Drug Use Management in Board and Care Facilities

Judith Garrard, PhD, Susan L. Cooper, RPh, MS, Christine Goertz, DC
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Long-term care for elderly people is provided over a continuum of facilities and across an intensity of services that range from nursing homes to board and care facilities to home health to assisted living arrangements on an as-needed basis (Jonas, 1986). Although nursing homes have been the focus of considerable regulatory, fiscal, and research interest over the past two decades, relatively little attention has been paid to board and care facilities, despite the fact that they are an increasing source of long-term care. A congressional committee has estimated that one million Americans reside in board and care establishments and an additional 3.2 million are at risk for such placement. Concerns have been raised about the quality of care and quality of life in these mostly unregulated facilities (U.S. Congress, 1989).

So little is known about board and care facilities that even the term has not been standardized (Spore et al, 1996). These facilities are referred to as residential care facilities, adult congregate living, rest homes, adult foster care, personal care, care facilities, and group homes (Jonas, 1986; Lux, Hawes, Wildfire, Mor, & LaLiberte, 1992; Wildfire, Hawes, & Lux, 1992). Licensure and regulation vary, and the number of unlicensed facilities has been estimated to be as numerous as those that are licensed (U.S. Congress, 1989).

Pharmacoeconomic research on prescription patterns and drug use by elderly persons in the rest home population is minimal compared with similar studies in nursing homes (Perfetto, 1992). In a study in three highly regulated states (California, Missouri, and Washington), the U.S. General Accounting Office reported serious problems with qualifications of staff who handle medications, procedures for the storing of medication, supervision of staff, and assistance of residents with medication administration, and appropriate drug exposure (U.S. General Accounting Office, 1992). Other research has demonstrated problems with inadequate care, widespread use of psychotropic medications, and problems with medication administration (Avorn, Dreyer, Connely, & Soumerai, 1989; Select Committee on Aging, 1989; U.S. General Accounting Office, 1989; U.S. General Accounting Office, 1992). In 1992, a congressional committee recommended greater regulation of prescription drug use management, especially of psychoactive drugs (Select Committee on Aging, 1992).

Although the information gathered in state and national surveys provides some information about...
the board and care sector, a more in-depth study is needed about variations in licensed board and care facilities and how prescription drugs, especially psychotropic drugs, are managed by staff. The purpose of this study was to examine how medications for elderly people are managed in board and care facilities throughout the state of Minnesota.

Methods

Participants

The unit of analysis in this study was the facility, unless otherwise noted. Licensed board and care facilities are defined by the Minnesota Department of Health (MDH) as settings of five or more residents that provide some supportive or health-related services in addition to room and board. The Health Department calls these facilities board and lodging with special services establishments; however, the more generic term is used throughout the remainder of this article.

A three-stage data collection protocol was used in which the results of each stage defined the sampling frame for the subsequent stage. A current list of all licensed board and care facilities throughout the state was compiled from MDH records. Facilities were excluded for purposes of this study if they served persons with mental illness or did not provide care for one or more elderly people. In 1993, the Minnesota Association of Homes for the Aging (MAHA) conducted a telephone survey of all facilities on the MDH roster. Working collaboratively with the MDH, MAHA identified facilities that served one or more elderly residents, and updated the files by noting which ones could not be reached after repeated calls, many of which had ceased operation. The resulting list of 145 board and care facilities that served elderly persons was both the population of known facilities throughout the state as well as the target sample for this study.

The sampling designs for the three stages of data collection consisted of the following:

1. A mail questionnaire was sent to directors of all known facilities (N = 145) throughout the state.
2. Of the questionnaire respondents (N = 98 facilities), a 10 to 20 minute telephone interview was conducted with either the director, owner, or licensed registered nurse, who provided health services supervision.
3. Of respondents to the telephone interviews (N = 64), 15 facilities were selected for site visits by the three-person research team. The purpose of the site visits was to gather in-depth information about a cross-section of facilities throughout the state. In choosing these sites, a purposive, non-random, stratified sampling design was used with three strata: (a) geographic location (different parts of the state with a rural/urban split), (b) size of establishment (large, medium, small), and (c) type of ownership (for profit, nonprofit).

Response rates for the questionnaire, telephone interview, and site visits were 68%, 66%, and 100%, respectively, of those contacted. An analysis of respondent/nonrespondent differences to the questionnaire and the telephone interview was not possible because of lack of information about the nonrespondents. Of the 145 facilities in the MAHA survey, information was not available that would enable us to compare the 98 respondents in our study with the 47 nonrespondents. At the end of the telephone interview, we asked interviewees if they would be willing to have a site visit; sites were subsequently chosen among those who agreed.

Instrument Development and Data Collection

Each of the three data collection instruments developed in this study focused on different aspects of facility and resident characteristics and drug management.

Questionnaire. — The questionnaire was designed to obtain information about (a) ownership, census, and availability of medical records, (b) characteristics of residents, nature of illness, and reasons for placement, (c) staff characteristics, including education, training, and scope of responsibilities, and (d) drug management systems.

The Dillman method was used to maximize response rates (Dillman, 1978). In mid-November 1993, the questionnaire, a cover letter, and a stamped, self-addressed envelope (SASE) were sent to all facilities, followed two to three weeks later by a second letter to nonrespondents with a postcard that could be returned indicating refusal to participate, followed three weeks later by another letter, a duplicate of the questionnaire, and a SASE sent to nonrespondents to either the initial questionnaire or the post card.

Telephone Interview. — The purpose of the telephone interview was to supplement questionnaire data about drug use management, including how residents obtained medications from the pharmacy, how medication was stored at the facility and administered to residents, oversight of medication-related aspects of resident care, interactions with pharmacists, training and continuing education of staff about medications, and record-keeping systems. Telephone interviews were conducted by three interviewers over a two-month period, mid April to mid June 1994. Up to seven calls were made in an attempt to contact each facility. The interviewers, two women and one man, were trained to the same level of standardization on the interview protocol prior to calling subjects.

Site Visit. — The purpose of the site visit was to collect qualitative and in-depth information in order to better interpret results of the questionnaires and telephone interviews. In addition to an interview protocol that had been pilot tested, the site visit also included a standardized drug utilization review by the pharmacist on the team.
The purpose of the medication review was twofold: (a) to inspect the actual storage and record-keeping system and to record prevalence of medications frequently used by the elderly residents, all psychotropic medications because of their potential for overuse or misuse, and drugs associated with noncompliance or requiring close monitoring. Medication administration records (MARs) or drug profile records, or both, were examined by the pharmacist on the project team; these records represented actual use rather than physicians' orders. In the facilities in which MARs were not available, data were obtained from prescription bottle labels. Over-the-counter drugs and prescription medications were included if records or labels, or both, indicated an order was to be given on a routine basis. Use of psychotropic drugs on a prn (pro re nata — as needed) basis was recorded also.

Site visits were conducted in July and August 1994, by the project team. Each visit took approximately one hour; interviews were conducted primarily by the senior author while the pharmacist conducted the medication review of records using a standardized form. In all but two of the 15 facilities, medications of all elderly residents were reviewed. The exceptions were a large facility (N = 99 residents) in which time constraints required that a sample (N = 33 records) be drawn and a facility in which the team was denied access to the records.

The questionnaire was pilot tested in three Twin Cities group homes that did not include elderly residents. The telephone interview was pilot tested in three other group homes and a halfway house. The site visit protocol was pilot tested by the research team in two adult foster care homes, a noncertified board and care facility that did not have elderly residents, a group home, and a homeless shelter. None of the facilities that participated in the pilot testing was included in the actual study.

Results

Facility, Staff, and Resident Characteristics

Facility Characteristics. — Characteristics of the 98 facilities surveyed by mail questionnaire are summarized in Table 1. Half of the 98 facilities surveyed were incorporated as for profit. The mean number of years in business for all facilities was 14.63 years (range: 1–90 years, standard deviation = 15.10). The majority had between 1–193 beds (M = 24.58), not all of which were filled on the day the questionnaire was completed (mean census of 20.37 residents per facility). Half of the facilities had one or more residents who participated in state or federal income subsidy programs, or both.

Staff Characteristics. — Based on the mail questionnaire, 64% of the 98 facilities had one or more staff members who worked 40 hours per week; most (44%) facilities employed one to three full-time employees. Respondents in three-fourths of the facilities that participated in the telephone interview reported that staff were required to have training about medication use before they could give daily reminders or assistance with medication administration to residents. In approximately one-fourth of these facilities, interviewees stated that one or more staff completed the Trained Medication Assistant program available in vocational technology programs. Of those, 80% said that the initial training included information about medication side effects. In 56% of the 64 facilities, respondents reported that continuing education about medication use was provided on a regular basis.

Resident Characteristics. — In the 98 facilities surveyed, the majority of residents were women (66%), and almost half (45%) of all residents were in the oldest-old age group (>85 years). As shown in Table 2, most facilities had one or more elderly residents with physical frailty, mental confusion, or some form of physical disability. Most facilities provided general services, including laundry, assistance in arranging appointments, some form of transportation, assistance with medical and social services, and shopping. In over half of the facilities, staff handled funds for residents in the form of cash, checks, or bank accounts.

Assistance was provided to residents who had difficulties in activities of daily living. Of these, help with bathing, grooming, and dressing were provided most frequently. In these facilities, one or more residents had seen each of the following types of health care providers during the previous 12 months: physician (in 92% of the facilities), dentist (85%), social worker (74%), public health nurse (66%), psychologist (56%), podiatrist (55%), physical therapist (46%), chiropractor (37%).
Residents were allowed to store medications in their rooms for nonprescription drugs in approximately half (55%) of the 64 facilities interviewed and prescription drugs in over a third (38%). Of the facilities that permitted residents to store their own medications, only 10% required that the drugs be kept in locked storage areas. The decision not to allow a resident to store his or her own medications was most often made by the doctor or a family member.

Most (92%) of the facilities stored prescription medications in a central facility storage area, and of those, 85% reported that the area was locked. In one third of these 64 facilities, controlled substances were stored separately from other medications. Nonprescription medications were made available in half of the facilities for residents to use when needed, as shown in Table 3.

In the 15 facilities site visited, all but one had a central storage area and in 8 of these facilities, the cabinet was locked at the time of our visit. In three other facilities, we were told that medications were always stored in a locked cabinet. Upon inspection, however, the cabinets were not locked. The storage cabinets were located in a variety of places, for example, a kitchen cabinet in most of the facilities. In one facility, storage was in a cupboard over the stove in the kitchen, and in another, in a damp basement.

**Medication Administration.** — As shown in Table 3, two thirds (66%) of the facilities reported that residents could self-administer nonprescription medications; however, less than half (44%) allowed self-administration of prescription medications. In facilities where this was permitted, staff were to be informed about self-administration in one third of the facilities for nonprescription drugs and in one fifth for prescription drugs. For both types of drugs, 71% of the facilities reported that some residents were not allowed to self-administer, and the individual(s) who made that decision was usually the physician or a family member.

Over three-fourths of the facilities reported that one or more residents was reminded by staff on a regular basis to take specific medications. In 84% of the facilities, one or more of the residents was given assistance with medication administration. In 32% of the facilities, that staff person was a nurse.

In two thirds of the facilities, staff supervised or assisted in the administration of injectable medications used by residents during the past year. In most of those facilities (92%), there were subcutaneous injections, including insulin, and approximately half of the facilities assisted in their administration. Intramuscular injections, including antibiotics, were administered in 45% of the facilities. Half of the residents who had injections also needed assistance in their administration.

Nine percent (n = 6) of the facilities in the telephone survey reported that within the past year, a resident had been hospitalized because of an adverse drug reaction or medication overdose.

In the site visits, all but one of the 15 facilities handled the prescription medications for most of
Table 3. Storage and Administration of Nonprescription and Prescription Medications

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Nonprescription Medications</th>
<th>Prescription Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Facilities</td>
<td>Percent of Facilities</td>
</tr>
<tr>
<td></td>
<td>Responding</td>
<td>That Responded &quot;Yes&quot;</td>
</tr>
<tr>
<td>Storage of medications</td>
<td>64</td>
<td>55</td>
</tr>
<tr>
<td>Stored in resident's room — yes</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td>• if yes, in locked area — yes</td>
<td>35</td>
<td>49</td>
</tr>
<tr>
<td>• if yes, some residents not allowed to store in room — yes</td>
<td>doctor</td>
<td>17</td>
</tr>
<tr>
<td>• if yes, who decides (check all apply)</td>
<td>family</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>resident</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>staff</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>other</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>don't know/no response</td>
<td>17</td>
</tr>
<tr>
<td>Administration of medications</td>
<td>64</td>
<td>66</td>
</tr>
<tr>
<td>Can residents self-administer — yes</td>
<td>42</td>
<td>31</td>
</tr>
<tr>
<td>• if yes, some residents not allowed to self-administer — yes</td>
<td>doctor</td>
<td>42</td>
</tr>
<tr>
<td>• if yes, who decides (check all apply)</td>
<td>family</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>resident</td>
<td>30</td>
</tr>
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<td></td>
<td>staff</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>other</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>don't know/no response</td>
<td>30</td>
</tr>
</tbody>
</table>

Note: Based on Telephone Interviews, N = 64 facilities.

the residents. In six of the facilities a nurse either preset up the medications or administered all medications for residents. (Several of the facilities were owned or managed by a nurse who performed this function.) One facility used a trained medication assistant (TMA) to set up the medications, and one facility used a pharmacy-supplied unit dosing system.

Actual medication administration was performed by facility staff in 11 of the 15 facilities, by licensed practical nurses (LPNs) in two facilities and by a TMA in one facility. Several facilities reported that their cooks were involved in passing medications at mealtime.

In the medication set-ups by nursing or staff, a variety of systems were used. Six facilities used seven-day Mediset or plastic day-of-week pill boxes. Four facilities preset up medications in plastic cups (one with actual medication cards, one not labeled, and the other two with resident's name only). One facility also used envelopes. The doses were set up for either one to two days, a week or two weeks, or a month supply, depending on the facility. Three facilities did not prepour medications: One poured from the bottle into the residents’ spoon at each meal-time, another passed medications as a nursing home does using a medication cart and recording information in a medication administration record (MAR), and the other used pharmacy-provided unit dose packaging.

When asked about their policy for medication refusal, respondents in five of the 15 facilities reported that this had never occurred. Most stated that they would contact the physician, a nurse, or social worker. One manager described compliance as a very important issue at the facility. Three facilities documented refusal in either an MAR or log book. Two facilities stated that medications had been disguised in food, with the physician’s or family’s permission, or both.

**Documentation of Medication Use.** — In response to the questionnaire, three fourths of the 98 facilities maintained a written record of residents' medication use. In most of the facilities, either a staff person (44%) or a staff nurse (40%) was responsible for this documentation. In over half of the facilities (58%), medication reminders were documented; in 89% of the facilities the name, dosage, and time of medications administered were documented. Controlled substances were documented differently from other prescription medications in 56% of the facilities.

In the site visits, medication records in all but one of the 15 facilities had records that listed the patient’s name, medication, dose, and times of administration. Four facilities recorded each dose administered on a MAR. One additional facility reported using an MAR, but the example we were shown was two years old. The other facilities did not document medication administration on a daily basis. Several reported documenting refusal of medications in a staff log. These records were stored permanently in

 Abused By Guest on 22 December 2018
eight of the facilities, and another two facilities reported keeping them for one and seven years. Two facilities stored records until the resident left, and one facility kept current records only.

Oversight of Medication-Related Aspects. — Approximately half of the 64 facilities interviewed had written policies about residents' medication use. These policies had been developed by one or more of the following individuals: nurse consultant in 27% of the facilities, facility director or coordinator in 24%, staff nurse in 21%, physician in 15%, and consultant pharmacist in 12%. When questions arose about residents' medication use or side effects, staff in most facilities (61%) called the physician, followed by the drug store pharmacist (in 49% of the facilities), a staff nurse (28%), nurse consultant (22%), or consultant pharmacist (19%).

In all of the facilities site visited, the pharmacist at the local pharmacy was described as the "consultant pharmacist," and most owners/managers were very positive about this relationship. In only one facility had the pharmacist ever visited the facility. The most helpful services provided were drug information and delivery of medications. When asked what additional pharmacy services were needed, six facilities had none to suggest, one would have wanted medications prepackaged by dose, and another would like to see the pharmacist come every six months to do a basic medication record review.

In the site visits, we also asked about the role(s) of nurses in the facilities. All had some contact with a nurse, either as a staff person, a family member, a consultant, or a public/county health nurse. In six of the facilities either a nurse was a staff employee or the owner/director was a nurse. A public health nurse was reported to visit facilities on a regular basis in 10 of the facilities, either to set up all medications, to draw up or administer injectable medications, or to assist with the care of specific residents.

Drug Profiles from the Site Visits

Drug profile information was obtained through record review for 143 residents in 14 of the 15 sites visited. The number of routine medications administered per resident ranged from 0 to 14 in the total group, with an overall average of 4.0 medications. Averages within facilities varied from 1.8 to 6.3 medications per resident.

The most frequent therapeutic categories of medications included cardiovascular drugs, antihypertensive medications or diuretics, or both, by 61% of the residents, many of whom (29%) received more than one of these medications on a regular basis.

Thirty-eight percent of the 143 residents had routine use of one or more of the three major classes of psychotropic drugs, including antipsychotic drugs used by 15% (n = 22) of the residents, antianxiety agents by 11% (n = 16), and antidepressant medications by 19% (n = 27).

Diversity Among the Facilities Site Visited

The 15 facilities site visited had several characteristics in common. All of the sites had elderly, in most cases vulnerable, residents; all provided meals and sleeping rooms; and all but one were involved in the storage and administration of prescription drugs. The diversity was greater than their commonality, however, not only in the physical plants, but also in the ways in which residents' lives were managed and services were provided and in the philosophies and attitudes of the care providers. These differences can best be characterized by summarizing our impressions of the facilities, the people interviewed, and the residents.

The facilities ranged from institution-like settings similar to nursing homes, to stately homes that had been refurbished, to modest dwellings converted to accommodate a number of people. In some facilities, each resident had a single bedroom that was homelike. Elsewhere, residents shared sleeping rooms with up to four beds, and in others, multiple beds were lined up along the wall in what had originally been the living room. Such crowded conditions might connote warehousing, but in some places these arrangements conveyed the sense that bed-bound residents were in the midst of the activities and social life of the facility.

About the only characteristic that the 15 owners or directors had in common was their race; all were Caucasian. Some had professional training in human services or clinical fields, or both, whereas others may have been high school graduates. A further description about differences in characteristics of the owners/managers, their attitudes and management of medications are described in the Appendix at the end of this article.

Among the residents themselves, many appeared to be slightly to profoundly confused and in various states of physical dependency. Most were mobile, but some, including a resident with advanced dementia, were completely dependent and would likely have qualified for placement in a nursing home.

Discussion

Summary

The purpose of this study was to describe medication management in Minnesota board and care facilities, with a focus on those that provide care for elderly persons. Of the 98 facilities surveyed by questionnaire, most provided medication storage and medication reminders, and two-thirds administered medications to one or more residents.

In follow-up telephone interviews with 64 of the 98 facilities in which there were elderly residents, we found that one or more residents were allowed to manage their own prescription medications in one-third of the facilities. In the majority of facilities that managed prescription drugs, most described a locked, central storage area. Most facilities provided medication administration, and this assistance was usually provided by a staff person. In over half of the facilities, staff supervised or assisted in the adminis-
The results showed that antipsychotics were used by 36% of the nursing home population (Garrard et al., 1995). Information about use of psychotropic drugs by elderly persons living in the community was collected in 1992 in a separate, unpublished study by the senior author of over 4,000 elderly people in the Twin Cities metropolitan area; results showed that 2% used antipsychotics, 12% used antianxiety drugs, and 16% used antidepressants (Garrard, Nitz, & Rolnick, 1996). Nursing home data based on all 33,000 nursing home residents in all Minnesota nursing homes (N = 376) also were available for the year (October 1, 1990 to September 30, 1991) following implementation of federal drug regulations mandated in the 1987 Omnibus Budget Reconciliation Act (OBRA). The results showed that antipsychotics were used on a regular basis by 15% of the nursing home residents, antianxiety drugs by 12%, and antidepressant drugs by 16%. One or more psychotropic drugs was used by 36% of the nursing home population (Garrard et al., 1995).

Strengths and Weaknesses

The weaknesses of this study included a moderate response rate to the questionnaire (68%) and, of those contacted, a similar response rate to the telephone interview (66%), although 100% of the facilities contacted about the site visit agreed to participate. Information about respondent and nonrespondent bias was not available. One of the methodological problems of studying facilities that offer board and care services is the lack of stability in an industry that is often based in individuals’ homes. Thus, neither we, nor the Minnesota Health Department, knew which facilities on the original list of 145 had closed or ceased to operate as a board and care establishment during the one year period between generation of the list of facilities, the survey by MAHA, and its use in this study.

Another methodological weakness in this study is the problem of unknown response bias. Of the population of 145 facilities that were sent questionnaires, we did not have information from the MAHA survey that would enable us to compare respondents (n = 98) and nonrespondents (n = 47) to our questionnaire survey. Furthermore, of the nonrespondents, information was not available concerning resident characteristics; thus, it was not known which facilities would not have met the inclusion criterion in this study of serving one or more residents age 65 or older.

Only Minnesota facilities were included in the target population; therefore, these results cannot be generalized, although the information from this study may be useful in designing future research about an industry that has had little study. The richest source of information was from the site visits; however, the 15 facilities visited were not a random sample. The sites were selected on a stratified basis with an emphasis on diversity including geographic location throughout the state, size in order to include large as well as small facilities, and for-profit and nonprofit status.

The strengths of this study included a target population of board and care facilities throughout the state that provide care for elderly residents, standardization and pilot testing of all data collection instruments, and a three-tiered approach to gathering information that offered advantages over the use of only one of these methods. Questionnaire data, supplemented by telephone interviews, with additional insights from site visits, provided a rich source of information about an industry that is often invisible to policymakers and researchers alike.

Future Considerations

As a university-based research team, independent of either a state health department or the long-term care industry, we have the following suggestions based on our findings.

Regulations. — We believe that there should be some minimum regulation of medication storage and administration in board and care facilities. Many of the residents are elderly, frail, and vulnerable, and society has a responsibility to assume some oversight of their welfare in these facilities. We are also convinced that specific standards should be established requiring a minimum level of training for staff who set up or administer medications, or both.

A Partially Hidden Industry? — We are concerned that not all board and care facilities have been identified. In this study, we had the advantage of working with lists of board and care facilities compiled by the state health department and contacted by one of the professional associations; however, we (like these two other organizations) suspected that the lists were not complete. In the site visits we inquired about other board and care facilities in the same geographic area, and a number of those described to us were not on the ‘complete’ list. Although lack of complete information about all board and care facilities may be a local problem, discussions with policymakers and researchers in other states leads us to suspect that the problem may be widespread. This is an industry that may be partially hidden from researchers and possibly from future regulators unless a coordinated effort is made by local and state agencies to identify all facilities.
Nurse Consultant. — We suggest that consideration be given to requiring that a nurse-consultant be involved with every board and care facility on a minimum of a once per month basis. Most facility managers said they could not afford to hire a nurse consultant four hours a week, but some had worked out an arrangement with the county or public health nurse for some of their residents. Could this kind of involvement be extended to all residents? Such a consultant could review medication management, advise staff on administration, and make suggestions for improvements in medication storage, administration, and documentation. She or he might also make suggestions to staff about additional sources of information on side effects or adverse drug reactions.

Consultant Pharmacists. — In contrast to the nursing home industry, which has had experience with consultant pharmacists for over a decade, there appears to be very little understanding in most board and care facilities about what a consultant pharmacist is or the tasks that he or she could perform. Pharmacy providers, specifically those providing nursing home services, need to be made aware of the special needs of these types of long-term care facilities. Board and care facilities also need to be made aware of the services available from pharmacists, including standardized protocols and forms for medication administration reviews and drug regimen reviews.

A drug regimen review on a quarterly or semi-annual basis would probably be sufficient as a starting point. Such a review might also help to minimize adverse drug reactions. Payment for such a service is a barrier, however, and a future study of the role of pharmacists or nurses may be warranted in order to fully evaluate the costs and benefits of such a recommendation.

Psychotropic Drug Use. — The use of antipsychotic medications by elderly people in board and care facilities, as observed in the 15 site visits, was similar to the levels of use in Minnesota nursing homes (Garrard et al., 1995) and higher than that of elderly persons living in the community. Concern about actual or potential abuse and mismanagement of this powerful class of drugs led the federal government to establish strict guidelines for nursing homes throughout the U.S. in 1989 (Health Care Financing Administration, 1989). Although our research team did not observe any abuse or mismanagement of psychotropic drugs during the site visits, this use profile suggests a rationale for at least a minimum level of regulation and staff training in medication management in board and care facilities.

With the aging of America and the potential growth in demand for long-term care, board and care facilities have an increasingly important role in the care of elderly people in this country. The challenge for the industry, government bodies, advocates for the elderly, and families is to develop a system of oversight that will protect the interests and well-being of future residents, while not destroying the advantages many of these facilities have in providing home-like and caring environments.

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Appendix

Diversity Among Owners and Managers

Judith Garrard, PhD

The owners or managers, or both, of the 15 board and care facilities site visited constituted a case study in diversity. We met both men and women, ranging from their early 30s to others who were indistinguishable in age from the residents who lived in these facilities. Some of the managers had professional training in human services or clinical fields, whereas others may have been high school graduates. We can illustrate some sense of this diversity by describing five of the people we interviewed.

- We met a full-time manager, not an owner, who had directed social services facilities for most of his professional life. He conveyed sympathy and tolerance in his description of the elderly, mostly male, group of residents in his facility, many of whom had had drug or alcohol...
problems and were or had been mentally ill. His matter-of-fact manner extended to a working philosophy about forcing residents to take their medications: “These people have had enough control and power taken away in their life. Every once in awhile, they refuse a med just to be able to say, ‘There is some vestige of my life that I still have control over.’”

This attitude of tolerance and sympathy did not extend to his own situation, however. He expressed weariness from the long hours. We had the sense that he was isolated from other working adults and lonely for professional contact. He described the frustration of too many demands. “This job is like putting a pot over your head and having someone bang on it while you conduct your business.” He longed for collegial contact. “[We] need community resources to be hooked into these places, not only for residents’ well being, but also for the mental health of the staff.”

• In another town, we interviewed a woman who was at the opposite end of this continuum of professional satisfaction and collegiality from the manager “with the pot over his head.” She was relatively young, having completed an LPN only a few years earlier, and had been a director for less than three or four years. Her manner was one of calm and professional competence. On our tour of the institution-like facility, she stopped to talk with staff, calling them by name, and was pulled aside by several residents for impromptu miniconferences. Most of the residents were slightly confused, well-dressed elderly ladies who had their own apartment-like rooms (without kitchens). Her genuine interest and excitement about the facility and the residents came through in her answers to the standard list of questions in the interview protocol. When we asked about professional isolation, she reassured us that that was not a problem. She had colleagues at the facility, as well as other nurse colleagues with whom she met on a regular basis outside of the facility.

She, too, had a tolerant attitude about requiring residents to take their medications, but confessed that behind her back, the residents called her an “angel of manipulation” when it came to gently persuading the recalcitrant. When faced with resistance, she would acquiesce, but then return in an hour or two with casual conversation accompanied by juice and the meds. This was not a demand, or a confrontation, but merely a physical gesture that did not require any direct discussion — like handing someone a sweater with the expectation that, of course, she or he would put it on without overt instructions.

• A third person who made a lasting impression was an elderly owner/director who lived with her husband in the facility, together with approximately 12 residents. She was extremely proud of the stately, turn-of-the-century home purchased some years ago. Medications were stored in the kitchen in unmarked paper cups, although the prescription vials stored in the same cabinet had the names of residents. She described how she sat up at night after everyone else was in bed and distributed the pills to the cups for administration the next day. She assured us that she knew by the color and shape of the pills which cup various residents took them, and if she had any questions, she called the daughter. She told us that at the time she bought the business, the only training she had had in medication administration was from the previous owner who taught her how to give injections by demonstrating the technique with an orange. She assured us that her daughter was a nurse, and if she had any questions, she called the daughter.

• The fourth example was an individual in another town who was the director of a facility that was part of a previously established nursing home. We did not see any residents in the separate board and care wing, nor did we see staff or visitors, although the nursing home section was busy with people. The director told us that not all of the board and care rooms were filled. He casually brushed aside our request to see what one of the rooms looked like and refused to show us any records or how medications were stored. He expressed his hope that this board and care wing would provide a financial boost to the fiscally strapped nursing home, but complained about how little the state subsidizes board and care expenses. In his opinion, the board and care portion of the building was like a motel in which residents should take care of themselves. If they needed a bit of extra supervision, then the desk staff on the nursing home side could occasionally run down the hall and check on them or the residents could always go to the desk to get assistance. He assured us that if the board and care residents needed any more help than that, then they should be in the nursing home.

• In contrast, we interviewed a husband-wife pair in another town who co-owned and managed a board and care facility during the day, but lived elsewhere. Staff were hired to provide all-night coverage for the six residents. They took us on a tour of the two-story, converted house that was of the same era but not as grand as the mansion the owners had purchased some years ago. Medications were stored in a locked pantry. A nurse came in once a week to set up medications for administration. They reported no problems with medication refusal.

This pair of owners seemed to be delighted with the six people who lived there and described how they evaluated new applicants for compatibility with the rest of the group. They took the residents on weekly group outings throughout the year, sometimes just to get an ice cream cone, other times for a simple meal, and once a year to a festival or the state fair. In the course of our interview, we were interrupted by one of the residents we had met earlier, a slightly confused elderly man, who wandered in and prepared to sit with us for a visit. The husband/owner diverted him by tactfully and gently asking if he would help with something, while guiding him into another part of the house. The atmosphere was relaxed and homelike, and the owners were comfortable in describing their management of the facility.

Despite their diversity, the 15 people interviewed in the site visits were identical in one respect: They were all convinced that they provided the very best care there was to offer to the residents in their facilities. This was an absolute conviction on their part. Although outsiders may quibble about this being the best-of-all-possible-care in every case, the research team feel that pride of a job well done was a definite management strength. If regulations are implemented in the future, the route to improvement, if needed, might stem from the willingness of owners and directors such as these to do the job right if approached as a group deserving of professional respect and mutual interest in helping to create standards of excellence.