Palliative Care, Inpatient Psych Urged to Consult

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SALT LAKE CITY — Collaboration between palliative care and the psychiatric inpatient unit can greatly improve mental health care for nursing home residents with behavioral and psychological symptoms of dementia, according to presenters at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. "Dementia is the most frequent reason for nursing home admissions, and nationally 80% of nursing home residents who are in need of psychiatric services fail to receive them," said Dr. Janet Bull, vice president of medical services for Four Seasons Hospice and Palliative Care in Flat Rock, N.C.

Four Seasons has a contractual relationship with every nursing home in Henderson County.

Nationwide, half of nursing homes do not have access to adequate psychiatric consultation, said Dr. Bull, who is board certified in both hospice and palliative care and ob.gyn.

In addition, mental health funding is being cut and the Deficit Reduction Omnibus Reconciliation Act guidelines limit pharmacologic treatment for psychotic conditions, she explained.

Untreated psychiatric disorders result in decreased functioning, poor quality of life, and increased mortality, and this leads to high use of psychiatric units by nursing homes. "Very often, we don't see these patients until they end up in the ICU in a state of crisis," Dr. Bull said.

So she and her colleagues forged a collaboration with the medical psychiatric unit of Park Ridge Hospital, in nearby Hendersonville, N.C., to create an interdisciplinary team consisting of the psychiatrist, a psychiatric nurse practitioner, a nurse, a social worker, a music therapist, an activities therapist, and the hospital chaplain.

Four Seasons team members included a palliative care physician (Dr. Bull), a palliative care nurse practitioner, and administrative support.

Last year, there were 308 admissions to the hospital medical psychiatric unit, of which two-thirds were related to behavioral and psychological symptoms of dementia (BPSD), Dr. Bull explained. "On the palliative care end, we received 242 referrals in 2006 and about two-thirds of those were related to BPSD."

Symptoms of BPSD—seen in 83% of dementia patients and undoubtedly the most common cause of nursing home placement—include aggression, screaming, restlessness, agitation, wandering, sexual disinhibition, hoarding, cursing, and shadowing, she said.

Two-thirds of the referrals to palliative care received in 2006 were related to BPSD.

DR. BULL

Unfortunately, there are several barriers to quality end-of-life care in the typical psychiatric setting, said Judith A. Adams, the palliative care nurse at Four Seasons.

"Psychiatrists often don't recognize end-of-life symptoms because they're focused on psychological symptoms, and there's a lack of knowledge of pain medications," Ms. Adams explained, adding that psychiatric patients face many stressors, such as physical restraints and noisy, busy environments.

Although the psychiatry profession is taking strides to improve end-of-life care, the psychiatry-palliative care partnership approach offers an excellent alternative, she said.

"However, roles have to be clearly defined. In the psychiatry department, the psychiatrist is the attending physician. Our role is strictly one of consultation, and this is a crucial point. We are assessing and treating pain and nonpain symptoms, and we're not going to treat unless the psychiatrist asks us to," Ms. Adams cautioned.

A second pitfall is not having clear communications on the expectations of the palliative care consult.

The partnership has resulted in improved patient quality of care; avoidance of suffering and futile care in future medical admissions related to clear goals; and overall enhancement of the hospital's palliative care service, Ms. Adams said. ■

Dementia Care: Go Beyond Patient

BALTIMORE — Supportive care for patients with dementia and their caregivers is an important component of overall dementia care, Dr. Constantine G. Lyketsos said at a meeting on Alzheimer's disease and related disorders sponsored by Johns Hopkins University.

Supportive care for the patient should provide comfort and emotional support, safety, structure, activity and stimulation, planning/assistance with decision making, management of medical comorbidities, and good nursing care for advanced stages, said Dr. Lyketsos, chair of psychiatry at Johns Hopkins Bayview Medical Center in Baltimore.

In terms of safety, "many patients with dementia, in fact most of them, should stop driving," said Dr. Lyketsos. "Most of them can't live alone entirely. That doesn't mean that there needs to be someone in the house 24 hours a day, but there needs to be some support."

Providing structure means ensuring a safe, predictable place to live with support for activities of daily living. "Because of diminishing cognition, making sure that structure is available is critical. … The more dementia advances, the more important it is to have daily structure in place that's predictable," he said.

Participation in activities can make a big difference. "One of the things we found in the Maryland Assisted Living Study was that the more participation there was in activities, the longer patients were able to stay in their assisted living facility," Dr. Lyketsos said.

Support for caregivers includes emotional support and comfort, education, instruction in the skills of caregiving, problem-solving and crisis-intervention help, respite, and attention to personal needs and wants.

"The piece that we don't have a good way to deliver yet is respite. Caregivers need breaks. They can get easily overwhelmed," he said. Caregivers tend to overlook their own health, so they need to pay attention to their personal needs and wants as well. They also need to maintain touch with social contacts, which is an important part of the support network.

—Kerri Wachter