THE WHO, WHAT, AND WHY OF ACUTE GEROPSYCHIATRY INPATIENT CARE

Connie Marsh MD
Clinical Associate Professor
University of Kansas School of Medicine-Wichita
ACUTE PSYCHOGERIATRIC CARE

- Important component of comprehensive services
- Safe and rapid treatment
- Prevention of chronic institutionalization
  - Correct diagnosis
  - Timely treatment
  - Clinical improvement
  - Rehabilitation
  - Resocialization
PRINCIPALS OF ACUTE GEROPSYCHIATRY CARE

- Multidisciplinary staffing
- Preadmission screening
- Maintaining the patient in the community
- Beginning discharge planning at admission
- Collaborating with community agencies
MULTIDISCIPLINARY STAFFING

• Team
  • Special interest in psychiatry of old age
  • Knowledge of social interventions
  • Knowledge of medical issues
MULTIDISCIPLINARY STAFFING MEDICAL ISSUES

- More than 75% of patients have at least one medical issue
- Majority have 3-4 medical issues
  - Most common—atherosclerosis
- Medical illnesses
  - Precipitate psychiatric admissions
  - Complicate treatment
  - Can be underlying reason for psychiatric symptoms
WHO ARE THE TEAM MEMBERS?
MULTIDISCIPLINARY STAFFING TEAM MEMBERS

- Psychiatrist
- Nursing
- Social Work
- Therapists
- PT/OT
WHY DO PREADMISSION SCREENING?
PREADMISSION SCREENING

• Prevent unnecessary admissions
• Prevent inappropriate admissions
• Prepare realistic discharge plans
MAINTAINING PATIENT IN THE COMMUNITY

• Commitment to returning patient to community
• Family and friends provided education and participate in care plan
• Community has organized network of mental health services and aging services
• Coordination between inpatient and community support services
WHAT COMMUNITY SERVICES HELP MAINTAIN PATIENT IN THE COMMUNITY?
MAINTAINING PATIENT IN THE COMMUNITY

• Community Resources
  • Respite Care facilities
  • Adult Day Care
  • Senior Centers/Activities
  • Home Health agencies
  • Hospice agencies
• Resources for families
  • Alzheimer’s Association
  • Central Plains Area Agency of Aging
  • Kansas Department for Aging and Disability Services
WHY DO DISCHARGE PLANNING ON ADMIT?
DISCHARGE PLANNING AT ADMISSION

• Understand patient’s living situation
• Maintaining the patient’s community resources
• Dealing with obstacles to returning home
DISCHARGE PLANNING AT ADMISSION

• Psychosocial history
• Assess family’s expectations for hospitalization and discharge place
• If appropriate, review finances to determine affordability of discharge plan
• If appropriate, help family begin Medicaid application process
• Facilitate DPOA for health care, finances
COLLABORATION WITH COMMUNITY AGENCIES

- Maintaining patient in the community

- Reduction of length of stay and readmission rates
  - Coordination of aftercare
  - Collaboration with community resources
GERIATRIC PSYCHIATRY INPATIENT UNITS

• Types of units
  • Part of general psychiatric units
  • Separate, smaller unit

• Separate units
  • Therapeutic milieu actively addresses problems of aging
    • Specialized staff
    • Specialized programming
    • Specialized physical space
DESIGN:
HOW CAN DESIGN BEST ACCOMMODATE FOR AGE RELATED DECLINES?
DESIGN OF UNIT

• Accommodations for age related decline
  • Visual impairment
    • Excellent lighting
    • Large print reading materials
    • Easy to read signs
  • Hearing impairment
    • Sound proofing interview rooms/dining rooms
    • Minimizing extraneous noise
DESIGN OF UNIT

• Accommodations for age related decline
  • Fall risk
    • Nonskid flooring
    • Wide corridors
    • Well located restrooms
    • Uncluttered rooms
    • Allow for safe wandering and exercise
DESIGN OF UNIT

• Maintain everyday skills
  • Laundry room
  • Kitchen area
INDICATIONS FOR INPATIENT TREATMENT

• Imminent danger to self or others
• Intensive evaluation or treatment required
• Failure of the caregiving system
WHAT IS IMMINENT DANGER TO SELF OR OTHERS?
IMMINENT DANGER TO SELF OR OTHERS

• Suicidal
• Homicidal, violent, or aggressive behaviors
• Threatening behavior while acutely psychotic
• Inability to attend to basic or essential care needs
• Dangerous wandering behavior
INTENSIVE EVALUATION OR TREATMENT REQUIRED

• Intensive Evaluation
  • Difficult diagnostic issues requiring close observation
  • Multiple medical problems or drug sensitivities

• Treatment
  • Drug or alcohol issues
  • Acute psychosis
  • Severe depression or mania
  • Need for electroconvulsive therapy
FAILURE OF CAREGIVING SYSTEM

• Caregiver dies, leaves, or needs relief
• Depletion of care resources
• Lack of or failure of community resources
WHAT ARE INAPPROPRIATE ADMISSIONS?
INAPPROPRIATE ADMISSIONS

• Medical needs are urgent and overshadowing psychiatric condition
• Comatose or moribund patient
• Patient only requires placement or other social support services
• Patients who could be treated in less intensive setting
WHAT IS TREATED ON AN ACUTE GEROPSYCHIATRY UNIT?
PSYCHIATRIC DIAGNOSES

• Depends upon unit type, medical support
PSYCHIATRIC DIAGNOSES

• Affective disorders
  • Depressive disorders
  • Bipolar affective disorders

• Delirium

• Major neurocognitive disorders (dementias)

• Alcohol and substance abuse

• Schizophrenia and other psychotic disorders
ASSESSMENT AND DIAGNOSIS

• Medical
  • Evaluation, labs, imaging, medication review

• Psychiatric
  • Evaluation including careful history
    • Can take time, review medical records, interview multiple family members, friends
    • SLUMS, MMSE
  • Observation
    • Patients can tend to exaggerate or minimize sx
    • Sleep, food intake, socialization, somatic concerns

• Psychological/Cognition
  • Neuropsychological testing
ASSESSMENT AND DIAGNOSIS

• Functional
  • Observations by nursing, staff
  • Assessing family and social resources by social work
  • Decision making capacity

• KELS by OT
WHAT IS A KELS?
KOHLMAN EVALUATION OF LIVING SKILLS

- Self care
- Awareness of dangerous household situations
- Identification of appropriate action for sickness/accidents
- Knowledge of emergency phone numbers
- Use of money
  - Source of income
  - Banking forms
  - Payment of bills
- Use of phone book/telephone
- Transportation
- Leisure Activities
OUTCOMES

• Ideally, return home or to preadmission residence
• LOS longer than younger adults
  • 19 days for Via Christi Unit
  • Average one to two weeks
  • Long LOS due to inability to secure LTC placement, securing DPOA or guardianship, Medicaid
• Premature discharge
  • Unsafe
  • Higher level of care
  • Readmission
TREATMENT MODALITIES

• Individualized treatment plan
  • With patient and family involvement
• Daily multidisciplinary staffing
TREATMENT MODALITIES

• Maintain or improve functioning
  • Wear own clothes
  • Do laundry
  • Kitchen activities
  • Self care
TREATMENT MODALITIES

• Occupational therapy
• Physical therapy
TREATMENT MODALITIES

- Music therapy
- Therapy dog
TREATMENT MODALITIES

• Milieu
  • Mixture of therapy groups
    • facilitate communication
    • observe symptoms
WHAT ARE CHALLENGES TO PSYCHOTHERAPY IN OLDER ADULTS?
PSYCHOTHERAPY CHALLENGES

• Cognitive impairment
• Sensory loss
• Stigma
• Medical problems
• Lack of mobility
• Fixed income
• Different concerns than younger adults (core themes)
TREATMENT MODALITIES

• Recreational therapies
  • Arts/crafts
  • Current events
  • Games, Bingo
  • Trivia
  • Sensory
TREATMENT MODALITIES

• Mixture of therapies
  • Individual and group
    • Problems common to geriatric patient
      • Loss
      • Adjusting to new roles
      • Finding worthwhile activities
      • Maintaining self esteem
      • Adapting to changes in family relationships
      • Increased dependency needs
  • Validation therapy
    • Emphasis on emotional aspect of communication rather than factual content
    • Respects person's feelings and beliefs
TREATMENT MODALITIES

• Individual psychotherapy
  • Supportive
  • Cognitive/Behavioral
    • Relaxation
    • Sleep hygiene
• Problem-solving
• Validation
TREATMENT MODALITIES

- Reminiscence
- Life Review
  - Acknowledge past conflicts and consider their meaning in their life as a whole
  - Positive memories shared in group settings to improve self-esteem and social cohesiveness
- Empirical support is sparse
PSYCHOTHERAPY FOR DEMENTIAS

• Validation therapy
  • Premise: patients with dementia use their remaining cognitive abilities to communicate with others
  • Validate efforts by
    • Simple speech
    • Empathetic voice tone
    • Reflect speech and behavior
  • Mildly positive results
    • Decreases in verbal and physical aggression
    • Nurses have greater confidence in managing problematic behaviors
At every age a happy life is made up of little things
TREATMENT MODALITIES
FAMILY THERAPY

• Dementia care is often family’s first experience with seeking help from agencies or other family members
• Caregivers may be overwhelmed, exhausted, depressed, anxious
  • Premature death is associated with spousal caregiver strain
  • Treatment of psychiatric consequences of caregiver burden
GOALS IN WORKING WITH FAMILIES

- Identifying precipitating stresses
- Address safety issues
- Identifying future stresses and plan strategies to manage
- Assessment of tolerance limits
- Mobilize secondary family support
- Elucidating family interactions
- Facilitate appropriate decision making
GOALS IN WORKING WITH FAMILIES

• Help family to accept help or let go of direct care
• Provide support around grief, loss, or conflict
• Address caregiver strain
• Educate Educate Educate
  • Understanding and acceptance of the illness
FAMILY THERAPY

• Family rarely has one voice
  • Close and distant family have different perceptions and expectations, often precipitating conflict
  • No perfectly fair and equal division of responsibility
FAMILY THERAPY

• Family care is an adaptive challenge
  • Few incentives will make unwilling family assume care
  • Few incentives will keep determined caregiver from honoring her commitment
FAMILY THERAPY

• Caregiver’s awareness of services or need for services does not necessarily lead to their use.
FAMILY THERAPY

• Primary caregiver at home is efficient and preferred
  • Primary caregivers need breaks, respite, backup people, services to supplement their care
THE WHO, WHAT, AND WHY
REFERENCES
