

BETTER COMMUNICATION MEANS LOWER RISK
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Liability exposure in the long term care (LTC) industry remains a pervasive problem with respect to the number of lawsuits, severity of settlements and jury verdicts. Some adverse events lead to lawsuits, yet other situations that may appear just as serious do not result in legal action.

Often, the difference is how caregivers communicated with the resident or the resident's family both before and after the adverse event. Communication patterns deeply affect perceptions of the quality of care at a facility, and this perception may, in turn, affect the decision to sue. Improving communication and interpersonal skills becomes a crucial element within the risk management strategy of every LTC organization.

The following two case histories demonstrate how communication can help shape the relationship between the facility and the resident and family, creating understanding and sympathy or, conversely, anger and distrust.

Carefully Speaking **CNA**

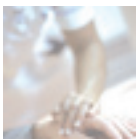
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Case One: Jane Doe

Jane Doe was admitted to a long term care community with diagnoses of vascular insufficiency, arteriosclerosis, arthritis and moderate dementia. She was moderately malnourished and her general state of health was compromised. The 96-year-old woman had previously lived with her daughter, who now found it difficult to manage her mother's care at home.

About a month after admission, Jane Doe suffered a stroke. Afterwards, she became non-ambulatory, had difficulty swallowing, was lethargic and confused. Her distraught daughter refused to permit staff to insert a feeding tube.

Over the course of the next six months, Jane Doe became severely malnourished, and her weight dropped to 89 pounds. Despite the best efforts of the staff, she developed a stage II pressure ulcer on her right hip and a stage III pressure ulcer on her right ankle. She died seven months after admission. The recorded cause of death was congestive heart failure and dehydration. Both the community administrator and the wound care nurse attended her funeral.



During Jane Doe's stay, she and her daughter developed a solid rapport with the staff, related, in part, to the following measures:

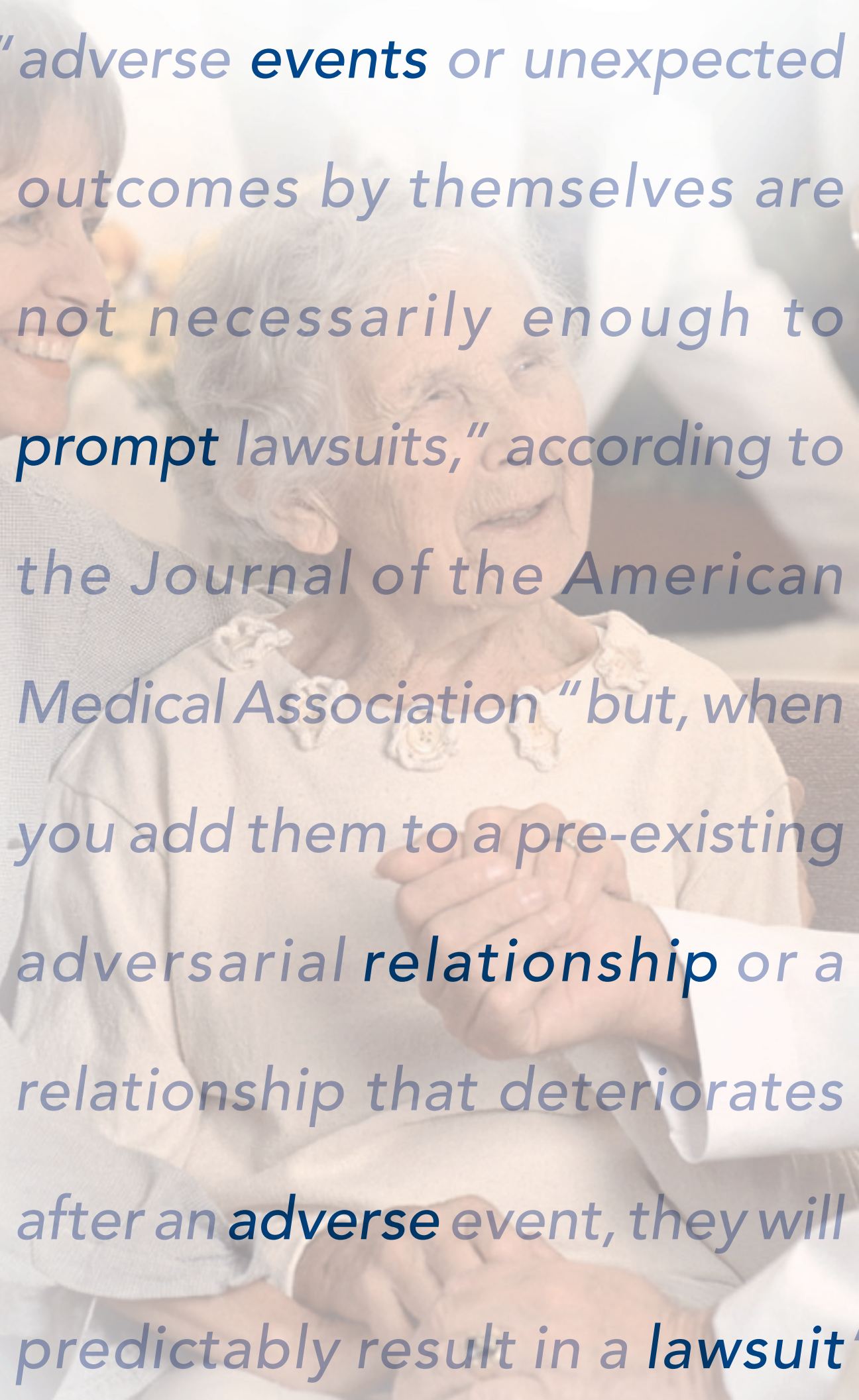
- *On admission*, Jane Doe and her daughter met a woman identified as "your nurse," and were given the nurse's name and phone number. It was made clear that the nurse would act as Jane Doe's advocate and was ready to coordinate care, find answers to questions, communicate with the physician and evaluate the proposed nursing plan of care.
- *Staff displayed genuine, respectful affection* for Jane Doe and established open, timely and regular communication with her daughter.
- *The facility developed a schedule* that allowed the daughter to meet with staff and review Jane Doe's "report card." Initially, the meetings were every two weeks, but this changed to weekly as Jane Doe's condition deteriorated.
- *Jane Doe's daughter was encouraged to talk to the nurse* on duty at every visit for a brief overview of the day or an account of changes since the last visit.
- *To avoid misunderstandings*, staff was instructed to be as specific as possible when talking to the daughter. For example, rather than saying that Jane Doe "ate pretty well today," the nurse would instead state that "she ate half her food but drank only half a glass of juice." The daughter also received a full and understandable explanation of the consequences of prolonged, progressive calorie reduction.
- *At the onset of Jane Doe's decline*, staff talked to the daughter and provided written information about skin integrity, pressure ulcers, nutrition and end-stage issues. They also offered emotional support and empathy.

When Jane Doe's health declined, her daughter did not express anger about the development of decubitus ulcers. Instead, she showed gratitude for the care that had been given.

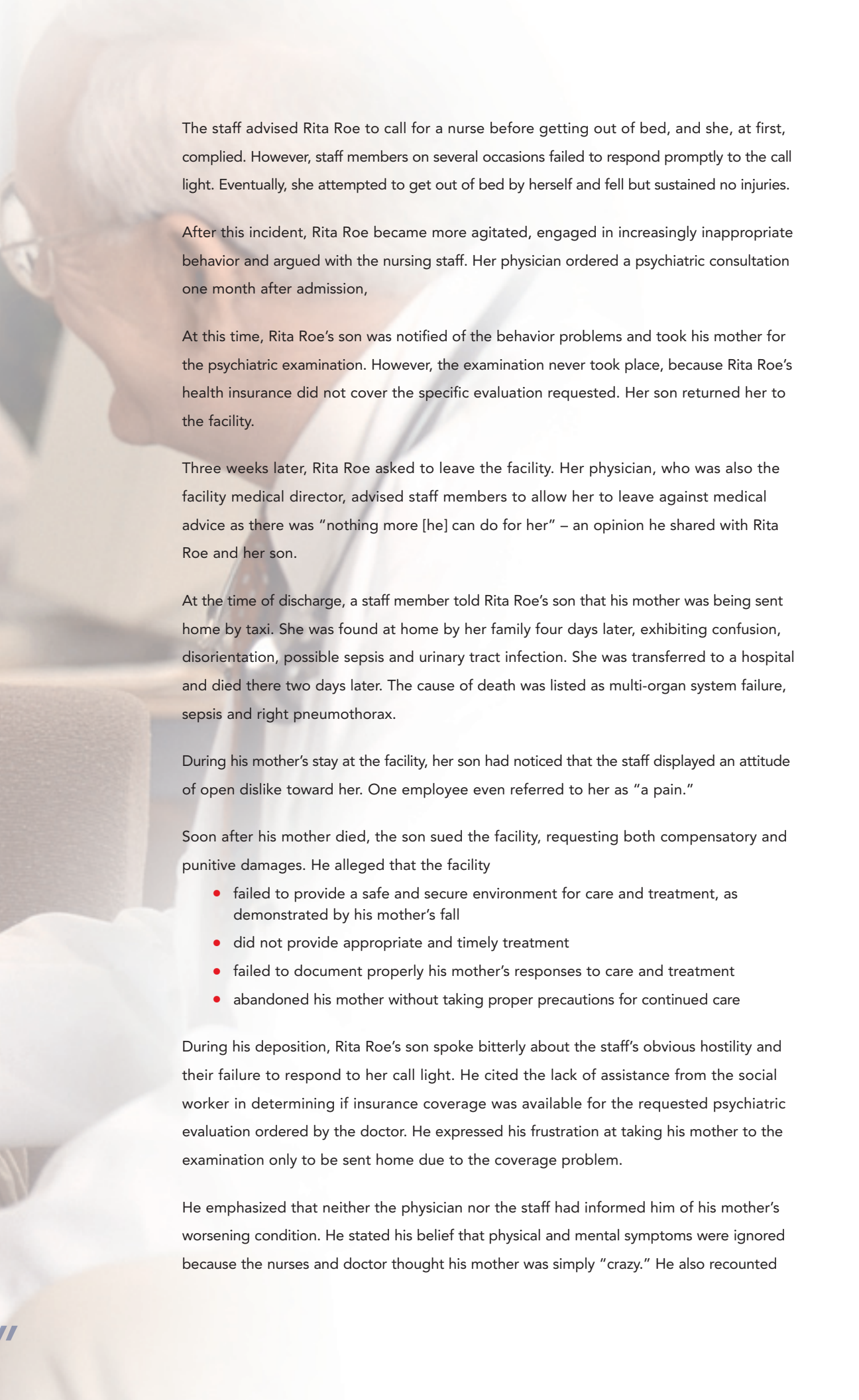
Case Two: Rita Roe

Rita Roe was transferred from a hospital to a long term care facility for continued rehabilitation after sustaining a fracture of the left tibia and fibula. At the time of admission, she was in a knee brace and required physical therapy. The initial plan was to discharge her home at the end of her rehabilitation.

Although Rita Roe was considered sufficiently competent to make her own decisions, she exhibited multiple episodes of uncooperative and inappropriate behavior after she was admitted. She refused medications, meals and physical therapy.



"adverse events or unexpected outcomes by themselves are not necessarily enough to prompt lawsuits," according to the Journal of the American Medical Association "but, when you add them to a pre-existing adversarial relationship or a relationship that deteriorates after an adverse event, they will predictably result in a lawsuit"



The staff advised Rita Roe to call for a nurse before getting out of bed, and she, at first, complied. However, staff members on several occasions failed to respond promptly to the call light. Eventually, she attempted to get out of bed by herself and fell but sustained no injuries.

After this incident, Rita Roe became more agitated, engaged in increasingly inappropriate behavior and argued with the nursing staff. Her physician ordered a psychiatric consultation one month after admission,

At this time, Rita Roe's son was notified of the behavior problems and took his mother for the psychiatric examination. However, the examination never took place, because Rita Roe's health insurance did not cover the specific evaluation requested. Her son returned her to the facility.

Three weeks later, Rita Roe asked to leave the facility. Her physician, who was also the facility medical director, advised staff members to allow her to leave against medical advice as there was "nothing more [he] can do for her" – an opinion he shared with Rita Roe and her son.

At the time of discharge, a staff member told Rita Roe's son that his mother was being sent home by taxi. She was found at home by her family four days later, exhibiting confusion, disorientation, possible sepsis and urinary tract infection. She was transferred to a hospital and died there two days later. The cause of death was listed as multi-organ system failure, sepsis and right pneumothorax.

During his mother's stay at the facility, her son had noticed that the staff displayed an attitude of open dislike toward her. One employee even referred to her as "a pain."

Soon after his mother died, the son sued the facility, requesting both compensatory and punitive damages. He alleged that the facility

- failed to provide a safe and secure environment for care and treatment, as demonstrated by his mother's fall
- did not provide appropriate and timely treatment
- failed to document properly his mother's responses to care and treatment
- abandoned his mother without taking proper precautions for continued care

During his deposition, Rita Roe's son spoke bitterly about the staff's obvious hostility and their failure to respond to her call light. He cited the lack of assistance from the social worker in determining if insurance coverage was available for the requested psychiatric evaluation ordered by the doctor. He expressed his frustration at taking his mother to the examination only to be sent home due to the coverage problem.

He emphasized that neither the physician nor the staff had informed him of his mother's worsening condition. He stated his belief that physical and mental symptoms were ignored because the nurses and doctor thought his mother was simply "crazy." He also recounted

the physician's statement that there was nothing more he could do. Sending his mother home alone by taxi was the last straw, proving to the son that no one at the facility cared at all.

Why People Sue

A prevailing view of those who sue nursing homes, hospitals, physicians and other health-care providers is that they are "out to get a free ride" or are "just doing it for the money." Generally, this is not the case.

A study published in the Archives of Internal Medicine (June 27, 1994) examined why patients or their families sued doctors. After reviewing a number of plaintiff depositions, the authors identified "problematic relationships" in over 70 percent of the cases. The study concluded that "the decision to litigate was often associated with a perceived lack of caring and/or collaboration in the delivery of health care. The issues identified included perceived unavailability, discounting patient and/or family concerns, poor delivery of information, and lack of understanding the patient and/or family perspective."

Another study published in the Journal of the American Medical Association (June 2002) echoed these findings. According to the author, the research indicates that "adverse events or unexpected outcomes by themselves are not necessarily enough to prompt lawsuits. But, when you add them to a pre-existing adversarial relationship or a relationship that deteriorates after an adverse event, they will predictably result in a lawsuit." The study placed most complaints into four categories: communication, care and treatment concerns, access and availability, and the "humaneness" of the physician.

The following examples illustrate four types of relationship problems common to LTC facilities:

- desertion
- discounting resident and family views
- failed communication
- failure to request resident and family input

Desertion is characterized by the resident's or family's feeling of being alone or abandoned.

Examples of desertion include

- a resident unsuccessfully attempting to call a staff member for assistance or waiting a long time for a call light to be answered
- a healthcare provider breaking a promise to return to a resident's bedside
- a provider telling a resident or family member that he or she is very busy and the resident will have to wait
- a nurse or physician sending a surrogate (such as an aide) to a resident's bedside, which suggests that the provider is too busy to address the resident's needs personally

Discounting resident and family views may be interpreted as evidence of a patronizing attitude on the provider's part. Specific behaviors in this category include

- scoffing at or ignoring the resident's or family's opinions
- dismissing or diminishing the resident's condition or pain
- not taking the time to answer fully the resident's or family's questions

Dysfunctional delivery of information/failed communication may lead to questions about the provider's or facility's competence and commitment. Specific examples include

- failure to provide explanations or reasons for recommendations
- failure to keep the resident or family up-to-date
- blaming the resident or family for a bad outcome or adverse event
- lack of sensitivity toward the resident or family

Failure to request the resident's and family's input may lead them to feel that no one cares about what they think. Examples of this problem include failure to

- solicit the opinion of the resident or family about care
- appreciate the resident's need to remain self-directed and autonomous
- recognize and address the psychosocial aspects of the resident's condition

These and other studies conclude that even in the face of a poor outcome or unexpected occurrence, people are less likely to sue if they feel that healthcare providers really care about them, and that their questions are answered in an honest, timely and respectful manner. Conversely, people are more likely to sue if they feel angry, believe their questions and concerns are dismissed or not answered fully, or suspect a cover-up.

Improving Communication at Your Facility

You can help create stronger relationships between your organization and residents, family members and the larger community by establishing formal policies and programs designed to improve communication. Here are some practical suggestions:

Build positive resident and family relationships by

- responding to resident needs in a timely and professional manner
- treating residents with respect and kindness
- ensuring that nursing staff talk with family members on a regular basis (weekly, if possible) to review the resident's "report card," give information and respond to questions and concerns
- establishing a plan to educate residents and families in such key areas as fall prevention, restraint reduction, skin integrity, nutrition, etc.
- initiating a formal guest relations program for all staff
- providing sensitivity training for all staff
- encouraging staff members at all levels to improve their communication skills
- including communication as an important factor in employee evaluations

Build positive community relations by

- hosting open houses, holiday parties, craft fairs and similar events, which encourage your neighbors to get to know your facility
- inviting community leaders to visit your facility
- developing and implementing a professional media relations plan
- appointing and utilizing a community relations board

Nothing can take the place of care and treatment that adheres to accepted standards, rules and regulations. However, a successful long term care facility tends to more than its residents' physical needs – it also considers the emotional and psychological need for dignity, respect and connection. By creating an environment conducive to open, full communication, LTC facility administrators can help foster a stronger rapport between residents and caregivers, defuse potentially adversarial situations, and reduce the risk of litigation.

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