**Section 299.345 Emergency Mental Health Care**

a) Residents in Need of Emergency Mental Health Care

1) When medical, treatment or security staff believe a resident is in need of emergency mental health care to prevent self injury, the AOD shall be notified.

2) The AOD shall immediately initiate placement of that resident into Mental Health Status 1 and provide continuous observation of the resident.

b) Resident Placement, Property Restriction and Observation Requirements

1) Placement. After placement in Mental Health Status 1 is initiated, and prior to the completion of the one-hour assessment by an MHP, the resident shall be placed in an empty, designated observation room. Following the one-hour mental health assessment, continued room placement of the resident shall be determined by consultation between security staff and the MHP assigning the resident to Mental Health Status 1 or 2. The decision regarding where to place the resident, and his/her movement while on Mental Health Status, shall be based on the level of risk the resident presents, as well as the institutional management challenges presented by the resident once placement is initiated.

2) Property. During initiation, the AOD may limit or restrict the personal or facility-provided property items, including clothing, the resident is permitted to possess. Once the mental health assessment is complete, the MHP assigning Mental Health Status shall indicate the appropriate, allowable personal or facility-provided property. This decision shall be approved by the Program Director.

3) Observation. The resident shall be under continuous visual observation once these procedures regarding Emergency Mental Health Status (EMHS) are initiated, and will remain under continuous visual observation until, in the opinion of an MHP, observation is not necessary.

c) Notification of Clinical Director or Designee

1) As soon as practicable, the AOD will notify the Clinical Director or designee that EMHS was initiated and shall request that an assessment of the resident's behavior be performed by an MHP.

2) If the need to initiate EMHS occurs when there is no MHP on-site, the AOD shall request that the duty nurse perform the assessment.

3) An on-site assessment of the resident's mental health needs shall be performed within one hour after placement in EMHS.

4) If EMHS is initiated after normal business hours, upon completion of the one-hour assessment, the duty nurse shall notify the Clinical Director or designee.

5) In all situations, an MHP will become the lead person in management of the resident through resolution of the crisis. The MHP will determine necessary interventions, including the need for continued observation, the type of observation, the need for a psychiatric consult, and/or any other appropriate mental health interventions. All measures taken shall be documented in the resident's clinical file.

d) Contacting Psychiatrist on Call

1) The Clinical Director or designee may, at his/her discretion, contact the psychiatrist on call and consult with him/her regarding the resident's apparent emergency mental health care needs.

2) The Clinical Director, AOC and psychiatrist on call, within their respective scopes of practice, shall determine the utility of emergency medication; the interval, frequency and type of observation (e.g., medical, general, security); room placement; and permitted property. They shall also direct the security staff and health care staff accordingly.

e) Minimal Standards for Care and Observation

While the resident remains in EMHS, the following are minimal standards for care and observation, unless otherwise directed:

1) The resident will be reassessed by an MHP or the duty nurse every shift while on EMHS.

2) Security and nursing staff shall follow all instructions from the Clinical Director or designee.

3) To assure continuity of care, the MHP or duty nurse shall, every shift, write a summary progress note that includes assessment, care and status of the resident. This note shall be placed in the resident's clinical file.

4) In all cases, the resident shall be evaluated face-to-face by an MHP, within 24 hours after being placed on EMHS, to determine the resident's continuing needs.

5) A resident may not be placed on EMHS for more than 24 hours unless continued by an MHP after conducting a face-to-face assessment of the resident.

6) Residents placed on EMHS shall be restricted to the living unit or healthcare unit and may only leave the unit for medical reasons, court writs, or as otherwise approved by the Program Director. All residents on EMHS shall be provided a 1:1 escort while off the living unit.

7) When a resident has been on Mental Health Status for a continuous period of 72 hours, the Clinical Director or designee shall review the resident's ITP with the facility psychiatrist. If the resident is continued on Mental Health Status, the psychiatrist will conduct a face-to-face evaluation of the resident and, with the treatment team, shall review the ITP weekly for the time the resident remains on Mental Health Status. A resident's ITP shall:

A) address individual behaviors and special needs;

B) address the need for special observation; and

C) provide guidance to staff who provide for the daily care and treatment of the resident.

8) All direct care staff shall follow the specific guidelines set forth in the ITP, including, but not limited to, behavior observation, data collection, documenting intervals, and interaction with the resident and the resident's response. This shall occur while the direct care staff continues to provide all other day-to-day care and treatment of the resident.

f) Incident Reporting Requirements

The AOD will ensure that the staff involved in the incidents leading up to the initiation of EMHS complete incident reports or chart notes as needed before they leave their shift. The shift supervisor shall ensure that all incident reports are delivered to the Program Director before the end of his/her shift.

g) Notification of Resident's Reassignment

1) On the first subsequent business day after a resident reassignment, the Clinical Director or designee shall notify the resident's primary therapist and facility psychiatrist of the reassignment and the behavior necessitating placement on EMHS.

2) On the first business day after placement on EMHS, the Clinical Director, primary therapist, or facility psychiatrist shall review the resident's continuing need for emergency mental health care.

A) If there is evidence of continued risk, the resident shall remain on EMHS. Continued assignment to EMHS shall then be reviewed every business day thereafter until the resident is reassigned to a different management status.

B) If, upon review, there is no evidence of continuing risk, the resident shall be returned to his/her previous management status with recommendations for follow-up treatment.

C) If the Clinical Director, primary therapist or facility psychiatrist determines the resident presents a risk of harm to self or others that is not related to his/her mental health, the resident will temporarily be reassigned to Special Management Status.

D) In the event of a re-assignment of the resident to Special Management Status, the Clinical Director, primary therapist, or facility psychiatrist shall notify the AOC and refer the matter to the Behavior Committee for review.

E) When a resident is temporarily reassigned to Special Management Status, the requirements specified in the Special Management Directive will be followed.

h) Daily Contact with Resident by Primary Therapist

1) While a resident is on EMHS, his/her primary therapist shall have daily, individual contact with that resident. The contact shall, at a minimum, involve:

A) Assessment of the resident's current dangerousness;

B) Mental status and mental health needs; and

C) The coordination of physical or medical needs, as required.

2) The primary therapist shall discuss the events and decisions resulting in the resident's reassignment to EMHS. Those events and decisions shall be viewed in light of the resident's overall ITP and, as appropriate, the ITP shall be modified and additional treatment recommended to reduce the frequency of the resident's reassignment to EMHS. The resident's primary therapist is responsible for ensuring that the resident is offered the following:

A) Daily recreation time as appropriate, based on the resident's mental status and assessed dangerousness;

B) Adequate access to personal hygiene and grooming supplies; and

C) All permitted personal and facility-provided property.

(Source: Added at 44 Ill. Reg. 8246, effective April 28, 2020)