A PMHCNS – RUN INTERDISCIPLINARY GEROPSychiatry CLINIC...PATIENT-CENTERED CARING COLLABORATION

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*The speaker has no conflicts of interest to disclose.

OBJECTIVES

1) DISCUSS WHY AN APRN IS SO QUALIFIED TO PROVIDE THE HOLISTIC PERSPECTIVE NEEDED TO RUN AN INTERDISCIPLINARY GEROPSychiatry CLINIC.

2) IDENTIFY 3 COMPONENTS OF AN EFFECTIVE INTERDISCIPLINARY TEAM GEROPSychiatry ASSESSMENT.

3) IDENTIFY THE BENEFITS OF CAREGIVER SUPPORT IN ENABLING FAMILIES/CAREGIVERS TO FUNCTION AT THEIR OPTIMUM LEVEL, TO IMPROVE COPING AND SELF CARE, TO REDUCE PROBLEMS AND STIGMA.

Top Story

WITH INCREASE IN OLDER POPULATION, NEED FOR HEALTHCARE WORKERS INCREASES.

“The U.S. has 78 million aging baby boomers who will increasingly need direct care workers to assist them with personal care.…..”

from ANA SmartBrief November 2007
Alzheimer's Disease, Scope of the Problem

4-5 + million people
Chances increase exponentially, by 85 years old, as high as 50%
Most at home, most with spouses or children
Costly-lack of programs to help with funding

MENTAL HEALTH PROBLEMS IN OLDER PERSONS—challenges

• Early detection of problems, e.g., mild cognitive impairment
• Beginning functional decline (Okonkwo et al. 2009)
• Detecting other psychiatric problems such as Depression, when pt has a dementia
• Grief issues
• Attending to personality issues
• “Normal VS Common” problems with aging
• Ethical issues, ethics of caring,
• End of life issues (Sorrell J, 2010)
• Quality of life issues (Scholzel-Dorenbos et al., 2006)
• Cultural factors (Agrawal N., 2000)

Risk factors for mental health problems in older persons

• Psychosocial factors
• Stress
• Family health history
• Loss
• Co-morbidities
• Hypertension
• High cholesterol
• Smoking
• Alcohol and other substance use/abuse
CNS PSYCH\MH-- QUALIFIED TO COORDINATE AN INTERDISCIPLINARY GEROPSYCHIATRY CLINIC

What an APRN, CNS brings to the table:

- Provides needed holistic perspective on care of the patient and family
  * Team perspective
  * Systems knowledge and skills
  * Skills in care coordination
  * Critical thinking

STARTING A GEROPSYCHIATRY PROGRAM

A. Some serendipity
B. Meeting the need, filling a gap
C. Planning and proposals
D. Geropsychiatry becoming part of Outpatient Mental Health

History of a Geropsychiatry Program in large medical center

1982-83: Interdisciplinary team developed a plan for a Geropsychiatry Outpatient program:

- Geropsychiatrist, CNS, staff RNs, LCSW, OTR, MH Worker (All with some previous work in psychiatry and geriatrics)
  * Many meetings, education, literature searches

1983: Geropsychiatry Outpatient Clinic established
PRE-1994 EARTHQUAKE

- Seamless transition (out patient to inpatient & back)
- Collaboration
- Support services
- Proximity to emergency and other medical services
- Close ties with Geriatric Medicine

**Geropsychiatry Outpatient Clinic**

“Original” Interdisciplinary team:
Geropsychiatrist, Clinical Nurse Specialist, Social Worker, Occupational Therapist, Geriatric MH worker, other nurses, trainees, administrative staff

This Clinic met one day/week, later more team clinics developed

Comprehensive “biopsychosocial assessment” of each patient and of caregiver issues

**MAINTAINING AN EFFECTIVE INTERDISCIPLINARY TEAM IN GEROPSYCHIATRY**—mix of key people, various perspectives and skills; a main component to comprehensive assessment and treatment planning and positive outcomes

The team when first started; and now**

- CNS**
- Geropsychiatrist**
- Neuropsychologist
- Licensed Clinical Social Worker**
- Rehab Medicine Therapist(s); Occupational Therapist**, Recreational Therapist**
- Clinical Pharmacist
- Administrative support
- Geropsychiatry Fellow**
- Geriatric Medicine Fellow** (part time)
- Trainees
Geropsychiatry Outpatient New Case Clinic

Clinic referrals usually for undiagnosed or newly diagnosed, usually 65 and older; memory problems, cognitive problems, depression, psychosis, etc.

Referrals received from:
- Primary Care, Psychiatry, Social Workers, MDs, NPs, CNSs, staff RNs, Nurse Managers, self-referrals, other families, Alzheimer's Association, other facilities, etc.

Geropsychiatry Inpatient Unit

- Plans were underway in first year to open a Geropsychiatry Inpatient unit.
- Geropsych was to be housed on a Nursing Home Care Unit (NHCU) at the medical center.
- Team = same plus additional providers, including: NPs, NHCU Nurse Manager, Staff RNs, Neuropsychologist, clinical pharmacist

Geropsychiatric Nursing Assessment*

I. Major complaint, reason for coming for help:
II. Demographic information, including
III. Psychiatric history
IV. Demographics and family history
V. Physical Health History, including current problems

*Adapted from Biopsychosocial Geropsychiatric Nursing Assessment (Brod 2002) & agency Mental Health Initial Assessment Form
Physical health history
Include:
• Review of systems
• Sleep
• History of head trauma
• Substance use/abuse
• Tobacco use
• Nutrition
• Pain
• Dentition
• Sexuality
• Fall Risk

Geropsychiatric Nursing Assessment
VI. Mental status, including:
   Mental status exam (MoCA*clock drawing), house drawing; short form Geriatric Depression Scale, observations, behavioral problems (observed and reported)
VII. Assessment of Risk Factors:
   – Suicidal behavior, danger to self, history, current thoughts and/or behavior
   – Violence toward others, danger to others, history, current thoughts and/or behavior

Add plan for safety, as needed

Geropsychiatry Nursing Assessment
VIII. Other mental health concerns, including
   • A. Current diagnoses
   • B. Dealing with actual and potential problems
   • C. Recent stress
   • D. Coping effectiveness
   • E. Abuse and trauma history
   • F. Bereavement, grief
Geropsychiatry Nursing Assessment

IX. Functional status overall, including Self-care, ADLs and IADLs

SAFETY

Driving

Resources – e.g., tools

driver safety evaluation, assistance at home

Geropsychiatric Nursing Assessment

X. Cultural and Spiritual factors

– Health and illness beliefs
– Values
– Cultural, spiritual, religious factors that may influence patient's participation in care and treatment
– Special considerations

Quality of Life issues

Outcomes

What works and why:

• Team work, mutual respect
• Managing the complex patient who has multiple co-morbidities, and additional problems
• Work with caregiver/family issues
• Identify non-pharmacologic as well as medications for treatment
• Follow-up
CASE SCENARIOS

Geropsychiatry Inpatient Unit
opened in 1984

- Staff education/preparation: done by CNS, NP, Psych RNs and Geriatric RNs, Nursing Education, other team members
- The Unit: about 16 beds; special doors, locks; safety issues; garden, patio; future plans
- Planned patient activities: community meetings, groups, gardening, outings, caregiver support group

BENEFITS OF CAREGIVER SUPPORT GROUPS

Enables families/caregivers to:
- Function at their optimum
- Gain new knowledge
- Improve coping skills
- Self care
- Caring for others
- Reduce problems, learn problem solving
- Reduce stigma
- Building new relationships, networks
- Reframing
- Learn how and when to ask for help
- Learn helpful hints
CAREGIVER SUPPORT GROUP

History, support & education group—began in 1983, and still going

Common issues, problems

Mantras: “choose your battles” and “keep your sense of humor”

Alzheimer’s Association

*…Sharing thoughts of caregivers, in their own words…*

IMPLICATIONS FOR NURSING PRACTICE

Nursing is a progressive art, in which to stand still is to go back. A woman who thinks to herself, ‘Now I am a full nurse, a skilled nurse, I have learned all there is to be learnt’—take my word for it, she does not know what a nurse is, and never will know; she is gone back already. Progress can never end but with a nurse’s life.”

Florence Nightingale (1859)
Questions, discussion

Peace.
It does not mean to be in a place where there is no noise, trouble or hard work. It means to be in the midst of those things and still be calm in your heart.

(unknown)