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| --- |
| **Clinical Focus Sheet** |
| **Topic Summary** |
| **Topic** | Clients with Complex Mental Health Alterations |
| **Clinical Objectives** | 1. Provide care to clients with complex mental health alterations utilizing the nursing process, caring measures, and client advocacy.
2. Formulate a nursing care plan for a client with a mental health alteration.
3. Explore interventions used by nurses and other mental health professionals for clients with mental health alterations.
 |
| **Prior to the Experience** | 1. Review communication skills.
2. Review principles of caring and advocacy.
3. Review all previous mental health content.
 |
| **During the Experience** | 1. Participate in pre-conference.
2. Become familiar with the treatment setting.
3. Obtain report from staff nurse and/ or mental health technician.
4. Review client's chart and MAR.
5. Provide care for assigned client.
6. Attend any available group or individual therapy sessions
7. Conduct a one-to-one interview with client.
8. Provide care to clients with a complex mental health alteration in a caring and empathetic manner.
9. Determine a client's cognitive status, if appropriate.
10. Complete a process recording with a focus on the psychosocial aspect of the assigned client.
11. Participate in post conference.
 |
| **Following the Experience****Are to be submitted via Email to Clinical Instructor** | 1. Submit a nursing care plan for a client you cared for during this experience. It can be either in the acute mental health setting or community setting but should be with a patient you have seen while in the clinical setting you have been assigned. Obtain the approval before you begin from your clinical faculty. This needs to be submitted by **April 20th by 5:00 p.m. to your clinical instructor.**
2. Self-evaluate your skills as they relate to care of a client with a mental illness.
3. Submit **weekly journal** entry to clinical faculty that reflects your

feelings on caring for a client with a mental illness, ethical or legal issues related to mental health, therapeutic self, client advocacy and caring behaviors. **Due to clinical instructors via E-Racer using the Collaboration slot under the Forum Home. The icon looks like this** Home Icon**. Place in the appropriate folder designated by clinical week and clinical group.**  |

**Clinical Packet (to be used for Post Conference Discussion)**

Student Name: Date:

# Date of this admission: \_\_

**DSM IV-TR**

**Axis I:**

**Axis II**:

**Axis III:**

**Axis IV:**

**Axis V:**

**Brief Admission History:**

**Past Psychiatric History: (# of admissions, reasons for admissions, differing diagnoses…)**

**History of Substance Use:**

**Family History**:

**Current Support Systems**:

**Current Psychiatric Medications: (Name, dose, route, side effects**):

**Pathophysiology of the disease**:

**Abnormal Lab Values: (date drawn, possible effect, follow up**)

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**Describe General Appearance:** Hygiene/grooming – clean, disheveled; fingernails long/dirty; does pt. need to shave, is hair combed; are clothes clean. Dress – appropriate to weather/season, bizarre, wearing many layers, exaggerated make up, odd clothing, seductive. Size – overweight, underweight, tall, short, etc. Note any aspect of physical appearance that is out of the ordinary.

# Describe mood and affect:

**Thought Processes:** Is conversation logical, appropriate and goal directed? If no, describe thought processes you have observed. (pressured speech, flight of ideas, tangential, circumstantial, loose associations, etc.)

# Describe thought content: (hallucinations, delusions, suicidal, homicidal)

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# Practice Charting: (This is charting about the patient. It should be clear, concise and objective. Describe the behavior, the intervention, and patient response.)

**What did you learn about yourself from this experience (working with patients who are mentally ill)? Has your attitude about persons with mental illness changed during this clinical rotation? If so, how?**

**Mental Status Exam**

|  |  |
| --- | --- |
| **C** | **Consciousness:** Note the patient’s ability to pay attention to a discussion and concentrate. |
| **A** | **Activity:** Is the patient restless and agitated, pacing up and down? Or is he sitting very still, scarcely moving at all? Is he making any strange or repetitive movements? |
| **S** | **Speech:** Note the rate, volume, articulation, and intonation of speech? Is there pressure of speech garbled or slurred (dysarthria)? Is the patient using any strange words? Slurring of speech suggests an organic problem. Accelerated or retarded speech suggests an affective disorder. |
| **T** | **Thought:** Listen to the patient’s story. What’s on his mind? Is he making sense? Is there anything unusual about his reasoning? Is he expressing apparently false ideas (delusions), such as a belief that the CIA is after him? |
| **A** | **Affect and Mood:** The patient’s mood may be most apparent in his body language. The patient sitting with shoulders drooping and head bent, for example, conveys depression. Note whether the affect - the expression of inner feelings - seems appropriate to the situation. |
| **M** | **Memory:** You can form an impression of the patient’s memory by listening to his reconstruction of events. A more precise assessment requires asking a few questions. Ask the patient if you may test his memory. If he assents, slowly say the names of three unrelated objects (e.g., apple, bicycle, sewing machine). After you have named all three, ask the patient to repeat them; that will test registration. A few minutes later, ask the patient if he can remember the three words you named before; that tests retention and recall. |
| **O** | **Orientation:** Ask what is the year, season, month, date, and day of the week. Ask the patient to state where he is, at the moment–the country, state, town, and specific location. |
| **P** | **Perception:** Detecting disorders of perception may be difficult, since patients are often hesitant to answer direct questions about hallucinations. Sometimes it is helpful to ask the patient, “Do you ever hear things that other people can’t hear?” |

**Self-Evaluation of Communication**

**Skills**

Keep this evaluation in mind when you are asked to evaluate your communication in the clinical area in future nursing courses.

1. The interview starts with a self-introduction as a nursing student.
2. The body language and words used foster trust and good will.
3. Before questioning starts the client knows the kinds of information you are interested in, the use of this information and how much of the client's time you plan to take.
4. Before you start, tell the client the components of the assessment (interview, limited physical assessment, diet recall).
5. The environment and time selected are conducive to sharing information.
6. The seating arrangements, your posture, eye contact and facial expression show interest but not intrusion.
7. Determine the client’s feelings about being touched before touching the client; use limited or no touch if appropriate.
8. Most of the questions are open ended and neutral. Avoid judging the client, refrain from using words such as "good", "you should", or "I agree".
9. Do not pry, challenge or act defensive. Allow the client to feel that you are on his/ her side.
10. The sequence of your questions shows logic.
11. You ask only one question at a time.
12. You use restatement to clarify the client's responses when needed.
13. The pace of the questioning is unhurried and comfortable for the client.
14. You honor the client's request to omit a question.
15. You use appropriately placed, brief periods of silence so the client can gather her/ his thoughts.
16. Responses to client statements show that you have been listening.
17. You invite your client to expand on selected statements.
18. You refocus the client on these topics as needed, limiting wandering to other topics.
19. At the end of each part of the assessment (interview, brief physical assessment, diet recall) you ask for questions.
20. At the end of the discussion, you briefly review the areas covered since the start of the interview, and express satisfaction with the process the two of you have completed.
21. You thank the client.
22. You express positive hopes for the client's health and wellbeing.

**Mental Health Nursing Care Plan Rubric**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Assessment**Data Collection | **20%** | * Complete and Accurate
 | 20% |  |
| **Diagnosis** Minimum of 2 Nursing Diagnosis | **25%** | * Nursing diagnosis correlates with assessment data obtained & are the priority
 | 10% |  |
| * Nursing diagnosis correctly stated using current NANDA approved diagnosis
 | 5% |  |
| * “Related to” correlates with patient’s data collected and is not a medical diagnosis
 | 5% |  |
| * “As evidenced by” correlates with assessment data documented on assessment form (only if actual diagnosis)
 | 5% |  |
| **Planning**1 short term and 1 long term goal for each NANDA. Each goal is related to: | **15%** | * 1 short- and 1 long-term goal
 | 3% |  |
| * Patient-centered
 | 3% |  |
| * Realistic for client situation
 | 3% |  |
| * Has a time frame
 | 3% |  |
| * Measurable
 | 3% |  |
| **Intervention**Nursing Measures | **30%** | * Contributes to achievement of goals
 | 10% |  |
| * Comprehensive
 | 10% |  |
| * Has scientific rationales
 | 10% |  |
| **Evaluation**Client Centered | **10%** | * Correlates with goal
 | 10% |  |
| **Total** | **100%** |  |
| ***(75% is the minimum grade to meet the objectives of this assignment)*** |

**Texas Lutheran Nursing Program**

**NURS 342 Behavioral Health Nursing Care Plan**

Student Name: Client Initials:

Client Admission Date: Age: Gender:

Admitting Medical Health Diagnosis & DSM V Axis:

Medical Diagnosis (if any list):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nursing Diagnosis (Minimum of 2 Mental Health Diagnosis) must include related to and evidenced by on each diagnosis used** | **Desired Outcomes****1 short term and 1 long term goal for each NANDA.** | **Nursing Interventions (I) for Independent or (C) for Collaborative** | **Rationale and Pathophysiology** | **Evaluation of Interventions****Indicate (M) Met or (NM) Not met** |
|  |  |  |  |  |

**Clinical Journal Assignment**

**Guidelines**

Journaling is a tool to assist you to develop appropriate clinical judgments by reflecting on your clinical practice, own behaviors, thoughts and feelings**.** Each week you will be required to submit a journal entry using one of the fourteen statements noted below. You may only use a statement once during the course. The statements with an asterisk (# 1, 2, & 3) must be utilized during the clinical experience. The required journal entries are intended to be a guided resource to help you learn from your clinical experiences. It will only be as useful as you make it for yourself. Complete the journal entry and submit to your clinical faculty within 96 hours or by Tuesday after your clinical experience. It is very important to complete the journal as soon as possible after the clinical experience is completed for the week. **Submit the entry each week via email to your clinical faculty**. Given thought and honest self-evaluation, your journal will help guide you in your learning. Each journal entry should be at least four paragraphs, typed, double-spaced, with correct grammar, spelling, and punctuation. Ideas should be organized and clearly communicated.

The first paragraph should describe the clinical situation. It should include **who** was involved, **what**

exactly happened, **where** did this occur, and **when** did this occur.

The second paragraph is your analysis. This is a “thinking out loud” process that deals with reasons, motives and interpretation of your experience. Emotional responses are very telling so it is important to analyze how the situation made you feel. Some questions to think about when answering the analysis section are:

* + How did the situation make you feel?
	+ What were you thinking at the time?
	+ How did you handle your reaction to the situation?
	+ What new things did you learn?
	+ In what way has this experience challenged your assumptions, prejudices, or biases?
	+ Discuss content area studied in the nursing program or in core courses that allowed you further knowledge or insight into the situation.

In the third paragraph you need to reflect on your analysis and self-assessment. You want to determine the WHY. You might want to begin with “In retrospect I realize or When looking back I recognize that” Consider answering the following in this paragraph:

* + How did this event impact you?
	+ This has taught me...

Finally you want to improve your nursing practice. Look to the future and determine how you can use what you learnt and incorporate it into your personal life or nursing practice. Utilize these questions when developing this paragraph:

* + How will you use the knowledge gained in the future?
	+ When a circumstance like this occurs again I will...?
	+ How will this experience alter your future behavior, attitudes, or career?

# CHOOSE FROM THE FOLLOWING EACH WEEK. YOU MAY ONLY USE THE STATEMENT ONCE.

1. Today I recognized the RN role when…
2. Today, I taught my client (or client’s family) about ----- and I felt (include health promotion and disease prevention)…
3. If I could repeat today, I would change how I…
4. Today my knowledge about cultural diversity helped me when…
5. Today my knowledge about growth & development helped me when…
6. Today I felt like I utilized my nursing knowledge when I…
7. The thing I did best today was (include why)….
8. Today, I recognized that my therapeutic communication skills were ---------, when I…
9. Today, I recognized that evidence based practice is essential, when…
10. Today, I demonstrated professionalism when I …
11. Today I felt sad/frustrated when …
12. Today I was a client advocate when I …
13. Before I began client care today I worried most about (include your thoughts and feelings before and after the clinical experience)…
14. Today I felt my greatest accomplishment was (include why)…

**Clinical Journal Assignment Rubrics**

|  |  |  |
| --- | --- | --- |
|  | **Potential Points** | **Points Earned** |
| The journal entry is neatly typed or handwritten. | 5 |  |
| The spelling, grammar, and punctuation in the journal are accurate. | 5 |  |
| The journal entries are submitted in a timely fashion. | 5 |  |
| The entries provide very descriptive explanation of what the learner has done. | 15 |  |
| The organization of the journal entries are clear and easy to follow. | 10 |  |
| Evidence of critical thinking principles and nursing process communicated and clearly defended in log/journal. | 15 |  |
| Reflection of clinical experience demonstrates insight and personal assessment. | 15 |  |
| Specific examples of learningand professional growth provided by learner. | 10 |  |
| The topic of the journal entry meets the requirements of the assignment. | 10 |  |
| The journal offers various experiences and perspectives of what the learner has done or observed. | 10 |  |
| **Total** | **100** |  |
| ***(75 points is the minimum grade to meet the objectives of this assignment)*** |