Engaging the Complex Psychiatric Patient

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Case of Mr. Z

- 69 y/o single Caucasian male who was admitted from a skilled nursing facility with weakness, dyspnea on exertion, orthostasis (stemming from a recent surgical complication)
- Inability to ambulate and loss of independence
- 5 previous hospitalizations in 3 months
- Upon admission to this hospitalization (which pt had requested), he expressed an intention to kill himself upon discharge if his condition did not improve

Clinical Pearls

- Establish rapport/build trust
- Social Archaeology – thorough psychosocial assessment
- Use your networks/team – may be outside of your organization
- Use humor when appropriate
- Multi disciplinary team approach
- Think outside the box
- Meet the patient where they are at

Case of Miss L

- 29 y/o single AAF who was admitted from an OSH with endocarditis
- Past medical history includes: bacteremia (concern for self-induced), IVDA, ESRD on HD, depression, DM, type I, and multiple atypical organisms (S. maltophilia, enterococcus, S. vestibularis, MRSE, GNB, and M. fortuitum)
- Concern for factitious disorder
- Pt has been difficult to engage; does not want to speak with providers

Miss L continued

- How would you try to engage with this patient?
- What questions would you ask?
- How would you approach with the patient the concern about factitious disorder?
- Who would you consider consulting with?

Clinical Pearls

- Normalization of role
- Collateral information
- Use non-judgmental language
- Look for connections in the patient's history
- Stay professional/emotionally detach from the situation
- It’s okay to say “no” to a patient and/or family member
- Set boundaries
Stacy

- 35 y/o female who repeatedly presented to ED after intentionally ingesting foreign objects
  - Industrial knife blades, scissors, broken glass, toothbrushes, razor blades etc.
  - Psych hx: borderline personality, anxiety, PTSD, depression, compulsive behavior
  - Medical hx: multiple endoscopies to remove foreign bodies
- ED—ICU(for endoscopy)—transfer to RNF—D/C(???)

Where to go? What to do?

- Prolonged stays on medical/surgical nursing units
- Care planning meetings
- Nurse executive
  - Clinical Nurse Specialist
  - Social work
  - Physician
  - Family (as able)
  - Community resource team (case manager)

Clinical pearls

- Know when it's too much for any one discipline
- Frequent rounding and checking in
- Have boots on the ground in the medical setting
  - In time coaching
- Consistent team
  - Develops trust
  - Prevents splitting

Discussion points

- What is your first priority?
- What do you do?
  - Are we not working hard enough to make her happy?
  - Do we ignore the behavior or confront?
- What resources would help?
- How could we have addressed this sooner?

Clinical Pearls

- Mrs. J is a 65 year old female recently admitted with exacerbation of chronic abdominal pain, nausea and vomiting. She has been treated with a variety of modalities over the years with minimal response. the treatment team has ordered a clear liquid diet, IV fluid and resumed her home medications.
- On day one she is accompanied by multiple family members. They leave at the end of the day for the three-hour ride home. No one returns to visit.
  - In spite of complaints of severe pain, unrelenting nausea and unwitnessed vomiting, she insists on a hamburger and French fries
  - Declares them inedible, throws against the wall
- Nurse manager spending hours at the bedside in service recovery
- Nursing unit at wits end

• Address the behavior with the patient early and often.
  - When the behavior happens
• Be transparent: “It upsets the care team when….(describe the behavior).
• Set limits and keep them
• Team approach
  - Everyone is on the same page
  - Eliminates splitting
  - Support one another