Behavior & Sleep Log

And the one page to send with her if she is ever admitted — because everything the unit knows will otherwise come from a chart.

DAY TO DAY DEMENTIA

Why this exists

Agitation, aggression, wandering and broken nights arrive as four separate catastrophes. They are usually one cluster. They come from the same underlying state — pain, exhaustion, constipation, infection, fear, boredom, a need with no words attached — and when one improves the others tend to improve with it.

Nobody can see a cluster from memory. Two weeks of marks on one page turns “she has become aggressive” into a pattern with a time of day, a trigger and a sleep trend attached. That is a different conversation with a doctor, and it is the conversation that gets a physical cause ruled out before anyone reaches for a medication.

> **The single most useful thing on this sheet is the sleep column.** Sleep collapse travels with agitation, and it is frequently the first thing to move when something underneath is treated. A clinician who is treating the agitation without looking at the nights is treating half the problem.

How to use it

- **Page 2** — fourteen days, one line each. A mark is enough; this is not a research study.
- **Page 3** — the incident sheet. Fill one in after something that mattered, while you still remember what came first.
- **Page 4** — the admission kit. Fill it out *before* you need it and keep a copy in your bag.
- Photograph it and send it through the patient portal before an appointment. That gets it into the record.

Rule out the physical first

A behavior that changed suddenly is usually reporting something. Before it gets treated as a behavior, ask that these be checked:

- Pain anywhere — including teeth, joints, back, skin under a brief
- Constipation or impaction — when was the last normal, formed stool?
- Urinary tract infection
- Dehydration
- Any medication started or changed in the last few weeks
- Hearing and vision — batteries, wax, missing glasses
- Sleep — has it collapsed, and when did that start?

Two-Week Behavior & Sleep Log

Name _____ Two weeks beginning _____

DATE	HOURS SLEPT	NIGHT WAKING	AGITATION 0–3	WORST TIME OF DAY	BOWEL MOVEMENT	WHAT HAPPENED — TRIGGER, WHAT HELPED, MEDICATION GIVEN

Agitation: 0 = settled · 1 = restless · 2 = resisting care or calling out · 3 = striking out or unsafe

WHAT CHANGED IN THESE TWO WEEKS

New or changed medication	
New staff, new room, new routine	
Questions for the doctor or nurse	

WHAT TO SAY WHEN YOU CALL

- “This started *[when]* — it is new.”
- “Here are two weeks of nights. Sleep went from *[x]* to *[y]*.”
- “It happens at roughly the same time every day. Here is when.”
- “Can we rule out pain, constipation and a urinary infection before we change medication?”
- “Which of her current medications could be causing this?”

Incident sheet

Fill one in after something that mattered, while you still remember what came first. What comes *before* is where the answer usually is.

Date and time	
Before — what was happening in the ten minutes leading up to it? Who was there, what was being asked of her, noise, light, temperature, how long since she ate, slept, or used the toilet	
What she did — describe it plainly, no labels	
After — what was done, what happened next, how long until she settled	
What helped, and what made it worse	

> **Aggression during personal care is situational.** Being undressed and washed by people she does not recognize, in a cold room, at somebody else's pace, can be experienced as an assault. In an NIH-funded trial, changing *how* the bath was given cut aggression toward caregivers by **56%**, agitation by **62%** and distress by **67%** — and residents got just as clean. Ask whether your unit's staff have been trained in person-centered bathing.

BEFORE ANYONE CALLS IT A BEHAVIOR, TRY CHANGING THE SITUATION

CHANGE	TRIED	WHAT HAPPENED
Different time of day		
One person instead of two		
A different aide — same one each time		
Room warmed first; her kept covered throughout		
Towel bath or wash in sections instead of a shower		
No-rinse products — less water, less noise		
Something in her hands to hold		
Music she knows; talking less; moving slower		
Stopping partway and finishing later		

If she is admitted

> **Ask this before you agree, and ask for it in writing.** Is her bed being held — for how long, at what cost, and what would make you refuse to take her back? Federal transfer and discharge protections apply to Medicare and Medicaid certified *nursing facilities*. Most memory care is licensed as *assisted living* and falls under state law instead. Involuntary discharge has been the leading complaint to long-term care ombudsman programs nationally for seven years running — call yours, free and independent, the day the question comes up.

ASK IN THE MEETING WHERE IT IS PROPOSED

- "Is this unit inside a general hospital, or a freestanding psychiatric hospital?" *(Medicare's 190-day lifetime limit applies only to freestanding psychiatric hospitals.)*
- "What is the expected length of stay, and what has to be true for her to be discharged?"
- "Who is the attending psychiatrist, and how do I reach them directly?"
- "Who tells me when a medication changes, and how quickly?"
- "What are we trying to change, specifically — and when do we try reducing it again?"

THE PAGE TO SEND WITH HER

Name she answers to	
Who she was — work, family, what she was proud of	
What calms her	
What sets her off	
How she shows pain (she may not be able to say)	
What her nights normally look like	
Food, drink, textures — and swallowing	
Glasses, hearing aids, dentures, mobility aid	
Medications stopped in the past, and why	
Who decides — name, relationship, phone, authority held	

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Education and peer support — not medical or legal advice. Admission pathways and assisted living discharge protections vary by state; verify with your state licensing agency and long-term care ombudsman.