Appendix E

Baker Act and Facilities Licensed Under Chapter 400

Introduction

The 1996 legislative reform of the Baker Act has had a significant impact on facilities and programs licensed by the Agency for Health Care Administration under the authority of Chapter 400, F.S. such as nursing homes, assisted living facilities, adult day care centers, and adult family care homes. Failure to follow the criteria and procedures provided under the Baker Act relating to the transportation, voluntary admission, and involuntary examination of a resident by a facility or its employee are grounds for action by the Agency for Health Care Administration against a licensed facility or program.

Before referring any resident or client to a Baker Act receiving facility on a voluntary or involuntary basis, the staff of the facility must make every effort to provide appropriate psychiatric interventions to avoid such referrals. However, if all appropriate on-site interventions prove ineffective and are fully documented in a resident’s record, a referral to a Baker Act receiving facility may be necessary. In such cases, the resident may be sent for either a voluntary admission or for an involuntary examination, following the provisions in the Baker Act. A person may not be sent for “assessment” at a facility, without first making the on-site determination through legal means of either voluntary or involuntary status. Referral of the resident to an emergency room or other site for this is contrary to the law.

The role of a Baker Act receiving facility is to provide psychiatric evaluations and short-term psychiatric treatment for persons in acute mental health emergencies. If the resident requires something different than psychiatric examination or short-term psychiatric treatment, he/she should not be sent to a receiving facility simply because of behavioral problems or to evade federal and state discharge/transfer requirements. Instead the resident should be transferred to a more appropriate type of facility.

Voluntary Admissions

s. 394.4625, F.S. Chapter 65E-5.270, F.A.C.

A person may go to a Baker Act receiving facility for voluntary psychiatric examination from a facility licensed under Chapter 400, F.S. only if the person is:

- Over the age of 18,
- Have a mental illness, as defined in the statute,
- Competent to provide express and informed consent to his or her own treatment, and
- Suitable for treatment.

Express and informed consent requires that a person be competent to make well-reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment.

Consent must be voluntarily given in writing after sufficient explanation of the need for admission so that the person can make a knowing and willful decision without any element of force or deceit.

If residents cannot meet these criteria, they cannot be on voluntary status in a Baker Act receiving facility, and instead, must be handled under the involuntary provisions of the law.

The Baker Act specifically states that the following persons cannot be sent on a voluntary basis to a receiving facility until after an initial assessment of the resident’s ability to give express and informed consent is conducted at the sending facility by an authorized independent professional. These residents include:

1. A person 60 years of age or older for whom an emergency transfer is being sought from a nursing home pursuant to s. 400.0255(6), F.S.
2. A person 60 years of age or older with a diagnosis of dementia for whom transfer is being sought from a:
   - Nursing home,
   - Assisted-living facility,
   - Adult day care center, or
   - Adult family care home.
3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under Chapter 765, F.S.

The initial assessment, documented on recommended form CF-3099, can only be performed by one of the following [see definition of each of the following in §394.455(6), (17), and (19), F.S.] as specified by the district office of the Department of Children and Families:

1) A mental health overlay program,
2) A mobile crisis response team, or
3) A licensed professional who is authorized to initiate an involuntary examination and is employed by a publicly funded community mental health center.

If none of the above services exist in the locale, or if the service cannot respond within two hours of being called, the facility may contact a licensed professional authorized to initiate an involuntary examination who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the Baker Act receiving facility to which the transfer may be made to conduct and document this assessment.

**Involuntary Examinations**

s. 394.463, F.S.    Chapter 65E-5.280, F.A.C.

A person may be taken to a Baker Act receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness, as defined in the law, and because of his or her mental illness:

The person has refused examination or is unable to determine whether examination is necessary; and

Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself, such neglect or refusal poses a real and present threat of substantial harm to his or her well-being, and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or others in the near future, as evidenced by recent behavior.

There are three and only three methods to initiate an involuntary examination. They are:

1. A physician, clinical psychologist, psychiatric nurse, clinical social worker, or licensed mental health counselor (see definitions in Baker Act) may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the professional’s observations upon which that conclusion is based. These observations should be those of the professional signing the certificate, rather than those of persons who are not authorized to initiate the involuntary examination. The professional should complete the form entitled “Certificate of Professional Initiating Involuntary Examination” (CF-MH 3052b). The professional’s observations should focus on the client’s overt behavior supporting the findings rather than just the diagnosis and specifically relate to the criteria for involuntary examination.

2. If no legally authorized mental health professional is available to conduct an examination and complete the professional’s certificate, a court may issue an Ex Parte Order for Involuntary Examination of the resident. To obtain such an order, one or more persons including facility staff, guardian or family members who have personally observed the resident’s behavior must go to the office of the Clerk of the Circuit Court (usually the Probate Division) at the Courthouse to file a petition(s). The petition must contain a sworn statement of the facts and circumstances that the petitioner(s) believe justify an involuntary examination of the person. The petition must be signed under oath by those who have personal knowledge of the person’s behavior.

3. In an emergency, law enforcement shall complete the “Report of a Law Enforcement Officer Initiating an Involuntary Examination,” (CF-MH 3052a).

**Transportation**

s. 394.462, F.S.    Chapter 65E-5.260, F.A.C.

Regardless of which of these three methods is used to initiate the involuntary examination, law enforcement is responsible for transporting the person to the nearest receiving facility for the examination. A law enforcement agency may decline to transport the person to a receiving facility only if:

1. The county has contracted for transportation, at the sole cost to the county, and the law enforcement
officer and medical transport service agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

2. In cases where the officer requests assistance from emergency medical personnel for the safety of the officer or the person in custody or the officer believes the person has an emergency medical condition.

3. When a transportation exception plan has been approved by the Secretary of the Department of Children and Families.

The law enforcement officer must complete the form entitled “Transportation to Receiving Facility,” (CF-MH 3100) describing the circumstances under which the person was taken into custody.

The Baker Act forbids the removal of a person from any program or residential placement licensed under Chapter 400, F.S. and transport to a receiving facility for involuntary examination unless a Professional’s Certificate, a court’s Ex Parte Order, or a Law Enforcement Officer’s Report is first prepared. If the client’s condition is such that preparation of a Law Enforcement Officer’s Report is not practicable before removal, the Report must be completed as soon as possible after removal, but in any case before the person is transported to a Baker Act receiving facility. If the sending facility fails to properly initiate an involuntary examination, the Baker Act receiving facility must report such failure to the Agency for Health Care Administration by certified mail on the next working day.

Nursing Homes
Psychotropic Medication Usage Issues

The following information has been provided by the pharmacy consultants with the Agency for Health Care Administration. It applies ONLY to nursing homes and regulatory requirements and guidelines as discussed regarding the use of psychotropic medication are based on information in the State Operations Manual governing nursing home care. This information does not apply to hospitals or assisted living facilities, each of which has different federal and state regulations.

Overview

The use of psychotropic medications in a nursing home setting is as appropriate as in any other setting, if the person has a diagnosis associated with the medication used. The physician must justify the use of any medication in the resident’s clinical chart as necessary to treat the condition with which the person is diagnosed. Mental Illnesses are highly treatable and persons of any age should have the opportunity to benefit from psychotropic medications, if their use if fully documented by a physician.

Federal and state regulations are not meant to cast a negative light on the use of psychotropic drugs in nursing home facilities. The use of such drugs can be therapeutic and enabling for residents suffering from mental illness such as schizophrenia or depression. The goal is to stimulate appropriate differential diagnosis of “behavioral symptoms” so the underlying cause of the symptoms is recognized and treated appropriately. This treatment may include the use of environmental and/or behavioral therapy as well as psychotropic drugs. The goal of federal and state regulations is to insure the proper use of psychotropic drugs and to prevent the use of these drugs when the “behavior symptom” is caused by conditions such as:

- Environmental stressors (e.g., excessive heat, noise, overcrowding, etc.);
- Psychosocial stressors; or
- Treatable medical conditions, including pain and medication interactions and side effects.

Pharmacy Services

Nursing homes must provide routine and emergency drugs and biologicals to its residents, or obtain these under an agreement.

Psychotropic Medication

Each group of psychotropic drugs has a different set of federal regulations regarding the use of anti-psychotic drugs, anti-anxiety drugs, anti-depressant drugs, and sedative/hypnotic drugs in the nursing home. It is essential that facilities and practitioners be aware of current regulations governing the use of each of these groups of medication. The nursing home regulation and guidelines governing the use of psychotropic drugs are located in the State Operations Manual for Nursing Homes [CFR 483.25(1)] under the regulations F-329, F-330, and F331.
Anti-Psychotic Drugs

Residents in nursing homes who receive treatment and services under the Baker Act often receive anti-psychotic drugs. Significant issues and questions have been raised by clinicians and nursing home administrators regarding the use of these drugs. It is important that this information be clarified to ensure the proper use of anti-psychotic drugs in these situations.

Based on the nursing home comprehensive assessment of a resident, the facility must assure that residents who receive anti-psychotic drugs are not given these drugs unless there is documentation in the clinical record of their need. This documentation must include an approved indication and identification of associated behaviors based on the Federal Guidelines. In addition, if an anti-psychotic drug or any psychotropic drug is used outside federal and state guidelines there must be justification in the clinical record for this usage and may include but is not limited to:

- A physician note indicating for example, that the dosage, duration, indication, and monitoring are clinically appropriate. The note should why this medication indicated and that risk/benefit of using the drug has been considered.
- A medical or psychiatric consultation of evaluation that confirms that in the physician’s judgment the use of this drug outside of the Guidelines is in the best interest of the resident.
- Physician, nursing, or other health professional documentation indicating that the resident is being monitored for possible adverse reaction and side effects.
- Documentation confirming that previous attempts at dosage reduction have been unsuccessful.
- Documentation showing resident’s subjective or objective improvement, or maintenance of function while taking the medication.
- Documentation showing that a resident’s decline or deterioration has been evaluated by the facility interdisciplinary care team to determine if the drug, dose, or duration may have been the cause of the resident’s decline.
- Documentation evaluating why the resident’s age, weight, or other factors would require a unique dose, duration, indication, or monitoring.

Anti-Depressant Medications in Nursing Homes

The under-diagnosis and under-treatment of depression in nursing homes has been well documented. It is estimated that over 50 percent of persons in nursing homes suffer with clinical depression. Many things contribute to clinical depression, including life losses, medications, certain medical conditions, and other genetic, cognitive, and biological factors. Clinical depression can be observed through symptoms of irritability, restlessness, changes in appetite or sleep, difficulty in concentrating, remembering or making decisions, among others. Clinical depression is a treatable medical illness, and its treatment can save lives.

CMS and AHCA continue to support the accurate identification and treatment of depression in nursing homes. Antidepressant drug therapy would be considered unnecessary only if a physician failed to adequately document the diagnosis, the need for the medication, or to monitor the resident’s response to the medication.

Dosage Reduction

Residents who are given an anti-psychotic drug or any psychotropic drug are not required to receive gradual dose reduction when clinically contraindicated. It is essential that the resident’s physician(s) and health care professionals fully document in the clinical record a justification of why the continued use of the drug and dose are clinically appropriate. Current medication usage and dosage reduction guidelines for psychotropic drugs including anti-psychotic, anti-anxiety, and sedative/hypnotic drugs are included in the State Operation Manual for Nursing Homes under the regulation F-329. Anti-depressant usage guidelines are also addressed under the regulation F-329, but dosage reduction is not required for these drugs.

Clinically Contraindicated

Clinically Contraindicated may be defined as:

1. The resident has an appropriate psychiatric diagnosis and has a history of recurrence of psychotic symptoms which have been stabilized with a maintenance dose of a psychotropic drug without incurring significant side effects.

or
2. The resident has had a gradual dose reduction attempted and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to the previous dose reduction was necessary.

Summary

The use of psychotropic medications in the nursing home setting must be justified and appropriate as in any other health care setting. The physician and health care professionals must document in the resident’s clinical record the need for any medication as based on the resident’s clinical condition and diagnosis. Mental illness is highly treatable and persons of any age as well as nursing home residents should have the opportunity to benefit from psychotropic medication. Proper documentation in the clinical record by physicians and health care professionals provides a mechanism for evaluating the need and insuring proper usage of psychotropic medication.

Frequently Asked Questions

Facilities Licensed Under Chapter 400, F.S.

General

1. Which facilities or programs are affected by the Baker Act?

Any facility or program that works with persons with a mental illness is affected; however, these guidelines will address the changes as they apply to nursing homes, assisted living facilities, adult day care centers, and adult family-care homes licensed by the Agency for Health Care Administration under the authority of Chapter 400, F.S.

2. When I visit a friend or family member at a Baker Act facility, how do I know what the person’s rights are and what rules the facility has?

Facilities are required to post the rights of persons in an open area, close to the telephones available for their use. Each person admitted to a facility is also given written and verbal information about their rights at the time of their admission. Information about the Florida Abuse Hotline, the Local Advocacy Council, and the Advocacy Center for Persons with Disabilities must also be posted. A schedule of daily activities also must be posted for review. Each facility is required to establish reasonable rules governing visitors, visiting hours, and the use of telephones. Check with the social worker or nurse on the unit if you have other questions.

3. What was the major change in the 1996 Baker Act reform as it applies to these facilities?

The major change involved the process by which persons may be voluntarily transferred to a psychiatric hospital and their rights under the Baker Act. However, violation by a facility licensed under Chapter 400, F.S. of the voluntary, involuntary or transportation provisions of the Baker Act became causes of action against such a licensed facility.

Preventing the Baker Act

1. If someone in a facility is acting in a manner that appears to be related to mental illness and this behavior is escalating, what should be done?

First there should be an assessment done by the facility to determine if something in the person’s environment may be causing this behavior and steps taken to alleviate the circumstances. If this fails, then consultation should be requested, i.e., psychiatrist, physician, psychologist, social worker, mental health worker, case manager, mental health coordinator in a licensed limited mental health assisted living facility, etc., as appropriate. All appropriate attempts to address the problem by providing care should be taken on-site prior to transfer and documented.

2. Are Baker Act receiving facilities equipped to treat behavior problems of persons with dementia and Alzheimer’s disease?

Receiving facilities are designated by DCF to perform psychiatric examinations and short-term psychiatric treatment. If the resident does not have a mental illness (as defined in the Law) and would not benefit from short-term treatment, they should not be sent to a receiving facility. Instead, a transfer should be negotiated with another nursing home that has the capability of meeting the resident’s needs.

3. How can I prevent harm to staff or other residents by a person with severe behavior problems?

Nursing and social work staff should work with skilled consultants when necessary, at the first sign of
behavior problems. Interventions, including behavior management, medications, redirection, comfort measures, change of rooms, one-to-one, revisions to plan of care, and other services are often successful. Choices are not limited to picking between the Baker Act and allowing staff/residents to be harmed.

A model policy and procedure for working with behavioral problems of residents has been developed by the Florida Health Care Association Quality Credentialing Foundation. The tool is titled "Behavior Management/Aggression Control (Involuntary Baker Act Guidelines) can be found at the end of this appendix. Use of this recommended Best Practice Tool will prevent many unnecessary transfers and improve quality care of residents in nursing facilities.

Preparing for Voluntary or Involuntary Examinations

1. If it is determined that a person needs to receive emergency psychiatric services outside of the facility, what steps should be taken?

A decision must be made whether the person meets the voluntary or the involuntary provisions of the Baker Act. They may not be sent out of the facility for this Baker Act initiation to be made. No one should be sent to an emergency room for this purpose — emergency rooms are to be used for medical emergencies only; not to substitute for responsibilities of the licensed facility.

Prior to certain persons being voluntarily transferred to a private or public receiving facility (a designated psychiatric hospital or unit in a hospital, or a public crisis stabilization unit) section 394.4625, F.S., requires that an assessment of the person's ability to give express and informed consent to treatment, as defined in section 394.455(9), F.S., is to be conducted by:

a. A mental health overlay program that either contracts with the Department of Children and Family Services for this service or is part of a public receiving facility that is also a publicly funded, not-for-profit community mental center or clinic which contracts with the Department of Children and Family Services; or

b. A mobile crisis response service attached to a public receiving facility; or

c. A licensed professional who is authorized to initiate an involuntary examination and is employed by a publicly funded, not-for-profit community mental center or clinic which contracts with the Department of Children and Family Services.

Voluntary Examinations

1. Which residents must be assessed prior to a voluntary transfer to a psychiatric center?

Section 394.4625, F.S., requires the assessment of the following persons prior to being moved on a voluntary basis from certain facilities licensed under Chapter 400, F.S.:

a. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.

b. A person 60 year of age or older for whom transfer is being sought from a nursing home pursuant to section 400.0255(6), F.S.

c. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under Chapter 765, F.S.

2. Who does a facility or program call to get an assessment for voluntary Baker Act admissions?

The Department of Children and Family Services’ district mental health program office will direct the facility or program to the appropriate resource, in accordance with a plan approved by that district administrator.

3. What if the voluntary assessment cannot be done in a reasonable amount of time?

When a voluntary assessment program is not available or it cannot be done within two hours after the request is made the requesting facility may arrange for assessment by any physician, clinical psychologist, clinical social worker, or psychiatric nurse (each as defined in the Baker Act), who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.
Appendix

Appendix B - Baker Act Handbook and User Reference Guide

2006

State of Florida Department of Children & Families

Chapter 400 Facilities

4. If it is determined by the facility that the person does not have the capacity to consent to voluntary treatment, what should be done?

If the person doing the assessment does not complete a professional’s certificate for involuntary examination, the facility has the following options:

a. The facility may get a mental health professional (a licensed clinical psychologist, a physician, a licensed clinical social worker, a licensed mental health counselor, or a psychiatric nurse, as defined in section 394.455, F.S.), to initiate a professional certificate for involuntary examination (CF-MH 3052b). At that time, law enforcement will transport the person to the nearest designated receiving facility; or

b. Section 394.462(1)(k), F.S. provides for an exception to transportation by law enforcement when a county has entered into a contract with a transport service. However, the law enforcement officer and the transport service representative must first agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. Preference for this transportation service for persons in nursing homes, assisted living facilities, adult day care centers, or adult family-care homes shall be given unless the behavior of the person is such that law enforcement is necessary; or

c. Law enforcement may initiate an involuntary examination; however, they must have reason to believe that the person is a danger to themselves or others or be unable to care for self; or

d. The circuit court may be petitioned for an ex parte order for involuntary examination.

5. What happens to a resident who gets to a Baker Act receiving facility on a voluntary status from a nursing home or ALF without the independent assessment? What happens if the resident is determined, once at the facility, to lack the capacity to make well reasoned decision-making?

A facility’s failure to obtain the independent assessment of a resident as required by law before sending a resident to a facility must be reported by certified mail within one working day to AHCA by the Baker Act receiving facility. In addition, a person who has been admitted to a receiving facility on a voluntary basis but determined by a physician within 24 hours of admission to lack the capacity to make well reasoned, willing, and knowing decisions about his/her mental health or medical care, must be discharged from the facility or a petition for involuntary placement promptly filed with the court.

Involuntary Examinations

1. Must a person who is to have an involuntary examination always have a certificate for involuntary examination, a report of law enforcement, or a Judge’s ex parte order for involuntary examination completed prior to the transfer of a resident?

YES. However, if the facility permits family or guardian to transport the resident for involuntary examination, no report of the facility’s failure to properly initiate the examination by the receiving facility to AHCA is required. Allowing a guardian or family to provide transportation of a resident for the involuntary examination may result in high liability to the facility if harm occurs during such transport.

2. Does the facility have to have an independent mental health professional conduct an evaluation prior to an authorized professional connected with the facility initiating an involuntary examination?

NO. The independent assessment required under the Baker Act is limited to voluntary admissions. An authorized mental health professional associated with the facility who has personally examined the person within 48 hours of signing the Certificate and whose observations are consistent with the criteria for involuntary examination is authorized, without independent corroboration, to initiate an involuntary examination.

3. Is there a preference as to which of the three methods of initiating an involuntary examination, e.g. Judge, law enforcement, or professional?

YES. One of the authorized mental health professionals (as defined in the Baker Act) who is either employed by or under contract with the facility should always be the first option to initiate the involuntary examination. This professional has the training and experience to evaluate the resident’s condition and determine if a consultation by a specialist would avoid the necessity of the transfer. It is essential that the Certificate form be fully
completed. Only in the case of a true emergency should a law enforcement officer be expected to act for the professional associated with the facility. If neither the authorized professional associated with the facility or a law enforcement officer has seen behavior consistent with the involuntary examination criteria and a law enforcement officer doesn’t believe the criteria has been met, staff who have seen such behavior should go to the probate office of the court and file a petition for an ex parte order.

4. Can the resident’s family refuse to have the resident transferred to a receiving facility for an involuntary examination?

NO. Such initiation of an involuntary examination is solely vested in an authorized professional, judge, or law enforcement officer. Family members may request transfer of the person to a different receiving facility, once the person has been taken to the nearest receiving facility. However, the facility should listen carefully to the concerns raised by the family and consider whether their concerns could be addressed in an on-site evaluation, in order to avoid the possible problems to the resident that often result from transfers.

Transfer to a Receiving Facility

1. What about the person's personal effects and medical record when the person is transferred?

The sending facility should do an inventory of the person’s personal effects such as eyeglasses, hearing aid, dentures, jewelry, etc. that will accompany the person or should be sent shortly thereafter. A copy of the medical record that shows current medications, dosages, frequencies, and allergies should accompany the person being transferred.

2. Does a facility have to notify anyone about the person's transfer?

YES. Section 400.0255(7), F.S., requires nursing homes to notify the person’s legal guardian or representative by telephone or in person before the transfer, or as soon thereafter as practicable, with documentation in the resident’s file.

3. Does the person's health care surrogate or proxy have the authority to give permission to transfer the person to a psychiatric hospital?

NO. The health care surrogate/proxy does not have the authority to give permission to transfer a person, either voluntarily or involuntarily, to a psychiatric hospital.

Transportation to a Receiving Facility

1. Is law enforcement transportation required to take a resident of a nursing home or ALF to a receiving facility for involuntary examination?

YES. The law requires that law enforcement be contacted and that they respond. If the law enforcement officer determines that, for the safety of the officer or the resident, that assistance from emergency medical personnel is needed, the officer can authorize EMS to provide the transport. The officer is required to complete the CF-MH 3100 form titled “Transportation to a Receiving Facility”, leaving the designated portions of the form to be completed by EMS personnel. The transportation form, along with one of the three documents initiating the involuntary examination, must accompany the resident to the receiving facility.

2. Is a facility permitted to allow family members or guardians to transport a person for involuntary examination?

The law only references law enforcement transportation, unless the officer determines that emergency medical personnel are needed. Since the resident has been determined, by virtue of the criteria for involuntary examination, to have refused or be unable to consent to the examination and to be subject to self-neglect or overt harm to self/others, facilities should consult with legal counsel about liability issues if persons other than law enforcement are authorized to transport.

3. What are the facility choices when law enforcement refuses to transport?

If law enforcement refuses to respond to the facility’s request for transporting a resident for whom an involuntary examination has been initiated, it is recommended that the facility administrator contact the supervisor of the officer refusing to respond. If the supervisor doesn’t assist, ask to speak with the attorney for the law enforcement agency. If none of these options result in law enforcement response, the facility should contact the district DCF mental health program office and or the AHCA field office.
If it occurs at night or on a weekend, and none of the above is available and the need for transfer is urgent, the facility should seek EMS assistance to transport the resident to the nearest receiving facility. On the next working day, the facility should contact DCF and AHCA to seek long-term resolution of this problem.

4. **Can nursing homes transport a resident who is stable enough and is in agreement to go for treatment?**

   A person who is able to give well-reasoned decision-making and understands the purpose of and is willing to go to a receiving facility meets the criteria for voluntary examination (cannot be a person who has been adjudicated incapacitated or who has a Health Care Surrogate or Proxy currently making decisions for them). In such cases, an independent assessment of the resident's capacity to make such decisions is required before transfer.

5. **Must the person always be transported to the nearest receiving facility?**

   a. If a person is to be treated voluntarily and has been determined by the independent assessment to have the capacity to consent to treatment, the person may be transported to the facility of his/her choice.

   b. If the person is transported on an involuntary basis by law enforcement or a county contracted emergency medical transport service, the person must be taken to the nearest receiving facility.

   c. Section 394.462(3), F.S., provides for exceptions to transportation requirements if there is a district plan approved by the Board of County Commissioners and the Secretary of the Department of Children and Families.

6. **What should happen to the resident when the nearest receiving facility is at capacity and not accepting new admissions?**

   A receiving facility must "accept" any person brought by law enforcement for involuntary examination. If at capacity, the receiving facility must contact other facilities in the community to find one with the capability and capacity to serve the person, and initiate a transfer. If EMS has been delegated responsibility by law enforcement via use of the 3100 form, the receiving facility is required to accept the person if presented by law enforcement. If the receiving facility is a licensed hospital (not a CSU) it must accept the person regardless of who provides transportation, if the person has an emergency psychiatric condition, (EMTALA). If receiving facilities are refusing to accept persons for involuntary examinations, complaints should be made with AHCA and DCF staff.

### Post Baker Act

1. **After residents are returned from the receiving facility to the nursing home or ALF, they are often so somnolent from new medications the behaviors are gone but the resident has declined in function. This apparent “over-medication” causes the facility staff to attempt a dosage reduction that often causes the psychiatric symptoms to escalate. What should the facility do?**

   Facility staff should not attempt to reduce medications. They should keep the attending physician informed of the resident’s condition, on a daily basis, if necessary, and follow doctor’s orders. If the facility cannot meet the resident’s mental health or medical needs, the resident should be transferred to another facility.

2. **Can a nursing home or ALF refuse to take a resident back after the resident has undergone examination and treatment at a receiving facility?**

   While a facility should not accept a resident back if their needs cannot be met, such a determination by the facility administration must be made in conjunction with the health assessment conducted after the person is examined and treated at a receiving facility and clearly documented in the chart. Federal and state requirements for transfer and discharge must be observed, even under emergency conditions.

   Given that such residents will generally be transferred to another nursing home, licensed and staffed the same as the first nursing home, this may indicate the first facility should have been able to manage the residents condition. Whenever the facility gives a different reason for refusing to accept a resident back than the reason given when the resident was transferred, ACHA will generally investigate to determine if federal/state regulations have been violated.
3. **What are Baker Act receiving facilities required to do in preparing a person for discharge?**

Baker Act receiving facilities are required, for all persons being discharged, to consider the person's transportation resources; access to stable housing; access to medications and access to an aftercare appointment. They are required to give persons education and written information about their illness and their psychotropic medications including other prescribed and over-the-counter medications, the common side-effects of any medications prescribed and any adverse clinically significant drug-to-drug interactions common between that medication and other commonly available prescribed and over-the-counter medications, as well as information about and referral to any community-based peer support services in the community; information about and referral to any needed community resources; and referral to substance abuse treatment programs, trauma or abuse recovery focused programs, or other self-help groups, if indicated by assessments. A resident may need long-term mental health treatment outside the scope of a Baker Act receiving facility that may take place on-site at the nursing home.
Person Seeking Voluntary Admission
(from a facility licensed under Chapter 400, F.S.)

All possible interventions have been tried, documented, and found to be ineffective
(See model policy and procedures developed by the Florida Health Care Association)

Determined by referring facility to meet voluntary admission criteria:
These extraordinary protections apply to persons:
• 60 years of age or older for whom an emergency transfer is being sought from a nursing home, or
• 60 years of age or older with a diagnosis of dementia for whom transfer is being sought from a nursing home, assisted-living facility, adult day care center, or adult family care home.
• For whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy.

Notified publicly funded mobile crisis response service, mental health overlay program or authorized professional employed by Community Mental Health Center

Publicly funded service responds within 2 hours
Assessed by service for ability to provide express and informed consent to treatment

Publicly funded service does not exist or informs facility it will be unable to respond within 2 hours
Contacts independent authorized licensed professional to perform assessment of ability to provide express and informed consent to treatment who is not employed by, under contact with, or has no financial interest in the sending or receiving facility

Able to give express and informed consent to treatment

May be transported by any safe method to facility of patient’s choice

Unable to give express and informed consent to treatment

May not be transported except after involuntary examination is initiated

If the person does not meet the criteria for voluntary admission, see flow chart for “Involuntary Examination.” A person may not be removed from any program or residential placement licensed under Chapter 400, F.S. and transported to a receiving facility for involuntary examination unless an ex parte order, a professional’s certificate, or a law enforcement officer’s report is first prepared. A receiving facility admitting a person for involuntary examination who is not accompanied by such documentation shall notify AHCA of such admission by certified mail no later than the next working day.
## Quality First Credentialing Program Best Practices Tools

| Title: Behavior Management/Aggression Control /Involuntary Baker Act Guidelines |
|---------------------------------|-----------------------------------------------|
| Original Date: 3-22-05           | Policy Number (if applicable):                |
| Latest Revision:                | Regulatory:                                   |
|                                 | # of Pages: 4                                 |
| Approved By: Quality First Credentialing Foundation Board/Subcommittee |

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### Mission:
This protocol is intended to comply with Federal and State statutes.

### Purpose:
To educate nursing staff in order to assure effective interventions in the management of resident behaviors; to provide guidelines for management of aggressive behavior.

### Policy:
To provide guidelines pertaining to the redirection of a resident exhibiting aggressive behavior that may present as a risk to self or others.

1. If a resident in a nursing home demonstrates aggressive behavior, (verbal or physical) and a potential for being an imminent threat to themselves or others, the nursing staff are to:

   a. Notify the DON or designee, the Unit Manager and/or RN of record for assistance with further assessment of the situation and the current health status of the resident.

   b. Be certain that the Administrator/designee is aware of the possibility of an involuntary admission for psychiatric examination, (Baker Act). Keep the primary physician and RP, (responsible party) notified and kept informed throughout the course of the treatment, and until the situation has resolved.

   c. Notify Social Services for therapeutic intervention, and direct involvement of the behavioral management plan for the resident.

   d. Provide for the safety of all other facility residents. Provide 1:1 staff oversight as possible. Enlist the help of staff that are familiar with the resident, and have successfully redirected behavior(s) in the past.

   e. Gather behavioral data using the behavioral flow record in the MAR and consider providing hourly documentation of the behavior within the clinical record.

   f. Verbally redirect and assist the resident to a quiet area of the facility that is free from all stimuli, and is away from other residents. Time outs are utilized for behaviors, which place others in potential danger due the negative behavior of the resident. As such these are specific timed activities, followed with appropriate praise for compliance.

   g. Review/revise the current plan of care as indicated. Notify the RP, and if they are available, suggest their assistance in calming the resident. Offer comfort measures that might include: Toileting, offering food and fluids, providing warmth, repositioning, rest, music, reminiscence therapy, aroma therapy, supervised activity outdoors in a safe secure area, or known diversions that may have worked with the resident in the past. Document the effectiveness of all interventions.

   h. Interact with the resident in a calm, non-threatening way. Assure the resident has the use of adaptive devices such as hearing aides and/or glasses so that communication efforts are maximized.
i. Be kind and direct when addressing the resident. Do not force care. If the resident accelerates, do not proceed. Back away and notify the nurse immediately.

j. Review the resident history and diagnoses.

k. Nursing will assess for signs and symptoms of an acute onset of infection. Monitor vital signs every shift or more frequently as warranted by nursing assessment. Do not proceed if the resident is resistant. Notify the physician if attempts to monitor clinical symptoms are unsuccessful due to resident’s behavior/resistance.

l. Assess for signs of acute pain. If the cause of the behavior is believed to be pain related, perform a pain assessment and notify the physician as warranted for tests, treatments, or alterations to the current pain management plan. Medicate for pain as indicated after checking to be certain there are no drug allergies. Document the effectiveness of the intervention. (See pain assessment policy).

m. Review the medication profile. Check for recent medication changes, e.g. omission, additions, or dosing adjustments. If time allows, request that the Pharmacist provide a review of the medication plan as warranted.

n. Medicate the resident with a sedative if required, as ordered by the physician. Document the frequency and method of administration, and monitor for any side effects or contraindications that may exist. Be sure that the legally authorized substitute decision maker has been notified, and has provided informed consent.

o. Discuss with the physician the possibility of lab work to rule out physiological causes. Consider asking for a chemical profile, CBC, UA, Thyroid profile, and pertinent medication levels e.g. Digoxin, Dilantin, etc.

p. If labs are ordered, request a STAT report to the facility.

q. Keep the physician/RP notified of the status of the resident and the need for further interventions/orders.

r. Inform the physician and RP, (responsible party), that the goal of the facility is to keep the resident within their known home environment as long as it remains a medically safe option for the resident, staff, and other residents.

s. The primary role of a Baker Act receiving facility is to perform psychiatric evaluations and provide short term psychiatric treatment. If a person has behavioral conditions that are not psychiatric in nature they should not be sent to a psychiatric facility.

t. Residents cannot be sent out for psychiatric examinations unless the voluntary or involuntary provisions of the Baker Act are followed. Residents should never be sent out to ER’s for “altered mental status”.

u. If the above noted interventions are not successful, notify the primary physician and implement one of the following options:

   i. As authorized by s394.463 (2)(a)3, F.S., the physician may elect to personally evaluate the resident on site to determine if the resident meets the criteria for involuntary examination, and will complete the form CF-MH3052b.

   ii. As authorized by s394.463 (2)(a)3, F.S., the physician may elect to have the involuntary examination (Baker Act), coordinated through the services of a clinical Psychologist, clinical social worker or psychiatric nurse. The requirements specify that the clinical social worker be licensed, or psychiatric nurse have a Masters degree or doctorate in psychiatric nursing with two years experience under the supervision of a physician as defined in the Baker Act.

   iii. A person may not be removed from any program or residential placement under Chapter 400, FS, and transported for involuntary examination unless an exparte order (CF-MH 3001), a law
enforcements officer’s report, (CF-MH 3052a), or a Professional’s Certificate, (CF-MH 3052b) is first prepared.

iv. In an emergency situation the police may be called for on site evaluation, but a law enforcement officer should not be expected to initiate an involuntary examination in a nursing home except in cases of imminent danger. Instead, the facility’s physician, or other authorized parties as noted in ii. should be called to initiate the examination.

v. A police officer must be notified for coordination of transport to the receiving facility. The officer shall execute a written report detailing the circumstances under which the person is taken into custody. The report and a copy of the certificate should be copied and made to be part of the resident’s clinical record.

vi. Law enforcement transportation is required for any person for whom an involuntary examination has been initiated, whether by the court, mental health professional, or law enforcement officer. The officer can make the determination to consign a person to medical transportation at any time that the officer determines that emergency medical personnel are needed or for the safety of the officer or others. This consignment can take place once the officer and EMS have agreed that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. In this case, the decision needs to be reflected within the clinical record.

vii. A law enforcement officer may decline to transport a resident if the county has contracted for transportation at the sole cost to the county and the law enforcement officer and medical transport service agree that the continued presence of law enforcement personnel is not expected to be necessary for the safety of the person to be transported or others. The statute requires that the law enforcement officer report to the scene, assess the risk circumstances, and if appropriate, to “consign” the person to the care of the transport company.

viii. If law officers refuse to respond to a facility’s request for transporting a resident for whom an involuntary examination has been initiated, it is recommended that the facility administrator contact the supervisor of the officer refusing to transport. If that fails it is recommended that the facility ask to speak to the attorney for the law enforcement agency. If that intervention fails, contact the local DCF mental health program office and/or the local AHCA field office. If it is at night or on a weekend, and none of the above is available and the need for transport is urgent, the facility should seek EMS assistance to transport the resident to the nearest receiving facility. On the next working day, contact DCF and AHCA to seek long term resolution. Document your actions in the resident record.

ix. The facility is responsible for assuring that appropriate notice of transfer is issued at the time of transfer. It is expected that the resident will be accepted back to the facility after the provision of treatment at a receiving facility. The facility should re-evaluate the resident prior to making a determination that they are no longer able to meet the individual needs of the resident.