LEGAL ISSUES

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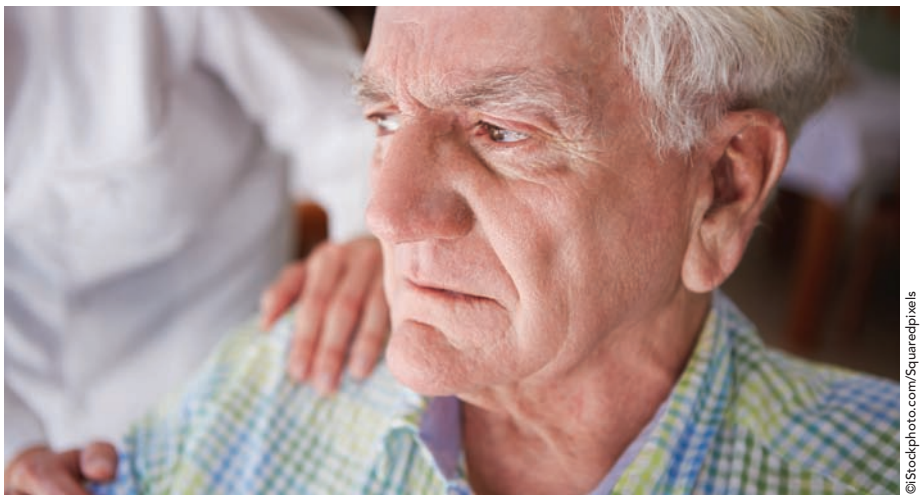
The Refusing Resident: Risk Management Principles

Ms. C was a 65-year-old woman admitted to a skilled nursing facility for rehabilitation after falling and sustaining a hip fracture that had been surgically repaired. Ms. C had a complex medical history including stage 4 breast cancer with metastasis to the lungs and increasing confusion. She was admitted to the SNF with discoloration to her sacrococcygeal area. She refused to allow her backside to be examined during the nursing admission assessment and also 2 days later for the history and physical examination conducted by her attending physician.

The physician documented a conversation with Ms. C's daughter and explained that her medical care was made more difficult by her continued refusals to allow herself to be examined. The attending physician ordered treatments to her backside, which were noted and carried out by the staff as she allowed. The staff noted several more refusals to allow skin treatment. Ms. C also refused several times to be turned and repositioned and insisted on lying on her back. The refusals were documented in the nursing notes.

Ms. C's skin broke down to a stage 2 pressure ulcer. She allowed herself to be examined and treated only intermittently. Three weeks after admission, Ms. C was discharged to the acute care hospital for respiratory distress and died 3 days later. The family sued the facility for elder neglect, alleging, among other things, that the facility failed to properly assess and treat her backside and allowed her to develop a stage 2 pressure ulcer that became infected and contributed to her untimely death.

The facility chart had ample and repeated documentation of Ms. C's refusals to be examined and treated, not only by the facility staff but also by the attending physician. But is this enough to successfully defend the facility in front of a jury? What steps does the facility have to take to show they did everything in their power to try to render care before they would cross the line and infringe on Ms. C's patient right to refuse care, even if she was confused?



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If the resident refuses specific treatments, the attending physician and facility staff should document all steps that were taken to address the resident's concerns and alternatives that were offered.

The Right to Refuse

Residents in an SNF have the right to consent to or to refuse any treatment or procedure, even to the detriment of their health. This right to refuse is juxtaposed with the facility's duty to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being and to ensure that the resident's condition does not decline unless it is medically unavoidable. Specifically, as it relates to pressure sores, the facility has a responsibility to ensure that residents entering a facility do not develop pressure sores and that residents who have them are given treatment to promote healing and prevent infection.

The Centers for Medicare & Medicaid Services surveyor guidelines address the refusing resident: "In order for a resident to exercise his or her right appropriately to make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility is expected to address the resident's concerns and offer relevant alternatives, if the resident has refused specific treatments." The guidelines state that the resident or a legal representative may decline treatment. If the resident's refusal of treatment results in a significant change of condition, the resident should be reassessed and the care plan should be modified as appropriate.

The facility also needs to assess the resident for decision-making capacity. Once capacity is assessed, "the facility is expected to determine and document what the resident is refusing, to assess the reasons for the resident's refusal, to advise the resident about the consequences of refusal, to offer pertinent alternative treatments, and to continue to provide all other appropriate services." It is generally the attending physician's determination as to whether a resident has decision-making capacity. In complex or ambiguous cases, a mental health professional (psychiatrist or psychologist) may be asked to weigh in.

According to the National Pressure Ulcer Advisory Panel, an avoidable pressure ulcer can develop when the provider did not do one or more of the following: evaluate the individual's clinical condition and pressure ulcer risk factors; define and implement interventions consistent with individual needs, individual goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

In the case of a refusing resident, the facility should not only document every incident of a refusal (or noncompliance/nonadherence), but also take the extra steps to conduct a timely interdisciplinary team (IDT) meeting; communicate with the attending physician and conduct a care conference with the family, documenting all the efforts made by the facility and the care team to try to render care; and encourage compliance and consider alternatives — in addition to explicitly stating the risks of continued refusals.

In Ms. C's case, there were no IDT notes regarding noncompliance and no notes about any attempts to discuss the issue with the family about what interventions were being attempted to encourage adherence with prescribed treatments and therapies. The chart did not reflect any efforts, other than the very first meeting between the daughter and the attending physician, to keep the family informed of every time Ms. C refused and what was being done to try to encourage her to cooperate with staff and allow treatments to be provided. There were no notes about alternative treatments that might have been considered or discussion of the risks of continued noncompliance.

Even if the staff did call the family after every single refusal, the chart did not reflect those phone calls being made. A jury can rely on the presumption that if the care was not documented, the care was not rendered. Similarly, if the communications with the family were not documented, the jury can presume that the communications never took place. Not surprisingly, Ms. C's family members took the position that the facility failed to inform them that their mother was refusing care and they were taken by surprise when they discovered she had skin breakdown upon admission to the acute facility.

The attending physician saw Ms. C several times during her brief 3-week stay at the SNF. However, there was only one note regarding communication with the family about her refusal of care. The attending physician's notes could have been helpful to the defense had they meticulously reflected Ms. C's continued refusals of care. This absence of documentation underlines another important aspect of risk management: communication between the facility staff and the attending physician. Again, relying on the presumption that if it is not charted, it did not happen, the facility will not be able to effectively use deposition testimony from staff or from the physician that communications were occurring when they were not documented in the chart. Thus, it is important for the facility staff to communicate the refusals to the physician and equally important for the physician to document those communications in his or her notes regarding the patient.

Best Practices

Documentation is key when caring for a resident who is refusing treatment and that refusal leads to a deterioration in condition. The facility should document the following:

- The resident's capacity to make decisions.
- What the resident is refusing.
- The reasons for refusal, if known.
- Advising the resident/responsible party about consequences of refusal.
- Offering pertinent alternative treatments.
- Continuing to provide all other appropriate services.

Attention to documentation may not prevent a lawsuit, but it will provide the facility with the best defense possible, with the goal of minimizing the risk involved.

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.