<table>
<thead>
<tr>
<th>REQUIRED READINGS AND ACTIVITIES:</th>
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<tr>
<td><strong>Review:</strong></td>
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<tr>
<td>N141 Ethics and healthcare</td>
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<tr>
<td><strong>Roles and Functions: Historical Synopsis of PMHN</strong></td>
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<tr>
<td><strong>Lecture</strong></td>
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<tr>
<td>Roles &amp; Functions, pp. 2-23, 89-99, p. 845, Appendix B, pp. 792-794</td>
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<tr>
<td>Syllabus: Psychiatric –Mental Health Nurses Phenomena of Concern.</td>
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<tr>
<td><strong>Nursing Process Lecture</strong></td>
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<tr>
<td><strong>Nursing Computer Lab:</strong></td>
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<tr>
<td>“Intake Interview and Mental Status” CAI</td>
</tr>
<tr>
<td>1. View during open nursing computer lab hours.</td>
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<tr>
<td>2. Turn on the computer if it is not already turned on.</td>
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<tr>
<td>3. On the desktop click on “Intake Interview and Mental Status”</td>
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<td>4. Complete the tutorial and turn off the computer.</td>
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<tr>
<td><strong>Syllabus:</strong> Psychosocial NANDA Diagnoses, also p. 844 FPMHN.</td>
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<tr>
<td><strong>Syllabus:</strong> Nursing Assessment and Worksheet, Care Plan Form, Medication Form (electronic form).</td>
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<tr>
<td><strong>Syllabus:</strong> NCP Case Presentation Guidelines.</td>
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<tr>
<td><strong>Syllabus:</strong> NCP Case Presentation Concept Map.</td>
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</table>

**Therapeutic Relationship Lecture**

Nurse-Client Relationships: pp. 156-173, 174-194,  
**Syllabus:** Guidelines for Setting up a Client-Nurse Contract.  
**Syllabus:** Video Feedback Communication Activity.  
**Syllabus:** Techniques of Therapeutic Communication.  
**Syllabus:** Process Recording Guidelines, Example, and Form (electronic form).  
**Syllabus:** Shift Report/Discharge.  
**Syllabus:** Writing and Keeping a Reflection Journal (Appendices)  
**Media Center:** View video “Communicating with Clients with Mental Disorders or Emotional Problems. 30”

See Web CT for additional resources and supplemental readings.
<table>
<thead>
<tr>
<th><strong>Theory Objectives</strong></th>
<th><strong>Content Outline</strong></th>
<th><strong>Lab/Clinical Objectives</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The student will (be able to):</td>
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<td>The student will (be able to):</td>
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</table>
| 1. Explore concepts of self-knowledge and values as it applies to your practice of psychiatric-mental health nursing. | II. Role function in Psychiatric Nursing  
A. Psychiatric nursing  
1. Historical perspectives  
2. Contemporary practice  
3. Nursing agenda  
4. Components of mental health  
5. Leading causes of disability  
6. Changes in the mental health system  
7. Roles of PMHN  
8. PMHN Skills/Interventions  
9. Standards of Practice  
10. Standards of Professional Performance  
B. Characteristics of therapeutic nurse-client relationship  
1. Personal qualities of the nurse  
   a. Awareness of self  
   b. Clarification of values  
   c. Exploration of feelings  
   d. Serving as a role model  
   e. Altruism  
   f. Ethics and responsibility  
2. Phases of the relationship  
   a. Pre-interaction phase  
   b. Introductory phase  
   c. Working phase  
   d. Termination phase  
3. Therapeutic communication  
   a. Verbal  
   b. Non-verbal  
   c. Communication process  
   d. Therapeutic techniques  
4. Beginning intervention strategies  
   a. Genuineness  
   b. Respect  
   c. Empathic understanding  
5. Advanced intervention strategies  
   a. Confrontation  
   b. Immediacy  
   c. Nurse self-disclosure  
   d. Emotional catharsis  
   e. Role playing  
6. Therapeutic issues  
2. Demonstrate behavioral changes as a result of feedback and theory application.  
3. Submit completed clinical papers within required time.  
4. Identify own strengths and weaknesses.  
5. Demonstrate flexibility and adaptability.  
6. Respect client’s space and territory needs.  
7. Demonstrate non-judgmental attitude.  
8. Identify barriers to communication with clients.  
9. Use consistency in setting limits.  
10. Validate effectiveness of care plan and limit setting with faculty/staff.  
11. Include teaching whenever applicable on written care plan.  
12. Communicate correct information related to client care and medications.  
13. Follow agency guidelines for charting.  
14. Initiate therapeutic communication with clients.  
15. Conduct a videotaped interaction demonstrating therapeutic communication skills  
16. Complete a process recording demonstrating evaluation of therapeutic and non-therapeutic |
<table>
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<td>communication techniques.</td>
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<td>b. Transference</td>
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<td>c. Counter transference</td>
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<td></td>
<td>d. Defense mechanisms</td>
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<td></td>
<td>e. Boundary violation</td>
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<td>7. Roles of the nurse</td>
<td>a. Socializing agent</td>
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<td>b. Teacher</td>
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<td>c. Parent-surrogate</td>
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<td>8. Documentation in clinical settings</td>
<td>a. P.I.E. format</td>
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<td>b. Nursing intake assessment</td>
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<td>c. Nursing care plans</td>
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<td></td>
<td>d. Problem lists</td>
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<td>9. Qualities of a therapeutic milieu</td>
<td>a. Management by nursing staff</td>
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<td>b. Interventions that promote health</td>
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<td>c. Socio-emotional climate</td>
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<td>d. Physical environment and impact on therapeutic community</td>
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<td>10. Mental status examination</td>
<td>a. Appearance</td>
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<td>b. Speech</td>
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<td>c. Motor activity</td>
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<td>d. Interaction</td>
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<td>e. Mood</td>
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<td>g. Perceptions</td>
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<td>h. Thought content</td>
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<td>i. Thought process</td>
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<td>j. Level of consciousness</td>
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<td>k. Judgment</td>
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<td>l. Insight</td>
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<td>m. Defense mechanisms</td>
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<td>n. Impulsivity</td>
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<td>11. Symptom rating &amp; behavioral rating scales</td>
<td>a. Uses</td>
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<td></td>
<td>b. Limitations</td>
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<td>c. Roles in outcomes and reimbursement</td>
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</table>
Forms and Related Information Included in Unit II

Nursing Process  Unit II  
**Syllabus:** NANDA Diagnoses. 
**Syllabus:** Nursing Assessment and Worksheet, Care Plan Form, Medication Form.  
**Syllabus:** NCP Case Presentation Guidelines.  
**Syllabus:** NCP Case Presentation Concept Map.

Role Functions  
**Syllabus:** Psychiatric-Mental Health Nursing’s Phenomena of Concern

Therapeutic Relationship Unit II  
**Syllabus:** Guidelines for Setting up a Client-Nurse Contract.  
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**Syllabus:** Techniques of Therapeutic Communication.  
**Syllabus:** Process Recording Guidelines, Example, and Form.  
**Syllabus:** Shift Report/Discharge.  
**Syllabus:** Writing and Keeping a Reflection Journal (Appendices)
ACTIVITY/REST—Ability to engage in necessary/desired activities of life (work and leisure) and to obtain adequate sleep/rest
Activity Intolerance
Activity Intolerance, risk for
*Activity Planning, ineffective
Disuse Syndrome, risk for
Dorsional Activity, deficient
Fatigue
Insomnia
Lifestyle, sedentary
Mobility, impaired bed
Mobility, impaired wheelchair
Sleep, readiness for enhanced
Sleep Deprivation
+Sleep Pattern, disturbed
Transfer Ability, impaired
Walking, impaired

CIRCULATION—Ability to transport oxygen and nutrients necessary to meet cellular needs
Autonomic Dysreflexia
Autonomic Dysreflexia, risk for
*Bleeding, risk for
Cardiac Output, decreased
Intracranial Adaptive Capacity, decreased
*Perfusion, ineffective peripheral tissue
*Perfusion, risk for decreased cardiac tissue
*Perfusion, risk for ineffective cerebral tissue
*Perfusion, risk for ineffective gastrointestinal
*Perfusion, risk for ineffective renal
*Shock, risk for

EGO INTEGRITY—Ability to develop and use skills and behaviors to integrate and manage life experiences
Anxiety [specify level]
Anxiety, death
Behavior, risk-prone health
Body Image, disturbed

2009-2011 NURSING DIAGNOSES
ORGANIZED ACCORDING TO A NURSING FOCUS
BY DOENGES/MOORHOUSE DIAGNOSTIC DIVISIONS

* = New diagnoses
+ = Revised diagnoses

ACTIVITY/REST—Ability to engage in necessary/desired activities of life (work and leisure) and to obtain adequate sleep/rest
Activity Intolerance
Activity Intolerance, risk for
*Activity Planning, ineffective
Disuse Syndrome, risk for
Dorsional Activity, deficient
Fatigue
Insomnia
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Mobility, impaired wheelchair
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*Perfusion, risk for ineffective renal
*Shock, risk for

EGO INTEGRITY—Ability to develop and use skills and behaviors to integrate and manage life experiences
Anxiety [specify level]
Anxiety, death
Behavior, risk-prone health
Body Image, disturbed

Conflict, decisional (specify)
+Coping, defensive
Coping, ineffective
Coping, readiness for enhanced
Decision Making, readiness for enhanced
Denial, ineffective
Dignity, risk for compromised human
Distress, moral
Energy Field, disturbed
Fear
Grieving
Grieving, complicated
Grieving, risk for complicated
Hope, readiness for enhanced
Hopelessness
+Identity, disturbed personal
Post-Trauma Syndrome
Post-Trauma Syndrome, risk for
Power, readiness for enhanced
Powerlessness
Powerlessness, risk for
Rape-Trauma Syndrome
[Rape-Trauma Syndrome: compound reaction-retired 2009]
[Rape-Trauma Syndrome: silent reaction-retired 2009]
*Relationships, readiness for enhanced
Religiosity, impaired
Religiosity, ready for enhanced
Religiosity, risk for impaired
Relocation Stress Syndrome
Relocation Stress Syndrome, risk for
*Resilience, impaired individual
*Resilience, readiness for enhanced
*Resilience, risk for compromised
Self-Concept, readiness for enhanced
+Self-Esteem, chronic low
Self-Esteem, situational low
Self-Esteem, risk for situational low

Sorrow, chronic
Spiritual Distress
Spiritual Distress, risk for
Spiritual Well-Being, readiness for enhanced

ELIMINATION—Ability to excrete waste products
Bowel Incontinence
Constipation
Constipation, perceived
Constipation, risk for
Diarrhea
*Motility, dysfunctional gastrointestinal
*Motility, risk for dysfunctional gastrointestinal
Urinary Elimination, impaired
Urinary Elimination, readiness for enhanced
Urinary Incontinence, functional
Urinary Incontinence, overflow
Urinary Incontinence, reflex
Urinary Incontinence, risk for urge
Urinary Incontinence, stress
[Urinary Incontinence, total-retired 2009]
Urinary Incontinence, urge
Urinary Retention
[acute/chronic]

FOOD/FLUID—Ability to maintain intake of and utilize nutrients and liquids to meet physiological needs
Breastfeeding, effective
Breastfeeding, ineffective
Breastfeeding, interrupted
Dentition, impaired
*Electrolyte Imbalance, risk for
Failure to Thrive, adult
Feeding Pattern, ineffective infant
Fluid Balance, readiness for enhanced
[Fluid Volume, deficient hyper/hypotonic]
Fluid Volume, deficient [isotonic]
Fluid Volume, excess
Fluid Volume, risk for deficient
Fluid Volume, risk for imbalanced
Glucose, risk for unstable blood
Liver Function, risk for impaired
Nausea
Nutrition: less than body requirements, imbalanced
Nutrition: more than body requirements, imbalanced
Nutrition: risk for more than body requirements, imbalanced
Nutrition, readiness for enhanced
Oral Mucous Membrane, impaired
Swallowing, impaired

HYGIENE—Ability to perform activities of daily living
Self-Care, readiness for enhanced
Self-Care Deficit, bathing
Self-Care Deficit, dressing
Self-Care Deficit, feeding
Self-Care Deficit, toileting
Neglect, self

NEUROSENSORY—Ability to perceive, integrate, and respond to internal and external cues
Confusion, acute
Confusion, risk for acute
Confusion, chronic
Infant Behavior, disorganized
Infant Behavior, readiness for enhanced organized
Infant Behavior, risk for disorganized
Memory, impaired
Neglect, unilateral
Peripheral Neuromotor System Dysfunction, risk for Sensory Perception, disturbed (specify: visual, auditory, kinesthetic, gustation, tactile, olfactory)
Stress Overload
[Thought Processes, disturbed-retired 2009]

PAIN/DISCOMFORT—Ability to control internal/external environment to maintain comfort

Comfort, impaired
Comfort, readiness for enhanced
Pain, acute
Pain, chronic

RESPIRATION—Ability to provide and use oxygen to meet physiological needs
Airway Clearance, ineffective
Aspiration, risk for Breathing Pattern, ineffective
Gas Exchange, impaired
Ventilation, impaired spontaneous
Ventilatory Weaning Response, dysfunctional

SAFETY—Ability to provide safe, growth-promoting environment
Allergy Response, latex
Allergy Response, risk for latex
Body Temperature, risk for imbalanced
Contamination
Contamination, risk for
Death Syndrome, risk for sudden infant
Environmental Interpretation Syndrome, impaired
Falls, risk for
Health Maintenance, ineffective
Home Maintenance, impaired
Hyperthermia
Hypothermia
Immunization Status, readiness for enhanced
Infection, risk for Injury, risk for
Injury, risk for perioperative positioning
Jaundice, neonatal
Maternal/Fetal Dyad, risk for disturbed
Mobility, impaired physical
Poisoning, risk for Protection, ineffective
Self-Mutilation
Self-Mutilation, risk for Skin Integrity, impaired
Skin Integrity, risk for impaired
Suffocation, risk for
Suicide, risk for
Surgical Recovery, delayed
Thermoregulation, ineffective
Tissue Integrity, impaired
Trauma, risk for
Trauma, risk for vascular

SEXUALITY—[Component of Ego Integrity and Social Interaction] Ability to meet requirements/characteristics of male/female role
Childbearing Process, readiness for enhanced
Sexual Dysfunction
Sexuality Pattern, ineffective

SOCIAL INTERACTION—Ability to establish and maintain relationships
Attachment, risk for impaired
Caregiver Role Strain
Caregiver Role Strain, risk for Communication, impaired verbal
Communication, readiness for enhanced
Conflict, parental role
Coping, ineffective community
Coping, readiness for enhanced community
Coping, compromised family
Coping, disabled family
Coping, readiness for enhanced family
Family Processes, dysfunctional
Family Processes, interrupted
Family Processes, readiness for enhanced
Loneliness, risk for
Parenting, impaired
Parenting, readiness for enhanced
Parenting, risk for impaired
Role Performance, ineffective
Social Interaction, impaired
Social Isolation

TEACHING/LEARNING—Ability to incorporate and use information to achieve healthy lifestyle/optimal wellness
Development, risk for delayed
Growth, risk for disproportionate
Growth and Development, delayed
Health Behavior, risk-prone
Health Management,
Nursing Assessment and Work Sheet

Client's initials: __________ Age: __________ Sex: __________

Marital Status: _______ Ethnicity: __________ Education: __________

Occupation (current or former): ______________________________________

Legal Status: ______________________________________________________

I. Review of Systems (Describe by reviewing the chart and asking the client)

CV:

Endocrine:

GI:

GU:

Integumentary:

MS:

Neurosensory:

Respiratory:

Diagnostic Tests (EKG, CT, MRI, EEG...):

<table>
<thead>
<tr>
<th>Labs: Name of Test</th>
<th>Date of Test</th>
<th>Normal Range</th>
<th>Client Values</th>
<th>Significance and Nursing Actions</th>
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II. General Information

A. Chief Complaint (per client): ____________________________________________________

B. Reason for hospitalization: ____________________________________________________

C. Pertinent family history: ______________________________________________________

D. Pertinent social history: ______________________________________________________

E. Psychiatric history: __________________________________________________________

F. Spiritual beliefs: (See Nursing Process lecture for questions).______________________

G. Cultural practices: (including beliefs regarding mental illness. See Nursing Process lecture for questions).

III. DSM IV Diagnostic Formulation:

Axis I diagnosis: ________________________________________________________________

Axis II diagnosis: ______________________________________________________________

Axis III diagnosis: _____________________________________________________________

Axis IV Psychosocial/Environmental Problems (your assessment): _________________

Axis V GAF (your assessment): ______ Date: ______ Chart GAF: ______ Date: _________

List the signs and symptoms from the DSM IV diagnostic formulation, which you have observed, or are documented for this client:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Client goals for clinical day:

Student goals for clinical day:

IV. Mental Status Exam (MSE) Describe your findings in objective terms
General Description
Appearance:

Speech:

Motor Activity:

Response to interviewer:

Emotional State
Mood:

Affect:

Experiences
Perceptions:

Thinking
Thought content:

Thought processes:

Sensorium & Cognition
Level of consciousness:

Memory: STM (short term memory):

LTM (long term memory):

Level of concentration:

Intelligence, logical reasoning, and abstract thought:

Insight:

Judgment:

Impulse control:

V. Relevant History - Personal
Social patterns/interactional ability (friendships, describe a typical day):

________________________________________________________________________

Interests and abilities (what good at, what brings pleasure):

________________________________________________________________________

Addictive habits and amounts:

________________________________________________________________________
Sexual patterns (active, orientation, difficulties, protection Most students find it more comfortable to include questions about sexual patterns in the review of systems section):

________________________________________________________________
________________________________________________________________

Coping strategies (functional and dysfunctional patterns, identify defense mechanisms used):

________________________________________________________________
________________________________________________________________

Support system:

________________________________________________________________
________________________________________________________________

Resources:

________________________________________________________________
________________________________________________________________

Developmental stage (Erickson):

________________________________________________________________
________________________________________________________________

Extent of developmental stage fulfillment:

________________________________________________________________
________________________________________________________________

Need level based on Maslow (document rationale for level):

________________________________________________________________
________________________________________________________________

Risk factors (Danger to self, others, impulsiveness, grave disability, flight risk, EPS, seizures, blood and body fluid precautions, special needs, sexually inappropriate behavior):

________________________________________________________________
________________________________________________________________

VI. Clinical impressions based on synthesis of all data gathered (include synthesis of labs, medications and symptom management. Include information regarding compliance to unit activities, medication compliance, relapse prevention):

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
Prioritize your nursing diagnoses based on Maslow’s Hierarchy of Needs and give your rationale.

1. __________________________________________________________________________________________________________________________
2. __________________________________________________________________________________________________________________________
3. __________________________________________________________________________________________________________________________

What does your client identify as their long-term goal? ______________________________________________________________________________________

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Expected Outcomes</th>
<th>Evaluation</th>
<th>Implementation</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>Relate to: (causes)</td>
<td>(Goals) (S &amp; S)</td>
<td>(Actual Outcomes) (Did nursing interventions lead to expected outcomes?)</td>
<td>(Nursing interventions, actions, teaching, treatments)</td>
<td>(Scientific principles - include source and page numbers)</td>
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Cite full reference in APA format
<table>
<thead>
<tr>
<th>Nursing Diagnosis Relate to: (causes)</th>
<th>Expected Outcomes (Goals) (Singular, measurable and realistic, dated)</th>
<th>Evaluation (Actual Outcomes) (Did nursing interventions lead to expected outcomes?)</th>
<th>Implementation (Nursing interventions, actions, teaching, treatments)</th>
<th>Rationale (Scientific principles - include source and page numbers)</th>
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<td>Cite full reference in APA format</td>
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<tr>
<th>Date Ordered</th>
<th>Medication: Trade &amp; generic name, dose, route, frequency, safe range, age considerations</th>
<th>Times given</th>
<th>1) Class given</th>
<th>1) Action</th>
<th>1) Why administered: Target Symptoms &amp; Side effects</th>
<th>Nursing implications</th>
<th>Expected outcomes</th>
<th>Evaluations (actual outcomes)</th>
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</thead>
<tbody>
<tr>
<td>Trade:</td>
<td>Generic:</td>
<td>Dose:</td>
<td>Route:</td>
<td>Frequency:</td>
<td>Safe Range:</td>
<td>Children:</td>
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<td>Elderly:</td>
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<td>Age Considerations:</td>
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<td>2) Action</td>
<td>1) Why administered</td>
<td>2) Side effects</td>
<td>Nursing implications</td>
<td>Expected outcomes</td>
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Case Presentation Rubric: Nursing Assessment and Care Plan

Student Name: ___________________________________________

Instructor Name: _________________________________________

Score: ___P   ___F

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<tr>
<th>Category</th>
<th>Pass</th>
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<tbody>
<tr>
<td>Prepared-ness</td>
<td>Student is completely prepared and has obviously rehearsed.</td>
<td>Student seems pretty prepared, but might have needed a couple more rehearsals.</td>
<td>Student is somewhat prepared, but it is clear that rehearsal was lacking.</td>
<td>Student does not seem at all prepared to present.</td>
</tr>
<tr>
<td>Volume Within Designated Timeframe</td>
<td>Presentation is 5-6 minutes long and is loud enough to be heard throughout the presentation.</td>
<td>Presentation is 4 minutes long and is loud enough most of the time.</td>
<td>Presentation is 3 minutes long and is loud enough some of the time.</td>
<td>Presentation is less than 3 minutes OR more than 6 minutes and volume is too soft to be heard.</td>
</tr>
<tr>
<td>Discusses Significant Data</td>
<td>Prioritizes data, discussing significant information all (100%) of the time.</td>
<td>Discusses significant (need to know) information most (90%) of the time.</td>
<td>Stays on topic some (75%) of the time. Includes nice to know information that detracts from significant data.</td>
<td>Unable to prioritize significant from insignificant data.</td>
</tr>
<tr>
<td>Synthesis</td>
<td>Synthesizes relevant findings integrating I through XI</td>
<td>Synthesizes findings integrating significant findings most of the time</td>
<td>Synthesized some findings from data but not always relevant and somewhat disorganized.</td>
<td>Unable to synthesize relevant findings from data presents or summary of findings is disorganized and lacks integration.</td>
</tr>
</tbody>
</table>
Case Presentation Guidelines: Nursing Assessment and Care Plan

- Directions: Be prepared to discuss all of the following components of a case presentation. Your instructor may ask you to focus on select items.

- Use your critical thinking skills to focus on presenting material that one NEEDS TO KNOW versus what it NICE TO KNOW. Another way to look at this is to focus on the MAJOR POINTS versus MAJOR DETAILS or MINOR DETAILS.

- You will be critiqued on your ability to be concise and complete at the same time.

I. Present demographics

II. DSM IV diagnostic formulation. Identify the signs and symptoms from the DSM IV which you have observed or which are documented

III. Significant finding from the MSE

IV. Significant findings from the review of systems (ROS)

V. Significant diagnostic tests

VI. Significant findings from the medication profile

VII. Significant lab values, r/t meds and ROS, include nursing actions

VIII. Significant findings from general and personal information

IX. Your overall goals for this client (NCP)

X. Discuss prioritization of 3 NANDA nursing diagnosis with rationale based on Maslow

XI. Share one NANDA nursing diagnosis, including goals, nursing interventions, rationale, and evaluation.

XII. Synthesis of relevant findings including I. through XI.
### Case Presentation Rubric: Concept Map and Care Plan

**Student Name:** ___________________________________________

**Instructor Name:** _________________________________________

**Score:** P_____ F_____

<table>
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</tr>
<tr>
<td>Concept Map</td>
<td>Concept Map creatively done and comprehensive. Pathophysiology correct and evidenced based article appropriate.</td>
<td>Concept Map is complete. Pathophysiology and evidenced based article included.</td>
<td>Concept Map with some errors, or Pathophysiology not correct, or article missing or not evidence based.</td>
<td>Concept Map incorrect or missing significant content. Pathophysiology incorrect or poorly done, article missing or not evidence based.</td>
</tr>
<tr>
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Case Presentation:  
Concept Map and Care Plan

A. Develop a care plan concept map with 1/3 of the content symbols, 1/3 pictures, and 1/3 words. Include significant data from the following:
1. Demographics
2. Review of Systems
3. General Information:
   a) Personal, social, family, psychiatric, history, interests, and abilities
   b) Developmental stage, need level, spiritual and cultural influences
4. Mental Status Assessment
5. Lab values
6. Medications
7. Compliance issues
8. Risk factors
9. DSM-EV diagnosis
10. NANDA Nursing Diagnosis and care plan

B. As part of CPCM include pathophysiology of one of the mental disorders that the client has (include on a separate sheet or back side of concept map care plan).
   a) Describe the disease process
   b) Signs and symptoms
   c) Diagnostic evaluation
   d) Treatment
11. Compare your client to the textbook picture
12. Include a reference and summary of at least one evidenced based practice article related to the nursing care for this disorder (include on a separate sheet or the back side of concept map care plan using APA format).
*Psychiatric-Mental Health Nursing’s Phenomena of Concern

ACTUAL OR POTENTIAL MENTAL HEALTH PROBLEMS OF CLIENTS PERTAINING TO:

♦ The maintenance of optimal health and well-being and the prevention of psychobiologic illness.
♦ Self-care limitations or impaired functioning related to mental and emotional distress.
♦ Deficits in the functioning of significant biological, emotional, and cognitive systems.
♦ Emotional stress or crisis components of illness, pain, and disability.
♦ Self-concept changes, developmental issues, and life process changes.
♦ Problems related to emotions such as anxiety, anger, sadness, loneliness, and grief.
♦ Physical symptoms that occur along with altered psychological functioning.
♦ Alterations in thinking, perceiving, symbolizing, communicating, and decision making.
♦ Difficulties in relating to others.
♦ Behaviors and mental states that indicate the client is a danger to self or others or has a severe disability.
♦ Symptom management, side effects/toxicities associated with psychopharmacologic intervention and other aspects of the treatment regimen.
♦ Interpersonal, systemic, sociocultural, spiritual, or environmental circumstances or events which affect the mental and emotional well-being of the individual, family, or community.

A contract with a client is an agreement between the nurse and the client. For our purposes the contract will be limited to an agreement that you, the student, will be talking with the client every clinical day for a specific period of time. Termination is discussed at the introductory phase of the relationship.

It is part of the contract that you will respect the confidentiality of the client. You must tell the client that what the client tells you and what is written down will be shared only with your instructor and with the treatment team involved with the client.

Clients may want to see what you have written and should be told that they may read this if they wish.

Clients should be told that you have two reasons for talking with them:

1. To help the client gain insight by talking about themselves and their problems.
2. To help you as a student nurse gain practice with therapeutic communication skills.

Clients should be told that the time you spend with them is their time to talk about themselves.
Videotaped Communication Skill Development Activity

Introduction/Purpose

You will be videotaped to improve your mental health assessment, interviewing, and communication skills. Each student will be videotaped as he/she performs a mental health interview and engages in a ten-minute therapeutic interaction with a mock client. The video will then be critiqued by self, peer(s), and a clinical instructor. The purpose of this project is to assist you in mastering interviewing and communication skills by allowing you to see the dynamic process of your own communications on video. The overall goal is to improve your communication skills to enhance your therapeutic interactions with clients.

Objectives

1. Incorporate videotaping as a teaching/learning modality to improve assessment, interviewing, and therapeutic communication skills.
2. Evaluate student’s perceived effectiveness of videotaping as a learning modality.
3. Improve student’s self-awareness of verbal and non-verbal forms of communication through the use of video.
4. Identify and evaluate interviewing obstacles and resistances which hinder the building of nurse/client rapport.

Directions

Each team will consist of three students (interviewer, interviewee, and camera person). Students will sign up for a lab time ahead of time. If you are unable to make this time you should cancel at least 24 hours with the nursing skills lab before your scheduled time. You will need to bring a DVR-R camcorder sized disk (sold in the Napa Valley College Bookstore) to your interview and 3 evaluations to the skills testing, a self, peer and instructor evaluation. The student conducting the interview will receive a randomly selected scenario for this activity. Open this envelope when you are ready to tape and read it out loud while you are being videotaped. You will complete a self-evaluation and be evaluated by your peer on the evaluation forms immediately following the videotaping. Turn in the 3 forms with your videotape in the envelope provided. Make sure you are facing the camera and speak loudly. Plan to videotape for at least ten minutes. State your three-part NANDA diagnosis at the end while videotaping. Do not bring any books or other supplemental materials to the testing area besides a pen.

It is to your advantage to review and practice all scenarios in relation to the checklist criteria. If you fail to successfully complete the interview you will have one opportunity to repeat another communication skill. To prepare for the vignette’s please see your textbook and online resources. For your week 1 journal review and critique your taped interview.
1. NANDA Diagnosis: Decisional conflict  
Client: “I’m just not sure what I’m going to do. My family will hate me no matter what I decide. There just isn’t any good way to resolve this situation. I just can’t make a decision about anything.” The client looks earnestly to the interviewing nurse for answers, wavering between multiple solutions. The client may also demonstrate poor concentration, and inability to take action.

2. NANDA Diagnosis: Social isolation  
Client: “What is the big deal? I just don’t feel like being around all these people. My room feels much safer than being out here in the dayroom. Can’t you guys all leave me alone?” Aside from this brief verbalization, the client has only brief responses to staff and peers, frequently resorting to 1-2 word answers with poor eye contact.

3. NANDA: Risk for suicide  
Client: “I just don’t see any way out of my problems. I think about ending it all so that my suffering will end. Nothing ever turns out right for me. This time, I hope they don’t find me and stop me from ending my life. I shouldn’t have to suffer like this.”

4. NANDA Diagnosis: Disturbed sensory perception  
Client: He or she is expressing delusions and inaccurate perceptions of environment. They are also having conversations with internal voices and at times refuse respond to people around them.

5. NANDA Diagnosis: Violence, [actual/] risk for other-directed  
Client: “This whole place is so messed up! I feel like smashing up all the furniture and then taking on anyone that wants to stop me. I wish they’d let me out of here right now. I hate being confined. This is just like jail.” While the client is speaking, they demonstrate intense hostility and restless physical movements.

6. NANDA Diagnosis: Anxiety  
Client: “I have suddenly experienced chest pressure, pounding heart, shortness of breath, and sweating at work. My doctor informed me that my heart is healthy and normal. I am noticing more episodes at work, home, in my care and while shopping. I am very fearful that others might think I am losing my mind.”

7. NANDA Diagnosis: Denial, ineffective  
Client: While gathering a family history, you find that the client has been drinking heavily (a 12-pack of beer or 2 liters of wine daily for the past 10 to 15 years). The client is currently on probation for driving under the influence. “My partner is exaggerating the amount I drink and I can quit drinking any time I want to: I have just been under a lot of pressure. My partner doesn’t understand that I need to have a few drinks to sleep and forget my problems.”

8. NANDA Diagnosis: Coping, ineffect  
Client: “No one can help me with this, it’s too embarrassing to discuss. I’m starting to shut down. I can’t talk about it and I can’t deal with it anymore by myself.”

9. NANDA Diagnosis: Noncompliance [Adherence, ineffective]  
Client: Your client tells you “When I take my medications it slows me down too much and robs me of my energy. I feel so embarrassed that I have to be on drugs to function. My family won’t take me back home unless I take my meds and attend the day treatment program regularly. Do you think that’s fair?”

10. NANDA Diagnosis: Hopelessness  
Client: The client presents with dysphoria, tearfulness, loss of energy and sexual interest, and insomnia. She says, “I feel hopeless about the future and I worry that I will never get better. I have so many problems.”
N144 Self Evaluation

Video Skill Therapeutic Communication Evaluation

Student Name________________   Date__________

NANDA Diagnosis Scenario_____________________________________

Pass_____   Fail_____

Evaluation Criteria
0 = Does not include
1 = Is seriously lacking in proficiency and/or accomplished poorly
2 = Does include, but is weak in this area
3 = Does include, is good in this area, and/or was accomplished well.
4 = Does include, and is very good in this area, and/or accomplished with a high degree of proficiency.

Evaluation Criteria:

<table>
<thead>
<tr>
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<td>4.  Use of restatement.</td>
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<td>5.  Use of techniques to reduce obstacles or resistance.</td>
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<td>6.  Use of professional nursing general demeanor.</td>
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<tr>
<td>7.  Use of nonverbal communication.</td>
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<tr>
<td>8.  Use of summary.</td>
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<tr>
<td>9.  In reflecting back, discuss anything you would have done differently?</td>
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<td>Answer:</td>
</tr>
<tr>
<td>10. Identify one therapeutic communication you did especially well</td>
<td></td>
<td>Answer:</td>
</tr>
<tr>
<td>11. Formulate a three-part NANDA Nursing Dx</td>
<td></td>
<td>ND:</td>
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</table>

Comments on your overall impression of the interaction (mandatory):
Please review your tape when returned and *address all instructor and peer comments* in your journal the following week whether you passed or failed.
N144 Peer Evaluation

Video Skill Therapeutic Communication Evaluation

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Date</th>
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NANDA Diagnosis Scenario

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<tr>
<td>9. Discuss what you would have done to strengthen the interview if you had been the interviewer</td>
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<tr>
<td>10. Identify one therapeutic communication the interviewer did especially well</td>
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</table>
N144 Instructor Evaluation  
Video Skill Therapeutic Communication Evaluation

Student Name________________  Pass_____ Fail_____ Date______  
Faculty Evaluator____________________  
NANDA Diagnosis Scenario___________________________

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Additional comments or observations (optional):
Techniques of Therapeutic Communication

“Broad Openings”. Confirm the presence of the client and encourage client to select the topic. Involves questions such as “What shall we discuss today” “Is there something you’d like to talk about?” “What are you thinking about?”

“General leads”. Giving a general lead allows the client to select the topic from within a range. Example: “How are you doing today?” “How are you feeling compared with yesterday?”

“Reflection of Feelings”. The emotional and/or cognitive component of a client’s statement is rephrased in your own words. Signifies understanding, empathy, interest and respect. Brings to focus feelings rather than content to bring the client’s feelings into clear awareness. A statement like “I’m really mad that my psychiatrist hasn’t come in to see me yet, I guess she has more important things to do. A reflective statement from the nurse could be: “You seem upset with your doctor. Are you feeling that she has more important things to do then see you?”

“Paraphrasing”. Similar to reflection, except it is translating the client’s words into your own thoughts. It consists of repeating in fewer and fresher words the essential ideas of the client. For example, client says, " I can't study. My mind keeps wandering." The nurse says, " Are you having difficulty concentrating?"

“Restatement”. All or part of the client’s main thought is repeated. If a client says “I am so scared about this hospitalization I could just cry!” The nurse could respond by restating, “You are scared about this hospitalization and you could just cry?"

“Silence”. Attentive listening may be preferred to a verbal response. This gives the client a chance to reflect on feelings and/or continue the conversation. It allows the client to take control of the discussion, if they so desire.

“Informing”. Giving information. Provide specific information to answer questions, educate, clear up misconceptions, or help the client evaluate their situation. Example “I think you need to know more about how your medication works.”

“Clarifying”. Seeking more information to better understand. “I’m not sure I understand about your arm pain completely. Could you repeat what you said?” Another example is: “I don’t follow you. Can you say it another way?”

“Focusing”. Taking notice of a single idea or even a single word. An example is “Tell me about what made you upset this morning” or “How has your mood been this week?”

“Probing”. Continue to focus and pursue further detail about an area. For example: “On a scale of 1 to 10 how anxious would you say you feel right now?” “On a scale of 1 to 10 how would you rate your feelings of sadness right now?”

“Summarizing”. Pulls together information for recording. Gives client a sense you understand. Gives client an opportunity to review and add. Example: “It is my understanding that your anxiety is at a level 1 since you’ve practiced your relaxation techniques an hour ago. Doing your relaxation exercises before you interact with others seems to help you complete the activities the team wants you to do for your rehabilitation. Is this correct?” Client responds “Yes, I find it helpful to practice my relaxation techniques before I do any ward activities. I also take a warm shower in the morning and that helps to reduce the tension I feel in my body.”
Nontherapeutic Communication

“False reassurance” Statements such as “Everything will be all right,” or “Don’t worry,” minimize the client’s feelings and do not encourage continued communication. Promises something that may not happen.

“Giving advice”. Reinforces dependency. Does not encourage problem-solving/decision-making. Imposes nurse’s opinion on client. Examples include, "I think you should...", "Why don't you..."

“Asking why questions”. Does not encourage further exploration. Elicits a defensive response or excuse making. Examples: "Why do you feel that way?" "Why were you late?"

“Changing the subject”. Usually occurs when the nurse isn’t listening or is uncomfortable with the subject matter. This discounts the personhood of the client. Example, Client: "I don't have anything to live for. I just want to die." Nurse replies, "Did you have visitors this weekend?"

“Giving approval or disapproval!”. Okay to acknowledge and support. Implies that the nurse has the right to pass judgment on whether the client's ideas or behaviors are "good" or "bad" and that the client is expected to please the nurse. An example is "That's good. I'm glad that you..." That's bad. I'd rather you wouldn't..."
Process recording guidelines

Process recordings are a useful tool for examining yours and the clients' communication patterns. Process recordings have some disadvantages, since they rely on memory and are subject to distortions. It is usually best if you can write verbatim (word for word) notes in a private area immediately after the interaction has taken place. Try not to take notes during the interview, as some clients may resent or misunderstand your intent. Attached is an example of a process recording. You record your words, the client's words, identify whether your responses are therapeutic or not, and recall your thoughts and emotions at the time.

You may feel overwhelmed by the severity of the clients' problems and feel responsible for "doing" something to positively affect the client. Studies have shown that the interest shown in the client has been more important than various other factors. This does not deny the importance of clinical training, skill, or experience. It does, however, emphasize the need for you to convey genuine interest in another human being without being patronizing or condescending.

Anxiety during the first interview is to be expected, as in any meeting between strangers. Clients may be anxious about their problems, your reaction to them, concerns about their treatment and so forth. You may be anxious about the client's reaction to you, your ability to provide help, what the instructor will think of you, and how you will do compared to your peers. Two common concerns are (1) how to begin the interview, and (2) what to do in response to client behaviors.

Directions: Schedule a purposeful interaction with your client. Record the interpersonal process according to the indicated format (sample recording on the next page). Analyze the interpersonal process recording according to the indicated criteria for evaluation. Include a statement regarding the purpose and context of the interaction. The purpose statement is nurse centered, written in measurable terms and appropriate for the client. The context of the interaction is specifically described: Setting, environmental conditions, and the stage of the therapeutic relationship. Verbalizations of both client and nurse are written verbatim. Your thoughts, feelings and behaviors during the interaction are described. Nonverbal behaviors are described and interpreted. Therapeutic (effective) responses are recognized. Non-therapeutic (ineffective) responses are recognized and rewritten.
### Example of a Process Recording

**Purpose:** To establish rapport with a new client

**Context of the interaction:** Conversation occurred in a corner of the day area at 0930. The setting provided privacy and safety and the only interruptions were the loud intercom announcements. We are in the orientation phase of the therapeutic relationship.

<table>
<thead>
<tr>
<th>What the Client Said</th>
<th>What I Thought and Felt</th>
<th>What I Said and Did</th>
<th>Principles/Techniques Used</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>START INTERACTION NEXT COLUMN →</td>
<td>I feel overwhelmed. I don’t know if I can help this man feel better.</td>
<td>&quot;Good Morning, Mr. L.&quot;</td>
<td>Broad opening.</td>
<td><strong>Therapeutic.</strong> Acknowledging a client by name can enhance esteem and communicates that he is viewed as an individual by nurse.</td>
</tr>
<tr>
<td>What am I doing here, how did I get here?*&quot; Spoken in a loud, demanding tone.</td>
<td>I feel scared I wish he would lower his voice.</td>
<td>&quot;I am Mrs. V. I am a student nurse from X college, and you are at Mt. Sinai Hospital. I would like to spend some time with you today.</td>
<td>Giving information.</td>
<td><strong>Therapeutic.</strong> Informing the client of facts needed to make decisions.</td>
</tr>
<tr>
<td>&quot;Oh... yeah.&quot; Silence 2 minutes. Shoulders slump, Mr. L stares at floor and drops head and eyes.</td>
<td>He looks so sad it makes me feel sad.</td>
<td>&quot;You were brought in by your wife last night after swallowing a bottle of aspirin. You had to have your stomach pumped.&quot;</td>
<td>Giving information.</td>
<td><strong>Therapeutic.</strong> Offering self. Making oneself available to the client.</td>
</tr>
<tr>
<td>&quot;Yeah, I just remembered... I wanted to kill myself.&quot; Said in a low tone almost to self.</td>
<td>I didn’t know what to say-his talking about killing himself made me nervous</td>
<td>&quot;You look sad and upset, Mr. L.&quot;</td>
<td>Reflection.</td>
<td><strong>Therapeutic:</strong> Giving needed facts so client can orient himself and better evaluate his situation.</td>
</tr>
<tr>
<td>&quot;What do you know about my life? You want to know about my wife leaving me... That’s what.&quot; Faced student nurse with angry expression on face - said in loud angry tones.</td>
<td></td>
<td>&quot;Oh, Mr. L, you have so much to live for. You’ll get over this. You have such a loving family.&quot;</td>
<td>False Reassurance.</td>
<td><strong>Therapeutic:</strong> Making observations about feelings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;I didn’t know. You sound terribly upset by her leaving.&quot;</td>
<td>Reflection.</td>
<td>Non-therapeutic. Changing the subject. Said something to make me feel more comfortable. I would rewrite it to say: . I could have said, &quot;You must have been very upset&quot; (verbalizing the implied) or &quot;Tell me more about this&quot; (exploring).</td>
</tr>
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</table>

**Analysis:**
- **Therapeutic.** Acknowledging a client by name can enhance esteem and communicates that he is viewed as an individual by nurse.
- **Therapeutic.** Informing the client of facts needed to make decisions.
- **Therapeutic.** Offering self. Making oneself available to the client.
- **Therapeutic:** Giving needed facts so client can orient himself and better evaluate his situation.
- **Therapeutic:** Making observations about feelings.
- Non-therapeutic. Changing the subject. Said something to make me feel more comfortable. I would rewrite it to say: . I could have said, "You must have been very upset" (verbalizing the implied) or "Tell me more about this" (exploring).
Napa Valley College Associate Degree Program in Nursing

Process Recording of Conversation

<table>
<thead>
<tr>
<th>What the Patient Said and Did (Include verbal and nonverbal responses)</th>
<th>What I Thought and Felt (As you listened and before you spoke)</th>
<th>What I Said and Did (Include verbal and nonverbal responses, behaviors, thoughts, feelings)</th>
<th>Principles/Techniques Used</th>
<th>Analysis (Therapeutic or nontherapeutic and why. Rewrite nontherapeutic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>START THE INTERACTION IN THE NEXT BOX</td>
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</tr>
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<td>What the Patient Said and Did (Include verbal and nonverbal responses)</td>
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</table>
Communication: End of Shift Report

Please include the following information when you report off at the end of your rotation. Remember, you need to communicate with the primary nurse as often as needed. Do not wait to communicate a significant change in your client’s behavior.

1. Clients' name, age, sex
2. Attending and consulting psychiatrist/physician(s)
3. Pertinent DSM-IV diagnosis (Axis I-V), history, assessment, psychosocial status
4. Any diagnostic tests, procedures or significant events
5. Pertinent medications given or omitted (including dosage and time) including all PRNs
6. Special needs or considerations: 1:1, frequent monitoring, isolation, risk factors
7. Compliance with unit activities.
8. Client/family educational needs and follow-up

Discharge Checklist

1. Early AM hygiene
2. Dressed/packed as appropriate
3. Transportation confirmed
4. After care plans completed
5. Medications/medication instruction sheet
6. Physician orders complete
Writing and Keeping a Reflection Journal

A journal, like a diary, is a personal recording of observations, opinions and feelings, and responses to ideas, people, events, and situations – in essence, a crystallization of who you were at a certain time and place on paper. You become your own biographer and publisher with YOU as your main topic. You capture some form of definition and experience of yourself, and can return to it at a later date to compare how your present self relates to your past self and your future self. For week one clinical write a critique of your interview role play, both areas of strength and areas you need to improve.

The emphasis of interpersonal communication centers on an individual evaluation of how you relate to people and how they relate to you – communication-wise. Keeping a journal will, hopefully, help you to more objectively consider the communication process that continually surrounds you, as you are made aware of it by this course and your own realizations.

Tips on journal writing
Journals may be handwritten but should be neat and legible. Try to write with a minimum of mechanical errors, although you will not be graded on your journal.
Write your journal in the first person point of view. Use “I” referring to yourself, of course.

Your journal will be collected weekly and reviewed during the rotation. The quality of your analysis will be reviewed, not the quality of your communication experiences. In other words, don’t be afraid to describe something that turned out negatively.

Directions for Reflective Journal
For each entry, date it, give it a title, address and # 1-6 below. Identify which objective in #5 you are addressing. This will give each entry a focus. Entries should each concern a selected critical experience. Do not restate the sequence of events for a given day. For each entry you are to examine a selected critical experience and include:
1. Significance to self or others
2. Perceptions, assumptions, meaning and/or understanding gained
3. Personal and/or professional questions raised
4. Impact this experience will have on your future nursing practice
5. Objectives (address one new objective each week of clinical)
   a. Describe the setting with a discussion of the philosophy and services provided. What services did you actually see provided?
   b. Describe something you saw in the clinical experience that is exciting to you as a health care professional. How could this make health care more client-oriented in any setting?
   c. How does your clinical facility deal with clients of varied ethnic, religious, and/or sexual orientations? What services are available that allow for differences in cultural values regarding health care?
   d. Describe how your agency implements health promotion and disease prevention measures that you observed or are aware of?
   e. Draw a model or chart that illustrates the interdisciplinary interaction in you assign agency.
6. Reflect on the experience of leading a seminar or patient group activity.
Erikson’s Eight Ages of Man

<table>
<thead>
<tr>
<th>Chronological Age</th>
<th>Developmental Conflict</th>
<th>Long-term Outcome of Successful Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>Basic trust vs. mistrust</td>
<td>Drive and hope</td>
</tr>
<tr>
<td>Toddler</td>
<td>Autonomy vs. shame and doubt</td>
<td>Self-control and willpower</td>
</tr>
<tr>
<td>Preschool</td>
<td>Initiative vs. guilt</td>
<td>Direction and purpose</td>
</tr>
<tr>
<td>School age</td>
<td>Industry vs. inferiority</td>
<td>Method and competence with tasks</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Identity vs. role diffusion</td>
<td>Devotion and fidelity</td>
</tr>
<tr>
<td>Young adult</td>
<td>Intimacy vs. isolation</td>
<td>Affiliation and love</td>
</tr>
<tr>
<td>Adulthood</td>
<td>Generativity vs. stagnation</td>
<td>Productivity and caring</td>
</tr>
<tr>
<td>Maturity</td>
<td>Ego integrity vs. despair</td>
<td>Life was meaningful and wisdom</td>
</tr>
</tbody>
</table>

*Successful outcome is evidenced by the development of the characteristic listed first
## Erikson’s Eight Stages of Development

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age</th>
<th>Central Task</th>
<th>Indicators of Positive Resolution</th>
<th>Indicators of Negative Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Birth to 18 months</td>
<td>Trust versus mistrust</td>
<td>Learning to trust others</td>
<td>Mistrust, withdrawal, estrangement</td>
</tr>
<tr>
<td>Early childhood</td>
<td>18 months to 3 years</td>
<td>Autonomy versus shame and doubt</td>
<td>Self-control without loss of self-esteem</td>
<td>Compulsive self-restraint or compliance</td>
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<tr>
<td></td>
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<td>Ability to cooperate and to express oneself</td>
<td>Willfulness and defiance</td>
</tr>
<tr>
<td>Late childhood</td>
<td>3 to 5 years</td>
<td>Initiative versus guilt</td>
<td>Learning the degree to which assertiveness and purpose influence the environment</td>
<td>Lack of self-confidence</td>
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<td></td>
<td>Pessimism, fear of wrongdoing</td>
</tr>
<tr>
<td>School age</td>
<td>6 to 12 years</td>
<td>Industry versus inferiority</td>
<td>Beginning ability to evaluate one’s own behavior</td>
<td>Over control and over restricting own activity</td>
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<td></td>
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<td></td>
<td>Loss of hope, sense of being mediocre</td>
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<td></td>
<td>Withdrawal from school and people</td>
</tr>
<tr>
<td>Adolescence</td>
<td>12 to 20 years</td>
<td>Identity versus role confusion</td>
<td>Coherent sense of self Plans to actualize one’s abilities</td>
<td>Confusion, indecisiveness, and inability to find occupational identity</td>
</tr>
<tr>
<td>Young adulthood</td>
<td>18 to 25 years</td>
<td>Intimacy versus isolation</td>
<td>Intimate relationship with another person Commitment to work and relationships</td>
<td>Impersonal relationships</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Avoidance of relationship, carefree life-style commitments</td>
</tr>
<tr>
<td>Adulthood</td>
<td>25 to 65 years</td>
<td>Generativity versus stagnation</td>
<td>Creativity, productivity, concern for others</td>
<td>Self-indulgence, self concern, lack of interests and commitments</td>
</tr>
<tr>
<td>Maturity</td>
<td>65 years to death</td>
<td>Integrity versus despair</td>
<td>Acceptance of worth and uniqueness of one’s own life Acceptance of death</td>
<td>Sense of loss, contempt for others</td>
</tr>
</tbody>
</table>
DETERMINATION OF ERIKSON’S STAGES OF DEVELOPMENT

Trust vs. Mistrust

**Trust**

Verbal behaviors
- “I believe you.”
- “I know I can tell you…”
- “You will help me.”
- “You are my friend.”

**Nonverbal behaviors**
- Asking for help with the expectation of receiving it.
- Accepting help from others comfortably.
- Sharing time, opinions, emotions, and experiences.

**Mistrust**

Verbal behaviors
- “I am afraid of you.”
- “I can’t tell you about anything.”
- “You cheat.”

**Nonverbal behaviors**
- Inability to accept help.
- Confining conversation to superficialities.
- Rigidly controlling behavior so that only that which is socially approved is exhibited.
- Refusal to share time, experiences, opinions, and emotions.

Autonomy vs. Shame and Doubt

**Autonomy**

Verbal behaviors
- “I will.”
- “I won’t.”
- “Okay, I’ll do it myself.”
- “This is my opinion.”
- “I can wait.”

**Nonverbal behaviors**
- Tries to dress self or perform other tasks on own.
- Accepting group rules but able to express dissent when it is felt.
- Accepting leadership role when it is appropriate.
- Expressing own opinion.
- Accepting postponement of wish gratification easily.
- Ability to cooperate.
- Demonstrates some self-control.

**Shame and Doubt**

Verbal behaviors
- “My opinion doesn’t count.”
- “I never know the answers.”
- “I don’t want to hear what you have to say.”
- “I must be right.”
- “I should do that.”

**Nonverbal behaviors**
- Overly concerned with being clean.
- Not maintaining own opinion when opposed.
- Failing to express needs.
- Maintaining own opinion despite adequate proof to the contrary.
- Lacks self-control.
- Unable to wait; hoarding; soiling.
- Being vindictive.

Initiative vs. Guilt

**Initiative**

Verbal behaviors
- “Let me try.”
- “What is it; how does it work?”
- “Where does that road go?”
- “Can I wash my hair?”

**Nonverbal behaviors**
- Exploring.
- Starting new projects with eagerness. Expressing curiosity.
- Being original.
- Ability to evaluate own behavior.
- Brushes teeth without being told.

**Guilt**

Verbal behaviors
- “I’m afraid to do that.”
- “You go first and I will follow.”
- “I’m ashamed to make a mistake.”

**Nonverbal behaviors**
- Imitating others rather than developing ideas independently.
- Expressing a great deal of embarrassment over a small mistake.
- Always taking the blame.
### Industry vs. Inferiority

**Industry**
- **Verbal behaviors**
  - "I’m working on this. When it is done I will start on that."
  - "I like to be busy."
  - "Group projects are fun."
  - "I’m going to do my homework now."
- **Nonverbal behaviors**
  - Completing a task once it is started.
  - Working well with others.
  - Using time effectively.
  - Feelings of competence.
  - Good self-esteem.

**Inferiority**
- **Verbal behaviors**
  - "I can’t work with other people."
  - "I have a lot of things going but nothing finished."
  - "I don’t thing I can do it."
- **Nonverbal behaviors**
  - Not completing any set tasks.
  - Not contributing to the work of the group.
  - Not organizing work.
  - Avoids responsibility.

### Identity vs. Role Diffusion

**Identity**
- **Verbal behaviors**
  - "I’m going to be a nurse."
  - "I believe in these principles."
  - "I think mothers should do this and fathers should do that."
  - "I know where I’m going."
  - "I feel good about myself."
- **Nonverbal behaviors**
  - Establishing relationships with the same sex and then with the opposite sex.
  - Planning realistically for the future. Reexamining values.
  - Asserting independence.
  - Trying various things.
  - Setting goals.

**Role Diffusion**
- **Verbal behaviors**
  - "I don’t know who I am."
  - "Where am I going?"
  - "Is it better to be male or female?"
  - "I don’t know what I mean."
- **Nonverbal behaviors**
  - Failing to differentiate roles or goals in life. Failing to assume responsibility for directing own behavior.
  - Imitating others indiscriminately.
  - Accepting the values of others without question.

### Intimacy vs. Isolation

**Intimacy**
- **Verbal behaviors**
  - "We are very close friends."
  - "I love Dan."
  - "My family is very close."
  - "I have lots of good friends."
- **Nonverbal behaviors**
  - Establishing a close and intense relationship with another person.
  - Acting out and accepting appropriate sexual behavior as desirable.
  - Maintaining a marital or other monogamous relationship.

**Isolation**
- **Verbal behaviors**
  - "I’m a loner."
  - "I don’t need anyone."
  - "I don’t care about anyone."
  - "I’m very lonely."
- **Nonverbal behaviors**
  - Remaining alone.
  - Not seeking out others for companionship or help.
  - Avoiding sex role by remaining non-descript in mannerisms and dress.
Generativity vs. Stagnation

Generativity

Verbal behaviors
“John and I have agreed to have two children.”
“He has his work and I have mine, together we make a team.”
“I am raising thee children.”
“I am employed at…”
“I love to sew.”

Nonverbal behaviors
Productive.
Maintaining employment.
Parenting.
Accepting interdependence.
Guiding others.
Creative.
Community or church leadership.
Completes creative endeavors; has hobbies.
Performs own self-care and takes responsibility for own health.

Stagnation

Verbal behaviors
“I can’t hold a job.”
“I don’t want to learn about it.”
“I haven’t time to volunteer.”
“You do it; I’m going out.”
“That’s too bad, but it isn’t my problem.”

Nonverbal behaviors
Not listening to others because of need to talk about oneself.
Constantly losing employment.
Showing concern only for oneself despite the needs of others.
Self-absorption.
Always finds excuses.
Refuses to learn self-care.

Integrity vs. Despair

Integrity

Verbal behaviors
“Life has been very good to me.”
“I can’t do the things I once did, but I enjoy other things.”
“I enjoy discussing current events.”
“I read the newspaper every day.”
“I love watching the birds at the feeder.”
“I enjoy seeing my children and my grandchildren.”

Nonverbal behaviors
Using past experiences to guide others.
Accepting new ideas.
Accepting limitations.
Maintaining productivity in some area. Exploring philosophy of living and dying. Enjoying some aspect of things as they are. Actively participating in own care as much as able.

Despair

Verbal behaviors
“I am no use to anyone.”
“Everyone is gone—my family, my friends.”
“What is the use of living; I can’t do anything.”
“Everything I did is gone now. Why did this happen?”
“These new ways are no good.”

Nonverbal behaviors
Crying; being apathetic and listless.
Not developing any new interests beyond a few routine activities.
Developing no new relationships.
Not accepting changes.
Limiting interpersonal contacts.
Demanding unnecessary help and attention.
Remaining in pajamas & robe all the time.