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Level of function scores of elderly after receiving psychiatric home care

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Level of Function Scores of Elderly
after Receiving Psychiatric Home Care

A Thesis

Presented to

The Faculty of the School of Nursing

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Janet M. Duffey

December 1996

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ABSTRACT

LEVEL OF FUNCTION SCORES OF ELDERLY AFTER RECEIVING PSYCHIATRIC HOME CARE

by Janet M. Duffey

This thesis measured functional outcomes in elderly individuals experiencing depressive disorders who received psychiatric home care service. Utilizing a quasi-experimental design, functioning of psychiatric home care clients (N=14) was measured using the Specific Level of Function (SLOF) tool. Prescores were obtained at the start of service and again after service.

The data supported the hypothesis that clients receiving psychiatric home care demonstrate an increase in functioning as measured by the SLOF tool. Each of the five subscales (physical, personal care skills, interpersonal relationships, social acceptability and activities) demonstrated statistically significant levels of improvement.

Chapter 1

INTRODUCTION

Purpose of Study

The purpose of this study was to measure functional outcomes in elderly individuals experiencing depression who receive psychiatric home care services on admission and 60 days later or discharge. Psychiatric home care nursing service is a relatively new area of practice. Much of the discussion around clinical practice has previously focused on themes of how to meet legal and reimbursement requirements. Literature discussing the phenomenon of successful psychiatric home care practice has almost exclusively focused on case examples of clients who have benefited from services.

Background and Significance

In the era of managed care organizations and health care reform, it behooves providers and payors alike to determine the impact of psychiatric home care services. Case examples raise issues of utilization, reimbursement, and practice standards. The benefit or impact of psychiatric home care service on clients has not been described with great frequency or detail. The payors and mental health benefit managers have requested empirical data to substantiate and generalize the benefit described by case examples. The primary emphasis is on the change occurring within the client. However, such a description will only indirectly measure the effect of psychiatric home care nursing interventions.

While it is important to determine the outcomes or impact of psychiatric home care for all clients, it is reasonable to focus first on the most frequent consumers of this service: elderly persons experiencing depressive disorders. They comprise over 50% of the psychiatric home care population treatment group and are therefore readily available. Generally they are willing participants experiencing a treatable illness with a reasonable expectation for improvement in symptoms that affect functioning.

A 1995 survey of 340 psychiatric home care referrals revealed that 54% had depressive disorders, 16% had dementia, 10% alteration in coping, 8% with bipolar affective disorders, 6% anxiety disorders, and 6% schizophrenia (Duffey & Miller. 1995).

Research Question

This study answered the question: “Do elderly clients experiencing depression receiving psychiatric home care services demonstrate improved functioning as measured by the Specific Level of Function (SLOF) Tool?”

Research Design

This study utilized a quasi-experimental design. Utilizing the Specific Level of Function (SLOF) tool, client functioning (the dependent variable) was measured at the start of care to acquire a baseline, pre-treatment score. Clients functioning was measured with the SLOF at 60 days or upon discharge from service, whichever came first, to determine the post-treatment score. The treatment (independent) variable was receiving psychiatric home care services.

Research Hypothesis

This study tested the hypothesis that the post scores on the SLOF of elderly clients receiving psychiatric home care services would be higher than their prescores as measured by the Specific Level of Function (SLOF) Tool. The dependent variable in this study is the level of functioning based on SLOF scores. The independent variable is receiving psychiatric home care services over a 60 day time period.

Definition of Terms

For the purposes of this study, the following definitions of terms were used:

1. Depressive disorders are diagnoses listed in the DSM-IV, including major depressive episode, either single occurrence or recurrent, dysthymia, and depressive disorder not otherwise specified (American Psychiatric Association, 1994).
2. Elderly clients are homebound individuals, ages 62 years old or greater. These individuals were newly referred to the home health agency for psychiatric home care services.
3. Psychiatric home care service is provision of psychiatric nursing care in a client's home setting rather than clinic or hospital settings.
4. Specific Level of Function (SLOF) tool is a 31 item behavioral rating tool used to determine the level of functioning demonstrated by the client (Scheider & Struening, 1983).

5. Client referral by the physician or psychiatrist indicates that the client is currently under the care of a physician or psychiatrist who has legally given an order to a home health agency to provide nursing care.

Scope and Limitations

This study is limited by the small nonrandom sample of clients with a variety of depressive disorders. Additionally, observations using the SLOF may not fully describe other clinically relevant factors such as severity, co-morbidity, and availability of support systems.

This chapter describes the purpose, background and significance of the research question, design, and hypothesis of this study. Relevant terms were defined as well as the scope and limitations of the study.

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Literature Review

The literature reviewed falls into three areas: general descriptions of the development of psychiatric home care practice, home care outcome measurements, and descriptions of psychiatric outcomes.

Psychiatric home care practice. Development of psychiatric home care practice was first described by Patusky (1989) as a new arena of nursing practice within the home health team. Descriptions of general psychiatric home care practice have been rather problem oriented, focusing on legal, reimbursement, and clinical practice issues such as suicide (Thobaben, 1989; Kruse & Jones, 1990). Except for basic “how to” articles, there have been few articles describing the theoretical underpinnings for psychiatric home care. Duffey, Miller, and Parlocha (1992) present a theoretical framework drawing from Orem’s self-care model, crisis intervention methodologies, and behavioral therapy. They also use a case example to demonstrate the usefulness and application of these ideas. Furthermore, they identify improving self-care functioning in elderly psychiatric home care clients with a variety of affective and psychotic disorders as one of the primary goals of psychiatric home care service (Miller & Duffey, 1993).

Harper (1989) discussed the increased in-home mental health needs of an aging population and policy formation within the Health Care Financing Administration (HCFA) that funded this type of care. Although funding authorized by HCFA was public record, this did not ensure that home health organizations understood how to develop or

implement psychiatric home health services in an effective or efficient manner. Authors have suggested practical management and program development strategies without directly addressing the issue of quantifying the outcomes of service delivery (Klebanoff & Casler, 1986; Kozlak & Thobaben, 1992; Miller & Duffey, 1993).

The accreditation body for home health care, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), includes the documentation of outcomes in their accreditation surveys as a means to determine the quality of services delivered (1994). This information is difficult to retrieve for general home care clients, but even more difficult in the case of a new and often difficult to measure area, psychiatric care (Peters & Eigsti, 1991). In a discussion of a home care quality assurance process, reviewing the care given to home care populations with chronic illnesses, Zotnick and Decker (1991) utilized the concept of quality of life. This may be a useful strategy for future research. but the authors do not report on the availability of standardized and valid testing tools.

Home care outcome measurements. In the general home care literature, functional assessment has been used to determine the need for home care services. Fortinsky, Granger, and Seltzer (1981) reported use of functional assessment to justify in home services but not for measuring clinical outcomes. Decreased functioning was described as the primary concern of providers of home care services rather than the medical or psychiatric diagnosis. This emphasis is a deviation from the medical model that typically focuses on diagnosis. Functional assessment, therefore, may be a useful idea in determining outcomes in psychiatric home care clients.

Hospitalization and service utilization were used as outcome measures for elderly receiving home care services by several investigators. Kellogg, Brinckner, Conley, and Conroy (1991) described risk factors for readmission of elders living in the community and their response to home care and case management services. They concluded that the use of home care services decreased the rate of rehospitalization for individuals receiving comprehensive in-home treatment. They did not focus on psychiatric symptoms or diagnosis as part of the study. In a similar study, Hughes, Manheim, Edelman, and Conrad (1987) studied utilization of hospital and nursing homes in relation to cost to determine if the financial outcome of home care was significant. They determined that the cost of long-term home care services was approximately 25% higher than the control group receiving traditional outpatient mental health services. The higher cost for home care was surprising; however, other outcome indicators supported the worthiness of this intervention. The home care clients were less likely to experience placement in intermediate level care homes and experienced a higher quality of life.

Utilization of standardized and reproducible methods has been a major flaw in most of the home care outcome studies. However, Martin, Scheet, and Stegman (1993) used the Omaha System to document problems and outcomes experienced by home health clients. The domains assessed in this data collection system are holistic in nature and detected a statistically significant improvement in the knowledge, behavior, and status ratings. This is among the best studies found in the literature reviewed, but it, too, has limitations. It is limited by the sensitivity of the outcome measurement markers that

are subjective and a difficult part of a complex and possibly not entirely accurate documentation system.

Descriptions of psychiatric outcomes. The research literature on outcomes for psychiatric home care is somewhat sparse due to its relatively recent development, lack of practice standards, and absence of retrievable objective outcome data. Hobbs and Runyon (1994) described outcomes for a sample of 128 psychiatric home care clients based on a chart review at the Visiting Nurse Association in Louisville, Kentucky. While their method is not unique or sophisticated, the reported changes are important to practice. They noted a 74% decrease in the rate of rehospitalization, 65% of the clients were compliant with prescribed psychotropic medications, and 85% followed up with their outpatient psychiatrist. The limitations of this study included their dependence on documentation that was reviewed and the ability to determine rates of rehospitalization. The strength of this contribution is that it focused on easily identified behaviors and events that are crucial to the wellness of individuals with psychiatric disorders requiring long-term treatment. One unanswered question in the Hobbs and Runyon 1994 study is, “What is the quality of the client’s existence or functioning when not hospitalized?”

While psychiatric home care in the United States is a relatively new phenomenon, the practice is much more common in England, possibly due to funding mechanisms. Watterreus, Blanchard, and Mann (1994) found that elderly with depressive disorders who received psychiatric home care services living in London demonstrated a decrease in depressive symptoms, reported feeling better, and expressed a higher degree of

satisfaction with care than the control group. Another study completed in London described the gains for a more diverse and global psychiatric population as being less dramatic (Burns, Beadsmoore, Bhat, Oliver, & Mathers, 1993). The delivery of psychiatric home care services within the National Health Service was evaluated after 1 year using treatment and control groups. The authors reported that there were fewer suicides in the treatment group, and better compliance with outpatient psychiatric clinic appointments, but no difference in clinical outcomes. The generalizability of these studies is limited by culture, delivery systems, and research methods, but the findings contribute to the knowledge about measurement and methodologies for outcome measurement for clients receiving psychiatric home care services.

Relationship between self-care and depression. Depression is one of many psychiatric illnesses that negatively impacts self-care. Hale (1989) reports that depression is the most common psychiatric disorder in the elderly population. However, the actual incidence of depressive disorders in the elderly population is reported with great variance due to population sampling. Blazer and Williams (1980) found depression occurring in 14.7% in the general elderly population. However, with the introduction of physical comorbidity, the rate increases to 35% (Jackson & Baldwin, 1993). Client functioning for psychiatric patients in the community was reported to have multiple contributing factors including concurrent physical illness and limited support systems (Krach & Yang, 1992; Fortinsky, Granger, & Seltzer, 1981).

Using the DSM-IV criteria for major depression, it is possible to identify self-care deficits. The DSM-IV lists ongoing depressed mood, diminished interest or pleasure in activities, weight change, lethargy, sleep disturbance, social isolation, and decreased concentration as key features of major depressive illness (American Psychiatric Association, 1994, p. 327). These symptoms negatively impact the self-care requisites as identified by Orem's Self-Care Deficit Theory (1991), the theoretical framework for this study, including maintenance of a balance between solitude and socialization, activity and rest, in addition to normalcy. Weight loss or gain commonly associated with depressive disorders may indicate inadequate or inappropriate intake of food and fluids.

While the symptoms of depressive disorders are distressing, the presence of symptoms alone does not always determine the need for hospitalization. Thobaben (1989) concluded that it was often the client's poor functioning and lack of appropriate self-care that caused them to require hospitalization rather than the degree of psychiatric symptoms.

Medicare has been the largest single payer for psychiatric home care services. This fact has shaped the practice of psychiatric home care more than any single factor. The reimbursement criteria discussed in the HIM-11, section 205.2 (Health Care Financing Administration, 1989) focuses on the functional limitations caused by Axis I disorders such as depression. Specific functional limitations listed on the Medicare plan of treatment include amputation, bowel/bladder incontinence, contracture, hearing, paralysis, ambulation, speech, endurance, dyspnea with minimal exertion, and "other."

While these conditions focus almost exclusively on physical conditions common to a variety of medical conditions, some can result from the symptoms associated with depressive disorders and comorbid conditions (Harper, 1989; Miller & Duffey, 1993).

Conceptual Framework

This study uses theoretical concepts from Dortha Orem's Self-Care Deficit theory and Aguilera's Crisis Intervention theory. Orem's self-care deficit theory describes the basic needs of the client, interventions, and therapeutic goals. While Orem's theory asserts that a crisis may precipitate increased health needs, it is not clearly focused on the nature of the crisis. Aguilera's crisis intervention theory is useful in understanding the nature of crisis, impact of the lack of balancing factors, and thus their negative impact on functioning. The shift of psychiatric care into the home setting has increased the services for individuals with mental illness in the community setting. By using these two theories, clients can be treated in the the least restrictive setting-the home.

Self-care deficit theory. Self-care deficit theory (Orem, 1991) focuses on restoring the individual to the highest possible self-care agency to accomplish universal self-care requisites. Using Orem's theory, it is possible to focus on functioning and restoring the individual to full self-care as the therapeutic mode and goal.

Using Orem's self-care theory (Orem, 1991), individual functioning becomes the primary focus rather than the level or nature of psychiatric symptoms. Orem (1991) describes basic activities of daily living as self-care requisites. These include air, food

and fluid, activity and rest, management of hazards, solitude and social interaction, as well as maintaining normalcy in functioning.

Orem defines a person as an integrated whole with respect to biological and social functioning. Environment is an interaction between physical, chemical, biological and social features. Health is the optimal state of an individual in which the highest possible level of self-care is occurring producing functional wholeness. While the goal of nursing, according to Orem, is to restore self-care, it occurs within the context of three nursing systems: wholly compensatory, partly compensatory and supportive educative.

An individual's self-care and functional abilities are influenced by environmental factors such as illness. Orem calls illness "health deviation," which necessitates nursing care in order to meet various self-care requisites. In this manner of intervening, the nurse provides only as much care as required to adequately meet the self-care requisites with the goal of restoration of full self-care. While Orem does not directly address psychiatric conditions in particular, the functional limitations resulting from psychiatric conditions, such as depression limiting the client's ability to perform self-care, become the targets of nursing intervention.

Crisis intervention theory by Aguilera. Aguilera (1994) has described both adaptive and maladaptive responses of individuals to crisis, and sources of crisis. The elderly population is subject to three types of crises from various internal and external processes or events. Coping may be challenged beyond their abilities resulting in a crisis which negatively impacts their ability to meet self-care requisites. These include

maturational crises due to events associated with the aging process, such as retirement, relocation, or the death of friends or spouse. Situational stressors such as deteriorating physical health, relocation, or marriage can present overwhelming change that exceeds their coping abilities. Adventitious crises are less common, but clearly exceed the usual coping abilities of both young and older clients alike. Natural and man-made disasters such as floods, earthquakes, hurricanes affect larger groups of individuals.

When clients are experiencing a crisis, regardless of the type, a state of disequilibrium exists. The presence or absence of balancing factors determines the severity and resolution of the crisis. The balancing factors are a realistic perception of the event, adequacy of situational supports, and adequacy of coping mechanisms. If one or more of these balancing factors are missing, the problem will be unresolved, continuing the state of disequilibrium and thus precipitating a state of crisis (Aguilera, 1994).

Summary

This chapter reviewed the literature of psychiatric home care practice, home care outcome measurements, descriptions of psychiatric outcomes and the relationship between self care and depression. In addition, Orem's Self-Care Deficit theory was described as well as Aguilera's Crisis Intervention theory.

Chapter 3

METHODOLOGY

Research Design

The study utilized a quasi-experimental design. The treatment (independent variable) was psychiatric home care service. Client functioning was measured at the start of care (pre-treatment/baseline) and again at 60 days or discharge from service, whichever came first, utilizing the Specific Level of Function (SLOF) tool.

This study was carried out on previously collected data obtained for a larger study on a variety of psychiatric conditions. The data were collected by the researcher and an advanced practice nurse at a home care agency in Northern California between November 1995 and August 1996. The full title of the larger study was: "Psychiatric outcomes: A comparison of functional status, cost, and patient satisfaction."

Data Collection

The data are from a non-randomized, convenience sample of patients referred to the psychiatric home care program with a variety of psychiatric disorders. All clients with depressive disorders were selected. Appropriate diagnoses included, but were not limited to, major depression, recurrent major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified. Clients were referred by their physician or psychiatrist. They were at least 62 years old, required home care services because of the severity of symptoms, were home bound because of psychiatric or other physical

symptoms, and were able to give consent for in-home treatment. Additionally, all participants had Medicare insurance that provides coverage for in-home psychiatric care.

Instrument

The Specific Level of Function (SLOF) tool was developed by Schneider and Struening in 1983. They were influenced by the trend toward more functional and objective assessments for the purposes of diagnosing the impact of mental illness on the quality of life (Schneider & Struening, 1983). Many of the observation items closely mirror those found in other activities of daily living scales. The assessment items report on five global functional scores, including physical functioning, personal care skills, interpersonal relationships, social acceptability, and activities of community living.

The SLOF has demonstrated an overall interrater reliability rating of .84 in the community setting. The overall mean reliability of the tool in the community setting was .79. These findings provide adequate support and justification for using the tool with a community based sample of psychiatric clients. While the tool was not specifically designed for elderly clients, they comprised 40% of the test population used by the authors (Schneider & Struening, 1983). Most symptom focused scales are valuable in identifying the psychological pathology affecting the individual's functional abilities. However, they do not describe how the functioning of the client in the community or home setting is affected.

The SLOF was chosen as a measurement tool for this study since it focused on daily living skills and maintenance of socially appropriate behaviors required for community living (see Appendix A). The 31 observations contained within the SLOF closely reflect the self-care requisites described by Orem and are the subject of intervention for psychiatric home care clients. Client's functioning rather than incidence of psychiatric symptoms was the outcome measurement.

The SLOF is a 31-item, multidimensional, five factorial functional rating tool with behaviors rated in the areas of physical functioning, personal care skills, interpersonal relationships, social acceptability, and activities of community living. Each individual item is rated using a five point Likert scale. A rating of five indicates an independent level of functioning, whereas one denotes total impairment or inability to perform the activity.

Specific items found within the sub-scale for physical functioning are vision, hearing, speech impairment, walking, and use of hands and arms. The personal care skills scale rates the individual's ability to manage toileting, eating, personal hygiene, grooming, care of own possessions, and care of own living space. The interpersonal relationship scale contains the items of accepting contact with others, initiating contact with others, communicating effectively, engaging in activities without prompting, forming and maintaining friendships, and asking for help when needed.

The social acceptability scale rates how frequently socially unacceptable behaviors occur from never to always along the five point Likert scale. The behaviors

described include verbally abusing others, physically abusing others, destruction of property, being fearful, crying and clinging, taking property from others without permission, and performing repetitive behaviors. The last scale rates activities required for community living. This sub-scale measures the ability of the client to perform basic household responsibilities such as handling personal finances, use of telephone, use of leisure time, recognition and avoidance of common dangers, and self-medication.

Research Procedures

For the data sample previously collected, the SLOF tool was completed during the first two visits made by the psychiatric home care nurse and repeated at 60 days or at discharge, whichever came first. Clients were rated by the nurse using direct observation of behavior and reports of clients and their caregivers about their level of functioning. The initial SLOF rating tool was submitted to the primary researcher to avoid influencing the second rating.

The psychiatric nurses at the home care agency were trained in the use of the SLOF tool, definitions of ratings, and the procedure for data collection. Items included in this training were the necessity of the study being conducted and the procedure for obtaining informed consent. Instructions on use of reference definitions for each item, and paper flow of completed SLOF tools to avoid comparison of ratings, were also included.

After completion of the 2 hour training, the field nurse and researcher completed a joint home visit, rating the client, then reviewing ratings together. Nurses obtained the

subject's informed consent, completed the initial SLOF, and submitted the preliminary observation to the researcher to avoid comparison of preliminary and final functional observations. Additionally, the nurses discussed any items they felt were unclear or difficult to rate for a particular client. All SLOF tools and consent forms were reviewed by the researcher for completeness.

Protection of Human Subjects

Data collection occurred under the approval by the committee for the protection of human subjects for the larger study. Permission to utilize the data for this study was obtained from the home health agency. Approval was given by San Jose State University Institutional Review Board to utilize the data as secondary analysis of existing data (see Appendix B).

The information provided to the researcher was the pretest and posttest SLOF ratings and demographic items: age, diagnosis, ethnicity, and number of visits for the 60 day study period. All names of participants and other identifying information were removed. Participants were listed by their assigned number only. Findings or results are reported as an aggregate without identifying any single individual. The data sets were kept in a secure, locked file, and confidentiality was maintained by the researcher.

Procedures for Data Analysis

A statistical consultant determined the appropriate statistical approach for the hypothesis testing. A t-test was used to determine if the changes in the test scores between the pretest and posttest means was statistically significant. Other descriptive

statistics, such as demographic characteristics including diagnosis, age, ethnicity, and number of visits, are reported by frequency.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

Description of Sample

The sample of 14 subjects was comprised of 7 males and 7 females with a variety of depressive diagnoses. The range of age spanned from 62 to 87 with a mean of 70.2 years. The ethnic distribution within the sample was 12 Caucasians and 2 African Americans. The actual number of nursing visits ranged from 6 to 19 with a mean of 16.

Results of Data Analysis

Data analysis was performed in consultation with a statistician. One-tailed t-tests were computed to determine if there was a statistically significant increase as hypothesized in the pretest mean and posttest mean functional scores. Possible scores on the SLOF range from 31-155. The total pretest scores ranged from 77 to 150. The posttest scores ranged from 91 to 155.

It is not reasonable to expect that individuals with chronic mental illness and concurrent medical conditions will achieve the maximum score. Only one client attained the maximum score of 155 on the SLOF. The remaining 13 participants had some residual symptoms that resulted in a functional impairment. A lower score implies that residual symptoms are present and negatively impacting functioning. Considering the chronic nature of some depressive disorders and concurrent medical conditions it is possible that they obtained their highest possible level of self-care and “functional wholeness” as described by Orem (1991).

The statistical analysis supported the hypothesis that the post scores on the SLOF (Specific Level of Function) tool of elderly clients receiving psychiatric home care services will be higher than their prescores as measured by the SLOF tool. As illustrated in the Table 1, all subscales were significant at p equal to .05. The end result is improved physical function, personal care, interpersonal relationships, social acceptability and community living skills. Overall, self-care deficits existing at the start of care precipitated by a variety of crises resolved over time while receiving psychiatric home care service.

Table 1

Mean SLOF Scores (N=14)

Sub-scale	Pretest	<u>SD</u>	Posttest	<u>SD</u>	One-tailed p value
Physical Function	3.97	.62	4.30	.64	.0300
Personal Care	4.00	.90	4.50	.75	.0060
Interpersonal	3.58	1.20	4.25	1.01	.0060
Social Acceptability	4.23	.59	4.74	.45	.0005
Community Living	3.36	1.08	4.13	.96	.0075
Total SLOF Score	119.14	22.61	136.5	21.81	.0040

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Summary of Study

This study measured the statistical significance in the change in SLOF scores before and after psychiatric home care services within a sample of 14 elderly homecare clients with depressive disorders receiving psychiatric home care intervention over a 60 day treatment period. Using the SLOF, a statistically significant change occurred in the clients' ability to function in the sub-scales of personal care, interpersonal relationships, social acceptability, and activities of community living. It is worth noting that all subscales and overall ratings on the SLOF achieved significance.

Conclusions

The study findings demonstrate that clients' ability to function over time in areas that relate to the individual functioning self-care increased. Aguilera's crisis intervention theory supported this study's findings that restoring and reestablished adequate situational supports and coping mechanisms were facilitated resolving the problem that caused the crisis. Psychiatric home care interventions assisted individuals in regaining equilibrium (Aguilera, 1994). The statistically significant increase in the total SLOF score demonstrated that clients functioned better over time. In addition, the social acceptability and interpersonal sub-scales increased significantly, suggesting better coping behaviors and improved ability to appropriately mobilize social supports.

The finding that clients improved with regard to functioning is consistent with the majority of what is known about outcomes for psychiatric home care clients. Generally, it is documented that they improve with regard to their disease process and functioning and have improved quality of life with psychiatric home care service (Burns, Beadsmoore, Bhat, Oliver & Mathers, 1993; Conrad, 1987; Kellogg, Brickner, Conley & Conroy, 1991; Martin, Scheet & Stegman, 1993). As reported by Hobbs and Runyon (1994), clients improved in their ability to take medications and demonstrate socially acceptable behavior in the community.

All of areas of function were found to improve within their respective sub-scales. These include self-care items such as eating, hygiene, grooming, dressing, and an investment in the care of one's possessions and living space. The interpersonal relationship sub-scale included the ability to accept contact, interact, form relationships, self-destructive behavior, crying, and self-isolation. The symptoms contained within the SLOF are similar to those listed in the DSM-IV criteria for depressive disorders (American Psychiatric Association, 1994). Findings of this study suggest that symptoms of depression decreased. Based on these behavioral observations, the findings in this study indicated that the clients' depressive symptoms decreased.

Limitations

While this study makes a contribution to the body of knowledge about psychiatric home care clients and how they function in the areas of physical, self-care, social acceptability, and community living skills after receiving psychiatric home care service, it

has limitations. The length of time for participation in the study may not accurately demonstrate the full, long term effect of the duration of home care services beyond 60 days or how long the positive effects will last. The study did not collect any data on other factors described by other researchers, such as financial, social, and personal resources which could impact functional outcomes.

The SLOF tool provides a unique and rich description of client functioning in the home setting. However, just as symptom rating scales do not fully describe the experience of psychiatric clients, the SLOF does not measure other important and relevant clinical factors such as severity of psychiatric symptoms, co-morbid conditions, complexity of treatment regimen, and availability of resources. The lack of descriptions of these factors limits the generalizability of the findings to larger groups of home care clients with depressive disorders.

The generalizability of the study is limited by the relatively small non-random sample size of 14 participants. Additionally, the lack of a standardized treatment protocol also limits the generalizability. The design would be strengthened considerably if it was comprised of a more homogeneous group, for example, elders who are experiencing their first major depressive episode, live alone, and receive a standardized home care treatment protocol, with a comparison group.

Recommendations

The findings of this study would be strengthened by having a larger and randomly selected sample from multiple sites. Inclusion of symptom rating scales and satisfaction

surveys in addition to the SLOF would provide a more complete description of clients. Lastly, a standardized and longer treatment period would determine the impact of psychiatric home care service over time.

Implications for Nursing Practice

One implication for nursing practice from this study is that psychiatric home care service is an effective treatment modality for elderly clients with depressive disorders. Clinicians, clients, and families can reasonably expect that client's functioning will improve with regard to ability to care for one's self, social acceptability, personal care, and interpersonal relationships. Based on these findings, clinicians can provide hope for clients experiencing a disease characterized by hopelessness and decreased functioning.

Psychiatric home care is a potentially satisfying area of nursing practice. Clients are seen for a longer duration than in other settings with greater opportunities for creative, rewarding therapeutic nurse-client relationships (Klebanoff & Casler, 1986) and improved client functioning.

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APPENDIX A

Specific Level of Function

Assessment Tool

LEVEL OF FUNCTIONING ASSESSMENT

Instructions: Circle the number that best describes this person's typical level of functioning on each item listed below. Be as accurate as you can. If you are not sure about a certain rating, ask someone who may know or consult the case record.

Patient Name: _____ MR#: _____ Date: _____

SELF MAINTENANCE

	No Problem Functioning	Problem, but no effect on general functioning	Slight effect on general functioning	Restricts general functioning substantially	Prevents general functioning
A. Physical Functioning					
1. Vision	5	4	3	2	1
2. Hearing	5	4	3	2	1
3. Speech impairment	5	4	3	2	1
4. Walking, use of legs	5	4	3	2	1
5. Use of hands and arms	5	4	3	2	1
	Totally self sufficient	Needs verbal advice or guidance	Needs some physical help or assistance	Needs substantial help	Totally dependent
B. Personal Care Skills					
6. Toileting (uses toilet properly; keeps self and area clean)	5	4	3	2	1
7. Eating (uses utensils properly; eating habits)	5	4	3	2	1
8. Personal Hygiene (body and teeth; general cleanliness)	5	4	3	2	1
9. Dressing self (selects appropriate garments; dresses self)	5	4	3	2	1
10. Grooming (hair, make-up, general appearance)	5	4	3	2	1
11. Care of own possessions	5	4	3	2	1
12. Care of own living space	5	4	3	2	1

SOCIAL FUNCTIONING

	Highly typical of this person	Generally typical of this person	Somewhat typical of this person	Generally untypical of this person	Highly untypical
C. Interpersonal Relationship					
13. Accept contact with others (does not withdraw or turn away)	5	4	3	2	1
14. Initiates contact with others	5	4	3	2	1
15. Communicates effectively (speech and gestures are understandable and to the point)	5	4	3	2	1
16. Engages in activities without promoting	5	4	3	2	1
17. Forms and maintains friendships	5	4	3	2	1
18. Asks for help when needed	5	4	3	2	1

SOCIAL FUNCTIONING

D. Social Acceptability	Never	Rarely	Sometimes	Frequently	Always
19. Verbally abuses others	5	4	3	2	1
20. Physically abuses others	5	4	3	2	1
21. Destroys property	5	4	3	2	1
22. Physically abuses self	5	4	3	2	1
23. Is fearful, crying, clinging	5	4	3	2	1
24. Takes property from others without permission	5	4	3	2	1
25. Performs repetitive behaviors (pacing, rocking, making noises)	5	4	3	2	1

COMMUNITY LIVING SKILLS

E. Activities	Highly typical of this person	Generally typical of this person	Somewhat typical of this person	Generally untypical of this person	Highly untypical
26. Household responsibilities (house cleaning, cooking,	5	4	3	2	1
27. Handling personal finances (budgeting, paying bills)	5	4	3	2	1
28. Use of telephone (getting number, dialing, speaking, listening)	5	4	3	2	1
29. Use of leisure time (reading, visiting friends, listening to music)	5	4	3	2	1
30. Recognizing and avoiding common dangers (traffic safety, fire safety)	5	4	3	2	1
31. Self-medication (understanding purpose, taking as prescribed, recognizing side effects)	5	4	3	2	1

Diagnosis: ☐ Depression ☐ Dementia ☐ Psychosis ☐ Anxiety ☐ Other (describe) _____	Age: () ☐ Under 55 ☐ 55-75 ☐ 76-85 ☐ 85+	Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other (describe) _____
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Other Comments:

Number of visits:

RN:

MSW:

PT:

OT:

RHA:

APPENDIX B

San Jose State University

Human Subjects Institutional Review Board

Approval Letter

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

TO: Janet Duffey
551 East Military
Benicia, CA 94510

FROM: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies & Research

DATE: September 5, 1996

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Psychiatric Outcomes: Detecting Changes in the
Level of Functioning in Elderly Home Care Clients
with Depression"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Serena Stanford, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at (408) 924-2480.