Kate L. M. Hinrichs, PhD
Consultation Case

Contextual Statement:

I am presenting the case of Mr. S, an 85-year-old, White, male, widowed, 10% service-connected, WWII-era Army veteran who was referred to Mental Health on 9/16/12 by the physician for behavior management in the context of increased yelling, cursing, code green (behavioral emergency), and threatening remarks to the nursing staff. He was initially referred to our sub-acute rehab unit on 12/8/11 status-post appendix perforation with drain placement and failure at an outside rehab facility. The outside rehab sent Mr. S back to the ER after <24hours was "irritable," "used harsh language with staff," and was "refusing to cooperate with care." His medical history included: Venous Insufficiency Ulcers, Hypertension, Macular Degeneration, Prostate Cancer treated with brachytherapy (2000), left total knee replacement (1999), right total knee replacement (2001), frostbite resulting in amputation of 4th and 5th digits (2006), depression/dysthymic disorder (diagnosed by PCP in 2001 and on Citalopram 20mg), alcohol abuse, and presumed "mild dementia".

Throughout his stay in our care Mr. S was intermittently irritable and verbally abusive toward staff. Mr. S had completed rehab, was transferred to the step-down unit, and was awaiting discharge when I was consulted regarding his behavior. In the previous week there had been several incidents where the veteran's behavior had escalated. Specifically, on 9/10/12 a Code Green was called when Mr. S became upset after a shower when the aid tried to help remove the bag that had been covering his cast (he had recently fallen and broken his wrist). Mr. S began yelling, cursing, and making statement such as "get the F out! I'll go right through out! I'll F'ing kill you!" The code team helped de-escalate the situation and Mr. S was escorted to his room. However, he later asked his nurse (who had called the code) to come closer and he quietly said to her "I'm going to beat the F'ing Shit out of you." A few days later it was reported that when an aid attempted to assist Mr. S in the dining room he again began cursing and threatening. When a nurse informed him he could not speak that way in the dining room Mr. S went on to scream at that nurse and come at him in his wheel chair. Eventually he backed down and went to the dayroom to watch TV. It was after these incidents that I was consulted.

On 9/17/12 I went to see Mr. S, but he did not prefer to meet for very long. I introduced myself and the role of Psychology and he agreed to meet the next day for a more comprehensive evaluation. Interestingly, he did allow me to explain the purpose of this evaluation and he denied feeling stressed lately. However, he did acknowledge that he sometimes "gets excited when I'm upset" but he laughed this off and made a lewd comment about my appearance. I spent additional time that day meeting with the nurses and aids who had been recently caring for Mr. S to gather their impressions about his increasingly hostile interactions. They offered many fruitful observations (e.g. behavior worsened after Mr. S broke his wrist and started needing more help, he has more pain lately, his daughter has not been around to assist with discharge planning as she had promised). This information would be incorporated into my reports and recommendations (see Behavior Initial Assessment and Behavior Plan below).

My approach to behavioral consultation is based in the Biopsychosocial framework. This typically begins with in-depth review of a comprehensive electronic medical record and interview with family members or providers who know the patient well. Fortunately Mr. S had received all of his care in the VA so his

records were robust. Further, Mr. S was able to participate in the evaluation and provided much information about himself and his recent frustrations. However, his daughter was unreachable so it was not possible to gather collateral information from family. Collateral information was instead gathered from staff including: nursing assistants/aids, nurses, MD/PA, the social worker, and recreation therapy. Prior to consulting me the medical team ruled out UTI or other obvious causes of changes in mental status or behavior. I find it essential to gain as much knowledge as possible to be able to determine what is leading to problematic behaviors and how to alter them moving forward as behaviors may be impacted by medical, psychological, or social factors. This approach allows staff at all levels to share their experiences and knowledge and to join in finding a solution. I find that if staff assists with creating a plan they are far more likely to implement said plan.

These interviews were completed on the unit. I was able to meet with the primary nurses and aid during their regular shifts, and met with Mr. S in his room at an agreed upon time on 9/18/12. Staff was able to share that Mr. S had the most trouble controlling his behavior in the dining room, shower room, and bathroom and his behavioral escalations were most frequent during times when he required increased assistance from staff. The aid proposed that Mr. S may not fully realize he needs assistance with certain tasks and he becomes embarrassed when staff intervenes. This leads to an angry outburst often involving cursing and threats of violence. Mr. S was able to calm down eventually but not before using his words to assert dominance over those who made him look “weak” by offering to help him. This situation had been occurring more since he broke his wrist, had additional pain, and was further debilitated by this fall and worsening vision. Mr. S also had a very limited support network. Strengths of his included: humor, some insight, and a desire to be more active (which also served as a source of frustration since he now required more help for many tasks).

It may have been useful to gather additional cognitive data since there was suspected cognitive impairment. However, Mr. S had previously turned me away for cognitive screening and his limited frustration tolerance led me to favor a clinical interview over cognitive screening. If we had further diagnostic questions I may have referred him for comprehensive neuropsychological testing, but this was not a clinical priority given that he was living in a supervised environment and his cognitive functioning did not appear to be grossly impacting his daily functioning. Further it was unlikely he would have agreed to such testing. It may also have been useful to inquire further about this veteran’s history of alcohol use since his chart indicated a history of alcohol abuse. But by the time I was consulted Mr. S had been in the hospital for over 10 months with no evidence of alcohol use so it was not suspected that intoxication was playing into his recent behaviors (though a history of such could certainly have lasting cognitive effects).

After this first round of interviews and data gathering I worked with the staff to draft an initial inter-disciplinary plan. In this Behavior Plan I agreed to begin meeting with the veteran to discuss his frustrations and coping techniques and to refer him to Psychiatry since it had been >9 months since he last saw a Mental Health prescriber. Recreation Therapy agreed to re-try inviting Mr. S to the Current Events Group, Exercise Group, and cook-outs as he had previously attended these activities at least intermittently. The medical team was asked to place a consult to Optometry as veteran would like to see if new glasses could help him read again. Veteran also requested assessment of the edema in his legs, which was bothersome to him. Nursing was advised to set limits around his cursing in public areas, threatening remarks, and to take breaks from providing care if Mr. S became abusive or threatening. This information

was placed in the chart and I attended shift change meetings to convey the plan to staff. I also used this opportunity to praise the many good things they had been doing with Mr. S and provide support to them.

In the days after my evaluation the Psychiatrist saw Mr. S and thought his irritability and reactive and angry mood may be due to anti-depressant associated mood changes like hypomania/bipolar II. Thus, he recommended stopping the Citalopram and Trazodone and initiating Aripiprazole in the mornings and Clonazepam at bedtime. However, the Aripiprazole was discontinued due to increased sedation. Staff reported a period of Mr. S staying in bed and asking to be left alone. During this time he persisted in harassing some staff (e.g. repeatedly saying "give me a kiss" during personal care, yelling), but was less threatening overall. Staff were repeatedly reminded and encouraged to stop care if Mr. S was threatening or abusive and this technique did seem to help reduce his abusive behavior over time. There were more shifts than not when no behavior disturbances were reported.

Additional meetings with Mr. S revealed ongoing frustration with increased debility (see Therapy Note below). He persisted in blaming staff for his outbursts and felt that if staff "treated me better" he would not have to yell or threaten them. Despite these beliefs Mr. S was having fewer outbursts and the outburst he had involved fewer threats of harm. Recommendations for working with Mr. S were discussed in weekly Behavior Rounds with the staff (see 10/1/12 Consultation Note below) where they were given an opportunity to share any new advice for working with him or new observations about what is helpful for him. Around this time there began to be increasing evidence of altered mental status and severe abdominal pain. Mr. S was transferred to the ER on 10/3/12 for acute appendicitis, which was again treated by drainage and he was sent to an outside rehab for care and eventually home .

Informed Consent: My setting does not utilize specific written consent for psychological services. I obtain informed consent verbally, and if the person cannot provide consent, I seek their assent to participate. In this instance, the veteran did appear to have the ability to provide informed consent for the clinical interview and did so.

Evaluation (including Initial Assessment, Behavior Plan, Therapy Note, and Staff Consultation Note):

Behavior Initial Assessment:

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LOCAL TITLE: BEHAVIOR INITIAL ASSESSMENT
STANDARD TITLE: MENTAL HEALTH INITIAL EVALUATION NOTE
DATE OF NOTE: SEP 18, 2012@11:50     ENTRY DATE: SEP 18, 2012@11:50:19
      AUTHOR: HINRICHS,KATE MARTI  EXP COSIGNER:
     URGENCY:                          STATUS: COMPLETED

Behavioral Management Team Initial Assessment
CPRS Title: "BMT Initial Assessment"

Reason for Referral: Per CLC physician's consult request "85 yr old
veteran with cognitive deficits, depression, HTN who was seen by
Psychiatry in Jan. 2012 with recent Code Greens and veteran's verbal
abuse, threats and uncooperativeness in participating in ADLs for
evaluation and reducing behavior problems and empowering the nursing
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staff to deal with the difficult behaviors and reducing Code greens. Thanks."

Difficult Behaviors: (List All)
Yelling at staff, Threatening staff, Cursing at staff

Target behaviors (from above; DESCRIBE EACH BEHAVIOR THOROUGHLY)
Behavior: Yelling at staff
Frequency of Behavior: weekly
Disruptiveness: Extremely
Type of Behavior: Verbal
Behavior: Cursing at staff
Frequency of Behavior: weekly
Disruptiveness: Extremely
Type of Behavior: Verbal

Medical problems that may contribute to behaviors:
Macular degeneration, HTN, hx of prostate removal, obesity, Depression, bereavement, Dementia

Medications that may contribute to behaviors (list all):
CITALOPRAM TAB 20MG PO QDAILY Depression
DOCUSATE CAP,ORAL 200MG PO QDAILY hold for diarrhea
MILK OF MAGNESIA SUSP,ORAL 1 TABLESPOONFUL PO BID PRN constipation
TRAMADOL TAB 50MG PO Q8H PRN Right Thumb pain
TRAZODONE**HYPNOTIC-1ST LINE AGENT** TAB 50MG PO QHS PRN insomnia

Delirium: Possible (labs pending, but doubt delirium)
Pain: Yes (pain in legs and fx'ed wrist
Pain Scale (0-10): 6

When does the behavior occur (day, time, shift):
When veteran most requires assistance from staff for ADLs

Setting of behavior (where does the behavior occur):
dining room, shower room, bathroom

Antecedents of behavior (what happens before the behavior occurs):
Veteran does not realize he needs additional help and becomes embarrassed when staff intervene.

Consequences of behavior (what happens after the behavior; how does staff respond):
Veteran eventually calms down, but not before making it clear to all involved that he is very upset/angry.

Unmet needs of resident (pain, hunger, thirst, stimulation, social interaction):
Pain (ongoing in legs, but pain in wrist has been a more recent problem). The fx of wrist also leaves him more debilitated and less able to do his own ADLs. Has a very limited support network. Pain, debility, loneliness.

Strengths of resident (abilities, memories, interests, skills):
Able to engage in discussion of his current functioning, uses humor to cope, maintains desire to be more active (misses reading now that his vision is worse). Acknowledges he has lost his temper here with staff. Able to understand consequences.

Limitations of resident (sensory deficits, mobility limitations, physical impairments):
Less able to ambulate independently than last year. Having more trouble with transfers to/from bed and to/from toilet. Vision has gotten worse. More dependent on others for care.

Mental Status:
Appearance: obese older man, wearing hospital PJs
Behavior: lying in bed, strong EC, at times made sexually inappropriate gestures/kissing faces
Speech: fluent, normal volume, some hesitations noted
Thought Process: somewhat tangential but ultimately goal-directed
Thought Content: mostly logical, nonbizarre, somewhat organized
Perceptual Disturbance: none noted or observed
Mood: "not great"
Affect: broad, congruent
Memory: appeared grossly intact
Attention/Concentration: appeared grossly intact
Insight/Judgment: fair

Current Medical Problems:
Kidney Neoplasms (ICD-9-CM 239.5)
Appendicitis (ICD-9-CM 541.)
Dementia in conditions classified elsewh
Methicillin resistant Staphylococcus Aureus
Cellulitis (ICD-9-CM 682.9)
Ulcer of lower Limb, unspecified (ICD-9-CM 707.10)
Frostbite of hand (ICD-9-CM 991.1)
Obesity (ICD-9-CM 278.00)
Malign Neopl Prostate
Venous Insufficiency (ICD-9-CM 459.81)
Other B-complex deficiencies (ICD-9-CM 2
Macular Degen, Wet (Armd)
Telangiectasia, Retinal
Peripheral Vascular Disease (ICD-9-CM 443.9)
Decubitus Ulcer (ICD-9-CM 707.0)
Dyspnea
SHORTNESS OF BREATH
Personal History of Colonic Polyps
Hematochezia (ICD-9-CM 578.1)
Gastroenteritis and colitis due to radiation (ICD-9-CM 558.1)
OTHER ATOPIC DERMATITIS
Prostate Cancer
Depression
Hypertension
RESPIRATORY ABNORM NEC
Alcohol abuse, continuous drinking

behavior
Bereavement OTH ORG/TISS REPL STATUS,NEC
PHYSICAL THERAPY NEC VITAMIN B DEFICIENCY NOS

Current Medications:
No Active Remote Medications for this patient
Active and Recently Expired Outpatient Medications (excluding Supplies):

	Active Non-VA Medications	Status
1)	Non-VA ASPIRIN 325MG EC TAB 325MG BY MOUTH EVERY DAY	ACTIVE
2)	Non-VA COLLAGENASE 250 UNT/GM TOP OINT LIBERAL AMOUNT TO SKIN EVERY DAY	ACTIVE

Active Inpatient Medications (including Supplies):

AMLODIPINE TAB 10MG PO QDAILY hold for bp <90/50	ACTIVE
CALCIUM (OYSTER SHELL) TAB 1 TABLET (CA 500MG) PO QAM	ACTIVE
CITALOPRAM TAB 20MG PO QDAILY Depression	ACTIVE
DOCUSATE CAP,ORAL 200MG PO QDAILY hold for diarrhea	ACTIVE
ERGOCALCIFEROL CAP,ORAL 50000UNT PO Q MONTH Vit D	ACTIVE
METOPROLOL TAB,SA 25MG PO QDAILY hold for bp<90/60, hr<55	ACTIVE
MILK OF MAGNESIA SUSP,ORAL 1 TABLESPOONFUL PO BID PRN constipation	ACTIVE
POLYVINYL ALCOHOL SOLN,OPH 1 DROP OU QDAILY	ACTIVE
TAMSULOSIN CAP,ORAL 0.4MG PO QHS LUTS	ACTIVE
TRAMADOL TAB 50MG PO Q8H PRN Right Thumb pain	ACTIVE
TRAZODONE**HYPNOTIC-1ST LINE AGENT** TAB 50MG PO QHS PRN insomnia	ACTIVE
TRIAMCINOLONE 0.1% CREAM,TOP MODERATE AMOUNT TOP BID left lower leg rash	ACTIVE

Allergies/Adverse Reactions:
VANCOMYCIN, OXYCODONE

Primary Nurse: Beth Seastrand, LPN
Primary BMT Member: Kate Hinrichs, PhD

/es/ KATE MARTIN HINRICHS PHD
PSYCHOLOGIST
Signed: 09/18/2012 12:37

Behavior Plan:

LOCAL TITLE: BEHAVIOR PLAN
STANDARD TITLE: MENTAL HEALTH TEAM NOTE
DATE OF NOTE: SEP 18, 2012@12:37 ENTRY DATE: SEP 18, 2012@12:37:35
AUTHOR: HINRICHS,KATE MARTI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

BMT Management Plan
CPRS Title: "BMT Management Plan"

Date of Initial Assessment: Sep 18,2012
Primary Nurse: JH, RN
Primary BMT Member: Kate Hinrichs, PhD

Reason for Referral: Recent outbursts of aggressive and threatening behavior on the unit (directed at staff) resulting in code greens.

Behavior: Verbal outbursts (yelling, cursing, threatening)
Frequency of behavior: weekly
Disruptiveness: Extremely
Type of Behavior: Verbal

Discharge Goal (indicate goal for frequency and severity of behavior):
Would like behaviors to occur <monthly and decrease in severity to moderately disruptive or less.

Psychology:
Will initiate weekly 1:1 meetings with veteran to provide time-limited psychotherapy to address depressive sxs and behavioral disturbances.

Psychiatry:
Will refer to Psychiatry to re-evaluate psych meds as it has been >9 mos since last appt.

Recreation Therapy:
May benefit from being included in activities such as the current events group, exercise, or cook-outs. Enjoys the news, but is sort of a loner. Defer to RT's judgment about appropriate activities for him.

Medical:
- Veteran would like an Optometry appt as he says current glasses do not work well enough for him to read (which he used to enjoy).
- Vet is also complaining about ongoing edema in his legs that he would like assessed.

Nursing:
- Nursing should continue providing excellent care to this veteran.
- When he becomes disruptive care, should stop immediately (as long as vet is safe) and staff should leave the room. They may return in 5 minutes if vet has de-escalated. Should also set firm limits about sexually inappropriate behaviors or threats.

Target Date for Discharge: Oct 31,2012

/es/ KATE MARTIN HINRICHS PHD
PSYCHOLOGIST
Signed: 09/18/2012 12:47

Therapy Note:

LOCAL TITLE: Inpatient/Psychology
STANDARD TITLE: PSYCHOLOGY INPATIENT NOTE
DATE OF NOTE: OCT 01, 2012@13:08 ENTRY DATE: OCT 01, 2012@13:08:28
AUTHOR: HINRICHS,KATE MARTI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Session Type: Individual Psychotherapy
Duration: 45 minutes

PURPOSE: To treat the following problems: behavioral outbursts, threats to staff

BACKGROUND:
Mr. John S is an 85yo, white, male, widowed, 10% SC, WW-II era, Army veteran who is being cared for on the step-down unit. Veteran was admitted to the BR VA TCU on 12/8/11 for rehab s/p appendix perforation/ IR drainage and behavior issues with stay at skilled rehab <24hrs at rehab facility. ER admission note mentioned irritability/refusal of care at <Community Nursing Home>. Nursing staff here also note irritability and verbal abuse from Mr. S, which has been a problem intermittently since his admission. He has since been transferred to the step-down unit and is awaiting d/c (which his daughter is supposed to be assisting with). Re-referred to MH for increased code greens and making threatening remarks to staff.

SESSION CONTENT/INTERVENTION:
Mr. S was found lying in bed, with a flushed face. He agreed to talk but denied any recollection of altercations with staff or of making threats to staff. He did explain several incidents where he was caused pain and thus cursed at the staff member he perceived as hurting him. Spent much time discussing his behaviors and how staff may respond to him when he makes sexual or threatening statements. He noted he feels "lousy" and has ongoing pain in his R hip and in his abdomen in the lower R quadrant. Feels discouraged about needing help with urination (thus does not drink much fluids), but feels he will be able to live independently with VNA services once he gets a bit stronger. Was informed that all future threats would be reported to the VA police and was reminded that staff have the right to press charges if they are threatened by him. He acknowledged this and agreed to continuing our weekly sessions.

MSE/Behavioral Observations: Veteran presented as mostly alert, attentive, and cooperative. Lying in bed, wearing VA pajamas, face flushed. Mood was "pissed off"; affect broad and mood congruent. Speech was fluent and understandable. Limited EC. Thought content was mostly appropriate to topic but was fixed on blaming others for his troubles. Thought process was somewhat tangential. Safety: SI/HI denied.

DSM-IV-TR Multi-Axial Assessment:

Axis I: Cognitive Disorder NOS vs. Dementia NOS
Mood Disorder NOS (r/o Bipolar)
Alcohol Abuse, in sustained remission
Axis II: Deferred

ASSESSMENT:
Today Mr. S appeared more sullen which he attributed to not feeling well. He spent much time justifying his behavioral outbursts by saying they were warranted given the way he was treated by staff. He was reminded that in order to be helpful to him staff must feel safe. Thus, they will be calling the VA police if he makes future threats. It will also be useful to rule out medical reasons for his AMS this weekend and to treat such. It will be useful to continue monitoring his pain level as this may be negatively impacting his mood as well. MH will continue to follow.

RECOMMENDATIONS/PLAN:
1) Continue to follow for time-limited psychotherapy to address depressive sxs and behavioral disturbances.
2) Please refer to BMT Management Plan dated 9/18/12.
3) Will refer to Psychiatry for a re-evaluation of his medications.
4) Please rule out medical causes for AMS/Delirium.
5) Consider additional pain control as vet complains of persistent pain.
6) Call VA police if veteran makes any threats against staff or other residents.

/es/ KATE MARTIN HINRICHS PHD
PSYCHOLOGIST
Signed: 10/01/2012 13:54

Consultation Note:

LOCAL TITLE: BEHAVIOR WEEKLY NOTE
STANDARD TITLE: MENTAL HEALTH NURSING E & M NOTE
DATE OF NOTE: OCT 01, 2012@15:33 ENTRY DATE: OCT 01, 2012@15:33:33
AUTHOR: HINRICHS,KATE MARTI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Session Type: BMT Rounds
Time spent discussing veteran: 20 minutes
Review for week of: 9/24/12

BMT Contact: <Postdoctoral fellow> and Kate Hinrichs, Ph.D.
CONSULTATIONS: Kayla, Angela, Christine, Sue, Jack PA

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Veteran was referred to the BMT for yelling at, cursing at, and threatening staff. Please see the 9/18/12 BMT Management Plan for details. Veteran last seen for weekly 1:1 psychotherapy 10/1/12.

Staff discussed veteran's recent behaviors of: screaming/yelling at staff, and making threatening comments to staff. Staff shared the observation that his behavior has worsened since he fractured his wrist and is more dependent on them for care. They think his behaviors are affected by: depression, pain, staying in bed, and being more dependent. Discussed the importance of setting limits and boundaries with the veteran, and the importance of documenting occurrences.
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NEW RECOMMENDATIONS:

1. When Mr. S becomes loud, or aggressive it is important to set limits with him. For example, you could say:
"Mr. S, if you continue speaking to me that way I will have to leave the room for 5 minutes so you can calm down."
He may then choose to correct his behavior, or you should stop care and leave the room for 5 minutes (as long as he is safe). If in 5 minutes he is calm, you may resume care. If not, let him know you will check back in another 5 minutes.
Repeat this until he can interact respectfully during care.

2. Continue to set consistent limits and boundaries when he is sexually inappropriate. You could say:
"I do not like it when you speak to me that way. Please do not do that."
If he stops you may continue care. If he continues, try taking a break (see #1 above).

3. Please see BMT Management Plan 9/18/12.

4. Continue to document behavioral incidents. Please contact Dr. Kate Hinrichs (psychologist), who has been following him for individual psychotherapy with questions or concerns.

5. As with most veterans, being treated with respect is important to Mr. S and improves his willingness to work with staff and be compliant with his care plan. Please make an effort to show him respect, even when he is difficult.

6. Staff are encouraged to share successful techniques with one another and to encourage each other to stick with this plan.

7. PA may consider a consult for KT or OT, as appropriate, as vet is deconditioned and not able to do as much for himself.

/es/ KATE MARTIN HINRICHS PHD
PSYCHOLOGIST