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GEROPSYCHIATRIC NURSING CONSULTATION AS AN ADJUNCT TO TRAINING IN LONG-TERM CARE FACILITIES: THE INDIRECT APPROACH

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Abstract

Creative, collaborative approaches between sub-specialties in nursing are needed to improve the quality of care and, hence, the quality of life for mentally ill and behaviorally impaired older adults living in long-term care (LTC) facilities. Results of a consultation survey collected as part of a larger geriatric mental health training project, and described in this article, support the position that consultee-centered geropsychiatric nursing consultation services are an important adjunct to training. However, this indirect approach to service enhancement may not be well understood and, as a result, not well utilized by LTC nurses. Methods to facilitate understanding and utilization of "indirect" mental health assistance to LTC residents and staff are explored within the context of building productive liaisons among nurses.

The prevalence of mental illness in nursing homes, which affects as many as 80% of residents (Finkel & Denison, 1990; German et al., 1992), underscores the need for nurses in long-term care (LTC) settings to develop additional skills, resources, and professional relationships to assist in the assessment and management of these often difficult-to-manage older adults. Creative, collaborative approaches between subspecialties in nursing, like the one between geropsychiatric nurse specialists and long-term care nurses described here, are needed to address the often multidimensional care problems encountered in nursing homes by both professional and paraprofessional caregivers.

Geropsychiatric nursing consultation in conjunction with in-service training is suggested as one method to improve the day-to-day provision of mental health interventions and management of behaviorally impaired older adults in nursing homes. The value of, and problems associated with, consultee-centered geropsychiatric nursing consultation (defined as technical assistance and case consultation in this project) are set forth in this article.

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PROJECT OVERVIEW AND OBJECTIVES

The consultation services and survey described here were part of a larger training project designed to increase the ability of nurses and nursing personnel in LTC facilities to provide quality care to their residents with psychiatric and behavioral problems. The three-year, three-phase project used a train-the-trainer model first locally (phase 1), then regionally (phase 2), and finally statewide (phase 3) in Iowa. In an effort to reach nurses and nursing personnel in increasingly remote facilities, a two-way interactive telecommunication strategy was employed in phases 2 and 3.

All three phases shared the same overall goals: (1) To train registered nurses (RNs) and directors of nursing (DONs) on geriatric mental health topics related to LTC; (2) to have those RNs and DONs in turn train a minimum of 10 additional staff members in their own facility; (3) to provide case consultation and technical assistance to participating facilities; (4) to provide a forum for discussion of training issues and disseminate new information about geriatric mental health; and (5) to evaluate the effectiveness of the geriatric mental health training program. Other aspects of the project and its evaluation are discussed elsewhere in the literature (Mitchell et al., 1994; Smith et al., 1994; Smith et al., 1995).

To achieve these goals, geropsychiatric clinical nurse specialists (GPCNSs) from a community mental health center (CMHC) developed detailed training materials for use by LTC nurses. Topics for training were selected on the basis of a comprehensive needs assessment of 22 LTC facilities prior to the development and implementation of the training series. In response to identified needs, six core modules were developed on geriatric mental health and illness topics: labeling issues in LTC, effective communication, control and power issues, depression, dementia, and aggressive behaviors. Each module contained all the materials needed to conduct the in-service training programs, including word-for-word lecturer’s scripts, handouts, slides, exercises, and discussion questions, along with detailed training tips.

Using these training materials, GPCNSs trained nurses from LTC facilities in three separate 2-day intensive training sessions (ITSs), one for each phase of training. In turn, these LTC “nurse trainers” used the training information and materials provided in the ITS to train additional staff in their own facility while being supported with case consultation and technical assistance provided by GPCNSs. Over the 3-year project, a total of 200 RNs and DONs, representing 99 facilities across the state, attended the 2-day ITSs offered. These 200 nurses together trained over 1600 additional staff members in their own facilities.

GEROPSYCHIATRIC CONSULTEE-CENTERED CONSULTATION

This article focuses on outcomes related to goal 3 above, the provision of case consultation and technical assistance to nurse trainers and nursing personnel in LTC facilities. The phrases “technical assistance” and “case consultation” were selected over the more accurate but theoretical label of “consultee-focused” consultation (Caplan, 1970), which is also known as “indirect” consultation, because these terms were believed to be unfamiliar to most nurses. Importantly, consultee-centered (indirect) consultation can be delivered “directly” by

face-to-face contact with the person requesting assistance, or “indirectly” via the telephone. Whether in person or over the telephone, however, the focus is on the consultee’s perception of the problem. In this project, consultation was provided both in person and by telephone in phases 1 and 2, and primarily by telephone in phase 3 because of geographic distance. The terms indirect and consultee-focused consultation are used interchangeably throughout this article to describe the assistance provided to LTC nurses both on-site and long distance in which the consultant focused on the *consultee’s* perception of the problem situation.

Thus, the more familiar medical model of client-centered consultation, in which the specialist evaluates, diagnoses, and actually treats the patient, was bypassed in favor of a nurse-to-nurse focused model. Instead of providing direct services to patients, the GPCNSs sought to indirectly influence the day-to-day mental health assistance provided to residents by attending to the problems and needs of LTC nurse trainers and facility staff. The goal was to change staff attitudes, beliefs, and behaviors in the arena of mental health nursing by providing accurate information (via the train-the-trainer process) then assisting the nurse trainer and her staff to better understand and apply program concepts to their resident population (via consultation that centered on their needs and views).

The provision of consultee-focused geropsychiatric consultation as an adjunct to training was considered paramount to the overall success of the project. In the years prior to this project, GPCNSs observed several trends in the training offered to local LTC facilities that suggested something more than training alone was needed to help nursing personnel integrate geriatric menial health principles into their everyday care routines with residents.

The “direct training” method, in which a GPCNS taught in-service education programs in local LTC facilities, typically proved to be effective only for short periods of time or as a stop-gap measure. In the absence of consultation that supported nursing personnel to apply the program concepts to residents’ care, the training too often “stayed in the classroom,” leaving both residents and staff frustrated. However, when LTC nurses utilized case consultation as an adjunct to in-service education programs, they expressed greater satisfaction with resident care outcomes and reported better staff morale (OCRME, 1989; Smith et al., 1991).

Consultee-centered nursing consultation (operationalized as on-site or telephone technical assistance and case consultation) was offered in this project to help nurses in LTC facilities become increasingly knowledgeable, skillful, and comfortable with geropsychiatric principles. The focus of technical assistance (consultee-focused *administrative* consultation) was to reassure and assist novice nurse trainers who were uncertain about the actual execution of the training sessions. Both practical issues (e.g., selecting participants, organizing the sessions to reinforce learning, managing out-of-control discussions) and conceptual matters (e.g., interpreting and/or applying program concepts, assessment tools, interventions, or exercises to residents while teaching) were targeted. Consultee-centered *case* consultation sought to assist the LTC facility staff to translate their classroom learning to the real-life challenges encountered in the day-to-day management of behaviorally impaired residents. Simply stated, the goal was to move learning from the classroom into the

daily care routine. Thus, the assistance provided to nurse trainers and their trainees *after* the 2-day ITS was perceived as equally important as the initial training itself.

Because consultation was believed to be a critical factor in the success of this train-the-trainer model, these services were discussed at each ITS. Technical assistance and case consultation services were explained using simple, descriptive language (as illustrated above), and emphasizing that the service was an integral part of the training project and therefore free. As noted earlier, on-site (in person) and telephone assistance was offered to phase 1 and 2 participants, whereas only telephone services were available to phase 3 facilities, because of geographic distance. To reinforce the availability of consultation services in each phase of training, a minimum of one telephone contact per facility was made by geropsychiatric specialists after the ITS. Although highly recommended and promoted during the ITS and afterwards, use of the on-site and telephone consultation services, like participation in the training and its evaluation, was strictly voluntary.

METHODS

Subject Recruitment

A total of 100 ($n = 100$) nurse trainers (RNs and DONs), representing 49 facilities, were asked to participate in the independent evaluation of the training project, which was conducted by the local university. The consultation survey was one component of the evaluation. Fifty-seven percent ($n = 57$) of nurses participating in the evaluation, representing 63% of the evaluation facilities, responded to the consultation survey.

Instrument

The consultation survey was specifically designed to explore nurse trainers' perceptions of the availability and effectiveness of consultation services offered in conjunction with the geriatric mental health training programs. The terms technical assistance and case consultation were further operationalized as four possible types of assistance. Both open-ended and Likert-type questions were included. Table 1 provides examples of questions asked in the consultation questionnaire.

The questionnaire was mailed to both the RN and DON from participating facilities at the end of their phase of training. To enhance both rate and validity of responses, no identifying information was solicited. Nurses were given the option of remaining anonymous and forms were returned directly to the university, thus providing confidentiality regarding their responses. Results from the three phases of training are combined here for the purpose of comprehensive discussion.

RESULTS

Of those responding, 38% reported using consultation services, 44% reported that they were aware of the services but did not attempt to use them, 11% reported that they were not aware of the consultation services, and 7% did not respond to the question regarding use. Refer to Table 2 for information regarding use of consultation services and perceptions of the quality of services.

A follow-up question was posed to those respondents who reported being unaware of the consultation services: “We mentioned the consultation services in the ITS and made personal phone calls to remind you of these services. How could we have better advertised these services?” Four of the 12 who responded (33%) noted that they did not remember hearing about the consultation service and did riot receive a follow-up telephone call. (The latter point suggests that their cotrainer took the telephone call but did not communicate that fact.) The remaining responses (n = 8 or 66%) suggested that the question was answered in error (e.g., “I was aware that you made personal phone calls to remind us of these services”; “We were well informed about the consulting service”; “I think these services were well advertised”; “No problem”).

A follow-up question was also posed to those trainers who reported being aware of consultation services but not using them. Of die 20 narrative responses regarding circumstances that may have increased the LTC nurses’ use of consultation services, 80% indicated that they would have sought consultation if they or their staff had encountered a problem they felt they could not handle on their own. See Table 3 for illustrations of comments made. The remaining respondents suggested that consultation would have been used if the consultant was closer geographically (n = 2), had more time to talk (n = 1), or if the consultee had “a better understanding of what all was available through consultation” (n = 1).

The 22 respondents who indicated that they used consultation services reported a total of 37 separate consultations. Nearly all of the respondents agreed that the consultation was delivered in a timely fashion (89%), that the consultant understood their problem well (86%), offered them realistic solutions (81%), and that they valued the consultation overall (97%). All agreed that they would use the service again.

Narrative comments on the survey (items 6, 7) also suggested that the consultations provided were generally helpful. As highlighted in Table 4, all of the 23 nurse trainers who responded to the question regarding the effect of the consultation on patient care practices (item 6) observed positive outcomes. Narrative comments indicated that the consultation helped staff manage (he problem behavior more effectively (50%), better understand the resident and/or their response to the resident (25%), find additional resources (12.5%), or simply reassured staff (12.5%).

Finally, six nurses responded to the request to share their thoughts about ways in which the consultation service might be improved (item 7). All responses were very positive, as illustrated by the following comments: “For me personally, I think the assistance given was excellent”; “I ‘m new to the training aspect of nursing and felt I was given every opportunity to grow. We were pleased with the consultation”; “We would like to continue this service. We need to make our long-term nurses more aware of this service”; “Your consultation services were very friendly and informative.”

In addition to administering the consultation survey, records of telephone and on-site consultation services were maintained by GPCNSs throughout the 3-year project. These records indicated that 17 on-site consultations were provided. On-site visits were provided

primarily to local facilities (e.g., those that were within a 60-mile radius of the CMHH) but visits were made as far away as 100 miles. In addition, 127 telephone contacts were recorded by GPCNSs to nurse trainers affiliated with the 49 evaluation facilities.

DISCUSSION

Several themes emerged from the consultation survey data and anecdotal notes maintained by GPCNSs throughout the three phases of training. Each is discussed briefly below. Recommendations for potential changes in psychiatric and geropsychiatric nursing practice are suggested to enhance collegial and cooperative approaches to improving mental health and illness nursing care in long-term care facilities.

Perceived Value of Consultation

First, project staff observed that the consultation services provided to LTC nurses were generally perceived as helpful, in terms of receiving assistance in a timely fashion, feeling understood by the consultant, and being offered realistic solutions to the problem at hand. Consultations were highly valued overall by the nurse trainers and believed to have a positive influence on patient care practices. Of the 111 responses on items that used a 5-point scale (1 = “not at all” and 5 = “very well”), 89% gave the service/consultant high ratings (i.e., “well” = 4 or “very well” = 5). Only 10% rated the service/consultant as being “moderately” helpful, and 1% found the service/consultant “somewhat” helpful. In no case was the service/consultant found to be “not at all” helpful. All nurses who used consultation services agreed that they would use them again, and requests for ideas to improve services were answered with praise. Thus, the vast majority of nurses who used the consultation services had a positive experience.

Anecdotal notes maintained by GPCNSs suggested that the few midrange ratings and comments received (11%) were most likely associated with consultations in which the consultee wanted immediate resolution of a long-standing problem. For example, two consultees sought support from the GPCNSs for involuntary discharge of a patient from the facility (which was not given). In another case, the consultee expected the consultant to “give them an answer” rather than “work through” the problem using concepts taught in the training programs. Some participants held a fairly narrow perception of “solutions” or “resolutions,” focusing primarily on difficult behavior being eliminated, rather than reducing it and/or helping staff feel more competent in managing it. The comment “It helped us to see the cause and effect and resulted in more manageable behavior but did not resolve the problem” noted in Table 4 illustrates this perception. In one case, the consultant noted that the consultee expressed frustration because the geropsychiatric nurse specialist did not provide the facility with a “standard care plan” for the problem. Instead, the consultant asked that the staff apply the program concepts to the development of individualized care plans, to which they responded that they “simply didn’t have that kind of time.” In another instance, the consultant’s recommendations focused primarily on changing staff behaviors (versus resident behaviors), an opinion that was clearly unpopular.

Thus, some consultees appeared less satisfied when the consultant suggested a more involved, proactive approach by the facility and/or staff. This resistance may reflect the need

for LTC providers to redefine their roles to clearly include responsibility for the day-to-day mental health/illness management of behaviorally impaired residents (Curtin, 1993) rather than assigning that role to psychiatric specialists. Likewise, psychiatric specialists may need to be aware of the potential for some LTC providers to shift the onus of responsibility for patient care onto the outside consultant/provider. This phenomenon is consistent with the client-centered consultation framework in which the consultant becomes directly involved in the evaluation and treatment of the person referred. Although that model has merit, the consultee-centered approach is believed to be of greater value in changing the day-to-day care practices of direct service staff within the facility, a matter that potentially improves quality of care for residents and staff morale alike. The emphasis placed on the *consultee's* information base (e.g., "You know the resident better than anyone; tell me what concerns you"), understanding of the situation (e.g., "Your description tells me you're seeing a pattern"), and ability to positively influence the outcome (e.g., "Your response to the resident really calmed him; maybe you should put that strategy in his care plan to help other staff') encourages and empowers LTC staff. Instead of turning to the consultant to "fix" the problem, they become increasingly able to find their own solutions to day-to-day care management challenges. However, this study suggests that psychiatric nurse consultants need to educate and/or persuade LTC nurses to use the nurse consultant as a resource person and facilitator, rather than as a direct service provider.

Underutilization of Consultation Services

The second theme that emerged was underutilization of free, on-site, and telephone case consultation services by LTC nurses. In spite of periodic contact to reinforce the availability and willingness of GPCNSs to provide any kind of consultee-centered support or assistance needed, only a modest number of facilities actually took advantage of the opportunity. Although a total of 100 RNs and DONs from 49 facilities were invited to utilize and evaluate the consultation services, only 22 nurses from 15 facilities reported actually doing so. That is, 22% of the nurse trainers (representing 31% of facilities) participating in the evaluation reported using the free consultation services available to them. Of the remaining nurses, 25% indicated that they were aware of the services but chose not to use them, 10% noted that they were unaware of the services or failed to respond to the survey question regarding use, and 43% failed to return the consultation survey altogether. The last point, response rate, is an important factor in the third theme observed.

Consultations Reported Versus Provided

The discrepancy between the number of consultations *reported* by LTC staff as part of the consultation survey versus the number of consultations *recorded* by CMHC staff during the training project was a matter of great interest. This discrepancy was most pronounced in the second phase of training, when geropsychiatric nurse specialists made periodic scheduled telephone contacts with nurse trainers to reiterate the availability of on-site assistance and to provide "here and now" answers to any questions that they may have had. The fact that 100 telephone contacts and 12 on-site visits were recorded, but only six nurses in four facilities reported using the service, raised some interesting questions.

The overall response rate by facility across all three phases was roughly 63% (i.e., nurses from 31 of the 49 evaluation facilities responded), a respectable figure considering the voluntary nature of the project and the turnover in nurse trainers during the three phases of training (about 25%). However, nurses in 15% of the 49 facilities received specific, in-depth telephone and/or on-site consultation (e.g., beyond the informal contacts made to reaffirm the availability of consultation services and answer “here and now” questions) and yet failed to return the survey. An additional 10% of the facilities dropped out and thus did not respond, and another 12% did not request or use additional services and did not respond.

It is possible that nurses failed to respond to the survey because they were “burned out” on paperwork, a common complaint in long-term care facilities. In another evaluation measure, Barriers to Training, many nurses reported difficulties with competing demands for their time and attention (Mitchell et al., 1994) which supports the idea that non-responders may simply have had no time or interest in filling out another form, in this case, an eight-page survey.

Another possible explanation for nonresponse among the 15% who were known to have used the service is based on the comment of a nurse trainer who repeatedly used both on-site and telephone consultation and expressed great appreciation and satisfaction with the service at the time of contact, yet failed to return the survey. During one visit this nurse noted that she felt “embarrassed” about asking for the geropsychiatric nurse’s help because she was “taught about mental health in her nursing education” and “should be able to do it by herself.” At the same time, she said that she thought that the consultant’s assistance prevented her from becoming “burned out,” that her staff frequently turned to her when they had questions about mental health issues, and that she felt that she had something to offer because of her role as the trainer.

Thus, some nurses may have felt ambivalent about asking for outside assistance, feeling that their request for consultation implied that they were a “personal/professional failure” for wanting additional assistance after the initial training session. This type of role expectation (e.g., “I shouldn’t need help”) is not unlike the stigma many people feel when they are unable to cope with or manage their problems and yet resist seeking out the help of a therapist because it makes them feel even more like a “failure.” As a result, some LTC nurses may need special assistance to see the psychiatric specialist as a colleague and resource person, and to view the liaison as a strength rather than as a weakness. Use of the consultee-centered approach to client-care problems may be an effective strategy to equalize authority and power bases. The consultee-focused model allows the consultant to emphasize and reinforce the consultees’ knowledge of the patient and situation, staff strengths, past efforts, and problem-solving abilities, which communicates respect and recognition of the skills and abilities of the consultee. By using consultee-centered approaches, geropsychiatric nurse consultants may be better able to challenge, inspire, enable, model, and truly encourage LTC nurses (McNeese-Smith, 1993) to facilitate their growth and change.

Definitions of Consultation

Another area of concern, and a possible explanation for the disparity between the number of consultations documented by the CMHC staff and those reported by respondents, was

nurses' understanding of nursing consultation in general, and consultee-centered consultation specifically. A common response to the offer of nursing consultation was to question whether the LTC nurse needed a "doctor's order" for the GPCNS to provide this service in their facility. Because many LTC nurses were educated in programs that did not expose them to nursing consultation, or at a time when nursing consultation was unknown or in its infancy, they may relate to consultation in terms of *client*-centered consultation (popular in medical practice) in which a physician (typically a specialist) evaluates a patient for a particular perceived problem, provides a diagnosis, and actually provides treatment that is needed. Project GPCNSs repeatedly encountered this mind-set, with many LTC nurses initially wanting the nurse specialist to evaluate and treat the "problem" resident.

Thus, a process of education was inherent in this project as geropsychiatric nurses oriented their LTC colleagues to the idea of consultee-centered consultation in which the GPCNS acted as a resource person, facilitator, and problem-solver with the nurse consultee and staff (D. Gregg, unpublished data). This approach encourages consultees to "own" the problem, while simultaneously empowering them to decide upon and implement their own solutions with support and assistance from an expert. The emphasis on "nurse-to-nurse" versus "specialist-to-patient" assistance that required physician orders also reinforced the idea that patient care management in LTC is frequently the domain of *nursing*, not medicine. In all cases this model of consultation was unfamiliar to participants, yet proved to be highly successful when explained to, and utilized by, LTC nurses. Thus, better communication and education about consultee-centered nursing consultation, the various possible roles of the psychiatric nurse as a consultant and liaison, and potential advantages of such assistance to residents and staff alike are needed. This dialogue may result in more productive, collaborative relationships among nurse generalists and specialists working in LTC settings, which, in turn, promotes the day-to-day mental health care of LTC residents.

SUMMARY

Results of the consultation survey conducted during this 3-year geropsychiatric training program support the belief that indirect nursing consultation as an adjunct to training is an important, although possibly underutilized, resource to nurses in LTC settings. Only 22% of the nurse trainers, representing 31% of LTC facilities participating in the evaluation, reported using the free consultation services provided as part of the train-the-trainer project. However, the vast majority of survey respondents who used the consultation services expressed great satisfaction with the experience and all noted that they would use the service again. These findings suggest that better communication and collaboration between geropsychiatric nurse specialists and nurses working in LTC are needed to maximize the potential benefits of such relationships.

To accomplish this, discussion and implementation of the various forms of nursing consultation, particularly consultee-centered approaches, are needed. Psychiatric nurse consultants who wish to develop partnerships with LTC facilities will no doubt need to aggressively advertise, explain, and reinforce the range and type of services they may provide. In practice, client-centered consultation (including resident assessment, diagnosis, and treatment) delivered on-site at LTC facilities may be the vehicle for introducing

additional changes in the day-to-day mental health nursing care practices among LTC staff via the indirect approach. The consultant may need to use this traditional role, which nurses in this project seemed to understand well, to initially engage LTC nurses. Direct services to residents can then be increasingly supplemented with consultee-centered consultation, training, and other forms of assistance. Thus, the consultant can help LTC nurses become more self-sufficient, encouraging them to "own" the everyday solutions to, and management of, psychiatric and behavioral problems, while using outside assistance to support, assist, and facilitate that process.

Redefinition of roles among both LTC nurses (e.g., as a facilitator, liaison, advocate, and provider of psychiatric and psychosocial interventions) and psychiatric/geropsychiatric nurses (e.g., as a resource person, facilitator, trainer, consultant, and role model to LTC personnel) is needed to improve the overall quality of care provided. Exposure to such diverse roles, and to various forms and benefits of nurse-to-nurse consultation, should be provided in basic nursing education programs and further defined, illustrated, and experienced as part of graduate nursing curriculums. In addition, role expansion and redefinition may be promoted among practicing nurses through educational workshops offered by geropsychiatric nurse specialists, articles in the nursing literature, and via the consultation process itself. Whatever methods are employed, however, it is imperative that nurses take charge of the care being provided in nursing homes. As Brandriet (1992) so aptly stated, "long-term care is an arena of opportunities; only nurses can make them nursing opportunities. If nurses do not seize the opportunity, others will" (p. 14). Collaborative approaches between individuals and specialty groups within the profession is one way to assure that nursing "seizes the opportunity" to make a positive impact on the quality of care and quality of life of mentally ill and behaviorally impaired older adults, their families, and staff working in LTC settings.

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Table 1.

Consultation evaluation survey: Sample questions

Four types of free client-centered consultation were described on the consultation survey in the effort to assist long-term care nurses to think broadly about nursing consultation services provided as part of the training project.

1	Assistance teaching the programs (e.g., setting up slides, being present to support the trainer, etc.)
2	Discussion of the program content (e.g., assistance with and/or discussion of issues, discuss interventions, interpret content to your staff)
3	Application of the program material to a resident (e.g., case consultation to discuss problem behavior and interventions or care plan)
4	Discussion of difficult behaviors seen in a resident but not addressed in the program (e.g., catatonic, paranoid, neurotic, or personality-disordered residents)

Respondents were asked to think about their experience(s) with geropsychiatric nurse consultants during the project and answer the following questions:

1	Were you able to have the consultation in time to effectively deal with the problem? Yes or no; if not, why not?
2	How well did the consultant seem to understand your problem?*
3	How realistic were the solutions offered to your problem?*
4	Overall, how valuable did you find the consultation?*
5	Would you use the consulting service again? Yes or no; if not, why not?
6	Please describe what effect, if any, this consultation had on the patient care you subsequently provided.
7	Please share any thoughts you have about this consultation that might help us improve the service we provide.

*These questions were rated on a 5-point response scale: 1 = not at all, 2 = somewhat, 3 = moderately, 4 = well, 5 = very well.

Table 2.

Results of the consultation survey

Characteristic	Total	Percentage of total[a]
Use of service reported by 57 survey respondents		
Not aware	6	(11%)
Aware, did not use	25	(44%)
Had 1 or more consultations	22	(38%)
No response	4	(07%)
Type of services reported (*N* = 37 separate consultations described by 22 nurses)		
Assistance teaching	8	(22%)
Assistance with program content	8	(22%)
Case consult: program related	14	(38%)
Case consult: problem behaviors	7	(19%)
Quality of the 37 consultations provided		
Timely	Yes = 33	(89%)
	No = 4	(11%)
Felt understood[b]	32	(86%)
Solutions realistic[b]	30	(81%)
Valuable overall[b]	36	(97%)
Use again	37	(100%)

[a]Rounded to the nearest whole number so may not sum to 100%.

[b]Rated 4 or above on a 5-point scale where 1 = not at all, 2 = somewhat, 3 = moderately, 4 = well, and 5 = very well.

Table 3.

Circumstances that may have increased use of consultation: Selected comments

The following comments were offered in response to the question, “Under what circumstances would you have been likely to use the consultation services?”
I would have used the services if:
• My staff and I were unable to apply the material to a resident or resident.
• We at that time had a resident who was having a problem which [the geropsychiatric specialists] could have helped address.
• I had trouble with program content or if we had difficulty with a resident.
• The training session and manual had not been thorough enough.
• I had been unable to simplify some of the concepts and terms for the nursing assistant level by using the references provided each trainer.
• I was not sure where to go.
• I would have had trouble with a program—but they were easy to follow.
• The need arose and the material and training had not prepared me for the situation.
• I had a question about something in the program. It was pretty self-explanatory though.

Table 4.

Effect of consultation on patient care

When asked to describe what effect the consultation had on patient care, nurse trainers offered the following comments:

- For federal [regulations] your expertise in evaluating psychotropics assists and reassures our staff and helps keep us in compliance with [regulations].
- Our difficult resident was evaluated and constructive advice was given. I always feel your expert's assessments reassure our staff.
- I found it very helpful to have input from a knowledgeable and objective professional. We feel inadequate at times in the areas of intervention.
- The consultation recommendations provided additional information to improve our plan of care.
- Staff developed increased understanding of "special needs" residents.
- This program will benefit the geriatric community for many years to come. Since completion [of the training] staff will be discussing problems and someone will mention a point that was learned in class.
- Staff were better able to recognize their own feelings and reactions and adapt. [It] was a great help to staff.
- It helped the nurses and CNAs to understand some of the difficult behavior.
- Everyone at the [CMHC] has been extremely helpful. They helped me understand issues to be able to pass on to staff.
- [The consultation] improved care and resolved the problem.
- We were better able to: offer the resident limited choices ($n = 1$); offer more choices ($n = 1$); reduce the disruptive behavior of the patient ($n = 2$); control the agitated resident's behavior ($n = 1$); manage our residents ($n = 1$); control our residents ($n = 1$).
- [We were] able to set up a care plan with citations for outbursts—resident now limits them to room according to care plan.
- It helped us to see the cause and effect and resulted in more manageable behavior but did not resolve the problem.
- [The consultation was] effective in partially decreasing negative behavior—gave us more approaches and reasons for acting out negative behaviors.
- [The] consultant was able to provide helpful outside resources and ideas that we could try ($n = 2$).
- [After the consultation, we] discussed [the problem] with the doctor; medication changes were made.