Behavioural assessment form

Residential Care Facility: _____

Client Name: _____

Instructions: The Behavioural assessment form should be completed every time a significant incident takes place.

Section A:

1. Behaviour – begin by filling out the middle column, i.e. clearly describe the behaviour.
2. Antecedents – describe what was happening before the behaviour occurred.
3. Consequences – what happened *immediately* afterwards (before you intervened).

<table>
<tr><th>Antecedents or activating events (what was happening before the incident)</th><th>Behaviour (what, exactly, was the incident).
Start in this section by describing the behaviour</th><th>Consequences of the behaviour
(what happened immediately afterwards? Who was affected and how?)</th></tr>
<tr><td>Date:</td><td>Observed behaviour:</td><td rowspan="4">What interaction/s took place immediately after the behaviour occurred?</td></tr>
<tr><td>Time:</td><td rowspan="3"></td></tr>
<tr><td>Where did it take place?</td></tr>
<tr><td>What interaction was going on?</td></tr>
<tr><td>What else was happening?
(Noise, unexpected events, etc.)</td><td>How long did it last?</td><td>What else happened?</td></tr>
</table>

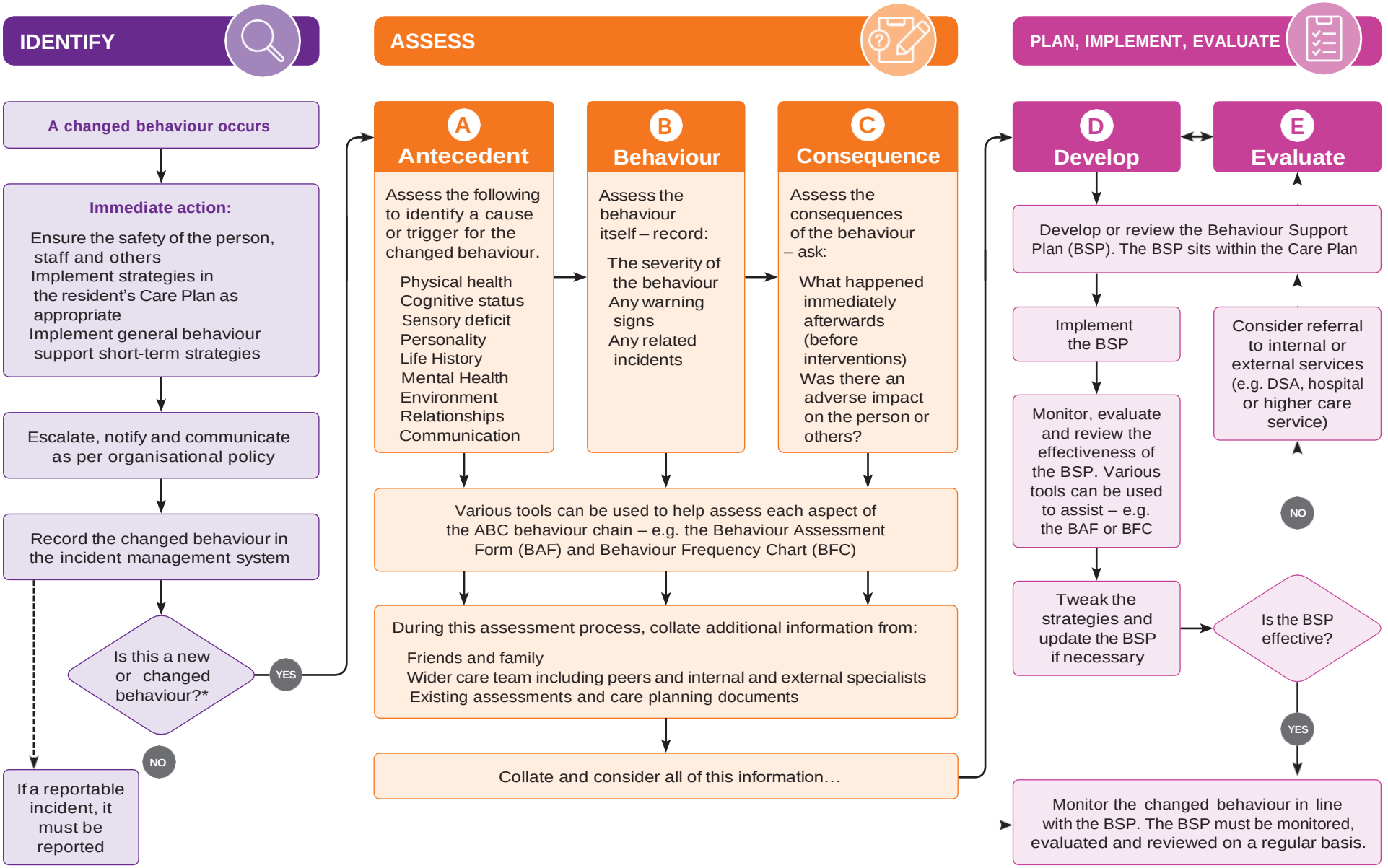
Section B:

Describe what your actions were and what effect they had on the person's behaviour.

Intervention/s	**Effect**

Overview of the behaviour support process

The Village Residence



*A 'new or changed behaviour' includes a new type of behaviour, a change in the frequency or intensity of a known behaviour or a change in response to existing strategies.

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Behaviour frequency chart

This chart is for use to record the frequency of a specific behaviour as outlined below. The form must be completed by ***all staff on every shift*** during the monitoring period to ensure accurate, complete assessment of the behaviour. **Every hour add one (1) check mark (|) for each occurrence of the behaviour described.**

Surname: _____ D.O.B.: _____

Given name: _____ Location: _____

	Behaviour type/description				Planned intervention/s									
Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /	
Starting at	Instances	Initial	Instances	Initial	Instances	Initial	Instances	Initial	Instances	Initial	Instances	Initial	Instances	Initial
00:00														
01:00														
02:00														
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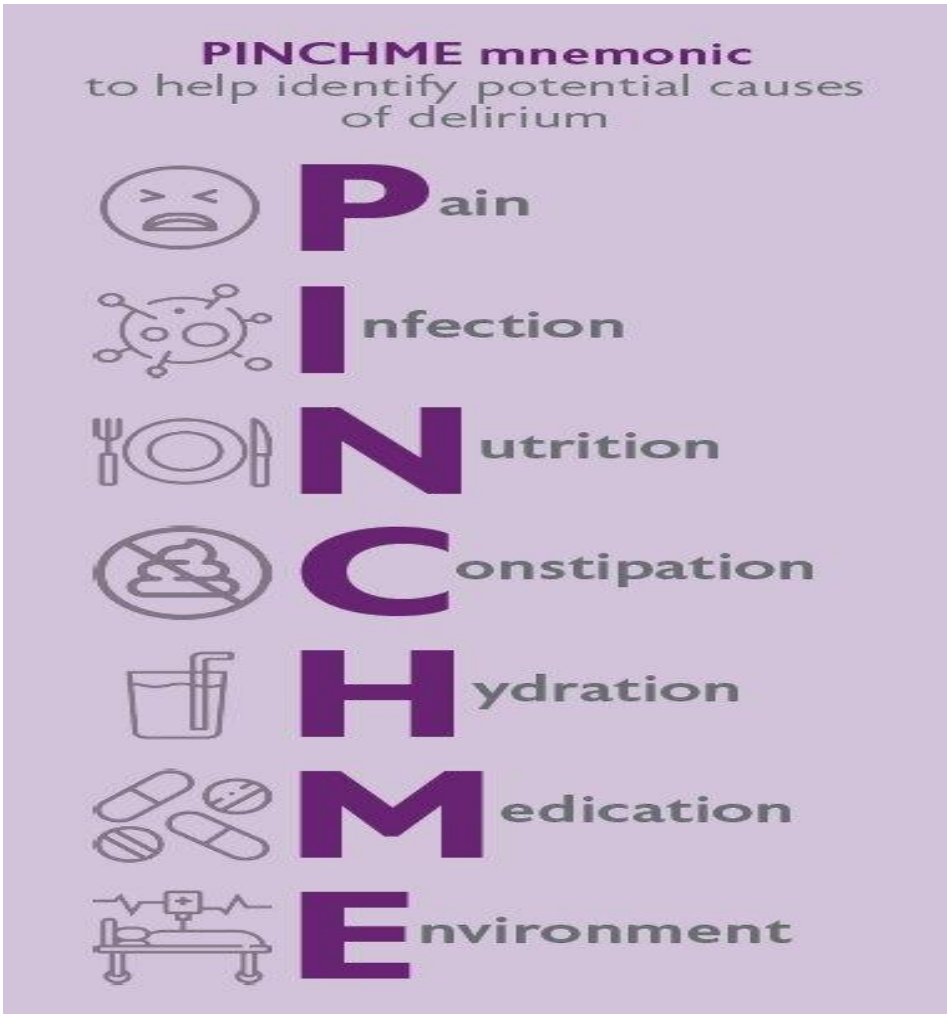

Assess for Potential Causes of Delirium:

'PINCH ME'

P – Is the person in pain? Has urinary retention been excluded?

IN – Infection: is there a possible infection?

C – Constipation: When was the last bowel movement?

H – Hydration / Nutrition: is there major electrolyte imbalance?

Has hypoxia, hypotension, hypoglycaemia been considered?

M – Medication: omission of regular medication or addition of new

medication?

E – Environment: change of environment, noise or activity levels

impacting sleep/ rest?

Guide to using the Cornell Scale for depression in dementia

The Cornell Scale for Depression in Dementia (CSDD) was specifically developed to assess signs and symptoms of major depression in people living with dementia. The CSDD is designed to be completed by someone that has regular contact with the resident, and an understanding of the resident's symptoms of depression **over the previous week**. In general, this is done with input by nursing staff and in consultation with the person's General Practitioner.

It is important to remember that:

- **The CSDD is not a diagnostic tool – it is a screening tool.**
- **The CSDD is reliable for those with a Mini-Mental State Examination (MMSE) score of 17 or more; it has not been validated in any group of people with a MMSE of less than 17.**
- **There are a number of items in the CSDD that overlap with symptoms of behavioural and psychological symptoms of dementia and so all results should be closely scrutinised.[1]**

1 Goodarzi, Z., Mele, B., Roberts, D., Holroyd-Leduc, J. Depression Case Finding in Individuals with Dementia: A Systematic Review and Meta-Analysis. *The American Geriatrics Society*. 2017; 65: 937–948.

There are five categories of questions to be assessed and a total of 19 items to be measured. Each item is rated for severity on a scale of 0–2 (0=absent, 1=mild or intermittent, 2=severe). There is also an 'Unable to rate' measure in circumstances where the resident's symptoms are the result of physical disability or illness, or for some other reason are unascertainable.

Once the CSDD has been completed, the item scores are added.

- **Scores above 10 indicate a probable major depression.**
- **Scores above 18 indicate a definite major depression.**
- **Scores below 6 as a rule are associated with absence of significant depressive symptoms.**

Information on assessing each of the items is set out below.

A. Mood related signs

1. Anxiety: *(anxious expression, ruminations, worrying)*

Does the resident have an anxious, tense, distressed or apprehensive expression? Have they been feeling anxious in the past week? Have they been worrying about things they may not ordinarily worry about, or ruminating over things that may not be that important?

2. Sadness: *(sad expression, sad voice, tearfulness)*

Has the resident been feeling down, sad, or blue this past week? Have they been crying at all? How many days out of the past week have they been feeling like this? For how long each day?

3. Lack of reactivity to pleasant events: *(does not cheer up when offered pleasant activities)*

Is the resident able to respond to friendly or supportive remarks or to humour? If a pleasant event were to occur today (e.g., going out with their spouse, friends, seeing grandchildren), would the resident be able to enjoy it fully, or might their mood get in the way of their interest in the event or activity?

Does the resident's mood affect any of the following:

- their ability to enjoy activities that used to give them pleasure?
- their surroundings?
- their feelings for family and friends?

4. Irritability: *(easily annoyed, short tempered)*

Observe whether the resident is easily annoyed and short-tempered. Has the resident felt short tempered or easily annoyed in the past week? Have they been feeling irritable, impatient, or angry this week?

B. Behavioural disturbance

5. Agitation: *(restlessness, handwringing, hairpulling)*

Has the resident been fidgety or restless this past week or unable to sit still for at least an hour? Was the resident so physically agitated that you or others noticed it? Agitation may include such behaviours as playing with one's hands, hair, hand-wringing, hair-pulling, and/or lip biting. Have you observed any such behaviour in the resident during the past week?

6. Slowness: *(slow movements, slow speech, slow reactions)*

Has the resident been talking or moving more slowly than is normal for them. This item should be scored exclusively on the basis of observations. Slowness is characterised by:

- slow speech
- delayed response to questions
- decreased motor activity and/or reactions

7. Multiple physical complaints: *(complaints about physical health more than is reasonable)*

In the past week, has the resident had any of the following physical symptoms (in excess of what is normal for them):

- indigestion
- constipation
- diarrhoea
- stomach cramps
- belching
- heart palpitations
- headaches
- muscles aches
- joint pain
- backache
- hyperventilation (shortness of breath)
- frequent urination
- sweating

If yes to any of the above: How much have these things been bothering the resident? How bad have they become and how often have they occurred in the past week? Do not rate symptoms that are side effects from taking medications or those that are only related to gastrointestinal ailments.

8. Loss of interest: *(less involved in usual activities – score only if change occurred acutely, and/or has lasted less than one month)*

How has the resident been spending their time this past week? Have they felt interested in their usual activities and hobbies? Has the resident spent any less time engaging in these activities? Has the resident had to be prompted to do the things they normally enjoy? Have they stopped doing anything they used to do? Can the resident look forward to anything or have they lost interest in many of the hobbies from which they used to derive pleasure?

Ratings of this item should be based on loss of interest during the past week. This item should be rated 0 if the loss of interest is long-standing (longer than 1 month) and there has been no worsening during the past month. This item should be rated 0, if the resident has not been engaged in activities because of physical illness or disability or if the resident has persistent apathy as part of his/her dementia.

C. Physical signs

9. Appetite Loss: *(eating less than usual)*

How has the resident's appetite been this past week compared to normal? Has it decreased at all? Have they felt less hungry or had to be reminded to eat? Have others had to urge or force them to eat?

Rate 1 if there is appetite loss but the resident is still eating on their own.
Rate 2 if the residents eats only with others' encouragement or urging.

10. Weight Loss: *(decrease in weight)*

Has the resident lost any weight in the past month that they have not meant to or been trying to lose? (If not sure: are the resident's clothes any looser?) If weight loss is associated with a present illness (i.e., not due to diet or exercise) how many kilograms has the resident lost?

Rate 2 if weight loss is greater than 2.5kgs in the past month.

11. Lack of energy: *(fatigues easily, unable to sustain activities – score only if change occurred acutely, and/or has lasted less than one month)*

Does the resident appear fatigued or drained of energy? How has the resident's energy been this past week compared to normal? Has the resident been tired all the time? Have they asked to take naps because of fatigue? This week, has the resident had any of the following symptoms due to lack of energy only (*not* due to physical problems):

- heaviness in limbs, back, or head?
- felt like they are dragging through the day?
- has the resident been fatigued more easily this week?

Ratings of this item should be based on lack of energy during the week prior to the interview. This item should be rated 0 if the lack of energy is long-standing (longer than 1 month) and there has been no worsening during the past month.

D. Changes in daily/nightly mood and behaviours

12. Changes in mood: *(mood changes as the day progresses with symptoms worse in the morning)*

Regarding the resident's mood (their feelings and symptoms of depression), is there any part of the day in which they usually feel better or worse (or does it not make any difference, or vary according to the day or situation)? If yes to a difference in mood during the day: Is the resident's depression worse in the morning or the evening? If worse in the morning: Is this a mild or a very noticeable difference?

The resident must consistently feel worse in the mornings (as compared to evenings) for this item to be rated.

13. Difficulty falling asleep: *(later than usual for this individual)*

Has the resident had any trouble falling asleep this past week? Does it take them longer than usual to fall asleep once they get into bed (i.e., more than 30 min)?

Rate 1 if the resident only had trouble falling asleep a few nights in the past week. Rate 2 if they have had difficulty falling asleep every night this past week.

14. Multiple awakenings during sleep: *(wakes up more than usual for this individual)*

Has the resident been waking up in the middle of the night this past week? If yes: do they get out of bed? Is this just to go to the bathroom and then they go back to sleep? Do not rate if waking is only to go to the bathroom and then the resident is able to fall right back asleep. Rate 1 if the resident's sleep has been restless and disturbed only occasionally in the past week and if the resident has not got up out of bed (besides going to the bathroom). Rate 2 if the resident gets out of bed in the middle of the night (for reasons other than voiding), and/or has been waking up every night in the past week.

15. Early morning awakenings*: (earlier than usual for this individual)*

Has the resident been waking up any earlier this week than s/he normally does (without an alarm clock or someone waking them up)? If yes: how much earlier is s/he waking up than is normal for them? Does the resident get out of bed when they wake up early, or do they stay in bed and/or go back to sleep?

Rate 1 if the resident wakes up on their own but then goes back to sleep. Rate 2 if the resident wakes earlier than usual and then gets out of bed for the day (i.e., cannot fall back asleep).

E. Ideational disturbance

16. Suicide: *(feels life is not worth living, has suicidal wishes)*

During the past week, has the resident had any thoughts that life is not worth living? Has the resident had any thoughts of hurting themselves?

Rate 1 for passive suicidal ideation (i.e., feels life isn't worth living). Rate 2 for active suicidal wishes, and/or any recent suicide attempts, gestures, or plans. History of suicide attempt in a subject with no passive or active suicidal ideation does not in itself justify a score.

17. Poor self esteem: *(self-blame, poor self-esteem, feelings of failure)*

How has the resident been feeling about themself this past week? Has the resident been feeling especially critical of themself, feeling that they have done things wrong or let others down? Has the resident been feeling guilty about anything they have or have not done? Has the resident been comparing themself to others, or feeling worthless, or like a failure? Has the resident described themself as "no good" or "inferior"?

Rate 1 for loss of self-esteem or self-reproach. Rate 2 for feelings of failure, or statements that the resident is "worthless", "inferior", or "no good".

18. Pessimism: *(anticipation of the worst)*

Has the resident felt pessimistic or discouraged about their future this past week? Can they see their situation improving? Can the resident be reassured by others that things will be okay or that their situation will improve?

Rate 1 if the resident feels pessimistic, but can be reassured by self or others. Rate 2 if the resident feels hopeless and cannot be reassured that their future will be okay.

19. Depressing delusions: *(delusions of poverty, illness, or loss)*

Has the resident been having ideas that others may find strange? Does the resident think their present illness is a punishment, or that they have brought it on themself in some irrational way? Does the resident think they have less money or material possessions than they really have?

References

Alexopoulos GA, Abrams RC, Young RC & Shamoian CA: Cornell scale for depression in dementia. Biol Psych, 1988, 23:271-284.

Alexopoulos GS, Abrams RC, Young RC, Shamoian CA: Use of the Cornell scale in nondemented patients. J Amer Geriatr Soc 36:230-236, 1988.

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

Name: _____ *(person being assessed)*

D.O.B: _____

Completed by: _____ *(name and designation)*

Date: _____ **Time:** _____

Latest pain relief given was _____ **at** _____

Enter pain score for each of the following six areas:

Absent 0, mild 1, moderate 2, severe 3

1. **Vocalisation** (e.g. whimpering, groaning, crying)	☐
2. **Facial expression** (e.g. looking tense, frowning, grimacing, looking frightened)	☐
3. **Change in body language** (e.g. fidgeting, rocking, guarding part of body, withdrawn)	☐
4. **Behavioural change** (e.g. increased confusion, refusing to eat, alteration in usual patterns)	☐
5. **Physiological change** (e.g. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor)	☐
6. **Physical changes** (e.g. skin tears, pressure areas, arthritis, contractures, previous injuries)	☐
Add scores for 1–6 and record the total pain score	☐

Tick the box that matches the total pain score

0–2 no pain ☐ 3–7 mild ☐ 8–13 moderate ☐ 14+ severe ☐

Tick the box that matches the type of pain

Chronic ☐ Acute ☐ Acute on chronic ☐

Abbey, J. A., Piller, N., DeBellis, A., Esteman, A., Parker, D., Giles, L., Lowcay, B. (2004). The Abbey Pain Scale. A 1-minute numerical indicator for people with late-stage dementia. International Journal of Palliative Nursing, 10(1), 6–13. (This document may be reproduced with this acknowledgement retained)

The Brain and Behaviour*

Everything we do requires a different part of the brain to function – often at the same time. Damage to the brain, will impact whatever function that part of the brain controls. At a very high level, the brain has two cerebral hemispheres: the dominant side of the brain is on the left in most people; the non-dominant side is on the right. A small strip down the centre controls movement. The left side moves our right arm and leg. The right side moves our left arm and leg. The rest of the brain controls our behaviour and all that makes us human: our thinking, emotions, behaviour and personality. Our brain is a highly complex organ, and when it is damaged – whether by injury or disease – this will impact our abilities, emotion and behaviour. Understanding how damage to different parts of the brain impact behaviour, can help inform our response.

* This is based on the video, 'Brain and Behaviour' by Dr Helen Creasey.

"SYNTHESIS OF SYMPTOMS": Symptoms can all add together to result in a behaviour. It may be that the brain is "deceiving" the person so that they are not able to see their behaviour as problematic and may misunderstand what others do. For example, if a carer points out that a plastic covering should be taken off food before it is placed in the oven, the person may not see they have done anything wrong.

Area of brain damaged	Common effects on behaviour	Examples
Temporal lobe [Memory] *Verbal memory* – from dominant side of brain (left) *Visual memory* – from non-dominant side (right)	Unable to remember words that are spoken, read, seen or heard (Note. Frequently recalled memories are usually more easily remembered, e.g. names/ faces of those close to us) **(Memory)**	A person forgets: • people and events • recent memories – quickly lost. In time, longer-term memory may also be affected
Dominant Parietal lobe [Analytical & logical centre]	Unable to use language (speech, writing and reading) to communicate Unable to calculate **(Communication / Calculation)**	A person has difficulty: • saying what they want to say • naming common objects • understanding what is said • doing maths/ handling money • balancing cheque book
Non-Dominant Parietal lobe [Spatial location (geography) centre – 3-D centre]	Unable to locate position of self, others or objects in space **(Spatial awareness)**	A person has difficulty: • knowing how to get somewhere • locating the car in the car park
Both Parietal lobes	Unable to recognise things **(Agnosia)**	A person is unable to recognise: • people or objects e.g. knife & fork • surroundings e.g. their house, area
	Unable to carry out planned or learned patterns of movement – purposive movements **(Apraxia)**	A person has difficulty: • putting clothes on in correct order • using appliances, e.g. stove, car • putting tablecloth on the table • following instructions (although may do if they decide to do it)
Frontal lobe – Lateral [Executive centre]	Unable to plan or organise Unable to learn new things **(Planning / Learning)**	A person: • goes to the shops without money • doesn't dress appropriately but believes they have • is unaware of uncleanliness of the house
Frontal lobe – Medial [Executive centre]	Unable to start an action "Starter motor" not working **(Initiation)**	A person appears: • apathetic & unmotivated • unable to comprehend
	Unable to stop once starting or saying something **(Perseveration)**	A person repeats questions, statements and actions
Frontal lobe – Orbitobasal [Executive centre]	Unable to keep on track and control social behaviour **(Regulation)**	A person can be: • easily distracted • wander • talk over others
Limbic region [Connecting system]	Unable to connect behaviours, emotions and memories Vegetative functions: eating, sleeping **(Connection)**	A person can: • have angry responses • make accusations of stealing • experience disruptions to sleep / eating patterns

The When and What of Behaviour Support Plans

Person is a permanent or respite resident → **Resident requires behaviour support (e.g. exhibits behaviours)** → **Behaviour Support Plan (BSP) must be prepared**

General BSP

Information about the person

Information and assessments about the person that help a provider to understand the person and their behaviour.

Consultation and consent

A description of the consultation on use of the care strategies with the resident or representative. Additional external consultation (e.g. with DSA) may also be included.

Information about the behaviour

Information about the changed behaviour and for each occurrence of a *new* changed behaviour*:

- Time, date, duration
- Adverse consequences
- Any related incidents
- Warning signs/triggers

**A new changed behaviour includes a change in the type/ manifestation of behaviour; frequency/ intensity of behaviour; or response to existing strategies*

Information about care strategies

1. Best practices strategies**
2. Other strategies used including information about their effectiveness and records of their monitoring and evaluation
3. Other strategies considered

***Those that: 1) are best practice alternatives to the use of restrictive practices 2) consider the person's preferences/ things that are meaningful to them 3) improve quality of life/ engagement.*

In addition, the following information must be included if restrictive practices are used

[That is, when restrictive practices: are assessed as necessary (s15HC of *Quality of Care Principles*); are used (s15HD); or a review of the use of the restrictive practices indicates an ongoing need for the restrictive practices (s15HE)]

Additional information about the behaviour and care strategies

Additional information about the behaviour that is relevant to use of the restrictive practices and about best-practice alternative strategies that must be used, or any other actions that were taken, before the use of the restrictive practices.

Additional information regarding consultation and consent

A description of the consultation about the use, or ongoing use of the restrictive practices with, and a record of consent by, the resident or the 'restrictive practices substitute decision-maker' (as per state and territory government requirements).

Also include consultation with external services (e.g. DSA) about use of restrictive practices.

Information about the restrictive practices

Information about the restrictive practices including how it is to be used, when the restrictive practices began to be used, its duration, frequency and intended outcome of use (and whether that was achieved).

Monitoring and escalating the restrictive practices

Information about how the restrictive practices or ongoing use of the restrictive practices is monitored and escalated (considering the nature of the restrictive practices and any care needs that arise out of use of restrictive practices).

Reviewing the restrictive practices

Information about how use of restrictive practices/ ongoing use of restrictive practices, will be reviewed including whether:

- the intended outcome of its use was achieved;
- alternative strategies could have been used to address the changed behaviour;
- a less restrictive form of restrictive practices could have been used to address the changed behaviour;
- there is an ongoing need for use of the restrictive practices; and
- if chemical restraint, whether the medication that is the restrictive practices, can or should be reduced or stopped.

Other assessments/ documentation***

Any documents required under s 15FB or 15FC of the Quality of Care Principles 2014. This includes any assessments, documentation or consultation that led the medical practitioner or nurse practitioner (for chemical restraint only) to be satisfied that the use of the restrictive practices was necessary.

****These must be included if the restrictive practices are assessed as necessary, in accordance with s 15FB or 15FC of the Quality of Care Principles 2014.*

NOTE: If use of restrictive practices are necessary in an emergency, additional matters must be recorded in the BSP (see s 15GB of the Quality of Care Principles 2014)

Matters to be set out in Behaviour Support Plans*

1. Information about the person

Include information/ assessments relevant to understanding the person/ their changed behaviour. This should include information about the person's past experience and life history -e.g. using the Lifestyle and Social History Questionnaire. It should also include information about known triggers and strategies to reduce/ remove those triggers.

2. Information about the behaviour

Include information about the nature of the changed behaviour **for which the person needs support (describe the behaviour, not the label). You should also include any information about immediate strategies that were implemented to reduce risks to safety and the response to those strategies.**

For each occurrence of a new changed behaviour, **note the following – additional space provided on page 3.**

	Adverse consequences	Related incidents	Warning signs/ triggers
Date:			
Time:			
Duration:			

**Please note, additional information must be included if restrictive practices are used. Please refer to s 15HD, 15HC and 15HE of the Quality of Care Principles.*

3. Information about the care strategies to address the changed behaviour

Best practice strategies:*		
Other strategies that were used:	**Effectiveness of the strategies?**	**Record of monitoring?**
Other strategies that were considered:		

4. Consultation and consent

Include information about the use of the care strategies to address the changed behaviour **with the resident or resident's representative.**

**Those that: 1) are best practice alternatives to use of restrictive practices 2) consider the person's preferences/ things that are meaningful to them 3) improve quality of life/ engagement.*

Additional space for filling in information about each occurrence of a new changed behaviour

Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:

Additional space for filling in information about each occurrence of a new changed behaviour

Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
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Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:

The ABCDE of Behaviour Support

First, ensure the safety of the person displaying behaviours and everyone around them.

Then: Follow the ABCDE's of the Behaviour Support Process.

A Antecedent

Ask: 'What could have caused the behaviour? What happened just before the behaviour? What is the person trying to tell me?'

Assess potential triggers – e.g., the person's physical, mental or social health needs, any pain or any environmental issues. Any strategies that can be immediately be implemented should be.

B Behaviour

Ask: 'What happened? What was the behaviour that I observed? What did the person say or do?'

Don't just label the behaviour, do your best to describe exactly what happened and to describe the behaviour that you saw.

C Consequence

Ask: 'What was the consequence of the behaviour? What was the impact, who did it impact and how did it impact them?'

Consider the impact of the behaviour on the person exhibiting it as well as anyone else (other residents, staff, visitors).

ASSESS

D Develop

Ask: 'What are some care strategies that I can develop to prevent the behaviour or prevent the severity of its impact?'

Care strategies should be tailored to the individual person. This is a process of trial and error. Strategies should be set out in the person's **Behaviour Support Plan**.

E Evaluate

Ask: 'Is the Behaviour Support Plan Effective? Are the strategies effective? Are strategies causing a change in care needs?'

The evaluation will depend on the strategies used. If strategies involve use of restrictive practices,* the evaluation must consider specific questions – e.g. whether the intended outcome was achieved and if non-restrictive strategies could be used instead.

PLAN, IMPLEMENT, EVALUATE

If the strategies to manage the behaviour are not effective, trial some new strategies and continue to monitor their effectiveness. If the strategies are still not effective, consider referral to internal or external services. Dementia Support Australia's dementia care consultants are available to assist.

**Restrictive Practices should only be used in very limited circumstances in accordance with the Aged Care Act 1997 and the Quality of Care Principles 2014.*

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Behaviour Care Planning Process

This guide provides a high-level summary of the behaviour care planning process. It outlines what information should be gathered before the resident enters care; the behaviour support process that is required on identification of a changed behaviour; and, the ongoing monitoring and evaluation that is required to support new or changed behaviours.

Pre-Admission

Complete assessments to understand **care needs**

Complete assessments to understand **who the resident is** including their likes, dislikes, family, friends and their social history

Through consultation with the resident and their family, seek out any other **information about the resident's life story** that will enable the service to tailor care and understand, connect and build a strong relationship with the resident.

Consider what tools are available to find out more about the resident.

For example:

The Lifestyle and Social History Form

Shortly after admission

If resident has behaviour requiring support:

Begin the behaviour support process:

- **Identify** the behaviour
- **Assess** the ABCs (Antecedent, Behaviour, Consequence)
- **Plan, implement and evaluate** the Behaviour Support Plan

Get to know the resident and continue to gather information about the resident to inform more effective care strategies

Consider what tools are available to conduct your assessment.

For example:

The Delirium Screening Tool

The Abbey Pain Scale

The Cornell Scale of Depression in Dementia

The Guide to the Cornell Scale of Depression

Consider what tools are available to develop the Behaviour Support Plan. For example:

The When and What of the Behaviour Support Plan

The Behaviour Support Plan Template

Regularly or when behaviour needs change

Use assessment tools to **monitor and evaluate** the Behaviour Support Plan

Tweak strategies if they are not effective by using **what you know about the resident** (e.g. their personality, previous work, old hobbies, old relationships), care assessments and discussions with partners in care (friends, family and others)

For new or changed behaviour repeat the behaviour support process

Consider what tools are available to monitor and evaluate the effectiveness of the Behaviour Support Plan.

For example:

The Behaviour Assessment Form

The Behaviour Frequency Chart

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Lifestyle and social history questionnaire

Surname: _____

Given name: _____

D.O.B.: _____

This form has been designed to help us better know those we serve. Knowing your life story helps us to understand and connect with you. This in turn can help us understand you, your preferred way of doing things and why you react to certain things that may happen. It also helps us know your identity, likes, dislikes and interests as well as the important people and life events that have helped shape who you are. This information will enable us to better tailor care to meet your individual needs. This is particularly important if you can no longer communicate what you need or prefer.

The information captured here will enhance the opportunity to build strong relationships through improving our understanding of you. It also provides a focus for communication and a resource for reminiscence. Reminiscence is an effective way we can support your sense of identity, reflect on your accomplishments and promote your self-esteem and sense of worth. This information will be helpful to develop your unique care plan.

What is your preferred name?

Do you have a nickname that you like or prefer people to use?

If so, what is your nickname and how did you get the nickname?

What languages have you spoken throughout your life?

What languages do you read, understand or speak now?

Goals and hopes

Now: .....

.....

.....

Previously: .....

.....

.....

Surname: _____

Given name: _____

D.O.B.: _____

Childhood

Where were you born?

If you were born overseas, when and why did you / your family move to Ireland?

What is your mother's name?

What is your father's name?

What is your family's cultural background?

Do you have brothers or sisters?

Yes ☐ **No** ☐

If so, what are their names?

Have you lost family members? *(please tell us which ones, if any, have passed away and when)*

Yes ☐ **No** ☐

Where did you live as a child?

Where did you go to school?

Were there any significant events or achievements in your childhood?

Questionnaire continues on the next page

Surname: _____

Given name: _____

D.O.B.: _____

Adult years

Have you been/are you married and/or had a partner?

Yes ☐ **No** ☐

If so, what is their name/s?

When and where did you meet them?

If you have been / are married, when and where did you get married?

Do you have children?

Yes ☐ **No** ☐

If so, what are their names?

Do you have grandchildren?

Yes ☐ **No** ☐

If so, what are their names?

Who is / has been your close friends or important people in your life?

Where have you lived?

Did you attend university, college or technical school? If so, what did you study?

Yes ☐ **No** ☐

What occupational or volunteer roles did / do you hold in life? *(what work did you do? Were you a stay at home mum/carer? Did you do war or community service?)*

What club affiliations did / do you have?

If you worked, when did you retire?

Surname: _____

Given name: _____

D.O.B.: _____

What did you do during retirement?

Do you / did you enjoy travel?

Yes ☐ **No** ☐

If yes, where have you travelled?

What were the significant events or achievements in your adult years?

What were the hurdles or heartbreaks in your life? *(loss of employment, migration, disability, death of family/friend/pet etc?)*

Personality, important values and beliefs

What is important to you?

How do you spend your days?

What brings you joy or happiness?

What makes you angry / sad? What strategies do you use to cope / what gives you comfort?

Is there anything you would like us to know about your routines, habits and preferences? *(you like to sleep in; you enjoy alcohol regularly or like a beer before dinner; you enjoy smoking or recreational drugs; you never leave home without lipstick on etc.)*

Surname: _____

Given name: _____

D.O.B.: _____

What values and beliefs are / have been important to you?

Do / have you belonged to a faith community?

Yes ☐ **No** ☐

If so, which faith community do / did you belong to?

What faith / spiritual practices have you been involved in?

What traditions and cultural events do / did you celebrate?

Are / were there any political beliefs or associations that are important to you?

Is there anything you would like us to know about your sexuality?

How would you or your family / friends describe your personality? *(introvert, extrovert, calm in a crisis, a worrier, etc.)*

Interests, hobbies and leisure activities

What creative activities or hobbies have you / do you enjoy? *(art, knitting, woodwork, etc.)*

What sports have you / do you play or enjoy watching? *(boxing, bowls, football, tennis, etc.)*

What are you favourite sporting team/s?

What social outings have you / do you enjoy? *(club, restaurants, theatre, cinema, etc.)*

Surname: _____

Given name: _____

D.O.B.: _____

What music have you / do you enjoy listening to? *(residential services to also complete a personalised music collection form)*

Have you / do you play a musical instrument?

What TV shows and movies do you like to watch? *(specific TV shows and movies)*

What leisure activities have you / do you enjoy? *(picnics, walking, cards, reading, computer, etc.)*

What domestic duties have you / do you enjoy? *(cooking, gardening, cleaning, washing, DIY maintenance, etc.)*

Did / do you have any pets?

Yes ☐ **No** ☐

If so, what pets and what were their names?

Is there anything else that you would like to tell us?

Matters to be set out in the Behaviour Support Plan when restrictive practices are used*

1. Information about the person

Include information/ assessments relevant to understanding the person/ their changed behaviour. This should include information about the person's past experience and life history – e.g. using the Lifestyle and Social History Questionnaire. It should also include information about known triggers and strategies to reduce/ remove those triggers.

2. Information about the behaviour

Include information about the nature of the changed behaviour for which the person needs support (describe the behaviour, not the label) including any information relevant to the use of restrictive practices. You should also include any information about immediate strategies that were implemented to reduce risks to safety and the response to those strategies.

For each occurrence of a new changed behaviour, **note the following – additional space provided on page** 6**.**

	Adverse consequences	Related incidents	Warning signs/ triggers
Date:			
Time:			
Duration:			

**That is, when restrictive practices: are assessed as necessary (s15HC of Quality of Care Principles); are used (s15HD); or, a review of the use of the restrictive practice indicates an ongoing need for the restrictive practice (s15HE).*

3. Information about the care strategies to address the changed behaviour

Best practice strategies* that must be used or trialled before the restrictive practice is used:		
Other strategies that were used:	**Effectiveness of the strategies?**	**Record of monitoring?**
Other strategies that were considered:		

**Those that: 1) are best practice alternatives to use of restrictive practices 2) consider the person's preferences/ things that are meaningful to them 3) improve quality of life/ engagement.*

4. Information about the restrictive practice

Information about the restrictive practice including:

How will the restrictive practice be used?	When did the restrictive practice begin to be used?	For how long is the restrictive practice used on each occasion?
How frequently is the restrictive practice used?	**What is the intended outcome of the use of the restrictive practices?**	**Is the intended outcome being achieved through the use of the restrictive practice?**
Are there any new care needs that arise out of the use of the restrictive practice?	**How will ongoing use of the restrictive practice be monitored?**	**How will ongoing use of the restrictive practice be escalated?**

For each review of the restrictive practice, please note the following – additional space provided on page 6.			
Date:	Are there alternative strategies that could have been used to address the changed behaviour?	Is there a less restrictive form of the restrictive practice that could be used?	Is there an ongoing need for the restrictive practice? If chemical restraint is being used, can the restraining medication be reduced or stopped?
Time:			
Duration:			

5. Consultation and consent

Include a record of consent and a description of the consultation that you conducted with the resident or the 'restrictive practices substitute decision-maker'* about the use or ongoing use of the restrictive practice. Also include information about any consultation with any external services about the use of restrictive practices (e.g. DSA dementia consultants).

Additional space for filling in information about each occurrence of a new changed behaviour

Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:
Date: **Time:** **Duration:**	Adverse consequences:	Related incidents:	Warning signs/ triggers:

Additional space for each review of the use of restrictive practices

Date: Time: Duration:	Are there alternative strategies that could have been used to address the changed behaviour?	Is there a less restrictive form of the restrictive practice that could be used?	Is there an ongoing need for the restrictive practice? If chemical restraint is being used, can the restraining medication be reduced or stopped?
Date: Time: Duration:	Are there alternative strategies that could have been used to address the changed behaviour?	Is there a less restrictive form of the restrictive practice that could be used?	Is there an ongoing need for the restrictive practice? If chemical restraint is being used, can the restraining medication be reduced or stopped?
Date: Time: Duration:	Are there alternative strategies that could have been used to address the changed behaviour?	Is there a less restrictive form of the restrictive practice that could be used?	Is there an ongoing need for the restrictive practice? If chemical restraint is being used, can the restraining medication be reduced or stopped?
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