LEGAL ISSUES

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The High Cost of Cutting Corners on Care Plans

Mr. H, an 80-year-old black man, was admitted to a skilled nursing facility for rehabilitation after undergoing an open reduction, internal fixation to repair a broken left hip. Mr. H had several comorbidities, including type 2 diabetes, dementia with behavioral disturbance, diabetic retinopathy, diastolic heart failure, and a recent urinary tract infection.

Upon admission, Mr. H was assessed for skin breakdown risk and was found to be at moderate risk. The admission nursing assessment revealed that Mr. H had non-blanchable redness to his coccyx. The treatment orders were to cleanse with soap and warm water, pat dry, and apply barrier cream for 14 days. The treatment administration record reflected that these orders were not carried out for the first 7 days of his admission.

Even though the staffing ratios during this time met the state standard, these statements from the staff would indicate that the facility was not staffed to meet the acuity level of the resident population.

Two days after admission, the interdisciplinary team conducted their first skin review. Mr. H was noted to have a stage 1 pressure ulcer to his coccyx. The wound was described as non-blanchable redness measuring 3 × 3 cm. Mr. H was also noted to be on an alternating pressure pad mattress and had a Roho cushion in his wheelchair. He was turned and repositioned every 2 hours in bed, and he was not allowed to sit in his chair for more than an hour at a time. The care plan implemented by the facility was a check-box, generic form that included measures irrelevant to the resident.

The wound continued to worsen, and it was determined to be a deep tissue injury that was present on admission but had not been identified as such. Eighteen days after admission, Mr. H's coccyx wound had deteriorated to a stage 3 and measured 5 × 4 × 1 cm with 50% light yellow slough and 50% pink granulation tissue to the wound bed. The wound was debrided at bedside, and the treatment orders were modified to include calcium alginate and Medihoney. The wound continued to deteriorate and developed undermining. Negative pressure treatment was begun, and the wound slowly began to heal.

Six weeks after admission, Mr. H developed a fever and was transferred to the hospital. Mr. H did not return to the facility and eventually died about 4 months later from unrelated, non-infectious cardiac causes. The pressure ulcer did not resolve, but it was not listed as a contributing cause of his death.

The family filed suit in superior court, and the parties agreed to binding arbitration due to Mr. H's valid arbitration agreement.

Defense Issues

The defense had several problems. The main issue that the plaintiff attacked was the facility's noncompliance with 42 CFR § 483.20(k) relating to the requirement that each resident have a comprehensive care plan.

Care plans are defined by Title 42. Section 483.20(k) 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."

The initial skin care plan in Mr. H's case was simply a form template generated by the electronic medical record, which did not contain any information that was specific to Mr. H's condition. Although this may have been a time-saving mechanism upon admission, a generic care plan did not satisfy the facility's documentation requirements.

Care Plan Follows Assessment

Any care plan is only as good as the assessment behind it. In Mr. H's case, the initial skin assessment was superficial and quick. It failed to take into consideration the fact that he had very dark skin, which made identification of potential skin issues more difficult. In a light-skinned resident, redness is very easy to see, and a quick look is usually all that is needed to identify deep tissue injuries or the beginning of skin breakdown. However, dark-skinned residents require a closer assessment to determine whether there is redness and whether the redness is superficial or indicative of a deep tissue injury. Palpation can sometimes reveal a boggy texture in the subcutaneous tissue. In hindsight, it was determined that Mr. H was admitted with a significant deep tissue injury on his coccyx that the initial admission assessment missed. When a deep tissue injury is possible, it is advisable to describe it as "suspected deep tissue injury."

The plaintiff focused on the lack of customized care plans and the fact that the care plans had been written by a licensed vocational nurse (LVN) rather than a registered nurse. In California, the scope of practice standards for LVNs explicitly states that LVNs may not assume responsibility for determining nursing interventions for specific patients. The plaintiff took this to mean that since the LVN had written the skin care plan in Mr. H's medical chart, the LVN had acted outside the scope of her license. Mr. H's skin care plan was not customized until almost 5 weeks after his admission and long after his coccyx wound had opened up to a stage 3. This was the basis for the allegation of "reckless neglect" and was very challenging for the defense.

Furthermore, the treatment records indicated that Mr. H was not being treated for anything more serious than simple redness on the coccyx until the deep tissue injury opened up. At that point, the facility realized that the condition was much more serious than had been initially assessed, and the care subsequently provided was appropriate; however, the damage had already been done.

During the investigation portion of the lawsuit, interviews with staff members revealed that the facility had undergone many staffing challenges just before Mr. H's admission and within the first couple of weeks of his admission. A registered nurse supervisor revealed that both the director of nursing and the director of staff development had left the facility and had not immediately been replaced. The supervisor said the senior nursing staff had been running the hands-on care on their own and "doing the best they could." Even though the staffing ratios during this time met the state standard, these statements from the staff would indicate that the facility was not staffed to meet the acuity level of the resident population — another basis for a finding of "recklessness," defined as a conscious disregard for a high probability of a bad outcome. This would be one explanation that a jury might find compelling for why Mr. H's initial skin assessment upon admission was cursory, rather than complete.

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No Cutting Corners

The lesson to be learned is that corners simply cannot be cut when it comes to initial assessments and care plans, or to adequate staffing. The staff reported feeling rushed and overworked. They were either failing to perform all their job requirements or doing them in a rushed manner, which meant that the residents' care was being compromised. The facility responded to these findings by hiring more staff of all different licensing levels.

As it related to Mr. H, the treatment nurse who performed the initial skin assessment simply failed to take the time necessary, or perhaps lacked the knowledge, to perform a comprehensive skin evaluation. Even though a dark-skinned resident might require more time because his skin would have to be more closely checked, she failed to realize the consequences of cutting a few minutes off her assessment. The few minutes she saved in her day translated into a cost of well over $250,000 to the facility because of the failure to adequately assess and treat a deep tissue injury.

The corner-cutting also affected the defense, because it removed the ability to argue that the stage 3 pressure sore was unavoidable, which it most likely was because it began as a deep tissue injury that was present upon admission. However, to argue that a pressure sore is unavoidable, the defense requires meticulous charting. The lack of a comprehensive, accurate initial skin assessment and individualized initial care plan, as well as the failure to chart treatments for the first week, probably cost the facility approximately $150,000 because these were the basis for the "avoidability" argument and opened the facility up to a finding of recklessness.

An unavoidable pressure ulcer can develop in a nursing home, and it is defined for the purposes of surveys as one that occurs even though the provider has evaluated the individual's clinical condition and pressure ulcer risk factors; has defined and implemented interventions consistent with the individual's needs and goals, and the recognized standards of practice; has monitored and evaluated the impact of the interventions; and has revised the approaches as appropriate.

The foundational requirement for the avoidability argument is a comprehensive assessment of the resident's skin upon admission. If that assessment is flawed, everything following it will be flawed.

Care plans and the assessments upon which they are based are critical to the defense in these cases. Facility staff should know that cutting corners, even if it seems like an innocuous few minutes, can have serious ramifications down the line.

This column is not to be substituted for legal advice. Mr. Wilson is a partner in the law firm Wilson Getty LLP, which represents 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.