



Increasing Resident Safety

Recommended Changes to Subpart S Rules

Background:

An internal working group of owners and facility management personnel skilled in services to SMI residents in nursing homes was convened concurrently with the Governor's Nursing Home Safety Task Force to make substantive recommendations for changes in regulations and practices related to SMI residents in nursing homes. This document represents considerable thinking and deliberation around ensuring resident safety. We are hopeful that this document will serve as a guide for our discussions.

Recommendation 1: Design a Certification Program for SMI Services

No facility should be permitted to accept a person with serious mental illness assessed as having a high-risk for harm to others unless they are certified in advance as meeting the full complement of Subpart S standards contained in the Nursing Home Care Act, including specialized psychiatric staffing. We will work collaboratively with the State to develop this program. This document may serve as the basis for further discussion.

Recommendation 2: Increase Pre-Admission Screening – Design New Mechanism

One of the critical factors is proper screening to determine the treatment necessary prior to admission. This process will ensure that a facility does not admit an individual for whom they are unable to provide proper care. The LTC Profession will engage a leader in the Mental Health Field to guide our collaborative work to develop a Pre-Admission Screening tool. This tool, which would not replace the more traditional and required nursing home pre-screening (DOA, PAS-R, DORS) or criminal background, would be used in conjunction with these other screenings to determine appropriateness for placement.

We believe the tool would be designed and function much like the Determination of Need (DON) tool currently used in the Department of Aging screening for appropriateness of need for nursing home services.

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Potential residents would be scored for appropriateness based on several criteria:

- Diagnosis both Psychiatric and Physical
- Age
- Criminal history and/or Incarceration
- What / When / How
- Criminal offenders would score higher point if crimes were violent in nature, against a person, and within five years of potential admission.
- Behaviors

We anticipate a scoring mechanism that would prepare a score to determine appropriateness. An example of the concept of what this tool might look for is the following example:

RESIDENT A	Score	RESIDENT B	Score
Schizophrenia	0	Schizophrenia w/ Borderline	
Trach / single leg amputee	-2	Personality Traits	5
Under 55	3	Under 35	5
Assault Charge (2002)	1	Assault charge (2005)	5
Drug Possession (2008)	1	Weapons charge	4
Verbally Aggressive	3	Verbally Aggressive	3
		Physically Aggressive	5
	6		27

We propose working together, in consultation with an acceptable mental health professional, to design this assessment tool. However, the following example may be used to guide our thinking about how the screening results could be used to determine appropriate placement.

For example the pre-admission screening could lead to the following results:

- Facilities may accept potential residents with scores below 10 with regular monitoring;
- Facilities may accept potential residents with scores from 11-20 if meeting “revised” rules; or
- Facilities may not accept residents with score above 20.

This assessment will lead us to the conclusion about which residents are most appropriate for the nursing home setting. It is clear that there may be some residents we simply can no longer safely admit in some facilities. When completed, this new assessment tool will be used for all new admissions and then conducted on all existing residents by a date determined during our work with the State in developing the assessment tool. It is difficult to estimate just how many residents may be found to be unacceptable. Until all necessary assessments are completed, every SMI resident admission will be considered conditional.

Recommendation 3: Solidify Admission Criteria

Proposed change is to add: We need to more clearly define admission, admission exclusion and discharge criteria. This would tie in with any assessment tool that would be developed to be used as a pre-screening tool for admissions. It would then also play a role with retaining residents if resident behaviors are unmanageable or if they become a threat and the facility must immediately discharge the resident.

Recommendation 4: Actively Relocate Residents with State Assistance

If the pre-admission screening results return a necessary treatment that the facility does not provide or if the condition of a resident changes such that the facility is no longer able to provide the required treatment and serve the resident in a manner that guarantees the safety for the resident and the other resident in the facility, the facility can request assistance from the State in finding another location for the resident to receive treatment. In this case, the facility would not be bound by the customary involuntary discharge procedures.

Recommendation 5: Institute More Stringent on-Going Assessments

Current Subpart S rules require a psychiatric evaluation be done as part of the 14 day comprehensive assessment after admission. As currently written the psychiatric evaluation can be done up to 90 days before admission. The psychiatric evaluation can be done by other mental health professionals including a nurse with certain credentials or an LCPC if co-signed by the psychiatrist or psychologist.

- **Proposed change is:** A psychiatric evaluation completed by a board certified or board eligible psychiatrist must be done no more than 30 days prior to admission.

Recommendation 6: Formalize Discharge Planning

Currently the assessment for discharge planning on annual basis is not very specific

- **Proposed change is to add:** A resident's ability to be discharged to a less restrictive environment must be assessed every 12 months. If the assessment indicates the resident is not ready for discharge; the reason must be clearly documented. The need for continuing stay must also be confirmed and documented by the resident's physician. It is also possible that we may be able to involve the community mental health agencies in this assessment process.

Recommendation 7: Increase Staffing Ratios and Resident Supervision

Currently in a Subpart S facility the PRSC ratio is 1:30 residents

- **Proposed change:** Increase the PRSC staff to 1:25 for SMI residents with at least one PRSC having to be in the facility 24 hours a day to provide supervision, support and therapeutic interventions.

There currently is a rule under Subpart S which clearly states that "facilities shall consider the location of a resident's room based on the resident's needs and the needs of other residents in the facility. Factors to be considered include aggressive behavior, supervision needs, noise levels, friendship patterns, common rehabilitative goals or services, sleep patterns, interests, recreational pursuits, and vulnerability".

- **Proposed change in addition to current rules:** The facility must identify a section (e.g. series of rooms, wing, floor) of a facility where residents who require increase supervision (e.g. potential for self-injurious behaviors, increase physical aggression or non-compliant smoker) or monitoring such as more frequent rounds.
- **Proposed change in addition to current rules:** The "behavioral history" of a SMI resident should be considered by the facility in assigning roommates, so that no resident's mental health

is adversely affected by his or her roommate(s). If a resident behavior changes after placement in a room and the change indicates that the current room would be harmful to a resident, rooms will be reassigned as necessary to protect all residents. In the event a change is not possible, other measures shall be taken to protect the resident's mental health, e.g. increase staff or supervision. To ensure the safety and protection of other residents, other options may need to be explored further such as total separation or locked area thereby prohibiting access to certain areas etc.

- **Proposed change in addition to current rules:** Residents who are identified as at immediate risk for harm to themselves or others will be monitored continuously until the resident can be evaluated and are determined not to be at risk by a physician, psychologist, or are transferred for such evaluation.

Recommendation 8: Expanded Staff Training Requirements

- All new employees will be provided at least 4 hours (same as Alz units) SMI training during their orientation period to include:
 - Understanding the diagnosis of severe mental illness;
 - How to identify changes in behavior; and
 - How to prevent and manage aggression.
- Social Service staff, nurses, CNAs and activity staff who work with residents with SMI diagnosis shall attend at least 12 hours of continuing education (same as Alzheimer units) every year related to servicing residents with an SMI diagnosis. This training is to include:
 - Understanding the impact of SMI diagnosis;
 - Understanding the role of psychiatric rehabilitation;
 - Preventative strategies for managing aggression and crisis prevention;
 - Basic Psychiatric Rehabilitation techniques and service delivery;
 - Resident Rights; and
 - Abuse Prevention.

Recommendation 9: Institute On-Going Quality Reviews and Quality Assurance Programs

- **Proposed change is to add:** The facility must establish a Quality Assessment and Improvement program specific to SMI services provided in the facility. The plan would be designed to monitor the SMI program. This would include evaluation of appropriateness of resident admission based on the facility capability to meet needs, resident assessment, development and implementation of care plans, discharge planning etc. This would be in addition or an additional part of any other Quality Assurance or Quality Improvement program in the facility.

Recommendation 10: Increase Consultation Resources for Staff and Resident Treatment

- **Proposed addition:** A facility serving residents with an SMI diagnosis are required to have an outside consultant to review programming, provide continuing education, training and assist with program development. The consultant would have to be a Psychiatrist, Psychologist, LCSW or LCPC. Four hours of consultation for every 25 SMI residents would be required monthly.