More Lessons from Litigation: Targeting Performance Improvement in Post-Acute and Long Term Care Facilities

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Bi-State Conference on Post-Acute and Long Term Care

April 28, 2019

Speaker Disclosures

- Dr. Huss has stated there are no disclosures to be made that are pertinent to this session.

Learning Objectives

By the end of the session, participants will be able to:

- Describe the main areas of litigation commonly encountered in PA/LTC facilities
- Discuss ways the medical director, attending physician, administrator and DON can glean lessons from PA/LTC litigation to use for performance improvement activities in their facilities that can serve to lessen the chance of being involved in litigation
- Recognize the importance of recognition of 'near miss' events and subsequent implementation of follow-up action to prevent liability with adverse outcomes
- Describe the importance of updated care plans that reflect appropriate goals of care for nursing facility residents in reducing the chance of litigation involving nursing facility residents

Outline

- Basics of medical malpractice litigation
- Common issues in nursing facility litigation with illustrative case studies
- Protecting the nursing facility and providers from liability
- Q&A/Discussion

Basics of Medical Malpractice Litigation

Elements of Malpractice Litigation

Plaintiff must prove presence of 4 elements

- Duty
- Breach of Duty (breach of standard of care)
- Damages/Injuries
- Causation

Duty

- Duty exists when health care provider and individual have a professional relationship
- Providers must act in accordance with professional standards
- Provider is expected to exercise the degree of care and skill of a reasonably prudent provider in same or similar conditions (SOC)
- Facility policies and procedures can appear to raise or set standards

Breach of Duty

- Failure to fulfill duties in accordance with standards of care
- In NH litigation, federal and state regulations typically form basis for claims of negligence
- In civil rights claims, burden of proof is on NH to prove they did not violate resident's rights

Damages/Injuries

- Injury=harm—physical, emotional or financial
- Damages result from injury:
  - Economic/compensatory
  - Non-economic/emotional and other
  - Punitive
    - Intended to serve as a warning to others
    - Conduct must be outrageous

Causation

- Examines whether provider's conduct was actual cause of patient's injury
- Injury or wrongful death must be causally related and a natural and continuous product of a defendant's omissions or actions
- Proximate cause: an event, natural and continuous, that results in an injury that would not have occurred otherwise
- "But for" rule

Burden of Proof

- Preponderance of evidence that negligent acts caused injury
  - With a reasonable degree of medical probability/certainty (>50%)
- In wrongful death must make connection of negligent acts as proximate cause of death
- Higher burden of proof for punitive damages—clear and convincing evidence

Current Common Allegations in Nursing Home Litigation

- Falls with injury
- Dehydration/weight loss
- Improper use of restraints
- Pressure ulcers
- Failure/delay to treat
- Medication errors
- Isolated event injuries (elopement, sexual assault, equipment failure, etc.)

Future allegations?

- EHR issues

Learning Points from Nursing Facility Litigation

Generating an Appropriate Initial Care Plan from an Accurate Admission Nursing Assessment

The Importance of the Admission Nursing Assessment

- Many of today's PA/LTC admissions involve complex residents with multiple serious comorbidities from acute care facilities
- Some referring facilities do not routinely utilize pressure injury prevention tools
- Of critical importance to accurately document resident's condition on admission, particularly presence or absence of any skin conditions or pressure injuries
- Failure to do so will likely result in your facility "owning" any such pressure injury discovered subsequently, despite appropriate care otherwise
- Critically important that nursing staff completing admission nursing assessment be very familiar with identification of and current nomenclature for pressure injuries

Why You DO NOT Want to "Own" a Pressure Injury

- Etiology, pathophysiology and treatment of pressure injury, esp SDTI, poorly understood by public, plaintiffs' attorneys and many providers
- Photograph documentation may be prejudicial in court; consider using documentation forms instead
- Plaintiffs' attorneys will claim *prima facie* evidence of neglect (res ipsa loquitor)
- Advanced pressure ulcers may result in osteomyelitis, sepsis or require flap closure, resulting in significantly larger damages, further complicating issues of causation

The Importance of the Initial Care Plan

- Begins with accurate admission nursing assessment and interim care plan, tailored to needs of resident
  - Accurately document new resident's conditions, status of wounds, risk factors, functional deficits, and needs for various protective or assistive measures
  - Note care and protective measures in place at referring facility, and if not to be continued, document reasons.

Case Study #1: Importance of Accurate Admission Nursing Assessment for Comprehensive Care Planning

Case Study #1

- 70 y.o. male with CKD stage 4 underwent T11-12 hemilaminectomy for T11-12 spinal stenosis with large disc herniation and thoracic myelopathy 5/23/16 at suburban hospital
- Post-op found to have bilat loss of function and sensation in lower extremities with loss of bowel and bladder control
- Stage 2 PU on sacrum/coccyx area noted from 5/27 and still present at D/C to SNF in his home town for rehab on 5/29/16
- Admission MDS and initial nursing assessment document “no” PU present, but that he needs extensive assistance w/ transfers, requires sliding board, mechanical lift
- Daily skilled nursing notes never document presence of PU
- On day 5 of SNF stay wound physician consulted by attending
- He documents 0.5 x0.3 x0.2 cm stage 2 PU, not infected
- Rec LAL mattress, WC pressure reduction pad, offload heels

Case Study #1

- Admission lab 5/30/16 showed BUN 136, Cr 4.2 (baseline 2.5), K 6.2; Kayexelate given
- Lab 5/31 BUN 170, Cr 4.1 K 5.9; Kayexelate repeated
- Lab 6/1 BUN 185, Cr 4.0 K 6.3; Kayexelate given bid
- Lab 6/3 BUN 204 Cr 4.0 K 6.3
- Day 6 at SNF (6/4/16) resident vomited up all am meds. When 6/3 lab reported to attending, ordered res to be sent to large urban medical center ED some 40 miles away

Case Study #1

- On arrival to ED res found to have SBO and acute on chronic renal failure, hyperkalemia
- Treated conservatively w/ NG and IV fluids with spont resolution of SBO and return of renal function to baseline
- Admission H&P failed to mention PU
- Hospital care plan did not address PU or risk for same
- Admission nursing notes document 1.5 x 1.0 cm stage 2 PU of coccyx
- Interventions: clean w/ soap and H20, apply Calmoseptine
- Pressure reduction mattress or chair cushion not used
- Turned q 2h per notes

Case Study #1

- Daughter dissatisfied with care at home town SNF; pt sent to SNF within hospital 6/8/16
- Transfer form noted “decubitus” on coccyx
- SNF care plan did not address “impaired skin/tissue integrity” until 6/24; no pressure reduction interventions other than “routine turn schedule”
- Sent to off site SNF in suburb of city 6/29/16 with no mention of PU
- SNF Immediately implemented LAL mattress, Roho cushion, and wound care consult (same consultant) who now notes unstageable sacral PU 7.0 x 4.5 cm with black eschar and purulent drainage from separating edge, w/ surrounding inflammation; rec resident be sent to hospital for abx and debridement; ultimately found to have osteomyelitis
- Following recovery, daughter sued city hospital and their SNF, as well as home town SNF on behalf of her father
- Case against hospital and their SNF settled following report of expert to defense attorney for hospital that care did not meet standard of care for paraplegic patient with existing stage 2 PU on admission

Lessons from Case

- One of most successful defense strategies for pressure injuries in a SNF is to be able to demonstrate that the injury did not happen here; it is “owned” by prior facility
- A thorough and accurate initial nursing assessment and documentation on admission to the facility is key in the ability to utilize this defense
- Recognize SDTI and use designation; particularly important in era of Medicare “never events”
- Implement appropriate initial care plan measures for pressure injuries based on initial assessment upon admission
- One of highest risk type resident for developing and worsening of PU is one with severely impaired bed mobility, esp paraplegic. Implement aggressive interventions on admission

Performance Improvement Tips

- Select sample of records of residents that have been treated for pressure ulcers
- Review initial nursing assessments and skin documentation done on admission for completeness, proper nomenclature of pressure injuries used
- Review preventive and treatment interventions implemented on admission for appropriateness and timeliness. Particularly important with residents with impaired bed mobility in era of elimination of even partial side rails
- If deficiencies identified (e.g. improper description or nomenclature used), formulate intervention such as inservice for key personnel, then later repeat study
- Consider Medical Director wound/skin rounds for new admissions with pressure ulcers

Learning Points from Nursing Facility Litigation

The Importance of a Continuously Updated Care Plan

The Importance of an Updated Care Plan

- Once MDS complete and formal care plan in place, update goals and interventions as resident's condition changes
  - Avoid boilerplate care plan templates
  - Avoid promising more than can be delivered
  - When goals of care are primarily palliative, be sure care plan elements appropriately reflect palliative approach to care
- Most importantly—follow the care plan!

Case Study #2: Importance of Updated Care Plan for Palliative/End of Life Care

Case Study #2

- 6/21/13: 82 y.o. male with Alzheimer's and hx of falls admitted to Brookwood nursing facility from home
- All appropriate fall precautions (for the time) implemented in care plan on admission:
  - Low bed, bedside mat, bed alarm, chair alarm, no side rails
- 10/5/13 Physician documented "it is hard to keep him from getting up. He is very prone to falling."
  - Plan: review meds that might contribute to falling. Stops one BP as BP running 100s/60s. Notes pt on prn 0.5 mg lorazepam and that it can contribute to risk of falls, but discussed with daughter and they felt he needed it to participate in PT and had not had increased falls since begun. Continued small dose risperidone.

Case Study #2

- “Fewer falls, doing better” documented by physician in Dec and Jan 2014 progress notes
- By March 2014, physician notes “Jim gets up w/o assistance and had had frequent falls.”
- In May progress note, notes he is on fall prevention program, “has bed alarms and he is in room closest to nurses station, where anytime alarm goes off, they jump and run, but still he can get up so quickly that he will fall before they get there.”
- As resident’s gait instability worsened, care plan updated with appropriate changes and interventions
- One of the falls in May resulted in head trauma with laceration requiring staples. CT head negative.

Case Study #2

- 6/3/14 nurses note documents “resident chewing on banana peel, swallowed it. Didn’t appear to understand request to spit it out. Slow to react”
- 6/28/14 nurses note documents resident becoming non-ambulatory, “continuing to not bear weight at all.” Physician notified and hip x-rays of hips and pelvis ordered; no abnormalities noted.
- Care plan updated: Hoyer for transfers, high lean back WC. No palliative care plan or discussion of Hospice found
- 7/3/14 nurses note: “difficult to arouse but will obey commands to eat or drink.”
- 7/17/14 Stage 3 buttock PU noted; LAL mattress and Roho cushion ordered, appropriate wound care plan, wound nurse consulted.
- 7/30/14 nurse’s note: “Resident unable to feed himself, follow directions or use utensils. Able to give himself a drink once handed the cup. Coughed x2 after taking drink.”

Case Study #2

- 7/31/14 Physician progress note: “He has developed a stage 3 decub on his buttocks. He has been in decline, he is not eating on his own and they are using the Hoyer lift on him, he is a 2 person max assist. Jim has some significant decline I think.” D/C’d risperidone.
- 8/14/14 4 am: “T 100.8, lethargic, slow to respond.
  - 7:30 am CMT reports resident with difficulty breathing, rapid respiration and wet cough, nonresponsive. LPN suctioned resident obtaining lg amt yellow mucus.
  - Resident continued to decline and resp ceased. Resident with no advance directives or DNR, so CPR begun and ambulance called. Transported to ED, placed on vent.
  - CXR in ED c/w aspiration pneumonia, resident remained unresponsive on vent
  - Lab in ED showed BUN 86, Creat 2.7 (baseline 1.4), Na 158, alb 2.0

Case Study #2

- 8/16/14 Vent removed, comfort care only, resident expired
- D/C summary lists cardiac arrest, aspiration pneumonia, aspiration of gastric contents as final diagnoses.
- Death certificate lists COD: Aspiration pneumonia, d/t aspiration of gastric contents. Fails to list Alzheimer's.
- Family sued Brookwood and administrator for negligent care and wrongful death in allowing resident to fall repeatedly and to develop PU, leading to decline, dehydration, malnutrition, weight loss and death.
- Defense expert opined death due to expected and natural decline at end stage of Alzheimer's disease, in no way result of any alleged negligence or falls.
- Case settled for undisclosed amount, attorney pleased.

Lessons from Case

- Alzheimer's is fatal disease with typical and expected complications of inanition and aspiration in final stage
- Lab studies if drawn in terminal decline will show evidence of dehydration, malnutrition
- Overly aggressive (and futile) care at end of life caused by lack of palliative care plan and DNR order created unnecessary difficulty for facility
- Communication with family regarding expected course and goals of care in final stage of dementia, coupled with updated palliative care plan reflecting these goals may have avoided this lawsuit
- Physician role critical in transition to palliative care. Progress notes helpful in regard to inability to prevent falls. Final progress note recognizes resident's decline but fails to recommend palliative care or discuss with family.

Performance Improvement Tips

- Identify residents with advanced dementia or other advanced illness nearing or at end of life
- Review care plans for updates consistent with their decline in functional status and palliative approach to care as appropriate
- Enlist attending physician for prognostication and discussions with patient or family regarding hospice or palliative approach to care, completion of DNR and DNH orders
- Document discussions and prognostication in the record

Learning Points from Nursing Facility Litigation

The Importance of Learning from Near Miss Events

The Importance of Learning from Near Miss Events

- When events such as falls without injury, med errors without harm, attempted elopements, entrapments by equipment or devices without injury, the temptation is to ignore the event as no harm occurred
- Near misses are learning opportunities that should be evaluated with RCAs and studied by the QAPI team to lead to improvements in care, and review/revision of policies
- Failure to do so may have disastrous consequences

Case Study #3: Importance of Learning from a Near Miss Entrapment

Case Study #3

- 82 y.o. female admitted to facility May 2012
- Multiple falls after admission—usually when getting up from bed in room and found on floor
- Falls attributed to sensory ataxia from peripheral neuropathy and dementia resulting in lack of safety awareness
- Resident frequently attempts to walk without asking for assistance
- Falls without significant injury

Case Study #3

- N.F. interventions:
  - Low bed with bedside pad
  - 1 half side rail up, 1 down
  - December 2012 began use of wheelchair
  - January 2013: Velcro “self-release” seat belt
- Within days began asking other residents and staff to release belt
- Many falls due to resident or others releasing belt

Case Study #3

- June 2013: Resident released Velcro closure on belt, got up and ambulated unassisted
- New wheelchair with attached seat belt and plastic clip closure ordered (resident unable to release)
- January 2014 “Near miss” event: Resident found in room yelling for help, trapped half out of chair trying to slide out under seat belt. Seat belt was around chest area. Attending/medical director notified.
- February and March 2014 often noted to be lethargic, sleeping in chair

Case Study #3

- Care Plan January 2014—Falls; Restraints
  - Problem: “Resident requires “self release” seatbelt in WC due to frequent attempts to walk without assistance resulting in falls
  - Goal: Resident will not have skin breakdown due to restraint
  - Approach:
    - Release resident q 2h to reposition;
    - Gel cushion in chair
    - Ambulate resident at least 3x/day;
    - Monitor skin integrity q shift for any signs of skin breakdown;
    - Toilet at least q 2 h and prn;
    - Keep resident close to area that is supervised

Case Study #3

- April 2014: Resident left unattended in room in WC, turned call light on. By time CNAs responded, resident found in wheelchair having partly slid out with the “self-release” seat belt around her neck, cyanotic, not breathing, having expired
- No evidence of reevaluation of type of or need for restraint after “near miss” event; care plan unchanged.
- No physician order for restraint. No PT assessment for restraint alternatives
- First physician order for “self release belt” in March 2014.
- Family sued facility and physician for wrongful death and deviation from standard of care in proper and safe use of restraints on resident
- Facility and physician settled case for undisclosed amount

Lessons from Case

- All 4 elements for successful litigation met: Duty, Breach of duty, Damages, Causation
  - Negligent to use restraints inappropriately and without proper safety precautions
- Failure to recognize and alter care plan after “near miss” event
- Failure to follow care plan
- Missed opportunity to review and revise policies surrounding use of restraints
- Absence of appropriate policies or protocols regarding periodic reevaluation of use of restraints
- Physician and medical director both had duty and opportunity to order reevaluation of appropriateness of restraint after “near miss” and failed to do so, thus creating their own liability

Performance Improvement Tips

- Regularly review near miss events, like elopements, med errors, restraint related falls or entrapments, falls without injury, with medical director and QAPI team
- Do RCAs as appropriate
- Plan interventions to avoid future occurrences
- Study incident reports in aggregate, mining for trends indicating facility process weaknesses
- Use opportunity to update policies and procedures or implement new ones

Case Study #4: Failure of Recognition of and Learning from a Near Miss Medication Error

Case Study # 4

- 82 year old Hispanic female admitted 8/24/17 to SNF with moderate dementia, DJD, S/P ORIF, CKD stage 4, hypertension after brief hospitalization for pneumonia
- Transfer sheet medication orders for rivastigmine patch, scheduled APAP, lisinopril BID and an antibiotic with appropriate stop date.
- APRN did initial visit same day and approved all meds; MD to see later in week on regular visit day for H&P
- 8/26/17 late AM found with increased confusion and lethargy, mild hypotension, afebrile, normal RR& HR. No focal neurological S/Sx on nurses assessment. Daughter notified. MD notified.

Case Study # 4

- MD considers CT of head but NN records he explained to nurse he would do this if STAT labs unrevealing.
- Continued lethargy, mild hypotension and now tachycardia reported to MD along with STAT lab values.
  - UA- specific gravity 1.022, positive LE, 5-10 WBC/hpf
  - CBC- mild neutropenia, Hb 10/Hct 31
  - Chem panel- mild elevation BUN/creatinine
  - Blood glucose 40 mg/dl

Case Study # 4

- MD reviews faxed med list from the MAR. These include APAP prn, lisinopril, allopurinol, tramadol, calcium with vitamin D, glyburide 10 mg daily.
- MD orders glucagon, then feed, reduce glyburide dose by half.
- Resident improves after glucagon. Message left for daughter that mom now back to normal, didn't mention hypoglycemia.
- 6 am 8/28/17 Resident found profoundly obtunded, unresponsive. FSBS-30. LPN attempted to give Insta-glucose, ran out of mouth.
- MD notified, orders glucagon and transfer to ER. Daughter notified and goes to meet mother at hospital.

Case Study # 4

- Resident still unresponsive to all stimuli in ED, had received D50 en route; BS up to 125. Intubated and placed on ventilator.
- ER physician explains to daughter she was likely severely hypoglycemic for a prolonged period overnight due to her diabetes medicine." Daughter exclaims "But, she's not diabetic".
- Never recovered consciousness and 4 days later with EEG showing signs of brain death, placed on comfort measures, ventilator removed, extubated and expired.
- Investigation reveals Ms. S admitted 8/24/17 at the same time as SNF received another new admit from same hospital with similar last name who's diagnoses include diabetes mellitus. In some fashion that no one could explain the residents' D/C med lists from the hospital got mixed up when meds entered into EHR. The other resident suffered no consequences other than hyperglycemia and untreated pain on 8/24-8/27.

Case Study # 4

- State surveyors investigate after facility self-reports and terminates nurse involved. State gives IJ at isolated event level of severity and imposes civil monetary penalty.
- Daughter sues facility, attending physician, nurse that entered wrong meds. Plaintiff's attorney cites state investigation and citation, CMP in pleadings.
- Case against facility settled for undisclosed amount as defense expert opined case indefensible
- Physician maintained he was blameless as he was given incorrect med list.

Lessons from the Case

- Be alert to same/similar names in facilities and double check
- Accurate med reconciliation on admission extends to order entry in the EHR
- Be especially alert for medication list errors at time of admission
- Think of near miss events as “gifts” and don’t squander the opportunity to discover and rectify process errors. But must recognize them to benefit.

Performance Improvement Tips

- Flag same/similar name residents' charts
- Develop checklist procedure for initial med entry into EHR that requires double checking
- QAPI team review of all med errors reported for process deficiencies in order entry, storage and distribution systems for meds, including certain patient and medication identification

Learning Points from Nursing Facility Litigation

The Importance of Accurate Communication

The Importance of Accurate Communication

- Many adverse events originate from poor communication
  - To and from hospital, SNF, outside facility or provider
  - Within SNF--shift change, to/from provider and between attending and consultants
  - Often involves lack of, or poor med reconciliation
  - SBAR format for all communications can improve accuracy and efficiency, and may result in fewer errors

Case Study #5: Importance of Accurate Communication Between Providers

Case Study # 5

- E.C., 80 y/o Caucasian male admitted to hospital after a fall associated with AMS on 11/5/12.
- Co-morbidities include DM2, gastroparesis, prostate CA and recent weight loss.
- W/U for cause of weight loss and AMS unrevealing but patient felt to suffer with mild dementia and depression. Discharge to SNF.
- Initial assessment showed weight 143# (at low end of IBW). Meds included glyburide, lactulose, lorazepam, clonazepam, omeprazole, APAP prn, and megestrol

Case Study # 5

- NN's record Resident as "obsessed" with toileting, sitting on commode for a long periods of time trying to void or defecate without results.
- NN's report Resident refusing to leave the commode to attend meals
- 11/29/12 –Care Plan adds problem of "self-inflicted" pressure ulcers on both buttocks from excessive sitting on commode, refusing rehabilitation and meals.
- Braden Scale 20 (low risk) on 11/20/12.

Case Study # 5

- Attending MD orders psychiatry consult on 12/3/12. On 12/6/12 psychiatric social worker visited Resident but declined to make recommendations until medical testing ruled out a medical cause for the behavior.
- On 12/14/12, after digital rectal exam, occult blood testing of stool x 3 and urinalysis were unrevealing, the Attending again asked for Psychiatry Consultation.
- Hospital records show that both urology and gastroenterology have examined E.C. with no somatic cause for toileting behavior.

Case Study # 5

- Psychiatric SW reports “blunted affect”, “patient demanding of staying on call light with many demands … persistent urge to defecate- possibly related to prostrate problems- states auditory hallucinations in past but can’t recall if it was after a beer binge”. She diagnosed major depression and anxiety along with mild dementia, Alz. Type.
- SW promised consultation with the Attending to encourage a surgical approach to prostate issue, hypothesizing this as cause of behavior re: toileting. Somatic delusion not considered in differential diagnosis.

Case Study # 5

- 1/14/13 supervising psychiatrist examined E.C. and recorded “history of depression and anxiety and reports hx of hallucinations. Though there are reasons to suspect a physical cause, the possibility of delusional etiology exists”.
- Psychiatrist did not address duplicate lorazepam and clonazepam prescription, absence of antidepressant Rx or consider trial of AP. In his note he did ask for a somatic work-up to seek a physical cause for the toileting behavior.

Case Study # 5

- Resident continued to lose weight, albumen fell below 2.0 mg/dl, PUs worsened and appeared infected. Indwelling F.C. placed and eventually showed colonization .
- S/S of sepsis (urosepsis vs. PU source) on 3/19/13.
- Deceased 3/19/13
- Family sued facility and physicians for failure to recognize and treat resident's severe depression with psychosis leading to multiple complications and ultimately his death
- Case settled for undisclosed amount

Lessons from Case

- Either thru direct communication or thru the medical record (or both) the Attending Service and any Consultants must communicate to contribute to diagnosis and treatment effectively, each from their areas of expertise.
- The Attending Physician is “captain of the ship” and so is primarily responsible to coordinate diagnostic activities and therapeutic trials and ensure follow-up.
- If a provider is unsure what another provider is doing (or not doing) and why, then ask!
- “Turfing” responsibility is dangerous for patients and providers alike.

Performance Improvement Tips

- Assure mechanism in place for timely transmission of notes from consultants to resident's attending physician
- If resident going out of facility for consult or follow-up visit, assure all relevant notes, including H&P, progress notes from attending and any notes from other consultants accompany the resident
- Keep copies of all physician and consultant notes in an up to date "hard" chart for easy access by attending and consultants as most NH EHRs are not physician friendly and often cumbersome for physician use

Performance Improvement Tips

- Nursing staff should assume role of case manager in communications between attendings and consultants to ensure:
  - Consultant addresses attending's concerns
  - Consultant's recommendations are acted upon or declined with explanation
- Create standard communication format utilizing SBAR methodology
- Utilize INTERACT process and forms

Case Study #6: Cascading Errors- Communication Failure, Inadequate Admission Care Planning and Ignoring Near Misses: Elopement with Injury

Case Study #6

- 7/11/07 70 y.o. female (“Sally”) admitted to locked secured Alzheimer’s unit on 2nd floor of NF due to moderate dementia, severely uncontrolled DM
- Exit seeking behavior noted from outset (“looking for a way to get out all evening”)
- Packed belongings repeatedly and constantly called family members to come and get her
- No assessment of, or care plan for, elopement risk

Case Study #6

- Resident found with window open and screen pushed out on several occasions over first 4 weeks (undocumented, only discovered later in police investigation)
- 8/6/07 Nurses notes: “Resident pushed the screen out of her window again” (1st notation in record)
- 8/8/07 Son and daughter met with administrator, asked if screws or bars could be installed. Administrator to check with fire marshal. They reported mom said she was going to leave facility even if had to tie sheets together and get out window
- Administrator informed CNAs and Maintenance to check on resident more frequently

Case Study #6

- 8/9/07 Resident found to have fallen from open window with screen out down into stairwell leading to basement level (~20’); sustained open fxs both ankles and closed head injury; two sheets tied together found tied to bedpost and hanging out window
- Police report
  - Administrator: “When reported to me, I knew immediately it was Sally.”
  - CNA: “We have walked by her room and seen her trying to crawl out the window. We go in and close it every time and she always reopens and kicks out her screen. She does this all the time.”

Case Study #6

- Police report
  - Maintenance: when arrived in room found sheets hanging out second story window tied to bedpost; pulled them in
  - Saw family below taking pictures, briefly talked to them
  - They came up to room and asked him to hang sheets back out window so they could take more pictures; he did
- Family sued for negligence in not maintaining safe and secure environment for resident
- Case settled for undisclosed amount

Lessons from Case

- Take elopement threats and attempts seriously; catastrophic outcomes common
- Facility has duty to provide safe and secure environment
- If window elopement possible and cannot be secured against, do not place above 1st floor
- Any co-worker who witnesses elopement attempt should report to supervisor and incident report should be completed, along with actions to prevent recurrence

Performance Improvement Tips

- Review elopement attempt incident reports with QAPI team to assess for appropriate response by staff and provider, likelihood of future success, and identify security deficiencies
- Review maintenance log for Wander Guard and similar security systems; elopement out of door much more likely and a faulty system long overdue for maintenance check was to blame in another case for which I provided expert review.
- Inservice all staff on importance of reporting any elopement threat or attempt
- Caution: attempts at preventing elopement must be balanced against Resident Rights; document mental incapacity

EHR in the Nursing Facility

Risk reduction or new source of liability?

Electronic Health Records in NF

- Many NF/SNFs now implementing EHR
- No Meaningful Use $ or other incentives available as for hospitals and physicians, thus much slower implementation and no industry standards
- Generally assumed that EHR can reduce errors and exposure to liability, but little evidence to date in hospitals and physician practices; none thus far in nursing facility environment
- In fact, some evidence from 1 malpractice insurance provider to the contrary
- NF/SNF EHRs typically do not interface nor interact with physician office or hospital EHRs

Electronic Health Records in NF

- Potential sources of liability
  - Failure to assure seamless flow of information during implementation “hybrid phase,” especially to physicians and nursing staff
  - Failure to integrate and train attending physician staff on use of EHR
  - Metadata issues: all transactions recorded with time stamps—can help defend malpractice claims, but can just as easily support allegations of rote charting or after the fact charting
  - Errors caused by bad EHR design may fall on provider and facility since vendor contracts often have “hold harmless” clauses and med mal coverage may exclude product liability and indemnification of 3rd parties

Electronic Health Records in NF

- Potential long term effects on SOC
  - Now that widely implemented, failure to adopt an EHR may constitute a deviation from the standard of care
  - Clinical decision support tools commonly in place with hospital and physician EHRs, less common in NF/SNF EHRs. Overriding warnings creates a record that physician or other provider may have to defend in court
  - Growth of HIEs and accessibility of outside records may increase liability for providers who fail to take advantage of that access or mismanage their own data

The Medical Director

Roles for risk reduction in the nursing facility

Medical Director Role

- Lead QAPI committee in true quality improvement, problem solving, safety initiatives, which are liability risk reduction tactics
- Review incident reports, individually and in aggregate, with QAPI team
- Review and update medical care policies with administration and/or QAPI team; eliminate unnecessary ones; assure those in place being followed
- Establish protocols for medication monitoring
- Be sure staff understands palliative care planning and when it should be utilized
- Champion SBAR communication format

Medical Director Role

- Regularly communicate with consultant pharmacist regarding resident care
- Be aware of quality of care issues in facility and intervene when appropriate
- Assure continuity of care, call coverage for residents
- Be a role model for rest of medical staff
- If medical director becomes aware of attending physician not providing appropriate care, action must be taken

Conclusions

- It is important to gain an understanding of the scope and process of litigation involving nursing facilities, including the main sources of liability
- Although scary, through examining and understanding actual LTC cases, QAPI teams in nursing facilities can lead improvements in practices and documentation that will lessen the chance of being targeted for litigation.

Questions/Discussion