Risk Management in Assisted Living

Joanne Kaldy

Managing risk in a care setting where physicians, pharmacists, nurses, and caregivers often communicate by phone or e-mail can be challenging. Nonetheless, assisted living facilities need to identify clinical areas of risk and be prepared to prevent avoidable problems or situations. This requires ongoing and effective communication among team players and between team leaders and residents and family members.

Managing Fall Risk

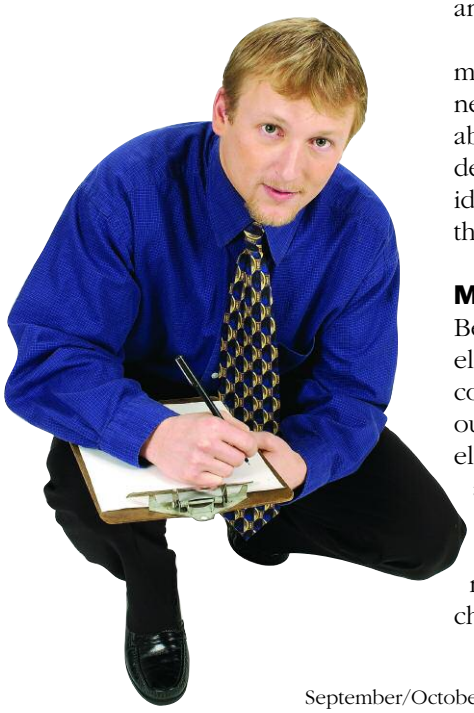
Addressing falls is a top priority for facilities. This is partly because falls are common in senior care settings, and injuries from falls often result in lost independence, hospitalization, and even death. Falls and fall-related injuries also are a leading cause of litigation against long term care facilities, including ALFs.

It is important to have processes in place that help facilities prevent falls and address unavoidable falls promptly. To prevent falls, facilities need to identify environmental factors that contribute to falls, such as poor lighting or glare, clutter or tripping hazards, flood conditions, lack of bathroom safety features, furniture that residents can trip over or bump into, poorly fitting footwear (including shoes with slippery soles or loose laces), and missing or loose wall rails. The trending of incident data regarding falls can help facilities determine what environmental issues need to be better addressed and where there are correctable problems. For example, if several falls are reported in a specific hallway, it will be useful to assess that hall for poor lighting, slippery or uneven flooring, and other environmental factors that increase the risk of falls there.

It is important to assess new residents for fall risk and to ensure that their residences are free of environmental hazards. ALFs also should educate residents and their families about falls and how they can help prevent them.

While physical and chemical restraints are more of an issue in nursing facilities than in ALFs, it is important that assisted living practitioners and staff—as well as residents and families—understand how these restraints can contribute to falls. Historically, physical restraints were seen as a risk management tool to keep patients safe from falls or wandering. However, numerous studies have documented the incidence of falls by and injuries to restrained residents. Facilities need to be prepared to utilize other tools and aides—such as low beds or bed alarms—to keep residents safe.

It is important to note that the mere occurrence of a fall doesn't necessarily mean that a facility is liable.



Chemical restraints also are less common in assisted living but also present a substantial risk. The excessive control of behavior by the use of medications presents a serious fall risk for residents. It is important that everyone in the facility understand that any drug used for discipline or convenience—instead of to treat medical symptoms—may be considered a chemical restraint and is unacceptable.

It is important to note that the mere occurrence of a fall doesn't necessarily mean that a facility is liable. It is the failure to protect residents from falls or to recognize residents who are at risk for falling that result in liability.

Managing Risk of Wandering

Behaviors such as wandering and elopement increase as residents' cognition declines. These are serious issues in assisted living. In fact, elopement claims have the highest average cost of all claims against assisted living facilities—with about 80% of incidents involving residents who are known as chronic wanderers.

There are several types of these behaviors:

- Tactile wandering which typically involves using hands to explore the environment
- Environmentally cued wandering where wandering is triggered by cues such as a hallway, a path, a sidewalk, etc.
- Reminiscent or fantasy wandering where the resident is looking for a place associated with his or her past
- Recreational wandering which generally is linked to a need for exercise and activity
- Agitated, purposeful wandering which is connected with confusion, fear, and panic; often accompanied by combativeness

To manage risk in this area, ALFs should identify residents who are at risk of wandering or elopement and work with the resident, family members, caregivers, and others to address high-risk residents. Managing the risk of wandering requires learning about the resident's habit, interests, and hobbies.

For example, one facility had an elderly male resident who regularly wandered and became combative. In talking to his family, they discovered that he had been a boxer when he was younger and worked out regularly into his senior years. Facility staff arranged for him to work out at a local fitness center a few days a week, and his behavior subsided.

Staff and families should be alerted to watch residents who are at risk for wandering. They should tell nurses or the resident's physician immediately if interventions to reduce wandering are unsuccessful.

Managing Pressure Ulcer Risks

The risk of pressure ulcers is higher for residents who are bedridden or wheelchair bound. Pressure ulcers are particularly common in frail elderly patients. Even when residents enter an ALF free of pressure ulcers, they can develop wounds from a brief trip to the hospital or some type of skin trauma.

Pressure ulcer risk should be assessed using a systematic risk assessment tool such as the Braden scale. Pressure ulcer risk should be reassessed at periodic intervals, especially when a resident experiences an acute change in condition or returns from a hospital stay. Residents who are bed- or chair-bound or those with an impaired ability to reposition themselves should be assessed for additional factors that increase the risk for developing pressure ulcers. Immobility, incontinence, diminished nutritional intake, and altered level of consciousness also should be triggers for reassessment.

Elopement claims have the highest average cost of all claims against assisted living facilities, with about 80% of incidents involving residents who are known as chronic wanderers.

To prevent skin injury, the facility should have a maintenance program to improve tissue tolerance to pressure. At the same time, a comprehensive educational program can help reduce the incidence of pressure ulcers.

To protect the facility and practitioners from unfair litigation, it is important to have:

- Supporting documentation showing rigorous adherence to standards of care for pressure ulcers
- Proof of an aggressive and comprehensive pressure ulcer prevention and treatment program
- Proof of pre-existing weakness or frailty
- Proof of refusal on the resident's part to comply with treatment
- Proof of a contributing medical condition
- Proof that the pressure ulcer developed in another setting such as a hospital

Managing Nutritional Risk

Maintaining appropriate nutritional status for ALF residents is another area that requires risk management. Contributing factors to nutritional problems in facilities include:

- Physical causes such as depression, swallowing disorders, mouth problems, and tremors that affect a resident's ability to adequately feed himself or herself or to self-administer liquids
- Adverse drug effects such as nausea, vomiting, diarrhea, and appetite suppression
- Inadequate attention from staff regarding residents' nutritional intake or lack of staff understanding about addressing nutritional issues

To reduce potential risks from nutritional issues, the ALF should ensure that:

- Thorough assessments are done to identify the presence or high risk of nutritional problems
- Consultations with the physician to determine if medications may be affecting the resident's appetite
- Residents are encouraged to exercise to stimulate their appetites
- Appropriate snacks are available and meals are palatable
- Residents have the opportunity to eat where and when they like

Family communication is crucial to preventing litigation regarding nutritional issues. Family members often associate weight loss—even

(continued on page 42)

My facility requires that outside physicians send something in writing explaining changes in plans, medications, treatments, tests, follow-up appointments, and so on. The facility keeps these on record for documentation purposes, and the nurses carry out these orders when necessary. I don't interfere in this process. However, when outside orders are ambiguous or the nurses have questions, they can seek my guidance or interpretations as needed.

I also usually review notes so that I can be familiar with all residents' conditions. Although I do not interfere with the patient-doctor relationships, I often am called in emergency situations and when there is an acute change of condition. And I need to have at least a rudimentary knowledge of each resident's health and history to respond effectively in these situations. This provides an additional level of care and usually reassures residents.

If AL medical directors don't have clear guidelines, we can end up with physicians who have lots of responsiblities without the authority to carry them out.

In addition to these major medical duties, I also attend team meetings, review admission applications and miscellaneous medical documents from outside physicians, hospitals, and emergency rooms, and interpret illegible physician handwriting, including my own. All of these duties are being refined and slowly expanded daily.

The Future Holds...

I like to think my role as a medical director is a model that other facilities will emulate in the coming years. I believe that my presence at the facility has enabled the highest possible level of care for residents. As the new care-based model becomes more prevalent in ALFs, it will become increasingly clear where opportunities and needs for physician leaders exist in this setting.

If regulations evolve, as I believe they will, the physician medical director's clinical experience and knowledge of geriatric care and research will be important to ensuring quality care for residents. As for the formal role of a medical director in ALFs, we have to be careful.

Both facility policies and state regulations must make the duties and authority of this position clear. Otherwise, if medical directors are placed in facilities without clear guidelines, we can end up with physicians who have lots of responsibilities without the authority to carry them out. This would serve only to significantly increase the legal liability of the medical director, as exists in the nursing home industry; and this possibly could kill the ALF medical care movement before it can grow to fruition.

The presence of a medical director can enable provision of a new level of clinical care in ALFs and help the residents who need it most. We just need to move forward with caution and purpose to maximize the value of the physician's presence in this setting. ALC

Alec Pruchnicki, MD, is a multi-facility medical director in New York. He also is an instructor of medicine at the New York Medical College and an attending physician at St. Vincent's Hospital.

Legal Corner

(continued from page 40)

unavoidable weight loss—with starvation or neglect. It is important to make sure that family members understand what is causing the weight loss, what (if anything) can be done about it, the advantages and disadvantages of any interventions, etc. Facility staff must be encouraged to find out about resident preferences and attend to these as much as possible.

Communication Strategies to Reduce Risk

There are many strategies that ALFs can implement to reduce risk and improve communication. These include:

- Communication with families via phone calls, e-mails, family night presentations
- Addressing expressed or potential conflict promptly
- Resident education via luncheon programs and other activities
- Team communication via meetings, quality initiatives, and other activities
- Documentation of any refusal of recommended treatment by residents
- Protocol for when it is appropriate to contact the resident's physician
- Documentation of residents' advance directives and other preferences

These activities can help make working at the facility less stressful and more enjoyable for staff. They also can maximize quality of life for residents and satisfaction on the part of family members. ALC

This column is adapted from the module on Clinical Risk Management in the Nursing Facility from the American Medical Directors Association's Curriculum on Geriatric Clinical Practice in Long Term Care Teaching Kit. To order this kit or for more information, go to www.amda.com.

Joanne Kaldy is Managing Editor of *Assisted Living Consult*.