Behavioral Problems among Patients in Skilled Nursing Facilities

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Abstract: This survey of a 33 per cent random sample (1,139) of 3,456 patients in 42 skilled nursing facilities (SNFs) in upstate New York yielded 64.2 per cent with significant behavioral problems. Of these, 257 (22.6 per cent) of the total sample had what were defined as "serious" problems (i.e., excluding those with only impaired judgment and/or physical restraint orders). Details of the problem behaviors of this group, their previous history, current management, frequency of psychiatric consultation, and adequacy of documentation were analyzed. Median age was the same as the general SNF population, a slightly lower proportion was female, and, while 66.5 per cent had diagnoses indicating organic brain syndrome, very few had specific psychiatric diagnoses, and only 4.7 per cent had been admitted from a psychiatric facility. The attending physician had noted the behavioral problem in the record in only 9.7 per cent and had requested psychiatric consultation in 14.8 per cent of these "serious" cases. The need for more staff training in mental health care, and more physician and psychiatric consultative assistance are discussed. (*Am J Public Health* 1984; 74:1118–1121.)

Introduction

The necessity for managing patients with significant behavioral problems in nursing homes is increasing, due in part to growth of the "very old" or "frail elderly" age strata in which both physical and mental health problems increase significantly. Social and economic factors leading to greatly increased availability and use of long-term care facilities as respositories for the infirm elderly also contribute to this problem. Even more specific to the issue of mental health care, however, is the deinstitutionalization policy at national and state levels over the past quarter-century which has resulted in immense reductions in numbers of patients cared for in public mental health institutions. Between 1955 and 1980, there was a 73 per cent decrease in the census of these institutions, from about 559,000 to 150,000.[1] As a result, a great many mentally ill patients who would have been in public mental health facilities previously are now residing in the community; the problems surrounding this phenomenon are well documented.[2,3] In the case of the elderly, especially those with accompanying physical infirmities, many are institutionalized in other long-term care facilities at both the Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) levels; the resulting problems are also well documented.[4,5] National data indicate a 48 per cent increase in the number of nursing home residents with mental disabilities between 1969 and 1974.[6] Estimates from secondary analyses of the National Nursing Home Survey of 1977 suggest that about 30 per cent of all nursing home residents had a "diagnosable mental disorder," and that 61 per cent had one or more "mental impairments or conditions."[5] Nevertheless, only 1.5 per cent of all patients discharged from nursing homes alive were discharged to a mental hospital; even in the case of those with primary diagnoses of mental illness on admission to nursing homes ("Mental disorders, and senility without psychosis"), only 9.2 per cent were discharged to mental hospitals.[7,8] Clearly, mental and behavioral problems are a major reality in nursing homes, and cannot be resolved by discharge; they are generally poorly understood and poorly served in these facilities.[5,9]

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The study reported here resulted from growing concern in the local long-term care community over the difficulties experienced in managing some of the more disturbed patients by staff of the SNFs, and their discouragement over the near impossibility of making transfers to the state psychiatric hospital. In facilities which are accustomed to a clientele composed of physically disabled elderly patients without significant behavioral problems, even one or two severely disturbed patients would provide a disproportionately great burden of care on staff. It was felt that professional and aide staff were not trained adequately in the care of these patients, and that even the legally mandated architectural constraints on the facilities might be obstructive to appropriate care (e.g., locked wards and "dutch doors" are prohibited in SNFs in New York State). Such considerations could lead to reluctance on the part of the facilities to accept any patient thought to present behavioral management problems.

For these reasons, the regional long-term care medical directors group and the facility nursing directors encouraged the development of this study in the format of a Medical Care Evaluation study as required under Medicare/Medicaid and state nursing home code regulations. The objectives were to identify and describe the patients perceived by SNF staff as having significant behavioral problems, to analyze the care of such patients, and to suggest appropriate solutions to the observed inadequacies.

Methods

The Regional Utilization and Medical Review Project of the Genesee Valley Medical Foundation, Inc., is responsible for performing the federal and state mandated utilization review and quality assessment in the 42 SNFs participating in this study. A number of Medical Care Evaluation studies have been performed in these facilities over the past several years, and study findings for each facility are reported back and compared with the aggregated data from all the regional facilities studied.[10,11] This report will deal only with the regionally aggregated results. The data were gathered on precoded and pilot-tested forms, specifically designed for the study, by a team of nurse surveyors, experienced in geriatric care and in utilization review; most of them had gathered Medical Care Evaluation study data previously.

Sample

A 33 per cent random sample of patients, based on their routine utilization reviews, in each of the 42 SNFs was drawn, yielding 1,139 patients out of a total of 3,456 beds.

Patients from this sample were selected as having "significant" behavioral problems from the nursing care viewpoint if they required "constant or active consideration" in their patient care plan for one or more of the following behavioral problems, as recorded on their most recent routine utilization review form: confusion, agitation, hallucination, depression, assaultiveness, abusiveness, regression, and wandering.

This method of case definition and selection depends on patient status as perceived by the Utilization Review Nurse, based on what is recorded in the patient chart by the staff nurses in charge. It is therefore subject to some errors of omission: some cases which, on more thorough examination might be found to have significant behavioral problems, may have been screened out; patients who might have had otherwise important mental disorders which did not pose care problems as perceived by staff would not be included. On the other hand, cases not actually having significant problems who were included in the group by errors of perception or by overreporting on the UR forms would be eliminated in the second more thorough phase of data collection. The purpose of the study was not to obtain an absolutely accurate estimate of exact numbers of significantly affected patients in any one facility.

This initial screening yielded a group of patients with "significant" behavioral problems as defined above. These patients were divided into two groups, described more fully later. Further data on patients defined as having "serious" behavioral problems were then obtained from the medical record and from the charge nurses in the facilities by the nurse surveyors. These data included:

- More details on the nature of the problem behaviors, including whether or not they were endangering to the patient or others or merely disturbing or bothersome;
- Previous history of behavioral problems, including relevant diagnoses, previous psychiatric care, and source of admission to SNF;
- Current management of the problem behaviors, including psychoactive drugs, use of restraints, specific behavioral and other therapies, and psychiatric referrals; and
- Completeness of documentation of the behavioral problems in the medical records by nurses, physicians, and other staff.

The results of the study were analyzed using routine data processing methods and SPSS programming packages.

Results

Total SNF Population

The sample of 1,139 patients included in the study was subdivided based on the utilization review forms' mental and behavioral characteristics as described above. Behaviors occurring more often than once per week or requiring constant or active consideration in the patient care plan were considered "significant". We found that 35.8 per cent (408) of the sample had no significant behavioral problems. The remaining 64.2 per cent were divided into two groups:

1) Those with "moderate" problems, including "impaired judgment" and/or physical restraint orders, but without other more serious behavioral problems affecting themselves or others (e.g., agressive behavior, physical resistance to care, uncontrolled wandering, etc.,) constituted 41.6 per cent (474) of the total sample.

2) Those with more "serious" behavioral problems accounted for the remaining 22.6 per cent (257). More data were gathered on this group of patients.

TABLE 1—Behavioral Problems in the 33 Per Cent Sample of All SNF Residents

	Number	Per Cent
No Significant Problems	408	35.8
Moderate Problems	474	41.6
Impaired Judgment Only	(257)	(22.6)
Physical Restraint Order Only	(57)	(5.0)
Both Impaired Judgment and Physical Restraint Order	(160)	(14.0)
Serious Problems	257	22.6
Total Sample	1139	100.0

Table 1 summarizes this initial breakdown of the total sample.

Patients with Serious Behavioral Problem

The frequencies of specific behaviors among the 257 "serious" patients, expressed as percentages of the *total* sample of 1,139, are listed in Table 2. Any patient could have had more than one of these behaviors. These patients had a median age of 84 years, the same as the general SNF level population in these facilities; only 14.4 per cent were under age 65, 25 per cent were male, as compared to only 20 per cent in the general SNF population. While 66.5 per cent of them had a diagnosis indicating organic brain syndrome (variously listed as senility, chronic brain syndrome, and cerebral arteriosclerosis, and rarely as Alzheimer's Dis-

TABLE 2—Specific Serious Problem Behaviors* as Per Cent of Total Sample (1139)

Types of Problem Behaviors	Number	Per Cent of 1139
Endangering Others		
Physically aggressive (deliberate striking, biting, etc.)	94	8.3
Indirectly endangering (unfastening others' restraints, dangerous smoking habits, etc.)	5	0.4
Endangering Self		
Physical self-abuse (scratching, banging head, removing catheter, etc.)	49	4.3
Dangerous ambulation (into unsafe areas; escaping restraints, etc.)	62	5.4
Physically resistive to care (spitting out medication, refusing to eat, etc.)	130	11.4
Other possibly endangering (verbal suicidal expression, severe agitation, etc.)	48	4.2
Disturbing to Others		
Verbally (noisy, abusive, etc.)	143	12.6
Inappropriate ambulation (into others' rooms, beds, etc.)	43	3.8
Physically disruptive (throwing food and objects, lying on floor, etc.)	28	2.5
Taking others' belongings and food	12	1.1
Inappropriate urination/defecation (urinating in waste baskets, smearing feces, etc.)	11	1.0
Sexually disturbing (exposing self, masturbating publicly, etc.)	4	0.4
Other bothersome behaviors	18	1.6
Non-endangering or Disturbing to Others (but of concern to staff)		
Reclusive (refusing to leave room, socialize, etc.)	57	5.0
Hoarding (food, clothes, etc.)	7	0.6
Other	32	2.8

*A patient could have more than one problem behavior.

TABLE 3—Diagnoses* in 257 Patients with Serious Behavioral Problems

Diagnosis	Number	Per Cent of 257
Organic Brain Syndrome	171	66.5
Psychosis (7 with Organic Brain Syndrome, 6 without)	13	5.1
Depression	23	9.0
Alcoholism	4	1.6
Mental Retardation	1	0.4
No diagnosis in medical record	70	27.2

*A patient could have more than one diagnosis.
Frequency of diagnoses: 1 diagnosis, 164 (63.8%)
2 diagnoses, 21 (8.2%)
3 diagnoses, 2 (0.8%)

TABLE 5—Management of the "Serious" Cases (N = 257)

Case Management	Number	Per Cent of 257
Psychoactive drugs ordered on a regular basis (not "p.r.n.")		
Tranquilizers	97	37.7
Sedatives/Hypnotics	67	26.1
Anti-depressants	29	11.3
Total patients with one or more	149	58.0
Restraints used in preceding 30 days	121	47.1
Reality orientation given in preceding 30 days	36	14.0
Psychiatric consultation given during current admission	38	14.8

ease), only a very few had a specific pyschiatric diagnosis, with "psychosis" being mentioned in only 5.1 per cent and "depression" in 9.0 per cent (Table 3). However, 57.2 per cent had evidence in the record of previous psychiatric or behavioral problems; only 17.5 per cent had had prior admissions for psychiatric care to another facility, 4.7 per cent having been admitted from a psychiatric facility on the current admission (Table 4).

The management of these "serious" cases is summarized in Table 5. Regular psychoactive drugs and restraints were used in about half the cases, but psychiatric referrals had been made in only 14.8 per cent of cases during the current admission. There was some documentation of the behavioral problems in 87.9 per cent of cases, as shown in Table 6. The remaining 12.1 per cent with problems were ascertained verbally from staff by the interviewers. The physician recorded the problem in only 9.7 per cent of the cases.

Patient care needs were discussed in an "open-ended" fashion with the nurses in charge, and it is of interest that they felt these patients might be more appropriately cared for in a psychiatric facility in only 5.1 per cent (12/234) of the cases.

Discussion

Of the cases deemed to have the most serious behavioral problems from the care and management viewpoint, only 4.7 per cent were actually admitted from psychiatric facilities, indicating that the deinstitutionalization issue is not a major one in this group of facilities. The facilities studied do not include publicly supported county infirmaries which may have had more such admissions. The nursing staff seemed resigned to the unlikelihood of patient transfer to psychiatric institutions as a current option in care.

That SNFs are becoming more and more the custodians of elderly patients with mental health problems is clear from national data, and this survey confirms the current status. While in the minority numerically, the 22.6 per cent of SNF patients considered as having serious management problems provide a disproportionately large challenge to staff for their care, especially where the staff is not trained specifically in psychiatric nursing techniques. The dearth of evidence of physician involvement in their management is of interest in this regard. Psychoactive drugs were ordered on a regular basis in 58 per cent, but only about 15 per cent had had a psychiatric consultation during the current admission. It should be noted, however, that while more physician involvement would be desirable, particularly in making specific psychiatric diagnoses where possible and instituting appropriate therapy, much of the management and even decision making on day to day care must rest with the nursing staff. Furthermore, recreational and socialization programs, when well-planned, frequently conducted, and responsive to patients' interests and needs, are likely to be of greater value in dealing with the problems of many patients than are strictly medical treatments. This is especially true when depression, loneliness, inactivity, and boredom are precursors to "behavioral" problems as perceived by the staff.

The findings of this study support concerns expressed in analyses and recommendations made at the national level.[5,9] Improved psychogeriatric care is essential in nursing homes which have become the major institutional source of care for the mentally impaired elderly. This care must be broadly conceived, and include availability of informed psychiatric consultation where needed; it should be based on adequate primary care physician evaluation, skilled nursing supported by inservice training programs in psychiatric and behavioral care, and sensitive and imaginative recreational and social programs.

TABLE 4—Prior Evidence of Psychiatric or Behavioral Problems* in the "Serious" Group (N = 257)

Evidence	Number	Per Cent of 257
Prior admission for psychiatric care to another facility	45	17.5
Current admission to SNF from a psychiatric facility	12	4.7
Prior referrals to psychiatrist	14	5.5
Had other reports of prior psychiatric or behavioral problems	134	52.1
History of any of the above	147	57.2

*A patient could have more than one behavioral problem.

TABLE 6—Documentation in Record of Behavioral Problems (N = 257)

Medical Record Documentation by:	Number	Per Cent of 257
Nurses	217	84.4
Physician	25	9.7
Social Worker	28	10.9
Other Staff	26	10.1
Any of the Above	226	87.9

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Society for Clinical Trials, 6th Annual Meeting
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The Society for Clinical Trials has issued a call for contributed papers or poster sessions for its 6th annual meeting to be held May 12–15, 1985 in New Orleans. The sessions will be concerned with all aspects of clinical trials. Abstracts must be received by January 2, 1985. Topics of interest include, but are not restricted to:

- New methodology for the design, monitoring, and analysis of clinical trials
- Methodological problems and controversies
- Quality control in clinical trials
- Clinical trials in which the unit of intervention is a group or community
- Clinical trials in special clinical areas
- Clinical trials in industry
- Data management: new methods, quality control, availability of data base management systems, availability of software for analysis
- Long-term monitoring of side effects
- Clinical trials related to nursing
- Cost savings in clinical trials
- Monitoring for adverse effects or side effects
- Studies of adherence monitoring
- Overlooked ethical issues in clinical trials
- Effective dissemination of clinical trial results
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