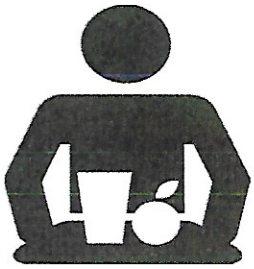
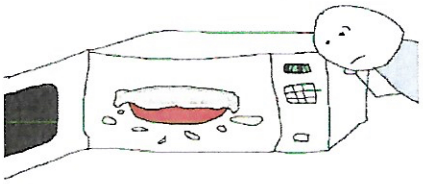
Dining Room Guidelines for Visiting Students

You are invited to use the patient cafeteria during your lunch while in rotation at Fort Logan.

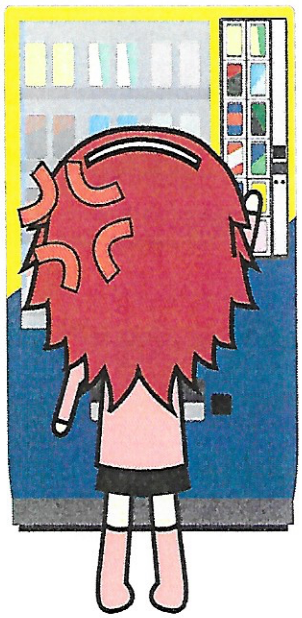
Following guidelines are implemented to allow Nutritional Services time and space to prepare meals and to give you space to enjoy your meal time:

- The hours available to you are from 11:45 to 12:45
- Please sit in the small dining room i.e. the designated area
- When you are finished please keep tables and microwave clean
- The designated areas (tables and microwave) are on the right side as you enter the cafeteria area
- You need to provide your own; food, drinks, utensils and napkins





Vending machines with soda, bottled water, candy, and chips are available to you in the hallways.



COLORADO MENTAL HEALTH INSTITUTE AT FORT LOGAN NURSING SERVICES

GUIDELINES FOR STUDENTS:

1. Discuss concerns and issues regarding working with psychiatric clients with preceptor before interacting with clients.

2. Discuss differences of opinion on treatment and interventions with your preceptor. The final decision on the client's treatment plan rests with the team but we want and need your input.

3. If you have any problems or concerns, please bring them to the preceptor immediately.

4. The consistent structure of the team's program decreases anxiety for the clients. Please, therefore, follow the program's structure consistently.

5. In the event that a client is escalating to the point of physical aggression, please go to the nursing station or office immediately and alert the staff.

6. Report all verbalizations of suicidal ideation, threats towards others, verbalization of wanting to run away and observation of possible medication side effects to an RN immediately.

7. If a client asks you a question and you are unsure how to answer, say to the person, "I will get back with you," and check with your preceptor about possible ways to proceed.

8. At times you may disagree with a staff member. If you disagree with a staff person, please do so in private when you both have a chance to discuss it.

9. Staff strive to build therapeutic relationships with clients. Discuss the differences between therapeutic and social relationships with your instructor. Do not discuss significant personal issues (e.g. personal family dynamics, personal problems, personal medical issues) with patients or among staff where patients can overhear. Don't share your personal email, phone, home address, or social network account information.

10. Confidentiality of your clients should be maintained throughout all phases of care. Students are free to access patient information for learning purposes; however, students may not photocopy any of our records and must protect the identity of clients in written papers for the course.

11. Nursing students are not allowed to escort patients to areas that are not under immediate staff observation and supervision and may not meet with patients alone. There must always be a staff person within sight.

12. All cell phones must be kept in the nurses station. No use of cell phones in patient care areas or where patients are being discussed (such as report, treatment plan reviews, etc.)

13. If you are asked by staff to do something that you feel uncomfortable with or were told by your clinical instructor not to do, let the charge nurse and your instructor know immediately.

14. You may not dress inappropriately, i.e. in revealing or potentially provocative manner. Clothing with logos related to drugs, alcohol, smoking, political or religious issues are not appropriate dress in this setting. Students will present as neat, professional appearance. Check with your clinical instructor for specifics regarding the dress code set forth by the school.

I have reviewed and agree to abide by these guidelines.

_____ _____

Student Signature Date

rev 2018 MJ

HIPAA / CONFIDENTIALITY FOR STUDENTS

- HIPAA stands for Health Insurance Portability and Accountability Act

- Protected Health Information (PHI) is individually identifiable information that is maintained or transmitted in any form (verbal, written, or electronic). It can relate to the past, present, or future treatment of a patient.

- HIPAA legislation was developed in 1996 as a way of addressing abuse in the release of individual's PHI. The intent of HIPAA is to protect all of us from having individual health information given out to others without our authorization to do so. HIPAA reinforces the Confidentiality practices that we have consistently followed at CMHIFL.

- HIPAA prohibits the use or disclosure of healthcare information that can identify a specific person without the individual's verbal or written authorization unless it is for the purpose of **Treatment, Payment, or Healthcare Operations,** or in the case of a **Medical Emergency.**

- The Privacy provisions of HIPAA went into effect on April 14, 2003. The Security Provisions of HIPAA went into effect in 2005.

- An individual can grant others the right to see their PHI by signing an Authorization for this access. An individual can withdraw his/her permission for access to his/her PHI at **Any Time.**

- The rule of thumb is that only the minimum amount of information necessary to provide for the patient is given out to those within the hospital and those outside of the hospital. For example, our dietary staff definitely need access to a patient's dietary preferences, allergies, and any dietary restrictions. However, the dietary staff should not read a patient's psychological testing report because this is not information they need to provide for the patient's nutrition.

- Patients have the right to review their PHI. This has been a patient right at CMHIFL for many years. There Is a standardized process which is utilized whenever a patient asks to see his/her PHI. If a patient asks you for their PHI refer them to regular CMHIFL staff - Don't give them anything out of their chart.

- Documents/notes including PHI must be shredded - do not throw any documents or notes with patient information on them into a wastebasket. Ask the team staff where the shredding box is and be sure to throw any patient information into this box.

- Violations of HIPAA, i.e., if a patient's PHI is given to another entity, without the patient's authorization can result in sanctions. These sanctions can include monetary fines to the hospital and personnel actions against the individual disclosing (sharing) the PHI. In extreme instances violations of HIPAA can result in incarceration of the individual responsible for the disclosure.

- Please note that under certain circumstances PHI may be released to others without the individual's permission. Laws and formal regulations specify when PHI can be released without an individual's permission. Examples when this might occur would be if there was a suspicion of Abuse or Neglect, to report certain communicable diseases such as tuberculosis or AIDS, or if there was a Court Order to provide specified health information. **Under no circumstances would you be authorized to report any patient information to these agencies - this is the responsibility of the CMHIFL staff.**

- Remember, if you are not sure about sharing some type of patient information ask CMHIFL staff before you say anything!

In addition to HIPAA requirements, CMHI-FL considers confidentiality of patient information to be a moral, ethical and legal issue of the highest priority. We have an obligation to the patients to maintain their confidentiality and respect their privacy. In the course of performing your student rotation, you may come into contact with patients you might know or information or material, which is highly confidential. It is important that you not share any of this information with your family, friends, acquaintances or co-workers.

Items of importance

- Each patient has the right to privacy and confidentiality.
- Patients have the right to be hospitalized without others knowing about it.
- Confidentiality applies to both voluntary and involuntary patients.
  No information shall be released or shared without the proper authorization to release information.

  The CMHIFL Privacy Liaison can be reached at (303) 866-7876.

I have read and understand the HIPAA guidelines as well as the confidentiality statements listed above. I agree that all patient information received during my clinical rotation will remain confidential. I agree to respect the rights of the patients at Colorado Mental Health Institute and be professional in not sharing any information outside the hospital.

_____ _____

Signature Date

Expectations for Nursing Students Attending TA groups (OT, TR, MT)

1. Always ask the group leader if you can be a part of the group:
   - Ask at least 10 minutes before group starts, to allow for orientation of the student to the purpose of the group, the planned intervention, and any specific directions.
   - Do not assume you can be in the group; the group leader, not the milieu staff or nursing instructor, is the one to give you permission.
   - Plan to remain after the group to briefly post hash the group dynamics with the leader - one value is in sharing and processing information from the leader's discipline's perspective.

2. Do what the group is doing, rather than just observing, charting, talking with each other; you may or may not be asked to share your answers during a group discussion - don't take it personally as the group is not about you or for your benefit but for the clients; if you are asked to share, make sure your input is quality and within the appropriate boundaries of what you should share.

3. Group participation is your opportunity to observe the clients and the leader, to interact with a client (group intervention specific) - take advantage of that in where you sit, who you share supplies with, and so forth.

4. Respect boundaries and group norms; do not have side conversations with the group leader (or clients, other students) - you can ask those questions after the group; be aware of safety considerations, personal space, appropriate topics, and the like.

5. Graciously accept limitations, including "no" re: specific group attendance or only one student participating in the group; take the initiative to ask another time that might be more conducive to your attendance.

6. The clients are our priority; next is one of the TA students participating in or leading a group (e.g., OT student); you may have to take turns attending treatment groups.

7. Pay attention to what is going on; if you get a directive from the group leader, do it, the first time you are told to do so - it might be for your safety and/or the safety of the group; you can process afterwards.

CMHI-Ft Logan Nursing Services Orientation Checklist for Nursing Students

Preceptors: This checklist is designed to provide a basic structure for orientation of nursing students at CMHI-FL. It should offer the student a solid foundation of information. Please remember to review these items as they relate to the role of the nursing student. Please initial each item as orientation is completed. Both student and preceptor should sign the bottom when the checklist is completed.

Name of student _____ School _____

Describe the purpose and location of the following:

____Panic alarms (including how to activate and respond to them)
____Emergency crash cart and contents
____Fire alarms/extinguishers
____Exits on units
____Treatment room
____Institute's policies and procedures, Nursing services manual, reference books, etc.
____Diet Roster

Describe the role of the nursing student during the following events:

____Code red emergency
____Fire evacuation, drills
____Reaching safety officers
____Seclusion/Restraint (including P&P and form #662)
____Acting out patient

Orient the student to the following:

____Philosophy of the hospital
____Program - Levels, status, rules
____Treatment planning (when and where so that students can attend)
____Treatment meetings - When and Where
____Nursing care plan - use and location
____Nursing assessment - use and location
____The what works book
____Patient's rights
____Shift documentation of patient behavior and response to treatment
____Admitting/discharging a patient (if opportunity presents)
____Computers for student use

This form should be completed during your first day on the clinical team. Please keep the completed form with your packet and return to the nursing department.

_____ _____
Student signature Preceptor signature

_____ _____
Date Date

Rev 5/18 MJ

Mental Health Report & Shift Change

Welcome to your mental health clinical rotations. During report, you might hear some abbreviations that are specific to mental health.

Please utilize this to assist you in clarifying the most common abbreviations. If you come across one that is not covered here, please ask the staff to assist you.

AUD	Alcohol Use Disorder
AD	Adjustment Disorder
ADHD	Attention Deficit Disorder
AP	Aggression Precautions
CBT	Cognitive Behavioral Therapy
CIWA	Clinical Institute Withdrawal Assessment (to score Alcohol withdrawal)
COWS	Clinical Opiate Withdrawal Scale (to score Opiate withdrawal)
CP	Chest Pain
DNMS	Developmental Needs Meeting Strategy (Therapy)
DT	Delirium Tremors
ED	Eating Disorder
EMDR	Eye Movement Desensitization and Reprocessing (Therapy)
E-Meds	Medications given under emergency circumstances without a court order
EP	Elopement Precautions
ESTC	Extended Short-Term Certification (after STC, can add additional 90 days)
Fall	Fall Precautions
GAD	Generalized Anxiety Disorder
HI	Homicidal Ideations
I-Meds	Involuntary Medications given with a court order
IOP	Intensive Outpatient Program
LOS	Line-of-sight
LTC	Long Term Certification (up to 180 days)
MDD	Major Depressive Disorder
M1	Mental Health Hold (involuntary hold lasting up to 72 hours)
ODD	Oppositional Defiant Disorder
OUD	Opiate Use Disorder
RTU	Restricted to Unit
SI	Suicidal Ideations
SIB	Self-Injurious Behavior
STC	Short Term Certification (up to 90 days)
SZ	Seizure precautions

Therapeutic Communication Definitions

Review: All communication (verbal, non-verbal) techniques prior to beginning IPR. This will make it easier for you to log the communication and recognize strengths and weaknesses of your communication process.
Communication: Transaction between sender and receiver
Non-verbal: Physical appearance/dress, body movement & posture, touch, facial expressions, eye movements, vocal cues

Therapeutic Communication Techniques

Silence: give time to collect thoughts, consider other concerns
Accepting: conveys attitude of reception and regard
Giving Recognition: acknowledge and indicate awareness (commend strengths)
Offering Self: making oneself available on unconditional basis (increases self-worth)
Broad Openings: allows patient initiative to introduce topic of concern (patient role)
Offer General Leads: offers patient the encouragement to continue
Placing the Event in Time or Sequence: clarifies event in time perspective
Making Observations: verbalizing what is observed or perceived (patient behavior)
Encouraging Perception Description: ask patient to verbalize what perceived hallucination
Encourage Comparison: ask patient to compare similarity and difference-reoccur/change
Restate: repeat main idea of what patient said (patient can clarify or continue on)
Reflect: questions and feelings referred back to patient to recognize/accept own view
Focusing: taking notice of a single idea or word (don't use if patient is anxious)
Exploring: delve further into subject (helpful if patient tends to be superficial in communication)
Seek Clarification/Validation: strive to explain the vague or incomprehensible
Present Reality: when patient has misperception, nurse indicates perception of situation
Voicing Doubt: expressing uncertainty of reality of patient's perception (delusions)
Verbalizing the Implied: put into words what patient has implied or said indirectly
Attempt to Translate Words into Feelings: find clues to feelings expressed indirectly
Formulate Plan of Action: when patient has a plan of action for stressful situation, it may prevent anger or anxiety form escalating into unmanageable level
Active Listening: sit facing patient, open posture, lean forward, eye contact, relax
Feedback: descriptive of behavior, specific rather than general, directed toward what can be changed, impart information not advice, well-timed (early after behavior)

Non-Therapeutic Communication Techniques (Blocks)

- Agreeing/disagreeing
- Belittling Feelings
- Defending
- Giving approval/disapproval
- Giving advice
- Giving reassurance
- Indicating Existence of an External Power
- Interpreting
- Introducing an Unrelated Topic
- Probing
- Rejecting
- Requesting an Explanation
- Stereotype Comments
- Using Denial

MENTAL STATUS EXAMINATION

The mental status examination is a process wherein a clinician systematically examines an individual's mental functioning. Each area of function is considered separately.

Appearance

This category covers the physical aspects of the individuals. Include: Physical appearance, height, and weight, how patient is dressed and groomed, dominant attitude during interview, such as degree of poise or comfort, degree of anxiety, and how anxiety is expressed.

Behavior

How does the patient move and the position in which the patient holds body? Note abnormal tics, movement disorders, and degree of movement.

Speech

Separate speech from content of thought. Note volume, rate, and flow of speech (fast, slow, halting, extremely loud). Include mannerisms, accent, stress or lack of it, hesitations, stuttering. Use descriptive words like garrulous, monotonous, loud, or emotional.

Mood/Affect

Affect is the outward show of emotion. Can vary thru depression, elation, anger, and normality, but if the overall sense from the examination is depressed, depressed is the word to describe the mood. Mood is the general pervasive emotional state as reported by patient. Range describes if the patient shows a full or even expanded range or if the affect is blunted or restricted. Include cultural considerations. Consider appropriateness of affect – is the emotion consistent with the topic being discussed. A patient with inappropriate affect may cry when talking about a parking ticket and show little or no emotion when discussing the death of a loved one.

Thought

Thought is divided into process (the way a patient thinks) and content (what the patient thinks).

Process: The rate of thoughts, how they flow and are connected. A formal thought disorder comprises processes such as pressured thoughts, (excessively rapid), flight of ideas, thought blocking (speech is halted), disconnected thoughts (loosening of association, derailment), tangentiality, circumstantial thoughts (over inclusive and slow to get to the point), word salad (nonsensical responses), punning (talking in riddles), poverty of speech (limited content).

Content: Includes those things discussed in the interview and the patient's beliefs. May have preoccupying thoughts – ideas of reference, obsessions, ruminations, or phobias. The patient may have delusions of control, thought insertion, broadcast, or delusions – persecutory, grandiose, religious, reference, somatic, morbid jealousy. For example, a depressed patient may have delusions of hopelessness, helplessness, or worthlessness.

Perceptions

Covers sensory areas and describes distortions such as illusions, delusions, or hallucinations. Describe the nature of the experience in detail. Auditory hallucinations (hearing voices) are more common in schizophrenics, visual disturbances are more common in organic problems. In addition, there are gustatory, olfactory, tactile, somatic, and kinesthetic hallucinations.

Ask "do you hear voices when no one else is around?" "Do you see things such as ghosts, spirits, or angels?" Ask if the voices are commanding the patient to do anything, particularly homicidal or suicidal acts. Hallucinations can be in the form of a running commentary. If the voices command a patient to do something,

does the patient obey the instructions or ignore them. Sometimes hallucinations are not well-formed voices or objects – patients may hear bells ringing, knocking at the door, banging sounds in his ears, or see vague things like halos or colors which are difficult to describe.

Note how patients cope with the hallucinations and whether they are pleasant, unpleasant, or terrifying. Comment on the hallucinatory behavior, such as patient looking back repeatedly, gesturing, or engaged in self-talk. To determine if the patient is having delusions, ask do you feel you have some special power or abilities? Does the radio or TV give them special messages? Does the patient have thoughts that other people think are strange?

Obsessions and compulsions: Is the patient afraid of dirt/germs? Does patient wash his hands frequently or wash hands repeatedly?

Phobias: Does the patient have any fear, such as animals, heights, snakes, crowds, etc.

Preoccupations: Ask about ideas about the patient's body: Patient may believe he or she is changing or has changed, that his elimination functions, sexual functions, or digestive functions work in different or bizarre ways.

Cognition

Look at areas of abstract thought which declines or is absent in several conditions such as schizophrenia or dementia, level of general education and intelligence, degree of concentration.

Consciousness

Level of conscious state is assessed whether it is steady, fluctuating, cloudy or clear.
Rating: 1=coma 2=stuporous 3=lethargic/evidence of drowsiness 4=alert.

Orientation

Ask if the patient knows the time and date, place, patient (who the patient is), and the situation the patient is in.

Memory

Memory is tested by looking for immediate recall. Give the patient 3 unrelated words (yellow, fox, Chicago) and ask patient to repeat them. In 5 minutes ask the patient to repeat them again. Do not tell the patient that you will ask them to repeat them in 5 minutes. (You might want to write them down, so you remember.)

Recent recall: What did the patient eat two meals ago?

Remote memory: When and where was the patient born? Where did patient go to high school?

Confabulation: Patients may do this if they cannot remember – if this occurs, just note it. You might have to check information with outside sources for verification. You can test for confabulation by asking if the patient has seen you before – the patient who confabulates may fabricate details of a meeting which did not take place.

Concentration and Attention

May be impaired for a variety of reasons: cognitive disorder, anxiety, depression, internal stimuli. Ask the patient to subtract 7 from 100 and keep subtracting 7 from the answer (serial 7s). Average time to complete is 90 seconds. Note the patient's response to the task: irritability, frequent hesitation, or questioning. Four or more errors is considered marginal; 7 or more indicates a poor performance. If the patient cannot begin the task, start at 50 and subtract 3s. If patient is unable to do that, have patient count backward from 10. Patient is not to use paper to complete the task.

Others

Dreams: Are there dreams, how often, how vivid, any repetitive dreams, nightmares? What is the content of dreams?

Déjà vu: Sensation of having been in situations like the present one.

Presence of suicidal/homicidal thoughts. Must inquire about specific plans, suicide notes, impulse control. If positive, will patient contract for safety?

Ask if patient has any thoughts of wanting to hurt anyone, wishing someone were dead? If yes, ask about specific plans.

Intellectual Functioning

General knowledge:

- Who is the President, name 5 last presidents?
- What is happening in the world? (war, economy).
- Name 5 major US cities.
- If you go to McDonalds and buy 2 hamburgers for 70 cents each and pay $2, how much change will you get back?
- Or how much is a quarter, dime, nickel, and penny?

Math calculations:

-Ask basic math problems: 4+6 or 13-8.
-Complex: Add 14+17.

Ability to abstract:

Determine similarities-

- How are an orange and a pear alike? Good answer = fruit, Poor answer = round.
- How are a fly and a tree alike? Good answer = alive, Poor answer = nothing
- How are a train and car alike? Good answer = modes of transportation, Poor answer = both have wheels

Proverbs-

- Ask "what does it mean to say: Don't count your chickens before they are hatched?" Good answer = Do not plan on future gains before they happen. Poor answer = chickens are little.

Judgment and Insight

Evaluate judgment with patient's response to: "What would you do if you were in a crowded theatre and smelled smoke?" "What would you do if you found an addressed, stamped envelope lying in the street?"

Insight: How does the patient perceive his present problem? "How did things come to be this way?

Mental Health Nursing Assessment Definitions

Emotions

Mood

Anxious	Feelings of fear or apprehension; can result from a tension caused by conflicting ideas or motivations.
Depressed	Feeling profound and persistent sadness
Despairing	Feelings of loss of all hope
Elated	Feeling ecstatically happy
Euphoric	Feeling intense excitement or happiness
Fearful	Feeling afraid
Guilty	Feeling culpable or responsible for a specified wrongdoing
Irritable	Feeling easily annoyed or angered
Labile	Feelings characterized by emotions that are easily aroused or freely expressed, and that tend to alter quickly and spontaneously; emotionally unstable.
Sad	Feeling depressed

Affect

Appropriate	When an individual reacts with the proper and expected emotion for the situation.
Blunted	Occurs when an individual's emotions or expressions are less reactive to stimuli than average.
Broad	Also known as full affect, describes the typical affect expected of the average person. An individual exhibiting broad affect shows the emotion that they are feeling.
Congruence with mood	Is the consistency between a person's emotional state with the broader situations and circumstances being experienced by the persons at that time
Flat	Occurs when an individual has a complete lack of expression, feeling, or emotion, regardless of the level of stimuli.
Inappropriate	Display of reactions that do not match the situation that you are in or possibly even your internal state.
Incongruence	Occurs when the individual's reactions or emotional state appear to be in conflict with the situation.

Labile	Occurs when a person's expressions shift unpredictably, frequently, and excessively.
Restricted	Also known as constricted affect, describes a small reduction in affect. An individual experiencing restricted affect may have dulled feelings or emotions but will still be relatively close to broad affect.

Thought Processes

	Form of thought
Able to concentrate	Being able to focus on a single thought or task.
Associative looseness	Characterized by a lack of connection between ideas. Associative looseness often results in vague and confusing speech, in which the individual will frequently jump from one idea to an unrelated one.
Attention span	Ability to attend to a stimulus or object over a period of time. This ability is also known as sustained attention or vigilance.
Circumstantiality	convoluted and non-direct thinking or speech that digresses from the main point of a conversation.
Clang associations:	Is a reflection of disorganized thought processes. Instead of a person's thinking and speech being directed based on meaning, in clang association, a person's thinking and speech is driven by the sound of words.
Concrete thinking:	Is reasoning that's based on what you can see, hear, feel, and experience in the here and now. It's sometimes called literal thinking, because it's reasoning that focuses on physical objects, immediate experiences, and exact interpretations.
Echolalia	Is a psychiatric disorder that makes someone meaninglessly repeat what another person says.
Flight of ideas:	Occurs when someone talks quickly and erratically, jumping rapidly between ideas and thoughts. Flight of ideas is not a medical condition in itself. It is a symptom that may occur as part of mania, psychosis, and some neurodevelopmental conditions.
Mutism	is a severe anxiety disorder where a person is unable to speak in certain social situations
Neologisms	Is the creation of words which only have meaning to the person who uses them.
Perseveration	Is the repetition of a particular response (such as a word, phrase, or gesture) regardless of the absence or cessation of a stimulus
Poverty of Speech	Is when there is reduced spontaneity and productivity of thought as evidenced by speech that is vague or full of simple or meaningless repetitions or stereotyped phrases.
Tangentiality	Is the train of thought of the speaker wanders and shows a lack of focus,

	never returning to the initial topic of the conversation.
Thought Blocking	Is a sudden cessation in the middle of a sentence at which point a patient cannot recover what has been said
Word salad	Are random words or phrases linked together in an often-unintelligible manner.

Content of thought

Compulsions	Are repetitive stereotyped behaviors that the patient feels impelled to perform ritualistically, even though he or she recognizes the irrationality and absurdity of the behaviors. Although no pleasure is derived from performing the act, there is a temporary sense of relief of tension when it is completed. These are usually associated with obsessions.
Control	is a person's ability or perception of their ability to affect themselves, others, their conditions, their environment, or some other circumstance. Control over oneself or others can extend to the regulation of emotions, thoughts, actions, impulses, memory, attention, or experiences.
Delusions	false fixed beliefs that have no rational basis in reality, being deemed unacceptable by the patient's culture
Grandiose	Is a false or unusual belief about one's greatness.
Homicidal Ideas	Is a thought pattern characterized by the desire to kill another person or persons, along with a mental plan for a method of doing it.
Ideas of Influence	The patient may believe that somehow, they caused an unrelated event to happen
Ideas of Reference	are erroneous beliefs that an unrelated event in fact pertains to an individual.
Magical thinking	The belief that one's ideas, thoughts, actions, words, or use of symbols can influence the course of events in the material world.
Nihilistic	Is the belief that all values are baseless and that nothing can be known or communicated.
Obsessions	are repetitive, unwelcome, irrational thoughts that impose themselves on the patient's consciousness over which he or she has no apparent control.
Paranoia/suspiciousness:	Are intense anxious or fearful feelings and thoughts often related to persecution, threat, or conspiracy
Persecutory	Patient believes, erroneously, that another person or group of persons it trying to do harm to the patient.
Phobias	Is an overwhelming and debilitating fear of an object, place, situation, feeling or animal.
Poverty of content:	Is a person talks a lot but does not say anything substantive, or says much more than is necessary to convey a message.

Reference	false beliefs that random or irrelevant occurrences in the world directly relate to a person.
Religiosity	Is when a patient experiences intense religious beliefs or episodes that interfere with normal functioning
Somatic	Is when a person feels extreme, exaggerated anxiety about physical symptoms.
Suicidal Ideas	having thoughts, ideas, or ruminations about the possibility of ending one's own life.

Perceptual Disturbances

Hallucinations

Auditory	Are the sensory perceptions of hearing noises without an external stimulus.
Gustatory	Are tastes that are often strange or unpleasant. Gustatory hallucinations are often metallic taste.
Olfactory	Are false perception of odors, which are usually unpleasant or repulsive, such as poison gas or decaying flesh.
Tactile	Are an abnormal or false sensation of touch or perception of movement on the skin or inside the body
Visual	Is the visual perception in the absence of any external stimulus.

Illusions

Depersonalization	Are a patients' feelings that he or she is not himself, that he or she is strange, or that there is something different about himself that he or she cannot account for
Derealization	Is a patients' feeling that the environment is somehow different or strange, but patient cannot account for these changes.

Sensory and Cognitive Ability

Memory

Capacity for abstract thought	The ability to understand concepts that are real, such as freedom or vulnerability, but which are not directly tied to concrete physical objects and experiences.
Confabulation	Filling in memory lapses by guessing or making up events.

Recent	Is the temporary storage of information that is used in managing cognitive tasks, like learning, reasoning, and comprehension.
Remote	Refers to memory for the distant past, measured on the order of years or even decades.

Interaction Process Recording (IPR) Instructions

The purpose of the Interactive Process Recording (IPR) is to demonstrate the student's skills in understanding and refining therapeutic interactions as part of the nurse-patient relationship if noticed. The analysis of interactions with the patient promotes the student's ability to use the key therapeutic tool, the use of self, to facilitate growth in the nurse-patient relationship. The IPR assists the student to recognize personal feelings, actions, and interactions throughout the orientation, working, and termination phases of the relationship and to identify areas needing improvement.

Dialogue/Analysis

1. Place all verbal statements and nonverbal communications in the appropriate columns. Statements by the student and patient are to be recorded verbatim
2. Student analysis column
   a. Enter the type of therapeutic technique used e.g., Silence, and whether it was Therapeutic (T) or Non-therapeutic (N).
   b. Student rationale – "to allow the patient more time to think about the death of his mother" – and your thoughts about the patient's response. For example: *Patient seemed close to tears and I felt uncomfortable that I may have made the patient cry. I did well not talking – I wanted to say something like I felt sad when my grandmother died, but I didn't – I allowed patient the time patient needed to process his feelings.*
   c. If applicable, write alternative statement(s) and for each (N) response.
3. Patient analysis column
   a. Analysis of patient's thoughts, feelings, and response.
   b. Anxiety level – rate none, mild, moderate, severe, or panic. May also use 0, +1, +2, +3, +4.
   c. Labile defense mechanisms. If none, state none seen.

General Suggestions

1. Be direct in asking the patient to talk with you. Nurse counseling is a legitimate role and nurses should be comfortable with it.
2. Use **who, what**, **where, and when** to follow up patient statements as appropriate.
3. Avoid use of **why and how** statements.
4. Avoid jargon, euphemisms, slang, and figures of speech; may be misunderstood.
5. Do not over-sympathize with the patient about problems
6. When the patient uses psychiatric terms, ask what they mean by them.
7. Avoid close-ended questions.
8. Do not tell the patient how to feel.
9. Do not spend time discussing a patient's diagnosis.
10. Do not give advice.
11. If the patient talks about things patient would not do, ask what patient would do or did.
12. Do not defend the staff or hospital.
13. Do not share information about yourself, students, or staff. Divert the questions by saying "This is your time to talk about you."
14. If your patient is crying or emotional at the end of a session, stay with them. Ask if they are feeling OK and if they have someone to talk to. Do not just leave them.
15. If concerning statements were made by patient, always report what patient told you to staff before leaving the unit.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

 This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times: _____ _____ _____ _____

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

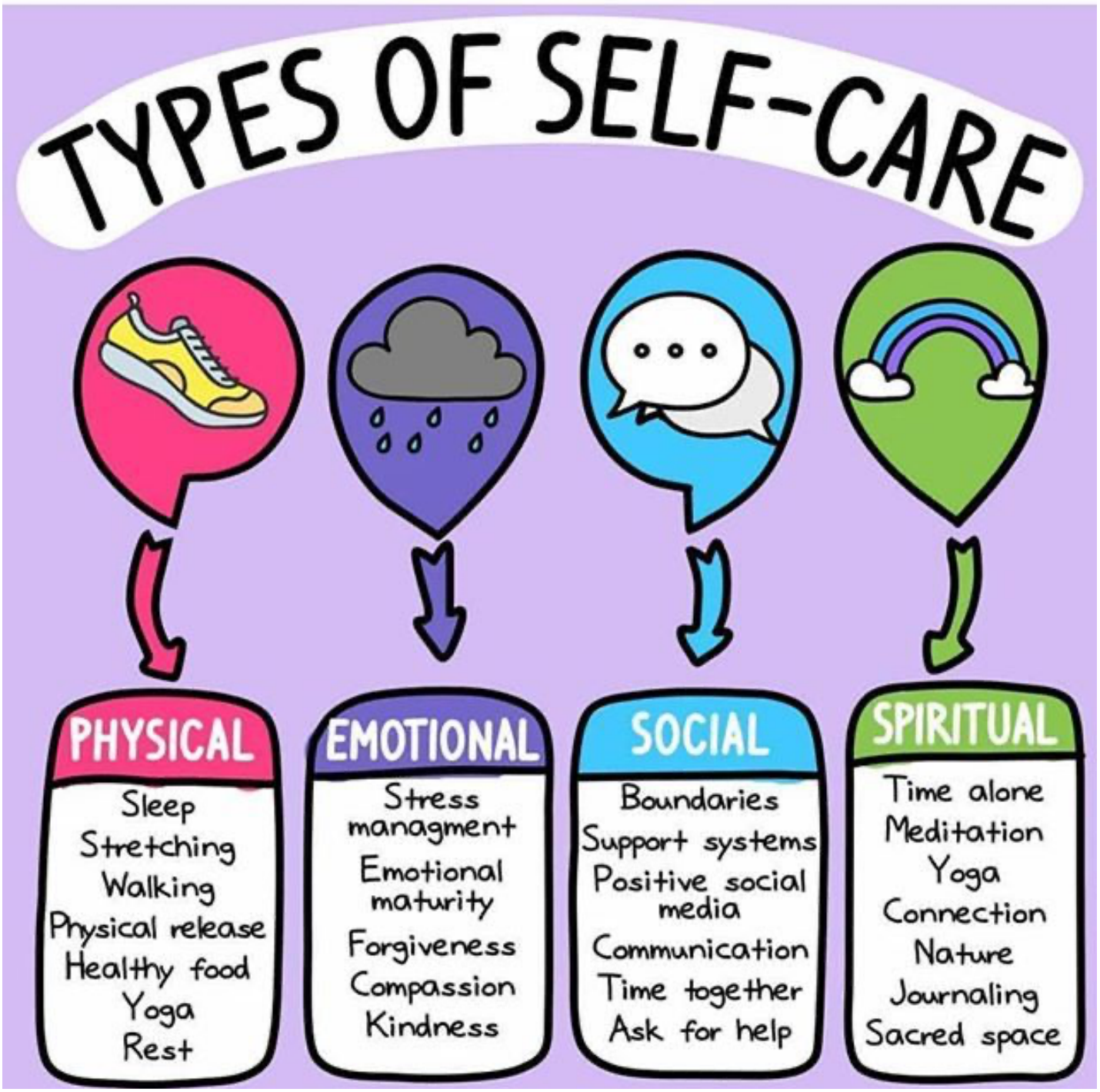
Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

Balancing Act

It is not always easy to keep calm and appear perfectly composed. Emotional conversations and events happen daily: unexpected comments that might derail you, frustrating colleagues, new learning environments, new preceptors, and less-than-welcoming healthcare staff on your assigned units.

Working through these experiences can be challenging. Learning how to pause and gain the clarity you need to respond in ways that reassure you — both in the moment and after it has passed – will support you in working through these experiences. Should you find yourself suddenly in an uncomfortable situation, try one or more of these strategies to regain your calm.

- Take deep breaths.
    - In fight-or-flight mode, your breathing becomes irregular, fast, short, and shallow. Changing your breathing pattern is your first line of defense.
    - Slowing down and deepening your breath will stimulate your vagus nerve and help to push you back into a more relaxed state of mind.
    - Lengthen your exhales and focus on breathing from your belly. Try inhaling for a count of four and exhaling for a count of eight. Deep abdominal breathing slows down your heartbeat, stabilizes your blood pressure, and encourages full oxygen exchange, which is critical to the brain's ability to function.
    - By stimulating the parasympathetic nervous system through this exercise, you can bring your prefrontal cortex back online, enabling you to think and respond sensibly.
- Distract yourself.
    - When you are in the heat of intense emotion, distraction is a helpful way to regulate your negative feelings, as it is less cognitively effortful than other techniques.
    - Distraction is anything you can do to temporarily direct your attention away from your strong emotion.
    - Focus on another sensation in your body, such as your weight pressing into your seat, wiggling each toe individually, or lightly rubbing your fingertips together to see if you can feel the ridges of your fingerprints. You can also try scanning your environment and looking for specific items— perhaps all the red objects in the room — to focus your mind on something else.
- Use your words.
    - Research shows that putting your feelings into words, or emotional labeling, can quickly reduce their grip on you and lessen your physiological distress. When you feel an emotional rush, ask yourself, "What are two or three words that describe how I feel right now?"
    - For example, suppose you are feeling overwhelmed. You might say to yourself, "I feel anxious/frustrated/worried/scared." Neuroimaging studies have shown that the act of thinking in words about your emotional state activates your prefrontal cortex and diminishes the response of your amygdala.
    - The goal of emotional labeling is not to deeply explore and fully process your feelings. It is about quickly pulling yourself away from the ledge.
- Be ready with a script.
    - The above strategies will help you break free from an amygdala hijack and increase the activation of your prefrontal cortex. But there may also be times when you will need to respond immediately and not have a private moment to collect yourself.
        - To prepare for these situations, come up with a couple of go-to lines that will allow you to respond quickly and buy more time. For example, you could say:
            - "That is interesting. Can you tell me how you came to that conclusion/reflection/insight?
            - "Thanks; I would like to think about that more before responding."
    - These lines might help you circumvent the situation's emotional impact and deflect attention away from you in vulnerable moments.
- Process your feelings.
    - Suppressing emotions and pretending not to be upset is a common strategy. Except, it has numerous harmful consequences over time, including adverse health effects, increased negative emotions, fewer close relationships, and lower well-being overall.
    - After the moment has passed, when you have more time to reflect thoughtfully, please process your feelings more fully. Talk to your friends and family, or reach out to your preceptor. Contact a counselor, psychologist, or psychiatrist if you need more assistance. Just be sure to find a healthy way to process your feelings.



Your mental health is just as important as your physical health!
Be sure to take care of yourself.