Supporting Adults with Intellectual Disabilities who Present with Challenging Behaviours:
A Cross-Case Analysis of Staff Perceptions of Work and Training

by

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ABSTRACT

Information and training to assist staff in preventing, managing and remediating challenging behaviours exhibited by individuals with intellectual disabilities is readily available. However, knowledge gained via training is not integrated easily or transposed into work settings. Instead, management of issues is often haphazard and based on what works for a specific situation at the given moment. Although an abundance of research has been conducted on knowledge uptake, direct support staff that are integral to effective service delivery have often been neglected. As well, consideration of whether staff find the evidence relevant and applicable within their work environment has not been measured.

The PARiHS Framework, Mindlines and Social Exchange theories assisted in addressing the question: what are staff experiences of applying training information into residential services for individuals with intellectual disabilities who present with challenging behaviours? Qualitative cross-case study methodology was employed and focused on two community residences governed by an agency offering supports to adults with intellectual disabilities.

Unit A findings highlighted five key themes that emphasized personal confidence, elements of communication, consistency in approach, connection with individuals, teams and leaders, as well as continuing education strengths and barriers. Within Unit B, five main themes that accentuated personal traits such as caring and nurturing, in addition to communication factors, changes and challenges within the work context, connection to others and perceptions of continuing education were established.

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CHAPTER I: INTRODUCTION AND RESEARCH PURPOSE

This chapter highlights elements that will be discussed and explored in further detail throughout the study. The importance of workplace culture and settings in combination with specific introductory definitions of intellectual disability, challenging behaviour, and knowledge translation are emphasized. Additionally, the relevance of applying qualitative case study methodology is reviewed.

Community Based Intellectual Disability Services

Since community supports strive towards encompassing person-centered values founded on rights and inclusion, daily practices should reflect a collaborative approach to ensure services are tailored to each individual (Forbat, 2006; Herbert, 2005). More specifically, within social service agencies designed for adults with intellectual disabilities, staff's ability to recognize diversity of needs and goals is essential to the success of programs. Presently service delivery within community programs rely primarily on direct support staff who have significant influence on individuals' lives and are responsible for providing an environment that is conducive to empowerment and quality (Campbell & Hogg, 2008; Forster& Iacono, 2008; McClean et al., 2005).

Within these settings, a continuum of staff performance exists which encompasses varying degrees of skill and knowledge relevant to the occupation. Furthermore, care provision to this vulnerable population is primarily carried out by unregulated staff who have little training (Dempsey & Arthur, 2000; Reback, Cohen, Freese, & Shoptaw, 2002). Significant staff shortages exist due to recruitment and retention issues related to stress and relatively poor wages (Mascha, 2007). As well, work environments that lack flexibility and resources, have excessive workloads, and limited supervision are well

documented (Mascha, 2007). Culmination of these factors leads to person-centered principles having low priority in present day practice (Dempsey & Arthur, 2000; Mansell, 2006; McClean et al., 2005; Young & Chesson, 2006).

Given the issues described, for an organization to effectively offer and deliver services to a designated population, employees must be able to demonstrate both knowledge of and skill in best practices ideally based on sound research evidence. Williams et al. (2008) propose the "capacity to identify, acquire, integrate, and apply progressive knowledge" is paramount to organizational growth and innovation (p.113). Presently, evidence-based practice and knowledge translation within various settings is actively promoted. Although there are numerous sources of information that identify the need for research to be transferred to practice, exploration of how direct support staff implement and adapt new information in the workplace is not evident.

The lack of information extending from researchers to front line staff who deliver programs within the social service field has led to missed opportunities for individuals and programs to reach their full potential (Riley-Tillman, Chafouleas, Eckert, & Kelleher, 2005). More specifically, while research has produced substantial amounts of information regarding best practices to address challenging behaviour, every day services do not reflect evidence-based knowledge despite training efforts (Dowey, Toogood, Hastings, & Nash, 2007). Campbell and Hogg (2008) relayed that while research has demonstrated staff training improves feelings of self-efficacy, the process of how to influence care-providers' understanding and management of challenging behaviour is less well understood. This gap in knowledge may result in unchanged practices despite new information and evidence being readily available within the field.

Research Question and Purpose

The overarching goal was to develop an understanding of the multiple considerations that must be addressed to integrate interventions based on best practices. This research was designed to explore each of the individual factors relevant to intellectual disability and challenging behaviour in combination with barriers and strengths for staff employing evidence-based practices to effectively manage everyday situations. The three main objectives were to explore staff perspectives of training, to understand the influences of interactions between staff and residents and within the team, and to identify the multiple factors in the staffs' workplace. Elements included current evidence, workplace culture as well as the needs of staff who support individuals with intellectual disabilities in the community and who present with challenging issues.

The findings of this research offer insight into how people who provide the most support to individuals who present with challenging behaviour manage situations. Factors of the individual work setting which either impede or support the integration of new knowledge from training sessions were described and discussed. Additionally, features related to social processes of working within teams and influence of supervision and leadership were explored. This research was intended to develop a foundation to bridge the gap between direct support staff realities based on their experiences and knowledge available to assist in remediating challenges.

Terms and Definitions

Relevant terms of intellectual disability, challenging behaviour, and knowledge translation are defined within the next section. These concepts are combined and explored in detail in relation to best practices for direct staff to employ from the

knowledge translation process. Applicable theories and case study methodology are also briefly introduced.

Intellectual Disability

Intellectual disability is described as degrees of intellectual impairment along a continuum based on an intelligent quotient. Diagnosis additionally considers an individual's functional capacity based on assessment standards. The American Association on Intellectual and Developmental Disabilities (2011) defines an intellectual disability as significant limitations in intellectual functioning which is evident before 18 years of age.

Challenging Behaviour

Challenging behavior includes culturally abnormal acts of physical aggression, self-injury, obsessive compulsive behaviour, property destruction, non-compliance, verbal aggression, and/or sexually inappropriate actions (Emerson & Einfeld, 2011; Grey & McClean, 2007; Smidt, Balandin, Reed, & Sigafoos, 2007). Negative effects not only for the individual who presents with the challenges but also the significant impact and consequences for direct support staff must also be considered (Hartley & MacLean, 2007). Presently, prevalence rates of challenging behaviour vary throughout the literature stemming from non-standardized reporting and diverse definitions of both intellectual disability and challenging behaviour (Grey & McClean, 2007).

Knowledge Translation

The Canadian Institute of Health Research (CIHR) defines knowledge translation as the "exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users" (Graham et al., 2006**,** p.15).

Within the field, many discrepancies in terminology exist. However, despite variations, most are in agreement that moving knowledge into action is effective when the information is credible, relevant, and adapted to the intended environment (Law, Missiuna, & Pollack, 2008).

Theories

Given that this research explored a number of factors to understand the workplace setting and experiences of staff, three theories which highlight different aspects were chosen. A major knowledge translation model, the Promoting Action on Research Implementation in Health Services (PARiHS) Conceptual Framework, is defined and discussed in terms of relevance. Additionally, Mindlines and Social Exchange theories which assisted in examining the influence of workplace relationships between the individual, teams and organization are also highlighted.

Case Study Methodology

The goal of case study methodology is to accurately depict the most complete description of a case using an iterative process (Merriam, 1998; Stake, 2000; Zucker, 2001). Case study is useful when the context of real life is needed to best address the research question and multiple sources of information are required to gain insight (Merriam, 1998; Yin, 2009). For these reasons, this methodology was applied to the research using a qualitative approach.

Within the next chapter, information on each concept is discussed in greater detail. Known best practice interventions based on research are also explored. As well, the present day status of direct support staff within the Province of Manitoba is included.

CHAPTER II: REVIEW OF THE LITERATURE

This literature review focused on intellectual disability in combination with challenging behaviours and research that provides guidance on how to best manage difficult situations that direct staff encounter. The impact of dealing with these situations and factors of workplace settings designed for people with intellectual disabilities were also explored. Key search terms included variations of: 'intellectual disability', 'challenging behaviour', 'direct support staff'', 'training', and 'best practice interventions'.

The search timeframe extended from January 2009 until September 2011. Databases reviewed for research and related literature published between 1997 to 2011 included: Academic Search Complete, CINAHL, Child Development and Adolescent Studies, Family and Society Studies Worldwide, Master FILE Premier, Mental Measurements Yearbook, PsycINFO, PubMed, Social Work Abstracts, and the Teacher Reference Center. Specific information on services funded by the Province of Manitoba in addition to staff training opportunities within the province were sought and updated in the summer of 2011.

Knowledge translation concepts and related theories that were applied to this research in addition to relevant texts that illustrate case study methodology were also reviewed during this time frame. Research that focused on children specifically, individuals with mental health concerns, and intellectual disability without secondary issues was excluded from this review. Within this chapter, key terms and evidence-based interventions specific to remediating issues that challenge staff along with barriers of implementation are highlighted.

Key Terms and Definitions

Intellectual Disability

The term "intellectual disability" is used interchangeably with "cognitive impairment" and "development disability" throughout this document. The American Association on Intellectual and Developmental Disabilities (2011) characterizes an intellectual disability as significant limitations in intellectual functioning which is evident before the age of 18 years. Adaptive behavior which includes typical social and practical skills is also recognized within this definition (www.aaidd.org).

The clinical term of "mental retardation" is defined as “significantly sub average general intellectual functioning” within the Diagnostic and Statistical Manual of Mental Disorders IV–TR (American Psychiatric Association, 2000, p. 41). Significance of impairment is described as an intelligence quotient (IQ) obtained by one or more of the standardized, individually administered intelligence assessments such as the Wechsler Adult Intelligence Scale. Categories related to level of cognitive functioning are: 1) Mild = 50-55 to 70, 2) Moderate = 35-40 to 50-55, 3) Severe = 20-25 to 35-40, 4) Profound = below 20 or 25 with borderline intellectual disability of an IQ of 70 +/- 5 points. Diagnosis also considers functional capacity therefore entitlement to services may be warranted if the level of disability falls within the border-line range.

Prevalence rate of intellectual disability is between 1% to 3%, with a male to female ratio of 1.5:1 (APA, 2000). In 2009-2010 Family Services and Consumer Affairs which oversees the Supported Living Program provided funding for residential, respite and day services to over 4,894 adults living with an intellectual disability in Manitoba.

Residential services alone supplied by various community agencies accounted for supports to 1486 people in 2009-2010 (Manitoba Government, 2010).

Challenging Behaviour

Challenging behavior has been defined as culturally abnormal actions that place a person's safety at risk or significantly limits his or her access to community integration due to the frequency, intensity and/or duration of the maladaptive behavior (Cudré-Mauroux, 2010, Emerson & Einfeld, 2011). Other acts include aggression, socially inappropriate, disruptive, and/or uncooperative behavior (Hartley & MacLean, 2007). Despite lack of consensus in regards to a standardized measure to define challenging behavior, many advocate for this working definition to not only highlight the negative effects for the person but also the impact and consequences for direct support staff (Hartley & MacLean, 2007).

Functions of challenging behaviour are considered to be attempts to control the environment, to communicate a message or need such as expression of pain, hunger, or thirst or, conversely, a request or rejection of objects, activities or environmental factors (Matson & Boisjoli, 2009; McGill, Bradshaw, & Hughes, 2007; Smidt et al., 2007). Prevalence rates of challenging behaviour are varied throughout the literature therefore the extent of the issues is often not accurately captured (Grey & McClean, 2007). This variability stems from non-standardized reporting and diverse definitions of both intellectual disability and challenging behaviour.

United Kingdom rates are approximated to be 8%, Ireland with 28% (Grey & McClean, 2007), while Australia and the United States are estimated to be as high as 40% (Smidt et al., 2007). Bailey, Hare, Hatton, and Limb (2006) report rates of challenging

behavior in a range between 8-15% to 38% depending on the working definition of what constitutes a challenge based on individual care-provider's perceptions. Despite attempts to modify behaviour with more adaptive approaches, these issues are typically unresolved as a thorough understanding of the underlying intended message remains unknown (Matson & Boisjoli, 2009).

As a result these issues demand an immense amount of staff resources and energy which can exact a negative toll on staff recruitment and retention due to extraordinary support requirements (Matson & Boisjoli, 2009; Van Ingen et al., 2010). Furthermore, challenging behaviour may result in risk of injury towards self and others, as well as increased risk of placement breakdown in residential and supported day settings (Grey & McClean, 2007; Matson & Boisjoli, 2009; Smidt et al., 2007; Van Ingen, Moore, Zaja, & Rojahn, 2010). Restricted access to community and/or family visits, in addition to reduced opportunities for social interaction and independence are also noted (Grey & McClean, 2007; Matson & Boisjoli, 2009; Smidt et al., 2007; Van Ingen, Moore, Zaja, & Rojahn, 2010).

Current Interventions Utilized

Despite lack of evidence for long-lasting effectiveness, overuse and extensive reliance on psychotropic medication to manage challenging behaviours in several settings is mentioned consistently (Grey & McClean, 2007; Matson & Boisjoli, 2009; McGill et al., 2007; Van Ingen et al., 2010). Also noted within the literature is the continued excessive use of physical interventions to manage behaviour despite best practice standards that advocate for restrictions to be utilized solely as a last resort (Matson & Boisjoli, 2009; McGill et al., 2007). While Baker and Bissmire (2000) relay use of

restraint within service settings is unusually high especially with regards to severe challenging behavior, other studies have shown physical interventions are also common in response to less problematic situations that do not pose a safety risk to self or others (Deveau & McGill, 2009; McGill et al., 2007).

In support of this statement, Hawkins, Allen, and Jenkins (2005) report physical restraint is estimated to be between fifty to sixty percent within the United Kingdom. Reasons provided for over reliance of more controlling reactive strategies such as chemical and physical restraint are related to lack of staff training and supervision (Hawkins et al., 2005). As well, a knowledge gap exists between research-based evidence that may not be easily transposed to realistic situations or to staff's level of understanding therefore more restrictive approaches are employed (Matson & Boisjoli, 2009).

Murphy, Kelly-Pike, and McGill (2001) acknowledge that while physical interventions are necessary at times, unplanned restraints are known to cause potential injuries to residents and staff. Lack of formalized assessment and treatment plans may increase the use of intrusive methods to manage behaviour which can lead to participant abuse (Feldman, Atkinson, Foti-Gervais, & Condillac, 2004). Documented deaths as a result of restraint highlight the seriousness of the danger. In the United Kingdom, an estimate of seven violent incidents per one thousand staff was recorded within intellectual disability services and is considered to be a work setting which poses great risk for employee injury (Murphy et al., 2001).

Staff Factors

Staff consistently report that challenging behavior is often the most stressful component of their work resulting in burnout (Wietske, van Oorsouw, Embregts,

Bosman, & Jahoda, 2010). Based on this ongoing stress, staff reactions to the specific issue may prove to be counter-productive as the immediate response may reinforce the behavior as opposed to utilizing a planned evidence-based strategy that could remediate the issue (McGill et al., 2007). Contributing factors that increase challenging behaviour are related to limited staff attention thus the individual may engage in attention seeking behaviour to interact. Furthermore, lack of communication or incongruent attempts to converse at the individual's comprehension level ultimately leads to unmet needs (Smidt et al., 2007).

Explanations for ineffectual responses may be due to a lack of training in behavioural analysis, or an underlying negative assumption of challenging behaviour which lead staff to believe they have limited ability to assist the person. Staff may also experience negative emotional reactions such as fear and insecurity when dealing with issues and will therefore react quickly to resolve the situation thereby reinforcing behaviour (McGill et al., 2007; Wietske et al., 2010). A combination of these factors may lead to an overall decrease of staff confidence in their ability to effectively deal with the situation.

As a result, many staff chose to leave workplaces that support adults with challenging behaviour due to the intensity of work demands and risk of injury (LaRue, Weiss, & Ferraiolli, 2008). Based on these findings, training that teaches staff how to identify functions of negative behavior and to develop techniques relevant to the participant's situation prior to frustration will be beneficial (Smidt et al., 2007). In research that explored staff attributions of challenging behavior, consideration of variations in types of behavior, individual participant needs, and potential reasons for the

inappropriate response were acknowledged by staff (Noone, Jones, & Hastings, 2006). Cudré-Mauroux (2010) suggests that an ecological perspective that includes the workplace environment, staff experiences, as well as participant challenges, be adopted to better understand the complexity of staff emotions and behaviours that are evident when managing difficult situations.

Contributing Factors

Potential contributing factors to a person's challenging behavior may be related to the general physical and sensory environments. Within communal living arrangements, the setting is not always conducive to individual preferences. As well, lack of independence and privacy within most residential settings or day services may exacerbate issues for individuals (McGill et al., 2007).

A larger systemic issue is the extreme shortage of consultants who specialize in the field of adults with intellectual disabilities with behavioural challenges. As a result, issues remain unresolved as staff often have limited resources that can assist directly within the setting. The situation of lack of specialists ultimately translates to the needs of the individuals not being met or considered (Forster & Iacono, 2008; Grey, Hastings, & McClean, 2007; Grey & McClean, 2007; McClean et al., 2005; McGill et al., 2007).

Finally, Akrami, Ekehammar, Claesson, and Sonnander (2006) highlight people with intellectual disabilities have historically been marginalized with very little power collectively or individually. The original belief that simply moving people out of institutions would reduce negative behaviours has not transpired into reality (Campbell & Hogg, 2008). While discrimination may not be blatant, an underlying belief that individuals with disabilities may not be as worthy to receive quality care may still

pervade the ability to exert their right to independence. Furthermore, when a person presents with challenging or risky behaviour not congruent with typical responses or choices, respect and understanding can quickly diminish resulting in staff and participant struggles. The next section highlights specific evidence-based practices directed to front line staff that support individuals with intellectual disabilities who present with challenging behaviours.

Challenging Behaviour Interventions

Within the intellectual disability field, best practices incorporate principles of person centered practices and social role valorization which acknowledges every individual with an intellectual disability has rights and responsibilities including full inclusion into the community (McClean et al., 2005). When a person presents with challenging behaviour, principles based on evidence can become less of a priority and therefore more difficult to uphold. Current literature related to specific research in this area proposes that a full continuum ranging from proactive to reactive strategies exist to assist the person in managing and resolving issues.

Feldman et al. (2004) relayed that while various strategies such as medication, physical intervention, counseling and behaviour management strategies are widely available, positive interventions based on identified functions of the issue and teaching appropriate adaptive responses are considered the best approach. As well, intrapersonal staff factors such as practical thinking has been associated with managing challenging behavior assertively (Willems, Embreghts, Stams, & Moonen, 2010). Other proactive approaches focus on environmental modifications, changing precipitating factors, developing participant skills, and differential reinforcement (Hawkins, Allen, & Jenkins,

2005; McGill et al., 2007; Smidt et al., 2007). Reactive strategies include safe and efficient responses to challenging behaviour via non-physical means such as distraction, diffusion, seclusion and physical restraints as a last resort (Hawkins et al., 2005; McGill et al., 2007; Smidt et al., 2007).

Based on this range of interventions, a holistic person-centered plan with comprehensive functional analysis of the behavior is essential. As well, risk management strategies based on observation and specific insights from staff should be central to the formation of the individual plan. McClean et al. (2005) support this finding and propose that front-line staff be directly included when developing support plans as they often possess the most accurate information and can assist in ensuring interventions have contextual fit.

If services are to truly incorporate current best practices, training that focuses on the previously mentioned factors for staff competencies in conjunction with knowledge of how to complete functional assessments that lead to effective interventions are required (Baker & Bissmire, 2000; Tierney, Quinlan, & Hastings, 2007). Specific research evaluating the effectiveness of interventions noted above is discussed within the next section. Detailed information on the effectiveness of a range of proactive to reactive strategies is captured within Appendix A.

Interventions within the Literature

Person-focused Training

Person-focused training is an alternative model of service delivery for people with severe challenging behaviour. The main premise is to train direct staff to complete functional assessments in addition to designing and implementing positive supports for

individuals with challenging issues. This strategy is intended to ensure contextual fit and long-term maintenance based on staff knowledge of the person and organizational culture. This approach is designed for assessments and interventions to take place within the natural environment by support staff as opposed to removing the participant from their home for intervention or relying solely on limited specialist involvement (McClean et al., 2005).

Positive behaviour support employs a collaborative style to consider all aspects of the person's life (Grey & McClean, 2007; McClean et al., 2005). Components of person-focused training include comprehensive psychosocial assessment, incident analysis, functional assessment followed by hypothesis testing (McClean et al., 2005). Recommendations for monitoring and follow-up on positive behaviour support plans are based on quarterly progress reports and regular file audits (McClean et al., 2005).

McClean et al.'s (2005) research on this model used information from a combination of staff with various roles and education reporting on one target behaviour and tracking changes overtime. Results showed that implementation of support plans were associated with significant improvement twenty-two months post training however, larger residences serving approximately 400 people were not as successful with reducing challenging behaviour. Training direct care staff to manage or reduce negative actions within the natural environment as opposed to reliance on external 'professional' assistance was therefore considered to be of benefit. Additionally, training staff to plan interventions assisted with overcoming other known barriers to implementation such as frequent failure to consistently apply interventions, utilization of overly simplistic

ineffective methods, and little consideration of organizational features (McClean et al., 2005).

McGill et al. (2007) conducted research to explore the impact of training from an undergraduate program on staffs' knowledge, attributions and emotional responses using a positive behaviour support approach. Results of this study found knowledge significantly increased across the three assessment periods at the beginning, middle and end of a two year part time course with interspersed practical work. They also report staff became less likely to attribute challenging behaviour to emotional causes although changes to making attributions varied as did negative emotional responses. Based on these results, the authors concluded that training courses are likely to be associated with better staff performance and outcomes for individuals who receive services; however, more research was warranted (McGill et al., 2007).

Grey and McClean (2007) completed a study to determine whether training of staff who had various education and experiences in developing assessment and support plans would remediate challenging behaviour. While their results showed no significant differences between control and target groups at the onset, significant reductions in frequency and severity of negative behaviour were discovered for the individuals supported by the target group after six months. No significant changes in the use of psychotropic medications for either group were noted throughout the study. Based on these findings, person-focused training was associated with significant reductions in challenging behaviours and therefore considered an effective model for providing support to individuals (Grey & McClean, 2007).

Active support is another person-focused model intended to increase engagement and participation in activities with an overall goal of improving upon the quality of life for individuals with intellectual disabilities (Totsika, Toogood, Hastings, & McCarthy, 2010). Two components of the active support model include group workshops followed by interactive staff training (Totsika et al., 2010). Totsika et al. (2010) explored the effectiveness of interactive training for individual activity engagement, challenging behavior and staff support without the initial workshop component (Totsika et al., 2010).

Results demonstrated a brief improvement in quality of staff support without a long lasting change in staff activity, engagement or overall change in remediating challenging issues. However, significant improvement for engagement with those who displayed aggression was noted immediately after the interactive training occurred (Totsika et al., 2010). While these findings highlight that combining workshops with interactive training may be more suited to realize longer lasting changes, future research on interactive training alone to assist staff with finding ways to interact with people who display challenging behaviours was warranted (Totsika et al., 2010).

Research Gaps

While this training model identifies the need to include staff during the entire process of managing challenging issues, consideration of the workplace context, influences of the team and leadership were not identified. As well, this body of research did not account for potential differences between various roles of staff in terms of amount of experience and influences of post-secondary education. Evaluation of staffs' overall perception and experiences of competence to manage challenging behaviours were not considered. Lack of baseline information via direct observations of staff, participant, and

team interactions within the actual work setting to detect changes weakened the application of these findings. Considerations of these variables within the research design would have added value to these studies.

Brief Challenging Behaviour Training

Tierney et al. (2007) acknowledge that staff have difficulty responding to and managing challenging behaviour and experience negative emotional reactions when dealing with these issues. The purpose of the authors' research was to examine effects of typical training on staff feelings of self-efficacy, negative emotional reactions and causal beliefs of challenging behaviour (Tierney et al., 2007). Staff responded to general scenario questions of challenging behavior via pre-post measures. Results demonstrated a considerable increase in self-efficacy to deal with issues however; no significant changes in either emotional reaction or causal beliefs were noted therefore further research of training methods were recommended (Tierney et al., 2007).

Research conducted by Dowey et al. (2007) examined the effects of a one day training program to evaluate if there was an effect on staff causal explanations (Dowey et al., 2007). Results determined that a number of correct causal hypotheses increased significantly from pre to post measures based on vignettes. These findings led the authors to conclude that staff explanations for challenging behaviour can be changed using a relatively brief training intervention (Dowey et al., 2007).

Research Gaps

An essential element to understanding staffs' dismissal or uptake of evidence-based practices can stem from everyday staff and participant interactions. Evidence from direct observation in the setting to understand the impact of everyday work conditions

can assist with uncovering items that are relevant to explore (Grey & McClean, 2007; McClean et al., 2005; McGill et al., 2007). Within the two studies reviewed, no actual observations within the workplace occurred.

General scenarios to assess attitudes of challenging issues may not truly capture the essence of the relationship including everyday interactions between actual staff and residents. Additionally, follow-up of training must be completely integrated into the environment, not only for a three month period. Delineation between amount of staff experience and positions was not accounted for which may have highlighted valuable differences to consider when training various staff groups.

Physical Restraint

Baker and Bissmire's (2000) study focused on understanding the extent of physical restraint when responding to challenging behaviour while evaluating the effectiveness of the Strategies for Crisis Intervention and Prevention module. The content is designed to assist and teach participants to maintain self-control and for staff to employ positive and non-aversive methods (Baker & Bissmire, 2000). Research results based on thirteen staff discovered that fifty-five percent out of one hundred incidents involved physical restraint. Staff reported low confidence in their ability to respond however improvement after training was noted. In addition, it was determined that staff tend to under-record use of physical restraint therefore this intervention was more likely employed greater than what was reported (Baker & Bissmire, 2000).

The purpose of Murphy et al. (2001) research was to evaluate the impact of policy on physical restraints defined as actions or procedures designed to limit mobility or movement. Senior staffs' views on a recent policy framework in Britain were polled

which resulted in one hundred fifteen completed questionnaires from a variety of services (Murphy et al., 2001). Murphy et al. (2001) reported that while most staff described the policy as helpful, results also indicated that an independent evaluation of effectiveness on the various physical intervention methods is needed in the future.

Hawkins et al.'s (2005) research explored the impact of receiving and completing physical interventions in response to challenging issues and how physical restraint may impact the relationship between participant and staff. Eight staff and resident pairs were included in this study. Staff perspectives demonstrated that they did have a clear understanding of training principles and were properly implementing the techniques (Hawkins et al., 2005). Individuals with intellectual disabilities noted feelings of uncertainty of why restraint had occurred coupled with remorse and sadness while staff reported increased stress with unpredictability of the participant's actions and the importance of de-briefing (Hawkins et al., 2005).

Reason for why the behaviour was taking place and perceived level of controllability influenced how staff felt about the person during physical intervention. While staff had a positive regard for the individuals they supported, a tendency to underestimate the negative impact that restraint has on the residents was noted (Hawkins et al., 2005). As well, participants and staff experiences were found to be linked and highlighted that restraints are dynamic events that impact relationships (Hawkins et al., 2005). Hawkins et al. (2005) concluded since accounts were primarily negative for both staff and residents, de-briefing as a method to assist in understanding the reason for restraint and to address the relationship for both staff and residents was recommended.

Wietske et al. (2010) completed research on implementation of a training program for staff who worked with individuals with challenging behavior. The training was designed to increase knowledge of challenging behavior and to improve the quality of physical interventions in order to decrease staff anxiety when dealing with incidents. Questionnaires to determine effectiveness of training in conjunction with observation of staff skills using pre-post measures were utilized to analyze changes. While this research demonstrated the program was effective at follow-up, the authors identified that 'knowing' how to manage a difficult situation is different than 'doing' when faced with an issue that is emotionally charged (Wietske et al., 2010).

Research Gaps

As with many of the other research studies reviewed, the context of the environment with regards to team and leadership was not considered. Observation of changes in workplace and identification of different types of physical responses were not acknowledged. If individual staff differences in relation to type of previous experience and years of employment within the field were accounted for, this may uncover areas that need to be addressed directly during training when following-up with staff.

Formal versus Informal Interventions

Despite known evidence-based practices for individuals with challenging behaviour, little research exists regarding the extent that participants receive formally documented interventions as opposed to informal support that has not been approved by appropriate professionals or documented in individual plans (Feldman et al., 2004). . Feldman et al. (2004) hypothesized that individuals with severe and dangerous behaviours living in institutions would have greater formal documented interventions.

Additionally, those supported would have more informal as opposed to formal interventions recorded and staff would view formal strategies as most effective and be associated with training and supervision (Feldman et al., 2004).

Results found no significant differences for gender, age, level of intellectual disability and type of residence. Medications accounted for over half of the intrusive interventions and most often associated with formal interventions for dangerous actions. As well, informants reported significant improvements with problematic behaviours with formal versus informal interventions (Feldman et al., 2004).

Feldman et al. (2004) concluded informal strategies were more prevalent and that half of the intrusive procedures were undocumented. Low levels of staff accountability, coupled with little training and supervision placed many individuals with challenging behaviour at increased risk for ineffective and unnecessary restrictive interventions, as well as an increased potential of physical abuse. These findings propelled the authors to advocate for the Ontario government to sanction documented intervention standards in all settings for individuals with intellectual disabilities. The intention was to ensure evidence-based strategies grounded in least restrictive supports with staff training and supervision became mandatory. Furthermore, it was proposed that adoption of the recommendations would decrease associated financial costs of challenging issues such as additional coverage for staff injuries and turnover (Feldman et al., 2004).

Research Gaps

While this research provided a lens to better understand the actual practices of staff, no direct observation was completed. Prescribed descriptions of formal intervention techniques decided upon by professionals not working directly within the environment

may over inflate the amount of 'informal' techniques as there is no consideration for the context of the situation. As well, data from staff in both day service and residential settings were amalgamated therefore recommendations may not transfer directly to each specific workplace.

Communication and Cognitive Training Program for Staff

Current best practice advocates for a full assessment to indicate what interventions are most relevant for individuals who present with challenging behaviour. Strategies to teach the participant alternative methods to transmit his/her message along with information for staff to understand where the issue stems from will foster better communication. Training staff on methods to better communicate with individuals, in addition to changing staff beliefs attributed to challenging behaviour were identified as important steps in this process (Smidt et al., 2007).

Smidt et al.'s (2007) study which focused on training in relation to both domains noted above discovered that staffs' use of appropriate communication methods combined with use of praise increased, inappropriate language decreased, and residents' level of negative behaviour were somewhat reduced post training. However, these results were not sustained based on incident reports and limited amount of staff and participant interaction noted during the follow–up process. It was therefore concluded that while staff training based on modifying attitudes and beliefs may be potentially beneficial to both staff and residents, further research was required (Smidt et al., 2007).

Campbell and Hogg (2008) investigated how staffs' cognitive dimensions of identity and causes of challenging issues, consequences of behaviour, emotional reactions, as well as treatment and control were affected by staff training. This was

measured via the ‘Challenging Behaviour Representation Questionnaire’ (Campbell & Hogg). Campbell and Hogg reported the experimental group outperformed two control groups by more than originally expected on the baseline on cause, and treatment and control. While all five dimensions of cognitive representation were affected to different degrees, training effects were relatively small given the amount of resources provided and did not necessarily translate into actual changes (Campbell & Hogg). Based on this, further studies into types of training were warranted.

Research Gaps

Within these two studies, isolation for different characteristics of individuals residing in the group homes was not outlined. As well, staff differences in terms of amount of experience and level of education was not considered. Information that summarizes reviews from a collection of research projects related to these specific issues is discussed in the next section.

Review Summaries

In their summary of staff training and challenging behaviour, Grey et al. (2007) propose there is considerable evidence that demonstrates the benefit of behavioural interventions to successfully manage challenging issues and to develop life skills. These authors concur with the previous research findings that staff’s ability and degree of competence in applying interventions is integral to the amount of success in remediating challenging issues. Based on this overview, Grey et al. (2007) concluded analysis to understand staff behaviour may offer a new perspective into the process of how incorporating individualized training may assist staff with embracing evidence-based practices.

LaRue et al. (2008) completed a review specifically related to assessments and interventions for adults with challenging behaviour by examining a number of direct and indirect functional assessments. Information on rating scales and functional analyses were provided as these have been shown to be the most effective methods for identifying variables that function to maintain problem behaviour. This review summarized that practitioners can maximize effectiveness by linking strategies to assessment results with function based interventions. Also noted in the summary was that despite established efficacy of interventions, discrepancies between evidence-based strategies suited for adults with intellectual disabilities and actual practices exist within the setting when managing issues (LaRue et al.).

Ager and O'May (2001) conducted a large meta-analysis by reviewing four-hundred eighty-two empirical studies on interventions for remediating challenging behaviour. A common finding from the review was that social behaviours can significantly improve with specific interventions based on a complete functional analysis of the individual coupled with strategies that focus on consequences of the behaviour (Ager & O'May, 2001). While these summaries provided more of an overview of the issues, the previous research captured within Appendix A that focused on specific variables does support the conclusions of these reviews.

Summary

As demonstrated in the findings highlighted within this section, recent research has focused on cognitive factors such as staff attitudes and beliefs in regards to causes of the presenting challenges; individual coping styles related to burn out and emotional reactions, as well as level of behavioural knowledge and self-confidence in managing

issues. Addressing long term maintenance of training knowledge and direct observation of real changes in the natural environment for either staff or participants post training is lacking. Additionally, while a small evidence base for outcomes of staff training related to challenging behaviour does exist, research has not extended the previous research on cognitive and emotional variables to actual observable measures in the setting (Grey et al., 2007). Potential reasons for overall lack of effectiveness are discussed within the next section.

Barriers to Implementation of Best Practices

Historical Barriers

The history of marginalization by society continues for people with intellectual disabilities (Akrami et al., 2006). Lord and Hutchinson (2003) note the paradigm shift away from professional control to self-determination is relevant for all people regardless of disability type. Individuals with an intellectual disability face considerable prejudice and have only recently been incorporated into community based services with the provincial Welcome Home Movement in the mid 1980's.

Traditionally intellectual disability services have been limited to institutional custodial care settings founded on a medical model. Regardless of the de-institutionalization process in the mid 1980's, a social model of care is relatively new and not sufficiently understood in the community (Jones, Ouellette-Kuntz, Vilela, & Brown, 2008; Mansell, 2006; Young & Chesson, 2006). Changes in policy and mode of service provision have not automatically translated to quality supports as the culture of custodial care has permeated community settings (Mansell, 2006). This reality highlights a need for systemic changes to ensure that person-centered practices become the standard.

Social System Barriers

Another underlying barrier to implementing evidence-based practices relates to the lack of social service coordination. Presently there is more consideration to gaining access to programs as opposed to placing external pressure on services to ensure supports are based on an individual's needs and strengths. As well, significant staff shortages exist due to the underfunding of the wage structure therefore implementation of person-focused principles are not standard practice (Mansell, 2006; McClean et al., 2005; Young & Chesson, 2006).

Inadequate systemic planning within the community places focus on costs and quantity as opposed to quality and internal resource development. In addition, specialized assistance either occurs out of placement for the individual with intellectual disabilities or follow-up is limited by irregular specialist visits within the setting. Therefore, interventions frequently lack contextual fit and participants have limited opportunity to receive follow-up services (Mansell, 2006; McClean et al., 2005; Young & Chesson, 2006).

Organizational Barriers

Organizational barriers to effective uptake of evidence-based practice have been noted repeatedly within the research and are attributed to lack of time coupled with a lack of a comprehensive organizational plan. While best practice advocates for services based on assessment and interventions tailored for the individual, this standard is difficult to enforce due to reduced supervision within programs and lack of direct leadership (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Grey & McClean, 2007; Johnson & Austin, 2006; Mansell, 2006; McClean et al., 2005; Smidt et al., 2007). Mansell states

this lack of leadership lends itself to ineffectual care practices related to insufficient active managerial assistance for staff.

An additional organizational barrier relates to providing supports collectively for various levels of individual need within a pre-arranged setting. Typically, this results in inflexible structures and services with limited resources to provide tailor-made interventions based on the number of people being supported (Mansell, 2006; McClean et al., 2005; Young & Chesson, 2006). Other underlying barriers acknowledged within the field include lack of organizational support, lack of or poor skills training, and negative staff perceptions of the individual coupled with limited understanding of behavioural interventions (Grey et al., 2007).

Resolving staff issues therefore needs to be central to implementing high-quality services as they are the cornerstone to combining organizational policies and the intended philosophy of service delivery (Hatton et al., 1999). Hatton et al. identify that staff appraise stressful situations by assessing the resources they feel are needed or available related to physical and financial materials as well as workload and staff relationships. A key consideration is that this appraisal and coping process is individual therefore every situation of challenging behavior is assessed and addressed differently by each staff member (Hatton et al, 1999).

As previously stated exposure to ongoing challenging behavior can lead to staff stress, burnout, absenteeism and depersonalization and ultimately results in less interaction with individuals receiving supports (Rose, Home, Rose, & Hastings, 2004). This may cause strained staff and participant relationships which can exacerbate negative challenges. Jahoda and Wanless (2005) investigated the interpersonal reactions to a

typical perception of threat and acknowledged the complex nature of the staff/participant relationship due to intense positive and negative personal interactions. This complexity must be considered when determining how to incorporate evidence into the work setting as the relationship is inherently intimate and dynamic (Jahoda & Wanless). An understanding of the informal, complex workplace culture influences and interpersonal struggles when attempting to manage these trying situations must be acknowledged and understood (Jahoda & Wanless).

Research Uptake Barriers

While there are presently significant amounts of literature related to managing challenging behaviour, information is not typically directed to the knowledge transfer process and uptake of evidence-based interventions for support staff (Mansell, 2006; McClean et al., 2005; Young & Chesson, 2006). Lack of dissemination and access to information is problematic as most findings are not 'user friendly' therefore recommendations do not sufficiently transfer to 'real world' situations. The paucity of long term maintenance of changes post research involvement consequently leads to findings not only difficult to apply but also to maintain within community settings (Ager & O'May, 2001; Campbell & Hogg, 2008; Forster & Iacono, 2008; Grey et al., 2007; Grey & McClean, 2007; Johnson & Austin, 2006; Mansell, 2006; McGill et al., 2007).

Staff Training Considerations in Manitoba

In 2009-2010 within Manitoba, training in Non-Violent Crisis Intervention (NVCI), First Aide, Foundations in Disability and Community Support, Vulnerable Persons Training, Person-Centered Planning, Personal Outcome Measures, and Social Role Valorization was completed by over 4,500 staff working in the field of intellectual

disability via Family Services and Consumer Affairs funding (Manitoba Government, 2010). Presently, post-secondary educational options range from a one-year certificate and a two-year diploma in Community and Disability Supports via Red River College. As well, a Bachelor Degree program focusing on disability supports has recently been developed at the University of Winnipeg which further prepares students for entrance into the Master level degree offered by the University of Manitoba.

Despite these options, a minimum entry level education typically requires a Grade 12 education for community-based services. NVCI courses related to principles of preventing or de-escalating issues and First Aide are also considered mandatory in many work settings. However, despite staff training in NVCI, actual practice within community settings providing services for adults with intellectual disabilities does not always reflect these principles.

As discussed previously within this document, staff can become quick to physically intervene when presented with a challenging behaviour or under-react by ignoring issues which may agitate the person further. Reliance on either of these measures to cope with challenges does not serve the best interests of participants or staff nor does it address the underlying reason for the issue (McGill et al., 2007; Tierney, Quinlan, & Hastings, 2007). Research has shown that repeated exposure to challenging behaviour negatively affects other participants and staff involved in the situation and further erodes positive relationships between the individual and others.

As previously noted in specific studies, staff attributions and beliefs of why the person is exhibiting challenging behaviour may influence this response (McGill et al., 2007; Tierney et al., 2007). In consideration of the environment and context, most

interactions that occur within work settings rely on a team based approach with staff often in close proximity with each other throughout the work shift. During these set times, there is a need to respond to many individuals' needs and preferences on a continual basis therefore decisions are often made within the team with little direct supervision and may not reflect strategies based on evidence. Ability to collaborate and to rely on each staff and supervisor is therefore paramount to providing quality services for individuals (Dowey et al., 2007).

Recommendations and Future Research Needs

Many barriers to implementing research into workplace settings exist. As acknowledged previously, front line staff are often the people with the most influence on a person's quality of life. Collaboration between researchers, social systems and organizations will only be successful if experiences of direct staff who support individuals with challenging behaviours are included (Reback, Cohen, Fresse, & Shoptaw, 2002). This ongoing alliance would also ensure adaptations based on individual needs remain congruent with evidence-based guidelines when disseminating information (Gonzalez-Castro, Barrera, & Martinez, 2004).

Future Research Needs Based on Literature Review

Within the research discussed, focus on a variety of types and methods of training for staff to adopt strategies based on evidence was the goal (Baker & Bissmire, 2000; McClean et al., 2005; Smidt et al., 2007; Tierney et al., 2007; Wietske et al., 2010). Research completed on training effects regardless of the topic area relied heavily on anecdotal information captured within scenarios or limited to reporting on an actual single behaviour, person or setting. While this research added value and overall support

of various training methods, future research should consider qualitative measures by directly asking staff their opinions to better understand their training experiences.

Understanding the degree of usefulness and effectiveness of current training techniques and identifying other resources within the work setting that assist or deter from implementing strategies would also be beneficial. Additionally, asking staff to directly assess if training was effective in increasing confidence while managing challenging situations considerate of workplace culture would be helpful. Research that isolates educational background, staff roles, and amount of experience is required as the research discussed previously did not consistently distinguish between these differences.

Observations of actual practices and staff interactions within the workplace are also needed (Lambrechts, van den Noortgate, Eeman, & Maes, 2010). This could be measured by obtaining staff and supervisor information via interviews combined with researcher observations directly within the environment. Methods to understand the type of participant behaviour could be measured via incident report information as opposed to sole reliance on anecdotal information. As well, volume of incidents could be valuable indicators of baseline rates in challenging behavior and risks relevant to each home.

Measures to assess the impact of workplace context and culture also need to be further explored. This information may be captured within staff meeting minutes and written documentation between staff. Consistently within the literature, the social impact of passing on clinical information within an agency has been deemed important. Qualitative measures that ask both staff and supervisors which staff members are most effective in dealing with challenging issues and what has the most influence on

colleagues may provide an opportunity to distinguish individual characteristics that assist in facilitating uptake of information.

Examining the amount and type of supervision and opportunity for follow-up post training with supervisors should also be included. Impact of the workplace structure, for example differences between working alone, in a one to one situations, or awake at night setting versus within a team, may explain levels of ability to effectively respond to challenging issues if other support is readily available. As acknowledged throughout the literature, since the process of how knowledge is transferred into practice for direct support staff is largely unknown, research that considers knowledge transfer processes would add to the present body of knowledge. Theories and frameworks to understand and to potentially assist with overcoming these barriers are discussed within the next section.

Knowledge Translation and Evidence-based Practices

While the process of how to transfer or disseminate relevant information to front line staff is not well-defined, progressive organizations are acutely aware that quality care and best practices are based on principles of individualism and humanism (Mercier, Bordelau, Caron, Garcia, & Latimer, 2004; Rycroft-Malone et al., 2004). Given this standard, it is imperative that work settings incorporate training strategies to bridge the gap between knowledge and practice to achieve both individual and systematic changes (Cunningham & Doncaster, 2002; Herbert, 2005; Riley-Tillman et al., 2005). Examining knowledge translation concepts and highlighting important indicators for effective staff training is a fundamental piece towards achieving this goal.

Definitions and Terms

Effective delivery of quality services is embedded within the collective ability of employees to demonstrate both knowledge and skill in accordance with best practice principles (Mercier et al., 2004; Williams et al., 2008). Rycroft-Malone et al. (2004) propose knowledge is an awareness gained though experience, whereas Levin (2008) advances knowledge construction is founded within social and political processes. While it is a given that knowledge in itself will not change practice behaviours, the process of how to translate information to observable skills remains largely unknown (Levin, 2008).

Estabrooks, Thompson, Lovely, and Hofmeyer (2006) report while there are many knowledge translation definitions, none encompass all aspects of the process. The Canadian Institute of Health Research (CIHR) defines knowledge translation as the "exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users" (Graham et al., 2006**,** p.15). Definitions from the World Health Organization and other national disability research organizations such as the National Center for the Dissemination of Disability Research, and the National Institute on Disability and Rehabilitation Research have emerged based on this CIHR description (Sudsawad, 2007).

Graham et al. (2006) relay the primary purpose of knowledge translation is to address the gap between what is known from synthesized research and what is implemented by relevant people to improve outcomes for individuals in receipt of services. Key components of this iterative process include creation of new knowledge and application for societal benefit with ongoing monitoring and feedback (Graham et al., 2006). Other characteristics of the knowledge transfer process include multidirectional communication within an interactive team and ongoing collaboration. As well, multiple

non-linear activities to apply research knowledge with consideration of user and context specifications to ensure a lasting impact are important (Sudsawad, 2007).

Alternate terms to describe the knowledge to action process include evidence-based practice, knowledge transfer and exchange, research uptake and utilization, in addition to dissemination and diffusion however, these are not synonymous (Estabrooks et al., 2006; Graham et al., 2006). Knowledge mobilization is a term utilized by the Social Sciences and Humanities Research Council of Canada which emphasizes social and political influences in a multi-dimensional process (Levin, 2008). Despite variations in terminology, the majority agree that moving knowledge into action is most effective when the source of information is known to be credible, relevant, and adapted to the intended environment (Law, Missiuna, & Pollack, 2008).

As identified previously, improving service delivery and overall quality of care for individuals is complex. To have a positive impact, evaluation of the environment to where the knowledge is to be implemented must consider the entire organization including teams of information users which is often challenging and time consuming (Strauss, Tetroe, & Graham, 2009; Tetroe et al., 2008). An understanding of how to extend mobilization strategies to direct care providers is urgently needed (Cunningham & Doncaster, 2002; Herbert, 2005; Riley-Tillman et al., 2005).

Evidence-Based Practice

While it is acknowledged that research alone will not improve or change behaviour, evidence-based practice derived from professional craft knowledge, clinical reasoning and a combination of work and life experiences, is a dynamic process that can influence action. Changing or improving practice requires an ability to reason and to

integrate knowledge into staff's existing attitudes and beliefs to effect change (Sudsawad, 2007). In support of this, Rycroft-Malone et al. (2004) state evidence-based practice must draw not only on knowledge but also incorporate research, clinical experience, participant/caregiver preferences, and local work setting and organizational factors (Rycroft-Malone et al., 2004). Person-centered practice is therefore complex as it must blend scientific and individual human experiences which do not always merge in a succinct manner (Kitson et al., 2008; Sudsawad, 2007). The following section describes theoretical perspectives that were applied to this research.

Theoretical Perspectives

Providing a theoretical foundation enhances the ability to predict outcomes when applying specific intervention techniques (Estabrooks et al., 2006). As indicated within the literature, application of theory should be an iterative process when thoroughly examining the setting and established research goals (Degner, 2005; Estabrooks et al., 2006). Kitson et al. (2008) propose that since a general lack of agreement exists on what constitutes a model, framework, or theory, these terms are often used interchangeably.

As the field of knowledge translation continues to be developed, a single over-arching knowledge mobilization definition or theory is neither available, nor viewed as essential to further the work of moving knowledge into practice (Estabrooks et al., 2006; Levin, 2008). Instead, a variety of theories that provide multiple perspectives for a specific situation is perceived as beneficial (Estabrooks et al., 2006). Conceptual frameworks founded in knowledge translation serve as tools to examine the components and relationships of learning and action. These frameworks additionally allow for meta-theories to be applied (Kitson et al., 2008).

Levin (2008) posits knowledge mobilization strategies must not only be congruent with an organization's setting, but must also recognize the importance of social and political connections within the setting. In consideration of these recommendations, the Promoting Action on Research Implementation in Health Services (PARiHS) Conceptual Framework in addition to Mindlines and Social Exchange theories were chosen to explore the knowledge translation process for this cohort. The intent was to highlight different approaches that can be applied to developing relationships between the individual and organization with the researcher dependent on what elements of the knowledge transfer route are known and what requires further consideration.

Promoting Action on Research Implementation in Health Services Framework

The PARiSH framework is recognized as a major theoretical base within the knowledge translation field and offers a representation of the complex processes of implementing evidence (Kitson et al., 2008; Rycroft-Malone, 2004). This framework is constructed around three main categories: evidence, context, and facilitation. Strengths or areas of potential needs within each domain are indicated within a rating system from high to low that need to be addressed before implementing new strategies or knowledge intended for action (Kitson et al., 2008; Rycroft-Malone, 2004).

Evidence incorporates not only research information but also the relationship between clinical experience, participant and caregiver preferences, and local work environments (Kitson et al., 2008). Rycroft-Malone et al. (2004) outline this integration process involves gaining an understanding of new evidence and information of the benefits, risks, and advantages by contrasting and comparing the new technique to known

strategies. Direction between ‘formal’ research knowledge and ‘informal’ experiential knowledge is therefore a complex non-linear pattern (Kitson et al., 2008).

The PARiHS Framework also highlights the need for ‘context’ to be addressed in order to successfully implement new information. The importance of supervision and effective leaders with flexible structures for evidence to be implemented within the work setting is acknowledged (Rycroft-Malone, 2004). Unique aspects of this framework include an in-depth focus on leadership in addition to implications of monitoring, evaluation, and feedback mechanisms (Rycroft-Malone, 2004). Organizational factors are considered in terms of complexity of decision-making, access to resources, professional autonomy, as well as support from peers, leaders and other team members (Estabrooks et al., 2009; Rycroft-Malone, 2004).

Facilitation factors within this conceptual framework focus on review of the level of preparedness and receptivity for both the individual and team, available resources, workplace culture and values, in addition to leadership and evaluation activity within the setting (Rycroft-Malone, 2004). Facilitation also considers what type of intervention is indicated, along with the role and skill level of the facilitator needed to assist the team in understanding and overcoming barriers (Rycroft-Malone, 2004). While ongoing dispute in regards to efficacy of specific techniques continue, implementation must involve a systematic, active process of ensuring evidence-based practices are relevant to the target audience (Kitson, 2009; Sudsawad, 2007). The method chosen to facilitate this ultimately depends upon the degree of engagement with the intended user group (Tetroe et al., 2008).

As noted previously, ‘evidence’ coupled with needing to understand the ‘context’ of the social organization and finally identifying ‘facilitation’ strategies based on the specific staff needs is required. In support of this holistic approach, Degner (2005) also recommends that an understanding of the workplace culture in terms of leadership style and evaluation practices of the organization in combination with individual resources is required. Professional qualifications, experience and knowledge along with staff attitudes, clear guidance from management, frequent supervision, and support and training for staff is highlighted as an area of need within this group of staff (Mansell, Beadle-Brown, Whelton, Beckett, & Hutchinson, 2008). Importance of the workplace context is noted by suggestions that guidance for staff procedures, training and supervision with team meetings, leadership and professional support assists with maintaining placements (Broadhurst & Mansell, 2007).

In consideration of available evidence, the impact of workplace culture and need for facilitation that is relevant to front line staff, the PARiHS Framework offers the most efficient manner to understand direct care providers’ needs to effectively mobilize information. As acknowledged, support staff are often the people who possess the most influence on a person’s quality of life. Collaboration between researchers and organizations will only be successful if line staff experiences are included (Reback et al., 2002).

Mindlines

As proposed previously, knowledge is a social process involving the individual staff person and others relevant to the given situation (Levin, 2008). Gabbay and leMay (2004) describe the concept referred to as ‘mindlines’ to provide a means of enhancing

our understanding of how an individual chooses and incorporates new practice information. This theory attempts to explain the process of 'sense making' when a person is faced with making a clinical decision (Gabbay & leMay, 2004).

'Mindlines' are collectively reinforced internalized decisions construed not only by science but also personal knowledge gained through social exchanges with peers (Barley, Pope, Chilvers, Sipos, & Harrison, 2008; Gabbay & leMay, 2004). Individual 'mindlines' are in turn negotiated based on the range of formal and informal interactions available (Barley et al., 2008). This non-linear process integrates knowledge which is categorized as a) a scientific component based on formally acquired training and subsequent personalized interpreted knowledge of training received and; b) a personal component which includes experiential knowledge founded on personal and clinical experience, in conjunction with contextual information based on a given situation (Barley et al., 2008).

The blending of this information allows staff to make decisions by networking with peers as opposed to relying solely on scientific evidence. Mindlines are congruent with the parameters of 'evidence' defined as a combination of research, clinical experience, patient/resident information and the local work context for staff identified within the Promoting Action on Research Implementation in Health Services (PARiHS) Framework (Rycroft-Malone et al., 2002). The concept of 'mindlines' additionally highlights the importance of social learning which is acknowledged as integral to uptake of new information.

Jones et al. (2008) and Whittington and Burns (2005) conducted separate studies examining how community residential staff take action to resolve issues arising in the

workplace. The authors report staff responses were based upon an understanding of specific resident needs, years of experience within the field, organizational factors, in combination with attitudes and peer consultation (Jones et al., 2008; Whittington & Burns, 2005). These findings are also consistent with the 'mindlines' theory.

Social Exchange Theory

Effective learning organizations which incorporate best practice must be designed to integrate ongoing learning and sharing opportunities for all employees. Levin (2008) reports that few work settings are organized enough or prepared to find methods to mobilize staff to transfer knowledge into action. Social exchange theory highlights the principle of reciprocity in that where there is trust, commitment, and perceived organizational support, employees will reciprocate and increase performance (Barker & Camarata, 1998).

Social exchange theory proposes that relationships founded on socially mediated goals reinforce positive behaviours and are thereby motivating factors for everyone and integral to the creation of a learning organization (Barker & Camarata, 1998; Riggs & Rantz, 2001; White & Klein, 2002). Alternately, if the agency's response is not in proportion to the expected return, staff may perceive this as inequality. This in turn may result in dissatisfaction and poor performance (Riggs & Rantz, 2001).

Within learning organizations, knowledge is considered an asset that will grow exponentially when effective communication is shared via social relationships, connection, and transparency with open dialogue (Barker & Camarata, 1998). Barker and Camarata propose team learning increases corporate intelligence therefore interconnection of leaders and staff is imperative. With these principles in place, the

results will yield valued empowered employees invested in positive reciprocal work relationships (Barker & Camarata).

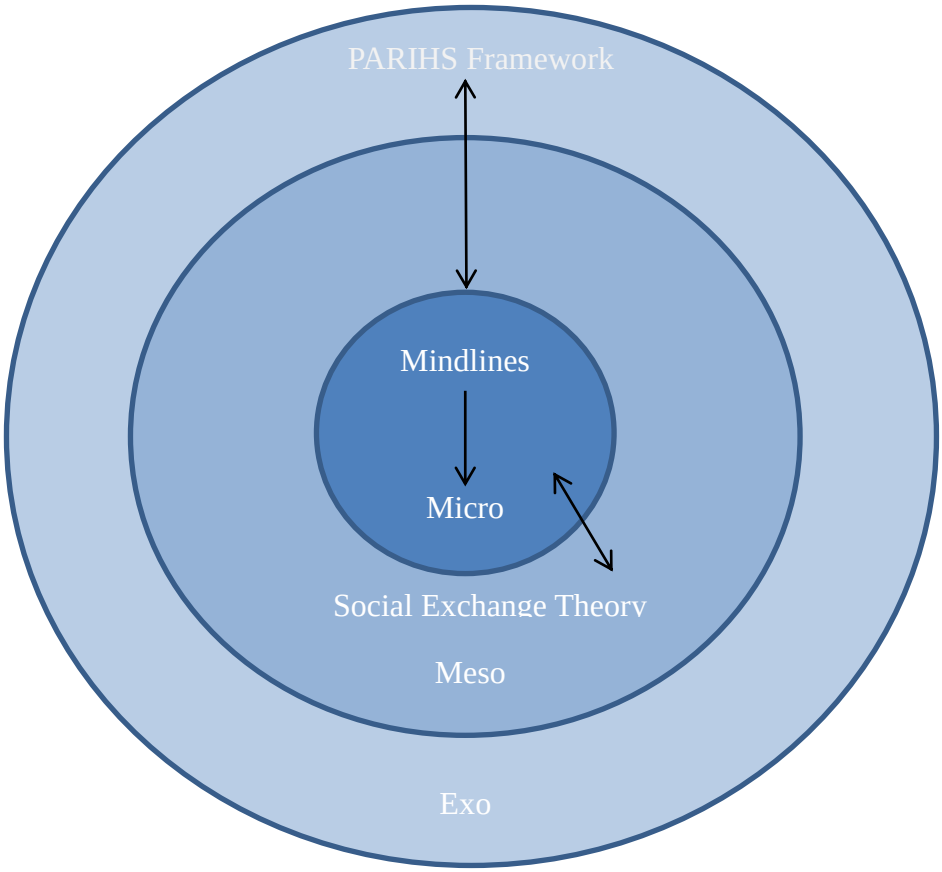
Within the non-profit community sector, social exchange theory is relevant as issues between management and staff are frequently noted by lack of supervision within programs and lack of direct leadership (Corrigan et al., 2001; Grey & McClean, 2007; Johnson & Austin, 2006; Mansell, 2006; McClean et al., 2005; Smidt et al., 2007). The ability to positively affect the workplace calls for regular supervision and respectful relationships between groups to ensure best practices are implemented (Mansell et al, 2008; Mascha, 2007). Within a study that examined the influences of organizational structure for staff employed in community residences, it was recognized that clear management guidelines, team meetings with frequent supervision and support from supervisors is what encouraged front line staff to enhance residents' lives positively (Mansell et al., 2008).

Propositions of social exchange theory based on reciprocity and respectful communication to effectively mobilize staffs' use of best practices are therefore relevant. The consistent feature of the framework and theories outlined is the importance of establishing an interactive, reciprocal relationship with knowledge producers and users to ensure information is disseminated and utilized. Specific strategies to understand individual staff's needs in concert with the organization culture, can be overcome with working relationships based on respect in a shared culture (Bowen & Martens, 2005; Dobbins, Rosenbaum, Plews, Law, & Fysh, 2007).

Application of how each of the theories interface with an Ecological Model is highlighted below. As indicated, Mindlines and Evidence from the PARiHS Framework

capture the relationship between staff and participants within the micro-system. Context as outlined in the PARiHS theory in addition to Social Exchange theory addresses the meso-level team influences. PARiHS's Facilitation factors accounts for the exo-system which describes the organization leadership and training styles.

Figure 1: Theory Application to an Ecological Model



Conclusions

Staff training on interventions that include person-focused training, brief challenging behaviour training, physical interventions with active support, and communication training most definitely assist staff with managing issues that pose challenges. The research discussed demonstrates that there is significant value in investing time and energy towards incorporating these strategies. However, training alone

has not nor will it change actual staff behaviours within the workplace context as also noted within these studies.

Although immense amounts of research have been conducted on knowledge uptake, extension to front line staff must be considered. Partnerships between residents-staff, staff-management, and staff-researchers are needed. As noted earlier, application of various theories and frameworks are beneficial to assist in framing the questions and a combination of theories can add both depth and breadth as opposed to application of a single over-arching theory.

In support of this, I utilized the PARiHS Framework as it not only demonstrated the complexity of knowledge mobilization but also provided a multi-factoral approach to apply within community residential settings. As well, mindlines and social exchange theories highlighted the individual and organization influences on decision-making. Each of these perspectives lent itself to providing a more global understanding of what to consider when approaching knowledge translation projects with staff that support vulnerable people. The methodology utilized to capture the information is discussed in detail within the next chapter.

CHAPTER III: METHODOLOGY

Since there are many unknown factors to understand how direct staff accept and translate knowledge to practice, choosing a methodology that encompassed a variety of perspectives through assorted data points was essential. This next chapter details case study methodology and its application to this research.

Case Study Methodology

Case study is one methodology that offers a multi-perspective approach and can be applied analytically or holistically in qualitative research (Patton, 2002; Stake, 2000; Yin, 2009). The goal of case study methodology is to accurately capture the most holistic description of the experience using an iterative process (Merriam, 1998; Stake, 2006; Zucker, 2001). Case study is also useful when the process and context of real life is needed to best address the research question and multiple sources of information are required to gain insight (Merriam, 1998; Yin, 2009).

The unique feature of this methodology is the focus placed on a ‘case’ as a bounded unit which can pertain to a person, program, or organization (Creswell, 2003; Merriam, 1998; Stake, 2000). Given that this research was designed to understand staffs’ experiences within a specific context, focusing on two specific residential units which could be isolated as distinct cases was ideal. Since the intention was to ultimately provide insight into potential practice and policy recommendations, this methodology was also seen as appropriate to achieve this goal (Merriam, 1998).

The process of designing, preparing, collecting in conjunction with analyzing the data to share information in a case report are consistent within the literature (Merriam, 1998; Stake, 2006; Tellis, 1997; Yin, 2009). However, as with other methodologies,

alternate perspectives from researchers who utilize case study design exist. The differences in strategies extend from how the research project is undertaken to how findings and comparisons are drawn. Both Merriam (1998) and Stake (2006) caution against generalizing one case to another during analysis as each case must be situated with cross-comparisons organized only at the final stage of data analysis. These authors further agree that cross-case findings must not only accentuate overall similarities but also the uniqueness of each case (Merriam, 1998; Stake, 2006).

Stake (2006) offers three reasons to use case study methodology dependent on purpose and intent. These include cases that are considered a) intrinsic to gain a better understanding of only one case, b) instrumental to provide insight beyond the case and external interest in order to advance an understanding and c) multiple or collective case study relevant to several cases which do not need to be similar (Stake, 2006). Yin (2009) offers definitions of cases as 'holistic' defined by a single unit of analysis or 'embedded' to define multiple units of analysis. These terms are applied to both single and multiple designs (Yin, 2009).

Research Setting

This research involved partnering with the Community Residential Program of St. Amant which is a Winnipeg based non-profit agency for individuals with intellectual disabilities. A range of comprehensive services provide support to approximately one hundred and eighty people within approximately sixty five community residential settings which includes community homes, foster care-provider models, supported independent living situations, and the Community Living Stabilization Services (CLSS) (http://www.stamant.mb.ca/main/index.html). St. Amant employs a variety of staff

including psychologists, therapists, nurses, and behaviour specialists. Direct staff within these settings are the people who provide the majority of direct support.

Sample

Formal purposive sampling allows for choosing specific circumstances where learning can be maximized (Stake, 2000). In this research, a cross-case design consisting of two community homes providing supports to adults with intellectual disabilities were chosen and each residence was considered a bounded unit or 'a case'. The process of identifying two settings that corresponded with the study criteria included collaborating with the Director of the program who was also instrumental in coordinating the initial interviews.

Maximal sampling was utilized by choosing one residence designed to provide services for adults with intellectual disabilities who present with challenging behaviours. A second home that offers supports for people with similar characteristics including comparable levels of intellectual disabilities, age and gender but who do not present with significant challenging behaviours was chosen. The anticipated diversity of issues that staff regularly encounter in the 'typical' home as opposed to a residence with greater inherent risk and unpredictability based on challenging behaviours was brought forth with this sampling strategy.

Ethical Considerations

Ethical approval was received from the Education/Nursing Research Ethics Board at the University of Manitoba. Access approval from St. Amant was sought and provided after ethics approval was gained. Refer to Appendices P and Q for certificates of approval. Permission to approach and subsequently recruit supervisors and their staff

according to characteristics identified within this proposal was granted. Supervisors were informed of the study by the Director of the Community Residential Program while Direct Support Staff were only contacted by the Principal Investigator if they had indicated interest to their supervisor after being notified of the study.

Consent forms were reviewed outlining that there were no known risks to participating in the study, that all data was to be identified with a pseudonym and general recommendations were to be made regarding the process of supporting individuals thereby avoiding loss of confidentiality. Assurances were made that data will be stored in a locked cabinet in the Principal Investigator's home based office for seven years and then destroyed. As well, any electronic data will be maintained in password protected files.

Since no direct observations of actual interactions between staff and residents were permitted and discussions were not to include any specific circumstances related to individuals being supported, potential reports of unjust practices were highly unlikely. However, since all staff and researchers have a duty to report any behaviour or conversation that is suspect, the consent form also identified that the signatures did not release researchers or people involved of legal or professional duties. Please refer to Appendices C through F for consent forms developed for support staff and leaders.

Procedures

A distinguishing feature of case study is that detailed data are collected with a variety of tools (Sofaer, 1999). Most common methods to collect data are through key informant interviews via open-ended, semi-structured or closed questions, review of documents and records, direct observations of events and situations, or participant

observer interactions, in addition to physical artifacts (Yin, 2009). Given that previous research had not included direct observation within the environment, key informant interviews based on interactions between the staff and individuals was originally proposed as the primary data collection method.

The consent process therefore included individuals who resided in the home along with people who supported their decision making where applicable. Consequently, permission to observe was not received by all relevant people and access to the residences was therefore not feasible. Since observation and conversational interviews were not permitted as the primary data collection method, a secondary plan to gain information via key informant staff interviews outside of the residence was employed and became the main source of data.

Key informant interviews with five staff per home were the central data points within this study. Supervisors of each home consisting of the Client Care Coordinator and Team Leader in addition to the CRP Training Coordinator and Behaviour Analyst were also interviewed in this process. The Training Coordinator, Behaviour Analyst and Supervisors were informed of the study by the Director of the Community Residential Program and provided with an introductory letter as noted in Appendix B. Direct Support Staff were notified of the study by their supervisor and provided with introductory information prior to being contacted by this researcher. Interviews with Unit A supervisors and staff were completed in full prior to initiating contact with Unit B.

Documents that described supervisory and risk management policies were reviewed as was an overview of the internal training program prior to the interview process. Refer to Appendix K for details of these policies. Areas that required further

description or clarification were added to the Semi-Structured Interview Guides included in Appendices G through J. This aided in gaining a comprehensive understanding of training opportunities, access to behavioural resources and insight into how knowledge gained during training sessions was transposed within the work setting. Table 1 describes the data collection process and purpose for each method.

Table 1: Data Collection Process and Purpose

Type of Data	Purpose	Method of Collection
Interviews	Direct experiences explored, highlighted & discussed	Training Coordinator, Behaviour Analyst, Staff & Supervisor individual key-informant interviews with guide
Demographic Questions	Explore differences between age, gender, years of experience	Part of individual interviews
Descriptors of Residents	Capture essence of type of needs globally for each 'case'	Supervisors' information prior to interview with general demographic characteristics
Descriptors of Staff & Type of Regular Shift Pattern	Capture differences between experience, age/gender, and available support from other staff	Information prior to each interview with staff & supervisor
Type/Timing of Staff Education (Mandatory/Optional)	Identify areas that are related to orientation & relevant to area where staff work	Interview with Training Coordinator, Review of training schedule and documents
Perceived Retention & Recruitment Rates	Understand perception of stability of staff in the unit	Supervisor information from Client Care Coordinator & Team Leader
Supervision Policy Staff & leadership interactions	Perceived level of support within context	Review of supervision policy Interviews with staff and supervisors
Incident Reports/Worker Injury Reports	Type/frequency of challenges, level of perceived risk, and/or staff injury	Review information with Client Care Coordinator per 'case'
Risk Management Policy/Unit Practice Guidelines	Direction from agency, available resources from specialist to manage situations	Supervisors information, Behaviour Analyst interview

Data Analysis Process

Analysis was completed through an iterative process using all data points which led to convergent categories and themes (Merriam, 1998). Yin's (2009) proposed technique to analyze the data via explanation building based on this process was employed. In consideration of Merriam (1998) and Stake's (2006) cautionary statements to avoid generalizing one case to another during analysis, case description and analysis for Unit A was completed prior to moving forward with Unit B data analysis. Cross case comparisons were drawn after both units were analyzed separately. Content was analyzed to emphasize findings identified as relevant either for its typicality or, conversely, for its originality, was referenced to the original research question and systematically documented (Merriam, 1998; Stake, 2006).

While interviews with the Leaders, Behavior Analyst and Training Coordinator occurred in St. Amant office space, staff interviews were held in mutually agreed upon local restaurants. As noted previously, since unanimous consent was not received by all decision makers, access to the staff's workplace was not permitted. Given that staff were leaving their shift to attend the interviews, accommodation to meet at nearby, accessible locations was necessary to mitigate the time away from the home and subsequent implications for the team and individuals receiving support. .

All interviews were audio-taped and transcription was divided amongst three independent people. Upon completion of each interview, information was fully reviewed and general impressions that were recalled during the meeting or discrepancies provided by the participant were noted. Please refer to the sample Initial Interview Review Form in

Appendix M. This iterative practice allowed for refinement of questions or for points to be clarified as interviews progressed.

Prior to categorizing the data, transcribed interviews were reviewed repeatedly by the researcher to ensure consistency during transcription while searching for common experiences. These notations were highlighted and written directly onto the transcripts. Initial categories were analyzed using phrases and sentences to develop larger aggregate categories that were relevant to each interview. These categories were further analyzed and arranged into common themes. Refer to Appendix N for a list of initial categories per grouping.

During the preliminary stages of this process one advisor reviewed and evaluated the initial categories that had been developed. This procedure revealed similar and consistent patterns with the original findings. While a significant number of categories were originally identified, considerable overlap was noted and each did not apply to every interview. However, the information did relate back to the original research goal which was to develop an understanding of the multiple considerations when attempting to integrate evidence-based.

In order to identify themes that could be applicable and broad in focus, all categories were reviewed and re-grouped according to overarching commonalities. This process involved refining categories into themes with operational definitions and properties. Refer to Appendix O for examples of aggregated category information. After both case interviews were transcribed and analyzed, all information including original transcripts, categories and themes were reviewed and evaluated by both co-advisors on this research project. Themes and conclusions were drawn from each case independently

and only combined for the entire study as the last piece of analysis (Merriam, 1998; Patton, 2002; Stake, 2006).

Trustworthiness

Merriam (1998) acknowledges that since the primary instrument in qualitative research is the researcher, systems to check potential biases are essential. By requesting information in a semi-structured manner, respondents were provided with opportunities to personally explain their own experiences of how training knowledge is or is not successfully implemented within the work setting. Triangulation from field notes, interviews, documents, and lastly from cross-case information, led to themes based on convergent and alternate viewpoints to provide assurances of completeness (Stake, 2006).

Verification was furthered by the researcher sharing the data analysis processes with the co-advisors. This reflective process included consulting and meeting with both advisors to discuss decision making processes and to clarify areas that required further explanation for those who do not work in the field of disability. Regular feedback was also provided as further cross case analysis and discussion points were drawn.

The opportunity to check perceptions and recognize potential gaps based on this researcher's background knowledge added value and depth to this research. Assumptions based on the researcher's professional and personal experiences were stated as well as professional affiliation. Reflective memos captured within a journal documented this researcher's experience and thoughts during the process.

Provision of an audit trail to describe the decision-making progression extending from interview preparation to how categories evolved into eventual themes added to the dependability of the research process. Consistent use of pre-determined guidelines

applied to each case was intended to allow for individual readers to gain perspectives within their local environment (Merriam, 1998; Yin, 2009). This strategy was anticipated to offer an opportunity for generalization of the research to be made for future research projects as well as potential knowledge translation efforts within agencies providing similar services.

Researcher's Background

The driving force behind this research was my keen interest in wanting to improve upon the lives of people who live with intellectual disabilities. This stems from being employed for approximately twenty five years in numerous positions within the field ranging from a Direct Support Staff, Supervisor, Private Occupational Therapy Consultant, Continuing Education Coordinator, Program Manager and currently; Director of Supported Day and Residential Services. My experiences of being involved either as a participant or equally as a facilitator in a variety of professional development sessions also contributes to this passion. Moreover, within this time span, I have repeatedly observed that a gap exists between what is taught and what actually occurs in the work place when faced with managing challenging situations despite training efforts.

Since I am employed with a large non-profit agency that also provides community supports to individuals with intellectual disabilities, I have consulted professionally with some of the leaders within this organization. As well, I am familiar with a number of participants who receive supports from St. Amant. Because of these acquaintances, steps were taken at the onset to ensure that interviews with Team Leaders and Direct Support Staff were not conducted with people I knew. Furthermore, information shared was not specified to my work association.

Summary

Quality of care for people with intellectual disabilities is reliant on the ability of direct staff to provide supports based on best practice. Services tailored for individuals who additionally present with challenging behaviours need to be further explored. Application of case study methodology to draw attention to potential differences between a ‘typical’ case and one with greater unpredictability and inherent risk due to challenging behaviours lent itself to a deeper understanding of these specific needs. Consideration of the physical, social and workplace cultural environments that direct support staff work within provided an opportunity for organizations and researchers to identify potential strategies that are relevant for individual staff and teams.

CHAPTER IV: RESULTS

The main data points within this research focused on semi-structured key informant interviews with five staff and two supervisors per home in addition to the Community Residential Program (CRP)'s Training Coordinator (TC) and Behaviour Analyst (BA). Semi-structured interview guides that assisted with framing the interviews are noted in Appendices G through J. Documents related to training, risk management, and supervision were also reviewed and outlined in Appendix K.

Instrumentation

During each support staff interview, demographic questions such as gender, age, amount of experience, educational background, years of service within the agency and typical shift patterns worked were asked. These are areas that previous research did not consistently isolate therefore potential differences were not able to be drawn (Grey & McClean, 2007; McClean et al., 2005; Smidt et al., 2007, Tierney et al., 2007). Perceptions of recruitment and retention rates within each residence were also collected during the supervisor interviews to highlight the potential impact of unresolved issues related to managing behaviour.

Interviews with the unit supervisors which included the Client Care Coordinator (CCC) and Team Leaders (TL) served as the initial entry points within each case. A general description of the people receiving supports provided within the home including age range, gender, diagnosis and challenges of the individuals was captured during these interviews as well as a review of similar questions posed to direct support staff. The number of incident reports to understand overall frequency and types of challenging

behavior relevant within the residence was provided by the CCC. This facilitated a better understanding of the volume of challenges that staff negotiate on a regular basis.

As noted previously, written documentation of agency policy and guidelines for supervision and managing difficult behaviours was reviewed. As well, information on timing and type of training received by staff was collected and outlined in Appendix L. This information also highlighted elements of the context and facilitation factors in place when considering available opportunities to provide follow-up post training.

Community Residential Program

The Community Residential Program (CRP) provides supports to approximately 180 individuals within 65 sites. This work is completed by over 500 staff employed in community homes, foster care-provider models, supported independent living situations, and the Community Living Stabilization Services (CLSS). These homes are well integrated into local residential communities. Rapid expansion, accentuated when the CRP assumed another community based residential program in 2005, has led to significant periods of growth.

While this research focused specifically on two residences that were matched and chosen by the Director of the program, an overview of the internal structure of the CRP was useful in identifying how information is disseminated and how decisions are implemented. Within the CRP, the lines of communication begin with the Director followed by the Program Manager who oversees all Client Care Coordinators (CCC). Each CCC is responsible for approximately eight community homes and supervises the Team Leaders (TL) who typically manages two residences depending on the needs of people supported. Within each home, unionized line staff offer support and care to the

individuals. The team also includes a key worker who provides functional supervision and works alongside the direct staff.

Entry level educational requirements for staff are: a) Direct Support Staff, Grade 12), b) Key Workers, Grade 12 and additional courses provided by St. Amant with preference given to Community and Disability Supports graduates, c) Team Leaders, university degree in social or health sciences, d) Client Care Coordinators, university degree in social or health sciences, e) Behaviour Analyst, Master level degree in Psychology and registration with the Psychological Association of Manitoba, f) Behaviour Technicians, Bachelor of Arts or Bachelor of Sciences Degree in Psychology.

Other resources internal to the program include Coordinators who report to the Director and are responsible for specific support services that are accessible to every home. For example, the Training Coordinator oversees all CRP training and collaborates with the leadership to ensure sessions are relevant to the given context of the home. As well, Clinical Services which includes the Behaviour Specialist and Analysts are available to all CRP residences upon referral from a supervisor.

Externally based organization services such as the Human Resource department assist with providing administrative assistance to each program within the agency. For instance, the St. Amant Human Resource Department is responsible for conducting the initial staff interview. A second ‘working interview’ is completed directly within the potential CRP community residence that is requiring support staff. Post hiring and prior to being involved in the areas related to the CRP specifically, all staff must attend a centralized Corporate Orientation for an introduction to the entire agency.

Once a staff becomes part of the CRP support team and assigned to work in a particular residence, relevant training modules that are mandatory to support the individuals in that specific home are arranged. For example, if a setting provides support to individuals who exhibit challenging behaviours, staff must partake in the corresponding level of Non-Violent Crisis Intervention (NVCI). Staff may also be involved in Specialized Behaviour Management Training at a later time.

These decisions are based on a comprehensive process to determine which settings require specific training information. In order to capture the content of all training components, policies and documents that pertained to staff orientation and training requirements were reviewed. In addition, the Training Coordinator who oversees the CRP continuing education program participated in an interview where sessions were discussed in detail.

Training Coordinator Interview

The Training Coordinator interview was completed in order to gain a better understanding of the training offered by the CRP. Importance of immediately setting the tone and expectation for new staff was highlighted consistently during this discussion. This is realized by ensuring the program's values in combination with developing skills specific for the workplace are included throughout training sessions.

Benefits of Internal Training

One of the main benefits to developing and facilitating sessions specific to the needs of the program is that training can repeatedly integrate person centered values while providing emphasis on enhancing quality of life. Collaborating with the leadership team per home including the CCC, TL and Clinicians also provided an opportunity to

guarantee that specific content identified as relevant was incorporated. Furthermore, flexibility and feedback for the session schedule allowed for adaptations based on the 'home' and staff needs as they developed. Written feedback from staff on each training session was also mentioned as a method to aide in identifying the most relevant content.

Providing a continuum of training with a pool of motivated, internal facilitators in conjunction with specialized training facilitated by agency professionals and external training assists with ensuring training was identified as a priority. If staff requires individual resources to augment the routine sessions, additional assistance was also available to aide with comprehension. The advantage of internal connections and familiarity between the Training Coordinator and potential leader was also viewed as an asset as staff will seek advice directly when requiring consultation either for themselves or for the team. An additional benefit to internal training was that when budget constrictions were realized, external resources that require payment of services were more at risk thereby preserving the integrity of the internal continuing education.

Transfer of Knowledge

Finding a balance of what the larger 'system' expects with philosophy of person-centered supports is imperative. This process includes interpreting restrictions with the proper level of support per individual in conjunction with an active appraisal of current practices. As indicated within this interview, the leadership team was responsible to ensure transfer of training occurred. This approach was based on the logic that since leaders tend to possess the most knowledge about specific participant's needs in conjunction with the workplace context, this process would provide a balance of the principles to individual circumstances.

During this discussion, differences between skill based versus value based training was highlighted. For certain skill based sessions, follow-up and timelines were explicitly stated such as Specialized Behaviour Management Training (SBMT) and training as outlined within In-House Checklists. While skill based training can be readily assessed for integration of learning, training information that focused on values was identified as subjective.

Integration of value based learning was noted as becoming increasingly evident during the Personal Outcome Measures (POM) meetings. This process required staff involvement to review current services and to ensure emphasis on participant goals were at the forefront of service delivery. While this method integrated positive involvement from staff and leaders, initial reactions were noted as being defensive to critical appraisal of services. The role of leadership to implement and to lead by example regarding Personal Outcome Measures training and quality of life factors was also emphasized.

Barriers and Future Considerations

As highlighted within this interview, although training ideally assisted with educating and retaining employees, staff did leave the organization regardless. This reality led to aligning the timing and content of training to the level of experience working in the program. Having the flexibility to accommodate the needs of new staff so that they were prepared to transfer this knowledge within the work setting was viewed as one means of balancing the negative effects of retention issues.

Other considerations that were noted as potential areas to address in the future were related to limited and restrictive advanced training for longer term staff excluding specific skill based refreshers. As well, succession planning for leadership positions was

also seen as requiring attention to ensure the organization retains prime staff who were natural leaders and demonstrated initiative. The Key Worker position was provided as a positive example of how external supervisory training for upcoming TL and CCC roles benefited not only the identified staff but also the program.

An external issue stemming from the significant time commitment to attend and complete established post-secondary training opportunities was discussed. As a consequence, this may have in turn discouraged staff to advance knowledge or to remain in the field. Incorporating an internal training program to address these outstanding needs was one approach to offset these barriers.

This interview additionally highlighted areas that were external to the influences of the agency. For example, importance of accreditation and advancing the field of disability as a whole was addressed as requiring attention. Focus on community based and person centered approaches in training was one method to assist with shifting away from the pervading medical model to one of individual personalized support. As well, since there is an overall lack of resource sharing between Manitoba based service providers, finding opportunities to collaborate to enhance the field of disability was also recognized as an area that required consideration.

Behaviour Analyst Interview

The main topic of this study was to explore staff's experience with providing services to those who present with challenging behaviours. Therefore an interview with the Behaviour Analyst involved primarily with Unit B was included and completed prior to meeting with the Unit B staff group. Since the Behaviour Analyst is one of the two

primary Specialized Behaviour Management facilitators, specific information in regards to the content of this training was reviewed as was the Clinical Consultation Policy.

The CRP Clinical Coordinator, who also is the Behaviour Specialist, oversees the Behaviour Analysts and Behaviour Technicians. The Behaviour Analyst who participated in the interview had over 6 years of experience working within various settings in the organization. This range of experience provided the ability to view different strengths and barriers within each program setting.

Staff Experiences and Personal Beliefs

The Behavior Analyst reported a challenge within the CRP is the extent of staff turnover as compared to other programs within the organization. The lack of a consistent team resulted in limited ability for new staff to develop a broader perspective of the amount of positive change that can occur for the person receiving behaviour supports. Moreover, newer staff lacked the initial experiences of challenges that necessitated the behavioural consultation and may have impeded the staff's level of acceptance into the plan negatively impacting the maintenance of recommended strategies.

Another potential barrier was that not all staff believed in the effectiveness or need for a behaviour plan. More recently, the behavioural team had noted a reduction in referrals which may have been attributed to some leaders not acknowledging a need for services. Instead, challenging behaviours were seen as an acceptance of the way a person was despite the negative impact on their quality of life and potential relationships with peers and staff.

Conversely, when discussing strengths and issues, it was noted that there were staff that chose to work in homes where there were significant behavioural challenges

and who remained committed to supporting these individuals. Seniority was not seen as a relevant indicator of an effective person who remained working in a challenging environment. Instead, these staff were viewed as being more engaged and willing to spend quality time with participants therefore they may have rarely experienced challenges. This discussion also demonstrated how issues could be resolved when staff were invested in learning about the underlying functions of a behavior which ultimately resulted in an improved standard of quality of life for the individuals receiving supports.

Leadership and Collaboration

Indicators of positive outcomes of behavioural services were identified as stable staff groups, effective management, and a consistent team approach. Based on experience, a major component to whether staff adopted a plan and continued to follow through was when the leadership team found value to the service and monitored staffs' performance. This level of buy-in from the CCC and TLs was interpreted as a positive indicator of assuring programs would be maintained post clinical involvement.

The initial collaborative process was described as meeting with the leaders to gather information, complete an assessment, and highlight potential intervention options. A draft plan was then brought to the team to receive feedback on what recommendations could be realistically applied within the context and culture of the home. Since consistency was identified as integral to long term success, consultation ensured that flexibility was embedded into the original treatment plan.

Implementation began with the Behavioural Analyst training two to three key staff to ensure modifications were made immediately if required. After a plan was established, follow-up with staff and program maintenance was monitored by the

Behavioural Technician. During the interview, it was also noted that the roles of the CCC and TL had significant influence with staff.

This was observed when shifts in the home's leadership resulted in staff choosing to follow the leaders to another location. Consequently, participants within the residence were often then left in a state of transition when established staff transferred from the home. As well, staff who chose to remain in the setting were attempting to frequently adapt to leadership changes and also further destabilized individual support.

Transfer of Knowledge

As noted previously, other key observations from the Behaviour Analyst included a recent reduction of wait lists for services which was attributed to streamlining the implementation plan for behaviour interventions. Inclusion and investment of the leadership team from the onset of the consultation process had provided an opportunity for the relevant team to adopt new practices and follow through more readily. This strategy had also reduced the cyclical nature of receiving a referral repeatedly with no long lasting resolution as leaders were better prepared to ensure programs were maintained.

One of the main feedback processes was through collecting data as trends which identified issues or positive changes were then tracked. As well, a Behaviour Technician was assigned to the home after the Behaviour Analyst had initiated the plan and routinely followed up directly by attending staff meetings and reviewing data documents. This feedback loop had assisted with highlighting areas that required further training or modification. During the interview, it was repeatedly noted that leaders were relied upon to train and to ensure consistent application of knowledge within the home.

Specialized Behaviour Management Training

Specialized Behaviour Management Training was completed by the Behaviour Specialist and Analyst approximately four times per year. Staff were referred to this training by the CCC implying that the decision to take advantage of this opportunity relied on the leader's assessed value of these services in conjunction with the perceived needs of the staff. At times, staff themselves had indicated a need for training as the leaders had not initiated a request for services. Changing the mindset of the benefits of behavioural services to ensure buy in was identified as an integral piece to the success of this service.

Specialized Behaviour Management Training began with staff collecting specific participant information prior to the workshop and completing written plans during the training. Establishing this process was relayed as assisting with setting the expectation that information will translate into action during and after the workshop. While follow-up by the Team Leader within the home post training was required, the final written product was reviewed by the Behavioural Specialist to analyze responses and assess the level of learning.

Since there were limited spaces and dates, timing of sessions for all relevant staff may not have matched the actual need. Recent budget restrictions had also meant that only selected homes were involved. As well, frequent staff turnover in some homes may have resulted in inconsistent application of approved interventions.

In summary, this interview identified that access and availability of behaviour clinical services in conjunction with specialized staff training were fulfilling a need for participants struggling with unresolved issues. Collaborating with leaders and support

staff to better understand these challenges assisted with designing supports relevant to the work context. These services ultimately provided a valuable resource to staff when attempting to address the unmet needs of individuals who received supports.

Unit A: Case Description and Analysis

Unit A Participants

This unit was home to three young men in their mid-twenties who had transitioned from a residence designed for children to this licensed adult service and had lived together as roommates for approximately eight years. The individuals were reported as requiring 24/7 supervision and assistance with daily living activities. Overall, the people were described as having limited verbal skills therefore staff frequently relied on non-verbal behaviour to understand the subtle communication patterns of the individuals.

The Director had chosen this home as an example of a setting that experienced limited to no challenging behavior. It is important to note that in the context of the CRP, these staff were not categorized as routinely managing challenging behavior. However, within the broader field of disability service providers, this may have been described as a home that did present challenges for staff. The overall culture of the agency therefore plays an important role as to what staff training is relevant to match the needs of the people who are supported.

Mandatory sessions within this home included the one day NVCI and Specialized Behaviour Management Training. This is above the standard training of orientation, documentation, person centered supports, nutrition, and ethics, etc. Incident reports and subsequent worker injury reports during the last year were reviewed and outlined below. As indicated, the majority of incidences arose from behavioural issues.

Table 2: Unit A Incident and Worker Injury Reports

Incident Reports **Total = 24**	Client Behaviour/ n=23 Property Damage, Theft/ n=1
Injury Reports = 1	Client Behaviour/ n=1

Unit A Staff

The staffing component within this home was comprised of seven regular staff, including one key worker, and two casual staff who primarily worked in teams of 2-3 during the evening and weekend. While one staff was scheduled for over-night shifts, they also worked with another team member every morning. As indicated previously, staff directly reported to the Team Leader who in turn was supervised by a Client Care Coordinator.

Individual key-informant interviews were conducted with five regular workers within this home. Staff demographics including age, gender, amount of experience in present job, range of experiences and educational background were collected from the direct staff. Collectively, the three men and two women were between 20 years old to 30 years of age. A Grade 12 education level was reported for all three men while both women were actively completing university degrees.

The range of experience within this setting was between 3 months to 10 years and all five staff had only worked in residential services. However the least amount of experience working in disability residential services was 2.5 years. Most staff began employment on a casual basis and had initially applied to the agency upon a recommendation from a St. Amant staff who was either a family member or friend. Transition into regular positions occurred within a short period of time.

Unit A Supervisors

Key-informant interviews with Unit A supervisors were also conducted as part of this research project. Both leaders had over 15 years of experience within the disability field, initially began as direct staff, and had post-secondary education rooted in the human service area. Key strengths of Unit A as described by the leaders included the manner in how staff consistently conducted themselves with the best interests of the people they supported.

In comparison to other homes the supervisors oversee, this home was not regarded as having a high turnover of staff and recruitment was not typically viewed as problematic. Retention was identified as more of an issue as a few staff had accepted shifts initially in the home and decided to not return. This was attributed to the individuals engaging in negative 'testing' type behaviours with newer members of the team who they were unfamiliar with.

Direct quotes compiled from the interviews were used to develop themes that incorporated the data collected from Unit A staff and supervisors. These five final themes include:

1. 'Confidence' and personal experiences
2. Communication
3. 'On the same page' (Consistency)
4. Connection: 'Once you get to actually know who they are'
5. Moving general training into individual support

Unit A Themes

Table 3: Unit A Theme Overview

Theme	Operational Definition	Properties	Key Exemplars
'Confidence' and Personal Experiences	Includes influences of personality traits, personal interests & life/work experiences.	Focus on confidence to be successful in work. Importance of patience, being trustworthy. Need to care & want to make a difference. Negative when not fitting into setting.	'we're all confident' 'reliable and caring' 'I'd rather work with people' 'feel like some people just aren't right for the job'
Communication	Includes written information/ processes. Impact of non-traditional participant communica-tion.	Communication between team/leader/ consultant. Value of documentation & discussion. Results of strained relationships can be noted in written communication. Important to ensure all staff understand individuals with limited expressive language.	'notes saying, do this do this and I did this...and then everybody caught on finally and..so it built structure for the guys' 'kinda like arguments through the paper' 'don't express themselves really traditionally...team have no problems with helping that expression and interpreting...for other people'
'On the same page' (Consistency)	Includes consistency in approach by staff for participants & by leaders for staff.	Importance of routine & structure. Effects of inconsistency on participants. Need for compromise when working in teams. Value of leadership & organizational guidelines.	'discuss what you're gonna do with everybody and make sure everyone's on the same page. I think that's the most important thing' 'a couple of new staff in and out so its kinda hard staying on the same page' 'majority of us are consistent but sometimes it's just that one person that can crack the chain' 'they get confused' 'if there is an issue they need to make a decision it can't just be in the air forever' 'they are organized...on top of things'

Connection: 'Once you get to actually know who they are'	Includes establishing personal connections between participants & staff, staff team, & leaders with staff.	Importance of getting to know each other. Value of ensuring participant goals are understood & respected by all. Lack of connection is stressful for participants & staff. Significance of team connection via collaboration & shared decision making. Effects of personal relationships & friendships. Importance of connection between leaders & staff affects morale.	'don't judge a book by its' cover because there are things that I get surprise with and I'm very impressed' 'once you get to actually know who they are then your view on them totally changes' 'but it's not a match and I don't think that's fair to the individual' 'if you don't have the proper team it's just gonna be hell not only for the team...but the guys' 'you're not on your own, everyone is backing you up' 'I've built friendships with them.....it just becomes like a routine, and the night, the shift goes well' 'it's good when you know that somebody has a genuine interest in your position and wants to encourage you'
Moving general training into individual support	Includes strengths & barriers of training & consultation. Applicability of content & transferring information into work setting.	Value of training resources & consultants for orientation. Generalized content not always applicable to specific environment. Benefits of external training to augment resources however can be irrelevant or cost prohibitive. Barriers to inflexibility of training programs. Limitations of follow-up post training. Importance of trainers/consultants with shared organization culture.	'training was good...just made you more comfortable' 'gives you a run-down of what to look for' 'each person is so individualized it'd be nice to get your own personal training' 'I think it's more about your client than the training' 'it might be good to know but at the same time...it kinda just falls on the back burner' 'like some of the courses don't really pertain to the guys that I work with' 'unless I am working 24 hours a day, it's tough to give immediate feedback' 'everybody in the company that has probably taken it you could just ask for ideas'

Theme 1: 'Confidence' and Personal Experiences

Examples of individual personal attributes that contribute to a positive work environment were discussed within each interview. While having patience, being trustworthy and caring along with having a positive outlook were mentioned frequently,

> CAROLYNE: I think reliable, and caring, like I think anyone, like it's, it's not too hard to get a job, with them and, some of them some people just do it... to do it…..for money and I think caring is, important cause, as much as, like we're their staff and we're getting paid to be with them we, you still kinda have to care about the person to make a difference….in their life. So caring... reliable because i-, like these people rely on, you every day and... having, a whole bunch of people call in sick and having casuals in the house…
>
> JEREMY: ….need to be patient for sure.

…....possessing confidence was a character trait that was repeatedly noted as an indicator of being an effective staff within this home.

> JOSEPH: …. just have the confidence that you know that when they walk through the door they just command some sort of respect'
>
> ERNEST: I'm big on confidence, you gotta be confidence knowing what you're getting yourself into. Good work ethic……..what needs to be done.
>
> ERNEST: We all know what we're doing we're all confident we're all... we all get along….

While experience was seen as one way that competence was gained, the amount of time a staff worked in an area did not always translate into increased confidence within the setting.

> JOSEPH: ….instead of making a decision they are sort of relying on somebody else to make it for them. So that's another thing that we are working on is trying to get people to take initiative and come up with their own ideas….

Moreover, some staff were not seen as fitting into the work place.

> JEREMY: ....I feel like some people just aren't right for the job.

> DOROTHEE: Move to different houses. CD: And they move to different houses because? X: Oh it's it's um... it's less stress...less yeah stress or working up. I could put it in one um... there was a girl that worked with us for couple months and I did not know this for a while. Before she started every shift she cried….

Other individual factors that were discussed within the interviews were that staff chose to work with people over other types of employment because they viewed this work as making a difference. Positive aspects related to the variety inherent in this type of employment, opportunity to take on additional responsibility and potential for advancement.

> JACKIE: that I'm more about people other than myself so she said that... this would be the perfect job for you.

> JACKIE: I can never, really stop because... you can never learn too much especially in within the company….

> JEREMY: …..I didn't want to work really with retail and that kind of area like I said I've been working and I just hated it. I'd rather work with people...

The combination of these individual characteristics and interests were viewed as contributing either positively or negatively to the work environment.

Theme 2: Communication

While communication played a significant role within other themes of connection and consistency, communication processes via written information between staff, consultants, and leaders was best captured within one single theme. As well, issues related specifically to participants who had limited communication were also highlighted within this theme.

Since all staff did not routinely work together, communication and documentation was seen as very important to ensure information was shared. In combination with experience, a willingness to ask questions, learn more about behaviours and contribute to

the team discussions were seen as ways in which a staff could gain confidence and contribute positively.

> YVETTE: The day-to-day is the big form of communication to the home, so it's every single day planned, not planned but there is tasks or notes or communications to each other about things that are happening in the homes for the people with the people or for staff.

> JACKIE: leaving notes, memos on our day planners letting 'em know, how their morning was or, what may have happened in the morning.

> JEREMY: good communication cause, I watched our, team like crumble, when, you know people just, kinda stay in their, cliques.

> ERNEST: We have like a communication page there so... we just write, write notes to each other just saying what needs to be done and what was done so it doesn't get done-double-

When issues did arise, communication between staff or with leaders could become strained. Having structures and processes to address these issues were seen as imperative to rectifying issues when this connection was diminished.

> JEREMY: when I first started working, I felt like, like it seemed a little obvious at meetings that like the night staff, and the day staff kind of, battle each other……Cause everyone did something differently whereas the day staff was all on one page and the night staff was on a different. And neither was right or wrong, but they clashed….But that's gotten a lot better, throughout the years and cha- staff changing and, I don't know it's like had to do with, our bosses or team leaders or whatever but, it's gotten better..

> ERNEST: the guys they needed stuff... but there was no communication for anybody to say, can you go out and buy it today they just- Assumed like... oh maybe the person the next day that's gonna work is gonna buy it. So eventually, I just like, left notes saying, do this do this do this I did this... and then everybody caught on finally and….So it built structure for the guys now that... they have... they're fully stocked... in... presenting themselves in the public

Stressed relationships could be reflected in written format and were directly attributed to conflict with other team members.

> JEREMY: Maybe its communication gotten better but, it's a lot better. ……sometimes it was just notes left, you know just like a heads up sorta like...

> but sometimes that got a little catty, and uh... so we like kinda like arguments through the paper …
>
> ERNEST: I did face uh, staff conflict….That was basically it like, but the ------I got along with the kids there, but it was the staff….It was not a pretty picture…

While communication factors related to understanding specific participant's needs and wishes were also addressed elsewhere, new staff who did not have a connection with either clients or staff also needed to become informed. This information was helpful if it included what to expect within the workplace and how to interact with non-verbal individuals.

> YVETTE: people supported there don't express themselves really traditionally so the staff team have no problems with helping with that expression and interpreting if they will for other people.
>
> JACKIE: Always in a positive way if you're having trouble, the staff team that I have will make you feel comfortable, to the point where, even if you're new, you can still feel comfortable asking them for help.
>
> DOROTHEE: Cause... since these guys are pretty much non-verbal... they work well off of body language more so than everybody anybody else…..Me noticing that they how they work, I watch them work with them-

Given the nature of various schedules and subsequent difficulties that may arise with limited ability to directly communicate, a variety of strategies must be employed to ensure staff are well informed.

Theme 3: 'On the Same Page' (Consistency)

This theme captured the importance of routine and structure when supporting people with intellectual disabilities. A consistent team approach was noted by each staff as an integral piece to ensuring balanced support. Compromise when deciding on a

course of action was also seen as an important part to reaching a decision that in turn needed to be followed by everyone.

> JACKIE: We've actually had, a couple new staff in and out, so it's kinda hard, staying on the same page but, at least the ones that, have been on the same page we stay consistent and we let the new ones know as well.
>
> CAROLYNE: Everyone, s- I mean there's some things that I might not necessarily agree on that we do, but that's what the team has decided and, you kinda have to stick with it.
>
> JEREMY: discuss... what you're gonna do with everybody and make sure everyone's on the same page I think that's the most important thing….
>
> ERNEST: And just being a team player like, just knowing that... you know you are getting, you are gonna be working in a group home. Tighter space...So, you'd have to get along with your coworkers.

Inconsistent staff approaches with participants caused confusion, prolonged negative behaviour and may have hampered relationships between all staff and clients. As well, turnover of staff frequently disrupted consistency in approach.

> CAROLYNE: I think it's really important because like, the guys, could get, you know used to one thing and I think the whole team needs to be on the same page, about everything because if, they know oh with this person I can do that and with this person I can do this……they get confused…..
>
> ERNEST: majority of us are consistent, but sometimes it's just that one person that can just crack the chain…

Leader and organization consistency to ensure guidelines and overall vision were adopted was also highlighted.

> JOSEPH: *'*one of the things that we are trying to put into practice and I mean you have an organization of this size, you have got how many ever staff trying to get on the same pages it's a lot of work or it's going to take a while'.
>
> CAROLYNE: They need to be able to listen but they also, I think need to, like take control. So, if there is an issue they need to make a decision it can't just be up in the air forever.

> CAROLYNE: they're making such a huge difference in so many people's lives and they... they're a good organization and they're, also like stable and reliable.
>
> JEREMY: if they're organized, um... on top of things and like respectful...

Theme 4: Connection: 'Once you get to actually know who they are'

Within this theme, relationships between participants and staff, within the staff team, between leaders and staff, as well as with staff and organizational leaders were highlighted and discussed.

The importance of staff knowing and connecting with the participants on a personal level was seen as extra-ordinary within this home. Significant value was placed on ensuring the individuals receiving support were understood and respected by all staff, leaders, and consultants. This became more readily evident when staff were new to participants who were getting to know new staff by 'testing' and staff providing information to assist the new staff with making that connection.

> YVETTE: they are pretty strong advocates and they are not afraid to speak on behalf of the people supported because they know them really well there.
>
> CAROLYNE: ….especially the more senior staff they're better at, s- like stopping it you know what I mean? ……Like in, with new staff the guys, they test, they test you more right?
>
> DOROTHEE: You know I mean like if it's guys first if they're able to work well with the guys then they're working- go further in-depth into that but, usually that's... that's uh... you know, more so, whoever, we try to, hire.

The importance of getting to know the person and their goals was stated by the staff and supervisors alike.

> JACKIE: And I'm very surprised with the things that they can do in, you know it's, it's nice it's nice to see that... you have to give them credit, for more then what you see……..That's always what it is. It's... really based on don't judge a book by it's cover because... there are things that I get surprise with, and I'm very impressed and I let them try it over and over again and-if it doesn't succeed the first time... I'll help them out but... later on we'll try it again.

> JACKIE: Once you get to actually know, who they are then... your view on them just totally, changes.
>
> JEREMY: ……they've had limited interaction with the clients but I also like I mean I just think they need to... work with the people more. I know that's tough cause it is time-consuming and it takes a long time to get to know someone….

Effects of the team not knowing each other or lack of connection translated to increased stress for staff and participants as well.

> JEREMY: But it's not a match and I don't think that's fair to the individual…..You know? …..Because they have to basically, not live with this person but spend a lot of their life with them… And if they don't like them... why, can't that person just be, like you know, possibly move somewhere else and try another fit like-
>
> DOROTHEE: If you don't have the proper team it's just... it's, yeah it's, it's gonna be hell for, not only the team... But but, the guys.CD: So it'll trickle down kind of thing? X: Yeah it's a hard thing, and then it drops morale.

Positive team aspects in Unit A were repeatedly highlighted by all five staff members interviewed. Reasons provided for this connection were expressed as being a younger group with senior staff who do not impose their beliefs onto those with less seniority. Collaboration, open communication and shared decision making during shifts and staff meetings were noted as being an integral piece of this process. The benefit of working collectively and being accessible to each other was also discussed.

> JOSEPH: I just think that we kind of just grew together as a group and we learned together, what worked for us and what didn't work….
>
> CAROLYNE: ……. I guess everyone gets to put their own input in, definitely and, you can see it from other... angles, different people's views….
>
> CAROLYNE: Just knowing that like they're all behind you too……you're not on your own….this happened to you but you're not on your own everyone, is backing you up on it.
>
> DOROTHEE: Like having people around... workin' as a team is... is great….it helps... us connect... and it helps us, you know, get a different point of view from

> everybody else….. If we did it a different way it would be awesome... you know, not just my opinion counts all the time.
>
> ERNEST: like we're the younger crowd as well so we would-... give it a shot. And we don't, try to... nobody tries to overstep anybody thinking that they're better than you thinking I have a better decision than you so. We we just like 'kay let's just try it out, and that's the end of it.

As well, each staff had a personal connection with someone within the agency that encouraged them to apply based on their positive employment experiences.

> JACKIE: And (person) was telling me that the job itself was very rewarding and... you know (person) just giving me positive feedback about the company-
>
> CAROLYNE: My (person) about it too and... (person) had really great things to say about... about their experience….
>
> ERNEST: well my (person) well (person) still does it but(person) was with St A as well……And... I was working... I was working at a restaurant and (person) said oh you know you're just really good at talkin' to people you know you should try it out.

Friendships that extended beyond work hours were identified as important. These connections also provided opportunity to informally debrief.

> JEREMY: I would just support them and, help out but... And also like I've now built friendships with them so it's just kinda like, it just becomes like a routine, and the night, the shift goes well and, I mean if I wanna change what we're doing, it's not a problem.
>
> DOROTHEE: It's just like you know I have a question about this... it's nothing big, but we still talk outside of work…
>
> DOROTHEE: I received a telephone call I had the roughest day ever do you wanna go for a drink.

Negative aspects of not having a balance when working together as a team were also indicated. Being accessible at all times or having unresolved conflict led to issues within the work setting as well.

> JOSEPH: you have staff that work together that develop really great friendships or people that are related that are working on the same team and so it can definitely work for you and there are sometimes it works against you.
>
> DOROTHEE: Because you're not there all the time so it's... you know what I mean is not like always you always wanna talk about work kinda thing.

Leader and staff relationships were noted as being positive when there is time to connect during informal discussion times or formal meetings, drop in visits or shifts that overlap in time. Additionally, having access after-hours to supervisors connected to the home when debriefing or seeking direction was identified as beneficial. This tactic was consistent with the "Supervision Policy" which stated that a variety of approaches was optimal to provide supervision and feedback.

> JOSEPH: ….it's good when you know that somebody has a genuine interest in your position and wants to encourage you to grow and learn new things and try new things and you know. Like I said, the approachable part, it's scary when you have a boss that you don't think you can go to….
>
> JACKIE: I'm pretty comfortable with (person). Sometimes I just let (person) know, just, things that need to improve on or things that we need to do around the house.
>
> JEREMY: (person) is very approachable so like you can always go to (person).

Lack of frequent connection between leaders and new staff was seen as a possible reason for a mismatch between staff and participants and poor morale within a home.

> JEREMY: I dunno maybe people need more... supervision in a way or I don't know but I feel- cause I we you know, we've had, um, co-workers come through before who like just weren't cut out, maybe just not cut out for our individuals….Like maybe better suited at a different home….And we voice that to them like not t- to them being like we don't think we don't like you but like, discussed what we thought they could work on, and it just hasn't, they just refuse to, you know change so then, we go up higher right because, we first went to them….And even, that doesn't matter, you know cause like technically they're not really doing anything wrong it's just it's not working but I mean, when the individuals are reacting so negatively towards them it's frustrating...

> JEREMY: you know you look to make sure like to see if like all the co-workers or all the workers are you know complaining 'bout work all the time and you know y-, not always the best environment to go get into if people already don't like it or...

The connection between staff and leaders was also identified as being essential to bettering the supports for individuals in a consistent manner within the Behaviour Analyst interview.

Theme 5: Moving General Training into Individual Support

The underlying topic of this research study was to understand how the experiences of being involved in training had informed staffs' work respective to their environment. For the most part, continuing education that included in-house training, training provided by consultants and mandatory sessions offered by the organization were seen as beneficial.

> CAROLYNE: Like all our training we get paid to go to……So that's nice too.

> JEREMY: some of the training was good in like, just made you more comfortable before you actually went and did I- like even just the….Training about meds and giving meds and how to like... um mark them and stuff like, I w-, it's always bad to go when kind of already having idea but I am still nervous...But at least you, kind of had that extra information in the training and, kind of practiced….

> ERNEST: the training really helps a lot it uh-kinda gives you a run-down of what to look for, where you gonna be working. Every house is different but... in the end that training is all the same.

Each staff emphasized that while continuing education was valuable as an overview, the generalized content could not be directly applied without knowing the participant. This was consistent with the information provided by the Training Coordinator. As well, if the training was not linked to the applicable work setting, the content was considered irrelevant. Having an opportunity to have individual sessions with the behaviour consultant was also seen as valuable.

> JOSEPH: there is some parts that you take out of training that you will remember that somebody sitting next to you won't. So I think you listen and pay attention to what's important to you and what you think you could use on a regular basis
>
> JACKIE: They're living it other than just reading about it, hearing about it, just... with the staff team yeah you, actually get to see it.
>
> CAROLYNE: Like the training is, great... the training we go through, but it's, it's almost, each person is so individualized it'd be nice to get... your own personal training on that... one particular person.
>
> JEREMY: Well the training's vague, and I mean it's gonna work over- So many homes so you really need to know your, client... to how it- te- s- I think it's more about your client, than the training…. I mean you have like your ground rules and like kinda basic knowledge from training but I think, once you get to know your client you know what works for them and what doesn't.
>
> ERNEST: it's just respect to start off, and then after that it's just, whatever ideas they have... right then and there, come out with it…and we could... talk it over work somethin' out.

Some staff also identified external educational resources as beneficial to the environment.

> CAROLYNE: .and my schooling like my psychology classes to help too.
>
> JEREMY: that's why I like in university we actually learn, you know the details of these, disorders and I found that interesting and, a bit more helpful. CD: So... what does that help you with? X: Just understand them more and, like it gives you behaviours like and like I mean what we learned about like behaviours and…they even suggested ways to deal with them so.

Issues related to training included the lack of acknowledgement of previous experiences or individual learning styles of staff. Identifying courses as mandatory as opposed to optional and interesting may have been viewed as a negative experience from the onset.

> JOSEPH: I think that when we put the word mandatory in front of training, it automatically becomes something that you don't want to do. I don't know how many staff have said that.

> JEREMY: I feel like the training is good but they... draw it out too much like they kind of, over-exaggerate and, almost maybe even dumb it down like, too much, where I, you know where I feel like, in the house that's not really, what it would be like but I guess you have to do that just to make sure you cover everything.
>
> DOROTHEE: With our company kinda thing so you've gotta do all the training all over again.

However, optional classes were seen as prohibitive due to time and potential cost even if interested in the topic.

> JEREMY: they've offered a few times and I mean there's training you you can take all the training if you want….But it's just... it's time consuming and….Usually boring and….If you don't need it for the home like it might be beneficial but sometimes it's just...Like if it's tube feeding and I don't have ever do tube feeding it's like I don't… I mean it might be good to know but... same time it's like it's just, it kinda just falls on the back burner.
>
> DOROTHEE: ….cause I found out like what these courses cost like... four five hundred dollars….. Yeah so I was like okay well... take as much as I can before you know, they go, they go dry.

Depending on the work setting, topics were frequently viewed as not relevant to those supporting individuals who were non-verbal and had limited life opportunities.

> JEREMY: I mean our house is pretty difficult, behaviour-wise, and I was not ready for it and like-... I mean what they told me to do like just didn't ever work….. Like it's what we were taught like for training like…Concern behaviours is sorta like, to redirect or just, try and get the client to talk to you. Stuff like that doesn't happen.
>
> DOROTHEE: it's just these little things like this some of the courses don't really pertain to the guys that I work with…..So, that's the only question that I have sometimes.

As identified in the interviews with the Training Coordinator and Behaviour Analysts, follow-up with staff post training sessions was the Team Leader's responsibility. Unfortunately this step to assist with the transfer of learning process was hampered by time constraints. Since team staff meetings were the primary means of

contact for the leader and staff, discussing continuing education sessions might have been less of a priority within this limited time frame.

> JOSEPH: unless I am working 24 hours a day it's tough to give immediate because I am more than willing to do that or have immediate feedback and have conversations about things that you are seeing or making sure that people are using the training that they've gone to.

> JACKIE: Yeah I just, go through my training and that's about it and if I have a chance to talk to them about my training then, that's probably the only time I get to talk to them….

Sessions were facilitated by the leadership group within the Community Residential Program. As stated by the Training Coordinator and staff, a benefit of internal trainers was that the organizational culture and expectations were shared consistently. Additionally, facilitators were able to highlight content as needed and to understand the staffs' perspective. As well, having leaders available to follow-up with all staff was a positive aspect when attempting to ensure that collective groups were following standards according to the vision of the organization.

> YVETTE: I appreciate that they can adapt our teaching style to sort of encompass a variety of things that they are not just here read this book or here I'm going to talk for 12 hours and have you listen; I like when people allow the learner to utilize different things that they are comfortable with, for example, I like to learn a lot by listening and hands on experience and you might learn differently than I, so I like that they could use different tools…..I think that a lot of our training does that, we have a lot of visual stuff, we have small group discussions, we have in the training that I do there is sort of times for different tools and teaching.

> JOSEPH: I definitely try to make things interesting and fun and I try to be entertaining and just because again, I know what it's like to sit on the other side of it.

> ERNEST: …any kind a training we take any questions or any questions we have we just refer back to. Like we could ask our team leaders our coordinators, basically everybody in the company that has probably taken it you could just ask for ideas.

In summary, this case analysis highlighted five themes that materialized from the content analysis process. These themes were found within both supervisors and staff interviews. Documents pertaining to policies on supervision, mandatory training, incident reporting, and the emergency response system were also consistent with the practices in place within this home.

Unit B: Case Description and Analysis

Unit B Participants

This residence was home to four young men in their early to mid-twenties. Two had lived together as roommates since they were in a children's residential program and the other two men had transitioned into the home within the last one to two years. While three of the individuals were reported as requiring constant supervision and complete assistance with daily living activities, one was defined as having higher cognitive capabilities with behavioural challenges. Overall, the people were described as having significant difficulties and extremely limited verbal skills. This resulted in a greater level of physical hands-on care provided directly by staff.

The Director chose this residence as an example of a setting where staff managed a fair number of challenging behaviours on a regular basis. Mandatory sessions included two days of NVCI which had been recently upgraded from the one day session. This modification was deemed necessary as the newest resident's behaviour required staff to have extensive knowledge of physical interventions.

While Specialized Behaviour Management Training was not identified as mandatory by the staff, this session was noted as compulsory by the supervisors. These requirements were above the standard training of orientation, documentation, person

centered supports, nutrition, and ethics of touch, etc. Incident reports and subsequent worker injury reports during the past year were reviewed and outlined below. As indicated, the majority of incidences stemmed from behavioural issues.

Table 4: Unit B Incident and Worker Injury Reports

Incident Reports **Total= 38**	Client Behaviour/ n=34 Property Damage, Theft/ n=4
Injury Reports = 1	Client Behaviour/ n=1

Unit B Staff

The staffing component was comprised of eight regular staff which included one key worker, and two casual staff who primarily worked in teams of 2-3 during the evening and weekend. While one staff was scheduled for over-night shifts, they also worked with another team member every morning. As indicated previously, staff directly reported to the Team Leader who in turn was supervised by a Client Care Coordinator.

Individual key-informant interviews were conducted with five regular workers within this home. Staff demographics collected from the direct staff accounted for gender, amount of experience in present job, range of experiences and educational background. Each of the Unit B staff informants did not provide information on their age therefore this cannot be reported. In total four women and one man were interviewed. Two staff had received their Health Care Attendant certificate, two staff had attended university, and one staff had completed a Physical Therapy Degree in another country as well as a Health Care Attendant certificate within Manitoba.

The range of experience within this setting was between 3 months to 18 years. Previous experiences of working within Personal Care Homes were mentioned by three

staff. While primary shifts were in the evenings and weekends, the newest resident required a significant amount of weekday supports due to irregular school attendance.

Unit B Supervisors

Both supervisors from Unit B were interviewed. Since the Client Care Coordinator oversaw both Unit A and Unit B, questions during the second interview focused more directly to Unit B information. This also provided an opportunity to follow-up with questions that required further clarification from the first interview. The Team Leader of Unit B had approximately 12 years of experience within the disability field and initially began as direct support staff. Part of this person's post-secondary education was based in administration.

Key strengths of Unit B as described by both leaders were that the staff were caring in nature and nurturing. These qualities were seen as positively meeting the needs of the people living within the home and consistent with perceptions gained during both the initial and working interviews. In comparison to other residences the supervisors oversee this home was regarded as having a high turnover of staff and recruitment at the time of being interviewed.

Reportedly this period of instability only began during the past two years and attributed to staff leaving for personal reasons in addition to unusual shift patterns. Furthermore, staff schedules were not as accommodating as other settings due to the intensive needs of the participants. As well, a shift in the people residing in the home who had different needs then the rest may have no longer matched staffs' preferences of work environments. Another factor identified by the supervisors was the recent leadership change which may have contributed to loss of a stable staff group.

Five final themes that incorporated the data collected from Unit B staff and supervisors included:

1. 'Caring' and personal experiences
2. Communication
3. 'People Change' (Changes and Challenges)
4. Connection: 'Have to get to know where each other's coming from'
5. Moving general training into individual support

Direct quotes compiled from the interviews were used to develop themes and are noted as follows.

Unit B Themes

Table 5: Unit B Theme Overview

Theme	Operational Definition	Properties	Key Exemplars
'Caring' and Personal Experiences	Includes influences of personality traits, personal attributes & previous life & work experiences.	Focus on care-giving & compassion to be successful in work. Importance of honesty and a willingness to assist others. Need to have a genuine interest in others and take pride in work. Value of previous work experiences in other care-giving settings.	'staff team here are....care-givers' 'definitely compassion, you have to have that' 'going beyond the call of duty but the honesty is important' 'I am proud...I like working with these people' 'seniority plays more of a major role than anything else but then again it depends on the person's personality' 'I don't think had I had worked in a nursing home, I probably wouldn't be able to....because it is very challenging at times'
Communication	Includes written processes & need for communication to develop	Importance of communication within team & need for staff meetings. Value of	'communication....sort of in an infancy stage with this team....they're trying to learn about each other' 'we don't want bickering,

	team. Impact of non-verbal participant communication.	documentation & discussion. Need to streamline processes to establish clear communication. Significance of interpreting participant behaviours due to limited communication.	so I put a lot of things to talk about at next staff meeting' 'sometimes people forget so it's better if everything is written' 'helping each other....not so much helping clients because clients can't do anything' 'learn as you as you work with them to know what he needs and how he reacts if something is wrong'
'People change' (Changes and Challenges)	Includes impact of changes & associated shifts in expectations with a loss of predictability.	Significance of change to types of participant support required. Impact of behavioural challenges incongruent to norm of setting & staff experiences. Effect of changes in leadership styles for team & new leaders.	'the last __into the home introduced behavioural problems that they hadn't encountered..fell outside of the normal scope of personal care' 'people change...now I am not comfortable working alone..I would rather work with team' 'sometimes it is hard, you get hurt too if the client's hard' 'just the style doesn't match...it is a difficult balance for sure'
Connection: 'Have to get to know where each other's coming from'	Includes establishing relationships between participants & staff, within the staff team, & leaders with staff based on matching interests.	Importance of matching direct staff interests/experiences & participant needs. Challenges to developing meaningful relationships when people present with behaviours. Value of staff becoming familiar with their team members & relying on each other. Limited trust & communication is stressful for participants & staff.	'schedules based on people again who lives there. So it's what's in their best needs and best interest' 'it depends on the relationship that any particular staff has with the client' 'you have to deal with it if you want to keep your job' 'you sorta have to get to know where each other's coming from' 'I prefer working with the team because sometimes when it gets to the point where maybe one of the clients are just a little too much,

		Significance of leader role during periods of instability. Value of developing connection & staff recognition improves staff morale.	you can walk away and let someone else take over' 'Sometimes the stress is your co-worker, not the client' 'if the team does not get along with each other...all the time there is something missing....these guys live all their life here so they need this environment a loving environment and a easy environment' 'knowing that you are appreciated....not just that you're a number or any employee but you're actually appreciated'
Moving general training into individual support	Includes strengths & barriers of training & consultation. Applicability of content & transferring information into work setting.	Value of having access to training resources & consultants for orientation. Generalized content not always viewed as realistic. Importance of consistent information. Significance of trainers/consultants with experience. Variable effects of accepting training versus other staff's opinion.	'unique training program.... because they give you first training' 'give real honest knowledge and try to teach me and show me the technique' 'everybody knows because everybody is taking the same thing' 'not only teach based on books, she teaches based on experiences' 'training is more, because the staff is maybe diluted...I don't trust those staffs but I would rather get from the source' 'it depends on the co-worker if he's a good partner it will work'

Theme 1: 'Caring' and Personal Experiences

Individual personal attributes and values that contribute to a positive work environment were discussed within each interview. Care-giving and compassion were

frequently mentioned as the most important characteristics when providing support to people with intensive needs.

> YVETTE: The staff team here are um care givers…… you can still find a balance with, with the care giver type
>
> ZOE: Definitely compassion, you have to have that. Um cause you're dealing with people that just can't do anything for themselves. You've got to have that you know. Um you, you definitely have to really want to work in that field.

Other characteristics that contributed to this team were identified as being honest, possessing a willingness to assist others, and having a genuine interest in people. As well, ensuring people took pride in their work was seen as paramount.

> ZOE: the most important thing for me is honesty. I don't know, I just have this thing with honesty. It's just the way that I was raised….honesty meaning across the board. You know. Doing your job. Um not stealing and doing the things that were, you know were you were expected to do. That we're getting paid to do and even going beyond the call of duty but the honesty is important.
>
> DAMIEN: You see those guys when we are playing they were laughing so it's a big accomplishment with me.
>
> SHERRY: I like working with that. Especially if I'm taking them out to the mall and walking and walk them to the mall. I am proud. ……I like working with this people.
>
> MAGGIE: if you are working in a home and it's not your home but your work place should be a very clean environment, the outside of your yard should be look presentable to the neighbourhood, you should have a good lifestyle of the neighbourhood, show the neighbourhood because we are community and we are St. A that we look down, it should be living up to the standards of the street and that's what I believe in.
>
> JOEY: …..work because they are going to make the money they don't care and I would rather look for workers that are ready to work those kind of things and they are interested.

When considering the impact of training for some staff, the underlying personality traits of the staff were deemed as better indicators of suitability to the work setting.

> VINCE: It's been my observation and experience that I sort of see the people that are attracted to the two different types of homes, the behavioural homes versus the personal care homes; they are a completely different mindset.

> ZOE: sometimes seniority plays, probably more so seniority plays more of a major role than anything else but then again it depends on the person's personality. Some people have a stronger personality and they're better leaders than others…. Just a natural leader.

> JOEY: some people obviously they want to over control they just want to be done. Yes there is a time that they just want to be do it their way…..

Significant emphasis was placed on previous life experiences that would lead other staff to either seek out opinions or to rely on their own judgment. As well, previous employment experiences of working within nursing homes and with other disability support services was also mentioned as contributing to the assessment of whether this current work situation was congruent with expectations.

> ZOE: I think um most of us have been in the field for many years so that probably would be the main strength……..I don't think had I had worked in a nursing home, I probably wouldn't be able to (chuckle) because it is very challenging at times. And um yeah, it prepared me for it more, more or less.

> SHERRY: it depends; it's hard if it's too much behaviour. I don't mind the...I like working with the disabled.

Theme 2: Communication

Communication within a team is integral to working together collectively to provide consistency, and ultimately connect with each other and with the participants who are in receipt of supports. Individuals who were unable to express themselves in a traditional method were often considered completely dependent as they rely on others to have their needs met.

> MAGGIE: Helping each other. Helping staff, not so much helping clients because clients can't do anything, the 2 staff has to be or the 3 staff have to be there. So I would say number one to work as a team.

> MAGGIE: You learn as you grow with them and work with them, so learn as you as you work with them to know what he needs and how he reacts if something is wrong. Like why is he not feeling well, why is he like this and you can't check to see – well we do have a log book every day, oh let me see ok that makes perfect sense, to have the communication that way. For day time but for night time there's us only but this person is really tired or whatever then you have to think oh maybe it's a new med or maybe he didn't eat enough or maybe he overate or to make him – you have to think about all those things or maybe just check for signs of temperature or diarrhea or maybe he had a milkshake and it didn't agree with him, so those are things that you learn as you go and you know.

Building a team requires time and a foundation where all people feel respected and equally valued for their contributions. Establishing effective communication between all members including leaders was seen as a vital component to this process. If efforts to discuss items directly were not sufficient, having an escalation process to ensure issues could be resolved was identified as important.

> YVETTE: Communication. I think that right now we're sort of in an infancy stage with this team because they're new. So they're still doing that storming and norming and forming and so they're, they're still in that infant stage right….they haven't been together for a long time, they're trying to learn about each other

> MAGGIE: we don't want bickering, so I put a lot of things to talk about at next staff meeting.

> MAGGIE: The main thing is for respect your team. And don't be too bossy. But important thing needs to be written. Words get lost…And listen to your team. Don't go in as a high and mighty because you know what? No. I don't think about myself that way. CD: So you don't want to have a power struggle. X: No. You go in and you listen and you are being advised even though you are a supervisor and you are being advised maybe this way do it this way, do it this way.

> JOEY: There is a time that we work together and yes when we work together anything it helps when we keep the teams up to date.

Since this type of work setting involved various shifts, clear communication via written documentation and verbal information shared during individual and team

meetings was seen as integral to ensure facts were highlighted in a timely manner.

> YVETTE: we've attempted pretty successfully to go even one step further, um there is um a committee that was trying to streamline everything…..So that all the homes if people were coming from one home to a different home that there would sort of be the standard set of binders

> DAMIEN: everybody has good communication and they say whatever they want to say but in a nice way rather than saying it behind your back. So it's a good one. It's a good team, communications it's ok.

> SHERRY: Part of staff communication and we have a book too for the client. What we did and what they need to do, what has to be done and the communication book is about our work….Sometimes people forgot so it's better if everything is written.

> JOEY: Well actually we have a meeting every month, once in a month, well we bring the issue together and then we discuss about it.

Theme 3: 'People Change' (Changes and Challenges)

This theme captured the shifting expectations associated with changes into a previous established work environment related to new participants and to new leadership. Challenges that came with a loss of routine and predictability while supporting people with different needs was also highlighted in a number of areas. Attempts to provide intensive supervision above and beyond the norm was also noted by staff.

> VINCE: most of the time changes are informed either by resident need or by management directive

> VINCE: the introduction of the last gentlemen into the home introduced behavioural problems that they hadn't encountered and it fell outside of the normal scope of personal care. So I had some feedback from some of the staff around different incidents, so he presents challenging behaviours….

> ZOE: one is always up and down, up and down, all night long and so, he's disrupting everybody else's sleep and you know you can't do your work because you have to watch him.

Issues related to managing new types of behaviours that had been introduced with an additional participant was mentioned in terms of the added stress of working alone and changes to schedules and routines. This placement had been recognized by many as not congruent for this residence. Since the larger system of disability support was not equipped to manage diverse needs, this pressure was felt on many levels.

> VINCE: It was identified fairly early on that it's not an ideal fit. And given the constraints of the system and the fact that there were no other openings to be had, then -------needed a placement……. so it's been a rollercoaster ride for me and everybody involved.

> VINCE: don't think he fits in and he changed everything….because you know now they are required to take the NVCI. Now they are required to deal with physical interventions

> SHERRY: I found out I'd rather because I like working nights before but I'm kind of change – people change sometimes, now I am not comfortable working alone especially at night, I would rather work with team……. Well because at least I feel more strong if I'm with somebody. CD: So you have that back up. X: I feel more reliant you know.

Dealing with unpredictable challenging behavior negatively impacted the stability of the workforce and had also taken an emotional and physical toll on individual staff which was also highlighted by the Behaviour Analyst. This could have resulted in attempts to re-establish the previous status by showing dissatisfaction through actions for example not following through with behavior support plans.

> VINCE: Well in terms of the severity of the aggression that we could encounter. And sort of the day to day anxiety level that people face, sort of that although it may not ever come to a physical confrontation throughout say a year, almost daily we could come close. So you've got this underlying tension that starts to take on the characteristics of an anxiety disorder. CD: For the staff? X: Yes. Because you are always on guard on getting punched in the face or something right. So that stress is what breaks people.

> DAMIEN: It's a challenging one because it tests your patience and involves physical activities, house works and something.

> SHERRY: That's what I like to go to a different house if there is an opening there, of course who does not want to work to where it is easy or hard and you choose easy. Sometimes it's hard, you get hurt too if the client's hard. CD: Has that happened to you? Have you been hurt on the job? X: Yes.

The addition of a new leader that had not yet established a connection with the staff group possibly led to more stress as there was not a foundation of trust at that time. This may have been amplified when additional expectations for staff were also associated with the transition of the new leadership and revised training standards.

> VINCE: try and satisfy management and try to satisfy residents, try to satisfy families and try to satisfy government…But it's a lot of competing demands and so yes it is a difficult balance for sure.

> VINCE: Sometimes it's just like the style doesn't match, I know that when we are doing some of the core training we talked about the storming process, groups get together and there is change...

Theme 4: Connection: 'Have to get to know where each other's coming from'

Within this theme, relationships between participants and staff, within the staff team, between leaders and staff, as well as with staff and organization were highlighted and discussed. Throughout the interviews, the participants were described as requiring constant supervision with direct hands-on support to manage everyday activities including personal hygiene. Importance of matching direct support staff from the onset to the interest and needs of the individuals was repeated on many levels.

> YVETTE: I don't know if there's some word of mouth you know within the agency. You know people that know other people that say well come and work here and this is why

> YVETTE: the schedules are based on people again who live there. So it's what's in their best needs and best interest.

> MAGGIE: They wouldn't fit in with all work habits and work ethic for the clients we served. It is a very hard home when it comes to working. So they won't be able to do their homework, they won't be able to go on the computer, they won't be able to do their cell phones…..because it's hands on from the time you go in to the time you leave.

The process of becoming familiar with each other's interests and needs was identified as vital to developing meaningful relationships between participants and staff. However, challenging behavior was seen as stressful by some during the transition period.

> ZOE: I think it depends on the relationship that any particular staff have has with the client….and um, that, that makes a difference. CD: So there's people that are better. X: Yeah. Yeah they can deal with certain situations better than others can.

> SHERRY:I guess at first, I have another client before and first it was very very hard although I am scared with this one I want to go to the past one. Well and then they don't allow me so I have to deal with her behaviour, well what can I do I have to deal with it until I get used to it until I get know the other client. CD: So getting to know that person? X: Yes that's true. Yes you have to deal with it. If you want to keep your job.

As well, the process of establishing relationships within the team was also recognized within each interview.

> YVETTE: they're still so fairly new that I feel like I have to um present things with less, with less jokes or more um serious and you know this is, until they get to know me better too you know.

> ZOE: Very important. Yeah you sorta have to get to know you know where each other's coming from. Uh in order to, you know deal with and relate to them properly because if not you, because a lot of people are in that home are from different cultures.

> ZOE: ….definitely trust each other. It's very important. Trust, if you don't have trust you don't have nothing. Uh respect. Um you know, just be willing to jump in when somebody else needs to take a break. That sort of thing. Um, I don't know. Just, just doing being fair. Doing your fair share of everything sorta thing.

Connection between staff was viewed as important to ensure effective and consistent teamwork especially when working within a high needs environment.

Opportunities to collectively participate in meetings to share ideas and issues were regarded as an integral piece of establishing this level of connection.

> ZOE: …it depends on who you're working with and uh, I prefer working with the team because sometimes when it gets to the point where maybe one of the clients are just a little too much, you can walk away and let somebody else take over.
>
> SHERRY: We talk and if everybody agree and it is fine.
>
> MAGGIE: Because you have to listen to each and everybody concerned and you have to listen and you have to do it, try it. Because they will say you favour her, you didn't take mine but mine would have been ok. Unless it's a no no then we completely so that's not going to work and then we all spoke it right there and then at the meeting that way nobody is backstabbing….So let's try it this way you know. It shouldn't be what I say and shouldn't be what TL says, it should be work as a team when it comes to the residents. And I think, I don't know, it should be a team we work in a home. And I do believe in team work.

When the level of trust and communication between staff was not present, stress directly attributed to staff relations was realized and potentially diminished the quality of life for the people being supported. These concerns were highlighted by some staff.

> SHERRY: Our chores have to be done, what the client – what we do for the client needs to be done everything mostly everything. The client, our chores, everything for that house needs to be done. Especially our house is kind of busy so if you're partner is not a good worker it's hard because there is lots of things to do. CD: So that adds to stress I guess. X: Sometimes the stress is your co-worker, not the client. Because for me I don't mind the job or the work as long as I'm working with good people…..I feel very tired if I don't like my partner. Even if I am tired of work, it's different. It's different.
>
> MAGGIE: . ….mostly I think those conflicts are staff……. if people don't like you, they will find faults on you to get you out and that's our biggest concern I think that's what it is.
>
> JOEY: going to come work and you have initiative and you want to do more and you are going to figure out and life is most for the person that live there and work there when the team is that good. The team is so important. I believe in teams, like if team has complication between teams and they are going to make it hard for the people who live there. CD: So they pay the price kind of thing? X: Yes you know, if team does not get along with each other and they don't understand

> each other and they have a group tie thing, all the time there is something missing, we are coming for working for 8 hours but these guys live all their life here so they need this environment a loving environment and a easy environment, they don't want to see teams bugging each other.

The roles of the Key Worker and Team Leader during times of instability were seen as integral to ensuring connections were made between staff and participants in addition to between the staff and to the larger organization.

> ZOE: ….as far as a leader goes, not feeling that he or she is above anybody else that um you know, that we're all equal. I mean a team has to be. Sure you need a leader in a team but in order for a team to function everybody has to sort of be able to jump in and help. Um but yeah that for sure in a leader. And somebody whose there, somebody who you can, you can um, get in touch with when you need to….

> MAGGIE:…..I just fit myself in it because I'm new I could change to their needs and that's exactly what I've done and I have warned everybody that I am a so and so at the beginning if I work with somebody new and that I like to do things this way and you continue with your ways and if I find that there is an error I will correct you as I'm there and that's exactly what I've done. So I don't over power anyone and I didn't take away anything away from anybody but I make sure that I'm this way and I like to do things this way but if I see a mistake happening it will be corrected.

Developing open and respectful connections between the staff team and leaders within the organization were recognized as important. Being accessible and expressing appreciation was also noted as significant.

> ZOE: The word that comes to me is appreciation. Knowing that you're appreciated. You know not just that you're a number or any employee but you're actually appreciated…….

> ZOE: ….my uh coordinator will phone every once in a while and just say thanks, you know I really appreciate what you've done and you stepped in for me and I didn't, when we couldn't find anybody else and, that sorta thing…. Those are nice…..not just expecting it, but actually phoning and saying thank you.

> DAMIEN: The team leader is always available you can call them and ask them what to do, he will tell you what to do.

> SHERRY: To ask everybody if there is a problem with everybody – if everybody is working together as a team. We can email if we have a concern, we tell them if we have a concern in the house and to the client.

Active listening from external consultants and leaders in conjunction with fair opportunities within the organization were seen as the cornerstone to developing mutual respect and appreciation between all parties.

> ZOE: I mean really listen to what the staff were saying and uh, and then be able to uh, to help implement things that would make a difference……Like this listening. With, with the uh input of the staff. Like everybody working together….

Theme 5: Moving General Training into Individual Support

As stated previously, this research project was designed to examine staffs' experiences of being involved in continuing education sessions. This included in-house training, access to consultants and the mandatory sessions relevant to the home. Participating in training sessions immediately upon entrance into the Community Residential Program was seen as beneficial to understanding their role and organization standards.

> DAMIEN: It helps a lot, especially in the first 3 days. They are going to taught you everything but you cannot pick up all the things right so they are going to be day by day you can pick up all the things or the techniques that they are going to do on each resident in the house.

> DAMIEN: Training is an easy one but the most important thing is the staff one. So they are going to teach you what we are going to do in the easy way not in a hard way

> JOEY: St. A- has a unique training than other places because they give you first training in a certain amount of time you are going to work or are you going to go to some other training, is that going to help you remember what you have trained and so also they have a very good training for opportunities that if I could make myself available.

Additionally, training was viewed as having value when the content and facilitation was realistic. Alternatively, sessions that were not directly applicable were not described as positively.

> ZOE: I did a refresher course not too long ago and uh the lady that facilitated it was excellent. She broke everything down. I mean anybody could have understood….. Like a child could have understood NVCI….And those are the things that are important because you don't want to walk away wondering well. What was that all about yeah…...making everything clear and fun….You know and making you feel like you can ask questions and not, you know feel like ah, you're interfering with my training sorta thing. Yeah she was real, she was excellent. Excellent.

> SHERRY: But it's mandatory you have to do it, you get paid right. But like if it's mandatory and it be one of your job then you take it. CD: Do you see a difference then say if it wasn't mandatory do you think people would be more likely to go or want to go should I say? X: Well some want to know, to have more knowledge and it's good too. Like even if I know how to cook when I attend that healthy eating a learned more things. That's good.

> JOEY: give real honest knowledge and try to teach me and show me the technique that I could really get the knowledge like more everything is to be learned. I went there to learn and show the way.

As noted by the Training Coordinator, flexibility of modifying the mandatory sessions within a home when a new situation arises was also identified as a strength to having an internal training program. As well, consistency in terms of content was seen as beneficial as all team members can share the information even when new staff have not yet attended.

> YVETTE: in the last year, is we've tried to um organize training more specifically to the homes right. So for non-violent then to actually, that's a good, a good example. Um we don't have um the expectation now that every single staff needs uh um to take the two day NVCI.

> SHERRY: Everybody knows because everybody is taking the same thing….those who doesn't know then they ask ok, how do you do that way?

> JOEY: I feel that everything I take the knowledge is good because every time I work in lots of houses and the things could happen you know and knowing is not bad, all the time is good.

In support of this statement, trainers expressed that they were much more comfortable and enthusiastic when they provided training consistent with their own experiences which staff also acknowledged as beneficial.

> YVETTE: you know the things that I like about it is that it's all so natural um for me to teach this training….It's sort of just like the everyday stuff that I'm telling people and its, it's time to really get excited about these fresh faces coming in and these are some of the things you're gonna expect and it makes me feel very proud.

> DAMIEN: The teachers at St. A- not only teach based on the books, she teaches based on experience in each and every house that she has been. So she applied everything that she learned from different house and she is going to teach us and then she is going to tell us with this kind of patients these are things that they are going to do.

Within this home, some staff stated that they are much more likely to trust training as opposed to staff opinion.

> ZOE: I would certainly go with how I was trained. Um and I guess it just depends on the other individuals. CD: On the other staff you mean? X: Yeah, just the staff.

> JOEY: I would say the training is more because the staff is maybe diluted their knowledge with other staff, like maybe they work for long time and they have experience either bad habits or good habits you don't know and I would rather go from fresh and real source first than getting second hand and it's getting from staff is second of course and I could learn something from staff but it doesn't mean that they could train me because everybody want to train their own way and if we are all true. I don't trust those staffs but I would rather get from the source.

Others identified that training was not as relevant as the connection with colleagues or individual characteristics. These discrepancies in opinion could have also been due to the lack of connection that existed at that time due to changes within the home.

> VINCE: I think that they are all kind of little hollow mechanisms without the heart or whole package of really understanding…..

> SHERRY: I think for everything I think it is good team work. It's good because everybody knows anyway the training. I think it depends on co-worker if he's a good partner it will work. Some you encounter not a good partner. CD: In terms of? X: For everything, the work.

In summary, this case analysis highlighted five themes that emerged during the content analysis process. These themes were founded on data from both staff and leader interviews. Documents pertaining to policies on supervision and mandatory training were consistent with the practices highlighted within these interviews.

Cross Case Analysis

As indicated previously, the final piece of data analysis within this research study focused on synthesizing the information for the cross-case analysis as proposed by Merriam (1998) and Stake (2006). Cross case comparisons were drawn after both units were analyzed separately. The tables below provide results of comparing and contrasting the demographic data related to participants and staff.

Table 6: Participant Cross Case Information

Participants	**UNIT A**	**UNIT B**
Living in the Home = n	3	4
Gender	Male	Male
Age Range	Mid 20s	Early to mid-20s
Level of Functioning	3 = assistance with activities of daily living, limited verbal skills, use of non-verbal cues to communicate	3 = constant supervision, complete assistance with activities of daily living, significant communication issues 1=higher functioning, behavioural challenges
Incident Reports	24	38

Table 7: Staff & Supervisor Cross Case Information

Staff n=5 Supervisor n=2	**UNIT A**	**UNIT B**
Gender	Staff = 2 Female/3 Male Supervisor = 2 Female	Staff = 4 Female/1 Male Supervisor = 1 Female/1 Male
Age Range	Staff = 20-30 Yrs	Staff = Not Reported
Education	Staff= 3 Grade 12/ 2 Post Secondary Experience Supervisor= 2 Post Secondary Completion	Staff= 2 Health Care Attendant Certificates/2 Post Secondary Experience/1 Post Secondary & Health Care Attendant Certificate Supervisor= 2 Post Secondary Completion
Years of Experience	Staff= 2.5 Yrs-10 Yrs Supervisor= 15+ Yrs	Staff= 3 Mths-18 Yrs Supervisor= 12+ Yrs
WCB Reports	1	1

Cross-case analysis identified themes that were both unique and distinct to that case or, alternately, comparable to the findings from the other setting (Merriam, 1998; Stake, 2006). This process allowed for differences and similarities amongst the key themes from both cases to be analyzed (Merriam, 1998; Stake, 2006). The following information discusses these comparisons within the seven collective themes in greater detail.

Table 8: Cross Case Theme Comparison

THEME	**UNIT A**	**UNIT B**
1. Confidence and Personal Experiences	✓	x
2. Caring and Personal Factors Experiences	x	✓
3. Communication	✓	✓

4. On the Same Page (Consistency)	✓	x
5. People Change (Changes and Challenges)	x	✓
6. A) Connection: 'Once you get to actually know who they are' **B) Connection: 'Have to get to know where each other's coming from'**	✓	 ✓
7. Moving General Training into Individual Support	✓	✓

Confidence and Personal Experiences

Within Unit A, the ability to demonstrate confidence was seen as integral to working effectively with the individuals. Role modeling a positive attitude and competence was emphasized especially during periods when the participants were testing new staff. Employees who were unable to represent themselves in a secure manner after a period of adjustment were seen as not being compatible with the home environment by the staff team.

While this was not a theme that distinctly emerged within Unit B, the leader provided examples of characteristics that were better suited to work with more challenging issues as opposed to working in a care setting. Questionable comfort levels or confidence when dealing with challenging behaviour were viewed as diminishing a staff's effectiveness. Therefore it is important to ensure individuals are comfortable and the setting is suited to the manner in which they approach their work.

Caring and Personal Experiences

Significant influence of previously working within care-giving settings was noted repeatedly within Unit B. The importance of providing care for those who cannot help

themselves was recognized as a motivating reason to work within this context. Characteristics of caring and nurturing were deemed necessary to properly support the individuals. With recent changes, the new participant's needs were not seen as congruent to the assistance provided within the home thereby struggles ensued.

Alternatively, while staff within Unit A also identified caring as one of many required characteristics to work in the field, emphasis was instead placed on advocating, interpreting preferences and needs, and supporting the individual through challenges with a confident approach.

Communication

Within Units A and B, both teams identified that the participants supported did not communicate in traditional ways. Unit A staff described how they interpret the individuals' actions and thereby respond and advocate accordingly on participants behalf. Conversely, in Unit B the lack of ability to communicate was construed as the individuals being dependent therefore all needs were taken care of by staff. This is a clear example of how different people attribute the ability to communicate to types of supports required.

Considering shift work does not lend itself to conversing directly with all staff, implementing practices that offer a variety of means to communicate was highlighted by both Unit A and Unit B. For example, importance of written documentation via daily logs and incident reports were noted as effective ways to share information. Since this format does not rely on the team having a connection, this can be a valuable method to develop a common understanding and sharing of what individual needs are and areas that require attention.

Team meetings to present concerns and to discuss options were identified as effective means to communicate when the team works collectively. Ensuring processes were in place to assist staff with managing issues as they arose either with the participants or staff alleviated confusion. Importance of supervisors leading and following up individually to achieve positive resolution was also identified. This requires leader direction especially when a team is struggling with direct communication.

'On the Same Page' (Consistency)

A theme of consistency became distinct within the Unit A data. The necessity for all staff to be on the same page was repeated during each interview. Emphasis on open communication while working collectively in the best interests of participants was mentioned frequently. Perceptions of the negative effects for participants and the team when individual staff had not maintained a consistent approach were shared.

At this stage within Unit B, the importance of taking direction from the leaders as opposed to collectively working through a situation to build consensus was highlighted. With recent staff and leadership changes, a consistent approach had not been established at that time. Collective input based on open communication that allows for connections to be developed requires focused energy and time.

'People Change' (Changes and Challenges)

This theme was highlighted within the Unit B data. Recent shifts with the addition of the latest participant had led to further training and behavioural consultation which ultimately increased the overall expectations within the home. As well, changes within the staff group including the leadership had placed significant strain on the team.

Challenges to establishing consistency, making connections amongst colleagues and maintaining staff confidence could be directly attributed to these significant changes.

With the addition of a key staff, connections between the group and leaders were expected to be positively developed. In support of this process, the Unit A leader provided examples of systems that were implemented to assist with the transition of their new leadership which provided challenges at the onset. Since change is inherent within any work setting, acknowledging that this period of adjustment will present new challenges may normalize the situation and assist staff with understanding this is a temporary state of transition.

Connection: 'Once you get to actually know who they are' & 'Have to get to know where each other's coming from'

Within both units, connection with the participant was noted as significant. Knowing the individual who receives support was seen as a process and imperative to providing quality care based on personal preferences. Having similar interests and matching staff styles to the person's needs was frequently discussed.

Connections between the staff team were identified within both groups. A dis-similarity is that within Unit A, an established connection was described by all team members on a variety of levels extending beyond work hours. Within Unit B connection was discussed as an ideal however given the newness of the team, this had not been fully realized.

Importance of having a connection with the leaders and organization was also mentioned within Units A and B. Being available for informal and formal conversations

via staff meetings, email, etc. was regarded as a necessity. Feeling appreciated and recognized by the organization was significant for both staff groups.

Moving General Training into Individual Support

Consistent statements from both staff groups indicated that continuing education must be realistic and balanced with knowing the person and context of the workplace. Both teams also noted the mandatory sessions were not always viewed as relevant to support participants with limited communication. Therefore, efforts to apply the information into the workplace context must be emphasized to ensure training content is not discounted.

One of the key differences between these two groups is that Unit A staff often referred to each other when making decisions on how to apply new methods. The best interest of participants was what guided whether the information would be integrated. Additionally, the process of how to implement knowledge was encouraged and role-modeled by leaders and discussed as a team.

In Unit B, some staff stated a preference to defer to training knowledge as opposed to relying on input from others. This difference may be attributed to this team's early stage of development whereas Unit A was well established. While training information is based on best practices, the integration of this knowledge must include the workplace context. An integral piece to that process needs to include the collective experience from colleagues that is founded on knowing the individuals.

Relying solely on either strategy can be counter-productive for the individual receiving support. Being isolated and working strictly on continuing education information hampers the team's ability to provide consistency. Conversely, discarding

information based on best practice and following the lead of staff who may not be integrating this knowledge is less than ideal.

Combining both types of knowledge provides the most benefit not only for improving upon the quality of services but also for the development of the team. In summary, this chapter reviewed the five main themes from Unit A and the five main themes from Unit B. Comparisons highlighting the uniqueness and similarities between both work contexts were also discussed.

CHAPTER V: DISCUSSION

This research explored staffs' experiences of training and influences within the work setting that either assist or detract from implementing best practices into the workplace. Two units/cases were examined and analyzed individually to develop themes based on those staff groups' perspectives. Both sets of data were in turn compared to understand similarities and differences within the homes.

Experiences of the Community Residential Program's Behaviour Analyst and Training Coordinator were also included in this research. As well, documents pertaining to staff training, supervision, and risk management were reviewed. Within the following section, the collective findings of this research in comparison to the literature and guiding theories are discussed. Application of a Social Ecological Model is also highlighted depicting how each theme applied to the individual cases. Additionally, potential limitations of this research are noted.

Findings and Relation to the Literature

Data that emerged from both cases are discussed and compared to the literature presented in Chapter II. Areas consistent with the literature or that provide alternative viewpoints are highlighted.

Experiences of Challenging Behaviour

During the interview with the Behaviour Analyst, underlying reasons for behaviour were discussed in relation to the effectiveness of behaviour based interventions. The reasons provided were consistent with the literature which explained that the functions of challenging behaviour are attempts to exert control over the individual environment and/or to communicate a message or need (Matson & Boisjoli,

2009; McGill, Bradshaw, & Hughes, 2007; Smidt et al., 2007). As well, within the Behaviour Analyst interview and Unit B 'people change' theme, acknowledgement that a number of behaviours remain unresolved was highlighted.

The reason for this related to the significant amount of time and staff effort required to remediate these behaviours. This is also consistent with Matson and Boisjoli's (2009) assertion that a thorough understanding of the underlying intended message often remains unknown. In support of these findings, 'consistency' in approach was recognized as being an important strategy to assist both participants and staff team within Unit A. This was identified as particularly important when following recommended strategies based on an in-depth behaviour assessment.

Throughout the literature, challenging behaviour was identified as imposing significant risk of injury towards self and others, in addition to posing an increased risk of community placement breakdown (Grey & McClean, 2007; Matson & Boisjoli, 2009; Smidt et al., 2007; Van Ingen, Moore, Zaja, & Rojahn, 2010). Within the Unit B theme 'people change', situations involving risk of staff injury were identified. However, risk of losing a residential community placement was not addressed.

Reduced opportunities for social interaction and independence were also noted by Grey and McClean (2007); Matson and Boisjoli (2009); Smidt et al. (2007); and Van Ingen, Moore, Zaja, and Rojahn (2010). This is consistent with the Unit B 'communication' findings which linked the perceived amount of support requirements to the participants' communication abilities which challenged the team. Furthermore, this influenced staff to provide intensive supervision and support due to the perceived level of dependence.

Comparison of Current Interventions

Within the literature, current interventions that were mentioned despite recognized best practices included over reliance on psychotropic medication and excessive use of physical interventions to manage challenging behaviours (Grey & McClean, 2007; Matson & Boisjoli, 2009; McGill et al., 2007; Van Ingen et al., 2010). These strategies were not discussed within any interviews conducted therefore not consistent with the literature. Potential reasons for this difference may be related to the Incident Report process which includes review and follow-up by leaders. This provides opportunity for immediate feedback based on the individual's needs in the context of his/her home. As well, the flexibility of the internal training program designed to be relevant for the level of intervention required within each home may be another reason for this positive difference.

Comparison of Staff Factors

As noted by Matson and Boisjoli (2009); Van Ingen et al. (2010); and Wietske, van Oorsouw, Embregts, Bosman, and Jahoda (2010), unresolved challenging behaviours demand an immense amount of staff resources and energy which negatively impacts staff recruitment and retention. As captured within the Unit B, 'people change' theme and information from the Behaviour Analyst interview, the negative impact that ongoing unpredictable situations had on staff was addressed.

However, as also highlighted within the Behaviour Analyst interview, challenging behaviour in itself did not equate to recruitment and retention issues. In support of this, Unit A themes of 'confidence' and 'on the same page' speak to the power that personal factors and consistency in approach have to being successful when working with people

who exhibit challenging behaviours. Furthermore, these findings also demonstrated how some staff were successful and enjoyed situations that presented challenges. This finding is supported by Chung and Harding's (2011) research which identified that staff personality traits influence how challenges are perceived.

Alternatively within the literature, it was noted that the ongoing stress and subsequent unplanned staff reactions may reinforce behavior (McGill et al., 2007). Again, this is consistent with the information provided by the Behaviour Analyst who also recognized contributing factors that maintained or increased behaviour were related to limited interactions therefore an individual may engage in attention seeking behaviour.

Within the literature, explanations for ineffectual responses were due to a lack of training in behavioural analysis, or an underlying negative assumption of challenging behaviour which led direct staff to believe they had limited impact on assisting the person (McGill et al., 2007; Wietske et al., 2010). While all CRP staff had access to the Specialized Behaviour Management Training and to individual Behavioural Services, the Behaviour Analyst noted not all leaders and staff found these services valuable therefore referrals may not have been received and challenges remained.

Within the Unit B theme 'people change', staff identified fear and anxiety as a result of managing new challenging behaviour. These situations were outside the regular scope of issues within that home and incongruent with staffs' previous experiences as noted in the theme 'caring and personal experiences'. This is supported by McGill et al. (2007) and Wietske et al. (2010) who found that staff may experience negative emotional reactions such as fear and insecurity when dealing with issues. A combination of these factors may lead to an overall decrease of staff confidence in their ability to effectively

manage the situation. As a result, many staff chose to leave workplaces that supported adults with challenging behaviour due to the intensity of work demands and risk of injury (LaRue, Weiss, & Ferraiolli, 2008).

Comparisons to other literature that explored stress management amongst professions that are exposed to unpredictable situations within their work environment such as police officers and nurses were consistent with the information shared by this staff cohort. For example, factors related to individual perceptions of stress and intrapersonal skills to manage conflict were noted repeatedly (Clarke & Cooper, 2000; Oginska-Bulik, 2005). Additionally, the role of external support systems, influences of peer and organization support were highlighted as having interactional effects on an individual's ability to cope (Johnson, Cooper, Cartwright, Donald, Taylor, & Millet, 2005; Landy, Quick, & Kasl, 1994). While this is a preliminary, non-exhaustive review of this particular body of literature, the overall findings provide further credibility to the recommendation that future research must consider the combination of individual, relational and organizational effects when exploring staff experiences who work in unpredictable situations.

Contributing Factors to Challenging Behaviours

Within the literature, a contributing factor to unmet participant needs was limited ability to communicate in conjunction with insufficient staff attempts to communicate at the individual's level (Smidt et al., 2007). The impact of having limited ability to communicate was highlighted not only in the 'communication' findings but also mentioned in the 'moving general training into individual support' theme within both

Units A and B. Staff reported that training sessions did not always address issues specific to people who were non-verbal or had significant communication deficits.

Cudré-Mauroux (2010) suggested that an ecological perspective be adopted to better understand the complexity of managing difficult situations. Moreover, strategies to manage challenging behaviours must be considerate of the workplace environment, staff experiences, as well as participant challenges (Cudré-Mauroux, 2010). In support of this statement, despite differences in what staff identified as being the most important and effective staff characteristics; 'confidence' in Unit A and 'caring' in Unit B, both groups reported that 'continuing education' must be realistic to the individuals in order to be considered relevant. These collective findings highlight that training must address the needs of the participants receiving support in concert with individual staff factors.

Comparison of Staff Training in Best Practices

Within the literature, best practice categories included Person-focused Training, Brief Challenging Behaviour Training, Physical Interventions, Communication and Cognitive Training, as well as Formal and Informal Interventions. As noted within the Training Coordinator interview and review of training documents, CRP sessions offered a comprehensive range of training opportunities which were consistent with the literature's recommendations as outlined in Appendices A and L. These included proactive strategies ranging from environmental modifications, changing precipitating factors, and developing participant skills to reactive strategies which included safe and efficient responses to challenging behaviour via non-physical means such as distraction, diffusion, seclusion and physical restraints as a last resort (Hawkins et al., 2005; McGill et al., 2007; Smidt et al., 2007).

For example, Specialized Behaviour Management Training which focused on the reasons for individual behaviour and how to address these concerns were consistent with the recommendations of Person-focused training, Brief Challenging Behaviour training and Cognitive Communication programs. As well, Non-Violent Crisis Intervention where physical responses were deemed necessary was also included in the continuum of sessions. These were added only when relevant to the staff needs and based on actual experiences within the setting.

Additional items that the CRP offered were value based sessions including person centered approaches and review of current services using Personal Outcome Measures. This was in conjunction with in-house training intended to set a standard for ensuring individuals were supported in a home environment and incorporated Individual Support Plans. Practices that may have been placing unnecessary restrictions were also reviewed and augmented with a Rights Restrictions process.

The ‘moving general training into individual support’ theme additionally highlighted the importance that internal training has for staff. Positive aspects of these sessions included flexibility and support available from the internally based Training Coordinator and Behaviour Analyst. Values and principles specific to the CRP were therefore also integrated into sessions. Another benefit to an internal training program was that all staff working within a specific setting received a consistent message in regards to the standards and expectations of the agency.

Potential drawbacks to the present curriculum as noted in both Unit A and Unit B was that some training did not appear to be viewed as relevant to working with individuals who had limited communication abilities. This may be related to the lack of

training that specifically included the needs of this group of people. Therefore adaptations within the workplace are required by the leaders to negotiate the transition from principles to practices for this group of individuals.

Barriers to Training Implementation

Historical Barriers

As noted within the literature, the social model of support with focus on individual preferences and needs is not sufficiently understood (Jones, Ouellette-Kuntz, Vilela, & Brown, 2008; Mansell, 2006; Young & Chesson, 2006). Service provision within the community does not automatically translate to quality services as the culture of custodial care has permeated community settings (Mansell, 2006). During discussions with the Training Coordinator and the Client Care Coordinators, emphasis was placed on how values of person-centered support had been integrated throughout the internal training sessions. This was seen as one way to counter-balance the lack of information and training available through other external resources.

Social System Barriers

Negative consequences from the shortage of consultants who specialize in the field of adults with intellectual disabilities who have behavioural challenges is a reality for most support services in Winnipeg. Within the Community Residential Program this was not a concern as all the homes had direct access to internal consultants. Issues of restricted external resources and lack of specialists was therefore not a systemic barrier for these participants or staff groups as described by Forster and Iacono (2008); Grey, Hastings, and McClean (2007); Grey and McClean (2007); McClean et al. (2005); and McGill et al. (2007).

Nevertheless, despite unrestricted access to specialist assistance, Unit A staff identified that a lack of time for trainers, leaders and consultants to understand individual needs was limited due to the volume of people supported. This was recognized by Mansell (2006); McClean et al. (2005); and Young and Chesson (2006) who stated that specialized assistance is limited by irregular visits within the setting therefore interventions may lack contextual fit. However, as indicated by the Behaviour Analyst, an added benefit to the CRP was the ongoing monitoring by the Behaviour Technicians which ensured flexible strategies and timely modification as needed

As discussed previously, direct staff do not consistently work together due to various shift patterns and may not be available to provide direct input into behavioural plans. The theme of 'communication' highlighted in both Units A and B demonstrated the benefit of written plans to ensure collective sharing of information. This process was identified as vital for all staff to be continually informed of changes.

Challenging behaviour not congruent with typical responses or choices can result in staff and participant struggles. This may stem from the setting not always being conducive to individual needs (McGill et al., 2007). 'People change' within Unit B captured how systemic barriers with the addition of a person requiring different supports than the rest of the individuals residing in the home presented challenges for all.

Inadequate systemic planning within the community places focus on costs and quantity as opposed to quality and internal resource development (Mansell, 2006; McClean et al., 2005; Young & Chesson, 2006). The lack of overall social service coordination placed more emphasis on gaining access to the program as opposed to

ensuring that services were based on an individual's needs and strengths. This again was addressed in the Unit B theme of 'people change'.

Mansell (2006); McClean et al. (2005); and Young and Chesson (2006) highlighted that significant staff shortages exist due to the underfunding of social services and subsequent wages. Consistent implementation of person-centered principles was therefore not standard practice. While issues of retention and negative impact of changes were addressed within the Training Coordinator, Behaviour Analyst and Unit B leader interviews, the CRP placed significant emphasis on support plans based on the person and ensured training sessions repeatedly highlighted this expectation.

Within the Training Coordinator interview, a need to develop and to share resources to professionalize the field of intellectual disability was discussed. As well, ongoing recruitment and retention issues were again seen to limit the ability to maintain a consistently well trained staff group as also noted in the Behaviour Analyst interview. These are issues that require collaboration between agencies, funders and staff.

Organizational Barriers

Within the literature, barriers to effective uptake of evidence-based practice were noted repeatedly and attributed to lack of time coupled with a lack of a comprehensive organizational plan. As well, a standard of best practice was recognized as difficult to uphold due to limited supervision and lack of direct leadership (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Grey & McClean, 2007; Johnson & Austin, 2006; Mansell, 2006; McClean et al., 2005; Smidt et al., 2007). Within the CRP, ongoing expansion had continued to challenge the leaders' ability to provide individual supervision and to follow-up with staff post training.

As indicated in Units A and B's findings, the addition of a key worker role had enhanced managing onsite supervisory needs. Regular staff meetings as well as the availability of leaders and team members as indicated within Unit A theme of 'connection" had assisted with establishing and maintaining communication. Internal training also provided opportunity for everyone to receive a consistent message while streamlining communication processes. Furthermore, Unit A staff identified that regular supervision may have also assisted newer staff who were struggling within the setting.

Hatton et al. (1999) identified that staff appraise stressful situations by assessing the resources they feel are needed or available related to physical and financial materials as well as workload and staff relationships. A key consideration is that this appraisal and coping process is personal therefore each situation of challenging behavior is addressed differently by individual staff members (Hatton et al., 1999). The theme of 'connection' within Units A and B as well as discussions with the Behaviour Analyst addressed how valuable being available and accessible is for staff and the team. This was also consistent with the 'people change' theme that Unit B staff identified. Furthermore, 'connection' as seen in Unit A or conversely the lack of connection within Unit B was associated with differences of staff relations with the supervisors and between colleagues.

Despite CRP's comprehensive program, post training follow-up to effectively transfer knowledge directly to the work setting based on individual needs and learning styles of staff required development. This was noted in themes related to 'moving general training into individual support' for relevance and flexibility of training. In support of this finding, Mansell (2006); McClean et al. (2005); and Young and Chesson (2006) also

noted that information was not typically directed to the knowledge transfer process and uptake of evidence-based interventions for direct staff.

Finally, the literature referred to a lack of dissemination of research based strategies (Ager & O'May, 2001; Campbell & Hogg, 2008; Forster & Iacono, 2008; Grey et al., 2007; Grey & McClean, 2007; Johnson & Austin, 2006; Mansell, 2006; McGill et al., 2007). As noted within the best practice section, content that was being shared with the CRP staff was based on evidence-based information. The main issue within the CRP related more to the transfer of training content to actual individual circumstances as noted within Unit A 'moving general training into individual support' theme.

Social Ecological Model and Case Themes

Applying an ecological perspective to better understand the complexity of staff's experiences of managing challenging situations was previously suggested by Cudré-Mauroux (2010). While there was some overlap of findings between the two case studies, there were also notable differences. Themes that correspond to each ecological system highlights differences between each case as noted in the following diagram and table.

Figure 2: Ecological Model and Themes

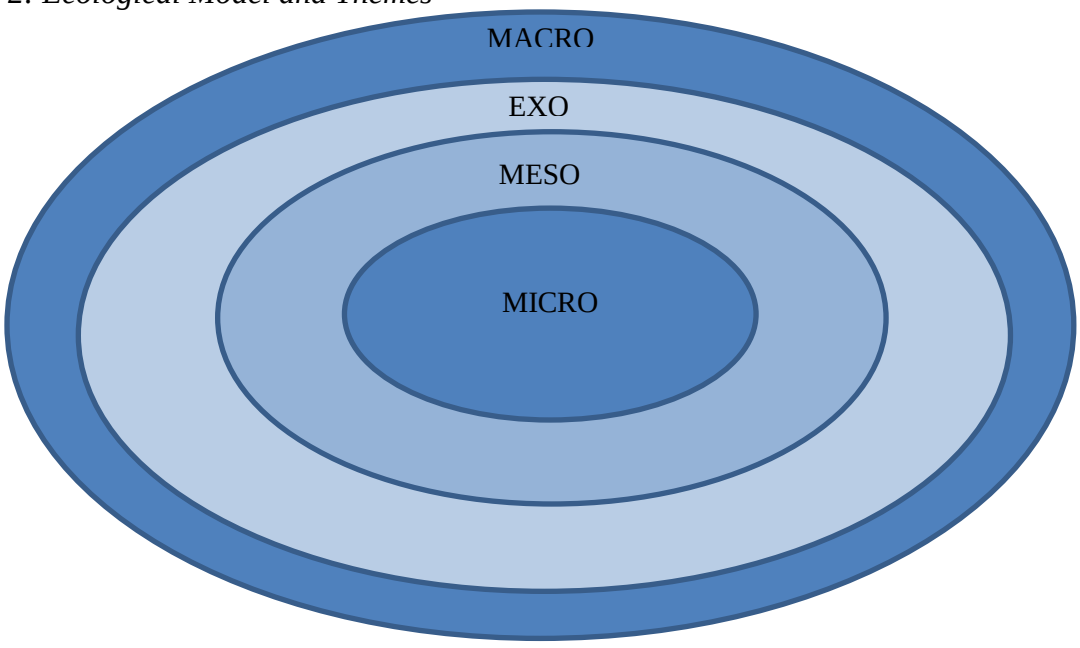


Table 9: Ecological Model and Themes

Ecological Level	Unit A Theme	Unit B Theme
Micro (Staff & Participants)	Confidence Connection Communication	Caring People Change Connection Communication
Meso (Staff Team)	Communication Connection On the Same Page	Communication Connection People Change
Exo (Leaders/Trainers/ Consultants)	On the Same Page Communication Connection Continuing Education	People Change Communication Connection Continuing Education
Macro (Systems/Researchers/ Society)	Continuing Education	People Change Continuing Education

This model demonstrates how the micro-system composed of staff and participants, meso-level consisting of the team interactions, exo-system including the leaders, trainers and consultants and the macro-level including researchers, society and social systems relate to each other. Distinctions can be made for each case. As well, similarities can be drawn between the two units.

Application of Theories to Research Findings

Theories that jointly addressed different aspects of training and staff experiences were presented to frame the research. Themes that emerged from the cases both individually and collectively are represented within each of these three theories in various aspects. Discussion on how themes connected to theories is outlined in the next section.

PARiHS

Evidence

Evidence incorporates not only research information but also the relationship between clinical experience, participant and caregiver preferences, and local work

environments (Kitson et al., 2008). As noted within the ‘moving general training into individual support’ theme in both Units A and B, if staff did not believe the training content was relevant to the situation in which they work, this information was discounted and training was viewed as irrelevant. During interviews with the Training Coordinator and Units A and B leaders, recognition that a leader or facilitator must assist with ensuring training information was transposed by adapting information to the setting was repeated. A definite strength of the CRP training program was the flexibility designed to accommodate needs within different settings to assist in the knowledge uptake process.

Context

Rycroft-Malone (2004) defines the element of context as including an in-depth focus on leadership in addition to implications of monitoring, evaluation, and feedback mechanisms. Organizational factors in terms of complexity of decision-making, access to resources, professional autonomy, as well as support from peers, leaders and other team members are included in the context (Estabrooks et al., 2009; Rycroft-Malone, 2004). Consistent within the Training Coordinator, Behaviour Analyst and Units A and B leader interviews, the importance of connecting with staff during sessions in addition to post training follow-up was stated repeatedly.

As noted within Unit B, when a new team is forming there was a tendency to rely on leaders for direction as opposed to shared decision-making. On the other hand, when a team was well developed, principles of quality of support and collective problem solving were highlighted as within Unit A. Lack of peer support additionally appeared to lead to lack of consistency.

As previously acknowledged in the literature and during the Behaviour Analyst interview, remediating behaviour is an intense extended process which requires a consistent approach. Importance of staff meetings to begin to establish connections and to have effective communication strategies may assist with laying the foundation to rectify challenges that exist. Furthermore, as identified within Unit A, if a solid team had been developed, staff would approach each other directly. However, if no connection existed, staff tended to direct all information to the leaders which did not assist with the development of trust within a team. As a consequence, if the team had not established a connection, evaluation and feedback from fellow colleagues was not readily shared.

Within both Units A and B, negative effects of unresolved conflict between colleagues were mentioned which negatively impacted individuals on all levels and directly affected quality of individual supports. This stemmed from staff leaving the workplace or, alternatively, remaining in the setting without working collaboratively in the best interests of participants. Establishing clear guidelines and processes to resolve conflict in a timely manner is required. This is a vital aspect for the agency to consider given that staff frequently work without direct supervision.

Facilitation

Facilitation factors within this conceptual framework focus on review of the level of preparedness and receptivity for both the individual and team, available resources, workplace culture and values, in addition to leadership and evaluation activity within the setting (Rycroft-Malone, 2004). This element also considers what type of intervention is indicated, along with the role and skill level of the facilitator needed to assist the team in understanding and overcoming barriers (Rycroft-Malone, 2004). Within the CRP, leaders

who serve as internal trainers were able to consistently integrate the expected values and skill sets as they were part of the culture and remained accessible afterwards.

An overwhelming need to transfer knowledge within the actual work context was addressed in the theme of ‘moving general training into individual support’ in both units. Leaders and key staff spoke to the importance that role modeling in-house expectations and skills gained from training sessions had for orienting new staff. An outstanding issue to ensure facilitation occurred was the competing demands from various aspects of work which inhibited the follow-up process. The increased level of engagement pre and post training within the Specialized Behaviour Management and In-House training sessions highlighted the expectation that staff would integrate information into the workplace. These serve as positive examples of how follow-up can be integrated into other sessions.

As noted previously, the culture of the workplace which includes the context is significant when identifying facilitation factors. Within the Unit A ‘moving general training into individual support’ theme some staff noted that their previous education or employment experiences were not considered. This highlighted that elements of training may be redundant for some as the content did not always match the needs of the staff.

The timing of introducing new training when the setting was struggling with ‘changes and challenges’ may have decreased receptivity and uptake of the information as seen within Unit B. While having a flexible, adaptable approach to accommodate individual learning styles and needs of the context were recognized, individual staff perceptions and experiences influence how staff ultimately accept or reject training. Alternatively the positive effects of timing were also noted where some of the Unit A staff volunteered for supplementary sessions when the environment was stable.

Additionally since general training content was not typically viewed as relevant to specific circumstances, efforts to draw connections to real life scenarios for direct staff must be considered. Given the value placed on internal trainers sharing their lived experiences and providing examples for staffs' reference, curriculum development where facilitators can integrate their knowledge with the staff experience is an integral strategy. Providing opportunities for discussion where staff can share not only their expertise focused on one person but also to broaden their awareness of how strategies can extend to other situations is imperative. This directly speaks to the influences of individual 'Mindlines' as discussed in the next section.

Mindlines

'Mindlines' are collectively reinforced internalized decisions that consider training based on science and also personal knowledge gained through social exchanges with peers (Barley, Pope, Chilvers, Sipos, & Harrison, 2008; Gabbay & leMay, 2004). Individual 'mindlines' are in turn negotiated based on the range of formal and informal interactions available (Barley et al., 2008). This non-linear process integrates information gained via formally acquired training and subsequent personalized interpretations of training received along with knowledge based on personal and clinical experience, in conjunction with contextual information within the given situation (Barley et al., 2008).

The blending of this information allows staff to make decisions by networking with peers as opposed to relying solely on scientific evidence. Individual personal factors identified within the findings of 'caring' in Unit B and 'confidence' in Unit A supported this theory. The theme of 'connection' also played a role in how training information was accepted or rejected.

An example of how individual mindlines are relevant within these work settings for direct staff became evident in Unit B's 'moving general training into individual support' theme. While some staff reported that positive relationships with their colleagues influenced if and how they would implement formal training information, other staff explicitly relayed that they did not trust other staff's opinions on how to manage situations. As a result, these staff stated that training information was deemed more significant than deferring to informal information received from co-workers.

Without a team connection, individual staff tended to rely solely on their own previous experience and only included other opinions on a limited basis also described in the Unit B 'moving general training into individual support' theme. Conversely, if there was an established team, staff were more open to others ideas and influences, and used a collaborative approach to decision making based on the best interests of the participants as indicated in the Unit A theme of 'connection'. Moreover, personal factors such as number of years working in the field were not always indicative of suitability within a setting, therefore those staff did not automatically influence junior staff. Instead, previous life and transferrable work experiences appeared to be better indicators of success.

Without this balanced approach, the work setting can be isolating for staff. As a result, individual supports may be inconsistent in approach which can cause confusion as identified in the Unit A theme of 'on the same page' and in the Unit B findings of 'people change'. Alternatively, if specific staff relationships are well developed but are not inclusive of everyone, these cliques based on friendship or family connections also do not serve the best interest of participants. Moreover, if support plans do not integrate best

practices, this collaborative decision-making will not serve the best interests of the person. Based on these results, establishing a team connection in combination with acknowledging styles and preferences is required within the workplace.

Social Exchange Theory

Social exchange theory is based on a principle of reciprocity in that where there is trust; commitment, and perceived organizational support, employees will reciprocate by providing solid services (Barker & Camarata, 1998). Furthermore, social exchange theory proposes that relationships founded on social elements will motivate staff and reinforce positive behaviours (Barker & Camarata, 1998; Riggs & Rantz, 2001; White & Klein, 2002). Alternately, if the organizational leaders' responses are not in proportion to the staffs' expectations, the perceived inequality results in dissatisfaction and poor performance (Riggs & Rantz, 2001).

The theme of 'connection' within both Units A and B highlighted the value of positive leadership and how this extended to work satisfaction. Feeling appreciated was identified as important as was having accessible leaders. This was supported by the Behaviour Analyst who additionally identified the positive influences leadership had on ensuring behaviour supports plans were implemented consistently.

Within the CRP, time is taken on the onset to ensure staffs' expectations, experiences and interests match the culture of the home. These expectations also extend to the organization. For example, Unit B staff who identified 'caring' and nurturing as important also stated these qualities are important for leaders and the organization. If this level of reciprocity was not matched to the style and expectations of staff, this lack of congruency was interpreted as being under-appreciated.

Further to this, lack of staff connection to leaders and with each other led to unresolved conflict which was recognized as having a detrimental effect on the quality of life for people residing in the home. External pressures from systemic barriers led to the introduction of a person with different needs being integrated into Unit B as identified within the 'people change' theme. Therefore the existing skill sets, staff expectations, and additional training resulted in less confidence and perhaps less overall support for all participants. These changes stressed relationships with leaders and led to reduced job satisfaction.

Additionally, Unit A staff identified that connection to existing St. Amant staff was what had brought them to the agency. Positive personal experiences within the work place environment assisted with recruiting these staff. While this can be an important resource strategy, consideration of how to balance a potential perceived conflict of interest between staff must be identified and managed to ensure teams develop in a cohesive and inclusive manner. These findings exemplified how relationships between participants, staff, and leaders are integrated. In summary, these three theories provided a framework to better understand the experiences of each case.

Limitations

Limitations of this research began as a result of not gaining access to observe interactions between staff and participants within the home. Conversational interviews based on observations were therefore not permitted. Unfortunately this eliminated the ability to capture and observe actual practices, team dynamics and needs of participants. Furthermore, written information captured within staff meeting minutes and documentation between staff was not reviewed. Since this form of staff communication

was highlighted as significant within both cases, this should be considered in future research.

While it is understood that this case research essentially was framed around the participant's home, conducting interviews offsite did not allow for direct interactions within what is also the staff's work place. Without direct contact, physical elements of the home that may assist or impede with the ability to manage challenging behavior were not included. Therefore this remains an issue to be addressed as previous research also did not factor in this potential effect.

As well, the level of extraneous noises within certain public settings often meant conversations required repetition of questions to gain clarification. At times this disrupted the flow of conversation or diminished sharing as we struggled to hear and subsequently understand each other. Due to staff time constraints and limited access, the possibility of conducting a second interview to further explore topics or to share initial perceptions through a process of member checking was not feasible.

The use of an inductive approach throughout the data collection and analysis phases allowed for opportunity to refine questions and to clarify initial thoughts and findings during interviews. Having an 'insider' perspective to the field of disability also assisted with overcoming these challenges. However, caution to not share my position in another agency was heeded to ensure staff were not pressured to respond in a manner incongruent with their personal opinion.

While each consent form identified that signatures on the form did not release researchers or people involved of legal or professional duties if any suspicious conduct was reported during the course of the interview, this was not stated explicitly. Given the

vulnerability of this population, this acknowledgement should be explained in greater detail even when no observation or direct conversation is expected at any time during the course of research. Finally, gathering data from only two cases limits the ability for the reader to generalize the findings to a full range of community based services. The following chapter offers a summary of this research project including future implications for research and practice.

CHAPTER VI: SUMMARY AND CONCLUSIONS

Quality of supports for people with intellectual disabilities relies upon staffs' ability to utilize best practices. Ensuring that services designed for individuals who additionally present with challenging behaviours are grounded in evidence-based practices is equally important. The goal of this research was to establish an understanding of the multiple elements related to staff experiences combined with knowledge use and how people who provide the most support to individuals who present with challenging behaviour manage everyday situations.

Factors included the current training sessions offered within the Community Residential Program (CRP), the workplace culture, and needs of support staff who are employed in the field of intellectual disabilities. Elements of the individual work setting which either impeded or supported the integration of knowledge from training sessions were described and discussed. As well, factors related to social processes of working within teams and influences of supervision and leadership were explored.

Guiding theories that informed this research included the PARiHS Framework to highlight not only the complexity of knowledge mobilization but also to provide a multi-factoral lens to understand community residential settings. As well, Mindlines and Social Exchange theories assisted in framing the individual and organizational influences on decision-making. The combination of these perspectives provided a broader understanding of what to consider when approaching knowledge translation studies with staff that support vulnerable people.

Cross-case study methodology allowed for attention to be drawn to potential differences between a 'typical' case and one with greater unpredictability and inherent

risk due to challenging behaviours. Individual interviews were conducted with direct support staff, along with a review of documents related to staff supervision, managing risk, and training. As well, interviews with the leaders of each home and the CRP Training Coordinator and Behaviour Analyst were included.

All data points were analyzed through an iterative process which led to categories and themes (Merriam, 1998). As well, cross-case synthesis was utilized to identify convergent or rival hypothesis (Yin, 2009). Content analysis assisted in identifying themes that were distinct within a specific case or consistent with the other unit (Merriam, 1998; Stake, 2006).

Unit A findings focused on five main themes that included personal factors with emphasis on confidence, elements of communication, consistency in approach, connection with individuals, team and leaders, as well as continuing education strengths and barriers. Within Unit B, five core themes included personal factors which emphasized caring and nurturing, communication factors, changes and challenges within the work context, connection to others and perceptions of continuing education. Comparison of these collective findings to the literature on best practices for challenging behaviour, staff factors and the knowledge transfer process resulted in identifying practical resource management strategies, training considerations and future research efforts.

The Social Ecological Model was introduced within the discussions of theory and themes as a way to understand the multiple layers of influence within work settings. This model assisted with demonstrating interactions between the micro-system composed of the staff and participants, meso-level consisting of the team interactions, exo-system

including the leaders, trainers and consultants and the macro-level including researchers, society and social systems. Recommendations based on the research findings targeting the four ecological levels are offered in the following section.

Future Resource Recommendations

Micro-level

Throughout the discussions, considerable focus was placed on aligning staff experiences, interests and personalities to participant's needs and interests as recognized within the themes of caring, confidence and connection. Given that initial interviews offer limited information about staff, ensuring realistic work scenario based questions are included is one aspect that can assist with exploring potential staff perspectives specific to a setting. Examining individual preferences for work environments as opposed to solely relying on descriptions of duties performed in past employment sites may provide a better evaluation of suitability for the particular context.

Potential adaptations to existing challenging behaviour questionnaires that are designed to assess staff's beliefs may offer additional information on whether the person would be effective within the setting. As well, given that confidence and caring were repeatedly noted within the findings, asking staff to describe their main characteristics may offer additional insight. This may assist in assessing whether they are suitable for potential employment opportunities within an agency or specific workplace.

Meso-level

The significance of interactions and relationships between staff teams was highlighted within the themes of communication, on the same page, people change and connection. Within the CRP, the hiring process includes an on-site working interview

which provides an opportunity for the individuals who will be supported to voice their opinion. This is an excellent method to augment the interview process when determining appropriateness to the actual work setting. A further consideration may be to extend this person centered approach by soliciting the opinion of specific staff to assess suitability within the setting when supporting individuals who have limited ability to communicate. Developing an objective format for key informants to assess if a potential staff will match the requirements within the home would aide in this pursuit.

Prior to the working interview, an assessment of the current team's strengths and gaps in terms of styles and personalities could also be developed and completed. Consideration of the culture within the home may offer an opportunity to balance and add to the team's diversity to better support all individuals. These approaches may also alleviate stress for new staff, participants living in the home and staff members.

Incorporating a routine formal staff evaluation period that requires input from not only the leaders but also the team would strengthen the feedback received. Furthermore, this strategy should also be extended to the individuals living within the home or by people who support decision-making. Identifying areas that need to be developed via training or during one to one staff sessions followed by establishing related goals could assist with solidifying expectations.

Exo-level

Communication, connection and consistency were addressed as significant themes in regards to the interactions and relationships between the staff, leaders, consultants and the larger organization. Ensuring competencies are outlined in job descriptions where

agency values are explicitly stated and translated into expected objective behaviours will assist with measuring whether staff are adopting the organization's vision and values. This formal process if applied consistently would reduce potential ongoing frustration for the staff and more importantly for the people being supported. Ultimately if the situation is not a match, alternatives may range from transferring to other settings more suitable to the style of staff and/or release of employment.

Benefit of regular staff meetings to guarantee communication and connection are developed and maintained was noted in many respects throughout the research. Ensuring staff also have opportunity to connect with the leaders on an individual basis would further strengthen relationships that were identified as crucial to staff leaders and the Behaviour Analyst. Within the CRP, routine feedback is provided by the leaders after each recorded participant incident. This is an excellent method to ensure supervisors remain involved in the participant plans and can provide timely and relevant suggestions on how to manage challenging situations.

As recognized within the 'people change' theme, changes are inherent in any workplace due to internal and external demands. While there are often no methods to prevent external pressures, mitigating stress for staff by providing individual and team support is integral. Relationship building is fundamental to maintaining a strong team which translates to positive person centered approaches for participants. At minimum, ensuring written communication is maintained to avoid loss of consistency and connection is paramount. Increasing supervision and contact during times of transition with clear expectations would also serve to assist with alleviating stress for staff and leaders.

Training and Consultant Recommendations

Meso-level

As noted throughout the study, staff typically work without direct supervision. Given that conflict between team members was highlighted as a significant source of stress, resolution training that assists staff to develop skill in solving issues within the team would be of benefit. As well, formalizing guidelines that explicitly outline how to manage conflict would assist with bridging that gap. Since there is a heavy reliance on the team to perform duties in a person centered manner, coaching teams to resolve issues effectively would ultimately better serve the people who are living in the home.

Exo-level

Leadership professional development recommendations were also addressed within the ‘moving general training into individual support’ theme. Promoting training to assist with enhancing supervisory techniques and developing teams could add value to an organization’s leadership group. This type of continuing education may have additional benefit for staff that have been promoted internally with limited supervisory experiences.

The Community Residential Program sessions far exceeded the established evidence-based practices highlighted in Chapter II. Moreover, internal trainer and consultant input held considerable value for staff as indicated within the ‘moving general training into individual support’ themes. A main area that required attention was to formalize a process for transitioning information into tangible strategies that were relevant to the individuals supported. Given the importance placed on facilitators who could speak from experience, training content should be designed to capitalize on

opportunities to explore how examples of challenges and interventions are linked to actual individual situations.

Furthermore, the positive impact and influence that leaders had on staffs' acceptance and utilization of new information was recognized repeatedly throughout the interviews. Given that leadership positions are frequently rearranging multiple priorities, any new strategy or process must be carefully considered to avoid adding to workloads. Therefore capturing the training content by transferring information into formats that can be readily observed will assist these efforts.

Developing implementation strategies based on the objectives of each session while establishing a process and expectation that information will be transferred into the workplace from the onset is required. One approach could include following up with the entire team to allow for group learning and to additionally serve as reminders to staff who have already completed the training. As well, adaptations to existing items such as modifying individual support plans and updating risk management strategies may be most applicable considering the value placed on having a variety of communication processes.

When modifying continuing education sessions, consideration of alternate modes of training such as group sessions specific to the participant with the trainers or consultants would be beneficial. This may assist with determining where struggles exist and what the team requires to move through difficult situations or new struggles. Allowing staff to potentially challenge exams if previous experiences or similar sessions had already been attended may add to the continuum of training opportunities. This

would also serve as another option for trainers to assess staff learning styles when developing continuing education sessions relevant to the work context.

Future Research Considerations

Micro-level

As noted within the research, micro-level themes that highlighted the connection and personal characteristics are integral to staffs' ability to perform their duties. Further research that focuses on individual staff factors in more depth given the importance placed on personality types would be beneficial. As well, Hastings (2010) and Thomas and Rose (2010) support the need for future studies to place emphasis on understanding the connection and interactions between participants, staff and within the team.

Meso and Exo-level

Being directly present within the work setting would also allow for elements of the physical context to be considered. This could include a review of documents and communication records that were noted as significant and beneficial within this research. Understanding how work environments are designed could assist with providing facilitation recommendations that will most effectively assist with knowledge uptake.

Macro-level

On a more systemic level, limitations of being able to gain access and to observe interactions must be balanced against the rights of vulnerable people to have their privacy protected. A risk to decreased access is that other researchers may not be prepared to navigate this protected system. While having an insider perspective allowed for this

barrier to not appear insurmountable, collaborating with an agency that values and promotes research efforts to improve upon services for people with intellectual disabilities was fundamental to the success of this study.

Conclusion

As stated previously, the overarching goal of this research was to develop an understanding of the multiple considerations related to direct staff experiences and use of evidence-based practices. Factors that were considered included the current evidence, workplace culture and needs of staff working with people who have intellectual disabilities. This research provided insight into how people who provide the most support to individuals that present with challenging behaviour manage situations in everyday practice.

Elements of the individual work setting which either impeded or supported the integration of new knowledge from training sessions were described and discussed. As well, factors related to social processes of working within teams and influence of supervision and leadership was explored. These findings contributed to recommendations for future practical, training and research efforts.

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Appendix A: Evidence-based Interventions for Challenging Behaviours

SECTION/ REFERENCE	*PURPOSE*	*DESIGN/ METHOD*	*SETTING*	*MEASURES USED*	*RESULTS*	*LIMITATIONS*	*RESEARCH NEEDS*
A) Person-focused Training: Positive Behaviour Support 1. McClean, Dench, Grey, Shanahan, Fitzsimons, Hendler, & Corrigan (May 2005)	To analyze if there is a reduction in behaviour after staff trained to conduct functional assessments, design & implement positive behaviour support for CB within natural environment	QN longitudinal outcome data for 138 behaviour support plans developed by staff for 7 years. Severe CB most prevalent 55% with physical aggression most reported. Based on wait list of CB, 188 referrals drawn. Each individual had 1 staff member who worked with individual for 3 months min.	Conducted in Ireland. Services: 2 large residences n=400 in each, 2 community based hostels, 40 community based homes, 28 day services, 4 supported employment areas. 188 staff: supervisors, nurses, psychologists, & line staff with no education. Range of experience: 2 months to 28 years. No significant	1 target behaviour selected & agreed upon by participant/ other caregivers (reliability data). Baseline data collected min. of 4 to max. of 8 weeks prior to plan. Intervention data collected first quarter of 65 subjects after 3 months of intervention. Follow-up data from most recent quarter report after 22.5	Implementation of BSP associated with significant improvement (77%) on avg. after 22 mths. Larger residences not as successful with reducing CB. Suggests can train front line staff to remediate negative behaviour in situ without reliance on 'professional' assistance. Use of consultant model with Person-focused training more helpful than reliance on specialist	Did not explore possible considerable differences in roles of staff & education except for psychologist. No account for variations in amount of experience & post secondary education or supervisory positions. Did not isolate for chronicity, severity of behaviours only categories of frequency. No follow-up of reliability data. Did not evaluate staff's	Assess QoL measures for individuals with CB not reliance on anecdotal information solely. Assess transferability of skills to other situations/ behaviours/ people that staff support. Isolate level of education & amount of experience staff have when making comparisons. Isolate differences between settings (day services vs. residences & size/#).

			difference in results between staff groups. Reported differences b/w psychologists & caregivers with no explanation of differences b/w supervisors & staff with diplomas/ degrees or front line staff.	months of intervention (3 mths – 5.5 years) for all 138 subjects. Inter-rater observation with avg of 92% at first data collection time.	model with lack of access. Degree of change noted on topography of behaviour, gender, age, level of disability, location of residence & role of staff. Staff design & implement BSP via Person-focused training supported. Can reduce known factors of frequent failure to achieve lasting positive changes: inconsistent application of interventions, utilization of overly simplistic interventions, failure to consider features of	perception of competence to manage other behaviours besides 1 target behaviour or person they reported on.	

					organization: assist or hinder use of new interventions.		
2. McGill, Bradshaw, & Hughes (2007)	To study impact of extended training in PBS on staff knowledge, causal attributions & emotional responses via training though under-graduate program with a PBS approach.	Students completed questionnaire at beginning/ mid/end of 2 year part time course with practical work interspersed. Process: person nominated by employer. Supervisor involved with portions of competency based training (reports or videos on practical work). 2-4 days of seminar over 2 yrs. Content: Social Role Valorization, applied behaviour analysis, observation, communication,	Conducted in England	Changes in knowledge of CB, causal attributions & emotional responses via questionnaires 3 times during 2 yr program. Captured data via student information form of gender, age, ethnic status, current work environment, educational attainment, professional qualifications, length of experience in disability/CB services & previous training in same. Other measures: completion of	Knowledge significantly increased across 3 times. Became less likely to attribute CB to emotional causes. Largest change between 1st & 2nd measures. Could be related to larger changes with new information as new students reach ceiling effect by 3rd measure in time. Changes in respect to making more behaviour attributions varied as did negative emotional responses	No real world changes in staff performance or for client reduction in behaviour explored.	Consider QL measures asking supervisors directly about changes. IR information via follow-up or descriptions of why incident occurred. Include observation methods to capture natural environment.

		participation, teaching & implementation for 1st year (29 days). Active support & not challenging behaviour. 2nd yr (28 days) focused on functional analysis & intervention for CB.		SIBUQ (Self Injury Questionnaire), CHABA (Challenging Behaviour Attributions Scale), Vignettes on Behavioural Function & ERBC (Emotional Responses to Challenging Behaviour Scale).	reduced more related to depression & anger. Training course associated with changes in knowledge, attributions & emotional responses likely better staff performance & outcomes for individuals with ID & CB. Importance for follow-up post training as staff may move towards more responsibility then training others in how to respond to CB & emotional responses.		
3. Grey & McClean (2007)	To determine whether staff training in developing	Non randomized matched control group. Matched on categories of CB, duration and gender for 6	Training conducted within large residential service & 2 conducted	CCB (Checklist for Challenging Behaviour) used to identify	No significant differences between groups at onset. Significant reductions in	No direct observations. Unsure which pieces intervention are	Determine effect of follow-up post training by supervisors to ensure maintenance of

	assessment of CB and develop-ment of support plans will remediate CB.	months. 30 clients/service users in total considered in 2 different service locations.	within community based services. Average duration of front line staff working with clients: 12 months. 15 staff qualified nurses, 7 residential care staff, 4 day service providers, 2 intensive support workers, 2 clinical psychologists. No other psychological interventions used during time frame.	primary CB for each individual on 2 occasions for both groups. No observational reports made for control group. No reliability info on target group available. Amount of psychotropic medication compared through comparable units documented. Training = 9 full days of training. Evaluated via 3 written assignments focused on behaviour assessment report, behaviour support plan	frequency, management difficulty & severity of CB found for target group. No significant changes in use of psychotropic meds for either group. PFT associated with significant reductions in CB & effective model for providing support to individuals.	most relevant out of 4 categories. Non-randomized methodology & lack of second rater of CB reduces strength of information. Did not isolate education & experience levels between staff groups or service delivery area.	learning. Observational methods & QL measures: ask how staff find training effective, does it meet their needs (i.e. increased confidence, transferability, etc.). What other training or support is needed for uptake of info.

				& quarterly progress review for 1 individual they worked with. Plan included 4 areas of: ecological skills teaching, skills teaching, direct interventions & reactive strategies.			
Person-focused Training: Active Support 4. Totsika, Toogood, Hastings, & McCarthy (2010)	To explore the effects of interactive training on resident engagement, challenging behaviours and staff assistance.	Observation and ratings of staff and resident behavior before, immediately after, and 6 month follow-up with 21 adults with ID after training.	Training of IT with 58 staff: mean age of 44.5 yrs. And average years of service as 6 yrs. Serving 21 adults with ID in 10 community homes.	Adaptive Behavior Scale-Residential and Community version. Information on residents challenging behaviours collected with Behavior Problems Inventory	Group level analysis with short-lived improvement in quality of staff support. Overall lack of change in staff behaviours, participant engagement and challenging behaviours. Sub-group analysis demonstrated significant	No comparison group. Lack of baseline information on challenging behavior to detect changes.	Understand complete effect of training holistically for long term.

					improvement in engagement for individuals with aggressive behavior at onset of study.		
B) Brief CB Training	***PURPOSE***	***DESIGN/ METHOD***	***SETTING***	***MEASURES USED***	***RESULTS***	***LIMITATIONS***	***RESEARCH NEEDS***
1. Tierney, Quinlan, & Hastings (2007)	To examine effects of typical training on staff feelings of efficacy, negative emotional reactions & causal beliefs of CB.	3 day training 'Understanding & Responding to Challenging Behaviour' : Day 1: comprehensive behavioural & functional assessment in identifying, modifying or removing environmental or individual setting events or triggers associated with CB' & use of Positive Behaviour Support Plans. Day 2: recognize escalating levels	48 staff (43 female/5 male) with varying degrees of experience (6 months to 24 years) from 6 ID organizations in Ireland. Staff: supervisors, nurses, chefs, OTs, house-parents (front line staff).	Self report postal questionnaires with 4 sections assessed demographic (age, gender, job title, amount of experiences, & brief description of job duties). Gave brief definition & scenario of challenging behaviour to base perceptions/ answers. CHABA used to measure causal beliefs	Perceived self efficacy in dealing with CB increased significantly from pre to post. No significant changes in emotional reaction to CB or causal beliefs. Sizeable impact of increased staff confidence after 3 days.	No actual observations, no records of changes in the workplace. Used general scenarios feelings versus 'real life' issues for staff. No follow-up immediately after training only 3 months post. Did not de-lineate between staff experience & positions which may have differences between sub-	Emotional reactions & psychological well being needs further research. QL measures: how changes effect directly in workplace via observation, measure changes in both staff feelings of efficacy & client incidents.

		of behaviour & staff attitudes, responses to de-escalate CB. Techniques & procedures based on Crisis Prevention Institute Non-Violent Crisis Intervention Training Program. Day 3: explore theory of stress & how stress affects how staff work with clients. 5 training courses over 1 year targeted. 48 completed responses of both questionnaires. Mailed out 1 week before course, follow-up with 2ND questionnaire 3 months post.		of CB. Staff perceived self efficacy measured with general 5 item scale related to feelings of confidence, control & satisfaction in dealing with CB, perception of positive impact, rating of difficulty to work with CB not related to specific individual situation. ERCB completed to measure feelings & emotions related to responding to CB from general vs. specific situation.		groups.	
2. Dowey, Toogood,	To determine if	1 day workshop based on	54 (18 male/36	Completed adapted SIB-	Number of correct	No workplace observation	QL methods and observation

Hastings, & Nash (2007)	there is an effect on staff causal explanations after 1 day of staff training.	principles of ABA. 1st session identifying CB from a vignette, explain why they considered them as challenging & identify possible causes for behaviour. 2nd session primarily on possible interventions. Lecture information on community participation & presence, choice, respect & competence.	female) front line staff in 6 separate groups. Asked how often they encountered CB. Trainers: members of a team specializing in functional assessment & behavioural interventions	UQ with changed factors related to Self Injury to CB before training began at start of day and end of training day. SIB-UQ asked questions about causes of CB presented in 11 short scenarios. 4 possible responses behaviour correct, behaviour incorrect, internal emotional, internal organic causal explanations.	behavioural causal hypotheses increased significantly from pre-post. Proportion of incorrect behavioural causal explanations also increased significantly from pre-post. Staff causal explanations for CB can be changed using relatively brief intervention.	methods recorded or measured pre/post. No control group. Vignettes used versus real life challenges. Changes noted only at end of training day with no stats taken after.	required, client behaviour management changes. Measures for staff within workplace culture need to be developed (e.g. Staff meetings, interactions with staff and others, written documentation/ notes). What types of training methods work best for staff (including those who are inflexible in their thinking).
C) Physical Intervention	***PURPOSE***	***DESIGN/ METHOD***	***SETTING***	***MEASURES USED***	***RESULTS***	***LIMITATIONS***	***RESEARCH NEEDS***
1. Baker & Bissmire (2000)	To understand extent of	9 residents throughout the study.	17 staff (8 female/9 male).	1 questionnaire designed for	13 staff completed due to attrition.	No observation of changes in workplace.	Longitudinal studies.

	physical restraint used as a response to CB & evaluate effectiveness of SCIP training.	2 day SCIP course provided. Lectures consist of service values, understanding CB, prevention, early intervention, health, safety & legal frameworks. Used demonstrations & practice physical interventions for approx 25% of time.	All care staff involved & between 19-34 years old. No written policy regarding use of physical intervention	evaluation prior to training & 3 months post. 5 point rating on how confident they felt dealing with & preventing CB. How much support they felt from organization in using physical intervention. Client records recorded incidents of CB 5 months before training with no written policy of how to record keep. Indicated by: no intervention/ ignored incident, verbal response, physical	55% of 100 incidents recorded involved physical restraint. Staff reported low confidence in ability to respond however improvement with training was noted. People tend to under-record use of physical restraint therefore more likely used more than reported.	No identification of different types of physical responses.	Training needs & best manner to implement needed.

				intervention (direct contact). Same data collected for 2 months following training. Data for month during training extracted from analysis.			
2. Murphy, Kelly-Pike & McGill (2001)	To evaluate training levels of senior staff and views on recent policy framework in Britain.	Purposeful sample: all participants had attended a conference on policy relevant within the UK & had purchased the policy document.	UK based. Participants worked in variety of services & well qualified. Most with some training on physical intervention related to 'brand' of training within workplace.	2 questionnaires designed related to training in & use of physical intervention methods & opinions on policy document. Asked participants what their training was in methods of physical interventions, use of these methods in	115 completed questionnaires. Most approved of policy & were developing policy on physical interventions. Most rated this policy as helpful. Clear need for guidance stated & need for determination of effectiveness of various physical intervention	Limited sampling to mostly managers. Focus on policy therefore answers may not reflect everyday practice. Front line staff responsible for conducting the actual restraints not considered. Did not isolate for type or 'brand' of training.	QL measures: Include front line staff into assessment of whether training & current restraint practice is sufficient. Is info on policy user friendly & how to look at ways to make information more user friendly.

				workplace, workplace policy on physical interventions, own attitudes to physical interventions, details of procedures used.	methods.		
3. Hawkins, Allen & Jenkins (2005)	To explore impact of receiving & completing physical intervention in response to CB & how this technique may impact each individual involved.	QL: Grounded theory, transcribed verbatim from audio-taped interview. Analyzed with NUD*IST. 8 participants resided in community & staff pairs interviewed within 1 week of a restraint that occurred between the 2. Specialist services had assessed residents on a scale of 1-10	Staff roles: house manager, senior support workers, & support workers with range of experience between 1-17 years with mean of 6 years, 6 months. Length of working with CB: 3 months to 7 years. All had training in physical restraint 6 months prior to interview.	Questions explored what personal impact for participants & for staff. What similarities & differences exist between the 2 accounts. Semi-structured interviews asking experience before, during & after physical interventions. Visual prompts used with more	Staff had clear understanding of training & implementation Participant/staff experiences linked & interactional. Effects related to more than technique, restraints have impact on relationships. Residents noted feelings of uncertainty of why restraint occurred, remorse, sadness. Increased stress	Limited perspective of accounts from 8 staff/residents perspective. Residents needed to be higher functioning therefore may not be transferrable to those who have limited or no verbal communication abilities. Not all staff have training who are working in the field & even those with	Observation methods. Separate categories of years of experience in field.

		with 10 being extreme CB: ratings between 6-10 with mean of 8.25. Data collected for 5 months. Post incident procedure used with 1 of 2 staff & resident interviewed after restraint & resident.	Residents between 18-43 years old.	structured interview for participants who 18+ & lived in community homes. Able to verbalize for interview purposes with restraint protocol in writing for them.	with unpredictability of behaviour, need for de-brief for staff found with demonstration of positive regard for participants. Reason for why behaviour taking place & level of controllability influenced how staff felt about person during restraint. Staff under estimated negative impact restraint has on residents. Accounts primarily negative for both staff & residents. Need for de-brief paramount for staff & resident as joint meeting may help with understanding	training do not always follow procedure. No observation directly in residence. Range of years working within field could be isolated for in terms of experience working with CB.	

					why restraint used & ways to mend relationship.		
4. Wietske,van-Oorsouw, Embregts, Bosman, & Jahoda (2010)	To increase staff knowledge regarding CB & to improve quality of physical intervention techniques.	70 direct care staff, 35 in control, 35 in experimental. Pre-post test with control group. Training of theories combined with physical intervention training over 7 sessions.	Residential homes in Netherlands.	Questionnaire of CB knowledge and observation of staff skills.	Staff knowledge of CB and quality of physical interventions techniques increased significantly.	Not randomized. No long term follow-up.	Effect of coaching and needs to transfer knowledge into everyday practice long term.
D) Formal/ Informal Intervention	***PURPOSE***	***DESIGN/ METHOD***	***SETTING***	***MEASURES USED***	***RESULTS***	***LIMITATIONS***	***RESEARCH NEEDS***
1. Feldman, Atkinson, Foti-Gervais & Condillac (2004)	To determine amount and type of formal documented vs. informal, un-documented intervention	Caregivers of 625 persons with ID in various service settings randomly selected to avoid bias of presence of CB. 92% residing in community. Staff who knew	Day/residence Ontario, Canada	Section 1: informant info related to target participant including medications, characteristics of living environment & day program, behavioural &	Overall, 55% of 2506 different interventions informal. No significant differences for gender, age, level of ID & type of residence. Significantly more informal	No direct observation - only verbal report therefore may not reflect actual actions. Stringent description of formal techniques may over-inflate amount of	Direct observation. Consider categories of formal/informal interventions.

		participants well with a mean of 4.6 years. Informants with mean of 9.7 years of experience. Current Management Strategies Interview (CMSI) designed for study. Used an open-ended interview format.		emotional issues. Challenging behaviour identified via frequency &/or intensity that caused harm to person, others, &/or property. Restrictions to participate in social, rec, voc, & community functions &/or disrupted general environment. Section 2: descriptions in own words of interventions used to assist with any issues identified in Section 1. Information whether interventions formal, required	strategies than formal behavioural interventions or counseling/ psychotherapy. No significant difference in overall prevalence of formal & informal procedures for crisis intervention, cognitive behaviour therapy or other interventions. Behaviour control medications accounted for 56.2% of intrusive interventions & more often associated with formal interventions for dangerous behaviours.	'informal' even though system is aware of intervention & is effective.	

				training & supervision, intervention start dates, how interventions monitored. Staff referred to client's file to ensure info accurate re: diagnosis etc. Effectiveness of interventions rated by estimating % change from start & pre-intervention score of zero & a -100 /+100 for degree of worsening or improvement at present time. Behaviour classification: decided by 4 professionals who agreed dangerous	Informants reported significant improvements with problematic behaviours with formal vs. informal interventions. Study found informal strategies are more prevalent & half of intrusive procedures undocumented. Low levels of intervention accountability, training & supervision may place many individuals with CB at increased risk for ineffective & unnecessary restrictive interventions, & physical		

				issues included self-injury & physical aggression reported most, inappropriate sexual behaviour, property destruction, excessive over-eating as determined by MD, elopement with lack of community awareness skills, & alcohol/ substance abuse. Interventions: 6 sections by 2 raters. Behavioural, cognitive behavioural, pharmacology counseling, crisis intervention, & other. Level	abuse. Results prompted provincial government to write province wide standards. Government sanctioned intervention standards are warranted to ensure evidence-based strategies based on least restrictive supports, appropriate use of crisis intervention techniques, staff training & supervision, clinical accountability & documentation mandated in all service settings. Widespread adoption of		

				of intrusiveness measured on scale of 0-6 with score of 5 + indicating significant degree. Formal interventions classified if designed & monitored by qualified professional, written intervention with documenta-tion of implementa-tion & periodic objective reviews. If intervention lacked one or more factors, strategy informal.	positive behaviour support would improve quality of life for individuals with intellectual disabilities & reduce costs related to challenging behaviour such as extra staffing, increased staff costs related to additional coverage for staff injuries, property destruction & staff turnover.		
E) Cognitive & Communica-tion Program	***PURPOSE***	***DESIGN/ METHOD***	***SETTING***	***MEASURES USED***	***RESULTS***	***LIMITATIONS***	***RESEARCH NEEDS***

1. Smidt, Balandin, Reed & Sigafoos (2007)	To determine if training will increase staff ability to reduce behaviour by changing staff beliefs and com-municating at an appropriate level with individuals.	Manager of home identified 1 client with CB to be involved. 18 staff with range of experience between a few weeks to 30 plus years involved in 4 training sessions. Training based on 'A Model of Interaction for the Analysis of Interaction & Communication' (MOSIAC) = communication program for staff working with adults with ID. Sessions focus on attitudes/beliefs of CB, communication interactions between client/staff & working as a team. Data collected used	3 residential organizations in Australia.	Non-concurrent multiple probe across settings designs. Changes measured with: 1. speech alone & alternative com-munication (AAC), 2. frequency of staff praise, 3. frequency of inappropriate language use (not matched to client), 4. frequency of CB collected via Incident Reports, & 5. staff beliefs measured via CHABA.	Staff use of AAC and praise increased, inappropriate language decreased, some decrease in resident's levels of CB however results not sustained. Staff training based on modifying attitudes & beliefs is potentially beneficial to both staff & residents.	Small number of residents & staff. No isolation for amount of experience or for individual staff changes. Different characteristics of individuals residing in the group homes not accounted. Unsure if details on challenging behaviour via Incident Reports were accurate. Training sessions had no follow-up after 4 weeks completed.	Larger scale model needed with follow-up post training to ensure intervention strategies continue to be adopted or modified. Consider training all staff in order for turnover to not impact consistency related to implementation of interventions. Separate staff characteristics to determine where other training may be required based on amount and type of experience.

		baseline of information collected 2-3 weeks prior to training via video-taped staff interactions, post & 3/6/12 months after training.					
2. Campbell & Hogg (2008)	To investigate how staffs' cognitive dimensions related to Identity, Cause, Con-sequences, Emotional Reactions and Treatment/ Control are affected by training.	2 main designs. Longitudinal: individuals as own controls for repeat measures & comparative subjects design. Questionnaire administered for 3 year period 4 times. Control group: no training with pre/post test measures on CBRQ used to evaluate training. 2nd group completed different course with CBRQ to measure changes. Main group in	Staff employed in various services & had range of experience working with adults with ID & CB.	Challenging Behaviour Representa-tion Questionnaire (CBRQ): theory based questionnaire used to evaluate impact of training course. Provides subscale scores on Identity, Cause, Consequence, Emotional Reactions & Treatment/ Control.	Experimental group outperformed 2 control groups by more than originally expected on baseline of pre-testing, & on Cause & Treatment/ Control. 5 dimensions on cognitive representation all affected but to different degrees. Size of training effect relatively small given amount of resources & training that occurred &	Only measurement was a theory based questionnaire (CBRQ) which limited amount of information generated. No information on actual changes in practice or on impact from client perspective.	Motivating factors for staff to be involved in training (mandatory versus self-initiated). QL measures to better understand relevance of training from the staffs' perspective & changes in practice related to better care of individuals via observation & behavioural reports.

		university course 'Approaches to People with Challenging Behaviour'. Compared with 2 groups & within group comparisons.			does not necessarily translate to actual practice. Evaluating outcomes on staff training important to measure level of knowledge uptake for best practice principles. Changes in staffs' cognition on causes/beliefs are multi-dimensional.		

APPENDIX B

Introductory Letter to Key Informants

March 28th, 2011

To: St. Amant Community Residential Program Staff

From: Charmayne Dubé, BMR (O.T.), MSc., PhD (c) & Dr. Bev Temple

Please accept this letter as a request for your assistance by participating in an interview at your convenience in my research titled: Supporting Adults with Intellectual Disabilities who Present with Challenging Behaviours: A Cross-Case Analysis of Knowledge Use and Practice.

The aim of this study is to gain an understanding of staff experiences of providing support to people with intellectual disabilities and integrating training knowledge intended to assist staff with managing everyday situations. This body of research will provide insight into how people who provide the most support to individuals who present with challenging behaviour manage situations in everyday practice.

Elements of the individual work setting which either impede or support the integration of new knowledge from training sessions will be explored. As well, factors related to social processes of working within teams and influence of supervision and leadership will be examined. Documents and information on training sessions and behavioural strategies are also considered relevant to understanding the supports offered by the agency.

The focus will be on two homes that Leanne Fenez, Director of the Community Residential Program has identified as meeting the intended criteria. One case will focus on staff and supervisors who provide residential support to individuals with intellectual disabilities. The second case will provide detail from staff and supervisors on providing support to people who have intellectual disabilities and who also present with challenging behaviours.

Permission to approach and recruit key informants corresponding to the staff roles highlighted above has been provided by Leanne Fenez. Confidentiality and voluntary participation is assured and informed consent will be obtained in writing from all participants being interviewed.

Participation in this project is voluntary and individuals are free to withdraw from the study at any time, and/or refrain from answering any questions, without prejudice or consequence.

There are no known risks to the participants for participating in the study. The data will be identified with a pseudonym to avoid any possibility that the individual could be indentified and will be considered at all times when reporting data. General

recommendations will be made regarding the process of supporting individuals, avoiding any possibility that any care provider would feel threatened in their roles. There will be no positive or negative impact on the staff's employment or status.

This study has the potential to not only improve the quality of life for people with intellectual disabilities living in community homes but also provide greater safety and satisfaction for residents and staff.

Please contact Charmayne Dubé, BMR (OT), MSc, PhD (c) by phone at--------or via e-mail------ and/or Dr. Beverley Temple by phone at------ or via email------- if you have any concerns, questions, or need additional information.

I look forward to learning from your experience and sharing the findings that will contribute to the agency's long standing commitment to improving upon lives both individually and collectively. Thank you for your consideration of this request.

Sincerely,

Charmayne Dubé, BMR (O.T.), MSc., PhD (c)

APPENDIX C

Helen Glass Centre for Nursing
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CONSENT FORM FOR KEY INFORMANT INTERVIEW: TRAINING COORDINATOR

Research Project Title: SUPPORTING ADULTS WITH INTELLECTUAL DISABILITIES WHO PRESENT WITH CHALLENGING BEHAVIOURS: A CROSS-CASE ANALYSIS OF KNOWLEDGE USE AND PRACTICE.

Principal Researcher(s): Charmayne Dubé, BMR (OT), MSc, PhD (c) & Dr. Bev Temple (advisor)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

About this Project:
The aim of this study is to gain an understanding of staff experiences of providing support to people with intellectual disabilities and integrating training knowledge intended to assist staff with managing everyday situations. This study has the potential to not only improve the quality of life for people with intellectual disabilities living in community homes but also provide greater safety and satisfaction for residents and staff.

An understanding of the Research Activities:
The *Training Coordinator, Behaviour Specialist and Supervisors* will be informed of the study by the Director of Community Residential Programs. Prior to beginning the interview they will sign a consent form. *Direct Support Staff* will be approached by the Principal Investigator. They will have been notified of the study by their supervisor prior to being contacted. They will be asked to sign a consent form after the study has again been reviewed with them. This will be done by the Principal Investigator. It is expected that individual key informant interviews will take between 1-2 hours approximately.

Benefits and Risk:
There are no known risks to the participants for participating in the study. The data will be identified with a pseudonym to avoid any possibility that the individual could be indentified and will be considered at all times when reporting data. General recommendations will be made regarding the process of supporting individuals, avoiding any possibility that any care provider would feel threatened in their roles. There will be no positive or negative impact on the person's employment or status. There is a potential for this study to improve the quality of life of many individuals with intellectual disabilities living in the community if the opinions and experiences of direct staff are included when making recommendations to improve individual support plans.

Use of Recording Device(s):
Interviews will be recorded with an audio-recording device which will be reviewed and transcribed at a later date to ensure full details to be included in the study.

Degree of Confidentiality:
Confidentiality will be maintained by reporting grouped data and removing any identifiers which could potentially risk confidentiality. The participants within the study will be named and interviewed by the Principal Investigator. The names will be removed from the data and cases will only be named by number or a pseudonym throughout. The actual providers who have participated will not be known by anyone in the organization. Effort will be made to not identify the specific cases in any reporting to outside groups. Data will be stored in a locked cabinet in the Principal Investigator's home based office for seven years and then destroyed. Any electronic data will be maintained in password protected files in the Principal Investigator's computer.

Feedback:
The findings will be presented to the agency who has participated in the study. The findings will be posted on the St. Amant Research Centre web site. When appropriate, opportunity to present at conferences and appropriate academic journals will be sought.

Voluntary Consent:
You understand that your participation in this project is voluntary. You are free to withdraw from the study at any time, and/or refrain from answering any questions, without prejudice or consequence. If you choose to withdraw from this study at anytime, please contact either researcher noted below by phone or e-mail to indicate your intention. All personal data that is collected to that point will be destroyed and not used within the study. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation in the project.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the project and agree to participate in an interview as a key informant. However in no way does this waive your legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. In addition, you understand that you may contact Charmayne Dubé, BMR (OT), MSc, PhD

(c) by phone at----or via e-mail----- and/or Dr. Beverley Temple by phone at------ or via email----- if you have any concerns, questions, or need additional information.

This research has been approved by the Education/Nursing Ethics Research Board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat at----- or e-mail--. A copy of this consent form has been given to you to keep for your records and reference.

Do you agree to participate in this study via an interview: Y/N

Participant's Signature Date

Principal Investigator's and/or Delegate's Signature Date

[IF YOU WOULD LIKE TO REQUEST A COPY OF A SUMMARY OF THE STUDY FINDINGS, PLEASE FILL OUT THE FOLLOWING FORM]

I would like to receive a hard copy of the summary report of the study findings:

Name:
_____

Address (with postal code):

OR

I would like to receive an electronic copy of the summary report of study findings:

E-mail address:
_____

APPENDIX D

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CONSENT FORM FOR KEY INFORMANT INTERVIEW: BEHAVIOUR ANALYST

Research Project Title: SUPPORTING ADULTS WITH INTELLECTUAL DISABILITIES WHO PRESENT WITH CHALLENGING BEHAVIOURS: A CROSS-CASE ANALYSIS OF KNOWLEDGE USE AND PRACTICE.

Principal Researcher(s): Charmayne Dubé, BMR (OT), MSc, PhD (c) & Dr. Bev Temple (advisor)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

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Benefits and Risk:
There are no known risks to the participants for participating in the study. The data will be identified with a pseudonym to avoid any possibility that the individual could be indentified and will be considered at all times when reporting data. General recommendations will be made regarding the process of supporting individuals, avoiding any possibility that any care provider would feel threatened in their roles. There will be no positive or negative impact on the person's employment or status. There is a potential for this study to improve the quality of life of many individuals with intellectual disabilities living in the community if the opinions and experiences of direct staff are included when making recommendations to improve individual support plans.

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Confidentiality will be maintained by reporting grouped data and removing any identifiers which could potentially risk confidentiality. The participants within the study will be named and interviewed by the Principal Investigator. The names will be removed from the data and cases will only be named by number or a pseudonym throughout. The actual providers who have participated will not be known by anyone in the organization. Effort will be made to not identify the specific cases in any reporting to outside groups. Data will be stored in a locked cabinet in the Principal Investigator's home based office for seven years and then destroyed. Any electronic data will be maintained in password protected files in the Principal Investigator's computer.

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Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the project and agree to participate in an interview as a key informant. However in no way does this waive your legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. In addition, you understand that you may contact Charmayne Dubé, BMR (OT), MSc, PhD

(c) by phone at--- or via e-mail-----and/or Dr. Beverley Temple by phone at------or via email----- if you have any concerns, questions, or need additional information.

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Participant's Signature Date

Principal Investigator's and/or Delegate's Signature Date

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Address (with postal code):

OR

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E-mail address:
_____

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Winnipeg, Manitoba

CONSENT FORM FOR KEY INFORMANT INTERVIEWS: SUPERVISORS

Research Project Title: SUPPORTING ADULTS WITH INTELLECTUAL DISABILITIES WHO PRESENT WITH CHALLENGING BEHAVIOURS: A CROSS-CASE ANALYSIS OF KNOWLEDGE USE AND PRACTICE.

Principal Researcher(s): Charmayne Dubé, BMR (OT), MSc, PhD (c) & Dr. Bev Temple (advisor)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

About this Project:
The aim of this study is to gain an understanding of staff experiences of providing support to people with intellectual disabilities and integrating training knowledge intended to assist staff with managing everyday situations. This study has the potential to not only improve the quality of life for people with intellectual disabilities living in community homes but also provide greater safety and satisfaction for residents and staff.

An understanding of the Research Activities:
The *Supervisors* will be informed of the study by the Director of Community Residential Programs. Prior to beginning the interview they will sign a consent form. *Direct Support Staff* will be approached by the Principal Investigator. They will have been notified of the study by their supervisor prior to being contacted. They will be asked to sign a consent form after the study has again been reviewed with them. This will be done by the Principal Investigator. It is expected that individual key informant interviews will take between 1-2 hours approximately.

Benefits and Risk:
There are no known risks to the participants for participating in the study. The data will be identified with a pseudonym to avoid any possibility that the individual could be indentified and will be considered at all times when reporting data. General recommendations will be made regarding the process of supporting individuals, avoiding any possibility that any care provider would feel threatened in their roles. There will be no positive or negative impact on the person's employment or status. There is a potential for this study to improve the quality of life of many individuals with intellectual disabilities living in the community if the opinions and experiences of direct staff are included when making recommendations to improve individual support plans.

Use of Recording Device(s):
Interviews will be recorded with an audio-recording device which will be reviewed and transcribed at a later date to ensure full details to be included in the study.

Degree of Confidentiality:
Confidentiality will be maintained by reporting grouped data and removing any identifiers which could potentially risk confidentiality. The participants within the study will be named and interviewed by the Principal Investigator. The names will be removed from the data and cases will only be named by number or a pseudonym throughout. The actual providers who have participated will not be known by anyone in the organization. Effort will be made to not identify the specific cases in any reporting to outside groups. Data will be stored in a locked cabinet in the Principal Investigator's home based office for seven years and then destroyed. Any electronic data will be maintained in password protected files in the Principal Investigator's computer.

Feedback:
The findings will be presented to the agency who has participated in the study. The findings will be posted on the St. Amant Research Centre web site. When appropriate, opportunity to present at conferences and appropriate academic journals will be sought.

Voluntary Consent:
You understand that your participation in this project is voluntary. You are free to withdraw from the study at any time, and/or refrain from answering any questions, without prejudice or consequence. If you choose to withdraw from this study at anytime, please contact either researcher noted below by phone or e-mail to indicate your intention. All personal data that is collected to that point will be destroyed and not used within the study. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation in the project.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the project and agree to participate in an interview as a key informant. However in no way does this waive your legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. In addition, you understand that you may contact Charmayne Dubé, BMR (OT), MSc, PhD

(c) by phone at -------or via e-mail ---and/or Dr. Beverley Temple by phone at-------or via email----if you have any concerns, questions, or need additional information.

This research has been approved by the Education/Nursing Ethics Research Board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat at-------or e-mail-----. A copy of this consent form has been given to you to keep for your records and reference.

Do you agree to participate in this study via an interview: Y/N

Participant's Signature Date

Principal Investigator's and/or Delegate's Signature Date

[IF YOU WOULD LIKE TO REQUEST A COPY OF A SUMMARY OF THE STUDY FINDINGS, PLEASE FILL OUT THE FOLLOWING FORM]

I would like to receive a hard copy of the summary report of the study findings:

Name:
_____

Address (with postal code):

OR

I would like to receive an electronic copy of the summary report of study findings:

E-mail address:
_____

APPENDIX F

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CONSENT FORM FOR KEY INFORMANT INTERVIEWS: DIRECT SUPPORT STAFF

Research Project Title: SUPPORTING ADULTS WITH INTELLECTUAL DISABILITIES WHO PRESENT WITH CHALLENGING BEHAVIOURS: A CROSS-CASE ANALYSIS OF KNOWLEDGE USE AND PRACTICE.

Principal Researcher(s): Charmayne Dubé, BMR (OT), MSc, PhD (c) & Dr. Beverley Temple (advisor)

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The aim of this study is to gain an understanding of staff experiences of providing support to people with intellectual disabilities and integrating training knowledge intended to assist staff with managing everyday situations. This study has the potential to not only improve the quality of life for people with intellectual disabilities living in community homes but also provide greater safety and satisfaction for residents and staff.

An understanding of the Research Activities:
The *Unit Supervisors* will be informed of the study by the Director of Community Residential Programs. Prior to beginning the interview they will sign a consent form. *Direct Support Staff* will be approached by the Principal Investigator. They will have been notified of the study by their supervisor prior to being contacted. They will be asked to sign a consent form after the study has again been reviewed with them. This will be done by the Principal Investigator. It is expected that individual key informant interviews will take between 1-2 hours approximately.

Benefits and Risk:
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Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the project and agree to participate in an interview as a key informant. However in no way does this waive your legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. In addition, you understand that you may contact Charmayne Dubé, BMR (OT), MSc, PhD

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[IF YOU WOULD LIKE TO REQUEST A COPY OF A SUMMARY OF THE STUDY FINDINGS, PLEASE FILL OUT THE FOLLOWING FORM]

I would like to receive a hard copy of the summary report of the study findings:

Name:
_____

Address (with postal code):

OR

I would like to receive an electronic copy of the summary report of study findings:

E-mail address:
_____

APPENDIX G

TRAINING COORDINATOR SEMI-STRUCTURED INTERVIEW GUIDE

Introduction:

1. How long have you been doing this type of work?
2. How long have you been working within a similar work environment (residential vs. day program)?
3. How long have you worked in a supervisory capacity?
4. What is your educational background? (Grade 12, Post Secondary Education: name of diploma/degree)
5. How many staff do you directly supervise?

Description of your role:

1. Supervisor of those training?
2. Supervisor of trainers?
3. Benefits/barriers of your position?

Mandatory Training Policy:

1. How do employees register, process?
2. What is QHR database?
3. Ties into performance management? Re-do? Etc?

Training Content:

1. How do you decide on what is taught to all vs. specialized?
2. Who are trainers? Level of train the trainer? Based on specialty?
3. Opportunity to follow-up in home after? K-A?
4. Overall Orientation-who does?
5. NVCI = How is that decided upon? Review if I needs, group needs?
6. SBMT = 14 hrs: What is content & can I review, goal of training, how different than NVCI? What is SBI-Same as SBMT?
7. Person Centered after 6 months- why? Can I review content? Rights restriction included?

Outcomes:

1. What is main objective? How measured?
2. Transfer to home situation?
3. Homework, pass/fail?
4. Refreshers? Timed or as needed?

Ideas for future:

1. What's missing and why?
2. What could be more beneficial?
3. Strengths of current training structure?

Anything I missed? Thank you

APPENDIX H

BEHAVIOUR ANALYST SEMI-STRUCTURED INTERVIEW GUIDE

Description of your role:

1. Benefits/barriers of your position?
2. Amount of contact with person with CB directly, work through staff mainly?

Process for referral:

1. Identifying priority?
2. Level of consultation with staff? Perceptions of staff integrated in initial stages?

Analysis/Implementation/Modify:

1. Identifiers that it will be successful or struggle? Characteristics of team, leadership?
2. How much time on average spent of assessment?
3. How much time, types of activities involved in implementation/
4. If not working out, how do you know, what do you do to assess what needs to be modified?

Staff Training:

1. You see a difference between staff with training for uptake?
2. If new home with 1 person with CB and no need previous for staff to be trained, is there a difference, how?
3. How do you tailor your approach to match need?
4. If having a difficult time, how do you address with leaders or staff directly?

Ideas for future:

1. What's missing and why?
2. What could be more beneficial?
3. Strengths of current structure?

Anything I missed?

Thank you

APPENDIX I

CLIENT CARE COORDINATOR SEMI-STRUCTURED INTERVIEW GUIDE

Introduction:

1. How long have you been doing this type of work?
2. How long have you been working within a similar work environment (residential vs. day program)?
3. How long have you worked in a supervisory capacity?
4. What is your educational background? (Grade 12, Post Secondary Education: name of diploma/degree)
5. How many staff do you directly supervise?
6. Do you have difficulty with recruiting and retaining staff in this residence? Why or why not?
7. Describe the strengths of this unit?
8. Tell me about areas where further development is needed?

Description of your supervisory role:

1. Any differences between managing homes with CB vs. non-CB? Strengths/struggles?
2. Benefits/barriers of your position?
3. Strategies you use to address leadership needs of each?
4. Strategies for communication with staff (meetings, how often? Daily notes? how?)
5. How often 1:1 supervision meeting?
6. Barriers to implementing training?

Role in training:

1. Benefits/barriers to supervising and training staff?

Policies

'In House Checklist' - Part 1:

1. Working Alone Policy on CRP employee page on Intranet-per home? Access for all employees?
2. Best Practice Manual per home, contents same/different, consists of what?
3. Emergency Procedures, who reviews?
4. CRP Orientation workbook, what are the contents?

'In House Checklist' - Part 2:'Person Specific'

1. Safety Plans: right restrictions why, what is process, is this only for CB, examples.

Policy: Emergency Response System

1. Purpose/goal of Policy?
2. ER = only for CB homes?

3. Protelec Alarms= decision making process, types of behavior that would warrant that?

Policy: Incident Reporting
1. 2 page St. Amant cover page, intended for what purpose, how is there follow-up?
2. Can I see review to get idea of numbers, type of challenges for staff? PRNs, staff injury, resident, need for NVCI, illness.
3. Occupational Injury Report? Types, frequency, time off work, noted in IR's, resident interaction, accidental

Ideas for future:
1. What's missing and why?
2. What could be more beneficial?
3. Strengths of current training and leadership structure?

What would be/are your top 3 most important points that you would/do look for in the following?
- Direct care staff
- Teams
- Supervisors
- Consultants
- Organizations
- Facilitators

Anything I missed?

Thank you

TEAM LEADER SEMI-STRUCTURED INTERVIEW GUIDE

Introduction
1. What is your date of birth?
2. Gender: Male/Female
3. How long have you been doing this type of work?
4. How long have you been working within a similar work environment (residential vs. day program)?
5. How long have you worked in a supervisory capacity?
6. What is your educational background? (Grade 12, Post Secondary Education: name of diploma/degree)
7. What are your typical shift patterns (evening team setting, weekend, days)
8. How many staff do you directly supervise?
9. Do you have difficulty with recruiting and retaining staff in this residence? Why or why not?
10. Describe the strengths of this unit?
11. Tell me about areas where further development is needed?

Resident Demographic Questions Posed to Supervisors Only

1. What is the age range of people who live in this home?
2. How many males/females reside within the home?
3. What range of intellectual disability do the individuals experience?
4. What other types of diagnoses have the individuals been given?
5. What are the typical challenges and issues that individuals and staff experience within this home?

Mindlines

1. How important are the connections and social aspects of working within this team and why? For example making friends with peers, etc.
2. When there are important issues related to challenging issues to be resolved, how do you decide what to do (Probe team, leader, external assistance)?
3. Are there people on the team who influence the decision on how to proceed in the given moment when attempting to resolve issues (Probe for why)?
4. How much would you say the training received to manage challenging behaviours plays into how things are actually managed?
5. When faced with an issue, who do you report the information to first?

PARIHS Framework

Evidence

1. How do you decide how or if you will apply information received from training into your work place?
2. Who is included in that decision making process and why?
3. Is there a difference in how you view training that is mandatory and training that you have identified as something that is important to how you do your work?

Context

1. Tell me about the process of how supervision meetings occur? (Probe for 1:1 time or group staff/meetings).
2. When and where would you bring information to the team/supervisor?
3. Is there a time designated to discuss learning and plans for implementation?
4. Are you consulted when there is a specific issue with a resident that must be addressed? By who? When?
5. Describe the strengths of working within this team when trying to implement new information to better deal with challenging behaviour?
6. Is there a time to de-brief after an issue or a problem at work has taken place? When? With who?
7. Are there challenges to this process? (Probe for organization factors, level of support from team/supervisors).

Facilitation

1. What is the process for signing up for courses? (Probe for self initiated, mandatory sessions, timing related to working in present environment, preparation)
2. When you return from training is the facilitator available to assist with implementing information?
3. How are your leader and team involved?
4. If a 'professional' like a Behaviour Specialist or Occupational Therapist is brought in to help, are you included in the discussions? How?
5. Describe how you have added new information and techniques into work.
6. Are there other resources available to facilitate this process?
7. Who is most helpful in this process (Probe who was key in process: team, leader, facilitator)?

Ideas for future (based on social exchange theory):

1. If you were in charge of managing the following positions/places, what would be your top 3 most important points that you would look for?
    - Direct care staff
    - Teams
    - Supervisors
    - Consultants
    - Organizations
    - Facilitators

APPENDIX J

DIRECT SUPPORT STAFF SEMI-STRUCTURED INTERVIEW GUIDE

Regular Full Time staff (evenings, overnights, weekends, casual)

Consent form and Introduction

Background including demographics:
What is your educational background?
How long have you been doing this type of work?
What brought you to the field of disability support?
How long have you been with St. Amant?
Did you previously work as a casual staff in other part of the agency or transfer in from another location? If so-Applicability/transferability of training specific to the other program?
Did you do similar work to the role you are in previously? how long, similar setting?
Do you see yourself working in this field in the future, why or why not?

MINDLINES: What is your typical shift pattern? What are your duties? Other staff members around?

1. How important are the connections and social aspects of working within this team and why? For example making friends with peers, etc.
2. When there are important issues related to challenging issues to be resolved, how do you decide what to do (Probe team, leader, external assistance)?
3. Are there people on the team who influence the decision on how to proceed in the given moment when attempting to resolve issues (Probe for why)?
4. How much would you say the training received to manage challenging behaviours plays into how things are actually managed?
5. When faced with an issue, who do you report the information to first?

PARIHS FRAMEWORK
Evidence
1. How do you decide how or if you will apply information received from training into your work place?
2. Who is included in that decision making process and why?
3. Is there a difference in how you view training that is mandatory and training that you have identified as something that is important to how you do your work?

Context
1. Tell me about the process of how supervision meetings occur? (Probe for 1:1 time or group staff/meetings).
2. When and where would you bring information to the team/supervisor?
3. Is there a time designated to discuss learning and plans for implementation?

4. Are you consulted when there is a specific issue with a resident that must be addressed? By who? When?
5. Describe the strengths of working within this team when trying to implement new information to better deal with challenging behaviour?
6. Is there a time to de-brief after an issue or a problem at work has taken place? When? With who?
7. Are there challenges to this process? (Probe for organization factors, level of support from team/supervisors).

Facilitation
1. What is the process for signing up for courses? (Probe for self initiated, mandatory sessions, timing related to working in present environment, preparation)
2. When you return from training is the facilitator available to assist with implementing information?
3. How are your leader and team involved?
4. If a 'professional' like a Behaviour Specialist or Occupational Therapist is brought in to help, are you included in the discussions? How?
5. Describe how you have added new information and techniques into work.
6. Are there other resources available to facilitate this process?
7. Who is most helpful in this process (Probe who was key in process: team, leader, facilitator)?

SOCIAL EXCHANGE THEORY
Ideas for future:

If you were in charge of managing the following positions/places, what would be your top 3 most important points that you would look for?
- Direct care staff
- Teams
- Supervisors
- Consultants
- Organizations
- Facilitators

Anything I have missed?

Thank you!

APPENDIX K

St. Amant Community Residential Program Policies and Practices

CRP POLICY	PURPOSE	PRACTICE
TRAINING		
Employee Orientation	Ensure all staff are properly oriented to CRP & relevant homes for CRP to fulfill its goal of providing excellent care.	Human Resources arrange for Corporate Orientation. CRP rep arranges CRP Orientation. Team Leader arranges 20-30 hours of in-house orientation.
Mandatory Training	Train staff to meet individual's specific needs of those being supported and demonstrate ability to meet evaluation standards.	CRP rep informs staff on training requirements for the home. Employees responsible to register, attend & pass evaluation.
SUPERVISION		
Supervision of Employees	Confirm that a staff is able to meet job expectations. If not meeting same, identify required improvement measures by providing solution focused feedback.	Supervisor schedules type of supervision required based on nature of need. Implement plan, record occurrence and outcome (e.g. monitoring via direct observation, review documents, spontaneous meetings).
RISK MANAGEMENT		
Emergency Response System	Access to assistance for select homes/ people if behavior is un-manageable despite training, support plans etc.	Depending on home can utilize a)'panic button', b) emergency response specific telephone, c) Protelec Panic Button with police dispatch as required, d) cellular phone to access responder if no other strategy in place as above. *Leadership team on rotation as responders.
Incident Reporting	Report provides a legal document of a serious incident. Serves as a communication tool between staff members and to administration. Provides outcome data reflective of interventions used to manage challenging behaviour.	Staff have access to information to guide decision making on when to complete an IR. Information must be shared within a specific time frame. Report reviewed by CCC. Copies available within home for team sharing. If staff is injured or staff's property damaged, an Occupational Injury Report also accompanies the IR.
Clinician Consultation Model	Identify lines of communication,	CCC prepares information for

	roles, and implementation process for specialist, leadership and staff based on specific individual needs.	referral. Program Manager reviews and consults with Coordinator of Clinical Services. Assessment completed in consultation with the CCC, TL, staff, family and/or person. Recommendations reviewed with team to discuss suitability of same. Review meetings occur once per month to adjust as needed.

APPENDIX L

St. Amant Community Residential Program Training Program

TRAINING SESSION	TARGETED CONTENT	DETAILS/TIMEFRAME
CRP Orientation (Value/Skill Based)	Overview of CRP philosophy & medical/health care.	Mandatory for all. Prior to working in home. CRP leadership team trains.
Ethics of Touch (Value/Skill Based)	Informs staff on privacy issues, relationships & intimate care principles.	Mandatory for all. Initial stages of employment. CRP leadership team trains.
CRP Documentation (Skill Based) *Behaviour plans/Incident Reports	Learn to formally collect & document information to be included in individual support and/or behaviour plans.	Mandatory for all. Initial stages of employment. CRP leadership team trains.
Non-Violent Crisis Intervention: Options: 1 or 2 day, Enhanced Verbal Skills, Applied Physical Training (Skill Based) *NVCI	Avoid & take control of an out of control situation (includes: verbal, non- physical & physical Interventions).	Mandatory in specific homes with content matched to needs of individuals within the home. Certified CRP trainers.
First Aide/CPR (Skill Based)	Respond to initial emergency needs.	Mandatory for all. Must have within 4 weeks of employment via St. John's.
Fundamentals of Person Centered Support (Value Based) *****Person-Focused Training	Understand: Personal Outcome Measures, Person Centered Planning, Power of Imagery, Basic Maintenance & Accountability.	Mandatory for all. Scheduled after 6 months of employment. Specific CRP trainers.
Specialized Behaviour Management Training (Value/Skill Based) *Brief Challenging Behaviour Training	Understand basic behaviour principles, strategies, philosophical & ethical considerations. Pre/Post assignments.	Only for homes where behavioural consultants are active. Must have worked in the home for at least 6 months. Behaviour Specialists provide training.
Protection Workshops (Adult only) (Value Based)	Learn about the Vulnerable Persons' Act around right to make decisions & receive assistance when necessary.	Mandatory for all adult homes. Initial stages of employment. External trainer from FS&CA.
Nutritional Workshop (Skill Based)	Understand basic nutrition & application for all people living within home.	Mandatory for all. Initial stages of employment. CRP leadership team trains.
Diabetic Management/Tube Feed Training/VNS/Back Care (Skill Based)	Train on specific individual needs.	Nurse/ Occupational Therapist trains based on need.
Applied Suicide Skills Intervention Training (Skill Based)	Recognize early suicidal risks & develop comprehensive plans.	Based on specific individual needs. Certified trainers.

In-house Training (Value & Skill Based)	Train on specific information related to In-House Checklists: Part 1: Administration & Part 2: Person Specific	Between 20-30 hours depending on need. Part 1: completed in 1 month, Part 2: completed within 4 months. Team Leader arranges.

Indicates training was identified as best practice from literature review

APPENDIX M

Initial Interview Review Form

Date: _____ Interview #

Field Notes:
Initial Thoughts:
Areas for follow-up/questions:

APPENDIX N

INITIAL CATEGORIES

Direct Support Staff Unit A:

1. Work environment at beginning is difficult due to behaviours
2. Important to develop relationship with client
3. Training assists with starting to understand expectations overall
4. Importance of routine and structure
5. Communication via written information or direct is key to consistency
6. Do not take behavior personal
7. Reinforce positive behavior and support via communication
8. Need patience 'just how I am', personality style
9. Positive staff group make feel comfortable, we all get along
10. Ask questions and for help
11. Welcoming new staff important
12. Help each other no matter what, always have back up
13. Don't see challenges of home after time in home
14. Team members direct person to debrief with, source of support
15. Use written documentation if no other staff around
16. Always looking for ways to better self by learning and improving support
17. Training offers ways to better and to confirm approaches
18. Team leader supports learning for all staff
19. Leadership is approachable, communicates regularly on day shifts
20. Not always time to discuss training in staff meetings
21. No need to discuss because training is simple
22. Ideas brought up during discussions and needs to fit clients
23. Problem solve directly with staff members
24. New job feel rushed all the time because do not know role
25. With experience feel like lots of time=comfort
26. Flexibility in training days but not with content
27. Behavior courses helpful to understand behavior and how to support, react
28. More learn by hands on, get to know people
29. Experience of trainers and supervisors helps
30. Limited exposure to behavior specialist
31. Easy transfer of learning with training if simplified
32. Communication, team player and initiative by taking control important
33. Need to be on same page, consistent
34. Direct approach with problems to solve
35. New staff difficult because not on same page, less consistency, confusing for all
36. Social aspects by welcoming is very important
37. Role modeling composure, calmness important for new staff
38. Confident and positive approach
39. Clients testing new staff but trying to get to know you
40. Honest communication with leaders

41. Evaluation and goal process more integrated into work than outlined
42. Consultants and supervisors should understand situation
43. Variety of work in organization and the home is positive
44. Primary thing is caring approach for clients
45. 'not just a job' need to better people's lives
46. Learn through experience, hands on
47. Normalize situation for new staff to build confidence
48. More responsibility means opportunity to learn more
49. Some training seen as irrelevant if not useful in workplace
50. Levels of learning or previous experience not accounted for=all same content
51. Appreciate that get paid to attend
52. Learning about clients all the time, 'don't judge a book by its cover'
53. Learning from team is important because they live the experience
54. Turnover in staff increases confusion for all
55. Clients don't actually don't have a say on who is hired when non-verbal
56. Staff need to interpret reactions, clients 'feeling them out'
57. Enjoys challenges and variety
58. Word of mouth brought staff based on positive experiences +++++
59. Personality fits with supporting people, want to work with people++++
60. Staff with previous experience willing to ask questions & offer suggestions
61. See self in field of disability long term
62. When new, observe staff with participants to learn and follow in footsteps
63. Entire team available to problem solve, often those with seniority
64. Important to have individual plans for each client
65. Newer staff think more training on behavior needed
66. Need combination of clients specific information & general training methods
67. Staff meetings seen as a key time to share, brainstorm,
68. Make plans based on various perspectives, all need to follow when decided upon
69. Training best with real life scenarios, balance individual with general
70. Team open to suggestions, comfort level
71. Helpful to have time to learn specifically about each individual with consultants
72. Informal supervision with TL, not an issue because approachable, email also
73. Staff need to be reliable, caring, want to make a difference
74. Trust in staff since people are vulnerable
75. Leaders need to listen but then be decisive
76. Disputes between staff seen in written documents when not on same page
77. New leaders changed negative to positive with consistency & communication
78. If dispute between staff unresolved can go to leaders, but decreases trust
79. Staff friendship helps to develop work relations, comfort level, debrief after hours
80. If always accessible to debrief after hours, boundaries can be crossed
81. Push from others to not always rely on senior staff, take initiative
82. Training is vague/basic, experience is specific so seen as more relevant for staff
83. Difficult behaviours and non-verbal issues not addressed in training
84. Individual plans assist the most with understanding and setting realistic goals
85. Experience of knowing client is most important for client includes subtleties
86. Training more important overall to improve services

87. Training is time consuming, no time for extra even if interested when not relevant
88. Background on disability is helpful to understand behaviours
89. Certain issues not always good to go direct to colleagues eg. if not connecting
90. Mandatory training seen as threat to keep employment if not attending
91. Verbal clients have more options in life & choices
92. Staff need compassion, patience, & communication without= team can crumble
93. Not everyone is cut out for certain settings, flexibility to move
94. Negatively effects clients, not fair to individuals no direct say in matter
95. Leaders need to know clients, staff = more time for connection, personal interest
96. Morale on team is good indicator of organization, leadership, etc
97. Cost of lack of team and low morale falls directly on clients quality of life
98. Increased supervision to ensure staff fit with needs of clients, most important
99. Long standing connection with clients and key worker
100. KW takes on extra with new staff=easier & admin functions & with behavior specialist
101. Relies on observing, reading non-verbal reactions from clients and staff to determine fit
102. Not invested in staff relationship until sees fit for clients
103. Interest in staying with home varies, important to be straight forward, honest about behaviours and challenges
104. Despite frequent turnover, no problem with filling shifts
105. Home seen as stepping stone due to behavior type, move for less stress
106. Some issues with follow through on work, balance of staff interests and wants to client needs
107. Set individual meetings assisted with improving consistency
108. Costs of extra training for supervisors seen as prohibitive, appreciate free course options
109. Certain staff chosen to take courses, see benefit of all training
110. Unresolved conflict can lead to leaving even if enjoy participants
111. Compromise needed for team work
112. Inconsistent staff lead to less routine
113. Young crowd seen as more open, no disapproval from those with seniority
114. Working alone offers advantage of following own mindset
115. Priority must be clients, importance of home environment, looking good
116. Consultants good if they are respectful of the home
117. Training is consistent but flexibility into homes needed, can never be just by the book.
118. Organization good if consistent with values of people supported=adults

Supervisors Unit A:

1. Key worker is right hand man
2. Benefit of supervisory core training
3. Training more natural if content matches experiences and interests
4. Supervision mix of formal and informal various methods
5. Staff meetings excellent way to check in with staff group
6. Engage staff in team meetings

7. Varied supervision times needed
8. Team Leader connection between team and clients
9. Problems go to TL for resolution, client issues seen in incident reports
10. Connection is unique between staff and clients
11. Long time staff calm confident
12. Staff who work well are confident and does not depend on seniority
13. Supportive, respectful, treat as equals
14. Outings in community, treat with respect, flexibility in approach
15. Need for structure and balance between support for other staff
16. Behaviours not seen with long time staff, little hands on training then for new staff
17. Staff sometimes default to long term staff with confidence instead of training
18. Staff have friendships can be positive or negative
19. Key worker more accessible therefore staff go to person first
20. Team Leader & Key Worker have supervisor meetings to establish consistent approach
21. Changes in leadership causes stress, must get to know each other, respect staff experience
22. Connect with staff and participants on decisions
23. Process for escalating staff issues in place
24. Standard written information for staff is beneficial
25. Goals of person is key, very individual and measurable
26. Conversations are key to knowing goals
27. Staff meetings are collective, must be flexible given staffs schedules with commitment to communicate regardless
28. Crisis plans & rights restrictions only in place where needed and reviewed with collaborative approach
29. On call assist with debrief if needed
30. Direct feedback given on Incident Reports for all staff to see
31. Personal Outcome Measures reflected in staffs interactions, recent shift
32. Balance of all job functions even with passion-person centered (eg documentation)
33. Working interview assists with clients having say and team input before hiring
34. In house training important before working alone
35. Staff speak on behalf of participants, help with interpreting
36. Organization strong in training
37. Importance of trainers to engage learners with various methods to teach
38. Training needs to be entertaining and meaningful
39. Feedback very helpful,
40. Availability to staff after training important if want true consistent culture shift
41. Rights needs balance with knowing person
42. Mandatory training can be seen as negative vs enticing staff to want to attend, may hinder buy in factor
43. Ability to sit with staff to ensure timely transfer of learning is compromised by lack of time

44. Technology good way to get a hold of Team Leader to communicate due to limited availability, also good for training options
45. Evaluations of staff are under review, needs more specific things and guidelines for following up on set goals
46. Written communication is key amongst staff
47. Leaders great if direct, available, approachable, genuine interest, supportive, encouragement to learn new things.

Direct Support Staff Unit B:

1. Word of mouth brings people to work
2. Training before starting shifts is beneficial
3. Need to know where all staff are coming from
4. Variety of different cultures =different expectations
5. Different staff have relationships with clients
6. Seniority plays role but also different staff personalities
7. Natural leaders
8. Trust training more depending on other staff individuals
9. Prefer working in teams for back up, someone else can take over
10. Constant vigilance needed at all times
11. Disruptive behavior effects other clients, staff, self
12. Working alone means trying to maintain control
13. NVCI not helpful with new person
14. Benefits of cross training equals more information
15. Supervision happens when shifts cross or staff meetings
16. Familiarity between staff leads them to go to those automatically
17. No set time to discuss training at work
18. Individual years of experience seen as positive
19. Behavior system =extra work, with helpful assistance in follow-up
20. Previous experience prepares staff
21. Constant supervision
22. Staff need compassion, want to work in that field
23. Clients can't do anything for themselves
24. Honesty is key, no stealing, trust in team
25. Go beyond call of duty, willing to jump in, do fair share,
26. Equality with leaders, be available
27. Training should be simple, clear, fun, safe to ask questions
28. Consultants ask for team input, listen, make a difference
29. Organizations be appreciative, don't just expect, say thank you
30. Challenging job, lots to do
31. Need to have good team to get everything done
32. Previous work in nursing homes helpful and background in disabilities
33. Go to staff with most seniority
34. In house training from leader is very helpful, cannot pick it up at once so time helps. Not the same as sessions

35. Leaders always available to help with training questions, leads by direction, staff meetings
36. Communication based on tasks
37. Training helpful with direct hands on approach, based on experience
38. Staff should love their work, patience, smiling
39. Enjoy time with clients, identify strengths
40. No longer comfortable working alone due to new client, back up from others
41. Follow process and the boss
42. Better if staff all hear consistent message at staff meeting, written messages because words get lost
43. New mandatory training is needed even if been there awhile
44. Benefit is same for team so learn from others if have not attended
45. Mandatory training benefit is you get paid and still learning
46. Important to follow direction
47. Training offers hands on but also books for follow-up
48. Teamwork is important with good partner to rely on
49. Home is busy=more reliance on each other, sharing, respect
50. Stress can be co-worker more than client
51. Enjoy work but can be stressed by partner
52. Leaders need to still work as team, ask questions, frequent contact
53. Behavior is stressful when not knowing person
54. Staff will naturally choose the easy place
55. Injured at work an issue even if accidental, unpredictable
56. Key worker has extra role as role model and provides direction
57. Knowing when to step in, assessment phase based on experience/confidence
58. Adapt to team without compromise, direct and learn from others
59. KW is between staff and TL
60. Experience plays role
61. People smart different then book smart however always benefit from training to be prepared for all jobs
62. Petty arguments is a problem
63. Team does the extra, does not sat ‘not my job’
64. Culture of home is different in each place, some staff not cut out for different places
65. Very difficult job, busy = no time for discussions of training, very rushed
66. Staff meeting is brainstorming ideas, needs for each client, team decisions best = fairness
67. Need to be a team for residents=effects quality of life, must be about participants
68. Live up to standards of neighborhood = pride
69. Organization helps to reduce negativity
70. Direct approach with each other otherwise to TL
71. Need to follow through with a duties
72. Staff must be available, meet people’s needs, help each other
73. Good fit with participants
74. Leader must respect and listen to the team
75. Organization needs to be fair, consistent

76. Personalities want to over control, all have something to share
77. Important to all work together, earn from each other
78. Experience from other places of work
79. Learn from training vs others=diluted information, staff wants to train their way
80. Need to be interested in job, not money, want to do more.
81. Complications between staff effects clients, whole lives

Supervisors Unit B:

UNIT B Leaders:

1. Positive of clients who know each other; history of living together, getting along
2. Significant communication deficits with increased personal care, dependent, medical based needs
3. Home has similar needs to personal care home
4. Staff are caregivers, nurturing group
5. Matched based on needs of the people
6. Working interview attracts caregiver type
7. Word of mouth also could draw staff types
8. Recruitment based on schedule structure dictated by participants needs
9. Careful to not burn out staff
10. Many staff with smaller positions, work elsewhere
11. New client means changes in schedule, new skill set for staff with more aggression
12. Increased staff stress with new person, different needs than others
13. Recent retention issues due more to lifestyle changes (eg. promotion) previous stability
14. Turnover with new leadership styles
15. Match of staff depends on what they are looking for, based on common interests
16. Solitaire type activities based on clients
17. Matches and placing also done by leaders during interview
18. Match to culture, needs of people
19. Match of key workers to participants, staff and team leaders
20. Match team leader to coordinator, coordinator not necessary to staff or participants
21. Benefit of centralizing all documents in homes, benefit to all staff
22. Supervision mix of formal times and informal, depends on need
23. Connected in many ways during each day
24. Organized staff training to needs of home because need to be able to implement.
25. Sessions of additional training modified easily based on new needs within home
26. Training facilitated well when have interests in topic, natural fit
27. Past experiences and education helpful to leader roles

28. Orientation and training sets standard, share values, expectations
29. Communication is key; team is new group so struggling currently
30. Learning about each other will help with communication
31. Key worker will help match to team needs and to team leader
32. Offer consistency, role model
33. Communication lacking with stronger personalities
34. Team leader assists with medical, family, good director
35. Behavior tech matches needs of home
36. Organization offers variety to match needs of staff
37. Leader identified need for Behaviour Analyst as some clients have persistent behaviours meant more work for staff
38. Limited socializing for staff with need to be more attentive to clients
39. Retention issues =challenging behavior causes underlying tension of unpredictability
40. Always on guard = stress breaks people
41. Staff try to reduce stress and pressure
42. Change in leadership causes stress, different expectations, styles=loss of trust
43. Leadership training helps with theory but not functioning
44. Staff do not know each other so testing each other
45. Seniority of staff and plays role if leader new to home
46. New client caused stress due to not interested in working in home with behaviour
47. Difficult to fill shifts with new behaviours, outside of scope for staff, not what I signed up for
48. Try to balance competing demands=participants, leaders, systems, parents and staff
49. Skill set for nurture different then behavior, not a balance
50. Different reasons people are attracted to different jobs/roles
51. System pressures reason for placement, everyone pays a price, rollercoaster for everyone
52. Staff supervision only by shift overlap, use of technology, monthly staff meetings
53. Not all training based= personality, previous life experiences, work experiences
54. Training and Behaviour Analyst seen as extra work
55. Skill set of staff need to include initiative, rationale, independent thinker approach helps with team decision making
56. Key is the ‘heart’, not training and education

APPENDIX O

Aggregated Categories

Aggregate categories from the Direct Support Staff Unit A:

1. **Approachable Leader:** Key worker (KW) is first person to approach when issues arise because they work alongside. Next in line to TL. Easily accessible. KW has added administrative duties. KW primary contact for assessing fit of new staff. Will provide feedback after watching interaction with participant first. Interprets behavior of participant and gives feedback accordingly. KW takes on extra work with newer staff will assume or keep responsibility to self. 'Easier if I do it myself'. Sometimes need to 'work around staff'. Depends on how they (staff) 'feeling that day'.
2. **Honest Communication:** with staff only important if new staff decides to stay. Importance of upfront, honest approach during in-house direct interview what to expect (eg. yelling, spitting). Lots of in house training as new staff frequently do not stay. House is like a 'stepping stone' to better jobs with less stress. Example of 1 staff crying in the car prior to every shift. Agency always hiring therefore always able to fit somewhere.
3. **Knowing**: Introduction of home is recalled as more physical and stressful at beginning with a definite transition period before comfortable. Those with previous experience able to establish themselves quickly by asking questions and taking the lead in making recommendations.

4. **Confidence:** Respect for those staff who are ‘motivated’ and ‘have a strong work ethic’ and not timid. Important to ‘ask lots of questions’ when new then become more successful.
5. **Social Interaction**: ‘Lead by example’. Supervision is more informal so discuss as needed. KW will know what is going on first. Informal debrief occurs ‘after hours’ for a drink, hang out as friends. Use of technology also assists. Develop friendships within team and issues are worked out through those relationships. Can ‘cross a line’ at certain points, don’t want to talk about work all the time. TL also available via email.
6. **Person-focused:** Primary needs are ‘guys first’ – need to understand non-verbal body language to understand their needs. Look for reaction, subtle communication which needs experiences between staff/participant. ‘Reading body language’. Match of staff seen as most important especially negative when not a fit to participants needs.
7. **All On Same Page**: stated by every staff. Consistency in approach is key via importance of sharing at staff meeting new ideas from training, brainstorming ideas. Team helpful in providing different ideas, collective imagination with need to ‘compromise’. Use of communication logs, etc. viewed as important. All ‘young’ not based on seniority, based on best ideas for participants. If 1 staff does not follow through due to lack of experience or limited shifts in home etc. can cause confusion. ‘1 person can crack the chain’ leads to inconsistency. If stress between staff is happening can be noted within communication book.

8. **Teamwork:** Quality of work is dependent on group effort and compromise. Will result in leaving workplace even if staff actually enjoys the participants. Team dynamics just as important as right match to participant. Some staff despite training just ‘not right match’ to home. ‘Not fair to participants’ and when not a natural fit, both staff and individuals pay the price.
9. **Conflict in team:** Stress of not getting along with others can be significant, tense situations between staff and within work environment. Can remain unresolved even if used avenues of going ‘up the chain’. If home is staffs’ work environment then stressful home as well for individuals. Working in team can be stressful within a ‘small physical setting’. If staff not motivated, then need to work around. Difference when working alone is know you are responsible, therefore get it done.
10. **Routine:** Process of adding structure, following routines and assigning duties to homemade situation between staff more solid within this home. Could be uncomfortable for new staff if they do not know what to do. Need leadership to set tone and establish level of interaction and responsibility. These have changed things for the better, noted by every staff.
11. **Training:** Some training makes no sense to real situation. Seems to be geared to higher functioning people. Different in this home as relying more on non-verbal behaviour. Training less applicable to non-verbal. Behaviour training etc. NVCI not relevant to home relying on verbal again. More important to know the individual and triggers. Mandatory training can be seen as threat to keeping employment, time consuming. E.g. Staff not sure if involved in SBMT or

provided. Staff can't remember training information and may have 'tossed' workbooks. Little reference to binders after being in home for awhile.

12. **Transfer of Training into Workplace:** Training is seen as general, 'an overview', 'vague', gives 'ground rules' and a 'good base'. Need to make leap to location even if not directly related right away. Benefit of experience to properly have context to apply training. Staff feeling *overwhelmed* with new info plus learning participants. Others feeling *underwhelmed* because info feels 'dumb down' need to consider previous work experience and previous training and previous post secondary training. Post secondary sessions have also added value to work etc. Understanding of diagnosis, behaviours, etc.
13. **Access to Trainers**: Positive of ability to check in with Training Coordinator. As well, positive of follow-up with internal trainers and Training Coordinator able to be point person if follow-up needed with external trainers. Leadership wants to take more training but cost prohibitive. Take what is free and available.
14. **Connection with Leaders**: need to be more involved, know the client, know the staff and struggles. Effective leaders make decisions and take lead. Understand time constraints may limit ability for leaders.
15. **Connection with Organization**: need to be interested in staff/people, the 'personal touch is important'. Staff realizes the constraints of time for people but still viewed as important. If staff doesn't feel valued, known to organization then morale drops and quality of care. Organizations with good morale make staff want to work there. Most staff came via 'word of mouth', good reputation.

16. **Connection with Consultants**: Important for consultants to treat place like home and respect individuals and staffs' collective input. Enjoy direct training from specialists with ability to problem solve on the spot and try out. Level of 'buy in'.

Initial aggregate categories from the supervisors Unit A:

1. **Connection:** Long term relationships between senior staff members and the individuals who live in the home seen as above and beyond the typical quality of support and commitment seen in other settings. Connection is key.
2. **Knowing participants**: Longevity of staff is positive as they truly know the participants and see that long term staff have the ability to move up (i.e. Key Worker).
3. **Person centered:** at all times, treated as equals. Laid back approach matches needs of participants. True advocates for people, protectors.
4. **Match for participants & staff**: Need to be willing to learn and important to be flexible, have enough staff to do individual activities that interests each person.
5. **Confidence:** Staff that act with confidence have better success, not necessarily related to seniority. Some staff tend to struggle more. Some staff typically defer to regular staff vs. integrating training. Confident staff no longer need to rely specifically on training so newer staff don't see 'modeling' behavior.
6. **Balance of duties**: importance to balance other administrative duties not related to direct work (i.e. documentation, etc.) However difficult to criticize if priority is Person Centered support.

7. **Connection between staff:** Staff know each other well and typically go to key worker first as work different shifts and overseeing more than 1 home. Mandatory supervision between Team Leader/Client Case Coordinator meet every 2 weeks, Team Leader and Key Worker meet weekly. Monthly staff meeting with staff and Team Leader. Difficult to supervise directly with workload however try different technologies to provide timely feedback.
8. **Consistency:** Process of collaboration with all staff important for buy in to program. Defer hierarchy with emphasis on team instead however defer to team who actually knows staff, trying to be on same page.
9. **Training**: Gap between training and then reality. Follow-up is best in staff meetings so all hear and collectively problem-solve on how to implement. Use of team as they are the local experts. Team Leader attempts to review however this is not stated explicitly as part of follow-up and time is limited. External opportunities are accessed for leadership teams.
10. **Connection to Training**: Is part of leadership role and seen as positive when interested in being involved. Try to put self in learners shoes when training, not boring or overloading. Make connection to actual scenarios. Want feedback from training style and able to follow-up. Strength of being an internal staff as able to connect afterwards. Possible negative connotation of mandatory training. Better if staff are motivated and have an interest.
11. **Person Centered**: Philosophy and values are integrated in all classes from the beginning. Sets standard from the onset.

Initial aggregate categories from the Direct Support Staff Unit B:

1. **Connection:** Key Worker role is very specific additional role between staff and the Team Leader. Approach is to learn from others as new to that home to adapt to needs of staff.
2. **Knowing each other**: Social aspects of work important, especially with different cultures need to understand each other and know likes and dislikes. Culture of workplace needs to be understood before making changes. Do the best work possible.
3. **Taking care**: Staff report they need to do everything for residents, 'can't do anything'. Importance for staff to get together and work collectively on all things in the home as staff must be available and ready at all times due to unpredictable nature. Need to make life good for participants e.g. of house looking nice and fitting into the community, outings, participating in community as much as possible. Know how to do basics of job, e.g. cooking, hygiene.
4. **Previous Personal Experiences**: in other work experiences e.g. nursing, physical therapy, personal care homes very useful and beneficial to working in this home.
5. **Home is also Workplace:** need to take pride. Live up to the standard of the neighborhood. Staff signs up automatically for extra physical chores to ensure home is presentable.
6. **Communication:** in a direct manner is difficult at present. Often defer to leaders. Written documents such as logs, communication books seen as a good method to track and keep staff up to date.
7. **Match to participants**: Some staff deal better with certain types of clients and each has a role. Not all cut out for working with aggressive behavior. Staff

preferred overnights previously. Moved to evenings because weary working alone with new individual. Need for team back up if behaviours increase.

8. **Influence:** Seniority has a major role but stronger personalities also have significant influence. All staff has knowledge of clients and needs to be considered.
9. **Training:** Staff rely on training more than other staff. Training offers the right way which may be diluted or different way or 'bad habits'. 'Rather get from the source'. Some staffs personalities 'overpower'.
10. **Team Conflict:** Good work day depends on who you are working with, also who you can depend on for assistance in risky situations. Sometimes easier to work alone. Varies from 'I love my job to I hate my job', depends on other staff. Stress is from other staff more so than participants. Stressful work if staff is not doing their part because 'there is lots of things to do', more tired. Mention of direct stress within home of "power struggles", 'not all respect authority'.
11. **Norm of Setting**: Would not be a good job for young staff as always need to be alert = no time for texting etc.
12. **Consistency**: Input from Behaviour Analyst needs to be documented so all staff receive message. All need to be consistent and follow the plan to reach the goal.
13. **Conflict affects Participants**: Staff needs to make home better because it is only work for them but for participants it is their home, going to make life hard for people who live there. Something is missing, need good environment 'we are only there for 8 hours'.

14. **Unpredictability**: Challenging behaviour of having to deal with individual who is demanding, not following schedule/routine of home. Lots of hygiene issues, total supervision ‘could get into anything’. ‘Very hard home to work in’. ‘Hard if it is too much behaviour’. Can be injured at work even accidently with some behaviours ‘just the way they are’ due to unpredictability.
15. **Knowing:** At first it is hard to get to know clients, once you know, you can deal. Important of knowing people.
16. **Lack of Connection in team**: Strength of team is based on amount of experience and individual strengths. Good to have team approach, need to be able to trust each other, respect, being fair. Major negative seen with back stabbing = no trust. Need to be on time, reliable as people need you to be there.
17. **Person Centered**: Best staff has compassion, patience, want to work with these people not for money, interested in people. Honesty +++ across the board, go beyond call of duty. ‘Proud to work with them’. Wanting to give back and help others.
18. **Connection with Leaders**: Best if leader attempts to work alongside but still direct as needed. Leader role models but learn from the staff as well. Should be able to jump in when needed, all equal not too bossy, respectful. Available= always have phone etc. when needed. Listen to both sides of issue. More hands on. Needs to be ‘professional’, responsive to all needs.
19. **Transfer of Training**: Difference between ‘people smart and book smart’. Training seen as different then trying to be ‘book smart’. NVCI seen as relevant, good info on personal space, etc. not on restraint but can be helpful in other

homes. Despite 2 day NVCI, never use physical restraint in this home. Has used before in other homes and found useful/applicable. Knowledge is good but also seen as not relevant by some staff. Facilitators need to break information down to being understandable. Make situations real, hands on, applicable with real life examples, honest knowledge. Want to have fun, learn more, safe to ask questions. Discussions at staff meetings involve timing of training sessions not how to apply. Little follow due to being very busy with constant care and a lot of paperwork and discussion on behaviours.

20. **Team training**: Training opportunities from St. A are seen as positive and more so then other work places. This includes both in house training and sessions. If cross trained, may have to catch up with training even after a set amount of time, seen as not necessary. Also hear about content from staff who have attended.
21. **Connection with Consultants**: Specialists need to really listen to what staff are saying. Need to make a difference. Include staff into 'team' approach.
22. **Connection with Organization:** need to appreciate, say thanks not just expected. Internal connections between leadership mean potential conflict of interest. Staff need to be careful around these connections as perceived as negative. Positive is good pay and benefits.

Initial aggregate categories from the supervisors Unit B:

1. **Connection between staff and participants**: Need to match needs and interests of participants to needs of staff. Need to match staff to the participants in home. In order for Key workers to be chosen, even with seniority, still need to fit the needs of home including staff and participants.

2. **Connection between leaders:** Client Care Coordinator matches leadership style to the needs of the Team Leader not necessarily to the home. Team Leader and Key Worker are more involved directly.
3. **Matching styles**: Behaviour Technician assigned to Unit B is well suited for staff styles. Different behaviour technician at Unit A who also matches that staffs style. When training, would attempt to match needs of staff within one home.
4. **Communication:** Streamlining of communication methods internally to CRP has helped with staff who are moving around for more consistency. Formalized supervision between leaders not always required as many other ways to communicate and connect throughout the work day. Staff and team need to be nurturing with good communication.
5. **Connection:** learn about each other = personal connection. Team Leader is more hands and be available for medical appointments, consults, etc. Connection to family members and systems. Key Worker needs to bridge the gap between staff and Team Leader. More stress seen without Key Worker is not around for both supervisors and staff. Integral piece is role modeling for staff. Technology to assist with accessibility and communication is seen as helpful.
6. **Training & Personal Experiences:** Involvement in training is seen as positive if interested and knowledgeable in topic even if not comfortable with leading sessions. Positive of having the opportunity to set the stage and expectation from onset with specific sessions. Positive of Personal Outcome Measures to ensure staff buy in and understand need for person centered programs. Also heavily involved in ‘in house’ training.

7. **Staff Experiences**: Previous background of staff who work in Personal Care Home seen as helpful within this residence. Used to challenges that are more indirect, accidental (e.g. self injurious).
8. **Inconsistent match to staff skill set**: New introduction of challenging behaviours has upset staff as this is not their background or expectation. Staff uncomfortable with new situation. Does not match nurturing ability.
9. **Unpredictability:** Need to be on top of all things going on in home based on constant supervision needs of residents. Unpredictability results in stress of being in perpetual awareness that behaviours can escalate even if they rarely do. Seen as the most stressful piece and the ultimate breaking point for staff. This also affects participants who may increase behaviour then as a reaction.
10. **Transition:** Recent move for leader means change in supervision style. Different expectations have caused strained relationships. Shift in thinking with less connection. Combination of new leadership and new behaviours causing stress.
11. **Transfer of learning**: Previous training identifies group as beginning to 'storm and norm'. Training does not provide techniques on how to help with little application into 'real world' practice.
12. **Balance:** of needs of staff with residents and applied to agency standards, difficult to facilitate all of these things and balance. Sometimes these are competing interests. Try to make life easy for staff as that will in turn make life better for individuals living in the home. New behaviour also means more difficulty with balancing time to role model for staff with new behaviours,

training new Key Worker and linking with family & Behaviour Analyst can be pulled in all directions.

13. **Constraints of system:** new person is not a good fit for home but limited other resources in system. All acknowledged not a fit. Introduced culture of a personal care home with matched staff (compassionate, caring, attention to hygiene) and now expectation of culture required for behaviour home (harder edged, no backing down, consistent approach with expectations).
14. **Shift in Expectations**: Staff saying this is not what I signed up for, chose to work in this environment and now changed it. Roller coaster for everyone. Not their skill set or comfort zone. New mandatory extra training also then seen as not helpful at that point (recent change to 2 Day NVCI, and SBMT). ALL = extra work = extra stress.
15. **Personality:** Job is complicated and cannot be addressed fully by training. Need to have right fit of basic personality, need the 'heart' in the work. Strengths of team is that different perspectives are being brought in (positive of staff turnover). Addition of Key Worker there to ensure consistency in approach will decrease stress. Key Worker seen as integral to bridging gap between the team.

APPENDIX P

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APPROVAL CERTIFICATE

December 7, 2010

TO: **Charmayne Dubé** **(Advisor B. Temple)**
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2010:125**
"Supporting Adults with Intellectual Disabilities who Present with Challenging Behaviours: A Cross-case Analysis of Knowledge Uses and Practice"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

APPENDIXQ

St.Amant

St.Amant
Decision of Research Access Committee

A local committee consisting of:

Name	Position
Dr. Angela Cornick	Director ABA Programs and Psychology Services
Ms. Leanne Fenez	Director, Community Residential Program
Dr. Carl Stephens	President & CEO

Has examined the research access application

Titled: **Supporting adults with intellectual disabilities who present with challenging behaviours: a cross-case analysis of knowledge use and practice.**

Proposed by: **Charmayne Dube and Dr. Beverley Temple**

And considers it to be acceptable for conduct within St.Amant.

Date: December 10/2010

Review Facilitator: Dr. Carl Stephens Signature: Carl Steph

* Please see the comments of the second reviewer.