MENTAL HEALTH NURSING · STUDY GUIDE

Exam 6 Study Guide

This guide covers chapters 11 and 12. First the disorders in which distress arrives wearing a body: the eating disorders with their cardiac, electrolyte and refeeding dangers, and the somatic symptom disorders, where the symptom is always real. Then the neurocognitive disorders: delirium as an emergency, dementia as a disease of an organ, behavior as communication, and the medications and care partners that come with them. Work one chapter at a time. Read the "what to know" paragraphs, study the tables, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts the thresholds in one place.

WHAT THIS GUIDE COVERS

- Chapter 11 · anorexia nervosa, bulimia nervosa, binge-eating disorder, ARFID and atypical anorexia; who gets missed; SCOFF and the first conversation; blind weights; what restriction and purging do; acid-base patterns; medical admission criteria; refeeding syndrome; meal support and post-meal observation; what to say; medications and delegation; somatic symptom disorder, illness anxiety, functional neurological symptom disorder, factitious disorder and malingering; the scheduled-visit model; red flags and SBAR.
- Chapter 12 · the six cognitive domains, major versus mild neurocognitive disorder, the three Ds, ageism and language, delirium subtypes and screening with CAM, 4AT and CAM-ICU, PINCH ME and DELIRIUM, anticholinergic burden and Beers, HELP prevention, dementia subtypes, reversible contributors, Mini-Cog, MoCA, MMSE, ADLs and IADLs, the GDS, responsive behaviors and DICE, validation, restraint law, delegation, cholinesterase inhibitors, memantine, anti-amyloid antibodies, the antipsychotic boxed warning, care partners and capacity.

CHAPTER 11

Eating Disorders and Somatic Symptom Disorders

Read it in full: **Chapter 11 in the textbook**. Practice it in the lab: **The Refeeding Bench** and **Presentation, Not Body Size**.

What to know

Anorexia nervosa: persistent restriction leading to significantly low weight for the person, intense fear of weight gain or behavior that blocks it, and disturbed experience of shape; restricting or binge-eating/purging type. **Bulimia nervosa**: recurrent binges with loss of control plus recurrent compensatory behavior, weight usually average or above. **Binge-eating disorder**: binges without regular compensation; the most common eating disorder. **ARFID**: restriction from sensory aversion, fear of choking or vomiting, or low interest, with no body image disturbance. **Atypical anorexia**: all anorexia criteria except low weight, and just as dangerous.

The stereotype misses most people. About one in three people with an eating disorder is male; all ethnic groups are affected, and Black and Hispanic patients are asked and referred less. People in larger bodies are congratulated into danger. Athletes may have relative energy deficiency in sport (amenorrhea, stress fractures, bradycardia misread as fitness). People with type 1 diabetes may omit insulin; ask about it with recurrent DKA. Say a person with anorexia nervosa, and chart behavior: "placed roll in napkin; said she felt panicked by the portion."

The **SCOFF** is five questions (Sick, Control, One stone, Fat, Food); two or more yes warrants assessment, and a negative screen does not close the question when bradycardia, amenorrhea or low potassium are present. Start with function ("a usual day of eating"), name behaviors plainly, and ask directly about suicide, a leading cause of death in anorexia. Use **blind weights**: facing away, in a gown, after voiding, same time each morning. Gain consent for each step of the exam; trauma rates are high.

Restriction is a shutdown, and the **heart kills**: heart rates in the 30s and 40s, low blood pressure, orthostasis, prolonged QT. Also hypothermia, lanugo, amenorrhea and low testosterone, bone loss that may not reverse, slow gut, starvation hepatitis, low counts, and rigid thinking that improves with food. Purging route sets the acid-base: **vomiting** gives hypochloremic, hypokalemic metabolic alkalosis; **laxatives** give a non-anion-gap metabolic acidosis with low potassium; diuretics give low potassium and alkalosis. Potassium below 3.0 with a long QT is an emergency. Signs: dental erosion, parotid swelling, Russell's sign. Ipecac damages the heart irreversibly.

Medical admission findings include heart rate below 40 (below 50 in a child), systolic below 90, orthostatic change above 20, QTc above 450 to 470 ms, potassium below 3.0, phosphate below 2.5, sodium below 125, glucose below 60, below about 75 percent of expected weight, temperature below 35.5 °C, and active suicidal intent. **Refeeding syndrome**: returning carbohydrate drives an insulin surge that pushes phosphate, potassium and magnesium into cells; **phosphate falls first**, and without it there is no ATP. Prevent it: identify high risk, **thiamine before calories**, start low on a written schedule, labs daily (twice daily in the first 72 hours), telemetry, daily weights. New confusion, breathlessness or edema in days one to three is hypophosphatemia until proven otherwise.

Meal support is an intervention: fixed times, a 30 minute meal and 15 minute snack window, staff at the table, no food or weight talk, a supplement rule decided before the meal, and no negotiation at the table. **Post-meal observation** lasts 30 to 60 minutes with bathrooms supervised. Restrictions are set at the least restrictive level and reviewed. Avoid appearance comments ("you look better"), numbers and threats; acknowledge the feeling, hold the plan, stay in the room. Family-based treatment is first line for adolescent anorexia; CBT-E for adult bulimia and binge-eating disorder. Bupropion is contraindicated with eating disorders and purging. Assistive personnel may sit at meals and record intake, not decide what happens after a refusal.

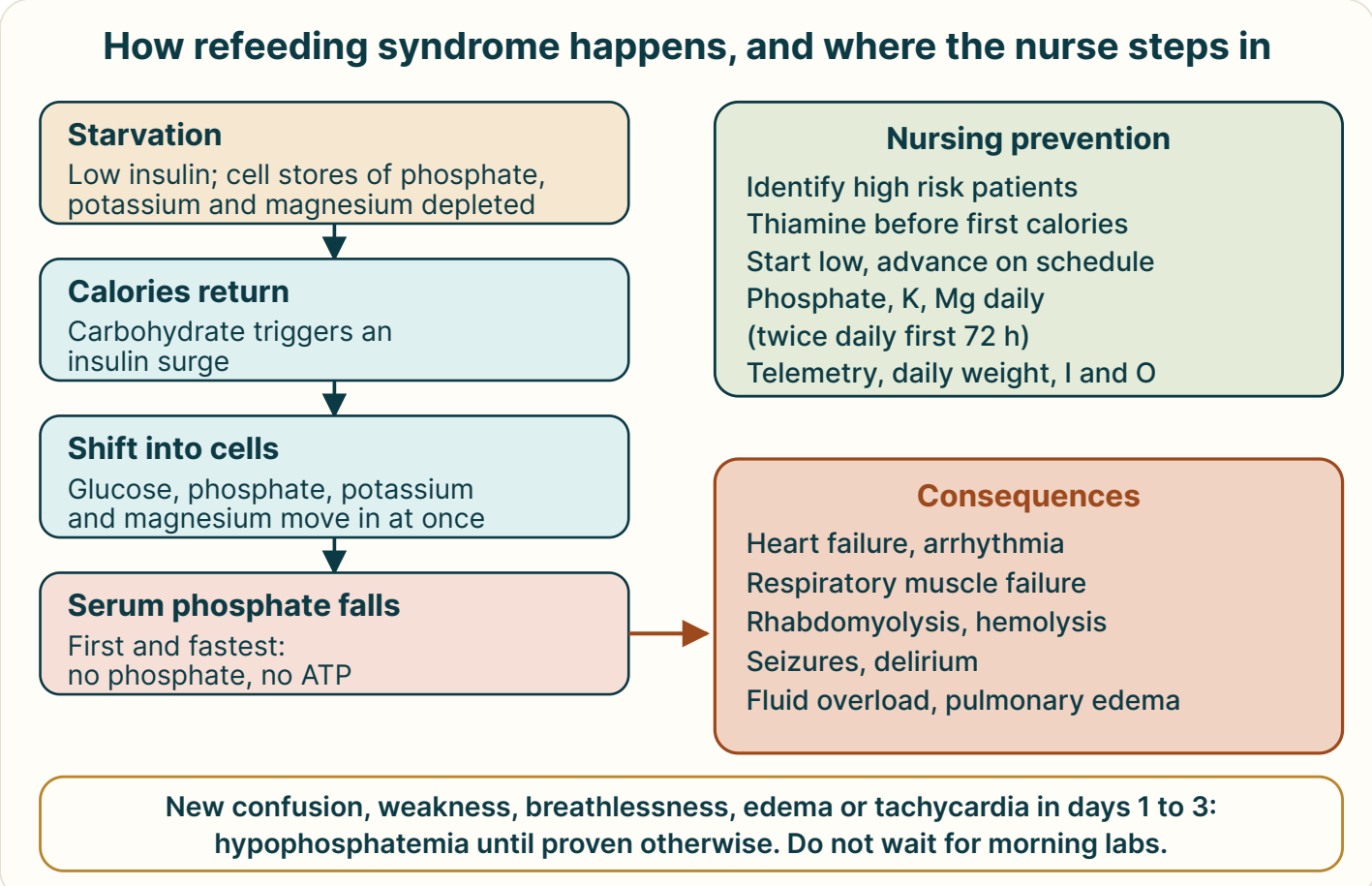
Somatic symptom disorder: distressing symptoms plus disproportionate thoughts, anxiety or time, usually over six months; the symptom may have a medical cause. **Illness anxiety disorder**: preoccupation with illness with mild or absent symptoms, with checking or avoidance. **Functional neurological symptom disorder**: real motor or sensory loss with positive signs such as **Hoover's sign**; it is not produced on purpose. **Factitious disorder** is intentional falsification without external reward; imposed on another, it is abuse and a mandatory report. **Malingering** is intentional for external gain, is not a mental disorder and is never a bedside diagnosis.

Never say "nothing is wrong"; say what dangerous cause was excluded and what the positive diagnosis is. Use the **scheduled-visit model**: one coordinating clinician, visits by the calendar not by symptoms, a brief real exam each time, and functional goals ("walk to the shop twice this week"). Order tests on objective findings, explain the reasoning, treat depression and anxiety, use CBT, and avoid opioids and benzodiazepines. Reassurance is a compulsion that works for twenty

minutes. A new or different symptom gets a full assessment: **diagnostic overshadowing kills**. New asymmetric weakness needs stroke excluded before anything is called functional.

LOCK THESE IN

- Diagnose by behavior, cognition and physiology, never by size; atypical anorexia is not milder.
- SCOFF 2 or more yes means assess; ask directly about suicide.
- Vomiting: hypokalemic metabolic alkalosis. Laxatives: non-anion-gap acidosis.
- Admission: HR under 40, SBP under 90, K under 3.0, phosphate under 2.5, temp under 35.5 °C.
- Refeeding: phosphate falls first; thiamine first; start low; labs daily.
- Empathy is unlimited; the meal plan is not negotiated at the table.
- Somatic disorders are diagnosed by what is present; the symptom is real.
- Every new symptom gets the same assessment as in anyone else.



Phosphate before calories. Refeeding kills through the insulin-driven shift of phosphate into cells. The second or third day of refeeding is often the most dangerous.

The eating disorders

Presentation	Core feature	Compensation	Body image	Weight
Anorexia nervosa	Restriction, fear of weight gain	In binge/purge type	Yes, central	Significantly low
Bulimia nervosa	Binges with loss of control	Yes, recurrent	Shape dominates self-worth	Average or above
Binge-eating disorder	Binges with distress	No	Varies	Any; often above average
ARFID	Sensory aversion, fear, low interest	No	No	Low, faltering growth
Atypical anorexia	All anorexia criteria but weight	May be present	Yes	Average or above after major loss

Medical admission thresholds in this chapter

Domain	Admit for
Cardiac	HR under 40 (under 50 child); SBP under 90; orthostatic change over 20; QTc over 450 to 470 ms; any arrhythmia
Metabolic	K under 3.0 mEq/L; phosphate under 2.5 mg/dL; low Mg; Na under 125 mEq/L; glucose under 60 mg/dL
Nutritional	Under about 75% of expected weight; rapid loss; acute food refusal
Temperature	Under 35.5 °C
Psychiatric	Active suicidal intent; cannot interrupt purging or exercise

Somatic symptom and related disorders

Disorder	Production	Motivation	Nursing emphasis
Somatic symptom disorder	Not intentional	Not applicable	Scheduled visits, function goals
Illness anxiety disorder	Not intentional	Not applicable	Reduce reassurance and checking
Functional neurological	Not intentional	Not applicable	Explain the positive diagnosis; physiotherapy
Factitious, on self	Intentional	Sick role, no external reward	Safety; team approach
Factitious, on another	Intentional	Sick role by proxy	Protect the victim; mandatory report
Malingering (not a disorder)	Intentional	External gain	Document observation only

Worked cases

WORKED CASE 1 · READING THE ELECTROLYTES

Two clients. Ms. Kerr vomits after most meals: K 2.8 mEq/L, chloride low, bicarbonate high. Mr. Dunn uses large amounts of stimulant laxatives: K 3.1 mEq/L, bicarbonate low, normal anion gap.

STEP 1 · MS. KERR

Vomiting loses hydrogen and chloride: **hypochloremic, hypokalemic metabolic alkalosis**.

STEP 2 · MR. DUNN

Laxatives lose bicarbonate-rich stool: **non-anion-gap metabolic acidosis** with low potassium.

STEP 3 · ACT ON THE NUMBER THAT KILLS

Ms. Kerr's potassium is below 3.0: telemetry, check the QTc, replace potassium and magnesium, escalate.

STEP 4 · ANTICIPATE

When Mr. Dunn stops laxatives, expect rebound edema and constipation; explain it so he does not restart.

LOOK FOR THE SIGNS

Dental erosion, parotid swelling, Russell's sign on the knuckles.

WORKED CASE 2 · DAY THREE OF REFEEDING

Mr. Ellis, 19, at 68 percent of expected weight, started refeeding with thiamine three days ago. Now: HR 118, RR 26, SpO2 91 percent, crackles, new edema, oriented to person only.

STEP 1 · RECOGNIZE

New confusion, breathlessness and edema on day three: **refeeding syndrome with hypophosphatemia and fluid overload** until proven otherwise.

STEP 2 · DO NOT WAIT

Do not wait for morning labs.

STEP 3 · SITUATION AND BACKGROUND

"Day 3 of refeeding for anorexia nervosa; admitted at 68 percent of expected weight; admission phosphate 2.9."

STEP 4 · ASSESSMENT

"HR 118, RR 26, SpO2 91 percent, crackles, edema, oriented to person only. This looks like refeeding syndrome."

STEP 5 · RECOMMENDATION

"See him now; urgent phosphate, magnesium, potassium, calcium and glucose, a 12-lead ECG, and hold the feed advance."

WORKED CASE 3 · AT THE TABLE

Ms. Sato, 16, stops halfway through lunch and says, "I cannot. I feel disgusting." There are twelve minutes left in the window.

STEP 1 · ACKNOWLEDGE

"I can see this is really hard right now."

STEP 2 · HOLD THE PLAN

"The meal stands, and I will sit here with you until the time is up."

STEP 3 · AVOID THE TRAPS

No threats about passes, no "you look great," no calorie numbers.

STEP 4 · FOLLOW THE PRE-AGREED RULE

If the meal is not finished in the window, the supplement replaces it as the team decided before the meal.

AFTER

Post-meal observation for 30 to 60 minutes with distraction and supervised bathrooms.

WORKED CASE 4 · A FUNCTIONAL DIAGNOSIS EXPLAINED

Mr. Ahmed, 39, has right leg weakness. Imaging is normal. Hoover's sign is positive. He asks, "So it is all in my head?"

STEP 1 · DO NOT DISMISS

Avoid "your scans are normal, nothing is wrong" and vague "it is stress."

STEP 2 · GIVE A MECHANISM

"It is in your nervous system. The wiring is intact, but the signaling for voluntary movement is disrupted. That is why the automatic movement works."

STEP 3 · GIVE A NAME AND A PATH

"It is called functional neurological disorder. It is real and common, and physiotherapy targets exactly this."

STEP 4 · CHART OBSERVATION

Describe the exam findings, never "faking."

SAFETY CHECK

New or asymmetric weakness needs stroke excluded before anything is called functional.

TRAPS PEOPLE FALL INTO

- **Judging risk by weight.** Atypical anorexia causes the same bradycardia and refeeding risk.
- **Calling bradycardia fitness.** A runner with HR 42, amenorrhea and weight loss is not fit.
- **Hanging dextrose before thiamine.** Thiamine before or with first calories.
- **Relaxing on day two or three of refeeding.** Often the most dangerous days.
- **Giving calorie numbers or appearance comments.** Both feed the illness.
- **Negotiating at the table.** Decide the rule before the meal; hold it warmly.
- **Saying "nothing is wrong."** Something is wrong: say what was excluded and what the diagnosis is.
- **Calling a patient a "frequent flyer."** A label, not a finding. Assess the new symptom fully.

Chapter 11 self-test · ten items

1. A 30-year-old lost 25 kg and now weighs in the average range. She restricts, fears gain and has a HR of 44. Which diagnosis fits?

A. Binge-eating disorder
B. Bulimia nervosa, nonpurging
C. ARFID with low interest
D. Atypical anorexia nervosa

D. Atypical anorexia nervosa All anorexia criteria are met except low weight. It is physiologically just as dangerous.

2. A child has eaten six foods since toddlerhood, has no body image concern, and is falling off the growth curve. What is this?

A. Anorexia nervosa, restricting type
B. Binge-eating disorder
C. Avoidant/restrictive food intake disorder
D. Other specified feeding or eating disorder

C. Avoidant/restrictive food intake disorder ARFID is restriction from sensory aversion, fear or low interest without body image disturbance.

3. Which lab pattern fits frequent self-induced vomiting?

A. Hyperkalemic metabolic acidosis
B. Hypokalemic metabolic alkalosis
C. High-anion-gap metabolic acidosis
D. Non-anion-gap metabolic acidosis

B. Hypokalemic metabolic alkalosis Vomiting loses hydrogen and chloride, causing hypochloremic, hypokalemic metabolic alkalosis.

4. Which finding alone meets a medical admission threshold in this chapter?

A. Serum potassium of 2.8 mEq/L
B. Temperature of 36.4 °C orally
C. Resting heart rate of 58 at night
D. Serum sodium of 133 mEq/L

A. Serum potassium of 2.8 mEq/L Potassium below 3.0 meets the threshold. The others are within the stated limits.

5. Which electrolyte falls first and fastest in refeeding syndrome?

A. Sodium
B. Phosphate
C. Chloride
D. Calcium

B. Phosphate Insulin drives phosphate into cells; without phosphate there is no ATP.

6. What must be given before or with the first calories in a high-risk refeeding patient?

A. Vitamin D
B. Folic acid
C. Thiamine
D. Iron

C. Thiamine Refeeding uses thiamine; giving it first prevents Wernicke encephalopathy.

7. A client says, "How many calories is this?" Which reply is best?

A. "No numbers; the dietitian built this plate for you."
B. "About 550, but you really should not worry about it."
C. "Why do you need to know the exact number today?"
D. "Enough to help you gain, so please eat all of it."

A. "No numbers; the dietitian built this plate for you." Numbers hand the illness a tool. Name the plan without argument.

8. A woman with rheumatoid arthritis spends hours a day researching her pain and fears it means disaster. Can she have somatic symptom disorder?

A. No; a medical cause rules it out at once
B. No; only unexplained symptoms can count
C. Yes, but only if she is faking her pain
D. Yes; the response defines it, not the cause

D. Yes; the response defines it, not the cause The diagnosis rests on disproportionate thoughts, anxiety or time, even when the symptom is medically explained.

9. A parent repeatedly induces illness in a child to assume the sick role. What is the nurse's duty?

A. Document "faking" and take no other action
B. Protect the child; make a mandatory report
C. Confront the parent alone at the bedside
D. Treat it as malingering and discharge them

B. Protect the child; make a mandatory report Factitious disorder imposed on another is abuse; the child is the victim and reporting is mandatory.

10. Which plan best fits a client with somatic symptom disorder?

A. A new scan each time the client feels worried
B. Visits only when new symptoms appear or worsen
C. Opioids and benzodiazepines given for comfort
D. Scheduled visits with one clinician; function goals

D. Scheduled visits with one clinician; function goals Calendar-based visits break the symptom-for-contact cycle; function goals are reachable.

CHAPTER 12

Neurocognitive Disorders: Delirium and Dementia

Read it in full: **Chapter 12 in the textbook**. Practice it in the lab: **Delirium: Score the CAM, Then Sweep for the Cause** and **The Three Ds Bench: Sorting Delirium, Dementia and Depression**.

What to know

DSM-5-TR uses **neurocognitive disorder**: decline in one or more of six domains (complex attention, executive function, learning and memory, language, perceptual-motor, social cognition). **Major** means the decline costs independence; **mild** means independence is kept with effort. Neither is diagnosed if the change occurs only during delirium. Dementia is not normal aging (slower but compensated) and not a loss of personhood; Kitwood's person-centered care preserves identity, comfort, attachment, occupation and inclusion. "A little confused" is not an assessment.

The **three Ds** are sorted by onset, course, attention and consciousness, not by confusion. **Delirium**: hours to days, fluctuating, worse at night, inattention is cardinal, consciousness altered, often reversible. **Dementia**: months to years, steady progression, attention preserved until late, consciousness clear. **Depression**: weeks, often datable, effortful "I do not know" answers, the person magnifies the deficit, highly treatable. They coexist: **any acute change in a person with dementia is delirium until proven otherwise**. Ageism kills: "she is 88 and gets like this" hides a UTI or hyponatremia.

Delirium is brain failure: about one in five medical inpatients, up to half after hip fracture surgery, most ventilated ICU patients, with high mortality. Subtypes: hyperactive (about a quarter), **hypoactive** (most common, worst prognosis, most missed, often charted "depressed" or "tired"), and mixed. It goes unrecognized in about two thirds of cases. Get the baseline from collateral. Screen with the **CAM** (1 and 2 and either 3 or 4), the **4AT** (4 or more suggests delirium) or **CAM-ICU with RASS**. Test attention with months backward. Screen at least every shift in at-risk people.

Delirium is a syndrome; find the causes, usually several. **PINCH ME**: Pain, Infection, Nutrition, Constipation, Hydration, Medication, Environment. **DELIRIUM** is the fuller list. Do the five-minute sweep: bladder scan, bowels, pain, SpO2, glucose, temperature, glasses and hearing aids, new drugs in 48 hours. High-risk drugs: anticholinergics (diphenhydramine, hydroxyzine, oxybutynin, tricyclics), benzodiazepines, opioids (meperidine), steroids, zolpidem, fluoroquinolones, H2 blockers. Total anticholinergic burden matters; use the Beers Criteria. About a third of delirium is preventable with the **HELP** bundle.

Treat the cause. Support with low stimulation, gentle reorientation (appropriate in delirium), family, glasses and hearing aids, mobility and fluids. **Restraint is not a treatment** for delirium. Antipsychotics are only for dangerous distress after non-drug measures fail; they do not treat or shorten delirium and are never for hypoactive delirium. Benzodiazepines worsen delirium except in alcohol or benzodiazepine withdrawal, NMS and catatonia.

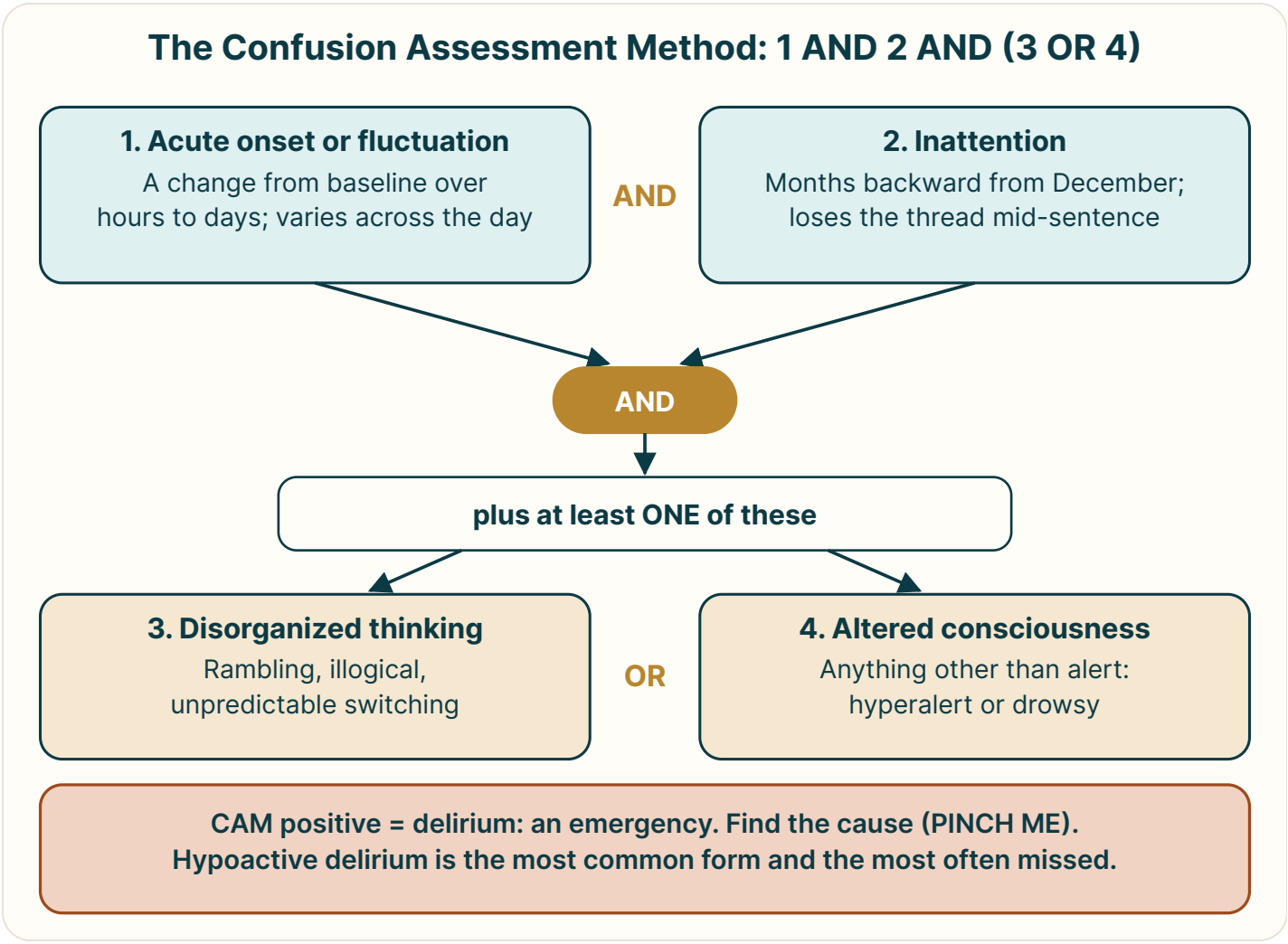
Subtypes change the nursing. **Alzheimer** (60 to 80 percent): plaques and tangles, cholinergic loss, recent memory first, then aphasia, apraxia, agnosia; emotional memory lasts. **Vascular**: stepwise drops, early executive and gait problems; treat blood pressure and other risks. **Lewy body**: fluctuating attention, well-formed visual hallucinations, REM sleep behavior disorder, parkinsonism, and **severe neuroleptic sensitivity**: avoid antipsychotics, never haloperidol; cholinesterase inhibitors help. **Frontotemporal**: onset 45 to 65, disinhibition, apathy, hyperorality, memory spared early. Exclude reversible contributors: B12, thyroid, neurosyphilis, normal pressure hydrocephalus (wet, wobbly, wacky), subdural hematoma, sleep apnea, depression, drugs, hearing loss.

Screens: **Mini-Cog** (three words plus clock), **MoCA** (out of 30, +1 for 12 or fewer years of school), **MMSE** (20 to 24 mild, 13 to 19 moderate, 12 or below severe). Function matters more: Katz ADLs and Lawton IADLs; medications and money fail first. The **GDS** runs from stage 1 to 7. Feeding tubes do not help in advanced dementia; careful hand feeding is the standard. **Responsive behaviors** communicate unmet needs: use **DICE** (Describe, Investigate, Create, Evaluate), suspect pain first (PAINAD, scheduled acetaminophen), then bladder and bowel. Approach from the front at eye level, one idea per sentence, wait, offer two choices, announce every touch. Do not quiz, argue or say "calm down"; validate the emotion and redirect. Never lie for compliance; do not force a truth that only re-traumatizes.

Cholinesterase inhibitors (donepezil, rivastigmine, galantamine): modest benefit; nausea, weight loss, vivid dreams, and **bradycardia**; check the apical pulse and hold under 60. **Memantine**: NMDA antagonist for moderate to severe Alzheimer disease; renal dosing. **Lecanemab and donanemab**: only for MCI or mild Alzheimer disease with confirmed amyloid; watch for **ARIA** (headache, confusion, visual change, gait change, seizure); APOE e4 homozygotes are at higher risk. **Antipsychotics carry a boxed warning** of increased mortality in dementia (about 1.6 to 1.7 times). Avoid routine benzodiazepines and diphenhydramine. A side rail raised to stop someone leaving bed is a restraint. Care partners are patients too; screen for abuse; capacity is decision-specific; plan driving, firearms and advance directives early. Suicide risk rises in the year after diagnosis.

LOCK THESE IN

- Delirium: hours to days, fluctuating, inattention, altered consciousness, reversible cause.
- Any acute change in dementia is delirium until proven otherwise.
- Hypoactive delirium is the most common and the most missed.
- CAM: 1 and 2, plus 3 or 4. Months backward tests attention.
- Sweep: bladder, bowels, pain, SpO2, glucose, temperature, glasses, hearing aids, new drugs.
- Lewy body: avoid antipsychotics, never haloperidol.
- Donepezil: check apical pulse; hold under 60.
- Behavior is communication; pain first; validate, do not argue.



Inattention is mandatory. Both features 1 and 2 must be present, plus 3 or 4. Test attention with months backward; orientation questions fail much later.

The three Ds

Feature	Delirium	Dementia	Depression
Onset	Hours to days, datable	Months to years, insidious	Weeks, often after a loss
Course	Fluctuates; worse at night	Progressive, stable across a day	Often worse in the morning
Attention	Impaired: cardinal sign	Preserved until late	Poor concentration but can engage
Consciousness	Altered	Clear until terminal	Clear
Memory testing	Fails through inattention	Recent memory first; may confabulate	"I do not know"; improves with cueing
Insight	Absent during episode	Often minimizes	Magnifies the deficit
First action	Find the cause: urgent	Function, safety, support	Mood and suicide risk; treat

Dementia subtypes and the nursing

Subtype	Signature	What changes
Alzheimer	Recent memory first; aphasia, apraxia, agnosia	Cue emotional and long-term memory; simplify
Vascular	Stepwise drops; focal signs; executive and gait	Blood pressure and risk teaching; falls
Lewy body	Fluctuation, visual hallucinations, RBD, parkinsonism	Avoid antipsychotics; cholinesterase inhibitors help
Frontotemporal	Age 45 to 65; disinhibition, hyperorality	Structure; supervise food and money
Parkinson disease dementia	Motor signs a year or more before cognition	Levodopa timing; same neuroleptic caution
Korsakoff	Amnesia with confabulation	Thiamine before glucose; do not challenge
NPH	Wet, wobbly, wacky	Potentially reversible: escalate

Worked cases

WORKED CASE 1 · WHICH D?

Mrs. Okafor, 82, two days after hip repair, was managing her own medications before admission. Today she is drowsy, cannot say the months backward past September, and was lucid at breakfast. She got oxybutynin and diphenhydramine overnight. T 38.2 °C, bladder scan 480 mL, no bowel movement in four days.

STEP 1 · ONSET AND COURSE

Acute, fluctuating, with a normal baseline: points to delirium.

STEP 2 · RUN THE CAM

1: acute and fluctuating, yes. 2: inattention, yes. 4: altered consciousness (drowsy), yes. **CAM positive**.

STEP 3 · NAME THE SUBTYPE

Drowsy and quiet: **hypoactive delirium**, the form most often missed.

STEP 4 · SWEEP FOR CAUSES

Fever (infection), urinary retention, constipation, and two anticholinergics.

STEP 5 · SBAR

"CAM positive delirium with fever, 480 mL retention and four days without a bowel movement after diphenhydramine and oxybutynin. Please see her now; I am asking for cultures, labs, in-and-out catheterization, scheduled analgesia, and stopping both anticholinergics."

WORKED CASE 2 · THE MAN IN THE CORNER

Mr. Hale, 76, with Lewy body dementia, says a man is standing in the corner. He is not frightened. The night nurse suggests PRN haloperidol.

STEP 1 · IDENTIFY THE SUBTYPE

Well-formed visual hallucinations are a core feature of Lewy body dementia.

STEP 2 · SEE THE DANGER

Severe neuroleptic sensitivity: haloperidol can cause rigidity, autonomic collapse and NMS.

STEP 3 · RESPOND

"I do not see him, but I believe you are seeing him. Does he frighten you?" Turn on a light to reduce shadows.

STEP 4 · ADVOCATE

Do not give haloperidol; tell the provider that cholinesterase inhibitors help hallucinations in this subtype.

IF DISTRESSING

Non-drug measures first; any medication decision goes to the provider with the subtype named.

WORKED CASE 3 · "I NEED TO GO HOME"

Mrs. Tolliver, 88, with moderate Alzheimer disease, says at 1600, "I need to go home. My mother is waiting." Her mother died in 1979.

STEP 1 · AVOID REORIENTATION

"Your mother passed away" delivers a fresh bereavement in moderate dementia.

STEP 2 · VALIDATE THE EMOTION

"You are missing your mother. Tell me about her."

STEP 3 · REDIRECT WITH MOVEMENT

Walk together toward the day room; offer a drink.

STEP 4 · PREVENT SUNDOWNING

Lights on before dusk, biggest meal at midday, calm late afternoon, consistent staff.

NEVER

Lie to gain compliance or build an elaborate false world.

WORKED CASE 4 · THE PULSE BEFORE DONEPEZIL

Mr. Grant, 79, takes donepezil. His apical pulse is 54. He felt dizzy this morning and nearly fell.

STEP 1 · APPLY THE RULE

Hold and notify the provider if the pulse is under 60.

STEP 2 · LINK THE EFFECT

Cholinergic excess causes bradycardia, heart block, syncope and falls.

STEP 3 · CHECK THE LIST

Look for anticholinergics such as oxybutynin that cancel the drug while adding side effects.

STEP 4 · TEACH

Report dizziness, fainting, weight loss, black stools.

ALSO

If vivid dreams disturb sleep, morning dosing may help.

TRAPS PEOPLE FALL INTO

- **Calling confusion normal aging.** Slowness is aging; loss of function is disease.
- **Charting "pleasantly confused."** It hides hypoactive delirium.
- **Relying on orientation questions.** Months backward detects inattention far earlier.
- **Restraining a person with delirium.** Restraint worsens agitation, injury and death.
- **Giving diphenhydramine for sleep.** A sedating anticholinergic that worsens delirium.
- **Haloperidol in Lewy body dementia.** Severe neuroleptic sensitivity can be fatal.
- **Quizzing: "Do you remember me?"** Each question is a test the person will fail.
- **Placing a feeding tube in advanced dementia.** It does not prolong life or prevent aspiration; hand feeding is the standard.

Chapter 12 self-test · ten items

1. What separates mild from major neurocognitive disorder?

A. Whether a brain scan shows any atrophy
B. Whether the person is older than 75 years
C. Whether memory is the first domain lost
D. Whether the decline costs independence

D. Whether the decline costs independence The line is functional: major disorder interferes with independence in everyday activities.

2. Which feature most clearly points to delirium rather than dementia?

A. Clear consciousness with poor recall
B. Inattention that fluctuates over hours
C. Trouble finding words in conversation
D. Slow decline in memory over two years

B. Inattention that fluctuates over hours Delirium is acute and fluctuating with inattention as its cardinal sign.

3. A quiet, drowsy older adult sleeps through meals two days after surgery. What should the nurse suspect first?

A. Major depression
B. New Alzheimer disease
C. Hypoactive delirium
D. Postoperative fatigue

C. Hypoactive delirium Hypoactive delirium is the most common form and the most often missed or called "tired."

4. Which CAM pattern is positive?

A. Acute onset, inattention and drowsiness
B. Inattention and drowsiness without change
C. Acute onset and disorganized thinking only
D. Disorganized thinking and drowsiness only

A. Acute onset, inattention and drowsiness CAM needs features 1 and 2 plus 3 or 4. Both 1 and 2 are mandatory.

5. Which medication on an older adult's list is most likely to worsen delirium?

A. Scheduled sertraline daily
B. Docusate twice each day
C. Diphenhydramine at bedtime
D. Acetaminophen every 6 hours

C. Diphenhydramine at bedtime Diphenhydramine is a sedating anticholinergic and a classic precipitant.

6. Which subtype is marked by severe neuroleptic sensitivity?

A. Vascular dementia, stepwise
B. Dementia with Lewy bodies
C. Early Alzheimer disease
D. Frontotemporal dementia

B. Dementia with Lewy bodies Antipsychotics can cause severe rigidity, autonomic collapse and NMS in Lewy body dementia.

7. A 58-year-old man has new disinhibition, sweet cravings and tactless remarks, with memory largely intact. Which subtype fits?

A. Vascular
B. Lewy body
C. Alzheimer disease
D. Frontotemporal

D. Frontotemporal Frontotemporal disorder starts younger, with behavioral change before memory loss.

8. A client with moderate dementia says, "My mother is waiting for me." What is the best reply?

A. "You miss your mother. Tell me about her."
B. "Your mother died many years ago, dear."
C. "She will be here soon, so wait in bed."
D. "Do you know what year it is right now?"

A. "You miss your mother. Tell me about her." Validate the emotion and redirect. Reorientation re-delivers grief; lying for compliance is not acceptable.

9. Mr. Park is due for his morning cholinesterase inhibitor. His apical pulse is 52 and he felt faint on standing. What does the nurse do?

A. Give the dose and recheck in one hour
B. Give half the dose with breakfast
C. Hold the dose and notify the provider
D. Give it with a glass of milk

C. Hold the dose and notify the provider Cholinesterase inhibitors cause bradycardia; hold and notify if under 60.

10. Which statement about antipsychotics in dementia is accurate?

A. They carry a boxed warning for higher mortality
B. They shorten delirium when given early
C. They are safe in Lewy body dementia at low doses
D. They are first-line for wandering and pacing

A. They carry a boxed warning for higher mortality Antipsychotics raise mortality in older adults with dementia-related psychosis and are a last resort.

ONE PAGE

Cram sheet

Everything from chapters 11 and 12 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
SCOFF	2 or more yes	One stone is about 6.35 kg
Admission: cardiac	HR under 40 (child under 50); SBP under 90; QTc over 450 to 470	Orthostatic change over 20
Admission: labs	K under 3.0; phosphate under 2.5; Na under 125; glucose under 60	Temperature under 35.5 °C
Weight	Under about 75% of expected	Rapid loss also counts
Refeeding labs	Daily; twice daily in first 72 h	Phosphate, K, Mg, Ca, glucose
Meal support	30 min meal; 15 min snack	Post-meal observation 30 to 60 min
Somatic symptom disorder	Typically more than 6 months	Symptom may be explained
Delirium	About 1 in 5 medical inpatients; up to half after hip surgery	Missed in about two thirds
4AT	4 or more suggests delirium	CAM-ICU uses RASS
MoCA	Out of 30; +1 for 12 or fewer years of school	More sensitive than MMSE
MMSE	20 to 24 mild; 13 to 19 moderate; 12 or below severe	Biased by education and language
Alzheimer share	60 to 80% of dementia	Frontotemporal onset 45 to 65
Donepezil	Hold if pulse under 60	Bradycardia, falls
Antipsychotics in dementia	Mortality about 1.6 to 1.7 times	Boxed warning

Mnemonics and models

Name	The parts
SCOFF	Sick, Control, One stone, Fat, Food
PINCH ME	Pain, Infection, Nutrition, Constipation, Hydration, Medication, Environment
CAM	1 and 2, plus 3 or 4
NPH	Wet, wobbly, wacky
DICE	Describe, Investigate, Create, Evaluate
HELP bundle	Orientation, mobility, sleep protocol, glasses and hearing aids, hydration and nutrition
Six domains	Attention, executive, memory, language, perceptual-motor, social cognition

Rules that keep people safe

Topic	The rule
Refeeding	Thiamine first; start low; labs daily; telemetry.
Meals	Rule decided before the meal; no negotiation at the table.
Somatic care	Never "nothing is wrong"; every new symptom is assessed.
Delirium	Treat the cause; no restraint; no benzodiazepines except withdrawal, NMS, catatonia.
Lewy body	No haloperidol.
Communication	Front, eye level, one idea, wait, two choices, announce touch.
Restraint	A raised side rail to stop leaving bed is a restraint.

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