(e) Standard: Drug usage

§483.450(e) Standard: Drug Usage

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§483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.

Guidance §483.450(e)(1)

Clients are alert and available for participation in daily living activities.

Some medications administered for medical reasons or to manage behavior may cause drowsiness as a side effect or due to an accumulation of the drug in the client's system. For clients who are observed to be sleeping in chairs during their work day, their programs or recreational times, there should be evidence that the facility staff notified the medical staff and an assessment was performed of the client including their medication regimen. Medical staff should make adjustments to address the issue if indicated.

§483.450(e)(2) Drugs used for control of inappropriate behavior must

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§483.450(e)(2) be approved by the interdisciplinary team and

Guidance §483.450(e)(2)

The physician and other team members discuss the risks and benefits of the medication to address the target behavior/symptoms, and approve the use of the drug as being consistent with the active treatment program. Decisions about the necessity of the use of drugs to manage inappropriate behavior should be made by the IDT. It is the responsibility of the IDT members to provide the physician with sufficient information regarding the need for a client to receive a drug for inappropriate behavior. The physician will make the ultimate decision to order the use of the drug. The IDT should document any disagreement with the physician's order.

In those instances where a client returns from a physician's visit with an order for an unsolicited drug to manage client's inappropriate behaviors, there must be evidence (e.g. IDT meeting notes or clients record) that the team concurred with the necessity for the order without trying less restrictive measures first and discussed any concerns with the physician.

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§483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

Guidance §483.450(e)(2)

All medications to manage behavior must be integrated into the IPP and the IPP must specify how the specific target behavior for which the medication is prescribed will be reduced or eliminated. This includes medications which are typically used for medical conditions that may be used to manage behavior (e.g. 1. propranolol (Inderal), an antihypertensive used for selfinjurious behavior, and 2. carbamazepine (Tegretol), an anticonvulsant, used for aggression).

Drugs for behavior management must not be ordered on a PRN basis for a client. The facility staff must contact the physician to obtain a one-time order if the situation necessities the use of medication. The facility policy must address the maximum number of times a medication can be used as an emergency prior to being

incorporated in the IPP, side effects of such medications, and the frequency of re-evaluation of ongoing behavior and its treatment.

Clients or their legal guardian have the right to choose sedation for medical and dental procedures. However, the facility cannot do routine administration of medication for sedation for medical and dental procedures without the agreement/consent of the client or their parent/legal guardian and they must follow the specific orders of the healthcare practitioner who will be providing services to the client. Decisions to order medications prior to medical and dental procedures must be made on an individual basis. Clients who demonstrate severe anxiety around these procedures should be considered for desensitization programs.

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§483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

Guidance §483.450(e)(3)

The risk(s) associated with the drug being used is consistent with the type and severity of the behavior/symptoms it is intended to affect.

At the time the drug was started and incorporated into the IPP, the behaviors were discussed and presented to team members. It was the documented decision of the team that the behaviors were of such a severity that pharmacological intervention was required and the physician was provided with the team information to assist him in his decision to prescribe the medication.

§483.450(e)(4) Drugs used for control of inappropriate behavior must be- -

§483.450(e)(4)(i) Monitored closely,

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§483.450(e)(4) in conjunction with the physician and the drug regimen review requirement at §483.460(j),

Guidance §483.450(e)(4)

The physician and pharmacist must regularly review use of drugs for control of inappropriate behavior for their effectiveness in changing the targeted behavior/symptoms, untoward side effects, contraindications for continued use, and communicate this information to relevant staff.

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§483.450(e)(4) for desired responses and adverse consequences by facility staff; and

Guidance §483.450(e)(4)

Direct support staff members are the people who most closely and most frequently observe and record client behaviors. There should be evidence that the direct support staff receive information via the IPP as to the behaviors to be observed, the side effects associated with the medication, the amount and types of documentation required and the communication with clinical staff which is indicated. See 483.430 (e)(1) for training on observations, documentation and communication related to behavior management.

§483.450(e)(4)(ii) Gradually withdrawn

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§483.450(e)(4) at least annually

Guidance §483.450(e)(4)

Clients receiving medications to control behavior must be evaluated at least annually for a possible reduction of the medication progressing the client toward final elimination of the drug or lowest possible therapeutic level of the drug. However, evaluation should be done earlier than annually if observations indicate that the client's behavior has improved to the point that reduction may be considered as determined by the IPP, unless otherwise ordered by the client's physician.

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§483.450(e)(4) in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

Guidance §483.450(e)(4)

The IDT is aware of and involved in planning the drug reduction program and participates in its implementation and monitoring.

Progress or regression of the client is monitored and taken into consideration in determining the rate of withdrawal and whether to continue withdrawal.

In determining whether there is clinical contraindication to the annual drug withdrawal, the physician and IDT should consider the client's clinical history, diagnostic/behavioral status, previous reduction/discontinuation attempts, and current regimen effectiveness.

If a client also has a diagnosis of a psychiatric condition that requires a stable level of a psychiatric medication in order to control the symptoms associated with the

psychiatric diagnosis, the annual evaluation for reduction of that particular medication for the symptoms of the psychiatric diagnosis would not apply. Documentation in the client's record from their psychiatrist or physician that medication reduction would be contraindicated or that the current level of medications is therapeutic meets the intent of this regulation.