Behaviours of concern

Resident displaying behaviours that indicate a risk to the safety or well-being of the resident or those around them

Is there an immediate risk of harm (or actual harm) to the resident or those around them?

YES

- Call QAS on 000
- Implement **immediate management strategies (see Practice point 1)**
- Notify GP
- Notify relevant decision maker*
- Notify **HHS RaSS**

NO

1. Employ immediate management strategies (see Practice point 1).
2. Check **vital signs** when safe to do so - review Recognition of the deteriorating resident.
3. If not immediately life-threatening, review Checklist for contact **and ring GP**.

UNSTABLE VITALS → Refer to Management of residents with unstable vital signs

STABLE VITALS

Perform holistic resident assessment - review structured assessment of resident with behaviours of concern (see Practice point 2)

Is there evidence of delirium or is there an identifiable physical cause?

YES → Refer to New or worsened confusion pathway

NO

Undertake cognition-appropriate pain assessment

PAIN PRESENT → Administer analgesia and refer to Pain management pathway; monitor behaviours and implement individualised behaviour support plan (see Practice point 3)

NO PAIN

Develop (or refer to **existing**) individualised behaviour support plan (see Practice point 3) and institute non-drug strategies (see Practice point 4)

ONGOING CHANGED BEHAVIOURS

Undertake Neuropsychiatric Inventory and Cornell Scale for Depression

- **UNCLEAR CAUSE** → Refer to HHS RaSS or community geriatrician at GP discretion
- **SUSPECTED MENTAL ILLNESS** → Consider treatment/s specific to mental health diagnosis; Refer to HHS older persons mental health service at GP discretion
- **ESTABLISHED DEMENTIA DIAGNOSIS OR COGNITIVE DECLINE** → Consider psychotropics as a last resort and in accordance with legislation (see Practice point 5). Refer to Dementia Australia Severe Behavioural Response Team or HHS dementia outreach service at GP discretion

* Where immediate management strategies and non-drug strategies are unsuccessful and restrictive practices are employed to ensure safety of the resident and / or others, ensure that these are proportionate to the risk of harm and ensure legislated requirements are followed; where restrictive practices are used, the restrictive practices decision maker hierarchy should be followed. Where there are no restrictive practices employed, involve the substitute health decision maker.

Behaviours of concern practice points

1) Immediate management strategies

1. **Reduce risk:**
   - Remove resident/s from danger
   - Remove potentially harmful objects if safe to do so
   - Reduce environmental noise and distractions & give the person space (stand back)
2. **Review resident's behaviour support plan:**
   - Where the behaviour is addressed by the plan, follow the plan of action
3. **Verbal de-escalation:**
   - Use a calm, gentle voice with a respectful, empathic tone and a slow, even speed
   - For non-English speaking residents assign a staff member who speaks the language or involve family / friends if appropriate;
   - Engage family, as appropriate, to identify unmet needs and support positive behaviours
   - Use eye contact consistent with the person's cultural needs
   - Use the resident's preferred name
   - Use simple sentences without patronising
   - Encourage resident to talk about what they are feeling and express any unmet needs
   - Communication should promote the resident feeling valued and respected
   - Do not attempt to reason or argue

2) Structured assessment of the resident with behaviours of concern

Perform & document assessment of the behaviour, including:

1. Description of the behaviour in clear, non-emotive terms.
2. A holistic assessment to identify the antecedent or activating event for the behaviour - this assessment should extend beyond the "observable" antecedent and involve assessment of the resident and their environment in collaboration with usual carers, GP, and family;

****Behaviours are often a way for residents to communicate their unmet needs****

3. What was the consequence of the behaviour for the resident; what did staff do and how did the resident respond? Were others affected by the behaviour? What are the maintaining factors of the behaviour?
4. Use the below assessments to identify the function of the behaviour for the resident and use this understanding to guide development (or modification) of the individualised behaviour support plan.

P - PHYSICAL assessment (with GP)

1. **Pain** - assess using a cognition-appropriate tool, treat and address underlying cause.
2. **Toileting needs** - urinary retention, constipation.
3. **Acute illness** - e.g. infection, acute injury or wounds, post-ictal behaviour, hypoglycaemia.
4. **Delirium** - perform Confusion Assessment Method (CAM).
5. **Polypharmacy** - community pharmacist review for potential interactions, dosage, adverse effects.
6. **Hunger or thirst**.

I - INTELLECTUAL assessment

1. Dementia related **cognitive changes** e.g. short-term memory loss, orientation, lack of insight.
2. Loss of **ability to communicate** needs effectively e.g. expressive or receptive aphasia.
3. Loss of **ability to initiate, sequence and complete motor tasks or apraxia**.

E - EMOTIONAL assessment

1. Are there neurovegetative signs of depression (recent changes in sleep, appetite or motivation) -perform Neuropsychiatric Inventory (NPI) and Cornell Scale for Depression in Dementia.
2. Does the behaviour seem driven by psychotic features e.g. false beliefs or hallucinations - perform NPI.
3. Assess for evidence of **grief or loss** e.g. loss of spouse, roles, home, independence.

Behaviours of concern practice points (cont'd)

2) Structured assessment of the resident with behaviours of concern (cont'd)

4. History of treatment for mood, anxiety or psychotic disorders especially if specialist psychiatrist involved or past history of self-harm or suicide attempts?
5. Have there been thoughts of suicide or self-harm or acts of deliberate self-harm or attempts at suicide?

C - CAPABILITY assessment

1. Undertake a resident **capability assessment** - is there a change to usual abilities?
2. Is the resident receiving **support to maximise capabilities**? This may include, for example, correction of sensory impairment through provision of hearing aids and / or glasses.
3. Is the resident being provided **meaningful activities**?

E - ENVIRONMENTAL assessment (consider social and physical environment)

1. Assess **physical environment** at time of behaviour for evidence of over- or under-stimulation: noise, temperature, smell, number of people, restrictions to movement, people / staff present.
2. Has there been a **recent change to environment or routine**?
3. Assess **social environment**: social isolation, meaningful contact, invaded personal space, interactions of other residents & staff with resident at time of behaviour.

S - SOCIAL SELF (consider cultural, spiritual and life story):

1. Review person's life history - are there any contributors from their life-experience e.g. traumas?
2. Cultural contributors to behaviours? E.g. language barrier with secondary frustration.
3. Are resident's personal preferences being addressed?
4. Are family relationships stable?
5. Are staff interactions with the resident undertaken with a supportive approach?

3) Individualised behaviour support plan

Develop (or review, and update where indicated, existing plan), document & implement an individualised behaviour support plan (in collaboration with the resident, their restricted practices decision maker, staff and the GP) - ensure that the plan includes strategies and objectives and addresses the resident's human needs, including:

1. Physical, intellectual, emotional, cognitive, environmental and social needs including: any assessments or investigations required to further evaluate these needs; known triggers that precede behaviours.
2. An individualised behaviour support plan to prevent / target behaviours or symptoms.

Non-drug person-centred care approaches should be the mainstay of a behaviour support plan, with strategies to:

1. Use a resident's preferences and life history to guide activities and avoid boredom.
2. Provide guidance to staff on:
   - Communication styles and interactions that avoid the aggressive behaviour
   - How to provide care in a manner that will prevent aggression e.g. individualised care based on understanding resident's preferences for daily cares such as preferred timing of cares, water temperature for bathing etc.
3. Avoid over- or under-stimulation and known triggers for behaviours (where clinically appropriate).
4. Use social interactions to engage residents and assist them to build meaningful relationships.

Where restrictive practices are included in the Behaviour Support Plan:

1. They are used as a last resort.
2. They encompass the least restrictive practice possible.
3. Their use is necessary and proportional to the risk of harm.
4. They are used for the shortest time possible.
5. Ensure documentation of the name of the resident's restrictive practices decision maker and the type of restrictive practice to which the appointed decision maker relates.

Providers should ensure that legislated requirements are fulfilled in relation to use of restrictive practices, If you have not received training and support to implement a resident's behaviour support plan, discuss with your facility clinical care manager. Dementia Support Australia may support providers with education or clinical support.

Behaviours of concern practice points (cont'd)

4) Non-drug strategies

Non-drug, person-centred care approaches include:

1. Non-drug strategies outlined in a resident's existing behaviour support plan.
2. Verbal de-escalation.
3. Distraction techniques.
4. Assess for and address resident's unmet needs:
   - Pain - assess using a cognition appropriate pain assessment tool
   - Hunger
   - Need to toilet
   - Lack of privacy
   - Lack of meaningful activity / boredom
   - Communication or social needs
5. Multi-component interventions tailored to the person's primary behaviours: therapeutic use of music or reminiscence therapy may assist with a wide array of behaviours; for anxiety / depression it may be of additional benefit to provide support and counselling; for agitation, consider additional use of massage or behavioural management interventions.
6. Montessori activities supporting independence through meaningful activities and environmental cueing.
7. Animal assisted therapy.

Dementia Support Australia may support providers with education or clinical support.

5) Psychotropic medications

- Non-drug approaches should be the mainstay of management. Review prior history and determine whether there have been previously effective management strategies utilised - note: ALL residents with cognitive impairment / dementia should have a behaviour support plan established to prevent and manage acute behavioural disturbance; use of psychotropic medications to manage behaviours of concern is considered a restrictive practice - where used, ensure use is a last resort and that relevant legislative requirements are adhered to.
- Review existing medications for contributors to behaviours of concern: Anticholinergics (e.g. oxybutynin), ranitidine, promethazine, anti-epileptics, Levo-dopa, dopamine agonists, opioids, psychotropics, corticosteroids, antibiotics, antivirals.
- Where there are unmet needs contributing to the behaviours, ensure these are appropriately managed before consideration of use of specific pharmacological therapies for behaviours (e.g. treat pain, treat underlying depression, modify environmental contributors).
- Effectiveness of medications in behavioural symptoms of dementia is low and there is increased risk of mortality with psychotropic or sedative medications.
- If non-drug methods are exhausted in management of agitation or aggression and the symptoms are severe, dangerous and / or cause significant distress to the resident, consult resident and their restrictive practices substitute decision maker and the resident's GP to consider a short-term trial of:
  - Risperidone commence at 0.25mg orally twice daily, gradually increasing if needed by 0.25 mg every 2 or more days to maximum 2mg daily(divided into 2 doses)
    OR
  - Olanzapine 2.5mg orally daily. Where indicated, gradually increase by 2.5mg daily every 2 or more days to a maximum of 10mg daily (divided into 2 doses)

Note: specific populations where specialist input may be warranted include those with:

- Parkinson disease or Dementia with Lewy bodies - seek geriatrician or psycho-geriatrician input
- On a palliative pathway, where alternate approaches may be indicated - seek specialist palliative care input

Behaviours of concern practice points (cont'd)

5) Psychotropic medications (cont'd)

Prior to commencement of psychotropic medications for behaviours of concern:

1. Obtain and document informed consent for the medication to be used (including discussion of risks and benefits relevant to the resident's individual circumstances) and for the use of the medication as a chemical restrictive practice from the relevant substitute decision makers; the name of the substitute decision maker and what they are authorised to consent for on behalf of the resident should be documented.
2. With GP, document a plan for:
    - Monitoring (for effect on behaviours and adverse effects) and
    - Review of ongoing requirement for the medication

6. Behaviours of concern: support resources

- Dementia Support Australia
- HHS older persons mental health services or dementia outreach services
- Dementia Behaviour Management Advisory Service and Severe Behavioural Response Teams
  Phone (24 hours a day): 1800 699 799
- Dementia Training Australia resources
- Supporting a restraint-free environment in residential aged care Aged Care Quality and Safety Commission
- Restrictive practices provider resources Aged Care Quality and Safety Commission

Behaviours of concern references

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Behaviours of concern version control

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