BEHAVIORS: CHALLENGING FOR THE PATIENT, CHALLENGING FOR THE TEAM

PRESENTERS: Jay Gordon, PhD and Kristen Schreier MA CCC-SLP, CBIST
Jay Gordon, PhD
- Neuropsychologist, Neuropsychology Pathways Associates
- Specializes with both pediatrics and adults
- Contact: DrGordon@PathwaysNA.com

Kristen Schreier, M.A. CCC-SLP
- Works with adults currently at HealthSouth Rehabilitation Hospital in Toms River and Neuropsychology Pathways Associates
- Certified Brain Injury Specialist Trainer with the BIAA
- In 2015 taught a graduate level class on Brain Injury
- Contact: Kristen.schreier@healthsouth.com
Today’s Agenda

- Overview of Behavior Management
- Behavior Occurrences after Brain Injuries
- Discussion of Developing and Implementing a Behavior Plan
- Interdisciplinary Role of Team Members in Behavior Management
- Open Discussion and Questions
Behaviors and Behavior Management

When we think of this concept, what comes to mind?

Who remembers learning about the ABC Model?

How do we best educate fellow staff members and families about behavior management?
Behavior Management Overview

Pictures!
ABC Model of Behavior Management

Antecedents

Behaviors

Consequences
ABC Model of Behavior Management

Antecedent
- What causes the behavior?
- Are there any patterns?

Behavior
- What is the behavior?
- Is it witnessed?

Consequence
- What are we doing about the behavior?
- What successfully stops the behavior?
Behaviors after Injury

- Why do injuries possibly cause behaviors?
  - Location of Injury
    - Frontal Lobe

- Typical Behaviors
  - Physical or Verbal Outbursts
  - Mental Rigidity
  - Disinhibition
  - Poor Judgment
  - Lack of Empathy
Types of Brain Injuries

- Injuries most associated with Behavior Challenges
  - Traumatic Brain Injuries, including concussions and “Mild” Brain Injuries
  - Frontal Lobe Tumors
  - Diffuse Acquired Injuries
    - Anoxia
    - Encephalopathy, especially with underlying co-morbidities such as Dementia
    - Other neuro-degenerative diseases
An Effective Behavior Plan

- What makes for Effective Behavior Management?
  - Structured
  - Consistent
  - Repetitive
  - Specific
  - Practical
  - Meaningful
Behavior Plan Development

- Identify the target behavior
- Gather information about the behavior (ABC’s). Collect data.
- Create a hypothesis to explain the behavior (ABC’s)
- Create an intervention based on the hypothesis
- Implement the intervention
- Keep collecting data
- Necessary Maintenance
The Steps of Behavior Plan Development
Step 1

- **Identify the target behavior**
  - Reasons for placing someone on a 1:1 for safety
    - Removing medical/safety equipment
    - Wandering
    - Agitation
    - Attempts to get out of bed without supervision
    - Other: ________________________________
Step 2

- Gather Information about the behavior.
- Antecedents and Consequences.
- Data collection.

...and she didn't even have any data to back it up.
### Questions to ask when collecting data for a behavior plan

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>When does the behavior occur</td>
</tr>
<tr>
<td>When did the behavior start</td>
</tr>
<tr>
<td>Where does the behavior occur</td>
</tr>
<tr>
<td>What frequency does the behavior occur</td>
</tr>
<tr>
<td>What is happening in the environment when the behavior occurs</td>
</tr>
</tbody>
</table>
Questions to ask when collecting data for a behavior plan

- What is happening with the patient when the behavior occurs (anxiety, urinary urgency, fatigue, etc)
- What changes may have taken place when the behavior started (i.e., cognitive status, change of medications, new medical issue, staff change, etc)
- What happens after the behavior
- What might the person be gaining from the behavior
- What has been done previously to manage the behavior and what happened.
Why is the behavior occurring: Antecedent Examples

- Noise
- Overstimulation
- Boredom
- Usual coping style
- Cognitive/linguistic impairment
- Nicotine/drug addition/dependence
- Poor insight and safety awareness
- Impulsiveness
- Lack of understanding of safety rules/procedures
- Fear of not making it to the toilet
- Need for attention
- Other
Why is the behavior occurring?

- Possible Consequence Examples
  - Attention
  - Feeling of control
  - Avoidance of an activity
  - Medication
  - Anxiety reduction
Step 3 and Step 4

- Create a hypothesis to explain the behavior
- Create an intervention based on the hypothesis
Intervention Strategies

- Frequent review of safety expectations/rules/procedures
- Decrease stimulation (i.e., limit the number of visitors or length of visits, close door, change roommate, etc.)
- Use of 1:1 patient activity
- Visual cues/prompts
- Increase positive reinforcement for desired behavior
- Practice appropriate behavior (example: train to use call light)
- Provide support/increased positive attention
- Modify environment (place familiar objects nearby, play relaxing music, etc.)
Intervention Strategies

- Schedule toileting
- Schedule adequate rest
- Monitor activity level (increase/decrease)
- Use redirection
- Use male/female aide/therapist
- Use same aide/therapist
- Refer for pharmacological intervention
- Gradually fade visual/verbal cue/prompts (ie distance of 1:1 from patient.)
“I’m behaving well. Are you sure you wouldn’t like to positively reinforce it?”
Step 5

- Implement the Intervention

- Our facility has created, the SAFE Plan
  - S- Safety
  - A- Awareness
  - F- Functional
  - E- Evaluation
Safety Awareness Functional Evaluation (SAFE)

- Used when someone is placed on 1:1 observation, or needs behavior modification.
- Spells out potential Causes or Antecedents - as mentioned above
- Gives a checklist for management strategies
- States a continued plan or to discontinue 1:1/plan
Our SAFE plan

- Patient
- Family
- Nursing Staff
- Therapist
- Doctor
SAFE plan roll out

- Interdisciplinary Team
  - 24 hour tracking
  - If the patient is with the staff member, that staff member tracks that time period
  - Neuro Patient Round
  - Role of each team member

- Expectations
  - Consistency
  - Use of variety of intervention strategies
  - Efficient achievement of patients’/staff goals
1:1 SAFETY AWARENESS FUNCTIONAL EVALUATION (SAFE)

REASON FOR 1:1 - BEHAVIOR
Removing medical/safety equipment
Wandering
Agitation

ATTEMPTS TO GET OUT OF BED WITHOUT SUPERVISION
Other: ________________________________

POTENTIAL CAUSES OR ANTECEDENTS
Noise
Overstimulation
Boredom
Usual coping style
Cognitive/linguistic impairment
Nicotine/drug addiction/dependence
Poor safety awareness

IMPULSIVENESS
Lack of understanding of safety procedures/rules
Lack of insight
Fear of not making it to the toilet
Need for attention
Other: ________________________________

POSSIBLE MANAGEMENT STRATEGIES
Frequent review of safety expectations/rules/procedures*
Decrease stimulation
Use of 1:1 patient activity (See attached form)
Visual cues/prompts
Increase positive reinforcement for desired behavior
Practice appropriate behavior (example, train to use call light)
Provide support
Modify environment (place familiar objects nearby, play relaxing music, etc.)
Schedule toileting
Schedule adequate rest
Monitor activity level (increase/decrease)
Use redirection*
Use male/female aide/therapist
Use same aide/therapist
Refer for pharmacological intervention
Gradually fade distance from patient and visual/verbal cue/prompts
Other: ________________________________

GOAL REQUIRED FOR DISCONTINUING 1:1
Three consecutive days of appropriate safety awareness/behavior
Other: ________________________________

NOTE: Therapist, nurses and aide should be monitoring occurrence of identified 1:1 behavior noting time of day, possible precipitating antecedents, and consequences.

* (Attempt to state in a positive manner. Attempt to state the behavior that is expected rather than using the words “no” and “don’t.”)
<table>
<thead>
<tr>
<th>Date</th>
<th>Behavior</th>
<th>Potential causes or antecedents</th>
<th>Recommended management strategies</th>
<th>Patient activity used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 Behavior not present</td>
<td>0 N/A</td>
<td>0. None used</td>
<td>0. None used</td>
</tr>
<tr>
<td></td>
<td>1 Remaining medical/safety equipment</td>
<td>1 Noise</td>
<td>1. Frequent review of safety equipment/procedures*</td>
<td>1. Demonstrate call light and have patient practice</td>
</tr>
<tr>
<td></td>
<td>2 Washing</td>
<td>2 Overstimulation</td>
<td>2. Encourage calmness</td>
<td>2. Encourage self-feeding</td>
</tr>
<tr>
<td></td>
<td>3 Agitation</td>
<td>3 Verbal</td>
<td>3. Increase positive reinforcement for desired behavior</td>
<td>3. Encourage patient to read or look at magazines</td>
</tr>
<tr>
<td></td>
<td>4 Attempts to get out of bed without supervision</td>
<td>4 Visual/auditory</td>
<td>4. Provide support</td>
<td>3. Review patient’s therapy schedule</td>
</tr>
<tr>
<td></td>
<td>5 Other</td>
<td>5 Other</td>
<td>5. Make environment (place familiar objects, call button, etc. nearby; play relaxing music, have family pictures and objects in room, etc.)</td>
<td>5. Review orientation to time and place by referring patient to communication board or log book (if patient has one)</td>
</tr>
<tr>
<td>3 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>4 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>5 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>6 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>7 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>8 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>9 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
<tr>
<td>10 PM</td>
<td>0, 1, 2, 3, 4, 5 Frequency</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8</td>
</tr>
</tbody>
</table>
Rehab Center Overview

- Continuum of Care for Patient
- Acute rehab level
  - Layout of our Hospital
  - Staff overview
  - Patient Schedule
  - Challenges?
Clinical Staff Challenges

**Communication**
- Best mode?
- Technology

**Staffing**
- Shift changes
- Rotating Staff Placement

**Campus Environment**
- Larger facilities
- Lack of a Locked Unit

**Stress**
- Poor stress management
- Poor communication
SAFE plan review

- What do we gain from it?
  - Interdisciplinary communication
  - Real-time documentation

- How does it help us?
  - We have consistent tracking, helping us develop future goals

- What will we do in the future
  - Computerized documentation
  - Increase the role of the neuropsychologist in the facility
  - Follow up with patients after discharge from our facility
How ours can help yours

- The SAFE plan is helping us to:
  - Become more interdisciplinary
  - Foster communication
  - Help our patients identify safety precautions
  - Help our patients reach their goal of independence, with no more 1:1 observation need
Questions?
Resources


