Behaviour Mapping

GOAL: Creation of a personalized CARE PLAN including behavioural trends, triggers and effective interventions. This data is learned through: (1) **Hourly Observations**, and, (2) Descriptive Notes in the **Multidisciplinary Progress Record (MPR).** Behaviour Mapping should continue for 2 weeks MAXIMUM before a care plan is created. If enough data is gathered sooner, a care plan may be created sooner.

1	**HOURLY Behaviour Observation** *Chart entry is letter(s) only unless the behaviour observed is notable*. If a behaviour is notable then details must be provided in the Multidisciplinary Progress Record (MPR).
A	**Agitation:** Refusing/Resistant to care; Calling out; Removing clothes
AF	**Affect:** Anxious; Paranoid; Sad; Depressed; Happy; Cooperative
AG	**Aggression (Verbal or Physical):** 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
S	**Sleeping**
SD	**Sexual Disinhibition:** Exposing; Inappropriate touching; Inappropriate comments
SEN	**Sensory:** Hallucinations (visual/auditory); Delusions; Suspicious; Picking
W	**Wandering:** Redirectable; Difficult to redirect; Elopement risk
O	**Other:**

2 **Multidisciplinary Progress Record (MPR)**

✓ *Follow the prompts below in creating your note.*
✓ *"Routine" MPRs are not necessary. Describe notable behaviours only.*
✓ Indicate you have made a note by adding "MPR" to your letter entry on the chart and circling it.

(A) ACTIVATING EVENT

- **Where did the behaviour occur?** *(Specific location)*
- **Who was present?** Identify by name and role. *("John S, LPN"* vs *"LPN")*
- **What were those present doing at the time?**

(B) BEHAVIOUR

- **What behaviour was observed?** *(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.)*

(C) CONTEXT *Examine the event to try to understand it - look for "triggers"*

- **Unmet needs?** Pain; Mobility; Nutrition/Hydration; Toileting; Rest
- **Environmental factors?** Too hot/Too cold; Change in routine/Relocation; Noise; Light; Overstimulation/Understimulation; Caregiver approach
- **Psychosocial factors?** Stress threshold/Overstimulation; Boredom; Depression; Loneliness
- **Clinical factors?** Medication side effects; Dementia/Depression/Delirium progression; Infection; Constipation; Ineffective disease management (e.g. low blood sugar)
- **Staff response/intervention?**
- **Patient's response?**
- **Plan?**

CARE PLAN

- ✓ Examine the chart for trends at specific times/days, with specific care providers, etc.
- ✓ Examine the MPRs for triggers and effective interventions. Consider events prior to the behaviour. (e.g. Nightly sedation might actually cause insomnia, as might a long nap the prior afternoon.)
- ✓ 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: Mapping may be done in the ABSENCE of behaviours. (e.g. If a patient is routinely agitated every afternoon but is content today - complete a note to understand what is different today.)