

# Behavioral Problems in Older Adults in Acute Care Settings: Challenges for Staff

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**ABSTRACT.** The combination of mental and physical changes with age will impact agencies focusing on both acute and chronic problems. One of

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the biggest challenges for staff new to such patients is contending with agitated and aggressive behaviors. Conducting a needs assessment with staff is one method of mapping the nature and extent of problem behaviors for a specific setting. In the current study, a total of 71 staff members from different disciplines, across three acute care units and two VA health care facilities, completed a survey assessing the type and frequency of reported behavior problems, the extent to which staff members could identify and document relevant patient risk factors and to identify gaps in their training. Staff reported a large range of problem behaviors. They felt highly confident in their ability to respond effectively to the most frequently observed behaviors, such as patients appearing anxious or having difficulty concentrating and trouble sleeping. However, they felt less prepared for less frequent behaviors, such as physical aggression. This information will be used to design follow-up training for the staff in targeted areas, including the management of various behaviors and the recognition of risk factors for problematic behaviors. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2001 by The Haworth Press, Inc. All rights reserved.]

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### INTRODUCTION

Older patients admitted to the hospital, in addition to being ill, fatigued, or considerable physical or mental distress, are suddenly faced with stimuli levels far above those in their home settings. The literature suggests that older patients admitted to acute care units are at increased risk for cognitive changes and behavioral problems (Hickey, Clinch, & Groarke, 1997). With the number of older adults on the rise, settings previously unlikely to encounter behavioral problems are finding that they are increasingly being called upon to manage a wide range of symptoms and behaviors that may occur more frequently in this population. While staff in facilities with a focus on such age-associated illnesses as dementia are trained to deal with the behavioral symptoms that accompany this illness, clinical staff in other settings do not necessarily have this training or experience.

Behavior problems account for the largest number of referrals for psychiatric consultation and are typically associated with patients suffering from some degree of dementia (Loebel, Borson, Hyde, Donaldson, Tuinen, Rabbitt, &

Boyko, 1991; Teri, Logsdon, Whall, Weiner, Trimmer, Peskind, Thal, & Members of the Alzheimer's Disease Cooperative Study, 1998). Many researchers studying dementia patients have defined agitated behavior (Cohen-Mansfield, Marx, & Rosenthal, 1989; Kopecky & Yudofsky, 1999) as a spectrum of inappropriate vocal and motor behaviors that are disruptive to staff, the patient and/or other patient's care and well-being. The etiology of behavior problems can be understood as the dynamic interplay between the patient's characteristics (i.e., diagnosis, level of illness), the environment on the unit and the institution. For institutions designed to address the needs of a wide range of patients, a better understanding of what is currently facing the staff in terms of patient care is essential.

Day, Musallam and Wells (1999) found in their observational study that adults with mild, moderate and severe dementia showed an increase in behavior problems when hospitalized for invasive medical procedures. The most frequent behavior problems documented by staff included restlessness, increased confusion, anxiety, agitation, disrupted sleep and withdrawal. Day, Musallam and Wells relay their belief that by identifying the behaviors that frequently occur in certain procedures and settings, staff can then be trained to intervene early enough to prevent or to decrease the intensity of the behaviors. Early action will decrease the probability of the behavior escalating and staff measures required to manage it, and will also increase the level of safety in the environment and the emotional well-being of both patients and caregivers.

Interventions can vary greatly, both among and within the disciplines associated with the health care environment. The range of approaches can include both non-pharmacological (Nasr & Osterweil, 1999; Volicer, Mahoney, & Brown, 1998) and pharmacological interventions (Flint & Van Reekum, 1998). The most common interventions include behavioral strategies, such as redirection, time out from reinforcement and distraction, physical restraints, and pharmacological interventions. The number of staff needed to implement such interventions depends on the intensity of the situation, the threat of potential harm, and the persons available to assist.

The purpose of this survey was to assess the current challenges in behavior management on acute care units so that subsequent interventions could be designed to provide topic-specific staff training. In particular, we were interested in whether staff were aware that increased age, and/or the presence of dementia or cognitive impairment, posed risk factors for the development of behavioral problems during hospitalization. Thus, we designed the needs assessment to ask about behavioral problems in general, rather than prompting staff for specific information on age as a risk factor. The resulting interventions could then be tailored to the specific needs of the acute care setting that will likely have different training needs and available interventions than a long term care unit focusing.

Logsdon, Uomoto, Zarit, & Vitaliano, 1992). The items were tailored to address those behaviors that were most commonly reported on acute care units at the two hospitals and can be seen listed in Table 2. Level of overall confidence in being able to respond to each of the behaviors effectively was also assessed. Confidence was rated using a five-point likert scale ranging from "not at all," "a little," "moderately," "very much," to "extremely" confident. Behaviors listed include destroying property, restlessness, verbally threatening. Behavior frequency was also rated on a likert scale, including the rating of "never," "in the past week," "1-2 times in the past week," "3-6 times in the past week" to "daily or more often."

### ***Procedure***

During the pilot phase, a shorter version of the survey was given to a total of 17 staff members (including RNs, LVNs and NAs) at the two hospitals at the four units. After incorporating this important feedback, several changes and additions were made to create the final draft of the survey. Changes included the addition of more open-ended questions about risk factors and various formats for future training of staff. In conjunction with management staff members were informed about the purpose of the survey in shift report meetings. Staff then completed the self-report survey.

## ***RESULTS***

Overall, staff report that the range of problematic behaviors in their patients, from verbal to physical abuse, occurs at a level meriting their attention and requiring their time. As seen in Table 3, 37% of those sampled report behaviors occur one to two times per week.

The most frequently observed behaviors include difficulty concentrating, appearing anxious, worried or sad, whining or complaining, difficulty sleeping, pulling out IV's and asking repetitive questions. A detailed list of behaviors and their frequency of occurrence, as rated by staff are included in Table 2.

Staff report that they feel very confident in responding to these most frequently observed behavioral disturbances and describe them as more irritating than worrisome. For all of these behaviors, staff reported that they were "very confident" on the rating scale. On the other hand, staff felt less able to manage a patient who displays the less frequently observed behaviors, such as wandering, dangerous behaviors (to self or others), sexual commenting, and p

## METHOD

### Subjects

A total of 71 staff members, at two San Francisco Bay Area Veterans Administration Hospitals completed the survey. Four different medical and surgical acute care units across the two sites were surveyed, and a range of disciplines was included. The breakdown of disciplines is presented in Table 1.

As can be seen in the table, registered nurses made up the largest proportion of the sample (50%).

### Survey

A self-report survey was used to assess staff needs. Overall components of the survey included staff demographics, type and frequency of behavior problems, level of confidence in managing behaviors, identification of the most difficult behaviors, and information related to risk factors (i.e., what are risk factors, availability of information), and training needs.

*Staff Demographics:* Demographic questions included work location, professional discipline and shift.

*Open-Ended Questions:* Most difficult behaviors, risk factors and nature, location, availability and lack of relevant information of such risk factors were queried. In addition, staff was asked about desired training opportunities.

*List of Behaviors:* The list of behaviors used in this survey was a compilation of staff feedback to the piloted version (e.g., behaviors that staff reported occurring and were difficult to manage) and several of the behaviors listed in the Revised Memory and Behavior Problem Checklist (RMBPC) (Teri, Truax,

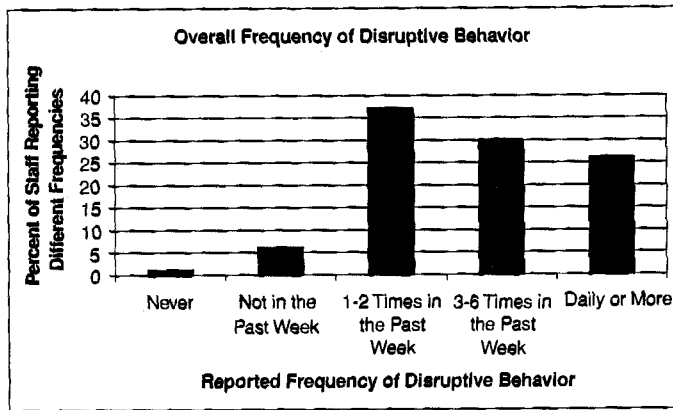
TABLE 1. Survey Sample

Across Sites:	
San Francisco VA	37
Palo Alto VA	34
Across Disciplines:	
MD	4
RN	35
LVN	16
NA	4
Other	11

TABLE 2. Percent Ratings of Behavior Frequencies as Reported by Staff on Acute Care Units

Behavior List	Never	Not in the past week	1-2 times in the past week	3-6 times in the past week	Daily or more often	No answer
Asking the same question over and over	3%	15%	22%	31%	26%	3%
Memory problems	3%	5%	33%	24%	30%	5%
Difficulty concentrating	4%	18%	22%	26%	26%	4%
Destroying property	31%	39%	11%	9%	6%	4%
Not being able to sleep at night	4%	9%	27%	16%	32%	12%
Talking too loudly and rapidly	6%	28%	27%	19%	12%	8%
Appears anxious or worried	3%	6%	21%	22%	44%	4%
Engaging in behavior that is potentially dangerous to self or others	7%	36%	23%	18%	15%	1%
Aggressive to others verbally	7%	24%	34%	21%	10%	4%
Aggressive to others physically	15%	38%	30%	4%	9%	4%
Appears sad or depressed	3%	14%	28%	23%	29%	3%
Climbing out of bed	6%	17%	29%	22%	22%	4%
Pulling out IV's, catheters, or tearing bandages	5%	21%	23%	27%	20%	4%
Crying and tearfulness	11%	36%	26%	16%	7%	4%
Commenting about death of self or others	19%	44%	23%	6%	7%	1%
Talking about feeling lonely	16%	36%	23%	11%	13%	1%
Comments about feeling worthless, like a failure or being a burden to others	14%	46%	15%	13%	9%	3%
Arguing and/or irritable	6%	13%	35%	27%	16%	4%
Whining and/or complaining	3%	14%	27%	24%	31%	1%
Yelling out	4%	22%	25%	23%	20%	6%
Combative during care	8%	30%	34%	15%	10%	3%
Requests for attention	3%	12%	34%	24%	24%	3%
Hitting, scratching, pushing, spitting, kicking	14%	47%	20%	7%	11%	1%
Wandering or pacing	9%	32%	27%	19%	10%	3%
Attempting to elope from facility	24%	45%	13%	8%	4%	6%
Temper outbursts	7%	34%	30%	15%	10%	4%
Making sexual comments	22%	41%	20%	7%	6%	4%

TABLE 3. Overall Frequency of Disruptive Behavior Reported by Staff or Acute Care Units



cally aggressive behaviors in which staff rated their level of confidence as only “moderate.”

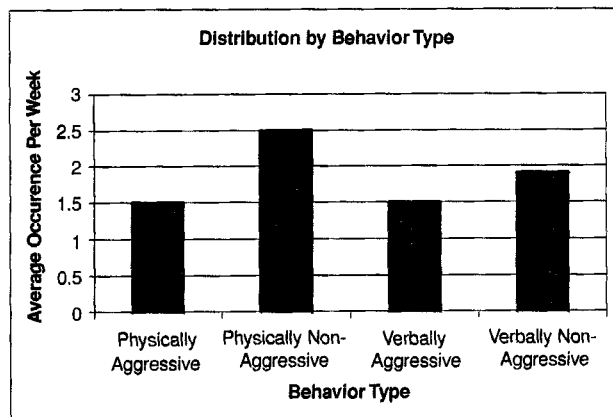
When asked about what factors might put a patient at risk for displaying problematic behaviors, a wide range of behaviors were reported. Change in the patient’s environment ( $n = 12$ ), withdrawal from alcohol or other drugs ( $n = 8$ ) pain ( $n = 6$ ), changes in mental status ( $n = 4$ ), a current or past psychiatric diagnosis and a dementia diagnosis ( $n = 11$ ), were some of the most repeated responses to this open-ended question.

### ***Most Difficult Behaviors***

Problem behaviors can be thought to fall into one of four categories: Physically aggressive, physically non-aggressive, verbally aggressive, and verbally non-aggressive. The relative frequency of the various types as reported by acute care staff can be seen in Table 4. The non-aggressive behaviors occur more frequently and understandably are easier to manage. This table not only reflects the high frequency of behaviors reported by staff but also highlights the difference in perception among staff that work in same environment.

Those patients who refuse or are combative during care are some of the most difficult patients to manage. In addition, behaviors are exacerbated by inconsistency imposed by different staff between and within shifts. For example if the day shift lets the patient smoke at off hours, those patients used to being able to push the limits of the existing plan will meet the evening shift with an increase in disruptive behaviors. Although this increase is much more likely to

TABLE 4. Distribution by Behavior Type



occur with patients who have a psychiatric history, this behavior may also be seen in mildly demented patients who typically respond better to a structured environment. Lastly, behaviors that are a result of environmental design issues, such as wandering off an open unit, are also difficult to contend with and can place the older, vulnerable patient at risk of getting hurt.

### ***Difficult to Find Information***

Staff report that they seek information regarding the presence of possible risk factors when they first admit (42%) or start working with the patient (24%), or after the first incident in which the patient displays behavior problems (23%), with only a small minority reporting that they only seek this information out when they have time (4%) or not at all (3%). The majority of staff felt that this type of information is easily (28%), or at least somewhat available (54%). However, there are some data that would be helpful to have but are more difficult to locate or access. Information including behavioral observations from previous settings, patients' psychiatric history and history of violent behavior were included in the comments of what information is harder to obtain. Several staff members also expressed their frustration that there are several cases where they feel that the patient is inappropriately placed on a less restrictive unit than they need.

### ***Training***

All staff reported that they had received some training in behavior management. Many requested additional training in all areas related to the manage-



ment of the behavior problems, including: How to approach a patient, how to stay physically safe, stress management, how to verbally deescalate a patient, environmental aids/considerations, education about related disorders, understanding the etiology of behavior problems and how to support and include families in the care of their patients. Providing staff with more pre-op teaching for the "high risk patient with behavioral problems" can be helpful in providing them the information they need to manage a new patient successfully. It also aids them in gathering the appropriate information and eliciting the support necessary to create a therapeutic environment. In addition, a couple of staff members acknowledged their desire for training but felt that training was not needed as much as more time to read the patients' charts and monitor the environment so that they can intervene prior to crisis.

### *DISCUSSION*

Responding to the increasing demands on acute care staff to manage disruptive behavior must begin with an assessment of the current environment. This survey demonstrates the utility of such a needs assessment. With the information gleaned from this survey, trainings and interventions can be designed that will target the gaps in knowledge and help address the most challenging behaviors. In this particular case, training regarding the etiology of observed behaviors and how to best respond to them, starting with the least invasive methods, would be recommended. In addition, staff would welcome stress management classes around the changing nature of this progressively aging population.

Targeting areas for further training is important on several levels. For one, staff on acute care units are less likely to have received training to manage a large number of disruptive patients than staff in chronic care settings. Related research has shown that without some knowledge and training in how to manage the behaviors commonly displayed by dementia patients, staff are at risk of feeling stressed and discouraged. This stress will lead to more feelings of job dissatisfaction, increased feelings of resentment toward their patients, and a tendency to detach emotionally from those in the environment (Kaplan, 1998).

The second area affected by this changing patient population is staff stress. Middleton, Stewart and Richardson (1999) showed that staff working in settings that care for the behaviorally problematic were less likely to personalize the patients' behaviors than those on units more unprepared to contend with challenging behaviors. In other words, what staff believe to be the cause of disruptive behaviors can directly influence their resulting levels of burnout and frustration. Staff members in settings where there is a specialized unit to care

for dementia patients also show lower turnover rates (Grant, Kane, Potthoff, & Ryden, 1996). Third, acute care units also care for patients requiring more intensive medical treatments and monitoring, thus taking away from staff members' time to utilize behavioral interventions. This puts the patients at a higher risk for being managed with pharmacological agents or physical restraints.

The results of this survey are being used to guide the development of support and training based on staff members' responses. It is likely that the behavior type (as illustrated in Table 4) and frequency (as illustrated in Table 3) will vary according to unit type (e.g., long term care, special dementia units, rehabilitation, acute care, respite). It is important to discover the differences between such settings to understand what the particular environment is for that setting (e.g., what is the most significant patient management problems). Although there are likely to be commonalities between similar units, researchers, administrators and front line staff are just beginning to recognize the need to characterize the unique needs of patients with behavioral disturbances. Given the increase in the need to care for this special group of patients, such a survey can be used to assess the staff needs so that appropriate support can be launched. Evaluations of such trainings and their usefulness in decreasing staff stress levels and disruptive behavior will be a crucial part of program development.

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