

Behaviour Support Plans

Your essential guide

Developing the skills needed to understand and support behaviour is part of being a great carer.



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Who this guide is for

This guide is written for everyone delivering care services to people in residential care environments. The Australian Government has introduced legislation that requires all care services to have Behaviour Support Plans in place for any residents needing behavioural support. This guide explains why.

Introduction

The way we behave is influenced by many things – our physical, social, emotional and mental health, our habits and routines, our relationships and changes in the environment. In general, most of us can manage the way we respond to the things going on around us, and, if there are things we don't like, we can change them. For example, if we're cold, we can put on a heater, sit in the sun or rug up under a blanket. In other words, if things are not the way we want them to be, we can stay in control of the way we respond and problem-solve to create change.

However, for many people, different things – illness, cognitive impairment, mental health problems, having to live with others – can affect their ability to control what's going on around them, as well as how they respond. At such times their behaviour may be the only thing they have left to respond or communicate with. And those changes in behaviours can sometimes *feel* challenging. We might see them as 'disruptive' or 'inappropriate'. But such behaviours are often the result of distress, a signal that they have an unmet need or that they are in an unwelcome situation. They can also be a sign of a changed medical condition.

These guidelines aim to support you to support the people you care for, well. To help you to understand the different things that can impact a person's behaviour, and how to provide care and support in response to changes in behaviours. One of the most powerful tools in your toolkit will be your **Behaviour Support Plan** – or **BSP** for short. A person with a good **BSP** is a **Better Supported Person**. That's why BSPs are something we all need to make sure we have in place, for everyone we care for.



A BSP makes life better for everybody.

OUR LANGUAGE

Dementia Support Australia (DSA), which runs the Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Team (SBRT), recognises the importance of using the right language to describe a behaviour that indicates the need for support and to not use words that unintentionally stigmatise the person or – incorrectly – attribute negative meanings to the behaviour. For this reason, DSA talks about:



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- 'behaviours that indicate the need for support' and describes them as **'changed behaviours'** rather than describing them as 'behaviours of concern' or 'challenging behaviour'; and,
- support in relation to responding to the impact or effect of behaviour, **'behaviour support'** rather than 'behaviour management.

Guiding Principles

'Behaviour support' means the processes we use, and strategies we develop, to help both avoid anything that might negatively impact a person's behaviour and to proactively respond to, and care for, a person expressing needs or stressors through behaviour.

Best practice behaviour support works by being personalised – designed specifically for the person involved. But there are some excellent guiding principles that apply across any behaviour support approach:



- 1. Many changes in behaviour are a signal that the person is stressed – or that they have an unmet need.** It might be about what's going on in the environment someone is in – an attempt to communicate a *feeling*, or to cope with an unmet need or to respond to something unwelcome – internal (in the mind or body) or external (something about the situation).



- 2. Behaviour support starts with knowing the person.** Focusing on understanding the detail about the person in your care – their likes, dislikes, past experiences and routines – is key to understanding what the person is experiencing or attempting to communicate and to responding with appropriate care strategies to support them.



- 3. Careful assessment, planning and partnership, enables effective responses to behaviour.** The use of your behavioural assessments and tools, as well as partnership with the person in your care, their friends, family and wider care team, allows ongoing care and support to address their needs.

What is the behaviour support process and how does it work?

Behaviour support is about the processes used, and strategies developed, to:

1. Proactively avoid things that might negatively impact a person and cause changes in their behaviour, and,
2. Proactively respond to, and care for, a person expressing the need for support through a changed behaviour.

What are 'Changed Behaviours' to be aware of?

The term 'changed behaviours' is descriptive rather than prescriptive. What constitutes changed behaviour, will differ depending on the individual expressing the behaviour. For this reason, identifying 'changed behaviour' that need responding to requires a good understanding of the person in your care, and whether the behaviour being experienced is different from what is 'normal' behaviour for that person. It is also important to consider whether the behaviour is distressing to that person or to others or to both.

DEFINITIONS



Why words really do matter!

The following definitions can provide some guidance as to common characteristics that can help to identify a changed behaviour that requires support:

"... any behaviour which causes distress to the person with dementia or others or is a manifestation of distress"¹

"... any behaviour which causes stress, worry, risk of or actual harm to the person with dementia, carers, family members or those around them. The behaviour deserves consideration and investigation as it is an obstacle to achieving the best quality of life for the person with dementia and may present as an occupational health and safety concern for staff."²

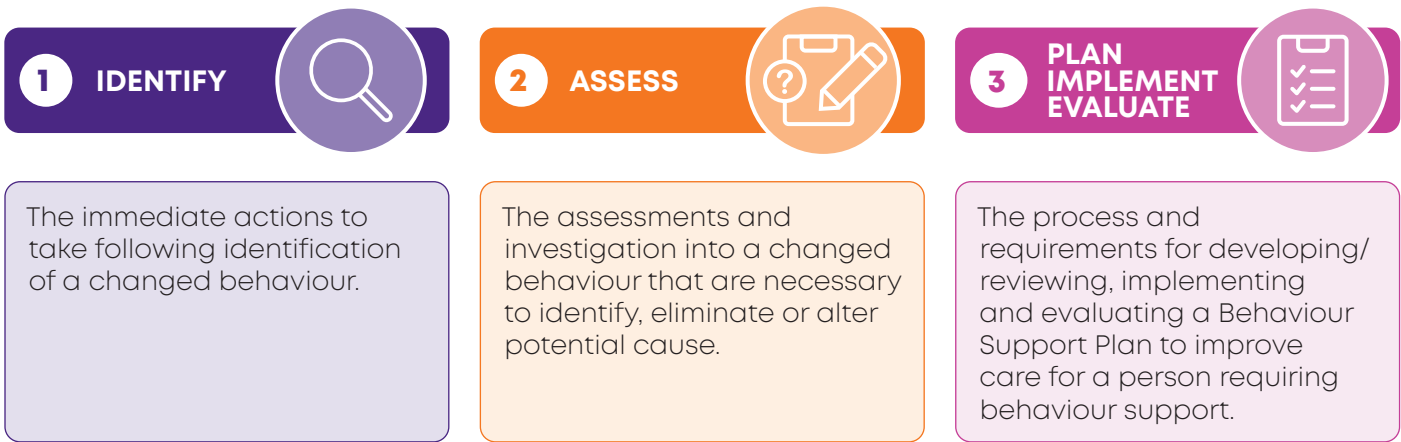
Research has shown that the use of stereotypical language to describe certain behaviours can negatively influence how we think about and interact with the person involved. It can lessen our valuing of them as a human being.³

1. Bird, M., Llewellyn Jones, R., Smithers, H., and Korten, A. (2002) Psychosocial approaches to challenging behaviour in dementia: A controlled trial. Australian Government Department of Health and Ageing, Canberra
2. Alzheimer's Australia National Dementia Advisory Service (2012), ReBoC: Reducing Behaviours of Concern – A Hands on Guide. Commonwealth Government Department of Health and Ageing, page 5
3. Kelly, F. (2010), 'Abusive interactions: research in locked wards for people with dementia', Social Policy & Society, vol. 9, no. (2), pp. 267–277.

As an example: If you label a person as the behaviour, e.g. ‘a wanderer’ or ‘screamer’, you create a sense of distance from them, rather than relating to them (e.g. “I wonder what’s making Fred feel the need to walk repeatedly from his room to the kitchen?”).

That’s why it’s so important to be fully aware of the words we use – to make sure language doesn’t discriminate against the person, or lead to broad-brush responses to a named behaviour. Instead, always assess any individual behaviour within the context of the person involved and their unique needs and preferences.

The behaviour support process:



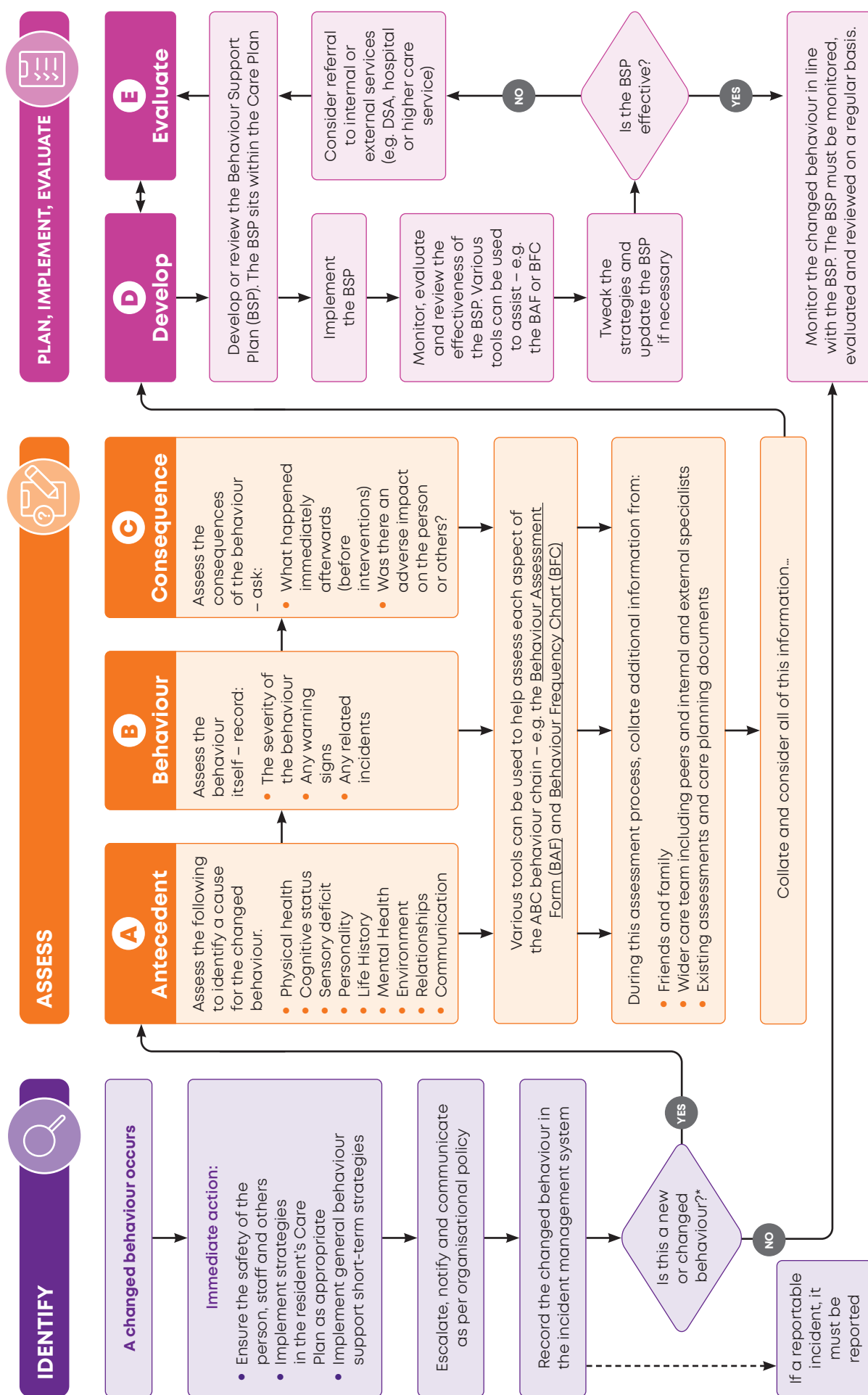
This section looks at the process and requirements for developing/ reviewing, implementing and evaluating a **Behaviour Support Plan** to improve care for a person requiring behaviour support. Each of these phases is explored in detail on the following pages and can be seen as a whole in the **Behaviour Support Flowchart** below.

It is important to remember that each person is unique and that there is no magic wand or ‘one-size-fits-all’ approach to effectively respond to every person and every behaviour. Responses must be tailored to the individual and based on a thorough assessment of their personality, lifestyle, needs and preferences.

While presented in a particular order, many of the elements of the behaviour support flowchart can occur in parallel or at the same time. Staff knowledge about a resident as well as their experience in supporting changed behaviour for the person involved, can also vary the sequence of steps, assessments and actions.

The completeness of information is more important than the order it is collected.

Overview of the behaviour support process



*A 'new or changed behaviour' includes a new type of behaviour, a change in the frequency or intensity of a known behaviour or a change in response to existing strategies.



IDENTIFY

Identify covers four key steps:

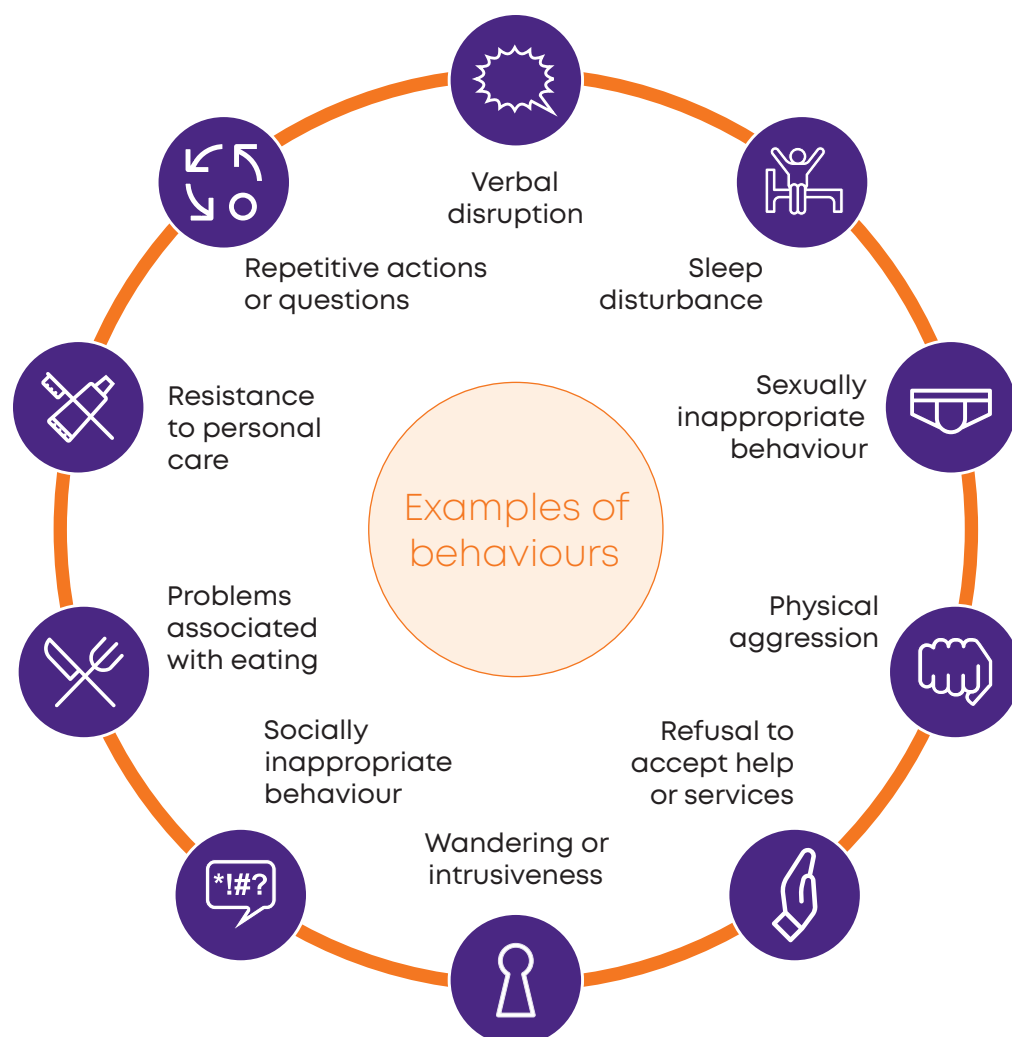
1. Identify there is a Changed Behaviour.
2. Identify any appropriate immediate response that might be needed to ensure safety.
3. Identify and implement any existing care plans in place.
4. Identify the changed behaviour to the wider care team through appropriate reporting.

1. Identify there is a Changed Behaviour

What does 'changed behaviour' look like?

While we have identified that any behaviours, and the reasons for them are unique to each individual, it is still useful and necessary to be aware of behaviours that indicate someone might be distressed. When we know what behaviours needing support might look like, we can respond – to identify potential problems, and to identify any unmet needs or contributing factors behind the behaviour. Some are very subtle things that we need to pay attention to see, and others are very obvious.

Some commonly identified 'categories' include:



What causes these types of behaviours?

Although changes in behaviour can be direct symptoms of an underlying disease process, many, are a consequence of, or impacted by, a wide variety of other internal and external factors. Common causes can be personal or emotional history, delirium, communication, carer approach, unidentified pain and environmental factors, all of which play a role in impacting behaviour and are discussed in more detail on pages 16–21. For people living with dementia or other illnesses, these things can also make an existing disability worse. Whenever we encounter a person that is expressing certain needs through behaviour, we should always begin by asking the key question:

‘What is this person trying to tell me?’

Our job is to help find out. Thinking through the causes and contributing factors behind behaviours is not only important in addressing that behaviour, it also reminds us that the sort of behaviour we are referring to here may not be deliberate or random. And it should definitely not be taken personally – in many instances, particularly for those living with dementia, the behaviour is an expression of unmet social, physical or personal care needs.

The following case study highlights the importance of taking the time to understand the context behind a person’s behaviour, rather than merely labelling the behaviour, and the usefulness of identifying tailored strategies to reduce the behaviour and its impact on others.



In many instances, particularly for those living with dementia, a behaviour needing support is an expression of unmet social, physical or personal care needs.

CASE STUDY

How Yvonne got her sense of meaning back

Yvonne had spent her adult life caring for her husband and children. She loved to bake and liked everything sparkling clean and enjoyed doing the washing and ironing every day. She rose early each morning before her family to attend to the daily chores.

When Yvonne came into care, she was very friendly and enjoyed engaging with the other residents. Staff saw her as being 'helpful', and were surprised at how easily Yvonne was settling in. Very soon, however, Yvonne started to tell all the other residents what to do, even going into their rooms in the morning and yelling at them to get out of bed or grabbing them by the arm when they were walking down the corridor and pulling them in the other direction. She would also go into other people's rooms and take their clothing and bedding and put it in her own room.

Through exploring Yvonne's history and spending time getting to know her, staff were able to understand what was happening for Yvonne. A big part of her daily life and purpose had been to care for her family. Daily chores were her expression of caring and gave her life great meaning.

Understanding this allowed the team to develop strategies to help her make sense of her changed environment and to cope – principally by setting out meaningful tasks for her to engage in. These included:

- at 4.30am when Yvonne would wake, night staff would have her help with getting her breakfast;
- they then set tasks for Yvonne, first getting her to wipe down all the tables and chairs, and then to assist getting the dining room and kitchen prepared for breakfast; and
- throughout the day, staff would get Yvonne to help with domestic chores around the cottage just as she would at home.

All of these strategies proved effective. With meaningful activities to engage in, Yvonne stopped walking into other people's rooms and taking their things. Although she continues to tell other residents what to do, staff now have plenty of strategies in place to limit any distress and to help keep Yvonne engaged in things that are meaningful and important to her. Yvonne now has a renewed sense of purpose in her life.



2. Identify any appropriate immediate response



Ensure safety of the person, staff and other residents

While the assessment and planning process is essential to supporting behaviour, the immediate response should focus on de-escalating the situation and making sure everyone is safe.

Depending on the circumstances, changed behaviours may present a risk to the safety of the person involved as well as to other residents, family, visitors and staff. If this is the case, immediate action must be taken to minimise any risk or minimise the impact of risks. This might include:

- removing potentially dangerous items in the environment;
- removing obvious provocations or causes for the behaviour;
- calling for additional assistance;
- maintaining good verbal and non-verbal communication (e.g. being calm, present and patient); and
- where appropriate and safe to do so, assisting other residents or visitors to leave.

3. Identify and implement any existing Care Plans in place



Implement strategies outlined in the person's Care Plan

In accordance with the Aged Care Act 1997 and the Quality of Care Principles 2014, every resident in aged care must have a care and service plan ('Care Plan'). The Care Plan includes information about the person, their needs and about how to care for that resident in a tailored, individualised way. **From 1 September 2021, if a person in residential aged care requires support for a changed behaviour, or where restrictive practices are considered, applied or used as part of their care, the Care Plan must include a Behaviour Support Plan (BSP) (this is discussed in detail on pages 29–35).**

Once safe to do so, strategies outlined in the resident's Care Plan and BSP to support the identified behaviours should be reviewed and, where appropriate, implemented.

It is important to recognise that even known or frequent behaviours may differ depending on the circumstances. Staff should use their judgement to assess the suitability of existing strategies as well as the resident's response to them. If the strategies are no longer appropriate, or have become ineffective, staff should work through each phase of the behaviour support flowchart to consider likely contributing factors behind these changes, reassess the behaviour, plan and trial new care strategies, monitor the impact of new strategies and update the BSP as appropriate.

Not all strategies are effective all the time – the goal here is to try and assess, then reassess as needed.



Implement general behaviour support strategies

In situations where the behaviour is new or where staff do not have time to consult the resident's Care Plan or BSP, the following strategies may assist in responding. It is important to remember that these are general strategies only and are not a substitute for thorough assessment of the individual's behaviours in the context of their needs and the surrounding circumstances. Careful investigation and problem-solving is required to support the resident and implement tailored strategies.

- **Keep calm.** Don't argue, or try to reason with the person. Regulate *your* response and respond to the resident's feelings/emotions rather than the behaviours.
- **Keep safe.** Always ensure that the resident and others (other residents, visitors and staff) are safe. If safety is a concern, respectfully and carefully divert the resident or if more appropriate, divert others from the immediate area.
- **Provide reassurance.** Validate what the person is feeling or experiencing. Remember that what they are feeling, or experiencing is very real to them.
- **Address the need.** Ensure that you address any immediate unmet needs for the resident such as the need to use the bathroom, comfort, hunger or thirst.
- **Assess the situation.** Consider whether anything in the environment may be causing distress for the resident. For example, noise, temperature or light, and remove or alter the environment as appropriate.
- **Redirect.** If possible, redirect and engage the resident in an alternate activity that they enjoy and/or which is meaningful to them.
- **Be flexible.** If a resident is resistive to care, it may be appropriate to reschedule for a later time.



Notify, escalate and communicate as necessary

Depending on the type and severity of the changed behaviours, it might be necessary to immediately communicate what's going on to make sure assistance is available to help you. Once immediate risks to safety have been addressed, the behaviour and any actions taken should be communicated more broadly to the care team and if necessary, escalated to the appropriate people.



Relevant stakeholders for notification of the changed behaviours include:

Who?	Why?
Other staff members	To enable them to provide any immediate help needed or advice in managing the behaviour and for ongoing observation of the person and delivery of appropriate care to them.
Your manager (e.g. Team Leader, Registered Nurse or Service Manager)	To provide advice and help to support the person involved and any assistance needed to ensure that all people involved are safe. They can also help with the next stages of behaviour support, assessing for contributing factors, and planning appropriate strategies for the future. The manager can also help you to identify if the incident is reportable under the <u>Serious Incident Response Scheme (SIRS)</u> or in accordance with your organisation's own escalation or incident management policy.
The resident's family or representatives (if that's appropriate)	To keep them aware of any changes to the person's care. The resident's family may also be able to provide some insight into the behaviour, potential contributing factors, and offer ideas for appropriate interventions.
Any other partners in their care (e.g. the resident's GP or other specialist services)	To keep them updated about the resident's needs, to invite their clinical insight and advice and to encourage their ongoing involvement in the person's care. In addition to the resident's own GP and other health practitioners, Dementia Support Australia (DSA) offers a free 24/7 support service as well as on-the-ground, practical advice, delivered by trained, dementia consultants – through our DBMAS and SBRT services. You can always contact DSA for help by calling 1800 699 799 or through an online referral at: https://dementia.com.au/contact/referral

Your service will have its own escalation and incident management policy which you must be aware of and follow. This will include both the circumstances and threshold for 'escalation' (advising more senior team members), the appropriate escalation point and reporting requirements. In general, a good guide for any escalation of issues is):

Changes in behaviour that are easily reduced or eliminated	➔	Report at handover and in the course of normal daily work
Rapid changes to behaviour that depart from the resident's 'normal' behaviour	➔	Report to the line manager as soon as possible
Behaviours that put the resident or other persons at risk or result in injury to a person – including physical aggression or unwanted sexual approaches towards another resident	➔	Escalate to the line manager as soon as possible (consider if a reportable incident)

When in any doubt about a behaviour, consult with other staff and your line manager. DSA is also available to support you 24/7.

4. Identify the changed behaviour to the wider care team through appropriate reporting

Recording and reporting the changed behaviour

In addition to communicating or escalating what is happening, it is essential that the incident is appropriately documented shortly after its occurrence and in line with the organisation's incident management policy. This enables a full, accurate record of the changed behaviour and enables appropriate analysis of the situation. How any incident is recorded for review will depend on your policies and procedures. In general, the changed behaviour should be reported as below:

1. In the resident's personal record or file	
Immediately	In progress notes and handover notes. This helps to communicate the behaviour and, most importantly, it can inform care planning.
Ongoing	Through resident assessments and forms. The assessment phase of the behaviour support process includes completion of behaviour specific assessments (see for example, the Behaviour Assessment Form and the Behaviour Frequency Chart). Following this assessment process, the behaviour and any strategies developed in response, must also be recorded in the resident's Care Plan and BSP.
2. In service systems and reports	
Immediately	In your incident management system. This will enable the incident to be investigated (to make sure the right procedures were in place before the behaviour), assessed (to review the incident in the context of service trends and risks) and escalated (if that's appropriate).
Ongoing	In Manager or service reports as appropriate.
3. Externally if appropriate	
Immediately	If you believe that an incident may be a reportable incident under the Serious Incident Response Scheme , you must escalate the issue immediately. Examples of reportable incidents include an allegation or suspicion of unreasonable use of force or unlawful sexual contact. More information about the Serious Incident Response Scheme can be found on the Aged Care Quality and Safety Commission's website .



ASSESS

This second stage of the behaviour support process focuses less on how to respond in the actual situation and more on understanding, through assessment and analysis, the possible factors involved in contributing to the behaviour taking place. This phase works through the behaviour chain and the behaviour support 'ABCs':



The assessment phase is vital to understanding and responding to any new or changed behaviour. New or changed behaviour includes new types of behaviour, a change in the frequency or intensity of an existing behaviour or a change in the response to an existing care strategy.

The level of detail that is needed in this assessment phase will depend on a number of things, including the ease of identifying contributing factors, the severity and frequency of the behaviour and the effectiveness of care strategies and interventions. A number of resources are available to assist your assessment – these are listed under the 'Resources during the Assessment phase' on pages 22–24.

A Antecedents

The first step of the assessment process is to consider possible antecedents that may have caused the resident's changed behaviour. Given that most behaviours are a response to something, rather than a random occurrence, understanding the background to the changed behaviour, provides essential insight into the person in care's point of view. Identifying things that may have activated a response also enables staff to modify or eliminate the causes and as a result, reduce or remove the occurrence of the changed behaviour.

Assessment of antecedents involves collecting broad information about what was happening before the changed behaviour occurred. This includes recording the time of day, the place, any events or incidents in the home or any interactions between staff, residents or others that may be relevant.



Antecedents or contributing factors are often highly individualised – they may be obvious and distressing to the person but might be invisible to others. For example, the behaviour may directly relate to something in the person's past or it might be an attempt to communicate an unmet need in the present. The following broad categories should be reviewed as potential activators to the changed behaviour and appropriately addressed if they are found to be causing or contributing to a resident's behaviour:



Physical health (e.g. impact of delirium, depression, pain, infection or medications)



Mental health (e.g. impact of mood disorders, psychological symptoms, depression and anxiety)



Personality and relationships (e.g. impact of relationships within and outside of the home)



Engagement or lack of engagement (e.g. feelings of loneliness or boredom)



History of past behaviours (e.g. understanding common causes or effective care strategies)



Cognitive health (e.g. impact of underlying cognitive illnesses such as dementia)



Sensory problems (e.g. impact of hearing loss, impaired vision or brain conditions such as apraxia)



Social history and routine (e.g. impact of a change in routine or loss of a sense of control)



Environment (e.g. impact of environmental factors such as lighting, noise and visual access)

The following pages provide further information about these potential contributors to a changed behaviour and helpful tools to assess whether those causes are underlying a person's behaviour. Reversible causes can be treated or addressed to reduce or eliminate the behaviour.



Identifying possible contributing factors: Physical health



Physical health can play a significant role in how we feel and in turn, how we behave. The following health needs are known to have a significant role in behavioural change for older people:

- **Delirium.** Delirium is a type of confusion that usually has a fairly rapid onset (e.g. days or weeks), and which can be caused by a range of illnesses, including infection, constipation or dehydration. People with delirium can experience different emotions – for example, being restless, agitated or aggressive or withdrawn, lethargic and quiet.
- **Depression.** Depression can cause certain behaviours and many of the symptoms of depression can also be noticeable as behaviours (for example, withdrawal and anxiety). Treatment of diagnosed depression may therefore reduce behaviours.
- **Pain.** Undiagnosed or untreated pain can significantly contribute to a person's behaviour. For residents that are unable to communicate their needs, it is essential that careful assessments are completed to understand if they are experiencing pain, and more importantly, the cause of that pain so that it can be treated.
- **Acute infections.** Infections such as urinary tract infections and respiratory infections can cause pain, discomfort, confusion or delirium and as a result, changed behaviour.
- **Discomfort.** Discomfort can be caused by a number of different things, for example, coarse fabrics, uncomfortable furniture, sensations of feeling hot, cold, bloated or hungry, or of being overwhelmed by unwelcome sensory experiences, like too much noise. Understanding the cause of discomfort is likely to lead to understanding the cause for a changed behaviour.
- **Medications.** Certain medications, particularly those with central nervous system activity, and in particular, with anticholinergic activity (acting on neurotransmitters – affecting brain chemistry), can set off or intensify behaviours. Residents should always be monitored for the side effects of medication as well as the effect of different drugs interacting.
- **Sleep.** Disruptions to sleep or changes in sleeping patterns can impact a person's behaviour, their 'normal' routine and can also have an impact on others. If sleep is an issue, techniques or strategies may be developed and trialled to help the resident return to a more regular sleep pattern.
- **Comorbidities.** A person's behaviour may also be the result of an unmet need in relation to a medical diagnosis or the interaction of comorbidities (when someone has more than one disease at a time and they, or their treatments, interact). Understanding the underlying illness may point to symptoms causing the changed behaviour.

Resources/ Tools to help with assessments

- [Delirium Screening Tool](#)
- [Cornell Scale for Depression in Dementia \(CSDD\)](#)
- [Guide to using the Cornell Scale for Depression in Dementia \(CSDD\)](#)
- [Support Guide: Understanding the impact of pain and dementia](#)
- [Abbey Pain Scale](#)
- [Responding to medication management issues – Helpsheet.](#)



Identifying possible contributing factors: **Cognitive (brain) health**

A person's 'cognitive' status (ability to think and reason clearly) can sometimes directly relate to changes in their behaviour. Understanding a person's cognitive health can help to differentiate behaviours that are symptomatic of an underlying disease process – like those caused by dementia and other neurological conditions – from behaviours that are due to other factors that may be causing problems thinking and reasoning. These other factors, like environmental factors, may be more easily changed or removed.

Behaviours that are symptomatic of an underlying disease may be more difficult to address but they still should not be ignored. As with any other behaviours needing support they should be identified and strategies trialled and tested to prevent the behaviours being triggered or reduce their impact if they are.

Resources/ Tools to help with assessments

- [Responding to delusions and hallucinations – Helpsheet](#)
- [Psychogeriatric Assessment Scales \(PAS\)*](#)
- [Mini-Mental State Examination \(MMSE\)*](#)
- [Rowland Universal Dementia Assessment Scale \(RUDAS\)*](#)
- [Indigenous Assessment Tool KICA](#)

**These assessments should be conducted by an RN and/or in consultation with the resident's GP or other specialist*



Identifying possible contributing factors: **Sensory problems**

Certain sensory losses or disabilities can significantly limit a person's ability to understand or anticipate what's happening in their environment, which can lead to increased confusion, surprise, or distress. Sensory challenges people experience include:

- poor vision
- poor hearing
- an inability to recognise familiar faces or objects or voices (agnosia)
- changes to a person's motor movements (apraxia)
- changes to person's ability to interpret the environment or actions of others (perception).

Some sensory problems can be improved through appropriate aids like hearing aids and glasses.

Resources/ Tools to help with assessments

- [The Brain and Behaviour Factsheet](#)
- Video: [Dementia and Sensory Challenges – My Life with dementia](#) (Dementia Centre with Agnes Houston)
- [Talking Sense by Agnes Houston and Julie Christie.](#)
- [Dementia and Sensory Challenges Resource.](#)



Identifying possible contributing factors: **Mental Health**

Mood disorders, psychological symptoms of dementia and mental health issues like depression and anxiety are common causes of distress and changed behaviour. While some mental health issues may require prescribed medication, others may be able to be managed well through various non-pharmacological interventions. For example, anxiety can be caused by changes in a person's familiar routine or by overstimulation or fatigue. Addressing those underlying causes of the mental health issue may minimise the changed behaviour.

Resources/ Tools to help with assessments

- Cornell Scale for Depression in Dementia (CSDD)
- [Guide to using the Cornell Scale for Depression in Dementia \(CSDD\)](#)



Identifying possible contributing factors: **Personality and relationships**

A person's personality and their relationships will impact how they react, relate and adapt to different situations. For example, some people have more outgoing personalities and will easily settle into shared living environments and be open to personal care. Others will be deeply private individuals. Understanding a resident's personality and how they might react to different situations can help you to prevent situations that might cause changes in behaviours or to understand how to de-escalate any behaviours that do occur.

It's also important to understand the relationships that each person has with others in, and outside of the home. For example, it may be that two residents tend to clash when in the same room – or that trusted family members can more effectively provide certain aspects of a person's care.

Culture can also play an important role – both the culture of the resident and those that are caring for them.

Resources/ Tools to help with assessments

- [Lifestyle and social history questionnaire](#)
- [Sexuality Assessment Tool \(SexAT\) for Residential Aged Care Facilities](#)



Identifying possible contributing factors: **Social history and routine**

While often under-appreciated, a person's life experience and daily routine have a significant impact on how they respond to seemingly normal situations. For example, a resident that has always lived in drought, may find it really distressing to be showered under a full pressure tap. When a resident is not able to communicate that distress, it's necessary for staff to step in and learn about the resident to understand why they might be responding in the way that they are. Likewise, changing a resident's routine can create or increase confusion and anxiety for the person. It can also lessen the 'feeling of control' that they feel that they have over their life, and as a result, increase anger, helplessness or apathy. Understanding what is important to the person can provide valuable information when assessing behaviour, identifying causes and planning interventions.

Resources/ Tools to help with assessments

- [Lifestyle and social history questionnaire](#)
- [Sexuality Assessment Tool \(SexAT\) for Residential Aged Care Facilities](#)



Identifying possible contributing factors: **Engagement**

A lack of meaningful things to do can cause boredom and loneliness and contribute to a person's changed behaviour. Through understanding the person's personal history, likes and dislikes, strategies can be developed to engage them in meaningful and enjoyable ways. This approach can not only prevent unhappiness or stress building up in the first instance, it can also offer effective ways to shift or reduce the impact if any behavioural expression of distress starts to take place.

Resources/ Tools that can help with assessments

- [Lifestyle and social history questionnaire](#)



Identifying possible contributing factors: **History of behaviour**

A review of a person's history of behaviour including type, frequency, contributing factors and strategies that have been helpful, can help with understanding what has triggered changes in the past and what may be effective when responding in the present. Monitoring certain trends in a person's behaviour over time can also help to reveal previously unidentified causes or prompt a different care strategy.

Resources/ Tools to help with assessments

- [Behaviour Assessment Form \(BAF\)](#)
- [Behaviour Frequency Chart \(BFC\)](#)



Identifying possible contributing factors: **Environment**

The environment should be assessed from the point of view of the resident experiencing the changed behaviour and in the context of their abilities and disabilities. Environmental factors such as lighting, noise, visual access, busyness, distractions, access to spaces and way finding, can all influence how a person feels and can be a major cause for changed behaviour. This is especially true where the resident is unable to communicate their frustration or is unable to change the environment themselves. The environment should be reviewed to understand how it impacts:

- a person's ability to understand their environment and to move about it (e.g. a confusing layout or design);
- a person's ability to perform tasks that are meaningful to them within the environment (e.g. an institutional 'feel');
- perception of control they have over their environment (e.g. strict routines that follow the organisation, not the person); and
- a lack of personalisation of their environment and things that are meaningful to them (e.g. having their own art or furniture).

It's also important to observe the environment for inadvertent cues that might be impacting the resident (e.g. the presence of other residents' family members visiting, seeing staff and other people leaving, or a busy, noisy environment causing overstimulation).

B Behaviour

After assessing for all possible contributing factors, the change in behaviour itself must also be assessed. In assessing the behaviour, staff should record, as objectively as possible, what the observed behaviour was. This should be a description of what specifically occurred including information about what the person with the behaviour, said and did. Staff should avoid merely labelling the behaviour and instead try to add as much detail as possible. For example:

- rather than simply saying that someone was 'wandering', you might say, 'the person (use their name) was constantly walking back and forth between their bedroom and the front door between 10am and 2pm'.
- rather than saying that someone was 'aggressive', you might say 'the person (use their name) would attempt to kick staff whenever staff tried to assist them to get out of bed in the morning.'

It is important to record the time and place of the behaviour in your assessment. This level of detail really helps with analysis and ensures that others that need to know about the changed behaviour, can understand exactly what happened. The more information that is known, the more likely it is that the right contributing factors will be identified, and the right care strategies will be developed.



The final step in the assessment process looks at the consequence or impact of the changed behaviour immediately after it happened. This includes understanding the impact of the behaviour on the person involved, and on others such as fellow residents, visitors and staff.

The impact on the person is important – while a behaviour may not appear disruptive (because of minimal impact to others), if it causes distress to the resident, it needs investigating and should not be overlooked. For example, a resident that is walking for many hours each afternoon, crying constantly, and stating that their child is lost, may have little impact on others, but is clearly in great distress. The behaviour should be examined, and strategies considered to help understand and remove the causes to the behaviour or to reduce the impact of the behaviour on the resident.

Resources during the assessment phase

Investigation into the changed behaviour relies on an in-depth review of the things that happened before it, the behaviour and any consequences. A number of tools are available to help your assessment; these are outlined below.

1. Behaviour Assessment Form

What: The **Behaviour Assessment Form (BAF)** provides a comprehensive record of the changed behaviour. The BAF includes an analysis of the things that happened before the behaviour, the behaviour itself and any consequences. The BAF includes trialled interventions and their effectiveness. It is a tool to help better understand a behaviour and to inform the person's Care Plan and BSP.

When: The BAF should be completed whenever a significant incident occurs including when:

- a new type or change in the changed behaviour is observed;
- a change in the pattern of a behaviour needing support, including when it happens more often or with greater severity;
- a change in the person's response to previously effective strategies to the behaviour needing support; and
- when a series of assessment forms are being completed in order to improve our overall assessment of a person and their behaviour.

Where appropriate, it may be useful to complete a series of BAFs over time – to get a more complete picture, including frequency, severity and any trends to how or when a behaviour happens. The amount of time a person is monitored for will vary depending on the circumstances. When a series of BAFs are collected, one BAF should be completed for each occurrence of the behaviour needing support.

Behavioural assessment form

Residential Care Facility: _____
Client Name: _____

Instructions: The Behavioural assessment form should be completed every time a significant incident takes place.

Section A:
1. Behaviour – begin by filling out the middle column, i.e. clearly describe the behaviour.
2. Antecedents – describe what was happening before the behaviour occurred.
3. Consequences – what happened immediately afterwards (before you intervened).

Antecedents or activating events (what was happening before the incident)	Behaviour (what did the person do?) (and if relevant, what was the person's response to the behaviour)	Consequences of the behaviour (what happened immediately afterwards and how did the person respond?)
Date: _____ Time: _____ Where did it take place? What interaction was going on? What else was happening? (Noise, unexpected events, etc.)	Observed behaviour: How long did it last?	What immediately took place immediately after the behaviour occurred? What else happened?

Section B:
Describe what your actions were and what effect they had on the person's behaviour.

Interventions	Effect

DS Dementia Support Australia

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How: Clear instructions on completing the BAF are outlined on the form. While the BAF is designed as a simple tool that can be completed by any care staff, it should always be reviewed by a manager or registered nurse. That's why a copy of the BAF should be kept in the person's file with a summary outlined in the progress notes.

When a series of BAFs are collected, the BAFs should be reviewed and discussed by the care team throughout the whole monitoring period and then analysed more closely at the end of the monitoring. Analysis of the series of BAFs should then be able to provide insight into possible causes and create a good opportunity to identify successful interventions.

When making referrals to Dementia Support Australia (DSA) for additional support, these BAFs are useful in helping DSA identify additional recommendations or interventions that might help.

2. Behaviour Frequency Chart

What: The **Behaviour Frequency Chart** (BFC) is a simple, objective tool to record the amount of times a specific behaviour is happening. The BFC can help to identify trends such as when a behaviour occurs during the day and when or whether different interventions are effective in reducing the behaviour. Where effective interventions are used, the BFC will show the behaviour slowing or stopping over time.

When: The BFC should be completed for every occurrence of behaviour over the monitoring period. Depending on the behaviour, this may include recording it multiple times throughout the day. The BFC should continue to be used until effective strategies are in place to reduce the frequency of the behaviour.

How: The BFC should be completed 'in real time', on all shifts and by all staff during the monitoring period. This helps to make sure that the record is complete and accurate. The BFC should be reviewed at the end of each day of the monitoring period and summarised once or twice weekly. BFCs are useful tools to show whether interventions are helping a person over time. They also help keep us as caregivers on track with meeting every resident's care needs.

Click on image to download form

3. Other assessment and screening tools

It's important to remember that any assessment of a changed behaviour, should build on **existing knowledge** about the person, including information gathered prior to their admission and through regular routine assessments. Assessment of the changed behaviour should therefore include a review of the resident's holistic current care needs and changing goals and preferences.

In addition to the BAF and BFC, which specifically assess the changed behaviour and effectiveness of interventions, general assessments and screening tools, such as the **Delirium Screening Tool**, can be helpful in understanding if there are any causes of a particular behaviour that can be addressed. Some of these tools are highlighted on pages 16–21.



4. Consultation with key partners in care (friends, family and wider care team)

Finally, assessment must include wide consultation with those that are involved in the person's life and care. This includes family and friends as well as the broader care team (for example, other care staff, the manager, clinicians and allied health staff as well as the resident's GP and health specialists). Collaboration with these partners in care offers a range of perspectives and unique insights into the person, their care needs and the behaviour. Specifically, consultation should seek to understand:

- More information about the person (including their history, their likes and dislikes, personality, emotional health and past behavioural needs) that may assist to understanding the behaviour.
- Information about the person's health needs including possible unmet needs that may have caused the changed behaviour.
- Review and input into the proposed care strategies and interventions to address the behaviour.

It is important to remember that family members will have often cared for the person at home before receiving formal care services and may be able to provide valuable insight into the changed behaviour and strategies for responding appropriately. They may be able to share knowledge about caring for the person, and, where appropriate and willing, be able to assist with aspects of the person's care.

Consultation with partners in care should occur both formally and informally through general case management and targeted consultation with respect to the specific behaviour.





PLAN, IMPLEMENT, EVALUATE

The final step in the behaviour support process is to plan, implement and evaluate care strategies to reduce the number of times a behaviour needing support happens and/ or any impact it has.

This phase involves careful consideration of the information gathered through the assessment process – from screening tools to consultation with the person's family and friends – to get a holistic overview of the person. Review of this information enables staff to see the 'whole person' and to consider potential contributing factors. This in turn, informs the development of tailored care strategies or interventions that are used to address each of the issues (whether unmet needs or environmental distractions) identified in the assessment process.

Once collected and analysed, this information is captured in the person's Behaviour Support Plan (BSP).



As of September 2024,⁴ any resident of an approved care provider (whether permanent or respite) that requires behaviour support, **must** have a BSP included in their Care Plan. The legal requirement for a BSP aims to ensure that changed behaviours are carefully investigated, appropriate care strategies are in place and that those strategies are monitored for their effectiveness. Very importantly, the BSP aims to make sure that restrictive practices are avoided.

Developing care strategies for responding to changed behaviours needing support

Developing appropriate care strategies to respond to changed behaviours is an art not a science. Using all of the information collected in the identification and assessment phase, staff need to work with the person and their partners in care to consider a range of strategies to help reduce causes for the behaviour or to support the behaviour in a way that reduces distress or impact to the resident and others.

Drug free interventions (non-pharmacological)

Some changed behaviours and strategies to help may be straightforward – for example, if the person had unidentified, treatable pain which was causing changed behaviours, treating the pain and continuing to monitor for it, is likely to reduce or resolve the behaviour. However, for the majority of behaviours, care interventions and strategies are likely to have less of a direct impact in completely resolving the behaviour all of the time. For this reason, it is necessary to consider a range of care strategies that can be trialled in different circumstances. While this is not a complete list, in addition to addressing any underlying antecedents or causes (see pages 16–21) potential types of care strategies to consider can include:

4. Under the Aged Care Legislative Amendment (Royal Commission Response No. 1) Principles 2021.



- **Engagement strategies:** engaging the person in things that they find meaningful and which they enjoy. For example, depending on the person this may include, general household activities, activities related to their previous working life, culture or background, music and creative activities, sensory activities, engagement with nature or community spaces.
- **Communication strategies:** working on ways to better relate to the person and their reality. For example, approaching the person in a certain way or with a certain tone, providing validation, acknowledgement or reassurance to them when they are distressed or gently orienting the person to the present, when they are confused. Communication may also be helped through tools or equipment that support sensory challenges (for example, glasses, hearing aids and translation tools). It is important to recognise differences in language and culture in communication too.
- **Environmental strategies:** in addition to removing potential causes to behaviour in the environment, the environment can also be used as a strategy to support certain behaviours. For example, well-designed outdoor spaces with engaging gardens and 'destinations', can provide a safe space for a person to calm down and may reduce risks of harm to the person and others.

Strategies should be as tailored as possible. To do this, staff must consider the 'whole person – not only their personal and clinical care needs, but the things that they know about them as a person. It is important to acknowledge that developing such strategies can take considerable time and require careful, consistent observation.

An example of this process in practice, is set out below. This is a real case study from Dementia Support Australia's Severe Behaviour Response Team (SBRT).





CASE STUDY: How building trust with Jerry significantly improved his quality of life

Jerry was referred to SBRT because of “daily unprovoked acts of aggression towards staff and visitors.” A DSA consultant attended and assessed Jerry over the course of two days, spending time observing him, and talking to his family, care staff and his general practitioner in order to build a complete picture of exactly who Jerry was.

As it happens, Jerry was a former union official in a factory, who had harboured a lifelong suspicion of ‘management types’. He also suffered low back pain from a lifetime of manual labour. Through detailed observation of Jerry and examination of his progress notes, the consultant was able to work out that he was severely constipated, having been in the habit of drinking up to 8 cups of coffee per day. The staff within the home, in an attempt to provide Jerry with meaningful activity, had provided him with a broom, with which he enjoyed sweeping the floor. It was a short-handle broom, however, and after several hours of sweeping in a stooped posture, Jerry clearly appeared to be in pain.

The period of observation also uncovered the fact that Jerry’s aggression was not indiscriminate and unprovoked. It was more likely to be directed at males, particularly those wearing white shirts, and towards staff who walked the floor carrying clipboards. Jerry would approach these staff members and demand to know what was on the clipboard. This exchange would then tend to escalate into a tug of war over the clipboard, and subsequently into aggression.

The DSA consultant formulated Jerry’s situation in a manner that included biological, psychological and social contributors, as follows:

- Jerry’s targeting of males in white shirts reflected his associating this type of clothing with ‘management,’ whom he had always distrusted.
- The use of clipboards by staff was interpreted by Jerry as representing the intrusion of ‘snooping management types’.
- The behaviours were aggravated by constipation, the daily development of pain in his lower back, and the stimulant effect of caffeine from multiple cups of coffee every day.

The interventions that DSA recommended, and supported staff in the implementation thereof, included:

- Education for staff and visitors about the triggering effect of white shirts.
- Advice to staff to restrict their use of clipboards whilst ‘walking the floor.’
- Advice to staff to simply hand over the clipboard to Jerry in the event he was concerned about it.
- Provision of a long-handled broom to eliminate the stooping posture that a short-handled broom had produced.
- Regular simple analgesia.
- Regular laxatives.
- A switch to decaffeinated coffee.

Three months later, the behaviours were no longer present.





Pharmacological (drug based) interventions

Medication can sometimes be a necessary and clinically appropriate approach to treating underlying health conditions that cause changed behaviours. However, *in general*, the use of medications, (in particular, psychotropic or antipsychotic medications) should not be used in the support of a person's behaviour unless:

- underlying causes and contributing factors have been assessed and addressed;
- non-pharmacological interventions have first been tried and found to be ineffective;
- after careful assessment it is considered the right clinical response by a medical practitioner;
- where use of the medication has been discussed with the person and, or the responsible person (as determined by the relevant state and territory requirements); and
- where there is a strategy to monitor, evaluate and stop or reduce the medication over time.

The effectiveness of using psychotropic and antipsychotic medications will depend on the nature of the behavioural symptom. The effectiveness of any medication must also be weighed by potential and serious adverse side effects. **The Psychotropic Medication in the Management of Behaviours Helpsheet**, provides some high-level principles on the use of medications in responding to behaviour.

While medication may be effective in treating some behaviours, many behaviours tend to be medication non-responsive. This includes behaviours that present as wandering, intrusiveness and calling out. In such circumstances, the only way that medication might reduce those behaviours is by sedating the person to the level that they can no longer engage in the behaviour. This is not an appropriate treatment goal and is likely to amount to a restrictive practice.



Dementia Support Australia (DSA) can help in the assessment of residents and their behaviour and in providing recommendations on appropriate interventions. This includes advice and medical reviews by aged psychiatry and geriatricians with the agreement of the resident's GP.

DSA however, cannot develop a care resident's BSP. The BSP must be developed by the aged care provider, in consultation with the person and their partners in care.

Developing the Behaviour Support Plan

Just as with the resident's Care Plan, the BSP is a living, dynamic document that is frequently referred to and regularly updated by the care team. In preparing, reviewing or revising the BSP any information gathered as part of the behaviour support assessment process, as well as any previous assessments about the person, must be considered. Furthermore, the following people must be consulted:

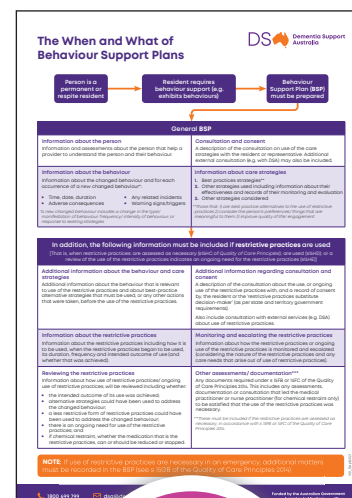


PLAN, IMPLEMENT, EVALUATE

While there is no set form or template for the BSP, there are certain legislative requirements about what information must be set out in a BSP. The information that must be included depends on the circumstances and whether restrictive practices are used. High-level summaries of the different scenarios are set out below and summarised in **'The When and What of Behaviour Support Plans'**.

While there is no set way of creating a BSP, it might be useful to refer the **Behaviour Support Plan Template (when no restrictive practices used)** or the **Behaviour Support Plan Template (when restrictive practices are used)**.

- 1 Follow Scenario 1 when restrictive practices are not a factor.
- 2 Follow Scenario 2 when the use of restrictive practice has been assessed as necessary.
- 3 Follow Scenario 3 when restrictive practices have been used.
- 4 Follow Scenario 4 when a review of the use of a restrictive practice indicates a need for ongoing use of the restrictive practice.



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1 Scenario 1: Things that must be set out in any Behaviour Support Plan

(See section 15HB of the Quality of Care Principles 2014)

Information about the person in your care
Information and assessments that help you as the care provider to understand the person you are caring for and their behaviour.
Information about the behaviour seen as needing support
<p>Information about the changed behaviour needing support and about each time there is a new or changed behaviour*. This includes:</p> <ul style="list-style-type: none">• the time, date and amount of time it went on for;• any negative consequences for the person involved and or any other people;• any related incidents; and• any warning signs or contributing factors. <p><i>*A new or changed behaviour is one where there is a change in the type or appearance of a behaviour needing support. A change in the frequency or the intensity of the behaviour, or when there is a change in the person's response to existing support strategies.</i></p>
Information about care strategies
<p>The BSP must include each of the following:</p> <ol style="list-style-type: none">1. Best practices strategies which are those that:<ol style="list-style-type: none">a. are best practice alternatives to restrictive practices;b. consider the person's preferences and the things that are meaningful to them; andc. improve the person's quality of life and engagement.2. Other strategies used (including their effectiveness and records of monitoring and evaluation).3. Other strategies considered.
Consultation
A description of the consultation on use of the care strategies with the resident or representative.

A new changed behaviour is one where there is a change in the type or appearance of the changed behaviour needing support. A change in the frequency or intensity of the behaviour needing support, or a change in the response to existing support strategies.



2 Scenario 2: Things that must be set out in the BSP when the use of restrictive practice has been assessed as necessary⁵

(See section 15HC of the Quality of Care Principles 2014)

Information about behaviour
Information about the changed behaviour that is relevant to the use of the restrictive practice.
Information about the restrictive practice
Information about the restrictive practice including: <ul style="list-style-type: none">• how it's going to be used;• how long it's intended it be used for;• how often; and• the intended outcome of using restrictive practices or restraint
Information about care strategies
Best practice alternative strategies that must be used (to the extent that is possible) before using any restrictive practice.
Monitoring and escalating the restrictive practice
Information about how the restrictive practice is monitored and escalated (considering the nature of the restrictive practice and any care needs that arise out of use of the restrictive practice).
Reviewing the restrictive practice
Information about how the restrictive practice will be reviewed including whether: <ul style="list-style-type: none">• the intended outcome of its use was achieved;• alternative strategies could have been used to address the changed behaviour;• a less restrictive form of restrictive practice could have been used to address the changed behaviour;• there is an ongoing need for its use; and• if chemical restraint, whether the medication that is the restrictive practice can/ should be reduced or stopped.
Consultation with the person and having their consent
<p>A description of the consultation on the use of the restrictive practice with, and a record of consent by, the person involved or the 'restrictive practices substitute decision-maker'.*</p> <p><i>This should clearly demonstrate that the decision maker has understood and been given all the available information relevant to consent to restrictive practice – this includes the impact of other interventions or strategies. They should also be provided with clear information about review points and evaluation of any restrictive practice to be used.</i></p> <p><small>* The restrictive practices substitute decision-maker is defined in s 4 of the Quality of Care Principles 2014 and depends on the state or territory in which the resident is receiving care.</small></p>
Assessments
Any assessments that were used to identify the restrictive practice as necessary. People that can assess use of restrictive practices as 'necessary' include an approved health practitioner who has day-to-day knowledge of the person in care (for any restrictive practices other than chemical restraint) or, a nurse practitioner (for chemical restraint only).

5. See s 15FB or 15FC of the Quality of Care Principles 2014 regarding when the use of restrictive practice has been assessed as necessary



3 Scenario 3: Things that must be set out in the BSP when restrictive practices have been used⁶

(See section 15HD of the Quality of Care Principles 2014)

Information about the restrictive practice
Information about when the restrictive practice: <ul style="list-style-type: none">• began to be used;• how long it was used for;• how often it was used;• the intended outcome (and whether that has been achieved); and• details of the people involved in the use of the restrictive practice.
<i>If, under the BSP, the restrictive practice is only to be used on an 'as needed' basis for specific changed behaviours or in specific circumstances:</i>
Information about the behaviour
Information about the changed behaviour that led to the use of the restrictive practice.
Information about strategies
Information about any action taken, or any care strategies implemented prior to use of the restrictive practice.
Consultation with external services
Any consultation with external services (e.g. dementia consultants) about the use of the restrictive practice.
Monitoring and escalating the restrictive practice
Information about how the restrictive practice is monitored and escalated (considering the nature of the restrictive practice and any new care needs that arise out of use of the restrictive practice).
Reviewing the restrictive practice/ outcome of review
Information about how the restrictive practice will be reviewed, including whether: <ul style="list-style-type: none">• the intended outcome of its use was achieved;• alternative strategies could address the changed behaviour;• a less restrictive form of restrictive practice could address the changed behaviour;• there is an ongoing need for its use; and• if chemical restraint, whether the medication that is the restrictive practice can/ should be reduced or stopped. The BSP should also include the outcome of the review (e.g. whether there is an ongoing need for restrictive practices).

6. See s 15FA of the Quality of Care Principles 2014 regarding the requirements for use of restrictive practice



4

Scenario 4: Things that must be set out in the BSP when a review of the use of a restrictive practice indicates a need for ongoing use of the restrictive practice

(See section 15HE of the Quality of Care Principles 2014)

Information about the restrictive practice
Information about the restrictive practice including: <ul style="list-style-type: none">• how it is used;• how long it is used for;• how often it gets used; and• the intended outcome of using this approach.
Monitoring and escalating the restrictive practice
Information about how ongoing use of the restrictive practice is monitored and escalated (considering the nature of the restrictive practice and any care needs that arise out of use of the restrictive practice).
Reviewing the restrictive practice
Information about how the ongoing use of the restrictive practice will be reviewed, including whether: <ul style="list-style-type: none">• the intended outcome of ongoing use is being achieved;• alternative strategies could address the changed behaviour;• a less restrictive form of restrictive practice could address the changed behaviour;• there continues to be an ongoing need for use of the restrictive practice; and• if chemical restraint, whether the medication that is the restrictive practice can/ should be reduced or stopped.
Consultation and consent
<p>A description of the consultation about the ongoing use of the restrictive practice with, and a record of consent by, the resident or the 'restrictive practices substitute decision-maker'. *</p> <p><i>This should clearly demonstrate that the decision maker has understood and been given all information relevant to consent to ongoing use of the restrictive practice – this includes the impact of other interventions or strategies. They should also be provided with clear information about review points and evaluation of restrictive practice.</i></p> <p><small>* The restrictive practices substitute decision-maker is defined in s 4 of the Quality of Care Principles 2014 and depends on the state or territory in which the resident is receiving care.</small></p>

If use of a restrictive practice is necessary in an emergency, additional matters must be documented in the relevant BSP as soon as practicable after the restrictive practice is used. These additional things to record include information about:

- the behaviours that were relevant to the need to use the restrictive practice;
- the alternative strategies that were considered or used prior to use of the restrictive practice;
- the reasons for why the use of the restrictive practice was necessary;
- the care to be provided to the resident in relation to their behaviour; and
- a record of the restrictive practices substitute decision-maker being informed of the use of restrictive practices.



Implementing the Behaviour Support Plan

Once the BSP is developed and care strategies are determined, the next step is to implement the strategies in the BSP and the broader Care Plan. It is crucial that effective communication systems are in place to ensure that all involved with the care of the resident experiencing the changed behaviour are aware of the changes to their care and are confident in delivering the support strategies in a consistent way. This will be through each staff member familiarising themselves with the BSP and through good consultation between members of the team. Consistency in the implementation of the BSP is essential to evaluating whether the care strategies are effective.

Strategies should be implemented through an approach of trial and error. A good understanding of the resident, their likes, dislikes and history, enables staff to creatively problem-solve and tweak care strategies depending on the specific circumstances. While the BSP provides key tools for the resident and their changed behaviour, nothing replaces knowledge of the person being cared for and careful judgment in the moment.

Monitoring, evaluating and reviewing the Behaviour Support Plan

The living, breathing nature of the BSP means that it should be regularly reviewed and revised to reflect the best approach to caring for the resident as their care needs change and in line with the organisation's policies and procedures.

The specific requirements for monitoring, evaluating and reviewing the BSP depend on the type of BSP that has been developed, on the resident experiencing the behaviour and how they respond to the strategies in the BSP.



In general:

Scenario	Monitoring requirements and evaluation/ reviewing requirements
No restrictive practices involved	<p>For any care strategies that are used to manage the changed behaviour, the BSP must set out:</p> <ul style="list-style-type: none">• the effectiveness of such strategies; and• records of monitoring and evaluating the success of the strategies.
Restrictive practices are used to manage the changed behaviour	<p>The BSP must include information about how the restrictive practice will be monitored and, if necessary, escalated. This includes consideration for:</p> <ul style="list-style-type: none">• care needs while the restrictive practice is in use (e.g. providing regular pressure area care);• the nature of the restrictive practice;• any care needs that arise out of the use of the restrictive practice; and• any negative reactions to use of the restrictive practice (e.g. sedation or reduced respiration). <p>The BSP must include information about how the use of the restrictive practice, or the ongoing use of the restrictive practice will be reviewed, including whether:</p> <ul style="list-style-type: none">• the intended outcome of the use of restrictive practice was achieved;• any alternative care strategies that could be used to address the changed behaviour;• a less restrictive form of restrictive practice could be used to address the changed behaviour;• there is an ongoing need for its use; and• if the restrictive practice is a chemical restraint, whether the medication that is the restrictive practice can or should be reduced or stopped. <p>Any review of the use of the restrictive practice, should also include the outcome of the review.</p>

In addition to the ongoing monitoring and evaluating of specific strategies the BSP must be 'reviewed regularly' or 'as soon as practicable' after any change in the person's circumstances.

Monitoring and evaluation is an ongoing responsibility for all staff. While there is no prescribed method or frequency for monitoring, use of the **Behaviour Assessment Form** (BAF) or **Behaviour Frequency Chart** (BFC) can assist in providing a template for monitoring the effectiveness of care strategies as well as any changes to the severity, frequency or duration of the changed behaviour. The BAF, BFC and any other tools should be used in conjunction with regular consultation with staff, the resident and their family.

Where it is clear strategies are not working, it may be necessary to adjust those strategies and update the BSP. If, however, the revised strategies are still not effective in addressing the changed behaviour, the service should consider referral to internal or external services – for example, internal dementia specialists, Dementia Support Australia, hospital services or a higher care service that may be better suited to caring for people with changed behaviours needing support.

Where you can get more information or assistance

Dementia Support Australia's website has a great range of useful tools for the behaviour support process and guidance on the development of Behaviour Support Plans. This includes the resources listed throughout these Guidelines.

Specific behaviour support guides and templates:

- [*The When and What of Behaviour Support Plans*](#)
- [*The Behaviour Support Plan Template \(when no restrictive practices are used\)*](#)
- [*The Behaviour Support Plan Template \(when restrictive practices are used\)*](#)
- [*DSA Behaviour Frequency Chart*](#)
- [*DSA Behavioural Assessment Form*](#)
- [*Behaviour Support Flowchart*](#)
- [*Behaviour Care Planning Process*](#)
- [*ABCDE Poster*](#)

General tools and assessments for determining possible causes for behaviour:

- [*Delirium Screening Tool*](#)
- [*Support Guide: Understanding the impact of pain and dementia*](#)
- [*Responding to medication management issues – Helpsheet*](#)
- [*Responding to delusions and hallucinations – Helpsheet*](#)
- [*DSA Lifestyle and social history questionnaire*](#)
- [*Brain and Behaviour Factsheet*](#)
- [*DSA Abbey Pain Scale*](#)
- [*Cornell Scale for Depression in Dementia*](#)
- [*Guide to using the Cornell Scale for Depression in Dementia*](#)
- [*Talking Sense by Agnes Houston and Julie Christie*](#)
- [*Psychotropic Medication in the Management of Behaviours Helpsheet*](#)

The DSA resources that are available aim to help you and all other aged care providers deliver behaviour support processes that inform effective and well-tailored BSPs. BSPs are not a tick-box template for compliance purposes. A best-practice BSP is the result of a thorough assessment and care planning process that ultimately improves care. The tools and templates help you not only meet legislative requirements but to also make sure that the people we care for are Better Supported People.

DSA is here to help you in the behaviour assessment and care planning process. Reach out any time to:

 24 Hour Phone Help: **1800 699 799**

 Online referral: <https://dementia.com.au/contact/referral>

 Live chat: www.dementia.com.au