

THE LONG-TERM CARE



Legal  
Desk  
Reference

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SECOND EDITION

Barbara Acello, MS, RN

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Legal  
Desk  
Reference

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**Barbara Acello, MS, RN**

**HCP Pro**

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# Introduction



This book is designed to assist administrators and nurse managers working in long-term care facilities, hospital skilled nursing units, and other units with long-term care facility licenses. Most legal books do not combine clinical practice with legal theory. You can't have one without the other. Legal theory would not be necessary without a practical component. Nevertheless, most books expect the reader to learn the law, then apply it to the healthcare setting.

This book is written with an emphasis on “real world” clinical practice, and provides awareness of and solutions to potential legal problems that managers encounter in the long-term care setting. More is expected of managers than ever before in the history of long-term care. To help you meet the ever-increasing expectations and demands of sicker, less stable, and increasingly fragile and complex residents, this text is designed to assist you in learning and identifying the pitfalls and problems that lead directly to the courtroom, and how to avoid them. *The Long-Term Care Legal Desk Reference*, Second Edition is designed to parallel the federal long-term care requirements, upon which many state laws are based. Although the federal requirements are standardized, each state has the flexibility to adjust its own laws to meet regional needs. If there is a discrepancy, follow your state laws.

*The Long-Term Care Legal Desk Reference* uses a practical, reality-oriented approach to lawsuit prevention based on need-to-know information in the long-term care facility. Current trends and issues in healthcare are emphasized, and when appropriate, real-world solutions to problems are presented. The text is designed to assist managers to be strong and proactive. The primary goal is to help you survive and thrive in avoiding the sometimes litigious long-term care facility environment of the 21st century. It is not meant to be an exhaustive or comprehensive source of long-term care or legal information. Very few legal references are available for the long-term care environment.

A typical legal book explains the law to you. This book explains the law as it applies to long-term care facility administration, nursing management, and clinical practice. It was written using current clinical information and standards of practice that are useful to managers and will complement more exhaustive sources of long-term care administrative, nursing, clinical, and legal information. The purpose in using this format was not to recite the law



## INTRODUCTION

to readers. Rather, issues and problems were selected that are common in long-term care litigation. The book discusses principles of the law and provides principles and practices that will assist the facility to comply.

As an experienced nurse, manager, educator, consultant, and author, I am considered an expert in some areas, including long-term care. I have been called upon to assist in many long-term care lawsuits as an expert witness and legal nurse consultant. An expert witness assists the attorneys, judge, and jury by explaining technical nursing information and operational aspects of long-term care. Much of the information in this book is based on my experience with the legal system, both in chart reviews and as a testifying expert at deposition and trial. With today's litigious society, I believe that managers must stay informed regarding legal issues. Hospital readmissions have become much more common and resident acuity has increased. Some areas of the United States have a nursing shortage, and caring for the residents has become much more difficult than in the previous decade. The number of lawsuits against long-term care facilities has also increased. In fact, litigation involving facilities has become a growth industry. Some law firms virtually survive because of lawsuits against long-term care facilities and their employees. I write about some of the issues here in hopes that you will benefit from the information in your personal practice and stay out of the courtroom, which is not a fun place to be.

There is so much important information to share and there are commonalities in lawsuits involving long-term care facilities. All of the information here is relevant to managers in long-term care practice. The format consists of information grouped in chapters by subject with various legal opinions, expert reports, standards of practice, diagrams, charts, lists, and tables so that you can readily access and apply or implement the information. Everything in the book is material for which a long-term care manager is accountable and may have potentially serious legal exposure.

In the author's opinion, the resident is the most important individual in the long-term care facility. All care is directed to providing the highest quality of life possible for facility residents. Managers will receive a great deal of personal satisfaction from working in long-term care. The staff at HCPro, Inc., is committed to helping you succeed by providing quality educational materials to assist with your journey in the long-term healthcare delivery system. If you have inherited a troubled or special focus facility (SFF), be patient and persistent. Set realistic short-term goals to move the facility forward.

The federal long-term care rules make it clear that each resident must be admitted to the facility with physician approval. Each resident's care must be supervised by a physician. Today, nonphysician practitioners are increasingly assuming primary healthcare duties that were formerly the exclusive province of physicians. The author and publisher acknowledge the many positive contributions that these nonphysician practitioners make to quality resident care. However, for ease of reading and grammar, this book uses the terms "doctor" and "physician" when referring to the healthcare provider. This is not meant to devalue the contributions that nurse practitioners, clinical nurse specialists, or physician assistants make to facility operations and resident care. Facilities are encouraged to use the services of these practitioners in keeping with state and federal laws.

## CONTENTS

To protect the privacy of the individuals involved, names of residents and facilities have been changed in the case histories and all example legal documents included in this book. All names are pseudonyms, and any resemblance to any individual, alive or dead, is purely coincidental. Where published legal opinions are quoted, the case style, number, and identifying information is factual.

Information in this book should not be construed as legal advice. This material is for informational purposes only. It is not intended to include or address all possible legal or risk management exposures or solutions. Advice given is general, and readers should consult professional counsel for specific federal and state long-term care facility rules and regulations. As you know, long-term care is a highly specialized area of practice that requires an individual who is well versed with its idiosyncrasies. Facilities are encouraged to retain your own legal advisors to assist you in developing policies, procedures, guidelines, practices, and a risk management plan specific to your own activities and services delivered.

## Acknowledgments

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Many unnamed individuals at HCPro handle the manuscript as it makes its way through the production process. Each individual makes a contribution that ultimately enhances the value of the book, and I am grateful for their efforts.

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June 2013



# 1

## Introduction to Working in Long-Term Care

**“All the results of good nursing, as detailed in these [notes] may be spoiled or utterly negated by one defect, viz: in petty management, or in other words, by not knowing how to manage that what you do when you are there, shall be done when you are not there.”<sup>1</sup>**

**—Florence Nightingale, 1859**

### Introduction

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Holding an administrative or nursing management position in long-term care is the toughest job you'll ever love. Some days you will be stressed, feeling as if you are spread too thin. However, on most days the job can be so rewarding and gratifying that you are proud of your facility, staff, and residents, bragging about them as a parent brags about a child.

To be successful, you must have an inherent love for the elderly or the types of clientele your facility serves. Other useful qualities are respect for your staff and others, good communication skills, adequate management skills, good organizational skills, a basic understanding of employee behavior, and an understanding of state and federal requirements. Think about the old adage, “The mark of a good manager is not how well the facility runs when the manager is present.” The well-managed facility will run well when the manager is not on the premises. Work with and teach your staff to achieve this goal.

As a long-term care administrator, you must strive to be the best at what you do and to make your facility the best in the area by setting long- and short-term goals for your department and facility. You also need to accept responsibility for your actions and avoid internalizing problems. However, you must also strike a balance to avoid blaming others for every problem that occurs in the facility. In addition, you may have to do a great deal of positive self-talk, such as telling yourself that “Failure is not an option,” and be proactive by finding better ways of doing things.

By striving to be the best and taking a proactive approach to facility management, you will greatly reduce your facility's and your own personal legal exposure.

### **New Trends and Concepts in Caregiving**

---

Long-term care facilities operate under a set of laws enacted by the Omnibus Budget Reconciliation Act (OBRA) of 1987. The OBRA rules have always stressed the importance of providing a homelike environment.

The facility is the permanent home for many residents. Therefore, the focus should be on a holistic model of care rather than a medical model. An understanding of nursing care versus medical care helps explain the focus. “Nurses have a different perspective on providing care compared with physicians, and it starts with the definition of our professions. Physicians diagnose and treat illness. Nurses, on the other hand, diagnose and treat the human response to illness. From day one, a physician's education is focused on the disease, illness, or injury, while a nurse's education is focused on how that same disease, illness, or injury affects the person.”<sup>2</sup>

Staff must view each resident as a whole person, with many strengths and needs. Residents are entitled to make decisions about their lives, their care, their living conditions, and daily routines. Even residents who are confused have some decision-making ability, and most have a means of expressing satisfaction or displeasure. Many facilities have broken away from the medical model by providing formal culture change systems, such as the Eden Alternative®, Wellspring, the Green House® Project, and Pioneer Network. Other facilities provide care in small communities, or neighborhoods, that are self-governed by the residents, and permanent staff are assigned to each community. Some facilities have implemented change gradually by switching to buffet meal service and family dining. Some serve meals on demand, while others prepare meals in the individual neighborhoods. These alternative models of care have proven successful in improving care, quality of life, and resident satisfaction.

### **Facility Advertising and Marketing Materials**

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Your advertising and marketing materials are designed to promote your facility and to fill the beds. Maintaining the census is essential to paying the bills and meeting payroll. However, you must be honest in your advertising and the promises you make. Review your advertising and marketing materials carefully to ensure they are not inviting a lawsuit. For example, one life care community had a residential (independent living) unit, an assisted living unit, and a skilled nursing unit. They were in separate buildings on the same property and operated autonomously. A resident in the assisted living unit became ill late one Friday evening, and the unlicensed staff failed to recognize the magnitude of the problem. By Monday, his condition had worsened markedly, and he was transferred to the hospital, where he died several hours after admission. The facility was named in a lawsuit. Its marketing brochure noted that “24-hour nursing care” was available. However, the facility failed to note that this applied to the skilled

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unit only. The family contended this was false and deceptive advertising. The assisted living unit was routinely staffed with unlicensed personnel, and no provision was made for a nursing assessment if residents became ill. However, medication aides could administer medications. Although the state law required the medication aides to be “remotely supervised” by a licensed nurse (the nurse does not have to be on the premises), a licensed nurse was not available on the unit. The medication aide did not even consider asking a nurse from the skilled nursing facility (SNF) to assess the resident because of the autonomous method of facility operations. The assisted living unit did not routinely interact with the nurses on the skilled unit. The jury in this case awarded the plaintiff a high-six-figure judgment.

Making unrealistic promises in marketing materials and contracts may fall under the fraud statutes in your state. Some marketing pitfalls are made innocently. Making statements such as “We are the best” or “We offer the best care” can come back to haunt you in a courtroom. There is a difference between a desire to provide excellent care and a declaration that you are providing excellent care. Marketing promises about quality of care and safety/security issues can be especially problematic. In fact, some of these promises may be easily refuted by reviewing the facility’s survey history. Monetary damages can be hefty in lawsuits involving false advertising. Negligence is a more common charge. If an injured party can prove fraud, they most likely will qualify for punitive damages. Although the plaintiff is compensated for his or her medical problems, the punitive damages are assessed to punish the facility and the corporation. Damages can meet or exceed the corporation’s assets. An example of a verdict of this nature is \$200,000 for negligence, plus \$100,000 in punitive damages. The facility may be required to pay an additional penalty, such as \$75,000 for breach of contract.

### **Meeting Expectations and Understanding Nursing Facility Care**

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Long-term care facilities are commonly misunderstood by the community at large. Because of this, they are often unfairly maligned by the public and the press. Most private citizens view them as an extension of the medical model provided by the hospital and expect the same standard of care. They do not understand that the philosophy and type of care provided is vastly different. Some do not realize that “24-hour nursing care” does not mean the residents need or will receive 24-hour care by licensed nurses.

Taking time to thoroughly explain the services offered at your facility and what the customer can expect prior to admission goes a long way toward avoiding lawsuits down the road. Explain that residents usually need and receive approximately two to four hours of licensed nursing time each day. Most care is given by paraprofessionals who will inform the nurse if further assessment is needed.

The many problems associated with the aging process provide additional grounds for misunderstanding within the long-term care environment. It is important that you make sure residents and families are aware that skin becomes

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more fragile, bones become osteoporotic, and reaction time will slow down with aging. Residents' abilities must be evaluated realistically in light of the aging process. Families may express dissatisfaction over the quality of resident care, when the real problem is loss of control over aging changes that are occurring to the resident. An understanding of the aging changes and what can be done to help compensate for them will reduce dissatisfaction.

You must also tactfully inform residents and families that there are no guarantees in long-term care facility care. Staff cannot always control resident decisions and activities. Because of this, falls and injuries can and do occur. Teach residents and responsible parties that the facility cannot protect the residents from the normal risks of living, such as falls, choking, and skin tears. However, you must provide a reasonable explanation regarding how the facility will address risk factors and abate the risks as much as possible. In the event an untoward event occurs, the resident or responsible party has a right to know how the facility will respond. If a problem occurs, the response may substantially affect the decision to file a lawsuit. All managers must ensure that their subordinates know facility policies and procedures, are well-prepared and tactful, and know how to apply critical thinking in emergencies.

### ***Customer service and guest relations***

You probably chose healthcare as a career because you genuinely like and want to help other people. Being nice, empathetic, and responsive to everyone will go a long way toward preventing litigation. You must also make sure that all staff are aware of the facility's commitment to customer service and guest relations. Provide in-services and role-playing activities to teach "people skills." Most people find it difficult to sue someone whom they respect and like and perceive to be helping them. Keeping the residents' best interests in mind is your ethical responsibility. Adhering to this ethical code also protects you from potential liability. Residents and families are less likely to file a lawsuit if they believe staff are sincere and conscientious, and if they are confident in your ability. Because of this, being nice to everyone and gaining resident and family support should be high priorities.

### ***Keeping residents and families informed***

Strive to develop and maintain positive relationships with families. Keeping residents and families informed of changes in residents' conditions is critical. The law requires the facility to notify the responsible party when a significant change in a resident has occurred. In this situation, notification must be prompt and timely.

However, it may behoove you to inform the responsible party of changes even when they are not considered significant. Verify the contact information for the responsible party at each care conference. Encourage the resident or responsible party to communicate with you if he or she has problems or concerns. Make sure he or she is aware of support groups, resident and family councils, and other resources. In addition, teach the personnel on the units how to respond to complaints by residents or residents' families. (Half of all complaints are made to direct-care

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staff, so they must understand how to manage them.) Focus on the importance of providing good customer service. Keeping the lines of communication open will do much to enhance resident and family satisfaction.

### ***Importance of staffing***

Each long-term care facility must have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. What constitutes “sufficient” is very subjective. Keeping the facility properly staffed is the greatest stressor experienced by nurse administrators. Discussing the problems associated with staffing issues in-depth is well beyond the scope of this book, but it is worth mentioning a few points about it. Even when the facility is staffed according to budget, floor workers may undermine the facility by complaining to residents, families, and others about “short” staffing. Unfortunately, there are no quick fixes to resolving staffing problems. Many facilities have been successful in forming committees of staff members to address turnover and staffing problems. Turnover is expensive, and it typically takes three to four weeks to replace a worker. Staff members are expected to work overtime, or agency staff are brought in. One study showed that 13% of the staffing budget in long-term care facilities was spent on overtime, compared with 5% in hospitals.<sup>3</sup> Paying overtime and using agency personnel are expensive options that increase your legal exposure. Resident sense of security is also affected because of the bonds they form with staff members. Reducing and stabilizing turnover is an admirable goal.

A certain amount of staff education may help you with staffing issues. To begin with, staff must understand that your staffing is at or above state minimum requirements. (This is the case in most facilities.) Even if a worker calls out and cannot be replaced, the facility is not breaking the law. Also, most people work in long-term care by choice. Environment has a profound effect on worker morale, and for some, the facility will be the nicest environment they come to each day. The environment must also foster worker respect, security, comfort, and safety, and the facility must ensure that staff have adequate resources to do the job. It is important that educational opportunities and in-services are available and wages and benefits are competitive. Some staff grumble about inadequate wages, although this is almost always an excuse for their unwillingness or inability to discuss the real issues. Teach your staff about the value of their benefits. Most are unaware of the value of the employer’s contribution to withholding taxes, paid vacations, holidays, and insurance programs. This is usually the equivalent of one-third to one-half of the salary. Understanding the value of your contribution helps change their perspective and garner loyalty.

## **Computing Budgets**

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Readers of this book range from students and novices to well-experienced administrators. Those who are well versed in working with budgets may wish to skip to the next section.



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Long-term care facilities use a ratio to determine budgets. Thus, if you ask how much staff the nursing department has, you will be given an answer, such as 2.9. This does not mean that the entire department has 2.9 staff members or 29 staff members. When staffing is presented in this manner, it means that the nursing department is budgeted for 2.9 hours of labor per patient (resident) day (HLPPD). In plain English, this means that the staffing is adjusted so that each resident receives an average of 2.9 hours of nursing care each day. Obviously, some residents require less, and some require more. Budgets are determined using this method because the number of staff allowed is based on the census. Staffing varies with occupancy. Using a mathematical formula makes it easier to calculate staffing that varies from week to week. If the census decreases or increases significantly during the month, your budgeted hours will change proportionately. Minor variations, such as a resident hospitalized overnight, do not usually affect staffing.

The formulas for converting staffing are as follows:

- A. Formula for number of staff hours per patient (resident) per day:
1. Total number of staff in the department for a 24-hour day.
  2. Multiply this number by the number of hours worked. Some employees may work 7.5 hours, and others work 8 hours. If this is the case, multiply the number of employees working 7.5 hours  $\times$  7.5, and the number of employees working 8 hours  $\times$  8. Add the totals together.
  3. Divide this number by the census for the day to determine the number of hours per resident per 24 hours.

**Example:** A facility has 100 residents. Thirty-one nursing assistants care for the residents in a 24-hour period. Nursing assistants work 7.5 hours a day. There are 13 assistants on days, 10 on second shift, eight on nights. The licensed nurses work 8 hours a day. There are seven nurses, excluding supervisory personnel (three on days, two on second shift, two on nights).

$$31 \text{ (nursing assistants)} \times 7.5 \text{ (hours a day)} = 232.5$$

$$\text{Seven (nurses)} \times 8.0 \text{ (hours a day)} = 56$$

$$232.5 + 56 = 288.5, \text{ or } 289 \text{ total hours of labor per 24 hours}$$

$$289 \text{ hours} \div 100 \text{ (census)} = 2.89, \text{ or } 2.9 \text{ hours of labor per patient (resident) day}$$

**Note:** Some facilities count supervisory personnel into the HLPPD figure, and some count them separately. Your number of direct-care hours per day will be determined by your facility's practice.

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B. Conversion by hourly figures:

1. Add the total number of hours for a 24-hour period.
2. Divide the number of hours by the daily census to compute the 24-hour number.

**Example:** A facility uses 375 hours a day in the nursing department. The census is 140.

$$375 \text{ (hours per day)} \div 140 \text{ (census)} = 2.67, \text{ or } 2.7 \text{ hours of labor per patient (resident) day.}$$

C. To use the budgeted hours to determine the number of personnel for a 24-hour period:

1. Multiply the budgeted HLPPD figure by the census.
2. Divide this number by hours of work (per shift) to determine the number of personnel required.

**Example:** The facility has a census of 100. The nursing department is budgeted for 2.8 HLPPD. This facility includes the director of nursing (DON) and assistant director of nursing (ADON) into the total HLPPD figure. The DON and ADON are budgeted at 5.8 hours each for seven days (they work eight hours a day for five days, which is the equivalent of 5.8 times seven days). The nurses in the facility work 8 hours a day. The nursing assistants work 7.5 hours a day.

$$2.8 \text{ (HLPPD)} \times 100 \text{ (census)} = 280 \text{ total hours per day}$$

$$5.8 \text{ (DON)} + 5.8 \text{ (ADON)} = 11.6 \text{ hours}$$

$$\text{Six licensed nurses a day} \times 8 \text{ hours} = 48 \text{ hours}$$

$$11.6 \text{ (DON/ADON)} + 48 \text{ (licensed nurses)} = 59.6 \text{ hours}$$

$$280 \text{ (total hours)} - 59.6 \text{ (total licensed hours)} = 220.4 \text{ (hours remaining for nursing assistants [NA])}$$

$$220.4 \text{ (total NA hours)} \div 7.5 \text{ (hours per shift)} = 29.38 \text{ (total number of NA for 24 hours)}$$

Due in part to public awareness of staffing challenges, new laws have been developed to require facilities to publicly post daily staffing hours. It is extremely important that you know and can defend the numbers you post. *The information in this section was selected for simplicity and ease of understanding. They are not recommendations for safe staffing levels.*

## Supply budgets

Supply budgets are also calculated by using an equation. You are told that you have \$1.20 to spend. This means that you can spend \$1.20 per patient (resident) per day (PPD), for supplies in a month. If the census decreases or increases significantly during the month, your budget will change proportionately.

- A. To determine the budgeted amount:
1. Multiply the budgeted amount per patient day by the average daily census.
  2. Multiply this figure by the total number of days in the month to obtain the total monthly budgeted amount.

**Example:** The nursing supply budget is \$1.20 PPD. There are 30 days in the month. The average census for the month is 150.

$$\$1.20 \text{ PPD} \times 150 \text{ (census)} \times 30 \text{ (days in the month)} = \$5,400 \text{ (total amount for the month)}$$

- B. To determine the amount you spend PPD:
1. Multiply the average daily census by the total number of days in the month<sup>2</sup>. Divide the figure by the total amount spent in the month.

**Example:** The average daily census in the facility is 110. The nursing department spent \$3,500 in April.

$$110 \text{ (census)} \times 30 \text{ (number of days in April)} = 3,300$$

$$3,300 \text{ (total resident days in April)} \div \$3,500 \text{ (amount spent)} = \$0.94 \text{ PPD}$$

Using the PPD method is a useful tool when comparing expenses from facility to facility. While dollar amounts may vary greatly between a 100- and 300-bed facility, the PPD amounts will be comparable.

## Need for Insurance

Insurance has become so expensive that some facilities have voluntarily dropped it. Some insurers have stopped offering long-term care facility coverage, particularly in the South. Insurance rates vary, depending on facility location. However, the starting rate is commonly \$1,000 to \$2,000 per licensed bed. Premiums increased an average of 130% between 2000 and 2001 and 143% between 2001 and 2002. Providers today are paying substantially more money for

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less coverage than they did in the past. Coverage excludes existing claims. Premiums are higher if the facility wants coverage for fines, penalties, and punitive damages.

Some insurers use a rating system to determine insurance costs. The insurer determines the degree of risk the facility poses to the insurer by reviewing lawsuit history, surveys, and whether the facility has a sound risk management program. This type of system rewards facilities with a good history and charges higher premiums to facilities with a history of problems. Alternatives such as self-insurance, group self-insurance, and joint underwriting agreements have made insurance more affordable for some facilities, but these types of programs are not available for all providers. The insurance industry contends that increases in premiums are needed to cover losses, but activist and consumer groups assert that inadequate oversight allows insurers to overcharge customers. During the recent explosion of tort reform laws, the Center for Medicare Advocacy did a study to evaluate the impact of frivolous lawsuits on insurance premiums. The study concludes that cases of abuse in the court system are not frivolous, and tort litigation is necessary to hold facilities accountable. Because the civil justice system complements the public regulatory system in its efforts to improve the quality of care, tort litigation can lead to significant improvements in care. This study also revealed that multi-million-dollar payouts are unusual, which is why they receive so much publicity. The study also demonstrates that tort litigation is not the cause of rising liability insurance premiums.<sup>4</sup>

Going without liability insurance may be referred to as “going bare.” Some facilities and healthcare providers advocate this method, believing that without insurance, no one will be interested in suing them. This may or may not be the case, because assets can be seized to satisfy a judgment. Interestingly, state law may prohibit jurors from being told about the presence or lack of insurance. Your state law may require jurors to determine damages, whether or not they are covered by insurance. Another consideration is insurance on the building itself, for fire and other damage. Going completely bare is risky business.

### ***Personal malpractice insurance***

The facility, the administrator, and the nurses are separate entities with separate interests. No one wants to be the scapegoat for interests divergent from their own. Some employers discourage nurses from purchasing personal malpractice coverage. This recommendation is made based on the belief that having additional coverage increases their legal exposure and that potential plaintiffs will sue anyone with “deep pockets.” The plaintiff attorney usually determines whom to name in the lawsuit based on information in the medical record. Early in the game, when the suit is filed, the plaintiff attorney is probably unaware of which individuals (if any) have personal malpractice coverage. The opposing attorney learns of your coverage after the suit has been filed. One large plaintiff firm routinely names the administrator, DON, and a charge nurse from each shift when it files a lawsuit.

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It also routinely names the MDS nurse and some supervisory nursing personnel. Its belief is that the facility will defend its employees, even if these individuals have separated from the entity. The employees (or former employees) may become witnesses for the plaintiff if the facility fails to defend them. Their inside knowledge of facility operations may be very damaging. The plaintiff is increasing the potential damage award substantially by naming both corporate entities and individuals.

If you do decide to purchase nursing malpractice insurance, it is easy to find. Several companies offer malpractice insurance for administrators. Consider the following when determining whether to purchase a personal malpractice policy:

- A jury will deliberate and recommend a verdict based on information presented in the courtroom only. If information is not presented at trial, it should not be considered when rendering a verdict. Most jurors know little to nothing about the nuances of long-term care. Their deliberations are based on the information and expert witness testimony given at trial. The medical record will be admitted into evidence and will be available for juror review. The record may or may not be helpful to your case.
- Jurors know nothing about your financial status and insurance information. They do not consider your ability to pay when making a verdict.
- Jurors evaluate the credibility of each witness. They may disregard testimony of a witness if they do not believe it.
- Sometimes the testimony of opposing experts cancels each other out. Both experts are well qualified and credible, but their opinions are on opposite ends of the spectrum.
- If criminal charges are involved, your employer's insurance policy will probably not cover you. Allegations of abuse, neglect, and drug diversion may have both civil and criminal penalties in your state.
- Regardless of the outcome, being sued is extremely stressful. You will probably not have the freedom to select an attorney. Your insurance carrier will designate your attorney. You will be the only client (associated with the facility) that this attorney represents in this lawsuit. You cannot talk about the lawsuit with other nurses, who would normally serve as your support system. The only one you can discuss the case with is your attorney and his or her employees.
- Never post information or details about a potential lawsuit on a listserv, online bulletin board, or social networking site. In addition to being a potential Health Insurance Portability and Accountability Act of 1996 (HIPAA) violation, you may be revealing information that the opposing party can use against you.

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- If you do not have a private insurance policy, the facility's attorney may defend your actions. However, you are the "secondary" client. The facility is the "primary" client. By defending your actions, the attorney helps to mitigate the case against the facility.
- If the facility does not pay for your attorney, you will be forced to pay privately to defend yourself. You will be expected to make a deposit on the front end and add to the legal fees as they are exhausted. You may pay additional fees for expert witnesses, paralegals, legal nurse consultants, and other researchers working on your case. You will be billed for time you spend on the phone with your attorney and his or her office.
- Regardless of the outcome, being named in a lawsuit may completely deplete your finances. Some states have laws protecting jointly held assets, or assets such as a house that are also owned by your spouse.
- Some county and public facilities are privileged to "governmental," "sovereign," or "charitable" immunity and cannot be sued without consent. The doctrine of governmental immunity originates in old English law and is based on the premise that "the king can do no wrong." If a resident is grievously injured, he or she is unable to sue the facility for compensation for medical expenses or punitive damages. In this case, the plaintiff will name personnel individually. Usually, multiple healthcare workers are named, including the physician, nurses, pharmacists, and paraprofessionals. Since the facility is not a party to this lawsuit, it may not defend its employees.
- Some states have enacted tort reform, which caps punitive damages in medical malpractice actions. In these states, the plaintiff may name as many individuals as possible in the lawsuit, to derive maximum financial benefit. As the nurse's individual legal exposure increases, so does the need for malpractice insurance benefits.
- Occasionally, other workers or managers sue nurses for libel and other situations. If this type of suit is filed, the facility's insurer may not cover you.
- Some healthcare facilities have been found negligent in malpractice suits because of the actions or omissions of their employees. These facilities have later sued their employees (or former employees) to recover their costs. Subrogation means substituting one person for another in regard to a lawful claim. The substitute succeeds to the rights of the other regarding the debt.
- If your employer's policy does not contain a subrogation clause, you may be personally sued to cover the damages your employer had to pay as a result of your actions or omissions in the lawsuit. A subrogation clause is a provision in the insurance policy or contract. It gives one party the right to act on behalf of another person in legal actions related to the subject of the contract or insurance policy.

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- The insurer may refuse to defend you, unless your name is individually listed on your employer's insurance policy. The employer cannot drop you from the facility policy if you are listed and elect to purchase a private malpractice policy.
- Many facilities have "claims-based" insurance coverage. This type of policy will cover you only during your employment. You will not be covered if a resident names you in a lawsuit after you have left the facility's employment. Most personal malpractice policies are "occurrence based." These policies cover you during the specified policy period. If an individual files suit after the policy lapses, you will be covered for injuries that occurred while it was in effect.
- If you are sued, you may prefer to fight things out in an attempt to clear your name. However, your insurer will call the shots. In most cases, the facility or insurer will settle the claim as quickly as possible, because doing so is cheaper. Settling typically involves admitting guilt and negotiating a fee to pay the plaintiff. You will be reported to the National Practitioner Data Bank and your state board of nursing may be notified. Depending on your insurance policy, you may have no say in how your case is defended or settled.

In simplistic terms, an employer's insurance will defend you if you are acting within the company's policy and procedures. Personal malpractice insurance will defend you only if you are acting within reasonable and professional guidelines. Some professionals refer to personal malpractice insurance as "painting a target on your back," while others consider it protection of their personal finances.

### **Policies and Procedures**

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Having up-to-date facility policies and procedures is essential. If you add a policy or teach staff to use a new piece of equipment, add the information to your manuals. In addition to maintaining a master set of manuals in the office, copies should be available in designated locations, such as nursing stations and offices for staff review and reference. Review the manuals in their entirety annually, and make sure they are current. Since lawsuits often reflect care given several years after the fact, maintaining a set of manuals by year is helpful.

In a lawsuit, all applicable policies and procedures will probably end up in the courtroom and be available to jurors for review. These manuals usually show that the facility and its staff were familiar with and had access to resources related to applicable standards of care. Other materials, such as videotapes, handouts, and other visual aids used for in-service, may also be used and reviewed by the jury. Staff is expected to be familiar with and to follow facility policies and procedures. If an in-service video presents a procedure to be followed by staff, this establishes a standard of care. When staff attend continuing education programs, particularly if the class is mandatory, the court may rule that the class(es) established an additional standard that they were required to meet. Verdicts are usually not

favorable when staff are not familiar with facility policies and procedures or fail to follow them. Likewise, surveyors will write deficiencies if staff members do not follow procedures as specified in the procedure manual or electronic procedure database.

### **Delegation, Responsibility for Monitoring Subordinates' Performance**

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Delegation is a management principle used to obtain desired results through the work of others, and it is a legal concept used to empower one to act for another. The nurse who can effectively work through others can expand access to nursing care, maintain and promote quality healthcare, and facilitate the effective utilization of healthcare resources. The appropriate use of delegation allows better use of licensed nurses' time in the provision of safe nursing care. Professional skill and expertise in delegation have a positive impact on resident care. Individuals to whom responsibility is delegated must have the ability to accept and perform delegated activities.<sup>5</sup>

Each state board of nursing addresses delegation in the nurse practice act or elsewhere. The American Nurses Association also addresses delegation. All long-term care managers work through other people. State and federal nursing home laws require managers to ensure that employees are competent in their responsibilities. The National Association of Directors of Nursing Administration/Long-Term Care (NADONA), American Association for Long Term Care Nursing (AALTCN), and American College of Healthcare Administrators (ACHCA) also describe delegated quality-of-care activities in their professional standards of practice. Because the art of delegation is so important, managers must ensure that delegation is appropriate and that delegated activities are properly and regularly monitored. We entrust the residents' lives to the hands of our employees. Managers have both an ethical and a legal responsibility to ensure delegation is appropriate.

### **The Importance of the Nursing Process**

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The nursing process is the model for long-term care assessment. This process consists of four separate and distinct steps. Each is equally important in the care of the residents. These steps are:

- Assessment and formulation of nursing diagnoses.
- Planning.
- Implementation of the plan.
- Evaluation of the resident's care plan. The development and maintenance of the care plan is an ongoing process.



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Resident care within a long-term care facility is designed to maintain or improve the residents quality of life and prevent deterioration in each resident's condition and ability to function. The long-term care nursing facility must use the nursing process to accurately assess the residents then develop and implement a plan of care to meet each resident's needs. The plan directs the nursing care of each resident and is revised as often as necessary to ensure it reflects the resident's current condition, problems, and nursing care needs. Revising the plan infrequently and failing to use the plan in daily care of the residents are probably the greatest contributing factors to negative outcomes and legal exposure.

The American Nurses Association (ANA) Code for Nurses notes the following: "The nurse assumes responsibility and accountability for individual nursing judgment and actions. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care. The nurse acts to safeguard the client and the public when healthcare and safety are affected by the incompetent, unethical, or illegal practice of any person."<sup>6</sup> The ANA Code for Nurses is not open to negotiation in employment settings. The Code for Nurses encompasses all nursing activities and may supersede specific policies of institutions, of employers, or of practices. Therefore, the Code for Nurses with Interpretive Statements is nonnegotiable.<sup>7</sup>

Most expert witnesses and legal nurse consultants will tell you there is a breakdown in the nursing process in each and every healthcare lawsuit in which negligence is proven. Whether you agree with the ANA code is immaterial. It constitutes the standard of care, and the nursing licensure board in every state supports it. If you think the nursing process is unrealistic, "pie in the sky" information, think again. The nursing process is the foundation for solid, sustainable nursing practice, and using it correctly provides a high degree of protection from legal exposure.

### **Skilled Nursing Facility Care Planning and Discharge Planning Requirements**

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Skilled nursing facilities (SNF) must develop a care plan and provide services according to the plan. They must also plan for each beneficiary's discharge. This helps ensure quality care and safe transitions from one setting to another. Several Office of Inspector General (OIG) investigations found quality-of-care deficiencies in SNFs. These facilities did not develop appropriate care plans and failed to provide adequate care.

A 2013 report published by the U.S. Department of Health and Human Services and the OIG examines the extent to which SNFs met Medicare care planning and discharge planning requirements. According to the report, Medicare paid approximately \$5.1 billion for stays in which SNFs did not meet the proper requirements. The OIG found that:

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- The plan of care did not meet requirements or the SNF did not provide services in accordance with the plan of care for 37% of the stays reviewed
- At least one of the care plan requirements was not met in 25% of the facilities reviewed
- One or more resident assessment protocols (RAPs) triggered or problem areas identified were not addressed in 19% of the facilities reviewed
- The care plans did not include measurable objectives in 7% of the facilities reviewed
- The care plans were not interdisciplinary in 2% of the facilities reviewed
- The facility did not provide one or more services according to the care plan in 15% of the facilities reviewed
- The facility did not meet at least one of the discharge planning requirements in 31% of the facilities reviewed
- The facility did not have discharge summaries in 16% of the facilities reviewed
- There were no postdischarge plans of care in 23% of the facilities reviewed

Reviewers found examples of poor quality care related to wound care, medication management, and therapy. OIG described some of these as “egregious” in their report. They suspected that facilities deliberately omitted pressure ulcer documentation so it would not be posted on the Nursing Home Compare website. These findings caused the government to question exactly what Medicare is paying for. The OIG may link payments to quality-of-care requirements in the future. In addition, they also decided that they should strengthen:

- SNF oversight. (Now that will make everyone happy!)
- Regulations on care planning and discharge planning.
- Surveyor efforts to identify SNFs that do not meet requirements (so they can hold these SNFs accountable).
- Surveyor follow-up monitoring for the SNFs that failed to meet care planning and discharge planning requirements or that provided poor-quality care.

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# THE LONG-TERM CARE Legal Desk Reference SECOND EDITION

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**Barbara Acello, MS, RN**

***The Long-Term Care Legal Desk Reference***, Second Edition, uses a practical, reality-oriented approach to lawsuit prevention based on need-to-know information in the long-term care facility. Current trends and issues in healthcare are emphasized, and when appropriate, real-world solutions to problems are presented. The text is designed to assist managers to be strong and proactive.

Written by accomplished author **Barbara Acello, MS, RN**, this resource will help your facility manage risk and provide quality care with practical information and advice delivered in plain, easy-to-understand language. The book identifies potential legal risks and provides the tools and techniques needed to manage them.

Written specifically for administrators and nurse managers, this book will help you:

- Identify the pitfalls and problems that lead directly to the courtroom, and how to avoid them
- Understand the law as it applies to long-term care facility administration, nursing management, and clinical practice
- Understand current clinical information and standards of practice that are useful to managers and will complement more exhaustive sources of long-term care administrative, nursing, clinical, and legal information

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