ABC behavior event record

Use one record per event. Write what you observed, the support actually provided, and what happened next. Continue on another sheet when needed.

Resident name or approved identifier _____ Facility _____

Event date _____ Shift _____ Entry date and time _____ Record ID _____

Observer name and role _____ Direct observation / Report from _____

Relevant care or behavior plan and date _____

A Before the behavior

_____

_____

What was happening just before? Include task, request, setting, people present and the resident's words. Record possible discomfort as an observation or report, not an assumed cause.

B What the resident did or said

_____

_____

Use actions and exact words. Count occurrences and describe effects on care or safety. Avoid labels such as "manipulative," "aggressive" or "noncompliant" without describing the action.

Event start _____ End _____ Elapsed duration _____ Count _____

C Staff response and what happened afterward

_____

_____

What did each staff member do? What did the resident do next? "Consequence" means what followed, not punishment. Complete actual support time and follow-up on page 2.

Immediate care or safety concern and action _____

_____

Support time and follow up

Complete with the event record. Event duration and actual staff support time are different measures. Record each person's work; do not assume all event time is billable.

Resident identifier _____ Event date _____ Record ID _____

Support actually provided

_____

_____

Staff name and role _____ Task or intervention _____

Support start _____ End _____ Actual minutes _____ Estimated? Yes / No

Second staff name and role _____

Specific task and why two people were needed at the same time _____

_____

Second staff start _____ End _____ Actual minutes _____ Estimated? Yes / No

Overlapping minutes _____ Other concurrent care or service _____

Record routine personal care separately from behavioral support when possible. Do not automatically add overlapping minutes or multiply event duration by staff count. Follow the applicable payer's rules.

Effect on care and next steps

_____

_____

What care was delayed, changed, completed or declined? What remained unmet? Record choices offered, the resident's preference and the plan followed. Respect informed refusal.

Person notified and role _____ Date and time _____ Response _____

_____

Follow-up owner _____ Due _____ Plan review requested? Yes / No

Record authentication

Author name and role _____

Signature _____ Date and time _____

Additional staff and signatures as required _____

Document promptly. If entered later, identify it as a late entry with actual event and entry times. Correct records through your facility's traceable process; do not erase the original or backdate.

Proactive support record

Use this when staff provide planned support even if no target behavior occurs. Do not invent an incident or assume the support prevented a crisis.

Resident identifier _____ Date _____ Shift _____ Record ID _____

Staff name and role _____ Entry date and time _____

Direct observation / Report from _____

Plan goal and support actually provided

_____

_____

Describe the planned support, such as a choice, calm environment, communication aid or scheduled check-in. Identify the relevant plan and do not document only “monitored.”

What was observed

_____

_____

Record the resident’s actions, words, participation and response. If no target behavior was observed, say so and state the observation period or opportunities. Do not claim continuous observation unless it occurred.

Observation period _____ Relevant opportunities _____ Target behavior count _____

Support start _____ End _____ Actual support minutes _____ Estimated? Yes / No

Other staff, simultaneous tasks and overlapping time _____

_____

Care completed or unmet needs and follow up

_____

_____

Person notified and role _____ Date and time _____ Next step _____

Signature _____ Date and time _____

Protect dignity and privacy

Use only necessary identifying details. Keep completed logs in the approved secure record. Share only through authorized channels with authorized recipients. Avoid other residents’ names. Never place completed logs in public blog posts or unapproved AI tools.

Respond to urgent needs first. Never delay care to finish a chart, provoke behavior, withhold essential care or increase distress to produce evidence.

Fictional training example

This is a made-up example, not a resident record. It demonstrates observation and documentation, not a treatment recommendation or a billing determination.

A Before the behavior

At 8:10 a.m., Staff A offered to help Resident X put on a long-sleeved shirt. Resident X was seated. When the sleeve touched the right wrist, Resident X said, “Stop. That hurts.” Staff A directly observed this.

B What the resident did or said

Resident X pulled the right hand away twice and said “Stop” once. Staff paused dressing. No hitting or injury was observed. The actions occurred from approximately 8:10 to 8:11 a.m. Event duration: approximately one minute. The chart does not label the resident as aggressive or infer a motive.

C Staff response and observed outcome

Staff A stopped the task, acknowledged the request and offered to wait or use a loose short-sleeved shirt. Resident X chose the short-sleeved shirt. Staff A helped with dressing after the resident agreed. Dressing was completed at 8:15 a.m.; no further pulling away was observed during that task.

Support time and follow up

Staff A: approximately 8:10-8:12, two minutes pausing, listening and offering choices. Approximately 8:12-8:15, three minutes assisting with dressing. No second staff member and no overlapping service were involved. The one-minute behavior duration is not the same as either staff activity period. This example does not determine what time is payable.

Staff A reported the resident’s statement about wrist pain to the designated nurse at 8:16 a.m. according to the care plan. Nurse directed staff to follow the existing discomfort-reporting protocol and report any change. Follow-up owner: Staff A. Real records must document the actual instructions and actions, not copy this example.

What this does and does not show

The record shows the order of events and the resident’s own pain report. It does not establish a diagnosis, prove that the sleeve caused pain or show a recurring pattern. Compare repeated observations, including times the same task goes smoothly, and seek appropriate clinical review. Record the resident’s choice without treating refusal itself as a symptom.

Using this template for review

Objective records help the state and the MCO compare assessed needs with actual care, evaluate support intensity, review response to interventions and check whether authorized services were delivered. A chart alone does not establish eligibility, justify every billed minute or guarantee approval.

This is an optional facility tool, not an official or universally required state ABC form. Follow current program, payer, contract and facility requirements. Add required fields, including secure client identifiers, when applicable. Keep the example separate from live records.

Source: Washington HCA Community Behavioral Health Support Services Billing Guide, effective September 1, 2026, documentation requirements. https://www.hca.wa.gov/assets/billers-and-providers/cbhs-bg-20260901.pdf