



Evidence-Based Clinical Assessment Toolkit

Behavioural Expressions Assessment Pack - Basic



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Not in Assessment Pack	Tool	Source
ACFI Assessment	Behaviour Records	https://www.dss.gov.au/ourresponsibilities/ageing-and-aged-care/aged-carefunding/residential-care-subsidy/basic-subsidyamount-aged-care-funding-instrument/aged-carefunding-instrument-acfi-assessment-pack
ACFI Assessment	Cornell Scale of Depression in Dementia (modified)	https://www.dss.gov.au/ourresponsibilities/ageing-and-aged-care/aged-carefunding/residential-care-subsidy/basic-subsidyamount-aged-care-funding-instrument/aged-carefunding-instrument-acfi-assessment-pack

BEHAVIOUAL DESCRIPTION	MAPPING				
<i>Must require staff intervention. Report what you see or hear.</i>	ACFI 7	ACFI 8	ACFI 9	ACFI 10	Neuro- psychiatric
Interfering with other people or their belongings	W1				
Trying to exit the building or property	W2				
Trying to get into inappropriate areas	W2				
Verbal refusal to participate in required ADL care		V1			
Cursing, swearing verbal aggression, obscenity		V2		Irritability: easily annoyed, short	
Verbal demanding (that is not an unmet need)		V2			
Loud noises, screaming (that is not an unmet need)		V2			
Verbal accusations based on excessive suspiciousness, that you know are not true. Leads to significant and regular disturbances of others.		V3			NPI-NH: Delusions
Inappropriate verbal sexual propositions		V4			
Verbal negativism - consider mood symptoms				Poor self-esteem:	
Harm to self e.g. burn self, cut self			P1		
Harm to other people e.g. kicking, biting			P1		
Harming other things			P1		
Sexual advances			P1		
Chronic substance abuse			P1		
Socially inappropriate handling of objects e.g. others belongings, faecal smearing,			P2		
Excessive hiding and hoarding			P2		
Ingesting inappropriate substances			P2		
Disrobing in public			P2		
Socially inappropriate sexual behaviour e.g. public masturbation			P2		
Constant restlessness- inability to sit still			P3	Agitation: restlessness,	
Repetitious mannerisms/abberant motor behaviour:			P3		Abberant motor behaviour
Agitation: restlessness, handwringing, hairpulling, lip biting, fidgety, restless, unable to sit still for at least an hour	P3: Constant restlessness- inability to sit still			Behavioural Disturbance	
Multiple physical complaints:in excess of normal- indigestion,				Behavioural Disturbance	
Retardation: NOT RELATED TO PHYSICAL ILLNESS				Behavioural Disturbance	
Loss of interest: NOT RELATED TO PHYSICAL ILLNESS				Behavioural Disturbance	
Sadness: feeling down, sad or blue, sad voice, tearful, crying				Mood related sadness	
Anxiety: anxious expression, ruminations, worrying about things more				Mood related anxiety	
Lack of reactivity: does not enjoy pleasant events -mood gets in way of enjoying activities/friends/surroundings				Mood related lack of reactivity	
Irritability: easily annoyed, short tempered, unusually impatient		V2: Verbal disruption		Mood related irritability	
Diurnal mood: mood symptoms worse in morning				Cyclic	
Difficulty falling asleep: later than usual				Cyclic	
Multiple awakening during sleep: exclude going to toilet and falling asleep again				Cyclic	
Early morning awakenings: than usual, stays in bed or goes back to sleep				Cyclic	
Appetitie Loss: eating less than usual				Physical sign	
Weight loss: unintended loss in past month				Physical sign	

BEHAVIOUAL DESCRIPTION	MAPPING				
	ACFI 7	ACFI 8	ACFI 9	ACFI 10	Neuro- psychiatric
Must require staff intervention. Report what you see or hear.					
Lack of energy: fatigues easily, unable to sustain activity, dragging thru the day				Physical sign	
Suicide: feels life is not worth living, would rather be dead, has wishes/plan, makes attempt				Ideational Disturbance	
Poor self-esteem: especially critical of self, self-blaming, feelings of failure, worthless, inferior, no good.				Ideational Disturbance	
Pessimism: anticipation of the worst, discouraged about the future				Ideational Disturbance	
Mood congruent delusions: delusions on poverty, illness, loss		V3: Does the resident have beliefs that are not true?		Ideational Disturbance	
Does the resident have beliefs that you know are not true? For example saying that people are trying to harm him/her or steal from him/her. Has he/she said that family members or staff are not who they say they are or that his/her spouse is having an affair?		V3: Paranoid ideation that disturbs others			NPI-NH: Delusions
Does the resident have hallucinations – meaning, does he/she see, hear, or experience things that are not present?	depends on how it is manifested	depends on how it is manifested	depends on how it is manifested		NPI-NH: Hallucinations
Does the resident have periods when he/she refuses to let people help him/her? Is he/she hard to handle? Is he/she noisy or uncooperative? Does the resident attempt to hurt or hit others?		V1: verbally unco-operative V2: Verbally disruptive	P1: Physically threatens to harm others		NPI-NH: Agitation/ Aggression
Does the resident seem sad or depressed? Does he/she say that he/she feels sad or depressed? Does the resident cry at times?				Mood related sadness	NPI-NH: Depression
Is the resident very nervous, worried, or frightened for no reason? Does he/she seem very tense or unable to relax? Is the resident afraid to be apart from you or from others that he/she trusts?				Mood related anxiety	NPI-NH: Anxiety
Does the resident seem too cheerful or too happy for no reason? I don't mean normal happiness but, for example, laughing at things that others do not find funny?					NPI-NH: Elation/ Euphoria
Does the resident sit quietly without paying attention to things going on around him/her? Has he/she lost interest in doing things or lack motivation for participating in activities? Is it difficult to involve the resident in conversation or in group activities.				Mood related lack of reactivity	NPI-NH: Apathy/ Indifference
Does the resident do or say things that are not usually done or said in public? Does he/she seem to act impulsively without thinking? Does the resident say things that are insensitive or hurt people's feelings? (Loss of control of impulses)		V4: Verbally sexually inappropriate	P2: Socially sexually inappropriate		NPI-NH: Disinhibition
Does the resident get easily irritated or disturbed? Are his/her moods very changeable? Is he/she extremely impatient?				Mood related irritability	NPI-NH: Irritability
Does the resident have repetitive activities or "habits" that he/she performs over and over such as pacing, wheeling back and forth, picking at things, or winding string? (Do not include simple tremors or tongue movements).	Possibly W2:		P3 Repetitious mannerisms		NPI-NH: Aberrant motor behaviour
Difficulty falling asleep				Cyclic symptoms	NPI-NH:
Wanders, pace, inappropriate night time activity	Possibly W2:				NPI-NH:
Wakes, dresses, plans to go out thinking it is morning					NPI-NH:
Does the resident have an extremely good or poor appetite, changes in weight, or unusual eating habits (count as "N/A" if the resident is incapacitated and has to be fed)? Has there been any change in type of food he/she prefers?				Physical signs	NPI-NH: Appetite and Eating Disorders
Has there been any change in type of food he/she prefers?					NPI-NH: Appetite and Eating Disorders

BEHAVIOUAL DESCRIPTION	MAPPING				
	ACFI 7	ACFI 8	ACFI 9	ACFI 10	Neuro- psychiatric
Must require staff intervention. Report what you see or hear. Excessive fear and anxiety and related behavioural disturbances- separation disorder, selective mutism, specific phobia, social phobia, panic disorder, agoraphobia, generalised anxiety(n most days in past 6 months, clinically sig distress,not attributable to substances or other mental disorder), substance/medication induced anxiety disorder					DSM-5: Anxiety Disorders
Mania- persistently elevated, expansive or irritable mood with goal-directed activity/energy. May have inflated self esteem or grandiosity, decreased need for sleep, more talkative, pressure to keep talking, flight of ideas or subjective experience that thoughts are racing, attention easily distracted to irrelevant external stimuli, increase in goal directed activity or psychomotor activity (non-goal directed activity), excessive involvement in activities with high potential for painful consequences (e.g. buying spree)					DSM-5: Mania
Delusions- fixed beliefs not amenable to change in light of conflicting evidence. Themes- persecutory, referential, somatic, religious, grandiose. Are bizarre if not plausible.					DSM-5: Psychosis (delusions)
Hallucinations- perception like experiences without external stimulus. Occur in any sense modality in a clear sensorium- not occurring during falling asleep or waking up.					DSM-5: Psychosis (hallucinations)
Disorganized thinking (speech)- answers to questions are obliquely related or unrelated, word salad is a severe example					DSM-5: Psychosis (delusions)
Grossly abnormal motor behaviour- rigid, bizarre posture, mutism, stupor (no motor response), excessive motor activity without cause, stereotyped movements, staring, grimacing, echoing of speech			P3 Repetitious mannerisms		DSM-5: Psychosis (psychomotor) (NPI-NH: Aberrant motor behaviour)
Negative symptoms-more common in Sz, reduced expression in face, eye contact, intonation of speech, hand/head mvts, reduce in motivationself initiated purposeful activities e.g. sit for long periods with no interest in activities, dimished speech output, decreased ability to experience pleasure from positive stimuli,lack of interest in social interactions.				Mood related lack of reactivity	DSM-5: Psychosis

Behavioural Assessment Form

Behaviour does not occur in a vacuum. Whether we can see it or not, there is always something that starts it off. Sometimes this is an event such as the delivery of a meal, sometimes it is a thought such as *'I am missing my husband.'*

The trigger to the behaviour is called the **Antecedent**, it is the A of the ABC.

The Behaviour itself is the B and the Consequences of the behaviour are the C.

The consequences have a strong influence on whether or not the behaviour will be repeated. If the consequences are experienced as rewarding the behaviour is likely to go on or be repeated, if they are not rewarding the behaviour it is likely to stop, eventually.

Effective behaviour management begins by trying to clearly describe the behaviour, identifying the triggers and analysing the consequences to see what is keeping it going. In other words, applying the ABC approach.

There are many varieties of forms, this example is modified form of the NARFRAME version of the John Bowles' version (*Bowles, 1986*). If the antecedents can be identified and changed the behaviour may be avoided. A simple, but actual, example of this involved a resident who repeatedly screamed *'Murder, murder'*. When the antecedents were identified it was found that these outbursts were often preceded by a door slamming loudly. When this was changed the behaviour did not occur as frequently. Similarly if non-rewarding consequences can be substituted for rewarding consequences the behaviour will also reduce. Disruptive, dangerous and unpleasant behaviours can be managed indirectly, i.e. by looking at what starts them and what keeps them going, more humanely and with more dignity than when confronted directly, by administering drugs or restraints.

Instructions for the Modified BAF

The Modified BAF should be completed every time a significant incident takes place.

If the person responsible for monitoring the resident is not present during the incident they should complete the BAF by discussing the events with staff who were present.

1. Begin by filling out the Behaviour i.e. clearly describe the behaviour;
2. Then describe what happened before; and then
3. What happened afterwards?

Name:..... DOB:// Room Number:

Date Assessment Completed://

Name of assessor: RN EN PCW AHP

Signature:

Modified Behavioural Assessment Form

Question	Behaviour (What, exactly was the incident)
Observed Behaviour	The Behavioural Descriptions list will assist you to provide an objective description of the behaviour.
How long did it last?	

Question	Antecedent (what was happening before the incident)
Date	
Time	
Place?	<input type="checkbox"/> Travelling out of the grounds <input type="checkbox"/> Outside, but within grounds <input type="checkbox"/> Bedroom <input type="checkbox"/> Ensuite <input type="checkbox"/> Shared bathroom <input type="checkbox"/> Corridor <input type="checkbox"/> Dining area <input type="checkbox"/> Activity area <input type="checkbox"/> Other (describe)
Who was there?	<input type="checkbox"/> Other resident/s <input type="checkbox"/> Other visitor/s <input type="checkbox"/> Own visitor/s <input type="checkbox"/> Doctor <input type="checkbox"/> Care staff <input type="checkbox"/> Therapy staff <input type="checkbox"/> Activity staff <input type="checkbox"/> Domestic staff <input type="checkbox"/> Maintenance/gardening staff <input type="checkbox"/> Alone <input type="checkbox"/> Other (describe)

Question	Antecedent (what was happening before the incident)
What interaction was going on?	<input type="checkbox"/> Staff assisted ADL care (nutrition/walking/personal hygiene/toileting,) <input type="checkbox"/> Independent self care (including taking medications) <input type="checkbox"/> Medication administration by staff <input type="checkbox"/> Complex health treatment by staff <input type="checkbox"/> Medical visit <input type="checkbox"/> Individual therapy (physio, massage, describe other type) <input type="checkbox"/> Activities (individual, describe type) <input type="checkbox"/> Activities (group, describe type) <input type="checkbox"/> With visitor/s <input type="checkbox"/> No interaction <input type="checkbox"/> Other (describe)
What else was happening?	Describe the environment e.g. Noise, stimuli, entertainment, TV, lot of people etc.
Question	Consequences (What, happened after the incident)
What interactions took place afterwards?	
Rate the disruption	<input type="checkbox"/> (0) Not disruptive <input type="checkbox"/> (1) A little disruptive, not disruptive to other residents or visitors <input type="checkbox"/> (2) Moderately disruptive, minor impact on other residents or visitors <input type="checkbox"/> (3) Very disruptive, interferes with others, their belongings or visitors, asocial behaviour <input type="checkbox"/> (5) Extremely disruptive, threatening safety of self or others or damaging things, requires immediate attention
Describe the intervention	How many staff, what is the intervention, other resources required, time taken
Rate the effectiveness of the intervention	<input type="checkbox"/> (0) No intervention by staff <input type="checkbox"/> (1) Very successful, co-operative response, settled quickly <input type="checkbox"/> (2) Successful, settled within 5 minutes <input type="checkbox"/> (3) Somewhat successful, settled for short time only or requires constant attention <input type="checkbox"/> (4) Not successful