Guidelines for Nursing Care Facilities Providing Services to Residents with Behavior Problems

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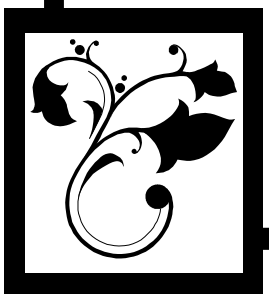

Colorado Department of Public Health and Environment
Health Facilities Division

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Chapter One

INTRODUCTION

A number of skilled nursing facilities in Colorado serve populations of residents who manifest significant behavioral problems as a result of mental illness, dementia and brain injury.

These guidelines are meant to serve as a source of information for facility staff and are not meant as a guarantee of compliance with the regulations for Medicare/Medicaid Certified Facilities, and Colorado, Chapter V Licensure Regulations for Long Term Care Facilities. Each facility that plans to implement these guidelines must develop written policies and procedures, specific to the facility, that provide instruction to staff for their use. It is recommended that the legal counsel for the facility review the policy and procedures prior to implementation.

It is important that facility staff do a careful pre-screening of each resident displaying behavioral problems prior to admission to the long term care facility. As a part of this screening and initial assessment, a preliminary care plan should be developed that addresses what the facility will provide for the resident. Included should be documentation that addresses what the facility will do for the resident that previous placement facilities were unable to provide for him/her. Facility staff must provide a thorough assessment, develop a behavior plan, and implement that plan as necessary to meet the needs of the resident. As a part of the pre-screening, a preliminary discharge plan should also be developed to explore the options for the resident, if the facility is unable to meet the needs of the resident after careful and knowledgeable implementation of the care plan. Facility staff must be aware that it is often very difficult to find placement for brain injured residents who display difficult behaviors. For this reason, a careful pre-admission screening and attention to a discharge plan may prevent having a resident in a facility where staff are unable to meet the resident's needs. The discharge of a resident from a facility must follow the regulations for transfer and discharge.

ABOUT THE GUIDELINES

The following guidelines are based on a psychosocial model that recognizes the physical component of disease, and also looks at the resident's social environment as it affects both appropriate and inappropriate behavior. All individuals having contact with the resident including staff, family, visitors and other residents make up the social environment that influence resident behaviors. The responsibility of staff in long term care settings is to provide a living situation that promotes positive behavior. In the guidelines are suggestions for interventions to implement when dealing with residents with difficult behaviors. The more restrictive interventions included in these guidelines must be used

judiciously. Where less restrictive interventions will provide the necessary safety for the resident and others, they must first be employed. In these guidelines, there is an attempt to ensure that the rights of residents with behavior problems and of those whose rights they violate or place at risk are taken into account in the development and implementation of behavioral interventions. 42CFR 483.10(F151 to F208), 42CFR 483.25(f) (F319)

These guidelines are meant to aid staff to conduct a meaningful assessment of resident behavior and to develop a behavioral management plan that provides a therapeutic environment promoting the highest practicable level of resident functioning. 42CFR483.25(F309). To do so, facilities must develop a "trust-based" relationship with the residents and family representatives, recognizing the uniqueness of each individual. At each step in the development of a plan of care, the input of the resident is important. A successful process involves the "buy in" of the resident. It is important to carefully document in the medical record to support the treatment given to the residents. All the careful observations conducted in the assessment are not helpful unless there is a method to track the resident's behavior through the assessment, through the care planning process, and into the implementation and evaluation of the care plan.

Staff training is essential to the successful implementation of any behavior management program.

Prior to the implementation of each individualized behavioral management plan, staff need to know what will be expected of them.

- A file of all individualized behavioral management plans should be available to all staff who work with the resident.

- During staff orientation and quarterly thereafter staff should be trained in the safety precautions to be used when providing care to residents having a history of dangerous behavior. More frequent training needs to take place for inexperienced staff. It is recommended that facilities hire staff who have previous experience dealing with residents with difficult behaviors.

- Staff should receive refresher training in the procedures employed by the facility to manage resident behavior at least once per quarter.

- The facility must have a policy in place that provides a plan for staff to implement when there is an emergency involving residents with behavior problems. The emergency plan is necessary when dealing with residents who are new to the facility, or whose acting out behavior occurs prior to an assessment or individualized care plan development.

Chapter Two

ASSESSMENT 42CFR 483.20 (F 272 through F278)

The assessment is the foundation for planning and delivery of care. The first step in completing an assessment of the resident is the clear identification of the problem. The use of global terms such as aggression, destruction and sexual assault should be avoided. The problem behavior should be defined in terms of the specific behavior. A problem identified as "touches women's breasts without their consent" presents a clearer picture of the problem behavior than a more global statement such as "sexual assault."

Key Points

Assessment:

- Identify the problem
- State why there is a problem
- Use Resident Assessment Protocols
- Rule out medical problems

The next step is to identify why the behavior is a problem. Determine how the behavior or its absence prevents the resident from functioning at his/her highest practicable level.

Once the problem behavior has been identified, a behavioral assessment must be completed. Resident Assessment Protocols (RAP) provide the link between the Minimum Data Set (MDS) and care planning. The RAP for Behavioral Symptoms, supplemented with the RAP for Delirium, Psychosocial Well Being and Mood State are very useful aids to use to assess the behavioral status of the resident.

The following information will also help to guide an assessment:

1. Time and setting in which the behavior occurs

Staff should observe the location and time of day in which the behavior is most likely and least likely to occur. What is the resident doing at the time of the behavior? Is s/he watching TV, eating a snack, participating in an activity, and so forth? Variables may also include events such as recent visits with family or being given bad news about something or someone important to the resident. Environmental variables such as temperature and the level of noise can also be important determinants of inappropriate behavior.

2. A determination of the circumstances that preceded the behavior

Staff should observe the events that take place immediately before the behavior occurred. The behaviors of other residents or staff frequently trigger inappropriate behavior. It should be specified which residents or staff members were present and exactly what they said or did. Assaultive behavior often occurs during the delivery of care. Note the type of care, the staff member involved and the details of the staff's approach with the resident.

3. The consequences of engaging in the behavior

The response of the staff, other residents, family, and visitors to the resident's behavior must be evaluated. Inappropriate behavior is often inadvertently reinforced by individuals having frequent contact with the resident. It may be helpful if staff observe how others respond to the appropriate behavior of the resident. Very often appropriate behavior is all but ignored and frequent attention is given to the resident only when the resident behaves inappropriately.

4. The frequency or duration of the behavior

Staff must determine how often a behavior occurs and how long the behavior continues. A baseline should be establish from the data collected during the assessment to determine whether or not the inappropriate behavior diminishes or increases after facility intervention.

Many factors may impact behavior and should be addressed prior to and during the implementation of a behavioral management plan. When completing an assessment of behavior, it is important for staff to rule out medical conditions which may impact behavior. These include, but are not limited to, infections such as pneumonia, sinus or urinary tract infections, bowel impaction, constipation, poor sleeping patterns, drug toxicity and side effects of medications. Hypoxia may result in increased confusion and agitation. Pain may cause a resident to be agitated, depressed and impulsive. Dehydration may result in confusion. Staff must be aware that at any time during the resident's stay in the facility, a resident's behavior may be affected by his/her medical status.

Chapter Three

COMMUNITY ADVISORY COMMITTEE

It is recommended that facilities which have residents whose behaviors are difficult to manage and whose treatment includes restrictions of rights, reach out to the community for guidance and support. As part of the facility's quality assurance program, a Community Advisory Committee should be established to meet at least quarterly to review:

- The impact on resident rights of facility policies and procedures developed to manage resident behaviors;
- Individualized behavioral management plans that involve a significant limitation of resident rights;
- Reports filed by the residents or their legal representatives concerning the investigation of allegations of resident abuse.

A workable advisory committee would advise the facility on matters of policy and be composed of individuals, a majority of whom reside in the facility's service area and none of whom are owners, employers or consultants to the facility. The committee should include: 1) an advocate for resident rights such as the local ombudsman and 2) at least one individual qualified by education, e.g., a graduate degree in social work, psychology, theology or a related area, and experience to assist the committee in assessing the appropriateness of behavioral interventions. When possible, the committee should also include a legal representative or a family member of a resident. The Community Advisory Committee could serve several different facilities.

THE BEHAVIORAL MANAGEMENT PLAN 42CFR 483.20(d) (F279)

After a thorough assessment has been conducted, a behavioral management plan must be implemented to assure consistency of staff responses to specific behaviors and to provide an environment that promotes positive change for the resident. The behavioral management plan is part of the overall care plan and serves to provide treatment and services for the psychosocial needs of the resident. Individualized behavioral management plans should be developed by an interdisciplinary committee including, but not limited to the administrator or his/her designee, nursing staff (including certified nurse assistants), social service staff, support staff and representatives of other agencies involved

Key Points

Individualized Behavioral Management Plans:

- Teach residents new skills and behaviors
- Use positive reinforcement
- Remove triggers to negative behavior
- Avoid attention to negative behavior

with the resident, such as the psychologist, mental health worker and the resident and family representative, legal representative, etc. Chapter V 19.4.2, 42CFR (F280). The care plan becomes each resident's unique path toward achieving or maintaining his/her highest practicable level of well-being. When the care plan reflects careful consideration of individual problems and causes, linked with appropriate resident-specific approaches to care, residents are more likely to experience goal achievement and an increased satisfaction with the quality of their lives.

1. Written as part of overall care plan

The individualized behavioral management plan should be written as part of the overall care plan to include measurable objectives and timetables to meet the resident's psychosocial needs as identified in the comprehensive assessment. The approaches to meet the goal should be clearly stated, available to all staff and to the resident to promote consistency and good communication. For example, writing an approach to "redirect" a resident who demonstrates a behavioral problem is not sufficient. It is important that the plan define the "WHO, WHAT, WHERE, and HOW" staff are to redirect the resident. Does it mean that the CNA take the resident by the hand and place him/her in a chair, or does it mean that the administrator and maintenance supervisor must physically separate the two residents, etc.? The plan must give enough information to all staff that each person who works with the resident has a clear understanding of the problem and a means to deal with that problem.

2. Involve the resident

When possible, the resident must be a part of the behavioral management plan team. Involve the resident with the development of the goal and approaches to address his/her behavioral problems.

Key Points

Care Plan:

- Developed by inter-disciplinary planning team
- Based upon the comprehensive assessment
- Defines specific time limits
- Provides measurable objectives
- Includes specific, realistic approaches
- Evaluated at least quarterly

3. Review

Behavioral management plans should be re-viewed by the inter-disciplinary Committee and be included in the resident's overall plan of care. 42CFR 483.20(b) (2) (F279 and F280), Chapter V 5.1.4. A significant change in the resident's condition or the failure of the plan to effect expected behavior change should trigger an early review.

4. Punishment

Punishment procedures must not be used in the management of resident behaviors. 42CFR 483.13(b)(c)(F223, F224 and F226). Examples of punishment include the infliction of physical pain, scolding or frightening the resident.

Punishment should not be confused with methods which may be implemented for the residents' well-being, such as the following:

A. The placement of a resident in a short term monitored separation may be used to reduce the frequency of behavior, reduce agitation, protect the resident or others until the resident's behavior no longer places him/her or others at risk or until a plan can be devised to eliminate the risk by other means.

B. The provision of nondemeaning verbal feedback to residents when there is a need for staff to identify and control threatening or dangerous behavior.

C. Restriction of the rights of a resident to have access to certain personal possessions or to participate in specified activities when the restriction is necessary to protect the resident or others.

5. Resident Rights

The behavioral management plan must not limit access to meals, routine snacks, scheduled activities, personal possessions, visitation and other objects or events that are a resident's right. However, special snacks and activities that are in addition to those routinely provided to all residents may be used to reinforce appropriate behavior. Similarly, possessions purchased with facility funds (actually owned by the facility) for the purpose of affecting behavior change may be made available to the resident contingent upon his/her behavior. These guidelines should not be construed to mean that residents can be allowed to violate the rights of others in the exercise of their own rights. For example:

A. If in the course of a meal or an activity, the resident engages in dangerous, destructive, or disruptive behavior, or other behavior that violates the rights of others, the resident may be removed from the dining room or that activity in order to protect the rights of others.

B. If the resident has engaged in dangerous, destructive, or disruptive behavior, or other behavior that violates the rights of others during off grounds or other activities where staff are unable to safely manage the resident's behavior, the resident may be denied the opportunity

to engage in these activities until s/he no longer presents a risk under these conditions.

C. If the resident uses personal possessions in a manner that results in dangerous, destructive, or disruptive behavior, or other behavior that violates the rights of others, the resident may lose access to that possession on a temporary or permanent basis depending upon the circumstances.

6. Individualized behavioral management plans should consider the following procedures to eliminate inappropriate behavior:

A. Teaching residents appropriate skills and behaviors

1) Modeling is an effective means of teaching skills and changing behavior. Residents with an intact nervous system may acquire new learning with the application of consequences. They may be able to learn new ways to behave in the same situation and they can learn how to behave in new situations. Events that in the past set the occasion for inappropriate behavior can, with new learning, set the occasion for appropriate behavior.

2) Residents with dementia or head injuries have limited short term memory and as a result may find it difficult or even impossible to learn from the consequences of their behavior and may be unable to learn to change their behavior. For these individuals, the emphasis of a behavioral management plan is on the elimination of the triggers which stimulate inappropriate behavior and the introduction of circumstances that promote appropriate behavior.

3) While residents with mental illness can generally learn new behaviors from the application of consequences, some disorders impair their ability to do so. Some psychotropic medications impair memory and some mental illness disorders limit the resident's ability to learn new behavior.

4) This is not to say that the reinforcement of appropriate behavior in residents with dementia, mental illness, or head injury should never be used. Residents with mild to moderate impairment in short term memory can sometimes learn from consequences when the consistent positive reinforcement of simple behavior is employed.

B. Positive reinforcement of residents' appropriate behavior

This area of day-to-day treatment of residents is frequently overlooked and is very important to the success of a behavioral management plan.

When reinforcement and motivation are indicated by the assessment of the resident, positive reinforcement of appropriate behavior can be a very effective intervention strategy. Edible reinforcers such as food and pop and tangible reinforcers such as cigarettes and money are often effective. Residents will often change their behavior in order to engage in activities that they enjoy. With all reinforcers, staff should use verbal praise. Telling the resident specifically what s/he has done well to earn the reinforcer makes it clear to the resident that s/he is being rewarded for his/her good behavior.

1) Thorough, frequent assessments and regular evaluations of the behavioral plan are important to determine the success of the reinforcements offered. Whether or not something works to positively reinforce a resident is determined by the effect that it has on resident behavior. Many things that staff think may be reinforcing may have no effect on the resident's behavior.

2) One effective way to eliminate negative behavior is to reinforce the resident for not engaging in inappropriate behavior. When a resident does not engage in the targeted inappropriate behavior during a specified interval of time, s/he should consistently be given a reinforcer. Time intervals at the beginning of the program need to be short in order to increase the chance of success. When the behavior seldom occurs during a given interval, the length of time may be gradually increased. It is important to limit the number of behaviors targeted at any one time for this to succeed. If too many behaviors are included, the resident may never meet the criteria for reinforcement and the intervention may fail.

3) The more immediately the reinforcement is presented after the occurrence of the behavior the greater the effect. For some residents a delay in reinforcement may be tolerated by giving the resident positive feedback after s/he engages in the behavior and telling him/her when s/he will receive reinforcement. In situations where the reinforcer cannot be given immediately, giving the resident a token that can later be exchanged for the reinforcer or marking a chart to show that

the resident earned the reinforcer may provide additional help to overcome a delay in reinforcement. In this situation, the token or the mark on the chart may function as positive reinforcers.

4) The greater the magnitude of the reinforcer, the more effect it will have on the behavior. If the identified reinforcer is too large to give to a resident each time the behavior occurs, the resident may be given points or tokens each time that s/he engages in the appropriate behavior. A given number of points/tokens may then be exchanged for the reinforcer.

5) When a resident is learning to engage in a new behavior, reinforcing the behavior each and every time it occurs will be more effective than intermittent (hit and miss) reinforcement. Once a behavior has become well established, intermittent reinforcement is an effective way to maintain the behavior.

C. Removal of triggers which precede inappropriate behaviors

1) Environmental and social triggers may result in assaultive behavior by the resident. For example, the snoring of a roommate may function as a trigger for assaultive behavior. When the roommate snores, the resident may hit him/her in order to eliminate the snoring. An easy way to eliminate the assaultive behavior in this example might be to place the resident in a room with a resident who does not snore. When the trigger is removed, the behavior no longer occurs. In this example, a room transfer is involved. The move should be care planned and monitored to assure that the move itself does not result in other behavioral problems. 42CFR 483.15(e)(2)(F157)

2) Residents often become assaultive during the provision of care, however, it is not unusual for these residents to cooperate with particular staff members. The place for staff to begin a behavior change program is to look at the approach used by the staff members who are assaulted and eliminate the circumstances that precede assault. The approach used by the staff members who are not assaulted present intervention strategies that may be used for cooperative behavior during care.

D) Withholding of rewards or attention in order to cause a decrease in a behavior

An important way to reduce the frequency of inappropriate behavior is to discontinue the positive reinforcement for the targeted behavior. For example, if a resident incessantly and inappropriately asks staff members to give him/her cigarettes, the behavior will subside if all staff members stop giving the resident cigarettes when s/he asks for them. One problem with using this technique by itself is that it leaves to chance the behavior that will replace it. In this circumstance, the resident may become abusive toward other residents in order to obtain cigarettes from them. This new behavior is worse than the behavior that had been discouraged. Another problem with this technique is that the frequency and intensity of the behavior may increase before it begins to decrease. It is extremely important that staff consistently respond to the targeted behavior and do not give in to the demands of the resident, or this method will not be successful.

7. In order to protect the resident or others, a resident may be required to remain in areas of the facility where staff are able to provide a level of supervision that will minimize the risk, e.g. areas within view of the nurses station or other areas used by residents where the resident's behavior can be monitored.

A. To the extent that high risk periods of the day or high risk conditions can be identified, restriction of the resident to certain areas should be limited to these specific periods or conditions.
B. The reason for the intervention and the procedures employed must be included in an individualized behavioral management plan.

8. Activities and Non-Traditional Therapies 42CFR 483.15(f)(1)(F248)

Activities that promote confidence and self-esteem, improvements in social skills, ability to improve relationships with others, and problem-solving are essential to the well-being of residents.

Key Points

Activities:

- Are essential
- Help residents exercise choice
- Help residents build self-esteem
- May include non-traditional therapies

A. An effective element in the management of problem behavior is the inclusion of a good activities program that provides activities that are intrinsically reinforcing to the residents.

B. Non-traditional therapies have an important role to play in developing a therapeutic environment. Music, art, horticulture, pets, massage and aroma therapies all support healthy self expression and feelings in residents. These engaging activities involve the resident in adaptive behavior that can replace behavior that is a problem to the resident or to others.

C. Therapeutic work programs are another excellent way to promote adaptive behavior and to improve self-esteem. The program must be supervised and should provide the resident with a positive self-worth experience. Care should be given to assure that any work the resident carries out, is performed to promote the resident's feeling of accomplishment and must not be merely for staff convenience. If the resident performs work usually accomplished by a staff member, the resident should be compensated either financially or through a reward system for that work.

9. Resident Choices 42CFR 483.10(F151 - F177)

Some residents who have histories of "institutionalization" and have experienced programs that focus on the management of behavior have expressed feelings that facilities are very controlling. The residents feel that they have little control over what happens to them. Groups and programs that help residents exercise responsible choice are essential to balanced nursing care programs. Giving residents the opportunity to develop menus, plan and lead activities, and have input into other decisions affecting their quality of life can be very empowering and useful in helping residents to develop important social skills and self-confidence.

Chapter Four

RESTRICTIONS OF RESIDENT RIGHTS, RISK MANAGEMENT, SHORT TERM MONITORED SEPARATION, TRANSFER AND DISCHARGE

When restrictive behavioral interventions are utilized in the behavioral plan, documentation must demonstrate the following:

- The reason for the use of the intervention;
- The effectiveness of the intervention; and
- Documentation of any negative effect that the intervention may have had on the resident.

1. RESIDENT RIGHTS 42CFR483.10(F151-F177) & 42CFR483.12(F201-F208)

Developing a plan of care for residents with problematic behaviors is a challenge for all facility staff. One of the difficulties that arises involves the possible limitation of the usual rights of an individual as a means to provide a therapeutic environment for that individual. Problems occur when the rights of one individual conflict with the rights of another. When facilities use procedures that limit a resident's rights, the facility staff need to develop policies and procedures that direct the development of the behavior management plans. These policies and procedures need to be reviewed by the community advisory committee.

Key Points

Resident Rights

- Infringement of rights should be limited
- Resident and legal representatives must be notified
- Document the reason and goals after limitation of rights

The following are guidelines to use when dealing with resident rights conflicts:

A. Residents rights may be limited when the assertion of a right places the resident or others at risk, or violates the rights of others.

B. Only the individual right that is directly linked to a risk situation or to the violation of the rights of others may be limited.

C. The infringement of the resident's rights should be as limited as possible to provide a therapeutic environment for the resident. The time of limitation must only be long enough to eliminate the risk or to assure the rights of others.

D. In extreme instances the right may be limited indefinitely; for example, refusing the resident access to a possession that may place the resident or others at risk, or a possession that has repeatedly been used to violate the rights of others.

E. Prior to admission, the resident and his/her legal representative should be notified of the restrictive practices of the facility that may apply to the resident, including but not limited to:

1) The use of behavior management programs;
2) The use of short term monitored separation;
3) The use of psychoactive medication;
4) The management of personal funds;
5) The restriction of smoking;
6) The restriction of sexual behavior;
7) The restriction of products containing alcohol;
8) The restriction of telephone use; and
9) The restriction of passes.

F. Written notification of these restrictive practices should include a statement indicating that the specific details of these restrictions may vary from resident to resident and should be based upon each resident's behavior.

G. Should the resident or legal representative, whichever applies, later find the above restrictions to be unacceptable and if the risk to the resident or others requires that the restrictions be continued, the facility should assist the resident or legal representative to locate an alternative placement. Staff must reassess the resident, and determine if the plan for treatment and services is appropriate to the current condition of the resident. If it is determined that the facility staff have acted appropriately to meet the resident's needs, then the resident will be subject to the restrictions as outlined in the behavioral plan until circumstances change. The facility must meet the regulations concerning transfer and discharge and should provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. 42CFR 483.12(F201-F204)

H. Should the resident appear to lack the capacity to make informed decisions about his/her health care and the resident does not have a legal representative, the facility will:

1) To the extent that it is reasonable, adhere to the health care decisions of the resident until a legal representative can be obtained;

2) Make a reasonable effort to obtain a legal representative for the resident; and
3) Notify the ombudsman or other resident rights advocate as appropriate.

2. RISK MANAGEMENT

A. If a resident presents an extreme danger to others, it is the facility's obligation to determine how staff can meet the resident's needs. An examination of options may indicate that short term twenty-four hour one-on-one staffing is necessary. It may be determined that a psychiatrist must be called in to meet with the resident or that hospitalization is necessary. However, facility staff must be aware that hospitalization may not be available for brain injured residents or for young residents with dementia. Because of the lack of resources, the facility has a responsibility to develop a plan of care in accordance with an accurate assessment that assists staff to deal with the problem behaviors that arise.

B. For residents who cannot safely leave the facility without supervision and who are at risk of elopement, the facility must conduct security checks and other interventions according to the comprehensive care plan to assure that they remain within the facility. The facility should have a plan for notifying the local authorities and for searching the neighborhood to locate missing residents.

C. Residents need not be segregated on different units or in different facilities on the basis of their diagnosis, but in making room assignments, dining room seating assignments and planning activities, consideration should be given to the resident's behavior that places others at risk and the resident's vulnerability to injury by others.

3. SHORT TERM MONITORED SEPARATION

Facilities have the responsibility to meet the needs of their residents. After a proper assessment has been conducted, staff must develop a workable plan and evaluate its effectiveness. It is expected that facilities have a continuum of options, from less restrictive to more restrictive, to manage residents who demonstrate problem behaviors. The following options may be considered when other, less restrictive methods have not worked to meet the resident's needs, or when using a less restrictive methods would present an unacceptable risk.

Short term monitored separation involves an approach in the behavioral management plan that separates a resident from the situation which promoted dangerous, disruptive, or destructive behavior, or other behavior that violates the

rights of others. Residents may also be placed in short term monitored separation when they exhibit behavior or signs of agitation that have in the past preceded dangerous behavior.

The resident may be placed in short term monitored separation only long enough to dispel the emergency.

In general, there should be no staff intervention other than the administration of medications, with regard to the resident's behavior while s/he is in short term monitored separation. However, the charge nurse will intervene, if in his/her judgement, the resident's behavior may result in serious injury.

Key Points

Short Term Monitored Separation:

- Is a therapeutic intervention
- Is utilized for disruptive, destructive and dangerous behaviors
- Used only long enough to dispel the emergency
- Is documented
- Is reviewed by an inter-disciplinary committee

For each use of monitored separation, staff must document the circumstances of the incident. The record should reveal what happened to trigger the behavior, how the resident responded to the separation and the name of the staff member(s) involved.

Each use of short term monitored separation should be reviewed by an interdisciplinary committee at least weekly to assure that the short term monitored separation was justified and that policies and procedures were followed.

If the cause(s) cannot be removed, the interdisciplinary team must decide whether or not to continue the use of short term monitored separation as an element of the behavioral management plan. A consideration of alternatives to the use of short term monitored separation must be considered no less than quarterly.

Chapter Five

COMMON BEHAVIORAL PROBLEMS

Providing the residents with daily care is not easy, especially when the residents are determined not to cooperate with the staff during the activities of daily living. Staff become frustrated as their schedules dissolve and their patience is drained. The negative behavior of the residents often escalate during these times. It is important that facility administrators appreciate the time and effort it takes to reassure, distract or comfort residents who, for any number of reasons reject care. The acuity of the difficult patient and the training and skill of the staff must be considered in the scheduling of the facility personnel.

Ways to manage behavioral problems may include matching the demands of the resident with his/her abilities to perform them. Provide the resident with a predictable routine each day, schedule periods of physical activity, provide for a quiet time during the day and provide for activities that allow the resident to succeed.

Staff's interactions with family members can be important ways to learn about the resident's changing abilities and needs. Family should be routinely informed about nursing care policy changes and changes in the resident.

When a resident shows decline in activities of daily living as evidenced by bathing, grooming, communication and dangerous and disruptive behaviors, the facility will need to determine if use of supervision, limited assistance or extensive assistance are needed to assure the resident does not deteriorate further. 42CFR 493.25 (F310)

Problem-solving methods for behavioral symptoms should first involve an assessment to observe and describe the behavior. Decide on realistic goals for behavioral change and the steps needed to reach those goals.

Bathing

Many residents refuse to bathe. While it is generally considered to be their right to do so, there are times when this right is in conflict with the rights of other residents or in conflict with their own needs for appropriate hygiene. Therefore, the following steps may be taken to give a resident a bath over his/her objections:

A. Staff will complete an assessment which includes talking with the resident in an attempt to ascertain the reason(s) that the resident is unwilling to bathe, e.g., privacy issues, gender of the certified nurse assistant, timing of bath, etc.

B. Based upon this assessment, bathing procedures will be developed and included in the care plan, as appropriate. Facility staff should involve the resident and family members to consider options to encourage bathing. The options may include, but are not limited to the following:

1) Attempt to arrange a time with the resident when s/he would be willing to bathe;
2) Offer the resident alternatives to a bath, such as a shower or a bed bath using a pan of water;
3) Offer the resident a positive incentive to bathe, such as a perfumed bath gel or time to linger in a comfortable bath;
4) Offer a reinforcement for the completion of a bath;
5) Assure the resident the assistance of staff personnel that deal successfully with the resident;
6) Assure the resident's privacy.

C. There are times that the resident refuses personal hygiene even after staff have assessed the reason for the resident's failure to bathe and developed and implemented a plan of care. When that resident becomes odorous, suffers physical consequences such as excoriation, or offends the rights of others around him/her, staff, after a period of time determined by the seriousness of the problem, in accordance with the care plan, involve the physician and to protect the rights of others, the resident's activities that affect the rights of others will be limited until s/he agrees to take a bath voluntarily. Facility staff must provide activities for the resident in an alternate manner.

Fighting

A. Fighting is a severe behavioral symptom that may cause potential harm to others and is most often caused when personal space is threatened. It is very common that residents are not able to resolve conflict without staff assistance.

B. For the immediate management of fighting:

1) Staff should first control the behavior by separating the residents. If necessary, more than one staff member may be needed.
2) To the extent practicable, staff who have the best relationship with each resident should intervene using a calm, but firm voice.
3) To the extent it is practicable, staff should keep a safe distance between the residents involved and themselves.
4) Staff should avoid being provocative or shaming of either of the residents.

C. Reasoning with residents during an emotional outburst when others may be at risk is generally not practicable. At a later time, when the residents are calm, it may be helpful to:

1) Tell each resident clearly what is expected of them under similar circumstances in the future.
2) Explain the consequences of their unacceptable behavior.

D. The behavioral management plan for combative residents should include steps for managing fighting and the limits that should be placed on their behavior.

E. The facility must have clear protocols and techniques for approaching and dealing with residents who need immediate management in dangerous and disruptive situations.

F. If the conflict occurred between roommates, reassignment of rooms may prevent further fighting. Facilities must demonstrate that they provided proper notification.

Medication

Residents have the right to refuse medication. 42CFR 483.15 (b)(F242). A resident who has behavior problems may often refuse to take medications, even when they are important to keep the resident functioning at his/her highest level. The facility should first make reasonable accommodations of the resident's individual needs and preferences. Staff must assess the resident to determine why the resident is not taking his/her medication. It is important to document what the staff does to meet the resident's needs and to identify the care and treatment needed to restore or maintain the functional abilities for the resident. As part of the assessment, staff should determine if the resident's behavior has changed because of a physical illness or possible side effects of the medications.

A. The physician must be made aware that the resident refuses to allow the administration of medication. If the physician determines that the medications are necessary, the legal guardian with power to affect medical decisions, should be called in to help plan the process necessary to assure the administration of the medications.

B. When a resident or legal representative refuses to consent to medication, the nurse should notify the physician and inform the resident or legal representative of the probable medical outcome from his/her refusal to consent to the medication and may state other reasons for taking the medication, as appropriate.

C. In non-emergency situations, a court order is required prior to administration of psychotropic medication to a resident who refuses to take it. 42CFR483.10(b)(4)(F155)

Telephone 42CFR 483.10(k)(F174)

Restricting the use of the telephone by a resident of an institution is a serious decision. Restrictions are limited to outgoing calls as authorized by the guardian or other legal authority.

A. After documentation of a careful assessment and implementation of a plan of care, residents with a history of telephone abuse (e.g. making harassing or threatening calls, calling 911 or making other inappropriate calls) may have their access to the telephone restricted in order to eliminate the abuse.

   1) Telephone times may be scheduled for residents who require monitoring to prevent telephone abuse.

   2) Staff will review telephone restrictions at least quarterly.

B. While the facility may take the action necessary to limit telephone access of residents on restriction, it must assure that telephone access is readily available to the other residents.

Smoking 42CFR 483.25(h)(2) F324

Unless a guardian has been given specific authority by the court to make decisions regarding smoking by the resident, the resident has the right to make day to day decisions in this area.

A. An assessment of the resident's ability to smoke independently may include, but is not limited to the following:

1) A history of unsafe smoking practices as evidenced by: burning fingers, burning clothes or furnishings, smoking in bed, or smoking in unauthorized areas.

2) An evaluation of the resident's ability to limit his/her own cigarette use, and to resist giving or receiving cigarettes from other residents.

3) A determination that the resident has memory loss, disorganized thinking or other conditions that prevent him/her from following facility smoking rules.

B. Upon admission and quarterly thereafter, each resident's need for supervised smoking must be assessed during the quarterly care planning conference.

C. When an assessment demonstrates that a resident presents a danger to him/herself or others while smoking, the resident may be restricted to supervised smoking. Supervised smoking may include, but is not limited to:

1) Staff responsibility to provide the resident access to cigarettes or matches. The resident will not be allowed to carry his/her own cigarettes or matches.

2) Staff supervision during cigarette smoking at designated times and places to observe and enforce safe smoking practices.

D. When a resident is unavailable to smoke at a designated smoking time because s/he had been placed in short term monitored separation or was engaged in another activity during the designated smoking period, staff does not have to allow the resident to smoke until the next designated smoking period.

E. Access to cigarettes purchased by the resident should not be used as reinforcers in adaptive behavior plans. However, cigarettes purchased with facility funds may be used to reinforce appropriate behavior.

Personal Funds **42CFR 483.10(c) F158**

A. For residents who are unable to effectively manage their personal funds, the facility may manage the residents' access to their funds.

B. Prior to assuming the management of resident funds the facility must complete an assessment with the resident and family or legal representative about the resident's ability to manage the funds independently. The assessment will include, but need not be limited to the following:

1) Does the resident lose or misplace his/her money so that it is not available when needed?

2) Is the resident exploited by others so that money is not available to meet his/her needs?

3) Does the resident spend all of his/her money as soon as s/he gets it resulting in his/her inability to meet needs later in the month?

4) Does the resident exploit others to obtain money after his/her own money has been spent?

5) Does the resident engage in disruptive, dangerous or destructive behavior when all of his/her money has been spent and there is no money to meet current needs?

C. In order to meet the needs of the resident, money management by the facility may include, but need not be limited to:

1) Providing the resident money only when needed to make a specific purchase;

2) Rationing money so that it will last until the next time that the resident will receive funds.

Products Containing Alcohol

A. Many residents with behavior problems have a history of alcohol abuse. When alcoholic beverages are not available to them in the facility, they will drink products containing alcohol and place themselves at risk. Since these residents may steal these products from other residents, it may be necessary to control the use of these products by all residents in the facility.

B. At the discretion of the facility, any or all residents may not be allowed to keep products containing alcohol, e.g., perfume, shaving lotion, mouthwash and beverages, in their rooms. Residents will be given periodic access to these items under staff supervision.

Passes

A. Residents who present a risk to themselves or others while on pass will not be allowed to leave the facility without appropriate supervision by family or friends.

B. For residents with a legal representative, the legal representative in consultation with the facility will determine which family members or friends may take the resident out on pass.

C. For residents with limited decision making capacity and who have no legal representative, the facility will have the responsibility of determining whether or not a resident may leave on pass and determining which family and friends are capable of providing the necessary supervision while the resident is absent from the facility. When these residents are denied passes over their objection, the facility will notify the ombudsman and make a reasonable effort to obtain a legal representative for the resident if appropriate.

Transfer and Discharge

A. It is not permissible to discharge a resident who displays behavior problems without conducting a thorough assessment, implementing a workable care plan and effectively evaluating the care plan for necessary adjustments before consideration of the discharge of the resident from the facility.

B. The resident, family member or legal guardian, and the interdisciplinary care planning team must work with the Ombudsman to consider all the options prior to discharge. However, if it is found that a transfer is necessary to meet the needs of the resident, the transfer must be in compliance with the regulations. 42CFR 483.12 (F201-F204)

Glossary of Terms

Assessment: The process of collecting and evaluating information about a resident for the purpose of developing a profile for care planning. The assessment process is both initial and ongoing.

Consequences: Events or objects following a behavior that exert control over future behavior. Acceptable consequences of behavior include positive reinforcement and extinction. Punishment is an unacceptable consequence.

Dangerous Behavior: Dangerous behavior is behavior that places the resident or others at risk of injury. Examples include:

1. hitting, cutting, kicking, biting, throwing objects at others, breaking glass, scratching or attempting to do so;
2. making forcible physical sexual advances; and
3. engaging in behavior that puts the resident or others at risk of contamination from feces or body fluids.

Destructive Behavior: Destructive behavior is behavior that results or is likely to result in unacceptable damage to property of value. Examples include:

1. throwing breakable objects;
2. pulling pictures, mirrors, etc. from the walls;
3. knocking over furniture or appliances or knocking items from furniture or shelves;
4. hitting one object with another; and/or
5. plugging toilets or drains.

Disruptive Behavior: Disruptive behavior is behavior that:

1. is so distracting that ongoing activities cannot reasonably continue;
2. is provoking or likely to provoke disruptive, destructive or dangerous behavior in other residents;
3. is likely to escalate into behavior that will place the resident or others at risk; or
4. violates the rights of others.

Emergency: An emergency exists when a resident's behavior places the resident or others in danger, is disruptive and/or results in destructive behavior and less restrictive intervention procedures included in the plan of care have failed or would be inappropriate or ineffective under the circumstances.

Interdisciplinary Committee/Team: An Interdisciplinary Committee/Team at minimum consists of the Administrator or his/her designee, Director of Nursing or his/her designee and the Director of Social Services or his/her designee. Other members of the staff and the staff of other agencies involved with the resident may also be members of the team at the discretion of the facility.

Legal Representative: The legal representative for a resident is the individual(s) who has guardianship, has a durable power of attorney or is a health care proxy.

Modeling: A situation in which an individual learns by imitation.

Pass: A pass is the verbal or written permission given by the facility for a resident to leave the facility for an agreed upon period of time without the supervision of facility staff.

Positive Reinforcement: A procedure that maintains or increases the rate of a behavior by consistently presenting a positive reinforcer following the behavior.

Positive Reinforcer: When an object or event follows or is presented as a consequence of a behavior, and the frequency of that behavior increases or maintains as a result, the object or event is called a positive reinforcer. Praise, attention, activities and edibles are often used as positive reinforcers. Nontechnical terms for positive reinforcers are incentives and rewards.

Punishment: A procedure in which an aversive event is presented immediately following a behavior for the purpose of reducing the frequency of the behavior. The infliction of physical pain and scolding.

Triggers: Events or objects preceding a behavior that exert control over a behavior. Triggers often signal the consequences for engaging in a particular behavior.

Appendix I

The Development of a Behavior Management Plan

- ***Assessment***
  - Identify the specific problem, stating why the behavior is a problem
  - Complete the Resident Assessment Protocols
  - Rule out a medical cause for the problem (See Appendix II)
  - Assess the time and setting in which the behavior occurs
  - Determine the circumstances that preceded the behavior
  - Determine the consequences to the resident for engaging in the behavior. Decide if the resident's negative behavior is reinforced by staff response.
  - Document the frequency or duration of the behavior

- ***Care Plan***
  - Develop with the input of an interdisciplinary committee and involve the resident.
  - Base the plan on the results of the assessment.
  - Write the care plan for one or two behavioral symptoms at a time.
  - Decide on realistic goals and specific steps needed to reach each goal.
  - Tell all care givers about the management care plan. Do this in writing and in person.
  - Define specific time limits for trying the care plan.
  - Begin the plan and continue for the time period stated. It is important that all shifts each day of the week carry out the plan in the same way. Keep each other informed about what is working and what is not.
  - Record the resident's behavior on the Behavioral Symptom Sheet.
  - Evaluate the plan when the time period is over.
  - Look at the Behavioral Symptom Sheet during the specific time period and determine if the negative behaviors have decreased. If so, discuss which steps helped. Decide which steps of the plan were not helpful.
  - Plan other possible solutions if needed.
  - If in spite of all the efforts of the facility staff, the behavior cannot be controlled and is dangerous, interferes with care or impairs the resident's function, call the physician for further evaluation.

Appendix II

Medical Evaluation for New or Worsening Behavioral Symptoms

1. ***Check Vital Signs:***
-Temperature.
-Lying down and standing blood pressure.
-Respiratory rate, pulse rate.
-Blood glucose (diabetics).
-Cognitive status, orientation.
-Oxygen saturation levels.

2. ***Review Medication Record:***
-Drugs added.
-Drugs stopped.
-Dose changes.
-Routes of administration changed.
-Therapeutic levels of medications.
-Poly pharmacy.

3. ***Review Chart:***
-Changes in urination or bowel habits.
-Changes in food and fluid intake.
-Changes in sleep patterns.
-Falls or injuries.
-Acute changes in orientation.
-Infections - URI, UTI.

4. ***Check General Body Position:***
-Guarding or protecting any part of the body.
-New neurologic deficits.
-New asymmetries or swellings.

5. ***Examine Skin:***
-Redness.
-Swelling.
-Bruises.

6. ***Check Joint Range of Motion:***
-Limitation.
-Tenderness or pain.
-Fractures.

7. ***Examine Abdomen:***
-Distention.
-Enlarged bladder.
-Catheter problems.
-Impaction.

8. ***Check Restraints***

9. ***Check for Environmental Changes:***
-Room change.
-New roommate.
-Remodeling.

10. ***Check for Recent Social Changes:***
-Family visit.
-Personal loss.
-Activities.

11. ***Check for Signs of Depression:***
-Sadness, crying.
-Anxiety, irritability.
-Loss of interest, feelings of worthlessness, withdrawn.
-Sleep problems, fatigue, decreased energy.
-Difficulty concentrating, slowed speech.
-Over-concern with health.