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Organic and Neurocognitive Disorders

Mental Health Nursing

Delirium, dementia, amnestic disorders, mental disorders due to medical conditions, clinical manifestations, investigations and nursing management.

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CHAPTER 14 / MENTAL HEALTH NURSING 14. Organic and Neurocognitive Disorders

1. Concepts

Older term "organic mental disorders" refers to psychiatric or cognitive symptoms associated with medical, neurological or substance-related causes. Modern terminology is more specific (delirium, major/mild neurocognitive disorders, mental disorders due to another condition). New mental status changes warrant assessment of medical causes before psychiatric attribution.

2. Delirium versus dementia

Feature	Delirium	Dementia/major neurocognitive disorder
Onset	Acute/subacute (hours-days)	Usually gradual over months-years
Course	Fluctuates during day	Usually progressive, may fluctuate by type
Attention/arousal	Impaired attention, altered awareness/arousal	Attention may be relatively preserved early in some types
Reversibility	Often improves with cause treatment; may persist	Many causes progressive; investigate treatable contributors
Priority	Medical urgency and precipitant treatment	Function, diagnosis, support and planning

Delirium

Definition and pathophysiology: Acute brain dysfunction related to infection, hypoxia, metabolic abnormalities, medication, withdrawal, pain or other triggers.

Clinical features and investigations: Inattention, fluctuating awareness and cognition, hyperactive/hypoactive/mixed presentation; use CAM/4AT where trained, assess vitals, glucose, medical cause.

Management and nursing care: Urgent assessment, treat cause, reorientation, hydration/nutrition, sensory aids, sleep preservation, mobility and medication review. Avoid routine restraints and sedatives; severe distress/risk requires specialist approach.

Dementia

Definition and pathophysiology: Acquired cognitive decline affecting independence; Alzheimer, vascular, Lewy body and frontotemporal types are examples.

Clinical features and investigations: Memory, language, executive, visuospatial or behavioural changes; history/collateral, cognitive and functional assessment, investigations for contributors.

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Management and nursing care: Person-centred routines, cues and safe environment, support functional independence, caregiver education, prescribed therapy by type. Be aware of antipsychotic sensitivity in Lewy body dementia.

Amnestic disorders and secondary psychiatric syndromes

Definition and pathophysiology: Memory impairment may follow brain injury, thiamine deficiency, neurodegeneration or other causes. Endocrine, infectious, epileptic, metabolic or medication disorders may cause psychiatric symptoms.

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B.SC. NURSING / CHAPTER-WISE STUDY NOTES

Clinical features and investigations: Anterograde (new memory) or retrograde (prior memory) deficits; confabulation may occur. Investigate with history, neuro exam, labs and imaging as indicated.

Management and nursing care: Treat cause promptly, provide memory aids, structured routine, rehabilitation and safety; suspected Wernicke encephalopathy needs urgent prescribed parenteral thiamine and medical management.

3. Documentation and care

Record baseline cognition and acute changes, medication review, hydration/output, attention, sleep, orientation, falls and response. Ensure swallowing/nutrition safety, avoid overstimulation and use accessible communication. Capacity is decision-specific; involve support appropriately. Do not confuse delirium with psychiatric relapse or assume incapacity because of diagnosis.

4. Important Examination Questions

Long Answer Questions

1. 1. Compare delirium and dementia and describe nursing management.

Short Answer Questions

1. 1. Describe causes of delirium
2. 2. explain amnestic disorders
3. 3. discuss dementia caregiver support.

Very Short Answer Questions (with answers)

1. 1. What is confabulation? - Unintentional inaccurate memory account.
2. 2. Is hypoactive delirium possible? - Yes.

5. Quick Revision

- Acute inattention is a warning sign.
- Identify reversible causes.
- Support dignity and functional ability.

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6. Conclusion

Acute inattention is a warning sign. Identify reversible causes. Support dignity and functional ability.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. Which course is most characteristic of delirium in the chapter's comparison?

A. Gradual progression over many years without acute change

B. A stable lifelong pattern of interpersonal behaviour

C. Acute onset with fluctuations during the day

D. A fixed cognitive pattern present from birth

2. Difficulty forming new memories is described by which term?

A. Retrograde memory deficit

B. Confabulation

C. Avolition

D. Anterograde memory deficit

3. What does confabulation mean?

A. An unintentional inaccurate account of memory

B. A deliberate plan to deceive staff

C. A perception without an external stimulus

D. An inability to initiate goal-directed activity

4. An older inpatient becomes acutely confused over several hours and attention fluctuates. What should the nurse suspect and escalate for assessment?

A. Normal ageing that needs no evaluation

B. A confirmed lifelong personality disorder

C. Delirium and its possible underlying causes

D. Definite dementia diagnosed by sudden onset alone

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Answer key and explanations

1. C - Acute onset with fluctuations during the day

Delirium typically develops acutely and fluctuates, unlike the usual gradual course of dementia.

2. D - Anterograde memory deficit

Anterograde impairment concerns new memories; retrograde impairment concerns prior memories.

3. A - An unintentional inaccurate account of memory

Confabulation is an inaccurate memory account that is not intentional deception.

4. C - Delirium and its possible underlying causes

Acute onset, fluctuating attention and cognitive change suggest delirium. Identify and assess possible causes such as illness, medicines, pain, hypoxia and dehydration.

Reference: https://www.nice.org.uk/guidance/cg103/chapter/Recommendations

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