The Journal of

# Legal Nurse Consulting

Volume 25 ▲ Number 2 ▲ Summer 2014


- ▲ Geriatric Syndromes and Their Implications for Nursing
- ▲ Clinical Evaluation of Swallowing Function for Institutionalized Elderly: Balancing the Scales for Safety and Quality of Life
- ▲ Resident and Patient Elopements: An Overview of Legal Issues and Trends
- ▲ Falls and Fall Prevention in Older Adults
- ▲ Legal Issues Involved in "Do Not Resuscitate" Orders
- ▲ Nursing Home Medical Record Standards

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# *The Journal of Legal Nurse Consulting*

## Purpose

The purpose of The Journal is to promote legal nurse consulting within the medicallegal community; to provide novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

## Manuscript Submission

The Journal accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org. Please see the next page for Information for Authors before submitting.

## Manuscript Review Process

We send all submissions blinded to peer reviewers and return their blinded suggestions to the author. The final version may have minor editing for form and authors will have final approval before publication. Acceptance is based on the quality of the material and its importance to the audience.

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# Submission Guidelines

The *Journal of Legal Nurse Consulting (JLNC)*, a refereed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). We invite interested nurses and allied professionals to submit article queries or manuscripts that educate and inform our readership about current practice methods, professional development, and the promotion of legal nurse consulting within the medical-legal community. Manuscript submissions are blinded for peer review; peer review author feedback is aggregated and blinded.

We particularly encourage first-time authors to submit manuscripts. The editor will provide writing and conceptual assistance as needed.

Please follow these instructions for articles submitted for consideration.

## Instructions for Text

- Manuscript length: 1500 – 4000 words
- Use Word© format only (.doc or .docx)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Use Times New Roman 12 point
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for peer review
- Text: Use APA style (Publication Manual of the American Psychological Association, 6th edition) (https://owl.english.purdue.edu/owl/resource/560/01/)
- Legal citations: Use The Bluebook: A Uniform System of Citation (15th ed.), Cambridge, MA: The Harvard Law Review Association
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

## Instructions for Art, Figures, Tables, Links

- All photos, figures, and artwork should be in JPG or PDF format (JPG preferred for photos). Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi
- Each table, figure, photo, or art must be submitted as a separate file attachment, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common comorbidities in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)
- Live links are encouraged. Please be sure they are functional and include the full URL for each.

## Instructions for Permissions

The author must accompany the submission with written release from:

- Any recognizable identified facility or patient/client, for the use of their name or image
- Any recognizable person in a photograph, for unrestricted use of the image
- Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc.
- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.

## General information

Acceptance will be based on the importance of the material for the audience and the quality of the material, and cannot be guaranteed.

All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.

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*Patricia Brown-O'Hara, RN PhD*

Geriatric syndromes are common clinical conditions that do not fit into specific disease categories but have substantial costly and quality of life implications for functionality and life satisfaction in older adults. A focus on geriatric nursing competence, with emphasis on the complexities of caring for older adults, is crucial in nursing practice. Understanding the unique features of common health conditions in older people is essential. In evaluating geriatric cases, the Legal Nurse Consultant must be aware and knowledgeable about the issues and relevant clinical recommendations based on evidence-based best practice.

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*Gary H. McCullough, Ph.D., CCC-SLP and Kim C. McCullough, Ph.D., CCC-SLP*

The clinical swallowing examination (CSE), or clinical/bedside examination, is administered by a certified speech-language pathologist. It is often confused with a "dysphagia screen," and its utility for assessing and treating individuals with swallowing impairment is poorly understood. The CSE is a critical assessment of cognitive and functional abilities in the context of oral feeding and swallowing. With increasing emphasis on patient preferences, oral intake, health status, and quality of life in institutionalized elderly, the CSE's role in comprehensive assessment of swallowing is particularly valuable. Other instrumentation methods of assessment are briefly described.

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*Paul David Meek MA, BSN, BEd, RN, CEN, CEM, CLNC*

When the National Institute for Elopement Prevention and Resolution was founded in 2001, literature was limited on the issue of resident or patient elopement. Elopement is self-reported and it is hard to get accurate information on its prevalence. Smith (2012), points to the International Association for Healthcare Security and Safety's 2009 membership survey on elopement incidents. Of the member facilities, 11% reported no elopements, 70% reported from one to fifty elopements, and 10% reported between 50 and 300 elopements for the year. As a legal issue, elopement affects long term care, assisted living communities, hospitals, inpatient rehabilitation centers, inpatient mental health hospitals, inpatient drug and alcohol treatment centers, and adult day care facilities. To provide effective support to these cases, Legal Nurse Consultants must be knowledgeable in the specifics and details of elopement.

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*Elizabeth Hill, RN, PhD, Hill Nurse Consulting, LLC and Lynn A. Fauerbach, RN, MSN, LTAC*

Patient falls have a tremendous financial effect on our healthcare system resulting from increased healthcare needs and decreased reimbursement issued by insurers. More important is the devastating effect falls with serious injuries inflict on patients and their families. With increased focus on falls and fall prevention in our healthcare and legal system, it is important to know the various definitions of what constitutes a "fall," as these depend on the setting and the corresponding regulatory body. Although the definitions are similar, considerable weight is given to interpretation. Great emphasis is placed on fall assessment tools, reflected by the number available to identify those at highest risk. Post-fall huddle tools are also available to identify system failures and areas for additional prevention strategies. Clinicians should use one that best fits the facility. Knowing about various types of falls helps nurses identify and implement the most effective, patient-specific fall prevention strategies. Education incorporating members of the expert interdisciplinary team and including proper fall risk assessment tool training.

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*Ann M. Peterson, EdD, MSN, RN, FNP-BC, LNCC*
The medical record provides an important means of communication with other providers involved in a resident's care, and whether an electronic or paper record, must be maintained according to applicable regulations and standards. Liability may be incurred as a result of a nurse's failure to adhere to standards of practice. Professional standards, regulatory demands, and the ever-increasing volume of litigation mandate accurate, timely, and comprehensive documentation. This article reviews federal and state regulations, professional standards and facility policies that set the criteria nurses need to be familiar with to avoiding liability when documenting in nursing home medical records. Issues in liability and components of litigation are also reviewed.

**Nursing Home Medical Records: Part 2: Documentation Review ........ 42**
*Ann M. Peterson, EdD, MSN, RN, FNP-BC, LNCC*
The medical record provides an important means of communication with other providers involved in a resident's care. Nurses are responsible and accountable to properly assess and monitor a resident and institute appropriate treatments and precautions, to document and report/communicate pertinent information, to perform nursing procedures correctly, and to report known deviations from practice. This article reviews the importance of the adhering to documentation criteria in the medical record in nursing home litigation cases.

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# Editor's Note

Greetings, and welcome to the July 2014 issue of the *Journal of Legal Nurse Consulting*. I'm honored that the AALNC Board has entrusted the *JLNC* to me, and am gratified and humbled by the great number of potential, novice, and seasoned legal nurses and others who have come together to bring you a new and, we think, improved publication.

The first thing I think you'll notice is a change in voice. Because we want our authors' expertise to come through loud and clear, we've made their communications even clearer. Articles will be more readable without sacrificing content or quality.

Many other professional publications find it's helpful to have each issue dedicated to a particular theme. Working with the Education Committee's last AALNC membership needs assessment survey, your editorial committee made choosing themes the first order of business, so now you'll be able to find a suite of articles with a common thread all in one place.

Electronic publication means we can give you live links to other resources. When you read the Journal online, you should be able to click on links and go directly to a cited source. If you print out a hard copy for later reference, you'll have the complete URLs.

We're also actively soliciting more graphics and photos to enliven the pages, including asking authors and advertisers to give you links to videos. You'll see more of this later.

We didn't have enough lead time for formatting changes in this issue, but the look of the Journal -- page size, layout, fonts, artwork, white space, and other design elements -- will change in the November issue to make our Journal more attractive and readable. We think you'll like it.

Look on the last page to see the topics we've planned for the next several issues. Of course, please feel free to send along comments, suggestions, ideas, and even artwork or photographs, anything you'd like to see included in any issue, to my email below. We look forward to making your Journal better and better.

All the best,

Wendie A. Howland

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# Letter from the President

Dear AALNC Members,

The AALNC Board of Directors is humbled by the opportunity to serve you and our wonderful association. Every day, the Board makes governance decisions based on AALNC's strategic plan to benefit our members, our association, and our specialty practice of legal nurse consulting.

Being a firm believer in open communication, accountability, and transparency, I have a goal of providing regular updates in the *JLNC* about the achievements and accomplishments we make towards reaching the strategic plan's goals.

AALNC's strategic plan has three main objectives:

1. Position AALNC as an industry leader
   a. By setting education standards and metrics
   b. By being the voice of the LNC community and research
   c. By improving visibility to the clinical nursing community
2. Improve visibility to the legal community
   a. By adjusting key communications, programs, and features to be "aligned" with the client view
   b. By developing relationships that are strategic and are a major leverage of AALNC assets
3. Develop a sound business model
   a. By using revenue generated from membership, educational programming, and other budget programs to develop and offer high-quality, innovative, competitively-priced educational products as well as other value-driven benefits and resources for legal nurse consultants.

In the two months following the 2014 Annual Education and Networking Forum, AALNC has:

1. Positioned AALNC as an industry leader
   - Received two year extension of our Provider Accreditation by the American Nurses Credentialing Center (ANCC) Commission on Accreditation
   - Exhibited at the American Association of Critical Care Nurses conference
   - Offered free "Virtual Job Fair" webinar as part of our ongoing quarterly free webinars series
   - Continued with our many other quality educational programming and initiatives, including webinars, case studies, *JLNC*, online LNC course, and LNCC© review course
2. Improved visibility to the legal community
   - Continued ongoing positions on:
     - ABA's Health Law Section's Nurses and Allied Health Professionals Taskforce
     - DRI's Nursing Home / Assisted Living Facility Litigation Seminar Steering Committee
     - DRI's Medical Liability and Health Care Law Seminar Steering Committee
3. Develop a sound business model
   - Exceeded budgeted revenue for the 2014 Forum
   - Invested funds to record and upload select Forum sessions for 24/7 access on AALNC's online store
   - Invested funds to increase the number of 2014 JLNC issues from two to three
   - Continued significant investment in overhauling the LNC online course
   - Offered orientation webinars for AALNC Committee Chairpersons and Committee members
   - Revised and updated AALNC Board of Directors Playbook and Policy Manual
   - Updated the AALNC Board self-evaluation tool

There are *many* other projects and initiatives underway, and I look forward to sharing those accomplishments with you in the near future.

Respectfully,

Julie Dickinson

**Julie Dickinson,** MBA, BSN, RN, LNCC
President, AALNC

# Geriatric Syndromes and Their Implications for Nursing

*Patricia Brown-O'Hara, RN PhD*

**KEY WORDS**
Geriatric Syndromes, Frailty, Frailty Syndrome

*Geriatric syndromes are common clinical conditions that do not fit into specific disease categories but have substantial costly and quality of life implications for functionality and life satisfaction in older adults. A focus on geriatric nursing competence, with emphasis on the complexities of caring for older adults, is crucial in nursing practice. Understanding the unique features of common health conditions in older people is essential. In evaluating geriatric cases, the Legal Nurse Consultant must be aware and knowledgeable about the issues and relevant clinical recommendations based on evidence-based best practice.*

## Introduction

According to the US Census Bureau projections, the population of adults age 65 and older will more than double between 2000 and 2030, growing from 35 million to more than 10 million (Ironside, Tagliareni, McLaughlin, King, & Mengel, 2010). Approximately 82% of older adults have at least one chronic disease and thus have become central to the business of health care. The over-85 age group is the fastest-growing, projected to double in size between 1995 and 2030 and increasing fivefold by 2050. These startling numbers will drive dramatic changes in health care and society. Geriatricians have adopted and embraced the term "geriatric syndrome" to capture those clinical conditions in older adults that do not fit into specific disease categories. Geriatric syndromes represent common serious conditions for older persons. These common conditions hold substantial implications for functionality and life satisfaction. Besides leading to increased mortality and disability, decreased financial and personal resources, and longer hospitalizations, these conditions can substantially diminish quality of life (Ironside et al., 2010). Health care providers find these syndromes in just about every older adult. This article will discuss geriatric syndromes and their effect. It will describe how to assess older adults for these syndromes and will direct nurses to appropriate resources.

## Geriatric Syndromes

According to the literature review, the five conditions most commonly considered geriatric syndromes are: pressure ulcers, incontinence, falls, functional decline and delirium. Malnutrition, eating and feeding problems, sleeping problems, dizziness and syncope and self-neglect have also been classified as geriatric syndromes (Inouye, Studenski, Tinetti, & Kuchel, 2007). The new "evolving" syndromes identified in the literature are sarcopenia (muscle atrophy, along with a reduction in muscle tissue and degeneration of the neuromuscular junction that contribute to functional decline), polyprovider, polypharmacy, pain, and frailty. Frailty syndrome (FS) is the most problematic expression of the elderly. It is defined as a "state of poor resolution to homeostasis after a stressor event and is a consequence of cumulative decline" (Clegg, Young, Iliffe, Rikkert, & Rockwood, p. 752). The stressor events that lead to frailty include falls, delirium, and decreased function, three of the top geriatric syndromes. Transition to a level of worse frailty is more common than improvement. More efficient methods need to be developed and used to detect and prevent frailty.

Most geriatric specialists agree with targeting the five most common conditions (pressure ulcers, incontinence, falls, functional decline, and delirium) and these new evolving syndromes for assessment, treatment, and prevention. The most evidence-based process to detect frailty and geriatric syndromes is a comprehensive geriatric assessment.

## Assessment

Geriatric syndromes are often defined by isolating the shared risk factors associated with them, including older age, cognitive impairment, functional impairment, and impaired mobility. Signs and symptoms of geriatric syndromes reflect the chief complaints of many patients seeking healthcare. Patients who do not receive successful treatment can consume an ever-increasing amount of resources, causing frustration among patients, caregivers, and healthcare providers. While searching for answers to their problems, older adults may change healthcare providers or specialists, visit various emergency departments and clinics, and have multiple hospitalizations (Inouye et al., 2007). Providers should perform a comprehensive assessment of geriatric syndromes on all older adults, especially in the case of the "old-old" adult, defined as aged 85 and over.

The Hartford Institute for Geriatric Nursing website, http://www.hartfordign.org/ offers many educational

resources for practicing nurses, nurse educators, nurse consultants, and nurse researchers on assessing and caring for older adults. The *Try This* and *How to Try This* series, available at http://www.hartfordign.org/practice/try_this/ offer more than thirty best-practice assessment tools for general nursing care of older adults, a dementia series, and a specialty practice series (see Table 1). These series are provided free through the Hartford Foundation and for many of the issues presented, offer video demonstrations on how to use these tools properly and effectively.

*The Fulmer SPICES: An Overall Assessment Tool for Older Adults*, a *Try This* tool, is an excellent beginning framework because it focuses on the six marker conditions which coincide with the five common conditions defined as geriatric syndromes. These six marker conditions are: **S**leep disturbances, **P**roblems with eating/feeding, **I**ncontinence, **C**onfusion, **E**vidence of falls and **S**kin breakdown. The SPICES tool is not intended to be all inclusive but rather can lead the nurse to critical areas for more in-depth assessment. The nurse can think of it as identifying nursing problems or diagnoses specific to the older adult, and then can develop a comprehensive care plan focusing in on these problems. The nurse can incorporate additional assessment tools as geriatric syndromes are identified. An identified geriatric syndrome with complex issues and coexisting acute and chronic conditions can pose a challenge to health care providers to treat and manage.

## Clinical Management

Evidenced-based practice is a framework for clinical practice that integrates the best available scientific evidence with clinician expertise and patient preferences and values to make decisions about health care (Capezuti, Zwicker, Mezey, Fulmer, Gray-Miceli, & Kluger, 2008). Clinicians should manage geriatric syndromes based on published research on best practice, using evidence-based geriatric nursing protocols for pressure ulcers, incontinence, falls, functional decline and delirium, because these reflect assessment and intervention strategies recommended by experts who have reviewed the evidence.

There are many resources available for advancing geriatric nursing with evidence-based geriatric nursing protocols: journal articles, textbooks, and on-line resources. A new framework, *Advancing Care Excellence for Seniors*, ACES, has evolved through a partnership of the National League for Nursing and Community College of Philadelphia with funding from the John A. Hartford Foundation, Laerdal Medical, and the Independence Foundation. The NLN website, (http://www.nln.org/facultyprograms/facultyresources/aces/) promotes ACES as essential nursing actions to improve quality of life for older adults, coordinate care, decrease care-giver stress and promote shared decision making.

Using ACES as a framework will guide nursing practice, nursing education and nursing research to deliver

### Table 1: *Try This* Assessment Tools

| Issue | Title |
|---|---|
| Issue 1: | SPICES: An Overall Assessment Tool of Older Adults |
| Issue 2: | Katz Index of Independence in Activities of Daily Living (ADL) |
| Issue 3.1: | Mental Status Assessment of Older Adults: The Mini-Cog |
| Issue 3.2: | Mental Status Assessment in Older Adults: Montreal Cognitive Assessment: MoCA Version 7.1 (Original Version) |
| Issue 4: | The Geriatric Depression Scale (GDS) |
| Issue 5: | Predicting Pressure Ulcer Risk |
| Issue 6.1: | The Pittsburgh Sleep Quality Index (PSQI) |
| Issue 6.2: | The Epworth Sleepiness Scale |
| Issue 7: | Assessing Pain in Older Adults |
| Issue 8: | Fall Risk Assessment |
| Issue 9: | Assessing Nutrition in Older Adults |
| Issue 10: | Sexuality Assessment for Older Adults |
| Issue 11.1: | Urinary Incontinence Assessment in Older Adults: Part 1 – Transient Urinary Incontinence |
| Issue 11.2: | Urinary Incontinence Assessment in Older Adults: Part II – Persistent Urinary Incontinence |
| Issue 12: | Hearing Screening in Older Adults |
| Issue 13: | Confusion Assessment Method (CAM) |
| Issue 14: | The Modified Caregiver Strain Index (CSI) |
| Issue 15: | Elder Mistreatment Assessment |
| Issue 16.1: | Beers' Criteria for Potentially Inappropriate Medication Use in the Elderly: Part I – 2002 Criteria Independent of Diagnoses or Conditions |
| Issue 16.2: | Beers' Criteria for Potentially Inappropriate Medication Use in the Elderly: Part II – 2002 Criteria Considering Diagnoses or Conditions |
| Issue 17: | Alcohol Use Screening and Assessment |
| Issue 18: | The Kayser-Jones Brief Oral Health Status Examination (BOHSE) |
| Issue 19: | Horowitz's Impact of Event Scale: An Assessment of Post Traumatic Stress in Older Adults |
| Issue 20: | Preventing Aspiration in Older Adults with Dysphagia |
| Issue 21: | Immunizations for the Older Adult |
| Issue 22: | Assessing Family Preferences for Participation in Care in Hospitalized Older Adults |
| Issue 23: | The Lawton Instrumental Activities of Daily Living (IADL) Scale |
| Issue 24: | The Hospital Admission Risk Profile (HARP) |
| Issue 25: | Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) |
| Issue 26: | The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults |
| Issue 27: | General Screening Recommendations for Chronic Disease and Risk |
| Issue 28: | Preparedness for Caregiving Scale |
| Issue 29: | Assessment of Fear of Falling in Older Adults: The Falls Efficacy Scale-International (FES-I) |
| Issue 30: | Assessment of Fatigue in Older Adults: The FACIT Fatigue Scale (Version 4) |
| Issue 31: | Reducing Functional Decline in Older Adults during Hospitalization: A Best Practice Approach |

Available at http://consultgerirn.org/resources/?tt_request=issue08.pdf

competent, individualized, humanistic care to older adults and will assist the legal nurse consultant (LNC) to analyze care. This framework looks at function and expectations first. Then the model helps clinicians plan care coordination and clinical management using evolving knowledge on geriatric syndromes and the special needs of older adults. The framework also gives the interdisciplinary team, patient, and family/caregivers ways to evaluate risks and benefits of care decisions. The team develops recommendations considering the older adult's wishes, expectations, resources, strengths and cultural traditions to treat geriatric syndromes safely and qualitatively, engage adoption of healthy behaviors, and promote improved quality of life. The ACES framework may help the LNC assess and analyze clinical decision and care appropriateness.

## Prevention

Preventing falls and skin breakdown, reducing adverse drug events, promoting oral health, and providing for adequate hydration can help prevent complications of geriatric syndromes. The literature identifies many proven preventive strategies for delirium, falls, and skin breakdown and translations into clinical practice and policy initiatives.

Assessing relative risk is the first step in a patient's plan of prevention. Failing to identify, diagnose, or treat underlying causes can adversely affect an older adult's health and longevity. Focusing on maintaining function, dignity, and individual control will promote health and quality of life.

Best practice exemplars of effective prevention programs use a strong geriatric nurse-centered interdisciplinary team approach to care for older adults. Research has shown that interdisciplinary teams have dramatically improved geriatric patient care and outcome. In the Institutes of Medicine's report, "Retooling for an aging America" (2008), interdisciplinary collaboration was identified as a vital part of caring for the aging population. The *Try This* website lists *The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults* as an assessment tool to identify patients at high risk for poor outcomes after hospitalization for acute or exacerbated chronic illness. Clinicians should discuss the implications of positive findings with the patient, caregiver, physician/other providers, and discharge planners. It is important that the discharge plan includes targeted interventions based on the evaluations, and further needs assessment at transitions to home, skilled nursing care, or other care settings. "Each of us must work together and be committed to provide a culture of safety that vulnerable older adults need in order to receive the safest evidence-based clinical care with optimal outcomes"(Capezuti et al., 2008).

## Conclusion

Every nurse clinician, nurse educator, and nurse researcher has a responsibility to be know that evolving knowledge of geriatrics and geriatric syndromes facilitates smart resource utilization, best practice and exciting opportunities for clinical research. Nurses armed with the knowledge of age-related changes, geriatric syndromes, and proper assessment tools can play a vital role in improving geriatric standards of practice.

Understanding the unique features of common health conditions in older people is essential for all health care personnel providers active in the care or consultation of elderly clients. Nurses can identify and implement many interventions proactively, thereby making a significant positive difference in improving outcomes. In reviewing medical-legal cases, the LNC must have knowledge of the pertinent issues and clinical recommendations to analyze liability and

**Table 2: Geriatric Resources**

| Source | Resources Available | Website |
|---|---|---|
| American Geriatric Society | Guidelines, clinical tools, and recommendations | http://www.americangeriatrics.org/heath_care_professionals/clinical_practice/clinical_guidelines_recommendations/ |
| Health in Aging | Educational material for patients and families | http://www.healthinaging.org/resources/resource:guide-to-geriatric-syndromes-part-i/ |
| Geriatric Care Online (subscription) | Clinical guidelines and recommendations | http://geriatricsareonline.org/?non-member=1 |
| NICHE (Nurses Improving Care for Healthsystem Elders) | "Solution series" for identifying problems and potential solutions | http://www.nicheprogram.org/niche_solutions_series |
| POGOe (Portal of Geriatric Online Education) | Geriatric educational materials, provides a source of evidence-based articles by topic, and a list of other geriatric resource | http://www.pogoe.org |
| The John Hartford Institute for Geriatric Nursing | Clinical resources/tools | http://consultgerirn.org/ |

damages. LNCs who recognize geriatric syndromes will be better-prepared to evaluate geriatric care cases if they know about evidence-based best practices for geriatrics, so they can educate attorney clients on the multiple factors that lead to geriatric syndromes and their effect on patient outcomes.

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# Clinical Evaluation of Swallowing Function for Institutionalized Elderly: Balancing the Scales for Safety and Quality of Life

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**KEY WORDS**
Deglutition, Deglutition Disorders, Clinical, Evaluation, Swallow, Swallowing

*The clinical swallowing examination (CSE), or clinical/bedside examination, is administered by a certified speech-language pathologist. It is often confused with a "dysphagia screen," and its utility for assessing and treating individuals with swallowing impairment is poorly understood. The CSE is a critical assessment of cognitive and functional abilities in the context of oral feeding and swallowing. With increasing emphasis on patient preferences, oral intake, health status, and quality of life in institutionalized elderly, the CSE's role in comprehensive assessment of swallowing is particularly valuable. Other instrumentation methods of assessment are briefly described.*

Aspirating food or liquid can lead to pneumonia and death (Ickenstein, Hohlig, Prosiegel et al., 2012). Ongoing inservice clinical education, comprehensive assessment, and interdisciplinary collaboration is particularly important for nurses and other providers to evaluate and treat swallowing disorders (dysphagia) (McCullough, Estes, McCullough, Rainey, 2007). Inappropriate or poorly-implemented interventions can result in dehydration, malnutrition, pneumonia, and even death (Holas, Halvorson, Reding, 1990). Balancing safety concerns, swallowing physiology, and aspiration with patient preferences and quality of life might lead to a clinical (bedside) swallowing evaluation to help define and implement appropriate care for a given individual. However, practitioners must understand when more information, i.e., an instrumental examination, is needed.

## Dysphagia

Swallowing is series of quick, precisely-timed movements that move food and liquid through the oropharynx into the esophagus to the stomach. Once a food or liquid bolus is formed in the mouth and squeezed toward the back with sequential lingual movements, sensations trigger the *pharyngeal swallowing response*, a rapid series of events that raises, closes, and protects the airway and propels the food or liquid through the pharynx and into the esophagus through a sphincter. Alternating muscular contractions in the esophagus move the bolus forward until it passes through another sphincter that opens to allow passage into the stomach (Kwiatek & Kahrilas, 2012).

Dysphagia, or deglution disorder, is a symptom, not a diagnosis (Suiter, Leder, & Karas, 2009). It is defined as any difficulty moving food or liquid from the mouth to the stomach (Logemann, 1998). It has also been described more specifically as an abnormality of bolus flow, where alterations in biomechanical movements or their timing or strength may cause food and liquid to either stop moving through the oropharynx and/or esophagus (residue) or be misdirected from its normal pathway through the vocal folds and into the airway (aspiration) (Rosenbek, Robbins, Roecker, Coyle, & Wood, 1996).

Causes of dysphagia can include, among other factors:

- Neurologic insult or disease
- Head and neck cancer
- Gastrointestinal disease
- Respiratory illness
- General systemic conditions

**Considerations with Aging**

Because the number of functional motor units and speed of neural transmission declines in the sixth, seventh, and eight decades of life, aging itself can increase risk of swallowing impairment (McCullough, Rosenbek, et al., 2007). The oropharyngeal musculature responds less efficiently, slowing bolus passage through the oropharynx and decreasing airway protection (McCullough et al., 2007). Weak oral musculature can lead to poor oral bolus control or manipulation, slowing oral transit. This may lead to food and liquid residue in the mouth and reduced oral intake (Logemann & Larsen, 2012). Aspiration risk increases from two mechanisms. First, pharyngeal swallow may be delayed, leaving the airway open as the bolus enters the pharynx. Second, unilateral or bilateral weak pharyngeal muscles can cause food or liquid to remain in the pharynx after the swallow, leading to post-swallow residue.

Aspiration pneumonia and even death (Ickenstien et al., 2012) sometimes overshadows other concerns. However, reduced ability to move food and liquid through the oropharynx can also lead to dehydration, weight loss, and malnourishment (Sura, Madhavan, et al., 2012). Such problems may subsequently lead to social isolation, fear of

choking, or other psychosocial or environmental problems, which may even more dramatically affect quality of life (Eslick & Talley, 2008).

### Incidence

Reports estimate that 7 to 10% of adults over the age of fifty have some degree of dysphagia; this increases to 14% over the age of 60 (Spieker, 2000; Agency for Health Care Policy and Research, 1999). Estimates of prevalence in hospitals are between 25-30% (Spieker, 2000). In nursing home residents, prevalence estimates vary, and can be as high as 75% (Spieker, 2000; Rosenvinge & Starke, 2005).

## Diagnostic Studies

There are three main studies for dysphagia evaluation. This article will briefly mention two, and look more closely at a third.

*Videofluoroscopic swallow study* (VFSS), also referred to as a modified barium swallow, is the gold standard for evaluation of swallowing (Martin-Harris & Jones, 2008). It provides a comprehensive assessment of swallowing function across all swallow stages. It is especially necessary for investigating esophageal function. It is, however, not available in most nursing facilities, requiring residents to be transported to another facility (e.g., hospital, outpatient surgery, freestanding diagnostic radiology) for the test.

*Fiberoptic endoscopic evaluation of swallowing* (FEES) (Langmore, 1988) is another method of instrumental assessment that can define bolus flow (i.e., aspiration or residue). FEES is portable and can be used in a long term care setting, as long as the practice is acceptable for speech-language pathologists in the state in which it is being employed (Hiss & Postma, 2003). However, it yields only limited information on swallowing physiology.

A *clinical (bedside) swallowing examination* (CSE), while the least specific method for determining swallowing physiology, is very important for functional assessment of feeding and swallowing ability. It also gives the examiner useful information on overall health status and quality of life related to oral intake. Since the examiner needs no special instrumentation to perform this widely available test, the clinical swallowing examination is an important part of evaluating institutionalized elderly in long-term care.

## Clinical Swallowing Evaluations in Detail

CSE is not a screen for dysphagia. A screen is a search for disease in a subclinical population (Sackett, 1996). Dysphagia screenings are often conducted in hospitals for certain diagnoses, such as stroke, and may be administered by nurses trained to perform them. However, it is not common practice for so-called "dysphagia screens" to be administered in long term care facilities. When a nurse or other healthcare provider suspects a patient may have swallowing impairment, a referral should be made to speech-language pathology for a CSE.

Clinical swallowing examinations typically consists of three sections: medical and historical information; oromotor/laryngeal function assessment; and trial swallows.

### Medical and Historical Information

Some of the most important applicable medical/historical diagnoses and problems in the medical and nursing documentation include:

- Multiple medical diagnoses
- Multiple medications
- Respiratory compromise
- Surgeries affecting head and neck
- Reduced cognition or alertness
- Poor nutritional status
- Poor functional status, including inability to care for self, feed self, and clean teeth/mouth

Research suggests multiple diagnoses, polypharmacy, and history of head and neck or respiratory surgery increase the risk of aspiration pneumonia significantly (Skarupski, Park, & Fries, 2002; Pace & McCullough, 2010). Lower functional status, including dependency for feeding and dependency for oral care, has been reported to be significantly associated with the development of aspiration pneumonia (Langmore et al., 2002). Pace and McCullough (2010) reviewed the relationship between oral hygiene and pneumonia and provided recommended instructions for nursing home staff and an oral care checklist. Cognitive impairment is often under-identified, affects care, and increases risk for adverse health outcomes (Boutani, et al., 2010). It is estimated that approximately 16 percent of older individuals may meet the diagnostic criteria for mild cognitive impairment (MCI) (Petersen et al., 2010) which can affect adherence to swallowing precautions and compensatory strategies. This can place them at greater risk for poor outcomes, including malnutrition (Orsitto et al., 2009).

Generally, if a patient has no history of respiratory disease, normal nutritional lab values, adequate oral hygiene, and is able to feed and care for himself, he is far less likely to develop negative endpoints than an individual with COPD and poor oral hygiene who is feeding dependent and has decreased mental status.

### Physical Examination

The physical examination begins when the clinician enters the patient's room to make observations regarding the three major concerns in a CSE: mental status, nutritional status, and respiratory status. These may or may not concur with historical information gathered in the medical record.

It is important to assess both structure and function during the physical exam. Structures at rest may provide visual clues to underlying physiologic or neurologic pathologies, such as lower motor neuron flaccidity. Likewise, movement of structures yields information regarding strength and speed of critical aspects to swallowing and involvement of specific cranial nerves. Table 1, "Major clinical measures to assess in physical exam and trial swallows," provides a list of the

cranial nerves and sensorimotor sites for assessment along with appropriate physical aspects to examine (McCullough & Martino, 2012). Most of these measures can be made with inexpensive observational ratings.

Instrumental measures provide more objective ratings in some cases. Lingual strength, for example, can be measured with the Iowa Oral Performance Instrument (IOPI) (Lazarus, Logemann, et al., 2003; Yeates, Mofenter, & Steele, 2008) and, more recently, the Madison Oral Strength Training device (MOST) (Hewitt et al., 2008). More research is necessary to determine the value of such instruments for use in CSE.

The importance of adequate oral care has already been discussed. During the physical exam, the clinician should note the number of decayed teeth and evidence of consistent or inconsistent toral hygiene (Pace & McCullough, 2010). The clinician should note tongue condition, looking for the milky white patches characteristic of thrush, a common fungal infection, which could lead to oral pain (Groher & Crary, 2010). Xerostomia (dry mouth) can impair taste and swallowing function; saliva quality and production should be noted (Chasen & Bhargava, 2009; Murphy et al., 2010).

Other examination components exhibit variable levels of reliability. The role of assessing gag reflex (cranial nerves (CN) IX and X) has been and remains controversial (McCullough et al., 2005). Logemann, Veis, and Colangelo (1999), reported observation of pharyngeal wall contraction on gag as a good sign of pharyngeal function for swallowing. However, pharyngeal sensation may be more accurately measured by perception of left/right discriminative touch (Davis, Kidd, et al., 1995). No additional studies have addressed this clinical measure. Observational measures of laryngeal function (CN X), volitional cough, and voice quality rating have also received mixed reviews in the literature (Daniels et al., 2000; McCullough, Wertz & Rosenbek, 2001; McCullough et al., 2005).

### Trial Swallows

Different studies and protocols for CSEs recommend various volumes and consistencies for testing. Different consistencies are considered standard and necessary; small and larger boluses of thin liquid, puree, pudding, and solid should be tried unless the examining clinician observes signs of impairment that indicate increased risk over possible benefit (Daniels, et al., 2009). If no signs of impairment are noted with 1-20cc boluses, clinicians may test the patient with multiple swallows, such as a 3-ounce swallow test (Suiter et al., 2009; Leder, Suiter, Warner, & Kaplan, 2011).

While administering trial swallows, the clinician should evaluate several important measures (Table 1). A wet or gurgly voice before or after a swallow (Daniels et al., 2000; McCullough et al., 2001, McCullough et al., 2005) may indicate laryngeal penetration or aspiration (McCullough et al., 2001; Schroeder, Daniels, McClain, Corey & Foundas, 2006). Because aspiration may be silent, however, assessing for the presence or absence of a cough reflex appears to provide limited information unless accompanied by other signs of impairment,.

**Table 1. Major clinical measures to assess in physical exam and trial swallows**

| | |
|---|---|
| **Initial Observations** | |
| Posture:<br>upright/able to sit upright | Respiratory:<br>Tracheostomy tube/ventilator<br>Pattern of respiration<br>Monitor: Rate & Sp02 |
| Nutritional:<br>Presence of feeding tube<br>Type of feeding tube | Mental Status:<br>Alertness<br>Cooperation<br>Communication<br>Orientation |
| **Structural/Cranial Nerve Assessment** | |
| CN V | Jaw mobility<br>Strength open/close against resistance |
| CN VII | Lips purse/retract<br>Raise eyebrows |
| CN IX/CN X | Gag reflex (pharyngeal strength)<br>Cough strength<br>Cough quality—wet/dry<br>Voice—sustΩained phonation/speech |
| CN XII | Tongue mobility<br>Strength—protrude/lateralize against resistance<br>Pressure—IOPI, MOST, Other Devices |
| **Oral hygiene/dentition**: Note oral care, number of decayed teeth.<br>**Structural**: Note for all above structural appearance, muscle tone & laterality of deviations<br>**Sensation**: All structures can be grossly assessed with cotton-tip applicator (left/right discrimination). | |
| **Trial Swallows (varying bolus size & consistency)** | |
| Oral Stage | Buccal and labial bolus hold in oral cavity<br>Rotary chewing efficiency<br>Post swallow bolus clearance<br>Oral transit time estimate |
| Pharyngeal Stage | Laryngeal palpation<br>Timing/Completeness/Number of swallows<br>Pre—Post Voice Quality<br>Coughing/Clearing |
| Additional Observations (often best with meal) | Need for assistance<br>Effects of compensations<br>Amount of nutritional intake |

*Adapted from McCullough & Martino, 2013*

The larynx should be palpated for swallow timing and completeness, as well as the number of swallows. This can be accomplished by placing the index finger on the thyroid notch and remaining fingers on the thyroid cartilage (Groher & Crary, 2010) or by using the four-finger method, where the index finger is placed submentally, the middle finger is placed on the hyoid, and the last two fingers are placed on the superior and inferior borders of the thyroid cartilage

(Logemann, 1998). Poor laryngeal elevation on palpation may indicate reduced laryngeal elevation and closure, especially when it occurs with other signs of dysphagia.

If the clinician observes signs of dysphagia during trial swallows, it may be necessary to attempt to manipulate the bolus or have the patient make postural and behavioral adjustments. This is particularly true if signs of dysphagia are borderline, overall health status is good, risks are low, and instrumental assessment is difficult to obtain. Many compensatory strategies (e.g., thickening liquids, tucking the chin, turning the head) can be attempted, but improvements may only be observed correctly if clinical signs are readily and accurately assessable. If such strategies do not obviously improve the passage of the bolus, their utility is minimal.

## Implications for Skilled Nursing Facilities

Since aspiration pneumonia is more common in elders, dysphagia assessment for elderly individuals has focused heavily on aspiration and its prevention. As noted above, instrumental examinations are more useful for defining swallowing physiology and are necessary to define the occurrence of bolus flow abnormalities, i.e., aspiration and residue. According to the Center for Medicare and Medicaid Services (CMS), instrumental examination is not necessary when dysphagia is not suspected on CSE (CMS, 2010). CMS does not comment on the necessity of instrumental examination when dysphagia is suspected but physiological information may or may not be needed.

With growing evidence that aspiration pneumonia is related to more than just the presence or absence of aspiration (Langmore et al., 2002; McCullough & Pace, 2010), multidisciplinary professionals have started to decrease focus on aspiration and increase attention on overall health status, functional ability, and patient preferences. For example, oral hygiene, ability to care for one's teeth, and ability to feed oneself are all more predictive of aspiration pneumonia than aspiration per se (Langmore et al., 2002). Knowing this may, in some instances, reduce (but not eliminate) instrumentation. CSE and well-defined physiological assessment provide the most comprehensive information regarding swallowing ability and risk for dysphagia-related complications.

Clinicians need assessments that define an individual's swallow physiology to make appropriate recommendations for rehabilitation, as exercises are based on physiology. However, there are times when such recommendations aren't necessary. For patients who doesn't swallow at all, who won't be able to do exercises, or who have advanced dementia, evidence suggests little benefit with assessment or intervention. Sometimes an individual may simply choose to eat what he wants regardless of the situation. The individual's wishes, when it is able to determine them, should guide assessment and treatment, or the lack thereof.

### Patient Preference

A recent publication entitled "New Dining Practice Standards" by the Pioneer Network Food and Dining Practices Task Force (2011) gives clinical guidelines that suggest redirecting attention away from some of the more traditional measures of physiologic impairment and towards measures of overall health and nutritional status. They particularly emphasize patient preferences, functional abilities, and quality of life, all measures which exist under the umbrella of a comprehensive CSE (McCullough et al., 2005). This document does not suggest an end to physiologic assessment, monitoring oral intake, or special diets. It does suggest ongoing comprehensive evaluation of health status and erring on the side of patient preference. Thus, patients who enter with a recommendation for a dysphagia-related pureed diet may choose from a list of softer natural foods instead.

This is not a new idea. In 1990, Curran and Groher presented an aspiration risk reduction diet with natural foods that would, potentially, prevent the need for radical changes in food consistency or alternative alimentation (e.g., tube feeding). A separate article by Groher (1990) emphasized the importance of patient rights and a comprehensive risk/benefit analysis for alternative alimentation, as well as a sound understanding of legal decisions surrounding the practice. Subsequent evidence-based review (Rimon, Kagansky, & Levy, 2005) supports his forward-thinking precautions, indicating that no published studies supported the hypothesis that tube feedings reduce the risk of aspiration pneumonia, decrease muscle wasting, or improve function or comfort.

The New Dining Practice Standards state, "Swallowing abnormalities … do not necessarily require modified diet and fluid textures, especially if these restrictions adversely affect food and fluid intake (p.22)." Interventions that focused only on redirecting and improving bolus flow can lead to outcomes worse than the dysphagia itself. Elderly patients with difficulty chewing food or moving solids through the oropharynx may be placed on pureed diets, which coupled with decreased smell and taste and alterations in thirst and appetite may lead to inadequate nutrition, leading in turn to further deterioration in muscle function and wasting, exacerbating the very problem being treated. Thickening liquids may slow liquid boluses and allow the larynx time to close and decrease the risk of aspiration, but they are poorly tolerated, with reports of nonadherence as high as 80% (Colodny, 2005). This may lead to dehydration and worse health consequences. These interventions can also greatly decrease quality of life, the pleasure of enjoying chosen foods and drink in the last months and years of life, and socialization at mealtimes and special activities.

The speech-language pathologist's job is often to provide a comprehensive clinical and instrumental assessment and provide evidence-based interventions. However, the speech-language pathologist's job may, in other instances, need to focus more on modest clinical adjustments at bedside, close collaboration with dieticians and nurses to determine the most comfortable and acceptable consistencies for chewing and swallowing, and making recommendations for reducing the risk of aspiration pneumonia. The clinical swallowing examination, administered by a well-qualified, certified

speech-language pathologist, may meet these objectives handily, and perhaps avoid instrumental assessment.

**Recommendations for futher care**

An individual, in or out of a care facility, who has good oral hygiene, no history of respiratory compromise, and the ability to follow instructions and adhere to recommendations may be able to consume a regular or modestly altered diet with minimal risk. If this person has good cognition, simple behaviors can sometimes facilitate improved swallowing. The cognitively intact individual may choose to accept the inevitable risks over the possibility of further limitations on quality of life. Monitoring by patient care staff over time would be essential, as would continued best practices, including proper oral care, proper positioning and feeding, and ongoing assessment of amount of food and liquid consumed, nutritional lab values, and overall health status.

## Legal and Ethical Considerations

Malpractice in therapy professions has been defined as "… the illegal, negligent, or improper professional evaluation or treatment of a patient, where the health care professional failed to follow current, general, and accepted standards of professional conduct, and to the detriment or injury of the patient" (Tanner, 2009, p. 21). Besides their ethical obligations, nursing home professionals have a legal obligation to provide care that is grounded in best practice and considers both safety and quality of life.

Sometime CSE is sufficient to understand an individual's dysphagia issues, and sometimes an instrumental assessment is necessary. Unfortunately, few and conflicting data define the critical variables to guide such decisions. If legal issues arise in a case of malpractice, the question to be asked is, "Given the same information about this dysphagic patient, would a reasonably competent and proficient clinician practicing at or above current accepted professional standards have reached the same conclusion and acted similarly?" (Tanner, 2009, p. 5)

The competent clinician should consider this question when choosing assessment methods and interventions, and ensure that the information is sufficient information. Will physiologic assessments serve to restrict intake unnecessarily or guide it more effectively? Outcomes depend on individual competency of clinician and staff who will interpret the information and implement the plan.

Recommendations made, even when appropriate, must have a collaborative plan for intervention that caregivers can implement. Poor communication, inadequate staffing, and lack of time are not acceptable excuses for improper care. All caregivers, including the individual and family members, must understand ongoing risks, identify problems immediately, and be ready to reassess and alter plans promptly.

Documentation is essential for ethical and legal reasons. Oral hygiene care, for example, should be well-documented. Institutions without good written protocols for oral hygiene and proper documentation should be more vigilant about liquid restrictions when aspiration is known to occur. If an individual must be fed rapidly, the likelihood of dysphagia-related complications rises regardless of assessment or recommendations.

The multidisciplinary team must be aware of new reseach findings that will improve care for the elderly at risk for dysphagia. They must review and update protocols and individualized plans of care regularly, taking into account the capabilities and environment of the institution as well as individuals' overall health status. Plans of care should be developed, when possible, with input from the individual and family, deferring to their concerns and desires when reasonable and possible.

## Summary

Elderly individuals deserve the best quality of life they can obtain, including the right to make choices when they are cognitively able. It is critical for clinicians to provide individuals and their caregivers a comprehensive assessment of feeding and swallowing abilities to enable them to make informed choices. CSE may be sufficient when administered by a highly qualified speech-language pathologist, providing information on the impact of cognition and physical function on deglutition in a way that no other examination can. When family and clinicians face difficult decisions, instrumentation gives specific information on bolus flow critical for understanding risks associated with eating and drinking to define risks and benefits more clearly.

Even when moderate to severe dysphagia is discovered, decisions must be made collectively by a qualified multidisciplinary team working with the individuals, when possible, and caregivers. Whether such information is needed to establish the proper plan of care may not be clear. What should be clear, however, is that knowledge and patient-centered care are not mutually exclusive in the hands of intelligent, conscientious, and passionate healthcare providers. Comprehensive documentation and effective communication with individuals, family, and all providers will improve the likelihood that individuals will experience minimal risks to health and well-being and the best possible quality of life.

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# Resident and Patient Elopements: An Overview of Legal Issues and Trends

*Paul David Meek MA, BSN, BEd, RN, CEN, CEM, CLNC*

**KEY WORDS**
Elopement, Wandering

*When the National Institute for Elopement Prevention and Resolution was founded in 2001, literature was limited on the issue of resident or patient elopement. Elopement is self-reported and it is hard to get accurate information on its prevalence. Smith (2012), points to the International Association for Healthcare Security and Safety's 2009 membership survey on elopement incidents. Of the member facilities, 11% reported no elopements, 70% reported from one to fifty elopements, and 10% reported between 50 and 300 elopements for the year. As a legal issue, elopement affects long term care, assisted living communities, hospitals, inpatient rehabilitation centers, inpatient mental health hospitals, inpatient drug and alcohol treatment centers, and adult day care facilities. To provide effective support to these cases, Legal Nurse Consultants must be knowledgeable in the specifics and details of elopement.*

The National Institute for Elopement Prevention and Resolution was founded in 2001 to develop and provide education to healthcare facilities about resident or patient elopement. At the time, the literature contained little information on this issue. Aud (2004) stated: "While wandering has been the focus of numerous research projects, research on wandering away (elopement), its causes, characteristics, outcomes, and prevention is scant"(p. 363). Though this work stated that little research had been published at that time, long term care and assisted living facilities were already seeing increasing litigation and dealing with increasing immediate jeopardy citations from the Centers for Medicare and Medicaid Services (CMS).

Late 1990s and early 2000s literature addressed elopement under *wandering* issues. However, we now know that the resident or patient who voices a desire to leave the facility or who sits near a secured door and attempts to leave when it is opened is displaying *exit-seeking behaviors*. These actions place them at a higher risk for elopement than a wandering resident/patient. This insight led to many architectural and technological changes in long term and acute care in an attempt to reduce elopements.

The (2014) Joint Commission's list of top 20 sentinel events has included elopement since 2001. In June 2011, the (2014) National Quality Forum (NQF) classified elopement in their list of serious reportable events (SREs) under patient protection events. Facilities self-report elopement incidents, making it hard to get reliable information on prevalence. Smith (2012) points to the International Association for Healthcare Security and Safety's 2009 membership survey on elopement incidents: of the member facilities, 11% reported no elopements, 70% reported from one to fifty elopements, and 10% reported between 50 and 300 elopements for the year. Bennet (2008) adds: "Ten percent of all lawsuits involving nursing homes deal with elopement. Seventy percent of these lawsuits involve the death of a resident, and in eighty percent of cases the resident experienced prior incidents of elopement or attempted elopements" (p. 54).

As a legal issue, elopement affects long term care and assisted living facilities, hospitals, inpatient rehabilitation centers, inpatient mental health hospitals, inpatient drug and alcohol treatment centers, and adult day care facilities.

## Defining Elopement

The lack of a universal definition of elopement is a significant issue during litigation. Why? This is an essential question that should have a simple answer, but does not.

Merriam-Webster (2014) defines elopement as, "to slip away, escape." The National Institute for Elopement Prevention and Resolution defines elopement as, "when a patient or resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired wanders away, walks away, runs away, escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge"(Meek, 2014, p. 9). Interestingly, CMS does not define elopement in their regulations, as demonstrated in multiple searches of the CMS website at www.cms.gov/ and publications since 2001 (including the *CMS Risk Management Handbook Volume I Chapter 10 CMS Risk Management Terms, Definitions, and Acronyms 1.1.5E*).

Nursing home surveyors use a combination of *CMS regulations including the State Operations Manual Appendix PP — Guidance to Surveyors for Long Term Care Facilities* at the Tag F323 to determine if elopement occurred and to determine if it rises to the level of immediate jeopardy that will result in a civil monetary penalty (CMP). The CMS 2007 update added the following information that appears to give a definition for elopement in nursing homes:

> Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e.,

> an order for discharge or leave of absence) and/or any necessary supervision to do so. … A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident (p. 289).

This part of *Appendix PP* references a published paper and provides an internet address which states this document is not available. A paper by the same author with a similar title was located on a different site where Bolts (2003) discussed elopement (combining wandering and elopement together) and focused on litigation issues. The 2007 update also added 4 separate "severity levels." Level 2 is defined as:

> Unsafe wandering and/or elopement, which resulted in no more than minimal harm because the facility had additional established measure(s) or practice(s) that limited the resident's exposure to hazards. For example, a resident with Alzheimer's disease left the locked unit and was quickly found unharmed on another unit, and the building was considered a safe environment, as there was no way for the resident to leave the building (p. 309).

This statement appears to suggest that a resident who was able to leave a secured unit would not be able to leave the unsecured building. Yet residents have been found dead inside or on the roof of facilities and hospitals.

The *CMS State Operations Manual Appendix A* does not mention elopement specifically, and gives no definition for it. It states only, "The hospital must protect vulnerable patients, including newborns and children."(p. 100)

Though The Joint Commission does track elopement, its website failed to provide a definition for it. According to their website statistics for 2012, elopement number 17 of the 28 sentinel events listed (2014).

## Criminal and Administrative Cases

Elopement incidents rarely result in criminal charges, though it can and does happen. Lash (2007) reported in the Pittsburg Post-Gazette that on February 9, 2007 an Allegheny County Common Pleas Court jury found the nursing home administrator guilty of neglect of a care-dependent person, involuntary manslaughter and reckless endangerment. In this case Lash (2007) reports the 88 year-old female died "after being trapped overnight in a locked outdoor courtyard at the nursing home"(p. 1). The charges came after it was discovered that the defendant and other staff had brought her body back indoors, washed it, and placed it in her assigned bed. The family was then told that she had died peacefully in her sleep.

In Commonwealth v. Life Care Centers (2010), the Supreme Court of Massachusetts overturned a conviction of involuntary manslaughter against the nursing home's parent company for an elopement resulting in the death of a resident. They concluded:

> An avoidable series of failures within the system resulted in this resident, a dementia patient, wheeling herself out the front door, falling down the front steps and being killed. No single error or omission or the actions of a single nursing home staff member can be singled out to as the reason this happened. The prosecution wants to aggregate all the separate errors and omissions which occurred into a single indictment of involuntary manslaughter committed by the nursing home's parent corporation, but that is not a valid legal premise.(p. 1)

If the court had upheld the lower court rulings, questions would have then arisen as to whom in the parent corporation would serve any sentence handed down by the court.

Administrative elopement cases involve disputes between facilities and CMS regarding the CMP imposed for a documented deficiency. These penalties can be quite large, as they can be assessed daily going back to the first day of the documented deficiency (CMS, 2014). When a facility has an elopement, the management is required to report it to the state regulating agency. When the surveyors investigate, they look back for previous elopements; these are not limited to the reported incident. Furthermore, if they identify documentation of an elopement prior to the date of the reported elopement, the CMP fine is assessed daily from the date of the earliest elopement found (CMS, 2014). In the author's experience, these CMPs have exceeded one million dollars; many were appealed first to CMS then brought before an administrative judge.

## Elopement Litigation Issues

In litigation about a resident/patient elopement, the court must consider many different factors. Are all elopements preventable? The large CMPs imposed by CMS and defenses' lack of success in getting the Administrative Courts to reduce them gives the impression that the healthcare regulatory system believes that all elopements are preventable.

What does the jury think? Boltz (2003) states: "When the family elects to place a loved one in an assisted living or nursing home, they usually assume that their family member is now safe" (p. 1). In Estate of Hollon v. Brookwood Medical Center (2007), a jury in Alabama awarded survivors $12,000,000 when a patient eloped, climbing the hospital's 12-foot high fence and ultimately falling to his death. It appears that this jury believed that all elopements are preventable.

## Can all elopements be prevented?

Elopement prevention is a challenge in healthcare facilities. They must maintain a therapeutic environment in the least restrictive means possible, but they must also provide a safe environment. Defending a health care facility against elopement litigation can be challenging especially when a facility is cited for deficiencies associated with the litigated elopement incident. In Diggs v. UPMC Med. Ctr. (2010), the elopement case against a large hospital settled out of court for over $900,000. In this case, the post-elopement surveyors documented twenty-four care plan violations over the previous nine months. The attorney for the plaintiff also pointed out that this hospital had experienced between twenty to thirty patient elopements in the two years preceding this litigated elopement. Another key factor was that this facility had not properly implemented the patients care plan. Furthermore, this facility had not updated their elopement policy in the past 2 years, nor conducted any emergency drills to implement an elopement response plan in that time. (Diggs v. UPMC, 2010)

## Is technology the answer?

Facilities use a variety of technologies for elopement prevention. However, potential litigation must consider a key question: Was the particular technology used by the facility (defendant) developed for elopement prevention? For example, the key pad entry/exit technology used by many healthcare facilities create secured units was not developed for elopement prevention, to contain people inside a secured unit. It was developed as a security device to keep unauthorized people out of an area. Simply stating that the alarm company sold the device for to the facility for elopement prevention is not a solid argument for the defense. However, a facility can adapt a technological item or system to attempt to prevent elopement. To do this, a facility must:

- State in their elopement policy that they are using this technology to decrease risk of elopement
- Document the weaknesses the technology might have when being used for this purpose
- Identify the facility's actions to address each weakness identified
- Include a plan to protect residents/patients when the technology fails

Now compare the key pad entry/exit technology with a WanderGuard® system, developed (Stanley Healthcare, 2014) specifically for elopement prevention. With the WanderGuard® departure alert system, patients wear a locking bracelet that triggers automatic door locks if they approach exits. However, a facility using this system still must have written policy and procedures to ensure it is properly maintained, tested, and used, and procedures for resident/patient safety when it fails.

## Other measures

Technology can be useful but it should never be the only tool a facility uses to decrease risk of elopement. The legal nurse consultant (LNC) should always look to see how thoroughly the facility addresses elopement risk in resident/patient admission forms, assessments, and nursing plans of care; and in facility elopement policy, disaster plans, relocation plans, and assessments.

Staff education is always a factor in any elopement litigation. The LNC should request and review training records of all staff involved with an elopement incident. The object is to discover who was responsible for the elopement training and who provided and updated this training. If working for the plaintiff, the LNC should advise the attorney to ask the director of nursing, the administrator and the educational coordinator to specifically describe these in interrogatories and deposition. If working for the defense, the LNC should advise the attorney to ask all state and federal surveyors this question. Also ask each of them to define elopement or to give you the official CMS definition. Their answers will likely be surprising.

## Summary

Today resident and patient elopement litigation affects all inpatient health care environments. Civil tort effects may be more burdensome on long term care and assisted living environments, but hospitals, rehabilitation centers, patient transport companies, and all inpatient facilities are potentially targets for litigation and even possible criminal prosecution.

CMS has demonstrated willingness to impose severe CMPs for elopement incidents based on perceived maximum potential for injury, even if no injury occurred. Furthermore, past attempts to appeal large CMPs have been met with minimal success although facilities are very limited in their ability to restrain anyone in any manner. This does not mean that reductions in CMPs are impossible but it does mean that it will take hard work to convince the Administrative Court Judge.

The fact that a facility was cited by a regulatory agency does not guarantee a finding for the plaintiff; lack of a documented citation does not guarantee a finding for the defense. Using state-of-the-art elopement prevention technology does not guarantee a finding for the defense. Look closely at the technology used along with the supporting policies and procedures in every case involving an elopement. Staff education will always be a factor.

Elopement cases will continue to increase as the litigation community sees opportunities in all inpatient healthcare facilities. We can expect this increase to require more LNCs in the future.

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# Online References and Resources

# Palliative Wound Care and End of Life Wounds

*Diane L. Krasner, PhD, RN, CWS, CWCN, MAPWCA, FAAN*

The following sites provide online resources for clinical practice, education and research and for legal nurse consultant reference. This listing is not intended to be all inclusive of resources available. No endorsement is made of any listed sites or services. Online sources change and should be confirmed prior to using as a reference.

## Glossary

**The National Pressure Ulcer Advisory Panel (NPUAP)**
NPUAP Terms and Definitions of Stages Related to Pressure Ulcers
**http://www.npuap.org/resources**

**World Wide Wounds**
The premier online resource for dressing materials and practical wound management information, including palliative and end of life wound care.
**http://www.worldwidewounds.com**

**WoundSource**
Features numerous blogs defining and discussing palliative and end of life wound care.
**http://www.woundsource.com/palliativewounds**

**Kennedy Terminal Ulcer**
**http://www.kennedyterminalulcer.com**

**Skin Changes At Life's End (SCALE)**
**http://www.epuap.org/scale-skin-changes-at-lifes-end**
**http://thewoundinstitute.com>resourcecenter>scale**

**Skin Failure**
**http://www.annalsoflongtermcare.com/article/skin-failure-identifying-and-managing-underrecognized-condition**

## Governmental Resources

**Palliative Wound Care at End of Life**
Agency for Healthcare Research and Quality (AHRQ)
**http://www.ahrq.gov/about/nursing/palliative.htm**

## Downloadable Fact Sheets

**F.R.A.I.L. For Recognition of the Adult Immobilized Life**
Palliative Wound Care and Healing Probability Assessment Tool
**http://www.frailcare.org/projects.htm**

**The National Pressure Ulcer Advisory Panel (NPUAP)**
Fact Sheets on pressure-ulcer related terms, stages/categories, prevention and treatment strategies, education
**http://www.npuap.org/resources**

## Continuing Education, Conferences, and Educational Opportunities

Palliative Care Institute, Center for Curative & Palliative Wound Care, Calvary Hospital, Bronx, New York
**http://www.calvaryhospital.org**

**Palliative Wound Care Conference, Hope of Healing Foundation**
Biannual conference, next conference May 2015 in Orlando, Florida
**http://www.HopeOfHealing.org**

## Protocols, Position Statements, and White Papers

**F.R.A.I.L For Recognition of the Adult Immobilized Life 2002**
**http://www.frailcare.org**

**The National Pressure Ulcer Advisory Panel (NPUAP)**
White Paper: Pressure Ulcers in Individuals Receiving Palliative Care 2010
**http://www.npuap.org/NPUAPwhitepapers**

**Skin Changes At Life's End (SCALE) Consensus Document 2009**
**http://www.epuap.org/scale-skin-changes-at-lifes-end or**
**http://thewoundinstitute.com>resourcecenter>scale**

**WoundSource**
White Paper: Perspectives on Palliative Wound Care: Interprofessional Strategies for the Management of Palliative Wounds.
**http://www.woundsource.com/whitepapers**

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# Falls and Fall Prevention in Older Adults

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**KEY WORDS**
Falls, Fall Prevention, Older Adults

*Patient falls have a tremendous financial effect on our healthcare system resulting from increased healthcare needs and decreased reimbursement issued by insurers. More important is the devastating effect falls with serious injuries inflict on patients and their families. With increased focus on falls and fall prevention in our healthcare and legal system, it is important to know the various definitions of what constitutes a "fall," as these depend on the setting and the corresponding regulatory body. Although the definitions are similar, considerable weight is given to interpretation. Great emphasis is placed on fall assessment tools, reflected by the number available to identify those at highest risk. Post-fall huddle tools are also available to identify system failures and areas for additional prevention strategies. Clinicians should use one that best fits the facility. Knowing about various types of falls helps nurses identify and implement the most effective, patient-specific fall prevention strategies. Education incorporating members of the expert interdisciplinary team and including proper fall risk assessment tool training provides the most comprehensive and effective prevention strategy possible.*

Falls in older adults are common. Approximately 30% of community-dwelling elders and 50% of older nursing home residents fall annually. The Center for Disease Control (CDC, 2011) estimates that every 17 seconds an older adult will require emergency medical treatment for a fall-related injury. Even more concerning: In the next 30 minutes an older adult will die from injuries sustained from the fall. The consequences of falls, particularly when alleged fall-related injuries are sustained, can have implications not only for the older adult experiencing the fall, but for their caregivers, significant others, medical providers, and healthcare and legal systems.

While consequences for individuals remain the focus of clinicians, overall economic implications of falls provide a wider perspective on the scope of the problem. And the economic consequences are considerable. They include both direct costs (e.g., diagnostic work-ups, hospitalization costs, and surgery) and indirect costs (e.g., decreased quality of life, rehabilitation, and nursing home care). The Center for Medicare Services and many state Medicaid agencies recently announced they will no longer reimburse hospitals for costs associated with treating injuries sustained by patients who fall while hospitalized. The financial impact on healthcare isn't yet fully realized, and only infrequent estimates of direct care costs have been published. Stevens et al. (2006) estimated that annual direct costs of falls in elders were approximately $19.2 billion in 2000; costs were $30 billion in 2010 (CDC, 2014). As baby boomers age over the next decades, the United States can expect the number of falls and associated costs to soar.

Fall-related injuries can be minor (e.g., small laceration, abrasion, and/or bruise), major (e.g., fracture, traumatic brain injury), or even fatal. Regardless of whether an older adult sustains any injury in a fall, health care providers should evaluate for other consequences, such as fear of future falls (fallophobia). This fear might lead to older adults choosing to restrict their mobility and/or their participation in activities of daily living (ADLs) such as bathing, grooming, dressing, toileting, and walking; or instrumental activities of daily living (IADLs), which are more complex activities such as cooking, cleaning, driving and shopping. Self-restrictions in these activities can lead to further deconditioning, social isolation, and reduced pleasure or enjoyment with living.

The need for more help with ADLs and IADLs may increase substantially after a fall, requiring elders in the community and their families to piece together adequate support at home or to seek a higher level of care. Long-term care arrangements such as assisted living environments or nursing homes become important considerations in cases where elders require more extensive help when current living arrangements are inadequate to maintain safety.

Fall prevention is a significant challenge in long-term care environments where treatment goals include maximizing mobility and minimizing restraint. Despite the best efforts of health care professionals, all falls are not preventable. This paper will provide an overview of the various types of falls, fall risk factor assessment, current fall prevention strategies, and suggestions for the management of a patient who has fallen.

## Defining A Fall

The definition of a fall varies, depending upon the agency or regulating body. In long-term care, the definition is in the assessment section of the long-term care minimum data set (LTCMDS), Minimum Data Set (MDS) 3.0, section J 1400 of the 3.0 Resident Assessment Instrument Manual (RAI). This defines a fall as:

> An unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair or bedside mat). The fall may be witnessed, reported by a resident or an observer, or identified when the resident is found on the ground. Falls include any fall whether it occurred at home, out in the community, in an acute hospital,

or in a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him or herself, or had not been intercepted by another person—this is still considered a fall (CMSDC, 2010).

The American Nursing Association's National Database of Nursing Quality Indicators (ANA-NDNQI, 2014) is recognized by leading researchers for comprehensiveness regarding improving patient safety outcomes. According to the ANA-NDNQI a fall is, "an unplanned descent to the floor, or extension of the floor, (e.g., trash can or other equipment), with or without injury."

Sometimes a fall is recognized and defined according to its cause. However, incident reports or other instruments may classify a fall according to the level of harm to a resident. The International Classification of Diseases 9 Clinical Modifications (ICD-9-CM) uses broadly defined codes to categorize falls including: accidentally bumping against a moving object caused by a crowd with subsequent fall, falling from one level to another, and falling on the same level from slipping, tripping, or stumbling (Curry, 2008). For the purpose of this paper, a fall is defined as coming to rest on the ground, floor, or other lower level regardless of whether injury occurs.

## Types of Falls

While the goal of nurses and interdisciplinary care team members (e.g. physicians, pharmacists, physical and occupational therapists, and social workers) may be to do all they can to prevent falls in patients under their care, it was recognized by Morse and others in a classic paper that not all patient falls were preventable (1987). Three types of falls outlined in the medical literature include *anticipated physiological falls, unanticipated physiological falls*, and *accidental falls*.

**Anticipated physiological falls** are attributed to known physiological conditions and are the most common, 78% of patient falls. Morse (2009) and others found that anticipated physiological falls occur in patients who are identified by a risk assessment as being "fall prone." An example of a fall-prone patient might include an 88-year-old woman with a history of falls, on multiple medications, with impaired gait and balance, urinary incontinence, and who sometimes forgets to call for help when standing.

**Unanticipated physiological falls** account for 8% of patient falls. According to Morse (2009), unanticipated physiological falls cannot be predicted before the first occurrence. They have medical causes such as seizures, spontaneous hip fractures, polypharmacy, and syncope, such as during an MI or CVA. An example would be a 65-year-old woman with severe osteoporosis and no prior history of falls who attempts to retrieve her cane from under her bed and falls to the floor because of a spontaneous hip fracture.

**Accidental falls** account for 14% of falls. Accidental falls result from the patient slipping, tripping, or falling due to an environmental factor or equipment issue.

## Fall Risk Factors

There are many factors that can identify a person at high risk for falling, with or without injury. When assessing an older adult for fall risk, as with any assessment, it is important to examine all the risk factors, since risks often potentiate one another. Any previous history of falls with their detailed descriptions is important. If there are identified circumstances in which a patient is more likely to fall, e.g., at a certain time of day, following a certain meal, or after taking certain medications, then staff can implement specific interventions to decrease the patient's fall risk. The result could be the prevention of a fall or resulting injuries.

Other identified risk factors include incontinence, impaired gait, visual changes, diminished cognition, pain, muscle weakness, and polypharmacy. Medications often identified as increasing a person's risk for fall include:

- Opiates
- Anticonvulsants
- Antihypertensives
- Diuretics
- Laxatives
- Sedatives
- Psychotropic medications

An individual may have varied responses to the same medication or to a familiar medication at a different dose. Therefore, it is important for staff to monitor the patient's response to any medication change.

## Fall Risk Assessment

When reviewing the medical record of an individual who has sustained an alleged fall, it is critical to have a basic understanding of fall risk. While there are many risks for falls documented in the literature, three major types of factors can put a long-term care resident at risk for falling (Hill et al., 2009).

**Person factors** are often referred to as *intrinsic risk factors*. Think of these as physiological or internal characteristics specific to the individual. Examples include:

- Impaired vision
- Change in cognition
- Vertigo
- Medications identified as increasing fall risk
- Difficulty walking and/or moving from one surface to another
- History of falls
- Incontinence
- Postural hypotension
- Impulsive behavior

**Environmental factors** are also known as *extrinsic risk factors*. These factors include objects that are part of the care environment (e.g. bedrails, ambulatory aids, obstacles, floor surfaces, and staffing/ratios).

**Interactive risk factors** (Hill et al., 2009) involve the person's interactions within the long-term care environment. For example, in persons with dementia, both the time of day the resident is admitted and the change in physical surroundings could result in sundowning. Unfortunately, interactive factors are not readily integrated into published fall risk tools.

In summary, fall risk is multifactorial, requiring careful, individualized, collaborative assessment with interventions to ensure resident safety in long-term care facilities.

Additionally, facilities should implement standard fall prevention measures for all residents, not just those identified as being at highest risk (*see* Unanticipated *and* Accidental falls, *above*). Some universal fall prevention measures include:

- Placing frequently used objects within reach
- Using the top two bedrails
- Providing orientation to the room
- Adequate lighting
- Demonstrating how to use the call bell for assistance

## Fall Risk Assessment Tools

While clinicians use many fall risk assessment tools in acute and long-term care settings, there are no guidelines recognizing one, single, best approach. Each facility should establish a standardized approach to fall risk assessment. Staff must be familiar with the adopted tool to identify residents who are at highest risk for falling.

In 2004, Oliver et al. reviewed fall risk factors and assessment tools. The authors recommended using only assessment tools that have been externally validated in multiple settings. Unfortunately, this leaves very few that could be recommended for use across patient care areas. Oliver also emphasized the importance of identifying potential reversible risk factors for inpatient falls. Examples of reversible risk factors include treatment of urinary tract infections in older adults and medication review with substitution or elimination.

One well-recognized tool used for many years in hospital and nursing home settings is the **Morse Fall Scale** (Morse, Tylko, & Dixon, 1987). This standardized approach begins with nursing staff completing one fall risk assessment consistently, at routine intervals as defined in the facility policies and procedures. Staff understanding of assessment items and response options is critical for scoring consistency. Because fall risk can be increased by a change in environment, particularly in older adults with dementia, staff should complete an initial fall risk assessment as soon as a resident is admitted to a facility, minimally within the first 24 hours.

Long-term care facilities' fall policies and protocols should provide specific guidelines for when fall risk should be reevaluated. Typically, this should occur with any change in resident condition, medications, cognitive function, after a fall, and with readmission to the facility.

Even if new employee orientation covers the "how-to" of completing a fall risk assessment and the corresponding falls protocol, continued proper implementation requires periodic well-documented staff re-education or updates

Users must look at a fall risk tool's *sensitivity, specificity, and inter-rater reliability* in predicting falls and falls with injury. Sensitivity refers to the number of patients identified to be a fall risk that did, in fact, suffer a fall. Specificity is the number of patients determined not at risk who experienced no falls. Inter-rater reliability is important because it demonstrates that two nurses can independently obtain the same score for an individual patient's risk. Using a valid assessment tool is the basis for implementing individualized plan of care interventions to mitigate the older adult's identified fall risks.

## Fall Prevention Strategies

When designing fall prevention protocols, facilities must rely on the best available evidence to ensure the highest quality patient outcomes and avoid potential litigation. The two cornerstones of successful fall prevention programs are using a standardized fall risk assessment tool properly and implementing interventions that target the individual's specific risk factors identified by the assessment.

Referrals to other disciplines can be critical. Older adults admitted because of dependence on others for ADLs must have occupational and/or physical therapy evaluations and therapy so they can perform ADLs safely. This is because studies have shown that individuals are at greater risk for falling when performing purposeful actions, such as reaching for an object or toileting (Hill et al., 2009). Nursing collaboration with physical and occupational therapy before and after initial evaluations and throughout the resident's stay are essential to achieve the overall goal of fall prevention.

Functional gait, balance, mobility, strength, cognition, and general neurological assessments are essential .A physiatrist's comprehensive assessment of the resident's motor abilities and limitations can be a significant asset to the care planning process.

Identifying and recommending dosage changes or drug substitutions can significantly decrease a resident's fall risk. According to 42 CFR 483.60 (j), each resident's medications must be reviewed quarterly by a pharmacist with input from the interdisciplinary care team; irregularities must be reported to the prescribing physician and the interdisciplinary care team (eCFR, 2014). Careful evaluation of each resident's medication profile for high fall risk medications, with the pharmacist's recommendations for safer alternatives, can prove invaluable.

Sometimes simply changing the administration time for certain medications can help reduce the risk of fall. For example, diuretics should be given early enough in the day to avoid nocturia. Diuretics given with antihypertensives can put elders at risk for orthostatic hypotension. Documenting regular postural blood pressure monitoring is also important.

Some of the most important interventions for long-term care residents involve assistive devices and ADL assistance recommended by occupational and physical therapy. For

example, a gripper and shoe horn can help a resident avoid bending or reaching beyond the center of gravity during routine dressing. Therapists can advise staff how and when to give cues or prompts, and when to assist. Because the goal of physical and occupational therapy is to promote gradual independence with ADLs, it's critical to strike a careful balance between over-reliance on staff assistance and resident safety. Inadequate supervision or lack of recommended nursing staff assistance can increase fall risk. These unsafe practices could be identified as potential deviations in the standard of care.

## Frequent Resident Checks

"Hourly rounding" is being employed more frequently in hospital settings to promote patient safety, attend to basic needs, and prevent falls. In a long-term care environment, staff should check on residents at least every two hours, or more frequently depending on resident needs. During rounds, nursing staff should check the "4 Ps": pain, potty, positioning and possessions (Meade, Bursell, & Ketelsen, 2006).

When rounds are completed nursing staff should ask about the "4 Ps" and check to ensure that needs are met for those with cognitive impairment or other communication difficulty. For example, nurses should observe these residents for nonverbal expressions of pain, provide checks and changes for incontinence, reposition for comfort, and place frequently used objects within resident reach. While not all facilities require written documentation of resident rounds or checks as part of the formal medical record, such documentation by staff is certainly helpful when litigating a case.

## Environmental Considerations

**Floors** in patient rooms and common areas should be checked for the following:

- Free of clutter
- Proper lighting including night lights,
- Well-maintained
- Wax free
- Free of uneven surfaces and spills
- Walking path free of multiple obstacles
- Avoid black and patterned floor surfaces

Some residents with visual changes may interpret patterned flooring and areas with black flooring near elevators as holes or gaps. They may lose their balance and fall as they attempt to step over these areas.

**Resident rooms** should be large enough to allow unrestricted mobility. Furniture should have a low center of gravity with a wide base. Placement should provide enough space within walking paths to promote safe passage of residents with assistive devices or human assist. Furniture should be stable (e.g., not gliders or rocking chairs), with arms that the resident can easily reach and hold.

**Bathrooms** should be large enough to allow safe transfers from wheelchairs to toilets. Adjustable toilet seats decrease transfer difficulty. Grab bars near toilets and sinks can also give additional support or serve as stabilizers for safer ADLs. Any pipes within the resident's reach or access should be padded to avoid contact related injuries (i.e., burn, tripping, and impact). Bathrooms also should have functional nightlights.

**Activity areas** should have safe places for residents with activity intolerance to rest during ambulation. Sturdy tip-proof chairs with arms are ideal and can be placed at intervals to prevent fatigue. Additions of interval seating areas are particularly important for facilities with long hallways. Well-maintained railings in hallways, placed at a standard height, can also provide intermittent support to residents and indirectly help to reduce fall risk.

## Monitoring Devices

The traditional call bell is frequently inadequate to meet needs safely when residents are forgetful or impulsive. For these residents, a wide array of bed/chair alarms and pressure sensor mats are currently available for acute and long-term care settings. Such devices must be placed outside of the resident's reach to prevent disabling. Staff should check and document alarm function and the resident's response to an alarm each shift. Careful nursing documentation related to alarm use and function are critical aspects in successful defense litigation.

Nursing home and assisted living facilities are installing surveillance cameras to help monitor resident safety and prevent elopement. Hallways, stairwells, and elevators are the most commonly monitored. Note that surveillance cameras alone do not prevent injury or elopement. Careful monitoring is critical, and documentation should be retained for future reference.

## Restraints

Restraints are defined as physical or chemical restrictors of movement administered or applied by a nurse (Levin, Shanley, & Hill, 2011). Physical restraints include any devices not readily removed by the resident, such as:

- All four bedrails
- Vest
- Jackets
- Wristlets
- Anklets

Physical restraints were initially used in healthcare settings to keep patients free of harm to self or others. However, researchers have noted an increase in restraint-associated falls, injuries, and death. Therefore, over the past few decades there has been an effort to reduce or eliminate physical restraints in patient care. Restraints are now a last resort, used only after other measures have been considered or used, e.g., reorientation, relocating the resident's room to an area near the nurses' station, bed/chair alarms or pressure sensor mats, and/or a 24 hour sitter/continuous observation. Documentation must clearly indicate that these other restraint-free alternatives were either considered or implemented.

## Beds and Floor Mats

While placing all four bedrails up is considered a form of restraint and requires a physician or ANP prescription, two and even three rails up can be a support for bed mobility. Nursing staff can work with physical and occupational therapy to determine the most effective techniques for bed mobility, including recommendations on the number of bedrails.

Resident beds should be kept locked and in the lowest position when occupied. Specialty low-beds in which mattresses are approximately 8-12 inches from the floor are in use in many nursing homes today. Low-beds are helpful for residents who have been known to roll out of bed or who have sustained injuries in falls from bed. Cushioned mats, two to three inches thick, with beveled edges lined with reflective tape, and covered by a rubberized material are also helpful for individuals who are at high fall risk and have histories of fall-related fractures. Mats with beveled/sloped edges and reflective tape assist residents in identifying changes in walking surfaces.

## Helmets and Hip Protectors

Falls are identified as the leading cause of traumatic brain injury (TBI) hospitalizations and mortality in men and women aged 75 years or older. Special lightweight custom-fitted helmets or caps provide the best protection against head injuries in frequent fallers (CDC, 2014).

Hip protectors provide high-impact protection for hip bones. They are available in many sizes and clothing options (e.g. undergarments, shorts, sweatpants, and incontinence briefs). Hip protectors are designed especially for individuals who are identified as a high fall risk and those with diminished bone density (i.e, osteopenia or osteoporosis). Despite widespread availability, hip pad protector quality does vary across manufacturer, and clinical trials do not conclusively support their overall effectiveness in preventing hip fracture. One of the largest challenges related to the use of hip pad protectors is adherence. Both the older adult and the caregiver must be vigilant about their use.

## The Centers for Disease Control (CDC)

The CDC website provides numerous resources for the prevention of falls in older adult populations for both consumers and health care professionals. A tool kit called *STEADI* (*Stopping Elderly Accidents, Deaths & Injuries*) *Tool Kit for Health Care Providers* that can be used in both inpatient and outpatient settings is available online (CDC, 2012).

## After a Fall

Despite diligent efforts by nursing staff to prevent falls in both acute and long-term care settings, all falls are not preventable. When an alleged fall occurs, it is critical that nursing staff respond promptly and appropriately. The nature of the response is dictated by the setting and facility protocol. For example, in acute care, a first action may be to call a "Dr. Down" or a falls code.

Key nursing staff actions include:

- Obtain available information from the patient or staff about the incident
- Assess for injuries
- Notify nursing supervisor (if in fall protocol)
- Perform head-to-toe assessment, vital signs, orientation, and neurological checks
- Provide first aid as indicated
- Monitor and treat for complaints of or signs of pain
- Notify physician
- Obtain x-rays or transfer to a hospital for emergency care as indicated

When a long-term care resident sustains a serious injury, such as head trauma, staff may call EMS or an ambulance before physician and/or family notification. Otherwise the family is typically notified after physician contact. Objective documentation in the medical record should follow assessment and stabilization. This should include:

- Thorough factual statement of the incident or how the resident was found
- Position in which the resident was found
- Proximity of any items or furniture
- Detailed assessment and treatment of injuries: location, appearance, size, shape, depth
- Notification of proper chain of command per facility policy (e.g. call to nursing supervisor)

Debriefing the resident, staff, and other witnesses about circumstances and events surrounding the fall is also critical. The early work of Morse, Tylko, & Dixon (1987) noted the importance of a detailed post-fall assessment; they found that more than half of all second falls occurred under circumstances similar to the first fall. During staff debriefing, also known as a "huddle," it is important to focus on any environmental clues about what the resident and/or direct care staff were doing or trying to do when the alleged fall occurred.

Finally, remember: As older adults lose independence, they hold on to what they can control. It is important to strike a balance between reminding them of their limitations and encouraging their independence. Individuals should learn about their fall risk, including how to participate in their individualized fall prevention plans, if they are cognitively able. Educating family members about what they can do such as informing the nursing staff of their departure and ensuring resident's personal items are within reach may be enough to prevent a fall.

## Conclusion

Fall risk assessments are not "one-size-fits-all" or the sole answer to fall prevention. When considering a fall risk assessment for use, facilities or staff must first evaluate the reliability and validity of the tool for use with their population. Once they select a tool to use, they should develop a comprehensive set of evidence-based interventions for each area in the fall risk assessment. Careful staff education planning

and reevaluation for periodic re-education are also integral to any successful fall prevention protocol. Coordinated effort involving all interdisciplinary team members is critical to the safety of older adults in all settings.

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# Legal Issues Involved in "Do Not Resuscitate" Orders

*Cynthia A. Jacobs, R.N., J.D.*

**KEY WORDS**
Informed Consent, Resuscitation, Advance Directive, Futility, Surrogate, DNR, DPOA

*This article discusses 1) a brief overview of health care decision-making legal principles, including surrogate decision-making; 2) health care decision-making legal principles specific to life-sustaining treatment; 3) "medical futility" principles and laws; and 4) the role of "do not resuscitate" (DNR) orders in the perioperative setting. Life-sustaining treatment decisions implicate the same principles of health care decision-making and informed consent as other treatment plans and orders do, but also have some unique aspects. These decisions often are made by surrogates, who should approach the decision from the patient's perspective. If that does not occur, or if treatment disputes otherwise arise in this context, the question of "medical futility" is frequently involved. There is no well-established national definition or process regarding medical futility; however, there is some guidance available from various state and "uniform" laws as well as from professional organizations such as the American Medical Association.*

Resuscitation orders, including "do not resuscitate" (DNR) orders, are essentially a variety of treatment order. As such, they implicate principles of healthcare decision-making and informed consent just as other treatment plans and orders do. However, life-sustaining treatment decisions also have unique aspects. This article will discuss the following: 1) a brief overview of health care decision-making legal principles, including surrogate decision-making; 2) health care decision-making legal principles specific to life-sustaining treatment; 3) "medical futility" principles and laws; and 4) the role of DNR orders in the perioperative setting.

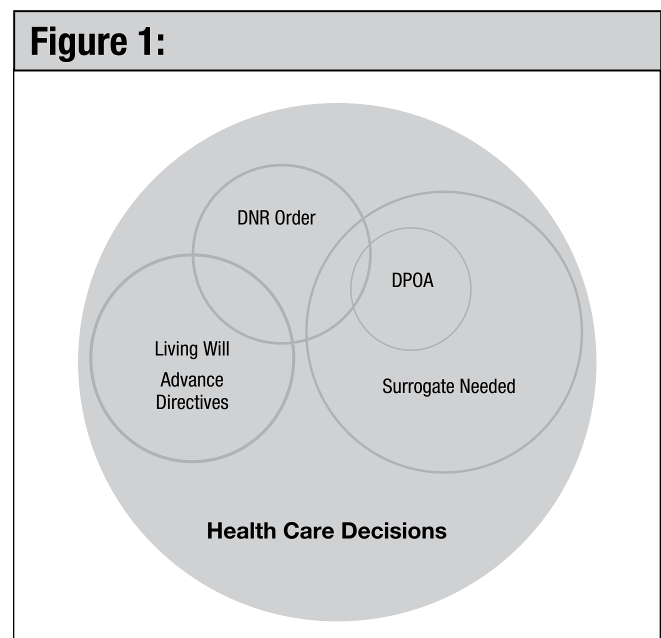
## General Informed Consent Law

The landmark U.S. Supreme Court case of Schloendorff v. Society of New York Hospitals, 211 N.Y. 125, 105 N.E. 92 (1914), first established a link between the right to self-determination and consent, and held that a competent adult must give consent for health care; accordingly, a health care provider who carries out treatment without consent would be liable for damages. Consent law has been further fleshed out in the ensuing years. While specific details may vary from state to state, the basic ideas are as follows:

- Sufficient information must be presented for a "reasonably prudent patient" to make an informed decision. This includes at a minimum, "material facts," such as nature of the treatment, and recognized risks and benefits.
- Discussion must take place with the patient if capable of decision-making, otherwise the discussion must be with the patient's "surrogate decision-maker." Some states have a specific surrogate hierarchy spelled out in consent laws, while in other states the surrogate hierarchy is extrapolated from other laws (e.g., inheritance laws). Surrogate decision-makers may include the patient's spouse or domestic partner, the patient's adult children or siblings, or any person who holds the patient's Durable Power of Attorney (DPOA) for health care.
- In emergent situations, consent may be implied and treatment may proceed without the above discussion, if precluded by time and/or circumstance.

Occasionally, health care professionals may feel that the surrogate is acting inconsistently with the patient's previously-expressed wishes, and/or not in the patient's best interests. In most of these cases, agreement can be reached via family conference. However, in rare cases, it may be necessary to seek court intervention.

**Figure 1:**



## Life-Sustaining Treatment Decisions

The bulk of U.S. case law around life-sustaining treatment decisions was generated primarily between the mid-1970s and the late 1980s. Most people remember the seminal cases of Karen Ann Quinlan {Matter of Quinlan, 355 A.2d 647, 70 N.J. 10 (N.J. 1976)} and Nancy Cruzan {Cruzan by Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224, 58 USLW 4916 (1990)}. In their wake, state and federal laws were passed to codify parameters for withholding and withdrawing life-sustaining treatment.

The above and subsequent laws resulted in some standardized concepts.[1] First, a patient with decision-making capacity has the right to accept or refuse any proposed treatment, including life-sustaining treatment. Second, if the patient does not have decision-making capacity, her surrogate may make necessary decisions about life-sustaining treatment. Under the principles of informed consent law, surrogates are expected to make these decisions using "substituted judgment," that is, based on what the patient would have wanted if competent. One type of health care advance directive, commonly known as a "Living Will," is intended to provide evidence of a patient's wishes around life-sustaining treatment, which can be consulted if the patient is no longer able to make decisions.[2] The 1991 federal Patient Self-Determination Act (PSDA) requires hospitals and other health care facilities (including nursing homes) to provide patients with information about such advance directives, and most states have specific laws about formats and other requirements for living wills.[3]

A living will, however, is not a "self-executing" consent document. As noted, it is simply evidence of the patient's wishes. Its intended uses include:

- Discussion aid for use by a health care provider seeking the patient's consent around life-sustaining treatment orders, if the patient is capable of making the needed decisions.
- Guidance document for the patient's surrogate decision-maker, if the patient is not capable of making the needed decisions.
- Guidance document for the health care team and/or the court, if the patient is not capable of decision-making and there is no surrogate available. Court intervention may be needed in this setting depending on the circumstances.

Before withholding or withdrawing life-sustaining treatment in accordance with an advance directive for a patient who does not have current decision-making capacity, the health care team should ensure that 1) the patient's condition satisfies the terms in the applicable state law regarding advance directives; and 2) the patient's surrogate (if any), the attending physician, and at least one other physician all agree that withholding/withdrawal of life-sustaining treatment is appropriate.[4] In this setting, life-sustaining treatment generally may be withheld or withdrawn without the need for a court order (see Grant [cited above] for Washington law; consult your legal counsel for variations in other states).

If there is no surrogate, no advance directive, and/or the patient's condition does not meet the terms of a state's advance directive law, healthcare providers may need to obtain a court order before withholding or withdrawing life-sustaining treatment. In these cases, they should consult th facility's ethics team, risk management office, and/or legal counsel.

Accrediting bodies also may have specific requirements related to advance directives and other life-sustaining treatment decisions. For example, The Joint Commission (TJC) requires hospitals to "address … patient decisions about care, treatment, and services received at the end of life," including "written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services, in accordance with law and regulation." Among other "elements of performance," hospitals must ascertain whether patients have advance directives, provide patients with written information about advance directives, assist patients as needed in formulating advance directives, and inform patients about the extent to which the hospital "is able, unable, or unwilling to honor advance directives." (TJC Comprehensive Accreditation Manual, March 2014, Standard RI.01.05.01). The American Medical Association (AMA) has published various "Ethics Opinions" regarding DNR orders and advance directives, which essentially reflect the principles discussed above (AMA Ethics Opinion 2.20, Withholding or Withdrawing Life-Sustaining Medical Treatment, updated 1996; AMA Ethics Opinion 2.22, Do-Not-Resuscitate Orders, updated 2005; AMA Ethics Opinion 2.225, Optimal Use of Orders-Not-to-Intervene and Advance Directives, 1998).

## Medical Futility

Resuscitation decisions can be fairly straightforward if they are made by a competent individual, or a surrogate who is clearly carrying out the individual's wishes, in an informed

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1 More recent widely-reported life-sustaining treatment cases, such as the Terry Schiavo case (Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1223 (11th Cir. 2005)) and the Jahi McMath case (Winkfield v. Children's Hospital & Research Center at Oakland, Case No. 4:13-CV-05993-SBA (N.D. Cal., 2013), have tried to revisit these concepts. Although the plaintiffs did not ultimately succeed in court, the cases nonetheless involved delays (years in the Schiavo case), as well as extrajudicial political activity.

2 A DPOA also is a health care advance directive. Unlike a living will, which contains only information about the patient's wishes, a DPOA actually designates a specific decision-maker of the patient's choosing.

3 Although the PSDA is most widely thought of in association with living wills, its scope is broader, also requiring that patients be provided with information about their general rights to make health care decisions.

4 Washington law governing advance directives and withholding/withdrawing of life-sustaining treatment requires a two-physician concurrence for certifying that the patient is in either a terminal or permanent unconscious condition, as well as agreement by the patient's surrogate (if any). As a practical matter the physician concurrence would inherently extend to the clinical appropriateness of withholding or withdrawing treatment. See RCW 70.122.020 (8); In re Grant, 747 P.2d 445, 109 Wn.2d 545 (Wash. 1987).

consent framework. Ethical and legal issues typically arise when the patient is deemed not capable of decision-making and either there is no surrogate or there is a treatment dispute between the surrogate, other family members, and/or the health care team (see example cases #1-5). A common question in these settings is whether health care professionals are obligated to provide "futile" treatment.

Various analytic approaches to the issue of medical futility are described in the literature (Schneiderman & Capron, 2000; Davis, 2008; Diekema & Botkin, 2009; Chwang 2009; Luce, 201); Joseph, 2011; Laventhal et al., 2011). The AMA Council on Ethical and Judicial Affairs considered the issue in a 1996 report; it did not provide any definition of futility, instead recommending a "process-oriented" approach. The AMA subsequently developed an ethics opinion providing that "[w]hen further intervention to prolong life becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure." (AMA, 1997). As with the 1996 report, AMA Ethics Opinion 2.037 (AMA, 1997) does not define futility, noting that certain value judgments must be included in assessing futility in a given situation, including the patient's/surrogate's assessment of a worthwhile outcome. The opinion recommends also taking into account community and institutional standards, and advises that "intent in treatment …should not be to prolong the dying process without benefit to the patient or to others with legitimate interests."

The AMA opinion recommends that all health care institutions adopt a policy on medical futility, and that such policies should follow a "due process" approach, including the following:

- Earnest attempts in advance to negotiate prior understandings between patient/surrogate, and physician on what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution.
- Joint decision-making to the maximum extent possible.
- Attempts to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate.
- Involvement of an institutional committee such as the ethics committee if disagreements are irresolvable.
- If the institutional review supports the patient's position and the physician remains unpersuaded, transfer care to another physician within the institution.
- If the process supports the physician's position and the patient/surrogate remains unpersuaded, transfer to another institution may be sought.
- If transfer is not possible, the intervention need not be offered.

Neither is there a consistent nationwide legal framework for the concept of medical futility, as state laws have not universally addressed it. The Uniform Health Care Decisions Act, which is one of many "model" laws available to states from the Uniform Law Commission, includes the following basic legal provisions regarding futility {Uniform Health Care Decisions Act, §7 (f)-(g)}:

- A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
- A health care provider or institution that declines to comply with an individual instruction or health care decision shall:
  - Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;
  - Provide continuing care to the patient until a transfer can be effected; and
  - Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

The Uniform Health Care Decisions Act (UHCDA), like other uniform laws, does not take effect in a state unless the state specifically adopts it (Table 1).[5]

| Table 1: States that have either entirely or mostly adopted the UHCDA | |
|---|---|
| Alabama | Maine |
| Alaska | Mississippi |
| California | New Mexico |
| Delaware | Tennessee |
| Hawaii | Wyoming |

Other states have addressed futility at different levels of detail in their state laws, some of which include partial UHCDA language. The 1999 Texas Advance Directive Act (TADA) includes perhaps the most detailed medical futility statutory process in the United States, providing very specific steps to be taken when a physician believes that requested care constitutes inappropriate treatment. These steps include a review process, a written decision to be given to the patient/surrogate, and a transfer option. The physician is immune from liability if the statutory process is followed, unless the physician does not exercise "reasonable care" in doing so.

Remaining state laws are generally silent on the specific issue of medical futility, except to the extent that they grant immunity from liability to health-care providers who honor advance directives, i.e., agree with the patient or surrogate that futile treatment will not be undertaken. This type of statutory provision is fairly common, but does not address

5 The UHCDA covers other health care decision-making issues in addition to futility, such as surrogate hierarchy and advance directives.

the question of whether the provider may, as a matter of law, decline to perform futile treatment that is requested by the patient or surrogate.

In any lawsuit brought as a result of declining to offer allegedly futile treatment, there will likely be a potential issue regarding the "standard of care" around the assessment of indications for the treatment. In a state that has not included this level of specificity in its laws, AMA Ethics Opinion 2.037 (1997) likely would be considered evidence of the standard of care in this area.

## Perioperative DNRs

In past years, many hospitals had policies requiring automatic rescission of DNR orders in the perioperative period. More recently, there has been a trend away from this type of black-and-white policy around perioperative rescission. Whether to rescind or adapt a DNR order perioperatively ideally should be addressed in an informed consent context as described above, based on the underlying rationale that the material facts surrounding a DNR order typically change in the perioperative arena (see example case #5).

Like medical futility, perioperative DNR rescission is not squarely addressed in a legal context. The American Society of Anesthesiologists' 2001 Ethical Guidelines in this area arguably represent the current standard of care, providing that the anesthesiologist and the surgeon, as well as other primary providers as indicated, should be involved in discussion and planning with the patient or surrogate. The guidelines recommend the tiered approach, outlined in Table 2, to perioperative resuscitation planning for patients with pre-existing DNR orders.

**Table 2: Approach to perioperative resuscitation planning for patients with pre-existing DNR orders**

| Full Attempt at Resuscitation | Limited Attempt at Resuscitation Defined With Regard to Specific Procedures | Limited Attempt at Resuscitation Defined With Regard to the Patient's Goals and Values |
|---|---|---|
| Full suspension of existing directives during anesthetic and immediate postoperative period. | Continue to refuse certain specific resuscitation procedures (e.g., chest compressions, defibrillation, or tracheal intubation). | Allow anesthesiologist and surgical team to use clinical judgment in determining which resuscitation procedures are appropriate in the context of the situation and the patient's stated goals and values. |
| Consent to use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time. | Should inform patient or surrogate which procedures are essential to the success of the anesthesia and the proposed procedure. | Example: manage adverse clinical events believed to be quickly and easily reversible, but refrain from treatment for conditions that are likely to result in permanent sequelae. |

The guidelines also provide a process for allowing the anesthesiologist to "withdraw" in cases of conflict and transfer the patient's care to another anesthesiologist.

## Case Examples

The following hypothetical case examples illustrate some of the more common types of fact patterns involving DNR decisions that are particularly relevant to nursing home patients. In these scenarios, the nursing home patients have been transferred to the hospital. As noted above, both hospitals and nursing homes are required by federal law, and usually by state law as well, to inquire whether patients have advance directives and to provide related information to patients. If a nursing home transfers a patient to a hospital, ideally it should let the hospital know about any advance directives and provide a copy if possible.[6]

These cases are all examples of situations where a family conference can be helpful in resolving decisional dilemmas without the need to resort to possible court intervention.

**Case #1**

An 80-year-old male patient is non-responsive following a stroke. He does not have an advance directive. The care team discusses with the patient's wife what to do if he arrests. She requests resuscitation medications but no chest compressions. The patient's adult children support their mother's request.

***Comment:*** In most states, the patient's wife would be authorized to make his health care decisions if he is unable to do so; his adult children would usually be next in the hierarchy. This type of misunderstanding generally can be resolved fairly easily—if the team explains to the family that medications generally will be ineffective without chest compressions, the family and care team likely will be able to agree on a different plan. If that does not occur, legal counsel should be consulted. Ultimately, the consensus is that a health care team is not obligated to provide ineffective care. The hospital could explore transfer or court intervention, or may decide it simply will not offer the care (in which case, the family should be informed in detail about what care will be offered.)

**Case #2**

A 75-year-old male patient has severe neurologic injuries from a head injury sustained in a fall. The care team agrees he will never recover completely, but it is unclear whether he may improve. The patient made an advance directive five years ago stating he does not want cardiopulmonary resuscitation (CPR) or other life-sustaining treatment. He has two adult children and a "significant other"[7] with whom he has lived for many years. The patient's children want all efforts made to resuscitate their father if he arrests. The patient's significant other, who does not hold the patient's DPOA, wants his advance directive honored.

6 In fact, this may be a licensing law requirement in some states, and also may be an accreditation requirement.

7 I.e., no formalized legal status as spouse or domestic partner, and thus no surrogate status unless there is a DPOA (or guardianship order).

***Comment:*** In most states, the patient's children will be the legally authorized decision-makers because the patient did not execute a DPOA naming the significant other as his decision-maker. A family conference and ethics consult may be helpful in resolving the conflict. If that is unsuccessful, the hospital may need to consider whether it wishes to seek guidance from the court. The issue would be whether the adult children are acting with the requisite "substituted judgment" in making this decision for their father's care: are they improperly failing to carry out what the patient would have wanted? This requirement is explicit in some state laws (e.g., Washington); in states where it is not explicit, it would be implicit in the underlying principles of surrogate decision-making. A transfer would not be a viable option here because there is an active treatment dispute between non-hospital parties. Note that any time court guidance is sought in a DNR setting, a "guardian ad litem" will be appointed to make recommendations to the court on behalf of the patient.

**Case #3**

A 70-year-old female patient with metastatic cancer decided to discontinue chemotherapy six months ago and then executed an advance directive stating that she does not want life-sustaining treatment. The patient's husband has been very upset by and disagrees with patient's decisions. The patient has no children. The patient's husband asks nursing home staff to send the patient to the ED after she begins demonstrating increasingly unresponsive behavior at the nursing home, and she is admitted to the hospital. Her husband makes it clear that he wants her resuscitated.

***Comment:*** This case is similar to Case #2 in that one alternative to carrying out the husband's wishes would be to seek court guidance on a "substituted judgment" theory. Because there is no other party disputing the decision-maker here, the hospital also could explore transferring the patient to a facility or provider team that would be comfortable with the husband's decision. Neither of these options should be undertaken until after consulting with legal counsel and after a team conference with the husband, ethics consult, etc., and other attempts to reach agreement are unsuccessful.

**Case #4**

A 78-year old male nursing home resident with advance dementia, dysphagia, dehydration, and weight loss is admitted to the hospital for evaluation and possible insertion of a percutaneous endoscopic gastrostomy (PEG) feeding tube. The patient does not have an advance directive, nor does there appear to be any evidence of what his wishes would have been when competent. His adult children want the tube inserted, but his wife (who is stepmother to his children) does not.

***Comment:*** This scenario is like Case #1. In most states, the patient's wife will be the legally authorized decision-maker. Because there is no practical ability to use "substituted judgment" here, however, the inquiry would be whether the wife's treatment decision would be in the patient's "best interests." A family conference and ethics consult may be helpful in resolving the conflict between her and her stepchildren. If that is unsuccessful, the hospital may need to consider whether it wishes to seek guidance from the court. As with Case #1, transfer would not be a viable option here because there is an active treatment dispute between non-hospital parties.

**Case #5**

An 85-year-old female patient is admitted for repair of a fractured hip. She tells her surgeon she has an advance directive stating that she does not want to be resuscitated if she has a cardiac arrest. She tells the surgeon that she does not wish to rescind this directive "if something happens during surgery." The surgeon discusses this request with the anesthesiologist, who tells the surgeon that one possible intraoperative arrest scenario would be due to the anesthesia medications themselves rather than the underlying injury or procedure.

***Comment:*** The anesthesiologist and surgeon should discuss the various "most likely" scenarios with the patient and explain the differences. Family members should be involved if possible, with the patient's approval. If the patient does not change her mind and/or agree to a "modified" approach to her advance directive, both physicians will need to decide whether they feel that they can honor her request; ideally any such decision would be based on the standard of care. If the physicians feel unable to honor the patient's request, legal counsel should be consulted, and transfer to a different physician can be explored. This situation is not amenable to court intervention, as the patient is a competent adult.

## Conclusion

As noted above, life-sustaining treatment decisions are conceptually no different than any other health care decision. However, there are specific laws and other unique criteria and factors for health care professionals to consider in this context. This is due in large part to the inherently heightened emotional atmosphere surrounding these decisions, as well as the finality of their consequences. These decisions are not easy in the best of circumstances and are especially susceptible to "treatment disputes" as discussed above. Accordingly, individuals and families should have discussions about these issues before they are placed in an acute decision-making situation. It would be ideal if the following were available to the health care team regarding each patient for whom a life-sustaining treatment decision has to be made: 1) an advance directive/living will; 2) clear knowledge/evidence (beyond the general tenets of a living will) regarding what the patient would have wanted related to specific types of treatment; and 3) a specifically identifiable surrogate, with DPOA as needed and relevant.

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# Nursing Home Medical Record Standards: Part 1: Nursing Liability

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**KEY WORDS**
Medical Record, Electronic Medical Record, Electronic Health Record, Liability, Litigation

*The medical record provides an important means of communication with other providers involved in a resident's care, and whether an electronic or paper record, must be maintained according to applicable regulations and standards. Liability may be incurred as a result of a nurse's failure to adhere to standards of practice. Professional standards, regulatory demands, and the ever-increasing volume of litigation mandate accurate, timely, and comprehensive documentation. This article reviews federal and state regulations, professional standards and facility policies that set the criteria nurses need to familiar with to avoiding liability when documenting in nursing home medical records. Issues in liability and components of litigation are also reviewed.*

The medical record communicates information about a resident's health status, treatments provided, and response to treatments. Therefore, it should be accurate, factual, and succinct. Medical record requirements are determined by standards and/or requirements from federal and state regulations[1], accrediting organizations such as the Joint Commission, institutional policies, and third party payors.

Congress enacted the 1987 Omnibus Budget Reconciliation Act (OBRA' 87) (42 CFR §483), also known as the Nursing Home Reform Act, to improve the quality of care and the quality of life for residents of skilled nursing facilities.

Specifically:

- 42 CFR §483.75(l) (1) requires facilities to ensure that resident and facility records are well maintained, complete, and accessible for review by regulatory agencies.
- 42 CFR §483.20(b) requires a comprehensive assessment of each resident.
- 42 CFR §483.20(b) (4) (iv) requires a facility to provide a prompt assessment after a resident experience a significant change.
- 42 CFR §483.20(k) requires that a facility develop comprehensive care plans for each resident that include measurable objectives and time tables to meet each resident's medical, nursing and psychosocial needs.

The Resident Assessment Inventory (RAI) is a framework for assessing, planning, and implementing care. It is composed of three parts: minimum data set (MDS) version 3.0, care area assessment (CAA) process, and utilization guidelines. (See Table 1) To receive payment from the Centers for Medicare & Medicaid Services (CMS), skilled nursing facilities (SNFs) and nursing facilities (NFs) must comply with the requirements in 42 CFR §483.

The Department of Health and Human Services (DHHS), authorized by the Social Security Act (1989), directs that all residents in Medicare- or Medicaid-certified nursing facilities, regardless of whether they receive Medicare or Medicaid, have regular periodic MDS clinical assessments following admission, while in residence, and at discharge. These are comprehensive screening assessments of physical, psychological, and psychosocial functional status collected through direct observation and communication with other direct care providers, family, and resident. MDS data are submitted to CMS to monitor quality of care and reimbursement levels. They are also used to identify a resident's care needs, develop a potential problem list and appropriate care plans, and determine staffing level to meet those needs (CMS, 2012a; CMS, 2012b).

## Plan of Care

The plan of care (POC) is a dynamic document intended to provide a framework for nursing care, enhance communication between providers, ensure continuity of care, and provide a mechanism for evaluating a resident progress and changes in status (Comer, 2005; DHHS, 2013a). POCs must be completed within 7 days of the MDS or between days 14-21 after admission (DHHS, 2013a). A POC is based on the initial assessment and updated regularly for changes in condition (Comer, 2005). Regardless of format, a POC should be individualized, specific, realistic, dated, and initialed. Nursing diagnoses, expected measurable outcomes/goals, planned intervention, and projected outcomes should be complete and specific, so they are clearly understood by

[1] A listing of federal and state regulations pertaining to clinical records is available at http://www.hpm.umn.edu/nhregsplus/NH%20Regs%20by%20Topic/NH%20Regs%20Topic%20Pdfs/Clinical%20Records/category-administration-clinical%20records-final.pdf

| Table 1: Resident Assessment Inventory & Plan of Care Requirements | | |
|---|---|---|
| **Component** | **Timeframe** | **Note** |
| Minimum Data Set | At admission- by nursing within 24-48 hours; by other disciplines within 7 days, it must be completed within 14 days of admission | Registered nurse (RN) will begin initial assessment and institute an interim plan of care (POC)<br>Each section completed must be signed and certified by the professional responsible, as per facility policy, for completing it<br>Every item on the assessment tool must be answered |
| | Quarterly reviews (90 to 92 days); revisions are made, if appropriate. | Nursing staff must assess the resident at least quarterly ensuring the assessment continues to be accurate. |
| | Promptly after "significant change" in residents physical or mental status<br>Subsequent reviews will be keyed to the last MDS date | Significant change is defined as a "decline or improvement in the resident's status that will not normally resolve itself without intervention by the staff or by implementing standard disease-related clinical interventions that have an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan."<br>Results are used to revise POC |
| | Every 12 months or 365 days | Assessment provides an opportunity to review and develop the POC |
| Resident Assessment Protocol | Used with the corresponding Guideline to determine if a problem exists, identify relevant factors, and develop an individualized POC | Problem oriented frameworks for additional assessment and problem identification<br>Professional conducting the assessment should summarize the complications and risk factors, need for referrals, and reasons for deciding whether to proceed with the particular POC |
| Triggers | Suggest additional assessment and intervention may be warranted<br>Identify hard to diagnose problems<br>Identify factors aimed at preventing problems<br>Identify candidates with good rehabilitation potential | Specific MDS responses may trigger a real or potential problem that needs to be addressed in the POC<br>This is a work sheet and need not be kept in the medical record |
| Care Area Assessment Process | Must be completed and signed by the nurse coordinator within 14 days of admission | The CAA evaluates areas triggered by the MDS and identifies those areas of concern that require individual care plan interventions<br>Locates information supporting documentation<br>Must be kept in the resident's clinical record |
| Care Area triggers | | Flag areas requiring further evaluation by the interdisciplinary team<br>Each area triggered must be assessed but need not require an individual care plan |
| Utilization Guide | Instructions on how each RAI should be used | |

*Source: Centers for Medicare & Medicaid Services. (2012a). Long-term care facility resident assessment user's manual. MDS 3.0 Manual.*

direct care providers (Begin, n. d.). If a problem is recognized, it should be addressed in the POC even if not triggered; however, not all triggered problems will require a separate care plan; related issues may be addressed in a single care plan if stemming from a common cause (CMS, 2012c).

## Establishing Nursing Standards and Documentation

Standards are minimums. Nurses have professional and ethical responsibilities to know and act in concert with the ANA Scope and Standards of Practice [American Nurses Association (ANA), 2010]. The ANA reviews and revises standards and scopes of practice to keep pace with changes in practice, role expansion, and new technology. The ANA Scope and Standards is the basis upon which nurse practice acts and rules and regulations regarding practice are developed (ANA, 2010).

The National Council of State Boards of Nursing Practice (NCSBN) notes that nursing is a scientific process, and that nurses are responsible for documenting care, communicating client responses, collaborating, and cooperating with other healthcare providers involved in a client's care (NCSBH, 2011, pp. 5-7). Nurse Practice Acts, overseen by the state boards of nursing, define the scope of nursing practice for registered nurses and licensed practical nurses and hold nurses responsible to "systematically assess the health status of individuals and groups and record the related health data" and to communicate with other healthcare providers to ensure quality and continuity of care (Mass. Gen. Laws, Chapter 244, CMR 3:02).

Advanced practice nursing is also addressed by specialty nursing organizations, such as the American Academy of Nurse Practitioners. The scope of nurse practitioners (NPs) varies widely; some state practice acts define it clearly and others only vaguely. Some states allow NP independent practice; 25 states require a collaborative relationship with a physician (Schiff, 2012). An increased aging population and the demand for access to primary care as a result of the Affordable Care Act will also require states to re-examine

nurse practitioner qualifications and scope of practice (Schiff, 2012).

NPs authorized by Medicaid to receive reimbursement as primary care providers play an important role in nursing homes. These primary care NPs must meet state standard of practice for registered nurses and state regulations for expanded nursing practice (Buppert, 2008). Federal regulation 42 CFR §483.40 needs clarification regarding physician delegation to an NP facility employee versus an NP who is not a facility employee but works in collaboration with the physician (DHHS, 2013b).

Nurses should be knowledgeable about the regulations and standards that guide their practice and be careful to stay within their scopes of practice. Nurses should know their strengths and weaknesses and only accept assignments they are competent to handle. When delegating, nurses retain responsibility and accountability and so they should be sure the person to whom they delegate can perform safely.

Nurses' aides are also bound by federal and state rules and regulations.[2] Federal regulation 42 CFR §483.152 sets the minimum requirements for nurse aide training and competency evaluations.[3] While their documentation is often limited to flowsheets, both the state and institutions may still outline rules for it.

Accrediting agencies may also supplement statutory requirements and contribute to establishing healthcare facility standards.[4] The Joint Commission (TJC), a non-governmental, not-for-profit organization that has been offering accreditation services to long-term care facilities since 1966 (TJC, n. d.), addresses medical record organization, completeness, and accuracy in standards RC.01.01.01 through RC.02.04.01 (TJC, 2012). A facility may elect to follow TJC policies and procedures that guide medical record compilation and maintenance. There are no statistics on the number of nursing homes opting to pursue certification via this voluntary process.

Written institutional documentation policies and procedures may be narrower and more specific than federal and state laws and regulations require (Peterson, 2012). For example, a facility may require that a nurse write a progress note on every shift daily, weekly, or monthly unless a resident has had a change in condition.

## Nursing Liability

Liability implies an obligation or responsibility (American Heritage Dictionary, 2009). A nurse is legally obligated to meet professional standards of practice and failure to act according to standards is negligence (Mosby's Medical Dictionary, 2012). Negligence as defined by the TJC is, "failure to use such care as a reasonably prudent and careful person would use under similar circumstances" (Stubenrauch, 2007). More simply stated, a nurse's actions should be reasonable and acceptable as he or she will be judged against another nurse with similar qualifications in similar circumstances. A nurse found to be negligent could face sanctions, including suspension or loss of license, by a state Board of Registration in Nursing.[5] The prudent nurse will therefore be familiar with and adhere to regulations, professional standards, and facility policies that govern nursing practice and may be used as a measure of competence.

There are no empirical data available about the incidence of nursing home litigation (Rustad, 2007). However, nursing home litigation is expanding rapidly, with nurses personally being named in 18% of all nursing home negligence cases (CNA Healthpro and Nurses Service Organization, 2011). Allegations related to nursing standards include (CNA Healthpro and Nurses Service Organization, 2011):

- Professional conduct
- Improper treatments or care
- Medication administration errors
- Abuse of patients' rights
- Documentation error or omission
- Scope of practice
- Assessment
- Monitoring

The following additional factors are cited as initiating factors by Conklin (2010), and Iyer, Blackmon & Bieber (2011):

- Resident falls
- Pressure ulcers
- Dehydration
- Malnutrition/weight loss
- Infection
- Aspiration
- Elopement
- Improper use of equipment
- Failure to act as a patient advocate

According to the American Nurses Association (ANA), nurses have a duty to promote, advocate for, and strive to protect the health, safety, and rights of the patient (ANA, 2010a; ANA, 2010b; ANA, 2010c). Nurse Practice Acts hold individual RNs and LPNs ultimately responsible and accountable for care provided or delegated, and for assessing and communicating patient status to other relevant healthcare providers (National Council of State Boards of Nursing Practice, 2011). Regulations and policies define mandatory standards of nursing practice to ensure delivery of quality care; adherence to these standards may limit allegations of negligence.

2 *See State Rules and Regulations Pertaining to Nurses Aide Training and Competency* available at http://www.hpm.umn.edu/nhregsplus/NH%20Regs%20by%20Topic/NH%20Regs%20Topic%20Pdfs/CNA%20Training/category_administration_nursing_aide_training_and_competency.pdf

3 42 CFR 483.152 available at http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-sec483-152/content-detail.html

4 A listing of accrediting agencies is available at http://en.wikipedia.org/wiki/List_of_healthcare_accreditation_organizations_in_the_United_States

5 For example, California Business and Professions Code Section 2761 (a)(4), grants the Board of Registered Nursing has authority to discipline a registered nursing license for violation of the Nursing Practice Act.

A report by the United States Department of Justice (2007) found claimants (usually residents or family members) waited an average of 15-18 months to file negligence claims. The report noted that it could take another 26-29 months for insurance companies to settle claims. If parties are unable to agree on settlement, a lawsuit may result.

An internet search can rapidly find an individual state's rules, regulations, and statute of limitations for filing suit. Once the decision is made to file a lawsuit, the attorney will initiate the process of discovering or gathering information and evidence for trial and will look back to the standards of care applicable at the time of the alleged injury. Discoverable evidence includes information collected pretrial to identify facts and persons relevant to the case (Roach et al., 2006). According to the second edition of West's Encyclopedia of American Law (2008), such information is obtained through "depositions, interrogatories, requests for the production and inspection of writings and other materials, requests for admission of facts, and physical examinations." The discovery process and trial preparation often takes two to five years and the medical record is usually the only detailed account of the event available providing evidence of whether the standards of care were met (Roach et al., 2006).

## Records in Case Development

The plaintiff attorney in a nursing home lawsuit bears the burden of proof to prove four elements (Miller, P. Z., 2010):

1. Duty: a professional relationship exists between the nurse and the resident, that is, the nurse has a responsibility to provide care to the resident. A nurse is duty bound to act in accordance with standards of care, to exercise the degree of care and skill of a reasonably prudent nurse in the same or similar conditions.
2. Breach of duty: failure to fulfill duties in accordance with standards of care.
3. Causation: the resident's injury was a result of the nurse's conduct.
4. Damages/Injuries: physical, emotional, or financial injury or loss was suffered by the resident as a result of the nurse's actions or inactions.

When negligence is alleged, attorneys look for facts and evidence (Roach et al., 2006). A good medical record review can help the attorney decide on the chances for a lawsuit or settlement. The recorded sequence of events and resident's subsequent condition will influence the outcome, so the reviewer will scrutinize the medical record for inconsistencies, omissions, and evidence of record tampering (Iyer, Levin, & Shea, 2006). Other sources of evidence may include witness statements, facility policies, administrative records, and expert testimony (Croke, 2003; Dearmon, 2009).[6] Experienced medical malpractice attorneys are often familiar with nursing standards and documentation requirements and know that the quality of documentation often reflects a nurse's knowledge, experience, and understanding of the resident's needs and care provided.

Since litigation can be costly and plaintiff attorney's fees are contingent on damages awarded by the court, plaintiff attorneys have a financial stake in their cases. Therefore they will look carefully to estimate the chances of winning a case before filing a lawsuit (Brickman, 1996, p. 268; Legal Information Institute, 2013; Task Force on Contingent Fees, 2004).[7] A case may be accepted on a contingency basis, that is, the attorney expects that costs to pursue the case will be recovered at its successful conclusion (Task Force on Contingent Fees, 2004). The contingency fee is often one third of the award plus expenses for cases that settle, up to 50% for cases that go to trial, and there is no compensation if the case is lost.

Recent large damage awards influence the attorney's decision to pursue a case. For example, the jury awarded $91.5 million to the family of a woman who died of severe dehydration (Taylor, 2012) and $200 million, including $140 million in punitive damages, to the family of a woman who was found dead at the bottom of a staircase still strapped to her wheelchair (Stanley, 2012).

Both plaintiff and defense attorney will often retain the services of a LNC to evaluate and summarize the facts of a case (Reed, 2009). The LNC will conduct an in depth review of the case and using the nursing process will identify factors that support or defend against the allegations (American Association of Legal Nurse Consultants, 2006).

To prevent undue pressure on professional judgment and ensure prevailing parties are made whole or fairly compensated, attorneys are ethically and, with a few exception, legally prohibited from fee-sharing (American Bar Association, n. d.). Ethically, LNCs also strive to maintain their objectivity when reviewing and analyzing cases and therefore are compensated based on their consulting role work and not on case outcome (American Association of Legal Nurse Consultants, 2006). The LNC will provide a professional, honest, and objective in-depth analysis to any client, identifying the possible breach of standards of care, causation, and assessment of damages (American Association of Legal Nurse Consultants, n. d.).

## Spoliation

A record that conforms to documentation standards will help provide a defense in a nursing negligence case, so attorneys will scrutinize the medical record for any signs suggesting that it was changed. Spoliation, intentional destruction, alteration, or concealment of a record, can be cause for

[6] A detailed outline of the civil litigation process can be found at http://www.delmarlearning.com/companions/content/1401824293/guides/CH6.pdf

[7] See Coppolo, G. (2003). Medical malpractice –attorney's fees. OLR Research Report. Available at http://www.cga.ct.gov/2003/olrdata/jud/rpt/2003-r-0664.htm

[8] Giurintano, K. J. & Elliott, E. M. (2008). Spoliation of evidence. A state by state summary. American Bar Association. http://apps.americanbar.org/tips/commercial/ctlcspoliation.pdf

civil action[8] or, in instances of reckless disregard for the resident's safety, criminal charges (Pozgar, 2012, Sanbar, 2007). Red flags include rewritten and partially destroyed records (Iyer, 2001). If a record is damaged and requires rewriting, the facility should keep the original, as the copy can be interpreted as fabrication. Self-serving, inaccurate, inconsistent, obliterated, or omitted information suggests poor quality care or a cover-up. Notes out of chronological order, notes squeezed in between two entries, or added later raise suspicion about record reliability (Iyer, Levin, & Shea, 2006). If spoliation is suspected, a request should be made to review the original record rather than any copy (Deutsch, 2001).

Spoliation will strengthen a plaintiff's case and weaken the defense's (Ratkowwitz, 2012).[9] Evidence of tampering with a medical record can invalidate professional malpractice insurance and result in loss of professional license, fines, criminal charges of fraud, and possibly incarceration (Texas Board of Nursing, 2008).[10]

## Conclusion

A properly maintained medical record helps ensure continuity of care provided by multiple healthcare professionals, improves the quality of care, and potentially protects the resident from harm. Documentation is a time-consuming process. Even so, although it may not be realistic to expect nurses to document everything they do for their residents, failure to document pertinent facts is a breach of nurse practice acts, and of state and federal regulations.

The objective record of the patient's condition and sequence of events is critical to the development and outcome of malpractice litigation. In a case alleging negligence, both sides will scrutinize records for evidence. The medical record is a basic legal document that, if well-written and organized, can serve as the best defense for the competent health care provider involved in litigation. If poorly written and disorganized, the medical record may be viewed as evidence of substandard care and an incompetent provider. Facilities can limit nursing liability by maintaining the integrity of the medical record and observing the goals of documentation: to adequately record the assessment of a resident's condition and progress, communicate clear, concise, objective and accurate information, and satisfy legal requirements.

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# Nursing Home Medical Records: Part 2: Documentation Review

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**KEY WORDS**
Medical Record, Electronic Medical Record, Electronic Health Record, Liability, Litigation

*The medical record provides an important means of communication with other providers involved in a resident's care. Nurses are responsible and accountable to properly assess and monitor a resident and institute appropriate treatments and precautions, to document and report/communicate pertinent information, to perform nursing procedures correctly, and to report known deviations from practice. This article reviews the importance of the adhering to documentation criteria in the medical record in nursing home litigation cases.*

## Nursing Homes and Documentation

Residents admitted to nursing homes take up residency for varying lengths of time depending upon condition, support systems, and home arrangements because they need care to help rehabilitate, restore, preserve, or adapt their functional skills. Staff are expected to assist residents, many with progressive conditions, to achieve functional independence and self-determination at the highest attainable mental, physical, and psychosocial levels (42 CFR §483.25). The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices (42 CFR §483.75) and State laws.[1]

Documentation substantiates care provided (required for Medicare reimbursement), reflects nursing accountability, and is fundamental to safe nursing practice (Keenan, Yakel, Tschannen, & Mandeville, 2008). The American Nurses Association (ANA) recognizes documentation as an important function of nursing and notes that it must clearly communicate the nurse's judgment and resident evaluation (ANA, 2010a). It must be timely, accurate, complete and legally sound, and provide evidence of care given. Documentation type and frequencey must comply with institutional polices. Properly written, an entry should be legible, timely, and systematic. Sloppy entries are a red flag for possible liability. (Iyer, Levin & Shea, 2006)

Documentation systems vary among institutions, Many nursing homes use charting by exception (CBE), in an effort to use the nurse's time more effectively and efficiently (Chizek, 2012; Hager R Munden, 2008). CBE requires charting only some aspects of a resident's care, i.e., deviations, abnormal, or significant findings. Legally this is problematic because the scarcity of entries makes it difficult to verify what was done or not done in giving care. It may fail to provide a written record of communication between healthcare team members, and the intermittent entries may be unclear as to whether or not interventions were triggered or implemented early enough (Hartley, 2007; Jaffe, 2011). The Nursing Service Organization (2012), noting CBE still demands sound clinical judgment, recommends the nurse ask, "Does this document tell the full story of the patient's condition and of our professional assessment and care?"

Physician practices and hospitals are required to have an electronic health record (EHR) system in place by 2015 or be penalized by lower Medicare and Medicaid reimbursement (MedicalRecords.com Team, 2013; University Alliance Online, 2013).[2] While this law is not applicable to nursing homes, moving to EHR is expected to allow rapid access to information pertinent to providing quality care to the resident (CMS, 2012). However, EHR transition is time-consuming and costly at start-up, especially given that long-term facilities are ineligible for incentives.[3]

Only 1% of long-term care facilities had an EHR system in place in 2005 (Kramer, Richard, Epstein, Winn, & May, 2009). By 2010, estimates ranged from 18% to 47% care (Kramer, Kaehny, Richard, & May, 2010). A study by Cherry (2009) identified the main barriers to EHR use in long-term care facilities were "costs, physician acceptance, disruption of current clinical practice, and lack of documentation standards (p. 8)."

Regulations and standards of medical record maintenance, confidentiality, and security are important. Safeguards must protect patient confidentiality and prevent

1 State Regulations Pertaining to Clinical Records. N.d. MS. Rerieved from http://health.cat/open.php?url=http://www.hpm.umn.edu/nhregsplus/NH%20Regs%20by%20Topic/NH%20Regs%20Topic%20Pdfs/Clinical%20Records/category-administration-clinical%20records-final.pdf

2 An analysis of factors effecting the adoption of EHRs is available at http://www.i-jmr.org/2013/1/e5/

3 More information regarding electronic health record incentives is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/35_basics.asp#TopofPage

others from modifying entries. Access must be limited and each provider must have his or her own username and password to ensure the computer log accurately reflects the provider making a documentation entry (AHIMA, 2011).

Many residents of nursing homes will require hospitalization for illness or injury; an electronic system that allows point-of-care documentation and integrated information access could improve the quality of care and improve the outcome. The change from manual to EHRs, however, comes with benefits and risks. Adoption of EHRs may potentially narrow information gaps between facilities by making a patient's medical information more readily accessible to providers helping to ensure the continuity and quality of patient care (Healthcare Information and Management Systems Society, 2008). But EHR templates may increase the risk of missed diagnoses, a significant legal issue [Association of American Medical Colleges (AAMC), 2011], because templates constrain clinical documentation with limited checkoff choices and space for free text. Just as a paper chart can be missing a page, so too an EHR printout can be missing a page of vital information (AAMC, 2011; Valerius, 2007). Finding information on hard copies can also be time consuming since the printed copy does not appear as viewed on the computer screen (Hillman & Watson, 2011). Furthermore, EHRs generally do not have search capabilities allowing information to be pulled up by entering a keyword (Lewis, 2012).

## Documentation Guidelines

The nursing process provides a framework for documenting care (Shaw, Meek, & Bucknall, 2007). The American Nurses Association recognizes six steps of nursing process that demonstrate nursing competency: assessment, diagnosis, outcome identification, planning, intervention, and evaluation (ANA, 1988). Its systematic and multidirectional approach helps nurses and other healthcare providers evaluate a resident's progress towards the outcome goals (ANA, 2010b). It also serves as a framework for attorneys trying to determine if care meets standards set by the federal and state guidelines from OBRA '87, Nurse Practice Acts, professional organizations, accreditation agencies, and institutional policies (Iyer, 2001).

Guidelines derive from existing research and the consensus of experts and are intended to improve efficiency and the quality of care (Open Clinical, 2006). They provide recommendations to meet the standards of practice but are less rigid than standards. Although guidelines are not set by statute and are not intended to set standards, some courts have allowed them to be presented as evidence of standard of care (Peterson, 2012).[4, 5], In developing a nursing negligence lawsuit, adherence to or deviation from the above guidelines can effect litigation outcome.[6, 7]

Adhering to documentation criteria can affect a nurse's liability in nursing home litigation cases. A guideline for charting can be found in Table 1.

## Narrative Notes

Documentation in progress notes should correspond to the plan of care. They should accurately reflect observations and assessments, interventions, and resident response (Table 1). Narrative notes are usually used with flow sheets or check lists and should be accurate, precise, objective, and, unless pertinent, should not duplicate information on the flow sheets (Iyer, Levin, & Shea, 2006). Illegibility, stylistic inconsistency, spelling errors, wordiness, imprecise wording, rambling, inappropriate remarks, or personal opinions can distort or make it difficult for the reader to quickly sort through information being communicated, and raise concerns about the writer's professionalism and competence (Documentation Guidelines, 2006).

Narrative progress notes should communicate patient assessments, interventions, and outcomes clearly. The SOAP (subjective, objective, assessment, plan) note is just one example of how to organize notes (Rosdahl & Kowalski, 2008). Whatever the format used, it should meet facility policy and provide evidence of critical thinking and a rationale for actions taken (Benner, Hughes, & Sutphen, 2008; Blair & Smith, 2012).

## Flow Sheets, Templates, and Forms

Licensed and unlicensed staff use flow sheets, e.g., for intake and output, vital signs, acts of daily living (ADL), behavior, medications, or treatments. They may be quick and easy to use but are space-limited and may require a progress note (Hager & Munden, 2008). Information should be consistent with nurse's narrative notes. For example, a flow sheet indicating a resident has consumed 100% of a meal would not be consistent with the nurse's narrative documenting poor appetite.

Entries should be initialed, with an identifying key on the document, not separately. If the facility approves specific symbols, letters, or numbers, a key to their meanings must be provided on the document (Rosdahl & Kowalski, 2008). Blank spaces raise questions about whether care was rendered; N/A should appear in the space as indicated. Documents with multiple sections or completed by multiple care providers (e.g., the MDS) must provide an area for each contributor's dated signature. Preprinted forms, checklists, and educational material should be signed and dated (CMS, 2005; Rosdahl & Kowalski, 2008).

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[4] *Pollard v. Goldsmith*, 572 P.2d 1201 (Ariz. App. 1977)
[5] *Swank vs. Halivopoulos*, 260 A.2d 240, 242-43 (N.J. Super. Ct. App. Div. 1969).
[6] *Levine v Rosen*, 616 A 2d 623 (Pa 1992)
[7] *Washington v Washington Hospital Center*, 579, 627 A 2d 177 (DC 1990)

**Table 1: Documentation Recommendations**

| Record | Documentation Recommendations |
|---|---|
| General guidelines for all documentation | • Handwritten entries must be in permanent ink<br>• Entries should specify the date and time of the entry<br>• Handwriting should be legible. Sloppy notes may be perceived by a jury as evidence of sloppy care.<br>• Use proper grammar and avoid misspellings<br>• Write clear, concise sentences using common terminology. Avoid excess words.<br>• Use only facility-approved abbreviations<br>• Record accurate factual and current information about resident health status, preventive health services, treatment, planning, and delivery of care.<br>• Do not chart in advance<br>• Avoid speculation<br>• Record pertinent information<br>• If unable to complete notes on a page sign that page and on the next page note that it is a continuation of the previous note.<br>• Do not leave blank spaces. Note if and why the resident is unavailable for care. Do not leave a blank line between entries. If there is insufficient room to write a note, draw a line through the space and start the note on the next page.<br>• Writers must authenticate each entry with a signature using first initial, last name, and status, e.g., J. Smith, RN. (Initials may be used if allowed by facility policy and a signature sheet is in the chart.) Draw a line from the end of the entry to your signature.<br>• Sign or initial only those notes that describe care you provided or supervised and observed. Do not sign or add to another provider's notes.<br>• Correctly identify late entries and why they are being added to the record. The correction must indicate the date, the signature of the person making the revision.<br>• Correct mistaken entries by drawing a single line through the entry so that it is still legible, write "mistaken entry" over or beside the original words, and date it. The original inaccurate entry must remain accessible and must not be obliterated.<br>• Do not destroy and rewrite the record. Altering the medical record can be seen as fraud and is subject to prosecution that could result in fines and / or imprisonment.<br>• A late entry written to add information that was missed or omitted in the initial entry must be identified as a "late entry," be written as soon as possible after an event and reference the original entry or event, provide a reason for the late entry and the date and time of the addition.<br>• An addendum is a late entry intended to provide additional information. It should be pertinent and factual and not be a reflection of the writer's personal opinion, perception, or defense. A late entry or addendum should not be added after the record has been copied or released. (C. Peterson, 2010)<br>• A late entry should not be added outside the workplace, e.g., on a home computer.<br>• A late entry should be completed in the same charting format (electric or manual) as original entries. |
| Progress Notes | • Document in chronological order and as close to the time as possible to the time of observation or care.<br>• Avoid block charting (one note for entire shift) as it can raise questions about timely recognition and intervention for a resident status change<br>• Document changes in the resident's condition<br>• Use direct quotes when describing a resident's chief complaint<br>• Describe the physical assessment well (e.g., location, radiation, severity, quality / quantity, frequency, timing, and alleviating/ aggravating factors) using measurable terms<br>• Document pertinent negative findings<br>• Describe what is observed, heard, felt or smelled<br>• Assess psychological and psychosocial factors<br>• Only draw conclusions that can be validated<br>• Document actions taken based on assessment<br>• Document if medications / treatments are omitted and why.<br>• Document the resident's response to interventions.<br>• If a resident refused care, note the date, time, treatment refused, resident's mental and physical status at that time, witnesses present, statements made to the resident and the resident's response; notify and document the response of the prescriber or supervisor.<br>• Document nonadherence and any reasons, discussion / education / communication regarding the resident's nonadherence. If warranted, complete an incident report.<br>• If a resident is hostile or aggressive, describe behaviors. Resist making assumptions or using negative labels.<br>• Document a resident's threats to harm another in objective terms, recording assessment of behavior and intervention.<br>• Avoid judgmental statements and do not criticize others.<br>• Document any incident in the progress notes adding statements made by the resident or family. Do not write that an incident report was completed in the medical record.<br>• Document education provided to the resident / family and their ability to comprehend, recall, and follow through.<br>• Document information reported and to whom, by name.<br>• Document referrals. |

| Record | Documentation Recommendations |
|---|---|
| Prescriber Orders | • Follow facility policy regarding verbal, phone or faxed orders.<br>• Verbal orders should be witnessed by two people, charted with date, time, and signature, and then co-signed by the prescriber as soon as possible.<br>• Document the time and initial orders when reviewed.<br>• Document in the progress notes when new orders are received. |
| Diagnostic test results | • Document date, time, and mode of notification of abnormal laboratory results.<br>• Document when and to whom, by name, results were called.<br>• Document the reason for any prescribed test not being done. |
| Medication/Treatment sheets | • Document the date, time, route, site, and response to medications.<br>• Document if medications / treatments are omitted/refused. |
| Flow sheets | • Complete flow charts only after providing care, and never fill out in advance.<br>• Do not leave blank spaces. |
| Incident Reports | • Follow facility policy when completing reports.<br>• Record in detailed, objective terms.<br>• Do not assign blame or make statements regarding how incident could have been avoided.<br>• Describe actions taken to provide care at the scene.<br>• Document notification date and time, and names of all those who were notified.<br>• If a roommate saw the incident, do not include this person's name, as this would violate confidentiality.<br>• Complete each segment of the report.<br>• Do not cross out, alter or destroy original document; if necessary a dated amendment can be added.<br>• Send the incident report to the designated person. |


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## Interdisciplinary Progress Notes

Physicians' visits, regulated by 42 CFR §483.40(c) are required at least once every thirty days for the first ninety days following admission and then at least every sixty days thereafter. However, visits occurring with ten days of specified periodic visits are still considered timely. Per 42 CFR §483.40(e) and §483.40(f) and if allowed by State law, a nurse practitioner, physician assistant, or clinical nurse specialist, not employed by the facility but working with the physician, may meet these regulations on the physician's behalf. Providers must write progress notes following each visit, signed, and dated. Specialized rehabilitative service providers must also document their services in the medical record (42 CFR 483.45).

## Prescriber's Orders

Staff must note prescribers' orders with a date, time and signature or initials, and transcribe them accurately. Staff must read back a verbal or telephone order to the prescriber and record how the order was taken, prescriber name, and recorder name (Institute for Safe Medication Practices, 2001; Rosdahl & Kowalski, 2008). Facsimile orders must be signed by the prescriber. Since facsimile paper fades over time, anything received by facsimile should be photocopied and filed in the chart, and the facsimile copy destroyed. If a prescription seems inappropriate, staff should contact the prescriber with any concerns and document the physician's response (Hager & Munden, 2008). If necessary, staff should contact the nursing supervisor and/or medical director (Nettina, 2010).

## Auxiliary Records

Other records documents found in the medical record include (but are not limited to) advance directives and consent forms (Roach Hoban, Brocclo, Roth & Blanchard, 2006). Incident /accident reports, systems such as a "Kardex®," correspondence, and authorizations for release of records are not part of the legal record, although they contain information about an individual resident (Hager & Munden, 2008). Notice of resident's rights may be provided orally or in writing at admission; if written, it may be referenced in the medical record (Hager & Munden, 2008).

## Advance Directives

Federal law (42 CFR §489.100) requires skilled nursing facilities to maintain written policies and procedures concerning advance directives. Advance directives (living will, durable power of attorney, do-not-resuscitate order, etc.) should be placed in a prominent part of a resident's medical

record (Rosdahl & Kowalski, 2008). *Do not resuscitate* and *comfort measures only* orders must comply with federal and state regulations[8] and facility policy. Nurses should be familiar with state requirements for advance directives, review their facilities' policies, and clarify any concerns during new-hire orientation.

## Resident's Right to Refuse Care

Federal law (Affordable Care Act), most state laws, accrediting agencies, and professional organizations (e.g., the American Hospital Association[9]), support a patient's Bill of Rights, including the right to refuse treatment (Rosdahl & Kowalski, 2008). Nurses should know their facilities' policies on patient rights and notification of physician and family. Staff should document attempts made to explain a treatment's purpose, and whether residents refuse recommended treatment or plan of care.

Knowledge and ability to understand health information, beliefs, social support systems, resident/provider relationship, and finances are some factors that influence treatment adherence (Jin, Sklar, Oh, & Li, 2008). Nonadherence can affect therapeutic outcome. Some states have contributory negligence laws[10] which limit damages awarded if the plaintiff's actions or omissions contributed to an injury.[11] A record of refusal of treatment or nonadherence may be used as a defense (Physician Risk Management, 2012). Documenting a resident's *informed refusal*[12] versus "noncompliance," indicates the resident understood 1) the proposed treatment and its benefits, 2) reasonable alternatives to treatment, and 3) the risks associated with the treatment (Roach et al. 2006), and suggests the resident made a conscious informed decision.

## Restraints Record

The Nursing Home Reform Act (OBRA 87) recognized a resident's right to be free from physical or chemical restraint imposed for convenience and not required to treat a medical symptom. This regulation is credited with a decline in the percentage of nursing home residents being restrained from 21.1% in 1991 to less than 5% in 2007 (CMS, 2008). Literature on declining restraint use in nursing homes is scarce, but restraints appear to be the exception rather than the rule (Burger, 2009). Unfortunately, however, nurses often use restraints rather than seek alternatives (American Association of Nurses, 2014). When warranted, restraint use should conform to 42 CFR §483.13 and facility policy. Facilities should have written policies about when restraints are warranted. Staff should adhere to these policies. A signed and dated patient / POA consent form is placed in the medical record. Staff should document the following:

- Type of restraint used
- Reason for use
- Safety precautions taken
- Times of restraint release to reduce pressure and promote circulation
- When staff performed range of motion exercises
- When staff offered food and drink
- When the resident was toileted[13]

## Incident Reports

CMS Regulation 42 CFR 483.13(c) (2) requires nursing homes to report mistreatment, neglect, abuse, and injuries immediately to the facility administrator and officials according to State law. The facility must file an incident (also called occurrence, variance, quality assurance, or situation) report for:

- An injury to a resident, staff, or visitor
- Event such as a medication error
- Unusual occurrence that warrants reports
- Suspected instances of abuse, mistreatment, and neglect

This documentation is intended to help nursing homes comply with regulations (Aging and Long-Term Support Administration, 2012). It also keeps the nursing home administrators informed of the event of a potential safety problems requiring correction and to alert risk managers of a potential lawsuit (Wagner, Capezuti, Clark, Parmelee, & Ouslander, 2008).

In some states the incident report is considered privileged information and granted confidentiality as an incentive to providers to report events to a quality assurance committee for root analysis (Mikk, 2008; Roach et al., 2006). Since it may be relevant to the lawsuit an attorney may seek a copy. If a judge determines disclosure is justified and allows the incident report to be released during the discovery process, this revokes the confidentiality of the report (Mikk, 2008).

When a reportable event occurs, staff must notify the supervisor and, as soon as feasible, objectively complete the facility's incident report form supplying only the information requested (Dearmon, 2009). See Table 1 for details.

In the case of equipment failure/malfunction, staff should put the equipment aside until it can be inspected and determined if it contributed to the injury, and document the problem and actions taken to safeguard the resident (Eichhorn, 2010).

Residents and families who feel angry and dissatisfied with sparse, incomplete, or unclear explanations of an incident are more apt to want revenge and to see the healthcare provider disciplined (Wei, 2006). Legislators

8 States must follow federal regulations but may opt to adopt additional state laws. For a list of states with advance directive regulations go to http://www.noah-health.org/en/rights/endoflife/adforms.html

9 For a review of patient rights go to http://www.qcc.cuny.edu/socialsciences/ppecorino/MEDICAL_ETHICS_TEXT/Chapter_6_Patient_Rights/Readings_The%20Patient_Bill_of_Rights.htm

10 *Conn. Gen. Stat.* § 52-190a(a) (2011)

11 *Charell v. Gonzalez*, 673 NYS2nd 685 (1st Dept. 1998

12 *Townsend v. Turk* (1990) 218 Cal.App.3d 278 [266 Cal.Rptr. 821]

13 Further information on restraint documentation can be found at http://www.uiowa.edu/~medtest/behavioralhealth/Restraint_Form_2.pdf and http://www.quammengroup.com/docs/presentations/best_practices_for_nursing_doc_restraint.pdf

hypothesized that apology laws, enacted by 36 states between 1986 and 2009 (eight other states and Puerto Rico have laws pending)[14] to provide legal safeguards to the healthcare provider who express sympathy or regret, would reduce the likelihood of litigation. Although there is some evidence suggesting apology and disclosure of mistakes can speed up and reduce malpractice payments by $55,000 to $73,000 per case, more evidence of these laws' effect on the number of negligence suits filed is needed (Ho & Liu, 2010).

Nurses named in lawsuits should notify their malpractice insurance carriers and their employers' nurse manager and risk managers as soon as possible (Dearmon, 2009). No lawsuit should be discussed with the resident, his family, or his attorney, colleagues, prescriber(s), or other employees (Reising, & Allen, 2007). No changes should ever be made to the resident's medical records.

By failing to maintain the medical record according to established standards a nurse fails to fulfill nursing's professional responsibility to the resident and the interdisciplinary team. Further, this increases risk for a lawsuit, with livelihood and financial situation at stake. "If it is not charted, it was not done," an adage familiar to nurses, will take on new significance when claimed by plaintiff's counsel.

## Conclusion

The medical record is key in nursing home litigation and can provide the basis for a suit or defense in nursing negligence claims (Dearmon, 2009). Nurses with authorization to access and document in a resident's medical record are held responsible for knowing documentation requirements and are held accountable for entries or omissions to the medical record (ANA, 2001; ANA, 2010b). When legal action is being considered the plaintiff attorney may obtain a copy of the medical record and will review the record for deficiencies and inaccuracies in the charting (Austin, 2011). The case outcome may hinge, in part, on the evidence provided within the context of the medical record.

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