Behavioural Care Plan

What is it?

The Behavioural Care Plan (BCP) is a resident centered, plain-language plan developed for specific behaviours. With the input from direct care staff, the plan is a step by step "**Care Recipe**". *Direct care staff* for the purposes of this document, includes, but not limited to, staff who provide hands-on care, such as Care Aides, nurses, recreation workers, OT and PT.

The purpose of the Behavioural Care Plan is to ensure consistent actions by staff when dealing with responsive behaviours for residents who are experiencing neuropsychiatric symptoms that cause distress, discomfort, self-neglect, or pose a safety threat to staff and/or residents.

Who completes the Behavioural Care Plan

The Behavioural Care Plan is created through a collaborative process between the resident's direct care staff and the nurse leading the process.

Who is it for?

The Behavioural Care Plan is for direct care staff that have hands-on contact with the resident.

How to develop a Behavioural Care Plan

* Before developing a Behavioural Care Plan, the resident who is presenting with a change or worsening of behaviours will need to have a P.I.E.C.E.S.™ assessment completed first. *Treatable issues such as delirium, infection, pain, constipation, should be resolved before creating considering a Behavioural Care Plan.

1. Direct care staff identify what actions have been successful and what approaches trigger resident's behaviour.

2. While the information on the form is being gathered, Care Aids that consistently work with the resident, are asked to write down exactly what they do when in contact with the resident.

3. When all needed information is in place, the nurse and Care Aid(s) complete the Behavioural Care Plan word template.
   a. **FOCUS:** Start with the one behaviour needing urgent attention and write it from **resident's perspective.**
      ***One behaviour per BCP page*.** *E.g.:* **"**I do not like staff touching me for any reason and will hit, kick and to stop them/protect myself when they do care."
   b. **GOALS:** Goals to be realistic and doable
   c. **INTERVENTIONS**: Interventions will reflect what the direct care staff are to do, "Step by Step", in short and directive instructions, when caring for the resident.
   d. **EVALUATION DATE:** The Behavioural Care Plan may need ongoing revisions/modifications. Record the date of the next planned evaluation.

4. The tools for evaluation may vary and will reflect the resident's issue. For example, the Cohen Mansfield Agitation Inventory (CMAI) is an excellent tool to use at the beginning of the Behavioural Care Plan and after this plan and/or medication adjustments have been made.

5. Once Behavioural Care Plan is completed, the care team is to review it prior to implementation.

6. It is recommended that staff read and sign at the back of the Behavioural Care Plan indicating they understand and will follow it.

7. The Behavioural Care Plan must be easily accessed by all direct care staff so they may review it prior to contact with the resident.