SeniorCare 360

propel INSURANCE AN ALERA GROUP COMPANY

Core *TRAC*

Claims and Litigation Management

TIER 2

REDUCING THE RISK BY PROACTIVE PLANNING

Reducing the risk of claims and litigation at the facility level is easier to address if risk management efforts focus on categories of exposure and identify the caveats in each area. This should be a personal evaluation which is based on specific knowledge of staff numbers, strength and talent of positions, operational procedures in place and litigation climate of venue.

Although operational protocols may address these high-risk areas from a policy standpoint, it is the location, staff, circumstances, and venue of the moment which will have the most impact on outcome. Locations have the power to contain the situation at the facility level if and only if each issue, concern, event is not handled as if this was the first time this had ever happened and the only time this will occur.

Most events which occur in any level of caretaking are not new to the business model. What creates a problem is if each occurrence is left in the hands of the best judgment call of the caregiver of the moment or the manager of the day.

The best decision of the day should not be the decision of the moment.

While the caregiver, the clinician, or the manager may be the one to take control at the time of incident or adverse event, proactive plans for most of the common occurrences and chain of events can make a real difference in the outcome.

Almost every event and causation exposure can fit into one of these Seven Categories:

- **Limitations of service vs. expectations**
- **Assumption of caregiving** and the myth of **complete protection**
- **Idealistic outcome** management
- **Foundation relationship** development and fostering
- **Concern intake** and resolution
- **Communication** down or up, horizontal, peer-to-peer
- **Notification and disclosure** consumer directed

Limitations of Service and Assumptions of Caretaking and Protection

People in general, residents, families, or the public are under the assumption

that once a resident is admitted to any level of healthcare, they are there for medical/clinical care and protection. Little acceptance is given for an unexpected clinical outcome or an adverse event or even decline. Most assume the resident entrusted to your care is safe and will improve.
If there is no recognition of this mind set at the time of admission and no plan at the facility level to outline care limitations, these assumptions of service, outcome, and protection will prevail.

STEPS TO SUCCESS

Step One. Plan for expectations and assumptions, develop a protocol and proactive presentation for care limitations, and a recognized procedure to address assumptions of care, expectations, idealistic outcomes, and unlimited protection.

It is also important who presents the conversation of what your location can and cannot do. This conversation will need to be continued and reinforced throughout the stay, which will need several staff members well-versed in how to have this discussion.

Service scripts can be developed for the right way to say it, explain it, or react to it for staff to learn and follow; this is often the approach fine hotels have for staff members. The hospitality approach and location ambiance are still one of the best risk management tools.

Develop a proactive plan to address:

- Disclosure and disclaimer of care level limitations, what you market, your business model and what you can and cannot do
- Consumer assumptions, solicit questions on what they assume you will be able to do now and in the long-term
    - Complete safety and protection from all harm
    - Idealistic outcome with uncompromising beliefs of improvement
- Hire for skill and personality and train in hospitality
- Compose proactive service scripts for encounters

RELATIONSHIP FOUNDATION AND CONCERN INTAKE

Step Two. Solidify the relationship. The main asset of exposure reduction is the relationship with resident/residents' family and staff members from the first day.

Everyone wants someone to go to. Everyone wants someone to care and have some answers, but most importantly they want something done about their

concern at the time it is voiced.

Quality care is often defined by residents, families or responsible parties as attentiveness, interaction, communication, and the basics of care.

Establishing a person to go to, one who is charged with relationship building and will interact and solicit concerns will reduce the opportunity of families or residents reaching the point of no return for location resolution.

Since most concerns are shared with paraprofessionals, education on proper intake of a voiced concern is imperative. It is also important for the front-line staff to know how to respond and agreeing or disagreeing is not always the answer. Listening attentively and then responding with a tangible, something the person can take away from the encounter, is one of the best methods to defray escalation.

"I will tell the nurse or administrator" is not usually the right answer even if it is the correct answer.

Layered offerings of customer service and hospitality niceties, for use by a paraprofessional will afford the bedside caregiver some control over the situation and give the family a tangible. The concern was voiced, and this was done goes a long way.

- Assign an admission partner
- Educate staff to actively listen for the perception of the problem
- Develop a list of "can do" tangibles for direct caregivers for at the moment solutions

COMMUNICATION REPORTING UP, DOWN AND SIDEWAYS, AND HEAD ON

Step Three. Invest in communication skills education. Information sharing requires honesty and tact as no message received is ever the complete message intended.
Communication can be essentially driven by the perimeters of regulations, ethics, or simply a therapeutic display of caring, concern, and empathy.

Most encounters will require approaches of all types. Few cohesive teams are developed by only interacting with essential communication. Education will be required not only in what to report but how to report, and not only what information needs to be shared, but how to share it and in what timeframe. Scenario training utilizing reoccurring situations and offering examples that are

easy to remember by all levels of staff members.

Not everyone is equipped for the various types of healthcare communication; this may have to be taught.

Technology has created a situation where much of the workforce communicates without having learned to rely on the benefit of facial expressions or body language. They are without the skill most residents and families use as a basis of effective communication and caring.

This is where step one and step two are blended into step three. Limitations are established, reality is discussed often, hospitality is part of the training, scripts are developed and required for encounters, and educational role playing prepares for the point of service experience.

Most reporting of information is at the time of an incident or negative outcome which is often after the fact. Many assumptions are also made by clinicians and caregivers, not just residents and families as they assume the next shift, or the next person knows what they know or will react as they would react. How and what to report or discuss should be established by procedural outline examples. Direct caregivers should attend or establish their own at-risk meeting.

- Educate in the skill of interactive communication
- Reinforce what each member of the team needs from teammates
- Establish procedural outline with reporting examples
- Develop scenario situations for orientations and reinforce routinely
- Share at risk meeting information with direct care staff

NOTIFICATION AND DISCLOSURE

Step Four. Make the art of information delivery a priority. Sharing details during the notification procedure has taken on a whole new role in healthcare. It requires the details and facts to be delivered skillfully, often quickly and in totality, even if this is not always possible. At times notification is delayed due to an anticipation and expectation of an emotional driven response of action, reaction, or anger. This anticipation may also lead to the conversation being brief and to the point, and even defending actions taken.

There is no perfect way to inform of the unexpected or expected but not accepted.

All adverse events and unexpected outcomes do not result in litigation and yet events do occur. Most who seek intervention from the legal world do this out of

needs not met. The need to be heard, the need to understand in detail, and the need to be involved even if they do not know how to be involved.

Successful communication resolution is based not only on the interaction at the time of the event, but the relationship and trust based on day-to-day involvement.

One of the biggest reasons families request medical records is to obtain information, to find out just what occurred and how it occurred, and what was done after it occurred. Most who request the medical record do not know exactly what they are looking for, but the belief is the facility knows more than it is saying. In some cases, this may be true as many times it does take a quality review/investigation to discover all the details.

Lay people do not understand this process and a delay in sharing details is seen as withholding. If the location does not provide the answer or the answer expected, families seek legal intervention.

Once an attorney gets involved the facts will not matter as much. Share as much information as possible at the time of notification and follow up with more. The sooner the better in this situation.

If the record is requested and the person has a legal right to the record, sit with the family and share and show them the documented interventions, the physicians' orders, the nurses' interactions. Better it be your trained location staff interpreting the medical record than an attorney.

There will always be some insensitivities to clinical intervention and some irrationalities to care delivery.

Error disclosure is required legally and ethically if there was a provider error which resulted in harm or a negative outcome, the failure of a planned action to be completed or the wrong plan carried out.

No one in healthcare can practice without making a mistake or error. When this mistake or error causes an injury, careful discussion with the resident and in most cases the family is the legal and responsible thing to do. Without disclosure subsequent suspicion or discovery by the resident or family will greatly increase the liability risk.

The suppression of evidence is always the strongest evidence.

Many states have adopted the Communication and Optimal Resolution law (CANDOR) or some segments of it. Being familiar with your state's statutes is important. The CANDOR law outlines the legal responsibility of healthcare providers to disclose but also offers guidance for the residents and families for an open discussion of what occurred, the outcome, and what was put in place by the facility to reduce the opportunity of recurrence.

Is it commission or omission and what was the result? This will have to be decided situation by situation. Was it a policy error or was it a minor procedural deviation?
Understanding what you are required to disclose before the need is essential to

success. Planning for this need or curiosity, or lack of trust, will be the beginning

of service recovery.

- Keep notification information current in the medical record
- Train in the art of information sharing
- Define by protocol who can receive notification and information
- Identify who can notify if adverse healthcare incident
- Plan the conversations
- Beware of the disclosure law in your state

Being aware of the risk categories and applying the steps to success can reduce the resource consumption of managerial staff who are charged with handling exposure generated losses.

Brainshark® Presentation can be viewed at:
https://www.brainshark.com/bentechre/ClaimsLitMgmtTier2-7Categories