

**PRTF Rules and Standards in North Carolina
Recommendations for Modifications**

ISSUE: Nursing Coverage

Federal Rules and Standards:

No specific standard on nursing coverage.

Federal Standards on orders for the use of restraint and seclusion in PRTF.

N-015; 483.358(d):

If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

State Licensure Rule 10A NCAC 27G .1902(e):

The PRTF shall provide 24 hour on-site coverage by a registered nurse.

Recommended NC Licensure Rule:

The PRTF shall provide 24 hour nursing coverage at a minimum as follows:

- (a) One RN or Nurse Practitioner on site for the PRTF facility or campus for the first 25 residents when children or adolescents are present and awake. AND
- (b) One LPN on site for the PRTF facility or campus for every additional 25 residents when children or adolescents are present and awake. AND
- (c) One LPN on site for the PRTF facility or campus for every 50 residents during sleep hours.

Definition: A PRTF campus is a facility with multiple units in the same physical location. It is not a facility with satellite units in various geographical locations.

ISSUE: Minimum Staffing Requirements

Federal Rules and Standards:

No specific standard on staffing ratios.

State Licensure Rule 10A NCAC 27G .1902(b):

At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit.

Recommended NC Licensure Rule:

The minimum number of direct care staff required when children or adolescents are present is as follows:

- (a) Two direct care staff shall be present for 1 to 6 children or adolescents.
- (b) Three direct care staff shall be present for 7 to 9 children or adolescents.
- (c) Four direct care staff shall be present for 10 to 12 children or adolescents.

Clarification: This does not change the existing staffing ratio in the current PRTF rules. It does, however, clarify the point at which additional staff must be present.

ISSUE: Orders for the Use of Restraint and Seclusion in PRTF

Federal Standards N-015; 483.358(a):

Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion and trained in the use of emergency safety interventions.

Current Interpretation in NC:

Order can be done by an MD, DO (Doctor of Osteopathy), NP (Nurse Practitioner), PA (Physician's Assistant), or Licensed Psychologist.

Recommended State Interpretation:

PRTF facility may utilize a physician; registered nurse; licensed psychologist; licensed clinical social worker; licensed professional counselor; nurse practitioner; or physician's assistant to order the use of restraint or seclusion. Staff must be trained in the use of emergency safety interventions and alternatives to restrictive interventions; and must be credentialed and privileged by the facility to order restraint or seclusion.

ISSUE: Assessment of Residents After the Use of Restraint and Seclusion in PRTF

Federal Standards N-020; 483.358(f):

Within 1 hour of the initiation of the emergency safety intervention, a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to (1) the resident's physical and psychological status; (2) the resident's behavior; (3) the appropriateness of the intervention measures; and (4) any complications resulting from the intervention.

Current Interpretation in NC:

Can be done by an MD, DO, NP, and PA. Cannot be performed by a licensed psychologist as this is outside of his scope of expertise. A facility using an RN to do the assessment who is not a Nurse Practitioner, is out of compliance.

Recommended State Interpretation:

PRTF facility may utilize a physician; DO; NP; PA; or Registered Nurse to assess the physical and psychological well being of residents. Staff must be trained in the use of emergency safety interventions and alternatives to restrictive interventions; and must be credentialed and privileged by the facility to conduct assessments of the physical and psychological well being of residents.

ISSUE: Interim Rate Granted for First Six Months of Operations

Current North Carolina Practice:

North Carolina provides an interim rate of \$ 437.04 for the first six months of operations. Once the first six months of service is completed, the agency submits a cost finding and the rate is set at 90% occupancy.

Problem:

The rate is insufficient to accommodate start up costs associated with low initial census when the professional and medical staffing requirements are very costly. Eliada’s costs for our first three cottages assessed at 90% occupancy were:

Unit	Actual Utilization	Based on 90% Utilization	Unit Capacity	Type
Reynolds	\$ 615.96	\$ 471.04	9	Adolescent
Lions	\$ 506.76	\$ 497.09	9	Adolescent
Earle	\$ 523.85	\$ 515.95	5	Latency

Unit	90% Utilization	Capacity	Weighted Average
Reynolds	\$ 471.04	9	\$ 4,239.36
Lions	\$ 497.09	9	\$ 4,473.81
Earle	\$ 515.95	5	\$ 2,579.75
Total	\$ 1,484.08	23	\$ 11,292.92

Weighted Average into capacity would equal a rate of \$491.00 (11,292.92/23 = \$ 490.99)

Recommendation:

Provide a facility specific interim rate based on cost projections, or increase the standardized interim rate.

Other Issues of Concern:

ISSUE: Technical Assistance for New PRTF Providers

The PRTF provider/licensure committee recommends that state agencies develop and implement technical information for new PRTF providers on reporting/paperwork requirements; relationships with LMEs; clinical expectations; and other pertinent information.

ISSUE: Clinical Home and Person Centered Plan

The PRTF provider/licensure committee identified issues with the current system of the community support agency developing and revising the PCP. Issues include difficulty in obtaining PCP revisions; PCPs that do not meet Medicaid standards; and inadequate treatment goals and strategies for PRTF level of care. The committee recommends that these issues be addressed along with plans for portal of entry and clinical home responsibilities with the proposed elimination of Community Support.