LIABILITY
landscape

BY LINDA WILLIAMS, RN

The case of the noncompliant resident

Have you ever had a resident refuse to follow his or her care plan and instead make an alternative choice that you and your staff felt was risky? Maybe you've had disagreements with a resident who only wants to bathe once a week, eats food that is contrary to his or her prescribed diet, or insists on using a cane for support instead of a wider-based walker. These are dilemmas that every healthcare provider faces from time to time.

When these clashes occur, it is important for management to take action in order to protect both the resident and facility. The following is a situation in which a nursing facility's staff encountered such a resident, and the facility was later sued for a poor outcome resulting from a series of poor choices. Please take the time to review the circumstances surrounding the situation and make changes as appropriate in your facility.

The Situation

A middle-aged woman with diabetes and resulting peripheral neuropathy stepped off a curb and fractured her left foot. Since her foot had no feeling, she continued to walk on it, and Charcot's foot developed, which warped the shape of her foot from her bones disintegrating. Soon after, a skin lesion developed and an infection set in, which took a month to resolve with aggressive antibiotic treatment. Four months after the accident, she had her fracture surgically repaired by open reduction internal fixation, fusion, and grafting.

Her physician put on a total-contact cast, which was molded to the shape of her foot. The cast allowed her ulcer to heal by distributing weight and relieving pressure. Because of her Charcot's foot, the cast controlled her foot's movement and supported its contours as long as she didn't put any weight on it. For the total-contact cast to be effective, she needed good blood flow in her foot, which required careful monitoring by a professional. The woman was alert and oriented and could make her own decisions, so she agreed to accept her physician's advice and go to a local nursing facility for therapy and nursing care until she could become independent enough to return home.

At the nursing facility, the woman was instructed to keep her injured left leg elevated while in her wheelchair and bed. The physical therapist would teach her how to use crutches and do pivot transfers using her right foot while bearing no weight on her left foot. She was to receive a strict diabetic diet, as she was insulin-dependent and not very stable. In fact, a month before the fracture, she had been hospitalized for a coma related to ketoacidosis that lasted eight days. She also had a history of alcohol abuse.

The woman was very pleasant and acknowledged an understanding of her responsibilities and care at the nursing facility. However, the day after she arrived, the evening nurse noticed some blood spots on the woman's cast and on the floor in her room. Apparently, she had taken a shower, and the nursing assistant reported that she was observed partially bearing weight on her left foot despite the aide's protest. The nurse reminded the woman why she shouldn't bear weight on that foot and notified her physician of the bleeding. The woman had good circulation, so the physician asked the nurses to continue to monitor it.

Two days later, the woman left the facility at 7:00 a.m. to visit her family and didn't return until 10:30 p.m. Upon her return, she complained that her left foot was swollen and the cast was "too tight." The nurse applied ice to the cast, encouraged her to keep her foot elevated, and gave her a pain-relieving medication. The nurse warned the resident that her insurance might not pay for her care if she continued to leave for long periods of time, and the woman acknowledged her understanding.

Despite the warning, the woman continued to leave the facility for visits home or to see her family for two to twelve hours almost daily. On the ninth day of her stay, she returned to the facility in the

late evening and told the nurse that she had been driving her car when it got a flat tire. When she got out of the car to check it, she stepped in some water and got her cast wet. The nurse examined the cast and found that it was soft at the bottom, with a slight tear. The nurse taped the tear and questioned the woman about the safety of her driving. The woman said that she would not do it again.

Three days later, the resident returned late from yet another family visit and told the nurse that her blood sugar would be high, as she had been drinking several beers that evening. She was right, and the nurse gave her enough insulin to provide adequate control. This was not the first sign of dietary noncompliance, as she frequently ate lunch and dinner outside the facility and often had to be given insulin upon her return. Both the nurses and dietitian had tried to reason with the woman about the need for dietary compliance, but to no avail.

Another noncompliance issue that the nurses encountered was that the woman would sometimes forget to bring her medications back to the facility when she returned from her outings. As a result, the nurses had to order duplicate medications so they would have enough to give her at the facility. Again, the nurses tried to discourage her outings, and finally she agreed to have her family visit her at the facility instead.

During the next few days, the circulation in the woman's foot remained good, although she was occasionally observed to bear weight on her left foot while walking or transferring. When confronted, she always responded that she had "forgotten."

Nearly two weeks into her stay, the resident accidentally got her cast wet while showering. The nurse gave her a hair dryer and encouraged her to dry it out a little, as her physician was expected to cut the cast off the next day. The nurse took her to the lounge, plugged in the hair dryer, and left her there to dry her cast. The woman attempted to dry the cast but had difficulty with the hair dryer, as it wasn't working properly. After ten minutes, the nurse checked the cast and thought it felt dry to the touch. Since her circulation remained good, the woman went to bed.

The following day when the woman awoke, the nurse noticed that her left big toe was black and blue and her other toes had intact white blisters underneath along the cast line. The physician arrived and replaced her cast, noting the intact blisters. For the next two days, the woman continued to bear weight on her left foot, despite staff discouragement. The nurses attempted to call her physician twice about her noncompliance. That evening the woman came to the nurses' station in tears, saying she had talked to her physician and he told her that "the nurses wanted to get rid of her." She further stated that her doctor asked her to fill out a report about the hair dryer incident, and that her family would be in later to photograph her wounds. The staff tried to comfort her and explain the situation, but she decided it was time for her to leave the facility, so she was discharged shortly thereafter. On the day of her discharge, some of the blisters had opened, but her physician felt that she could still go home with support from home healthcare services.

Nearly two years passed after the woman's discharge when the facility received a notice that it was being sued by the woman for the nurse's negligence in letting her use a hair dryer to dry her cast. The suit alleged that this had resulted in second- and third-degree burns, which became infected, ultimately causing permanent damage to her foot. The woman's attorney offered to settle the case for $150,000.

The facility's attorney argued that it had limited exposure, and even if the blisters were related to the hair dryer incident, they healed in approximately two months and did not have any significant effect on the woman's health. The woman's orthopedic physician was deposed and stated that when he saw the woman on the morning that the blisters were discovered, his immediate reaction was that they were caused by a breakdown of the cast from her walking on it. He felt that perhaps pressure and friction had caused the blistering, since the cast was broken down on the bottom. He further stated that the cast was made from fiberglass, which could get wet and not break down. The case eventually was settled out of court for a minimal amount.

Protecting Your Facility and Residents

Most would agree that if there was any negligent action on the part of the staff in this facility, it occurred when the nurse gave the woman the hair dryer and left the room. But did that lone act negate all of the other actions taken by the woman that contributed to her alleged demise? One action that the facility might have considered taking when it discovered the woman's resistance to comply with her care plan was to develop a Shared Risk Agreement.

A Shared Risk Agreement is an agreement between a healthcare provider and a resident or surrogate decision maker who acts on behalf of the resident, in which the resident assumes certain risks in exchange for the provider's accommodation of a preference of the resident. The surrogate decision maker can be an agent, attorney-in-fact, or guardian of the resident legally authorized to make long-term care decisions.

The risks in question usually involve issues that are not routine or easily resolved through care planning. Often, they are matters that run contrary to the provider's risk-management policies or practices. The agreement enables the resident to take full responsibility for any consequences that may occur as a result of the choice that he or she has made. However, if a federal or state regulation or a local ordinance prohibits the provider from accommodating the resident's preference, a Shared Risk Agreement should not be drafted.

Shared Risk Agreements are a relatively new phenomenon in the long-term care industry. Although promoted by the assisted living industry and cited in state regulations on assisted living and guidance on Medicaid waiver programs for home- and community-based care, Shared Risk Agreements have rarely been tested in court. Nevertheless, providers can increase the likelihood that their drafted agreements will help reduce the risk of litigation by following these steps:

- **Identify the cause for concern.** Clearly state the resident's preference with respect to the issue under consideration. Also state the provider's perspective, including any policies, practices, and professional recommendations that conflict with the resident's preference.
- **Identify any/all potential negative outcomes.** For example, in the case of a reckless smoker, the risk of causing a fire.
- **Identify alternative actions that might**

be acceptable to the provider. Using the same example from above, alternative actions might include dispensing cigarettes one at a time, smoking only under supervision in designated areas, etc.

- **Acknowledge that the resident or surrogate decision maker understands the risks and the alternatives.** Clearly state and document that the resident or surrogate decision maker had ample opportunity to review and discuss the Shared Risk Agreement with legal counsel, medical professionals, and any other person chosen to consult with before signing the agreement.
- **Make clear the agreement between the resident or surrogate decision maker and provider.** Specify the terms, conditions, expectations, and responsibilities of each party.
- **Discuss the liability waiver.** State the resident or surrogate decision maker's release of any claim against the provider for injuries that the resident may suffer as a direct result of provider actions in compliance with the agreement and all applicable health and safety laws and regulations, including any applicable regulatory waivers.
- **Identify a sunset provision and interim review process.** The sunset provision should specify when the contract will terminate automatically. A logical date to use is the time frame for reviewing care plans under state regulation. This automatic termination will cause the provider and resident or surrogate decision maker to periodically review the contract in light of any changes in circumstances, at which time they may decide to modify and renew it.

Finally, seek legal counsel to assist in the development of this agreement. ■

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