AMERICAN DATA

Behaviorist

Open the Behaviorist Access screen

1. Log into ECS as a user with access to the Behaviorist Access screen.
2. Once your Access screen begins to load, you will be presented with a Name Selection screen.
    a. Utilize the Filter button if wanting to narrow down the name(s) by specific floors, units, or wings.
    b. Click the Multi button.
    c. Choose the name(s) you would like to chart on.
    d. Click OK.
    e. Your access screen will load with the names of the residents that you have chosen listed on the left side of the screen.

Main Behaviorist Access screen

This screen is divided up into three sections: Charting, Reports, and Other.

Behaviorist	Charting	Reports		Other
Main Menu	Behavioral Assessment	Comp. Functional Assessment	Behavior / Mood Plan	Goal Target Dates (Calendar)
	Additional Assessments	Face Sheet	Behavior / Mood Monitoring	View Chart
	Seizure Record	Review Psychotropic Meds	Behavior / Mood Review	Schedules
	Behavior / Mood Plan	Behavior / Mood Charting	Behavior / Mood Review (Graph)	Write Internal Memo
			More Reports	

Part 1: Charting

Click onto a button within the charting column to load the Write screen. Select name(s) needing to document on. Work from left to right in the screen clicking onto the relevant answers. Once completed, click onto Sign to save documentation, and be brought back to the Access screen.

Click onto Clear if wanting to start over completely. Click **More…** to access additional charting features, such as spell checker (*Spelling* button) or on-screen keyboard (*Keyboard* button).

If wanting to document on another resident within the list, utilize the arrow to the left/right of the resident name or click the downward arrow to access the dropdown list and select a new name.

Potential Charting Topics

The topics available may vary based on your facility's policies and procedures, as well as required assessments. However, each charting topic will work in the same manner as described above.

Behavioral Assessment: Utilize this assessment to document different behaviors, frequency of these, severity, and interventions to be utilized when/if these behaviors occur.

Additional Assessment: When this button is clicked onto, a section will display with all other available assessments in the system. Some examples of assessments available include BIMS, Cornell Scale for Depression, GAD-7 Anxiety Scale, PHQ-9, Sleep, Smoking Safety Evaluation, and Trauma Informed Care Tools. Click onto an assessment folder to load that topic. All scored assessments will total automatically.

Seizure Record: If a user witnesses a seizure, they should document what was witnessed within this topic. Items addressed include the resident's awareness, head movements, speech, vital signs, post ictal, start time, and length of seizure. All information entered within this topic will flow into the Seizure Record report.

Behavior/Mood Plan: This topic is part of the overall habilitation plan. Some facilities may call this the problem list, goals, or the program. The verbiage of your facility will be adjusted within the database so that it matches what you are used to seeing. This is the topic that is used to create the behavior/mood goal. Utilize the topic working from left to right for each of the different programs. The resident may have several behavior/mood programs, and each may be written within this topic, but will need to be documented as separate entries. Any programs assigned to AM, PM, or NOC shift will automatically display on the CNA/Hab Aide charting screens as required.

Part 2: Reports

Click onto a button under the Reports column to run that specific report. Once clicked onto, the user will be prompted to select resident name(s) to view the report on. You may also be prompted to select a date/date range. This will then narrow down the results shown within the report to only display documentation within the selected date range.
If a report loads, click onto the printer, or save icon, if needed. Click onto **Export**, if available, if wanting to export the report to Excel. Utilize the **Control** button to change name(s) or date(s).

If a view screen loads, click onto the **More…** button to access additional features, such as a big A (to increase font size), print button, and a search option.

The reports available may vary based on your facility's policies and procedures, as well as required assessments.

Comp. Functional Assessment: This will run the Comprehensive Functional Assessment report.

Face Sheet: This will display the Face Sheet report. This includes resident information including their demographic information, original admission date, payer sources, emergency contacts, and primary care provider.

Review Psychotropic Meds: A view screen will load and display all current active psychotropic orders. To also view orders that are no longer active, click onto **Control**, place a checkmark in **D/C'd Entries**, click **OK**, and **Go** to update the screen. Discontinued entries will display grayed out.

Behavior/Mood Charting: A Control screen will load prompting the user to first enter in a date range. Click onto Start Date/End Date to enter in dates or utilize the Last Month/Current Month buttons. If not wanting to restrict based on a date range at all, click OK without selecting any dates. Click Go to run the view screen and display the information. All behavior and mood notes from nursing, CNAs, and targeted behavior monitoring for psychotropic medications will display.

Behavior/Mood Plan: Some facilities may call this the problem list, goals, or the program. The verbiage of your facility will be adjusted within the database so that it matches what you are used to seeing. This report will display only the behavior/mood goal.

Behavior/Mood Monitoring: Once this button is clicked onto, the user will be asked to select a date range. Utilize the Start Date/End Date, or place the dot into Today, Current Month, or Last Month. If wanting to see all documentation, regardless of the date, simply click OK to run the report.

BEHAVIOR / MOOD - HABILITATION DOCUMENTATION

08/01/2021 - 01/18/2022

Name: Depp, Johnny		Room:	Birthdate: 05/08/1956	Age: 65 Yrs	Sex: M
MRN: 2014-134	Admit Date: 08/06/2018	Physician: Dr. Hugh O'Connor	Code Status:		

Date	Field	Value
08/06/2021	SHIFT:	AM (Residential)
	MOOD/BEHAVIOR PROGRAM:	Emotions
	BEHAVIOR MANAGED	Able to manage behavior
	SUCCESSFUL:	yes
		(Waedekin, Jacquelyn M Clinical Trainer)
08/13/2021	SHIFT:	AM (Residential)
	MOOD/BEHAVIOR PROGRAM:	Emotions
	BEHAVIOR MANAGED	Not able to manage behavior 5
	SUCCESSFUL:	no
		(Ceaser, Heather D Clinical Project Manager)
08/13/2021	SHIFT:	PM (Residential)
	MOOD/BEHAVIOR PROGRAM:	Emotions
	BEHAVIOR MANAGED	Able to manage behavior
	SUCCESSFUL:	yes
		(Ceaser, Heather D Clinical Project Manager)

Behavior/Mood Review: This report can be used for reviews of the program, whether these are completed monthly, quarterly, or for a custom time frame. The report displays the behavior/mood program as well as supporting documentation totaling the number of behaviors/emotions the resident had in each residential and day program (if applicable).

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Behavior/Mood Review (Graph): This graph report will display the total number of behavior "occurrences" over the past three months as well as all the behavior/mood programs for tracking of emotions or behaviors. Below the graph, the programs will display.

More Reports: Displays all reports available within the system that the user has rights to. Select any report in the list to view it and click **OK.**

Part 3: Other

Goal Target Dates (Calendar)

When you click onto this button, it will load a calendar for the current month. Calendar reports display the name and "event", in this case the target date word, on the left-hand side of the report. On the right-hand side is every day of the current month. Weekends are shown in a shaded green color. A "1" on a day indicates that is when that program goal is coming due and therefore should be reviewed on or before that date. If nothing displays when this is opened, that may mean that there are no programs written or none that are coming due this month. To adjust the dates shown, click onto **Control**, change the dates, and click **OK** to reload it. Calendar reports may be easily printed or exported by utilizing the buttons on the upper left-hand side of the screen.

View Chart

1. From the Access menu, click onto the **View Chart** button in the Other column.
2. Select name(s) and click **OK**.
3. Select more than one resident by holding the **CTRL** key on the computer keyboard.
    a. If a Control screen appears, put in a start and end date and click **OK**.
        i. Click **Go** at the top of the view screen to retrieve the notes in the specified date range.
4. When finished viewing, click **Exit**, which will take the user back to the Activities Access menu.

This button allows a user to select any documentation within the records granted rights to view. Click **Topic** or **Task** to choose the area of the chart to be viewed. Click **Control** to select a start and end date. Click the **Look** tab to select other options to view (*i.e.,* show names of initials, topic name, cosign, or free text highlighter). Once all options have been selected, click **OK** and then **Go** to retrieve the requested information.

- Adjust the font size by clicking **More…** and clicking on the big or little "A."
- Search for words within the view screen by clicking **More…** and onto the magnifying glass symbol. Type in the text to be searched and click OK. This feature will search both words that were clicked on within a topic as well as free text.

    - Click the arrow to the right of the search feature to have it bring you to the next found word.
- **Control button > Filter Tab**
    - *D/C'd Entries* – Displays all discontinued entries.

- *Users* – Use this to narrow down the charting being viewed based on the user(s) who entered it in. This is a great tool for auditing specific user(s) charting.
- *Free Text* – Allows the user to search within the charting on the view screen for a specific free typed word. If wanting to search through all the fall notes for a specific caregiver's name, simply enter the name in the Free Text box, click OK and Go.

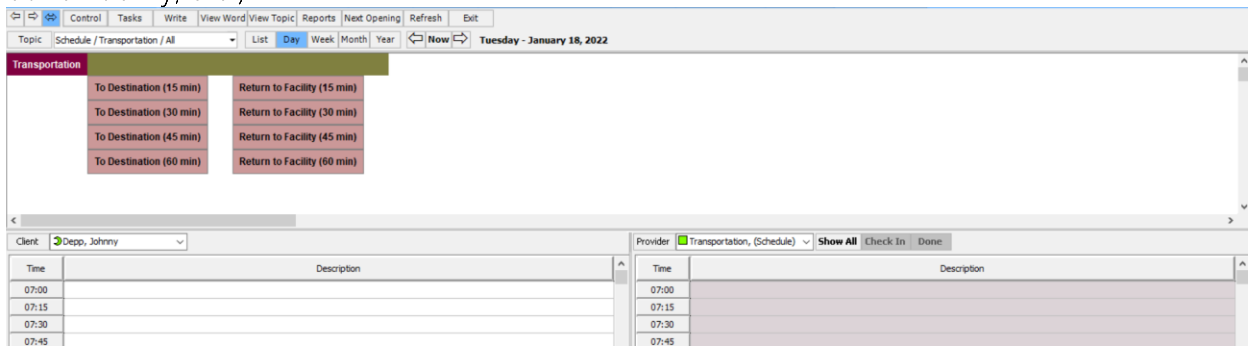
- Control button > Look Tab
  - *Separator* – For ease of viewing, the user may choose to add lines/spaces between entries or topics.
  - *Order* – Allows the user to determine the order in which the entries display on the screen.
  - *Show Name of Initials* – Displays the full name and title of the person who entered/discontinued each entry.
  - *Free Text Highlighter* – Used frequently in troubleshooting as it will turn all free text on the view screen blue.
  - *Show Topic Name* – Displays the topic that the entry was documented in.

Schedules

Schedules may be utilized within a facility to enter/view in-house visits, out of facility appointments, transportation needs, home visits, or care conferences. If a facility is utilizing this feature, the user will be displayed with a list of different schedule types.

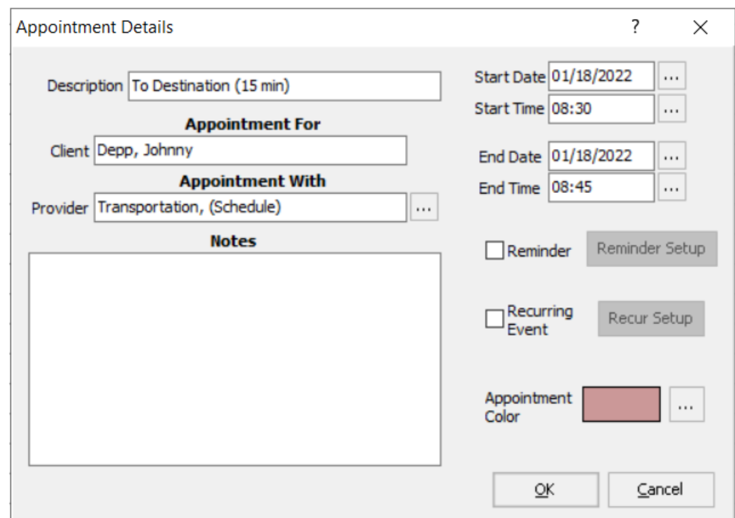
Schedule Appointment

If you select a schedule task that states "schedule" behind it then that is utilized to add new items onto the schedule or edit existing items. Once a task has been selected, a three-way split screen will appear. The top portion of the screen is where a user will have a list of options to select from. The bottom left displays the resident's schedule. The bottom right displays the entire facility's schedule in relation to this schedule type (i.e., transportation, in-house consults, out of facility, etc.).



To add to the schedule, click onto an item in the top portion of the screen and click into the lower left-hand side of the screen. Once you click into it, you will be presented with an

Appointment Details box which allows for additional adjustments (start date/time, end date/time, reminder's to users/user groups, or setups for a recurring event).



View Appointments

If you select a schedule task that states "view", a two-way split screen will appear omitting the option to select a schedule task type. Or a scheduler task may load without a split screen as it is intended to show only a resident's schedule or only the entire facility schedule. Although the view options are primarily for viewing, you may also right click onto an appointment and edit it from within this screen as well.

Write an Internal Memo

1. From the Access menu, click the **Write Internal Memo** button.
2. Once in the Internal Memo topic, the user will be presented with a pop-up that states, "This task has clients associated with it. Do you want to override your currently selected clients?" Always click **Yes**. (Messages written in this topic most likely will *not* have anything that belongs in their medical record, which is why a fake client is created to attach to this Internal Memo task so that all the messages written are on the fake client's record.)
3. Document the message to be sent.
4. Select a user group(s) to send the message to or click **pick user on Save** to select the person(s) from a user list once the entry is saved.

Part 4: Editing

1. Click the **View Chart** button under the Other column.
2. Select name(s) and click **OK**.
3. Select a date range and click **OK**.
4. Click **Go**.
5. Click the entry that needs to be edited. The entry will turn red. This is called 'tagging' the entry.
6. Click **Edit**.
7. Click the desired editing feature.
8. When using Append, DC and Explain, or DC and Copy, make the desired change and then click **Next**.
9. Click **Go** to see your changes.

Editing features which are bolded are utilized most often in Behaviorist Documentation.

Editing Feature	Function	Example
Append / Append All	Information is permanently attached to the entry; further editing will not be able to be done to the entry except to discontinue	Cosigning a student's documentation
New	A new, separate entry made in the same topic area	Can be used to add a new discipline approach to a care plan for example
Copy	An exact copy of the entry is made	An entry was accidentally discontinued and needs to be made active again
Copy One (All) to Other Client[s]	An exact copy of the entry is made and placed in another resident's chart	An entry was accidentally made in the wrong resident's chart. Use ALL if more than one entry was selected
Discontinue and Append	**Entry is discontinued and user is taken to a Write screen to document additional notes**	**An error was made in documenting the entry and the user would like to explain why the entry is being discontinued**
Discontinue and New	Entry is discontinued, a new entry is made in its place	Not typically used when editing department notes
Discontinue and Copy	**Entry is discontinued, copy of entry is displayed allowing user to make changes to the original entry**	**User forgot to use a button word when documenting and would like to 'insert' the word into the entry**
Discontinue	Entry is discontinued	Not typically used when editing department notes
Discontinue All	All highlighted entries are discontinued for one client	Not typically used when editing department notes
Discontinue Multiple Client Entries	All highlighted entries are discontinued for multiple clients	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Highlighted an entry that does not need editing