Session 3: Documentation

Required Reading


Recommended reading


Physician Documentation: The Basic Regulatory Requirements

Under OBRA '90, a resident has a right to physician services. Requirements for such services are:

- 24/7 availability/coverage and supervision by the attending physician
- The attending must review the comprehensive care plan, medications and treatments at each visit
- The attending must see each resident on admission, at least every 30 days for the first 90 days after admission, then at least every 60 days,
- The attending may see a resident any time it is medically necessary.
- Physician visits are timely if within 10 days of the due date.
- Required visits after the initial visit may alternate between the physician, PA, NP or Clinical nurse specialist.

Required documentation:
Admission H&P
Admission orders
DNR orders can only be entered by a physician
Document the need for Skilled Services (Certification/recertification)
Required physician visits (outlined above)
Document need for restraint use
Document the need for use of certain medications
Transfer or discharge summary
Unavoidable decline/Abuse and Neglect
Physician Documentation: To demonstrate that you met expectations, or explain why you cannot.

It all based on OBRA 87:

In 1965, Medicare and Medicaid came into existence and along with it came federal nursing home regulations. Nursing homes that qualify and voluntarily elect Medicare and Medicaid to their facility must follow a set of nursing home regulations put forth by federal standards. The Center for Medicare and Medicaid Services (CMS) which is part of the United States Department of Health and Human Services enforces these nursing home regulations. Congress authorized the first set of standards that were to be met by nursing facilities in 1967 and created classifications for the Skilled Nursing Facilities and Intermediate Care Facilities. In 1980 and again in 1987, these nursing home regulations were updated with the most current standards imposed under the Omnibus Budget Reconciliation Act of 1987.

**OBRA 87: Omnibus Budget Reconciliation Act of 1987 (OBRA 87)**

OBRA 87 requires that the facility provide each patient with care that will enable the patient "to attain or maintain the highest practicable physical, mental and psychosocial well-being."

- Quality of life for patients is the goal. The facility must allow patient choice in activities, schedules and health care decisions.
- OBRA 87 requires that SNFs and ICFs provide 24-hour licensed practical nurse care seven days a week, and have at least one RN on duty at least 8 hours per day, seven days a week. Nurse’s aides are required to undergo special training.
- OBRA 87 makes it the State’s responsibility to establish, monitor and enforce state licensing and federal standards. States are required to maintain investigatory units and Ombudsman units, and to fund and staff them adequately.

**OBRA 90: Omnibus Budget Reconciliation Act of 1990 (OBRA 90)**

The Patient Self Determination Act covers all long-term care facilities that participate in Medicare or Medicaid. At the time of admission to a hospital or nursing home, at the time of enrollment with an HMO, Hospice, or Home Health Care Agency, the following must happen:

- The facility must provide the patient written information concerning the resident’s rights under state law to participate in decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, the right to formulate advance directives.
- The facility must provide a written statement of its policy regarding implementation of these rights.
- The facility must document in its records whether the patient has executed an advance directive. Note: the facility is not required to provide advance directives to patients.
- The facility is forbidden to discriminate in the provision of medical care on the basis of whether a patient has or has not executed an advance directive.
- The facility is required to comply with all state laws regarding advance directives.
- The facility must provide for staff and community education on issues related to advance directives.
Document “Unavoidable Decline”

Many declines may in actuality be attributed to the aging process or to inevitable complications of chronic illness (e.g. aspiration, pressure sores, skin tears, bruises), these physical signs can be mistakenly categorized as indicators of abuse and neglect and visa versa.

There must be good documentation especially when you are asked to see a patient to evaluate the following issues:

1. Falls
2. Pressure Ulcers
3. Weight loss and malnutrition, dehydration
4. Restraint use (Justify the necessity of psychotropics or physical restraints)
5. Incontinence (and the need for an indwelling catheter)
6. Decline in ADLs or functional status
7. Pain

In order to prevent citations you should document that the complication is an expected consequence in the course of a resident’s illness, that is everything possible was done to prevent and/or treat it these conditions, and that the care is consistent with the wishes of the resident (careful documentation of your advanced directive discussion).

It is unlikely that a facility will be cited in the face of appropriate physician documentation.

Nursing homes are required by federal law to have intervention strategies and regular monitoring to prevent neglect and abuse. The nursing home should reevaluate these measures on a regular basis. The facility/medical director should review policies and procedures, provide ongoing educational inservices regarding care and documentation, and have quality assurance committees monitoring these areas.

If the Nursing Home doesn’t comply with OBRA Regulations, as determined by State Surveyors, this information will be made public. Penalties may include payment of a fine, replacement of management/staff, or closure of the nursing home.
Physician Documentation: To protect yourself from being accused of abuse and neglect!

During the State Survey process, if surveyors are concerned about abuse or neglect, they can cite you for “Immediate Jeopardy” - noncompliance with requirements has actually caused or is likely to cause (potential) serious injury or death. Nursing homes can be cited for “Immediate Jeopardy” as ABUSE (willfully infliction of injury or harm) or NEGLECT (failure to prevent harm).

Abuse and Neglect

According to the Nursing Home Reform Act of 1987, all residents in nursing homes are entitled to freedom from neglect, abuse, and misappropriation of funds. Neglect and abuse are criminal acts whether they occur inside or outside a nursing home.

**Neglect:** Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional. For example, a caring aide who is poorly trained may not know how to provide proper care. Examples include:

- Incorrect body positioning -- which leads to limb contractures and skin breakdown;
- Lack of toileting or changing of disposable briefs -- which causes incontinence and results in residents sitting in urine and feces, increased falls and agitation, indignity and skin breakdown;
- Lack of assistance eating and drinking -- which leads to malnutrition and dehydration;
- Withholding nutrition/hydration without clear documentation in chart of rationale;
- Lack of assistance with walking -- which leads to lack of mobility;
- Lack of bathing -- which leads to indignity, and poor hygiene;
- Poor handwashing techniques -- which leads to infection;
- Lack of assistance with participating in activities of interest -- which leads to withdrawal and isolation;
- Ignoring call bells or cries for help.
- Failure to monitor drug therapy for adverse side effects
- Failure to treat pain

**Abuse:** Abuse means causing intentional pain or harm. This includes physical, mental, verbal, psychological, and sexual abuse, corporal punishment, unreasonable seclusion, and intimidation. Examples include:

- Physical abuse from a staff member or an intruder or visitor from outside the facility -- including hitting, pinching, shoving, force-feeding, scratching, slapping, and spitting;
- Psychological or emotional abuse -- including berating, ignoring, ridiculing, or cursing a resident, threats of punishment or deprivation;
- Sexual abuse -- including improper touching or coercion to perform sexual acts;
- Substandard care which often results in one or more of the following conditions -- immobilization, incontinence, dehydration, pressure sores, and depression;
- Rough handling during care giving, medicine administration, or moving a resident.
- Use of restraints without proper documentation of need
**Misappropriation of Property/Funds:** This means the deliberate misplacement or misuse of a resident’s belongings or money without the resident’s consent. Examples include:

- Not placing resident funds in separate interest-bearing accounts where required;
- Stealing or embezzling a resident’s money or personal property.

**REPORTING NEGLECT AND ABUSE**

It is a violation of State and Federal law for any person, including facility staff, volunteers, visitors, family members or guardians, or another resident, to neglect or abuse a resident.

Anyone can and should report neglect and abuse. If you suspect neglect or abuse, or if a resident tells you they are experiencing this problem, it is important to believe the resident and REPORT THE ALLEGATION IMMEDIATELY. This will help prevent further suffering by any resident.

Many states have laws that require the reporting of abuse and neglect.

**May be Reported To:**

- The nursing home’s administrator, director of nursing, and social worker
- The state or local ombudsman
- The local police or State law enforcement
- A Protection and Advocacy or Adult Protective Services agency
- The state survey agency that licenses and certifies nursing homes (often in the Health Department)
- A citizen advocacy group, or other church or community group that visits regularly.

**In Hawaii:**

For more information, Executive Office on Aging:

Where to Call to Report Abuse: **Adult Protective Services (APS), Department of Human Services**
To report abuse, neglect, or exploitation of dependent adults age 18 and older, call Adult Protective Services (APS) in your county:

- **Oahu**: (808) 832-5115
- **Hilo/Hamakua/Puna**: (808) 933-8820
- **Kona/Kohala/Kamuela/Kau**: (808) 327-6280
- **Kauai**: (808) 241-3432
- **Molokai/Maui**: (808) 243-5151
- **Lanai**: (808) 565-7104

*Last updated: 10/5/2012*
To report concerns of older adults residing in licensed long-term care settings, or to request assistance, call the Long Term Care Ombudsman. Statewide: (808) 586-0100 or Visit the Ombudsman website.

Some national statistics:
90 Complaints (unsubstantiated) per 1,000 LTC beds.
1 out of every 3 Nursing Homes was cited for physical, sexual, or verbal abuse throughout a 2-yr period.
Over 9% of US NH were cited for abuse that caused actual harm, placed residents in serious danger, or resulted in significant injury or death.

Probably under-reported
Surveys of NH staff reveal that abuse is common. One study noted at 36% of staff had witness an episode of physical abuse (use of restraints, or aggression) and 81% had witness psychological abuse (insulting, yelling, threatening) over a one-year period.
Cases Examples of Poor Documentation

Case 1
70 year old man with uncontrolled IDDM has been here ICF for ADL assistance. Patient has had severe venous stasis which got worse recently due to loss of activity.

Nurse has been dressing the ulcer with mild compression. Nursing note says "pressure ulcer has developed and treated as wound nurse recommended" When you talked to nurse, you decide to write a note.

MD Note:
Exam
Patient has 3+ pitting edema with discoloration in bilateral lower extremities up to his knee level. There are multiple shallow ulcerated lesion, surrounded by erythematous area. No pus was seen. A: Pressure ulcer, stage 2. P: Increase Furosemide. No infection. Continue current dressing."

Q1. What is the issue?
Q2. Why?

Case 2
81 y/o woman with occasional functional incontinent due to recent TKA surgery. She is recovering and tolerating PT/OT very well. Able to get to the bath room with CGA. Because of her worry, SNF has provided pull-ups for her occasional incontinent.

MD Note:
# incontinence, occasional
Most likely functional, due to limitation in mobility after TKA. Improving. Continue Diaper use for supportive care.

Q1. What's the issue?
Q2. Why?

Case 3
81 y/o woman with severe dementia developed unintentional weight loss. (10 lb in 2 month) with poor PO intake. On Ensure daily

MD Note:
A: Unintentional weight loss, poor po intake
P: Increase Ensure to BID, monitor weight for now

~2 month later, at recertification visit
Patient has lost further weight, 4 lb loss since last visit. still poor po intake

MD Note:
A: Unintentional weight loss, poor po intake continued
P: Ensure to TID, monitor weight for now

Q1. What is the issue(s)?
Q2. What would you do as MD to improve care in this Nursing Home?
Case 4

92 M had a fall out of bed overnight and was found on the floor when the alarm went off. No injuries noted.

MD Note: Fall out of bed. No LOC. No lacerations, erythema, welling, or pain noted on body. Patient able to ambulate with assistance.
A/P: 92 M with dementia, fall out of bed, no injuries. Monitor.

Q1: What is the issue(s)?
Q2: Why?
Case 1

Q1. accurate diagnosis:
   pressure ulcer > venous stasis ulcer
Q2
Dx does not indicate "unavoidable decline" and can be interpreted as poor nursing and medical care (poor management of diabetes).
An important Quality Indicator (QI) is PU—don’t take credit for PU when it is not.
The physician should document the work-up, accurate dx, risk factors, and treatment of the underlying problem, as well as current treatment of the ulcer.

other example
dehydration vs poor intake

Case 2

Q1.
accurate name of nursing/care supply :
diaper > pull ups

Q2
Diaper use is a red flag for Indignity!
any decline in ADL or incontinence have to be justified by documentation if present.
Diaper is not considered as "alternative" or "just in case" supply
You should document that scheduled toileting was considered to maximize the resident’s function.

Case 3

Q1.
No investigation or appropriate assessment/plan for this patient
No explanation for this weight loss (F-tag) –Can this be construed as “neglect”?
No system to prevent this event from happening. (Risk evaluation, preventive action plan at admission
No system/IDT approach to initiate appropriate care by Non-Physician staff.

Case 4

Q1. No evaluation regarding underlying cause..
No system to prevent this event from happening. (Risk evaluation, preventive action plan at admission
No system/IDT approach to initiate appropriate care by Non-Physician staff.
Limiting Litigation in the Nursing Home

**Litigation in the Nursing Home**
Since the 1990’s medical malpractice lawsuits have increased in long-term care facilities. Possible reasons may include: Nursing shortage (nurses and nursing assistants), decreasing Medicare and Medicaid reimbursement rates (and reimbursement influences quality of care for patients and salaries), residents and older and sicker than previously, Physicians are not immediately available, and many non-professionals are giving direct care, Baby boomers more assertive and seek legal action when incidents, injuries, accidents or complications occur.

**Problems:** Rising malpractice premiums have caused some physicians to stop seeing patients in NH, and some insurance carriers have ceased their coverage of NH altogether. Some premiums to NH are drastically on the rise—causing some facilities to go bankrupt or to do business without coverage at all.

**Two major categories**
A. Environmental Negligence: (NH litigation) claims against the facility. (e.g. slips, falls, fires, security breakdown, failure of equipment)
B. Professional Negligence (medical malpractice): claims against physicians and staff. (e.g. medication errors, pressure ulcers, resident abuse, wandering-related harm, CPR related issues)

**Who**
65% initiated by resident’s children
20% initiated by spouse
Majority involved chronic long stay residents
Over half involved deaths
States filing the most lawsuits: CA, FL, TX, AZ, GA, LA, OK

**The most Common Reasons**
1. Falls causing fractures (2/3 of all claims, dropping a resident during transfers or fractures accompanying a fall are hard to defend)
2. Pressure Ulcers (only 10% of claims, but 87% get compensated with huge financial settlements as high as $312 million in damages. JAGS 2005;53(9):1587-1592); relatively easy, enlarged photos make compelling exhibits)
3. Dehydration and malnutrition/ weight loss (inadequate staffing, liquids inaccessible, failure to intervene after weight loss documented, and care plans that do not reflect end of life make defense difficult)
4. Elopement resulting in injuries (unlocked door, inactivated or no door alarm)
5. Abuse (physical, restraint-related, psychological=emotional distress)

**How**
Plaintiff must prove the presence of 4 elements:
- Duty – health care provider and patient have a professional relationship
- Breach of Duty (breach of “standard of care”)-failure to fulfill duties, or prove they did not violate residents rights
- Causation- conduct of provider was the actual cause of the injury, and would not have occurred otherwise
- Damages/Injuries-harm was inflicted by negligence or abuse, act was a proximate cause of death
**Responsibilities of the Attending Physician**

- Follow all state and federal guidelines on required medical visits (admission, monthly x3, then every 2 months) and interdisciplinary treatment planning.
- Follow up on inadequate responses to treatments/ complications/drug interactions/ side effects of all treatments ordered.
- Follow up all abnormal lab results appropriately.
- Respond to acute changes in resident’s conditions in a timely manner, and order appropriate intervention (including hospitalization).
- Respond in a timely manner to nursing concerns and telephone inquiries from nursing staff.
- Respond to consultant pharmacist recommendations and if inappropriate, document reason. (particularly for potentially inappropriate medications like psychotropics and benzodiazepines). Beware F-tag 329 (unnecessary medications)
- Provide coverage by another physician when unavailable.
- Communicate with the resident/family about treatment options and document clearly (especially decisions regarding DNR, hospitalization, psychotropic medications or physical restraints).
- Discuss with family and document any palliative plans of care- inevitability of weight loss, decline, inability to heal wounds, dysphagia)

**Responsibilities of the Medical Director**

**NOTE:** In addition to their own malpractice insurance, the medical director should also make sure they are also listed under administrative acts under the facility’s insurance policy.

When issues arise from the resident’s medical care, what was the medical director’s participation? What kind of oversight was provided? Were there systems in place?

- Needs to review credentials of all attending physicians/ reviewing attending physicians admitting privileges.
- Make sure that the attending physicians are kept abreast of changes in policies.
- Needs to assure 24/7 physician coverage. (so if staff cannot contact the attending physician or their coverage, they should go to the medical director next)
- Ensure frequency of visits by attending physicians are assured.
- Provide specific guidance for physician performance expectations.
- Help a facility ensure that a system is in place for monitoring the performance of health care practitioners.
- Responsible for deviations in the standard of care by attending physicians in their facility and make sure they are performing within their scope of practice. If attending physician is not providing appropriate care, the medical director must intervene (F-tag 501).
- Advise on Infection Control issues; Epidemics must be reviewed.
- Responsible for implementation of medical care policies and coordination of medical care in the facility. (may include reviewing an individual’s case, consultants recommendations, provide feedback and review with attending, reviewing ancillary services, and release of medical information.)
What are some things that the medical director/physician can do?

Prevention
Review policies and procedures (including the incident reporting process)
Get involved in the monthly QA/CQI meetings
Get involved in educational inservices
Complete and follow up on incident reports for potentially litigious events (do not document these investigations in the patient chart), and use statistical analysis in QA and safety committee reports.
Routine and timely chart and data review

Good Communication
Create a physician notification system/policy
Attend some family council meetings/support groups
Begin a newsletter to update/remind attending physicians regarding certain policies/procedures/programs.

Good Documentation
Need to document changes in timely fashion
Periodic visits must address on-going problems or major illnesses that have occurred since the last visit
Need to document follow-up by attendings for staff reported incidents (falls, fevers, medication rxns, abnormal labs)
Assess risk factors for pressure ulcers, falls or elopement on admission and as needed.
Need to document how problems identified are evaluated and what interventions were implemented.
Needs to be legible.
Use neutral language, be honest with the facts. Do not criticize other caregivers in the medical record (don’t use blaming or judgemental language, or exclamation marks)
Never alter the medical record.
Need to document if problems are inevitable or unavoidable (as opposed to bad care).

Good Care Planning
Especially for palliative and end of life, unavoidable events.

What can the facility do?

Risk Management Program
A systematic program designed to reduce preventable injuries and accidents and minimize the financial severity of claims = Liability control and loss prevention. In Long-term Care facilities, It MUST include increased sensitivity to the emotional needs of the residents/families. Therefore the impact of the provider-patient relations cannot be overemphasized. Good communication and public relations is central to good medical care and the very core of the problem of medical malpractice litigation.

It should include:
- Establishing a Risk management Committee which reviews their database of incident reports. May be combined with QA or CQI programs
- Inservice Education for NH Staff (should also include fostering a positive attitude among staff, the importance of documentation, repeated on a regular basis)
- Corrective action by facility= develop, implement and document a plan of correction for ALL critical incidents
- Involvement of the Medical Director early in all complaints, alleged abuses, and facility-wide epidemics
- Restraint Committee
- Family Council Meetings (build resident/family rapport, discuss areas of concern)
CASE A:
A resident with psychiatric history, poor impulse control, diabetes, noncompliance with medical care, history of seizures, and multiple falls, had a fall while in NH and fractured his ankle. The family was very upset about this incident. A few weeks later, while the ankle was recovering, he suddenly developed SOB, and sent to the hospital, where he was diagnosed with a pneumonia and went into sepsis and was intubated. They had difficulty weaning him off the vent and he wound up getting a tracheostomy and a G-tube for feeding. After 3 weeks in the ICU, he was finally transferred onto a regular medical floor, where he got out of bed, and drank 3 cans of tube feed supplement sitting at his bedside. He aspirated, coded, was admitted to the ICU again. He never regained consciousness and died.

The family brought a lawsuit suing the nursing facility and the hospital for poor care. They cited the problem of multiple falls at the nursing home. They also claimed that the nursing home did not catch the pneumonia soon enough and that’s why his infection became so severe.

What happened:
The nursing home documented on admission the issue of his high falls risk, and in three separate notes documented what they did to try to minimize his risk, without use of physical restraints, including monitoring him more frequently and moving him closer to the nurses station. The physician evaluated his medications and labs as a response to each of his falls, and documented these, some psychotropic medications were titrated.

With regard to the pneumonia, the patient was actually seen by the attending physician the day prior to the hospital transfer (Monday) in order to monitor some erythema of his toe after a podiatry visit the previous week. A note was written regarding his toe. But there was no mention within that note of any patient complaints of feeling unwell, cough, fever, chills, or SOB.

In looking at the nursing notes, there is mention of a low grade temp 99F 2 days prior to his hospital transfer, a mild sore throat and patient “feeling tired”. The covering physician was told, who thought it was probably just a viral URI and could be managed with conservative management, and monitoring of VS. Otherwise there was no other documentation regarding cough, SOB, other changes in VS or fevers. On arrival to the hospital, he was diagnosed with pneumonia and sepsis. There is no mention in the chart or deposition that the covering physician or nurses spoke to the primary physician about the patient’s URI symptoms.

Questions:
1) Did the facility provide care to the patient that was consistent with the “standard of care”?
2) Did the physician provide care to the patient consistent with the “standard of care”?
3) Was the conduct or negligence of the nurses the immediate cause of his demise?
4) Was the conduct or negligence of the physician the immediate cause of his demise?
5) Was nursing documentation adequate? Was physician documentation adequate?
6) How can communication between nursing staff and physicians be improved?
7) How could the facility have improved communication with the family?
8) Do you think this lawsuit could have been prevented?
What they did well:
Good nursing documentation on admission of high falls risk and that they continued to intervene with every incident.
The physician addressed and documented their evaluation and intervention to reduce falls risk further. Documenting that the patient was particularly difficult and noncompliant (along with the excellent documentation of interventions), makes it look less like “bad care” and more like an “unavoidable” problem.
The physician examined the patient recently (not just telephone management)

Problems uncovered:
When the covering physician addressed the “URI sx”, there is no indication that they spoke to the primary doctor about the patient or that there were any issues to follow up on. No labs were ordered.
It did not seem that the nurses notified the primary doctor about the URI sx for evaluation, and just monitored the “cold”, as instructed by the covering physician. There was no clear system in place for physician notification for changes in condition, or signout process for covering physicians. Clipboard? Notebook? Fax?

Nurses and physicians could have communicated with the patient and family better, and enlist them in helping manage the patient to minimize his risks.

The plaintiff could not bring a case against the physician or the nurses for negligent care, and despite good documentation, the facility and medical staff could work on improving communication—with each other, and with the family.
CASE B
A patient with some mild dementia was previously living in community, but entered the the SNF for short-term rehabilitation for deconditioning after hospitalization for pneumonia. Pt fell while standing in parallel bars with PT, knee buckled and patient landed on the floor, and complained of R ankle pain. She had no swelling or ecchymosis per nursing assessment. The physician did not order an x-ray. The following day when PT tried to get her up to ambulate, the pain got worse, so an x-ray was ordered. It showed a R ankle fx. She was sent to the hospital. Despite surgery and rehab, the patient was unable to walk as she did before, and was not able to return home. The family accused the therapist of not being able to catch the patient before she fell. They accused the facility and the physician for not getting her immediate or appropriate medical attention. The patient died of an unrelated cause 1 year later, and the family sued the facility.

What happened:
The lawyers went through the chart. They said that in the admission, she was deemed a HIGH falls risk (poor safety awareness and deconditioning), and therefore should never have been left “unattended” in the parallel bars, as the patient and family claimed she was. During the deposition, the therapist said she was within 3 feet of the patient at all times, and that she did in fact catch the patient as she was falling, and helped to lower her to the ground. Then immediately stopped therapy and got the nurse to assess her.

After the fall, nurses documented their immediate assessment, and treatment with rest, ice and elevation. Noted that the patient said the pain subsided, and there was no swelling or ecchymosis on physical exam. They then notified the physician as required. Therefore, there was no nursing negligence involved.

As the typical scenario is that the physician was not on site, physicians must rely on nursing judgement to render a decision. And since the injury appeared minor (probably a sprain), the physician could not be blamed for medical malpractice for not ordering an x-ray immediately. However, when the pain worsened with PT the next day, the physician appropriately ordered an x-ray, and subsequently a transfer to the hospital. This all happened within 24 hours, so the physician was not able to make it into the facility to see the patient or write a note before the transfer.

On further review of social work notes, it is evident that the actual reason the patient was unable to return home was NOT mainly because of her functional status, but rather her cognitive status. Because of her dementia she had poor safety awareness and required supervision 24/7.

Questions:
1) Could the nurses have done anything to prevent further injury after the first fall? Did the nurses provide care to the patient that was consistent with the “standard of care”?  
2) Could the therapist have done anything to prevent further injury after the first fall? Did the therapist provide care to the patient consistent with the “standard of care”?  
3) Could the physician have done anything to prevent further injury after the first fall? Did the physician provide care to the patient consistent with the “standard of care”?  
4) Was the conduct or negligence of the nurses the immediate cause of her demise? Or inability to return home again?  
5) Was the conduct or negligence of the therapist the immediate cause of her demise?  
6) Was the conduct or negligence of the physician the immediate cause of her demise?  
7) Was nursing documentation adequate? Was the therapist’s documentation adequate? Was physician documentation adequate?  
8) How was communication between nursing staff and physicians?  
9) How could the facility have improved communication with the family?  
10) Do you think this lawsuit could have been prevented?
What they did well:
The nurses notes were very thorough and timely. The physician orders had date/time demonstrating timely assessment and intervention.

What could have been done differently?
The therapy note was entered late (the next day after the fx was discovered), and the therapist did not document the entire sequence of events.  
In retrospect, the physician could have ordered non-wt bearing status until further assessment or xray. But could not really be blamed for negligence for this particular case (did not fall below the “standard of care”). Other things uncovered on chart review: the physician did a very brief and illegible admission note and had not seen her or nor performed another evaluation since then (2 months). On speaking to the nursing staff and reviewing charts, he routinely managed his patients by phone and rarely saw his patients. One patient was not seen for 6 months.

It was felt that the plaintiff had no case against the physician or nurses, but possibly against the therapist (especially because of the poor documentation). The case was settled with monetary compensation to the family.

What should the facility do next to prevent this from happening again in the future?
- Inservices about documentation.  
- Perform a review of incident reports of falls, especially those resulting in fractures. 
- Medical director involvement to educate, monitor performance, and discipline attending physicians who are not in compliance with regulations or providing medical care.
THE ROLE OF THE MEDICAL DIRECTOR

**Systems For Quality of Care**

- Ex: Review staffing concerns and facilitate IDT solutions to provide better supervision for high risk residents

**Physician Leadership**

- Ex: Ensure a clear physician notification system (when, why, how, who)

  Ex: Ensure physicians examine residents in a timely fashion especially regarding high risk events

**Education/ Communication**

- Ex: Attend some family council meetings

- Ex: Provide educational inservices regarding abuse and neglect.

- Ex: Provide educational inservices regarding proper documentation (neutral language, no blaming, no exclamation marks)

**Clinical Patient Care**

- Ex: Follow up on incident reports, and implementation of corrective action

- Ex: Review policies and procedures for falls prevention

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Leadership  Partnership  Culture Change