

KINGSBOROUGH COMMUNITY COLLEGE
of
The City University of New York

Department of Nursing
Nursing 20 Nursing the Emotionally Ill
Credit Hours: 4crs. 14 hrs.
Prerequisite: Psy 32
Recommended: Soc 31; Eng 24

Course Syllabus: 2008 - 2009
(One-half semester)

Catalog Description:

Introduction to nursing care of clients who are experiencing difficult meeting psychosocial needs and, focuses on how emotional illness affects the needs of the individual and family in their efforts to adapt to stressors. Laboratory sessions are on campus as well as in hospitals or other health agencies.

Course Overview:

This course introduces the student to the nursing care of the client experiencing difficulty meeting psychosocial needs. The major topics are organized to show how emotional illness affects the needs of the individual and family in their efforts of adapting to stressors. Nursing process, man as holistic being, Maslow's hierarchy of needs and the health illness continuum provide the organizing structure of this course. Students are introduced to the principles of management of client groups. Classroom, instruction and laboratory sessions, at the college, in the community in selected health agencies are held weekly throughout the semester. The community and other health agency experiences are utilized to extend learning. Classroom instruction: 5 hours, weekly on-campus labs, and 8 hours of community and health agency laboratory.

Course Objectives: Upon completion of this course the student will:

1. integrate knowledge and skills from the biological, physical and behavioral sciences in caring for clients with psychosocial problems.	7. maintain legal and ethical standards when providing care for the client who has psychosocial problems.
2. demonstrate knowledge of the influence of culture on the delivery of nursing care with clients experiencing psychosocial disorders.	8. implement a therapeutic nurse-client relationship maintaining psychosocial safety.
3. analyze how developmental stage affects the ability of the individual to adapt psychologically.	9. explain the effects of psychotropic medication for clients who have various psychiatric disorders.
4. use critical thinking skills in the application of nursing process to assist the client who has psychosocial problems across the health continuum.	10. incorporate teaching and learning principles to promote psychosocial adaptation across the health continuum.
5. communicate therapeutically to assist clients in adapting to psychosocial needs.	11. identify available community support groups for clients who have chronic psychosocial disorders.
6. collaborate with the health team in providing care to clients who have psychosocial problems.	12. participate in leading a group involving several clients.

Topical Outline

Unit 1-Orientation to nursing care of the emotionally ill client

- 2-Assessment and management of the client who has a psychotic disorder
- 3-Assessment and management of the client who has a mood disorder
- 4-Assessment and management of the client who has a disorder of aggression
- 5-Assessment and management of the client who has an anxiety management disorder
- 6-Assessment and management of the client who has an addictive disorder
- 7-Assessment and management of the client who has an organic brain syndrome

Teaching Strategies

Lecture/Discussion
 Computer-assisted instruction/ on-campus labs
 Case Studies
 Role play
 Multimedia
 Pre and Post conference
 Health Agency experiences
 Community Experiences

Textbooks:

1. Textbooks required for course:

Nursing 20: Boyd MaryAnn (2008) Psychiatric Nursing: Contemporary Practice, 4th Edition, Lippincott, Philadelphia

2. Program Required texts:

Carpenito, L. (2006) Nursing Diagnosis Handbook, 11th Edition. Lippincott.

Abrams, A. C. (2007) Clinical Drug Therapy, 8th edition, Lippincott.

Dudek, Susan G (2006) Nutrition Handbook for Nursing Practice, 5th Edition, Philadelphia, Pa: J.B. Lippincott, 1997.

Thomas, Clayton L., editor. (2007) Taber's Cyclopedia Medical Dictionary, 19th edition. Philadelphia, Pa. F.A, Davis Company

3. Optional References:

Fortinash, K and Holoday-Worret (2006) Psychiatric Nursing Care Plans 4th Edition, Elsevier

Townsend, Mary (2008) Essentials of Psychiatric Mental Health Nursing, 4th Edition, F.A. Davis

Videbeck, Sheila (2008) Psychiatric Mental Health Nursing, 4th Edition, Lippincott

Hogan, MA & Smith, GB (2008) Mental Health Nursing: Reviews and Rationales 2nd edition Prentice Hall

Attendance

Complete participation in class is possible only when students are able to focus attention on the class, therefore entering class after it has begun is disrespectful to Faculty and classmates. Talking out of turn or exhibiting other disruptive behaviors is not tolerated and students will be asked to leave the classroom or lab. All pages, wireless phones, electronic games, radios, tape or CD players or other devices

that generate sound must be turned off when any member of the academic community enters a classroom. Cellular devices are allowed to be on in the classroom only if the owner is using the caller ID, voice messages or a vibrating battery/ universal clip mechanism. Members of the academic community must exit the classroom to make or receive calls.

More than 5 hours of lecture/ lab or more than one-half clinical agency experience day.

Attendance at the first on-campus day is **MANDATORY FOR ALL STUDENTS**.

Attendance at pre and post conferences for agency experiences is required.

Absence from pre or post conferences constitutes an absence

for that day 's experience. Students are not permitted to be absent from the last agency experience because of the importance of termination in a therapeutic relationship When a student is excessively absent, a grade of "W" or "WU" will be assigned as described in the college catalog

Malpractice Insurance - Health Clearance - CPR Certification:

Students are required to have malpractice insurance and health clearance and evidence of CPR certification prior to registration.

During the semester, any change in the student's health clearance (e.g. serious illness, accident, pregnancy, etc.) necessitates evaluation/ clearance by student health service. Student responsibility includes notification of the clinical instructor and course coordinator.

Health clearance must be maintained to continue course enrollment.

Evaluation:

Grades will be calculated according to college policy as follows:

A+ 98 - 100% A 95 - 97% A- 90 - 94

B+ 88 - 89% B 85 - 87% B- 80 - 84

C+ 78 - 79% C 75 - 77% C- 70 - 74

D+ 68 - 69% D 65 - 67% D- 60 - 64

F -59% and below

INC -Incomplete (counts as an F unless work is completed within six months)

WU -Withdrew Unofficially (counts as failure)

W -Withdrew without penalty

Nursing 20 Course Grades will be determined as described below:

60% quiz average (3 quizzes)

40% final examination

S/U clinical performance (a minimum process recording average of "C" is needed to obtain a grade of "S" for clinical performance)

S/U antipsychotic medication report

S/U substance abuse case study

Academic Integrity

The Department of Nursing adheres to the policy and procedures on academic integrity put forth by the City University of New York. For details, refer to KCC Nursing Handbook, KCC catalogue, and/or CUNY website.

Students are expected to take all exams on the scheduled dates. All makeup final exams will follow the college policy. Students who do not take an exam on the scheduled date are required to take a makeup. All makeup exams will be given at the end of the semester. Students who fail to take the scheduled makeup exam will receive a grade of zero for that test. All Students must use the Test taking strategies program located in M220 within the first two weeks of the course. All students are required to take the mandatory NLN Exam on the scheduled date. Failure to take the exam on the scheduled date will result in a grade of incomplete for the course.

Clinical Performance. Student performance in the clinical agency will be evaluated as Satisfactory or Unsatisfactory. Clinical agency performance that has been designated as Unsatisfactory at the end of the course will result in failure of the course. A minimum process recording average grade of “C” is required for a satisfactory clinical grade. Additional assignments include the antipsychotic medication report and a support group reaction report. Unsatisfactory Process Recordings/Nursing Care Plans can not be revised and resubmitted for grading. A conference with the instructor is required during the first three weeks of the semester, mid-semester, and at the end of the course at which time the student's progress in the course will be discussed. In addition, students may initiate a conference with the instructor at other times.

Process Recordings

Process recordings are due weekly. One only is to focus on the initial phase; 2-4 on the working phase; and one only on the termination phase of the nurse-client therapeutic relationship. Written assignments are to be turned in to the clinical instructor on the date they are due. A deduction of 5 points per day will be given for late assignments. Beyond five (5) days defeats the continuity of the learning process and these papers will receive a grade of “0”. Process Recording grade is computed based on the average grade of the 5-6 required process recordings. Additional assignments required include the anti-psychotic medication side effect analysis and a substance abuse case study to be discussed in clinical post-conference. A minimum average grade of 75 is required to receive a satisfactory

At the Clinical Instructor's discretion, a Process Recording/NCP based on a case study or a report of Day Hospital/Case Management, or alternative experiences may be required. This would be included in the clinical grade (PR) computation.

Clinical Agency Experience Requirements:

To fulfill the clinical agency experience requirements, the student will:

a. be on time for the scheduled pre-conference.

- b. have a written nursing care plan for the assigned client as designated.
 - c. have drug information for the assigned clients medication needs.
 - d. attend and participate in pre and post conferences.
 - e. attend a practice laboratory at the college when requested to do so by the clinical instructor.
- If these requirements are not met, the student may be requested to leave the clinical area, this being considered an absence.

Dress Requirements:

*ANY ATTIRE THAT MAY NEGATIVELY IMPACT A CLIENT'S PSYCHOPATHOLOGY is not permitted. (This specifically refers to clients who are paranoid and/or impulsive) Students are expected to dress appropriately in professional attire (no dungarees) in the clinical area (uniforms are not to be worn). **No short skirts; low cut tops; tight seductive clothing; jeans; tee shirts; sneakers; sweats. No attire/tinted glasses which cover the student's eyes and/or face is permitted.** If a student is sent home because of inappropriate attire, this will count as a clinical absence.*

In addition the following are required:

Students must present themselves as professional role models.

1. Current KCC photo ID must be worn.
2. Watch with second hand.
3. Subdued makeup and hair style.
4. No jewelry of any kind other than plain wedding band, no pointed ornaments in the hair.
5. Students may not carry cigarettes on the unit.
6. **STUDENTS MAY NOT BRING TAPE RECORDERS, BEEPERS, OR CELLULAR PHONES ON ANY OF THE PSYCHIATRIC CLINICAL SITES**

Drug Calculation Policy

Nursing 17 "Drug Calculations in Nursing is a pre or co requisite of Nursing 18 and a pre-requisite to all other nursing courses. Throughout the rest of the program, drug knowledge and skills will be integrated and tested in every nursing course.

CRITERIA FOR RETENTION IN THE NURSING PROGRAM

Effective Fall 2008

Criteria for retention in the Nursing Program mandates that students:

- a. Receive no grades below a C in any of the co-requisite courses;
- b. Earn a minimum a “C” grade in every required Nursing course with a clinical component;
- c. **Students who fail a clinical nursing course achieving a grade of not less than “C-” may apply to repeat the course one time only in the semester immediately following the failure. Repeating the course is subject to space availability.**
- d. *Students must submit an “Intent to Return to Nursing Courses Form” outlining what they thought caused them to be unsuccessful and include a plan for success that demonstrates significant changes in how they will approach the course when repeated.*
- e. A second earned grade of less than a “C” in any nursing course with a clinical component will result in dismissal from the Nursing program.

Nursing students who enter Nursing 17 and Nursing 18 for the first time **MUST** complete the Nursing Program within four years from the date of entry into the core nursing courses. Any student who has not attended nursing courses for two or more consecutive semesters cannot be readmitted into the Nursing Program unless qualifying examinations have been passed in sequential order in the courses previously completed. In accordance with the retention criteria of the Nursing Department, qualifying examinations may be repeated only once.

1993; revised 2003; revised 2008)

Unit I - Introduction to Psychiatric Nursing

**LEARNER OBJECTIVES CONTENT/LECTURE DISCUSSION RELATED LEARNER EXPERIENCES LABORATORY/
CLINICAL**

OBJECTIVES

<p><i>Upon completion of this unit The learner will:</i></p> <p>1. Identify course requirements</p> <p>2. Discuss/ review basic mental health concepts</p> <p>3. Identify adaptive responses for a client who has a psychiatric disorder.</p> <p>4. Describe the nursing assessment of a mentally ill client.</p> <p>5. Develop a plan of care for</p>	<p>1.1 Course Overview a. Review of syllabus b. Client assignments c. Agency policies d. Pre and post conferences</p> <p>2.1 Mental Health b. Definition c. Pathophysiology d. Etiological factors e. Classifications 1. DSM IV 2. NANDA 3. Persistent mental illness 4. Stress/ defense mechanisms 5. Community management of mental illness</p> <p>3.1 Related Factors: a. Age b. Genetics c. Homelessness d. Substance abuse/ M.I.C.A. e. Transcultural considerations</p> <p>4.1 Assessment a. Nursing history b. Mental Status exam c. Physical assessment d. Psychological Testing e. developmental assessment: Freud, Piaget, Erickson</p> <p>5.1 Planning</p>	<p><i>Required Readings:</i></p> <p>1. Nursing 20 Syllabus</p> <p>2. Review: Psy 11 and Psy 32 Nursing 17, 18, 21</p> <p>3. Boyd, MaryAnn (2008) Chapters 1,2, 3, 4,5,6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 33 Appendix A, B</p> <p>4 Abrams, Chapter 6</p> <p><i>Handout in class –</i> 1. Frisch, NC and Frisch, CE (2001)Electronic Chapter:<u>The Mental Status Exam</u></p> <p>2. Shea, Kathy (2006) Reframing: A Fresh outlook helps Patients Envision Positive Outcomes <u>2006 Pathways to Professional Development</u> www.nurseweek.com</p> <p><i>Recommended Resources</i></p> <p>1. Kaysen, S. (1996) <u>Girl Interrupted</u> Sage Publications</p> <p>2. Walker, Charles (1998) Homeless People and Mental Health <u>AJN</u> 11 (1-11).</p> <p>3. American Psychiatric Association (2002) <u>Diagnostic</u></p>	<p><i>On-Campus lab #1:</i> The student will:</p> <p>1. Describe the phases of a therapeutic relationship.</p> <p>2. Identify problems encountered in therapeutic relationships</p> <p>3. Describe therapeutic and non therapeutic techniques</p> <p>4. Role play establishing a contract with a client</p> <p>5. Practice completing a process recording.</p> <p>Clinical Agency objective</p>
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<p>clients with psychiatric disorders</p> <p>6. Implement a plan care for psychiatric clients</p> <p>7. Evaluate the plan of care.</p>	<p>a. Expected outcome criteria b. Health promotion activities c. Therapeutic interventions d. Legal/ethical implications of e e. HIPAA</p> <p>6.1 Independent activities a. Coping strategies b. Therapeutic communication</p> <p>6.2 Collaborative activities 1. Cognitive therapy 2. Group 3. Millieu 4. Behavior modification 5. Team concepts 6. Crisis intervention 7. Family therapy</p> <p>d. Referral/community resources e. Discharge planning 1. day hospital 2. long-term in-patient care 3. domicillary/ assisted living 4. case management</p> <p>7.1 Evaluation of outcome criteria 7.2 Revision of plan</p>	<p><u>and Statistical Manual of Mental Disorders IV-R</u> 4th edition revised, Washington, D.C. APA.</p> <p>4. www.cognitivetherapy.com</p> <p>5. www.group-psychotherapy.com</p> <p>6. www, nyc.gov/html.doh/support groups</p> <p>Learner activities: 1. Complete developmental worksheet on Blackboard 2. Complete defense mechanism worksheet on blackboard 3. Access internet sites on Blackboard 4. Answer reflective questions on Blackboard</p>	<p>The student will:</p> <p>a. Perform a nursing assessment on a psychiatric client b. Analyze assessment data c. Formulate all relevant nursing diagnoses (minimum 4) d. Prioritize nursing diagnoses e. Formulation plan to achieve client outcomes f. Implement the plan. g. evaluate client outcomes. h. Communicate & collaborate with client, family, and healthcare providers. i. Teach clients: 1. preventive health strategies 2 health maintenance a. Coping skills b. medication use c. lifestyle modifications.</p>
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Unit II - Assessment and management of the client who has a Psychotic disorder

Learner Objectives	Content/Lecture Discussion	Related Learner Experiences	Lab/ Clinical Objectives
<p><i>Upon the completion of this unit: The learner will:</i></p> <p>1. Defines psychotic disorders</p> <p>2. Identify adaptive responses for a client who has a psychotic disorder.</p> <p>3. Describe the nursing assessment of a client who has a psychotic disorders.</p> <p>4. Formulate actual and potential nursing diagnoses RT psychosis</p>	<p>1.1 Overview a. Definition 1.2 Pathophysiology 1.3 Etiological factors 1.4. Classifications 1. paranoid 2. disorganized 3. catatonic 4. undifferentiated 5. residual 1.5. Complications 1. water intoxication 2. neuroleptic malignant syndrome 3. extrapyramidal side effects 4. Agranulocytosis</p> <p>2.1 Related Factors: a. Age b. Support network c. GAF/ chronicity d. Transcultural considerations</p> <p>3.1 Assessment a. Nursing history b. Mental status exam 1. positive symptoms 2. negative symptoms c. Diagnostic tests/lab tests 1. neuroanatomical studies 2. psychological testing</p> <p>4.1 Nursing diagnoses a. Disturbed thought processes b. Disturbed sensory perception c. Decisional conflict</p>	<p>Required Readings:</p> <p>1. Boyd, MaryAnn (2008) Chapters 18, 19, 33 and pages 109-115 Appendix C, D & E</p> <p>2. Abrams, Chapter 9 and 12</p> <p>Recommended Resources</p> <p>1. Murphy, Kathryn (2005) <i>The separate Reality of Bipolar Disorder and Schizophrenia</i> <u>Nursing Made Incredibly Easy</u> 3 (3) 6-19</p> <p>2. Kennedy, M. etal (2000) <i>Symptom Self Management and Relapse in Schizophrenia</i> XIV (6) 266-275</p> <p>3. Kudzma, E. C. (1999) <i>Culturally Competent Drug Administration</i> <u>AJN</u> 99 (8) 46-5</p> <p>4. McCann, E. (2001) <i>Recent Developments in Psychosocial Interventions for People with Psychosis</i> <u>Issues in Mental Health Nursing</u> 22, 99-107</p> <p>4. www.docguide.com/schizophrenia</p>	<p><u>On-Campus lab #2:</u> The student will</p> <p>1. Perform a mental status exam using CAI. 2. Identify manifestations of paranoia. 3. Analyze data from case study and prioritize nursing diagnoses. 4. Describe measures to detect anti-psychotic medication side effects. 5. Develop a comprehensive plan of care for a paranoid client. 6. Identify teaching strategies for a chronic schizophrenic client.</p> <p><u>Clinical Agency objective</u> The student will:</p> <p>a. Perform a nursing assessment on a client who is psychotic. b. Analyze data c.. Formulate relevant nursing diagnoses for a psychotic client (minimum 4) d. Prioritize nursing diagnoses e. Formulation plan to achieve client outcomes for a psychotic client f. Implement the plan. g. Evaluate client outcomes. h. Communicate & collaborate with client, family, and</p>

<p>5. Develop a plan of care for a client who has a psychotic disorder.</p> <p>6. Implement a plan of care for a client who has psychotic disorder.</p> <p>7. Evaluate the plan of care.</p>	<p>d. Ineffective management of therapeutic regimen e. Impaired social interaction f. Impaired verbal communication g. Disturbed personal identity</p> <p>5.1 Planning a. Expected outcome criteria b. Health promotion activities c. Therapeutic interventions d. Legal/Ethical implications</p> <p>6.1 Independent activities a. Health promotion</p> <p>6.2 Collaborative activities a. Medications 1. traditional anti-psychotics 2. atypical anti-psychotics 3. anti-cholinergic/anti-Parkinson medications. b. Procedures/ treatments 1. Acute phase 2. Rehabilitation phase c. Referrals/community resources d. Discharge planning 1. day hospital 2. case management 3. long-term placement 4. domiciliary care e. Transcultural considerations</p> <p>7.1 Evaluation of outcomes 7.2 Revision of the plan</p>	<p>Learner Activities:</p> <p>1. Complete the anti-psychotic medication analysis of side effects on Blackboard</p> <p>2. LWW clinical simulations: Paranoid schizophrenia</p> <p>3. Case study: Paranoid schizophrenia</p> <p>4. Answer reflective questions on Blackboard</p>	<p>healthcare providers. i. Teach a psychotic client: 1. Preventative health strategies 2. Health maintenance a. Coping skills b. Medications c. Lifestyle modifications</p>
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Unit III - Assessment and management of the client who has a Mood disorder

Learner Objectives

Content/Lecture Discussion

Related Learner Experiences

Lab/ Clinical Objectives

<p>4. Formulate actual and potential nursing diagnosis for a client who has a mood disorder</p> <p>5. Develop a plan of care for a client experiencing a mood disorder.</p> <p>6. Implement a plan of care for a client experiencing a mood disorder.</p>	<p>4.1 Nursing Diagnoses</p> <ol style="list-style-type: none"> Risk for violence: self directed Hopelessness Powerlessness Chronic low self-esteem Social isolation Risk for suicide Risk for loneliness Dysfunctional grieving Ineffective management of therapeutic regimen <p>5.1 Planning</p> <ol style="list-style-type: none"> Expected outcome criteria Health promotion activities Therapeutic intervention Legal/ethical considerations Cultural considerations <p>6. Implementation</p> <p>6.1 Independent Activities</p> <ol style="list-style-type: none"> Health promotion <ol style="list-style-type: none"> physical/protective needs interpersonal relationships cognitive- behavioral therapy dietary restrictions <p>6.2 Collaborative Activities</p> <ol style="list-style-type: none"> Medications <ol style="list-style-type: none"> serotonin reuptake inhibitors (SRIs) tricyclic antidepressants atypical antidepressants monoamineoxidase inhibitors Mood Stabilizers: lithium, anti-convulsants antipsychotic medications 	<p>1.LWWMentalHealth simulations:</p> <ol style="list-style-type: none"> Suicidal client Depressed client Manic client <p>2. Case studies: on Blackboard:</p> <ol style="list-style-type: none"> Major depressive disorder Mania <p>3. Answer reflective questions on Blackboard</p>	<p>disorder:</p> <ol style="list-style-type: none"> Preventive Health strategies Health Maintenance <ol style="list-style-type: none"> dietary MAOIs medication use lifestyle modifications <p><u>On-Campus lab #4:</u> The student will</p> <ol style="list-style-type: none"> Identify manifestations of mania Analyze data from case study and prioritize nursing diagnoses Describe measures to detect mood stabilizer medication side effects Develop a comprehensive plan of care for a manic client.
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<p>7. Evaluate plan of care</p>	<p>7.Lithiumtoxicity b. Procedures/Treatments 1. Electroconvulsive therapy 2. cognitive-behavioral 3. group therapy 4. family therapy c. Discharge planning d. Referrals/community resources</p> <p>7. Evaluation 7.1 Evaluation of outcome criteria 7.2 Revision of plan</p>		
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<p>3. Assess the maladaptive responses of the client resulting in disorders of aggression.</p> <p>4. Identify nursing diagnoses for a client who has an aggressive disorder,.</p> <p>5. Develop a plan of care to meet the needs of an aggressive client.</p> <p>6. Implement a plan of care to meet the needs of an aggressive client.</p>	<p>disorders.</p> <ol style="list-style-type: none"> a. age b. gender c. culture d. environment e. support network <p>3.1 Assessment</p> <ol style="list-style-type: none"> a. Nursing history b. Physical assessment c. Diagnostic tests <p>4.1 Nursing Diagnoses</p> <ol style="list-style-type: none"> a. risk for other directed violence b. self mutilation c. ineffective coping. d. rape trauma syndrome e. compromised family coping f. ineffective sexuality patterns g. Ineffective role performance <p>5.1 Planning</p> <ol style="list-style-type: none"> a. expected outcome criteria b. health promotion activities c. therapeutic interventions d. legal/ethical considerations e. cultural considerations <p>6. Implementation</p> <p>6.1 Independent activities</p> <ol style="list-style-type: none"> a. Health promotion/teaching <ol style="list-style-type: none"> 1. Anger management strategies. 2. Behavior modification 3. Support groups 	<p>3. Answer reflective questions on Blackboard</p>	<p>care providers.</p> <ol style="list-style-type: none"> i. Teach clients: <ol style="list-style-type: none"> 1. Preventive health care strategies 2. Health maintenance <ol style="list-style-type: none"> a. dietary b. medications c. lifestyle modifications
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<p>7. Evaluate the plan of care</p>	<p>4. Follow-up care</p> <p>6.2 collaborative activities</p> <p>a. Medications</p> <ol style="list-style-type: none"> 1. Anti-psychotics 2. Anti-depressants 3. Anti-anxiety needs <p>b. Procedures/treatments</p> <ol style="list-style-type: none"> 1. Restraint 2. Seclusion 3. Behavioral management 4. Anger control <p>c. Referrals/community resources</p> <p>7. Evaluation</p> <p>7.1 Evaluation of outcome criteria</p> <p>7.2 Revision of plan</p>		
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Unit V- Assessment and management of the client who has anxiety management disorder

Learner Objectives	Content/Lecture Discussion	Related Learner Experiences	Lab/ Clinical Objectives
<p>Upon completion of this unit, the learner be able to will:</p> <p>1. Describe terms related to the anxiety disorders:</p> <p>1B. Discuss common behavior problems associated with anxiety</p> <p>2. Identify adaptive responses for a client experiencing an anxiety disorder.</p> <p>3. Describe the nursing assessment when caring for a</p>	<p>1. Content reflective of previously learned knowledge from psychology 11</p> <p>1.2 Overview</p> <p>a. Define anxiety</p> <p>b. Describe levels/stages of anxiety</p> <p>1.3. Classifications</p> <p>a. generalized anxiety disorder</p> <p>b. phobias</p> <p>c. obsessive-compulsive disorder</p> <p>d. panic disorder</p> <p>e. conversion disorder</p> <p>f. dissociative disorders</p> <p>g. psychosomatic illness</p> <p>h. hypochondriasis/somaticization disorders</p> <p>i. eating disorders: bulimia, anorexia nervosa.</p> <p>1.4 Etiological factors .</p> <p>a. genetic/biochemical</p> <p>b. psychological</p> <p>c. socio-cultural</p> <p>2.1 Factor affecting the development of an addiction disorder:</p> <p>a. Age</p> <p>b. Gender</p> <p>c. Culture</p> <p>d. Mental status</p> <p>e. Support network</p> <p>3.1 Assessment</p> <p>a. Nursing history</p>	<p>Required readings</p> <p>1. Boyd, MaryAnn (2008) <u>Psychiatric Nursing: Contemporary Practice</u>, 4th Ed. Lippincott Chapters 14, 21, 23, 24, 36, 37 Pages 123- 125</p> <p>2. Abrams, Chapter 8</p> <p>Videos shown in class:</p> <p>a. Panic Disorder</p> <p>b. Obsessive Compulsive Disorder</p> <p>c. Anorexia</p> <p>Recommended Resources</p> <p>1. Murphy, Kathryn (2005) Anxiety: When Is It Too Much <u>Nursing Made Incredibly Easy</u> 3 (5) 22-33</p> <p>2. Murphy, Kathryn (2007) The Skinny on Eating Disorders <u>Nursing Made Incredibly Easy</u> 5 (3) 40 - 49</p> <p>3. www.adaa.org</p> <p>Learner Activities:</p> <p>1. Case study: anorexia client on Blackboard</p> <p>2. Access internet site on Blackboard</p>	<p><u>On-Campus lab #6:</u></p> <p>The student will</p> <p>1 Identify manifestations of anorexia</p> <p>2. Analyze data from case study and prioritize nursing diagnoses</p> <p>3. Describe measures to prevent purging by an eating disorder client</p> <p>9. Develop a comprehensive plan of care for an anorexic client.</p> <p>10. Describe the use of cognitive therapy for an eating disorder client</p> <p><u>Clinical Laboratory</u></p> <p>The student will:</p> <p>a. Perform a nursing assessment on clients with manifestations of anxiety</p> <p>b. Analyze data</p> <p>c. Formulate nursing diagnoses related to anxiety disorders.</p> <p>d. Prioritize diagnoses.</p> <p>e. Formulate a plan to achieve client outcomes</p> <p>f. Implement the plan</p> <p>g. Evaluate client outcomes</p> <p>h. Communicate and collaborate with client, family, and health care providers</p> <p>i. Teach anxiety disorder clients:</p> <p>a. Prevention health strategies</p>

<p>client who has an anxiety disorder.</p> <p>4. Formulate actual and potential nursing diagnoses for a client who has an anxiety management disorder.</p> <p>5. Develop a plan of care to meet the needs of a client experiencing an anxiety disorder.</p> <p>6. Implement a plan of care to meet the needs of a client experiencing anxiety disorder.</p>	<p>b. Psychological history c. Diagnostic evaluations</p> <ol style="list-style-type: none"> 1. psychoanalysis 2. trait characteristics 3. adversity stimulus <p>4.1 Nursing Diagnoses</p> <ol style="list-style-type: none"> a. Anxiety b. Fear c. Defensive coping d. Post trauma syndrome e. Disturbed body image f. Impaired adjustment g. Imbalanced nutrition: less than body requirements h. Deficient fluid volume <p>5.1 Planning</p> <ol style="list-style-type: none"> a. Expected outcome criteria b. anxiety management strategies c. Adaptive coping mechanisms d. Therapeutic interventions <ol style="list-style-type: none"> 1. Treatment modalities: <ol style="list-style-type: none"> a. medications b. cognitive behavioral therapy c. systematic desensitization d. flooding e. relaxation; imagery f. behavioral contract g. Legal/ethical implications of care 6.1 Independent activities 6.2 Collaborative activities <ol style="list-style-type: none"> a. Medications <ol style="list-style-type: none"> 1. Anxiolytics 	<p>3. Answer reflective questions on Blackboard</p>	<p>b. Health maintenance</p> <ol style="list-style-type: none"> a. Dietary b. Medication use c. Lifestyle modifications
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<p>7. Evaluate of plan of care</p>	<p>2. Benzodiazepines 3. Antidepressants: b. Psychotherapies c. Referrals/community resources d. Discharge planning/community resources e. Transcultural considerations</p> <p>7.1 Evaluation of outcome criteria 7.2 Revision of plan.</p>		
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<p>addictive disorders.</p> <p>4. Formulate actual diagnoses for a client who has an addictive disorder</p> <p>5. Develop a plan of care for a client who has an addictive disorder.</p> <p>6. Implement a plan of care for a client who has an addictive disorder.</p>	<p>b. Physical c. behavioral assessment d. Diagnostic tests 1. serum levels 2. urine toxicology 3. hair analysis 4. liver function tests</p> <p>4.1 Nursing Diagnoses a. ineffective denial b. ineffective coping c. disturbed sensory perception d. altered role performance e. diversional activity deficit f. chronic low self esteem g. dysfunctional family processes:Alcoholism</p> <p>5.1 Planning: a. Expected outcome criteria b. Health promotion activities c. Therapeutic intervention d. Legal/Ethical considerations e. Cultural considerations</p> <p>6 Implementation 6.1 Independent activities a. Health promotion 1. H.A.L.T. 2. Support Groups 6.2 Collaborative activities a. Medication 1. Antagonists (Narcan; anti-lerium) 2. Detoxification protocols 3. Aversion therapy: antabuse naltrexone 4. Dopamine stimulatiors:</p>		
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<p>7. Evaluate the plan of care.</p>	<p>bromocriptine (parlodel), amantadine (symmetrol)</p> <p>5. Overdose management</p> <p>b. Procedure/Treatments</p> <p>1. detoxification</p> <p>2. Recovery –groups: counselor –led, peer</p> <p>c. Discharge Planning</p> <p>d. Referrals/community referrals</p> <p>7. Evaluation</p> <p>7.1Evaluation of outcome criteria</p> <p>7.2Revision of plan</p>		
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Unit VII- Assessment and management of the client who has addictive disorder

Learner Objectives	Content/Lecture Discussion	Related Learner Experiences	Lab/ Clinical Objectives
<p>Upon completion of this unit the learner will be able to:</p> <ol style="list-style-type: none"> 1. Define organic brain disorder (delirium) and organic brain syndrome (dementia). 2. Identify predisposing and/or causative factors. 3. Assess the maladaptive responses of the client who has an organic brain disorder and syndrome. 	<ol style="list-style-type: none"> 1.1 Overview <ol style="list-style-type: none"> a. Definition aging, cognition, delirium, dementia 1.2 Pathophysiology of delirium & dementia 1.3 Etiological factors: <ol style="list-style-type: none"> 1. cerebral atherosclerosis 2. hormonal imbalances 3. polypharmacy 4. alcoholism/substance abuse 5. trauma 6. infection/fever 7. AIDS 8. MS/Parkinson's 9. Alzheimer's 1.4 Complications <ol style="list-style-type: none"> 1. Injury 2. Caregivers stress 3. Institutional care 2.1 Factors related to delirium/dementia <ol style="list-style-type: none"> a. Age b. Genetic/biochemical c. Psychological d. Societal attitudes e. Cultural considerations 3.1 Assessment <ol style="list-style-type: none"> a. Physical b. Emotional c. Behavioral d. Social e. Cultural 	<p>Review aging issues presented in NUR 18, 21; PSY 11, 32</p> <p>Required Readings:</p> <ol style="list-style-type: none"> 1. Boyd, MaryAnn (2008) Chapters 30, 31, 32 2. Abrams, pp. 288 - 290. <p>Recommended Readings:</p> <ol style="list-style-type: none"> 1. Gray-Vickery (2005) What's Behind Acute Delirium <u>Nursing Made Incredibly Easy</u> 3 (1) 20- 29 2. Lynch, S.H. (1997) Elder Abuse: What to Look For, <p>Learner Activities:</p> <ol style="list-style-type: none"> 1. Answer reflective questions on Blackboard 	<p>Clinical Laboratory</p> <p>The student will:</p> <ol style="list-style-type: none"> a. Perform a nursing assessment on clients who have an OBD or OBS; identify capacities and limitations. b. Analyze data. c. Formulate nursing diagnoses d. Prioritize diagnoses e. Formulate a plan to achieve client outcomes f. Implement the plan. g. Evaluate client outcomes h. Communicate and collaborate with client, family, and healthcare providers i. Teach clients: <ol style="list-style-type: none"> 1. Preventive health strategies 2. Health maintenance <ol style="list-style-type: none"> a. dietary b. medication use c. lifestyle modifications j. Terminate with assigned client and record on process recording.

<p>4. Formulate actual and potential nursing diagnoses for a client who has an organic brain syndrome.</p>	<p>4.1 Nursing diagnoses: a. Acute confusion b. Chronic confusion c. Impaired memory d. Impaired environmental interpretation syndrome e. Caregiver role strain f. Wandering</p>		
<p>5. Develop a plan of care to meet the needs of a client who has an organic brain syndrome.</p>	<p>5.1 Planning a. Expected outcome criteria b. Therapeutic interventions c. Health promotion activities d. Legal/ethical implications of care</p>		
<p>6. Implement a plan of care to meet the needs of a client who has an organic brain syndrome.</p>	<p>6.1 Collaborative activities a. Procedures/treatments 1. physical needs 2. safety needs structured environment 3. socialization needs 4. self-esteem needs b. Medication therapy 1. antipsychotics 2. antidepressants c. Health teaching 1. physical/protective measures d. Discharge planning, follow up care e. Referrals/community resources (support groups, day programs) f. Transcultural considerations</p>		
<p>7. Evaluate the plan of care.</p>	<p>7.1 Evaluation of outcome criteria 7.2 Revision of plan</p>		

