DeAnza College

School of
NURSING

NURSING 85AL

Psychiatric Rotation Clinical

Rebecca Sherwood, DNSc, RN

2015-2016

WELCOME AND INFORMATION

It is a pleasure to have you in De Anza College's Nursing Program. The following summary and guide to additional sources of information have been prepared to assist you towards successful completion of courses as you progress through the nursing program.

Change of address/phone number: You are responsible for reporting, in writing, any change on address or phone number to your lead and clinical instructors, the screening coordinator, and the office of admissions and records. *This is very important in order that you can be reached if needed.*

Reporting injury: You are to immediately report, to your clinical instructor, any injury that occurs to you in the clinical area. Together with your instructor, you will complete an incident report for the Nursing Department and determine follow-up action. You must also report this injury to the De Anza College Health Service Office as soon as possible. *If this report is not made within twenty-four hours of the injury you may not be covered by Workman's Compensation.*

I.V. regulations: I.V. therapy is not addressed during Quarter 1. Regardless of your prior experience and education you will apply and implement concepts during 2 through 6 quarters.

Attendance: The attendance policy for each course in the program is listed on the Green Sheet, which will be distributed on the first day of each class.

Dress code: The Nursing Department student dress code is detailed in the Nursing Student Handbook. Please review this policy prior to enter the clinical area. Remember that the blue vest is to be worn in the clinical areas only. The vest is to be removed upon leaving the clinical facility and is not to be worn on campus or socially.

Patient confidentiality and socialization/fraternization: These issues will be discussed at length during the program. All students will be asked to sign a statement regarding these issues. Remember that this policy continues to be in effect throughout the program. If you have any questions contact your instructor or the Director of Nursing.

Immunizations: The physical examination and all immunizations must be completed and current in order to be in the clinical setting. A tuberculosis testing is required before entering the nursing program and upon completion of and before graduation from the nursing program.

CPR: A CPR certificate must be presented upon entry into the program and must be current throughout the program. (American Heart Association issues 2-year certificates)

Nursing Skills Laboratory: The nursing skills laboratory hours are Mon-Fri., 7:30 a.m. to 4:30 p.m. (Closed 11:30 a.m. to 12:30 p.m.)

Telephone numbers: For instructors not listed below, contact numbers and instructions will be listed in the Green Sheet.

FULL TIME FACULTY

~~Susan Bruch~~	~~864-8638~~
Judith Clavijo. Director .	864-8397
Sherri Cozzens	864-8533
Cassie Hanna	864-8843
Catherine Hrycyk	864-5529
Olga Libova	864-5494
Patricia O'Neil	864-8641
Rebecca Sherwood	864-8633

STAFF

Jean Burke. Nursing Lab.	864-8897
Melissa Ingalls. Adm. Assistant	864-8773
Robert Jeckell. Nursing Specialist.	864-5618
Marge Sainten, Resource Center	864-8687
. Div Dean	864-8332

Schedule of classes: The days, times, and location of classes can be found, for the most part, in the Schedule of Classes. Prior to the new quarter, course information can be obtained from the "lead" instructor's telephone message, office door, program web-site, and/or Green Sheet.

Nsg ~~54KL~~ 85AL

Registered Nursing Program

NURSING [redacted] 85AL

Psychiatric/Mental Health Nursing Clinical Component

SYLLABUS

UNITS:

5 (15 hours of clinical)

PREREQUISITES:

Same as Nursing [redacted] 85A
Co-requisite: Nursing [redacted] 85A

FOREWORD:

Clinical objectives are achieved in acute, subacute, and community-based psychiatric/mental health care settings and medical-surgical care settings. Clients will be selected from across the life span and will represent culturally diverse populations whenever possible. Students will have the opportunity to care for persons experiencing helplessness and hopelessness, psychotic behaviors, and substance abuse/dependency as well as additional psychopathological states and conditions.

Critical thinking and problem solving skills will be utilized in the application of theoretical concepts with consideration for the Registered Nurse's specific scope of practice.

COURSE OBJECTIVES:

1. Examine assumptions and points of view that provide a conceptual framework for the care of individuals in psychiatric/mental health settings.

   Clinical Objectives

   1.1 Employ legal-ethical-managerial practices that protect client confidentiality and other client rights at all times.

 2012 - New unit rule - NO pulling out of cell phones on the unit!

1.2 Demonstrate awareness of and respect for the client's emotional, physical and psychological safety and well being at all times.

1.3. Critique own personal reactions and feelings encountered in the clinical setting.

2. Collect an accurate, descriptive and comprehensive Orem assessment database.

Clinical Objectives

2.1 Collect accurate, descriptive and comprehensive data regarding the individual's universal, developmental and health-deviation self-care requisites.

2.2 Critique assessment database of assigned clients during clinical conference sessions and with clinical instructor and clinical staff.

3. Organize self-care requisite assessment data and infer relevant nursing diagnoses.

Clinical Objectives:

3.1 Calculate self-care deficits from a list of pertinent assessment data for assigned clients.

3.2 Choose nursing diagnoses that are based upon the calculated self-care deficits.

3.3 Appraise choice o nursing diagnoses during clinical conferences.

4. Interpret the relevance of comprehensive client data in terms of goals for meeting the client's therapeutic self-care demands.

Clinical Objectives:

4.1 Apply knowledge of the client's specific self-care actions in tailoring relevant long and short-term goals.

4.2 Discuss desired outcomes in restoration of self-care capability with the client, the family and the interdisciplinary team members.

5. Assemble realistic and precise consequences of reasoning into a nursing system for implementing a plan of care.

Clinical Objectives:

5.1 Design a nursing system tailored to the self-care capability of specific clients.

5.2 Validate the nursing system with reference texts, clinical staff, clinical instructor and in clinical conference sessions.

6. Evaluate outcomes and give meaning to the client's efforts toward restoration of self-care ability.

Clinical Objectives:

6.1 Judge the sufficiency and efficiency of self-care and make or recommend adjustments in the nursing system.

6.2 Predict future deficit relationships on the basis of anticipated decreases in self-care capability or increase in therapeutic self-care demand or both.

6.3 Illustrate the collaborative role of the nurse by initiating and responding to contacts with the interdisciplinary team and with the family in evaluating the client's self-care capability.

CLINICAL TOPICAL OUTLINE:

Topics are arranged by week of presentation.

WEEK 1:

Orientation to the clinical sites will include an introduction to key professional staff, explanation of policies and procedures and emergency protocols. Clinical objectives and expectations of the student will be carefully reviewed. Factors that are essential for clients' physical and emotional safety and well-being will be discussed. Role playing with Biopsychosocial Assessment Form and basic interviewing techniques for the psychiatric setting will be practiced.

WEEKS 2 THROUGH 11:

student will be assigned to one client per week for every week of the quarter. In some cases, students will be able to follow a client for more than one week or less than one week, if unexpected discharge occurs. In that event, the student will be assigned a new client. The student must follow the nursing process each week with his or her client

by completing a Biopsychosocial Assessment Form, writing three nursing diagnosis with appropriate goals and interventions and narrative evaluation statements. All of the following clinical objectives with relevant clinical experience and behaviors will be expected of the student every clinical week throughout the quarter:

Clinical Objectives

1.1 Employ legal-ethical-managerial practices that protect client confidentiality and other client rights at all times.

Clinical experience

1. Students will leave all hospital or computer-generated paperwork at the clinical site. Only client initials and student notes and psychosocial assessment form will leave the clinical site.

2. All client assessments regardless of setting (hospital or community) will not contain any identifying information about the client, e.g., occupation will be stated as "engineer", not "engineer at Lockheed".

3. Students will not discuss clients (even if client names are not mentioned) off the assigned unit, e.g., in elevators, the cafeteria, hallways, etc.

4. Students are prohibited from any social contact with clients outside of assigned areas or following discharge of the client or following the student's completion of this course, including after graduation from De Anza College.

5. Students will maintain client rights and will report any suspicion of violation of client's rights to the instructor, responsible nurse and charge nurse.

6. Students will facilitate management of the unit by working towards timely participation in activities and assisting clients to attend scheduled activities on time.

7. Students will not discuss in individual clients or individual situations at home with their families or friends or with other students or staff/faculty at De Anza College. Only the clinical instructor directly involved with the course is at liberty to discuss individual clients or settings with students. Case examples discussed in class will be done in a way to protect the person's identity.

8. Students will report any information pointing to abuse of a client from any source (e.g., parent, spouse, co-worker, etc.) to the responsible nurse and to the instructor.

9. Students will recognize and show respect for the knowledge and expertise of other members of the treatment team.

1.2 Demonstrate awareness of and respect for the client's emotional, physical and psychological safety and well-being at all times.

Clinical experience

1. Use of communication that does not "break" denial.

2 Allowing the client to reveal information as he is ready to do so at his own pace.

3. Focusing time together on client's situation not on the student's

4. Awareness that everything done in the clinical setting should be for the benefit of the client and for no other reason.

5. Know client's level of suicide risk and follow suicide precautions as well as escape precautions.

6. Take responsibility for all clients on a unit in terms of observing and reporting behaviors that are potentially harmful or detrimental to the client or to anyone on the units.

7. Showing respect for the clients at all times by not behaving in ways that could be construed by clients as talking about the client in a judgmental way or laughing at the client.

8. Conducting self in a professional manner that instills trust by clients. This includes not slouching in chairs or dozing off during group meetings or leaving group meetings until the meeting is clearly over (unless for the purpose of assisting a client who must leave the group and as directed by the group leader).

9. Concentrating on the unit activities at all times instead of reading magazines or newspapers except on official breaks and not in the presence of clients.

10. Lying down to rest anywhere in the clinical setting is unacceptable behavior. Students must notify the instructor immediately if any fatigue or illness necessitates lying down.

11. Keeping walkways and passage ways clear by not standing alone or with others in a manner that blocks flow of movement of others throughout the unit and nursing station area.

12. Conducting self as an "individual" on the unit rather than as part of a class; do not group together or cluster together (even with one other student)

during the clinical day; do not sit next to another student during groups or meetings that include clients

13. Refraining from carrying clipboards around unit during one-on-one time or in meetings unless for specific purposes such as v/s or checks of client's whereabouts.

1.3. Critique own personal reactions and feelings encountered in the clinical setting.

Clinical experience

1. During clinical conference and with instructor or other clinical staff, share own personal reactions that may have potential to elicit nontherapeutic responses if not acknowledged and recognized and understood and in some cases, altered.

2. Give feedback to others as they relate personal responses in terms of potential for affecting client care (during clinical conference sessions).

Clinical Objectives:

2.1 Collect accurate, descriptive and comprehensive data regarding the individual's universal, developmental and health-deviation self-care requisites.

Clinical experience

1. Completion of an Orem psychosocial form for each client assigned, using descriptive and precise words; avoid qualitative data in favor of quantitative data.

2. Carry out psychosocial assessment on the first day of working with the client.

2.2 Critique assessment data base of assigned clients during clinical conference sessions and with clinical instructor and clinical staff.

Clinical experience

1. Showing willingness to discuss own client assessment and to listen attentively to others describe their clients; no writing or doing individual work during clinical conference.

2. Giving and receiving feedback from peers and instructor in clinical conference.

3. Verify client assessment data with clinical staff.

Clinical Objectives:

3.1 Calculate self-care deficits from a list of pertinent assessment data for assigned clients.

Clinical experience

1. Examination of assessed data for unmet needs.

2. Listing and categorizing problems (unmet needs) on the assess form.

3.2 Choose nursing diagnoses that are based upon the calculated self-care deficits.

Clinical experience

1. Formulating lists of problems into the nursing diagnosis terminology

3.3 Appraise choice of nursing diagnoses during clinical conferences.

Clinical experience

1. Demonstrating willingness to discuss own nursing diagnoses and those of others in clinical conference and with the instructor.

Clinical Objectives:

4.1 Apply knowledge of the client's specific self-care actions in tailoring relevant long and short-term goals.

Clinical experience

1. Writing appropriate goals for three nursing diagnoses that have been identified for each client assigned.

2. Writing at least three goals each during the quarter related to client teaching, psychopharmacology, nutrition, and communication.

3. Sharing goals and discussing goals with the treatment team, instructor and peers (during clinical conference).

4.2 Discuss desired outcomes in restoration of self-care capability with the client, the family and the interdisciplinary team members.

Clinical experience

1. Collaboration with the interdisciplinary team, client and family regarding achievement of short-term and long-term goals.

Clinical Objective:

5.1 Design a nursing system tailored to the self-care capability of specific clients.

Clinical experience

1. Developing a care plan for each assigned client.

2. Tailoring the interventions to the individual client.

3. Following through on interventions during the time allotted.

4. Communicating with the treatment team regarding interventions and follow through by staff.

5.2 Validate the nursing system with reference texts, clinical staff, clinical instructor and in clinical conference sessions.

Clinical experience

1. Using all clinical resources to verify interventions.

2. Actually carrying out the interventions within the opportunities available, including contacting resources outside the immediate treatment team, e.g., the registered dietician, pharmacist, chemical dependency services, etc., as appropriate and as approved by the responsible nurse and instructor.

Clinical Objectives:

6.1 Judge the sufficiency and efficiency of self-care and make or recommend adjustments in the nursing system.

Clinical experience

1. Write narrative, descriptive observations of client and client's comments as well as family comments to document progress toward the goals.

6.2 Predict future deficit relationships on the basis of anticipated decreases in self-care capability or increase in therapeutic self-care demand or both.

Clinical experience

1. Anticipate the client's home situation and whether the client's current capability is adequate to the changing environment.

2. Anticipate the client's self-care capability and whether self-care ability will decrease due to course of illness, medication, or increasing stress or other factors.

6.3 Illustrate the collaborative role of the nurse by initiating and responding to contacts with the interdisciplinary team and with the family in evaluating the client's self-care capability.

Clinical experience

1. Collaborating with the interdisciplinary team, e.g.., psychiatric social workers, occupational therapist, art therapist, in evaluating the achievement of goals and the need for further intervention.

STUDENT EXPECTATIONS:

General

Students are to be familiar with the published guidelines for performance and dress in the clinical area and abide by the guidelines at all times. Additional behaviors for Psychiatric/Mental Health Nursing outlined in course objectives are to be adhered to as well.

2. Students are to read assigned material and be prepared for all classroom and clinical sessions. Assignments for classroom and clinical sessions for this course are included.

3. Students are expected to demonstrate retention of previously learned objectives and incorporate theory principles in all interactions.

4. Students are expected to transfer theory from required courses in the natural and behavioral sciences as well as speech and English into the applied science of nursing.

5. Students are responsible to initiate a conference with the instructor to determine "make-up" experiences for absences. Refer to green sheet for specific absence policy.

Clinical

Students must notify the clinical setting at least 30 minutes before the time the clinical experience is scheduled to start of any absence and a message is to be left for the instructor. In addition students are to contact the instructor and the director of the nursing program if an extended absence is predicted.

2. Lateness to any clinical experience is not allowed, and students are expected to remain in the clinical area the fully scheduled time each clinical day.

NURSING CARE PLAN:

The expanded format of the Nursing Care Plan has been developed by the nursing faculty to assist the student in applying the Nursing Process. It can also be used to assist the student to integrate Orem's model of self-care.

CLINICAL EVALUATION:

The clinical evaluation for this course has been designed to measure each clinical behavior that is expected of the student. An evaluation will be completed three times during the quarter; the student is expected to take an active part in the process. Clinical performance, based on the clinical evaluation, is determined to be satisfactory or unsatisfactory. At anytime the instructor deems the student's performance unsatisfactory, the instructor will prepare and discuss with the student a Plan for Clinical Improvement (PCI); this agreement will include goals and a time-line of achievement. "Critical element" describes behavior or performance that the faculty considers essential to safe and effective nursing care. Satisfactory completion is required of the critical elements. The student cannot take the final theory examination until satisfactory clinical performance has been demonstrated and evaluated. Failure to meet the clinical objectives will result in no credit in the clinical portion of the course or the theory portion.

REFERENCES:

A. A.Schultz and Videbeck, Manual of Psychiatric Nursing Care Plans, 5th (or current) edition, J.B. Lippincott, Philadelphia 1998
B. Barry, Patricia D. Psychosocial Nursing Care of the Physically Ill Person, 3rd (or current) edition, J.B. Lippincott, Philadelphia 1996
C. Lewis, Heitkemper, Dirksen, Medical Surgical Nursing Assessment and Management of Clinical Problems, 5th (or current) edition, Mosby, 2000
D. Potter and Perry, Basic Nursing, A Critical Thinking Approach, 4th (or current) edition, Mosby 1999
E. Curren, Munday, Math for Meds, Dosage and Solutions, 7th (or current) edition, W.I. Publications, Inc. 1995
F. Ackley and Ladwig, Nursing Diagnosis Handbook, A Guide to Planning Care, 3rd (or current) edition, Mosby, 1997
G. Lipson, Dibble, & Minarik, Culture and Nursing Care, 3rd ed., University of California Nurse Press, San Francisco 1998
H. Course syllabus
I. De Anza College, Department of Nursing, Student Handbook, Current Edition

To be revised in Fall 2012.

Role of Nursing Students in Claire's OT Groups

First, I really appreciate your help in my groups! Some OT groups we have here are: Task (Crafts), Expressive Arts, Stress Management, Sensory Modulation, Movement, & more. That being said, here are some things to keep in mind:

We have different types of OT groups here, & your role may be different in each type of group or on either side of the unit. The main point is to introduce yourself to me, & let me know a few minutes ahead of time if you are interested in helping out with group. I'll let you know at that point what I anticipate needing from you for that particular group. Also, each therapist may run their group a little differently, so just check in with them ahead of time.

In some groups, I may have to limit the number of nursing students attending, due to ratio of pts:nursing students, acuity, etc. For example, in one of my PICU Expressive Arts Group that has only one space at the table, then I may only be able to take one nursing student, as, in this type of group, relaxation/silence/introspection are highlighted. Also, pts may feel uncomfortable with students just standing & observing them, hovering, etc. Typically, I can accommodate 2 students for PICU Expressive Arts. However, for PACU Expressive Arts, there is rarely any space at the table. In this case, you are welcome to help set-up & clean up yet you may have to sit on the seats on the periphery, not table, to simply observe.

As an OT, I use even mundane things, such as passing around materials in group, as an opportunity to observe and assess patients' attention, organization, sequencing, memory, etc. So, I ask that you not jump in to grab materials and hand them out to everyone unless I have asked you to do that. I will definitely sometimes ask you for help in setting up before a group like Expressive Arts (ex: cups of water for painting), but, during group, I usually say, "I'm going to pass around this box of Sharpies. Take one & pass it on". Here's what I ask:

1) During group, relax, observe, & wait quietly for me to ask for your help in getting/passing materials, assisting patients, etc.
2) Often, I will ask you to join in working on the project. This helps model desired behavior for the patients, especially in PICU.
3) Let me direct the conversation, if appropriate in group. In some groups, such as PICU Task or Expressive Arts, I may want it very quiet at first so irritable or anxious patients can focus & relax. In other groups, especially in PACU Task, I may want to draw out depressive patients more. If informal conversation is in order, you can certainly join in as long as you include everyone (ie, not just talk to another student; this happened in one of my groups recently!).
4) If you want to ask me a question about a pt, please wait until after the group. I had a student ask me about a pt in front of another one, & it would have been inappropriate/confidential information if I had answered.

Basically, there are no hard & fast rules for what will happen in particular groups. It is always a judgment call on my part for what kind of atmosphere I want to create in group, so just relax & wait for me to direct you. Again, great to have you all in group & looking forward to working with you soon.

QUICK REFERENCE TO PSYCHOTROPIC MEDICATIONS®

DEVELOPED BY JOHN PRESTON, PSY.D., ABPP

To the best of our knowledge recommended doses and side effects listed below are accurate. However, this is meant as a general reference only, and should not serve as a guideline for prescribing of medications. Please check the manufacturer's product information sheet or the P.D.R. for any changes in dosage schedule or contraindications. (Brand names are registered trademarks.)

ANTIDEPRESSANTS

NAMES		Usual Daily Dosage			Selective Action On Neurotransmitters[2]		
Generic	Brand	Range	Sedation	ACH[1]	NE	5-HT	DA
imipramine	Tofranil	150-300 mg	mid	mid	++	+++	0
desipramine	Norpramin	150-300 mg	low	low	+++++	0	0
amitriptyline	Elavil	150-300 mg	high	high	++	++++	0
nortriptyline	Aventyl, Pamelor	75-125 mg	mid	mid	+++	++	0
protriptyline	Vivactil	15-40 mg	mid	mid	++++	+	0
trimipramine	Surmontil[3]	100-300 mg	high	mid	++	++	0
doxepin	Sinequan, Adapin[3]	150-300 mg	high	mid	++	+++	0
clomipramine	Anafranil	150-250 mg	high	high	0	+++++	0
maprotiline	Ludiomil	150-225 mg	high	mid	+++++	0	0
amoxapine	Asendin	150-400 mg	mid	low	+++	++	0
trazodone	Desyrel	150-400 mg	mid	none	0	++++	0
nefazodone	Generic Only	100-300 mg	mid	none	0	+++	0
fluoxetine	Prozac[4], Sarafem	20-80 mg	low	none	0	+++++	0
bupropion-X.L.	Wellbutrin-X.L.[4]	150-400 mg	low	none	++	0	++
sertraline	Zoloft	50-200 mg	low	none	0	+++++	+
paroxetine	Paxil	20-50 mg	low	low	+	+++++	0
venlafaxine-X.R.	Effexor-X.R.[4]	75-350 mg	low	none	++	+++	+
desvenlafaxine	Pristiq	50-400 mg	low	none	++	+++	+
fluvoxamine	Luvox	50-300 mg	low	low	0	+++++	0
mirtazapine	Remeron	15-45 mg	mid	mid	+++	+++	0
citalopram	Celexa	10-60 mg	low	none	0	+++++	0
escitalopram	Lexapro	5-20 mg	low	none	0	+++++	0
duloxetine	Cymbalta	20-80 mg	low	none	++++	++++	0
vilazodone	Viibryd	10-40 mg	low	low	0	+++++	0
atomoxetine	Strattera	60-120 mg	low	low	+++++	0	0
MAO INHIBITORS							
phenelzine	Nardil	30-90 mg	low	none	+++	+++	+++
tranylcypromine	Parnate	20-60 mg	low	none	+++	+++	+++
selegiline	Emsam (patch)	6-12 mg	low	none	+++	+++	+++

[1]ACH: Anticholinergic Side Effects
[2]NE: Norepinephrine, 5-HT: Serotonin, DA: Dopamine (0 = no effect, + = minimal effect, +++ = moderate effect, +++++ = high effect)
[3]Uncertain, but likely effects
[4]Available in standard formulation and time release (XR, XL or CR). Prozac available in 90mg time released/weekly formulation

BIPOLAR DISORDER MEDICATIONS

NAMES		Daily	Serum[1]
Generic	Brand	Dosage Range	Level
lithium carbonate	Eskalith, Lithonate	600-2400	0.6-1.5
olanzapine/ fluoxetine	Symbyax	6/25-12/50mg[4]	2
carbamazepine	Tegretol,Equetro	600-1600	4-10+
oxcarbazepine	Trileptal	1200-2400	(2)

NAMES			Daily	Serum[1]
Generic	Brand	Dosage	Range	Level
divalproex	Depakote		750-1500	50-100
lamotrigine	Lamictal		50-500	(2)
topiramate	Topamax		50-300	(3)
tiagabine	Gabitril		4-12	(3)

[1]Lithium levels are expressed in mEq/l, carbamazepine and valproic acid levels express in mcg/ml.
[2]Serum monitoring may not necessary [3]Not yet established [4]Available in: 6/25, 6/50, 12/25, and 12/50mg formulations

ANTI-OBSESSIONAL

NAMES		
Generic	Brand	Dose Range[1]
clomipramine	Anafranil	150-300 mg
fluoxetine	Prozac[1]	20-80 mg
sertraline	Zoloft[1]	50-200 mg
paroxetine	Paxil[1]	20-60 mg
fluvoxamine	Luvox[1]	50-300 mg
citalopram	Celexa[1]	10-60 mg
escitalopram	Lexapro[1]	5-30 mg

[1]often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.

PSYCHO-STIMULANTS

NAMES		
Generic	Brand	Daily Dosage[1]
methylphenidate	Ritalin	5-50 mg
methylphenidate	Concerta[2]	18-54 mg
methylphenidate	Metadate	5-40 mg
methylphenidate	Methylin	10-60 mg
methylphenidate	Daytrana (patch)	15-30 mg
dexmethylphenidate	Focalin	5-40 mg
dextroamphetamine	Dexedrine	5-40 mg
lisdexamphetamine	Vyvanse	30-70 mg
d- and l-amphetamine	Adderall	5-40 mg
modafinil	Provigil, Sparlon	100-400 mg

[1]Note: Adult Doses. [2]Sustained release

ANTIPSYCHOTICS

NAMES Generic	Brand	Dosage Range[1]	Sedation	Ortho[2]	EPS[3]	ACH Effects[4]	Equivalence[5]
LOW POTENCY							
chlorpromazine	Thorazine	50-800 mg	high	high	++	++++	100 mg
thioridazine	Mellaril	150-800 mg	high	high	+	+++++	100 mg
clozapine	Clozaril	300-900 mg	high	high	0	+++++	50 mg
mesoridazine	Serentil	50-500 mg	high	mid	+	+++++	50 mg
quetiapine	Seroquel	150-600 mg	mid	mid	+/0	+	50 mg
HIGH POTENCY							
molindone	Moban	20-225 mg	low	mid	+++	+++	10 mg
perphenazine	Trilafon	8-60 mg	mid	mid	++++	++	10 mg
loxapine	Loxitane	50-250 mg	low	mid	+++	++	10 mg
trifluoperazine	Stelazine	2-40 mg	low	mid	++++	++	5 mg
fluphenazine	Prolixin[5]	3-45 mg	low	mid	+++++	++	2 mg
thiothixene	Navane	10-60 mg	low	mid	++++	++	5 mg
haloperidol	Haldol[5]	2-40 mg	low	low	+++++	+	2 mg
pimozide	Orap	1-10 mg	low	low	+++++	+	1-2 mg
risperidone	Risperdal	4-16 mg	low	mid	+	+	1-2 mg
paliperidone	Invega	3-12 mg	low	mid	+	+	1-2 mg
olanzapine	Zyprexa	5-20 mg	mid	low	+/0	+	1-2 mg
ziprasidone	Geodon	60-160 mg	low	mid	+/0	++	10 mg
iloperidone	Fanapt	12-24 mg	mid	mid	+	++	1-2 mg
asenapine	Saphris	10-20 mg	low	low	+	+	1-2 mg
lurasidone	Latuda	40-80 mg	mid	mid	+	+	10 mg
aripiprazole	Abilify	15-30mg	low	low	+	+	2 mg

[1]Usual daily oral dosage
[2]Orthostatic Hypotension Dizziness and falls
[3]Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
[4]Anticholinergic Side Effects.
[5]Dose required to achieve efficacy of 100 mg chlorpromazine.
[6]Available in time-release IM format.

ANTI-ANXIETY

NAMES Generic	Brand	Single Dose Dosage Range	Equivalence[1]
BENZODIAZEPINES			
diazepam	Valium	2-10 mg	5 mg
chlordiazepoxide	Librium	10-50 mg	25 mg
prazepam	Centrax	5-30 mg	10 mg
clorazepate	Tranxene	3.75-15 mg	10 mg
clonazepam	Klonopin	0.5-2.0 mg	0.25 mg
lorazepam	Ativan	0.5-2.0 mg	1 mg
alprazolam	Xanax, XR	0.25-2.0 mg	0.5 mg
oxazepam	Serax	10-30 mg	15 mg
OTHER ANTIANXIETY AGENTS			
buspirone	BuSpar	5-20 mg	
gabapentin	Neurontin	200-600 mg	
hydroxyzine	Atarax, Vistaril	10-50 mg	
propranolol	Inderal	10-80 mg	
atenolol	Tenormin	25-100 mg	
guanfacine	Tenex	0.5-3 mg	
clonidine	Catapres	0.1-0.3 mg	
prazosin	Minipress	5-20 mg	

[1]Doses required to achieve efficacy of 5 mg of diazepam

HYPNOTICS

NAMES Generic	Brand	Single Dose Dosage Range
flurazepam	Dalmane	15-30 mg
temazepam	Restoril	15-30 mg
triazolam	Halcion	0.25-0.5 mg
estazolam	ProSom	1.0-2.0 mg
quazepam	Doral	7.5-15 mg
zolpidem	Ambien	5-10 mg
zaleplon	Sonata	5-10 mg
eszopiclone	Lunesta	1-3 mg
ramelteon	Rozerem	4-16 mg
diphenhydramine	Benadryl	25-100 mg

OVER THE COUNTER

Name	Daily Dose
St. John's Wort[1, 2]	600-1800 mg
SAM-e[3]	400-1600 mg
Omega-3[4]-EPA	1-2 g

[1]Treats depression and anxiety
[2]May cause significant drug-drug interactions
[3]Treats depression
[4]Treats depression and bipolar disorder

REFERENCES and RECOMMENDED BOOKS

Quick Reference • Free Downloads
Website: www.PsyD-fx.com

Handbook of Clinical Psychopharmacology For Therapists (2010) Preston, O'Neal and Talaga

Clinical Psychopharmacology Made Ridiculously Simple 6th Edition (2011) Preston and Johnson

Consumer's Guide to Psychiatric Drugs (2009) Preston, O'Neal, Talaga

Child and Adolescent Psychopharmacology Made Simple (2010) Preston, O'Neal, Talaga

Assignments Fall 2013

Section I & II are located in the Theory Syllabus –

III: Assignments for Nsg 85AL (Clinical)

Weekly clinical work is required including the last week of clinical. Clinical work consists of the following:

First day of Patient Assignment: Assess your patient(s) according to the "Daily Prep Sheet" (this is acutally a multiple page form) located in the assessment. This is a complete Orem assessment to include universal, developmental and health deviation self-care requisites.

Second day of Patient Assignment: Arrive at clinical with two nsg dx based on your patient assessment with goals and interventions. Carry out the interventions and at the end of the day write a **narrative evaluation note** for each dx. Ask if you do not know what a narrative note is.

Subsequent Weeks:

If you keep the same patient the following week, use your assessment from the week before and update it as needed. Add a new nsg dix the first day of the week (prepare ahead of time if you know you will have the same pt(s) and be ready with your new dx, goals and interventions. On Wed. of each week write a narrative evaluation note for **all nsg dx's.** For example, keeping the same patient, by Wed. of Week two you will have 3 nsg notes to write (for the 2 nsg dx the first week, and the 3rd nsg dx the second week). Each week add one additonal nsg dx. If you keep the same patient for five weeks, you should have six nsg dx by week five and you will need to write six evaluation notes on Wed. of Week Five, seven if you are 2nd 6 wks.

If you get a new patient each week you will assess the first day and write two nsg dx with goals and interventions, the second day,carry out the interventions and write the two evaluation notes at the end of the day.

Other Required Clinical Work:

1. One Critical Thinking Worksheet: Due by Week 4. Earlier is better if you will be asked to "redo" anything.
2. "Clinical Conference Planning Form": Due weekly to Clinical Instructor for Weeks 2,3,4, 5 (and 6 for six week clinicals). Form is located in the Workbook.

Note: The Instructor will check your work daily or weekly during clinical hours, and give you feedback. At times, your work may be collected by the Instructor for detailed review, and returned to you the next clinical day. Also be aware that based on variations on when the student will have an assigned patient the sequence of assessment and care plan may vary, e.g. the student may need to assess/write nsg dx on a Wed. instead of a Tuesday. Work closely with your Instructor to be sure you are up to date on assessments and care plan/evaluations.

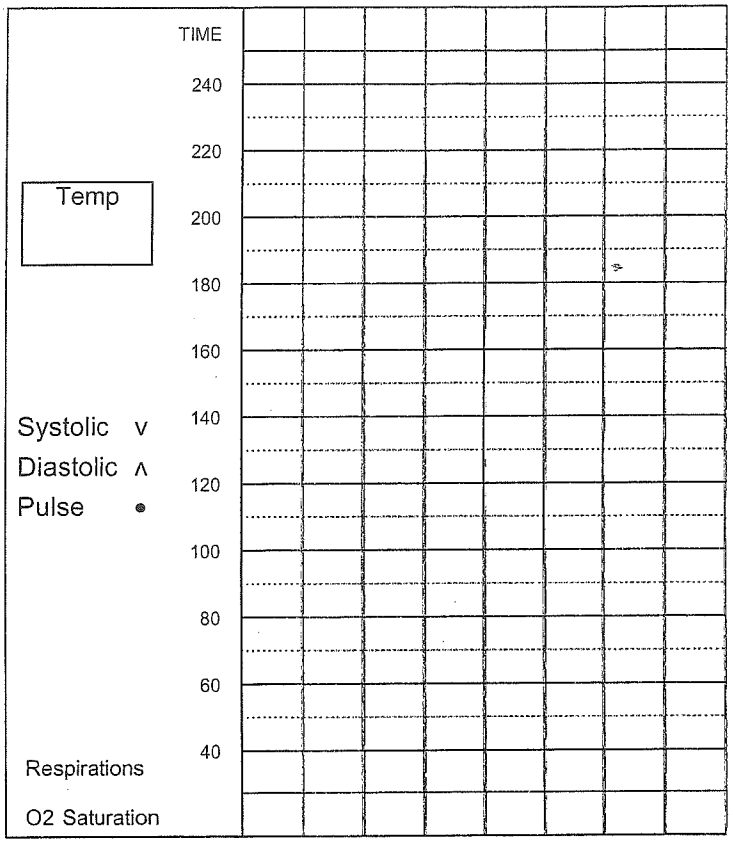
El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY
2500 Grant Road, Mountain View, CA 94040-4378

PATIENT LABEL

Post ECT Procedure Nursing Note

Time	Medication	Route	Initials

Time Arrived in Unit _____



Aldrete Score:	Time ▶ ADM	Dischg
Motor 2= Voluntarily moves 4 extremities 1= Voluntarily moves 2 extremities 0= Voluntarily moves 0 extremities		
Respiratory 2= Deep breathes & coughs freely 1= Dyspnea, limited breathing 0= Apnea		
O2 Saturation (Baseline) 2= O2 sat > 92% on Room Air 1= Needs O2 to maintain sat > 90% O= O2 sat < 90% on O2		
Circulation (Baseline) 2= BP within 20% pre-anesthetic level 1= BP within 20-50% pre-anesthetic level 0= BP > 50% pre-anesthetic level		
Consciousness 2= Fully awake 1= Arousable on calling 0= Not responding		
For A Total of 10.....		

IV Amount Given _____ Report To _____ Discharge Time _____

Comments _____

_____

RN Signature _____ Date _____ Time _____

Discharge Nursing Note Time Arrived On Unit _____ Time Discharged Home _____

Time _____ Temp _____ Pulse _____ Resp _____ BP _____ O_2Sat _____ Pain level _____

Time _____ Temp _____ Pulse _____ Resp _____ BP _____ O_2Sat _____ Pain level _____

Comments _____

_____

Discharge Instructions Given ☐

RN Signature _____ Date _____ Time _____

6801B

Required Cover Sheet

De Anza College
Nursing Student

Nursing Care Plan
Course: NURS 85AL

Instructor: _____

Name of Student: _____

Date(s) of Assignment: _____
(List each date every day you are assigned to this patient)

Required Cover Sheet

De Anza College
Nursing Student

Nursing Care Plan
Course: NURS 85AL

Instructor: _____

Name of Student: _____

Date(s) of Assignment: _____
(List each date every day you are assigned to this patient)

Student Name: _____ Date of Assessment: _____

N85AL: PSYCHOSOCIAL NURSING ASSESSMENT

Patient's Initials: _____ Age: _____ Gender: _____ Admission Date: _____

Reason for Admission: (include evidence of pts ability to seek and obtain Health Care:

_____

_____

Diagnosis DSM-IV-R:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: (CURRENT GAF)_____(HIGHEST GAF)_____

Patient's understanding of illness: (Health Deviation Self-Care Requisites)

1. Pts knowledge of dx and sx: _____

_____

2. Pts knowledge of medications: _____

_____

3. Pts perceived role in managing illness: _____

_____

4. Pts adherence to prescribed trt: _____

_____

5. Pts ability to regulate discomforting side-effects of trt (knows side-effects/manages side-effects/knows when to call MD): _____

_____

6. Pts understanding/response of psychosocial changes (chronic illness vs acute illness): _____

_____

_____

7. Family's understanding/response to psychosocial changes:_____

_____

8: Pts integration of spiritual and cultural beliefs: _____

_____

N85AL: DEVELOPMENTAL SELF-CARE REQUISITES

(Think Erikson)

1. Where does pt live and with whom: (Barriers: e.g. stairs, access to BR, laundry or cooking facilities)

2. Home/facility responsibilities:

3. Significant others (immediate): (e.g. How are relationships? Does family live nearby? Do children visit? Frequency of contact?

4. Social support system (extended):

5. Church, friends, community groups (protective factors):

6. Recent losses or crises:

7. Occupation:

8. Ethnic Background:

9. Education:

10. Spiritual/Religious:

11. Leisure Activities/Hobbies:

Medications				
Medication / Dosage / Frequency / Route	**Specific Type of Medication** (Include drug classification)	**Action** (How does this medication work?)	**Why is <u>your patient</u> taking this medication?**	**Significant things you need to do or watch for on <u>your patient</u> with this medication. Include specific side effects & nursing implications**

N85AL: UNIVERSAL SELF-CARE REQUISITES

AIR: Hx: _____ _____ _____ Smoking Hx: _____ _____	**Medications:** _____ _____ _____ _____ _____	Respiratory Rate: _____ Pattern: _____ Quality: _____ Cough: _____ Deep breathing: _____ Lung Sounds: _____ O2: _____
WATER: Hx: _____ _____ _____ _____ _____	**Medications:** _____ _____ _____ _____ _____	BP: _____ Pulses: _____HR:_____ Quality: _____ Skin Color: _____ I&O/ 24hr_____ Urine color/quality: _____ Skin turgor: _____ Edema: _____ MM:_____
FOOD/ELIMINATION: **Hx:**_____ _____ _____ _____ _____	**Medications:** _____ _____ _____ _____ _____	Diet: _____ % Meals Eaten: _____ Wgt:_____ Hgt:_____ IBW: _____ BS: _____BM's:_____ Abd. Quality: _____

N85AL: UNIVERSAL SELF-CARE REQUISITES

ACTIVITY/ REST: Hx: _____ _____ _____ _____ _____	**Medications:** _____ _____ _____ _____ _____	Sleep: _____ Hours/night: _____ Naps: _____ ROM/Strength: _____ Wgt bear? _____ Gait steady: _____ Assistive device: _____ ADL/Activity Level: _____
PREVENTION OF HAZARDS: Hx: _____ _____ _____ _____ _____	**Medications:** _____ _____ _____ _____ _____	Temp: _____ Pain: _____ **Danger to self:** (suicidality, cutting): Skin Check: _____ Wounds: _____ **Danger to others:** (assaultive): _____ **Gravely Disabled:** (Impaired thought, unable to care for self): _____ Substance Use: _____ AMA/AWOL): _____
SOLITUDE & SOCIAL INTERACTION: Hx: _____ _____ _____ _____ _____	**Medications:** _____ _____ _____ _____ _____	General Comments: _____ Leisure time activities: _____ _____ _____

N85AL: MENTAL STATUS

Level of awareness and orientation: _____

_____

Appearance and behavior (hygiene, combative, cooperative, eye contact, restlessness, akathesia, motivation): _____

_____

Speech and communication (clear, slurred, appropriate, aphasic/type): _____

_____

Affect and mood (congruent?): _____

_____

Thinking process (logical, circumstantial, tangential, loose associations, word salad, delusional):

_____

_____

Perception (hallucinations): _____

_____

Abstract thinking: (proverbs/related items): _____

_____

Social judgment: _____

_____

Memory (short term/long term/immediate): _____

_____

Normalcy: (what does the pt do to stay healthy? What are pts coping mechanisms? (see next page)

(continued)
Normalcy: _____

_____

Problem List:

Look over your assessment and list all of the problems you can find. Use everyday terms, such as "no appetite," "has lost 10 pounds in the last two weeks," "feels hopeless," "unable to return to home," " going through a divorce," " recent widow," " laid off from work," " dropped out of school due to illness," " has thoughts of driving car into a tree," " paralysis of left arm," " aphasic," " sleep disturbance," " poor judgment," " short-term memory loss," etc.

Then look over your problems and see which ones go together and might form a nursing diagnosis. For example, "no appetite," and " has lost 10 pounds in the last two weeks," and knowledge of height and weight loss/low weight would point to the nursing diagnosis of, "Alteration in Nutrition less than body requirements."

Feels hopeless," and "has thoughts of driving car into tree," would establish a nursing diagnosis of, "Risk for Self Directed violence."

Be sure to use everyday words for your problem list (not nursing diagnosis terms).

List of problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Ide 1

Add a new Nsg Dx each Week = same pt.

Documented Client Care Plan

Name: Date of Care: Clinical Site:	**Documented Key:**
Pertinent Assessment Data:	

Nursing Diagnosis Universal = U Developmental = D Health Deviation = H	Client Goal Short Term = ST Long Term = LT	Nursing Interventions Wholly Compansatory = WC Partially Compansatory = PC Supportive Educative = SE	Rationale & Documentation	Evaluation & Modification Week: Date:
NANDA: R/T: AWBEB:	ST: LT:			

Continue Evaluation ——→ over

IDE 2

Nursing Diagnosis

Weekly NANDA

Evaluation

Date:	Date:	Date:	Date:	Date:

Joint Commission
National Patient Safety Goals: *2009*
New Ones and Some Old Favorites

The Joint Commission considers patient safety of the highest importance.
All staff must know (and follow) these goals and what El Camino Hospital is doing to comply.

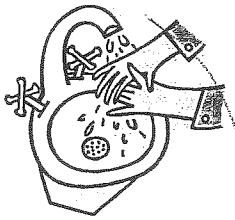
Identify / Verify

1. Use at least ***two*** patient identifiers when administering meds, blood products, taking samples or performing procedure/treatment. Patient armband must be compared to information in ECHO or chart (for out-patients).
   a. **Inpatients:** Name and Medical Record number
   b. **Outpatients:** First & Last Name and Birth date
2. Label specimens collected at the bedside ***before*** leaving the patient's room.
3. Label all medications / containers on and off the sterile field.
4. Conduct a ***"time out"*** to confirm the correct patient, procedure, and site using active communication techniques. All members of the team must participate.
   a. All departments must do a ***"time out"*** before any surgery / invasive procedure.
   b. Use the ***Boarding Pass***. Make sure it is filled out completely. Patient may not proceed to the Operating Room or procedure unless everything is complete.

Communicate

1. For verbal or telephone orders AND Critical Results (including ABG's & Radiology "panic values"), staff must ***write it down*** and ***"read back"*** the complete order or test result received.
   a. ***Document*** in ECHO that the "read back" was done for verbal / phone orders.
   b. ***Document*** in ECHO the "read back" was done for Critical Results. Use paper flowsheet if ECHO not available.
   c. ***Report*** Critical Results to physician with ***30 minutes***.
   d. ***Do Not Use*** any of the dangerous / eliminated abbreviations on the El Camino Hospital Do Not Use list in any area of the chart.
   e. ***Handoff*** patient information anytime a patient is transferred, sent to another department or anytime care is transferred to another caregiver. (change of shift, break). There must be an opportunity for questions to be asked.

Cleanse Hands even on behavioral health!



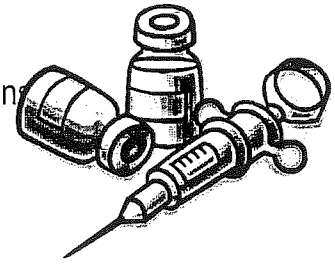
1. Hands must be cleansed ***upon entry*** to a patient's room and ***upon exit*** of the patient's room even if you are wearing gloves.
   a. Use alcohol based gel or soap and water. If soap and water is used, cleansing must continue for at least 15 seconds. Soap and water must be used with patients who have *C. diff.*
   b. Gloves do not replace hand cleansing and should only be worn when coming into contact with blood or body fluids.
   c. Do not touch objects outside the room of an isolation patient until removing gloves and cleansing hands *(i.e., keyboard, glucometer, etc.)*
   d. Do not re-use or wash gloves (unless they are EVS utility gloves, which may be re-used).
   e. Direct caregivers: Fingernails must be kept short and ***artificial fingernails are prohibited***.

Prevent Falls

1. ***Perform and document*** a Fall Risk Assessment when admitting an inpatient and each time med regimen has changed. Reassess at times of transfer or change in patient condition. Outpatients should have a risk assessment performed and documented at first visit and at intervals thereafter.
   a. ***Educate*** patients and families about Falls Program. ***Document*** that education was completed. Provide THUD Kits to patients in inpatient areas.

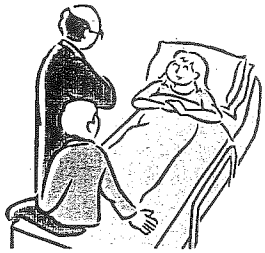
Administer Medication Safely / Reconcile Medications

1. Pay special attention to the ECH list of ***"Look-Alike, Sound-Alike"*** medications.
2. ***Double check*** the following types of medications with another nurse:
   a. Chemotherapy
   b. Insulin
   c. Anticoagulants
   d. PCA
   e. Epidural
3. ***Remember*** to release the roller clamp when giving piggyback medication.
4. Read alerts on infusion pump screens.
5. Always perform the ***"5 Rights":***



   - Right Patient
   - Right Med
   - Right Time
   - Right Dose
   - Right Route

6. For ***Medication Reconciliation*** across the continuum of care, gather all outpatient medication info from your patient upon admission or at each visit for outpatients. Include dosage, frequency and last time taken. Enter into ECHO / chart.
7. Take meds into room for only ***one patient at a time.***



Involve Patient and Family

1. Help patients (and their families) participate in the patient's care by telling them to:
   a. ***Ask questions*** such as, "What is my major problem? What do I need to do? Why is it important for me to do it?
   b. Ask caregivers if they have cleansed their hands.
   c. Ask if they have any questions or concerns or if they don't understand what is going on.
   d. Watch the video, "You Are a Part of Your Healthcare Team", available on TV in patient rooms.
   e. Read and use bedside cards that tell how to report concerns.
   f. Explain how to use ***Code HELP***.
   g. Educate patient / family on Fall Reduction Program / strategies.
   h. Encourage patient / family to report concerns about safety.
   i. Encourage patients to participate in Medication Reconciliation and Discharge Instructions.

Assess Safety Risks For A Given Population

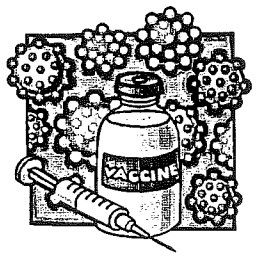
1. If patient has diagnosis of emotional / behavioral disorder, assess for suicide risk.

Reduce the Likelihood of Patient Harm Due to Use of Anticoagulant Therapy (NEW)

1. Pharmacy is developing a program.

Improve Recognition and Response to Changes in a Patient's Condition (NEW)

1. ECH has a Rapid Response Team that is accessible using Vocera.
2. Code HELP.



Subacute (2 East) – All of the Preceeding Plus:

1. Reduce risk of influenza and pneumococcal disease with vaccine program. ECH has implemented a vaccination program.
2. Prevent healthcare associated pressure ulcers. ECH has implemented an active prevention program.

Note Well! You are responsible for maintaining confidentiality.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

REQUIRED
To be turned in to Nursing Education prior to or on clinical start date.
Needed for each clinical rotation.

CONFIDENTIALITY STATEMENT (2.01)

As an El Camino Hospital employee, volunteer, student, intern, instructor, person employed through a registry/temporary agency or under contract services, or vendor or other observer, you have a legal and ethical responsibility to protect the privacy of patients and the confidentiality of their health information. All information that you see or hear regarding patients, directly or indirectly, is completely confidential and must not be discussed, viewed or released in any form, except when required in the performance of your duties.

A patient whose medical information has been unlawfully used or released may recover actual damages as well as punitive damages, plus attorney fees and court costs. Unauthorized disclosure of medical information is also criminally punishable as a misdemeanor. The mere acknowledgement that a patient is being treated, for psychiatric disorders, drug abuse, or alcohol abuse, may expose the hospital and the person making the unauthorized disclosure to substantial fines and liability.

If you are assigned a computer code that allows access to patient information, the code gives you access to confidential information that should only be used in caring for patients. Access codes are assigned based on the need to have information in order to carry out assigned responsibilities as determined by your manager.

All system passwords use a unique identification code that serves as a signature when entering the particular system. It is your responsibility to keep your passwords strictly confidential. Under no circumstances may you give your passwords to someone else.

If you have access to employee information, El Camino Hospital financial information or any other proprietary information, you are expected to treat the confidentiality of such information in the same manner as patient information.

Additionally, protection of confidentiality is required when transmitting sensitive data outside El Camino Hospital.

Refer requests for medical records to:	Health Information Management	650-940-7066
Refer media requests for information to:	Marketing and Community Relations	650-988-7767

Confidentiality of Patient Information

1. I understand that access to patient information may be required for me to do my job, and that I am only permitted to access patient information to the extent necessary for me to provide patient care and perform my duties. Therefore, I will treat all patient, physician, employee and hospital business information (e.g., medical, social, financial, and emotional) acquired during the course of my work as strictly confidential.

2. I understand that "confidential" means that patient information must not be revealed or discussed with other patients, friends, relatives, or anyone else outside of the El Camino Hospital health care environment. In other words, a patient's personal and medical information

can only be discussed in private with appropriate individuals who have a medical and/or business related need to know, whether on duty or off.

3. I will not release or disclose patient information, unless my job requires it, and then will disclose only minimum necessary patient information needed to carry out my responsibilities for El Camino Hospital. I will not disclose identifying information (e.g. name, date of birth, etc.) if the information can be removed and is not essential to the analysis. If I am not sure whether the information should be released, I will refer the request to the appropriate department (e.g. Health Information Management) or appropriate individual (e.g. Chief Privacy Officer or Compliance Officer).

4. I will appropriately dispose of patient information and reports in a manner that will prevent a breach of confidentiality. I will never discard confidential or patient identifiable information in the trash, unless it has been shredded or recycled.

5. I understand that I have a duty to protect El Camino Hospital patient information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to El Camino Hospital any breach of patient confidentiality.

6. I will access patient information only when needed in order to do my job, and understand that retrieving/viewing/printing or copying information (computerized or paper), on other patients such as friends, relatives, neighbors, celebrities, co-workers, or myself is a breach of confidentiality and may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

Confidentiality of Business Information

1. I understand that information regarding the business and operations of El Camino Hospital is confidential, and that such information is owned by and belongs to El Camino Hospital.

2. I understand that I am only authorized to access business information if it is required for me to perform my duties. This information must not be revealed or discussed with others within or outside of El Camino Hospital except to the extent that this discussion is necessary to perform my duties.

3. I understand that I have a duty to protect El Camino Hospital business information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to El Camino Hospital any breach of business information confidentiality.

4. I understand that failure to follow this agreement may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

Information System Security

1. I understand that El Camino Hospital's information systems are company property and are to be used only in accordance with the hospital's policies. I also understand that I may be given

access codes or passwords to El Camino Hospital information systems, and that I may use my access security codes or passwords only to perform my duties.

2. I acknowledge that I am strictly prohibited from disclosing my security codes or passwords to anyone, including my family, friends, fellow workers, supervisors, and subordinates for any reason. I will keep my security codes and passwords in confidence and will not disclose them to anyone (other than the System Security Administrator) for any reason.

3. I agree that I will not breach the security of the information systems by using someone else's security codes or passwords, nor will I attempt in any way to gain access to any unauthorized system. Also, I will not allow anyone else to access the information systems using my security codes or passwords.

4. If I leave my workstation for any reason, I will initiate security measures in accordance with hospital procedures so no unauthorized person may access patient or business information, or enter information under my security codes or passwords; I will make sure the system screen or paper record is not left open and unattended in areas where unauthorized people may view it.

5. I will not misuse or attempt to alter information systems in any way. I understand that inappropriate use of any information system is strictly prohibited. "Inappropriate use" includes:
   (a.) personal use which inhibits or interferes with the productivity of employees or others associated with El Camino Hospital, or which is intended for personal gain;
   (b.) transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission and values of El Camino Hospital;
   (c.) disclosure of confidential information to any individual, inside or outside the organization, who does not have a legitimate business-related need to know; and
   (d.) the unauthorized reproduction of information system software.

6. Only El Camino Hospital approved and officially licensed software may be added to El Camino Hospital systems.

7. I understand that I will be held accountable for all work performed or changes made to the systems or databases under my security codes, and that I am responsible for the accuracy of the information I put into the systems.

8. If my employment or association with El Camino Hospital ends, I will not access any El Camino Hospital information systems that I had access to and acknowledge that legal action may result if I do.

9. I understand that El Camino Hospital reserves the right to audit, investigate, monitor, access review and disclose information obtained through the organization's information systems at any time, with or without advance notice to me and with or without my knowledge.

10. I understand that I have a duty to protect El Camino Hospital information systems from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to El Camino Hospital any breach of information system security (for example, if the confidentiality of my or another's password has been broken) or any inappropriate use of information systems.

11. I understand that a violation of computer security or any component of this agreement is considered a violation of hospital policies, and may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

I will ask my supervisor for clarification if there are any items I do not understand before signing this agreement. My signature below acknowledges that I have read and understand this agreement and realize it is a condition of my employment/association with El Camino Hospital. I also acknowledge that I have received a copy of this signed agreement.

Signature:_____ Date:_____

Print Name:_____

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

REQUIRED
To be turned in to Nursing Education prior to or on clinical start date. Needed for each clinical rotation.

CLINICAL STUDENT ORIENTATION

Name (print) _____ Date _____ Student Phone Number _____
School _____ Instructor's Name _____ Clinical Area _____

The following list is to be read and signed by the clinical student. This form is to be completed prior to start of clinical, signed by an El Camino Hospital designee / instructor, and sent to the Nursing Education Department at PAR119, (c/o Cathy Patton).

Yes	N/A	**Emergency Management Codes:**
☐	☐	Dial "55" **to report all emergencies** such as fire, CPR, toxic spills, rapid response team, stroke alert. State your name, the type of emergency, location and number of injuries, if applicable.
☐	☐	**Code Blue**=Cardiac/respiratory arrest or Medical Emergency for Adult
☐	☐	**Code White-Neonatal**=Cardiac/respiratory arrest or Medical Emergency (28 days or less)
☐	☐	**Code White-Pediatric**=Cardiac/respiratory arrest or Medical Emergency (over 28 days)
☐	☐	**Code Red**=Fire, flames or visible smoke. If you discover fire, **RACE:** **R** Remove anyone in immediate danger; **A** Alarm. Pull nearest fire alarm box and Dial "55," state location; **C** Confine. Close all doors and windows; **E** Extinguish and/or Evacuate.
☐	☐	**Code Orange**=Hazardous materials spill/leak
☐	☐	**Code Triage**=Internal/external disaster, meaning high influx of patients or need for evacuation of extended area
☐	☐	**Code Gray**=Angry/violent patient or visitor
☐	☐	**Code Silver**=Person with a weapon/hostage situation
☐	☐	**Code Yellow**=Reported bomb threat
☐	☐	**Code Pink**=Infant Abduction (1 year or less)
☐	☐	**Code Purple**=Child Abduction (over 1 year)
☐	☐	Refer to emergency management flip guides posted on walls throughout the hospital and/or the Environment of Care Safety Program Policies available online.

Yes	N/A	**General Safety:**
☐	☐	Walk don't run.
☐	☐	Isolate all spills immediately and report to **Environmental Services, ext. 7317**
☐	☐	Familiarize yourself with emergency exits.
☐	☐	Return to assigned area in the event of an emergency unless unable to do so.
☐	☐	Close drawers and cabinets to prevent injury.
☐	☐	Store material in limited heights (below 5ft.) to prevent falling or collapsing.
☐	☐	Report unsafe conditions to supervisor.
☐	☐	The use of illegal drugs or alcohol on the hospital premises is prohibited.
☐	☐	Working while impaired through the use of intoxicating substances is prohibited.
☐	☐	Follow your department's policy regarding low-heeled, closed-toe, nonskid shoes.
☐	☐	Obey directional signs used by Environmental Services when floors/carpets/stairs are being cleaned.
☐	☐	Cords and wires should be positioned in a manner to preclude tripping and obstruction of traffic.

Yes	N/A	**Fire Safety:**
☐	☐	El Camino is a "non-smoking" hospital.
☐	☐	Do not use elevators during a fire or earthquake.
☐	☐	Store flammable substances in nonflammable storage cabinets.
☐	☐	Keep aisles and passageways clear for emergency access or evacuation.
☐	☐	All storage must be at least 18 inches below fire sprinkler heads
☐	☐	Keep fire extinguishers and hoses clear at all times.

Yes	N/A	**Electrical Safety:**
☐	☐	Review and follow manufacturer's policies for equipment safety features.
☐	☐	Make sure all electrical equipment is grounded and a green dot hospital grade plug is used.
☐	☐	Do not use any appliances or machinery while touching metal or anything wet.
☐	☐	Use of adapter plug is not permitted.
☐	☐	Use of extension cord is not permitted, except in emergency.
☐	☐	Report all frayed wires, cracked plugs, or inoperative equipment to **Clinical Engineering, ext. 7314**.
☐	☐	Remove defective or inoperative equipment from service and separate it from other equipment. Attach a note to equipment explaining the problem.

Yes	N/A	**Body Mechanics:**
☐	☐	Do not lift patients manually. Use transfer belts and/or lift equipment when moving patients up in bed, to or from gurney or wheelchair, to walk, or to use bathroom.
☐	☐	Bend knees and use leg muscles to lift heavy objects.
☐	☐	Keep back straight.
☐	☐	Maintain wide stance: turn your whole body, don't twist.
☐	☐	Lift load close to body and carry load close to body.
☐	☐	Seek assistance if an object/patient will be too heavy for you to safely move by yourself.

Yes	N/A	**Department-Specific Safety:**
☐	☐	See the department specific "Emergency Preparedness" section in the Safety Binder located on the unit on which you will be on.

Yes	N/A	**Hazardous Materials Safety:**
☐	☐	Know what hazardous chemicals are in your work area.
☐	☐	Review Material Safety Data Sheets (MSDS) located in the MSDS Pro online system accessible through the "ECH Toolbox."
☐	☐	Know methods of detecting hazardous chemicals in your work area.
☐	☐	Use proper protective equipment (gloves, aprons, and eye protection) when handling hazardous materials.
☐	☐	Use only chemicals from containers that are labeled.
☐	☐	Report containers missing labels to your supervisor.
☐	☐	Medical gas cylinders must be properly secured when transported and stored (chained to wall or carts, in designated storage racks).
☐	☐	A maximum of 12 oxygen cylinders can be stored in one area at any time.
☐	☐	Do not carry oxygen; use a cart

Yes	N/A	**Infection Control:**
☐	☐	Follow Standard Precautions protocols.
☐	☐	Cleanse your hands before and after patient contact, after removing gloves, after using the restroom, after handling money or food.
☐	☐	Use anti-microbial hand gel/foam whenever possible.
☐	☐	Use soap and water for 15 seconds when hands are visibly soiled, after contact with patients with C. Diff., and after using the restroom.
☐	☐	Find out about safety-engineered devices used in your department (IV catheters, needles, scalpels, etc.).
☐	☐	Always engage safety devices immediately after use.
☐	☐	Don't recap or break needles/sharps.
☐	☐	Dispose of needles/sharps in puncture-resistant containers. Notify **Environmental Services, ext. 7317** to exchange containers when 2/3 full.
☐	☐	Use red bags to dispose of blood/body fluid contaminated items.
☐	☐	Locate protective equipment (i.e., gloves, gowns, masks and goggles) in your area.
☐	☐	Wear gloves and appropriate barrier attire when coming in contact with blood and body fluids.
☐	☐	Utilize resuscitation bags to minimize need for mouth to mouth.
☐	☐	Do not wear gloves or yellow gowns out into the hall.
☐	☐	Follow hospital procedures for disposing of pharmaceutical waste.

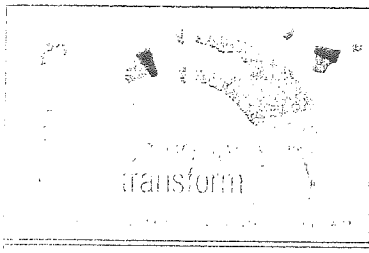
Yes	N/A	**Patient Safety:**
☐	☐	Check arm bands prior to administration of patient care.
☐	☐	Use two patient identifiers: inpatient—name and medical record number; outpatient—name and date of birth.
☐	☐	Label all specimens at the bedside in front of patient.
☐	☐	Write down and read back all verbal orders and test results.
☐	☐	Do not use eliminated/dangerous abbreviations in written documentation.
☐	☐	Assess for suicide risk for patients with diagnosis of emotional/behavioral disorder.
☐	☐	Utilize "time out" and "right site" marking for surgical/invasive procedures.
☐	☐	Keep patient call systems within easy reach.
☐	☐	Set brakes on all beds, wheelchairs, commodes and gurneys when not in motion.
☐	☐	Maintain hand contact with patient while transferring, walking, etc.
☐	☐	Use safety belts on all gurneys.
☐	☐	Keep side rails up on all beds and gurneys.
☐	☐	Keep side rails up and double tops on cribs as specified for crib climbers.
☐	☐	Maintain occupied beds in a low position when not attended by hospital staff.
☐	☐	Do not permit space heaters in patient care areas. Do not permit patient owned appliances except those that are battery operated or used for hygiene (hair dryers, razors, etc.)
☐	☐	All medication rooms/carts are to be secured.
☐	☐	Store IV fluids apart from irrigation fluids.
☐	☐	Five Rights Method must be used before administering medications.
☐	☐	Insulin, IV Potassium and Heparin must be checked with another RN before administering.
☐	☐	Liquids not intended for consumption shall not be placed in food or beverage cups left on a bedside table.
☐	☐	Alarms on equipment must NOT be disabled or muffled.
☐	☐	Engage patients and family members in their safety; let them know how to report any concerns they may have

Yes	N/A	**Corporate Compliance:**
☐	☐	El Camino Hospital employees and contractors are expected to foster an environment of honesty, integrity, and fairness in communication and decision-making. All ECH associates must follow hospital policies on confidentiality of patient information. No provider shall receive payment in exchange for the referral of patients. No provider shall bill or file a claim for services not performed. Sexual harassment, in any form, is not tolerated. If you know of or suspect any improper conduct speak to your supervisor or call the confidential **Compliance Hotline ext. 7733.**

I have read and understand the above Orientation Checklist. I have asked and had answered any questions I had regarding this list.

Clinical Student Signature _____ El Camino Hospital Designee / Instructor _____ Date _____

REQUIRED
To be turned in to Nursing Education prior to or on clinical start date. Needed for each clinical rotation.



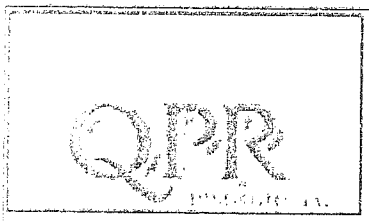
You can Help

Anyone who may be thinking about Suicide

Learn How to Help through QPR

FREE Online Training for Suicide Prevention

for anyone who lives or works in Santa Clara County (SCC)



Like CPR, QPR is an emergency response to someone in crisis

To Sign-up Email

jean.kaelin@hhs.sccgov.org

Specify that you are from NAMI Santa Clara County

You will Learn

- Myths & Facts about Suicide
- Warning Signs of Suicide
- To Question (or talk with) Suicidal People
- To Persuade them to seek Help
- To Refer them to Resources

- Takes 1 to 1.5 hours
- Available Online Anytime Anywhere!

Hope Begins with You!

Training brought to you by YOUR Mental Health Services Act (MHSA) Dollars!!!

Santa Clara Valley Mental Health Department

SANTA CLARA VALLEY MENTAL HEALTH DEPARTMENT

MISSION

To assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams and quality of life goals.

To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity.

VALUES

We believe without reservation that:

- All people have the right to mental health and well-being
- All people must be treated with fairness, respect, and dignity in a culturally and linguistically competent way
- With effective treatment and support, recovery from mental illness is achievable
- Consumers will actively participate in their own recovery and treatment goals
- Consumers and their families will be at the center in the development, delivery, implementation, and evaluation of their treatment

SANTA CLARA COUNTY SUICIDE PREVENTION PROGRAM

1-408-885-3982

Distributed by:
NAMI Santa Clara County
National Alliance on Mental Illness
1150 S. Bascom Avenue, Ste. 24
San Jose, CA 95128
408.453.0400 Fax: 408.453.2100
E-Mail: info@namisantaclara.org
Website: www.namisantaclara.org

California Mental Health Services Authority

CalMHSA
California Mental Health Services Authority

Compassion. Action. Change.

MISSION

The mission of CalMHSA is to provide member counties a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts in:

- Development and implementation of common strategies and programs
- Fiscal integrity, protections, and management of collective risk
- Accountability at state, regional, and local levels

VALUES

CalMHSA shall continually promote:

- Efficiency, expertise, innovation, accountability and quality;
- Transparency and stakeholder input;
- Prevention and early intervention;
- Community collaboration; cultural competence;
- Recognition that geographical features might require unique program interventions;
- Client/family-driven mental health system for children, transition age youth adults, older adults;
- Wellness focus, including recovery and resilience;
- Integrated service experiences and interactions; (integration may occur in other systems such as primary care, aging services, education, etc.)
- Qualified, culturally competent and diverse public mental health workforce with the knowledge and skills to work with age-specific and racially, ethnically and culturally diverse populations.

SUICIDE PREVENTION INTERVENTION WORKGROUP

Suicide Prevention and Crisis

A resource for you and your loved ones

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

connect. empower. transform.

8084 REV 5/13

Prevention

- Research shows that many individuals who attempt suicide show warning signs of their attempt before they act.
- Some of the signs of a person at risk are:
  - Depression
  - Change in sleep patterns
  - Eating (more/less)
  - Giving away prized possessions
  - Lack of interest in normal activities
  - Hoarding medication
  - Flat demeanor/wax face
  - Expressing hopelessness
  - Drug/alcohol relapse

Resources

- SANTA CLARA SUICIDE & CRISIS HOTLINE
  1-855-278-4204
- MENTAL HEALTH URGENT CARE
  1-408-885-7855
- NATIONAL VETERANS SUICIDE PREVENTION LINE 1-800-273-8255 PRESS 1
- VETERANS ASSOCIATION PALO ALTO
  1-800-455-0057
- FRIENDSHIP LINE/SENIORS
  1-800-971-0016
- FREE SUICIDE PREVENTION TRAINING
  1-408-885-3723
- NATIONAL ALLIANCE ON MENTAL ILLNESS
  1-408-453-0400

Intervention

- When anyone suffers, it is one too many.
- When you feel there is no hope, you are NOT alone

Need Help?
Suicide & Crisis Hotline
1-855-278-4204
Toll-Free
24 hours/ 7 days

Resources

- NATIONAL ALLIANCE ON MENTAL ILLNESS
  1-408-453-0400
- ZEPHYR WALK IN SERVICES
  1-408-792-2140
- EMQ MOBILE CRISIS (Youth)
  1-408-379-9085
- EMERGENCY PSYCHIATRIC SERVICES
  1-408-885-6100
- MENTAL HEALTH URGENT CARE
  1-408-885-7855
- EMERGENCY 24/7 Call 911
  Ask for CIT Officer
- TEEN HOTLINE 24/7
  1-888-247-7717
- THE LGBTQ YOUTH SPACE
  1-408-343-7940

Postvention

- No one should feel ashamed or weak because of a suicide attempt.
- There are many of us who are suicide attempt survivors and we are grateful to be alive.
- When you have lost a loved one to suicide, you are a survivor.
- There is support for you, you are not alone.

Resources

- MENTAL HEALTH URGENT CARE
  1-408-885-7855
- NATIONAL ALLIANCE ON MENTAL ILLNESS SANTA CLARA CHAPTER
  1-408-453-0400
- SURVIVORS OF SUICIDE SUPPORT GROUP
  1-855-278-4204
- KARA 1-650-321-5272
- GOLDEN GATEWAY
  1-408-295-5288
  Outreach to seniors 60+
- CALIFORNIA SURVIVOR OUTREACH
  1-925-462-6866
- CENTER FOR LIVING WITH DYING
  1-408-243-0222

Community Resources

Counseling Resources

Catholic Charities	(408) 944-0282
Family and Children's Services (Palo Alto)	(650) 326-6576
Family and Children's Services (San Jose)	(408) 288-6200
Partial Hospital Program at El Camino Hospital	(650) 940-7035
Santa Clara County Mental Health Call Center	(800) 704-0900

Child and Adolescent Services

Child Protective Services	(408) 299-2071
Community Health Awareness Council (CHAC)	(650) 965-2020
EMQ Children and Family Services	(408) 379-9085
Parental Stress Hotline	(650) 327-3333

Older Adult Services

Adult Protective Services	(408) 928-3860
Community Services Agency of Mtn.View/Los Altos	(650) 968-0836
Health Resource Center – El Camino Hospital	(650) 988-7622
Older Adult Transitions, Behavioral Health Services at El Camino Hospital	(650) 940-7138

Chemical Dependency

Al-Anon and Alateen Information	(408) 379-1051
Alcoholics Anonymous	(408) 374-8511
Coast to Coast (nationwide referral service)	(800) 616-9998
Gateway (Santa Clara County)	(800) 488-9919
Narcotics Anonymous	(408) 998-4200
The Sequoia Center	(650) 364-5504

Domestic Violence

Support Network for Battered Women (Hotline)	(650) 940-7855
Next Door, San Jose (Hotline)	(408) 279-2962

Shelters

Emergency Housing Consortium	(408) 294-2100
San Jose Family Shelter	(408) 926-8885
Shelter Hotline	(800) 774-3583

Suicide and Crisis Hotline ..... (408) 279-3312

National Alliance for the Mentally Ill (NAMI)..... (408) 280-7264

Crisis Intervention Discharge Instructions

You have received an assessment, and we have made recommendations for follow-up care. It is important that you follow through with recommended treatment in order to help you through this period. We would also like to offer the following suggestions:

1) **Allow** yourself plenty of rest. It is not unusual after a crisis to feel let down and exhausted. Eat adequately and try to get some fresh air and exercise. Try not to brood over your situation. Give yourself permission to think about other things, or to simply relax.

2) **Avoid** the use of illicit drugs and alcohol. In both the short and long-term, drug and alcohol use will tend to make your situation worse.

3) **Learn** to recognize your symptoms of stress. Some common indications include: anxiety, headaches, fatigue, sleep problems, irritability, and feeling overwhelmed. Allow yourself to take breaks from what is bothering you.

4) Above all, **be kind to yourself.** You have been through a lot already.

Seeking help takes courage. Please call your therapist, your doctor or even a friend when you need some assistance. On the back of this form are some other phone numbers that may be of help, particularly if you currently do not have access to a mental health professional.

EL CAMINO HOSPITAL

REFERRAL NUMBERS

ALCOHOLICS ANONYMOUS	(408) 374-8511
AL-ANON (AND ALATEEN) INFO	(408) 379-1051
NARCOTICS ANONYMOUS	(408) 998-4200
COCAINE ANONYMOOUS	(408) 496-9107
MARIJUANA ANONYMOUS	(408) 350-0796
C0-DEPENDENTS ANONYOUS	(408) 496-1570
BRN COMPLAINT LINE (INFO ON DIVERSION)	(916) 322-3350
DIVERSION SELF-REPORTING LINE	1-800-522-9198
WE CARE FOR CHEMICALLY DEPENDENT HEALTH PROFESSIONALS	(408) 235-1178
PHYSICIAN REPORTING LINE	1-800-263-2600

WEB SITES OF INTEREST

ncaddsiliconvalley.org	NCADD-National Council on Alcoholism and Drug Dependence
www.nida.nih.gov/	NIDA-National Institute on Drug Abuse

85AL

NSG ~~54KL~~ Syllabus

Section V:

Forms for Assignments

Read!

Legal and Ethical Considerations

Confidentiality

* Do not take any computer printouts off the unit!

Amy Wysoker, RN, CS, NPP, PhD

Despite recent strides to decrease the public's negative views of mental illness, the stigma of mental illness unfortunately continues. The confidentiality of psychiatric patients takes on added meaning because of this stigma. That psychiatric treatment was rendered may in itself create problems in the public's eyes. Thus, psychiatric nurses must not only be diligent in keeping patients' information confidential, but also the mere fact that treatment was indeed sought. Confidentiality is our ethical and legal responsibility. Generally, treatment records and statements made to physicians or therapists are confidential. This is based on the notion that a person's health is an intimate matter and is no one else's business (Levy & Rubenstein, 1996). The American Nurses Association's Code of Ethics (1985) outlines the profession's ethical responsibilities for confidentiality, and, in many states, the patient's right to confidentiality is specified in their nurse practice acts.

Amy Wysoker, RN, CS, NPP, PhD, is an associate professor of nursing at the C. W. Post Campus of Long Island University in Brookville, New York, and is in private practice as a psychiatric nurse consultant and medical-legal nurse consultant in Forest Hills, New York.

Reprint requests: Amy Wysoker, RN, CS, NPP, PhD, 108-19 72nd Ave., Forest Hills, NY 11375.

J Am Psychiatr Nurses Assoc (2001). 7. 57-8.

1078-3903/2001/$35.00 + 0
66/1/115759

doi:10.1067/mpn.2001.115759

The need for trust and the right to privacy are crucial in promoting a therapeutic environment. Patients should have the opportunity to share their thoughts freely and work through their concerns without fear that confidentiality may be violated. Any threat to confidentiality may jeopardize the therapeutic relationship. Unauthorized release of medical information is a breach of confidentiality and raises ethical and legal concerns.

Any threat to confidentiality may jeopardize the therapeutic relationship.

A breach of confidentiality frequently occurs when nurses and other health professionals discuss clients in areas where other persons may overhear the conversation. In addition, nurses often have fairly open access to patient records. It is imperative that anyone not directly related to the case be prevented from viewing the patient's chart. Using computers to share information and store patient records creates additional problems regarding the rights to privacy and confidentiality. Because of the highly sensitive nature of the psychiatric information, reliable security measures for computerized documentation must be in place.

Most states have enacted laws limiting the sharing of private communication among physicians, therapists, and other clinicians and their patients, unless the patients consent to the release of information. Some states also have laws that prevent clinicians from releasing records concerning inpatient treatment without consent.

It is important for nurses to be aware of situations in which jeopardizing the patient's right to confidentiality may be an issue (Levy & Rubenstein, 1996). Family members or significant others may be questioned in an effort to obtain much-needed information to provide the best treatment for a patient. This may place a nurse in a precarious situation. Although health care professionals may obtain information from other sources, in doing so they must be very careful not to disclose personal information shared with them by the patient. There is a distinction between gathering information and protecting the patient's right to privacy. Every effort must be made to protect this right (Wysoker, 1997).

Furthermore, patients also have the right to refuse to allow the nurse to speak with others regarding his or her case. Although this may prevent the nurse from gaining needed additional information, the nurse must honor the patient's wishes. If this information is particularly important, the nurse needs to pursue the refusal and its related meaning in the therapeutic process to gain the person's permission to seek the information (Wysoker, 1999).

Continuity of care is of utmost importance in the treatment of the mentally ill. The need for continuous treatment warrants referrals to other treatment facilities and resources. It is important for the nurse to discuss with the patient who will receive the information, what information is necessary to share, and the reasons for sharing the information. The nurse should not proceed without consent. Release forms should signed by the patient (Keglovits, 1992).

* Do not take any Confidential info off the unit!

Recently, however, there have been state proposals to make an exemption to the rule of confidentiality between mental health facilities. With such legislation, patient consent would no longer be required. It is claimed that obtaining written consent is too time consuming and costly and is frequently met with refusal from the patient (Levy & Rubenstein, 1996). It may be routine for some mental health organizations to provide facility-to-facility communication without consent. However, it is important for the nurse to not automatically follow such agency protocols related to sharing information—written or verbal—unless there are state laws allowing this. Nurses need to check their state laws.

PRIVILEGED COMMUNICATION

Privileged communication is a legal term applicable in court proceedings. It protects information shared by a client with certain persons from disclosure in court. Historically, communications between attorney and client, clergy and parishioner, and husband and wife were confidential. In many states these persons are not legally mandated to testify or share confidential information in certain legal proceedings if the affected person wishes otherwise. Although psychiatric nurses are not listed in the statutes of all states, a recent U. S. Supreme Court decision, Jaffe v. Redmond (1996), determined that psychotherapist-client confidentiality privileges exist. However, in many states, whether psychiatric nurse–patient communication is privileged must be further defined by the respective courts. Nurses should check their individual state's laws to clarify the legal dictates of privileged communication.

Although many states grant professionals the privileged communication right, there are specified exemptions to that privilege. Most common exceptions include the following:

- When the courts order an examination.
- When the therapist seeks civil commitment.
- When child abuse is suspected.
- When the patient brings a defense of mental illness into the litigation proceedings.
- When the patient's mental state is at issue.
- When government programs pay for the cost of treatment, such as Medicaid or Medicare.
- When the patient presents a danger to others.

(Keglovits, 1992; Levy & Rubenstein, 1996)

It is the nurse's ethical responsibility to provide care for the client and to protect others in the process.

Duty to Protect

In Tarasoff v. Regents of the University of California, (Monahan, 1993), the court established "duty to protect" as an exception to privileged communication. Duty to protect exists when a patient presents a danger to others. Advanced practice registered nurses conducting psychotherapy and nurses working in ambulatory settings must report information to the proper authorities or take steps to protect the possible victim if there is evidence that a client may inflict danger on a specific person. It is the nurse's ethical responsibility to provide care for the client and to protect others in the process. Despite the confidential nature of the therapeutic relationship, nurses must take legal action to protect others from harm.

GIVING UP THE RIGHT TO CONFIDENTIALITY

There are times when a patient must relinquish the right to confidentiality and allow information regarding treatment to be shared with others. This applies when health insurance companies require the patient to waive this right to receive benefits. Life insurance policies and public benefits, such as Social Security Disability Insurance, also require a patient to waive the right to confidentiality. In addition, filing a lawsuit against a practitioner necessitates giving up the right to confidentiality (Levy & Rubenstien, 1996).

CONCLUSION

Confidentiality is a right granted to all persons in this country. Psychiatric nurses need to understand not only the ethical and clinical ramifications if confidentiality is not maintained, but the legal implications as well. Patients can report violations to their state boards of nursing and sue for damages for breach of contract (Levy & Rubenstein, 1996). Psychiatric nurses need to avoid such incidents not only for their own protection but, more importantly, for patient protection. As patient advocates, we promote the rights of the mentally ill person. Honoring the patient's right to confidentiality is one way to do this.

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Levy, R., & Rubenstein, (1996). *The rights. People with mental disabilities: The authoritative ACLU guide to the rights of people with mental illness and mental retardation.* Carbondale, IL: American Civil Liberties Union.

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Nursing 54K

Student:_____
Date:_____
Week:_____ _____

Clinical Conference Planning Form

The purpose of clinical conference is to think through, or "process" your experience, better understand the experience, and thereby help make the experience a good learning opportunity. One way of doing this is to link the clinical experience with what is being learned in the theory portion of the class. The following exercises are designed to help you zero in on what was learned from a subjective as well as objective viewpoint.

I. Name two theoretical concepts or ideas that you learned or "saw in action" during clinical and briefly describe the clinical event/activity/interaction/situation, etc. that stimulated your learning or better understanding of the concept.

a. Concept:_____

Clinical event:

b. Concept:_____

Clinical event:

II. Pick one subjective feeling or response (nurse's own response or "process level") that you experienced related to patient care e.g. happy, sad, joyful, angry, frustrated, hopeless, elated, despair, hopeful, remorseful, and so on, and relate the statements that follow to that feeling. (May or may not be related to Part I above.)

a. Feeling: _____

b. I believe I felt the above emotion because: (based on personal knowledge of self rather than the external situation) _____
_____
_____
_____
_____ _____

c. The above emotion affected my response to the patient by causing me to:
_____
_____
_____

d. A more therapeutic response might have been: _____
_____
_____

Q 215 F 99

Name_____ Client Initials_____

Date of Care_____

Critical Thinking Work Sheet

ASSESSMENT DATA

Instructions:

1. Document basic assessment data according to Orem.
* * * 2. Document comprehensive assessment data according to Orem.
3. Write the rationale(s) for performing the assessment.
* * * 4. Nursing diagnosis (3 part).
5. Modify plan of care by synthesizing data and predicting possible outcomes.

* * * Scope of practice: not required of the LVN

AIR (respiratory)

1.

* * * 2.

3.

4.

* * * 5.

WATER/FOOD (cardiovascular)

1.

* * * 2.

3.

4.

* * * 5.

ACTIVITY & REST

1.

* * * 2.

3.

4.

* * * 5.

ELIMINATION

1.

*** 2.

3.

4.

*** 5.

SOLITUDE & SOCIAL INTERACTION

1.

*** 2.

3.

4.

*** 5.

PREVENTION OF HAZARDS

1.

*** 2.

3.

4.

*** 5.

DEVELOPMENTAL SELF-CARE REQUISITES

1.

*** 2.

3.

4.

*** 5.

HEALTH DEVIATION SELF-CARE REQUISITES

1.

*** 2.

3.

4.

*** 5.

Guide to understanding the Assessment data/Critical Thinking Worksheet

By Elaine LePage, RN, MSN

A. How to read the instructions.

1. Basic assessment data according to Orem – In this section, you need to identify your assessment data. That is all the information you have obtained from your history and physical assessment, as it pertains to each self-care topic.
   - Examples include: all physical, psychological and pertinent social findings such as: VS. lung sounds, pt's mood, urinary output (ect)

2. Comprehensive assessment data according to Orem - In this section, extrapolate on your assessment findings. Here are some examples: (This is not an all inclusive list)
   - If you tested the patient's O2 sat on room air (off O2), report the value here.
   - If you obtained additional history from a family member or health care team member.
   - If you have noted a pattern of change in the patient(i.e. weight loss over a few days or change in pattern of vital signs)
   - Pertinent past medical history related to a self care NURSING need (Hx of smoking related to nursings need to provide smoking secession teaching)
   - Implications of medical diagnosis (OK to use the medical diagnosis but identify the symptoms which affect nursing care such as: "Pt has CHF which compromises his respiratory abilities and pot for fluid overload")
   - Pertinent lab data
   - Erickson's developmental stages
   - Grief theory stages

3. Rationale for performing each assessment - Why did you conduct each assessment? Why did you ask each question? What did you plan to do with the information? Ultimately, you needed to narrow down the patient story and list of symptoms into something you could help him with. This question is asking what were you trying to find out in your history and physical? What do the lab values tell you about the patient? There may be multiple items you were trying to identify or rule out.

For example if your friend had flu like symptoms, you might ask the following questions:
Do you have a fever? (To determine if this is a viral or bacterial infection Vs malaise: may also dictate treatment)
Do you have nasal congestion? (To determine airway compromise: need for humidifier)
Do you have a cough? (To determine lung involvement/ O2-Co2 exchange problems/ help determine possible treatments)
What color is the phlegm? (To determine presence or absence of infection)
What have you been doing to treat yourself? (To determine patient's self care ability)
Auscultating his lungs (To assess areas of lung involvement and quality of breath sounds, which may dictate treatment)
Assess temperature (To assess the body's ability to react to infection)

4. Actual or Potential high-risk conditions – This is simply asking for the nursing diagnosis. Develop the nursing diagnoses', including the statements *related to(r/t)* and *as evidenced by (AEB) For* example: alt in cardiac output r/t bradyarrthymias AEB HR 50's, lightheadedness and postural hypotension Nursing diagnoses may also be potential problems such as the post operative patient always has a potential risk of infection. With potential problems, you cannot have ABE (as evidenced by) symptoms, for if you do, you have an actual problem

5. Modify plan of care by synthesizing data and predicting possible outcomes – This question is asking you to develop a plan of care, that all members of the nursing team can follow. Remember, as a RN you will be responsible for directing the LVN and NA staff members. Include interventions that are realistic and appropriate for the patient. Consider using other resources such investigating your med/surg books to develop diagnosis specific interventions or consulting with the medical staff. For example: Thyroidectomy patients have a risk of parathyroid removal, which can lead to hypocalcemia. Interventions such as monitoring serum calcium levels and performing Chvostek's sign are appropriate interventions.

Final Notes:

- Make sure you cover all your bases. If you identified an abnormal assessment finding, you need to address it in sections 3, 4, & 5 of the critical thinking worksheet.
- Use your resources to develop critical thinking interventions. Use books, Doctors or experienced nurses to assist you. Know the disease process that your patient is experiencing because as the RN, you will be expected to !
- Use the patient's Kardex and existing care plan as guides.

B. How to categorize the self-care topics.

Orem's theory is based on a client's ability to perform self-care that is: taking care of them selves without outside assistance. Orem developed Universal; Developmental and Health-Deviational self care requisites (SCR). These items have been categorized on the attached assessment sheet.

Developmental SCR's refer to the patient's ability to adjust to life in an age appropriate manner. (I.e. – Is you five year old client behaving more like a two year old, still in diapers)

Health-Deviational SCR's refer to the client's ability to adjust to life while incorporating a disease state. (I.e.- How is your diabetic client managing at home with his new health care requirements? Is he performing self-care or does he still require nursing assistance, called partially compensatory interventions)

C. Clinical Judgement Worksheet

The key to this work sheet is PRIORITIZATION. Ask your self, what are this patient's main problems? Where do I have to focus my nursing care? What body system am I focusing the most on with this patient?

Section 1 – List the MOST PERTINENT assessment data you identified for this patient. Do not list past, resolved problems. For example: If your patient is post operative and experiencing severe pain, then PAIN is his main symptom. True, he may be NPO and not

receiving nutrition but this is not his main problem. It is expected that he will remain NPO until bowel sounds resume. In section 1, you should identify all these symptoms (pain and NPO status) but keep in mind your priority for section 2.

Section 2 – Using list 1, develop the nursing diagnosis that best pertains to the patient's main problems, then rank order them. For example: If you had a patient who had a diminished level of consciousness, you would instruct the NA not to feed the patient. The priority is to monitor the alt level of consciousness, not to address the Nutrition. The care is now INDIVIDUALIZED.

Section 3 – In this section, you need to explain why you prioritized the patient's needs the way you did. For example in section 1, the NPO status was not as critical as the pain because you would not expect the patient to have bowel sounds yet. In section 2, if the NA fed a somnolent patient, he may aspirate.

Section 4 – In this section, you need to select 6 areas of teaching and write a rationale. Include family and caregivers where appropriate.

D. Pointers for Nursing Care Plans, the Orem way!

Nursing Diagnosis section: include if the diagnosis is a U (universal), D (developmental) or HD (health devotional) need. Simply write the appropriate letter next to the nursing diagnosis.
Examples: U = alt in breathing pattern r/t pneumonia ABE copious secretions
D = alt in coping r/t stressful family dynamics AEB crying a times
HD= alt in self image r/t BKA AEB fears of moving, inability to look at stump

Client goals: Make these goals measurable for the patient. For example: Pt will maintain an O2 sat >95%, is more measurable than, patient will not have any SOB. You need to develop short and long term goals; then identify them ST or LT. The duration of goals will vary with individual patients.

Nursing Interventions: Orem's nursing care can be categorized into 3 types
1. Wholly compensatory – when the nurse is expected to accomplish all of the patient's self care needs.
2. Partially compensatory – when both the nurse and the patient engage in meeting the self care needs.
3. Supportive educative – when the nurse provides assistance with patient's decision making or behavior control or learning.

Rationale : This refers to your rationale for your nursing interventions. Your Med/Surg book may be a good guide.

Evaluation: Must refer to your goals. If your goals are measurable, this will be easy

NAME _____ LVN/RN

DATE OF CARE _____ CLIENT INITIALS _____

CLINICAL JUDGMENT WORK SHEET

*** NOT REQUIRED BY L V N STUDENT
(TO BE COMPLETED WITH EACH DAILY ASSIGNMENT)
THE NUMBER OF BLANKS THAT YOU COMPLETE DEPEND ON CLIENT ACUITY AND NEED

1. Scrutinize the basic *** comprehensive assessment data that you have collected and identify the pertinent data

a b c

d e f

g h i

j k l

2 *** Select and prioritize the appropriate Nursing Diagnosis using the three part statement

a b c

d e f

g h i

j k l

3 *** Explain the rationale for your prioritization

a. rationale _____ b. rationale _____ c. rationale _____

d. rationale _____ e. rationale _____ f. rationale _____

g. rationale _____ h. rationale _____ i. rationale _____

j. rationale _____ k. rationale _____ l. rationale _____

4 Select at least 6 areas for self-care teaching that focus on prevention and/or recognition of signs and symptoms of problems. Write your rationale for each selection.

a. rationale _____ b. rationale _____ c. rationale _____

d. rationale _____ e. rationale _____ f. rationale _____

g. rationale _____ h. rationale _____ i. rationale _____

j. rationale _____ k. rationale _____ l. rationale _____

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Section VI:

FORMS FOR CLINICAL IMPROVEMENT

De Anza College
Department of Nursing

Program Reflection

Student's Name_____
Facility/Unit_____
Course_____
Date_____

Event/Situation prompting this document_____

_____

_____

_____

On a separate piece of paper, write a narrative note reflecting on the event/situation. In accordance with the Student Handbook, under **Student Performance, Reflection,** follow the guidelines listed:

1. Describe the incident in your own words.
2. What factors led (contributed to this incident?
3. How would you approach this or a similar situation in the future?

DATE DUE: _____ At this time the appropriateness of the written reflection will be determined.

The following signature indicates that the student understands the purpose of this document.

Student signature:_____ Date:_____

**Instructor's signature:_____ Date:_____

The following signature indicates that the student has been presented with this assignment but has refused to sign the document.

Witness:_____ Date:_____
(Any other De Anza Nursing Instructor)

**INSTRUCTORS: Keep this original: give a copy to student.

Plan for Improvement

TO:
FROM:
DATE:
RE:

I: I have identified that your performance is deficient in the following areas:

1.

2.

3.

II: In order to achieve satisfactory improvement of your performance and successful resolution of the Plan for Improvement, you must be demonstrating the following:

1.

2.

3.

III: Evaluation of the improvements: Immediately and ongoing, through the last clinical/ theory day of this course, or until_____, you must be demonstrating accurate performance of the above designated behaviors. During this period **any** infraction of these will lead to immediate removal from the course, failure of the course and a withdrawal with penalty. If no infractions happen during this period, your PI will be considered "successfully resolved." If, during the course of the nursing program, you acquire two additional PIs for _____, you will be withdrawn with penalty.

IV: Suggested activities for improvement:

Clinical and/or theory instructor(s) will provide you with verbal or written feedback on an as-needed basis.

The following signatures indicate that the instructor has explained the student performance deficiencies that led to this Plan for Improvement. Furthermore, the following student signature indicates that student has read, understands, and has had the opportunity to discuss this Plan with the instructor.

Student_____Date_____

Instructor_____Date_____

Plan for Improvement Outcome(s):

The student must provide a copy and discuss all PIs with all clinical and theory instructors involved during the time frame in which the PI is in force.

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Section VII:

EVALUATION FORMS

PSYCHIATRIC MENTAL HEALTH NURSING
CLINICAL EVALUATION

Student's Name: _____ Quarter: _____ Lead Instructor's Name: _____
Course Number: **NURS 85AL** Year: _____ Clinical Setting(s): _____

DIRECTIONS: Using blue or black ink, place the date of the evaluation above the vertical column. Under S (student) column, place the letter S (satisfactory), U (unsatisfactory), or X (experience not available) for **each** item. Add written comments in the corresponding "Comments" space. Also write your goals/areas for improvement in the student "Summary Comments" section on the last page. Please limit all comments to **YOUR OWN** clinical performance. Submit the completed evaluation to your instructor at the designated time. Following completion and signing by the instructor (I), you will be asked to review the evaluation and sign the "Summary Comments". Program Critical elements are marked with a plus (+). Course-specific Critical Elements are marked with an asterisk (*). **Critical elements describe behaviors or performances the faculty consider essential to safe and effective nursing care. Satisfactory completion of the critical elements is required to successfully complete the course.**

Nursing-85AL / Sherwood Or 6 **Clinical Evaluation**

Specific Rotation →			**COMMENTS (Student & Instructor)**
Date of Evaluation →			***(DATE EACH COMMENT)***
NURSING PROCESS:	Stu.	Ins.	
1. Assessment			
+ 1.1 Completes a ***Comprehensive/Basic physical and psychosocial assessment with particular attention to each Orem category as follows:			
+ 1.1.1 Universal Self-Care Requisites			
+ Air, Water and Food			
+ Activity and Rest			
+ Elimination			
+ Solitude and Social Interaction			

Specific Rotation →			COMMENTS (Student & Instructor)
Date of Evaluation →			*(DATE EACH COMMENT)*
NURSING PROCESS:	Stu.	Ins.	
1. Assessment (Continued)			
+ **Prevention of Hazards**			
+ **Normalcy**			
+ **1.1.2 Developmental Self-Care Requisites**			
+ Age / gender/Ericksons Stages			
+ Culture / education / occupation			
+ **1.1.3 Health Deviation Self-Care Requisites**			
+ Ability to seek care information / Compliance with regimen, self-concept R/T illness			
+ **1.2 Assesses** pain level of each client within Orem categories (e.g., activity / rest, solitude, etc.)			
+ **1.3 Gathers** and Recognizes pertinent clent data			
+ **1.4 Collects** and **reports** laboratory data (ie. Lithium, Depakote, HCT, K levels)			
+ **1.5 Assesses** the need for interdisciplinary team members			
+ **1.6 Prioritizes** assessments based on client acuity			
+ **1.7 Collaborates** in the formulation of a Nursing Care Plan			
+ **1.8 Analyzes** and **interprets** the laboratory data and **reports** the implications			
+ **1.9 Assesses** client using the Psychosocial Prep Sheet			
2. Nursing Diagnosis			
+ **2.1 Uses** NANDA in writing the 3-part nursing diagnostic Statement and **Selects** nursing diagnoses specific to client self-care requisites			
3. Goals			
+ **3.1 Establishes** realistic and measurable short- and long long-term goals involving client and family			

Specific Rotation →			COMMENTS (Student & Instructor)
Date of Evaluation →			*(DATE EACH COMMENT)*
NURSING PROCESS:	Stu.	Ins.	
4. Interventions			
+ **4.1 Develops** interventions that are related to specific nursing diagnoses and goals			
+ **4.2 Prioritizes** needs while implementing care			
+ **4.3 Maintains** asepsis including handwashing/hand cleaners			
+ **4.4 Impliments interventions** appropriate to the levels of intervention in each of the following nursing systems: • partially compensatory • wholly compensatory • supportive-educative			
+ **4.5 Selects** & taylors interventions from these categories: • psychotherapeutic • health teaching • ADL's • somatic • milieu • continuing care			
5. Evaluation			
+ **5.1 Evaluates** achievement of short- and long-term goals			
+ **5.2 Identifies** & **Collaborates** changes in the plan of care and pertinent data to modify the Nursing Care Plan			
+ **5.6 Writes** narrative, client-centered notes for each goal			
+ **5.7 Includes** direct client quotes in evaluation notes			

Specific Rotation →			COMMENTS (Student & Instructor)
Date of Evaluation →			*(DATE EACH COMMENT)*
CURRICULUM THREADS:	Stu.	Ins.	
6. Client / Family Teaching			
+ 6.1 **Identifies** specific learning needs related to age, ethnicity, education level, spiritual beliefs, and socioeconomic status.			
+ 6.2 **Collaborates** with interdisciplinary health team members when planning client teaching and plan for discharge			
+ 6.3 **Formulates** a teaching plan (ie. Medication and coping skils education) specific to self-care learning needs			
+ 6.4 **Implements** supportive-educative interventions and **Evaluates** for teaching effectiveness			
7. Communication			
+ 7.1 **Employs** principles of therapeutic communication with clients and families			
+ 7.2 **Confirms** plan of care with instructor and staff R.N.			
+ 7.3 **Identifies** client conditions that require immediate reporting			
+ 7.4 **Reports** (verbal and/or written) client assessments / status accurately, organized and in a timely manner to the staff R.N. and/or instructor.			
+ 7.5 **Accurately documents** medications and procedures\ per facility protocol			
+ 7.6 **Demonstrates** understanding of the nursing process conveying conceptual integration			
+ 7.7 **Shows** sensitivity and respect for client's feelings			
+ 7.8 **Avoids** judgmental verbal or nonverbal communication with client			

Specific Rotation →			COMMENTS (Student & Instructor) *(DATE EACH COMMENT)*
Date of Evaluation →			
CURRICULUM THREADS:	Stu.	Ins.	
7. Communication (continued)			
+ **7.9 Relates** own personal responses in clinical conference			
+ **7.10 Gives** feedback to others in clinical conference			
+ **7.11 Presented and discussed** pt assessment & care plan at clinical conferences			
+ **7.12 Collaborates** with the interdisciplinary team			
+ **7.13 Presents and discusses** client care with instructor and at clinical conference			
8. Legal / Ethical / Managerial			
+ **8.1 Maintains** client confidentiality as outlined in course Syllabus			
+ **8.2 Reports** any actual or potential "break" in confidentiality to instructor			
+ **8.4 Maintains** appropriate social and emotional boundaries with clients			
+ **8.5** When escorting / supervising client(s), **remains** with client(s) at all times			
+ **8.6 Keeps** nursing station areas, doors, and hallways unblocked			
+ **8.7** After entering or leaving a locked ward, locked patient room, or other locked area, **confirms** that doors are re-locked			
+ **8.8 Reports** off to Responsible Nurse or Charge Nurse whenever leaving the unit and at the end of shift, **giving complete** information about client care			

Specific Rotation →			COMMENTS (Student & Instructor) *(DATE EACH COMMENT)*
Date of Evaluation →			
CURRICULUM THREADS:	Stu.	Ins	
8. Legal / Ethical / Managerial (Continued)			
+ **8.9 Assumes** accountability for own actions and learning			
+ **8.10 Accepts** constructive criticism and **utilizes** it for growth			
+ **8.11 States** purpose, rationale, and expected results of procedures being performed			
+ **8.12 Demonstrates** retention of previously learned theoretical concepts and skills in client care			
+ **8.13 Seeks** appropriate assistance when unsure of skills and/or procedures			
+ **8.14 Follows** program policies as outlined in the Student Handbook			
+ **8.15 Completes** and **submits** written assignments on time			
+ **8.16 Utilizes** pain scale appropriate to each facility to evaluate, manage, and document pain			
+ **8.17 Provides** nursing care in a safe and effective manner			
+ **8.18 Follows** facility policy regarding identification of client			
+ **8.19 Demonstrates** awareness of the following, including legal implications: • informed consent • advanced directives • restraints			
+ **8.20 Utilizes** facility's pain scales to evaluate, manage, and document pain			
+ **8.21 Differentiates** the RN / LVN scopes of practice			

Specific Rotation →			COMMENTS (Student & Instructor)
Date of Evaluation →			*(DATE EACH COMMENT)*
CURRICULUM THREADS:	Stu.	Ins	
9. Pharmacology			
+ **9.1 Student knows pts meds & side effects**. Student observes for side effects			
+ **9.2 Fills out** pharmacology form completely and accurately for each medication patient is prescribed			
9.3 Relates implications of psychotropic drugs to clients self-care requisites: • Universal • Developmental • Health Deviation			
+ **9.4 Makes** decisions, with guidance, toward effective pain management • pharmacological • non-pharmacological			
+ **9.5 Demonstrates** knowledge of actions and nursing implications of medications administered			
10. Nutrition			
+ **10.1 Assesses** the client for nutritional self-care requisites including normal patterns and recent changes			
+ **10.2 Relates** nutritional implications of psychotropic/other mediations to client's nutritional status			
+ **10.3 Relates** impact of various affective and psychotic states on nutritional state			
+ **10.4 Evaluates** the laboratory data in relation to nutritional self-care requisites and health care deviations			
+ **10.5 Considers** ethnicity and cultural beliefs when addressing self-care requisites			

EVALUATION -PLEASE DATE AND SIGN EACH SUMMARY COMMENT

Instructor's summary comments:	Student's summary comments:
Date: Instructor signature:	Date: Student signature:
Date: Student signature:	Date: Instructor signature:

De Anza College Nursing Program
Student Evaluation of Clinical Experience

Instructor's Name_____Course_____Date_____

Use the following scale for rating the clinical instructor by circling the words or appropriate number.
Use spaces provided for comments, if desired.

CLINICAL TEACHING PRACTICES

		Rating					
	not effective	1	2	3	4	5	effective
Student's clinical objectives and responsibilities stated in a clear and understandable manner.							
Learning experiences selected based on individual student needs							
Clinical assignments relate theory to implementation.							
Supervises, guides and supports students in new and/or difficult situations.							
Guides students in using problem solving technique.							
Demonstrates understanding and sensitivity to students needs.							
Provides supportive feedback for student, offering suggestions for self-improvement when necessary.							
Encourages realistic goals for student performance.							

Please respond to the following 2 questions.
What SPECIFIC characteristics of the instructor's teaching assisted you in your learning?

SPECIFIC characteristics of the instructor's teaching hindered or impeded you in your learning?

DE ANZA COLLEGE

STUDENT EVALUATION OF CLINICAL AGENCY

Hospital: _____ Unit: _____ Date: _____

Quarter: _____ Weeks in Agency: _____

Please rate how effectively the **CLINICAL AGENCY** (considering you worked with a number of people) carried out the following activities, from your point of view. 1 = Outstanding, 2 = Good, 3 = Average, 4 = Below Average, 5 = Unsatisfactory If ratings are #4, Below Average, or #5, Unsatisfactory, please make constructive suggestions for improvements on the back of this sheet. Do remember this is an agency evaluation, not your instructor evaluation.

ACTIVITIES OF AGENCY	OUTSTANDING 1	GOOD 2	AVERAGE 3	BELOW AVG. 4	UNSATIS. 5
Provided adequate rooms for conference					
R. N. staff nurses role modeled hign standards of nursing care					
Staff nurses answered questions in a supportive manner					
Other health team members answered questions in a supportive manner					
Role modeled effective communication with patients & families					
Role modeled ways to communicate professionally to physicians & health team					
Is physical environment of agency conducive to learning?					
Would you consider returning to this agency as an R. N.?					

STRENGTHS/AREAS FOR IMPROVEMENT:

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

REQUIRED
To be turned in to Nursing Education prior to or on clinical start date. Needed for each clinical rotation.

CONFIDENTIALITY STATEMENT (2.01)

As an El Camino Hospital employee, volunteer, student, intern, instructor or person employed through a registry/temporary agency or under contract services, you have a legal and ethical responsibility to protect the privacy of patients and the confidentiality of their health information. All information that you see or hear regarding patients, directly or indirectly, is completely confidential and must not be discussed, viewed or released in any form, except when required in the performance of your duties.

A patient whose medical information has been unlawfully used or released may recover actual damages as well as punitive damages, plus attorney fees and court costs. Unauthorized disclosure of medical information is also criminally punishable as a misdemeanor. The mere acknowledgement that a patient is being treated, for psychiatric disorders, drug abuse, or alcohol abuse, may expose the hospital and the person making the unauthorized disclosure to substantial fines and liability.

If you are assigned a computer code that allows access to patient information, the code gives you access to confidential information that should only be used in caring for patients. Access codes are assigned based on the need to have information in order to carry out assigned responsibilities as determined by your manager.

All system passwords use a unique identification code that serves as a signature when entering the particular system. It is your responsibility to keep your passwords strictly confidential. Under no circumstances may you give your passwords to someone else.

If you have access to employee information, El Camino Hospital financial information or any other proprietary information, you are expected to treat the confidentiality of such information in the same manner as patient information.

Additionally, protection of confidentiality is required when transmitting sensitive data outside El Camino Hospital.

Refer requests for medical records to:	Health Information Management	650-940-7066
Refer media requests for information to:	Marketing and Community Relations	650-988-7767

Confidentiality of Patient Information

1. I understand that access to patient information may be required for me to do my job, and that I am only permitted to access patient information to the extent necessary for me to provide patient care and perform my duties. Therefore, I will treat all patient, physician, employee and hospital business information (e.g., medical, social, financial, and emotional) acquired during the course of my work as strictly confidential.

2. I understand that "confidential" means that patient information must not be revealed or discussed with other patients, friends, relatives, or anyone else outside of the El Camino Hospital health care environment. In other words, a patient's personal and medical information can only be discussed in private with appropriate individuals who have a medical and/or business related need to know, whether on duty or off.

3. I will not release or disclose patient information, unless my job requires it, and then will disclose only minimum necessary patient information needed to carry out my responsibilities for El Camino Hospital. I will not disclose identifying information (e.g. name, date of birth, etc.) if the information can be removed and is not essential to the analysis. If I am not sure whether the information should be released, I will refer the request to the appropriate department (e.g. Health Information Management) or appropriate individual (e.g. Chief Privacy Officer or Compliance Officer).

4. I will appropriately dispose of patient information and reports in a manner that will prevent a breach of confidentiality. I will never discard confidential or patient identifiable information in the trash, unless it has been shredded or recycled.

5. I understand that I have a duty to protect El Camino Hospital patient information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to El Camino Hospital any breach of patient confidentiality.

6. I will access patient information only when needed in order to do my job, and understand that retrieving/viewing/printing or copying information (computerized or paper), on other patients such as friends, relatives, neighbors, celebrities, co-workers, or myself is a breach of confidentiality and may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

Confidentiality of Business Information

1. I understand that information regarding the business and operations of El Camino Hospital is confidential, and that such information is owned by and belongs to El Camino Hospital.

2. I understand that I am only authorized to access business information if it is required for me to perform my duties. This information must not be revealed or discussed with others within or outside of El Camino Hospital except to the extent that this discussion is necessary to perform my duties.

3. I understand that I have a duty to protect El Camino Hospital business information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to El Camino Hospital any breach of business information confidentiality.

4. I understand that failure to follow this agreement may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

Information System Security

1. I understand that El Camino Hospital's information systems are company property and are to be used only in accordance with the hospital's policies. I also understand that I may be given access codes or passwords to El Camino Hospital information systems, and that I may use my access security codes or passwords only to perform my duties.

2. I acknowledge that I am strictly prohibited from disclosing my security codes or passwords to anyone, including my family, friends, fellow workers, supervisors, and subordinates for any reason. I will keep my security codes and passwords in confidence and will not disclose them to anyone (other than the System Security Administrator) for any reason.

3. I agree that I will not breach the security of the information systems by using someone else's security codes or passwords, nor will I attempt in any way to gain access to any unauthorized system. Also, I will not allow anyone else to access the information systems using my security codes or passwords.

4. If I leave my workstation for any reason, I will initiate security measures in accordance with hospital procedures so no unauthorized person may access patient or business information, or enter information under my security codes or passwords; I will make sure the system screen or paper record is not left open and unattended in areas where unauthorized people may view it.

5. I will not misuse or attempt to alter information systems in any way. I understand that inappropriate use of any information system is strictly prohibited. "Inappropriate use" includes:
   (a.) personal use which inhibits or interferes with the productivity of employees or others associated with El Camino Hospital, or which is intended for personal gain;
   (b.) transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission and values of El Camino Hospital;
   (c.) disclosure of confidential information to any individual, inside or outside the organization, who does not have a legitimate business-related need to know; and
   (d.) the unauthorized reproduction of information system software.

6. Only El Camino Hospital approved and officially licensed software may be added to El Camino Hospital systems.

7. I understand that I will be held accountable for all work performed or changes made to the systems or databases under my security codes, and that I am responsible for the accuracy of the information I put into the systems.

8. If my employment or association with El Camino Hospital ends, I will not access any El Camino Hospital information systems that I had access to and acknowledge that legal action may result if I do.

9. I understand that El Camino Hospital reserves the right to audit, investigate, monitor, access review and disclose information obtained through the organization's information systems at any time, with or without advance notice to me and with or without my knowledge.

10. I understand that I have a duty to protect El Camino Hospital information systems from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to El Camino Hospital any breach of information system security (for example, if the confidentiality of my or another's password has been broken) or any inappropriate use of information systems.

11. I understand that a violation of computer security or any component of this agreement is considered a violation of hospital policies, and may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

I will ask my supervisor for clarification if there are any items I do not understand before signing this agreement. My signature below acknowledges that I have read and understand this agreement and realize it is a condition of my employment/association with El Camino Hospital. I also acknowledge that I have received a copy of this signed agreement.

Signature:_____ Date:_____

Print Name:_____

REQUIRED
To be turned in to Nursing Education prior to or on clinical start date. Needed for <u>each</u> clinical rotation.

EL CAMINO HOSPITAL

CLINICAL STUDENT ORIENTATION

REQUIRED
To be turned in to Nursing Education prior to or on clinical start date. Needed for each clinical rotation.

Name (print)_____ Date _____ Student Phone # _____
School _____ Instructor's Name _____ Clinical Area _____

The following list is to be read and signed by the clinical student. This form is to be completed prior to start of clinical, signed by an El Camino Hospital designee / instructor, and sent to the Nursing Education Department PAR114. (c/o Alicia Potolsky)

Yes	N/A	Emergency Management Codes:
☐	☐	Dial "55" to report all emergencies such as fire, CPR, toxic spills. State your name, the type of emergency, location and number of injuries, if applicable.
☐	☐	Code Blue=Cardiac/respiratory arrest or Medical Emergency for Adult
☐	☐	Code White-Neonatal=Cardiac/respiratory arrest or Medical Emergency (28 days or less)
☐	☐	Code White-Pediatric=Cardiac/respiratory arrest or Medical Emergency (over 28 days)
☐	☐	Code Red=Fire, flames or visible smoke. If you discover fire, RACE: R Remove anyone in immediate danger; A Alarm. Pull nearest fire alarm box and Dial "55," state location; C Confine. Close all doors and windows; E Extinguish and/or Evacuate.
☐	☐	Code Orange=Hazardous materials spill/leak
☐	☐	Code Triage=Internal/external disaster, meaning high influx of patients or need for evacuation of extended area
☐	☐	Code Gray=Angry/violent patient or visitor
☐	☐	Code Silver=Person with a weapon/hostage situation
☐	☐	Code Yellow=Reported bomb threat
☐	☐	Code Pink=Infant Abduction (1 year or less)
☐	☐	Code Purple=Child Abduction (over 1 year)
☐	☐	Refer to Emergency Management flip guides posted on walls throughout the hospital and/or the red Safety Program for Managing the Environment of Care binder in each department.

Yes	N/A	General Safety:
☐	☐	Walk don't run.
☐	☐	Isolate all spills immediately and report to Environmental Services, ext. 7317
☐	☐	Familiarize yourself with emergency exits.
☐	☐	Return to assigned area in the event of an emergency unless unable to do so.
☐	☐	Close drawers and cabinets to prevent injury.
☐	☐	Keep aisles and passageways, exits and hallways clear of objects.
	☐	Store material in limited heights (below 5ft.) to prevent falling or collapsing.
	☐	Report unsafe conditions to supervisor.
☐	☐	The use of illegal drugs or alcohol on the hospital premises is prohibited.
☐	☐	Working while impaired through the use of intoxicating substances is prohibited.
☐	☐	Follow your department's policy regarding low-heeled, closed-toe, nonskid shoes.
☐	☐	Obey directional signs used by Environmental Services when cleaning floors/carpets/stairs.
☐	☐	Cords and wires should be positioned in a manner to preclude tripping and obstruction of traffic.

Yes	N/A	Fire Safety:
☐	☐	El Camino is a "non-smoking" hospital.
☐	☐	Do not use elevators during a fire or earthquake.
☐	☐	Store flammable substances in nonflammable storage cabinets.
☐	☐	Keep aisles and passageways clear for emergency access or evacuation.
☐	☐	Keep fire extinguishers and hoses clear at all times.

Yes	N/A	Electrical Safety:
☐	☐	Review and follow manufacturer's policies for equipment safety features.
☐	☐	Make sure all electrical equipment is grounded and a green dot hospital grade plug is used.
☐	☐	Do not use any appliances or machinery while touching metal or anything wet.
☐	☐	Use of adapter plug is not permitted.
☐	☐	Use of extension cord is not permitted, except in emergency.
☐	☐	Report all frayed wires, cracked plugs, or inoperative equipment to BioMed, ext. 7314.
☐	☐	Remove defective or inoperative equipment from service. Attach a note to equipment explaining the problem.

Yes	N/A	Body Mechanics:
☐	☐	Bend knees when lifting heavy objects.
☐	☐	Keep back straight.
☐	☐	Maintain wide stance: Pivot, don't twist.
☐	☐	Lift load close to body and carry load close to body.
☐	☐	Seek assistance if an object/patient will be too heavy for you to safely move by yourself.

Yes	N/A	Hazardous Materials Safety:
☐	☐	Know what hazardous chemicals are in your work area.
☐	☐	Review Material Safety Data Sheets (MSDS) located in the red Safety Binder in all departments.
☐	☐	Know methods of detecting hazardous chemicals in your work area.

DeAnza College

School of NURSING

NURSING 85A

Psychiatric Mental Health Nursing Theory & Lecture Notes

Rebecca Sherwood, DNSc, RN

2015-2016

TABLE OF CONTENTS

Lecture notes (attached)

WELCOME AND INFORMATION

It is a pleasure to have you in De Anza College's Nursing Program. The following summary and guide to additional sources of information have been prepared to assist you towards successful completion of courses as you progress through the nursing program.

Change of address/phone number: You are responsible for reporting, in writing, any change on address or phone number to your lead and clinical instructors, the screening coordinator, and the office of admissions and records. *This is very important in order that you can be reached if needed.*

Reporting injury: You are to immediately report, to your clinical instructor, any injury that occurs to you in the clinical area. Together with your instructor, you will complete an incident report for the Nursing Department and determine follow-up action. You must also report this injury to the De Anza College Health Service Office as soon as possible. *If this report is not made within twenty-four hours of the injury you may not be covered by Workman's Compensation.*

I.V. regulations: I.V. therapy is not addressed during Quarter 1. Regardless of your prior experience and education you will apply and implement concepts during 2 through 6 quarters.

Attendance: The attendance policy for each course in the program is listed on the Green Sheet, which will be distributed on the first day of each class.

Dress code: The Nursing Department student dress code is detailed in the Nursing Student Handbook. Please review this policy prior to enter the clinical area. Remember that the blue vest is to be worn in the clinical areas only. The vest is to be removed upon leaving the clinical facility and is not to be worn on campus or socially.

Patient confidentiality and socialization/fraternization: These issues will be discussed at length during the program. All students will be asked to sign a statement regarding these issues. Remember that this policy continues to be in effect throughout the program. If you have any questions contact your instructor or the Director of Nursing.

Immunizations: The physical examination and all immunizations must be completed and current in order to be in the clinical setting. A tuberculosis testing is required before entering the nursing program and upon completion of and before graduation from the nursing program.

CPR: A CPR certificate must be presented upon entry into the program and must be current throughout the program. (American Heart Association issues 2-year certificates)

Nursing Skills Laboratory: The nursing skills laboratory hours are Mon-Fri., 7:30 a.m. to 4:30 p.m. (Closed 11:30 a.m. to 12:30 p.m.)

Telephone numbers: For instructors not listed below, contact numbers and instructions will be listed in the Green Sheet.

FULL TIME FACULTY

~~Susan Bruch~~	~~864-8638~~
Judith Clavijo. Director .	864-8397
Sherri Cozzens	864-8533
Cassie Hanna	864-8843
Catherine Hrycyk	864-5529
Olga Libova	864-5494
Patricia O'Neil	864-8641
Rebecca Sherwood	864-8633

STAFF

Jean Burke. Nursing Lab.	864-8897
Melissa Ingalls. Adm. Assistant	864-8773
Robert Jeckell. Nursing Specialist.	864-5618
Marge Sainten, Resource Center	864-8687
. Div Dean	864-8332

Schedule of classes: The days, times, and location of classes can be found, for the most part, in the Schedule of Classes. Prior to the new quarter, course information can be obtained from the "lead" instructor's telephone message, office door, program web-site, and/or Green Sheet.

Accountability Statement

Your socialization into nursing includes the earning of certain rights that will be essential to your practice. Since these rights are not owed to you automatically, you must begin to integrate them into your practice while you are a nursing student. The nursing faculty is accountable to society, clients, clinical agencies, DeAnza College, and the individual student to insure that the student is a safe and effective practitioner and, therefore, has the authority and professional responsibility to give feedback to the student related to clinical and theory performance in a timely manner.

Some important rights for you to begin earning as a nursing student include the following:

1. the right to practice nursing in accord with professional standards
2. the right to be trusted by members of the public
3. the right to be believed when speaking in the area of his/her expertise
4. the right to be trusted by colleagues
5. the right to intervene when necessary to protect patients, clients or the public.

The above stated rights reflect the duties or responsibilities of the nurse that must be upheld. Failure to uphold the duties of practicing within the standards of nursing can mean the withholding of the rights either legally (through the BRN/BVN) or through the action of the employer or even fellow professionals or patients/clients and/or their families.

Specifically, the primary duty of the nurse is to provide adequate and safe care within standards defined by professional and institutional/agency policies. For a nurse to fulfill this primary duty, he or she must possess some important character traits, namely: benevolence, honesty, respect, fidelity and integrity.

In brief, this means that a nurse must be truthful and honest, respect the human rights of others, and be committed to the goals of nursing. From the moment you enter nursing school, you are expected to practice and demonstrate these character traits. Therefore, in all matters relevant to patient care you will be held accountable for speaking the truth; and for all behaviors that impact on patient care:

1. Patient safety and welfare are more important than your need to *appear* "perfect" or "right" all the time.

2. Patient safety and welfare are more important than your desire to avoid:
   - o losing points for attendance (e.g., when you are sick)
   - o a reprimand or plan for improvement
   - o filling out a reflection.

3. Patient safety and welfare depends on prompt acknowledgment and reporting of errors in the clinical setting (e.g., omission of a scheduled treatment or a medication error). These kinds of serious errors generally require remediation (e.g., practice in Skills Lab); however, *lying* about an error is even more serious and could result in immediate disqualification from the Nursing Program.

References: 1/ "Collegial Ethics of a Caring Profession", Leah L. Curtin, *Nursing Management*, vol. 25, no. 8, pp. 28-32, (1994).

2/ ANA Code for Nurses.

Rev. 6-14-99

ADA Compliance Statement

In compliance with the 1990 Americans with Disabilities Act (ADA), De Anza College School of Nursing does not discriminate against qualified students with disabilities. According to the ADA, a disability is:

- a physical or mental impairment that substantially limits one or more "major" life activities
- a record of such impairments
- being regarded as having such an impairment

A qualified student is one who satisfies the skills, education, experience, and job-related requirements. Nursing students at De Anza College need to be able to perform essential nursing skills with or without reasonable accommodation. A nursing student should not pose a direct threat to the health and safety of others.

The mission of De Anza College School of Nursing is to educate and prepare safe and effective entry level nurses who are able to provide nursing care in a variety of health care settings. To this end, the faculty have identified essential skills which student nurses must be capable of performing. These essential skills can be categorized into the areas of cognitive learning, communication, and psychomotor skills. Examples of each of these areas are delineated as follows:

Cognitive Learning Skills

- Possess critical thinking abilities sufficient for clinical judgment: the ability to assess patient status and make appropriate clinical decisions regarding course of action within given time constraints
- Effectively synthesize client data from a variety of sources including written, verbal, and observational (assessment)
- Prioritize nursing care for needs of multiple patients simultaneously
- Demonstrate independence in reasoning and decision making
- Solve practical problems and deal with a variety of variables in situations where only limited standardization exists
- Perform mathematical calculations for medication preparation and administration

Communication Skills

- Communicate clearly, verbally, nonverbally, and in writing using appropriate grammar, vocabulary and word usage
- Interact effectively on an interpersonal level with clients, families, and groups
- Function effectively under stress
- Provide client teaching in a variety of modalities including: written, oral, and demonstration
- Receive instruction verbally, written, and telephone; interpret and implement
- Demonstrate appropriate control of affective behaviors, verbal, physical, and emotional levels to ensure the emotional, physical, mental, and behavioral safety in compliance with the ethical standards of the American Nursing Association

Psychomotor Skills

- Demonstrate sufficient sensory perception (visual, auditory, tactile) to accurately assess and monitor client health needs and respond quickly to emergencies
- Demonstrate physical abilities and stamina sufficient to move from room to room and maneuver in small spaces

If the student is unable to perform any of these essential skills, it is his/her responsibility to request an appropriate accommodation. The School of Nursing will determine, on an individual basis, whether or not the necessary accommodations or modifications can reasonably be made.

REGISTERED NURSING PROGRAM

NURSING [redacted] 55A

PSYCHIATRIC/MENTAL HEALTH NURSING

UNITS:

4 (4 hours of theory)

PREREQUISITES:

Nursing 54IR, Nursing 54IL & Nursing 54JR or Nursing 55B, Nursing 55BL, and Nursing 55C

Co-requisite: Nursing 54KL

FOREWORD:

Psychiatric/Mental Health Nursing is a quarter long course consisting of four theory hours. It is designed to prepare the student to utilize the Nursing Process in meeting client's self-care deficits with an emphasis on the biopsychosocial needs of individuals across the life span who experience acute and chronic psychopathology. Theories of psychosocial nursing will be taught in concert with nursing care of clients experiencing acute and chronic psychopathology as well as pathophysiology.

Critical thinking and problem solving skills will be employed through group and individual exercises with consideration for the Registered Nurse scope of practice.

COURSE OBJECTIVES:

1. Examine assumptions and points of view that provide a conceptual framework for the care of individuals in psychiatric/mental health settings.

   Theory Objectives:

   1.1 Define the legal-ethical-managerial responsibilities of the nurse in psychiatric settings.

   1.2 Review need-oriented theories that are useful to nursing in understanding human behavior.

   1.3 Identify cultural/ethnic and other individual differences among clients that influence nursing actions.

   1.4 Apply concepts of human behavior to one's own personal experience and values.

   1.5 Explain the biopsychosocial theories that underlie the individual's impaired capability for meeting therapeutic self-care demands that result in a mental disorder.

2. Collect an accurate, descriptive and comprehensive Orem assessment database.

   Theory Objectives

   2.1 Assess the individual's universal, developmental and health-deviation self-care requisites.

   2.2 List all categories of self-care requisites to be assessed and cite examples of what is assessed in each.

3. Organize self-care requisite assessment data and infer relevant nursing diagnoses.

   Theory Objectives:

   3.1 Identify self-care deficits based on the relationship between the client's therapeutic self-care demands and his self-care capability.

   3.2 Select nursing diagnoses for self-care deficits associated with certain mental disorders or conditions.

4. Interpret the relevance of comprehensive client data in terms of goals for meeting the individual's therapeutic self-care demands.

   Theory Objectives:

   4.1 Formulate long term and short term goals that are common to specific alterations in human functioning that affect mental health self-care capability.

   4.2 Recognize common personal reactions and feeling of the nurse to clients with selected mental health self-care deficits.

5. Assemble realistic and precise consequences of reasoning into a nursing system for implementing a plan of care.

Theory Objectives:

5.1 List categories of nursing interventions common to individuals in psychiatric/mental health settings and give examples of each.

5.2 Interpret medical and other interdisciplinary team treatment protocols in terms of need for nursing actions.

5.3 Develop nursing systems based on representative case studies within psychiatric/mental health care settings.

6. Evaluate outcomes and give meaning to the client's efforts toward restoration of self-care ability.

Theory Objectives:

6.1 Describe the client's performance of self-care measures as well as the nursing action indicated toward specific therapeutic self-care demands.

References Required:

Please see the current "Reading List" or "Required Readings".

Fall 2013

I: Assignments for Nurs85A (Theory)

Week 1: Fill out the "Student Success Questionnaire", Respond to the question on "Silence" and "Know Thyself". Read the "Patients' Rights Handbook"(no written work required)
Forms for the first 3 assignments are in the "Workbook". Obtain the Pts Rights Handbook from your clinical area. Complete these assignments and turn in by Friday of Week One.

Week 2: "Culture Paper": Write a one page typed paper on any aspect of mental health/illness from your own life's experience within your culture. This should be from your own lived or observed experience. Turn in on Friday of Week 2.

Week 3: "Suicide Response": Respond to the statement "Anyone who really wants to kill himself will do it and there is nothing you can do about it." Give careful thought to the validity of this statement and think about what you have learned in this course that has changed your previous thinking. Turn in your typed one page paper on Friday of Week 3.

Week 4: (1) Complete the Self Learning Module, *"Nursing Management of Alcohol Withdrawal"*, and turn in the test questions on Friday of Week 4. (2) Turn in your report on your visit to an Alcoholics Anonymous (AA) mtg. Use the format on the form located in the "Workbook", but type your paper and turn in Friday of Week 4.

Week 5: "Family Violence": Respond to the statement "She will just go back to him anyway so what's the point (of providing care and resources)? Do you agree or disagree? Why or why not? What have you learned in this course that has altered the way you would have answered this question before? Turn in your typed one-page response by Friday of Week 5.

Note: Because of holiday schedules or other circumstances, the Instructor may change the due dates for assignments as needed. Students are responsible for letting the Instructor know ahead of due dates if they have extenuating circumstances or need more time to complete work. Students, as adult learners in a collegiate course are expected to plan well ahead to have multiple coursework requirements ready during the same week, e.g. exams, class presentations, and papers, as well as clinical assessment/careplans will be due concurrently.

(please see Page II for Video/DVD Assignments)

Cont. Assignments
Fall 2013

II. Instructions for Required Videos and Write-Up (Theory Assignment)

Four (4) videos are required to fulfill the class points for videos per the Greensheet. However, viewing as many as you can is strongly recommended for best learning and understanding of course material. For viewing videos beyond the four that are required there is no write up to turn in.

For each write-up: Make a list of four to six main points. Then, write a short paragraph (four to six sentences) on how you will apply what you have learned in any area of your work as a nurse. **Please type your papers.**

Every student is required to watch ***"I'm Still Here"*** (TURN IN FRIDAY OF WEEK 2), and ***"Physicians Perspective on Domestic Violence"*** (TURN IN FRIDAY OF WEEK 4)

The two videos of your choice are due FRIDAY OF WEEK 5 .

Recommended other videos from which to choose:

Chemical Dependency (or Addictions) a set of four.

Family Violence (or Domestic Violence) a set of four (not the same as Physicaians Perspective above)

OCD (Obssessive Compulsive Disorder)

Healthy Women 2000

Dying to Be Thin

The Long Journey Home (the family's response)

Schizophrenia (set of 3)

Extrapyramidal Symptoms

Mental Status Exam

Additional videos/DVDs are on the 5th qtr shelf, please check with Marge in the Lab

Note! Section III "Clinical Assignments" is located in the SSAL Syllabus.

De Anza College
Department of Nursing

Program Reflection

Student's Name_____
Facility/Unit_____
Course_____
Date_____

Event/Situation prompting this document_____

_____

_____

_____

On a separate piece of paper, write a narrative note reflecting on the event/situation. In accordance with the Student Handbook, under **Student Performance, Reflection,** follow the guidelines listed:

1. Describe the incident in your own words.
2. What factors led (contributed to this incident?
3. How would you approach this or a similar situation in the future?

DATE DUE: _____ At this time the appropriateness of the written reflection will be determined.

The following signature indicates that the student understands the purpose of this document.

Student signature:_____ Date:_____

**Instructor's signature:_____ Date:_____

The following signature indicates that the student has been presented with this assignment but has refused to sign the document.

Witness:_____ Date:_____
(Any other De Anza Nursing Instructor)

**INSTRUCTORS: Keep this original: give a copy to student.

Plan for Improvement

TO:
FROM:
DATE:
RE:

I: I have identified that your performance is deficient in the following areas:

1.

2.

3.

II: In order to achieve satisfactory improvement of your performance and successful resolution of the Plan for Improvement, you must be demonstrating the following:

1.

2.

3.

III: Evaluation of the improvements: Immediately and ongoing, through the last clinical/ theory day of this course, or until_____, you must be demonstrating accurate performance of the above designated behaviors. During this period **any** infraction of these will lead to immediate removal from the course, failure of the course and a withdrawal with penalty. If no infractions happen during this period, your PI will be considered "successfully resolved." If, during the course of the nursing program, you acquire two additional PIs for _____, you will be withdrawn with penalty.

IV: Suggested activities for improvement:

Clinical and/or theory instructor(s) will provide you with verbal or written feedback on an as-needed basis.

The following signatures indicate that the instructor has explained the student performance deficiencies that led to this Plan for Improvement. Furthermore, the following student signature indicates that student has read, understands, and has had the opportunity to discuss this Plan with the instructor.

Student_____Date_____

Instructor_____Date_____

Plan for Improvement Outcome(s):

The student must provide a copy and discuss all PIs with all clinical and theory instructors involved during the time frame in which the PI is in force.

De Anza College Nursing Program
Student Evaluation of Theory Course

Course _____ Quarter: (Fall Winter Spring) Year ____

Please evaluate the course by using the provided Scantron form. Mark the Scantron for each of the 17 questions below according to the following guidelines:

A = Strongly agree
B = Agree
C = Disagree
D = Strongly disagree
E = No opinion/Not applicable

1. The course objectives were clear.
2. The objectives of the course were obtainable.
3. The amount of work required for this course was appropriate for the credit received.
4. The complexity of the course was appropriate for this level.
5. The required textbook for this course was helpful for meeting the objectives.
6. The out-of-class assignments (eg., A.V., group activities, etc.) were relevant to the course objectives.
7. The out-of-class suggested reading and A.V. assignments were accessible.
8. The assigned reading and A.Vs for this course were appropriate.
9. The tests (quizzes, etc.) in this course related to the course objectives.
10. The assigned papers for this course contributed to the achievement of course objectives.
11. The course was well structured (ie., the progression seemed logical).
12. The lectures/demonstrations in the course were appropriate.
13. Class time allowed for discussion and questions was appropriate.
14. The methods for presenting content were effective.
15. The course has helped me to improve in clinical performance.
16. The topics covered in exams and assignments for this course were consistent with the course objectives.
17. Compared to other courses in my major, I would rate this course as effective.

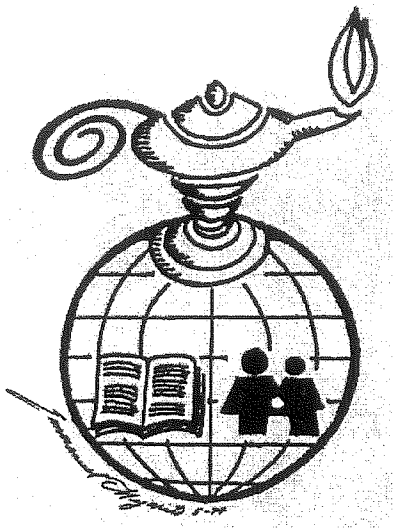
Written Evaluation: (Please respond to the following):

1. What did you like about this course?

2. What did you dislike about this course?

3. What specific changes could improve this course?

4. Please make any additional comments or suggestions about this course.



De Anza College

School of NURSING

NURSING ~~54K~~ 85 A

Psychiatric Mental Health Nursing

Lecture Notes

Rebecca Sherwood, DNSc, RN, CS

REQUIRED READING LIST

Important: Read the Chapters PRIOR to each class.

TEXT:

- **Halter, Margaret J. *Varcarolis' Foundations of Psychiatric Mental Health Nursing: A Clinical Approach* , W.B. Saunders, 2014 (7th Edition).**

WEEK-1:

Chapter 4: Settings for Psychiatric Care
Chapter 7: The Nursing Process and Standards of Care
Chapter 8: Therapeutic Relationships
Chapter 9: Communication and the Clinical Interview
Chapter 10: Understanding and Managing Responses to Stress

WEEK-2:

EXAM I: (Covers readings for Week 1)

Chapter 3: Biological Basis for Understanding Psychiatric Disorders and Treatments: pages 37-52
Chapter 15: Anxiety and Obsessive-Compulsive Disorders (pages 279-282 and Table 15-2 (Defense Mechanisms)
Chapter 12: Schizophrenia and Schizophrenia Spectrum Disorders

WEEK-3:

EXAM II: *(Covers Week 2 Readings)*

Chapter 3: (Cont.) Biological Basis for Understanding (remainder)
Chapter 15: (Cont.) Anxiety Disorders and OCD (remainder of chapter)
Chapter 14: Depressive Disorders
Chapter 23: Suicide and Non-Suicidal Self-Injury

WEEK 4:

Exam III: *(Covers Week 3 Readings)*

Chapter 13: Bipolar and Related Disorders
Chapter 22: Substance-Related and Addictive Disorders

WEEK-5:

Chapter 18: Feeding, Eating and Elimination Disorders
Chapter 28: Child, Older Adult, and Intimate Partner Abuse
Chapter 5: Cultural Implications

WEEK –6:

EXAM IV: Exam IV is the Final. It is a comprehensive exam, (covers Weeks 4 and 5 as well as all other Required Readings for the entire course). The Final will be given on Friday of Week 6 for the first half of the quarter, and for the second half, it will be given **on Friday of the day of the last class meeting**.

NOTE: Chapters assigned per week may vary (i.e.be required in earlier or later weeks) from quarter to quarter, depending on holiday schedules or other circumstances. Exam dates may also vary depending on school holidays.

4, Settings for Psychiatric Care

CHAPTER 5 MENTAL HEALTH NURSING IN ACUTE CARE SETTINGS

TREATMENT ACUITY AND GOALS

Behavioral Health
mental health treatment programs
treatment for substance abuse
community based options

Inpatient Treatment
danger to self
danger to othersor others
"gravely disabled"

Goals of Treatment
prevention of self-harm
prevention of harm to others
stabilization of crisis
return to community-based services
psychotropic medication
regain compensation
rapid establishment of a plan

RIGHTS OF THE HOSPITALIZED PATIENT

rights as a citizen
specific rights are summarized in Box 5
refer to agency handbooks and unit policy and procedure manuals

INTERDISCIPLINARY TEAMWORK AND CARE MANAGEMENT

Interdisciplinary team: nurse, social worker, counselor, psychologist, occupational and activities therapists, psychiatrist, medical doctor, pharmacist, and mental health workers and case managers

Clinical Pathways
Example given on page 106

CONTINUED ON OTHER SIDE

NURSING ON THE INPATIENT UNIT

Management

Therapeutic Strategies

Milieu

Group Activities

Management of the Milieu

Safety

Documentation

Psychopharmacological Responsibilities

Crisis Management

Preparation for Discharge to the Community

Policy Review and Revision

CHAPTER 9 ASSESSMENT STRATEGIES AND THE NURSING PROCESS

Major Concepts and Terms

ASSESSMENT

Obtain understanding of current problem
Assess person's current level of psychological functioning
Identify goals
Perform mental status examination
Identify behaviors, beliefs, or areas of client life to be modified to effect positive change Formulate a plan of care

Considerations Regarding the Psychiatric Nursing Assessment

primary (preventive)
secondary (treatment)
tertiary (rehabilitative

Nurses need to examine personal beliefs and clarify their values so as not to impose them on others.

Countertransference issues may play a role in the nurse's perceptions.

Recognize that increased anxiety is "data."

Age Consideration

A thorough physical examination must be completed before any medical diagnosis is made because a number of physical conditions mimic psychiatric disorders.

Assessment of an Elderly Client

Assessment of Children

Assessment of an Adolescent Client

The Psychiatric Nursing Assessment

Gathering Data

Verifying Data

Ch 9 p 2

Special Areas to Assess

Spiritual assessment: questions relevant to spiritual assessment include the following:

What role does religion/spirituality play in your life?
Does your faith help you in stressful situations?
Do you pray/meditate?
Who or what supplies you with strength and hope?
Has your illness affected your religious/spiritual practices?
Do you participate in any religious activities?
Do you have a spiritual advisor or member of the clergy available?
Is there anyone I can contact to help put you back in touch with your church/place of worship?

Cultural and Social Assessment

Questions that help with a cultural and social assessment are the following:

What is your primary language? Would you like an interpreter?
How would you describe your cultural background?
Whom are you close to? Whom do you seek in times of crisis?
Whom do you live with?
Whom do you seek when you are medically ill? Mentally upset or concerned?
What do you do to get better when you are medically ill? Mentally ill?
What are the attitudes toward mental illness in your culture?
How is your mental health problem viewed by your culture? Is it seen as a problem to fix, a disease, a taboo, a fault or curse?
Are there special foods that you eat?
Are there special health care practices that address your particular problem?
What economic resources are available to your family?

Use of Rating Scales

Rating scales are used for evaluation and monitoring. Table 9–4 lists several.

NURSING DIAGNOSIS

A nursing diagnosis has three structural components:

1. Problem (unmet need).
2. Etiology (probable cause).
3. Supporting data (signs and symptoms)

Formulating a Nursing Diagnosis

OUTCOME IDENTIFICATION

Ch. 9 p. 3
8

Determining the Desired Outcomes

Goals
are stated in observable/measurable terms;
indicate client outcomes;
set a specific time for achievement;
are short and specific;
are written in positive terms.

PLANNING

IMPLEMENTATION (Interventions)

Counseling:

reinforcing healthy patterns of behavior;
employing problem-solving,
interviewing and communication skills;
crisis intervention
stress management;
relaxation techniques;
conflict resolution
and behavior modification.

Health Teaching

Self-Care Activities

Psychobiological Intervention

Milieu Therapy

Continuing Data Collection

Data collection is an ongoing process throughout all phases of the nursing process.

EVALUATION

Evaluation is an ongoing process throughout all phases of the nursing process.

Evaluating Outcome Criteria

Ch 9 p. 4

The three possible outcomes when goals are evaluated are goal met, goal not met, goal partially met. Client behaviors should be recorded as evidence.

DOCUMENTATION

Client progress is documented throughout hospitaliztion:

Client condition (emotional and physical)
Medications
Treatments
Tests
Response to treatment
Pain response and treatment

The various charting methods are reviewed in Table 9–6.

STUDY ACTIVITIES

CHAPTER OBJECTIVES
CRITICAL THINKING QUESTIONS
CHAPTER REVIEW QUESTIONS
WEBSITE QUESTIONS

8: Therapeutic Relationships

CHAPTER 10 DEVELOPING THERAPEUTIC RELATIONSHIPS

UNDERSTANDING THE HELPFUL NURSE-CLIENT RELATIONSHIP

Types of Relationships

Social relationships

Intimate relationships

Therapeutic relationships

FACTORS THAT ENHANCE GROWTH IN OTHERS

The following factors are considered crucial for effective helpers.

Genuineness

Empathy

Positive Regard

Helping Clients Develop Resources

ESTABLISHING BOUNDARIES

Blurring of Boundaries

Transference

Countertransference

Self-Check on Boundary Issues:

Table 10–3 illustrates how the nurse can self-test for boundary "issues" (p.228)

Ch 10 p 2
9

UNDERSTANDING SELF AND OTHERS

Values

Values Clarification

Seven Processes of a Value:

Prizing one's beliefs and behaviors (emotional)
1. Cherishing the value
2. Publicly affirming the value when appropriate.

Choosing one's beliefs and behaviors (cognitive)
3. Choosing the value from alternatives
4. Choosing the value after consideration of consequences
5. Choosing the value freely

Acting on one's beliefs (behavioral)
6. Acting in accordance with the value
7. Acting on the value with a pattern, consistency, and repetition.

PHASES OF NURSE-CLIENT RELATIONSHIP:

Preorientation Phase

Orientation Phase

(1)parameters of the relationship (i.e., purpose of the meetings)
(2) a formal or informal contract (i.e., an agreement on specific places, times, dates, duration of meetings, and goals for meetings);
(3) confidentiality (i.e., the information the client shares with the nurse will be shared with the treatment team, but not with others with no need to know);
(4) termination (i.e., the client should know the date of termination if the relationship is not open-ended).
(5)During this phase the nurse will need to be aware of transference-countertransference issues; respond therapeutically to client "testing" behaviors; promote an atmosphere of trust; foster client articulation of problems; and establish mutually agreed-upon goals.

Working Phase

Tasks include maintaining the relationship; gathering further data; promoting clients'

problem-solving skills, self-esteem, and use of language; facilitating behavioral change; overcoming resistance behaviors; evaluating problems and goals, and redefining them as necessary; and fostering practice of alternative adaptive behaviors. Unconscious motivation and needs may cause the client to experience intense emotions and prompt client behaviors such as acting out anger inappropriately, withdrawing, intellectualizing, manipulating, and denying. Transference and countertransference may be experienced.

Termination Phase

This is a time for summarizing goals, reviewing situations that occurred, and evaluating progress.

WHAT HINDERS AND WHAT HELPS THE NURSE-CLIENT RELATIONSHIP

Helpful Behaviors:

consistency, pacing, listening, positive initial impressions, promoting client comfort and balancing control, trust on the part of the client, and client active participation in the relationship.

Behaviors that Hinder the Relationship:

The specific behaviors that hindered development of positive relationships were inconsistency, unavailability, lack of self-awareness on the part of the nurse, and negative feelings on the part of the nurse.

9: Communication & The Clinical Interview

CHAPTER 11 -- THE CLINICAL INTERVIEW AND COMMUNICATION SKILLS

10

THE CLINICAL INTERVIEW

Goal of the Nurse:

- To understand client problems
- To facilitate client problem-solving

What approach does the nurse use?

- Allows the client to determine the content and direction
- Uses therapeutic communication skills
- Uses good observation skills of nonverbal behavior
- Provides the environment for goal achievement

How to Begin the Interview:

- Setting
- Seating
- Introduction
- How to Start
- Tactics to avoid
- Helpful guidelines

CLINICAL SUPERVISION AND PROCESS RECORDINGS

The nurse examines his/her own beliefs, attitudes, behaviors

- Use of supervision
- Self analysis by introspection
- Use of process recordings of interactions with clients

WHAT TO DO IN RESPONSE TO SPECIFIC CLIENT BEHAVIORS

- Crying
- Asking the nurse to keep a secret
- Threatening to commit suicide
- Leaving the interview
- Asking the nurse personal questions
- Giving the nurse a present
- Stating "I don't want to talk"

(study Table 11–2 for these and additional examples)

COMMUNICATION SKILLS

The Communication Process

- stimulus
- sender
- message
- receiver
- feedback

Factors That May Affect Communication

- Mood
- Knowledge levels
- Language use
- Previous experience
- Cultural differences
- Language
- Environmental factors

Verbal Communication

Verbal communication means all ***words*** that a person speaks.

Words spoken communicate to others:

- Beliefs and values
- Perceptions and meanings
- Interest and understanding
- Insult or judgmental attitudes
- Clarity or confusion
- Honest or distorted
- Differing interpretations

Nonverbal Communication

- tone of voice, manner, facial expression,
- body posture, eye contact, eye cast,
- hand gestures, sighs, fidgeting, and yawning
- depends on culture, class, gender, age, sexual orientation, and spiritual norms.

Interaction of Verbal and Nonverbal Communication

- verbal message is the content
- nonverbal message is the process
- verbal and nonverbal messages to be congruent
- double or mixed message if not congruent

Negotiating Cultural Communication Barriers

Communication styles:

- Hispanic, French, and Italian
- Asian Americans, German Americans, and English Americans
- African American clients.

Eye contact:

- Hispanic, Japanese, and Native American
- Chinese
- Arab
- German, Russian, French, English, and African American

Touch:

- Hispanic, Italian, French, and Russian Americans
- (TOUCH CONTINUED)
- German, Swedish, and English Americans
- Chinese Americans
- Japanese
- India

EFFECTIVE COMMUNICATION SKILLS

Degree of Openness

- open-ended questions
- closed-ended questions

Clarifying Techniques

- Paraphrasing
- Restating
- Reflecting
- Exploring

Use of Silence

- indicates willingness to let the client set the pace
- communicates strength and support
- provides an opportunity to think.

Active Listening

- Observing nonverbal behaviors
- Listening to and understanding client's verbal message
- Listening to and understanding the person in the context of his life
- Listening for inconsistencies or things the client says that need clarification
- Consideration of cultural biases
- Helps clients use their abilities to solve problems, clarify thinking, and link ideas
- Enhances client self-esteem.

OBSTRUCTIVE TECHNIQUES TO MONITOR AND MINIMIZE

- Asking Excessive Questions
- Giving Approval or Disapproval
- Advising
- "Why" Questions

A GOOD PHRASE TO KEEP IN MIND FOR THERAPEUTIC COMMUNICATION:

"Respond to the person instead of trying to make a good response."

CHAPTER 12 UNDERSTANDING STRESS AND HOLISTIC APPROACHES TO STRESS

LECTURE NOTES/STUDY OUTLINE

STRESS

Hans Selye, Father of Stress Respose
Nnspecific result of any demand
G.A.S.

Fight or flight:

Prolonged Stress:

Distress

Eustress

STRESSORS

Physical

Psychological

STRESS AND COPING

Mediating Factors
Age
Sex
Culture
Life experiences
Life style

Social support

Self-Help Groups

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11

Culture and Stress

What is considered dangerous
How to manage violations of social code
What reactions are permissible
How a stressful event is appraised
How emotion should be expressed
How people experience stressors
What interventions will be useful
Somatic expressions of stress

Spirituality and Stress

Religious and spiritual beliefs
Immune system and sense of well-being.

ASSESSING STRESS AND COPING STYLES

Measuring Stress

Life Change Questionnaire

Health
Work
Home and Family
Personal and Social
Financial

Gender differences

Assessing Coping Styles

Health-sustaining habits
Life satisfactions
Social supports
Response to stress

Positive Responses

Negative Responses

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11

HOLISTIC APPROACHES TO STRESS

Benefits of Stress Reduction:
altering the course of medical conditions
decreasing need for medications
diminishing or eliminating unhealthy behaviors
enhancing learning
allowing creative perceptions of events
increasing sense of well-being

Behavioral Approaches

Relaxation techniques:

Benson's relaxation technique

Induce parasympathetic response
Importance of proper selection of patients

Meditation:

Calms the mind
Decreases sympathetic response

Guided imagery

Pain relief
Support of Immune System

Breathing Exercises

Respiratory retraining
Abdominal breathing
Reverses negative thinking
Decreases anxiety

Behavioral Techniques Requiring Special Training

Progressive muscle relaxation (PMR)

Biofeedback

Cognitive Approaches

Journal keeping
helps identify sources of daily stress

Restructuring and setting priorities
introducing daily pleasant events

Cognitive restructuring and reframing
replacing worried self-statements with more positive self-statements
restructuring a disturbing event to one that is less disturbing
reduces sympathetic nervous system stimulation
reduces secretion of cortisol and catecholamines.

Assertiveness training
simple assertion via a direct statement
empathic assertion
nonaccusingly describing the situation, stating one's feelings about the situation, and asking for change
confrontational assertion

Other Effective Stress Reducers

Music
Pets
Exercise

REVIEW ACTIVITIES
Have you achieved the chapter objectives?
Did you think through the critical thinking questions?
Did you answer the multiple choice questions?
Did you visit the *Simon* website for the post-test?

2. Biological Basis Chapter 3

Psychobiology Handout

STRUCTURE AND FUNCTION OF THE BRAIN

Psychiatric illness and the treatment of psychiatric illness alter brain functioning. Some examples of this are the following:

1. Monitoring of the external world
    - Altered sensory experience
        - e.g. hallucinations, illusions
2. Control over skeletal muscles
    - Movement disturbances
        - Extrapyramidal symptoms
        - Respiratory alterations
        - Slurred speech
3. Regulating internal muscles
    - Autonomic nervous system
        - blood pressure alterations
    - Parasympathetic nervous system
        - Anxiety
    - Endocrine regulation
        - Menstrual cycle irregularities
        - Stress response
    - Regulating basic drives
        - Overeating or undereating
        - Low sexual drive
4. Regulating sleep cycle
    - Sleep disturbance
    - Hypervigilance
    - Drowsiness
5. Mood

6. Neurotransmitter dysregulation

   - Serotonin
   - Norepinephrine

7. Conscious experience

   - Distorted thought patterns
     - delusions
   - Disorganized speech
     - Word salad

8. Memory

   - Inability to retain or recall past experience
   - Learning disorders

CELLULAR COMPOSITION OF THE BRAIN

Neurons

- Specialized cells of the CNS
- Respond to stimuli
- Conduct electrical impulses
  - Inward flow of sodium ions
  - Outward flow of potassium ions
  - Change in polarity
  - Electrical charge from dendrite to axon

Release of neurotransmitters (NT)

- NT released into synaptic cleft
- NT attaches to surface of next neuron
- NT then detaches and is destroyed is taken back up in original neuron to be reused or destroyed (reuptake)

ORGANIZATION OF THE NERVOUS SYSTEM

Brainstem

- Regulates internal organs
  - Vital functions
  - Initial processing center for sensory information
  - Reticular activating system (RAS)
    - Sleep-wake cycles
    - Focused mental activity
- Determines emotional meaning of sensory stimuli

Cerebellum

- Regulates skeletal muscle coordination
- Maintains equilibrium

Cerebrum

- Responsible for mental activites
  - Conscious perception
  - Emotional states
  - Memory
  - Willful control of skeletal muscles
  - Language/communication

- Basal ganglia functions
  - Regulation of movement

- Amygdala and hippocampus functions
  - Emotions
  - Memory & learning
  - Basic drives

BRAIN IMPAIRMENT AND DISEASE

Frontal Cortex

- Schizophrenia
- Obsessive-Compulsive Disorder (OCD)

Prefrontal Cortex

- Depression

Limbic System

- Various disease symptomatology

MAJOR TARGETED NEUROTRANSMITTERS FOR PHARMACOLOGICAL RX

Monoamines

- Norepinephrine
- Dopamine
- Serotonin

Acetylcholine

GABA (gamma aminobutyric acid)
\

Corticotrophin-Releasing Hormone (CRH)

Endorphins

MECHANISMIS OF ACTION OF PSYCHOTROPIC DRUGS

Most psychotropic drugs act by either increasing or decreasing the activity of certain neurotransmitter systems.

Antipsychotics

1. Conventional (Standard, Typical or older drugs)

    - Phenothiazines and related classifications

        - Dopamine blockers
            - Motor disturbances due to basal ganglia blockade
            - Reduce the "positive" symptoms of Schizophrenia

        - Muscarinic blockers (acetylcholine)
            - Blurred vision, dry mouth, urinary retention, constipation

        - Alpha-1 receptor-blockers (norepinephrine)
            - Vasodilation & orthostatic hypotension
            - Ejaculatory failure

        - H-1 receptors (histamine)
            - Sedation
            - Weight gain

2. Atypical (Novel, newer drugs)

    - Very few, to no motor disturbances
    - Blocks D-2 in limbic system (not basal ganglia)
    - Target positive symptoms of Schizophrenia
    - Block receptors for serotonin
    - Target negative symptoms of Schizophrenia

    - Side-effect Profiles

        - Clozapine
            - Agranulocytosis
            - Convulsions (infrequent)
            - Drowsiness
            - Hypersalivation
            - Tachycardia
            - Dizziness

- Risperidone
  - Orthostatic hypotension
  - Sedation

- Quetiapine
  - Alpha-1 blockade effects
  - Muscarinic blockade effects
  - Minimal EPR effects
  - Weight gain
  - Sedation

- Olanzapine
  - No agranulocytosis
  - Other S/E similar to clozapine
  - WEIGHT GAIN (very severe problem)

Mood Stabilizers

1. Lithium

- Unknown mechanism of action
- Likely stabilizes electrical activity of brain by interaction with Na & K
- Fluid balance disturbances
- Cardiac dysrhythmias, convulsions, tremor
- Requires close monitoring of lithium blood levels

2. Anticonvulsants

- Alter electrical conductivity in the brain
- Reduce the firing rate of neurons
- Reduce mood swings of bipolar disorder
- Drugs used include:
  - Tegretol (carbomezapine)
  - Depakote (divalproex sodium)
  - Klonopin (clonazepam)
    - Strongly sedating

Antidepressants

A deficiency of norepinephrine or serotonin or both is thought to be a causative factor in depression.

1. Typical (Standard) Antidepressants

- Tricyclics (TCA's)
  - Block reuptake of norepinephrine and to a lesser extent, serotonin thus increasing amounts of both in the synapse
  - Block muscarinic receptors

- Block histamine-1 receptors
- Names of TCA's:
  - Anafranil (clomipramine)
    - Used for OCD also
  - Elavil (amitriptyline)
  - Tofranil (imipramine)
    - Used also for panic attacks
  - Pamelor (nortriptyline)

- Selective Serotonin Reutake Inhibitors (SSRI's)
  - Block the reuptake of serotonin
  - Minimal or no effect on other monoamine transmitters
  - Minimal blocking of muscarinic and H-1 receptors
  - Also used for OCD
  - Names of SSRI's:
    - Prozac (fluoxetine)
    - Zoloft (sertraline)
      - Used also for social phobia
    - Paxil (paroxetine)
    - Citalopram (Celexa)

- Monoamine Oxidase Inhibitors (MAOI's)
  - Inhibit the enzyme MAO from degrading monoamine neurotransmitters
  - Increase the availability of monoamine NT's in the synapse
  - Risk of hypertensive crisis
    - Monoamine oxidase (MAO) in the liver is also inhibited
    - Tyramine injested in food cannot be degraded in the liver without MAO
    - Tyramine builds up to dangerous levels and goes into bloodstream
    - Increased tyramine in the blood can cause a life-threatening hypertensive crisis
    - Tyramine containing foods must be eliminated when a patient is on an MAOI
  - Names of MAOI's:
    - Nardil (phenelzine)
    - Parnate (tranylcypromine)

2. Atypical (Novel) Antidepressants

- Mechanism of action is not clearly defined
- Act on serotonin by increasing and decreasing levels at different stages of neurotransmission
- Minimal affect on norepinephrine
- Names of Atypical Antidepressants
  - Desyrel (trazodone)
    - Orthostatic hypotension
    - Sedation
    - Minimal anticholinergic effects
  - Serzone (nefazodone)
    - No orthostatic hypotension
    - No sedation

- Effexor (venlafaxine)
  - Useful in severe depression
  - May cause anxiety, nausea and vomiting, dizziness
  - Impotence in males
- Remeron (mirtazapine)
  - Sedation and weight gain
  - Dry mouth and constipation
- Wellbutrin (bupropion)
  - Headache, insomnia, nausea, restlessness

Antianxiety / Anxyiolytics

- Enhance GABA
- Sedative-hypnotic effect
- Reduction of anxiety
- Reduces seizure activity
- Reduces neuronal overexcitability in alcohol withdrawal
- Impairs motor activity, attention span, and judgment
- Names of benzodiazepines:
  - Valium (diazepam)
  - Klonopin (clonazepam)
  - Ativan (lorazepam)
- Non-benzodiazepine:
  - BuSpar (Buspirone hydrochloride)
    - Reduces anxiety
    - Minimal sedative-hypnotic effects

15: Anxiety and OCD

Understanding Anxiety & Anxiety Defenses

Anxiety Disorders

Definition of Anxiety

- universal human experience
- feelings of apprehension & dread
- real or perceived threat
- anxiety versus fear
- body's response

Types of Anxiety

1. Normal
2. Acute
3. Chronic

Levels of Anxiety

Mild Anxiety

- Perceptual field:
  - Alert
  - Able to grasp what is happening
  - Able to identify source of anxiety

- Ability to learn:
  - Able to problem-solve
  - Able to respond effectively

- Physical / Behavioral response:
  - Restlessness
  - Irritability
  - Mild tension-relieving behavior

Moderate Anxiety

- Perceptual field:
  - Narrowing of perceptual field
  - Grasps less of what is happening
  - Selective inattention

- Ability to learn:
  - Decreased problem-solving ability
  - Guidance from others benefits learning
  - Still able identify problem/threat
  - Still able to take effective action

- Physical/Behavioral Response:
  - Voice trembles
  - Voice higher pitched
  - Shakiness

- Repetitive questioning
- Somatic complaints
- Increased pulse and respirations
- Increased muscle tension
- More extreme tension-relief behavior

Severe Anxiety

- Perceptual field:
  - Greatly reduced perceptual field
  - Focused on details
  - Focused on self, not aware of environment
  - Unable to focus even with assistance
  - Environment may be blocked out

- Ability to learn:
  - Unable to problem solve
  - Unable to act effectively
  - Distorted perceptions

- Physical/Behavioral response:
  - Feelings of dread
  - Sense of impending doom
  - Confusion
  - Purposeless activity
  - Hyperventilation

- Tachycardia
- Withdrawal
- More intense somatic complaints
- Loud, rapid speech
- Threats and demands

Panic Level of Anxiety

- Perceptual field:
  - Terrified
  - Unable to focus
  - Environment blocked out
  - Emotional paralysis
  - Possible psychosis
  - Loss of touch with reality

- Ability to learn:
  - No ability to problem-solve
  - Unable to act effectively
  - Irrational
  - Disorganized
  - Mute
  - Agitated
  - Exhausted

- Physical / Behavioral response:
  - Markedly disturbed behavior
  - Immobility or flight
  - Dilated pupils
  - Erratic
  - Impulsive
  - Unintelligible or Speechless
  - Severe shakiness
  - Severe withdrawal

Interventions

Mild to Moderate Anxiety

- Assist patient to focus
- Facilitate problem-solving
- Open-ended questions
- Broad openings
- Maintain calm presence
- Willingness to listen
- Acknowledge patient's distress

Severe to Panic Anxiety

- short, simple statements
- orient to reality
- determine themes of fear
- reduce environmental stimuli
- provide a safe environment
- attend to physical needs
- medication as needed
- restraint only as required

Reducing Stress and Anxiety

- The Nurse's Response
  - Self-awareness
  - Professional supervision

Defense Mechanisms

Definition

- Automatic response
- Protect the ego
- Lower anxiety
- Maladaptive uses

Properties of Defense Mechanisms

- manage conflict and affect
- relatively unconscious
- discrete
- reversible
- adaptive as well as maladaptive.

Mature Defenses

- Altruism
- Sublimation
- Humor
- Suppression

Neurotic Defenses

- Repression
- Displacement
- Reaction Formation
- Somatization
- Undoing
- Rationalization

Immature Defenses

- Passive aggression
- Acting out
- Dissociation
- Devaluation
- Idealization
- Splitting
- Projection

Psychotic Defenses

- Denial
- Psychotic denial

Nursing Application

- Assess and diagnose *the level of anxiety*
- Goal is to *reduce the level of anxiety* (e.g., from severe to moderate)
- Interventions are *appropriate for the level of anxiety*

Evaluation determines *whether anxiety is reduced or not*

Chapter 12:

Name of Disease: **Schizophrenia**

Definition

A Group of Disorders
Uncertain Cause
A Disorder of Thinking and Behaving

- Hallucinations
- Delusions
- Severe Social Withdrawal

Onset
Prevalence
A Tragic Disease
Economic Burden ($65 Billion)

Comorbidity

Substance Abuse

- Nicotine dependency

Depression
Anxiety
Suicide Risk

Historical Overview

All Cultures
Described Throughout Time
Eugen Bleuler and the "Four A's"(1920's)

- Autism
- Ambivalence
- Affect
- Associative Looseness (Incoherence)

Term Schizophrenia

- "fragmenting' of mental capacity

Overdiagnosis in 50's and 60's
Revised Criteria for Diagnosis: 1980

Pathophysiology and Etiology

Freudian Psychodynamic Theory

- "The Schizophrenogenic Mother"

Genetics

- Family Studies
- Twin Studies
- Adoption Studies
- Molecular Techniques

Neuroanatomy

- Cerebral Ventricular Enlargement
- Frontal Lobe Size Decreased
- Thalamus Decreased

Neurodevelopment

- Brain maturation disturbance
- Neuronal injury (perinatal)
- Viral Infections
- Nutrition

Neurochemistry

- Dopamine Hypothesis
- Other Neurotransmitter Systems
  - Norepinephrine
  - Serotonin
  - GABA
  - Neuropeptides

Social and Family Factors

- Inner City vs Suburbs
- Social Class Consequences

Signs and Symptoms

Positive Symptoms

Definition of Positive Symptoms

- Something added

Types of Positive Symptoms

1. Hallucinations
   - Definition of Hallucinations
   - Types of Hallucinations:
     - Auditory
     - Tactile
     - Visual
     - Gustatory
     - Olfactory
     - Other Abnormalities of Perception
       - Depersonalization
       - Derealization

2. Illusions

3. Delusions
   - Definition of Delusion

- Types of Delusions
  - Thought broadcasting
  - Thought insertion
  - Thought withdrawal
  - Delusions of Persecution
  - Delusions of Reference
  - Delusions of Control
  - Grandiose delusions

4. Disorganized Speech
   - Associative Looseness
   - Illogical thinking
   - Tangentiality
   - Concrete thinking
   - Distractibility
   - Clanging
   - Neologisms
   - Echolalia
   - Thought blocking

5. Disorganized Behavior
   - Catatonic stupor
   - Catatonic excitement
   - Waxy flexibility
   - Stereotypical behaviors

- Echopraxia
- Automatic Obedience
- Negativism
- Compulsive behaviors
- Social withdrawal
- Personal neglect
- Poor social judgment

6. Inappropriate Affect
   - Incongruent ("split") affect

Negative Symptoms

Definition of Negative Symptoms
- Something missing

Types of Negative Symptoms

1. Avolition/Apathy
2. Alogia/Poverty of Speech
3. Affective Flattening
4. Anhedonia
5. Attentional Impairment

Diagnosis of Disease

- Diagnosis requires continuous signs of illness for at least six months
- An Active Phase with psychotic symptoms is required for Dx

Differential Diagnosis

- Dementias
- Organic Delusional Syndromes
- Other Psychotic Disorders
- Obssessive Compulsive Disorder
- Factitious Disorder
- Personality Disorders (Cluster C)
- Cultural and Religious Beliefs
- Mental Retardation

Course of Disease

1. Prodromal Phase
   - Deterioration from previous level of functioning
   - Social withdrawal
   - Impairment in role functioning
   - Odd or peculiar behavior
   - Poor grooming/hygiene

- Blunted affect
- Inappropriate affect
- Speech disturbances
- Lack of initiative, interests or energy
  - "No longer the same person as they were before"

2. Active Phase
   - Delusions
   - Hallucinations
   - Associative looseness
   - Incoherence
   - Catatonic behavior

3. Residual Phase
   - Similar to Prodromal Phase
   - Flat/Blunt Affect very common
   - Impairment in role functioning very common

Types of Schizophrenia

1. Paranoid Schizophrenia
2. Disorganized Schizophrenia
3. Catatonic Schizophrenia
4. Undifferentiated/Residual Types

Medical Treatment

Antipsychotic Medication

- Conventional Agents
  - Thorazine
- Atypical Agents
  - Olanzapine

Side-Effect Management

- Extrapyramidal Symptoms (EPS)
  - Artane
  - Benadryl
- Tardive Dyskinesia
  - no treatment
  - AIMS assessment
- Neuroleptic Malignant Syndrome (NMS)

Other Categories of Medications

Psychosocial Management

- Community Settings
- Social Service Agencies
- Social Skills Training
- Vocational Training
- Coping Strategies

Alcohol/Drug Abuse

- Abstinence
- Detox and Rehab

Hospitalization

- Danger to Self or Others
- Gravely Disabled

Family Intervention

- Education Programs (NAMI)

Prognosis

- Return to full premorbid functioning is unlikely
- Acute exacerbations with residual impairment between episodes is the most common course

Name of Disease: **Anxiety Disorders**

Definition

Conditions characterized by:

- the main symptom of anxiety
- behaviors designed to ward off the anxiety
  - ➢ adaptive ways -- promote personal growth
  - ➢ maladaptive ways -- lead to higher anxiety & destructive behavior patterns.

Defense Mechanisms

- the various ways of lowering anxiety
- most operate automatically at unconscious level

Anxiety

- response to threatening situations
- considered normal
- can become pathological
  - ➢ when behavior interferes with normal life routine
  - ➢ Example: "checking behaviors"

Prevalence

- the most common of all psychiatric disorders

Comorbidity

- frequently occurs together with depression
- can occur together with substance abuse, somatization, & other anxiety disorders

Etiology

Significant causes:

- biological
- psychosocial
- cultural factors

Genetic Correlates

- tends to run in families
- no specific gene has been identified

Biological Findings

- General anxiety and panic disorder:
  - linked to deficiency in GABA
  - panic attacks linked to sodium lactate infusions and inhalation of carbon dioxide
- Phobias
  - Social phobias may be related to an excess of epinephrine.

- Obsessive-compulsive disorder:
  - defects in frontal inhibition
  - dysregulation of serotonin

- Posttraumatic stress disorder (PTSD):
  - extreme stress (due to physical, sexual or psychological abuse) may be associated with damaging effects to the brain
  - reduction in size of the hippocampus

Psychological Factors

- Psychological theories

  - Freudian theory
    - unconscious conflicts cause anxiety
    - repressed ideas or emotions
    - defense mechanisms control anxiety by protecting ego from unacceptable thoughts.

  - learned-behavior theories
    - from frightening childhood experiences
    - from distortions in thinking and perceiving

Cultural Considerations

- Behavior not considered pathological, if characteristic of person's culture.

Signs and Symptoms

1. Panic Disorder

- ***Panic Disorder with Agoraphobia***
  - recurrent panic attacks
  - fear of being in environment or situation from which escape might be difficult or embarrassing
- ***Simple Agoraphobia***
  - fear of being in an environment or situation from which escape might be difficult

2. Phobias

- persistent irrational fears of a specific object, activity, or social situation

3. Obsessive-compulsive disorder

- thoughts, impulses, or images that cannot be dismissed from the mind.
- ritualistic behaviors

4. Generalized Anxiety Disorder

- excessive anxiety lasting for 6 months or longer

5. Anxiety due to Medical Condition

- pheochromocytoma, cardiac dysrhythmias, hyperthyroidism, etc.

6. Substance-Induced Anxiety Disorder

7. Posttraumatic Stress Disorder

- Repeated re-experiencing of a highly traumatic event
- Symptoms usually begin within 3 months after the incident.
  - flashbacks
  - persistent avoidance of stimuli associated with the trauma
  - numbness or detachment
  - increased arousal

8. Acute Stress Disorder

Application of the Nursing Process

1. Assessment

Overall assessment

- Usually involves determining if anxiety is from secondary source (medical condition) or primary source (anxiety disorder).

- ***Symptoms of Anxiety Disorders***
  - sense of impending doom
  - difficulty concentrating
  - increased vital signs
  - complaints of palpitations, urinary frequency or urgency, nausea, tight throat
  - complaints of fatigue, insomnia, irritability, disorganization.
  - panic attacks, phobias, obsessions, and compulsions.

- ***Defenses Used in Anxiety Disorders***

Self-Assessment

Assessment Guidelines

(1) Physical and neurological examinations help determine if anxiety is primary or secondary.
(2) Assess for potential for self-harm.
(3) Do psychosocial assessment to identify problems that should be addressed by counseling.
(4) Check for suicidal ideation.
(5) Cultural differences can affect the way in which anxiety is manifested.

2. Nursing Diagnosis

- Useful diagnoses include:
  - Anxiety, Ineffective coping
  - Chronic low self-esteem
  - Powerlessness
  - Social isolation
  - Disturbed sleep pattern
  - Self-care deficit, Imbalanced nutrition
  - Impaired skin integrity

3. Outcome Criteria

4. Planning

5. Intervention

Overall Guidelines for Interventions

(1) identify community resources that can offer the client effective therapy
(2) identify community support groups for people with anxiety disorders
(3) assess need for interventions for families and significant others
(4) provide thorough teaching when medications are used.

Counseling

- *Cognitive Therapy*
- *Cognitive Restructuring*
- *Cognitive Behavior Therapy*
- *Behavioral*
  - *Relaxation Training*
  - *Modeling*
  - *Systematic Desensitization or Graduated Exposure*
  - *Flooding (Implosion Therapy)*
  - *Response Prevention (Behavior Therapy)*
  - *Thought Stopping*

Milieu Therapy

Self-Care Activities

- *Nutrition & Fluid Intake*
- *Hygiene & Grooming*
- *Elimination*
- *Sleep*

Psychopharmacology

- ***Anxiolytics***
  - Reduce anxiety to allow clients to participate in therapies directed at underlying problems.
  - Benzodiazepines prescribed for short periods of time only because they are habituating.
  - Buspirone is a nonbenzodiazepine and does not cause dependence.

- ***Antidepressants***
  - Tricyclics are used to treat panic attacks (imipramine, desipramine, clomipramine) and PTSD (imipramine, amitriptyline).
  - Clomipramine is the drug of choice for OCD.
  - MAOIs are effective in treatment of panic and social phobias.
  - SSRIs are effective for panic attacks, agoraphobia, OCD, and generalized anxiety disorder.

- ***Beta Blockers***
  - Useful for treatment of social phobias.

- ***Antihistamines***
  - Hydroxysine (Atarax, Vistaril) relieves symptoms of anxiety but produces no dependence, tolerance, or intoxication.

Potential Alternative & Complementary Therapies

- herbs & dietary supplements to relieve stress
- not subjected to rigorous testing
- studies show Kava kava (herb) may have promise

Case Management

- Aims to provide continuity of care, cost-effective use of resources, and reduced admissions.
- Usually provided in the outpatient setting

Evaluation

- In general, evaluation will focus on:
  - whether or not there is reduced anxiety
  - recognition of symptoms as anxiety-related
  - reduced incidence of symptoms
  - performance of self-care activities
  - maintenance of satisfying interpersonal relationships
  - assumption of usual roles
  - use of adaptive coping strategies

Chapter 14: Ch. 12

Name of Disease: **Major Depression**

DEFINITION OF DISEASE

One of the most prevalent medical disorders. Recognized as a distinct pathological entity back to early Egyptian times.

"Blue" mood versus the extreme depth and breadth of a true clinical depression -- feelings of despair and hopelessness

- commonly missed diagnoses in the general medical clinic.
- associated with many physical medical disorders
- may present itself in the form of multiple physical complaints.

Major Depressive Disorder is a type of Mood Disorder

- A persons mood is ***abnormally low or sad.***

- Can occur at any age, but the average age at onset is about 40 years
- May be difficult to diagnose in children
- Older adults often misdiagnosed as dementia.
- Major Depression is diagnosed when a person has symptoms of depression ***only***
- Cultural influences
- Noticeable change from patient's usual level of functioning

COMORBIDITY

- Schizophrenia, substance use, eating disorders, anxiety disorders, and personality disorders.
- Cardiovascular disease (MI, CHF), collagen disorders (rheumatoid arthritis, lupus erythmatosus), infectious disease (HIV, hepatitis), endocrine disorders (diabetes, cushings, hyper and hypothyroidism).

- Neurologic disorders (CVA, dementia, Parkinson's, multiple sclerosis).

- Vitamin deficiencies (B-1, pernicious anemia (B-12), and other diseases such as alcoholism, and uremia.

ETIOLOGY

Biological Theories

Genetic Theories —

Biochemical Factors — relative deficiencies and excesses of neurotransmitters are implicated as causative factors in depression. These neurotransmitters are serotonin, norepinephrine, GABA, acetylcholine and dopamine.

Alterations in Hormone Regulation – The pituitary-adrenal axis, including thyroid abnormalities.

Sleep Abnormalities – Up to 90 percent of patients with depression suffer from alterations in sleeping patterns.

Psychosocial Factors – Older Freudian psychoanalytical views have largely given way to biological vulnerability as the cause of depression,

Beck's Cognitive Theory – The notion that pessimistic and negative thinking as a cause of depression has led to a well-know treatment modality called Cognitive Behavioral Therapy (CBT). medication.

Learned Helplessness (Seligman) – Depression occurs when a person gives up and feels he has no control over the outcome of a situation.

SIGNS & SYMPTOMS OF DEPRESSION

Mood: For most of nearly every day, the patient reports a depressed mood or appears depressed to others. .

Interests: For most of nearly every day, the patients interest or pleasure in nearly all activities is markedly decreased – again as noted by the patient or others.

Eating and Weight: There is a marked loss or gain in weight

Sleep: Nearly every day the patient sleeps excessively or not enough.

Observable Psychomotor activity: Nearly every day others can see that the patients activity is speeded up or slowed down.

Fatigue: Nearly every day there is tiredness or loss of energy.

Self-Worth: Nearly every day the patient feels worthless or inappropriately guilty.

Concentration: Nearly every day the patient is indecisive or has trouble thinking or concentrating – as noted by the patient or others.

Death: The patient has repeated thoughts about death

DIFFERENTIAL DIAGNOSIS

MEDICAL TREATMENT

Antidepressants

- SSRIs are the first choice in most types of depression. SSRIs have a good side-effect profile and a faster onset of action than tricyclics. A serious side effect is known ast central serotonin syndrome (CSS) manifested by abdominal pain, diarrhea, sweating, fever, tachycardia, elevatedBP, delerium, leading to cardiovascular shock.

- Novel Antidepressants include Serzone, Effexor, Wellbutrin and Xanax.

- Tricyclics act by inhibiting reuptake of norepinephrine and serotonin

- Monoamine Oxidase Inhibitors are effective for atypical depression . The side effect profile is very serious because unless the patient observes a ***tyramine-free diet*** the danger of a ***hypertensive crisis leading to a CVA or convulsions and death*** can occur. In cases of overdose with MAOI death is likely due to the lethality of the side effects.

Electroconvulsant Therapy – ECT is used when a rapid, definitive response to lift depression is needed to prevent suicide or when there has been a poor response to medication.

PROGNOSIS

Suicide Lecture

Any health care setting
prompt assessment
prompt intervention
self-assessment

PREVALANCE

- eighth leading cause of death,
- 30,000 deaths each year.
- fourth leading cause of death for children between 10 and 14
- 1 in 5 people with Bipolar Disorder commit suicide

COMORBIDITY

- Mood Disorders
- Schizophrenia
- Substance Use Disorders
- Borderline & Antisocial Personality Disorder
- Panic Disorder
- Organic Mental Disorder

ETIOLOGY

Psychobiological

- hopelessness
- loss of a loved one
- loss of a job, or
- negative life outcomes

Biochemical-Genetic

- Twin studies and adoption studies
- Low levels of serotonin

ASSESSING THE RISK OF SUICIDE

General Assessment

➢ Clues to Suicide

1. Verbal Clues:
   - direct statements
   - indirect statements

2. Behavioral Clues:
   - giving away prized possessions
   - writing farewell notes.

3. Situational Clues:
    - major life stressors
    - involve loss of meaning
    - loss of one's identity in the world.

4. Other Situations:
    - acute delirium
    - psychotic disorder
    - suicide by imitation occurs in teenagers
    - to get even
    - 4% of people who commit suicide will kill other people first

More on General Assessment

➢ "SAD PERSONS" Scale

10 major risk factors for suicide:

"S" is for Sex, or the patient's gender. Males are at three times more risk than females, however females have more attempts

"A" is for Age . High risk groups under 19, and over 65.

"**D**" is for Depression. 35 to 79 percent of those who attempt suicide are depressed

"**P**" is for Previous Attempts. 65 ot 70 percent have had made previous attempts

"**E**" is for ETOH. 65 percent of cases have involved use of alcohol

"**R**" is Rational Thinking Loss. Those with psychosis (loss of touch with reality) are more likely to commit suicide than the general population.

"**S**" is for Social supports, lacking. Three areas are assessed, a suicide person often lacks significant others, meaningful employment and religious or spiritual support.

"**O**" is for Organized plan. A specific date, time and place increases the risk

"**N**" is for No spouse. Being widowed, separated, divorced, or single are greater risks than being married.

"S" is for Sickness. Chronic, debilitating, severe illness increases risk.

Specific Assessment

- Ask them about their thoughts in a very direct manner.

- Assess the lethality or the degree of risk.
  - high risk methods
  - lower risk methods

SELF ASSESSMENT

- Anxiety
- Irritation
- Avoidance
- Denial

NURSING PROCESS / APPLICATION

- assessment
- nursing diagnosis
- goal
- interventions
- evaluation

Suicide Assessment: SAD PERSONS Scale

S	Sex	Men kill themselves three times more often than women, although women make attempts three times more often than men.
A	Age	High risk groups: 19 years old or younger; 45 years old or older, especially the elderly of 65 years old or older.
D	Depression	Studies report that 35% to 79% of those who attempt suicide manifested a depressive syndrome.
P	Previous Attempts	Of those who commit suicide, 65% to 70% have made previous attempts.
E	ETOH	ETOH (alcohol) is associated with up to 65% of successful suicides. Estimates are that 15% of alcoholics commit suicide. Heavy drug use is considered to be in this group and is given the same weight as alcohol.
R	Rational thinking loss	People with functional or organic psychoses are more apt to commit suicide than those in the general population.
S	Social supports lacking	A suicidal person often lacks significant others (friends, relatives), meaningful employment, and religious supports. All three of these areas need to be assessed.
O	Organized plan	The presence of a specific plan for suicide (date, place, means) signifies a person at high risk.
N	No spouse	Repeated studies indicate that persons who are widowed, separated, divorced, or single are at greater risk than those who are married.
S	Sickness	Chronic, debilitating, and severe illness is a risk factor.

Source: Patterson W., et al. (1983). Evaluation of suicidal patients: The SAD PERSONS scale. *Psychosomatics*, 24(4):343. Can also be found in the following textbook: Varcarolis, E., "Foundations of Psychiatric Mental Health Nursing, 4th Edition, W.B Saunders (2002), pages 643-644.

How to Use: Count 1 point for each item in the SAD PERSONS scale that applies to the client.

Points	Guidelines for Intervention
0 - 2	Treat at home with follow-up care.
3 - 4	Closely follow up and consider possible hospitalization.
5 - 6	Strongly consider hospitalization.
7 - 10	Hospitalize.

Name of Disease: **Bipolar Disorder**

Definition

- Manic episode
  - Self-esteem
  - Motor activity
  - Speech
- Bipolar I Diagnosis
  - One manic episode required
  - Extreme, often bizarre symptoms
  - Probable past hx of depression
  - Expectation of future depression
  - Mood swings back and forth
- Other Bipolar Diagnoses
  - Bipolar II Disorder,
  - Cyclothymic Disorder

Comorbidity

Substance Use Disorders
Personality Disorders,
Anxiety Disorders,
Bulimia Nervosa
Attention-Deficit Hyperactivity Disorder.

Epidemiology

Age of onset is 21 years
Men and women equally affected
1% of the general adult population affected
Believed to be strongly hereditary

Etiology

No single, proven cause

Genetic Factors:

- Frequent familial occurrence
- monozygotic twins 80 percent
- dizygotic twins 19 percent
- Adoption studies point to biological causes
- chromosome studies in progress

Biochemical Factors

- No agreement about specific biochemistry causes

Past research

- Manic Episode
  - increase in dopamine and norepinephrine
  - alterations in serotonin metabolism.
  - Electrolyte disturbances
  - increased sodium excretion
  - decreased potassium levels.

- Depressed episode
  - increased adrenal glucocorticoid level
  - decreased thyroid-stimulating hormone
  - decreased prolactin levels
  - decreased growth hormone

Neuroendocrine Disorders

- Temporal lobe epilepsy
  - Electrical discharges in limbic system

- Circadian rhythms
  - Changes in sleep-wake cycle

Psychosocial Factors

- Not causative factors
- May precipitate manic or depressive episodes

Signs and Symptoms

Abnormal mood

- For at least one week mood is:
  - *abnormally* high, irritable, or expansive
  - has an intense, driven quality

Three or more of the following symptoms (four if presenting mood is irritable)

- Grandiosity or exaggerated self-esteem
- Reduced need for sleep
- Speeded up activity
- Poor judgment
- Increased talkativeness
  - Pressured speech
  - Sexually explicit
  - Vulgar language
  - Clanging (rhyming)

- Poor attention span
- Disorganized/incoherent
- Flight of ideas or racing thoughts
- Easy distractibility

Differential Diagnosis

Schizoaffective Disorder
Schizophrenia
Other psychotic disorders
Medical conditions or due to the use of
Drugs (including prescribed medications)

Medical Treatment

Mood Stabilizers

1. Lithium
   - Introduced 1970's
   - Effective in 70% patients
   - Contraindicated with kidney or thyroid disease
   - Initial dosage of 300 to 600 mg tid to reach therapeutic blood levels

- Maintenance blood level of 0.4 to 1.3 mEq/L
- Maintenance dose is 300 mg tid
- Narrow "therapeutic window" (therapeutic dose is close to toxic dose)
- Side Effects and Toxic Effects

  - Expected S/E (0.4 - 1.3 mEq/L)
    e.g. fine hand tremors, mild thirst, mild nausea, wt gain

  - Early Signs of Toxicity (1.0 - 1.5 mEq/L)
    e.g. nausea, vomiting, diarrhea, thirst, polyuria, slurred speech, muscle weakness or twitching

  - Advanced Signs of Toxicity (1.5 - 2.0 mEq/L)
    e.g. coarse hand tremor, GI upset, mental confusion, incoordination

  - Severe Toxicity (2.0 to over 2.5 mEq/L)
    e.g. ataxia, blurred vision, large output dilute urine, seizures, severe hypotension, cardiac arrhythmia, peripheral circulatory collapse, and death

2. Anticonvulsants
    - Tegretol
    - Depakote
    - Depakene
    - Neurontin

3. Antipsychotics
    - Thorazine
    - Risperdal

4. Benzodiazapines
    - Ativan

Psychosocial Treatment

NAMI
Support Groups
Psychoeducation

Prognosis

Some patients experience a stable mood for long periods of time between episodes of mania and depression. Others have a more turbulent course with frequent, rapid cycling of mood and these individuals may have severe disruption in all aspects of their personal and social lives.

Nursing Application

Nursing Process
Mini-Review
Case Study
Critical Thinking Questions

(Chemical Dependency)

Name of Disease: **Substance Use Disorders**

Ch. 22 Addictive Disorders

INTRODUCTION & STATISTICS

Alcohol Abuse

- A major public health problem.
- **Third cause of death behind heart disease and cancer.**
- 100,000 deaths per year .
- 25,000 people die and 150,000 are permanently disabled
- 13.8% of American adults have had a problem with alcohol
- 13 million people need treatment for alcohol use disorders
- 2.4 million over age 12 need treatment for other drugs of abuse.

DEFINITION OF DISEASE

- mind-altering substances
- central nervous system affected
- pathological use occurs

- Substance Dependence
  - Dependence
  - Tolerance
  - Withdrawal
  - Time devoted to substance use
  - Continued use despite consequences
- Substance Abuse
  - Substance use has produced problems
- Substance Intoxication
- Substance Withdrawal

COMORBIDITY

Psychiatric Comorbidity

- Fifty-one percent of people with a serious mental illness
- Dual diagnosis

Medical Comorbidity

- Alcohol
- Cocaine
- IV drug users
- Nicotine
- Intranasal use of substances

ETIOLOGY

- Genetic Theories
- Pathophysiology
- Psychosocial Factors

SIGNS AND SYMPTOMS OF INTOXICATION & WITHDRAWAL

Central Nervous System Depressants

Intoxication

Signs and symptoms of CNS intoxication include:

- slurred speech
- incoordination
- ataxia
- drowsiness
- disinhibition of sexual and aggressive impulses
- impaired judgment
- impaired social, and occupational functioning
- impaired attention and memory

Alcohol Withdrawal

- Early stages -- a few hours after cessation or reduction in the amount of intake.
  - anxiety,
  - irritability
  - shakiness
  - diaphoresis,
  - rapid pulse (over 100),
  - elevated blood pressure (over 150/ 90) ,
  - anorexia,
  - insomnia,
  - transient hallucinations or vivid nightmares
  - nausea and vomiting.
  - illusions

- Alcohol Withdrawal Delirium

✓medical emergency
✓mortality rate of up to 10%

  - tachycardia
  - diaphoresis
  - elevated blood pressure
  - fever of 100 to 103

- disorientation
- visual or tactile hallucinations
- delusions (which are usually of the paranoid type)
- agitated behaviors
- fluctuating levels of consciousness
- delirium can last 2 or 3 days
- the patient could die for a number of reasons

Treatment for alcohol withdrawal

- benzodiazepines.
- Valium or Librium

Central Nervous System Stimulants

- amphetamines
- cocaine, crack
- caffeine, and nicotine

Signs of abuse:

- dilated pupils
- excessive motor activity
- tachycardia
- elevated BP, elevated temperature
- muscular twitching

- insomnia
- anorexia
- grandiosity, impaired judgment
- paranoid thinking, and hallucinations
- convulsions resulting in death

Opiates

- opium, heroin
- meperidine, morphine
- codeine
- methadone, hydromorphone
- Fentanyl

Physical signs of intoxication:

- psychological effects
- symptoms of overdose
- withdrawal symptoms .

Hallucinogens

- LSD
  - intoxication
  - treatment
  - overdose

➢ PCP

Intoxication:

- ataxia, muscle rigidity, nystagmus, a blank stare and a tendency toward violence
- hyperthermia, chronic jerking of the extremities, hypertension and kidney failure
- dulled thinking, lethargy, loss of impulse control, poor memory and depression.

NURSES SELF-AWARENESS

➢ Attitude of the nurse

THE CHEMICALLY IMPAIRED NURSE

- Nurses have a 30 to 50 percent higher rate of chemical-dependency frequent tardiness or absences
- deteriorating physical appearance
- irritability
- blaming others
- being a loner
- signs of depression.
- patients may complain that their pain is unrelieved by their prn

Ch. 18 Feeding, Eating and Elimination Disorders

Eating Disorders

DEFINITION

- separate syndromes
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Eating Disorder NOS
- no common cause, course, or pathology

There is, however an important interaction between psychology and physiology in the Eating Disorders so understanding a little bit about normal eating behavior is helpful in understanding the Eating Disorders.

PHYSIOLOGY & PSYCHOLOGY OF NORMAL EATING

Physiology:

- Physiology and psychology interact
- Hypothalamus controls eating behavior
- Pancreatic and gastrointestinal hormones
- Balance between neuropeptides and neurotransmitters
- Metabolic rate
- Sensory taste and smell

Psychology:

- Appearance and texture
- Accessibility
- Nutritious value
- Climate/room temperature
- Presence of other people
- Stressors
- Learned patterns

PREVALENCE

- anorexia nervosa 0.5% to 3.7%
- bulimia nervosa 1.1% to 4.2%
- culture
- occupation

COMORBIDITY

- Major depressive disorder or dysthymia 50% to 75%
- Bipolar disorder as high as 13%
- Obsessive-compulsive disorder
- Anxiety disorder
- Substance abuse disorder
- Personality disorder
- Sexual abuse

THEORY

Neurobiological-Neuroendocrine Interactions

- a variant of a depressive disorder
- biological relatives of clients and depression
- neuroendocrine
- low cholecystokinin

Psychological Interactions

- issues of control in anorexia
- affective (mood) instability in bulimia
- poor impulse control in bulimia.

Sociocultural Models

- societal ideal of thinness
- role conflict
- performance in spors or occupation (males).

Biopsychosocial Theories

- genetic vulnerabilities; twin studies
- OCD; Dieting; Excessive exercise
- Sports; Body building (males)
- Identify conflict (females)

**** ANOREXIA NERVOSA ****

Signs and Symptoms

- preoccupation with body weight
- preoccupation with food
- driven to lose weight
- peculiar patterns of handling food
- weight loss
- intense fear of gaining weight
- disturbance of body image
- amenorrhea.

Binge-eating/purging Type

- Self-induced vomiting
- Misuse of laxatives, diuretics, or enemas

Restricting Type

- Minimal or no binge-eating or purging

Medical Complications

- Leukopenia
- Lymphocytosis
- Hypokalemic alkalosis
- Elevated serum bicarbonate levels

Medical Complications (continued)

- Hypochloremia
- Hypokalemia
- Electrolyte disturbances
- Sudden cardiac arrest
- Elevated serum enzymes
- Elevated serum cholesterol
- Carotenemia

Epidemiology

- Increased incidence over past 30 years
- 6-fold increase in Scotland

Course

- Single episode and recovery
- Relapses
- Unremitting leading to death
- Mortality rate
  - 6.6% (10 year follow-up)
  - 18% (30 year follow-up)

Etiology and Pathogenisis

- Willful dieting
- Food restriction
- Involuntary starvation

Etiology and Pathogenisis (continued)

- Phobic avoidance response to food
- Denial of emaciation
- Denial of hunger
- Sense of ineffectiveness
- Disturbed hypothalamic functioning
- Dopamine, serotonin and norepinephrine dysregulation
- Blunted growth hormone response
- Genetic vulnerability to depression

Medical Management

- Restore nutritional state first
- Monitor weight, food, and calorie intake, urine output
- Assess serum electrolytes
- Behavior therapy
  - Operant-conditioning
  - Cognitive-behavioral
- Family Therapy
- Medications
  - Zyprexa
  - Prozac
  - Clomipramine (Anafranil)

**** BULIMIA NERVOSA ****

Definition

- "binge eating"
- negative feelings about self
- use of cathartics
- binge-fasts pattern
- high calorie foods
- excessive quantities
- Purging-Type
- Non-Purging Type

Signs and Symptoms

- Binge episode
- Self-induced vomiting
- Don't eat normal meals
- Don't feel satiated
- Eat alone at home
- Weight normal or near normal
- Depression
- Poor self-concept
- Problems with relationships

Medical complications

- Hypokalemic alkalosis
- Elevated serum bicarbonatae levels
- Hypochloremia
- Hypokalemia
- Low serum bicarbonate levels (with laxative abuse)
- Metabolic acidosis
- Electrolyte disturbances
- Erosion of teeth
- Elevated serum amylase levels Parotid gland enlargement)

Medical emergencies

- Acute dilation of the stomach
- Esophageal tears → shock
- Ipecac intoxication
  - ➢ Chest pain, dyspnea, hypotension, tachycardia

Epidemiology

- Bingeing & purging
- Common in female students
- Little known of incidence or prognosis

Etiology

- Strict dieting
- Neurotransmitter dysfunction
- Hx of depression
- Hx of alcohol abuse
- Personality disorders

Medical management

- Variety of treatment programs
- Psychotherapy
- Cognitive Behavioral Therapy (CBT)
- Medications
  - Tricyclic antidepressants
  - SSRI antidepressants

***** Eating Disorder "NOS" *****
(Not Otherwise Specified)

Definition

- Excess body fat
- BMI: weight(in kilograms) divided by height (in meters) squared
- Mildly overweight (BMI of 25 to 30)
- Obesity (BMI above 30)

Signs and Symptoms

- No distinct psychopathology
- Inability to distinguish hunger
- Emotional eating
- Effects of social stigma

Medical Complications

- Hypertension
- Diabetes
- Pulmonary dysfunction
- Toxemia
- Cancer

Etiology

- No single etiology
- Familial
- Culture
- Environment

Medical Treatment

- Balanced diet
- Exercise program
- Behavior modification
- Surgical procedures
- Cognitive behavior (CBT)
- Possibly SSRI's

NURSING APPLICATION

- Self-assessment
  - Misunderstanding of seriousness of disorder
  - Judgmental attitude
  - Own issues with weight and body image
- Assessment:
  - Assess signs and symptoms of the specific disorder
- Nursing Diagnosis
  - Altered Nutrition, Hopelessness, etc.
- Goals
  - Normalize eating patterns, weight restoration, modify self-concept, identify alternate behaviors, etc.
- Interventions
  - Monitor physiological functioning
  - Milieu therapy
  - Commuication
  - Health Teaching
  - Long-term treatment
  - Psychopharmacology
- Evaluation
  - Effectiveness of goals

Ch 28

Child, Older Adult, Intimate Partner Abuse

FAMILY VIOLENCE

Prevalence

- half of all Americans have experienced violence in their families
- 1 million Americans 60 years old or older are abused each year.

Comorbidity

- Secondary effects of violence: anxiety, depression, and suicide
- Social factors: Violence in TV, movies, etc.

Theory

Definitions:

- **Family Violence:** physical injury to or causing mental anguish deprivation of essential services
- **Perpetrator:** Person who initiates violence against another:
  - Male or female
  - Behavior rooted in childhood
  - Poor social skills
  - Enmeshed, co-dependent relationships

- **Vulnerable Person:** Person who is abused
  - Pregnancy
  - Woman becoming independent
  - Leaving the relationship
  - Children under 3 years of age
  - Adolescents
  - Older adults

- **Crisis Situation:** an event that puts stress on the family
  - Social isolation
  - Ineffective coping

The Cycle of Violence

1. Tension-building stage
2. Acute battering stage
3. Honeymoon stage

Types of Maltreatment

1. Physical violence
2. Sexual violence
3. Emotional violence
4. Neglect (physical, developmental, or educational deprivation)
5. Economic maltreatment

Application of the Nursing Process

Assessment

- Self-Assessment:

Strong emotions on the part of the nurse
Professional or peer supervision is necessary

- Nursing Assessment:

The Process and Setting of the Interview

- Assess without perpetrator present
- Sit near client
- Establish rapport
- Reassure client that he or she did nothing wrong
- Allow client to tell story without interruption
- Be nonjudgmental
- Use open-ended techniques
- Determine need for further help assess violence indicators
  - levels of anxiety
  - coping responses
  - family coping patterns
  - support systems
  - suicide risk
  - drug and alcohol use
- Be open and direct about the situation

Types of Maltreatment

Physical Violence

- Overt signs of battering include
  - bruises; scars; burns
  - wounds around head, face, chest, arms, abdomen, back, buttocks, and genitalia
  - injuries in various stages of healing
  - Covert minor complaints often heard include "accidents," "back trouble," "falls."
- Sexual abuse may be suspected with bruising or injury around genitalia
- Suspect abuse if:
  - client minimizes the seriousness of the injury
  - a child under 6 months has bruises
  - respiratory problems are present in young child (may suggest "shaken-baby syndrome")
- Ask clients directly whether the injury was caused by someone close to them
- Observe nonverbal response for hesitation or lack of eye contact
- Ask specific questions about the abuse

Sexual Violence

- Depression
- Under-recognized in males

Emotional Violence

- Emotional violence occurs if physical or sexual abuse occurs
- May occur alone
  - low self-esteem
  - anguish
  - isolation

Neglect

- Undernourished
- Dirty
- Poorly clothed
- Inadequate medical care

Economic Maltreatment

- Failure to provide for the needs of the victim even when adequate funds are available.

Assessing the Level of Anxiety & Coping Responses

- Note nonverbal responses
- Note defensiveness about loved ones

Assessing Family Coping Patterns

- Show a willingness to listen
- Avoid use of a judgmental tone

Assessing Support Systems

- Dependency on perpetrator
- Isolation

Assessing Suicide Potential

- Assess vulnerable person and perpetrator

Assessing Homicide Potential

- Guns in the home
- Alcohol or other drugs
- History of violence
- Jealousy or possessiveness
- Safety about going home.

Assessing Drug and Alcohol Use

- Victim may self-medicate
- Allow person to become sober before referring
- Don't discharge victim with perpetrator

Maintaining Accurate Records

- Accurate, detailed history
- Descriptions of findings
- Verbatim statements about injuries
- Body map, photos
- Physical evidence of sexual abuse

Nursing Diagnosis

- Risk for injury, Anxiety, Fear
- Ineffective coping, Disabled family coping, Powerlessness, Caregiver role strain, Chronic low self-esteem, Interrupted family processes, Impaired parenting.
- Pain related to physical injury would take a high priority.

Outcome Criteria / Goals

- Specific to Nsg Dx

Planning

- Client safety is priority
- Consider willingness of abuser to seek treatment

Intervention

- Nurses are mandated reporters
- Reasonable suspicion of maltreatment is all that is required
- Immunity from criminal or civil liability
- Cultural issues may affect response to violence
- Translators should NOT be a member of the victim's family.

Primary intervention

- Reducing stress
- Increasing social support
- Increasing coping skills

Secondary prevention

- Early intervention in abusive situations

Tertiary prevention

- Rehabilitation and support

Communication Guidelines

- Crisis Intervention counseling
- Problem-solving support
- Referrals

Case Management

- Coordination of resources

Milieu Therapy

- Individual and family therapy
- Family service agencies

Self-Care Activities

- Goal is empowerment
- Legal counseling
- Vocational counseling
- Parenting education