Completion Guide
Behavioural Assessment (WRHA Form #W-00909)

1) **Purpose:**
To assist in the completion and documentation of a thorough interdisciplinary behaviour assessment for residents experiencing behavioural and psychological symptoms of dementia.

2) **Definitions:**
C.A.U.S.E.: An acronym for Cognition, Abilities, Underlying Illness/Injury, Social, Environment

Interdisciplinary Team (IDT): Formal and Informal supports which may include: resident, family, HCAs, nurse, recreation, OT, PT, rehab assistants, prescriber, pharmacist, social worker, dietitian, management, speech-language pathologist, food services, housekeeping, volunteers, companions, external agencies etc.

3) **Procedure**:
   a) Used by the interdisciplinary team (IDT) when behavioural and psychological symptoms of dementia are present.
   b) Accompany requests for overcost funding for constant care and referral to the Geriatric Mental Health Team (GMHT).
   c) This assessment is meant to be completed over several days or weeks with input from the Interdisciplinary Team.

4) **Guidelines for Completion**:
   a) Add the resident demographics to upper right corner of all 6 pages (e.g., addressograph or label).
   b) Document the date that the assessment was initiated.
   c) Interdisciplinary Team members to print their names, designation, sign, and date on page 6 when the initial contribution to the assessment is made.

Base Information

a. Indicate whether this is an initial or reassessment. For a reassessment, document the date of the previous assessment.

b. Document the resident's admission date to asses if the resident may still be in the transition period.

c. Check all Interdisciplinary Team members who contributed to the assessment.

1. What has CHANGED?

The purpose of this section is to identify any behaviours or new concerns with the resident's behaviour.

i. Describe the current behaviour as thoroughly as possible
ii. Indicate if the behaviour is worse and when the change emerged.
iii. Indicate if there is a diagnosis of major neurocognitive disorder (dementia) or cognitive decline
   a. If yes, specify what type of dementia
   b. If no, indicate if there is a plan to seek a diagnosis

2. What are the RISKS?

The purpose of this section is to identify risks that the behaviour poses to the resident, other residents, family, or staff. Identifying and evaluating the risks helps to determine the urgency of the situation and next steps in the assessment and care planning.

Have you ruled out delirium as a cause of the behaviour? Delirium is a medical emergency and requires investigation as to the cause of delirium.

Prioritize the **immediate actions** as listed in the box. Addressing these areas may resolve behavioural and psychological symptoms without needing a full assessment.

i. Using the I.S.S.U.E. acronym identify potential risks with the identified behaviours.
ii. In the comments & actions section, describe any immediate actions required if the identified risks are imminent.

3. What are the possible C.A.U.S.E.s?

Use the C.A.U.S.E. acronym to assess the potential contributing factors to the resident's behavioural and psychological symptoms. Indicate which tools were used in the assessment by dating and initialing.

There are two separate components to this section. The rows do not directly correlate to each other. The tables should be completed separately.

Left side of the table: What are the Potential Causes?

Complete left side table first. The left side of the table relates to possible causes. Check off areas of consideration that may be contributing to the behaviour. Use the comment section to elaborate.

Right side pf the table: What are the Possible Actions/Investigations?

The purpose of this section is to determine other assessments or investigations *to be considered or followed up on* in order to complete the assessment.

i. Check all that apply. There is no need to check all boxes if the investigation/ assessment or consult is not required for the resident.
ii. Add comments as necessary.
iii. Other actions - indicate any other assessments or investigations that may be of value.
iv. Indicate the date the action or investigations was complete and initial.

Other tools that may assist you:

This section includes commonly used tools that address multiple areas of the cause through assessment and intervention. Use only the tools that are appropriate for this particular resident and situation or as recommended by an assessment team.

4. Plan of Care:

Based on the information from the assessment, indicate the **individualized** plan for the resident. While investigations, further assessments, and trialing different interventions may continue, there still needs to be a plan of how to interact with the resident today. Please consider how interactions can promote comfort and safety (both for resident and others).

a. Include care approaches, and communication strategies that are specific to this resident. Be more specific than "kind, gentle approach". For example, approach slowly from the left side as resident is unable to see out of right eye.
b. Document any changes to add to the integrated care plan and ADL sheet indicating how the resident will be approached differently.

Communication:

Share the changes to the care plan with the interdisciplinary team so everyone is aware of the plan. Indicate how you will communicate the individualized plan of care to the interdisciplinary team and to whom the information will be communicated.

a. Ensure that the resident/family and all members of the interdisciplinary team are included in the communication.
b. Include all members of the interdisciplinary team who need the information or who are involved in the care of the resident or interact with the resident (e.g., housekeepers, dietary staff, all shifts, etc.).
c. Ensure each staff member is informed and educated on the process for communication and changes.

Evaluation:

Indicate how you are going to evaluate the effectiveness of the interventions and the individualized plan of care.

a. What is being evaluated and when will the evaluation be done?
b. What tools will you use or reuse to determine whether your actions/plan of care has been successful or effective? (e.g., repeat the DOS, discussion on casual observations, etc.)
c. If not successful, are there new assessments that need to be done or interventions that need to be tried?

Documentation:

Check the boxes to indicate whether you have:

i. Reviewed the assessment and plan of care with the resident or to the family/substitute decision maker. Document the name of the person who was spoken to, the team member who performed the review, and the date it was completed
ii. Documented in resident's integrated progress notes (IPN) that the Behavioural Assessment was initiated (at minimum). Additional documentation may be required depending on the situation or facility requirements.
iii. Updated the resident's care plan.
iv. Updated the resident's ADL sheet.
v. Completed referrals as needed. Indicate which referral was sent, the date and who sent it.
vi. Set reminder for reassessment date.

Signature:

i. Interdisciplinary Team members to print name, designation, sign, and date at the end of the form when initial contribution to the assessment is made.

Filing: File in resident health record. May be thinned with file to keep most current assessment form in resident health record.

Resource to aid in the assessment process:

- Dementia Care Quick Reference Guide
- Sample Behavioral Assessment
- Responsive Behaviour Pathways for LTC
- Infographics
- Site Educator
- Regional LTC Educator
- Alzheimer Society of Manitoba