presbyterian homes & services

AL Behavior Management Process

Original Effective Date: November 18, 2008
Updated Effective Date: August 1, 2021, February 26, 2023

Purpose & Context

The purpose of the Behavior Management Process is to approach challenging behaviors through a pro-active, multi-disciplinary, systematic process which focuses on preserving the person's dignity.

Education, creative thinking, proactive interventions, innovative approaches, and referral recommendations are the methods used to enhance the individual's quality of life. The desired outcome is that the individual functions at his/her highest level of independence. A general principle is to use least intrusive strategies first.

Procedure

1. All residents will be assessed for behaviors and a history of trauma upon admission, with change in condition and ongoing (with clinical assessments).
    a. Resident's residing or planning to reside in the Arbor will also have an AL Arbor Behavior Review completed prior to admission and within 14 days of admission.
2. Residents with behavioral needs and concerns are discussed and reviewed regularly. Clinical Administrator or designee will facilitate the meetings and assist the team in determining when to initiate and to discontinue formal behavior monitoring. The Clinical Administrator or designee, with input from the interdisciplinary team, will notify family and medical staff as appropriate.
    a. IA AL: this may include the implementation of a managed risk consensus agreement.
3. The interdisciplinary team may include but is not limited to all employees who work in the dementia care unit: activities staff, housekeeper, resident assistants, nurses, dietary, managers, social workers and chaplain if applicable.
4. Any team member may initiate discussion regarding a resident's behavior at any time.
5. The interdisciplinary team will determine when formal monitoring is no longer required based on the resident's improvement, lack of improvement or need for alternative approaches.
    a. IA AL: this may include a review of the retention criteria for the resident.
6. Licensed staff will complete a progress note summarizing any changes to the behavior management process for the resident. This information may be used for communication with family members, physicians, and staff members as necessary.
7. When to consider formal monitoring:
    a. Resident's behavior may be dangerous to self or others OR
    b. Resident's behavior is disturbing to self or others AND occurs frequently (3 or more times in 7 days) OR
    c. Resident is on a new psychotropic medication for a behavior problem or has a change in current medication.
    d. Some examples of behaviors which may require formal monitoring:
        i. Combativeness; aggression; self-destructiveness; compulsive behaviors; sexually inappropriate behaviors; socially inappropriate behaviors; suicidal ideation; unprovoked, unpredictable, controlling, demanding behaviors; and unsafe wandering.
        ii. If the resident does not pose an immediate threat to self or others, the initial

approach to behavior management should focus on environmental modifications, behavioral interventions and non-pharmacologic interventions.

iii. Situations where medical interventions for disruptive behavior may be a primary option:
    1. Violent behavior that does not respond to other interventions
    2. Distressing hallucinations, delusions or paranoid ideation
    3. Abrupt worsening of condition
    4. Depression with impaired function
    5. Abrupt changes in behavior or cognition associated with an acute medical condition
    6. Suicide attempt

8. The Clinical Administrator or designee is responsible for completing documentation regarding the nature of the problem, potential causes and approaches or interventions with the involvement of the interdisciplinary team.
    a. Optional tool: Behavior Worksheet, if utilized:
        i. The Clinical Administrator or designee is responsible for the completion of the worksheet the involvement of the interdisciplinary team. The worksheet includes an assessment of the behavior to determine root cause as well as the behavior plan.
        ii. This worksheet will help the team determine the nature of the problem, potential causes, and potential approaches/interventions. This document will be kept in the resident's medical record.
        iii. After completing the assessment component, a behavior plan is developed.
    b. Guidelines for interventions:
        i. Use the PHS Care Partner Guide for suggested interventions which are evidence based (https://thevinephs.org/functions/purposeful-living/dementia-care/phs-care-partner-guide.aspx)
        ii. Consult with the resident's provider (MD/NP) if necessary
        iii. Consider referral to a psychologist or psychiatrist if necessary
        iv. Plan behavior management interventions:
            1. Behavior management interventions are non-pharmacologic interventions that are person-centered approaches, individualized to each resident to maximize the resident’s dignity, autonomy, privacy, socialization, independence, choice, comfort and safety.
        v. Implement interventions:
            1. Interventions will be communicated to staff using the services which are available on the assignment sheets, service charting, and services section of the care plan.
        vi. Communicate to all necessary people and ensure all staff respond consistently when dealing with the resident's behavior.
        vii. Review the interventions regularly, minimally with each clinical assessment and with change in condition.
9. Behavior Monitoring:
    a. The behavior monitoring is used to gather specific information on behaviors. This is helpful in identifying patterns related to time of day, triggering events, etc. The interdisciplinary team will review the behavior documentation regularly to monitor progress and need for changes.
10. After internal approaches have been tried, and with input from resident's providers and family, and

subject to resident's insurance coverage, referral resources outside the facility may be utilized such as:

a. Psychologist
b. Psychiatrist
c. Hospitalization to a senior treatment program for behaviors
d. Discharge to a facility that specializes in behavior management

References

MN Assisted Living Statutes – 144G.84 Services for Residents with Dementia
Iowa Inspections and Appeals Code Chapter 69 Assisted Living Programs, 481 – 69.31 Managed risk policy and managed risk consensus agreements
Iowa Inspections and Appeals Code Chapter 69 Assisted Living Programs, 481 – 69.32 Life Safety
Iowa Inspections and Appeals Code Chapter 57 Residential Care Facilities, 481 – 57.6 Special Classifications
WI DHS 83 Community-Based Residential Facilities, 83.35(1)(c)6Assessment, individual service plan and evaluations