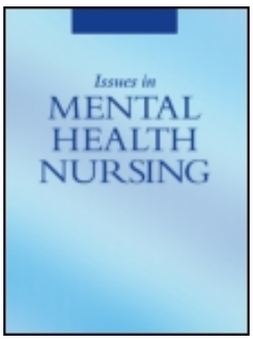

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MANAGING PERPLEXING PATIENTS: THE CASE OF HELEN

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The challenges faced in provision of high quality and effective care to geriatric psychiatric inpatients are substantial for all members of the interdisciplinary team. Common care dilemmas, including the interplay of social, medical, and psychiatric factors in treating complex patients, are perhaps best understood by examining such a case. The hypothetical case of "Helen" illustrates the multi-dimensional and often perplexing care needs of patients admitted multiple times for inpatient care. Linked nursing diagnoses, outcomes and interventions, and interdisciplinary care plans emphasize the changing care needs of such patients.

Clinical staff's perceptions that older adults admitted to geropsychiatric inpatient units over the last decade are increasingly complex and time-consuming (Inventor, Henricks, Rodman, Imel, Holeman, & Hernandez, this issue) are grounded in day-to-day experiences with real-life patients whose medical and psychiatric symptoms converge, interact, and make both diagnosis and treatment difficult. In spite of the best efforts of interdisplinary team members to fully cooperate with one another, providing excellent and accurate assessments, multifaceted behavioral and medication interventions, patient and family teaching, and referrals and discharge planning to assure continuity of care, some patients' problems persist.

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These patients are often complex, and as important, perplexing, to treatment team members, and often result in multiple admissions. Although each patient is unique and different from others, shared characteristics of these perplexing patients often include the presence of multiple and unclear psychiatric diagnoses, often with suspicion of a new and emerging problem such as cognitive impairment; presence of medical diagnoses that symptomatically overlap and mimic psychiatric ones; use of multiple medications that increase risks of side effects, interactions, and medication errors outside the hospital; and challenged family or caregiver support systems that add another layer of complexity to care questions.

The last issue, family and caregiver contributions to complex and perplexing cases, is particularly difficult for many interdisciplinary care teams. Although team members may each view problems and challenges from a somewhat different perspective because of their individual specialty, failed discharge plans are equally disappointing to each discipline, whether nursing and nursing personnel, social work, psychiatry, medicine, occupational therapy, or other supportive therapy staff. Readmitting a patient in a decompensated state shortly after the person was discharged in a stable and functioning condition is frustrating, puzzling, and, at times, discouraging to geropsychiatric inpatient care team members.

Family and caregiver themes that complicate stabilization and maintenance of complex and perplexing care cases in our own tertiary care setting include denial (e.g., not accepting the patient's level of impairment and need for supervision and assistance); resistance (e.g., failing to sustain supportive care needed to promote optimal function following discharge); divergent opinions on care needs and options (e.g., disagreement about placement needs, unrealistic expectations for the patient's ability to function, or failure to adapt environments or routines to promote functional capacity); and indifference (e.g., failing to make any arrangement, in spite of having decision-making authority and capacity). Although there is no data to support this proposition, a common complaint heard among inpatient providers is, "The patient isn't so bad; it's the family that has the problem."

Although scientific evidence to support the propositions offered here are sadly lacking, anecdotal data suggests that complex and perplexing cases are increasingly the "norm" in inpatient geropsychiatric care units. To illustrate common care challenges and dilemmas, a case vignette that synthesizes key care challenges is described and analyzed. The patient, "Helen," is a fictitious character that represents commonly encountered challenges in assessing and treating these patients, and team

efforts to promote adaptation and function following discharge to family caregivers and long-distance community service providers.

Helen's changing nursing, psychiatric, and ancillary care needs are reviewed and discussed, and summarized in tables. Linked nursing diagnoses, outcomes and interventions in this hypothetical case illustrate common care challenges, and the value of this approach in formulating care plans (Johnson, Bulechek, Dochterman, Maas, & Morehead, 2001; Maas, Buckwalter, Hardy, Tripp-Reimer, Titler, & Specht, 2001; Morehead, Johnson, & Maas, 2000). The growing movement toward use of uniform and standardized nursing language is believed to be particularly beneficial in tracking often subtle changes in status among complex patients. While other members of the interdisciplinary team make equal contributions to the promotion of comfort and function of complex patients, documentation methods differ substantially. As a result, interdisciplinary outcomes noted in tables are approximated from narrative descriptions commonly found in clinical records. However, other disciplines also could use nursing outcomes classification.

THE CASE OF HELEN

Helen's First Admission

Helen was admitted to the geriatric psychiatric unit from her home for evaluation and treatment of "severe depression," including symptoms of social withdrawal, refusal to participate in daily activities, fearfulness, restlessness, insomnia, and angry outbursts toward her husband and adult son. Accompanying records indicated that the 82-year-old married female had been treated in her local community for depression that developed in conjunction with a hip fracture repair following a serious fall. Her course of treatment for the fracture was difficult, including the development of complications, several hospitalizations, and relatively unsuccessful rehabilitation. The previously functionally independent woman now had limited physical mobility, walked with a walker, required assistance with bathing and grooming, and complained persistently of pain. Her depression was viewed by family as a "natural response" to her situation, but one she "needed to get over, and just move ahead."

On interview, Helen expressed frustration and anger with her husband, noting that she was "afraid" and in pain nearly every day, that she had no desire to be out in the community doing things with him, and wished he could somehow understand that her life had been "turned upside down"

TABLE 1. First Admission Diagnoses, Outcomes, and Interventions

Discipline	Diagnosis/problem	Outcomes		Interventions & referrals
		Admission[a]	Discharge	
		Nursing care		
Nursing	Depression: Reactive, situational	Depression level: 1 = Severe	Depression level: 4 = Mild	• Individual counseling • Participation in milieu activities • Anticipatory guidance • Coping enhancement • Decision-making support • Medication management
	Pain	Pain level: 2 = Substantial Pain disruptive effects: 2 = Substantial	Pain level: 4 = Mild Pain disruptive effects 5 = None	• Medication management • Environmental management
	Sleep pattern disturbance	Sleep: 2 = Substantially compromised	Sleep: 5 = Mildly compromised	• Sleep enhancement: pain management, anxiety reduction, coping enhancement, positioning, simple massage, environmental management • Sleep hygiene: eliminate caffeine, offer bedtime snacks, avoid daytime bed rest • Medication management
	Self care deficits: Bathing/hygiene Grooming/dressing	Self-care status: 2 = Substantially compromised	Self-care status: 4 = Mildly compromised	• Self-care assistance: bathing; ear, foot, hair, nail, perineal cares; dressing • Oral health maintenance • Individual teaching following OT recommendation

	Walking: Impaired	Mobility: 3 = Moderately compromised	Mobility: 2 = Mildly compromised	• Exercise therapy: Ambulate twice on days and evening shifts, walk to toilet at night • Encourage proper use of walker • Avoid wheelchair use
	Social interaction: Impaired	Social interaction skills: 1 = Never demonstrated	Social interaction skills: 4 = Often demonstrated	• Socialization enhancement: activity therapy, values clarification, emotional support, humor
	Anxiety	Anxiety level: 3 = Moderate	Anxiety level: 2 = Mild	• Coping enhancement • Calming techniques • Medication management
	Injury: Risk for falling	Fall preventive behavior: 3 = Sometimes demonstrated Fall occurrence: 5 = None	Fall preventive behavior: 5 = Consistently demonstrated Fall occurrence: 5 = None	• Environmental management • Surveillance
		Interdisciplinary care		
Psychiatry	Axis I: Major depression with anxious features	Severe	In partial remission	• Change psychiatric medications: sertraline for paxil; trazodone for ativan • Standard labs: urinalysis (UA), complete blood count (CBC), thyroid function, B12, folate • Refer to occupational, activity and physical therapies • Request/review past medical and psychiatric histories

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TABLE 1. First Admission Diagnoses, Outcomes, and Interventions *(Continued)*

Discipline	Diagnosis/problem	Outcomes		Interventions & referrals
		Admission[a]	Discharge	
	Axis III: Pain associated with hip fracture repair, hypertension in good control	Pain: Moderate hypertension (HTN) Good control	Pain: In reasonably good control HTN: Unchanged	• Discontinue ibuprophen; substitute acetaminophen 650 mg every 4 hours while awake • Continue antihypertensive regimen prescribed by patient's local internist
Social work	Family conflicts	Moderate to substantial	Moderate	• Identification of family stressors, coping mechanisms • Supportive counseling: family • Supportive counseling: patient
Occupational therapy	Functional impairments: Bathing, grooming, mobility	Substantially impaired; motivation low	Mildly impaired; motivation questionable	• Conduct full assessment • Assist with morning personal cares and use of adaptive strategies • Ambulation • Participation in OT groups
Physical therapy	Potential gait instability	Moderate	Mild; continued PT, exercise, and use of walker highly recommended	• Ambulate twice daily
Activity therapy	Activity deficits: Leisure	Substantial	Mild; greatly improved participation and interaction	• Participation in daily AT groups • Individualized program of leisure activity: word puzzles, music, television viewing, reading

[a] The nursing outcomes identified at admission are baseline measurements against which the discharge outcomes are compared, allowing a change in rating to be calculated. This difference in score captures the effect of the nursing interventions used. All data are fictitious, representing an amalgam of cases commonly seen in geropsychiatric inpatient nursing and interdisciplinary care.

following her fall. She viewed her behavior changes as a "natural reaction" to discomfort and fear of falling again, noting that she also "never liked being a socialite" and was grateful for the excuse to "just stay home." She described her husband and son as "pushy, demanding, macho men" who were accustomed to her "catering to their every whim." Her closest ally was her only daughter who lived several states away and rarely visited. However, she and her daughter talked on the phone weekly, and the calls were one of the few bright spots in Helen's daily life. Her daughter, a nurse, was described as "the only person who really understands what it's like to suffer." Helen concluded that she didn't really have much of a problem. It was her husband who had the "real" problem, and that he resented her new dependency.

Helen was often observed frowning, wincing, and looking fearful while sitting in the dayroom of the unit. When asked if she was "all right," her most common response was "How can I be all right? I'm here, aren't I? How can anyone be all right in *this* place?" Even when asked directly about her worried facial expression, or fidgeting, restless movement that suggested anxiety, she denied feeling "anxious" and instead blamed "bad nerves" related to her aches and pains, and just wanting to "just go back home."

Helen's medications were adjusted, including tapering and discontinuing Paxil and substituting Sertraline. Trazodone 25 mg three times a day was prescribed to reduce anxious behaviors and Ativan was discontinued due to the associated risk of falling. Occupational and physical therapy referrals were made and Helen cooperated with both assessments and interventions, responding well to prompting, cueing, and substantial encouragement. Nursing personnel observed that Helen had a very dry sense of humor that was difficult to distinguish from hostility and anger, but responded well to support, encouragement, and empathy. After sufficient rapport was established, staff successfully used humor to divert Helen's attention from negative to more positive thoughts. Individual counseling sessions offered support for setting limits with her husband and son, and supported and reinforced her realistic desire to guard against additional physical injury by falling a second time. These sessions provided information about the potential effects of depression on motivation and feeling hopeful, and strongly encouraged increased activity, particularly in the arena of continued physical therapy to increase functional abilities. Helen improved, becoming increasingly pleasant and conversant, cooperating in nearly all daily routines and cares, and was discharged "in partial remission" to return to care in her local community.

Helen's Second Admission

Within three months, Helen was readmitted to the geropsychiatric inpatient unit for a second evaluation, this time based on her husband's observation that she was "threatening him" and that "things only got worse after they got home." Her 50-year-old son accused the clinical staff of "closing their eyes" to his mother's "serious depression," complaining that she "wasn't right" and was "just getting worse." In contrast, Helen's daughter offered support for her mother "setting limits with those two spoiled boys."

On exam, Helen's depressive symptoms appeared no worse than her status at discharge. Anxious behaviors, on the other hand, were increased. Her facial expression was one of apprehension and worry, with her brow drawn down and watchful eyes that darted around the dayroom room as if monitoring potential threats to her well-being. She refused to walk, even with assistance, stating that she "just can't do it" and only wanted "to be left alone." Persistent and repetitive questions about "when can I go home?" and "why are you doing this to me?" emerged as a new theme, and were accompanied by sleep disturbance, urinary incontinence, and episodes of yelling for help, instead of using a call-light, when alone in her room.

Anxious and somewhat confused behavior dominated her clinical presentation, suggesting that delirium might be overlapping on her "anxious depression." Episodes of tearfulness and sad affect occurred only in the context of staff instructing her to be more independent, to participate in physical and occupational therapy activities oriented at self-care capacity, and to "talk to them" about her experiences and feelings. In response to the last, she regularly burst into tears, saying "Why can't you just leave me alone? I am an old woman! I don't deserve to be treated like this! Why can't I just go home and do what I want? What is so wrong with *that*?!" As if to emphasize her distress with being returned to the hospital, Helen refused to engage in nearly all therapeutic and rehabilitative activities, stating she was "fed up with this nonsense" and had no interest in "getting better" since that only meant having to "keep up with him [her husband] again."

Helen's evaluation and treatment during her inpatient stay addressed the combined presentation of depressive and anxious symptoms, employed both physical and occupational therapies to promote self-care activities, and explored marital and family conflicts as a potential source of stress that complicated her recovery from "anxious depression." Although persistent apprehensive and worrisome signs and symptoms were observed and her behavior prior to admission had agoraphobic

TABLE 2. Second Admission Diagnoses, Outcomes, and Interventions

Discipline	Diagnosis/problem	Outcomes		Interventions & referrals
		Admission[a]	Discharge	
		Nursing care		
Nursing	Anxiety	Anxiety level: 1 = Severe Mood equilibrium: 2 = Rarely demonstrated	Anxiety level: 3 = Mild Mood equilibrium: 4 = Often demonstrated	• Individual counseling • Coping enhancement: calming techniques, emotional support, active listening • Anxiety reduction, hope instillation, humor • Behavior management, limit-setting, anticipatory guidance, structure/information provision • Medication management
	Acute confusion	Cognitive orientation: 2 = Substantially compromised	Cognitive orientation: 5 = Not compromised	• Reality orientation: conversational verbal orientation; calendar placed in room; assure glasses, hearing aide, and watch are worn • Calming techniques: touch, presence, self-care assistance, reassurance, redirection • Pain, sleep management • Fall prevention; surveillance related to safety

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TABLE 2. Second Admission Diagnoses, Outcomes, and Interventions

Discipline	Diagnosis/problem	Outcomes		Interventions & referrals
		Admission[a]	Discharge	
	Urinary incontinence	Urinary continence: 2 = Rarely demonstrated	Urinary continence: 5 = Consistently demonstrated	• Determine usual voiding habits • Establish a toileting schedule based on usual habits • Assist to toilet and prompt to void • Increase/decrease toileting intervals based on incontinence episode • Promote fluid intake; avoid caffeine • Record accurate intake and output for 72 hours and re-evaluate • Cleanse skin, genital area after incontinent episodes • Monitor and document skin integrity
	Pain	Pain level: 3 = Moderate Pain disruptive effects: 1 = Severe	Pain level: 4 = Mild Pain disruptive effects: 4 = Mild	• Medication management • Environmental management
	Sleep pattern disturbance	Sleep: 1 = Severely compromised	Sleep: 4 = Not compromised	• Sleep enhancement: pain management, positioning, simple massage, environmental management • Sleep hygiene: eliminate caffeine, offer bedtime snacks, avoid daytime bed rest • Medication management

Disruptive vocalization	Expressive communication: 2 = Substantially compromised	Expressive communication: 5 = Not compromised	• Coping enhancement: calming techniques, emotional support, active listening, reassurance • Surveillance: address patient during 15 minute checks; provide call light; avoid use of intercom system; avoid isolation in room; encourage being in public areas
Family coping: Compromised, ineffective	Family coping: 2 = Rarely demonstrated	Family coping: 3 = Sometimes demonstrated	• Family mobilization: increased involvement of daughter • Decision-making support: Patient • Coping enhancement: son, husband • Referrals in cooperation with social work
Activity intolerance	Endurance: 1 = Severely compromised	Endurance: 4 = Mildly Compromised	• Exercise promotion • Pain management • Body mechanics promotion • Environmental management
Depression: Reactive, situational	Depression level: 4 = Moderate	Depression level: 4 = Mild	• Individual counseling • Participation in milieu activities • Medication management
Injury: Risk of falling	Fall prevention behavior: 1 = Never observed	Fall prevention behavior: 4 = Often observed	• Environmental management • Body mechanics promotion • Surveillance

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TABLE 2. Second Admission Diagnoses, Outcomes, and Interventions *(Continued)*

Discipline	Diagnosis/problem	Outcomes		Interventions & referrals
		Admission[a]	Discharge	
		Interdisciplinary care		
Psychiatry	Axis I: Depression with anxious features; Rule out generalized anxiety disorder vs. agoraphobia without panic attacks	Depression: Moderate; Rule out anxiety disorder	Depression: Mild	• Increase sertraline • Increase trazodone to 25 mg QID, add 50 mg at HS • Request/review past medical and psychiatric histories • Internal medicine consult: Evaluate possible new onset medical problems • Collect collateral history from family members
	Rule out delirium vs. early dementia	Rule out delirium	Delirium, in remission	• Neuropsychiatric consult: Evaluate possible new onset cognitive impairment • Labs: UA, CBC
	Axis III: Pain associated with hip fracture repair, hypertension in good control	Pain: Moderate HTN: Unchanged	Pain: In adequate control HTN: Unchanged	• Add celecoxib 100 mg BID • Continue antihypertensive regimen prescribed by patient's local internist • Change acetaminophen to 650 mg to every 6 hours
Social work	Family conflicts	Severe	Moderate: Additional community support and follow-up recommended; Multiple referrals	• Supportive counseling: family • Supportive counseling: patient • Multiple community resource referrals:

				✓ Area agency on aging chore service: Ramp/rails on steps into house ✓ Visiting nurses: home health aide to assist with personal cares ✓ Community mental health center: in-home counseling service for older adults ✓ OT evaluation: in-home assessment of safety, use of adaptive equipment and devices, home modifications to promote function
Occupational therapy	Cognitive and functional impairments	Severely impaired: Motivation low; Cognitive impairment moderate	Moderately impaired: Motivation improved; Cognitive impairment mild; Requires some supervision at home	• Conduct full assessment • Assist nursing personnel with provision of daily cares; reinforce use of adaptive strategies • Assist nursing personnel with 2-person assist to ambulate • Participation in OT groups
Physical therapy	Gait instability	Severe: Motivation and cooperation low	Mild: Motivation and cooperation improved	• Ambulate twice daily • Independent PT exercises to be continued at home
Activity therapy	Activity deficits: Leisure	Severe: Withdrawn, indifferent, uncooperative	Groups interaction: Greatly improved from admission; Independent activities: Moderately impaired	• Participation in daily AT groups • Individualized program of leisure activity: Reevaluate current interests and willingness to participate

[a]The nursing outcomes identified at admission are baseline measurements against which the discharge outcomes are compared, allowing a change in rating to be calculated. This difference in score captures the effect of the nursing interventions used. All data are fictitious, representing an amalgam of cases commonly seen in geropsychiatric inpatient nursing and interdisciplinary care.

components, Helen's clinical picture appeared more related to recent stress and life change, marital discord, and real-life fears based in her immediate past history.

To best understand Helen's reasonably stable depressive symptoms but increased anxiety and confusion, a comprehensive medical work-up was initiated to rule out potential new onset health problems and to evaluate her underlying cognitive status, including consultations with internal medicine and neuropsychiatry. Neuropsychological testing suggested a pattern of variable mental status performance with sustained impairment in delayed memory, although she was not sufficiently impaired to warrant a diagnosis of dementia. Her memory performance overall was felt to be significantly influenced by her depressive symptoms. As before, PT and OT were initiated with goals of facilitating self-care and making reality-based recommendations to family regarding Helen's abilities and potential for further rehabilitation. Family therapy targeted development of realistic and mutually agreeable expectations for Helen's participation in personal, family, and community life, and exploration of anxious feelings and behaviors prior to falling a year ago.

During these sessions, Helen's husband and son expressed great dismay about her deterioration and management, and high expectations for her recovery. History of long-term anxiety was not revealed, however long-standing family dysfunction was suspected, and later confirmed by Helen's daughter. During family sessions, special attention was given to Helen's real-life limitations based on PT and OT evaluations. An emphasis was placed on the need for her husband and son to lower their expectations and to provide additional emotional support and actual assistance in household chores or employ outside assistance. They needed to adjust daily routines and further adapt the home to facilitate Helen's comfort and function (e.g., building a ramp as an alternative to the unrailed steps into the home).

Therapists noted that most suggestions for change were supported by Helen but resisted by the husband and son. However, frequent telephone calls from Helen's daughter offered support, encouragement, and reassurance that the treatment team was "right on target" and should pursue all referrals to help her mother be successful after returning home. Helen's daughter warned, "don't let him [her father] give you the line that he 'can't afford it!' " noting that her parents had considerable financial resources with which to work, and her mother had complete rights to "everything that cheap b—has for waiting on him hand and foot!"

Medications were again adjusted. Having responded inadequately to two trials of selective serotonin reuptake inhibitors (SSRIs) at therapeutic doses, a trial of Venlafaxine was initiated. However, the interdisciplinary

team concluded that the empathic and supportive roles played by nursing staff, the social worker, and activity, occupational and physical therapy personnel produced as many positive outcomes in Helen's confused and anxious behavior as did the pharmacotherapy. She was again discharged to home, to return to the care of her local psychiatrist and internist. However, additional referrals were made to the local mental health center that offered in-home counseling by a nurse-therapist, to the local OT service to conduct an in-home assessment of possible household adaptations to promote function, to visiting nurses for in-home health aide and homemaker services, and to the local area on aging chore service for potential assistance in building a ramp to the home.

Helen's Third Admission

Helen returned to the inpatient service a third time several months later. According to the report of the local nurse-therapist, Helen maintained and gained in abilities during the three months she had weekly in-home supportive counseling. Although numerous recommendations were made as a result of in-home OT evaluation, Helen's husband refused to make any changes, either in adapting the home or in providing household assistance. The home health aide and homemaker were both "fired" shortly after services were started, and the plan to add rails to existing steps into the home was vetoed. According to verbal reports, Helen's husband persisted in the belief that his wife "could get better if she only wanted to." In spite of his failure to make recommended changes, Helen appeared to be stable and in-home counseling was discontinued.

Shortly after in-home counseling services were stopped, Helen's husband took her to the emergency department of the local hospital because of threats toward him and again demanded treatment of her "depression." She was again referred to the tertiary care inpatient unit for evaluation. At the time of admission, Helen's level of decompensation was troubling to all interdisciplinary team members. Given Helen's level of functioning prior to her most recent discharge, and reports provided by local community care providers, her presentation at readmission seemed disproportionately impaired and dysfunctional. She was withdrawn, indifferent, dependent in all daily cares, and appeared psychotically disconnected from staff and other patients alike, even though no overt delusions or hallucinations were detected. As in earlier admissions, anxiety-related behaviors included restlessness, irritability, insomnia, and agitation when pressed to perform, answer questions, or comply with "unnecessary" daily routines. During the interval period that Helen had been in the community, further medication trials had been attempted by her local

physician. These trials included tricyclic antidepressants, which she did not tolerate due to constipation, as well as Ritalin augmentation, which only increased her anxiety and was discontinued.

Comprehensive interdisciplinary reassessment was conducted to evaluate new causes for cognitive, depressive, and anxious symptoms. The regimen of interventions implemented in Helen's most recent hospitalization was reinstituted, and despite feelings of frustration and disappointment, staff regularly referred to Helen as "needing to get her spunk back" and being "too tired to give us trouble right now." In spite of being what staff called a "repeat offender" (a term affectionately applied to patients with high recidivism), respect and affection for Helen was visible in all care provided. In spite of Helen's current level of withdrawal, indifference, and apathy, staff fondly reminisced about her earlier "attitude problems" and felt confident that she would again revive and "tell them all where to go." The possibility of electroconvulsive therapy (ECT) was brought up with Helen and her family, although the chronicity of her condition did not overwhelmingly favor this as an optimal choice. The notion of ECT was not acceptable to Helen, who would not discuss it further.

As before, nursing care promoted self-care, self-esteem, independent decision-making, discussion of thoughts and feelings, participation in the milieu, and cooperation in habilitative therapies. Activity, occupational, and physical therapies focused on independent function, promotion of self-worth, and engagement in ongoing protocols aimed at maintaining and increasing functional abilities. Medication adjustments were again made, but the discharge plan eventually resulted in Helen's placement in a nursing facility. Her discharge diagnosis, as at her first admission, continued to be depression with anxious features. No additional anxiety disorder diagnosis was made as the interdisciplinary team concluded that her anxiety and fearfulness were grounded in her recent traumatic experiences with falling, injury, and loss of ability, and were exacerbated by her husband and son's failure to grasp her real life pain, disability, and fear of further decline. Questions about early cognitive impairment remained, but awaited later evaluation to confirm declines. Perhaps not surprisingly, Helen was supportive of her discharge to a nursing home where, as she said, she might finally be "left alone."

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