Elder Care In Hospital  *Behaviour Tracking Form*

**This is NOT to be a part of the medical record.**

Interdisciplinary Behaviour Record for: (Name)  
Recording Period: (Date)  
Behaviour being tracked:  
To be analyzed by: (Name)

<table>
<thead>
<tr>
<th>Date of Event</th>
<th>Behaviour</th>
<th>What do you think caused this behaviour?</th>
<th>Intervention Tried</th>
<th>Immediate Outcome of Intervention</th>
<th>Staff Person Involved</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Regular/Casual</td>
<td>What was the behaviour of patient 45 minutes later?</td>
</tr>
</tbody>
</table>

**Please see the back of this page for instructions on how to complete this form.**
Instructions for Completing the Behaviour Tracking Form

1. Fill in the patient's name at top of page.
2. Fill in the behaviour you plan to track. Do NOT say "agitation" because this is not specific enough. You must put in a very specific behaviour like "wandering" or "verbal aggression" or "calling out" etc.
3. Fill in your name or the name of the person who has agreed to review and analyze the tracking form. Do NOT leave this blank. If it is left blank, the form will sit unattended and collect information indefinitely. Staff get frustrated that nobody is looking at the form.
4. Be sure to fill in the dates you want to track the behaviour between. If the behaviour is severe you likely will only have to track it for about 4 days. If it is less severe you may need to track it for 2 weeks.

How Do I Analyze the Information on the Behaviour Tracking Form?

1. **ANYONE** can analyze the information!
2. At the end date of the designated Tracking time period, it is important that the information be reviewed and a summary written in the Progress Notes on the patient's chart.
3. **Begin** by making a list of 2-hour time frames for the 24-hour clock on a piece of blank paper (8-10 a.m.; 10-12 noon; 12 noon-2 p.m.; 2-4 p.m.; 4-6 p.m.; 6-8 p.m.; 8-10 p.m.; 10-12 midnight; 12 midnight-2 a.m.; 2-4 a.m.; 4-6 a.m.; and 6-8 a.m.).
4. Next count the total number of entries on the form. How many times did the behavior occur? How many times was the entry saying the behaviour did not occur?
5. Look at each individual behaviour entry and look at exactly what time it occurred. Put a tick (✓) on your clock list next to the time frame that the behaviour occurred in. For example, if the Behavior Tracking said that John was wandering at 9:15 a.m. and again at 3:20 p.m. then put a tick next to the 8-10 a.m. time slot and another next to the 2-4 p.m. time slot.
6. Total up the number of ticks in each 2-hour time slot.
7. The time slot that has the greatest number of ticks is when the behaviour is occurring the MOST often. *It does not mean that it never occurs at another time, but we want to see when it is occurring the most.* For example, in the time slot for 8-10 a.m. the behaviour “wandering” may have occurred 3 times. For 2-4 p.m. it occurred 7 times. For the time slot 6-8 p.m. it occurred 2 times. The time when the wandering behaviour is occurring the most is between 2-4 p.m.
8. What interventions worked to stop the behaviour? What interventions did not work? **WHY do you think the behaviour is happening? Look at triggers.**
9. In the Progress Notes you would write something like: "Behaviour Tracking for Mr. Jones' wandering behaviour took place between April 4-20th, 2015. There were a total of 14 entries on the Tracking Form. Most of the wandering occurred between 2-4 p.m. with a total of 7 out of 14 incidents happening at this time. Interventions that were successful in stopping the behaviour were 1:1 x 20 minutes, taking him to the toilet. An intervention that did not seem to work was giving Ativan. Behaviour seems to be triggered by a sense of loneliness when his wife leaves. We will review the care plan to ensure that the interventions are implemented between 2-4 p.m."
10. **Next have a care planning meeting with your colleagues.** Discuss the Tracking Form's information. Brainstorm for ideas that will help address the behaviour. When did the group notice a change in behaviour? What interventions have worked for them? **WHY do you think the behaviour is happening? What are the triggers?** Is it boredom? Is patient looking for companionship? Looking for a toilet? Are they hungry? Cold? Etc. What is the patient's Life Story? Are there things we could put in the care plan that reflect what they like to do?
11. Try to keep the care plan for behaviour to 1 page maximum. Revise the care plan as needed and leave a visible copy for all staff to see. Share the information. Remind staff of updated care plan at shift change. Everyone must be on board to trial the care plan.
12. Be sure to set a date to evaluate the care plan. Are the interventions making a difference? If not, revise the plan.