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**II. How to Self – Assess Your Facility for Risk Exposure**

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| **II. How to Self-Assess Your Facility for Risk Exposure** |

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| **By Richard J. Henry, JR., CNHA; and Christine A. Stevens, RN, MBA** |

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| The long-term care business model is a unique blend of healthcare and social services burdened by extensive federal and state regulations. By its very nature, this balancing act increases risk potential. Furthermore, changes in the survey process over the past few years have played a significant role in increasing risk exposure to litigation.  We know that risk, by definition, cannot be eliminated; however, we can manage the factors that contribute to the probability of risk and create a more defensible facility by implementing a risk-management protocol based on a team assessment process.  **A Logical Approach**  Major risk-exposure areas within your facility should have corresponding operational approaches to mitigate that exposure. The top five major risk areas in long-term care are:  **1. Slip/fall exposures.** Resident falls are one of the most frequent claims carriers receive.  **2. Elopement/wandering.** The percentage of our residents affected by various forms of dementia is approximately 44% nationally and represents a significantly “at-risk” population. Resident elopements in these cases can be the most costly type of claim, generating settlements and jury verdicts of staggering proportions.  **3. Skin integrity.** Some of the most notable litigation cases involve skin breakdown issues. Contributing inversely to the likelihood of litigation is the degree to which the facility adopts the most current technology to prevent wounds and provide and document wound care.  **4. Resident rights/abuse/neglect issues.** How often have operators been subjected to an allegation of abuse or neglect simply because a resident or family member had an unrealistic expectation of the level of service or care? Resident and family communication protocols, such as “shared-risk agreements,” can be an effective preventative against abuse allegations. Moreover, there are occasions in which resident abuse/neglect claims are more a reflection of a facility’s situation than of a true abusive event. For example, imagine an elderly resident who has been prescribed blood-thinning medication. We know that this resident will be prone to bruising, whether living at home or in a long-term care facility. Yet should this resident come to our facility, we could be subjected to an allegation of abuse with bruising as evidence! Unless we properly advise all parties of our expectations (in writing), we set ourselves up for an unfair allegation.  While it might feel unnatural for care-givers to share difficult scenarios such as this with customers, we must now begin to inform and educate the consuming public about the realities of our service model. These discussions could include frank language regarding falls, bruises and behavioral characteristics typical to our caregiving environment, for example: *We do not restrain our residents with your mom’s type of diagnosis and, as a result, in the normal course of living she might fall…. Dad might experience significant bruising as a result of the medication he is on…. Your uncle will steadily decline as the effects of Alzheimer’s disease advance, and he will begin to exhibit the following behaviors…. We do not offer a staff ratio of one-on-one care; should you desire this level of care you might wish to employ a companion…. We will offer the following interventions to mitigate the effects of these undesirable outcomes…. Please sign here indicating that we have discussed these issues and that you understand our service level and approach to care.* |

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| **” Know thyself ” Is a long-standing motto for success-and can be your facility’s best defense against liability.** |

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| **5. Medication and treatment errors/omissions.** Facilities must monitor their training and staffing systems continuously to achieve the level of control necessary for risk reduction in clinical care. Although it is readily apparent that staff training and adequacy are critical elements in managing such risk exposure, all too often training systems and floor staffing are casualties of other pressing operational demands.  **Elements of Self-Assessment**  Facilities can employ specific strategies to create a culture that values ongoing and meaningful risk-reduction oversight. As an example, we have created the following assessment approach used by our team consultants to assess a facility’s risk exposure level and defensibility posture.  **Step one: Gather data and review potential areas of risk.** Many of our clients have indicated that the process of collecting and organizing these data in preparation for an on-site review by our team has in itself initiated a meaningful risk-management process. It begins by gathering and organizing: |

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| 1. Survey results from the last four standard surveys and from any complaint surveys that have been conducted in the last six months 2. Quality Indicator Reports: Facility Characteristics, Facility Profile (QIs) and the Resident Summary 3.A current CMS Form 672-resident census and condition of residents 4.A current CMS Form 802-resident roster 5. Safety committee minutes from the last meeting 6. Family council minutes from the last meeting 7. Resident council minutes from the last meeting 8. Results of any resident and/or staff satisfaction surveys conducted with-in the last 12 months 9. The facility’s marketing brochure 10. A complete admission packet 11. The last quarterly quality assessment and assurance (QAA) committee meeting minutes and all supporting work product 12. The last pharmacy consultant review report 13. The last consultant dietitian report 14. The last infection-control committee report 15. The activities calendar for the current month 16. The annual in-service schedule with dates and topics shown 17. A current copy of the facility newsletter 18. Clinical policies and procedures for the following key protocols: wound care protocols and assessment tool, pain management protocol, elopement prevention protocol and missing person procedure, occurrence/incident reporting procedures and forms, abuse prevention policies and procedures, and fall prevention protocol and assessment tools. |

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| **Step two: Observe facility practices in action.** After gathering assessment data, take time to observe staff in action and take notes on their performance. Ask for and read the health records for residents who are at greatest risk for falls, elopement or skin breakdown. Review residents’ MDSs and care plans. Have a staff nurse explain how a particular care plan was written and how it is being implemented. Ask managers and staff members questions about facility procedures and protocols. Ask families and residents for their views on how they perceive service delivery and its quality. You will be amazed how helpful and honest they will be and, as you conduct this exercise, you will participate in a most valuable risk-reduction process: families and residents appreciating your interest and seeing you as a “friend.” And the long-held axiom still holds true: “Friends don’t sue friends.”  **Step three: Identify the risk exposures.** Look at the clinical and nonclinical systems affecting resident care outcomes noted above and draft a compilation of issues that, in your view, could potentially expose the facility to risk.  **Step four: Assign a level of risk exposure.** This “defensibility rating” is a subjective opinion of how the facility would fare in defending its practices. During this part of your assessment, think of examples of the facility’s practices that require facility action to improve the rating. Some examples include:   * staff’s clinical expertise with clinical audit systems; * medical records legibility and completeness; * staff interaction with residents, families and each other; * leadership skills; * elopement, falls, and medication and treatment error response processes; and * abuse prevention systems.   **Step five: Create a facility action plan to prevent and/or decrease risk exposure and improve defensibility.** Facility staff should meet to review all data gathered and candidly discuss the results of the observation and interview processes. From this, a jointly crafted action plan can be drafted that will address all areas where risk exposures have been identified. Some key considerations include:  *A. Policies and procedures.* Policy and procedures must be current and include risk-reduction language. Consider having your legal department or an outside consultant assist in the review and/or writing of certain polices and procedures that might include:   * Shared-risk language in the admission documents regarding falls, skin tears, bruising, etc. * Clinical protocols and best practices * Process for employee criminal background checks * Physician and vendor referral protocols   *B. Quality assurance system.* Some suggestions to enhance this system would include:   * Develop a risk checklist that is presented to the resident and family upon admission. This checklist can then be signed by the responsible party and reviewed at the care conference, where it can be customized and incorporated into the care plan. * Maintain all complaint, grievance and incident documentation in a secure location with limited access. * Designate all consultant reports, QA committee and subcommittee reports and minutes as QA Work Product to protect their confidentiality and inhibit discoverability. Date and sign all minutes. * Include confidentiality clauses in all contracts, even if contracts are unrelated to resident care. * Consider using the federal survey as the basis for a work plan assigning potential “F tags” for follow-up by specific department heads and staff.   *C. Loss history and claims litigation issues.* An important component of managing your risk exposure is an ongoing awareness and response to claims filed and losses incurred. Ask your broker or agent to generate a 5-year loss run, and review all recorded professional and general losses. As the administrator, it is important that you:   * are aware of any past and current claims filed against the facility, * ensure that proper documentation and follow-up are completed, * develop a process to ensure that all events that could lead to a claim are quickly handled and resolved, and * ensure that facility protocols exist to prevent future such events.   **Conclusion**  Regardless of how your facility team ultimately chooses to approach the creation of a risk-reduction program, the time and effort invested to assess and craft a facility action plan will produce a lasting payoff. As most of us know, the most beneficial facility practice is one in which all staff participates in its creation and understands the reasons behind certain required actions. By employing a team approach as described here, we can reduce our risk of litigation and improve our facility’s position of defensibility. **NH**  **Richard J. Henry, Jr., CNHA, is president of LTC Alliance, LLC, a consulting and service firm offering risk-management consultation and risk-assessment surveys, training seminars, survey data reports and custom policy and procedure systems for long-term care. The firm conducts nationwide on-site inspections for domestic and London-based insurance carriers and offers risk-management training seminars for underwriters, brokers and administrators. For more information, phone (888) 815-8250, or contact the firm at info@ltcalliance.com. Christine A. Stevens, RN, MBA, is an education consultant whose clients include LTC Alliance and SimplyDigi.com. She writes long-term care in-services and CE courses specifically for long-term care.** |