3-31-25 Weekly Clinical Update

Based on recent survey findings, and the emphasis on the importance of documentation of non-pharmacological interventions included in the rapidly upcoming revisions to Appendix PP, a guide to behavior management documentation may be warranted. Documentation of non-pharmacological interventions for behaviors should include:

- Assessment of behaviors: Documentation of behavioral assessments is expected to include DETAILED observations of a resident's specific behaviors (not generalized behaviors). Documentation must include triggers, frequency, severity of behaviors and any impact the behaviors may have on the resident and/or other residents or staff. This guidance implies an effective Root Cause Analysis will be conducted on individual resident's behaviors to determine those triggers.
- Based on the results of the Root Cause Analysis (RCA), the documentation should include specific non-pharmacological interventions that have been implemented in the resident's care plan. Additionally, all staff are EXPECTED to know what the triggers are, and what the individualized non-pharmacological interventions are. Surveyors are instructed to observe and interview to ensure that staff are INTENTIONALLY avoiding identified triggers and INTENTIONALLY implementing the care planned non-pharmacological interventions.
- Each resident's individualized, person-centered care plan must include clear goal for interventions, along with expected outcomes.
- A step that is frequently cited in deficiencies is the lack of specific documentation of monitoring and evaluation of the care planned non-pharmacological interventions. This step should be documented on a "real-time" basis if possible, but certainly on a per-shift basis. Quarterly care plan review documentation must be based on timely monitoring and evaluation documentation. Staff, family members and practitioners should anticipate that not all non-pharmacological interventions will be effective at the time of every behavioral incident. Flexibility should be anticipated with a "back-up plan" care planned. Individualization of approaches is critical to success
- Interdisciplinary collaboration among healthcare professionals, care partners, residents and family members is essential to not only occur, but must be documented. Documentation by facility team members and resident and family team members is essential for appropriate documentation by physician and other practitioners in evaluation of the effectiveness of the non-pharmacological interventions for evaluation.

All documentation must align with evidence-based best practice, State and Federal regulations as outlined in Appendix PP and other discipline guidance.