Healthcare

CAREFULLY SPEAKING®

A Risk Management Resource for Aging Services | 2020 Issue 1

Geriatric Psychiatric Units: Six Keys to Safe and Efficient Care

Approximately one quarter of residents admitted to aging services settings have a primary diagnosis of schizophrenia, bipolar disorder, depression or anxiety disorder, and a significantly higher proportion exhibit some degree of dementia or memory loss.[1] Yet many facilities lack the requisite clinical and environmental safeguards to provide high-quality care for cognitively and behaviorally impaired individuals.

Lapses in mental health-related care can expose organizations and providers to both legal/regulatory sanctions and allegations of negligence, including, but not limited to, the following:

- Misdiagnosis of mental health conditions.
- Inadequately trained staff.
- Lack of appropriate monitoring procedures.
- Delayed psychiatric treatment and/or referral to specialists.
- Misuse of psychotropic drugs.
- Improper use of physical or chemical restraints.
- Failure to provide a safe living environment.
- Noncompliance with federal and state laws and regulations.

Facing a rising number of mental health admissions, as well as associated statutory/regulatory requirements and liability exposures, healthcare organizations of all types are committing themselves to improving their delivery of behavioral health services.[2] For many aging services facilities, this commitment takes the form of adopting a geriatric psychiatry (geri-psych) practice model. This edition of *CareFully Speaking*® focuses on the six central components of a successful geri-psych program:

1. Specialized medical direction.
2. Ongoing staff training.
3. Sound behavioral health-related policies and procedures.
4. Trauma-informed care principles.
5. Collaborative approach to individual care.
6. Effective environmental safeguards.

Geri-psych units are often but not necessarily freestanding. Organizations lacking the resources and/or capacity to support a separate ward instead may establish a transitional care setting designed to stabilize and treat high-risk psychiatric admissions.

Regardless of the type of structure adopted, aging services organizations can provide safer, more efficient care for mentally ill residents and protect themselves against loss by incorporating basic elements of the geri-psych approach. A gap analysis tool, included on pages 7-10, is intended to help administrators judge staff readiness to implement such a program.

In this issue…

1 See Rahman, M. et al. "Serious Mental Illness and Nursing Home Quality of Care." *Health Services Research*, August 2013, volume 48:4, pages 1279-1298.
2 See "The Mental Health Crisis: Managing Risk in Emergency, Aging Services and Primary Care Settings." A special resource from CNA, 2019.

1. Specialized Medical Direction

Today's aging services organizations often serve a variety of resident populations, including a growing number of both older and younger individuals with chronic behavioral health issues. In view of this shift in demographics and resident needs, facilities should consider hiring a geriatric psychiatrist to serve as a unit medical director/executive. Such an appointment brings a useful level of specialized expertise, facilitating diagnosis and management of a wide range of behavioral health disorders, including depression, anxiety, substance abuse and various forms of dementia.

A full-time geriatric psychiatrist can perform a number of important duties, including:

- **Conducting expert psychiatric evaluation, risk assessment and treatment of residents** on a daily basis, especially with respect to medication management.
- **Providing ongoing education and in-service training for staff** in the areas of behavioral health, dementia care and other mental health-related topics.
- **Assuming a leadership role within the organization,** in order to address ethical, risk management and quality improvement issues.
- **Resolving conflicts that may arise** between staff and residents or family members.
- **Participating in family meetings** regarding the condition, prognosis and care needs of residents.
- **Managing unit crises** and coordinating transfer of residents to tertiary care facilities.
- **Chairing team meetings** of the geri-psych staff.

To learn more about the field of geriatric psychiatry and to view the professional association's position statements on clinical practice issues, visit the website of the American Association for Geriatric Psychiatry.

2. Ongoing Staff Training

Under the guidance of a properly credentialed specialist, clinical staff can focus on acquiring and maintaining the requisite knowledge and skills to deliver safe, quality care to residents in a geri-psych setting. Training and refresher sessions should focus on the following topics, among others:

- Assessment parameters.
- Treatment plans, including non-pharmacological approaches to care.
- Approved techniques for de-escalating and managing resident agitation and aggression.
- State and federal regulations regarding psychotropic drug use.
- Suicide risk assessment and prevention.
- Substance abuse treatment.
- Stress management.

The medical and monitoring needs of high-risk mental health residents differ considerably from those of elderly individuals with physically degenerative diseases. To help all levels of nursing staff meet the care demands of older adults with mental health and substance abuse disorders, the Geropsychiatric Nursing Collaborative has developed the Geropsychiatric Nursing Competency Enhancements, a geri-psych educational resource designed for staff employed in various types of healthcare settings.

The **medical and monitoring needs** of high-risk **mental health** residents **differ considerably** from those of elderly individuals with physically **degenerative diseases**.

3. Behavioral Health-related Policies and Procedures

For a geri-psych setting to function most effectively, organizational leadership must formulate written behavioral health-related policies and procedures governing the following activities, among others:

- **Assessment of high-risk residents,** i.e., those who exhibit aggression, self-harming behavior, suicidal ideation or homicidal intent.
- **Observation of high-risk residents** and related precautions, including documentation requirements.
- **Suicide risk screening** and associated documentation.
- **Stabilization of residents who are agitated** and/or suffering from psychosis.
- **Safe detoxification of residents** with substance abuse issues.
- **Searches of residents** and their belongings.
- **Use of restraints, seclusion rooms and other coercive behavioral management techniques,** including appropriate criteria and limitations.
- **Visitor identification and sign-in** to protect all parties, including residents and staff.
- **Transfers to acute care settings,** including formal medical criteria and appropriate documentation procedures.

These policies and procedures should be addressed in both staff orientation and training sessions, and made readily accessible to employees, residents and families. In addition, performance evaluations should include review of staff members' knowledge of and compliance with mental health-related protocols.

Quick Links

- Dementia Care Toolkits, created by Alzheimer's Los Angeles.
- General Assessment Tools, courtesy of ConsultGeri, a clinical resource website of the Hartford Institute for Geriatric Nursing.
- Guides, Kits and Tools, a set of resources vetted and recommended by the Recovery Council of the American Psychiatric Nurses Association.
- The Internet Geriatric Psychiatry Self-assessment Program (iGPSAP), an interactive web tool offered by the American Association for Geriatric Psychiatry.
- Multimorbidity Pocket Card, available for purchase from the American Geriatrics Society.

4. Trauma-informed Care Principles

The number of residents who have experienced severe trauma – including veterans with post-traumatic stress disorder (PTSD), younger individuals with chronic mental illness, victims of elder abuse and individuals experiencing homelessness – is on the rise. In response, the Centers for Medicare & Medicaid Services (CMS) recently revised its Requirements of Participation to include trauma-informed care provisions for aging services organizations, thus acknowledging that lifelong or episodic physical and emotional abuse, neglect, discrimination and violence can have long-term emotional, cognitive, behavioral and psychological consequences for individuals.

According to the new CMS F-tag 699, "The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident." Other relevant regulations include F-tags 659 and 740-743. Compliance with trauma-informed care regulations requires ongoing assessment of the behavioral health status of residents, as well as specialized services – such as PTSD education and exposure practice using real-world traumatic situations – designed to improve resident engagement, enhance outcomes and reduce unnecessary costs associated with caring for the mentally ill. (For additional details, see Davis, C. "Trauma-Informed Care: What It Is – and Isn't." American Association of Post-Acute Care Nursing, June 12, 2019.)

Notwithstanding the new mandate to adopt trauma-informed approaches to care, a recent study reveals that one-third of aging services organizations cannot meet the mental health needs of their residents, as they lack critical capabilities in such areas as counseling, behavior management and neurocognitive therapy. By designating a team of behavioral health specialists – including a board-certified geriatric psychiatrist, certified geri-psych clinical nurse specialists, and representatives from nursing, pharmacy, social services and various therapeutic modalities – organizations can help staff better manage a range of chronic psychiatric conditions and behavioral disturbances, while also achieving compliance with CMS requirements.

The following core interventions, when performed correctly by behavioral management specialists, can help curb violence and aggression, self-injurious acts, sexual inappropriateness and other undesirable resident conduct:

- **Screen for mood, thought and substance-related disorders upon admission,** using the following evidence-based screening and assessment tools, among others:
  - American Geriatrics Society Updated Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults
  - Geriatric Depression Scale (GDS)
  - Mental Status Assessment of Older Adults: The Mini-Cog™
  - Short Michigan Alcoholism Screening Test – Geriatric Version (SMAST – G)
- **Consult with family members regarding resident history,** as well as past care provision and interventions.
- **Provide ongoing staff in-service training** on principles of psychotherapy, stress management, and the effects of trauma on personality and behavior.
- **Prioritize non-pharmacological behavior management methods,** and consult with nursing staff on therapeutic decision-making processes and care plan interventions.
- **Adopt a conservative approach to psychopharmacology,** with the goal of gradually reducing the use of antipsychotic and other psychotropic drugs.
- **Respond to unit crises on a 24/7 basis,** performing emergency assessments and creating or revising treatment plans, as indicated.

For additional tips on proactive management of trauma-related behavioral health symptoms, see *Implementing Trauma-informed Care: A Guidebook*, issued by LeadingAge™ Maryland, 2019.

An **interdisciplinary, individualized,** frequently updated **care plan** is key to enhancing resident outcomes, **managing symptoms** of mental illness and **strengthening legal defensibility**.

5. Collaborative Approach to Individualized Care

An interdisciplinary, individualized, frequently updated care plan is key to enhancing resident outcomes, managing symptoms of mental illness, and strengthening legal defensibility against allegations of delayed diagnosis and/or treatment. Resident care plans should include the following core components:

Individualized interventions. Care plans should be both comprehensive in scope and highly customized, with interventions targeting underlying mental health diagnoses as well as specific symptoms. A range of care plans addressing psychiatric conditions can be found here.

Multidisciplinary input. Unlike the traditional chronic care model, in which the medical director/executive dictates treatment and specialty providers are consulted as needed, geri-psych units function as interdisciplinary teams, consisting of geriatric psychiatrists, specially trained nursing staff, pharmacists, social workers, behavioral management specialists, and physical and occupational therapists.

Psychiatric oversight. In order to provide effective treatment to residents with mental health conditions, geriatric psychiatrists must be promptly notified of new symptoms and of changes in existing ones. Resident care plans should reflect timely physician-ordered interventions, such as adjustment of medications, therapeutic modalities and/or crisis management strategies, among other elements of care.

Pharmacological management. To safeguard residents and limit exposure to allegations of inappropriate drug use or adverse drug interactions, geri-psych providers should thoroughly, accurately and consistently document the medication management process and the rationale for any modification in drug regimens. (For recommendations, see "Managing Medication Regimens to Prevent Inappropriate or Excessive Drug Use" on page 5.)

Ongoing communication. The questions and concerns of residents with mental illness and their family members or other advocates regarding delivery of care should be solicited, acknowledged, responded to, documented and acted upon in a timely and decisive manner. Regularly scheduled family conferences help keep residents and their relatives apprised of modifications to care plans, which can translate into greater trust, improved compliance and fewer complaints.

Managing Medication Regimens to Prevent Inappropriate or Excessive Drug Use

When monitoring drug regimen effectiveness:

- **Work as a team in reviewing medication lists,** in order to eliminate drugs that are no longer necessary or are causing harmful side effects.
- **Define the objectives of therapeutic monitoring,** conveying to staff such basic goals as evaluating treatment choices, observing positive or negative changes in condition, and determining whether the drug therapy is well or poorly tolerated.
- **Note the aims and anticipated duration of drug therapy,** and review resident status frequently to determine if specific drugs are still needed.
- **Develop written guidelines for medication-assisted treatment (MAT)** of residents who have completed opioid detoxification and are receiving addiction treatment drugs such as methadone, buprenorphine or naltrexone, and measure and document compliance with these guidelines. (For MAT guidelines and related tools, visit the Substance Abuse and Mental Health Services Administration site.)
- **Investigate persistent or abrupt changes in clinical status** to ascertain whether they may be the result of drug interactions or allergies.

When considering whether to revise a drug regimen:

- **Identify potential drug-drug, drug-disease and drug-food interactions,** and modify the resident's medication regimen or diet accordingly.
- **Revisit the guidelines for psychotropic medication utilization and gradual dose reduction (GDR),** and ensure that residents' drug regimens are in compliance with established norms. (For guidance in implementing GDR initiatives, including regulatory compliance concerns, see Mathew, R., Butler, B. and Hobbs, D. "An Electronic Template to Improve Psychotropic Medication Review and Gradual Dose-reduction Documentation." *Federal Practitioner*, October 2016.)
- **Cite medication safety profiles** in clinical notation.
- **Avoid excessive doses, frequencies and durations of medications,** utilizing the Beers Criteria.
- **Document any changes in the clinical need for or response to prescribed medications,** especially regarding anti-psychotics, antidepressants and hypnotics.

When deciding whether to continue or stop a medication:

- **Thoroughly assess the resident,** documenting the effects of drug therapy to date and whether the conditions/symptoms being treated pharmaceutically have been resolved or at least brought under control.
- **Quantify the severity of symptoms,** using a 1-5 scale.
- **Consider whether current drug therapy is likely to provide significant benefits** in view of the resident's overall condition, prognosis and life expectancy, as well as actual and potential drug side effects.
- **Note the use and effect of non-pharmacological treatment strategies,** such as art and music therapy, meditation and/or guided relaxation techniques.
- **Reduce or discontinue only one drug at a time,** in order to ease transitional stress.

6. Environmental Safeguards

By establishing a distinct, specially designed geri-psych unit dedicated to the treatment of mentally ill residents, aging services organizations can significantly reduce the likelihood of violence, aggression, falls and elopement, as well as suicide and acts of self-harm.

The first step in converting a traditional residential living space into a behavioral health setting is to perform an environmental safety assessment. The following resources can help guide the inspection and evaluation process:

- Hunt, J. et al. *Behavioral Health Design Guide*, edition 9.0. Behavioral Health Facility Consulting, LC, November 2019.
- Key Components/Elements of a "Safe" Environment. A resource listing compiled by the Council for Safe Environments, American Psychiatric Nurses Association.
- Mental Health Environment of Care Checklist (MHEOCC). VA National Center for Patient Safety, U.S. Department of Veterans Affairs, updated May 2019.

Once the space is secured, the next step is to implement sound practices and protocols. The following suggestions can serve as a starting point for facilities seeking to create a safer environment of care for mental health residents:

- **Train staff to assess and manage acute psychiatric emergencies,** emphasizing the need for ongoing evaluation of at-risk residents.
- **Institute effective safety procedures,** including 1:1 monitoring when appropriate, body and belongings searches for drugs and other contraband, seclusion or unit restriction, supervised visits, removal of all sharp objects and securing of windows.
- **Emphasize to staff that they must never leave high-risk residents unattended,** even momentarily, and remind them that many suicide attempts occur in the bathroom.
- **Remove potentially hazardous objects,** such as weight-supporting fixtures and rods, shoelaces and belts, electrical appliances, razors and plastic trash can liners.
- **Consider the compatibility of residents when making room assignments,** in order to minimize friction between roommates and potential aggressive behavior.
- **Establish "quiet rooms"** where agitated residents can be treated in a calm, safe environment.
- **Conduct around-the-clock safety and security rounds** in areas where mentally ill residents are treated.
- **Use trained personnel as observers or sitters,** rather than relying upon family members or volunteers.
- **Formulate safety plans for high-risk residents,** outlining specific actions that staff and residents can take in emergency situations, including seeking immediate medical care or contacting a crisis help line.
- **Consider utilizing "no-harm contracts,"** in which residents pledge to report suicidal impulses to staff and take a more active part in their recovery.

As the number of residents with mental health and substance abuse diagnoses continues to grow, aging services organizations must evaluate their ability to manage these conditions in a safe and effective manner. By implementing a geriatric psychiatric practice model, as outlined herein, facilities can help ensure that residents obtain essential care and support, while protecting the organization from professional liability claims and regulatory sanctions.

Emphasize to staff that they must **never leave high-risk residents unattended,** even momentarily, and remind them that many suicide attempts occur in the bathroom.

Gap Analysis Tool: Assessing Staff Readiness to Deliver Geriatric Psychiatric Care

Areas of Potential Concern	Yes	No	Comments
Staffing considerations:			
1. **Job descriptions reflect a resident-directed approach to nursing care** and a compassionate, respectful workplace culture.			
2. **Mental health employees are required to undergo a formal pre-employment screening process,** which includes a documented background check and verification of references, as well as a process for identifying potential criminal records and registered sex-offender status.			
3. **Licensing, accreditation and certification are verified and documented** for all geriatric-psychiatric (geri-psych) providers and staff.			
4. **Staffing levels and skill mix are adjusted on an ongoing basis** to reflect changes in resident census and acuity.			
5. **Staff members' behavior and attitude toward mentally ill residents are evaluated regularly,** as is their understanding of geriatric psychiatry.			
6. **Staff members are instructed to avoid using derogatory, dehumanizing labels for residents with mental conditions,** such as "wanderer," "screamer," "difficult" and "unmanageable."			
7. **A formal procedure is established for investigating and documenting acts of real or threatened violence,** abuse, harassment or assault aimed at mental health residents.			
Staff training and assessment:			
1. **All caregivers are instructed in resident-directed care principles** and incorporate these concepts into daily activities and interactions.			
2. **Geri-psych staff are trained in core clinical competencies,** including, but not limited to, the following:			
• **Major psychiatric diagnoses and pathology,** including borderline personality disorder, bipolar disorder, psychosis/schizophrenia, anxiety disorders and depression.			
• **Resident assessment,** including symptomology and suicide risk screening.			
• **Uses of and limits on resident restraint,** including physical, mechanical and chemical techniques.			
• **Resident seclusion,** including acceptable rationales for this practice and proper documentation.			
• **At-risk resident monitoring** and sitter observation.			
• **Creating a safe environment of care,** including assessment of both private and public spaces.			
• **Crisis response and violence prevention,** including de-escalation techniques and tactics for communicating with aggressive and/or violent residents.			
• **Security protocols** for managing agitated or violent residents.			

Areas of Potential Concern	Yes	No	Comments
Staff training and assessment (cont.):			
3. **All clinical staff members are cross-trained to cover peer work assignments,** and residents are introduced to new caregivers as soon as any staff assignment changes occur.			
4. **Staff members are assigned a mentor** who understands geri-psych practices and can model normative culture and values.			
5. **Staff training and competency levels are documented in personnel files,** including ongoing continuing education.			
6. **A formal process is implemented to evaluate staff interactions with residents** and to determine if communication techniques and/or interpersonal skills need improvement.			
7. **Performance reviews are conducted at least annually** to assess staff members' knowledge of standard operating procedures, as well as their proficiency in implementing them.			
Resident screening and intake:			
1. **Formal admissions policies are developed,** which realistically reflect the scope of available services and the range of mental health diagnoses that can be safely and effectively managed and treated.			
2. **The following items are compiled by staff members during the intake process** and documented in the resident healthcare information record:			
• Initial risk assessment.			
• Psychiatric crisis evaluation.			
• Medication history and compliance.			
• Behavioral management team consultation findings.			
• Clothing and personal belongings inventory.			
3. **Residents who present with emergency or potentially life-threatening conditions are continuously monitored by staff** until the screening process is completed and a treatment plan is established.			
4. **The persons and personal belongings of aggressive, addicted or potentially suicidal residents are searched upon admission** for weapons, sharp objects, drugs, belts, shoelaces and other potentially harmful items.			

Areas of Potential Concern	Yes	No	Comments
Plan of care:			
1. **Mental health-related conditions and symptoms are comprehensively documented** in the resident healthcare information record, with particular attention paid to the following diagnoses:			
• **Suicidal ideation,** as indicated by suicide planning or attempts, morbid or irrational thinking, dwindling of prior interests and social connections, and/or lack of concern with the future.			
• **Borderline personality disorder,** including manipulative, risky, self-harming, argumentative, attention-seeking and/or suicidal behavior.			
• **Psychosis,** including paranoid reactions, hallucinations and/or social withdrawal.			
• **Bipolar disorder,** including manic activity, delusions of grandeur, impulsiveness, inappropriate language, inattention to hygiene and/or rapid speech, as well as abrupt onset of depression symptoms, as noted below.			
• **Depression,** including impaired judgment, inability to trust staff or ask for needed help, unrealistic thinking, flattened affect, sense of being overwhelmed by life, low energy, disturbed sleep patterns and/or exaggerated passivity.			
• **Anxiety,** including repetitive thoughts/questions, chronic indecisiveness, restlessness, signs of stress, poor judgment, sleep problems and/or overreaction to staff requests.			
• **Substance abuse,** including evident chemical dependence/addiction, self-medicating habits, and/or self-harming or suicidal behaviors.			
2. **A written plan of care is drafted** in consultation with mental health specialists, outlining the following treatment and behavior management strategies, among others:			
• **Utilizing a case management approach to problem behaviors,** including frequent agitation, unpredictable verbal and/or physical outbursts, aggression and/or withdrawal.			
• **Placing limits on negative behaviors** and explaining the consequences of violations.			
• **Communicating realistic expectations of care** to residents and family members, in order to avoid potential conflicts and misunderstandings.			
3. **Residents are regularly assessed for major risks** – including aggressive behavior, suicide or self-harm, elopement, drug/alcohol impairment, and acute detoxification with seizures or delirium – and the plan of care is updated accordingly.			
4. **If necessary, a treatment plan for suicide risk is created** in consultation with mental health specialists, which includes such strategies as 1:1 observation, visitor monitoring, no-harm contracts, ongoing therapy and/or transfer to an acute care facility.			

Areas of Potential Concern	Yes	No	Comments
Medication management:			
1. **Written guidelines are developed for pharmacological treatment of various conditions,** including agitation, dementia, psychosis, depression and anxiety.			
2. **Medication reconciliation is performed upon admission** and following transfer from an acute care or psychiatric care setting, and medication profiles are shared with the behavioral management team.			
3. **Psychotropic drugs are administered only after a consultation with a psychiatrist and/or pharmacist is conducted** and documented in the resident healthcare information record.			
4. **Staff are taught gradual dose reduction requirements for psychotropic medications,** as well as safe implementation of medication-assisted treatment for addicted residents who have completed opioid detoxification.			
Team structure and functioning:			
1. **A multi-disciplinary behavioral management team is formed** to serve as a resource for geri-psych staff members.			
2. **A clear reporting structure is established,** permitting staff to obtain information and support from the behavioral management team.			
3. **Staff compliance with geri-psych policies and protocols is reviewed annually,** and findings are reported to unit leadership.			
4. **When necessary, behavioral management team subcommittees are convened** to address incidents, near misses, staff training deficits, system failures and other high-risk situations.			
Crisis response and suicide prevention:			
1. **Staff members are trained to adhere to established principles of crisis intervention,** which includes the following duties:			
• **Stabilizing mental health emergencies** and performing crisis counseling.			
• **Conducting a prompt psychiatric evaluation** and documenting findings.			
• **Initiating 1:1 observation when indicated,** in order to prevent accidental injury or self-harm.			
• **Inspecting resident environments and removing potential hazards,** including weight-supporting fixtures, razors, plastic trash can liners, belts, shoelaces and unsecured window coverings.			
2. **Behavioral health emergency drills are conducted on a regular basis** to assess staff knowledge of and compliance with organizational protocols.			
3. **A suicide risk screening tool is utilized** to facilitate evaluation of residents and documentation of protective measures taken.			
4. **Staff are trained to monitor and manage suicidal residents,** with an emphasis on continuous risk assessment and thorough documentation of findings and measures taken.			
5. **Staff are trained to report incidents in an efficient and consistent manner,** utilizing appropriate reporting formats within required time frames.			

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