



Special Populations in Psychiatric Emergency Services: The Geriatric Patient

18

Gene T. Robichaux Jr., Cecilia M. Fitz-Gerald,
and Mary Jo Fitz-Gerald

Contents

18.1	Introduction.....	190
18.2	The Challenges of Older Patients.....	190
18.3	Aggression and Agitation.....	191
18.4	Depression.....	193
18.5	Suicidality.....	193
18.6	Elder Abuse and Neglect.....	193
18.7	Making Emergency Services Work for Geriatric Individuals in Crisis.....	194
18.8	Training in Geriatric Psychiatry/Medicine.....	196
18.9	Summary.....	197
	References.....	197

Abstract

This chapter focuses on the geriatric patient with mental illness in the emergency department. As the number of individuals over 65 years of age has increased worldwide, the number of geriatric patients with psychiatric concerns seen in the emergency room has also increased. This chapter discusses the specialized diagnoses that one must consider when evaluating individuals in this population, necessary accommodations for evaluation and treatment, and recommendations for improvements in care delivery for the geriatric patient in the psychiatric emergency arena.

G. T. Robichaux Jr. (✉) · M. J. Fitz-Gerald
Louisiana State University Health Shreveport, Shreveport, LA, USA
e-mail: thomasrobichaux@bellsouth.net

C. M. Fitz-Gerald
University of Texas Southwestern Medical Center, Dallas, TX, USA
e-mail: CECILIA.FITZ-GERALD@phhs.org

18.1 Introduction

Just as for children, adolescents, and the forensic population, geriatric individuals with emergent psychiatric needs also face a crisis. Complications frequently arise for the geriatric patient cared for in the emergency department (ED), the ED physician, and the medical staff. The geriatric demographic, defined as individuals age 65 or older, represents an increasing proportion of the population. The elderly composed almost 15% of the general population in the United States in 2013 and are expected to increase to over 20% of the population by 2040 [1]. According to a United Nations report, the number of individuals over age 60 has also increased internationally and is expected to comprise over 15% of the global population by 2030 [2]. Elderly individuals exhibit increased emergency department (ED) usage rates compared to younger patients and increased lengths of stay while in the ED [3, 4]. In addition, they demonstrate higher rates of return to the ED, inpatient admissions, and suffer increased morbidity and mortality. Studies in other countries, such as Taiwan [5], Italy [6], Pakistan [7], Turkey [8], and Switzerland [9], show similar increases in visits to the ED by the elderly. Specifically, the elderly accounted for almost one-sixth of all emergency room visits in the United States in the years 2009–2010 [10].

According to data from the Centers for Disease Control and Prevention, and the National Association of Chronic Disease Directors, mental illness occurs in approximately one-fifth of individuals ages 55 and older [11]. The most common psychiatric disorders in this age group are depression, adjustment disorder, psychosis, cognitive disorders, and anxiety disorders [11, 12]. Delirium, a neuropsychiatric emergency, occurs in 8–10% of geriatric patients in the ED [11, 12]; yet, less than 30% of individuals with delirium had mental status examinations documented by the ED physician [13]. Delirium may be the first sign of a medical or surgical emergency, complicate medical treatment, and raise concerns about discharge [14].

This chapter discusses the challenges that complicate the diagnosis and treatment of medical and psychiatric conditions in the geriatric patient and recommends innovations and accommodations to improve the care of this population.

18.2 The Challenges of Older Patients

Older adults in the ED setting require special considerations due to normal physiologic changes of aging. For example, older adults may have chronic deficits in visual sensory input and processing that can limit their ability to navigate a clinical environment; falls and other accidental injuries are a major concern for this age group [15]. Hearing deficits, especially in the absence of appropriate hearing aids, may limit their ability to hear and understand education about illnesses or basic commands. Aphasia or other neurological deficits from prior neurologic insults may limit the capacity to speak or communicate relevant information. The insidious development of a neurocognitive disorder may not be apparent during a cross-sectional interview, and as a result, a progressive, serious illness may not receive

necessary attention and treatment. Lastly, social concerns and the potential for coercion or elder abuse may complicate presentation and management.

The ED environment can also be problematic to the geriatric patient. The unfamiliar environment, frequent examinations by medical personnel, and the absence of familiar faces can increase disorientation in the ill geriatric patient. Further complications requiring clinical interventions may arise after the patient receives “medical clearance” and goes to the specialized psychiatric emergency service (PES). The PES may not allow the use of canes, walkers, or wheelchairs due to the fear that other patients in the facility may use the device as a weapon. Furthermore, the ED or PES may not be handicap accessible.

Often the patient needs to remove assistive hearing devices, eyeglasses, or dental appliances during the medical workup only to find that these items were lost in the hospital transfer process. The loss of hearing aids, eyeglasses, or dentures can affect communication between the patient and family or the patient and physician, and cause confusion in an individual with already impaired cognition. The loss of dental appliances may also affect speech and the ability to eat certain foods. Staff should remember that medications, psychiatric and medical, can lower blood pressure, increase fall potential, and elevate risk of injury to the patient.

Older age frequently carries the burden of multiple medical comorbidities. A given individual may be receiving medicines for hypercholesterolemia, hypertension, diabetes, or other chronic medical conditions in addition to any neuropsychiatric complaint such as insomnia. The ED staff must decipher which of the medications may be exacerbating the presenting problem. Even with electronic medical records, the physician may have difficulty reconciling medications from multiple sources. The evaluation of physical and psychiatric problems, combined with communication difficulties, presents a challenge to any ED staff; studies show that many emergency physicians feel ill-equipped to deal with the geriatric patient [16]. Finally, the severity and number of medical illnesses can result in difficulty with placement as inpatient psychiatric facilities want “medically stable” patients, resulting in problems of boarding where the patient remains in the ED for prolonged periods of time while waiting for an inpatient bed.

18.3 Aggression and Agitation

Aggression and agitation in the elderly are common presenting problems in the ED that may be problematic to the staff. Aggression in the ED or hospital may occur in patients who were, or were not, agitated prior to admission. Not only is the etiology of aggression perplexing, but the presence of aggression raises safety concerns for the staff.

Clinical staff should ascertain the exact signs of agitation and the patient’s baseline status. Agitation may lead to violence toward staff or caregivers. Many individuals (even medical staff) have difficulty dealing with geriatric patients due to misperceptions, prior experiences, patient sensory deficits, and the presence of cognitive disorders in the elderly. These biases, and the fear of violence, make the process of determining the cause and treatment of agitation more difficult. The myriad

diagnoses that could lead to agitation can be perplexing to a clinician. Diagnoses that can cause agitation include medical illness, delirium, pain, dementia with behavioral problems, personality problems, psychosis or mania, and substance abuse. Treatments for all of these conditions are different, and medication actions and interactions can complicate the picture.

Delirium, a common cause of agitation, is a frequent comorbidity to medical illnesses in patients over 65 years [17, 18] and has been shown to be an independent predictor of poor patient prognoses, including mortality, the need for residential placement, and continued decline in cognitive function [19–21]. Delirium often resembles a major neurocognitive disorder and over 60% of incidents of delirium occur in the context of neurocognitive disorder [20]. The only ways to differentiate delirium and major neurocognitive disorder involve careful mental status evaluation, collateral information from individuals familiar with the patient's baseline behavior and cognitive function, and specialized assessment tools. A suspicion of a diagnosis of delirium requires careful diagnostic workup, treatment for the underlying condition, and the provision of appropriate instruction and education to the individuals who assist the patient during their hospital stay and upon discharge.

Neurocognitive disorders, with or without delirium, occur in over one-fourth of elderly patients in the ED, and many cases will go unrecognized [13]. Many of these individuals do not have a cognitive disorder diagnosis prior to the visit [13]. The ED can be frightening to an individual with a cognitive disorder, as they do not understand what is going on. The person may believe that the facility is stealing body parts or involved in another evil endeavor. Confusion can lead to agitation. In turn, ED staff may take less time to understand what is going with the patient due to safety concerns. Evaluation of cognitive disorders is time consuming; one must eliminate medical causes, and treatment options for agitation in delirium may cause even greater problems due to unwanted side effects.

Another cause of agitation or aggression is behavioral manifestations of untreated pain experienced by the patient [22]. Studies show that patients with neurocognitive disorder receiving treatment for pain are less agitated than those who do not receive pain medication [22]. Depression may also be a cause of agitation in the elderly as citalopram, a selective serotonin reuptake inhibitor, has shown to be effective in some studies of agitation [23, 24]. Citalopram may also be effective in treatment of agitation in dementia not related to depression [24].

Substance abuse or withdrawal can cause agitation and should be in the differential for any presenting problem to the psychiatric emergency department. Alcohol and sedative withdrawal can cause delirium tremens, a lethal syndrome [25]. Almost 10% of elderly individuals indicate heavy alcohol use; the use of marijuana in older adults is almost 5% and expected to rise as more states legalize use [26]. Iatrogenic drug use is common in individuals over 65, and physicians frequently prescribe benzodiazepines and opioids for the elderly. The combination can be deadly, and the potential for withdrawal is high [27]. State prescription monitoring programs (PMPs) may be of benefit in helping to detect substance use and misuse. Many states mandate that the prescriber views the PMP record prior to providing prescriptions for controlled substances.

18.4 Depression

Mood disorders, recognized or unrecognized, may be the presenting complaint in the ED for older adults. An older individual may arrive at the ED with symptoms of poor appetite, insomnia, pain, dizziness, or even constipation. Astute questioning may reveal an underlying depression. Due to the higher rates of depression and completed suicide in the elderly population, adequate screening, recognition, and evaluation for psychiatric complaints are a necessity. Untreated depression leads to increased physical morbidity and mortality [28]. Screening tools or questions, such as the Geriatric Depression Scale [17], are helpful in identifying at risk individuals. Due to decreased sensitivity with co-morbid cognitive impairment, medical staff should seek collateral from family or caretakers in order to identify symptoms of depression when the concern arises in these populations.

18.5 Suicidality

Suicidality in the elderly is of particular concern as this population has the highest completed suicide rate; therefore, assessment of suicidality is an important component of the geriatric evaluation by physicians [28]. Risk factors to consider in terms of completed suicide include substance use disorder, medical problems, isolation, impulsiveness, chronic pain, recent stressors, history of completed suicide in the family, older age, Caucasian race, single relationship status, personal history of suicide attempt, and a recent psychiatric hospitalization [29].

18.6 Elder Abuse and Neglect

Chart review and physical examination may indicate that the individual is a victim of abuse or neglect. Concerning factors for abuse or neglect include malnourishment, multiple or unexplained injuries, frequent admissions to the hospital, and non-compliance. Elder abuse occurs in up to 10% of older adults every year [30]. Abuse increases the rate of ED usage, hospitalization, and nursing home admission, and may be the cause of new onset behavioral or psychiatric disorders [30, 31]. In addition, elder abuse may increase risk for psychiatric illness, such as neurocognitive disorders and depression, and contribute to worsening health in general [32].

Elder abuse can range from neglect to psychological, sexual, physical, or financial abuse; the most common types are neglect, psychological abuse, and financial abuse. Comparatively, sexual abuse and physical abuse occur less commonly [30]. The causes for such abuse can be dramatic, such as the attempted expulsion of the abuser from the home by the victim, or a minor disagreement [32]. Ironically, while placing an individual in a nursing home may be the solution in many situations, there is a higher prevalence of elder abuse in the nursing home setting, possibly as high as 25%. Some of the greatest predictors of abuse in a nursing home are the

presence of limitations in activities of daily living (ADLs) and disturbances in a patient's behavior [31].

Elder abuse and neglect represent a challenge in the ED setting as the staff often have limited time and collateral information to investigate such concerns. Additionally, there are often limited resources for social support and rapid placement of potential victims of such abuse [30, 32]. Many times, the safest course of action is to admit the patient for a social admission to prevent further harm. The mandated reporting of elder abuse in most jurisdictions poses an additional burden on ED staff [25].

18.7 Making Emergency Services Work for Geriatric Individuals in Crisis

Over the past two decades, more research has emerged about what components are necessary to care for the elderly patient in the emergency department. Necessary components include facility design, use of appropriate screening tools, transitions of care, aftercare arrangements, caretaker involvement, and staff training and education. Four US medical organizations (American College of Emergency Physicians, American Geriatric Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine) established guidelines for the care of the geriatric patient in the ED in 2013 [33].

Staff should assess all patients, especially older patients, for mobility concerns at the initial presentation to the ED (triage). Most geriatric individuals merit attention to fall risk due to frailty, medical conditions, prescribed medicines, or substance abuse. The use of wheelchairs, gurneys, and bedside examination equipment can lessen the risk of falls and reduce the confusion that often arises from change in location. For those with intact mobility, adequate lighting and level uncarpeted spaces can help maintain functional status. One study suggested that the use of reclining chairs would cause less distress to older individuals in pain [34]. Staff should minimize the use of restraints. Patients with delirium or a neurocognitive disorder tend to become more confused with restraints as they often do not know what is occurring. Furthermore, restraints can tear already thin skin [35].

Additional environmental intercessions help stimulate cognition and reduce distress. Staff members should provide frequent re-orientation, optimize illumination during the day, minimize noise, reduce staff disruptions and room changes, adjust the room temperature, and provide assistive devices such as hearing aids and glasses. The presence of family members or caretakers is optimal to reduce confusion and provide reorientation [1, 36].

Screening tools are invaluable assets and can elicit diagnoses which would otherwise be missed due to communication barriers. Due to the high risk of delirium associated mortality, screening this patient population will aid in assessment and management. Screening tests include the Confusion Assessment Method (CAM), the Folstein Mini Mental State Examination (MMSE), Brief Mental Status Examination, Delirium Rating Scale (DRS), and Nursing Delirium Screening Scale.

The CAM (which only takes 5 min to administer) is the recommended standardized screening tool for diagnosing delirium in the ED due to the high sensitivity and specificity of the assessment, and the ease of administering it [1, 37, 38]. If the individual has impaired cognition without delirium, dementia is in the differential.

Geriatric patients with a history of substance use disorders may present to the emergency department not only for substance-induced altered mental status, but also for a myriad of physical complaints due to substance use complications. Thus, all patients deserve a careful assessment for substance use. In addition to a careful history and review of medications and pharmacy records (if possible), staff members may utilize screening instruments such as the CAGE (Cut Down, Annoyed, Guilty, Eye-opener) questionnaire, the Alcohol Use Disorders Identification Test-Consumption Questions (AUDIT-C), and the Short Michigan Alcohol Screen Test-Geriatric Version [39, 40].

Other screening assessments include the presence of depression or suicidality [17]. Staff should also screen for falls in the past year, ability to care for self, and presence or absence of social support. The Regional Geriatric Program of Toronto has numerous screening tools, including those mentioned above, available on their website [41].

Not all geriatric patients show the same characteristics. Some individuals who are younger than 60 may have more medical issues than someone who is 80. While medical clearance may not be necessary in the 25-year-old with a history of multiple hospitalizations for schizophrenia, medical clearance is essential in the geriatric patient due to the high incidence of comorbid medical illnesses, use of multiple medications, and drug interactions that mimic psychiatric syndromes. As with all individuals, staff must ascertain the stability of vital signs and physical status. A brief physical exam may highlight possible abuse issues. Routine laboratory studies such as urinalysis, comprehensive metabolic panel, complete blood counts, thyroid functions, electrocardiogram, chest X-ray, vitamin B12, folate, computed tomography scan of the head (if appropriate), and toxicology screens may pinpoint the etiology of delirium. The exam may also highlight ambulation problems that will affect the patient's stay in the ED.

Multiple problems may arise for any patient with transitions in care [42]. For instance, the oncoming shift of healthcare workers may not receive important historical information. The lack of this information, which may not be documented, can cause tremendous harm to anyone. The setting in a busy ED compounds the problems in care transitions given the number of individuals caring for a patient, shift work, and the volume and acuity of patients. An individual of any age who has difficulty communicating needs may be lost in the shuffle of the ED. An individual may leave the psychiatric emergency service (PES) with a prescription for an antibiotic for a urinary tract infection. If the individual lacks resources to buy the medication, the infection could worsen and the individual could become delirious. Other problems that older individuals encounter include difficulty reading or understanding the prescription label, and the inability to open the bottle. Perhaps the individual leaves the hospital with an antidepressant but then develops hypotension, falls, and breaks a hip. Without social support or the ability to reach a phone, the person may

be in pain for a considerable period. These examples highlight the need for defined plans for transitions to care and involvement of the caretaker. Unfortunately, regulations in the United States which require computerized pharmacy printouts of drug medication facts, or lengthy after visit summaries required by electronic medical records, only compound the problem due to the sheer amount of material which is often difficult to comprehend.

The above are recommendations for optimal care of the elderly in the ED. Knowledge of these recommendations can improve outcomes, even in rural emergency rooms without access to a psychiatrist. However, the development of specific geriatric emergency departments designed to address the unique needs of geriatric patients provide solutions to the problems discussed [43]. Ideally, these facilities would utilize a multi-disciplinary approach staffed by geriatric emergency physicians, pharmacists, social workers, case managers, geriatric life specialists or aging-life care specialists, and nurses who specialize in the care of geriatric patients [44]. Appropriate staffing, access to medical services, and access to family are necessary elements for such a unit. In addition, the unit must provide enough personnel and safety measures to monitor for falls and prevent patient danger to self or others. Geriatric patients have been treated in special emergency department settings with some success [35, 45], and specialty units for emergency geriatric psychiatric patients can provide the amenities needed for safe and effective care. When specialist consultation services are not available, telepsychiatry is a viable option to hasten diagnosis and provide effective management [46, 47].

Safety in the patient area is a primary concern. A determined geriatric patient may use tubing, extension and power cords, or intravenous lines in order to make a suicide attempt. Hardware, doors, mirrors, and shower facilities should meet guidelines to lessen the risk of completed suicide [48]. One should not assume that an older suicidal patient poses less risk than a younger individual; geriatric patients often require more vigilance in alleviating all safety risks in patient care areas.

18.8 Training in Geriatric Psychiatry/Medicine

Education and training are invaluable for treating and evaluating geriatric patients in the ED. In the United States, psychiatry residency is a 4-year curriculum approved by the Accreditation Council for Graduate Medical Education (ACGME) that includes a month of geriatric psychiatry. Geriatric psychiatric fellowship is an additional year of training in an accredited geriatric fellowship program. Emergency medicine, internal medicine, and family practice are all 3-year residencies after medical school. After completion of internal medicine or family practice residencies, an individual may choose to enter a 1-year accredited geriatric fellowship in those fields. At this time, geriatrics is not an accredited emergency medicine fellowship, nor is emergency psychiatry an ACGME approved fellowship in psychiatry [49]. Emergency psychiatry is not a requirement of the geriatric psychiatry fellowship. The presence of geriatric specialists in an ED promotes optimal care for this

age range. As mentioned previously, the use of telepsychiatry can provide access to a geriatric psychiatrist if none are available locally [46, 47].

In the United States, geriatric nurses must possess a registered nurse degree and receive either clinical training or advanced education in geriatrics. A geriatric nurse specialist requires a Master's degree and additional specialized training in geriatrics. Case managers and social workers are beneficial to arrange for home health nursing, medication assistance, placement, and supportive care for the caregivers.

The presence of even one of these specialists in an ED that cares for geriatric emergency patients can make a vast difference in care. Specialists provide training for others in the ED and model approaches to take with these patients. Quality improvement and safety initiatives can also provide education and training for the healthcare workers.

18.9 Summary

Psychiatric care of geriatric patients in the ED can be both rewarding and challenging. The interplay of medical and psychiatric issues combined with social issues requires diligence, patience, and investigation. Similar to problems encountered for forensic, child, and adolescent patients, the ED staff benefits from educated staff to provide care for a population desperately in need of their services.

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