1-204 Ensure the continuity of successful intervention

TIPS Question:

Do you have any suggestions to ensure the continuity of a successful intervention re: behaviour is carried out over all shifts involved? I find everyone is happy when the intervention works successfully but it gradually becomes lost and the problem reoccurs. Interventions are in care plans and master profiles and on the HCA Behaviour Flow Sheets.

Response:

The most important factor relating to continuity of a successful behavioural intervention is: consistency.

Consistency is largely dependent on:

1. Communication of the behavioural intervention
2. Caregiver's responses
3. Complexity of behavioural intervention
4. Client's profile:
   - abilities and cognitive status
   - understanding of intervention
   - disease process

1. You stated that the interventions are in care plans, etc. It sounds like you and the team are making an excellent effort in increasing communication. I find it very common that shifts carry through behavioural plans differently. Facilities have had to get together and be very creative in their communication techniques.

2. Note the write-up on "Your Response" from fall training. People need to be aware and objective of their own responses as we do not always know how we are perceived by others.

3. Complexity of behavioural interventions vary according to the inappropriate behaviour; staff/client ratio; staff experience with behavioural interventions, etc. You may remember from the fall session that complex behaviour interventions are not recommended for facilities. It is often too difficult to ensure consistency, especially across shifts.

4. Client's profile must be understood before a behavioural intervention can be designed. This is especially true regarding cognitive status. It would be interesting to first ask those involved what they think the cognitive status is and then present assessment information. This can be very meaningful if done in a supportive manner. People often over-estimate a person's cognitive abilities. You might want to consider a frontal-lobe type dementia that exhibits disinhibited types of behaviour, i.e. verbal abuse. This type of dementia actually scores quite high on the M.M.S.E. For this reason staff may falsely assume that the person "knows what they are doing". Questions that focus on reasoning and problem solving would capture a frontal lobe type of dementia.

Whenever the care plan does not appear to be working it is always helpful to take a step back and as a team ask ourselves, what information do we have and what do we still need to know?

- At this point it is always worth reviewing, as inclusively as possible, who are the partners involved in this person's care and should we be considering anyone else. This is a good opportunity to look for partners (both internally and externally) that may not be as actively involved as possible. Remember to include the family – sometimes it is helpful to review their role in both the assessment (or reassessment) and care planning stages to see if their involvement can be enhanced.
- It will be important to think back to the problem/behaviour that was identified as a concern. While there is always an antecedent or triggering factor to behaviour, the process of identification can sometimes be complicated – for example, there may be more than one antecedent or trigger, and they may fluctuate. As a result, we sometimes have to take a second run at it.
- If you administered either the DOS or the Cohen Mansfield Agitation Inventory it might be helpful to re-administer one or both of these tools – has the information changed, is a pattern more evident or different, what does it tell you about the triggers now?

- Review the possible causes again – including all aspects of the P.I.E.C.E.S. framework i.e. physical (ruling out disease, infections, drugs effects, delirium and discomfort); intellectual (do we know everything we need to know about this resident's cognitive functioning – how are they experiencing/interpreting their environment and the actions of others?); emotional (possible mood changes, psychosis), is there a good match between the person's capabilities and what is expected of him/her, etc.; are there environmental factors that could be triggering the behaviour, or that might be considered as possible interventions; has anything been overlooked in terms of understanding this person's social, cultural, background and how it might shape expectations for care.
- The above review will provide the basis for reformulating the care plan as appropriate – take another look at the goals; are they still realistic, do they need to be reformulated, do we need to communicate the plan differently (what worked, and what did not) to optimize consistency in approach. Sometimes the plan of care is appropriate but there are challenges in the implementation – it may be helpful to review the suggestions for Questions 6 – *What are the best care strategies* re: goal setting, deciding on the plan, trying it out and evaluating its effectiveness
- It is discouraging when we have developed a plan of care based on a comprehensive assessment, and problems persist. Retracing our steps can be very helpful and not as time consuming as you might think – but always time well spent. Using a structured and systematic approach to reviewing the issues again helps keep us focused.

You are correct in identifying that people are happy when the intervention works successfully and then it gradually becomes lost and then the behaviour reoccurs. I often warn people of this cycle. It is human nature not to work too hard on a behavioural intervention when the behaviour is no longer causing stress. Perhaps when you point out this cycle to the staff they will try to "hang-on" to the behavioural intervention longer. I find a reminder meeting helps keep staff committed.

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.*