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**Developing Risk-Management Protocols in Assisted Living**

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| **BY SANDI PETERSEN, RN, MSN, CLNC** |

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| **Developing risk-management protocols in assisted livingAssisted living has its own litigation traps for the unwary** |

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| There are many misconceptions about long-term care. It is truly very different from living at home even as much as we try to normalize the lives of residents. As providers, we strive to ease that transition and make residents comfortable. As providers, we know that this is easier if everyone knows what to expect before they sign on the dotted line. We cannot erase the fact that no matter how comforting we make these surroundings, it is not the same as home. Transitioning to a new lifestyle will be difficult for many. Thus, establishing expectations is a first step in defining and delivering quality care and services and minimizing risk in the long-term care environment.Because of increased litigation within the industry (some reports indicate that assisted living now surpasses long-term care in the amount of awards), risk management has become a key concern for many assisted living providers. A larger percentage of market share for the assisted living industry means the increased attention of not only state and local authorities, but also the federal government, in addition to plaintiffs’ attorneys.Back in the mid-1990s, assisted living trade organizations proposed best practices and risk-limiting protocols for the industry. The guidelines covered four main areas: services, environment, consumer protections (including resident rights, contracts, and risk negotiation), and management responsibilities. These still serve as the basis for risk-management protocols in the current assisted living environment:* **Services.**Resident screening should occur before move-in. In additional, each resident must undergo assessments for health, psychosocial, and cognitive status. This ensures that the facility is able to meet the resident’s needs and serves as a basis for the development of a comprehensive service plan. Information from the resident’s physician and documents such as guardianship papers, powers of attorney, living wills, and do-not-resuscitate orders also should be obtained at the time of admission. The service plan should be developed with the help of the resident and/or designated agent. The plan should include the scope, frequency, and duration of services and monitoring, and it must be responsive to the resident’s needs and preferences. The plan should be reviewed at routine intervals after move-in and annually thereafter, or as the resident’s needs or preferences change.
* **Environment.**A safe, homelike environment should be provided for all residents. This environment should support choice, independence, privacy, comfort, and individuality.
* **Consumer protections.**Residents should not be physically or chemically restrained, except when expressly ordered by a physician to treat a medical condition. Residents’ records should be kept confidential and released only with consent. In addition, providers should ensure residents’ choices and the right to autonomy for as long as possible, even if that means taking some risks. Residents should share responsibility for decisions affecting their lives and be fully informed of their rights and responsibilities.
* **Contracts and agreements.**Resident contracts should contain all the facility’s commitments and actual practices, including the criteria and procedures for admission, on-site transfers, and discharge. Payment information should be comprehensive and include: rate structure and payment provisions for both covered and noncovered services; an explanation of billing, payment, and credit policies; criteria for determining level of service and additional charges; fees and payment arrangements for third-party providers; provisions for payment during absences; and the facility’s policy for residents who can no longer pay for services.
* **Shared or negotiated risk.**When a resident wants to engage in potentially risky behavior, such as service refusal, a risk agreement should be negotiated, following open discussions with management and family members about the consequences of the resident’s choice. If the resident’s mental or physical condition changes substantially, the risk agreement should be reviewed. Providers must be careful to avoid using the negotiated risk or shared-risk process as a means of retaining residents who are beyond the scope of care that can be provided in the setting.
* **Staffing.**The facility should maintain sufficient qualified staff members capable of meeting scheduled and unscheduled resident needs at all times. The facility should have ongoing training for staff on how to monitor changes in residents’ physical, cognitive, and psychosocial conditions. In facilities serving residents with dementia, direct-care staff should receive dementia-specific training each year.
* **Advertising.**The rule is “Under-promise. Over-deliver.” Facilities must be vigilant about advertising specific features if they cannot ensure 100% service or compliance. Quality-of-care claims or “overselling the product” can leave a facility vulnerable to a lawsuit if they cannot be evidenced through documentation. Examples of such claims include: “Happy House Assisted Living provides the best care possible care,” “24-hour assistance provided,” “around-the-clock support designed to meet the individual personal care needs of residents,” “24-hour supervision,” “Happy House supports aging in place; no need to ever move again.” Avoid verbal statements that promise residents and families services that cannot be delivered. For example, “Our security system will keep your mom from eloping.” If the facility does not provide a locked unit, this claim is untrue. Statements of deficiencies from past surveys can be used to contradict such statements and can lend support to plaintiff’s claims.

The development of risk-management protocols requires a baseline assessment of all operating systems within the facility. Providers with successful risk-management programs always think of quality and safety as core values. These are always stressed over efficiency. The organization emphasizes quality and safety as the major components and focus of the philosophy and mission of the organization. All business decisions are made with regard to the potential or actual impact on resident safety and quality of care. Everyone in the organization and served by it takes ownership in teamwork, risk awareness, and risk reduction. Here are some tips that will assist in building risk-management protocols into your business:**1. Hire well and train well.**Recruiting and selecting the highest quality staff are imperative to protect residents and provide good care. Criminal background checks and reference checks, physical exams, and TB screenings (although not required by all states) should be an integral part of the selection process. All new employees should receive a planned orientation that includes both general and specific information about their employment responsibilities and a means for testing and documenting their competency.**2. Perform a thorough physical and functional assessment of all residents.**A full head-to-toe physical assessment should be performed on all residents admitted to the facility. Documentation of bruises, pressure sores, skin tears, or contractures is critical; otherwise, it will be assumed later on by anyone reading the resident’s chart that these developed “in-house.” It is equally important to document residents’ histories. Histories of poor appetite, falls, elopement, weight loss, etc., should be noted in the record.**3. Define areas of risk early on.**Develop negotiated- or shared-risk agreements where appropriate. Identifying residents who are at risk for a problem, such as a fall or elopement, *before* it occurs is much more important than addressing it afterward. Aside from fall risk, other assessments that should be performed and documented, both upon admission and routinely thereafter, include risk for skin breakdown such as pressure sores (with tools such as the well-known Braden Scale becoming a routine part of detecting potential for skin breakdown, for example), weight loss, elopement, mental status exams, depression screening, self-medication ability, and functional decline. Don’t make promises you can’t keep; ensure that you can effectively meet the needs of each resident admitted.**4. Communicate effectively. Address risk factors quickly.**Identifying risk is only half the battle. If facilities identify residents at risk but fail to initiate an action plan involving specific interventions through a shared-risk process, they have merely documented their own negligence. A negotiated- or shared-risk agreement does not excuse nonaction. Family members and responsible parties must be kept advised of all resident occurrences. As always, all communication, whether for training or information, should be documented. Documentation of refusal of care or refusal of emergency services is a key part of risk identification and management, as well.**5. Program reliability into your systems.**The Reliability Theory of Risk Management states, “If you do a task the same way each time, you are likely to get the same result.” If areas of risk are routinely reviewed, anomalies are quickly identified and can be addressed. Routine performance of skin assessments for residents at risk for breakdown, routine weight assessments for those at risk for weight loss, fall risk assessments, elopement risk assessments, or self-medication assessments helps detect issues. The basis for many facilities’ legal troubles is often a lack of systems in place to identify concerns before a negative outcome occurs.**6. Sometimes bad things happen. Empower staff with tools to cope effectively.**Eventually, unfortunate incidents involving residents will occur, requiring staff to react appropriately. How staff respond to an incident immediately after it occurs can, at times, mean the difference between life and death for a resident. All nursing staff members need to know what appropriate actions to take when events such as a resident fall or a medication error occur. Afterward, all details must be documented thoroughly in the resident’s chart and incident report. Sometimes it is just this documentation that determines the facility’s defensive strategy in the event of a lawsuit.**7. Be forthright in communicating and documenting negative occurrences.**Facilities should never try to hide incidents such as falls, elopements, allegations of abuse, or medication errors from the resident’s family and/or responsible party, or from the physician and state regulatory agencies (if reporting is warranted). When a bad outcome occurs, the *most* important thing the provider can do is to maintain contact with the family. Offering to do whatever is necessary to help the family with arrangements for care or to run errands can help. While administration and staff are certainly remorseful when something bad happens to a resident, they are often reticent or afraid to express those feelings of caring. Failure to show interest and caring may lead the family to believe that the provider is “only interested in money” or “only interested in filling beds.” When families or residents get the impression that the provider does not care, they are more inclined to respond in anger and may consider litigation, filing a report with the authorities, or spreading ill will in the community.As unpleasant or seemingly trivial as an incident might seem, families or responsible parties have a right to be informed, and staff members have an obligation to keep them as such. Systems *must* include mechanisms for enabling staff to keep one another informed, via verbal or written communications or taped reports supplied between arriving and departing shifts. These communications must detail any changes in resident status so that follow-up assessments and other important interventions can be appropriately performed and carefully, consistently documented.**8. Manage ongoing interventions effectively.**Often, simply responding to and reporting a resident occurrence is not enough. The resident may require ongoing treatments, assessments, and/or monitoring. In the event of a newly discovered pressure sore, for instance, follow-up documentation must be conducted on a weekly basis (at minimum) until the wound is healed. Likewise, if a resident is refusing a treatment or is noncompliant, the resident’s family and/or responsible party should be informed at once, with the risks explained and documented, and a shared-risk agreement developed. The exchange of this information should be formally documented, with signatures obtained from all involved parties.**9. Provide follow-up to ensure that interventions are working.**At times, facilities find that, despite their best efforts to prevent a fall, elopement, or other mishap, it occurs anyway. The important response for the facility is to investigate and determine which preventive steps worked and which were not effective, then revise or add new interventions to the resident’s service plan. Whether in a survey situation or in a courtroom, facilities will always be judged by the way in which any reasonable, prudent care facility would have responded under the same or similar circumstances. If the facility can produce a three-page list of all the preventive interventions the staff has attempted, it’s doubtful that anyone can accuse the facility of neglect. Unfortunately, too many facilities wait until the resident suffers a mishap *multiple* times before they surmise that their interventions were not sufficient.**10. Develop a means of inspecting what you expect. Perform routine quality/risk-management audits.**Reviews of systems, at least quarterly, and root-cause analysis posting sentinel events help ensure the maintenance of quality and risk-management protocol. Without vigilant inspection, staff may become complacent and begin to take shortcuts. Always document efforts to monitor and correct issues. Such monitoring is invaluable should litigation occur and may become extremely beneficial in the successful negotiation of lower liability insurance premiums.**11. Document, document, document.**Documentation of occurrences and the interventions put in place to address them is the “glue” that supports any successful risk-management program. The age-old adage, “If it’s not documented, it’s not done,” still holds true in legal and risk matters. Accurate, timely documentation of incidents, ensuing interventions, timely communication with doctors and families alike, and both follow-up and resolution record care can help minimize risk. Even when unwanted events occur, as they will, accurate, timely communication and documentation is the key to minimizing risk and exposure.**12. Develop satisfaction surveys for residents.**Querying residents and their families through surveys often leads to insights about potential risks. Resident and family complaints may give clues to unsafe practices by staff or services. Look for trends in qualitative and quantitative data emerging from these surveys. Trends indicating dissatisfaction with services may point out inconsistencies in delivery systems and, thus, point to potential risk. Exemplary customer service and timely response to customer concerns is an indispensable factor in minimizing risk. Even when bad things occur, customers are less likely to consider litigation if they feel they have been heard and that their needs or concerns were thoughtfully addressed.**13. Conduct staff satisfaction surveys.**Conducting formal surveys of staff on a routine basis, as well as exit interviews when employees are terminated, helps isolate potential risks for workers’ compensation and employment lawsuits. Trends may indicate a risk for injury to staff and/or residents and may be an indicator of system failures or even potential litigation.**14. Study results and determine meaning.**Results of surveys are useful indicators for changes in policies and procedures and systems and processes, as well as with regard to hiring and training practices. Results of surveys are valuable tools that can be used to determine the causes of particular problems. Results of this sort may also help organizations take a leap from a “blaming” culture to a learning culture. Learning from mistakes and problems and resisting the urge to blame someone for occurrences is imperative in the development of a successful risk-management program.**15. Track and trend resident and staff events.** Tracking resident and staff occurrences (variances or incidents) is another way of avoiding unnecessary risks and identifying system problems. Recording events and then frequently looking at trends helps determine the root cause of incidents and spearheads the identification of system problems. Tracking and trending of resident and staff events on an ongoing basis serves as an indicator for effectiveness of interventions or corrections to systems, policy changes, and new training agendas. It is recommended that all departments across the organization be involved in the review of resident and staff events. Taking ownership of risk throughout the organization and input from all is necessary to the success of any related program.**Summary and Resources**Senior management of the organization must support risk-management efforts through consistent awareness and support. Leaders and individual employees must realize the impact that their performances may have on the rest of the organization. *Ownership by every single employee is the key!* The organization’s structure must be “flexible” to accommodate needs related to risk. That means that employees closest to any resident event should be afforded the opportunity to have a voice and affect change. Everyone is a stakeholder in arriving at conclusions about the meaning of occurrences in a non-blaming culture. The focus must be on identifying the source of the problem, establishing its cause, and addressing or “remedying” the problem.Many liability insurance carriers have excellent risk-management materials available at no cost to the provider. Some providers may also seek the assistance of an outside consultant. Also, some organizations offer dedicated risk-management protocols aimed at assisted living providers. In any event, seeking outside assistance might just prove the differentiating factor in the event of an unfortunate occurrence among residents.Check your own facility’s risk-management preparedness with the checklist provided (see “Risk Management Checklist”). An ounce of prevention may just be the pound of cure in developing risk-management protocols in assisted living. **Sandi Petersen, RN, MSN, CLNC, serves as Chief Nursing Officer at Dallas-based Trinity Hospice, the nation’s seventh largest hospice provider. Trinity offers palliative care and support services to terminally ill patients and their families from 26 locations across nine states. Prior to this, Peterson was Senior Vice-President for Quality and Clinical Care for Assisted Living Concepts of Portland, Oregon, developing and implementing risk-management programs for the company’s 185 facilities. For further information, phone 214-329-1956 or visit**[**www.trinityhospice.com**](https://www.trinityhospice.com/)**.** *To send your comments to the author and editors, e-mail**petersen1105@nursinghomesmagazine.com**. To order reprints in quantities of 100 or more, call (866) 377-6454.* |