

# Building A Foundation Of TRUST

Keeping patients and their families well-informed about the nursing facility experience—including the risks—can avoid surprises that could lead to litigation.

Long term care facilities may face \$5.3 billion in liability claims this year alone, according to data in a March study conducted by AON Risk Consultants. The group studied a sample of facilities comprising about 26 percent of all U.S. nursing facilities. The providers studied estimated that they would pay about \$1.3 billion in claims this year.

Between 1991 and 2002, both the number of claims brought against a single operator and the average size of a claim tripled. Providers incurred an average of 4.6 claims per 1,000 beds in 1991; in 2002 that number was 14.5 claims per 1,000 beds. The average size of a claim in 1991 was \$63,500; it was just under \$200,000 in 2002.

## **Tort Reality**

In some states, liability insurance is essentially unavailable for long term care, according to the AON study. Even where insurance was available, the annual commercial premium levels increased an average of 143 percent between 2001 and 2002, often with reduced coverage. And that's following a 130 percent increase between 2000 and 2001. The

providers studied paid \$7 million more in premiums for \$57 million less in coverage last year.

Extrapolating those figures for all U.S. providers would mean that long term care providers paid \$28 million more in premiums for \$228 million less in coverage. This is partly due to "the continued extreme uncertainty associated with projecting future claim costs," according to the study's authors.

So providers are working hard to come up with ways to reduce their risk of being sued. Many companies are including voluntary arbitration agreements in their admissions materials. Arbitration agreements can be tricky, and many jurisdictions consider them invalid for health care services, despite a federal act that in some cases preempts state law.

"Arbitration is an excellent idea, because [it means] negotiating the risk that everybody's faced with at admission," says Tra Beicher, who was a long term care registered nurse for 20 years and an expert witness for 15 years under 35 law firms.

The problem with arbitration, says Beicher, is that "the majority of the people who come to a nursing

home are your average, everyday layperson, and the majority of arbitration clauses are done by corporate attorneys. The courts often see it as a situation in which a layperson is seeking health care services at a stressful point in life, and is then faced with five or six pages of ‘Here’s what happens if something goes wrong,’” says Beicher. “So, the courts don’t like [arbitration agreements] because the layperson doesn’t understand the [agreement’s] language and is already signing multiple paperwork to get [their loved one] inside,” she says. In court, “the plaintiff’s lawyer goes right to the ‘heretos’ and ‘wherefores,’ and so far I haven’t seen it work too well,” she says.

What’s necessary to make the arbitration agreement approach work, she says, is educating families about arbitration’s benefits and writing the agreement itself in laypersons’ terms.

Some companies are turning to a newer approach to preventing litigation: “expectations management.”

### Managing Expectations

Only developed within the past couple of years, formal expectations management programs try to ensure that families fully understand the realities of life in a nursing facility so that they won’t be distressed or angered when unrealistic expectations are not met.

Along with clearly describing the aging process and how nursing facility services can and cannot help the individual, the approach strives to minimize the risk of complaints based on unrealistic expectations turning into litigation against the facility. In fact, some liability insurance providers are beginning to require the use of approved expectations management programs, language, and multimedia presentations.

Often, the cycle that ends in litigation follows a pattern of guilt, anger, and reprisal by lawsuit, say risk management professionals. Expectation management materials, language, and

programs seek to stop this pattern before it starts.

### Families Likely To Need

- A daughter who has cared for the patient with little support from siblings.
- A family that cared for the patient at home for a long time.
- Family members who disagree on what kind of care their relative should receive.
- An only son admitting his mother.
- Family members who work in health care.
- Family members who have a legal background.
- A family with many siblings, especially females.
- Families in the lower socioeconomic scale.

The approach is “designed to explain that a facility should not be held to a standard of perfect care,” says Chip Kessler, development manager of Johnson City, Tenn.-based Extended Care Products, which produces expectations management packages consisting of a 15-minute video called “Setting Realistic Expectations,” collateral print materials, a pamphlet for facility staff that explains the approach and how to use the video as a tool for sparking realistic discussions of often-difficult subjects, a newsletter for staff covering developments in litigation and ways of minimizing a facility’s risk, and “suggested language” to be incorporated into the admissions agreement.

The package was two years in development, says Kessler, and underwent a review process involving long term care professionals, attorneys, and risk management professionals. It was tested at nine facilities and released late in 2001. So far, Kessler says, his company has “received no reports from

any facility that is using the video that [it] has entered into subsequent litigation.”

Life Care Centers of America, Cleveland, Tenn., has developed its own gentler set of videos called “Caring to Know”—one five-minute introductory video and a 35-minute video with a thorough discussion about the company, scenarios of various potentially problematic situations, and specific data about such things as frequency of falls, some of which was gathered from the company’s own incident-tracking system. Along with the videos, Life Care Centers’ package for family members and patients includes extensive print materials on both the aging process and long term care at its facilities.

Both Life Care and Extended Care Products suggest that the videos be given to families to take home, review, and possibly show to other family members and friends of the patient.

Both companies’ packages stress that as people age, their health, mood, cognitive and physical functioning, and bodies—their skin and bones in particular—may deteriorate. These maladies may not heal in a facility, but may well continue and even worsen with age.

Some of the major points covered in the two videos include:

- Round-the-clock nursing care doesn’t mean 24-hour, one-on-one care for each patient. The Life Care video states that the average patient will receive about two hours of nursing care in any 24-hour period.
- Some patients will fall or break bones even with the best of care.
- Complaints about food may need to be taken up with the patient’s physician. Both videos emphasize that the food served to a patient must be in compliance with the patient’s physician’s orders, and so may be low-fat or low-salt and therefore unappetizing to the patient.
- Patients can be encouraged—but not forced—to eat. If a patient refuses food because it’s unappetizing or due

to depression, staff can try to encourage the individual to eat or treat other conditions that may be causing the food avoidance. But families should understand that forcing patients to eat would violate their rights as individuals.

■ The skin of elderly people is very delicate and prone to tears and bruising. Families need to understand that bruises, skin tears, and pressure ulcers are not invariably the result of neglect or abuse.

■ The patient may become depressed or develop dementia in the facility. The videos acknowledge the emotional stress many patients experience upon moving into a nursing facility and recommend that families visit often and become involved in the care of their loved one, alerting staff to any health, behavioral, or cognitive changes they may notice.

The information may at first seem disturbing for families, but once it is digested and families understand that they must be realistic, they often appreciate the facility's honesty and openness, say administrators.

"Residents and families have been pleased we took the time and effort to share the 'realistic' truth and expressed appreciation for our sincere honesty," says Sandy Deakins, administrator of a facility using the Extended Care product.

"The reaction to these videotapes—both from within Life Care and without—has been enormously positive, from providers and from families," says Beecher Hunter, executive vice president of corporate and community relations at Life Care Centers of America.

### Using Videos In Court

Along with managing patients' and family members' expectations about life in a nursing facility, the Extended Care Products video was designed to be shown to juries in a courtroom setting should a litigious situation develop, in order to visually communicate the good-faith attempt of the facility

to educate the family members (or plaintiffs).

Often, family members, even those not actively involved, feel considerable guilt about placing their loved one in a nursing facility—especially if he or she didn't want to go there in the first

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place, says Kessler. If a situation later occurs in which the loved one suffers a broken bone, bruise, or other injury, that guilt can easily morph into anger directed toward the facility, says Kessler, anger that may cause family members to seek out an attorney and bring suit against the facility.

Extended Care Products also recommends that facilities' admission agreements contain language that makes explicit certain issues that families may not otherwise be clear about.

The patient and representative "agree that the services provided by this facility and others within this facility are not designed to somehow protect the resident from the everyday, normal risks and responsibilities of living, including, but not limited to, such general accidents and situations such as falling, choking on food, and weight loss and/or dehydration resulting from a resident's failure to partake of food and drink."

The language also provides an opportunity for the patient or representative to specifically state whether

they would like to purchase one-on-one care or monitoring of the patient, or to accept the facility's "routine, reasonable, and customary service."

The recommended language also addresses patients' refusal of services that staff have made a good-faith effort to provide and states that the facility is not responsible for negative outcomes resulting from such refusals: "Should a resident refuse food, fluids, treatments, therapies, medications, grooming, therapeutic bathing, etc., and/or refuse to comply with physicians orders, the facility shall in no way be responsible for the outcomes."

And, finally, the recommended language addresses the video itself, asking patients and their representatives to "acknowledge that they have seen and clearly understand the content and message" of the video and that they agree to the admission of the video into evidence in the event of arbitration or any other legal or administrative proceeding.

### A Culture Of Responsiveness

Along with helping families to become more realistic in their expectations, facilities need to help their own staff to be more responsive to patients and staff to effectively minimize their litigation risk, says attorney and former nursing facility administrator Robert Bua.

"Overall, I always feel like the facility whose staff can be as friendly and empathetic and responsive as possible to residents and families is going to avoid a lot of litigation, and that's the same in any occupation," says Bua. "If I empathize with someone's complaint and respond to it, they like me and they know I'm helping them. You don't want to sue someone who's helping you," he says.

Bua is president and chief executive officer of CareScout, a Wellesley, Mass.-based company that helps private-pay individuals find a long term care setting that best serves their needs, by providing quality informa-

## Training Staff To Communicate Effectively

- Make eye contact.
- Try to be at the eye level of the other person.
- Keep your arms at your sides, and don't cross them or put your hands in your pockets.
- Vary facial expressions to show concern; don't frown, roll your eyes, show disapproval, squint, or curl your upper lip.
- Keep within a foot or two of the other person, and don't back away if the other person needs to be closer.
- Speak in a voice that is at a moderate, pleasing pitch, and don't whine, yell, or speak harshly or with a full mouth or so softly that the patient can't hear.
- Recognize escalating behaviors, such as pacing, talking faster or louder, pointing, or crossing the arms across the chest, and work to de-escalate the behavior.
- Verbally acknowledge the emotional state of the other person.
- During a conversation, sit down with the patient or family member so that the other person doesn't feel hurried and knows that you are giving the person your full attention.
- Limit distractions, such as ringing phones or beeping pagers.
- Use positive body language. Lean slightly toward the person speaking.
- Repeat the person's concern back to them to make absolutely certain—both for yourself and for the other person—that you correctly understand the problem and acknowledge that it exists.
- Say what you can do to resolve the problem, and then do it. If the resolution requires another staff person to do something, follow up to make certain it's resolved.
- Write down the concern, using the words that the patient or family used. If the concern is complicated, read what you've written to the other person so that they can correct any mistakes or clarify points.
- Don't get defensive; focus on creating a climate of collaboration and negotiation.
- Agree with the other person's statements whenever possible.
- Say "yes" whenever possible.
- Project confidence and competence.
- Sit up straight.
- Use the patient's or family member's name often.
- Don't shy away from stressful encounters.
- Listen to the problem, not the way the person is saying it; focus on the facts, not the emotion.
- Have the discussion in a quiet, nonthreatening, and neutral area. Having the family member walk away from an area of intense emotions will allow for cooling down and collection of both thoughts and reactions.
- Listen for the solutions expected by the family.
- Thank the patient or family member for bringing the problem to the staff's attention.

*Source: "A Facility-Based Risk Management Program," by Tra Beicher*

tion on facilities as well as a discount for consumers who choose one of the facilities in CareScout's network.

Friendliness and responsiveness can be reflected even in admissions paperwork. Bua recommends including a nonbinding agreement that whenever the patient's decision maker is concerned about something, that person will come and talk with the administrator so that the problem can be resolved.

If a facility "can establish this line of communication from the very start," its liability risk will be reduced, he says. "That's the first thing: You have to be friendly, empathetic, and respon-

sive and show that from day one."

Beicher agrees. "Most lawsuits are based on an adverse event that follows weeks or months of basic-level needs going unmet," resulting in the family developing a perception that the facility's staff provide poor care, according to her recently published book, "A Facility-Based Risk Management Program."

The focus of reducing the exposure to lawsuits should be on "creating a sense of well-being for the resident and a sense of all-is-well for family members," according to Beicher.

Margaret Casey-Mederios, a registered nurse who has been developing

training courses for long term care caregivers for 20 years, agrees.

"I believe that there has to be a culture of caring within a facility to be successful," says Casey-Mederios, co-author of the American Health Care Association's (AHCA) recently published "How To Be a Nurse Assistant: Making a Difference in Long Term Care." "If you don't have a culture of caring and responsiveness, you have to build that. Culture starts at the top, and you have to filter it all through what you do."

### Get Staff Involved

To do that, all of the facility's staff

## Hidden And Emerging Risks

**A**long with the familiar risk areas of falls, elopements, nutrition/hydration deficiencies, and wound development or worsening, providers should identify two other kinds of risks: those that are hidden and those emerging.

Hidden risks include a new admission who doesn't know what to expect about life in a nursing facility, a patient or family member considered "hard to deal with," unreported confrontations between staff and family members, reported problems that aren't resolved, and procedural or system failures that aren't changed.

Emerging risks include:

- The steadily increasing overall acuity level of incoming patients.
- Educated consumers who today have more access to information about nursing facilities and health care in general than ever before.
- Outcome-based care plans that are unrealistic—such as no falls within 90 days for a patient at high risk to fall—especially when these unrealistic goals are communicated to family members in care plan conferences.
- Staff from multiple ethnic backgrounds caring for patients who are also from multiple ethnic backgrounds, which can result in communication breakdowns between staff and patients, staff and families, and staff and staff.
- Multiple gatekeepers, including monitoring by federal, state, and private gatekeepers, along with insurance companies and managed care contracts. Managed contracts may be especially risky because it's in the intermediary's interests to keep the patient at as low a level of care as possible. Even if the clinical staff feel the nursing facility can adequately care for a patient whose condition is declining rapidly, the family may feel very differently.
- Broader customer base that is expanding to include populations other than the elderly, such as AIDS patients, paraplegics, quadriplegics, patients needing short-term rehabilitation, cancer patients, and terminally ill children, all of whom need a different approach to care.
- Communities with a spectrum of levels of care. Families and patients may be unprepared for the changes associated with moving the patient to a higher level of care, or unable to accept that their loved one's health and functioning is declining.

*Source: "A Facility-Based Risk Management Program," by Tra Beicher*

cal, receive training on how to be truly responsive to patients' and families' needs. But it's especially important that direct caregivers receive this training, because they daily encounter most situations that could lead to a lawsuit. Because direct care staff are the first to encounter them, they have the first opportunity to prevent the building dissatisfaction that, after an adverse event, can result in the family calling their lawyer.

### The Real Triggers

What a caregiver considers risky may be very different from what constitutes a genuine exposure to litigation. Traditionally, a risk has been defined as an adverse event such as an injury. Beicher believes that defining what constitutes a genuine exposure to litigation requires understanding who or what causes one situation to be more likely to lead to litigation than another.

A patient falling doesn't always lead to litigation. So, what elements cause some families to sue a facility after an adverse event?

The biggest factor is the people involved: the staff and the family members, Beicher says. Staff who aren't genuinely responsive to families, and families who perceive that lack of responsiveness as a lack of caring, can lead to a lawsuit, she says.

### Being Proactive

Given this understanding of risk, along with the traditional definition, a facility can engage in an interesting and informative experiment. Every staff member can be asked to list all the areas and practices that they think could be high-risk exposure. The answers will both identify areas where staff need more training and identify possible risk exposures that hadn't occurred to management, Beicher says. The exercise will also get staff involved in the quest to broaden their understanding of risk and become more alert to possible risks that would otherwise not be addressed or reported.

must be involved in what is essentially a culture change. Staff will need to be trained in effective listening, empathetic but accurate communication, how to convey a cheerful and competent attitude—complete with open, attentive, and responsive body language—in their everyday interactions with patients, families, and staff, she says.

And more than anything else, staff must learn how to respond to complaints, even those expressed with great

anger, with an ability to identify the root cause of the problem, defuse hostility, engage the dissatisfied person in a joint effort to solve the problem, send the individual away feeling satisfied with the outcome, and do it all with their professionalism intact.

A tall order. But with thorough training and commitment from management, it can work.

Beicher recommends that all staff, from janitorial to food service to clini-

Management and staff together can then prioritize the risks, develop an action plan to resolve each problem, and assign a staff member to monitor the elements and patterns of the exposure. Staff need to see results of these steps—whether the problem is fixed or not—so that they know that identifying and reporting risks brings results.

“Staff should have the ability to identify exposures and the authority to report such exposures, regardless of his or her area of training or clinical background,” writes Beicher.

“Near misses”—those times when an accident was narrowly averted—are essential in the process of identifying risk. “Near misses are very important predictors of major system failures,” writes Beicher. The facility loses the opportunity to fix systems, and staff lose the opportunity to learn from the cause analysis. And without understanding the cause, service recovery is very difficult.

Stick to the facts when reporting incidents, advises Bua. “When a facility is completing accident and incident reports, and any written record, be sure that the employees filling them out provide all the facts and don’t provide assumptions,” he says. “I call it 360 degrees of facts. A lot of time someone will write in some assumed blame on the facility. ‘The floor was wet because Henry mopped the floor five minutes earlier.’ Well, if we only knew that there was a huge spill, we cleaned it up, and a sign was up saying ‘Don’t walk here, it’s wet,’” a completely different picture emerges, he says. “You need the whole story, and that’s going to avoid litigation.”

And, just as important, as soon as an administrator learns of an incident that could be alarming, he or she should “call the family proactively and say, ‘Gosh, I feel awful about this. Let’s talk about it. Are you coming in? I’d really like to talk with you,’” says Bua.

### **Staff Training**

Responsiveness is really just another

## Partnering With Families

**F**acilities can foster partnership with families through support groups, a family council, and social clubs.

Support groups can be an educational opportunity for the families. Experts within the facility can speak to the groups about topics of concern, such as dementia, depression, the Medicare/Medicaid system, patients’ transition into the facility, regulations, diabetes, Parkinson’s disease, death and dying, aging skin, osteoporosis, and nutrition.

Family councils are an opportunity for families to be a part of the facility and contribute to patients’ quality of life through various volunteer activities. Families who don’t attend council meetings can be kept in the loop with a mailing that contains a condensed form of the information. Invite the families to discuss any areas further.

But to foster partnership it’s important for the facility to remain involved with the council’s activities. Otherwise, the council can become a forum for families to voice their complaints and reinforce in each other any idea that the facility’s quality of care or responsiveness to complaints is lacking.

Social clubs can work with the activities department to sponsor activities that, for example, celebrate seasons or holidays—activities that both patients and family members participate in. These events can also involve the public, which can be not only a marketing tool but an opportunity to build good will within the community from which juries will likely be drawn should a lawsuit go to trial.

word for good customer service. Orientation for new staff members and inservices for existing staff should teach customer service, emphasizing that these tools can make interacting with families and patients easier, says Beicher.

This training should be interactive; studies show that training that includes activities such as role-playing and skits results in participants learning, understanding, and retaining much more of the information presented. Employees skilled in customer service can demonstrate various techniques, and patients can talk to the group about what it’s like to live in a nursing facility, completely dependent on others to meet their every need. One element of good customer service is demonstrating a positive attitude, and employees’ attitudes come across not only in everything they say, but in how and where

they say it, according to Beicher’s book.

If the employee says something inappropriate, or something that’s inappropriate given the context of the immediate environment, it can make patients and families feel insecure and anxious. Families may begin to monitor care more closely and look for things to complain about, and patients may become more restless and demanding, or begin to refuse care.

To further enhance an environment of customer service, the facility can develop scripts for certain situations, such as answering the phone, introducing oneself, responding to common questions, responding to requests that are out of their scope, interrupting politely if an interruption is necessary, apologizing for inconveniences, or responding to angry complaints.

## Involving Families In Care

Staff members will never be able to please families who complain very frequently, because the actual problem isn't the care itself but the family's loss of control over the care, according to Beicher. In these cases, the most knowledgeable staff members with the most self-control should interact with the family. Providers should find ways to give the family control, such as involving them in care processes and decision making.

In decision making, providers should narrow the choices down to two or three that are equally valid and allow the family to choose between them. In care processes, providers should frequently report the patient's progress to the family and inform them of any decline so that they are informed and prepared before a big change in the patient's health status. That way, the change is more likely to be seen as due to natural aging and disease progression rather than due to care and services, Beicher says. Providers should ask the family for their advice, especially if the patient's health is declining or if the patient is becoming combative or refusing medications.

Whenever staff have involved the family in care planning, providers should document their involvement.

## Handling Complaints

About 45 percent of complaints are made to caregivers, according to studies, so caregivers must be trained to handle them.

A big part of handling complaints is developing good listening and communication skills, say many long term care experts. When a conflict or confrontation occurs between a staff member and a patient or family member, the staff member should stop what he or she is doing, give the person their undivided attention, keep eye contact, avoid negative body language, and find a way to respond with a "yes," whether it's "Yes, I'll fix that problem now," or "Yes, I understand your frustration. I'll

discuss it with management so that we can fix it."

If a longer discussion with family members is called for, it should never take place at the patient's bedside, but in a location that is neutral for both the family and the staff member.

During the discussion, the staff member should strive to determine what the dissatisfied person wants. The most important thing is to listen actively, which means expressing non-verbally, such as nods or facial expres-

**About 45 percent of complaints are made to caregivers, so caregivers must be trained to handle them.**

sion, that they understand what the person is saying.

If the family member responds to everything a staff member says with cold silence, the only appropriate thing the staff person can do is to say something like, "I'm willing to listen to what you have to say" and become silent, too, and wait, she says.

Once the caregiver understands the complaint, he or she should offer an apology, find a way to give the dissatisfied person something concrete (anything from fresh sheets to a specific follow-up date) to show that the problem will be resolved, and follow up.

If possible, the problem should be addressed and resolved as soon as the complaint is made, and preferably in the person's presence. If a problem lies beyond the employee's scope, the employee should personally take the patient or family member to a person who can solve the problem.

If the problem will take time to

resolve, a single staff member should be designated as the family's contact during the resolution process and introduced to the family.

Every complaint or concern should be treated as valid—even though later investigation may show that the patient or family member misunderstood the situation—and verbally acknowledged. Then the complaint should be referred to the appropriate facility personnel, who will begin an investigation. Finally, it's important to document all steps in the investigation, the complaint, the action taken, and follow-up.

People don't always verbally express their complaints, but words like "always," "never," and "every time" should alert an employee that the individual is getting increasingly upset about a situation, says Beicher.

## Problem Resolution

Before a formal meeting with a family to resolve a significant problem, providers should try to achieve agreement on the agenda so that staff can prepare to address the concerns. On the day of the meeting, providers should check with the clinician and nurse assistants who work with the patient to find out if any concerns have been recently voiced.

Providers should hold the meeting in a quiet, neat office when interruptions are unlikely, making sure to remove anything that the family might read and misinterpret, such as incident reports or telephone messages.

If the problem involves a fall or sudden decline, the care planning team or attending physician should be available. Beicher also suggests having someone present who knows and has an established rapport with the family and the patient.

During the meeting, providers should address what each family member thinks the problem is, as well as the problem as seen through clinicians' eyes. Providers must understand what the family or patient views as most important and what they consider a

satisfactory resolution. Then participants can negotiate a resolution that is realistic and works for both family and facility. Finally, participants should agree on a basic plan for follow-up and support.

### **Managing Adverse Events**

What caregivers do during an adverse event, such as a fall, has the biggest impact on how patients and families will perceive the facility's role in the event. Caregivers must keep their cool; they must think critically and logically about the most clinically sound actions to take. When an adverse incident happens, the patient, family, and nurse assistants should feel that the clinician has the situation under control.

The family should be contacted immediately after an adverse event has occurred and given the results of initial tests and told of treatment plans.

Staff understanding of policies and procedures, regulations, critical thinking, and follow-through has become a focal point for plaintiffs' attorneys, according to Beicher.

"The logical thinking process in long term care has got to be shored up," she says. "Sometimes there's a lag time between when the clinician discovers a fall and makes the assessment, or between that and making a decision, or before taking action after a decision," she says. For example, the assessment shows a fracture, but the clinician doesn't make a decision until an hour later. The patient has had pain and suffering that whole time. Or say

the assessment shows he wasn't injured, and the clinician decides not to do anything but doesn't document the reasons for that decision in the record and doesn't notify the doctor or the family.

Then, "later that night he starts complaining of pain, and it turns out he's got a fracture," says Beicher. "And then everyone's mad." And the facility's facing a lawsuit in the making. ■

### **For More Information**

■ To order "How To Be a Nurse Assistant: Making a Difference in Long Term Care," third edition, by Amy Bennet Coats and Margaret Casey-Mederios, RN; or "A Facility-Based Risk Management Program: A Practical Guide For LTC Providers," by Tra Beicher, RNC, call (800) 321-0343 or go to [www.achapublications.org](http://www.achapublications.org).