POLICY & PROCEDURE NUMBER:
DEPARTMENT: *Nursing* **SUBJECT:** *Responsive Behaviours*

APPROVAL DATE: Sept 2014
REVISION DATE: Oct. 2019; March 2023
REVIEW DATE: Dec. 2020; March 2021; March 2022

Philosophy

The fundamental principle of the *Fixing Long-Term Care Act*, 2021 (FLTCA), is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where residents may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

Policy

The home is committed to ensuring the needs of residents with responsive behaviours are met.

Preamble

The term "responsive" behaviours is used to describe a means by which persons with dementia or other conditions may communicate their discomfort with something related to, for example, the physical body (e.g., urinary tract or other infection), social environment (e.g., boredom, invasion of space) or the physical environment (e.g., lighting, noise, busyness). Responsive behaviours can also be 'protective behaviour'. In the past, these behaviours have often been termed "disruptive," "challenging" or "aggressive" and this previous terminology negatively labels residents.

Understanding the sources/underlying causes of responsive behaviours is key to providing the optimal care for a resident. Responsive behaviours often indicate an unmet need a person may have (cognitive, physical, emotional, social, environmental or other need). Or, sometimes behaviours are a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person.

When an individual's responsive behaviours escalate, this can lead to altercations among residents or staff and may be harmful or abusive. Therefore, a key aspect of resident care is to prevent or minimize the situations in which a resident exhibits responsive behaviours. The staff of the home can achieve this preventative approach by integrating the most effective strategies for individual residents into their plan of care, and implement these strategies through a coordinated, interdisciplinary approach.

Prior to Admission

All application's for admission submitted by the Local Home and Community Care Support Services (HCCSS) will be reviewed by administration (Administrator/Manager of Resident Care/Resident Care Coordinator/Manager of Support Services). Where there is reference made to responsive behaviours, administration may request further information, suggest further assessment, and/or complete an onsite visit prior to admission and subsequently determine if appropriate to offer admission. A decision will also be made regarding appropriate placement of the resident within a resident home area to reduce risk of injury to self, residents and staff.

On Admission

An assessment of resident for potential responsive behaviour will be completed on admission to the facility. If responsive behaviours are identified, a referral will be made to the internal BSO (Behavioural Supports Ontario) team and a PIECES assessment will be completed by a PIECES trained registered staff. The potential for responsive behaviour will be noted in the nursing care plan and procedures for management will be planned and implemented. Documentation of incidents of responsive behaviour will be done to enable monitoring of such incidents and to evaluate appropriate interventions.

Assessment and Care Planning

On-going assessment and treatment plans will be implemented and evaluated for effectiveness. A referral to the internal Behaviour Supports Ontario (BSO) team will be initiated when responsive behaviours are identified. Referrals to specialized programs, e.g. mobile BSO team, Regional Geriatric Program or Psychogeriatric programs will be initiated if behaviours are unmanageable. Multidisciplinary conferences will be used to provide a consistent approach to the care of residents. Family members of the resident will be invited to conferences and planning of care for the resident. Support mechanisms for staff include case conferencing, dementia care education, incident reporting and other facility education plans to enable staff to discuss concerns relating to responsive behaviour.

Definitions

Responsive Behaviours: actions that may include a resident exhibiting one or more of:

- physically non-aggressive or protective behaviours such as pacing, undressing, handling objects
- physically aggressive or protective behaviours such as spitting, hitting, throwing objects, physical sexual advances
- physically hurting self or others
- verbally non-aggressive or protective behaviour such as verbal complaints, constant requests for attentions
- verbally aggressive or protective behaviour such as cursing, sexual comments
- verbal abuse
- resisting care
- socially inappropriate or disruptive actions
- difficulty with psychosocial adjustments or symptoms of depression (e.g. isolation, refusing to eat, withdrawal from usual activity pattern)
- delirium

Prevention

1. Identify the causes and triggers (e.g. environmental such as lighting, social, food, medications, and specific activities) for responsive behaviours, altercations and harmful interactions. This assessment will include clinical assessments to ensure identification of causes of responsive behaviours such as, medication related, or chemically or physiologically based.

2. Develop Strategies for Prevention which may include:
   - Environmental adaptation strategies such as noise reduction e.g. voice levels, radio, TV, scraping chairs, room temperatures, arrangements and design, lighting that accommodates vision changes, eliminate unpleasant odours
   - Orientation and training programs for staff, families and volunteers especially on prevention, how to recognize the triggers and strategies to prevent escalation, how to communicate and how to manage a situation which has escalated (e.g. training to avoid particular places, events or circumstances)
   - Awareness, skills and knowledge related to responsive behaviours for staff and contractors
   - Awareness orientation and training for volunteers regarding how to recognize responsive behaviours, how to communicate with residents who exhibit responsive behaviours when involved directly with residents

- Information for families, people of importance to residents and substitute decision makers related to the home practices regarding residents with responsive behaviours
- In practice, staff and volunteers proactively communicating with residents to prevent and respond to responsive behaviours and potentially harmful interactions
- Developing interventions to minimize triggers or respond effectively for specific residents and to prevent the escalation of potentially harmful or abusive situations
- Use of internal and external tools, experts and resources for screening, assessing and developing strategies for managing responsive behaviours, including staff duress tools/systems.

3. Screening Protocols and Tools: Utilise screening tools and protocols to assist caregivers to understand the cause(s) of a resident's responsive behaviour(s) and to track the patterns of these behaviours. MDS RAI is an example of a screening tool that flags a problem or observation by staff, family and others of changes in a resident's behaviour and potential for altercations between/among residents or staff that may be harmful.

Purpose of Screening

Screening identifies level of risk associated with the behaviour (potential or imminent), and may identify behavioural triggers, patterns, contributing factors, environmental factors, type of behaviour, frequency of behaviour, potential for adverse drug reaction causing responsive behaviour, potential for altercations between residents.

Risks identified may include: e.g. elopement, or leaving the home without staff knowledge, roaming, imminent physical harm, (fire, falls, knives/sharp objects, firearms), suicidal ideation, deteriorating relationship with staff/family, risk of fuelling another resident's behaviour, smoking, and substance misuse. High risk situations may require one to one staffing or transferring the resident to the hospital emergency department.

Screening Tools may include, but is not limited to:

- Putting it All Together P.I.E.C.E.S.™ - see Appendix A
- Dementia Observation System

- Cornell Scale for depression
- Cohen Mansfield Agitation Inventory
- P.I.E.C.E.S.™"Psychotropic Template" - see Appendix A
- Pain Assessment
- Priming, Timing, Miming – see sample in Appendix A

Refer to Behavior Supports Ontario for other recommended resources;
https://brainxchange.ca/BSO/BSO-Provincial-Toolkit

See www.**pieces**canada.com/pdf/Resources, for all P.I.E.C.E.S.™ tools + "putting it all together" user guidelines. All of these tools aid the interdisciplinary team to assess, communicate and co-ordinate the support for the resident in the most effective manner possible.

Escalating/NewResponsive Behaviours

Responsive Behaviour/Aggression which may result in injury to others:

Resident: In the event of Resident to Resident interaction resulting in physical contact of an aggressive nature the following will be completed by the Registered Staff immediately:

- Ensure both resident and staff safety
- Immediately report as per Resident Abuse Policy Admin. 2.11- Contact Manager of Resident Care (MRC)/Designate
- MRC/Designate to contact Personal Representative/POA
- MRC/Designate initiates Ministry of Health and Long-Term Care Critical Incident Reporting System as per reporting guidelines
- Contact Physician depending on the severity of the incident
- Documentation in Point Click Care in progress notes under "Behaviour Patterns"
- Resident Assessments (neurological, vital signs, head to toe, skin, etc.).
- Implement strategies for resident safety
- Update Care Plan and Point of Care kardex with interventions
- Complete Risk Management Incident in Point Click Care
- Initiate Behaviour Mapping
- Referral to internal BSO Team/Mobile Team as required

- Multi-disciplinary conference as required
- Utilize a debriefing tool (if required)– see sample Appendix A

Staff: In the event of Resident to Staff interaction which may result in injury one or more of the following will be implemented:

- Immediately suspend care and re-approach resident later unless there is a safety risk to the resident or it is inappropriate to stop.
- Immediately implement the staff duress tools (i.e. paging, whistle, call bell, staff duress system if available)
- Immediately report to registered staff
- Registered staff assess staff member for injury/first aid-complete Injury/Accident Report
- Provide staff time away from incident site
- Consideration for change of resident home area assignment
- Support from co-workers/management
- Employee Assistance Program
- Refer to Resident Abuse Policy Admin. 2.11

Assessment:

More in depth **interdisciplinary** assessments are carried out to integrate assessment findings and collaboratively problem solve for possible solutions.

- MDS RAI historical perspective
- P.I.E.C.E.S. ™ Information
- SW HCCSS (MDS HC)
- Family/SDM (See Appendix A for sample tools -Family History and 5 Favourite things)
- Possible causes of behaviour to be investigated further e.g. medications, urinary tract infection
- Is the resident hallucinating and acting on beliefs, tormented by beliefs?
- Is the behaviour disturbing to others?
- Is the responsive behaviour manageable in the present setting?
- Referral to BSO in Point Click Care) with follow-up to be completed by BSO team.

Note: The home will establish a Responsive Behaviour Team which may include: P.I.E.C.E.S.™ internal resource staff, Personal Support Workers, Registered Nurses, Registered Practical Nurses, senior management, Pharmacist, Life Enrichment/Recreation/Therapies, Dietary, Housekeeping, RAI Coordinator, internal BSO team. This team may also include other external specialty resources such as External BSO team and/or Specialized Outreach Teams.

Plan of Care

Establish resident focused, interdisciplinary goals and strategies to ensure resident well being and quality of life and resident/interdisciplinary team safety based on assessment findings.

- Adapt strategies for the individual that respond to triggers and responsive behaviour. Consider the following strategies:
  - meaningful, purposeful, activity participation (e.g., photo albums, physical activity such as a walk, baking, sanding wood, dusting, delivering mail, activities that bring familiarity and enjoyment e.g. singing, dancing, attending church, etc.)
  - social interaction (e.g., sitting and talking with a person including active listening to the persons needs or struggles)
  - environmental intervention (e.g., remove noise/distraction, change lighting, prevent unpleasant odours, use suitable seating, etc.)
  - varying strategies for different times of day or night (e.g., late afternoon or evening)
- Integrate evidence–based strategies such as **GENTLECARE ™** approaches, Gentle Persuasive Approach techniques, to address specific behaviour as well as observing for triggers, method of communication, removing from certain situations, rest period, activity periods
- Procedures to minimize the risk of altercations (between residents or staff) or responsive behaviours for staff or residents who are at risk of harm or who may have been harmed
- Medications to prevent and manage responsive behaviours may be considered, after all other treatment alternatives have been tried and eliminated as a solution
- Strategies to address in depth assessment findings e.g. pain, infection, anxiety
- Observe for escalation of responsive behaviour from anxious ->verbal-> physical
- Include techniques such as calming activity, redirection, diversion, reassurance, do nothing, do not argue with the person, etc.
- Consider use of multidisciplinary behavioural care plan – e.g. Priming, Timing, Miming and Debriefing Tool (see samples in Appendix A)

Monitoring and Communication

Observe and document the resident's response to the care plan strategies, this can include:

- observation and documenting observations in charts and progress notes
- regular re-assessment using MDS-RAI 2.0 on a quarterly basis or with significant change.
- medications dose, effectiveness and any negative reactions

All staff should be informed at the beginning of each shift when residents require heightened monitoring. Any new responsive behaviour and any behaviour that may cause risk to the resident or others should also be communicated to staff. Staff will use the responsive behaviours debriefing tool (Appendix J) to assist in identifying causative factors/triggers that lead to an incident and interventions that were used to deescalate the incident.

Referral Protocols for Consideration

Methods of referral will vary according to residents' needs and/or availability of specialized experts.

These referrals may be appropriate when the resident's condition is very complex, when there is an imminent risk of harm, or when a psychiatric condition is suspected. Specialized service referrals for consideration include:

- External BSO Mobile Team
- Geriatricians or Geriatric Psychiatrist
- a Clinical Pharmacist regarding medications
- the Physician in an emergency situation for Form 1 (i.e. an application for a psychiatric assessment)

Program Evaluation:

Quality Improvement: evaluate and update at least annually in keeping with evidence-based practices or if there are none, prevailing practices. A written record of the annual evaluation, who participated in this evaluation, and a summary of the types of changes made (and when) as a result of the evaluation.

Possible Indicators

- Trends in the types, numbers and frequency of occurrences of responsive behaviours
- Use of tools/compare scores such as Putting it all Together or Cohen Mansfield Inventory, behaviour monitoring charts
- Trends in MDS RAI 2.0 data and outcome scores
- Quality Reporting Indicators E.g. Incident reports, Critical incident reports, use of chemical restraints, number of staff, contractors and volunteers receiving training

Individual Resident: follow up according to assessed needs and the care plan; reassess every 3 months at a minimum.

- MDS RAI outcome scales
- Staff recording resident's response to interventions – making changes if required

Orientation and Training

All staff providing direct care and volunteers must be oriented prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behaviour management. Training shall include but not be limited to:

- Identification, prevention and management of responsive behaviours,
- Mental health issues, including caring for persons with dementia
- Behaviour management
- Staff duress tools (i.e. paging, whistle, call bell, staff duress system if available)

References: OANHSS LTCH Act Implementation Member Support Project

Fixing Long-Term Care Act, *2021,* & Ontario Regulation 246/22 s. 58, 59

"PUTTING IT ALL TOGETHER" RAI-MDS© AND P.I.E.C.E.S.™ INTEGRATION JOB AID

The information captured in the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and the (P.I.E.C.E.S.) (Physical, Intellectual, Emotional, Capabilities, Environment, Social) Framework can be integrated to enhance the person's and his/her TEAM care planning process and eliminate unnecessary assessment duplication.

RAI-MDS® and P.I.E.C.E.S.™ Integration

The RAI-MDS and the P.I.E.C.E.S. Framework both:

- ✓ Foster an interdisciplinary, person-centered approach to care;
- ✓ Are grounded in the principles of seeking effective intervention and evaluation for care planning; and
- ✓ Facilitate appropriate referrals such as:
  - Referral to the P.I.E.C.E.S. Resource Staff team members;
  - Referral to the PRC;
  - Referral to other interdisciplinary partners such as Psychogeriatric Outreach; Palliative Care, Pain Consultant; Stroke Strategy team, rehabilitation partners, Alzheimer Society

The RAI-MDS and P.I.E.C.E.S. Framework – How Do They Connect?

1. The most recent RAI-MDS assessment, the CAPs[1], and Outcome Measures provide evidence-based information to inform the P.I.E.C.E.S. 3-Question Assessment Framework for those "IN the MOMENT" situations that occur when a person is experiencing an acute change between RAI-MDS assessments.
   i) "What has changed?" – What was the person's status on the most recent assessment? What's different now?
   ii) "What are the RISKS and possible causes?" - What were the risks identified on the most recent assessment? What are they now?
   iii) "What is the action?" - What interventions were in place to address a triggered CAP for the most recent assessment? Is there a need for changes in the intervention(s) now?

[1] Clinical Assessment Protocols were released by CIHI May 2008. Jurisdictions that have not implemented CAPs may continue to use Resident Assessment Protocols (RAPs) for the RAI 2.0 and Client Assessment Protocols (CAPs) for the RAI-HC

2. If a person is experiencing an acute change situation, the P.I.E.C.E.S. Assessment Framework may assist in addressing the care needs "IN the MOMENT" and in determining the need for a full RAI-MDS "Significant Change" assessment.

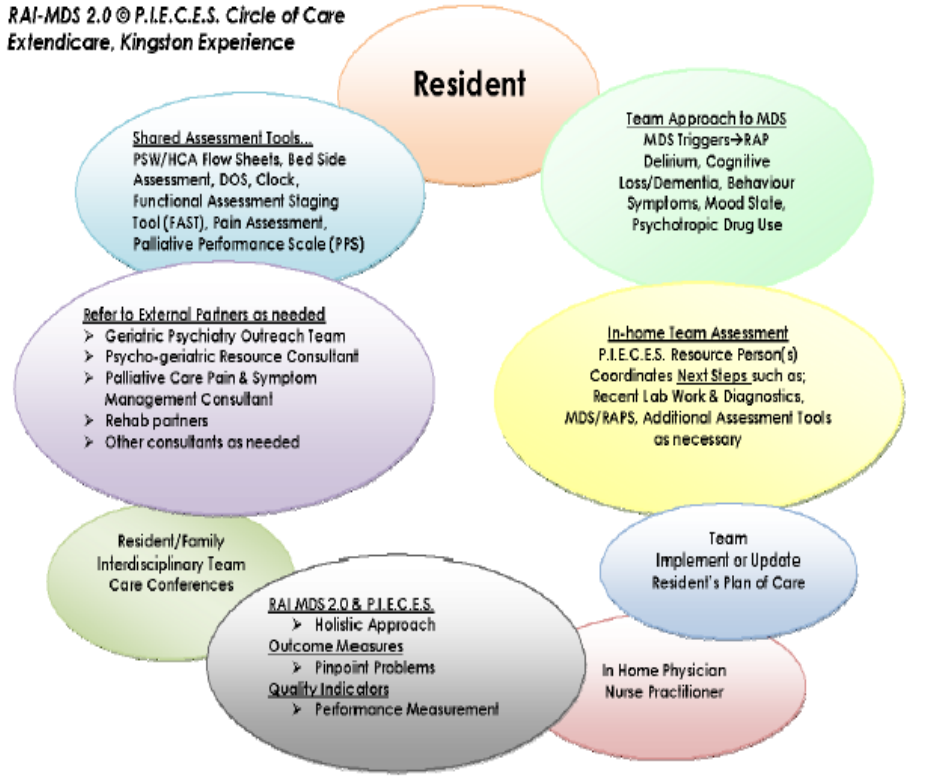
3. The P.I.E.C.E.S. Assessment Framework can be used to assist with care planning when CAPs are triggered (e.g., Delirium, Cognitive Loss, Behaviour, Mood, and Pain) during routine assessments.

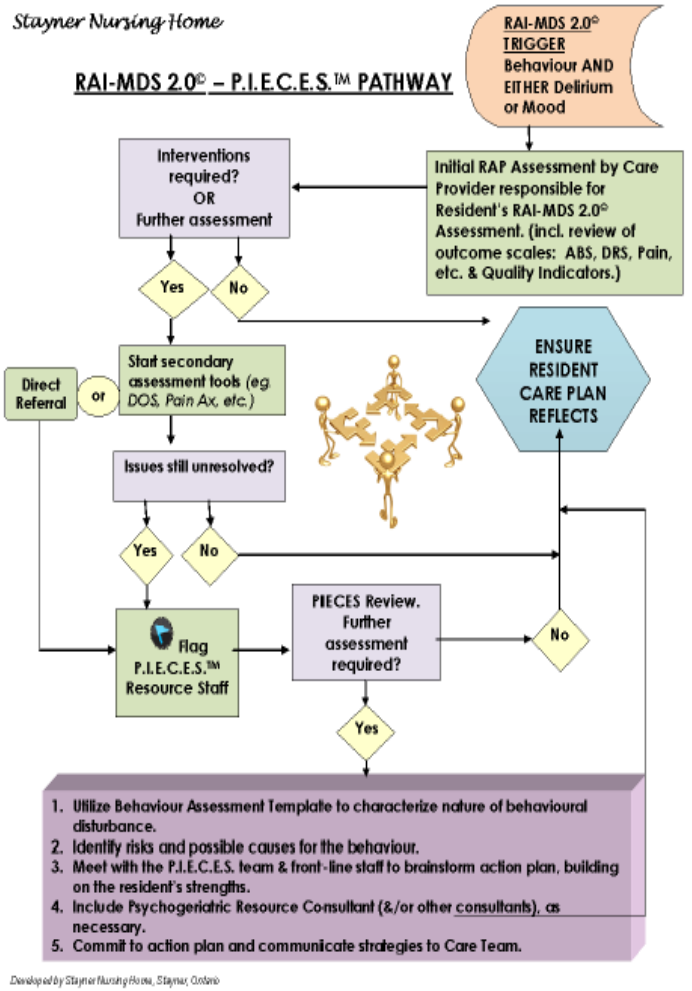
4. The completion of a RAI-MDS assessment may prompt the need for more specialized assessment using the P.I.E.C.E.S. Assessment Framework and/or referral to PRC or other interdisciplinary partners.

5. Intervention(s) initiated as part of a P.I.E.C.E.S. assessment and team discussions can be evaluated by comparing the RAI-MDS Outcome Measures from the "before and after intervention".

Two models that provide examples of P.I.E.C.E.S. and RAI integration are shown on the flip side of this page. They may be adopted or customized to an organization's standards and policies for practice.

"PUTTING IT ALL TOGETHER" RAI-MDS© AND P.I.E.C.E.S.™ INTEGRATION JOB AID…cont'd





P.I.E.C.E.S.™ "PSYCHOTROPIC TEMPLATE"

Three-Question Framework for Selection and the Detection, Monitoring the Use, Risk, and Benefits of Psychotropics

1. When should a psychotropic be used or considered?
2. How do I select the right medication?
3. How do I monitor the response and side effects (with person, family, providers)?

Are the benefits outweighing the risks and side effects (to this treatment vs. other treatments)?
- ☑ How long is the medication to be used, and when is it to be reviewed?
- ☑ What are the indicators for increasing or decreasing the medication?

Important Note:

- Withdrawal symptoms are associated with many psychoactives, including SSRIs (flu-like symptoms). The dose must be *reduced slowly* and the status monitored closely.

If no response, consider non-adherence, wrong diagnosis, wrong dose, or not enough time.

CLASS	Preferred choices, starting doses	Side Effects	Notes & max. recomm. doses
SSRI	Citalopram (10 mg), Escitalopram (5-10 mg), Setraline (25 mg): preferred Paroxetine, fluoxetine, fluvoxamine: more common or severe drug interactions; prolonged side effects with fluoxetine	Headache, Agitation, Nausea, Diarrhea Sweating, Somnolence **HANDS** Monitor for hyponatremia. Anticholinergic effects: paroxetine	
SNRI	Venlafaxine (37.5 mg)	Headache, nausea, elevated BP in higher doses.	Watch for suicidal risk when "energy" increased but still despondent. Max. recommended dose: 300 mg daily
	Duloxetine (Start dose 30 to 60 mg)	Dry mouth, Appetite loss, Nausea, Constipation Equilibrium (dizziness), Somnolence or sleep disturbance **DANCES**	Not for use with persons with liver disease and/ or severe kidney problems, uncontrolled glaucoma. Watch for drug-drug interaction (i.e. not with fluvoxamine, MAOI some antibiotics i.e. Cipro etc)
NASA	Mirtazapine (15 mg)	Dry mouth, drowsiness, weight gain, dizziness: mild anticholinergic activity	Weight gain can be substantial. Maximum recomm. Dose: 45 mg
NDRI	Bupropion (100 mg)	Seizures, Headache, Agitation, Rash, Emesis, Sleep disturbance **SHARES**	Maximum recommended dose: 150 mg BID
SARI	Trazodone (25-50 mg)	Drowsiness and orthostatic hypotension	Used more for sedation than for antidepressant effect. Effects last approx. 4 hours
RIMA	Moclobemide (150 mg)	Monitor for hypotension. When combined with MAO-B (Eldepryl), MAOI diet/full precautions needed	In doses up to 600 mg per day, no dietary precautions required. Given BID from 300 mg to 600 mg daily
STIMULANT	Methylphenidate (5 mg in morning)	Cardiovascular risks: high BP, agitation, sleeplessness	Usually not a first line treatment
TRICYCLIC	Avoid most TCAs, Nortriptyline or Deipramine may be considered in treatment resistant depression	(C)ardiovascular: Orthostatic hypotension (dizziness), falls, ↑ pulse rate Anti(C)holinergic: Urinary retention constipation, dry mouth, blurred vision **3 C's** (C)onfusion: Monitor with the C.A.M.	Usually not a first line treatment

P.I.E.C.E.S.™ "PSYCHOTROPIC TEMPLATE"…Cont'd

Atypical Antipsychotics	Newer Antipsychotics – Side Effects to Monitor	Clinical Response
Common Olanzapine Risperidone Quetiapine **Advantages of New Antipsychotics** • Less EPS • Less risk of developing tardive dyskinesia • Less cognitive effects • May stabilize mood	Dizziness, Agitation (early), Somnolence, Hypotension May cause weight gain May cause tachycardia, with higher doses – EPS Watch for sedation **Cautions:** • Lipid increases • Insulin resistance (glucose changes) • Weight gain • Potential cardiovascular events ***DASH***	The clinical factors to monitor include the 7 parameters of delusion: 1. Dangerous, threatening 2. Distressing to self 3. Disturbing to others 4. Direct Action, if acting on them 5. JeoparDizing independence 6. Distant or present 7. Definite (fixed) vs insight Initial / Later Tranquilizing effect usually occurs early; however, resolution of psychosis may take 1-2 months
Traditional antipsychotics or neuroloeptics	**Traditional Antipsychotics - Side Effects to Monitor**	**Mainly used if delirium**
High potency – Haloperidol Mid potency – Loxapine, Perphenazine Low potency – Chlorpromazine	• Constriction: EPS: rigidity, tremors, showed movements, drooling, leaning to one side, parkinsonian gait and falls • Less EPS but more anti-cholinergic than haloperidol ***4C's*** • Anti-Cholinergic side effects, Confusion, Cardiovascular side effects	In general, should be avoided
If it is an anxiolytic, what class is it?	**Side Effects to Monitor**	**Response**
Benzodiazepine – Lorazepam, Oxazepam, Alprazolam, Temazepam, Clonazepam	Confusion and memory problems, ataxia (poor balance) and falls, disinhibition leading to inappropriate or aggressive behaviour	• decreased agitation and anxiety • Rapid response within 1-2 hours • Best in panic attacks or catastrophic reactions
Mood stabilizers	**Side Effects to Monitor**	**Response**
Lithium Carbonate	Ataxia and falls, confusion, weakness, diarrhea usually when serum level is greater than 0.8 mmol/L some GI upset in early treatment. Polyuria, tremor may occur at therapeutic doses. Maintain serum levels between 0.4 to 0.7 mMol/L	• stabilization of mood and behaviour within 2-4 weeks at therapeutic dose/level • Mostly used when previous recurrent mood disorder, particularly bipolar illness
Antiepileptic – Na Valproate, Carbamazepine, Lamotrigine	Sedation, ataxia, nausea; if there is bruising or bleeding of any type, call physician. Check if drug levels and blood work done regularly (liver, hematology). Watch for rashes particularly with Lamotrigine.	• May be considered in lability of mood and behavioural problems in dementia
Drugs to treat Dementia	**Side Effects to Monitor**	**Response**
Cholinesterase inhibitors – Donepezil, Rivastigmine, Galantamine	Muscle cramp, Insomnia, Nausea, Diarrhea and weight loss Slow pulse, heart block, peptic ***MIND***	• Improve or prevent decline in ADLs, Behaviour, Cognition, and Decrease caregiver time (ABCD)
Cognitive Enhancers (Potential Problems) Breathing Problem Seizures Nausea and peptic ulcer Low pulse (bradycardia)		**© P.I.E.C.E.S.™ Consultation Team & Associates January 2009** Pam Hamilton BA Curriculum and Clinical and Education Consultant. Joanne Collins. RSW. Curriculum and Education Consultant> Nova Socita Coordinator. Diane Harris R.N. MSc CHRD, CPT. Performance & Learning Consultant, Project Coordinator J. Kenneth LeClair MD, FRCP(C). Clinical Advisor, Curriculum & Education Consultant Marie France Rivard MD, FRCPC(C). Chair, Steering Committee for P.I.E.C.E.S. for Family Physicians
Glutaminergic agent	**Side Effects to Monitor**	**Response**
Memantine • Indicated for moderate to severe dementia	Confusion, Headache, Equilibrium, Constipation, Kidney function ***CHECK***	• Cognition - improved • Socialization – improvements • Household tasks • ADLs - improved function • Persecutory thoughts decreased • Excessive activity/irritability decreased • Caregiver time saved ***C-SHAPES***

Family History

We ask that you kindly return this Family History form. The more information we learn about your loved one, the better picture we have of their life. This information will enable us to provide the best care possible for your family member. We appreciate you taking the time to complete the form and mail it back or drop it off at the office when you are in for you next visit.

Name: _____

1. **Date and Place of Birth:**

2. **Spousal Information:**

3. **Children's Names:**

4. **Education and Occupations:**

5. **Significant Traumatic/Emotional Event:**

6. **Special Dates: (Anniversary, Retirement, Migration Date, Favourite Holiday/Season, etc.)**

Family History

7. **Where They Grew Up:**

8. **Last 3 Towns Lived In:**

9. **Travel Destinations:**

10. **Favourite Meals:**

11. **Pet Information:**

12. **Loved Activities: (Sports, Gardening, Reading, etc.)**

13. **Favourite Genre of TV/Movies/Music:**

14. **Any additional, helpful information**

NAME:

5 Of My Favorite Things!

1.

2.

3.

4.

5.

The Priming, Timing, Miming©
MULTIDISCIPLINARY BEHAVIOURAL CARE PLAN

Name: **Date Created:** **CB#:**
Prepared by:
Review Date(s):

Behavioural Goals:
1.
2.
3.

Sensory Status: Adequate Vision: YES / NO Wears Glasses: YES / NO Hearing Adequate: YES / NO Wears Hearing Aids: YES / NO
Communication: Expressive Language: Adequate Aphasia Allow time to respond Nonverbal Gesture Writing
Receptive Language: Adequate Aphasia Slow rate One-step Repetition Gesture Writing

Diagnostic/ Physical Status:

AREA Instructions: Circle / highlight appropriate items/fill in blanks

Bathing
Priming Bath / Shower
Independent / #___ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing ____ times per week
Morning / afternoon / evening
Needs: slower instructions / slowed pace of activities
Miming Needs to be shown / demonstration of using: washcloth shampoo soap; on body upper lower / hair
Extra comments:

Oral Hygiene & Grooming
At sink / Bedside; Own Teeth / Dentures: Upper Lower / No Teeth; Electric Razor: YES / NO
Priming Independent / #____ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing _____X per week
Morning / afternoon / evening before / after meals
Needs: slower instructions / slowed pace of activities
Miming Needs to be shown / demonstration of using: toothbrush paste cup denture soak comb/brush razor
Extra comments:

Toileting
Continent / Incontinent: Bladder Bowels / Wears Briefs Indicates when soiled: YES / NO
Priming Independent / #____ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing Toileted at regular intervals _____ staff led / client led
Voids in inappropriate areas: YES NO
Washroom use at night: YES NO / Urinal
Needs: slower instructions / slowed pace of activities
Miming Needs demonstration of: removing pants or briefs sitting on toilet wiping washing hands
Needs to be shown: toilet toilet paper sink soap
Extra Comments:

Dressing
In Bed / Bedside / In Tub Room First side to dress: Right / Left
Priming Independent / #____ person assist for ability / aggression
Set-up / cuing only / one article at a time / some assistance / total assistance
Timing Morning / afternoon / evening
Needs: slower instructions / slowed pace of activities
Miming Needs to be shown: others being dressed articles of clothing
Needs demonstration of dressing: upper torso lower torso
Extra comments:

Priming, Timing, Miming Behavioural Care Plan (continued) Name:
CB#:

Eating
Diet: regular / diabetic _____kj / finger foods / soft / minced Choking risk: YES / NO
Preferences:
Priming Independent / #____ person assist for ability / aggression
Set-up (includes opening containers) / cuing only / some assistance / total assistance
Timing Snack: mid-morning / mid-afternoon / HS Breakfast: late-morning / prefers to skip
Needs: 1 item @ time / slower instructions / slowed pace of activities / decrease distracters
Miming Needs demonstration of using: cutlery napkin cup
Extra comments:

Ambulation Aids: NO / YES: Walker / Wheelchair (type:_____) Risk of Falls: YES / NO
Priming Uses aids / independent / #____ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing More unsteady: morning / afternoon / evening
Needs cueing to: use aids / slow pace / apply brakes
Miming Needs demonstration of using: using aids / applying brake
Extra comments:

Transfers *Type: bed-walker-_____ / bed/wheelchair-_____ / walker/toilet-_____*
Priming Uses aids / independent / #____ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing More unsteady: morning / afternoon / evening
Needs: slower instructions / slowed pace of activities
Miming Needs nonverbal cues to transfer: YES / NO
Extra comments:

Sleep
Priming Pre-bedtime routine:
Timing Bedtime: Wake time:
Up at night: NO / YES for: Washroom Confusion/Agitation
Miming Needs nonverbal cues to signal sleep: NO / YES:_____
Extra comments:

Agitation / Defensive / Aggressive Behaviours:
Priming Trigger for agitation / aggression: cares / over stimulation / boredom / other:_____
Demonstrated by: pacing / talking louder / swearing / banging tabletop / spitting / kicking
Striking out / biting / pinching / throwing objects: _____
Strategies: re-approach later / use calming phrase / redirect to a pleasurable activity
Other Strategies: PRN:
Timing: Late day agitation? YES / NO Other Key times:
Miming Nonverbal cues patient is becoming agitated:
Nonverbal strategies to reduce agitation:_____
Extra comments:

Additional Strategies:

Pleasurable Activities:

Family Support:

Plan:

_____
Staff Signature and Designation

Responsive Behaviours Debriefing Tool

Resident: _____ Time: _____
Resident to: ☐ resident ☐ staff ☐ visitor/family
Injury: ☐ Yes ☐ No
If yes: Who was injured: _____
Where is the injury: _____ _____
What type of injury: _____
Where did this incident occur? :
☐ Residents Room ☐ Hallway ☐ Tub Room
☐ Bathroom ☐ Other area: _____

Identify any known Triggers
Environmental:
☐ Crowding ☐ Noise ☐ Lack of stimulation
☐ Other: _____

Physiological
☐ Recent Illness
☐ Recent change in Medications/New Medications
☐ Confused ☐ Current UTI
☐ Pain Other: _____

Predisposing Situation
☐ Recent Room Change ☐ Admitted within Last 72h
☐ Large Groups ☐ Restrained ☐ Wanderer
☐ Active Exit Seeker ☐ Change in personal care provider
☐ Personal Care being delivered:
☐ Bathing ☐ Pericare ☐ dressing/undressing
☐ Toileting ☐ Other: _____

Please List any other causative factors/triggers that lead to incident:
_____
_____
_____

Please List any immediate interventions that were used to deescalate the incident:
☐ Removed/Separated ☐ Other: _____

Distraction methods used (ie: sang a song, gave an item such as a teddy bear, etc):
_____
_____
_____

Suggestions to avoid a reoccurrence:
_____
_____

Responsive Behaviours Debriefing Tool

Resident: _____ Time: _____
Resident to: ☐ resident ☐ staff ☐ visitor/family
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_____
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