Evidence-Based Clinical Assessment Toolkit (EBCAT)

Behavioural Expressions Workbook

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Other Contributors

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Acronyms and Glossary

ABBEY	Abbey Pain Assessment
ACCR	Aged Care Client Record
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
AHP	Allied Health Professional
BAF	Behavioural Assessment Form
BCOPE	Best Care For Older People Everywhere
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CCF	Care Continuum Framework
CDAMS	Cognitive, Dementia and Memory Service
CHA	Comprehensive Health Assessment (CHA) of the older person in health and aged care. Assessment template 2014.
CHAOP	Comprehensive Health Assessment of the Older Person
CMA	Comprehensive Medical Assessment
CSDD	Cornell Scale for Depression in Dementia
CTRAC	Continence Tools for Residential Aged Care
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcomes Measurement Suite
EBCAT	Evidence Based Clinical Assessment Toolkit
EBCAT Assessment Packs	Each workbook has an assessment pack which contains the recommended assessments for the Topics.
EBCAT Introductory Guide	This document presents the project methodology, an overview of the products, and details of the Management role.
EBCAT Resource Pack	This document contains • CHAOP modules 3,4 & 7 • Quality of Life questionnaire • SMART Goals sheet • Standardised Care Processes
EBCAT Topics	1. Nutrition; 2. Mobility; 3. Self Care (Personal Hygiene, Toileting) 4. Continence 5. Cognition 6. Behavioural Expressions (Wandering, Verbal & Physical, Mood) 7. Medicines 8. Pain 9. Swallowing 10. Skin & Wounds
EBCAT Workbooks	The toolkit is presented in six 'user friendly educational Workbooks' to walk the user through the process of using evidence-based clinical assessment tools for each domain of:

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	• ADL Workbook (Topics 1-3) • Continence Workbook (Topic 4) • Cognition Workbook (Topic 5) • Behavioural Expressions Workbook (Topic 6) • Medicine Workbook (Topic 7) • Complex Health Workbook (Topic 8-10)
FRAT	Falls Risk Assessment Tool
GP	General Practitioner
IPA	International Psychogeriatric Association
KICA-Cog	Kimberley Indigenous Cognitive Assessment- Cognitive Assessment
MP	Medical Practitioner
M-BAF	Modified Behaviour Assessment Form
M-VRBPI	Modified Resident Verbal Brief Pain Inventory
NATFRAME	National Framework for Documenting Care in Residential Aged Care Services http://webarchive.nla.gov.au/gov/20140803082152/http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe01.htm
NCD	Neuro-Cognitive Disorder
NPI-NH	Neuro-Psychiatric Inventory for Nursing Homes
NRS	Numeric Pain Rating Scale
PAINAD	Pain Assessment in Advanced Dementia
PAS-CIS	Psychogeriatric Assessment Scales- Cognitive Impairment Scale
PCC	Person Centred Care
PMS	Physical Mobility Scale
PSRACS	Public Sector Residential Aged Care Services
QoC	Quality of Care
QoL	Quality of Life
RACF	Residential Aged Care Facilities
RNDC	Resident Nutrition Data Card
ROM	Range Of Movement
RUDAS	Rowland Universal Dementia Assessment Scale
SCP	Standardised Care Process
SCORE	Strengthening Care Outcomes for Residents with Evidence
	Self Administration of Medicines
Skin Integrity Assessments	Residential Care Services Skin Integrity Assessment Waterlow Pressure Ulcer Risk Scale Braden Risk Assessment Scale Norton Scale For Predicting Risk Of Pressure Ulcer
Visual Analogue Pain Scales	Facial Thermometer
Wound Assessment	Residential Care Services Wound Assessment and Progress Chart

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Overview of the Toolkit Products

The Evidence-Based Clinical Assessment Toolkit (EBCAT) consists of the following products:

Resource	How used
Introductory Guide	The Introductory Guide presents the project methodology; an introduction to the products; and details on the Management role.
Resource Pack	The Resource Pack provides further reference information for the background reading section of each workbook. This pack contains reading material which cannot be sourced from the internet. References for supporting material that can be sourced off the internet are provided in workbook appendices. There is also a sample Quality of Life questionnaire in the Resource Pack.
Workbooks	The EBCAT Reference Workbooks provide the background materials that inform on the training and e-learning content. There are six workbooks which cover the domains of: • Activities of Daily Living • Continence • Cognition • Behavioural Expressions • Medicine • Complex Health Each workbook contains detailed information and case studies on how to complete the recommended assessment tools as part of a nursing-based process. The Appendices provide references for the suggested resources.
Quick Guides	There are six Quick Guides, one for each Domain. The Quick Guide is a quick reference to the EBCAT process and tools. It is recommended it be kept handy for use on the ‘floor’, whenever required.
Assessment Packs	The Assessment Packs contains the recommended assessment tools. There is one Assessment Pack per domain. The assessment tools are used as part of the process of identifying the needs of the residents.

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Suggested Roles for Staff Implementing the Toolkit

The toolkit requires the participation of three types of staff as described below.

	Who and what they do in regard to the Toolkit
Governance and change management role	This group will ensure that systems and roles are in place to support quality documentation and accurate ACFI claiming. The role possibly includes: o Managing the readiness of the organisation to implement EBCAT changes o Selecting key personnel o Managing and monitoring the implementation of the EBCAT toolkit The role is further described in detail in the Introductory Guide.
Person responsible for leading the care team	This role will lead and provide mentoring of the process on the floor. The role possibly includes: o Collaborating with the Management group t o Training and supporting the care team The leadership role is described in detail in the Introductory Guide.
Care Team	This group deliver the care to the resident, it includes nursing staff, Allied Health Professionals, and Health Professionals. They may contribute to the resident assessment and care planning processes, and the documentation activities.

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Introduction to the Behavioural Expressions Workbook

The Behavioural Expressions Workbook is one of six that form the Evidence Based Clinical Assessment Toolkit (EBCAT). This workbook is one of four resources relevant to the Behavioural Expressions domain which comprise:

- Resource Pack
- Behavioural Expressions Workbook
- Behavioural Expressions Quick Guide
- Behavioural Expressions Assessment Pack

The toolkit aims to provide a resource to assist Public Sector Residential Aged Care Services (PSRACS) staff to systematically and consistently determine and manage both resident care needs and funding requirements. The toolkit uses evidence-based clinical assessment tools for assessing and managing residents with the goals of improving the clinical and quality of life for the residents and demonstrating accountability to government regulators for example, with the Aged Care Funding Instrument (ACFI) requirements.

During 2013, the Australian Government made changes to the Aged Care Funding Instrument (ACFI) requiring further evidence to support funding claims made by services for activities of daily living support needs. In addition, the Australian government introduced more stringent penalties for providers with inaccurate or misleading ACFI appraisals from 1 July 2013.

This workbook will assist your service to meet the ACFI evidence requirements for the three ACFI behaviours items (ACFI 7- Wandering; ACFI 8- Verbal Behaviour; ACFI 9- Physical Behaviour) and the depression item (ACFI 10- Depression). The workbook uses familiar and freely available Australian toolkits and resources including:

- ACFI Assessment Pack (including Behaviour Records, Cornell Scale for Depression in Dementia)
- ACFI User Guide
- Best Care for Older People Everywhere (BCOPE). The toolkit.
- Dementia Outcomes Measurement Study (DOMS)
- Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5)
- The International Psychogeriatric Association (IPA) Guides to Behavioural and Psychological Symptoms of Dementia (BPSD)

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- An Initial Nurse Assessment – e.g. the Comprehensive Health Assessment of the older person in health and aged care
- The NATFRAME (National Framework for Documenting Care in Residential Aged Care Services)
- Neuropsychiatric Inventory- Nursing Home Version (NPI-NH)
- Standardised Care Processes (SCP Physical Restraint and SCP Depression)

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Topic 6:
Behavioural Expressions

The Behavioural Expressions Topic

This topic covers behavioural symptoms associated with cognitive impairment disorders as well as psychological/neuro-psychiatric symptoms (e.g. depressive symptoms, hallucinations, delusions etc).

Behaviour is the externally visible activity, response or expression of a person to an internal and/or external stimuli or unmet need (i.e., something they perceive or is actually happening or a form of communication related to an unmet need). The activity, response or behavioural expression is determined by the way a person interprets and processes the stimuli or communicates the unmet need. A person with moderate or severe cognitive impairment or dementia will have a limited ability to make a rationale or logical interpretation of the stimuli or how to communicate an unmet need. The behavioural expressions can be considered a form of communication (Kozman et al, 2006) but in the case of a person with dementia it will not form a volitional, deliberate or rationale course of actions designed to produce a particular outcome.

The characterisation of a behaviour as problematic in the case of residential aged care is contextual and framed by the prevailing societal norms, expectations, views and attitudes of others such as other residents, the family/visitors and the staff who are supporting the person on a daily basis.

When evaluating behavioural expressions it is important to understand the contributions of the:

(i) social and physical environment

(ii) care routines

(iii) staff and resident relationships and interactions

(iv) the needs of the person and how they try and communicate; and

(v) person’s broader health care needs

Any analysis of the reasons for problematic behavioural expressions requires a comprehensive understanding of the ‘trigger’ events to determine the contributing factors to the behavioural expression.

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Investigating Behavioural Expressions

The following four process steps should be followed when investigating behavioural expressions (consistent across all EBCAT topics). The steps are:

1. **Preparation of staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required. Staff will need to have a good level of background knowledge of possible psychological and neuro-cognitive behavioural symptoms, what they are and how they impact on people. Resources incorporated into the background reading section include:

    - The International Psychogeriatric Association Guidelines
    - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)
    - On-line education module "Evidence-based tools for BPSD Assessment.

    The references for these resources can be found in the Behavioural Expressions Appendix.

2. **Identifying** – gathering the resident's history by collating documents and talking with residents and their family, looking for signs and symptoms in the initial nurse assessment, completing a comprehensive assessment approach and assessing the scope of the challenge. A comprehensive approach will include:

    File Notes Review:

    - Aged Care Client Record (ACCR) – Parts 4 and 5 provide information on cognitive, behaviour and psychological aspects
    - Comprehensive Medical Assessment – which (if available) may have sections on behavioural, psychological and neuro-psychiatric symptoms

    Screen:

    - Initial nurse assessment – e.g. the CHA (found in the Resource Pack) records if lowered mood is apparent
    - A screening step across all behavioural expressions that will cover the ACFI items 7 to 10

    Further Assessment:

    The following assessment tools (found in the Behavioural Expressions Assessment Pack) are recommended for assessing the person's behavioural needs:

- For behaviours (ACFI 7, ACFI 8, ACFI 9) the mandatory assessments are Behaviour Records
- For depression (ACFI 10) the mandatory assessment is the Cornell Scale of Depression in Dementia
- The assessment of behaviours (ACFI 7, ACFI 8, ACFI 9) are also supported with a behaviour assessment approach based on the literature recommended 'ABC' theory (i.e. the modified Behavioural Assessment Form)

The SCORE Standardised Care Processes are also recommended for addressing the systemic clinical risks of delirium. The SCPs are found in the Resource Pack and are referenced in the Behavioural Expressions Appendix.

3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

   - Undertaking referral options to complete gaps or seek specialist advice
   - Planning evidence-based care strategies to assist the person to maintain or possibly improve their participation ability
   - Listening to and setting goals with the consumer (resident and family) to hear their understanding and personalise the approach
   - Understanding the role of communicating the care needs, goals and strategies through care plans and resident file notes to provide the documentation trail
   - Completing ACFI documentation

4. **Evaluating** – monitoring and evaluating the effectiveness of the process, interventions and looking for ways to further improve the care outcomes for residents.

The overall process and associated activities are illustrated in Figure 1 which shows the phases (e.g. prepare, identify, implement, evaluate), the steps within each phase and the aim for each phase (e.g. have identified the care needs of the resident). Each topic of the Behavioural Expressions Workbook follows the same pattern. Consistent application of this process will assist your facility provide systematic, accountable care and facilitate the best possible resident care outcomes.

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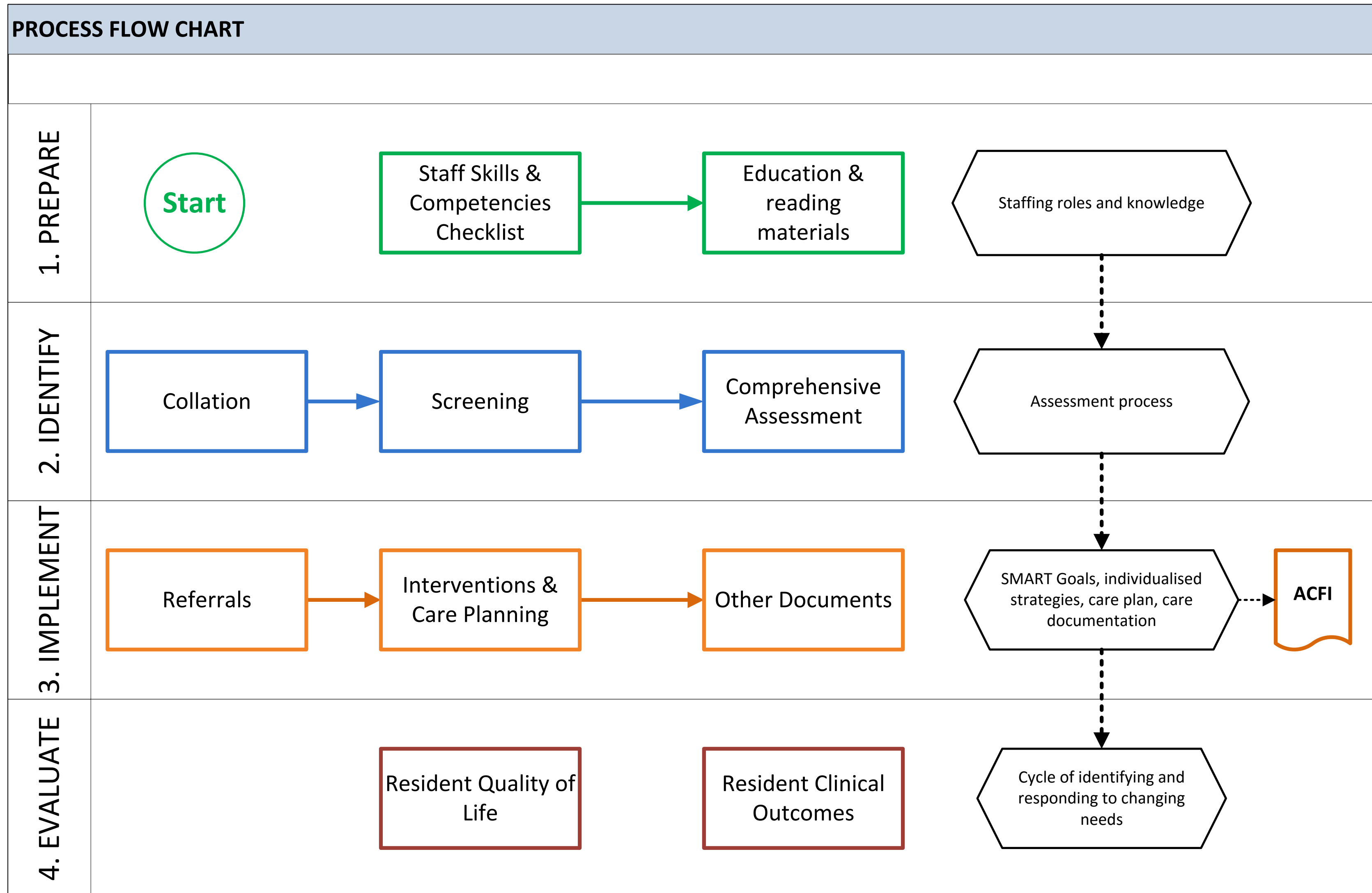
Figure 1: Behavioural Expressions Process



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Getting Started with a Behavioural Expressions Example

This case study will be referred to as we discuss the topic of behavioural expressions.

Mr. Tony Grey is 80 years old, married with one son, a retired plumber, whose hobby was amateur theatre acting and singing. He has advanced dementia, is independently mobile and manages his personal hygiene tasks with a little bit of prompting and setting up by his wife. His wife manages the household (finances, domestic chores, the garden and transport etc).

It is his wandering away from home and verbal combativeness that is worrying his wife. She described him as a "man on a mission"- walking out of the house most mornings and heading up the street. When his wife tried to stop him, he often seemed not to recognise her, and she found him quite threatening when he yelled at her to get out of his way. Usually he returned within a few minutes forgetting why he left the house, and a cup of tea settled him down.

Tony's urgent outings had become more frequent, and he is more restless and more unresponsive to his wife's conversation or directions. There were a few times when he had to be returned by the police as he was unable to find his way home.

He was recently assessed by the Aged Care-Assessment Service and approved for residential care, and a bed has become available at a local aged care facility.

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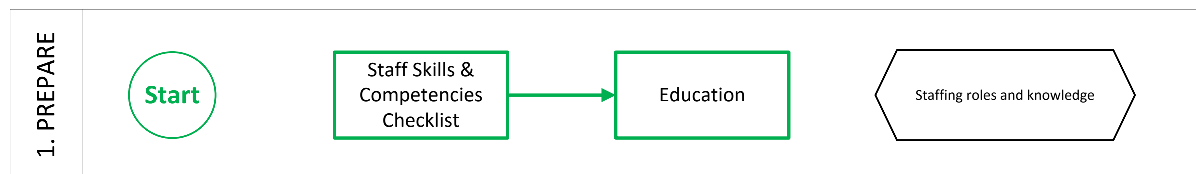
Preparation



There are two specific aspects to **preparing** staff for understanding and assisting residents with behavioural expressions. They are:

1) Ensuring that staff have the required qualifications or competencies; and

2) Completing the pre-reading if required

Recommended Staffing Skill Set

Table 1 below provides a structure for management to identify which staff have the skills required to complete activities within the behavioural expressions process. The process includes:

- Identifying the required activities (examples provided in Table 1)
- Assessing staff competency to complete the activities
- Addressing identified gaps

This will assist management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in the behavioural assessment and management activity, the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge, or identifying a local Allied Health Professional (i.e. Psychologist) who could complete the assessment.

The introductory guide also provides further instructions for management in preparation for implementing this toolkit.

Table 1: Staff Activities for the Behavioural Expressions Process

Activities	Staff Resources
Collating Documents	
Identifying needs from collation documents	
Screening: Initial Nurse Assessment e.g. CHA	

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Activities	Staff Resources
Behavioural Descriptions	
Charting: Behaviour Records	
Behaviour Assessment: Modified Behaviour Assessment Form (BAF)	
Depression Assessment: Modified Cornell Scale for Depression in Dementia	
Documenting into file notes	
Determine and action Referrals	
Develop Interventions, Goals and the Care Plan	
Complete ACFI associated documents	
Review/ monitor the Care Plan and Goals	

Background Reading

Staff should complete the background reading or be able to demonstrate that they have adequate experience and knowledge of behavioural and psychiatric issues in older people. It is expected that staff will have:

- A comprehensive understanding of the behavioural expressions topic and how it is impacted by other health areas
- An awareness of associated diagnoses, signs and symptoms
- Knowledge about and training on how to use the assessment tools
- Knowledge about evidence informed practices associated with the behavioural expressions topic to assist with the development and implementation of evidence-based care plans

The background reading relevant to the behavioural expressions topic is:

- **IPA Complete Guides to Behavioural and Psychological Symptoms of Dementia (BPSD) –Specialists Guide and Nurses Guide**. The content is designed to contribute to the improved management and support of residents with dementia and BPSD and to reduce some of the stresses experienced by care team. The principle of Person Centred Care approach is widely supported in these guides. Each module includes an in-depth discussion and analysis of its subject area and concludes with a reference and recommended reading list.

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Prepare

The IPA Complete Guides to BPSD – Specialists Guide provides extensive background reading covering eight modules. "BPSD is recognizable, understandable and treatable. The recognition and appropriate management of BPSD are important factors in improving our care of dementia patients and their caregivers and is central to the development of The IPA Complete Guides to BPSD."(Preface p. iii.)

The Specialists Guide has eight modules:

- Module 1 – An introduction to BPSD
- Module 2 – Clinical issues
- Module 3 – Etiology
- Module 4 – Role of family caregivers
- Module 5 – Non-pharmacological treatments
- Module 6 – Pharmacological management
- Module 7 – Cross-cultural and transnational considerations
- Module 8 – Long-term care

The related Nurses Guide is in a shorter, summary format, and is designed to complement the Specialists Guide.

- **Australian Dementia Training Study Centres on-line education module "Evidence-based tools for BPSD Assessment"**

  The Australian Dementia Training Study Centres (DTSCs) provide a broad range of dementia related educational services to meet the needs of the health and aged care sector. The Queensland DTSC has developed an on-line education module "Evidence-based tools for BPSD Assessment" which informs on three topics and describes symptoms and their status, discusses common assessment tools that are evidence based, and discusses interventions/care planning for:

  - Agitation/Aggression
  - Apathy
  - Wandering

References for these resources are found in the Behavioural Expressions Appendix.

Some Basics

Person-centred care advocates the importance of language to change perceptions of people living in care. For example:

Prepare

- It is not a "demented person," "dementia patient" but "a person with dementia," putting the person first
- It is not "suffering" from dementia; it is a person "living with dementia"
- Instead of describing actions of people with dementia for example as "stealing" which implies that these are deliberate actions we should use words which simply describe what was observed to happen without incorrectly labeling the person's intent. Please note that most behaviour scales have not updated the description of behaviours to fit this example.

Behavioural expressions can often be a reaction to a changed environment or relationships with people; hence the importance of the relationship with care team and why person centred care is so important.

What are behavioural expressions?

The International Psychogeriatric Association (IPA) 'Nurses Guide to Behavioral and Psychological Symptoms of Dementia' provides a list of behavioural symptoms and psychological symptoms.

Behavioural symptoms	Agitation; Calling out; Crying; Physical aggression; Restlessness; Screaming; Sexual inappropriate behaviour; Verbal aggression; Wandering These are usually identified by observation.
Psychological symptoms	Anxiety; Apathy; Delusions; Depressed mood; Disinhibition; Euphoria; Hallucinations; Misidentifications; Sleeplessness These are usually identified by interview (with the person and caregiver), and some by observation.

Specific behavioural and psychological symptoms are not universally agreed upon in the literature as they are often interrelated, and they are not grouped for diagnosis purposes. It is not the grouping of behaviours that is primarily important, but it is important to understand the broad types of behaviour when reading the literature.

Many of the behavioural symptoms of BPSD relate to the wandering, verbal and physical behaviours targeted in the ACFI questions 7, 8 and 9.

Most of the psychological type symptoms of BPSD relate to mood and psychotic symptoms (e.g. confused thinking, delusions).

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It is not of primary importance which group a behaviour or symptom belongs to. Rather it will be important to clearly describe the behaviour or symptom by what is seen or heard, without interpretation or judgement. This is the first step in unpacking the behaviour or symptom. Understanding of the person and the context of the behaviour is then vital in understanding the behaviour or symptom, and that requires looking at the interplay of physical, psychological, interpersonal, social and environmental factors.

Why is BPSD important?

- With the aging of the world's population, there is a significant increase in the absolute number of older people with dementias
- Dementia is associated with progressive cognitive decline, a high prevalence of behavioural and psychological symptoms of dementia (BPSD) such as agitation, depression and psychosis
- BPSD are an integral part of the disease process and present severe problems to persons, their families and caregivers
- BPSD are treatable and generally respond better to therapy than other symptoms or syndromes of dementia
- Treatment of BPSD offers the best chance to alleviate suffering, reduce family burden, and lower societal costs in persons with dementia

Untreated BPSD contribute to:

- Early institutionalisation (Colerick and George, 1986; Morriss et al., 1990; Steele et al., 1990; O'Donnell et al., 1992; de Vugt et al., 2005);
- Increased financial cost (Cohen-Mansfield, 1995; Herrmann et al., 2006);
- Decreased quality of life for both the caregiver and the patient (Deimling and Bass, 1986; Burgio, 1996);
- Significant stress to caregivers (Rabins et al., 1982) and nursing staff in residential facilities (e.g., Rodney, 2000; Draper et al., 2000);
- Excess disability (Brody 1982; Hinton et al., 2008). Once symptoms are ameliorated or removed, functional level improves (reducing distress and improving quality of life).
  (International Psychogeriatric Association 'Specialists Guide to Behavioural and Psychological Symptoms of Dementia' Module 1, p.1.2-1.8)

Behavioural Symptoms

The following section is based on the *International Psychogeriatric Association 'Specialists Guide to Behavioural and Psychological Symptoms of Dementia' Module 2, p.2.11-2.13.*

Prepare

Wandering

This includes aimless wandering, exit seeking or trying to leave a building. It may be associated with faulty navigational ability (e.g., they feel lost), boredom or anxiety (e.g., looking for something or someone, don't know where they should be).

For example:

- looking for the bathroom
- looking for food or drink
- looking for a bed to lie down on
- acting on an old routine such as leaving home for work
- trying to escape the noise, tension or pandemonium of the environment
- searching for familiar faces (friends and relatives who may or may not be living)
- in pain, looking for relief
- desiring fresh air; may be triggered by outdoor clothing or view

Agitation

Agitation (like BPSD) is not a diagnostic term, but rather a term used by clinicians for a group of symptoms that may reflect an underlying disorder. Cohen-Mansfield and Billing (1986), described agitated behaviour in three ways:

• It may be abusive or aggressive toward self or other

• It may be appropriate behaviour performed with inappropriate frequency, such as constantly asking questions

• It may be inappropriate according to social standards for the specific situation, as in taking off clothes in a public space

Agitation usually increases with increasing cognitive impairment, and has been associated to a number of factors - neurobiological changes, health issues, pre-morbid personality, and the psychological and social environment. It is seen in physical symptoms (restless, wandering, hiding things etc) and verbal symptoms (constant requests, repetitive questions or complaints etc).

Aggression

Verbal aggression such as screaming and cursing is often associated with depression, pain and other health problems. Physical aggression symptoms include hitting, pushing, biting etc.

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Resistiveness to care

Resistiveness to care is different to agitation; it is related to accepting assistance with daily activities like taking medicines, and undertaking ADLs. It is linked to the person's ability to understand the situation and what is expected, and is therefore likely to increase with the progression of the cognitive impairment, and it is often associated with behavioural expressions.

Inappropriate sexual behaviour

Inappropriate sexual behaviour or sexual disinhibition may result in physical and/or verbal behaviours.

Sundowning

This is BPSD in the afternoon and early evening. Dementia's can cause disturbance in the circadian rhythms which results in sleep disturbances. These symptoms have been also associated with hormonal changes (e.g. changes in body temperature), physiological and environmental factors.

Catastrophic reactions

These are usually acute and brief and are usually an expression of overwhelming anxiety/frustration triggered by a task (e.g. getting dressed) or health factors (e.g., delirium, pain, infection, and certain medications).

Psychological Symptoms

The Cognitive Workbook discussed how depression and dementia are difficult to disentangle. Both share symptoms, for example, of being withdrawn, and depression is not uncommon in a person with dementia particularly in the early stages of dementia. Depression symptoms can also include symptoms we typically associate with cognitive impairment (trouble thinking, concentrating, making decisions and remembering things).

Depression is a mood disorder that is much more severe than simply feeling down or flat emotionally after a loss or setback. It affects how a person feels, thinks, and acts and can lead to other emotional and physical problems. Symptoms are persistent day after day, and may include:

- Feelings of sadness, emptiness or unhappiness
- Outbursts of anger, irritability or frustration, even over small matters
- Loss of interest or pleasure in normal activities
- Sleep disturbances, including insomnia or sleeping too much

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- Tiredness and lack of energy for even small tasks
- Changes in appetite —usually reduced appetite and weight loss, but cravings leading to weight gain in some people
- Anxiety, agitation or restlessness
- Slowed thinking, speaking or body movements
- Feelings of worthlessness or guilt, fixating on past failures or blaming yourself for things that are not your responsibility
- Trouble thinking, concentrating, making decisions and remembering things
- Frequent thoughts of death, suicidal thoughts, suicide attempts or suicide
- Unexplained physical problems, such as back pain or headaches

Many treatments are available, including medications and psychological therapies. There is evidence that exercise, getting outdoors and re-engaging in meaningful activities are all mood lifters. Depression is not a normal part of ageing, and people may not let others know they may have depression (BCOPE, p172).

In the most severe form of depression (psychotic) a person can have also have delusions (false beliefs, typically of being a bad person, deserving punishment or that bad things will happen) and hallucinations that may involve hearing voices, smelling unpleasant odours or other physical sensations (BCOPE, p172).

Early screening can assist in identification and timely intervention, and assessment by a mental health specialist is recommended for suspected depression and/or psychotic disorders (BCOPE, p172).

Psychiatric Symptoms

Symptoms of psychosis include hallucinations, delusions, disorganised speech, abnormal psychotic behaviour, negative symptoms, impaired cognition, depression and mania. There are shared symptoms across psychotic disorders, cognitive impairment and depression. Many people with psychotic disorders also have cognitive impairments or depressive symptoms that affect their capacity to function (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013). Following is a brief description of these symptoms.

Term	DSM-5 Description
Hallucinations	Perception like experiences without external stimulus. Occur in any sense modality, not occurring during falling asleep or waking up.

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	(DSM-5)
Delusions	Fixed beliefs not amenable to change in light of conflicting evidence. Themes include persecutory, referential, somatic, religious, and grandiose. (DSM-5)
Disorganised speech	Inferred from the speech, answers to questions are obliquely related or unrelated, word salad is a severe example.
Abnormal psychotic behaviour	Rigid, bizarre posture, mutism, stupor (no motor response), excessive motor activity without cause, stereotyped movements, staring, grimacing, echoing of speech.
Negative symptoms	More common in schizophrenia, two most common are diminished emotional expression and avolution (lack of drive or motivation).
Impaired cognition	Complex attention (sustained, divided, selective, processing speed); Executive functioning (planning, decision making, mental flexibility); Learning and memory (immediate/recent/long term memory); Language (expressive and receptive); Perceptual motor (visual perception, visual constructional, perceptual motor, praxis, gnosis); Social cognition (recognition of emotions)
Depression	Depressed mood most of day, markedly diminished interest, significant weight change, insomnia or hypersomnia, psychomotor agitation/retardation, fatigue, feelings of worthlessness or hopelessness, diminished ability to think/ concentrate, recurrent thoughts of death, poor appetite/over eating.
Mania	Persistently elevated, expansive or irritable mood with goal-directed activity/energy.

Hallucinations

The most common type of hallucinations in dementia are:

- Visual around 30%, up to 80% in person's with Lewy body dementia.
- Auditory around 10%
- Olfactory and tactile are rarer in dementia

Hallucinations may or may not be distressing to the person experiencing them, and may possibly be a visual misperception. Estimates of the frequency of hallucinations in people with dementia range from 12% to 49% (Swearer, 1994).

(*International Psychogeriatric Association 'Specialists Guide to Behavioral and Psychological Symptoms of Dementia' Module 2, p.2.6)*

Misperception

Disorders of perception occur in the presence of external stimuli. There are 4 main types of misperception:

- Presence of persons in the person's own house (the 'phantom boarder' syndrome)
- Misidentification of the person's own self (often seen as not recognising their own mirror reflection)
- Misidentification of other persons
- Misidentification of events on television (the person imagines these events are occurring in real three-dimensional space)

An earlier study of misidentifications found them to be present in 16% of people with Alzheimer's disease and 17% of those with Dementia Lewy Body (Harciarek & Kertesz, 2008). (*International Psychogeriatric Association 'Specialists Guide to Behavioral and Psychological Symptoms of Dementia' Module 2, p.2.7)*

Delusions

The most common type of delusions in dementia are:

- People are stealing things
- Abandonment
- Home is not own home
- Spouse is an imposter
- Spouse infidelity

The frequency of delusions in people with dementia is cited as being between 10% and 73% depending on the study population and the definition of dementia (Wragg & Jeste, 1989). (*International Psychogeriatric Association 'Specialists Guide to Behavioral and Psychological Symptoms of Dementia' Module 2, p.2.5*).

How Behavioural Expressions Interact with Other Domains

Behavioural and psychological symptoms may result from multiple causes although the actual origin remains undetermined. There are "neurobiological, psychological (premorbid personality features and responses to stress), and social (environmental change and caregiver factors) aspects (Kozman et al 2006 in Hersch et al 2007).

Therefore it is important to consider the impact of any other reduced functional abilities such as vision, hearing, mobility, incontinence etc. They may have other co-morbid health issues such as pain or depressive symptoms. Hersch et al (2007) indicates that

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“Undiagnosed medical problems such as pain, depression, dehydration, sleeping difficulty, anxiety and delirium can all lead to agitation. (p.612)”

Resistiveness to care behaviours sometimes impact on the performance of daily living activities (ADLs). These activities vary from taking medicines to trying to assist the person with eating, personal hygiene and self care activities. In addition, as these are primarily private, intimate tasks, the person with dementia may feel unsettled and insecure when a stranger attempts to undress them or help them with toileting. A verbal or physical behavioural expression may be a reaction to the fear.

A person with depressive symptoms also finds it difficult to engage in activities of daily living particularly morning hygiene activities, as their symptoms are typically worse in the morning. They may be withdrawn, feel too tired to participate, and lack interest in usual activities and social interactions.

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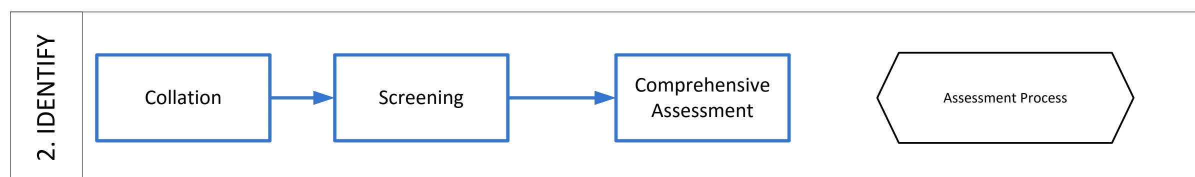
Identification Process



The steps in the process of **identifying** are:

- Gathering history from current documentation and information from carers, family and the consumer if possible;
- Identifying a need (e.g. initial nurse assessment/screen); and
- Completing a comprehensive assessment of the needs

Gathering the History

Before you start assessing, look at what documents you have which provide information on the resident? You will be able to build a picture of the person's relevant history through the documentation (i.e. ACCR, medical notes) and their personal history through discussions with their family members and carers.

Documentation

The current documentation should be reviewed, checking for relevant diagnoses, documented signs and symptoms, and previous assessments. Below is an example of the types of documents to be collated and reviewed and the information that is being sought for behavioural expressions.

Document	Looking for
ACCR	Part 4 (Q28): Mental and Behavioural Diagnoses; Part 5 (Q35) Assessment Summary (cognitive behaviour/ psychological symptoms) Part 5 (Q38 Q42) notes may inform on care strategies Parts 4/5: Notes on other impairments such as sensory loss that could further impact on behavioural/mood/psychiatric symptoms
Medical Notes/CMA	Mental and Behavioural Diagnoses, cognitive status, other impairments, behavioural concerns, mood, psychological and psychiatric symptoms, and assistance required
Clinical Report on	Mental and Behavioural Diagnoses, mood symptoms, cognitive

Depression	behaviour/psychological aspects, comments and care strategies
Mental Health Professional notes/assessment	Mental and Behavioural Diagnoses, notes on symptoms and strategies

Here are a few examples of how the collated diagnoses and issues may be used to understand the person's care needs:

Diagnoses/issues	**How it may impact on the care needs**
Diagnosis or evidence of • cognitive impairment • behavioural concerns • mood symptoms • psychosis symptoms	An accurate diagnosis is essential for understanding the behavioural expressions and for developing appropriate strategies and interventions.
Specifics about the behaviour and symptoms	It is important that the behaviour or symptom is objectively described e.g. what is seen or heard by staff. This will assist staff communication, provide the most accurate information and ensure the Behaviour Records are accurate. It will also assist in identifying evidence-based care strategies.
Behavioural and Psychological Symptoms of Dementia	The person with dementia has increasing trouble deciphering and interacting with their environment - ability to communicate their needs - ability to understand verbal requests - ability to remember how to do basic activities (e.g. affects motor skills) - misinterpreting their environment (e.g. hearing and seeing things, holding incorrect beliefs) They can become physically and verbally restless and aggressive due to the confusion they experience, they may not understand where they are, why they are there or what they should be doing etc.
Mood symptoms	Depression has been under diagnosed in residential care. It is important to increase the awareness of mood symptoms as mood affects participation in everyday activities. Residents may be withdrawn, sad, or display symptoms of cognitive impairment (e.g. memory loss). There are both non pharmacological and pharmacological treatment options with proven efficacy.
Sensory Loss(e.g. sight, hearing)	Most likely to increase the affect of the cognitive/behavioural impairment, making it more difficult for the person to participate in activities, may become withdrawn.

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Resident and Family

It is important to seek input from the resident and his or her family members. The family knowledge of the person's medical and personal history, cognitive functioning, communication style and preferences, and routines is an important source of ongoing information for the care team. Families and carers who are regular visitors may be more likely to notice the subtle changes in cognition and behaviour which can serve to highlight the need for further investigation. Family members may also know helpful hints when supporting a person with dementia. For example the conversation cues that can help to re-settle them (i.e. significant life events, pleasant events, favourite pastimes, work history, personal history).

Screening

For a new resident, staff should note and document (in progress notes and against a standardised checklist e.g., the modified Behavioural Assessment Form and the Behavioural Descriptions list) all disruptive behavioural symptoms expressed by the person. Mood may not appear disruptive but it is likely to be concerning to the resident themselves. Behaviours and symptoms may be disruptive or concerning to the resident as well as other residents and visitors or staff.

When in the screening phase staff should be observing the person to identify if behaviours are present. **The behaviour may or may not be associated to an ACFI behaviour item or question at this stage. The aim at this point is NOT about completing ACFI documentation.** Staff should document these interactions providing an objective and individualised description of the behaviour, including what was occurring at the time, the type of staff response and the outcomes. At this point the resident may still be settling in, (a change of environment is an unsettling experience for anyone and especially for a person with a cognitive impairment), so it is best not to do the ACFI assessments in the first week.

The most important thing at this stage is to be developing a description of the behaviour/symptom, based on what is *"seen or heard"* by staff or their family.

- Staff should document what is seen and heard including the contextual information.
- Staff teams should then identify which behaviours are problematic (i.e. require staff intervention). Sources of information that may be considered could include:
    - Gathered documents (admission documents, medical notes etc)
    - Interviews with family
    - Nursing notes, handover notes etc
    - Behavioural Description List

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The Behavioural Descriptions List

When noting a behavioural expression it is important to limit the description to the context (what was happening at the time) and 'what is seen and heard'. This step requires practice as it is common for care staff to include a judgement and/or interpretation of the reason for the behaviour e.g. the resident 'won't sleep because they like to get attention' or use a generic term that does not describe what is seen or heard e.g. the resident was 'restless tonight'. A resident may also be described as 'restless at meal time' however a better description covers what was seen and heard such as 'the resident constantly moved their plate and cutlery around the table and did not eat their food' as the aim of this step is to describe objectively what happened. The behaviour and the context in which it occurred should be described for that resident and should allow a person not present at that time to visualise or be aware exactly what was occurring and the associated context.

Next insert your 'unique behaviour description' into your Behavioural Descriptions List (a master copy is provided in the Behavioural Expressions Assessment Pack). Using the ACFI User Guide (p44) investigate if your behaviour description can be matched to an ACFI 7, 8, 9 behaviour. Also using the CSDD assessment, investigate if your behaviour description can be matched to the CSDD (ACFI 10). Not all behavioural expressions will map to an ACFI question. However, all behaviours that require an intervention and management should be fully investigated. The behavioural expressions management method is a comprehensive care planning approach driven by quality care that goes beyond compliance to ACFI requirements.

For example the following behavioural descriptions can be mapped to the ACFI:

- ☑ *Tony was seen walking up and down the corridor and was observed entering another resident's bedrooms and emptying the content of the drawers onto the bed.* This behaviour may map to ACFI 7 (Interfering while wandering) and/or ACFI 9 (Socially inappropriate handling of objects.)

- ☑ *Tony refused to take his underwear off during his morning shower, he would scream out "no, no, leave them on"' and "hit out" at the staff if the staff tried to pull them down.* This behaviour may map to ACFI 8 (Verbal refusal of care- Verbal refusal to participate in daily care- dressing, washing, hygiene) and/or ACFI 9 (Physically threatens or does harm to self or others property)

Not all behavioural symptoms will map to an ACFI question.

- ✘ *Tony was aimlessly walking around the facility but not disturbing others.*

- *Tony was laughing and chatting with someone who was not there (i.e. hallucinating), Tony did not show any signs of distress and it did not impact on other people as he was in his bedroom*.
- *Tony is constantly moving around in his chair because he wants to go to the toilet"*
- *Tony pulls the sheet over his head when asked to get out of bed.*

After the behaviour has been described;

- the mood symptoms should be further investigated using the modified CSDD – ACFI 10
- the behaviours that map to an ACFI 7, ACFI 8 or ACFI 9 behaviour, should then be charted (using the modified BAF).

The objective behaviour description will ensure that all staff understand the behaviours so they can accurately participate in the charting. Insert the description into the chart (modified BAF) and complete for 7 days. The information will help staff understand the context of the behaviour and the behaviour pattern. This information is vital in developing evidence informed behaviour management strategies.

Note that an individualised description should be provided of the behaviour or symptom of interest as well as documenting in the progress notes during this investigation period. It is important that there is a clear understanding across the care team of the behavioural expressions, the full descriptions of the behaviour will provide that picture.

The screening stage could be undertaken over the first two weeks which allows for new residents to settle in before starting ACFI assessments. The care team will obtain enough information to identify the behaviours and symptoms that will be targeted in the next step of the comprehensive assessment.

The mood related behavioural expressions are then targeted in the next step of the comprehensive assessment approach (modified CSDD). All behaviours that cause distress or disruption should be investigated and managed by assessment and care planning. This may include referral to a Mental Health or Behaviour team.

Table 2 provides a modified extract from an example of a Behavioural Description List. This snapshot covers some of the behavioural symptoms and demonstrates how the behavioural expression can be mapped to the ACFI questions. In a full version the list may cover many more behaviours and symptoms that maps to a wider range of behaviour and mood symptoms:

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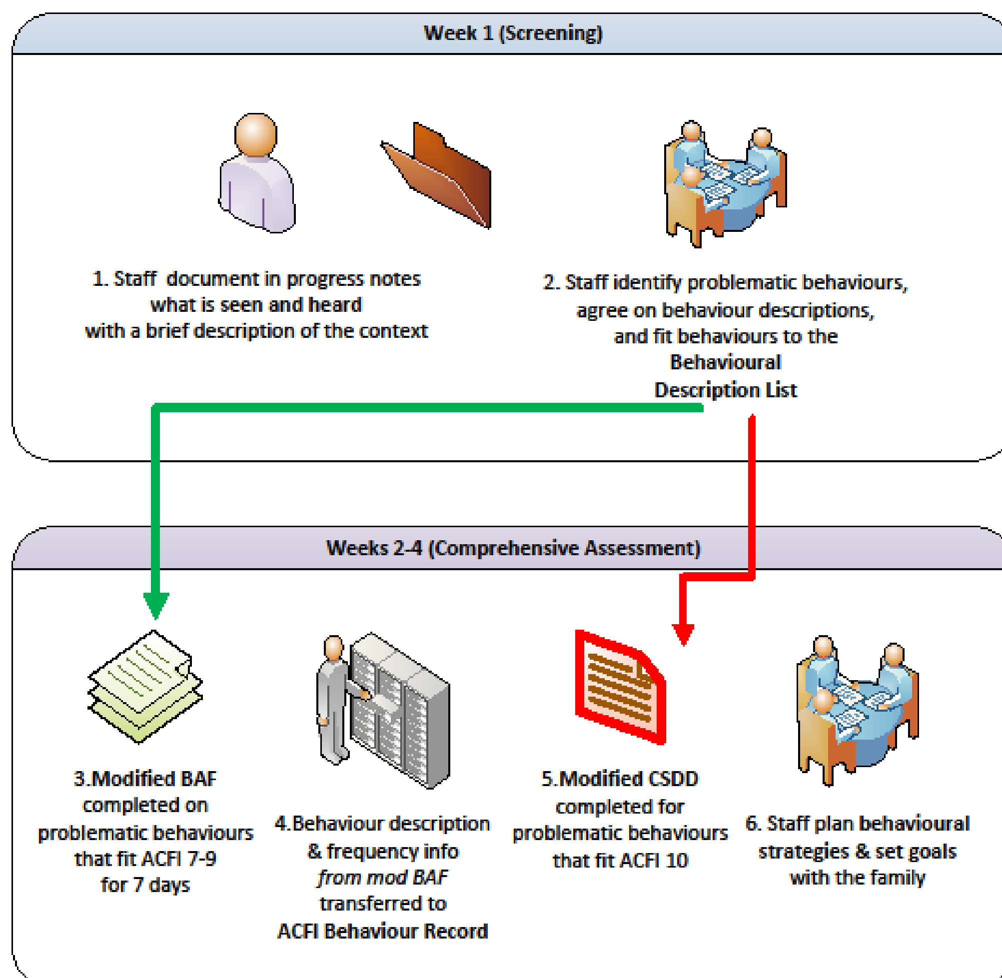
- Behavioural symptoms- some which may map to Wandering (ACFI 7), Verbal Behaviour (ACFI 8) and Physical Behaviour (ACFI 9)
- Psychological symptoms - which may map to Depression (ACFI 10)
- Psychiatric symptoms

Figure 2 provides an overview of the assessment process the screening step is undertaken in week 1, and the comprehensive assessment steps in weeks 2-4.

Table 2: Extract from the Behavioural Descriptions List

BEHAVIOURAL DESCRIPTIONS LIST	POSSIBLE MAPPING			
Must require staff intervention. Report what you see or hear.	**ACFI 7**	**ACFI 8**	**ACFI 9**	**ACFI 10**
Tony was seen walking up and down the corridor and was observed entering another resident's bedrooms and emptying the content of the drawers onto the bed	W1: Interfering while wandering		P2: Socially inappropriate handling of objects	
Tony was pacing around the facility and garden when he was observed trying to climb over the fence.	W2: Trying to get to inappropriate places- exit the building or property			
Tony was walking up and down the corridor and was observed entering another resident's bedroom	W2: Trying to get to inappropriate places- trespassing within other resident's room			
Tony was seen aimlessly walking around the facility but not disturbing other residents.	n/a	n/a	n/a	n/a
Tony refused to take his underwear off during his morning shower, he would scream out "no, no, leave them on"' and "hit out" at the staff if the staff tried to pull them down.		V1: Verbal refusal of care- Verbal refusal to participate in daily care- dressing, washing, hygiene	P1: Physically threatens or does harm to self or others property.	
Tony yelled loudly "bloody well leave me alone" at staff when they delivered his morning tea.		V2: Verbal disruption to others (not an unmet need)- Cursing, swearing, temper outbursts, verbal anger, verbal combativeness, screaming		Note cannot claim an item that has been claimed in ACFI 8 or ACFI 9.

Figure 2: Behavioural Assessment Process



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Comprehensive Assessment

Following a positive identification in the screening phase behavioural symptoms will have been identified that require staff intervention. The following approach is recommended and the assessment tools listed below can be found in the Behavioural Expressions Assessment Pack:

- Modified Behavioural Assessment Form (BAF) for behaviour symptoms
- Modified Cornell Scale for Depression in Dementia (CSDD)

The next step is to determine if it is a 'behavioural' or 'mood' or 'psychiatric' symptom. The Mapping Document found in the Behavioural Expressions Assessment Pack will assist staff to identify what grouping the behaviour or symptom is associated with. , A brief overview is as follows:

Behaviour

- Wandering behaviour (e.g. interfering while wandering, exiting behaviour, trying to get to inappropriate places, aimless wandering, pacing)
- Physical behaviour (e.g. harming self/others/property, disrobing, inappropriate sexual behaviour, eating or drinking inappropriate substances, hiding things, repetitive movements, constant restlessness,)
- Verbal behaviour (e.g. verbal refusal to participate in ADLs, strange noises, negativism, repetitive sentences, cursing, screaming, excessive suspiciousness or verbal accusations of delusional thoughts)

Mood/depression

An expression of mood/depression could be:

- Mood symptoms (e.g. anxious expression, crying, lack of reactivity, irritability)
- Behavioural disturbance (e.g. agitation, displayed in pulling one's own hair or picking at clothing/ physical restlessness etc, slow movements, loss of interest)
- Physical signs (e.g. appetite, weight loss, lack of energy)
- Cyclic functions (worse in morning, sleep difficulties)
- Ideational disturbance (e.g. feels worthless/a failure, expects the worse)

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Psychiatric

Residents with a neuro-cognitive psychiatric disorder (e.g. delusions, hallucinations) will likely exhibit a behaviour that is described by the symptoms outlined above under the behaviour heading.

For example a resident with a delusional disorder may (i) start to act out on their irrational belief verbally or even physically which ultimately becomes disturbing to other residents and staff or (ii) they become extremely bothered by the irrational belief which causes a major disruption to their quality of life. It will not usually be the 'delusion' that staff become aware of initially, but rather a disturbing behavioural 'acting out' due to the underlying delusion e.g. verbal disruption or physical behaviour that can be subsequently linked back to the delusional disorder.

For these psychotic symptoms, you should still describe the symptom/s objectively (i.e., what you see and hear the person doing), and refer the person to a Mental Health specialist for further assessment. It is the severity of the symptoms in psychosis which will guide the likely course and intervention required (DSM V, 2013).

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For wandering, verbal or physical behaviour

The suggested approach is:

- Modified Behavioural Assessment Forms is undertaken for 7 days. The data can then be transcribed to the ACFI Behaviour Records.

- The modified Behavioural Assessment Form (found in the ACFI Assessment Pack) will record the detailed behaviour description, frequency and pattern of the behaviour, and the contextual information. It is important that the link from the objective description as identified during screening is continued into the comprehensive assessment step. A further description of this tool is provided below.
- The description of the behaviour will help to determine (i) is it of concern to the person and/or to others (ii) does it need a referral and (iii) what strategy would be appropriate to assist settle or manage the behaviour.
- Complete the modified BAF and the Behaviour Record by transcribing the behaviour type and frequency data, this comprehensive information will inform on possible strategies and complete the ACFI ratings.

The Modified Behavioural Assessment Form

The modified Behavioural Assessment Form (BAF) provides a standardised way to describe the contextual setting (a copy is found in the Behavioural Expressions Assessment Pack). The Behavioural Assessment Form (BAF) has been modified to include standardised responses. The BAF is based on the ABC theory of behaviour, an approach supported by the literature.

"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."(Behaviour Assessment Form, NATFRAME pp. 145)

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Behaviour assessment and management is not well understood or documented in residential aged care. To address this gap the EBCAT recommendations provide a process that produces:

- Accurate behaviour descriptions based on what is seen and heard
- Documentation of the contextual information (i.e. the circumstances at the time of the event) to ensure the behaviour is fully described
- A relevant documentation base that will then (i) allow the development of evidence informed strategies and interventions and (ii) also provide helpful information if external referrals are indicated

It is important that staff are encouraged to describe the behaviour in its natural context not by the ACFI broad behaviour descriptions during both the screening and the comprehensive assessment steps.

The modified BAF (a copy is found in the Behavioural Expressions Assessment Pack) has been recommended, because it collects both frequency and standardised contextual information. The modified BAF is not commenced until week two as the frequency data for the ACFI Behaviour Record cannot be started till after the first week to allow for new residents to settle in. The use of the modified BAF in the comprehensive assessment step will provide data that can be transcribed to the ACFI Behaviour Record and provides the detailed contextual information required for developing interventions and care planning.

The modified Behaviour Assessment Form items cover:

Questions	Responses
Antecedents	
Date and time, How long did it last?	
Place	1. Travelling off campus 2. Outside of building (but within the grounds) 3. Bedroom 4. Ensuite 5. Shared bathroom 6. Corridor 7. Dining area 8. Activity area 9. Other (describe)
Who was there?	1. Other resident/s 2. Own visitor/s 3. Other visitor/s 4. Doctor 5. Care staff (describe)

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Questions	Responses
	6. Therapy staff 7. Activity staff 8. Domestic staff 9. Maintenance/gardening 10. Other (describe)
What interaction was going on?	1. Self care (nutrition/walking/personal hygiene/toileting, self medicating) 2. Assisted care (nutrition/walking/personal hygiene/ toileting, medication round, complex health care) 3. Medical treatment/visit 4. Therapy (physio, massage, describe other) 5. Activities 6. Other (describe)
What else was happening?	Describe the environment e.g. Noise, stimuli, entertainment, TV, lot of people etc.
Behaviours	
Observed Behaviour	Describe what was **seen and heard** *For example: Tony was pacing around the facility and garden when he was observed trying to climb over the fence*
Consequences	
Describe the intervention	How many staff, what is the intervention, other resources required, time taken
Disruption Level	Rate the disruption ☐ (0) None (Not disruptive no intervention by staff) ☐ (1) Mild (A little disruptive co-operative response to intervention, not disruptive to other residents or visitors) ☐ (2) Moderate (Moderately disruptive not always co-operative, but can be resolved with intervention, sometimes disruptive to other residents or visitors) ☐ (3) Severe (Very disruptive sometimes requires immediate intervention, interferes with others, their belongings or visitors, asocial behaviour) ☐ (4) Extreme (Extremely disruptive always requires immediate intervention, wakes others at night, disruptive to others during the day, requires one or more staff, attention or constant attention)
Rate the effectiveness of the intervention	Effectiveness is rated ☐ (0) No intervention by staff ☐ (1) Very successful, co-operative response, settled quickly ☐ (2) Successful, settled within 5 minutes ☐ (3) Somewhat successful, settled for short time only or requires constant attention

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For a mood symptom

The mandated approach is:

- The modified Cornell Scale for Depression in Dementia (CSDD). A copy is found in the ACFI Assessment Pack and the ACFI User Guide provides detailed instructions on how to complete this assessment.

The ACFI Assessment Pack provides the modified CSDD tool which is a validated (objective and standardised) assessment for identifying those residents with symptoms of depression. The CSDD assessment is:

- Based on signs and symptoms that staff have opportunity to notice, it does not include symptoms such as phobias that require a reliable self report
- Has defined signs and symptoms so as to reduce the subjective interpretation
- Appropriate and validated for aged care staff that have been appropriately trained on the application of the tool
- A screening test and requires GP/specialist follow-up for diagnosis and management assistance (following good practice)
- A tool that uses multiple sources of information to complete which improves the objectivity, accuracy and quality of information collected
- A tool that fosters staff awareness of signs and symptoms of depression
- A tool that can be used to objectively assess for improvement

The modified CSDD assessment in the ACFI Assessment Pack provides detailed process steps to ensure an accurate assessment is completed. For example the modified CSDD instructions indicate:

- The symptoms must have occurred in the past week (and should have a description of the symptom/behaviour in context for that resident, not a generic description)
- The exclusions due to dementia etc
- The descriptions of how to rate the severity of symptoms such as mild or severe effects (based on frequency and minor/major interference):-

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- Mild = minor interference (regular encouragement required with ADLs, social and interpersonal) and symptoms occur occasionally (not every day)/or often (nearly every day)
- Severe = major interference (limited participation in ADLs, social and interpersonal) and symptoms occur often

The modified CSDD criteria guidelines are recorded in the sub-steps. It is important to indicate the response to the sub steps in each question of the assessment and not just provide the score for each item. **This is a valuable source of information that can inform on strategies that are important regardless of the final summary score.**

If a resident is identified as having a possible change in their behaviour or mood status, it is recommended that this assessment phase is repeated.

Clinical Risk Management

To address systemic clinical risks associated to depression or physical restraint, the following Standardised Care Processes (SCPs) are recommended:

- Standardised Care Process for Depression
- Standardised Care Process for Physical Restraint

References for the recommended Standardised Care Processes (SCP) are found in the Behavioural Expressions Appendix and copies of the SCPs are found in the Resource Pack.

The Depression SCP describes a systematic approach to addressing depression from initial recognition, assessment, monitoring, re-assessment, referrals, including and providing information to the resident and the family, individualised care planning, monitoring the effectiveness, and staff education requirements.

Physical Restraint is not considered good practice, if there is a system issue related to the use of physical restraint, the SCP Physical Restraint is recommended to be used to review physical restraint practices as it offers alternatives.

Bringing the information together

As is the case with all of the EBCAT topics, the assessor should use their clinical reasoning skills to consider the impact of interactions across assessments from the other domains and care topics on Behavioural Expressions. The gathering and reviewing of documents followed by the assessment of behaviours and mood should include information from other domains in order to avoid missing relevant information.

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These might include:

- Sensory impairment (e.g. as identified in an initial nurse assessment)
- Physical impairment (e.g. as identified in an initial nurse assessment)
- Medications being taken as reported in the medication record or chart

Back to Mr. Grey

Tony has been at the aged care home for a week now. He arrived at the home in the company of his son and wife. John had convinced his father that the move was necessary because of his wife's health problems, but Tony seemed quite down and withdrawn.

In spite of his mixture of vascular dementia and Alzheimer's disease, Tony was relatively healthy.

The staff reported that while the personal history they learnt from his wife was useful in gaining his cooperation during ADLs (talking about musicals and his plumbing job); he is not cooperative with changing his underwear. He constantly paced around the facility and did not interact with the staff or residents. The home was securely fenced but six times in the week Tony was found trying to climb the fence.

To address the wandering behaviour:

(i) The dietitian recommended a supplement to fortify his diet due to his 'restlessness' and (ii) the physiotherapist introduced an exercise program to provide a controlled outlet for that restlessness sand (iii) the psychogeriatrician recommended an anti-depressant, in part to reduce Tony's anxiety and restless behaviour, and in part to lift his apathetic mood.

The staff realised that they needed to know what might set off his wandering behaviour (the antecedent). What was the trigger that was making Tony think he had to leave?

They started a Behaviour Record: There was a set pattern- he set off in the morning (about 8-9am) or in the afternoon (about 3pm).

They watched more closely at these times (completing a modified Behaviour Assessment Form) and found a delivery van often turned up at the home in the morning, and this was visible to Tony if he was in the garden. Was he reacting to old routines – being picked up for work after breakfast?

In the afternoon at 3pm the next care shift started, there was a lot more activity with people coming and going. Did he think this was a cue to go home?

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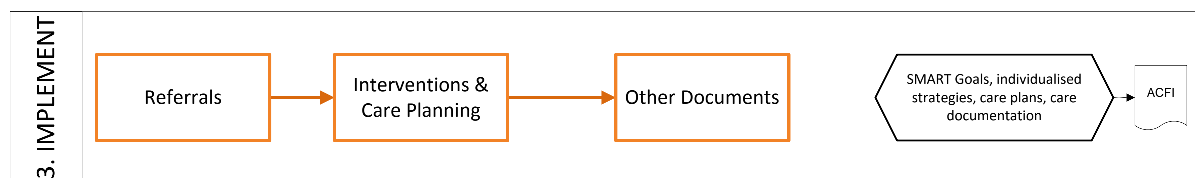
Implementation Process



This phase of the toolkit demonstrates how to use the information gained from the identification phase to implement interventions and care planning.

The implementation process has three main aspects. These are:

- Undertaking **referrals as identified** to gather further needed information;
- Designing **interventions** and developing **care plans that provide a coherent picture of what is to be done and why**;
- Completing **other documents** that support the care process such as for the ACFI funding claims and daily documentation.

Referrals

If there is an identified need for further behaviour assessment or management that cannot be provided on site, a referral to a Dementia Behaviour Management Assessment Service (i.e., DBMAS or CDAMS) or a dementia consultant could be considered. If there is an identified need for further mood assessment or management that cannot be provided on site, then a referral to an Aged Psychiatry service or private psychiatrist or psychologist could be considered.

If there is an identified need for medication or medical review, then the matter should be directed to a Medical Practitioner (i.e. GP), who can implement treatments, or make referrals to medical specialists such as the geriatrician or psychogeriatrician.

We recommend that the management group develops referral lists based on what your health service can provide, what is available in your local area and a list of important website contacts to find a practitioner or advice (Table 3).

After completing the screens and assessments (modified BAF, Behavioural Description List, and the CSDD if appropriate) there will be informative, objective and detailed information suitable to complete a standardised referral template to a behaviour support service.

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Table 3: Referral for Behavioural Expressions

Health Professional	Source	Contact
Medical Practitioner	Health Service X	Name, contact details
Geriatrician	Health Service X	Name, contact details
Psychogeriatrician	Health Service X	Name, contact details
Aged Psychiatry Services	Health Service X	Name, contact details
Behavioural Assessment Team	Health Service X	Name, contact details
Dementia Consultant	Health Service X	Name, contact details
DBMAS	Health Service X	Name, contact details

Interventions

In the identification phase, the residents' healthcare and personal needs were identified. The intervention program will address these identified issues, by developing strategies to improve or maintain the residents' health status and their quality of life.

The intervention program targeting behavioural expressions should involve evidence informed strategies (refer following) that address the behavioural needs, and importantly the strategies should be specifically tailored for each individual to be most effective. The approach and actions you use to support one resident may be very different from those implemented for another resident.

When designing interventions consider the resident history and personal preferences, the assessment outcomes, the context the strategy will operate in (i.e. the physical environment, the social environment), the knowledge and attitudes of staff, residents and family, and the types of resources required and their availability. Interventions are likely to be medical, psychosocial, educational or nursing in nature.

It is also important that all staff follow a systematic process when implementing an intervention 'program'. This will increase the likelihood of your intervention's success. Having a systematic process which you can describe will also enable other staff to repeat your interventions if they prove successful.

Interventions may be based on pharmacological or non-pharmacological approaches. A pharmacological approach should be developed by a Medical Practitioner, the resident's GP or via a referral to a medical specialist e.g., geriatrician, psychogeriatrician or a dementia specialist service.

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Non Pharmacological Approaches

Good dementia care can be good care for any resident. Interventions that include a relaxed social environment, access to meaningful activities, and positive staff- resident relationships should be considered for all residents. Here are some examples of non pharmacological approaches.

Physical Environment	The physical environment should be calm and supportive- small, homelike, with ready access to staff, and an arrangement of shared areas, single bedrooms with ensuites and access to safe garden walks. Noise and lighting should also be considered.
Relationships	Staff, other residents and the community should engage with the person as far as possible and encourage social interaction.
Person Centred Care	Taking into account the cultural, family values, interests and likes of the person, that personal goals are understood and respected when understanding the person. Looking after the whole of the person, their quality of life and their health needs.
Activity and recreation	Meaningful activities that the person can relate to, even if they have memory loss.
1-1 interaction	Engaging the person in their surroundings, in conversation. Using daily interactions to engage the person. Ensuring the work place practices (roster, attitudes) support staff to interact with residents.
Physical activity	Exercise, incidental activity is good for the body and the brain.
Pleasant Events	Provides an opportunity to improve or maintain mood.
Sleep	Allowing people to sleep in and awake naturally.

When a person with dementia has a limited vocabulary, the behaviours may be expressing “I want to go home” or “I’m uncomfortable, I need some reassurance”. The key is to decipher the spoken and unspoken message by having a background history on the person - the history we have collected in the identification phase, especially the personal family, previous interests and working life.

Sometimes reminiscence can be comforting. “Do you mean you want to go back to Bendigo, where you grew up? Tell me what it was like there.”

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When a man is worried about finding his spouse, for example, sometimes simply giving him a chance to reminisce about her is comforting. If his wife has died, a picture of her can help him reminisce. Perhaps a tape or video recording made by his wife or a family member will offer a reassurance and can be played anytime.

Communicating Effectively

When we are talking about behavioural expressions as a form of communication resulting from a cognitive impairment and a diminished verbal vocabulary, it is doubly important that the care team's verbal and non-verbal messages to people are clear and sensitive.

Some suggestions for providing verbal messages to people with cognitive impairment are:

Don't underestimate what people understand. Always include them in conversations if possible.

Introduce yourself when you come into the person's presence.

Slow down and be as patient as possible. Slowing down is probably the most important thing we can do in communicating with anyone and especially someone with a cognitive impairment or impaired mood.

When giving directions, use short sentences, and take one step at a time. "I'm going to help you put on your blouse. Let's start with this sleeve."

Don't over-explain. As dementia progresses, the people who have it tend to speak less. We have a tendency to fill in those conversational gaps with detailed explanations which can make the person more anxious.

State things positively. If you say to a person, "Don't go outside," he is likely to focus on going outside. Avoid negatives and say what you really want, i.e. "Stay inside."

Issue an invitation. If you ask the person with dementia if they want to do exercises it will likely result in a "No, thank you". Instead, issue an invitation such as "Tony, would you please come with me to the sing-along? I need your wonderful voice"

Use concrete terms. "Put that over there" is likely to be meaningless to the person with dementia. "Please put your plate on the table" is better.

Respect the person's right to say "no." When things aren't working, leave, and come back later.

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As a person's dementia progresses, avoid open-ended questions and limit choices. Asking a person with dementia, "What would you like for lunch?" may be overwhelming. Asking, "Would you like the cheese or the tuna sandwich?" is an easier decision.

Use multisensory clues. A bath towel and soap can indicate that it is time to have a shower. The more ways you can signal what is happening next, the more likely it is that the person with dementia will understand you and start thinking about the next step.

Having a conversation. If you ask multiple questions in a row, the person with dementia may become more confused. Ask one thing at a time, for example:

- Where you go to school?
- Did you walk to school?
- Was it far away?
- Did you like your teachers?

Substitute statements for questions. For example if you ask while walking with Mr. Grey, "Tony, would you like to use the bathroom?" he will likely say no, but if you say "here is the bathroom" it sets an expectation and may get a different response.

Be silent when necessary. Some people with dementia need all their powers of concentration to focus on the task you are assisting them with. If you start to talk about the weather, they will forget they were trying to put on a shirt or blouse, and be confused for a while before they can return to the task. It is important to recognise what an individual resident needs in any given situation to make them as comfortable as possible.

Back to Mr. Grey

For Tony, the harder challenge is to solve the "man on a mission" sort of wandering that he frequently does. This is sometimes referred to as "exit-seeking" behavior because the person is determined to leave the building or property. The feeling of having obligations – work to get to, children to pick up, and dinner to prepare – is often strong in the middle stage of Alzheimer's disease. If you try to stop mission driven people, they may become frustrated or anxious because you don't allow them to complete their tasks.

Sometimes, as happened when Tony lived at home, letting him go, and counting on him to return on his own when the urgency left him, can work just fine, at least for a while. That isn't usually practical and it may not be safe in many circumstances.

Sometimes a person can be distracted by a conversation (especially over a cup of tea and biscuits). For example staff could ask him about his work, "Was it hard, or messy? Were the customers pleasant?" Or ask for his opinion. Tony may also retain his career-related vocabulary. So ask, "My kitchen tap is old and has started to drip. Do you think I should replace it?"

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Sometimes a person can be distracted by a job to do. It may be slightly related or totally unrelated to his occupation or skills. Sometimes you need to be creative. Placing an item of interest in a garden may provide the distraction that reduces the urge to leave the home. It is important to include staff and family members when developing strategies and to see what works best for that resident and the facility.

The staff have identified and described the wandering behavior, completed a further behavior assessment looking at the antecedents and consequences of these occurrences over the last week, and talked with the family.

Following is a sample item from Tony's revised care plan related to his wandering.

Staff planned new routines and distractions for the two periods that set off the exit seeking behaviour.

There were two secure gardens at the home and the second garden area was directly off the dining area and did not give a view of the delivery vehicles. The activities staff set up an after breakfast activity just off the dining area where Tony had breakfast. He (and other residents) were invited to listen and sing along to resident's favourite music for one hour. This activity was attractive to Tony's personal interests and distracted him away from the other garden area in the morning. It was also hoped that this pleasant event would encourage interaction between him and some other residents. Another goal was to establish a new morning routine for Tony.

A new routine was also needed in the afternoon about the time that many staff left. They asked his wife to visit in the afternoon when possible. From talking with Mrs. Grey they learnt that Tony had enjoyed shredding their papers and taking them to the local council dog pound. It was decided that on two afternoons, they would start shredding paper and cardboard for the local dog pound.

It was hoped that by distracting Tony with useful work during the two times he was most likely to try and leave, he would stop doing so.

It was important that Tony's and other resident's access to the external areas was not affected, as it was good for all resident's to get outdoors for walks in the secure garden area. They would also see if they might be able to get him outdoors for some gardening activities – another way to give him fresh air and a sense of purpose. They would re-evaluate how things were going a week later.

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Care Planning

A comprehensive care plan will be more than a summary of care needs, it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs.

Facilities may have their own care plan or the NATFRAME Care Profile (refer to the Reference Table in the Appendix for reference details about the NATFRAME) could be used as a starting point e.g. as a summary care plan. Although the NATFRAME Care Profile will probably not record enough details for your home, it is an example of how to collect and document information in a systematic, professional and accountable manner.

Linking the Evidence

This is about showing the link between the evidence from the background and assessment information (what has been collected in the identification phase) and the care that has been provided to address the identified care needs (in the implementation phase).

The links are:

- Begin by looking at and noting any underlying issues (e.g. dementia diagnosis) or symptoms (e.g. increasing agitation in the afternoon), connect the link to the body structures and/or functions that are impacted (e.g. disruptive behavioural symptom)
- Describe the associated activity limitations (e.g. requires supervision in afternoon). It's important to look at remaining strengths (e.g. enjoys being helpful and busy)
- Describe the intervention program and how it addresses the limitations to assist the resident to improve or maintain his or her status and ensure continued participation in a quality life (e.g. introduce new activities in the afternoon)
- Finally, define the care goals (to reduce afternoon agitation) and resident goals (feeling useful) that will be evaluated. Goals give purpose to the care and provide a measurement for evaluating the outcomes.

Below is an example of linking the evidence from the case study of Tony Grey:

- There was a diagnosis of moderate to severe dementia, with symptoms of excessive wandering and exit seeking behaviour. Also symptoms of verbal combativeness to his wife. Depressed mood was noted after admission to the facility. This was evidenced in the Medical Notes, ACCR, and progress notes.
- From the identification process, we identified the body structures/ functions that were affected. This was mood, behaviours and cognition. The cognitive assessment showed concentration issues, short term memory loss and disorientation to place

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and time. The Behavioural Expression assessments showered physical restlessness, exiting behaviour, verbal refusal of some personal aspects of care, and loss of interest. These issues have resulted in reduced independence in personal hygiene and limited interaction with staff and residents.

- Interventions included distraction combining pleasant events, personal hobbies and interests i.e., music activity after breakfast included social interaction with other residents, and paper recycling twice a week.
- The aims of the care plan were then defined as goals (e.g. reduce exit seeking behaviour, increase social interaction with staff and residents) that will be evaluated.

Goal Setting

Moving beyond compliance to funding, the care planning should also address setting goals based on clinical outcomes and the resident‘s perspective on their care needs and what is important to maintain their quality of life. It is recommended that a **Quality Of Life** (QoL) questionnaire be used to ascertain the resident's view of their quality of life. This could be implemented during the resident/family meeting to sign off on the Care Plan. The goals developed with the resident/family should cover **resident QoL**, **clinical outcomes** and **quality care outcomes** to address a wide range of documentation needs (i.e. consumer satisfaction and clinical expectations). An example of a QoL questionnaire is provided in the Resource Pack.

SMART Goals are an example of a standardised approach to goal setting with measurable outcomes. The SMART acronym (www.projectsmart.co.uk) stands for goals that are:

Specific, that is, they provide clarity, focus and direction.

Measurable - Objective measures can demonstrate the effectiveness of the goals.

Action-oriented, that is, they provide a strategy for achieving them.

Realistic – because if they're not, we're just setting up for almost certain failure that will then impact on the residents motivation, interest and involvement; and

Time-based- meaning for a specific duration. That enhances their ability to be measured and re-evaluated on an ongoing basis

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Role of Documentation

Documentation of care is essential because members of the care team are accountable for their actions and decisions when providing care to a resident. Accountability is also a vital function of professional, legal, accreditation and funding mechanisms and processes.

Documentation is also a communication tool about what has been investigated and the information collected, what interventions have been tried for a particular problem with a particular resident and to identify what is and isn't working. It's a communication tool that can help all staff give the best possible care.

Good documentation supports the process which drives the care. It should incorporate evidence informed care, evidence-based assessments and interventions, utilise staff skills and drive a quality care approach.

The documentation process should leave a trail that provides robust and accountable information. The documentation is the basis of an evidence profile which provides objective and transparent information for the reason that assistance is or is not required. This supports the ACFI claim which is an outcome of the process, not a driver.

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required.
- Prepare the care plan with details on the care to be provided, why, and the resident's goals and desired outcomes (in consultation with the resident and family where possible). Record the evaluation of the care provided and the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this assists the information and communication flow and allows the process to be tracked for quality purposes.

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Completing the ACFI documentation

The data collected can now be used to complete the **ACFI 7, ACFI 8, ACFI 9 and ACFI 10 checklists and ratings** (Tables 4 and 5).

The mandatory ACFI assessments for ACFI 7, 8, 9 and 10 (i.e. Behaviour Records and the Cornell Scale for Depression in Dementia) should be no more than 6 months old and should reflect the current needs of the resident.

To support a B, C or D rating in ACFI 7, 8 and 9, the required ACFI assessment is the Behaviour Record (Table 4). It is recommended that users refer to the **ACFI User Guide and Assessment Pack** to support implementation of the tool. The ACFI claim is directly linked to the frequency as recorded in the Behaviour Record. It is the same approach for all three behaviour groups. The mapping shown on the Behavioural Descriptions List (found in the Behavioural Expressions Assessment Pack) will assist you to determine which ACFI claim(s) to make.

Table 4: ACFI Questions 7 to 9 Checklists

ACFI 7, 8 & 9 Behaviour Checklists	Where to find the information
Behaviour does not occur or occurs less than once per week (Rating A)	The mandatory evidence is the Wandering/ Verbal/Physical Behaviour Records which will inform on the frequency during the appraisal period. Supporting Evidence: ACCR or Medical Practitioner notes will inform on related medical and behavioural diagnoses. Clinical reports can inform on cognition and associated behaviours. Progress Notes and Care Plans should be congruent with the claim. Other assessments (Cognition, Behavioural Descriptions List, and modified Behavioural Assessment Form) should be congruent with the claim.
Behaviour occurs at least 2 days in a week (Rating B)	
Behaviour occurs at least 6 days in a week (Rating C)	
Behaviour occurs twice per day or more, at least six days in a week (Rating D)	

To support a B, C or D rating in ACFI 10, the required ACFI assessment is the Cornell Scale of Depression in Dementia (Table 5). It is recommended that users refer to the **ACFI User Guide and Assessment Pack** to support implementation of the tool. The ACFI claim is directly linked to the assessment score and a diagnosis is required for a claim for Rating C or D.

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Table 5: ACFI Question 10 Checklist

ACFI 10 Symptoms of Depression Checklist	Where to find the information
Minimal symptoms or symptoms did not occur (Rating A)	CSDD assessment score 0-8. Progress Notes, Behavioural Descriptions List and Care Plans should be congruent with the claim.
Symptoms caused mild interference with the person's ability to participate in their regular activities (Rating B)	CSDD assessment score 9-13. Progress Notes, Behavioural Descriptions List and Care Plans should be congruent with the claim.
Symptoms caused moderate interference with the person's ability to function and participate in regular activities. (Rating C*)	CSDD assessment score 14-18. Progress Notes, Behavioural Descriptions List and Care Plans should be congruent with the claim.
Symptoms of depression caused major interference with the person's ability to function and participate in regular activities (Rating D*)	CSDD assessment score 19-38. Progress Notes, Behavioural Descriptions List and Care Plans should be congruent with the claim.
There is a diagnosis or provisional diagnosis of depression completed or reconfirmed in the past 12 months OR Diagnosis or provisional diagnosis of depression being sought and will be made available on request within 3 months of the appraisal date	*Required for a Rating C or D ACCR or Medical Practitioner notes can provide the required diagnoses if they meet the time period criteria.

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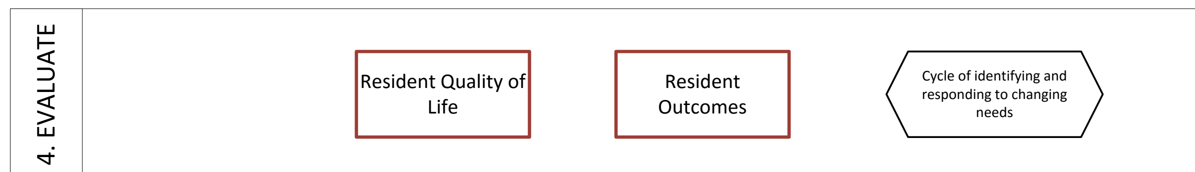
Evaluation Process



The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better? In what ways (e.g. happier, healthier)? What might have produced this outcome? This could be determined by revisiting the Quality of Life questionnaire or by interviewing the resident and family.

- Resident Care Outcomes

  Have the interventions been successful, for example reduced exiting behaviour?

- Further improvements

  What needs re-assessing, what could be implemented in a slightly different way?

Outcomes

An evaluation of Tony's care plan has shown:

- *A week later, there has been good progress, Tony is joining in the music activity, and cooperating with the controlled exercise program. There has been no exiting behaviour noted in the morning.*
- *He is also interacting more with staff and other resident's during the music activity. He appears to be much happier, smiling more, interacting with the environment.*
- *Staff have reported that they are building a better rapport with Tony during ADLs also, with reduced resistance to staff assistance during ADLs.*
- *He has only attempted to exit the grounds twice during the past week, in the afternoon, when there was no activity in place to distract him.*

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Summary: Steps and Information Flow

Figure 3 shows the phases and steps in the behavioural expression process. It involves:

The Identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Screening using the Behavioural Descriptions List and an Initial Nurse Assessment
- Completing further Assessment (Behaviour Records, modified Behaviour Assessment Form, modified Cornell Scale for Depression in Dementia)

The implementation phase which comprises:

- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

The evaluation phase which comprises:

- A review of the effectiveness of the interventions on resident outcomes Monitoring the progress and effectiveness of the interventions will inform if any changes should be considered
- If a review is required, then at this point the process returns to the identification phase and the associated steps
- Completing Standardised Care Processes to address any systemic clinical risk management issues (Depression, Physical Restraint)

The Evidence Based Clinical Assessment Toolkit (EBCAT) is so named because evidence gives us a reason to follow a particular plan toward improved care.

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Figure 3: Behavioural Expressions Summary: Steps and information flow

Identify
Implement
Evaluate

Personal History
Collate
Documentation
Screen
CHA ; Beh'l Descriptions List;
Review needed
Comprehensive Behavioural Expressions Assessment
Behaviour Records; modified BAF; modified CSDD
Referral needed
Referrals
Interventions & Care Planning
Best Practice Int
Evidence Model
Goal Setting
Progress Notes
Handover
Charting
ACFI
Other Documents
Document
Status change
Monitor Effectiveness
NO Status change
Resident Outcomes & QOL

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Behavioural Expressions Resources

The recommended resources and information on where they are found in the toolkit are listed below (Table 6).

Table 6: Behavioural Expressions Workbook Resources

Resource Type	Details	Document
Background Reading	IPA BPSD guidelines- Specialist's guide and Nurses guide DTSC On-line dementia course Module 1	Facility to download
Screen	Initial Nurse Assessment (e.g. CHA)	Resource Pack
Screen	Behavioural Descriptions List	BE Assessment Pack
Screen/Assessment	Modified Behaviour Assessment Form (BAF)	BE Assessment Pack
Mandated Evidence	Behaviour Records	ACFI Assessment Pack
Mandated Evidence	Modified Cornell Scale for Depression in Dementia (CSDD)	ACFI Assessment Pack
Standardised Care Processes (SCP)	Delirium	Resource Pack
Standardised Care Processes (SCP)	Physical Restraint	Resource Pack
QoL questionnaire	Quality Of Life Questionnaire	Resource Pack
Goal setting example	SMART Goals	Resource Pack

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Behavioural Expressions References

The recommended resources and references are provided below (Table 7).

Table 7: References for the Behavioural Expressions Workbook

Document name	Reference
ACFI Assessment Pack October 2014	Sourced at: https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-assessment-pack
ACFI User Guide October 2014	Sourced at: https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-user-guide
Best care for older people everywhere (BCOPE). The Toolkit (2102).	Department of Health Victoria (2012) Best care for older people everywhere. The toolkit. Sourced at http://www.health.vic.gov.au/older/toolkit/index.htm
Comprehensive Health Assessment (CHA) of the older person in health and aged care. Assessment template 2014.	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria The CHA is an example of an initial nurse assessment.
Comprehensive Health Assessment of the Older Person (CHAOP)	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria Resource developed for comprehensive health assessment training for PSRACS (2013).
Cornell Scale for Depression in Dementia (CSDD)	Refer to the ACFI Assessment Pack, October 2014.
Dementia Training Study Centre (DTSC)	10 part on-line dementia education modules. Module 1: Evidence-based tools for BPSD assessment Sourced at: http://www.dtsc.com.au
Diagnostic and Statistical Manual of Mental Disorders	American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA, American Psychiatric Association, 2013
IPA Complete Guides to Behavioral and Psychological Symptoms of Dementia	Sourced at: www.ipa-online.org

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Document name	Reference
(BPSD) –Nurses Guide. –Specialists Guide	
Kozman et al 2006	Authors: Kozman MN, Wattis J, Curran S. Reference: Pharmacological management of behavioural and psychological disturbance in dementia. *Hum Psychopharmacol. 2006 Jan; 21(1):1-12.)*
NATFRAME Behaviour Assessment Form	Section 7 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource. Sourced at: http://webarchive.nla.gov.au/gov/20140803082152/http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe01.htm
NATFRAME Care profile	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource. Sourced at: https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/suggested-assessment-tools-for-aged-care-funding-instrument-acfi
Standardised Care Processes (SCP) Depression & Physical Restraint	Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Authors: La Trobe University ACEBAC Sourced at: Depression http://www.health.vic.gov.au/agedcare/downloads/score/depression_scp.pdf Physical Restraint http://www.health.vic.gov.au/agedcare/downloads/score/restraint_scp.pdf

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