Margaret P (not real name of the resident)

History

Ms. Margaret is a 72-years old woman, a home maker, also worked as a receptionist. She sustained intracranial hemorrhage due to fall and head injury two years ago. She has been in current nursing home for one and a half year. She was in another nursing home for 6 months prior to this nursing home. Per staff, Ms. Margaret has been paranoid (convinced that staff are intentionally trying to hurt her, poison her as "there are so many pills"), physically aggressive (hitting staff during personal care), yelling at the staff, frequently cries, and has not been eating or sleeping well for months, increased in the last several weeks. She also has mild to moderate chronic musculoskeletal pain (lower back and right shoulder). She frequently cries before shift change and reports that she needs to go to the bathroom. She is unable to void on her own, has obesity and needs Hoyer lift. She often yells for staff and if staff fail to respond promptly, she starts "wailing" and disrupts the whole milieu and agitates other residents who often start yelling at her and telling her to "shut up." Staff have noted her to be frequently anxious, refusing to cooperate with staff during cares for toileting or dressing. Ms. Margaret also has excessive daytime sleepiness for last few weeks. Current psychiatric medications "have done nothing" per staff.

She enjoys 1 on 1 attention, being read newspapers in the morning, musical performances, country music, and hand massages. She does not like group activities and refuses to attend them.

Interview findings:
Ms. Margaret replied "It's a nice place to be if you are sick" regarding what she thinks of the care she is receiving. She answered "watching TV" when asked what she looks forward to every day. She endorsed many symptoms of depression including feeling sad, down, tearful, hopeless at times, and also reported pain "all over" but added pain today was "not bad." She reported that her wheelchair (a Broda wheelchair) was comfortable. She became quiet when asked if her husband said or did anything that was hurtful or that upset her.

When her husband, Mr. Dave arrived, he was very suspicious of the psychiatrist's presence and asked him what he was doing. After the psychiatrist introduced himself and explained that he wanted to address his wife's depression, he accepted the explanation and then took over the conversation showing a stack of photos of his current wood working projects. Upon inquiry, he stated that they have been married since 1972 and proceeded to talk mainly about himself and his work.

Recent stressor: Her friend and fellow resident Helen recently moved to a different facility and Ms. Margaret now does not have a friend to "look after."

Chronic stressor: Staff have noted that her husband of 45 years is verbally abusive towards her most of the time during his visits (almost daily visit for around one hour).

I requested a life history of Ms. Margaret to understand better how her past experiences may be influencing her current behaviors. The social worker indicated that she has one daughter with her husband Mr. Dave but the daughter is not currently involved in Ms. Margaret's life. Mr. Dave has a son from a previous marriage and he is also not involved in Ms. Margaret's life. Mr. Dave did construction work and drove trucks for a living and is currently retired. Ms. Margaret waited on him when he got home. Ms. Margaret is 10 years younger than Mr. Dave and he expected her to take care of him and seems to resent the fact that the roles are reversed. Mr. Dave visits her several times a week but is very critical of Ms. Margaret and often yells at her and often tells her to "shut up".

Allergies:
No known medication allergies

Current psychiatric medications
Mirtazapine 15mg daily at bedtime for Major depression (recently added)
Escitalopram 10mg daily for Major depression (started a year ago, has helped partially)
Trazodone 25mg daily at bedtime for insomnia
Risperidone 0.5mg daily for Vascular dementia with psychotic symptoms and aggression
Lorazepam 0.5mg as needed q6hours for anxiety (average use 1 per day, in late afternoons)

Current Non-psychiatric medications
Amlodipine 10mg daily for Essential HTN
Carvedilol 12.5mg twice daily for Essential HTN
Hydrochlorthiazide 12.5mg once daily for Edema
Potassium chloride ER 20 meq once daily supplement as patient on a diuretic
Losartan 100mg once daily for Essential HTN
Loratadine 10mg once daily for Allergic rhinitis
Fluticasone 2 sprays in each nostril once daily for Allergic rhinitis
Tramadol 25mg four times a day for Chronic pain
Gabapentin 300mg twice daily for Muscle spasms related pain
Polyethylene glycol 17 grams twice daily for Constipation
Multivitamin one daily as a supplement

PRN Medications
Hydrocodone-acetaminophen 5/325 mg as needed q6hours for pain (uses 1-2 per week)
Acetaminophen 650mg prn q4 hours for pain (uses on average 5-7 times a week)

Past Psychiatric History
She has not seen a psychiatrist in the past but did see a counselor for a few times after she was fired from her job. No past history of significant depressive symptoms or suicidal ideas or any other significant psychiatric symptoms.

Medical and Surgical History

Fall and intra-cranial bleed with residual significant neurological deficits (left upper extremity weakness [left arm in a fixed flexed posture], dysarthria, ataxia) causing patient to be in wheel chair. MRI of brain 7/16: old hemorrhage along the left posterior frontal cortex and the right inferior cerebellum.
Chronic pain (chronic low back and shoulder pain)
Chronic Kidney Disease Stage 3
Type II diabetes
Obesity (BMI 35)
Remote history of poliomyelitis

Family history

Positive for depression in each of her three sisters and one niece

Additional Social history

Graduated from high school, worked at a telephone company and also at a coffee enterprise as a receptionist until she was fired (reasons unclear).

Examination:

Pulse: 68
RR: 18
BP: 124/68

Neurological exam:

No involuntary movements seen.

Mental Status Exam:

Ms. Margaret was awake, alert, cooperative, quite social, smiled spontaneously, spoke in a very low volume, although sometimes it was hard to decipher what she said due to dysarthria and low volume. She answered in short sentences with minimal spontaneous speech. She reported feeling "okay" and her affect was blunted with some occasional smiling. There was good eye contact. She denied any suicidal or homicidal ideas, and no evidence of any hallucinations or delusions. Ms. Margaret did not endorse any paranoid thoughts that staff had reported.

Cognition

She could tell correctly the year, the name of the facility, the season, the floor. 3/3 immediate recall and 2/3 delayed recall. She said "I don't know" to doing serial 7 subtractions. When asked to count backwards from 20 by subtracting 3, she thought for a bit and then stated "that's a hard one." Ms. Margaret could think of only two words starting with *P* in one minute and only four animals in one minute. She could name the current president ("Trump") and the candidate that ran against him ("Clinton") and the president assassinated in 1960 ("Kennedy") but could

not name the president before Mr. Trump. Ms. Margaret's answers were slow and cognitive testing seemed taxing to her and hence further testing was abandoned.

Witnessing agitation
During observation from the side, Ms. Margaret at one time was shaking and yelling in high-pitched voice until staff came and addressed her toileting needs.

Laboratory data
CBC, CMP, Vitamin B12, TSH, EKG unremarkable.
Mild sleep apnea found on sleep study but patient refused CPAP machine.

Diagnosis: Affection and Fun Deficit Disorder, Trauma, and Major depressive disorder single episode, moderate severity, with significant anxiety symptoms, and treatment resistant. Chronic pain not adequately treated and contributing to depression and anxiety.

Outcomes tracked:
PHQ-9 score: Currently 17.
Frequency of crying spells per shift
Frequency of yelling episodes per shift

Treatment Recommendations:

1. Geriatric Scalpel: Rational Deprescribing
    a. Taper and discontinue risperidone and lorazepam over two weeks as their risks outweigh any potential benefits
    b. Discontinue trazodone as it's risk of drug-drug interaction with tramadol (serotonin syndrome and seizure), and risk of sedation
    c. Decrease and discontinue mirtazapine over one week due to risk of weight gain and it may be contributing to excessive sleepiness.
    d. Discontinue hydrochlorthiazide and potassium (with agreement of patient's Primary care clinician) and monitor edema of her feet (patient does not have congestive heart failure)
    e. Decrease and discontinue gabapentin (with agreement of patient's Primary care clinician) as patient's pain is essentially thought to be musculoskeletal with small neuropathic component.

2. SPPEICE: Strengths-based Personalized Psychosocial sensory spiritual Environmental Initiatives and Creative Engagement
    a. Individual on-site supportive psychotherapy (a licensed counselor to visit Ms. Margaret once a week to address her distress related to losses and support Ms. Margaret's strengths and positive coping behaviors).
    b. Scheduled 1 on 1 with favorite staff (and volunteers and member of clergy) for 5-15 minutes at least three times a day, preferably before periods of expected distress

(e.g. change of shift). Ms. Margaret has had many losses in her life and if most of the interactions throughout the day are with staff during tasks, she is not having any positive social interactions on most days.

c. Individualized Pleasant Activity Schedule (list of activities that are identified by Ms. Margaret is "fun and pleasant" and staff check marks activities each day that Ms. Margaret has engaged in)
d. Requested husband Mr. Dave's to limit visits to 30 minutes (with agreement of the ombudsman and ALL team members) daily.
e. Personal Favorite Music with headphones
f. Bright light therapy and increased exposure to sunlight for 20 minutes' daily
g. Physical activity and restorative physical therapy
h. Finding one or more activities that makes Ms. Margaret feel that she is needed or is helping others, especially "looking after" someone.

3. <u>STEPS (Staff Training Education Praise and Support)</u> was initiated as staff are emotionally drained, want Ms. Margaret to be transferred to another facility or to an inpatient psychiatric unit, and feel helpless that they are not able to alleviate Ms. Margaret's distress. Education and training focused on staff understanding behavioral contingency, positive and negative reinforcement, and differential reinforcement strategies. Role play was used to improve understanding of staff regarding how their response may inadvertently reinforce negative behaviors. Staff were educated that medication changes take time and importance of diligently following plan of care (e.g., topical analgesics and SPPEICE). Staff was praised for their efforts as many other facilities would have tried to send patient to the local ED for acute inpatient psychiatric treatment or transfer to another facility. Director of nursing was urged to provide more support to the unit manager.

4. <u>Rational Prescribing</u>
   a. Increase escitalopram to 15mg daily for two weeks, then 20mg daily and monitor for adverse effects (especially serotonin syndrome as patient is on tramadol). Some LTC residents may need higher doses of antidepressants and often tolerate them but do need close monitoring for adverse effects including adverse drug-drug interactions.
   b. Topical analgesics (Bio-Freeze) to lower back and shoulder three times daily.
   c. Topical diclofenac gel to the right shoulder daily.
   d. Acetaminophen 650mg three times a day

<u>Two month follow up</u>

Ms. Margaret is tolerating escitalopram well and daytime sleepiness has improved but still present, especially in the mornings. Ms. Margaret is "doing much better" per staff, crying and yelling episodes have reduced, PHQ-9 score is 10, and husband has not opposed shorter and less frequent visits request.

<u>Four month follow up</u>

Ms. Margaret continues to do well and morning sleepiness has resolved. She continues to have some residual symptoms of depression, anxiety and agitation and hence, psychiatrist documents that gradual dose reduction of escitalopram is clinically contraindicated. Option of adding aripiprazole in the near future for treatment resistant major depression is discussed with team.