Avoid Liability? Let Will Rogers Be Your Guide

BY LINDA WILLIAMS, RN

If it weren't for bad news, we'd get no news at all—a sentiment echoed by many workers in the long-term care industry as they read newspaper headlines across the country. Never before has the industry received so much bad press over the problems of so few facilities. If the great journalist-philosopher Will Rogers* were alive today, I'm sure he could offer a few bits of wisdom to help this hurting industry cope with its problems. Let's see how 10 of his famous quotes might apply to liability (and headline) avoidance.

1. "It's not what you pay a man but what he costs you that counts." Recruiting and selecting the highest-quality staff are imperative to protect residents and provide good care. Criminal background checks, although not required by all states, should be an integral part of your selection process. Other checks should include:

- employment references (both past and present, if possible),
- credentials (state board of nursing, nurse aide registries, etc.) and
- pre-employment physicals (including tuberculosis testing).

All new employees should receive a planned orientation that includes both general and specific information about their employment responsibilities.

2. "Always drink upstream from the herd." In other words, don't be quick to take on problems flowing from elsewhere. That is why a full-body assessment should be performed with each resident admitted to the facility. If it's not documented that a resident was admitted with a bruise, pressure sore and/or contracture, it will be assumed later on by anyone reading the resident's chart that it was facility acquired. It is equally important to document residents' histories—especially in cases such as the arrival of the little elderly lady who has weighed 80 pounds for the last 20 years and is not likely to ever reach her ideal body weight at age 93.

* American entertainer (1879-1935) .

3. "Lettin' the cat outta the bag is a whole lot easier 'n puttin' it back in." Likewise, it's a whole lot easier to identify residents who are at risk for a problem, such as a fall, before it occurs than to address it afterward. Besides fall risk, other assessments that should be performed and documented both upon admission and routinely thereafter include risk for skin breakdown (i.e., pressure sores), weight loss, elopement and functional decline.

4. "The quickest way to double your money is to fold it over and put it back in your pocket." What good is a $5,000 mechanical lift if the staff doesn't know how to use it or which residents to use it with? Likewise, if the staffers do nothing more than identify residents at risk and fail to initiate an action plan involving specific interventions, they've merely documented their own negligence. Family members and responsible parties also need to be kept informed so that they will understand that the facility has their loved one's best interests at heart. As always, all communication, whether it be for training or information, should be documented on the appropriate form. When an intervention, such as a chemical or physical restraint, is indicated, staff should make sure that appropriate parties sign an informed consent that explains both risks and benefits.

5. "It doesn't take a genius to spot a goat in a flock of sheep." If you're routinely looking for things that shouldn't be there, you'll spot them instantly when they occur. That is the value of performing weekly skin assessments, recording resident weights and documenting resident participation in restorative and/or activity programs. The basis for many facilities' legal troubles is often a lack of systems in place to catch problems before it's too late.

6. "If you find yourself in a hole, the first thing to do is stop diggin.'" Sooner or later, unfortunate incidents involving residents will occur, requiring staff to stop what they're doing and assess the situation. How the staff reacts to an incident immediately after it happens can, at times, mean the difference between life and death—and litigation or no litigation. All nursing staff need to know what appropriate actions to take when events such as a resident fall or a medication error occur. Afterward, everything must be documented

thoroughly in the resident's chart and incident report. Sometimes this documentation alone determines the facility's defensive strategy in the event of a lawsuit.

7. "Rumor travels faster, but it don't stay put as long as truth." Facilities should never try to hide incidents such as falls, elopements, allegations of abuse or medication errors from the resident's family and/or responsible party, as well as the physician and state licensing officials (if warranted). As unpleasant or seemingly trivial as an incident might seem, each of these parties has a right to know what's happened to the resident, and staff members have an obligation to keep them informed. Besides the above incidents, another common mistake has involved staff forgetting to report abnormal lab values or diagnostic results, sometimes leading to dire consequences for a resident's health and well-being. All of this makes it doubly important for staff to keep each other informed, via verbal, written or taped reports between arriving and departing shifts, regarding changes in residents' status so that follow-up assessments and other important interventions get done.

8. "Even if you're on the right track, you'll get run over if you just sit there." Often, simply responding to and reporting an incident are not enough because the resident requires ongoing treatments, assessments and/or monitoring. In the event of a newly discovered pressure sore, for instance, follow-up documentation must be done on, minimally, a weekly basis until the wound is healed. It's highly recommended that the nurse responsible for doing this be specially trained in measuring, staging and describing skin conditions. For skin conditions that have not improved as a result of treatment or show no progression toward healing, the physician should be notified promptly and a new plan of care developed. Likewise, if a resident is refusing or is noncompliant with treatment, the resident's family and/or responsible party should be informed at once, with the consequential risks explained and an alternative plan of care developed. The exchange of this information should be formally documented, with signatures obtained from all involved parties.

9. "Good judgment comes from experience, and a lot of that comes from bad judgment." At times, facilities find that despite their best efforts to prevent a fall or other mishap, it occurs anyway. The important thing for the facility to do is to investigate and determine what preventive steps worked and what didn't, then revise or add new interventions to the resident's plan of care. Whether in a survey situation or in a courtroom, facilities will always be judged by the degree of care that any facility of ordinary prudence would have exercised under the same or similar circumstances. If the facility can produce a three-page list of all the preventive interventions the staff has attempted, it's doubtful that anyone can accuse the facility of neglect. Unfortunately, too many facilities wait until the resident falls for the third time before they figure out that the personal alarm wasn't enough.

10. "If you're ridin' ahead of the herd, take a look back every now and then to make sure it's still there." Sometimes, as managers, we think that our problems have all been solved because we've finally got the right systems in place—only to find out later that somehow, somewhere, somebody stopped doing what he/she was supposed to be doing. That's why effective quality assurance programs and continual auditing are so vital. And, as always, leave a documentation trail behind (in everything you do) to prove that, at the very least, you've done your best! **NH**

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