End-of-Life Expectations

A failure to communicate has big consequences: A medicolegal case history

BY LINDA WILLIAMS, RN

With today's growing elderly population, the nursing home industry has been forced to re-evaluate the ways it accommodates and communicates with residents and their family members. Given their longer life expectancies and shortened inpatient hospital stays, nursing home residents are older, sicker, and more frail than in the past. Nursing homes have been required to provide increasingly complex medical care for their residents, some of whom arrive in the active or acute dying process. The challenge to nursing home staff becomes not only providing appropriate end-of-life care, but also helping families prepare for their loved ones' death-and-dying process.

When this challenge goes unmet, strife can ensue. Many lawsuits against nursing facilities arise as a result of poor communication among providers, residents, and their families. The following is a summary of such a case.

The Situation

An 83-year-old woman was admitted to a nursing home after being discharged from a hospital where she received treatment for a left wrist fracture that she sustained from a fall in her apartment. Besides the fracture, her diagnoses included:

- Congestive heart failure
- Chronic atrial fibrillation
- Recurrent chest pain
- Atypical angina equivalent
- Insulin-dependent diabetes
- Hypertension
- Chronic obstructive pulmonary disease

In addition, the woman's medical history included coronary artery bypass surgery, pacemaker implantation, and a stroke. Her current medication regimen included various drugs to treat her life-threatening cardiac, pulmonary, and diabetic conditions.

Throughout her stay and after discharge from the hospital, the woman complained of chest pain and difficulty breathing. When she arrived at the nursing home, her chest pain and breathing difficulties intensified. A staff nurse at the nursing home promptly notified the woman's physician about her condition. The physician ordered a medication treatment that the nurse hastily administered. After receiving the treatment, the woman expressed some relief and was able to weakly assist with a few of her activities of daily living.

The chest pain and breathing problems never completely resolved, and she had another episode of dyspnea the following day, requiring the same medical intervention. By the third night, the woman's chest pain and breathing difficulties began to escalate yet again. As before, the night nurse promptly called the physician, although this time she spoke with an on-call doctor. After the nurse explained the woman's history and current condition, the physician ordered a breathing treatment, oxygen, and nitroglycerin. The physician also ordered the woman to be transported to the hospital if her condition did not improve.

After the woman received the treatment and medications at 2:40 a.m., her condition seemed to stabilize, so the nurse closely monitored her every 5 to 10 minutes until 4:50 a.m. Throughout this time, the woman did not voice any complaints and appeared to be sleeping with less distress. When the nurse checked the woman again at 5:25 a.m., she discovered that the woman had passed away.

That morning, the woman's distraught daughter came to the facility to express her unhappiness with the night nurse for not calling her in time so that she could say goodbye to her mother. The night nurse contended that her mother's condition had not, by that time, changed to a critical status. As they talked, it became clear that the daughter thought that her mother was admitted to the facility with only a fractured wrist and did not understand how she could have died just three days later. She clearly did not know the seriousness and implications of her mother's multiple diagnoses.

A year later, the daughter filed a lawsuit against the nursing home alleging that staff were responsible for wrongful death, negligence, mental anguish, and loss of consortium. Her demand was for $220,000.

The Trial

When the daughter was deposed, she stated that she saw her mother every day while at the nursing home. On the first day, she noticed that her mother was lethargic and she so informed the staff. She continued to advise the staff on each of the other days and alleged that they did nothing in response (i.e., did not call the doctor or send her mother to the hospital). She noted, however, that she did not notify anyone else when she was dissatisfied with the actions of the staff.

The plaintiff's expert witness stated that the staff nurse should have noticed a change in the woman's respiration level on the night that she died and should

have immediately sent her to the hospital, per the on-call physician's telephone order. However, the defense attorney contended that the woman was monitored on a frequent basis and administered prescribed treatments/medication as ordered by the attending physicians throughout her brief stay at the nursing home. He further concluded that, given the woman's declining medical condition, she was sent to the nursing home to die because there was nothing more that the hospital or physicians could do for her.

Both parties agreed to a monetary settlement, albeit a substantially lower one, before the trial concluded.

What Went Wrong

The obvious problem in this case study was that no one had addressed the gravity of the resident's situation with her daughter. This might have been because of the nursing home staff's assumption that either the hospital or the resident's attending physician had already discussed the matter with her daughter. Or perhaps the staff planned to discuss it at the woman's first care plan meeting in another week. It also is possible that the nurses did not realize how close to death the woman actually was or did not recognize the potential additional complications of a fracture (i.e., pulmonary emboli).

Many people assume that "terminal illness" is a key factor when they think about the end of life. Cancer is the most common illness with a distinct terminal phase, yet fewer than one-fourth of Americans die of cancer; most die of chronic diseases in which the prognosis is uncertain and functional decline is nonlinear and often sudden. As a result, most nursing home residents, particularly those who are chronically ill, are never diagnosed as "terminal."

Risk Management Practices

You can minimize the risk of a similar situation happening in your facility by implementing the following risk management practices:

1. Preadmission screening is crucial to make sure the nursing home can meet the resident's needs. The preadmission screening process should include:

On-site assessment of the resident by an RN to identify acuity needs. All progress notes should be reviewed for indications of prognosis. If there is no clear indication, the physician should be contacted. If the rehab potential or prognosis is fair or poor, potential outcomes should be discussed with the physician.

Identification of a designated family representative for ongoing contact and notification. Negotiate and document criteria for when and under what circumstances the representative wants to be called. Communicate these criteria to all disciplines and document them, especially when it is determined that there may be an area of concern.

Discussion with the resident and family regarding expectations of goals and outcomes. Determine their understanding of what the physician has told them about recovery and long-term considerations. The discussion should be frank and straightforward regarding disease processes, potential complications, and what can be expected of the nursing home staff. Consider using an educational video about setting realistic expectations to enhance this discussion. When it is determined that there is a significant lack of understanding or denial on the part of the resident or family member, it is important to involve the attending physician, medical director, social services, and even clergy as needed.

Discussion of conflict resolution procedures. A mechanism to resolve ethical issues or disagreements among the resident, family, and/or staff should be in place and understood by all.

2. Develop an interim plan of care within the first 24 hours of admission or readmission. The nurse should assess the resident's physical condition and safety needs, then develop an interim plan of care until an MDS assessment is completed. This plan of care should be discussed with the resident and his/her designated representative. Help them understand the resident's diagnoses, medications, and prognosis. If indicated, discuss hospice care options.

3. Communicate changes in condition by instructing the nursing staff to inform the resident's representative of the following:

- details of the resident's status, that the physician has been notified, and the orders received.
- the current situation and realistic expectations regarding care and services to be provided, should a change occur in an ongoing chronic process.
- the nursing interventions that are being implemented and the staff's understanding of the resident's code status.
- the need to know responsible parties' wishes regarding treatment options. Do they want the resident hospitalized? At what point do they want to consider further options? Be sure to communicate family wishes to the physician and encourage preparation or revision of an advance directive, if indicated.
- that if family members report a change in the resident's condition, staff will listen attentively to their concerns, tell them what they plan to do about it, and ask if they have any suggestions to offer from past experience; e.g., have they ever known the resident to have these symptoms before? What helped the situation?

Document all of the above in the resident's record, update the care plan as needed, and follow up with the resident's representative within the next two days (or sooner if needed) regarding the resident's condition.

Proactive risk management in a long-term care setting is an ongoing challenge, but all the time and trouble are definitely worthwhile if incidents such as this can be avoided. **NH**

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