# Responsive Behaviours

## Part 1: Interdisciplinary Assessment & Care Planning

**If the behaviour is not an imminent physical risk or an acute change, we can start by initiating a Behaviour Assessment and looking for what the behaviour is telling us. Ask these questions:**

### #1 What has changed?

If there has been a clear change in situation or health status, you may be able to determine what needs to be done at this step. **If it is an acute change, make sure to assess for delirium and acute illness and notify the prescriber for next steps.**

### #2 What are the risks?

Asking this helps us decide on what to do, who needs to be protected and from what. The answers can range from “staff are annoyed” to “suicide risk.”
Think I.S.S.U.E.

### #3 What might be "C.A.U.S.E.-ing" the behaviour?

Consider each area, and if you need to, use assessment tools to learn more about the resident's status and what the behaviour might be telling you.

**C** OGNITION - Look for changes in memory, orientation, recognition of people or objects, language and comprehension or reasoning and insight.

**A** BILITIES - Are there communication barriers, changes to mobility, ADLs, restraint use, loss of dignity, sleep changes?

**U** NDERLYING ILLNESS - Look for new or worsening symptoms of existing conditions, medication changes, substance use, allergies/intolerances, pain, mood, mental illness?

**S** OCIAL - Think about their life story, is there a connection to unmet needs? Can we meet a need by considering social needs, family, cultural or spiritual needs, work history, hobbies, interests, a need to feel valued and be productive? Is there a trigger to a past trauma?

**E** NVIRONMENT - What could be causing distress in the environment? Noise, temperature, personal space, privacy, over or under stimulation, change in room or facility, staff changes, lighting, odours, and rigid routines are some examples to consider.

**Consider using these tools if they might help you understand the resident's situation:**

- Delirium: CAM (Confusion Assessment Method) and PRISME
- Cognitive status (e.g. MMSE, MoCA, CPS)
- Patterns of behaviour (e.g. DOS, ABC Behaviour Mapping, CMAI, VPP care alert)
- Mood status (e.g. SIG E CAPS acronym, GDS, DRS)
- Pain assessment (e.g. PAINAD, faces scale, numeric scale)
- Suicide Risk Screening Tool and Risk Assessment for Suicide Tool (RAST)

### #4 What is the action/plan of care?

- Use the whole team to make an individualized plan.
- Consider approaches, communication and dealing with possible causes that can be changed.
- Share the plan with all staff, resident, and family.
- Consider consults like OT, SLP, Dietitian, Recreation
- Monitor behavioural response to the plan (e.g. DOS, ABC Behaviour Mapping).
- **Be consistent and give the plan some time.**

**If you need other supports you can consider:**

- Consult WRHA Continuing Care Dementia Care Working Group
- Consult Geriatric Mental Health Team (GMHT) or BRaCT and review previous recommendations
- Assess the need for constant care
- Contact LTC Access Centre to discuss Transition Advisory Panel