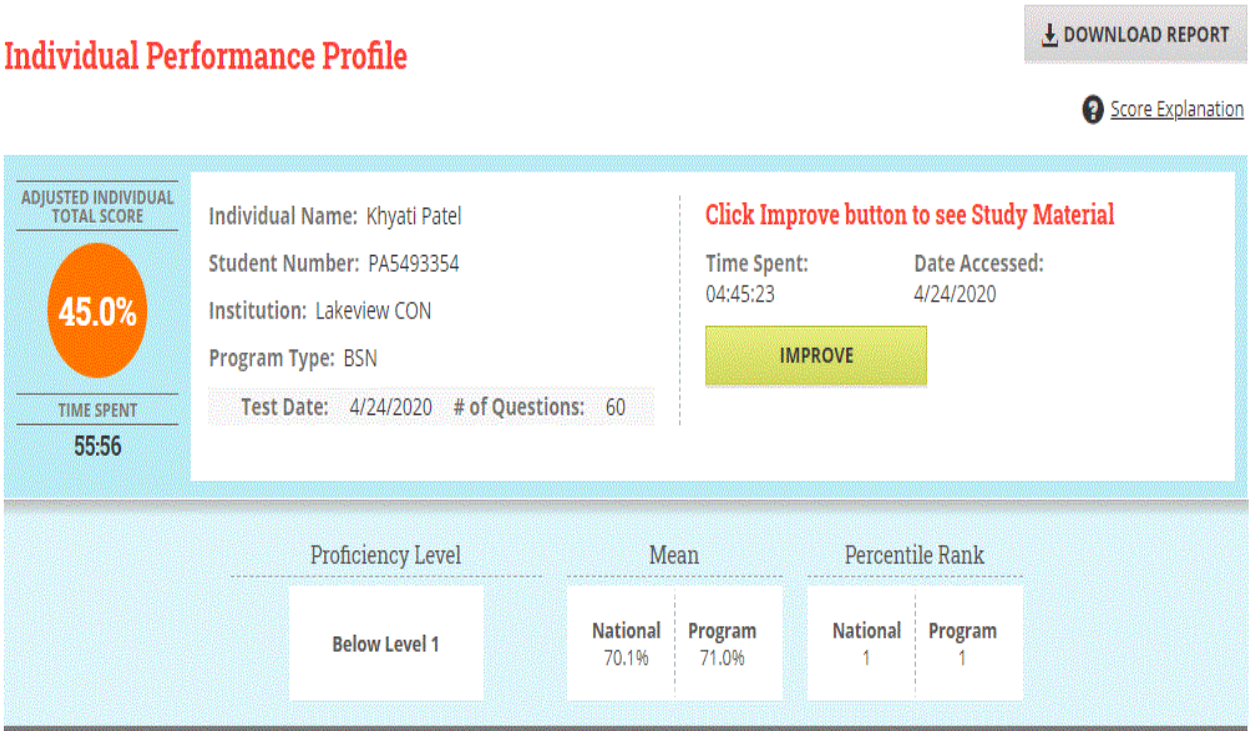

❖ Pharmacological and Parenteral Therapies

Medication foe substance use disorders: Managing alcohol withdrawal:

Disulfiram:

- It is a daily oral medication that is type of aversion therapy.

It is used concurrently with alcohol will cause acetaldehyde syndrome to occur.

- Effects: include nausea, vomiting, weakness, sweating, palpitations, and hypotension.
- Nursing actions: Monitor liver functions tests to detect hepatotoxicity.
- Client education:
  -- Avoid alcohol,
  -- Wear a medical alert bracelet,
  -- Participate in a self-help program

Naltrexone:

- It is a pure opioid antagonist that suppresses the craving and pleasurable effects of alcohol.

- Nursing actions: Assess the client's history to determine whether the client is also dependent on opioids. Suggest monthly IM injections of depot naltrexone for clients who have difficulty adhering to the medication regimen.
- Client education: Take this drug with meals to decrease gastrointestinal distress.

Buprenorphine:

- It is an agonist-antagonist opioid used for both withdrawal and maintenance. This medication decreases feelings of craving and can be effective in maintaining compliance.
- FDA has approved a variety of schedule III buprenorphine products, some containing naloxone, and are available as sublingual tablets, buccal film, and a surgical skin implant.
- Nursing actions: Administer the medication sublingually.

Substance use and addictive disorders: Teaching about disulfiram:

- Encourage the client to adhere to the treatment plan.
- Advise clients taking disulfiram to avoid all alcohol.
- Drinking any alcohol is potentially dangerous.
- Avoid use or contact with any products that contain alcohol.
- Wear a medical alert bracelet.
- Participate in a self-help program.
- Medication effects persist for 2 weeks following discontinuation of disulfiram.

❖ Reduction of Risk Potential

Medications for Depressive Disorder: Planning interventions for a client who has a Serotonin syndrome

- Serotonin syndrome can begin 2 to 72 hr after the start of treatment, and it can be lethal.
- Manifestations: Mental confusion, difficulty concentrating, Abdominal pain, Diarrhea, Agitation, fever, anxiety, hallucination, tremors, diaphoresis.
- Nursing actions: -- Start symptomatic treatment (medications to create serotonin receptor blockade and muscle rigidity, cooling blankets, anticonvulsants, artificial ventilation).
- Client education: Observe for manifestations. If any occur, withhold medication, and notify the provider.

❖ Health Promotion and Maintenance

Psychotic Disorder: Planning care for a client who has a Schizophrenia:

- Promote therapeutic communication to lower anxiety, decrease defensive patterns, and encourage participation in the milieu.
- Establish a trust relationship with the client.
- Use appropriate communication to address hallucinations and delusions.
- Promote self-care by modeling and teaching self-care activities within the mental health facility.
- Relate wellness to the elements of manifestation management.
- Provide teaching regarding medications.
- Whenever possible, incorporate family in all aspects of care.
- Collaborate with the client to use manifestation management techniques include such strategies as using music to distract from “voices,” attending activities, walking, talking to a trusted person when hallucinations are most bothersome.
- Do not argue with a client’s delusions but focus on the client’s feelings and possibly offer reasonable explanations.
- Be genuine and empathetic in all dealings with the client.

❖ Safety and Infection Control

Legal and Ethical issues: Use of restrains on school-age child:

- The nurse should never use restrain for
  - Convenience of the staff
  - Punishment of the client
  - Clients who are extremely physically or mentally unstable
  - Clients who cannot tolerate the decreased stimulation of a seclusion room
- Time limits for restraints are based upon the age of the client.
  - Age 18 years and older: 4 hr
  - Age 9 to 17 years 2 hr
  - Age 8 years and younger 1 hr
- The facility protocol should identify the nursing responsibilities, including how often the client should be
  - assessed including for safety and physical needs, and the client’s behavior documented
  - Offered food and fluids
  - Toileted
  - Monitored for vital signs
  - Monitor for pain
- Complete documentation every 15 to 30 min includes a description of the following:

- Medication administration
- Time released from restraints
- The time treatment began
- Alternative actions taken to avoid seclusion or restraints
- Precipitating events and behavior of the client prior to restraints
- The client's current behavior, what foods or fluids were offered and taken, needs provided for, and vital signs.

Bipolar disorders: Providing care to a client who is experiencing a manic episode:

Therapeutic Milieu

- Decrease stimulation without isolating the client if possible. Be aware of noise, music, television, and other clients, all of which can lead to an escalation of the client's behavior.
- Follow agency protocols for providing client protection if a threat of self-injury or injury to other exists.
- Implement frequent rest periods.
- Provide outlets for physical activity.
- Do not involve the client in activities that last a long time or that requires a high level of concentration.
- Protect client from poor judgement and impulsive behavior, such as giving money away and sexual indiscretions.

Communication:

- Use a calm, matter of fact, specific approach.
- Give concise explanations.
- Avoid power struggles, and do not react personally to the client's comment.
- Use therapeutic communications

Maintenance of self-care needs:

- Monitoring sleep, fluid intake, and nutrition.
- Supervising choice of clothes
- Giving step-by-step reminders for hygiene and dress

Legal and Ethical issues: Guidelines for the use of mechanical restraints

- Nurses must know and follow federal/state/facility policies that govern the use of restraints
- Use of seclusion rooms and/or restraints can be warranted and authorized for the clients in some cases.
- The provider must prescribe the seclusion or restraint in writing.

- If needed for seclusion or restraints continues the provider must reassess the client and rewrite the prescription, specifying the type of restraint, every 24 hour or the frequency of time specified by facility policy.

- The facility protocol should identify the nursing responsibilities, including how often the client should be
  - assessed including for safety and physical needs, and the client's behavior documented
  - Offered food and fluids
  - Monitored for vital signs
  - Monitor for pain
- Complete documentation every 15 to 30 min includes a description of the following:
  - Medication administration
  - Time released from restraints
  - The time treatment began

❖ Management of Care

Delegation and supervision: Delegating tasks to assistive personnel

Examples of task nurses may delegate to LPNs and APs

- Activities of daily living:
  - Bathing
  - Grooming
  - Dressing,
  - Toileting,
  - Ambulating
  - Feeding
  - Positioning
- Routine tasks:
  - Bed making,
  - Specimen collection,
  - Intake and output,
  - vital signs
- To LPNs:
  - Monitor findings,
  - reinforcing client teaching from a standard care plan,
  - Performing tracheostomy care,
  - Suctioning,
  - Checking NG tube patency,
  - Administering eternal feedings,
  - Inserting a urinary catheter

Legal and Ethical Issues: Informed Consent for Electroconvulsive Therapy

- Client also have various specific rights, including
  - Informed consent and the right to refuse treatment
  - Confidentiality
  - A written plan of care/treatment
  - Provision of adequate interpretive services if needed
  - Care provided with respect, dignity, and without discrimination
- Voluntary admission: The client or client's guardian chooses admission to a mental health facility in order to obtain treatment. This client is considered competent and so has the right to refuse medication and treatment.
- Client admitted under involuntary commitment are still considered competent and have the right to refuse treatment, including medication.
- The guardian can sign informed consent for the client. The guardian is expected to consider what the client would want if they were still competent.

Creating and Maintaining a Therapeutic and Safe Environment: Establishing a Therapeutic Nurse-client relationship

- Consistently focus on the client's ideas, experiences, and feelings.
- Identify and explore the client's needs and problem.
- Discuss problem-solving alternatives with the client.
- Help to develop the client's strengths and new coping skills.
- Encourage positive behavior change in the client.

Diverse Practice Settings: Referral to a health care Professional

- Nurses working in community care programs help to stabilize or improve clients mental functioning within a community. They can teach, support, and make referrals in order to promote positive social activities.
- Nursing interventions in community settings provide for primary treatment as well as primary, secondary, and tertiary prevention of mental illness.
- Team members in acute care include nurses, mental health technicians, psychologist, psychiatrics, other general health care providers, social workers, counselors, occupational and other specialty therapist, and pharmacists.
- The interprofessional team has the primary responsibility of planning and monitoring individualized treatment plans or clinical pathways of care, depending on the philosophy and policy of the facility.

Legal and Ethical Issues: Identifying ethical principles

- Clients who have a mental health disorder diagnosis or who are receiving acute care for mental health disorder are guaranteed the same civil rights as any other citizen.
- The right to humane treatment and care
- The right to vote
- The rights related to granting, forfeiture, or denial of driver's license
- The right to due process of law, including the right to press legal charges against another person

- Some legal issues regarding health care are decided on court using a specialized civil category called a tort.
- State laws can vary greatly. The nurse is responsible for knowing specific laws regarding client care within the state or states in which the nurse practices.

Creating and Maintaining a Therapeutic and safe Environment: Identifying Countertransference

- Countertransference occurs when a health care team member displaces characteristics od people in their past onto a client.
- *Behaviors:*
  - Nurse overly identifies with client
  - Nurse competes with client
  - Nurse argues with client
- *Example***:** A nurse can feel defensive and angry with a client for no apparent reason if the client reminds them of a friend who often elicited those feelings.
- *Nursing implications:* A nurse should be aware that clients who induce very strong personal feelings can become objects of countertransference.

Neurocognitive Disorders: Priority finding for a client who has an Alzheimer's disease:

- The onset is Gradual deterioration of function over months or years.
- Outcome is Irreversible and progressive
- Cognitive deficits are not related to another mental health disorder.
- Advanced age is the primary risk factor. Other causes include genetics, sedentary lifestyle, metabolic syndrome, and DM.
- Manifestations: Impairments in memory, judgement, speech, ability to recognize familiar objects and movement, impairments do not change throughout the day.
- LOC is usually unchanged

Suicide: Priority Nursing Assessment

- Assess the client's suicide plan
  - Does the client have a plan?
  - How lethal is the plan?
  - Can the client describe the plan exactly?
  - Does the client have access to the intended method?

- Has the client's mood changed? A sudden change in mood from sad and depressed to happy and peaceful can indicate a client's intention to commit suicide.

- Assess carefully for verbal and nonverbal clues. It is essential to ask the client if they are thinking of suicide. This will not give the client the idea to commit suicide.
- Assess for potential suicide risk using a standardized assessment tool, such as the SAD PERSONS scale.

❖ Psychosocial Integrity

Family and Community Violence: Risk Factors for Child Abuse 32

- The child is under 4 years of age.
- The perpetrator perceives the child as being different.
- The child is the result of an unwanted pregnancy, is physically disabled, or has some other trait that makes them particularly vulnerable.
- A history of being abused or neglected as a child
- Physical or mental illness, such as depression or post-traumatic stress disorder (PTSD)
- Family crisis or stress, including domestic violence and other marital conflicts, or single parenting
- A child in the family who is developmentally or physically disabled
- Financial stress, unemployment, or poverty
- Social or extended family isolation
- Poor understanding of child development and parenting skills
- Alcohol, drugs, or other substance abuse

Bipolar Disorders: Client indications of Acute Mania 14

- Increase in talking and activity
- Dislike of interference and intolerance of criticism
- Distractibility and decreased attention span
- Attention- seeking behavior: flashy dress and makeup
- Inappropriate behavior
- Denial of illness
- Possible presence of delusions and hallucinations
- Labile mood with euphoria
- Agitation and irritability
- Restlessness

Group and Family Therapy: Identifying Characteristics of a family who has rigid boundaries 8

- Rules and roles are completely inflexible
- These families tend to have members that isolate themselves and communication is minimal

- Members do not share thoughts and feelings.

Eating disorders: Planning Care for a Client who has Anorexia Nervosa 19

- Establish realistic goals for weight loss or gain
- Monitor the client's vital signs, intake and output, and weight
- Use behavioral contrasts to modify client's behaviors
- Decide for the client to attend individual, group, and family therapy to assist in resolving personal issues contributing to the eating disorder.
- Closely monitor the client during and after meals to prevent purging, which necessitate accompanying the client to the bathroom

Care of clients who are dying and/or Grieving: Assisting a Client with Grieving 27

- Educate the client and family on the stages and tasks associated with the grieving process.
- Use therapeutic communication. Name the emotion that the client is feeling
- Use silence and personal presence to facilitate mourning of feelings.
- Avoid communication that inhibits open expression of feelings.
- Encourage the client to use coping mechanisms that have worked in the past

Anxiety Disorders: Caring for a client During a Panic Attack 11

- Assist the client to identify defense mechanisms that interfere with recovery
- Use relaxation techniques with the client as needed for relief of pain, muscle tension, and feeling of anxiety
- Provide a structured interview to keep the client focused on the present
- Perform a suicide risk assessment
- Provide a safe environment for the clients and staff

Stress and defense Mechanism: Evaluating Constructive use of Defense Mechanism 4

- Individuals can use defense mechanisms as a way to manage conflict in response to anxiety
- Defense mechanisms are reversible, and the client can use them in either an adaptive or maladaptive manner
- Adaptive use of defense mechanisms helps people to achieve their goals in acceptable ways and reduce anxiety,
- Maladaptive use: defense mechanisms become maladaptive when they interfere with functioning, relationships, and orientation to reality and are used in excess.

Bipolar Disorders: Alterations in Mood 14

- Mood Disorders Questionnaire: A standardized tool that places mood progression on a continuum from hypomania to acute mania to delirious mania.
- Medications: Mood stabilizers – Lithium carbonate and Anticonvulsants
  - First generation antipsychotic medications: chlorpromazine and loxapine
  - Second generation: olanzapine, risperidone
  - Antidepressants: such as SSRI fluoxetine, used to manage a major depressive episode
- ECT can be used to moderate extreme manic behavior, especially when pharmacological therapy has not worked.

Psychotic Disorders: Identifying a Client's Delusions 15

- Alterations in thoughts are false fixed beliefs that cannot be corrected by reasoning and are usually bizarre.
- Ideas of reference: Misconstrues trivial events and attaches personal significance to them, such as believing that others, who are discussing the next meal, are talking about him
- Persecution: Feels singled out for harm by others, such as being hunted down by the FBI
- Somatic delusions: Believe that their body is changing in an unusual way, such as growing a third arm

Stress and defense Mechanism: Identifying Defense Mechanisms 4

- *Altruism:* Dealing with anxiety by reaching out to others
- *Sublimation:* Dealing with unacceptable feelings or impulses by unconsciously substituting acceptable forms of expression
- *Suppression*: Voluntarily denying unpleasant thoughts and feelings
- *Repression*: Repression is an unconscious defense mechanism employed by the ego to keep disturbing or threatening thoughts from becoming conscious
- *Regression*: Sudden use of childlike or primitive behaviors that do not correlate with the person's current development level
- *Displacement*: Displacement is the redirection of an impulse (usually aggression) onto a powerless substitute target. The target can be a person or an object that can serve as a symbolic substitute.
- *Reaction formation*: Unacceptable feelings or behaviors are controlled or kept out of awareness by overcompensating or demonstrating
- *Undoing*: Performing an act to make up for prior behavior
- *Rationalization*: Creating reasonable and acceptable explanation for unacceptable behavior
- *Dissociation*: A disruption in consciousness, memory, identity, or perception of the environment that results in compartmentalization of uncomfortable or unpleasant aspects of oneself
- *Denial*: Pretending the truth is not reality to manage unpleasant, anxiety-causing thoughts or feelings.
- *Compensation*: Emphasizing strengths to make up for weaknesses.

- *Identification*: Conscious or unconscious assumption of the characteristics of another individual or group
- *Intellectualization*: Separation and logical facts when analyzing or coping with a situation or event
- *Conversion*: Responding to stress through the unconscious development of physical manifestation not caused by a physical illness
- *Splitting*: Demonstrating an inability to reconcile negative and positive attributes of self or others into a cohesive image
- *Projection*: Attributing one's unacceptable thoughts and feelings onto another who does not have them.

Anxiety Disorders: Expected Findings of Posttraumatic Stress Disorder 11

- Re-experiencing the trauma through intrusive distressing recollections of the event, flashbacks, and nightmares.
- Emotional numbness and avoidance of places, people, and activities that are reminders of the trauma.
- Increased arousal such as difficulty sleeping and concentrating, feeling jumpy, and being easily irritated and angered.

Psychotic Disorders: Teaching About Relapse 15

- Develop social skills and friendships
- Participate in group work and psychoeducation
- Comply with the medication
- Provide teaching regarding medications

Substance Use and Addictive Disorders: Medication to Administer for Alcohol withdrawal 18

- *Diazepam:* Diazepam is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. Diazepam is sometimes used with other medications to treat seizures.
- *Carbamazepine*: Carbamazepine is an effective alternative to benzodiazepines for the outpatient treatment of alcoholic withdrawal symptoms. Carbamazepine appears to be particularly effective for patients in whom detoxification failed in the past.
- Naltrexone: is a pure opioid antagonist that suppresses the craving and pleasurable effects of alcohol.
- *Clonidine*
- *Chlordiazepoxide*
- *Phenobarbital*

Substance Use and Addictive Disorders: Heroin Withdrawal 18

- Effects of intoxication is slurred speech, impaired memory, pupillary changes --- decreased respiration which can cause of death
- Withdrawal is very unpleasant but not life-threatening

- Abstinence syndrome begins with sweating and rhinorrhea progressing to piloerection, tremors, and irritability followed by severe weakness, diarrhea, fever, insomnia, pupil dilation, nausea and vomiting
- Pain in muscles and bones and muscle spasms

Medications for substances use Disorders: Manifestations of Alcohol Withdrawal 26

- Manifestations usually starts within 4 to 12 hr of the last intake of alcohol and can continue 5 to 7 days
- Common manifestations include nausea, vomiting, tremors, restlessness, and inability to sleep, depressed mood or irritability, increased heart rate, blood pressure, respiratory rate, and temperature
- Alcohol withdrawal delirium can occur 2 to 3 days after cessation of alcohol. This is considered a medical emergency.

Medications for substances use Disorders: Teaching about Methadone 26

- Inform clients that the methadone dose must be slowly tapered to produce detoxification
- Inform the client that the medication must be administered from an approved treatment center.
- Encourage the client to participate in a 12-step program

Medications for substances use Disorders: Planning Care for a client Experiencing Acute Alcohol Withdrawal 26

- Obtain baseline vital signs
- Monitor vital signs and neurologic status on an ongoing basis
- Provide for seizure precautions
- Provide for the patient’s safety and comfort

Effective Communication: Reflective Communication 3

- Reflecting: Directs the focus back to the client for the client to examine his feelings.
- Patients often ask nurses for advice about what they should do about problems or in specific situations
- Nurses can ask patients what they think they should do, which encourages patients to be accountable for their own actions and helps them come up with solutions themselves.