

Best Practice in the Management of Complex Behaviors in Patients with Acquired Brain Injury (ABI)

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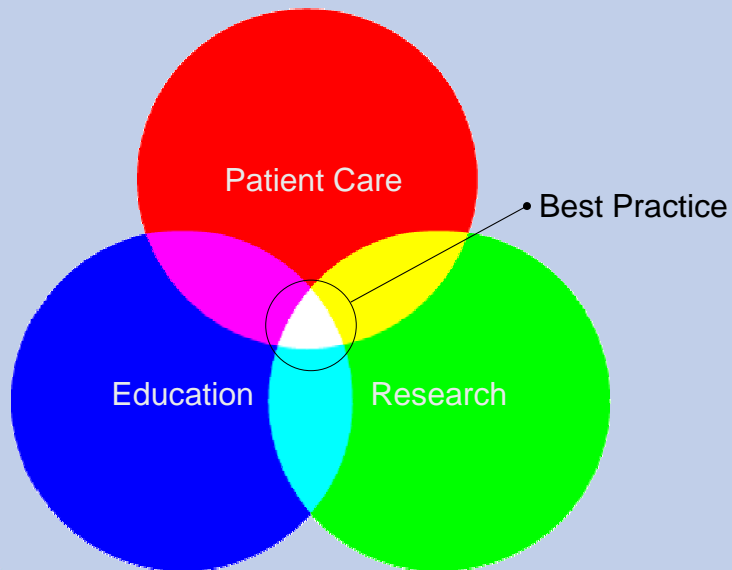
Overview

- Review Toronto Rehab's Best Practice Model
- Overview of application to behavior management in ABI program
- Current implementation to date
- Next steps



Model & Process for Clinical Best Practice at Toronto Rehab

- developed to facilitate a systematic and consistent approach to best practice;
- defines the process of best practice in the context of rehabilitation;
- guides clinicians in identifying patient needs, reviewing present practice, determining best practice priorities, facilitating and implementing best practice, as well as evaluation of patient-based outcomes and sustainability.





ABI Program at Toronto Rehab

- 31 in-patient beds (16 NC and 15 NP)
- Secured unit
- Moderate to severe cognitively impaired patients
- Frequent behaviors seen:
 - Severe episodic memory
 - Agitation/aggression
 - Exit seeking/wandering
 - Impaired insight and judgment
 - Sexual inappropriateness (verbal and physical)



Patient Need

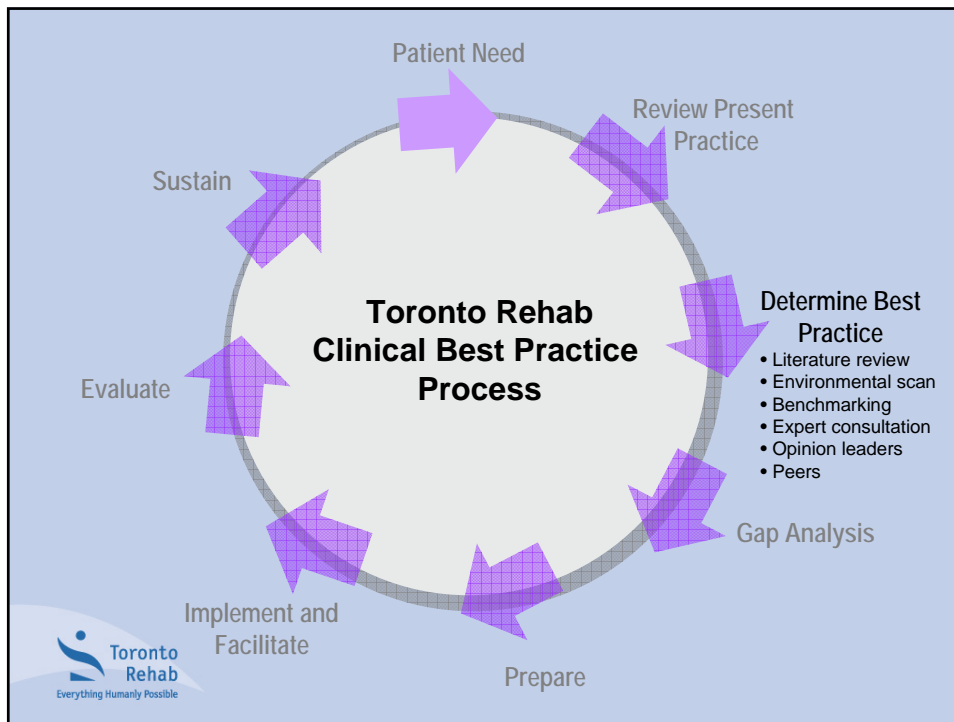
- Patient satisfaction surveys
- Patient and family focus groups
- Interprofessional working group
- APL needs assessment
 - Observation feedback from staff & management
 - Rounds discussion
 - Discharge challenges
 - Transitions across continuum





Problem Solving Worksheet

Current State	Preferred State	Gap Summary	Actions to Close the Gap	Expected Outcome	Potential Indicator
-Patient -Staff Practice -Issues -Education -Resources -Data sources					



Determine Best Practice

- Literature review performed
 - Neurobehavioral approach
 - The application of behavioral principles to challenging behaviors in ABI as informed by knowledge of brain-behavior relationships
 - Kreutzer
 - Wood
- Ongoing peer consultation with local experts
- ABIKUS (ABI Knowledge Uptake Strategy – led by Dr. Mark Bayley)

Determine Best Practice

- **Examples of Best Practice**

- **Recommendations – ABIKUS Conference**

- Staff should be trained in specific behavioural change strategies, especially in understanding of brain-behaviour relationships, and applied consistently. (C)
 - Behavioural Assessment data must identify possible or probable cause/function of targeted behaviour. The relationship of environmental triggers, and reinforcing events to the occurrence of both target behaviours and adaptive alternatives must be described. The influence that brain injury-related cognitive and communication impairments are hypothesized to play in the expression of behaviour must be described. (B)



Gap Analysis

- Behavior management more reactive rather than proactive
- Did not actively address the precipitating factors (antecedents) that contribute to behavioral problems
- ABI application did not always contain the information required to anticipate and plan effectively for behavioral patients



Gap Analysis

- Nursing assignment and continuity of care
- Interprofessional team knowledge related to behavioral management
- challenges in our ability to effectively and consistently communicate behavior plans and changes to the behavior plans to all staff working with a behavioral patients

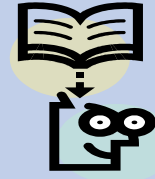




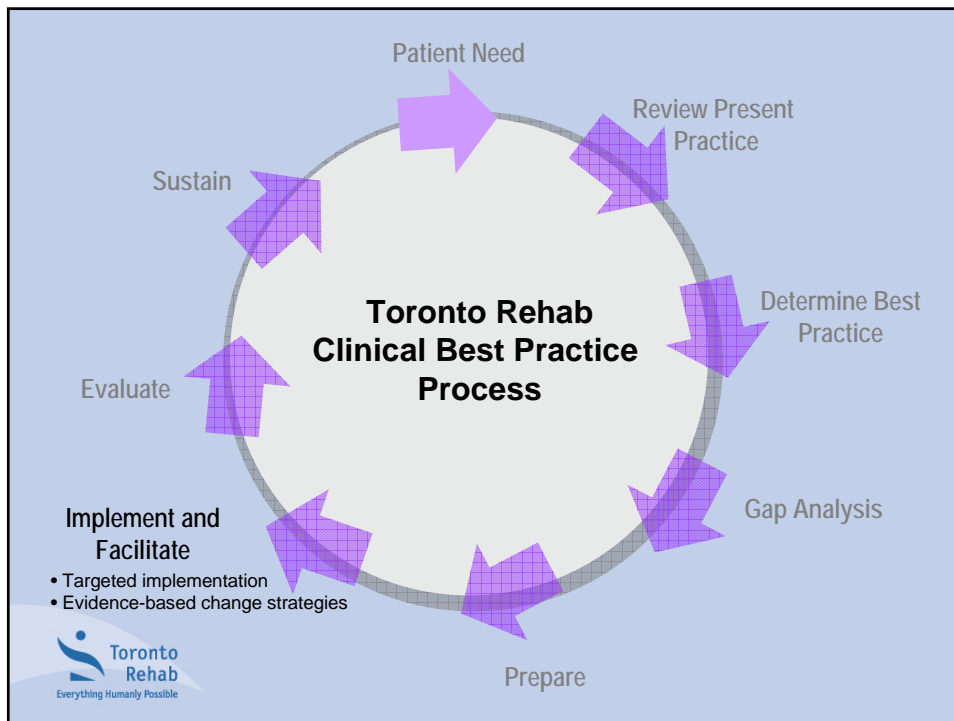
Prepare

- Identify resources
 - Internal program expertise and passion
- Identify enablers
 - Management team support, new care delivery model
- Stakeholder engagement and buy-in
 - Interprofessional working group, ABI Network
- Identify and address barriers

Prepare



- Identify champions
 - Interprofessional working group, behavior management team
- Identify education needs
 - Education needs assessment via focus group
- Implementation plan
 - Action plan with targets outlined for implementation and indicators to be monitored quarterly via scorecard



Implementation



- Phased approach
 - TRI participation in Restraint subgroup – ABI Systems Coordination Committee
 - Input into referral form
 - ABI Network form revision 2006
 - GTA common referral form in 2007
 - Behavioral approach to admission process with proactive behavior management where appropriate
 - Primary nursing care delivery model implemented enhancing continuity of care

Implementation



- Behavioral workshop
 - All IP staff stroke and ABI
 - Workbook created
- Agitated Behavior Scale (ABS)
 - In-services to nursing staff and IP team in early 2007
 - 7 day graphed results reviewed and reported at pharmacy and team rounds

Implementation



- Behavior Orientation
 - Focus on nursing and to be expanded to all clinical staff
- Interprofessional competencies developed for behavior
- Education/mentorship toolkit being developed for orientation / CPD



Evaluation



- Quarterly indicators
 - Code white/yellow, 1:1 hours, behavior incidents (staff and/or patient injuries), repatriation of admissions related to behavior
- Consults
- Pre-post testing for behavior workshops
- Compliance with completion of ABS
- Process indicators – project benchmarks

Evaluation - Results



- Significant decrease in frequency of;
 - Code white (agitated patient)
 - Code yellow (missing patient)
 - Staff/patient incidents and injuries
 - 1:1 usage required
- >90% compliance with the use of the ABS with nursing



Sustainability

- Implementing “just in time” education
- Integrating into pre-existing and supported processes (admissions, rounds)
- Standardized communication and care planning processes related to behavior
- Quarterly reporting on indicators
- Case reviews and debrief critical incidents
- Formalize behavior in orientation

Next Steps

- Toronto Rehab corporate review and population specific implementation of falls prevention best practice
- Exploring how to support ABI patients in other programs more effectively within existing resources



Final Thoughts...

- Real change takes time...be patient and tenacious!
- Working with behavioral patients can be stressful – support staff through difficult cases and recognize successes big and small
- Management support and stakeholder buy-in was critical to our success

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Questions?

