

Behaviour Mapping Chart

Last Name <i>(Legal)</i>				First Name <i>(Legal)</i>			
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>					
PHN		ULI <input type="checkbox"/> Same as PHN		MRN			
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown			

Date <i>(yyyy-Mon-dd)</i>															
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Behaviour Mapping

Goal

Creation of a personalized Behavioural Support Plan including behavioural trends, triggers and effective interventions.

Steps:

- (1) **hourly observations** (*behaviour mapping chart*)
- (2) **descriptive notes** (*patient progress record*). **Both observations and descriptive notes** should be used to create the Behavioural Support Plan and to keep it consistently updated. Begin creating the Behavioural Support Plan upon initiating the behaviour mapping process.

HOURLY Behaviour Observation	
1	✓ Chart entry is letter(s) only. If an observed behaviour is notable, further detail is required (<i>Step 2</i>).
A	Agitation: Refusing/Resistant to care; Calling out; Removing clothes
AF	Affect: Anxious; Paranoid; Sad; Depressed; Happy; Cooperative
AG	Aggression (<i>Verbal or Physical</i>): Biting; Spitting; Kicking; Hitting; Pinching; Yelling
H	Hypoactive: Drowsy; Somnolent; Comatose; Unusually quiet compared to typical
Q	Quiet: Alert, Awake
R	Restlessness: Fidgeting; Impulsive activity; Pacing
S	Sleeping
SD	Sexual Disinhibition: Exposing; Inappropriate touching; Inappropriate comments
SEN	Sensory: Hallucinations (<i>Visual/Auditory</i>); Delusions; Suspicious; Picking
W	Wandering: Redirectable; Difficult to redirect; Exit seeking; Elopement Risk
O	Other:

2	<p>DESCRIPTIVE NOTE (<i>entered in the patient's progress record</i>)</p> <ul style="list-style-type: none"> ✓ On the Behaviour Mapping Chart, circle the letter identifying the notable behaviour. This indicates descriptive information has been provided. Follow these prompts below to create your descriptive note. ✓ If focus charting, the focus word is "Behaviour Mapping" to easily identify corresponding descriptive notes. ✓ Describe notable behaviours only. (<i>"Routine" entries are not necessary</i>).
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Examine the event to try to understand it - look for "triggers"	
(A) ACTIVATING EVENT	
Assess if the behaviour is the result of:	
<ul style="list-style-type: none"> • Delirium (<i>complete CAM</i>) • Care provider approach? (<i>e.g. Was patient startled? Crowded? Rushed?</i>) • Clinical/medical factors? (<i>e.g. Constipation; Pain; Depression; Apathy; Medication effects</i>) • Environmental factors? (<i>e.g. Noise; Too hot/cold; Change in routine or location; Light; Over / Understimulation; Restraint</i>) • Unmet needs? (<i>e.g. Hunger/thirst; Fatigue; Boredom; Loneliness; Need for increased Comfort Rounds?</i>) 	
Include	
<ul style="list-style-type: none"> • Where did the behaviour occur? (<i>Specific location</i>) • Who was present? Identify by name and role. (<i>"John S, LPN" vs "LPN"</i>) 	
(B) BEHAVIOUR	
<ul style="list-style-type: none"> • What behaviour was observed? (<i>Be specific. e.g. "While seated for lunch, Mrs. B refused to eat. She was muttering but her words could not be understood. When John S, LPN asked what she would like she yelled 'Go away!' and threw her coffee cup at him."</i>) 	
(C) CONTEXT	
<ul style="list-style-type: none"> • Staff response/intervention to the behaviour? • Patient's response to the staffs intervention? 	

Behavioural Support Plan
✓ Examine the chart for trends at specific times/days, with specific activities or care providers, etc.
✓ Examine descriptive notes for triggers and effective interventions. Consider events prior to behaviours. (<i>e.g. Nightly sedation may actually contribute to insomnia, as might a long nap the prior afternoon</i>).
✓ Suggested inclusions: Likes/Dislikes; Triggers; Effective interventions; Patient's preferred routine; Safety
✓ Care plan should be kept in a location accessible to all caregivers and must be reviewed regularly
NOTE: Descriptive notes may be done for the ABSENCE of responsive behaviours. (<i>e.g. It is notable if a patient who is routinely agitated at meals appears content today. Complete a note to understand what is different today</i>).