



## **NURSING HOME CHARTING TIPS: A LEGAL PERSPECTIVE**

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## **Nursing Home Charting and Documentation**

The health care industry, including nursing homes, has long been a target for litigation in America. In fact, in many states, including Illinois, there are laws designed to encourage private civil suits against nursing homes by shifting the responsibility for the plaintiff's attorneys' fees to the defendant nursing home. All health care providers have a duty to provide appropriate care to their patients/residents. Of course, even with the best care provided, nursing home residents become ill, fall, develop infectious diseases, and even die. In many cases, residents, and/or their families, blame the nursing home for causing the resident's injury or death.

Nursing homes provide a valuable service for some of the most care-dependent individuals in our society. Because nursing home residents are so vulnerable, and sometimes incapacitated, the care nursing homes provide is often scrutinized with a suspicious eye. Nursing homes are expected to provide the same care that is generally accepted from similar nursing homes within the same community. Therefore, a nursing home will be measured against the standard of care established by nursing homes in its own surrounding area, as well as those standards promulgated by the Federal Government and each State Government.

In lawsuits filed against a nursing home for the death or injury to a resident, residents often claim that the nursing home negligently caused their injury, either by some affirmative action, or a failure to act. The most common harms alleged in nursing home lawsuits, include: falls, pressure ulcers and bed sores, dehydration and malnutrition, physical or verbal abuse, and medication errors. In essence, residents claim that the nursing home had a duty to care for the resident and that the facility "breached" that duty, causing the resident's injury or death. The focus of almost all nursing home cases is the resident's chart. Most of

the time, the best evidence to prove, and disprove, that the nursing home breached its duty of care, lies within the resident's chart.

The resident's chart is designed to be a complete and accurate record of the resident's care while at the facility. If something is missing from the chart, or is not clearly identified within the chart, the assumption is that it was never done. Likewise, if it is documented and clearly identified within the resident's chart, there can be little dispute over the fact that the questioned care was provided absent contradictory evidence from another source.

Whether a nursing home was negligent will often be determined by what can be proved, or not proved, through careful examination of the resident's chart. Therefore, it is extremely important that nursing facilities conform their documentation practices to a standard that ensures the accuracy and completeness of patient records. Charting in such a manner will ensure that nursing facilities and their employees are protected if litigation occurs, but more importantly, it will allow facilities to provide the best possible care and treatment to its residents. The recommendations that follow are offered as guidelines in formulating internal procedures and practices and should be reviewed by your own counsel and management team before implementation.

### ***General Charting Procedures and Practices***

The following procedures and practices are recommended for all nursing facilities:

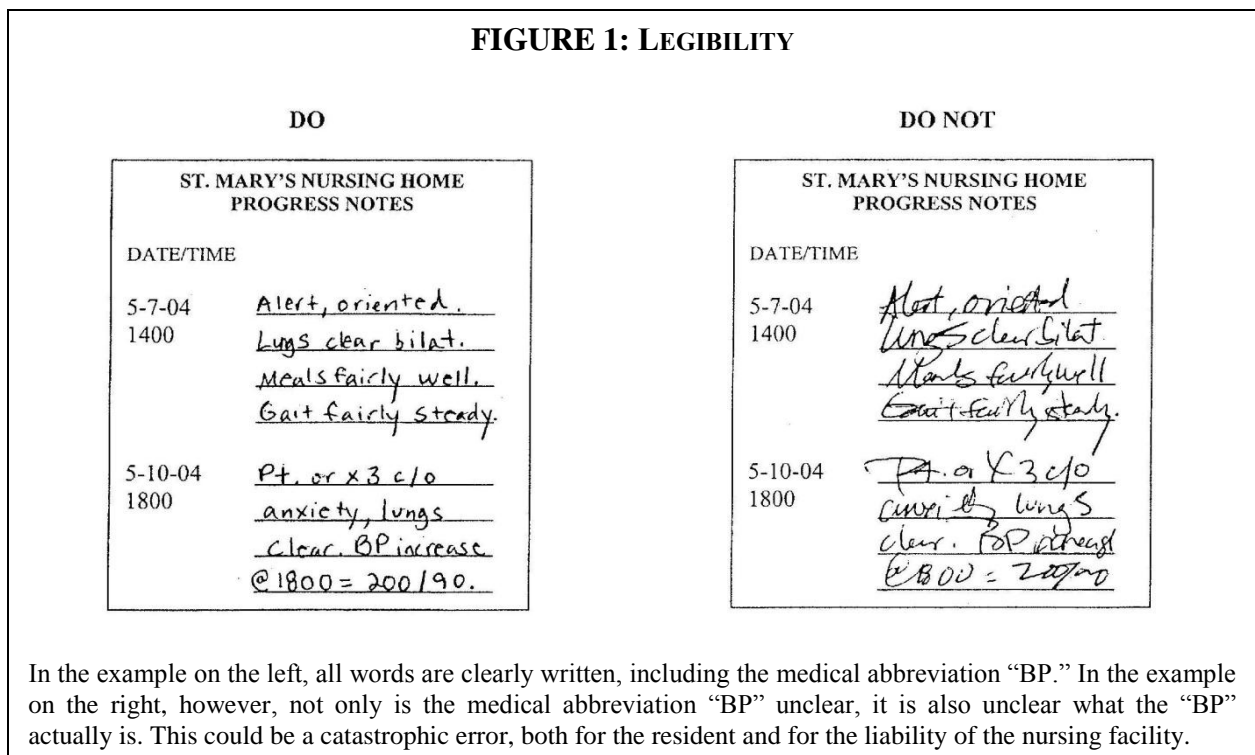
#### **Internal Procedures**

Follow Own Documentation Standards: Many facilities incorporate internal documentation procedures into the state-mandated charting requirements. If these internal policies are not followed, they can, and will, be used against the nursing home to show that the facility violated its own standard of care. As such, it is imperative that each and every staff member is familiar with the facility's own documentation standards and procedures. More importantly, every staff member who enters items in the chart must strictly adhere to the facility's own policies. Every facility should employ quality assurance and quality

improvement systems—or random checks—to ensure that the facility’s documentation procedures are being followed.

### Documentation Practices

Legibility: While many nursing facilities have moved to an electronic system of record-keeping, any handwritten records should be legible. Illegible documentation may interfere with the staff’s ability in providing proper care and treatment to residents. Moreover, records that cannot be read are the equivalent of no record at all.



Abbreviations: Although abbreviations are customarily used in the medical profession, they may be misinterpreted, ambiguous, or illegible. Therefore, only those symbols that are well known in the medical community and in the skilled care facility should be used.

Basic Information: It is quite possible that pages from a resident’s chart may become separated from the chart. Therefore, the name of the resident and the resident’s ID number should be placed on every page of the record, so that each page is readily identifiable in the event it is misplaced. Similarly, if a

facility uses an electronic record-keeping system, any handwritten notes or records should be adequately referenced in the electronic record. From a legal perspective, it is crucial to be able to use a resident's chart to prove that proper care was given, and that the standard of care was therefore met; a chart that contains the proper care documentation but lacks the resident's name cannot prove these things. Moreover, missing pages from a chart demonstrates a lack of carefulness, destroying the facility's credibility.

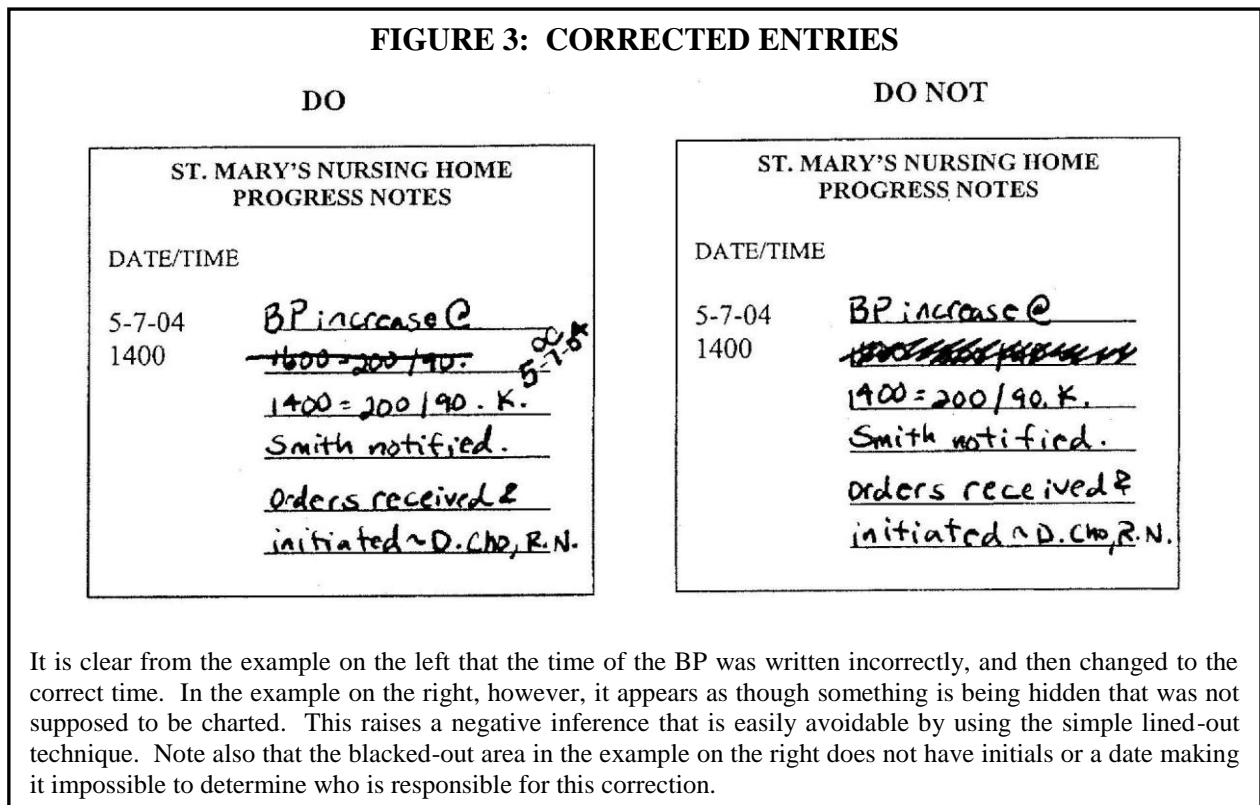
In addition, each entry in the chart should contain the day, month, and year the entry is made, along with the time of the entry. Furthermore, the author should sign each entry. Particular attention should be given to charting documentations that continue from one page onto the next. The continuing entry must be re-dated and signed on the following page, as well as the page where the initial entry began. For example, the chart should conform to Figure 2 below.

**FIGURE 2**

ST. MARY'S NURSING HOME PROGRESS NOTES	
DATE/TIME	
10-8-98 @0800	Alert, oriented x3. Lungs clear bilat. No SOB or resp distress noted VSS Afebrile Abd soft, nontender (BS(+)) 4 quads. Continent of bowel & bladder. Tol. Meals fairly well. ADL'S & transfers with assist. Gait fairly steady. Uses walker to amb (R) hip incision OTA & healing well. Pedal pulses (+) bilat. 2 + bilat pedal/ankle edema noted. c/o (L) shoulder discomfort esp. during PT/OT. Dr. Smith notified per physical therapist & will see pt. in AM ~ C. Wilson, RN
10-8-98 @1600	BP increase = 200/90. K. O'Shannon notified. Orders Received & initiated ~ C. Wilson, RN
10-8-98 @2030	Pt. or x 3 c/o anxiety, lungs clear. Vasotin given for increase BP ~ P. Bera, M.D.
	Doe, Jane 087& F 11/01/1914 019566199

Specific and Substantive Terminology: Vague terminology fails to effectively communicate the resident's condition. For example: "Resident reports that she is feeling better today," is not very informative and has little substance. A more effective entry might read, "Resident reports less pain in her right leg. She has eaten a full breakfast and is fully ambulatory."

Correcting Documentation Errors: Entries in a resident's record should *never* be erased, obliterated, altered with corrective fluid, or otherwise deleted. The inference that may be drawn from a correction that is erased or unreadable is that the entry is, or was, damaging to the facility. Therefore, each individual facility should have procedures in place for correcting documentation errors, and every staff member should be made aware of the facility's internal procedures for correcting errors. The general practice in correcting handwritten chart errors is to draw a single line through the entry to allow a subsequent reader to interpret the "lined-out" entry. The corrected note should appear in the next available space, and the person making the correction should date and initial the "lined-out" entry.



Documenting Medications: The resident's chart should include a separate page entitled, "Medication Administration Record" (MAR), or something comparable. The MAR should document the name of the resident, the dosage, and frequency of each medication administered. This record should also clearly state the date and time the medication was ordered, the name of the physician that ordered the medication, the date that the order expires, and the time and date of each administration. The individual administering the dose should also initial the notation. To prevent confusion among staff members and prevent any potential problems, the staff should never chart a medication before it is given to the resident. Any refusal of medication or "cheeking" of medication must also be charted, and the resident's physician and legal guardian should be informed.

Contemporaneous Documentation: All charting entries must be made at the time that the care is given. For example, suppose a pressure sore is discovered on 5/10/12. On that same date, the proper procedure of notifying the resident's physician and family is followed, a care plan is put into place, and the care plan is implemented beginning on 5/10/12. Suppose that all of this information is not entered into the resident's chart on that date; instead, an entry is made on 5/15/12 indicating that a pressure sore was discovered five (5) days earlier, and a care plan was implemented at that earlier date. Because the charting was improper, it is as if the resident did not receive care until 5/15/12.

Jurors are often skeptical about late entries, and view them as cover ups. Furthermore, when charting is not concurrent with the care given, subsequent physicians and staff members are unaware of the care provided to the resident. While it is understandable that working in a nursing home setting can be demanding, hectic, and at times overwhelming; it is essential that staff members chart concurrently with detail and with accuracy. At a minimum, if charting cannot occur concurrently, it should occur as close as possible to the time when the care is provided, with proper notation if the entry is late. Finally, your memory regarding the care provided and/or your assessment of a resident only fades over time. The sooner you chart, the more likely the charting will be complete and accurate.

Criticisms of Care: The nursing home resident's chart is meant for the documentation of facts. It is designed to reveal the medical information and progress of a resident. Therefore, the resident's medical records should never contain notations criticizing the care and treatment rendered by the facility, another medical professional, or a staff member. A staff member's concern over a resident's care or treatment should be presented through the proper channels. For example, the following entry is improper because it criticizes the level of care provided:

Resident Doe complains of pain in her right hip from being left in her chair for several hours.

On the other hand, the following entry is proper because the entry is limited to the resident's medical condition:

Resident Doe complains of a tingling sensation in her right hip following hip replacement surgery.

Transfer/Discharge Forms and Instructions: The documentation of a resident upon transfer or discharge must be as thorough as the intake evaluation. Residents often return to nursing facilities with new medical issues that were not present at the time of transfer. To protect the nursing facility from liability, all medical issues must be carefully documented when a patient is leaving or returning to the facility. Thorough and accurate charting at transfer/discharge will prevent the nursing facility from incurring liability for the negligent care of previous and subsequent medical providers or the family. Of course, it will also serve to provide the most appropriate care for the resident.

Often times, nursing home residents claim that they were never given proper instructions pertaining to their home care at the time they were discharged from the nursing home. Residents argue that because the facility failed to pass along these instructions, they were harmed. As such, it is essential that detailed instructions are given to every resident at discharge. A copy of the discharge instructions should also be given to the resident's family members or primary caregivers. More importantly, the content of those instructions must be specifically documented in the chart. When a facility provides a discharged resident



with written discharge instructions, a copy of these instructions should be made part of the resident's record, as well.

### ***Contents of the Chart***

The required contents of a nursing home resident's chart varies from state-to-state. However, the following guidelines are representative of a majority of the states' mandates.

Face Sheet<sup>1</sup>: At the time of admission, the facility must create a face sheet for the newly admitted resident. The face sheet must include the resident's name, age, race and/or national origin, social security number, and marital status. The sheet must also note whether the resident, or the resident's spouse, is a veteran, prior address, emergency contact person, physicians' names and telephone numbers, whether the resident has been admitted before, date of current admission, and the applicable diagnosis at the time of admission. A new face sheet should be prepared for each separate admission. Therefore, if a resident is discharged to the hospital for one week, upon the resident's return, a new face sheet should be prepared.

Transfer Forms<sup>2</sup>: A transfer form, describing the resident's condition and reason for the transfer, should be completed for all transfers between the facility and other care facilities (i.e. hospitals and hospices). When the resident is transferred from the nursing home to another care facility, such as a hospital or hospice center, the nursing home should include a copy of any advanced directives, a list of all medications and allergies, and a list of all the resident's personal belongings being sent with the resident to the new facility. A transfer from the facility back to the nursing home should be documented as thoroughly as the intake evaluation of any new patient and should include instructions for care, and any follow-up care, if needed.

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<sup>1</sup> 77 Ill. Adm. Code 300.1820(a)

<sup>2</sup> 77 Ill. Adm. Code 300.1810(c)(8)

Medical History and Physical Examination Form<sup>3</sup>: The resident's physician should conduct an initial physical and mental examination upon admittance, and *should document all existing problems at that time*. Special attention should be given to any pre-existing conditions. The physician should also conduct a visual examination of the resident's skin for any pre-existing sores. If the doctor finds a sore, a conspicuous note should be made in the file, and measures should be put into place to prevent the sore from worsening. The nurses, and any other staff dealing with the resident, should also be made aware of the resident's condition. (See "Documenting Pressure Sores" below.)

Intake Evaluation<sup>4</sup>: While a facility has no control over what a physician charts in the initial physical and mental examination of a resident, it does have control over what is contained in the Minimum Data Sheet (MDS). Upon admission to a facility, the resident's primary nurse must conduct an MDS, a federally mandated assessment, capturing detailed information regarding the resident's ability to perform daily life functions, and noting specific impairments in functional capacity. **The initial assessment should note all of the resident's current and pre-existing medical problems and complaints.**

Care Plan: The Care Plan is a treatment plan created by an interdisciplinary team addressing the care issues noted in the MDS and prescribing the appropriate interventions. Family members should be encouraged to attend the Care Plan meetings. Correspondence inviting family members to the meetings should be saved. Attendance should be taken and minutes kept of the care planning meetings.

Of course, a Care Plan generated by the MDS may not occur for several days; therefore, it is imperative to create an initial care plan upon a resident's admission to your facility. The initial care plan should identify any and all known problems and/or risks and include interventions to help protect the resident. Knowledge of potential risks can come from the hospital records of a resident transferred to your facility; physician orders and/or conversations with the resident's physician; conversations with the resident;

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<sup>3</sup> 77 Ill. Adm. Code 300.1820(c)(1)

<sup>4</sup> 77 Ill. Adm. Code 300.1810(e)

conversations with the resident's family; and through the nurses' own exam and assessment of the resident upon admission and throughout the resident's stay, but before a comprehensive care plan is initiated.

Nursing Notes: The nursing staff should document, at least once a month, all observations regarding the nursing and personal care provided by the facility for each resident. Of course, any changes in condition or any new assessments of a resident should also be noted as they occur. If no development occurs for a month, this observation should be noted, as well. The nursing facility should, at a minimum, conduct annual physicals on each resident. The date the physical is set to take place should be clearly indicated in the chart. However, for Medicare residents, a facility is required to assess a resident and document the assessment at least once per day. Again, there should be a clear policy within your facility with regard to what to chart when no "out-of-the-ordinary" conditions are noted. However, if an assessment is performed, the fact that it was done should always be charted, even if nothing "out-of-the-ordinary" is noted.

Physician's Orders and Progress Notes: The physician must maintain an order sheet, with all medications, treatments, therapies, diet, activities, and special procedures for the resident. Every order should contain the time of each therapy/treatment, the time frame for the treatment, and any special instructions for the nurses and/or assistants. The physician's progress notes should also be included in the record, with at least one notation every sixty to ninety days, depending on whether the resident is in an intermediate or skilled facility.

Although not always expressly mandated by law, the following documents should be included in every resident's chart:

Social Service Notes: Social service notes are forms completed by the social worker addressing the interaction between various family members, and should include the number of visits each family member is making. In addition, these notes should document the type of relationship that each visiting family member has with the resident. These notes are typically helpful in attacking the claims brought by

family members in lawsuits filed after the death of a resident if the family was not as involved as they claim to have been.

Also, it is important to document within the nurses' notes when family is present and when family is invited to participate in any care-planning or other conference with the facility, but declines to participate.

Advanced Directives: Advance Directives include "Do Not Resuscitate" Orders (DNR), consent to withhold treatment, and living wills. If the resident has any of the above, a copy must be placed in the chart.

### ***Charting Communications with Physician, Resident, and Family***

Physician Communications and Visits: Because the physician is considered the primary healthcare provider of the nursing home resident, every nursing facility is expected to regularly communicate with each resident's primary care doctor. Specifically, a staff member is expected to notify the resident's primary physician when there is a significant change in the resident's condition. If the nursing home's primary contact with a resident's physician is through the doctor's nurse practitioner, the chart should indicate the name of the nurse practitioner the nursing home is in contact with, as well as the name of the attending physician. With every notification, the staff member should record the date and time the physician was contacted. The name of the doctor should be clearly documented, along with a summary of the substance of the communication, including all information relayed to the physician or nurse practitioner about the resident. Any and all information that the physician reports to the nurse with respect to how to proceed with care should also be noted. Any directive and/or physician order should be clearly set forth in the record, too.

Additionally, each physician or nurse practitioner visit must be clearly charted with the date and time of the visit and name of attending physician and/or nurse practitioner. Specifically, thorough details of all communications are extremely important. The details of what she told the resident should be documented along with an indication that the resident understood the discussion and any treatment plan. If

the proper authorization has been given, information concerning physician visits should also be communicated to the appropriate family member or guardian.

Family Communications: Due to the sensitivity of family members' concerns for the resident's well-being, communications with families must be continuous, consistent, and precisely charted. In addition, federal regulations require a nursing facility to notify a resident's family in the following situations: 1) the resident is involved in an accident that may require physician intervention; 2) the resident experiences a significant change in condition; 3) there is a need to alter treatment significantly; and 4) the facility has decided to transfer or discharge the resident.<sup>5</sup> Communications should be made to each family member indicated in the resident's admission materials. Notations concerning communications with a resident's family should include the date and time of each contact, along with the signature of the staff member making the communication.

Often times, the resident's family is the party that ultimately bringing suit against the nursing facility; therefore, it is important to keep the family updated with any potential complications or changes in the resident's condition. At the very least, regular communications with a resident's family will create a relationship between the family and the nursing facility, making it less likely that the family will file a lawsuit against the facility in the future.

Resident Communications: The resident should be at the center of all communications. Even in situations where it is unclear whether the resident is capable of understanding, or the resident is non-responsive, all pertinent information must still be conveyed to the resident. According to federal regulations, residents have the right to be informed of and participate in their care and treatment.<sup>6</sup> Notations describing communications with the resident should include whether the resident understood what was discussed, and how the resident indicated his/her understanding, e.g. "resident verbalized that

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<sup>5</sup> 42 CFR §483.10(b)(11)

<sup>6</sup> 42 CFR §483.10(d)

he/she understood the treatment plan.” The date and time of each contact should also be charted, along with the signature of the staff member making the communication.

Guardian Communications: A resident may have a court appointed guardian, who has the authority to make decisions concerning the resident’s treatment and care. In several respects, the Illinois Nursing Home Care Act bestows the same rights a resident has on his/her guardian. Accordingly, facilities should document all communications made with a resident’s guardian, following the procedures set forth above.

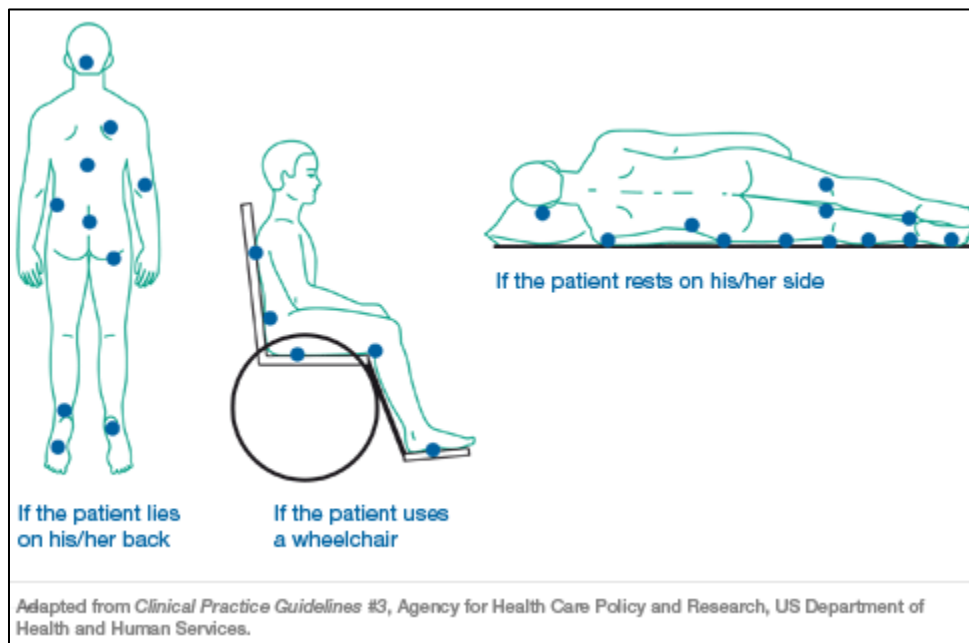
Attempted Communications: It is just as important to document all communications *attempted* with a resident’s physicians and family, as it is to document all communications actually made. The date and time of each attempt must be charted immediately following each attempted communication, no matter what medium of communication is used (i.e. call, page, fax, email, etc.). Of course, the signature of the staff member attempting to make the contact must be listed, as well. The telephone number used to make this contact should be part of the chart entry. In the case of physicians, if one of the doctor’s employees or agents takes a message for the doctor, note this person’s first and last name.

### ***Documenting Pressure Sores***

A pressure sore is a lesion caused by unrelieved pressure resulting in damage to underlying tissue. Put another way, a pressure sore is a chronic ulcer that often appears in debilitated patients who are confined to a bed or otherwise immobilized. Pressure sores usually develop because of friction and/or shear. Friction occurs from skin repeatedly rubbing against a resistant surface, such as a bed sheet. Shear is a combination of friction and pressure, which causes the skin to be pulled from its normal resting position. Nutrition, hydration, incontinence, mobility, and weight can also affect the development of pressure sores. Areas that are particularly prone to pressure sore development are areas where bones are located near the surface of the skin, such as heels, ankles, elbows, and hips. Figure 4 depicts the common areas where pressure sores develop.

Pressure sores can look very different depending on the severity of the sore or how long the sore has gone unnoticed. As is more fully described below, early damage presents as a red patch or a blister on the skin. If left untreated, it may progress to a condition where a “deep cavity” is present. The wound may also contain dead (necrotic) tissue, which may be hard and black, or soft, sticky, and yellow.

**FIGURE 4: COMMON AREAS WHERE PRESSURE SORES DEVELOP**

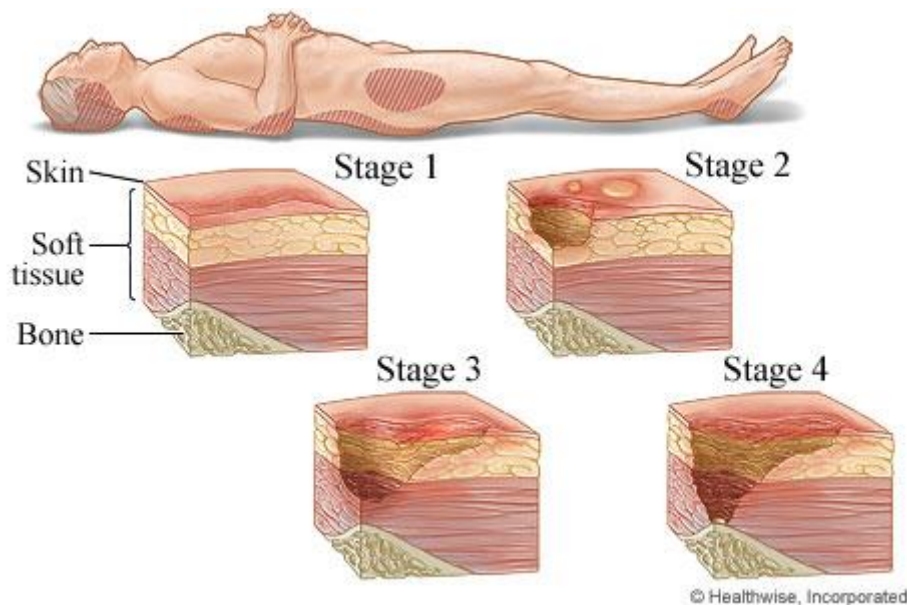


In recent years, the number of pressure sore lawsuits brought by residents against nursing homes is on the rise, with many verdicts nearing seven-figures. In one study, experts surveyed over 4,700 nursing home lawsuits across the country, and found that 16% involved allegations of pressure ulcers and bed sores.<sup>7</sup> In fact, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and other regulatory bodies have looked at all medical facilities' pressure sore rates. Due to the increase in attention devoted to pressure sore rates and the increase in resulting lawsuits, medical communities must give more attention to the prevention of pressure sores. In addition, pressure sores can cause severe pain and discomfort, jeopardize a resident's condition, and cost a nursing facility a substantial amount to properly

<sup>7</sup> David M. Studdert, et al., *Relationship Between Quality of Care and Negligence Litigation in Nursing Homes*, N Engl J Med 364;13, March 31, 2011.

treat. Hence, nursing home staff should make certain that the presence of a pressure sore is carefully treated and accurately documented. It is imperative that the documentation procedure for pressure sores begins as soon as a sore is first noted, whether upon initial admission, transfer, or at any time during a resident's stay. Moreover, any corrective measures, including any medications taken, should be documented, as well. Pressure sore/ulcer documentation should include the following:

Staging: The development of pressure sores is typically described in four stages. The stages can be categorized and described as follows<sup>8</sup>:



It is very important that the health care provider document the progress of the ulcer with specificity, noting any and all actions taken to correct the pressure sore, and remarking on the improvement or lack of improvement of the ulcer. The exact stage of the pressure should be noted, as well, and the resident's physician should be contacted if there are any worsening changes to the sore, including, but not limited to, size, color, odor, and any other potential signs of infection.

Assessment: An assessment of the ulcer should be done on a regular basis. The date and time of the assessment should be recorded, in addition to the name of the professional performing the

<sup>8</sup> Source of images: <http://www.emedicinehealth.com>



assessment. Additionally, the exact dimensions of each pressure sore should be recorded frequently. Once the assessment has been performed and the severity of the ulcer noted, a treatment plan should be instituted and described in the chart with specificity, including the members of the team who authorized the treatment. The identity of any medical professional that consulted with the treatment team, such as a nutritionist, should be noted in the chart as well. Of course, any consult should be separately charted by the individual involved in the consultation. A copy of the consultant's notes/report should be made part of the resident's chart.

Treatment: Preventing a pressure sore is the key. Specifically, "Pressure Ulcers in Adults: Prediction and Prevention" offers the following advice<sup>9</sup>:

- Inspect the skin at least once a day (document even if there is no change);
- Individualize bathing schedule;
- Use proper lubricants to reduce friction;
- Institute a rehabilitation program;
- Minimize skin exposure to moisture; and
- Cleanse skin at time of soiling.

In order to help insulate the facility from liability for improper care, staff members must Make careful and accurate notations of each and every preventative measure that is taken, and the resulting effect of each measure. Once a bedsore develops, a comprehensive treatment plan must be created, specifically identifying the steps that will be taken to address the sore. The date and time of each treatment should be clearly marked, and the individual performing the treatment should always sign and/or initial the form, indicating that the treatment was, in fact, completed.

Notify the Family: It is important that the resident's family is notified as soon as a pressure sore is identified. Staff should work to recognize pressure sores as early as possible and notify families while the sore is still in its initial stages. A care plan should be put into place immediately, documented accordingly, and communicated to the family and the resident.

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<sup>9</sup> *Pressure Ulcers in Adults: Prediction and Prevention*. U.S. Dep't of Health and Human Services. Publication No. (AHCPR) 92-0047, Rockville, MD, Public Health Service, AHCPR, 1992.

Notify the Physician: To ensure proper care of a pressure sore, the physician should be notified immediately. Even if a staff member is unsure whether a pressure sore is in its initial stages, the physician must be informed of the possibility so that the doctor can take the appropriate steps towards treatment and prevention. Place the onus on the physician to make the appropriate treatment plan. This communication should be documented as described previously.

### ***Documenting Falls***

Nursing facilities have historically used restraints to curtail falls. However, with the enactment of the Omnibus Budget Reconciliation Act of 1987 (OBRA – 87), which gives nursing home residents the “right to be free from any physical or chemical restraints...not required to treat the resident’s medical symptoms,”<sup>10</sup> falls have become one of the most highly litigated areas with respect to nursing homes. Because nursing facilities must use caution with respect to employing restraints, nursing home residents are now given more mobility and freedom during the day. This mobility and freedom has resulted in an increase in the number of falls a facility is likely to have.

To decrease the occurrences of falls, the interdisciplinary team should collaborate to develop a fall prevention program, specifically designed to meet the individual needs of the resident and the facility. The program, as well as the explanation communicated to the resident, should be clearly document within the resident’s chart.

However, simply because a resident falls, does not mean that the facility has provided substandard care. To ensure that fault is properly assessed, nursing home staff members must react quickly to the fall and document it as follows:

Interview the Resident: Immediately following the fall, question the resident about how the accident occurred. Ask the resident what caused him to fall. Staff should also question residents who have fallen about where they were when they fell, what they were doing immediately prior to the fall, and whether

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<sup>10</sup> C.F.R. 483.13(a)

they noticed anything in the area before they fell that may have caused the fall. Contemporaneously documenting these facts will be helpful in showing that the facility responded to the fall quickly and that there was an unobstructed pathway for the resident to walk. If possible, the staff member should quote the resident verbatim. If the resident changes his or her version about the incident and brings a lawsuit, the facility may be able to use the documented language as to the nature of the accident to its advantage.

Notify the Physician: After a fall, a nursing home staff member should promptly notify the resident's primary care physician. Notification should be documented in the resident's chart. Specifically, the staff member should record the date and time that the physician was contacted. The information supplied to the physician should be documented, as well. If the staff member notified the physician's assistant, instead of the physician directly, the staff member should record the time of the phone call, whom he or she spoke with, and the nature of the conversation. If the staff member was unable to reach the physician, he or she should note in the resident's chart that the initial contact was unsuccessful. Repeat attempts at contacting the physician should be made until successful, and documented accordingly.

Notify the Family: Reasonable family members understand that there is a chance that their loved one may fall while residing in the nursing home through no fault of the facility. In fact, most family members do not ever contemplate that the facility's negligence may have caused the fall. However, if a family member or caregiver finds out about a fall only after hearing about it from someone other than an employee of the facility, or by noticing a bump or bruise and inquiring about its origin, it is likely that a family member may think twice about the fault of the facility in the fall. Therefore, to guard against any unfair charges of cover-ups and conspiracy, it is certainly wise to contact the resident's family or caregiver to advise them of any falls in the facility as soon as they occur. The nursing home should provide specific information regarding the circumstances surrounding the fall, the plans that the facility put in place to care for any injury sustained in the fall, and the strategy the facility will follow to prevent further falls. Any communications with the family concerning incidents of falls should be documented as described previously.

### ***Documenting the Use of Restraints***

Illinois, like many states, defines a “physical restraint” as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to a [nursing home] resident’s body that the resident cannot remove easily and restricts freedom of movement or normal access to one’s body.”<sup>11</sup> Restraints, including side rails, may only be used after a determination that the use of less restrictive measures would not attain or maintain the resident’s highest practicable physical, mental, or psychosocial well-being. The decision-making process that was followed to come to this conclusion should be documented in the chart.

Many states require that a restraint may be used only with the informed consent of the resident, or his/her legal representative, and with the order of a licensed physician. For the consent to be legally binding, the resident must be fully informed of the risks and benefits associated with the use of a restraint and their alternatives, thereby allowing the resident to choose among indicated therapies. Furthermore, all of this must be specified in writing in the nursing home record and/or consent form.

Arguably, restraining an individual without his or her prior consent constitutes battery (that is, an intentional and offensive invasion of the resident’s bodily integrity, without his consent). However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question.

Charting Restraints: The facts that underlie cases involving restraints often unfold over weeks, months, or years, and may involve complex events. They may include behavioral changes, institutional transfers, assessments and reassessments, multiple injuries, and hospitalizations. As such, the following factors must be clearly documented and specifically addressed in the resident’s chart:

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<sup>11</sup> 210 ILCS 45/2-106

- The physician's order for restraint use;
- Executed written consent form for restraint application or removal;
- Family notification of need for restraint;
- Description of the discussion with resident and/or the family regarding the restraint use;
- A description of communications regarding the use of the restraint;
- Alternative methods to restraints that were attempted;
- Medical reason for restraint use;
- Resident's clinical condition, circulation, and condition of limbs;
- Type and size of restraint used;
- Time frame for restraint use;
- How the resident will be observed and monitored while the restraint is employed;
- How staff will meet the resident's hydration and toilet needs with the restraint;
- Length of time the restraint was used;
- Resident's response to being restrained; and
- Restraint reduction efforts.

Medical communities should also maintain ongoing assessments of all residents that are being treated with the use of restraints. The ongoing assessments should also note the following:

- The resident's clinical condition;
- Staff's monitoring circulation and condition of limbs;
- Expected time frame remaining for restraint use;
- The staff's continuous observation and monitoring of the resident while restraint is in use;
- The execution of the staff's plan for hydrating the resident and satisfying the resident's toilet needs;
- Changes in plan made to accommodate the resident's condition; and
- The resident's response(s) to being restrained.

Documenting these factors, with as much detail as possible, can demonstrate that a facility met the standard of care, and that the resident's medical condition caused the injuries, not the facility's failure to implement a proper fall prevention program. If a side rail or other restraint was used, which may have contributed to the accident, the position of the rails, and/or the purpose of the restraint must be clearly indicated in the record.

### ***Documenting Nutrition and Hydration***

Malnutrition is not a normal response to aging; rather, it occurs for a variety of reasons. Its presence may indicate that the resident is suffering from a serious or life-threatening illness, or it can

impede a resident's ability to recover from whatever ailment brought him to the nursing home. Therefore, it is extremely important that all staff members tending to the resident are familiar with, and document, the warning signs of malnutrition.

Risk of Malnutrition: The following are some of the signs that a resident may be at risk for, or suffer from, malnutrition:

- Unintended weight loss;
- Needs assistance in eating and drinking;
- Refuses to eat or pockets food;
- Eats less than half of his or her meal/snacks;
- Experiences mouth pain;
- Has improperly fitted dentures;
- Experiences difficulty with chewing and/or swallowing food;
- Chokes or coughs when eating;
- Displays depressive symptoms, such as crying;
- Has been diagnosed with diabetes, chronic obstructive pulmonary disease; cancer, HIV, or other chronic diseases; and
- Irregular lab results.

Each and every nursing home resident should be monitored for the above signs. If any are noted, their presence should be carefully documented and the resident's primary nurse and physician should be notified of the condition. If the symptoms are noted, a treatment plan should be incorporated into the resident's medical chart to ensure that the resident stays properly nourished. Interventions to consider include:

- Diet change;
- Supplements;
- Food preferences;
- Assistance with eating;
- Eating in the dining room; and
- Feeding tube.

The facility should also ensure that the resident has a positive dining experience, including the following:

- Encourage the resident to eat;
- Honor food likes and dislikes;
- Offer many kinds of foods and beverages;

- Allow enough time to finish eating;
- Notify nursing staff if resident has trouble using utensils;
- Provide oral hygiene care before meals; and
- Position resident correctly for feeding.

Dehydration: Dehydration is a condition in which water or fluid loss far exceeds

fluid intake. The body may lose fluids from the following:

- When urinating;
- When vomiting;
- When sweating;
- From the lungs during normal breathing; and
- Diarrhea.

If the body loses a substantial amount of fluids which are not quickly replaced, dehydration can occur. When dehydration occurs, the body becomes less able to maintain adequate blood pressure, deliver sufficient oxygen and nutrients to the cells, and rid itself of waste.

The degree of dehydration is graded according to signs and symptoms that reflect the amount of fluid lost. Symptoms of early or mild dehydration include the following:

- Flushed face;
- Extreme thirst;
- Dry, warm skin;
- Reduced amounts of urine – dark yellow in color;
- Dizziness made worse when standing;
- Weakness;
- Cramping in the arms and legs;
- Crying with few or no tears;
- Irritability;
- Headaches; and
- Dry mouth and tongue with thick saliva.

Symptoms of moderate to severe dehydration include:

- Low blood pressure;
- Fainting;
- Several muscle contractions;
- Convulsions;
- Bloated stomach;
- Heart failure;
- Sunken dry eyes;
- Skin loses its firmness;

- Lack of elasticity of the skin;
- Fast, weak pulse; and
- Lab results – increased Sodium levels.

In severe dehydration, these symptoms become more pronounced. If left untreated, the resident may develop evidence of hypovolaemic shock, including diminished consciousness, lack of urine output, cool and moist extremities, low blood pressure, and peripheral cyanosis. Death can follow without proper treatment. Therefore, early detection is the key in maintaining the resident's hydration level.

Most residents need a minimum of six cups of liquids each day to stay hydrated. The fluid intake of the resident should, therefore, be documented on a daily basis. A facility can monitor the intake, without constricting intake, by ensuring that a pitcher of water and cup are near the resident at all times. The facility should also make sure that the resident is able to pour his or her own beverage. If the resident is unable to hydrate himself or herself, the facility should make sure that staff members are frequently attending to the hydration needs of the resident.

Nursing home personnel should perform an initial dehydration risk assessment once a resident is admitted. Thereafter, the facility should continually monitor each resident for any signs or symptoms of dehydration noted above. If the resident is suffering from a life threatening disease, or is recuperating from surgery, the checklist should be performed more regularly. If any of the symptoms are noted, their presence should be documented in the resident's chart. Moreover, the primary care physician should be notified of the condition and a treatment plan should be instituted. If a nursing home establishes a fluid intake requirement for its residents, then the facility must convey this requirement to its nurses and aides and monitor that each resident is consuming the amount required. If not, then such deficiencies must be reported to the resident's physician, guardian, and family.

### ***Documenting Non-Compliance***

If a resident or his/her personal representative refuses medication or any other treatment/therapy, including food and/or fluids, the time and date of the refusal should be documented. Moreover, the refusal



should be reported to the resident's primary care physician. Such notification should also be noted in the chart. If a resident "checks" himself/herself out of the facility against medical advice, this departure should be documented with specificity, including a description of any conversations that took place with the resident before he or she left.

### ***Reminder***

It is illegal to document treatment that has not occurred. The actual care provided to the resident must reflect the documented plan of care.

### ***Conclusion***

A detailed chronology can visually demonstrate a nursing home's negligence, or be a powerful exculpatory tool showing a resident's pre-existing conditions, secondary injuries, and progressively worsening disease. It can mean the difference between winning a case and losing it. The following are points to remember:

- Document any conversations with family;
- Document all staff teaching and instructions;
- Document all nursing assessment and interventions;
- Perform and document a thorough initial assessment;
- Plan of care should reflect problems identified during an assessment;
- Any changes in a resident's condition should generate new assessments and possibly new plans of care;
- Document all interdisciplinary conversations (with physicians, physical therapists, etc.);
- Document in an objective, rather than a subjective manner.

## **About the Authors**

### **Andrew Kopon, Jr.**

Mr. Kopon's extensive trial work has been in a variety of matters, including wrongful death cases, product liability, insurance coverage, and employment law.

Mr. Kopon currently serves as national counsel for Christian Brothers Services and has worked as national and regional counsel for product manufacturers. Mr. Kopon's trial experience includes the defense of catastrophic injury and wrongful death cases. His employment practice includes federal and state statutory and common law actions. He has served as a faculty member on prestigious national and state defense trial programs. He has tried high profile cases and has also successfully argued before the Illinois Supreme Court on behalf of his clients.

Mr. Kopon is also a member of The Leading Lawyers Network Advisory Board (LLNAB) whose members are selected based upon their reputation and professional ethics, in addition to their knowledge of the lawyers within their practice area and respective region of a state.

### **Michael A. Airdo**

Mr. Airdo is a founding member of Kopon Airdo. His practice focuses on the litigation of complex civil matters, including premises cases, healthcare matters, and municipal matters. Through his work with Christian Brothers Services, he has a broad base of experience in representing the unique legal needs of religious institutes and religiously sponsored ministries, including nursing homes. Mr. Airdo also specializes in legal matters involving not-for-profit corporations, educational institutes, small businesses, and mental health professionals. He has a wide array of experience in resolving matters through the alternative dispute resolution process.

Mr. Airdo is a frequent lecturer on topics related to his legal practice. Most recently, he has spoken on topics specific to nursing homes and assisted living facilities, HIPAA, and the liability issues that arise in retail establishments. Michael Airdo has regularly lead workshops on the legal and pastoral response of child-serving organizations to victims of childhood sexual abuse.

For several years, Mr. Airdo has served as civil legal counsel for the Conference of Major Superiors of Men ("CMSM"). CMSM serves the leadership of the Catholic orders and congregations of the more than 20,000 vowed religious priests and brothers of the United States. He has also worked closely with the Resource Center for Religious Institutes ("RCRI"), whose membership is composed of leadership from religious institutes and societies of apostolic life from the United States and Canada. Mr. Airdo is also counsel to the Tooling & Manufacturing Association based in Park Ridge, Illinois.

### **P. Patrick Cella**

Mr. Cella is a member of Kopon Airdo, LLC. He concentrates his practice on the defense of nursing homes in civil personal injury matters in several states, as well as in administrative hearings before the Illinois Department of Public Health. His tort litigation work also includes the representation of high schools, colleges and universities, religious orders, and retail establishments in a wide range of matters, including,

premises liability actions, negligent supervision, and intentional torts. He also practices in a variety of commercial and contract matters, including, risk management strategies, contract drafting and negotiation, and commercial contract and property disputes.

In his work with nursing homes and long term care facilities, Mr. Cella has become well-versed in the issues presented by the Illinois Nursing Home Care Act, as well as the regulations promulgated by the Federal government, the State government, and the Illinois Department of Public Health.