KEY STEPS IN ADDRESSING BEHAVIOR AND PSYCHIATRIC SYMPTOMS AND RELATED MEDICATIONS

CARE PROCESS STEP	EXPECTATIONS
RECOGNITION / ASSESSMENT	
1. Identify behavior, including behavior changes, in a timely fashion	- Within 24 hours of identifying the onset of, or significant change (e.g., more frequent or intense) in behavior, mood, thinking, or level of consciousness, or identifying someone who is currently receiving medical treatment for a behavior issue or a psychiatric disorder, start an in-depth evaluation of mood, cognition, function, and behavior. - Review significant symptoms with a practitioner and request practitioner involvement as early as needed, especially in more complex or challenging cases. - Identify urgent situations requiring more rapid assessment and intervention.
2. Describe behavior in enough detail (new admission or existing resident / patient) to enable correct cause identification and management	- Describe an individual's mood, cognition, function, and behavior in detail, including: - when it began, what happened (in sequence), who it affected, the intensity (severity) of behavior, frequency (how often it occurred), duration (how long it continued) and what happened over time, its consequences (including impact on self and others) - related items including appearance, thought content, attention, and level of consciousness (e.g., mental status examination) - content of any hallucinations and delusions - impact on resident's quality of life and function. - Use a consistent approach and vocabulary to identify and describe behavior. - All symptoms must be described in some detail, instead of by a single word such as "agitated" or "combative." For example, "motor restlessness" may indicate very different causes such as major medication side effects, pain, or anxiety. - Identify factors that are known to influence behavior, including situational and environmental factors, previous inclinations and behavior patterns, interventions that have worked previously, and customary routine.
3. Discuss and document why behavior is considered to be significant enough to need an intervention	- Discuss and document why a behavior is considered problematic, instead of a variation of a normal or a natural response to a situation - Managers / supervisors, practitioners, and other appropriate staff collaborate to define these issues, incorporating observations and other objective evidence.

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4. Review current and past interventions and compare intended to actual results.	- When a resident is receiving interventions related to behavior or mood, including (but not limited to) psychopharmacological medications (including antipsychotics), identify exactly what the interventions are meant to prevent or improve. - Identify, to the extent possible, the chronological history of medications prescribed for behavior, mood, and psychiatric symptoms and the alleged rationale (including but not limited to diagnoses) for their initiation or change. - Identify and document recent and current trials of nonpharmacologic interventions as well as previously attempted dose reductions or tapers. - Compare the current and intended results.
	NOTES on Recognition and Assessment: - In addition to chronological story and symptom details, examples of information sources for documentation and review may include: a) behavior alert/flow sheet; b) behavior consultant note; c) psychiatrist note; d) the 24 hour report; e) resident profile (past jobs, family, hobbies, education level, favorite music, favorite TV or movies, etc.), f) resident and family input, f) psychosocial and function (ADL) history, g) any recent hospital discharge summary - The nursing staff and practitioners (physician, nurse practitioner, physician assistant) are primarily responsible for this review and discussion. While they may request consultative support, they should not just defer to psychiatric consultants, consultant pharmacists, and others.
DIAGNOSIS/CAUSE IDENTIFICATION	
5. Attempt to identify cause(s) of any problematic behavior.	- In conjunction with the practitioner, use the information gathered in Steps 1-4 to try to identify causes of behavior, mood, thinking, or level of consciousness. - Review factors that are known to influence behavior, including situational and environmental factors, previous inclinations and behavior patterns, interventions that have worked previously, and customary routine. - Review with the practitioners potentially treatable medical and psychiatric causes such as delirium, medication adverse consequences, and psychosis. Among other things, use the Confusion Assessment Method (CAM) screening tool in the MDS to help identify delirium. - Request more extensive practitioner involvement if a cause is not apparent or addressing a presumed cause does not bring improvement as anticipated. - Document the basis for conclusions about the cause(s) of a resident's behavior, especially if

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	the situation is not stable or improving.
6. Evaluate the current medication regimen as a potential source of problematic behavior	- In conjunction with the practitioner, review the entire current medication regimen (not just psychopharmacological medications) for medications that can affect thinking, mood, behavior, or level of consciousness. - Discuss with the physician if high-risk or problematic medications are identified or suspected, and document such a review. - If delirium is suspected, the staff and practitioner should ask promptly, including medical intervention as indicated to address underlying causes.
	NOTES on Cause Identification: - Staff and consultants should collaborate with the practitioners to validate psychiatric diagnoses (i.e., whether the patient meets the criteria for specific diagnoses) and point out discrepancies to the practitioners (e.g., when someone is receiving medication for an alleged diagnose, but there is no evidence to support that diagnosis).
TREATMENT / MANAGEMENT	
7. Identify specific goals and objectives for managing behavior	- Before or soon after initiating any interventions, identify and document resident-specific goals for managing behavior; for example, reduce frequency of aggressive behavior, stabilize mood, correct underlying causes of behavior, minimize undesirable medication side effects, etc.
8. Implement an appropriate plan to address behavior and any other psychiatric symptoms.	- Implement a care plan that addresses target symptoms, identified causes, and resident-specific goals and needs, including (but not limited to) specific non-pharmacological, behavior management strategies. - When the cause(s) of problematic behavior is (are) identified or suspected, the staff and practitioner address the causes or indicate why they could not do so (for example, cause not treatable, previous adverse response to intervention, etc.).
9. Identify and document a rationale for specific interventions, including any medications.	- Identify and document evidence and a rationale (not just a diagnosis) for choosing specific interventions, and how such interventions relate to identified or suspected causes of behavior or psychiatric symptoms. For example, psychosis may or may not represent a problem for the resident's function and quality of life, and may or may not respond to medications.

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	NOTES on Treatment - Symptomatic interventions may be indicated when causes of behavior are not readily identifiable or treatable. - Therapeutic trials with close monitoring can show whether a medication is helpful. - If an intervention is not bringing an identifiable reduction in frequency, intensity, or duration of a symptom, its continued use should be reconsidered. - All orders (or related documentation) for psychopharmacological medications should include a) the rationale (which may be more than just a diagnosis), b) target symptoms (e.g., verbal/physical abuse of other residents or staff); c) dose, frequency, and route; d) duration of treatment if not ongoing, and e) monitoring parameters and f) action plan if medication is not effective or adverse consequences are identified or suspected. - While the staff and practitioners may seek help from a psychiatric consultant in choosing and using medications, they should remain aware of the rationale for treatment and the context of treatment in the overall care of the resident/patient, and not just abdicate all responsibility to the consultant.
MONITORING	
11. Monitor an individual's behavior and adjust treatment accordingly.	- In conjunction with the practitioner, monitor periodically the progress of a resident with behavior issues, using the preceding basic care process steps. - Discuss the behavior and treatment plans periodically, depending on how stable the situation is (for example, for urgent or emergency problematic behavior, monitor at least daily until the individual is stable or improving). - Document details of target behavior (including frequency, intensity, and duration) over time and use this information to determine whether/how to modify planned interventions. - If a target behavior is not stable or not gradually resolving as anticipated, review the current interventions with the practitioner and discuss whether/how to modify the interventions.
12. Monitor closely for significant complications of psychopharmacological medications.	- Review medication regimens for medications that may be associated with increased risk of complications. - When a medication-related complication is suspected or identified, discuss with the practitioner about how to address complications. - Either change doses or discontinue medications in the presence of identified or suspected complications, or document reasons for not doing so.

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	NOTES on Monitoring: - Have a detailed review and discussion with the practitioner no more than a week after medication is started or changed, to ensure that it is working and not causing adverse consequences. For acute situations, review may need to occur sooner and more frequently until the situation is stabilized. - An attempted dose reduction or discontinuation may be in order if it is not clear whether the medication and/or dose are effective or if may be causing adverse consequences. - Any use of lab tests to monitor (e.g., hyperlipidemia, hyperglycemia) should be consistent with overall goals of care.