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MDS Alert

Risk Management: Reduce Your Facility's Litigation and Liability Exposure

Learn from others' mistakes, successes to stay out of trouble.

Time and again providers open themselves up to malpractice and wrongful death lawsuits by doing certain things, or failing to do others, warn two nursing home medical directors who also act as expert witnesses in cases involving nursing facilities. "We've been doing expert witness review for a number of years now, and we keep seeing the same issues arise over and over again," **Randall Huss, MD, CMD**, medical director for **Rolla Manor Care Center** in Rolla, Missouri, lamented at the "Nursing Facility Litigation and Liability: A Case-based Tutorial" session at the **AMDA**conference earlier this year.

"Some of the things that we've learned from our experiences can help other facilities and providers stay out of trouble," added **David Smith, MD, CMD**, president of **Geriatric Consultants of Central Texas**, in Brownwood, Texas. Common issues and allegations in nursing home litigation include wrongful death, pressure ulcers, falls/fractures, dehydration/weight loss, failure to treat, improper use of restraints, medication errors, single event injuries and emotional distress.

Key: In preparing a defense against a wrongful death claim, providers need to recognize that the plaintiff must prove that the death was causally related, and a natural and continuous product of your actions or omissions, Huss explains. "It can't just be that you committed a negligent act that resulted in an injury and then the patient died of an unrelated issue. The plaintiff will have to connect the dots all the way from the act or omission to the death. That's how you can usually successfully defend a case involving a claim of wrongful death," he says.

Document resident nonadherence to care plan

Even if the plaintiff is able to prove a cause and effect chain of events, you may be able to launch a successful defense by documenting a resident's nonadherence to the care plan. Smith recounts a wrongful death case in which a facility was accused of failing to prevent a resident's fall, hip fracture, and subsequent death from pneumonia. The resident, a 93-year old woman with overactive bladder, had recurrent falls ambulating to the bathroom. The care plan was for scheduled toileting, modified fluid intake schedule, call bell within reach, prompt CNA attention to any call bell, and ambulation with a walker with the assist of one.

Despite this plan of care, the resident frequently took herself to the toilet without her walker or an assist. One day while doing this, she fell at the threshold of the bathroom door, suffering an intertrochanteric fracture of the right hip. She was hospitalized, underwent an ORIF, received DVT/PE prophylaxis and was returned to the SNF, but within a few weeks, she developed pneumonia, was rehospitalized and succumbed.

"Although the expert for the defense agreed with the plaintiff that the resident's walking independently and falling did ultimately lead to her death, the facility had clearly documented that the resident was mentally capacitated for decision-making, and that she repeatedly ignored staff requests for her to use the call bell and to let them help take her to the bathroom," Smith notes.

Best practice: As a result of this careful, proactive documentation, the expert for the defense was able to depose that the resident was capable of the decision to use the call bell and to summon assistance with ambulation but chose not to. In addition, depositions of the resident's family revealed that she was intensely modest and very independent, Smith added.

So, the defense was able to successfully deflect the plaintiff's retort that the resident had the right to fall and break a hip and die by positing that the resident had the same right to privacy as anybody else. (For more tips on how to defend yourself in falls litigation, see the related article "Falls are Inevitable; Losing a Falls Case Doesn't Have to Be" on pg. 102.)

Choose your words carefully

Resident nonadherence to care plans must be charted proactively, not after the complaint, Smith emphasizes. In addition, providers should be careful how they phrase nonadherence in the chart. Do not say pejorative things in the medical record about the resident. It is better to use the term "nonadherence" rather than "noncompliance" and state that the resident "declines" rather than "refuses" treatment, Smith advises. "The residents get to make their own decisions. That's not ours to judge whether those are good or bad decisions. Use of the word "refused" inserts my value system into the resident's decision and that's inappropriate. You don't want to get nasty; it doesn't look good later on," he explains.

In contrast, Huss detailed a case where a nursing facility was found liable for the injury a resident suffered during an elopement attempt, because the facility failed to properly document and intervene. "A resident with dementia was admitted to the second floor of a nursing facility's Alzheimer's unit. She exhibited exit-seeking behavior from the outset . . . One of the nurse's notes said that the resident was looking for a way to get out all evening," Huss recalls.

On several occasions over the first four weeks of this resident's stay, she was found with her room window open and the screen pushed out, but these events were undocumented, he notes. These instances were only later discovered during the police investigation after the resident fell from her second-floor window while trying to rappel down the building using two sheets tied together bound to the bedpost, Huss explains.

The police report included statements from the administrator that she knew immediately which resident had fallen as soon as she heard, along with a statement from a CNA that they had walked by her room and saw her trying to crawl out the window. "We go in and close it every time and she always reopens and kicks out her screen. She does this all the time," the CNA told the police. Despite these events, the only intervention implemented by the facility was to inform the CNAs and maintenance staff to check on the resident more frequently. As a result of these failures, the facility ended up having to settle the case for an undisclosed amount.

The bottom line: The lessons from this case, Huss warns, are to take elopement threats and attempts seriously since catastrophic outcomes like these are common. "The facility has a duty to provide a safe and secure environment. If window elopement is possible and cannot be secured against, do not place the resident above the 1st floor. Any co-worker who witnesses an elopement attempt should report it, and an incident report should be completed, along with the actions taken to prevent recurrence," Huss says.