Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg

SAMPLE

Long Term Care

Behavioural Assessment

- For use when behavioral and psychological symptoms of dementia are present
- This assessment is meant to be completed over several days with the interdisciplinary team

Mrs. B. B.

Available Resources:

Dementia Care Quick Reference Guide
Site Educator
Dementia Care Education trained staff

Date initiated: 16AUG2020 (D D M M M Y Y Y Y) ☑ Initial Assessment ☐ Reassessment - previous date: _____ (D D M M M Y Y Y Y)

Admission Date: 05OCT2019 (D D M M M Y Y Y Y)

Individuals included in this assessment (check all that apply):

☐ Resident ☑ Family (specify): Daughter - Betty ☑ HCA ☑ Nursing ☐ Recreation ☐ OT ☐ PT ☐ Rehab
☐ Prescriber ☐ Pharmacist ☐ SW ☐ RD ☐ Management ☐ SLP ☐ Food Services ☐ Housekeeping ☐ Other: _____

1. What has CHANGED?

Is the behavior/problem new? Is it worse or different? When did the change emerge? Describe specific details of the behaviour change.

Began 3 weeks ago. Change in behaviour - resident wandering into other resident rooms and taking things - plants mostly. Had altercation with another resident while doing this + slapped other resident who tried to stop her. Also at times physically reactive during am cares. Sometimes difficulty sleeping.

Known diagnosis of major neurocognitive disorder (dementia) or cognitive decline?

☑ Yes (specific type if known) vascular dementia ☐ No

If no: What is the plan to seek a diagnosis? What are your next steps?

2. What are the RISKS?

Think **I.S.S.U.E.**

- Injury/Illness (physical causes, pain, rule out delirium - ***delirium is a medical emergency***)
- Suicidal ideation
- Safety (substance use, self-neglect, elopement, conflict, etc.)
- Us (relationships with others, harm by person, or to person, including neglect or isolation)
- Environment (disruption, damage to property)

Comments & Actions:

Describe any **immediate** actions required to address **imminent** risks.

- risk for delirium - had previously, shortly after adm. due to medication - effects of opioids, ✓ for delirium
- hx of depression and suicidal ideation, ✓ for suicide + depression
- risk of injury to self and others - physically reactive with cares & strikes out if confronted going into rooms
- hx of falls on adm. - Keep from going in other resident rooms

Immediate Actions:

- Rule out delirium
- Review medications
- Assess pain
- Consider unmet needs
- Complete Dementia Observation System (DOS)
- Initiate C.A.U.S.E. assessment below

LEGEND

ADL - Activities of Daily Living
C.A.U.S.E. - Cognition, Abilities, Underlying Illness/Injury, Social, Environment
COPD - Chronic Obstructive Pulmonary Disease
DOS - Dementia Observation System
HCA - Health Care Aide
OT - Occupational Therapist
PCH - Personal Care Home
PRN - As needed
PT - Physiotherapist
RD - Registered Dietitian
Rehab - Rehabilitation
SLP - Speech-Language Pathologist
SW - Social Worker

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

What actions and investigations are required? What are the outcomes? Include behaviour triggers that are already known. Check (✓) all that apply:

C - Cognition

✓ Potential causes related to cognition	✓ Possible actions/investigations	Date D D M M M Y Y Y Y	Initials
☑ Changes in memory, orientation, or concentration	☑ Mini Cog	15 AUG 2020	DJ
☐ Changes to recognition of people or objects	☐ Medication review		
☑ Changes in language skills, comprehension, or communication	☐ Mini Mental Status Exam (MMSE)		
☐ Are there unique changes to this individual's intellectual functioning?	☑ Clock Test	15 AUG 2020	DJ
☐ Existing intellectual or learning disability	☐ Montreal Cognitive Assessment (MoCA)		
☑ Changes to judgment, reasoning and insight	☐ Cognitive Performance Scale (CPS in Minimum Data Set - MDS)		
☐ Consider and identify the impact of the 7As *(Amnesia, Aphasia, Agnosia, Apraxia, Anosognosia, Apathy, Altered Perception)*	☐ Other actions:		

Comments (e.g., what did you learn about the resident's cognition that might be contributing to the cause of the behaviour?)

Short term memory issues, still recognize family, some aphasia - occasional trouble understanding but generally able to communicate with simple conversation/requests. Responds well to cueing.
Mini cog: change from baseline (2 words, 8 animals with 1 rpt) VS now (1 word, 5 animals with 2 repeat)
Clock test: change from baseline - now perseverating.

A - Abilities

✓ Potential causes related to abilities	✓ Possible actions/investigations	Date D D M M M Y Y Y Y	Initials
☐ Changes in mobility	☐ Lawton Brody		
☐ Change in ability to execute tasks, follow directions, complete Activities of Daily Living (ADLs)/Instrumental activities of daily living (IADLs)	☐ OT/PT referral		
☐ Changes in ability to eat (feeding, swallowing)	☐ RD/SLP referral		
☐ Loss of dignity and autonomy	☐ Meal Observation Screening (MOS)		
☑ Sleep pattern disturbances	☐ Audiology		
☐ Sensory changes (vision, hearing, taste, smell, touch)	☐ Sleep assessment and review pattern of sleep from DOS		
☐ Changes in communication and barriers	☐ Vision screening assessment		
☐ Changes in language	☐ Recreation observations		
☐ Consider and identify the impact of the 7As *(Amnesia, Aphasia, Agnosia, Apraxia, Anosognosia, Apathy, Altered Perception)*	☑ Medication review	18 JUL 2020	
	☐ Other actions:		

Comments (e.g., what did you learn about the resident's abilities that might be contributing to the cause of the behaviour?)

No change in functional ability, no falls since admission. No changes to medications. Occasional bladder incont if unable to find bathroom; uses liner and mesh pants

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U - Underlying Illness/Injury

✓ Potential causes related to physical health	✓ Possible actions/investigations	Date D D M M M Y Y Y Y	Initials
☐ Delirium ***Medical Emergency***	☑ Confusion Assessment Method (CAM) or 4AT or 3D CAM	15 AUG 2020	DP
	☑ PRISME (physiological reasons for delirium)	15 AUG 2020	DP
	☑ Assess for possible signs and symptoms of infection	15 AUG 2020	DP
☐ Diseases/disorders (e.g., new or worsening symptoms of existing conditions)	☑ Respiratory assessment e.g., worsening COPD, infection	15 AUG 2020	DP
	☑ Blood work (list): CBC, lytes, BUN, Creat Hgb A1C	16 AUG 2020	BD
	☐ Diagnostic imaging (specify):		
	☐ Other (e.g. urinalysis):		
☑ Pain (e.g., discomfort, aches, itchy, tender etc.)	☑ Pain scales (e.g. PAINAD, numeric, faces scale)	15 AUG 2020	DP
	☑ Pain assessment	15 AUG 2020	DP
☐ Medications and supplements: Review current meds including PRNs and consider recent changes and medication concerns • Drug interactions • Dose or frequency changes (e.g., adjusted for renal or liver impairment) • Over the counter/natural health products	☐ Medication review (consult pharmacist)		
	☐ Monitoring of new medications or dosage changes		
	☑ Vital signs:	15 AUG 2020	DP
	☐ Substance Use/Misuse Screening Tools (e.g. CAGE, DAST-10)		
☐ Substance use: • Alcohol • Tobacco • Cannabis • Illegal or illicit drug use	☑ Skin assessment weekly with bath	13 AUG 2020	BD
	☐ Other actions:		
☐ Allergies/intolerances			

Comments: (e.g., what did you learn about the resident's physical health that might be contributing to the cause of the behaviour?)

CAM-negative. PRISME: Pain assessment: current analgesia keep pain well controlled. Ø restraints, Ø urinary retention or frequency. Ø constipation - BM every 2 days - normal for resident. Ø signs of infection: chest clear, no cough, no wounds, oral intake unchanged. VS unchanged from baseline 118/68 - 128/74, HR 64-76, RR 18-20, SaO2 95-98% RA Temp 36.4-37(o). Ø change in appetite. Occasional trouble sleeping. Family visits several times per week. Participates in recreation activities and church services - Ø social isolation. Ø changes in medications since last review in July. Diabetic stable; Hgb A1C 7.2-7.4. New neighbour next door.

Aug 17, 2020 - bld work normal.

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U - Underlying Illness/Injury

✓ Potential causes related to mental health	✓ Possible actions/investigations	Date D D M M M Y Y Y Y	Initials
☐ Changes in mood and affect	☑ SIG E CAPS (signs of depression)	17 AUG 2020	BJ
☐ Withdrawn (loss of engagement or interest)	☐ Cornell Depression Scale for Depression		
☐ Change in appetite (increase or decrease)	☐ 7 Ds (risk of mental illness behaviors)		
☐ Sleep disturbances	☐ Geriatric Depression Scale		
☐ History of mental illnesses	☐ Depression Rating Scale (MDS):		
☐ Desire or thoughts about self-harm or suicidal ideation	☐ Suicide Risk Assessment		
☐ Psychosis (delusions, illusions, hallucinations)	☐ Other Actions		
☐ History of Trauma			

Comments: (e.g., what did you learn about the resident's mental health that might be contributing to the cause of the behaviour?)

Hx of depression; SIG E CAPS negative, Ø withdrawn, Ø thoughts self harm, Ø loss of engagement, Ø change in appetite,

S - Social

✓ Potential causes related to social history	✓ Possible actions/investigations	Date D D M M M Y Y Y Y	Initials
☐ What do you know about this person and what do you need to know?	☐ How is information made available to staff? Specify:		
☐ Social network, family relationships	☐ Meaningful activities posted/listed		
☐ Culture, religion, community	☑ "Getting to Know Me" form withadrn	20 Oct 2019	BJ
☐ Language barrier	☐ Social history		
☐ Work, occupation, volunteering	☐ Recreation assessment		
☑ Hobbies, interests and accomplishments	☐ Family care conference		
☐ Expectations, goals, desires	☐ Informal family meeting or family huddles		
☐ Personal preferences, values, what matters to them	☐ Consider life story		
☐ Significant life events	☐ C.A.R.E. alert (violence prevention) activated	01 AUG 2020	BJ
☐ Past trauma	☐ Other:		
☐ Negative associations or triggers			
☐ Consider and identify the impact of the 7As *(Amnesia, Aphasia, Agnosia, Apraxia, Anosognosia, Apathy, Altered Perception)*			
☐ Other:			

Comments: (e.g., what did you learn about the resident's social history that might be contributing to the cause of the behaviour?)

Likes to garden - maybe reason why she takes plants? Likes to wander rooms now if TV volume up in lounges

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E - Environment

✓ Potential causes related to environment	✓ Possible actions/investigations	Date D D M M M Y Y Y Y	Initials
☐ Noise	☐ "Look" checklist (environment scan)		
☐ Temperature, air circulation	☐ Assess noise level (e.g. ECAT)		
☐ Consider and identify the impact of 7As *(Amnesia, Aphasia, Agnosia, Apraxia, Anosognosia, Apathy, Altered Perception)*	☐ Changes on unit or immediate environment (describe)		
☑ Issues with personal space and belongings (preferences)	☐ Address individual environmental needs		
☐ Issues with privacy and shared spaces	☐ Discussion with resident and family		
☐ Environment not conducive to preferred activities	☐ Other Actions:		
☑ Over stimulation/under stimulation			
☐ Lighting/colors/patterns			
☐ Odours			
☐ Resident routines / facility / flexibility			
☐ Relocation - new to PCH or room change			
☐ Esthetic changes (e.g., construction, repairs, maintenance, upgrades)			
☐ Use of restraints (list in comments)			
☐ Lack of appropriate cues (signage, visuals, etc.)			
☐ Issues with access to locations or belongings			
☐ Staff changes or inconsistent staff			

Comments: (e.g., what did you learn about the resident's environment that might be contributing to the cause of the behaviour?)

↑wandering if lounge TV loud. Goes into other rooms & takes things - mostly plants. Hx of having a cat sleeping with her.

Other tools that may assist you:

☐	**Cohen Mansfield Agitation Inventory (CMAI)**
	Comments:
☑	**Dementia Observation System (DOS)**
	Comments: Reactive behaviours with am care happen after not sleeping well. Also made worse if more than 1 staff assist with pm care. No wandering if visitors or recreation.
☐	**ABC Behaviour Mapping Tool**
	Comments:
☐	**Social Connection Plan**
	Comments:

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4. Plan of Care

Based on the information from the assessment, what is the plan for the resident (including care approaches and communication strategies) that best addresses the identified needs?

Pain assessment if difficulty sleeping & daily. Have daughter bring in some plants for her to care for. Offer warm milk @ bedtime. Find activity to do in evenings with no visitor/intervention - maybe music? Delay morning care if not slept well. No more than 1 person to provide peri care. Get a toy/plush cat to stay on her bed

Communication

How are you going to communicate the plan to the team (including the resident or family)?

Huddles and shift change. Update care plans and ADL sheet. Discuss with daughter, Betty & write IAV.

Evaluation

How will you know if the interventions are working. **When** will you reevaluate? **What** tools will you use?

Repeat ODS in 2 weeks - September 4, 2020 for 3-5 days to see if better sleeping & less physically reactive behaviours.

Have you:

☑ Reviewed with resident or family/substitute decision maker

Name: Betty Miller Date: 21 AUG 2020 (D D M M M Y Y Y Y)

Team member name/signature: Barb Jessie RN

☑ Documented in integrated progress notes (as needed)

☑ Updated resident care plan

☑ Updated resident ADL sheet

☐ Completed referrals as needed

☐ Set reminder for the reassessment date: 04 SEP 2020 (D D M M M Y Y Y Y)

Team members involved in this assessment sign below:

Print Name and Designation	Signature	Date (D D M M M Y Y Y Y)
Debbie Smith	Debbie Smith	16 AUG 2020
Barb Jessie	Barb Jessie	16 AUG 2020