

R I S K M A N A G E M E N T

PEARLS

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American Society for
Healthcare Risk Management
of the American Hospital Association



for

LONG - TERM
CARE & SKILLED
NURSING FACILITIES



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Catalog No. 178558
(single copy)

Catalog No. 178559
(pack of 5 copies)

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Hospital Association
One North Franklin
Chicago, IL 60606

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Printed in the U.S.A.

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Pearls For Long-Term Care & Skilled Nursing Facilities

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Introduction

More than 9 million Americans need long-term care services, according to the Bureau of the Census. This fact serves as a prompt for greater understanding of the unique issues facing the more than 17,000 Skilled Nursing Facilities (SNFs) and Long-Term Care Facilities (LTCs) in America. With improved understanding of these issues, the risks to residents and those who care for them are minimized.

In addition to sheer numbers, changing perceptions related to SNFs and LTCs must be addressed. In recent memory, SNFs and LTCs were places where a person went to die. Disability and death were accepted outcomes and caregivers were perceived as angels of mercy.

Editorial Style Note

The term “resident” should be read to also refer to “patients,” “clients” or other terms used for those individuals to whom care is rendered in the facility.

Today, seniors (and their families) expect care to empower them to maintain long, productive lives. Some people also believe there is waste, fraud and abuse in SNFs and LTCs. These beliefs, coupled with growing plaintiffs’ verdicts and – when available at all – increased professional liability insurance premiums, prompted this *Pearls* edition. It is the intention of the 2002 ASHRM Pearls Task Force to both outline the risks and then identify and review risk reduction strategies for professionals who may not have risk management backgrounds.

Proactive quality improvement and risk management programs can and do improve resident care; reduce risks and ultimately reduce occurrences, claims and lawsuits.

Resident Safety

The Nursing Home Quality Protection Act, enacted in 2001, provides stringent safeguards from institutional elder abuse to sub-par nursing home care. The staff needs to be vigilant in identifying and reporting any unsafe condition.

“Resident fall” is the most frequent claims allegation against long-term care providers, accounting for about 30-50 percent of all claims. “Patient monitoring issues,” making up about 5 percent of claims allegations, stem from wandering, elopement and restraint-related issues. (HCQA, National Healthcare Cost and Quality Association, Article: “Negligence in Post-Hospital Care,” Lewis Mustard, March 2001)

Falls/Fall Prevention

Of the 1.5 million nursing home residents nationwide, approximately half fall at least once each year resulting in 1,800 deaths. Many falls result in serious injuries and often result in decreased physical functioning, disability and a reduced quality of life. Decreased confidence and fear of falling again can lead to further functional decline, depression, feelings of helplessness and social isolation.

Common causes of falls include:

- * Weakness and gait problems/musculoskeletal impairments, poor foot care;
- * Slippery footwear, water or urine on floor;
- * Poor lighting;
- * Improper bed height;
- * Tripping over equipment or furniture;
- * Improperly maintained or fitted wheelchair;
- * Medications;
- * Changes in physical or mental condition.

Risk Reduction Strategies

- ★ Combine ongoing nursing assessments and medical treatment, rehabilitation, environmental modifications and technological interventions.
- ★ Perform a thorough fall risk assessment upon admission, quarterly and when there has been a change in condition.
- ★ Provide physical conditioning and/or rehabilitation to improve strength and endurance.
- ★ Make environmental assessments and modifications to improve mobility and safety (e.g., grab bars, raised toilet seats, lowered bed heights, hallway handrails, good lighting; also proper equipment maintenance on wheelchairs, commodes, beds).
- ★ Review medications to assess potential risks and benefits.
- ★ Employ appropriate devices (e.g., safety belts, alarm systems that are activated when residents try to get out of bed or move unassisted, hip pads).
- ★ Adopt a program to alert the staff and visitors of residents who are at risk for falls. (e.g., medical record documentation, "Fall Alert" stickers, verbal reminders).
- ★ Comprehensively evaluate a fall immediately after an occurrence.
- ★ Track and trend data to identify opportunities for improvement.

Medication Systems/Error Reduction

The elderly take an average of eight medications per day in nursing home settings and experience 350,000 adverse drug events (ADEs) every year, of which nearly 20,000 are fatal or life threatening.

Psychoactive drugs (antipsychotics, antidepressants, sedatives and hypnotics) are the medications most often associated with preventable ADEs, including over-sedation, confusion, hallucinations, deliriums, falls and bleeds. They are also the most commonly prescribed medications.

There is a direct relationship as well between the numbers of drugs a resident takes and the frequency of falls. Many of the most commonly prescribed

drugs for geriatric residents can cause confusion and sedation. (NursingSpectrum.com, “Fall Prevention Among the Elderly,” Carol Anne Weiss, June 2002)

Risk Reduction Strategies

- ★ According to the American Society of Consultant Pharmacists, there are approximately 90 steps in a typical cycle of medication administration, so opportunities for making or preventing errors abound. There is no single fix. Combining strategies (education, computerized order entry, multidisciplinary reviews of medication profiles, etc.) can create a safety net against errors.
- ★ Refer to ASHRM’s *Risk Management Pearls for Medication Error Reduction* for more general information regarding medication errors and medication error prevention programs.

Restraints

Discussion of restraints generally centers on two types: physical and chemical.

A physical restraint is attached or adjacent to the resident’s body. The resident cannot remove it easily, which restricts freedom of movement or normal access to one’s body. Examples include waist belts, geri-chairs, hand mitts, wheelchair safety bars and lap pillows.

Practices that could be defined as physical restraint include tucking in a sheet so tightly that a resident cannot move and placing a wheelchair-bound resident by a wall so that he or she is prevented from rising.

Chemical restraints are psychoactive drugs used to treat behavioral symptoms for discipline or staff convenience.

Federal Regulations

Federal regulations do not prohibit the use of restraints; rather, they set parameters for appropriate use. The physical restraint must be used only after a comprehensive assessment indicating that the device

is the least restrictive intervention and that it promotes the highest level of function. Restraint must be monitored for adverse effects and ongoing attempts must be made to find less restrictive alternatives.

Medicare/Medicaid-certified nursing homes cannot use physical or chemical restraints unless they are needed to treat medical symptoms. Federal law requires certified facilities to care for residents in a way that maintains or enhances quality of life. Restraints should not be used without the consent of the resident or the legal representative. If restraints are necessary, they must be used in a way that does not cause these losses. Residents must be released from restraints and exercised at least every 2 hours.

Risks of restraint use include decreased range of motion and muscle tone; agitation; symptoms of depression, including social withdrawal, incontinence, skin breakdown; and increased fall-related injuries and death.

Alternatives to restraint use are numerous. The key is to evaluate the resident and determine what plan of care can be used as an alternative to restraints.

Risk Reduction Strategies

- ★ Train staff to assess and meet each resident's needs.
- ★ Provide rehabilitative/restorative nursing programs (e.g., walking, independent eating, bowel and bladder training, bathing).
- ★ Establish a wheelchair management program to ensure that wheelchairs are in good working order and the correct size.
- ★ Play video visits or taped messages from family when the resident is agitated.
- ★ Schedule toileting for residents at risk to fall.
- ★ Establish an environmental management program including safety devices that trigger an alarm when a wandering resident tries to leave a safe protected environment, body alarms that attach to chair or bed

and alarm when the resident tries to get up unassisted, good lighting, individualized seating, and a low bed.

- ★ Have a rehabilitation dining area to help residents increase mealtime skills and independence.

Wandering and Elopement

In a nursing facility, “wandering” refers to the ability of a resident to move about aimlessly within the facility and/or without appreciation of personal safety. Wandering may lead to “elopement,” the ability of a resident who is not capable of self-preservation to leave unsupervised and undetected and enter into a harmful situation (according to the Nursing Home Residents Legal Center). Elopement is considered a Sentinel Event by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Risk Reduction Strategies

- ★ Identify residents who likely will wander or elope. Assessment must include history and changes in mental status that could contribute to wandering or elopement. Routine reassessments can identify changes in mental status, behavior and the effectiveness of interventions. Immediate communication to all staff – identifying residents at risk – is necessary.
- ★ Employee training and interventions, suggested by CNA Healthpro’s www.praeventus.com consultants, include:
 - Having an elopement plan, with periodic drills;
 - Monitoring exits during shift changes and emergencies;
 - Hourly tracking of residents known to wander, with documentation;
 - Reviewing effectiveness of medications that may cause anxiety, confusion or impaired vision;
 - Decorating rooms with favorite pictures to provide a sense of familiarity;
 - Giving residents who wander a designated item of clothing for identification;
 - Encouraging family to visit often.
- ★ Physical and visual preventive measures include door

alarms, automatic door locking system, Wander Guard bracelets, stop signs and environmental camouflage (e.g., wallpaper or curtains on doors).

- * A missing resident plan should include photo ID and description of residents; staff assignments for a facility and grounds search; timely notification of management and family, police and state agencies; and detailed documentation of efforts made.

Abuse and Neglect

Abuse of residents in long-term care facilities is not a new phenomenon, however it has recently received greater media attention. Abuse may include criminal conduct of members of the staff or acts of criminal conduct occurring because of the staff's failure to protect the resident from others.

Abuse may include assault; battery; sexual assault, battery, rape; unreasonable physical constraint; deprivation of food or water; or physical restraint or psychotropic medication for any purpose not authorized by the physician.

Neglect refers to the negligent failure to exercise reasonable care. Neglect may include failure to assist in personal hygiene or in the provision of food, clothing or shelter; failure to provide proper medical care; failure to protect from hazards; or restraints and/or seclusion for unreasonable lengths of time.

Abuse can show itself in many ways, including:

- * Physical abuse (indicated by wounds or discoloration, caretaker's inability to explain condition, sudden change in behavior, loss of weight, burns);
- * Emotional abuse (indicated by agitation, extreme withdrawal, unusual behavior such as sucking, biting or rocking);
- * Neglect (indicated by dehydration, malnutrition, pressure sores, poor hygiene, begging for food, feces and/or urine odor, wandering/elopements).

Factors that may play into abuse may include:

- ★ A resident's impairment;
- ★ Caregiver stress, understaffing;
- ★ Lack of oversight and enforcement of policies and procedures.

Federal and State Laws

The Nursing Home Reform Act of 1987 specifies that a facility “must provide services and activities to attain or maintain the highest practicable physical, mental, and psychological well being of each resident in accordance with a written plan of care.”

Centers for Medicare & Medicaid Services (CMS) regulations provide that “residents have the right to be free from verbal, sexual, physical, or mental abuse; corporal punishment; and involuntary seclusion and to be free from any physical or chemical restraints imposed for purposes of discipline or convenience.” Under federal regulations, facilities must:

- ★ Develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse and misappropriation of resident property;
- ★ Report to the state nurse aide registry or licensing authorities any knowledge of actions by a court of law against an employee that would indicate unfitness for services;
- ★ Ensure that all alleged violations involving mistreatment, neglect or abuse – including injuries from unknown sources – are reported immediately to the facility administrator, to the state survey or certification agency and any other officials as required by law;
- ★ Be able to provide evidence that all alleged violations are thoroughly investigated and prevent further potential abuse;
- ★ Report findings of the facility's investigation to the administrator, to the state survey and certification agency and to other officials in

accordance with state law within 5 working days of the occurrence; if the violation is verified, take corrective action.

Risk Reduction Strategies

- ★ Hire competent staff with no history of abusing or mistreating individuals.
- ★ Provide continuing education to staff related to:
 - Dementia and other underlying causes of resident aggression;
 - Specific techniques for managing conflict with residents;
 - Stress management training;
 - What constitutes physical, verbal and emotional abuse and neglect;
 - The facility's written policy against abuse, and maintaining a workplace that conforms to the policy;
 - State elder abuse reporting statutes with knowledge of which individuals are mandated reporters in the state.
- ★ Reduce job stress, burnout and dissatisfaction among staff.
- ★ Match the needs of residents to the capabilities of the staff and facility.
- ★ Protect residents from abuse from other residents.
- ★ Maintain an effective system for addressing complaints made by residents or family members.
- ★ Contact and work cooperatively with the local long-term care ombudsman's office in developing abuse prevention programs.
- ★ Maintain an internal reporting system in which staff members feel free to report observed instances of abuse.