Evidence-Based Clinical Assessment Toolkit

Quick Guide for Behavioural Expressions

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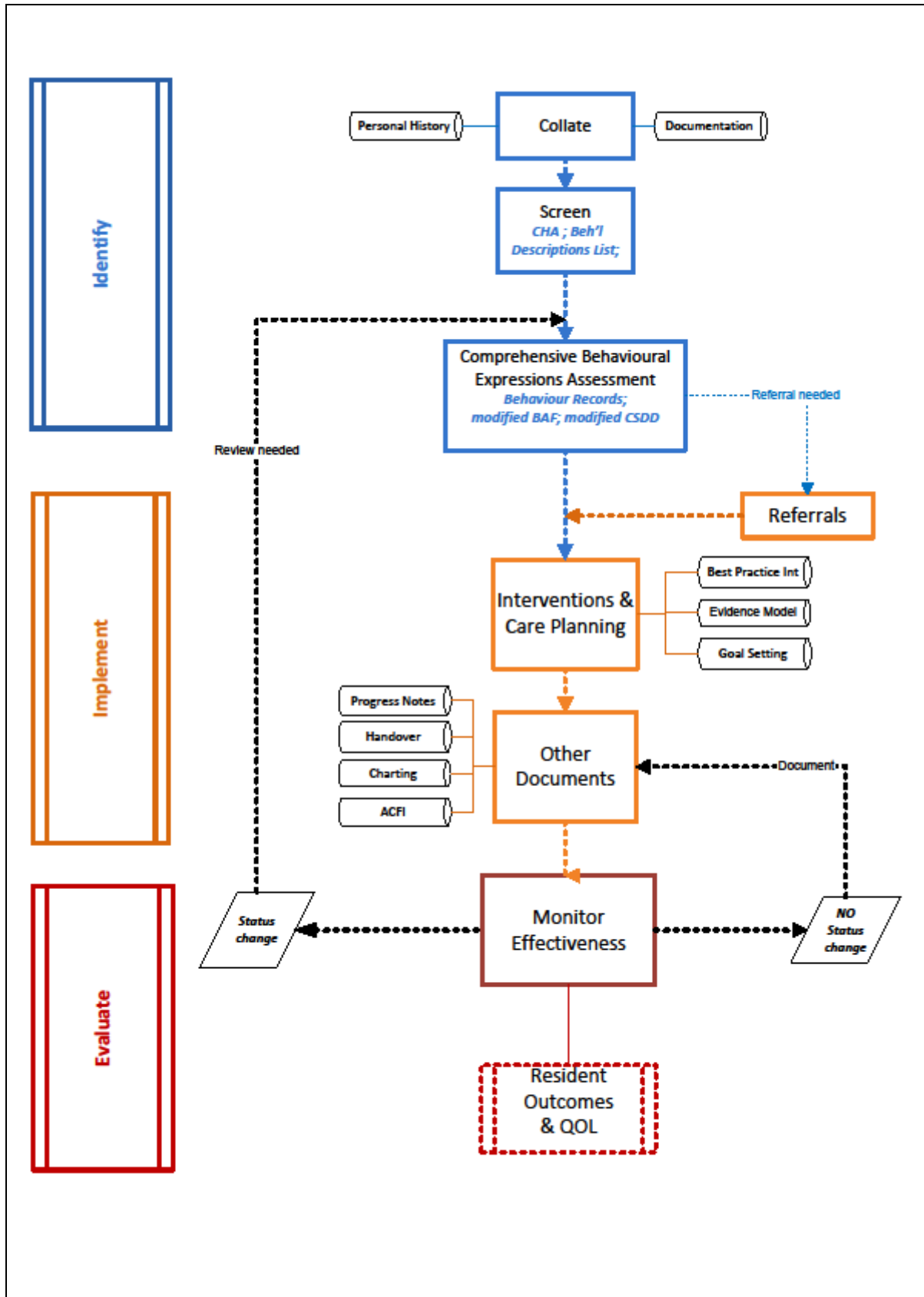
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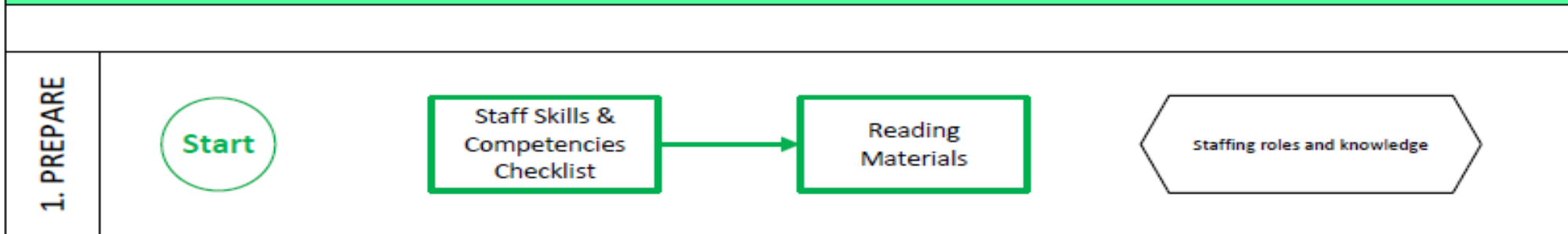
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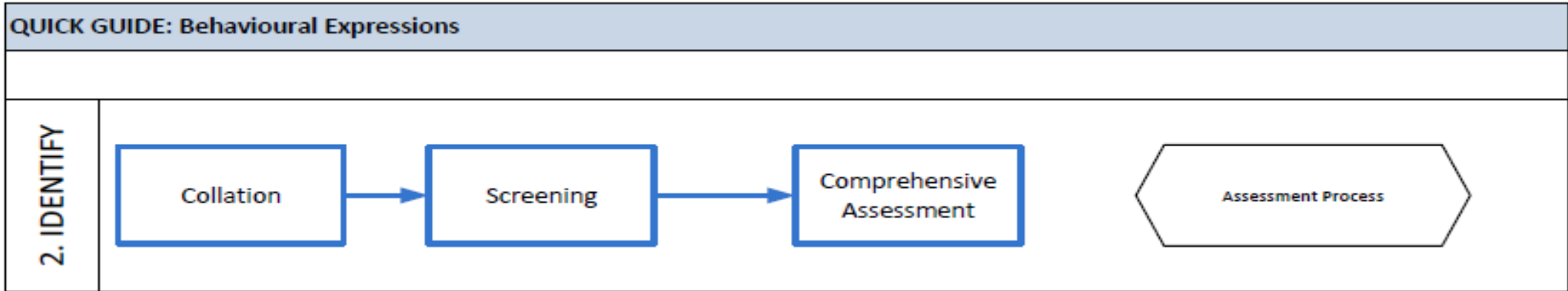
Behavioural Expressions Summary: Steps and Information Flow

Identify

Personal History → Collate ← Documentation

Screen
CHA ; Beh'l Descriptions List;

Comprehensive Behavioural Expressions Assessment
Behaviour Records; modified BAF; modified CSDD

Referral needed

Referrals

Implement

Interventions & Care Planning
- Best Practice Int
- Evidence Model
- Goal Setting

Progress Notes
Handover
Charting
ACFI

Other Documents

Document

Evaluate

Review needed

Status change

Monitor Effectiveness

NO Status change

Resident Outcomes & QOL

QUICK GUIDE: Behavioural Expressions

1. PREPARE

Start → Staff Skills & Competencies Checklist → Reading Materials

Staffing roles and knowledge

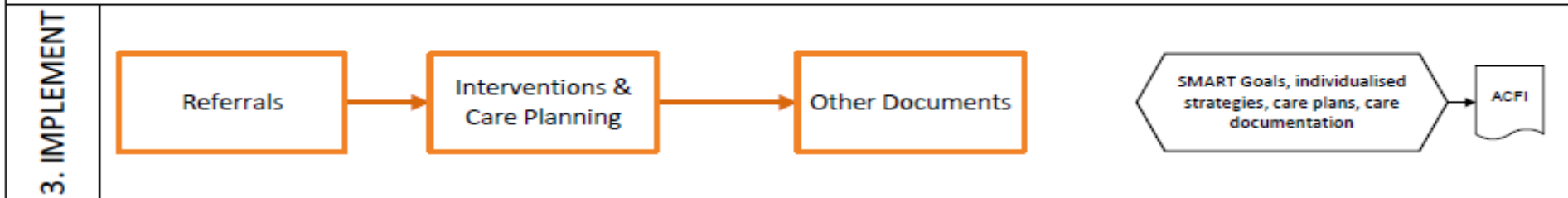| Step	Action	Outcomes
Staff Skills & Competencies Checklist	☐ Determine the skills or competencies required to complete each activity	Due diligence is applied to the process
	☐ Identify staff or staff type competent to complete each activity	Management have identified the staff that fit the required skill set to complete activities within the process. It assists to select staff and determine the roles of staff to ensure the process can be completed, and assists to identify training and education needs

Step	Action	Outcomes
Reading Material	☐ Reading materials or summaries from the recommended resources are provided for each topic	Introduces some basic information staff should understand about the topic. The Behavioural Expressions Workbook is intended to cover behavioural symptoms associated with cognitive impairment disorders as well as psychological (e.g. depressive symptoms) and psychiatric symptoms (e.g. anxiety, psychosis etc). Discusses the interaction with other domains.

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Step	Action	Outcomes
Collation	☐ Gathering the history from the resident and family	Preferences (related to the care, social and environmental aspects), pleasant events, what has been tried, what works for the family. Involving the resident and family in their care underpins the principles of Person Centred Care.
	☐ Gathering diagnoses, clinical information, personal history from file note (ACCR, CMA, AHP)	Diagnoses and information associated to behavioural symptoms, psychological (e.g. depressive symptoms) and psychiatric symptoms (e.g. anxiety, psychosis). Information about other domains that may interact e.g. sensory impairment, physical functioning, mobility, continence, medications etc

Step	Action	Outcomes
Screening/ Initial Assessment	☐ Comprehensive Health Assessment (CHA) items	CHA can inform on the screening process and parts of the comprehensive assessment (i.e. can inform on impact from other domains). Mood responses are collected, but not based on a validated assessment tool. Assists in identifying a mood issue.
	☐ Progress Notes	Staff objectively record what is seen and heard and the contextual information of the event.
	☐ Behavioural Descriptions list	Behavioural list to identify a broad range of behaviours and symptoms, not limited to an ACFI focus, supports staff to identify problematic behaviours and to map to ACFI items.

Step	Action	Outcomes
Comprehensive Assessment	☐ Modified Behavioural Assessment Form	Takes the user through documenting significant behavioural episodes- describing the behaviour, the antecedents and consequences in an objective manner.
	☐ Behaviour Records	Transcribe the frequency and pattern of identified behaviours from the modified BAF
	☐ Clinical Risk Management	Recognising and minimising system wide risk factors of Depression and Physical restraints.
	☐ Clinical Reasoning	Includes the awareness of the impact of other impairments e.g. sensory, physical, medications etc.

QUICK GUIDE: Behavioural Expressions

Step	Action	Outcomes
Referrals	☐ Management to complete Referral Tables	Completed Referral Tables based on a due diligence approach (see below)
	☐ Referral Process	Provide a protocol and process that provides a documentation trail for the referral process, is there - a current log of Health Professionals ; a referral request template; - an information pack prepared for the Health Professional you refer out to; - an outcomes template for the Health Professional to report the outcomes to you;
	☐ Medical Specialist e.g. Geriatrician	Specialist aged medical care
	☐ Aged Psychiatry/MH Specialist	Specialist Mental Health Assessment and best practice interventions
	☐ Dementia Consultant	Specialised assessment, staff support and best practice interventions
	☐ Behaviour support services e.g. DBMAS	Specialised assessment, staff support and best practice interventions

Step	Action	Outcomes
Interventions	☐ Person Centred Care	To provide a good quality of life for all residents requires a systematic approach
	☐ Pharmacological	To possibly improve memory, mood, sleep or anxiety outcomes for the individual
	☐ Staff / family education	To improve knowledge, co-operation and understanding of interventions
	☐ Physical Environment	Domestic size, homelike, calm and supportive, safe walking areas inside and outside
	☐ Effective communication	Pace, multi sensory, concrete terms, closed questions, not complex, single commands
	☐ Psychosocial environment	Person's interaction/ relationships with community, staff, family and friends.
	☐ Physical Activity	Maintain their overall physical health
	☐ Daily Activities	Use 1-1 activities to engage the person with their surroundings and in conversation.
	☐ Pleasant Events	Understand the person and offer interactions that will please them
	☐ Meaningful activities	To improve the quality of life of the resident

Step	Action	Outcomes
Goal Setting	☐ Specific	State exactly what it to be accomplished (Who, What, Where, Why)
	☐ Measurable	How will you demonstrate if the goals were met?
	☐ Action-oriented	What is the action to be completed?
	☐ Realistic / Relevant	Ensure the changes are feasible and affordable
	☐ Time-based	Date or elapsed time to complete the goal
	☐ Consumer focus	Resident has participated in the process, and considerations relevant to their Quality of Life (enjoyment of life) have been incorporated

Step	Action	Outcomes
Care Planning	☐ Documentation	Recording care needs, strategies, goals and the evaluation of the goals and the care. Consumer participation in the process and feedback is to be sought.
	☐ Communication	Provides information about care needs in an accessible format. Congruent with other documentation.
	☐ Consumer focus	Consumer has participated in the process. Involving the resident and family in their care underpins the principles of Person Centred Care (PCC).

Step	Action	Outcomes
Linking the Evidence	☐ Diagnosis and symptoms	Accurate diagnosis is crucial for understanding the behavioural expressions and identifying possible interventions
	☐ Impact on body structure/function	Linking diagnosis to a body structure/function e.g. misperceptions, lowered mood
	☐ Activity Limitation	Linking body structure/function an impacted activity e.g. may be socially inappropriate, withdrawn from activities and interactions
	☐ Strategies (actions) to improve enjoyment of life and participation	Document how the interventions address the activity limitation e.g. pleasant events to encourage social interaction

Step	Action	Outcomes
Other documents	☐ Progress Notes	Document new observations, assessments, strategies, and changes made to the care plan. Care plan, progress notes and assessments to be congruent. Provide clear and consistent communication to staff and other Health Professionals.
	☐ Handover Notes	Handover notes update Progress Notes and Care Plans.
	☐ Charting	Update charting information.
	☐ Complete the ACFI	Use the assessment outcomes and the evidence links to determine and support the claims.

QUICK GUIDE: Behavioural Expressions

4. EVALUATE		Resident Quality of Life	Resident Clinical Outcomes	Cycle of identifying and responding to changing needs

Step	Action	Outcomes
Quality of Life Outcomes	☐ Repeat Quality of Life questionnaire (if suitable)	Objectively evaluate Quality of Life goals as relevant to the topic Learning about the resident's views on their life. Involving the resident in their care underpins the principles of Person Centred Care (PCC).
	☐ Seek feedback from the resident and/or family	Involving the resident and family/friend in their care underpins the principles of Person Centred Care (PCC).
	☐ Seek staff feedback	Identify any incongruence between staff and consumer views; this may identify education opportunities for staff and/or family.

Resident Care Outcomes	☐ Evaluate Care Goals	Objectively evaluate care goals as relevant to the topic.
	☐ Monitor Incident Forms/Audits	Update risk assessments and strategies
	☐ Monitor Standardised Care Processes	Monitor system level clinical issues
	☐ Monitor Resident File documents	Ensuring the Resident File documentation is current and congruent. Ensuring the communication to care staff and other Health Professionals is congruent. This would include all Progress Notes (by nursing/ AHP/Medical Practitioners etc), new assessments and Care Plans