PSYCHIATRIC EMERGENCIES IN THE NURSING HOME

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4/20/2000

FIRST THINGS FIRST WHEN ASKED TO EVALUATE A PATIENT:

After introducing oneself to the patient and making an attempt to establish some rapport, the examiner's first probing question should almost always be "Are you in pain?" Failure to ask this question and address the pain issue has led to many misdiagnoses and inappropriate treatment, which has only prolonged the suffering of a patient and caused many unnecessary side effects.

1. Adjustment disorders

Upon admission to a nursing home ward, a patient will often become agitated, tearful, depressed, anxious or even psychotic. This usually occurs within the first forty-eight hours after admission and lasts from 4 to 10 days.

Major interventions include reassurance, spending more time with the patient, asking nursing staff to spend more time with the patient, frequent re-orienting of the mild-moderately demented patient, low dose prn risperidone (oral concentrate) and/or lorazepam.

Seldom does a patient need to be transferred to acute psychiatry for the treatment of this problem. If a patient is on voluntary or other non-LPS status and demands to leave during this time, he/she should be placed on a 5150 and almost always this 5150 can be discontinued before the end of the 72-hour period. If, however, it appears as though the reaction is more severe and may be more prolonged requiring a 14-day certification and LPS conservatorship, the patient needs to be transferred to acute psychiatry.

2. "Catastrophic reactions"

Dementing patients are prone to having sudden, emotional outbursts as a result of what seems to others (us) as a minor stressor. These are usually tearful and/or anxious outbursts, which occur suddenly and are not preceded by signs and symptoms of a major, Axis I psychiatric disorder although they can appear to be very similar to a panic attack. They are short-lived but intense. They can occur at any time—just after institutionalization or at any time during the patient's stay.

Interventions are similar to the ones listed under Number 1 above.

Patients rarely need to be considered for transfer to acute psychiatry for this kind of reaction.

3. Assaults or other aggressive outbursts

There are several different but frequent types of aggressive patients:

a) Patients who have had a life-long history of aggression and, often, a Cluster B personality disorder. Their aggressive outbursts may be more severe and intense as they become demented.

b) Patients who have aggressive outbursts ONLY at times of caregiving such as bathing, toileting, brief/diaper changing, etc. These are usually dementing persons who simply don't understand why a "strange" person or group of people is coming to get them and take off all their clothes.

c) Patients who develop an aggressive behavioral disorder after they suffer brain damage (such as after a CVA, head injury, etc.) or after they begin to suffer from a brain disease--such as Alzheimer's disease or a tumor. These patients are unpredictably aggressive and assaultive outbursts can occur without any apparent warning and at any time. It is usually very difficult to understand the precipitating cause(s).

d) Patients with pain

e) Patients suffering from delirium

f) Patients suffering from major psychotic disorders such as psychosis, mania, major depression, PTSD, etc.

g) Patients with problems related to the environment, i.e. too cold, too hot, poor lighting, overcrowding, conflict with staff members, etc.

h) Patients with sensory deprivation such as hearing loss or visual impairment.

The assessment and treatment of such patients is complex. Emergency interventions usually include the use of a neuroleptic medication (e.g. risperidone or haloperidol oral concentrate are often preferable at this time). Benzodiazepines sometimes cause disinhibition or intoxication in such patients and they should be used with great caution unless it is clear that anxiety is the underlying problem—and then they may be the drugs of first choice. If there is a fear that benzodiazepines might cause disinhibition/intoxication, trazodone (crushed, given in pudding or sauce) may be useful for situations where anxiety is suspected, although one should not use this drug if the patient has a history of bipolar illness as an episode of mania could be precipitated.

One of the key questions is this: was the aggressive outburst so severe or are the outbursts so frequent and severe that the capacity of nursing home nursing staff to care for such a patient is exceeded? If the answer is "yes," the patient should be transferred to acute psychiatry.

If nursing staff feel that they can continue to manage the patient in the nursing home setting while a work-up is performed and treatment measures are initiated, the assessment of this kind of patient should proceed as quickly as possible.

4. Suicidal thoughts

Many elderly and dementing patients develop suicidal ideation; often it is in the context of a mood disorder but other problems also lead to suicidal thoughts.

A major consideration is this: the behavior of a person with diminished cognitive reserve may be less predictable than someone who is not dementing. Impulsive behavior may occur more readily and very serious (and often lethal) suicidal attempts are common in the elderly.

One must never be "reassured" by this thought: "Oh, he is poseyed to his bed and seems largely immobile. He can't do anything to harm himself." Experience has shown that a determined patient in 5-point leather restraints can successfully kill himself. Poseyed patients have also successfully committed suicide.

One of the key differential points is determining if the patient is attempting to discuss end of life issues and states "I wish I were dead." Such a patient is usually open to discussing their thoughts and is not truly suicidal. They respond well to interventions such as this: "We will focus our attention on helping you with any discomfort you have and we will see you frequently--you won't be abandoned." Supportive psychotherapeutic interventions are often very helpful.

Demoralization rather than major depression is an important differential diagnostic point in the sad patient talking about end of life issues. It is often very difficult to determine whether a patient is demoralized or suffering from major depression. However, patients with longstanding chronic non-psychiatric medical illnesses or disabilities may be demoralized and not suffer from the full major depression syndrome. Sometimes, however, the only way to make the differential diagnosis is to try treatment modalities known to be more effective for demoralization than for major depression. For example, psychostimulants such as dextroamphetamine may work quickly, especially when combined with supportive psychotherapy and efforts to help the patient find something in their life which restores somewhat their sense of meaning and also helping them find some things in life which they can still control. Psychostimulants alone, which can work quickly in the demoralized patient, are less likely to be helpful in the patient with major depression.

Management of a suicidal patient in a nursing home is very difficult and requires the physician to order constant observation. Because this is either not feasible or too costly, the best course is almost always to transfer such a patient to an acute psychiatric setting particularly if there is any doubt at all about the ability of the nursing home staff to monitor the patient.

5. Delirium

One study reported that fifty percent or more of patients over 65 developed delirium when admitted to a hospital. Similar high figures occur in patients admitted to nursing homes. The patient can develop a “hypoactive" or more subtle form of delirium but the most common type is the "hyperactive" delirium. The assessment for the cause of delirium is most always in the non-psychiatric medical sphere. However, "psychosocial" delirium has been reported and an adjustment disorder such as "transfer trauma" can lead to delirium.

The psychiatrist is often called to help manage the symptoms of delirium and the most common symptom is agitation.

Major symptomatic interventions include the following:

If the patient is in pain, his/her pain should be adequately treated and this may lessen the delirium (although opiates themselves are often delirogenic).

If there is a question of alcohol or sedative-hypnotic withdrawal delirium, benzodiazepine treatment (lorazepam or oxazepam are preferred) should be initiated.

If not already started, thiamine treatment should be initiated immediately to prevent a Wernicke's encephalopathy (which can also be acutely precipitated if the patient is given a large IV glucose load as in the alcoholic diabetic patient who is hypoglycemic and delirious).

The symptoms of other forms of delirium are well treated by neuroleptic medication and IV administration (usually haloperidol) can be very successful.

In one large, 2000 patient, study, "triple therapy" was used for delirious cancer patients: oxycodone for pain, lorazepam for anxiety and haloperidol for agitation. The dosages used ranged from minuscule to huge and the route of administration was often IV. Today, in this facility we often use fentanyl patches to control pain and this medication is not as delirogenic as other opiates. There is considerable debate over the efficacy of this "triple therapy" but it is something which to be considered.

The goal of symptomatic treatment is to help render the patient less uncomfortable and better able to participate in a workup for the underlying cause of the delirium.

Delirious patients are probably best managed in their current setting if at all possible as transferring them to another unit (e.g. acute psychiatry) adds another delirogenic influence and, because of the less than optimal non-psychiatric medical coverage on such units, the assessment for an underlying cause of delirium may be prolonged.

6. Acute mania

This is not an uncommon problem in patients who are in nursing homes. The stressors of communal living may be sufficient to precipitate a new manic episode, many patients are being treated with antidepressants and may "overshoot" into mania (even if there was no previous history of mania), secondary mania may occur in patients who have had CVAs and the head injured or brain diseased patient may suddenly develop mania for the first time. There are many other possible causes for secondary mania.

As above under #3 the key question is this: is the manic episode so severe that the capacity of nursing home nursing staff to care for such a patient is exceeded? If the answer is "yes," the patient should be transferred to acute psychiatry.

If nursing staff feel that they can continue to manage the patient in the nursing home setting while a work-up is performed and treatment measures are initiated, the assessment of this kind of patient should proceed as quickly as possible.

The most common initial psychopharmacologic intervention includes the regular dosing with neuroleptic medications (olanzapine and quetiapine are preferred at this time [April 2000]).

If one is confident that one is dealing with a mania (and not delirium or other difficult-to-differentiate problem), lithium, carbamazepine, lamotrigine, gabapentin or valproic acid therapy can be initiated. These can be started while the workup is in progress unless there is strong contraindication to their use.

***Cautionary note*: If one wishes to use valproic acid, one needs to be mindful of the not-infrequent side effects that may occur, particularly in the elderly patient. Gradually worsening cognition, the onset of tremor, rigidity and gait disturbance plus the onset of thrombocytopenia may lead to discontinuation of this drug. The reader is urged to read this article: Armon, et.al. Reversible parkinsonism and cognitive impairment with chronic valproate use. *Neurology* 1996 47(3):626-35. Many nursing home patients have degenerative cognitive and neurological disorders. If a patient is taking valproic acid and the patient's cognition or neurological status are deteriorating quickly, the patient must be given a trial off valproic acid before one can attribute all the deterioration to an underlying degenerative disease.**

7. Catatonia

Making the diagnosis of catatonia presumes that one is familiar with the fact that catatonia is most frequently found in patients with non-psychiatric medical conditions or with mood disorders such as major depression AND that one is familiar with the criteria for making this diagnosis. For example, the criteria developed by Rosebush, et. al. can be very helpful:

Catatonia can be diagnosed if the patient has three primary or two primary plus two secondary signs/symptoms:

- **Primary signs/symptoms:**
  - **Immobility**
  - **Mutism**
  - **Withdrawal**
- **Secondary signs/symptoms:**
  - **Staring**
  - **Rigidity**
  - **Posturing**
  - **Waxy flexibility**
  - **Echo phenomena**
  - **Stereotypy**
  - **Verbigeration (stereotypic verbalization)**

Catatonia is not a rare problem in the nursing home setting. It is rarely a true emergency although it can become one if autonomic instability (fever of unknown/uncertain etiology, tachycardia, hypotension, hyperpnoea, etc.) accompany the condition; if this later problem occurs, then malignant catatonia is the most likely problem and this disorder is almost always fatal unless emergency ECT is started.

A psychiatric emergency may also occur when the catatonia begins to break" at which point the patient often has excellent recall of what happened to him/her during the catatonic state and may become extremely angry and assaultive if the patient felt ignored or insulted in some way while catatonic.

Usual and initial interventions for a catatonic patient include the use of lorazepam. Since catatonia is most often seen during a period of severe mood disorder and during non-psychiatric medical illnesses, assessments and treatments focused on such illnesses should begin.

Neuroleptic treatment can also be the etiology of a catatonic state and there is some clinicians favor the idea that the head injured or older brain diseased patient is more prone to development of this disorder than are younger, healthier patients receiving neuroleptics.

If a patient is acutely psychotic as he/she emerges from a catatonic state and it is felt that neuroleptic treatment was not a possible etiology for the catatonia, neuroleptic treatment can be started once appropriate signs and symptoms so indicate.

Patients with catatonia are best treated on an acute psychiatry service and arrangements should be made as soon as possible for such a patient to be transferred.

8. Neuroleptic malignant syndrome (NMS) and the serotonin syndrome

Many elderly, nursing home patients are taking neuroleptic medications and the index of suspicion for the neuroleptic malignant syndrome must be high.

It is also important to remember than NMS may present differently and more subtly in an elderly patient (as do so many other syndromes and diseases). High fever, rigidity and an elevated CPK are the usual hallmarks of this disorder but, in a Parkinson's patient or a patient with Lewy body dementia (as two examples) rigidity may already be present as part of the illness. The CPK may also not be as wildly elevated in an elderly patient as it usually is in a younger person. A fever (of unclear or unknown etiology) coupled with a moderately elevated CPK should be considered NMS until proven otherwise.

IN ALL SUCH PATIENTS, NEUROLEPTIC TREATMENT SHOULD BE DISCONTINUED OR HELD UNTIL THE DIAGNOSIS IS CLEAR AND NMS IS RULED OUT.

NMS is a medical emergency and is best treated in the acute medical hospital. "Milder" cases can probably be treated with supportive interventions only in the nursing home setting.

A similar and potentially fatal syndrome, the serotonin syndrome, can occur in the nursing home setting. This is more common now that drugs felt to have a major impact on serotonin neurotransmission are so commonly prescribed.

The major signs and symptoms of the serotonin syndrome include various combinations of myoclonus, rigidity, hyperreflexia, shivering, confusion, agitation, restlessness, coma, autonomic instability, low-grade fever, nausea, diarrhea, diaphoresis, flushing, and rarely, rhabdomyolysis and death.

Awareness of the growing number of drugs—especially those used in psychiatry for the treatment of depression—and the drugs that may interact with them (interactions mediated by the cytochrome P450 group of enzymes) is vital information for all physicians and especially for psychiatrists.

The serotonin syndrome is caused by drug-induced excess of intrasynaptic 5-hydroxytryptamine. The clinical manifestations are mediated by the action of 5-hydroxytryptamine on various subtypes of serotonin receptors. There is no effective drug treatment established. There is some evidence suggesting the efficacy of chlorpromazine and cyproheptadine in the treatment of serotonin syndrome. The evidence for cyproheptadine is less substantial, perhaps because the dose of cyproheptadine necessary to ensure blockade of brain 5-HT2 receptors is 20-30 mg, which is higher than that used in the cases reported to date (4-16 mg).

Unless the syndrome is very mild and the etiologic agents are easily identified and discontinued, patients suffering from this syndrome should be transferred quickly for acute medical care.

9. The patient who has stopped eating

There are several approaches to the patient whose oral intake has slowed or stopped and each one has been effective with patients:

a) **The patient may suffer from an apathetic syndrome. Some patients are so apathetic that they just don't have any interest in bringing a fork of food to their mouths. These patients often deny feeling depressed and don't have high depression scores on measures such as the Geriatric Depression Scale but do have high scores on the Marin Apathy Scale. The motivation of these patients is very poor and they sometimes 'whine' and state, "Not now, I can't do that, I don't want to do that now." The treatments of choice include the psychostimulants or bupropion. If psychostimulants are used, it is preferable to use dextroamphetamine because of its longer half-life and less abrupt onset and offset of action (in comparison with methylphenidate). It is recommended that one start with a single morning dose of 5 mg and then gradually (two or three days between dosage increases) increasing the dose to 7.5 mg in the morning and then to 10 mg as a single morning dose. If bupropion is used, it is recommended that one start with a single morning dose of 37.5 mg, which is then gradually increase by 37.5mg or 75mg increments to a 150 mg – 225 mg total daily divided dose—morning and noon are preferred in order to minimize problems with insomnia. Psychostimulants are appetite stimulants in the elderly apathetic (or demoralized) patient rather than appetite suppressants. Also, the development of tolerance is uncommon so that the dose, which is initially effective, continues to be effective.**
b) **If one feels the patient is depressed--and a trial of an antidepressant is often indicated because this problem is so common--bupropion is often very effective because of its mild energizing effect and its "anti-apathetic" effect. Apathy is, of course, a problem associated with depression but it may also be an independent syndrome without depression and without a history of psychosis such as schizophrenia. Relief of depression may, of course, bring a resumption of appetite and eating.**

c) The so-called "M&M diet," developed by Carol Winograd, M.D., and a geriatrician can work wonders. This "diet" is based on these two principles:

1) **To "jump start" a patient with respect to eating (to "prime the pump" so to speak), one wants to maximize, initially, the number of calories a patient is receiving and less time is spent worrying, in the initial phase, about the patient having a "perfectly balanced diet;"**
2) **Learn from the patient's relatives or friends which foods (including 'junk' foods) were the patient's favorites—even if the favorite 'food' was M&Ms.**
3) **Then, give the patient all he/she wants of his/her favorite foods even if it is just a big bowl of M&Ms by the chair or bedside. If chocolate milkshakes are preferred, get the best possible and give the patient these calories morning noon and night. Again, the "balanced diet" concept can be put aside temporarily. At this point, the functions of the body (including the brain) require calories!**
4) **If this "diet" works, the patient will soon be "primed" or "jump-started" and, after a time, will start "getting sick of" the favorite food and start eating a more normal/balanced diet of other foods.**

d) Many older patients are steroid deficient. Steroid administration often makes a person ravenously hungry. The patient can be given a relatively high-dose, fast taper (20 mg prednisone, 15, 10, 5, 2.5 mg and off) over a 5 day period and this may "jump start" their appetite.

e) If the patient has lost his/here appetite due to pain, effective treatment of the painful condition may lead to a resumption of eating.

f) Some dementing older patients are psychotic but can't tell us clearly about their hallucinations or delusions. A presumptive diagnosis of psychosis and a short trial of neuroleptics may be helpful. If the patient's refusal to eat is based on suspiciousness or paranoia or other psychotic process, the patient may begin eating again after the psychosis is adequately treated. This is an especially serious problem in the patient with dementia with Lewy bodies.

g) Some patients may be anxious or agitated and lose their appetite. As with the "quiet depressive" there are the "quietly anxious and agitated" patients. Presumptive treatment may be useful. Buspirone or benzodiazepines may be very helpful with such patients. Buspirone's onset of action may require up to three (or even four) weeks. While waiting for buspirone to provide relief, lorazepam or oxazepam may be useful. The latter drugs can then be discontinued when buspirone begins to be effective. When a patient begins complaining of excessive drowsiness and/or nursing staff notice this problem, it is time to taper the patient off benzodiazepine treatment.

h) Should a patient ever be tube-fed in the nursing home? This is a medical, psychiatric and an ethical decision particularly for the patient suffering from severe major depression. Tube feeding for relatively short periods while awaiting the onset of antidepressant medication or waiting for approval for a course of ECT is certainly indicated. Dying with an eminently treatable mental illness is not acceptable practice.

10. Acute psychosis

The differential diagnosis for a patient who develops an acute psychosis is very long. Until the etiology of the psychosis is clear (secondary to stress, associated with a cognitive disorder, secondary to medication, substance induced, secondary to a non-psychiatric medical disorder, associated with a mood disorder, idiopathic psychosis, etc.) prn medications are preferred. Low doses of risperidone liquid concentrate (colorless, odorless, tasteless) can be very useful for the emergency situation and quetiapine is probably the best-tolerated neuroleptic. Usually, a patient of this sort will need acute psychiatric treatment, particularly if the behavior associated with the psychosis is a major problem in the nursing home setting. The emergency use of neuroleptics should be considered as a measure to relieve pain and suffering until the etiology of the psychosis can be determined.

11. Pisa syndrome

The physician or psychiatrist may be called to evaluate a patient who has suddenly started to lean (or "tilt") to the left or right or to be leaning backwards. This is probably the dystonic syndrome first described by Ekbom (Germany) in 1972 as a side effect of neuroleptic treatment in 3 *elderly* women taking haloperidol. Criteria for the diagnosis of the Pisa syndrome include:

- **A. Tonic flexion of the trunk to one side or also seen as a leaning backward as well--patients unable to stand straight!**
- **B. Accompanied by a slight truncal rotation**
- **C. Remarkable indifference to a grossly abnormal posture**
- **D. Current neuroleptic or antidepressant treatment**

The prevalence of this syndrome in general clinical practice is unknown except that Yassa (*Biol Psychiat* 1990;29:942-45) identified eleven out of 133 first-time psychogeriatric admissions (8.3%) with the Pisa syndrome. It is somewhat more common in women than in men and can develop immediately or have a delayed onset (up to four months after neuroleptics or antidepressants have been started).

The only effective treatment is to reduce or discontinuing the medication causing the syndrome. Anticholinergic medications have been tried but have not been effective and have caused worsening cognition in most patients.

12. Sundowning syndrome

Patients with dementing disorders often become more confused in the late afternoon or evening "when the sun goes down." Some feel that this is caused by the diurnal variation in blood melatonin levels or a special sensitivity of the suprachiastmic nucleus. Patients with this syndrome usually become increasingly disoriented and exhibit agitated and/or aggressive behavior as daylight wanes. Often, the abnormal behaviors associated with this syndrome continue into the night and usually cause massive disruption in the patient's life as well as in the lives of those caring for the patient.

Various strategies—both pharmacologic and non-pharmacologic—have been tried to relieve patients' distress. Usually, low dose neuroleptics or a drug such as trazodone given just before the onset of the syndrome and then midway through the cycle have been helpful. Each patient has a fairly regular pattern that can be identified. For example, for the patient who starts showing symptoms at 4:00 PM, a dose of trazodone at 3:00-3:30 PM can help attenuate the severity of the syndrome; another dose given between 7:30-8:00 PM can relieve the patient of further distress and help insure that both the patient and his/her caregivers get rest at night. Trazodone dosing usually starts at 25mg at each of the two times and is slowly increased until the correct dose for the patient is found. A useful alternative is risperidone, oral concentrate, starting at 0.25 mg and a slow upward titration of the dose if necessary.

13. Personality disorders

A patient with a severe personality disorder can cause a great deal of disruption in the nursing home routine and the type of disruption is directly related to the nature of the personality disorder. Effective interventions are almost always behavioral and non-pharmacologic. For example: the patient with a borderline personality disorder who may repeatedly try to 'split' staff into "good nurses" and "bad nurses" needs to have a care plan designed so that a single member of the nursing staff is the patient's "primary contact person" through whom all requests and complaints are made. Strict limit-setting with behavioral contracts may have to be developed for patients with behavior characteristic of the person with an antisocial personality disorder. Clear, consistent and direct explanations need to be made by all staff involved with the patient who has a paranoid personality disorder. Assisting the staff in implementing these kinds of measures can help a lot in ameliorating behaviors, which can be very disruptive and even lead to requests for psychiatric emergency evaluation. Education of the staff about the nature and characteristics of patients with the various personality disorders may be helpful. However, once a psychiatric emergency has been identified, it may be necessary to temporarily remove the patient from the nursing home setting (and hospitalize the patient in another setting such as the acute psychiatry setting) so that the staff have an opportunity to learn more and deal with the anger and frustration such patients can generate.

14. Environmental problems

Various environmental problems can lead to serious behavior problems in patients, particularly in patients suffering from dementia. Noise, heat, cold, overcrowding, etc., are just a few of the environmental problems that may be the etiology of patients' aberrant and disruptive behavior. Awareness of these issues is important in arriving at a treatment plan for the patient and careful attention must always be paid to the environment in which the patient is expected to live. For many people, living in a group setting occurs for the first time when they are admitted to a nursing home. This usually occurs at a time in their life when patients are least able to deal with the many stressors inherent in group living because of dementia or physical disability due to chronic illness. Sensitivity to this issue is key in helping the patient adjust and helping the staff assist the patient in adjusting.