

9. Judgement

10. Insight Evaluation (understanding of illness and hospitalization)

Summary:

Nursing Diagnoses:

Chosen Diagnosis:

Short term goals with interventions:
Long term goals:

Evaluation:
Nursing Diagnosis #1

LTG # 1a
STG 1

Interventions/Rationales
1
2
3
Evaluation of Interventions

Nursing Diagnosis #2

LTG #2b
STG1
Interventions/Rationales
1
2
3
Evaluation of Interventions

*Evaluation of Short term goals*
Weekly Medication Card

MEDICATION ________________________________________
Classification _________________________________________________
Use for this client ____________________________________________
Dose to be given __________  Recommended dosage (mg/kg) __________
Calculated safe dose ___________  Major Side Effects _____________
Metabolism ___________________________________________________
Interactions with other drugs _____________________________________

_____________________________________________________________
Client’s Drug Level _____________  Safe Level _________________
Nursing Considerations_________________________________________
Teaching _____________________________________________________

_____________________________________________________________
MEDICATION ________________________________________
Classification _________________________________________________
Use for this client ____________________________________________
Dose to be given __________  Recommended dosage (mg/kg) __________
Calculated safe dose ___________  Major Side Effects _____________
Metabolism ___________________________________________________
Interactions with other drugs _____________________________________

_____________________________________________________________
Client’s Drug Level _____________  Safe Level _________________
Nursing Considerations_________________________________________
Teaching _____________________________________________________

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