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Interdisciplinary development and implementation of a dementia skills training program in a VA community living center: a pilot study

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ABSTRACT

This pilot study investigates the usefulness of a dementia care training program developed by an interdisciplinary team to address problem behaviors associated with dementia. Staff members of a VA Community Living Center completed an 8-hour workshop covering fundamental knowledge about dementia and instruction in skills to use with patients through video, lecture, and role-plays. Measures on dementia knowledge and perceived self-efficacy were completed by staff members before and after the workshop. Results revealed increases in self-efficacy and knowledge, with particular gains in general knowledge of dementia and communicating with patients. Younger staff members scored higher on tests of knowledge at pre- and post-test, whereas staff members with more years of work experience rated their self-efficacy higher at post-test only. There was an associated decrease in assaultive behaviors by patients with dementia in the year this workshop was implemented. Results highlight the benefit of interdisciplinary collaboration in developing educational content and the value of providing staff training on managing dementia-related behaviors. Adjustments to this training program are discussed.

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Introduction

Over 5 million Americans are estimated to be currently living with Alzheimer's disease or another dementia.¹ As cognitive and functional abilities decline with the degenerative forms of dementia, most persons with these diseases will exhibit behavioral and/or psychological symptoms.^{2,3} Although many factors can result in the decision to place a loved one in long-term care, caregivers are often less concerned about the memory decline as they are about behavioral excesses. These challenging dementia-related behaviors are among the more commonly cited reasons for placement in a long-term care facility.⁴

Once in the long-term care environment, some of the most challenging dementia-related behaviors are those that require the greatest amount of nursing attention. These behaviors can be hazardous to the patient, other residents, and staff, such as wandering, resistance to care, general restlessness, and physical aggression.⁵ Frequent challenging behaviors are physically and mentally taxing on

staff, contribute to burnout, and are viewed as generally disruptive to the milieu of the unit. Across the United States, approximately 37% of the long-term care population carries a formal diagnosis of dementia,⁶ although it is likely that many cases are not formally diagnosed, especially when access to a qualified provider is limited (e.g., those living in rural locations). It is also worth noting that even residents with less severe forms of cognitive impairment can present challenges to staff in the form of repetitive questions, constant requests for assistance, forgetfulness, and impulsivity.

Historically, prescribing providers have relied on antipsychotic medications for the management of behavioral and psychiatric disturbances,⁷ offering a sedation-like effect and subsequent reduction in activity or behaviors.⁸ However, these medications carry a greater risk of mortality in older adults with dementia,⁹ prompting the initial black box warning against use of atypical antipsychotics in 2005. In response, governmental (e.g., 42 C.F.R. § 483.25; Centers for Medicare and Medicaid Services, 2014¹⁰), accreditation (e.g., Joint Commission Memory Care Standards), and professional standards, such as those put out by the American Psychiatric Association¹¹ have mandated or strongly encouraged reduced antipsychotic use in older adults diagnosed with dementia.

Acknowledging challenges inherent to conducting research in the long-term care environment, enterprising researchers have established a growing body of evidence on the effectiveness of staff

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training for the non-pharmacological management of dementia-related behaviors (see Beeber, Zimmerman, Fletcher, Mitchell, & Gould, 2010¹²; Eggenberger, Heimerl, & Bennett, 2013¹³; Seitz et al., 2012¹⁴). For example, a review by Beeber et al. (2010)¹² highlighted how several randomized clinical trials (RCTs) and non-RCTs have shown increased positive affect among staff, greater staff knowledge about dementia, improvement in dementia care skills, and greater self-efficacy. Furthermore, evidence supported a decrease in resident agitation and distress in some of the studies.

This work is imperative, as some commonly considered interventions may not be as well supported in literature reviews (see O'Neil et al., 2011¹⁵; Testad et al., 2014¹⁶), but may be routinely implemented on the unit. Existing interventions overwhelmingly target nursing staff, especially nursing assistants, as they spend much of their time in direct contact with the residents. Various programs have been devised and discussed in the literature, but little consistency prevails, allowing flexibility for facilities to tailor training to their specific needs and population.

Staff training often includes a component on increasing staff members' knowledge about the dementia process and symptoms (e.g., Kuske et al., 2007¹⁷; Kuske et al., 2009¹⁸; Vasse, Vernooij-Dassen, Spijker, Rikkert, & Koopmans, 2010¹⁹). As interactions between staff and resident are core to the dementia care experience, trainings in non-pharmacological interventions may include utilization of social interactional activities to promote resident engagement (such as reminiscence, music, and exercise; Testad et al., 2014¹⁶), behavioral management skills (such as responding to a behavioral escalation, use of distraction techniques, and setting realistic goals; Testad et al., 2014¹⁶), and more specific and foundational to behavioral management, communication skills training. Regarding the latter, this may further break down into training on verbal skills (e.g., announcing your presence, using positive statements, how to properly repeat a phrase) and non-verbal and emotional skills (e.g., making eye contact, allowing enough time of the resident to respond, and showing empathy; Eggenberger et al., 2013¹³).

While some researchers appropriately call for greater clarity and consensus on how to define and measure communication to strengthen our dementia training programs,²⁰ our current body of evidence largely supports staff communication training for persons with dementia as efficacious. In a review of the research, Eggenberger et al. (2013)¹³ identified three different types of communication training in residential care settings. This included skills training between the resident and caregiver, but two additional types focused on adding training related to staff-staff interactions, resident-resident, and resident-visitor communications.¹³

Using self-report and observational measures, RCTs and non-RCTs reviewed by Eggenberger et al. (2013)¹³ reported increased emotional tone of the caregiver, increased use of positive statements, and greater respect. Staff receiving these trainings reported on them positively, finding they had a deeper understanding of the residents. While several communication skills training programs reported a decrease in challenging dementia-related behaviors, a few studies reported no difference in behavior.

In another review of staff training, Seitz et al. (2012)¹⁴ concluded that there was some support for staff training interventions, but cautioned that few studies reported outcomes that could be defined as clinically meaningful change. Moreover, their analysis of trainings discovered that most interventions required resources found outside of the long-term care facility itself (i.e., experts on training or dementia care) and required a significant amount of time to be effective. Seitz et al. appropriately questioned if the current literature base could be applied in actual long-term facilities where access to resources were scarce, such as rural locations.

Developing a program specific to a facility requires awareness of the resident population, current needs, nature of challenging be-

haviors, knowledge of previous dementia training (if any), as well as how much time can be devoted to training. A review of what factors are key for an effective dementia education program, Surr et al. (2017)²¹ underscored importance of dedicating several hours of time to the training, including face-to-face participation, and practice-based learning, among others. Our setting, a U.S. Department of Veterans Affairs (VA) Community Living Center (CLC) is comprised of long-term care, short-stay rehab, and inpatient hospice. In 2013, staff and nursing leadership identified dementia care skills as a critical need considering the number of patient-to-staff assaults, most often perpetrated by patients with dementia. In developing a program for our setting, an interdisciplinary task-force was established comprising of geropsychology, nursing (including nursing leaders, nurse educator, RNs, LPNs, and nursing assistants), social work, recreation therapy, and nutrition.

Based on our review of the existing literature (e.g., Burgio et al., 2001²²; Burgio et al., 2002²³; Chang & Lin, 2005²⁴; Engelman, Altus, Mosier, & Mathews 2003²⁵; Kuske et al., 2007¹⁷; McCabe, Davison, & George, 2007²⁶; O'Neil et al., 2011¹⁵; Ripich, Wykle, & Niles, 1995²⁷; Teri, Huda, Gibbons, Young, & van Leynseele, 2005²⁸) and skills training programs established in other long-term care facilities,^{29,30} we decided to include the following aspects: 1) dedicated training staff (second and third authors) responsible for implementation, 2) a multimodal, multimedia approach to reach different types of learners, 3) nursing management support for implementation of training; 4) demonstration of skills by training staff, 5) practice and role-play of skills, 6) discussion on barriers that staff may encounter, 7) identification of "champions" from each unit/shift that could provide on-unit consultation and modeling of skills, and 8) collection of information on the effectiveness of the training program. This pilot study will describe the process of developing our dementia care training workshop tailored to the needs of the facility, and present data on the effectiveness of this program. We hypothesized that upon completing the training program, participants would demonstrate improved knowledge of dementia care, as well as perceived self-efficacy in providing dementia care, as measured by paper-and-pencil assessments.

Methods

Phase I: Development of dementia training program

An examination of incident reports filed by CLC staff members revealed that in 2013, there were 65 reported assaults by patients on staff and other residents of the CLC, particularly among those with a dementia diagnosis. Consultation with nursing and aide staff suggested assaults were more likely during meals and staff shift changes. Psychology, in collaboration with nursing, developed an 8-hour workshop aimed at improving care to patients with dementia and reducing assaultive behaviors. This workshop was the basis of recurrent meetings (i.e., the Dementia Task Force), including psychology and nursing staff from various levels, as well as vested stakeholders that sought to identify key areas for improvement in dementia care. To develop workshop content, a psychology fellow (second author) and nursing educator (third author) reviewed several sources, including existing educational materials from the VA, which consisted primarily of online knowledge-based presentation of information followed by brief quizzes, an informal survey of staff members regarding their prior experiences with dementia care training (most often in the context of school courses or on-the-job training), and a review of relevant literature. Specifically, we reviewed the Staff Training for Assisted Living Residencies (STAR) program,²⁸ and its VA-specific version, STAR-VA.³⁰ Together, the psychology fellow and nursing educator outlined the content for the workshop and presented this outline to the Dementia Task Force

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