

Long-Term Care Survey Alert

Risk Management: DISCLOSE RISKS TO SUCCEED UNDER NEW JCAHO REQUIREMENT

Is the Joint Commissions upcoming self-disclosure requirement a plaintiff lawyers wildest dream come true or a potentially effective risk management tool?

The answer should become apparent next year. Starting Jan. 1, 2003, nursing facilities accredited by the **Joint Commission on Accreditation of Healthcare Organizations** must inform residents and their families of unexpected outcomes, such as injuries resulting from falls or medication errors. The requirement is part of JCAHOs new resident safety standards for nursing facilities.

While such disclosures can indeed heighten the chance of malpractice lawsuits, the strategy can be a highly effective risk management tool, experts say.

The strategy can work in the long-term care facilities favor if staff forms a partnership with the resident and family from the residents admission on, according to **Mary Tellis-Nayak**, chief executive officer and president of the **American College of Health Care Administrators**. "That means informing residents and families of the risks of certain adverse events, such as falls, and asking them to collaborate in the care planning process to prevent those outcomes," she tells **Eli**.

Then if the outcome does occur, the resident and family have been informed that the resident was at high risk for such an eventuality and they know that the facility tried various approaches, with their input, to prevent it.

"The self-disclosure process is not going to work if the facility staff call someone out of the blue to whom they have never spoken and say, Oh by the way, your family member has fallen or has been given the wrong medication," warns **Lynn Swisher**, a risk management expert and president of **Chase Health Specialists** in Lincoln University, PA. "Yet when residents and families are involved collaboratively with the nursing facility so that everyone pulls together to make the best possible decisions for the resident, they are going to be more understanding if something does happen to go wrong," Swisher adds.

Use an Organized Approach

Good Samaritan Nursing Facility in West Islip, NY, has already implemented a self-disclosure policy. While the facilities administrators believe the policy can be very positive, they caution that it can also expose the facility to more liability, if staff dont use an organized approach.

"The regulations are so tight that we have to report anything that happens to the health department anyway, so we also speak to the resident/ family immediately" to inform them of the incident, reports **Vicki Tucker**, vice president of mission and program development for **Good Samaritan Hospital Medical Center**.

Next, the facility does a root cause analysis to determine the cause of the adverse event. Once thats complete, the facility designates a specific person or team of people to discuss the findings with the resident/family or responsible person. "At that point, residents and families are also informed as to how the facility is taking steps to prevent a similar incident from occurring again," Tucker says.

Dont Jump the Gun

Good Samaritans approach underscores two main principles for reducing the liability inherent in the self-disclosure

process. For one, the facility assigns a single person or team to explain the incident and its causes to the resident/family. This is a good idea, legal experts say, because otherwise the resident/family may hear conflicting stories from various staff members who don't have their facts straight. Such statements can be used in malpractice actions against the facility.

Under the JCAHO standard, "the licensed independent practitioner is the one responsible for disclosing the unanticipated outcome of care or designating someone to do it," **John Fishbeck**, JCAHO's associate director of standard development, tells **Eli**. If the resident is too cognitively impaired to understand the information, then the facility must inform the person appointed as a surrogate decision maker for the resident.

Secondly, it's important to avoid "jumping the gun" with initial speculative reports to the resident/family or state as to the cause of the incident.

"Most states require nursing facilities to report incidents immediately or within so many hours," notes Arlington, VA, health care attorney **Joseph Bianculli**, "so initial reports must make very clear that the facility is continuing its investigation unless the facility is absolutely clear about what happened at the time of the first report."

And even then, the facility may be surprised by the rest of the story when all the facts are in. Bianculli reports a case some years ago where a facility reported to the state that a resident had choked during a meal. "The autopsy later revealed the resident had suffered a stroke, which caused the choking," says Bianculli.