EXAM 1 - ATI MH Ch. 1, 2, 3, 5, 6, 7, 8, 15, 17, 24, 27

Chapter 1 - Basic MH Nursing Concepts

Mental Status Examination (MSE)

- LOC
    - Alert - pt is able to fully respond, answer Qs spontaneously and appropriately
    - Lethargic - able to open eyes and respond but is drowsy and falls asleep readily
    - Stuporous - pt requires vigorous or painful stimuli (pinching a tendon or sternal rub) to elicit brief response. Might not be able to respond verbally.
    - Comatose - pt is unconscious, does not respond to painful stimuli
        - Abnormal posturing in comatose pt
            - DeCORticate rigidity - flexion and internal rotation
            - Decerebrate rigidity - neck and elbow extension wrist and finger flexion
- Behavior - assessment of voluntary and involuntary body movements and eye contact
    - **Mood** - provides info about emotion that pt is feeling
    - **Affect** - objective expression of mood (flat affect or lack of facial expression)
- Cognitive and intellectual abilities
    - Orietation - to person, place and time
    - Memory - recent and remote
        - **Immediate** - repeat a series of #s or list of objects
        - **Recent** - recall recent events (visitors from current day)
        - **Remote** - state a fact from their past that is verifiable (DOB, mothers Maiden name)
    - Assess Level of knowledge
    - Assess ability to calculate
    - Assess ability to think abstractly
    - Perform objective assessment of pts perception of illness
    - Assess pts judgement based on answer to a hypothetical Q
    - Assess pts rate and volume of speech and quality of their language.
        - Should be meaningful, articulate, and appropriate

Standard screening tools

- Mini-Mental State Exam (MMSE)
    - Used to objectively assess cognitive status of pt
    - Evaluates
        - Orientation to time and place
        - Attention span and ability to calculate
        - Registration and recalling objects
        - Language, incl. naming objects, following commands, and ability to write
- Pain Assessment - rating on FACES scale or #s, PAINAD (Pain assessment in advanced dementia) scale

Diagnostic and Statistical Manual of Mental Disorder 5th edition (DSM-5)

- Used by MH professional to diagnose MH disorders in pts following the standard criteria.

Therapeutic strategies in MH setting

- Counselling
    - Therapeutic communication
    - Problem solving
    - Crisis intervention
    - Stress management
- Milieu therapy
    - Orient pt to physical setting
    - Rules and boundaries of that setting
    - Safe environment
    - Assist pt to participate in activities
- Promo of self care activities
    - Offers assistance with self-care tasks
    - Allows time for pt to complete task
    - Incentives to promote self-care
- Psychobiological interventions
    - Admin meds
    - Teach pt/family about meds
    - Monitor adverse effects and pharmacological effectiveness
- Cognitive and behavioral therapies
    - Modeling
    - Operant conditioning
    - Systematic desensitization
- Health teaching
    - Teach social and coping skills
- Health promo and maintenance
    - Assist with cessation of smoking
    - Monitor other heath conditions
- Case management
    - Coordinate holistic care
        - Such as medical, MH, and social services

Chapter 2 - Legal and Ethical issues

MH pts are guaranteed to the same civil rights as any other citizen

- Right to humane Tx and care (medical and dental care)
- Right to vote
- Rights related to granting, forfeiture, or denial of a drivers license
- Right to due process of law
    - Including the right to press charges against another person

All pts (including MH pts) have various specific rights

- Informed consent and right to refuse Tx.

- Confidentiality
- Participation in the care plan and review of that plan
- Communication with people outside of the MH facility
- Interpreters
- Care provided with respect, dignity, and w/o discrimination
- Freedom from harm
    - Physical/pharmacological restraints, seclusion, and physical.mental abuse or neglect
- Psychiatric advanced directive
    - Includes Tx. preferences in event of involuntary admission to MH facility
- Least restrictive interventions needed to meet pts needs w/o allowing them to harm themselves or others

Beneficence- doing good
Autonomy- pt right to make own decisions
Justice- fair and equal treatment
Fidelity- loyalty and faithfulness, keeping promises
Veracity- honesty when dealing with pt

HIPAA

- Pt must provide written consent so the nurse can share information with people not involved in the Tx plan
- Specific MH issues where Healthcare professionals can break confidentiality
    - Include duty to warn and protect their parties
    - Reporting of child and vulnerable adult abuse

Types of admission to a MH facility

- Informal admission
    - Least restrictive form of admission
    - Pt does not pose a substantial threat to self or others
    - Free to leave at any time even AMA
- Voluntary admission
    - Pt or guardian chooses admission to a MH facility in order to obtain Tx
    - Pt considered competent
    - Has the right to refuse medication and Tx
    - Involuntary admission by a provider can be initiated if deemed necessary by physician
- temporary emergency admission
    - pt admitted for emergent MH care due to inability to make decisions about here
    - MH care provider **can** initiate admission and must be evaluated by care provider
    - Length of temporary admission varies by need and state law
        - Usually not to exceed 15 days
- Involuntary admission
    - pt enters the MH facility against their will for indefinite period of time
    - criteria include

        - presence of mental illness
        - danger to self or others
        - severe disability or inability to meet basic necessities such as food clothing shelter
        - required treatment but unable to seek it voluntarily related to impact of illness
    - requires two Physicians to certify that the pt condition requires commitment to MH facility
    - patient can request legal review at any time
    - limited to 60 days
        - Then legal and psychiatric review of admission is required
    - Pt is till considered competent and has right to refuse treatment including meds
- Long-term involuntary admission
    - similar to Temporary commitment but must be in implemented by the court
    - time varies but is usually 60-80 Days
        - sometimes there is no set release date

Seclusion and restraints

- least restrictive measures
    - verbal intervention
    - diversion of redirection
    - providing a column quiet environment
    - offering PRN meds
- should never be used for
    - Convenience of the staff
    - Punishment
    - mental or physical instability
    - pt that cannot tolerate the decrease stimulation of a seclusion room
- must occur in order to use to clean our strength
    - provider prescription in writing
    - set time limit
    - reassessment and rewriting of prescription if necessary
        - must specify type of restraint
- Nursing responsibilities
    - assess for safety and physical needs end document Behavior of pt
    - offer food and fluids
    - Toileted
    - Monitor VS
    - monitor pain
- documentation must occur every 15 to 30 minutes
    - must include events and Behavior leading to seclusion/restraint
    - alternate actions taken to avoid seclusion/ restraint
    - time treatment began
    - current behavior, foods and fluids offered and taken, needs provided for, and vital signs

    - medication administration
    - Time released from seclusion/restraint

Intentional torts - willful actions that damage a client's property or violate client rights

- More likely to occur in a MH setting due to increased likelihood of violence end behavior that can be challenging to facility staff
    - false imprisonment
    - Assault - threat
    - Battery - touching in a harmful or offensive way

unintentional torts - actions or inactions that cause unintended harm as a result of failing to meet one's duty of care in a personal or professional situation

- Negligence - failing to provide adequate care when one has an obligation to do so.
    - harm must occur to be held liable for negligence
- Malpractice - professional negligence

Chapter 3 - effective communication

<u>Basic levels of communication</u>

- Intrapersonal
    - Self-talk That takes place when an individual is thinking thoughts and not outwardly verbalizing them
- Interpersonal
    - Occurs one-on-one with another individual
- small group
    - Occurs between two or more people
- Public
    - occurs with in large groups of people

<u>verbal communication</u>

- Vocabulary
    - Use of medical jargon can decrease client understanding
- denotative/ connotative meaning
    - participants of communication must share meanings in words used
    - words that have multiple meanings can cause mass communication
- clarity/ brevity
    - shortest and simplest communication is usually most effective
- timing/ relevance
    - knowing when to communicate allows the receiver to be more attentive to the message
    - a patient in pain or distracted will have a difficult time understanding the message
- Pacing
    - rate of speech can communicate meaning
    - speaking too fast can give you the impression that the nurse does not have time for the patient

- Intonation
    - tone of voice can communicate feelings

nonverbal Communication (NVC)

- Assess the pts NVC for meaning being conveyed
- NVC can have more impact on the message compared to the verbal words

Essential components

- Time - some pts can require a longer period of time to respond to questions
- attending behaviors are active listening - he mentally available to your patient
- caring attitude
- Honesty
- Trust - demonstrate reliability
- Empathy
- non-judgmental attitude

Children

- simple straightforward language
- Be aware of your own nonverbal communication because children are more sensitive to it
- Enhance communication by being at the child's eye level
- Incorporate play into interactions
- Be aware o fpts level of development

Adolescents

- Determine how they perceive the MH Dx
- Does the Dx affect their relationship with peers?

older adults

- might require amplification
- minimize distractions, face them while speaking
- allow plenty of time to respond
- utilize family on best way to communicate if deficits are present

Effective communication skills and techniques

- Silence - allows time for meaningful reflection
- active listening
- Questions - allow nurse to obtain specific or additional information
    - **open ended questions** - facilitate spontaneous response is an interactive discussion
    - **closed-ended questions** - helpful if you sparingly during initial interaction to obtain specific data
    - **projective questions** - what if is used to assist in exploring feelings and gain a greater understanding of problems
    - **presupposition questions** - explores pts life goals or motivations by presenting a hypothetical situation where they no longer have the MH disorder
- clarifying techniques - used to determine if the message received was accurate

    - **Restating**- uses pts exact words
    - **Reflecting**- direct the focus back to the pt in order for them to examine their feelings
    - **Paraphrasing** - restates pts feelings and thoughts for them to confirm what has been communicated
    - **Exploring**- allows the nurse to gather more info regarding important topics mentioned by the pt
- offering General leads, broad opening statements- encourages pt to determine where the communication can start
- showing acceptance and recognition- acknowledges the nurses interest And non-judgmental attitude
- focusing- concentrates on what is important
- getting information- provides details that the pt might need for decision-making
- presenting reality- used to help the pt focus on what is actually happening and dispel delusions, hallucinations, or faulty beliefs
- summarizing- emphasizes important points and reviews what has been discussed
- offering self - demonstrates willingness to spend time with pt. shows nurse has genuine concern
- Touch- **if appropriate**, communicates caring and provides comfort

Chapter 5 - creating an maintaining a therapeutic and safe environment

<u>Milieu Therapy</u>

- Create an environment that is supportive therapeutic and safe.
    - also called Therapeutic Community for therapeutic environment
        - management of the milieu refers to management of the total environment in the MHU. provides the least amount of stress and promotes greatest benefit for pt
- GOAL: pt will learn the tools necessary to cope adaptively, interact more effectively and appropriately, and strengthen relationship skills.
- nurse is responsible for structuring and/or implementing aspects of the therapeutic milieu
- Characteristics of a therapeutic milieu
    - physical setting
        - clean and orderly
        - comfortable Furniture to promote interaction
        - solitary spaces for reading and thinking alone
        - color scheme and Design should be appropriate for age of pt
- Boundaries of the therapeutic relationship
    - must be established in order to maintain a safe and professional relationship
    - blurred boundaries occur if relationship begins to meet the needs of the nurse rather than the pt, or if the relationship becomes social rather than therapeutic
        - **social relationship** - primary purpose is for socialization/ friendship with a focus on the mutual needs of the individuals involved in the relationship

        - **therapeutic relationship** - primary purpose is to identify pts problems or needs and focus on assisting them in meeting resolving those issues.
        - **Transference**-pt views a member of the healthcare team as having characteristics of another person who has been significant to their personal life
        - **countertransferenc**e- Healthcare team member displaces characteristics of people in their past onto a pt
- activities within the therapeutic milieu
    - Community meetings -Interaction and communication between staff and pts
    - individual therapy - scheduled sessions with a MH provider to address specific MH concerns
        - Ex) depression
    - group therapy - scheduled sessions for group of pts to address comment MH tissues
        - Ex) Substance use disorder
    - psycho-educational groups- based on pts level of functioning and personal needs
        - Ex) adverse effects of meds
    - recreational activities - games and Community outings
        - Ex) volleyball, pool
    - unstructured, flexible time - opportunities for the nurse and other staff to observe pts as they interact spontaneously within the milieu
        - Ex) movies, library
- Phases and tasks of therapeutic relationship
    - Stage 1: Orientation
        - Nurse: state purpose, date of termination
        - Pt: understand the expectations
    - Stage 2: working
        - Nurse: encourage the pt to problem-solve & promote self-esteem
        - Pt: Explore, learn, and practice
    - Stage 3: termination
        - Nurse: summarize goals and achievements
        - Pt: Accept termination as final

Chapter 6 - Diverse Practice Settings

Acute care

- provides intensive treatment and supervision for pts with severe mental illness Who present a danger to self or others

forensic nursing

- sexual assault nurse Examiner (SANE)
- special training on sexual assault
- use scientific investigation to help victims of violence abuse and traumatic accidents

history of mental health in the US

- the concept of case management was introduced around 1970 to meet the individual needs of pts in the MH setting
- in 1999 mental illness was determined to be a disability with the Americans with Disabilities Act (ADA)
- manage Behavioral Healthcare organizations (MBHOs) we're later developed to coordinate care and limit stays in acute care facilities

factors that will affect the future of MH care

- ↑ in aging pop.
- ↑ in cultural diversity in US
- Expansion of Technology

Acute MH care settings

- Criteria:
    - Danger to self or others
    - Inability to meet own basic needs
    - Failure to meet expected outcomes of community based Tx
    - Dangerous decline in MH status
- GOALS:
    - Prevention of pt harming self or others
    - Stabilizing MH crisis
    - Return of pts who are severely ill to some type of community care

Levels of Prevention

- Primary
    - Promotes health and emphasizes efforts on preventing MH problems from occuring
- Secondary
    - Focuses on early detection (screening) of mental illness
- Tertiary
    - Focuses on rehab and prevention of furthur problems with pts who have previous Dx. Goal is to prevent furthur deterioration or complications.

Chapter 7 - psychoanalysis, psychotherapy, and behavioral therapies

Classical psychoanalysis - therapeutic process of assessing unconscious thoughts and feelings and resolving conflict

therapeutic tools

- free association - spontaneous, uncensored verbalization of whatever comes to a pts mind
- dream analysis and interpretation- urges and impulses of the unconscious mind played out through dreams
- defense mechanisms- used to reduce anxiety

psychotherapy- verbal therapist to client interaction, develop a trusting relationship to explore problems

- psychodynamic psychotherapy - focuses on pts present State rather than their early life tends to last longer than other treatments
- interpersonal psychotherapy - address is specific problems, improves interpersonal relationships communication row relationship and bereavement.
    - Goal: improve interpersonal and social functioning to reduce the psychiatric manifestations
- cognitive therapy - based on the cognitive model, focuses on thoughts and behaviors to solve current problems. treats depression anxiety eating disorders and other issues
- behavioral therapy- changing Behavior to treat key problems
    - Used to successfully treat phobias & substance use for Addictive disorders
- cognitive behavioral therapy- uses cognitive and behavioral approaches to assist with anxiety management
- dialectical behavioral therapy - cognitive behavioral therapy for pts with personality disorder and exhibit self injurious behavior
    - focuses on gradual Behavior changes and provides acceptance and validation

cognitive reframing - develop supportive ideas that replace negative self-talk

- priority restructuring
    - assist in identifying what requires priority
- Journal keeping
    - Helps pts right down stressful thoughts and has a positive effect on well-being
- assertiveness training
    - Teaches pts to express feelings and solve problems in a nonaggressive manner
- monitoring thoughts
    - Helps pts to be aware of negative thinking

Modeling - therapist or others serve as role models and the client imitates the modeling to improve Behavior

operant conditioning - client receives positive rewards for positive behavior

systemic desensitization - Planned Progressive or graduated exposure to anxiety-provoking stimuli in real life situations or by imagining events that cause anxiety. during exposure the client uses relaxation techniques to suppress anxiety response

aversion therapy- pairing of a maladaptive Behavior with a punishment or unpleasant stimuli to promote a change in Behavior

Meditation, guided imagery, diaphragmatic breathing, muscle relaxation, and biofeedback - control pain tension and anxiety

Flooding- exposing a client to a great deal of an undesirable stimuli to turn off the anxiety response

response prevention- preventing a client from performing a compulsive Behavior intent is that anxiety will diminish

thought stopping- teaching a client with negative thoughts or compulsions arise to say or shut up stop. goal overtime is for the client to use the command silently

validation therapy - used for neurocognitive disorders, communicating with a disoriented older adult and respecting invalidating their feelings.

Chapter 8 - Group and family therapy

Homogeneous group- all members share certain shows and characteristic

phases of group development

- orientation phase - Define the purpose and goals of the group
- working phase - promote problem-solving skills to facilitate behavioral changes
- termination phase - Mark's the end of group sessions and summarizes the work of the group

Types of families

- nuclear family - include children who reside with married parents
- single parent families - children who live with a single adult can be related or not related to children
- adoptive families - children to live with parents who have adopted them
- Blended families- children who live with one biological or adoptive parent and a non-related step parent who are married
- cohabitating families - children who live with one biological parent and a non-related adult who are cohabitating
- extended families - children living with one biological or adoptive parent and a related adult who is not their parent such as a grandparent aunt or uncle
- other families - include children living with related or non-related adults who are neither biological nor adoptive parents

Areas of functioning in families and family therapy

- Communication
    - Healthy Families- there are clear understandable messages between family members and each is encouraged to express individual feelings and thoughts
    - dysfunctional families- one or more of the members use unhealthy patterns such as
        - **Blaming** - used to shift Focus away from their own inadequacies
        - **Manipulating**- use dishonesty to support their own agendas
        - **Placating**- one member takes responsibility for problems to keep peace at all cost
        - **distracting**- insert irrelevant information during attempts at problem solving
        - **Generalizing**- members use overall descriptions when describing family and counters such as always or never
- Management
    - Healthy Families- adults in family agree on important issues
    - dysfunctional families- management is chaotic, child making management decisions at all times
- Boundaries
    - Healthy Families- they are distinguishable clear and understood by all
    - dysfunctional families

        - **Enmeshed boundaries** - individual rules are unclear
        - **rigid boundaries-** rules and roles are completely inflexible, some members isolate themselves and communication is minimal
- Socialization
    - healthy families- all members interact plan and adopt healthy ways of coping
    - dysfunctional families- children do not learn healthy socialization skills and have difficulty adapting
- emotional/ support
    - healthy Families- emotional needs are met most of the time. conflict and anger do not dominate
    - dysfunctional families- negative emotions predominant most of the time members are isolated and Afraid and do not show concern for each other.

- scapegoating- member of the family with little power is blamed for problems with in the family
- triangulation- a third party is drawn into the relationship with 2 members whose relationship is unstable
- multi-generational issues- these are emotional issues or themes within a family that continue for at least three generations (such as substance use or dictive disorders and divorce)

Chapter 15 - Psychotic Disorders

Types of disorders

- Schizophrenia - psychotic thinking or behavior present for at least 6 months. areas of functioning are significantly impaired
- Schizotypal personality disorder - impairments of personality functioning, but not as severe as schizophrenia
- delusional disorder- delusional thinking for at least one month.
- brief psychotic disorder- psychotic manifestations that last one day to one month in duration
- schizophrenia form disorder- manifestation similar to schizophrenia but duration is 1 to 6 months
- schizoaffective disorder- disorder meets the criteria for both schizophrenia and depressive or bipolar disorder
- substance-induced psychotic disorder- psychosis due to substance intoxication or withdraw. psychotic manifestations are more severe than typically expected
- psychotic or catatonic disorder not otherwise specified- exhibits psychotic features or bizarre behavior or a significant change in motor activity Behavior but does not meet criteria for diagnosis with another specific psychotic disorder

characteristic dimensions of psychotic disorders

- positive symptoms - things that are present but should not be
    - Hallucinations

    - Delusions
    - Alterations in Speech
    - bizarre behavior (walking backward constantly)
- Negative symptoms - things that should be there but are not, more difficult to treat them positive symptoms.
    - Affect- usually blunted or flat
        - facial expressions never change, narrow range of expression
    - Alogia - poverty of thought or speech
        - mumbling or vague responses are normal
    - Anergia - lack of energy
    - Anhedonia- lack of pleasure or joy
    - Avolition- lack of motivation and activities and hygiene
- cognitive findings - problems with thinking
    - disordered thinking
    - can't make decisions
    - no problem solving
    - can't concentrate
    - no memory
    - no abstract thinking
- affective findings - involve emotion
    - Hopeless
    - suicidal ideation
    - unstable/ rapidly changing mood

alterations in thought (DELUSIONS)

- false fixed beliefs that cannot be corrected by reasoning, usually Bizarre
    - ideas of reference
        - Misconstrues Trivial events
        - attaches personal significance to them
    - Persecution
        - feel singled out
    - Grandeur - believe they are a god
    - somatic delusions- believe body is changing an unusual way
        - growing a third arm
    - Jealousy - when there is no reason to be
    - being controlled - by an outside force
    - thought Broadcasting - thoughts heard by others
    - thought insertion- thoughts are being inserted in their mind
    - thought withdrawal- thoughts are being removed by an outside agency
    - religiosity- obsessed with religion
    - magical thinking- actions or thoughts are able to control a situation or affect others
        - wearing a hat that makes them invisible

alterations in speech

- associative looseness- inability to concentrate on a single thought
    - results and incoherent speech
- Neologisms- made up words
- Echolalia- repeat words spoken to them
- clang Association- rhyming with forceful tone
- word salad- jumbled words

alterations in perception

- hallucinations are sensory perceptions that do not have any apparent strong stimulus
    - Auditory
        - Command- VoiceInstructs them to perform an action to hurt themselves or others
    - Visual
    - Olfactory- smell
    - Gustatory - taste
    - Tactile

personal boundary difficulties

- disenfranchisement with one's own body Identity or perceptions
    - depersonalization- nonspecific feeling of losing identity
    - derealization- perception that environment has changed
    - illusions- misperceptions or misinterpretations of real experience

alterations in Behavior

- extreme agitation
    - pacing or rocking
- stereotyped behaviors
    - motor patterns that used to have meaning but now lack purpose
- automatic obedience
    - respond like a robot
- waxy flexibility
    - maintaining specific position for extended period of time
    - FROZEN STILL
- Stupor
    - motionless for long periods of time
    - COMA - LIKE
- Negativism
    - doing opposite of what is being requested
- Echopraxia
    - imitation of movements made by others
    - THINK ECHO - REPEATING
    - THINK ECHOLALIA (repeating spoken words)
- Catatonia
    - severe increase or decrease in movement
- motor retardation
    - severe slowing of movements
- impaired impulse control

    - Cant resist impulses
- gesturing or posturing
    - unusual or ideological expressions
- boundary impairment
    - can't see where one person's body ends and anothers begins

standardized screening tools

- abnormal involuntary movement scale (AIMS)
    - used to monitor involuntary movements end tardive dyskinesia
    - used for patients on anti-psychotic meds
- World Health Organization disability assessment schedule (WHODAS)
    - helps determine level of global functioning for patient

MEDICATIONS

First generation/Conventional antipsychotics

- Treat mainly positive psychotic symptoms
- examples include
    - Haloperidol
    - Loxapine
    - Chlorpromazine
    - Fluphenazine
- Monitor for EPS
- Anticholinergic effects
- Ortho Hypo

Second generation/Atypical antipsychotics

- Meds of choice for psychotic disorders
- treat positive and negative symptoms
- examples include
    - Risperidone
    - Olanzapine
    - Quetiapine
    - Ziprasidone
    - Clozapine
- Regular exercise
- Monitor weight
- Adverse effects
    - Agitation
    - Dizziness
    - sedation
    - sleep disruption
- Monitor WBC
    - Agranulocytosis

Third generation antipsychotics

- Treat positive and negative symptoms
- improve cognitive function
- example drug
    - Aripiprazole
- lower risk of EPS and TD
- lower risk for weight gain and anticholinergic effects

Antidepressants

- treat depression
- example drug
    - Paroxetine
- Temporary
- monitor for suicidal ideation
- do not stop abruptly

mood stabilizing agent and benzodiazepines

- treat anxiety
- treat positive and negative symptoms
- example drugs
    - Valproate
    - Lamotrigine
    - Lorazepam
- caution in older adults
- No alcohol or other substances
- sedate of effects

Chapter 17 - Neurocognitive Disorders

Neurocognitive disorders (NCD) include

- Delirium
    - short-term and reversible if treated rapidly
- mild neurocognitive disorder
    - may or may not progressed to Major disorder
- major disorder disorder (commonly known as dementia)
    - Progressive and irreversible
- neurocognitive disorder due to Alzheimer's disease
    - Neurodegenerative
    - gradual impairment of cognitive function
    - most common type of NCD
- neurocognitive disorder due to Parkinson's disease
- neurocognitive disorder due to Huntington's disease

Defense mechanisms

- Denial
- Confabulation- make up stories when questioned about events or activities they don't remember
- Preservation - avoid answering questions by repeating phrases or behavior

screening/ assessment tools

- confusion assessment method (CAM) - for delirium
- Neelon-champagne (NEECHAM) confusion scale - for delirium
- functional dementia scale- used 2 determine the extent of memory loss, mood changes, degree of danger to self and others, inability to perform self care
- brief interview for mental status (BIMS) - long-term care setting
- mini mental status exam (MMSE)
- functional assessment screening tool (FAST)
- Global deterioration scale
- blessed dementia scale - provides behavioral information based on information from a secondary source

Delirium

- rapid onset
- disorientation and confusion worse at night and early morning
- altered LOC
- four types
    - hyperactive with agitation and restlessness
    - hypoactive with apathy and quietness
    - mixed, combo of hyper and hypo
    - unclassified- doesn't fit into any of the above
- restlessness, anxiety, motor agitation, fluctuating moods are common
- rapid personality change
- hallucinations and delusions can be present
- unstable vital signs
- **medical emergency**
- Causes
    - Infection
    - Malnutrition
    - Depression
    - electrolyte imbalance
    - substance use (withdraw from pain medication after surgery)

Neurocognitive disorder (NCD)

- Gradual deterioration of function over months or years
- impaired memory speech judgment
- no change in LOC
- restlessness and agitation are common

- Sundowning
- personality changes gradual
- VS are stable
- Causes
    - cognitive deficits
    - Advanced age
    - genetic
    - sedentary lifestyle
    - metabolic syndrome
    - DM
- Subtypes
    - Alzheimer's disease
    - traumatic brain injury
    - Parkinson's disease
    - other disorders affecting the neurologic system
- Irreversible and Progressive

MEDICATIONS
Neurocognitive Disoders

- Cholinesterase inhibitor medications
    - Drugs
        - Donepezil
        - Rivastigmine
        - Galantamine
    - improve ability to perform self-care
    - slow deterioration of Alzheimer's disease in mild-to-moderate stages
    - adverse effects
        - GI effects
        - bradycardia, syncope
    - Contraindications
        - Asthma
        - obstructive pulmonary disorders
    - Interactions
        - NSAIDs cause GI bleeding
        - antihistamines, Tri cyclic antidepressants and conventional antipsychotics reduce therapeutic effect of donepezil
    - nurse admin
        - start low dose gradually increase
        - paper Med
        - Take it bedtime
        - Take Rivastigmine with food to reduce GI upset
- Memantine
    - drug used for moderate-to-severe stages of Alzheimer's disease
    - adverse effects

        - Dizziness
        - Headache
        - confusion
        - Constipation
- other meds include
    - SSRIs for depression
    - anti-anxiety agents for agitation
    - antipsychotics for hallucinations or delusions as a last resort

Chapter 24 - Meds for Psychotic Disorders

Goal of Tx
- Suppression of a cute episodes
- prevention of acute recurrence
- maintenance of highest level of functioning

First generation antipsychotics (Conventional)

therapeutic uses
- Tx acute and chronic psychotic disorders
- Schizophrenia
- Bipolar
- Tourette's
- agitation

Potencies
- Low
    - Low EPS
    - Moderate sedation
    - Low anticholinergic effects
- Medium
    - Moderate EPS
    - Moderate sedation
    - Low Anticholinergic effects
- High
    - High EPS
    - Low sedation
    - Low anticholinergic effects

Drugs
- Haloperidol, High potency
- Fluphenazine, High potency
- loxapine, medium potency
- Thiothixene, high potency
- Perphenazine, medium potency
- Trifluoperazine, High potency

Complications

- agranulocytosis
    - Monitor WBC
- Anticholinergic effects
- EPS
    - acute dystonia
        - severe tongue neck face and back spasms
        - treat with benztropine
    - Pseudoparkinsonism
        - Bradykinesia
        - rigidity, Shuffled gait, tremors
        - Drooling
        - treat with benztropine or trihexyphenidyl
    - Akathisia
        - inability to sit or stand still
        - continual pacing and agitation
        - manage with antiparkinsonian agents, beta blockers, lorazepam/ diazepam
            - suicidal ideations when severe
    - tardive dyskinesia
        - involuntary movements of the tongue, face, legs, arms, trunk
            - no reliable treatment for TD
    - neuroendocrine effects
        - Gynecomastia
        - weight gain
        - menstrual irregularities
        - Galactorrhea
            - Monitor weight
    - **neuroleptic malignant syndrome**
        - High fever, changes in BP, sweating, tachycardia, muscle rigidity, decrease LOC, coma
        - **MEDICAL EMERGENCY**
            - Administer dantrolene or bromocriptine to relax the muscles
- Ortho Hypo
- Sedation
- SZR
- Severe Dysrhythmias
    - Monitor ECG and potassium
- Sexual dysfunction
- Photosensitivity and contact dermatitis
- Hepatotoxic

Contraindications

- Parkinson's disease
- liver damage

- older adults with dementia

nurse admin

- AIMS
- Teach patient about delayed therapeutic effect
    - 2-4 weeks

Second and third generation antipsychotics (Atypical)

Drugs

- Risperidone
- Clozapine
- Ziprasidone
- Olanzapine
- Asenapine
- Aripiprazole

therapeutic use

- negative and positive symptoms of schizophrenia
- psychosis induced by leave it open therapy
- relief of psychotic manifestations
- impulse control disorder start

Complications

- metabolic syndrome
    - new onset of DM
    - Dislipidemia
    - greater risk of HTN
- anticholinergic effects
- agitation, dizzy, sedation, sleep disruption
- Mild EPS, tremor
- elevated prolactin levels
    - Monitor for galactorrhea, gynecomastia, amenorrhea
    - Notify provider
- sexual dysfunction

contraindications/ precautions

- Risperidone
    - Dementia
    - Infection
    - Alcohol
    - CVD
    - DM
    - SZR
- Clozapine
    - Risk of fatal agranulocytosis
    - Hypersalivation
- Olanzapine

    - must be monitored for 3 hours after Administration to monitor for adverse effects
- Ziprasidone
    - administer with food
    - Monitor ECG

nurse admin

- monitor for cheeking the meds

Chapter 27 - Care for clients who are dying and/or grieving

types of loss

- necessary loss - anticipated but intensely felt
    - moving to another state so Leaving your house
- actual loss - loss of a valued person or item
- perceived loss - defined by the client and not obvious to others
    - Loss of self esteem
- maturational Loss - do to developmental processes of life
    - Loss of youth
- situational loss - unanticipated loss caused by external event
    - Tornado

Grief

Kubler-Ross five stages of grief

- No one experiences grief the same, they could experience it in a different order and st different times
- DABDA
    - Denial
    - Anger
    - Bargaining
    - Depression
    - Acceptance

Bowlby: 4 stages of grief

- Numbness or protest
    - denial over reality of loss
    - feeling a shock
- Disequilibrium
    - focuses on the loss and has intense desire to regain what was lost
- disorganization and despair
    - feelings of hopelessness the impact ability to carry out ADLs
- Reorganization
    - acceptance of loss

Engel: 5 stages of grief

- shock and disbelief
- developing awareness
- Restitution

- resolution of loss
- Recovery

Worden: 4 tasks of mourning

- Task 1 - accepting the reality of loss
- Test 2 - processing pain of grief implementing coping mechanisms
- task 3 - adjusting to the world without the lost entity
- test 4 - finding an enduring connection with the lost while embarking on New Life

normal grief

- Uncomplicated
- feelings of anger, resentment, withdrawal, hopelessness, and guilt
- acceptance by 6 months after loss
- somatic manifestations include
    - chest pain
    - Palpitations
    - Nausea
    - sleep disturbances
    - Fatigue

anticipatory grief

- letting go of an object or person before the loss
- unconscious process of disengaging to prevent getting hurt

complicated grief

- delayed and does not improve
    - delayed or inhibited grief
        - remain in denial stage for extended period of time
        - inability to progress through the stages minor loss can trigger the grief response
    - distorted or exaggerated grief response
        - feelings and somatic manifestations on an exaggerated level
        - unable to perform ADLs
        - remain in Anger stage of grief end direct anger towards others
        - can develop clinical depression
    - chronic or prolonged grief
        - remain in denial stage of grief unable to accept reality of loss
        - inability to perform ADLs
    - disenfranchised grief
        - laws cannot be publicly shared or is not socially acceptable
            - suicide and abortion