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Contemporary Themes

Psychogeriatric Ward for Mentally Disturbed Elderly Patients

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Summary

The operation is described of a special psychogeriatric ward of 23 beds set up in 1967 to provide treatment for mentally disturbed elderly patients who could not be kept in a general ward or at home. The unit is in a predominantly geriatric hospital which serves a population of 340,000 and in the four and a half years reviewed 600 patients were admitted. Half of the admissions were emergencies. A consultant geriatrician was in charge and the nursing staff were general trained. The number of beds was found to be adequate for the demand. Few patients had to be transferred to a psychiatric hospital, but, since the mental disturbance was often associated with severe illness and the patients were old, the death rate was high. The nursing staff have found the work interesting and stimulating.

Introduction

The incidence of organic brain disease in those aged over 65 has been stated to be 10%, and 40% of patients in geriatric wards may show severe psychiatric symptoms.¹ Because noisy patients in any ward disturb others they may be over-sedated and thus under-diagnosed and under-treated. In 1967 a special psychogeriatric ward was opened at the Guisborough General Hospital, in the South Teesside Hospital Group, for the admission of elderly disturbed patients requiring any form of hospital treatment. Its effectiveness after five years is now clear, and this paper describes the unit and the patients it has dealt with in the period from its opening in May 1967 to the end of 1971.

The Psychogeriatric Ward

An unused, modern, well-constructed nurses' home at the hospital provided the sort of accommodation that was required—namely, many single rooms in a building relatively

isolated from the main hospital but with access to full diagnostic and therapeutic facilities. Minimal alterations were made, call bells and observation windows were installed in each, sanitary facilities were improved, and a treatment room was provided. Much of the original furniture was retained, but conventional hospital beds were installed for the physically ill in rooms under direct observation from the sister's office. The ward was equipped to deal with acute physical illness in addition to disturbed behaviour. It consisted of 19 single and two double rooms, 23 beds in all, and three day/dining rooms. It was called Cleveland Ward.

There were no problems in accommodating both sexes and it was possible roughly to group the patients in the three day rooms according to their mental deterioration. There were no restraints but the hospital beds had slide-under cot sides. The front door was locked only when the unit housed a very active wanderer. A fenced garden with a circular path was later added for the benefit of patients who liked to wander. The treatment room was used for most diagnostic procedures and the patients' rooms remained free of medical equipment. The rooms adjoining the sister's office could be observed through large windows, and all patients were admitted to one of these for the first few days.

POPULATION SERVED

The South Teesside Hospital Group served a population of 340,000. The proportion aged over 65 was 10.6%, which was below the national average. Teesside family attitudes to elderly relatives were generally good; housing was conventional, with very few blocks of flats; there were many groups of sheltered housing with wardens; and the provision of homes for the elderly was about average. Industry was mainly heavy with no large-scale employment of women.

The average number of patients on general practitioners' lists was 2,632. The hospitals in the area catered for all specialties in 2,088 beds. The psychiatric hospital had 481 beds and there were 295 acute or long-stay geriatric beds.

Patients

In the period under review the unit treated 600 disturbed geriatric patients who were admitted because they could not be easily managed in an ordinary ward. Some of the patients

were readmitted on one or more occasions, and there were 700 admissions (221 male, 479 female) among the 600. Of the patients admitted 46 were aged under 65. The ages of the remainder ranged from 66 to 100, most (480) being between 70 and 86. Assessment was not considered to be a major function, since "primary assessment"² in the non-urgent cases had already been made elsewhere. Patients known to be disturbed were admitted direct from their homes while those who were found to be disturbed after admission to hospital were transferred from other wards.

So far as possible one bed was kept empty for an emergency admission from either within or from outside the hospital. About half the cases, 345 out of 700, were emergency admissions. Most were for difficult behaviour caused by a change in the patient's clinical condition. Isaacs³ suggested that most emergency geriatric psychiatric admissions resulted from a breakdown in arrangements for home care, but this was only rarely an important factor in our patients. The most urgent requests for admission came from other consultants faced with a noisy, difficult, aged patient in the ward, and these patients were taken without any other assessment. Non-urgent cases were admitted within one to four weeks as beds became available.

The 144 emergency admissions from geriatric acute wards (table I) indicates the large number of patients whose behaviour after admission was found to be severely disturbed. Most of them were from general medical, orthopaedic, or neurological or neurosurgical wards. Admissions from the halfway house were mostly readmissions of patients discharged from the unit who had deteriorated and needed further treatment. The 46 admissions of patients below the age of 65 included cases of long-standing brain damage due to head injuries, neurosyphilis, presenile dementia, arterial disease, and one case of spastic diplegia (admitted five times).

TABLE I—Sources of Admissions

Source of Admission	Emergency	Waiting List	Total
Home	173	249	422
Geriatric acute ward	144	37	181
Other acute wards	14	48	62
Geriatric long-stay ward	6	2	8
Psychiatric hospital	1	14	15
Halfway house	7	5	12
Total	345	355	700

TABLE II—Diagnostic Grouping of Causes of Mental Disturbance in 700 Admissions and Numbers in Each Group

Diagnostic Group	Male	Female	Total
Arteriosclerotic dementia	100	189	289
Senile dementia	31	127	158
Secondary to acute organic disease	48	83	131
Intoxications	14	8	22
Psychoses	11	31	42
Neurological disease	9	18	27
Non-psychiatric	8	23	31
Total	221	479	700

DIAGNOSTIC GROUPINGS

The causes of the mental disturbances that were the reason for admission to the unit have been classified according to seven diagnostic groups (table II). Inevitably there was some overlapping of clinical features but the main diagnostic points in each of the groups were as follows:

Arteriosclerotic Dementia.—Usually a relatively short history of minor strokes, often with step-like mental decay but patient capable of short lucid conversations, with de-

terioration towards evenings, evidence of arterial disease; and abnormal neurological findings.

Senile Dementia.—Prolonged history of steady and uniform mental deterioration without sudden episodes; no abnormal neurological signs.

Secondary to Acute Organic Disease.—Patients in this group had usually been mentally frail before developing a physical illness or sustaining an injury.

Intoxications.—These included intoxication from alcohol, barbiturates, anti-Parkinson drugs, and one case of bromide medication.

Psychoses.—Patients with functional mental illnesses, mainly depression, some with agitation; lifelong schizophrenia; paraphrenia; chronic psychoneurosis; and known psychotics who developed physical illnesses.

Neurological Disease.—Patients with long-standing neurological disease and brain damage, including cases of cerebral tumour, both primary and secondary; neurosyphilis; presenile dementia; epilepsy; subarachnoid haemorrhage; Huntington's chorea; and spastic diplegia.

Non-Psychiatric.—The apparently irrational and disturbed behaviour patterns of patients in this group were erroneously diagnosed as psychiatric in origin when they were in fact due to a variety of causes, deafness and failure to comprehend being the most common, associated with the crisis of a severe illness. Aphasia, blindness, and wilful misbehaviour also caused errors of diagnosis, and several patients who were admitted on a history of antisocial behaviour given by ill-disposed relatives were quite rational when handled by nursing staff.

The rate of admissions did not vary with the season of the year.

MANAGEMENT

The objective was to treat the mental condition until the patient was fit to be discharged either home, to an acute ward to continue treatment, or to long-stay nursing accommodation when this was required. Patients remained in the unit until their behaviour no longer presented a problem.

The nursing staff ratio was one nurse to two beds—a total of 12 nurses for 23 beds. They were general trained and had had no formal psychiatric training. The nurses who originally volunteered to work in the unit were still in it from their own choice at the end of the period under review and only four nurses had asked to be moved during the whole period. The consultant in charge was a physician in geriatric medicine who had help from a consultant psychiatrist on request.

Treatment of physical disorders of all kinds was required. Complete cessation of medication in heavily sedated patients⁴ more often than not improved the behaviour disturbance. The most valuable drug for overactive, aggressive, unco-operative patients was chlorpromazine. Sympathetic, experienced nursing in single rooms was a major calming influence.

There were 196 deaths and 504 cases of discharge to home or to other wards. The results of treatment in the 504 cases discharged were assessed as improved, unchanged, or worse (table III). The behaviour in even the most intractable group of cases, senile dementia, often improved.

TABLE III—Results of Treatment in 504 Cases Discharged

Diagnostic Group	Improved	Unchanged	Worse
Arteriosclerotic dementia	134	52	24
Senile dementia	58	37	12
Secondary to acute organic disease	65	15	3
Intoxications	21	0	1
Psychoses	27	5	2
Neurological disease	7	8	6
Non-psychiatric	20	7	0
Total	332	124	48

The length of stay in the unit of patients in the three large diagnostic groups (table IV) showed that no time limit could be fixed. As our experience increased with time more patients were discharged within a week. Some very difficult long-stay patients paralysed after strokes were uninhibited in their behaviour. They needed geriatric nursing care but were too noisy for a long-stay ward and too ill and disabled to be removed to a psychiatric hospital.

TABLE IV—Length of Stay in Unit

Diagnostic Group	1-6 Days	7-28 Days	More than 28 Days
Arteriosclerotic dementia	30	127	132
Senile dementia	8	56	94
Secondary to acute organic disease ..	38	63	30

The psychiatric state of each patient was assessed during the regular ward round, which included the medical staff, the medical social worker, and the geriatric nursing liaison officer from the community health service. The ward sister's opinion was the most important factor in deciding a patient's fitness for discharge.

The ward management of the patients did not present big problems but the degree of nursing dependency was high. Patients were nursed in bed when necessary but most were up and dressed and shared the day-rooms, though in constant need of guidance and supervision. The more disturbed patients occupied one day-room, which made for a better atmosphere elsewhere. The patients seemed satisfied with the unit. Visiting was unrestricted and encouraged. Some visitors were upset, not by the state of their relatives but by the sight of a room full of similar patients. In these cases visiting in the patient's own bedroom was arranged.

Behaviour usually improved within a few days after admission. Aggressiveness and incontinence were less troublesome than persistent wandering and stripping. Cases of dementia did not greatly improve, but in many cases the symptom that caused the admission could be relieved. Nocturnal restlessness and depression responded well to treatment and aggressive behaviour was also usually controllable. Relatives were then prepared to take the patient home again provided that they were assured of support and readmission if necessary.

DEATHS AND DISCHARGES

The death rate was higher than expected. Many of the most disturbed patients were very ill and 196 patients died—43 within a week of admission, 62 within two to four weeks, and 91 after four weeks. This compared with a 25% death rate in a West Cornwall psychogeriatric unit⁵ and a death rate never exceeding 20% in Teesside geriatric acute admission wards.

Of the 131 cases admitted with disturbed behaviour secondary to acute organic disease 48 (36.6%) died, and 79 (27.3%)

of those with arteriosclerotic dementia and 51 (32.3%) of those with senile dementia also died. In only 180 cases were the patients discharged direct to their own home (table V).

The Department of Health and Social Security^{6,7} suggested the probable number of beds a psychogeriatric ward would need, but made no reference to the effect that admissions to such a unit might have on the number of long-stay beds needed in an associated geriatric department. When our unit was opened we feared that the long-stay beds would gradually become filled by psychogeriatric cases and that our unit would need to be backed up by a large number of long-stay beds. The number of patients in long-stay wards who had at any stage occupied a bed in the psychogeriatric unit were therefore counted at intervals and it never exceeded 40—fewer than half occupying a long-stay bed for more than two years.

Arrangements after discharge from hospital could have been better. There were no local authority hostels for the mentally frail and patients discharged to old people's homes had to be fit to mix with otherwise normal residents.

The discharge of doubtful cases from the unit to the halfway house, with self care and minimal nursing, was found to be a valuable test of fitness for final discharge. Day hospital treatment was only rarely appropriate for discharged patients, though several were observed and assessed in the day hospital before admission. Cases of brain damage did not seem to benefit and probably deteriorated with the disturbance in surroundings during the day.

RELATIONSHIP WITH PSYCHIATRIC HOSPITAL

The South Teesside psychiatric hospital service, based on St. Luke's Hospital, had an almost identical catchment area and continued to treat many patients over the age of 65 with functional mental illness, but cases of brain damage admitted were few and mostly from a waiting list. Few cases of organic dementia were being treated. During the period under review 26 patients had to be transferred from the psychogeriatric unit to the psychiatric hospital. Four were psychotics, two were strippers (both men), one had attempted suicide, and the remainder were active wanderers or too violent to control. The number of admissions to the wrong unit closely resembled that reported by Mezey *et al.*⁸

Fifteen patients suffering from disabling physical disease without a severe behaviour problem were transferred from the psychiatric hospital to the psychogeriatric unit. Eight had cerebral arteriosclerosis with strokes and seven were deteriorated, quiet, non-ambulant cases of senile dementia. Movement of patients between the two departments was minimal and the selection of hospital by general practitioners seemed to be appropriate, the cases of functional mental disease going to the psychiatric hospital and those of organic brain damage to the psychogeriatric ward. Those with severe dementia but not suffering from other significant physical illness⁶ caused some uncertainty about correct hospital placement. Though most settled quickly when admitted to the psychogeriatric unit transfer of the most difficult cases to the psychiatric hospital was often necessary.

TABLE V—Distribution of 196 Deaths Among Diagnostic Groups and Disposal of 504 Cases Discharged

Diagnostic Group	Deaths	Discharges						Total
		Home	Long-stay Bed	Geriatric Acute Ward	Other Acute Ward	Psychiatric Hospital	Halfway House	
Arteriosclerotic dementia	79	71	58	52	3	12	14	289
Senile dementia	51	25	46	16	1	4	15	158
Secondary to acute organic disease ..	48	35	8	30	6	1	3	131
Intoxications	0	13	3	6	0	0	0	22
Psychoses	8	16	5	8	0	4	1	42
Neurological disease	6	9	1	3	2	5	1	27
Non-psychiatric	4	11	5	6	0	0	5	31
Total	196	180	126	121	12	26	39	700

Conclusion

Easy access to a unit which provides both medical and psychiatric care improves the management of disturbed elderly patients in hospital. Patients at home in a disturbed mental state and suffering from organic disease or brain damage may also need swift admission to hospital. Admission to a psychiatric hospital is rarely appropriate or immediately feasible and a psychogeriatric acute unit with full diagnostic and therapeutic facilities clearly has a place in a general hospital service.

Dealing with the problems presented by disturbed patients admitted to such a unit proved to be within the competence of general trained nursing and medical staff, and psychiatric help, willingly given on request, was only occasionally needed. The interest of the staff in these patients increased and opened up a new dimension in geriatric medicine. To try to run a geriatric department now without an acute psychogeriatric unit would be unthinkable. Knowing that patients can quickly be transferred, ward staff, uneasy at first in trying to deal with psychiatric disturbance, are now confident, and they feel that they can manage almost any patient.

It was a relief to find that the number of long-stay beds occupied by patients discharged from the psychogeriatric ward was much smaller than expected. It was also pleasing to find that the work of the ward was both interesting and stimulating and that it was one of the busiest and most

effective of the hospital admission units, with about 150 admissions annually to 23 beds. General practitioners and consultants in the area all know about the unit and that a bed can always be obtained in an emergency. It provides for the psychogeriatric needs of a population of 340,000, has been effective in the management of a distressing group of patients, and forms one of the essential components of a service concerned with the care of the elderly.

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Hospital Topics

Testicular Biopsy in Evaluation of Male Infertility

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Summary

Testicular biopsy findings in 100 infertile men were correlated with the clinical findings. Mild or moderately severe tubular lesions were seen in 57 cases and severe changes in 43. Clinical examination and semen analysis were no guide to the severity of the testicular lesion. Though patients with normal sized testes more commonly had mild tubular lesions, many were severe. Patients with small testes more often had severe lesions but some had only mild tubular changes. Biopsy findings in both aspermic and oligospermic patients ranged from normal to a complete loss of germinal tissue.

Testicular biopsy is advocated in infertile men for the complete assessment of the case and for identifying those which are potentially treatable. Patients with a severe lesion can be spared further investigations. The choice

and results of treatment are discussed, particularly the surgical treatment of varicocele or obstruction. Only patients with a mild or moderate testicular tubular lesion should participate in future trials with drugs for male infertility.

Introduction

At present there is little hope of finding the cause or of treating most cases of infertility in otherwise normal men. Surgery offers some hope for a carefully selected few, but otherwise no treatment has yet been shown to produce a consistent and prolonged improvement in sperm production. Nevertheless, new drugs are always coming forward and it is important to be able to identify the patients who may benefit from them.

Testicular biopsy in infertile men was first advocated by Charny¹ to distinguish cases of obstructive aspermia from non-obstructive, to classify cases of oligospermia, and to aid prognosis. Its use as a diagnostic procedure has not, however, been universally accepted. Hanley² found it of no value as a routine procedure, Scott³ recommended it only in cases of aspermia, while Ellis⁴ and Garduno and Mehan⁵ have used it in a wider context. The study reported here was done to assess the value of testicular biopsy as an addition to clinical evaluation.

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