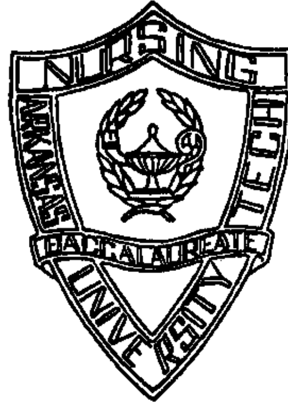
ARKANSAS TECH UNIVERSITY

DEPARTMENT OF NURSING



NUR 4405

PRACTICUM IN NURSING III

NURSING CLIENTS IN CRISIS

Fall 2009

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ARKANSAS TECH UNIVERSITY
Department of Nursing

Course: NUR 4405 (01)

Course Title: Practicum in Nursing III - Nursing Clients in Crisis

Credit Hours: Five (5) Hours

Contact Hours: Five (5) Hours

Placement: Fall Semester Senior Year

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Catalogue Description:

This is a clinical nursing course that provides the opportunity for the integration of concepts and theories taught in NUR 4206. Expected nursing behaviors include promotive, supportive and restorative behaviors. The nursing process is applied in a caring way to the care of clients undergoing major psychosocial and/or physiological maladaptations. The nursing roles utilized in the delivery of care are those of communicator, care giver, collaborator researcher, teacher, and advocator. The quality of care is measured according to the criteria of professional nursing standards. The practicum is conducted in hospitals, outpatient treatment programs and other community settings.

Required Textbooks:

Retain texts from previous nursing courses.

Additional Texts:

Smelter, S., Bare, B., Hinkle, J., & Cheever, K. (2008). Textbook of Medical-Surgical Nursing (11th Ed.). Philadelphia: Lippincott, Williams, & Wilkins.

American Nurses Association (2001). Code of Ethics for Nurses with Interpretive Statements. Silver Spring, MD.

Boyd, M. A. (2008). Psychiatric nursing contemporary practice (4th ed.). Philadelphia: Lippincott.

American Nurses Association (2004).Nursing Scope and Standards of Practice.Silver Spring, MD.

Optional Text:

Carpenito, L. (2004). Nursing diagnosis application to clinical practice (11th ed.). Philadelphia: Lippincott.

Auto-tutorial materials are available in the Student Learning Laboratory for student use.

Bibliography

Use the required and suggested readings in this syllabus and in the Nursing Theories and Concepts syllabus, readings at end of chapters in texts and the computerized nursing indexes as bibliography.

Justification/Rationale for the Course

By the completion of this course the student will progress toward program goals/outcomes 1, 2, 3, and 4.

This upper division professional nursing practicum course provides opportunities for the student to apply knowledge and skills from the general education component and from nursing courses to the care of individuals, families and groups.

C. Course Objectives:

On completion of the course, the student should be able to:

1. Utilize the nursing process to provide care for individuals, families, and groups who are experiencing physical and/or psychological mal-adaptation.

2. Incorporate promotive, supportive, and restorative concepts in the application of nursing care to individuals, families, and groups in crises.

3. Incorporate roles of care giver, communicator, researcher, teacher, collaborator, and advocator in delivery of nursing care.

4. Apply nursing theories and concepts in the care of individuals, families, and groups experiencing crises.

5. Integrate professional nursing standards into nursing practice.

6. Recognize legal and ethical issues related to the delivery of professional nursing care for clients in crises.

7. Demonstrate scientifically based psychomotor and psychosocial skills.

8. Value the bio-psycho-social, spiritual, and cultural aspects of man in the delivery of caring, holistic nursing care.

9. Apply clinical research findings as they relate to the care of individuals, families, and groups who are experiencing physical and/or psychological crises.

Assessment (Evaluation) Methods

1. Grading Scale

   A = 90-100
   B = 80-89
   C = 75-79
   D = 68-74
   F = 67 and below

2. A grade of "C" or above must be achieved in every nursing course in order to progress in the nursing program.

3. A semester grade of "I" or "Incomplete" will be given to those students whose work is incomplete because of illness or other circumstances beyond the student's control. This grade will be assigned at the discretion of the instructor according to the amount of time missed, the ability of the student to complete the necessary assignments, and the quality of the student's previous work.

4. Course Grade

   Clinical Performance..80%
   (Includes Daily Care Plans and other written work)
   Comprehensive Care Plan...20%

   100%

Clinical performance must be at least 75% before comprehensive care plan will be averaged with that grade.

A grade of 75% or above must be achieved in each clinical area before a passing grade is earned for the course. If a clinical grade falls below a 75%, the student will not be successful in passing Practicum IV.

Professional Points: Maximum of two points may be designated for this course.

Communication

A great deal of communication between faculty and students will take place through Blackboard. It is the students responsibility to regularly check for email messages and Blackboard announcements.

Policies

Practicum Attendance:

1. The student must attend, on a regular basis, all nursing experiences as attendance is an indicator of professionalism. Absences will be reflected in the evaluation of the student's ability to meet course objectives and may seriously jeopardize the student's grade. For clinical rotations, an absence will result in a make-up assignment. Make-up assignments will equal the number of clinical hours missed. Assignments may vary with instructor. Failure to make up clinical assignments will result in failure of the course. The student is responsible for contacting the instructor regarding make-up assignments within one week of absence. If a student is absent for more than 2 clinical days, the student may be dropped from the course.

2. The student is responsible for being prepared and on time for all clinical experiences. The student shall review pertinent content and objectives from Nursing 4206 and pertinent objectives and content from this syllabus prior to arrival at the clinical setting.

3. In the rare event of a necessary absence, personal notification must be made to the proper agency as well as to the clinical instructor prior to the absence.

4. Planned learning experiences outside the classrooms are an integral part of the nursing course. These experiences will be announced at least three (3) weeks in advance and all students are expected to participate.

5. The student is responsible for verbally notifying the instructor if he/she will be late to clinicals. Tardiness reflects a lack of professionalism and excessive tardiness will be reflected on students evaluations.

6. Please refer to Attendance Policy in Student Handbook for further information.

Background Checks:

Students will be required to complete a criminal background check per departmental policy.

Insurance:

All students must show evidence of having liability insurance prior to starting clinical experience.

C.P.R. Certification:

All students must present evidence of certification for cardiopulmonary resuscitation, a negative TB skin test, and completion of the Hepatitis B vaccinations.

Transportation:

Students are responsible for providing transportation to clinical sites. Students may be required to attend clinical in cities such as Fort Smith, Morrilton, or Conway.

Dress and Behavior:

1. The student must wear the standard school uniform while attending any clinical experience. Appropriate street clothes will be worn in psychiatric care settings. Students are expected to be neat and clean in appearance. When obtaining clinical data for the client assignments, students must wear a laboratory coat with an ATU name badge over their appropriate street clothes (see Dress Code, Student Handbook).

2. The students will be expected to maintain a professional attitude at all times while in the clinical area. Client **confidentiality** must be maintained. Students will abide by the agencies' regulating policies.

3. Students are expected to:

   a. Present written work that is theirs alone.

   b. Correctly document any materials from a textbook, pamphlet, journal, etc. that is used for an assignment.

   c. Only use authorized devises or materials for an examination and no copying from other students' papers.

4. Plagiarism is defined as stealing and presenting as one's own ideas or words of another, or not documenting material correctly. Any identified plagiarism will be automatic failure and dismissal from the program.

5. All resources must be documented on clinical paperwork.

Medication Calculation Exam:

1. The student must pass the Level III medication calculation exam before attending practicum.

2. Passing score is considered to be 80%.

3. The student may have three attempts to pass the exam.

4. If the student does not pass the exam after the third attempt, the student may be withdrawn from the course.

COURSE OUTLINE

PRACTICUM IN NURSING III:

I. Orientation

II. Psychosocial related foci

III. Physiological related foci

IV. Arkansas State Nursing Student Convention

V. Tri Chapter Research Day

Teacher Role:

Demonstrator, Evaluator, Facilitator, Resource Person, Role Model, Communicator, and Supporter.

Student Role:

Learner, Teacher, Advocate, Care Giver, Collaborator, Communicator, and Researcher.

Teacher-Learning Strategies:

A variety of critical thinking activities, including:

Pre and post care conferences, actual and simulated demonstrations, use of resource persons, charts, diagrams, anatomical models, selected observational experiences, nursing interventions for selected groups and selected clients, role play and role modeling, nursing rounds, process recordings, nursing care plans, auto-tutorial materials, and milieu and mental status assessments.

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Practicum Evaluation Tool
NUR 4405 - Level III Practicum

Student Name ___________________________________ Date _______

DIRECTIONS: Score each Criteria as follows (see grading criteria for the clinical Evaluation tool):

10 - 9	Excellent	I - Incomplete
8.9 - 8	Good	NA - Not applicable
7.9 - 7.5	Average	NA - Not Observed
7.4 - 7.0	Poor (unsatisfactory)	

*CRITERIA	CIRCLE ONE	SCORE
Objective 1	7 . 8 . 9 . 10	_____
Objective 2	7 . 8 . 9 . 10	_____
Objective 3	7 . 8 . 9 . 10	_____
Objective 4	7 . 8 . 9 . 10	_____
Objective 5	7 . 8 . 9 . 10	
Objective 6	7 . 8 . 9 . 10	
Objective 7	7 . 8 . 9 . 10	
Objective 8	7 . 8 . 9 . 10	_____
Objective 9	7 . 8 . 9 . 10	
SCORE		_____ x 1.1
Total Grade		______

Student Signature: _____________________________ Date:_____________

Faculty Signature: _____________________________

Comments:

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 - Level III Practicum

PERFORMANCE ASSESSMENT TOOL

Student Name ________________________________ Date _______

DIRECTIONS: Score each objective as follows:

10 - 9	Excellent	I - Incomplete
8.9 - 8	Good	NA - Not applicable
7.9 - 7.5	Average	NA - Not observed
7.4 - 7.0	Poor (unsatisfactory)	

Objectives/Criteria Behaviors	Score
1. Utilizes the nursing process to provide care for individuals, families, and groups who are experiencing physical and/or psychological maladaptation.	
a. Collects data from a variety of sources such as records, physical assessment, health history, laboratory data, and health care provider. b. Compares data with expected norms and Identifies deviations from norms. c. Identifies crisis situations and intervenes appropriately. ** d. Demonstrates ability to form appropriate nursing diagnoses for individuals and families. e. Develops mutual goals for nursing care based upon realistic needs and priorities of patient. f. Collaborates with peers, health care team members, faculty and others in implementing nursing care. g. Modifies plan of care as indicated.	
2. Incorporates promotive, supportive and restorative concepts in the application of nursing care to individuals, families and group in crises.	
a. Determines patient's/families' abilities to meet own needs. b. Uses self as a therapeutic tool. c. Utilizes independent and interdependent functions in the delivery of care.	
1. Incorporates roles of care giver, communicator, researcher, teacher, collaborator and advocate in delivery of nursing care.	
a. Integrates medical plan into nursing care plan. b. Uses self as a therapeutic tool. c. Collaborates with peers, health care team members, faculty and others in implementing nursing care.	

Performance Assessment Tool (continued)

Objectives/Criteria Behaviors	Score
4. Applies nursing theories and concepts in the care of individuals, families, and groups experiencing crises.	
a. Utilizes theories, nursing research, and scientific rationale as a basis for planning, implementing and evaluating nursing care.	
5. Integrates professional nursing standards into nursing practice.	
a. Performs nursing care efficiently demonstrating good time management skills. b. Performs procedures according to policies of the nursing school and the clinical agency. c. Bases evaluation of interventions on established standards of care. d. Distinguishes between social and professional roles. **e. Uses professional, legal, and ethical standards as guidelines for nursing practice. ***f. Notifies nursing instructor as well as clinical agency of absence, tardiness, or need to leave early. If instructor is not available, notifies nursing office. g. Completes clinical assignments in a timely manner. h. Documents clinical log reflecting depth of thought. i. Prepares for clinical experience as assigned by instructor.	
6. Recognizes legal and ethical issues related to the delivery of professional nursing care for patients in crises.	
a. Performs nursing care in a safe manner. b. Performs nursing care efficiently demonstrating good time management skills. c. Seeks help appropriately. d. Bases evaluation of interventions on established standards of care. **e. Maintains professional appearance and hygiene according to departmental and agency guidelines. f. Uses legal, professional and ethical standards as guidelines for nursing practice, recognizes deviations and issues related to nursing care, and seeks appropriate input.	

Performance Assessment Tool (continued)

Objectives/Criteria Behaviors	Score
7. Demonstrates scientifically based psychomotor and psychosocial skills.	
**a. Performs nursing care in a safe manner. b. Seeks help appropriately. c. Uses critical thinking in making nursing judgements. d. Performs with self direction. e. Assumes responsibility for own learning. **f. Demonstrates ability to communicate effectively with patient, peers, health team members, and faculty members.	
8. Values the bio-psycho-social, spiritual, and cultural aspects of man in the delivery of caring holistic nursing care.	
a. Develops mutual goals for nursing care based upon realistic needs and priorities of patient. b. Implements nursing care in a culturally sensitive manner.	
9. Applies clinical research findings as they relate to the care of individuals, families, and groups who are experiencing physical and/or psychological crises.	
a. Seeks out current nursing research related to clinical area. b. Shares research with peers, staff and instructor.	

** Critical objective. Failure to meet this objective can result in failure of NUR 4405.
*** Failure to meet the criteria will result in reduction of grade for NUR 4405 by one letter grade.

Total Score: __________

Student Signature: ____________________________ Date:____________

Faculty Signature: ____________________________ Date:____________

Comments:

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COMPREHENSIVE NURSING CARE PLAN GUIDELINES

The comprehensive nursing care plan is a learning tool designed to facilitate synthesis of the principles, theories, and concepts studied in Theories and Concepts III and Nursing Practicum III. It is also a way to utilize critical thinking skills in the comprehensive care of a selected client. The care plan is to be developed in the format of a formal paper utilizing APA format.
The paper is due **Friday November 14, 2008**.

Submit the original with one copy to the level coordinator by 4:30 p.m. of the assigned due date. The paper should have a cover page stating in which hospital and department the student provided care. One full letter grade will be deducted for each day the paper is late.

The care plan will be written about a patient for whom the student has provided nursing care this semester and must include all aspects of that care.

A copy of research articles used will be submitted with the comprehensive care plan.

Evaluation:

The percentage of points for each section of the paper is indicated in the outline below. Evaluation will be based on appropriate content as well as creative effort. Critical thinking questions are added on next pages to help you as you write the care plan.

Components:

I. Introduction/Medical Summary ....……........ 5%

II. Nursing Theories/Concepts to include:...............................……...80%
- Theories/Conceptual Model ....… 10%
- Standards of Care...… 5%
- Legal and Ethical Implications...…...5%
- Nursing Roles including caring...…..5%
- Holism/Life Cycle/Culture...….10%
- Crisis/Adaptation..…..10%
- Nursing Process (Assessment, Plan, Implement, Evaluate) 20%
- Application of Pertinent Research...................................…. 5%
- Patient Education...….5%
- Critical Thinking Questions………………………………..5%

III. Summary...…… 5%

IV. Format (grammatical issues, APA, etc.).......................……...... 10%

100%

COMPREHENSIVE NURSING CARE PLAN EVALUATION TOOL

COMPONENT	POINTS POSSIBLE	POINTS EARNED
I. Introduction/Medical Summary	**5**	________
II. Nursing Theories/Concepts	**80 total**	
A. Theories/Conceptual Model 1. (Briefly) what is the basis of the theorist/model (i.e. self-care, wellness, barriers, adaptation) 2. How do you apply this theory/model to the care of your patient? 3. Based on this model, what does nursing do?	10	________
B. Standards of Care How did you implement the ANA Standards of Nursing Practice and Standards of Professional Performance? Diagnosis specific standards of care?	5	________
C. Legal and Ethical Implications As you cared for this patient, what legal issues were involved? What ethical implications can you identify? What were or should have been your actions? How did you apply the ANA Code of Ethics?	5	________
D. Nursing Roles What major roles did you use in caring for the patient? Describe these roles. How would you use these roles to provide for continuity of care for this patient and family? (i.e. after discharge)	5	________
E. Holism/Life Cycle /Culture Describe these concepts in relationship to your nursing care for this patient. How did your nursing care reflect the patient's developmental stage, culture and his physical, psychosocial, environmental and spiritual needs? How did these factors influence your care?	10	________

Comprehensive Nursing Care Plan Evaluation (continued)

	Points	Score
F. Crisis/Adaptation Describe this patient in terms of crisis, adaptation, and crisis intervention.	10	________
G. Nursing Process (Assess, Plan, Implement, Evaluate) Describe nursing care for this patient/family in terms of the nursing process. What were the challenges, the successes, the failures?	20	________
H. Application of Pertinent Research After reading nursing research which applies to your patient's care, describe how you can or did apply the research findings to the care of your patient/family. Refer to at least one specific nursing research.	5	________
I. Patient Education What were the patient's/family's education needs? Describe the needs assessment and how you intervened to meet these needs.	5	________
J. Critical Thinking Questions Raise critical thinking questions which should be asked regarding the care of your patient/family.	5	________
III. Summary	5	________
IV. Format (grammar, sentence structure, spelling, APA, etc.)	10	________
	Total 100	**Total:** _____

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INTERPERSONAL PROCESS RECORDING

Focus:

To assist the student to develop skill in observation, in communicating and in gaining the ability to apply theories and concepts to nursing situations.

Objectives:

1. To apply psychiatric/mental health concepts to a nurse-client interaction.

2. To develop the ability to identify his/her thoughts and feelings in relation to self and others.

3. To increase ability to identify client's needs and skill in meeting these needs.

4. To plan, structure and evaluate nursing action on a conscious level.

5. To analyze client behavior based on psychiatric/mental health concepts.

The process recording is a systematic method of collecting data prior to interpreting, analyzing, and synthesizing the data obtained. It is a verbatim report of the verbal and non-verbal communication between two people for the purpose of assessing their interaction.

Procedure:

Select a client in the clinical setting for participation in a one-to-one relationship. You are required to turn in two interpersonal process recordings with clients, including thoughts and feelings as soon after the interactions as possible. The recordings should be a full account of the interactions.

Confidentiality:

All client records contain privileged information and are to be carefully guarded. Process records should be read only by the appropriately designated persons. Do not use the client's name but substitute initials for the name. The client as a human being, has the right to know with whom you are sharing the information about him. The process recording will be shared with your instructor, classmates, and appropriate clinical staff.

Items To Be Included

I. Introductory Material

A. Description of the client
Chief complaint, age, marital status, predisposing causes of illness, etc.
B. Description of setting (lighting, noise, temperature, etc.)
Where interaction took place
What client was doing when approached, etc.
C. Description of your thoughts and feelings prior to the interaction.
D. Therapeutic objectives/goals of the interaction (patient centered)

II. Recording of Interaction (use 3 columns)

A. Describe how interaction was initiated
B. Client communication:
verbal, non-verbal, silence, etc.
C. Nurse communication: verbal, thoughts, feelings, hypotheses, and validation with client
D. Applicable behavioral concepts/principles and meaning of the communications/ behaviors
E. Describe termination of the interaction
F. Analysis: communication techniques, why are they used, what are you hoping to accomplish?

III. Evaluation for Nursing Intervention

A. Description of your thoughts after the interaction.
B. Goals for future interactions.
C. Describe areas for improvement related to therapeutic communication.
D. Evaluate planned objective/goals of the interaction.

Review communication techniques, chapter nine, Boyd, prior to communicating with clients.

EXAMPLE ONLY

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Interpersonal Process Recording Example

NURSE: VERBAL AND NONVERBAL	**PATIENT: VERBAL AND NONVERBAL**	**PRINCIPLES THAT EXPLAIN BEHAVIOR AND INTERVENTION, FEELINGS AND OBSERVATIONS**
Date:	**Interaction Number 12**	***Goal: Patient will identify situations arousing discomfort and how he handles them.**
Mr. E. had just returned from a home visit. He came over to me and said he had to check his clothes and would be right back. I said I would wait for him in the usual place. He returned ten minutes later at 8:10 a.m.		I was a little irritated that Mr. E. would be late; even though I knew it was ward policy that his clothes be checked at once. However, I waited in the usual place. Reinforcing trust by being on time and remaining there for patient. Maintaining terms of contract.
	How was your weekend?	
Fine, and yours?		Focus conversation back to patient.
	Well, I was out on pass. I had a good time. I spent a lot of time straightening things up - putting summer clothes away and sorting out things. I could only work a few hours and then had to take a snooze.	Fatigue may be emotional as well as physical. Sleep can be a defense against a trying situation.
	We had company too. My sister had just told people that I wasn't feeling well. She didn't tell them what was wrong and they expected to see me with casts or something. She left it to me to tell them what was wrong.	Patient's anxiety rose here, shown by much moving around in his chair, embarrassed laughter, and lack of eye contact. Sister probably gave responsibility to patient because of her own feelings.
How did you feel about telling them?		Focusing to get pt to express feeling.
	Oh, I had no feelings about it at all. They're friends and they understand. They've seen me upset and angry. They understand.	Denial of feelings as a protective mechanism. Hopes friends understand but not sure.
What do you do when you get angry?		Exploring pt.'s usual coping strategies and helping patient to be aware of his behavior in reaction to stress.
	Well, I count to ten. Mostly I keep it in. My friends realize that. I don't get violent like some people.	– Continue – *** This is an example only. Your IPR should be longer than this example.**

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PSYCHIATRIC CARE PLAN
GUIDE

I. ASSESSMENT

A. BIO-PSYCHO-SOCIAL: Include initials of client, age, sex, religion, description of family structure, financial status, occupation and other psycho-social-cultural info. Identify stage and what development task client is dealing with according to Erickson. Include a brief history of patients' illness, treatment, medication regimen, etc. List current medications and other treatment ordered.

B. MENTAL STATUS ASSESSMENT - Complete this assessment during your time with client, focusing on current status. Include other mental status information from chart, but **identify it as such**.

C. PHYSICAL ASSESSMENT - Do as much physical assessment of client as is appropriate; remembering that much will be from direct observation.

D. NURSING DIAGNOSIS - From all the above information, formulate nursing diagnoses for client. Identify each as "actual" or "high risk for." Include "related to" supporting information for each. Arrange diagnoses according to patient priority.

E. COLLABORATIVE PROBLEMS - At bottom of care plan, note relevant collaborative problems.

II. PLAN OF CARE

Identify at least one long-term goal for client that addresses his psychosocial problems.

NURSING DIAGNOSIS	EXPECTED OUTCOME	IMPLEMENTATION	RATIONALE	EVALUATION

Milieu Assessment

Objectives:

1. Identify the components of the therapeutic milieu and their implications for inpatient psychiatric nursing practice.

2. Analyze a specific therapeutic milieu in which psychiatric nursing is practiced (Vista Health, St. Anthony's Geripsych or alternate setting with instructor's permission).

Prior to milieu assessment:

1. Read Boyd, chapter 13, pp. 227-229 prior to milieu assessment experience.

2. Complete inpatient psychiatric nursing care critical thinking activity on next page.

3. Complete milieu assessment.

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MILIEU ASSESSMENT

Setting ______________ Date _____ Name __________________________

Evaluate the milieu in terms of the following characteristics:

1. Provision for physical safety and security

2. Provision for validation of humanity (include family, cultural, religious and other affiliations)

3. Provision for structured interaction

4. Provision for open communication with client by nursing staff and other members of the health care team.

Summary of the strengths and weakness of this milieu:

Suggestions for change:

MENTAL STATUS EXAM

Objectives:

1. Describe the nature, purpose and process of the mental status examination (M.S.E.).

2. Analyze the observations and clinical implications of each category of the M.S.E.

3. Discuss how information for the M.S.E., along with data from the physical exam, lab test results, patient history, descriptions of the presenting problem, and information from family, care givers and other health professionals, is used to make nursing diagnosis and develop a plan of care for the patient.

4. Identify characteristics of the interviewer that enhance effective data collection during a M.S.E.

5. Recognize the purpose of the mini-mental state exam and when it is used instead of a full M.S.E.

6. Perform a mental status exam on an inpatient psychiatric client and document on form in syllabus.

7. Perform a mini-mental status exam on a client in an inpatient unit or in a gerio-psychiatric setting and document on form in syllabus (attached).

Prior to mental status exams in practicum setting:

1. Read Boyd, chap. 11, pp. 200-204.

2. Complete critical thinking activities and mental status exam on the following pages.

3. Prepare to review/discuss in practicum session on assigned date and turn in mental status and mini-mental state exams.

MENTAL STATUS EXAM

Student_________________________ Client Initials_____ Date_________

1. General appearance: motor activity, interaction during interview, grooming and dress, facial expression, level of consciousness.

2. Emotional state (mood and affect): If potential for suicide, suicidal or homicidal thoughts? If so, assess further.

3. Thought content and perceptions (delusions, illusions, hallucinations, depersonalization, obsessions or compulsions, phobias, fantasies, daydreams, etc.).

4. Flow of thought and speech.

5. Sensorium and cognition:

   a. Orientation

   b. Memory (remote, recent, immediate)

   c. Intellectual Functioning

      1) Concentration and calculation

      2) General information and intelligence

      3) Abstract thinking

      4) Judgement

6. Insight

Impressions: Nursing diagnoses (prioritized):

MINI-MENTAL STATE ASSESSMENT

STUDENT'S NAME _________________ Setting ____________________
CLIENT INITIALS _____ Date __________

Maximum Score	Score	
		ORIENTATION
5	( )	What is the (year) (season) (date) (day) (month)? (1 point for each)
5	( )	Where are we (state) (county) (town) (hospital) (floor) (1 point for each)
		REGISTRATION
3	( )	Name three objects: Give one second to say each. Then ask the patient to repeat all three after you have said them. (1 point for each item) Give one point for each correct answer. Then repeat them until the patient learns all three. Count trials and record.
		ATTENTION AND CALCULATION
5	( )	Serial sevens. Give one point for each correct. Stop after five answers. Alternatively, spell "world" backwards.
		RECALL
3	( )	Ask for three objects repeated above. Give one point for each correct.
		LANGUAGE
9	( )	Name a pencil and watch when pointed to (2 points) Repeat the following, "No ifs, ands, or buts." (1 point) Follow a three-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." (3 points) Read and obey the following: "Close your eyes." (1 point) Write a sentence. (1 point) Copy design. (1 point) – See p. 202 (Boyd)

Total Score _____

Nursing Diagnoses based on your exam:

From: Boyd (2005). Psychiatric nursing contemporary practice. Lippincott

GROUP PROCESS OBSERVATION FORM

PARTICIPATION

1. Who are the high participators?
2. Who are the low participators?
3. How are the silent people treated? How is their silence interpreted?
4. Who talks to whom? Do you see any reason for this in the group's interactions?

INFLUENCE

1. Which members are high in influence? That is, when they talk others seem to listen.
2. Which members are low in influence? Others do not listen to or follow them.
3. Do you see any rivalry in the group? Is there a struggle for leadership?

STYLES OF INFLUENCE

1. Autocratic: Does anyone attempt to impose his will or values on other group members to try to push them to support his decisions?
2. Peacemaker: Who eagerly supports other group members' decisions?
3. Laissez faire: Are any group members getting attention by their apparent lack of involvement in the group?
4. Democratic: Does anyone try to include everyone in a group decision or discussion?

DECISION-MAKING PROCEDURES

1. Does anyone make a decision and carry it out without checking with other group members?
2. Is there any evidence of a majority pushing a decision through over other members' objections?
3. Is there any attempt to get all members participating in a decision (consensus)?
4. Does anyone make any contributions that do not receive any kind of response or recognition (plop)? What effect does this have on the member?

TASK FUNCTIONS

1. Does anyone ask for or make suggestions as to the best way to proceed or to tackle a problem?
2. Does anyone attempt to summarize what has been covered or what has been going on in the group?
3. Is there any giving or asking for facts, ideas, opinions, feelings, feedback, or searching for alternatives?
4. Who keeps the group on target? Who prevents topic-jumping or going off on tangents?

MAINTENANCE FUNCTIONS

1. Who helps others get into the discussion (gate openers)?
2. Who cuts off others or interrupts them (gate closers)?
3. How well are members getting their ideas across? Are some members preoccupied and not listening?
4. How are ideas rejected? How do members react when their ideas are not accepted?

Group Process Observation Form (continued)

GROUP ATMOSPHERE

1. Who seems to prefer a friendly congenial atmosphere?
2. Who seems to prefer an atmosphere of conflict and disagreement?
3. Do people seem involved and interested?

FEELINGS

1. What signs of feelings do you observe in group members: anger, irritation, frustration, warmth, affection, excitement, boredom, defensiveness, competitiveness?
2. Do you see any attempts by group members to block the expression of feelings, particularly negative feelings? How is this done? Does anyone do this consistently?

Practicum Guide

Vista Psychiatric Hospital, Fort Smith

The student will upon completion of this practicum experience:

1. Recognize problems associated with a diagnosis of a psychiatric disorder for the :

   a. individual
   b. family
   c. community

2. Recognize own feelings concerning acute psychiatric clients.

3. Describe activities/services provided by the agency that improve mental functioning.

4. Evaluate the nurslings' role in the institution, utilizing the ANA Scope and Standards of Psychiatric-Mental Health Nursing Practice as well as the roles of the baccalaureate prepared nurse.

5. Correlate nursing research to practicum experiences.

6. Evaluate group process based on the group process observation form found in your syllabus and the presence of Yalom's curative factors.

7. Read Boyd chapters 10,11,12, &14, pp 64-670,

8. Select a patient in the unit to which you are assigned and develop a plan of care for this patient for each practicum day. (This will include a Mental Status Exam [at least one during this practicum experience] or a Mini Mental Status Assessment.)

9. Complete a psychopharmacologic profile of current psychopharmacologic interventions being utilized and you will select one drug and contact a local pharmacy for the cost for a months supply. This will be presented in post conference.

10. Complete a milieu assessment and at least one IPR during this practicum experience.

11. Submit a log answering the above objectives and documenting learning experiences in conferences during a practicum period.

PRACTICUM GUIDE

Alcohol and Drug Treatment Center - (Freedom House)

Prior to experience, read Boyd, Psychiatric Nursing, Chapter 14, Group Interventions, and Chapter 23, Substance Abuse Disorders. Pay special attention to the 12 steps of Alcoholics Anonymous.

1. Describe the type of treatment program provided clients in this setting.
2. Outline the behaviors and roles of the nurse as a member of the team, including the performance of independent and dependent nursing functions. If a nurse is not a member of the team, identify roles the nurse could assume in this setting. How could a professional nurse be beneficial in this setting? Use course objective #3.
3. Describe the model(s) of psychiatric care you saw utilized on the unit: medical model, behavior modification model, psychoanalytic model, social-interpersonal model or other.
4. Describe the behaviors exhibited by patients. Compare these behaviors with S/S of substance abuse as discussed in Boyd, Chapter 23.
5. Establish a beginning nurse-client relationship in a caring manner with at least one client/family and complete IPR (if allowed by agency).
6. Submit a research article and discuss how this information was or could be applied to patient care at this agency
7. Submit a log answering the above objectives and documenting learning experiences.

ARKANSAS TECH UNIVERSITY
Department of Nursing

PRACTICUM GUIDE

Geriopsychiatric Nursing

Objectives:

1. Recognize own feelings about both the aging process and clients with organic mental disorders.

2. Recognize the problems associated with an organically impaired client for the:

   a. Individual b. Family, particularly care givers c. Community

3. Describe the services provided by agency for this population.

4. Identify criteria used for accepting clients into the geriopsychiatric center or unit.

5. Identify various behavioral manifestations of dementia.

6. Identify possible nursing diagnoses for clients and their care-givers with organic mental disorders using latest ND list.

7. Describe characteristics of aging that you observed in clients at the center.

8. Describe how this center is involved with:

   a. Promotive behaviors b. Supportive behaviors and/or c. Restorative behaviors

9. Discuss how a nurse might contribute to the center (include concept of roles of baccalaureate nursing using course objective # three – page five).

10. Perform a mini-mental status exam on at least one client (page 30).

11. Identify support groups that are helpful for families of clients with organic mental disorders.

12. Complete a nursing plan of care for at least one client.

Prior to experience, review: Boyd. Chapters 27-29

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405
Day Treatment/Transitional Unit Day Program/Acute Unit

Objectives:

1. Recognize own feelings concerning chronic psychiatric clients.
2. Participate in client group activities and describe the group process. Discuss curative factors of group.
3. Complete at least one Interpersonal Process Recording.
4. Describe activities/services provided by the agency. How do these services improve mental functioning? How do these services benefit the community?
5. Describe how the agency promotes client independence.
6. Describe how the nurse might make a greater contribution to patient care (include roles of baccalaureate nursing using course objective #3, page 5).
7. With another student(s), plan and implement an educational session for a selected group.
8. Apply current research to care of client. Submit research article supporting application.
9. Document medications being taken by the clients. Observe for any side effects and document.
10. Plan and implement one group evening activity.
11. Assess the community for services for clients with chronic psychiatric problems.
12. Submit a clinical log answering the above objectives and documenting learning experiences.

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Clinical Objectives for Practicum in Intensive Care Unit

The nursing student is expected to:

1. Locate the crash cart and all emergency equipment/supplies in the unit.

2. Observe use of special equipment used in the ICU (e.g. ventilator) and demonstrate proper use of such equipment after receiving instructions on use.

3. Identify priority physiological and psychological nursing diagnosis and appropriate interventions for selected clients.

4. Utilize the nursing process to care for clients and families in the critical care setting.

5. Incorporate physical examination into assessment of clients.

6. Analyze the ICU milieu and its effects on clients and care givers.

7. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.

8. Compare normal laboratory values with those of clients in the ICU setting

9. Evaluate effects of nursing interventions and revise interventions as necessary.

10. Seek assistance from instructor when unfamiliar with any aspect of client care.

11. Discuss ethical-legal issues in the ICU environment.

12. Be prepared to present verbal care plan to clinical instructor.

ICU Verbal Care Plan

The student will be **prepared** to answer the following questions at the beginning of the clinical day. The instructor may choose a time later in the day to discuss the care plan with the student; however, the student should always be prepared at the beginning of the clinical shift. This information is presented to the clinical instructor *without* the use of notes, with the exception of lab values and medications. The instructor may ask the student to update this information during the course of the day.

1. What acute disease does your client have?

   Explain the basic pathophysiology

2. What chronic diseases does your client have?

   Explain the basic pathophysiology of each and how they may relate to the acute disease.

3. Explain lab and radiology data (may use notes).

4. Tell about your client's medications (may use notes).

   Discuss purpose, common side effects, and priority nursing implications.

5. Describe the client's social, spiritual, and personal status.

   How does this impact care? Who lives with the client? Describe client's relationships. Does the client have any spiritual needs or concerns?

6. Identify two to three nursing diagnoses for this client in order of priority.

   Which nursing diagnosis in first in priority? Explain rational for the order of priority of these diagnoses.

7. Describe your plan of care today.

   List one goal for each nursing diagnosis. Explain interventions. What teaching will be planned for client and/or family?

8. At the end of your clinical day, evaluate your plan of care.

   What changed during the course of the shift? Was it necessary to revise the plan of care based on changes in the client's condition or diagnosis? Was it necessary to revise priorities of diagnosis? Was nursing care holistic?

NURSING CARE PLAN GUIDE: INTENSIVE CARE

Student Name ___________________________ Date ___________

Patient Initials ___________ Age ___________

Medical Diagnoses: _________________________
____
____

Short-term GOALS:

#1

#2

NURSING DIAGNOSES	INTERVENTIONS	RATIONALE	EVALUATION

NURSING DIAGNOSES	INTERVENTIONS	RATIONALE	EVALUATION

MEDICATION	DOSAGE	ROUTE	FREQUENCY	NURSING IMPLICATIONS

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Clinical Objectives for the Practicum in Emergency Department (ED)

The nursing student is expected to:

1. Locate the crash cart and make medication cards on at least five major drugs used in emergency situations.

2. Familiarize self with the special equipment used in the Emergency Department and demonstrate appropriate interventions in the use of that equipment.

3. Write an abbreviated care plan on three selected clients in the ED setting, which should include: one priority nursing diagnosis, one short-term goal, nursing assessment (vital signs, observations), nursing interventions, and evaluation.

4. Utilize the nursing process to provide care for a variety of clients, comparing normal and abnormal values of lab and x-ray exams.

5. Complete admission and referral procedures on selected clients.

6. Incorporate physical examination into the assessment procedure of such clients.

7. Compare coping patterns of at least three clients in crisis because of an emergency medical or surgical problem.

8. Make a judgment as to the adequacy of these coping patterns and document any interventions that were effected by the nurse in helping these clients cope.

9. Document the adequacy of support systems of selected clients in crisis because of an emergency medical or surgical problem.

10. Document the triaging of clients. Identify principles being used.

11. Discuss ethical-legal issues in the ED environment.

12. Analyze the ED milieu and its effects on clients, care givers and staff.

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Objectives for Orthopedic/Rehabilitation/Post Surgical Unit Experience

1. Locate equipment and supplies used on the orthopedic and rehabilitation units.
2. Utilize the nursing process to provide care to clients with orthopedic or neurological dysfunction.
3. Identify therapies unique to these units.
4. Identify the diversity of health care team members giving care to ortho/neuro clients.
5. Explain the impact of various medical conditions on clients with orthopedic dysfunction.
6. Describe protocol that determines a client's eligibility and potential for rehabilitation.
7. Write an abbreviated care plan (5 x 8 index card) on one client each week. Include vital information, medical diagnosis, nursing diagnoses, etc.
8. Complete log documenting each objective and how it was met.

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III

Arkansas State Nursing Student Convention

Objectives:

At the end of the Arkansas Student Nurses Association (ASNA) Convention the student will be able to:

1. Value the importance of belonging to a professional organization.

2. Describe the composition of the ASNA and its primary focus on the local, state, and national level.

3. Identify, voting delegate from ATU SNA and state ASNA and the delegates responsibilities.

4. Explain what learning occurred from each session attended.

5. Evaluate attendance to the conference.

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III

Tri Chapter Research Day

Objectives:

At the end of the Tri Chapter Research Day, the student will be able to:

1. Discuss at least two poster presentations the student found interesting.
2. Summarize at least two presentations made by speakers. Discuss application of research to nursing practice.
3. Discuss the importance of nursing research to the advancement of the profession.
4. Identify the role of the BSN, RN in the research process.
5. Evaluate attendance to the conference.