SECTION E: BEHAVIOR

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact.

This section focuses on the resident's actions, not the intent of his or her behavior. Because of their interactions with residents, staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent (e.g., "Mr. A. doesn't really mean to hurt anyone. He's just frightened."). Resident intent should **not** be taken into account when coding for items in this section.

E0100: Potential Indicators of Psychosis

	E0100. Potential Indicators of Psychosis
	↓ **Check all that apply**
☐	**A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	**B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	**Z. None of the above**

Item Rationale

Health-related Quality of Life

- Psychotic symptoms may be associated with
  — delirium,
  — dementia,
  — adverse drug effects,
  — psychiatric disorders, and
  — hearing or vision impairment.
- Hallucinations and delusions may
  — be distressing to residents and families,
  — cause disability,
  — interfere with delivery of medical, nursing, rehabilitative and personal care, and
  — lead to dangerous behavior or possible harm.

> **DEFINITIONS**
>
> **HALLUCINATION** The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.
>
> **DELUSION**
> A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.

E0100: Potential Indicators of Psychosis (cont.)

Planning for Care

- Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress.

Steps for Assessment

1. Review the resident's medical record for the 7-day look-back period.
2. Interview staff members and others who have had the opportunity to observe the resident in a variety of situations during the 7-day look-back period.
3. Observe the resident during conversations and the structured interviews in other assessment sections and listen for statements indicating an experience of hallucinations, or the expression of false beliefs (delusions).
4. Clarify potentially false beliefs:

    - When a resident expresses a belief that is plausible but alleged by others to be false (e.g., history indicates that the resident's husband died 20 years ago, but the resident states her husband has been visiting her every day), try to verify the facts to determine whether there is reason to believe that it could have happened or whether it is likely that the belief is false.

    - When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. Do not, however, challenge the resident.

    - The resident's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed.

Coding Instructions

Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply.

- **Check E0100A, hallucinations:** if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.

- **Check E0100B, delusions:** if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary.

- **Check E0100Z, none of the above:** if no hallucinations or delusions were present in the last 7 days.

E0100: Potential Indicators of Psychosis (cont.)

Coding Tips and Special Populations

- If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, **do not** code it as a delusion.

- If a resident expresses a false belief but easily accepts a reasonable alternative explanation, **do not** code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, **code as a delusion**.

Examples

1. A resident carries a doll which she believes is her baby and the resident appears upset. When asked about this, she reports she is distressed from hearing her baby crying and thinks she's hungry and wants to get her a bottle.

   Coding: E0100A would be **checked** and E0100B would be **checked**.
   Rationale: The resident believes the doll is a baby which is a delusion and she hears the doll crying which is an auditory hallucination.

2. A resident reports that he heard a gunshot. In fact, there was a loud knock on the door. When this is explained to him, he accepts the alternative interpretation of the loud noise.

   Coding: E0100Z would be **checked.**
   Rationale: He misinterpreted a real sound in the external environment. Because he is able to accept the alternative explanation for the cause of the sound, his report of a gunshot is not a fixed false belief and is therefore not a delusion.

3. A resident is found speaking aloud in her room. When asked about this, she states that she is answering a question posed to her by the gentleman in front of her. Staff note that no one is present and that no other voices can be heard in the environment.

   Coding: E0100A would be **checked.**
   Rationale: The resident reports an auditory sensation that occurs in the absence of any external stimulus. Therefore, this is a hallucination.

4. A resident announces that he must leave to go to work, because he is needed in his office right away. In fact, he has been retired for 15 years. When reminded of this, he continues to insist that he must get to his office.

   Coding: E0100B would be **checked.**
   Rationale: The resident adheres to the belief that he still works, even after being reminded about his retirement status. Because the belief is held firmly despite an explanation of the real situation, it is a delusion.

E0100: Potential Indicators of Psychosis (cont.)

5. A resident believes she must leave the facility immediately because her mother is waiting for her to return home. Staff know that, in reality, her mother is deceased and gently remind her that her mother is no longer living. In response to this reminder, the resident acknowledges, "Oh yes, I remember now. Mother passed away years ago."

> **Coding:** E0100Z would be **checked.**
>
> **Rationale:** The resident's initial false belief is readily altered with a simple reminder, suggesting that her mistaken belief is due to forgetfulness (i.e., memory loss) rather than psychosis. Because it is not a firmly held false belief, it does not fit the definition of a delusion.

E0200: Behavioral Symptom—Presence & Frequency

E0200. Behavioral Symptom - Presence & Frequency		
Note presence of symptoms and their frequency		
Coding: 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**	↓ Enter Codes in Boxes	
	☐	A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	☐	B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
	☐	C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Item Rationale

Health-related Quality of Life

- New onset of behavioral symptoms warrants prompt evaluation, assurance of resident safety, relief of distressing symptoms, and compassionate response to the resident.
- Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress.

Planning for Care

- Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems—and may therefore require treatment planning and intervention—from those that are not problematic.
- These behaviors may indicate unrecognized needs, preferences, or illness.
- Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact.
- Subsequent assessments and documentation can be compared to baseline to identify changes in the resident's behavior, including response to interventions.

E0200: Behavioral Symptom-Presence & Frequency (cont.)

Steps for Assessment

1. Review the medical record for the 7-day look-back period.
2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident.
3. Observe the resident in a variety of situations during the 7-day look-back period.

Coding Instructions

- **Code 0, behavior not exhibited:** if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days.

- **Code 1, behavior of this type occurred 1-3 days:** if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days.

- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days.

- **Code 3, behavior of this type occurred daily:** if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days.

Coding Tips and Special Populations

- Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.

- Code as present, even if staff have become used to the behavior or view it as typical or tolerable.

- Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care.

- Item E0200C does not include wandering.

Examples

1. Every morning, a nursing assistant tries to help a resident who is unable to dress himself. On the last 4 out of 6 mornings, the resident has hit or scratched the nursing assistant during attempts to dress him.

    Coding: E0200A would be **coded 2, behavior of this type occurred 4-6 days, but less than daily.**
    Rationale: Scratching the nursing assistant was a physical behavior directed toward others.

E0200: Behavioral Symptom-Presence & Frequency (cont.)

2. A resident has previously been found rummaging through the clothes in her roommate's dresser drawer. This behavior has not been observed by staff or reported by others in the last 7 days.

> **Coding:** E0200C would be **coded 0, behavior not exhibited.**
> **Rationale:** The behavior did not occur during the look-back period.

3. A resident throws his dinner tray at another resident who repeatedly spit food at him during dinner. This is a single, isolated incident.

> **Coding:** E0200A would be **coded 1, behavior of this type occurred 1-3 days of the last 7 days.**
> **Rationale:** Throwing a tray was a physical behavior directed toward others. Although a possible explanation exists, the behavior is noted as present because it occurred.

E0300: Overall Presence of Behavioral Symptoms

E0300. Overall Presence of Behavioral Symptoms	
Enter Code ☐	**Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?** 0. **No** → Skip to E0800, Rejection of Care 1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

Item Rationale

To determine whether or not additional items E0500, **Impact on Resident**, and E0600, **Impact on Others,** are required to be completed.

Steps for Assessment

1. Review coding for item E0200 and follow these coding instructions:

Coding Instructions

- **Code 0, no:** if E0200A, E0200B, and E0200C all are coded 0, not present. Skip to **Rejection of Care—Presence & Frequency** item (E0800).
- **Code 1, yes:** if any of E0200A, E0200B, or E0200C were coded 1, 2, or 3. Proceed to complete **Impact on Resident** item (E0500), and **Impact on Others** item (E0600).

E0500: Impact on Resident

E0500. Impact on Resident	
	Did any of the identified symptom(s):
Enter Code ☐	**A. Put the resident at significant risk for physical illness or injury?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Significantly interfere with the resident's care?** 0. **No** 1. **Yes**
Enter Code ☐	**C. Significantly interfere with the resident's participation in activities or social interactions?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Behaviors identified in item E0200 impact the resident's risk for significant injury, interfere with care or their participation in activities or social interactions.

Planning for Care

- Identification of the impact of the behaviors noted in E0200 may require treatment planning and intervention.
- Subsequent assessments and documentation can be compared to a baseline to identify changes in the resident's behavior, including response to interventions.

Steps for Assessment

1. Consider the previous review of the medical record, staff interviews across all shifts and disciplines, interviews with others who had close interactions with the resident and previous observations of the behaviors identified in E0200 for the 7-day look-back period.
2. Code E0500A, E0500B, and E0500C based on **all** of the behavioral symptoms coded in E0200.
3. Determine whether those behaviors put the resident at significant risk of physical illness or injury, whether the behaviors significantly interfered with the resident's care, and/or whether the behaviors significantly interfered with the resident's participation in activities or social interactions.

Coding Instructions for E0500A. Did Any of the Identified Symptom(s) Put the Resident at Significant Risk for Physical Illness or Injury?

- **Code 0, no:** if none of the identified behavioral symptom(s) placed the resident at clinically significant risk for a physical illness or injury.
- **Code 1, yes:** if any of the identified behavioral symptom(s) placed the resident at clinically significant risk for a physical illness or injury, even if no injury occurred.

E0500: Impact on Resident (cont.)

Coding Instructions for E0500B. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Care?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly interfered with the resident's care.
- **Code 1, yes:** if any of the identified behavioral symptom(s) impeded the delivery of essential medical, nursing, rehabilitative or personal care, including but not limited to assistance with activities of daily living, such as bathing, dressing, feeding, or toileting.

Coding Instructions for E0500C. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Participation in Activities or Social Interactions?

- **Code 0, no:** if none of the identified symptom(s) significantly interfered with the resident's participation in activities or social interactions.
- **Code 1, yes:** if any of the identified behavioral symptom(s) significantly interfered with or decreased the resident's participation or caused staff not to include residents in activities or social interactions.

Coding Tips and Special Populations

- For E0500A, code based on whether the risk for physical injury or illness is known to occur commonly under similar circumstances (i.e., with residents who exhibit similar behavior in a similar environment). Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability, or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.
- For E0500B, code if the impact of the resident's behavior is impeding the delivery of care to such an extent that necessary or essential care (medical, nursing, rehabilitative or personal that is required to achieve the resident's goals for health and well-being) cannot be received safely, completely, or in a timely way without more than a minimal accommodation, such as simple change in care routines or environment.
- For E0500C, code if the impact of the resident's behavior is limiting or keeping the resident from engaging in solitary activities or hobbies, joining groups, or attending programmed activities or having positive social encounters with visitors, other residents, or staff.

Examples

1. A resident frequently grabs and scratches staff when they attempt to change her soiled brief, digging her nails into their skin. This makes it difficult to complete the care task.

   Coding: E0500B would be **coded 1, yes.**
   Rationale: This behavior interfered with delivery of essential personal care.

E0500: Impact on Resident (cont.)

2. During the last 7 days, a resident with vascular dementia and severe hypertension, hits staff during incontinent care making it very difficult to change her. Six out of the last seven days the resident refuses all her medication including her antihypertensive. The resident closes her mouth and shakes her head and will not take it even if re-approached multiple times.

   Coding: E0500A and E0500B would both be **coded 1, yes.**
   Rationale: The behavior interfered significantly with delivery of her medical and nursing care and put her at clinically significant risk for physical illness.

3. A resident paces incessantly. When staff encourage him to sit at the dinner table, he returns to pacing after less than a minute, even after cueing and reminders. He is so restless that he cannot sit still long enough to feed himself or receive assistance in obtaining adequate nutrition.

   Coding: E0500A and E0500B would both be **coded 1, yes.**
   Rationale: This behavior significantly interfered with personal care (i.e., feeding) and put the resident at risk for malnutrition and physical illness.

4. A resident repeatedly throws his markers and card on the floor during bingo.

   Coding: E0500C would be **coded 1, yes.**
   Rationale: This behavior interfered with his ability to participate in the activity.

5. A resident with severe dementia has continuous outbursts while awake despite all efforts made by staff to address the issue, including trying to involve the resident in prior activities of choice.

   Coding: E0500C would be **coded 1, yes.**
   Rationale: The staff determined the resident's behavior interfered with the ability to participate in any activities.

E0600: Impact on Others

E0600. Impact on Others	
	Did any of the identified symptom(s):
Enter Code	A. Put others at significant risk for physical injury? 0. No 1. Yes
Enter Code	B. Significantly intrude on the privacy or activity of others? 0. No 1. Yes
Enter Code	C. Significantly disrupt care or living environment? 0. No 1. Yes

E0600: Impact on Others (cont.)

Item Rationale

Health-related Quality of Life

- Behaviors identified in item E0200 put others at risk for significant injury, intrude on their privacy or activities and/or disrupt their care or living environments. The impact on others is coded here in item E0600.

Planning for Care

- Identification of the behaviors noted in E0200 that have an impact on others may require treatment planning and intervention.

- Subsequent assessments and documentation can be compared with a baseline to identify changes in the resident's behavior, including response to interventions.

Steps for Assessment

1. Consider the previous review of the clinical record, staff interviews across all shifts and disciplines, interviews with others who had close interactions with the resident and previous observations of the behaviors identified in E0200 for the 7-day look-back period.

2. To code E0600, determine if the behaviors identified put others at significant risk of physical illness or injury, intruded on their privacy or activities, and/or interfered with their care or living environments.

Coding Instructions for E0600A. Did Any of the Identified Symptom(s) Put Others at Significant Risk for Physical Injury?

- **Code 0, no:** if none of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.

- **Code 1, yes:** if any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.

Coding Instructions for E0600B. Did Any of the Identified Symptom(s) Significantly Intrude on the Privacy or Activity of Others?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly intruded on the privacy or activity of others.

- **Code 1, yes:** if any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities (not organized or run by staff). Includes coming in uninvited, invading, or forcing oneself on others' private activities.

E0600: Impact on Others (cont.)

Coding Instructions for E0600C. Did Any of the Identified Symptom(s) Significantly Disrupt Care or the Living Environment?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly disrupted delivery of care or the living environment.

- **Code 1, yes:** if any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

Coding Tips and Special Populations

- For E0600A, code based on whether the behavior placed others at significant risk for physical injury. Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.

- For E0600B, code based on whether the behavior violates other residents' privacy or interrupts other residents' performance of activities of daily living or limits engagement in or enjoyment of informal social or recreational activities to such an extent that it causes the other residents to experience distress (e.g., displeasure or annoyance) or inconvenience, whether or not the other residents complain.

- For E0600C, code based on whether the behavior interferes with staff ability to deliver care or conduct organized activities, interrupts receipt of care or participation in organized activities by other residents, and/or causes other residents to experience distress or adverse consequences.

Examples

1. A resident appears to intentionally stick his cane out when another resident walks by.

   Coding: E0600A would be **coded 1, yes**; E0600B and E0600C would be **coded 0, no.**
   Rationale: The behavior put the other resident at risk for falling and physical injury. You may also need to consider coding B and C depending on the specific situation in the environment or care setting.

2. A resident, when sitting in the hallway outside the community activity room, continually yells, repeating the same phrase. The yelling can be heard by other residents in hallways and activity/recreational areas but not in their private rooms.

   Coding: E0600A would be **coded 0, no**; E0600B and E0600C would be **coded 1, yes.**
   Rationale: The behavior does not put others at risk for significant injury. The behavior does create a climate of excessive noise, disrupting the living environment and the activity of others.

E0600: Impact on Others (cont.)

3. A resident repeatedly enters the rooms of other residents and rummages through their personal belongings. The other residents do not express annoyance.

    Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**

    Rationale: This is an intrusion and violates other residents' privacy regardless of whether they complain or communicate their distress.

4. When eating in the dining room, a resident frequently grabs food off the plates of other residents. Although the other resident's food is replaced, and the behavior does not compromise their nutrition, other residents become anxious in anticipation of this recurring behavior.

    Coding: E0600A would be **coded 0, no**; E0600B and E0600C would be **coded 1, yes.**

    Rationale: This behavior violates other residents' privacy as it is an intrusion on the personal space and property (food tray) . In addition, the behavior is pervasive and disrupts the staff's ability to deliver nutritious meals in dining room (an organized activity).

5. A resident tries to seize the telephone out of the hand of another resident who is attempting to complete a private conversation. Despite being asked to stop, the resident persists in grabbing the telephone and insisting that he wants to use it.

    Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**

    Rationale: This behavior is an intrusion on another resident's private telephone conversation.

6. A resident begins taunting two residents who are playing an informal card game, yelling that they will "burn in hell" if they don't stop "gambling."

    Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**

    Rationale: The behavior is intruding on the other residents' game. The game is not an organized facility event and does not involve care. It is an activity in which the two residents wanted to engage.

7. A resident yells continuously during an exercise group, diverting staff attention so that others cannot participate in and enjoy the activity.

    Coding: E0600A and E0600B would be **coded 0, no**; E0600C would be **coded 1, yes.**

    Rationale: This behavior disrupts the delivery of physical care (exercise) to the group participants and creates an environment of excessive noise.

E0600: Impact on Others (cont.)

8. A resident becomes verbally threatening in a group discussion activity, frightening other residents. In response to this disruption, staff terminate the discussion group early to avoid eliciting the behavioral symptom.

>   **Coding:** E0600A and E0600B would be **coded 0, no**; E0600C would be **coded 1, yes.**
>
>   **Rationale:** This behavior does not put other residents at risk for significant injury. However, the behavior restricts full participation in the organized activity, and limits the enjoyment of other residents. It also causes fear, thereby disrupting the living environment.

E0800: Rejection of Care—Presence & Frequency

E0800. Rejection of Care - Presence & Frequency
Enter Code [ ]	**Did the resident reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**

Item Rationale

Health-related Quality of Life

*   Goals for health and well-being reflect the resident's wishes and objectives for health, function, and life satisfaction that define an acceptable quality of life for that individual.

*   The resident's care preferences reflect desires, wishes, inclinations, or choices for care. Preferences do not have to appear logical or rational to the clinician. Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment."

*   It is really a matter of resident choice. When rejection/decline of care is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident's choice. Education is provided and the resident's choices become part of the plan of care. On future assessments, this behavior would not be coded in this item.

*   A resident might reject/decline care because the care conflicts with his or her preferences and goals. In such cases, care rejection behavior is not considered a problem that warrants treatment to modify or eliminate the behavior.

*   Care rejection may be manifested by verbally declining, statements of refusal, or through physical behaviors that convey aversion to, result in avoidance of, or interfere with the receipt of care.

E0800: Rejection of Care—Presence & Frequency (cont.)

- This type of behavior interrupts or interferes with the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.
- A resident's rejection of care might be caused by an underlying neuropsychiatric, medical, or dental problem. This can interfere with needed care that is consistent with the resident's preferences or established care goals. In such cases, care rejection behavior may be a problem that requires assessment and intervention.

Planning for Care

- Evaluation of rejection of care assists the nursing home in honoring the resident's care preferences in order to meet his or her desired health care goals.
- Follow-up assessment should consider:
  - whether established care goals clearly reflect the resident's preferences and goals and
  - whether alternative approaches could be used to achieve the resident's care goals.
- Determine whether a previous discussion identified an objection to the type of care or the way in which the care was provided. If so, determine approaches to accommodate the resident's preferences.

> **DEFINITIONS**
>
> **REJECTION OF CARE**
> Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.
>
> **INTERFERENCE WITH CARE**
> Hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.

Steps for Assessment

1. Review the medical record.
2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period.
3. Review the record and consult staff to determine whether the rejected care is needed to achieve the resident's preferences and goals for health and well-being.
4. Review the medical record to find out whether the care rejection behavior was previously addressed and documented in discussions or in care planning with the resident, family, or significant other and determined to be an informed choice consistent with the resident's values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed.
5. If the resident exhibits behavior that appears to communicate a rejection of care (and that rejection behavior has not been previously determined to be consistent with the resident's values or goals), ask him or her directly whether the behavior is meant to decline or refuse care.

E0800: Rejection of Care—Presence & Frequency (cont.)

- If the resident indicates that the intention is to decline or refuse, then ask him or her about the reasons for rejecting care and about his or her goals for health care and well-being.
- If the resident is unable or unwilling to respond to questions about his or her rejection of care or goals for health care and well-being, then interview the family or significant other to ascertain the resident's health care preferences and goals.

Coding Instructions

- **Code 0, behavior not exhibited:** if rejection of care consistent with goals was not exhibited in the last 7 days.
- **Code 1, behavior of this type occurred 1-3 days:** if the resident rejected care consistent with goals 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the resident rejected care consistent with goals 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.
- **Code 3, behavior of this type occurred daily:** if the resident rejected care consistent with goals daily in the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.

Coding Tips and Special Populations

- The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision maker.
- Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and determined to be consistent with the resident's values, preferences, or goals. Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."

Examples

1. A resident with heart failure who recently returned to the nursing home after surgical repair of a hip fracture is offered physical therapy and declines. She says that she gets too short of breath when she tries to walk even a short distance, making physical therapy intolerable. She does not expect to walk again and does not want to try. Her physician has discussed this with her and has indicated that her prognosis for regaining ambulatory function is poor.

   Coding: E0800 would be **coded 0, behavior not exhibited.**
   Rationale: This resident has communicated that she considers physical therapy to be both intolerable and futile. The resident discussed this with her physician. Her choice to not accept physical therapy treatment is consistent with her values and goals for health care. Therefore, this would **not** be coded as rejection of care.

E0800: Rejection of Care—Presence & Frequency (cont.)

2. A resident informs the staff that he would rather receive care at home, and the next day he calls for a taxi and exits the nursing facility. When staff try to persuade him to return, he firmly states, "Leave me alone. I always swore I'd never go to a nursing home. I'll get by with my visiting nurse service at home again." He is not exhibiting signs of disorientation, confusion, or psychosis and has never been judged incompetent.

    Coding: E0800 would be **coded 0, behavior not exhibited.**

    Rationale: His departure is consistent with his stated preferences and goals for health care. Therefore, this is **not** coded as care rejection.

3. A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 of the past 7 days. The resident was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

    Coding: E0800 would be **coded 1, behavior of this type occurred 1-3 days.**

    Rationale: The resident's care rejection behavior is not consistent with his values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.

4. A resident chooses not to eat supper one day, stating that the food causes her diarrhea. She says she knows she needs to eat and does not wish to compromise her nutrition, but she is more distressed by the diarrhea than by the prospect of losing weight.

    Coding: E0800 would be **coded 1, behavior of this type occurred 1-3 days.**

    Rationale: Although choosing not to eat is consistent with the resident's desire to avoid diarrhea, it is also in conflict with her stated goal to maintain adequate nutrition.

5. A resident is given his antibiotic medication prescribed for treatment of pneumonia and immediately spits the pills out on the floor. This resident's assessment indicates that he does not have any swallowing problems. This happened on each of the last 4 days. The resident's advance directive indicates that he would choose to take antibiotics to treat a potentially life-threatening infection.

    Coding: E0800 would be **coded 2, behavior of this type occurred 4-6 days, but less than daily.**

    Rationale: The behavioral rejection of antibiotics prevents the resident from achieving his stated goals for health care listed in his advance directives. Therefore, the behavior is coded as care rejection.

E0800: Rejection of Care—Presence & Frequency (cont.)

6. A resident who recently returned to the nursing home after surgery for a hip fracture is offered physical therapy and declines. She states that she wants to walk again but is afraid of falling. This occurred on 4 days during the look-back period.

    Coding: E0800 would be **coded 2, behavior of this type occurred 4-6 days. Rationale:** Even though the resident's health care goal is to regain her ambulatory status, her fear of falling results in rejection of physical therapy and interferes with her rehabilitation. This would be coded as rejection of care.

7. A resident who previously ate well and prided herself on following a healthy diet has been refusing to eat every day for the past 2 weeks. She complains that the food is boring and that she feels full after just a few bites. She says she wants to eat to maintain her weight and avoid getting sick, but she cannot push herself to eat anymore.

    Coding: E0800 would be **coded 3, behavior of this type occurred daily. Rationale:** The resident's choice not to eat is not consistent with her goal of weight maintenance and health. Choosing not to eat may be related to a medical condition such as a disturbance of taste sensation, gastrointestinal illness, endocrine condition, depressive disorder, or medication side effects.

E0900: Wandering—Presence & Frequency

E0900. Wandering - Presence & Frequency	
Enter Code [ ]	**Has the resident wandered?** 0. **Behavior not exhibited** → Skip to E1100, Change in Behavioral or Other Symptoms 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days**, but less than daily 3. **Behavior of this type occurred daily**

Item Rationale

Health-related Quality of Life

- Wandering may be a pursuit of exercise or a pleasurable leisure activity, or it may be related to tension, anxiety, agitation, or searching.

Planning for Care

- It is important to assess for reason for wandering. Determine the frequency of its occurrence, and any factors that trigger the behavior or that decrease the episodes.

- Assess for underlying tension, anxiety, psychosis, drug-induced psychomotor restlessness, agitation, or unmet need (e.g., for food, fluids, toileting, exercise, pain relief, sensory or cognitive stimulation, sense of security, companionship) that may be contributing to wandering.

E0900: Wandering—Presence & Frequency (cont.)

Steps for Assessment

1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period.

    *   Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to his or her physical or safety needs. The resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff know is deceased).

2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period.

Coding Instructions for E0900

*   **Code 0, behavior not exhibited:** if wandering was not exhibited during the 7-day look-back period. Skip to **Change in Behavioral or Other Symptoms** item (E1100).

*   **Code 1, behavior of this type occurred 1-3 days:** if the resident wandered on 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).

*   **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the resident wandered on 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).

*   **Code 3, behavior of this type occurred daily:** if the resident wandered daily during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).

Coding Tips and Special Populations

*   Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering.

*   Wandering may occur even if resident is in a locked unit.

*   Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity) is not considered wandering.

E1000: Wandering—Impact

Answer this item only if E0900, Wandering—Presence & Frequency, was coded 1 (behavior of this type occurred 1-3 days), 2 (behavior of this type occurred 4-6 days, but less than daily), or 3 (behavior of this type occurred daily).

E1000. Wandering - Impact	
Enter Code ☐	**A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place** (e.g., stairs, outside of the facility)? 0. **No** 1. **Yes**
Enter Code ☐	**B. Does the wandering significantly intrude on the privacy or activities of others?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Not all wandering is harmful.
- Some residents who wander are at potentially higher risk for entering an unsafe situation.
- Some residents who wander can cause significant disruption to other residents.

Planning for Care

- Care plans should consider the impact of wandering on resident safety and disruption to others.
- Care planning should be focused on minimizing these issues.
- Determine the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety if wandering places the resident at risk.
- Determine when wandering requires interventions to reduce unwanted intrusions on other residents or disruption of the living environment.

Steps for Assessment

1. Consider the previous review of the resident's wandering behaviors identified in E0900 for the 7-day look-back period.
2. Determine whether those behaviors put the resident at significant risk of getting into potentially dangerous places and/or whether wandering significantly intrudes on the privacy or activities of others based on clinical judgement for the individual resident.

Coding Instructions for E1000A. Does the Wandering Place the Resident at Significant Risk of Getting to a Potentially Dangerous Place?

- **Code 0, no:** if wandering does not place the resident at significant risk.
- **Code 1, yes:** if the wandering places the resident at significant risk of getting to a dangerous place (e.g., wandering outside the facility where there is heavy traffic) or encountering a dangerous situation (e.g., wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders).

E1000: Wandering-Impact (cont.)

Coding Instructions for E1000B. Does the Wandering Significantly Intrude on the Privacy or Activities of Others?

- **Code 0, no:** if the wandering does not intrude on the privacy or activity of others.
- **Code 1, yes:** if the wandering intrudes on the privacy or activities of others (i.e., if the wandering violates other residents' privacy or interrupts other residents' performance of activities of daily living or limits engagement in or enjoyment of social or recreational activities), whether or not the other resident complains or communicates displeasure or annoyance.

Examples

1. A resident wanders away from the nursing home in his pajamas at 3 a.m. When staff members talk to him, he insists he is looking for his wife. This elopement behavior had occurred when he was living at home, and on one occasion he became lost and was missing for 3 days, leading his family to choose nursing home admission for his personal safety.

   Coding: E1000A would be **coded 1, yes.**

   Rationale: Wandering that results in elopement from the nursing home places the resident at significant risk of getting into a dangerous situation.

2. A resident wanders away from the nursing facility at 7 a.m. Staff find him crossing a busy street against a red light. When staff try to persuade him to return, he becomes angry and says, "My boss called, and I have to get to the office." When staff remind him that he has been retired for many years, he continues to insist that he must get to work.

   Coding: E1000A would be **coded 1, yes.**

   Rationale: This resident's wandering is associated with elopement from the nursing home and into a dangerous traffic situation. Therefore, this is coded as placing the resident at significant risk of getting to a place that poses a danger. In addition, delusions would be checked in item E0100.

3. A resident propels himself in his wheelchair into the room of another resident, blocking the door to the other resident's bathroom.

   Coding: E1000B would be **coded 1, yes.**

   Rationale: Moving about in this manner with the use of a wheelchair meets the definition of wandering, and the resident has intruded on the privacy of another resident and has interfered with that resident's ability to use the bathroom.

E1100: Change in Behavioral or Other Symptoms

E1100. Change in Behavior or Other Symptoms Consider all of the symptoms assessed in items E0100 through E1000	

Enter Code
 	
☐
	How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**
	  0. **Same**
	  1. **Improved**
	  2. **Worse**
	  3. **N/A** because no prior MDS assessment

E1100: Change in Behavioral or Other Symptoms (cont.)

Item Rationale

Health-related Quality of Life

- Change in behavior may be an important indicator of
  — a change in health status or a change in environmental stimuli,
  — positive response to treatment, and
  — adverse effects of treatment.

Planning for Care

- If behavior is worsening, assessment should consider whether it is related to
  — new health problems, psychosis, or delirium;
  — worsening of pre-existing health problems;
  — a change in environmental stimuli or caregivers that influences behavior; and
  — adverse effects of treatment.
- If behaviors are improved, assessment should consider what interventions should be continued or modified (e.g., to minimize risk of relapse or adverse effects of treatment).

Steps for Assessment

1. Review responses provided to items E0100-E1000 on the current MDS assessment.
2. Compare with responses provided on prior MDS assessment.
3. Taking all of these MDS items into consideration, make a global assessment of the change in behavior from the most recent to the current MDS.
4. Rate the overall behavior as same, improved, or worse.

Coding Instructions

- **Code 0, same:** if overall behavior is the same (unchanged).
- **Code 1, improved:** if overall behavior is improved.
- **Code 2, worse:** if overall behavior is worse.
- **Code 3, N/A:** if there was no prior MDS assessment of this resident.

Coding Tips

- For residents with multiple behavioral symptoms, it is possible that different behaviors will vary in different directions over time. That is, one behavior may improve while another worsens or remains the same. Using clinical judgment, this item should be rated to reflect the overall direction of behavior change, estimating the net effects of multiple behaviors.

E1100: Change in Behavioral or Other Symptoms (cont.)

Examples

1. On the prior assessment, the resident was reported to wander on 4 out of 7 days. Because of elopement, the behavior placed the resident at significant risk of getting to a dangerous place. On the current assessment, the resident was found to wander on 2 of the last 7 days. Because a door alarm system is now in use, the resident was not at risk for elopement and getting to a dangerous place. However, the resident is now wandering into the rooms of other residents, intruding on their privacy. This requires occasional redirection by staff.

   Coding: E1100 would be **coded 1, improved.**

   Rationale: Although one component of this resident's wandering behavior is worse because it has begun to intrude on the privacy of others, it is less frequent and less dangerous (without recent elopement) and is therefore improved overall since the last assessment. The fact that the behavior requires less intense surveillance or intervention by staff also supports the decision to rate the overall behavior as improved.

2. At the time of the last assessment, the resident was ambulatory and would threaten and hit other residents daily. He recently suffered a hip fracture and is not ambulatory. He is not approaching, threatening, or assaulting other residents. However, the resident is now combative when staff try to assist with dressing and bathing, and is hitting staff members daily.

   Coding: E1100 would be **coded 0, same.**

   Rationale: Although the resident is no longer assaulting other residents, he has begun to assault staff. Because the danger to others and the frequency of these behaviors is the same as before, the overall behavior is rated as unchanged.

3. On the prior assessment, a resident with Alzheimer's disease was reported to wander on 2 out of 7 days and has responded well to redirection. On the most recent assessment, it was noted that the resident has been wandering more frequently for 5 out of 7 days and has also attempted to elope from the building on two occasions.

   This behavior places the resident at significant risk of personal harm. The resident has been placed on more frequent location checks and has required additional redirection from staff. He was also provided with an elopement bracelet so that staff will be alerted if the resident attempts to leave the building. The intensity required of staff surveillance because of the dangerousness and frequency of the wandering behavior has significantly increased.

   Coding: E1100 would be **coded 2, worse.**

   Rationale: Because the danger and the frequency of the resident's wandering behavior have increased and there were two elopement attempts, the overall behavior is rated as worse.