Behaviours That Challenge

SEPTEMBER 2011
Behaviour / what is it?

- Behaviour is neutral - we interpret and put a meaning on it

- Behaviour is anything we do - walking, talking, sneezing, coughing, dancing, etc

- It is a unique feeling of life and one that is observable
Behaviours That Challenge, A Definition

“Behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities”

(Eric Emerson – 1987)
Behaviour Audit Findings 2009

Behaviour Audit
Older Persons Care 2009

Verbal Aggression 16.7%
Physical Aggression No Injury 28.8%
Physical Aggression Mild-Mod Injury 16.7%
Mean Average 13.2%
Sexual Inappropriate Behaviour 3.0%
Near Miss Incidents 34.8%
Behaviours that Challenge

- Behaviours that challenge have a purpose
- Behaviours that challenge communicate
- Behaviours that challenge are generally not random
- A specific episode of behaviour can serve multiple purposes for the resident
Examples of Behaviours that challenge

An individual may display one, several or all of these:

- Aggression (hitting; kicking; biting, spitting)
- Disruption (of other people)
- Wandering Behaviour
- Destruction (ripping clothes; breaking windows)
- Self – injury (eye-poking; head banging)
- Stereotyped behaviour (rocking; echolalia = repetitiveness)
Behaviours

- Many behaviours require minimal intervention to eradicate them once assessed
- Typically an Intervention / Activity programme often assists / eradicates the behaviour
- Understand that we CANNOT change them; the resident / client, we can only change OURSELVES and the ENVIRONMENT
- Understand that in most cases, their response is not really about you, it’s about the situation and their own turmoil and inability to cope with it
- Medication is only introduced as a last resort
Behavioural interventions assist in...

- Protecting our Residents from danger
- Meeting their physical and medical needs
- Helping them to manage distressing emotions and to change inappropriate behaviours
- Creating opportunities for them to engage in activities that they find interesting and enjoyable
- Creating opportunities for them to have new experiences and to learn new skills
- Joining with other staff, family members and others to provide a supportive network for each resident
The referral process in COH

- **Guidelines for Behaviours that challenge referrals to CNS**
- On admission there is no initial assessment unless a behaviour is evident and the following procedure is followed
- All emergencies will take priority whether behaviour exhibited is an isolated incident or not
- When Behaviour that challenges is identified on the unit, line manager / nurse in charge to put a care plan in place or delegate S/N to input same
- All care plans for Behaviour to be separate i.e. verbal, physical, wandering each require an individualised care plan
- Line manager / nurse in charge to assess the risk using the HSE risk assessment in accordance with hospital policy and risk assessment to be put in residents care record immediately
CNS referral’s

- Referral form for CNS Behaviour to be completed (ensure all details are filled in) and sent with a copy of the HSE risk assessment to the CNS.

- The CNS will contact the unit and give an estimated time frame when assessment will be carried out.

- Referrals are prioritized and severity of behaviour will always require immediate assessment.

- On assessment the CNS will decide whether further information to assess the behaviour is required and if deemed necessary will implement same.

- When further documentation is implemented the time frame may vary from two to four weeks for documentation of behaviours, it is important to note only the resident referred will be assessed on this document after the referral has been received and it is not for use on any other resident unless stated by the CNS.

- When documentation is in use staff must not add any additions or examples to the existing document all staff are required to do is fill in the criteria requested.
CNS Assessment

- The CNS will carry out a functional assessment gaining information from the resident, their significant other, staff; medical & nursing notes.
- A functional analyses will then be carried out; this is where the Abc is initiated to take observations to answer the question why is the behaviour that challenges occurring.
- When the information is obtained Behaviour in residents / clients can be far better managed and even more successfully changed when the interventions are based on a functional analysis of ABC data.
The ABC Form

- The ABC form is initiated after the CNS carries out a behaviour assessment.
- The ABC form is a direct observational tool that provides information about what is really happening in the resident’s / clients environment.
- Information gathered by the CNS during interview with the resident / client is compared to the information from observations occurring in the environment.
- ABC = Antecedent-Behaviour-Consequence
Guidelines for using the ABC Form

- Cherry Orchard Hospital
- Staff please read before completing documentation
- Guidelines for using the ABC functional analyses chart
- When documenting

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The Antecedent is what the resident was doing before the behaviour occurred e.g. were they sitting down watching television, were they walking on the corridor, were they having their dinner etc. (please do not write the behaviour here) also write the name of staff and any other resident involved.

- The target behaviour is the behaviour they exhibited e.g. were they shouting at staff or residents, did they physically hit out at staff, here you must also document what you clearly define as aggressive or inappropriate behaviour, write what they said the residents words not your interpretation (E.G. writing verbally aggressive is not acceptable, clearly state how the resident was verbally aggressive)

- The consequence is what happened when the target behaviour stopped e.g. were they reprimanded by staff, did they return to their room, did they walk away from the area where the behaviour occurred, document exactly what they did
**Sample Functional Behaviour Assessment Chart**

**Target Behaviour:** Please complete each time the resident / client engages in a target behaviour i.e. (the specific behaviour) for example each time the resident / client is hitting out

<table>
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<tr>
<th>Date / Time</th>
<th>Antecedent (before)</th>
<th>Target Behaviour (what is the problem behaviour?)</th>
<th>Consequences (after) what did you do? What did you say to the resident / client? What did the resident / client do?</th>
<th>Staff please sign and print name</th>
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Analysing the data from the ABC

- Data is analysed after a two to four week period in an attempt to identify correlations between times of day, activities & behaviours exhibited or any precipitating factors identified.

- From here an MDT meeting is arranged to discuss findings identified from the ABC; an MDT individualised plan of care is formulated and initiated.

- Individualised plan of care will include:
  - Problem need identification
  - Goal specification
  - Specific interventions
  - Specific MDT Interventions
  - Monitoring & ongoing reassessment
  - Communication
  - Information & education
  - Plan of care is evaluated at two weekly intervals unless otherwise indicated by the team.
SAMPLE CARE PLAN
(to be reviewed in 3 months and re-written in 6 months)
Topic Heading: Sample (Behaviour) Care Plan

This Care Plan has been discussed, agreed and drawn up with the involvement of the Resident or their Significant Other: ☐ Yes ☐ No. Signed.................................(Resident/Significant Other)

(If the resident/significant other is unable or unwilling to participate a narrative note must be recorded)

DateSignature01/01/10

PROBLEM / NEED IDENTIFICATION

Mary displays verbal aggression related to acquired brain injury

GOAL SPECIFICATION

To reduce and / or fade out Mary’s episodes of verbal aggression by 2 weeks

SPECIFIC INTERVENTIONS

■ All staff must use the same firm approach with Mary when aggressive behaviour is exhibited.
■ Do not respond back to any verbally aggressive statements/behaviours exhibited by Mary.
■ Staff will react in a calm voice and attempt to redirect the conversation, (Use the Information obtained in the “A key to Me” to redirect the conversation).
■ Do not revisit the behavioural event, as Mary is unlikely to remember what has happened. This serves no useful purpose.
- Staff should re-establish communication with Mary after each episode has resolved.
- Always explain to Mary any procedures staff wish to carry out.

- If Mary becomes agitated when staff are attempting to carry out a procedure walk away and approach again later if safe to do so. (within hour)
- Ensure routine medications are administered at the correct times.
- Refer to Mary’s preferred activities see Meaningful Activities Care Plan.
- Mary particularly likes the rummage box and her life story being read to her.
- Allow time for Mary to express herself e.g. anxieties, fears. Offer Mary reassurance and encouragement at all times
- Monitor / observe and document any verbal/ non-verbal signs of aggression e.g. rigid body, clenched fists or verbally aggressive behaviour using the ABC Functional analyses form as directed by the CNS
- Note any triggers evident prior to the behaviour
- Document clearly any incidence of behaviour
- Refer Mary back to the MDT before her scheduled evaluation date should there be a deterioration in behaviour despite following interventions implemented by the MDT.
- Educate resident, significant other and family on interventions implemented & EVALUATION OF CARE *(based on goals specified)*
Mood Chart Recording

- **Behaviour/Mood Chart**
  - Choose from the following e.g. if “Angry mark © in box
  - Please only record one category in the time frame, record the category that happens the most frequent in that time frame

**EXAMPLES**
- A = Anxious/agitated/frightened
- B = Frustrated
- C = Angry
- D = Happy/content
- E = Verbally Aggressive
- F = Overly Happy
- G = Engaged in Activity
- H = Sad/unhappy/depressed
- I = Asleep

The mood chart helps identify times of day that activity interventions can be put in place to reduce & or fade out behaviours exhibited

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Butterfly approach

- A tool developed by David Sheard, Dementia care Matters 2008; works well with all residents regardless of dementia diagnosis or not
- A useful intervention to prevent the possible risk of social isolation & promote inclusion is the adapted butterfly interaction activity programme
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Adapted butterfly interaction activity programme
Please allocate staff daily to rotate carrying out a 1:1 activity with resident
For a minimum of ten minutes every 2 hours e.g. conversing, newspaper reading, life story, listening to music etc (staff please encourage resident to interact) only the activity that staff implements with the Resident is to be recorded not the care routine

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Audits

- In COH Behaviour Audits are carried out Annually & consist of
  - Staff Incidences
  - Older persons care units
  - Dementia care units
  - Young chronic sick units
  - Immunocompromised & drug detoxification units

- A data base of all incident reports received is maintained by the CNS, they are correlated weekly & calculated annually unless otherwise indicated

- Data is graphed, findings & Action Plan developed

- Comparison study of previous year is also completed
Comparison of Behaviour Audit
Older Persons Care 2009 & 2010

- Verbal Aggression
  - 2009: 16.7%
  - 2010: 6%

- Physical Aggression
  - No Injury
  - 2009: 28.8%
  - 2010: 14.8%

- Physical Aggression
  - Mild-Mod Injury
  - 2009: 16.7%
  - 2010: 8.9%

- Sexual Inappropriate Behaviour
  - 2009: 3.0%
  - 2010: 3.7%

- Near Miss Incidents
  - 2009: 34.8%
  - 2010: 66.6%
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Comparison Audit

2009 & 2010

- Incident / accident reporting on behaviours that challenge

- Area: Older Persons Care

A total of 66 incident report forms were received between the period of January 1st 2009 to December 31st 2009

A total of 135 incident report forms were received between the period of January 1st 2010 to December 31st 2010

These were then divided into five categories

- Verbal aggression exhibited
- Physical aggression exhibited, no injury (includes spitting)
- Physical aggression exhibited and/or received by resident (such as hitting, kicking, pinching, scraping) resulting in mild – moderate injury (such as bruising, scratch, localised pain, strain/sprain)
- Sexual inappropriate behaviour exhibited by resident
- Near miss incidents (includes breaking items & leaving unit unaccompanied)

The findings were as follows

- Verbal aggression in 2009 = 16.7% & 2010 = 6% showing a reduction of 10.7%
- Physical aggression no injury in 2009 = 28.8% & 2010 = 14.8% showing a reduction of 14%
- Physical aggression mild – moderate injury in 2009 = 16.7% & 2010 = 8.9% showing a reduction of 7.8%
- Sexual inappropriate behaviour in 2009 = 3.0% & 2010 = 3.7% showing an increase of .7%
- Near miss incidents in 2009 = 34.8% & 2010 = 66.6% showing an increase of 31.8% (as a result of behaviour interventions staff intervene thus preventing the occurrence of an acting out event)
Comparison study
Action Plan
2009 & 2010
Audits:
January 1st 2009 to 31st December 2009
January 1st 2010 to 31st December 2010
Data Analysed and Action Planned
Topic: Accident / Incident Reports on Behaviours that Challenge
Areas
▲ Older Persons Care Units

The action plan from the findings of this comparison audit include
Ongoing education on behaviours that challenge & communication strategies in the health care setting throughout the campus
▲ Continuous evaluation of the impact education has on staff practice, (through direct & indirect observation of interventions used to re-direct / de-escalate situations & to monitor the outcome
Focus for education
▲ Residents and significant other
▲ All grades of staff, (including agency and relief staff)
Incident / Accident Recording
▲ Correlate incidents weekly to establish patterns to specific residents and assist in assessing, planning, implementing & evaluating personalised plans of care for residents exhibiting behaviours that challenge, (resident case load)
MDT incident review group to meet as required to discuss individual action plan of care (for behaviours that challenge); also to establish outcome of interventions implemented, progress and / or need for further interventions

Risk Assessments

Ongoing Risk assessment implementation and education with all grades of staff

Ongoing Monitoring

To identify target the behaviours exhibited in specific areas and the needs throughout the campus

Identify the staff for retraining in non-crisis prevention intervention training

MDT Meetings

Weekly Ward rounds/ Resident reviews established to assess resident’s progress, review of medications, planning desired activity schedule, receive suggestive evidence from Multidisciplinary team on incidence of behaviours that challenge

Resident case review to include family members and / or significant other when any ongoing target behaviours are identified

To re-audit December 31st 2011 to establish the effectiveness of the interventions delivered in Behaviour management by reduction in incident reporting; to target education from the data analysed for future education

Comparison study of previous audits annually
Policy & Procedures

For Behaviour interventions to work

- Know the existing policy
- Know the referral system to the CNS Behaviour
- Report any behaviour that you feel is out of the ordinary
- Ensure any incident of behaviour that challenges is recorded; following the hospital policy guidelines

“once you have tried behavioural interventions, you'll want to do it again”