

**Policy, Regulations and Legislative Actions Committee**  
**“Caring for Residents with Challenging Behaviors”**  
**Minutes of Meeting February 25, 2004**

Group discussion follows:

- Lack of definition/monitoring of specialized units/dementia units; keypad vs locked (literal lock and key) units. purpose/ intent of segregation; achieving balance/support of “wandering behavior” and concept of least restrictive environment; JAHCO no longer certifies specialized units; number of locked/secured units in State unknown
- Identify existing research related to working with residents presenting challenging behaviors (i.e. recent JAMA article regarding resident to resident violence and previous studies undertaken by the Braceland Center several years previously)
- Consideration that any risk assessment be applied to all residents rather than any target population; disconnect regarding risk/liability issues experienced by providers/ conservators and impact on residents presenting challenging behaviors
- Identification of Care Plan and actual delivery/follow through as critical piece in work with individual residents; Use of screening tool in care plan; Level II evaluation; on site clinical judgement; observation/frequency of behavior; determination of triggers and what interventions have/have not worked in past; PAS/RR
- Units where residents and staff able to progress through stages of dementia (unit for all stages of Progressive diseases) vs units specialized for certain stages of a dementia/diagnosis; Bazelton Center supports mainstreaming; issues of acute/episodic behaviors vs chronic/progressive behavior
- Identify best practices (i.e. environmental support through lighting, sound)
- Tennessee model for Alzheimers/dementia unit; Colorado model (21-64 yrs)
- Need for Public Education regarding:
  - risk assessment
  - stabilizing staff/training
  - regulation with regard to facility risk aversion
- Facilities no longer trust quality/uniformity/reliability of W-10 information; need for standardized definitions/language/”tags”; adequacy/quality of information shared between facilities (Nursing homes, hospitals, psychiatric

and/or geriatric units) being questioned; DONs left to document everything which might constitute inappropriate behavior

- Disconnect between mandated reporting; industry concern with OBRA survey deficiencies, plan of correction, penalization; review history; streamline process
- Difficulty in predicting danger to oneself and/or others; when to discharge back to facility; failure to readmit; consider extension of 15 day bed hold in light of time needed for medications to be evaluated
- Consideration of existing resources: Qualidigm; mental health mobile crisis teams; improve existing reporting process; improve yet standardize W-10 process; review “best facilities”/types of complaints: regional sponsorship/approach to Breaking the Bonds; Healthcare Administrators Association; Medical Director to serve as liaison between ERs and/or Psych units
- Consider pilot regulation/negotiation/arbitration body/process, similar to internal dispute negotiations in MA

Workgroup members agreed to follow up on a number of issues:

Jan Van Tassel:	Colorado HCBS waiver
Carol Lee Hall:	Specialized unit certification
Rick Brown:	MA IDR (Internal DisputeNegotiation) Survey waiver JAMA article
Mag Morelli:	W-10 form
Gene Hickey:	Braceland Center Behavioral Studies
Marilyn Denny:	Comparison of Federal/State statutes