Paperwork Guidelines and Sample Forms for Mental Health Psychiatric Nursing Clinical Posting (Clinical Requirements)

A. Learning Outcomes: Upon successful completion of this clinical practicum, the students will be able to:

1. Obtain a psychiatric and mental health history for a client.
2. Assess mental health by utilizing interview and observation skills.
3. Provide nursing care to mentally ill clients using nursing process.
4. Apply psychiatric nursing principles in caring for mentally ill clients.
5. Establish and maintain a therapeutic nurse-client relationship.
6. Maintain a therapeutic milieu in the environment.
7. Demonstrate skill of observation and recording.
8. Demonstrate skill in process recording.
9. Assist with selected therapies (ECT, Behavior therapy, and Group therapy).
10. Evaluate client's response to psychotropic medications, including effectiveness, side effects, and compliance

B. List of Requirements

1. Nursing Care Plans *(Daily)*
2. Pre-conference and Post-conference seminars *(One seminar per student per rotation.)*
3. Clinical Journal (NPI)
4. Process Recordings
5. Case Study (Paper submission)

   List of attachments for the Case Study:

   a. Nursing Care Plan *(Daily)*
   b. Mental Health Assessment Tool *(Completed on the <u>first</u> week)*
   c. Process Recording Form *(Once a week)*
   d. Ongoing Psychiatric Nursing Assessment Record *(Once a week)*
6. Case Presentation *(Last week of Clinical Posting)*

GUIDELINES

1. **Nursing Care Plans (NCP)** *(Daily. Please follow the format attached).*

A nursing care plan should be completed daily based on the presentation of the client, the long-term goals for treatment, and the therapeutic opportunities of the setting. The key elements of a daily nursing care plan are:

1. A thorough mental status examination.
2. A list of two prioritized nursing diagnoses which reflect analysis of the mental status of the client, progress toward overall outcomes, events of the last few days, new data gathered by you.
3. A list of one long-term, client-centered goals for each of the nursing diagnoses. Note these are time sensitive.
4. A list of one short-term goal for each of the nursing diagnoses. Note these are time sensitive.
5. A list of three relevant nursing interventions with rationales. Along with an evaluation of whether those interventions were achieved.
6. An evaluation of the effectiveness of the care plan and description of modifications made to the care plan, as appropriate.

2. **Pre-Conference And Post Conference Seminars** *(One seminar per student per rotation.)*

Students are expected to attend all clinical conferences, which will be comprised of three general aims: 1) The first aim is operational. Students and faculty discuss clinical experience goals, turn in paperwork, discuss upcoming assignments, and the like; 2) The second aim is informal discussion of the events of the clinical experience. Students report learning that they have accomplished as well as problems, needs, and concerns that need to be addressed. Here, the CI may provide theoretical content, and students provide problem solving and support to peers; and 3) The third aim of the clinical conference is to apply theory learned to

practice in clinical settings. In order to accomplish this goal, each student is expected to make one presentation each rotation on a selected concept. Each student is expected to lead one of these pre-conferences and post-conferences. The CI might also lead some discussions as warranted or desired based on the possible and identified nursing problems such as but not limited to:

a. Use of Defense mechanisms
b. Low Self Esteem
c. Crisis state
d. Sensory overload
e. Inability to identify and express feelings
f. Value conflict
g. Dependence
h. Unresolved grief
i. Limited decision making ability
j. Chaotic family of origin
k. Cognitive distortion
l. Impaired identity
m. Mistrust
n. Hopelessness
o. Helplessness
p. Learned Optimism
q. Stress Management
r. Other area of interest as arranged with clinical faculty

3. **<u>CLINICAL JOURNAL</u>** (*Note: use a small notebook for this purpose. The CI will check and sign the entry daily*).

Describe a significant situation or event that occurred in your clinical day. Explain why the event was important to you as related to developing understanding of the nursing care of a client who has (a) mental health condition(s). Note that "significant event" differs from "critical incident;" i.e. the event or situation about which you write your journal entry should reflect your specific personal insight, as

opposed to an evaluation of the situation. Discuss how this event might have been perceived by others involved and those external to the event. For example, pretend you are someone else (a client, staff nurse, teacher, classmate, etc.) and react to something you did today in your clinical practice; i.e. if you attempted to communicate with a client who had aphasia today, write about the situation from the perspective of the client, etc. Explore alternative ways of interpreting and responding to the event including an evaluation of the feasibility and acceptance of each of these alternatives. Identify what specific learning has occurred for you in reflecting about this event. What specific thing(s) did you learn today and how will you apply that learning in your practice as a nurse? Identify some differences in what you learned today from what you learned previously. How will you apply this learning in your practice as a nurse? As appropriate, you may wish to re-read a journal entry from a previous week and write a reaction to what you wrote in relation to new learning that has occurred over time.

4. **PROCESS RECORDINGS.** *(Once a week)*

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 five (5) components *(described in detail below).* Students should prepare process recordings using as a guideline the copy of the form that is provided below. Process recordings should be prepared on the *Process Recording Form (see attached files).*

1. ***Objectives for Interaction with Client*****.** Prior to meeting with a client for whom you will do a process recording, you should have in mind one to three specific objectives for the meeting. You will record your specific objectives at the beginning of your process recording to turn in to your clinical instructor. An objective should indicate 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 that 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? Also 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. ***Verbatim Nurse-Client Interaction.*** Record a 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. 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 that 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?

4. ***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. Include references here.

5. ***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. Rationale stated for each intervention should be drawn from the literature as opposed to documenting your opinion only. Again, cite references. 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). Finally, you 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 the chance to "do the conversation twice" (once as it occurred, and again as you think it should have occurred)

(**NOTE:** *Process recordings are a learning tool. They are not supposed to be perfect; they are supposed to be critical. They are evaluated according to whether the interaction was analyzed critically, corrections were suggested with appropriate rationale, and references were used appropriately. Unless negotiated differently with an individual clinical instructor, all process recordings should be typed using the format provided.)*

5. **OTHER INSTRUCTIONS.** *Please use the following forms for all your Mental Health Psychiatric Nursing clinical requirements (see attached files):*

a. Mental Health Assessment Tool *(Completed on the first week)*
b. Nursing Care Plan *(Daily)*
c. Case Study Format *(Completed on the last week – for case presentation)*
d. Process Recording Form *(Once a week)*
e. Ongoing Psychiatric Nursing Assessment Record *(Once a week)*
f. ECT *(Reference)*
g. Marking Guideline for Case Presentation *(Reference)*
h. Marking Criteria for Pre and Post Conference Seminars *(Reference)*

NURSING CARE PLAN

ASSESSMENT (Subjective/ Objective Cues)	**Nursing Diagnosis**	**Case Background**	**GOALS** (Short term / Long Term)	**Nursing Intervention**	**Rationale**	**Evaluation**

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ONGOING PSYCHIATRIC NURSING ASSESSMENT RECORD

NAME: **DOA:**

Ward: **Diagnosis:**

				DATE									
DAILY ASSESSMENT CRITERIA				**M**	**E**	**N**	**M**	**E**	**N**	**M**	**E**	**N**
Appearance	1	Grooming & Hygiene	1. Good 2. Poor									
	2	Dress	1. Appropriate 2. Inappropriate									
	3	Posture	1. Erect 2. Slouched 3. Bedbound									
	4	Gait	1. Steady 2. Unsteady									
Behavior	1	Affect (Feeling)	1. Appropriate 2. Hopeless 3. Helpless 4.Powerless 5. Shame 6. Guilty 7. Humiliation 8. Apathy									
	2	Attitude:	1. Cooperative 2. Friendly 3. Non cooperative 4. Hostile									
	3	Activity:	1. Normal 2. Underactive 3. Overactive 4. Self-destructive 5. Aggressive 6. Harming others									
	4	Mood:	1. Normal 2. Elated 3. Depressed 4. Anxious 5. Irritable 6. Withdrawn 7. Panic									
	5	Speech:	1. Normal 2. Slurred 3. Incoherent 4. Irrelevant 5. Loud 6. Soft 7. Continuous 8. Repetitious									
	6	Coping Mechanisms	1. Adequate 2. Denial 3. Anger 4. Repression 5. Withdrawal 6. Day dreaming 7. Dependence on substance									
Cognition	1	Orientation	1. Yes 2. No if No (Time, place and person)									
	2	Attention & Memory	1. Intact 2. Impaired									
Thought	1	Process	1. Logical 2. Illogical 3. Flight of ideas 4. Neologism 5. Clang association 6. Confabulation 7. Thought blocking 8. Echolalia									
	2	Content	1. Relevant 2. Illogical 3. Flight of ideas 4. Obsession 5. Compulsion 6. Paranoid 7. Depersonalization 8. Phobias									
	3	Perception	1. Normal 2. Illusion 3. Hallucination (***A,V,T,O,G***)									
	4	Insight	1. Normal 2. Poor									
	5	Suicidal Ideation	1. Yes 2. No									
	6	Suicidal Attempt	1. Yes 2. No									
Others	1	Withdrawal symptoms	1. Yes 2. No									
	2	Rest & Sleep	1. Normal 2. Increased 3. Deprived 4. Sedated									
	3	Faith in God	1. Yes 2. No									
SIGNATURE/INITIAL OF STAFF			**M – Morning**									
			E – Evening									
			N - Night									

Process Recording Form

Student _____ Client Initials _____ Age _____ Date ___/___/___
Time ___:___ a.m./p.m.

Objectives for the Interaction:

1.
2.
3.
4.
5.

Context of the Interaction:

Context Of The Interaction *(Verbatim dialog between client and nurse)*	**Interpretation Of The Interaction** *(Include Citations)*	**Nursing Care, Rationale, And Modifications** *(Include Citations)*

1. Summarize interaction; were your goals met?

2. What did you learn from this experience?

3. What are two or three goals for future interactions with this patient?

Mental Health Assessment Tool

Student's Name: _____ *Class:* _____

Clinical Area: _____ *Grade:* _____

Client's Identifying Information

Initials Only		*Languages Spoken*	
Nationality		*Level of Education*	
Age/ Sex		*Date of Admission*	
Marital Status		*Ward/ Room*	

Living Arrangements

Financial Status and Occupation

Immediate Patient Care Giver / Support System

Sources of Data

Chief Complaints:

(The reason, in the client's own words, for coming or being sent for treatment).

History of the Present Problem/ date of onset of the problem/ symptoms

Medical Diagnosis

Past Medical History:

Date & Reason of Previous Admission/ (Previous Treatment Modalities & Medications Prescribed/ Previous ECT Sessions (Date of last course)/ History of violent behavior, suicidal attempt, alcohol or drug abuse (Explain):

Past Medical history. (Head injuries, epilepsy, disorientation, etc.)

Current history of:

Suicide:	☐ *Yes*	☐ *No; Specify*
Alcohol or substance abuse:	☐ *Yes*	☐ *No ; Specify*
Physical or sexual abuse:	☐ *Yes*	☐ *No; Specify*

Growth & Development History: Childhood (Psychological & Physiological), Adolescent HX:

Family Medical History

History of: ☐ *Mental Illness* ☐ *Epilepsy* ☐ *Drug Abuse* ☐ *Alcohol*

Other Significant Family History Findings (Specify):

Performance of Activities of Daily Living:

Eating

Elimination

Drinking

Sleeping

Exercise & Activity

Has patient experienced neurovegetative changes? If yes, explain

Mental Status Examination

A. Overall General Appearance (Describe:

Facial Expressions _____

_____

Grooming & Dress _____

_____

Gait & Posture _____

_____

General State of Health _____

_____

General State of Nutrition _____

_____

Hygiene & Cleanliness _____

_____

B. Motor Activity:

☐Normal ☐Hyperactive ☐Hypoactive ☐Purposeful ☐Disorganized
☐Stereotyped ☐Tics ☐Tremors ☐Grimacing ☐Echopraxia
☐Others; specify ....

C. Communication:

1. *Facial Expressions*
☐Sad ☐Worried ☐Frightened ☐Tense
☐Pupil: ☐Constricted ☐Dilated
☐Others; specify ....

2. *Speech*
☐Slow ☐Rapid ☐Loud ☐Soft ☐Audible
☐Aphasia ☐Pressured ☐Stuttering ☐Slurred
☐Coherent ☐Incoherent
☐Logical ☐Illogical ☐Vague ☐Others; specify ....

3. *Signs of Impaired Communication*
☐Thought Blocking ☐Circumstantially ☐Flight of Ideas
☐Preservation ☐Verbigeration ☐ Ward Salad
☐Neologism ☐Echolalia ☐ Mutism
☐Clang Association ☐Racing Thoughts ☐ Vague Thoughts
☐Punning ☐Tangentiality

Explain by giving vivid examples:

_____

_____

_____

_____

_____

_____

D. Emotional State:

Affect	*Attitude*	*Mood*		
☐ Flat	☐ Friendly	☐ Depressed	☐ Euphoric	☐ Anxious
☐ Labile	☐ Embarrassed	☐ Sad	☐ Calm	☐ Agitated
☐ Blunted	☐ Evasive	☐ Nervous	☐ Confused	☐ Angry
☐ Incongruent	☐ Fearful	☐ Discouraged	☐ Others; specify	
☐ Bright	☐ Resentful			
☐ Anxious	☐ Negative			
☐ Sullen	☐ Impulsive			
☐ Others; specify	☐ Liability			
	☐ Others; specify			

Describe the relationship between the patient's mood and the content of his thought:

_____ _____

_____ _____

_____ _____

Attitude & degree of cooperation during the interview: ☐ *Passive* ☐ *Active*

Client's Defense Mechanisms (Coping strategies)

Healthy Techniques	*Unhealthy Techniques*

E. Intellectual Processes:

Thought Content (Describe:

- *Delusion*
  - *Delusion of Reference*
  - *Persecutory Delusion*
  - *Delusion of Control*
  - *Nihilistic Delusion*
  - *Delusion of Grandeur*
  - *Somatic Delusions*

Thought Content (Describe: ☐ Thought withdrawal ☐ Thought broadcasting ☐ Thought insertion

Explain :

Illusion & Hallucination (Describe):

- *Illusion* ☐ *Yes* ☐ *No , If yes, explain ...*
- *Hallucination* *Auditory* ☐ *Yes* ☐ *No; Explain ...*

  Visual ☐ *Yes* ☐ *No; Explain ...*

  Olfactory ☐ *Yes* ☐ *No; Explain ...*

  Gustatory ☐ *Yes* ☐ *No; Explain ...*

  Tactile ☐ *Yes* ☐ *No; Explain ...*

  Others, specify .....
- ***Obsession*** ☐ *Yes* ☐ *No; Explain ...*
- ***Compulsion*** ☐ *Yes* ☐ *No; Explain ...*
- ***Phobia*** ☐ *Yes* ☐ *No; Explain ...*

F. Cognitive Functioning:

1. *Memory:*

☐ Intact *If not intact, specify:*
☐ Not Intact *Remote:*----------
Recent:----------
Immediate: ----------

2. *Orientation:*

☐ *Time* ☐ *Person* ☐ *Place*

3. *Concentration:*

A. *Digit Span:* ----------
B. *Simple Calculation:* ----------
C. *Conclusion:* ----------

4. *Abstract Thinking:*

A. *Finds Meaning in Proverb:*----------
B. *Finds Similarities Between Things:*----------
C. *Conclusion:*----------

5. *Insight:*

☐ Lack of Insight ☐ Good Insight ☐ Poor Insight

(Does Patient Find Treatment Necessary?)

6. *Judgment:*

A. Social Judgment:

B. Family Judgment:

C. Financial Judgment:

D. Employment Judgment:

Your Conclusion:

Prescribed Medications				
Drug	***Dose***	***Frequency***	***Route***	***Indication for your patient***

Other Treatment Modalities: Discuss

Diagnostic Evaluation & Date	*Rational*	*Result*	*Interpretation*

Coping Strategies: What method the patient uses to manage his stress:

Healthy Techniques		Unhealthy Techniques	
Method	**Applied**	**Method**	**Applied**
Physical Activity		Smoking cigarettes	
Setting		Over eating	
Takes hot bath		Drinking liquor	
Cleaning the house		Thinking things over	
Knitting/Sewing		Throwing things	
Cooking		Over working	
Reading		Having a temper tantrum	
Writing		Chewing gum	
Day Dreaming		Spending money	
Listening to music		Biting finger nails	
Playing an instrument		Moping isolating himself doing nothing	
Change environment (e.g., travel)		*Others: if yes, specify:*	
Going to movies and watching T.V			
Going for a ride			
Talking with friends			
Talking on phone			
Praying			
Talking to a spiritual guide			
Trying to ignore the problem			
Change his look to life			
Talking to a therapist			
Listening to self improvement tapes			
Use a form of relaxation technique			
Others: if yes, specify:			

CASE STUDY / PRESENTATION FORMAT

I. DEMOGRAPHIC PROFILE

a. Name
b. Address
c. Age
d. Sex
e. Civil Status
f. Occupation
g. Educational Attainment
h. Admitting Diagnosis
i. Chief Complaint
j. Chief Complaint
k. Present Diagnosis

II. HISTORY OF PRESENT ILLNESS

Past Medical History (Present Illness and Hospitalization)
Family History
Socio Economic
(Please use the Psychiatric history format provided)

III. PHYSICAL ASSESSMENT

(Focus on the disease process)

IV. PSYCHOPATHOLOGY

S/S, predisposing factors
Disease Process

V. MEDICAL MANAGEMENT, TREATMENT AND DIAGNOSTIC PROCEDURES, LABORATORY PROCEDURES

VI. DRUG STUDY *(Latest medications)*

Name of Drug	Generic name	Action	Indications	Contraindications	Nursing Responsibility

VII. NCP

Assessment	Nursing Diagnosis	Case Background	Goal	Implementation	Rationale	Evaluation
Subjective Cues Objective Cues			Short term Long Term			

VIII. EVALUATION

Prognosis of the patient
Condition upon discharge
Discharge Instruction

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Electroconvulsive therapy

Introduction

In electroconvulsive therapy (ECT), an electric shock is delivered to the brain by way of electrodes placed on the patient's temples. Electrodes may be placed bilaterally or unilaterally. ECT is an effective way to treat patients with affective disorders and selected schizophrenias or related psychoses.

A doctor is primarily responsible for administering ECT, but safe and effective therapy requires an interdisciplinary approach and cooperation. The nurse's role is to provide care during the assessment, preparation, treatment, and recovery of the patient. The treatment team also includes a certified registered nurse-anesthetist (CRNA) or anesthesiologist and, possibly, a nurse or nurse practitioner (NP).

The doctor's role is to obtain appropriate consent, order pretreatment and posttreatment regimens, titrate drug doses, administer treatment, and determine when the patient may be released from the post-ECT recovery unit. The CRNA is responsible for ensuring a patent airway, administering positive-pressure oxygen during the treatment and until the patient is breathing well on his own, and administering specific drugs during the procedure. If a nurse or an NP is part of the team, she's responsible for making sure all equipment, drugs, and emergency equipment are available; preparing the patient by attaching electrocardiograph (ECG) and EEG monitors; explaining the procedure to the patient; and completing a preprocedure assessment.

Equipment

- Appropriate EEG/ECG machine and connection wires
- Rubber headband
- Two stimulus electrodes
- Conduction gel
- ECG electrodes
- Crash cart with emergency drug kit and defibrillator
- Suction machine with sterile pharyngeal catheters
- Endotracheal (ET) intubation tray
- Rubber mouthpiece
- Electronic blood pressure monitor
- Pulse oximeter and sensor
- Oxygen source and tubing with positive-pressure equipment
- Two pairs of gloves
- Alcohol pads
- 21G needles

- Butterfly infusion set
- Sterile 3-ml, 5-ml, and 10-ml syringes
- Methohexital
- Succinylcholine (Anectine)
- Glycopyrrolate (Robinul)
- Dantrolene (Dantrium)
- Tape
- Sterile water or normal saline solution for injection
- Tourniquet
- Patient's medical record
- Documentation records
- Stretcher
- Optional: protective equipment such as gloves, gowns, masks, and eye protectors

Preparation of Equipment

Plug in the EEG/ECG machine and make sure all recorders have paper and are working properly.

Set the treatment parameters as ordered for pulse width (ms), frequency (Hz), duration (sec), and current (amp). These parameters represent the "total volume" of electrical stimulus applied, which differs depending on the patient's age, medication, seizure threshold, and other factors. Plug in the electronic blood pressure monitor. Also make sure the crash cart with emergency drug kit and defibrillator, as well as suction equipment, an ET intubation tray, and oxygen, are readily available and that needed medications are properly prepared. (See *Medications for ECT*.)

MEDICATIONS FOR ECT		
Even though the doctor or certified registered nurse-anesthetist administers these medications during electroconvulsive therapy (ECT), you should become familiar with them so you can assess the patient for adverse effects. Brief descriptions of the most commonly used drugs appear below.		
Drug	**Actions**	**Adverse reactions**
1. dantrolene (Dantrium)	Dantrolene is a direct-acting skeletal muscle relaxant that's effective against malignant hyperthermia.	Seizures, muscle weakness, drowsiness, fatigue, headache, hepatitis, nervousness, insomnia
2. glycopyrrolate (Robinul)	Glycopyrrolate has desirable cholinergic blocking effects because it reduces secretions in the respiratory system as well as oral and gastric secretions. It also prevents a drop in heart rate caused by vagal nerve stimulation during anesthesia.	Dilated pupils, tachycardia, urine retention, anaphylaxis, confusion (in elderly), dry mouth

3. methohexital	Methohexital is a rapid, ultra-short-acting barbiturate anesthetic agent.	Hypotension, tachycardia, respiratory arrest, bronchospasm, anxiety, hypersensitivity reaction, emergence delirium
4. succinylcholine chloride (Anectine)	Succinylcholine is an ultra-short-acting depolarizing skeletal muscle relaxant. Given I.V., it causes rapid, flaccid paralysis.	Bradycardia, arrhythmias, cardiac arrest, prolonged respiratory depression, malignant hyperthermia, anaphylaxis

Implementation

1. Check the doctor's order.
2. Gather the appropriate equipment.
3. After arrival in the ECT room, confirm the patient's identify using two patient identifiers according to your facility's policy and check his nothing-by-mouth status.
4. Explain the procedure to the patient *to allay anxiety*. Provide teaching on what to expect before and after the procedure, including possible confusion, disorientation, and short-term memory loss.
5. Make sure the doctor has obtained written informed consent.
6. Make sure the patient's history (including allergies to medications or latex), physical examination, and dental evaluation are documented in his chart.
7. Make sure the following diagnostic tests have been completed and assessed: complete blood count, metabolic panel, thyroid profile, urinalysis, ECG, pseudocholinesterase activity determination (especially in patients with severe liver disease, malnutrition, or a history of sensitivity to muscle relaxants or similar substances), chest and spine X-rays, EEG, and cranial computed tomography scan.
8. Perform hand hygiene and put on gloves.
9. Help the patient remove dentures, partial plates, or other foreign objects from his mouth *to prevent choking.*
10. Remove and dispose of gloves.
11. Make sure the patient removes all jewelry, metal objects, and prosthetic devices before the procedure *to prevent injury.*
12. Have the patient dress in a hospital gown and ask him to void *to prevent incontinence during the procedure.*
13. Help the patient onto the stretcher.
14. Put on gloves and insert an I.V. catheter. (See the "I.V. catheter insertion" procedure.)
15. Attach the patient to an electronic blood pressure monitor and check his baseline vital signs.
16. Attach the patient to a pulse oximeter to monitor his respiratory status during the procedure *because the drugs used cause respiratory depression.*

17. Attach the patient to the ECG monitor.
18. Attach the EEG electrodes and stimulus electrodes to the rubber headband. Coat the electrodes with conduction gel and place the band around the patient's head. Place the large, silver-colored stimulus electrodes on each temple at about eye-level. Space the small, brown-colored EEG electrodes across the forehead.
19. Connect the stimulus electrodes to the stimulus output receptacle on the machine.
20. Run the machine in the self-test mode. When the machine is ready, it displays the message "Self Test Passed" and prints the date, time, treatment parameters, a brief ECG strip, and EEG monitors.
21. The CRNA or doctor then administers glycopyrrolate, followed by methohexital. Methohexital acts very rapidly. Expect an abrupt loss of consciousness when the appropriate dose is infused.
22. After the patient is unconscious, succinylcholine is administered. A tremor or fasciculation of various muscle groups occurs due to the depolarizing effect of this drug. Succinylcholine also causes complete flaccid paralysis, so mechanical ventilation is started at this time. A rubber mouthpiece is inserted and positive-pressure oxygen is given.
23. The doctor initiates the stimulus, and mild seizure-like activity occurs for about 30 seconds. The patient's jaw and extremities must be supported while avoiding contact with metal.
24. Monitor vital signs as well as ECG and EEG rhythm strips. Assess the patient's skin for burns.
25. When spontaneous ventilation returns, usually in 3 to 5 minutes, discontinue the I.V. infusion. Continue to monitor vital signs.
26. As the patient becomes more alert, speak quietly and explain what is happening. Remove the rubber mouthpiece.
27. Place the patient on his side *to maintain a patent airway.* Measure and document vital signs every 15 minutes until they stabilize.
28. Discharge the patient from the recovery area when he's able to move all four extremities voluntarily, can breathe and cough adequately, is arousable when called and oriented, has an Aldrete score that is seven or greater, has stable vital signs and temperature within 1° of the pretreatment value, and has a normal swallowing reflex. A doctor's order is required to release the patient from the recovery area.
29. One hour after treatment, obtain and record the patient's vital signs. Check the patient's temperature to assess for malignant hyperthermia. Then continue to check vital signs every hour as necessary until the patient is stable.
30. Document the procedure.

Special Considerations

1. If the patient is taking benzodiazepines before the procedure, obtain an order to begin tapering and discontinue the drugs 3 to 4 days before the procedure. Benzodiazepines

and anticonvulsant drugs (such as lorazepam and phenytoin) would negatively affect the patient's response to treatment.

2. Contraindications to ECT include brain tumors, space-occupying lesions, and other brain diseases that cause increased intracranial pressure. The seriousness of any physical illness, such as heart, liver, or kidney disease, and the psychiatric disorder always have to be weighed against each other before ECT is initiated.

3. Malignant hyperthermia is an uncommon but potentially life-threatening complication that can follow the administration of an anesthetic agent or a depolarizing muscle relaxant such as succinylcholine. Immediately report an oral temperature above 100° F (37.8° C) within 1 hour after treatment. Follow your facility's policy and procedure for a malignant hyperthermia crisis.

Documentation

Document using flow sheets or progress notes. Include the patient's vital signs and responses during the treatment sequence, recovery, and post-recovery. Assess and document the patient's physical and mental status and any behavioral changes or lack of such changes.

References

1. American Psychiatric Association. *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging (A Task Force Report of the American Psychiatric Association)*, 2nd ed. Arlington, Va.: American Psychiatric Association, 2001.
2. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Standard NPSG.01.01.01. Oakbrook Terrace, Ill.: The Joint Commission, 2010.
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4. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Standard PC.03.01.09. Oakbrook Terrace, Ill.: The Joint Commission, 2010.
5. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Standard RC.01.03.01. Oakbrook Terrace, Ill.: The Joint Commission, 2010.
6. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Standard UP.01.01.01. Oakbrook Terrace, Ill.: The Joint Commission, 2010.
7. Kavanagh, A., and McLoughlin, D.M. "Electroconvulsive Therapy and Nursing Care," *British Journal of Nursing* 18(22):1370, 1372, 1374-7, December 2009-January 2010.
8. Mohr, W.K. *Psychiatric-Mental Health Nursing: Evidence-Based Concepts, Skills and Practices,* 7th ed. Philadelphia: Lippincott Williams & Wilkins, 2008.
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10. Nettina, S.M. *Lippincott Manual of Nursing Practice,* 9th ed. Philadelphia: Lippincott Williams & Wilkins, 2010.
11. Videbeck, S.L. *Psychiatric-Mental Health Nursing,* 4th ed. Philadelphia: Lippincott Williams & Wilkins, 2007.

Electroconvulsive therapy

1. Check the order.
2. Gather and prepare the appropriate equipment.
3. Confirm the patient's identity.
4. Explain the procedure and make sure informed consent has been obtained.
5. Check for the appropriate laboratory results and that the patient has been nothing-by-mouth (NPO) status for at least 8 hours.
6. Perform hand hygiene and put on gloves.
7. Remove any dentures or plates from the patient's mouth and remove any personal effects from the patient.
8. Have the patient change into a gown and void.
9. Check the patient's vital signs, including pulse oximetry.
10. Attach the patient to the electrocardiogram (ECG) monitor and electroconvulsive therapy (ECT) machine.
11. Run the ECT machine in self-test mode.
12. Monitor the patient's ECG and EEG strips.
13. Discontinue the I.V. infusion when spontaneous ventilation returns.
14. Position the patient on his side to maintain an open airway.
15. Assess the patient, and monitor his vital signs every 15 minutes until they're stable.
16. Discharge the patient from the recovery area, when appropriate.
17. Document the procedure.

Clinical Evaluation Form

Student Name: _____ Date ___/___/___

Clinical Instructor: _____Hospital: _____

A. Assessment (20% of final grade) : _____

Student Examples and Rating:

Faculty Comments and Rating:

B. Planning (10% of final grade) : _____

Student Examples and Rating:

Faculty Comments and Rating:

C. Implementation (35% of final grade) : _____

Student Examples and Rating:

Faculty Comments and Rating:

D. Evaluation (10% of final grade) : _____

Student Examples and Rating:

Faculty Comments and Rating:

E. Professional Role (worth 25% of final grade) : _____

Student Examples and Rating:

Faculty Comments and Rating:

F. Specific Strengths in Clinical Performance

1.

2.

3.

Instructor Comments:

_____
_____
_____
_____

G. Areas for Continued Development in Clinical Performance

1.

2.

3.

Instructor Comments:

_____
_____
_____
_____

H. Specific Strategies for Improving Clinical Performance

1.

2.

3.

Instructor Comments:

_____
_____
_____
_____

Signature of CI:_____
Date*:*

MARKING CRITERIA FOR CLINICAL ASSIGNMENT

Name :……. Student's ID……..

Program : …….. …… Group……. …….. …..……

A. Psychiatric Patient Assessment (Use of Health Assessment Tool (25 Marks)	**Marks allocated**	**Marks obtained**	**Comments**
a. Completed Demographic Profile	**5**		
b. History of The Present Illness	**5**		
c. Past Medical History	**5**		
d. Growth and Development History	**5**		
e. Family Medical History	**5**		
B. Mental Status Examination (20 Marks)			
a. Appearance	**5**		
b. Behavior	**5**		
c. Cognition and Thinking Process	**5**		
d. Defense mechanisms	**5**		
C. Psychopathology (10 Marks)			
a. Presentation of Client problems	**5**		
b. Discussion with citations and References	**5**		
D. Drug study and other treatment modalities (10 Marks)			
a. Presentation of Current Medication	**5**		
b. Nursing responsibilities	**5**		
E. Nursing Care Plan (20 Marks)			
a. Presentation of 2 Actual Problems	**2.5**		
b. Presentation of 3 Potential Problems	**2.5**		
c. Nursing Intervention	**5**		
d. Evaluation	**5**		
F. Completed Forms (20 Marks)			
a. Nursing Care Plan	**5**		
b. Mental Health Assessment Tool	**5**		
c. Process Recording Form	**5**		
d. Ongoing Psychiatric Nursing Assessment Record	**5**		
Total Marks	**100**		

Assessor …….Signature……. Date……..

Dr. Arnel Banaga Salgado, Ed.D., D.Sc., RN, MA Teaching (Psychology)
Assistant Professor

RAK Medical & Health Sciences University
(Member of RAK Human Development Foundation)

جامعة رأس الخيمة
للطب والعلوم الصحية
(عضو مؤسسة رأس الخيمة للتطوير والتعليم والتنمية البشرية)

Name:…… Student's ID……..

Program: ..…….. Group…….……

Subject: PSYCHIATRIC NURSING (Case Presentation)

Topic ……

A. Structure (30 marks)	**Marks allocated**	**Marks obtained**	**Comments**
1. Presentation of self a. Poise b. Confidence 2. Clarity of presentation a. Diction b. Voice projection c. Eye contact d. Pace e. Command of language f. Creativity 3. Logical organization a. Flow b. Sequence 4. Use of audio-visual aids	6 12 6 6		
B. Content (70 marks)			
1. Introduction and background 2. Literature review : a. Concept clearly explained b. Literature /source cited 3. Discussion 4. Implication to nursing 5. Recommendation & Conclusion	5 20 25 15 5		
Total Marks	**100**		

Assessor ……Signature…… Date……..

Arnel Banaga Salgado, Ed.D., D.Sc., RN
Assistant Professor

CRITERIA FOR THE PRE-CONFERENCE AND POST CONFERENCE SEMINAR

Student Name: _____ Date ___/___/___

Clinical Instructor: _____Hospital: _____

Criteria	Marks Allocated	Marks Obtained	Comments
1. Clear definition of the problem, concept or issue.	20%		
2. Oral discussion of at least two non-internet sources of information about the topic.	30%		
3. Two to three clearly generated theory based nursing interventions that address the cause of the nursing problem.	20%		
4. Generation of at least one discussion question to be considered by the clinical group.	10%		
5. Provision of relevant handouts summarizing main points with references.	10%		
6. Clear and concise presentation (about 10 minutes before discussion).	10%		
TOTAL	**100%**		

Signature of CI:_____
Date*:*