



Atlantic Technical College

Mental Health Technician

Program Syllabus

2025-2026



Instructor Name: Carolyn Khan MSN, Ed., RN
Instructor Name: Jean Nicholas MSN Ed., RN
Department Name: Health Science
Office/Classroom Location: Bldg. 5, Room 272
Phone Number: 754-321-5158
Email Address: Carolyn.Khan@browardschools.com

Instructor Office Hours:
Monday-Friday: 2:00pm – 3:00pm
Please make an appointment if you want to discuss your test. Within 24 hours of the test.
Makeup Labs: Tuesday-2pm -3pm

*Instructor responses to student inquiries will be provided within 24 hours of regular school operating hours:
Monday – Friday, 7:00am – 3:15pm.*

Student Hours:

Monday – Friday

Class Hours: 7:05 am – 1:50 pm
(Clinical hours may vary according to facility/agency)

Break: 9:05am – 9:20am

Lunch: 11:05am – 11:35am

Note: It is important that students come to school on time and follow school policies regarding attendance, tardiness, makeup work, dress code, conduct, and professionalism. Please refer to the ATC Student Handbook; ATC Code of Conduct & the Mental Health Technician Program Student Handbook.

Program Name: Mental Health Technician

Program Description: The purpose of the program is to prepare students for employment as Mental Health Technicians, Psychiatric Aids or Technicians, and Nursing Assistants. Mental Health Technicians work in a variety of healthcare facilities under the supervision of a psychiatrist, registered nurse, counselor, or social worker and participate in the development and implementation of basic nursing care and therapeutic treatment plans for patients with mental health issues. Students will receive training in physical assessment, psychiatric and substance use disorders, developmental disabilities, health/wellness education, emergency and crisis intervention, and basic nursing assistant skills. Upon successful completion of the program, students will have the opportunity to take the Certified Nursing Assistant (CNA) examination given by the Florida Board of Nursing.

Program Requirements: Attend an ATC Health Science Orientation; Achieve Basic Skills Testing (**Reading 9, Math 9, and Language 9**) or an exemption. Meet with the Program Counselor. For onsite clinical healthcare facilities: Negative Drug Screen; Level 2 Background Clearance, Immunizations, and Health Physical will be required.

OCPs	Course Names	Hours
A	HSC0003 – Basic Healthcare Worker	90
B	HCP0121 – Nurse Aide and Orderly (articulated)	75
C	HCP0810 - Mental Health Technician	315

Program Student Learning Outcomes (PSLOs):

1. Safe, Patient-Centered Care – Deliver safe, patient-centered nursing care by employing evidence-based practices while effectively managing the needs of multiple patients.
2. Caring Behaviors – Foster a compassionate approach in nursing care by integrating caring behaviors when supporting diverse patients, families, and communities.
3. Communication – Utilize effective communication strategies to enhance safety and facilitate informed decision-making in the management of patient care.
4. Clinical Judgment – Apply clinical judgment effectively to ensure high-quality outcomes in the management of patient care.
5. Collaboration – Engage in collaborative relationships to enhance patient outcomes while providing nursing care for diverse patients, families, and communities.
6. Leadership – Demonstrate leadership competencies across various healthcare settings while managing care for diverse patient populations.

Course Student Learning Outcomes (CSLOs):

1. Demonstrate safe, evidence-based nursing care for individuals with psychiatric and mental health conditions, considering their physical, psychological, and social needs.
2. Exhibit compassionate and empathetic care to individuals with psychiatric and mental health conditions, promoting their dignity and well-being.
3. Utilize effective communication techniques to establish therapeutic relationships, facilitate informed decision-making, and advocate for the rights of individuals with psychiatric and mental health conditions.
4. Apply critical thinking and clinical judgment to assess, and plan interventions for individuals with psychiatric and mental health conditions, ensuring optimal outcomes.
5. Collaborate with interdisciplinary healthcare teams to provide comprehensive and coordinated care for individuals with psychiatric and mental health conditions.
6. Develop leadership skills to promote quality improvement, patient safety, and evidence-based practice within psychiatric and mental health settings.

Technical College Policy/Adult Student Attendance:

- A student must be withdrawn after being absent for six (6) consecutive days.
- Two (2) additional absences may be allowed under certain circumstances with appropriate documentation.
- Please refer to the Student Handbook for high school students and postsecondary students. <http://www.atlanticechnicalcollege.edu/atc-student-handbook/>

Magnet High School/Attendance Policy:

A student who has had at least five unexcused absences, or absences for which the reasons are unknown, within a calendar month, or 10 unexcused absences, or absences for which the reasons are unknown, within a 90-calendar-day period, may be exhibiting a pattern of non-attendance according to (F.S. 1003.26 (1) (b)) and the School Board of Broward County, Policy 5.5.

Required Book(s) and/or Online Access: Available for purchase at the ATC Bookstore: • AES Core Curriculum Access Code • BLS For Health Care Providers • <i>Psychiatric Mental Health Nursing</i>, Videbeck, 9th Edition • <i>Nursing Assisting: A Foundation in Caregiving</i>, Hartman 6th Edition, Text and Workbook	Required Materials/Supplies: Purchased from ATC Bookstore- <i>(some items only for health care facilities, check with Instructor)</i> CPR Valve needs to be bought by Friday by 8/15 • Wristwatch with secondhand needs by 8/18 • USB drive by 8/15 • Uniform: ATC logo Caribbean Blue scrub top by 8/18 • ATC logo t-shirt (optional) • Stethoscope (optional) Not Purchased from ATC Bookstore: • Shoes: black or white shoes, sneakers with white or black ankle socks to match shoes • Uniform: Caribbean Blue Cherokee scrub bottom • White nylon long sleeve shirt to wear underneath uniform scrub top (optional) and/or Scrub Jacket (White, or Caribbean Blue) to wear over uniform for cold weather days. (optional)																		
<i>All required books and most materials/supplies can be purchased from the ATC bookstore. Stop by during operational hours for pricing and purchasing information- please check with Instructor first before purchasing.</i>																			
Grading System: <table> <tr><td>A</td><td>90 - 100%</td></tr> <tr><td>B</td><td>80 - 89%</td></tr> <tr><td>C</td><td>70 - 79%</td></tr> <tr><td>D</td><td>60 - 69%</td></tr> <tr><td>F</td><td>0 - 59%</td></tr> <tr><td>I</td><td>Incomplete</td></tr> </table>	A	90 - 100%	B	80 - 89%	C	70 - 79%	D	60 - 69%	F	0 - 59%	I	Incomplete	Virtual Program Specific Grading Information: <table> <tr><td>Course Tests</td><td>90%</td></tr> <tr><td>Quizzes, Class Participation & Professionalism</td><td>10%</td></tr> <tr><td>Clinical (including Simulation & Labs)</td><td>Pass/Fail (S or U)</td></tr> </table> <i>Note: Postsecondary students with disabilities must self-identify, present documentation, request accommodation if needed, and develop a plan with their counselor.</i>	Course Tests	90%	Quizzes, Class Participation & Professionalism	10%	Clinical (including Simulation & Labs)	Pass/Fail (S or U)
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Course Tests	90%																		
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Clinical (including Simulation & Labs)	Pass/Fail (S or U)																		
Online Course Grading Policy: Online students' grades and attendance are based on the following: • Scheduled assignments are due by 7:00am on the day they are due. Late submission of work will affect the assignment grade. • Students assume full responsibility for the content and integrity of submitted work. As the guiding principle of academic integrity, a student's submitted work, examinations, reports, projects, etc. must be their own. Any work from Chat GPT will earn you a zero. • Unless otherwise stated by the instructor, physical or digital references including books, charts, graphs, diagrams, photos, notes or calculators may not be utilized during assessments or exams. Blank scratch paper will be permitted during certain assessments. • Exams may include an oral or lab/skills component, and exams used for determining competency will be delivered in a proctored environment or lockdown browser. Clinical and Written Assignments: Students may be required to submit written assignments. Successful completion of these assignments will be based on earning a pass as outlined in the grading rubrics included in the syllabus. Students who do not pass a written assignment (i.e.: Careplan, Concept Maps and Teaching Plans) will have one opportunity to revise the assignment for resubmission. Students who fail to complete this assignment or who do not earn a pass per the rubric after the allowed repeated attempt will not meet the requirements for this course and will earn a grade of "F" for said assignment. Late Assignment Policy All assignments are expected to be submitted by the due date. Late assignments, without faculty consent, may result in a grade of "0". Late assignments, with faculty consultation and consent, may result in a penalty of 5% per day due on the written assignments. No assignments will be accepted after the official term end date. Initial weekly discussions or reflections will be penalized for lateness according to the rubric and instructions.																			

Makeup Exam/Quiz Policy

Students are expected to take all exams and quizzes as scheduled. A student who will be late for or misses an exam or quiz is expected to notify faculty in advance. The decision to offer a make-up exam or quiz will be at the discretion of the course faculty member in collaboration with the program Administrator. The number of make-up exams or quizzes per term may be limited. The make-up exam or quiz may be different from the originally administered version and standardized reporting for feedback regarding the exam may be unavailable. The program director must approve any change in the scheduling of the last exam administered in the course. **FYI!!!! POP QUIZZES ARE NOT MADE UP.**

View Your Grades:

Grades can be viewed online by following the directions below:

1. Go to Clever SSO Website link: <https://sso.browardschools.com> and login:
 - a. Username: 10-digit student ID number
 - b. Password: PMM/DD/YYYY (or your personally created password after initial login)
2. Click on the FOCUS app on your Clever opening page.
(You may need to scroll down the page to see the FOCUS app.)
3. Enter your FOCUS username and password.
NOTE: If the Focus App. is not visible after logging into Clever, please navigate to the Broward Focus website directly: <https://broward.focusschoolsoftware.com/focus/>.
4. This class is lock-step program meaning you will be promoted to the next section once you are successful with the previous section.

Classroom/Lab Rules: *See Mental Health Technician Handbook*

Industry Certification & State Credential Exam Cost:

- Upon passing the Certified Nursing Assistant licensure exam **and** skills test, students can become a Certified Nursing Assistant- \$155.00 Prometric CNA application
\$97.00 FL DOH CNA Digital Fingerprinting
- Students may also be eligible after graduation from the program and further work experience of 1,000 hours of competency in the fields of mental health or substance abuse to obtain Florida Board Certification as a Behavioral Health Technician-\$100.00.
- COMPLIO Fees are \$105 and must be paid on or before 8/29 to start the process of achieving compliance to go to one of our local clinical facilities.
- Adults students need to register by November 7 if eligible to take Certified Nursing Assistant Tests.

You may qualify for certification reimbursement of your exam cost(s) upon passing. Credential fees are subject to change.

Outstanding Student Recognition Information:

A gold seal will be applied to a Program Completion Certificate or an Applied Technology Diploma if the student has earned a 3.5 GPA or higher in their Career and Technical Education (CTE) classes.

Program Name: Mental Health Technician

Course Number: HSC0003

Course Name: Basic Healthcare Worker

Occupational Completion Point: A

Intended Outcomes: (From FL DOE Curriculum Framework)

Students will be able to:

- Demonstrate knowledge of the healthcare delivery system and health occupations.
- Demonstrate the ability to communicate and use interpersonal skills effectively.
- Demonstrate legal and ethical responsibilities.
- Demonstrate an understanding of and apply wellness and disease concepts.
- Recognize and practice safety and security procedures.
- Recognize and respond to emergency situations.
- Recognize and practice infection control procedures.
- Demonstrate an understanding of information technology applications in healthcare.
- Demonstrate employability skills.
- Demonstrate knowledge of blood borne diseases, including HIV/AIDS
- Apply basic math and science skills.

Course Number: HCP0121

Course Name: Nurse Aide and Orderly (articulated)

Occupational Completion Point: B

Intended Outcomes: (From FL DOE Curriculum Framework)

Student will be able to:

- Use verbal and written communications specific to nurse assisting
- Demonstrate legal and ethical responsibilities specific to nurse assisting
- Perform physical comfort and safety functions specific to nurse assisting
- Provide personal patient care
- Perform patient care procedures
- Apply principles of nutrition
- Provide care for geriatric patients
- Apply the principles of infection control specific to nursing assisting
- Provide biological, psychological, and social support
- Perform supervised organizational functions, following the patient plan of care
- Assist with restorative (rehabilitative) activities

August 11- Class begins

August 15 -Last day to drop

August 18-last day to sign classroom expectations and turn in & Mental Health Handbook Acknowledgement.

August 20-Last day to Register

August 29- Last day of core

Course Number: HCP0810

Course Name: Mental Health Technician

Occupational Completion Point: C

Intended Outcomes: (From FL DOE Curriculum Framework)

Students will be able to:

- Demonstrate and implement knowledge of mental health, mental illness, including substance use/ abuse and addiction.
- Identify the spectrum of interventions and treatment for mental health problems and the types of delivery of care in the stabilization and rehabilitation of the mental health patient.
- Demonstrate an understanding of various mental health disorders, observable signs and symptoms and general interventions to be implemented by the mental health technician.
- Provide therapeutic communication, knowledge of therapeutic relationships, and support for the mental health patient.
- Perform skills and documentation related to caring for and supervising the mental health patient in various types of treatment settings.
- Implement crisis intervention techniques and emergency services, if necessary, in the mental health setting.
- Participate as a member of a multidisciplinary team in the planning and implementation of care and treatment for individual patients.
- Provide patient education and information on the various resources and support groups available for the mentally ill, substance using or addictive client and family members.
- Conduct individual, group and family presentations / discussions to facilitate patient recovery and wellness.
- Perform pharmacological aspects of care as directed (residential and assisted living facility settings).

Blueprint for Exams: CORE From Weeks 1-4 Follow CORE schedule posted in classroom. Weeks 5 & 6 Intensive Lab Skills Follow posted schedule in class

Exam 1/Unit 1 Mental Health		
Weeks	Content / Chapters	# of Items
Week 7	1. Foundations of Psychiatric- Mental Health Nursing -pages 1-14 2. Neurobiologic Theories and Psychopharmacology- pages 15-40 3. Psychosocial Theories and Therapy- pages 41-63 4. Treatment Settings and Therapeutic Programs-Pages 64-78	
Week 8	5. Cultural Implications 6. Legal and Ethical Considerations 7. The Nursing Process and Standards of Care	
Week 9	8. Therapeutic Relationships 9. Therapeutic Communication 10. Stress Responses and Stress Management	
Total		50 Questions
Exam 2/ Unit 2 Mental Health		
Weeks	Content	# Of Items
Week 10	11. Therapeutic Relationships-pages79-95 12. Therapeutic Communication- Pages 96-117 13. Clients Response to Illness- Pages 118-129 14. Assessment-Pages 130-144	

Week 11	15. Anxiety and Obsessive-Compulsive Disorders 16. Trauma, Stressor-Related, and Dissociative Disorders 17. Somatic Symptom Disorders	
Week 12	18. Eating and Feeding Disorders 19. Sleep-Wake Disorders 20. Sexual Dysfunction, Gender Dysphoria, and Paraphilic Disorders	
Total		50 Questions
Exam 3/ Unit 3 Mental Health		
Weeks	Content	# of Items
Week 13	21. Legal and ethical Issues-Pages145-154 22. Grief and Loss -Pages 155-174 23. Anger, Hostility and Aggression-Pages 174-187 24. Abuse and Violence- Pages 188-204	
Week 14	25. Impulse Control Disorders 26. Substance-Related and Addictive Disorders 27. Neurocognitive Disorders Illness and health issues in Older Adults	
Total		50 Questions
Exam 4/ Unit 4 Mental Health		
Weeks	Content	# of Items
Week 15	28. Trauma and Stressor- Related Disorder pages 205-221 29. Anxiety and Anxiety related Disorders Pages 222-240 30. Obsessive-Compulsive and related Disorders-Pages 241-253	
Week 16	31. Schizophrenia pages-254-283 32. Mood Disorders and Suicide- Pages 284—327 33. Personality Disorders and Suicide Pages-328-355	
Week 17	34. Addiction pages-356-381 35. Eating Disorders- Pages 382-402 36. Somatic Symptom Illnesses- Pages-403-419	
Week 18	37. Neurodevelopmental Disorders- Pages 420—436 38. Disruptive Behavior Disorders- Pages 437-450 39. Cognitive Disorders- Pages 451-475	
Total		50 Questions

Weekly Discussions Guidelines:

Participation in weekly discussion forums is mandatory. Each discussion forum includes participation requirements within the instructions. Your responses should be substantive and reflect your thoughts and critical thinking related to the discussion topic. References to reading assignments and other professional resources will help validate your understanding of the discussions.

These discussion forums count as pass/fail for the course. You will need an overall average of 70% on your postings to pass this course. A grade of 0 will be earned for each week a student does not post. Late submissions will not be accepted for grading. Any submissions outside of the assigned unit week will not be counted.

Your course faculty will use the following rubric to grade your weekly discussions and participation.

Weekly Discussions Grading Rubric:

CRITERIA	20% For Each Criteria	15% For Each Criteria	10% For Each Criteria	0% For Each Criteria	Percent Earned/ Comments
Demonstrates Knowledge and Understanding of Content	Expresses opinions and ideas in a clear and concise manner with obvious connection to topic.	Opinions and ideas stated clearly and accurately but lack connection to topic. More substantive content in discussion post needed.	Unclear connection to topic evidenced in minimal expression of opinions or ideas.	Does not express opinions nor ideas clearly; no connection to topic.	
Integration of Assigned Reading Assignment and Professional Resources	Discussions show evidence of knowledge and understanding of reading assignments and applicability of professional resources; including resources that extend the learning such as textbooks, scholarly websites, or other appropriate resources that extend the learning.	Discussions show evidence of knowledge and understanding of reading assignment and applicability to professional resources.	Discussions show little evidence of knowledge and understanding of reading assignment and applicability to professional resources.	Discussions show no evidence of knowledge and understanding of reading assignment and applicability to professional resources.	
Responses to Other Students and Faculty	Postings consistently adhere to guidelines posted by faculty. Student routinely responds to faculty comments and other students in the discussions.	Postings periodically adhere to guidelines posted by faculty. Student periodically responds to faculty comments.	Postings do not adhere to guidelines posted by faculty. Student occasionally responds to faculty comments.	Postings do not adhere to guidelines posted by faculty. Student does not respond to faculty comments.	
Utilizes Professional Language	Postings consistently show appropriate vocabulary and writing style. References consistently cited in APA format.	Postings usually show appropriate vocabulary and writing style. References periodically cited in APA format.	Postings often include inappropriate vocabulary and writing style. APA format not utilized when citing references.	Postings consistently show inappropriate vocabulary and writing style. APA format not utilized when citing references.	

CRITERIA	20% For Each Criteria	15% For Each Criteria	10% For Each Criteria	0% For Each Criteria	Percent Earned/ Comments
Ensures Timeliness of Discussion	Student posted initial response on time and participated in the forum discussions on other days as required in the instructions.	Student posted initial response on time but did not meet all participation requirements for the week as required in the instructions.	Student did not post initial response on time but participated in the forum discussion on other days as required in the instructions.	Student did not participate in discussions as required in the instructions.	
Total percentage	100	75	50	0	
Learner's Total Score					
Learners must achieve 70% to meet the objectives of this assignment.					

Learning Activity

Provide a definition and an example for each of the following defense mechanisms.

Compensation	
Denial	
Regression	
Repression	
Sublimation	
Projection	
Suppression	

STUDENT/COURSE: _____

DEMOGRAPHICS:

Patient's Age: _____

Patient's Gender: _____

Date of this Admission: _____

HT: _____ **in.**

WT: _____ **lb. / kg**

Allergies:

☐ **NKDA**

☐ **Other** _____

Psychosocial and Environmental Problems:

☐ Primary support group:

☐ Educational:

☐ Housing:

☐ Access to health care services:

☐ Social environment:

☐ Occupational:

☐ Economic:

☐ Interaction with the legal system/crime

Mental Health Diagnosis:

Brief Admission History (What led up to your patient needing psychiatric hospitalization?):

Describe any Family History of Psychiatric Issues if available:

Describe any Substance History if available:

Describe any Trauma History if available: (Domestic Violence, sexual or physical abuse, etc.)

STUDENT/COURSE: _____

4. **MENTAL STATUS EXAMINATION (MSE)**

ASSESSMENT OF CLIENT MENTAL STATUS: OBJECTIVE AND SUBJECTIVE DATA
YOUR ASSESSMENT AFTER INTERACTING WITH THE CLIENT

Describe General Appearance: (select all that apply)

Eye Contact:

- ☐ Absent
- ☐ Avoided
- ☐ Intermittent
- ☐ Direct
- ☐ Physical Handicaps

Dress:

- ☐ Conservative
- ☐ Non-conservative
- ☐ Appropriate
- ☐ Inappropriate
- ☐ Other: _____

Build:

- ☐ Thin
- ☐ Medium
- ☐ Heavy
- ☐ Very Obese
- ☐ Other: _____

Posture:

- ☐ Appropriate
- ☐ Happy ☐ Slumped

- ☐ _____
- ☐ Odorous

Gait:

- ☐ Steady
- ☐ Ataxic
- ☐ Hostile ☐ Rigid
- ☐ Mask-like ☐ Sad
- ☐ Rapid

Hygiene:

- ☐ Clean
- ☐ Unkempt
- ☐ Slow
- ☐ Unshaven

Facial Expression:

- ☐ Calm
- ☐ Vacant
- ☐ Neat

- ☐ Worried
- ☐ _____

Activity:

- ☐ Hyperactive
- ☐ Hypoactive
- ☐ Restless
- ☐ Normal
- ☐ _____

Response to examiner:

- ☐ Defensive
- ☐ Trusting
- ☐ Cooperative
- ☐ Indifferent
- ☐ _____

5. Notes Regarding General Appearance:

Describe Behavior, Mood and Affect:

BEHAVIOR: (select all that apply)

☐ Cooperative ☐ Uncooperative ☐ Non-adherent ☐ Compulsions ☐ Posturing
☐ Restless ☐ Agitated ☐ Relaxed ☐ Tearful ☐
Manipulative ☐ Withdrawn ☐ Catatonic ☐ Seductive ☐
Lethargic
☐ Other: _____

MOOD: (select all that apply)

☐ Dysthymic ☐ Happy ☐ Elated ☐ Angry ☐ Calm ☐ Suspicious ☐
Anxious

☐ Ashamed ☐ Frightened ☐ Consistent with thoughts ☐ Inconsistent with
thoughts ☐ Other: _____

AFFECT: (select all that apply)

☐ Flat ☐ Blunted ☐ Labile ☐ Bright ☐ Fearful ☐ Euphoric ☐ Congruent ☐ Limited Range ☐
Full Range ☐ Intense ☐ Other: _____

6. Notes Regarding Behavior, Mood and Affect:

STUDENT/COURSE: _____

7. **Describe Thought Processes and Content:**

SPEECH: (select all that apply)

- | | | |
|---|---|-------------------------------------|
| ☐ Clear | ☐ Rapid | ☐ Pressured |
| ☐ Mute | ☐ Slurred | ☐ Echolalia |
| ☐ Soft | ☐ Barely audible | ☐ Loud |
| ☐ Sarcastic | ☐ Hostile | ☐ Rhyming |
| ☐ Confabulation | ☐ Neologisms | ☐ Word Salad |
| ☐ Clang Associations | | ☐ _____ |

THOUGHT PROCESSES: (select all that apply)

- | | | | | | |
|--|--|---------------------------------|-------------------------------------|-------------------------------------|--------------------------------|
| ☐ Goal Directed | ☐ Slow | ☐ Rapid | ☐ Coherent | ☐ Incoherent | ☐ Loose |
| Associations | ☐ Flight of Ideas | ☐ Normal | ☐ Tangential | ☐ Blocking | ☐ |
| Circumstantial | ☐ Concrete | | | | |
| ☐ Impoverished | | | | | |

THOUGHT CONTENT:

- ☐ Appropriate to Interaction

Delusions: (select all that apply) **Hallucinations:** (select all that apply)

- | | |
|--------------------------------------|------------------------------------|
| ☐ None | ☐ None |
| ☐ Somatic | ☐ Auditory |
| ☐ Grandiose | ☐ Visual |
| ☐ Persecutory | ☐ Tactile |
| ☐ Erotomaniac | ☐ Olfactory |
| ☐ Religious | ☐ Gustatory |
| ☐ Nihilistic | |
| ☐ Control | |

INTELLECT:

- ☐ Above Average ☐ Average ☐ Below Average ☐ Unable to assess ☐
- _____

ALERTNESS:

- ☐ Normal ☐ Hypervigilant ☐ Confused ☐ Drowsy ☐ Stuporous ☐ _____

ORIENTATION:

- ☐ Person ☐ Day ☐ Date ☐ Time ☐ Situation ☐ Place ☐ _____

ATTENTION:

- ☐ Focused ☐ Distractible ☐ Poor ☐ Responsive ☐ _____
- _____

MEMORY:

- ☐ Immediate Impairment ☐ Recent Impairment ☐ Remote Impairment ☐ Intact ☐ _____

INSIGHT:

- ☐ Fair ☐ Knows reason for treatment ☐ Denies Problems ☐ Poor ☐ Resists treatment ☐ Other: _____

JUDGEMENT:

- ☐ Impulsive ☐ Impaired ☐ Good ☐ _____

RELIABILITY:

- ☐ Good ☐ Fair ☐ Poor ☐ Questionable ☐ _____

STUDENT/COURSE: _____

Suicidal Risk Assessment: Ask your client the following questions:

☐ Do you feel that you or your family would be better off if you were dead? ☐

Yes ☐ No ☐ If yes, explain: _____ ☐ Have you ever

had thoughts about killing yourself? ☐ Yes ☐ No

☐ If yes, explain: _____ ☐ Do you have thoughts about
killing yourself, now? ☐ Yes ☐ No

☐ If yes, explain: _____

8. **Notes Regarding Thought Process, Content and Suicidal Ideations:**

PROBLEM - ORIENTED RECORD CHARTING SAMPLE

A charting sample related to one of the patients you have taken care of is included in the clinical packet.

S = Subjective –Client’s verbal reports- I feel nervous

O = Objective Data-Observation – the client is pacing

A = Assessment-Evaluation/interpretation of S and O

P = Plan –Actions to resolve the problem

I = Intervention- Descriptions of actions that are completed (based on treatment team recommendations)

E = Evaluation-Reassessment to determine results and necessity of new plan of action

STUDENT/COURSE: _____

PROBLEM ORIENTED RECORD CHARTING

[illegible]

STUDENT/COURSE: _____

Date: _____

Client Plan of Care with Nursing Interventions and Goal(s)

Instructions: Review the data collected and identify alterations that interfere with the client's healing process or the ability to function at his/her highest level. Prioritize the problems indicating the **most important first**.

Document what you as the nurse/ MHT will do in caring for the patient to help with his/her problem/need. Sample Nursing Diagnoses are listed in the column on the left. Mental Health will complete two (2) full Nursing Diagnoses with Nursing Interventions and Goals. **While only 3 Nursing Interventions are listed, students are expected to list all nursing interventions appropriate to meet the patient goal.*

Impaired
memory
Confusion
(Acute/Chronic)
Altered
sensory
Altered thought process
Impaired
verbal
communication
Safety Risk for
Injury
Grieving,
Complicated
Grieving Risk
for
Complicated
Grieving
Compromised
Family Coping
Disturbed
Sleep Pattern
Post Trauma
Syndrome

Nursing Diagnosis #1:

R/T

As Evidenced by:

Nursing Intervention #1:

Nursing Intervention #2:

Nursing Intervention #3:

Short-term Goal:

Short-Term Goal Evaluation:

Ineffective
Health
Maintenance
Hopelessness
Powerlessness
Risk for Other-
Directed
Violence Risk
for Self-
Directed
Violence
Defensive
Coping
Impaired
Social
Interaction
Risk for
Suicide
Chronic
Low Self-
Esteem
Ineffectiv
e Coping
Self-Care Deficit
(also in neuro)
Interrupted
Family Processes
Disturbed
Personal Identity
Ineffective
Impulse Control
Ineffective
relationship (or
risk for)

_____ **Long-term Goal:**

_____ **Long-Term Goal Evaluation:**

_____ **R/T** _____

_____ **As Evidenced by:**

_____ **Nursing Intervention #1:**

_____ **Nursing Intervention #2:**

_____ **Nursing Intervention #3:**

Impaired
Parenting
Risk for
Self-
Mutilatio
n
Spiritual
Distress
Impaired Verbal
Communication
(also Neuro)
Caregiver Role
Strain (also Neuro)
Ineffective coping
Fear, Anxiety Social
Isolation
Impaired
adjustment Body
image disturbance
Noncompliance
Powerlessness

Short-term Goal:

Short-Term Goal Evaluation:

Long-term Goal:

Long-Term Goal Evaluation:

STUDENT/COURSE: _____

Mental Health Packet Grading Rubric:

Criteria:	<u>Exceeds Expectation</u> Documentation of assessment is accurate and complete for each content area. No errors noted	<u>Satisfactory</u> Documentation of assessment is moderately complete and accurate for content area. Missing only 1-2 critical elements. Minor spelling and/or grammatical issues noted	<u>Needs Improvement</u> Documentation of assessment is partially complete and accurate for content area. Missing 3-4 critical elements. Several spelling and/or grammatical issues noted.	<u>Unsatisfactory</u> Documentation of assessment is incomplete or inaccurate for content area
Demographic Assessment				
Current Psychiatric Medications				
MSE: General Appearance				
MSE: Behavior, Mood & Affect				
MSE: Thought Process & Content				
Suicide Risk Assessment				
Total Score:				Pass / Fail

Problem Oriented Record Charting Grading Rubric:

Criterion	<u>Exceeds Expectation</u>	<u>Satisfactory</u>	<u>Needs Improvement</u>	<u>Unsatisfactory</u>
	Problem oriented record charting is complete and accurate based upon documentation. No spelling and/or grammatical issues noted.	Problem oriented record charting is moderately complete based upon documentation. Missing only 1-2 critical elements. Minor spelling and/or grammatical issues noted.	Problem oriented record charting is partially complete based upon documentation. Missing 3-4 critical elements. Several spelling and/or grammatical issues noted.	Problem oriented record charting is incomplete based upon documentation. Many spelling and/or grammatical issues noted.
Problem oriented record charting will include addressing the following critical elements: Subjective and objective data, assessment and plan information. Interventions will be based on treatment team recommendations and evaluation of the interventions. In addition, Problem Oriented Record Charting needs to include safety and therapeutic communication performed throughout the shift.				
Total Score:				Pass / Fail

STUDENT/COURSE: _____

Date: _____

Client Plan of Care with Nursing Interventions and Goal(s) Grading Rubric:

Criterion	<u>Exceeds Expectation</u>	<u>Satisfactory</u>	<u>Needs Improvement</u>	<u>Unsatisfactory</u>
	Client plans of care with nursing interventions and goal(s) are complete and accurate based upon documentation. No spelling and/or grammar issues noted. All diagnoses are NANDA approved and correlate to patient's data and history. The interventions contribute to the patient/family goal. The interventions are specific to the patient/family. The interventions are appropriate and prioritized, including documentation and references in APA. The goal statement is SMART and patient/family oriented, evaluated and evidence provided.	Client plans of care with nursing interventions and goal(s) are complete and accurate based upon documentation. 1-2 spelling and/or grammar issues noted. All diagnoses are NANDA approved and correlate to patient's data. The interventions contribute to the patient/family goal. The interventions are specific to the patient/family. The interventions are appropriate and prioritized, including documentation and references in APA. There may be one (1) APA issue noted. The goal statement is SMART and patient/family oriented, evaluated and evidence provided. The goal may be missing one (1) SMART element.	Client plans with nursing interventions and goal(s) are incomplete and contain inaccurate subjective and objective data based upon documentation. 3-4 spelling and/or grammar issues noted. Some diagnoses are NANDA approved but do not correlate to patient's data. The interventions do not contribute to the patient/family goal. The interventions are not prioritized or specific to the patient/family. References are not in proper APA or are missing. The goal statement is not SMART or patient/family oriented. Evaluation of goal may not be complete.	Client plans of care with nursing interventions and goal(s) are not based upon documentation. Many spelling and/or grammar issues noted. The nursing diagnoses were not complete. The related to were not complete. The interventions were not complete. The goal was not complete.

The Plan of care with nursing interventions and client goals facilitate the prioritization of care through the proper data collection and analysis; thus, requiring the student to critically think and manage client care.				
Total Score:				Pass / Fail

Final Score:

Psychiatric Assessment Total	Narrative Total	Client Plan of Care Total	FINAL GRADE
Pass / Fail	Pass / Fail	Pass / Fail	PASS / FAIL

**Students must earn a minimum of Satisfactory or greater in each category to pass this assignment.*

Assignment: Mental Health Reflective Journal

Each student is required to complete a mental health reflective journal at the completion of their mental health course as part of their journal entries per quarter. Because mental health is a specialty that requires trauma-informed care and psychological safety for all, please follow these directions when completing this journal entry:

Directions:

1. Write about your experience in the mental health setting during this term. Reflect upon how you felt before you went into the setting, how you transitioned during your clinical experiences, and how you feel now about moving forward in your career as a nurse. How will this opportunity for learning mental health nursing translate into other experiences in the future? Describe how you have grown personally, professionally, spiritually, and academically?
2. Within your writing you must use at least two patient scenarios as examples that support your learning. Remove all identifying information for patient privacy.
3. As you reflect, you must demonstrate your learning in the nursing process, clinical judgment, communication, and diversity.
4. Reflection should be at least 500 words, Times New Roman, 12 pt font, double spaced, and written in APA proper using citations when necessary.

Reflection on the Clinical Experience	Excellent (20)	Satisfactory (15)	Needs improvement (12)	Unsatisfactory (0)	Comments/ score
<i>Student Reflects on their mental health setting experience during this term:</i> • Must include at least two patient scenarios to support learning. • Must remove all identifying patient information.	The student reflection provides an in-depth summary of their experience including a minimum of two clearly stated patient scenarios that support their learning. All patient identifiers are removed to protect patient privacy.	The student reflection provides a summary of their experience including a minimum of two patient scenarios that support their learning. All patient identifiers are removed to protect privacy.	The student reflection provides a summary of their experience; however, it lacks depth or only has 1 patient scenario. All patient identifiers are removed to protect privacy.	The student reflection provides a summary of their experience; however, it lacks depth and has no patient scenarios to support their learning. All patient identifiers are removed to protect privacy. OR The student reflection provides a summary of their experience; however, it lacks depth or only has 1 patient scenario. Patient identifiers we're not all removed to protect privacy.	

Reflection on the Nursing Process	Excellent (20)	Satisfactory (15)	Needs improvement (12)	Unsatisfactory (0)	Comments/ score
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	The nursing process narrative provided an in-depth reflection and examples of how the student incorporated various aspects of nursing process into patient care (nursing process, critical thinking, clinical judgement, policies, and evidence-based practice).	The nursing process narrative provided a reflection with examples of how the student incorporated various aspects of nursing process into patient care (nursing process, critical thinking, clinical judgement, policies, and evidence-based practice).	The nursing process narrative reflection lacks depth and/or contains very few examples of how the student incorporated various aspects of nursing process into patient care (nursing process, critical thinking, clinical judgement, policies, and evidence-based practice).	The nursing process narrative reflection lacks depth and/or contains no examples of how the student incorporated various aspects of nursing process into patient care (nursing process, critical thinking, clinical judgement, policies, and evidence-based practice).	
Reflection on Clinical Judgment	Excellent (20)	Satisfactory (15)	Needs improvement (12)	Unsatisfactory (0)	Comments/ score
	The clinical experience narrative provided an in-depth reflection and examples of the student's clinical experience (including all 6 components of labs, diagnostic tests, medications, assessments, skills/procedures, and areas of practice).	The clinical experience narrative provided a reflection with examples of the student's clinical experience but may be lacking all components.	The clinical experience narrative provided a reflection but lacks depth and/or lacks examples of the student's clinical experience.	The clinical experience narrative provides a reflection but lacks depth and lacks examples of the student's clinical experience.	
Reflection on Communication/Diversity	Excellent (20)	Satisfactory (15)	Needs improvement (12)	Unsatisfactory (0)	Comments/ score
	The communication and diversity narrative provided an in-depth reflection and examples of communication and diversity (included all	The communication and diversity narrative provided a reflection with examples of communication and diversity but may be	The communication and diversity narrative provided a reflection but lacks examples of communication and/or diversity.	The communication and diversity narrative provides a reflection but lacks examples of both communication and diversity.	

	<i>examples</i> of therapeutic communication with the patient and/or family, Interprofessional communication, patient key cultural characteristics, and application of nursing cultural considerations).	lacking all components.			
Reflection on Growth/Professional Role	Excellent (20)	Satisfactory (15)	Needs improvement (12)	Unsatisfactory (0)	Comments/ score
	The personal growth narrative provided an in-depth reflection and examples of personal growth (includes 500-word count, Times New Roman 12 pt font, double spaced, and written in APA professional language with proper citations when needed).	The personal growth narrative provided a reflection and examples of personal growth but lacks 1 of the criteria stated.	The personal growth narrative provided a reflection and examples of personal growth but lacks 1-3 of the criteria stated. OR The personal growth narrative provided a reflection without examples of personal growth and/or lacks 1 of the criteria stated.	The personal growth narrative provided a reflection but lacks examples of personal growth and lacks 4 or more of the criteria stated.	
Total:					_____ / 100

Assignment: Process Recording

A process recording is a tool used by nurses/Mental Health Technicians to help guide in the acquisition of self-reflection skills, and to focus one's thoughts, beliefs and actions/reactions in relation to clinical situations. It documents the client- nurse exchange and allows for identification of what one did well and where improvement may be needed. It gives attention to both the content and the unfolding of the interaction with the client on multiple communication levels.

1. Generally, learners should plan to include a portion of a full interview (a rule of thumb is 20-30 minutes). Plan to record a **minimum of 8 interactions** between interviewer and interviewee. If breaks in conversation occur, indicate this in the Process Recording.
2. Learners should complete this as soon after the actual interview as possible, to assure accurate recall.
3. Be as exact in wording as you can; however, you cannot write things down as you are speaking to the client (write the interaction as if writing a play).
4. Template includes 8 rows for interactions, but please replicate as many rows as needed to record the entirety of the interaction.
5. When doing a process recording, care must be taken to disguise identifying information such as no client name (in accordance with HIPAA regulations) to protect client confidentiality and privacy.
6. Client-Nurse Exchange Planning. Identify the goal for the therapeutic communication interaction, components of Peplau's Interpersonal Relationship Orientation Stage and Erikson Stage per chronological age and developmental stage with characteristics.
7. Within the process recording, include the following:
 - a. Verbatim Documentation of an actual conversation with a client. (Nurse Statements, Client Response, Non-Verbal Actions, Communication Techniques, More Appropriate Response, Student Thoughts and/or Feelings)
 - b. Distinguish between therapeutic and non-therapeutic communication techniques. Identify communication techniques utilized. Identify open-ended/closed ended communication used. List defense mechanisms employed by the client.
 - c. Propose more appropriate responses as needed for non-therapeutic statements/questions or closed-end statements.
8. Submit a Self-Evaluation/Summary along with the process recording answering the following questions:
 - a. What were the main themes of the entire contact?
 - b. Did you effectively use your communication skills?
 - c. What was your impression of the interaction?
 - d. Based upon theory and practice knowledge, what happened in the situation?
 - e. What is/are your role(s)?
 - f. What communication skills did you use?
 - g. Was the stated purpose or goals for the interaction achieved?
 - h. What obstacles were present?
 - i. How effective were you in this interaction?
 - j. What can you do to improve for next time?
 - k. This is the time for "self-reflection."

Process Recording Template:

Name: _____

Date: _____

Client-Nurse Exchange Planning:

Goal for the Therapeutic Communication Interaction: _____

Peplau Interpersonal Relationship Orientation Stage Components: _____

Erikson Stage: Chronological Age Stage: _____

Developmental Stage: _____; Characteristics: _____

Nurse Statements	Client Response	Non-Verbal Actions	Communication Techniques	More Appropriate Response (If Needed)	Student Thoughts and/or Feelings (Process)
Hi, my name is _____ from ATC. I would like to talk to you. Tell me how you are feeling today.	Hi, I'm NH. I am feeling pretty good today. I had a really good therapy session. I might get to go home soon. What would you like to talk about?	I took a seat next to patient at a 90-degree angle. Hands on lap, feet on floor. Client sitting cross legged and hands tucked under arms.	Therapeutic or Non-Therapeutic Open or Closed Communication Technique Examples: Giving Information, Offering Self, Exploring, etc. Defense Mechanism Employed	I might have said _____ I would like to hear more about _____	What are your feelings about the setting/location and timing, the process, content, etc. Tune in to your internal process. I felt _____, because _____. Example: I felt nervous approaching the patient. What if I said something wrong or upset them because I said something wrong. I felt the setting was appropriate, but I think the timing may not have been good.

Self-Evaluation/Summary:

- a. What were the main themes of the entire contact?
- b. Did you effectively use your communication skills?
- c. What was your impression of the interaction?
- d. Based upon theory and practice knowledge, what happened in the situation?
- e. What is/are your role(s)?
- f. What communication skills did you use?
- g. Was the stated purpose or goals for the interaction achieved?
- h. What obstacles were present?
- i. How effective were you in this interaction?
- j. What can you do to improve for next time?
- k. This is the time for “self-reflection.”

Process Recording Grading Rubric:

Criteria	Excellent (10)	Satisfactory (8)	Needs improvement (6)	Non-Performance (0)	Comments/ score
Planned Client-MHT Exchange. Included the goal for the therapeutic communication interaction, components of Peplau's Interpersonal Relationship Orientation Stage and Erikson Stage per chronological age and developmental stage with characteristics.	The client-MHT exchange planning included all 5 components: the goal for the therapeutic communication interaction, components of Peplau's Interpersonal Relationship Orientation Stage and Erikson Stage per chronological age and developmental stage with characteristics.	The client-MHT exchange planning included 4 components: the goal for the therapeutic communication interaction, components of Peplau's Interpersonal Relationship Orientation Stage and Erikson Stage per chronological age and developmental stage with characteristics.	The client-MHT exchange planning included 3 components: the goal for the therapeutic communication interaction, components of Peplau's Interpersonal Relationship Orientation Stage and Erikson Stage per chronological age and developmental stage with characteristics.	The client-MHT exchange planning included 0-2 components: the goal for the therapeutic communication interaction, components of Peplau's Interpersonal Relationship Orientation Stage and Erikson Stage per chronological age and developmental stage with characteristics.	
Criteria	Excellent (15)	Satisfactory (12)	Needs improvement (9)	Non-Performance (0)	Comments/ score
Process recording includes a minimum of 8 interactions between interviewer and interviewee.	Process recording includes a minimum of 8 interactions between interviewer and interviewee.	Process recording includes 6-7 interactions between interviewer and interviewee.	Process recording includes 4-5 interactions between interviewer and interviewee.	Process recording includes 4 or less interactions between interviewer and interviewee.	
Criteria	Excellent (25)	Satisfactory (19)	Needs improvement (15)	Non-Performance (0)	Comments/ score
The process recording consists of verbatim documentation of an actual conversation with a client and includes the following components: MHT Statements, Client Response, Non-Verbal Actions, Communication Techniques, More Appropriate	The process recording included verbatim documentation of an actual conversation with a client and all 6 components of MHT Statements, Client Response, Non-Verbal Actions, Communication Techniques, More Appropriate Response, Student Thoughts	The process recording included verbatim documentation of an actual conversation with a client and 5 components of MHT Statements, Client Response, Non-Verbal Actions, Communication Techniques, More Appropriate Response, Student Thoughts	The process recording included verbatim documentation of an actual conversation with a client and 4 components of MHT Statements, Client Response, Non-Verbal Actions, Communication Techniques, More Appropriate Response, Student Thoughts	The process recording did not include verbatim documentation of an actual conversation with a client or included 0-3 components of MHT Statements, Client Response, Non-Verbal Actions, Communication Techniques, More Appropriate Response, Student Thoughts	

Response, Student Thoughts and/or Feelings).	and/or Feelings.	and/or Feelings.	and/or Feelings.	and/or Feelings.	
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Criteria	Excellent (25)	Satisfactory (19)	Needs improvement (15)	Non-Performance (0)	Comments/ score
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The process recording distinguishes between therapeutic and non-therapeutic communication techniques, identifies communication techniques utilized, identifies open-ended/closed ended communication used, lists defense mechanisms employed by the client and proposes more appropriate responses as needed for non-therapeutic statements/questions or closed ended statements.	The process recording includes all 5 components of distinguishing between therapeutic and non-therapeutic communication techniques, identifying communication techniques utilized, identifying open-ended/closed ended communication used, lists defense mechanisms employed by the client and proposes more appropriate responses as needed for non-therapeutic statements/questions or closed ended statements. employed by the client.	The process recording includes 4 components of distinguishing between therapeutic and non-therapeutic communication techniques, identifying communication techniques utilized, identifying open-ended/closed ended communication used, lists defense mechanisms employed by the client or proposes more appropriate responses as needed for non-therapeutic statements/questions or closed ended statements.	The process recording includes 3 components of distinguishing between therapeutic and non-therapeutic communication techniques, identifying communication techniques utilized, identifying open-ended/closed ended communication used, lists defense mechanisms employed by the client or proposes more appropriate responses as needed for non-therapeutic statements/questions or closed ended statements.	The process recording includes 0-2 components of distinguishing between therapeutic and non-therapeutic communication techniques, identifying communication techniques utilized, identifying open-ended/closed ended communication used, lists defense mechanisms employed by the client or proposes more appropriate responses as needed for non-therapeutic statements/questions or closed ended statements.	
Criteria	Excellent (25)	Satisfactory (19)	Needs improvement (15)	Non-Performance (0)	Comments/ score
Submit a Self-Evaluation/Summary along with the process recording answering the following questions: - What were the main themes of the entire contact? - Did you effectively use your communication skills?	Submitted a Self-Evaluation/Summary along with the process recording answering all 11 of the following questions: - What were the main themes of the entire contact? - Did you effectively use your	Submitted a Self-Evaluation/Summary along with the process recording answering 9-10 of the following questions: - What were the main themes of the entire contact? - Did you effectively use your	Submitted a Self-Evaluation/Summary along with the process recording answering 7-8 of the following questions: - What were the main themes of the entire contact? - Did you effectively use your	Submitted a Self-Evaluation/Summary along with the process recording answering 6 or less of the following questions: - What were the main themes of the entire contact? - Did you effectively use your	

• What was your impression of the interaction? • Based upon theory and practice knowledge, what happened in the situation? • What is/are your role(s)? • What communication skills did you use? • Was the stated purpose or goals for the interaction achieved? • What obstacles were present? • How effective were you in this interaction? • What can you do to improve for next time? • This is the time for "self-reflection."	communication skills? • What was your impression of the interaction? • Based upon theory and practice knowledge, what happened in the situation? • What is/are your role(s)? • What communication skills did you use? • Was the stated purpose or goals for the interaction achieved? • What obstacles were present? • How effective were you in this interaction? • What can you do to improve for next time? • This is the time for "self-reflection."	communication skills? • What was your impression of the interaction? • Based upon theory and practice knowledge, what happened in the situation? • What is/are your role(s)? • What communication skills did you use? • Was the stated purpose or goals for the interaction achieved? • What obstacles were present? • How effective were you in this interaction? • What can you do to improve for next time? • This is the time for "self-reflection."	communication skills? • What was your impression of the interaction? • Based upon theory and practice knowledge, what happened in the situation? • What is/are your role(s)? • What communication skills did you use? • Was the stated purpose or goals for the interaction achieved? • What obstacles were present? • How effective were you in this interaction? • What can you do to improve for next time? • This is the time for "self-reflection."	communication skills? • What was your impression of the interaction? • Based upon theory and practice knowledge, what happened in the situation? • What is/are your role(s)? • What communication skills did you use? • Was the stated purpose or goals for the interaction achieved? • What obstacles were present? • How effective were you in this interaction? • What can you do to improve for next time? • This is the time for "self-reflection."	
Total <i>(74 points is the minimum grade to meet the objectives of this assignment)</i>					

Student signature: _____

Faculty signature: _____

Print Name: _____

Print Name: _____

Date: _____

Date: _____

Self-Evaluation of Communication Skills

Keep this evaluation in mind when you are asked to evaluate your communication in the clinical area in future nursing courses.

1. The interview starts with a self-introduction as a nursing student.
2. The body language and words used foster trust and goodwill.
3. Before questioning starts the patient knows the kinds of information you are interested in, the use of this information and how much of the patient's time you plan to take.
4. Before you start, tell the patient the components of the assessment (interview, limited physical assessment, diet recall).
5. The environment and time selected are conducive to sharing information.
6. The seating arrangements, your posture, eye contact and facial expression show interest but not intrusion.
7. Determine the patient's feelings about being touched before touching the patient; use limited or no touch if appropriate.
8. Most of the questions are open-ended and neutral. Avoid judging the patient, refrain from using words such as "good", "you should", or "I agree".
9. Do not pry, challenge or act defensive. Allow the patient to feel that you are on his/ her side.
10. The sequence of your questions shows logic.
11. You ask only one question at a time.
12. You use restatement to clarify the patient's responses when needed.
13. The pace of the questioning is unhurried and comfortable for the patient.
14. You honor the patient's request to omit a question.
15. You use appropriately placed, brief periods of silence so the patient can gather her/ his thoughts.
16. Responses to patient statements show that you have been listening.
17. You invite your patient to expand on selected statements.
18. You refocus the patient on these topics as needed, limiting wandering to other topics.
19. At the end of each part of the assessment (interview, brief physical assessment, diet recall) you ask for questions.
20. At the end of the discussion, you briefly review the areas covered since the start of the interview, and express satisfaction with the process the two of you have completed.
21. You thank the patient.
22. You express positive hopes for the patient's health and wellbeing.

Please initial each section that you have read completely and understand each section. If you do not understand something written in the syllabus. Please let me know:

Signature of Student: _____ Dates _____

Signature of Parent: _____ Dates _____

Signature of Faculty: _____



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