

# Taking Steps to Help Prevent Being Involved in Litigation

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How to Consult Workshop

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# THE CHAIN OF EVENTS

1. Unmet needs and disappointment
  - Patient/family feels wronged
2. Promises made and broken
  - Told them we would take good care of patient/family member
3. Dissatisfaction and anger
  - Family never called and found out bad outcome later
4. Allegations and litigation

# WHO IS AT RISK?

- Facilities
- Health care professionals
  - Wrongful death charged to administrators and professionals
    - Can be manslaughter in some states

# CONCERNS DIFFER

- Attorneys
  - What was and wasn't documented—defense of your work is based on what you document
  - What were the standards back then?
- Family members
  - Human care and treatment
    - Communication and courtesy
    - Comfort, understanding, respect and dignity

Plaintiffs have a  $> 75\%$  chance of winning a jury award

The average recovery amount for paid claims whether resolved in or out of court was about \$406,000 per claim

92% of cases settle out of court

# WITH LITIGATION ON THE RISE— CHART SMART

- Was the problem avoidable or not
- Was the problem painful or not
- Was the problem managed well or not
  - Did you provide preventable/treatable care?

# DISCOVERY

- Gather information not found in the medical chart
- Nursing home and its parent corporation may be asked to produce records

# POTENTIAL ITEMS IN THE DISCOVERY PROCESS

- Personnel files, including job descriptions
- Staffing pattern and workload documents
- Time sheets including work assignments
- Outside consultants
- In-service training reports

# POTENTIAL ITEMS IN THE DISCOVERY PROCESS

- Policy and procedure manuals
- Log books—temperatures etc.
- Incident reports, accident reports
- Maintenance repair books
- Facility investigations
- Quality assessment reports, history of criticisms and complaints from residents, families, and employees

# POTENTIAL ITEMS IN THE DISCOVERY PROCESS

- Other lawsuits involving the facility, consultant, staff member
- Government regulatory forms and regulatory findings and sanctions
- Documents identifying the governing body, relationships with ownership/management entities and financial data
- Advertisement brochures
- Facility design

# LIABILITY FOCUSED AREAS

- Pressure Injuries:
  - Lack of consistency of care
  - Lack of clinical records
  - What is percent of pressure ulcers that were unexpected--separating these in the QA report as some may be an expected outcome

# LIABILITY FOCUSED AREAS

## ■ Nutrition

- What is percent where not an expected outcome?
- Good facilities will have <2% of unexpected weight loss

# LIABILITY FOCUSED AREAS

- Dehydration
  - Works as a hospital admission diagnosis by Medicare
  - Leading diagnosis of those admitted to hospitals
  - When dehydration is on admission papers to the NF, make sure that there is clinical evidence of this diagnosis or have it removed

# PATIENTS/RESIDENTS MUST IMPROVE OR REMAIN STABLE WITHIN THE LIMITS OF:

- Patients/residents right to refuse treatment
- Recognized pathology-realistic condition assessment
  - Good pain management
  - Infections identified and physician alerted
- Normal aging process

# Accurate and Comprehensive Documentation

The Key to Avoiding Litigation

# DECREASE LIABILITY OPPORTUNITIES

- Policies and procedures
- Care plans
- QA
- Documentation of condition on admission
- Nursing notes
- Nutrition assessment
- Physician documentation
- Well-written plans of correction

# TOP TEN DOCUMENTATION ERRORS<sup>17</sup>

1. Lab values not addressed appropriately
2. Missing diagnoses that increase metabolic needs when assessing calorie/protein/fluid needs
3. Not making concise statements that identify if needs are being met
4. Wounds not addressed appropriately—skin is an organ and it will fail, too.
  - Underlying medical conditions that lead to unavoidable wound—PVD, uncontrolled DM
5. No follow up on recommendations

# TOP TEN DOCUMENTATION ERRORS

6. Making recommendations that don't follow standards of practice
7. Poorly written or no care plan
8. Failing to identify drug nutrient interactions
9. Not documenting on high-risk residents—uncontrolled diabetes leading to pressure injuries
10. RD notes do not correlate with others

# HIGH NUTRITIONAL RISK REFERRALS TO RD

All patient/residents meeting the following criteria should be referred to the RD immediately!

- Patients/residents that trigger screens
- Dx of malnutrition
- Enteral or parental feedings
- Transition from tube feeding to oral feeding
- Renal or Liver Disease

## HIGH NUTRITIONAL RISK REFERRALS, CONT.

- DX reflecting difficulty in digestion, absorption, or utilization of nutrients, i.e., uncontrolled diabetes, colitis, or Crohn's disease
- Clients with Stage II-IV Pressure Injuries
- Non-healing open areas/burns
- Weight loss greater than 5% in one month
- Weight loss greater than 7.5% in three months
- Weight loss greater than 10% in six months
- Knowledge of insidious weight loss
- Persistent constipation or diarrhea

# HIGH NUTRITIONAL RISK REFERRALS,<sup>21</sup> CONT.

- BMI less than 23
- Dysphagia
- Dialysis
- Infectious diseases, HIV and Guillian Barre`
- Chronic food complaints

# PURPOSE OF CHARTING

- Required by the facility
- Regulatory requirement
- Possible ethical/legal standpoint
- Maintenance of continuity of care
- Support fiscal viability
- Communication

# GOOD CHARTING

- Complete
- Consistent
- Accurate
- Timely
- Objective

# GOOD CHARTING

- In today's litigious culture documentation must now be made with the potential for a lawsuit in mind.
- The chart doesn't interpret itself—as you review documentation, look for trends over time—are you only repeating what was written earlier?
- Document more than routine care

# PAINT THE PICTURE

- Reviewer should be able to reconstruct the care received by reviewing the chart
- Always address the three vital aspects of care:
  - Assessment
  - Intervention/Plan for care
  - Patient/resident response

# PAINT THE PICTURE, CONT.

- Any significant deviation from normal demands a notation showing what is being done about it
  - If you notify the doctor, record the time you made call, doctor's response and whether you carried out order or if you couldn't contact the doctor
    - Has the doctor failed to return your call or fax within the hours set forth by your policy

# PAINT THE PICTURE, CONT.

- Document observations in detail
- Chart deficits, such as lack of response
- Describe non-compliant behavior
  - Not an excuse for poor outcomes
  - Requires plan of care, notification
  - Remember resident legally has the right to make own choices
- Use patient/resident quotes for patient/resident self-assessment and education

## Paint the picture, cont.

- Document intervention/protective measures
- Clarity leaves no room for interpretation
- Document all discussions with patients/residents, including risks and recommendations
- Forward recommendations to nursing staff and document referral

# PAINT THE PICTURE, CONT.

- Ask yourself:
  - What is the purpose of this entry?
  - Have I communicated clearly to others—physician, therapist, nursing staff, dietary staff?
  - Does this note satisfy its intended purpose?

- REMEMBER: A defensible record takes the collaboration of all those involved in the resident's care
- Omissions are more defensible than lies—do not alter the chart



THINK ABOUT TRYING <sup>31</sup>  
TO PROVE IMPORTANT  
FACTS & FINDINGS  
2-3 YEARS LATER AFTER  
THE CHART IS COLD!

# ORGANIZED APPROACH

- Record order
  - Decide on chart order
    - Can physicians find the weight easily?
    - Where are your recommendations?

*Remember: The ability to locate information quickly may make the difference between a good decision and a less than desirable one*

# ORGANIZED APPROACH

- Documentation format
  - Helps keep the fact retrieval and information outline in order
  - Helps jar your memory when it comes time to capture information in words

*Remember: No matter what format always address:  
Assessment, Intervention, Response, Plan*

# WILL YOUR ENTRY SUPPORT YOU IF YOU GO TO COURT?

- Does it reflect initial assessment data?
- Does it identify actual and potential problems?
- Does it outline medications, treatments, and procedures to be delivered?
- Does it involve the interdisciplinary team?
- Can you tell what types of care this resident received?

# CREATING A DEFENSIBLE RECORD

- Did you use all available resources to gather information
  - Resident
  - Family
  - Any available paperwork
- Did you review all diagnosis—discussed those such as dehydration/malnutrition with physician

# CREATING A DEFENSIBLE RECORD

- Has the physician addressed in the progress notes diagnosis/prognosis?
- Did you educate the family regarding what you may or may not be able to do?
- Did you support these efforts in the medical record?

# PITFALLS OFTEN HEARD

- “We were too busy to document everything.”
- “We were short staffed.”
- “I had never worked with the resident/patient before so I didn’t know...”
- “Come on—everyone makes mistakes on occasion.”
- “I was running late that day so didn’t see the resident/patient—just charted from what others had said.”

# CLEAR DOCUMENTATION

- Resident's needs calculated at 1850 calories, 65 grams protein and 1850 mL fluid related to Stage 4 open area on coccyx and Stage 3 open area at L-3 and 4. Current intake records reviewed with intake estimated at 1000 calories, less than 40 grams protein and 1100 mL fluid. Receives a regular diet which is appropriate with ethnic preferences provided. Facility provides meals from the local Asian restaurant which are delivered just prior to lunch and dinner which are often refused although it was one of her favorite places to dine prior to admission to this nursing facility. Family has also been bringing in favorite foods, but resident has been refusing these

# CLEAR DOCUMENTATION—CONT.

Favorite snacks are often refused. We have also tried Ensure, Juven, Breeze drink, Magic Cup and numerous other high calorie protein dense options as can be seen in previous nutrition progress notes. There are no identified chewing or swallowing problems. Meds remain constant with no food/drug interactions identified. Weight loss has continued as documented in facility weight records and is currently 105#—down 12% in past 6 months with steady consistent loss monthly. In the past resident and family have rejected enteral support. IDT will once again discuss at upcoming care conference.

# CLEAR DOCUMENTATION—CONT.

- Labs show slightly elevated BUN possibly related to diminished fluid intake, low albumin and normal electrolytes. Presently we are unable to meet the resident's calculated needs for food and fluid intake due to the personal choice of the resident even though we are providing the resident's favorite foods and purchase meals from the resident's favorite restaurant. We will continue to work with the resident and trial other calorie dense foods/fluids and supplements hoping to identify something she will accept. Present care plan goals for weight stability not met.

# CLEAR DOCUMENTATION—CONT.

- Care Plan Note: The family states understanding and wishes no aggressive nutrition support, consistent with signed advance directives. Family was updated on condition at care plan meeting today (1/15/2021). The physician has been notified via fax on 1/15/2021 after meeting with the resident, resident's representative, family and IDT including social worker, CNA, Nurse Mentor and this registered dietitian. Fax from physician returned with no change in orders

# HEADING OFF LEGAL CLAIMS

- Identification
  - All staff must be proactive
  - Staff must be made aware of incidents that would indicate the presence of or potential for a legally sensitive problem

# HEADING OFF LEGAL CLAIMS

- Investigation
  - Should be done immediately
  - Consult with legal council on how the system should be set up as a quality assurance project—may need to use liability insurance company's legal counsel or claims representatives to direct the investigation

# HEADING OFF LEGAL CLAIMS

- Intervention
  - First proactive approach is to *listen*
    - Resident or family will tell you what they are unhappy about
  - Once you know, can tailor your response to the problem
  - If start talking without the entire story, may give them extra ammunition

# Heading off legal claims

- Know State and Federal Rules & Regulations
- Identify Patients at risk
- Hold Nutrition at Risk Meetings w/minutes
- RD Referral policies are a must to avoid litigation
- Immediate assessment by RD on high risk admissions-  
fax or tele-dietetics (24-72 hours)

# HEADING OFF LEGAL CLAIMS

- Relationship with facility
- MNT Protocols
- Standing Orders
- Policy on Referrals
- Strong policies and procedures related to advance directives that address aggressive measures such as feeding tubes

# HEADING OFF LEGAL CLAIMS

- Strong patient/resident weight management program
- Documented thorough review of drugs by nursing/pharmacist/dietitian
- Agreement of all disciplines
- Thorough documentation of EVERYTHING that is done on behalf of the patient/resident with revisions made to the plan of care, as needed

# HEADING OFF LEGAL CLAIMS, CONT.

- Having excellent listening skills, being empathetic, being trusted and respected by the family
- NOT BEING DEFENSIVE

Meal rounds, monitoring systems  
accurate weighing and good communication  
with nursing, physician, family and the CDM  
and/or RD prevent lawsuits.

PR ,Customer Service, and Good  
Communication.

Appetizing hot food & friendly  
service go a long way.

**DECREASE LAWSUITS!!!**

# PROTECT YOURSELF

- Keep professionally current
- Use and expand available resources
- “Highest Practicable” Workplace
- Supervise Actively
- Establish standards of excellence
- Understand corporate philosophy

# PROTECT YOURSELF

- Follow professional standards of practice
- Don't tolerate illegal behaviors or acts
- What does community say?
- Practice survey management
- Keep staff trained and updated
- Abide by the care plan/resident's or patient's rights/advance directives

Minimize potential for legal action by:

- Understanding your role in patient or resident care
- Appropriate charting/documentation
- Teamwork among the disciplines
- REMEMBER: *every individual employee* has the power to determine the level of customer satisfaction in the facility

# FAMILIES THAT GET GREAT SERVICE DON'T SUE

- “Today when I visited the nursing home I dealt with:”
  - Kind, caring, compassionate staff
  - Staff that showed sincere concerns and empathy
  - A staff of team players
  - Staff that communicated information so I could understand what was really going on
  - Staff that were professional not only in presentation of information but in appearance
  - Staff who advocated for my family member