

## BEHAVIOR MONITORING RECORD

**NAME:** \_\_\_\_\_

**Mo./Yr.**

**MEDICATION ORDER** (Chart ONLY episodes that occur on your shift **DO NOT CHART "0"**):

**JUSTIFYING DIAGNOSIS:**

**TARGETED BEHAVIOR #1:**

#1	Hr.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Noc																																
	Day																																
	PM																																

**TARGETED BEHAVIOR #2:**

#2	Noc																															
	Day																															
	PM																															

**TARGETED BEHAVIOR #3:**

#3	Noc																															
	Day																															
	PM																															

**TARGETED BEHAVIOR #4:**

#4	Noc																															
	Day																															
	PM																															

**Care Plan Goals:** \_\_\_\_\_ **Met/Unmet – Explain:** \_\_\_\_\_

**Changes in behavior since last review:**  YES  NO

If yes, explain: \_\_\_\_\_

**ASSESSMENT OUTCOME: Med. change contraindicated:**

- Previous attempts failed.
  - Mental illness/Behavior: stable/maintenance – on current dose.
  - Resident refuses reduction.
- Need for M.D. Review:**  YES  NO
- Frequency of behaviors decreased/increased.
  - PRN use indicates need for M.D. review.
  - Other (explain): \_\_\_\_\_

See nurses' notes for intensity/duration.

**SIDE EFFECTS R/T MED. - ALTERNATIVE INTERVENTIONS**

- |  |   |
|--|---|
| <input type="checkbox"/> None                | <input type="checkbox"/> Comfort (pain, position) |
| <input type="checkbox"/> TD                  | <input type="checkbox"/> Activities               |
| <input type="checkbox"/> Tremors             | <input type="checkbox"/> Redirection (what) _____ |
| <input type="checkbox"/> Increased confusion | <input type="checkbox"/> 1:1 Interactions;        |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Snack                    |
| <input type="checkbox"/> Lethargy            | <input type="checkbox"/> Toileting                |
| <input type="checkbox"/> Other: _____        | <input type="checkbox"/> Touch/Back rub           |
|  | <input type="checkbox"/> Reassurance/emotional    |

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_