Acknowledgements

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We would like to thank Sheile Mercado-Mallari, Robert Gill, Leslie Gamble, Fraser Health and Interior Health for sharing their valuable resources with the PVPSC. We respectfully ask that individuals who use this resource appropriately recognize those who developed the materials for the work they have done. We ask that you please acknowledge the author and/or author organization, even if you modify or adapt the resources.

The resources on the Responding to Excessive and Aggressive Behaviours (REAB) Program, the InterRAI Program and the Medical Legal Charting were not developed by the PVPSC, and distribution should not be interpreted as endorsement of the resources as “best practices” or joint agreement. Any use, modification, or adaptation of this resource is done at the user’s discretion and the user assumes responsibility for the outcome.

Revised June 2009
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Introduction to BC’s Provincial Violence Prevention Steering Committee

The healthcare sector represents 10% of the provincial workforce, yet 40% of all province-wide WorkSafeBC claims due to “violence” arise out of the healthcare sub-sector. To address the issue of violence in healthcare, the Provincial Violence Prevention Steering Committee (PVPSC) was created with the support of BC’s healthcare stakeholders. The PVPSC is coordinated by the Occupational Health and Safety Agency for Healthcare in BC (OHSAH). The PVPSC’s purpose is to develop and oversee implementation of a comprehensive, cohesive, and effective provincial violence prevention strategy for healthcare worksites in BC.

In many healthcare workplaces, violent behaviour is commonly not reported because it is not recognized as “violence.” The PVPSC definition of violence (in box at right) includes intentional or unintentional behaviour, regardless of illness/injury. It also includes behaviour that is often called “aggression.” All violence must be reported so that appropriate corrective action(s) can be taken to keep healthcare staff safe.

For more information about the PVPSC, please visit: http://www.ohsah.bc.ca/pvpsc.

Introduction to the Behavior Documentation Toolkit

Scope of the Problem: Underreporting of Violent Incidents

Often when there is a violent incident involving a patient (here the term ‘patient’ is used inclusively to mean ‘resident’ or ‘client’ as appropriate), incident investigation reveals several warning signs or indicators of escalation (sometimes over days) that were not reported or documented. Reporting escalating or unusual behaviour is central to preventing violence; even when the behaviour on its own is not physically threatening. Reporting allows for other workers to be warned of risks, for preventative measures to be put in place, and to call attention to violence as an important issue. However, in discussions with healthcare workers and Occupational Health and Safety (OHS) specialists, there are several barriers to reporting violent behaviour that come up repeatedly:

- The perception that reporting a violent incident does not result in any feedback or improvement.
- Lack of support from managers, supervisors and co-workers.
- The perception that it takes too long to fill in forms.
- The high frequency of near-misses and minor violent incidents are so common that a worker could spend as much time reporting violence as doing patient care activities.
- Workers fear reprisal, being blamed for the attack and being re-victimized.
- Complexity of filling out the appropriate reporting forms.
- Violent behaviour that is not intentional due to illness/injury is not recognized as “violence.”

PVPSC definition of Violence

Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving a direct or indirect challenge to their safety, well-being or health.
Overview of Behaviour Reporting and Documentation

Behaviour documentation is meant to capture the subtle or repeated behaviours that would otherwise go unreported, and to capture any escalation in behaviour that could act as an indicator of an upcoming major outburst. Examples of behaviours that should be documented include:

- An increase in the frequency or intensity of an anxious or aggressive behaviour e.g. a patient who regularly lightly slaps the hand of anyone who assists in feeding starts to slap with more force on the caregiver’s shoulder.
- An unusual behaviour for a patient/client e.g. a client that is normally calm and quiet starts mumbling and wringing his/her hands.

Most of these behaviours are unlikely to be captured using incident investigation because of the length of time to fill out these forms and the frequency with which these subtle behaviours occur. Documenting behaviour in a simpler, shorter, clinically-based format has the advantages of:

- Being quick and simple, and therefore more likely to be completed for subtle behaviours.
- Providing healthcare staff with a tool to identify trends or changes in behaviour before a violent event.
- Helping healthcare staff prevent a violent event by identifying what may be triggering the aggressive behaviour.
- Potentially being accessible to healthcare staff that observe clinically relevant behaviour so that a more comprehensive picture of a patient’s behaviour is recorded.
- Being incorporated into clinical practice so that appropriate controls are more likely to be implemented in a timely way.

Although the behaviour reporting described here fills a gap in existing OHS processes, it does not replace other reporting methods. Any serious violent behaviour that results in injury (or could potentially have resulted in injury) needs to be formally reported in writing and investigated immediately. Serious or major incidents should have a formal investigation via participation of the Joint Occupational Health and Safety Committee (JOHSC) and workers/witnesses involved. The behaviour documentation process does not replace formal incident reporting and incident investigation.

The General Behaviour Documentation and Reporting Process

One key feature of the behaviour documentation process is that it integrates violence prevention with clinical practice. It helps document anxious, or aggressive, violent behaviours for the patient record and focuses on how to adapt the patient’s care plan, and improve patient care as well as health outcomes, with a built-in follow-up mechanism within the clinical/care planning framework. This process can also serve as a communication tool that will notify patient care staff about important changes in (or status of) patient behaviour.

A typical behaviour documentation process would consist of:

1) Utilization of a behaviour observation form for documentation.
2) Regular review of behaviour documentation.
3) Incorporation of the behaviour information to modify care plans and/or implement other control measures.

Depending on the healthcare sector and facility, the behaviour documentation process will vary in terms of:

- Who is allowed to document patient behaviour.
- Who is responsible for reviewing the behaviour documentation to identify trends or changes in behaviour.
- Who is responsible for incorporating behaviour documentation information into care plans/interventions.

**Behaviour Documentation Tools**

This toolkit features three different examples of behaviour documentation tools: the Responding to Excessive and Aggressive Behaviours (REAB) program developed by Fraser Health, the InterRAI Corporation’s Minimum Data Set (MDS), and the Behavioural Observation Sheet (BOS) developed by the PVPSC’s Violence Prevention Advisory Group (VPAG). Each documentation tool is summarized in the following sections.

At the February 11-12, 2009 PVPSC Violence Prevention Stakeholder Workshop, participants were asked for their feedback on the patient behaviour documentation processes exemplified by the tools contained in this toolkit. Workshop facilitators recorded participant feedback and OHSAH consolidated and incorporated the applicable recommendations into the Behaviour Observation Toolkit. The PVPSC is not in a position to recommend changes to the InterRAI systems or the REAB Program. Participant feedback on the InterRAI systems were incorporated to the BOS where applicable; Fraser Health received a summary of participants’ comments about the Identification of Agitated and Excessive Behaviour and Client-Centered Interventions Clinical Practice Guideline.
**Responding to Excessive and Aggressive Behaviours (REAB) Program**

The REAB Program was developed jointly by Fraser Health, the Vancouver Island Health Authority, Healthcare Benefit Trust, and OHSAH to provide knowledge, skills and tools for direct care staff to understand approaches and to use appropriate interventions that may prevent and/or minimize excessive and aggressive behaviours in adult clients in complex care settings. The need for the REAB Program was recognized as a result of the common occurrence of excessive and aggressive behaviours in residents and its impact on client and staff safety and employee health.

**Excessive behaviour** is defined as any behaviour leading to discontent in a resident or irritation or harm to others including other residents, visitors or interdisciplinary team members. Behaviours may be inappropriate due to intensity, frequency or the context in which they are exhibited.¹ **Aggression** is defined as physical and/or verbal behaviours that are disruptive and/or pose a threat of physical harm to self or others.²

The REAB Program has several resources that address the issue of excessive and aggressive behaviours in residents in a methodical manner while integrating clinical and OHS perspectives. One component of the REAB program is client documentation which refers to a process for identifying, recording and sharing resident information for the purpose of providing quality care and ensuring the safety of healthcare staff and other residents.

Examples of REAB client documentation tools include:

1) *Client-Centered Interventions Clinical Practice Guideline (CPG) Flowchart* (p.8 of this document),
2) *Identification of Behaviours and Guidelines for Interventions* form (p.10 of this document),
3) *Behaviour Pattern Record* (p.11 of this document), and
4) *Client 7-Day Observation Record* (p.12 of this document).

These observation tools are to be used by clinical staff as part of the Identification of Agitated and Excessive Behaviour and Client-Centered Interventions CPG. This CPG applies to clients that display anxiety, inner tension and other symptoms related to changes in memory, cognition and functional abilities. The process for using each of these behaviour documentation tools to identify clients’ needs and agitation triggers and develop individualized care plans are summarized below.

**REAB Behaviour Documentation Process**

Please refer to the CPG Summary Flowchart on page 8 for a visual summary of the REAB Behaviour Documentation process.

1. **Identify and analyze patient behaviours**

The *Identification of Behaviours and Guidelines for Interventions* form is intended for use by the clinical staff team within 14 days of admitting a patient and on an as-needed basis thereafter (i.e. when there is a change in behaviour). Information collected on the *Identification of Behaviours and Guidelines for Interventions* form allows clinical staff to identify patient behaviours and their frequency and classify them as verbal or physical behaviours.

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CPG Summary Flowchart
Identification of Agitated & Excessive Behaviours and Client-Centred Interventions
Clinical Practice Guideline

ADMISSION
and/or
Change in Behaviour

HISTORY
Review Health Record
Medical and Social History
Interview Client and Social Supports

OBSERVATION
Physical, Mental, Cognitive Assessment
Relationship with Supports
Response to Environment

PREVENTION
Be respectful, actively listen
Get to know the client and history
Provide choices
Calm Environment
Individualized Care Plan

Identify and Analyze Behaviours: Verbal, Physical
Identification of Behaviours and Guidelines for Intervention
Identify and name behaviour(s) and frequency
Classify as physical, verbal
Initiate: Behaviour Pattern Record or Client Observation Record

Individualized Plan of Care
Collaborate with members of the interdisciplinary team to develop
individualized Care Plan considering:
Environmental Alterations Supportive Therapies Pharmacology

Document / Evaluate / Educate
Summary of assessment findings and rationale for interventions in Progress Record
Provide Client / Supports education and document response
Evaluate Care Plan's effectiveness

Sudden change in behaviour?
Yes
Refer to Delirium CPG
No
2. Identify triggers and patterns of excessive behaviour

Once the Identification of Behaviours and Guidelines for Interventions form has been completed, clinical staff will use the Behaviour Pattern Record or Client 7-Day Observation Record to identify triggers and patterns of excessive behaviour.

The Behaviour Pattern Record or Client 7-Day Observation Record is meant to capture information about the patient including:

- Results of the client’s physical assessments.
- Benefits and adverse effects of the client’s medications.
- Client’s facial expressions for affect, indicators of pain, anxiety, depression.
- Client’s ability to be understood and to understand others.
- Client’s personal factors, such as grooming, positioning, and fatigue.
- Client’s interpersonal relationships and impact on well being.
- Client’s adaptation to present circumstances.
- Client’s response to environment, such as lighting, noise, and routines.
- The results of any assessments conducted on the client, such as cognitive tests, chronic pain assessment, and sleep assessments.

3. Develop individualized plan of care

Once information has been collected on the Behaviour Pattern Record or Client 7-Day Observation Record, clinical staff should review the data and identify triggers leading to aggressive behaviour and the client’s pattern and frequency of behaviour.

The clinical staff team should collaborate to develop an individualized care plan for the patient. The care plan is then communicated to all staff, the client, and the client’s family members.

4. Evaluation of the care plan

After the individualized care plan has been implemented, the care plan should be evaluated for its effectiveness.

The Identification of Behaviours and Guidelines for Interventions form, Behaviour Pattern Record, and Client 7-day Observation Record are included on pages 10 – 12.
# Identification of Behaviours and Guidelines for Interventions

## Frequency

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several times an hour</td>
<td>1. Name &amp; state frequency of behaviour</td>
</tr>
<tr>
<td>Once or twice a day</td>
<td>2. Initiate Behaviour Pattern Record or Client Observation Record or screen for Delirium</td>
</tr>
<tr>
<td>Several Times a week</td>
<td>3. Assess for pain, constipation, itchy skin, need for toilet</td>
</tr>
<tr>
<td>Less : once a week</td>
<td>4. Assess tolerance for environmental pressures</td>
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<tr>
<td></td>
<td>5. Speak in short simple statements</td>
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<td></td>
<td>6. Validate feelings, clarify meaning of their words</td>
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<td></td>
<td>7. Set limits</td>
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<tr>
<td></td>
<td>8. Encourage consistent visitors and times of visits</td>
</tr>
<tr>
<td></td>
<td>9. Neuroleptics &amp; adjunct meds may assist some clients to reduce verbal outbursts</td>
</tr>
</tbody>
</table>

## Mark an X in the column

<table>
<thead>
<tr>
<th>Verbal Behaviours</th>
<th>Physical Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repetitive sentence/questions</td>
<td>Pacing or aimless wandering</td>
</tr>
<tr>
<td>Making noises: crying, moaning, grinding teeth</td>
<td>Trying to get to a different place</td>
</tr>
<tr>
<td>Complaining: somatic complaints, repetitive complaints</td>
<td>Handling things: moving furniture</td>
</tr>
<tr>
<td>Negativism: nothing is right</td>
<td>Hiding things/hoarding</td>
</tr>
<tr>
<td>Verbal sexual advances; sexually explicit talk</td>
<td>Eating/drinking inappropriate substances</td>
</tr>
<tr>
<td>Constant unwarranted requests for attention/help</td>
<td>General restlessness: fidgeting</td>
</tr>
<tr>
<td>Screaming</td>
<td>Resists or refuses care</td>
</tr>
<tr>
<td>Swearing, verbal anger, criticisms</td>
<td>Performing repetitive mannerisms</td>
</tr>
</tbody>
</table>

## Interventions for Excessive Verbal Behaviour

1. Name & state frequency of behaviour
2. Initiate Behaviour Pattern Record or Client Observation Record or screen for Delirium
3. Assess for pain, constipation, itchy skin, need for toilet
4. Assess tolerance for environmental pressures
5. Speak in short simple statements
6. Validate feelings, clarify meaning of their words
7. Set limits
8. Encourage consistent visitors and times of visits
9. Neuroleptics & adjunct meds may assist some clients to reduce verbal outbursts

## Interventions for Excessive Physical Behaviour

1. Name & state frequency of behaviour
2. Initiate Behaviour Pattern Record or Client Observation Record or screen for Delirium
3. Ensure staff safety: remain 3 feet and 1 additional stride backward, supportive stance
4. If client is resistive to care withdraw & try later
5. Assess for pain, constipation, need for toilet
6. Develop and implement consistent schedule
7. Provide meaningful activities and distractions
8. Develop team consensus on approaches to client
9. Consistent team response to behaviours
10. Clients demonstrating physical excessive behaviours may benefit from a neuroleptic or adjunct medication
11. Regular dosage as well as a p.r.n. dose

<table>
<thead>
<tr>
<th><strong>When</strong></th>
<th><strong>What</strong></th>
<th><strong>Where</strong></th>
<th><strong>Why</strong></th>
<th><strong>How</strong></th>
<th><strong>Outcome and suggestions for future Care Planning</strong></th>
</tr>
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<tbody>
<tr>
<td>Date:</td>
<td>What behaviour was observed? Refer to Identification of Behaviour</td>
<td>Where did the behaviour occur? BR, DR, beside bed</td>
<td>What was happening just before behaviour occurred? Who else was present? Unusual noises?</td>
<td>What interventions were used? How were interventions implemented?</td>
<td>How did the client respond?</td>
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<td>Initials:</td>
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<td>Initials:</td>
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</table>
## Client 7-Day Observation Record

Use corresponding numbers to record in ½ hour intervals

<table>
<thead>
<tr>
<th>Verbal Excessive Behaviour</th>
<th>Excessive Physical Behaviour</th>
<th>Other</th>
<th>Analyze the coded entries to determine if there is a pattern with identified triggers</th>
</tr>
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<thead>
<tr>
<th>YY/MM/DD</th>
<th>Time</th>
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Adapted from P.I.E.C.E.S. program
InterRAI Assessment Systems

InterRAI is a collaborative network of researchers in over 30 countries committed to improving healthcare for persons who are elderly, frail, or disabled. InterRAI has developed a suite of comprehensive assessment systems that use a common language and clinical concepts across sectors to collect healthcare-related information on patients in a consistent way to inform comprehensive care planning. InterRAI Home Care (HC) is a computer-based assessment system that was developed to provide a common language for assessing the health status and care needs of frail, elderly, and disabled individuals living in the community. The InterRAI Long Term Care Facility (LTCF) is a standardized, computer-based assessment system for evaluating the needs, strengths, and preferences of elderly and disabled adults in chronic care and nursing home institutional settings.

In British Columbia, Canadian versions of the InterRAI HC system (Minimum Data Set Home Care (MDS-HC)) and the InterRAI LTCF system (MDS 2.0) have been mandated by the B.C. Ministry of Health for use in all home and community care and residential care settings, respectively. InterRAI patient assessments must occur within a standardized timeframe. In home and community care settings, full MDS-HC patient assessments should be conducted annually. In residential care settings, full MDS 2.0 patient assessments should be conducted within 14 days of admission to a facility, annually, or whenever there is significant clinical change.

Patient information collected using MDS-HC and MDS 2.0 includes:

- Cognitive patterns
- Communication/hearing patterns
- Vision patterns
- Mood and behaviour patterns
- Social functioning
- Physical functioning
- Continence
- Disease diagnosis
- Health conditions
- Nutrition/hydration status
- Dental status (home care only)
- Skin condition
- Environmental assessment (home care only)
- Service utilization (home care only)
- Medications
- Activity pursuit patterns (residential care only)
- Special treatments and procedures (residential care only)

In general, healthcare staff with a clinical background have the ability to conduct MDS-HC and MDS 2.0 assessments. Examples of healthcare occupations that may assess patients include: licensed practical nurses, registered practical nurses, registered nurses, occupational therapists, home care case managers and social workers.

Clinical Assessment Protocols (CAPs)

Once a patient assessment has been completed, MDS-HC and MDS 2.0 will refer healthcare staff to Clinical Assessment Protocols (CAPs) which are a clinical application of the InterRAI assessment.

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CAPs are designed to assist the healthcare staff to systematically interpret all the information recorded on an assessment. The CAP will identify areas of clinical need (i.e. chronic pain) for the patient and assist the clinical care team in developing individualized care plans.

**Behaviour CAP**

The Behaviour CAP is produced by InterRAI when patients display troubling behaviours in the following areas on a daily basis:

- Wandering
- Verbal abuse
- Physical abuse
- Socially inappropriate or disruptive behaviour
- Resisting care

Information in the Behaviour CAP is based on observations recorded in Section E: Mood and Behaviour Patterns of the long term care and home and community care based InterRAI assessments. Please refer to Section E from MDS 2.0 and MDS HC on Pages 15 and 16 of this document.

The Behaviour CAP provides guidelines on how to characterize the nature of the behavioural disturbance and identify the factors causing or aggravating the behaviour. Examples of questions and recommendations in the Behaviour CAP include:

- Is the person receiving a new medication or has there been a change in dosage? Review the length of time from the change to the onset or worsening of behavioural symptoms.
- Does the person have a long-standing mental health problem possibly associated with the behavioural disturbances? A detailed psychiatric evaluation and a physician-directed plan of care are required when these conditions may be contributing to disruptive behaviour.6

**Outcome Scales**

Embedded within each InterRAI assessment system are various scales and indices that can be used to evaluate client status over time. Examples of the outcome scales include the Depression Rating Scale, Pain Scale, and Index of Social Engagement. InterRAI has recently developed the Aggressive Behaviour Scale (ABS). The ABS is scored from 0 to 12, with a higher score indicating greater frequency and intensity of aggressive behaviour. This is not yet implemented in BC, but may be in the future.

Once the CAPs and Outcome Scales are provided to healthcare staff, the information should be reviewed by a clinician and used with other clinical assessments to document aggressive behaviour and assist healthcare staff with informed clinical decision making when developing care plans for patients.

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6 CIHI, 2008. *interRAI Clinical Assessment Protocols (CAPS) - For Use With interRAI's Community and Long-Term Care Assessment Instruments*, March 2008 Ottawa: CIHI.
### Minimum Data Set (MDS) 2.0 Canadian Version (Long Term Care) – Section E: Mood and Behaviour Patterns

#### INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

<table>
<thead>
<tr>
<th>Code for indicators observed in LAST 30 DAYS, irrespective of the assumed cause.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Indicator not exhibited in last 30 days</td>
</tr>
<tr>
<td>1. Indicator of this type exhibited up to 5 days a week</td>
</tr>
<tr>
<td>2. Indicator of this type exhibited daily or almost daily (≥ 7 days)</td>
</tr>
</tbody>
</table>

**VERBAL EXPRESSIONS OF DISTRESS**

- a. Resident makes negative statements (e.g., "Nothing matters; Would rather be dead; What’s the use; Regrets having lived so long; Let me die.") *  
- b. Repetitive questions (e.g., “Where do I go? What do I do?”)  
- c. Repetitive verbalizations (e.g., Calling out for help; “God help me.”)  
- d. Persistent anger with self or others (e.g., easily annoyed, anger at placement in facility, anger at care received)  
- e. Self depreciation (e.g., “I am nothing, of no use to anyone.”)  
- f. Expressions of what appear to be unrealistic fears (e.g., fear of being abandoned, left alone, being with others)  
- g. Recurrent statements that something terrible is about to happen (e.g., believes is about to die, have a heart attack)  
- h. Repetitive health complaints (e.g., persistently seeks medical attention, obsessive concern with body functions)  
- i. Repetitive anxious complaints or concerns—non health (e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, relationship issues)  

**SLEEP-CYCLE ISSUES**

- i. Unpleasant mood in morning  
- k. Insomnia or change in usual sleep pattern

**SAD, APATHETIC, ANXIOUS APPEARANCE**

- 1. Sad, pained, worried facial expressions (e.g., furrowed brows)  
- m. Crying, tearfulness  
- n. Repetitive physical movements (e.g., pacing, hand wringing, restlessness, fidgeting, picking) *

**LOSS OF INTEREST**

- o. Withdrawal from activities of interest (e.g., no interest in longstanding activities or being with family, friends) *  
- p. Reduced social interaction *

**MOOD PERSISTENCE**

- One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to “cheer up”, console, or reassure
  - the resident in LAST 7 DAYS.  
- 0. No mood indicators  
- 1. Indicators present, easily altered  
- 2. Indicators present, not easily altered

**CHANGE IN MOOD**

- Resident’s mood status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).  
- 0. No change  
- 1. Improved  
- 2. Deteriorated

**BEHAVIOURAL SYMPTOMS**

- (Code for behaviour in LAST 7 DAYS.)  
- A. Behavioural symptom frequency in last 7 days  
- 0. Behaviour not exhibited in last 7 days  
- 1. Behaviour of this type occurred on 1 to 3 days in last 7 days  
- 2. Behaviour of this type occurred 4 to 6 days, but less than daily  
- 3. Behaviour of this type occurred daily  
- B. Behavioural symptom alterability in last 7 days  
- 0. Behaviour not present—OR—behaviour was easily altered  
- 1. Behaviour was not easily altered

| a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) |
| b. VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS (others were threatened, screamed at, cursed at) |
| c. PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) |
| d. SOCIALLY INAPPROPRIATE or DISRUPTIVE BEHAVIOURAL SYMPTOMS (made disruptive sounds, noises, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others’ belongings) |
| e. RESISTS CARE (resisted taking meds or injections, ADL assistance, or eating) |

**CHANGE IN BEHAVIOURAL SYMPTOMS**

- Resident’s behavioural status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).
- 0. No change  
- 1. Improved  
- 2. Deteriorated

---

7 Canadian Institute for Health Information, 2002. Minimum Data Set (MDS) 2.0 Canadian Version MDS 2.0 Form. Ottawa: CIHI.
### Minimum Data Set (MDS) Home Care (MDS-HC)® Canadian Version – Section E: Mood and Behaviour Patterns

<table>
<thead>
<tr>
<th>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</th>
<th>(Code for observed indicators irrespective of the assumed cause)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Indicator not exhibited in last 3 days</td>
<td></td>
</tr>
<tr>
<td>1. Exhibited 1–2 of last 3 days</td>
<td></td>
</tr>
<tr>
<td>2. Exhibited on each of last 3 days</td>
<td></td>
</tr>
<tr>
<td>a. A FEELING OF SADNESS OR BEING DEPRESSED,</td>
<td></td>
</tr>
<tr>
<td>that life is not worth living, that nothing</td>
<td></td>
</tr>
<tr>
<td>matters, that he or she is of no use to</td>
<td></td>
</tr>
<tr>
<td>anyone or would rather be dead</td>
<td></td>
</tr>
<tr>
<td>b. PERSISTENT ANGER WITH SELF OR OTHERS—e.g.</td>
<td></td>
</tr>
<tr>
<td>easily annoyed, anger at care received</td>
<td></td>
</tr>
<tr>
<td>c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS—e.g.</td>
<td></td>
</tr>
<tr>
<td>fear of being abandoned, left alone, being</td>
<td></td>
</tr>
<tr>
<td>with others</td>
<td></td>
</tr>
<tr>
<td>d. REPETITIVE HEALTH COMPLAINTS—e.g.</td>
<td></td>
</tr>
<tr>
<td>persistently seeks medical attention,</td>
<td></td>
</tr>
<tr>
<td>obsessive concern with body functions</td>
<td></td>
</tr>
<tr>
<td>e. REPETITIVE ANXIOUS COMPLAINTS, CONCERNS—e.g.</td>
<td>Repetitive seeks</td>
</tr>
<tr>
<td>attention/reassurance regarding schedules,</td>
<td></td>
</tr>
<tr>
<td>meals, laundry, clothing, relationship</td>
<td></td>
</tr>
<tr>
<td>issues</td>
<td></td>
</tr>
<tr>
<td>f. SAD, PAIRED, WORRIED FACIAL EXPRESSIONS—e.g.</td>
<td></td>
</tr>
<tr>
<td>frowning brows</td>
<td></td>
</tr>
<tr>
<td>g. RECURRENT CRYING, TEARFULNESS</td>
<td></td>
</tr>
<tr>
<td>h. WITHDRAWAL FROM ACTIVITIES OF INTEREST—e.g.</td>
<td>No interest in long</td>
</tr>
<tr>
<td>standing activities or being with family/friends</td>
<td></td>
</tr>
<tr>
<td>i. REDUCED SOCIAL INTERACTION</td>
<td></td>
</tr>
<tr>
<td>Mood indicators have become worse as</td>
<td></td>
</tr>
<tr>
<td>compared to status of 90 days ago (or since</td>
<td></td>
</tr>
<tr>
<td>last assessment if less than 90 days)</td>
<td>0. No 1. Yes</td>
</tr>
<tr>
<td>BEHAVIOURAL SYMPTOMS</td>
<td></td>
</tr>
<tr>
<td>Instances when client exhibited behavioural</td>
<td></td>
</tr>
<tr>
<td>symptoms. If EXHIBITED, ease of altering the</td>
<td></td>
</tr>
<tr>
<td>symptom when it occurred.</td>
<td></td>
</tr>
<tr>
<td>0. Did not occur in last 3 days</td>
<td></td>
</tr>
<tr>
<td>1. Occurred, easily altered</td>
<td></td>
</tr>
<tr>
<td>2. Occurred, not easily altered</td>
<td></td>
</tr>
<tr>
<td>a. WANDERING—Moved with no rational</td>
<td></td>
</tr>
<tr>
<td>purpose, seemingly oblivious to needs or</td>
<td></td>
</tr>
<tr>
<td>safety</td>
<td></td>
</tr>
<tr>
<td>b. VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS—Threatened, screamed at, cursed at others</td>
<td></td>
</tr>
<tr>
<td>c. PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS—Hit, shoved, scratched, sexually abused others</td>
<td></td>
</tr>
<tr>
<td>d. SOCIALLY INAPPROPRIATE/ DISRUPTIVE BEHAVIOURAL SYMPTOMS—Disruptive sounds, noises, screaming, self-abusive acts, sexual behaviour or disrobing in public, smears/ throws food/feces, rummaging, repetitive behaviour, rises early and causes disruption</td>
<td></td>
</tr>
<tr>
<td>e. RESISTS CARE—Resisted taking medicines/ injections, ADL assistance, eating, or changes in position</td>
<td></td>
</tr>
</tbody>
</table>

### Changes in Behavioural Symptoms

Behavioural symptoms have become worse or are less well tolerated by family as compared to 90 DAYS AGO (or since last assessment if less than 90 days)

0. No, no change in behavioural symptoms or acceptance by family
1. Yes

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Behaviour Observation Sheet (BOS)

The BOS was developed for use in long term care facilities by the Violence Prevention Advisory Group (VPAG), which is a sub-group of the PVPSC. The form has not yet been piloted or implemented, and should be considered a draft proposal.

The purpose of the BOS, which can be found on pages 21-22 of this document, is to assist healthcare workers in:

- Reporting chronic anxious, aggressive, or violent patient behaviour;
- Incorporating documentation of violence indicators into clinical practice; and
- Linking violent behaviour reporting with control measures.

The BOS allows a healthcare worker to chart the less serious or repeated behaviours that would otherwise go unreported, and to identify any escalation that precedes a potential violent incident. The intent behind the behaviour documentation process is to incorporate the information collected when there is a violent event or change in behaviour into the care plan review process so that preventative measures may be included in the care plan. The behaviour documentation process is meant to complement existing reporting forms/processes and may be adapted for each healthcare setting.

Who reports patient behaviours

One of the unique features of the BOS is that any worker within a facility can report patient behaviours, even non-clinical staff. In many organizations, only those with the authority to chart patient behaviour have an impact on clinical practices or care plans. However, anyone working in the organization could observe clinically relevant behaviour, even those without clinical charting authority.

The BOS is intended for use by any individual working in a healthcare facility, including clinical staff. Examples of individuals that may use the BOS include: housekeeping staff, laboratory personnel, physiotherapists, nurses, care aides, activity aides, food service staff, and maintenance staff. The power of this behaviour reporting process is to make use of everyone’s observations to help prevent future violent incidents.

Follow-up for the BOS

The main goal of the BOS process is to identify trends and patterns in behaviour and incorporate this information into the existing care plan review process. The care plan can then be updated to reflect changing needs, flag physical or mental causes of behaviour, and implement preventative changes in provision of care or other violence prevention control methods. This will involve reviewing the BOS, updating care plans, and communicating changes.

Any aggressive or violent incident should be communicated to the healthcare workers on the next shift. This could be accomplished during the shift change or report.

A diagram illustrating the overall process for using the BOS is below in Figure 1.
The individual reviewing the behaviour observation sheets should be someone within the organization or department who has the expertise and authority to make changes to care plans, influence clinical practice, and is ultimately accountable for implementing the change and communicating it to workers. This individual can adapt the care plan or other aspects of care to reduce exposure to violence, notify workers of increasing risk, and request any additional controls. It may be that on reviewing the report
of a more serious incident, the lead clinician initiates a formal incident reporting and investigation process.

**Reviewing the BOS**

The process for summarizing the BOS and identifying potential underlying causes for change in a patient’s behaviour is described in detail in Appendix A. Once a BOS has been completed, the person responsible for reviewing it should assess the information on the BOS for indications of potentially violent behaviour. The Behaviour Observation Summary Sheet in Appendix A may be used to summarize the information collected in each BOS and help identify common events or triggers associated with repeated behaviours.

To identify potential underlying causes of violent patient behaviour, it is recommended that the supervising clinician:

1. Characterize the nature of the behavioural symptoms. Assume that the behaviours may be a method of communicating the presence of existing or new health problems, discomfort, an unmet need, or fears.

2. Try to identify the factors that may be causing the behaviour or making the behaviour worse. Disruptive behaviours may be addressed through changes in patient care. Examples of factors that may be considered when determining what may be contributing to the behaviour include: the patient’s physical health, the patient’s mental health, and medication side effects.

Appendix C describes several factors that may be contributing to changes in a patient’s behaviour. It is recommended that each factor be considered one by one in the context of the patient and the behaviour to identify the causal factor. Once the factors have been identified, all care providers should be consulted to develop a modified care plan to address the underlying factor.

After review, it is key for the supervising clinician to communicate back to the worker who reported the behaviour; ideally this will include recognition and appreciation for reporting and a description of what steps are being taken to address the behaviour.

**Adapting the BOS**

The “Type of Behaviour” section on the BOS lists a cross-section of the different types of behaviour a patient may exhibit; it is not meant to be inclusive and will not apply to every patient in every healthcare setting. The types of aggressive behaviours listed should be tailored for the patient that is being observed. Please refer to the bank of example expressions and behaviours in Appendix B that can be incorporated into the BOS.

An intensity scale may be added to the BOS under the “Type of Behaviour” section as a method of capturing any changes in intensity or frequency of different behaviours. The intensity is a measure of a person’s judgment on the amount of force or emotion involved in the behaviour. Please note that this scale may not be applicable in situations where individuals making observations may not have regular contact with the patients. Please refer to the example of an intensity scale below:

<table>
<thead>
<tr>
<th>Overall Intensity (circle the number that best matches the intensity of the behaviour):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low 1 2 3 4 5 6 7 8 9 10 High</td>
</tr>
</tbody>
</table>
A section that allows the observer to record who or what the behaviour was directed towards may be added under “Type of Behaviour”. An example of the format for this section is below:

<table>
<thead>
<tr>
<th>Who or what was the behaviour directed towards?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ The patient – please describe the area of self-harm e.g. the patient’s right elbow, the top of the patient’s head, the right side of the patient’s jaw.</td>
</tr>
<tr>
<td>□ Other patient(s) – please provide a description of the patient(s) or list their name(s):</td>
</tr>
<tr>
<td>□ Care giver(s) – please provide a description of the care giver or list their name(s):</td>
</tr>
<tr>
<td>□ Visitor(s) – please provide a description of the visitor(s) or list their name(s):</td>
</tr>
<tr>
<td>□ Object – please describe (e.g. bathroom door, wheelchair):</td>
</tr>
</tbody>
</table>

The “Triggers, events” section on the BOS lists potential events, environmental factors or activities that may be associated with a patient’s behaviour. This list of triggers or events may be modified to suit the facility or organization, or for specific patients in care settings where care providers interact with the patient on a regular basis. Please refer to Appendix B for more examples of triggers and events.

The “Follow-up” section on the BOS outlines various resources and actions that the supervising clinician may take in response to changes in a patient’s behaviour. This list should be tailored to include resources available to the organization or facility. Please refer to Appendix B for examples of follow-up actions that may be included on the BOS.
**Behaviour Observation Sheet (Long Term Care)**

RESIDENT NAME:____________________________________________    Date:  __ __/__ __/__ __ __ __   Time:  __ __:__ __

Your Initials:    ___________              dd/  mm  / yyyy       hh:mm

Location:  □ resident’s room   □ dining room   □ activity room other: ____________________________________________

<table>
<thead>
<tr>
<th>Type of Behaviour</th>
<th>Triggers, events</th>
<th>How did you react?</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>(check all that apply)</td>
<td>(check all that apply)</td>
<td>Was this effective?</td>
<td>(to be filled in by supervising clinician)</td>
</tr>
<tr>
<td>□ Pacing</td>
<td>□ Wringing hands</td>
<td>□ Feeding</td>
<td>Name of follow-up : ________________</td>
</tr>
<tr>
<td>□ Fist-clenching</td>
<td>□ Mumbling to self</td>
<td>□ Bathing</td>
<td>Follow-up review date:__ <strong>/</strong> <strong>/</strong> __ __ __</td>
</tr>
<tr>
<td>□ Staff-seeking</td>
<td>□ Repetitive noises/questions</td>
<td>□ Toileting</td>
<td>dd/  mm  / yyyy</td>
</tr>
<tr>
<td>□ Crying</td>
<td>□ Racist remarks</td>
<td>□ Dressing</td>
<td>Available resources/actions to consider:</td>
</tr>
<tr>
<td>□ Swearing</td>
<td>□ Sexual remarks</td>
<td>□ Family visiting</td>
<td>□ Alert placed on patient file</td>
</tr>
<tr>
<td>□ Screaming</td>
<td>□ Threatening gestures</td>
<td>Please describe family members or list names:</td>
<td>□ Geriatrics specialist consult</td>
</tr>
<tr>
<td>□ Grabbing</td>
<td>□ Strike objects</td>
<td>□ Animals visiting</td>
<td>□ Acquired brain injury specialist consult</td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td>□ Other:</td>
<td>□ Refer to special care unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Cognitive-behavioral specialist consult</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Psychiatry consult</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Other: ________________</td>
</tr>
</tbody>
</table>

Comments:

For incidents that cause injury (or have potential to cause injury) please report to a nurse AND your supervisor and complete formal incident report forms in writing.
### Behaviour Observation Sheet (Home and Community Care)

**CLIENT NAME:** ________________________________  
**Date:** __ __/ __/ __ __ __  
**Time:** __ __:__ __  
**Your Initials:** ___________  
**Location:**  
- □ client’s room  
- □ dining room  
- □ living room  
- □ bathroom  
- □ kitchen  
- □ other: ____________________________________

#### Type of Behaviour  
(check all that apply)

- □ Pacing  
- □ Fist-clenching  
- □ Staff-seeking  
- □ Crying  
- □ Swearing  
- □ Screaming  
- □ Grabbing  
- □ Scratching  
- □ Pinch  
- □ Other:

#### Triggers, events  
(check all that apply)

- □ Pacing  
- □ Wringing hands  
- □ Fist-clenching  
- □ Mumbling to self  
- □ Staff-seeking  
- □ Repetitive noises/questions  
- □ Crying  
- □ Racist remarks  
- □ Swearing  
- □ Sexual remarks  
- □ Screaming  
- □ Threatening gestures  
- □ Grabbing  
- □ Strike objects  
- □ Scratching  
- □ Slapping  
- □ Pinch  
- □ Throwing objects  

#### How did you react?  

**Was this effective?**

#### Follow-up  
(to be filled in by supervising clinician)

**Name of follow-up:** ________________

**Follow-up review date:** __ __/ __/ __ __ __

**dd/ mm / yyyy**

**Available resources to consider:**

- □ Alert placed on patient file
- □ Geriatrics specialist consult
- □ Acquired brain injury specialist consult
- □ Refer to special care unit
- □ Cognitive-behavioral specialist consult
- □ Psychiatry consult
- □ Other: _______________________

**Follow up with worker needed?**

---

**Comments:**

---

*For incidents that cause injury (or have potential to cause injury) please report to a nurse AND your supervisor and complete formal incident report forms in writing.*
**Behaviour Observation Sheet Instructions**

The purpose of this sheet is to assist healthcare workers in documenting and identifying changes in behaviour to allow for preventative efforts that can avert a violent incident.

1) Fill in the patient’s name and your initials.

2) Indicate the date (day/month/year) and the time (using 24 hour clock) the behaviour took place.

3) Identify the location of the behaviour.

4) Indicate the type of anxious/aggressive/violent behaviour observed.
   NOTE: If the behaviour causes injury (or has potential to cause injury) contact your supervisor and make a formal written incident report according to your organization’s procedures.

This section can be tailored to reflect the types of behaviour that would be the most common for the patient.

5) Describe triggers that may have contributed to the patient’s behaviour and any events or conditions that were occurring at the time.
   These could be activity-related triggers such as feeding, lifting, repositioning, dressing, transporting, bathing, grooming, waking, toileting, redirecting, or visits from family.
   These could be environmental triggers such as noise, lighting, temperature, smells, food, different/rigid routine, or a new environment.
   These could also be any other triggers that you feel contributed to the behaviour or are relevant.

This section can be tailored to reflect the triggers or events that would be the most common for the patient or the patient’s environment.

6) Record the actions you took in response to the patient’s behaviour (e.g. moved patient to a quieter spot, discontinued care until more calm), and whether these actions were effective. This can help with developing preventative strategies.

7) Comments: any additional information can be recorded in the comments box, including details about the incident (e.g. quote directly what the patient said, describe who the behaviour was directed towards or who was around when the behaviour occurred, or include more detailed observations about the patient’s behaviour), insight into the causes (e.g. change in medication), or suggestions on how to prevent escalation or repeated behaviours.

8) The follow up column is for the lead clinician to fill in when reviewing reports.
Appendix A – Behaviour Observation Summary Sheet

<table>
<thead>
<tr>
<th>When was the behaviour observed?</th>
<th>What behaviours were observed?</th>
<th>Who was present? Was the behaviour directed at anyone/anything?</th>
<th>Where did the behaviour occur?</th>
<th>What happened before or while the behaviour occurred?</th>
<th>What interventions were used? What was the follow-up to the behaviour report?</th>
<th>What was the outcome? Any recommendations for future care plan changes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date (dd/mm/yy):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time (hh:mm):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date (dd/mm/yy):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time (hh:mm):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date (dd/mm/yy):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time (hh:mm):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

9 Adapted from the Fraser Health REAB Program Behaviour Pattern Record form.
Instructions for Behaviour Observation Summary Sheet:

1. Transfer the information collected on each Behaviour Observation Sheet onto one row of the Behaviour Observation Summary Sheet.

2. Look through the column describing the patient’s behaviour and look for reoccurring behaviours. If no reoccurring behaviours are present, continue to collect behaviour observation sheets until more repeating behaviours are reported.

3. Try to identify trends in events/triggers that took place when the patient exhibited reoccurring behaviours by comparing: who was present, where the behaviour took place, time of day, day of the week/month, and what events were happening before or while the behaviour was occurring. If no common events/triggers can be identified, continue to collect behaviour observation sheets until more repeating behaviours are reported.

4. Once trends in the patient’s behaviour or a patient’s behaviour triggers have been identified, consult Appendix C for recommendations on how to identify and address potential underlying causes of potentially violent patient behaviour.

5. Consult with the healthcare providers that work with the patient to brainstorm ideas on how to modify the care plan to address ways to prevent triggering the patient.

If information recorded on any behaviour observation sheet indicates an increase in frequency of a patient’s behaviours or that the patient’s behaviour is potentially violent, please refer to Appendix C for recommendations on how to identify and address potential underlying causes of potentially violent patient behaviour.
Appendix B - Bank of Expressions/Behaviours, Example Triggers and Events\textsuperscript{10}, and Follow-Up Actions for the BOS

There are several different types of expressions or behaviours that a patient may have. Below are lists of expressions and behaviours that may be selected to personalize the BOS for the patient that is being observed.

**Expressions**
- Negative statements e.g. “Nothing matters.”; “I would rather be dead.”; “What’s the use?”; patient regrets having lived so long – “Let me die.”
- Repetitive questions e.g. “Where do I go?”; “What do I do?”
- Repetitive expressions e.g. Calling out for help – “God help me.”
- Persistent anger with self or others e.g. easily annoyed, anger at care received
- Self-depreciating statements e.g. “I am nothing.” “I am no use to anyone.”
- Expressions of unrealistic fears e.g. fear of being abandoned, left alone, or being with others.
- Repetitive statements that something terrible is about to happen e.g. patient believes he/she is about to die, have a heart attack.
- Repetitive health complaints e.g. persistently seeks medical attention, obsessive concern with body functions.
- Repetitive non-health related complaints or concerns e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, or relationship issues.
- Sad, pained, worried facial expressions e.g. furrowed eyebrows
- Crying, tearfulness

**Behaviour**
- Repetitive physical movements e.g. pacing, hand wringing, restlessness, fidgeting, picking.
- Withdrawal from activities of interest e.g. no interest in longstanding activities or being with family and friends.
- Reduced social interaction.
- Wandering – moving with no rational purpose, seems oblivious to needs or safety.
- Verbally abusive behaviour e.g. threatening, screaming, swearing, racist remarks, sexual remarks.
- Physically abusive behaviour e.g. hitting, biting, kicking, slapping, shoving, scratching, pinching, grabbing, spitting, throwing objects, striking objects, sexual abuse.
- Socially inappropriate or disruptive behaviour e.g. making disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour, disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others’ belongings.
- Resists care e.g. resists taking medication, injections, assisted daily living (ADL) activities, eating.

**Example Triggers/Events**
- **Activities**: feeding, lifting, repositioning, dressing, transporting, bathing, grooming, waking, toileting, redirecting, or visits from family/pets.

\textsuperscript{10} Canadian Institute for Health Information, 2002. Minimum Data Set (MDS) 2.0 Canadian Version MDS 2.0 Form. Ottawa: CIHI.
- **Environmental triggers**: noise (e.g. background music, television), lighting (e.g. too dark or bright), temperature, weather, smells, food, different/rigid routine, a new environment, time of day, time of the year (e.g. patient’s birthday, Christmas, Mother’s Day etc.), change in patient’s caregiver, caregiver’s characteristics (e.g. gender, ethnicity), change in service provided to patient, presence of family members, visitors, or fellow patients.
- **Other triggers**: difficulty communicating, medication side effects, change in the patient’s physical health, change in the patient’s mental health.

**Example Follow Up Actions**
- Alert placed on patient file.
- Geriatrics specialist consult.
- Acquired brain injury specialist consult.
- Refer to special care unit.
- Cognitive-behavioral specialist consult.
- Psychiatry consult for mental health assessment.
- Assess patient’s physical health for conditions such as constipation, urinary tract infections, dehydration, visual/hearing impairment.
- Assess patient to determine if he/she is in pain.
- Request physician review of patient’s medication.
- Assess patient for cognitive loss related conditions e.g. dementia, Alzheimer’s disease, delirium.
- Consult with patient’s family to determine patient’s history, usual behaviour i.e. personality, daily routine, habits.
Appendix C - Recommendations on How to Identify Potential Underlying Causes of Potentially Violent Patient Behaviour\textsuperscript{11}

To identify potential underlying causes of potentially violent patient behaviour, the following approach is recommended:

1) Characterize the nature of the behavioural symptoms. Assume that the behaviours may be a method of communicating the presence of existing or new health problems, discomfort, an unmet need or fears.
   - If the person is able to communicate, ask him/her directly about their view of the situation.
     - Does the person have an explanation for their behaviour? Was he/she aware of the consequences of their actions?
   - Evaluate what was happening when the behaviour occurred by considering:
     - If the person was provoked.
     - If the behaviour was directed at someone else or defensive.
     - If the behaviour had a purpose or if it was a reflexive response.
     - If the behaviour was intended to be harmful.
     - Who was near the person and who was involved with the person.
     - Any pattern when the behaviour occurred i.e. during specific activities or certain times of the day.
     - The person’s environment.
     - If the behaviour was related to the person’s hearing or vision impairment.

2) Try to identify the factors that may be causing the behaviour or making the behaviour worse. Disruptive behaviours may be addressed through changes in patient care. Examples of factors that may be considered when determining what may be contributing to the behaviour include:
   - The patient’s mental health condition. Schizophrenia, bipolar disorder, depression, anxiety disorder, and post traumatic stress disorder may be associated with behavioural disturbances - this list is not comprehensive. If the patient’s mental health condition may be contributing to changes in his/her behaviour, consider requesting that the patient undergo a detailed psychiatric evaluation to assess the patient’s mental health and determine which treatments may be effective.
   - The patient’s cognitive state. The patient’s behaviour may be associated with cognitive loss due to delirium, dementia, Alzheimer’s disease, or a stroke. Consider assessing the patient for health conditions that may result in a decline in his/her cognitive performance. Try to determine the basis for the patient’s behaviour by considering:
     - Whether the patient is trying to communicate an unmet need or discomfort that he/she cannot verbalize e.g. the person is wandering because he/she feels the urge to urinate but is too disoriented to find a bathroom.
     - Whether the patient is misinterpreting the environment or actions of others e.g. a person with memory loss may think that a housekeeper that is straightening up the room and picking up clothing is a thief.
   - The patient’s physical health. The patient may have a new or acute physical health problem or flare-up of a chronic condition that may be causing the behaviour. Examples of conditions

\textsuperscript{11} CIHI, 2008. interRAI Clinical Assessment Protocols (CAPS) - For Use With interRAI’s Community and Long-Term Care Assessment Instruments, March 2008 Ottawa: CIHI.
that can cause behaviour disturbances include: infection (e.g. urinary tract infection), dehydration, constipation, chronic pain, and congestive heart failure. Assess the patient’s physical health for potential underlying health conditions that may be causing his/her behaviour. For example, if the person is visually impaired, they may be startled by individuals appearing in their field of vision unexpectedly. Try to determine if anything is interfering with the patient’s ability to get enough sleep. If the patient is receiving some form of pain management therapy, review it to determine it is effective (i.e. dosage, type of medication, frequency of administration).

**Medication side effects.** Change in dose or type of medication could result in changes in behaviour. Review the length of time between the change in medication type/dose and the onset/worsening of the patient’s behaviour to determine whether the medication is affecting the patient’s behaviour. Common medications with side effects that may lead to changes in behaviour include:

- Antiparkinsonian drugs which can cause hyper-sexuality and socially inappropriate behaviour.
- Some sedatives, centrally active antihypertensives, cardiac drugs, anticholinergic agents can cause paranoid delusions, induce delirium symptoms or cause reversible cognitive damage.
- Drugs used to treat respiratory problems, such as bronchodilators, can increase agitation and cause difficulty sleeping.
- Excessive nicotine and caffeine can increase agitation and cause difficulty sleeping.

**Family member and caregiver interaction with patient.** The actions and responses of family members and caregivers may affect the patient’s behaviour; they need to be aware of the person’s level of cognitive patterns and physical functioning. Actions that may assist individuals provide care to the patient include:

- Dividing larger tasks into a string of small activities the patient can perform.
- Providing the patient with cues, reminders and reassurance to help the person make sense of what is happening.
- Communicating with patient by using simple statements/questions and allowing time for the patient to respond to them.
- Identifying which family members, other patients, or staff the patient appears to have an interpersonal conflict with and modifying the patient’s care plan to manage the patient’s interaction with individuals the patient conflicts with.

3) Once a specific cause has been identified as the probable explanation, work with all care professionals to establish a remedial plan of care. A list of general care planning tips for managing violence is included in Appendix D as a general reference.
Appendix D – Care Planning Tips for Managing Violence

Below is a list of general suggestions on ways to manage violence when providing care to patients:

- Consider changing the process used to provide care i.e. bathing an individual in bed instead of assisting them in the shower.

- Provide the patient with energy boost by feeding them before an activity, especially late at night or early in the morning.

- Determine what the patient likes – try to incorporate their interests or favourite activities when providing care to the patient i.e. giving the patient their favourite book to read while brushing their hair.

- If possible, ensure you are a safe distance from the patient (one leg length) while determining if it is a safe time to provide care.

- Do not touch the patient until you feel it is safe and only do so to provide care.

- Provide physical care when the patient is willing to accept it safely – if the patient is already agitated or frustrated, leave and provide care at a later time when the patient appears calm.

- Do not isolate yourself with the patient – try to have another co-worker assist you or at a minimum have a co-worker check on you.

- Consider the use of plastic utensils, paper plates and styrofoam cups to limit the availability of sharp or breakable objects.

- If possible, search the patient’s room on a regular basis and remove any sharps or other potentially dangerous items.

- If you are uncomfortable with the situation, leave and request a co-worker to assist the patient or inform the patient when you will return and then return at that time.

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