Healthcare

CAREFULLY SPEAKING®

A Risk Management Resource for Aging Services | 2024 Issue 2

Residents with Serious Mental Illness: Addressing Common Risks

The proportion of aging services residents with a serious mental illness (SMI) – i.e., schizophrenia, major depressive disorder, bipolar disorder and other emotional and behavioral conditions that significantly impair functionality – has almost tripled over the past few decades. According to the most recent data available, 31.4 percent of residents have an SMI-related diagnosis. At the same time, resident populations have gotten younger, with the proportion of residents 65 years of age or less nearly double since the start of the millennium. (See "The Rise of Serious Mental Illness in Aging Services" on page 2.)

The influx of younger residents with chronic mental illness is due, in part, to the long-ago decision to close down many inpatient mental health facilities, coupled with the failure to provide sufficient outpatient treatment alternatives. In fact, most patients with SMI are discharged to aging services facilities only for short-term, post-acute care. However, due to the lack of available housing and community-based programs for the mentally ill, these "temporary" placements often end up becoming semi-permanent. As depicted in the cycle-of-care diagram on page 2, aging care settings are admitting a steady flow of high-risk mental health residents, many of whom are noncompliant due to episodic care, uninsured or underinsured, and vulnerable to homelessness.

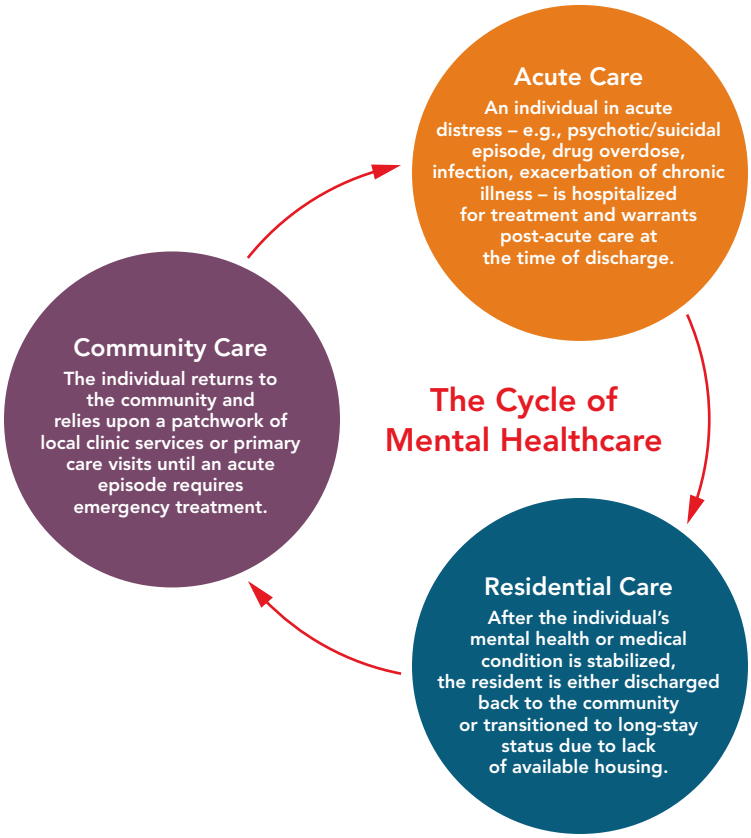
While most organizations have experience managing residents with age-related behavioral healthcare issues, some lack the staff, resources or tools to safely provide care for younger individuals with complex psychiatric needs. And while there have been calls within the industry for reforms – such as federal waivers to finance home- and community-based services – to help address the distinct needs of individuals with chronic disabilities, these efforts have not yet come to fruition, for the most part.

In this issue…

In the interim, to help aging services organizations address the risks associated with psychiatric care, this edition of *CareFully Speaking*® examines common liability exposures and offers practical strategies designed to strengthen admissions, care-planning and discharge processes; improve oversight of advanced practice providers (APPs); manage remote consultations and the use of psychotropic drugs; and prevent or at least mitigate violent and self-harming behaviors on the part of mental health residents. (Please note that while many of these risk control measures apply to all aging services organizations, depending upon resident acuity level, some are more germane to skilled nursing facilities than to assisted and independent living settings.)

The Rise of Serious Mental Illness in Aging Services

- Fifty-six percent of the assisted living population is diagnosed with serious mental illness (SMI); of residents with SMI, 93 percent suffer from major depression, 29 percent from schizophrenia and 22 percent from bipolar disorder.
- One in five long-term-stay residents – i.e., a stay longer than 90 days – is diagnosed with bipolar disorder, schizophrenia or another psychotic disorder.
- Aging services residents diagnosed with SMI tend to be younger than the non-SMI resident population, with half under 65 years of age.
- Residents with an SMI diagnosis are four times more likely to segue from skilled post-acute care to long-term residential care than those without such a diagnosis.
- Mental health residents are disproportionately Black, indigenous or persons of color.
- Residents with SMI are more likely to be admitted to skilled nursing facilities with poor quality-of-care indicators, including higher rates of hospitalization and untreated pain, as well as lower Five-Star Quality ratings as issued by the Centers for Medicare & Medicaid Services.



Creating a Risk Management Framework

Establish realistic admissions criteria

The federal Preadmission Screening and Resident Review (PASRR) program – enacted over three decades ago to assist skilled nursing facilities in determining appropriate level-of-care determinations for prospective residents with SMI – has come under scrutiny as the prevalence of serious mental illness continues to rise. State waivers of the screening requirement have effectively permitted residents to be directly admitted from hospitals or short-term rehabilitation units without a thorough evaluation of their mental health status.

The PASRR program's original goal was to enable more people with mental illness to remain in the community. However, critics argue not only that the program has done little to reduce SMI acuity in aging services facilities, but also that its shortcomings tend to reduce quality of care in such areas as physical restraint use and hospitalization rates, among other indicators.

Given the limitations of PASRR, aging services organizations should establish admission criteria that reflect the scope of available services and the range of mental health diagnoses that can safely be managed and treated. Before admitting individuals with signs of significant mental disturbance, substance abuse/withdrawal or highly aggressive behavior, administrators should carefully consider whether the facility is capable of securely housing and caring for them.

Hospitals and family members may downplay a prospective resident's condition or history, so it is important to thoroughly review records of prior treatment during the admissions process. Ideally, prospective admissions should be reviewed by a team of behavioral health specialists, including a board-certified psychiatrist or psychologist; certified behavioral health APPs; and representatives from nursing, pharmacy, social services and various therapeutic modalities. By conducting a thorough diagnostic review of psychiatric conditions and behavioral disturbances, such a team can help uncover hidden problems and ensure that the facility is a suitable place for the resident.

Employ APPs trained in behavioral health

At a time of chronic physician shortages, a growing number of nurse practitioners and physician assistants have stepped forward to provide care for residents who struggle with depression, anxiety, psychosis and other debilitating mental health conditions. The roles and responsibilities of APPs vary based upon their licensure and authorized scope of practice, but most provide the following core services, among others, at aging services facilities:

- **Managing the ongoing primary care** of long-term mental health residents.
- **Providing acute care** to short-stay and residential residents.
- **Educating staff, residents and family members** about mental health and related care.
- **Consulting on clinical care issues,** including psycho-pharmacology, resident safety protocols, care coordination, care transitions and discharge planning.
- **Participating in the quality assurance process** and performance improvement initiatives.

In larger facilities, APPs are often located onsite for daily resident care, while smaller settings may utilize offsite providers for weekly or monthly clinical rounds. In either case, increased reliance upon non-physician providers may create exposure to allegations of negligence, such as lack of supervision, misdiagnosis, psychotropic drug mismanagement and failure to obtain resident consent, among others. (For recommendations on minimizing APP-related risks, see the sidebar on page 7.)

Common Mental Health Risk Exposures and Contributing Factors

Failure to assess residents for the risk of violence.

- **Failure to assess and document behavioral history,** including violent tendencies, upon admission.
- **Insufficient training of staff** to detect warning signs of aggression, e.g., agitation, pacing, yelling.
- **Lack of mock-scenario instructional sessions** on anticipating and managing dangerous situations.

Mismanagement of psychopharmacology.

- **Failure to establish thresholds for psychotropic drug use** and chemical restraint policy.
- **No formal process to review resident diagnosis,** drug dosages and alternatives to drug therapy.

Failure to monitor for suicide risk or other self-harm behaviors.

- **No suicide risk assessment** upon admission, following changes in condition or before discharge.
- **Insufficent monitoring** of at-risk residents.
- **Poor documentation of environmental safety measures** taken in response to voiced threats.

Improper supervision resulting in elopement.

- **Minimal staff training on elopement risk,** resident assessment and monitoring requirements.
- **Inadequate staffing levels** to safeguard against wandering and elopement.
- **Lack of environmental safeguards,** as well as elopement mitigation and response policies.

Failure to provide a safe living environment.

- **Lack of realistic admission criteria** for residents with serious mental illness.
- **Commingling of violence-prone younger individuals** with frail elderly residents.
- **No formal protocols** governing staff response to combative behaviors and other danger signs.

Delay in treatment or failure to transfer to a tertiary care setting.

- **Misdiagnosis of mental health conditions** and/or delays in stabilizing acute conditions.
- **Lack of transfer agreements** with local hospitals, emergency departments and psychiatric facilities.
- **Failure to delineate "absolute conditions" for referral or transfer,** e.g., incidents of violence, suicidal thoughts, self-harming behaviors.

Negligent discharge/abandonment.

- **Lack of documentation** regarding the clinical reason for discharge/transfer.
- **Failure to refer to community-based resources** and crisis intervention support programs.
- **Refusal to readmit residents** following transfer to an inpatient facility.

Implement sound telehealth policies and procedures

Remote mental health consultations are a necessity for many aging services facilities that lack onsite psychiatrists, psychologists and counselors. During the pandemic, a waiver was granted, giving aging services organizations greater freedom to make use of remote behavioral healthcare services. These flexibilities were made permanent for Medicare residents under the Consolidated Appropriations Act of 2023.

It is not always easy to detect and manage suicidal ideation or other harmful impulses or behaviors via video or audio connection, particularly in the assisted living setting where residents tend to live more independently than in skilled care settings. In order to minimize liability exposure, certain safeguards – including but not limited to the following measures – should be incorporated into remote consultations:

- **Ascertain whether the setting's computer system and internet connection can handle virtual interactions,** and create a backup plan in case of technical difficulties.
- **Determine on a case-by-case basis if remote consultations are appropriate** for residents with cognitive or perceptual impairment, and document the rationale in the resident healthcare information record.
- **Coordinate with state or regional telepsychiatry networks** when selecting licensed behavioral health professionals for consultations.
- **Ask residents to complete a pre-visit questionnaire** that screens for suicidal ideation or self-harm behaviors.
- **Implement a rapid response protocol** to notify medical providers, emergency responders, law-enforcement agencies and/or crisis units should a screening questionnaire indicate possible suicide risk.
- **Provide residents with contact information for emergency resources,** including the national suicide prevention lifeline, as well as local law enforcement agencies, mental health crisis lines and support services.
- **Document the location and availability of emergency medical facilities** if transfer is needed during the virtual interaction.

Reduce antipsychotic drug use

Misdiagnosis of schizophrenia and subsequent administration of powerful and sometimes dangerous sedatives remains a problem in the aging services industry. The Centers for Medicare & Medicaid Services (CMS) has intensified its scrutiny of erroneous schizophrenia diagnoses. This has taken the form of audits of resident healthcare information records, including assessments and history notation that justify the clinical use of antipsychotics, antidepressants, anxiolytics and similar medications. A survey finding of inaccurate diagnostic coding and consequent unfounded use of a psychotropic drug may adversely affect an organization's CMS Five-Star Quality rating.

To safeguard residents and prevent rating downgrades, facilities need to institute an effective psychotropic medication management policy, which should incorporate the following basic guidelines, among others:

- **Assess the resident** and seek input from family members, if available, to identify the underlying cause(s) or patterns of adverse behavior.
- **Consider non-pharmacological therapeutic approaches** to minimize side effects and drug interactions.
- **Perform a risk-benefit analysis** of psychoactive drugs prior to prescribing them.
- **Select appropriate drug dosages and durations,** based on the resident's clinical condition, weight, age and symptoms.
- **Introduce psychoactive drugs at the lowest possible dose and strength** and discontinue medications or reduce dosage if side effects emerge.
- **Monitor medications** for safety and efficacy.
- **Understand the guidelines for prescribing psychotropic medications, as well as gradually reducing dosages,** to help prevent both overuse and unnecessary restriction of these drugs.
- **Inform residents about the risks of abruptly stopping a medication,** if any, and offer appropriate alternatives should they decline treatment, including prescribing the medication at a lower dosage.

(For additional guidance with regard to psychopharmacology, see "Psychotropic Medications in the Skilled Nursing Facility: How to Manage the Process," which is posted on the website of the American Association of Post-Acute Care Nursing. And for clinical guidance on caring for residents who have completed opioid detoxification and are receiving addiction treatment drugs, such as methadone, buprenorphine or naltrexone, visit the website of the Substance Abuse and Mental Health Services Administration.)

Provide trauma-informed care

Past events or situations often have long-term mental health consequences. In 2016, CMS revised its Requirements of Participation in the Medicare and Medicaid programs to include trauma-informed principles of care, which emphasize the special needs of residents who have experienced trauma, including availability of culturally appropriate services. At a minimum, surveyors will expect organizations to comply with the following measures, which are designed to enhance treatment of traumatized residents:

- **Train staff in trauma-informed and culturally competent care,** enabling caregivers to relate to all residents in a more sensitive and empathic manner.
- **Identify the cultural background of residents,** taking into account language preferences, religious practices, basic values and healthcare norms. Consult family members if possible.
- **Screen residents for mood, thought and behavioral disorders upon admission** and determine whether trauma-related symptoms exist. (For sample screening tools, visit the International Society for Traumatic Stress Studies.)
- **Determine what triggers trauma reactions in residents** – such as loud noises or opposite-sex caregivers – and incorporate these findings into care plans.
- **Prioritize non-pharmacological behavior management methods** – but if psychopharmacology is clinically necessary, adopt a conservative approach.
- **Assess residents on an ongoing basis** to determine whether services are effectively meeting emotional and psychosocial needs.
- **Revise care plans** following any changes in resident condition.

(For recent CMS guidance in this area, see "Trauma-Informed Care Update: September 2022," issued by *Leading Age*.™)

Evaluate combative and aggressive behaviors on a daily basis, looking for **known triggers,** such as new-onset **illness and medication changes, side effects, interactions and withdrawal**.

Train staff to prevent and manage violent situations

Around-the-clock safety and security rounds in settings that care for residents with SMI are an effective means of preventing violence and aggression, while roommate compatibility assessments can help minimize friction between residents. In addition, dedicated "quiet rooms," which provide a calm, safe environment for agitated residents, can significantly reduce aggressive tendencies.

The following proactive measures also may aid in forestalling and mitigating violent situations:

- **Train all levels of staff to detect the potential for violence,** including continuous movement, appearing to respond to internal voices, unmotivated shouting, and the expression of delusional ideas or irrational fears.
- **Screen residents upon admission** to identify past incidents of aggression and violence, utilizing a standard tool such as the Brøset Violence Checklist.
- **Avoid commingling** of higher-risk individuals with frail, elderly residents.
- **Evaluate combative and aggressive behaviors on a daily basis,** looking for known triggers, such as new-onset illness and medication changes, side effects, interactions and withdrawal.
- **Document behavioral cues that may indicate the potential for violence,** using the acronym "STAMP" – i.e., **S**taring, **T**one and volume of voice, **A**nxiety, **M**umbling and **P**acing – along with responses to these behaviors.
- **Using role-playing sessions, train staff in how to de-escalate crisis situations** and communicate with potentially violent residents, e.g., by talking in a calm and respectful voice, acknowledging the resident's feelings, and remaining firm and direct in manner.

In addition, organizations should institute a crisis intervention protocol, encompassing the following provisions, among others:

- **Create a rapid response team** – consisting of at least two staff members – to contain belligerent and aggressive residents and remove them to a safe, quiet location.
- **Instruct staff to immediately report incidents of violence to a medical provider** for purposes of stabilization, and to contact family members soon thereafter.
- **In non-emergency situations, medicate aggressive or violent residents only after they have been examined** and given their consent.
- **Use physical restraint as a last resort** and in accordance with written policy and clinical indications.
- **Conduct a thorough debriefing after any violent occurrence,** which should include post-incident documentation and discussion of staff reactions and lessons learned.

Adopt suicide prevention measures

Mental health residents present a heightened risk of harming themselves or others. Implemented consistently and documented thoroughly, the following measures can help safeguard residents while shielding aging services organizations against allegations of failure to monitor or to take due precautions:

- **Train staff in managing at-risk patients,** emphasizing the need for ongoing assessment.
- **Initiate 1:1 observation,** when warranted, to prevent accidental injury or deliberate self-harm.
- **Use trained personnel as observers or sitters,** rather than relying upon family members or volunteers.
- **Formulate a safety plan** that not only delineates staff responsibilities, but also provides guidance for residents and family members. (For suggestions on drafting such a plan, click here.)
- **Transfer residents who exhibit suicidal ideation** to the nearest facility for higher level care.

Review discharge management protocols

As noted earlier, many mental health residents are admitted to aging services settings on a short-term basis, exposing facilities to negligent discharge and abandonment claims if the resident stay is not properly concluded.

Discharge planning is key to both minimizing risk and helping residents transition to life outside the facility. It is a multidisciplinary process that should commence upon admission and include the following aims, among others:

- **Educating residents** about their primary diagnosis and comorbidities.
- **Preparing a medication plan** tailored to the individual's condition, needs and situation.
- **Coordinating referrals** to outside providers and community services.
- **Identifying available support systems** and housing arrangements.
- **Providing a list of crisis support services,** together with up-to-date contact information.

The following strategies can help ensure that mental health residents obtain the ongoing post-discharge assistance they need:

- **Prior to discharge, talk to the resident and their significant others about medication management,** e.g., the name, dosage, schedule and reason for all prescriptions, as well as instructions on taking them and possible consequences if they are abruptly discontinued.
- **Have prescriptions filled before the resident leaves the facility,** whenever possible.
- **Schedule initial medical appointments and counseling sessions,** avoiding open-access or walk-in arrangements to the extent possible.
- **Identify areas of personal need or stress,** including but not limited to food insecurity, housing instability, utility needs and transportation deficits.
- **Notify social workers early on** and inform them of the resident's post-discharge needs.
- **Develop a crisis plan** that clearly describes emergency warning signs and indicates steps to take in response.
- **Ensure that the crisis plan includes contact information for the facility,** as well as a listing of local crisis services, toll-free hotlines and local emergency responders.
- **Provide a written discharge summary** in the resident's preferred language and send a copy to the first clinician that the resident is expected to see post-discharge.
- **Contact discharged residents within 24 hours,** reiterating the importance of complying with medical appointments and other follow-up activities, obtaining prescribed medications, attending support groups and scheduling necessary lab work.

As the number of residents requiring psychiatric care continues to mount, aging services organizations find themselves having to deal with a wide range of pressing safety-related challenges and emerging risks. The strategies outlined in this article can help administrators enhance quality of care, reduce liability exposure, and help mental health residents achieve a more secure and stable existence.

Clinical Safeguards for Advanced Practice Providers

During orientation, emphasize resident safety, including care expectations, risk management guidelines, communication requirements, clinical documentation protocols, and referral policies and procedures.

Where mandated by state law, require collaborating/supervising physicians to be available during assigned work hours – in person, if possible, or via telephone, if necessary.

Institute written practice agreements that comport with state practice regulations and which address the following fundamentals of resident care, among others:

- Admitting new residents.
- Reviewing past medical and mental health history.
- Ordering, approving and performing diagnostic testing.
- Developing a care plan.
- Prescribing medication and ordering gradual dose reductions for psychotropic drugs.
- Obtaining informed consent from residents for tests, procedures and medication management.
- Reviewing and signing entries in the resident healthcare information record.
- Conducting case management reviews to support extended stay authorizations.
- Planning for end-of-life care as a resident's condition changes.
- Discharging residents.

Review practice agreements annually, and revise them if necessary to ensure that changing state requirements are met.

Hold regular team meetings, enabling nurse practitioners (NPs), physician assistants (PAs) and staff to discuss issues of concern and reach a consensus on treatment plans.

Require that NPs and PAs consult with a physician in certain situations, including the following:

- A resident experiences a medical or behavioral emergency.
- A resident requests a physician consultation.
- A resident's condition fails to respond to treatment.
- A resident's needs go beyond the practitioner's prescribed scope of practice.
- A resident requires hospitalization or referral to a psychiatric specialist.

Perform routine documentation audits, encompassing the following areas, at a minimum:

- Diagnostic descriptions.
- Prescription practices to ensure compliance with both the relevant state licensing act and organizational practice guidelines for psychotropic medications.
- Rationale for referrals to outside mental healthcare providers.
- Resident counseling given and treatment decisions reached.
- Informed consent/refusal process.

Require that ID badges of NPs and PAs display their credentials, and educate residents about these providers' roles at first meeting.

Hold regular team meetings, enabling nurse practitioners, physician assistants and staff to **discuss issues of concern** and **reach a consensus on treatment plans**.

Quick Links to CNA Resources

- *AlertBulletin*® 2023-Issue 1, "Hourly Resident Rounding: Key to Enhanced Safety and Satisfaction."
- *CareFully Speaking*® 2021-Issue 2, "Resident-on-resident Sexual Abuse: Taking Aim at a Growing Risk."
- *CareFully Speaking*® 2020-Issue 1, "Geriatric Psychiatric Units: Six Keys to Safe and Efficient Care."
- CNA Special Resource, 2019, "The Mental Health Crisis: Managing Risk in Emergency, Aging Services and Primary Care Settings."
- *Vantage Point*® 2024-Issue 2, "Telemedicine Update: Coordinating Remote and In-person Care."

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