

Appendix 4: Questions to facilitate comprehensive assessment

The aim of these questions is to facilitate comprehensive assessment, which will assist in supporting the person who presents with behaviours and psychological symptoms associated with dementia (BPSD). Within each area, sub questions are suggested as further prompts for the clinician. Some questions specifically pertain to residential or community care provided by formal carers, however the underlying principles equally apply to dementia care provided in the community, acute care and other contexts. See *A Clinician's BPSD Guide 2023, Module 1* page 14 onwards for further information on comprehensive assessment to aid in addressing BPSD.

The person living with dementia:

QUESTIONS TO FACILITATE ASSESSMENT	EXTENSIONS TO QUESTIONS/NOTES
COGNITIVE STATUS	
How are cognitive changes contributing to the behaviour or psychological symptom?	Which cognitive changes are contributing to the behaviours, psychological symptoms and/or responses to these? Consider memory changes, planning deficits, difficulty with thinking, inability to reason, lack of organisational skills, disorientation and other limitations.
Has the type of dementia been identified?	Does dementia type (dementia with Lewy bodies, fronto-temporal, alcohol related, vascular, Alzheimer's disease) influence behaviours or psychological symptoms?
How long have the symptoms of dementia been evident?	Does the progression of dementia impact on the behaviour? Are carers familiar with the history of the condition?
Do other factors impact on cognitive functioning and hence, may be relevant to behaviours or psychological symptoms?	Do the physical, sensory and care aspects of the environment impact negatively on the person's cognition and function? Has the person recently experienced changes to their environment e.g. transitioned to residential care, moved to a different room/living environment, lost/gained a roommate.
Has there been a recent, sudden decline in cognitive and/or functional abilities?	Exclude physical illness with or without delirium. See <i>Module 2</i> pages 38-40 for information on delirium in dementia.
Has cognitive testing been attended recently and are results available?	How current and valid was the testing? How culturally appropriate was the testing?
EMOTIONAL HEALTH	
How readily is the person with dementia able to be engaged in meaningful activity?	What is the nature of the person's refusal to be involved in apparently meaningful activities e.g. could it be anxiety-related? Does the person sit for extended periods without interest in their surroundings? See <i>Module 6</i> and <i>Module 8</i> for information on apathy and depression in dementia, respectively.
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 does it present? What positive feelings are evident, and when are they displayed?

Do other people prompt a change in the person's emotional status?	Does the person with dementia react differently with some staff, residents, carers, visitors, family members and/or others in their environment?
Does the person with dementia show signs of anxiety?	Do facial expressions, body movements and/or vocalisations suggest anxiety e.g. fight, flight/avoid or freeze reactions? See <i>Module 5</i> for information on anxiety in dementia.
MENTAL HEALTH	
Is the person with dementia experiencing hallucinations?	Does the person describe seeing/hearing people, animals or objects that are not present? Are these beyond the context of the person's known cultural and/or spiritual beliefs and not attributable to misidentification or misunderstanding due to perceptual impairments? Is the person talking to or responding to stimuli that are not observable to others? See <i>Module 7</i> for information on hallucinations in dementia.
Does the person describe delusional ideation?	Is a fixed, false belief described and maintained? Is the belief beyond the context of the person's known cultural and/or spiritual beliefs and not attributable to misidentification or misunderstanding due to perceptual impairments? See <i>Module 7</i> for information on delusions in dementia.
How does the person with dementia react to the hallucinations or delusional ideation?	Is the response fearful or neutral? How is an anxious/fearful response demonstrated?
Does the person with dementia show evidence of depressive symptoms? How long have symptoms been present?	Does the person present with low mood, sadness, crying, irritability, negativity, poor appetite, withdrawal, aggression and/or feelings of hopelessness? See <i>Module 8</i> for information on depression in dementia.
Are results of a <i>Geriatric Depression Scale</i> or <i>Cornell scale for Depression in Dementia</i> assessments available?	Do results indicate that the person with dementia is depressed?
PHYSICAL HEALTH	
Have recent changes to the person with dementia's physical health been evident or reported?	Have investigations commenced? Are results available?
Are the person's vital signs within normal limits?	Has the person's temperature, pulse, respiration, blood pressure and/or urinalysis been recorded? Are observation records or results available?
Does the person show indicators of delirium?	Are recent and/or sudden changes in mood, cognition, functional abilities, speech and/or BPSD evident or reported? See <i>Module 2</i> pages 38-40 for information on delirium in dementia.
Has a delirium screen been completed, including urine, chest X-ray, basic bloods?	Have test results been reported? Are results available?
Does the person with dementia show signs of poorly managed pain?	Are there changes evident which suggest a painful body area, such as limp, reduced mobility, changes in eating habits, changes in sleep, protection of a body part, pallor and/or facial expression. See <i>Module 2</i> pages 41-42 for information on pain in dementia.

Has a pain assessment been completed?	Have the results been interpreted and/or actioned?
Is there evidence of a change to the person's comorbid chronic conditions?	Are potential implications of changes to chronic conditions understood by carers?
Have unmet physical needs been considered?	Have thirst, hunger, comfort, elimination, rest, activity, over- or under-stimulation and/or environmental factors such as temperature, lighting, noise level, or overcrowding been considered as contributing to the BPSD?
Is there evidence of physical discomfort associated with specific body systems?	Is discomfort associated with digestion, elimination, respiration, oral cavity and/or mobility evident or reported?
Are senses intact or adequately compensated for, where tolerated?	Have vision/hearing impairments been recently assessed, where possible? Are glasses and hearing aids available, in working order, fitted correctly and used appropriately?
PHARMACOLOGY	
Is a current list of the person's prescribed medications available?	Have there been recent changes to the person's prescribed medications or the medication regimen?
Are there indications of potential side effects, adverse reactions, interactions or drug toxicity?	Does the timing of the onset of a behaviour or psychological symptom suggest possible effects of recently prescribed medications? Has a GP/pharmacist/geriatrician/psychogeriatrician been consulted to review medications?
Do carers, family members and staff understand the potential implications of psychotropic medications on the person with dementia?	Are carers, family members and staff aware of potential adverse effects of psychotropic medications? Are carers/staff informed of, and able to, recognise a developing adverse response to psychotropic medications? See <i>Module 2</i> pages 47-48 for information on the use of psychotropic medications in dementia.
Has written, informed consent for the use of psychotropic medications been provided and documented by the person with dementia or their substitute decision-maker?	If not, is verbal consent documented? Check local regulations for specific requirements.
Is the pain regimen congruent with current comorbid conditions? Is analgesic medication prescribed regularly or as required?	Is the person with dementia's capacity for verbal requests/responses influencing the administration of pain relief? Are verbal responses likely to be an accurate reflection of pain-related needs? Did the person receive pain relief more regularly when they were able to express their symptoms of pain verbally and request medication? See <i>Module 2</i> pages 41-42 for information on pain in dementia.
Is compliance with the medication regimen evident?	If relevant, what are staff and/or carers' responses to the person with dementia's refusal to take prescribed medication?
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 the person's past life events integrated into current care?	Are life events used to promote conversation, activities and contribute to personalised room décor?
Is there evidence that the person with dementia is recalling disturbing life events from their past?	Has the person with dementia's life story been explored for possible disturbing/distressing events?
Are previous habits and interests potentially contributing to the behaviour or psychological symptom?	Is the information that has been reported and available adequate to make a judgement?
Are lifetime habits, interests and values included in the care plan and behaviour support plan?	Could lifelong values, attitudes and interests be influencing presentation of the changed behaviours or psychological symptoms?
Has the person with dementia's pre-morbid personality been reported by available family members or significant others?	Is their pre-morbid personality acknowledged as contributing to the changed behaviours or psychological symptoms?
PSYCHOSOCIAL - CURRENT	
Are interpersonal interactions influencing the presenting changed behaviours or psychological symptoms?	Does documentation indicate that some people in the person's environment feature more frequently in negative BPSD descriptions than others? Does the person acknowledge any other people as friends? Are particular staff/activities associated with the incidence of BPSD? Are significant family members readily available?
Are activities and events scheduled to meet the person with dementia's social and emotional needs?	Are outings and activities congruent with cognitive status, past interests and/or previous experiences as well as age-appropriate?
Are activities observed or reported as successful and providing pleasure?	If unsuccessful or do not provide pleasure, have possible reasons been investigated, established, reported and/or alternatives/modifications trialled?
CULTURAL CONSIDERATIONS	
Is the person with dementia of Aboriginal and/or Torres Strait Islander background?	Are the person's needs, in relation to their unique historical and ongoing experiences, acknowledged as potentially impacting on the BPSD? See <i>Modules 1 and 2</i> for additional considerations for dementia and BPSD in Aboriginal and Torres Strait Islander peoples.
Is the person with dementia from a culturally and linguistically diverse (CALD) background?	How long has the person with dementia lived in Australia? How long have family members lived in Australia? See <i>Modules 1 and 2</i> for additional considerations for dementia and BPSD in people from CALD backgrounds.
Has the person with dementia come from/escaped a background of war, torture, deprivation, discrimination, refugee experiences or other trauma.	Is the need for trauma-informed care acknowledged? See <i>Module 2</i> pages 42-43 for information on potential impacts of trauma in dementia.
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? Was the person previously fluent in English? Are language limitations contributing to the behaviours or psychological symptoms? Is an interpreter required? See <i>Module 1</i> pages 11-14 for information on

	working with an interpreter during assessment.
Is the person with dementia's cultural background acknowledged and accommodated, if appropriate?	Do the meals provided reflect cultural tastes and/or needs? Do interactions, activities and approach to personal care activities accommodate cultural norms/practices as appropriate for the individual person? See <i>Module 2</i> pages 42-43 for information on culturally competent communication in dementia.
Are religious and/or spiritual beliefs and practices significant for the person with dementia?	Are opportunities provided and offered for religious practices to be observed and/or experienced?
Does the physical environment reflect the culture of the person with dementia?	What strategies are reported to provide a culturally aware/sensitive/safe environment? See <i>Module 1</i> pages 21-22 for information on additional considerations related to the care environment. Where appropriate, is the person's cultural background evident 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 the person with dementia's functional status been recently assessed and documented?	Is documentation of task analyses for activities of daily living (ADLs) available?
Are there components of their ADLs that the person with dementia could be more actively involved in?	Has a task analysis identified components of their ADLs that the person can do for themselves with prompting/encouragement?
Are capabilities/strengths/retained abilities recognised, utilised and encouraged by carers and staff?	Does the care plan encourage the maintenance of retained abilities and strengths?
Is function being overestimated by others, resulting in unrealistic expectations and inevitable failure by the person with dementia?	Functional losses may be inconsistent resulting in unrealistic expectations from family members, carers and/or staff. Is education required in strategies for setting the person with dementia up to succeed?
LIFESTYLE/ACTIVITIES	
What proportion of their day is the person with dementia engaged in familiar, enjoyable 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 the person's executive function sufficient to enable initiation and/or planning of activities? See <i>Module 6</i> for information on apathy in dementia.
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 staff and carers aware of how and when to implement strategies that have previously been effective?

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 leave the group or disturb others in the group?
Does the person remain engaged in small group activities?	Are small group activities more appropriate to stimulate meaningful or enjoyable participation?
Are previous activities and interests effectively utilised to engage the person with dementia?	Are these potentially helpful in addressing episodes of BPSD?
Are activities offered congruent with the person's functional and cognitive abilities?	Physical function may be preserved but cognitive impairments may preclude appropriate physical functioning.

Care/living environment:

QUESTIONS TO FACILITATE ASSESSMENT	EXTENSION QUESTIONS/NOTES
APPROACH TO CARE	
Does the care philosophy articulate the principles of good practice in dementia care?	For further information see <i>Dementia Australia's Roadmap for Quality Dementia Care, Parliamentary Friends of Dementia Paper, 2021.</i>
Does the physical care environment support the person with dementia?	Does the layout of the care environment increase disability and frustration 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 people with dementia? Are the times when meaningful activities/interventions are available insufficient or inappropriate for people with dementia?
Are carers provided with sufficient education in dementia and BPSD to support them to provide appropriate dementia care?	Do staff members attend training where provided? How does staff turnover and use of agency staff impact on the consistency of care delivery?
Is a restraint-free environment an organisational goal?	See <i>Module 2</i> pages 49-52 for information on restrictive practices in residential and community care settings.
Are care plans and behaviour support plans easily accessed by all care staff and written in a manner that encourages access and compliance?	Does jargon, complicated language and/or insufficient detail reduce their accessibility and/or utility? See <i>Module 1</i> pages 22-23 for information on behaviour support plans.
COMMUNICATION	
Is communication by carers, family members, staff and others appropriate for the communication abilities of the person?	Do others have an awareness of, and try to accommodate, the person's communication difficulties and receptive language impairments? See <i>Module 1</i> page 9 onwards for information on communication in dementia.
Does communication during care tasks optimise the person with dementia's functioning and understanding?	Does conversation or direction from carers/staff overwhelm the person with quantity of information or speed of delivery?

Do attempts to reason with the person with dementia cause distress?	Do carers or staff (unintentionally) confront the person with their mistakes/failures or argue with them, exacerbating their distress?
Is staff, family members and carers' nonverbal communication appropriate for the person with dementia?	Do others' nonverbal gestures and body language reflect patience and support for the person with dementia?
CARE DELIVERY	
Are the person with dementia's 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 the person's past routine and/or habits?
Does the person live in an urban, rural or remote area?	Are culturally appropriate support services available and accessible to the person with dementia, their family and their carers?
Does the pace of care/assistance provided to the person with dementia optimise their comfort and function?	Is the emphasis on completing tasks, rather than considering comfort and actively involving the person with dementia where their capacity permits?
How many carers or staff are involved in care delivery?	Is the number of staff or carers likely to overstimulate, confuse, offend or frighten the person with dementia and exacerbate BPSD?
Do care 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 behaviours or psychological symptoms?
Have alternative approaches to personal care/hygiene activities been considered and/or implemented?	Showering is not always the most comfortable or most suitable approach to personal hygiene.
Are the person's current abilities recognised and incorporated into care routines to maximise independence and choice?	Are retained skills acknowledged in the care plan and behaviour support plan?
Does the person with dementia express frustration around impairment of abilities and functional losses?	Does frustration arise from retained insight into their limitations or lost abilities?
Does the person with dementia feel embarrassed during personal care activities?	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 the person with dementia to recollect previous sexual functioning and experiences?	Removal of clothes by another may be misinterpreted by the person and prompt inappropriate sexual gestures or requests, if they are reminded of previous experiences. See <i>Module 9</i> for information on disinhibition.
Could the delivery of personal care prompt recollections of previous trauma which could result in a catastrophic reaction?	Is there documentation or reports of any relevant history that may potentially prompt the person with dementia's reaction?
Does the delivery of care foster manageable choice and control for the person with dementia?	Is the degree of choice and control appropriate to the cognitive status of the person with dementia? Is too little choice offered, or inappropriate choice/control which has the potential to lead to unsafe care practices?