PSYCHIATRIC NURSING
Skillful, knowledgeable and compassionate in every interaction
Welcome to our 8th edition of the UC San Diego Journal of Nursing! This issue features our Psychiatric units and displays how important the nurses caring role is to this patient population. Did you know that according to the Center for Disease Control and Prevention and the Merck Company Foundation, by the year 2030 approximately 20% of the US population (71 million people) will be over the age of 65 years? The patient population on these units is one that challenges each nurse to be skillful, knowledgeable and compassionate in every interaction with both the patient and the family.

UC San Diego is a NICHE (Nurses Improving Care for Health System Elders) designated hospital that is working to create a more senior friendly patient care and environment. To get a great example of how the psychiatric nurses are going beyond typical methods of treatment be sure to read about our Healing Touch therapy taking place in the units and our Senior Behavioral Health Healing garden which offers a tranquil place for both the patients and families of these units all the staff here at UCSD. This is a perfect example of how nurses can heal through alternative methods and use nature to improve mental, physical, cognitive, behavioral and social health. Another fact you will learn in this journal is that the UCSD Functional Assessment Scale (UFAS) was recently developed as an instrument of measuring the patient’s ability to function with everyday tasks. This assessment scale was created by the Department of Psychiatry team consisting of nurses, psychiatrists and psychologists representing our three psychiatric units (Neuropsychiatry Behavioral Medicine Unit, Senior Behavioral Health and Child and Adolescent Psychiatric Services). I love hearing of this type of innovation from our staff!

Once again, UC San Diego Health System is ranked among the nation’s best in U.S. News & World Report’s 23rd annual “America’s Best Hospitals” issue. UC San Diego Health System has been among the top hospitals in this ranking for 19 years. Also, big congratulations to our physicians and staff for receiving an “A” Hospital Safety Score, the highest level of recognition by The Leapfrog Group, which is a consortium of public and private purchasers of employee health coverage. Thank you for your commitment to patient safety and making this achievement possible.

I hope you enjoyed yourselves at our 2012 Nurses Week events this May as we tried something new with the Gourmet Food Trucks! These events received excellent reviews and it sounds like this will become an annual event! It was such a pleasure to award 162 scholarships to our nursing staff this year along with 56 awards for Nursing Excellence including our new Nurse of the Year Award to Cheryl Kosits. Congratulations are also in order for Christine Geniza who is the unit award winner for NBMU, Rebecca Caruso for CAPS and Sharyn Wilensky for SBH. These nurses are true examples of nurses who embody Jean Watson’s carative factors which address the mind, body and soul of the patient.

Recently, we invited all of our staff members to our first All Staff Event and we explored how each of us makes a valuable contribution that significantly impacts our outcomes. The Clinical Strategic Plan was also discussed so that everyone has a clear understanding of our roadmap for the future. This event was well attended and we hope that you enjoyed the guest speaker, Simon Bailey, as he shared how we can release the brilliance within us to be the absolute best we can be! In these articles you will learn more about the nurses within our psychiatric units and the brilliance they are bringing to the bedside every day.

Sincerely,

Margarita Baggett RN MSN  
CHIEF NURSING OFFICER
On the front cover: Carol O'Donnell, RNC, conducting a memory enhancing activity with the patients on SBH. Inset left, staff from SBH. Inset right, staff from NBMU.
I am proud to share with you this issue of our UC San Diego Nursing Journal highlighting our inpatient psychiatric units’ nurses. There are two acute care psychiatric units: Neuropsychiatry and Behavioral Medicine Unit (NBMU), and Senior Behavioral Health (SBH). On July 1, 2012 the UC San Diego Child & Adolescent Psychiatry Services’ (CAPS) nursing staff became a part of RCHSD. You can read about their continued excellent work in this journal.

The Neuropsychiatry and Behavioral Medicine Unit (NBMU) has been a vital part of UC San Diego Health System for over thirty years. This acute care, 18 bed adult inpatient unit cares for patients with severe psychiatric conditions which cannot be successfully managed in an outpatient setting. Sherri Stolte, RNC, is the dedicated, talented, and empathetic nurse manager of this unit. Her knowledge and understanding of this population during her 15 years managing this unit is readily shared with her physician partners through orienting, coaching and mentoring new staff. Treatment takes place within a multidisciplinary team format with shared responsibility and includes the following: pharmacotherapy, psychotherapeutic and behavioral interventions, electroconvulsive therapy, family therapy, neuropsychological assessments, group therapy, recreational therapy, and health education. Excellent team work contributes to great outcomes. In FY 2012, overall nursing care score on the Press Ganey Patient Satisfaction Survey was rated at the 99th percentile as compared with UHC hospitals and Magnet Hospitals. Additionally only 0.1% of patients required the use of restraints.

The Senior Behavioral Health Unit (SBH) opened in July, 1997. It was my pleasure as the first nurse manager to hire and develop a talented group of nurses capable of working with elderly patients with severe psychiatric issues as well as complex medical problems. It is not uncommon for a patient on this unit to require IV antibiotics, blood transfusions, complex skin care, and other medical interventions. SBH offers a structured treatment program for patients 65 and older. The multidisciplinary team strives to provide each patient a safe, caring and supportive treatment environment which stimulates independent positive living. In 2002, SBH moved to Hillcrest, 7 East. If you visit, you will find our “living room” in the center of the unit where patients and families enjoy listening and singing to live music, engaging in brain-stimulating group activities, and other specially designed activities under therapeutic light levels that promote positive sleep/wake cycles as well as improvement in mood. Under the expert leadership of Debbie Crutchfield, BS, RN, Nurse Manager, SBH nurses have advanced their knowledge of the geriatric patient with over 75% of career RNs and LVNs completing the entire 14 module course on geriatric nursing provided through the NICHE (Nurses Improving Care for Healthsystem Elders) program this past year.

Our patient population is one that challenges each nurse to be knowledgeable, skillful and compassionate in every interaction and to practice according to our Professional Practice Model. Each year when capital requests are made, I know that my department’s list will be short. With both NBMU and SBH’s employees rating their units at Tier I on the recent employee opinion survey, it is clear we have phenomenal staff. No new technology can replace the heart and mind of a caring nurse connecting with the pain and suffering of the psychiatric patient to create a clearer reality.

Sincerely,

Judith Pfeiffer, PhD, RN, PMHCNS-BC, NEA-BC
Nursing Director, Psychiatric Services
Many people have chosen to become nurses, often out of a desire to take care of people. From the beginning of life working in the obstetrics department, to the end of life working in hospice, nursing offers many varied opportunities and settings in which people can care for others. The first nurse theorist, Florence Nightingale, gave nursing its early guidelines and provided an introduction to nursing research in “Notes on Nursing: What It Is and What It Is Not.” According to Nightingale, the main goal of nursing is to affect an improved state of health (Alligood, 2010, 99). Nursing has changed and developed over the years since Florence Nightingale first wrote her book. Leading this change has been Jean Watson. It is interesting to explore how the major concepts of Watson’s “Theory of Human Caring” influence the nurse and patient interaction in the clinical setting. What Watson calls a “caring moment” can be used to analyze her theory’s assumptions as they relate to the patient, health, nursing, and the environment. Watson’s ten “carative factors” can also be demonstrated within the context of a caring moment.

Jean Watson’s concern is that nurses could easily lose themselves in the tasks that they have to complete. Technology has advanced and developed many new machines including monitors that allow nurses to monitor and assess a patient’s condition. The improved technology is important, but the foundation of nursing is in the nurse’s ability to connect with a patient on the human level. Nursing is both an art and a health science. According to Watson, “a person exists as a living, growing gestalt. The person possesses three spheres of being—mind, body, and soul—that are influenced by the concept of self. The mind and the emotions are the starting point, the focal point, and the point of access to the body and soul.” The human connection that nurses make with the patient is the basis of Watson’s Theory of Human Caring.

The major elements of Jean Watson’s theory are (a) the carative factors, (b) the transpersonal caring relationship, and (c) the caring occasion/caring moment (Cara, 2003). The carative factors are a list of guidelines that Jean Watson wrote for nurses to follow when providing care for patients. She used the word “carative” because the factors relate to care rather than using “curative” and relating the factors to the medical concept of a cure. The carative factors address the mind, body, and soul of the patient. In accordance with Watson’s theory, the carative factors include

- a humanistic-altruistic system of value;
- faith-hope;
- sensitivity to self and others;
- a helping-trusting, “human care” relationship;
- expressing positive and negative feelings;
- a creative, problem solving, caring process;
- transpersonal teaching-learning;
- a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment;
- human needs assistance;
- existential-phenomenological-spiritual forces (Watson, 1988b, p. 75).
The transpersonal caring relationship occurs when the relationship between the patient and nurse goes deeper than that of a casual acquaintance. Nurses can either practice as straightforward technicians, or they can choose to operate from a perspective of transpersonal interactionism, in which the nurse is known as the “facilitator of healing” (Clark, 2003). Both the nurse and the patient benefit from the transpersonal relationship. The nurse can seek a deeper spiritual relationship through her ability to promote comfort and healing. The goal of a transpersonal caring relationship is to protect, enhance, and preserve the person’s dignity, humanity, wholeness, and inner harmony (Cara, 2003).

The caring moment occurs when the nurse and the patient come together and share an experience in which they are genuinely in the moment and have a human to human interaction. The caring occasion becomes transpersonal when “it allows for the presence of the spirit of both—then the event of the moment expands the limits of openness and has the ability to expand human capabilities” (Watson, 1999, pp. 116-117). The interaction must be real, meaningful, and both people must benefit from the contact.

**THE CARING MOMENT**

The following carative factors will be highlighted and marked with the abbreviation “CF” and the appropriate number in the succeeding example: a humanistic-altruistic system of value (CF1), transpersonal teaching-learning (CF7), a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment (CF8), human needs assistance (CF9), and existential-phenomenological-spiritual forces (CF10).

George G. is an 82 year old male admitted to the medical unit. He is accompanied by his wife, Sophie. His wife starts to unpack his belongings and he looks about the room. When asked if he wants to have his wife in the room during the assessment, he says “no” and adds that she needs to go home, and that someone is waiting for her downstairs because she does not drive (CF#9). The nurse steps out of the room and tells the patient and his wife that she will be back in ten minutes, giving them a chance to say good bye and providing some privacy (CF#8). The nurse returns and asks George how he wants to be addressed. He says that George is fine. He appears anxious and the nurse inquires about his medical history. This is only the second time that George has been admitted to a hospital. The first time was in 1998 when he had surgery for an abdominal aortic aneurysm. He had complications, and he was in the ICU for two weeks. George was here for a medical evaluation regarding his shortness of breath, tiredness, and lack of appetite. He has had a 15 pound-weight loss in the past month. George has smoked non-filtered Camel cigarettes since he was 12 and had just stopped smoking six months ago because he developed breathing problems. George shares that his wife is very worried and scared. George and Sophie have been married for 62 years, and the only time they have been separated was when he was in the hospital. The nurse and patient share information and the nurse tells George about her grandparents, who are in a very similar situation (CF#1). The nurse reassures George that he can talk with his wife and that she can call the nurse anytime. She gives him the unit and room phone numbers.

George completed his work-up and the physician informs him that he has stage four lung cancer. George shared his concerns with the nurse. He is worried about his wife. She has always taken care of him and the house, while he has done the bills and the driving. He wonders now what his wife is going to do when he dies. The nurse asks George if he and his wife have ever considered what would happen if either of them died. He said no—that he had tried after his last hospitalization but his wife did not want to discuss the subject. George was asked if he wanted to talk to a chaplain or call his own minister (CF#8). He did not want to do that yet. He asked what would happen next. George was asked if he had ever completed an advance directive. He had not and had not thought about it. He asked the nurse to help him complete the form. His main wish was not to be in pain, but he did not want any procedures done such as feeding tube. George had difficulty discussing his concerns about dying, but he could share with the nurse his desire to maintain his dignity and hoped that he would go quietly in the night (CF#10). The nurse educated George about hospice and he agreed to have the hospice nurse come out to his home, especially because hospice would also help his wife (CF#7). George died quietly at home within four months of his hospitalization.

**THE CARING MOMENT APPLIED**

In the scenario, CF1 demonstrates the nurse establishing a relationship with the patient by finding more information on a more intimate level and using this information and shares similar information with the patient. She shows a desire to participate.
and listen to his personal story. CF7 involves the nurse teaching the patient information in a manner that shows understanding of his experiences, self-care needs and his limitations. The nurse uses his concerns and helps set goals for his care and that of his wife during his final stages of life. CF8 requires the nurse to provide a supportive, protective, and spiritual environment. In this case she has offered privacy for the patient and his wife and in a later aspect has also made available the ability to talk with a minister of the patient’s choosing. CF9 encompasses the nurse’s ability to note who is a support to the patient and what level she will be able to assist him in meeting his needs. This carative factor also involves identifying the appropriate modalities that the patient will require. Additionally, the patient discussed his fears and concerns about the future. In CF10, the nurse is allowing the patient to make decisions and express his wishes about his impending death.

Jean Watson’s definition of personhood states that people have needs on all levels including biophysical, psychophysical, psychosocial, and interpersonal. A person needs to be cared for, valued, and respected. In the caring moment presented, the patient’s diagnosis was terminal cancer. The nurse educated the patient about hospice, which would help him to function to the best of his ability and at the same time work to keep him free of pain and die with dignity. In this way she addressed the main concerns identified by the patient.

Watson’s description of health is the ability to function to full capacity. She takes a holistic approach to health. Hospice provides a multidisciplinary approach to end of life issues. In this example, the nurse was supportive and caring in educating the patient regarding how he could best deal with his pending death.

Environment is essential to maintaining a person’s health and per Watson’s theory must be a part of a holistic approach to health. A hospital room is usually not the most conducive place for healing. In this scenario, the patient returned home to be with his wife. The home was the best environment for this patient to meet his needs.

Nursing is the cornerstone of Jean Watson’s caring theory; the nurse provides the professional and caring interactions required for both a preventative and healing holistic approach to health care. In this example, the nurse took time to talk with the patient and obtain his history—both medical and personal. She learned what was important to the patient, and she shared some of her own feelings. To “humanistically” care requires the presence and use of the nurse “self” and the sharing of the self with another (Chipman, 1991, 175).

My personal reflection on this caring moment is that it was somewhat difficult as the situation was very similar to that of my grandfathers who had also died of lung cancer and my grandparents had been married for 61 years. Though it was difficult, I was also more open and understanding of my patient's biophysical, psychophysical, psychosocial, and interpersonal needs. I believed that we made a human connection. This experience had a wonderful impact on me because I came away thinking that I had “given of myself” and that the patient had a better outcome as a result. He did not physically benefit as I could not change the diagnosis, but emotionally he could express his thoughts and feelings and was receptive to my interventions. I received a very nice letter from his wife after George G. died, thanking me for caring. Looking back, I do wish I could have spent more time with the patient. Time is a commodity of which nurses do not have enough. While we are constantly triaging our various patients’ needs, each patient is prioritizing his or her needs as the most important.

In conclusion, our health care system is placing less emphasis on the human aspect of health care, which is caring. As nurses, we must take a stand and ensure that caring is an ideology that continues as a core value in our profession.

REFERENCES:
Functioning, defined as the ability to engage successfully in everyday activities such as feeding oneself, maintaining hygiene, and engaging in social interactions, is severely impacted in individuals who have serious mental illness and/or dementia. The measurement of everyday functional ability is arguably as important, or perhaps even more important, than the measurement of psychiatric symptoms when assessing the “real-world” impact of psychiatric illness and cognitive disorders.

The measurement of functioning has faced some methodological and practical problems. Self-report measures such as the SF-36 are problematic as psychiatric patients, and indeed the population in general, tends to be inaccurate in self-assessment of their own behaviors and capabilities. One commonly-used, rapidly-generated index of functioning, the Global Assessment of Functioning, is based on clinician observations and minimizes the bias of self-report. However, this index is a very broad measure with a single score that may not be particularly informative about specific domains of function. Thus Psychiatry services have traditionally struggled with selecting appropriate indices of real-world functioning and outcomes. At the same time, there has been a recent national emphasis on identifying relevant indicators of psychiatric treatment outcome.

In response to this need, the UCSD Department of Psychiatry developed a novel instrument of measurement, the UCSD Functional Assessment Scale (UFAS). The vision of our department was to design a measure that was brief, user-friendly, and could provide clinicians with information about the day-to-day changes in our patients’ abilities to complete important everyday tasks. The UFAS was conceived by a multidisciplinary team of nurses, psychiatrists, and psychologists representing the three inpatient psychiatric units: the Neuropsychiatry and Behavioral Medicine Unit (NBMU), Senior Behavioral Health (SBH), and Child and Adolescent Psychiatric Services (CAPS). The scale captures functioning in seven domains: Communication Skills, Eating Behavior, Grooming, Social Programming, Comfort in Social Relationships, Coping Strategies, and Use of Medication.

The implementation of the UFAS was timed to coincide with the launch of the EPIC electronic medical record system in the spring of 2011. Nursing staff complete the instrument electronically, twice a day, on every patient on the three psychiatric units. The scores are also automatically represented throughout the course of the patient’s hospital stay (see Figure 1). The scores are also automatically.
inserted into the physician’s daily progress note. Monthly and quarterly statistical analyses of UFAS admission and discharge scores are also conducted to help NBMU, SBH, and CAPS track unit-based trends in patient outcomes.

The validation of this new measure is a work in progress. In order to ensure that nurses are scoring the UFAS in the same way, each unit has conducted interrater reliability studies in which two nurses rate the same patient during the same shift. Their scores are then compared in order to define their degree of agreement. These studies, as well as regular UFAS-focused conferences with the nursing staff on the three units, have been invaluable in further refining the instrument so that it is relevant and useful across the patient population in psychiatry. For example, nurses on the Senior Behavioral Health Unit pointed out that the wording of the “Eating Behavior” item should be revised to account for patients who are NPO for a procedure such as electroconvulsive therapy.

The UFAS is a completely unique approach to assessing treatment response in a clinical setting. Psychiatry’s multidisciplinary and collaborative approach to developing and implementing this novel measure can serve as a model for other services who are interested in tracking patient outcomes.

Figure 1: UCSD Functional Assessment Scale Screen Shot
Registered Nurses in the mental health field often have to balance their duty to patient autonomy (respecting a patient’s choices) with ethical principles like beneficence (the duty to do good) and non-maleficence (doing no harm). Therefore, it is important to identify the ethical issues in mental health nursing related to the puzzle between paternalism and autonomy and to discuss the patient’s risk of falling and its prevention as a measure of safety versus a violation of the patient’s autonomy.

Working as a nurse in Senior Behavior Health, I have come to realize that accidental falls and their consequences are not only the biggest cause of apprehension in our unit, but they are also a significant subject for detailed analysis in the inpatient and outpatient hospital setting. The reasons for such consideration of falling are fall-related injuries and fall-related deaths. According to National Vital Statistic Reports, unintentional injuries were the 5th leading cause of death in the United States in 2010 (Sherry et al., 2012).

Extrinsic risk factors for falling and fall-related injuries related to the physical environment include environmental hazards, inadequate walking aids and assistive devices, footwear and clothing, and the use of medications. “There is a significant increased risk of falling with the use of medications such as psychotropic, class 1a anti-arrhythmic medications, digoxin, diuretics, and sedatives... Risk is increased significantly if a person is on more than four medications” (Skelton, 2004). Medications can be associated with extrinsic and intrinsic aspects. Intrinsic risk factors, such as reduced vision, unsteady gait, impaired cognition, previous falls, nutritional deficiency, and chronic illnesses are integral to the patient’s system, and are often associated with age-related changes.

Because of all the physical and cognitive changes associated with aging, the incidence of falls also increases with age. A study by O’Loughlin and his peers states that “thirty percent of people over 65 and 50% of those over 80 fall each year” (1993). According to statistical data provided by the Center of Disease Control and Prevention, “in the next 17 seconds, an older adult will be treated in a hospital emergency department for injuries related to a fall.” Additionally, they say that “in the next 30 minutes, an older adult will die from injuries sustained in a fall” (CDC, 2005). As age progresses, not only physical, but also cognitive impairment can increase.

According to statistical data, cognitive deficiency is the next leading factor for a high fall risk in the elderly. “Cognitively impaired patients were more likely to be fallers or recurrent fallers and more likely to sustain an injury than cognitively intact patients” (Vassallo et al, 2009).

According to Todd Skelton, “cognitive deficit is clearly associated with increased risk, even at a relatively modest level (short of florid dementia).” Immediate memory,” he continues, “has been demonstrated to be an independent risk factor for falls in those over 75 as part of the Longitudinal Aging Study Amsterdam. Skelton also mentions that “nursing home residents with diagnosed dementia fall twice as often as those with normal cognition” (Skelton, 2004). Because the risk for falling doubles in geriatric patients with cognitive impairments, mental health nurses have the most difficulty debating and implementing ethical principles while trying to respect patients’ choices and recognizing their own obligation to protect the patient.

The following is one hypothetical situation that can help to illustrate the challenge facing the staff nurse in the Senior Behavior Health Unit in trying to make a proper decision.

**Patient is high fall risk:** 85 years old, diagnosed with Dementia, has medical history of CHF, HTN, Osteoarthritis and history of multiple falls. Patient’s prescription includes antidepressant, psychotropic and blood pressure medications. Patient is confused, oriented by name only, and impulsive with frequent episodes of angry outbursts. Patient is getting up in the middle of the night, confused, unsteady, and
walking toward the bathroom.

**Nurse:** Let me help you.

**Patient:** No.

**Nurse:** You are not very steady right now, you can fall.

**Patient:** Get out of here.

**Nurse:** Please, let me help you.

**Patient (screaming):** Get out of here! The bathroom door is slammed right in the nurse's face.

What step should the nurse take next? Should the nurse remain by the bathroom door and respect the patient's privacy, or should she/he take the initiative by walking into the bathroom to assist the patient, in spite of the patient's refusal of such assistance? Such a choice between respecting the patient's autonomy and the patient's safety is a hard decision to make. If the patient should sustain an injury, will the respect for autonomy be interpreted as negligence? Or else, can the safety precautions be interpreted as overprotection (otherwise known as paternalism)?

According to Roberts, autonomy is the "right or condition of self-government" (Roberts, 2004). Paternalism can be defined as "the policy or practice on the part of people in positions of authority of restricting the freedom and responsibilities of those subordinate to or otherwise dependent on them" (Roberts, 2004, and Pearsall, 1998).

The "autonomy versus paternalism" dilemma has defenders on each side. The advocates of A. Fisher's theory (Chiovitty, 2011) support self-government and the patient's right "to manage their own behaviors and their simultaneous responsibility for maintaining unit safety." This "Patient Has the Right to Fall" doctrine is one of the hot topics for discussion on the nurses' Internet forums, and one of these postings has been reproduced below.

"I had a guy one night in the CICU who was on a GII/IIIB inhibitor (like Integrilin) and WOULD NOT stay in bed as instructed. He was told that if he fell and hit his head he could die from bleeding into his brain. Didn't help--he kept getting OOB without help. He was A&O, just stubborn. Every time I found him OOB I documented it, put him back to bed, made sure he had his call light and urinal. The night nurse was told to watch him. She also documented his being OOB without help. Then it happened--he got up and fell, hit his head and bled into his brain. Died that night. Our supervisor wanted to know why we hadn't restrained him. That's because restraining a patient against their will is ILLEGAL! Yes, they have a right to fall--just make sure you document each and every time they put themselves at risk" (JustMe "Having the Right to Fall, 2008, pg.6)."
Senior Behavioral Health Healing Garden: The Use of Therapeutic Horticulture

By Debbie Crutchfield, BS, RN

The Senior Behavioral Health Program (SBH) is a unique program specifically for seniors with mental health issues. The program is located on the seventh floor of UCSD Medical Center, Hillcrest. This unit has many features that are specifically designed to meet the needs of the senior population. One such feature is special lighting that is much brighter than you will find on any other unit, which helps with maintaining the circadian rhythm of the patients. Another special feature of the unit is the outdoor garden area which is found to the right of the main Hillcrest hospital entrance.

The outdoor garden area contains planters of different heights, providing patients in wheel chairs or using walkers easy access to planting herbs, flowers, vegetables, or fruits. If you look closely, you may notice that many of the planters are recycled ash trays put to good use after UCSD became a non-smoking facility. Gardening promotes socialization and can be a stimulus to reminisce about past experiences. The SBH occupational therapist and staff provide opportunities for gardening groups twice a week. The garden is an area in which family members can bring beloved pets to visit. The garden can help distract patients from sadness, loneliness, and medical or cognitive decline as they water, weed, and plant. Patients enjoy bringing some of the flowers up to the unit for other patients who may not have been able to go to the garden or to decorate the dining room. The dementia patients benefit from the healing garden, as it provides generationally and developmentally appropriate activities that support the dignity and social history of the age group. The gardening activities also positively engage the seniors—resulting in higher engagement rates than those found in many other activities (Gigliotti & Jarrott, 2005).

California Title 22 requires that a geriatric psychiatric program have a designated outdoor area. The SBH frequently utilizes the garden area for groups and special activities for the patients such as “Spring Fling” or “Go Green.” However, this area has many other uses. Daily, UCSD staff use the area for lunch or for some quiet time in order to rejuvenate before going back to providing high quality care to the patients. Patients, families, and visitors utilize the area to momentarily step out of the realm and the hustle and bustle of the inpatient units. Recently, there was a pediatric patient who had been confined to the unit for a few months who was now able to come out and enjoy the garden. The pediatric patient and the seniors were able to interact, bringing laughter and smiles to all.

The American Horticultural Therapy Association (AHTA) provides a definition and differentiation between four types of horticulture programs: horticultural therapy (HT), therapeutic horticulture, social horticulture, and vocational horticulture. Horticultural therapy facilitation done by a trained therapist who documents individual treatment goals and the session must be based on the overall treatment plan. Conversely, in a therapeutic horticulture program there are no specified individual goals, and the program is led by a trained leader (who can be a nurse). The goal of this type of program is to improve an individual’s well-being. Social horticulture is different because it is focused on leisure activities and does not require a trained leader or therapist. Vocational horticulture, which is not applicable to the SBH program, simply involves training individuals to work in the horticultural industry (Messer & Diehl, 2010).

Psychiatry uses HT more than any of the other medical disciplines. It is one of many treatment modalities available for the treatment of mental health issues. HT is also used for people with physical disabilities, the developmentally disabled, and the elderly. HT groups aim to challenge cognition, activity tolerance, balance, safety, integration of adaptive techniques, and to promote a social supportive environment (Payne & Sonkin, 2010). HT activities are used as treatment modalities for people with depression and dementia—with positive results for both groups of
The benefits from intermingling with nature include improvement in mental, physical, cognitive, behavioral, and social health resulting in restoring an individual’s mind, body, and spiritual well-being (Kim, 2003). Therefore, HT is a wonderful way to boost one’s spirits.

The SBH Healing Garden is an asset to UCSD and all of its visitors. For many it is a hidden secret, as they are not aware of its existence, and for others it is a small oasis in which spending a few minutes can help renew their spirit. For the seniors, it is a place to look forward to visit in order to enjoy the weather, to water the plants, pull weeds, plant, rest, or eat a fresh grown strawberry.

If you have not had the opportunity to visit the Senior Behavioral Health Garden, we invite you to take a moment to take in the beauty of the plants and flowers, and smell the herbs.

Gardening is about enjoying the smell of things growing in the soil, getting dirty without feeling guilty and generally taking the time to soak up a little peace and serenity. Lindley Karstens, noproblemgarden.com.

REFERENCES:
I first experienced Healing Touch because of the suggestion made by my Director of Nursing, Judith Pfeiffer. She sent an email out to the staff a couple of years ago letting us know about healing touch. She was trying to get the staff interested!

Actually, no one was more surprised than me when I found myself signed up and walking into “Level I Healing Touch” taught by Mary Jane Aswegan, RN, CHTP/I, from Scripps. You see, I didn’t believe that I’d really go through with it. However, I’ve always been interested in alternative modalities. In high school, I paid my $100 to be indoctrinated into the world of Transcendental Meditation, or TM, as it was called. I took TM very seriously and practiced it through college (especially during my last two years, when I was in nursing school). It came in quite handy when the stress of school became too great.

But, let’s get back to Healing Touch. For two days from 8:00 a.m. to 6:00 p.m., our class of 14 was immersed in the world of biofield energy therapy. At first I was skeptical. As both an observer and a participant, I found it difficult to believe that Healing Touch could “do” anything for my patients. By the end of the second day, I was as prepared as one can be as a new provider to offer another mode of comfort for my patients. It was 9:00 p.m., and the patient in Room 720 was extremely anxious, constantly calling for help, and actually begging staff to do something to relieve his anxiety and muscle twitching which was preventing him from sleeping. He had been previously medicated with an anxiolytic, but it clearly wasn’t helping. I asked the staff for their cooperation and not enter his room.

I asked my patient for permission to perform Healing Touch after explaining what it was and how it could help. He agreed. The lights were dimmed, and after assisting the patient into the most comfortable position possible, I asked him to try to close his eyes. I did not pressure him, I just made gentle suggestions. I began by “setting my intention—which is where the provider centers herself by bringing the body, mind, and emotions to a quiet, focused state of mind. Slowly I began what I could remember of the steps of clearing the negative energy away from his body. I heard Mary Jane saying “it’s not important whether you do all the steps perfectly...just do what you remember.”

After 45 minutes of performing the steps to re-balance what was clearly, in the terms of Healing Touch, an energy disturbance, my patient fell asleep. His muscle twitching had stopped. He began to settle into the rhythmic passes of my hands after 20-25 minutes with his eyes closed. I continued until I could see his breathing had quieted; he was peacefully sleeping, free of anxiety and muscle twitching. We had agreed that if he fell asleep I would not be letting him know I was finished, instead I would gently “ground” him, and let him sleep without disturbing him. (Grounding helps the patient to reestablish a connection with himself, and in this case it was done by placing my hands on both of his feet and barely giving them a squeeze to signify the end of the energy work I had done.)

I was so excited that I could help someone in this way! I could hardly contain myself in report to night shift when I explained what had happened. The second time I provided Healing Touch, it went exactly as the first. An extremely shaky, anxious woman was sleeping peacefully after 30 minutes of Healing Touch. The next day she told everyone what I had done for her. She was so appreciative and thankful. The results of both these patients brought tears to my eyes. It was a very moving experience, and I felt fortunate to be a nurse. Through this experience I have decided to pursue Healing Touch and continue on to Level 2. I have become involved in the committee for holistic and integrative nursing at UCSD. It is just in the planning stage, but there are so many exciting opportunities ahead to provide alternative modalities.
of care. I look forward to being a part of this dynamic nursing committee!

I'm glad I listened to my parents and became a candy striper when I was a young girl. I'm also glad I had a father who insisted that not only his son would go to college and become financially independent, but that his daughters would be successful as well. When I became a nurse I wanted to go to the college that would allow me to live away from home. It also happened to have a BSN program. I knew it meant studying hard the first two years in order to be accepted into the nursing program, but I decided to jump in and give it my all. The last semester was particularly grueling, and I felt like I would not make it through. I called my father and told him I was planning on driving the 8 hours home, and that I was going to give up because it had become too difficult and I was under way too much pressure. I was told quite simply that coming home was not an option, and that the door would be locked. My father said “you will be financially able to support yourself, and in your life you never know what will happen, so you must finish—become a nurse, it is what you must do.” I was 21 when that happened, and my father died two years later. He was only 58, so his diagnosis of “sudden heart death” was sudden indeed. Every day that goes by since he died I feel I honor his memory by being a nurse, and I hear his voice through the care and love I give to my patients.

I'm so proud to be a nurse working in Senior Behavioral Health, and my patients are very special to me. I love you Dad... and thank you.

Another Path to HEALING TOUCH

By Carol O'Donnell, RN, BC

I became an RN after “trying on” several other careers first and not finding the correct fit. When I was in high school, I was focused on becoming a commercial artist. I was talented, loved to draw people, and loved fashion and the creative freedom I thought it would provide me. So I enrolled in college in NYC and subsequently received a degree in Fashion Illustration and Advertising Design. When I joined the work force however, I found that the occupation wasn’t as fulfilling as I had imagined. My options were to either free-lance to maintain my own style and creativity (but without the security of a stable job with benefits) or, as I ended up choosing, to work in an art studio under a designer who directed what I drew and painted (hence stifling my style and creativity, but providing me with job security).

After several years I realized that living in NYC wasn’t all that I had dreamt it would be, so I moved back upstate and took several college courses until I obtained a job working as an engineering technician in a semiconductor manufacturing plant. That occupation provided me with a stable income and good benefits but wasn’t emotionally rewarding. I worked in an isolated clean-room lab environment interacting more with machines and silicon wafers than with human beings. Yet I kept that job for almost a decade.

When I was 39 years old, a colleague of mine went back to school to become a RN. I noticed the enthusiasm and pride that she took in her studies and I decided that I wanted that for myself as well. By this time, I was more mature and had been asking myself “what do I really want to do when I grow up?” Nursing seemed to be the answer. When I was fresh out of high school, I never could have imagined myself working in a profession that dealt with illness, injury and bodily fluids. But now that I was the mother of a young child, I told myself confidently “I can do that!” and immediately enrolled in nursing school. Since that day, I have never looked back and am so grateful for a career that I can take pride in, that enables me to work with a wide variety of people (both patients and colleagues), that allows me to help people and touch so many lives in a positive manner. It’s the best decision that I’ve ever made!

Carol Behrends O’Donnell, RN, BC has been a full-time career RN at UCSD on the Senior Behavioral Health Unit since June, 2001. Carol has been SBH’s “Nurse of the Year” and has been an active member of UCSD’s hospital-wide Nursing Education & Competency Committee for the past nine years, which she chaired in 2011. She has also been a member of the Magnet Champion’s Council and the Clinical Informatics Committee, the latter being an offshoot from her involvement with the EPIC Multidisciplinary Clinical Design Team. In 2009, Carol received acknowledgment from the Frontline Nursing Leadership Academy, in 2010 she received her Board Certification from the ANCC as a Psychiatric & Mental Health Nurse Specialist and in 2012 she completed a NICHE training module specifically for general geriatric care.
Greetings from AFGHANISTAN

By Douglas (Shane) Coudding, MSN, RNC
Intro by Debbie Crutchfield, Nurse Manager, Senior Behavioral Health

Shane Coudding is a registered nurse who works per diem in the UCSD Senior Behavioral Health (SBH) Unit, and has been an employee of UCSD since September of 2008. He holds a Master's of Science in Nursing. Shane works per diem at UCSD and fulltime for the VA as a Federal Recovery Coordinator (FRC). As a FRC, he is responsible for national care-coordination of catastrophically ill and injured active duty service members and veterans. Shane is recognized as an expert resource dealing with spinal cord injuries (SCI), served as clinical service director at the VA, developed and implemented the SCI Telehealth-care program, and is experienced in surgical/medical, rehabilitation, home care, and psychiatric nursing. He is also in the United States Naval Reserve, and is currently deployed to Kandahar, Afghanistan working as a psychiatric clinical nurse specialist. The SBH staff appreciate Shane’s calm demeanor, his ability to de-escalate agitated patients, and his patience with our seniors.

Shane has a wife, daughter, and son who are anxiously awaiting his return home. The SBH staff wishes him a safe and swift return back home to his family and to SBH. We would also like to thank Shane and the men and women in all of our Armed Services for their dedication to protecting our rights and freedom.

The following is an abridged version of some of Shane’s accounts of his life and work while deployed in Afghanistan.

May 17, 2012
Greetings from Afghanistan,

I’m doing as well as can be expected. The tempo has increased over here with the fighting season under way. The Taliban don’t like to fight in the winter. Work has been SURPRISINGLY very satisfying and rewarding so far. What an experience this whole thing has been thus far..... I feel like I’ve really been able to significantly impact peoples’ lives. That has helped make this whole thing worthwhile. To me, as a nurse, and on a personal level, that’s what I’m/it’s all about--helping others and making a difference.

...It’s getting very hot over here. Still VERY dusty, dirty, and smelly as ever. It either smells like smoke from the burn pits or smells like a port-o-potty (and that’s describing it politely) from the sewage plant at the edge of the base. I’m tell’n ya.... I’m not going to miss the smells and rocket attacks of this place...

Well that’s about it for now. Take care and miss all you guys!!!

-Shane,

AKA “Dirt Sailor”

(This is what they call Navy sailors that are stationed/ deployed away from water)
Greetings from Afghanistan,

...It has been very busy over here. Fighting season is well underway. The hospital has been very busy with both physical and mental injuries. I don’t know if I told you what my job is here. I’m working as a psychiatric clinical nurse specialist in the outpatient mental health dept. There is no inpatient mental health here. If they need to be inpatient, I medi-vac them out of AFG—STAT. I’m the only mental health nurse here. I am functioning as a therapist for outpatient as well as hospital staff and trauma. Everyone I work with is awesome. I work with some great Navy and Army psychiatrists. Actually, one of the Navy psychiatrists did a rotation through SBH when he was doing his residency several years ago...

The primary dx’s I see here are adjustment d/o, depression, anxiety, and +SI/HI. There is some psychosis, but (surprisingly) it’s very rare. Lots of PTSD and insomnia/sleep pattern disturbance. Most of the people I see are 23-28 y.o., but some are in their 40’s and 50’s (all branches of the military as well as some civilian contractors and NATO forces). Safety is key here and I often determine if someone is going to make it here or if they need to be medically evacuated back to the states for more intense tx... I’m telling you the scares of war are hell. War is HELL. It’s definitely a life changing experience.

It has been really hot and the temp continues to creep up weekly. It’s been consistently between 105-110 degrees, however I’m told it should top out between 118-124 next month and stay that way until Sept... It’s still as dusty and nasty as ever...

The base I’m at is called Kandahar. It is a very large base. In many ways it reminds me of a scene from Star Wars. Everything is dead here. No water and greenery. The only green is the NATO multicam uniforms we wear and the rare scrub tree. Everything is shades of brown here. I hear some places in AFG are green but this isn’t one of them. It is CRAZY here. Unlike anything I’ve ever experienced and will likely ever experience in the future. This is a NATO base full of soldiers from many different countries. There are French, Slovaksians, Bulgarians, Romanians, British, Australian, Dutch, German and people from many other countries. I even saw a soldier from the Columbia military here one day. I thought to myself “since when did the Colombians become part of NATO?” (they aren’t). There are rocket bunkers all over the place here. We were getting rocket attacks pretty routinely but as of late only once or twice every couple of weeks. The hospital and barracks I live in are considered rocket proof (haven’t actually been tested yet and I hope they aren’t if ya know what I mean) so that makes it nice when the rocket attack sirens go off. I don’t have to evacuate to another location. All in all I’m fairly safe. So far I haven’t had to leave this base to go to another.

Well that’s about it for now. I’m adding a few pics for you all to get a laugh out of. Please tell everyone I said hi and I can’t wait to come home. It feels like I’ve been gone FOREVER.

Take care,

-Shane

AKA- Dirt Sailor
VALUES DIVERSITY — ADAPTS TO DIVERSITY
As an inpatient geropsychiatry unit, we determined the need for an educational diversity program to better understand the differences in cultural values, beliefs and practices of our multicultural staff and patients. From the beginning of the program in 2004, we accomplished this with our on-going “Divers-a-Days” Program, celebrating different cultures and groups every other month. Our program has received a yearly UCSD Diversity Award from 2005 to 2008, reinforcing the importance of our ongoing diversity educational goal. We strive to maintain awareness of diverse cultures, and to respect and develop the potential of its members. Our multicultural nurses, physicians and allied health professionals maintain a good understanding of cultural differences in transcultural healthcare practices in order to give quality care of our patients of diverse cultures. Literature has highlighted the importance of transcultural education so that all patients from different cultures will be cared for by health professionals that understand culture and can provide culturally competent services.

Dorothy Brown, BSN, RN is the Administrative Nurse for Psychiatry. She has been a UC San Diego Health System Nurse for more than 11 years. She received a Best Practices Award in the Treatment of Behavioral Disorders Associated with Dementia after submitting an abstract to the American Psychiatric Nurse Association. She also received a Healthcare Champion Award for San Diego County, San Diego Psychiatric Nurse of the Year, and Philippine Nurses Association Administrator Nurse of the Year. For the past two years, her passion has been photography and has done photo shoots for several UCSD events.

Chancellor’s Diversity Award Ceremony
THE SENIOR BEHAVIORAL HEALTH UNIT
To achieve our goal of maintaining awareness of diverse cultures through educational activities, we schedule specific celebrations for the following months: September/Asian-American culture; November/Northeast USA culture; January/African-American culture; March/Mexican culture; May/South-East USA; and July/Euro-American culture. During the celebrations, the unit is decorated with photographs, specialty items, and clothing relevant to the specific culture/group. Poster boards, created with historical and geographical information, are used as educational tools. A potluck luncheon, cultural music, videos, and trivia are featured for each celebration. During the trivia sessions, patients, visitors, and staff group together for a question and answer period about the respective culture. This activity heightens awareness and appreciation by our staff, patients, the patients’ families, and staff from other units who attend the “Divers-a-Days” celebrations.

MANAGES THE DYNAMICS OF DIFFERENCE
Our Senior Behavioral Health Unit is rich with staff members of different cultures able to interact with patients in the patient’s own native language. Staff members speak English, Spanish, German, Tagalog, Russian, Farsi, Vietnamese, Korean, and Danish. Some patients never learned English or with age and memory loss may revert back to their native language, even though able to speak English. This adds an important inherent dimension, effective cross-cultural communication in providing culturally competent services. Multilingual staff members adjust to our patients’ changing needs. We strive to maintain awareness of diverse cultures and to offer culturally sensitive, linguistically appropriate care, in response to each patient's health care needs.

Asian Diversity Unit Celebration
According to the Center for Disease Control and Prevention and the Merck Company Foundation, "by the year 2030, approximately 20% of the U.S. population (71 million people) will be over the age of 65 years" (2007). The elderly are a vulnerable population that has difficulty accessing health care. This population’s situation is complicated by the fact that many of their complaints are seen as a natural part of aging. Many myths about aging exist and, unfortunately, there are many health care professionals that believe these myths. A common education shortcoming of many health care professionals is the lack of emphasis on taking care of the elderly, particularly when it comes to determining what their specific needs are in relationship to health and how the results of medications and laboratory results differ for the elderly in comparison to the adult population.

Many educational institutions do not have mandatory courses for the education of health care professionals in caring for the elderly, even though the elderly population is the largest growing group of health care consumers. The other concern is that there are not enough health care professionals specializing in geriatric medicine. This may be due to the fact that, according to Daniel Perry, executive director of the not for profit Alliance for Ageing Research, “ageism is a deep and often-unconscious prejudice against the old, an attitude that permeates American culture” (Cosgrove-Mather, 2003).

UCSD is a Nurses Improving Care for Health System Elders (NICHE) designated hospital that is working to create a more senior friendly care and environment. The Senior Behavioral Health Program located on 7 East in Hillcrest provides mental health care for patients 65 years and older. The unit is specifically designed for the seniors, including brighter lighting that works with a person’s circadian rhythm. The staff is knowledgeable about both medical and psychiatric disorders. The unit also offers specific programming for the seniors, including trips down to the Senior Behavioral Health Healing Garden, a program called Memories in the Making (art), music groups, and cognitive therapy groups.

It is important that there be an increased awareness of health care providers regarding the vulnerability of the elderly and how the staff’s perception of the elderly influences the care provided to senior patients.

REFERENCES:

Aging is not lost youth but a new stage of opportunity and strength. Betty Friedan (1921-2006)
Ida Mae, age eighty-four, walked through the psych unit locked door for the third time. Her daughter urged her on, it’s going to be all right, Mom, you know the nurses here. Hanging onto frailty, she bent to the task and settled in a nearby chair. Her hands twisted the strap of a large black purse held securely on her flowered skirt.

She’s not eating or talking and she sleeps all day. What can we do for her this time? Held hostage by her brain wandering its own path through voids and loose connections, Ida Mae was now limited to words strung out in random order.

We knew her well and stories from our memory rambled around the work of pills and mealtime. We took trips into the life of this tall red-head with fiery green eyes as she strut through the Bronx in familiar vintage photographs, back where long term memories were made.

One quiet Sunday at noon, our heads bent to the order of desk work, Ida Mae appeared at the nurses’ station, and spoke to us in true New York style, “I really appreciate all that you are doing for me and the patients here. You nurses work so hard to serve the public, something I know about, dealing with people. I was a telephone operator in the City for 49 years.”

Our response, slowed by surprise, was reduced to a simple thank you for your kind words. Ida Mae’s moment of clarity, gone as fast as it came, held its warmth and wonder long after she left on her way back to her room, and back to that vacant spot in her brain.

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Christine Robinson, NP

is a board certified Family Nurse Practitioner. She has over ten years of experience in adult and geriatric psychiatry in the Department of Psychiatry at U.C. San Diego. Christine has an advanced certificate in Addiction Studies and an MA in family therapy. Her nursing career includes extensive experience in inpatient and outpatient behavioral medicine, chemical dependency, and chronic pain management. Influenced by more than 50 years in the nursing field, she has a strong desire to share unique experiences by writing poetry and fiction: displaying the perfect right/left brained (intuitive/logical) balance. She especially enjoys the writing process, which offers the excitement of surprise in the making.
I grew up in a family of nurses; my mother, grandmother and great-grandmother were all nurses. Growing up, I never imagined that one day I would be going back to school to become a nurse too. It was while caring for my aging grandparents that I realized that I wanted to become a nurse. I spent many hours at the hospital and saw many good and, unfortunately, many bad nurses. It was the good nurses that really made a difference in my grandparents’ lives, as well as in my own. I slowly started to see myself in the role of a caregiver—and the rest is history. As I work my way through nursing school, I am really motivated to be as good as the nurses who cared for my grandparents.

I chose gero-psych as my nursing specialty for a couple of reasons. First, psychology has always been my passion. I graduated from UCSD in 1995 with a degree in psychology. My very first job was at the California Smokers’ Helpline at Moores Cancer Center, where I worked for a number of years as an addiction counselor and then went on to become a counseling supervisor. Once I decided to go back to school to further my education, becoming a psych nurse seemed like a natural progression for me. I also enjoy working with the senior population. Seniors have a lifetime of wonderful stories to share. I can remember sitting for hours with my Grandmother and listening to all the wonderful stories she had to tell. One only has to take a few minutes to sit and talk with a senior to fully understand what I mean. Often in Western Culture our seniors get lost and are forgotten about in the midst of our busy lives. With our Baby Boomers entering their golden years, there is a need now more than ever to find health care professionals specializing in working with this population. I have always been impressed with Hospice nurses—they are special people, consistently kind and compassionate. Several of my family members (including my grandparents) received hospice care, and the nurses were wonderful people. It takes a special type of person to be a hospice nurse. It was during my experience in working with them that I realized I could really make a difference in someone’s life. These are just a few reasons I chose to include geriatrics in my nursing career path. This will be my second career and hopefully my last. I believe nursing will provide me with lots of variety and opportunity for growth. I am open to management opportunities, but I fear losing the patient contact, which for me is the most rewarding aspect of the profession.

I feel that my philosophy of nursing is most similar that of Jean Watson. Jean Watson’s theory is all about caring. Watson believes that caring is central to nursing, as do I. The following is a list of Watson’s seven assumptions about the science of caring:

• Caring can be effectively demonstrated and practiced only interpersonally.
• Caring consists of carative factors that result in the satisfaction of certain human needs.
• Effective caring promotes health and individual or family growth.
• Caring responses accept the person not only as he or she is now, but as what he or she may become.
• A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.
• Caring is more “healthogenic” than is curing. A science of caring is complementary to the science of curing.
• The practice of caring is central to

By Jeremy Reeder is registered nurse at Senior Behavioral Health (7E) in Hillcrest. He also serves as the Diabetes Champion, attending monthly Diabetes Initiative Group meetings, providing staff education, and auditing patient blood sugar levels. Jeremy occasionally works per diem in a vascular/telemetry unit at Eisenhower Medical Center in Rancho Mirage. A recent grad, he earned his BSN from the University of Oklahoma in 2010. Prior to entering nursing school, Jeremy worked for many years as a counselor and clinical supervisor at UCSD’s California Smokers’ Helpline. A UCSD Alumni, Jeremy earned his BA in psychology in 1995. Jeremy is also a disaster response volunteer for the San Diego Chapter of the American Red Cross. Outside of work, Jeremy loves going to the gym, old house projects, travel, and spending time with his Italian Greyhounds.
nursing (Saleem, 2009).

Watson’s seventh assumption, “the practice of caring is central to nursing” is at the top of my list. My journey through nursing school has only strengthened my belief in caring and its importance to nursing.

In the article “Can the Study of Ethics Enhance Nursing Practice?” Peter Allmark argues that ethics do enhance nursing (2005). He proposes that the “knowledge of ethical theories can be of practical use to nurses in at least three ways” (Allmark, 2005). First, ethics help the nurse identify the types of questions that need to be addressed in resolving a problem. Next, ethics will help the nurse develop methods to answer the questions. Finally, ethics will help the nurse to develop sound ethical beliefs (Allmark, 2005). Allmark does not, however, claim that ethics will help nurses solve ethical dilemmas (Allmark, 2005). In the short period that I have been in nursing, I have observed many nurses that do not have sound beliefs. This is unfortunate, because as Allmark points out, “someone with sound views will be better for patients and clients” (Allmark, 2005).

Another article written about ethics in nursing is Ethical Analysis by Ruth Robinson. Robinson’s article presents a case-study about a terminally ill patient by the name of Margaret. Margaret is faced with some end of life decisions that lead to an ethical dilemma with her family. Margaret has reached acceptance in terms of her death, but her family is not willing to let her go. In contrast to the first article by Allmark, Robinson actually attempts to resolve an ethical issue in Ethical Analysis. According to Robinson, one can resolve an ethical issue by understanding four ethical principles: autonomy, nonmaleficence, beneficence, and fidelity (Robinson, 2003). Margaret was terminally ill and wanted to be taken off the ventilator and be allowed to die. Her family was “horrified” at the thought and her doctor refused this option. Margaret argued that the “technology that would enable her to live longer would not provide her with an acceptable quality of life” (Robinson, 2003). As the patient advocate, the nursing staff felt it was their duty to support Margaret and respect her autonomy. With this nursing decision, I completely agree. Robinson also agrees, and says that the principle of autonomy is “fundamental when discussing issues regarding patient decision making” (Robinson, 2003).

I strongly believe in the ethical principle of autonomy. My grandmother was diagnosed with breast cancer at the age of eighty-eight. It was during a routine mammogram that a small, pea-sized mass was discovered in her breast. Grandma had been a nurse for over 40 years and she was well aware of the treatment options available for treating breast cancer. Deciding which treatment option was a difficult task, even for someone with years of healthcare experience. As the family, we had our own ideas about what was best for grandma, but she was competent and able to make her own healthcare decisions. She decided to have the mass removed but chemo and radiation treatments were entirely out of the question. The surgery was a success. The mass was removed and fortunately the cancer had not spread to nearby tissue or the lymph nodes. It was a full five years until the cancer returned, but it was as aggressive as ever. It had metastasized to several of grandma’s organs, including a small spot on her brain. The doctor told us that she had two weeks at most to live. Ever since I was a young boy my grandma always told me she was afraid to die. She never said why she was afraid to die, but my guess is that she was afraid of dying alone. Maybe that explains why she would sit and hold a patient’s hand for hours as she waiting patiently for them to die. My grandma was my best friend and I loved her too much to tell her the truth about her disease. And because I had power of attorney for her health I decided not to. Did I violate the ethical principle of veracity by not telling grandma that she was going to die? Maybe so. Or did I uphold the ethical principle of beneficence? Grandma died exactly two weeks to the day the doctor said she was going to. To this day I honestly do not know if grandma knew she was going to die so quickly. I believe in my heart that I made the right decision based on the information I had.

My biggest responsibility as a nurse is to provide the best possible care given the information I am provided. I will always follow the nursing Code of Ethics to the best of my ability. But applying the ethical principles is only the beginning. I am motivated and committed to be as good as the nurses that cared for my own grandparents. I will treat every patient as I would want my family member to be treated. Every patient is somebody’s child, mother, brother, sister, or best friend. I agree with Allmark, in that the study of ethics can enhance the practice of nursing. Ethics cannot teach you how to care, because compassion and caring come from within.

REFERENCES:
The criteria for inpatient psychiatric admission are based on a number of interrelated factors. Disciplines outside of psychiatry have scant understanding of what criteria are required for an appropriate psychiatric admission. These requirements are based primarily on three clusters of functional symptomatology. In a broad sense these include: (a) an acute threat of self-harm (suicidal ideation with a plan/intent); (b) an acute risk of harming others; (c) an inability to provide/utilize food, clothing, or shelter (aka Grave Disability). These must be determined to be secondary to a primary psychiatric illness not including dementia or personality disorders. A systematic review of the current literature on nursing handoffs shows that there are no established guidelines for the handoff of psychiatric patients. A review of the literature published in the American Journal of Nursing in 2010 concurs with this finding (Riesenberg, Leitzsch, & Cunningham, 2010). This article seeks to provide a template for the handoff of psychiatric patients based on the mnemonic “PACE,” a format for assisting RNs in comprehensive, thorough, and safe handoff of such patients.

Perspective psychiatric patients are expected to attend and participate in daily groups, programming, and milieu therapy. There must be clear expectations of the desired outcomes of hospitalization. Individuals accepted to the psychiatric unit must be deemed medically stable. This excludes patients who need IVs, drains, supplemental oxygen, or telemetry. Patients with unstable vital signs or grossly abnormal labs are not considered eligible for admission until those issues are addressed. The primary objective is the safety of all patients. Patients also must be ambulatory or wheelchair bound as to facilitate participation in their programming. Once these criteria are understood, the key components for the RN handoff can be more effectively and safely communicated. This reduces the chance of transfers to the medical floor or the need for rapid response.

Before elaborating on the PACE mnemonic it is important to understand proper reporting of psychiatric symptoms. Providers should try to avoid vague terms such as “psychotic,” “depressed;” or “delusional.” Instead, when describing a patient with psychosis, they should use examples such as “auditory hallucinations that tell patient to harm his/her self” or “grandiose delusions—thinks he is God” or “paranoid ideation—thinks the Mafia is out to get him.” The same goes for depressive type symptoms such as “suicidal ideation with a plan to overdose on medications” or “has not slept or bathed in 3 days,” or “has not eaten in 3 days,” or “withdrawn and isolative to room.” Generally, it is important to be specific.

The PACE handoff is defined into the following 4 categories:

- **P** refers to Patient and/or Problem. This includes the patient’s name, age, and legal status, how the patient arrived in the ED, and the psychiatric diagnosis (to include current acute symptoms), as well as any medical diagnosis/history/symptoms that are relevant to current admission.
- **A** refers to Assessment and/or Actions. This includes nursing assessment and interventions based on the patient’s problems. This includes tests, Vital Signs (VS), labs.
(provider must ensure there is a urine tox screen and BAL ordered), as well as medications given.

- The “C” in the PACE mnemonic refers to Continuing and/or Changes. This category includes any follow-up needed or anticipated changes in the patient’s condition or plan of care once the patient is transferred. Examples of follow-up include lab tests, treatments, VS, etc.

- The “E” in PACE stands for Evaluation. This category includes the completion of the handoff with notation of the patient’s response to interventions and his/her mental status upon transfer (Schroeder, 2006).

Here is an example of a report a RN might keep using the PACE template:

P: Jane Doe, 35 yr. old female on 72 hr. hold for danger to self, BIB by Paramedics after husband called reporting pt. overdosed on medication, empty pill bottle at bedside, pt. drowsy but responsive. Dx. of Major Depressive Disorder. Has been off her antidepressant medication x 3 weeks. Medical: hypertension.

A: Pt. given charcoal in ED. Tox consult. No medications given. VS WNL except for BP of 140/90. Patient slightly sedated. Labs WNL. Urine tox positive for Benzodiazepines. BAL 0.

C: Continue monitoring of current suicidal thoughts, S/P overdose. Follow-up with recheck of BP.

E: Patient calm but tearful, verbalizing remorse for overdose. Asking to see husband. Gait steady and oriented x 4.

In summary, using a standardized format in handoff can assist the RN with giving a concise, organized, and relevant report which then leads to a safe and successful handoff from the ED to the Psych bedside.

REFERENCES:


I see the desperation in your eyes and the Helplessness reflected on your flat facial expression I see a human being fighting for his place And his moment in time To whom even the ability of expression himself Is being denied I see a lost soul, like a ship being abandoned To be left afloat in the middle of the ocean Wandering through eternity, for you will not know Whether you are dead or alive I see a man fighting a losing battle, Betrayed by his very own body. I see all that and more; however, I want you to know my friend, that You are not alone in this battle I’ll be that ray of light that will guide your way I’ll be that bridge connecting you with the moment and the now.

I won’t let them upset, you, and I’ll support your independence with my guidance Allow me to reach within you Wherever it is you are Hold my hand and close your eyes For I am here to ease your fear hold my hand and close your eyes For a friend you never knew you had, your nurse, is here.

I see the desperation in your eyes and the Helplessness reflected on your flat facial expression I see a human being fighting for his place And his moment in time To whom even the ability of expression himself Is being denied I see a lost soul, like a ship being abandoned To be left afloat in the middle of the ocean Wandering through eternity, for you will not know Whether you are dead or alive I see a man fighting a losing battle, Betrayed by his very own body. I see all that and more; however, I want you to know my friend, that You are not alone in this battle I’ll be that ray of light that will guide your way I’ll be that bridge connecting you with the moment and the now.

I won’t let them upset, you, and I’ll support your independence with my guidance Allow me to reach within you Wherever it is you are Hold my hand and close your eyes For I am here to ease your fear hold my hand and close your eyes For a friend you never knew you had, your nurse, is here.
The UC San Diego Child and Adolescent Psychiatry Service (CAPS) was a well-established twenty-bed acute psychiatric inpatient center for the evaluation and treatment of children and adolescents with severe psychiatric disorders, and is now operated by RCHSD. CAPS treats patients from childhood to the age of eighteen. CAPS is overseen by board-certified child and adolescent psychiatrists, psychologists, pediatricians, social workers, occupational therapists, recreational therapists, mental health workers, San Diego Unified School teachers, and dedicated RNs who work as an interdisciplinary team to address the special needs of each patient. CAPS strives to provide excellent care and coordinates with the outpatient providers to insure outpatient continuity of care.

CAPS nurses are compassionate, caring, ethical professionals who provide the best care for each patient, based upon the patient’s individual diagnosis and needs. The nurses know that living with a child or an adolescent with emotional and behavioral problems can be an overwhelming experience for most families. In order to ensure optimal patient care, the nursing staff at CAPS is adamant about the importance of patient family-centered care and promotes positive patient outcomes. One exemplary illustration of patient family-centered care came from a CN III project by Jeunita (Nita) Roux-Ward, RNC.

This project, conceived and implemented by Nita, was designed to address the reality that adolescent psychiatric patients can suffer serious consequences due to their escalating behavioral problems, which ultimately can result in restraints or seclusion (R/S). These emergency situations have the potential to cause psychological harm, loss of dignity, violation of patient’s rights, and even death. To minimize the need for R/S, as Nita’s project describes, the CAPS nurses implemented a process for engaging the family and patient in developing an Emergency Plan of Care (EPOC) individualized to each patient. They created an EPOC form that is implemented upon admission, reviewed at change of shift, and updated when new information is received. To create the EPOC, the admission nurse discusses the following with the patient and family:

- What are the cues/antecedents to maladaptive behaviors?
- What alternative responses does the patient suggest the staff employ when he or she is feeling anxious or losing control?
- What measures could the staff take when it is necessary to assist the patient gain self-control? For instance, one patient may prefer to be left alone to calm down, while another needs to have someone hold and comfort him or her.

If restraint or seclusion is necessary, the nurse initiates a de-briefing session with the staff and the patient to review better methods to assist the patient in sustaining appropriate behaviors. The EPOC is revised at this time, if necessary.

**CHILD AND ADOLESCENT PSYCHIATRIC UNIT**

The CAPS program provides behavioral health care to some of the most vulnerable and needy children and families in the community. CAPS’s Registered Nurses, along with the multi-disciplinary team of board-certified psychiatrists, clinical psychologists, social workers, occupational therapists, recreational therapists, licensed
Nita Roux-Ward, RNC has been committed to the health and healing of Child and Adolescent mental health patients for over 35 years. She is currently the AM charge nurse for the RCHSD, Child & Adolescent Program. Her leadership and dedicated work on restraint reduction resulted in marked reduction of restraint use on the CAPS unit.

vocational & psychiatric nurses and mental health workers, initiate the contact with the family during pre-admission consultation with the County’s Emergency Service Unit.

The family or surrogate family designee is referred by a PCP or community clinic to the county's emergency service unit (ESU). Once an assessment is made and the need for acute psychiatric hospitalization is determined, the ESU nurse contacts the CAPS's unit. At that time specifics about the family situation is reviewed as well as other important clinical issues. One key goal for hospitalization is for the patient to find a safe, comforting environment in which compassionate, nurturing care is evident…. restraints are used only as a last resort.

When the patient arrives at the CAPS site, the intake process includes exploring details of the home situation. When a parent or parent surrogate is present, the RN educates the family about the principles involved in maintaining a safe environment for their child during hospitalization. Registered Nurses assess the parent’s perspective on their child’s potential for violence and the measures utilized in the home to help their child feel calm when stressed or feeling out-of-control. Parents are asked to complete a behavior checklist (available on site) that is used to assess where adaptive and maladaptive behaviors may be present. The information that the family provides helps the treatment team plan for both individual and family therapy that is focused on the child’s behavior and how the parents respond to the behavior. Plans can then be put in place at home that will assist the child in maintaining behavioral control. Specific routines that are known to be soothing are identified and added to the “Emergency Plan of Care” tool. If the child has a special toy or other object that helps them become calm, the parents are encouraged to bring the object for their child to keep during the hospital stay.

<table>
<thead>
<tr>
<th>CAPS Seclusion and Restraint Data</th>
<th>Fiscal Year 2010-2011-2012</th>
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<tr>
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<td>Seclusion</td>
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<td>Restraint</td>
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CULTURALLY COMPETENT NURSING
A Review of Culturally Competent Nursing of Elderly Hispanic Adults

By Trisha Tebo, Debbie Crutchfield, Sharman Plaugher, Mitzy Dawkins-Julien

Cultural Competence is a way of practicing nursing that is respectful of the patient’s values and traditions, while still providing the patient with the care necessary for his or her well-being (De Chesnay & Anderson, 2008). This allows nurses to integrate Jean Watson’s theory of human caring and provide the patient with holistic nursing care. The nurse can care for the patient’s mind, body, and spirit once they understand his or her culture and beliefs. Cultural competence includes learning about cultures different from one’s own. Nurses can use demographic information, health risk factors, environmental risk factors, and community risk factors to help determine the needs of people within a certain culture. To deliver care in this manner, nurses must recognize the barriers and challenges associated with providing culturally competent nursing, and develop strategies to ensure culturally competent care.

Cultural Competence is a way of practicing nursing that is respectful of the patient’s values and traditions.

According to the Centers for Disease Control and Prevention (CDC), Hispanics are persons of Mexican, Cuban, Puerto Rican, or Latin American origin. Each subgroup has its own unique history and customs, therefore there is a lot of diversity between these groups (CDC, 2011). However, there are many similarities among the Hispanic subgroups that can be used to help nurses to understand their culture and their health care needs (University of Missouri, 2005). Hispanics live in all parts of the United States, however the greatest concentration of Hispanics is found in the southwestern states including Florida, Texas, California, New Mexico, Arizona, and Nevada. Texas and California have the highest population of Hispanics: 13.7 million and 9.1 million respectively (CDC, 2011).

ELDERLY HISPANIC ADULTS

The Hispanic population has an increased rate of death compared to White Americans due to cardiovascular disease, which includes heart disease and stroke. Hispanics are also twice as likely as non-Hispanic Whites to develop diabetes, and they are 1.5 times more likely to die from diabetes-related complications than non-Hispanic whites. Fewer Hispanics receive the Influenza vaccine that non-Hispanic Whites (51.3 percent of non-Hispanic Whites received the flu vaccine compared to 35.5 percent of Hispanics). In addition to these illnesses, there are several diseases that have a higher prevalence among the Hispanic population. These diseases include asthma, obesity, chronic obstructive pulmonary disease (COPD), tuberculosis (TB), and mental health diseases (CDC, 2011).

HEALTH RISK FACTORS

Many Hispanic elders immigrated to the United States with their children, making them the original immigrants of their family. Their children, if not born in the United States, are first generation immigrants. Second generation immigrants are children born in the United States to at least one foreign-born parent. Third generation immigrants are children born to two American born parents with one or more foreign-born grandparent. Original and first generation immigrants have less economic and academic opportunities than second and third generation immigrants. First generation immigrants have the benefits of attending public school, which allows them to learn English and other valuable information about their physical health.
and the health care system (Cruz, 2009). Original immigrants encounter issues related to the language barrier more than other generations. They also have less knowledge about the American health care system. Elderly Hispanics rely on their family for much of their health care information; however their family members may not always guide them appropriately due to their own lack of knowledge regarding the health care system. Elderly Hispanic adults may delay necessary health care due to fear or mistrust of mainstream service providers. Poor access to transportation to hospitals or other medical facilities can also delay necessary health care for this population (University of Missouri, 2005). Additionally, healthcare workers may be biased in regard to cultures different from their own. Therefore, previous health care experiences of elderly Hispanics may affect their desire to seek help from a facility where they may have had a bad experience.

ENVIRONMENT AND COMMUNITY RISK FACTORS FOR ELDERLY HISPANICS

Several nursing models have been specifically developed to explore the dimensions of cultural competence. These models have helped to evolve nursing from a view of cultural sensitivity to a view of cultural competence. While cultural sensitivity focuses on awareness, cultural competence focuses on behaviors. Nurses should try to meet patient’s needs by engaging in his culture and helping him to maintain his practices while under their care (De Chesnay & Anderson, 2008). Kim-Goodwin, Clarke, and Barton developed their cultural competence model in regard to community health care, but it can be adapted to fit other areas of nursing as well. Their model focuses on the relationship between cultural competence and measurable health outcomes for culturally diverse populations. Their model uses a cultural competence scale to measure cultural sensitivity, cultural knowledge, and cultural skills. This provides a method for nurses to develop and assess cultural competence in their own practice to improve patient outcomes in diverse communities (Kim-Goodwin, Clarke, & Barton, 2001). Nurses can assess their cultural competency and improve their abilities based on the assessment. This enables them to provide quality care for patients with cultures that differ from their own. This is important for the elderly Hispanic population because this group contains many sub-groups such as Mexicans, Puerto Ricans, and Cubans. Their individual cultural practices can differ between sub-groups, increasing the need for cultural competent nursing.

CULTURAL COMPETENCE MODEL

In order to provide culturally competent care to the elderly Hispanic population, nurses must develop strategies and programs. Many elderly Hispanics participate in traditional folk remedies. While this could become a barrier against American health care, nurses can help the patient to continue these practices in conjunction with American medicine. Healthcare professionals who work with Hispanic elders should familiarize themselves with Curanderismo, Santeria, and Espiritismo. Curanderismo includes folk healing, prayer, herbal medicines, healing rituals, and spiritualism. Santeria is an old word religion rich in symbolism, practiced in Columbia and Puerto Rico. Espiritismo is the belief that good and evil spirits can effect health and other elements of human life (Yee and Weaver, 1994). Nurses should keep an open mind, even if they do not share the beliefs of their patients. Incorporating traditional folk remedies with a patient’s plan of care can help to increase compliance with a patient’s health care regimen. The Promotora model is program in which lay advice-givers help to bridge the gap between the Hispanic community and the health care system. People who are already respected members of the community are trained to give informal advice during every day interactions. The Promotoras have an established relationship with the Hispanic communities that “outsiders” may not have. This relationship allows the Promotoras to help address the attitudes and beliefs that social groups may have regarding health care and the American health care system. This type of program has been successful in many communities because the Promotoras are available in a non-threatening environment and can give reliable information to their fellow community members. This in turn helps to break down the barrier of mistrust that can hinder health care access for the elderly Hispanic population (Sherrill et al., 2005).

Education for elderly Hispanics must be provided in a user-friendly format that is culturally appropriate to the patient. If the patient is not able to read,
pictures can be used. If the patient’s eye sight is poor, larger print or audio information can be made available. Communication is the key to culturally competent care, so if a nurse is not sure about something, her best approach is to ask the patient or a family member how the situation should be handled. This will provide the best outcome and will help the nurse to educate herself about the culture of her patient.

**CULTURALLY COMPETENT CARE**

Language barriers are a challenge throughout the health care field for both elderly Hispanic patients and those that provide their care (Zucker & Cummins, 2004). When trying to provide culturally competent care, nurses must be able to communicate with their patients in a language that they can understand, and at an educational level that they can comprehend. The best solution to this problem is to employ bilingual health care providers—however this is not always achievable. Other options include on-site qualified health care interpreters or off-site interpretation services over the phone. Most health care facilities have the latter, at the least. If Spanish is the patient’s first language but the patient speaks English as well, an interpreter can still be used if it is easier for the patient to understand health care information and health education in their primary language.

Modern medicine, especially diagnostic testing, can be very foreign to a patient that is accustomed to traditional folk remedies. This can be a barrier to providing health care to the elderly Hispanic population. Promotoras programs are aimed to help the health care field gain the trust of the Hispanic population. Community health screenings and educational materials can raise awareness among all generations of the Hispanic population regarding important health care issues (Sherrill et al., 2005).

Many Hispanic elders use their family members, especially their children, for health care advice, so giving the younger generation the appropriate information will help to spread this information to the older generations.

**CHALLENGES OF CULTURALLY COMPETENT CARE**

Dr. Jean Watson developed her Theory of Human Caring based on the idea of caring for the patient’s mind, body, and spirit. Her theory is based on 10 statements, known as carative factors. Watson’s Theory of Human Caring is easily adaptable
to transcultural strategies that can help with the nursing care of elderly Hispanics. Watson’s 10 carative factors are aspects of nursing that promote the therapeutic healing process for both the patient and the nurse (Morris, 2006). Watson’s theory states that both the patient and the nurse mutually benefit from the therapeutic relationship, even if they are from different cultures. Integrating Watson’s Theory of Human Caring in to nursing practice allows the nurse to honor different cultures without losing her own spirituality.

**WATSON’S TEN CARATIVE FACTORS**

Hispanic people have a very strong tie to religion, and most Hispanics practice the Roman Catholic religion. Generally speaking, elderly Hispanics attach more meaning to religion than younger Hispanics. The nurse caring for elderly Hispanics can incorporate many of Watson’s Curatives, especially Carative Factor 10, which states that nurses should “attend to spiritual, mysterious, unknown dimensions of life-death-suffering; allowing for a miracle” (Watson, 2008). When caring for this elderly population, nurses should remember that spiritualism and faith should be integrated into traditional nursing care whenever possible. Cultural competence helps nurses to provide optimal nursing care while becoming skilled in transcultural communication and health care. Understanding the practices and priorities of other cultures is vital to caring for a patient’s mind, body, and soul (Tate, 2003). A nurse who understands Watson’s Theory of Human Caring can attend to the deep faith of the elderly Hispanic population while caring for members of the population. This knowledge enables the nurse to transcend Hispanic cultural barriers and to provide care to their patients as Watson’s theory promotes. Establishing this relationship with patients opens the gate for communication regarding health promotion and disease prevention, which are vital to decreasing the health disparities that elderly Hispanics experience.

**ALLEVIATING HEALTH CONSEQUENCES**

Culturally competent nursing allows nurses to care for their patients in a way that respects the patient’s culture and beliefs. Elderly Hispanic adults are one cultural subset that nurses encounter often, no matter where they practice nursing. Although there are many challenges in providing culturally competent care to this population, nurses can use various strategies to ensure their patients are cared for in this manner. Watson’s Theory of Human Caring promotes holistic nursing care, and culturally competent nursing allows the nurse to accomplish providing holistic care because she can truly care for the patient’s mind, body, and spirit once she understands the patient’s beliefs and culture. Integrating cultural competence into nursing promotes better quality of care for all patients, no matter what their culture may be.

**REFERENCES:**


MENTAL ILLNESS IN HOMELESS FAMILIES

By Christine Geniza, MSN, PMHNP-BC

I. Homeless Statistics:
A. On any given day in the U.S., 800,000 individuals are homeless—200,000 of those are children. 2.3-3.5 million are homeless at some point in a year. 33% of these are families with children. Abuse, depression, poverty and a mother’s emotional state are all factors for influencing mental illness in homeless families.

II. Homeless Families
A. Definition of Homeless: “an individual without permanent housing who many live on the street, homeless shelters, missions, single room occupancy (SRO), abandoned buildings, vehicles, or doubled up with friends or family.”
B. Families with children represent the greatest increase in homeless population with single mothers heading the household.
1. 58% A.A., 22% White, 15% Latinos.
2. Most women have hx of physical and sexual abuse with depression and PTSD. Also common: mental health disorder.
C. Children of homeless families are at a higher risk for mental illness. Those children who experience violence and aggression have higher rates of social isolation, relationship problems, and higher rates of mental disorders. As a result of their homelessness and nomadic lifestyle:
1. They lack access to referrals/treatment.
2. Since many are not enrolled in school, public assistance is lacking and children are not dx or “fall through the cracks.”
3. Social isolation secondary to availability of support systems outside of immediate family.
4. Experience higher rates of developmental delay, language acquisition, and reading skills.
5. 30% may not attend school and out of those that do, only 42% read at the expected level for their age.

III. Contributing factors to homelessness/parent’s perceptions and a homeless child’s academic and behavioral issues.
A. Unstable relationships associated with addiction issues and frequent domestic violence were precipitating factors to homelessness.
B. Lack of personal responsibility by the parents (blaming others for their child’s issues.)
1. Students living in unstable home environments achieve lower scores on achievement tests and are more likely to have to repeat a grade.
2. Parents saw themselves as “good parents” and believed that teachers should handle the behavioral problems inside their classroom.
C. Lack of parenting skills relating to school absenteeism, teacher responsibility, and a child’s academic progress and behavior in the classroom.

IV. Effects of mental illness on homeless families.
A. Increasing trend for women experiencing acute or chronic mental health problems.
B. The greater the psychiatric symptoms experienced by the mother, the more anxiety and depression experienced by the child.
C. The greater the mother’s experience with violence as an adult (DV), the more likely they were to report behavioral problems with their children.
D. Children’s mental health problems were related with their mother’s own emotional problems.

V. Overall Findings
A. Parents did not recognize the connection between their behavior choices and the current effects of their homeless situation on the behavioral problems of their children.
B. Withdrawal and social isolation/rejection is triggered by aggressive behaviors as a result of culminating effects of stressors of daily living in homeless families which then extends over to the children in these families.
C. Mothers who have suffered violence may inadvertently communicate mistrust and negative beliefs about others to their children creating negative feelings with peers, teachers and other mental health workers.
D. Children in homeless families suffer more academically, socially, and mentally than children from intact families with stable living environments.

VI. Implications for Advanced Practice Nurses
A. Build trust: many have been victims of physical and sexual abuse.
B. Provide access to care: After hour clinics.
C. Recognized nomadic lifestyle: medication access, refrigeration, water access? Wallet-sized card for medical information.
E. Screenings for adolescents and children: developmental delays, sexual and/or physical abuse, mental health, immunizations etc.
F. Coordinate care: social workers, case managers, school nurses.
G. Accommodate for diet: adequate food and breakfast programs etc.
A psychiatric consult service for UCSD Hillcrest Emergency Room patients with co-occurring mental health and substance abuse disorders.

**PCRP Brief Interventions & Services**

- Motivational Interviewing to enhance substance abuse and/or mental health behavior change.
- Referrals to community alcohol and drug treatment programs, mental health services, and homeless resources and services.
- Facilitation with placement to crisis houses, substance abuse or co-occurring disorders treatment programs, dependent on eligibility and bed availability at time of disposition planning.
- Follow up referral/support available by phone.

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**PCRP Hours**

Monday-Friday, 7am - 7pm
UCSD Hillcrest Emergency Room
*PCRP services can be requested by ER staff through the Psychiatric Consult Team.*
PSYCHIATRIC NURSING

The first of the following questions are True or False, and the last five are multiple choice. All of the answers are listed at the end. Try to answer what you can!

TRUE/FALSE QUESTIONS

1. The incidence of suicide is lower in men over 65 than in men under 45. T F
2. When a patient with major depression with suicidal ideation begins to feel better, have regular meals, and sleep better, the need for the nurse to observe the patient closely can be decreased. T F
3. Most older adults will suffer with dementia. T F
4. The average older adult is either uninterested in or physically unable to participate in sexual activity. T F
5. Older adults are more depressed than younger adults. T F
6. It is too late or it’s pointless to change bad habits in later life. T F
7. Older adults prefer to become less involved with their family and community as they age. T F
8. In general, all older adults are alike. T F
9. Losing one’s memory is expected as you age. T F
10. Older adults should have decisions made for them because they are incapable of making them alone. T F
11. Most older adults live in nursing homes. T F
12. Polypharmacy can lead to a change in mental status. T F
13. Aging is a universal phenomenon. T F
14. Older adults may present with atypical symptoms that complicate diagnosis. T F
15. The body’s reaction to changes in medications remains constant with advancing age. T F
16. If the nurse observes a sudden change in mental status in an older adult, medication side effects should be investigated as a likely cause. T F
17. Primary causes of delirium in older adults include medications, dehydration, and infection. T F
18. Dehydration is not common in older adults. T F
19. Older adults experiencing a decline in daily function will show no benefit from early rehabilitation. T F
20. A decline in functional ability for an older person may indicate the onset of a new illness. T F
21. Urinary incontinence is common in older adults and it is a normal part of aging. T F
22. Approximately 18-25 percent of the elderly are in need of mental health care. T F
23. A patient with a diagnosis of Schizophrenia, Paranoid Type, Continuous, will have a primary symptom of only paranoia. T F

MULTIPLE CHOICE QUESTIONS

24. How many admissions did NBMU from the ED from 7/1/11- 6/15/12? (a) 156 (b) 378 (c) 457 (d) 549
25. How many NBMU patients were in behavioral restraints from 7/11-6/12? (a) 0 (b) 5 (c) 11 (d) 24
26. For a patient to carry a diagnosis of Polysubstance Dependence, how many substances within a 12 month period is used repeatedly with no one specific substance being predominant must a patient be using? (a) 2 (b) 3 (c) 4 (d) 5
27. A patient with a diagnosis of mild mental retardation must have an IQ range of (a) 75–85 (b) 60–74 (c) 35–55 (d) 20–30.
28. Which one of these criteria must be evident when placing a patient on a 72 hold (5150)? (a) Danger to self (b) Danger to others (c) Inability to provide/utilize food, shelter and clothing (d) Any of the above

We proudly recognize...

Neuropsychiatry and Behavioral Medicine Unit (NBMU) and Senior Behavioral Health (SBH) Registered Nurses:

**Academic Achievement:**
- 85% of SBH career RNs has BSN or MSN degree
- 76% of NBMU career RNs has BSN or MSN degree

Christine Geniza, MSN, RNC graduated September, 2011 from Long Beach State with a MSN and Psychiatric Nurse Practitioner-Board Certified.

Ella Linden advanced from LVN to RN with Associate Degree in May, 2010—currently in MSN program at Pt. Loma Nazarene College

Debbie Crutchfield, BS, RN will be graduating with a MSN from the University of Phoenix in spring, 2013.

**Professional Certifications:**
36% of career Psychiatric/Mental Health RNs at UC San Diego Health System have earned their professional certification.

1. Angel Estacio, BSN, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
2. Carol Behrends O’Donnell RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
3. Sharyn Wilensky, BSN, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
4. Lisa Ross, BSN, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
5. Shane Coudding, MSN, RNC — ANCC Certified as Rehabilitation Nurse
6. Melissa Hardy, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
7. Elisabeth Waterman, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
8. Rosie Heller, BSN, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing
10. Sherri Stolte, RNC — ANCC Certified in Adult Psychiatric and Mental Health Nursing.

**Presentations:**
Judith Pfeiffer will present RN-to RN Review on Clinical Units at the Honor Society of Nursing, Sigma Theta Tau International, 23rd International Nursing Research Congress in Brisbane, Australia—July 30-August 3, 2012.

**Professional Publications:**

**Shared Governance:**
NBMU—38% of Career RNs are active on hospital-wide councils.

SBH—61% of Career RNs are active on hospital-wide councils.

**DAISY Awards**
Tim Hebert, MSN, Senior Behavioral Health
Gina Santiago, BSN, Senior Behavioral Health

**Professional Organizations and Community**
Christine Geniza, MSN, PMHNP-BC teaches at Cal State, San Marcos and works 1 day/week at North County Health Services as a NP for this underserved population in the San Marcos area.

Sherri Stolte, Brad Vandersall, Debbie Crutchfield, and Dorothy Brown have served on several committees for 10+ years at the San Diego Psychiatric Nursing Society’s Annual Recognition Award event.

More than 20% of career nurses are members of the American Psychiatry Nursing Association.

Dorothy Brown, RN and Regina Noveda, RN are active in the Philippines Nursing Association.
Embrace the vision. Join us at UCSD.

For current opportunities, both internal and external, please log on to http://jobs.ucsd.edu.

For more information about nursing at UCSD, log on to our nursing website at http://medinfo.ucsd.edu/nursing.