

## **Caring for Residents with Challenging Behaviors**

**January 14, 2004**

### **Highlights and Key Points of Panel Presentations and afternoon discussion session. (Please refer to conference agenda for Panel titles and speaker names)**

The purpose of this conference/workgroup is to focus on agency collaborative efforts through model approaches and realistic solutions that can be implemented within our current systems and to come up with short-term and long-term recommendations.

It is our hope that as major stakeholders you will join us in our commitment to achieve this goal.

#### **Panel I**

- Overview of Federal Guidelines
- Overview of State regulations
- Training modules to providers
- Regulatory agencies inspect whether or not care plan is being followed by providers
- Regulatory agencies check to see that resident's individual needs are being addressed
- Staff Education on De-escalation techniques
- More appropriate activities
- Restraint Alternatives
- Advanced Directives
- Care Alternatives
- De-institutionalization and the need for community options
- USE of Tools such as a Risk Assessment Tool that may be on file but not in use
- Focus on person and not label issued via diagnosis. By putting people first, we can care-plan how the illness affects the individual

#### **Panel II**

- Acute psychiatric residents are not permitted admission to Nursing Facilities in the PAS/RR screen
- Only residents with a primary medical diagnosis may be permitted admission to a nursing facility for a short-term stay. These residents require follow up by Advanced Behavioral Health within 30 days
- 180 out of 3,600 residents reviewed monthly, require a Level II
- 300 residents were exempted this year
- 50% of screens list Dementia without an associated mental illness
- Dementia is not classified as a mental illness
- Federal guidelines address Mental Illness only
- Risk Behavior is not currently followed by a Level II evaluation
- Change in Condition reporting does not address "gray areas"

- Chronic behaviors may not require treatment in an acute care setting. These people may be approved for nursing facility placement if other criteria are met
- Department of Mental Health may make recommendations for a plan of care but does not oversee
- FY 2003, 56% of Level II screens were on people under age 65
- Number suggests more young people with mental illness are being sent to nursing facilities due to limited options in community. It may also be due to complications secondary to chronic treatment for mental illness
- Facilities today are not designed for today's population
- Connecticut's narrow definition of Specialized Services leaves many without supportive services that could be offered by the State of Connecticut. Responsibility has been shifted to the industry
- Let's explore a home and community based waiver for individuals to live in the community, reaching home campaign, use of peer engagement specialists
- Improvement is psychiatric consultation process to decrease hospitalization costs
- Level II risk assessment could include recommendations for surveyors to check on during survey process
- Bill of Rights to address Quality Assurance standard

### **Panel III**

- Recommend a more specific identification of population: Who are they and where?
- Exceptions to Wait List laws are many
- The statute requires that residents sent to the hospital for treatment must be able to return to the facility
- Increased transfers after initial facility placement will increase risk of behavioral management problems
- When is a transfer to a hospital a discharge?
- Residents have a right to refuse treatment; that includes transfer to hospital
- Hospitalization as a result of PEC does not negate resident's rights
- Fair Hearing decisions review cited that most findings were narrow in scope focusing on technicalities surrounding proposed discharge as opposed to the greater problem addressing resident needs
- Recommend changes in State transfer and discharge remedies to conform with Federal remedies so that the authority of the Hearing Officer to send a person back to a Nursing Facility is made clearer
- Facilities need to make a better effort to treat people instead of transferring them to the hospital emergency department as a means of intervention for behavioral management problems
- The average Length of Stay at a hospital to manage symptoms and medication is 20 days. This perpetuates the cycle of transfers and ultimately the disservice to the resident our current system fosters
- Problems in continuity of care are seen through delays in transfers and loss of bed hold

- Exceptions in Specialized Units may pose problems
- More oversight is needed that is specific to Specialized Units and Specialized Services
- Recommend better relationship between transfer and discharge requirements and hospital psychiatric discharge procedures

### **Points in Discussion: Afternoon Session**

1. Identify challenging behaviors
2. Address behaviors as they affect individual and not diagnosis as a means of labeling
3. Seek trends in diagnosis for refusal to return to facility: LTCOP finds dementia and young age to be factors
4. Who is the behavior a problem for?
5. Language used in documentation may trigger acceptance and / or admission problems: Let's re-examine words
6. Policies may not offer an individualized approach
7. Many residents transferred to Emergency Department frequently have Delirium; Better understanding can prevent transfers
8. Fear of not reporting may influence treatment interventions. Involve Regulatory Agencies
9. Clarification of "Failure to Protect"; and provider's fear of being sited when they do report
10. A definition of "Zero Tolerance" for incidents; criminal intent
11. Additional Guidance with examples of what needs to be reported might help
12. Training to all facilities with surveyors on deciphering "willful intent"
13. Develop from today's workgroup a series of in-service training modules
14. Information sharing among agencies
15. Develop a standardized form for reporting incidents more consistently ex: check list forms
16. Nursing Facility population is more diverse; specialized services do not have a singular meaning: How do we specialize to address complex needs?
17. Nursing Facility offers a sense of community
18. Specialized units / specialized programs should be monitored
19. Many variables are needed to ensure any one population is not excluded
20. Special Units: Do they offer better care?
21. What constitutes a Specialized Care Unit? Assaults investigated have involved mixed populations
22. Segregation for treatment does not necessarily help the resident who lives in the same environment even when treatment is not being delivered. What is the social environment in a clinical model?
23. We do not know how many residents are in nursing facilities who do not need to be there? Let's explore alternatives and not try to build systems to keep people in nursing facilities

24. Challenging behaviors will exist even if previous problem is solved. We need a balanced perspective
25. Difference between Mental Illness with severe behaviors and Dementia; Treatments may work in the first group towards a discharge potential but will not necessarily in the second. Thus the second group will less likely be reintegrated in the community. Each population should be addressed separately
26. Let's be sensitive about stigmatizing populations
27. Reactions of residents in either population may be reacting to their needs not having been met
28. Report on Violence in Nursing Homes indicates violence is more frequent among individuals suffering from various forms of dementia
29. Are there instances where the Specialized Units seem to work? Can people with a differential diagnosis help each other in this community setting?
30. Finding Best Practices may offer some answers
31. Individualized care is a requirement. Facility needs to reassess what the facility community is like. Diagnosis is not necessarily the focal point
32. Waiting List Laws may discriminate against Medicaid recipients who may want to remain in their own geographic region

These notes have been put together for the working participants of this group. We look forward to working with you . The Long Term Care Ombudsman Program email address is:

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