COAHOMA COMMUNITY COLLEGE
ASSOCIATE DEGREE NURSING PROGRAM
NUR 2124 MENTAL HEALTH NURSING
FALL 2017

COURSE COORDINATOR/ INSTRUCTOR: OFFICE LOCATION: RM 113
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CLASS/CLINICAL TIME: SEE TOPICAL OUTLINE

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Course Description:

This course focuses on the application of the nursing process and therapeutic communication skills in the care of clients experiencing a variety of mental health disorders. Clinical practice settings include in- patient settings with adult clients. Hospitals and ambulatory care facilities serve as practice settings. Effective and therapeutic communication skills and clinical decision making are integrated. Pre-requisites: NUR 2013. Credit: 4 credit hours/3 theory and 1 clinical. (3 theory clock hours per week and 1 clinical clock hours per week with lab hour ratio 1 to 3; 45 total theory clock hours/ 45 total clinical clock hours).

Textbooks:

Required:

Lawler, K., Prater, D., Hines, J., Burke, N., et al. (2016). *Registered nurse mental health nursing review module 10th ed.* Overland Park, Kansas: Assessment Technologies Institute, LLC.

Townsend, M., & Morgan, K. (2017). *Essentials of* p*sychiatric-mental health nursing 7th ed.* Philadelphia, PA: F.A. Davis Company.

Recommended:

Manning, L., & Rayfield, S. (2016). *Pharmacology made insanely easy 4th ed.* Duluth, GA: CAN Publishing, Inc.

Rayfield, S., & Manning, L. (2016). *Nursing made insanely easy 8th ed.* . Duluth, GA: I CAN Publishing Inc.

End-of-Program Student Learning Outcomes:

Upon completion of the Associate Degree Nursing Program at Coahoma Community College, the graduate will be prepared for a professional nursing practice role by:

Core Concepts	End-of-Program Student Learning Outcomes
Nursing Process/Clinical Reasoning	Exercising clinical reasoning skills as the basis for carrying out the nursing process to meet the physiological, psycho-social, and cultural needs of the client across the life span.
Safe and Effective Care Environment	Providing and directing safe client care to protect the client and health care personnel from health and environmental hazards.
Health Promotion	Utilizing various strategies in implementing and evaluating methods including the teaching and learning process to assist clients in meeting their self-care needs to promote health and prevent health disorders throughout the life span.
Psychosocial Care	Demonstrating therapeutic communication, caring and professionalism in interpersonal interactions with clients and documentation of client care.
Pharmacological Management	Providing pharmacological management to ensure a safe and effective client care environment.
Client Safety/Evidence-Based Practice	Managing client care to incorporate evidence-based practice and nursing informatics for the improvement of nursing care delivery and client safety.
Reduction of Potential Risk	Reducing potential risk through reassessment and recognition of changes in the client's condition that requires intervention.
Leadership	Demonstrating leadership behaviors consistent with the roles and responsibilities of the registered nurse.

Student Learning Outcomes:

Upon completion of this course, the student should be able to do the following:

1. Demonstrate clinical reasoning skills using the nursing process to provide safe nursing care to meet the physiological, psycho-social, and cultural needs of clients with mental health disorders in behavioral health settings.

2. Identify the learning needs of mental health clients and apply the teaching- learning process to meet the self care and coping needs of clients.

3. Establish rapport through therapeutic communication and document care of clients experiencing mental health disorders.

4. Plan and implement interventions and advocate for quality and safety in the care of clients with mental health disorders including psycho-pharmacological care.

5. Interact with members of the interdisciplinary team to implement out a comprehensive plan of care for clients with mental health disorders.

6. Prioritize appropriate nursing interventions in the care of clients with mental health disorders.

7. Demonstrate accountability and ethical decision- making issues associated with self-learning and nursing actions based on accepted standards of nursing care when caring for clients with mental health disorders.

8. Use evidence based research and best practices to understand the differences in nursing roles and responsibilities in the care of mental health clients compared to care of medical surgical clients.

Attendance:

3.1 The Absentee Policy for the Associate Degree Nursing, Respiratory Care, Polysomnography, and Practical Nursing programs is as follows:

Fall and Spring Courses

One semester hour course one absence

Two semester hour course two absences

Three semester hour course and higher three absences

Absences greater than those listed above result in the student being dropped from the class.

3.2 Refer to specific program requirements regarding make up for time missed (class and clinical).

3.3 Three tardies will be recorded as an absence. Three occurrences of leaving class before the class period is completed equals one absence.

3.4 Class work and assignments missed due to absence: In order to make up class work and assignments missed due to being absent, the student must provide documentation to support the reason for the absence immediately upon return to class. When a student is allowed to make up class work and assignments the absence is still recorded. (**see 3.1**)

3.5 A student must call prior to the beginning of an assigned clinical activity as follows:

- One hour prior to an absence, other than an emergency
- 30 minutes prior to a tardy, other than an emergency
- In the event of an emergency, there must be proper documentation of that emergency, and the student must call as soon as possible after becoming aware of the situation.

Absence from Class for School Sanctioned Activities

The nature of the educational programs at Coahoma Community College is such that it is necessary for every student to attend class regularly. Instructors will keep accurate class attendance records, and those records will become part of the student's official record. Regular class attendance and punctuality are expected. All arrangements for completing missed work are to be made with the instructor. It is the student's responsibility to initiate these arrangements. *Excessive absences may result in loss of credit for the course concerned as well as loss of grant refunds and/or financial aid eligibility.* For more information, see the Attendance Policy section in the College Catalog.

Make-up Policy:

Make-up-When a scheduled test is missed the students must upon return to class bring documentation of the reason for the absence in order to make up. The make-up test will be a different test but cover the same content and will be according to the time scheduled by the instructor. The make-up test may be a paper and pencil test and include essay-type questions.

Academic Dishonesty:

Cheating and plagiarism (the representation of someone else's work as your own, usually by directly copying or paraphrasing without a reference to the original source) will not be tolerated. The penalty will be receiving a (0) for that assignment, without any possibility of make-up work or alternative assignments. Additionally, according to the Student Handbook, *such acts will be considered a severe infraction and carry a possible sanction of suspension in semester (s) length or expulsion.* For a more in-depth explanation of academic dishonesty, see the Student Handbook.

5.2 Dishonesty in any form is absolutely forbidden. Areas that are considered dishonest include, but are not limited to:

- Giving or receiving examination or quiz answers
- Copying from another student
- Talking during examinations and quizzes
- Plagiarism in any form includes but is not limited to:
  - Taking other authors work and not crediting the author
  - Cut and paste
- Making statements not based in fact (lying, gossip, etc.)
- Failing to inform the instructor of a clinical mistake, e.g. medication error, documentation, etc.
- Falsification of documentation, including but not limited to, date, time, procedures, medication entered into the medical record improperly or with intent to mislead

5.3 Students in violation of the honesty policy will be removed from the classroom, laboratory, or clinical affiliate and referred to the Vice President for Health Sciences for disciplinary action. Disciplinary action may be up to and including dismissal from the healthcare programs. (see Coahoma Community College Student Handbook

Electronic Devices in Class

The use of cellular phones, pagers, CD players, radios, and similar devices is prohibited in the classroom and laboratory facilities. Instructors can make exceptions in the classroom for learning activities.

Classroom and Clinical Policies and Procedures

See http://www.coahomacc.edu/healthsciences/HealthP&P.pdf for classroom and clinical policies sections I-XII and Appendix A.

Non-Discrimination/Disability Policy

Non-Discrimination Statement

Coahoma Community College is an equal opportunity institution in accordance with civil rights and does not discriminate on the basis of race, color, national origin, sex, disability, age, or other factors prohibited by law in any of its educational programs, activities and employment opportunities. The following person has been designated to handle inquiries regarding the non-discrimination policies: Michael Houston, Director of Human Resources/Coordinator for 504/ADA, Title IX Compliance Officer, Office #A100, Vivian M. Presley Administration Building, 3240 Friars Point Road, Clarksdale, Mississippi 38614, Phone: (662) 621-4853, Email: mhouston@coahomacc.edu.

Accommodations for Students with Disabilities

Coahoma Community College is committed to ensuring equal access to an education for enrolled or admitted students who have verified disabilities under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA). College policy calls for reasonable accommodations to be made for eligible students with verified disabilities on an individual and flexible basis.

Any student enrolling in Coahoma Community College with a documented disability, who requests accommodations, must first provide a current evaluation of the disability from a medical professional. This documentation, which is required by federal guidelines, will remain on file in the office of Michael Houston; Coordinator for Section 504/ADA, Title IX Compliance Officer, Office #A100, Vivian M. Presley Building, 3240 Friars Point Road; Clarksdale, MS 38614, Telephone: # (662) 621-4853, Email: mhouston@coahomacc.edu.

Instructional Techniques:

Lectures/Discussions
Group Discussions/Role Playing
PowerPoint & Overhead Presentations
Computer Assisted Learning
Handouts/Reading Assignments
Case Studies
Focus Reviews of Concepts
SAFETY Format
AIDE Format

Methods of Evaluation:

Unit Exams & Comprehensive Final Exam
ATI Practice & Proctored Tests
Class Assignments and Discussion
Interactive Class Work (Davis Edge)
Direct Observation
Virtual Clinical Excursion Activities

Clinical Evaluation Tool
Concept Map
Interpersonal Process Recording/Journaling
Comprehensive Health History & Mental Status Assessment

Grade Scale:

Grading Scale for Associate Degree Nursing Program

Grade	Scale	Quality Points
A-Excellent	**93-100**	**4.0**
B-Good	**85-92**	**3.0**
C-Average	**77-84**	**2.0**
D-Poor	**70-76**	**1.0**
F-Failure	**69 or Below**	**0.0**
I-Incomplete		**0.0**
W-Withdrawal		**0.0**
Z-Unassigned grade		**0.0**
CR: This grade will be assigned when the student successfully completes program-specific requirements for advancement to the Associate Degree Nursing program.		
Associate Degree Nursing Program courses require a letter grade of "C" (minimum 77%). Failure to attain these score will prevent the student from progressing to the next scheduled semester.		

Course Grading System:

Theory

Unit Exams (5)	90%
Final Exam	10%
	100%

Grading Criteria for Course:

NUR 2124 is a blended course composed of a theory and clinical component. Students must earn 77% or "C" in the theory component of the course and achieve satisfactory performance in the clinical component to pass clinical. The student must pass theory and clinical in order to pass the course.

Theory: There will be five (5) computerized unit tests which count for 18% each. The comprehensive final exam will count for 10%. ***Student must take ATI Proctored Mental Health Exam to take the comprehensive final exam. Student cannot take proctored Mental Health Exam until the practice tests are completed. This is mandatory per ATI policy which the program has agreed to comply.*** Formative assessments will be conducted throughout the course at the instructor's discretion which will constitute the daily average. The daily average consists

of the average of formative assessments given by the instructor. The points received for the daily average will be added to the lowest unit test. The point system is as follows: A = 5 points, B = 3 points and C = 1 point. Types of formative assessments include pre and post lecture quizzes, class assignments, case studies, ATI tutorials and practice tests, and other learning activities provided by the instructor.

Assessment Technologies Institute®, LLC (ATI) Resources: The Associate Degree Nursing Program utilizes ATI resources to enhance learning and to provide a means for evaluation of student comprehension of content and concepts presented in the nursing curriculum classes. An orientation to utilization of ATI resources will be provided to the students at the beginning of the semester. Resources include practice tests, proctored tests, and tutorials relevant to the content and concepts taught within each class of the nursing curriculum. Completion of Mental Health practice tests A and B is required for the student to be allowed to take the Proctored Mental Health test at the end of the course. Students will receive points added to the final exam based on the average achieved on the ATI Communication and Mental Health quizzes. The student is responsible for keeping a notebook containing printed information related to results on practice tests, proctored test, tutorials, and focus review materials that address deficiencies identified by practice and proctored tests. This notebook is to accompany the student when meeting with their advisor for academic counseling. Academic counseling sessions will be scheduled weekly by your advisor. Additional counseling sessions with advisor may be scheduled at the discretion of the instructor. Students who make 77 or less on a unit exam will be referred to the student navigator.

Clinical: The student will be assessed and evaluated on four (4) components in the clinical area. The clinical components are a comprehensive health history and mental health assessment, an interpersonal recording (IPR), a concept map on their assigned client, and a clinical evaluation of student's expected behaviors. Each clinical component will be accompanied with a grading rubric and placed on Canvas. **The student must achieve a satisfactory on all four (4) clinical components in order to pass the clinical section of this course.**

Clinical Evaluation Tool: Each student will be evaluated daily on expected student behaviors in the clinical area. Behaviors will be scored satisfactory (S) or unsatisfactory (U). Satisfactory is defined as actions meet established standard of care and ensure client's safety. Unsatisfactory is defined as actions that do not meet established standard of care and/or poses a threat to client's well-being. Three unsatisfactory behaviors or repeating an unsatisfactory behavior will result in failure of the course.

Unit Tests and Final Exams: There will be five (5) computerized unit tests which count for 18% each. The comprehensive final exam will count for 10% of grade. Students must take the ATI- Mental Health Proctored Exam prior to taking the comprehensive final exam.

The ATI-Mental Health Proctored Exam will be used as the fifth unit test score:
Level 3 = 100
Level 2 = 92
Level 1 = 84
Below Level 1 = 76

ATI Grading Scale: Students will receive points based on level of achievement on the ATI-Communication and Mental Health practice and final quizzes combined average. These points will be added to their final exam score. Example of scoring will be provided during orientation.
The point system is as follows: A **= 5 points B = 3 points**

Coahoma Community College
Associate Degree Nursing
NUR 2124 Mental Health Nursing- Fall 2017
Course Grade Worksheet

Name_____ Date_____

Course Grading Worksheet:
Unit tests and final exam: your score * % worth = points earned

Theory (Unit Tests and Final Exam**)**	**Your Score**	**% Worth**	**Points Earned**
1. Unit I - Foundation of Mental Health Nursing		**.18**	
2. Unit II - Nursing care of Clients with Mental Health Disorders (Part 1)		**.18**	
3. Unit III - Nursing Care of Clients with Mental Health Disorders (Part 1)		**.18**	
4. Unit III - Nursing Care of the Client with Mental Health Disorders (Part 2)		**.18**	
5. ATI -Mental Health Proctored Exam		**.18**	
Comprehensive Final Exam		**.10**	
Assignments for Daily Grades Average			
Clinical (Satisfactory or Unsatisfactory)			
1. Interpersonal Recording IPR		**NA**	**NA**
2. Concept Map		**NA**	**NA**
3. Comprehensive Health History & Mental Status Assessment		**NA**	**NA**
4. Clinical Evaluation		**NA**	**NA**
Total			

ATI- Communication and Mental Health Quiz avg _____ Points Earned _____
Daily Grade Points____
TOTAL POINTS: _____ COURSE GRADE _____
Faculty_____
Student_____
Date: _____ I concur_____ I do not concur____

Unit Objectives:

Upon completion of the units of study, the student should be able to do the following objectives:

Unit I: Foundations for Mental Health Nursing

1. Understand and document key terms associated with the treatment and care of clients experiencing mental health disorders.
2. Demonstrate use of American Psychiatric Association Diagnostic of Statistical Manual of Mental Health Disorders, 6th edition, Text Revision (DSM-V TR) when conducting a comprehensive health history and mental health status assessment.
3. Describe and differentiate how interventions at the primary, secondary, and tertiary prevention levels are implemented.
4. Recognize neurobiological causes of mental disorders including structures, processes, and functions of the brain.
5. Identify the psychosocial treatment modalities and the theory in which each treatment strategy is based.
6. Identify the roles of the registered nurse in varied mental health treatment settings and programs.
7. Identify components, types and phases of the therapeutic relationship as well as recognize behaviors that will diminish the therapeutic relationship.
8. Identify therapeutic and non-therapeutic communication skills including nonverbal communication.
9. Recognize influences that may impact a client's response to mental health disorder including cultural and religious practices.
10. Demonstrate knowledge legal and ethic issues and rights of client's rights in a psychiatric setting.
11. Apply principles that guide pharmacologic treatment of clients experiencing psychiatric-mental health disorders including mechanism of action, dosage, side effects, food and drug interaction, client teaching, and cultural considerations.
12. Recognize signs, symptoms, and behaviors of a client experiencing the phases of aggression and implement appropriate nursing interventions.
13. Recognize clients at risk for abuse and violence and provide education to promote prevention and early intervention for clients experiencing abuse and violence.
14. Identify factors that increase a client's susceptibility to complications related to grief and apply the nursing process to facilitate grieving for clients and families.
15. Perform a comprehensive health history and mental health status assessment on clients.

Unit II: Nursing Care of Clients with Mental Health Disorders: Neurocognitive, Anxiety, Obsessive-Compulsive, Schizophrenia, and Related Disorders

1. Recognize anxiety as a response to stress and the levels of anxiety with behavioral changes related to each level.
2. Identify defense mechanism used by clients with anxiety, anxiety-related disorders, obsessive-compulsive and related disorders, schizophrenia, and cognitive disorder.
3. Distinguish the positive and negative symptoms of schizophrenia.
4. Distinguish between delirium and dementia in terms of symptoms, course, treatment, and cognitive disorders.

5. Determine the etiologic theories related to anxiety, anxiety-related disorders, obsessive-compulsive and related disorders, schizophrenia, and cognitive disorder.
6. Apply the nursing process to the care of clients with anxiety, anxiety-related disorders, obsessive-compulsive and related disorders, schizophrenia, and cognitive disorder.
7. Demonstrate knowledge to provide education to clients, families, and communities to increase knowledge and understanding of anxiety, anxiety-related disorders, obsessive-compulsive and related disorders, schizophrenia, and cognitive disorder.

Unit III: Nursing Care of Clients with Mental Health Disorders (cont.): Personality, Addiction, Mood, Eating Disorder, Somatoform, Neurodevelopmental, and Disruptive Disorders

1. Identify the characteristics, risk factors, and family dynamics prevalent with addiction.
2. Identify risk factors and characteristics of personality, addiction, mood, eating, somatoform, neurodevelopmental and disruptive disorders.
3. Determine the etiologic theories of personality, addiction, mood, eating, somatoform, neurodevelopmental and disruptive disorders.
4. Demonstrate knowledge of personality disorders in terms of the client's difficulty in perceiving, relating to, and thinking about self, others, and the environment.
5. Recognize factors thought to influence the development of personality disorders.
6. Apply the nursing process to the care of clients with personality, addiction, somatoform, mood, eating, neurodevelopmental and disruptive disorders.
7. Determine the etiologic theories related to neurodevelopmental and disruptive disorders.
8. Demonstrate knowledge to provide education to clients, families, and communities to increase knowledge and understanding of personality, addiction, mood, eating, somatoform, neurodevelopmental and disruptive disorders.

Clinical Learning Activities:

1. Ensures proper identification of client prior to providing care (medications, treatment, education, dietary, procedures, etc.)
2. Applies principles of infection control when providing care to client (hand hygiene/washing, standard precaution, transmission- based/ isolation precautions, aseptic and/or sterile technique, proper disposal of sharps and biohazard materials, and room assignment)
3. Knowledgeable of medications for assigned clients.
4. Assesses, responds and reports changes in client's condition (vital signs, behavior, etc.).
5. Protects clients from injury (falls, equipment, self-inflicted injuries, impaired staff, etc.)
6. Identifies and reports client experiencing side effects and adverse reactions of medication.
7. Performs comprehensive health history and mental status assessment including allergies/sensitivities (food, latex, & environment).
8. Identifies pathophysiology related to an acute or chronic condition (signs & symptoms).
9. Assesses client for potential or actual abuse/neglect and intervene when appropriate.
10. Assesses the potential for violence and initiate /maintain safety precautions (e.g., suicide, homicide, self-destructive behavior)
11. Incorporates behavioral management techniques when caring for client (e.g., positive reinforcement, setting limits).

12. Assesses client for drug/alcohol related dependencies, withdrawal, or toxicities and intervene when appropriate.
13. Establishes and maintain therapeutic relationship with client.
14. Uses therapeutic communication techniques to provide support to client.
15. Recognizes non-verbal cues to physical and/or psychological stressors.
16. Addresses client needs based on visual, auditory, or cognitive distortions (e.g., hallucinations).
17. Provides care and education for acute and chronic behavioral health issues (e.g., anxiety, depression, dementia, eating disorders).
18. Recognizes impact of illness/disorder on individual/family lifestyle.
19. Assesses psychosocial, spiritual and occupational factors affecting care and plans interventions as appropriate.
20. Assesses family dynamics in order to determine plan of care and facilitates client/family coping.
21. Provides a therapeutic environment for clients with emotional /behavioral issues.
22. Assesses and plans interventions that meet the client's emotional and spiritual needs.
23. Considers client's cultural practice when planning and providing care.
24. Maintains confidentiality/privacy of client's information and HIPAA compliance.
25. Provide and receive report on assigned client(s).
26. Verify that client comprehends and consents to care/procedures.
27. Evaluates therapeutic effect of medication/treatment.
28. Prioritizes workload to manage time effectively.
29. Provides and receive report on assigned client.
30. Protects client from injury and /or complications (falls, suicide, procedures, malfunctioning equipment, errors, and impaired staff).
31. Complies with state and federal requirements for reporting client conditions (abuse/neglect, communicable disease, GSW, dog bites).
32. Acts as a client advocate.
33. Acknowledges and documents practice errors when appropriate.
34. Evaluates the results of diagnostic testing and intervene when appropriate.
35. Complies with federal/state/institution requirements regarding the use of client restraints and/safety device.
36. Manages client experiencing side effects and/ or adverse reactions to medications, treatment, or procedure.
37. Evaluates the results of diagnostic testing and intervene as necessary.
38. Evaluates and documents therapeutic effect of treatment and/or procedure.
39. Follows clinical facility policies/procedures and CCC School of Nursing clinical policies.
40. Provide care within legal scope.
41. Practice in a manner consistent with a code of ethics for registered nurse.
42. Provide individualized client-centered care consistent with Standard of Practice.
43. Collaborate with health care members in other disciplines when providing client care.
44. Recognizes limitations of self and others, seeks assistance and/or begin corrective measures at the earliest opportunity.
45. Prepared for clinical (on time, in appropriate uniform with ID badge, and necessary equipment to perform nursing care).
46. Participates in pre/post clinical conference learning activities.

47. Assists other students and staff members without Instructor prompting.
48. Demonstrates sound clinical judgment in urgent situations without prompting.
49. Works actively with other group members toward a common goal and allows the group the recognition.
50. Accepts constructive criticism and makes necessary changes in personal and professional behavior.

Clinical Expectations:

See Coahoma Community College Student handbook for health Science Programs Appendix A Associate Degree Nursing Section 7: Clinical Practicum
http://www.coahomacc.edu/healthsciences/HealthP&P.pdf

Guidelines for Preparation of Process Recording

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

1. Objectives for interaction with client: Prior to meeting with a client for whom you will do a process recording. Student should have in mind from 1 to 3 specific objectives for the meeting. Student will record your specific objectives at the beginning of the process recording to turn in to clinical instructor. An objective should specify a specific, readily measurable change in the client's behavior, and function as a guide for your interaction with the client.

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

3. Nurse-Client interaction: After recording your objectives for the interaction, use a 4 column format for writing the process recording. In the first column, entitled Nurse-client Interaction, *the **verbatim** conversation between you and the client should be recorded (not just a summary of what you and client said).* This account should include not only the verbatim account of what was said on the part of the nurse and the client, but also nonverbal cues for both the client and the nurse, such as tone of voice, rate of speech, body posture, quality of eye contact, and changes in facial expressions.

4. Each time the nurse and client communicate once with each other is referred to as an "exchange". Periods of silence are also important to record. Following the record of the conversation should be a brief description of events involving the client which transpired immediately after the interaction. For example, did the client return to his/her previous activity, or perhaps choose to isolate him/herself by going outside or to another room.

5. Interpretation of the interaction and your reactions to the interaction: Use this column to record your thoughts and reactions to the interaction. The emphasis in this part of the process recording is on analyzing that which is not explicit, understanding the probable meaning of the data as recorded in the previous column, and recognizing relevant nursing actions. For example, an analysis might focus on identifying a client's apparent underlying anger, speculating as to the possible causes of the anger, and clarifying why you reacted the way you did, or what prompted you to say or do a particular thing during the interaction. The process of interpretation may well begin during the interaction itself;

however, an **in-depth** interpretation of what occurred during the interaction should take place after the interaction with the client. Your interpretation should reflect knowledge of theoretical concepts and psychiatric nursing care principles for work with clients.

6. Nursing care, rationale, and modifications: In the final column, you should apply relevant theoretical nursing concepts and psychiatric nursing care principles to stating rationale for why you did what you did in the interaction at each exchange. Alternatively, if there is something that you would have done differently within a given exchange, you should state rationale for why the alternative action would have been better.

7. Reaction to client's interaction: Student will show his or her reaction to the conversation throughout the interpersonal process recording.

8. **Rationale stated for each intervention should be drawn from the literature, as opposed to documenting your opinion only**. Specific examples of what you could have said or done differently should be included for each exchange. For example, you might explain how anger can adversely affect a client if not dealt with in an appropriate fashion by the client, as a rationale for reflecting to the client that he/she seems angry (rationale drawn from literature).

9. Finally, student should include a brief summary to evaluate whether or not your initial objectives for the interaction were met. If your objectives were not met, provide a brief analysis of why. Note that this section of the process recording provides you the opportunity to think about how you would rework/modify a conversation, when you can devote undivided time to think over what transpired in the interaction with the client; i.e., you have a chance to "do the conversation twice" (once as it occurred, and again as you think it should have occurred).

<u>Note</u>: ***All process recordings are to be typed*****. The student must make 85 points or above to receive satisfactory on the IPR.**

Sample Process Recording Format

Name of Student_____ Client initials_____ Date_____ Time_____

Objectives for the Interaction	**Nurse/Client Interaction: (verbatim conversation)**	**Interpretation of the Interaction Your reaction to the interaction (describe behaviors)**	**Nursing Care, Rationale & Modification**	**Reaction to Interaction**
5 pts	**25 pts**	**30 pts**	**20 pts**	**20 pts**