Defuse Claims of Negligence with Your Nursing Home Documentation

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1. **Admission Skin Evaluations:**

   Problem: Delay between admission and evaluation with measurements and detailed description by the facility wound nurse, during which time wound decline occurs.

   Solution: A comprehensive skin assessment should be done within hours of admission. All floor nurses should be competent with this assessment. Measurements should be taken right away. Describe wound appearance in detail. Take photographs if appropriate. Ask for and compare the last wound notes from the previous facility, if notes are available, and document differences. Wounds can decline within one shift of the last assessment before transfer. Do not stage the wound. Erroneous staging is always an issue in a lawsuit. Update the resident and/or family about the resident's condition upon admission. Don't wait!

2. **Suspected Deep Tissue Injury Upon Admission:**

   Problem: A suspected DTI is visible upon admission. It will likely blossom over the next week or two and be blamed on the skilled nursing facility.

   Solution: Show and tell the resident and the family what to expect if a DTI is suspected. Document, "Resident and family [specify who] informed that a deep tissue injury is suspected and the injury under the skin will likely open into a deep bedsore soon despite everything we do to prevent it. The tissue damage must heal from underneath and it can take weeks." Formulate a Care Plan right away to include a WC cushion and a pressure-reducing mattress, and document provider notification.

3. **Decline of wound:**

   Problem: Decline of a wound is reported to a provider by phone or in person, but the provider does not actually look at the wound.

   Solution: Clearly document which provider was notified and what he/she was told, i.e., "Dr. ____ was called, told of increased wound dimensions, new odor, purulent drainage, A.M. vitals. Orders received." Update the Care Plan!

   Problem: Provider notes are unclear as to whether or not they actually viewed the wound.

   Solution: Clearly chart a provider's evaluation of a wound, i.e., "Removed dressing to evaluate coccyx wound with Dr. _____, discussed current treatment and options with provider. Dr. _____stated the wound looked like a DTI and is aware resident was in hospital for 29 days in ICU before arrival to SNF. New orders received." That makes collaboration with the physician obvious and a lawsuit less likely.

4. **Incontinence:**

   Problem: Documentation of the extent of wound contamination due to incontinence is lacking. Numerous cares during each shift are not reflected in the record.

   Solution: Document, "Incontinent of urine [or stool] in brief x 3 this shift. Linens changed as needed. Incontinent cleanser used after each incontinent episode. Unavoidable urine [or stool] contamination of coccyx dressing occurred with each void, wound cleansed with wound cleanser each time and redressed.

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Provider _____was notified of recurrent wound contamination with urine [or stool].” Chart every PRN dressing change on the TAR. Update the Care Plan! Keep the resident and/or family advised and chart the conversation.

5. **Dehydration:**

Problem: Insidious dehydration occurs in the elderly, often associated with an infection. Plaintiffs allege dehydration in nearly every nursing home case. Nurses often chart, “Encouraged fluids,” but do not say if the resident actually took a drink.

Solution: Chart in more detail, i.e., “Encouraged fluids, but would only take one sip.” Or “drank 1 cup of water with assistance.”

If a resident is not drinking, notify the family/medical power of attorney, as well as the provider. If staff believes a resident is getting dehydrated, call a provider with vital signs and request he/she order chemistry labs and a UA and chart your request. Also chart what was discussed with the family, for instance, “Called MPOA to inform her that her mom isn’t drinking well. Asked her what drinks her mother likes to drink. MPOA said, 'It was a continual struggle at home to get mom to drink. She doesn't like anything.'” Update the Care Plan! If dehydration is suspected and promptly addressed, a lawsuit is less likely.

6. **Additional Factors Affecting Pressure Ulcer Risk:**

Problem: Plaintiffs allege delay in obtaining specialty mattress, lack of WC cushion, and/or failure to turn and reposition every 2 hours.
Solution: If all of the facility's mattresses are all pressure-reducing, chart the make & model upon admission. Other examples of helpful charting, are, "Alternating air pressure mattress with pump ordered from ____ at 0900, arrived and put on bed at 1500." Or, "Gel WC cushion always used when up for meals."

Problem: Residents on tube feeding must have the head of the bed up 30 degrees or more to prevent aspiration of regurgitated formula, increasing pressure on the coccyx.
Solution: Turn the resident at least every 2 hours and document if turned more often. Use pillows or wedges to prop on side. Document the use of 2 or 3 assists for turning and if, for instance, 6 pillows are needed to prop the resident onto his/her side. Notify a provider and the family, and document the notification, if you have trouble keeping a resident off his/her coccyx. Explain to the MPOA the dilemma of keeping the resident off his/her coccyx while needing to have the HOB up to prevent reflux and aspiration of tube feeding solution, and subsequent, potentially fatal, aspiration pneumonia. Chart the conversation.

Problem: Residents at risk for aspiration must be at nearly 90 degrees sitting up in a chair while eating or drinking, increasing pressure on the sitting surfaces.
Solution: Document the use of a gel or other WC cushion (not just a pillow) and, "Resident up in WC <2 hours for each of 2 meals today at 90 degree angle while eating/drinking to prevent aspiration. Turned side to side at least every 2 hours when in bed with HOB up 30 degrees as ordered." Make sure resident and family are made aware of the balancing act between preventing aspiration and preventing pressure ulcers and chart the conversation.

7. **Family:**

Problem: Family members sue a facility for negligence and/or wrongful death despite being minimally or not involved the resident's life.

Solution: Chart who visits, when, and how long they stay. Chart any statements about family members, i.e., “My son ___ only lives 20 miles away and hasn’t visited me in 2 years.” Or, "I don't want to go home again. My daughter doesn't help me. She only wants my money." Or, "I have six kids, but only ___ comes to see me."

8. **Refusals of Care:**

Problem: Residents refuse meals, showers, peri-care, turning, getting out of bed, going back to bed, and/or RNA treatments or skilled therapy.

Solution: Chart all refusals of care, specifying what cautionary education was given, i.e., "If you don't let us turn you, you will get a bedsore," and chart the resident's response, "I don't care." Notify the MPOA of refusals, ask their advice, and chart their response, i.e. "Keep trying, but I know he can be difficult. I don't know what else you can do." Ask the MPOA to talk to the resident about complying with care, and document same.

If pain is the reason for refusals to turn, call the provider to address pain. Call again if those measures don't work. Get an order for Milk of Magnesia or Dulcolax tabs every 3rd night to combat constipation if narcotics cause problems.

Chart education given to the MPOA about restrictions on restraining the resident, restrictions about forcibly turning someone against their will, and restrictions on using seat belts in WC's or straps in bed to keep a resident on his/her side. Document the response of the MPOA, "Yes, I know you are doing the best you can." Update the Care Plan!

9. **Staff Relationship with Resident/Family:**

Problem: Family members sue a facility for negligence and/or wrongful death despite months or years of good care provided to the resident. Multiple incidents of tender loving care of a resident by staff are not reflected in the records.

Solution: Nurses and CNA's should introduce themselves to family members. Sometimes a go-to staff member can defuse a complaint. Inform family of the care being given to the resident, and chart the conversation, such as, "Told daughter ___ that her dad is up in a WC for three meals a day, has therapy for about 30 minutes BID 3-5 times a week, a wound nurse changes his dressing QD and more often as needed, we make sure he repositions at least every 2 hours, and we help him back to bed in between meals and activities so he can rest."

Document extra care taken to make the facility seem less clinical and more like the resident's family home. Nurses and CNA's should do brief narrative notes more often. Notes such as these below present a positive image of the staff to a jury. Charting examples:

- Wheeled resident outside to patio to watch birds at feeder for 20 minutes. Resident smiled whole time.
- Brought resident to rec room to hear 1 hour of Christmas music today. Said she enjoyed it a lot. Rested in bed between meals, turned Q 2 hours.
- Resident had a good day. Watched a funny movie in day room and had popcorn provided by staff.
- Resident refused dinner because not hungry, but successfully spoon-fed her 200 ml of Ensure ice cream at 2300.
- Resident had no clean trousers, brought her clean black trousers from donation closet. Notified Social Services to contact family for clothes.
- Resident said, "I like it here. You take good care of me."
- Resident had shower and shampoo today and said he enjoyed it a lot. Moisturizing lotion applied to legs and arms. Coccyx dressing removed for shower and reapplied by LPN. No new skin issues.
- Resident taken all over facility in WC today for 20 minutes, greeted multiple staff by name. Resident smiled a lot.
- Accompanied resident to ortho doctor today to check leg. Brought back new orders to Charge Nurse. Resident enjoyed being out. Nurse bought her a milk shake on the way back.

The ACTIVITY DEPT staff should chart more often, in addition to their periodic assessments and attendance checklists. They often interact with the resident many times a week. Their notes can also contribute to the image of the facility as "home" rather than "institution." Examples:

- Visited 1:1 for 15 minutes with resident today. She was happy to tell me about her 5 grandchildren. Invited her to come to bingo and August birthday party for residents today. CNA agreed to bring her in WC.
- Resident smiled and tapped her foot throughout guitar concert in day room today.
- Resident smiled during the whole one-hour visit from her granddaughter, Jennifer.
- Two sons visited together today for <2 hours. Paul appeared intoxicated and smelled of liquor. James assisted his mother with lunch.

10. Declining Resident:

Problem: Residents age. Multiple comorbidities add up. General decline and/or the dying process begins subtly. Families sue because of unrealistic expectations when their loved one dies. Providers do not often educate families about long term prognosis. The "cause of death" does not reflect the whole picture.

Solution: Nurses are the resident's advocate. Call providers to come in when a resident is declining. Chart, "Called provider. Informed of V/S taken at 0800, poor fluid intake for last 2 days, and lethargy. Informed provider this is a change in resident." If provider does not give orders for labs, IV hydration, or transfer to the E.R. and the nurse isn't comfortable with that, don't be afraid to say, "I know this resident and something is really wrong. Can you order some stat labs for us? Or can we send her to E.R.?" If refused, call up the nursing chain of command. Call the family to inform them of the nurse noticing that the resident is not feeling well over the last couple of days, that the provider was called and about any orders received. Tactfully educate the family about future decline before it happens so that their expectations will be realistic and they won't blame the facility for the inevitable. Enlist the providers' help often with family education.

11. Things That Torpedo the Facility's Defense:

Problem: Staff is slow to answer call lights and says to the resident or family:

- We are short staffed today.
- We are so busy because we are two people short today.
- We only have one nurse today, so she's swamped.

Solution: Don't EVER say you are short-staffed. An apology goes a long way. Better statements would be:

- I'm so sorry. I got delayed with a doctor on the phone.
- I'm so sorry. I was assisting another resident when you called and couldn't leave her in the bathroom alone.
- I'm so sorry you had to wait. I'm here now. How can I help?
- I'm sorry you are having to wait for the LPN to bring that pain pill. She had a couple of medication requests just before yours. Can I help you get more comfortable in the meantime?
- Turn the call light off as soon as the resident's needs are addressed so fewer call lights are on in the hallway.
- Don't appear idle, gather in the break room, or have personal conversations at the Nurses Station when call lights are on in the hall in full view of families.

Problem: A resident is sent to the E.R. from the facility with an acute issue on top of multiple chronic issues, but the E.R. staff isn't given all relevant information. They write damaging chart entries such as:

- Has stage IV pressure ulcer that daughter says he got in the nursing home.
- Profoundly dehydrated. Says he was rarely given a drink at the nursing home.
- Has a Foley of unknown age, urinalysis indicative of UTI.

Keep in mind that the E.R. staff typically has no idea of patient outcomes in long term care. To them, pressure ulcers and dehydration they see in the E.R. are always the fault of the transferring facility.

Solution: The discharging nurse should CALL the E.R. triage nurse to give a good report and send copies or fax over more relevant records than are typically sent. Examples of important data often not given to E.R.:

- "He came to the nursing home with a deep tissue injury on his coccyx from _____ Hospital three months ago, which blossomed into a stage IV despite a specialty mattress and daily treatments. Dr. _____, the attending at the facility requests an evaluation for a muscle flap by a plastic surgeon now that the wound eschar is gone." "This 90-year-old woman has been nearly unresponsive, bedridden on a specialty mattress, and on tube feedings for >6 months, and the family continues to want everything done. Dialysis is due tomorrow."
- Fax past hospital records, if available, the facility's Admitting Nurse Assessment and any relevant subsequent notes, Provider Notes, Wound Nurse Notes, Labs, the latest MAR and TAR sheets, PT/OT Notes, Nutrition Notes and anything else to give the E.R. staff a complete picture of the resident's condition.
- Recurrent, resistant UTI's, date of last culture
- Recurrent pneumonia and/or sepsis
- Has been in hospitals or nursing homes for the past _____ months or years
- Date of last Foley change
- Last course of antibiotics—drug, dose and dates

A bad impression of the facility by the hospital staff might be deflected if a Charge Nurse or Director of Nurses from the facility gives the E.R. staff a phone number and informs them, "Don't hesitate to call us with any questions about Mrs. _____. We have taken care of her for a long time." Repeat that call in a day or so to the Charge Nurse of the unit where the resident is admitted. Good P.R. can go a long way!