The Intermediate Care Facility Survey

October 1995 to January 1996

Summary and Highlights

The Intermediate Care Facility Project
Phase I

Acknowledgement

Sincere thanks are extended to the busy health care professionals throughout British Columbia who took the time and effort to complete the Intermediate Care Facility Survey. Without their thoughtful participation, worthwhile research projects in the fields of aging and health care, such as the present one, could not proceed.

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The Intermediate Care Facility Project

The Centre on Aging, University of Victoria, is currently conducting a study to identify the dimensions of care that are most likely to lead to quality care for those with dementia residing in British Columbia's intermediate care facilities (ICFs). The *ICF Project* is funded by the National Health Research and Development Program, Health Canada, and will be conducted over a three year period (July 1995 to July 1998).

The study will involve a number of ICFs, including both special care units and integrated units. A longitudinal study of persons admitted with dementia is being undertaken, involving the resident, his or her family, and institutional caregivers. The ultimate goal is to determine which of the dimensions of care are most strongly associated with the best outcomes for those with dementia. Dimensions of care include care planning, non-use of restraints, staff training and education, and physical environment. Additionally, a study of the costs involved in the caring for residents with dementia is being conducted. The cost of caring for a resident with dementia in both monetary and capital terms, is included.

The results of the study will be shared with health care professionals, researchers, administrators and policy makers, to help all facilities provide the best care possible for dementia sufferers.

The Intermediate Care Facility Survey

In the first phase of the study, all ICFs in the province were surveyed between October 1995 and January 1996 to obtain an accurate picture of the type of care currently provided for persons with dementia. The *ICF Survey* collected information on facility size, staff training and education, care planning, use of restraints, resident

activities, approaches to care and the physical environment. Interest in the project is at a high level, as *all* ICFs in the province responded to the 13 page survey. Instructions in the survey requested that directors of nursing (DONs) or directors of care (DOCs) complete the questionnaire. Following is a description of some of the findings.

ICFs in BC: An overview

In total, 194 facilities responded to the survey. These 194 facilities consist of 185 integrated units and 67 special care units (SCUs), for a total of 252 units in the province. Sixty facilities have both an integrated ward *and* an SCU. Of the 125 integrated units that did not have an SCU at the time of the survey, 21 (17%) indicated that there are plans in the works to start one within the next year.[1]

Background information was collected to determine the number of beds in each facility, the percentage and number of residents with dementia, and the breakdown of the severity of dementia of those residents. This information was collected separately for SCUs and for integrated wards. On average, SCUs have 30 beds and integrated wards, 70. The largest SCU has 66 beds and the largest integrated unit, 240. On average, 98% of SCU residents have some form of dementia, compared to 52% of integrated ward residents. Based on the number of beds reported and the percentage of residents with dementia, SCUs have on average 29 residents with dementia and integrated units have 36. As expected, however, the severity of dementia varies between SCUs and integrated wards, with the SCUs generally taking on those residents with more severe dementia. DONs were asked to provide a breakdown of the severity of dementia, of the resident population that has dementia,

[1] ICFs with fewer than 10 beds and those that do not serve residents with dementia are not included in this report.

in their respective integrated ward or SCU. The results are shown in Table 1.

Table 1. Percentage breakdown of resident population with dementia by severity of dementia and type of ward, British Columbia ICFs, 1995/96

Severity of Dementia	Type of Unit SCU	Integrated
Mild	4	29
Moderate	11	29
Moderately Severe	29	21
Severe	32	13
Very Severe	24	7
	100%	100%
	N=185	N=67

Source: ICF Survey 1995/96

Predictably, SCU residents tend to suffer from more severe dementia than do residents with dementia in the integrated wards. Over half of all SCU residents (56%) have at least severe cognitive decline and almost all (85%) have at least moderately severe cognitive decline. In contrast, only 20% of residents with dementia in integrated wards are in the severe to very severe range.

Pre-admission and admission

All facilities use some type of pre-admission and admission procedures for the purpose of correct placement of residents. Overall, 60% of facilities in BC use standardized *pre-admission* forms (most of the others rely solely on the Long Term Care Assessment) and 76% use standardized *admission* forms. Twenty five percent have *written criteria for admission.*

Care planning

The ICF Survey inquired about several aspects of *care planning*. These include the types of forms used for care planning, involvement of the family, the administration and monitoring of medications, and the frequency of attendance at care conferences by staff and others.

In care planning, 18% of facilities use a standardized form, 61% use an individualized form, 18% use both and 3% use neither. Eighty-eight percent of all facilities indicate that they hold patient care conferences on an "as required" basis, and 94% hold regularly scheduled patient care conferences.

In nearly all facilities, families of residents with dementia are involved to some extent in care planning for the resident. Families are more likely to be involved in care planning in those facilities with higher proportions of residents with dementia. In 94% of the facilities, families are *sometimes* or *always* involved in care decisions regarding resident medical issues. In 75% of facilities, families are *sometimes* or *always* involved in direct, hands-on care. Most facilities (71%) provide families of residents with dementia with services such as one-to-one counselling and family support groups.

Another important part of care planning is the administration and monitoring of medications. Overall, 49% of facilities indicate that a medical coordinator is *often* involved in care planning, 34% *sometimes*, 8% *never* and 10% do not have a medical coordinator. The smaller the facility, the more likely that a medical coordinator will be involved in care planning. All facilities report that a pharmacist monitors the drug profile of each resident on a regular basis. On average, pharmacists monitor drug profiles 3.3 times per year per resident. Most facilities (54%) complete 2 drug profiles per year per resident, while a few (6%) complete as many as 12 per resident. Twenty five percent complete 4 drug profiles per year per resident.

Over 75% of all facilities report attendance of dietary, medical, nursing and recreational staff, and family at the *initial* care conference. Housekeeping, occupational therapy, physiotherapy, pharmacy and social liaison staff are less likely to attend.[2] Care conferences *after* the initial conference are similarly attended.

Restraints

The ICF Survey inquired about the use of both physical and pharmacological restraints *as means to manage behavioural difficulties* in the last year. A range of physical restraints were listed, and DONs were asked which ones are used for behaviour management difficulties, which ones are not used, and which ones their facility does not have. For pharmacological restraints, 17 different drugs were listed in three categories (antidepressants, anxiolytics and neuroleptics), and DONs indicated whether their facility used each of them.

Physical restraints

Ninety two percent of all facilities report having in place a non, or least, physical restraint policy or guidelines. Nonetheless, certain physical restraints are being used to manage behavioural difficulties. Results are presented in Table 2.

The most commonly used physical restraints are bed rails, geri-chairs and lap belts, with about half of all facilities reporting the use of these for behaviour management purposes. Dutch doors, isolation, seclusion, the posey vest, wheel chair trays and "other" restraints are less frequently used. Ankle cuffs, sheet and wrist restraints are rarely or never used.

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[2] It should be noted that 64% of facilities do not have an occupational therapist, 38% do not have a physiotherapist and 45% do not have a social liaison service.

Table 2: Physical restraint use in British Columbia ICFs, 1995/96: Percent indicating use of each type of restraint for management of behavioural difficulties

Has your ICF used any of the following techniques in the *last year* to manage behavioural difficulties of residents with dementia (aggressive behaviour *or* physically nonaggressive behaviour *or* verbally agitated behaviour)?

Restraint Type	Percent Using	Restraint Type	Percent Using
Geri-chair	53	Seclusion	10
Lap belt	50	Isolation	8
Bed rails	46	Sheet restraint	2
Wheelchair tray	28	Wrist restraint	1
Dutch doors	13	Ankle cuff	0
Posey vest	11	Other	13

N=252

Source: ICF Survey 1995/96

Pharmacological restraints

The same question was asked of facilities concerning the use of pharmacological restraints. DONs were asked to indicate whether or not they had used any of the drugs listed for the purpose of behavioural management difficulties. Results are presented in Table 3.

Of the *antidepressants*, Desyrel, Luvox, Paxil and Prozac are the most commonly used, with just over half of all facilities reporting their use for management of behavioural difficulties. Aventyl, Elavil and Sinequan are used less often, but not infrequently. On average, facilities report the use of 3.1 different antidepressants, from the seven listed, to manage behavioural difficulties.

Of the *anxiolytics*, over half of all facilities use Ativan, Restoril, Serax and Xanax to manage behavioural difficulties. Ativan is by far the most popular choice, with 88% of all facilities using this drug. On average, facilities use 3.1 of these 5 drugs for

this purpose.

Table 3: Pharmacological restraint use in British Columbia ICFs, 1995/96: Percent indicating use of each drug for management of behavioural difficulties

In the *last year* has your ICF used any of the following medications to manage behavioural difficulties of residents with dementia (aggressive behaviour *or* physically nonaggressive behaviour *or* verbally agitated behaviour)?

Medication Name	Percent Using	Medication Name	Percent Using	Medication Name	Percent Using
Antidepressants:		Anxiolytics:		Neuroleptics:	
Aventyl	33	Ativan	88	Haldol	62
Desyrel	54	Restoril	60	Loxapac	94
Elavil	43	Rivotril	39	Mellaril	46
Luvox	54	Serax	67	Orap	10
Paxil	53	Xanax	51	Risperdal	45
Prozac	52				
Sinequan	23				

N=238

Source: ICF Survey 1995/96

Loxapac is the most commonly used *neuroleptic* (94% use it) and Haldol is the second most used (62%). Just under half of all facilities use Mellaril and Risperdal, while only 10% use Orap to manage behavioural difficulties. On average, facilities use 2.6 of the 5 drugs on this list to manage behavioural difficulties.

In addition, facilities that tend to use a greater variety of physical restraints to manage behavioural difficulties, also tend to use a greater variety of pharmacological restraints. While there appears to be a direct relationship between the level of cognitive impairment in a facility and the number of physical restraints used (the higher the overall severity of impairment of the resident population, the more physical restraints used), there is no such relationship between pharmacological restraints and severity of cognitive decline among residents in a facility.

Physical environment

The physical environment in an ICF can be an important factor in the care of a resident with dementia. The ICF Survey collected data on some of the more salient features of the physical environment including wandering space, environmental cues, homelike atmosphere and security.

Sixty percent of facilities report having continuous *indoor wandering space* and 73% report that they have unimpeded *outdoor wandering space*. The higher the proportion of residents with dementia, the more likely a facility is to have both indoor and outdoor wandering space.

Most facilities report having *environmental cues* to support memory functions of residents with dementia. Over 80% have familiar music, large faced calendars and clocks, labels, pictures or signs and bulletin board cues to support memory functions. About one quarter report the use of other types of cues. Additionally, such things as landmarks, seating areas in hallways and door labels are used to assist residents in finding their way around in just over half of all facilities. The use of such schemes as colour coding, orientation boards in each corridor, extra large lettering on doors or a picture of what the door represents entry into, were less frequently reported.

Eighty two percent of DONs describe their facility as *"homelike"* as opposed to *"institutional"*. Smaller facilities are more often described as homelike than are larger facilities. Seventy percent of all facilities are in modified or renovated buildings, and 30% are purpose built. The most common *security systems* (reported in 93% of facilities) are installed in exit/entry doors (for example, coded entry, buzzer system, delayed opener). Forty two percent report having secured windows, 34% have surveillance security (for example, a video camera) and 13% have concealed door security (for example, inserted door knobs).

Staff training and education

Training and education of staff who care for persons with dementia is an important and ongoing concern for all facilities. The ICF Survey collected information about education and training that takes place *during orientation* for staff and others, as well as *ongoing* training and education that takes place after orientation. The areas covered include inappropriate behaviour, the role of the family, stress reduction techniques, safety issues, and on- and off-site training in dementia care. DONs were requested to provide information on the training and education of care aides, licensed practical nurses (LPNs), registered nurses (RNs), support staff and "others" (for example, family, pastoral services and volunteers).[3]

- *Is specialized education in care for residents with dementia a condition of employment at the present time for your ICF?*

Care aides are most likely to require such training before being employed, with 36% of facilities indicating that this is a condition of employment at their facility. Of those facilities that employ LPNs, 25% require specialized education. Twenty eight percent require this specialization of RNs, and 10% of support staff.

- *Does your ICF provide on-site instruction in the care of residents with dementia?*

Overall, facilities are more likely to provide *on-site education* in the care for residents with dementia *after* orientation, than they are to provide it *during* orientation. For example, 55% of all facilities provide such education for care aides during orientation, but 94% do so after orientation. Similarly, RNs are provided with specialized training during orientation in 44% of facilities, and after orientation in

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[3] It should be noted that 59% of facilities do not employ LPNs. The percentages for LPNs shown in this section are based on the 41% of facilities that do employ LPNs.

96%. The numbers for LPNs are almost identical as those for RNs, for support staff 44 and 85%, and for others such as family, volunteers and pastoral services, 35 and 69%, respectively.

- *Does your ICF provide on-site instruction in management of inappropriate behaviour (aggressive behaviour or physically nonaggressive behaviour or verbally agitated behaviour)?*

About one half of all facilities indicate that care aides and RNs receive instruction during orientation and about 95% after orientation. Among those facilities with LPNs, the figures are 41 and 93%, for support staff 42 and 84%, and for "others" 33 and 75%, respectively.

- *Does your ICF provide on-site instruction in the role of the family?*

Again, about one half of the facilities provide instruction on the role of the family for care aides and RNs during orientation, but only two-thirds do so after orientation. This compares to 46 and 59%, respectively, for LPNs. Forty two percent provide such instruction at orientation for support staff, and 59% after orientation. The figures for "others" are 34 and 54%, respectively.

- *Does your ICF provide on-site instruction in stress reduction techniques for those working with residents who have dementia?*

About one fifth of facilities provide instruction in stress reduction techniques for RNs, care aides, LPNs (among those with LPNs), support staff and others. Care aides and RNs in two-thirds of all facilities, and LPNs, support staff and others in about half of all facilities provide instruction in stress reduction after orientation.

- *Does your ICF provide on-site instruction in safety issues (for example, elopement, inappropriate behaviours) associated with working with residents who have dementia?*

Most facilities (between 60 and 70%) provide care aides, RNs, LPNs and support staff with safety instruction at the orientation. Forty six percent provide "others" with such instruction. Over 90% of facilities provide care aides and RNs with instruction in safety issues after orientation, between 85 and 90% for LPNs and support staff, and about three-quarters for "others".

- *Does your ICF provide support for off-site training in dementia (for example, financial remuneration, conference or workshop)?*

A majority of facilities do provide support for off-site training in dementia. In 86%, care aides receive such support and in 93%, RNs. Of those facilities with LPNs, 78% provide support for off-site training. Sixty seven percent provide support for support staff and 39% for "others".

The emphasis in training and education for staff and others in ICFs that care for residents with dementia is on continuing education. At the time of hiring, most facilities do not require that a new staff member already have specialized education in the care of residents with dementia. However, those facilities with higher *proportions* of residents with dementia are more likely than facilities with lower *proportions* of residents with dementia to require specialized training as a condition of employment for care aides, LPNs, RNs and support staff. There is no such positive relationship between the overall *severity* of dementia of a resident population in any given facility and the requirement that new staff be hired on the basis of their previous training in dementia care. In other words, upon hiring, facilities whose residents tend to have severe cognitive decline are no more likely to require that new staff already have specialized training in dementia care than are facilities whose residents tend to have

mild cognitive decline. As for continuing education, it makes no difference whether a facility has a high proportion of residents with dementia, or whether that facility has a resident population that has an overall high level of cognitive decline: ongoing staff education in dementia care is provided equally by facilities with high and low proportions of residents with dementia, as well as in facilities with high and low overall levels of cognitive decline in the resident population.

Conclusion

Intermediate care facilities are changing in response to the changing demographic composition of the population of British Columbia. British Columbians are becoming on average older, with more and more people living to older ages. The number of people that will be stricken by diseases such as dementia - diseases that tend to strike in the later years - is projected to increase. Thus, the need to provide adequate care for persons with dementia in an ICF setting is likely to increase. The ICF Survey has provided us with a snapshot of the types of care currently being provided for residents with dementia in intermediate care facilities. Just as we know that facilities were undergoing change in response to resource availability and demographic changes in the society before the survey was conducted, we know that they changed to some extent during the period of the survey, and will continue to change in the future. The results of the survey nonetheless serve as an indication of the current situation among intermediate facilities that care for persons with dementia in British Columbia.

Further information

If you have questions or comments about the ICF Survey or the ICF Project, or would like additional copies of the survey results, please contact the project coordinator, Colin Reid, at:

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