3-92 DOS assessment with incomplete data

TIPS Question:

When using DOS, some shifts are less compliant than others to complete the form. If there are 3 concurrent evenings not completed and 2 night shifts partially completed, is the assessment incomplete or do we just use the remaining days that are completed to do our assessment?

Response:

Variability among staff in terms of their involvement in and commitment to completing behavioural monitoring tools such as the DOS is not uncommon. This is more likely to be the case early on when they are still becoming familiar with the assessment tools, why they are being used and what they can meaningfully contribute to the care of the resident. It also takes time to help them to recognize how their participation in the assessment process (and remember: assessment is a step-by-step process) can enhance their own learning and help them to do their job better and often with less, not more stress.

If the DOS is partially completed, and in this case it would appear that you have been able to gather data about the resident's behaviour during the day, and only partially for the evening and nights hours, you still have valuable information to review *as a team*. After you have colour coded the DOS look for as many opportunities as possible to share this information with your team members e.g. during report at the change of shift (over several days), in 1:1 conversations whenever possible, team meetings, care conferences, etc. Validate their efforts to complete the DOS, even if only partially, and brainstorm together about what the findings might reveal, possible patterns, and what further questions still need to be asked. If staff is given the opportunity, the DOS often triggers excellent discussion and problem solving. Hopefully they will see how valuable the completed data is in terms of guiding next steps. This may also encourage greater participation the next time the DOS is used. If you implement any changes to the care plan for this resident (behavioural and/or psychotropic care strategies) plan to repeat the DOS and ensure that the team is involved in this planning process.

Just a word in general about getting staff 'buy-in' and your role as a resource and a 'coach'; Remember that direct care staff know the resident very well. Their participation in the gathering of information using the tools e.g. Cohen, DOS, SIGECAPS, etc. provides an excellent opportunity for them to share what they know. Their observations are valuable and indeed critical to the assessment and care planning process. It is important to convey to them that you are trying to build on their knowledge and experience, validating what they already know. Coaching them in the use of the tools will be more effective when it is case-based rather than general (the teachable moment), and if they feel they have some control in the process and decision-making. Provide them with ongoing feedback on the results i.e. how their observations and their knowledge about the resident have been captured by using the tools, and explore ways of having them involved in the process e.g. have them share in the presentation of the information to the rest of the team involved in the resident's care including the physician, specialty geriatric team partners, etc. I know of some PRPs who have the front line staff help to do the colour coding of the DOS. Also provide them with the opportunity to reflect on and refine the process of gathering information using the tools will be valuable – what worked well, how could things be changed, how effective was communication between and among team members and how could it be improved?

I also find it helpful to remind myself that screening tools are used within the context of a structured assessment and as such provide only part of the picture. They are not a means unto themselves. Once you have gathered the data, whether it is regarding the pattern of the person's behaviour (using the DOS, CMAI, ABC's etc), his/her cognitive functioning (MMSE/Clock), or emotional health if you are concerned about mood (Cornell; SIGECAPS, etc), you want to use those results to help answer specific questions. The information you then gather and the answers to those questions should help to direct the care plan.

Remember too, that you have the U-First! wheel to help you promote that dialogue. Model the use of the wheel, explaining it one person at a time, in care conference, team meetings, etc, to help stimulate and focus discussion, and identify the questions that are still unanswered. The goal is always to problem solve together as a team, in an effort to understand what the resident's behaviour means for him/her, and the possible causes.

Remember, it takes time to coach others but finding those opportunities, in the moment, on the job and building in a "teaching" nugget pays off over time. It certainly strengthens positive staff and often helps to gradually shift the perceptions of others that require a little more support and encouragement. Finally, To help you serve as a *resource* to others you will want to review again the section *Learning happens on the job* in the P.I.E.C.E.S. guide.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*