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BRIEF REPORT

Australian National Aged Care Classification behaviour assessment and people living with dementia in residential aged care: Inclusive language for reform?

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Abstract

Objective: To examine the language of the behaviour assessment in the new Australian National Aged Care Classification (AN-ACC) funding instrument. We explored whether the (BRUA) will support an inclusive and progressive approach for people living with dementia in residential aged care.

Methods: Databases were searched to identify publicly available literature relating to the development of the AN-ACC and BRUA, and hand searches of reference lists and selected websites were completed to identify additional grey literature, dementia language and best practice guidelines. Criteria for language use were extracted and compared with the BRUA in the light of the current national aged care reform agenda, as well as research with and perspectives of people with lived experience of dementia.

Results: The language within the BRUA did not align with international dementia language guidelines, and the content presented was disrespectful to those with lived experience. The assessment appears inconsistent with international best practices and is potentially discriminatory within the aged care cohort.

Conclusions: The BRUA is intended as a funding instrument and not as a care planning tool, yet the negative representation of the lived experience of people with dementia embedded within a mandated assessment is likely to influence industry practice by condoning unsuitable language and attitudes amongst assessors, providers and staff. For better alignment with the current positive agenda for aged care reform in Australia, we recommend continued review and updating of this tool to avoid unintended consequences.

KEYWORDS

Australia, aged care reform, behaviour assessment, dementia, homes for the aged, language, residential facilities

1 | INTRODUCTION

The Australian National Aged Care Classification (AN-ACC) tool[1] is the new aged care funding instrument and a key component of Australian Government reform.[2,3] The AN-ACC was developed to measure 'key cost drivers' in residential care and improve the allocation of funding to better meet resident care needs and to sever the influence of funding on care planning.[4,6]

Resident behaviour is one variable which impacts care delivery costs.[5,7,8] Accordingly, the AN-ACC includes the 'Behaviour Resource Utilisation Assessment' (BRUA).[1] This assessment is applied to all residents but will be especially relevant to people living with dementia, as up to 90% experience behavioural symptoms or changes.[9] Conservatively, 53% of people in aged care are living with dementia,[10] so this element of the AN-ACC may significantly impact this vulnerable group.

Language use is well understood as reflective of attitudes and a vehicle for perpetuating stereotypes.[11–15] Language within assessments, including adjectives to describe or 'frame' people, can tap into cognitive bias, resulting in potential negative or positive effects.[15-17] Language guidelines provide preferred terms for referring to older people and people living with dementia.[12,14,18,19]

We are concerned that language used within the (Rf Box 1) BRUA does not meet dementia language guidelines, nor reflect best practice clinical guidelines, community expectations or aged care reform aspirations. We aim to evaluate the potential impact of language used in the BRUA against international language and dementia guidelines and consider findings in the context of the Australian aged care reform agenda for people living with dementia.

2 | METHODS

Scopus, CINAHL and Medline were searched using the following terms: 'BRUA' or 'Behaviour Resource Utilisation Assessment'; 'Australian National Aged Care Classification' or 'AN-ACC'; 'dementia language guideline*'; 'dementia practice guideline*'. We hand-searched reference lists, government aged care websites and websites from peak bodies such as dementia associations.

Principles and criteria for language use reported in the guides were extracted and reviewed against the BRUA by one author (JW) with incongruities discussed with at least one team member, which were then discussed with all authors to obtain consensus. We considered current research[7,13,15,20–22] and the perspective of a person with lived experience (Rf Box 2). Finally, we considered the practical implications that language in the BRUA may have on people living with dementia in residential aged care.

Policy Impact

A strength-based, inclusive approach to changed behaviour is the best practice for people with dementia in residential care. The language of mandated assessments should support this approach. We contend that the Behaviour Resource Utilisation Assessment in the Australian National Aged Care Classification (AN-ACC) battery is potentially discriminatory and could be better aligned with human rights and aged care reforms.

3 | RESULTS

3.1 | Behaviour resource utilisation assessment (BRUA)

Database searches revealed two papers,[5,6] and hand-searching resulted in additional reports[1,4,8,23,24] relating to the development of the AN-ACC and BRUA. The latter originated as a subcomponent of an assessment to predict capacity for work in school-leavers with disabilities (aged 17–24 years; with intellectual disability (40%), speech disability (16%), physical disability (15%) and other conditions).[24] It was a later addition to the AN-ACC, replacing the Neuropsychiatric Inventory—Nursing Home version (NPI-NH).[25] Assessors testing the AN-ACC with 1877 residents raised issues with the NPI-NH, noting 'logistical difficulties': it was time-consuming; and relied on staff reports as it was difficult to make judgements about *'aspects of the resident's neuropsychiatric symptoms that could not be easily observed in an initial one-hour interview.'*[8,p9] The BRUA was considered a simpler alternative, and its inclusion was recommended by the Function, Cognition and Behaviour RUCS Clinical Advisory Panel after analysis of reassessment data (4–6 months after initial assessment with approximately 1000 residents, incorporating both NPI-NH and BRUA[4,p36]).

The BRUA provides the behavioural assessment to ensure the funding allocation algorithm adequately reflects the additional time required to support people living with dementia participate in everyday activities.[5,23] Behaviour is rated according to how much monitoring/supervision is required for five items: wandering/intrusiveness, verbal disruption/noisy behaviour, physical aggression/inappropriateness, emotional dependence and danger to self or

BOX 1 Behaviour Resource Utilisation Assessment (BRUA)

General description

The Behaviour Resource Utilisation Assessment (BRUA) tool is designed to capture the implications of the person's behaviour for carers and service providers, in terms of the levels of monitoring and supervision required.

Assessment tool

Behaviour Resource Utilisation Assessment (BRUA) (Tick one box per row)

		1	2	3	4
Problem wandering or intrusive behaviour	Includes day or night wandering and also refers to the person wandering, or attempting to abscond, from the facility or, while wandering in the facility, interfering with other people or their belongings				
Verbally disruptive or noisy	Includes abusive language and verbalised threats directed at family, carers, other people or a member of staff. It also includes a person whose behaviour causes sufficient noise to disturb other people. That noise may be either (or a combination of) vocal or non-vocal noises such as rattling furniture or other objects.				
Physically aggressive or inappropriate	Includes any physical conduct that is threatening and has the potential to harm another resident, a family member, a carer, a visitor or a member of staff. It includes, but is not limited to, hitting, pushing, kicking or biting and throwing furniture/damaging property. Also included is disinhibition, i.e. inappropriate touching or grabbing of staff/other people.				
Emotional dependence	Is limited to the following behaviour: (a) active and passive resistance other than physical aggression, (b) attention-seeking, (c) manipulative behaviour, (d) withdrawal (including apathy), (e) depression, (f) anxiety and (g) irritable.				
Danger to self or others	Refers only to high-risk behaviour other than physical aggression. It includes behaviour requiring supervision or intervention and strategies to minimise danger. Examples of such behaviour include unsafe smoking habits, walking without required aids, climbing out of a chair/bed, hoarding and self-harm or the potential to try to die through suicide. It applies where there is an imminent risk of harm.				

Assessment tool

Select one scoring option for each of the five BRUA items.

There are four scoring options for each of the five BRUA items:

1	Extensively	Requires monitoring for recurrence and supervision
2	Intermittently	Requires monitoring for recurrence and then supervision on less than a daily basis (during a twenty-four-hour period)
3	Occasionally	Requires monitoring but not regular supervision
4	Not applicable	Does not require monitoring (person has not engaged in the behaviour in the past)

Detailed description of the assessment tool

The Behaviour Resources Utilisation Assessment (BRUA) tool consists of five items covering wandering/intrusiveness; verbally disruptive or noisy; physically aggressive; emotional dependence; and danger to self or others.

The BRUA rates what the person does (Do Do), rather than what they are capable of doing, e.g. the actual behaviours—current or usual state. What the person actually does—not that they have the potential to exhibit a particular behaviour.

Scoring instructions:

- Not applicable: means that you learn of no circumstances in which the resident has engaged in the behaviour in the past.

BOX 1 (Continued)

- Monitoring: means that you learn of circumstances in which the resident has engaged in the behaviour in the past. Current and future service providers will need to observe the resident, be aware when similar circumstances occur and take appropriate intervention to prevent the recurrence of the behaviour.
- Supervision: means that current or future service providers will need to ensure that specific situations or triggers, which are likely to give rise to the behaviour do not occur, or are managed in ways to minimise the likelihood of occurrence.
- Daily: means during a twenty-four-hour period.

BOX 2 Person with lived experience's reflections

I was diagnosed with younger onset dementia 10 years ago. My fears were not around losing memories, rather how my behaviour might change and how others might act towards me. As my dementia progresses, I have increasingly felt disconnection between my body and mind, and a change in the way I think. It is almost as though I have changed from a *thinking person with feelings*, into a *feeling person with thoughts*.

As an example, I fell off my horse last year and cracked some vertebrae. In the busy emergency room, I experienced acute sensory overload. I was panicky, fearful and feeling very vulnerable. Without warning, a nurse adjusted my bed: I responded with loud protest and cries of pain. I was subsequently described as 'showing typical aggressive behaviour of dementia'. I felt I was reacting to pain in a very normal way. The word 'aggressive' was humiliating and does not reflect who I am as a person.

I have read the AN-ACC tool. I was horrified when I came to the BRUA. My initial response was that this was a brutal, blunt instrument, lacking in insight. Implicit in the wording was the need for 'suppression' of these 'unsavoury behaviours'. Within a human rights context, the language is shaming and derogatory. The overall tone of the tool very directly implies nefarious intent on behalf of the person being assessed: I maintain that behaviour cannot be 'manipulative' or 'attention-seeking' in the context of dementia. To understand dementia, we need to appreciate that people who have led full and useful lives may be in desperate emotional pain as they lose connection with their lives. It is also reasonable that if communication skills are impaired or gone, the physical body will attempt to express this pain or distress in any way it can. Surely the language of the BRUA will have an impact, at the very least, on depersonalising and demonising people, and perpetuating a fundamental misunderstanding of what funding may be required to support people with these symptoms.

It is my sincere hope that this part of the funding tool can be reviewed, with a view of understanding *the drivers of behavioural symptoms*, using appropriate language, to derive the costs of safely supporting people with dignity and respect without shame or blame.

others[1] (scores range 1–3; lower scores indicating higher care need). BRUA results are combined with other assessments, such as ADL measures, considered as proxies for behaviour.[4,5] Combined assessment results in the AN-ACC determine the individual component of the funding (variable payment), where a particular casemix class is assigned and funded accordingly.[4–6,23]

3.2 | Principles and criteria for language usage

The four dementia language[12,14,18,19] and three practice guidelines[26–28] located consistently describe a positive and inclusive approach through using '*…words and phrases that empower people, treat them with dignity and respect…*'[18,p2] and state that language use in all aspects of dementia care should be accurate, balanced and respectful.[12,14,18,19,26–28] Review of these documents revealed six specific themes, stating that language should be:

- Accurate, specific and objective or neutral[12,14,19]
- Inclusive and facilitate acceptance[12,14]
- Strength-based and empowering[12,18,27]
- Respectful[12,14,18,19,27,28] and supportive of positive relationships[15,27,28] with a person-centred/person-first approach
- Non-stigmatising, avoiding stereotypes and labelling[12,18,27]

- Based on a human rights approach that is non-discriminatory.[14,28]

One clinical practice guideline explicitly endorsed using language consistent with language guidelines as a principle of care[26] while others discussed the importance of the person's perspective and individuality.[26,27] All endorsed the importance of relationship-based support and care.[26–28]

3.3 | Appraisal of the language in the BRUA

When we compared language and behavioural descriptors in the BRUA against the published guidelines and criteria above, we found that they were not aligned. For example, the first word of the first item is *'problem' wandering*[4]: assuming 'wandering' is a problem without capturing for whom the problem exists. *'Intrusive behaviour'* is also categorised within the same item, suggesting that *'problem wandering'* is synonymous with *'intrusive behaviour'*. This language is subjective, does not encourage consideration of underlying causes of behaviour and is neither specific nor accurate. This item also contravenes all other criteria, effectively conveying a negative, disempowering stereotype. Using this example, alternative language could be 'walking but disorientated to place', prompting strategies such as simple wayfinding cues in the environment and verbal prompts from staff, promoting relationship-focussed care to support the person more effectively.

Other descriptors used in the BRUA include '*noisy*', '*inappropriate*', *'emotionally dependent'*, *'manipulative'* and '*attention-seeking*'.[1] This language neither captures behavioural symptoms as an expression of unmet need nor does it account for associated cost implications for meeting these needs. Further, terms like '*manipulative*' imply intent and cognitive ability beyond the capacity of a person with severe dementia, labelling them inaccurately and perpetuating misunderstanding. All five items in the BRUA and their descriptors did not meet the expected principles and criteria.

4 | DISCUSSION

This paper examined whether the language of the behaviour assessment in the new AN-ACC funding instrument would support an inclusive and progressive approach for people living with dementia in residential aged care. We found that the language used was inconsistent with both dementia language guidelines and practice guidelines. In addition, this language does not align with Australian Government reforms in aged care, encapsulated in the 'five pillars of reform',[2,3,29] which aim to *'confront the inadequacies in aged care' and 'strengthen and enhance the protection and rights of older Australians'*.[29,p2] Foundational principles underlying the new regulatory framework are human rights-based, and person-centred, flexible approaches to care, which are high quality and culturally safe.[2,3,29]

These reforms are highly congruent with Australian Dementia Clinical Practice Guidelines[26] and best practice recommendations.[27,28] Broadly, clinical and best practice guidelines conceptualise behavioural symptoms as an expression of unmet need or lowered stress threshold, and consider behaviour as a form of communication where people with dementia may not be able to express underlying causes of distress such as pain, anxiety or severe disorientation.[7,14,26,28] In an intentional move away from language that labels, NICE dementia quality standard 184[27,p26] refers to behavioural symptoms as distress; that people with dementia can *'become distressed, … leading to symptoms such as increased aggression, anxiety, …'*.

Language within assessments is central to moving towards a rights-based Australian aged care system and should dissuade labelling or perpetuate misunderstanding and stigma.[15] While acknowledging the BRUA is intended for purposes of funding allocation, not care planning,[5,6,23] this goal may be undermined by using behavioural descriptors that fall short of capturing actual care needs, and language that is potentially discriminatory and universally maligned with guidelines,[12,14,18,19] best practice recommendations[26–28] and research with people living with dementia.[21,22]

5 | CONCLUSIONS

The impact of the language in the BRUA on the frameworks or schemas that aged care providers, care staff and industry consultants use as reference to identify care needs is an important consideration. We recognise that the AN-ACC is designed for the purpose of funding, and a separate assessment is required for care planning purposes.[6,23] However, in the absence of such an assessment battery, the industry may draw inferences from the BRUA to guide clinical decisions. Moreover, the descriptive language may become systematised if inculcated into providers' software systems, as in the case of Aged Care Funding Instrument (ACFI) descriptors reporting on 'wandering, physical and verbal aggression'. It is unclear whether providers will continue to use embedded ACFI descriptors, but with assessors using the BRUA, it is clear that the language in neither of these tools promotes inclusion and positive behaviour support.

We welcome funding assessment updates in aged care but are concerned that in its present form, the BRUA could undermine those very rights that recent restrictive practice legislation intends to strengthen. We hope that by raising these concerns, further refinement will occur. 'Modifying how we think and speak of older persons...'[15,p3] is both a national and international imperative and thinking again about the language in the BRUA might serve us well.

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CONFLICTS OF INTEREST

JW was previously employed at Montefiore Homes and continues to have a professional link with them. She has previously received funding from Dementia Australia and has provided advice about restrictive practice legislation via a local PHN. HB is an advisory board member or consultant to Biogen, Nutricia, Roche and Skin2Synapse. He is a medical/clinical advisory board member for Montefiore Homes and Cranbrook Care. Other authors state there are no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Data sharing for this manuscript is not applicable - no new data were created or analysed in the report.

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