BSO-DOS©

Behavioural Supports Ontario-Dementia Observation System

Answering Your Questions!

Following up regarding questions posed at the brainXchange webinar:

Implementing the BSO-DOS©: Strategies for Your Team

Live event: October 3, 2019; Click here to access the archived event

1. **How soon would you recommend a team to initiate the BSO-DOS© after admission/move in to get a baseline understanding of the individual?**

   Deciding when to initiate the BSO-DOS© requires clinical judgment, critical thinking, and team collaboration. It is also important to know your organizational standards and policies regarding admission assessments. Some organizations may decide to complete a BSO-DOS© for all individuals moving in or admitted. For other organizations this may not be a part of standard practice, and may leave it to the clinical team to decide when there is value in completing the BSO-DOS©. If a patient/resident has a history of responsive behaviours/personal expressions, the decision to initiate the BSO-DOS© upon admission may be made. In some cases, teams do not start a BSO-DOS© until responsive behaviours/personal expressions are observed. Engage in dialogue with your clinical team when you are unsure when to initiate the BSO-DOS©.

2. **In the behavioural menu, categories #4 and #5 are both colour-coded using yellow. Can you help us understand why these two categories are the same colour? What is the rationale for not differentiating between these behaviours?**

   The colour code system used for the BSO-DOS© indicates the level of risk of a specific responsive behaviour/personal expression. The behaviours that are coded with the same colour present a similar level of risk. As you can see in the Observed Behaviours Legend, behaviours #2 'awake/calm' and #3 'positively engaged' are colour-coded in green because they do not pose any risk. The colour yellow is used to code categories #4 'vocal expressions (repetitive)' and #5 'motor expressions (repetitive).' Yellow represents the potential of increasing risk and is an indicator that these behaviours warrant implementation of non-pharmacological interventions that can be tailored to address the unmet needs. Yellow coding indicates that staff will likely increase monitoring or observation to determine whether interventions are successful or if behaviours intensify.

   In addition, practicality and simplicity were prioritized when developing this tool. In order to use the BSO-DOS© effectively, six highlighters are required to colour-code the numbers corresponding to the Observed Behaviours Legend. Adding more colours would have caused challenges in finding highlighter packages with greater than six colours.

3. **What strategies do you recommend we use to familiarize point-of-care staff with the behaviour operational definitions found in the manual?**

   Clinical leads, educators, and/or advance care clinicians in your area can be a great resource to support point-of-care staff in this process by providing print outs of the behavioural operational definitions, and answer any questions staff may have regarding the definitions. Having a physical copy on hand can help point-of-care staff understand the behaviours as they are observing them. It can also be helpful to keep laminated copies of the definitions near documentation stations as a reference point.

4. **In the Observation Behavioural Legend, can we change the check boxes in each behavioural category to letters so we can record them in the observed behaviour column? That way we will know exactly when the specific behaviour was expressed.**

   This was considered when creating the BSO-DOS©, but the DOS Working Group was committed to a tool that is simple and easy to use for point-of-care staff. Therefore, although knowing what specific behaviour occurred at specific times of the day could provide additional information, coding each type of behaviour with a letter will complicate the tool and compromise its ease of use. In addition, since the Context Legend is coded with letters, coding the behaviours with letters will cause confusion. At the end of the 5 day observation period the BSO-DOS© allows the team to be able to see the various behaviours expressed, and analyze which behaviours present a risk and which behaviours require interventions or further assessments. The BSO-DOS© is a copyrighted tool, thus changing any components (e.g., the Observed Behavioural Legend, Context Legend, etc.) is not permitted. If your team has any recommendations that BSO should consider for the next revision, please share them with us by sending an email to provincialBSO@nbrhc.on.ca.

5. **Under the Context Legend, how do we distinguish between the patient/resident being alone versus sitting in a quiet environment?**

   According to the BSO-DOS© Resource Manual, a patient/resident who is by themselves and separated from others can be documented as 'alone.' A quiet environment is a calm space without any disturbances. It is important to note that being alone and sitting in a quiet environment is not always mutually inclusive, meaning one context can be present while the other is not. For example, a patient/resident who is found sitting by himself in the dining room can be documented as being alone and in a quiet environment; however, if there are traffic or sirens heard from outside, the context can be captured as alone, but not quiet. More details on context definitions can be found on page 22 of the Resource Manual, which can be located at www.brainxchange.ca/BSODOS.

We want to hear about your team's experience in implementing the BSO-DOS©!

Share what is going well, challenges and solutions through the survey below:

https://www.surveymonkey.com/r/BSO-DOS_Implementation

Document created by: Shankavi Jeyabalan, RN, BScN, Debbie Hewitt Colborne, RN, MScN, GNC(C) and Dr. Lori Schindel Martin RN, PhD, GNC(C).