

APPENDIX B

GUIDELINE FOR THE MANAGEMENT OF INAPPROPRIATE BEHAVIOR AND RESIDENT TO RESIDENT ABUSE

I. The initial resident assessment should include a psychosocial behavior component with interventions, if appropriate, in the care plan. Reassessment should be done at least quarterly, or at any time when a resident's pattern of behavior changes. Resident response to interventions should be recorded in the medical record.

II. Inappropriate behavior and/or actions should trigger an immediate reassessment with adjusted interventions; notification of the physician and/or the designated resident representative. Resident response should be recorded in the medical record. The facility's actions/interventions in response to behavior changes should also be part of the plan of care and should be appropriately recorded. Prompt reassessment of behavioral changes will in most cases avert the continued progression of inappropriate behavior.

III. Inappropriate behavior and/or actions involving other residents should be identified in the records of all involved residents including assessments, interventions and responses. Notifications of physician and/or designated resident representatives should also be recorded in medical records of all involved residents.

IV. Incidents of inappropriate behavior or actions of abuse between residents should result in the following actions, as applicable:

A. Immediate assessments of involved residents.

B. Notification of attending physicians or advanced practice nurses.

C. Interventions and responses of residents.

D. Notification of residents' designated representatives.

E. Protection of involved residents' civil and constitutional rights.

F. Determination by administrator of facility's ability to assure safety and security of all patients.

G. Implementation of emergency or short-term precautions to assure safety while working toward resolution.

H. Notification of police if necessary.

V. In the event that it is determined that a resident must be removed from the facility, the transfer should be initiated in accordance with the provisions of this chapter.

VI. Transfer from the facility should be based on the appropriate evaluation and transfer order of the attending physician, advanced practice nurse, facility medical director and/or consultant psychiatrist.

VII. In the event of an immediate emergency situation only:

1. Have patient removed to emergency room of local hospital for medical and/or psychiatric evaluation and consultation by a physician or advanced practice nurse. Return of patient to the long-term care facility should be based on the physician's or advanced practice nurse's written notation of the appropriateness of returning the resident to the long-term care setting. The administrator is responsible for the decision to accept or deny the return of the resident according to N.J.A.C. 8:39;

2. A police complaint should be filed against the abuser and have the individual removed. The complaint can be filed by the facility or the abused party; and

3. Notify all agencies (that is, Medicaid if applicable, Ombudsman for the Institutionalized Elderly, if applicable (over 60) and the Department of Health and Senior Services.)

VIII. In the event all guidelines have been followed and resolution has not taken place, assistance should be requested from the Department.

IX. Facility policies and procedures to address inappropriate resident behavior, including resident to resident abuse, should include all of the above outlined actions.

X. To determine resident's emotional adjustment to the nursing facility, including his/her general attitude, adaptation to surroundings, and change in relationship patterns, the following areas should be evaluated:

1. Sense of Initiative/Involvement

Intent: To assess degree to which the resident is involved in the life of the nursing home and takes initiative in activities.

Process: Selected responses should be confirmed by the resident's behavior (either verbal or nonverbal) over the past seven days. The primary source of information is the resident. Secondarily, staff members who have regular contact with the resident should be consulted (for example, nursing assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Also, consider how resident's cultural standards affect the level of initiative or involvement.

Definition: At ease interacting with others--Consider how resident behaves during time you are together, as well as reports of how resident behaves with other residents, staff, and visitors. Does resident try to shield himself/herself from being with others? Does he/she spend most time alone? How does he/she behave when visited?

At ease doing planned or structured activities--Consider how resident responds to such activities. Does he/she feel comfortable with the structure or restricted by it?

At ease with self-initiated activities--These include leisure activities (for example, reading, watching TV, talking with friends), and work activities (for example, folding personal laundry, organizing belongings). Does resident spend most of his/her time alone, or does resident always look for someone to find something for him/her to do?

Establishes his/her own goals--Consider statements resident makes like, "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. Some things may not be stated.

Involvement in life of the facility--Consider whether resident partakes of facility events, socializes with peers, discusses activities.

Resident accepts invitations into most group activities--Is resident willing to try group activities even if later, deciding the activity is not suitable and leaving? Does resident regularly refuse to attend group programs?

2. Unsettled Relationships

Intent: To indicate the quality and nature of the resident's interpersonal contacts (that is, how resident interacts with staff members, family, and other residents).

Process: During routine nursing care activities, observe how the resident interacts with staff members and with other residents. Do you see signs of conflict? Talk with direct-care staff (for example, nursing assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that the staff members describing these relationships may be biased.

Definition: Covert/open conflict with and/or repeated criticism of staff--Resident chronically complains about some staff members to other staff members; resident verbally criticizes staff members in therapeutic group situations, causing disruption within the group; or resident constantly disagrees with routines of daily living. [Note: Checking this item does not require any assumption about why the problem exists or how it could be remedied.]

Unhappiness with roommate--Includes frequent requests for roommate changes, grumbling about roommate spending too long in the bathroom, or complaints about roommate rummaging in another's belongings.

Unhappiness with residents other than roommate--Includes chronic complaints about the behaviors of others, poor quality of interaction with other residents, lack of peers for socialization. This refers to conflict or disagreement outside of the range of normal criticisms or requests (that is, beyond a reasonable level).

Openly expresses conflict/anger with family or close friends--Includes expressions of feelings of abandonment, ungratefulness, lack of understanding, or hostility regarding relationships with family/friends.

Absence of personal contact with family/friends--Absence of visitors or telephone calls from significant others in the last seven days.

Recent loss of close family member/friend--Includes relocation of family member/friend to a more distant location, even temporarily (for example, for the winter months); incapacitation or death of a significant other; a significant relationship that recently ceased.

3. Past Roles

Intent: To indicate recognition or acceptance of feelings regarding role or status now that the person is in the nursing home.

Definition: Strong identification with past roles and life status--This may be indicated, for example, when resident enjoys telling stories about own past; or takes pride in past accomplishments or family life; or prefers to be connected with prior lifestyle (for example, celebrating family events, carrying on life-long traditions).

Expresses sadness/anger/empty feelings over lost roles/status--Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use; I'm not capable of doing the things I always liked to do." Resident cries when reminiscing about past accomplishments. Be careful not to take the reaction out of context.

Process: Discuss past life with resident. Use environmental cues to prompt discussions (for example, family photos, grandchildren's letters or artwork). This information may emerge from discussions around other MDS topics (for example, Customary Routine, Activity Pursuits, ADLs). Direct-care staff may also have useful insights relevant to these items.

XI. To determine resident's mood and behavior patterns, the following elements should be considered:

1. Sad or Anxious Mood

Intent: To identify the presence of behaviors that may be interpreted as physical or verbal expressions of sadness or anxiety.

Definition: A distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful). This may be a disorder of mood which is usually, but not always, accompanied by a painful mood of such magnitude that it calls for relief because it is severely, or unnecessarily, distressing or threatening to physical health and life, or interferes with functional performance and adaptation. These symptoms may be preceded by anger or withdrawal.

Process: Determine if resident expressed signs of a sad or anxious mood over the past 30 days. Draw on your own interactions with the resident. Pay particular attention to statements of direct-care staff, social workers, and licensed

personnel who may have evaluated the resident in this area. Does the resident cry or look dejected (unhappy) when no one is talking with him/her? When you talk with the resident, does he/she sound hopeless, fearful, sad, anxious? Does the resident report feelings of worthlessness, guilt? Does the resident appear withdrawn, apathetic, without emotion?

If you are unsure, seek confirming information from others who regularly come in contact with the resident (for example, activities professionals, social workers, or family members).

2. Mood Persistence

Intent: To identify a persistent sad/anxious mood that has existed on each day over the last seven days and was not easily altered by attempts to "cheer up" the resident.

Process: Normally, these moods apply to one or more of the indicators mentioned above of sad/anxious mood.

3. Problem Behavior

Intent: To identify the presence of problem behaviors in the last seven days that cause disruption to facility residents or staff members, including those that are potentially harmful to the resident or disruptive in the environment, even though staff and residents appear to have adjusted to them (for example, "Mrs. R's calling out isn't much different than others on the unit; there are many noisy residents.")

Definition: Wandering--Movement with no identified rational purpose; resident appears oblivious to needs or safety. This behavior must be differentiated from purposeful movement—for example, a hungry person moving about the unit in search of food; pacing.

Report on the most disruptive resident behavior across all three shifts. Code "1" if the described behavior occurred less than daily and "2" if the behavior occurred daily or more frequently.

4. Resident Resists Care

Intent: Identify problem behaviors related to delivering care/ treatment to the resident. These behaviors are not necessarily positive or negative; they provide observational data. They may prompt further investigation of causes in the care-planning process (for example, fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness to participate in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Consult medical record and primary staff caregiver. How does

the resident respond to staff members' attempts to deliver care to him/her? Signs of resistance may be verbal and/or physical (for example, verbally refusing care, pushing caregiver away, scratching).

5. Behavior Management Program

Intent: Determine if a behavior-management program is in place wherein staff members identified causal factors and developed a plan of action based on that understanding. There must be evidence of structure and continuity of care in the program (for example, written documentation). This category does NOT include behavioral management by physical restraints or psychoactive drugs, if these are the only interventions used.

Process: Consult medical record (including current care plan); consult primary caregiver.

Examples

Mrs. S has been observed on numerous occasions to hit, shove, and curse the woman seated next to her at each meal. After observing the pattern of Mrs. S's behavior for several days, staff noticed that her tablemate was in the habit of moving toward Mrs. S to take food from her tray. As a result of their observations, the primary nurse made a change in seating arrangements. (Note: Although staff might have increased the amount of food provided at meals, the real issue was the taking of food; Mrs. S would not want to share with others, no matter how much food she was given.) Mrs. S does not tend to ask staff for help when she is annoyed; she takes direct and aggressive action on her own. Now that staff understand this behavior, they are aware of the need to be vigilant. Code "1" for Yes.

Provisions were made for safety monitored wandering for Mr. V (including use of "secure bands" that activate an alarm if he wanders away from a designated area). Mr. V does not really disturb others (he does not go into others' rooms). Without this "band," however, staff lost track of him and he was in danger of harming himself if he got off the unit (a busy street is very near his unit). Code "1" for Yes.

6. Change in Mood

Intent: Determine whether the resident's mood changed in the past 90 days, that is, onset of recent mood problem or changes in a longstanding problem. Changes may have been expressed verbally or demonstrated physically; they include increased/decreased number of signs/symptoms, or increase/decrease in the frequency, intensity, or persistence of sad or anxious mood.

Examples

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was disruptive. After the medication was discontinued, these feelings and behaviors improved. She is better than she was, but still has feelings of sadness. Code "1" for "Improved." Mrs. D is now better than her worst status in the 90-day period, but she has not fully recovered. [Note: If the mood problem was no longer present due to the continued efficacy of the treatment program, the correct code would also be "1" (Improved).]

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About 2 months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital. For the last 30 days (following readmission), Mrs. Y has improved and her appetite is restored. Code "1" for Improved.

7. Change in Problem Behavior

Intent: Determine if problem behaviors or resistance to care increased/decreased in number, frequency, or intensity in the past 90 days-- that is, onset of recent behavior problems or changes in a more longstanding problem. Changes can occur in many different areas, including (but not limited to) wandering, verbal or physical abuse, socially inappropriate behavior, or resistance to care.

Changes can be exhibited as increases/decreases in the number of signs/symptoms and/or change in the frequency or intensity of the behavior(s).

Process: Review nursing notes, medical records, and consult with primary staff caregiver.