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INSIDE

Special Report: Psychiatric Home Care

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Educate staff about elder abuse

Home care workers may not recognize the problem

Anywhere from 500,000 to 2 million elderly people are abused each year, and home care staff may see many of them without realizing there's a problem. A recent study concludes that only 16% of abuse cases involving people over age 60 are reported to local Adult Protective Services agencies. The National Elder Abuse Incidence Study found that the exact number of abused seniors is difficult to determine because health care workers and others have missed the signs of abuse.[1] **(A report on the study has been published on the World Wide Web. See Internet Connect, p. 15, for details.)**

The study, which ran from October 1994 to December 1997, was conducted by the National Center on Elder Abuse at the American Public Human Services Association in Washington, DC, and Baltimore-based Westat, a social science and survey research firm. The study showed that the greatest percentage of cases of elder abuse occurred among victims age 80 or older. More than half the cases of neglect involved people in the 80+ age group, and about 44% of physical abuse involved people in that age group.

The five types of abuse involving the elderly typically are described as neglect, emotional, physical, financial, and abandonment.

Every state has laws addressing elder abuse. Most states require health care workers to report any suspected or known abuse. So perhaps it's time for your agency to hold an inservice on domestic violence and elder abuse to make sure your staff understand what to look for and what their responsibilities are if they suspect the presence of elder abuse.

Comprehensive Home Healthcare Services in Middlesboro, KY, recently held a half-day workshop on family violence as part of a Kentucky requirement for licensed nurses. Other staff were invited to attend as well. The workshop provided information that could be useful to aides and other home care employees, says **Deborah Hembree**, RN, staff development coordinator for the freestanding agency, which has offices in Kentucky, Tennessee, and Virginia. The agency is managed by Health Management Association of Chicago, and it serves a 150-mile radius in the three-state area.

Hembree invited domestic violence experts to speak at the workshop, which was divided into four modules of about one hour each. Those modules were:

1. Dynamics of family violence.

Hembree asked two social workers to present this portion of the workshop. "They talked about how women often are in situations where they feel trapped," Hembree says. "They showed a video about the elderly, showing how women who had been married 40 to 50 years were still being abused."

The five types of abuse involving the elderly typically are described as physical, emotional, financial, neglect, and abandonment. The National Elder Abuse Incidence Study found that the greatest percentage of elderly who suffered from any one of those five types of abuse had household incomes of $5,000 to $9,999. Here is a guideline to the different types of abuse:

❑ **Physical abuse.**

"The easiest type of abuse to identify is physical abuse," says **Jimmy Middleton**, a family service worker clinician with the Community Based Services Protection and Permanency of the Department of the Kentucky Cabinet for Families and Children in Barbourville, KY. Middleton, who spoke at the home care workshop.

He says cigarette and other types of burns are quite common, and health care workers should be alert to signs of bruising, specifically looking at colors of bruises. "The color is an indication of how old the bruise is. So if there are several bruises of different colors on a person, then there's an indication the bruises were made at different times." This type of bruising could mean a person is being battered, he adds.

Another indicator is the location of the bruises. Bruises on the upper arm might be caused by someone grabbing and shaking the person. Health care professionals sometimes can see indications of a fingertip in a bruise or thumb marks on opposite sides of finger marks. This type of pattern could be evident on a person's neck if he or she was choked.

"Also, if they used an instrument, quite frequently you can see the print of that instrument," Middleton says. "For example, I've seen on children a fly swatter grid, or you can see belt marks."

❑ **Emotional/verbal abuse.**

When home care workers visit patients, they should pay attention to how the patient's family talks to the patient. In cases of emotional or verbal abuse, the perpetrator might have trouble sounding civil even when other people are present.

When the verbal exchanges between patient and family members offer no clues, home care professionals should be alert to odd behaviors by the patient. Victims of emotional abuse might behave as though they are afraid, even when there is no apparent reason. They also might appear to be withdrawn and unwilling to trust their health care workers. "They might act like a pet that's been mistreated," Middleton says.

❑ **Financial abuse.**

This could manifest in the elderly person being defrauded or exploited financially. Home care professionals might see signs of financial abuse if the patient appears unable to afford medication or other important medical items when an admission assessment indicated the patient had adequate income.

Other forms of financial abuse include running up bills the victim is responsible for paying, including long-distance phone calls; withholding money or access to money; and forcing the victim to commit welfare fraud. A victim's family member also may refuses to buy the supplies the person needs for comfort and recovery. For example, suppose a home care patient needs a special lotion for his or her skin, but the patient's spouse is unwilling to buy the product although the money is available, Middleton says.

Home care professionals also should check to see if the patient's food and nutritional needs are being met, he notes.

❑ **Neglect.**

Neglect concerns the environmental conditions of the home. Home care professionals should note whether the home is in poor repair or whether it is adequate to meet the patient's needs. Neglect also

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might involve a family member preventing the patient from keeping medical appointments and receiving follow-up care, Middleton suggests.

In terms of basic caregiving, bedridden or very sick patients need help with personal care, and it might be evident they are not receiving such help. The patient might have bed sores, for example. "The home health aide might go into the home and find that the patient has had a bowel movement that was not removed or cleaned up."

❑ **Abandonment.**

Some patients may be homebound and left to fend for themselves, even though they had family members living in their homes before their illness.

2. Characteristics of victims of domestic family violence.

A police officer speaking at the workshop described domestic violence he had seen in homes, including victims of child abuse and women who wanted to leave their abusive husbands but were afraid to do so. Health care workers might recognize in their patients some of these common characteristics of an abused adult:

- admits to being a victim of maltreatment;
- has a history of prior abuse or neglect;
- is physically and mentally frail;
- is fearful of partner or caregiver;
- appears anxious or fearful;
- complains of chronic pain and other physical problems;
- is overly aggressive or passive;
- has sleeping or eating disorders;
- makes comments about suicide;
- has injuries to genitalia, breasts, or rectum;
- has an injury that is inconsistent with the cause named.

Other major characteristics of abused elderly persons include an inability to care for themselves, mental confusion, and moderate to severe depression. Also, while more elderly women than men are victims, there is a higher percentage of men who are abandoned. About 62% of the victims of abandonment, according to The National Elder Abuse Incidence Study, were men, while about 38% were women. Women (76%) were more likely than men (24%) to be victims of emotional abuse.

3. Prevention and intervention strategies.

The National Elder Abuse Incidence Study recommends that health care workers be trained to detect instances of abuse and neglect. Elderly abuse victims often are more isolated than other abuse victims, so health care workers may be their first line of defense. Home care agencies should have a list of organizations that assist the elderly and handle elder abuse reports. All staff should know where to find the list. In Kentucky, for instance, the Community Based Services Protection and Permanency Department has information for anyone who wants to learn more about abuse and neglect, Hembree says.

If a home care worker suspects abuse when visiting a patient's home, the workers should report the suspicion to an agency director, and the agency may send a social worker to the home to assess the situation, she says. Any suspected abuse should be reported to the state. However, adult victims who are mentally competent are entitled to refuse services, Middleton says.

Elderly abuse victims often are more isolated than other abuse victims. Health care workers may be their first line of defense.

Home care workers should keep in mind that elder abuse doesn't follow the same pattern as domestic violence. Whereas domestic violence among adults under age 60 typically involve a male perpetrator and a female victim, elder abuse perpetrators may as likely be women. The study showed that 52.5% of the incidents involved male perpetrators, and 47.5% involved female perpetrators. If the abuse is neglect, which is the most frequent type of maltreatment, it's more likely to involve a female perpetrator. The other forms of abuse are more likely to be caused by men.

Also, most abusers are children of their elderly victims. Abusers also might be friends, neighbors, or other relatives. Grandchildren account for a far smaller percentage of abusers, and the victim's spouse is even less likely to be an abuser.

Some abusers may act out of ignorance or because they feel overwhelmed with caring for a homebound patient. Home care nurses could prevent these types of neglect by carefully educating caregivers or making referrals to agencies that could provide respite care.

4. Legal and social mandates.

Hembree invited legal experts to speak with Comprehensive Home HealthCare's staff about Kentucky's legal requirements for health care professionals."They said that if we suspected abuse and didn't report it, we could be held liable," she says.

Kentucky and many other states require health care workers to report suspected physical abuse and neglect. "If they suspected abuse and didn't report it, they could be sued by the victim's family members at a later date," says **Mike Pace**, who spoke at the home care workshop. Pace is domestic violence attorney advocate for the Appalachian Research and Defense Fund of Kentucky in Barbourville.

He suggests health care workers include a question on their admission forms, asking patients if they have ever been involved in a domestic violence situation. "Each organization or company or hospital could word it however they felt it would best suit their needs."

Reporting suspected abuse

Some states also carry statutes requiring health care workers to report emotional or verbal abuse of the elderly. In Kentucky, this type of abuse should be reported only if it involves a direct or indirect threat to harm the victim. "Arguing or name-calling is not covered," Pace says. "There has to be an actual threat of violence."

In addition to reporting suspected abuse to state officials, home care workers should document these incidences in agency files, so these notes could be used in a court proceeding, he adds. Finally, home care workers should call 911 if they enter a home and witness a violent situation.

Reference

1. National Center on Elder Abuse of the the American Public Human Services Association, Westat. The National Elder Abuse Incidence Study. Washington, DC; Baltimore; 1998. ■

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Resources available on abuse, domestic violence

If you'd like to learn more about domestic violence and elder abuse, try these resources:

• **The American Academy of Nursing** publishes a collection of papers on violence and health care, called *Violence: A Plague In Our Land.* The 72-page publication costs $19 per copy and can be ordered by calling (800) 637-0323. Or write to: 600 Maryland Ave. SW, Suite 100 W, Washington, DC 20024-2571. Phone: (202) 651-7238. Fax: (202) 554-2641.

• **American Association of Medical Assistants** published an article on elder abuse in *Professional Medical Assistant* magazine's November/December 1998. It costs $3. To order, call (800) 228-2262. Or write to: Communications Department, 20 N. Wacker Drive, No. 1575, Chicago, IL 60606-2903. Phone: (312) 899-1500. Fax: (312) 899-1259.

• **American College of Obstetricians/Gynecologists** publishes the *Battered Women Technical Bulletin,* which is free for a single copy and available by calling (202) 638-5577, and a slide lecture presentation called "Domestic Violence: The Role of the Physician in Identification, Intervention and Prevention," which costs $150 and is available in Spanish and English; it can be ordered by calling (800) 762-ACOG.

• **American Physical Therapy Association** publishes a Women's Issues Resource Guide. Contact: Department of Women's Initiatives, 1111 N. Fairfax St., Alexandria, VA 22314-1488. Phone: (703) 684-2782. Fax: (703) 684-7343.

• **American Psychological Association** publishes *Violence in the Family,* a report of the APA Presidential Task Force on Violence and the Family. The first copy is free; additional copies are $5. Contact: 750 First St. NE, Washington, DC 20002. Phone: (202) 336-6046. Fax: (202) 336-6040.

• **Chicago Abused Women's Coalition Hospital Crisis Intervention Project** provides these free materials: screening/interviewing tool on domestic violence; an article titled, *Domestic Violence: Challenges to Medical Practice*; and an article titled, *Limitations of the Medical Model in the Care of Battered Women*. Contact: P.O. Box 477916, Chicago, IL 60647-7916. Phone: (312) 433-2390. Fax: (312) 433-2391.

• **Domestic Violence Project** provides these educational tools at no charge: the "Medical Power Wheel," the "Advocacy Wheel," and a

protocol called *The Assessment & Treatment of Victims of Domestic Abuse,* which includes forms for medical documentation of injuries. Contact: 6308 8th Ave., Kenosha, WI 53143. Phone: (414) 656-8502. Fax: (414) 656-0075.

• **Domestic Violence Training Project, University of Connecticut, New Haven,** provides *A Guide for Health Care Professionals* at no charge. Contact: Kate Paranteau, 900 State St., New Haven, CT 06511. Phone: (203) 865-3699. Fax: (203) 865-3779.

• **Family Violence Prevention Fund, Health Resource Center on Domestic Violence** publishes a variety of information, including protocols, information packets, posters, and bumper stickers at prices ranging from free to $1 plus $5 for shipping. The organization also publishes *Best Practices: Innovative Domestic Violence Programs in Health Care Settings,* which costs $5, and a resource manual called I*mproving the Health Care Response to Domestic Violence: A Guide for Health Care Providers,* which costs $75. Contact: 383 Rhode Island St., Ste. 304, San Francisco, CA 94103. Phone: (888) Rx-ABUSE. Fax: (415) 252-8991. E-mail: fund@igc.apc.org. Web site: www.fvpf.org/fund/.

• **National Coalition Against Domestic Violence** publishes the *National Directory of Domestic Violence Programs: A Guide to Community Shelter, Safe Home and Service Programs,* which costs $50 plus $7 shipping. Contact: P.O. Box 18749, Denver, CO 80218. Phone: (303) 839-1852. Fax: (303) 831-9251. Web site: www.ncadv.org.

• **National Domestic Violence Hotline** has posters and telephone stickers. Contact: 3616 Far West Blvd., Ste. 101-297, Austin, TX 78731-3074. Phone: (800) 799-SAFE (7233). Fax: (512) 453-8541.

• **New Jersey Department of Community Affairs** provides domestic violence guide, brochures on partner abuse, and other materials. Contact: Division on Women, 101 S. Broad St., Trenton, NJ 08625. Phone: (609) 292-8840. Fax: (609) 633-6821.

• **New York State Department of Health and Office for the Prevention of Domestic Violence** provides health care information packets, the *Domestic Violence Intervention Guide for Health Care Professionals,* a victims' rights notice, a personalized safety plan for victims, and other resources. The first copies are free, and additional copies are $5 each. Contact: Domestic Violence Program Specialist, Capitol View Office Park, 52 Washington St., 3rd floor, Renssalaer, NY 12144. Phone: (518) 486-6262. Fax: (518) 486-7675. ■

Special Report: Psychiatric Home Care

Going the extra mile for psychiatric patients

Staff Builders creates modular program

(Editor's note: This is the second part of a series on psychiatric home care. In the December issue, Homecare Education Management *featured articles on psychiatric services and training mental health aides. In future issues there will be more articles on specific mental illnesses, such as depression.)*

Staff Builders in Lake Success, NY, goes the extra mile in training psychiatric nurses. The national home care company has created an extensive psychiatric nurse competency program that accompanies its mental health aide training.

"We want to provide a safe patient-care setting," says **Carolyn Scott**, RN, MS, national coordinator of the behavioral health program for Staff Builders Home Health Care in Chicago. She says the company has had difficulty finding psychiatric nurses because many believe insurers are unwilling to pay for mental health benefits and so are leaving the field. "But that is not true anymore. That's why we're showcasing mental health at Staff Builders because it's an opportunity for us to meet this mental health need."

Staff Builders offers its psychiatric nursing training only to nurses who have met Medicare's minimum criteria for psychiatric nurses:

• an associate of arts degree and two years of experience in a mental health treatment center, either outpatient or inpatient, or a psychiatric hospital;

• a bachelor of arts degree and one year of recent experience;

• master of arts degree in psychiatric nursing or counseling.

"We also look for seasoned psychiatric care nurses who have three to five years of experience, no matter what their degrees are, because of the high degree of autonomy required in home care," Scott explains.

The company also evaluates psychiatric nurses for these two qualities:

• **Caring:** This is evaluated through an interview, supervisory visits, reference checks, and ongoing clinical supervision.

• **Compulsiveness:** This is evaluated through the nurse's timeliness, completeness of documentation, and care management efforts on a patient's behalf. "We try to find the most well-balanced, seasoned, mature individuals," she says.

All potential psychiatric nurses must pass a competency test with a score of 80% or higher. "If nurses pass the psychiatry exam with 80% or better, they don't need to go through the psychiatric written training program," Scott says. "It's assumed, based on their test scores, that they know the material and have a basic level of expertise to see psychiatric patients."

About three-fourths of Staff Builders branches have at least one nurse who has met all the requirements to become a psychiatric nurse, she says. The chief incentive for nurses who undergo the competency program and training is that it will broaden their horizons. "If you are a professional, you have to keep your personal and professional growth continuing no matter what."

Nurses are given three chances to pass the competency test. These are among the competency areas included **(for more details, see Staff Builders' psychiatric nurse competencies, p. 7)**:

• maintaining appropriate boundaries;
• teaching assertiveness, problem-solving, and thought-stopping techniques;
• offering supportive interventions;
• safely handling psychiatric emergencies;
• communicating therapeutically;
• setting up a behavioral plan;
• accurately administering, scoring, and interpreting assessment tools;
• performing venipuncture safely and competently.

Nurses who fail the test may study Staff Builders psychiatric nursing manual, which includes self-learning modules in these areas:

• behavioral modification with children;
• thought-stopping techniques, a type of cognitive therapy **(see related story, p. 13)**;
• assertiveness training;
• how to solve problems;
• how to deal with difficult or violent patients;
• medication management;
• communication and interpersonal strategies;
• various mental illness diagnoses.

Nurses may study only the modules in which they did poorly on the test and then can take that portion of the test again.

Psychiatric nurses also are encouraged to refer to Staff Builders' manual on psychiatric drugs, so they can look up any medications they have questions about. The manual includes patient education with clear, easy-to-understand wording. Nurses may copy these materials to give patients when appropriate. **(See sample patient teaching medication guide, inserted in this issue.)**

For example, Scott says, suppose a patient has been diagnosed recently with schizophrenia, and he and his family know nothing about his illness. The psychiatric nurse may refer to the manual and pull out the pages on schizophrenia medication, including a list of side effects. Those materials supplement the nurse's own medication instruction.

"By teaching people about their illness and medications, the hope is they won't stop taking their medications prematurely," Scott says. "Many psychiatric patients don't like the side effects. They stop taking the medication and get sick, ending up back in the hospital."

Looking for consistency in training

The psychiatric program includes additional patient teaching literature as well. Any of the materials can be copied and given to staff, patients, or caregivers when needed. **(See insert for patient teaching tips on coping skills and memory loss.)**

Staff Builders' rationale for creating the comprehensive psychiatric nurse competency program was to make sure nurse training was consistent at each of the more than 200 Staff Builders agencies, she says. "If you're going to try to have a standardized high-level program nationally, then you have to draw the line somewhere of what will be the minimum standard. Otherwise, you have 200 different versions."

Because inservices and specialized training can be expensive, the company created the nurse education modules as self-learning tools that could be used only when necessary, such as when psychiatric nurses fail the competency exam. This saves time and money because agencies don't have to put aside several hours of a nurse's time to provide psychiatric training.

The modules serve a dual purpose. They provide all the information a staff educator might

need for a staff an inservice on a particular subject. If an agency has had a rash of patient-staff problems, the education manager can pull out the inservice on dealing with difficult patients and teach staff that material. Although it is part of the psychiatric program, its information might work as well with a general patient population. ■

Staff Builders' psychiatric nurse competencies

Staff Builders Home Health Care, based in Lake Success, NY, has developed extensive psychiatric nurse competencies as part of the company's Restore program. The program's Implementation Resource Guide describes the psychiatric nurse competencies as follows:

❏ Nurses will pass each education module found within the Staff Builders' Psychiatric Competency Examination, as well as general questions, with a score of 80%.

This examination tests knowledge of handling psychiatric emergencies; thought-stopping techniques; behavioral modification; teaching problem-solving and assertiveness skills; medication, communication, and psychotherapeutic techniques; and use and scoring of standardized and proprietary assessment tools. The nurses have three chances to pass the exam with a score of 80% or better.

❏ Nurses will demonstrate during a field observation the correct use and scoring of selected standardized and proprietary assessment tools.

❏ Through the clinical supervision process and ongoing chart review, the nurse's competence in handling psychiatric emergencies will be evaluated.

❏ Through the clinical supervision process, ongoing chart review, and role playing, the nurse's competence in using appropriate communication strategies will be evaluated. (These strategies also are covered in the Staff Builders psychiatric competency exam.)

❏ Through the clinical supervision process, ongoing chart review, and field observations, the nurse's competence in maintaining appropriate therapeutic boundaries (such as exercising judgment regarding the amount of self-disclosure and knowing when to discharge patients) will be assessed. ■

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Verna Benner Carson, RN, PhD, CSP, National Director of Behavioral Health, Staff Builders Home Health and Hospice, 2612 Gunpowder Farms Road, Fallston, MD 21047. Phone: (410) 803-9571.

Tips help staff deal with psych patients

Expert offers practical advice

Nurses who work with psychiatric patients often enter unfamiliar territory. Severely mentally ill patients often have very poor coping skills. They might have low medication compliance without supervision, which means they become "frequent fliers" at the local hospital, and they may become dangerous to themselves or others.

"Any time you go into a home environment, your concern has to be your safety as well as your patient's safety," says **Andrea K. Schroder**, LCSW, team leader for Intensive Psychiatric Community Care (IPCC) at the VA Medical Center in Denver. The VA Medical Center has an intensive psychiatric in-home program, one of 43 similar programs employed by more than 40 Department of Veterans Affairs hospitals.

The program provides intensive intervention and community and at-home counseling services to veterans with severe mental illness. It is based on the Program of Assertive Community Treatment, which was developed at the Mendota Mental Health Institute, a state psychiatric hospital in Madison, WI.

"The idea is to help people until they're integrated into the community," says **Mike Neale**, PhD, clinical psychologist and IPCC project director at the Northeast Program Evaluation Center of the VA Connecticut Healthcare Service in West Haven, CT. "For most patients, we have an ongoing type of treatment. But we also have a one-year track where we're trying to see what we can do in that period of time."

Schroder's IPCC work is different from traditional medical home care because she and other clinicians may visit patients regularly for years. Although such supervision is costly, studies have shown it is less expensive than if these patients were left to bounce back to inpatient treatment. One study showed that severely mentally ill patients who were assigned to a VA IPCC program had greater long-term clinical improvement and cost less than the same type of patients who received inpatient services.

Success starts with the nurse's assessment

Despite the differences between the IPCC program and the services a home care agency might provide for mentally ill patients, Schroder says home care nurses might learn something from her experiences. Here are some of her suggestions about how to handle psychiatric patients:

• **Make medication compliance a top priority.** Psychiatric patients may be unreliable in taking their medications. An elderly patient might experience mental confusion in addition to his mental illness. A patient with manic-depression might begin to feel good and believe medication is no longer necessary, which means home care professionals must emphasize medication compliance and perhaps monitor it closely when the patient first is admitted to home care.

"Sometimes the staff go every day to patients' homes to make sure they're taking their medication," Schroder says. In one case, an IPCC nurse would visit an elderly patient once a week and fill his medication box so he could easily take his morning and afternoon pills each day.

"We have some patients we see as often as three times a week because they are psychiatrically unstable and have mood swings or are depressed and unable to get out of bed," she says. "We were worried they would not eat and not take their medications."

• **Learn how to stabilize these patients.** The first step is to make sure the nurse does a good assessment and develops a treatment plan that includes the patient's and family's input, she advises. That includes finding out what the patient's history has been with regard to medical care and social problems.

When possible, the nurse also should assess the patient's financial situation and his or her medical compliance before home care admission. "You need to have a clear understanding of what has gone wrong up to this point," Schroder adds.

Next, the nurse should make sure the patient voluntarily agrees to allow home care visits from a nurse or therapist to help work on problems. Also, home care professionals always should be aware that their own safety and the patient's safety are top priorities. "We don't go into any homes where there's a history of assault or a history of owning firearms or weapons," she says.

• **Watch for "transference."** The psychiatric concept of transference means that the feelings patients have for their home care caregivers are based on their experiences with the important people in their lives."All patients bring some components with significant others into their relationships," Schroder explains. "If you had good experiences with women in your life, then you will have a better perception of a female nurse who comes to your door than would someone whose mother was abusive and whose wife just left him." One patient of Schroder's referred to her as "the devil," and she felt unsafe returning to that patient's home. The staff agreed to treat the patient in the clinic instead.

• **Assess the home environment for safety issues.** Schroder suggests home care nurses follow a typical evaluation for unsafe environmental features and to determine whether there is adequate food and finances. "At the first home visit, you do an assessment of the environment and develop some kind of plan of what you need."

Nurses should ask what will help patients stay in the community and improve their lives. This might be extensive help with household management. In one case, Schroder helped a patient obtain an apartment by taking him to the bank where he withdrew enough money to pay rent. Then she drove him to a secondhand store and

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helped him select basic kitchen items. She even took him to the grocery store to buy coffee, bread, meat, and other goods. "Then we put the groceries away, and I met with the manager of the apartment building and let her know who I was. We went over the rental agreement, and I told the patient I'd come back in two days."

She continued to see the patient twice a week for several weeks, and then one morning she found him outside the apartment building, yelling and asking for a beer. He wanted her to walk up to the apartment, but she refused. Instead, she talked to the apartment building manager, who called the police. Schroder convinced the police officers to take the patient to a detoxification facility.

The point to remember is that she did nothing to endanger herself or the patient once she saw his condition and alcohol abuse were out of control. However, she also did her best to keep him safe by waiting for and talking with the police. "It's been our experience that it takes six months to a year of more intensive work to get somebody stabilized," she says. "We need time to develop a trusting relationship with the patient and to help patients stabilize their lives medically and socially."

• **Help patients find financial help, when appropriate.** "Some of our patients have bad financial circumstances," she says. "Another reason people often enter the hospital is that they don't have money to find a place to live."

Some mentally ill patients will spend their money as soon as they receive it, or they might have drug and alcohol problems. The IPCC program provides basic information on money management, helps them find a guardian, and shows them how to shop for groceries and clothing.

Home care staff must be aware that these patients are prone to being abused financially and alert the agency and state authorities when there's evidence of abuse.

Suggested reading

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Rosenheck R, Neale M, et al. *Intensive Psychiatric Community Care (IPCC): A New Approach to Care for Veterans with Serious Mental Illness in the Department of Veterans Affairs.* West Haven, CT: Department of Veterans Affairs, Northeast Program Evaluation Center; Nov. 1997, p. 30. ■

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Tips From the Field

Teach staff how to deal with difficult patients

Be assertive and stop their negative thoughts

Any patient can become difficult or unmanageable at times. Perhaps a patient, suffering from dementia or mental illness, will clench his fists and tell an aide or nurse they were sent to spy on him. Or a patient may become excited and shout when she speaks with a nurse. Whatever the problem, home care nurses can benefit from an inservice on coping with patients who become noncompliant, unpleasant, negative, or violent.

Home care agencies sometimes have patients who are so difficult that nurses don't know what to do with them, says **Carolyn Scott**, RN, MS, national coordinator of the behavioral health program for Staff Builders Home Health Care in Chicago. "Nurses may not know how to respond to crying or anxiety or to the unfair anger directed at them," she says.

Staff Builders includes a comprehensive teaching module for nurses on handling difficult patients. Scott was one of the creators of this tool,

which is part of the company's Restore program. **Verna Benner Carson**, RN, PhD, CSP, national director of behavioral health for Staff Builders Home Health and Hospice in Fallston, MD, was the lead researcher and author of Restore. The program also teaches staff how to be more assertive, communicate more clearly, and help patients eliminate self-defeating thought patterns. Here are its key points:

1. **Follow guidelines for handling difficult patients.** "This area has to be fleshed out in terms of what kinds of patients we're talking about," Scott explains. "Are we talking about dementia patients who are beating up on caregivers because they're so frightened of getting a shower?" Or is the patient psychotic, experiencing hallucinations that tell him to kill the next person who walks through the door?

Nurses will need some training to understand how to deal with the various types of patients, because actions will be quite different depending on why patients are behaving irrationally. For example, the nurse might teach caregivers how to approach dementia patients in a way that does not alarm them. Caregivers might use a calm, gentle tone when preparing patients for a shower, for instance. Or they may help patients take baths instead, she says.

If it appears psychotic patients are not responding well to current medication or have stopped taking their medication, the nurse might call the psychiatrist to discuss making a change. Another strategy is to recognize the most important characteristic of potentially violent patients: a history of violent behavior. This may include threats, assaults, arrests, or a criminal record.

Violent patients also might have characteristics such as drug abuse, mental retardation, schizophrenia, paranoia, borderline or antisocial personality disorders, and cerebral lesions. Psychological tendencies could include fear, an inability to tolerate stress, poor insight, tendency to blame others, childhood abuse, poor educational and social background, and a lack of social support systems.

Clinicians often observe violent patients exhibiting behaviors such as fist clenching; violent gestures; intense facial expressions of anger, hostility, and fear; refusal or sabotaging of medical procedures; generally being uncooperative; over-controlling behaviors; dependency; and helplessness. Nurses can defuse violent situations by doing the following:

- Take all threats seriously.
- Use good listening skills.
- Never try to deceive or disarm violent patients.
- Verbally acknowledge the patients' emotional state to provide insight into how their behavior is perceived by others.
- Allow patients to vent anger in a nondestructive manner.
- Provide a quiet environment.
- Have a family member present during home visits, if appropriate.
- Avoid intense eye contact.
- Stay aware of patients' personal space to avoid making them feel threatened.
- Avoid escalating their violent behavior.
- Use direct statements to set limits, such as "Jane, when you lower your voice, I will continue our conversation."
- Determine if patients are using street drugs.
- Recommend low doses of a sedative for elderly patients or those with medical problems.
- Use assertive behaviors, but adapt them from situation to situation.
- Trust your instincts. Don't become involved in potentially dangerous situations, especially if a patient appears volatile. "If you're going to be clearly threatened, remove yourself from the home," Scott advises.
- Be prepared for any emergency situation. Carrying a cellular phone is recommended.

2. **Use thought-stopping techniques.** These techniques are a type of cognitive therapy, Scott says. "It's kind of an interesting process that psychiatric nurses use with patients who are very negative in their thinking and ruminating about dire consequences." A very simple technique is to take a rubberband and put it around the patient's wrist," she says. "Every time the patient thinks a negative thought, they should pull the rubber band back so it gives them a little whack."

The same technique could work by suggesting patients imagine a stop sign every time they have a negative thought. As patients become more aware, those concerns might begin to subside. "This works well with patients who don't do well on medication. It gives them hope they might get some relief from their fears," she says.

Once patients become aware of their negative

thoughts, nurses can discuss how those thoughts can be altered into positive ones. The idea is that a nurse or other clinician could help a patient take a negative thought or a depressed mood and, through talk therapy, turn these into more realistic thinking and a more positive mood. **(For more details, see *Patient Classroom*, p. 11.)**

3. **Offer examples of assertive behavior.** Nurses and other home care staff who deal with difficult patients must learn assertiveness skills because clear, effective, and firm communication is key with such patients. Staff Builders' Restore program defines assertive behavior as setting goals, acting on them in a clear and consistent manner, and taking responsibility for the consequences of those actions. Assertive people are able to stand up for the rights of others as well as for their own rights. Nurses should use assertive behavior when patients become difficult, which includes taking measures to ensure their own safety, Scott says.

Education managers can show staff how to develop assertive skills by focusing on the following points:

- **Demonstrate respect.** Assertive statements do not violate the rights of others or cause them to lose face. These types of statements are made with a relaxed, attentive posture and appropriate eye contact, and they are spoken in a calm and friendly tone. For example, assertive people will not hide in global statements, such as "You always do this and mess things up." Instead, they might say, "I worry whenever you do this."
- **Use "I" statements.** When a statement begins with "I," it suggests the speaker accepts full personal responsibility for his or her own feelings and role in the conflict. "You" statements, on the other hand, sound accusatory. "We" statements may be made when the speaker wants to explore an issue together with the listener. Examples of "I" statements include empathetic ones, such as "I understand that . . . ." or "I hear you saying . . . ." Other types describe the speaker's feelings or thoughts about a situation: "I feel that . . . ." or "This situation seems to me to be . . . ."
- **Make clear statements.** Avoid questions, especially those beginning with "why," because they put the listener on the defensive. "How" questions are OK because they ask for neutral, fact-based information. Clear statements might include those that state expectations, such as "I want . . . ." and "What is required by the situation is . . . ." Clear statements also might list consequences such as "If you do this, then [state positive outcome] will happen" or "If you don't do this, then [state negative outcome] will happen."
- **Be firm.** Use a firm, moderate presentation because it is often as effective as what you're saying in conveying a message. On the other hand, a soft, hesitant, passive presentation can undermine the assertive message, and a hostile, harsh, and aggressive tone can increase the conflict.
- **Acknowledge your personal feelings.** It's OK to agree to disagree.
- **Focus on the present:** People can learn from the past, but no one can change it, and because the future is never completely predictable, you should focus on the present. The present is the only reality people have much decision making power as to choosing how to act. ■

* * * *

Internet Connect

Download a study on elder abuse from the Web

If you would like to learn more about elder abuse, there is plenty of material on-line. You can find out everything from the racial background of elder abuse victims to the name, address, and phone number of the organization that fights domestic violence in your state. Web sites addressing this topic, as well as other topics featured in *Homecare Education Management* newsletter, are listed below:

- **www.aoa.dhhs.gov/abuse/report/default.htm:** This site contains a 28-page report that details results from the National Elder Abuse Incidence Study. The study was conducted by the National Center on Elder Abuse at the American Public Human Services Association in Washington, DC, and by Westat of Baltimore, MD. The study's conclusions are included in the executive summary on the first page. Best feature: The site shows statistical graphics and pie charts that easily explain its key findings about elder abuse.

• **www.ncadv.org:** The National Coalition Against Domestic Violence of Denver sponsors this site, which is easy to read and use. It includes telephone numbers of more than 50 state domestic violence organizations. It lists national and international organizations and resources. There's a section that could be used as a patient teaching guide that tells abused people how to get help and how to plan for their safety. It also includes links to other resources.

• **www.staffbuildersintl.com:** Staff Builders of Lake Success, NY, has a colorful site that promotes the large home care provider's services, employment possibilities, and mission. There also are some useful resources on the site, including a page with patient home safety tips.

• **www.ink.org/public/keln/keln_abuse.html:** This site has some good information that explains whether elder abuse is a crime, and it offers crime prevention tips for seniors. It also has a variety of links to other elder abuse sites.

• **www.cyberbeach.e/~seac/eldabuse.htm:** You will find this site easy to read, with clear one- or two-page printouts you can download. It includes a page with case studies of elder abuse, a page that lists causes of elder abuse, and a page giving action plans for preventing elder abuse.

• **www.mincava.umn.edu/:** Sponsored by the Minnesota Center Against Violence and Abuse, the site has a variety of information, including papers and reports on abuse and a complete file called "Domestic Violence Legislation Affecting Police and Prosecutor Responsibilities: A 50 State Review," from the Institute for Law and Justice. It is available to read on-line or to download.

• **www.oaktrees.org/elder/links.shtml:** This site serves as a link to more than 30 sites with domestic violence and elder abuse information. One listing is titled, "Elder Abuse Prevention: Information and Resource Guide." ■

CE objectives

After reading this issue of *Homecare Education Management*, continuing education participants will be able to:

1. Recall some common characteristics of elderly patients who are suffering from abuse.
2. Select the psychological tendencies of difficult or potentially violent home care patients.
3. Employ these assertive behaviors.
4. Explain effective problem-solving skills. ■

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