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Division of Welfare

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450 W. State Street
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INFORMATIONAL LETTER #93-3

DATE: February 1, 1993

TO: ALL SKILLED NURSING FACILITIES

FROM: Jean Schoonover, R.N., Chief
Bureau of Facility Standards

SUBJECT: Management of Combative Residents

Many facilities have requested assistance in the area of management of combative residents. Based on review of the relevant federal requirements, the following guidelines are suggested.

When a resident first becomes combative:

1. As with any major change in condition, notify the attending physician and the resident's family or legal representative (F164). Before obtaining medical orders, the following information should be considered:

   a. The facility's primary responsibility is to protect all residents from abuse. One-to-one (1:1) staffing may be necessary until the problem behavior is stabilized.

   b. The use of psychotropic medications prior to the implementation of non-medication approaches to maintain or control a resident with a lesser amount of effort by the facility constitutes chemical restraint for reason of convenience, and the facility would not be in compliance with F222. Therefore, chemical restraint is prohibited, even in an emergency situation, if the resident can be controlled any other way. Non-medication approaches include but are not limited to:

      i. use of a calm voice to redirect the resident,
      ii. involve the resident in structured activities,
      iii. temporary, **monitored** separation,
      iv. reprioritizing patient care in order to free up staff time for increased monitoring of the resident.

These attempts to control the behavior without restraint need to be clearly documented. If the resident's behavior cannot be controlled by any other means, psychotropic medication may be used.

c. Physical restraints may be used for brief periods to permit medical care in an emergency situation. However, physical restraint, used to control resident behavior, is prohibited if the behavior can be controlled in any other way. If a resident is physically or chemically restrained because of combative behavior without non-medication approaches being attempted or because there are not enough staff for temporary one-to-one (1:1) monitoring, the intent of F221 is not met.

d. Involuntary separation may be used on a short-term, emergency basis. The Interpretive Guide at F223 states, "Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs."

2. The resident should be evaluated as soon as possible by the interdisciplinary team (IDT), including a professional knowledgeable in the area of maladaptive behaviors and behavior modification (F279, F292, F297). The social worker and/or social service designee must be included as part of the IDT (F257). The assessment of the combative resident should include:

a. Baseline to determine the intensity, duration, and frequency of the behavior.

b. Study of antecedent behaviors and activities.

c. Identification of recent changes or additional risk factors in the resident's life.

d. Environment factors such as time of day, staff members involved, noise levels, etc.

e. Medical status.

f. Staffing patterns at times of acting out behavior.

g. Alternative, structured activities or behaviors that have been successful or unsuccessful for the resident in the past.

3. Utilize the appropriate RAPs.

4. The IDT should design a plan of care to address the problem behavior, based on the assessment (F295). Behavioral approaches must be attempted before medications are instituted. Directions to staff need to be very clear regarding how to prevent the behavior and how to respond to the behavior when it occurs.

5. If the IDT decides to institute a psychotropic medication, a short-acting benzodiazepine is suggested before an antipsychotic.

6. Staff need to be trained in the implementation of the care plan. Staff consistency is crucial to the success of a behavior modification plan.

7. Document all incidents of the behavior. The record should contain clear information in nursing and social progress notes regarding the ongoing status of the problem (F344, F348, F527). Social service notes should include the following:

   a. Intensity and frequency of the behavior.

   b. Effectiveness of behavioral approaches and/or medication.

   c. Outside referrals; i.e., psychologist, psychiatrist, mental health.

   d. Discharge plans/efforts.

8. Do not hesitate to seek outside consultation as needed. However, facilities are cautioned to clarify with outside consultants exactly what services they can provide. For example, which of the following needs can the consultant meet:

   a. Direct assessment of the resident.

   b. Assistance in development of behavioral approaches in the plan of care.

   c. Recommendations relating to the resident's medication regime.

   d. Staff training in the area of behavior management.

Always insist on a written report for the record. A psychological evaluation, for example, does the facility no good if feedback and recommendations are never received.

Some possible resources are:

Roger Letourneau, State Hospital South

Nancy Bardsley, R.N., M.S.W., Intermountain Hospital

Mental health staff at the local Health and Welfare office.

Jean Schoonover

Jean Schoonover, R.N., Chief
Bureau of Facility Standards

JS/tm

cc: John Hathaway, Supervisor, Long Term Care
Idaho Health Care Association

INFORMATIONAL LETTER #93-3
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