HOW TO GET SUED in FIVE EASY STEPS

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Everyone involved in long-term care service delivery faces the looming specter of lawsuits. Some unscrupulous attorneys have exploited the public's fear of old age to deliver huge jury awards in cases against long-term care providers. Unfortunately, real incidents lend credence in the eyes of the public to even the most outrageous claims by plaintiffs. The assisted living industry has historically been relatively insulated from litigation, but that special status is starting to change. Consider the following: a family sues an assisted living facility in Wisconsin for frostbite injuries sustained when an elderly woman suffering from dementia wanders outside in freezing weather; a man chokes on food and a state survey shows that the only caregiver on duty was not properly trained in basic cardiopulmonary resuscitation techniques. Just because your facility would never allow such things to happen doesn't mean that you are invulnerable to lawsuits.

We are both clinicians who work almost exclusively in the long term care setting. We have discussed care—good and bad—at length with hundreds of candid residents and family members. One of us has served as an expert defense witness on behalf of facilities being sued. One of us has, herself, had several family members in long term care facilities. For these reasons, we believe that we have a unique perspective on the steps that long term care facilities take to increase their likelihood of getting sued, and we hope that our insights are helpful to you in avoiding common mistakes.

Step Number One:

Invest in impressive marketing materials such as brochures and advertisements that promise "comprehensive care" or "aging in place" to potential clients. When physical or behavioral problems arise, blame the patient.

We are called over and over to examine patients who "refuse to stay in their wheelchair." Staff tell us that no matter how often they remind a resident," He just will not stay seated and always wants to get up." We have seen residents with documented diagnoses of dementia (and clear clinical symptoms) left without even a lap restraint for hours in a dark room alone. When they fall, the family is told, "He never listens. He knows not to get up on his own."

It is imperative to fully understand how dementia affects the actions and judgment of a resident. This cannot be overstated. As many as fifty percent of your residents likely have dementia, and you cannot adequately care for them if you don't have as clear an understanding of dementia as you do of decubitus ulcers. Patients with dementia cannot be expected to take responsibility for their own safety. If they could, they would not likely be in your facility.

Step Number Two:

Avoid documentation that reflects the condition of the patient.

While documentation of change in condition is important, documentation of ongoing abnormalities is even more critical. Staff will request medication for aggressive patients when the only chart documentation is about prior antibiotic administration. Nothing is more frustrating than to be asked to treat a resident for aggressive behavior and have no information on the resident's mood, appetite, level of arousal, or calls for help. The explanation usually given is, "He's always this way." We have seen residents who are actively hallucinating (seeing visions or hearing sounds that are not there), do not know their own names, and are visibly dehydrated with no assessment for dementia, no documentation of the presence or absence of a mental disorder, and no mention to the family of the resident's behavior. As health professionals dealing with a population with a high prevalence of dementia, it is your responsibility to recognize disorientation, psychosis, and memory loss and to document appropriately. If you are unsure of your (or your staff's) clinical skills in this area, invest in adequate training to correct any deficiencies.

Step Number Three
Make unilateral decisions without fully communicating with the patient or his/her family.

We have been asked to see residents who were "difficult to manage" or "violent" and told that if we couldn't intervene quickly, the resident would be evicted or moved to a lower level of care. In such cases, it is not uncommon that the family and resident have no idea that there is any talk of their leaving the facility. Planning a life-changing move without warning to the resident or her family—particularly if your marketing materials promise care through the end of life—is devastating and will almost surely provoke rage. Angry residents or families who are scared and sense that you want to be rid of them will likely see legal action as their only recourse. Aggressive behavior in a resident is difficult for everyone, but it is a common behavioral problem associated with dementia. Families are understandably frightened, ashamed and upset to hear that their loved one is aggressive. Careful consideration of the family's feelings, inclusion of the family in discussions of the problems, and collaboration with the family to find solutions leave little room for allegations of negligence.

Step Number Four

Ignore consultants' recommendations, explaining to them that you do not have enough staff.

This most commonly occurs when there are behavioral disturbances and one of us has recommended behavioral interventions rather than medication. It is not uncommon for on of us to be asked for recommendations and to have them completely ignored. For example, patients who "won't" stay in their wheelchairs and "insist on walking" need closer monitoring, aided ambulation, increased stimulation, pain management, and

possibly a toileting program before medication is even considered. After a perfunctory attempt at keeping the resident in the dayroom more, without a concerted attempt at an integrated behavioral program, the staff will say, "We've tried everything" and begin restraining the resident in the wheelchair or bed. The inevitable falls as the resident fights the restraints or climbs over bedrails are often grounds for legal action by families, especially if you have indicated that you do not have adequate staff to provide the care you promised.

Step Number Five

Attempt to cover your mistake by saying that the patient is "confused."

Staff and facilities make mistakes. There is no way that any facility can be perfect all the time, but covering mistakes by attributing disparate reports with the excuse that the resident is "confused" is inexcusable and will quickly ruin rapport with even the most supportive of families. For instance, it is not uncommon for residents to be told at night to use their diapers rather than being taken to the restroom when they request it. Addressing a complaint by telling families and physicians that this doesn't occur and the resident must be "confused" has various consequences: The resident becomes more helpless and hopeless, and eventually clinically depressed. The necessary monitoring of pressure ulcers may be omitted because the true frequency of soiled linens is not reported. A jury will often forgive an honest mistake, but deliberately discounting a helpless resident's complaints because of a convenient diagnosis of dementia will likely cause the jury to make an example of a facility.

Clearly, all facilities have caring, concerned, and dedicated staff. Not all facilities have engaged in the tactics we have described above. It remains true, however, that because of the extreme vulnerability of long term care residents, public scrutiny of long term care facilities is intense. We all lament the growing paperwork of defensive medicine, but there are other steps you can take to mitigate the danger of legal action against your facility. Two things - consistent communication with families and knowledge about dementia - can prevent many woes. We hope that you have found these examples helpful as you provide care.