

# Behavioural and Psychological Symptoms in Dementia (BPSD) in Residential Care

## SBAR Checklist to prepare for conversation with Physician (Not intended for FAX)

<b>S</b> SITUATION	Resident Name: _____	Date: _____	Time: _____	
	Antecedents (behaviour triggers):			
	Describe Behavioural Concern:			
	Consequences:			
	Acute/sudden Change?			
	<input type="checkbox"/> If Yes, consider delirium      Confusion Assessment Method (CAM) Score _____ <input type="checkbox"/> If No, date of onset _____      Cohen Mansfield Agitation Inventory (CMAI) _____			
	Is there a care plan for this behavior?			
	Non-pharmacological Interventions tried			
Pharmacological Interventions tried				
<b>B</b> BACKGROUND & CLINICAL INFORMATION	Review: <input type="checkbox"/> MAR/Med Profile <input type="checkbox"/> Lab results <input type="checkbox"/> Advance Care Plan <input type="checkbox"/> Medical Orders for Scope of Treatment (MOST), Goals of Care, Other			
	<b>Think PIECES</b>			
	<b>Physical</b>	BP _____/_____	Last BM _____	Vision _____
	SpO2 _____	Pulse (HR) _____	Last void _____	Hearing _____
	Glucose _____	Resp _____	PVR _____	Pain _____
	Allergies _____	Temp _____	Relevant Medical Hx _____	
	Level of Consciousness: <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Fluctuates			
	<b>Intellectual</b> (type of dementia):			
	<b>Emotional</b> (mood, hallucinations, delusions, anxiety, sleep):			
	<b>Capabilities</b> (mobility, continence):			
<b>Environment</b> (where/when behaviour occurs):				
<b>Social</b> (life story):				
<b>A</b> ASSESSMENT	<input type="checkbox"/> The change/issue is _____			
	<input type="checkbox"/> I am not sure what the problem is but the resident is deteriorating.			
	<input type="checkbox"/> The risk is (type & degree i.e. imminent danger to _____)			
<b>R</b> RECOMMENDATION	Please consider: _____			
	<input type="checkbox"/> Assess the resident onsite (expected time) _____			
	<input type="checkbox"/> Further consultation with: _____			
	<input type="checkbox"/> Further tests or treatments: _____			
	<input type="checkbox"/> If the resident does not improve when do we call again? _____			