Appendix 1: Questions to facilitate assessment

The purpose of this table is to facilitate comprehensive assessment in each of the following areas. Within each area, sub questions are identified for further assessment. Questions to ask carers and extensions to the questions are suggested as prompts for the clinician. Some questions specifically pertain to residential or community care provided by formal carers, however many of the underlying principles equally apply to dementia care provided in any context.

The person with dementia

QUESTIONS TO FACILITATE ASSESSMENT	***EXTENSIONS TO QUESTIONS/NOTES***
COGNITIVE STATUS	
How are cognitive changes contributing to the behaviour?	Which cognitive changes are contributing to the behaviour or responses to behaviour: memory changes, planning deficits, inability to reason – others?
Has the type of dementia been identified?	Will type of dementia (dementia with Lewy bodies, fronto-temporal, alcohol related, vascular, Alzheimer's disease) influence assessment of the behaviour?
How long has the dementia been evident?	Does the progression of dementia prior to current referral impact on the behaviour? Are carers familiar with the rate and history of the condition?
Is the current cognitive status congruent with rate and duration of the progression of dementia?	Do the physical, sensory and care aspects of the environment impact negatively on cognition and function?
Has there been a recent, sudden decline in cognitive and/or functional abilities?	Exclude physical illness with or without delirium.
What cognitive testing results are available?	How valid was the testing? How current and culturally appropriate was the testing?
EMOTIONAL STATUS	
How readily is the person with dementia able to be engaged in meaningful activity?	Is refusal to be involved in apparently meaningful activities described? Is the person with dementia able to initiate activities? Does the person with dementia sit for extended periods without interest in their surroundings?

Does the person with dementia express positive or negative emotions?	Are expressions of sadness observed or reported? Is assertive behaviour observed or reported? If so, how is it described? What positive feelings are evident, and when are they displayed?
Do others prompt a change in emotional status?	How do different staff or family members experience the person with dementia differently or prompt different responses from the person with dementia?
Is anxiety evident?	Do facial expressions, body movements or vocalisations suggest anxious behaviours?
MENTAL HEALTH	
Is the person with dementia experiencing hallucinations?	Do they describe seeing/hearing people or objects that are not present? Are they talking to or responding to stimuli that are not observable?
How does the person with dementia react to the hallucinations?	Is the response to hallucinations fearful or neutral? How is an anxious/fearful response demonstrated?
Does the person describe delusional ideation?	Is a false fixed belief described and maintained?
How does the person with dementia respond to the delusional ideation?	Is the response to delusions fearful or neutral? How is an anxious/fearful response demonstrated?
Is there evidence of depressive symptoms?	Low mood, sadness, crying, withdrawal or anxiety?
Are results of Geriatric Depression Scale or Cornell scale for Depression in Dementia assessments available?	Do the results indicate that the person is depressed?
PHYSICAL HEALTH	
Have recent changes to physical health been reported?	Have investigations been commenced? Are results available?
Are vital signs within normal limits?	Temperature, pulse, respiration, blood pressure, urinalysis recorded/available?
Are there indicators of delirium?	Are recent and/or sudden changes in mood, cognition, functional abilities, speech and/or BPSD evident or reported?
Has a delirium screen been attended – urine, chest X-ray, basic bloods?	Have test results been reported? Are results available?
Is the person with dementia experiencing pain?	Are there changes evident which suggest a painful body area, such as limp, reduced mobility, changes in eating habits, protection of body part, pallor and/or facial expression.

Has a pain assessment been completed?	Have the results been interpreted and/or acted on?
Is there evidence of a change to any chronic conditions?	Are the potential implications of changes to chronic conditions understood by carers?
Are there unmet physical needs?	Have thirst, hunger, comfort, elimination, rest, activity been considered as contributing to the behaviour?
Is there discomfort from any physical system?	Is there evidence of discomfort associated with digestion, elimination, respiration, oral cavity, and/or mobility?
Are senses intact or adequately compensated for?	Have vision and hearing impairments been recently assessed, where possible? Are glasses and hearing aids available, in working order and used appropriately?
PHARMACOLOGY	
Is there a current list of prescribed medications available?	Have there been recent changes to the regimen?
Are there indications of potential side effects, adverse reactions, interactions or drug toxicity?	Does the behaviour suggest possible effects of recently prescribed medications? Has a GP/pharmacist/geriatrician/psychogeriatrician been consulted to review medications?
Is the pain regimen congruent with current comorbid conditions? Is analgesic medication prescribed regularly or as required?	Are verbal requests/responses from the person with dementia influencing the administration of pain relief? Are verbal responses likely to be an accurate reflection of pain-related needs?
Is compliance with the medication regimen evident?	Are carers’ responses to the person with dementia’s refusal to take medication appropriate for the situation?
PSYCHOSOCIAL HISTORY	
Is a detailed life history available?	Has the person with dementia’s life history been provided by involved family members or significant others?
Are past life events integrated into current care?	Are life events used to promote conversation, activities and contribute to personalised room décor?
Is there evidence of recall of disturbing life events?	Has the person with dementia’s life story been explored for possible disturbing events?
Are previous habits and interests contributing to the behaviour?	Is the information available adequate to make a judgment?

Are life time habits, interests and values included in the care plan?	Could lifelong values, attitudes and interests be influencing presentation of the behaviours?
Has pre-morbid personality been reported by available family members or significant others?	Is pre-morbid personality acknowledged as contributing to the behaviours?
PSYCHOSOCIAL PRESENT	
Are interpersonal interactions influencing behaviour?	Does charting indicate that some people feature more frequently in negative behaviour descriptions than others? Does the person acknowledge any other people as friends? Do particular staff members influence the behaviour? Are significant family members readily available?
Is there evidence of activities and events that are scheduled to meet social and emotional needs?	Are outings and activities congruent with cognitive status, past interests and/or previous experiences?
Are activities reported as successful and providing pleasure?	If they are unsuccessful or do not provide pleasure, has a reason been investigated, established and/or reported?
CULTURAL CONSIDERATIONS	
Is the person of Aboriginal and/or Torres Strait Islander background?	Does the person live in an urban, rural or remote area?
Is the person from a culturally and linguistically diverse group?	How long has the person with dementia lived in Australia? How long have family members lived in Australia?
What languages does the person with dementia speak and understand?	Has the primary language been maintained and is it now used accurately? Has English been lost or was the person previously fluent in English? Are language limitations contributing to the behaviours? Is an interpreter required? (for further information see Module 1)
Is the person with dementia’s culture acknowledged and accommodated?	What strategies are reported to provide a culturally aware/sensitive/safe environment? (for further information see Introduction) Do meals provided reflect cultural tastes and/or needs? Do interactions, activities and personal care practices accommodate cultural norms and practices?
Are religious and/or spiritual beliefs and practices significant for the person with dementia?	Are opportunities provided for religions practices to be observed and/or experienced?
Does the physical environment reflect the culture of the person with dementia?	Is there evidence of the person with dementia’s cultural background in their personal and wider environment to provide a sense of familiar?

Activities of daily living

QUESTIONS TO FACILITATE ASSESSMENT	***EXTENSIONS TO QUESTIONS/NOTES***
ACTIVITIES OF DAILY LIVING / FUNCTIONAL STATUS	
Has functional status been recently assessed and documented?	Is there evidence of task analyses for activities of daily living (ADLs)?
Are there components of their ADLs that the person with dementia could be more actively involved in?	Has a task analysis been attended to identify components of ADLs that the person with dementia can perform?
Are capabilities/strengths/retained abilities recognised, utilised and encouraged by carers?	Does the care plan provide evidence of encouraging the maintenance of retained abilities and strengths?
Is function being overestimated by carers, resulting in unrealistic expectations and inevitable failure by the person with dementia?	Functional losses may be inconsistent resulting in unrealistic expectations on the part of family members and staff. Is education required?
LIFESTYLE	
What proportion of their day is the person with dementia engaged in familiar and/or meaningful activities?	How many unoccupied hours does the person experience between meals and personal care?
Is the person with dementia able to effectively initiate meaningful activity?	Is executive function sufficient to enable initiation and/or planning of activities?
Are those engaged in the person with dementia’s care aware of strategies for effectively engaging the person?	Have activities been designed to maximise the likelihood of engaging the person with dementia? Are RACF staff aware of the strategies and how and when to implement them?
Does the person remain engaged in large group activities?	Are large group activities appropriate to engage, stimulate and provide meaning for the person with dementia? Does the person with dementia wander or disturb others in the group?
Does the person remain engaged in small group activities?	Are small group activities more appropriate to stimulate meaningful participation?
Are previous activities and interests effectively utilised to engage the person with dementia?	If yes, are these transferrable to episodes of BPSD?
Are activities provided congruent with functional and cognitive abilities?	Physical function may be preserved but cognitive impairments may preclude appropriate physical functioning.

Care environment

QUESTIONS TO FACILITATE ASSESSMENT	***EXTENSION QUESTIONS/NOTES***
CARE PHILOSOPHY	
Does the care philosophy articulate the principles of good practice in dementia care?	For further information see Alzheimer's Australia Position Paper No 2: Quality Dementia Care, 2003.
Does the physical care environment support the person with dementia?	Does the layout of the care environment increase disability through long corridors, dead ends, visual access to restricted outdoor areas, multiple destinations, inappropriate lighting and/or overstimulation.
Do staffing levels and/or support from management promote appropriate dementia care?	Could changes to rostering facilitate better support at times of greatest need for the person with dementia? Are the hours when activities/interventions are available insufficient or inappropriate to provide adequate cover for those with dementia?
Are carers provided with sufficient education in dementia and BPSD to provide appropriate dementia care?	Do staff members attend training where provided? Do excessive levels of staff turnover and use of agency staff impact on consistency of care delivery?
Is a restraint free environment an organisational goal?	See Module 2: alternatives to restraint.
Are care plans easily accessed by all care staff?	Are brief care plans located in the resident's room while preserving confidentiality?
Are care plans written in a manner that encourages compliance by care staff?	Does jargon, complicated language and/or insufficient detail reduce the accessibility and/or utility of resident care plans?
Do carers understand the implications of administering psychoactive medications?	Are carers aware of potential adverse effects of psychoactive medications? Are carers able to recognise developing adverse responses to psychoactive medications?
Is written informed consent for psychotropic medications documented? If person is unable to give informed consent has proxy given consent?	If not, is verbal informed consent documented?
COMMUNICATION	
Is the carers' communication appropriate for the cognitive and communication abilities of the person with dementia?	Is there evidence of an awareness of, and conscious effort to accommodate, communication difficulties and receptive language impairments?
Do attempts to reason with the person with dementia cause distress?	Do carers confront the person with dementia with their mistakes or argue with them?
Is carers' nonverbal communication appropriate?	Do carers' nonverbal gestures and body language reflect patience and support for the person with dementia?

PERSONAL CARE DELIVERY	
Are current and/or past preferences and routines in ADLs recognised and accommodated?	Does the time of day or specific day impact on the delivery of care? Are there unrealistic expectations around ADLs that do not reflect past practice?
Is the pace of personal care assistance designed to maximise comfort and function?	Is there greater emphasis on completing ADL tasks than consideration for comfort and involving the person with dementia?
How many carers are involved in each personal care activity?	Is the number of staff or carers likely to overstimulate, confuse, offend or frighten the person with dementia?
Is communication during personal care tasks maximising function and understanding?	Does conversation or instructions from carers overwhelm the person with quantity of information or speed of delivery?
Do RACF routines conflict with personal preference and/or the person with dementia's previous routine?	Are meals and personal hygiene activities scheduled to accommodate carer/organisational convenience?
Are potentially painful situations and movements recognised and accommodated?	Has the impact of shower chairs, uncomfortable clothing, painful joints, etc been considered as contributors to behaviour?
Have alternative approaches to personal care been considered and/or implemented?	Showering is not always the most comfortable or most suitable approach to personal hygiene.
Are abilities recognised and incorporated into personal care tasks to maximise independence?	Are retained skills acknowledged in the care routine?
Does the person with dementia express frustration around impairment of abilities?	Does frustration arise from retained insight into difficulties or lost abilities?
Does the person with dementia feel embarrassed during personal care?	Is embarrassment due to care provision by staff of the opposite gender and/or a feeling of loss of dignity?
Could the delivery of personal care prompt recollections of sexual function or previous trauma?	Removal of clothes in a confined environment by a member of the opposite sex may prompt inappropriate sexual gestures or requests (for further information see Module 8: Disinhibited behaviours).
Could the delivery of personal care prompt recollections of previous trauma which could result in a catastrophic reaction?	Is there an awareness of any potential history that may be relevant to the individual with dementia?
Does the delivery of personal care foster manageable choice and control?	Is there evidence of a degree of choice and control appropriate to the cognitive status of the person with dementia? Is there evidence of too little choice offered or inappropriate choice/control which has the potential to lead to unsafe care practices?