Implementation of Mental Health Huddles on Dementia Care Units*

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RÉSUMÉ

Les comportements réactifs sont communs chez les résidents des unités de soins de longue durée (SLD), mais le personnel en soins directs reçoit peu de formation, de support ou d'opportunités de discuter et de collaborer pour gérer ces comportements. Pour ce projet de recherche-action participative, nous avons utilisé la technique du caucus de santé mentale pour faciliter la discussion et la gestion des comportements réactifs. Nous avons impliqué des membres du personnel en soins directs (p. ex., travailleurs de soutien personnel, infirmières autorisées et auxiliaires autorisées, personnel d'entretient) dans l'apprentissage de l'utilisation des caucus. Ces caucus ont servi de forums pour informer le personnel, résoudre des problèmes et développer des plans d'action centrés sur le client. Cinquante-six caucus ont eu lieu sur une période de 12 semaines, chacun impliquant de deux à sept membres du personnel en soins directs. Des groupes de discussion auxquels ont pris part nos participants ont indiqué une amélioration de la collaboration, du travail d'équipe, du support et de la communication au sein du personnel lors de la discussion de comportements réactifs spécifiques. Les caucus de santé mentale ont offert au personnel en SLD l'opportunité de collaborer et d'aborder des stratégies pour optimiser les soins du client. Des études supplémentaires sur l'impact des caucus sur les soins du client sont nécessaires.

ABSTRACT

Client-responsive behaviours occur commonly among residents in long-term care (LTC) settings; direct-care staff, however, receive little education, support, or opportunities to discuss and collaborate on managing such behaviours. Our participatory action project introduced mental health huddles to support staff in discussing and managing client-responsive behaviours in long-term care. This research project engaged direct-care staff (e.g., personal support workers, registered practical nurses, housekeeping staff, and registered nurses) in learning how to use these huddles. Staff workers used huddles as a forum to stay informed, review work, problem solve, and develop person-centered action plans. Fifty-six huddles occurred over a 12-week period; two to seven direct-care staff participated in each huddle. Focus groups indicated improved staff collaboration, teamwork, support, and communication when discussing specific responsive behaviours. Huddles provided LTC staff with the opportunity to collaborate and discuss strategies to optimize resident care. Further research on how huddles affect resident care outcomes is needed.

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Introduction

Population projections indicate that the percentage of older adults will double over the next 25 years. In 2009–2010, Statistics Canada estimated that more than 200,000 residents were living in 2,136 long-term care (LTC) homes (Statistics Canada, 2011); 42 per cent were aged 85 and older. As many as 30–50 per cent of elderly individuals over age 85 are affected by dementia, and dementia is the leading reason for admitting elderly people to LTC facilities (Hale & Frank, 2011). Dementia includes a large class of neurological diseases that result in the deterioration of the brain (Alzheimer Society of Canada, 2010). As these diseases progress, individuals may lose the ability to care for themselves, emotionally and physically. Characteristics associated with dementia may include the following: inadequate nutritional intake; reduced hygiene; difficulty taking medications; deterioration of emotional health; difficulty communicating; delirium; sleep difficulties; personal safety challenges; and responsive behaviours (RB).

Responsive behaviours reflect how actions, words, or gestures are used by persons with dementia to express something important about their personal, social, or physical environment (Dupuis & Luh, 2005; Murray Alzheimer Research and Education Program, 2012). More specifically, responsive behaviours describe a set of reactions that arise from environmental stress or unmet needs (Dupuis, Wiersma, & Loiselle, 2012). The Ontario government has adopted the language and philosophy of responsive behaviours, as demonstrated in the Long-Term Care Act and Regulations (2007). Cohen-Mansfield (2000) categorized such behaviours as verbally non-aggressive behaviours (such as complaining and negativism); verbally aggressive behaviours (e.g., cursing, screaming, and verbal sexual advances); physically non-aggressive behaviours (e.g., pacing, wandering, and hiding things); and physically aggressive behaviours (e.g., hurting self or others, kicking, biting, and throwing things). Responsive behaviours are common among persons with dementia, with 58 per cent of LTC residents exhibiting such expressions (Canadian Institute for Health Information, 2010). Unfortunately, many LTC facilities are not equipped to provide specialized care for persons with responsive behaviours.

Furthermore, direct-care staff (e.g., personal support workers, registered practical nurses, housekeeping staff, and registered nurses) in LTC settings tend to receive little education and support to care for residents with responsive behaviours, resulting in a discrepancy between the staff's skills and knowledge and the residents' mental health and care needs. Responding to the need for providing evidence-based standards for mental health issues in LTC, the Canadian Coalition for Seniors' Mental Health (CCSMH) published national guidelines for the assessment and treatment of mental health issues in LTC homes, including preventive strategies (CCSMH, 2006). One component of the guidelines focuses on mood and behaviour management.

The coalition's overall recommendations focused on the implementation of strategies that promote communication among staff, residents, and their families. Individualized care plans should be provided with consideration of best-practice guidelines and recommendations; each facility should have an assessment protocol that specifies that screening for depressive and behavioural symptoms will occur in the early post-admission phase and continue at regular intervals, as well as in response to significant changes in resident status (CCSMH, 2006). For situations where staff are caring for clients with responsive behaviours, CCSMH (2006) has recommended considering social contact interventions, especially when the goal is to minimize sensory deprivation and social isolation, to provide distraction and physical contact and to induce relaxation. Sensory/relaxation interventions should be considered when the goal is to reduce responsive behaviours, stimulate the senses, and enhance relaxation. Structured recreational activities should be considered where the goal is to engage the resident.

At an organizational level, LTC facilities should have a written protocol in place related to staffing needs specific to the care of older residents with responsive behaviours, an education and training program for staff related to the needs of residents with responsive behaviours, and a physical and social environment that is therapeutic (CCSMH, 2006). System recommendations by CCSMH (2006) included ensuring adequate planning, allocation of required resources and

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organizational and administrative support for the implementation of best practice guidelines, and monitoring and evaluating the implementation of best-practice recommendations. In our participatory action project described in this article, we examined the use of *mental health huddles* (MHHs) to facilitate implementation of the relevant CCSMH recommendations. This article describes the process of MHH implementation, the huddles' content, and direct-care staff's perceptions of the implementation.

Huddles

Huddles, similar to safety briefings (Verschoor et al., 2007), are based on the after-action review model of knowledge transfer that has been used for decades by organizations such as the United States Army (U.S. Department of Veterans Affairs, 2010). Huddles enable teams to have short but frequent briefings to stay informed, review work, make plans, and support progress. Huddles offer a mechanism for immediate knowledge transfer and learning following errors or "close calls" (U.S. Department of Health and Human Services Administration on Aging, 2010). These allow staff to assess an event or situation in order to understand what has taken place and to identify corrective actions that may be used in a similar future event.

Huddles have been used for many years in a variety of health care settings, especially in acute-care facilities. Research on huddles in the acute-care setting has found that they improve workplace culture through enhanced communication and collaboration (Quigley et al., 2009; Ryan, Mericle, & Meliones, 2008), result in higher patient and staff satisfaction scores (Huijbregts et al., 2012), and contribute to improved patient flow in acute-care settings (Hayden, Rockey, Ware, & Smith, 2008).

Since huddles have been found to be effective in other settings, we aimed to introduce the huddles concept into the LTC setting to help direct-care staff interact more effectively with residents with responsive behaviours. Since direct-care staff are often not active participants in the care planning process (Wagner, Damianakis, Mafrici, & Robinson-Holt, 2010), huddles in LTC facilities are unique in that they serve as direct-care-staff–driven, unit-based, and "just in time" moments to enhance resident-centered care. By introducing mental health huddles, direct-care staff members were given the opportunity to discuss issues and generate solutions to mental-health–related concerns (e.g., how to prevent and manage a responsive behaviour) in a timely manner. Our goal was for the MHH approach to enable direct-care staff to capitalize efficiently on the skills and knowledge of all staff when making care decisions and to allow decisions to be specific and resident-centered.

Participatory Action Research

Our approach to introducing MHHs on an LTC unit was through the use of *participatory action research* (PAR) (Huijbregts et al., 2012; Sidani & Epstein, 2003). Team members – all staff who worked on the unit during our project – chose the PAR approach as a foundation for development and implementation of MHHs. PAR begins when staff recognizes any issues in an institution and a need for change (e.g., improving how staff help residents with responsive behaviours). A hallmark feature of this approach is to engage staff throughout the research process (Minkler & Wallerstein, 2008). The use of PAR allows for true and meaningful participation of all involved staff and results in outcomes that are more relevant to "real life" daily clinical practice (Chapman, 2009; Sidani & Braden, 1998). This approach was initially developed on the assumption that staff would be actively involved in the planning and implementation process. Furthermore, PAR must be undertaken in a culture where change is embraced, and actively includes those whom it will influence and affect (Sidani & Epstein, 2003). The PAR process during an earlier project supported ongoing critical reflection on resident-centered care that was provided, on the impact of the specific recommendations that were implemented, and on the experience of the staff when they incorporated these recommendations into their daily practice (Huijbregts et al., 2012). This experience informed our choice of PAR for the current project.

Objectives

With PAR established as the framework to guide the MHH project's implementation, we set the following objectives for this research study: (1) to implement mental health huddles on an LTC unit for residents expressing responsive behaviours; and (2) to identify the topics discussed in the huddles and the resulting actions/interventions. The study was approved by the research ethics board (REB) for human subject protection of an academically affiliated health sciences centre.

Methods

Design

The research involved a descriptive phenomenological study of huddle implementation and assessment on a single LTC unit to address patients' responsive behaviours. This study used the PAR approach with all members of the PAR team included in the discussion

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points of each step. There were six steps: (1) identifying the issue and possible solutions; (2) identifying key roles and responsibilities of the PAR team; (3) identifying how the team would collect data; (4) analyzing and interpreting the data; (5) deciding how the team would take action with the results; and (6) evaluating the effectiveness of the solutions through critical reflection and open discussion among team members (Watters & Comeau, 2010).

PAR Team Members

Members of the PAR team were all staff who worked on the unit where huddles were being implemented. PAR team members included unit-based nurses (i.e., registered nurses and registered practical nurses); personal support workers; an MHH coordinator; the director of quality, risk, and patient safety; a researcher; and a research assistant. Although all team members participated in each step of the process, the direct-care staff led the clinical implementation efforts, and the research team members focused on the evaluation. The MHH coordinator and director of quality, risk, and patient safety provided project leadership and coordination. Since the PAR process was an important component of an earlier study (Huijbregts et al., 2012), the team found it helpful to continue with this approach.

Setting

The intervention took place in a large, urban, research-intensive academically affiliated LTC home. One dementia care floor, divided into three separate "neighbourhood" units with a capacity of 79 residents was purposively selected. All residents admitted to these units had a diagnosis of dementia with responsive behaviours but were medically stable, and required minimal to total assistance in a structured nursing and medical environment. Common behaviours expressed by residents on these units included hoarding of food, wandering, shouting, falls, inappropriately expectorating sputum, and kicking/hitting.

Population

The study population was direct-care staff defined as registered nurses, registered practical nurses, personal support workers, and housekeeping staff.

Pre-Huddle Preparation

Focus groups were held both pre- and post-intervention to explore the implementation process of the huddles. Two focus groups were held in the pre-intervention period with a total of 11 staff members. The time involved ranged from 27–32 minutes for each group. These focus groups were held to help guide decisions around implementation of the huddles. The pre-intervention focus group data were primarily used to help guide the team's PAR approach to implement the huddles, and thus were not included in the results reported here. Questions for the focus groups were derived by the PAR team. Examples included: "What is it like to care for residents with responsive behaviours?" and "What resources do you have to care for residents with responsive behaviours?"

Huddle Implementation

The MHH intervention lasted for 12 weeks. All day and evening direct-care staff (n = 34) working on the floor were trained on how to participate in a mental health huddle by the MHH coordinator. The PAR team used the PAR process to develop and conduct training. Training included information about mental health huddles, how and why they could be used to improve resident-focused care and safety, a review of the MHH documentation sheet, and scheduling huddles along with participants' roles and responsibilities. A binder was made available to staff on the unit and included MHH guidelines, information for MHH leaders, and copies of the MHH documentation sheet (binder contents available from the authors). The initial huddle consisted of unit-based MHH training and modeling.

From weeks 2 through 8, the MHH coordinator or a mentored unit staff member initiated the huddle. From weeks 9 through 12 of the pilot intervention period, the staff member who raised the resident's concerns assumed the role of MHH leader. Staff also took on the role of scribe, ensuring that documentation was completed. Mental health huddles were held on the unit, in the nursing station and lasted 15 minutes, on average. To the best of their ability, staff scheduled the huddles weekly, on the same day of the week, and at the same time at a staff-agreed-upon time.

Huddle Evaluation

Evaluation of the MHH intervention was conducted using two different measures. First, researchers examined the MHH documentation sheets completed by the staff members during each huddle. The documentation sheets were developed by the PAR team and were guided by prior research on huddles. These sheets included attendees' names and the day's topic, plus several questions: (1) What is happening? (2) What have you tried so far? (3) What can we try now? (e.g., a recommended action plan, who will lead, when will we follow up?) (4) What challenges can we anticipate? and (5) How will we address this?

To minimize bias, the researchers did not examine the MHH sheets until the study period was completed,

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although random periodic checks were made by the coordinator to ensure that the data were being collected. In keeping with the PAR approach, the MHH coordinator reviewed the process weekly with unit staff, and the PAR team made changes to the process when needed. For example, to ensure shift-to-shift communication about the MHH, the staff decided to include the MHH documentation sheets with the "change of shift" report. When the next mental health huddle occurred, the previous documentation sheet was placed in the binder, and the new documentation sheet was included with the written shift report.

The second measure to evaluate an MHH intervention involved post-intervention focus groups, which were held after the evaluation period using standardized focus group methodology. This methodology included the use of a trained focus group facilitator and a note taker to record any non-verbal interactions, and the group followed a semi-structured guide (Krueger, 1994; Wagner et al., 2010). A total of nine staff participated in two post-intervention focus groups led by the research assistant. The average time of each focus group interview was 22 minutes. Focus group questions targeted the following: "How did you feel about the huddle intervention?" "How has communication with residents been affected by your experience with the huddles?" "What were some issues discussed in the huddles?" and "How has your confidence changed in caring for residents with responsive behaviours?"

Data Analysis

We calculated descriptive statistics (frequencies and percentages) to describe the staff members working on the PAR floor as well as to summarize data obtained from the MHH documentation sheets. We then categorized the MHH documentation sheet data into themes based on input from the PAR team (see Table 1) using content analysis (Berg, 2001). Second, we audio-recorded focus group sessions in the post-intervention period, which were then professionally transcribed verbatim. We analyzed them using content analysis techniques.

The content analysis steps as described by Berg (2001) were used to analyze both the MHH documentation sheets as well as the focus group sessions. With an inductive approach, two members of the PAR team completed data analysis, by independently coding the data using line-by-line open coding, where phrases and words were assigned codes that were meant to capture the meaning of what was being expressed (Stage 1). Stage 2 of the data analysis involved systematically collapsing and placing codes from all participant responses into their corresponding categories and related subcategories by subsuming the codes under themes. A number of strategies were implemented to enhance methodological rigor, including inter-rater reliability checks on codes and independent coding. Researchers conducted the analysis with periodic consultation from the MHH coordinator. An additional strategy included sharing the results at each phase of data coding with the rest of the PAR team. The PAR team chose to theoretically ground analysis of the focus group data by using the *Nursing Home Survey on Patient Safety Culture* (Agency for Healthcare Research and Quality, 2012) to categorize the key themes. This theoretical grounding was chosen, a priori, based on the strong associations between responsive behaviours, mental health, and client safety (Brickell et al., 2009). The themes, listed in Table 2, are italicized in the Results section for emphasis.

Results

Implementation of the Mental Health Huddles

A total of 56 mental health huddles took place from December 2009 through March 2010 on the intervention floor of the LTC facility. All huddles were facilitated by staff, although the MHH coordinator provided mentorship in half of them. Forty-five huddles were acceptable for review, and 11 were rejected (six were unclear regarding which resident/issue/topic/no action; four huddles took place but were not documented, one due to no topic that week). The smallest huddle included two staff members and the largest had seven. Since huddles primarily occurred in the daytime during the pilot period, the same staff participated in them. The majority of staff participants were women ($n = 27$; 79.4%). Personal support workers comprised the largest portion of participating staff ($n = 24$; 70.6%).

Table 1 summarizes the MHH topics and examples of interventions that were suggested by staff participating in them. MHH topics most commonly focused on expressions such as physically responsive behaviours during nursing care, verbally expressive responsive behaviours, exit seeking, and wandering (50.5%). Second-most-common topics were resident and staff safety concerns such as food hoarding and infection control (34.7%), followed by quality of life and care expressions (26.3%). Staff were also concerned about residents who were too heavy for a bath, residents in pain, and those in need of emotional support.

The actions and interventions discussed most frequently addressed staffing/teamwork/communication issues (67.4%), behavioural interventions (44.2%), and physical/functional interventions (23.2%). Examples of actions/interventions that were discussed include consistency in approach to resident; redirecting; distraction; and development of specific, resident-focused

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Table 1: Breakdown of huddle topics and action/interventions from the huddle documentation sheets

Huddle Topic	Frequency (%)	Example
Responsive Behaviours	48 (50.5)	▪ Physically expressive behaviour during care ▪ Verbally expressive: Screaming ▪ Exit seeking, wandering
Resident and Staff Safety	33 (34.7)	▪ Infection control issues (food hoarding) ▪ Resident at risk for falls ▪ Resident physically aggressive with staff or caregiver
Quality of Life and Care Issues	25 (26.3)	▪ Resident too heavy for a bath ▪ Resident experiencing pain ▪ Resident in need of emotional support re: his/her partner
Resident's Family Issues	15 (15.8)	▪ Resident's family bringing in inappropriate food ▪ Resident's family not following care plan ▪ Family coping challenges with resident's admission
Teamwork and Communication	5 (5.3)	▪ Sharing information/strategies across shifts ▪ Scheduling appropriate huddle time ▪ Communication with involved departments
Action / Intervention	**Frequency (%)***	**Example**
Staffing / Teamwork / Communication	64 (67.4)	▪ Document follow-up; use Antecedent-Behaviour-Consequence (ABC) charting ▪ Unit staff to consult other health professional ▪ Consistent approach to residents, families
Behavioural	42 (44.2)	▪ Redirect or distract resident ▪ Praise, reinforce good behaviour ▪ Provide education to resident's family
Physical / Functional	22 (23.2)	▪ Provide resident with a wheelchair ▪ Create toileting schedule; trial use of briefs ▪ Review audiology report
Environmental	16 (16.8)	▪ Cover window on exit door ▪ Place gym mat beside resident's bed ▪ Review use of exit-seeking bracelet, wander guard, bed sensor
Psychosocial	9 (9.5)	▪ Involve resident in therapeutic recreation programs ▪ Identify resident's likes/dislikes ▪ Play music; talk with resident to help calm agitation
Pharmacological	2 (2.1)	▪ Check resident's prescriptions ▪ Use pain medications as needed

*** *Actions/Interventions identified not mutually exclusive; percentage calculation will exceed 100%.***

toileting routines. Only two per cent of the huddles resulted in an action plan involving a pharmacological intervention.

Focus Group Evaluation of the Mental Health Huddles

Table 2 details the benefits and limitations to the huddles as well as how the themes coincided with the safety culture dimensions (Table 2, Column 1). The PAR team felt that the safety culture dimensions as a framework provided the necessary structure to examine the qualitative impact of the huddles on safety culture.

Direct-care staff on the unit reported that the mental health huddles were a helpful *organizational learning* resource. One nurse stated that they were "good to bring awareness to some behavioural issues" and to share and learn about staff *overall perceptions of resident safety* issues and behaviour management techniques. Another pointed out "it makes me feel a little safe … makes my residents safe … I approach it a little differently". Direct-care staff also reported that the huddles promoted *feedback and communication* about strategies that worked and did not work to "pass it (information) on … so everybody is on the same page," and allowed them to share new ideas and provide learning opportunities, and foster a supportive *teamwork* environment. One participant reported, "Huddles give us a chance to come together … [and] learn about that resident".

According to staff, the huddles were an effective strategy for improving *training and skills*, and to discuss and support alternative methods of managing responsive behaviours. For example, a direct-care staff member noted, "it's given us some new ideas on what to do with their behaviours" and "more confidence, to build with this kind of resident … that we have the kind of resources, where to get it, and whom to approach …".

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Table 2: Staff focus groups – Benefits and limitations of the huddles

Safety Culture Dimension	Benefits	Limitations/Suggestions
Organizational Learning	▪ In-service provided on managing challenging behaviour also helpful, to some extent	▪ Limitation: Differences in attitudes across units ▪ Suggestion: Make the huddles into policy so to be best incorporated into personal practice
Overall Perceptions of Resident Safety	▪ Learned to approach some residents differently	▪ Limitation: A lot of resident turnover on the unit recently; a lot of new residents and behaviours to learn
Feedback and Communication	▪ Outside of the huddle, listening to other staff experiences is an important resource as is sharing information across shifts	▪ Suggestion: Set a particular huddle time; those staff able to attend share the information with co-workers ▪ Suggestion: Solutions need to be communicated and shared
Teamwork	▪ Able to learn about residents cared for by other staff, may help to support staff ▪ Having a supportive unit contributes to worker safety	▪ Limitation: Huddles not consistent, therefore staff acting individually
Training and Skills	▪ Provide new ideas, insight into how to manage challenging resident behaviour ▪ Improves confidence in managing challenging behaviours	▪ Limitation: Delivery of care and documentation has not changed greatly
Handoffs	▪ Morning report used as an alternative resource to discuss and share issues	
Staffing		▪ Limitation: Staff are busy every day; challenging to schedule a brief huddle that most staff can attend especially with part-time or casual staff ▪ Suggestion: Have one Personal Support Worker left on the floor to monitor residents while huddle takes place and to structure huddles into workers' schedules
Adherence to Procedures	▪ Huddle used to clarify Code White procedure	▪ Limitation: Huddles are not held on consistent basis
Supervisor Actions and Expectations		▪ Suggestion: It should be the role of the supervisor to organize a huddle or have institution-wide training

PSW = personal support worker

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Written communication in the MHH binders was an effective strategy for developing resident-centered care and maximizing *handoffs* because nurses could "discuss how an issue can be tackled or what needs to be done". Staff members were able to follow up with specific residents, their families, and other staff members if a change in resident status were noted. In one MHH session, for example, a staff member was concerned about the emotional state of a resident and documented it for inclusion in the MHH binders so that other staff would be aware of the situation. Later, another staff member, after reading about the resident, checked in with the resident and family members and was able to implement resident-centered care based on previous MHH sessions.

During MHH sessions, staff mentioned that it was difficult to address the responsive behaviours of residents with whom they were not familiar, which was caused largely because the floor on which this project was implemented did not use consistent resident assignment *staffing* (e.g., same staff-to-resident assignment). Therefore, staff mentioned that "we cannot go together at the same time," "part-time are coming on different days," and "it [staff] fluctuates, it's all different." The huddles encouraged the staff to communicate more, "so that you can advance the practice and you can deal with behaviours, aggression, [and] incontinence …".

While the PAR approach was implemented successfully, there were some initial staff issues with *adherence to procedures.* Some nurses mentioned that their unit director "found the information and told us this is the procedure, this is what we have to do". Regarding implementing the huddles, "it's difficult for somebody to come and do a huddle and make us change our way." Although the personal support workers found the huddles useful, devoting time to them was sometimes questioned. The MHH coordinator and unit staff members of the PAR team spent a considerable amount of time empowering and encouraging the personal support workers to participate in the huddles. At times, staff did not view huddles as a priority when there were "so many other things going on." Since staff agreed that there was "never a good time", the MHH coordinator encouraged them to work together to find an appropriate time to schedule a huddle. Once staff began to see small successes, they realized the value of the huddles. It was important that there was both flexibility and rigidity in the timing, as if a huddle was cancelled and did not get rebooked shortly thereafter, the staff might have forgotten about it. The staff also felt it was critical that the unit director (*supervisor) actions and expectations* "come from the director of care per floor … [therefore] remind the nurses that one of your jobs, one of your standards, is education" and also ensure that huddles regularly occur on the unit in order to maximize the learning process.

Discussion

The implementation of mental health huddles in an LTC setting supported direct-care staff and residents. Hung and Chaudhury (2011) found that a culture that is unsupportive to relational care leads to frustrations and resentment among staff and residents. Mental health huddles allowed staff to share effective strategies for addressing responsive behaviours among the residents they cared for, and they also provided other staff members with new ideas and insights.

To handle the role of caring for a resident, a staff person must not only have a basic knowledge of the disease but also have specific knowledge of the resources and weakness of the individual resident as well as that resident's life history, life patterns, and continued capacity (Coogle, Head, Parham, & Zeman, 2004). Residents who expressed responsive behaviours were discussed in huddles by direct-care staff. The literature indicates that responsive behaviours may result from the resident's not feeling heard when personal preferences are not considered and decisions are made for them by staff (Hung & Chaudhury, 2011). The enhanced communication among staff to share information about resident preferences was used in this project as a tool to help minimize such incidents.

Given that direct-care staff provide the majority of care for residents, it follows that with consistent care assignment, direct-care staff can more easily learn, understand, and follow resident preferences (Castle, 2011). Consistent care assignment is defined as "the same caregivers consistently caring for the same residents almost every time they are on duty" (Care Practice Workplace Practice Environment, 2010). Staff in our focus groups found that understanding more about a resident increased their overall perceptions of safety and confidence in dealing with residents when they exhibited responsive behaviours even when not having a consistent care assignment.

Implementation of consistent assignment is another way to increase staff knowledge about residents, improve safety through better management of responsive behaviours, and support the administration of resident-centered care plans. Direct-care staff members, such as personal support workers, are more likely to advocate for resident preferences when they regularly care for the same residents (Castle, 2011). Our organization was unable to implement consistent staff to resident assignments because of organizational and human resource (or labour) considerations.

Brown and Davies (2009) found that as staff developed their understanding of how each resident approached

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life, staff were able to notice when things altered for the resident and therefore to adapt their care approach accordingly. Understanding the residents' interpretations of what was happening in their daily lives, and how this influenced their behaviour and experiences, is an attribute of person-centered care. Respect and understanding of a resident's individuality has significant consequences not only by improving resident satisfaction, but also by enriching the relationship between the staff and the resident (Hung & Chaudhury, 2011). Knowledge about intervention strategies that are effective or ineffective for specific residents can increase resident and staff safety. If a resident exhibits a particular behaviour, staff could reference information shared during MHH sessions to manage and comfort the resident.

Structured, scheduled mental health huddles supported staff in addressing communication issues, improving teamwork, and increasing staff collaboration. Information discussed in huddles was shared across shifts and with different interprofessional team members within the LTC facility. Knowledge utilization was possibly enhanced when peer relationships on units were collaborative (i.e., *teamwork*) (Janes, Sidani, Cott, & Rappolt, 2008). Huddles allowed staff to follow up with each other and to discuss strategies that were effective or ineffective in providing care to residents.

Brown and Davies (2009) found that stories shared by residents and their families helped staff to understand the type of person the resident had been before moving to the LTC facility and what was important to them at present. Such information could then be used to improve the resident's experience in ways that were meaningful to them and could assist them in understanding any responsive behaviours the resident expressed. Examples of such information included individual residents' likes and dislikes, such as interest in participating in therapeutic recreation programs, and knowledge of residents' toileting schedule might help staff to feel they could provide residents with safer, more comprehensive care. Identifying challenges such as which residents' families were bringing in inappropriate food, not following or participating in the residents' care plan, or experiencing coping challenges related to the residents' admission could enable the staff to develop a consistent approach with the residents' families. Recognizing the importance of doing "the little things" in the residents' care routines, staff are able to see how small details have the potential to influence the quality of the resident's experience and a family's visit (Brown & Davies, 2009).

Limitations

This study was not without limitations. The study site was a large, academically affiliated research setting, which is unusual for an LTC setting, making it difficult to generalize the study findings. This environment was felt to be ripe to test new interventions and ideas, as staff and administration had substantial experience with the research process. The use of PAR may have facilitated implementation of our research initiative as this approach facilitates a sense of ownership and commitment among staff towards new care processes being implemented, as well as input in the decision-making strategies. Further research on mental health huddles in the LTC setting needs to occur in order to test the effectiveness of this strategy to support residents with responsive behaviours, with the inclusion of a control group design. With this research, the development of a theoretical grounding with huddles as a knowledge translation strategy is key. Knowledge translation strategies, in addition to further research on what is needed to support a culture change to person-centered care, could be used to develop a strong theoretical basis for huddles (Estabrooks, Squires, Cummings, Teare, & Norton, 2009; McCormack, Dewing, & McCance, 2011; Shura, Siders, & Dannefer, 2011).

In this LTC setting where staffing and time were very limited, scheduling a brief huddle time that allowed the majority of staff to attend, especially part-time and casual staff, proved challenging. Not all staff members were able to attend the huddles due to workers' schedules, especially other members of the interprofessional team who were not always present on the unit (e.g., housekeeping, dietician). Hung and Chaudhury (2011) proposed that one way to improve staff attitude and quality of care was to establish reflective practice within the unit in which staff members met regularly to reflect on what really happens on the unit. Issues and solutions discussed in huddles were not always communicated and shared with other staff on the unit or with other health care providers who were on the unit less frequently. In addition, casual and part-time staff were not always aware of what had been discussed during huddles.

Demographic data, except for gender, were not collected as part of the focus group session because we have found that direct-care staff are hesitant to report potentially identifiable data. Furthermore, staff turnover data were not available from this time period, although the turnover on this unit has typically been very low with approximately one new staff member every quarter.

Incorporating the concepts from organizational change theory (Simpson & Flynn, 2007) and nursing home culture change (Rahman & Schnelle, 2008) should be considered in the future so that mental health huddles are sustained. Such huddles now occur regularly on two floors in the LTC home. One floor holds huddles

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weekly and the other, twice daily and as needed. The care staff on the unit schedules the huddles.

Conclusion

When direct-care providers are fully engaged in the process of caregiving, the resident can benefit greatly (Tellis-Nayak, 2007). This study is a logical step towards improving mental health care in the LTC setting, by engaging and empowering staff who spend the most time with residents. However, further research is needed on how huddles can impact care outcomes, improve resident and staff safety, and increase quality of care.

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