Grip on Challenging Behaviour

Zwijsen, S.A.

2014

document version
Publisher's PDF, also known as Version of record

Link to publication in VU Research Portal

citation for published version (APA)
Zwijsen, S. A. (2014). *Grip on Challenging Behaviour: Development, implementation and evaluation of a care programme for the management of challenging behaviour on dementia special care units*.

Introduction

The main goal of the research project described in this thesis was to develop and study the effects of a care programme that that would be able to guide care teams in managing challenging behaviour. By structuring the management of challenging behaviour and prearranging multidisciplinary involvement it was expected that the care programme would be able to diminish challenging behaviour-related outcome measures. This chapter summarises and discusses the main findings of this project. It also addresses the methodological issues and the implications for clinical practice and health care policy. Finally, the implications for further research are discussed.

Summary of the main findings

Chapter 2 and 3, study protocol and development of Grip on Challenging Behaviour (GRIP). In chapter 2, the design of the GRIP project is described. A stepped wedge design was chosen, in which different clusters of Dementia Special Care Units (DSCUs) cross over from control to intervention condition over time. Resident outcomes were planned to be measured on six separate occasions, and care staff outcomes were planned to be measured over three separate occasions. In total, a 20-month period was chosen to implement GRIP and study the effects.

In chapter 3, the development process of GRIP is described.

GRIP was based on the national and international guidelines for the management of challenging behaviour. Several expert meetings were organised to further develop the structure of GRIP and the accompanying forms. In the expert meetings, discussions regarding the goal, content, and feasibility of GRIP were held with representatives from different disciplines engaged in long-term care for people with dementia. This development process resulted in a structure for the multidisciplinary management of challenging behaviour that can be used by the several involved disciplines (e.g. care staff, psychologist, physician). The structure of GRIP consists of four steps, which are detection, analysis, treatment, and evaluation. Detection can be performed by care staff either in daily care or by a detection tool which is administered every six months. After challenging behaviour is detected, the care staff fills in an analysis form and consults either the psychologist or physician. Both clinicians can use their own analysis form, which is based on the discipline-specific guidelines. After the analysis, a treatment plan is formed based on the results of the analysis. Finally, by using a flow chart, the evaluation takes places. The structure of GRIP, individual steps and forms, and underlying principles of GRIP are all explained through two training sessions at the start of the implementation.

Chapter 4, process evaluation of the implementation of GRIP.

To evaluate the validity of the results of the effect study on GRIP, as well as to evaluate the barriers and facilitators to implementing GRIP for future implementation purposes, a process evaluation of the implementation of GRIP was undertaken. In chapter 4, the results of the process evaluation are described. The first order process data show that the preconditions for implementation and interpreting the effects of implementation are met; e.g. the recruitment and reach both allow for the generalisation of the results and GRIP was judged to be feasible and relevant to long-term dementia care.

The initial reaction of the care teams to the implementation of GRIP was positive. People were confident that GRIP could reduce challenging behaviour and they were contented with the structure GRIP could bring to the way challenging behaviour is managed. Through interviews and questionnaires, facilitators and barriers for implementing GRIP could be determined.

First, there were organisational aspects that hindered the implementation. Although in the preparation of the project, the management of the participating organisations was thoroughly informed about the (time) investment the project would cost, factors such as high workload, staff turnover, concurrent projects, insufficient time for multidisciplinary consultation, and organisational changes hindered the implementation in some of the DSCUs. In some cases there seemed to be a gap between the management, which judged the implementation of GRIP to be possible and desirable for their organisation, and actual daily care practice. These findings demonstrate the value of conducting a process evaluation, as these factors can be reckoned with in future implementations, for instance by involving more care staff members and clinicians in the decision making process on participating in the implementation of GRIP.

Next, the culture of the organisation could form either a barrier or a facilitator for implementing GRIP. The support of a key person who was enthusiastic about using GRIP made an obvious difference in the implementation rate, and accordingly, when a key person resigned, it was very difficult to maintain enough attention for the use of GRIP. In addition, in the project there were units with a culture open to change and innovations, whereas there were other units that were more focused on keeping things the way they were.

Lastly, there were specific aspects of GRIP that formed a barrier for implementation for some units. The amount of forms that were used put some people off and the fact that GRIP was not digitally available meant that for some units the working method of GRIP did not attune with other working methods in daily care. Again, these are factors which can be reckoned with in future implementations.

Chapter 5, effects on resident outcomes.

The effects of GRIP on challenging behaviour and the use of psychoactive drugs and restraints are described in chapter 5. The effects on the main outcome measurement, the Cohen Mansfield Agitation Inventory (CMAI)[1], were small. There were no effects on the total amount of clinically relevant neuropsychiatric symptoms measured with the neuropsychiatric

inventory (NPI-NH)[2], but significant positive effects on residents showing signs of delusions, depression, apathy, disinhibition, and aberrant motor behaviour were found. Furthermore, significant effects on the prescription of antipsychotics and antidepressants were found. No changes in restraint use were found. Adjusting analyses for the implementation rate shows that better implementation leads to larger effects of GRIP.

Chapter 6 and 7, the experience of challenging behaviour by care staff

Next to diminishing challenging behaviour and the use of psychoactive medication, the impact of challenging behaviour on care staff was also considered an important field of research. First of all, there seemed to be a lack in the literature about the relation between individual forms of challenging behaviour and the experience of distress of care staff. Therefore, in chapter 6, a closer look is taken at this relation. It became clear that agitation causes the most distress for care staff and that euphoria causes the least amount of distress. Furthermore, the severity of symptoms is a far more important predictor for the amount of distress experienced by care staff than the frequency of behaviour.

The results that were found differ from the research amongst informal carers. For example, delusions and apathy do not cause as much distress in formal care as in informal care. In case of delusions, this might be a sign of a positive professional attitude, in case of the latter, apathy, this might be a sign of professional indifference, which asks for more education and attention for the seriousness of this symptom.

Chapter 7 proceeds with the effects of the use of GRIP on professional carer outcomes. According to the demands-control-support (DCS) model, high-demand jobs with low decision authority and low work-related social support increase the risk for burnout and lowered job satisfaction. In the Grip on Challenging Behaviour study, no beneficial effects on burnout were measured, but job satisfaction improved when GRIP was used. The introduction of GRIP has probably led to an enhanced feeling of decision authority and social support, which, according to the DCS model, has led to higher job satisfaction while job demands stayed the same.