

Increasing The Efficiency Of Program Status Reporting By Residential Direct Care Staff

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Abstract

In large residential treatment centers for adolescent youth, program administrators and clinical staff rely on the information imparted to them by direct care staff to make appropriate decisions regarding administrative and clinical support functions so that the residents in care can receive the best treatment possible. This study was designed to increase the efficiency of program status reporting by direct care residential staff in a large residential setting serving an average daily census of 95 youth residing in four distinct residential programs: including programs for sexually abusive adolescents, sexually reactive adolescents, adolescents with anger management problems, and a latency age children's program. Staff were trained to implement a 13 item checklist specifying key information such as the number of critical incidents, physical holds, family contacts, completion of scheduled unit activities and completion of required documentation at the end of each residential shift. Direct care staff were trained to implement the status report protocol using a staff management package including antecedent procedures consisting of instructions, role-playing and feedback on the use of the reporting protocol and consequent procedures comprised of written and verbal feedback provided by a supervisor to staff on a weekly basis. The feedback given to direct care staff consisted of the percentage of items they reported correctly from the 13-item status reporting protocol. The staff management intervention package was assessed employing a multiple baseline design across the four programs. Reliability data were collected on an average of 58% of the reports given by staff during baseline and intervention. The data indicated that the staff management package was successful in increasing the efficiency of program status reporting by direct care staff.

Keywords, adolescent resident treatment, antecedents, program management.

The design and successful operation of social technologies such as residential programs for children and youth are guided in part by legal policy, judicial decisions, governmental regulations, and standards set forth by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA) and Commission on Accreditation of Rehabilitation Facilities (CARF). It is noted that the "application of legal policy may affect any aspect of human service, in intervention design it generally entails at least the specification of guidelines involving client rights and practitioner, agency, program, or institutional responsibilities." (Thomas, 1984, p.128). For example, the Massachusetts Office of Child Care Services (OCCS) specifies clear guidelines for the documentation and reporting of restraints and critical incidents involving clients residing in residential programs for children and youth.

Group care facilities write agency policy and procedures to bring their youth care practices into compliance with licensing regulations. In turn, these policies and procedures are taught to staff so they can implement them with the residents in their care and insure that the organization adheres to appropriate legal policy set forth by licensing and accrediting agencies. However, even if a residential program adheres to licensing requirements, this does not imply that the program is providing quality care, particularly if licensure is not based on naturalistic observations of staff and client behaviors (Repp & Barton, 1980). Even organizations

that are successfully certified via procedures such as the federal Medicaid program survey process cannot be successfully discriminated from agencies that are not certified, particularly in regard to the treatment of clients. In addition, a reactivity analysis of one such survey indicated that direct care staff performed differently during the survey by increasing interactions with clients and decreasing non-work behavior. It is also been noted that when provider agencies are polled regarding the consistency, accuracy, and objectivity with which survey teams determine agency compliance with accreditation and certification guidelines, they report considerable variability in the assessment of standards by accrediting agencies (Reid, Parsons, Green, & Schepis, 1991).

One possible explanation for the inability of policies and legal guidelines to consistently occasion appropriate staff behavior is that they function as antecedent management techniques in the form of instructions to staff. Memos, public posting of responsibilities, scheduling of staff assignments, specification of policies, goal setting, general explanations regarding what a job entails and specific instructions detailing what a task involves, where it is to be done, when to do it and with whom are all examples of instructional techniques often employed to occasion desired staff behaviors (Andracik, McNamara, and Abbott, 1978). In spite of the fact that instructional methods are among the most commonly employed techniques for managing staff behaviors (Madle, 1982), little behavior change results from these methods (Iwata, Bailey, Brown, Foshee, and Alpern, 1976). Generally, the use of instructional techniques alone produces no change in staff performance (Quillitch, 1975), minimal change or short-lived change (Pommer and Streedbeck, 1974).

It is not surprising that job performance is not greatly affected by the exclusive use of traditional instructional methods. Instructional methods for motivating staff performance may be considered as unreinforced instructions to staff and as such would not be expected to exert a powerful effect over their performance (Ayllon and Azrin, 1968). Instructions will control staff behavior if they are followed-up and reinforced through other management techniques like performance based feedback (Kurtz, Lutzker, Cuvo, Eddleman, Lutzker, Meagson, and Gulley, 1982).

The value of instructional procedures is that they help to set the occasion for the effectiveness of other staff management procedures like performance based feedback (Seys and Duker, 1978). In addition, instructional techniques that specify desired work behaviors make it easier for managers to monitor the occurrence of these behaviors (Risley and Favell, 1979). Even though instructional techniques alone have shown little positive impact, they are a desirable and necessary adjunct to other more effective staff management procedures (Connellan, 1978).

The previous discussion underscores the necessity for supervisors to monitor, follow-up and reinforce those behaviors that have been taught to staff through antecedent performance procedures such as modeling, role-playing, prompting, verbal instructions, memos, goal setting and publication of organizational policies. Unless follow-up occurs, it is unlikely that the time and energy invested in the use of these various procedures will result in desired changes in staff performance.

Effective models of staff management consist of multifaceted management procedures in which a large number of different techniques are combined into a maximally powerful intervention package using resources indigenous to the organization (Ivancic, Reid, Iwata, Faw, & Page, 1981). Previous research in residential settings has established the efficacy of staff management packages for imparting such diverse staff skills as nutritional practices in community-based group homes (Kneringer, & Page, 1999), student participation in functional activities (Dyer, Schwartz, & Luce, 1984), and direct care staff teaching behaviors (Page, Iwata, & Reid, 1982). However, few studies have demonstrated the utility of staff

management packages for improving the implementation of agency policy and procedures by direct care staff. The focus of this study was to increase the efficiency of program status reporting by direct care staff in accordance with agency policy and OCCS legal licensing requirements utilizing a staff management package including instructions, modeling, behavioral rehearsal, staff monitoring and supervisor feedback.

METHOD

Participants

Twenty-five direct care staff, in most instances senior counselors, who worked in seven separate units of a children's residential treatment facility served as subjects. These individuals typically worked three days during the week from 2:00pm – 10pm and one weekend day from 8am – 10pm. As the senior lead-on counselor they were charged with the responsibility for giving the unit status report covering events and activities that occurred during their shift, i.e., 10:00 P.M. Verbal status reports by the senior lead-on counselor were made to Program Directors via telephonic voice mail messages at 10p.m each evening at the end of their respective shifts.

Setting

The facility is a ninety-nine bed residential child care facility located in a semi-urban setting in close proximity to a major city in western Massachusetts. The client population consisted of children and youth between the ages of 6 and 17 involved in four distinct clinical programs housed in five cottage settings: latency age boys, pre-adolescent and young adolescent girls with histories of chronic complex trauma, sexually reactive latency age boys, male adolescent sexual offenders, and adolescent males with anger management issues. All clients manifested significant and varying degrees of the following symptoms: behavioral, psychological, interpersonal, psychiatric and neuropsychologic and all exhibit DSM-IV-TR diagnoses. All children attended the center's therapeutic school located on the campus adjacent to the residences, with the program offering a range of special educational services as well as behavior management programs designed to interface with residential treatment goals and objectives. A variety of psycho-educational, psychosocial, psychotherapeutic, psychiatric, and psychopharmacologic treatments were offered depending upon the child's unique situation and need. Mean length of stay is approximately 16 months.

Instrumentation

A 13-item, forced choice (Yes/No) checklist, the Status Report Evaluation Checklist (SREC), was used to capture essential client information needed to insure consistent and effective communication between all shifts. The checklist captures information in relation to first and second shifts: global unit status (excellent, good, fair, poor), number of corrective physical interventions (CPI), critical incidents, (e.g., fights, injuries, AWOL's, etc.), family contacts (visits and telephone), scheduled Unit activities (trips, shopping), and reference of documentation being completed; i.e., incident reports (see appendix A). The SREC was designed to function as a tool to obtain comparative data across staff and programs, serve as a self-monitoring device for staff, and as written record of feedback on their performance (McClannahan, McGee, MacDuff, & Krantz, 1990).

Measurement

On a daily basis Program Directors listened to telephonic status reports via agency voice mail recording made by direct care staff during both baseline and treatment periods and then rated the reporter's effort utilizing the SREC. Results documented the percentage of required information given by staff. An independent rater also listened to a sample (58%) of both the baseline and treatment reports and compiled reliability information. Inter-rater reliability data for the baseline period was 88.77% based on a random sample of 77 reports, while the inter-rater reliability measures for the treatment period increased to 93.36% based on a sample of 121 reports. The overall inter-rater reliability for both baseline and intervention measures averaged 91.07%.

Procedure

A multiple baseline design across settings was used to evaluate the effects of training and feedback. During both baseline and treatment the subjects were unaware of the dependent variables being evaluated.

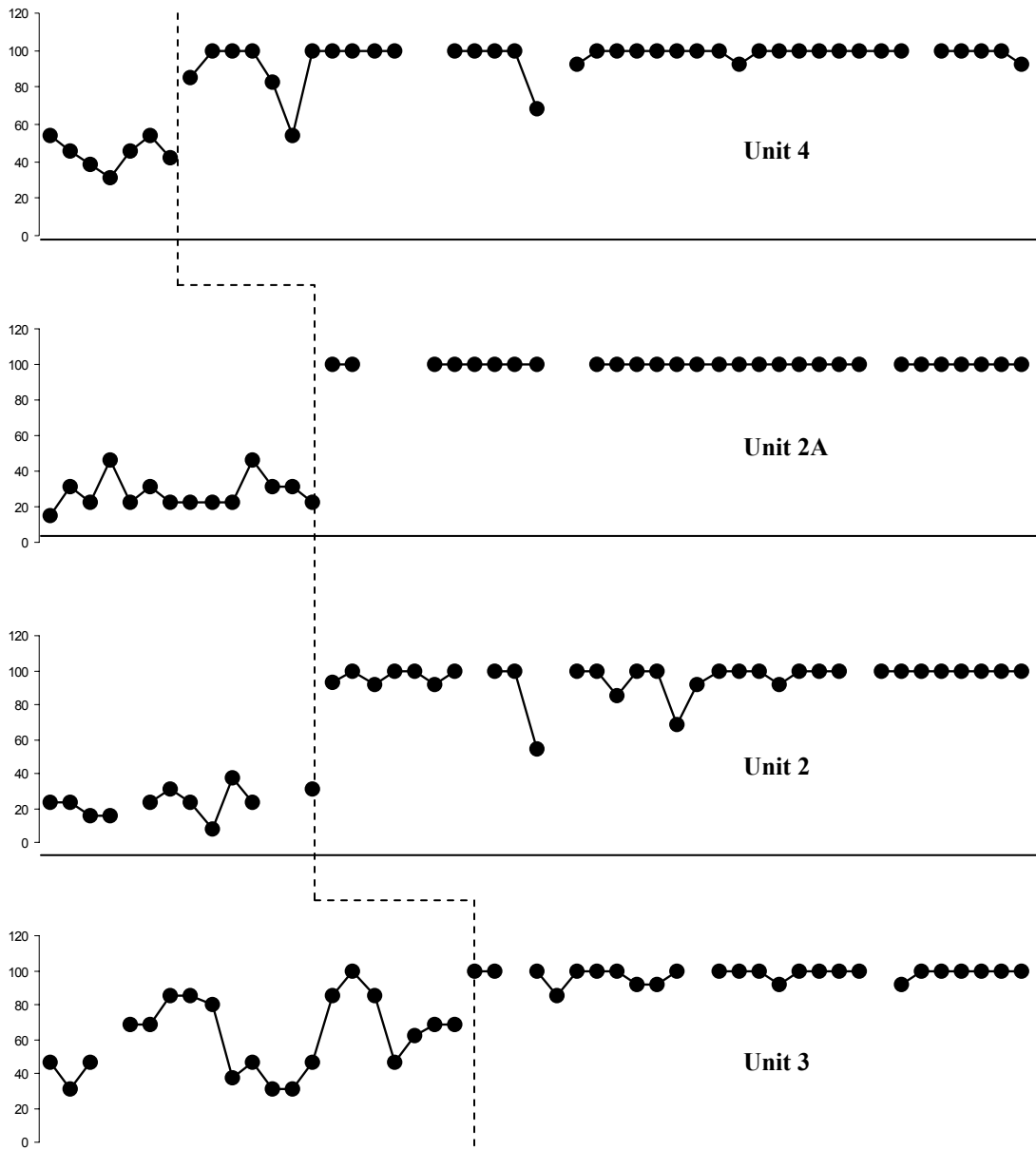
Baseline: During baseline, the subjects followed typical agency procedure for making program status reports (see appendix B for a copy of the agency policy and protocol). No written or verbal feedback was given to staff regarding the completeness or accuracy of their status reports. Baseline measures were begun simultaneously across seven distinct units: units 4, 2A, 2, 3, 5, 6, and 6A.

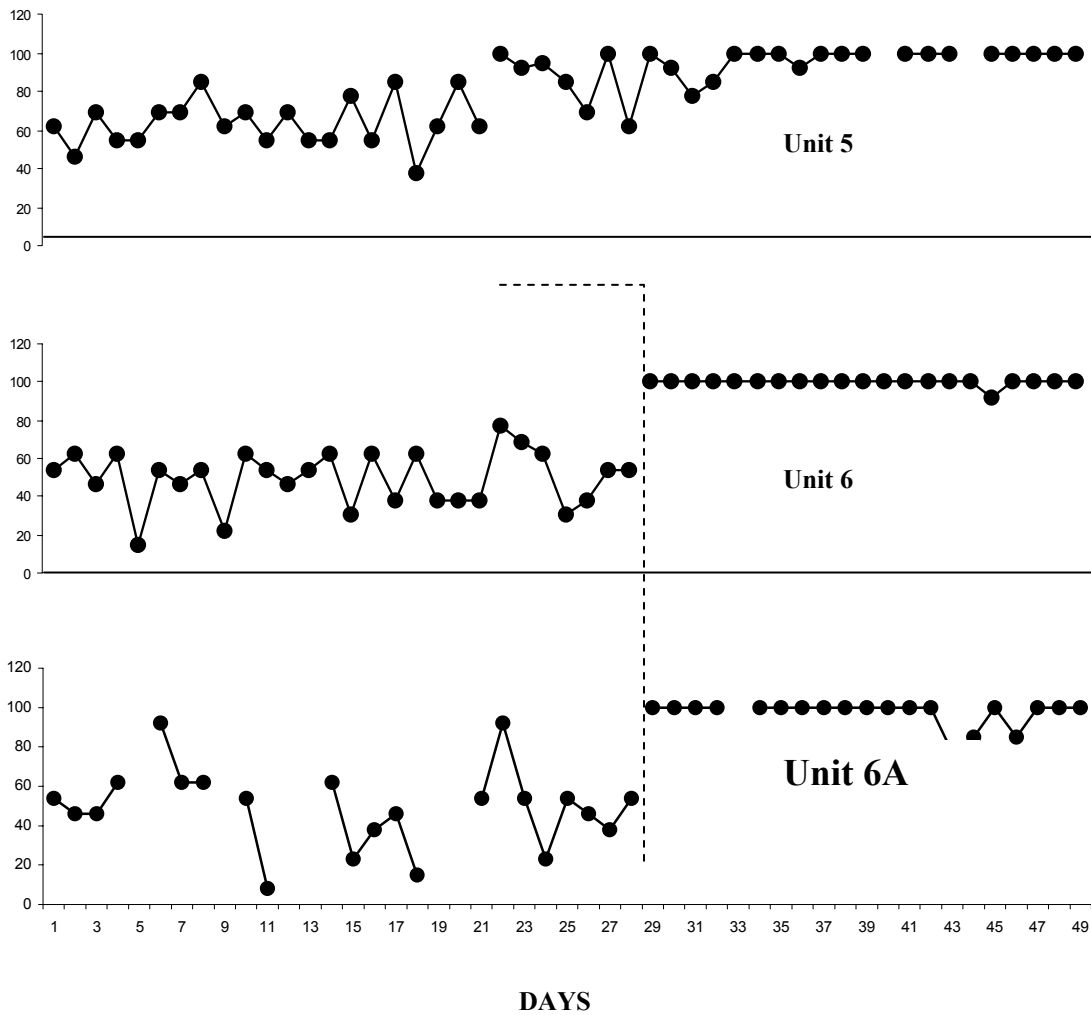
Intervention: A performance management training package was employed to re-train direct care staff on how to make program status reports utilizing the SREC. The performance management package consisted of antecedent techniques including instructions regarding the status report policy and procedure, introduction of the SREC, modeled use of the SREC, as well as behavioral rehearsal and feedback on the use of the SREC. The trainer informed staff they would also receive weekly written and verbal feedback on their performance of the use of the SREC. In addition, staff were given laminated copies of the SREC and instructed to use them to monitor their performance during the reporting of program status reports. Program Directors monitored their respective staff giving status reports on a daily basis and provided weekly written feedback to them in terms of the number of correctly reported items on the SREC as well as verbal qualitative feedback on their performance. The staff management package was implemented across programs and units in a staggered fashion in intervals of one week utilizing a multiple baseline design.

RESULTS

Figure 1 shows the multiple baseline across programs for all seven units involved in the study. All staff behaviors across the four programs improved as a result of the application of the staff management package. The percentage of items reported correctly on the program status report increased from a mean baseline of 45.59% to 97.38% during intervention. Measures for each of the units were as follows: U4 increased from 44.43% to 96.5%, U2A increased from 28% to 100%, U2 increased from 23% to 95.6%, U3 increased from 60.95% to 98.12%, U5 increased from 64% to 94.14%, U6 increased from 49.46% to 99.62%, and U6A increased from 45.49% to 97.38%.

During baseline status reports were missing on 6.8% of the total measures taken. A total of 7.82% of the measures during intervention were missing due to problems with the phone system not working properly, untrained staff filling in at the last minute for scheduled staff who called in sick and unexpected staff call outs from work.





DISCUSSION

A staff management package consisting of instructions, modeling, behavioral rehearsal, staff monitoring and performance feedback was successful in increasing the percentage of items that direct care staff reported via the agency status reporting system in accordance with agency policy and procedure. Even though staff had been previously trained on how to make program status reports, this training was insufficient to impart the necessary job skills. It was only when the staff management package was implemented did staff attain high levels of agency compliance with the status reporting protocol. This study underscores the finding that training alone, especially on agency policy and procedures has limited value in imparting the skills that a policy and procedure prescribes (Ziarnik, & Bernstein, 1982).

The results of this study also call into question the value of outside surveys and reviews as an effective mechanism for insuring program quality. It can be argued that the review process can be conceptualized as a highly organized set of antecedent procedures and as such would not exert long-term control over the staff behaviors it is intended to prescribe and reinforce. Program administrators should not

rely on the feedback from reviewers as an effective mechanism for insuring that staff will carry out recommendations made through the review process. Supervisors need to conceptualize program implementation not only as training and feedback on what needs to be done, but also follow-up and reinforcement on what is actually done (Parsons, & Reid, 1994).

One of the limitations of this study is that it is hard to know what specific elements of the staff management package were responsible for changes in staff behavior. For example, it is not clear to what extent staff self-monitoring via the use of the SREC played in the overall results versus the provision of performance feedback (Richman, Riordan, Reiss, Pyles, & Bailey, 1988). It is also not easy to determine whether the daily feedback to Program Directors on their direct care staff's behavior via the SREC affected the quality of performance feedback they provided to staff (Page, Iwata, & Reid, 1982).

It is interesting to note that two off campus group home programs that were not included in this study spontaneously began using the SREC protocol during the study with no direction or training from supervisors. Anecdotal data indicated that staff began implementing a higher level of program status reporting once the SREC protocol and staff management package were implemented in other programs within the agency. Further study should be conducted to see how direct care staff implementation of policy and procedures can be affected when not directly trained and reinforced.

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