Adult CCRN/CCRN-E/CCRN-K Certification Review Course: Behavioral

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Disclosures

- Nothing to disclose
Behavioral Content

- Abuse/neglect
- Antisocial behaviors, aggression, violence
- Delirium and dementia
- Developmental delays
- Failure to thrive
- Mood disorders
- Depression
- Substance dependence
- Suicidal behavior

Psychosocial Assessment

- Acute care hospitalization is a potential crisis for patient and family
- Preexisting mental health diagnosis
- Undiagnosed mental health problems
- Prehospitalization coping skills
Psychosocial Assessment (cont)
- Anxiety level
- Scope of control/powerlessness
- Sources of support
- Family stress
- Cognitive level

Psychosocial Assessment (cont)
- Sleep deprivation
- Pain level
- Grief and loss
- Fear level

Psychosocial Assessment (cont)
- Attention level
- Ability to retain information
- Physical symptoms of mental stress
Review Questions

A. Hold a family meeting and demand that their behavior change at once
B. Call the nursing supervisor and have the patient transferred to another unit
C. Arrange to have a nursing care conference and discuss possible solutions
D. Put a note by the charge nurse station to always assign this patient to the float or PRN nurse

Question 1

The charge nurse is having trouble finding nurses who will accept responsibility for a "difficult" patient and family who have been on the unit for 2 months. Once the assignment is determined for the next shift, the next action of the nurse might be to:

A. Hold a family meeting and demand that their behavior change at once
B. Call the nursing supervisor and have the patient transferred to another unit
C. Arrange to have a nursing care conference and discuss possible solutions
D. Put a note by the charge nurse station to always assign this patient to the float or PRN nurse

Question 1—Rationale

The charge nurse is having trouble finding nurses who will accept responsibility for a "difficult" patient and family who have been on the unit for 2 months. Once the assignment is determined for the next shift, the next action of the nurse might be to:

C. Arrange to have a nursing care conference and discuss possible solutions—Communication, collaboration, and a consistent plan are what is needed. If this had been done earlier, the situation this shift might have been avoided
   • Hold a family meeting and demand that their behavior change at once—A family meeting is always a good idea. Communication is always good, but we cannot demand an adult do anything
   • Call the nursing supervisor and have the patient transferred to another unit—This is not a solution to the actual issue/problem
   • Put a note by the charge nurse station to always assign this patient to the float or PRN nurse—Continuity of care works best with behavioral or customer service issues
Delirium

“Characterized by rapid onset and fluctuating course, the symptoms of delirium include disturbances in consciousness and attention and changes in cognition, such as memory deficits or perceptual disturbances”

– American Psychiatric Association, Diagnostic and Statistical Manual–IV

Delirium (cont)

- Hallucinations, illusions, and delusions are not required
- Not psychosis
- Old names?
- Potentially avoidable
- Must be assessed on a regular basis

Dementia

- Gradual onset of memory impairment and cognitive disturbances
- Slow, steady decline in cognitive function
- Can be organic or metabolic in etiology, but typically not reversible and often not treatable
Delirium: Etiologies and Risk Factors

- All things in acute care
- History of...
- Medical history of
  - Renal and/or liver failure
  - CHF
  - HIV
  - Endocrine disorders

Delirium: Clinical Presentation

- Disorientation/confusion
- Decreased attention span and ability to focus
- Hyperactive type
  - Restless and agitated
  - Does not follow commands
  - Wide mood swings
  - Attempts to get out of bed

Delirium: Clinical Presentation (cont)

- Hypoactive type
- More common, worse outcome
  - Lethargy
  - Withdrawal
  - Decreased responsiveness
Delirium

- Prevention!
- Early identification of risk factors
- THINK
  - Toxic Situations (CHF, meds, organ failure)
  - Hypoxemia
  - Infection/Immobilization
  - Nonpharmacological interventions
  - K+ or Electrolyte problems

Delirium

- Prevention!
- Early identification of risk factors
- Accurate assessment
  - Delirium Rating Scale
  - Confusion Assessment Method – ICU
  - Richmond Agitation and Sedation Scale

Delirium: Treatment Options

- Treatment—modification of risks
- Review all medications
- Treat electrolyte and metabolic derangement
- Nonpharmacological
- Pharmacological
Mood Disorders

Behavioral Depression

An abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

Depression: Etiology and Risks

- Fear and anxiety related to illness
- Response to loss and/or grief and/or deprivation
- Diminished self-esteem
- Guilt—real or perceived
- Metabolic causes
- Sleep deprivation
Question 2

A 78-year-old, hearing-impaired patient was admitted to the telemetry unit for syncope 5 days ago. The nurse notices that the patient is confused off and on, appears more withdrawn, and is not interacting with visitors as much today. The most appropriate nursing action would be to:

A. Move the patient to a private room and limit visitors
B. Place the patient on the unit sleep protocol and review medication list
C. Keep the lights on in the room so he can see where he is at all times
D. Discuss with the physician the need for an antidepressant

Question 2—Rationale

A 78-year-old, hearing-impaired patient was admitted to the telemetry unit for syncope 5 days ago. The nurse notices that the patient is confused off and on, appears more withdrawn, and is not interacting with visitors as much today. The most appropriate nursing action would be to:

B. Place the patient on the unit sleep protocol and review medication list—The hospital environment and change in routine are the first things to consider as causes of delirium
   • Move the patient to a private room and limit visitors—The lack of stimulation might make the delirium worse
   • Keep the lights on in the room so he can see where he is at all times—Lighting can help with safety concerns, but might disrupt sleep even more
   • Discuss with the physician the need for an antidepressant—Before prescribing medications, a diagnosis should be made
Behavioral Health Issues: Nursing Priorities

- Identify and request mental health consultation
- Safe environment
- Identify and treat the cause
- Risk of injury?
- Orientation

Behavioral Health Issues: Nursing Priorities

- Assist with
  - Crisis management
  - Stress management
  - Coping skills
  - Social support

Behavioral Health Issues: Nursing Priorities

- Pharmacological management
- Education of patient/family/support system
- Discharge planning
Behavioral Review Questions

**Question 3**

A patient with a documented history of schizophrenia is admitted with diabetic ketoacidosis. A priority of the admission nurse would be to do all of the following, except:

A. Review all preadmission medications
B. Contact the patient’s counselor with the patient’s permission
C. Hold all psychiatric medications pending regulation of the blood glucose level
D. Ask the patient if he knows why he was admitted

**Question 3—Rationale**

A patient with a documented history of schizophrenia is admitted with diabetic ketoacidosis. A priority of the admission nurse would be to do all of the following, except:

C. Hold all psychiatric medications pending regulation of the blood glucose level—Medications should only be held when there is a clear benefit to doing so. Many of the psych meds have a long half-life, and holding them can affect the steady state
  * Review all preadmission medications—Should be done with all patients
  * Contact the patient’s counselor with the patient’s permission—Continuity of care is important with every admission, and always important with behavioral health issues
  * Ask the patient if he knows why he was admitted—Should be done with all admissions
Substance Abuse: Nursing Concerns

- Physical/mental dependence
- Withdraw symptoms
- Assessment of cause
- Current health
- Nutritional state

Substance Abuse: Nursing Concerns (cont)

- Tolerance/cross-tolerance
- Mental health issues
- Self-care postdischarge
- Patient education and adherence
- Addiction referral
- Community and social support
Question 4

Three days after undergoing elective hip replacement, a patient has HR 125, RR 36, BP 164/84; is diaphoretic; and has dilated pupils. He is anxious, denies pain, and appears to be having auditory hallucinations. Despite frequent reorientation from the nurse, the patient continues to try to climb out of bed. Which of the following orders might be appropriate?

A. Lorazepam (Ativan)  
B. Soft wrist restraints  
C. Methadone  
D. Leaving the TV or radio on in the room for background noise

Question 4—Rationale

Three days after undergoing elective hip replacement, a patient has HR 125, RR 36, BP 164/84; is diaphoretic; and has dilated pupils. He is anxious, denies pain, and appears to be having auditory hallucinations. Despite frequent reorientation from the nurse, the patient continues to try to climb out of bed. Which of the following orders might be appropriate?

A. Lorazepam (Ativan)—The timing and assessment indicate the patient might be in DTS. Of the four choices, prescribing a benzo would be the most appropriate  
   - Soft wrist restraints—Restraining this patient would be unsafe, and might even escalate the hallucinations  
   - Methadone—No indication for this medication at this point  
   - Leaving the TV or radio on in the room for background noise—Decreasing the stimulation would be preferred
Antisocial Behavior Aggression and Violence

Post-Traumatic Stress Disorder (PTSD)
- PTSD
- Post-Intensive Care Syndrome (PICS)
  - Physical
  - Cognitive
  - Mental Health

PTSD and PICS
- Risk Factors
- Clinical Presentation
  - Strong correlation between Delirium and PICS
  - Long Term Impact
  - Treatment/Prevention

Behavioral
Review Questions

Question 5

A nurse walks into the family waiting room and discovers a physical altercation between two visitors has just begun. The nurse should:

A. Get between the two individuals and tell them their behavior is inappropriate
B. Ask the largest man in the waiting room to break it up
C. Pull the fire alarm by the door
D. Call security

Question 5—Rationale

A nurse walks into the family waiting room and discovers a physical altercation between two visitors has just begun. The nurse should:

D. Call security—Think safety first, for yourself and everyone else. Our security colleagues are trained to handle these situations
  • Get between the two individuals and tell them their behavior is inappropriate—This would be unsafe
  • Ask the largest man in the waiting room to break it up—This would be unsafe
  • Pull the fire alarm by the door—Although this would bring many people to the location, it is not as appropriate as calling security
Suicidal Behavior

- ICU → Physical needs
- Counseling, psychotherapy when appropriate
- Not always obvious

Suicidal Behavior (cont)

- Elderly, chronically and terminally ill
- Family and support system—essential
- ETOH and drugs
- Hard for critical-care team
REFERENCES - Behavioral:


