1-209 Time to do DOS

TIPS Question:
We are using an elopement watch q _ hour and find it hard to keep staff on track completing it. Could we adapt DOS sheet to either target a specific behaviour or decrease to q one hour while behaviour is acute because q _ hour for 2 weeks seems overwhelming? I can see merit to using DOS but time-wise doesn't seem practical.

Response:

If there is a specific behaviour you are trying to monitor for its frequency, the time of day when it occurs, whether there is a pattern over the course of the day, week, etc., yes, you can adapt the behavioural key to reflect the unique needs of the resident. If the legend does not include the behaviour of concern you can add it. Similarly, if you are sure that certain behaviours indicated on the legend (e.g. verbal or physical aggression) are not problems you can remove them if that seems to help staff in terms of their perception about the amount of work involved. I would, however, like to caution you about observing and recording only 'negative' behaviours. It is extremely valuable to know the 'positive' behaviours as well (e.g. calm/awake). This may have implications for care e.g. activity planning, etc. It also helps to avoid focussing only on the problems or the limitations of the resident rather than on his/her strengths.

I always find it helpful to remind myself that screening tools are used within the context of a structured assessment and as such provide only part of the picture. They are not a means unto themselves. Once you have gathered the data; whether it is regarding the pattern of the person's behaviour (using the DOS, CMAI, ABC's etc), his/her cognitive functioning (MMSE/Clock), or emotional health if you are concerned about mood (Cornell; SIGECAPS, etc), you want to use those results to help answer specific questions. The information you then gather and the answers to those questions should help to direct the care plan.

From your question it appears that you have very specific concerns about the resident's exit seeking behaviour. I can certainly appreciate your worries about safety. When exit seeking behaviour emerges it can of course be for a variety of reasons; e.g. a resident's fear and anxiety caused by the unfamiliar, or wandering that becomes exit seeking in response to certain environmental triggers (e.g. staff coming and going at change of shift), or when a resident knows h/she is in a LTCF and due to poor self-awareness/insight does not recognize the need for assisted care. I am sure that in addition to gathering information about when the behaviour occurs, if there is a pattern, etc. your assessment includes identifying possible underlying causes – think P.I.E.C.E.S.

You can reduce the recording to q 1hour intervals if you know the behaviour(s) of concern do not occur with high frequency but I like q _ hour intervals because of the richness of the information it provides. While absolutely recognizing the constant pressures on staff re: time, the decision about what tools to use, at what intervals, etc. should be determined by the questions you are trying to answer; as this will always give you the best information to help you with care planning. If you think a period of 7 days will give you what you need then by all means record for 7 rather than 14 days. At some point after you change the care plan you may want to record for another 7 days to see if the interventions are working.

Just a word about getting staff 'buy-in' and your role as a resource and a 'coach'; Remember that direct care staff know the resident very well. Their participation in the gathering of information using the tools e.g. Cohen, DOS, SIGECAPS, etc. provides an excellent opportunity for them to share what they know. Their observations are valuable and indeed critical to the assessment and care planning process. It is important to convey to them that you are trying to build on their knowledge and experience, validating what they already know. Coaching them in the use of the tools will be more effective when it is case-based rather than general (the teachable moment), and if they feel they have some control in the process and decision-making. Providing them with ongoing feedback on the results i.e. how their observations and their knowledge about the resident have been captured by using the tools, and exploring ways of having them involved in the process e.g. having them share in the presentation of the information to the rest of the team involved in the resident's care including the physician, specialty geriatric team partners, etc. Also providing them with opportunity to reflect on and refine the process of gathering information using the tools will be valuable – what worked well, how could things be changed, how effective was communication between and among team members and

Time to do DOS continued

how could it be improved?

You may want to have a look at the TIPS Resource Centre on the P.I.E.C.E.S. Website as there are a number of TIPS responses addressing questions about the use of the DOS and other tools, as well as how to get staff 'buy-in."

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*