Improving Engagement Level and Staff-Resident Interaction in a New Therapeutic Day Unit

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Previous research studies have found evidence of the importance of providing feedback and training to direct care staff. Changes in attitude, support and maximum involvement at all levels of staff are necessary if activity levels of engagement are to be successfully increased. The ways in which staff encourage residents to participate and give them attention for doing so can influence the things that residents do. This study is an observational research intended to provide some baseline and 5-month follow-up data on levels of engagement and staff-resident interaction as part of a longer-term programme to develop a high-quality service in a new therapeutic day unit. Baseline and follow-up data were collected by direct observations of the staff-resident interaction and the engagement levels of 14 people with learning difficulties during seven different activity sessions. The results showed that residents increased their engagement level from 37.5% to 43.2% and staff-resident interaction increased from 36.8% to 64.5% after 5-month follow-up. The implications of these data, the importance of attitude change and the positive effects of staff involvement and participation in organising the day unit are discussed.

INTRODUCTION

Previous research studies have been concerned with behavioural procedures to reinforce specified behaviours. There has also been an emphasis on environmental design, such as play areas, hydrotherapy pools and physical structure of the settings, to promote desirable behaviours.[1] Jones et al[2] studied the properties of materials and the physical environment which encourage residents to engage in play activities.

Structured activities have been found to provide more verbal interactions between residents and staff than unstructured situations.[3] Porterfield et al[4] found that staff could raise the engagement level of a group of eight adults with severe learning difficulties in a one-hour activity period from 31% in baseline to 81%. All these approaches have been aimed at providing residents with purposeful activities to promote their learning.

Other researchers have shown evidence of the importance of providing feedback and training to direct care staff. They have also shown the crucial influence that staff attention has on the way that residents behave. The ways in which staff encourage residents to participate and give them attention for doing so can influence the things that residents do.

Fleming and Sulzer-Azaroff[5] showed that direct care staff improved their teaching skills when provided with feedback on the job, but that these skills were not maintained after a 2-month follow-up. There is also evidence that training staff, increasing the structure of staff job assignments and providing feedback can contribute to the increase of residents' participation in activities.[6]

Other studies have investigated the application of self-monitoring procedures to staff management programmes and provide support for the value of the combination of self-monitoring and feedback procedures.[7]

Increased engagement and more interaction with staff in small community homes have also been demonstrated by Thomas et al.[8] Care staff should feel part of the team, without whom the success of the therapeutic programmes and the achievement of residents' learning and independence would be impossible.

Normalisation refers to the rights and benefits of people with learning difficulties. Wolfensberger[9] suggested that people have the right to experience a 'normal' life style. Normalisation is a defence against the abuse and neglect of people with learning difficulties.

Sinson and Stainton[10] demonstrated how difficult it is to change people's negative attitudes towards those with learning difficulties and that the media did not present positive images of people with learning difficulties.

While the environment and activities play an important part in the development of residents, changes in attitude towards them are the main element required to give people with learning difficulties their rights and benefits which will allow them to become more independent. This, in turn, will help to develop the quality of social interactions and relationships between residents and staff, and improve their quality of life.

Quality of life is 'the satisfaction of an individual's values, goals and needs through actualisation of their abilities or life style'.[11] This implies that people must be treated as individuals who are valued members of society. How we view people affects how we behave towards them.

Because direct care staff members are the most likely to have more contact and develop strong relationships with residents, increased quality of staff-resident interaction would promote a higher level of engagement and continue the residents' learning and behavioural development.

This study is an observational research intended to provide

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some baseline and 5-month follow-up data on levels of engagement and staff-resident interaction as part of a longer-term programme to develop a high-quality service in a therapeutic day unit. The study also provided an opportunity to explore the importance of attitude change and the positive effects of staff involvement and participation in the organisation of the day unit.

METHOD

Setting

The study was carried out in a therapeutic day unit situated within a locally based hospital unit (LBHU) in East Dorset. The aim of the unit is to provide intensive treatment activities for a maximum of 15 residents, primarily from two LBHUs, who require special care and therapeutic programmes due to physical disability and/or challenging behaviour and are, therefore, unable to attend training centres.

The service provided by the day unit is based on interdisciplinary assessment and treatment programmes to meet the needs of the residents. The multidisciplinary team (that is, occupational therapist, clinical psychologist, physiotherapist and speech therapist) meets regularly to review and revise residents' progress.

The unit is staffed by a senior occupational therapist, a basic grade occupational therapist, a technical instructor III, an occupational therapy helper and four regular care assistants from the LBHUs. The day unit provides activities between 9.30 am and 5.00 pm; these are organised in two living rooms, one dining room and the garden of the LBHU.

Recreational activities are an important part of the weekly programme in the day unit. Outings are set up regularly according to the availability of the community resources.

Subjects

At the time of the study, there were 14 residents with learning difficulties attending the day unit. These were 10 males and 4 females, ranging in age from 22 to 65 years (average 33). Seven residents had recently been transferred from a large hospital to a new LBHU.

Two residents showed behavioural problems (absconding or self-stimulatory behaviour) and were regarded by the staff as the most difficult to manage. Twelve of the residents were unable to speak and had very few self-help skills, so staff had to deal with incontinence problems. Two residents were blind and five were non-ambulant. All the residents required personal and physical care as well as individual training in self-help skills.

Measurement

Seven 1-2 hour sessions were observed by the researcher. The activity sessions observed were sensory stimulation, greeting, body awareness, collage, cookery, music and group games.

A 'time sampling' procedure whereby the occurrence or absence of a particular behaviour is noted at a specific moment of time was carried out and observations were divided into 10-minute periods. At the beginning of each period, the observer noted on the recording sheet the behaviour of each resident (14 individual observations) in a specified order, followed by noting the behaviour of each member of the staff (8 individual observations). A total of 6 (1-hour session) or 12 (2-hour session) observations were made for each resident and member of staff respectively during each session.

A resident was considered to be engaged if he/she was (a) occupied with materials, (b) responding when encouraged to use materials, or (c) participating in a group activity (such as passing a ball). Interaction was recorded when a staff member (a) gave positive attention to residents, (b) provided a choice of materials, (c) prompted residents to start using materials, or (d) praised and encouraged residents to participate in the activity.

Single percentages for engagement and interaction respectively were calculated for each session by totalling the number of 'residents-engaged' scores and dividing this by the total of the 'residents-present' scores, and then expressing the result as a percentage. A reliability observer took part in the observations simultaneously during five sessions. The scores for all five sessions were averaged to give the overall interobserver agreement. Interobserver agreement for engagement averaged 93.8% and that for staff-resident interaction averaged 98.9%.

Occupational therapy staff were asked to keep a record of daily goals based on residents' needs (that is, to encourage J to participate in painting, or for K to make eye contact) and their use of community resources (such as shops, café, pubs and swimming pool). The day unit had its own daily activity planning as well.

Feedback

After each session observed, informal meetings were held with staff to discuss the outcome of the session; feedback was given about care assistants' involvement, disruptions, residents' engagement, ways of improving engagement level, work on a 1:1 basis, residents' needs, behavioural problems, occupational therapy helpers' motivation, group organisation, staff training and houseparents' participation.

At the end of the baseline, results of the observations, in the form of graphs and charts about individual residents' engagement and staff-resident interaction levels, were given to staff.

Training and involvement of care staff

Many changes took place during the months following the baseline. Training sessions for the care staff were organised, covering areas such as the role of the occupational therapist, occupational therapy resources and how residents can benefit from the day unit input.

Participation in weekly meetings was encouraged: all members of staff had the opportunity to discuss problems, to suggest new ideas and to be involved in making decisions on the day-to-day running of the day unit. The role of each member was discussed, and opportunities to explore and implement individual ideas were facilitated. Praise and recognition of good work and achievement were given. The importance of the contribution of each member of the staff in the success of the day unit was recognised.

Follow-up

The follow-up was conducted to determine whether or not the engagement level and staff-resident interaction had increased. The follow-up observations were made 5 months later and the same procedure as for the baseline was carried out.

The same seven sessions were observed and engagement level and staff-resident interactions were recorded for each resident present in each session.

In addition, an adapted form of the Sheltered Care Environment Scale[12] was administered to all those who work regularly within the day unit. The scale consists of 70 items covering seven areas, all of which represent important forms of stress within the working environment.

1. *'Cohesion'* measures how helpful and supportive staff members are towards residents.
2. *'Conflict'* measures the extent to which residents express anger and are critical of each other and of the facility.

3. *'Independence'* assesses how self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self-direction they are encouraged to exercise.
4. *'Self-exploration'* measures the extent to which the environment encourages residents to express and openly discuss their feelings and concerns.
5. *'Organisation'* assesses how important order and organisation are in the facility, the extent to which residents know what to expect in their day-to-day routine, and how explicit the rules and procedures are.
6. *'Resident influence'* measures the extent to which the residents can influence and change the rules and policies of the facility and the extent to which the staff restrict the residents through regulations.
7. *'Physical comfort'* measures the extent to which comfort, privacy, pleasant décor and sensory satisfaction are provided by the physical environment.

It should be pointed out that this scale represents the opinions of the staff on those areas covered by the scale and does not reflect residents' opinions about the stress in the environment.

RESULTS

The results of this study provided useful information for the therapeutic day unit. They were based on a random sample of the different activities organised by the day unit, and engagement level and staff-resident interaction may vary from day to day according to the residents' mood, external conditions and environmental and organisational factors.

Fig.1 shows the mean percentage of residents engaged in activities for each session, during the baseline and the follow-up. During baseline, the overall mean percentage of engagement was 37.5% (range 13.9% to 60.7%). During the subsequent follow-up, the engagement increased to an overall mean of 43.2% (range 20.3% to 75%). A Friedman test showed no significant evidence of differences (chi^2=0.14, df 1).

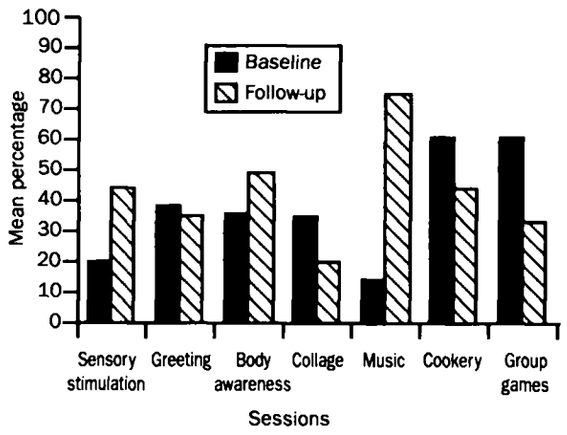

Fig.1. Mean percentage of engagement level.

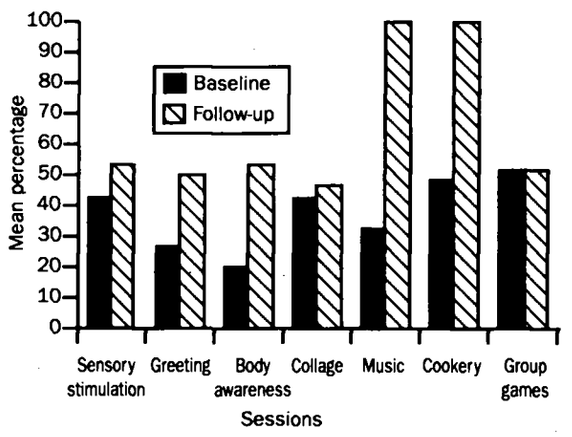

Fig.2. Mean percentage of staff-resident interaction.

Fig. 2 shows the mean percentage of staff-resident interaction during each session. The overall mean level of interaction during baseline was 36.8% (range 20% to 50%). Data collected on the follow-up observations showed that the level of interaction increased to 64.5% (range 46.2% to 100%). A Friedman test showed a significant difference between baseline and follow-up (chi^2 = 5.14, df 1, $p<0.02$).

An average of 60 goals a month were set by staff within the day unit. Goals were set every morning. In the afternoon, when the unit had closed, it was noted whether these goals had been achieved or not. An average of 15 goals was achieved a week. A weekly average of five community resources was continually used by the unit.

The level of disruptive behaviour was much higher during baseline than the follow-up. A major problem for the staff was that residents would leave their places and engage in a variety of dangerous or disruptive behaviours, such as pushing staff, knocking over chairs or running out of the room. In dealing with disruptive behaviour, the staff ignored minor incidents and encouraged residents to participate in the activities.

Five staff members answered the Sheltered Care Environment Scale. A percentage of agreement was calculated for each subscale: cohesion 71%, conflict 33%, independence 92%, self-exploration 28%, organisation 69%, resident influence 35%, and physical comfort 4%.

DISCUSSION

This research, although simple in conception and design, provides an important contribution in showing that changes in attitude and staff training, and participation in the running of a day unit, can improve interaction with residents, increase job satisfaction and help residents to improve their level of engagement.

Staff-resident interaction was especially higher and its content and relationship to residents' behaviour has a number of commendable features consistent with the general orientation and principles of the therapeutic day unit.

The results showed an increase in level of engagement and, although this increase was low, there was optimism among the staff that the participation of residents in activities will improve. One of the reasons for this low increase might be that the residents had been recently transferred from a large institution where they did not have the opportunity to take part in activities and group sessions were uncommon.

Another reason why there was a decrease in engagement in some activities might be that the follow-up was conducted during the very hot summer of 1989 and this could have led to a low disposition to take part in some activities, such as cookery and collage, which were held indoors.

Due to the difficulty of engaging the residents, they required more attention and encouragement to take part in the activities; engagement levels were highest when staff interacted with residents. Continuous feedback, support and the maximum involvement of all levels of staff were necessary to increase and maintain the level of engagement.

Although not completely eliminated, the disruptive behaviour no longer presented a major problem to the staff during the sessions. Great emphasis was given to the use of Makaton signs, which helped to improve understanding and communication with residents.

Results from the Sheltered Care Environment Scale show that staff agreed on how supportive and helpful they were towards the residents and how they were encouraged to be

creative and to do more things on their own. There was a very low agreement on physical comfort; staff agreed that the physical environment, because of the lack of space, does not provide the comfort, privacy, pleasant décor and facilities for sensory satisfaction.

There was also low agreement on self-exploration and resident influence. The staff suggested that these areas, as measured by the scale, were difficult to assess due to the severity of the residents' handicaps. With respect to organisation, the care staff felt that residents knew that they were expected to take part in the daily activities and would not be allowed to leave the day unit. The resident influence was expressed in the flexibility of the daily programmes and the emphasis on individual needs.

The use of graphs has been of great assistance to staff and helped them to monitor the residents' progress. This was introduced by the researcher as part of the feedback to staff.

One of the main problems faced by the day unit staff was the lack of space and own facilities. The unit had to make use of some of the areas of the residential unit (LBHU), which did not provide and facilitate good environmental conditions for the implementation of therapeutic programmes.

In spite of all these disadvantages, the day unit has improved not only the residents' quality of life but also relationships between the residential unit and the day unit staff. This has led to improvement in staff morale and in the consistency with which all staff interacted positively with individual residents.

During the baseline, it was observed that some care staff would spend most of the time holding a resident's hand without encouraging him/her to participate or they would sit waiting for a qualified staff member to tell them what to do.

The introduction of carefully planned individual training programmes has increased the residents' involvement and is helping them to become more independent. In fact, some of the sessions observed during the follow-up were conducted in small groups and on a 1:1 basis, giving more attention and emphasis to individual needs. This might explain why the level of engagement was higher in some sessions than others.

The most positive aspect of this research is the high increase in staff-resident interaction. This has been achieved by training sessions and the development of team work. Care staff showed more initiative, confidence and responsibility, they felt respected and valued, and their job satisfaction was much greater.

Care staff were more enthusiastic, were happier and showed a good sense of humour, always interacting with residents or attending someone who was not engaged. A good response from residents promoted more interaction from staff and vice versa.

During meetings, all the staff were involved in making decisions about the running of the unit; care staff had the opportunity to explore and implement their own ideas, and initiative was encouraged. Each member felt involved and responsible for the running of the day unit.

It appears that for people with learning difficulties to achieve high levels of participation, more staff attention and changes in attitude are required. An important component of therapeutic programmes is the residents' interaction and development of relationships with staff members. Since such programmes can only be implemented with the cooperation of the staff, it is important that consideration be given to those environmental events that will provide opportunities to achieve and implement such relationships.

After many ups and downs, the unit is succeeding in improving its image and status and is providing residents with the opportunity to learn, develop new skills and become more independent.

CONCLUSION

In these times of equality and social changes, it is imperative to re-evaluate our views towards people with learning difficulties. Community care and normalisation, which aim at recognising people with learning difficulties as valued human beings, will never be possible unless society as a whole redefines its principles and realises that stigmatisation or rejection of people is the worst degradation that the human race can inflict on itself.

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References

1. Bennett S, Crisp AG, Sturmey P. Evaluation of the use of an inflatable with adults with severe mental handicap: an observational study. *Br J Ment Subnorm* 1988; **34**, part 2 (67): 105-11.
2. Jones ML, Favell JE, Lattimore J, Risley TR. Improving independent engagement on nonambulatory multihandicapped persons through systematic analyses of leisure materials. *Ann Interv Dev Disabil* 1984; **4:** 313-32.
3. Prior M, Minnes P, Coyne T, Golding B, Hendy J, McGillivary J. Verbal interactions between staff and residents in an institution for the young mentally retarded. *Ment Retard* 1979; **17:** 65-69.
4. Porterfield J, Blunden R, Blewitt E. Improving environments for profoundly handicapped adults: using prompts and social attention to maintain high group engagement. *Behav Modification* 1980; **4**(2): 225-41.
5. Fleming RK, Sulzer-Azaroff B. Enhancing quality of teaching by direct care staff through performance feedback on the job. *Behav Residential Treatment* 1989; **4**(4): 377-95.
6. Parsons MB, Cash VB, Reid DH. Improving residential treatment services: implementation and norm-referenced evaluation of a comprehensive management system. *J Appl Behav Anal* 1989; **22:** 143-56.
7. Richman GS, Riordan MR, Reiss ML, Pyles DAMm, Bailey JS. The effects of self-monitoring and supervisor feedback on staff performance in a residential setting. *J Appl Behav Anal* 1988; **21**(4): 401-409.
8. Thomas M, Felce D, De Kock U, Saxby H, Repp A. The activity of staff and of severely and profoundly mentally handicapped adults in residential settings of different sizes. *Br J Ment Subnorm* 1986; **32**, part 2(63): 82-92.
9. Wolfensberger W. The definition of normalisation: update, problems, disagreements and misunderstandings. In: Flynn RJ, Nitsh KE, eds. *Normalisation, social integration and community services.* Baltimore, Md: University Park Press, 1980.
10. Sinson JC, Stainton LS. An investigation into attitudes (and attitude change) towards mental handicap. *Br J Ment Subnorm* 1990; **36**, Part 1, (70): 53-64.
11. Emerson EB. Evaluating the impact of deinstitutionalisation on the lives of mentally retarded people. *Am J Ment Defic* 1985; **90:** 277-88.
12. Lemke S, Moos RH, Gauvain M, Mehren B. *Multiphasic environmental assessment procedure (MEAP).* Palo Alto, Ca: Stanford University School of Medicine, 1979.