IT CAN HAPPEN TO YOU!

When Your Nursing Care Comes Under Legal Scrutiny

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RUSING LOPEZ & LIZARDI, PLLC 602-321-3828 (cell)

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- 21-year lawyer and Partner at Rusing Lopez & Lizardi, PLLC
- Professional liability: niche practice in LTC, Skilled Nursing, & Rehabilitation
- Property/casualty
- Business litigation

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RUSING LOPEZ & LIZARDI
ATTORNEYS AT LAW

ABOUT THE FIRM

- Business contract matters;
- Liability defense;
- Structuring healthcare business transactions & joint ventures;
- Regulatory compliance;
- Resolve payor disputes;
- Mergers & acquisitions of healthcare practices;
- Defend against government investigations & audits;
- Navigating privacy & security laws.

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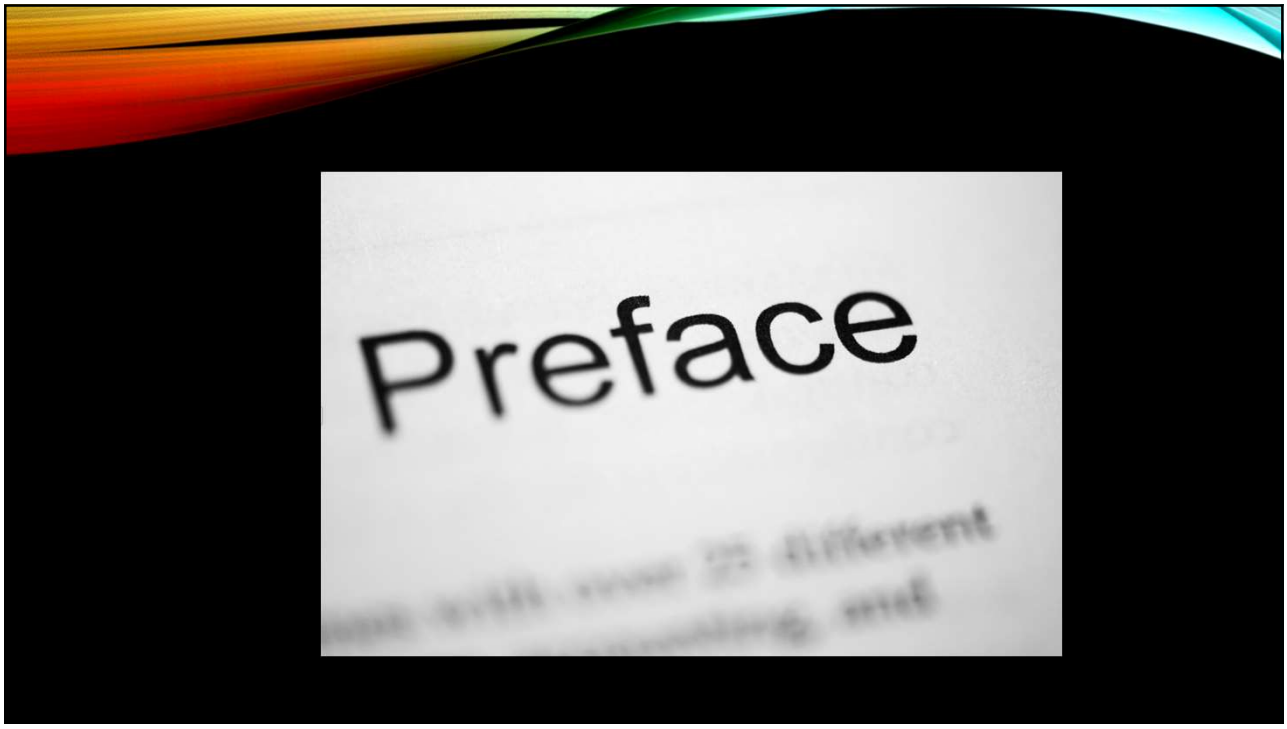

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HOW DO YOU KNOW?

1) Board Action

- Facility Survey

2) Legal Claim

3) Lawsuit

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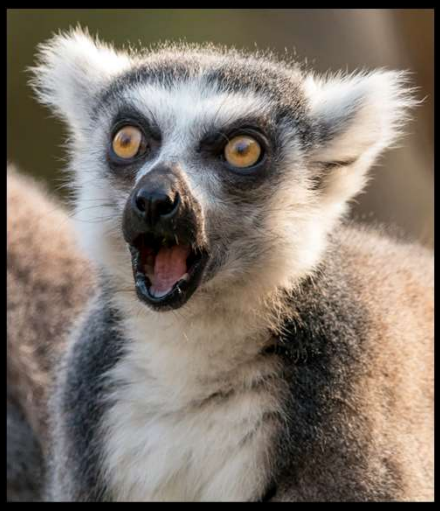
WHAT CAN HAPPEN?

1) BOARD COMPLAINT

- ✓ Fine or civil penalty
- ✓ Referral to a discipline or practice monitoring program
- ✓ Public reprimand, censure
- ✓ Probation, suspension, revocation of license
- ✓ Most common clinical referral: failing to monitor a patient adequately



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WHAT CAN HAPPEN?

2) LEGAL CLAIM

May Turn into a lawsuit/indictment

- ✓ Civil – Personally named or not. Could go criminal or to the Board
- ✓ Criminal – Redonda Vaught

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WHAT CAN HAPPEN?

3) LAWSUIT

- ✓May Turn into a Board Action
- ✓National Practitioner Databank
- ✓If Criminal, OIG List

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NATIONAL PRACTITIONER DATABANK

40 CFR Part 60

- If payment is made on a malpractice action or claim

  Or Adverse Action is taken by a Federal or State enforcement agency, or Fraud enforcement agency

  Or adverse licensure or professional review action is taken

- A report is made to the NPDB

  By health care entities, Boards of Licensure Examination, Peer Review Organizations, Private Accreditation Entities, Insurance Companies

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NATIONAL PRACTITIONER DATABANK

40 CFR Part 60

The most commonly reported profession to the NPDB is *nurses* – not physicians!

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PLEASE, GOD… MAKE IT GO AWAY!

Failure to respond can have dire consequences.

1) Board – Adverse Action

2) Legal Claim – Increases chances more comes of it.
   Sometimes insurance have a requirement that you cooperate in order to make payment on your behalf.

3) Lawsuit – Can be disastrous!
   Won't prevent you from getting subpoenaed.
   Last thing you want to do is testify without preparation.

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THREE DIFFERENT STANDARDS

1) Board – Unprofessional conduct

2) Civil Claim/Lawsuit – Negligence/Gross Negligence/Abuse, Neglect or Exploitation

3) Criminal – Usually criminal negligence

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ABUSE & NEGLECT

What is it?

Inadequate health care, education, supervision, protection from hazards in the environment, unmet basic needs, physical/psych/sex abuse.

Don't Get On the List of Excluded Individuals/Entities (LEIE)

✓ OIG investigates claims of abuse & neglect.

✓ Cannot work for Federal/State Programs - facilities can lose their Medicare/Medicaid funding for patients if they let you.

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FAILURE TO PREPARE

- Admissions become your legacy.
- Reptile traps you may not recognize or know how to avoid.
- Unknown & Unrequested Information.
- Fail to Stay in Your Lane!

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WHEN A LAWYER CONTACTS YOU

1) Which lawyer is contacting you?

2) Contact your Administrator or Risk Manager

2) If it is your contracted defense lawyer, call them back & do all you can to cooperate.

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"But, I don't Remember Anything"

It doesn't matter.

1) You may think you don't but once you hear the facts, look at the records, or see a photo of the patient , you may remember something.

2) We still need to know about your custom & practice in caring for a patient like this and under these circumstances.

- Compare that to your charting.
- Not everything you do is documented in the medical records.

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"I'm Scared."

Fear of the unknown is quashed with knowledge.

The attorney can:

1) Remove the unknown and surprise.
2) Help you avoid inappropriate admissions.
3) Critically think about the care you provide and documentation you completed
4) Teach you not to submit to global truths or "safety" stereotypes. No traps!

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"I'm Scared."

The more you prepare, the more comfortable you will be.

In the game of chess the difference between a novice player and an advanced player comes down to 2 words:
thinking ahead.

Experienced players anticipate what the other player is going to do and are a few moves ahead.

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Meeting With Your Lawyer

IN-PERSON, PLEASE

- Review the native record
- Administrator Support
- Impromptu Meetings
- Control the surroundings
  - ✓ Distancing
  - ✓ Masks-No Masks

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Meeting With Your Lawyer

Remote Meetings

- Technology Requirements
- You Have to Control Your Environment
- No Masks, Please
- "Well, let me show you this part."

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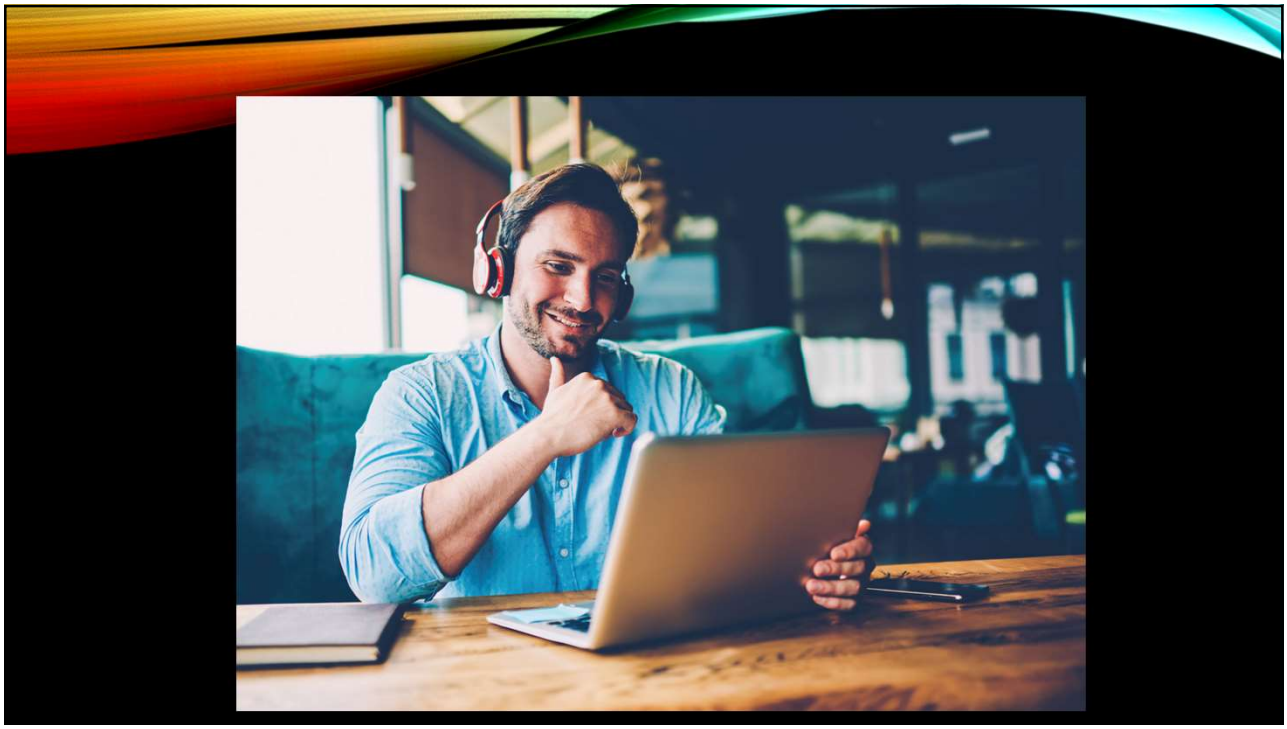

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HOW TO PREVENT YOUR CARE FROM COMING UNDER LEGAL SCRUTINY?

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TEXT MESSAGING/PHOTOS

Non-HIPAA Compliant Actions
with no preservation policy or practicality.

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HIGH TURN-OVER

Low interaction with other staff & administration is reflected in nurses' unwillingness to cooperate when called and willingness to temper negative testimony.

Team Communication Breakdown

Less chance of identifying changes in condition

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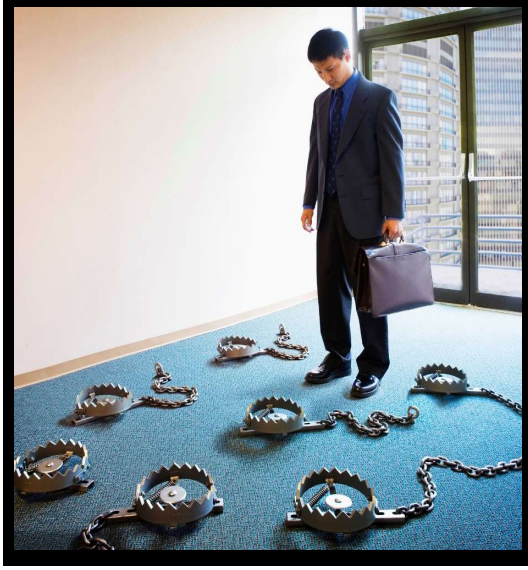
DOCUMENTATION



It's a Trap!

1) Copy & Paste
2) Conversations with Family
3) Conversations with HCPs
4) Regusals
5) Patient Education
6) Holes
7) Work Selection
8) Audit Trails
9) Late Notes
10) Incident Reports & Investigations

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Resist the Urge!

COPY & PASTE / AUTOMATION

[redacted]

Progress Notes *NEW*

DOB: [redacted] Gender: Female MR#: [redacted]

Date Range: 7/30/2022 to 8/20/2022

Primary Physician: All Progress Note Type: **SELECT APPROPRIATE TYPE**, Activity Participation Note, Admission Summary, Admission/Readmission Note, Alert Note, Appointment departure note, Appointment return note, Behavior Note, Care Management, COMMUNICATION - with Family/NOK/POA, COMMUNICATION - with Physician, COMMUNICATION - with Resident... Effective Date Range: 07/30/2022 to 08/20/2022 Effective Time Range: All Created Date Range: All Created Time Range: All Author: All Department: All

Resident Name : [redacted]

Location :

Admission Date : 07/30/2022

Medical Record # : [redacted]

Gender : F

Date of Birth : [redacted]

Physician :

Pharmacy : Omnicare of Chandler

Allergies : No Known Allergies

Diagnoses : DEPRESSION, UNSPECIFIED(F32.A), ESSENTIAL (PRIMARY) HYPERTENSION(I10), CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION(F06.1), ENCEPHALOPATHY, UNSPECIFIED(G93.40), DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED(R26.2), MUSCLE WEAKNESS (GENERALIZED)(M62.81), DEHYDRATION(E86.0)

F06.1 CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION

I10 ESSENTIAL (PRIMARY) HYPERTENSION

F32.A DEPRESSION, UNSPECIFIED. . . . . .. Alert and able to make needs known. Med compliant. No c/o pain or discomfort expressed. One person assist with adl cares, mobility, and transfers. Incontinence care provided; pt also continent at times. Pt up at HS with expression of getting OOB and ambulating to bathroom; however not steady; bedpan provided. Continues skilled therapy services as indicated. Psych consult in progress 2/t depression and catatonia expression. Call bell and fluids within reach.

Comments:

Author: [redacted] - RN [e-SIGNED] Signature: _____

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Resist the Urge!

COPY & PASTE / AUTOMATION

Created Date: 08/04/2022 03:01

Effective Date: 08/04/2022 02:54 Type: Skilled Note v.2

Note Text : T 97.7 - 8/3/2022 23:52 Route: Oral P 63 - 8/3/2022 23:52 Pulse Type: Regular R 16.0 - 8/3/2022 23:52 BP 130/74 - 8/3/2022 23:52 Position: Pnl 0 - 7/31/2022 06:56 Pain scale: Numerical . G93.40 ENCEPHALOPATHY, UNSPECIFIED

R26.2 DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED

M62.81 MUSCLE WEAKNESS (GENERALIZED)

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Comments:

Author [redacted] - RN [e-SIGNED] Signature: _____

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CONVERSATIONS WITH FAMILY

- Avoid generic references such as "discussed with family."
- Specify who was educated, warned, or advised & that all questions were answered.
- Document time spent.
- Assume those present will deny the education ever happened.

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Note Text : Late Entry for [redacted] I was passing medications on the 100 hall on the morning of March 5th. I had been in Mr. [redacted] oom several times that morning and he had relayed to me that his legs were hurting bad and he wanted some pain medications. I was in the room several times in a row talking to him and then I went back to passing medications. When I filled [redacted] m edications I went into [redacted] oom thinking in my head about his pain and his complaints and I lost focus of who I was treating. I accidently gave him [redacted] medicalions. I realized what I had done when I walked back to the nursing station and saw my computer on [redacted] name. I immediately told my coworker Patrick what I had done and that we needed to get Narcan just in case he reacts to the morphine in a narcotic an adverse. We went to the site where we keep an emergency drug pixus and pulled out the Narcan. I then went into the room to explain to the family what I had done. I stayed calm and explained to them I had accidently given him a timed release morphine and how I heard that he doesn't react very well to narcotics. They told me that he didn't have an allergy but he did hallucinate once at Presbyterian Rust hospital. I told the family that what we generally can do for someone who has ingested a narcotic is administer Narcan to counter react on those receptor sites and occupy them so he will not get the narcotic high. I told them I would be back and to call me if they see any cognitive changes. I then called the physician Amy Lala and she immediately called a pharmacist to see how long the half life of the medication was and how much narcan that he may need if any. I also called my supervisor to let her know about the error. I then administer 0.4 mg of narcan and monitored the patient for shallow respiration and any visible sign of toxicity but there were none. [redacted] continued his visit. He talked on the phone for awhile but no visible signs of toxicity. Later in the afternoon he even went out with another family member and they were gone several hours. He came back and I went in to talk to him about his day and he was tired and just wanted to sleep. So I let him go to sleep. When I was relieved at 1800 hours I relayed to the oncoming nurse that I had inadvertently given him a timed release narcotic but he tolerated it fine all day but just to be safe I would check him hourly which she agreed and said it was no problem. The time of morning that I passed his medications was about 830. I had administered the narcan not even an hour after that. I watched him every hour after that with no adverse effects at all. He had visitors, phone calls and even went out with a family member whom I questioned if he noticed any abnormal changes in patient, which he said that it was the best he had felt in awhile. I said good I was glad. I continued to monitor anyway for changes but had none to report.

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REFUSALS / NON-COMPLIANCE

- Ensure the patient/family understand the benefits/purpose of the treatment, & the potential consequences of refusing.
- Document all instances of informed non-compliance in detail, including the # of attempts to obtain compliance.
- Pervasive non-compliance requires targeted interdisciplinary care plan.

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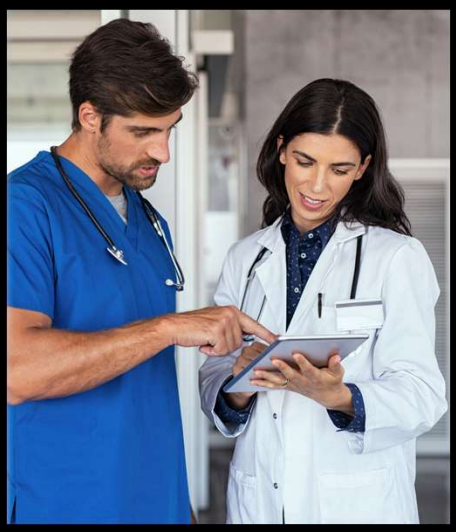
HCP CONVERSATIONS

- Please write it down with specifics.
- Document the call-back, when it was, & what you were told.



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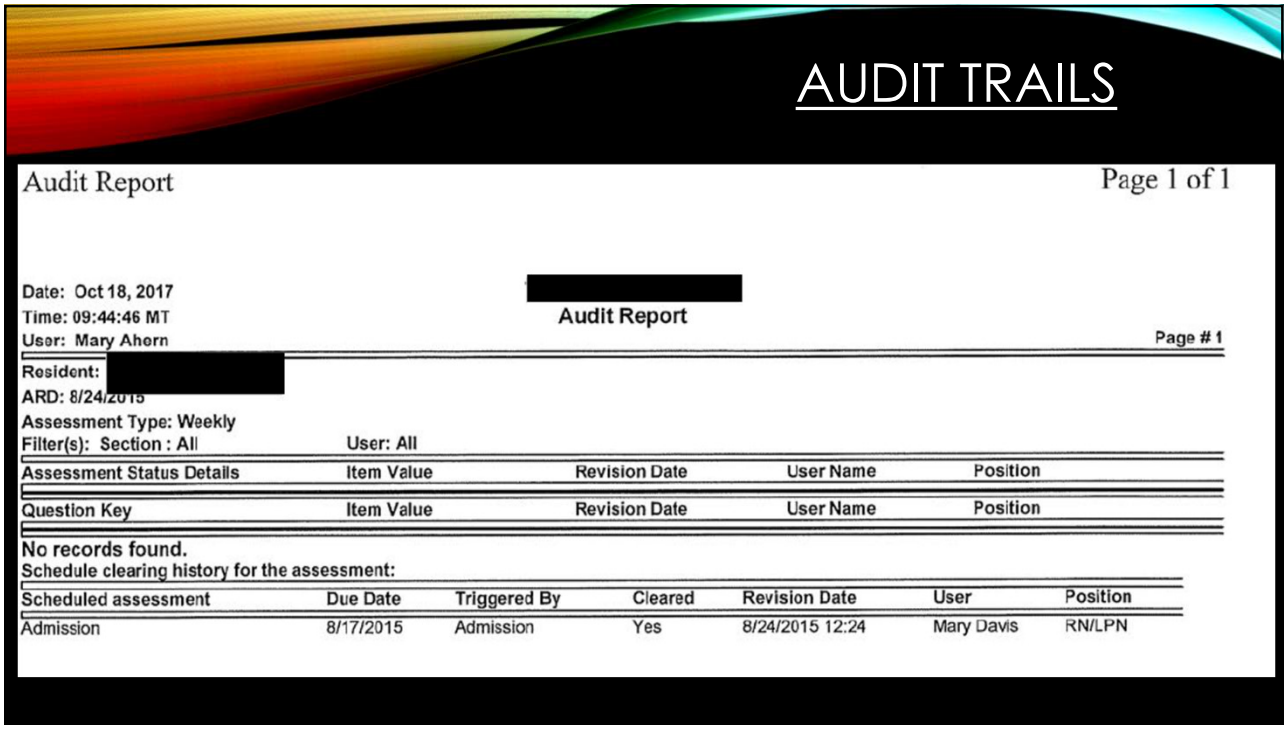
AUDIT TRAILS



Audit Report

Page 1 of 1

Date: Oct 18, 2017
Time: 09:44:46 MT
User: Mary Ahern

[redacted]
Audit Report

Page # 1

Resident: [redacted]
ARD: 8/24/2015
Assessment Type: Weekly
Filter(s): Section : All User: All

Assessment Status Details	Item Value	Revision Date	User Name	Position

Question Key	Item Value	Revision Date	User Name	Position

No records found.
Schedule clearing history for the assessment:

Scheduled assessment	Due Date	Triggered By	Cleared	Revision Date	User	Position
Admission	8/17/2015	Admission	Yes	8/24/2015 12:24	Mary Davis	RN/LPN

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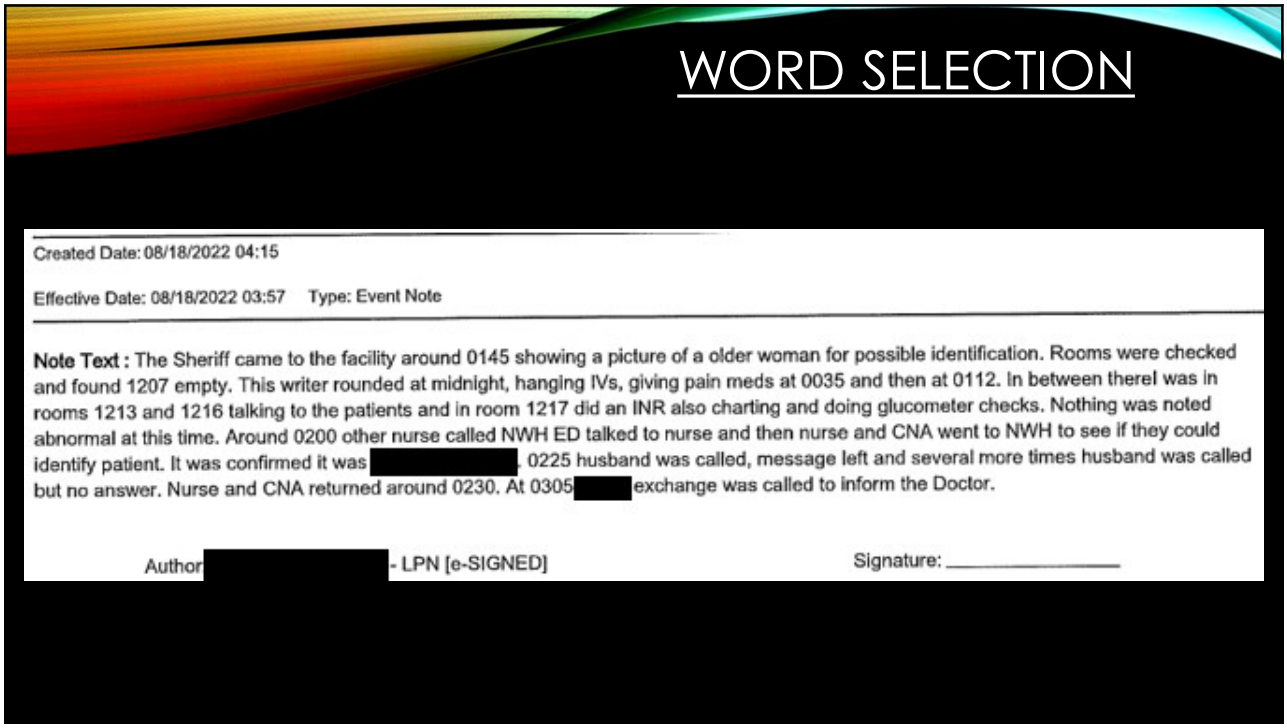
WORD SELECTION



Created Date: 08/18/2022 04:15

Effective Date: 08/18/2022 03:57 Type: Event Note

Note Text : The Sheriff came to the facility around 0145 showing a picture of a older woman for possible identification. Rooms were checked and found 1207 empty. This writer rounded at midnight, hanging IVs, giving pain meds at 0035 and then at 0112. In between therel was in rooms 1213 and 1216 talking to the patients and in room 1217 did an INR also charting and doing glucometer checks. Nothing was noted abnormal at this time. Around 0200 other nurse called NWH ED talked to nurse and then nurse and CNA went to NWH to see if they could identify patient. It was [redacted]. 0225 husband was called, message left and several more times husband was called but no answer. Nurse and CNA returned around 0230. At 0305 [redacted] exchange was called to inform the Doctor.

Author [redacted] - LPN [e-SIGNED] Signature: _____

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WORD SELECTION

Repeat Only What You Know

Created Date: 08/11/2022 00:30

Effective Date: 08/02/2022 23:00 Type: encounter

Date of Service : 08/03/2022
Visit Type : Follow Up
Transition of Care : No transition occurred.
Details : This is a copy of a signed encounter note documented in GEHRIMED.
Progress Note
History
Code Status:
Do Not Attempt Resuscitation (DNR/no CPR).
Chief Complaint / Nature of Presenting Problem:
F/U on admission
No appetitie
History Of Present Illness:
[redacted] doing. uch better over the past 2 days. She is now A+Ox 3, answering questions appropriately. She did cause a scare with the night nurse last PM as she was up out of bed, roaming the hallways. She is not eating well, "no appetitie". Agreeable to Ensure supplement.
Asking about when shencan go home.

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WORD SELECTION

Repeat Only What You Know

[redacted] DOB: [redacted] Gender: Female Progress Notes *NEW* MR#: [redacted]

Date Range: 7/30/2022 to 8/20/2022

Primary Physician: All Progress Note Type: **SELECT APPROPRIATE TYPE**, Activity Participation Note, Admission Summary, Admission/Readmission Note, Alert Note, Appointment departure note, Appointment return note, Behavior Note, Care Management, COMMUNICATION - with Family/NOK/POA, COMMUNICATION - with Physician, COMMUNICATION - with Resident... Effective Date Range: 07/30/2022 to 08/20/2022 Effective Time Range: All Created Date Range: All Created Time Range: All Author: All Department: All

Resident Name : [redacted]
Location :
Admission Date : 07/30/2022
Medical Record # :
Gender : F
Date of Birth : [redacted]
Physician : [redacted]
Pharmacy : Omnicare of Chandler
Allergies : No Known Allergies
Diagnoses : DEPRESSION, UNSPECIFIED(F32.A), ESSENTIAL (PRIMARY) HYPERTENSION(I10), CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION(F06.1), ENCEPHALOPATHY, UNSPECIFIED(G93.40), DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED(R26.2), MUSCLE WEAKNESS (GENERALIZED)(M62.81), DEHYDRATION(E86.0)

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Comments:

Author: [redacted] - RN [e-SIGNED] Signature: _____

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LATE ENTRIES:

Don't Be That Guy!

Created Date: 08/11/2022 16:15

Effective Date: 08/10/2022 23:00 Type: encounter

Created Date: 08/11/2022 00:30

Effective Date: 08/02/2022 23:00 Type: encounter

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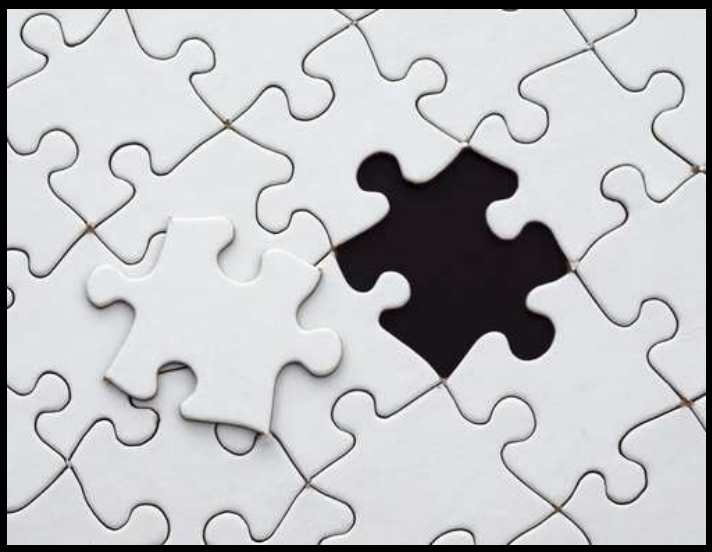
HOLES



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INCIDENT REPORTS & INVESTIGATIONS

- ✓ Make them as detailed as possible
- ✓ Assume every word will be agonizingly scrutinized in future lawsuit and your words blown up 8ft tall to a jury
- ✓ Get statements from everyone involved before memories fade
- ✓ Obtain input from all departments involved

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INCIDENT REPORTS & INVESTIGATIONS

- ✓ Continue to add subsequent diagnosis and treatment information even if they are discharged to a higher level of care
- ✓ Don't leave any sections blank, and don't "close" the investigation until all relevant information is obtained
- ✓ Use exact quotes where appropriate

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INCIDENT REPORTS & INVESTIGATIONS

Event Report: [redacted] **R (Full Code) MR#: 1181-01**

Unit: **Status:** Discharged **Age:** 38 **Sex:** M
Attending: Eric Metzler MD **Room/Bed:** (Full Code)

Diagnosis: G91.9 Hydrocephalus, unspecified(Primary, Admission), E11.9 Type 2 diabetes mellitus without complications, E66.01 Morbid (severe) obesity due to excess calories, I63.9 Cerebral infarction, unspecified(History of), I69.821 Dysphasia following other cerebrovascular disease, R13.12 Dysphagia, oropharyngeal phase, Z93.1 Gastrostomy status, J96.12 Chronic respiratory failure with hypercapnia, R26.81 Unsteadiness on feet, R27.8 Other lack of coordination, R41.841 Cognitive communication deficit, R53.1 Weakness, Z93.1 Gastrostomy status, Z93.1 Gastrostomy status, R27.0 Ataxia, unspecified, R13.12 Dysphagia, oropharyngeal phase, I69.821 Dysphasia following other cerebrovascular disease, G91.9 Hydrocephalus, unspecified, E66.01 Morbid (severe) obesity due to excess calories, E11.9 Type 2 diabetes mellitus without complications

Allergies: No known drug allergies

Safety Events -- Fall **Status: Closed**

EVENT INFORMATION

Creator:	[redacted] DON	**Stat Priority:**	No
Event Date:	11/07/2019 09:17AM	**Date Recorded:**	11/08/2019 09:17AM
Closed Date:	12/04/2019 01:28PM	**Closed By:**	[redacted] DON

DESCRIPTION

Resident leaned forward in wheelchair and fell forward causing abrasion to his forehead.

EVENT DETAILS

Description of occurrence

Resident's description of occurrence (include what was happening just prior to fall)

Location Of Fall

- Day Room/ Activity Room
- Dining Room
- Hallway
- Outside, Not On Facility Grounds
- Outside On Facility Grounds
- Resident Bathroom
- Resident Room
- Shower Room
- Other

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PATIENT EDUCATION

Document the details & time spent.

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WHAT IS NOT IN THE RECORD?

- Made sure bed in low position?
- Provided non-slip socks?
- Checked/repositioned every 2 hours?
- Reminded them not get up on their own?
- Communicated X to next nurse or to doctor?
- Encouraged eating/drinking? Knew how much the resident ate?
- Dressing CDI – did you really check it?
- *"We are understaffed."*
- *"I don't have time to do X for you right now."*

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TOP CLINICAL RISKS

1) Falls are highest source of claims & total % of payments made
2) Wounds/skin
3) Medication Variance
4) 4) Infection
5) Elopement has largest payouts, though fewer clams
6) Staffing shortages with increased acuity

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WHAT'S COMING

TECHNOLOGY

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hbohnke@rllaz.com

520-529-4292 (direct)

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