Higher Acuity in Assisted Living: Risk or Reward?

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American Assisted Living Nurses Association
Center for Excellence in Assisted Living

CEAL
• Nonprofit collaborative of 11 national organizations
  • Alzheimer’s Association, AALNA, AAHSA, AARP, ASHA, ALFA, CCAL, NCAL, NCB Capital Impact, PVA, Pioneer Network
  • www.theceal.org

Acuity in assisted living continues to climb
Truth or just rumors?
We’ve been talking about higher acuity for years...

Assisted Living State Regulatory Review
2012 edition at www.ncal.org
30% of states made changes to assisted living regulations last year.

Nursing Services
94% of communities have a licensed nurse available to residents 24 hours/day.

NSRCF
First time national assisted living data collection effort by the CDC/NCHS/ASPE.
ADLs
37% of residents receive assistance with 3+ activities of daily living

50%
of AL residents have three or more chronic conditions

42%
have Alzheimer’s disease or other dementia
Making higher acuity work:

1. Acceptance is the first step
2. Let the regulations be your guide
3. Is everyone on the same page?
4. Now comes the hard part...
Care Transitions

Fundamental Disconnect...

*Dr. Eric Coleman's slide, printed here with permission.

35% of assisted living residents in ER in the last 12 months
1 in 5 Medicare recipients discharged from the hospital are readmitted within 30 days.

That translated to 2.6 million seniors and over 26 million seniors and over $26 billion annually.

The Patient
Protection and
Affordable Care Act
ACA
Readmission penalties

ACA
Accountable Care Organizations

Medication Management
85% of assisted living residents require assistance with medications.

Older adults take an average of 5 prescription medications per month.

Those with 3+ chronic health conditions average 6-7 prescription medications per month.
Assisted Living Residents

- 10 routine medications per day
- 3 PRN medications per day

"assisting with self-administration"  
a regulatory play on words

state regulations  
are all over the map
CEAL/UNC Research:

35% of medication administrations involved an error.

71% of errors were again related to dose timing.
< 3% of errors had moderate to significant potential for harm

Med Techs did NOT have a higher error rate than nurses

Written test results “predicted” likelihood of errors
Challenges:
Large volume of routine medications

Challenges:
PRN Medications

Challenges:
Injections
Challenges:
Healthcare providers who do not specialize in geriatrics

Focus on high-risk medications

1/3 of emergency room visits by older adults presenting with ADE are caused by 3 drugs:
- Warfarin
- Insulin
- Digoxin
CEAL/ UNC Research Showed majority of errors with potential for harm related to:

- Warfarin
- Insulin
- Risperidone

Warfarin
- Monitor for s/s of bleeding
- Coordinate lab tests
- Monitor OTC use

Insulin
- Follow delegation procedures
- Monitor residents who self-administer
Individualized Medication Plans
Promote person-centered care in all aspects of resident care

Manage High Risk Concerns

Manage high risk:
Dementia care
wandering and elopement
Manage risk: Falls
account for up to 40% of
lawsuits in assisted living

Manage risk: Medications
1/3 of emergency department
visits by older adults presenting with ADEs
are caused by 3 drugs — warfarin,
insulin, and Digoxin

Higher acuity is here to stay!
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LeadingAge NY Annual Meeting
Saratoga Springs NY
May 22, 2013

What are the risks?
How can we minimize the risks?

Lawsuits as a Result of Falls

Older
↓
Frail/Unsteady
↓
Falls
↓
Injury
↓
Lawsuits

Lawsuits: Medication Matters

Older
↓
Ailments
↓
Medications/Multiple Meds
↓
Opportunity for Error/Adverse Reactions
↓
Lawsuits
Lawsuits: Dementia Issues

- Older
  - Dementia
  - Wandering
  - Injury (or worse)
  - Lawsuits

Lawsuits: The Psychological Factor

- Something Goes Wrong
  - Anger/Fingerpointing or Guilt
  - Lawsuits

DOH Retention Standards

ACF regulations prohibit retention when resident:
- needs continual medical/nursing care/supervision as provided by hospital or nursing home
- requires continual skilled observation of symptoms/reactions
- refuses or is unable to comply with prescribed treatment plan
- is chronically bedfast
- is chronically chairfast and unable to transfer or chronically needs assistance to transfer

DOH Retention Standards (cont’d)

- is chronically in need of assistance to walk
- is chronically in need of assistance to climb or descend stairs (unless he/she lives on ground floor)
- has chronic unmanaged incontinence
- is dependent on medical equipment (with certain limited exceptions)
DOH Retention Standards (cont’d)
• If facility retains resident when DOH retention standards exceeded, risk of censure by DOH (complaint or survey)

Lawsuits: Resident Refusal to Leave

Higher Acuity
↓
Exceed DOH Retention Standards
↓
Resident Refuses to Leave
↓
Lawsuit to Evict

EALR/Authorized Retention
ALR license and EALR certification allows retention of those who are:
• chronically chairfast and unable to transfer or chronically requires assistance of one or more persons to transfer
• chronically requires assistance of one or more persons to walk or climb/descend stairs

EALR/Authorized Retention (cont’d)
• dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel
• have chronic unmanaged incontinence
EALR/Authorized Retention (cont’d)

• Discharge required if resident needs 24-hour skilled nursing care or medical care. Resident may stay if:
  ➢ resident hires appropriate nursing, medical or hospice staff to care for increased needs
  ➢ resident’s physician or home care agency and/or hospice determines that, with additional services, resident will be safely care for
  ➢ operator agrees to retain resident
  ➢ resident otherwise eligible

How to Minimize Risk

The three C’s:
• Communicate
• Communicate
• Communicate

The Six D’s
• Disclose
• Disclose
• Disclose

FULL DISCLOSURE

• Document
• Document
• Document

Residency Agreement

Disclose
Disclose
Disclose
Marketing and Admission
- Ensure marketers and marketing materials carry message consistent with facility policies
- Engage resident and family in discussion to ensure understanding of facility requirements/limitations/expectations

Residency Agreement
- Plain English
- State cost of services
- Identify resident and provider responsibilities
- Be specific as to what is included/what is not
- Address circumstances when discharge required (esp. scope of services limitations)

Risk Management
Responsibility for Risk Management:
- Who is responsible?
- Develop reporting mechanism
- Develop system for communicating questions/concerns
- Coordinate team effort

Hiring
- Strong orientation program
- Strong ongoing in-service training program
- Communicate expectations to staff at all levels
Hiring
- Ensure credentials of all staff, including temporary
- Document steps taken to credential
- Strict liability of provider for actions of employees can be an issue
- Any reason to foresee that neglect might occur?
  ➢ Too much for staff to handle?

Private Duty Companions
- Facility has obligation to provide safe environment
- Establish written policy for private duty companions
  - Name tags
  - Sign in/sign out
  - Notify if change in resident condition
  - Resident/companion indemnifies facility
  - No solicitation of other residents
  - Acknowledge receipt of House Rules

Policy and Procedure Manual
- Develop strong policies and procedures
- Keep P&P manual updated
- Train staff on P&P and retrain
- Communicate changes in P&P manual
- Monitor staff adherence to P&P
- Ensure actual practices conform to P&P

Defensive Documentation
- Document circumstances thoroughly and accurately
- Be aware outsiders may review records
- P&P on proper documentation for service plans, execution of plans, QI, investigations of incidents
- Document routine matters (tasks performed) as well as significant change
- Increase documentation after a significant change
Defensive Documentation
- Document at time of activity, not before or long after
- Make documentation factual; avoid opinions, legal conclusions
- No cross-outs, white-outs, erasures
- Don’t skip lines in recording notes
- Properly date and initial addenda/late entries; don’t overuse
- Never falsify documentation

Investigation of Incidents
- Who should investigate? Counsel? Staff person?
- Investigator should be skillful in interviewing, able to weigh evidence and evaluate credibility, identify corroborative and contradictory evidence, pursue alternatives
- Develop P&P for investigation protocol
- Assess actual purpose and objectives of investigation
- Review relevant P&P

Internal Investigations
- Identify specific questions to be resolved (Who, What, When, Where, Why)
- Preliminarily identify witnesses and information sources
- Establish order of interviews
- Prepare preliminary questions to ask
- Document as “preliminary investigation plan”
- Interview promptly

Internal Investigations
- Be thorough: follow up on new leads/apparent contradictions
- Start with open-ended questions, move to more specific questions:
  - Have you observed any...?
  - How do x and y get along?
  - Have you observed x and y in...?
- Close with open-ended questions: Is there anything else?
Internal Investigations
- Strive for accuracy, but don’t lead
- Be fair and impartial
- Do not promise absolute confidentiality
- Develop a chronology of events
- Document results with summary of factual findings and conclusions of investigator
- Avoid written witness statements

Communications with Families
- Involve family in development of service plan
- Ask family to sign off on service plan
- Communicate with families on regular basis
- Ask for feedback from families

Staff Communications
- Establish system for staff communication concerning resident condition/needs
- Require staff to put their complaints in writing
- Investigate complaints
- Conduct exit interviews and document discussion

Quality Improvement and Quality Assurance
- Develop QI/QA mechanism
- Coordinate all staff involved
QI/QA

- Consider implementation of fall prevention program (but don’t rely solely on special equipment without ensuring proper maintenance/monitoring)
- Document discussions with resident/family about individual QA measures
- Document general QI/QA measures

In summary:
- Communicate
- Disclose
- Document
- Run a tight ship

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