Significance of Cognitive Behavioral Therapy-Trained Nurses in Reducing Rates of Depression and Anxiety for Patients on a Cardiac Floor

QSEN Paper

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"This paper represents my own work in accordance with School and University regulations."

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3.10.2019

My first day on the cardiothoracic floor, I was given my patient assignment and both the night and day shift nurses couldn't say enough nice things about our patient. He was an LVAD patient on "destination therapy" who had been in the hospital for several days because he found blood in his stool. Although he had already received a colonoscopy, the doctors were unable to find a reason for this issue and told him they'd have to do an endoscopy and another colonoscopy. When I went to the room to get end-of-day vitals, his wife left to get some food, and his cheery demeanor turned into one of frustration and confusion. He opened up to me about his frustrations regarding his unclear results and began saying phrases like, "I feel like this is the end of the road for me. I don't know what the point is in trying anymore. I don't want to put my family through any more pain and I'm just exhausted." He and I walked through some solutions of how we could fix his minor grievances through the day, but I left the room and immediately told my nurse about what Mr. Smith said, worried about his sudden depressive state. She was shocked and said, "But he was so happy this morning!" Confused, she said, "I'm not sure what I can do. I guess I can see if he wants to talk to a chaplain?" However, the chaplain wouldn't be up on the unit for another few hours and I was worried Mr. Smith wouldn't open up to the chaplain the way he did to me if his wife returned to the room.

The uncertainty of how to combat a behavioral situation with a patient on a non-mental health floor is an issue that I saw among the nurses on unit 6E. Although many of the nurses had the skills of therapeutic communication, it seemed that they were unclear on what to do when an actual mental health situation presented itself, other than call and wait for the chaplain to arrive. By initiating the presence of a group of Cognitive Behavior Therapy (CBT) trained nurses on Unit 6E, we can decrease the rates of escalated depression, anxiety and trauma among our cardiac patients, thus decreasing the number of rehospitalizations and improving their overall

quality of life (Hwang et al., 2015). This hypothesis is focused on improving safety of patients and staff members at Emory Hospital in cardiac, non-mental health floors.

Patients suffering from cardiac conditions endure a wide range of treatment plans and experience symptoms which can cause fluctuations in mood, anxiety level and emotional will power (Mulligan et al., 2012). Along the journey from diagnosis to therapy, new options can arise, or new doors can close, causing patients to go through emotional and mental roller coasters. As their nurses, our job is to focus on improving their quality of life throughout their journey in the hospital to the best of our ability. Along with taking care of their physical ailments, we must also care for patients' emotional and mental conditions as part of their holistic safety. Our goal is to reduce any potential risk of harm to themselves or their nurses (Quality, 2019).

When compared to patient groups suffering from arthritis, CPOD, and general healthy populations, individuals with heart failure are among the most likely to settle for a lower quality of life after receiving their prognosis. According to a meta-analytic review, the prevalence of anxiety among patients with heart failure is between 40-63% (Mulligan et al., 2012). Additionally, 15-38% of all patients who have received cardiac surgery experience depression, resulting in increased rates of delayed recovery, rehospitalization, and mortality related to cardiac issues (Hwang et al., 2015).

The development of a Behavioral Emergency Response Team (BERT) is becoming more common on non-mental health units. BERTs are made up of nurses and other staff members on the unit who are specifically trained to assess and de-escalate behavioral emergencies seen on the floor (Zicko, Schroeder, Byers, Taylor, & Spence, 2017). Similarly, to a Rapid Response Team, BERTs are called when a patient's mood or demeanor begins to escalate to unsafe levels.

Although, BERTs are usually implemented to reduce exposure to assaultive or abusive behavior and increase the safety of the medical staff, I believe a similar idea can be implemented for lower-risk mental health conditions experienced by the patients, to help increase the safety of the patient (Zicko, Schroeder, Byers, Taylor, & Spence, 2017).

One research study explained how a similar process could work. A select group of nurses completed the standardized Cognitive Behavioral Therapy (CBT) training at the Beck Institute in Philadelphia. Patients who had received cardiac surgery were then given the Beck Depression Inventory (BDI), a self-reported questionnaire to determine the presence of depressive signs or symptoms. For those patients with a score greater than 10 or who had history of depression, a CBT-certified nurse conducted weekly sessions of therapy with each patient who was considered "at risk" for depressive/mental health disorders (Hwang et al., 2015). Along with the CBT, studies have revealed that the intentional presence of a nurse who is holistically caring for a cardiac patient, greatly reduces stress and anxiety rates among patients undergoing coronary artery bypass surgery (Gelogahi, Aghebati, Mazloum, & Mohajer, 2018). This concept can be applied to other cardiac treatment plans.

My suggestion is, along with the Fall Risk Assessment, Delirium Assessment, and Goals that are done daily/upon admission for patients, the unit can add the Beck Depression Inventory (BDI) assessment to their required charting. This way, patients can be appropriately assessed on mental health status regarding their depression and anxiety following their diagnosis or treatment plan. Additionally, the unit should establish a group of 6E nurses, along with all charge nurses, to become CBT-trained so that during each shift there is at least one CBT-trained nurse on the floor. Every shift, the CBT-trained nurse's phone number can then be added to patient's erase boards who have been evaluated as "at risk" according to their BDI score. Rather than

implementing numerous weekly sessions with patients, the CBT-trained nurses could be available on an on-call basis. The combination of trained CBT nurses implementing therapeutic strategies, along with their intentional, physical presence in the patient's room, can greatly reduce negative mental health responses to diagnosis and treatment among cardiac patients.

Among the hospitals that have implemented similar interventions, there are negative and positive outcomes. Unfortunately, few interventions have been able to replicate the long-term effects on mental health status post discharge from the cardiac floor. Generally, six months after CBT has concluded between the patient and nurse, the effects of the intervention on improving mental state were statistically insignificant (Jiang et al., 2018). However, the positive side is that training nurses in CBT and utilizing a team of nurses that are already working on the floor, rather than hiring more psychologists or therapists, is an inexpensive and simple way to reduce the amount of depression and anxiety experienced by cardiac patients (Gelogahi, Aghebati, Mazloum, & Mohajer, 2018).

The goal of my QSEN project is to improve patient safety by decreasing the rates of negative mental health symptoms among patients on a cardiac floor. This will be done by assessing patients using the BDI questionnaire and implementing a group of CBT-trained nurses to counsel patients that are "at risk" for developing depression or anxiety related to condition or treatment.

References

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