

## 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
  - Orientation - 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 health 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 still considered competent and has right to refuse treatment including meds
- Long-term involuntary admission
  - similar to Temporary commitment but must be 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 or redirection
  - providing a calm 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 and 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 and 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

### Basic levels of communication

- 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

### verbal communication

- 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 - be 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 of pts 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

### Milieu Therapy

- 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
  - **countertransference**- 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 common 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 occurring
- Secondary
  - Focuses on early detection (screening) of mental illness
- Tertiary
  - Focuses on rehab and prevention of further problems with pts who have previous Dx. Goal is to prevent further 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.

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 than 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 another's begins

#### standardized screening tools

- abnormal involuntary movement scale (AIMS)
  - used to monitor involuntary movements and 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 (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 Disorders

- 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 acute 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 at 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
- Task 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