Patient Safety: Case Discussion

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Disclosures

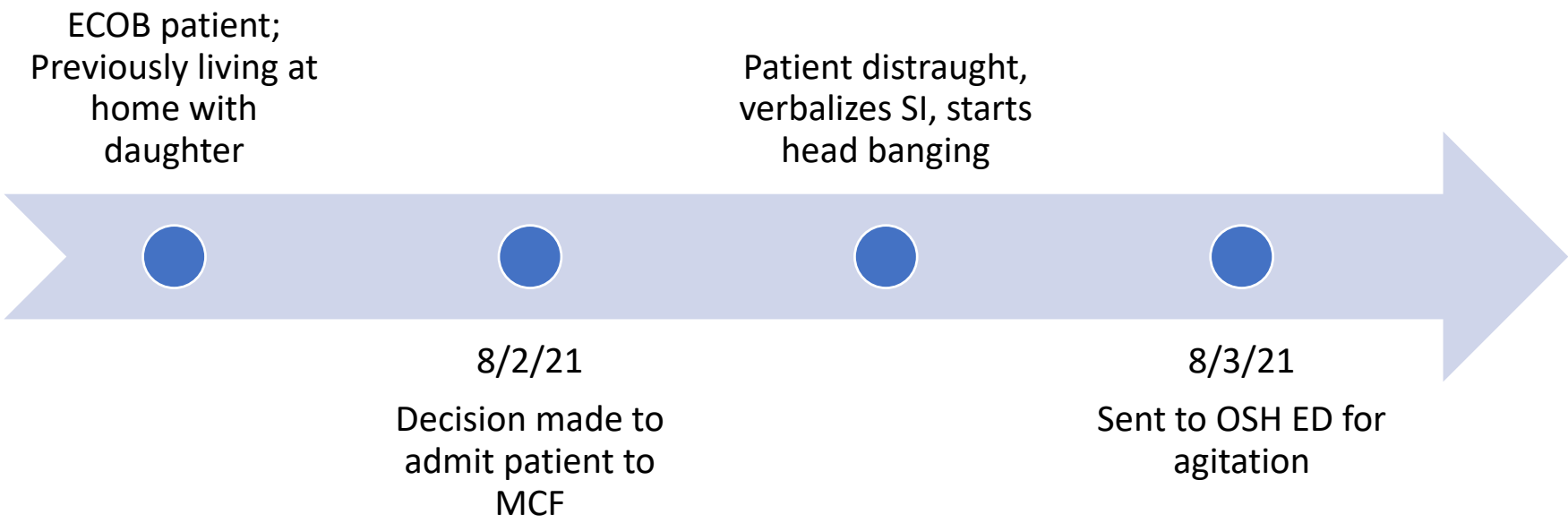
- None

Learning Objectives

- Analyze how to improve transitions between different levels of care for patients with dementia
- Recognize barriers in the emergency care of older adults with dementia
- Discuss the responsibility of the accepting facility in ensuring medical stability of older adults with dementia
- Understand ways to improve goals of care conversations

Case

- 85 yo F, PMH unspecified major NCD who presented to OSH from memory care facility for agitation and SI



Past Medical History

- Atrial Fibrillation
- CKD Stage 4
- GERD
- HTN
- HLD
- Open Angle Glaucoma with resulting blindness
- OSA, mild
- Osteopenia
- Fully vaccinated for COVID in 2/2021 and 3/2021

Past Medical History

- **Unspecified Major Neurocognitive Disorder**
  - 2017: daughter managing iADLs
  - ECOB Intake 9/2020:
    - ADLs: assistance bathing and dressing, uses walker/wheelchair
    - MRI 7/2020: significant parietal and temporal atrophy consistent with AD as well as significant vascular burden
    - MMSE: 17-20/27
    - Dx mixed dementia due to Alzheimer's, vascular disease
  - ECOB Follow-up 6/2021:
    - Worsening memory, apathy, paranoia, needing more assistance with ADLs
    - MMSE 8-10/21
    - Social work begins to assist with memory care facility placement

Social Hx / Family Hx

- Marital Status: Widowed x 13 years
- Education: 1 year of college in Philippines
- Occupation: Retired beautician
- Living situation: Owns her house and daughter lives with her
- Substance use: none, never smoker
- Family History: no known memory problems or psychiatric illness

Home Medications

- Amlodipine 2.5mg daily
- **Apixaban 2.5mg BID**
- Atorvastatin 40mg daily
- Cetirizine 10mg daily
- Dorzolamide-timolol 2%-0.5% ophthalmic solution 1 drop both eyes BID
- Gabapentin 300mg daily and 900mg nightly
- Latanoprost 0.005% ophthalmic solution 1 drop both eyes nightly
- Omeprazole 20mg daily
- Rivastigmine 3mg BID

Transitions to residential care

- What went wrong in this patient's move to the MCF?
- How can we improve transitions to residential care?

Prince M , Prina M , Guerchet M . *World Alzheimer report 2013: journey of caring: an analysis of long-term care for dementia*[Internet]. London : Alzheimer's Disease International ; 2013 Sep [cited 2014 Feb 27].

Evaluation at OSH

- **HPI:**
  - “Per EMS, patient **repeatedly banging her head on the wall** last night stating that she wanted to kill herself because she did not want to be in the facility.”
  - “Oriented to only herself”
- **Vitals:** T 36.7, HR 88, RR 18, BP 180/112, SpO2 100%
- **Notable Physical Exam Findings:**
  - General: “Alert and oriented,” “well-appearing,” “No acute distress”
  - HEENT: “Small ecchymosis under left eye”
  - Heart: RRR
  - MS: “Ecchymosis overlying the BL LE without bony abnormality”
  - Neurologic: “A&Ox1, CN 2-12 intact, EOMI, No focal neurological deficits”
  - Psychiatric: “Agitated” “endorsing SI, stating staff have taken her money”

Differential Diagnosis

What workup would you want to do?

Evaluation at OSH

- **Workup:**
  - **CBC:** WBC 10.7 (H), Hgb 11.2 (L), Hct 36.8, MCV 73.9 (L), MCH 22.5 (L), MCHC 30.4 (L), PLT 201, Neutro Absolute 8.27 (H), otherwise WNL
  - **BMP:** Na 137, K 4.6, Cl 103, CO2 22, Cr 1.4 (H, baseline=1.4-1.6), BUN 30, Glu 153 (H); Ca 10.1, Mg 2.3
  - Trop 0.013
  - **PT/INR:** 13/1.0
  - **COVID PCR:** Negative

Evaluation at OSH

- Psychiatry Consult:
  - “Not cooperative with interview, placed on 5150 for DTS in context of SIB with head-banging and making suicidal statements”
  - “Head CT is considered given head injury with blood thinners, however, patient is at her baseline and injury was incurred sub-acutely. Patient would require sedation for CT imaging and labs, which are of low clinical utility in this setting. Risk of sedating patient for further testing outweighs benefits of testing at this time.”
  - Recommend transporting to UCSD for inpatient geripsych admission

ED Assessment / Plan

- ”85 yo F, h/o dementia, presenting from outside facility for SI…No evidence of tachycardia or hypotension….Ecchymosis underlying the left eye, however, no proptosis, no facial instability, or other evidence of head trauma. No battle sign or raccoon’s eyes suggest basilar skull fracture. Patient ambulatory, moving all extremities spontaneously, no focal neurological deficits to suggest acute intracranial process such as intracranial hemorrhage or mass occupying lesion. Patient offered medical work-up to include laboratory testing, imaging of the head, however, initially declined. Patient does not demonstrate capacity at this time. Will obtain basic labs. No indication for sedation in order to obtain imaging, as risks of decompensation, arrhythmia, or airway compromise outweigh the benefits of obtaining these times at this time. Patient intermittently attempting to leave, stating staff have stolen her money and that she would like to go home. Patient is redirectable and noncombative, no indication for medical or physical restraints at this time….Patient currently medically cleared for transport to UCSD for inpatient psychiatry.”

Barriers in emergency care of dementia patients

- Environment
  - Overstimulation (visual and auditory), cold temperature
- Communication
  - Poor historian, capacity to make decisions
- “Diagnostic overshadowing”[1]
  - Receiving inadequate or delayed treatment on account of the misattribution of physical symptoms to mental illness
- Stigma
  - Can lead to delayed care, inadequate care, discrimination, avoidance of help-seeking behaviors

What's an accepting facility to do?

- If you're reviewing the medical records for this patient, would you accept them to SBH?

Course at SBH

Aug 3. 2150

Direct admit to SBH. Per nursing: "eyes closed…refused vital signs."

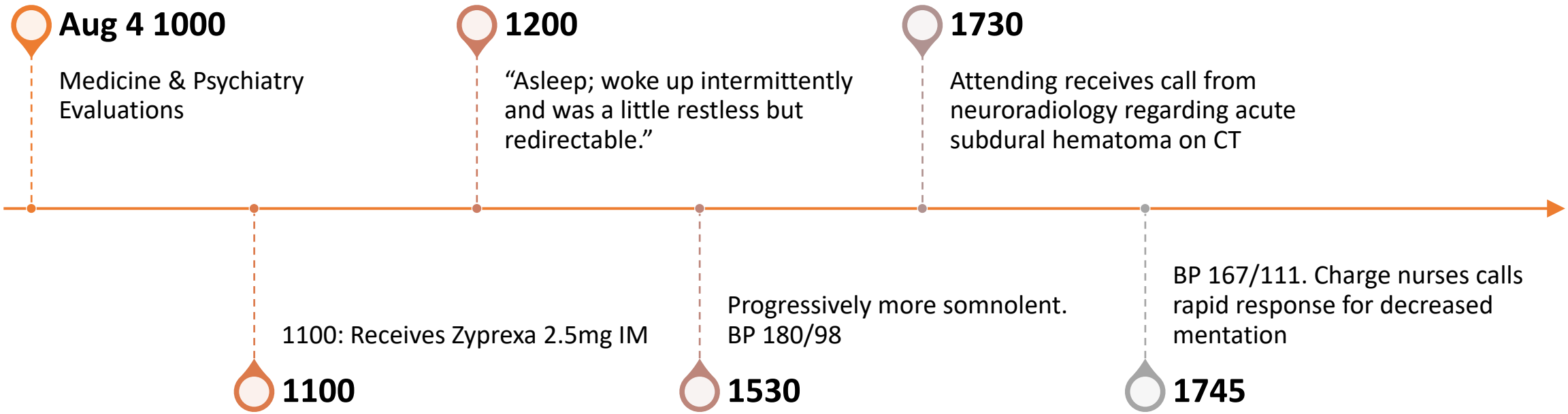
Aug 3. Overnight

”Alarm went off, seen at edge of bed, naked, incontinent of urine. Oriented to self only. Pt is disorganized, appears to be hallucinating, calling her mother and seeing things. Slept for 3.5 hours"

Aug 4. 0604

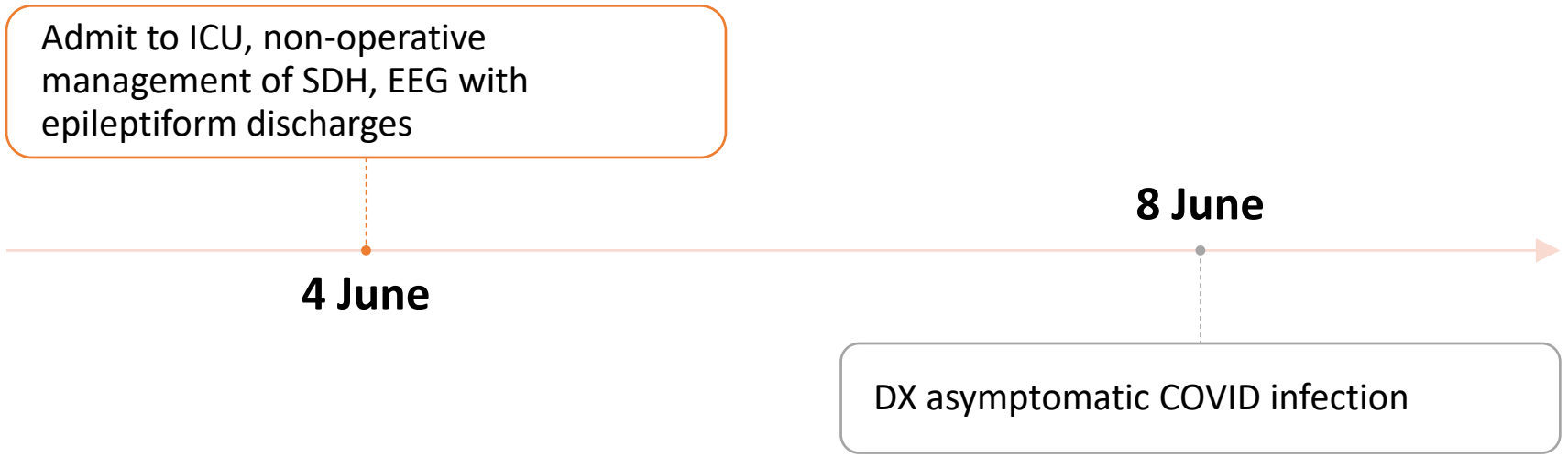
Gabapentin 100mg for anxiety, getting up impulsively, unable to sit still, perseverating about going to toilet, medication not effective."

Course at SBH

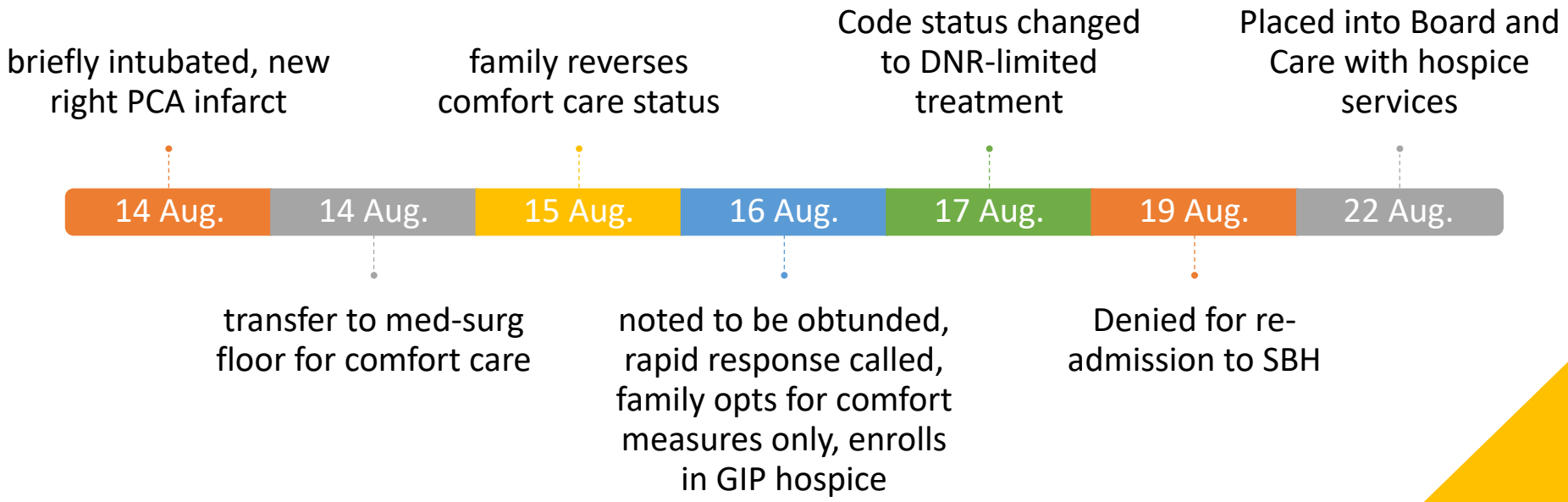


What could we have done differently?

Hospital Course (8/4-8/22)



Hospital Course (8/4-8/22) & Disposition



Goals of Care Discussions in Hospital Setting

- Multiple code status changes
- How can we improve communication amongst teams regarding goals of care conversations?