THE RISK OF REALITY

THE DEMENTIA DIAGNOSIS FROM ADMISSION TO LITIGATION

For a resident to be admitted and then remain in a place they relate to, whether a skilled facility, assisted living, or specialized memory care environment, is a matter of "fit" between the care needs of the resident and the capacity of the facility to provide care and support. This includes the ability to manage social, clinical, and related medical needs often including progressive decline.

This decline can be subtle, unnoticed by families and creating a service creep risk with increasing needs being met by staff without the benefit of an assessment, or rapid resulting in an incident leading to a need for quick higher level placement.

State rules and protocols usually set the parameters for retention for assisted living and memory care, most decisions for skilled location retention are critical thinking by direct caregivers and protocol, but there are the gray areas in all settings of *can the needs be met?*

Regardless of the setting, providing care and service to a resident with a mild cognitive impairment (MCI), a diagnosis of general dementia, or Alzheimer's specific is a risk reality.

This risk is three-prong, and the proactive risk prevention and control efforts should focus on each of these three: the care setting and caregivers, marketing and expectations, exposures and events. The prongs are starting points for education of staff, residents, and families, and risk reduction selections of verbiage in any document driving decision making whether marketing material, the admission agreement, or general management policies.

CARE SETTING – the Admission and the Retention Decision is Your Responsibility

A common risk rating of the liability associated with most admissions can be determined on a case by case basis with this question, *can the majority of residents admitted really age in place?*

Most admissions in reality are temporary for any setting with a need eventually for the next level of care. This decision and discussion is the one which is most misunderstood by families.

Risk mitigation should focus on the care setting risk in thirds, the myth of the location being the solution for health and cognitive problems, the first two weeks after admission when expectations meet reality, and the last one third of the residency when the next step of the next level of care must be decided on.

Check Point

- Is the community protocol which drives the assessment of needs and placement suitability in place, followed, and functional?
- Is there full disclosure of services and service limitations propelled by preplanned service script conversations?
- Is the transfer and/or transition criteria clearly defined before the need?

- Are arbitration agreements and negotiated risk agreements in use, skillfully presented, and legally signed.

It is common for most to be somewhat prepared and accepting of the eventual conclusion of life. Few, however, are prepared and accepting of the journey. This journey, and the associated retained risks, is the specialty of senior care. Mitigating the risk areas of the journey requires distinct understanding of the exposures of nature of the business model in general, and the associated risks of servicing a client grouping with limitations and vulnerabilities. See the *Progression Timeline*.

Highlighting the benefit of living in a caregiving community is a well-accepted part of marketing, and most decisions on move in or placement are based on these encounters. However, attached to this process should also be introductions of known limitations. These service boundary conversations should be part of the employee learning process so key points will be discussed comfortably and routinely.

Conversation examples

This is the service and support interactions we offer and with all services there are some limitations.

- There may be a need for a move to a higher level of care, these changes may be gradual or call for a quick decision. This will be our procedural steps at this time.
- We cannot provide 24-hour direct supervision. There will be independent times and there can be self-governing decisions during these times which may result in an event with injury.

Here is what we do provide. Is this your understanding?

- The disease progression of MCI or dementia will likely continue. It can be rapid and require quick decisions, or there may be recognized changes as weakness, increased confusion which may result in uncommon behaviors, falls, decrease in appetite with weight loss and possible compromised skin.

Here is what we provide as support measures. Is this your understanding?

CAREGIVERS – Direct Caregivers are Your First Line Risk Managers

Whether recognized or not, the direct caregivers and clinicians' interactions and the decisions they independently make day to day comprises a big part of risk mitigation efforts.

Recent studies indicate the demand for direct caregivers is projected to grow by 40% by 2026, with availability declining. While projections can be wrong, one thing is clearly a driver of reality about 1 in 9 people 65 and older has an Alzheimer's diagnosis. While several forms of caregiving are available, most with this diagnosis will seek admittance to a congregate care setting.

Concentrating on the main areas of risk reduction which can be managed and that can make a difference empowers management. This empowerment and risk control knowledge should also drive staffing direction and training. Empowering direct line staff with examples of encounters to assist with their decision making at bedside and when an accident occurs and involving them in protocol development can make the most of staff in place now, and future retention and recruiting.

Risk Tips

- Increase the confidence of the staff in place with directed education, especially of mild cognitive impairment (MCI), dementia, and related diagnoses.
- Create risk scenarios and role play best practices which will be encountered.
- Create a five step easy to remember rule for all staff "if this happens do these five steps".
- Ask direct care staff for suggestions to streamline processes.
- Re-purpose the headcount by identifying the standouts, showing them appreciation but leaving them on the front line.
- Look for staff members with standout talent for assessment and monitoring and let them show and tell others.
- Tap the talents of the Alzheimer's Association education and published material for both staff, residents, and families.
- Audit processes for redundancy and time consuming steps, do not assume just because you have electronic medical records it is more efficient.

EXPECTATIONS – Everyone Has Them

The majority of allegations of sub-standard care and resulting litigation is often the result of lack of understanding by the community staff of what the exposures are before any event, lack of introducing the limitations of the care setting at admission, expressed guarantees of retention, and the lack of understanding by all of the descending nature of this diagnosis.

The phenomenon of aging in place and quality of life both depend on the reality of acceptance of what will happen as residents age and stay in place and conveyance of what care and service can be provided to accommodate the transition.

Without a developed plan to address these two retained risks, the event, whether an incident, change of condition, or general decline, will result in the need of someone to blame.

Many claims involving residents with dementia are based on care delivered compared to the perception of promised care. To the public, healthcare environments are envisioned by most as safe, nurturing, and to some degree healing.

Placement is often viewed as a treatment modality.

Concentrate your front line mitigation efforts with arbitration agreements, negotiated risk agreements, assessments and timeframes, and documentation education. Nurses are not taught how to document defensibly; this is a learned process.

EXPOSURES AND EVENTS – There is a Difference

The recently published CNA claims overview indicated dementia to be the contributing factor in 72.9% of all assisted living fall related closed claims events and 57.7% in the skilled environment.

Events are going to happen, many at no fault by the community process or staffing. Some can be directly related to failure to follow process, process failing the task at hand, or staff involvement or awareness.

However, all events, even those with a negative outcome, do not end in allegations of substandard care or negligence. Some families understand, and it often comes down to how the community has and is prepared for the exposures. See the attached *Risk Mitigation Sieve*.

Many events like falls are products of the business model, they will happen; ever present exposures are usually what drive the event and outcome out of your control. These exposures can be managed with recognition of the risk reality.

Providers must now take a different role, with clarification and reality when families who are faced with placement are looking for a placement of safety and a solution.

The Alzheimer's Association gives some indication of diagnosis disconnect with statistics of 35% of primary care physicians who are not fully comfortable diagnosing mild cognitive impairment (MCI), and one half, 51%, are not fully comfortable diagnosing MCI related to Alzheimer's disease.

What you see and evaluate for admission may not be what your staff will have to be prepared to care for, once in your location the risk of decline and increased incidents are yours to manage.

When an admission is completed the resident and the family have needs, wants and expectations, all which have to be recognized even if all cannot be met.

Being aware of the associated exposures of residents, families, systems, and staff and using them as a basis to formulate criteria for education, interactions, and documentation is risk control.

Exposures are there to be managed and contained long before the admission, event, or incident. Recognizing these main areas of risk and using them as a basis for developing actions, interactions, and policy development can make a difference. Review the *Risk Mitigation Sieve*.

- Residents who are admitted with a progressive disease with unanticipated needs and must be monitored for medical, emotional, and physical changes.
- Families who are unprepared for the reality of decline if placed in a healthcare facility dedicated to dementia and memory care, the location modality myth.
- Processes which do not meet the everchanging need of the moment and/or fail the staff for support of actions and decisions.
- Staff who often are reactionary at the wrong time and driven by habit for monitoring without anticipating the safety risk of periods of self-governing and decline.

Event risk prevention and control plans should start with not only adequate numbers of staff and carefully selected staff talent, but education for encounters which do not follow a typical or expected pattern. Staff trained appropriately and comfortable with scenarios of incidents, refusals, aggression, and falls may be more effective for all than numbers.

A second component of risk prevention is to capture with documentation those things which are out of your complete service control as a provider. You cannot control all the decline and the changes which may be subtle and slow or rapid, and you cannot control all falls.

CONNECTING THE DOTS

Clearly understanding the exposure groups as families, residents, staff, processes, and the perception of healthcare and grasping the risk link to the clinical and medical consequences of dementia is the foundation of a risk management plan.

A picture is often worth a thousand words, complex and multiple ideas and talking points can be conveyed best by a visual, an image can be remembered and recalled at the point of decisions and discussions. We have referenced the attached visuals throughout the text of our informational.

The illustrations selected can accomplish a visual memory and can become the drive for understanding, open the door for needed conversations, and be the point of change at time of conflict. Most importantly, it can be used for education of staff, posing questions for critical thinking, and gateway introduction and understanding for families.

The *Progression Timeline* offers checkpoints along the journey of dementia progression where most events occur highlighting the expected changes and the most frequent legal allegations.

The *Risk Mitigation Sieve* takes the main exposures and events and filters out many contributing factors which are often overlooked for discussion as contributing to many outcomes often attributed to the care setting and the caregivers. It can provide an opportunity for what to consider for both conversations and documentation supporting some unavoidable outcomes.

Both can be used to raise awareness for encounters before and after an admission of expectations and reality.

Risk Tips

- Market your limitations along with your capabilities
- Do not promise retention
- Let families know dementia residents often have difficulty complying with interventions
- Train staff with scenarios they will encounter
- Use the five step rule for setting staff expectations
- Outline managerial expectations for monitoring changes and resident location
- Assume there will be falls, train staff for rapid response, assessment, and documentation
- Understand the exposures and develop a plan, the exposure is the foundation of most event escalations