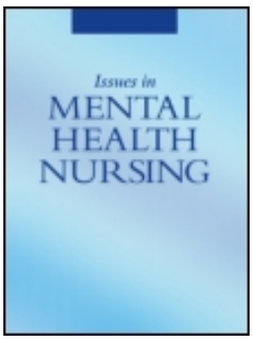

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THE IMPACT OF MEDICAL ISSUES IN INPATIENT GERIATRIC PSYCHIATRY

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At an advanced age, serious medical and psychiatric illnesses frequently coalesce. Often, the need for admission to inpatient geriatric psychiatric care arises from coexisting medical problems. While cognitive and behavioral interventions are important, the complexity of physical comorbidities usually becomes the focus of hospitalization and requires intensive medical treatments. This paper describes adaptations made in one metropolitan geriatric psychiatry unit in order to better treat complex patients who experience both medical and psychiatric illness. The need for all members of the interdisciplinary team to expand their practice and the importance of complementary approaches of psychiatry and medicine are emphasized.

At an advanced age, serious medical and psychiatric illnesses frequently coalesce, blurring the boundaries of psychiatry and medicine (Blazer, 2000). Thus, the need for admission to inpatient geriatric psychiatric care often arises from coexisting medical problems and not purely from psychiatric reasons. Because of this trend, a greater number of medically complex patients are being admitted to geriatric psychiatric units.

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This paper reviews problems, issues, and solutions associated with increasing medical and psychiatric comorbidity among older adult patients admitted for evaluation and treatment in an 18-bed geriatric psychiatry inpatient unit of the Johnston R. Bowman Center (JRBC) within Rush University Medical Center, Chicago. The Bowman Center has offered inpatient care to older adults for over 24 years in areas of subacute/transitional care, physical rehabilitation, and geriatric psychiatry. During that time, changes in the type and severity of problems precipitating admission have changed, with increasingly frail and medically complex patients becoming today's norm. In turn, roles and responsibilities of interdisciplinary team members have needed to adapt and change, and are described here. The perspectives offered combine the personal knowledge and expertise of Bowman's interdisciplinary team and information slowly emerging in the literature about medical treatment of geriatric psychiatry inpatients.

A CHANGING LOOK

The trend observed by JRBC's interdisciplinary team, that more medically complicated patients are being admitted than ever before, is multifactorial. Increasing life expectancy and sheer growth in the number of older adults throughout the country contributes to increasing medical complexity among older adults admitted to geriatric psychiatry units. For example, U.S. Census data reports that 12.3% of the total U.S. population is comprised of people 65 years and older (U.S. Census Bureau, 2002). Within this group of older adults, 21.6% take more than four prescribed drugs, increasing their susceptibility to drug interactions and falls, and 50% experience comorbid conditions. When admitted for psychiatric inpatient treatment, older adults account for 48% of all days of hospital care. Psychosis, which is one of the ten leading causes of all hospitalizations (Guralnik & Ferrucci, 2003), and delirium superimposed on existing dementia may create additional problems (Lauria, Pitkala, Strandberg, & Tilvis, 2004).

The trend observed locally by our staff is also reported in the literature. In a recent analysis of geriatric psychiatric practices in America, Colenda and colleagues observed a major change towards more medical diagnoses (Colenda, Pincus, Tanielian, Zarin, & Marcus, 1999). Although those working in geriatric psychiatry experience a myriad of medical problems in day-to-day practice, literature documenting the actual increase in medical diagnoses is sparse. Analysis of our unit's data over an 11-year period shows a modest and fluctuating increase in medical diagnoses (Henricks et al., 2004). Of importance, this study also

showed that psychiatrically trained staff often failed to record many medical conditions that should be coded on Axis III diagnoses, potentially reducing the accuracy of this data set as an indicator of medical acuity. Similarly, most JRBC staff agree that various nursing acuity measures are not helpful in quantifying changes in the medical care. Thus, one barrier to better understanding this phenomenon may be the type of tracking methods currently available in psychiatric care settings. As a result, much information is anecdotal and experiential, rather than the result of well-designed and systematically documented evaluation or research.

From the experiential perspective, JRBC staff note that pressures to discharge patients from acute medical floors, combined with perceived inadequacies of skilled nursing care units to provide geriatric psychiatric rehabilitation, often result in admissions to a geriatric psychiatry unit. These patients are recovering from acute medical illness but still have delirium, psychosis, poor oral intake, severe deconditioning, or other problems that suggest continued inpatient treatment would be beneficial. In other instances, medications being used effectively to control behavioral symptoms of dementia may be discontinued when patients are admitted for medical procedures (Draper, 2000). As a result, the patient decompensates and is readmitted for stabilization.

Another contributing factor may be the general closure of skilled and subacute nursing units. These units were added to hospitals to move patients to less costly care while keeping them "in house" and under appropriate medical supervision until stable. However, when Medicare reimbursement rules changed in 1998 (Health Care Finance Administration, Department of Health and Human Services, 2000), these units became financial liabilities and most were forced to close (Liu & Black, 2003). The resulting absence of extended care for patients within the hospital system may have caused an inadvertent triage system whereby the most fragile and cognitively challenged older patients are now sent to geriatric psychiatry. That is, medically ill and frail patients with overlapping psychiatric syndromes who are not ready for discharge to their "usual" environment, whether home or care center, are increasingly transferred to geriatric psychiatry care to give them the best chance of recovery prior to discharge. Although this policy may seem reasonable, additional problems are encountered in geropsychiatric care as a result.

As patients are admitted from acute medical floors, geriatric psychiatry unit staff repeatedly face issues and procedures that are common in medical settings. The combination of confusion, behavioral disturbances, and medical care can make completing even the simplest task

very time consuming, exhausting, and frustrating for nursing personnel. Undiagnosed medical issues, which regularly contribute to delirium, anxiety, sleep disturbance, depression, and pain, are often markers of behavioral disturbances that must be understood and treated by the team. Placement issues are more complex for social workers because of overlapping medical and psychiatric needs. In short, many adaptations are needed to better accommodate medically ill geriatric psychiatry patients.

In the sections that follow, we review the important perspectives of key members of the interdisciplinary team, highlighting common challenges and describing changes or practices undertaken to best treat more medically ill patients. Three common patient care challenges related to medical comorbidity—physical frailty, delirium, and polypharmacy—are then reviewed.

TEAM DEVELOPMENT AND PERSPECTIVES

When the JRBC opened in 1980, most staff came from medical backgrounds. At that time, the primary focus was training acute care nurses in psychiatric techniques, a responsibility that was shared by the unit's senior advanced practice nurse, social workers, and the psychiatrist who served as unit chief. Nurses who came to geriatric psychiatry from medicine required training in psychiatry, and similarly, those with psychiatric background needed training to refresh basic medical care skills. All team members required some adjustments to best accommodate geriatric patients: psychiatrists increased their knowledge of medicine; internists increased their psychiatric and "pediatric" skills (e.g., diagnosing and treating patients who lacked language to describe their experiences); psychiatric occupational therapy adjusted their physical rehabilitation skills toward a more habilitative model; dietitians and nutritionists factored more family and systems ideas into their approaches; physical therapy adopted a slower improvement curve; and social work refreshed their knowledge of medical discharge planning. At that time, the primary focus was on shifting from a more medical orientation to a psychiatric one.

Today, the unit's interdisciplinary team is challenged to renew its medical orientation to better serve increasingly ill and frail geriatric psychiatry patients. Since high-quality geriatric care is based on close and collaborative multidisciplinary approaches (Toseland, Palmer-Geneles, & Chapman, 1986), needed expansions in practice are described from each discipline's point of view, including nursing, geriatric psychiatry, internal medicine, occupational therapy, and social work.

Nursing Challenges

The greatest contrast between adult and geriatric psychiatric nursing care is the increased medical acuity of patients. Because of their advanced age, older patients have more medical diagnoses and suffer the consequences of long-term illnesses such as hypertension, renal failure, Parkinson's disease, heart disease, and a host of other chronic physical health problems. Infections also are more common in older adults, particularly urinary tract infections, pneumonia, and wound healing. Likewise, the consequences of malnutrition and dehydration are more severe in geriatric patients than in the general population. As even more medically ill patients are admitted to our unit, changes in various nursing functions have occurred in response to demands to provide medical procedures while managing the milieu and providing therapeutic individual and group therapies.

Medical Procedures

Many of our psychiatrically trained nurses find themselves caring for patients requiring medical modalities previously not encountered. Nursing personnel are regularly confronted with gastrostomy tube feedings, skin breakdown and resulting wound care, blood transfusions, bladder scans, catheterizations, and tracheostomy care. Intravenous (IV) and peripherally inserted central catheter (PICC) lines are used for fluid and medication administration with both demented patients who have lost their ability to swallow and severely depressed patients with life-threatening anorexia. Risks of physical deconditioning and contractures are a constant threat and require vigilant nursing care.

Performing these procedures entails considerable time, especially with confused or cognitively impaired patients who are resistant to care. Regrettably, the time required to perform medical nursing functions decreases opportunities to engage in more typical psychiatric interventions such as therapeutic one-on-one conversations and structured group activities. As a result changes in routines have been made.

Milieu Management

Impaired cognitive ability among many geriatric patients impacts the depth of psychotherapy. Decreased self-awareness and diminished memory, especially memories of successful interventions from previous therapy sessions, make cognitive behavioral therapy very difficult and possibly less effective. In turn, this poses a challenge for staff to group patients based on their functional capacity when managing the milieu. For example, patients with higher cognitive functioning can be grouped

together for specific tasks requiring higher cognitive ability such as cooking group, word games, or trivia questions to prevent their frustrations when assimilated with lower-functioning patients. For those who are not able to participate in activities that require high cognitive skills, supportive therapy and engagement in activities, such as manipulating plastic pipes or other tools, tossing a ball, folding towels or clothes, or holding a lifelike doll can have calming effects by helping patients remember more pleasant times in their lives. Simple questions during group therapy, such as asking about patient's favorite dessert, color, or vacation places, can replace more difficult inquiries to elicit participation.

Speaking and hearing abilities are often impaired so careful attention must be paid to ensure clear communication, a core element in geriatric psychiatry. Modifications for decreased speech and hearing include use of voice amplifiers and using better techniques to communicate such as speaking into patient's dominant ear and using basic and concise sentences with appropriate tone of voice. Even if the patient is nonverbal, everything is explained to him or her. The use of touch, such as back rubs, holding hands, and combing hair, is an effective intervention for providing reassurance of safety, comfort, and gentle distractions for agitated individuals.

Due to brain damage (e.g., progressive dementia, stroke) many patients lose the ability to organize thought and express themselves with language. As a result, our unit subscribes to the idea of "behavior as communication." Creativity often is needed to interpret behaviors as "signals" for meeting needs such as ambulation, toileting, emotional connection, physical comfort (e.g., too hot/too cold), and even basic food or fluid needs. Early anticipation to meet patient's needs may prevent some behavior outbursts. For example, an increased level of anxiety and agitation was noted in early afternoon among patients who are unable to communicate and frequent attempts to independently ambulate by those with unsteady gait. The behaviors were later attributed to patients' need for toileting and rest. In response to this, staff scheduled toileting and a short nap during this time, which in turn decreased anxiety among patients and may have lessened the risk of falls.

Balancing the level of stimulation in the milieu is another common challenge. Many staff expect to provide a stimulating environment for depressed patients (e.g., music, television, board games), yet must balance the potential of the stimuli contributing to agitation and over-excitement in patients with dementia, with resulting yelling or other disruptive behaviors. The agitated patient is then removed from the common area, which increases the potential for isolation and loneliness. Thus, the level of stimulation throughout the unit is carefully monitored by all staff.

Milieu management also may allow for wandering behaviors when safe, and at appropriate times. To a certain degree, wandering may be an anxiety-releasing behavior for some patients that should be met by providing constant observation or one-to-one staffing when available. The goal is to maintain safety (e.g., no intrusion to others, steady gait) and not agitate other patients. The use of discriminate lighting in the whole unit, especially when it is time to go to bed, and relaxing music adds calm to an otherwise frenetic environment.

The fundamental Rogerian belief in unconditional positive regard for patients is the key to decision-making and patient care. The tenet provides the essential framework of caring for individuals who may be nearing the end of their lives. It also is valuable for imparting comfort and a sense of security to persons with dementia. Nursing staff needs this framework when redirecting patients who wander recreationally but are considered intrusive, and when dealing with confused, delirious, or demented patients who are physically and verbally aggressive to staff.

Our unit limits use of television to rooms of bedridden patients. Patients who are ambulatory are strongly encouraged to come out of their rooms and socialize with others. Activities are carefully selected to involve patients who are chair bound (e.g., ball toss, word games, question and answer, simple puzzles, art work). Basic activities of daily living such as grooming and eating have become group interventions so that all patients can participate. There is a schedule for a supervised grooming group, which is usually run by the occupational therapists. Here, patients are encouraged or assisted to do their hair or make-up or shave. This group endeavor has provided patients with pleasurable activity while allowing staff to identify other areas of need, especially with fine motor skills and decision-making.

Health Teaching

Providing health-related education and training is an important focus of care throughout the hospital stay and in preparation for discharge. Since many physically ill and demented patients are unable to retain and apply needed information, family members and other caregivers are regularly involved in education. Health teaching is individualized, but may include topics such as effective use of as needed (PRN) medications for management of pain and agitation, dietary restrictions for certain medications, diabetic regimen, safe ambulation, transfers, and use of assistive devices to assure that effective interventions are continued after discharge.

Another important goal is to help reduce or prevent caregiver burnout as much as possible when patients are discharged. Successful strategies

and patient's preferences noted during hospitalization for making daily tasks such as bathing, feeding and ambulating easier to handle are shared with family. Examples of these teachings may include techniques of giving baths without agitating the patient, ways to encourage patients to eat, drink, and take medications, strategies for lessening anxiety and providing information on good sleep hygiene. The same information is provided through written discharge instructions to family members as well as to appropriate personnel when patients are discharged to institutional settings (e.g., nursing home, residential care, skilled nursing care, rehabilitation center).

Ensuring Patient Safety

Ensuring safety is a top priority in traditional psychiatric care, and becomes even more important with older adults who have both medical and psychiatric needs. The range of medical problems and procedures encountered by JRBC staff raised questions related to providing safe medical care to our patients. To address this issue, nursing staff has identified what medical procedures can be provided safely. For example, the unit can admit patients with central lines, dialysis, pressure sores, tracheostomies, or gastrostomies, but cannot take patients needing cardiac monitoring. The JRBC admission coordinator is aware that patients with certain medical concerns should be referred first to the charge nurse or the clinical nurse coordinator before approval of admission. For patients who seem to be medically intense when pre-admission screening is done, the unit director or clinical nurse coordinator assesses these patients prior to transfer. As a result, staff is assured that all medically complicated patients can be cared for safely in the unit and patient safety is maintained.

Safe patient care also relies on nursing personnel having the needed range of skills required to care for acutely ill patients. Thus, both skill development and hiring staff with preexisting geriatric and/or medical care experience is a priority for our unit. Given the increasing complexity of our geriatric patients, traditional psychiatric nursing skills alone are not sufficient. Today, our unit increasingly seeks nurses who have a firm background of medical, surgical, geriatric, or community health nursing. These nurses are then helped to gain skills in psychiatric care.

Staff education and development is continual, as we help staff to become adept with medical procedures needed for patient care, facilitate nurses attending continuing education programs, and offer in-service education to brush up on procedures that they may have not performed since nursing school. Staff nurses with more medical background become valuable resources to others, and are frequently assigned to patients

requiring more medical care. As a result of these efforts, JRBC staff has developed an increased level of comfort and is better prepared to meet the overall needs of our current patient population.

Physical restraints are always considered the last resort, but are sometimes needed when patients interfere with medical treatments and alternatives fail to ensure their safety. To assure that restraints are only used when truly needed, and used appropriately, our unit established a "restraint task force," consisting of nurses, mental health workers, social worker, and occupational therapist to look into best practices in preventing and reducing restraint usage (Restraint Task Force, 2003). The team also developed a decision tree to guide staff in using restraints for medical versus behavioral reasons. See Figure 1 to review the decision tree utilized for the use of restraints.

Geriatric Psychiatrist Challenges

From the standpoint of the geriatric psychiatrist the inpatient population is clearly more medically complex. As mentioned previously, the reasons for this are multifactorial and almost certainly are heightened in a tertiary care setting. On our unit, this phenomenon is in part addressed by the division and overlap of medical care provided by assigning both an internist and a psychiatrist to each patient. While the psychiatrist attends to and manages the cognitive, emotional, and behavioral aspects of a patient's illness, these issues are inextricably related to medical issues—not only in cases of delirium, but also in dementia, mood disorders, and psychotic disorders. The diagnostic role of the psychiatrist becomes critical in directing not only staff interventions, but also in assessing potential causative or contributing factors and working with the medical consultant to fully evaluate these factors.

General advances in medical care in the U.S. have resulted in older patients with more medical problems being treated with a panoply of pharmacological agents. This requires greater familiarity with a wider array of medical problems and a keener awareness of drug interactions among all members of the treatment team. These issues may be contributory or simply comorbid. Frequently, environmental changes (as in intensive care unit delirium) can play a role as patients are moved from unit to unit, contributing not only to delirium, but aspects of depressive symptoms or psychotic manifestations.

Finally, engagement and education of patient families becomes more crucial as medical complexity increases. Treatment decisions, placement issues, and legal issues are frequently addressed by all members of the

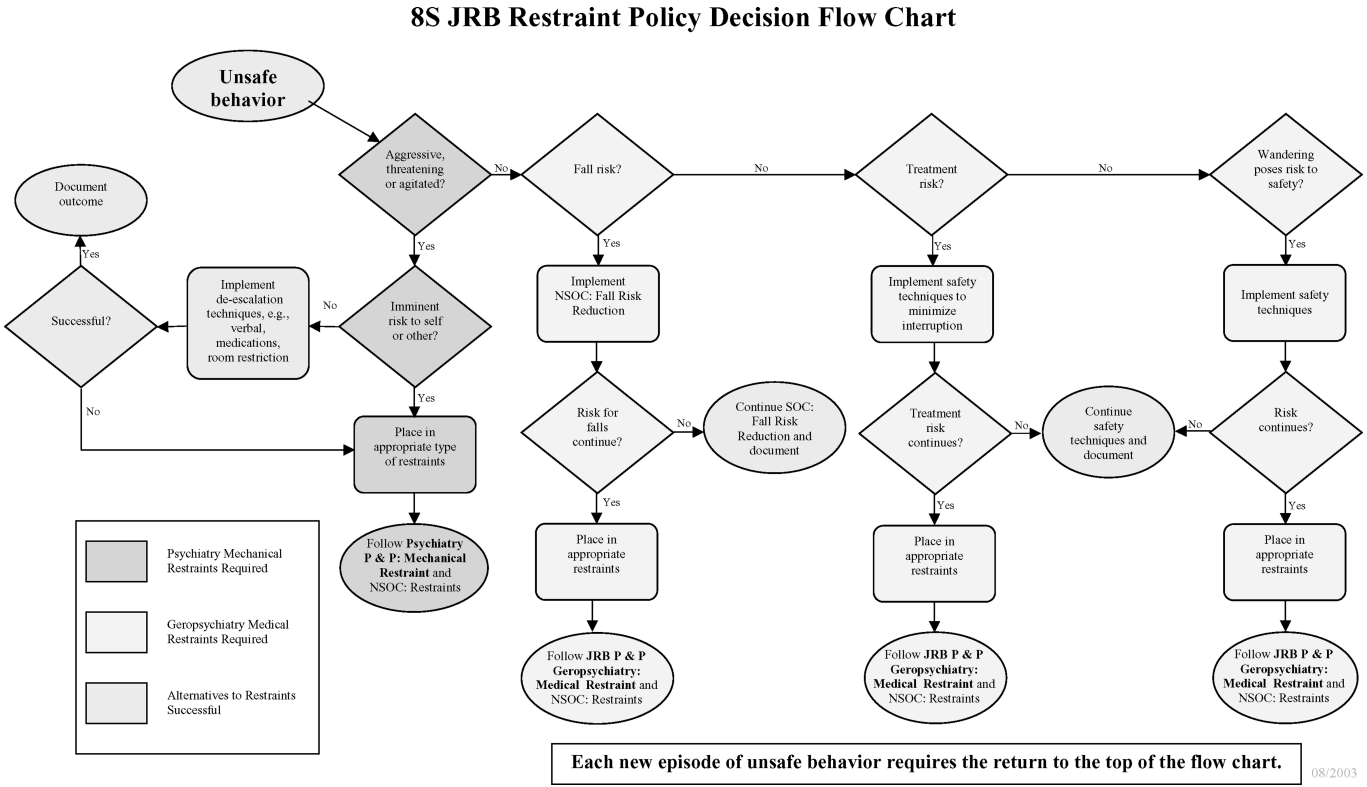

FIGURE 1. JRB restraint policy decision flow chart. (Reprinted with permission from Rush University Medical Center. All rights reserved.)

treatment team, but may require more direct attention by the attending psychiatrist.

Internist Challenges

Medical doctors caring for geriatric psychiatry patients must be prepared to treat problems that in other circumstances would be found on an acute medical unit. Because the geriatric psychiatry unit in our hospital is physically separate from medical units, it functions without benefit of medical house staff or purely medical nursing staff. Medical doctors must hone their skills in diagnosing, often with little or no history provided by the patient. In many ways the skills needed on the geropsychiatric unit parallel those of our pediatric colleagues who regularly treat nonverbal patients and rely more heavily on collateral history, scrutinizing available medical records, and a keen sense of intuition.

Both doctors and patients rely on the medical skills of nursing staff in the treatment of acutely ill patients on geriatric psychiatry units. Given the need for medical care, the apportionment of manpower must consider skill levels and schedule staff with appropriate training. As noted earlier, staff development is continuous to assure that nurses provide medical procedures safely, including blood transfusions, intravenous fluids or antibiotics, tube feedings, intravenous drips, and suctioning. Physicians also need to develop a level of comfort with the available medical care on these units. When to move a patient to a medical unit and the reliability of nursing personnel in the absence of medical house staff to promptly assess and intervene for urgent problems or emergencies are some of the concerns that must be carefully addressed. Although these challenges may occur in providing care to medically complex patients, staff in the geriatric psychiatry unit are better equipped to care for the overall needs of patients, reducing the risk of using physical restraints as is often the case on acute medical units.

Occupational Therapy Challenges

Occupational therapy (OT) is the therapeutic use of self-care, work, and play activities to assess or increase cognitive and physical functioning. An occupational therapist's role on a geriatric psychiatry unit is to assess a person's cognitive level and determine his or her highest level of functioning. A formal assessment is completed upon admission to the hospital and is continually reassessed during activities.

Group activities are set up to structure a person's daily routine and to create a successful environment in which the therapist can continually

reassess a person's level of functioning. Determining appropriate interventions entails analyzing an activity, breaking it down into specific steps, and engaging a person in the activity at a level that corresponds with his or her functional ability. Through group and individual treatment, the occupational therapist gains insight into a person's ability to learn new information, and to exhibit goal-directed behaviors (Allen, Earhhart, & Blue, 1992).

On the geriatric psychiatry unit, OT has required some modifications as older adults are admitted with more medical problems. Continuing to follow occupational therapy's mission of maximizing functional abilities, therapy incorporates some practices from a rehabilitation model of practice. Therefore, increased strengthening, movement, and positioning are incorporated into occupational therapy groups and individual treatment. Accommodating the population's physical demands requires the therapist to seek additional training in these less familiar areas. With increased continuing education courses, research, and in-service training the psychiatric occupational therapist should be able to fulfill the physical and cognitive needs of this population. At the same time, psychiatric training provides the occupational therapist with skills to match the amount of cognitive energy a task requires with a person's cognitive abilities. Both sets of skills are valuable with geriatric psychiatric inpatients.

Social Work Challenges

The general functions of a social worker on a geriatric psychiatry unit provide a framework for discussing medical care. Social workers function as conveners of the geriatric team by scheduling family conferences and staffings (Toseland, Palmer-Geneles, & Chapman, 1986). They meet with patients and families to gather collateral information for a comprehensive psychosocial assessment, which is used to help diagnose the patient, assess family dynamics, and explore the family's theories of what is occurring (Coster, 2000). Ideally, the family's role as team member is quickly established. This process is used therapeutically to reframe the family's distress by focusing on past strengths and helps to put recent challenges into the proper perspective. This discussion is the beginning of a supportive relationship with the family who are also viewed as the client. If all is successful the relationship continues throughout the patient's life.

After data is gathered, the social worker asks how the caregiver is coping, provides support and hope to the family as needed, and "gives permission" to caregivers to take care of themselves. At admission, the

family often feels that they have failed. Many have endured an ordeal in bringing the patient to the hospital and may have lied to get him or her here, which induces guilt. Praise for the efforts that the family has expended in caring for their loved one is extended and support for making difficult decisions is offered. Normalization of a patient's difficult behaviors is sometimes also helpful to reassure and support the family. Two key social work roles, maintaining continuity of care and discharge planning, are described next.

Continuity of Care

The ability to maintain continuity of care is extremely important for successful treatment of all patients, but is a particularly important issue with medically complex geriatric psychiatric patients. Like other team members, social workers need to look at the entire picture. For example, even though placement may seem to be the ideal outcome, the family may want to take the patient home with an increase in support. Although outward indicators suggest this plan is not workable, support and assistance are provided to help families feel they have "done their best" and not to be overwhelmed with guilt about possible later placement. Potential neglect cases need especially strong engagement with the family to assure close monitoring by the psychiatrist and home health providers after discharge. Every effort is made to help families feel comfortable with the unit, as this generally promotes continued close contact with staff after the patient is discharged. Day care referrals are especially helpful with cases that involve questionable levels of support. Day care services provide support, assistance, and monitoring of patients' well-being as well as emotional and practical support for caregivers. By providing the needed respite, the quality of the family relationships may improve.

Assuring continuity requires that financial concerns are addressed, as fear of poverty is often great among older adults and their families. Many are shocked when they realize that most long-term care is an out-of-pocket expense. Problems and issues must often be reviewed more than once to come to consensus regarding placement. This decision making process (also called "Staffing") is actually family therapy, and includes the patient, family members, and the team. The psychiatrist, primary nurse, occupational therapist, and social worker consistently attend staffings, and may be joined by residents and students of social work, occupational therapy, and nursing as well as nutritionists, internists, chaplains, and an ethicist as needed.

The team constantly attempts to assist the family to accurately assess their loved one's needs and the level of care that is appropriate for his or her ongoing care. There is often a discrepancy between the family's

and the professionals' assessment, as the team regularly recommends more care or structure than the patient was receiving prior to admission. Recommendations rely heavily on the Allen Cognitive Level (ACL) of functioning, which is used to assess patient's needs and safe level of independent function (Allen et al., 1992). The ACL also provides a basis for educating and training family related to patient care needs. Staffings also provide a format for identifying potential resistances or cultural issues that are key to development of a successful treatment approach. The resulting care plan is promulgated to all team members who then reinforce patient and family teaching and reality issues of the assessment.

Discharge Planning

As in other social work roles, assuring continuity of care extends to discharge planning. Behavioral problems associated with dementia regularly create placement challenges, especially with large robust male patients. Payment issues also may limit suitable placements, and as before, close work with family and all team members is essential.

The increasing medical complexity of some patients necessitates more consultations with medical discharge planners about equipment, quality of suppliers, and ways to arrange nutrition and oxygen therapies. Working with hospice services also has become more common. As treatment effectiveness dwindles for patients with advanced medical and psychiatric problems, effective management of end-of-life issues becomes a key issue. Telephone follow-up and support may be initiated following reports from home health, day care agencies, the internists, and psychiatrists who follow patients on an outpatient basis. Although families are told at discharge to call us at any time if they have any questions, initiating contact to express interest and offer assistance is often appreciated by stressed family caregivers.

Additional time is needed for social workers to review medical conditions with which we are unfamiliar, to understand the effects the disease may have on psychiatric and family issues, and then to make needed adjustments in routines. Geropsychiatric social workers are challenged to increase their own medical skills in order to help train and mentor social work students and to better understand issues faced by nursing staff while caring for medically ill psychiatric patients. Geropsychiatric social workers also facilitate all team members becoming more holistic and multi-skilled as the geriatric psychiatric unit continues to evolve. The staffings provide an opportunity to ask medical questions of the attending psychiatrists and nurses, who are all used to teaching and are very open to training students. All social work students attend the

psychiatric, geriatric, and preventive medicine grand rounds if these can be scheduled.

COMMON CARE CHALLENGES

The impact of medical issues on day-to-day practices in our geriatric psychiatric unit is illustrated in adaptations made to best accommodate three common care challenges: physical frailty, delirium, and polypharmacy. Each of these is briefly reviewed, focusing on solutions to common problems encountered.

Frailty

Many of JRBC's patients exhibit weight loss, weakness, fatigue, inactivity, decreased food intake, and depression, a constellation of symptoms that most geriatricians have agreed are manifestations of frailty. Older patients who are frail are at the highest risk for dependency, falls, injuries, acute illness, slowed or blocked recovery, and death (Fried & Walston, 2003). Comorbidity is a prime risk for a downward spiral to frailty (Blazer, 2000). Comorbid depression and medical illness, commonly encountered in our unit, is associated with poorer physical, emotional, mental, and social functioning than either depression or physical illness alone (Wells & Sherbourne, 1999).

The boundaries of psychiatry and medicine often blur among complicated cases. As noted earlier, the dual demand for expert care is addressed at JRBC by assigning both an internist and a psychiatrist to each individual. Although this is done for every patient admitted, close collaboration between medicine and psychiatry is especially critical when complex medical and psychiatric problems co-occur.

Individualized nursing care is provided to all patients. Special attention is given to physically ill patients who are often isolated in their rooms, and thus require more nursing time to assure safety, appropriate monitoring, and psychosocial and medical care. Recovering from or stabilizing patients' physical illnesses and meeting their basic needs like nutrition and pain management are top priorities. Ill and frail patients regularly require more 1:1 time, but are slowly incorporated into the milieu as they become physically able to do so.

Pain management, which is known to improve quality of life and reduce behavioral disturbances among patients with dementia (Brummel-Smith, London, Drew, Krulewitch, Singer, & Hanson, 2002), is a primary focus of nursing care. History and description of pain should be assessed for appropriate management and evaluation. The most accurate

and reliable evidence for the existence of pain is the patient's description (Ferrell & Chodosh, 2003). Staff also can use any available numeric, graphic faces, and word descriptor pain scales to quantify pain intensity. However, pain assessment can be challenging for patients with cognitive impairment. Grimacing and groaning may indicate pain for some, but others may sleep through pain. Some patients may have changes in routine activities and interactions or exhibit restlessness and agitation. JRBC staff are trained in pain assessment of nonverbal and cognitively impaired individuals. The patient-centered approach makes it possible for staff to know patients more closely and establish a method of communication for pain assessment. Behavior changes that may be associated with pain can be recognized early. A simple yes-or-no question may provide reliable answers. JRBC staff also use the FLACC (face, leg, activity, cry, consolable) behavioral assessment scale, developed for use with children, to quantify pain intensity for nonverbal patients (Willis, Merkel, Voepel-Lewis, & Malviya, 2003). Input from family members and other caregivers can be helpful and is considered when evaluating for pain or response to treatment. Analgesia is provided when needed or scheduled round the clock in patients who have conditions that are associated with pain such as musculoskeletal problems and malignancies. Pain management also is given prior to uncomfortable procedures such as physical therapy or wound care. Difficult cases, especially for patients with malignancies non-responsive to pain medications, are referred to the pain center for management.

Maintaining nutritional intake and strength is essential for frail older adults (Fried & Walston, 2003). Depression regularly contributes to poor intake and inactivity, factors that gradually improve as the depression resolves. During acute medical crises, potential consequences of malnutrition, dehydration, and immobility are more severe in geriatric clients. Intravenous fluids, central venous nutrition, and, occasionally, gastric tube feedings may be indicated to provide the needed nutrients. However, these invasive procedures should only be used temporarily and are not a permanent solution for food refusal. Patients can revert back to natural eating when able. The decision for permanent enteral tube placement may be controversial with families and even some healthcare professionals. Benefits and disadvantages are discussed during interdisciplinary team meetings and family conferences. In advanced dementia, tube feedings do not prevent aspiration or improve quality of life and comfort and increase the risk for use of restraints (Hurley & Volicer, 2002). Tube feeding may still be considered by some people as "life-sustaining." As difficult as it may be, discussions with families about the enteral tube placement is necessary to support

family members and ensure that the patient's quality of life is given priority.

Patients with cognitive and emotional problems are often unable or unwilling to participate in traditional forms of physical therapy. These patients may flatly refuse, are too agitated to participate, or are too cognitively impaired to process instructions. However, exercises for frail patients are important to prevent consequences of inactivity and immobility. Thus, JRBC incorporates exercise and movement into patients' daily activities whenever possible. For example, instead of offering a bedpan, staff encourages those who can ambulate to walk to the bathroom. We include simple exercises in group activities, such as active range of motion exercises for neck, shoulder, and arms performed while seated. As noted earlier, OT modified their practices, such as including strengthening exercises, to better accommodate physically frail patients.

Legal and ethical considerations also have important roles in the quality of life for severely ill patients. Together with families, the interdisciplinary team is often faced with difficult decisions regarding life-sustaining approaches, especially in the absence of advance directives. At times, hospital ethicists are consulted to help us with the process. JRBC staff works diligently to educate families about advance directives, starting at admission to the unit. Over time, trusting relationships with patients and their families can be built, making difficult decisions somewhat easier because there is mutual hope for positive outcomes.

Delirium

Delirium, which is also called acute confusion in the nursing literature, is another significant problem encountered among geropsychiatric inpatients and medically ill patients transferred to our unit. An acute disorder of attention and global cognitive function (Agostini & Inouye, 2003), delirium is characterized by clouding of consciousness, disorientation, and recent memory loss (Maxmen & Ward, 1995). Delirium complicates hospitalization for more than 2.3 million older adults, accounting for more than $4 billion each year (Agostini & Inouye, 2003). Its etiology is multifactorial and complex (Sandberg, Gustafson, Brannstrom, & Bucht, 1999). McCusker and colleagues (2001) showed that the presence of delirium during hospitalization is associated with significantly worse physical and cognitive status in older medical inpatients, even after discharge. Typically, hospital stays in acute medical floors are much shorter than the time required to resolve delirium, and increasingly patients with this problem are transferred to the geriatric psychiatric service for continued hospitalization.

Treatment of delirium is based on its multifactorial causes. Aside from resolving predisposing and precipitating factors, the mainstays of managing delirium are nonpharmacologic approaches (Agostini & Inouye, 2003). Close attention is given to environmental factors that may be confusing to the older patient, and that contribute to his or her delirium, as well as depression or psychosis. The use of calendars and clocks in common areas and patients' rooms often helps with reality orientation. Continuous redirection, cueing, and reassurance for safety are very important for patients and done throughout the day. Patients' personal items are kept in the same place to lessen confusion. Families are encouraged to bring some personal objects, such as cards, photographs, and "security" objects, from home to promote orientation. Patients are involved in self-care to the fullest extent possible, and are encouraged to make their own decisions and maintain normal daily routines.

The primary care model applied in JRBC has been beneficial in the care of delirious patients. To maintain familiarity with care providers, each patient is assigned a primary staff associate to avoid frequent staffing changes. This has been helpful for confused patients to see a familiar face when everything seems strange. Working with the same patients also assists staff to establish trust within a shorter period of time. Nursing procedures are often easier to complete when patients recognize and trust their caregiver.

JRBC staff work diligently to manage behavior problems associated with delirium with nonpharmacological interventions (e.g., comfort measures, engagement in activities, distraction, decreased stimulation) before using medications. These approaches often are efficacious and very satisfying, as supported in some studies (Colenda, Rapp, Leist, & Poses, 1996; Hughes & Medina-Walpole, 2000). The use of more medications increases the risk for drug-drug interactions and possibly confounds the problem of delirium. If psychoactive medications are indicated, the general geriatric prescribing principle, "start low and go slow," is applied.

Polypharmacy

Behavior problems often contribute to inappropriate use of pharmacological treatments. Although over-medication is a common problem, other regularly encountered problems include over-reliance on medication as an intervention, treating patients symptomatically, erroneously using medications in combination, and failure to titrate medications to reach their full therapeutic benefit. These challenges are described in the literature. Colenda and colleagues (1996) found that physicians are

more likely to rely on medications as first-line intervention for reducing agitation. This practice may mask the root cause of the problem by attending only to the symptomatology of the disease while ignoring underlying causes that may be reversible. For example, effective treatment of depression has been shown to decrease behavioral disturbances (Kunik, Graham, Snow-Turek, Molinari, Orengo, & Workman, 1998). However, those who are unfamiliar with late-life depression may not consider it as an etiology for agitation.

Other reports indicate that many medically ill and depressed elderly patients receive no antidepressants, inappropriate choices of drugs, or subtherapeutic doses when treated (Koenig, George, & Meador, 1997), problems that are regularly addressed in our unit. Another problem commonly observed by JRBC staff is that medications that were effective in controlling behavioral problems associated with dementia are frequently discontinued, ignored, or withheld when patients are transferred to other units or facilities for medical procedures. In the absence of needed medications, the patient's comfort and well-being are compromised, behavioral symptoms become troubling, and readmission to our unit for stabilization is required. When patients are readmitted, admitting nurses and attending physicians compare previous records with new ones and adjustments are made as needed.

Polypharmacy, defined as the use of more medications than are clinically necessary, is associated with increased risk of adverse drug reactions and falls in the elderly (Rho & Wong, 1998). Medically complex psychiatric patients with behavioral disturbances admitted for geropsychiatric evaluation and treatment are at particularly high risk for polypharmacy for a number of reasons. First, these patients have multiple chronic diseases, so it is common for them to be taking several medications. In the age of specialty medical practice, patients can have many health care providers prescribing a number of medications with little coordination of care or medications (Larsen & Hoot Martin, 1999). Almost all of the patients admitted to our unit have four or more prescribed medications at the time of admission. Second, patients may have been treated based on symptomatology and not the underlying cause. For example, antipsychotics and benzodiazepines may have been used to treat psychosis and agitation among patients with psychotic depression but these patients may not have been appropriately treated with antidepressants. In addition, alternative non-pharmacological measures may not have been tried initially to alleviate certain problems such as difficulty sleeping or behavior outbursts. Instead, patients were quickly given medications. Furthermore, patients may have been prescribed medications to treat side effects of other drugs that they are

already taking. For example, laxatives were used to relieve constipation from antipsychotics without first trying to promote bowel motility using non-pharmacological methods, such as increased dietary fiber or fluid intake.

The solution to polypharmacy is not simple. The first step is to ensure effective communication among all health care providers from the first admission, throughout the hospital stay, and after discharge (Lilley & Guanci, 1996). JRBC staff are cognizant of medications taken by the patient. Upon admission a detailed list of prescribed and non-prescribed drugs, including alternative medicine or home remedies, is obtained. Known drug-drug interactions are identified and reported to the physician, and all medications are reviewed by JRBC's pharmacists for potential adverse side-effects and drug interactions. The pharmacist may make recommendations for discontinuing or changing medications, as well as lowering or increasing drug doses when appropriate.

JRBC nursing staff are committed to non-pharmacological approaches prior to the use of medications to manage certain situations when applicable. For example, interventions for pain management start with repositioning, ice pack, heat, massage, or distraction before giving analgesics. Warm milk and light snack, environmental modifications, and comfort measures are tried for insomnia instead of sleeping pills. Reality orientation, frequent interactions, reassurance, engagement in activities, and time-outs in room to decrease stimulation are used to manage anxiety or agitation without using anti-anxiety drugs. Some nutritional deficiencies may be prevented with dietary modifications and supplements without adding more drugs.

Age-related physiologic changes require cautious medication and dosage adjustments. Adverse effects of medications, such as psychosis, can be very disturbing to patients, adversely affect their activities of daily living, and even lead to hospitalization (Pestka, Billman, Alexander, & Rosenblad, 2002). Thus, judicious use of medications, especially when managing behavior problems, can not be over-emphasized.

SUMMARY AND STEPS AHEAD

Our treatment program requires a multidimensional approach that binds medical, psychopharmacological, cognitive, and behavioral methods (Colenda et al., 1996; Rosenberg, 2000). Our unit employs comprehensive geriatric assessment that focuses on syndromes rather than individual disease entities. Multiple factors that cause the cluster of symptoms with which patients present are emphasized and care

plans target increasing function, improving quality of life, and preventing frailty through an interdisciplinary team approach (Ashley, Rockwell, Gladsjo, & Jeste, 2000; Blazer, 2000). The complementary approaches of psychiatry and medicine are indispensable tools in the management of this challenging population, and interdisciplinary care plan staffings are integral parts of patient care. Only with a unified plan from all disciplines can we tease out the intricacies surrounding care of a frail elderly patient in psychiatry.

The increase in the number of older adults in the U.S. over the next several decades will have a substantial impact on the demand for health care services. The sheer growth in numbers will result in more older patients suffering from mental illnesses along with physical problems. Likewise, additional advances in medical technology will facilitate living longer in more frail states of health. Challenges currently faced in geropsychiatric care will no doubt change and potentially increase, thus demanding new solutions and strategies.

Research has been the backbone for developing innovative ways in dealing with current problems. Because gerontology, and particularly geriatric psychiatry, are relatively new specialty areas, research-based practices often lag behind. Most evidence-based treatment modalities in current use (e.g., new psychotropic medications) are the result of studies based on the general population. Likewise, older adults are not regularly included in clinical trials evaluating new medications prior to Federal Drug Administration approval, raising questions about safety and efficacy for use among older adults. As Jeste (1997) suggests, clinical trials should include adequate numbers of elderly psychiatric patients to evaluate new medications for efficacy, side effects, drug interactions, and dosing in older adults prior to their approval. However, the issues surrounding older adults such as biological heterogeneity, more physical and cognitive comorbities, polypharmacy, higher side effects from drugs, socioeconomic stressors, and ageism call for more research that specifically targets older adults (Jeste et al., 1999). For many geropsychiatric providers, research that improves health-related quality of life and functional status among frail older patients is as important as finding a "cure." For example, studies are needed on how to successfully translate interventions used during hospitalization (medication management, fall prevention, exercise and dietary regimen) to care provided following discharge, using health status and rates of rehospitalization as outcomes.

Those working in geriatric psychiatry also need to reassess current practices and become proactive in dealing with the increasing medical complexities of older patients. Nursing care and interdisciplinary protocols are needed to astutely manage physical comorbidities.

Keen-minded assessment, monitoring, and ongoing interventions are essential to prevent conditions that potentially contribute to psychological distress. For example, problems associated with delirium may be reduced or prevented by early recognition of risk factors and prompt nursing interventions to modify nursing routines and environmental influences.

Education and training will continue to be a high priority. Methods to attract and retain appropriately trained staff are needed to meet new and increasing demands in geriatric mental health. (Refer also to the articles by Puntil and Specht & Mobily in this issue.) Likewise, strategies to involve caregivers in health teaching and prepare them for what could be a difficult transition need to be developed and evaluated. Mental health policies and procedures should be reevaluated and modified to address current demands. By working together as an interdisciplinary team, these challenges may be converted into opportunities that expand our knowledge and steer our therapies towards adding new life to the remaining years of frail elderly patients.

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