Practical Risk Management: Improving Quality While Reducing Liability Exposure

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Objectives

Participants will be able to:

a. Identify everyday, common-sense treatment and documentation strategies to reduce liability exposure and improve quality of care
b. Recognize elements of a malpractice lawsuit
c. Be aware of common allegations resulting in geriatric malpractice and nursing home negligence lawsuits

Risk Management = Common Sense

* Good Care + Good Documentation = Low Risk
  * When either is lacking, risk increases
  * Good care is more important than good charting, but poor documentation increases risk greatly
* Treating Patients/Families Well Goes a Long Way
  * Communication can be critically important

Risk Management = Common Sense

Policies and Procedures

* Having Good Policies & Procedures Helps
* Up-to-date
* NOT excessively prescriptive
* Regulatory based
* Guidelines and does not substitute for medical or nursing judgment

Risk Management = Common Sense

- Individualize Care: Culture Change is a real thing!
  - New regulations are full of references to person-centered care
- Emphasis = Quality of Life + Resident Rights
  - Free Choice
  - Self Determination
  - Refusal of Care
    - Risks
    - Benefits
    - Alternative treatment options

What Are the Elements of a Successful Malpractice Suit?

- **DUTY**
- **BREACH OF STANDARD OF CARE** (NEGLIGENCE)
- **CAUSATION** (a causal link between the negligent act/omission and some injury to the plaintiff)
- **DAMAGES** (the actual costs or burdens, including pain and suffering, that the negligent act or omission caused)

MEDICAL NEGLIGENCE

STANDARD OF CARE
FOR HEALTH CARE PROFESSIONALS

- *A [health care provider] is negligent if he/she fails to use the level of skill, knowledge, and care in the diagnosis and treatment that other reasonably careful [health care providers] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as the "standard of care."*
- *A Non-Physician Provider (NP/PA/CNS) who is performing services may be held to the same standard as a physician*
- *Exact Language Varies among Different States, but Concept is the Same: Standard of Care is NOT Optimal Care*

MEDICAL NEGLIGENCE

- How Is Standard of Care Determined?
  - EXPERT TESTIMONY is Required
    - Can be Extremely Variable (and Questionable!)
  - Polices & Procedures, Regulations Do Not Automatically Constitute the Standard of Care
    - Plaintiffs & Defense Attorneys Disagree on This
- An Error in Clinical Judgment is *Not Necessarily* a Breach of the Standard of Care.
  - As Long as this Judgment is a "Thoughtful Decision Based on Adequate Information," it may Meet the Standard
  - Reasonable People May Differ in Opinions
  - There are often multiple courses of action that meet the standard of care
  - Outcome Will Depend on Expert Testimony

Common Liability Claims in Geriatrics & LTC

- Wounds (pressure, stasis, ischemic, traumatic)
- Falls/Injuries
- Restraints (Physical/Chemical) & Consent/Refusal
- Advance Directives/Failure to Transfer
- Hydration, Nutrition
- Elopement
- Medication Errors/Adverse Drug Reactions
- Failure to Thrive
- Delinquent Visits/Inadequate Supervision
- Lack of Responsiveness to Calls or Other Communication

Common Liability Claims in Geriatrics & LTC

- Dysphagia
- Pain Control/Monitoring
- Contractures
- Failure to Notify (Family/Physician)
- Failure to Follow Up on Abnormal Lab/X-Ray/Change of Condition
- Failure/Delay in Carrying Out Orders
  - Medications, Diagnostics, Consultations
- Residents/Families with Unrealistic Expectations
- Failure to Follow Policies & Procedures
- Incorrect Risk Stratification (Falls, Pressure Ulcers, etc.)
- Inadequate Staffing
- Failure to timely diagnose (e.g., cancer) or failure to screen

Pressure Ulcers

- Assess Risk Status regularly and appropriately
- To photograph or not to photograph?
  - Can be helpful or harmful, but more often the latter
  - If your policy is to photograph, stick to it.
- Measure wounds regularly, at least weekly
  - Not that hard to measure with every dressing change
  - When time permits, document/measure wounds before each trip out of the facility (to hospital/ED, appointments, dialysis, etc.)
- Document All Dressing Changes
  - If dressing changes are painful, pre-medicate with analgesic
- Keep Resident/Family Apprised of What is Going On!
  - If a wound is considered non-healable, let them know
  - Direct Communication from physician (and nurses) can shape realistic expectations, and is usually much appreciated
  - Educate family that skin breakdown is often unavoidable

Pressure Ulcers

- Consider Wound Care Consults if not Healing (for wounds that are deemed healable)
- If you are going to culture it, be sure it is done correctly
- Consider Specialty Mattress early
- If resident is noncompliant with turning and repositioning, document it each time
  - But need to do more than just this—take other measures, including specialty mattress
- In especially high-risk situations, consider documenting each turn/reposition (like in an ICU)
- On transfer paperwork or any accompanying documentation for outside visits, mention high-risk status for wounds and any specific wounds already present.

KNOW YOUR WOUNDS

Differentiation: Not every wound is a pressure ulcer

* Moisture-Associated Dermatitis
* Arterial Ulcers
* Stasis Ulcers
* Pressure Ulcers
* Diabetic Neuropathic Ulcers
* Trauma/Shear
* Malignancies
* Know DTI, Unstageable ulcers

FALLS / ACCIDENTS

* Policy & Procedures for Falls Program
* Risk Assessment upon Admission
* Ongoing assessment for prevention
* Ongoing observation / supervision for accident prevention
* Specialized falls program
* Post-fall analysis and change of CP if appropriate

FALLS / ACCIDENTS

* FALL INVESTIGATION:
  * Location
  * Cognitive / mood / behavior
  * Physical limitations
  * Environmental factors
  * Equipment factors
  * Medical / Disease Influences
  * Medications

RESTRAINTS

* Goal Restraint Free (National Average now <1%)
  * Restraint Assessment
    * Comprehension
    * Mobility
    * Behavior
  * Non-restraint Measures (Alarms falling out of favor too)
  * Least Restrictive
  * Ongoing monitoring
  * Reduction Attempts

AVOIDABLE v. UNAVOIDABLE

- SNF Federal Regulations Allow For:
  - Decline in Activities of Daily Living
  - Pressure Ulcers
  - Range of Motion
  - Nutrition
  - Psychosocial Adjustment
  - *Note: Dehydration not specifically addressed*
- Clinical necessity / justification
  - Urinary Catheters
  - Gastric Feedings

Medications

- Influenza & Pneumococcal immunizations

- Unnecessary Drugs
  - Excessive Dose / duplicate therapy
  - Excessive duration
  - Without adequate monitoring
  - Without indications for use
  - In the event of adverse side effects

Pearls for Everyone in LTC

- Write Legibly
- Document Truthfully
- Avoid Value Judgments
  - But fine to use direct quotes from residents/families, even if profane
- Picture Your Notes being blown up in front of a jury
- Be a good communicator
- Be sensitive to cultural nuances
- Strive to elevate long-term care and our perception

Pearls for All Disciplines

- Treat people like you would want to be treated (or want your family to be treated)—respectfully, as individuals
- Be responsive to resident/family concerns and complaints
- Don't criticize other health care providers
- Acknowledge the difficult and bewildering situation our patients and families are often experiencing in our homes, and help them navigate it.

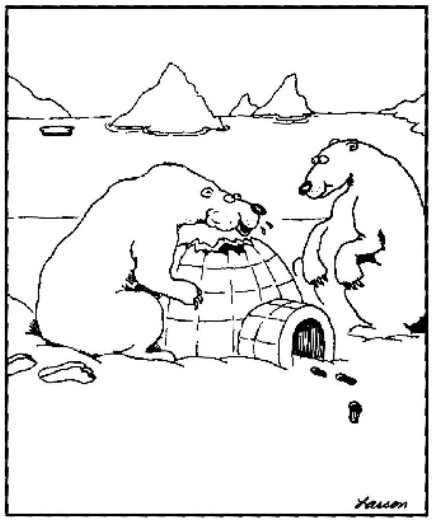
Pearls for Clinicians in LTC

- Actually Look at Pressure Ulcers and other wounds
  - If you are not comfortable doing this, make sure another qualified clinician is doing it! You are overseeing the total plan of care.
- Consider Documenting Phone Conversations with Family, even when Off-Site (especially "challenging" ones)
  - e.g., keeping a phone log or carrying a voice recorder (smart phone)
  - Can also place a note in chart remotely for some facilities using EHR
- Read Nurses' Notes, Talk to Nurses/CNAs
- Discuss and document treatment preferences, POLST

Pearls for Clinicians in LTC

- Check Residents' Weights, Labs, etc.
- Address Interval Changes/Events (Falls, Weight Loss, etc.)
  - Document in your notes, along with some sort of plan
- Become Familiar with Fall Prevention Measures available in your facilities
- Make timely visits on a consistent basis (routine/episodic)

Nutrition/Hydration are Important!



"Oh, hey! I just love these things! ... Crunchy on the outside and a chewy center!"

Pearls for Clinicians in LTC

- **Diabetic Management**
  - Actually Look at Blood Sugars & Mention Control
  - If Tight Control not needed, reduce the monitoring and document that this has been considered (with informed consent, ideally)
  - Hypoglycemia is dangerous, better to run high than low
  - If using meds that are sensitive to renal function, keep that in mind
- **When called by family (or resident), call facility first to get an update—or better yet, actually see the resident.**
  - But Don't Delay in responding to concerns
- **When giving telephone orders, insist on read-back**

Pearls for Clinicians in LTC

- Do Not Merely Copy & Paste Electronic Notes—Make Sure to Actually Modify Notes to Reflect Current Status
- Document Reasoning and Consent for Off-Label Prescribing, especially antipsychotics
- Document Informed Consent/Refusal for other issues when appropriate
  - e.g., Refusing Therapeutic Diet, Use of Splints, etc.
  - Can state, "Risks, benefits and alternatives reviewed, resident/family understands these and wishes to…"
- Consider looking at your TOs before signing them

Pearls for Clinicians in LTC

- Get used to talking about end-of-life, feeding tubes, failure to thrive, frailty, etc. and be proactive with families
  - Enlist hospice or palliative care consults appropriately
  - Educate families on what to expect
  - Defuse fears about dehydration/hypovolemic shock
  - Discuss hospitalization benefits and burdens
  - Explain that "No CPR" does not mean "No Care"
- Don't hesitate to get a second opinion, Ethics Committee, other consultations in difficult or unclear situations
- When appropriate, document in terms of "unrealistic expectations," "medical ineffectiveness/futility," "unavoidable" (best used before the unavoidable thing occurs, but can be used after the fact)
  - e.g., "pt. skin currently intact, wt. 140→126 in last 2 months, albumin level 2.0, meal intake 25-50%, feeding tube not desired, daughter understands that skin breakdown may be unavoidable"

Pearls for Clinicians in LTC

- Consider Attending IDT/Care Conferences
- Don't Forget Pain, the Fifth Vital Sign
- Have a Custom & Practice, and stick to it
  - Always ask for latest creatinine/eGFR before ordering antibiotics or other meds with renal prescribing implications
  - Always ask if a resident is on warfarin before starting an antibiotic that has a potential interaction (and latest INR, etc.), and adjust prn
  - Always ask for latest vitals, recent labs, etc.
- When called about a patient's change of condition:
  - Consider explicit orders to ↑ frequency of vitals, check orthostatics, step up blood sugar monitoring, perform neuro checks, etc.
  - Consider specific parameters to call back (e.g., SBP<90, pulse>100)
- Be sure that people with whom you share clinical duties (on-call, etc.) are reasonably competent

Pearls for Clinicians in LTC

- Pain Control
  - Don't Forget Pain, the Fifth Vital Sign
  - Pain Control
  - Opioid prescribing
- High-risk cases for liability: Step up the documentation. You know who these people are.

Pearls for Nursing Staff in LTC

- Maintain an Active Problem List (and ask doctor for input)
- Avoid Rote Charting!!
  - "Call light within reach"
  - "Alert & verbally responsive"
  - "New orders obtained"
- Be sure your entry does not contradict another chart entry
- Make sure goals in care plan are realistic
- Follow your own policies & procedures

Pearls for Nursing Staff in LTC

- Document Pain Assessment /Management Consistently
  - Post-intervention assessment should be quantitative, not just "improved"
- Be Proactive with Bowels and Pain Management
  - Don't be afraid to advocate for your residents
  - Request pre-medication for therapy, dressing changes, and other painful procedures
  - Request long-acting or 'round-the-clock analgesics if needed
- Be Compulsive about Notifying Doctor & Family:

Notification is **Mandatory**!
42 CFR §483.10 (a)(11)

Notification of changes.

(i) A facility must *immediately* inform the resident; consult with the resident's physician; and if known, notify the resident's **legal representative or an interested family member** when there is –

(A) An **accident** involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A **significant change** in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A **need to alter treatment** significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to **transfer or discharge** the resident from the facility as specified in §483.12(a).

Pearls for Nursing Staff in LTC

- **When to Notify the Physician:**
  - **Abnormal Vital Signs**
    - **Nursing Judgment, Common Sense, Consider Baseline**
  - **Skin Breakdown or Worsening Wound Status**
  - **Reduced Dietary or Fluid Intake**
  - **Weight Loss**
  - **Falls/Near-Falls, other Injuries**
  - **Behavioral Disturbances**

Pearls for Nursing Staff in LTC

When to Notify the Physician:

- Abnormal Lab/X-Ray Studies
- ***Family Concerns ***
  - Usually OK to let Family Know How to Contact Doc
  - Usually NOT OK to Page Doc from Nurses' Station for Family & Hand Phone Over! (Ambush!)
- When in doubt, call/fax and document the action
- Decide whether it requires a response—if so, get one

Pearls for Nursing Staff in LTC

- Other Times to Initiate Contact with Physician
  - Resident Symptoms (Pain, Cough, Dyspnea, Nausea, Bowel Irregularities, Dysuria, Confusion, etc.)
  - When an Order is Not Carried Out as Directed
    - Labs Not Drawn for any Reason
    - Medication Not Administered or Delivered (Timely)
      - Can Solicit a Substitute from E-Kit if Appropriate (esp. for Pain or when Serious Infection is Suspected)
      - Repeated Need for Holding BP meds for low BP parameters
    - Refusals of Medication or Treatment
    - Refusals of Turning & Repositioning or Use of Splints, Adductor Pillows, Heel Protectors, etc.
    - Delays in Appointments for Diagnostics/Consultations
    - Trend of high/low blood sugars, abnormal vitals

Pearls for Nursing Staff in LTC

- Avoid Late Entries Unless Truly Necessary
- Never Alter a Chart Entry After the Fact
  - OK to strike out an entry along with initials and date(/time)
- If attending physician/NPP does not return a call, have a procedure for notifying someone (DON, medical director)
  - Use judgment on the time frame
- Ensure Policies & Procedures are up-to-date
- Be well prepared before calling the clinician about a change of condition, abnormal lab result, etc.
  - Consider AMDA Tool Kits/CPGs/Know-It-All sets, INTERACT, SBAR, or your own protocols

Pearls for Nursing Staff in LTC

- Have All Information Ready for Physician/NPP
  - Chief Complaint & Associated History
  - Vital Signs, Full Set, Recent!
    - Actually Measure a Respiratory Rate
    - Include Orthostatics, BS if Appropriate
  - Oxygen Saturation
  - Results of Focused Physical Assessment
    - e.g., Lung Sounds, Abdominal Exam (Bowel Sounds, Tenderness, Distention), Cardiac Rhythm/Sounds
    - Check for Impaction, Check for Bladder Distention
    - Assess Mental Status in Comparison to Baseline
      - Actually Assess Orientation—Residents Can Fool You!
      - Delirium Grossly Underdiagnosed & Carries Poor Prognosis

Pearls for Nursing Staff in LTC

Have All Information Ready for Physician/NPP

- **Know Preferred Intensity of Treatment/Goals of Care/POLST status, especially if "do not hospitalize"**
- **When appropriate, call Family before calling physician**
- **Have Medication List Handy**
  - Tell if Resident is on Coumadin (Antibiotic Interactions)
  - Tell if Resident is or has been on Antibiotics recently
    - (Increased Risk of *C. diff*., Yeast, Drug Reaction, etc.)
- **Insist on Reading Back All Orders**
- **OK to have an impression and an agenda, but be flexible**

Pearls for Nursing Staff in LTC

Have All Information Ready for Physician/NPP

- **Know baseline vital signs for the resident**
- **Recent & Remote Lab Work (Baseline) should be available and shared with the clinician**
- **Have MARs with recent Blood Glucose values, and Current Diabetic Regimen (Insulin, etc.)**
- **Know when last BM & Void Occurred, Meal Intake**
  - Know Hx of Previous Impaction, Retention, Infections

Pearls for Nursing Staff in LTC

- Have Reasonable, Realistic Goals on Care Plans
- Plans of Correction Should Also Be Reasonable/Realistic!
  - Deficiencies/Citations Are sometimes admissible in court
- Update Care Plans Regularly (Note: 48h initial CPs now required)
  - Consider Dating All Modifications to Care Plans
- Monitor bowel movements carefully and accurately, and document them—a 10-day span between BMs looks bad
- Same applies to bathing
- Meal percentages, I/Os are notoriously unreliable, but if we are measuring and documenting them, someone needs to be keeping an eye on them and reporting anomalies

Pearls for Administration in LTC

- Have a policy for delinquent visits
  - Document calls/faxes to attending physician
  - Have medical director call delinquent doctor, then actually see resident within a few days (10 days' grace period beyond due date)
- Perform credentialing : Know who is seeing your residents
- Try to create a culture of caring and teamwork
  - Disgruntled former employees are often a plaintiff's best friend
- Have a pleasant, engaged greeter where people enter

Pearls for Administration in LTC

- Encourage families to visit often and be nice to them
- Have employees wear name tags and identify themselves whenever making contact with residents/families
- Knock on doors as a courtesy before entering
- Be responsive to concerns and complaints
- Foster a culture that does not blame or scapegoat employees (promote just culture)
- Embrace QAPI
- Discourage speaking in foreign languages, cell phone use
- Social media: Privacy Issues, always get consent for photos

Pearls for TEAM

- Sentinel Events
  - Impaction
  - Dehydration
  - Low Risk Pressure Ulcers
  - Falls with Injury
- Incident Reports/QA Documentation, QAPI PIPs
  - Generally not discoverable in a legal action (protected)
  - Should be done in a practical matter, to improve care
  - Analyze data, celebrate successes

Pearls for TEAM

- Quality Assurance/Performance Improvement (QAPI)
  - Include top five:
    - Pressure Ulcers / wounds
    - Falls
    - Weight Loss
    - Restraints
    - Medication Errors
  - Internal Investigations
  - Action Plans
  - Reporting requirements
  - Ombudsman
  - Outside Counsel

Summary

- High-quality care translates to reduced liability
- It is largely a matter of common sense
- Always keep the patient's best interests in mind
- If you show you care about your patients, that also helps reduce liability exposure
- Picture every word you document in a chart being blown up and shown to a jury
- Being sued for malpractice is stressful: Try to be resilient
  - It's just business to the attorneys, even though it feels personal
  - Sometimes we do make errors, nobody is perfect
  - Apologizing can be helpful on multiple levels

Thank You!