LEGAL ISSUES

William Wilson, Esq.

Admitting and Treating Patients With Mental Illness and a History of Self-Harm

Due to the changing dynamic in the health care industry, the number and percentage of elderly patients admitted to skilled nursing facilities with mental illness (schizophrenia, bipolar disorder, depression, or anxiety) and dementia (along with the accompanying behaviors) will continue to increase in the next 10 years.

This trend presents patient behavior challenges to SNFs, both in terms of resources and increased level of risk exposure. To adapt to the trend, SNFs need to ensure the correct decisions are made in deciding whether to admit a patient at the outset. They must determine whether they are able to provide the level of care required by the individual patient; if so, they must ensure appropriate patient-centric care plans are developed, implemented, and updated as needed. This is increasingly important now that SNFs are virtually obligated to readmit residents who have been discharged but want to return as soon as a bed becomes available, except in specific and unusual circumstances. The importance of frequent communication and a collaborative approach between the SNF and attending and consulting practitioners in the care of such patients is imperative, as outlined in the following case study.

Case Study

Mrs. W had a complex medical history, including long-standing psychiatric diagnoses of bipolar disorder with psychotic features and a history of self-harm. She'd had four prior incidents of self-harming behavior, including attempted suicide via slashing one or both wrists. The last incident had occurred just seven weeks before her admission to a SNF. She was admitted to the SNF directly from a secured psychiatric facility.

Mrs. W committed an act of self-harm in the SNF — she cut and stabbed both her wrists with a metal eating utensil, resulting in significant blood loss. There was also a delay in finding her after the incident because she had been left unsupervised with the utensils in her room during meal service. The staff's care plan had failed to provide one-person assistance or supervision during meals, despite the patient's prior episodes of self-harm.

Mrs. W was being followed closely by an external mental health therapy service. Before the incident at the SNF, her therapist had spoken with the director of nursing (DON) and expressed concern about the patient being left unsupervised with metal eating utensils. She also had reminded the DON about the patient's history of self-harm.

The resident's records also demonstrated that her mental health therapy team had been aware of Mrs. W's active suicidal and self-harming ideations in the days before her injury. Her mental health team had considered a further 5150 hold (involuntary due to being a danger to self or others) but ultimately had declined to initiate it. More importantly, the psychologist on the team had failed to report Mrs. W's suicidal and self-harming ideation to the SNF staff. Had such communications been made, the outcome in the case probably would have been different. Significantly, the mental health therapy team was not named in the lawsuit, providing an "empty chair" defense and helping to reduce the overall exposure of the SNF in the case.

The patient and her family sued the SNF for elder neglect, alleging among other things that the SNF had failed to properly assess the patient and failed to implement appropriate plans of care to address the potential for further episodes of self-harming behavior, which had culminated in her injuries.

Issues

The primary issues in the case were the decision to admit the patient at the outset, followed by the failure to implement an appropriate activities of daily living care plan for feeding the patient with supervision. Finally, the SNF had failed to act immediately after warnings from the patient's mental health therapist and from the patient herself, culminating in the episode of self-harm and the ensuing lawsuit.

The big question for the SNF is whether it was able to provide the level of care required by Mrs. W, immediately after her discharge from a secured psychiatric facility and just several weeks after she had caused self-harm in a prior incident.

The physician who had assessed the patient upon her admission to the SNF did not issue specific orders for supervision of the patient during her meals or preventing Mrs. W from having metal silverware, despite the fact that she had a recent history of using similar metal instruments to engage in self-harming behavior.

Given the patient's history of self-harm, the decision to replace metal eating utensils with plastic eating utensils should have been a straightforward one. Investigation revealed the system for communicating such requests to the SNF's kitchen was rudimentary and deeply flawed, at best.

Mrs. W's injury was ultimately the result of a breakdown in communication at multiple levels and between various care providers, specifically her mental health therapy team, who failed to report her suicidal ideation to emphasize the urgency of their recommendation for one-to-one (1:1) supervision and the removal of metal eating utensils during meals; and her primary care physician, the SNF team, and the DON, who failed to implement a timely, appropriate plan of care despite being forewarned of the issue.

Best Practices

- A preadmission assessment should have been considered to determine whether the SNF was capable of providing the level of care necessary for a geriatric psychiatric patient who had exhibited significant psychiatric behavior before admission to the SNF.
- Although the SNF administrator had told the family that staff would not provide the 24-hour, 1:1 supervision that had been provided in prior acute facilities, this statement was not documented anywhere. Better charting would have memorialized this discussion before the resident's admission. It's also not clear that telling a patient or family that 1:1 supervision will not be provided can prevent liability if in fact at some point that appears to be the level of care that the resident requires; the regulations state (somewhat vaguely) that SNFs must be staffed "sufficient[ly] to meet the needs of the residents."
- The SNF team should have had much greater integration with the patient's behavioral health services team and primary care physician from the date of admission by

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Nursing Facility Influenza Study Opens Enrollment

A team of nationally recognized long-term care researchers from Brown University Stefan Gravenstein, MD, MPH, and Vincent Mor, PhD, are undertaking a large-scale quality improvement study to evaluate the impact of the annual influenza vaccine choice on long-term care facility residents' hospitalization risk for the 2019-2020 influenza season. Nursing facilities that meet eligibility and agree to participate will be allocated to one of two CDC recommended influenza vaccines for adults. Facilities will also receive a free supply of vaccine for staff. **The Foundation for PALTC Medicine** will receive a donation of $100 for each facility that enrolls in this study based on their referral.

If you are interested in this important project, please contact the study coordinating center, Insight Therapeutics, LLC at 757-625-6040 or NHFlustudy@inther.com.

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and were able to say, 'your home is still there,'" she said. "Many residents miss their homes, so we've done this with others as well."

About 70% of the system's content is group-oriented, and 30% is geared for individual use. Jack York, the founder and president of It's Never 2 Late (https://in2l.com/), said the company tracks what's being used across the 2,700-plus subscribing SNFs, assisted living communities, and memory care units, and it updates the content every other month. In addition to music, trivia, and games, he said, experiential programs for individuals with dementia and therapeutic activities for speech and occupational therapy are popular.

At any one time, 60% to 70% of the 3,000-plus applications and content items run offline, Mr. York said. The system can also be customized so that individuals or their families can maintain personal collections of favorite iN2L content as well as links to photos, voice recordings, or videos of grandchildren or other loved ones. Recently, the company released its own tablet to sync with the system, and Mr. York said they're following advances in voice technology and virtual reality, always looking for system enhancements.

Signature, in the meantime, has been pilot-testing Amazon's voice-activated Alexa with nine long-term residents and nine short-term residents of Jefferson Place, its skilled nursing community in Louisville. Each resident received an Echo Dot or a TV Fire Cube with training on how to use simple terms and specific word orders to talk to Alexa and access Memory Lane, Vintage Radio, Bingo, and other skill sets. "We saw smiles on the face, and tears in the eyes, because it was that easy," said Christopher Houser, chief information officer of Signature HealthCARE Services and the leader of the Alexa pilot program.

In addition to cognitive engagement and empowerment for the residents, Mr. Houser sees potential with smart speaker technology to facilitate more efficiency and job satisfaction for the staff. By building community information into the system, a resident could say, "Alexa, ask Signature, tell me the activities — are we having a bingo night?" or "Alexa, ask Signature to bring me a glass of water." Some questions will be answered by Alexa (with answers shown on the TV Fire Cube when it's there); others will be answered by the nurse or another staff member on the other end.

Alexa has also been tested in retirement communities by the Front Porch Center for Innovation and Wellbeing, which is part of the Southern California provider Front Porch. And an Alexa-powered platform called Aiva is being piloted in Cedars-Sinai hospital in Los Angeles. Ms. Rose of the Thrive Center said she's following Aiva with interest because it appears to be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Sunrise Senior Living's December 2018 announcement of a nationwide rollout for SingFit, its digital therapeutic music program, is another sign that communities and their future residents and families are increasingly looking for engagement technologies, Ms. Rose said. She is planning to bring to the Thrive Center a proactive social robot called ElliQ (Intuition Robotics, Israel), which uses artificial intelligence to offer personalized, cognitively stimulating activities and games and daily routine reminders. She also is looking into new virtual reality products for individuals with dementia and Alzheimer's disease. Such products will sit alongside iN2L, various types of companion pets, the SingFit program, and other technologies.

Although there's still a need for more products and programs for people with Alzheimer's and more advanced dementia, "we're really getting creative overall on products and solutions that can engage and stimulate the mind," Ms. Rose said. While some products are costly, not all innovations are necessarily high tech or high cost, she noted. This August, her center will be hosting sessions for members of the Pioneer Network when they gather for their annual meeting.

For skilled nursing and other settings, Mr. Houser of Signature envisions viable economic models for integrating engagement technology. For instance, facilities that have a high-speed internet connection could replace cable and satellite TV with live-streaming TV and various voice-activated skills and services that are useful for that community, he said.

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recalled with a laugh. The intervention significantly improved the participants' physical performance (measured using the Short Physical Performance Battery) at 12 months (P = 0.02). Although the number of fall-related fractures did not differ significantly between the groups, exercise did reduce the number of injurious falls (those resulting in pain, bruising, laceration, or fracture). In other words, exercise helped the participants to avoid falls; even when those in the exercise group did fall, their falls were not as bad as those experienced by the group who did not exercise.

Their study happened to be published around the time of policy review in Australia. Dr. Hewitt presented her team's findings to the Minister of Aged Care, who connected her with the policymakers in charge. The outcomes of their study and others, along with the lobbying efforts of the Australian Physiotherapy Association, helped to tip the scales. The draft of new policy currently under consideration now includes therapeutic exercises for aged care in Australia.

Recognizing the impact of her research, Dr. Hewitt admitted, "My hope for my work is to change the way people live. While recognition and policy are important, I find the greatest reward in the feedback my residents and their families give me when I go in [the community] to conduct an exercise session. I hear and see something rewarding every time." That positive feedback and the obvious improvement in the residents' well-being is what has kept her in the field of elder care for almost 30 years after her transition from sports physical therapy. "For athletes, my work is just a way to boost performance, maybe, by several percent, while for the elderly, exercise can be a life-changer." She recalls a resident with cerebral palsy who "walks tall and doesn't drag his foot anymore," now at the age of 91. "His walking is better than it was when I first met him at age 80!"

Aside from providing positive physical changes, her exercise program has boosted morale in the communities. "Residents were so proud of themselves. The activity also gave them something to talk about before and after each session. Some of them said it had changed their lives; others needed to buy workout clothes for the first time ever."

Dr. Hewitt hopes that her findings will inspire additional research in the field and support the policy changes needed for residents to reap the benefits of exercise. While policy varies broadly, the effectiveness of exercise in preventing falls and its value to seniors remain high, regardless of the geography.

Dr. Boyum is the managing editor of *Caring for the Ages*.

EXPERT COMMENTARY

This study supports previous research that we can't get residents, families, or caregivers to really believe: exercise is the best way to prevent falls! The problem is everyone would rather just take vitamin D, which we now know is not as effective. Along with the evidence of the value of exercise, the study also confirmed the low rate of willingness to participate (25% among residents). Further, adherence overall was poor, with attendance rates of 60% for the 25 weeks of classes and an even lower adherence of 31% to 50% for the maintenance activities. So unfortunately yet again we have learned that exercise is effective, but we can't get residents to engage in this level of activity or staff to encourage and support it at the level needed.

There were a couple of unknowns in this report. First, although attendance was reported, it was not noted to what degree the participants actually completed the recommended exercises (i.e., did the resistance exercises progress as planned?). Further we do not know how often the staff actually helped with the intervention activities or maintenance activities.

The ability to translate this type of intervention to the United States really depends on the facility's commitment to and belief in the benefits of exercise and on establishing sufficient resources to allow the program to happen. This requires teaching staff how to motivate and engage residents, how to provide this level of exercise activity, and how to evaluate each individual's underlying capability and match the exercise program with his or her needs.

— Barbara Resnick, PhD, CRNP

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including representative(s) of her mental health therapy team in the interdisciplinary team and care-planning decisions.

- One helpful approach is to establish regularly scheduled behavioral rounds for the mental health providers, social worker, and supervising registered nurse.
- The number of psychiatric patients admitted should not overwhelm the SNF's capability to appropriately address their needs.
- In-service training should be implemented for staff to upgrade their skills to better understand and manage the emotional and behavioral issues of geriatric psychiatric patients. With Phase 3 of the new Requirements of Participation going into effect in November, SNFs will also need to train staff in trauma-informed care.
- As always, proper documentation of these efforts is a must. Documentation may not prevent a lawsuit, but it will minimize the SNF's risk and provide the best defense possible if a claim is made.

This column is not to be substituted for legal advice. Mr. Wilson is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance.