Disclosures

- There is no conflict of interest or relevant financial interest by the faculty or planners of this activity.
- AACN does not endorse any commercial product related to this activity.
- The entire webinar and the program evaluation must be completed to earn contact hours.

APRN Initiative: Transitioning to Adult-Gerontology APRN Education

Part IV:
Strategies to Infuse Geropsychiatric Content Into Nursing Curricula

Geropsychiatric Nursing Collaborative

Cornelia Beck, PhD, RN, FAAN
Christine Williams, DNSc, PMHCNS-BC
Caroline Stephens, PhD, MSN, APRN, BC

Preparing Nursing’s Workforce for the Mental Health Needs of Older Adults

Cornelia Beck, PhD, RN, FAAN
Co-Director, Hartford Geropsychiatric Nursing Collaborative
Co-Director, Arkansas Hartford Center of Geriatric Nursing Excellence

Objectives of Presentation

- Provide an overview of the Geropsychiatric Nursing Collaborative and creation of geropsychiatric nursing competency enhancements.
- Present newly developed geropsychiatric nursing competency enhancements and how to locate linked curricular resources on POGOe.
- Review the general background and structure of an interactive, evolving case study as a learning resource.

Key Points

- One in five older Americans needs mental health services.
- There is a dearth of geriatric providers in any of the core mental health professions, including nursing.
- The Hartford Geropsychiatric Nursing Collaborative at the American Academy of Nursing is one initiative aimed at filling this gap.
- Enhancing geropsychiatric nursing preparation at all levels of nursing is an important strategy for the near term.

Geropsychiatric Nursing History

- 1970s: Blended subspecialty—Geropsychiatric Nursing emerged from Psychiatric Mental Health Nursing and Gerontological Nursing
- Advanced Practice Registered Nurses provide large share of mental health services to older adults; mental health preparation unknown
- 2004: National survey of geropsychiatric nursing education in graduate programs revealed few programs and little integration of didactic and clinical content
Definition of Geropsychiatric Nursing Practice

- Includes holistic support for and care of older adults and their families as they anticipate and/or experience developmental and cognitive challenges, mental health concerns and psychiatric/substance misuse disorders across a variety of health and mental health care settings.
- Is based on expert knowledge of normal age-related changes and common psychiatric, cognitive and co-morbid medical disorders in later life.
- Promotion of mental health and treatment of psychiatric/substance misuse and cognitive disorders emphasizes strengths and potentials; integrates biopsychosocial, functional, spiritual, cultural, economic and environmental factors, and addresses stressors that affect mental health of older adults and their families.

Background

- White Papers on education, science, and practice and a strategic plan for bridging the gaps published in JAPNA 12 (2,3), 2006.

2008: Formation of the Geropsychiatric Nursing Collaborative (GPNC)

- Three Hartford Centers of Geriatric Nursing with strength in Advanced Practice Geropsychiatric Nursing: Universities of Arkansas for Medical Sciences, Iowa, and Pennsylvania
- Leadership Team: Cornelia Beck, Kathleen Buckwalter, Lois Evans

Overall Aim

To improve the cognitive and mental health of older Americans

Goal

To improve the quality of mental health care provided to older adults by enhancing the knowledge and skills of nurses.
GPNC Objectives

• Create and include core geropsychiatric nursing competencies in all levels of nursing education programs.
• Review and disseminate teaching resources for inclusion of geropsychiatric nursing in entry level, advanced practice, and continuing education programs.

GPNC Objectives

• Strategic Decision:
  • Generate enhancements to existing competencies rather than imposing new sets.
  • Focus on three groups: Entry level, Advanced Practice Nurse generalists (adult, family, women, acute care), and Advanced Practice Nurse specialists (gero, psychiatric-mental health).

Methods

• Reviewed all existing competencies & mapped to gerontological competencies.
• Convened Core Competency Workgroup & National Advisory Panel and developed core competency enhancements.
• Enhanced awareness via national presentations & reports.

Methods

• Collected and reviewed curriculum materials from schools with gero/geropsych programs for match to key concepts.
• Held focus group with FNP, ANP, GNP, ACNP, WHNP, PMHNP faculties to explore case studies as a method for infusing GPN content.
• Identified, developed and disseminated curriculum materials.

Key Concepts

I. Assessment
   A. Normal aging: biopsychosocial theories
   B. Appropriate instruments/clinical evaluation tools
   C. Adapting assessment procedures
   D. Atypical presentations; Co-occurring Illness; Psychiatric manifestations: medical conditions
   E. Common disorders
   F. Comprehensive
   G. Stressors affecting mental health

Key Concepts

II. Management
   A. Care transitions
   B. Behavioral, environmental and pharmacological interventions and communication for behaviors
   C. Pharmacotherapeutics
   D. Referrals
   E. Influence: Decisional capacity, health literacy
   F. Patient/family/peer education: Mental and physical health interactions
   G. Ethical/legal and socioeconomic factors
Key Concepts

III. Approach to Older Adult
   A. Age-related adaptations
   B. Age/culturally appropriate interventions and communications
   C. Recognize personal & societal biases
   D. Sensitivity: end of life

Key Concepts

IV. Role
   A. Promotes safety and risk factor reduction
   B. Knowledge of geriatric mental health/illness
   C. Lifelong learning
   D. Policy/advocacy
   E. Research participation/utilization
   F. Quality improvement initiatives
   G. Interdisciplinary
   H. Delivery systems
   I. Service barriers

Webinar will continue with
- Christine Williams, DNSc, PMHCNS-BC from Florida Atlantic University
  - She will present information about the newly developed geriatric mental health nursing competency enhancements and how to locate linked curricular resources on POGOe.
- Caroline Stephens, PhD, MSN, APRN, BC from the University of California, San Francisco.
  - She will review the general background and structure of an interactive, evolving case study as a learning resource.

Objectives of Presentation

Present newly developed geropsychiatric nursing competency enhancements and how to locate linked curricular resources on POGOe.

Geropsychiatric Nursing Competency Enhancements

- Seven sets of competency enhancement statements:
  - Entry Level Nursing
  - Gerontological Clinical Nurse Specialist
  - Gerontological Nurse Practitioner
  - Psychiatric Mental Health Clinical Nurse Specialist
  - Psychiatric Mental Health Nurse Practitioner
  - Other Clinical Nurse Specialists who provide care to older adults
  - Other Nurse Practitioners who provide care to older adults.
• Twelve nursing and gerontological professional organizations have endorsed these enhancements
  • American Association of Neuroscience Nurses
  • American Psychiatric Nurses Association
  • American Society for Pain Management Nursing
  • Gerontologic Advanced Practice Nursing Association
  • Emergency Nurses Association
  • Hospice and Palliative Nurses Association
  • National Association Directors of Nursing Administration/Long Term Care
  • National Gerontologic Nursing Association
  • National Organization of Nurse Practitioner Faculties
  • National Student Nurses' Association
  • Oncology Nursing Society
  • Society for Vascular Nursing

Competyency Enhancements
• Successfully infused into revised competencies for:
  • Entry Level nursing
  • Adult-Gerontology Primary Care Nurse Practitioner and Clinical Nurse Specialist
  • Adult-Gerontology Acute Care Nurse Practitioner and Clinical Nurse Specialist

Infusion Currently Underway with National Organization of Nurse Practitioner Faculties (NONPF)
• Psychiatric Mental Health Nurse Practitioner
• Women’s Health Nurse Practitioner
• Family Health Nurse Practitioner

Competency Enhancements for Psychiatric Mental Health Clinical Nurse Specialists
• Organized within the existing domains of the organizing framework and Clinical Nurse Specialists Core Competencies developed by National Association of Clinical Nurses Specialists in 2008.
• Recommended 31 new statements

Enhancements for Psychiatric Mental Health Clinical Nurse Specialists
NEW (Sample)
Direct Care Competency: Conducts a comprehensive assessment that includes the differentiation of normal age changes from acute and chronic medical and psychiatric and substance misuse disease processes, with attention to commonly occurring atypical presentations & co-occurring health problems including cognitive impairment.
Nurse Practitioners

Competency Enhancements for Gerontological Nurse Practitioners
- Based on 2002 National Organization of Nurse Practitioner Faculty competencies.
- Recommended 27 new statements & selected enhancements to existing statements.
- These were later infused into the 2010 Adult/Gerontology Primary Care Nurse Practitioner Competencies and the Adult/Gerontology Acute Care Nurse Practitioner

Purpose of POGOe
- Provide resources to faculty to enhance course objectives, teaching strategies, learning content, and/or clinical experience by providing ready to use curricular materials.

Categories of products related to Key Concepts
- Websites
- Curriculum Materials

Applicable to:
- Entry level programs
- Advanced practice programs in psychiatric mental health nursing or adult-gerontology nursing
- Separate or stand alone geropsychiatric nursing courses
- Continuing education courses

Accessing Geropsychiatric Nursing Collaborative Materials Housed in Portal of Geriatric Online Education (POGOe)
Geropsychiatric Nursing Curriculum Enhancements on POGOe-

- Organized by Key Concept domains
  - Domain I Assessment
  - Domain II Management
  - Domain III Approach to Older Adults
  - Domain IV Role

Accessing POGOe

To Access:
- If not registered, go to www.POGOe.org, click on Register for free in upper right hand corner. There you can create a new account.
- Once you create account, you can access documents associated with a product for free.
POGOe Report: 8,279 views*

- Product 20660: Geropsychiatric Nursing Collaborative Competency Enhancements
- Top ranked product for the entire POGOe site

*As of November 15, 2011

Geropsychiatric Nursing Materials in POGOe

All Materials are located in the Product Library Series
“Geropsychiatric Nursing Curriculum Materials”
www.POGOe.org/series/Geropsychiatric-Nursing-Curriculum-Materials

Materials include:
- Curriculum Products and Resources
- Complete Set of Competency Enhancements (Product 20660)
- Nine Minute Video: Discover Mental Health: The Forgotten Piece in Elder Care (Product 20893)

Evolving Geropsych Case Studies as a Learning Resource

Caroline Stephens, PhD, MSN, APRN, BC
Assistant Adjunct Professor
Gerontological Nurse Practitioner
Geropsychiatric Advanced Practice Nurse
University of California, San Francisco

Objectives

- Review the general background and structure of an interactive, evolving case study as a learning resource
- Provide an overview of salient aspects of an evolving case study to illustrate how it can assist students in achieving geropsychiatric nursing competencies

Evolving Case Studies

- Modeled after the Geriatrics and the Advanced Practice Curriculum: A Series of Web-Based Interactive Case Studies (http://hartfordgn.org/education/geriatrics_and_the_advanced_practice_case_studies/)
- User-friendly way for APRN faculty to include necessary content
- Cases are web-based, interactive, and tutorial in format
Evaluating Acute Confusion: A CNS Perspective

Caroline Stephens, PhD, APRN, BC
Assistant Adjunct Professor
John A. Hartford Foundation Claire M. Fagin Fellow
VA Quality Scholar Postdoctoral Fellow
Geropsychiatric Advanced Practice Nurse
Gerontological Nurse Practitioner
University of California, San Francisco

At the completion of this case study, the student should be able to:

- Use a systematic approach to assess the multifactorial etiologies that can contribute to acute mental status changes (i.e., delirium) in older adults
- Understand how the under-recognition of delirium superimposed on dementia leads to potential deleterious outcomes for hospitalized older adults
- Describe evidence-based strategies for assessing, preventing and managing delirium in persons with dementia in the hospital setting
- Recognize the system challenges that impact the quality of care for hospitalized older adults and begin to develop potential solutions

Learner Outcomes

Required Reading

- See www.consultgeriRN.org and search:
  - “need help stat” for abrupt change in mental status
  - “evidenced-based geriatric topics” for dementia and depression

Mr. Perez

- You are being consulted by the Emergency Room (ER) nurse about Mr. Perez who is an 83 y/o married, Mexican-American male who presents with increased confusion x 3 days.
- He has a past medical history significant for hypertension (HTN), gastroesophageal reflux disease (GERD), hyperlipidemia, and osteoarthritis with no known drug allergies.
- He was brought in by police and his wife early this morning due to a severe mental status change, paranoia and very aggressive behavior.

- Mrs. Perez, his wife of 60 years, called the police at 3 AM this morning when she realized he had wandered away during the (middle of the) night.
- He was found at the neighborhood park incontinent of urine, disheveled, disoriented, and physically and verbally aggressive.
- When the police approached him, he cursed at them, threw a glass bottle into the street and tried to hit one of the police officers.
- He is currently in four point restraints on a gurney in the hallway and has been given lorazepam and haloperidol.
- The plan is to admit him to a medical bed, but there are currently none available.
Subjective Data from Nursing, Wife & Initial Chart Review

1. Probable delirium x 72 hours
2. Severe physical/verbal aggression & paranoia – 4 point restraints. Haloperidol 5mg & lorazepam 2mg both IM q4hr prn for agitation.
3. HTN – taking hydrochlorothiazide (HCTZ) 25mg daily. Denies headache, dizziness, chest pain, dyspnea, blurred vision, or dependent edema. Wife states it is difficult to get him to eat a low salt diet as he always wants her to cook traditional Mexican food.

3. GERD – taking cimetidine 400mg QID prn. Wife states he likes to eat spicy foods despite having heartburn or indigestion afterwards.
5. Osteoarthritis – Tylenol PM 1-2 tabs qhs prn. Rubs isopropyl alcohol on his knees BID-TID. Wife also admits that she gave him “some” of her hydrocodone/acetaminophen the past couple of nights because he wouldn’t go to sleep.

Question #1

- What other subjective information related to his acute confusion/delirium do you need to know – from patient/wife, nursing, and chart?

Answer #1 – From Patient/Wife

History of Cognitive/Psychiatric Status
- Is the confusion acute or chronic? What is his baseline cognitive function? Does he have a history of dementia? Has he had episodes of similar behavior in the past? If yes, what were the circumstances?

Answer #1 from Nursing

History of Cognitive/Psychiatric Status
- Rationale for assessment questions:
  - Persons with dementia are at high risk for developing delirium due to pre-existing brain damage
  - Delirium in an older adult with pre-existing dementia is commonly unrecognized and untreated leading to life-threatening complications
  - Persons with delirium superimposed on dementia are at greater risk for prolonged hospitalizations, further decline in cognitive and physical functioning, re-hospitalization, institutionalization and death
  - Prior episodes of delirium also increase the risk for future episodes as well as potential long term cognitive impairment

Key Restraint Status Assessment Parameters
- Why were restraints applied (e.g., specific behaviors, disruption of needed medical therapies, etc)?
- What other non-pharmacological strategies were used prior to both chemical and physical restraints?
- Is this the least restrictive restraint?
- Is there another means by which the intended effect can be achieved?
- Is the use of restraints in the patient’s best interest?
- Is there a plan in place for evaluating the ongoing need for and timely removal of the restraint?
Restraint Status Assessment Rationale & Resources

Restraints:
- are independently associated with the development of delirium;
- may exacerbate underlying restless/hyperactive behavior;
- may restrict patients to bedrest which can lead to physiological and functional decline; and
- further limit external stimuli which can further increase the risk for delirium.

http://consultgerirn.org/topics/physical_restraints/want_to_know_more

Answer #1 from Nursing

Medication review:
- How did he respond to the haloperidol & lorazepam? Did it make him worse or better?
  - Older adults can often have a paradoxical (opposite) reaction to lorazepam resulting in increased agitation.
  - Such high doses of lorazepam, although commonly used in younger patients, can cause increased confusion and over sedation in this older population.
  - Older adults, particularly those with a history of Lewy Body Dementia, can have severe side effects from neuroleptics, like haloperidol, often causing oversedation, drooling, rigidity, tardive dyskinesia (TD), extrapyramidal symptoms (EPS).

Answer #1 from Nursing

Based on the subjective data, what does your initial differential diagnosis for his delirium include? How would you classify his current delirium (e.g., hyper-, hypo-, mixed)? What are the possible etiologies?

For each diagnosis, provide a rationale for its inclusion.

Question #2

Based on the subjective data, what does your initial differential diagnosis for his delirium include? How would you classify his current delirium (e.g., hyper-, hypo-, mixed)? What are the possible etiologies?

For each diagnosis, provide a rationale for its inclusion.

Today’s visit from Mr. Perez

S: “Get those things!”

O: Mental status exam reveals:
- A frail, disheveled, older gentleman, mildly restless, lying on a gurney in 4 point restraints.
- He is lethargic, drooling, but easily arousable, oriented to person only.
- He is mostly disengaged, unable to focus his attention on the interview and appears easily distracted by things he sees on the ceiling (although nothing is present).
- He seems easily started by loud noises on the TV.
- Due to his disorganized thinking and incoherent speech, he is unable to describe what he is seeing on the ceiling although it appears to be distressing to him.
- Due to his impaired cognition, his mood state is not ascertainable, however his affect appears anxious due to the visual hallucinations and physical restraints.
- No overt auditory hallucinations or paranoia evident at this time. Insight & judgment are poor.
- No tardive dyskinesia (TD) or extrapyramidal symptoms (EPS).

Labs & Studies

- Glu 98 (normal: 60-110mg/dl)
- Na+ 135 (normal: 135-147mEq/L)
- K+ 4.2 (normal: 3.5-5.2mEq/L)
- Cl - 97 (normal: 95-107mEq/L)
- BUN 31 (normal: 7-20mg/dl)
- Cr 1.5 (normal: 0.5-1.4mg/dl)
- AST/ALT wnl (normal: <35IU/L)
- Hgb 11.5 (male normal: 13.5-16.5g/dl)
- Hct 36.6 (male normal: 41-50%)
- WBC 11.8 (normal: 4,500-10,000cells/mL)
- Plt 240 (normal: 100-450x106L)
- MCV 104.5 (normal: 80-100)
- B12 108 (normal: 200-900pg/mL)
- Folate 12 (normal: 2.7-17.0ng/mL)
- TSH 2.0 (normal: 0.25-4.30)
- RPR negative
- UA C&S small nitrites, mod. leukocyte esterase, mod. bacteria & WBCs. Culture pending.
- Urine toxicology positive for opiates, otherwise negative
- Head CT without contrast cortical atrophy with periventricular white matter changes; no acute findings
- CXR clear

Question #3

What is your assessment of Mr. Perez’s delirium and potential etiologies? Provide a rationale for your assessment.
### Indicator Delirium Dementia Depression

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Delirium</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychomotor changes</td>
<td>Y</td>
<td>N or N</td>
<td>Y or N</td>
</tr>
<tr>
<td>[hypo/hyperactive]</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Alternating/Fluctuating level of consciousness</td>
<td>Y</td>
<td>N or N</td>
<td>N</td>
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<tr>
<td>Acute Illness</td>
<td>Y</td>
<td>N or N</td>
<td>N</td>
</tr>
<tr>
<td>Confusion Assessment Method (CAM)</td>
<td>Y or N</td>
<td>N or N</td>
<td>N or N</td>
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<tr>
<td>MMSE</td>
<td>Y or N</td>
<td>N or N</td>
<td>N or N</td>
</tr>
<tr>
<td>Depression GDS-15</td>
<td>Y or N</td>
<td>N or N</td>
<td>N or N</td>
</tr>
<tr>
<td>Attention Span</td>
<td>Y or N</td>
<td>N or N</td>
<td>N or N</td>
</tr>
<tr>
<td>Change in Orientation</td>
<td>Y or N</td>
<td>N or N</td>
<td>N or N</td>
</tr>
</tbody>
</table>

Mental Health Toolkit (NCCN)

### Question #4

- What is your plan for this visit? Include all components and provide a rationale for your choices.

### Answer #4

- **Diagnostic**
  - No additional laboratory testing or studies are needed at this time

- **Therapeutic**
  - Speak with psychiatry & attending MD/Acute Care Nurse Practitioner (ACNP) re: reducing/discontinuing lorazepam & haloperidol and removing restraints due to high risk of side effects, exacerbation of delirium and safety concerns
  - See: “Avoiding Restraints in Older Adults with Dementia”
  - Obtain a constant 1:1 observation to maintain safety. In addition, engage the family to supplement/assist with this 1:1 surveillance in order to provide calm, familiar comfort and reassurance.
  - Discontinue cimetidine (alternatively use carafate or proton pump inhibitor (PPI) if needed), hydrocodone/acetaminophen, and Tylenol PM to reduce polypharmacy and anticholinergic load

### Referral/Consult

- PT/OT evaluation for early mobility, strength/endurance training and evaluate for assistive devices
- Speak with psychiatry (e.g., “curbside consult”) as above re: lorazepam & haloperidol as well as restraints they ordered on admission

### Nursing Staff Education/Interventions

- Assess cognition & shift using the CAM and observing behaviors
- Assign a male CNA (if available) for ADL care (particularly bathing and catheter/continence care) to maintain privacy and dignity.
- Be aware and respectful of patient/family cultural/ethnic background. See the following links:
  - [http://consultgerm.org/topics/ethnogeriatrics_and_cultural_competence_for_nursing_practice/want_to_know_more](http://consultgerm.org/topics/ethnogeriatrics_and_cultural_competence_for_nursing_practice/want_to_know_more)
  - [http://www.ethnicelderscare.net/ethnicity&dementiatitle.htm](http://www.ethnicelderscare.net/ethnicity&dementiatitle.htm)

### Follow-up hospital day 2

- Mr. Perez was finally admitted to the medical unit 18 hours after initial presentation to the ED
- He is in a room close to the nurses’ station and is now on ciprofloxacin for his UTI, IV fluids for dehydration, B12 injections for B12 deficiency, carafate for GERD prophylaxis, simvastatin for hyperlipidemia, HCTZ for hypertension, and Tylenol q6hr for pain (w/good relief)
- The four point restraints have been removed and he now has constant 1:1 observation, or what the nursing staff call a ‘sitter’

- The ‘sitter’ and nursing staff report that he has been fairly lucid and cooperative this morning, however, last night he became increasingly restless, tried to climb over the full side rails and to pull out his IV and urinary catheter.
- He is still taking haloperidol 0.5mg po qhs and lorazepam 0.5mg po q4hr prn. The nursing staff state they have been giving him the lorazepam regularly, but it “doesn’t seem to help at all” and “possibly even makes him worse” (e.g., more restless and physically aggressive than sedated).
- Upon questioning the nurses, you discover that he is better able to take fluids by mouth and his medicines crushed in applesauce when he is more awake and alert. PT/OT saw Mr. Perez a few hours ago and worked with him on range of motion exercises and safe transferring and ambulation.
Question #5

- What is your current assessment and plan? Provide rationale.

Question #6

- What are the transitional care needs of Mr. Perez and his family? What resources would be beneficial?

Question #7

- What are some "system issues" that you, as the CNS, could address to improve standard processes of care for future patients like Mr. Perez?

Summary

- Interactive, evolving geropsychiatric case studies can be a valuable learning resource
- They are user friendly, tutorial in nature and can be easily integrated into the generalist curriculum to infuse essential geropsychiatric content

Q & A

Presented on December 15, 2011 as part of the American Association of Colleges of Nursing's Faculty Webinar series. For more information on the Geropsychiatric Nursing Collaborative see www.aannet.org/GPNC/Geropsych
Click here
to complete the evaluation