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| BEHAVIOR MANAGEMENT | | | | NO. | |
| PURPOSE:  To provide guidelines for an effective Behavior Monitoring/Management Program.  STATEMENT OF POLICY:  It is the goal of this facility to provide a Behavior Management Program that will differentiate the diagnosis of “behavioral symptoms” so that the underlying cause of the symptom is recognized and treated appropriately. Our goal is to prevent the use of psychopharmacological drugs when the “behavioral symptom” is caused by conditions such as environmental stressor, psychosocial stressors, and treatable medical conditions. It is also our goal to prevent masking of symptoms with sedating drugs. In some cases, behavior problems that are dangerous or extremely disruptive must be controlled before further assessment and planning are completed. In such cases, we will provide an appropriate, immediate action to ensure the safety of our residents.  PROCEDURE:   1. Procedure for identifying residents that may need Behavior Monitoring and/or a Behavior Management Program. 2. Resident with New or Worsening Behavioral Symptoms should be evaluated quantitatively and objectively to establish an effective Behavior Management Program. This should be accomplished in the following steps: 3. Licensed Nursing staff will complete an “Evaluation for New or Worsening Behaviors” (see attachment # 1) This will provide information used in: 4. Assessing whether the behavioral symptom needs intervention. 5. Determining if the behavioral symptom is temporary or permanent. 6. Assist in determining potential causes from life events. 7. Assist in determining potential causes from environmental stressors. 8. Assist in ruling out potential medical causes. 9. Licensed Nursing staff will initiate a “Behavior Management Documentation” record for all staff to document new or worsening behaviors (see attachment # 2) 10. The “Behavior Management Documentation” record will include the behavior, interventions to try (individualized and other), activity when behavior occurred, time that behavior occurred, outcomes and initials. 11. If the behavior requires more specific documentation, the Licensed Nurse can provide more documentation in the Nurses notes. 12. Residents with diagnosis of Organic Mental Syndromes (delirium, dementia, amnestic, and other cognitive disorders) with associated psychotic and/or agitated behaviors, may require the use of antipsychotic medication. Residents is having behaviors that present a danger to himself/herself or to others; continuously screaming, yelling or pacing, if the behaviors cause an impairment in functional capacity; and/or experiencing psychotic symptoms (hallucinations, paranoia, delusions), which cause the resident distress or impairment in functional capacity. Behaviors should be monitored by: 13. Licensed Nurse and/or IDT will initiate and maintain a “Behavior Management Documentation” record will provide information used to: | | | | | |
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| 1. Develop a Behavior Management Program, if appropriate, with identification and implementation of interventions. 2. Make a decision on appropriate medication management for the resident. 3. Evaluate the effectiveness of Behavior Management Program and medication management. 4. Identifying new, worsening, or escalating behaviors. 5. The “Behavior Management Documentation: record includes the behavior occurred, time that behavior occurred, outcomes, and initials. 6. IF the behavior requires more specific documentation, the Licensed Nurse can provide more documentation in the Nurses notes. 7. Resident who is undergoing a gradual dose reduction of a psychoactive medication.   Behaviors should be monitored by:   1. Licensed Nurse and/or IDT will initiate and maintain a “Behavior Management Documentation” record during the dose reduction period, for all staff to document behaviors. (see attachment # 2) The “Behavior Management Documentation” record will provide information used to: 2. Document number of behavioral symptoms to determine the success or failure of the attempted gradual dose reduction. 3. Support continued use of psychoactive medications, if necessary. 4. Support failure of gradual dose reduction attempt. 5. Support the discontinuation of psychoactive medication. 6. The “Behavior Management Documentation” record will include the behavior interventions to try (individualized and other) activity when bad behavior occurred, time that behavior occurred, outcomes, and initials. 7. If the behavior requires more specific documentation, the Licensed Nurse can provide more documentation in the Nurses notes. 8. Procedure for use of the Behavior Management Documentation Records and Behavior Management Meeting. 9. The Behavior Documentation Record may be used for Behavior Monitoring and/or Behavior Management. 10. The record may be included with the ADL documentation for the Certified Nursing Assistants to document behaviors, in the chart for Licensed Nurses to document behaviors, and a separate note book for all other staff to document behaviors, OR 11. The record may be placed in a separate notebook that is accessible to all staff for documentation. (REMEMBER: ALL EPISODES OF THE BEHAVIOR THAT IS BEING MONITORED NEED TO BE DOCUMENTED FOR THE PROGRAM TO BE SUSSESSFUL.) 12. At least monthly, all documentation will be collected and evaluated by the IDT in a Behavior Management Meeting. 13. Behaviors will be quantitatively evaluated to ascertain if the approaches being used are successful or if medication management is appropriate. 14. The team should consist of, but is not limited to the DON/Designee, RN in charge of psychoactive drug reviews, Social Services Director, Psychiatrist/Psychologist/Consultants as available, MD as available, and if possible, staff responsible for the direct resident care. 15. Minutes of this meeting should be maintained and presented to the QA committee quarterly. | | | | | |
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| 1. All residents of Behavior Monitoring/Management should have interventions noted on the individual resident’s care plan. (See attachment # 3) 2. Evaluation of the Behavior Management Program for each resident should be highly individualized and should not take over a few weeks. If the program is successful, then the interventions should be added to the care plan for the staff to follow; at which time the resident should be taken off the program. If the program is not successful after 4-8 weeks period, and it is clear that after creative, individualized approaches have been used, the resident is not benefiting from the program, it should be discontinued.   REFERENCES:  F-322 RESIDENT BEHAVIOR AND FACILITY PRACTICES  F-329 TO F-331 UNNECESSARY DRUGS  ATTACHMENTS:  Evaluation for New or Worsening Behaviors  Instructions for Completing Behavior Management Documentation Record  Behavior Management Documentation | | | | | |
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