LEGAL ISSUES

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Risk Management for a Resident Who Won't Follow Medical Advice

Mrs. H and her husband are residents at a skilled nursing facility. They are elderly and have extensive gait instability, but are cognitively intact. Mr. H is rehabilitating after a compression fracture of the thoracic spine. They are both receiving physical therapy and occupational therapy. After rehab, Mr. H is discharged home to the community to live with his adult children, but his wife must remain in the SNF.

Every day after his discharge, Mr. H visits his wife and wants to walk with her in the hallways like they used to do when they both resided at the SNF together. The only problem with this scenario is that they refuse to have an attendant walk with them to provide contact assistance for potential falls. Mrs. H and her responsible parties (her adult children) have been advised that allowing her husband to walk with her, with no contact assistance, is not believed to be safe by nursing staff or physical therapists, due to their gait instability. Facility personnel are concerned about the risk of one of them losing their balance and both of them falling as a result.

Mr. H insists that he be allowed to walk with his wife. The adult children insist their father be allowed to walk with their mother every day. They also refuse to hire an attendant to walk with them. What can the facility do to manage its risk for the anticipated fall and lawsuit, but still honor Mrs. H's decision not to follow medical advice?

This issue is challenging for a facility because of the balancing act between respecting a resident's right to refuse certain treatments and protecting a resident, and her guest, from known hazards. The facts described above may never turn into litigation; however, the facility administrator anticipates two potential falls with potentially serious outcomes. If the facility refuses to allow Mr. H to walk with his wife, the facility is exposed to a claim that they violated Mrs. H's right to be with her husband.

Verify Informed Refusal

The notion of informed consent is well established in medical ethics. The corollary to that is informed refusal, where a patient chooses not to adhere to the recommendations of the physician or treatment team. Documentation of informed refusal in a resident's medical chart is an important tool in the facility's risk management toolbox. In order to be "informed," the resident or responsible party must be provided with all information that is material to a decision to accept or refuse any proposed treatment or procedure. In this scenario, material information would consist of the risks and benefits of Mrs. H continuing to walk with her husband who has gait instability, with no other form of assistance. Potential negative outcomes include falls, fractures, subdural hematomas, and death. Ideally, this conversation should occur more than once with the attending physician and the interdisciplinary team, and the resident and her responsible party. The conversations need to be documented in the resident's medical chart.

Update the Care Plan

The facility needs to make sure to update its fall risk care plan for Mrs. H to reflect the refusal to follow the physician's recommendations as it relates to her walking with her husband. The care plans cannot be generic — they must be specifically designed to address the resident's needs and desires. In this case, the care plan would address the fact that Mrs. H has gait instability and is at high risk for falls, yet she refuses to follow medical advice and desires to continue to walk with her husband, who also has gait instability.

Care Plans are defined by Title 42. §483.20(k), which states: "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following —

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

(2) A comprehensive care plan must be —

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must —

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care."

In this case, the fall risk care plan must be meticulously updated to include any interventions the family agreed to, plus the refusal to agree to recommended interventions. Nursing staff also must meticulously document in the progress notes the refusal and their attempts to ensure compliance with the recommended medical advice.

Alternative Treatment Consent

Alternative treatment consents (ATCs), acknowledgments, and waivers can reduce the risk of deficiency citations and lawsuits that result from allowing residents to exercise their rights to refuse treatment orders and medical recommendations. When a resident (or responsible party) makes a decision that exposes the resident to harm, this decision provides the foundation for an inference that the facility failed to provide care and services to help the resident attain and maintain her highest practicable level of well-being.

The State Operations Manual effective June 10, 2016, outlined what the Centers for Medicare & Medicaid Services expects a facility to do when honoring a resident's right to refuse care and services. In the narrative discussion under Right to Refuse Medical or Surgical Treatment under F 155 §483.10(b)(4) and (8), it is stated that if a resident declines treatment, he or she may not be treated against his or her wishes. The facility is expected to:

- Reassess the resident and modify the care plan as appropriate
- Assess the resident for decision-making capacity and invoke the health care agent or legal representative if the resident does not have decision-making capacity
- Determine and document what the resident is refusing
- Assess the reasons for refusal
- Advise the resident about the consequences of refusal
- Offer pertinent alternative treatments
- Continue to provide all other appropriate services.

The ATC or waiver, ideally, would reflect all the action items listed above that the facility undertook in order to comply with the guidance set forth by CMS.

In allowing Mrs. H to exercise her right to refuse to follow medical advice, the facility developed a waiver that explicitly enumerated the risks and benefits of following the physician's advice not to walk with her husband and to allow her to be escorted by a facility attendant with a gait belt or other contact assistance. The facility provided the family with the opportunity to hire an extra caregiver to be present with Mr. and Mrs. H at all times while he was in the facility with her, but the family refused to pay for the extra assistance. That was also included in the waiver. Time will tell if the waiver will be tested in court.

Practical Challenges, Suggestions

In developing an investigative protocol for determining "proper" refusal, what would a surveyor look for in deciding whether to substantiate a deficiency citation?

1. *Interviews with either the resident or the personal representative.* What has the facility done to determine resident care and treatment choices? What did the staff and practitioner do to inform the resident or her responsible party about her medical condition, treatment options, and prognosis?
2. *Facility staff.* How does staff help the resident document treatment choices? How are choices and treatment decisions communicated to the interdisciplinary team?
3. *Health care practitioners.* How does the facility staff seek, identify, and document the resident's wishes about her care plan? How does the facility staff ensure medical orders and treatments reflect the resident's choices and goals?
4. *Record review.* Is there documentation of the rationale for recommendations and treatment decisions? Are practitioner orders consistent with the resident's documented choices and goals?
5. *Criteria for compliance.* Has the facility helped the resident exercise rights by explaining the risks and benefits of declining treatment? Has the facility incorporated resident choices into the medical record and orders related to treatment care and services? Has the facility consistently maintained advance directives and resident goals in the same section of the clinical record for all appropriate residents?
6. *Facility policies and procedures.* Has the facility revisited its policies and procedures that address this situation

INTERACT: A Nurse's Perspective

Christine Kilgore

Jill M. Shutes, MSN, GNP-BC, sees nursing home care and decision-making from both sides of the fence. Having worked both as a geriatric nurse practitioner and a clinical services manager for Evercare, she knows how challenging it can be, as a clinician, to receive information about a resident that is more "big picture" than concise. And she knows how frustrating it can be, as a nurse, to lack confidence in communicating with a clinician about a resident's status and to receive orders that are sometimes unclear and even indefinite in nature.

This is why the INTERACT (Interventions to Reduce Acute Care Transfers) quality improvement program care paths and their compatible order sets are so important for nursing homes, Ms. Shutes said at the AMDA — the Society for Post-Acute and Long-Term Care Medicine Annual Conference in Orlando, FL.

Ten Care Paths

INTERACT enables the early identification and management of 10 common symptoms and conditions that have been shown to be responsible for the majority of potentially avoidable hospitalizations.

The program is in essence a set of tools and strategies for communication and documentation. Its 10 care paths, which cover areas such as acute mental status changes and symptoms of lower respiratory illness, are one of INTERACT's main tools for nurses in their decision making about when and how to evaluate changes in a resident's condition, and when to communicate with primary care clinicians. The care paths also provide some guidance on management.

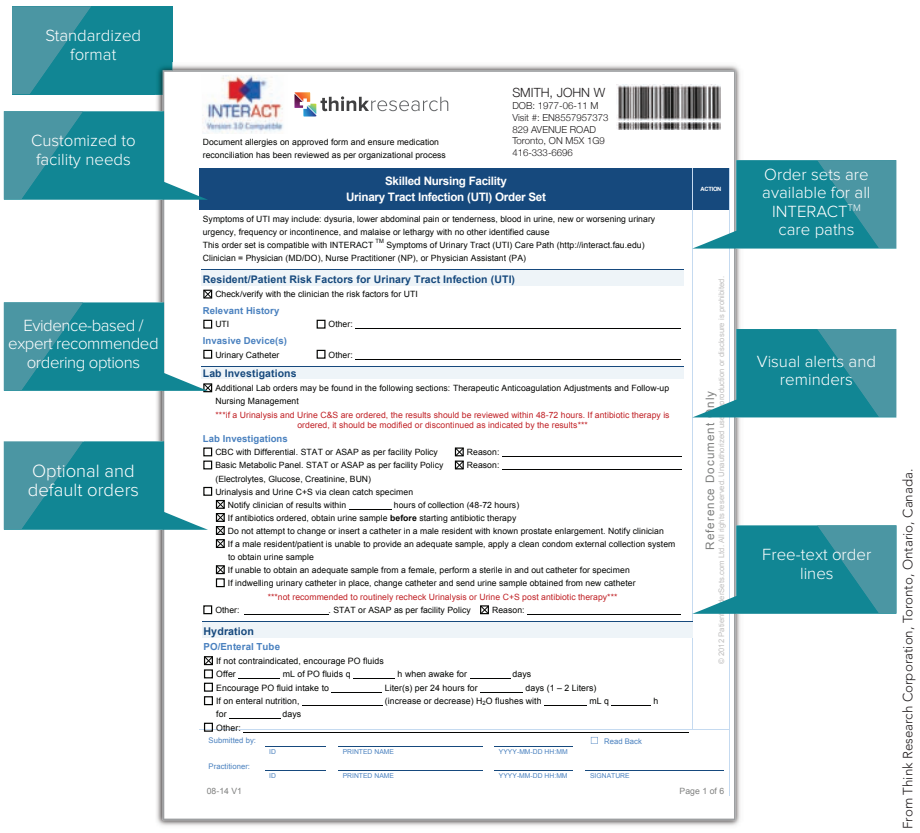
The INTERACT-compatible patient order sets were developed more recently to give physicians and nurses more specific and practical assistance in managing a patient's individualized nursing, diagnostic, and treatment orders. Each of the 10 evidence-informed order sets is compatible with a care path; the acquired pneumonia patient order set, for instance, is an extension of the INTERACT care path for symptoms of lower respiratory illness.

Ms. Shutes, a research associate at Florida Atlantic University and an assistant professor at Palm Beach Atlantic University, has a vested interest in the program. She served on the expert advisory panel that collaborated with the Think Research Corporation on developing the order sets, and she continues to serve as a consultant for the company. The advisory panel was led by FAU's Joseph Ouslander, MD.

Her conviction in INTERACT's value is deeply rooted. The care paths and order sets "have validated everything I've been doing on a regular basis as a geriatric nurse practitioner," Ms. Shutes said. "There are a lot of nurse practitioners in nursing homes who aren't geriatric trained, who need that extra layer of geriatric guidance, and there are nurses who need that extra support."

Solid Knowledge

Nurses' knowledge is solid, she said. When she trains nurses on how to use the care path for symptoms of congestive heart failure, for instance, she first "turns it upside down" and asks them to name symptoms of CHF, to describe an evaluation, and to name the criteria and vital sign measures that should prompt notification of the clinician. "They miss very little," Ms. Shutes said. "They just sometimes need a little guidance and support to be able to get through the process and to [effectively] communicate the information to the physician."



From Think Research Corporation, Toronto, Ontario, Canada.

The Interact patient order sets are particularly helpful to nursing staff when they receive clinician orders that are unclear or undefinitive.

Once contact with the physician is made, the practitioner completes the order set, marking orders for laboratory studies, for instance, and indicating steps to be taken for managing the condition in the nursing home. He or she then sends it back to the charge nurse.

Order sets have a standardized format, with menus of evidence-based and expert-recommended orders as well as optional and default orders, and visual alerts and reminders. But like the care paths, order sets can be customized for individual facilities and groups of providers.

Each order set incorporates evaluative results obtained with the associated care path, and it may, in turn, refer back to the care path for parameters or other guidance relating to continued management. The order sets can be used as part of a paper record process or integrated into an electronic record system.

Most importantly, Ms. Shutes said, order sets enable "physicians and nurses [to] communicate on the same level … to speak the same language," which is increasingly important as the Centers for Medicare & Medicaid Services, the Society, and others work to reduce hospitalizations among patients in skilled nursing facilities.

Care paths are available on the INTERACT website (http://interact.fau.edu), and the order sets are available through Think Research (www.thinkresearchgroup.com).

An overview of the program, including a description of the care paths and findings on the program's effectiveness, was published two years ago (*J Am Med Dir Assoc* 2014;15:162–70), and a description of the order sets ran last year (*J Am Med Dir Assoc* 2015; 16:524–26).

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and considered preparing a policy if one does not exist?

7. *Assessment.* Is the facility hypervigilant about assessing gait stability in this situation to track any changes or decline in Mr. or Mrs. H's gait stability? These assessments should be well documented in the chart, noted on the care plan, and communicated to the physician and family.
8. *Reporting.* If a fall occurs, is the facility prepared to immediately report it to the local state survey agency?

Conclusion

Resident rights and preferences place nursing facilities in a difficult position of providing a homelike and safe environment while still allowing the resident to self-determine her care plan as much as possible. Walking with a spouse is part of a homelike environment and provides for a resident's psychosocial well-being, but it is not without its risks. As long as the walking occurs on the facility grounds, the facility must be vigilant in its assessments, reporting, communication, and documentation in order to manage the potential risk while still honoring the resident's right to refuse treatment and medical recommendations. Although nothing can completely eliminate the risk of a lawsuit if Mrs. H falls and suffers a negative outcome, good documentation can significantly reduce the probability of a lawsuit being filed, and substantially reduce the probability of a successful lawsuit if one is filed.

This column is not to be substituted for legal advice. Mr. Wilson is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance.