3-655 Paranoia and refusing meds

TIPS Question:

Mrs. L. is an 82 yr old, who had a slight stroke affecting her left leg. Upon entering rehab she fell and fractured her right hip. She had a hip replacement and had to be put in a nursing home. A very religious lady, went to church daily, is now very paranoid and had auditory and visual hallucinations about people making porno movies of her. She calls people whores and witches, and thinks people are trying to kill and poison her. She's very clear about her paranoia and she will argue that it is really happening. She was started on an antidepressant and an antipsychotic, but she'll pick these out of all her meds and refuse to take them. She's getting worse to the point of talking suicide and stopped drinking tea and is missing meals because she feels they're poisoning her.
What more can we do for her and what can we do next?

Response:

It is complex presentations such as you describe that require a framework for assessment. The issue is the resident's very marked change in behaviour, presenting with paranoia and psychosis. The behaviour is affecting the resident and all who interact with her. The challenge is to investigate the causes of the behaviour. It is unclear as to over how long a time frame this has evolved and what testing has already happened. Although not all-inclusive these are some of the important questions you and your care team can ask.

Physical Mrs. L has had both a stroke, recent fracture, plus surgery. Were there residual effects from the CVA other than her left leg? Were there perceptual changes? Did Mrs. L. experience a delirium related to her anaesthetic? Is she still experiencing a delirium? Could there be a delirium related to medications? Pain? Etc. Have new medications been added over the past weeks? Any medication including those for physical problems, psychotropics or pain medication can cause delirium. Is there a potential infection? Has a CAM been completed?

Intellectual What is Mrs. L's cognitive status? Do we know her cognitive status prior to the fall? She sounds as if she was high functioning if she were able to attend church regularly so this marks a dramatic change. All the more important to find out what has caused this change and intervene quickly! Are there family and/or friends who can help you understand Mrs. L's previous functioning? Does her cognition fluctuate through the course of the day? Her ability to recognize psychotropic medications and remove them prior to ingestion suggests a fairly high level of cognition.

Is Mrs. L competent to make treatment decisions? This is a very important determination to make. Given her fixed delusional state it is highly unlikely. Is there an SDM to discuss treatment options with the care team? If a Folstein cannot be completed, as MRS. L. is too distressed, try the clock as it can be used to monitor change in cognition.

Emotional As your medications suggest, Mrs. L. may be experiencing a psychotic depression. (Was there a Cornell completed? The score would most likely support a depressive component based on your description.) Mrs. L. has had tremendous changes not to mention physical assaults to her body, all of which could have significant impact.

Capabilities & Environment Given all of Mrs. L's recent trauma it will be important to try to maintain as much of her physical/ADL capabilities as possible. Ensuring eye glasses are in place, cues to her environment, etc., should be used whenever possible to prevent excess disability. These environmental supports are also very important if delirium is suspected. If you consider Mrs. L. has "lived' in at least four locations in a relatively short period of time her ability to adapt is significantly compromise.

Social Is there anyone that can help support this distressed resident and provide some sense of safety and security? Currently she feels in danger and distress from her total environment and is having to maintain vigilance just to save her life (by her perception). Has a Specialty 'Geriatric Psychiatry Team been involved in Mrs. L's assessment/care? It may be necessary to bring in another Partner in Care.

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Mrs. L. is very ill and in extreme distress. As a care team you are working to find and treat the cause of her distress. Interacting with a resident who is psychotic can be challenging. Refer to the P.I.E.C.E.S. Resource Guide to assist in understanding some of the strategies of caring for someone with Mrs. L.'s presentation. As her treatment is implemented you may use the guidelines for monitoring the treatment response in your manual.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*