JRIPE

Journal of Research in **Interprofessional Practice and Education**

Vol. 2.2
February, 2012

Implementation of a Mental Health Guideline in a Long-Term Care Home: A Participatory Action Approach

Maria Huijbregts, PT, PhD; Lisa Guttman Sokoloff, MS, CCC-SLP; Sid Feldman MD, CCFP, FCFP; David K. Conn, MB, FRCPC; Kelsey Simons, PhD, MSW; Leenah Walsh, BASc; Lynda Dunal, MSc, BScOT, OT Reg. (Ont.); Ruth Goodman, MSW, RSW, PhD(c); & Nasreen Khatri, PhD, CPsych

Abstract

Background: The goal of this pilot study was to implement a Canadian mental health guideline in a long-term care residence in order to improve interprofessional care of clients with mood and behavioural issues.

Methods: Using a participatory action approach, this pilot study engaged staff/physicians, residents, and families in identifying key priorities for action related to the goal of improving interprofessional care. This resulted in the implementation of educational interventions, a mandate for non-registered nursing staff to attend interprofessional rounds, and enhanced interprofessional collaboration through unit-based huddles. A staff satisfaction survey and focus groups were conducted to assess perceptions of change.

Findings: The staff satisfaction survey revealed statistically significant improvements in perceived job satisfaction, leadership, and workplace resources. Focus group findings indicated improved interprofessional collaboration, teamwork, support, and communication. Staff noted a stronger perception of being valued and increased confidence in their own contributions.

Conclusions: Both qualitative and quantitative improvements were noted in staff job satisfaction. Despite some limitations, these findings suggest that further dissemination of this initiative with rigorous evaluation is warranted.

Keywords: Long-term care; Mental health; Guideline implementation; Participatory action research; Knowledge translation

Introduction

All residents in long-term care (LTC) homes have unique physical, social, and mental health needs. In addition to requiring assistance for one or more activities of daily living (e.g., bathing, dressing, eating, toileting, and so forth), residents are likely to experience cognitive decline, depression, and/or anxiety. In Canada, it is reported that 20% of people aged 65 and older live with a mental illness [1], and many long-term care home residents present with cognitive impairment as well as mental health issues [2-4]. The clinical complexity of individuals living in long-term care raises challenges for healthcare providers wanting to deliver the best possible care.

It is especially difficult to provide optimal care for residents with different levels of cognitive impairment when they present with challenging behaviours such as resisting both medical interventions and personal care. Staff at the point of care, including personal support workers (PSWs), also known as healthcare aides or nursing assistants, are not commonly trained in behavioural and psychosocial

Journal of Research in Interprofessional Practice and Education (JRIPE)

Vol. 2.2

Corresponding author:
MHuijbregts@baycrest.org

approaches to care [5,6]. However, we know that best practice guidelines focused on addressing these behaviours promote greater use of non-pharmacological approaches [7,8]. In addition, pharmacological therapies for behavioural and psychological symptoms of dementia (BPSD) have not been well studied in LTC, and, in general, best practice for implementing evidence-based approaches in this environment remains unclear. Despite an accumulation of best practice knowledge for mental health services in LTC, as embodied by clinical guidelines, there is still a need for practical translation to bedside staff.

Interprofessional approaches to mental health in LTC

Interprofessional care is an essential component of quality care in LTC homes. Residents require and receive care from a variety of staff, including dieticians, nurses, pharmacists, physicians, social workers, as well as physical, occupational, and recreation therapists. In addition, residents receive daily attention and, quite often, social support from housekeeping, food services, and administrative staff. Personal support workers are essential and constant members of the healthcare team, providing hands on, direct care to LTC residents. Although all staff play an important role in providing care and emotional support, it is often difficult to achieve collaboration between these groups. For example, the nature of shift work may serve as a barrier to communication among staff across shifts [9]. Likewise, bureaucratic structures and professional hierarchies may marginalize direct care staff [10] even though they often possess the greatest knowledge of residents' day-to-day health and well-being [10,11].

Mental health guidelines

In response to the need to improve interprofessional approaches to mental healthcare in long-term care, the Canadian Coalition for Seniors' Mental Health (CCSMH) published clinical guidelines for The Assessment and Treatment of Mental Health Issues in Long Term Care (Focus on Mood and Behavioural Symptoms) in 2006 [8]. This guideline included 54 recommendations for an interprofessional approach to addressing mental health issues. Areas of focus include General Care, Assessment, Treatment, and Organizational and System Issues. Various treatment interventions and approaches are listed accompanied by a rating indicating the strength of the supporting evidence.

Guidelines in general are difficult to implement, sometimes fail, and may prove to be costly [12,13], but those relating to mental healthcare are perhaps amongst the most challenging. This, in part, is because the provision of mental healthcare relies on tacit knowledge, which is "based on capabilities and routines that have not been or are difficult to codify" [14]. Approaches to caring for residents with mood and behavioural symptoms vary depending on contextual factors, including the resident's psychosocial history, comorbidities, environmental or biological factors that trigger the behaviour, and available resources. Therefore, mental health guidelines are not as straightforward to implement as, for example, guidelines for managing pressure ulcers [14,15]. Other factors that contribute to the difficulty of implement-

ing guidelines include financial and time constraints [16-18], difficulties of consistency in providing the intervention (e.g., across shifts and to part-time and relief staff) [16,17], and difficulties obtaining staff buy-in for changing long-standing medical and care approaches and practices [16,17,19].

Project objectives

Research into guideline implementation in LTC settings is minimal and, in particular, scarce as it relates to mental health issues. To address this gap in knowledge, we conducted a pilot implementation of the CCSMH mental health guidelines (*The Assessment and Treatment of Mental Health Issues in Long Term Care*) [8] on three units of a large long-term care facility during 2008 and 2009. The project focused on enhancing interprofessional collaboration to improve mental healthcare processes on the units. The overall goal was to improve staff satisfaction and team processes regarding the provision of mental healthcare.

Participatory action approach

It was understood early on in the development of the project that staff involvement would be a critical determinant of its success. It has often been noted that guideline implementation is typically done "from the top down" [16], where management selects areas for improvement and implements changes [14,20]. Top-down decision making is prevalent in many organizations, but it reduces staff participation in the process and thus often limits staff buy-in to projects [14,21]. One way to address this concern is an approach called participatory action. Using this process, researchers collaborate with participants to identify major issues, conduct research, formulate actions, and study the results [22,23]. The process is cyclical and iterative, ensuring ongoing input and guidance from the participants. After studying the results, the information is used to re-evaluate the issue and recommence the cycle [22,23]. Because it is less hierarchical and more inclusive than traditional guideline implementation models, participatory action can lead to a gradual culture shift in an organization and may improve buy-in for change across many levels of staff. For this project we used a participatory action approach, facilitating optimal participation of all stakeholders in the different stages of the initiative within the limitations of clinical and program resources.

Methods

Recruitment and procedures

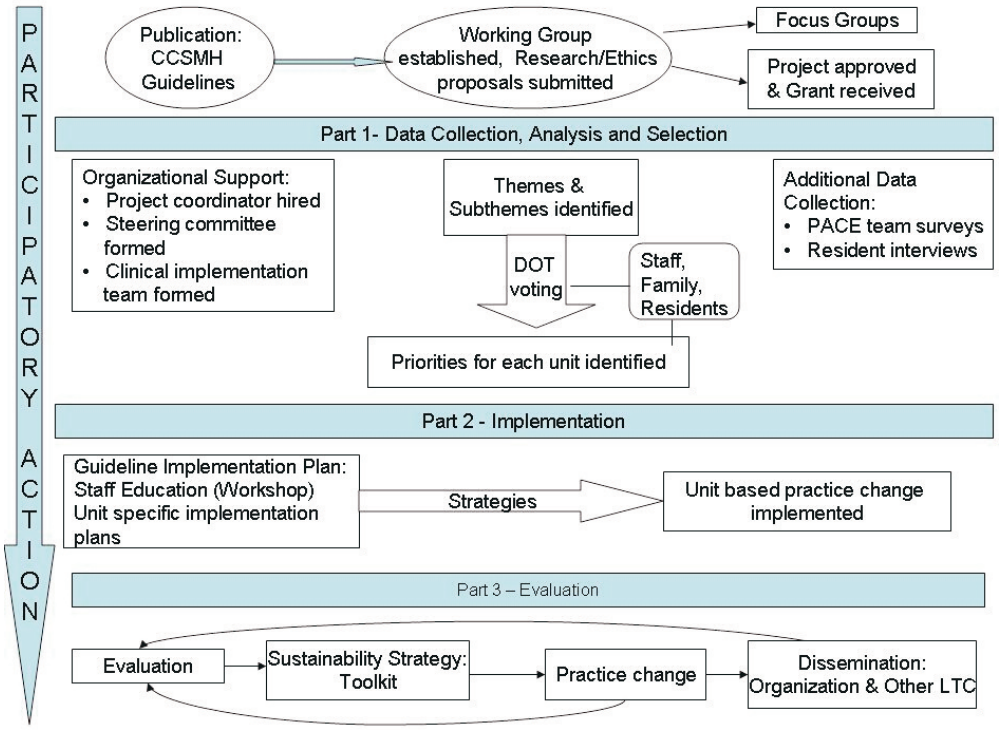
The pilot study used a pre-post experimental design with mixed methods. Although participation in evaluation of the project was voluntary, all staff were expected to participate in the implementation of the initiative as part of their clinical practice. Ninety-one staff members participated in a workshop and were invited to participate in the evaluation. Three out of 18 units at the LTC home were purposively selected for the pilot based on the nature of the resident population on these units: a 28-bed cognitive support unit, a 23-bed behavioural support unit, and a 28-bed mental

health unit. The combined population of all three units at the beginning of the study was 79 residents. The study was approved by the organization's research ethics board.

Recruitment for the evaluation varied by group (staff, residents, and families). Staff were approached in person and were invited to complete the satisfaction survey and participate in the focus groups pre- and post-intervention. Small-group information sessions were held on the floors to explain the project to participants. When it was not possible to meet staff face to face, they were given a letter explaining the project and requesting their participation. Written consent was obtained. Capacity of a resident to consent to participate in interviews or focus groups was determined by the attending physician and unit social worker after consultation with the Unit Director and the nurses who were most familiar with each particular resident. Additionally, residents and/or their substitute decision makers were provided with a letter explaining the project. Family members were invited to participate in pre- and post-focus groups as well. Consent was obtained pre- and post-intervention.

A total of 90 staff were recruited at the outset. Sixteen residents provided their perspectives before implementation (11 in interviews; 5 in a focus group), and ten participated in post-implementation interviews. Three residents participated both pre- and post-implementation. There were 9 family members who participated in the initial focus group and 4 in the post-implementation focus group. Only one family member participated in both.

Figure 1
Project flowchart



Pilot implementation and project flow

The project flowchart (Figure 1) reflects that participatory action was a key driver throughout the initiative. Two project teams were formed at the onset of the project: a steering committee and a clinical implementation team. The steering committee was established to develop and guide the project and to champion the project within the facility. It consisted of senior administrative staff (including a member of the Executive Team), researchers, and lead clinical staff within the organization. A clinical implementation team (CIT) was established to guide the practical clinical implementation of the selected recommendations. The CIT included registered nurses and PSWs from the pilot units from day and evening shifts, interprofessional staff, members from Volunteer Services, and staff with experience in implementing best practice/knowledge translation. The CIT provided support and problem-solved around clinical issues arising during the implementation process, participated in the selection of the specific recommendations from the clinical practice guidelines for implementation, facilitated/enabled teams to access resources, and provided a link between the steering committee and the clinical teams. The CIT also promoted, marketed, and championed the implementation of the mental health guidelines project as informal opinion leaders. The CIT members were instrumental in preparing the Workshop Day and many of the knowledge translation activities. They also ensured their units were well informed and that issues affecting implementation were addressed in a timely manner. Critical to the success of this project was the team coach and project co-ordinator, who provided leadership and guidance for the CIT and played a key role in liaising between the CIT and the steering committee.

Problem identification

Focus groups were conducted with primary stakeholder groups (unit staff, families, and residents) to collect baseline information with regards to the current state of practice for psychosocial and mental healthcare on the units. Participating family members attended an evening focus group. Staff members were divided into groups based on their unit, shift, and professional association (i.e., registered nursing staff, PSWs, interprofessional team). Pre-implementation there were five focus groups (2 groups of registered staff, 1 PSW group, and 2 groups of interprofessional team members). Post-implementation, food and nutrition and housekeeping staff also participated in focus groups, for a total of eight focus groups (2 registered staff, 2 PSW, 2 interprofessional team, 1 food and nutrition services, 1 housekeeping). Focus groups were conducted by members of the steering committee, who were not involved in clinical care on the units, and by a research assistant. A research assistant also conducted interviews with residents (13 pre-implementation and 10 post-implementation) who were capable of participating and preferred to give input individually rather than as part of a group (see Methods for information on the structure of the interview and Appendix B for the focus group guides).

It was recognized that attempting to implement all 54 recommendations from the CCSMH Guideline [8] was not feasible. Therefore, a "dot voting" process [24]

was used for staff, family and residents to identify areas of concern for their specific unit and to help narrow the focus of the initiative. Based on the voting results, the CIT identified three primary areas of concern for each unit. All three units identified interprofessional education regarding "mental health and challenging behaviours" as one of the top three areas requiring improvement. As a result, the CIT and steering committee decided to focus on this one issue for all three units. The specific recommendation as stated in the CCSMH guidelines was as follows:

> LTC homes should have an education and training program for staff related to the needs of residents with depression and/or behavioural concerns. Ideally, dedicated internal staff would be available to provide leadership in this area, including the development and delivery of best practices. [8]

By focusing on this one recommendation, we implicitly addressed ten recommendations in the guideline (see Appendix A for a comprehensive list).

Change processes

Implementation of the recommendation began with a day-long staff workshop. All staff, including dieticians, family physicians, housekeeping staff, nursing staff (registered and non-registered) physiotherapists, psychiatrists, social workers, therapeutic recreation staff, unit clerks, unit directors, and unit volunteers were invited to participate. The workshop included an introduction to the mental health clinical practice guideline, didactic education on topics such as mental health in LTC and strategies for managing challenging behaviours, unit-based case discussions conducted in interactive small groups, a discussion of the resources available to staff, and several collaborative/motivational components. At the workshop staff also recommended other changes that they felt could improve the management of mental health issues on the unit.

After the workshop several of the change improvements identified at the workshop and "easy win" themes from focus groups were implemented on the units. For example, during the workshop it was identified that communication between the PSWs, who provide the daily care, and other members of the interprofessional team needed improvement. To enhance communication and improve teamwork, PSWs were invited to participate in weekly interprofessional team rounds to provide first-hand reports about the residents and to participate in discussions around recommendations for care. Additionally, in response to the staff's request for "just-in-time" learning, each week small, unit-based meetings, called huddles, were held to discuss resident-specific issues related to mental healthcare and behavioural care (e.g., hoarding food, aggressive behaviour in the dining room). During huddles, staff brainstormed solutions/action plans for the issue with a semi-structured format, assigned tasks relating to the action plan (which was documented and kept in a binder on the unit), and anticipated possible challenges.

The following week staff reviewed the action plan and the outcome, and either revised the plan or addressed a new issue depending on the situation. Initially the

huddles were facilitated by the team coach/project co-ordinator or research assistant; responsibility later transferred to the nursing staff. Huddles were based on the "After Action Review" process as developed by the US military [25] and have been used elsewhere in healthcare, especially for improvement in patient safety [26]. Another change was the increased use of available resources, including the Psychogeriatric Resource Consultant (PRC) for general education sessions and specific case-based issues. The PRC program was developed as part of the provincial Ministry of Health and Long Term Care's Alzheimer Strategy to provide educational and consultative resource persons to LTC homes across Ontario [27]. Each PRC provides support to approximately 12 LTC homes. The PRC was engaged to provide ongoing formal education on relevant topics (e.g., depression, dementia, and delirium) based on staff request and to provide suggestions about management of specific challenging cases.

Evaluation

The evaluation plan included focus groups and a staff satisfaction survey addressing interprofessional teamwork. Time 1 focus groups also provided a means for identifying targets for improvement. Time 1 focus groups were conducted nine months prior to implementation; findings were used to develop and guide implementation of specific guidelines and to examine the impact of this initiative. Time 1 resident interviews and the staff satisfaction survey were conducted four months prior to implementation. Time 2 focus groups, interviews, and satisfaction surveys were conducted eight months post-implementation.

Focus groups and resident interviews

Focus group and resident interview guides were developed by members of the steering committee, many of whom had expertise in mental health and BPSD care in LTC homes. As part of the family and resident focus groups and interviews, participants were asked about their general perceptions of the unit as well as their perceptions of mental healthcare and relationships with staff. Staff members were asked similar questions, but were also asked about the challenges they experienced when trying to manage mental health and BPSD issues, the efficacy of interprofessional teamwork, the available resources for mental healthcare, and whether they had used such resources. Focus groups and interviews were audio recorded and professionally transcribed verbatim. An initial codebook, based on the themes generated, was developed and verified by the research team. All transcripts were initially read and coded by a research assistant using NVivo 2.0 (QSR International, Inc., Cambridge, MA). A member of the research team who had not participated in the original codebook development read the transcripts a second time to verify codes. Codes were placed into 5 main categories: 1) mealtime issues, 2) social isolation, 3) communication among the team, 4) teamwork, and 5) resource availability; as well, a number of subthemes emerged from the data. Consensus was reached through discussion and review of transcripts for examples of direct quotes to verify themes. (See Appendix B for samples of the focus group questions.)

Demographic data

Demographic information was collected to describe study participants who completed the satisfaction surveys and interviews. No demographic information was collected for client, family, and staff focus group participants.

Satisfaction survey

The Program of All-Inclusive Care for the Elderly survey (Outcomes Research in PACE Survey) [28] is a self-administered questionnaire completed by staff, which contains several subscales that assess a variety of interprofessional team and organizational characteristics, including leadership, team cohesion, communication, coordination, conflict management, team effectiveness, workplace conditions, and workplace resources. Scoring is on a 5 point Likert-type scale.

Analysis

Demographic data were analysed using descriptive statistics. Independent samples *t*-tests were conducted to determine whether there were any significant changes in staff satisfaction with interprofessional team processes from pre- to post-implementation. Qualitative methodologies were applied to analyze focus groups and interviews using content coding procedures.

Results

Participants

Sample characteristics for both staff and residents participating in the project evaluation are shown in Tables 1, 2, and 3. The vast majority of staff participants were women ($N = 84$, 92.3%) and most were employed full-time at the facility ($N = 51$, 56.7%). PSWs constituted the largest portion of participating staff ($N = 36$, 40.0%), followed by registered practical nurses (RPNs), ($N = 13$, 14.4%), food and nutrition services staff ($N = 13$, 14.4%), and registered nurses (RNs) ($N = 9$, 10.0%). Other clinical and non-clinical staff, such as unit directors, housekeepers, unit clerks, and social workers accounted for the remainder of participants ($N = 19$, 20.9%). Physicians made up 3% ($N = 3$) of the participants. On average, PSWs had fewer years of work experience compared with staff in other professional categories (10.41 years vs. 14.77 years); $t(77.61) = -2.104$, $p = .04$.

As shown in Table 2, the pre-implementation resident sample ($N = 11$) was primarily composed of women ($N = 9$, 82%), and the average age was almost 86 years ($M = 85.82$, $SD = 8.99$). The majority spoke English as a primary language ($N = 10$, 91%). A considerable number were widowed ($N = 3$, 27%) and were Holocaust survivors ($N = 3$, 27%). As described in Table 3, resident participants in post-implementation interviews ($N = 10$) were also mainly women ($N = 9$, 90%), with an average age of 83 years ($M = 83.20$, $SD = 9.77$). The majority spoke English as a primary language ($N = 8$, 80%) and were widowed ($N = 6$, 60%). Fewer were Holocaust survivors ($N = 1$, 10%).

Table 1

Staff descriptive data (*N=91*)

	n	%	*M*	*SD*
Female	84	92.3		
Occupation				
PSW	36	40.0		
RPN	13	14.4		
Food & Nutrition Services	13	14.4		
RN	9	10.0		
Unit Clerk	3	3.3		
Unit Director	3	3.3		
Social Worker	3	3.3		
Psychiatrist	2	2.2		
Volunteer	2	2.2		
Housekeeping	2	2.2		
Physician	1	1.1		
Recreation Therapist	1	1.1		
Dietician	1	1.1		
Pharmacist	1	1.1		
Status				
Full-time status	51	56.7		
Part-time status	39	43.3		
Age			44.77	11.50
Years of experience (all staff)			13.07	10.29
PSWs			10.41	6.71
non-PSWs			14.77	11.91
Years of employment in facility (all)			8.64	6.81
PSWs			7.53	4.37
non-PSWs			9.32	8.05

Table 2

Residential demographic data – Pre-implementation interviews (*N=11*)

	n	%	*M*	*SD*
Age			85.82	8.99
Female	9	82		
Widowed	3	27		
Holocaust Survivor	3	27		
English as Primary Language	10	91		

Table 3

Residential demographic data – Post-implementation interviews (*N=10*)

	n	%	*M*	*SD*
Age			83.20	9.77
Female	9	90		
Widowed	6	60		
Holocaust Survivor	1	10		
English as Primary Language	8	80		

Staff – PACE survey

Table 4 contains the results of the PACE survey at Time 1 and Time 2. At both time points, responses to questions tended to be on the higher end of the scale, reflecting positive perceptions of the different domains. However, mean scores were generally higher at Time 2 than at Time 1, with three domains (job satisfaction, leadership, and workplace resources) demonstrating statistically significant change ($p < .05$)

Table 4

PACE survey results

	N	*M*	*t*	*df*
Job satisfaction				
Time 1	61	3.48		
Time 2	56	3.84	-2.32**	115.00
Leadership				
Time 1	74	3.55		
Time 2	61	3.86	-2.41**	133.00
Workplace resources				
Time 1	73	3.38		
Time 2	58	3.79	-2.74***	127.87
Team cohesion				
Time 1	75	3.92		
Time 2	60	4.05	-1.15	133.00
Communication				
Time 1	74	3.54		
Time 2	60	3.53	.02	132.00
Coordination				
Time 1	73	3.71		
Time 2	59	3.84	-1.15	130.00
Team effectiveness				
Time 1	74	4.07		
Time 2	59	4.22	-1.40	131.00
Conflict management				
Time 1	72	3.64		
Time 2	58	3.65	-.07	128.00
Workplace conditions				
Time 1	74	2.72		
Time 2	58	3.01	-1.80*	130.00
Meeting effectiveness				
Time 1	25	3.63		
Time 2	22	3.68	-.28	45.00
Meeting communication				
Time 1	24	3.76		
Time 2	22	3.69	.41	44.00
Meeting leadership				
Time 1	25	3.69		
Time 2	22	3.69	.00	45.00

Notes: *$p < .10$; **$p < .05$; ***$p < .01$

and one domain nearing significance (workplace conditions) (p = .07). Scores for communication, conflict management, meeting communication, and meeting leadership remained unchanged at Time 2. *P*-values might have been smaller if paired *t*-tests for dependent samples were used. However, this would have restricted the use of the data to staff who completed the survey at both Time 1 and Time 2, whereas a substantial number of participants completed the surveys only once, either pre- or post-implementation.

Focus group and interview findings

Pre-implementation focus groups identified specific areas where staff, family members, and residents felt that mental healthcare was not provided optimally or that barriers to care existed. Specific concerns focused on mealtime issues, social isolation, communication among the team, teamwork, and resource availability. For example, regarding social isolation, staff reported the desire to have more time to spend with residents, whereas residents reported they wanted more activities. One staff member stated,

> It can be quite difficult and quite challenging for us to give the time that we need to give to everybody, all 28 residents.

Residents also commented on the isolation they noticed:

> There's other people who feel confined, right … who can feel confined on the unit … they're not able to do as much as they used to do and they feel, hemmed in a bit, right.

There was a "disconnect" in communication reported between staff, families, and residents. Part of the communication issue was felt to be a lack of understanding of mental health issues and the resulting challenging behaviours. When communication was addressed, there was a positive effect on behaviour, as noted in this staff quote:

> I find personally, when I go in a room, and she's … not always aggressive when you're beginning. At the beginning, she [is] always polite, saying something to you. If you can just find a way to respond [to] her, make her understand what she's saying, and explain to her.

Staff

In all of the post-implementation focus groups, staff repeatedly commented on improved teamwork and the positive effect that had on care:

> We do our rounds, there's more communication and they [are] more organized. Like, before the start of the shift, we give the nurses, just our staff, give them report. And give them updates what's going on, or things that need to be follow[ed] up. And they're all there listening. And then that's it. They do their own thing. They know their assignments well. They're more organized. I know this.

In the focus groups, staff indicated that they felt an increased sense of belonging and being personally valued on the units. They commented on improvements in teamwork, participation, communication, and support from team members. For example, "There's a lot more openness and sharing of information." One team member commented that she was "taking more leadership, taking an active role in engaging the PSWs and taking the lead on smaller projects … where I didn't really see that much before." Staff also reported a positive change in attitude and an improved understanding of the resident and the resident's mental health/challenging behaviours. A food server noted, "It's more than the food, what I'm doing … cause uh, I learn about their behaviour, I learn about their personality, and I learn how they are, who they are, and what they are." Staff also indicated that they had attempted to use external resources, but that their experiences were varied. However, they said it was valuable to have access to those resources, if necessary. Nursing staff were generally more positive about the experience than other professional staff, such as physicians and dieticians, who indicated that the huddles, et cetera, seemed to be more focused on the nursing staff. Staff in these latter groups commented that they had not noticed a significant difference on the units; however, when specifically asked, clinical team members commented that they appreciated having the PSWs at team rounds, as their first-hand input was informative and helpful for their understanding of the client. PSWs also expressed increased satisfaction with their role on the unit and spoke positively of their participation in rounds.

Families and residents

The focus groups with the families did not yield information pertaining to the impact of the project. Families in the post-implementation group seemed happier with the care provided, but only four families participated. Additionally, families stated that they were not sufficiently involved on the unit to be able to discuss the impact of the guideline implementation project or to comment on specific changes in care delivery. Residents were unable or unwilling to participate in a post-implementation focus group. Analysis of the one-on-one resident interviews indicated that residents felt there had been no significant changes in the way mental healthcare was provided pre- and post-implementation, although overall they were happy with the current level of care.

Discussion

To our knowledge, there are no previous studies using a participatory action approach for guideline implementation. Our results support the idea that engaged and consulted staff are more willing to participate in organizational change processes, such as guideline implementation. [12,14]. The staff on the CIT became agents of change, were ambassadors for the project, and encouraged their colleagues to participate. Likewise, expanding the traditional definition of the "interprofessional team" to include administrative, housekeeping, and food service staff allowed these individuals to provide their insight into more informal moments of care and to highlight their role as team members. Although the ultimate goal of care

providers is always to enhance client outcomes, staff performance and perceptions were considered to be key indicators of the success of the initiative. Overall, the strong contribution of the participants was critical in identifying issues and guiding the intervention; their input and direction drove the project.

Positive changes in staff attitude and practice occurred. Attendance of PSWs at weekly team rounds highlighted the importance of their role to other team members and gave everyone an enhanced sense of value of the PSWs' contribution to client goals. PSWs were able to participate in discussions on patient behaviour and emotional state and could directly and immediately implement any suggested changes in care. This contributed to advancing practice and professionalism of all staff.

Participation in the huddles also allowed staff equal opportunity to express opinions, share ideas, and problem solve as a team. There was explicit recognition that all contributions were equally valuable regardless of the team member's role. Staff felt more supported by the team and their leaders. Support from senior administration and unit-based leaders was perceived as critical to the initial and ongoing implementation of this practice. An unexpected and positive by-product was enhanced staff capacity for engaging in knowledge dissemination. For example, RNs, RPNs, and PSWs participated in dissemination of this initiative by presenting at external conferences and taking leadership roles at internal meetings.

Unit staff were keen to participate and responded positively when asked to complete the pre- and post-evaluations. Participation was enhanced with a range of recruitment strategies, primarily scheduling flexibility. However, we did encounter challenges in engaging staff across shifts in the implementation of the behavioural strategies. Huddles were scheduled on specific day and evening shifts. No huddles were conducted on night shift. As a result, some staff never had the opportunity to participate in the huddles. One huddle topic was "better communication across shifts," attempting to directly address this difficulty. Moreover, weekly team rounds were held during the day and therefore staff on other shifts could not participate in these and were not provided with the same opportunities to learn about behavioural management. The interprofessional team members work across different programs and often had scheduling conflicts that limited their ability to attend huddles. Some staff indicated that this project seemed to be more "focused on day-shift nursing."

Limitations

There was a risk associated with using a participatory action approach for guideline implementation. Although this approach has gained favour as a research methodology, it is sometimes criticized for lack of scientific rigor [29, 30]. In contrast to more traditional research approaches where the researcher chooses the methodology and recommendation(s) to implement, in our study, staff, families, and residents influenced study questions, interventions, and overall implementation. The process was time consuming and delayed the selection and implementation of the chosen recommendations, as they were tailored to the needs of each pilot unit. However, this approach appeared to enhance team motivation and participation.

Scheduling issues resulted in the project having an enhanced focus on day shift and nursing staff and resulted in less participation from some interprofessional team members.

Another limitation concerned the small number of resident and family participants. Recruitment of residents was challenging. Some residents outright refused to participate, as did family members. Some residents indicated that there was "nothing to change," while some family members questioned the benefits of research on client care. Specific family requests for information were addressed by the project co-ordinator. Family and residents were kept informed of the initiative via phone calls, letters, and individual meetings. Even family members who chose not to participate acknowledged that they did appreciate receiving letters and phone calls informing them of the study. Currently, the organization is emphasizing the integration of care, education, and research, and it is expected that this focus will address the family concerns.

Sustainability

In order to sustain this initiative across the organization, and as part of the next cycle of the participatory action process, a toolkit focused on managing challenging behaviours through enhanced care and team discussions was developed. Staff identified huddles as the most important component for the toolkit. Other resources such as strategy cards used to facilitate management of challenging behaviours were also included. The toolkit was recently piloted on other units in the facility. It is anticipated that this toolkit can be shared with other LTC facilities at a later date.

Conclusions

Although the project targeted implementation of one specific recommendation from the guideline, 10 of the 54 recommendations from the guideline were addressed. The enhanced awareness and specific skills acquisition also had an impact beyond the narrow scope of the recommendations. The positive study findings are reflective of this. This study presents a strong case for the many possible benefits of using a participatory action approach to improve interprofessional team processes for providing mental healthcare to LTC residents with challenging behaviours. Moreover, the further development of and scholarly approach to the implementation of the planned toolkit will greatly contribute to the body of knowledge related to the interprofessional management of challenging behaviours in LTC residents with mental health disorders.

Acknowledgements

We would like to thank all the staff, residents, and family members on the three pilot units. This project could not have been completed without the hard work and dedication of the members of the steering committee, including Amy Rothwell, Claire Taasin-Lau, Penelope Villella, Kim Wilson, and the CIT, including Emma

Alde, Anne Arenas, Rosemarie Bonadie, Berma Donaldson, Olive Dowlah, Suada Kamhi, and Eudice Rotfarb. Invaluable administrative support was provided by Phoun Bounsong-Hughes and Carole Lee. We would also like to thank the CCSMH for their support throughout this initiative, and Healthforce Ontario, Ministry of Health and Long Term Care, for the funding of this project.

References

1. MacCourt, P. (2005). *Proceedings of the Standing Senate Committee on Social Affairs, Science and Technology: Issue 20 – Evidence.* Vancouver, BC: Senate of Canada.
2. Dudgeon. S. (2010). *Rising tide: The impact of dementia on Canadian society.* Toronto, Ontario, Alzheimer Society of Canada.
3. Herrmann, N., & Gauthier, S. (2008). Diagnosis and treatment of dementia: 6. Management of severe Alzheimer disease. *Canadian Medical Association Journal, 179*(12), 1279-87.
4. Rovner, B., German, P., Broadhead, J., Morriss, R.K., Brant, L.J., Blaustein, J., & Folstein, M.F. (1990). The prevalence and management of dementia and other psychiatric disorders in nursing homes. *International Psychogeriatrics, 2*(1), 13-24.
5. Hyer, L., Yeager, C.A., Hilton, N., & Sacks, A. (2009). Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care. *American Journal of Alzheimer's Disease and other Dementias, 23*(6), 528-539.
6. Speziale, J., Black, E., Coatsworth-Puspoky, R., Ross, T., & O'Regan, T. (2009). Moving forward: Evaluating a curriculum for managing responsive behaviors in a geriatric psychiatry inpatient population. *The Gerontologist, 49*(4), 570-576.
7. American Geriatrics Society and American Association for Geriatric Psychiatry. (2003). Consensus statement on improving the quality of mental healthcare in US nursing homes: Management of depression and behavioural symptoms associated with dementia. *Journal of the American Geriatric Society, 51*(9), 1287-1298.
8. Canadian Coalition for Seniors' Mental Health. (2006). The assessment and treatment of mental health issues in long term care homes (focus on mood and behaviour symptoms). *National guidelines for seniors' mental health.* Toronto: CCSMH. URL: http://www.ccsmh.ca [November 5, 2011].
9. Forbes-Thompson, S., Gajewski, B., Scott-Cawiezell, J., & Dunton, N. (2006). An exploration of nursing home organizational processes. *Western Journal of Nursing Research, 28*(8), 935-954.
10. Castle, N. (2007). Assessing job satisfaction of nurse aides in nursing homes: The nursing home nurse aide job. *Journal of Gerontological Nursing, 33*(5), 41-47.
11. McGilton, K., McGillis Hall, L., Wodchis, W.P., & Petroz, U. (2007). Supervisory support, job stress, and job satisfaction among long-term care nursing staff. *Journal of Nursing Administration, 37*(7/8), 1-6.
12. Grimshaw, J.M., Thomas, R.E., MacLennan, G., Fraser, C., Ramsay, C.R., Vale, L., Whitty, P., Eccles, M.P., Matowe, L., Shirran, L., Wensing, M., Dijkstra, R., & Donaldson, C. (2004). Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Technology Assessment, 8*(6), 1-71.
13. Shiffman, R., Dixon, J., Brandt, C., Essaihi, A., Hsiao, A., Michael, G., & O'Connell, R. (2005). The Guideline Implementability Appraisal (GLIA): development of an instrument to identify obstacles to guideline implementation. *BMC Medical Informatics and Decision Making, 5*(23). URL: http://www.biomedcentral.com/1472-6947/5/23 [November 5, 2011].
14. Berta, W., Teare, G.F., Gilbart, E., Soberman Ginsburg, L., Lemieux-Charles, L., Davis, D., & Rappolt, S. (2005). The contingencies of organizational learning in long-term care: Factors that affect innovation adoption. *Health Care Management Rev, 30*(4), 282-292.
15. Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: Effective implementation of change in patients' care. *The Lancet, 362*(9391), 1225-1230.
16. Davies, B., Edwards, N., Ploeg, J., & Virani, T. (2008). Insights about the process and impact of implementing nursing guidelines on delivery of care in hospitals and community settings. *BMC Health Services Research, 8*(29). URL: http://www.biomedcentral.com/1472-6963/8/29 [November 5, 2011].
17. Resnick, B., Quinn, C., & Baxter, S. (2004). Testing the feasibility of implementation of clinical practice guidelines in long-term care facilities. *Journal of the American Medical Directors' Association, 5*(1), 1-8.

18. Vaughan, T.E., McCoy, K.D., BootsMiller, B.J., Woolson, R.F., Sorofman, B., Tripp-Reimer, T., Perlin, J., & Doebbeling, B.N. (2002). Organizational predictors of adherence to ambulatory care screening guidelines. *Medical Care, 40*(12), 1172-1185.
19. Hysong, S.J., Best, R.G., & Pugh, J.A. (2007). Clinical practice guideline implementation strategy patterns in veterans affairs primary care clinics. *Health Services Research, 42*(1 Pt 1), 84-103.
20. BootsMiller, B., Yankey, J., Flach, S., Ward, M.M., Vaughn, T.E., Welke, K.F., & Doebbeling, B.N. (2004). Classifying the effectiveness of veterans affairs guideline implementation approaches. *American Journal of Medical Quality, 19*(6), 248-254.
21. White, G., Suchowierska, M.A., & Campbell, M. (2004). Developing and systematically implementing participatory action research. *Archives of Physical Medicine and Rehabilitation, 85*(S2), s3-s12.
22. Young, L. (2006). Editorial: Participatory action research (PAR): A research strategy for nursing? *Western Journal of Nursing Research, 28*(5), 499-504.
23. Kelly, P. (2005). Practical suggestions for community interventions using participatory action research. *Public Health Nursing, 22*(1), 65-73.
24. Audience Dialogue. (2005, February 4). Australia: Dennis List. *Dotmocracy.* URL: http://www.audiencedialogue.net [May 28, 2008].
25. Darling, M., Perry, C., & Moore, J. (2005). Learning in the thick of it. *Harvard Business Review,* Jul-Aug, 1-9.
26. Quigley, P., Hahm, B., Collazo, S., Gibson, W., Janzen, S., Powell-Cope, G., Rice, F., Sarduy, I., Tyndall, K., & White, S.V. (2009). Reducing serious injury from falls in two veterans' hospital medical-surgical units. *Journal of Nursing Care Quality, 24*(1), 33-41.
27. Ontario Ministry of Health and Long-Term Care. (1999). Ontario's strategy for Alzheimer disease and related dementias: Preparing for our future. Toronto: Ontario Ministry of Health and Long Term-Care.
28. Temkin-Greener, H., Mukamel, D.G., Gross, D., & Kunitz, S. (2004). Measuring interdisciplinary team performance in a long-term care setting. *Medical Care, 42*(5), 472-481.
29. Dover, G. (2008, June). *Participatory Action Research & Organizational Change Blog: Criticisms of PAR.* URL: http://participaction.wordpress.com/2008/06/05/critical/ [June 5, 2008].
30. Argyris, C., & Schon, D.A. (1989). Participatory action research and action science compared: A commentary. *American Behavioral Scientist, 32*(5), 612-623.

Appendix A

CCSMH Guideline Recommendations Implemented

Treatment of Depressive Symptoms and Disorders:

- Social contact interventions, including interventions that promote one's sense of meaning, should be considered where the goal is to reduce depressive symptoms.
- Structured recreational activities should be considered where the goal is to engage the resident.
- Consider the impact of comorbid dementia in developing a treatment plan.

Treatment of Behavioural Symptoms:

- Social contact interventions should always be considered, especially where the goal is to minimize sensory deprivation and social isolation, provide distraction and physical contact, and induce relaxation.
- Structured recreational activities should be considered where the goal is to engage the resident

Organizational and System Issues:

- LTC homes should develop the physical and social environment as a therapeutic milieu through the intentional use of design principles.
- LTC homes should have an education and training program for staff related to the needs of residents with depression and/or behavioural concerns. Ideally, dedicated internal staff would be available to provide leadership in this area, including the development and delivery of best practices.
- LTC homes should obtain mental health services from local practitioners or multidisciplinary teams with interest and expertise in geriatric mental health issues.
- LTC homes should ensure adequate planning, allocation of required resources, and organizational and administrative support for the implementation of best practice guidelines.
- LTC homes should monitor and evaluate the implementation of best practice recommendations.

Appendix B

Focus Group Sample Questions

Family Focus Group

1. *What are your impressions of the relationships between staff on the unit?*
2. *What are your impressions of the relationship between staff and residents?*
3. *What is your family's involvement in supporting mental health care?*
4. *Can you describe what you do?*

Resident Focus Group/Interviews

1. *Can you give me a sense of what it is like for you living here?*
2. *How does it feel to you?*
3. *Can you tell me how the staff supports your emotional well-being?*
4. *Can you tell me a bit about your relationship with the staff?*
5. *Are there any ways this relationship could be improved?*

Staff Focus Group

1. *Many of the residents have a diagnosis that includes mental health issues. How does that affect the care you provide?*
2. *How do residents respond to your approaches?*
3. *How do the mental health issues affect the way you work together as a team?*
4. *Do you feel that you can provide the care the residents need?*