CARE PATH
Change in Behavior
Evaluation of Medical Causes of New or Worsening Behavioral Symptoms

New or Worsening Behavioral Symptoms
- Physical aggression (e.g. biting, hitting, kicking, spitting, etc.)
- Physical symptoms, non-aggressive (e.g. inappropriate disrobing or voiding, repetitive mannerisms, wandering or attempts to elope)
- Verbal aggression (e.g. cursing, screaming, etc.)
- Verbal symptoms, non-aggressive (e.g. repetitive calling out or requests for attention, constant complaining or whining, etc.)
- Social withdrawal (e.g. isolation, apathy)
- Depression (e.g. crying, hopelessness, not eating, multiple somatic complaints)

Vital Sign Criteria (any met?)
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300

Further Nursing Evaluation
- Mental Status
- Cardiovascular
- Functional Status
- Respiratory
- Gastrointestinal / abdomen
- Genitourinary
- Skin
- Pain

Evaluate Symptoms and Signs for Immediate Notification*
- Danger to self or others
- Suicidal ideation
- Symptoms or signs of pain
- Not eating or drinking at all
- Acute decline in ADL abilities
- Nausea, vomiting, diarrhea
- Abdominal distention or tenderness
- New cough, abnormal lung sounds
- New or worsened incontinence, pain with urination or blood in urine
- New skin condition (e.g. rash, redness suggesting cellulitis, signs of infection around existing wound or pressure ulcer/injury)
- Unrelieved pain
- Signs and symptoms suggest possible sepsis**

Consider Contacting MD/NP/PA for orders (for further evaluation and management)
- Portable chest X-ray
- Urinalysis and C&S if indicated
- Blood work (Complete Blood Count, Basic Metabolic Panel)

Manage in Facility
- Monitor vital signs, fluid intake/urine output every 4-8 hrs for 24-72 hrs
- If on diuretic, consider holding
- Consider IV or subcutaneous fluids if needed for hydration
- Evaluate for unmet needs, environmental factors, other non-medical causes***
- Consider non-pharmacologic interventions (e.g. sensory, environmental, exercise, others that have been effective for this resident in the past)***
- Update advance care plan and directives if appropriate

Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

Tests Ordered

Evaluate Results
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

Notify MD / NP / PA

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

* Refer also to other INTERACT Care Paths as indicated by symptoms and signs
** If sepsis is being considered, refer to INTERACT Guidance on Possible Sepsis and INTERACT Guidance on Infections
*** See resources available from the “National Nursing Home Quality Improvement Campaign” at https://surveyortraining.cms.hhs.gov/pubs/handinhand.aspx