NCLEX MENTAL HEALTH SERIES · 2026 TEST PLAN

Neurocognitive Disorders.

Acquired disorders marked by a decline in one or more cognitive domains — memory, attention, language, executive function, perceptual-motor, and social cognition.

SYSTEM
Neurological / Mental Health

DSM-5-TR CATEGORY
Delirium · Major NCD · Mild NCD

HIGH-YIELD
Safety · Prioritization · Pharm

01 Definition & Overview

WHY IT MATTERS

- **Neurocognitive Disorders (NCDs)** = acquired decline in cognition from a medical condition, substance, or neurodegenerative process — *not* developmental.
- NCDs are a **top cause of functional decline & death** in older adults; affect safety, independence, and caregiver health.
- Nurses must distinguish **reversible (delirium)** from **progressive (dementia)** — the wrong label = the wrong care.

DSM-5-TR CLASSIFICATIONS

Delirium | Mild NCD | Major NCD

Major NCD subtypes: Alzheimer's, Vascular, Lewy Body, Frontotemporal, Parkinson's, HIV, TBI, Substance-induced.

02 Pathophysiology — Simplified

MECHANISM FLOW

DELIRIUM (ACUTE & REVERSIBLE)

STEP 1	→	STEP 2	→	STEP 3	→	STEP 4	→	STEP 5
Trigger: **infection, hypoxia, meds, electrolytes, pain**		Neurotransmitter imbalance: **↓ ACh, ↑ dopamine**		Global cerebral **dysfunction**		Acute confusion, fluctuating LOC		**Reverses** when cause treated

DEMENTIA SUBTYPES (CHRONIC & PROGRESSIVE)

Alzheimer's
β-amyloid plaques + tau tangles → hippocampal atrophy → memory loss first.

Vascular
Ischemia/infarcts → **stepwise** decline; tied to HTN, stroke hx.

Lewy Body
α-synuclein deposits → visual hallucinations + parkinsonism + fluctuating cognition.

Frontotemporal
Frontal/temporal atrophy → **personality & behavior** change first.

03 Signs & Symptoms

EARLY VS LATE

Delirium — Acute · Hours-Days

- **Rapid onset**, fluctuating LOC
- Disorientation to time/place
- **Visual hallucinations**, illusions
- Hyperactive (agitated) or hypoactive (lethargic)
- Disrupted sleep-wake cycle
- Inattention · incoherent speech

Dementia — Early — Mild

- **Short-term memory loss**
- Word-finding difficulty (anomia)
- Misplacing items, repeating questions
- Mild disorientation, poor judgment
- Social withdrawal, mood changes

Dementia — Moderate

- **Sundowning** (↑ confusion at dusk)
- Wandering, pacing

Dementia — Late — Severe

- Total dependence for ADLs
- Incontinence (bowel/bladder)

- Aphasia, apraxia, agnosia begin
- ADL assistance required
- Confabulation · paranoia
- Dysphagia · aspiration risk
- Mutism, immobility, contractures
- Failure to thrive

RED FLAGS — ACT NOW

- **Acute change in LOC** in a previously stable patient → suspect **delirium** (medical emergency, rule out UTI/hypoxia/sepsis)
- Suicidal ideation in early-stage dementia (retained insight = ↑ risk)
- Aggression, wandering, elopement → safety crisis
- Refusal to eat/drink, aspiration, weight loss
- New-onset visual hallucinations — Lewy body vs delirium workup

04 Priority Nursing Interventions

ABC · SAFETY · MASLOW

A	B	C
AIRWAY — ASPIRATION RISK	BREATHING — HYPOXIA → DELIRIUM	CIRCULATION — PERFUSION, VITALS

- ✓ **ASSESS** for reversible causes first: UTI, dehydration, meds, hypoxia, electrolytes
- ✓ **ENSURE SAFETY**: bed low, call light in reach, bed/chair alarm, remove hazards
- ✓ **MONITOR** swallowing, I&O, skin integrity, nutrition
- ✓ **ORIENT** gently — clock, calendar, familiar objects, photos
- ✓ **MAINTAIN** consistent routine & consistent caregivers
- ✓ **REDUCE** stimuli during sundowning — soft lighting, calm voice, reduce noise
- ✓ **REDIRECT** — do **not argue** with hallucinations/delusions; validate feelings
- ✓ **COMMUNICATE** in short, simple sentences; one step at a time
- ✓ **RESTRAINTS = LAST RESORT** — try distraction, reorientation, 1:1 sitter first
- ✓ **SUPPORT** caregivers — respite, resources, grief anticipation

05 Pharmacology

HIGH-YIELD DRUGS

CHOLINESTERASE INHIBITORS
Donepezil · Rivastigmine · Galantamine
USE Mild–moderate Alzheimer's
MOA ↑ acetylcholine by blocking breakdown
SE GI upset, **bradycardia**, syncope, vivid dreams
NSG Check **HR < 60 = hold**; give at bedtime; slows — does not cure

NMDA ANTAGONIST
Memantine (Namenda)
USE Moderate–severe Alzheimer's
MOA Blocks glutamate excitotoxicity
SE Dizziness, headache, confusion, constipation
NSG Often combined with donepezil; titrate slowly

ATYPICAL ANTIPSYCHOTICS
Risperidone · Quetiapine · Olanzapine
USE Severe agitation/psychosis only (last line)
MOA Dopamine & serotonin blockade
SE Sedation, EPS, metabolic, falls, ↑ stroke risk
NSG Lowest dose, shortest time, reassess often

⚠ *BLACK BOX* **All antipsychotics carry ↑ mortality risk** when used in elderly with dementia-related psychosis. **AVOID benzodiazepines** in older adults — cause paradoxical agitation, falls, and worsen delirium (Beers Criteria).

06 NCLEX Test Traps

DON'T GET FOOLED

TRAP **Delirium ≠ Dementia.** Delirium is **acute & reversible**; dementia is **chronic & progressive**. Sudden LOC change → think delirium, not "worsening dementia."

TRAP Never **argue** with hallucinations or "correct" delusions repeatedly. **Redirect + validate the emotion.**

TRAP A **low-stim** environment ≠ silent or dark room. Darkness/sensory deprivation **worsens** confusion. Use soft light.

TRAP **Safety > orientation.** If the patient is wandering toward an exit, address the safety risk first — not the reality orientation.

TRAP Cholinesterase inhibitors **slow progression** — they do NOT cure or reverse Alzheimer's.

TRAP **Always check HR** before donepezil. Hold if <60. Watch for syncope.

TRAP **Restraints and benzodiazepines are NOT first-line** for agitation in elderly. They worsen confusion & cause falls.

TRAP Sundowning is managed with **environmental modification**, not PRN sedation.

07 Patient & Family Education

CAREGIVER FOCUS

- Establish **consistent daily routines**; avoid schedule changes
- **Label** rooms, drawers, bathroom doors with pictures
- Use clocks, calendars, whiteboards for orientation
- **Home safety**: remove rugs, lock cabinets, install grab bars, secure stove & exits
- Medication organizers + caregiver oversight for adherence
- Begin **advance directives & POA** early — while patient still has capacity
- Engage in **familiar, simple activities**: music, photo albums, walks
- Avoid arguing or over-correcting; shift focus instead
- Caregiver **respite & support groups** (Alzheimer's Association)
- Plan for progression: adult day care → assisted living → hospice

08 Memory Boosters & Mnemonics

MAKE IT STICK

🧠 The 4 A's of Alzheimer's

- **A** mnesia — memory loss
- **A** phasia — can't find words
- **A** praxia — can't do familiar tasks
- **A** gnosia — can't recognize objects/people

🔎 Delirium Causes — "DELIRIUMS"

- **D** rugs (anticholinergics, opioids, benzos)
- **E** lectrolyte imbalance
- **L** ack of drugs (withdrawal)
- **I** nfection (UTI #1 in elderly!)
- **R** educed sensory input
- **I** ntracranial (stroke, bleed, tumor)
- **U** rinary/fecal retention
- **M** yocardial/pulmonary (hypoxia, MI)
- **S** leep deprivation

🧩 The 3 D's — Quick Differentiation

FEATURE	DELIRIUM	DEMENTIA	DEPRESSION
Onset	Hours–days (acute)	Months–years (insidious)	Weeks
Course	Fluctuating	Progressive decline	Diurnal (worse AM)
LOC	Altered	Clear until late	Clear
Attention	Severely impaired	Usually intact early	Minimal impairment
Reversible?	✅ YES — treat cause	❌ Usually no	✅ YES — treatable

"Delirium is Dramatic & Dangerous. Dementia Declines over Decades."